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574th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
June 10, 2020

(The Commission will begin in public session at 12:00 pm for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 p.m.)

EXECUTIVE SESSION
12:00 pm

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 SESSION
1:00 pm

1. **Review of Minutes from the Public Meeting held on May 13, 2020 and the Public and Closed Meetings on May 21, 2020**

2. **Docket Status – Cases Closed**

   2503R - Johns Hopkins Bayview Medical Center

3. **Docket Status – Cases Open**

   2520A - University of Maryland Medical Center

   2521A - University of Maryland Medical Center

   2522A - Johns Hopkins Health System

4. **Final Recommendation on the Update Factor for FY 2021**

5. **Final Recommendation on Ongoing Support of CRISP for FY 2021**

6. **Final Recommendation on the Maryland Patient Safety Center for FY 2021**

7. **Final Recommendation on Changes to Relative Value Units for Clinic Evaluation & Management (E&M)**

8. **Report on Uncompensated Care for FY 2021**

9. **Policy Update and Discussion**

    a. **Model Monitoring**

10. **Hearing and Meeting Schedule**

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF JUNE 2, 2020

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2520A	University of Maryland Medical Center	5/28/2020	N/A	N/A	ARM	DNP	OPEN
2521A	University of Maryland Medical Center	5/28/2020	N/A	N/A	ARM	DNP	OPEN
2522A	Johns Hopkins Health System	5/29/2020	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

Final Recommendation for the Update Factors For Rate Year 2021

June 10, 2020

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Table of Contents

List of Abbreviations

ACA	Affordable Care Act
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFS	Fee-for-service
FFY	Federal fiscal year, refers to the period of October 1 through September 30
FY	Fiscal year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
MPA	Medicare Performance Adjustment
PAU	Potentially avoidable utilization
QBR	Quality Based Reimbursement
RY	Rate year, which is July1 through June 30 of each year
TCOC	Total Cost of Care
UCC	Uncompensated care

Summary

The following report includes a final recommendation for the Update Factors for Rate Year (RY) 2021. This update is designed to provide hospitals with reasonable inflation to maintain operational readiness, both during and after the COVID-19 response, and to keep healthcare affordable in the State of Maryland.

This recommendation generally follows approaches established in prior years for setting the update factors. Staff recognizes that the COVID-19 crisis has created significant uncertainty and will likely drive large short and long-term changes in the healthcare industry. However, in order to maintain simplicity and stability during the crisis, this policy reflects approaches established prior to the COVID-19 crisis and does not explicitly address COVID-19 specific challenges. Staff plans to continue to work with all stakeholders to develop and adapt existing policies in specