



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 December 14, 2022 Public Meeting:

1. Draft Recommendation on the Traditional Medicare Performance Adjustment (MPA) for CY 2023

WRITTEN COMMENTS ON THE AFOREMENTIONED STAFF DRAFT RECOMMENDATIONS ARE DUE IN THE COMMISSION'S OFFICES ON OR BEFORE DECEMBER 21, 2022, UNLESS OTHERWISE SPECIFIED IN THE RECOMMENDATION.



**601st Meeting of the Health Services Cost Review Commission
December 14, 2022**

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

EXECUTIVE SESSION

11:30 am

1. Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104
2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104
3. Update on Commission Response to COVID-19 Pandemic - Authority General Provisions Article, §3-103 and §3-104

PUBLIC MEETING

1:00 pm

1. Review of Minutes from the Public and Closed Meetings on November 9, 2022
2. Docket Status – Cases Closed
2589R – Shady Grove Adventist Medical Center 2601N - Luminis Doctor’s Community Medical Center
3. Docket Status – Cases Open
2603R – Luminis Anne Arundel Medical Center 2608R – Shady Grove Adventist Medical Center
2609A – Johns Hopkins Health System 2610A – Johns Hopkins Health System
4. RY 2025 Maryland Hospital Acquired Conditions Policy – Final Recommendation
5. CY 2022 Performance and Adjustments to TCOC - Final Recommendation
6. Traditional MPA – CY 2023 Performance – Draft Recommendation
7. Statewide Integrated Health Improvement Strategy (SIHIS) Overview – 2021 Performance
8. Policy Update and Discussion
 - a. Community Benefits – FY 2021 Activities
 - b. Maternal and Child Health – FY 2022 Report
9. Hearing and Meeting Schedule

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

AS OF DECEMBER 6, 2022

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

Docket Number	Hospital Name	Date Docketed	Purpose	Analyst's Initials	File Status
2603R	Luminis Anne Arundel Medical Center	7/22/2022	FULL	KW	OPEN
2608R	Shady Grove Adventist Medical Center	7/18/2022	CAPITAL	GS	OPEN
2609A	Johns Hopkins Health System	7/6/2022	ARM	DNP	OPEN
2610A	Johns Hopkins Health System	11/30/2022	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

**IN RE: THE APPLICATION FOR
ALTERNATIVE METHOD OF RATE
DETERMINATION
JOHNS HOPKINS HEALTH
SYSTEM
BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2022
* FOLIO: 2419
* PROCEEDING: 2609A**

Staff Recommendation

December 14, 2022

I. INTRODUCTION

Johns Hopkins Health System (the “System”) filed an application with the HSCRC on July 6, 2022, on behalf of its member hospitals (the Hospitals), requesting approval to continue to participate in a global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplant services. The Hospitals request that the Commission approve the arrangement for one year beginning September 1, 2022.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

favorable.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one-year period beginning September 1, 2022. The Hospitals must file a renewal application annually 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
ALTERNATIVE METHOD OF RATE
DETERMINATION
JOHNS HOPKINS HEALTH
SYSTEM
BALTIMORE, MARYLAND**

*** BEFORE THE MARYLAND HEALTH
* SERVICES COST REVIEW
* COMMISSION
* DOCKET: 2022
* FOLIO: 2420
* PROCEEDING: 2610A**

Staff Recommendation

December 14, 2022

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on November 30, 2022, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (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 heart failure services and solid organ and bone marrow transplants with Optum Health, a division of United HealthCare Services, for a period of one year beginning January 1, 2023.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

The staff found the experience for this arrangement last year to be favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for heart failure, solid organ, and bone marrow transplant services for a one-year period commencing January 1, 2023. 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.



maryland
health services
cost review commission

Final Recommendation for the Maryland Hospital Acquired Conditions Program for Rate Year 2025

December 14, 2022

This document contains final recommendations for the RY 2025 Maryland Hospital Acquired Conditions Program.

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List of Abbreviations

AHRQ	Agency for Health Care Research and Quality
APR-DRG	All Patients Refined Diagnosis Related Groups
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DRG	Diagnosis-Related Group
FFY	Federal Fiscal Year
FY	State Fiscal Year
HAC	Hospital-Acquired Condition
HAI	Hospital Associated Infection
HSCRC	Health Services Cost Review Commission
ICD	International Statistical Classification of Diseases and Related Health Problems
MHAC	Maryland Hospital-Acquired Condition
NHSN	National Healthcare Safety Network
NQF	National Quality Forum
PMWG	Performance Measurement Work Group
POA	Present on Admission
PPC	Potentially Preventable Complication
PSI	Patient Safety Indicator
QBR	Quality-Based Reimbursement
RY	Rate Year
SIR	Standardized Infection Ratio
SOI	Severity of Illness
TCOC	Total Cost of Care
VBP	Value-Based Purchasing
YTD	Year to Date

Key Methodology Concepts and Definitions

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

At-risk discharge: Discharge that is eligible for a PPC based on the measure specifications

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

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

Severity of Illness (SOI): 4-level classification of minor, moderate, major, and extreme that can be used with APR-DRGs to assess the acuity of a discharge.

APR-DRG SOI: Combination of Diagnosis Related Groups with Severity of Illness levels, such that each admission can be classified into an APR-DRG SOI "cell" along with other admissions that have the same Diagnosis Related Group and Severity of Illness level.

Case-Mix Adjustment: Statewide rate for each PPC (i.e., normative value or "norm") is calculated for each diagnosis and severity level. These **statewide norms** are applied to each hospital's case-mix to determine the expected number of PPCs, a process known as **indirect standardization**.

Observed/Expected Ratio: PPC rates are calculated by dividing the observed number of PPCs by the expected number of PPCs. Expected PPCs are determined through case-mix adjustment.

Diagnostic Group-PPC Pairings: Complications are measured at the diagnosis and Severity of Illness level, of which there are approximately 1,200 combinations before one accounts for clinical logic and PPC variation.

Zero norms: Instances where no PPCs are expected because none were observed in the base period at the Diagnosis Related Group and Severity of Illness level.

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effects on Health Equity
<p>The quality programs operated by the Health Services Cost Review Commission, including the Maryland Hospital Acquired Conditions (MHAC) program, are intended to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance.</p>	<p>The MHAC program is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time.</p>	<p>The MHAC policy currently holds 2 percent of inpatient hospital revenue at-risk for complications that may occur during a hospital stay as a result of treatment rather than the underlying progression of disease. Examples of the types of hospital acquired conditions included in the current payment program are respiratory failure, pulmonary embolisms, and surgical-site infections.</p>	<p>This policy affects a hospital's overall GBR and so affects the rates paid by payers at that particular hospital. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.</p>	<p>Historically the MHAC policy included the better of improvement and attainment, which incentivized hospitals to improve poor clinical outcomes that are often emblematic of disparities. The protection of improvement has since been phased out to ensure that poor clinical outcomes and the associated health disparities are not made permanent, which is especially important for a measure that is limited to in-hospital complications. In the future, the MHAC policy may provide direct hospital incentives for reducing disparities, similar to the approved readmission disparity gap improvement policy.</p>

Recommendations

The MHAC policy was redesigned in Rate Year (RY) 2021 to modernize the program for the new Total Cost of Care Model. This RY 2025 final recommendation, in general, maintains the measures and methodology that were developed and approved for RYs 2022 through 2024.¹

These are the final recommendations for the RY 2025 Maryland Hospital Acquired Conditions (MHAC) program:

1. Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.
 - a. Maintain a focused list of PPCs in the payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
 - b. Assess monitoring PPCs based on clinical recommendations, statistical characteristics, and recent trends to prioritize those for future consideration for updating the measures in the payment program.
 - c. Engage hospitals on specific PPC increases as indicated/appropriate to understand trends and discuss potential quality concerns.
2. Use more than one year of performance data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs). The performance period for small hospitals will be CYs 2022 and 2023.
3. Continue to assess hospital performance on attainment only.
4. Continue to weigh the PPCs in the payment program by 3M cost weights as a proxy for patient harm.
5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent and continuous linear scaling with a hold harmless zone between 60 and 70 percent.

¹ See the [RY 2022 policy](#) for detailed discussion of the MHAC redesign, rationale for decisions, and approved recommendations.

Introduction

Maryland hospitals have been funded under a population-based revenue system with a fixed annual revenue cap under the All-Payer Model agreement with the Centers for Medicare & Medicaid Services (CMS) beginning in 2014, and continuing under the current Total Cost of Care (TCOC) Model agreement, which took effect in 2019. Under the global budget system, hospitals are incentivized to shift services to the most appropriate care setting and simultaneously have revenue at risk in Maryland's unique, all-payer, pay-for-performance quality programs; this allows hospitals to keep any savings they earn via better patient experiences, reduced hospital-acquired infections, or other improvements in care. Maryland systematically revises its quality and value-based payment programs to better achieve the state's overarching goals: more efficient, higher quality care, and improved population health. It is important that the Commission ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) quality programs reward quality improvements and achievements that reinforce the incentives of the global budget system, while guarding against unintended consequences and penalizing poor performance.

The Maryland Hospital Acquired Conditions (MHAC) program is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time. The program currently holds 2 percent of hospital revenue at-risk for hospital acquired complications that may occur during a hospital stay as a result of treatment rather than the underlying progression of disease. Examples of the types of hospital acquired conditions included in the current payment program are respiratory failure, pulmonary embolisms, and surgical-site infections.

For MHAC, as well as the other State hospital quality programs, annual updates are vetted with stakeholders and approved by the Commission to ensure the programs remain aggressive and progressive with results that meet or surpass those of the national CMS analogous programs (from which Maryland must receive annual exemptions). For purposes of the RY 2025 MHAC Final Policy, staff vetted the updated final policy in October with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies.

Additionally, with the onset of the Total Cost of Care Model Agreement with CMS on January 1, 2019, each program was overhauled to ensure they support the goals of the Model. For the MHAC policy, the overhaul was completed during 2018, which entailed an extensive stakeholder engagement effort. The major accomplishments of the MHAC program redesign were focusing the payment incentives on a narrower list of clinically significant complications, moving to an attainment only system given Maryland's sustained improvement on complications, adjusting the scoring methodology to better differentiate hospital performance, and weighing complications by their associated cost weights as a proxy for patient harm. The

redesign also assessed how hospital performance is converted to revenue adjustments, and ultimately recommended maintaining the use of a linear revenue adjustment scale with a hold harmless zone.

In light of the recent MHAC program redesign, and the COVID-19 Public Health Emergency (PHE), this RY 2025 MHAC policy proposes minimal changes to the program. The assessment section does, however, include an evaluation of PPCs in “Monitoring” status because the approved recommendations for RY 2021 and future rate years included identifying PPCs that due to worsening performance should be included back into the MHAC program. Furthermore, the assessment section outlines necessary timeline changes and the current plan to assess the impact of COVID-19 for both the RYs 2023 and 2024 policy.

Background

Exemption from Federal Hospital-Acquired Condition Programs

The Federal Government operates two hospital complications payment programs, the Deficit Reduction Act Hospital Acquired Condition program (DRA-HAC), which reduces reimbursement for hospitalizations with inpatient complications, and the HAC Reduction Program (HACRP), which penalizes hospitals with high rates of complications. Detailed information, including HACRP complication measures, may be found in Appendix I.

Because of the State’s unique all-payer hospital model and its global budget system, Maryland does not directly participate in the federal pay-for-performance programs. Instead, the State administers the Maryland Hospital Acquired Conditions (MHAC) program, which relies on quality indicators validated for use with an all-payer inpatient population. However, the State must submit an annual report to CMS demonstrating that Maryland’s MHAC program targets and results continue to be aggressive and progressive, i.e., that Maryland’s performance meets or surpasses that of the nation. Specifically, the State must ensure that the improvements in complication rates observed under the All-Payer Model through 2018 are maintained throughout the TCOC model. Based on the 2020 PPC results, CMS granted Maryland exemption from the federal pay-for-performance programs (including the HAC Reduction Program) for Federal Fiscal Year 2022 on October 29, 2021; HSCRC is awaiting CMS’ response to our exemption request for FFY 2023.

Overview of the MHAC Policy

The MHAC program, which was first implemented for RY 2011, is based on a system developed by 3M Health Information Systems (3M) to identify potentially preventable complications (PPCs) using present-on-admission for eligible secondary diagnosis codes available in claims data. 3M originally developed

specifications for 65 PPCs², which are defined as harmful events that develop after the patient is admitted to the hospital and may result from processes of care and treatment rather than from the natural progression of the underlying illness. For example, the program holds hospitals accountable for venous thrombosis and sepsis that occur during inpatient stays. These complications can lead to 1) poor patient outcomes, including longer hospital stays, permanent harm, and death; and 2) increased costs. Thus, the MHAC program is designed to provide incentives to improve patient care by adjusting hospital budgets based on PPC performance.

MHAC Methodology

Figure 1 provides an overview of the three steps in the RY 2024 MHAC methodology that converts hospital performance to standardized scores, and then payment adjustments, as outlined below:

Step 1. For the PPCs identified for payment, clinically-determined global and PPC-specific exclusions, as well as volume based hospital-level exclusions are identified to ensure fairness in assignment of complications.

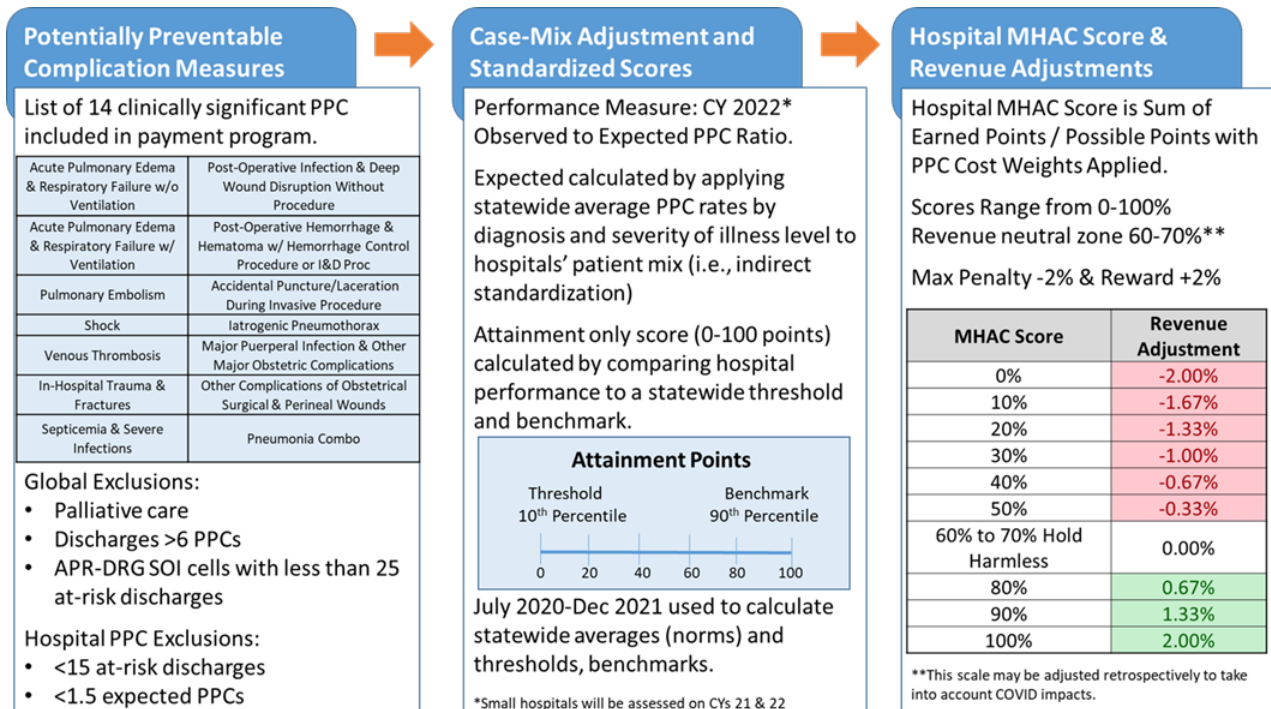
Step 2. Case-mix adjustment is used to calculate observed to expected ratios that are then converted to a standardized point based score (0-100 points) based on each hospital's attainment levels using the same scoring methodology that is used for CMS Value-Based Purchasing and Maryland QBR program.

Step 3. Overall hospital scores are then calculated by taking the points for each PPC and multiplying by the 3M PPC cost weights, then summing numerator (points scored) and denominator (possible points) across the PPCs to calculate a percent score. A linear point scale set prospectively is then used to calculate the revenue adjustment percent. This prospective scaling approach differs from national programs that relatively rank hospitals after the performance period.

Because of the ongoing COVID PHE, consistent with the CMS HAC reduction program, staff has requested that CMS allow the state to suspend revenue adjustments for the RY 2023 program. Further, working with PMWG and other stakeholders, staff will consider retrospective adjustments to the approved RY 2024 methodology outlined above and illustrated in Figure 1 below. Among the potential changes are inclusion versus exclusion of COVID patients, updates to the base and performance periods, and updates to the performance standards. Additional information on the current MHAC policy can be found in Appendix II.

² In RY 2020, there were 45 PPCs or PPC combinations included in the program, from an initial 65 PPCs in the software, as 3M had discontinued some PPCs and others were deemed not suitable for a pay-for-performance program.

Figure 1. Overview Rate Year 2024 MHAC Methodology



Assessment

In order to develop the RY 2025 MHAC policy, staff solicited input from the PMWG and other stakeholders. In general, stakeholders support the staff's recommendation to not make major changes to the RY 2025 MHAC program. This section of the report provides an overview of the statewide PPC trends—for those used for payment, under monitoring, and overall—and updates related to 3M clinical logic and MHAC methodology.

Statewide PPC Performance Trends

Complications Included in Payment Program

Under the All-Payer Model, Maryland hospitals saw a dramatic decline in complications and, as a State, well exceeded the requirement of a 30 percent reduction by the end of CY 2018. These reductions were achieved through clinical quality improvement, as well as improvements in documentation and coding.

As mentioned previously, the MHAC redesign assessed which PPCs should be included in the pay-for-performance program based on criteria developed by the Clinical Adverse Events Measures (CAEM) subgroup that are outlined in the "Monitored Complications" section below.

Under the TCOC Model, Maryland must maintain these improvements by not exceeding the CY 2018 PPC rates. Figure 2 below shows the statewide observed to expected (O/E) ratio from 2016 through June CY 2022.³ The O/E ratio presents the count of observed PPCs divided by the calculated number of expected PPCs (which is generated using normative values applied to the case-mix of discharges a hospital experiences). An O/E Ratio of greater than 1 indicates that a hospital experienced more PPCs than expected, and conversely, an O/E Ratio less than one indicates that a hospital experienced fewer PPCs than expected. Figure 2 below also indicates how Maryland is performing relative to CY 2018, which is the time period that will be used to assess any backsliding on performance.⁴ Specifically, there has been a 22% decrease in the ratio based on the most recent data available (CY 2018 O/E ratio = 1.18 and CY 2021 YTD O/E ratio = 0.92).

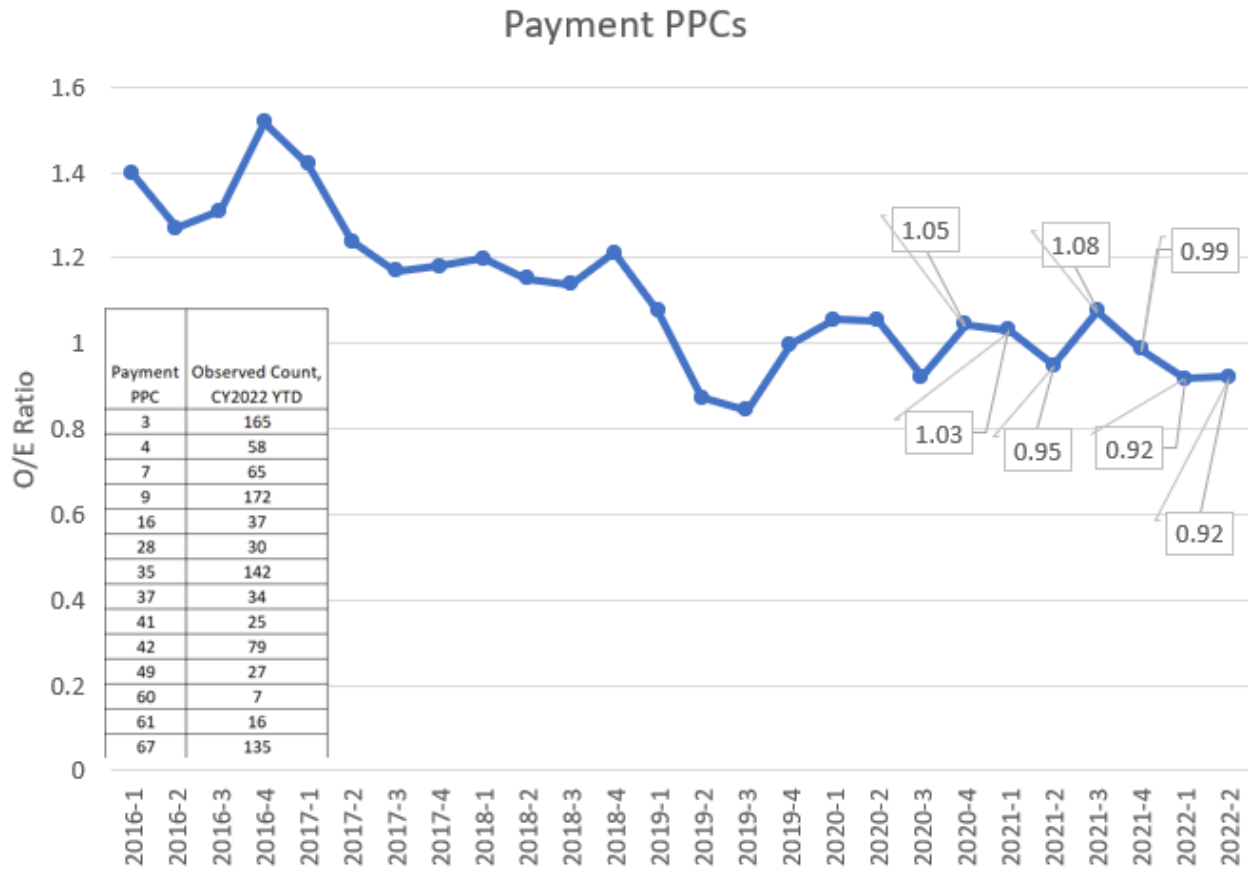
PPCs in the MHAC payment program include:

- 3 Acute Pulmonary Edema and Resp Failure w/o Ventilation
- 4 Acute Pulmonary Edema, Resp Failure w/ventilation
- 7 Pulmonary Embolism
- 9 Shock
- 16 Venous Thrombosis
- 28 In-Hospital Trauma and Fractures
- 35 Septicemia & Severe Infections
- 37 Post-Operative Infection & Deep Wound Disruption Without Procedure
- 41 Post-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D
- 42 Accidental Puncture/ Laceration During Invasive Procedure
- 49 Iatrogenic Pneumothorax
- 60 Major Puerperal Infection and Other Major Obstetric Complications
- 61 Other Complications of Obstetrical Surgical & Perineal Wounds
- 67 Pneumonia Combo (with and without aspiration)

³ Staff notes that, consistent with federal policies during the COVID Public Health Emergency, PPC data from January-June 2020 will not be used for assessing quality of care.

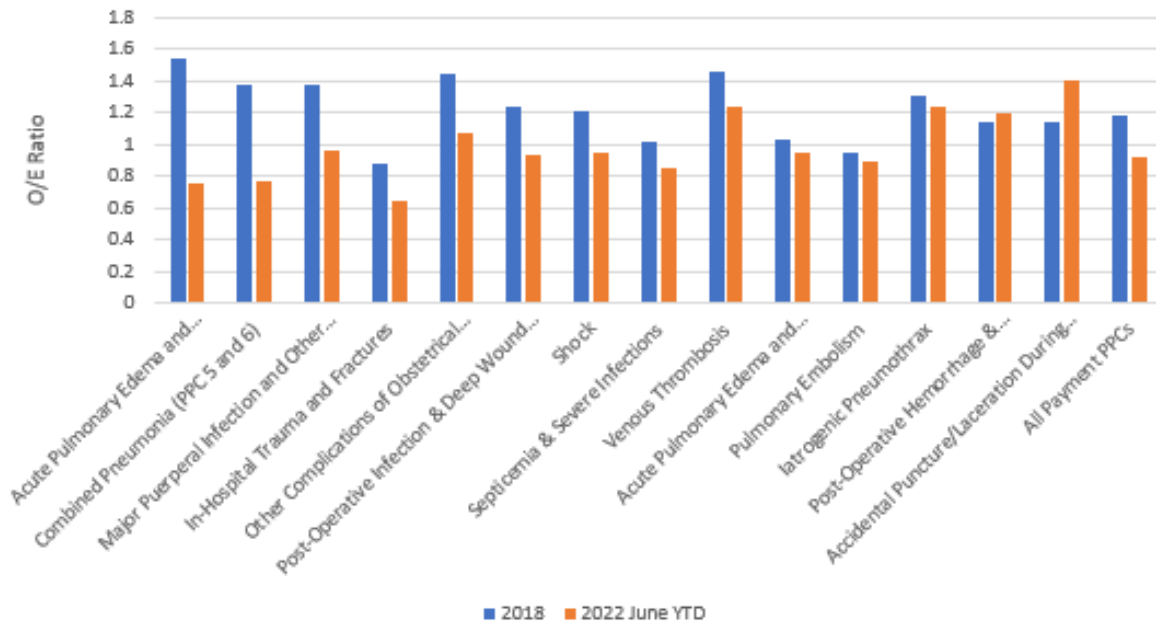
⁴Beginning in v38 of the 3M PPC grouper, COVID exclusions vary by PPC.

Figure 2. Payment Program PPCs Quarterly Observed to Expected Ratios CY 2016 to CY 2022 June



In terms of specific improvements among the 14 payment PPCs, Figure 3 shows the O/E ratios for CY 2018 and CY 2022 YTD, sorted from greatest percent decrease (on the left) to greatest percent increase (on the right). The two PPCs that worsened during this time period include PPC 41- Postoperative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D and PPC 42-Accidental Puncture/ Laceration During Invasive Procedure. The three PPCs with the greatest decreases include PPC 4- Acute Pulmonary Edema, Resp Failure w/ventilation, PPC 60- Major Puerperal Infection and Other Major Obstetric Complications and PPC 67 - Pneumonia Combo (with and without aspiration).

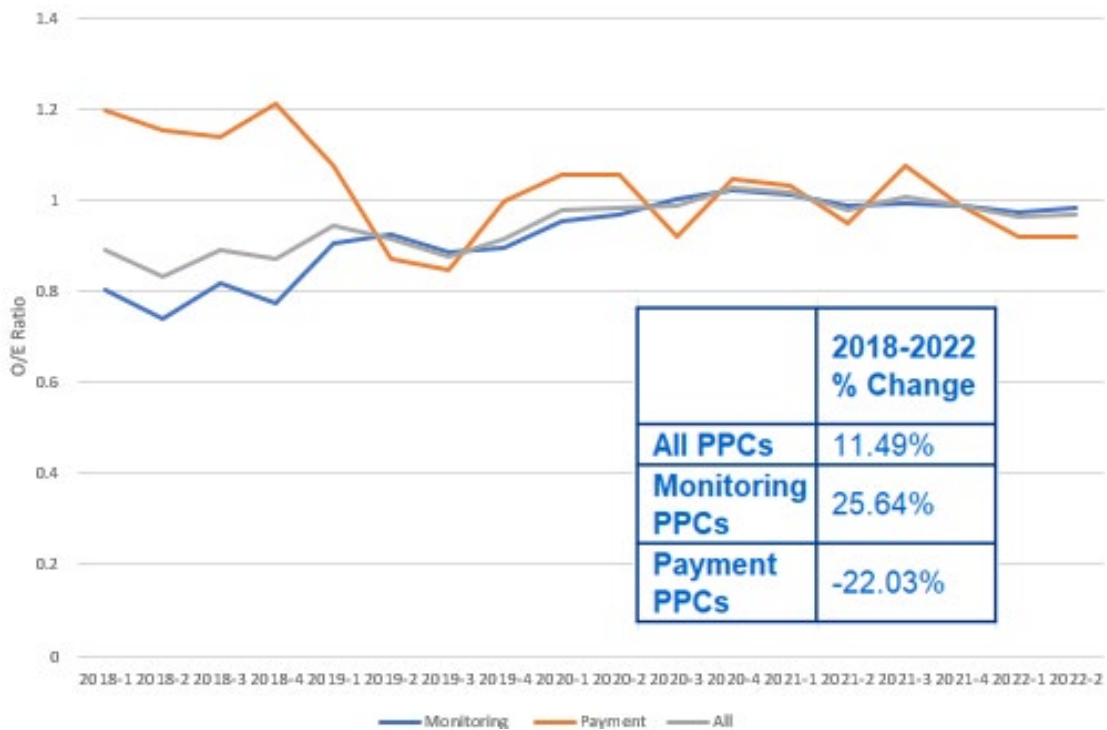
Figure 3. Payment Program PPC Observed to Expected Ratios CY 2019 and CY 2022 June YTD



Monitored Complications

In addition to focusing on a narrowed list of PPCs for payment, as stated previously, the RY 2021 MHAC policy included a recommendation to monitor the remaining PPCs. Staff fulfills this recommendation by monitoring all PPCs that are still considered clinically valid by 3M, and distinguishing between “Monitoring” and “Payment” PPCs. The overall PPC trend across all 54 PPCs shows that there has been an increase in the overall statewide O/E ratio from 0.87 in CY 2018 to 0.97 in CY 2022 YTD; the worsening performance is driven primarily by increases in PPCs under monitoring status, and not increases in the payment program PPCs, as illustrated in Figure 4. In the RY 2023 policy, staff reached out to hospitals with increases in monitoring PPCs and were given several reasons for the increase unrelated to declining quality. Appendix III provides the statewide changes in observed, expected, and the O/E ratios for the monitoring PPCs sorted by the observed PPCs that accounted for the largest proportion of the increase from 2018 to 2022 YTD through June.

Figure 4. PPC O/E Ratio Trends CY 2016 Through CY 2022 Qtr 2



As mentioned previously, the MHAC redesign process assessed which PPCs should be included in the pay-for-performance program based on criteria developed by the Clinical Adverse Events Measures (CAEM) subgroup. To support determining the monitored PPCs that are the best candidates for re-adopting into the payment program, staff and stakeholders are using the previously established criteria that include:

- PPC Data Analysis/Statistics
 - Greater than 50% increase in O/E ratio comparing 2022 to 2018
 - Rate per 1,000 generally 0.5 or above
 - Volume of observed events 100 or above (over two years)
 - Significant variation across hospitals O/E ratios less than .85 and greater than 1.15
 - At least half of the hospitals are eligible for the PPC
- Additional Considerations
 - PSI overlap
 - Clinical significance
 - Opportunity for improvement
 - All-payer

Based on staff assessment to date of monitored PPC trends and the criteria above, staff vetted the PPCs listed below with PMWG stakeholders⁵. Staff established two tiers of PPCs currently monitored to consider for use in the payment program, which were listed in the RY 2024 policy. For RY 2025, staff assessed the increases in monitoring PPCs and found that PPC 31 (Decubitus Ulcer) and PPC 47 (Encephalopathy), which were in the “Strongly Consider” tier in last year’s analysis, are still of concern according to the criteria for re-inclusion into the payment program that is listed above.

As stated above, staff is committed to ensuring that the additional monitored complication measures that are areas of concern and are deemed appropriate for a pay-for-performance program are proposed for re-inclusion. Therefore, Staff is recommending that PPC 47 be included in the MHAC payment program beginning in RY 2025. Staff’s analyses show that the O/E ratio of PPC 47 has consistently increased since CY 2016 and meets all of the aforementioned criteria for re-inclusion in the payment program; the results of these analyses are included in Appendix III. Although there are concerns regarding the increases seen in PPC 31, staff is not recommending inclusion in the payment program because of the significant overlap with PSI.

Small Hospital Criteria

The current MHAC program handles small hospitals in two ways: 1. Hospitals are excluded because they do not meet the minimum criteria of 2 expected and 20 at-risk for any PPC; and 2. Hospital performance is assessed using two years of data, if across all 14 payment PPCs the hospital has less than 20,000 at-risk or 20 expected. With the addition of PPC 47 encephalopathy, the staff propose increasing the criteria for using two years of data proportionally to the number of PPCs. So with 15 payment PPCs, two years of data will be used if a hospital has less than 21,500 at-risk or 22 expected PPCs.

COVID-19 Update

The RY 2025 policy will use data during the COVID PHE to determine performance standards (i.e., the two year base period will be July 2020 through June 2022) under PPC Grouper Version 40. Thus, the

⁵ In addition to adjusting the expected rates at each hospital by their APR-DRG Severity of Illness (SOI) patient mix, staff has noted that the MHAC program also relies on the work of 3M to review the PPC clinical logic and perform PPC Grouper updates annually. Staff has encouraged stakeholders, particularly clinicians, to review 3M updated global exclusion logic and PPC-specific assignment and exclusion logic and to weigh in on the monitored PPCs they believe are best to include in the payment program

performance standards will be determined post-COVID, thereby reducing the concerns of using a pre-COVID time period. As with PPC Grouper Version 39, the Version 40 grouper has clinical logic that determines if a discharge with a COVID diagnosis can be assigned a PPC, which in effect means that the PPC Grouper is acknowledging that these PPCs for COVID patients are not potentially preventable. Below is the list of PPCs that can be assigned for discharges with a COVID diagnosis, with the five payment PPCs bolded.

- 20 Other Gastrointestinal Complications
- 23 Genitourinary Complications except Urinary Tract Infection
- 26 Diabetic Ketoacidosis & Coma
- 27 Post-Hemorrhagic & Other Acute Anemia with Transfusion
- **28 In-Hospital Trauma and Fractures**
- 29 Poisonings except from Anesthesia
- 30 Poisonings due to Anesthesia
- 31 Pressure Ulcer
- 32 Transfusion Incompatibility Reaction
- 36 Altered Mental Status
- **37 Post-Procedural Infection & Deep Wound Disruption without Procedure**
- 38 Post-Procedural Infection & Deep Wound Disruption with Procedure
- 39 Reopening Surgical Site
- **42 Accidental Puncture/Laceration during Invasive Procedure**
- 44 Other Surgical Complication - Moderate
- 45 Post-Procedural Foreign Bodies and Substance Reaction
- 48 Other Complications of Medical Care
- **49 Iatrogenic Pneumothorax**
- 50 Mechanical Complication of Device, Implant & Graft
- 51 Gastrointestinal Ostomy Complications
- 52 Infection, Inflammation & Other Complications of Devices, Implants or Grafts except Vascular Infection
- 54 Central Venous Catheter-Related Infection
- 59 Medical & Anesthesia Obstetric Complications
- **60 Major Puerperal Infection and Other Major Obstetric Complications**
- 64 Other In-Hospital Adverse Events
- 65 Urinary Tract Infection
- 66 Catheter-Related Urinary Tract Infection

While staff believes the post-COVID base for performance standards and the grouper logic largely handle COVID concerns, hospitals should alert staff of any COVID concerns for review and possible retrospective changes.

Palliative Care Update

Last year for RY 2024, the MHAC program adjusted its methodology to exclude palliative care cases because the palliative care diagnosis became exempt from present-on-admission coding. Under the 3M PPC Grouper Version 40, palliative care has moved from a global exclusion to a PPC specific exclusion. Moving forward, the MHAC program will rely on the 3M clinical logic to determine what PPCs can be assigned to discharges with a palliative care diagnosis (whether or not present-on-admission). Below is the list of PPCs that can be assigned for discharges with a palliative care diagnosis, with the two payment PPCs (PPC 28 and 42) bolded.

Palliative care exclusion is applicable to all PPCs except:

- **PPC 28 In-Hospital Trauma and Fractures**
- PPC 29 Poisonings except from Anesthesia
- PPC 39 Reopening Surgical Site
- **PPC 41 Post-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D**
- **PPC 42 Accidental Puncture/Laceration during Invasive Procedure**
- PPC 48 Other Complications of Medical Care
- PPC 64 Other In-Hospital Adverse Events
- PPC 66 Catheter-Related Urinary Tract Infection

Case-Mix Adjusted PPC Rates

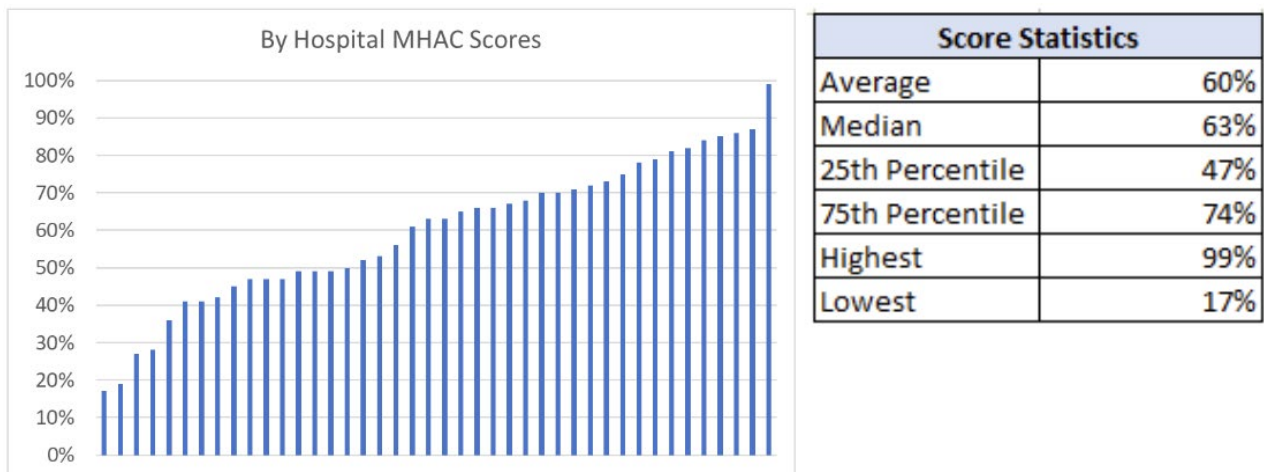
As Maryland hospitals continue to improve on payment PPCs, staff plan to pursue statistical methods that will better address small cell size issues and statistical reliability and validity. Thus, during CY 2023, staff will work with our contractor MPR to explore whether changes are needed to the program. The methods that will be considered are similar to methods used by CMS for the same concerns (i.e., Bayesian smoothing) and modeling will be presented to the PMWG in the winter/spring for consideration in RY 2026.

Hospital Scores and Revenue Adjustments

The hospital scores are calculated across all payment PPCs and then converted to revenue adjustments using a prospectively determined revenue adjustment scale, which allows hospitals to track their progress

throughout the performance period. Since the redesign the scale has remained the same--that is it goes from 0 to 100 percent with a hold harmless zone between 60 and 70 percent. Despite historical concerns regarding the lack of a continuous scale from some stakeholders, staff still believe that the hold harmless zone is reasonable given the lack of national benchmarks for establishing a cut-point. Using historical data under v39 of the PPC grouper, staff modeled scores for hospitals with encephalopathy included. Figure 5 shows the distribution of hospital scores and statistics indicating for example that the median score was 63 percent. Given the time periods used for this modeling (Base: FY 2021 and 2022; Performance CY 2021), these results should be interpreted with caution since CMS and the HSCRC suspended the RY 2023 MHAC program that was based on CY 2021 data. Furthermore, hospital revenue adjustments are not included since the statewide numbers are skewed by the large hospitals. However, using the current RY 2024 scale, 19 hospitals would receive a penalty, 10 hospitals would be held harmless (i.e., no penalty or reward), and 13 hospitals would receive a reward. Given the average scores are within the hold harmless zone, staff do not recommend changing the current revenue adjustments scale for RY 2025.

Figure 5. Modeled MHAC Scores



Health Equity

Over the past year, Staff began to analyze the quality programs and measures for racial and sociodemographic disparities. Specifically for the MHAC program, the results for the payment PPCs were stratified by race, payer and area deprivation index (ADI) and was risk-adjusted for age, sex, Admit-DRG, and Severity of Illness level. Results of this analysis suggested that there are statistically insignificant differences between racial categories; however, there were statistically significant differences between payers and ADI categories. While statistically significant differences were found between payers and ADI

categories, the odds ratios are relatively low and are, therefore, not an area of large concern for staff compared to the disparities uncovered in other quality measures, for example, Timely Follow-Up. Staff remains committed to addressing health equity, but at this time does not recommend including additional incentives for reducing disparities in PPC performance because of the overall low rates in PPCs and the relatively low odds ratios between payer and ADI categories. Over the next year, Staff will continue to monitor disparities in the quality programs' measures and develop disparity measure(s) and incentives that will drive improvement in disparities.

Stakeholder Feedback and Responses

Staff discussed the draft policy with PMWG and received one comment letter in response to the RY 2025 draft MHAC policy. The one letter received from the Maryland Hospital Association was supportive of the draft recommendation, which largely remains unchanged. There was support from both PMWG members and the MHA with the inclusion of the PPC 47 encephalopathy. As always the staff appreciate the expertise of stakeholders who provide input on our quality policies.

Recommendations

The MHAC policy was redesigned in Rate Year (RY) 2021 to modernize the program for the new Total Cost of Care Model. This RY 2025 final recommendation, in general, maintains the measures and methodology that were developed and approved for RY 2024.⁶

These are the final recommendations for the RY 2025 Maryland Hospital Acquired Conditions (MHAC) program:

1. Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.
 - a. Maintain a focused list of PPCs in the payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
 - b. Assess monitoring PPCs based on clinical recommendations, statistical characteristics, and recent trends to prioritize those for future consideration for updating the measures in the payment program.
 - c. Engage hospitals on specific PPC increases as indicated/appropriate to understand trends and discuss potential quality concerns.

⁶ See the [RY 2024 policy](#) for detailed discussion of the MHAC redesign, rationale for decisions, and approved recommendations

2. Use more than one year of performance data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs). The performance period for small hospitals will be CYs 2022 and 2023.
3. Continue to assess hospital performance on attainment only.
4. Continue to weigh the PPCs in the payment program by 3M cost weights as a proxy for patient harm.
5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent and continuous linear scaling with a hold harmless zone between 60 and 70 percent.

Appendix I. Background on Federal Complication Programs

The Federal Government operates two hospital complications payment programs, the Deficit Reduction Act Hospital Acquired Condition program (DRA-HAC) and the HAC Reduction Program (HACRP), both of which are designed to penalize hospitals for post-admission complications.

Federal Deficit Reduction Act, the Hospital-Acquired Condition Present on Admission Program

Beginning in Federal Fiscal Year 2009 (FFY 2009), per the provisions of the Federal Deficit Reduction Act, the Hospital-Acquired Condition Present on Admission Program was implemented. Under the program, patients were no longer assigned to higher-paying Diagnosis Related Groups if certain conditions were acquired in the hospital and could have reasonably been prevented through the application of evidence-based guidelines.

Hospital-Acquired Condition Reduction Program

CMS expanded the use of hospital-acquired conditions in payment adjustments in FFY 2015 with a new program, entitled the Hospital-Acquired Condition Reduction Program, under the authority of the Affordable Care Act. That program focuses on a narrower list of complications and penalizes hospitals in the bottom quartile of performance. Of note, as detailed in Figure 1 below, all the measures in the Hospital-Acquired Condition Reduction Program are used in the CMS Value Based Purchasing program, and the National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures are also used in the Maryland Quality Based Reimbursement (QBR) program.

Figure 1. CMS Hospital-Acquired Condition Reduction Program (HACRP) FFY 2020 Measures

<p>Recalibrated Patient Safety Indicator (PSI) measure:[^]</p> <ul style="list-style-type: none"> ● PSI 03 – Pressure Ulcer Rate ● PSI 06 – Iatrogenic Pneumothorax Rate ● PSI 08 – In-Hospital Fall with Hip Fracture Rate ● PSI 09 – Perioperative Hemorrhage or Hematoma Rate ● PSI 10 – Postoperative Acute Kidney Injury Requiring Dialysis Rate ● PSI 11 – Postoperative Respiratory Failure Rate ● PSI 12 – Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate ● PSI 13 – Postoperative Sepsis Rate ● PSI 14 – Postoperative Wound Dehiscence Rate ● PSI 15 – Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate
Central Line-Associated Bloodstream Infection (CLABSI) ^{^*}
Catheter-Associated Urinary Tract Infection (CAUTI) ^{^*}
Surgical Site Infection (SSI) – colon and hysterectomy ^{^*}
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia ^{^*}
Clostridium Difficile Infection (CDI) ^{^*}

[^]Recalibrated PSI Composite Measures included in the CMS VBP Program beginning FFY 2023. ^{*} National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures included in both the CMS VBP and Maryland QBR Programs.

For more information on the DRA HAC program POA Indicator, please refer to:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index>

For more information on the DRA HAC program, please refer to: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/FAQ-DRA-HAC-PSI.pdf>

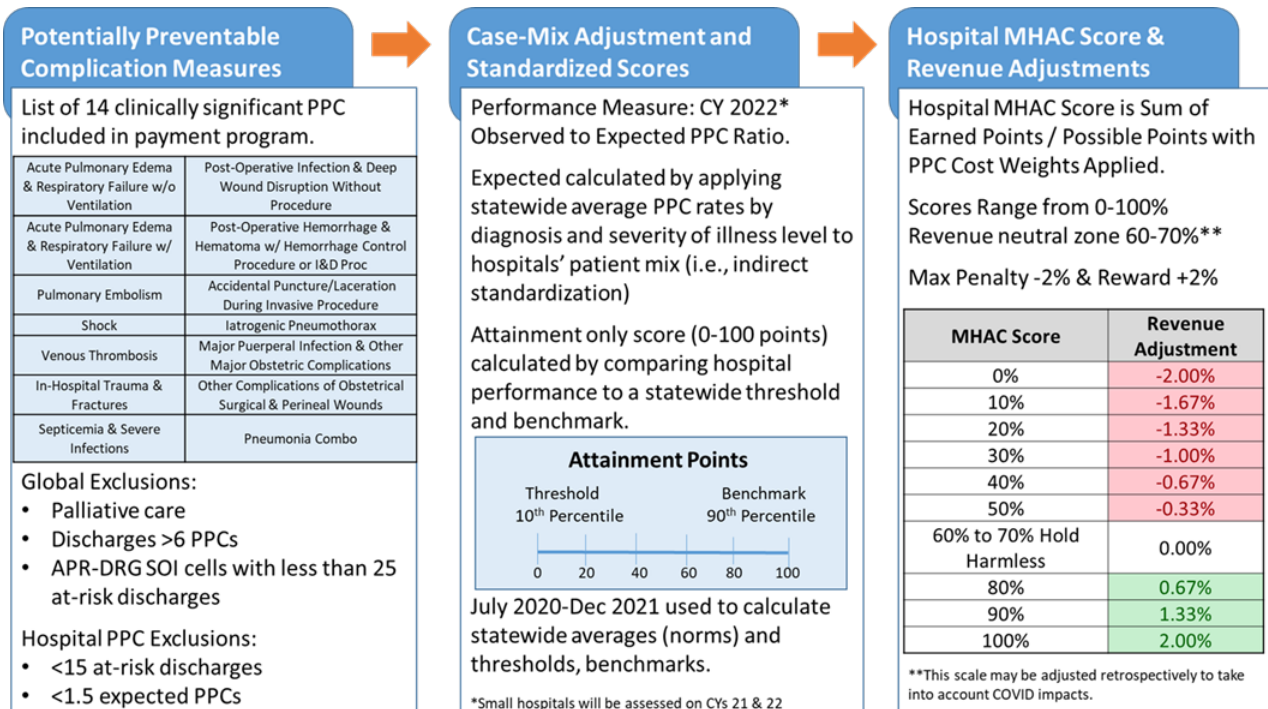
For more information on the HAC Reduction program, please refer to:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program>

Appendix II: RY 2024 MHAC Program Methodology

Figure 1 below provides a summary overview of the approved RY 2023 MHAC methodology.

Figure 1. Overview of RY 2024 Approved MHAC Methodology



Performance Metric

The methodology for the MHAC program measures hospital performance using the Observed (O) /Expected (E) ratio for each PPC. Expected number of PPCs are calculated using historical data on statewide PPC rates by All Patient Refined Diagnosis Related Group and Severity of Illness Level (APR-DRG SOI). See below for details on how expected number of PPCs are calculated for each hospital.

Observed and Expected PPC Values

The MHAC scores are calculated using the ratio of *Observed* : *Expected* PPC values.

Given a hospital's unique mix of patients, as defined by APR-DRG category and Severity of Illness (SOI) level, the HSCRC calculates the hospital's expected PPC value, which is the number of PPCs the hospital would have experienced if its PPC rate were identical to that experienced by a normative set of hospitals.

The expected number of PPCs is calculated using a technique called indirect standardization. For illustrative purposes, assume that every hospital discharge is considered "at-risk" for a PPC, meaning that all discharges would meet the criteria for inclusion in the MHAC program. All discharges will either have no

PPCs, or will have one or more PPCs. In this example, each discharge either has at least one PPC, or does not have a PPC. The unadjusted PPC rate is the percent of discharges that have at least one PPC.

The rates of PPCs in the normative database are calculated for each diagnosis (APR-DRG) category and severity level by dividing the observed number of PPCs by the total number of admissions. The PPC norm for a single diagnosis and severity level is calculated as follows:

Let:

N = norm

P = Number of discharges with one or more PPCs

D = Number of “at-risk” discharges

i = A diagnosis category and severity level

$$N_i = \frac{P_i}{D_i}$$

In the example, each normative value is presented as PPCs per discharge to facilitate the calculations in the example. Most reports will display this number as a rate per one thousand discharges.

Once the normative expected values have been calculated, they can be applied to each hospital. In this example, the normative expected values are computed for one diagnosis category and its four severity levels.

Consider the following example in Figure 2 for an individual diagnosis category.

Figure 2. Expected Value Computation Example for one Diagnosis Category

A Severity of illness Level	B At-risk Discharges	C Observed Discharges with PPCs	D PPCs per discharge (unadjusted PPC Rate)	E Normative PPCs per discharge	F Expected # of PPCs	G Observed: Expected Ratio
			= (C / B)	(Calculated from Normative Population)	= (B x E)	= (C / E) rounded to 4 decimal places
1	200	10	.05	.07	14.0	0.7143
2	150	15	.10	.10	15.0	1.0000
3	100	10	.10	.15	15.0	0.6667
4	50	10	.20	.25	12.5	0.8000
Total	500	45	.09		56.5	0.7965

For the diagnosis category, the number of discharges with PPCs is 45, which is the sum of discharges with PPCs (column C). The overall rate of PPCs per discharge in column D, 0.09, is calculated by dividing the total number of discharges with PPCs (sum of column C) by the total number of discharges at risk for PPCs (sum of column B), i.e., $0.09 = 45/500$. From the normative population, the proportion of discharges with PPCs for each SOI level for that diagnosis category is displayed in column E. The expected number of PPCs for each severity level shown in column F is calculated by multiplying the number of at-risk discharges (column B) by the normative PPCs per discharge rate (column E). The total number of PPCs expected for this diagnosis category is the expected number of PPCs for the severity levels.

In this example, the expected number of PPCs for the APR DRG category is 56.5, which is then compared to the observed number of discharges with PPCs (45). Thus, the hospital had 11.5 fewer observed discharges with PPCs than were expected for 500 at-risk discharges in this APR DRG category. This difference can be expressed as a percentage difference as well.

All APR-DRG categories and their SOI levels are included in the computation of the observed and expected rates, except when the APR-DRG SOI level has less than 30 at-risk discharges statewide.

PPC Exclusions

Consistent with prior MHAC policies, the number of at-risk discharges is determined prior to the calculation of the normative values (hospitals with <10 at-risk discharges are excluded for a particular PPC) and the normative values are then re-calculated after removing PPCs with <2 complication expected. The following exclusions will also be applied:

For each hospital, discharges will be removed if:

- Discharge is in an APR-DRG SOI cell has less than 31 statewide discharges.
- Discharge has a diagnosis of palliative care (this exclusion may be removed in the future once POA status is available for palliative care for the data used to determine performance standards); and
- Discharge has more than 6 PPCs (i.e., a catastrophic case, for which complications are probably not preventable).

For each hospital, PPCs will be removed if during July 2020 to December 2021:

- The number of cases at-risk is less than 15; and
- The expected number of PPCs is less than 1.5.

The PPCs for which a hospital will be assessed are determined using the July 2020 to December 2021 data and not reassessed during the performance period. This is done so that scores can be reliably calculated during the performance period from a pre-determined set of PPCs. The MHAC summary workbooks provide the excluded PPCs for each hospital.

Combination PPCs

Based on clinical input and 3M recommendation, starting in RY 2021 two pneumonia (PPC 5 Pneumonia & Other Lung Infections & PPC 6 Aspiration Pneumonia) PPCs were combined into single pneumonia PPC and the 3M cost weight is a simple average of the two PPC cost weights.

Hospital Exclusions

Acute care hospitals that do not have sufficient volume to have at least 15 at-risk and 1.5 expected for any payment program PPC are excluded from the MHAC policy.

Benchmarks and Thresholds

For each PPC, a threshold and benchmark value are calculated using the determined base period data. In previous rate years when improvement was also assessed, the threshold was set at the statewide median of 1 and the benchmark was the O/E ratio for the top performing hospitals that accounted for 25% of discharges. For RY 2021 under an attainment only methodology, staff adapted the MHAC points system to

allow for greater performance differentiation by moving the threshold to the value of the observed to expected ratio at the 10th percentile of hospital performance, moving the benchmark to the value of the observed to expected ratio at the 90th percentile of hospital performance, and assigning 0 to 100 points for each PPC between these two percentile values.

Attainment Points (possible points 0-100)

If the PPC ratio for the performance period is greater than the threshold, the hospital scores zero points for that PPC for attainment.

If the PPC ratio for the performance period is less than or equal to the benchmark, the hospital scores a full 100 points for that PPC for attainment.

If the PPC ratio is between the threshold and benchmark, the hospital scores partial points for attainment.

The formula to calculate the Attainment points is as follows:

- $\text{Attainment Points} = [99 * ((\text{Hospital's performance period score} - \text{Threshold}) / (\text{Benchmark} - \text{Threshold}))] + 0.5$

Calculation of Hospital Overall MHAC Score

To calculate the final score for each hospital, the attainment points earned by the hospital and the potential points (i.e., 100) for each PPC are multiplied by the 3M cost weights. Hospital scores across PPCs are calculated by summing the total weighted points earned by a hospital, divided by the total possible weighted points (100 per PPC * 3M cost weight). Figure 5 provides a hypothetical example of the points based scoring approach with the 3M cost weights.

RY 2023 Update: Small Hospital Methodology

Hospital-specific PPC inclusion requirements were maintained in the RY 2023 policy, i.e., all hospitals are required to have at least 15 at-risk discharges and 1.5 expected PPCs in order for a particular PPC to be included in the payment program. Because of the volatility in performance scores for smaller hospitals, the Commission also approved the following policy updates in RY 2022:

“Establish small hospital criteria for assessing performance under the MHAC policy based on the number of at-risk discharges and expected PPCs (i.e., small hospitals are those with less than 20,000 at-risk discharges and/or 20 expected PPCs across all payment program PPCs) as opposed to the number of PPC measure types, and for hospitals that meet small hospital criteria, increase

reliability of score by using two years of performance data to assess hospital performance (i.e., for RY 2022 use CY 2019 and 2020). “

Because of the COVID PHE, the above proposal was not implemented for RY 2022 but instead, the MHAC scores and revenue adjustments for RY 2021 were repeated in RY 2022.

For RY 2023, staff proposed to maintain the small hospital criteria and expected to utilize CY 2020 and CY2021 for the assessment of small hospitals. However, staff will need to reconsider this approach due to the COVID related suspension of data use for January to June of 2020. Thus, in the RY 2023 recommendations, staff proposed that for small hospitals more than one year of data be used, and that the performance period will be CY 2021 plus yet to be determined performance period. For example, if the Commission decides to use July to December 2020 data, then small hospitals could be assessed on data from July 2020 through December 2020 and January to December 2021

Appendix III: Monitoring PPCs

The table below shows the monitored PPCs O/E ratios for CY 22 YTD (through June) and the percent changes in the observed-to-expected ratio from CY 2018.

PPC	2022 YTD O/E Ratio	2018-2022 % Change
45: Post-Procedure Foreign Bodies	25.47%	-78.77%
2: Extreme CNS Complications	46.04%	-60.54%
5: Pneumonia & Other Lung Infections	77.78%	-50.42%
66: Catheter-Related Urinary Tract Infection	39.74%	-42.35%
6: Aspiration Pneumonia	73.74%	-35.06%
21: Clostridium Difficile Colitis	100.53%	-18.26%
39: Reopening Surgical Site	80.32%	-17.98%
65: Urinary Tract Infection without Catheter	99.37%	-10.84%
33: Cellulitis	99.45%	7.59%
11: Acute Myocardial Infarction	97.61%	10.91%
25: Renal Failure with Dialysis	138.51%	11.65%
19: Major Liver Complications	69.02%	13.86%
14: Ventricular Fibrillation/Cardiac Arrest	80.11%	14.32%

40: Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc	95.96%	20.43%
10: Congestive Heart Failure	84.03%	25.69%
27: Post-Hemorrhagic & Other Acute Anemia with Transfusion	99.22%	29.40%
54: Infections due to Central Venous Catheters	89.46%	36.95%
8: Other Pulmonary Complications	124.86%	38.89%
44: Other Surgical Complication- Mod	61.23%	40.33%
1: Stroke & Intracranial Hemorrhage	97.45%	46.48%
52: Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection	98.06%	47.07%
17: Major Gastrointestinal Complications without Transfusion or Significant Bleeding	90.32%	51.06%
29: Poisonings due to Anesthesia	142.19%	52.18%
20: Other Gastrointestinal Complications without Transfusion or Significant Bleeding	101.41%	53.47%
23: GU Complications Except UTI	102.47%	69.48%
48: Other Complications of Medical Care	90.20%	69.56%
34: Moderate Infections	92.15%	69.64%

50: Mechanical Complication of Device, Implant & Graft	99.59%	90.65%
13: Other Cardiac Complications	103.61%	103.73%
59: Medical & Anesthesia Obstetric Complications	105.55%	125.40%
18: Major Gastrointestinal Complication with Transfusuib or Significant Bleeding	117.47%	130.00%
51: Gastrointestinal Ostomy Complications	119.35%	131.61%
38: Post-Operative Wound Infection & Deep Wound Disruption with Procedure	81.23%	133.71%
53: Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infusions	181.68%	145.34%
15: Peripheral Vascular Complications Except Venous Thrombosis	124.30%	152.27%
26: Diabetic Ketoacidosis & Coma	121.83%	152.62%
64: Other In-Hospital Adverse Events	131.92%	155.78%
31: Decubitus Ulcer	98.59%	214.82%
47: Encephalopathy	130.43%	243.51%
30: Poisonings due to Anesthesia	0 Observed	
32: Transfusion Incompatibility Reaction	0 Observed	

Encephalopathy on the criteria used to re-include a monitoring PPC into the payment program.

Monitoring PPC: Analysis of PPC 47

- Greater than 50% increase in O/E ratio comparing to 2018
 - 177.27% in 2021, 243.51% for 2022
- Clinical considerations
- Observed counts: 233 in 2021, 138 in 2022
- 3M v39 cost weight: 0.8728
- Percent of hospitals with O/E ratios less than .85 or greater than 1.15 (variation): 86.62 in 2021, 82.5% in 2022
- Rate per 1000 at risk: 1.12 in 2021, 1.43 in 2022
- Predictive validity: Adequate
- Reliability: Substantial
- 3M Group: Other Medical and Surgical Complications
- 3M Level: Major



Maryland
Hospital Association

November 23, 2022

Dr. Alyson Schuster
Deputy Director, Quality Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dr. Schuster:

On behalf of the Maryland Hospital Association's 60 member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) *Draft Recommendations for the Maryland Hospital Acquired Conditions (MHAC) Program for Rate Year 2025*. **We support the staff's recommendations, which are largely unchanged from the existing policy.**

We support the staff's recommendation to re-include Potentially Preventable Complication (PPC) 47 Encephalopathy into the payment program due to rising rates and previously set criteria for inclusion. However, we believe it is important that hospitals can focus on addressing PPCs that are both clinically significant and have room for improvement. We look forward to working with staff to review trends in both payment and non-payment PPCs to ensure we maintain a focused set of PPCs in the program.

We look forward to continuing to work with the Commission on this and future policies.

Sincerely,

Brian Sims
Vice President, Quality & Equity

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



maryland
health services
cost review commission

Final Recommendation on Adjustments to Maryland Medicare Total Cost of Care Performance

December 14, 2022

This document contains a final recommendation on adjustments to Maryland's Medicare total cost of care performance.

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Introduction

The Commission is tasked with monitoring compliance of the Total Cost of Care (TCOC) Model contract agreement with CMMI, including attaining quality and population health targets, as well as providing consistent savings to the Medicare program. This recommendation examines the projected Medicare TCOC growth in Maryland in relation to the nation and potential adjustments that are warranted to ensure Maryland's growth stays closer to national growth.

Maryland has a rich history, dating back 50 years, of an all-payer hospital financing system. This system results in equitable distribution of hospital charges between payers and equitable funding of uncompensated care between hospitals, which ensures access to hospitals for all Maryland patients. This system provides the foundation for pay-for-performance programs, which link quality outcomes to hospital payment. Finally, this system provides support for the State-designated Health Information Exchange, workforce training, and other programs that strengthen the health care system in Maryland. The Commission applies all-payer rate adjustments to hospital payments in keeping with this tradition. This recommendation contains both all-payer rate adjustments, as well as Medicare-specific rate adjustments in recognition of the significant excess growth in Medicare costs in Maryland in calendar year 2022. Historically, the Commission has applied virtually all adjustments on an all-payer basis. The inclusion of Medicare-specific rate adjustments in this recommendation is a recognition of the size and timing of the current challenge which requires that payers other than Medicare need to bear a greater share of the shortfall given the challenge in the Medicare savings test. It does not represent a shift in the permanent focus of the Commission to adhere to an all-payer rate setting system. Moreover, the HSCRC remains committed to the goals and objectives of the Maryland TCOC Model to improve quality, reduce disparities, enhance access, and reduce costs for all Marylanders.

Background on Medicare TCOC Savings Targets

The State of Maryland is leading a transformative effort to improve care and lower healthcare spending growth through the Maryland TCOC Model. The TCOC Model builds on the successes of the All-Payer Model (APM), a 5-year demonstration project with the Centers for Medicare and Medicaid Services (CMS), which began January 1, 2014, and ended December 31, 2018. The TCOC Model, which began on January 1, 2019, aims to control total healthcare costs, enhance the quality of care, and improve health by progressively transforming care delivery across the healthcare system.

While the APM focused primarily on hospitals, the TCOC Model focuses on transforming care across the entire healthcare system. The Model will continue through 2028 so long as Maryland meets the following spending and quality requirements included in the TCOC State Agreement:

- Average annual hospital revenue growth per capita must stay at or below 3.58 percent on a cumulative basis since 2013;
- Annual savings in Maryland Medicare TCOC per Beneficiary must reach \$120 million by (2019) and \$300 million by 2023;
- The State's Medicare TCOC per Beneficiary growth cannot exceed national Medicare FFS growth by more than 1 percent in any given year or exceed the national growth two years in a row;
- The State must maintain the improvements made in certain hospital quality measures; and
- Ninety-five percent of in-state hospital regulated revenue must be under population-based budget agreements.

As of the end of CY 2021, Maryland successfully met all the annual spending requirements mandated under the State agreement. While 2020 to 2021 growth was above the nation (0.6 percent), i.e. Maryland's Medicare TCOC per beneficiary growth rate exceeded the nation by 0.60 percentage points,¹ this was a consequence of very low trends in 2020 during the early stages of the COVID crisis, which drove a bounce back in 2021.

Despite slight TCOC dissavings in CY 2021, average per capita revenue growth of 3.08 percent from 2019 to 2021 is well below the 3.58 percent contractual limit, and Maryland achieved \$380 million in annual Medicare savings — surpassing the \$300 million annual savings requirement for Model Year 5.

Continued ripple effects from the COVID-19 pandemic, including unpredictable changes in utilization patterns and escalated costs in labor and supplies, have resulted in Maryland's growth rate exceeding the nation in CY 2021, and this trend, unfortunately, continues through CY 2022.

CY 2022 Medicare TCOC Performance

Per the terms of the contract, Maryland is required to deliver \$267 million of annual TCOC savings in CY 2022, building up to \$300 million in annual Medicare TCOC savings in CY 2023. Based on projections, Maryland may miss the CY 2022 requirement by close to \$200 million, which could require a formal corrective action plan by the State. Staff have determined that the driving force behind the estimated TCOC dissavings is limited national growth of approximately 1.5 percent versus the CMS Office of the Actuary (OACT) estimates of 7.1 percent that the Commission utilized to establish the Update Factor for RY 2023 global budgets. Given that the TCOC Model allows Maryland hospitals to recoup most of the global budget revenues as volumes decline, it is self-evident that TCOC dissavings would increase when utilization in a national fee-for-service delivery system remains well below expectations.

¹ Annual Medicare TCOC Savings and Maryland year over year growth is subject to validation by CMMI.

If national growth fails to align with OACT estimates, the State could potentially miss the CY 2023 target of \$300 million annual TCOC savings, if no adjustments are made proactively. As CY 2023 is the final year before decisions are made on the future of the Model, Maryland should take proactive steps to improve Maryland’s performance relative to the nation.

The tables below show the projected annual Medicare TCOC savings for CY 2022, as well the comparison to the target for CY 2022 outlined in the contract with CMMI.

Table 1. Projected Annual Medicare TCOC Savings, CY 2022 (in \$ millions)

CY 2022	
Prior Year Savings	\$380
Projected Current Results	(\$300)
Year-end position	\$80

Table 2. Comparison to Target for CY 2022 (\$ in millions)

CY 2022	
Year-end position	\$80
Target	\$267
Excess/(Shortfall)	(\$197)

For purposes of this recommendation, Staff is focusing on the CY 2022 Medicare TCOC performance in planning its adjustments for CY 2023. Staff will continue to monitor and make adjustments as necessary into CY 2023. However, the deficit from CY 2022, projected to be almost \$200 million below the target, could potentially result in a formal corrective action plan in CY 2023 if the State takes no action and is significant enough to warrant proactive mid-year adjustments.

Adjustments to Maryland Medicare TCOC

The Commission dedicated time during the October Commission meeting to solicit input from stakeholders on addressing the excess TCOC growth that is seen in the current calendar year. During that meeting, the

Commission discussed considerations that should be used to guide the potential action steps to adjust Maryland's Medicare TCOC growth. These include:

- **Broad Mandate** - Commission should consider actions that support the broad mandate of the Model to drive savings and cost growth reductions, appropriately fund hospital delivery to incentivize care transformation, and fund population health efforts.
- **Recognition by State and Federal Partners** - Commission should advocate for State and Federal consideration to support Model success and appropriate adjustment actions.
- **Balance All-Payer and Medicare-only savings tools** - Commission should prioritize all-payer tools to preserve the character of the Maryland Model, to the extent possible. Given the magnitude of the excess cost growth in Maryland in CY 2022, the State should consider additional Medicare-only savings tools that provide one-time relief to the Medicare program.
- **Balance Temporary and Permanent Adjustments** - The 'miss' in CY 2022 appears to be attributable to slower than expected national growth in 2022; therefore, adjustments should be one-time in nature in response to the year over year dissavings. Permanent policy adjustments should be considered only if they contribute to longer-term Model success, or if there is a belief that the rebound of national TCOC growth will lag over a number of years.
- **Timing of Adjustments** - The adjustments should be implemented on January 1st to spread the global budget modifications over the entire calendar year, understanding that additional steps can be taken during the July 2023 update factor discussion to ensure compliance and to respond to national growth rate trends.
- **Adhere to Implementation of Existing Policies** - While short term adjustments may be necessary to adjust for the abnormality that occurred in CY 2022, the Commission should continue to implement existing policies and programs to plan for long-term Model success.

This final recommendation contains a number of options that could be implemented to adjust the trajectory of Maryland's Medicare TCOC growth, while adhering to the above-mentioned considerations. Importantly, the State is pursuing both federal and State relief that could be provided to assist the Model in meeting its contractual obligations. Some of the options are within the Commission's control and some require approval by CMMI or the State. The options also spread the actions across hospitals, payers, and the State including:

- All-Payer Rate adjustment effectuated through hospital rate orders (reversal of 0.40 percent provided in RY 2023 Update Factor)
- Medicare-only payment reductions effectuated through the Medicare Performance Adjustment (MPA) Savings Component

- Public Payer rate reductions through an increase to the Public Payer Differential for the duration of FY 2023 and 2024 (requires CMMI approval²)
- State contribution through Medicaid Deficit Assessment or additional grant dollars (requires State/Legislative approval)

Below is a table that summarizes the potential savings associated with each of the abovementioned actions that could be used to mitigate the excess cost of care growth in Maryland. If all options are implemented, hospital revenue would decrease by \$80 million beginning in January 2023, as the Medicare payment reduction would ultimately be offset by a reduction in the Medicaid Deficit Assessment.

Table 3. Savings/Cost by Payer Type

	All-Payer	Medicare	Medicaid/State	Individuals and Businesses holding Commercial Insurance	All Other (e.g. Medicare Advantage, Out-of-State Medicare)
Reversal of 0.40% Provided in RY 2023 Update Factor	(\$80 million)	(\$27 million)	(\$16 million)	(\$32 million)	(\$5 million)
Public Payer Differential Request	–	(\$26 million)	(\$16 million)	\$50 million	(\$8 million)
MPA Savings Component	-	(\$50 million)	–	–	–
State Contribution through Medicaid Deficit Assessment	-	–	\$50 million	–	–
Total	(\$80 million)	(\$103 million)	\$18 million	\$18 million	(\$13 million)

² Specifically, the contract reads that “The State shall submit a request to change the Public Payer Differential no fewer than 120 days before the first day of the Model Year in which the modified Public Payer Differential would take effect, or by such other deadline specified by CMS.”

In addition to the specific actions that the Commission votes to advance through all-payer rate reduction, Public Payer Differential, and MPA Savings Component, the State should expect to see additional savings through previously approved policies and GBR mechanics. These include:

- Scoring the net of Undercharge Reversals and RRIP rewards (\$5 million Medicare savings); and
- Scoring the result of approved traditional MPA policy for CY 22 (\$20 million Medicare savings)

Options to Scale Payment Reductions

Stakeholder feedback suggested that a portion of the required Medicare savings be scaled to inefficient hospitals or in some other manner that recognizes excess Medicare costs in the State. Specifically, the Maryland Hospital Association suggested a 25/75 split, so that 25 percent of the payment reduction is implemented as an across the board reduction according to revenue and 75 percent of the payment reduction is scaled to efficiency. In this recommendation, Staff presents three ways that the MPA Savings Component reduction could be scaled, coupled with an across the board reduction. For purposes of discussion by stakeholders and Commissioners, staff summarizes each option below as well as the advantages and disadvantages to each option, which should be made clear as the Commission decides how to implement the payment reduction. Further, Appendix 1 includes a chart comparing the scaling options and the respective effect on each hospital's revenue.

1. 2019 Integrated Efficiency

When contemplating this one-time adjustment on efficiency, the most salient issue is the point in time that is used to measure efficiency. The HSCRC Integrated Efficiency policy uses a 50/50 blend of hospital cost efficiency measured by a volume-adjusted ICC and a Total Cost of Care performance measure to account for the TCOC Model goals of reducing costs against a benchmark. The benefit of using this approach is that it aligns with the Commission's approved efficiency policy; however, the latest published Integrated Efficiency policy utilizes RY 2019 ICC volumes and 2018 TCOC benchmark data. Volumes in RY 2019, in a pre-pandemic time, are very different from the volume distribution that is currently at hospitals in Maryland. Additionally, the latest iteration of TCOC benchmarks available is 2020, which coincides with the greatest disruptions to service delivery during the COVID public health emergency.

The IE analysis was last used to make permanent rate reductions in RY 2022. Using IE will therefore duplicate the penalty associated with this time period. Furthermore, some of the change in volumes that affect a hospital's ICC position is due to hospitals' share of COVID related services (pulmonary, ventilator support and infectious disease), and by using an outdated ICC this payment reduction options could potentially penalize hospitals that incurred more COVID cases during RY 2021.

2. Traditional MPA

Another option is to utilize the ranking associated with the traditional MPA. The benefits to this approach is that it would recognize differential opportunities in TCOC performance but also put additional emphasis on a hospital's performance on TCOC since the start of the Model. Using this approach would further penalize hospitals that continue to drive excess Medicare total cost of care. The downside to this approach is that the MPA was not envisioned to be used in an ordinal ranking methodology and like the Integrated Efficiency policy it was not envisioned to scale all hospitals' revenue base.

3. 2021 Stand-in Efficiency

Due to the concerns over relying on hospital volumes and TCOC benchmarks from a pre-pandemic time period, staff have modeled a stand-in efficiency approach that utilizes RY 2021 volumes in the ICC (one half of the approved Integrated Efficiency policy) and TCOC performance under the MPA ranking approach described above. The downside to this approach is that these assessments do not align with the Commission's approved "Integrated Efficiency" policy and staff still have concerns about the degree to which hospital volumes in RY 2021 represent permanent market shares and efficiency. The benefit to this approach is that it does utilize more updated data that reflect potentially permanent shifts in market share that occurred since the start of the pandemic.

4. Across the Board

Similar to the all-payer rate reduction, the MPA Savings Component payment reduction could be distributed to all hospitals according to its share of gross hospital revenue. This approach is the simplest way to effectuate the payment reduction and could be applied to all acute care hospitals and freestanding medical facilities/emergency departments.

Taking into account the request by the Maryland hospital industry to scale the payment reduction to efficiency, Staff finds it permissible to use the updated stand-in efficiency measure on a one-time basis only. The more recent analysis of volumes takes into account the movement of services both between/among hospitals and away from hospitals to non-hospital settings. Additionally, the stand-in efficiency approach that utilizes MPA performance, in lieu of outdated TCOC benchmarks, appropriately penalizes hospitals that have continued to drive excess Medicare total cost of care. The payment scale should be coupled with an across the board reduction, as indicated by the hospital industry. All global budget hospitals that are not subject to the Integrated Efficiency policy and/or the MPA will incur a pro rata revenue reduction.

Public Comments

Staff received sixteen comment letters from the public including: Medicaid, MedChi, the Maryland Association of Health Underwriters, CareFirst, League of Life and Health Insurers of Maryland, Kaiser Permanente, the Mid-Atlantic Business Group of Health, the Maryland Hospital Association, Johns Hopkins Health System, University of Maryland Medical System, MedStar Health, Lifebridge Health, UPMC, TidalHealth, Mt. Washington Pediatric Hospital, and Ascension St. Agnes. On balance, all comment letters recognized the need for the Commission to take action to correct the problem of excess Medicare TCOC growth that has been seen in CY 2022. Perspectives varied on the amount of adjustment necessary and the tools that the Commission should use to make those adjustments.

All-Payer Rate Reduction Proposal

The Maryland Hospital Association, as well as the comment letters from hospitals and health systems object to the use of an all-payer rate reduction on the grounds that the adjustments are needed to correct Medicare growth, not all-payer revenue growth. The hospital letters further cite the continued financial challenges that collectively face the industry.

While Staff recognizes the fact that the adjustment is needed to achieve Medicare TCOC financial targets, the underlying structure of the Model is an all-payer rate setting system. Any actions taken to address excess growth should include an all-payer element, as mentioned in the guiding principles discussed during the November meeting. Staff also acknowledges the very difficult financial position facing hospitals. Across the State, total operating margins decreased from 4.0 percent in RY 2021 to 0.5 percent in RY 2022. The weak margins are driven by unsustainable unregulated losses. In RY 2022, the average regulated margin was 6.0 percent, while the unregulated margin was -41.2 percent. On an average year, unregulated losses are supported by healthy regulated margins. However, in RY 2022, unregulated margins deteriorated by 7.8 percent (compared to RY 2021) and put additional pressure on total operating losses. Despite weaker RY 2022 results, hospitals continue to have a higher level of Days Cash on Hand than the pre-GBR period. As of June 30, 2022, systemwide Days Cash on Hand for the Maryland based systems was 180 days, 38 percent above 2013 pre-GBR levels.

Some hospital comment letters recognized the need for all-payer rate reduction, but urged that the Commission make that a one-time reduction as opposed to a permanent rate reduction. Staff continues to believe that a permanent all-payer reduction should be made. Future adjustments (increases or decreases) to permanent all-payer rates can be determined with the RY 2024 update factor in June.

Medicare Performance Adjustment Savings Component

Hospital comment letters encouraged the Commission to focus on a Medicare payment reduction as the tool to accrue Medicare TCOC savings. However, Medicaid urged caution in implementing a Medicare-only

payment reduction, as the Department believes it could constitute a violation of the Medicaid Upper Payment Limit (UPL) and go against the all-payer tenet of the system.

Staff appreciates the comments regarding the MPA Savings Component. Because the payments associated with the MPA are performance based, Staff does not believe that this tool would violate the UPL. Staff believe that this issue was contemplated by the federal government when the TCOC Model went through federal clearance, as the State agreement signed by the State, HSCRC, and CMMI includes specific language regarding the MPA. Based on this review and the subsequent clearance process, Staff believes that the performance-based payments associated with the MPA and the Model in general are excluded from the UPL calculation. Staff have asked CMMI to confirm this review.

Public Payer Differential Request

Hospital comment letters all supported the request to increase the public payer differential. Comment letters from commercial payers oppose this option. Specifically, the comment letters cite a lack of policy basis or empirical evidence to support an increase to the differential and that such an action would unduly shift costs to other payers and violate the all-payer nature of the system. The one previous adjustment to the differential in 2018 provided a cost-based justification for the increase to the differential. However, in this instance, Staff recommendation is to request the increase for one year only, as allowed under the TCOC Model Agreement, for the purpose of meeting the next year's savings target. Staff understands that the request to increase the differential will be subject to CMMI approval, as well as legal review.

Comment letters from CareFirst, the League of Life and Health Insurers, and Kaiser Permanente also point to the failed request to increase the differential for Medicare Advantage (MA) plans as evidence that CMMI would similarly reject this request for differential increase. Staff would like to clarify that the previous proposal to increase the differential for Medicare Advantage only pertained to one public payer (i.e. MA). In proposing an increase to only one public payer, the request would have resulted in increased rates for Medicare FFS and Medicaid, along with the commercial payers. Staff recommendations in this report propose to increase the differential for **all** public payers and would not create staggering differentials for various public payers. In that respect, this recommendation is starkly different from the proposal to address Medicare Advantage.

There are also concerns that an increase to the differential for the period of one-year could become permanent and result in a permanent cost shift to commercial payers.

The MidAtlantic Business Group on Health also cites concern with shifting costs onto commercial payers which will then put additional financial pressure on employers (including not-for-profit employers) and subsequently their employees.

Finally, comment letters opposing the differential increase do not believe that this option reflects true savings or system transformation. Staff acknowledge that savings from both the MPA Savings Component and the differential increase are ways to drive time-limited savings for Medicare. However, these steps are necessary in order for the Model to continue to invest in long-term strategies that transform the care delivery system, reduce unnecessary utilization and improve patient outcomes in Maryland.

Final Recommendation

In light of the significant excess Medicare cost growth in Maryland experienced to date in CY 2022, Staff believes that it is imperative to act to adjust that trajectory as early as possible in CY 2023. To that end, Staff recommends actions that can be taken by this Commission that could accrue approximately \$100 million in Medicare savings in the coming year. Staff believe that this step is warranted to keep the State better aligned with national growth. Additional steps can be considered in July 2023 to ensure full compliance with the contractual obligations with CMMI. Final recommendations are as follows:

1. Staff recommends a permanent all-payer rate reduction of 0.40 percent that will be taken from the January rate orders across the board for global budget hospitals;
2. Staff recommends requesting an increase to the Public Payer Differential of 1 percent for the remainder of FY 2023 and the duration of FY 2024, as allowed under the terms of the State Model Agreement and contingent upon approval by CMMI;
3. Staff recommends implementation of the Medicare Performance Adjustment Savings Component of \$50 million for global budget hospitals, scaled 25 percent according to statewide revenue and 75 percent according to the updated stand-in efficiency measure on a one-time basis; and
4. Staff recommends that the Commission send a formal request to the State to reduce the Medicaid Deficit Assessment by \$50 million, contingent upon approval by the State Legislature.

Staff and Commissioners will continue to advocate to the State and federal government for additional allowances that can help the State meet the long-term goals and objectives of the Maryland Model.

Appendix 1: Medicare Performance Adjustment Savings Component Scaling Options (% Reductions)

Hospital	Pro Rata Revenue	MPA Rank	2021 Stand-in Efficiency	2019 Integrated Efficiency
Anne Arundel Medical Center	0.26%	0.24%	0.31%	0.11%
Atlantic General Hospital	0.26%	0.19%	0.19%	0.24%
Calvert Memorial Hospital	0.26%	0.17%	0.28%	0.30%
Carroll Hospital Center	0.26%	0.13%	0.27%	0.37%
Doctors Community Hospital	0.26%	0.22%	0.23%	0.21%
Fort Washington Medical Center	0.26%	0.34%	0.34%	0.10%
Frederick Memorial Hospital	0.26%	0.24%	0.32%	0.27%
Garrett County Memorial Hospital	0.26%	0.23%	0.15%	0.19%
Greater Baltimore Medical Center	0.26%	0.17%	0.25%	0.27%
Harford Memorial Hospital	0.26%	0.15%	0.20%	0.36%
Holy Cross Germantown	0.26%	0.07%	0.06%	0.09%
Holy Cross Hospital	0.26%	0.20%	0.17%	0.09%
Howard County General Hospital	0.26%	0.13%	0.10%	0.06%
Johns Hopkins Bayview Medical Center	0.26%	0.34%	0.31%	0.37%
Johns Hopkins Hospital	0.26%	0.30%	0.25%	0.22%
MedStar Franklin Square Hospital Center	0.26%	0.10%	0.10%	0.32%
MedStar Good Samaritan Hospital	0.26%	0.06%	0.10%	0.36%
MedStar Harbor Hospital Center	0.26%	0.10%	0.12%	0.25%
MedStar Montgomery Medical Center	0.26%	0.32%	0.35%	0.28%
MedStar Southern Maryland Hospital Center	0.26%	0.11%	0.15%	0.26%
MedStar St. Mary's Hospital	0.26%	0.31%	0.21%	0.20%
MedStar Union Memorial Hospital	0.26%	0.27%	0.26%	0.36%
Mercy Medical Center	0.26%	0.28%	0.28%	0.30%
Meritus Medical Center	0.26%	0.37%	0.25%	0.21%
Northwest Hospital Center	0.26%	0.12%	0.21%	0.39%
Peninsula Regional Medical Center	0.26%	0.18%	0.16%	0.23%
Prince Georges Hospital Center	0.26%	0.20%	0.25%	0.32%
Shady Grove Adventist Hospital	0.26%	0.31%	0.35%	0.19%
Sinai Hospital	0.26%	0.38%	0.41%	0.47%
St. Agnes Hospital	0.26%	0.25%	0.27%	0.21%
Suburban Hospital	0.26%	0.21%	0.25%	0.08%
Union Hospital of Cecil County	0.26%	0.33%	0.37%	0.41%
University of Maryland Baltimore Washington	0.26%	0.27%	0.20%	0.16%
University of Maryland Charles Regional	0.26%	0.16%	0.15%	0.22%
University of Maryland Medical Center	0.26%	0.38%	0.32%	0.22%
University of Maryland Medical Center Midtown	0.26%	0.09%	0.19%	0.40%
UMROI	0.26%	0.38%	0.42%	0.35%
University of Maryland Chestertown	0.26%	0.26%	0.36%	0.39%
University of Maryland Easton	0.26%	0.29%	0.36%	0.37%
University of Maryland St. Joseph Medical Center	0.26%	0.35%	0.36%	0.31%
Upper Chesapeake Medical Center	0.26%	0.14%	0.17%	0.30%
Washington Adventist Hospital	0.26%	0.08%	0.12%	0.16%
Western Maryland Regional Medical Center	0.26%	0.36%	0.30%	0.39%
UM DORCHESTER	0.26%	NA	NA	NA
GRACE MEDICAL CENTER	0.26%	NA	NA	NA
UM LAUREL MEDICAL CENTER	0.26%	NA	NA	NA
GERMANTOWN EMERGENCY CENTER	0.26%	NA	NA	NA
UM-QUEEN ANNE'S FSE	0.26%	NA	NA	NA
UM-BOWIE HEALTH CENTER	0.26%	NA	NA	NA
LEVINDALE	0.26%	NA	NA	NA
UM-SHOCK TRAUMA	0.26%	NA	NA	NA



Maryland
Hospital Association

November 28, 2022

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

Dear Mr. Kane:

The Maryland Hospital Association (MHA) and our 60 member hospitals and health systems appreciate the opportunity to participate in finding ways to improve our Total Cost of Care Model savings performance.

We applaud the Commission for invoking the exogenous factors clause in the contract with the federal government to gain relief with respect to calendar year (CY) 2022 performance. The COVID-19 pandemic and its after-effects have disrupted health care operations massively, imposing new permanent costs and forcing constraints on vital delivery capacity.

Hospitals also appreciate that Maryland needs to act seriously to get back on track toward meeting contractual targets, notwithstanding the fact that the savings shortfall is driven mainly by lower-than-projected national Medicare spending, not excessive spending in Maryland.

A sound corrective action plan must do three things: (1) improve Model performance where it matters most, in the Medicare segment; (2) equitably share the financial burden among the major stakeholders; and (3) ensure that hospitals are funded adequately to meet patients' needs, and to continue to invest in population health improvement efforts.

As reflected in the staff's November draft recommendation, Maryland is targeting \$100 million of CY 2023 savings, incremental to the \$160 million CY 2022 run rate. The hospital field agrees with parts of the Commission staff's proposal. We do, though, differ on other aspects of the plan because, when taken together, they do not satisfy the three crucial criteria.

Our recommendations are summarized below. These positions are supported by data and analysis presented in the addendum.

1. **Support the staff's proposal to raise the public payer differential 1% and to secure state support of \$50 million.** Maryland's Model benefits multiple stakeholders. All stakeholders—hospitals, private payers, and the state—should contribute equitably to improving our performance. In contrast to our hospitals, insurers' finances and the state's finances are more than sound. Reduced demand for care and hefty premium increases have boosted health insurers' profits and reserves. And the state's finances are vigorous thanks to federal relief dollars and unbudgeted surpluses.

2. **Remove the proposed all-payer rate reduction of 0.4%.** The problem with the Model right now is a Medicare problem, not an all-payer problem. Maryland remains well within our all-payer, per capita spending limit. Our Medicare spending is as predicted. The Medicare savings shortfall is primarily the result of utilization nationally not matching up to the Medicare actuary's own forecast.

Regardless of the now-observed softening of national Medicare cost growth, HSCRC was correct to add 0.4% for rate year (RY) 2023 inflation. If the Commission retracts the 0.4%, cost inflation for just this one year will be underfunded by 1.16%. That equates to a shortfall of hundreds of millions of dollars hospitals need to care for Maryland patients.

3. **Count the expected traditional Medicare Performance Adjustment (MPA) savings from 2022 performance.** The MPA makes each hospital accountable to deliver total cost of care savings. Because Maryland's total cost of care performance in CY 2022 was poor, almost all hospitals face a financial penalty. The financial adjustments are directly linked to performance results, therefore ought to count toward the savings. If Maryland's performance improves, penalties will ease, and if not, they will continue to be assessed.
4. **Use the MPA – Savings Component (MPA-SC) to deliver the balance of savings.** The MPA-SC tool was purpose-built for situations where Medicare savings are off track. When deployed, it properly limits savings to Medicare without shifting the burden to other payers. Hospitals' payments fall and Medicare gets its savings.

And please be reminded that there was strong consensus from the hospital field to share a \$25 million reduction, with 75% based on the HSCRC's efficiency policy and 25% shared evenly among all hospitals according to their revenues. We ask that HSCRC defer to field consensus for any recommended reduction, consistent with HSCRC's history.

As we write this letter, Maryland is facing a surge of pediatric respiratory illnesses, rising influenza among vulnerable groups, persistent COVID hospitalizations, and unprecedented demand for behavioral health services. Demand is spiking and other care sources—from pediatric practitioners to community behavioral health providers to nursing facilities—are unable to withstand the onslaught. All while costs are climbing rapidly and vacant positions go unfilled. Our hospitals face a crunch. We ask you and all commissioners to take that into account.

Sincerely,



Bob Atlas
President & CEO

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Maulik Joshi, Dr.Ph.
James Elliott, M.D.

Stacia Cohen
Sam Malhotra
Katie Wunderlich, Executive Director

Addendum – Support for Maryland Hospital Association’s Recommended Action

MHA’s recommended approach produces the savings HSCRC is aiming for and satisfies the three key criteria. Moreover, our proposal emphasizes incremental action because the current national trend appears anomalous. National spending could take a different turn in 2023 and 2024, so the Commission should monitor movements and act accordingly if conditions warrant.

Our rationale is outlined below. The first two sections explain why HSCRC should be cautious in adjusting payments, the third outlines MHA’s proposal for shared accountability, the fourth describes the inflation funding shortfall and supports avoiding an all-payer rate reduction, and the final section offers evidence of Maryland hospitals’ unfavorable financial performance.

- 1) **Global budgeted revenue incentives and Model limits.** Global budgets trade steady growth for revenue limits that allow for reasonable price and service growth. Managing utilization relative to the nation has been disrupted compared to historical norms during this unique period.
- 2) **COVID-related one-time adjustments must settle.** HSCRC provided reasonable, if not conservative, *permanent* update factors throughout the pandemic. Additional one-time impacts will be reversed by the end of 2022, giving HSCRC a better understanding of actual performance in early 2023.
- 3) **Shared accountability.** Comparing HSCRC’s draft recommendation with MHA’s proposed alternative shows the disproportionate impact on hospitals. Commercial payers and the State have adequate resources to contribute comparable amounts.
- 4) **HSCRC permanent hospital rate funding is conservative.** When judging Maryland’s Model performance, 2022 and 2023 rate increases were moderate, and largely formulaic. While HSCRC added 40 basis points to 2023 inflation when deciding the update, new data show inflation still underfunded by 80 basis points.
- 5) **Hospital financial performance is unfavorable and is likely to remain so.** In fiscal 2022, more than half of Maryland hospitals’ operating expenses were higher than revenues. Including non-hospital services in hospital-based health systems, the average operating margin was -0.3% with a 15% decline in cash.

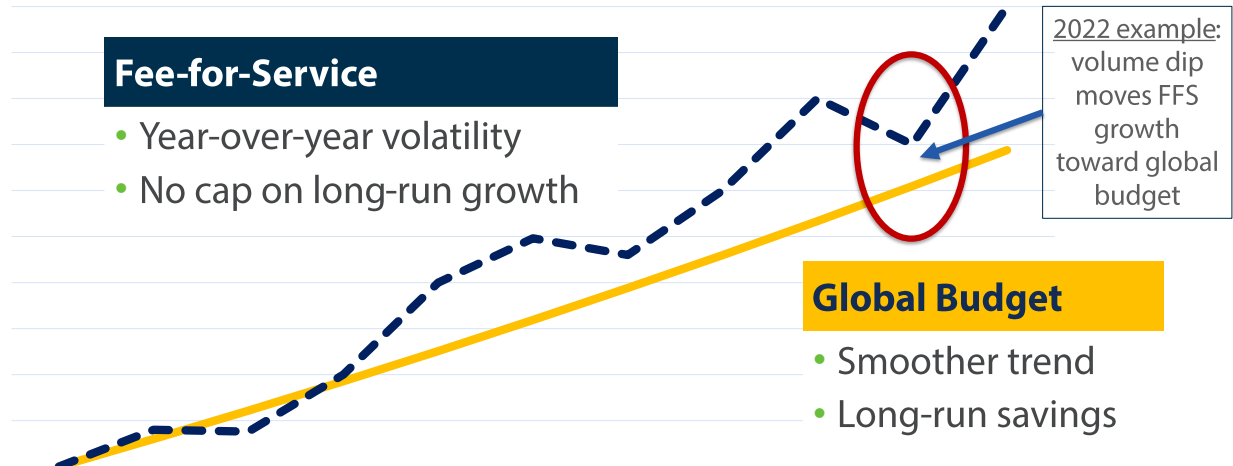
1. Global Budgeted Revenue Incentives and Model Limits

Maryland’s historic waiver program capped growth of price per hospital admission. In 2014 the All-Payer Model introduced global budgeted revenue that capped growth of spending on hospital services. In 2019 the Total Cost of Care Model added risk on hospitals for spending beyond the hospital. So today, our hospitals live with not only fixed revenues but also risk for costs of services they mostly do not control. Then, in 2020, the COVID-19 pandemic caused massive disruption, the effects of which continue to reverberate to this day both in Maryland and across the United States.

Maryland’s Model was designed to deliver income stability for hospitals and cost savings for payers over the long term. The Model introduced an all-payer hospital spending growth limit of 3.58%, plus reasonable Medicare hospital and total spending limits. Hospital revenues were meant to grow at a reasonable pace with hard revenue limits enforced by the annual payment update. In contrast, prior to the Model’s launch, with no limits placed on hospital volume growth, *per capita hospital spending grew 6.78% each year for 10 straight years.*

Figure 1 below illustrates global budgets compared to fee-for-service payment. Under global budgets, hospital revenues are regulated to grow steadily. Both prices and utilization are, in effect, capped. In contrast, under a fee-for-service system, even if prices are regulated, the absence of sufficient incentives to limit the volume of services means spending is more volatile and will tend to rise more over time.

Figure 1: Illustration of GBR versus Fee-for-Service



Under fee-for-service outside of Maryland, spending may fall when utilization falls, but as the evidence shows, utilization in aggregate almost always rises. However, 2022 was extraordinary. Utilization dropped across the nation. This phenomenon only occurred because the COVID-19 pandemic and its aftershocks dramatically altered both the supply of and demand for health care.

In 2021, the Center for Medicare & Medicaid Innovation (CMMI) touted the Maryland Model as one of only six demonstration projects to produce savings, out of 50 that were evaluated since 2010. In absolute dollar terms Maryland ranked #1. Evidence shows that Maryland can, and does, limit cost growth. From 2014 through 2021, cumulative total cost of care growth was more than 3% below the nation with \$378 million in annual Medicare savings – well ahead of that year’s \$222 million interim target. Only the peculiarities of this one year changed this trajectory.

Year to date savings *have* declined significantly. The national trendline dipped while Maryland maintained our steady pace. But national hospital volumes will not be suppressed for long. Our own state’s experience tells us that delays in routine care have left people with more serious health conditions, resulting in the need for more care at higher intensity. Once the national pattern resumes, Maryland will be back on track to produce savings.

2. COVID Related One-Time Adjustments Must Settle

HSCRC made several one-time adjustments to help hospitals absorb the financial shocks of the pandemic in 2020 and 2021. To understand our true performance, one must quantify the effects of reversing those adjustments. These adjustments include the 2022 \$100 million advance, rate year (RY) 2021 undercharge support of \$215 million, additional COVID surge funding, and the actual differences in undercharges and overcharges in 2021 and 2022. Reversing all COVID-related one-time adjustments will improve savings by \$80 million.

Adding that amount to HSCRC staff's projected year-end 2022 savings of \$80 million gives a 2023 baseline savings run rate of \$160 million.

HSCRC is targeting \$100 million in additional savings, meant to recover half of an estimated \$200 million difference between Maryland's 2022 target and our projected result. We also know that Maryland is only one side of the savings measure. Given the instability of the national market and the need to shore up hospital finances, we urge HSCRC and CMMI to acknowledge that a \$100 million improvement may not completely close the 2023 performance gap. The agencies should again look to the exogenous factors clause in the contract for 2023.

3. Shared Accountability

MHA respects HSCRC's determination to act promptly. Though the burden of corrective action must be borne equitably by all stakeholders: hospitals, commercial insurers, and the state. As shown in Figure 2 below, however, the impact of staff's recommendation fails that test.

Figure 2: HSCRC Draft Recommendation
(\$ in millions)

	Medicare Savings	Contribution, in (), or Offset				
		Hospitals	Commercial Payers	State	Medicaid	State
Reduce hosp. portion of Medicaid assessment - \$50m	\$ -	\$ 50		\$ (50)		\$ (50)
Raise Medicare Differential - 1%	26	-	(50)	16	16	-
All-Payer Rate Reduction - 0.40%	27	(80)	32	16	16	-
MPA - Savings Component - balance	50	(50)	-	-	-	-
Total	\$ 102	\$ (80)	\$ (18)	\$ (18)	\$ 32	\$ (50)
MPA - Traditional - 1/2 Year, 2023 only	20	(20)	-	-	-	-
Readmissions Savings	5	(5)				
Grand Total	\$ 127	\$ (105)	\$ (18)	\$ (18)	\$ 32	\$ (50)

Overwhelming burden borne by hospitals

Notes:

Impacts from HSCRC staff recommendation or consistently scaled. Total does not equate by payer because other payers are excluded.

Medicare, Medicaid and Commercial payer impacts per HSCRC staff recommendation figures

Traditional MPA is \$40m, assumes 1/2 year impact in 2022.

Figure 3 shows MHA's alternative for producing \$100 million in Medicare savings in a way that passes the shared accountability test. Our explanation follows.

Figure 3: MHA Alternative Sharing the Burden Equally Among Stakeholders
(\$ in millions)

	Medicare Savings	Contribution, in (), or Offset				
		Hospitals	Commercial Payers	State	Medicaid	State
State direct funding - \$50m	\$ -	\$ 50		\$ (50)		\$ (50)
Raise Medicare Differential ~ 0.65%	17	-	(33)	11	11	-
All-Payer Rate Reduction - 0.0%	-	-	-	-	-	-
MPA - Traditional - 1/2 Year, 2023 only	20	(20)	-	-	-	-
MPA - Savings Component - balance	63	(63)	-	-	-	-
Total	\$ 100	\$ (33)	\$ (33)	\$ (39)	\$ 11	\$ (50)

Burden shared equitably by all three Model stakeholders

Notes:

Impacts from HSCRC staff recommendation or consistently scaled. Total does not equate by payer because other payers are excluded. Medicare, Medicaid and Commercial payer impacts per HSCRC staff recommendation figures
Traditional MPA is \$40m, assumes 1/2 year impact in 2022.

a) Raising the Public Payer Differential

MHA does not take lightly the all-payer nature of the Model, recognizing that Maryland has only changed the differential once in the past 40 years. However, COVID was an unprecedented event that requires all stakeholders to support corrective action.

Commercial payers benefit greatly from all-payer rate setting. According to the Health Care Cost Institute, Maryland commercial payers enjoy the lowest hospital outpatient costs and the second lowest inpatient hospital costs. If Maryland’s commercial insurance payments were moved to the national median, *commercial hospital spending in Maryland would jump \$2.3 billion*, including \$680 million inpatient and \$1.6 billion outpatient. Increasing the differential by 65 basis points will cost commercial payers just \$33 million.

The language below from Section 8.b.ii.1. of the Model contract allows Maryland to use the differential if all-payer hospital spending per capita is less than the limit, which is the case now.

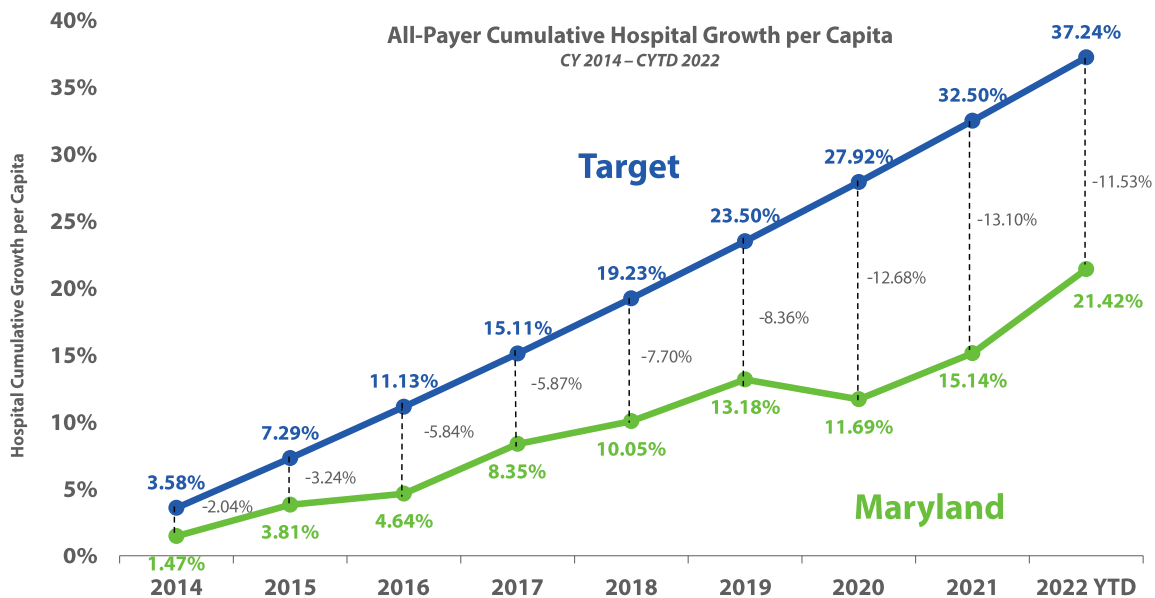
1. Beginning in Model Year (MY)1 for implementation in MY2, the State may submit to CMS a request to change the Public Payer Differential calculated by the State under any of the following circumstances:
 - a. To enable the State to meet the Annual Savings Target for the subsequent Model Year, provided that hospital expenditures for the current Model Year are less than the All-Payer Revenue Limit calculated by the State in accordance with Section 6.f and Appendix B of this Agreement for that Model Year.

Earlier contract drafts included a “Medicare Payment Savings Adjustment,” designed to allow Medicare to directly reduce hospital payments if Maryland’s all-payer hospital performance was favorable and Medicare performance was unfavorable. Ultimately, that section was deleted because CMMI agreed that we could use the Medicare Performance Adjustment – Savings

Component (MPA-SC) to achieve Medicare savings, or the State could request a change in the differential should today's exact circumstance occur.

The contract sets the annual all-payer revenue limit as 3.58% compounded growth from the 2013 base period. Figure 4 shows Maryland's performance to be well below the 2022 limit. The 2020 to 2022 results are not surprising as the COVID-19 pandemic curtailed hospital service use, resulting in lower aggregate spending on hospital services.

Figure 4: Maryland's All-Payer Growth Limit and Actual Performance



Commensurately, commercial health insurers are seeing lower medical expense ratios and enjoying very favorable financial results. Figure 5 shows most large insurers have seen large profits in both 2021 and 2022, with most growing their profits this year.

Figure 5: Health Insurers' Net Income Increases

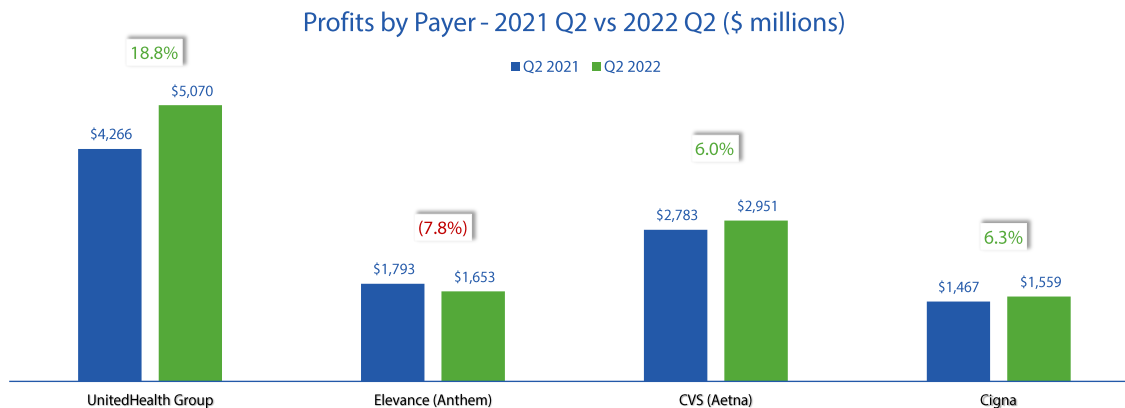
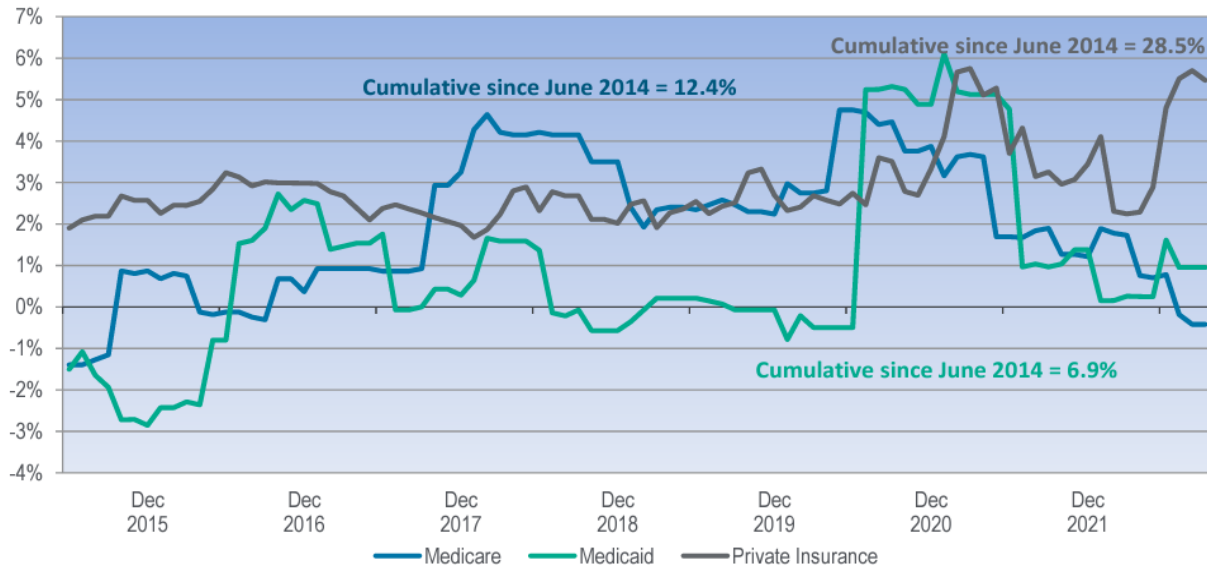


Figure 6 shows private insurance hospital prices rising 28.5% nationally since 2014, more than double the rate of Medicare and for than four times Medicaid. The sharpest increase occurs after December 2021 as hospitals outside of Maryland shift higher prices to private insurance.

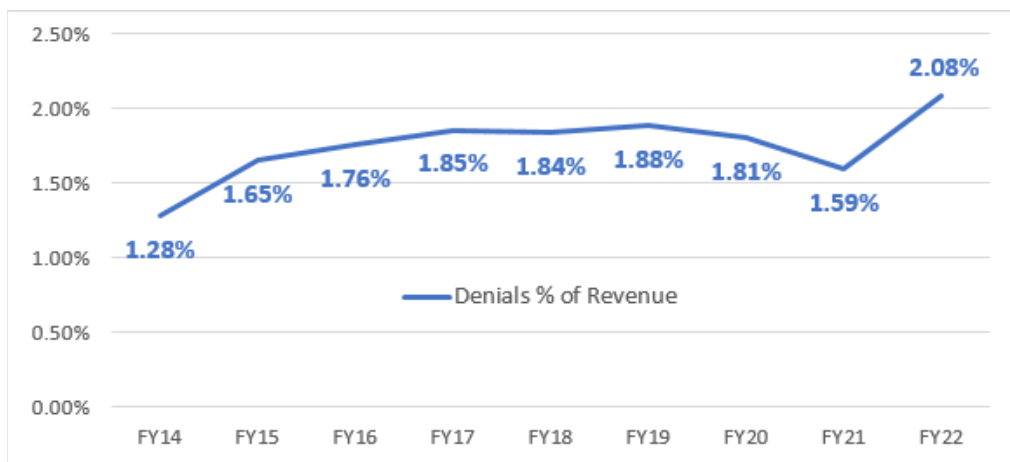
Figure 6: Year-over-Year Change in Hospital Price Growth, by Payer



Source: Altarum, “Health Sector Economic Indicators – Price Brief,” October 21, 2022 (Exhibit 8) https://altarum.org/sites/default/files/uploaded-publication-files/HSEI-Price-Brief_October_2022.pdf

Additionally, as Figure 7 shows, there has been a sharp uptick in hospital claim denials by insurers. This change cannot be driven by hospitals suddenly submitting claims for services that aren’t medically justified. Rather, by increasing denials, insurers boost their profits directly at the expense of hospitals.

Figure 7: Hospital Denials as a Percent of Revenue



Source: HSCRC 2022 Annual Filings (29 out of 45 hospitals reporting)

b) State Support

We support HSCRC's intent to secure an equitable contribution from the state. The state reaps economic benefits from the Model, both by keeping commercial hospital payments well below the national average and not having to use state funds to own or subsidize safety net hospitals.

There are two paths. Either the State could reduce by \$50 million the hospital portion of the Medicaid deficit assessment, as reflected in the staff's recommendation, or the state could deliver \$50 million directly to hospitals as pandemic-related funding.

In fiscal year 2023, the state budgeted for federal Medicaid matching funds to drop because the enhanced match is due to expire at the end of the public health emergency (PHE). Yet the PHE will remain in place at least until April 2023, so the state is reaping this line-item surplus.

The Medicaid budget surplus and federal ARPA came to Maryland because of the COVID-19 pandemic. The pandemic and its aftershocks caused our unfavorable Model performance. It therefore stands to reason that the state can use those funds to make this contribution to stabilize performance. Plus, the state's cost is partly offset by increasing the public payer differential.

c) Medicare Savings – Count Traditional Medicare Performance Adjustment (MPA) and use MPA Savings Component (MPA-SC)

Combined with raising the differential and securing state funding, HSCRC need not reduce all-payer rates. We showed in Figure 4 that Maryland hospitals are delivering more all-payer hospitals savings than required. Counting the traditional MPA results toward our savings target, then using the MPA-SC, is the appropriate way to address any remaining Medicare shortfall.

The contractually required MPA enforces hospital accountability for total cost of care growth. Revenue adjustments are made by comparing each hospital's performance to a national growth rate. Maryland grew faster than the nation in 2022 and because the traditional MPA adjustment has already been approved, the results will be realized.

Annualizing year-to-date 2022 traditional MPA performance projects \$45 million in Medicare payment reductions, a \$35 million increase from 2021. Half of this amount will affect RY 2023, and another half will be reflected in RY 2024. (One half of this amount is reflected as \$20 million in figures 2 and 3, consistent with HSCRC's draft recommendation.) While this amount has not traditionally been "permanent," should Maryland's unfavorable performance continue, unfavorable MPA results will persist.

After accounting for \$20 million in traditional MPA savings, the balance of Medicare savings—after raising the public payer differential and securing state funding—should be secured via the MPA-SC.

Using MHA's formulation, an additional \$63 million of statewide Medicare savings is required from the MPA-SC. This amount nets to a statewide increment of \$13 million after accounting for \$50 million in state support to hospitals.

4. HSCRC Permanent Hospital Rate Funding Is Conservative

HSCRC should not reverse 0.4% of permanent inflation funding, regardless of the national Medicare projection. HSCRC did not deliver hospitals a permanent windfall in the last two years. Rather, because of recent cost spikes, HSCRC has underfunded inflation since the beginning of the pandemic and the beginning of the Model. To take back funding undermines a core principle when revenue growth is limited under global budgets.

RY 2022 and RY 2023 Permanent Inflation

In RY 2022, HSCRC funded 2.57% inflation, adding 20 basis points to known inflation at the time, HSCRC projected RY 2022 permanent revenue growth of 2.44% after accounting for other adjustments. In RY 2023, HSCRC provided 4.06% inflation, adding 40 basis points to known inflation at the time, and estimated permanent hospital revenue growth of 3.38%. The underlying permanent inflation and projected revenue growth seemed reasonable if not conservative.

At the time of the RY 2023 annual update, MHA urged HSCRC to consider CMS Office of the Actuary projection of 2022 national spending growth of 7.1%. Obviously, that projection did not prove accurate, and our savings shortfall ensued. However, regardless of the comparison figure, HSCRC’s allowances for inflation still fell short of actual inflation.

Newer measures of inflation reveal how short. IHS Markit’s 3rd Quarter 2022 release puts RY 2022 inflation at 4.79% and RY 2023 inflation at 4.80%. Both figures are expected to grow with the next release. Had HSCRC not added 20 basis points in 2021 and 40 basis points in 2023, funded inflation would be even further below actual.

Figure 8: Funded vs Actual Inflation, RY2022-RY2023, COVID-19 Pandemic Period (2020-2023), and New Model Period (2014 – 2023)

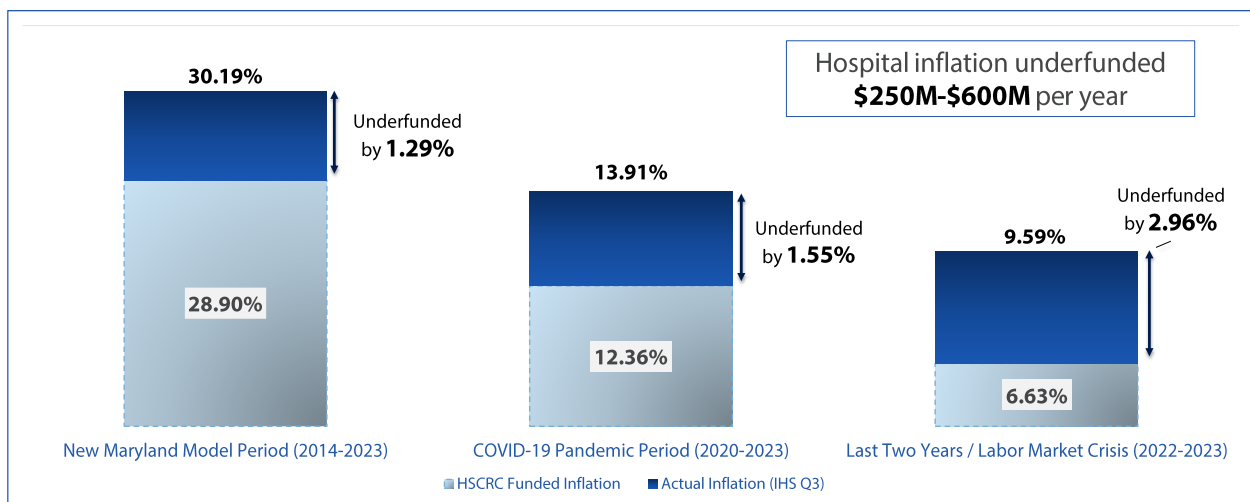


Figure 8 above reflects cumulative cost inflation for three different periods: RY2022-RY2023, COVID-19 pandemic period (2020-2023) and the New Model Period (2014-2023). In any frame, hospital inflation is prospectively underfunded between \$250 million and \$600 million. Were

these figures to include both infrastructure funding and potentially avoidable utilization offsets, hospitals would be prospectively underfunded by more than \$700 million per year through 2023.

After seeing higher inflation in hospitals' costs of production earlier this year, CMS adopted MedPAC's recommendation to give higher inflation allowances in Medicare's prospective payment systems. Should inflation continue to climb, Medicare can boost its update in 2023.

What is more, hospitals outside of Maryland will seek significant price hikes from commercial payers to compensate for insufficient funding of inflation by public payers (Figure 6).

5. The Dire Financial Condition of Maryland Hospitals

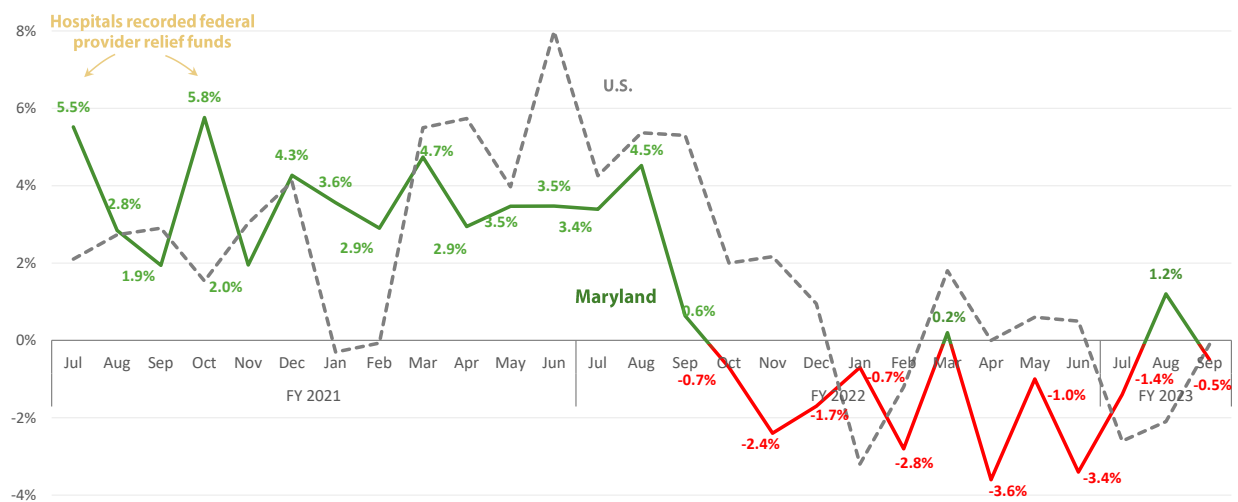
By law, HSCRC has a dual mission: to promote health care cost containment for consumers and their insurers *and* to support hospitals' financial viability. Recent financial performance of our hospitals suggests HSCRC revisit a core provision in Health General 19-212 (2) –

[The commission shall] concern itself with solutions if a [hospital] facility does not have enough resources.

Like others across the country, Maryland hospitals are facing their worst financial crisis in decades. Huge increases in input costs—labor especially—have severely depressed operating margins. Cash and investments have receded as hospitals cover steep operating losses. Hospitals cannot continue to deplete their fund balances and they can only cut expenses so much before patients' access to care is diminished.

Our hospitals' operating margins were well below the nation in fiscal year 2022. And whereas margins were negative for U.S. hospitals two months of the year, Maryland operating margins remained negative for eight of the twelve months.

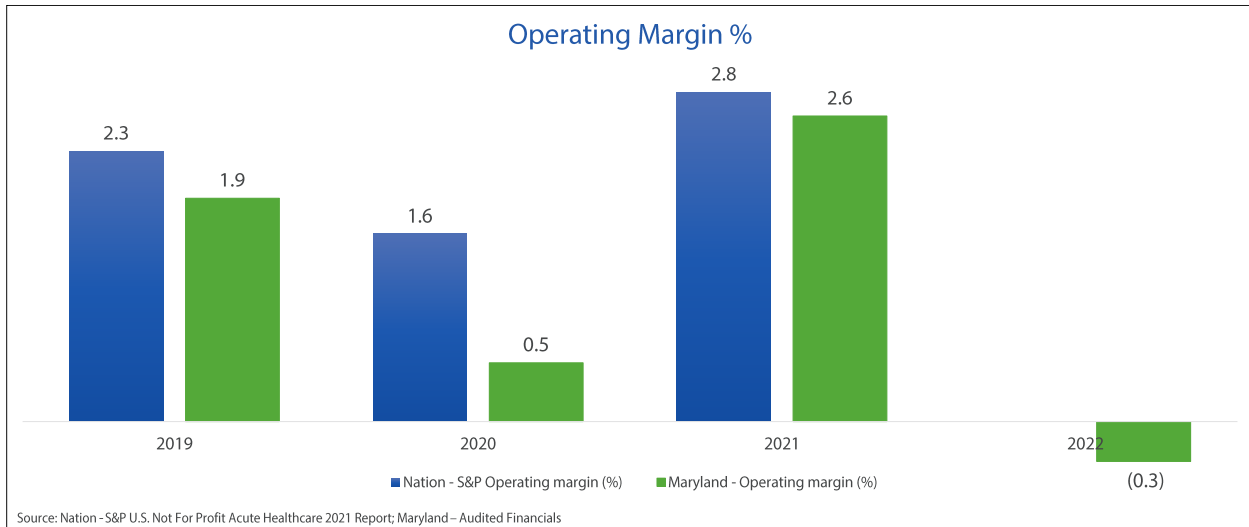
Figure 9: Maryland and National Hospital Margins



Sources: Maryland, HSCRC monthly reports. Nation, Kaufman Hall Flash Report.

Health system audited financial data for 2022, including non-hospital services, show a median loss of 0.3%, the worst in four years, while days cash on hand has fallen by 15%. As reflected in Figure 10, Maryland’s health system margins are consistently below rating agency medians.

Figure 10: Maryland and National Health System Median Operating Margins



American Hospital Association (AHA) data in Figure 11 show Maryland’s margins much lower than the nation for years. Historically, this difference was understood and accepted because of Maryland’s rate setting system and HSCRC’s mandate to support hospitals. Over time, operating margins remained steady in Maryland compared to the nation. In 2019, the U.S. had its second-highest operating margin in 16 years, while Maryland’s average margin was about half the U.S., 3.62% compared to 7.13%. While margins everywhere fell in 2020 (the latest year for which AHA has data), Maryland margins remained well below the nation, 3.81% compared to 5.52%.

Figure 11: Maryland and US Operating Margins 2005-2022

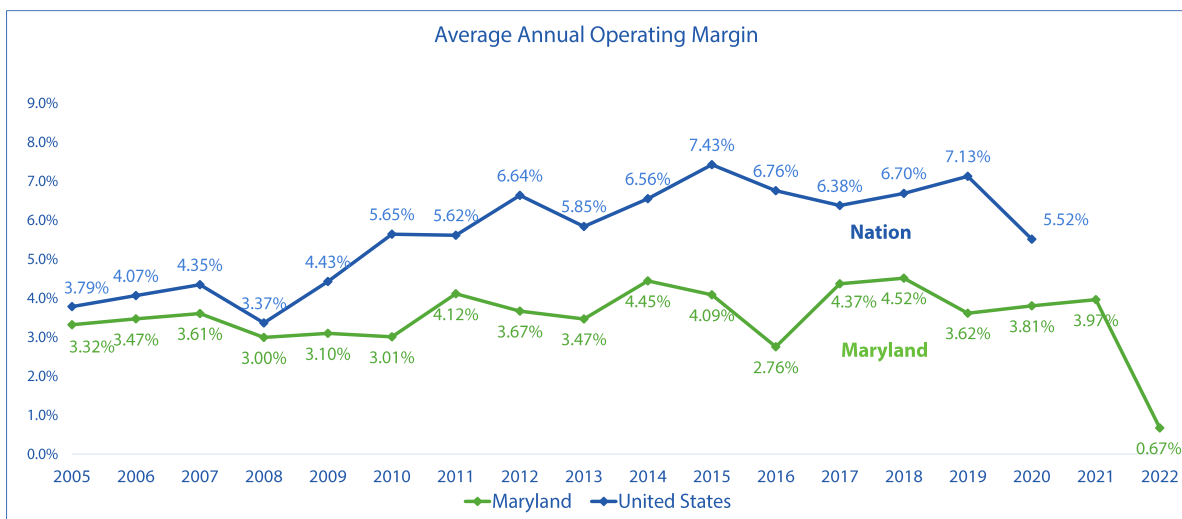


Figure 12 reflects *all-payer*, hospital net revenue and expenses per unit and per capita, explaining how Maryland hospitals reduced avoidable utilization to limit spending growth. When hospitals were placed on GBRs, net revenues and expenses per capita were below the nation, 6.8% less and 3.6% less, respectively. As of 2020, they are much further below the nation, 18.25% less and 15.6% less.

Figure 12: Net Revenue, Expenses per Unit, per Capita; Select Utilization Measures

	MARYLAND	NATION	VARIANCE	%
Total Net Revenue				
per EIPA	\$ 10,517	\$ 9,994	523	5%
per EIPD	\$ 1,931	\$ 1,769	162	9%
per capita (per 1000 population)	\$ 2,965	\$ 3,624	(659)	(18%)
Total Expenses				
per EIPA	\$ 10,020	\$ 9,226	794	9%
per EIPD	\$ 1,839	\$ 1,633	206	13%
per capita (per 1000 population)	\$ 2,825	\$ 3,346	(521)	(16%)
Community Health Indicators				
IP Admissions /1000	84.0	95.3	(11)	(12%)
IP Days /1000	457.5	538.2	(81)	(15%)
OP Visits /1000	1,322.8	2,176.6	(854)	(39%)
ED Visits /1000	308.9	374.1	(65)	(17%)

At the same time, we acknowledge that price per unit—per adjusted admission and per adjusted patient day—have grown. Expense per equivalent inpatient admission (EIPA) went from 0.4% below the nation to 8.6% above the nation. Expense per inpatient day (EIPD) changed from 20.3% above the nation in 2010 to 12.6% in 2020. This is exactly what the Model provides for: following the incentives to contain service growth and create savings per beneficiary.

Community health indicators support this notion as well. Prior to 2013, Maryland ranked higher than the U.S. on inpatient admissions and emergency department visits per 1,000 beneficiaries. The state has been below the nation on every metric reported since 2014, with consistent improvement. In 2020, Maryland was 11.8% below the nation on inpatient admissions, 15% below on inpatient days, 39.2% below on outpatient visits, and 17.4% below on ED visits.



Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Dennis R. Schrader, Secretary

November 23, 2022

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

Dear Chairman Kane:

On behalf of the Maryland Medicaid Administration of the Maryland Department of Health (the Department), I appreciate the opportunity to comment on the ongoing dialogue surrounding Maryland's Total Cost of Care Model (TCOC Model), including the current recommendations developed by Health Services Cost Review Commission (HSCRC) staff for the Commission's consideration, which are as follows:

- (i) **An all-payer rate adjustment** effectuated through hospital rate orders, *i.e.*, reversal of 0.40% provided in rate year (RY) 2023 Update Factor.
- (ii) **Medicare-only payment reductions** effectuated through the Medicare Performance Adjustment (MPA) Savings Component.
- (iii) **Public-payer rate reductions** through an increase to the Public Payer Differential for the duration of fiscal years (FY) 2023 and 2024, which would require Center for Medicare and Medicaid Innovation (CMMI) approval.
- (iv) **A state contribution through the Medicaid Deficit Assessment** or through additional grant dollars, which would require approval by the General Assembly and/or the Department of Budget and Management, respectively.

The Department appreciates that the Commission staff has outlined a broad-based solution to address the Medicare savings shortfall and is pleased to provide the following comments on staff recommendations (ii) and (iv).

MPA Savings Component

The staff recommendation suggests the application of the MPA Savings Component to adjust Medicare rates on the backend (i.e., outside of charges), thereby bringing the state into compliance with the savings targets. As communicated in our comment letter on the RY 2023 staff recommendation dated May 17, 2022, we believe this recommendation would be a violation of the Medicaid Upper Payment Limit test. Federal rules do not permit Medicaid to pay more than Medicare. This test is applied whether the adjustment to rates occurs upfront (i.e., when establishing and setting charges) or on the backend. The same adjustment to Medicare would need to be made to Medicaid. We believe this deviation from all-payer rates would not align with a central tenet of the Total Cost of Care Model.

Additionally, the Department encourages staff to work with CMMI to consider total cost of care guardrails for Medicaid. In conversations regarding Medicaid alignment with the Maryland Primary Care Program, CMMI shared that a goal for Medicaid primary care alignment would be to shift dollars from hospitals to primary care. This can be only achieved if Medicaid receives at least the same level of hospital savings as Medicare. This would require the MPA Savings Component adjustment to apply to Medicaid hospital services as well.

The Department understands the challenges of trying to project national Medicare spending. This uncertainty necessitates building a level of conservatism into the rate updates each year.

Medicaid Deficit Assessment (MDA)

As you know, any reduction in the MDA would need to be approved by the General Assembly. As noted in our last testimony, the vast majority of states use assessments as a way to bring more federal dollars into their states. The assessment monies used as the state share for Medicaid expenditures allow states to receive a federal match. For Maryland, this federal matching rate is around 60 percent. Accordingly, a reduction of the MDA by \$50 million would total more than \$125 million in lost Medicaid dollars.

We promised at the last Commission meeting to provide an overview of the hospital assessments across other states (see attached). According to a 2022 analysis by the Kaiser Family Foundation, 44 states (including the District of Columbia) have a hospital provider tax.¹ At less than 3.5 percent of net patient revenue, Maryland's hospital provider tax (i.e., the Medicaid Deficit Assessment) is not an outlier compared with other states.

¹ Kaiser Family Foundation "How the Pandemic Continues to Shape Medicaid Priorities: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023."
<https://www.kff.org/report-section/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023-provider-rates-and-taxes/>

Please note that the MDA is currently \$295,825,000. Since its peak at \$412,455,978 in fiscal year (FY) 2014, the successive decreases in the MDA, combined with the elimination of the MHIP Assessment and decreases in uncompensated care, have generated cumulative savings in excess of \$1.3 billion since that time.

Lastly, although the TCOC Model's Medicare savings fall \$187 million short of the target, the staff recommendations only total \$100 million. The Department would like to point out the likelihood that, absent additional and palatable interventions, this conversation may need to be revisited as part of the Rate Year 2024 update-factor development.

Please contact me with any questions via phone at 410-767-5809 or via email at tricia.rodny@maryland.gov.

Sincerely,

A handwritten signature in blue ink that reads "Tricia Roddy". The signature is written in a cursive, flowing style.

Tricia Roddy
Deputy Medicaid Director

Enclosure

CC: Katie Wunderlich
Marc Nicole
Steven Schuh
Laura Goodman

Overview of Hospital Assessments

Provider Group Subject to Tax: Hospitals		
State	In Place in FY2022	Size of tax as a percentage of net patient revenue (as of July 1, 2022)
AK	0	
AL	1	>5.5%
AR	1	≤3.5%
AZ	1	5.01% - 5.5%
CA	1	≤3.5%
CO	1	>5.5%
CT	1	>5.5%
DC	1	≤3.5%
DE	0	
FL	1	≤3.5%
GA	1	≤3.5%
HI	1	≤3.5%
IA	1	≤3.5%
ID	1	≤3.5%
IL	1	4.01% - 5%
IN	1	4.01% - 5%
KS	1	≤3.5%
KY	1	≤3.5%
LA	1	≤3.5%
MA	1	≤3.5%
MD	1	≤3.5%
ME	1	≤3.5%
MI	1	3.51% - 4%
MN	1	3.51% - 4%
MO	1	5.01% - 5.5%
MS	1	≤3.5%
MT	1	≤3.5%
NC	1	≤3.5%
ND	0	
NE	0	
NH	1	5.01% - 5.5%
NJ	1	≤3.5%
NM	0	
NV	0	
NY	1	4.01% - 5%
OH	1	3.51% - 4%
OK	1	≤3.5%
OR	1	>5.5%
PA	1	≤3.5%
RI	1	5.01% - 5.5%
SC	1	≤3.5%
SD	0	
TN	1	4.01% - 5%

2021 data used for AR & GA

Source: Kaiser Family Foundation "How the Pandemic Continues to Shape Medicaid Priorities: Results from an Annual Medicaid Budget Survey for State Fiscal Years 2022 and 2023" <https://www.kff.org/report-section/medicaid-budget-survey-for-state-fiscal-years-2022-and-2023-provider-rates-and-taxes/>

TX	1	>5.5%
UT	1	≤3.5%
VA	1	>5.5%
VT	1	>5.5%
WA	1	≤3.5%
WI	1	≤3.5%
WV	1	≤3.5%
WY	1	≤3.5%



Charlene MacDonald
Senior Vice President,
Chief Government Affairs Officer

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Washington, DC 20065
Tel. 202-680-5207

December 1, 2022

Dear Chairman Kane:

Thank you for the opportunity to comment on the “Draft Recommendation on Adjustments to Maryland’s Total Cost of Care (TCOC) Performance.”

CareFirst believes in Maryland’s all-payer system and the Total Cost of Care Model (the Model)’s underlying principles to drive innovation, reduce health care expenditures and advance access to high-quality, equitable, affordable healthcare for Marylanders. As noted in the agreement, the Model tests “whether State-wide health care delivery transformation, in conjunction with Population-Based Payments, improves population health and care outcomes for individuals, while controlling the growth of Medicare total cost of care.”¹ CareFirst is proud to join stakeholders across the healthcare system in supporting this innovative approach to promoting cost containment, affordability, and quality in Maryland.

We recognize the value our hospital partners provide to Marylanders, the financial pressure the industry is facing, and the fact that hospitals assume responsibility for the industry’s total cost of care performance since their rates are the only lever the Health Services Cost Review Commission (HSCRC) can pull. HSCRC has already taken many steps to address these financial pressures, including guaranteeing undercharges for two years, expanding unit rate corridors, advancing \$100M in January, and providing an incremental 0.4 percent in the update factor. CareFirst and all other payers have been paying the approved rates resulting from these HSCRC measures, which aimed to ensure the financial stability of hospitals through a period of unprecedented uncertainty. Now, as we emerge from this public health crisis, we must not abandon our commitment to care transformation, improved outcomes, and controlled cost growth that spurred Maryland’s innovative approach to hospital payment policy.

We recognize the difficulty Maryland’s 2021 and 2022 year-to-date Model performance presents, especially against the backdrop of challenging economic circumstances for individuals and businesses. We understand there are several contributing factors to this performance. Given the value of the Model for Marylanders, it will be important to make appropriate adjustments that demonstrate the State’s commitment to the Center for Medicare and Medicaid Innovation (CMMI) as a partner.

1. Maryland Total Cost of Care Model State Agreement; Recitals; p.1
2. “Inflation signals unrest ahead for health care”; <https://www2.deloitte.com/us/en/insights/industry/health-care/health-care-affordability-inflation.html>

As the HSCRC contemplates adjustments, it is important to recognize the current macro state of economics and healthcare financing to ensure the model continues to meet its intended goals. National healthcare spending continues to rise as we all confront record inflation growth and continue to deal with lingering impacts of the COVID-19 pandemic. Deloitte's 2022 Pulse Survey of US Consumers showed that 28 percent of consumers feel less prepared to pay for unexpected medical costs than they did last year². Deloitte notes health insurance prices in September 2022 were up nearly 30 percent from a year ago which is outpacing the rate of inflation growth of roughly 8 percent². With overall costs rising, it is more important than ever for the model to drive care transformation to support improved health outcomes and ultimately lower costs.

HSCRC Staff has recommended adjustments that, if implemented, would drive \$102 million in Medicare savings in 2023. This would be achieved through a combination of all-payer hospital rate reductions, Medicare-only rate reductions with a corresponding elimination of the hospital component of the Medicaid Deficit Assessment paid to the State of Maryland, and an increase in the public payer differential.

Maryland has relied on hospital savings to meet Model requirements since global budgets were established. HSCRC Staff recently released data to the Total Cost of Care workgroup demonstrating that during the period 2013-2019, Maryland averaged \$39 million in annual savings relative to Medicare's national rate of growth. However, in a reversal of prior years' trends, comparing the first six months of 2022 to the same period in 2021, Maryland Medicare hospital spend has grown by \$144 million more than the nation, representing 77 percent of Maryland's excess cost. When Staff looked deeper at inpatient trends in Maryland, they found that the primary driver of Maryland's excess inpatient cost was cost per day, not an increase in admissions or case mix. There have been attempts to frame this as a Medicare-only issue that we all should be working to solve, but CareFirst's members, other commercial members, Medicaid, and Medicare beneficiaries have all been subject to the same all-payer rates driving this cost per day, making it clear this is not just a Medicare issue. Thus, we support the Staff's first step in their proposal of an all-payer rate reduction, acknowledging this is an all-payer system.

However, we are deeply troubled by Staff's recommendation to increase the public payer differential by one percent, shifting \$50 million in public payer spending to individuals and businesses holding commercial insurance. This would yield \$26 million in "savings" for Medicare Fee-for-Service, but would fail to address underlying issues with respect to utilization and cost growth.

- **Lack of policy basis or empirical evidence** – The public payer differential has a long history in Maryland and is in place for 2 reasons: (1) to account for prompt payment, which applies to all payers; and (2) to account for public payer business practices, which avert bad debt. In 2018, HSCRC approved a historic adjustment to the public payer differential. At the time, Staff provided extensive analysis that demonstrated their policy rationale for the proposed adjustment. This adjustment was based on changes in bad debt percentages by payers and was intended to correct for market dynamics. In this recommendation, the HSCRC also included the following conditions:

1. Maryland Total Cost of Care Model State Agreement; Recitals; p.1

2. "Inflation signals unrest ahead for health care"; <https://www2.deloitte.com/us/en/insights/industry/health-care/health-care-affordability-inflation.html>

“...The success of the Model is dependent on improving care, reducing avoidable utilization, and providing efficient and effective care. To this end, the Commission should not use changes to the differential to meet TCOC savings performance requirements.”

“...It is the intent of the Commission to make a one-time adjustment at the beginning of the TCOC Model, as permitted by the contract to correct for cost inequities within the system and to avoid future changes to the public payer differential to assure the stability of the system and to preserve the all-payer nature of the Maryland Model.”

The draft recommendation violates these conditions that were approved by HSCRC to avoid this scenario. There is no evidence that market dynamics have changed between payers nor any rationale for the one percent increase. The public payer differential, which has a foundational purpose, is inappropriately being used as a vehicle to plug the remainder of required Medicare savings. Approval of this recommendation would call into question the integrity of the Model and the State’s commitment to an all-payer system.

- **Precedent setting** – The Model’s savings requirements are in place to hold the State accountable for driving care transformation, lower cost growth, and improved outcomes. If HSCRC chooses to use a cost shift to meet these savings targets, it sets the precedent that when the Model’s performance is in question, the public payer differential can serve as a backstop. This is not why the differential is in place and we advise against setting that precedent.
- **Implications at CMMI** – The apparent purpose of the public payer differential in this proposal is to artificially improve its performance for one payer. The Model specifically references “avoiding shifting costs” with regard to the public payer differential. The intent of the Model is to drive improved population health and true transformation of the delivery system, not to shift costs away from Medicare to other payers and consumers. We already know how CMMI will react to this – HSCRC put forward a proposal to CMMI that would have used the payer differential to help solve the Medicare Advantage benchmark problems faced by Maryland. This proposal was rejected by CMMI, because they do not support cost shifting in an all-payer system. We would caution the HSCRC against ignoring that history.

During the discussion at HSCRC’s November public meeting, HSCRC Staff responded to concerns about the public payer differential adjustment proposal by noting that it was intended to be temporary, ending in fiscal year 2024. CareFirst opposes this proposal even though it is temporary, because of the principles laid out above, not its material or immaterial impact on our business. Notwithstanding, it is unclear how the HSCRC expects to be able to reverse the adjustment in 2024 without shifting cost onto Medicare, presenting some of the same guardrail and savings challenges we face today. In its history, HSCRC has made several temporary adjustments that have become permanent, namely the artificial rate realignment of 25% of

1. Maryland Total Cost of Care Model State Agreement; Recitals; p.1
2. “Inflation signals unrest ahead for health care”; <https://www2.deloitte.com/us/en/insights/industry/health-care/health-care-affordability-inflation.html>

inpatient costs to outpatient rate centers, which shifted costs from Medicare to commercial payers, and the continued use of the Medicaid Deficit Assessment, which was initially used to temporarily take fiscal pressure off the State budget during the previous economic downturn.

CareFirst always appreciates the unique opportunity we have in Maryland to partner with the HSCRC and hospitals to advance the principles and intent of our Model. As HSCRC identifies appropriate adjustments to address Maryland's current Model performance, we simply encourage adherence to the fundamental tenets of this system. Thank you for the opportunity to comment on this important issue.

Sincerely,

A handwritten signature in black ink, appearing to read 'Charlene MacDonald', with a long horizontal flourish extending to the right.

Charlene MacDonald

1. Maryland Total Cost of Care Model State Agreement; Recitals; p.1
2. "Inflation signals unrest ahead for health care"; <https://www2.deloitte.com/us/en/insights/industry/health-care/health-care-affordability-inflation.html>

November 21, 2022

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

Dear Ms. Wunderlich,

Thank you for the opportunity to provide responses to the Health Services Cost Review Commission's (HSCRC) request for input regarding proposed actions considering the State's current performance on the Total Cost of Care (TCOC) Agreement with the Centers for Medicare and Medicaid Services (CMS). TidalHealth appreciates the HSCRC's efforts to consider comments from the hospital industry on how best to address this issue.

As we noted in our earlier comments on potential actions, TidalHealth supports a limited adjustment beginning in January 2023. In determining the magnitude of the recovery, the HSCRC needs to balance various competing factors, including the following:

- The recovery needs to be of a sufficient size to demonstrate to CMS that the State, and by extension Maryland's hospitals, is taking its obligations seriously under the TCOC Agreement.
- Since the final performance for CY 2022 will not be known until mid CY 2023, the recovery needs to be based on the best data available, including by considering a wide range of potential projections, so as not to cause significant revenue swings if a subsequent correction is needed on July 1, 2023.
- Although a correction is needed based on the most recent performance data, Maryland's hospitals, similar to national peers, are experiencing unprecedented financial pressures. While Maryland cannot be an island unto itself, the rate setting system was specifically established to ensure solvency for efficient and effective hospitals.

TidalHealth supports a long-term plan based on existing policies with certain modifications to create a more targeted approach than may be able to be developed with the limited time before January 1, 2023. While the Commission is appropriately developing a corrective response to the state's current performance under the Model agreement, it is likely that both the Maryland healthcare industry and healthcare nationally have yet to reach a steady state in the pandemic's aftermath. This fact suggests that the state's current underperformance may not persist to the degree documented in current data and that policy corrections should be applied with caution to avoid undue financial hardship to hospitals that could result from an overcorrection.

TidalHealth is supportive of the all-payer nature of the rate setting system and believes that it has been a foundational success over the past several decades. By establishing certain quality programs such as the Readmissions Reduction Incentive Program (RRIP) as all-payer, providers are able to focus holistically on clinical delivery approaches that are in the best interests of the patients, regardless of payer. This type of approach has set Maryland apart from other regulatory models and value-based programs nationally, which are typically more fragmented and lack the cohesiveness of the all-payer system.

In that spirit, TidalHealth supports the staff's proposal to remove the 0.4% increase in the update factor that was provided for Fiscal Year 2023. We view this reduction as a prudent step toward realigning the state's per beneficiary total cost of care with national trends. We note, however, that this is an all-payer response to a fundamentally Medicare policy issue. Because this increase was intended to address the shortfalls in revenue that Maryland hospitals are experiencing in the face of rising inflation, we ask that the Commission make this change a temporary adjustment with the intention of restoring this revenue to the rate base as the system stabilizes. Inflation represents a permanent increase in our costs, and a permanent rate reduction will cause continued financial stress in the face of rising costs across the board.

Although TidalHealth supports the all-payer system, we believe that a temporary Medicare-only action is also warranted in this situation. The TCOC Agreement with CMS is based on achieving Medicare savings, not all-payer savings. Since the State is currently failing this Medicare-only test while continuing to meet the all payor per capita growth rate, any action that recovers funds on an all-payer basis is unnecessary and only adds to the financial distress of the hospitals.

By applying the recovery on an all-payer basis, the savings will accrue to commercial insurers who already receive significant financial benefit from the all-payer rate setting system, paying less for hospital services than their peers in other states. If an all-payer recovery is implemented, the HSCRC should work with their colleagues at the Maryland Insurance Administration to ensure that these savings are passed along to premium payers, e.g. consumers, and not solely increase the financial margins of the insurers. The staff's proposal to increase the payer differential on a temporary basis is a fair suggestion to directly address the issue of commercial payer engagement during this policy response.

Moreover, TidalHealth supports a thoughtful and targeted approach to any Medicare-only recovery rather than an across-the-board reduction. Although TidalHealth has concerns regarding the current Integrated Efficiency Policy (including in its use of the TCOC benchmarks as currently designed), the basic premise of providing additional funding for low cost and price efficient hospitals while taking money away from higher cost and price inefficient hospitals is sound policy. The HSCRC should apply this same premise to any recovery, rather than implementing an across-the-board reduction that doesn't distinguish between inefficient and efficient hospitals and is inconsistent with HSCRC's stated policy goals.

TidalHealth believes that any rate adjustments in January should be based on the goals of existing HSCRC policies while we – the hospital industry and HSCRC – work towards a longer-term solution that could be implemented in July. TidalHealth offers the following suggestions for areas of discussion and opportunity, to be considered now and as a longer-term policy is developed:

- **Modifications to the current Integrated Efficiency Policy.** The current policy includes a TCOC calculation that is based on information that substantially misrepresents reality, that unfairly penalizes rural areas of the state, and that runs counter to the HSCRC's and CMS's goal of

improving health outcomes while achieving health equity. For example, we believe that the selection of benchmark counties was based on a limited set of matching criteria that failed to adequately consider social determinants of health and, more importantly, lacked any analysis of desired health outcomes. Using these benchmark counties lowers the TCOC benchmarks for Maryland rural hospitals, thereby placing them at risk of losing money – money that is needed to fulfil their statutory mandate of improving the health of their communities. We also believe that the failure to adjust for price differences across geographies—most critically by ignoring the Medicare hospital wage index, which is used to directly adjust Medicare hospital payments under the IPPS and OPPIs, as well as the payments for several other non-hospital providers—was arbitrary and capricious. This fatal flaw compounds the problematic redistribution of revenue from rural counties to affluent areas, further increasing inequities in the Maryland healthcare system, all in direct contravention of our Model’s goals. We plan to continue to evaluate our legal options to challenge the existing TCOC benchmark methodology. While we intend to submit a more detailed proposal as part of discussions regarding the longer-term plan, we ask that the Commission remove the problematic TCOC benchmarks from any solution that is implemented on January 1, 2023. We propose replacing the use of the benchmarks in the Integrated Efficiency Policy with a TCOC growth calculation measure instead.

- **Excess capacity and retained revenue.** TidalHealth believes that the HSCRC’s current position on this issue needs to be revisited. By not addressing excess capacity and locking fixed revenue in increasingly price inefficient hospitals, the current HSCRC position:
 - Increases costs for patients receiving services at these facilities;
 - Reduces funding for needed investments at hospitals still providing needed clinical services; and
 - Provides a perverse incentive for hospitals to eliminate services, regardless of the needs of the communities that they serve.

TidalHealth does not agree with the premise that addressing retained revenue will provide a disincentive for hospitals to continue to reduce utilization. A policy could be developed that allows for the retention of these funds for a defined period of time, with an expectation that they would be used for specific purposes and reduced in a thoughtful way over time to reflect the reduced level of service that the hospital is providing. This premise is already reflected in the conversion of acute care hospitals to Freestanding Medical Facilities (FMF). The HSCRC reduced funding for FMFs because they were providing fewer services than had previously been provided by their acute care hospital predecessors. The same should hold true for acute care hospitals that are providing less care than they once did.

- **Review of existing assessments and add-ons in rates.** Over time, the HSCRC has included many assessments and add-ons in rates for things like the Medicaid deficit assessment, Graduate Medical Education, and Catalyst Regional Partnerships. While each of these on their own potentially has merit or meets a pressing need, they collectively add cost to the system, negatively impacts our performance under the TCOC Agreement, and can make otherwise price inefficient hospitals appear to be more efficient. As part of the longer-term process, the HSCRC and industry should examine each of these assessments and add-ons to determine if they are still appropriate, both in their policy goals and magnitude. The proposed reduction in the state’s deficit assessment that has existed for several years is a promising beginning to that process.

Thank you again for the opportunity to provide feedback to the HSCRC on this important issue. The leadership of TidalHealth will make itself available should you or your staff have any questions.

Sincerely,

A handwritten signature in blue ink, appearing to read "Steve Leonard", written in a cursive style.

Steve Leonard



15 School Street, Suite 200
Annapolis, Maryland 21401
410-269-1554

For information, contact:
Matthew Celentano, Executive Director

November 28, 2022

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

Re: Public Payer Differential Adjustment

Dear Ms. Wunderlich:

On behalf of the League of Life and Health Insurers of Maryland, Inc. (League), thank you for the opportunity to provide comments on the public payer differential adjustment. The League is the state trade association representing life and health insurance companies in Maryland. On behalf of the five carriers in the state's commercial market (Cigna, CareFirst Blue Cross Blue Shield, CVS/Aetna, Kaiser Permanente, and UnitedHealthcare), who provide coverage to millions of Marylanders, the League appreciates the opportunity to comment and express our concerns with proposed adjustment to the differential.

League members are very supportive of the proposed overall goals of the Total Cost of Care Model (Model), but are very concerned about the current public payer differential adjustment discussion. The HSCRC's proposal to increase the differential 1% will just shift the cost from public payers to the commercial market and ultimately Maryland consumers in higher premiums.

Unfortunately we are not currently seeing the promise of the cost savings through outcome improvements in the Model, and the discussion departs from that objective by asking commercial carriers and their members to fund the Model's Medicare savings target, rather than driving true transformation of the delivery system. The proposal represents rate manipulation and will ultimately just be a pass through to individuals, employers, and the employees they are trying to cover. Not only does the proposal hurt these stakeholders, but it's a bad precedent as Maryland and the Center for Medicare and Medicaid Innovation (CMMI) try to realize the goals of the Model.

The League of Life and Health Insurers of Maryland, Inc.
15 School Street, Annapolis, MD 21401
410-269-1554
www.leaguemaryland.com

In addition to the above concerns, we are concerned about the damage the proposal could do to Maryland's relationship with CMMI. In 2021, the HSCRC put forward a proposal to CMMI that would have used the payer differential to generate savings for Medicare Advantage plans, with the goal of increasing choice, enhanced benefit offerings, and competition that could be offered through a stronger MA market. This proposal was rejected by CMMI, because they do not support cost shifting in an all-payer system. We are concerned that this proposal could jeopardize the waiver – if the HSCRC relies on a payer differential adjustment to meet the savings target, and CMMI rejects that approach, the State will have lost valuable time to explore other options to achieve \$300 million in savings by the end of 2023.

Lastly, the current proposal is in direct conflict with past HSCRC approved policies. In 2018, the HSCRC approved a historic adjustment to the public payer differential. At the time, Commission staff provided extensive analysis that demonstrated their policy rationale for the proposed adjustment. This adjustment was based on the changes in bad debt percentages by payers due to increasing levels of uncompensated care. As part of that recommendation, the HSCRC stated that the change was being made for equity purposes and “the Commission should not use changes to the differential to meet TCOC savings performance requirements.” Furthermore, it noted that the HSCRC should “avoid future changes to the public payer differential to assure the stability of the system and to preserve the all-payer nature of the Maryland Model.” HSCRC staff have not provided analysis or policy justification for this proposal. Thus, it is clear the public payer differential is being used as a vehicle to inappropriately shift costs between payers in an all-payer system.

Thank you, again for the opportunity to provide this feedback on the public payer differential adjustment. Should you have any questions, please do not hesitate to contact me. We are happy to continue the discussion and find solutions that attain the needed financial stability.

Sincerely,

A handwritten signature in black ink, appearing to read "Matthew Celentano", with a long horizontal line extending to the right.

Matthew Celentano
Executive Director
The League of Life and Health Insurers of Maryland, Inc.

October 7, 2022

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

Dear Katie,

On behalf of the members of the Maryland State Medical Society (MedChi), I am writing to provide feedback to the Health Services Cost Review Commission (HSCRC) regarding its recent request for information on potential actions to be taken to address the expected shortfall of the State of Maryland under the Total Cost of Care (TCOC) Agreement with the Centers for Medicare and Medicaid Services (CMS).

As part of any action to address the expected shortfall, I would encourage the HSCRC to advocate for highlighting the exogenous factors provision in the TCOC Agreement in its discussions with CMS. These are unprecedented times that we are living through, with volumes remaining relatively flat nationally and CMS' own actuaries being off in their projections – used by HSCRC staff as part of the annual rate update for Maryland's hospitals – by several percentage points.

If CMS is unwilling to recognize the exogenous factors that have led to our current situation, then MedChi supports the position of the Maryland Hospital Association that a modest rate adjustment is needed January 1, 2023, to demonstrate the State's commitment to the success of the TCOC Agreement. MedChi believes that the adjustment should be viewed as an incremental step while a full assessment to better understand the magnitude of the issue is completed, allowing for a more comprehensive and longer-term solution to be implemented July 1, 2023.

In developing a longer-term solution, MedChi strongly advocates for the HSCRC to revisit the issue of excess capacity and retained revenue. By not addressing these issues in a comprehensive way, the current HSCRC position has the unfortunate consequence of increasing costs for patients receiving care at these facilities. It also limits the amount of funding available for needed clinical services and provides a perverse incentive for hospitals to eliminate services, regardless of the needs of the communities that they serve.

MedChi does not agree that removing retained revenue from the global budgets will necessarily provide a disincentive for hospitals to continue to reduce utilization. A complementary policy could be developed that allows a hospital to keep some of these funds, with the expectation that they would be used for specific purposes and reduced in a thoughtful way over time to reflect the reduced level of service that the hospital is providing. This policy premise is already reflected in HSCRC's position on the conversion of acute care hospitals to Freestanding Medical Facilities (FMF). In approving these new types of facilities, the HSCRC removed funding from the historic global budgets because they were providing less services than had previously been provided by their acute care hospital predecessors. The same should hold true for acute care hospitals that are providing less care than they once did.

It is in this spirit that MedChi continues to raise concerns about the lack of action by the HSCRC regarding the full rate review for Medstar Health. If the HSCRC had acted on the full rate review as approved by the Commissioners, it may have been able to identify significant savings and set a precedent by which future policies regarding retained revenue could be based. In the absence of the HSCRC acting on the full rate review, it has limited the policy tools available to it and ensured that funds that could be better spent on patient care are instead trapped in increasingly price inefficient facilities.

In its deliberations to identify potential solutions, MedChi strongly encourages the HSCRC to not remove any funding or make changes to two critical programs for the future success of the TCOC Agreement – the Episode Quality Improvement Program (EQIP) and the Maryland Primary Care Program (MDPCP). MedChi strongly supports and agrees with the separate letter sent by the management of the Maryland Primary Care Program. EQIP and MDPCP are strongly supported by the MedChi membership, align community practitioners with the hospitals, and have the potential to accelerate and deliver upon the savings requirements of the TCOC Agreement.

Thank you for the opportunity to provide comments.

Sincerely,

A handwritten signature in blue ink that reads "Gene M. Ransom III". The signature is written in a cursive style with a horizontal line at the end.

Gene Ransom
CEO
MedChi, The Maryland State Medical Society

cc: Adam Kane, Chairman, HSCRC
Joseph Antos, Vice Chairman, HSCRC
Tori Bayless, Commission, HSCRC
Stacia Cohen, Commissioner, HSCRC
James Elliot, Commissioner, HSCRC
Maulik Joshi, Commissioner, HSCRC
Sam Maholtra, Commissioner, HSCRC



November 28, 2022

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

Dear Chairman Kane,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the draft recommendation for adjusting for excessive Total Cost of Care (TCOC) growth in CY2022. JHHS appreciates the balanced approach that the Health Services Cost Review Commission (HSCRC) has taken with the draft recommendation. The approach leverages support for adjustments across all stakeholders that benefit from the Maryland Model, including hospitals, commercial payors and the state of Maryland. While JHHS is generally supportive of the HSCRC's draft recommendation, specific comments and concerns are noted below.

Staff recommends an all-payer rate reduction of 0.40% that will be taken from the January rate orders across the board

JHHS, and the majority of the hospital industry, supports a targeted approach to rate reductions, rather than across the board. The hospital industry developed a consensus position, recommending a reduction in hospital Medicare rates with the majority of the reduction achieved using the latest efficiency policy. This approach was proposed by Maryland Hospital Association (MHA) at the October meeting, and most of the Maryland hospitals supported this approach. Reducing rates based on the efficiency policy accounts for the fact that some hospitals are better positioned to sustain rate reductions than others. Less efficient hospitals have retained revenue and the industry recognizes that 75% of the rate reduction should come from inefficient hospitals and 25% from the remainder. JHHS would encourage the HSCRC to reconsider this aspect of the recommendation and instead honor the industry consensus to achieve the reductions in a targeted way, utilizing the HSCRC approved efficiency policy. We strongly encourage staff to adhere to existing policies. To change policy stances in response to a correction period causes us to pause in trying to understand the purpose of a policy that has been used in the past, but is now not considered by staff to be "accurate" or "relevant" to help address the issues before us. Constant policy changes that are not properly vetted with the industry undermines the stability of the Maryland Model.

We would also encourage the HSCRC to alter the all-payer rate reduction when the state is failing the Medicare targets – there is only a need reduce Medicare costs in Maryland in order to achieve compliance. The hospital industry is facing unprecedented labor and supply costs, with operating margins deteriorating significantly. Implementing an all-payer rate reduction will worsen hospital financial conditions, resulting in difficult decisions about staffing and services for some hospitals, while providing minimal targeted savings to address the Medicare issue directly. There is no need to reduce rates to all payers, particularly when commercial payers already receive the benefit of reduced hospital costs.

Staff recommends requesting an increase to the Public Payer Differential of 1% for the remainder of FY 2023 and the duration of FY 2024, contingent upon approval of the Center for Medicare and Medicaid Innovation (CMMI)

JHHS strongly supports using the differential as a temporary tool to reduce Medicare costs in Maryland. Insurers are the biggest benefactor of Maryland’s all-payer system, resulting in hospitals costs to commercial payers that are on average 25% less than the nation. Expecting all stakeholders to contribute to corrective actions sends a strong message to state and federal policy makers, recognizing that success and failure of the Maryland model requires support, commitment, and sacrifice from all parties. Additionally, as more charity care and bad debt is associated with insured patients being enrolled in high-deductible health plans, revisiting and revising the differential may be sound public policy.

Staff recommends implementation of the Medicare Performance Adjustment Savings Component of \$50 million

JHHS strongly supports using the Medicare Performance Adjustment Savings Component (MPA-SC) as a policy to bring Maryland cost growth in line with the nation. As noted earlier, JHHS believes that any reduction to hospital rates should be Medicare-only, and implemented based on the integrated efficiency policy, not across the board. The MPA-SC was developed and approved as a methodology to achieve the Medicare savings target if needed. The policy should be implemented now and used to mitigate across the board and all-payer reductions.

Additionally, given that there are various factors still in flux that will impact final model performance, JHHS believes the HSCRC should be cautious not to overcorrect with the adjustments under consideration. Of note, the actions inherent in the July 1, 2022 rate adjustments are not yet included in the data, and will have an impact on the state’s final performance.

Staff recommends that the Commission send a formal request to the State to reduce the Medicaid Deficit Assessment by \$50 million, contingent upon approval by the State Legislature

JHHS also supports this recommendation. Similar to the differential position, reducing the Medicaid Deficit Assessment demonstrates a multi-stakeholder commitment to protecting and preserving the Maryland Model, where all parties benefit. The staff recommendation notes that any

reduction to the Deficit Assessment is contingent upon approval by the State Legislature. However, a reduction to the remittance portion of the Deficit Assessment likely does not require any action by the Legislature. The laws governing the Medicaid Deficit Assessment were last revised by Chapter 16 of the Acts of 2019. The language currently states, “for fiscal year 2021 and each fiscal year thereafter, the budgeted Medicaid Deficit Assessment shall be \$294,825,000.” There is no reference in current law to a remittance portion, which is currently \$56 million. In fact, any requirement for a remittance portion of the Medicaid Deficit Assessment was removed from law after 2016. In reviewing the law as it is currently written, the HSCRC and the Maryland Department of Health have the authority to abandon the remittance portion of the Medicaid Deficit Assessment so long as the total assessment remains as \$294,825,000.

We appreciate concerns from the Maryland Medicaid program around long-term implications of this policy. However, the recommendation is a one-time only action, and is certainly justifiable when hospitals are experiencing unprecedented financial struggles and the Maryland Medicaid program is experiencing unprecedented financial surplus due to funds through the public health emergency.

Taking Corrective Actions Without Addressing Underlying Issues with the Model is Problematic

In addition to pursuing corrective action and as JHHS noted in our previous comment letter on potential corrective action, we also encourage the HSCRC and the industry to pursue a thoughtful evaluation of the policies within the TCOC Model that are improving patient care and those that are not. We must address the systemic problems within the Maryland Model and the Global Budget Revenue (GBR).

To this end, JHHS must reiterate our concerns around the issue of retained revenue and the need for a rational population-based and clinical needs approach to right-sizing bed capacity, especially in Baltimore City where the population has experienced a decline. There is a need for clear and updated policies and guidance on the impact of retained revenue on volume reduction. Data indicate that since the implementation of GBR, hospitals with retained revenue have seen an overall decrease in volume, not just potentially avoidable utilization (PAU). There is no data at this time to indicate that hospitals with decreased volume and retained revenue have achieved that decrease through population health investments – instead, this may have been achieved simply through the elimination or reduction of services:

- Recent Vizient and Sg2 data show that nationally, staffed beds at community hospitals declined by 3%, while Maryland has experienced a 17% decline in staffed beds at community hospitals. Simultaneously, AMC beds have grown 9% nationally, while in Maryland, AMC staffed beds remain stagnant.
- Nationally, community hospitals are shrinking; the revenue from these hospitals is being shifted to the hospitals that provide medically necessary care for those patients. However, in Maryland, this shrinkage is accelerated, while most of the revenue remains with the hospitals closing beds.
- Additionally, the population of Baltimore City is shrinking; the Baltimore City population was 576,498 in 2021, a 7.2% decrease from the population of 620,942 in 2010. As community hospitals are operating at a fraction of their fixed capacity and are projected

to see fewer inpatients over time, it is clear that their long-term role in the care continuum is changing.

- The Maryland Model should support hospitals that either deliver medically necessary care or serve as a vital resource to a community – like in more rural areas. The model should not protect and insulate hospitals from bed declines that are either deliberate or the result of population shifts.
- The HSCRC should investigate and explore potential regulatory opportunities regarding length of stay (LOS). The current regulatory environment in Maryland has resulted in challenges related to getting patients admitted into long-term care facilities, which in turn increases LOS, particularly for complex patients.
- The HSCRC should also explore regulatory opportunities related to skilled nursing facilities (SNFs). Due to low Medicare Advantage penetration in Maryland, there is very little utilization management, resulting in more SNF bed days in Maryland compared to the nation. This becomes a crucial consideration as we evaluate total cost of care performance compared to the nation.

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

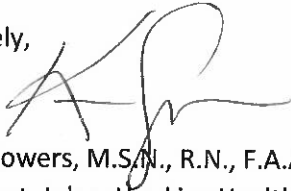
JHHS, like many other hospital partners and policy makers, believes that the Maryland Model is intended to incentivize thoughtful investments in community and population health strategies that will produce the long-term outcome of reduced hospital utilization through lower rates of chronic conditions, improved health, and addressing the underlying social determinants of health (SDOH). There is a critical need to rebalance the system with longer-term policy corrections in order to achieve savings targets along with population health goals. JHHS remains firm in its belief that the goals of the model cannot be achieved over a 10-year period without directly reinvesting retained revenues in population health, creating quantifiable savings and investments. Population health investments should be strategic and regional with the initial focus on jurisdictions with higher rates of poverty and health disparities. As JHHS has noted in previous comment letters, industry-wide savings targets will be increasingly hard to reach if all retained revenue is allowed to stay within the system. Locking retained revenue in facilities that no longer provide clinical care will also greatly limit the state’s ability to invest in the types of transformative strategies that CMMI is expecting, namely housing and SDOH-focused interventions.

JHHS believes that corrective action needs to be pursued in order support the long-term viability of the Maryland Model. However, we also believe there are fundamental issues with the Maryland Model’s policies and methodologies that hinder the State and industry from achieving our goals and financial targets. In order to achieve these goals, it is necessary to implement longer-term policy corrections that address retained revenues and inappropriate volume reductions. JHHS would

encourage the HSCRC to begin work in January to realign the existing incentives within the Model, with the goal of implementing a comprehensive approach that addresses the underlying challenges of the current Model and places Maryland on a stronger path to success.

JHHS appreciates the opportunity to comment on the draft recommendation and longer-term policy corrections that may be required of the State and the industry.

Sincerely,

A handwritten signature in black ink, appearing to be 'KS', written over a light blue horizontal line.

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

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, R.N.
Katie Wunderlich

Maulik Joshi, Dr.P.H.
James Elliott, M.D.
Sam Maholtra



Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

November 28, 2022

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
750 E. Pratt Street
Baltimore, MD 21202

RE: Draft Recommendations for Adjustments to the Total Cost of Care Model

Dear Ms. Wunderlich:

Thank you for the opportunity to provide comments on the draft recommendations for adjustments to the Maryland Medicare Total Cost of Care Model. As the largest integrated health care delivery system in the United States,¹ [Kaiser Permanente's approach to care](#) shares similarities with the Maryland Model – a focus on care coordination, quality improvement, and population health, with aligned financial incentives.

From that perspective, we uniquely appreciate the promise of the Total Cost of Care Model to ensure access to high quality, equitable, and affordable care for all Marylanders. Nevertheless, we are concerned about the Commission's proposal to increase the public payer differential by one percent, shifting costs from public payers to commercial payers and ultimately to the members that they serve. Specifically, our concerns are as follows:

- **The proposal does not reflect true savings.** This approach undermines the central objective of the Total Cost of Care Model, which is health system transformation. The Model is based on the premise that better care coordination and quality will improve patients' health while generating cost savings to hospitals and ultimately consumers. The proposal under consideration departs from that objective by asking commercial carriers and their members to fund the Model's Medicare savings target, rather than driving true transformation of the delivery system.
- **CMMI has previously rejected cost-shifting proposals.** In 2021, the HSCRC put forward a proposal to CMMI that would have used the payer differential to generate savings for Medicare Advantage plans, with the goal of increasing choice, enhanced benefit offerings, and competition that could be offered through a stronger MA market. This proposal was rejected by CMMI, because they do not support cost shifting in an all-payer system. We are concerned that this proposal could jeopardize the waiver – if the HSCRC relies on a payer differential adjustment to meet the savings target, and CMMI

¹ Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

rejects that approach, the State will have lost valuable time to explore other options to achieve \$300 million in savings by the end of 2023.

- **The proposal conflicts with the HSCRC’s past positions.** In 2018, the HSCRC approved a historic adjustment to the public payer differential. At the time, Commission staff provided extensive analysis that demonstrated their policy rationale for the proposed adjustment. This adjustment was based on the changes in bad debt percentages by payers due to increasing levels of uncompensated care. As part of that recommendation, the HSCRC stated that the change was being made for equity purposes and “the Commission should not use changes to the differential to meet TCOC savings performance requirements.” Furthermore, it noted that the Commission should “avoid future changes to the public payer differential to assure the stability of the system and to preserve the all-payer nature of the Maryland Model.”

We appreciate that the COVID-19 pandemic has put tremendous financial pressure on hospitals and are open to discussion about additional actions that could be taken to achieve financial stability. Thank you for the opportunity to comment. Please feel free to contact Allison Taylor at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,



Allison Taylor
Director of Government Relations
Kaiser Permanente



250 W. Pratt Street
24th Floor
Baltimore, MD 21201-6829
www.umms.org

CORPORATE OFFICE

November 28, 2022

RE: UMMS Comments Regarding the HSCRC November 9 Draft Staff Recommendation on Adjustments to the Maryland Medicare TCOC Performance

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

Dear Mr. Kane and Ms. Wunderlich:

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, We appreciate the opportunity to state our position regarding the HSCRC's November 9 Draft Staff Recommendation on Adjustments to the Maryland Medicare TCOC Performance.

The Maryland Total Cost of Care (TCOC) Model is enormously beneficial to providers, commercial payers, and, most importantly, the citizens of Maryland. UMMS is a strong proponent of the Maryland Model and recognizes the serious nature of the Model performance. It is critical that stakeholders come together in the effort to tackle the shared task of improving Model performance and respond collectively. As such, we continue to strongly support the industry's position that any corrective action plan should share the financial burden among stakeholders and provide adequate funding toward hospital operations that support long-term per capita savings and population health improvement goals.

Maryland hospital's financial condition has greatly deteriorated and UMMS is also experiencing declining financial results as we have experienced operating losses through fiscal year to date October 2022. We urge the HSCRC to consider the industry's position when determining a final decision. With this in mind, our comments regarding the Recommendation are below.

UNIVERSITY OF MARYLAND MEDICAL SYSTEM
University of Maryland Medical Center • University of Maryland Medical Center Midtown Campus •
University of Maryland Rehabilitation and Orthopaedic Institute • University of Maryland Baltimore Washington Medical Center •
University of Maryland Shore Regional Health – University of Maryland Shore Medical Center at Easton -
University of Maryland Shore Medical Center at Chestertown - University of Maryland Shore Medical Center at Dorchester –
University of Maryland Shore Emergency Center at Queenstown •
University of Maryland Charles Regional Medical Center • University of Maryland St. Joseph Medical Center •
University of Maryland Upper Chesapeake Health System – University of Maryland Upper Chesapeake Medical Center -
University of Maryland Harford Memorial Hospital •
University of Maryland Capital Region Health – University of Maryland Bowie Health Center –
University of Maryland Laurel Medical Center – University of Maryland Prince George's Hospital Center •
Mt. Washington Pediatric Hospital

UMMS Supports Raising the Public Payer Differential by 1% and Pursuing \$50M in State Support

All stakeholders benefit from the Maryland Model and should share accountability more equitably to ensure the Model's success. Raising the payer differential and securing state funding ensures that hospitals do not carry the full burden of the corrective action. Maryland hospitals are delivering significant savings to all-payers. Raising the payer differential is a reasonable approach to ensuring payer participation in securing the future of the Model.

Additionally, reducing the Medicaid Deficit Assessment to hospitals represents another important opportunity for shared accountability. We urge the HSCRC to pursue this avenue with the State and to investigate the potential avoidance of Legislature action.

The 0.4% All- Payer Rate Reduction Should be Replaced with a Medicare-only MPA-SC Adjustment

UMMS strongly disagrees with the proposed 0.40% all-payer reduction and believes it should be eliminated. The state's current performance is not driven by hospital volume or price growth, but rather a slowing in the growth rate of the nation. Since all stakeholders in the state benefit from the model, the majority of the financial burden must not be borne by hospitals, but rather shared across all stakeholders. As indicated earlier, hospitals are facing significant financial challenges and implementing an all payer reduction of 0.40% would place a disproportionate financial burden on hospitals, when a smaller, more directed adjustment could be made in the MPA-SC.

Savings from the Traditional Medicare Performance Adjustment Should be Counted

The traditional Medicare Performance Adjustment (MPA) already measures change in TCOC performance from CY 2019 to CY 2022 versus the nation. As statewide performance has eroded, the overall MPA adjustment for the state is expected to be a significant reduction to hospital payments, potentially as high as \$45 million. Excluding this amount from any corrective action would result in providing more savings to Medicare than is required.

Medicare Performance Adjustment Savings Component Should Be Used for the Remaining Required Savings

Using the MPA-SC both limits the financial burden to hospitals by providing direct savings to Medicare and avoids shifting any further financial burden to other payers via other mechanisms. Using the MPA-SC protects the all-payer model given the need to ensure Medicare savings and avoids providing rate reductions to other payers that already achieve savings from the Model.

As stated in our October letter, we are supportive of distributing a small portion of the correction across-the-board, while distributing the majority of the MPA-SC according to the existing efficiency policy.

UMMS believes it is necessary to evaluate existing policies as part of a broader process to address the appropriate distribution of resources within our capped system. In our October letter, we provided remarks on this matter and continue to support those comments. Importantly, UMMS serves a broad, diverse set of communities in Maryland. Policies must account for the differential resources required to serve the unique circumstances of academic medical centers, sole community providers and providers with safety net functions. Working together to develop policies that create clear, direct incentives around all of these issues will be key to the long-term sustainability of our Model.

UMMS appreciates the opportunity to provide comments on the Draft Staff Recommendation and we look forward to continuing discussions with the Commission on policy topics.

Sincerely,



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

Cc: Joseph Antos, PH.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen
James Elliott, M.D.

Maulik Joshi
Sam Maholtra
Michelle Lee, CPA CFO
Alicia Cunningham



November 28, 2022

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

Dear Katie –

Thank you for continuing to allow Maryland hospitals to offer comments and suggestions on how an adjustment to Global Budget Revenues in response to Maryland’s current performance on Total-Cost-of-Care (TCOC) might be applied at an individual hospital basis.

LifeBridge Health understands the Health Services Cost Review Commission position to possibly allocate the reductions to revenue using a combination of overall regulated revenue and performance on an efficiency measure – either ICC ranking, MPA performance or a hybrid of both. As we noted previously, we continue to remain supportive of the MHA proposal to allocate a \$25 million Medicare adjustment using a 25% proportioned reduction and 75% efficiency policy measure, but maintain concerns about the sole use of the ICC for larger overall revenue reductions given some of the unique issues highlighted in our October 6th comment letter and included below again for reference.

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

CARE BRAVELY

2401 W. Belvedere Ave., Baltimore, MD 21215-5216 • lifebridgehealth.org

While we raise concerns with what we see as issues which might contribute to making the ICC a difficult method to use to apportion statewide revenue reductions, we remain both supportive of the Commission's goal of taking actions designed to stabilize TCOC performance and committed to the long-term success of Maryland waiver model.

Sincerely,

David Krajewski (signed MDM)

David Krajewski

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

Michael D. Myers

Michael D. Myers

Vice President Regulatory Reporting and Reimbursement, LifeBridge Health
& CFO Carroll Hospital

MidAtlantic BUSINESS GROUP ON HEALTH

November 28, 2022

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Executive Director**

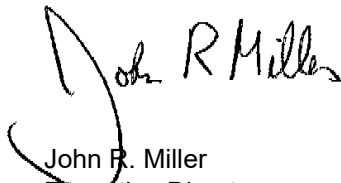
Dear HSCRC Leadership Team,

This letter is regarding the public payer differential change being considered by HSCRC. However, I'd first like to take this opportunity to express appreciation and support for the Maryland Total Cost of Care program. Over the years, the MidAtlantic Business Group on Health has sought to educate commercial healthcare purchasers (employers) on the unique situation that exists in Maryland. In fact, the Maryland TCOC approach aligns very well with what employers are driving for all over the country.

I have recently learned that HSCRC is considering a recommendation to increase the public payer differential by one percent. Of course, this will shift spending from public payers to commercial insurers (and indirectly to fully insured employers), self-insured employers, and ultimately workers.

Certainly, hospitals face economic pressures. However, shifting the responsibility for meeting these challenges to commercial purchasers of healthcare seems counter to the spirit and intention of the Maryland waiver. Many employers (including not-for-profit employers) are also facing economic pressures, as are their employees. I urge HSCRC to keep this conversation open, and to continue to find and consider options to avoid setting this precedent.

Very few non-healthcare employers are aware of HSCRC's existence, much less the details of HSCRC's calculations, and are thus unlikely to weigh in on this situation. Thanks for this opportunity to represent an employer's viewpoint.



John R. Miller
Executive Director
MidAtlantic Business Group on Health

November 28, 2022

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

Dear Mr. Kane and Ms. Wunderlich:

On behalf of the MedStar Maryland hospitals, we appreciate the opportunity to provide comments on the HSRC staff's Draft Recommendation on Adjustments to Maryland Medicare Total Cost Of Care (TCOC) Performance dated November 9, 2022.

We support the goal of overcoming the Maryland Model's immediate challenges created by pandemic driven volatility. Although hospitals continue to face unprecedented financial challenges as a direct result of the volatility of the COVID-19 pandemic, MedStar Health appreciates the need to improve the TCOC Model performance ensuring the longevity of our unique and valued reimbursement system which benefits all participants: patients, payors and hospitals alike. To that end, **MedStar Health supports the approach laid out in the Maryland Hospital Association's (MHA) comment letter which emphasizes a Medicare-focused reduction that is shared equitably across hospitals, payors and the state.**

Maryland's Model performance was running favorable to target prior to the pandemic and the current challenges meeting the guardrails are a direct impact of this unprecedented pandemic. Given this unique situation, we support HSCRC and the State activating the built-in flexibilities in the Model contract including:

- Invoking the exogenous factors clause
- Raising the public payor differential

To date, hospitals have shouldered a significant and disproportionate load of the financial burden associated with this once in a lifetime pandemic. National nursing shortages have placed hospitals in a precarious position. Workforce shortages and inflationary pressures have driven costs up significantly and macro-economic conditions have resulted in erosion of cash reserves for the health care industry. Nursing vacancy rates in the Mid-Atlantic are higher than the nationwide industry average highlighting the critical challenges associated with staffing. Further

underfunding inflation and/or disproportionately negatively impacting hospitals will further stress all Maryland hospitals' ability to remain competitive on a national level in attracting the necessary clinical resources to care for Maryland residents. **It is imperative that any solution does not further exacerbate the current underfunded inflationary crisis faced by hospitals.**

There have been large fluctuations in hospital volumes and healthcare needs since the pandemic began. Historical information is likely to look much different than current and future state. As we move forward, policy changes undoubtedly will be necessary; however, decisions made on historic data may not reflect current realities and could jeopardize delivery of healthcare services. As a result, HSCRC's historical disciplined approach will be even more critical in making future policy changes.

In closing, we ask that the HSCRC balance the need for action with stability and predictability, which have been hallmarks of the Maryland Model.

Thank you for the opportunity to provide comments.

Sincerely,



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

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



Mt. Washington
Pediatric Hospital

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December 7, 2022

Jerry Schmith
Principal Deputy Director, Revenue and Compliance
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Mt. Washington Pediatric Hospital – Comments Regarding TCOC Performance and Potential Corrective Action Steps

Dear Jerry:

This letter is to provide commentary to the Health Services Cost Review Commission (“The HSCRC”) in response to the request at the September Public Session for input on potential corrective action steps that may be required if the State does not meet the financial targets required by the Maryland Total Cost of Care Model.

As proposed, the HSCRC would reduce all-payer rates, in an effort to improve Model performance in the Medicare segment. However, as a children's hospital, MWPH has virtually no Medicare revenue. In FY21 and FY22, total gross regulated Medicare revenue at MWPH averaged about \$24,000, or 0.03% of total revenue.

At the same time, a rate reduction of 0.4% would cost the hospital approximately \$250,000 in a year when we are struggling financially due to low volumes/revenue related to staffing shortages.

MWPH is unlike most acute care hospitals in the State, is not on a Global Budget Revenue reimbursement arrangement. It is our request that the HSCRC note the impact of these proposed changes and consider the exclusion of MWPH from the proposed corrective actions.

Sincerely,

Mary Miller, Chief Financial Officer MWPH

cc: Derrek Myers, Director, UMMS
Alicia Cunningham, SVP, UMMS

Accredited by The Joint Commission
and by Commission on Accreditation
of Rehabilitation Facilities

mwph.org

Mt. Washington Pediatric Hospital
1708 West Rogers Avenue
Baltimore, Maryland 21209
410-578-8600

Dennis Phelps, HSCRC
Cait Cooksey, HSCRC

**Mt. Washington Pediatric Hospital
at UM Capital Region Medical Center**
901 North Harry S. Truman Drive,
8th Floor, Largo, Maryland 20774
240-677-1800 (inpatient)
240-677-1850 (outpatient)



Ascension Saint Agnes

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

November 28, 2022

Dear Ms. Wunderlich,

I am writing on behalf of Ascension Saint Agnes to provide feedback to the Health Services Cost Review Commission (HSCRC) on the draft recommendation on adjustments to Maryland's Medicare Total Cost of Care (TCOC) Performance.

The HSCRC staff has proposed a series of reductions to increase Maryland's Medicare savings by a total of \$102 million beginning January 1, 2023. These reductions include:

- All-Payer Rate adjustment effectuated through hospital rate orders (reversal of 0.40% provided in RY 2023 Update Factor)
- Medicare-only payment reductions effectuated through the Medicare Performance Adjustment Savings Component
- Public Payer rate reductions through an increase to the Public Payer Differential for the duration of FY 2023 and 2024
- State contribution through Medicaid Deficit Assessment or additional grant dollars

Ascension Saint Agnes appreciates the comprehensive approach that the HSCRC staff has proposed, including leveraging other policy options such as reducing the Medicaid Deficit Assessment, but we remain concerned about any reductions that are unnecessarily broad-based and not directly targeted to providing savings to Medicare. While we agree in the all-payer nature of the TCOC Model and believe that it should be a central tenet of any customary actions adopted by the HSCRC, our current situation is an outlier largely caused by circumstances outside of Maryland's control, including relying upon actuarial estimates provided by the Centers for Medicare and Medicaid Services (CMS) that proved to be largely inaccurate. The goal of any

reductions should be to balance between taking proactive steps to restore some of Maryland's savings under the model while not overly removing needed revenue from hospital rates while we are still struggling with ongoing staffing and other inflationary issues.

Ascension Saint Agnes also supports a targeted approach to any reductions based on the Integrated Efficiency Policy. An across-the-board reduction that doesn't distinguish between inefficient and efficient hospitals is inconsistent with the HSCRC's stated policy goals. Any actions taken by the HSCRC to improve Maryland's current TCOC performance should be consistent with existing policies that distinguish performance amongst hospitals and distribute rewards and penalties accordingly.

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

Sincerely,

A handwritten signature in blue ink, appearing to read "Ed Lovern". The signature is fluid and cursive, with a large initial "E" and "L".

Ed Lovern
President and CEO

UPMC Western Maryland

12400 Willowbrook Road
Cumberland, MD 21502
240-964-7000

November 28, 2022

Mr. Adam Kane, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Kane,

I am writing on behalf of UPMC Western Maryland (UPMC Western Maryland) to share our feedback regarding the draft recommendation on adjustments to Maryland's Medicare Total Cost of Care (TCOC) performance recently presented at the November 9th meeting of the Health Services Cost Review Commission (HSCRC).

The HSCRC staff proposed a series of actions to increase Maryland's Medicare savings by a total of \$102 million beginning January 1, 2023, to address the current projections and Maryland's anticipated shortfall in meeting the TCOC Model's compound savings target for Calendar Year 2022. These actions include:

- All-payer rate adjustment effectuated through hospital rate orders (reversal of 0.40% provided in RY 2023 Update Factor)
- Medicare-only payment reductions effectuated through the Medicare Performance Adjustment Savings Component
- Public payer rate reductions through an increase to the public payer differential for the duration of FY 2023 and 2024
- State contribution through the Medicaid Deficit Assessment or additional grant dollars

UPMC Western Maryland appreciates the HSCRC's interest in hearing directly from the hospital field regarding these potential actions. We acknowledge the necessity of acting in January to demonstrate Maryland's commitment to the TCOC Model, including the need to achieve the agreed upon savings over time, but we encourage the HSCRC to be thoughtful in its approach and not overcorrect which will result in undue harm for the industry that is already struggling. UPMC Western Maryland, like our colleagues across the state, continues to struggle with increased labor expenses and other inflationary pressures that are limiting our ability to invest in needed clinical and community programs that are critical in this rural area of the state.

Since the State is currently failing this Medicare-only test while continuing to meet the all payor per capita growth rate, any action that recovers funds on an all-payer basis is unnecessary and only adds to the financial distress of the hospitals. We encourage the HSCRC to utilize the Medicare Performance Adjustment Savings component to target the adjustment to Medicare only.

UPMC Western Maryland

12400 Willowbrook Road
Cumberland, MD 21502
240-964-7000

UPMC Western Maryland understands the desire to target the rate reduction, however concerns remain with the TCOC methodology which is part of both the MPA and Integrated Efficiency Methodology. As stated previously, we believe the TCOC benchmarking methodology is biased against rural providers in areas with poor socio-economic factors. If a targeted approach is utilized, we feel it should be based on price efficiency only to address retained revenue which has resulted in higher hospital prices.

Thank you for your time and attention to our feedback. If you have any questions, please do not hesitate to contact me.

Sincerely,



Amber Ruble
Chief Financial Officer

CC: Katie Wunderlich, Executive Director
Joseph Antos, Ph. D.
Victoria Bayless
Stacia Cohen, RN, MBA
Maulik Joshi, DrPH
James N. Elliott, M.D.
Sam Malhotra



November 30, 2022

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

RE: Draft Recommendations for Adjustments to the Total Cost of Care Model

Dear Ms. Wunderlich:

My name is Jon Frank, and I am a senior legislative consultant for the Maryland Association of Health Underwriters (MAHU). On behalf of MAHU, I am writing to offer comments on the referenced recommendations.

MAHU is a trade association of several hundred licensed health insurance brokers, agents and consultants who represent a substantial portion of small and medium-sized businesses in Maryland that offer health benefit plans among other employee benefits. A critical role for MAHU members is to identify cost-effective coverage options for employees of their business clients including advice on subjects such as cost-sharing, tax-deductible options for employees, and other methods of addressing the cost of health insurance.

The rapid growth of inflationary factors across our broad economy has affected health care services as well, including the cost of health insurance. In fact, although the small employer health insurance market in Maryland has enjoyed stable enrollment for a number of years, for the first time in recent memory it is experiencing double digit rate increases due to inflation. Small employers are especially sensitive to such increases.

Another factor driving costs are recent changes in the individual health insurance market. On MAHU's behalf, I participated in a study conducted by the Maryland Health Benefit Exchange this year on the subject of proposed subsidies in the small group market, a change originally proposed in Senate Bill 632. That study was overtaken by events at the federal level with new, additional subsidies adopted in the individual health insurance market. As a result, potential subsidies in Maryland small group have been put on hold, pending the expiration of these new individual subsidies several years from now. Nevertheless, these subsidies place additional pressure on employers who are considering whether to keep their small group health plans or simply send employees to the individual market (or no market at all).

To this dual effect of general inflationary pressures and the new individual market subsidies, the HSCRC now proposes an additional rule change increasing the public payer differential that will add some tens of millions of dollars in higher costs. The policy argument in favor of this rule change has not, to our knowledge, been presented. Instead, the reason seems to be simply to address a savings shortfall that, in the opinion of the Commission, should be filled in this manner. We respectfully disagree.

We are aware that the Commission, in approving a previous adjustment to the public payer differential in 2018, engaged in a detailed analysis to demonstrate the reason for the change. That adjustment, in simple terms, was

based on changes in bad debt percentages resulting from higher levels of uncompensated care. The Commission also stated at that time that it "should not use changes to the differential to meet TCOC savings performance requirements." The logic of that statement also applies today.

MAHU appreciates the opportunity to offer comments on the draft recommendations under consideration by the Commission. We hope that you find our comments to be constructive.

Very truly yours,

A handwritten signature in blue ink that reads "Jon Frank". The signature is written in a cursive, flowing style.

Jon Frank

cc: Bryson Popham
Nancy Colaianne



maryland
health services
cost review commission

Medicare Performance Adjustment

Draft Recommendation

December 2022

This document contains the draft staff recommendations for the CY 2023 Medicare Performance Adjustment.
Comments for this policy are due by December 21, 2022 to hsrc.tcoc@maryland.gov.

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Draft Recommendations For CY 2023 MPA Policy

Staff recommend the following incremental revisions to the Medicare Performance Adjustment (MPA) policy for calendar year 2023 (CY2023) to align with State and federal policy directives:

1. Formalize the geographical attribution algorithm;
2. Remove the Supplemental Maryland Primary Care Program adjustment; and
3. Increase the amount of revenue at risk by increasing the weight of the MPA quality adjustment.

In 2021, Staff completed a major policy review of the MPA. As a result of the review, the Commission revised the attribution algorithm and the methodology for calculating the rewards / penalties under the MPA. During the review, stakeholders emphasized that the MPA policy had changed numerous times and stressed the need for consistency in the future. Correspondingly, Staff recommend keeping the majority of the MPA unchanged. However, Staff are recommending the minor changes described above to keep the MPA aligned with other State and federal policymaking. The following discussion provides rationale and detail on each of these recommendations.

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The Total Cost of Care (TCOC) Model Agreement requires the State of Maryland to implement a Medicare Performance Adjustment (MPA) for Maryland hospitals each year. The State is required to (1) Attribute 95 percent of all Maryland Medicare beneficiaries to some Maryland hospital; (2) Compare the TCOC of attributed Medicare beneficiaries to some benchmark; and (3) Determine a payment adjustment based on the difference between the hospitals actual attributed	This MPA recommendation fulfills the requirements to determine an MPA policy for CY 2023 and makes incremental improvements to the current policy.	The MPA policy serves to hold hospitals accountable for Medicare total cost of care performance. As such, hospital Medicare payments are adjusted according to their performance on total cost of care. Improving the policy improves the alignment between hospital efforts and financial rewards. These adjustments are a discount on the amount paid by CMS and not on the amount charged by the hospital. In other words, this policy does not change the GBR or any other rate-setting policy that	This policy does not affect the rates paid by payers. The MPA policy incentivizes the hospital to make investments that improve health outcomes for Marylanders in their service area.	This policy holds hospitals accountable for cost and quality of Medicare beneficiaries in the hospital's service area. Focusing resources to improve total cost of care provides the opportunity to focus the hospital on addressing community health needs, which can lower total cost of care.

TCOC and the benchmark.		the HSCRC employs and – uniquely – is applied only on a Medicare basis.		
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Overview of the MPA Policy

The Medicare Performance Adjustment (MPA) is a required element for the Total Cost of Care Model and is designed to increase the hospital's individual accountability for total cost of care (TCOC) in Maryland. Under the Model, hospitals bear substantial TCOC risk in the aggregate. However, for the most part, the TCOC is managed on a statewide basis by the HSCRC through its GBR policies. The MPA was intended to increase a hospital's individual accountability for the TCOC of Marylanders in their service area. In recognition of large risk borne by the hospitals collectively through the GBR, the MPA has a relatively low amount of revenue at risk (1 percent of Medicare fee-for-service revenue).

The MPA includes two “components”: a Traditional Component, which holds hospitals accountable for the Medicare total cost of care (TCOC) of an attributed patient population, and an Efficiency Component, which rewards hospitals for the care redesign interventions. These two components are added together and applied to the amount that Medicare pays each respective hospital. The MPA is applied as a discount to the amount that Medicare pays on each claim submitted by the hospital.

Traditional Component

Currently, the HSCRC assigns patients to hospitals based on their geographic residence. In CY22, the Commission assigned patients to hospitals based on the hospital's Primary Service Areas (PSAs) as designated in the original hospital GBR agreements. However, based on industry feedback, staff proposed to move towards a geographic algorithmic PSA Definition.. For CY 2023, Staff recommends using the revised geographic attribution algorithm going forward, as described below.

1. Hospitals are attributed the costs and beneficiaries in zip codes that comprise 60% of their volume. Beneficiaries in zip codes claimed by more than one hospital are allocated according to the hospital's share on equivalent case-mix adjusted discharges (ECMADs) for inpatient and outpatient discharges among hospitals claiming that zip code. ECMADs are calculated from Medicare FFS claims for Calendar Year 2019. ECMADs are also used in calculating the volumes in the 60% test.
2. Zip codes not assigned to any hospital under step 1 are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed a 30 minute drive-time from the hospital's PSA.

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

4. An alternative attribution approach for the AMCs will be used, consistent with that approved for CY2022, where beneficiaries with a CMI of greater than 1.5 and who receive services from the AMC are attributed to the AMC as well as the hospital under the standard attribution. AMCs will also have a geographic based attribution. Staff recommend that AMCs be assigned a set of zip codes based on a negotiation with the hospital, since the algorithm approach does not work as well for the AMCs.

The MPA then penalizes or rewards hospitals based on their attributed TCOC. Hospitals are rewarded if the TCOC growth of their attributed population is less than national growth. Beginning in 2021, the HSCRC scales the growth rate target for hospitals based on how expensive that hospital's service area is relative to other geographic areas elsewhere in the national. This policy is intended to ensure that hospitals which are expensive relative to their peers bear the burden of meeting the Medicare savings targets, while hospitals that are already efficient relative to their peers bear proportionally less of the burden. This approach and calculation are the same as was used in CY2022. The TCOC growth rate adjustments are shown in Table 1 below.

Table 1: Scaled Growth Rate Adjustment

Hospital Performance vs. Benchmark	TCOC Growth Rate Adjustment
1 st Quintile (-15% to + 1% Relative to Benchmark)	0.00%
2 nd Quintile (+1% to +10% Relative to Benchmark)	-0.25%
3 rd Quintile (+10% to +15% Relative to Benchmark)	-0.50%
4 th Quintile (+15% to +21% Relative to Benchmark)	-0.75%
5 th Quintile (+21% to +28% Relative to Benchmark)	-1.00%

Historically, hospitals were required to beat the national TCOC growth rate each year. But in 2021, the HSCRC changed the way that the TCOC is calculated for hospitals. The HSCRC will trend the hospital's baseline TCOC forward based on the national growth rate and the TCOC adjustment factors. This was intended to create more predictability for hospitals. A hospital can now predict what their target will be two or three years out. An example of the methodology to calculate the TCOC targets is shown in Table 2 below.

Table 2: Calculation of the MPA Targets

Variable		Source			
A = 2019 TCOC		Calculation from attributed beneficiaries			
B = 2020 National TCOC Growth		Input from national data			
C = 2021 National TCOC Growth		Input from national data (assumed to be 3% in example below)			
D = Growth Rate Adjustment Factor		From Growth Rate Table (applies to 2021 and all subsequent years)			
E = MPA TCOC Target		$A \times (1 + B) \times (1 + C - D)$			
Example Calculation of MPA Targets					
Hospital	Quintile	Target Growth Rate	2019 TCOC	2020 MPA Target	2021 MPA Target
Hospital A	1	$3\% - 0.00\% = 3.00\%$	\$11,650	\$12,000	\$12,359
Hospital B	2	$3\% - 0.25\% = 2.75\%$	\$11,193	\$11,529	\$11,846
Hospital C	3	$3\% - 0.50\% = 2.50\%$	\$11,169	\$11,504	\$11,792
Hospital D	4	$3\% - 0.75\% = 2.25\%$	\$11,204	\$11,540	\$11,800
Hospital E	5	$3\% - 1.00\% = 2.00\%$	\$10,750	\$11,073	\$11,294

The hospital is rewarded or penalized based on how their actual TCOC compares with their TCOC target. The rewards and penalties will be scaled such that the maximum reward or penalty is 1% which will be achieved at a 3% performance level. Essentially, each percentage point by which the hospital exceeds its TCOC benchmark results in a reward or penalty equal to one-third of the percentage. The amount of revenue at risk under the MPA policy is capped at 1% of the hospital's Medicare fee-for-service revenue. An example of the hospital's rewards/penalties is shown in the table below.

Table 3: Example of MPA Reward & Penalty Calculations (excluding quality adjustments)

Variable	Input
E = MPA Target	See previous section
F = 2021 MPA Performance	Calculation
G = Percent Difference from Target	$(E - F) / E$
H = MPA Reward or Penalty	$(G / 3\%) \times 1\%$
I = Revenue at Risk Cap	Greater / lesser of H and + / - 1%

Example MPA Performance Calculations				
Hospital	MPA Target	MPA Performance	% Difference	Reward (Penalty)
Hospital A	\$12,359	\$12,235	-1.00%	0.30%
Hospital B	\$11,846	\$11,941	0.80%	-0.30%
Hospital C	\$11,792	\$11,556	-2.00%	0.70%
Hospital D	\$11,800	\$12,154	3.00%	-1.00%
Hospital E	\$11,294	\$11,859	5.00%	-1.00%

In addition, the agreement with CMS requires that a quality adjustment be applied that reflects hospital quality outcomes. Revisions to the quality adjustment for CY 2023 are outlined below.

Efficiency Component

The MPA includes additional rewards and penalties for hospitals that reduce the TCOC through care redesign program, include the Episode Care Improvement Program (ECIP), the Care Transformation Initiatives (CTI), and the Maryland Primary Care Program (MDPCP). The HSCRC increases the MPA reward or penalty based on the success of these programs. The HSCRC developed the Efficiency Component because the Traditional MPA was not targeted well enough to reward a hospital for a specific target population. A hospital would only be rewarded for a successful care redesign effort under the Traditional Component of the MPA, if every beneficiary included in the effort was attributed to the hospital and if the impact of the program was not washed out by the impact on other beneficiaries who were also attributed to the hospital. Historically, the Traditional MPA has not been well aligned with individual hospital care redesign efforts which necessitated the development of the Efficiency Component.

MPA Draft Recommendations

Staff recommends three changes to the MPA for CY2023: 1) formalize the revision of the geographic attribution algorithm as described above; 2) eliminate the Supplemental MDPCP Adjustment; and 3) increase the weight placed on quality measures. Once those changes are made, Staff recommends maintaining the MPA for CY2023 and CY2024, in order to create as much stability for hospitals as possible.

Revised Attribution

In CY22, the Commission moved to a geographic attribution algorithm to assign beneficiaries to hospitals under the MPA (in addition to a separate attribution tier for the state's two Academic Medical Centers).

Geographic attribution was based on hospital primary service areas (PSAs) listed in hospitals' Global Budget Revenue (GBR) agreements. During a review of the MPA Policy in CY21, staff and the industry concluded that the PSAs in the GBR had become dated and the industry suggested adopting a more algorithmic approach. The CY 2022 Recommendation directed the staff to develop a standardized approach to assigning zip codes to hospitals. Staff recommend that hospitals should be assigned the zip codes that constitute 60% of the hospital's volumes, as determined by ranking each zip code from largest volume to least and assigning the zip codes to the hospitals until 60% of the hospital's volume has been attributed. Further specifics of the approach are described above.

Supplemental MDPCP Accountability

In 2021, the Commission directed staff to increase the accountability for managing the TCOC in the MDPCP since the MDPCP program itself did not include direct TCOC risk. Therefore, HSCRC added a supplemental MPA adjustment for hospitals that are affiliated with practices that are participating in MDPCP. The MDPCP supplemental adjustment rewards / penalizes hospitals for the relative success of their MDPCP programs. However, in CY 2022, CMS announced a Track 3 of MDPCP for CY 2023 that includes direct TCOC risk. Therefore, the Supplemental MDPCP Adjustment is redundant. Staff recommend eliminating the MDPCP Supplemental Adjustment.

Increased Quality Adjustment

In its approval of the CY 2022 MPA, CMMI indicated that they would like to see an increase to the revenue at risk in the MPA and a greater focus on population health. Currently, the MPA quality adjustment is equal to the sum of the hospitals Readmission Reductions Incentive Program (RRIP) and Maryland Hospital Acquired Conditions (MHAC) program. The percentage for the two quality programs is summed and multiplied by the amount that the hospital is above or below the MPA target. That is, the MPA adjustment is equal to the TCOC result $\times \frac{1}{3} \times (1 + \text{RRIP} + \text{MHAC Reward/Penalty})$. Since the RRIP and the MHAC programs have a maximum revenue at risk of 2%, at this point the maximum adjustment is $\pm 1.04\%$. Finally, the MPA is capped at 1% reducing the final maximum to $\pm 1.00\%$. Since the cap occurs after the application of the quality adjustment, a hospital already at the limits of the financial adjustment may have no impact from their quality adjustment.

In order to meet CMMI's request to increase the revenue at risk, Staff recommend applying the 1% revenue at risk cap earlier in the calculation and doubling the weight of the quality adjustment. Therefore, the calculation would be TCOC results $\times \frac{1}{3}$ (capped at 1% of Medicare revenue) $\times (1 + 2 \times (\text{RRIP} +$

¹ The TCOC results is the % by which the hospital exceeds or falls short of target to a maximum of 3%. The fraction of $\frac{1}{3}$ rd is applied to translate the result into a maximum penalty of $\pm 1\%$.

MHAC Reward/Penalty)). This will modestly increase the maximum adjustment to $\pm 108\%$, or $\pm 1.08\%$ of the hospital's Medicare revenue as opposed to 1.00% under the current approach.

Finally, Staff recommend including a population health quality measure in the MPA, once approved by CMS and the Commission. Staff have been working on an all-payer measure for diabetes screening with the Performance Measurement Workgroup for monitoring purpose in CY 2023. Staff have proposed measuring the rates of diabetes screening but deferring any adjustment on payment rates until the following year. Staff are also considering potential alternative monitoring measures. In CY 2024, once that measure, or an alternative population quality health measure, is fully developed and incorporated into our quality programs, Staff recommend including that measure into the MPA Quality Adjustment with a weight of 4%. The MPA adjustment would be $\text{TCOC results} \times \frac{1}{3}$ (capped at 1% of Medicare revenue) $\times (1 + 2 \times (\text{RRIP} + \text{MHAC Reward/Penalty} + \text{population health quality measure}))$. This will increase the maximum adjustment to 1.16% of the hospital's Medicare revenue and reflect the dual desire to increase revenue at risk and incorporate additional SIHIS-related population health quality measures into Maryland's hospital quality program.

Statewide Integrated Health Improvement Strategy- 2021 Milestone Summary

Domain 1: Hospital Quality

Goal	Status	Performance
Goal 1: Reduce Avoidable Admissions	Met	8% improvement Actual Performance: 25.19% improvement
Goal #2: Improve Readmission Rates by Reducing Within-Hospital Disparities	Met	Establish and monitor a measurement methodology and payment incentive for reducing within hospital readmission disparities and set a 2023 and 2026 target Actual Performance: While not a 2021 milestone, based on current trends through August 2022, 10 hospitals are on track to meet their 2026 goal.

Domain 2: Care Transformation

Goal	Status	Performance
Goal 1: Increase the amount of Medicare TCOC or number of Medicare beneficiaries under Care Transformation Initiatives (CTIs), Care Redesign Program, or successor payment model	Met	12.5% of Medicare TCOC under a CTI or CRP or successor payment model 7.5% of Medicare Beneficiaries covered under a CTI or CRP or successor payment model Actual Performance: 33.11% of Medicare TCOC under a Care Transformation Program 25.68% of Medicare Beneficiaries under a Care Transformation Program
Goal 2: Improve care coordination for patients with chronic conditions	Not Met	72.38% , 2.16% improvement Actual Performance: 70.07% (National Performance: 67.68%)

Domain 3: Total Population Health- Diabetes

Goal	Status	Performance
Goal: Reduce the mean BMI for adult Maryland residents	All Met	<ul style="list-style-type: none"> Delaware, Virginia, Mississippi, and Washington, DC were selected as the cohort of states to serve as the control group to measure progress. <ul style="list-style-type: none"> While performance against the cohort of other states was not a 2021 milestone, the State DID achieve a more favorable change from baseline mean BMI than the control group by 0.1 BMI. Launched the Diabetes Prevention and Management Program track of the HSCRC Regional Partnership Catalyst Program. Incorporated a quality measure for all MDPCP practices requiring BMI measurement for all patients, and for patients with an elevated BMI, requiring documentation of a follow-up plan Expanded the CRISP Referral Tool to Regional Partnerships to increase patient referrals for Diabetes Prevention Programs.

Domain 3: Total Population Health- Opioid Use

Goal	Status	Performance
Goal: Improve Overdose Mortality	All Met	<ul style="list-style-type: none"> Massachusetts, New Jersey, Delaware, and DC were selected as the cohort of states to serve as the synthetic control group to measure progress. Launched the Behavioral Health Crisis Programs track of the HSCRC RP Expanded Screening Brief Intervention and Referral to Treatment (SBIRT) to 200 practices participating in MDPCP

Domain 3: Total Population Health- Maternal & Child Health

Goal	Status	Performance
Maternal Health Goal: Reduce severe maternal morbidity rate	All Met	<ul style="list-style-type: none"> Re-launched the Perinatal Quality Collaborative. Piloted a Severe Maternal Morbidity Review Process with eight Birthing hospitals Completed Maryland Maternal Strategic Plan. Launched MCH investments to support Medicaid/MCO and Public Health initiatives.
Child Health Goal: Decrease asthma-related emergency department visit rates for ages 2-17	All Met	<ul style="list-style-type: none"> Obtained Population Projections. Developed Asthma Dashboard. Launched MCH investments to support Medicaid/MCO and Public Health initiatives. Incorporated asthma-related ED visit as a Title V State Performance Measure and shifted some of the Title V funds for asthma-related interventions.

Diabetes Domain

Diabetes Prevention Recognition Program Enrollment

Introduction:

The official SIHIS measure aims to capture the change in the average body mass index (BMI) among adult Maryland residents from the 2018 baseline. Maryland's success in the measure is defined as having a more favorable change in BMI compared to a cohort of states with similar characteristics related to BMI.

HSCRC will be conducting the final measure assessment. This report presents a proxy measure from which stakeholders can assess measure performance to date. Therefore, the results presented in this report may differ from the official SIHIS measure performance. Refer to the User Guide for information about the data sources and parameters for both the official and proxy measures.

Proxy Measure:

Change in Diabetes Prevention Recognition Program (DPRP) enrollment among adults with pre-diabetes who reside in Maryland relative to the 2018 baseline. The change in DPRP enrollment in Maryland is compared to the national change overall.

Key Findings:

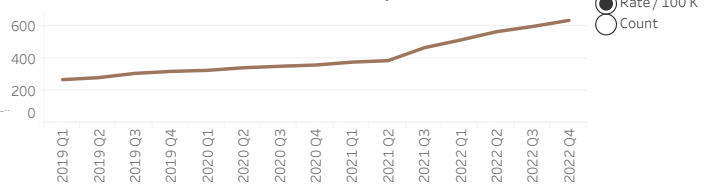
- Maryland has experienced a 161.2% increase in DPRP enrollment per 100k population since 2018. This rate of change is faster than the nation overall, which has experienced a 93.1% increase over the same time period.
- By Race/Ethnicity, NH Asian population has the lowest DPRP enrollment per 100k which is 257.8. This enrollment rate is 56% lower than the Non-Hispanic White population.

Data available through October 2022

Cumulative DPRP Enrollment Compared to National Average

	2018 Baseline (A)	Most Recent Rolling 12 Months (B)	Percent Change (B-A/A)	National Comparison Change
Rates per 100K	269.9	704.9	161.2%	93.1%
Total Count	4,328	11,316	161.5%	112.8%

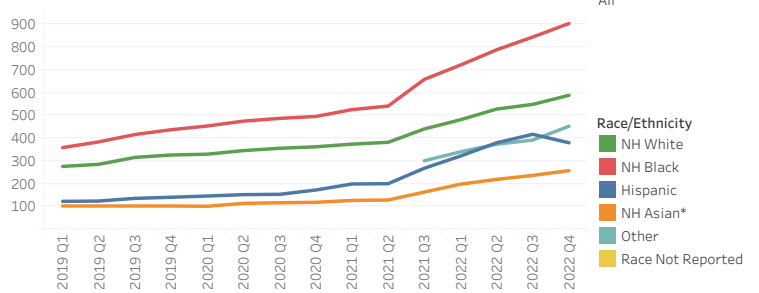
Cumulative DPRP Enrollment By Quarter



Cumulative DPRP Enrollment Rates per 100K: Race/Ethnicity & Disparity Index

Race/Ethnicity	2018 Baseline (A)	Most Recent Rolling 12 Months (B)	Percent Change (B-A/A)	Disparity Index (Race: NH White)
NH White	276.2	589.2	113.3%	1.0
NH Black	359.0	905.1	152.1%	1.5
Hispanic	122.5	380.3	210.5%	0.6
NH Asian*	102.1	257.8	152.4%	0.4
Other	N/A	453.1	N/A	0.8
Race Not Reported	N/A	N/A	N/A	N/A
Statewide Total	269.9	704.9	161.2%	1.2

Cumulative DPRP Enrollment By Quarter By Race/Ethnicity



* Data for NH Asian is cumulative as of January 1st, 2020.

*Effective September 1, 2021, data for "Other" race/ethnicity has been divided into "Other" and "Data Not Reported". As such, a 2018 baseline is not available for these categories.

Opioids Domain Overdose Fatalities

Introduction:

The official SIHIS measure aims to capture the annual change in overdose mortality as compared to a cohort of states with historically similar overdose mortality rate and demographics.

HSCRC will be conducting the final measure assessment. This report presents a proxy measure from which stakeholders can assess measure performance to date. Therefore, the results presented in this report may differ from the official SIHIS measure performance.

Proxy Measure:

Annual change in overdose mortality in Maryland as compared to the nation overall.

Refer to the User Guide for information about the data sources and parameters for the official and proxy measure.

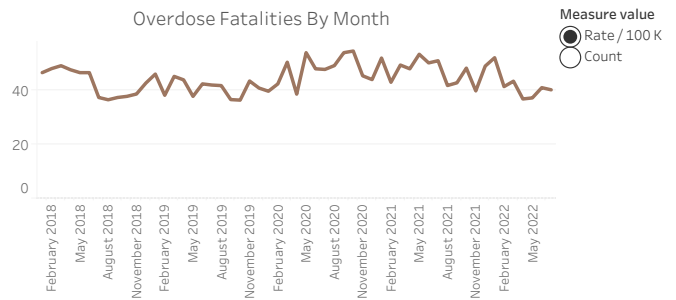
Key Findings:

- Maryland has experienced a -1.3% decrease in Overdose Fatality per 100k population since 2018. This rate of change is slower than the nation overall, which has experienced a 50.1% increase over the same time period.
- By Race/Ethnicity, overdose fatality among the Non-Hispanic Black population is 1.4 times higher than the Non-Hispanic White population.

Overdose Fatalities Compared to National Average

	2018 Baseline (A)	Most Recent Rolling 12 Months (B)	Percent Change (B-A/A)	National Comparison Change
Rates per 100K	42.63	42.06	-1.3%	50.1%
Total Count	2,406	2,547	5.9%	51.6%

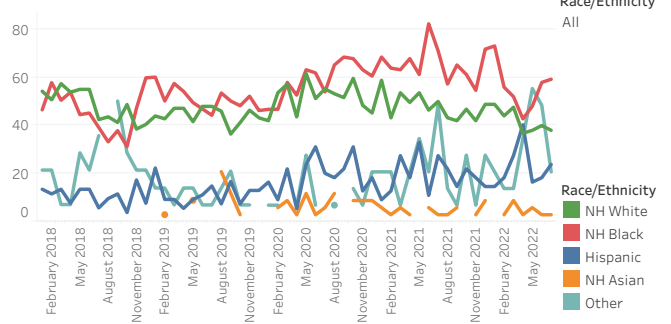
Data available through July 2022



Overdose Fatality Rates per 100K: Race/Ethnicity & Disparity Index

Race/Ethnicity	2018 Baseline (A)	Most Recent Rolling 12 Months (B)	Percent Change (B-A/A)	Disparity Index (Race: NH White)
NH White	48.47	43.02	-11.2%	1.0
NH Black	45.59	58.26	27.8%	1.4
Hispanic	10.80	20.93	93.9%	0.5
NH Asian	0.00	3.93	NA	0.1
Other	22.10	24.23	9.6%	0.6
Statewide Total	42.63	42.06	-1.3%	1.0

Change in Overdose Fatalities By Month By Race/Ethnicity



Maternal and Child Health Domain Severe Maternal Morbidity Rate

Introduction:

The official SIHIS measure aims to capture the annual rate of severe maternal morbidity (SMM) per 10,000 delivery hospitalizations. Maryland's success in the measure is defined as having an SMM rate per 10,000 deliveries that is lower than the target.

HSCRC will be conducting the final measure assessment. Therefore, while this report attempts to track the official SIHIS measure, the results presented in this report may differ from the official SIHIS measure performance. Refer to the User Guide for information about the data sources and parameters for both the official measure and any modifications made for this report.

Reported Measure:

Annual severe maternal morbidity rate per 10,000 delivery hospitalizations among women ages 12-55. The official targets have been established to represent an improvement from the 2018 baseline.

Key Findings:

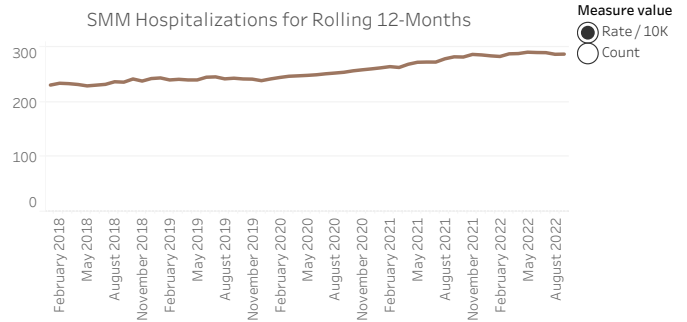
- Maryland had 287.7 SMM-related hospitalizations per 10,000 delivery discharges over the last 12 months. This rate is 68.4 hospitalizations per 10,000 higher than the 2023 target. It is also 45 hospitalizations per 10,000 higher than 2018 baseline.
- By Race/Ethnicity, NH Black population has the SMM hospitalization rate per 10,000 deliveries, which is currently 1.8 times higher than the Non-Hispanic White population.
- NH Black population experienced the largest annual growth in SMM hospitalization rate per 10,000 deliveries, with an increase of 70.5 SMM hospitalizations per 10,000 deliveries since 2018.

Data available through September 2022

SMM Hospitalizations Compared to 2023 Target

	2018 Baseline	Most Recent 12 Months	2023 Target	Difference - Most Recent 12 months to Target
Rates per 10K	243.1	287.7	219.3	68.36
SMM Events	1,585	1,801		
Eligible Deliveries	65,199	62,609		

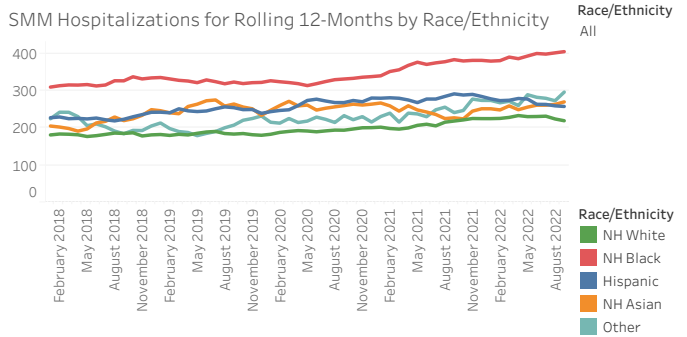
SMM Hospitalizations for Rolling 12-Months



SMM Hospitalization Rates per 10K Compared to 2023 Target:
Race/Ethnicity & Disparity Index

Race/Ethnicity	2018 Baseline	Most Recent 12 Months	2023 Target	Difference - Most Recent 12 months to Target	Disparity Index
NH White	181.4	219.3	169.8	49.5	1.0
NH Black	334.2	404.7	295.7	109.0	1.8
Hispanic	242.0	257.7	213.2	44.5	1.2
NH Asian	249.0	269.9	217.7	52.2	1.2
Other	205.2	296.2	204.6	91.6	1.4
Statewide Total	243.1	287.7	219.3	68.4	<b style="color: red;">1.3

SMM Hospitalizations for Rolling 12-Months by Race/Ethnicity



Maternal and Child Health Domain Childhood Asthma

Introduction:

The official SIHIS measure aims to capture the annual rate of childhood asthma-related emergency department (ED) visits. Maryland's success in the measure is defined as having an ED visit rate per 1,000 children that is lower than the target.

HSCRC will be conducting the final measure assessment. Therefore, while this report attempts to track the official SIHIS measure, the results presented in this report may differ from the official SIHIS measure performance. Refer to the User Guide for information about the data sources and parameters for both the official measure and any modifications made for this report.

Reported Measure:

Annual rate of asthma-related emergency room department visits for children 2-17. The official targets have been established to represent an improvement from the 2018 baseline.

Key Findings:

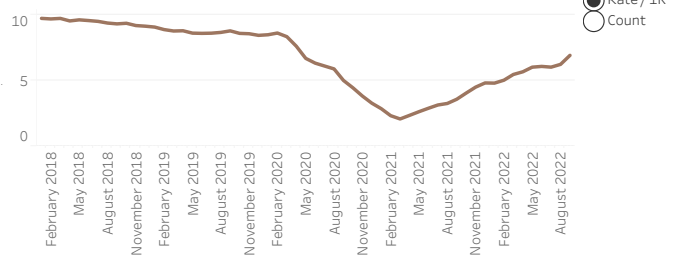
- Maryland had 6.9 asthma-related emergency department visits per 1,000 children over the last 12 months. This rate is 0.3 visits per 1,000 children lower than the 2023 target
- By Race/Ethnicity, NH Black population has the highest asthma-related emergency department rate per 1,000 children, which is currently 4.5 times higher than the Non-Hispanic White population. However, this rate is still 0.5 visits per 1,000 children lower than the 2023 race/ethnicity target of 14.36.

Data available through September 2022

Childhood Asthma-Related ED Visits Compared to 2023 Target

	2018 Baseline	Most Recent 12 Months	2023 Target	Difference - Most Recent 12 months to Target
Rates per 1K	9.2	6.9	7.2	-0.3
Total Count	10,974	8,281		

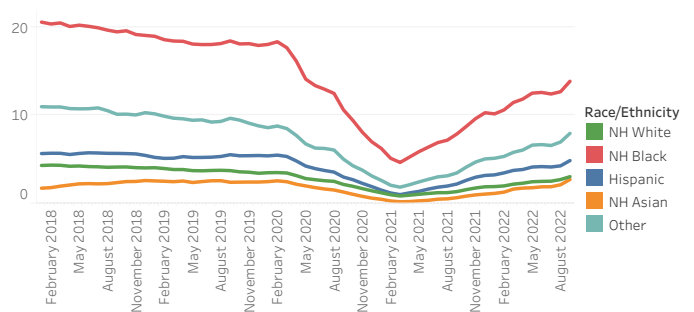
Childhood Asthma-Related ED Visits for Rolling 12-Months



Childhood Asthma-Related ED Visit Rates per 1K Compared to 2023 Target: Race/Ethnicity & Disparity Index

Race/Ethnicity	2018 Baseline	Most Recent 12 Months	2023 Target	Difference - Most Recent 12 months to Target	Disparity Index
NH White	4.1	3.1	3.50	-0.4	1.0
NH Black	19.1	13.9	14.36	-0.5	4.5
Hispanic	5.5	4.9	4.70	0.2	1.6
NH Asian	2.6	2.7	2.60	0.1	0.9
Other	10.3	8.0	7.30	0.7	2.6
Statewide Total	9.2	6.9	7.2	-0.3	2.3

Childhood Asthma-Related ED Visits for Rolling 12-Months by Race/Ethnicity





maryland
health services
cost review commission

Maryland Hospital Community Benefit Report: FY 2021

December 2022

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List of Abbreviations

ACA	Affordable Care Act
CBR	Community Benefit Report
CBSA	Community Benefit Service Area
CHNA	Community Health Needs Assessment
DME	Direct Medical Education
ED	Emergency Department
FPL	Federal Poverty Level
FY	Fiscal Year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
IRS	Internal Revenue Service
LHIC	Local Health Improvement Collaboratives
NSPI	Nurse Support Program I
PSA	Primary Service Area
SIHIS	Statewide Integrated Health Improvement Strategy
UCC	Uncompensated Care

Introduction

The term community benefit refers to initiatives, activities, and investments undertaken by tax-exempt hospitals to improve the health of the communities they serve. Maryland law defines community benefit as a planned, organized, and measured activity that is intended to meet identified community health needs within a service area.¹ Examples of community benefit activities can include the following:

- Community health services
- Health professional education
- Research
- Financial contributions
- Community-building activity, including partnerships with community-based organizations
- Charity care
- Mission-driven health services

In 2001, the Maryland General Assembly passed House Bill 15,² which required the Maryland Health Services Cost Review Commission (HSCRC or Commission) to collect community benefit information from individual hospitals and compile it into a statewide, publicly available Community Benefit Report (CBR). In response to this legislative mandate, the HSCRC initiated a community benefit reporting system for Maryland's nonprofit hospitals that included two components. The first component, the *Community Benefit Collection Tool*, is a spreadsheet that inventories community benefit expenses in specific categories defined by the HSCRC's *Community Benefit Reporting Guidelines and Standard Definitions*. These categories are similar—but not identical—to the federal community benefit reporting categories found in Part I of the Internal Revenue Service (IRS) Form 990, Schedule H.³ The second component of Maryland's reporting system is the CBR narrative report.

In 2020, the Maryland General Assembly passed HB 1169/SB 774, which required the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments (CHNAs).⁴ This bill required the HSCRC to establish a Community Benefit Reporting Workgroup and adopt regulations recommended by the Workgroup regarding community benefit reporting. The bill also modified the definition of community benefit and expanded the list of items that hospitals must include in their CBRs.

¹ MD. CODE. ANN., Health-Gen. § 19-303(a)(3).

² H.D. 15, 2001 Gen. Assem., 415th Sess. (Md. 2001).

³ <https://www.irs.gov/pub/irs-pdf/f990sh.pdf>

⁴ S. 774, 2020 Leg., 441st Sess. (Md. 2020).

This summary report provides background information on hospital community benefits and the history of CBRs in Maryland, summarizes the community benefit narrative and financial reports for fiscal year (FY) 2021, and concludes with a summary of data reports from the past 10 years.

Background

Federal Requirements

The Internal Revenue Code defines tax-exempt organizations as those that are organized and operated exclusively for specific religious, charitable, scientific, and educational purposes.⁵ Nonprofit hospitals are generally exempt from federal income and unemployment taxes, as well as state and local income, property, and sales taxes. In addition, nonprofit hospitals may raise funds through tax-deductible donations and tax-exempt bond financing.

Originally, the IRS considered hospitals to be “charitable” if they provided charity care to the extent that they were financially able to do so.⁶ However, in 1969, the IRS issued Revenue Ruling 69-545, which modified the “charitable” standard to focus on “community benefits” rather than “charity care.”⁷ Under this IRS ruling, nonprofit hospitals must provide benefits to the community in order to be considered charitable. This ruling created the “community benefit standard,” which is necessary for hospitals to qualify for tax-exemption.

The Affordable Care Act (ACA) created additional requirements for hospitals to maintain tax-exempt status. Every §501(c)(3) hospital—whether independent or part of a hospital system—must conduct a CHNA at least once every three years to maintain its tax-exempt status and avoid an annual penalty of up to \$50,000.⁸ A CHNA is a written document developed for a hospital facility that includes a description of the community served, the process used to conduct the assessment, identification of any persons with whom the hospital collaborated on the assessment, and the health needs identified through the assessment process. CHNAs must incorporate input from individuals who represent the broad interests of the communities served, and hospitals must make them widely available to the public.⁹ CHNAs must include an implementation strategy that describes how the hospital plans to meet the community’s health needs, as well as a description of what the hospital has historically done to address its community’s needs.¹⁰ Further, the hospital must identify any needs that have not been met and explain why they were not addressed. Tax-exempt hospitals must report this information on Schedule H of IRS Form 990.

⁵ 26 U.S.C. § 501(c)(3).

⁶ Rev. Ruling 56-185, 1956-1 C.B. 202.

⁷ Rev. Ruling 69-545, 1969-2 C.B. 117.

⁸ 26 U.S.C. § 501(r)(3); 26 U.S.C. § 4959.

⁹ 26 U.S.C. § 501(r)(3)(B).

¹⁰ 26 U.S.C. § 501(r)(3)(A).

Maryland Requirements

The Maryland General Assembly adopted the Maryland CBR process in 2001,¹¹ and the first data collection period was FY 2004. Maryland law requires hospitals to include the following information in their CBRs:

- The hospital's mission statement
- A list of the hospital's activities to address the identified community health needs
- The costs of each community benefit activity
- A description of how each of the listed activities addresses the community health needs of the hospital's community
- A description of efforts taken to evaluate the effectiveness of each community benefit activity
- A description of gaps in the availability of providers to serve the community
- A description of the hospital's efforts to track and reduce health disparities in the community
- A list of the unmet community health needs identified in the most recent community health needs assessment
- A list of tax exemptions the hospital claimed during the immediately preceding taxable year¹²

This FY 2021 report represents the HSCRC's 18th year of reporting on Maryland hospital community benefit data.

Updates to Maryland's Reporting Instructions

In response to HB 1169/SB 774 passed during the 2020 legislative session, the HSCRC made changes to reporting instructions. Among other items, hospitals will be required to:

1. Report on initiatives that directly address needs identified in the CHNA
2. Within the financial report, separately itemize all physician subsidies claimed by type and specialty
3. List the types of tax exemptions claimed
4. Self-assess the level of community engagement in the CHNA process

Understanding that hospitals need time to implement these changes, items 1 and 4 above were made optional for FY 2021 reporting but will be mandatory and published in the FY 2022 report. Three hospitals completed this optional reporting in FY 2021.

¹¹ MD. CODE. ANN., Health-Gen. § 19-303.

¹² MD. CODE. ANN., Health-Gen. § 19-303(c)(4).

Narrative Reports

This section of the document summarizes the findings of the FY 2021 narrative reports by major report section.

Hospitals Submitting Reports

The HSCRC received 48 CBR narratives from all 51 hospitals in FY 2021. This is because the University of Maryland Medical System submits a single CBR for three of its hospitals on the Eastern Shore and another CBR for two of its hospitals in Harford County. Table 1 summarizes the hospitals submitting CBRs by hospital system.

Table 1. Maryland Hospitals that Submitted CBRs in FY 2021, by System

Adventist HealthCare	Luminis Health
Adventist HealthCare Fort Washington Medical Center	Anne Arundel Medical Center
Adventist HealthCare Rehabilitation	Doctors Community Hospital
Adventist HealthCare Shady Grove Medical Center	McNew Family Health Center
Adventist HealthCare White Oak Medical Center	MedStar Health
Ascension	MedStar Franklin Square Medical Center
Saint Agnes Healthcare, Inc.	MedStar Good Samaritan Hospital
Christiana Care Health System, Inc.	MedStar Harbor Hospital
Christiana Care, Union Hospital	MedStar Montgomery Medical Center
Independent Hospitals	MedStar Southern Maryland Hospital Center
Atlantic General Hospital	MedStar St. Mary's Hospital
CalvertHealth Medical Center	MedStar Union Memorial Hospital
Frederick Health Hospital	TidalHealth
Greater Baltimore Medical Center	TidalHealth McCready Pavilion**
Mercy Medical Center	TidalHealth Peninsula Regional
Meritus Medical Center	Trinity Health
Sheppard Pratt	Holy Cross Germantown Hospital
Johns Hopkins Health System	Holy Cross Hospital
Howard County General Hospital	University of Maryland Medical System
Johns Hopkins Bayview Medical Center	UM Baltimore Washington Medical Center
Johns Hopkins Hospital	UM Capital Region Health
Suburban Hospital	UM Charles Regional Medical Center
Jointly Owned Hospitals	UM Rehabilitation & Orthopaedic Institute
Mt. Washington Pediatric Hospital*	UM Shore Regional Health
LifeBridge Health	UM St. Joseph Medical Center
Carroll Hospital Center	UM Upper Chesapeake Health
Grace Medical Center	UMMC Midtown Campus
Levindale Hebrew Geriatric Ctr. & Hospital of Balt.	University of Maryland Medical Center
Northwest Hospital Center, Inc.	UPMC
Sinai Hospital of Baltimore, Inc.	UPMC Western Maryland
	WVU Medical System
	Garrett Regional Medical Center

*Mt. Washington Pediatric is jointly owned by the University of Maryland Medical System and Johns Hopkins.

**TidalHealth McCready Pavilion is no longer a designated hospital, instead functioning as a Freestanding Medical Facility that is a department of TidalHealth Peninsula Regional.

Section I. General Hospital Demographics and Characteristics

Section I of the report collects demographic and other characteristics of the hospital and its service area.

Hospital-Specific Demographics

The first section of the CBR narrative collects information on hospital utilization statistics (Table 2). Overall, there were 475,985 inpatient admissions.

Table 2. Hospital Bed Designation, Inpatient Admissions, and Patient Insurance Status, FY 2021

Hospital Name	Inpatient Admissions
Adventist HealthCare	
Adventist HealthCare Fort Washington Medical Center	1,666
Adventist HealthCare Rehabilitation	0 ¹³
Adventist HealthCare Shady Grove Medical Center	17,229
Adventist HealthCare White Oak Medical Center	8,952
Ascension	
Saint Agnes Healthcare, Inc.	12,754
Christiana Care Health Services, Inc.	
Christiana Care, Union Hospital	4,516
Independent Hospitals	
Atlantic General Hospital	2,720
CalvertHealth Medical Center	5,210
Frederick Health Hospital	14,176
Greater Baltimore Medical Center	14,547
Mercy Medical Center	10,770
Meritus Medical Center	14,415
Sheppard Pratt	6,677
Johns Hopkins Health System	
Howard County General Hospital	14,224
Johns Hopkins Bayview Medical Center	17,066
Suburban Hospital	11,186

¹³ HSCRC did not have admissions data for Adventist HealthCare Rehabilitation.

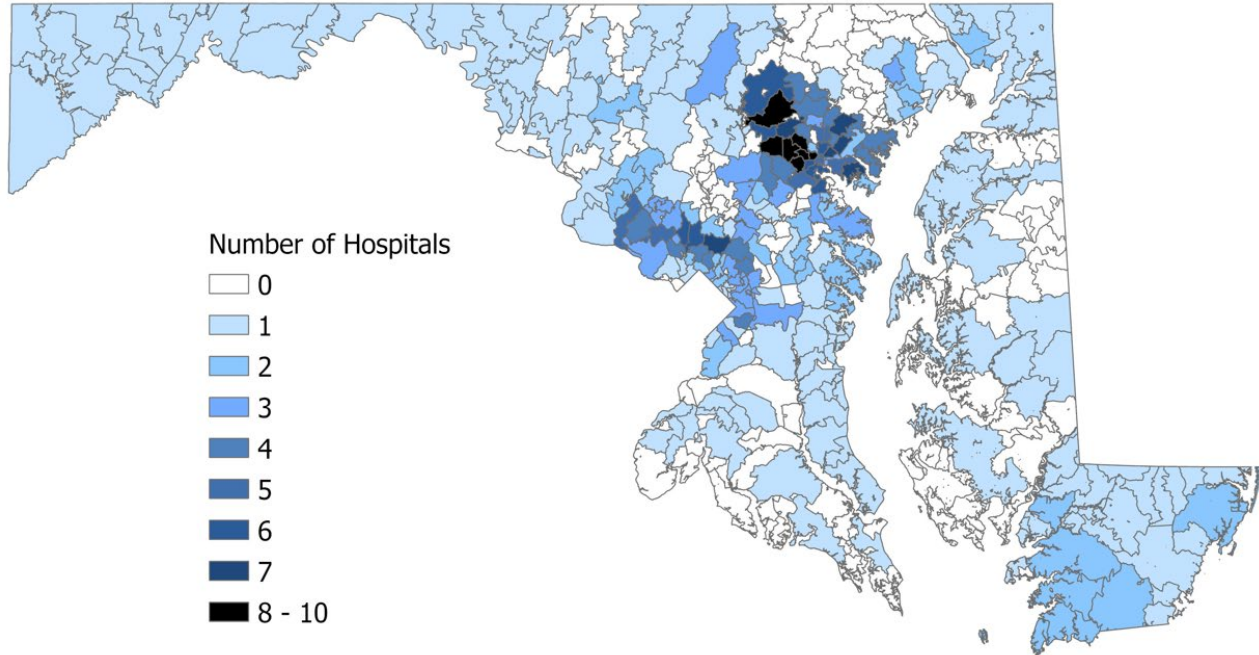
Hospital Name	Inpatient Admissions
Johns Hopkins Hospital	37,436
Jointly Owned Hospitals	
Mt. Washington Pediatric Hospital	542
LifeBridge Health	
Carroll Hospital	7,994
Grace Medical Center	222
Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	1,522
Northwest Hospital Center, Inc.	7,525
Sinai Hospital of Baltimore, Inc.	15,626
Luminis Health	
Anne Arundel Medical Center	23,542
Doctors Community Hospital	9,746
McNew Family Health Center	741
MedStar Health	
MedStar Franklin Square Medical Center	17,446
Medstar Good Samaritan Hospital	8,421
Medstar Harbor Hospital	6,722
MedStar Montgomery Medical Center	4,981
MedStar Southern Maryland Hospital Center	9,800
MedStar St. Mary's Hospital	6,555
MedStar Union Memorial Hospital	9,696
TidalHealth	
TidalHealth McCready Pavilion	0
TidalHealth Peninsula Regional	13,823
Trinity Health	
Holy Cross Germantown Hospital	5,598
Holy Cross Hospital	22,637
University of Maryland	
UM Baltimore Washington Medical Center	16,802
UM Capital Region Health	9,879
UM Charles Regional Medical Center	5,510
UM Rehabilitation & Orthopaedic Institute	1,946
UM Shore Regional Health – Easton	5,155
UM Shore Regional Health – Dorchester	824
UM Shore Regional Health – Chester River	540
UM St. Joseph Medical Center	12,868

Hospital Name	Inpatient Admissions
UM Upper Chesapeake Health – Harford Memorial Hospital	4,148
UM Upper Chesapeake Health – Upper Chesapeake Medical Center	11,387
UMMC Midtown Campus	4,701
University of Maryland Medical Center	24,575
UPMC	
UPMC Western Maryland	9,538
WVU Medical System	
Garrett County Memorial Hospital, DBA Garrett Regional Medical Center	1,429
Total	475,985

Primary Service Area

Each hospital has a primary service area (PSA), as defined in its global budget revenue (GBR) agreement.¹⁴ Figure 1 displays a map of Maryland’s ZIP codes. Each ZIP code has a color indicating how many hospitals claim that area in their PSAs.

Figure 1. Number of Hospitals Claiming the ZIP Code in Their PSAs, FY 2021*



*: Does not include Luminis Health J. Kent McNew Family Medical Center.

Community Benefit Service Area

The CBR also collects the ZIP codes included in each hospital’s community benefit service area (CBSA). Each hospital defines its own CBSA and must disclose the methodology behind this definition in both their CBRs and federally mandated CHNAs.¹⁵ Table 3 summarizes the methods reported by Maryland hospitals. The most common method was based on patterns of service utilization, such as percentages of hospital discharges and emergency department (ED) visits. In general, the other methods that hospitals reported were based on proximity to the facility, social

¹⁴ The exception is the specialty hospitals that do not have GBRs. For these hospitals, the ZIP codes that account for 60 percent of discharges are reported.

¹⁵ 26 CFR § 1.501(r)-3(b).

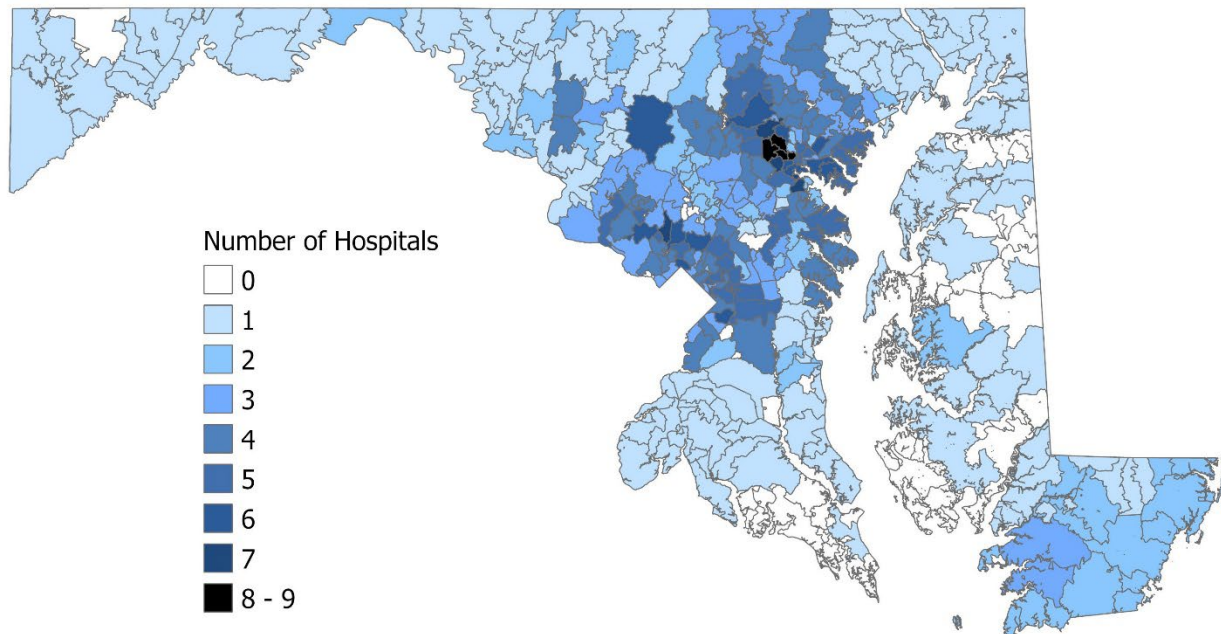
determinants of health indicators, and the proportion of residents who were medically underserved or uninsured/underinsured. Nine hospitals based their CBSAs on the PSAs described above.

Table 3. Methods Used by Hospitals to Identify their CBSAs, FY 2021

CBSA Identification Method	Number of Hospitals
Based on ZIP Codes in Financial Assistance Policy	4
Based on ZIP Codes in their Global Budget Revenue Agreement	9
Based on Patterns of Utilization	33
Other Method	25

Figure 2 displays the number of hospitals claiming each ZIP code in their CBSAs. A total of 93 ZIP codes—those that appear white on the map—are not a part of any hospital’s CBSA. This is a slight increase over FY 2020, which identified 91 ZIP codes that were not covered. Four ZIP codes in Baltimore City/County—those that appear black on the map—are part of eight or more hospitals’ CBSAs. Although hospital CBSAs and PSAs overlap to some degree, there are differences in the footprint of the CBSAs and PSAs. Please note that there is no requirement for CBSAs and PSAs to overlap. Please also note that hospitals may include out-of-state ZIP codes in their CBSA, but these are not displayed below.

Figure 2. Number of Hospitals Claiming the ZIP Code in Their CBSAs, FY 2021



Other Demographic Characteristics of Service Areas

Hospitals report details about the communities located in their CBSAs. Because most of the required measures in this section of the report are not available at the ZIP code level, they are reported at the county level. Table 4 displays examples of the county-level demographic measures required in the CBR. Because hospitals vary in their approaches to describing their service areas, the data in Table 4 were retrieved independently. See Appendix A for other community health data sources reported by hospitals.

The following measures were derived from the five-year (2016-2020) average estimates of the U.S. Census Bureau's American Community Survey: median household income, percentage of families below the federal poverty level (FPL), percentage uninsured, percentage with public health insurance, mean travel time to work, percentage that speak a language other than English at home, percentage by racial categories, and percentage by ethnicity categories. The life expectancy three-year average (2018-2020) and the crude death rate (2020) measures were derived from the Maryland Department of Health's Vital Statistics Administration.

Table 4. Community Statistics by County

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race: % White	Race: % Black	Ethnicity: % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Maryland		87,063	5.9	5.9	32.7	25.2	33.0	19.0	58.0	32.1	10.3	78.6	992.0
Allegany	1	49,449	10.1	4.5	46.9	34.6	22.4	3.7	90.1	9.8	1.9	75.5	1664.4
Anne Arundel	8	103,225	3.8	4.3	28.0	18.4	31.2	11.7	75.7	19.3	8.0	79.0	862.8
Baltimore	11	78,724	6.1	5.3	33.9	26.4	29.8	14.6	61.8	31.2	5.6	77.5	1199.9
Baltimore City	16	52,164	15.0	6.0	45.5	46.6	31.1	9.9	32.3	64.1	5.4	71.8	1330.1
Calvert	1	112,696	2.9	3.3	26.9	17.4	42.2	4.5	84.5	14.5	4.1	79.4	881.0
Caroline	1	59,042	9.5	6.2	47.4	38.8	32.7	8.4	82.0	15.9	7.5	76.2	1218.2
Carroll	3	99,569	3.0	3.2	27.1	15.0	36.1	5.2	92.9	4.9	3.7	78.4	1089.3
Cecil	1	79,415	6.4	4.2	36.6	27.7	30.6	6.2	90.0	8.7	4.6	75.1	1179.7
Charles	1	103,678	4.5	4.2	28.5	22.2	45.4	8.3	46.1	51.5	6.1	77.9	873.3
Dorchester	1	52,799	10.9	4.9	52.6	43.0	27.3	6.3	69.5	29.9	5.8	75.7	1400.2
Frederick	5	100,685	4.4	4.5	27.7	17.5	35.4	14.4	83.3	11.9	10.0	80.1	836.9
Garrett	1	54,542	6.1	6.4	44.4	31.9	23.7	2.5	97.9	1.6	1.2	77.7	1528.5
Harford	2	94,003	4.2	3.3	29.7	19.5	32.7	7.3	81.0	15.9	4.7	78.5	1002.7
Howard	3	124,042	3.6	3.7	24.0	15.8	31.1	25.9	59.5	21.6	7.0	82.7	632.8
Kent	1	60,208	6.0	4.1	45.4	27.6	28.2	5.7	82.5	15.9	4.5	78.0	1683.0
Montgomery	9	111,812	4.4	6.8	27.4	20.0	34.4	40.9	56.3	20.7	19.5	84.2	728.9
Prince George's	7	86,994	5.6	10.3	32.6	26.7	37.0	27.8	18.8	64.7	18.8	78.4	925.1
Queen Anne's	2	96,467	3.1	4.3	33.7	18.3	36.0	5.3	91.3	7.3	4.1	79.8	901.0
Saint Mary's	1	95,864	6.7	4.7	29.5	21.7	31.7	7.1	81.5	16.6	5.3	78.2	882.4
Somerset	3	44,980	15.1	5.2	51.1	38.6	24.2	4.7	56.3	44.6	3.7	75.7	1379.0

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race: % White	Race: % Black	Ethnicity: % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Talbot	2	73,102	5.5	4.1	45.8	24.3	27.4	7.9	85.9	13.7	6.9	79.4	1490.3
Washington	1	63,510	8.8	5.2	40.5	31.6	30.2	7.4	85.8	13.8	5.4	75.9	1302.1
Wicomico	2	60,366	8.9	6.7	44.1	36.7	22.0	10.9	68.5	28.4	5.4	76.1	1154.9
Worcester	2	65,396	6.3	5.4	47.3	27.4	24.1	6.7	85.2	14.2	3.6	79.9	1414.0
Source	16	17	18	19	20	21	22	23	24	25	26	27	28

¹⁶ As reported by hospitals in their FY 2021 Community Benefit Narrative Reports.

¹⁷ American Community Survey 5-Year Estimates 2016 – 2020, Selected Economic Characteristics, Median Household Income (Dollars),

<https://data.census.gov/cedsci/>.

¹⁸ American Community Survey 5-Year Estimates 2016 – 2020, Selected Economic Characteristics, Percentage of Families and People Whose Income in the Past 12 Months is Below the Federal Poverty Level – All Families.

¹⁹ American Community Survey 5-Year Estimates 2016 – 2020, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – No Health Insurance Coverage.

²⁰ American Community Survey 5-Year Estimates 2016 – 2020, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – With Public Coverage.

²¹ 2020 Census (denominator) and The Maryland Medicaid Dataport, the Hilltop Institute (numerator).

²² American Community Survey 5-Year Estimates 2016 – 2020, Selected Economic Characteristics, Commuting to Work – Mean Travel Time to Work (Minutes).

²³ American Community Survey 5-Year Estimates 2016 – 2020, Language Spoken at Home, Population 5 Years and Over, Speak a Language Other Than English.

²⁴ American Community Survey 5-Year Estimates 2016 – 2020, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races - Total Population – White.

²⁵ American Community Survey 5-Year Estimates 2016 – 2020, ACS Demographic and Housing Estimates, Race alone or in combination with one or more other races - Total Population – Black or African American.

²⁶ American Community Survey 5-Year Estimates 2016 – 2020, ACS Demographic and Housing Estimates, Hispanic or Latino and race - Total Population - Hispanic or Latino (of any race).

²⁷ Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2020, Table 7. Life Expectancy at Birth by Race, Region, and Political Subdivision, Maryland, 2018 – 2020.

²⁸ Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2020, Table 39A. Crude Death Rates by Race, Hispanic Origin of Mother, Region, and Political Subdivision, Maryland, 2020.

Section II. Community Health Needs Assessment

Section II of the CBR narrative asks hospitals whether they conducted a CHNA, when they last conducted it, and whether they adopted an implementation strategy. All hospitals reported conducting CHNAs that conform to the IRS definition within the past three fiscal years as well as adopting an implementation strategy. See Appendix B for the dates in which hospitals conducted their last CHNAs. These dates ranged from June 2018 to June 2021.

This section also asks the hospitals to report on the internal and external participants involved in the CHNA process, including their corresponding roles. Table 5 shows the number of hospitals that reported collaborating with one of several types of external organizations. Only 17 hospitals partnered with local health improvement collaboratives (LHICs) in their most recent CHNA efforts, a significant reduction from what was reported in FY 2020. See Appendices C, D, and E for more detail on the internal and external participants in development of the hospitals' CHNAs.

Table 5. Number of Hospitals that Collaborated with Selected Types of External Organizations for Their Most Recent CHNA

Collaborator Type	Number of Hospitals	% of Hospitals
Post-Acute Care Organizations	6	13%
Local Health Departments	20	42%
Local Health Improvement Collaboratives	17	35%
Other Hospitals	18	38%
Behavioral Health Organizations	17	35%

Section III. Community Benefit Administration

This section of the narrative CBR requires hospitals to report on the process of determining which needs in the community would be addressed through community benefit activities. Hospitals also must report on the internal participants involved in community benefit activities and their corresponding roles. Table 6 presents some highlights, and Appendices C and F provide full detail. Of note, around 96 percent of hospitals employed population health staff.

Table 6. Number of Hospitals Reporting Staff in the Following Categories

Staff Category	Number of Hospitals	% of Hospitals
Population Health Staff	46	96%
Community Benefit Staff	41	85%
Community Benefit/Pop Health Director	46	96%

Since reporting related to CHNA external partners was optional in FY 2021, these results should be interpreted with caution.

Internal Audit and Board Review

This part of the report addresses whether the hospital conducted an internal audit of the CBR financial spreadsheet and narrative. Table 7 shows that 47 out of 48 hospitals conducted some kind of audit of the financial spreadsheet. Audits were most frequently performed by hospital or system staff. These figures are similar to what was reported in FY 2020.

Table 7. Hospital Audits of CBR Financial Spreadsheet

Audit Type	Number of Hospitals	
	Yes	No
Hospital Staff	42	6
System Staff	37	11
Third-Party	12	36
No Audit	1	47
Two or More Audit Types	36	12
Three or More Audit Types	8	40

This section also addresses whether the hospital board reviews and approves the CBR spreadsheet and narrative. Table 8 shows that most hospital boards review and approve the CBR. Of the hospitals that reported that they did not submit their reports for board review, their rationale was largely related to timing issues or because the board had delegated this authority to executive staff. For example, several hospitals reported that their board meets only twice per year and did not have the opportunity to review before the report deadline. These responses were very similar to what was reported in FY 2020.

Table 8. Hospital Board Review of the CBR

Board Review	Number of Hospitals	
	Yes	No
Spreadsheet	39	9
Narrative	39	9

This section also asks if community benefit investments were incorporated into the major strategies of the Hospital Strategic Transformation Plan. Table 9 shows that most hospitals indicated that community benefit investments were a part of their Strategic Transformation Plan.

Table 9. Community Benefit Investments in Hospital Strategic Transformation Plan

Community Benefit Investments in Strategic Transformation Plan	Number of Hospitals
Yes	43
No	5

Section IV. Hospital Community Benefit Program and Initiatives

The CBR asks hospitals to describe the community benefit initiatives undertaken to address CHNA-identified needs in the community. Table 10 summarizes the most commonly identified needs among all hospitals. A full accounting of all CHNA-identified community health needs is available in Appendix G.

Table 10. Top 5 CHNA-Identified Community Health Needs

CHNA-Identified Community Health Need	Number of Hospitals
Health Conditions - Mental Health and Mental Disorders	46
Health Conditions - Diabetes	39
Health Conditions - Heart Disease and Stroke	35
Social Determinants of Health - Health Care Access and Quality	35
Health Conditions - Cancer	33

Table 11 summarizes the CHNA-identified community health needs most commonly addressed by a hospital initiative in FY 2021. Appendix G shows the number of hospitals reporting initiatives to address all CHNA-identified community health needs.

Table 11. Top 5 CHNA-Identified Community Health Needs Addressed

CHNA-Identified Community Health Need	Number of Hospitals
Health Conditions - Mental Health and Mental Disorders	25
Social Determinants of Health - Health Care Access and Quality	23
Health Conditions - Diabetes	21
Health Conditions - Heart Disease and Stroke	19
Health Conditions - Addiction	19

Since initiative reporting was optional in FY 2021, these results should be interpreted with caution.

Community Benefit Operations/Activities Related to State Initiatives

Hospitals were asked how their community benefit operations/activities worked toward the state's initiatives for improvement in population health, as identified by the Statewide Integrated Health Improvement Strategy (SIHIS). The SIHIS provides a framework for accountability, local action, and public engagement to advance the health of Maryland residents. In the context of the state's Total Cost of Care Model, hospitals are tasked with improving quality, including decreasing readmissions and hospital-acquired conditions. Of the 48 hospitals, 43 reported that their community benefit activities addressed at least one SIHIS goal. Table 12 presents the number of hospitals that addressed at least one goal under each SIHIS category. Because hospitals targeted their community benefit initiatives to address community health needs identified in their CHNAs, the SIHIS goals selected tended to be those that were in alignment with hospital CHNAs. Reducing the mean BMI for Maryland residents, related to diabetes was the SIHIS goal most addressed by hospitals' community benefit activities. Decreasing asthma-related ED visits for children was the SIHIS goal that was least commonly addressed.

Table 12. Number of Hospitals with CB Activities Addressing SIHIS Goals, FY 2021

SIHIS Goal	Number of Hospitals in Alignment
Diabetes – Reduce the mean BMI for Maryland residents	39
Opioid Use Disorder – Improve overdose mortality	33
Maternal and Child Health – Reduce severe maternal morbidity rate	18
Maternal and Child Health – Decrease asthma-related emergency department visit rates for children aged 2-17	11

Section V. Physician Gaps in Availability

Maryland law requires hospitals to provide a written description of gaps in the availability of specialist providers to serve their uninsured populations.²⁹ Each hospital uses its own criteria to determine what constitutes a physician gap. Table 13 shows the gaps in availability that were identified by the hospitals and the number of hospitals that reported each gap. The most frequently reported gap was Internal Medicine (reported by 22 hospitals), followed by Emergency Medicine, Obstetrics & Gynecology, Pediatrics, Psychiatry, and other specialties. Six hospitals reported no gaps. Seven hospitals did not fully and accurately complete this section of the narrative report and

²⁹ MD. CODE. ANN., Health-Gen. § 19-303(c)(4)(vi).

were excluded from this table. See the mission-driven services section of the financial report summary for a related discussion.

Table 13. Gaps in Physician Availability

Physician Specialty Gap	Number of Hospitals
No gaps	6
Internal Medicine	22
Emergency Medicine	20
Obstetrics & Gynecology	19
Pediatrics	19
Psychiatry	19
Other	19
Surgery	18
Anesthesiology	17
Cardiology	14
Endocrinology, Diabetes & Metabolism	12
Neurology	12
Oncology-Cancer	12
Orthopedics	11
Family Practice/General Practice	10
Radiology	10
Urology	9
Neurological Surgery	8
Ophthalmology	8
Otolaryngology	8
Pathology	3
Plastic Surgery	3
Geriatrics	2
Physical Medicine & Rehabilitation	2
Preventive Medicine	2
Allergy & Immunology	1
Medical Genetics	1
Dermatology	0

Section VI. Financial Assistance Policies

Finally, the narrative section of the CBR requires hospitals to submit information about their financial assistance policies. Maryland law established the requirements for hospitals to provide free or reduced cost care as part of their financial assistance policies as follows:³⁰

- Hospitals must provide free, medically necessary care to patients with family income at or below 200 percent of the FPL.³¹ Twenty hospitals reported a more generous threshold.
- Hospitals must provide reduced-cost, medically necessary care to patients with family income between 200 and 300 percent of the FPL.³² Forty-four hospitals reported a more generous threshold.³³
- Hospitals must provide reduced-cost, medically necessary care to patients with family income below 500 percent of the FPL who have a financial hardship, which is referred to as the financial hardship policy.³⁴ In order to qualify as having a financial hardship, the medical debt incurred by a family over a 12-month period must exceed 25 percent of the family's income.³⁵ Seven hospitals reported a more generous threshold.

Staff noted variation among the hospitals in the content and format of their financial assistance policy documents.

Section VII. Tax Exemptions

Newly required under HB 1169/SB 774 of 2020, hospitals reported on the types of tax exemptions claimed. Table 14 shows the number of hospitals that reported claiming each type of tax exemption. Hospitals that selected "Other" indicated that they also claimed an exemption from the federal unemployment insurance tax (FUTA). One hospital reported claiming some exemptions from some property taxes depending on usage but not from all local property taxes.

Table 14. Tax Exemptions

Tax Exemption	Number of Hospitals
Federal corporate income tax	47
State corporate income tax	47
State sales tax	45
Local property tax (real and personal)	44
Other (describe)	6

³⁰ MD. CODE. ANN., Health-Gen. § 19-214.1; COMAR 10.37.10.26.

³¹ MD. CODE. ANN., Health-Gen. § 19-214.1(b)(2)(i); COMAR 10.37.10.26(A-2)(2)(a)(i).

³² COMAR 10.37.10.26(A-2)(2)(a)(ii).

³³ For this analysis, the FAPs of hospitals at which patients receive free care up to 300% FPL, making the guidelines for reduced-cost care without financial hardship inapplicable, were counted as more generous than Maryland law requires for both the "free care" and "reduced-cost care" (without financial hardship) items.

³⁴ COMAR 10.37.10.26(A-2)(3).

³⁵ COMAR 10.37.10.26(A-2)(1)(b)(i).

Financial Reports

The CBR financial reports collect information about staff hours, the number of encounters, and direct and indirect costs of community benefits, categorized by type of community benefit activity. The reporting period for these financial data is July 1, 2020, through June 30, 2021. Hospitals were instructed to use data from audited financial statements to calculate the cost of each of the community benefit categories contained in the CBR financial reports and to limit reporting to only those hospital services reported on the IRS 990 schedule H. Fifty-one hospitals submitted individual financial reports.

FY 2021 Financial Reporting Highlights

Table 15 presents a statewide summary of community benefit expenditures for FY 2021. Maryland hospitals provided roughly \$1.95 billion in total community benefit activities (before adjusting for rate support) in FY 2021—a total that is slightly higher than FY 2020 (\$1.94 billion). The FY 2021 total includes: net community benefit expenses of \$703 million in mission-driven health care services (subsidized health services), \$644 million in health professions education, \$330 million in charity care, \$148 million in community health services, \$56 million in Medicaid deficit assessment costs, \$26 million in community building activities, \$16 million in financial contributions, \$14 million in research activities, \$14 million in community benefit operations, and \$1 million in foundation-funded community benefits. These totals include hospital-reported indirect costs, which vary by hospital and by category from a fixed dollar amount to a calculated percentage of the hospital's reported direct costs.

Table 15. Total Community Benefits, FY 2021

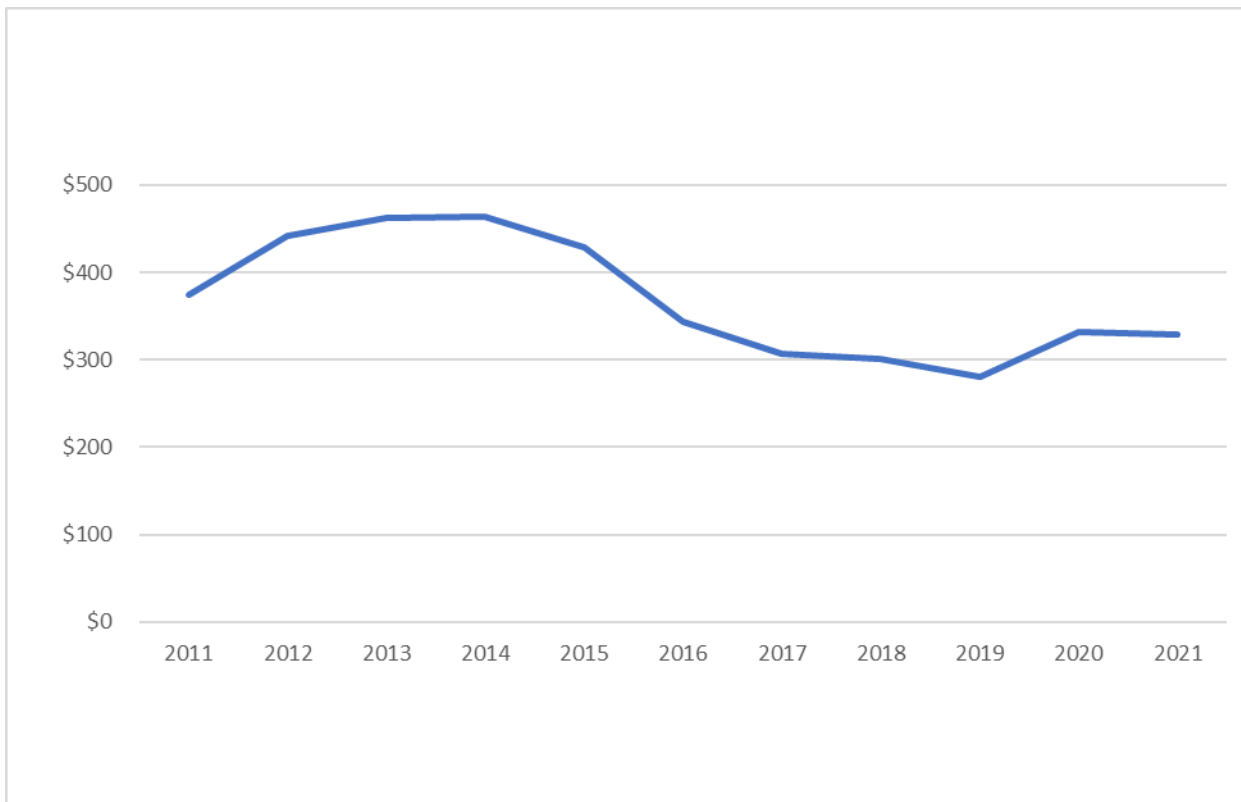
Community Benefit Category	Net Community Benefit Expense	Percent of Total CB Expenditures	Net Community Benefit Expense Less Hospital-reported Rate Support	Percent of Total CB Expenditures w/o Rate Support
Unreimbursed Medicaid Cost	\$55,638,248	2.85%	\$55,638,248	4.62%
Community Health Services	\$147,560,517	7.56%	\$136,149,801	11.32%
Health Professions Education	\$644,376,489	33.00%	\$235,701,245	19.59%
Mission Driven Health Services	\$703,102,308	36.01%	\$703,102,308	58.44%
Research	\$13,834,648	0.71%	\$13,834,648	1.15%
Financial Contributions	\$16,296,497	0.83%	\$16,296,497	1.35%

Community Benefit Category	Net Community Benefit Expense	Percent of Total CB Expenditures	Net Community Benefit Expense Less Hospital-reported Rate Support	Percent of Total CB Expenditures w/o Rate Support
Community Building	\$25,945,729	1.33%	\$25,945,729	2.16%
Community Benefit Operations	\$14,494,733	0.74%	\$14,494,733	1.20%
Foundation	\$1,334,192	0.07%	\$1,334,192	0.11%
Charity Care	\$329,992,676	16.90%	\$581,306	0.05%
Total	\$1,952,576,038	100%	\$1,203,078,708	100%

In Maryland, some activities that are considered community benefit are built into the rates for which all hospitals are reimbursed by all payers, including the costs of uncompensated care (including charity care), graduate medical education, the nurse support programs, and the regional partnership catalyst grants. These costs are essentially “passed through” to the payers of hospital care. To comply with IRS Form 990 and avoid accounting confusion among programs that are not funded by hospital rate setting, the HSCRC requests that hospitals exclude from their reports all revenue that is included in rates as offsetting revenue on the CBR worksheet. Appendix I details the amounts that were included in rates and funded by all payers for charity care, direct graduate medical education, and nurse support programs in FY 2021. *New to this year’s report, please note that the nurse support program II and the regional catalyst grants are counted as rate support, so the rate support adjustments are higher in FY 2021 compared with prior years.*

Figure 3 shows the rate support for charity care from FY 2011 through FY 2021. This decreased slightly in FY 2021 after an increase in FY 2020 followed several years of decreases in the wake of ACA implementation. See Appendix H for more details on the charity care methodology.

Figure 3. Rate Support for Charity Care (in millions), FY 2011-FY 2021



Another social cost funded through Maryland’s rate-setting system is the cost of graduate medical education, generally for interns and residents trained in Maryland hospitals. Included in graduate medical education costs are the direct costs (i.e., direct medical education, or DME), which include the residents’ and interns’ wages and benefits, faculty supervisory expenses, and allocated overhead. The HSCRC’s annual cost report quantifies the DME costs of physician training programs at Maryland hospitals. In FY 2021, DME costs totaled \$374 million.

The HSCRC’s Nurse Support Program I (NSP I) and NSP II are aimed at addressing the short- and long-term nursing shortage affecting Maryland hospitals. In FY 2021, the HSCRC provided \$18 million in hospital rate adjustments for the NSP I and \$17 million for the NSP II. See Appendix I for detailed information about funding provided to specific hospitals.

When the reported community benefit costs for Maryland hospitals were offset by rate support, the net community benefits provided in FY 2021 were about \$1.2 billion, or 7.4 percent of total hospital operating expenses. This is similar to the \$1.2 billion in net benefits provided in FY 2020, which totaled 7.2 percent of hospital operating expenses.

Table 16 presents expenditures for health professional education by activity. As with prior years, the education of physicians and medical students made up the majority of expenses, totaling

\$569.6 million. The second highest category was the education of nurses and nursing students, totaling \$40.6 million. The education of other health professionals totaled \$25.7 million.

Table 16. Health Professions Education Activities and Costs, FY 2021

Health Professions Education	Net Community Benefit with Indirect Cost
Physicians and Medical Students	\$569,607,102
Nurses and Nursing Students	\$40,571,665
Other Health Professionals	\$25,744,142
Scholarships and Funding for Professional Education	\$4,760,602
Other	\$3,319,298
Total	\$643,822,809

Table 17 presents expenditures for community health services by activity. As with prior years, health care support services comprised the largest portion of expenses in the category of community health services, totaling \$62.7 million. Community health education was the second highest category, totaling \$25.8 million, and community-based clinical services were the third highest, totaling \$15.6 million. For additional detail, see Appendix J.

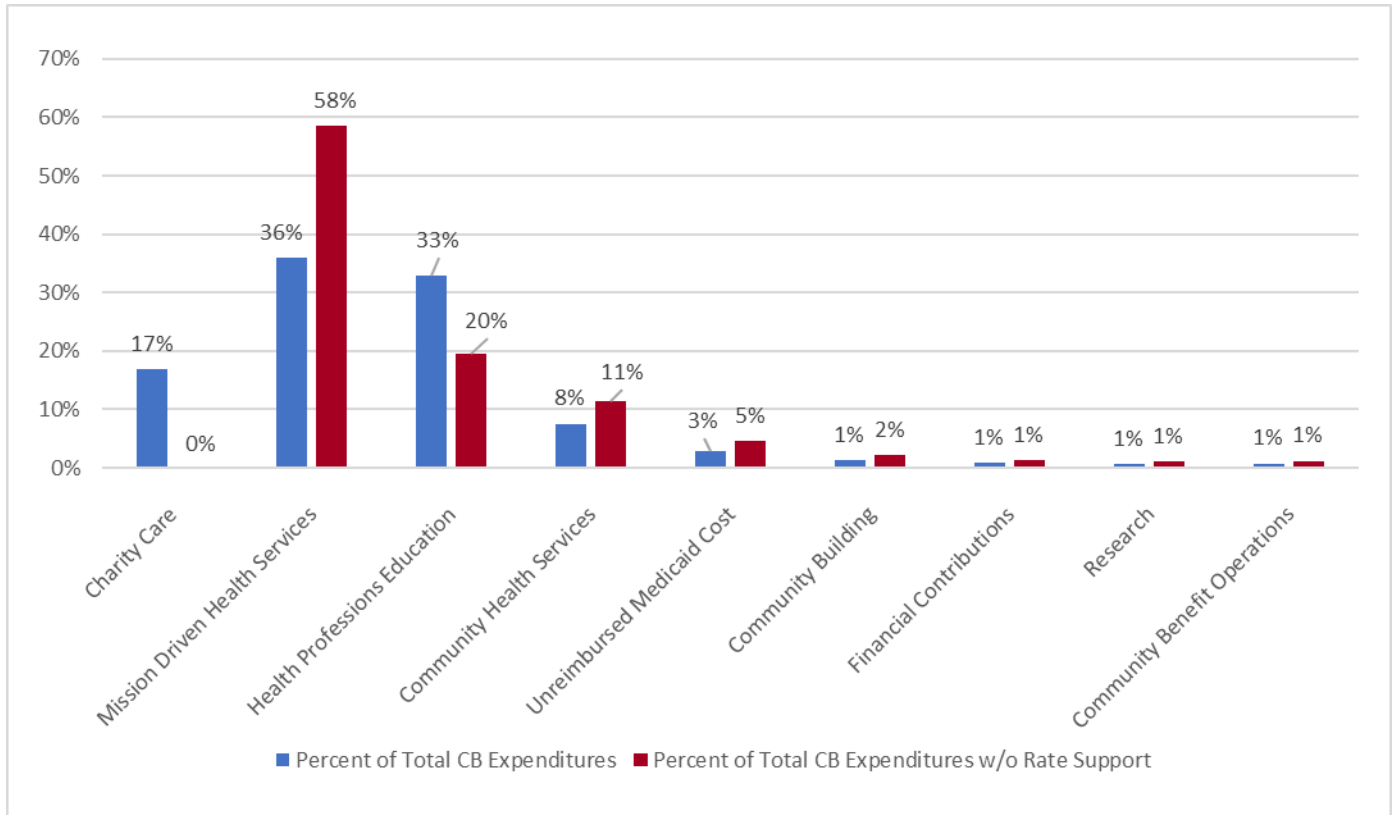
Table 17. Community Health Services Activities and Costs, FY 2021

Community Health Services	Net Community Benefit with Indirect Cost
Community Health Education	\$25,833,662
Support Groups	\$4,601,521
Self-Help	\$931,651
Community-Based Clinical Services	\$15,593,667
Screenings	\$3,275,382
One-Time/Occasionally Held Clinics	\$692,083
Free Clinics	\$13,593,461
Mobile Units	\$325,069
Health Care Support Services	\$62,706,553
Other	\$14,285,590
Total	\$141,838,639

Accounting for rate support significantly affects the distribution of expenses by category. Figure 4 shows expenditures for each community benefit category as a percentage of total expenditures. Mission-driven health services, health professions education, and charity care represented the majority of the expenses, at 36 percent, 33 percent, and 17 percent, respectively. Figure 4 also shows the percentage of expenditures by category without rate support, which changed the distribution: mission-driven health services remained the category with the highest percentage of

expenditures, at 58 percent, followed by health professions education at 20 percent, and community health services at 11 percent.

Figure 4. Percentage of Community Benefit Expenditures by Category with and without Rate Support, FY 2021



Appendix K compares hospitals in terms of the total amount of community benefits reported and the amount of community benefits recovered through HSCRC-approved rate supports (i.e., charity care, direct medical education, and nurse support) or as revenue from billable services. The HSCRC continues to encourage hospitals to incorporate community benefit operations into their overall strategic planning.

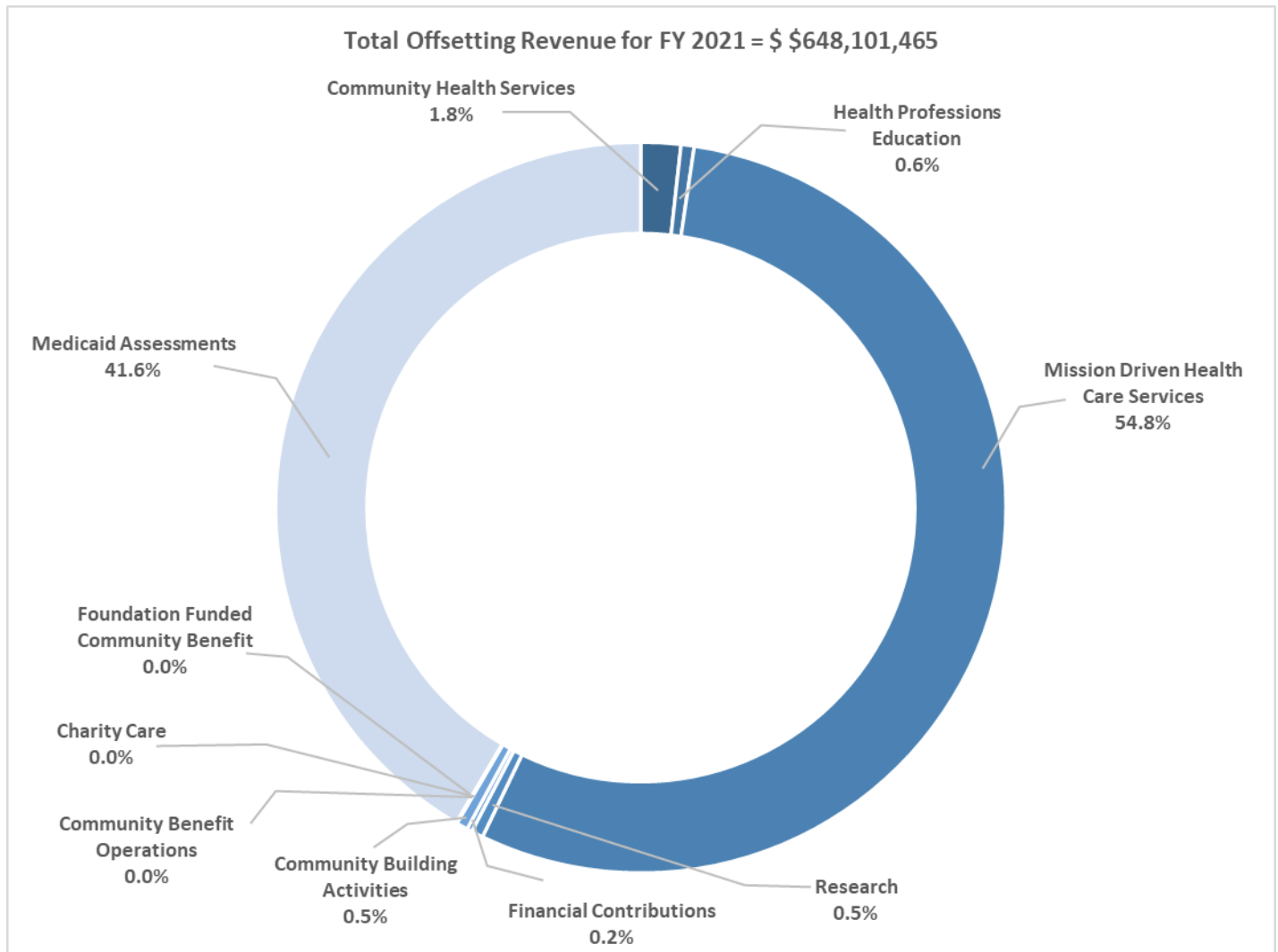
The total amount of net community benefit expenditures without rate support as a percentage of total operating expenses ranged from 0.6 to 21.4 percent, with an average of 6.6 percent, which was slightly lower than the average of 7.8 percent in FY 2020. Ten hospitals reported providing benefits in excess of 10 percent of their operating expenses, compared with eleven hospitals in FY 2020.

Mission-Driven Services and Offsetting Revenue

The instructions for the financial report require hospitals to report offsetting revenue for their community benefit activities, which is defined as any revenue generated by the activity or

program, such as payment for services provided to program patients, restricted grants, or contributions used to provide a community benefit. Figure 5 presents the total FY 2021 offsetting revenue by community benefit category. The largest components of offsetting revenue were mission-driven health care services (54.8 percent) and the Medicaid deficit assessment (41.6 percent). Last year, these two categories accounted for 56.6 percent and 39.5 percent of offsetting revenue, respectively. Other categories had minimal offsetting revenue. Please note that the Medicaid deficit assessment is a broad-based uniform assessment to hospital rates that is set by the Maryland General Assembly. The hospitals pay this assessment, but a portion of it is reimbursed back to the hospital through all-payer rates, which is then reported as offsetting revenue. Therefore, the offsetting revenue reported for the Medicaid deficit assessment is different from the offsetting revenue reported for other community benefit categories.

Figure 5. Sources of Offsetting Revenue for Maryland Hospitals, FY 2021



Mission-driven health services accounted for the majority of offsetting revenues. By definition, mission-driven services are intended to be services provided to the community that are not expected to result in revenue. Rather, hospitals undertake these services as a direct result of their community or mission driven initiatives, or because the services would otherwise not be provided in the community. Table 18 presents offsetting revenue for mission-driven services by hospital. The hospitals are sorted in increasing order of the proportion of reported expenditures offset by revenue. Twelve hospitals did not report any offsetting revenue from mission-driven health services. Seven hospitals reported offsetting revenue for 50 percent or more of their mission-driven expenditures.

Table 18. Mission-Driven Health Services Expenditure and Offsetting Revenue among Maryland Hospitals, FY 2021

Hospital Name	Total Expenditure	Offsetting Revenue and Rate Support	Proportion of Total Expenditure Offset by Revenue and Rate Support	Net Community Benefit
Meritus Medical Center	\$85,331,375	\$40,549,051	47.5%	\$44,782,325
Univ. of Maryland Medical Center	\$24,923,248	\$9,987,519	40.1%	\$14,935,729
Univ. of Maryland Capital Region Medical Center	\$54,720,768	\$12,811,724	23.4%	\$41,909,044
Holy Cross Hospital	\$9,308,178	\$1,023,924	11.0%	\$8,284,254
Frederick Memorial Hospital	\$15,336,911	\$125,069	0.8%	\$15,211,842
Univ. of Maryland Harford Memorial Hospital	\$3,698,023	\$1,045,671	28.3%	\$2,652,352
Mercy Medical Center, Inc.	\$21,711,159	\$700,208	3.2%	\$21,010,951
The Johns Hopkins Hospital	\$13,417,980	\$504,928	3.8%	\$12,913,052
Univ. of Maryland Shore Medical Center at Dorchester	\$7,243,072	\$0	0.0%	\$7,243,072
Ascension Saint Agnes Hospital	\$30,794,570	\$15,253,412	49.5%	\$15,541,158
Sinai Hospital of Baltimore	\$34,903,414	\$8,860,372	25.4%	\$26,043,042
Grace Medical Hospital	\$11,245,499	\$6,439,640	57.3%	\$4,805,859
MedStar Franklin Square Hospital	\$34,953,780	\$18,721,494	53.6%	\$16,232,286
Adventist White Oak Hospital	\$35,880,458	\$19,268,622	53.7%	\$16,611,836
Garrett Regional Hospital	\$9,939,579	\$3,045,264	30.6%	\$6,894,315
MedStar Montgomery General Hospital	\$11,427,263	\$8,315,136	72.8%	\$3,112,127
TidalHealth Peninsula Regional Medical Center	\$23,574,697	\$12,694,920	53.8%	\$10,879,777
Suburban Hospital	\$16,113,928	\$620,108	3.8%	\$15,493,820
Anne Arundel General Hospital	\$37,187,135	\$0	0.0%	\$37,187,135
MedStar Union Memorial Hospital	\$7,538,794	\$3,460,111	45.9%	\$4,078,683
UPMC Western Maryland Hospital	\$93,970,345	\$44,098,271	46.9%	\$49,872,074
MedStar St. Marys Hospital	\$14,131,037	\$4,413,996	31.2%	\$9,717,041
Johns Hopkins Bayview Med. Center	\$8,579,886	\$1,091,043	12.7%	\$7,488,843

Hospital Name	Total Expenditure	Offsetting Revenue and Rate Support	Proportion of Total Expenditure Offset by Revenue and Rate Support	Net Community Benefit
Univ. of Maryland Shore Medical Center at Chestertown	\$9,524,532	\$0	0.0%	\$9,524,532
ChristianaCare, Union Hospital	\$19,707,732	\$9,037,022	45.9%	\$10,670,710
Carroll Hospital Center	\$12,132,057	\$36,235	0.3%	\$12,095,822
MedStar Harbor Hospital Center	\$20,318,099	\$9,499,418	46.8%	\$10,818,681
Univ. of Maryland Charles Regional Medical Center	\$16,472,957	\$5,612,902	34.1%	\$10,860,055
Univ. of Maryland Shore Medical Center at Easton	\$24,234,642	\$0	0.0%	\$24,234,642
Univ. of Maryland Medical Center Midtown Campus	\$22,593,449	\$3,367,952	14.9%	\$19,225,497
CalvertHealth Medical Center	\$17,700,917	\$2,151,022	12.2%	\$15,549,895
Northwest Hospital	\$13,023,115	\$3,860,564	29.6%	\$9,162,551
Univ. of Maryland Baltimore Washington Medical Center	\$25,141,622	\$14,405,920	57.3%	\$10,735,702
Greater Baltimore Medical Center	\$127,870,204	\$77,664,643	60.7%	\$50,205,561
TidalHealth McCreedy Pavilion	\$49,994	\$0	0.0%	\$49,994
Howard County General Hospital	\$16,164,087	\$0	0.0%	\$16,164,087
Univ. of Maryland Upper Chesapeake Medical Center	\$8,265,189	\$2,439,898	29.5%	\$5,825,291
Doctors Community Hospital	\$9,144,918	\$0	0.0%	\$9,144,918
MedStar Good Samaritan Hospital	\$12,312,058	\$4,875,724	39.6%	\$7,436,334
Adventist Shady Grove Medical Center	\$15,617,469	\$403,023	2.6%	\$15,214,446
Univ. of Maryland Rehabilitation & Orthopaedic Institute	\$3,233,065	\$801,401	24.8%	\$2,431,664
Adventist Fort Washington Medical Center	\$1,045,707	\$0	0.0%	\$1,045,707
Atlantic General Hospital	\$390,073	\$68,527	17.6%	\$321,546
MedStar Southern Maryland Hospital	\$14,608,279	\$6,477,917	44.3%	\$8,130,362
Univ. of Maryland St. Josephs Medical Center	\$37,685,478	\$0	0.0%	\$37,685,478
Levindale Hebrew Geriatric Center & Hospital	\$592,620	\$49,395	8.3%	\$543,225
Holy Cross Germantown Hospital	\$2,979,709	\$0	0.0%	\$2,979,709
Mt. Washington Peds	\$831,564	\$271,393	32.6%	\$560,171
Sheppard & Enoch Pratt Hospital	\$19,331,839	\$1,443,918	7.5%	\$17,887,921
J. Kent McNew Family Medical Center	\$227,088	\$0	0.0%	\$227,088
Adventist Rehabilitation	\$1,132,052	\$0	0.0%	\$1,132,052
Total	\$1,058,261,615	\$355,497,356	33.6%	\$702,764,259

FY 2004 – FY 2021 18-Year Summary

FY 2021 marks the 18th year since the inception of the CBR. In FY 2004, community benefit expenses represented \$586.5 million, or 6.9 percent of hospitals’ operating expenses. In FY 2021, these expenses represented roughly \$1.95 billion, or 10.7 percent of operating expenses. Figures 6 and 7 show the trend of community benefit expenses with and without rate support. On average, approximately 50 percent of expenses were reimbursed through the rate-setting system.

Figure 6. FY 2011 – FY 2021 Community Benefit Expenses with and without Rate Support (in millions)

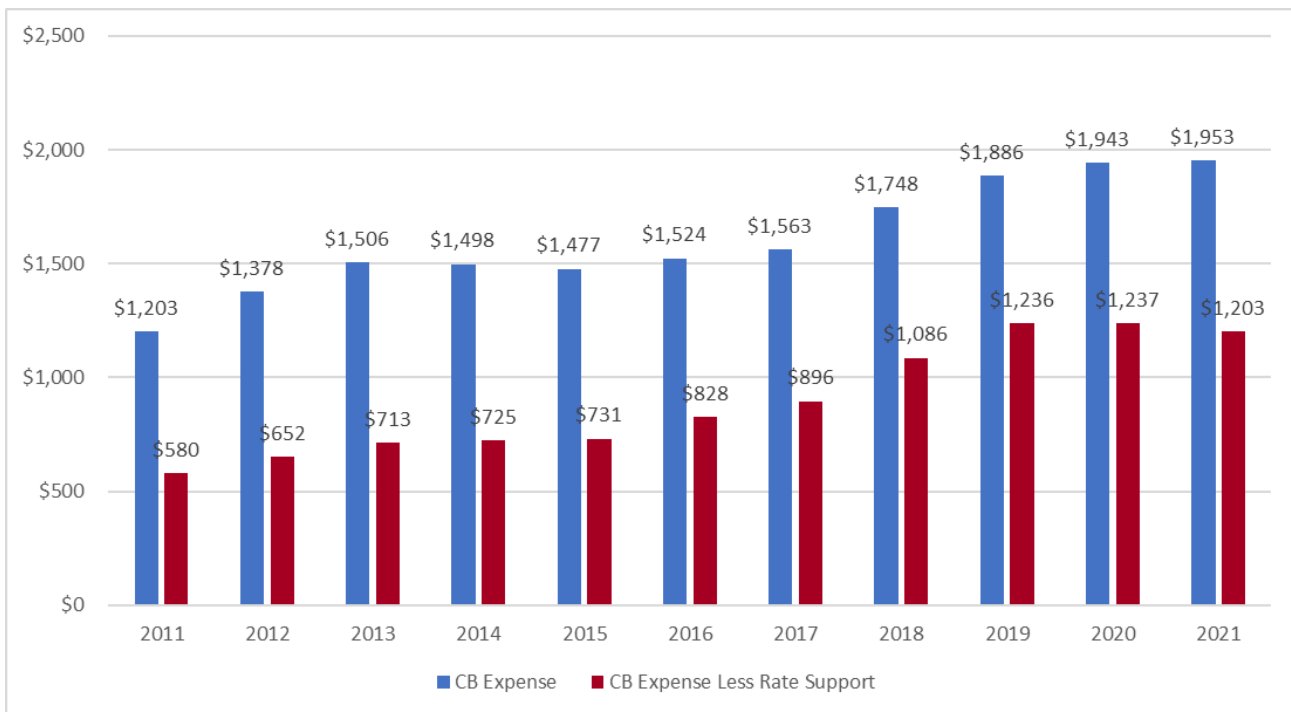
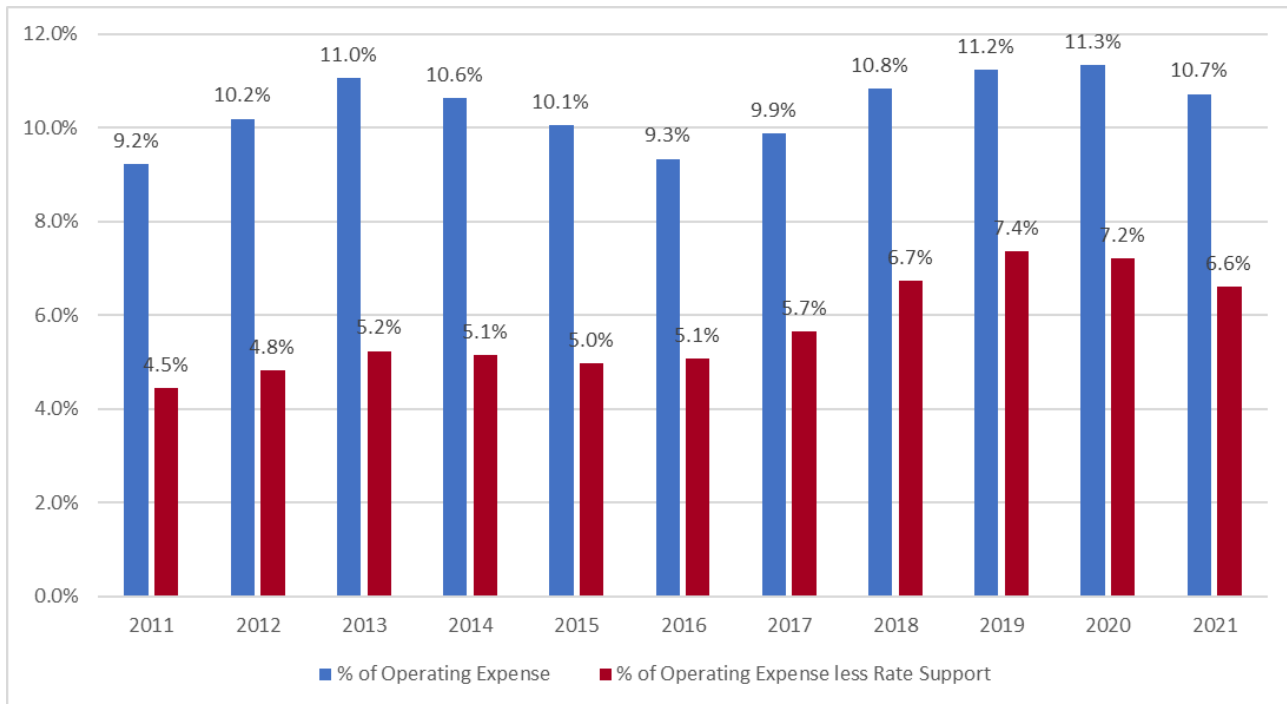


Figure 7. FY 2011 – FY 2021 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support



Conclusion

In summary, all 51 Maryland hospitals submitted FY 2021 CBRs, showing over \$1.9 billion in community benefit expenditures, slightly higher than in FY 2020. The distribution of expenditures across community benefit categories remained similar to prior years, with mission-driven services accounting for the majority of expenditures. Overall, expenditures as a percentage of operating expenses decreased from 11.3 percent in FY 2020 to 10.7% in FY 2021. After accounting for rate support, expenditures as a percentage of operating expenses slightly decreased from 7.2 percent to 6.6 percent (driven by accounting for additional types of rate support this year).

The narrative portion of the CBR provides the HSCRC with richer detail on hospital community benefit and CHNA activities beyond what is included in the financial report. The hospitals continued to be very responsive to using the reporting tool, and all hospitals successfully submitted their reports online. Encouraging findings of the review include a senior-level commitment to community benefit activities and community engagement. For example, 96 percent of hospitals employed a population health director, and most reported that these staff members were involved in selecting the community health needs to target and in developing community benefit initiatives. Eighty-seven percent of hospitals employ staff dedicated to community benefit. Most hospitals (over 80 percent) report having initiative targeting the SIHIS diabetes goals.

The review also identified the following areas for improvement:

- Staff continued to note variation in the format and content of the hospitals' financial assistance policy documents. Standardization of these documents could provide greater clarity for consumers.
- Hospitals historically took inconsistent approaches to reporting offsetting revenue and physician subsidies within mission-driven health services. While hospitals demonstrated improvement in reporting physician subsidies in the new line-item format, discussion with hospitals indicated that more clarity and guidance is needed to ensure consistent reporting across hospitals.

Commissioners may expect next year's report to include new data on community benefit expenditures that tie directly to CHNA-identified needs.

Appendix A. Community Health Measures Reported by Hospitals

In addition to the measures reported in Table 4 of the main body of this report, hospitals reported using a number of other sources of community health data, including the following:

- Baltimore Neighborhood Indicators Alliance
- CareFirst Community Health and Social Impact
- CDC Chronic Disease Calculator
- CDC Interactive Atlas of Heart Disease and Stroke
- CDC Wonder Database
- Conduent - Healthy Communities Institute
- County and Local Health Departments' Community Health Statistics
- Chesapeake Regional Information System for our Patients (CRISP)
- Cigarette Restitution Fund Program – Cancer in Maryland Report
- Feeding America
- Focus Groups and Interviews
- Local Police and Public School Systems Data
- Maryland Behavioral Risk Factor Surveillance System
- Maryland Department of Health and Mental Hygiene
- Maryland Health Services Cost Review Commission
- Maryland Hospital Association
- Maryland Office of Minority Health and Health Disparities
- Maryland Physician Workforce Study
- Maryland Sexually Transmitted Infections Program
- Maryland State Health Improvement Plan (SHIP)
- Maryland Vital Statistics
- Maryland Youth Risk Behavior Survey
- Metropolitan Washington Council of Governments (COG) Health Officials Committee
- Meritus Health Cancer Registry Report
- National Cancer Institute
- National Survey on Drug Use and Health
- Nielsen/Claritas
- Robert Wood Johnson Foundation – County Health Rankings
- United Way – United for ALICE (Asset-Limited, Income Constrained, Employed)
- University of Wisconsin School of Medicine and Public Health – Neighborhood Atlas

- U.S. Census Bureau - American Community Survey
- U.S. Department of Health and Human Services – Healthy People 2030
- U.S. Health Resources and Services Administration

Appendix B. CHNA Schedules

Hospital	Date Most Recent CHNA was Completed
UM Charles Regional Medical Center	Jun-18
Doctors Community Hospital	Apr-19
McNew Family Health Center	May-19
Howard County General Hospital	May-19
Frederick Health Hospital	May-19
Sheppard Pratt	May-19
Meritus Medical Center	May-19
Atlantic General Hospital	May-19
Adventist HealthCare Fort Washington Medical Center	May-19
UM Shore Regional Health	May-19
Anne Arundel Medical Center	May-19
ChristianaCare, Union Hospital	Jun-19
Suburban Hospital	Jun-19
UM Capital Region Health	Jun-19
TidalHealth Peninsula Regional	Jun-19
UM Baltimore Washington Medical Center	Jun-19
TidalHealth McCreedy Pavilion	Jun-19
Garrett County Memorial Hospital, DBA Garrett Regional Medical Center	Aug-19
Holy Cross Germantown Hospital	Oct-19
Holy Cross Hospital	Oct-19
Adventist HealthCare Rehabilitation	Dec-19
Adventist HealthCare Shady Grove Medical Center	Dec-19
Adventist HealthCare White Oak Medical Center	Dec-19
Grace Medical Center	Jun-20
UPMC Western Maryland	Jun-20
CalvertHealth Medical Center	July-20
Johns Hopkins Bayview Medical Center	May-21
Greater Baltimore Medical Center	May-21
UM Rehabilitation & Orthopaedic Institute	May-21
Mt. Washington Pediatric Hospital	May-21

Hospital	Date Most Recent CHNA was Completed
Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	Jun-21
Northwest Hospital Center, Inc.	Jun-21
Sinai Hospital of Baltimore, Inc.	Jun-21
Carroll Hospital Center	Jun-21
UM Upper Chesapeake Health	Jun-21
University of Maryland Medical Center	Jun-21
UMMC Midtown Campus	Jun-21
Mercy Medical Center	Jun-21
Johns Hopkins Hospital	Jun-21
Saint Agnes Healthcare, Inc.	Jun-21
MedStar Harbor Hospital	Jun-21
MedStar Good Samaritan Hospital	Jun-21
MedStar Franklin Square Medical Center	Jun-21
MedStar Union Memorial Hospital	Jun-21
MedStar St. Mary's Hospital	Jun-21
MedStar Southern Maryland Hospital Center	Jun-21
MedStar Montgomery Medical Center	Jun-21
UM St. Joseph Medical Center	Jun-21

*Data Source: As reported by hospitals on their FY 2021 CBRs.

Appendix C. CHNA Internal Participants and Their Roles

CHNA Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Member of CHNA Committee	Participated in the Development of the CHNA Process	Advised on CHNA Best Practices	Participated in Primary Data Collection	Participated in Identifying Priority Health Needs	Participated in Identifying Community Resources to Meet Health Needs	Provided Secondary Health Data	Other
CB/ Community Health/Population Health Director (facility level)	4	13	31	30	28	26	31	30	18	3
CB/ Community Health/ Population Health Director (system level)	6	10	24	27	29	24	27	26	20	5
Senior Executives (CEO, CFO, VP, etc.) (facility level)	3	0	33	31	25	13	38	20	5	6
Senior Executives (CEO, CFO, VP, etc.) (system level)	3	9	15	22	24	12	20	12	3	5
Board of Directors or Board Committee (facility level)	10	2	12	13	15	3	15	11	2	12
Board of Directors or Board Committee (system level)	11	9	1	9	13	0	12	4	1	9
Clinical Leadership (facility level)	5	0	29	23	27	18	41	32	11	2
Clinical Leadership (system level)	12	9	16	18	20	6	24	18	3	3
Population Health Staff (facility level)	7	10	27	21	18	17	29	29	21	2
Population Health Staff (system level)	13	9	21	24	21	20	24	21	17	4
Community Benefit staff (facility level)	3	12	32	31	30	27	33	30	30	2
Community Benefit staff (system level)	8	14	20	24	24	20	22	20	18	8
Physician(s)	3	0	25	18	19	15	39	29	7	2
Nurse(s)	7	0	26	22	20	17	37	33	7	1
Social Workers	9	0	21	15	17	17	33	33	6	1
Hospital Advisory Board	8	17	11	12	13	8	21	16	4	2

CHNA Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Member of CHNA Committee	Participated in the Development of the CHNA Process	Advised on CHNA Best Practices	Participated in Primary Data Collection	Participated in Identifying Priority Health Needs	Participated in Identifying Community Resources to Meet Health Needs	Provided Secondary Health Data	Other
Other (specify)	8	1	4	4	6	6	6	6	1	2

Appendix D. CHNA External Participants and Their Level of Community Engagement During the CHNA Process

CHNA Participant Category	Level of Community Engagement					
	Informed - To provide the community with balanced & objective info to assist in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision- making in the hands of the community	Community Driven/Led - To support the actions of community initiated, driven and/or led processes
Other Hospitals	13	15	14	15	6	7
Local Health Department	18	16	14	15	5	8
Local Health Improvement Coalition	14	15	10	12	5	5
Maryland Department of Health	12	7	2	1	0	0
Other State Agencies	4	4	2	1	0	0
Local Govt. Organizations	10	11	5	1	1	1
Faith-Based Organizations	15	15	10	7	0	2
School - K-12	13	11	7	4	0	1
School - Colleges, Universities, Professional Schools	12	11	4	3	0	0
Behavioral Health Organizations	14	16	8	5	3	3
Social Service Organizations	10	10	5	6	0	0
Post-Acute Care Facilities	5	6	2	0	0	0
Community/Neighborhood Organizations	12	14	8	1	0	2

CHNA Participant Category	Level of Community Engagement					
	Informed - To provide the community with balanced & objective info to assist in understanding the problem, alternatives, opportunities and/or solutions	Consulted - To obtain community feedback on analysis, alternatives and/or solutions	Involved - To work directly with community throughout the process to ensure their concerns and aspirations are consistently understood and considered	Collaborated - To partner with the community in each aspect of the decision including the development of alternatives & identification of the preferred solution	Delegated - To place the decision- making in the hands of the community	Community Driven/Led - To support the actions of community initiated, driven and/or led processes
Consumer/Public Advocacy Organizations	6	6	5	2	1	1
Other	10	12	6	3	1	1

Appendix E. CHNA External Participants and the Recommended CHNA Practices They Engaged in

CHNA Participant Category	Recommended Practices							
	Identify & Engage Stakeholders	Define the community to be assessed	Collect and analyze the data	Select priority community health issues	Document and communicate results	Plan Implementation Strategies	Implement Improvement Plans	Evaluate Progress
Other Hospitals	16	16	16	16	15	13	11	6
Local Health Department	17	14	15	15	13	12	12	11
Local Health Improvement Coalition	14	9	7	13	9	10	8	8
Maryland Department of Health	2	0	3	0	0	1	0	1
Other State Agencies	2	1	3	1	1	1	2	2
Local Govt. Organizations	7	5	1	8	1	2	3	4
Faith-Based Organizations	8	6	2	11	2	7	3	2
School - K-12	9	7	4	8	2	2	4	3
School - Colleges, Universities, Professional Schools	7	5	4	6	1	0	3	1
Behavioral Health Organizations	13	8	5	13	6	8	8	6
Social Service Organizations	10	6	3	9	5	4	4	3
Post-Acute Care Facilities	3	3	1	3	0	1	2	1
Community/Neighborhood Organizations	9	8	2	10	4	5	4	4
Consumer/Public Advocacy Organizations	4	3	2	2	3	2	0	2
Other	5	6	2	8	3	2	2	1

Appendix F. Community Benefit Internal Participants and Their Roles

Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Selecting Health Needs That Will Be Targeted	Selecting the Initiatives That Will Be Supported	Determining How to Evaluate the Impact of Initiatives	Providing Funding for CB Activities	Allocating Budgets for Individual Initiatives	Delivering CB Initiatives	Evaluating the Outcome of CB Initiatives	Other
CB/ Community Health/Population Health Director (facility level)	3	12	31	33	33	19	29	30	30	2
CB/ Community Health/ Population Health Director (system level)	8	9	30	29	31	16	20	19	29	3
Senior Executives (CEO, CFO, VP, etc.) (facility level)	4	0	40	40	25	39	35	8	21	0
Senior Executives (CEO, CFO, VP, etc.) (system level)	11	8	20	21	19	20	21	10	18	4
Board of Directors or Board Committee (facility level)	10	2	15	20	6	7	9	2	12	4
Board of Directors or Board Committee (system level)	15	8	12	11	1	3	1	0	4	2
Clinical Leadership (facility level)	4	0	38	28	25	8	9	22	24	1
Clinical Leadership (system level)	13	8	22	21	11	5	7	3	11	0
Population Health Staff (facility level)	3	10	25	24	32	11	12	31	32	0
Population Health Staff (system level)	18	8	18	17	17	7	10	18	20	0
Community Benefit staff (facility level)	4	13	22	23	25	9	13	27	29	1
Community Benefit staff (system level)	8	13	15	15	25	2	3	14	23	4
Physician(s)	11	0	25	23	15	3	3	24	18	5
Nurse(s)	10	0	23	22	19	6	6	28	22	1
Social Workers	17	0	18	17	13	4	4	24	17	2
Hospital Advisory Board	14	17	15	7	5	2	3	3	10	2
Other (specify)	11	0	7	7	9	4	4	8	8	1

Appendix G. FY 2021 CHNA-Identified Community Health Needs and Initiatives to Address

CHNA-Identified Community Health Need	Number of Hospitals Identifying Need	Number of Hospitals Addressing Need
Health Conditions - Mental Health and Mental Disorders	46	25
Health Conditions - Diabetes	39	21
Social Determinants of Health - Health Care Access and Quality	35	23
Health Conditions - Heart Disease and Stroke	35	19
Health Conditions - Cancer	33	16
Health Behaviors - Nutrition and Healthy Eating	31	12
Health Conditions - Overweight and Obesity	31	9
Health Behaviors - Physical Activity	28	6
Health Behaviors - Drug and Alcohol Use	27	6
Health Conditions - Addiction	26	19
Health Behaviors - Preventive Care	26	14
Populations - Older Adults	26	5
Settings and Systems - Health Insurance	25	6
Settings and Systems - Transportation	24	14
Health Behaviors - Tobacco Use	23	3
Health Behaviors - Health Communication	21	6
Settings and Systems - Health Care	21	6
Social Determinants of Health - Social and Community Context	20	5
Settings and Systems - Community	20	0
Social Determinants of Health - Economic Stability	19	12
Health Behaviors - Vaccination	18	11
Settings and Systems - Housing and Homes	18	10
Other	18	9
Populations - Women	18	5
Health Behaviors - Violence Prevention	17	8
Populations - Children	17	3
Populations - Adolescents	16	2
Populations - Infants	16	2
Settings and Systems - Hospital and Emergency Services	15	5
Health Conditions - Pregnancy and Childbirth	14	5
Populations - Men	12	7
Populations - Workforce	12	6

CHNA-Identified Community Health Need	Number of Hospitals Identifying Need	Number of Hospitals Addressing Need
Social Determinants of Health - Neighborhood and Built Environment	12	6
Settings and Systems - Schools	12	3
Health Conditions - Infectious Disease	11	5
Populations - Parents or Caregivers	11	2
Social Determinants of Health - Education Access and Quality	11	2
Health Conditions - Respiratory Disease	11	1
Health Conditions - Sexually Transmitted Infections	10	3
Health Conditions - Oral Conditions	10	1
Health Conditions - Chronic Pain	8	2
Health Behaviors - Child and Adolescent Development	8	2
Populations - People with Disabilities	8	2
Health Behaviors - Injury Prevention	7	2
Populations - LGBT	6	4
Health Conditions - Dementias	5	0
Health Conditions - Osteoporosis	5	0
Settings and Systems - Workplace	5	0
Health Conditions - Arthritis	4	0
Health Conditions - Chronic Kidney Disease	4	0
Health Behaviors - Family Planning	4	0
Settings and Systems - Environmental Health	4	0
Settings and Systems - Public Health Infrastructure	4	0
Health Conditions - Blood Disorders	3	0
Settings and Systems - Health IT	3	0
Health Conditions - Health Care-Associated Infections	2	0
Health Behaviors - Emergency Preparedness	2	0
Settings and Systems - Health Policy	2	0
Health Conditions - Sensory or Communication Disorders	1	0
Health Behaviors - Sleep	1	0
Health Conditions - Foodborne Illness	0	0
Health Behaviors - Safe Food Handling	0	0
Settings and Systems - Global Health	0	0

*Data Source: As reported by hospitals on their FY 2021 CBRs.

Appendix H. Charity Care Methodology

The purpose of this appendix is to explain why the charity care amounts reported by hospitals in their community benefit reports may not match the charity care amounts applied in their global budgets for the same year. The charity care amounts in rates are part of the HSCRC's uncompensated care (UCC) policy, which is a prospective policy applied at the beginning of the rate year. In contrast, the amounts reported by hospitals in their community benefit report retrospective.

The HSCRC applies the following procedures to calculate the charity care dollar amount to subtract from total dollars provided by hospitals in the statewide Community Benefit Report.

Step 1

Determine the amount of uncompensated care that was projected for each hospital for the fiscal year being reported (in this case, the FY 2021 Community Benefit Report) based on the policy approved by the Commission for the beginning of the rate year (also FY 2021).

- The HSCRC uses a logistic regression to predict actual hospital uncompensated care costs in a given year (FY 2021).
- The uncompensated care logistic regression model predicts a patient's likelihood of having UCC based on payer type, the location of service (i.e., inpatient, ED, and other outpatient), and the Area Deprivation Index.³⁶
 - An expected UCC dollar amount is calculated for every patient encounter.
 - These UCC dollars are then summarized at the hospital level.
 - These summarized UCC dollars are then divided by the hospital's total charges to estimate the hospital's UCC level.
- The hospital's most current fiscal year financially audited UCC levels (FY 2021) are averaged with the hospital's estimated UCC levels from the prior FY (FY 2020) to determine hospital-specific adjustments. These are predicted amounts provided to hospitals to fund the next year's UCC.

Step 2

Retrospectively, determine the actual ratio of charity care to total UCC from the hospital's audited financial statements to determine the rate of charity expense to apply to the predicted UCC amount from the rate year 2021 policy. The resulting charity care amount is the estimated amount provided in rates that will be subtracted from the hospital's community benefit.

Example Johns Hopkins Hospital:

³⁶ The Area Deprivation Index represents a geographic area-based measure of the socioeconomic deprivation experienced by a neighborhood.

Predicted Value from FY 2016 Estimated UCC Levels 3.60%

FY 2017 Audited Financial UCC Level 2.25%

Predicted 50/50 Average 3.02%

Split between Bad Debt and Charity Care Amounts – FY 2017 Audited Financials

Regulated Gross Patient Revenue	Regulated Total UCC	Regulated Bad Debt	Regulated Charity	Bad Debt	Charity Chare
\$2,352,718,900	\$61,819,012	\$40,121,239	\$21,697,773	64.90%	35.10%

Estimate amount of UCC \$ provided in rates at the beginning of FY 2017:

FY17 Regulated Gross Patient Revenue (\$2,352,718,900) * 3.02% (3.02192482223646%) = \$
71,097,396

Estimate of Charity \$ provided in rates at the beginning of FY 2017:

35.10% (35.0988673193289%) * \$71,097,396 = \$24,954,381.

Appendix I. FY 2021 Funding for Nurse Support Program I, Nurse Support Program II, Direct Medical Education, Regional Partnership Catalyst Grant Awards, and Charity Care

Hospital Number	Hospital Name	DME	NSP I	NSP II	Regional Partnership Catalyst Grant Program	Charity Care	Total Rate Support
210001	Meritus Medical Center	\$3,502,400	\$369,067	\$369,067	\$579,420	\$5,964,504	\$10,784,458
210002 & 218992	Univ. of Maryland Medical Center	\$128,109,107	\$1,557,658	\$1,557,658	\$731,787	\$20,877,000	\$152,833,210
210003 & 210055	UM Capital Region	\$5,333,622	\$398,235	\$398,235	\$1,062,088	\$10,022,746	\$17,214,927
210004	Holy Cross	\$2,432,375	\$518,074	\$518,074	\$368,247	\$24,306,972	\$28,143,743
210005	Frederick Memorial Hospital	\$0	\$354,398	\$354,398	\$431,550	\$4,832,900	\$5,973,245
210006	Univ. of Maryland Harford Memorial Hospital	\$0	\$108,110	\$108,110	\$0	\$1,430,000	\$1,646,220
210008	Mercy Medical Center, Inc.	\$4,893,836	\$553,680	\$553,680	\$76,574	\$22,257,214	\$28,334,983
210009	Johns Hopkins	\$125,062,232	\$2,474,648	\$2,474,648	\$1,679,877	\$37,793,300	\$169,484,705
210010	Univ. of Maryland Shore Medical Center at Dorchester	\$0	\$45,197	\$45,197	\$0	\$682,626	\$773,019
210011	St. Agnes Hospital	\$7,239,785	\$430,111	\$430,111	\$247,549	\$15,371,696	\$23,719,252
210012	Sinai Hospital	\$19,450,628	\$790,819	\$790,819	\$415,927	\$3,243,100	\$24,691,293
210013	Bon Secours Hospital	\$0	\$111,845	\$111,845	\$0	\$545,410	\$769,100
210015	MedStar Franklin Square Hospital	\$10,768,726	\$554,969	\$554,969	\$78,112	\$9,875,732	\$21,832,507
210016	Washington Adventist Hospital	\$0	\$302,988	\$302,988	\$216,030	\$11,912,201	\$12,734,208
210017	Garrett County Memorial Hospital	\$0	\$63,470	\$63,470	\$0	\$2,866,760	\$2,993,700
210018	MedStar Montgomery General Hospital	\$0	\$180,055	\$180,055	\$0	\$3,346,776	\$3,706,887
210019	Peninsula Regional Medical Center	\$0	\$455,208	\$455,208	\$888,956	\$12,739,921	\$14,539,293
210022	Suburban Hospital Association, Inc.	\$531,821	\$336,635	\$336,635	\$338,404	\$5,868,370	\$7,411,866

Hospital Number	Hospital Name	DME	NSP I	NSP II	Regional Partnership Catalyst Grant Program	Charity Care	Total Rate Support
210023	Anne Arundel General Hospital	\$4,368,064	\$639,657	\$639,657	\$0	\$3,806,489	\$9,453,866
210024	MedStar Union Memorial Hospital	\$11,605,786	\$420,493	\$420,493	\$58,690	\$7,263,945	\$19,769,407
210027	Western Maryland Hospital	\$0	\$336,124	\$336,124	\$568,667	\$12,026,960	\$13,267,874
210028	MedStar St. Marys Hospital	\$0	\$190,672	\$190,672	\$82,926	\$3,483,120	\$3,947,390
210029	Johns Hopkins Bayview Med. Center	\$26,222,961	\$691,568	\$691,568	\$486,571	\$22,241,000	\$50,333,668
210030	Univ. of Maryland Shore Medical Center at Chestertown	\$0	\$50,208	\$50,208	\$0	\$619,436	\$719,852
210032	Union Hospital of Cecil County	\$0	\$164,258	\$164,258	\$0	\$1,763,814	\$2,092,330
210033	Carroll County General Hospital	\$0	\$233,904	\$233,904	\$32,599	\$857,000	\$1,357,407
210034	MedStar Harbor Hospital Center	\$2,256,718	\$187,756	\$187,756	\$25,817	\$3,598,223	\$6,256,270
210035	Univ. of Maryland Charles Regional Medical Center	\$0	\$155,775	\$155,775	\$210,154	\$1,355,000	\$1,876,704
210037	Univ. of Maryland Shore Medical Center at Easton	\$0	\$231,728	\$231,728	\$0	\$3,056,991	\$3,520,447
210038	Univ. of Maryland Medical Center Midtown Campus	\$3,690,816	\$230,208	\$230,208	\$540,816	\$3,929,000	\$8,621,047
210039	Calvert Memorial Hospital	\$0	\$153,315	\$153,315	\$0	\$3,510,406	\$3,817,036
210040	Northwest Hospital Center, Inc.	\$0	\$271,509	\$271,509	\$37,508	\$1,379,379	\$1,959,904
210043	Univ. of Maryland Baltimore Washington Medical Center	\$730,773	\$448,593	\$448,593	\$0	\$6,901,000	\$8,528,959
210044	Greater Baltimore Medical Center	\$8,130,176	\$477,484	\$477,484	\$66,712	\$4,545,000	\$13,696,854
210045	McCready Foundation, Inc.	\$0	\$16,060	\$16,060	\$0	\$166,400	\$198,520
210048	Howard County General Hospital	\$0	\$307,992	\$307,992	\$323,489	\$5,129,000	\$6,068,472
210049	Univ. of Maryland Upper Chesapeake Medical Center	\$0	\$323,917	\$323,917	\$0	\$3,671,000	\$4,318,833
210051	Doctors Community Hospital	\$0	\$256,445	\$256,445	\$113,852	\$6,776,100	\$7,402,843
210056	MedStar Good Samaritan Hospital	\$2,953,444	\$256,874	\$256,874	\$37,256	\$5,827,941	\$9,332,391
210057	Shady Grove Adventist Hospital	\$20,870	\$470,397	\$470,397	\$333,748	\$7,659,261	\$8,954,673
210058	UMROI	\$4,095,451	\$124,573	\$124,573	\$0	\$1,884,000	\$6,228,596
210060	Fort Washington Medical Center	\$0	\$53,091	\$53,091	\$149,560	\$613,543	\$869,284
210061	Atlantic General Hospital	\$0	\$110,793	\$110,793	\$296,319	\$1,099,600	\$1,617,505
210062	MedStar Southern Maryland Hospital	\$0	\$273,965	\$273,965	\$794,940	\$5,579,397	\$6,922,268

Hospital Number	Hospital Name	DME	NSP I	NSP II	Regional Partnership Catalyst Grant Program	Charity Care	Total Rate Support
210063	Univ. of Maryland St. Josephs Medical Center	\$0	\$389,174	\$389,174	\$54,168	\$6,367,649	\$7,200,164
210064	Levindale	\$0	\$60,471	\$60,471	\$0	\$918,967	\$1,039,910
210065	Holy Cross German Town	\$0	\$111,194	\$111,194	\$82,403	\$4,743,425	\$5,048,216
213300	Mt. Washington Peds	\$0	\$66,002	\$0	\$0	\$33,673	\$99,674
214000	Sheppard Pratt	\$2,499,790	\$159,883	\$0	\$0	\$4,629,793	\$7,289,465
214020	J Kent McNew Family Medical Center	\$0	\$0	\$0	\$0	\$37,632	\$37,632
213029	Adventist Rehabilitation	\$0	\$63,255	\$0	\$0	\$0	\$63,255
	Total	\$747,798,761	\$17,532,501	\$17,243,362	\$11,410,716	\$329,411,371	\$1,123,396,711

Appendix J. FY 2021 Community Benefit Analysis

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense Less Hospital-reported Rate Support	Total CB as % of Total Operating Expense	FY 2021 Amount in Rates for Charity Care, DME, NSPI, NSPII, & Regional Partnership Catalyst Grant*	Total Net CB minus Charity Care, DME, NSPI, NSPII, Catalyst Grant in Rates	Total Net CB (minus Charity Care, DME, NSPI, NSPII, Catalyst Grants in Rates) as % of Operating Expense	CB Reported Charity Care
Univ. of Maryland Medical Center	\$1,867,360,000	\$249,725,986	13.37%	\$152,833,210	\$96,892,776	5.19%	\$20,877,000
The Johns Hopkins Hospital	\$2,809,105,000	\$309,985,196	11.04%	\$169,484,705	\$140,500,491	5.00%	\$37,794,000
Atlantic General Hospital	\$146,641,248	\$2,491,086	1.70%	\$1,617,505	\$873,581	0.60%	\$1,217,677
MedStar Union Memorial Hospital	\$469,421,642	\$38,444,531	8.19%	\$19,769,407	\$18,675,125	3.98%	\$7,263,945
Univ. of Maryland Rehabilitation & Orthopaedic Institute	\$111,255,000	\$12,054,029	10.83%	\$6,228,596	\$5,825,434	5.24%	\$1,884,000
Levindale Hebrew Geriatric Center & Hospital	\$83,280,000	\$2,672,482	3.21%	\$1,039,910	\$1,632,572	1.96%	\$1,768,778
Adventist Fort Washington Medical Center	\$51,160,794	\$1,941,540	3.79%	\$869,284	\$1,072,256	2.10%	\$0
Johns Hopkins Bayview Med. Center	\$714,247,000	\$94,748,769	13.27%	\$50,333,668	\$44,415,100	6.22%	\$22,241,000

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense Less Hospital-reported Rate Support	Total CB as % of Total Operating Expense	FY 2021 Amount in Rates for Charity Care, DME, NSPI, NSPII, & Regional Partnership Catalyst Grant*	Total Net CB minus Charity Care, DME, NSPI, NSPII, Catalyst Grant in Rates	Total Net CB (minus Charity Care, DME, NSPI, NSPII, Catalyst Grants in Rates) as % of Operating Expense	CB Reported Charity Care
MedStar Montgomery General Hospital	\$184,307,676	\$8,482,621	4.60%	\$3,706,887	\$4,775,734	2.59%	\$3,346,776
Holy Cross Germantown Hospital	\$123,537,343	\$8,421,562	6.82%	\$5,048,216	\$3,373,346	2.73%	\$4,751,018
Univ. of Maryland Baltimore Washington Medical Center	\$434,108,000	\$21,922,297	5.05%	\$8,528,959	\$13,393,339	3.09%	\$6,901,000
MedStar Franklin Square Hospital	\$613,396,845	\$51,424,263	8.38%	\$21,832,507	\$29,591,756	4.82%	\$9,875,732
Mt. Washington Peds	\$62,131,847	\$2,128,315	3.43%	\$99,674	\$2,028,641	3.27%	\$33,673
MedStar Southern Maryland Hospital	\$266,837,862	\$16,199,890	6.07%	\$6,922,268	\$9,277,622	3.48%	\$5,579,397
Univ. of Maryland Upper Chesapeake Medical Center	\$294,765,774	\$14,840,151	5.03%	\$4,318,833	\$10,521,318	3.57%	\$3,671,000
Ascension Saint Agnes Hospital	\$462,155,000	\$48,049,941	10.40%	\$23,719,252	\$24,330,689	5.26%	\$17,929,501
Sinai Hospital of Baltimore	\$852,535,000	\$75,918,984	8.91%	\$24,691,293	\$51,227,690	6.01%	\$3,261,955
Holy Cross Hospital	\$482,480,260	\$48,828,937	10.12%	\$28,143,743	\$20,685,195	4.29%	\$28,661,872
TidalHealth McCreedy Pavilion	\$9,152,200	\$554,487	6.06%	\$198,520	\$355,967	3.89%	\$167,600

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense Less Hospital-reported Rate Support	Total CB as % of Total Operating Expense	FY 2021 Amount in Rates for Charity Care, DME, NSPI, NSPII, & Regional Partnership Catalyst Grant*	Total Net CB minus Charity Care, DME, NSPI, NSPII, Catalyst Grant in Rates	Total Net CB (minus Charity Care, DME, NSPI, NSPII, Catalyst Grants in Rates) as % of Operating Expense	CB Reported Charity Care
Adventist Rehabilitation	\$52,271,127	\$2,098,748	4.02%	\$63,255	\$2,035,494	3.89%	\$242,956
MedStar Good Samaritan Hospital	\$292,805,277	\$23,836,233	8.14%	\$9,332,391	\$14,503,842	4.95%	\$5,827,941
TidalHealth Peninsula Regional Medical Center	\$423,885,800	\$35,598,165	8.40%	\$14,539,293	\$21,058,872	4.97%	\$13,233,221
Univ. of Maryland Harford Memorial Hospital	\$98,857,946	\$6,391,324	6.47%	\$1,646,220	\$4,745,104	4.80%	\$1,430,047
Adventist White Oak Hospital	\$297,894,224	\$28,026,737	9.41%	\$12,734,208	\$15,292,529	5.13%	\$2,682,922
Northwest Hospital	\$276,365,800	\$16,410,328	5.94%	\$1,959,904	\$14,450,423	5.23%	\$1,379,300
Frederick Memorial Hospital	\$383,617,000	\$26,845,083	7.00%	\$5,973,245	\$20,871,837	5.44%	\$5,525,800
Adventist Shady Grove Medical Center	\$408,846,144	\$32,342,997	7.91%	\$8,954,673	\$23,388,324	5.72%	\$6,258,689
Doctors Community Hospital	\$240,162,000	\$21,356,973	8.89%	\$7,402,843	\$13,954,130	5.81%	\$6,776,100
ChristianaCare, Union Hospital	\$181,465,929	\$14,800,262	8.16%	\$2,092,330	\$12,707,932	7.00%	\$1,763,814
MedStar Harbor Hospital Center	\$207,141,258	\$23,082,210	11.14%	\$6,256,270	\$16,825,940	8.12%	\$3,598,223

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense Less Hospital-reported Rate Support	Total CB as % of Total Operating Expense	FY 2021 Amount in Rates for Charity Care, DME, NSPI, NSPII, & Regional Partnership Catalyst Grant*	Total Net CB minus Charity Care, DME, NSPI, NSPII, Catalyst Grant in Rates	Total Net CB (minus Charity Care, DME, NSPI, NSPII, Catalyst Grants in Rates) as % of Operating Expense	CB Reported Charity Care
MedStar St. Marys Hospital	\$176,289,631	\$16,652,258	9.45%	\$3,947,390	\$12,704,868	7.21%	\$3,589,292
Suburban Hospital	\$335,865,000	\$33,706,779	10.04%	\$7,411,866	\$26,294,914	7.83%	\$5,868,000
Greater Baltimore Medical Center	\$557,120,000	\$65,221,016	11.71%	\$13,696,854	\$51,524,162	9.25%	\$4,777,000
Univ. of Maryland Medical Center Midtown Campus	\$245,964,000	\$31,818,707	12.94%	\$8,621,047	\$23,197,660	9.43%	\$3,929,000
Sheppard & Enoch Pratt Hospital	\$210,491,083	\$26,809,550	12.74%	\$7,289,465	\$19,520,085	9.27%	\$4,629,793
Grace Medical Hospital	\$66,425,000	\$6,147,417	9.25%	\$769,100	\$5,378,317	8.10%	\$545,277
Carroll Hospital Center	\$219,612,494	\$19,301,414	8.79%	\$1,357,407	\$17,944,006	8.17%	\$856,982
Mercy Medical Center, Inc.	\$527,348,607	\$78,594,888	14.90%	\$28,334,983	\$50,259,905	9.53%	\$22,257,214
Howard County General Hospital	\$280,849,000	\$30,491,290	10.86%	\$6,068,472	\$24,422,818	8.70%	\$5,128,938
Anne Arundel General Hospital	\$600,619,000	\$67,118,054	11.17%	\$9,453,866	\$57,664,187	9.60%	\$3,806,489
Univ. of Maryland Charles Regional Medical Center	\$138,614,740	\$15,366,360	11.09%	\$1,876,704	\$13,489,656	9.73%	\$1,355,034

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense Less Hospital-reported Rate Support	Total CB as % of Total Operating Expense	FY 2021 Amount in Rates for Charity Care, DME, NSPI, NSPII, & Regional Partnership Catalyst Grant*	Total Net CB minus Charity Care, DME, NSPI, NSPII, Catalyst Grant in Rates	Total Net CB (minus Charity Care, DME, NSPI, NSPII, Catalyst Grants in Rates) as % of Operating Expense	CB Reported Charity Care
J. Kent McNew Family Medical Center	\$8,462,000	\$940,375	11.11%	\$37,632	\$902,743	10.67%	\$37,632
Meritus Medical Center	\$417,623,284	\$59,137,484	14.16%	\$10,784,458	\$48,353,027	11.58%	\$6,062,105
Univ. of Maryland Capital Region Medical Center	\$348,047,000	\$60,253,322	17.31%	\$17,214,927	\$43,038,395	12.37%	\$9,544,000
Univ. of Maryland Shore Medical Center at Easton	\$219,817,000	\$29,468,359	13.41%	\$3,520,447	\$25,947,911	11.80%	\$3,380,000
Univ. of Maryland St. Josephs Medical Center	\$353,751,000	\$51,032,616	14.43%	\$7,200,164	\$43,832,453	12.39%	\$6,890,000
CalvertHealth Medical Center	\$143,031,020	\$21,626,250	15.12%	\$3,817,036	\$17,809,213	12.45%	\$3,510,458
Garrett Regional Hospital	\$61,545,442	\$11,025,424	17.91%	\$2,993,700	\$8,031,724	13.05%	\$2,721,400
UPMC Western Maryland Hospital	\$331,929,405	\$69,562,821	20.96%	\$13,267,874	\$56,294,947	16.96%	\$14,029,126
Univ. of Maryland Shore Medical Center at Chestertown	\$46,947,000	\$10,508,243	22.38%	\$719,852	\$9,788,391	20.85%	\$629,000
Univ. of Maryland Shore Medical Center at Dorchester	\$34,558,000	\$8,169,284	23.64%	\$773,019	\$7,396,265	21.40%	\$501,000

Hospital Name	Total Hospital Operating Expense	Total Community Benefit Expense Less Hospital-reported Rate Support	Total CB as % of Total Operating Expense	FY 2021 Amount in Rates for Charity Care, DME, NSPI, NSPII, & Regional Partnership Catalyst Grant*	Total Net CB minus Charity Care, DME, NSPI, NSPII, Catalyst Grant in Rates	Total Net CB (minus Charity Care, DME, NSPI, NSPII, Catalyst Grants in Rates) as % of Operating Expense	CB Reported Charity Care
All Hospitals	\$18,226,100,702	\$1,952,576,037	10.71%	\$749,497,330	\$1,203,078,707	6.60%	\$329,992,676

Appendix K. FY 2021 Hospital Community Benefit Aggregate Data

	Type of Activity	Direct Cost	Indirect Cost	HSCRC Grant/Rate Support	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
Unreimbursed Medicaid Costs							
T99	Medicaid Assessments	\$324,933,118			\$269,294,870	\$55,638,248	\$55,638,248
Community Health Services							
A10	Community Health Education	\$18,141,133	\$9,100,381	\$136,262	\$1,271,590	\$25,833,662	\$16,733,281
A11	Support Groups	\$2,935,572	\$2,138,791	\$471,112	\$1,730	\$4,601,521	\$2,462,730
A12	Self-Help	\$651,372	\$352,541		\$72,261	\$931,651	\$579,111
A20	Community-Based Clinical Services	\$14,211,423	\$5,968,771	\$579,280	\$4,007,247	\$15,593,667	\$9,624,896
A21	Screenings	\$2,575,696	\$1,650,733		\$951,047	\$3,275,382	\$1,624,649
A22	One-Time/Occasionally Held Clinics	\$808,369	\$136,706		\$252,992	\$692,083	\$555,377
A23	Free Clinics	\$10,966,734	\$2,627,221		\$494	\$13,593,461	\$10,966,240
A24	Mobile Units	\$1,186,718	\$453,864		\$1,315,513	\$325,069	(\$128,795)
A30	Health Care Support Services	\$47,619,715	\$19,972,607	\$1,568,178	\$3,317,592	\$62,706,553	\$42,733,946
A40	Other	\$11,329,168	\$6,121,751	\$2,967,046	\$198,283	\$14,285,590	\$8,163,839
A99	Total	\$110,425,900	\$48,523,365	\$5,721,878	\$11,388,748	\$141,838,639	\$93,315,274
Health Professions Education							
B1	Physicians/Medical Students	\$375,662,840	\$197,265,566	\$553,680	\$2,767,624	\$569,607,102	\$372,341,536
B2	Nurses/Nursing Students	\$25,667,173	\$15,106,675		\$202,182	\$40,571,665	\$25,464,990
B3	Other Health Professionals	\$16,655,503	\$9,209,002		\$120,363	\$25,744,142	\$16,535,140
B4	Scholarships/Funding for Professional Education	\$3,143,919	\$1,616,683			\$4,760,602	\$3,143,919
B50	Other	\$2,304,870	\$1,519,725		\$685,296	\$3,139,298	\$1,619,573

	Type of Activity	Direct Cost	Indirect Cost	HSCRC Grant/Rate Support	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
B99	Total	\$423,434,304	\$224,717,651	\$553,680	\$3,775,466	\$643,822,809	\$419,105,158
Mission-Driven Health Services							
	Mission-Driven Health Services Total	\$917,250,601	\$141,011,014	\$338,049	\$355,159,307	\$702,764,259	\$561,753,245
Research							
D1	Clinical Research	\$9,133,413	\$4,008,918		\$3,085,010	\$10,057,321	\$6,048,403
D2	Community Health Research	\$2,896,439	\$857,758		\$312,658	\$3,441,538	\$2,583,781
D3	Other	\$190,681	\$145,108			\$335,789	\$190,681
D99	Total	\$12,220,533	\$5,011,783		\$3,397,668	\$13,834,648	\$8,822,865
Financial Contributions							
E1	Cash Donations	\$7,691,208	\$1,860		\$200	\$7,691,008	\$7,689,148
E2	Grants	\$3,607,150	\$5,374	\$242,596	\$1,438,597	\$1,925,958	\$1,920,584
E3	In-Kind Donations	\$3,170,720	\$28,858		\$32,932	\$3,137,788	\$3,108,930
E4	Cost of Fund Raising for Community Programs	\$3,299,148				\$3,299,148	\$3,299,148
E99	Total	\$17,768,226	\$36,092	\$242,596	\$1,471,729	\$16,053,901	\$16,017,809
Community-Building Activities							
F1	Physical Improvements/Housing	\$1,137,733	\$143,396		\$82,281	\$1,198,849	\$1,055,452
F2	Economic Development	\$623,850	\$20,707			\$644,557	\$623,850
F3	Support System Enhancements	\$7,765,875	\$4,452,619		\$1,360,007	\$10,858,487	\$6,405,868
F4	Environmental Improvements	\$767,634	\$416,261		\$1,560	\$1,182,335	\$766,074
F5	Leadership Development/Training for Community Members	\$131,331	\$90,331			\$221,662	\$131,331
F6	Coalition Building	\$3,302,944	\$1,858,806		\$1,321,107	\$3,840,643	\$1,981,837
F7	Community Health Improvement Advocacy	\$1,258,485	\$271,860		\$2,436	\$1,527,909	\$1,256,049

	Type of Activity	Direct Cost	Indirect Cost	HSCRC Grant/Rate Support	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
F8	Workforce Enhancement	\$3,308,479	\$1,662,358		\$566,935	\$4,403,902	\$2,741,544
F9	Other	\$1,354,739	\$712,648			\$2,067,387	\$1,354,739
	Total	\$19,651,069	\$9,628,986		\$3,334,326	\$25,945,729	\$16,316,743
Community Benefit Operations							
G1	Dedicated Staff	\$6,037,915	\$3,308,983	\$179,230	\$40,258	\$9,127,410	\$5,818,427
G2	Community health/health assets assessments	\$1,709,394	\$1,201,367		\$17,016	\$2,893,746	\$1,692,378
G3	Other Resources	\$1,757,046	\$537,302			\$2,294,348	\$1,757,046
G99	Total	\$9,504,355	\$5,047,652	\$179,230	\$57,274	\$14,315,503	\$9,267,851
Charity Care							
	Total Charity Care						\$329,992,676
Foundation-Funded Community Benefits							
J1	Community Services	\$740,578	\$6,695		\$47,077	\$700,196	\$693,501
J2	Community Building	\$808,997			\$175,000	\$633,997	\$633,997
J3	Other	\$0			\$0	\$0	\$0
J99	Total	\$1,549,574	\$6,695		\$222,077	\$1,334,192	\$1,327,497
Total Hospital Community Benefits							
A	Community Health Services	\$110,425,900	\$48,523,365	\$5,721,878	\$11,388,748	\$141,838,639	\$93,315,274
B	Health Professions Education	\$423,434,304	\$224,717,651	\$553,680	\$3,775,466	\$643,822,809	\$419,105,158
C	Mission Driven Health Care Services	\$917,250,601	\$141,011,014	\$338,049	\$355,159,307	\$702,764,259	\$561,753,245
D	Research	\$12,220,533	\$5,011,783		\$3,397,668	\$13,834,648	\$8,822,865
E	Financial Contributions	\$17,768,226	\$36,092	\$242,596	\$1,471,729	\$16,053,901	\$16,053,901
F	Community Building Activities	\$19,651,069	\$9,628,986		\$3,334,326	\$25,945,729	\$16,316,743
G	Community Benefit Operations	\$9,504,355	\$5,047,652	\$179,230	\$57,274	\$14,315,503	\$9,267,851
H	Charity Care	\$329,992,676				\$329,992,676	\$329,992,676

	Type of Activity	Direct Cost	Indirect Cost	HSCRC Grant/Rate Support	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
J	Foundation Funded Community Benefit	\$1,549,574	\$6,695		\$222,077	\$1,334,192	\$1,327,497
T99	Medicaid Assessments	\$324,933,118			\$269,294,870	\$55,638,248	\$55,638,248
K99	Total Hospital Community Benefit	\$2,166,730,356	\$433,983,239	\$7,035,433	\$648,101,465	\$1,945,540,605	\$1,511,593,458
	Total Operating Expenses	\$18,226,100,702					
	% Operating Expenses w/ Indirect Costs	10.67%					
	% Operating Expenses w/ o Indirect Costs	8.29%					



**Maternal and Child Health Population Health
Improvement Fund**

Program Year One – FY 2022

Annual Report

December 2022

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Background

In 2019, the State of Maryland collaborated with the Center for Medicare and Medicaid Innovation (CMMI) to establish the domains of healthcare quality and delivery that the State could impact under the Total Cost of Care (TCOC) Model. The collaboration also included an agreed upon process and timeline by which the State would submit proposed goals, measures, milestones, and targets to CMMI. In December 2020, the State submitted its proposal for a Statewide Integrated Health Improvement Strategy (SIHIS), which aligns statewide efforts across three domains: hospital quality, care transformation across the system, and total population health. Under the third domain, total population health, the State identified three key health priority areas for improvement: diabetes, opioid use, and maternal and child health. CMMI approved the State's proposal on March 17, 2021.

While the State identified diabetes and opioid use as key population health priority areas in the first year of the TCOC Model, the third priority area was not selected until later in 2020. In fall of 2020, the State formally selected maternal and child health (MCH) as the third population health priority under SIHIS. Consistent with the State's guiding principle to select goals, measures, and targets that are all-payer in nature, maternal and child health was deliberately considered as a priority area even though it is not Medicare focused. The selection of maternal and child health as a priority area reflects its importance in the State and acknowledges both the longstanding history of disparities, as well as the large potential for improvement.

The U.S. faces higher maternal and infant mortality rates compared to other industrialized countries, with large racial/ethnic disparities for each outcome; Maryland's maternal mortality rate from 2013 to 2017 (24.8 maternal deaths per 100,000 live births) ranks 22nd among states, with the rate for African Americans almost four times that of Whites (44.7 maternal deaths vs. 11.3 per 100,000 live births).

In addition, pediatric asthma contributes to increased healthcare utilization and spending, missed school days, and sub-optimal overall health and well-being in Maryland children. Pediatric asthma also has a significant impact on parental productivity. In Maryland, approximately 9.7 percent of children have asthma.

As part of the SIHIS proposal, the State identified two areas to improve maternal and child health:

- Severe maternal morbidity rate in overall reduction and stratified goals by race and ethnicity, and
- Asthma-related emergency department (ED) visit rates for ages 2-17 in overall reduction and stratified goals by race and ethnicity

Table 1. SMM Rates per 10,000 delivery hospitalizations, disaggregated by race and ethnicity

Population	Baseline (2018)	2023	2026	Absolute change	Relative Percentage Change
Total	242.5	219.3	197.1	45.4	19%
White NH	183.6	169.8	156.1	27.5	15%
Black NH	328.5	295.7	262.8	65.7	20%
Asian NH	241.9	217.7	193.5	48.4	20%
Hispanic	236.9	213.2	189.5	47.4	20%
Other	227.3	204.6	181.8	45.5	20%

Table 2. Childhood Asthma-ED Visit Rates per 1,000, disaggregated by race and ethnicity

Population	Baseline (2018)	2023	2026	Absolute change	Relative Percentage Change
Total	9.2	7.2	5.3	3.9	42%
White	4.1	3.5	3.0	1.1	26%
Black	19.1	14.36	9.6	9.6	50%
Asian	2.7	2.6	2.5	0.2	9%
Hispanic	5.4	4.7	4.0	1.4	25%
Other	10.6	7.30	5.5	5.1	48%

In 2021, the Health Services Cost Review Commission (HSCRC) approved cumulative funding of \$40 million across four years (FY 2022 – FY 2025) to support MCH investments led by Medicaid and the Prevention and Public Health Administration (PHPA) under the Maryland Department of Health (MDH or the Department), in conjunction with the Medicaid HealthChoice Managed Care Organizations (MCOs). This funding will scale existing statewide evidence-based programs and promising practices and support the expansion of new services for mothers and children. Additionally, using the funding in this manner also creates an opportunity for the State to receive federal match funding to nearly double the investment.

Funds are added to hospital annual rates as temporary adjustments through a uniform, broad-based assessment. Hospitals transfer funds to the Maternal and Child Health (MCH) Population Health Improvement Fund (or “Fund”). The MCH Population Health Improvement Fund, created through the 2021 Budget Reconciliation and Financing Act (BRFA), will receive funding from hospital rates to invest in maternal and child health initiatives, as approved by Commissioners. The Fund sunsets in 2025.

The MCH Population Health Improvement Fund committed \$8 million in annual funding from fiscal year (FY) 2022 through FY 2025 to support Medicaid initiatives to address severe maternal morbidity, in alignment with the inclusion of MCH as a population health priority area under SIHIS. These monies are eligible for federal matching dollars, bringing the combined total to \$16 million annually. An additional \$2 million in annual funding is directed to PHPA to support childhood asthma initiatives and additional interventions to address severe maternal morbidity.

Funding supports the following MCH initiatives within Maryland Medicaid:

- Home Visiting Services pilot expansion;
- Reimbursement for doula services;
- CenteringPregnancy, a clinic-based group prenatal care model;
- HealthySteps, a clinic-based intensive prenatal and postpartum case management framework; and
- Maternal Opioid Misuse (MOM) model expansion/intensive case management for high-risk pregnancies.

Funding to PHPA supports the expansion and/or implementation of mutually reinforcing programs:

- Medicaid's asthma home visiting program
- Community-based asthma home visiting initiatives (all-payer)
- Community-based home-visiting services and CenteringPregnancy implementation (all-payer)

The Memorandum of Agreement (MOA) between the HSCRC and MDH that governs the MCH Population Health Improvement Fund requires MDH to submit an annual report that will outline progress toward the Fund's goals.

This document serves as the annual report for the first year of funding and details the implementation process for the five Medicaid programs and the initiatives under Public Health Services. This first report contains mostly implementation measures; outcome measures will be incorporated into future reports as data become available. The report culminates with a report on FY 2022 expenditures and spending plans for upcoming years.

Medicaid Programs

Program Implementation

The Department created a monthly office hours meeting dedicated to the five MCH initiatives described below. These calls provided opportunities for MCOs to ask questions and for Medicaid to provide any programmatic updates. In addition, the Department created an MCH-specific email address to facilitate communications with external stakeholders.

Home Visiting Services Expansion

Program Overview

In 2017, the Department established a Medicaid Home Visiting Services (HVS) Pilot under the authority of the §1115 HealthChoice demonstration to test a service expansion initiative in Maryland aimed to improve both maternal and childhood health. This pilot included reimbursement for two evidence-based home visiting models, Healthy Families America (HFA) and Nurse Family Partnership (NFP). Both models employ specific developmental and health screenings, and have an established track record of improving the health and well-being of both the birthing parent and the child. Sites requesting coverage for this service must maintain certification of accreditation or fidelity by the national HFA or NFP organization.

On an individual level, Medicaid participants must meet the following eligibility criteria to receive HVS: receive services through a HealthChoice MCO or be enrolled in Fee-For-Service (FFS) Medicaid; and be pregnant, or infant must be younger than 90 days old at the time of enrollment and comply with requirements from the HFA and NFP programs. Harford County and Garrett County participated in the original demonstration; the MCH Population Health Improvement Fund allowed for statewide expansion of the benefit.

Implementation Update

With the approval of the Fund in May 2021, the Department dedicated FY 2022 to building the infrastructure to transition the pilot program into a full Medicaid benefit.

The Department established a new provider type, Home Visiting Services (HVS), within the electronic Provider Revalidation and Enrollment Portal (ePREP) for this new service. These providers are instructed to use 99600 as a billing code for all home visits. To accompany the billing code, the Department recommends use of the diagnosis code, Z34.902 for home visits prior to delivery and Z76.23 for any home visit that occurs after delivery. All qualifying home visits will be reimbursed at a fee-for-service rate of \$188 per home visit.

Effective January 13, 2022, Maryland promulgated regulations that provided coverage for both models as a new statewide benefit for Medicaid beneficiaries. Additionally, the Department submitted, and CMS approved, a State Plan Amendment (SPA) covering home visiting under the innovative preventative service authority.

To enroll as a Medicaid provider, eligible home visiting programs must acquire a Type 2 Organizational NPI number under the taxonomy of a “Health Educator.” Once accomplished, each site is eligible to apply for enrollment as a Medicaid HVS provider and subsequently to contract with the appropriate MCOs for their region. The Department provided extensive outreach and technical support to home visiting program sites, stakeholder groups, MCOs and participants to successfully implement this new service. These resources including program materials, webinars and FAQs remain available on the Department’s MCH Medicaid Initiatives website.

As of September 2022, there are nine sites enrolled as Medicaid providers for home visiting services. These sites represent 37 percent of the county jurisdictions within Maryland. The Department continues to serve as a resource for home visiting programs as they make the transition to become Medicaid

providers and increase their comfort with the billing process. It can be expected that claims will increase in months and years ahead.

Doula Reimbursement

Program Overview

Effective February 21, 2022, the Department began Medicaid coverage for doula/birth worker services to Medicaid participants. A doula, or birth worker, is a trained professional who provides continuous physical, emotional and informational support to birthing parents before, during and after birth. Certified doulas serving Medicaid participants provide person-centered, culturally competent care that supports the racial, ethnic and cultural diversity of members while adhering to evidence-based best practices.

The reimbursement model is straightforward – doulas provide three kinds of services: prenatal visits, attendance at labor and delivery, and postpartum visits. Medicaid provides coverage for up to eight perinatal visits, as well as attendance at labor and delivery, known as the 8:1 model. The 8:1 model allows for any combination of prenatal and postpartum visits that equals eight or fewer visits per birthing parent. Doulas can enroll as individual providers or be affiliated with a doula practice that bills for provided services on their behalf. All doulas must be trained by one of nine Medicaid-approved doula certifying organizations.

Program Implementation

To create the reimbursement model, the Department reviewed the development and implementation of doula coverage by other state Medicaid agencies, including Minnesota, New Jersey, New York, Oregon, Rhode Island and Virginia. In addition, the Department reached out to local stakeholders, especially members of Maryland’s Doula Technical Advisory Assistance Group (DTAAG).

Through this research, regulations were drafted and published for public notice. After making some adjustments due to comment received, regulations were promulgated to establish the new provider type, the conditions of participation and reimbursement model. The Department also submitted and CMS approved a SPA, which covered doula services as a preventative service.

The Department established a new provider type, doula (DL), within ePREP for this new service. In addition, three new codes were opened in MMIS for billing prenatal and postpartum visits (W3701 and W3702, respectively), as well as attendance at labor and delivery (W3700). As there are no established HCPCS codes for these doula services, the Department also submitted a request to CMS to designate them. These requests are currently being reviewed by CMS.

The Department created a number of resources for this new provider type, including an FAQ document explaining the basics of Medicaid for those who might be unfamiliar. This FAQ was and will be regularly updated with questions from providers. Additionally, the Department hosted live webinars, which were recorded, on how to enroll as a Medicaid provider specific to both individual doulas and group practices, as well as written guides to accompany them. All of these resources are available on the newly created

Doula webpages for providers and beneficiaries, respectively. The Department will continue to update these resources and support doulas who are interested in becoming Medicaid approved.

The Department also held regular meetings with the MCOs to review the doula benefit and provide technical assistance as the services came online. This included creating and updating a program manual, as well as a FAQ based on MCOs questions.

As of September 30, 2022, there are six doulas enrolled as Medicaid providers. At the suggestion of the stakeholder community, the Department conducted a review of the approved certification organizations, putting out a call for nominations for additional organizations. Three new trainings were selected, and as of the start of FY 2023, regulations were being updated to include them as approved certifications. The Department has also been in communication with colleagues at Public Health to work collaboratively to expand the pool of Medicaid-approved doula providers.

CenteringPregnancy and HealthySteps

Program Overview

The Department is utilizing the Fund to expand access to innovative approaches to prenatal care and early childhood well-being through CenteringPregnancy and HealthySteps, respectively. Because prenatal care and child health visits are already covered services, the Fund provides an enhanced payment to support practices that have undertaken these programs. The Department combined implementation efforts for these two programs, which included developing infrastructure for Medicaid reimbursement, technical assistance for the MCOs and ongoing communication with the CenteringPregnancy and HealthySteps national organizations and their respective providers in the State.

The Department is updating the Maryland Provider Services Manual to reflect the new CenteringPregnancy and HealthySteps benefits and define the reimbursement guidelines for the enhanced payment of these services. The Provider Services Manual is incorporated by reference into the Code of Maryland Regulations (COMAR). Effective January 1, 2023, the Department will reimburse CenteringPregnancy and HealthySteps providers an enhanced payment for services consistent with the models of care provided at an accredited site or a site pending accreditation by their respective parent organizations.

CenteringPregnancy

CenteringPregnancy is an evidence-based group prenatal care model for low-risk pregnancies. The model focuses on three core components: health assessment, interactive learning and community building. Facilitators support a cohort of eight to ten individuals of similar gestational age through a curriculum of ten 90- to 120-minute interactive group prenatal care visits that largely consist of discussion sessions. Discussion topics include medical and non-medical aspects of pregnancy, such as nutrition, common discomforts, stress management, labor and birth, breastfeeding and infant care.

Studies¹ have shown that CenteringPregnancy improves health outcomes, such as decreased risk of preterm birth, as well as improves patient satisfaction.

CenteringPregnancy Implementation

The Department received technical assistance and subject-matter expertise from the national parent organization, the Centering Healthcare Institute (CHI), to develop and design the CenteringPregnancy benefit. Effective January 1, 2023, the Department will pay an enhanced rate to CenteringPregnancy providers. The enhanced payment is meant to support the overall operations of CenteringPregnancy practices and will be billed alongside the typical group prenatal care procedure code for up to 10 perinatal care visits per pregnancy (*i.e.*, the period from conception to 60 days postpartum).

The Department identified code 99078, defined as “group ed services by physician,” for the enhanced rate for services. The Department created a new category of service and activated code 99078 for billing within the MMIS and ePREP systems. CenteringPregnancy providers will be required to update their Medicaid provider accounts with a letter from CHI attesting that they are an accredited site or pending accreditation. This will allow providers to add the category of service “CP” to their accounts, enabling them to bill for the code 99078.

There are seven active CenteringPregnancy practices in Maryland. Eligible practices will be able to update their Medicaid provider accounts starting in early FY 2023. Medicaid anticipates additional providers will work towards the CenteringPregnancy model implementation due to the partnership and grants from the Department’s Maternal and Child Health Bureau (additional detail under ‘Public Health Programs,’ below).

HealthySteps

HealthySteps, a program of the national accrediting body ZERO TO THREE, is a pediatric primary care model that promotes positive parenting and healthy development for babies and toddlers. Under the model, all children ages zero to three and their families are screened and placed into a tiered model of services of risk-stratified supports, including care coordination and on-site intervention at accredited, or pending accreditation HealthySteps sites. The HealthySteps Specialist, a child development expert, joins the pediatric primary care team to ensure universal screening, provide referrals to external services and follow-up to the whole family.

HealthySteps Implementation

Effective January 1, 2023, the Department will reimburse an enhanced payment for evaluation and management services provided by providers at an accredited or pending accreditation HealthySteps site.

Similar to CenteringPregnancy, the enhanced payment will support the overall operations of HealthySteps practices, including the salary of the HealthySteps Specialist. HealthySteps providers will

¹<https://centeringhealthcare.org/why-centering/payment>: Centering Saves Lives & Money

bill the code H0025, defined as a behavioral health prevention education service. The Department created a new category of service and activated code H0025 for billing within the MMIS and ePREP systems. This code reimburses the practice for overall support of the benefit and will be billed alongside a typical pediatric visit code (either a well-child visit or an appropriate evaluation and management code). This benefit is limited to outpatient offices and outpatient hospital clinics.

HealthySteps providers will need to update their ePREP provider accounts with a letter from ZERO TO THREE attesting that they are an accredited site or pending accreditation. This will allow providers to add the category of service "HS" to their accounts, enabling them to bill code H0025. Eligible practices will be able to update their Medicaid provider accounts starting in early FY 2023. The Department will provide further guidance for providers on the Medicaid website.

The Department received technical assistance and subject-matter expertise from the national parent organization, ZERO TO THREE, to develop and design the HealthySteps benefit. The Department also worked with Maryland-based HealthySteps providers to alert them of the new funding mechanism for these services.

There are two anticipated eligible providers in Maryland (University of Maryland Pediatrics Associates) and three in DC (MedStar Georgetown - MedStar Medical Group at Fort Lincoln, Children's National - Children's Health Center at THEARC and Anacostia locations). In addition, Kaiser Permanente is transforming its practices in South Baltimore and Woodlawn into HealthySteps sites, to comply with the new Medicaid requirement.

MCO Incentive Program

To support the Department's MCOs in building the infrastructure and successfully implementing CenteringPregnancy and HealthySteps, the Fund established a voluntary milestone-based incentive program for MCOs. MCOs have the opportunity to earn a total of \$50,000 for each program for meeting three milestone categories: work plan, contracting and service implementation.

The first milestone requires MCOs to draft and submit a detailed work plan outlining how their organization will implement the two benefits in jurisdictions where they are active. The work plan was to address assigned roles, claims configuration, contracting and participant enrollment, among other topics. The Medicaid program reviewed the submitted work plans and inquired further with MCOs if there were specific questions to be addressed.

The second milestone requires MCOs to contract with at least two CenteringPregnancy and HealthySteps providers. While Medicaid regulations will only require MCOs to contract with one CenteringPregnancy provider and one HealthySteps provider, the incentive milestone sets a higher target. MCOs are required to provide documentation to Medicaid indicating that they have contracted with two providers in each provider type to receive these incentive monies.

The final milestone requires MCOs to have at least one member receive benefit services for CenteringPregnancy and HealthySteps, respectively, and to alert Medicaid when this has been

completed. This milestone indicates that the MCO has successfully set up the CenteringPregnancy and HealthySteps benefits.

In addition to the monthly office hours meetings, the Department provided additional technical assistance meetings specific to CenteringPregnancy and HealthySteps and utilized the MCH inbox to respond to questions and feedback.

Medicaid will host a webinar for providers explaining how to update their Medicaid provider accounts to designate that they are a CenteringPregnancy or HealthySteps provider.

Eight out of nine Medicaid MCOs are participating in the incentive program. Once the new regulations are effective on January 1, 2023, all MCOs will be required to cover CenteringPregnancy and HealthySteps benefits and pay the enhanced rate to providers. In addition, the CY 2023 MCO contract will require that MCOs contract with at least one CenteringPregnancy and one HealthySteps provider.

Maternal Opioid Misuse (MOM) Model

Program Overview

The MOM model addresses fragmentation in the care of pregnant and postpartum Medicaid participants with opioid use disorder (OUD) through enhanced case management services, with an emphasis on increasing health service utilization, as well as screening and referral for the social determinants of health.

As part of a CMMI demonstration, the MOM model has supported efforts in increasing provider capacity to treat the maternal OUD population; in addition, in FY 2022, the demonstration funded a per member, per month (PMPM) payment to MCOs for the enhanced case management services. Starting July 1, 2022, the payments transitioned to the MCH Population Health Improvement Fund, with federal matching dollars authorized under the §1115 HealthChoice demonstration. As of January 1, 2023, Maryland will cease its participation in the federal CMMI demonstration, although it will continue to offer MOM case management services and screenings to members.

Program Implementation

MOM model services started on July 1, 2021 as a pilot in St. Mary's County, continuing for one year. Starting in FY 2023, after the culmination of the pilot, the model expanded into Baltimore City, in addition to the following counties: Anne Arundel, Baltimore, Cecil, Garrett and Harford. Starting January 1, 2023, the MOM model will expand to be completely statewide, available to all eligible HealthChoice members. The MOM model was added to the §1115 HealthChoice demonstration waiver renewal in 2021, ensuring that the benefit will continue to be available to all eligible members after the culmination of the CMMI demonstration period on December 31, 2024. Starting FY 2023, the PMPM payments will be built into MCO capitation rates.

As of the end of October 2022, there have been six participants in the MOM model. Model participants to date have demonstrated an interest in engaging in treatment for their OUD, as well as efforts to change life circumstances, including enrolling in educational courses, learning to drive and securing

stable housing. As the model expands to be available statewide, the Department anticipates a corresponding increase in enrollment.

With complementary CMMI funds, the MOM model has partnered with outside organizations, the Maryland Addiction Consultation Service (MACS) and Bowie State University, to augment its positive effects. Through the partnership, MACS launched the MACS for MOMs program to build provider capacity to better treat the maternal OUD population. The program includes teleECHO clinics, a warmline for phone consultations, and a variety of trainings, including those for receiving a DATA 2000 Waiver which allows providers to prescribe buprenorphine. To strengthen the MOM model by making it more attractive to communities of color, the Department partnered with Historically Black Colleges and Universities (HBCUs), led by Bowie State, to tailor the program to be more culturally responsive to Maryland's Black population.

Public Health Programs

The Public Health Services/Prevention and Health Promotion Administration administers funds to improve maternal and child health. Specifically, for the MCH Population Health Improvement Fund, the Maternal and Child Health Bureau (MCHB) implements the maternal health initiatives, and the Environmental Health Bureau (EHB) implements initiatives related to asthma.

Maternal Health Initiatives

Home Visiting Expansion

Program Overview

Home visiting programs can impact maternal morbidity in different ways, including: 1) creating human-to-human relationships that enable home visitors to provide tailored support based on the specific needs of each family; 2) reducing pregnancy induced hypertensive disorders, preterm birth and maternal depression; 3) creating connections between mothers and health practitioners in the community, breaking down barriers to care and strengthening the link between healthcare resources and the families who need them; 4) providing screening in maternal depression both prenatal and postpartum and connecting mothers in need with the appropriate community-based behavioral health care; 5) providing referrals for mothers when certain risk factors, including trauma or domestic violence, are present in the home; and 6) targeting social determinants of health (SDOH) affecting families, such as social support, parental stress, access to health care, income and poverty status and environmental conditions.² The State currently funds 10 sites and 19 programs that meet federal evidence-based criteria across Maryland to implement home visiting through the Maternal, Infant Early Childhood Home Visiting Program (MIECHV). Through the MCH Population Health Improvement Fund, the Department plans to award a total of \$2.26 million over three years (August 15, 2022 through June 30, 2025).

² <https://www.socialworkers.org/LinkClick.aspx?fileticket=7mhUWCptNL4%3D&portalid=0>

Implementation Update

During the summer and fall of 2021, the Bureau prepared a Request for Applications. The process involved consulting with the Office of Minority Health and Health Disparities and the MIECHV Home Visiting Program to ensure there was alignment with existing home visiting programs as well as to ensure the grantees would reach out to the population in need.

On November 23, 2021, the Department issued a request for applications (RFA) to solicit applications for up to four awards for the expansion of statewide infant and early childhood home visiting services. Due to procurement challenges within the Department, the RFA was reposted on March 24, 2022. In September 2022, the Department announced more than \$865,000 in grant funding for FY 2023 to four organizations to expand evidenced home visiting service in high-priority areas. The selected organizations include Montgomery County Health Department, Washington County Health Department, Baltimore Healthy Start and The Family Tree.

Montgomery County Health Department will expand the Babies Born Healthy (BBH) program using the March of Dimes Becoming Mom (BAM) curriculum. BAM improves maternal knowledge through a community-based collaborative model of care, prenatal education and quality prenatal care. BBH will serve approximately 40 high-risk pregnant people beginning at any stage in their pregnancy and follow the mother and infant until the child turns six months of age. The program will place priority and focus on providing services to the following high-risk zip codes in Montgomery County: 20903, 20904, 20906 and 20912.

Washington County Health Department will expand existing home visiting services through the local program affiliate of Healthy Families America (HFA). The program will offer services to 50 additional families starting prenatally over the course of three years and continuing through the child's fifth birthday. Participating families have the option to graduate early when the focus child turns three years old and has met the criteria set for graduation by HFA.

Baltimore Healthy Start (BHS) will partner with Chase Brexton Glen Burnie Health Center to expand home visiting services to postpartum women in Anne Arundel County, in the following zip codes: 20724, 21060, 21061, 212225 and 21226. The program will use the Great Kids curriculum, designed for home visits beginning in the gestational stage of pregnancy. Families will be offered standard BHS case management and care coordination services through the Chase Brexton-based Medication Assisted Treatment for Substance Use Disorder Program. The program intends to provide services to 40 additional families annually.

The Family Tree will expand home visiting services in Baltimore City through the Parents as Teachers (PAT) model. Home visitors make regular visits from prenatal through kindergarten age. The PAT curriculum focuses on mental health, nutrition, maternal depression, substance use and domestic violence. The program intends to provide home visiting services to 20 additional families annually.

Coordination and Collaboration

To ensure coordination, the Department is currently preparing to conduct an introductory meeting amongst the birthing hospitals, the Maryland Hospital Association (MHA) and the home visiting sites. This introductory meeting will help to increase referrals and strengthen relationships and collaborations among stakeholders.

Increasing Access to CenteringPregnancy Sites

Program Overview

The effectiveness of CenteringPregnancy is shown most dramatically among populations of color, who disproportionately experience adverse maternal outcomes. In response to the disproportionate SMM rates affecting Black birthing persons in Maryland, the Department has reserved a total of \$429,197 for a period of three years (from FY 2022 to FY 2025) to fund the implementation CenteringPregnancy in five additional sites across Maryland. In alignment, participating practices may be eligible for Medicaid's CenteringPregnancy benefit, outlined above.

Implementation Update

At the beginning of 2022, the Department issued a RFA for grantees to develop and implement a two-year demonstration project utilizing the CenteringPregnancy model in prenatal clinical sites in Maryland. **Mercy Medical Center** (Mercy Medical) was awarded funds in the fourth quarter of FY 2022 and in FY 2023 to implement CenteringPregnancy in Baltimore City. During the fourth quarter Mercy Medical prepared and planned for the implementation of CenteringPregnancy: completion of CHI's CenteringPregnancy training and hiring of staff. On December 8th, 2022 Mercy Medical will be launching CenteringPregnancy. Mercy Medical will have eight to ten pregnant people from the same gestational age and eight (8) to ten (10) group sessions.

The program will serve patients from their downtown Metropolitan OB/GYN practice, which serves a high number of individuals that are disproportionately affected by SMM.

In June 2022, the Department issued a second RFA for one grant recipient to successfully recruit, implement and administer up to four CenteringPregnancy sites in priority jurisdictions in Maryland. This decision was based on feedback from stakeholders, who recommended the need for more direct recruitment and outreach to clinics due to impacts of the COVID-19 pandemic, lack of resources and challenges of the State's RFA process. Currently, this award is being processed and the Department expects to start in November 2022.

While not funded directly by MCH Population Health Improvement Fund, the Department has also funded **Greater Baden Medical Services** (GBMS) to implement CenteringPregnancy in April of 2022. This site is funded via the Babies Born Healthy Program.

Improving Childhood Asthma Initiatives

Asthma Home Visiting Program

Program Overview

Home visiting programs have been shown to improve asthma, including adolescent asthma, as it offers tailored services to address a family's specific needs. Below is a description of the efforts of the Department to improve childhood asthma outcomes.

Implementation Update

The Department has utilized funds to support the Asthma Home Visiting Program (The Asthma HV Program) that operates in eleven jurisdictions (Anne Arundel, Baltimore, Charles, Dorchester, Frederick, Harford, Montgomery, Prince George's, St. Mary's and Wicomico Counties and Baltimore City). The Asthma HV Program provides up to six home visits for children with moderate to severe asthma by a Local Health Department (LHD) community health worker (CHW) and/or supervising case manager. These visits include an evaluation of environmental triggers, parent education and provision of supplies shown to reduce asthma severity, including a HEPA vacuum cleaner and other interventions demonstrated to improve outcomes for children with moderate to severe asthma. The Asthma HV Program also ensures care coordination amongst all providers who interact with the child through the use of asthma action plans. In FY 2022, more than 600 children with lead poisoning or asthma received services through this program. In support of the SIHIS and Departmental goal of addressing health disparities, 80.3% of the children with asthma served in the program were Black or African American.

COVID-19 continued to limit the ability of LHDs to conduct home visits in 2021 and much of 2022, but LHDs have persisted in their efforts to improve childhood asthma outcomes. In FY22, 353 children with asthma were enrolled at some point for home visiting by local health departments – 201 of those children were newly enrolled in that fiscal year (the others enrolled in a different fiscal year but were in the program at some point in FY 2022).

Improving Referrals to Local Health Department Asthma Home Visiting Programs

One of the most significant challenges to the asthma home visiting programs has been the challenge of recruiting families into the program. The Department has developed several strategies to improve the referral process, including:

- Care Alerts to health care providers through the state's health information exchange, Chesapeake Regional Information System for our Patients (CRISP)
- Direct electronic referrals to LHDs of children recently discharged from emergency departments or inpatient admissions for asthma exacerbations through CRISP
- Incorporation of information about the LHD home visiting program
- Direct referrals from hospitals and managed care organizations to LHD home visiting programs

Taken together, these strategies have significantly increased referrals to LHD home visiting programs and improved the recruitment of families into the program. In particular, on September 8, 2022 the first direct electronic referrals of children with recent emergency department visits or hospitalizations due to asthma were from CRISP to LHDs, and have continued at the rate of 10 children per LHD per week.

Community-Based and Other Programs Focused on Asthma

In addition to the \$1 million from the Population Health Improvement Fund used to strengthen the LHD home visiting program, the Department released a \$250,000 competitive request for applications for community-based programs to address pediatric asthma. The Green and Healthy Homes Initiative, Inc. (GHHI) received funding for two programs, one in Baltimore City, the other in Prince George's County. These funds will allow GHHI to address asthma through both educational interventions and home-based interventions and will also expand the number of children and families in the state who may be eligible for services.

The most recent GHHI interim report for Prince George's County summarizes the performance measures and progress to date:

210 children in total will be enrolled in the Program over 42 months (3.5 years). In the initial 6 months, GHHI was planned to enroll and serve 30 asthma diagnosed children and their households. After the initial 6 months concludes, GHHI will enroll and provide services to 60 clients annually thereafter for the next 36 months (3 years). In total, 210 Children will receive full services including in-home asthma prevention resident education and case management, asthma trigger environmental assessment, and Tier I Plus and Tier II asthma trigger reduction housing interventions.

Interim Report Update: GHHI received 2,300 referrals of Prince George's County children ages 2-17 who are diagnosed with asthma and whose asthma is deemed to be uncontrolled. GHHI has commenced the scheduling of asthma resident educations and environmental assessments with the Amerigroup client referrals and other referrals from GHHI marketing and outreach and healthcare and other partner referrals. GHHI fully expects to complete all services for 90 asthma resident educations and environmental assessments for asthma triggers as well as asthma trigger reduction housing interventions for higher level intervention (where applicable) client units by June 30, 2023 in meeting the performance measures for the first 18 months of the Program.

In Baltimore City, GHHI has also had some challenges in receiving referrals from its primary source (a large managed care organization), as noted in its update for the

280 children in total will be enrolled in the Program over 42 months (3.5 years). In the initial 6 months, GHHI was planned to enroll and serve 40 asthma diagnosed children and their households. After the initial 6 months concludes, GHHI will enroll and provide services to 80 clients annually thereafter for the next 36 months (3 years). In total, 280 children will receive full services including in-home asthma prevention resident education and case management, asthma trigger environmental assessment, and Tier I Plus and Tier II asthma trigger reduction housing interventions.

Interim Report Update: GHHI received 1,900 referrals of Baltimore City children ages 2-17 who are diagnosed with asthma and whose asthma is deemed to be uncontrolled. GHHI has commenced the scheduling of asthma resident educations and environmental assessments with the Amerigroup client referrals and other referrals from GHHI marketing and outreach and

healthcare and other partner referrals. GHHI fully expects to complete all services for 120 asthma resident educations and environmental assessments for asthma triggers as well as asthma trigger reduction housing interventions for higher level intervention (where applicable) client units by June 30, 2023 in meeting the performance measures for the first 18 months of the Program.

Asthma Community of Practice (CoP) and Provider Education

The Asthma Community of Practice (CoP) was created by the Prevention and Health Promotion Administration (PHPA)/ Environmental Health Bureau (EHB) with the vision that all people and families living with asthma in the State of Maryland receive the best possible care so that asthma does not affect their quality of life, and with the mission of improving practice through information and resource sharing. The purpose of the Asthma CoP is to:

- 1) Serve as a forum to exchange best practices and information regarding asthma treatment, management and prevention;
- 2) Improve collaboration among stakeholders involved in asthma care; and
- 3) Ensure that Marylanders with asthma get the best possible care and access to prevention services.

The first Asthma CoP meeting was held on March 31, 2022. Attendees included LHDs and asthma stakeholders across the state, including the Green & Healthy Homes Initiative, Johns Hopkins School of Medicine Department of Pediatrics, local community organizations and insurers. Items discussed in the first meeting included the purpose of Asthma CoP, asthma management in Maryland and practices and strategies to address populations with the greatest need. The Asthma CoP met again on July 13, 2021; Tere H. Dickson, MD, MPH (Physician Advisor for Medicaid's Medical Benefits Management Administration), presented a model for Improving Asthma Outcomes in New York City. The final CoP meeting was held on November 2, 2022, and included presentations by the ImpactDC asthma program based at National Children's Hospital, and a discussion about how to improve the design and use of Asthma Action Plans used across Maryland. EHB plans to conduct three Asthma CoP Meetings annually.

SIHIS Measure Performance

As per the terms of the MOA between the HSCRC and MDH, continued funding is contingent upon successful achievement of the interim 2023 SIHIS targets. MDH staff closely monitor performance on the SMM and childhood asthma goals as part of their ongoing implementation responsibilities under SIHIS. COVID-19 has had an undeniable impact on SMM and childhood asthma goals.

Concerning childhood asthma, there has been an association between pandemic lockdowns with fewer ED visits for asthma exacerbation, that is likely due to reduced exposure to viral infections and environmental allergens, decreased availability of primary physicians and families reluctance to arrive to the ED. Early in the pandemic, the CDC identified patients with moderate to severe asthma as a high risk group that may experience greater morbidity from COVID-19 and thus encouraged avoiding asthma

triggers, using prescribed asthma medications and following a personalized asthma action plan.³ MDH will continue to monitor the childhood asthma rates pre-pandemic, pandemic and post pandemic to work towards a continual improvement in asthma and child health.

The majority of first year activities focused on building infrastructure, launching procurements, and issuing awards to community-based organizations to implement evidence-based-interventions. The new and enhanced benefits through Medicaid, as well as community interventions funded by PHPA, need additional time to mature to demonstrate impact on maternal and child health in the State.

Severe Maternal Morbidity Performance

Statewide Performance

As a result of COVID-19, the State's SMM rate has increased since 2018 and is currently above the State's 2018 baseline. Based on conversations with stakeholders such as providers and hospital administrators, the effects of COVID and other respiratory viral illnesses have contributed to the SMM rate increase. There are similar performance trends nationally. A cohort analysis of 1.6 million pregnant patients across 463 US hospitals published by the Journal American Medical Association (JAMA) indicated a small but significant increase in pregnancy-related complications and maternal deaths during delivery hospitalization.⁴ The rate of pregnancy complications included hypertensive disorders and hemorrhage. Prior to the pandemic, 15.3 percent of patients had a pregnancy-related hypertensive disorder compared with 16.6 percent during the pandemic; 5.1 percent of patients experienced hemorrhage, compared with 5.5 percent during the pandemic.

In addition, previous internal analysis from 2021 Maryland data demonstrated that there was an increase in respiratory conditions contributing to SMM, particularly in cases requiring ventilation. The rate of SMM requiring ventilation among COVID-19 positive SMM cases was 43 percent higher than among COVID-19 negative SMM cases. Although COVID-19 vaccination rates have increased in the State, the SMM rates remain elevated. These are most likely due to the long-lasting impact of COVID-19 that is beyond the acute infections but also has affected stress, access to health care, employment, transportation, childcare, and other social determinants of health. MDH will continue to monitor performance throughout 2023 and communicate with CMMI regarding trends.

SMM indicators were recently updated by federal partners to exclude blood transfusions, due to lack of specificity. Given these updates, the State is examining the impact of updating the SMM indicators to align with the national SMM calculations.

MDH will continue to monitor performance throughout 2023. As previously mentioned there has been a small but significant increase in SMM at the national level. Despite the influence of COVID-19 on SMM

³ Moore WC, Ledford DK, Carstens DD, Ambrose CS. Impact of the COVID-19 Pandemic on Incidence of Asthma Exacerbations and Hospitalizations in US Subspecialist-Treated Patients with Severe Asthma: Results from the CHRONICLE Study. *J Asthma Allergy*. 2022 Aug 31;15:1195-1203. doi: 10.2147/JAA.S363217. PMID: 36068863; PMCID: PMC9441176.

⁴ Molina RL, Tsai TC, Dai D, et al. Comparison of Pregnancy and Birth Outcomes Before vs During the COVID-19 Pandemic. *JAMA Netw Open*. 2022;5(8):e2226531. doi:10.1001/jamanetworkopen.2022.26531

outcomes, staff is working diligently to expand and implement the funded interventions to improve maternal health and reduce SMM in Maryland.

Based on data through August 2022, Maryland had 287.8 SMM-related hospitalizations per 10,000 delivery discharges over the prior 12 months. This rate is 68.5 hospitalizations per 10,000 higher than the 2023 target (219.3) and 45 hospitalizations per 10,000 higher than the 2018 baseline (243.1).

Figure 1. SMM Rate for Rolling 12-Months (2018 - August 2022)

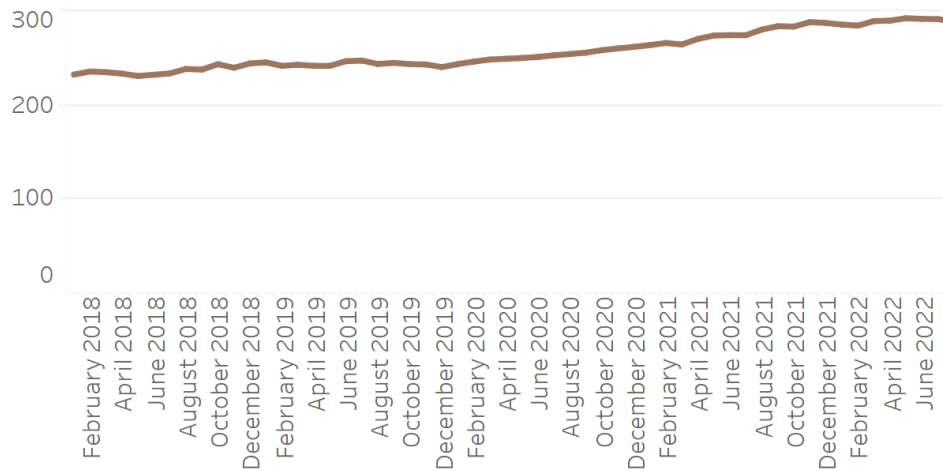


Table 1. SMM Hospitalizations Compared to 2023 Target

	2018 Baseline	Most Recent 12 Months	2023 Target	Difference - Most Recent 12 months to Target
Rates per 10K	243.1	287.8	219.3	68.47
SMM Events	1,585	1,815		
Eligible Deliveries	65,199	63,071		

Health disparities are also increasing due to challenges discussed earlier in this report, further illustrating the critical need to invest in evidence-based interventions dedicated to addressing maternal health.

Figure 2. SMM Hospitalizations for Rolling 12-Months by Race/Ethnicity, 2018-August 2022

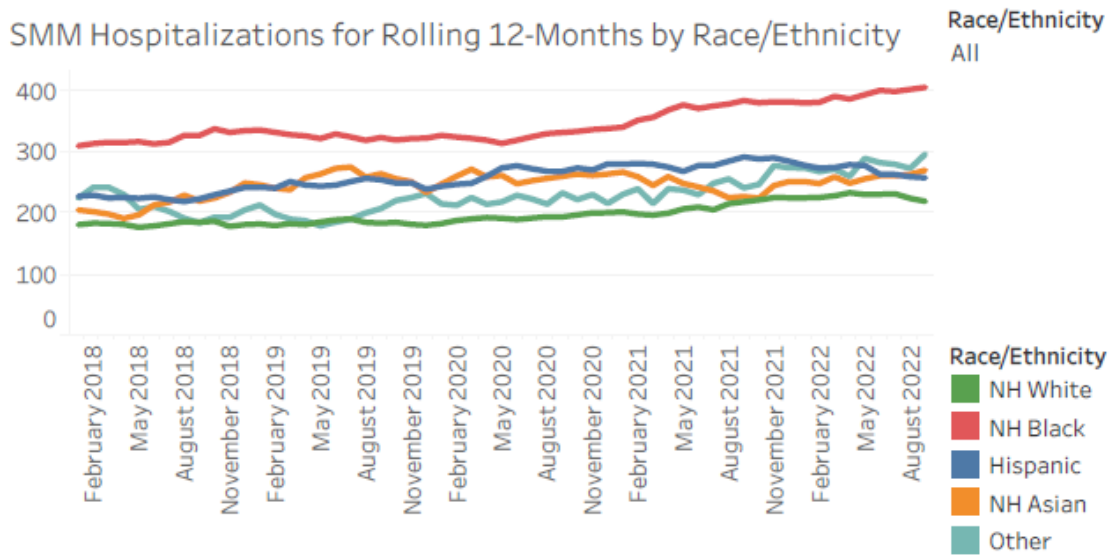


Table 3 . SMM Hospitalizations Rates by Race/Ethnicity, 2018-August 2022

SMM Hospitalization Rates per 10K Compared to 2023 Target:
Race/Ethnicity & Disparity Index

Race/Ethnicity	2018 Baseline	Most Recent 12 Months	2023 Target	Difference - Most Recent 12 months to Target	Disparity Index
NH White	181.4	219.3	169.8	49.5	1.0
NH Black	334.2	404.7	295.7	109.0	1.8
Hispanic	242.0	257.7	213.2	44.5	1.2
NH Asian	249.0	269.9	217.7	52.2	1.2
Other	205.2	296.2	204.6	91.6	1.4
Statewide Total	243.1	287.7	219.3	68.4	1.3

Performance by Payer

Staff is also monitoring SMM performance by payer. Both Medicaid and commercial payers are trending upward, in line with Statewide performance. However, while Medicaid performance has been higher than other payers since 2018, it has grown at a slower pace than commercial (11 percent versus 26 percent). The graph and table below show performance between the 2018 SIHIS baseline and data through September 2022.

Figure 3. SMM Rate by Payer, 2018- September 2022

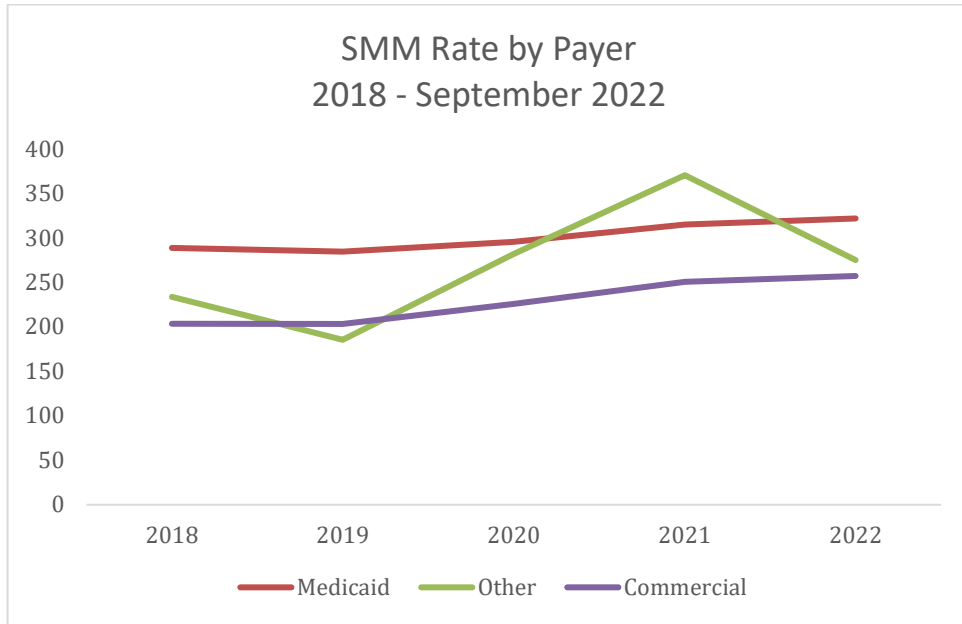


Table 4 . SMM Rate by Payer, 2019 – September 2022

Payer	2018	2019	2020	2021	2022 YTD	% Change Since 2018
Medicaid	289	285	296	315	322	11%
Medicare	687	634	842	954	764	11%
Other	234	185	282	370	275	18%
Commercial	203	203	226	251	257	26%

Childhood Asthma Emergency Department (ED) Visit Rate

As is true for hospitals nationally, Maryland hospitals saw sharp declines in ED volumes in 2020 and early 2021 due to COVID-19. Understandably, Maryland’s asthma-related ED visit rate for ages 2-17 declined during this period. While 2022 volumes are trending back to 2018 baselines, they are still artificially low. Despite lower ED volumes, staff believes that the underlying dynamics of childhood asthma in Maryland did not change and is working in earnest to implement interventions that will reduce childhood asthma and health disparities.

Statewide Performance

Based on data through August 2022, Maryland had 6.2 asthma-related emergency department visits per 1,000 children over the prior 12 months. This rate is 1.0 visits per 1,000 children lower than the 2023 target.

Figure 4. Childhood Asthma-Related ED Visits for Rolling 12-Months

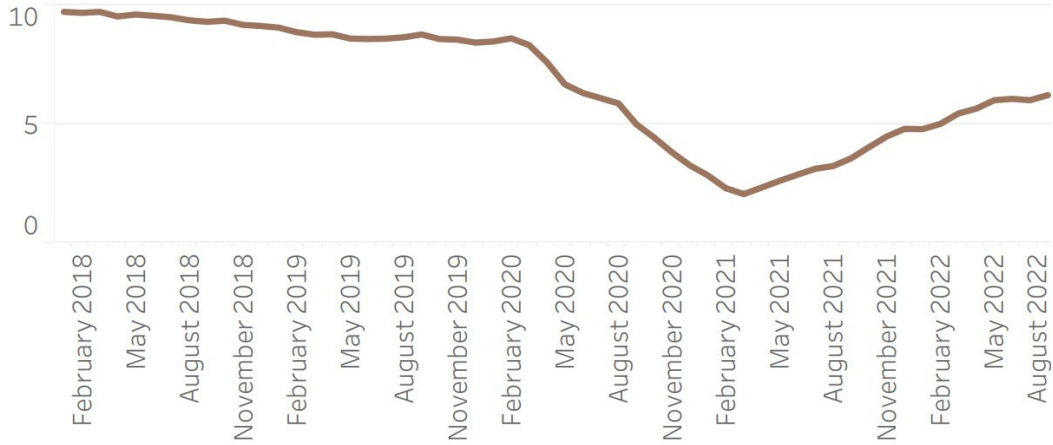


Table 5. Childhood Asthma-Related ED Visits Compared to 2023 Target

	2018 Baseline	Most Recent 12 Months	2023 Target	Difference - Most Recent 12 months to Target
Rates per 1K	9.2	6.2	7.2	-1.0
Total Count	10,974	7,457		

As with the SMM rate, the impacts of COVID-19 have had a deleterious impact on health disparities, most notably with the non-Hispanic Black population. Continued investment in initiatives and programs to address childhood asthma is critical to eliminating these disparities and putting Maryland back on a path to reach the improvement goals set under SIHIS.

Figure 5 . Childhood Asthma-Related ED Visit Rates by Race/Ethnicity, 2018-August 2022

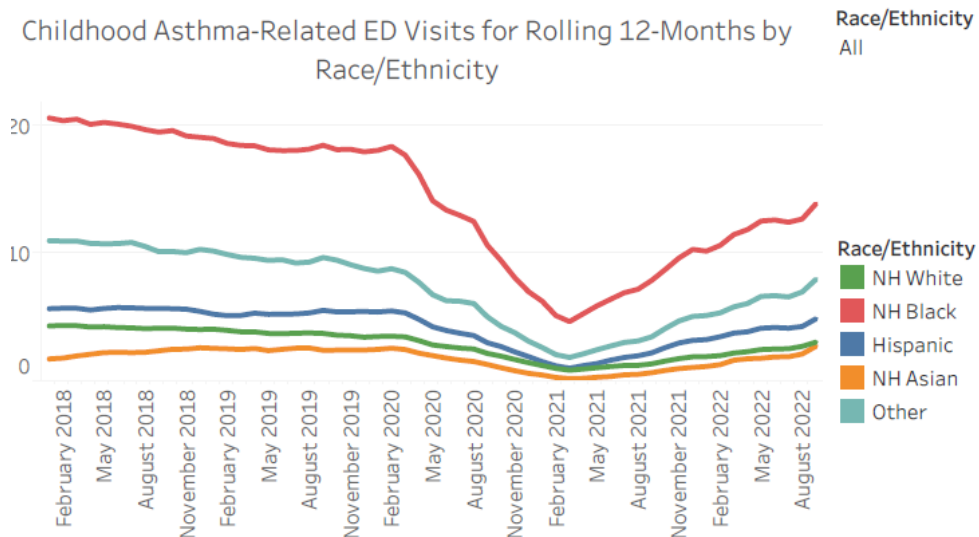


Table 6 . Childhood Asthma-Related ED Visit Rates by Race/Ethnicity, 2018-August 2022

Childhood Asthma-Related ED Visit Rates per 1K Compared to 2023 Target:
Race/Ethnicity & Disparity Index

Race/Ethnicity	2018 Baseline	Most Recent 12 Months	2023 Target	Difference - Most Recent 12 months to Target	Disparity Index
NH White	4.1	3.1	3.50	-0.4	1.0
NH Black	19.1	13.9	14.36	-0.5	4.5
Hispanic	5.5	4.9	4.70	0.2	1.6
NH Asian	2.6	2.7	2.60	0.1	0.9
Other	10.3	8.0	7.30	0.7	2.6
Statewide Total	9.2	6.9	7.2	-0.3	2.3

Performance by Payer

The State is also monitoring performance by payer. As stated earlier in the report, the State believes these declines in the asthma-related ED visit rate in Maryland mirror both State and national reductions in overall ED visits due to COVID-19. Continued and expanded interventions to address childhood asthma are critical to preventing further growth in health disparities resulting from patients potentially not seeking care during the pandemic.

Figure 6. Childhood Asthma-Related ED Visit Rate per 1K, 2018-September 2022

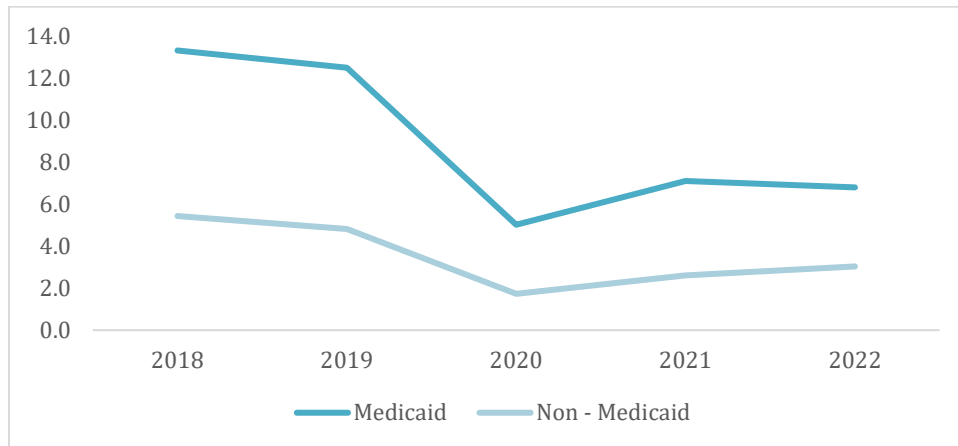


Table 7 . Childhood Asthma-Related ED Visit Rate per 1K by Payer, 2018-September 2022

Payer	2018	2019	2020	2021	2022	% Change since 2018
Medicaid	13.3	12.5	5.0	7.1	6.8	-49%
Non - Medicaid	5.4	4.8	1.7	2.6	3.0	-44%

Year One Spending

The Medicaid program devoted its efforts in FY 2022 to establishing the infrastructure to launch the new and enhanced benefits supported by the Fund. As detailed above, implementation efforts spanned benefit design, systems changes for both payment and provider enrollment and development and approval of regulations (state authority) and Medicaid State Plan Amendments (federal authority), in addition to provider enrollment and education. The Medicaid program intends to maximize the Fund’s contribution by pulling down federal matching funds, which relies on service implementation. Because the first year focused on infrastructure development, the Medicaid program did not have any expenditures under the Fund in FY 2022.

The Medicaid program is building the full \$16 million into its budget for CY 2023 and expects service delivery to increase as provider networks continue to grow. Medicaid is considering additional program enhancements that may increase service uptake and spending in FY2023 which may include:

- Supporting the Maryland Addiction Consultation Service (MACS) at the University of Maryland School of Medicine to continue leading capacity-building activities for maternal health providers who serve patients with OUD;
- Funding Bowie State University—an HBCU—to research and provide recommendations on increasing the attractiveness of and engagement with the MOM model to communities of color;
- Standing up a doula training scholarship program, in coordination with PHS/PHPA;
- Supporting marketing activities to increase public awareness and uptake of the new and expanded services; and
- Supporting the conversion of Maryland Prenatal Risk Assessments - a major referral source for MCH programs - from paper to electronic.

PHS/PHPA dedicated FY 2022 to planning and preparing the Requests for Applications. Overall, 39 percent of funding was spent on Year 1 for funding allocated to PHPA.

Table 8. PHPA Grant Funds Expenditures - FY 2022

Initiative	FY 2022 Spending
Asthma Home Visiting Program ⁵	\$640,633
Community-Based Asthma Programs ⁶	\$100,035
Maternal Home Visiting	\$28,258
CenteringPregnancy	\$17,926
Program Total	\$786,852

Due to procurement challenges and time spent on developing the grant applications, there were initial delays. Because the funds will be able to be rolled over, PHPA intends to use the carryover funds in

⁵ This is an estimate. Final spending will be available in early 2023.

⁶ These are estimates. Final spending will be available in early 2023.

following years. The rollover funds have already been incorporated into budget planning for the home visiting expansion grant funds and the CenteringPregnancy grant funds.

Conclusion

In FY 2023, the State will continue to invest towards the projects described above that have been strategically designed to provide services to underserved populations and those who are at greater risk of being affected by SMM and severe asthma. The State will continue to monitor and provide support to the home visiting sites and community-based asthma programs by developing tools and resources to increase awareness of services, provide opportunities for collaboration between home visiting sites, local health departments and health organizations. The State will continue strengthening networks both internally and externally to advance maternal and child health.



TO: HSCRC Commissioners
FROM: HSCRC Staff
DATE: December 14, 2022
RE: Hearing and Meeting Schedule

Adam Kane, Esq
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

Stacia Cohen, RN, MBA

James N. Elliott, MD

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Katie Wunderlich
Executive Director

William Henderson
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Allan Pack
Director
Population-Based Methodologies

Gerard J. Schmith
Director
Revenue & Regulation Compliance

January 11, 2023 To be determined – HSCRC Offices/GoTo Webinar

February 8, 2023 To be determined – HSCRC Offices/GoTo Webinar

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

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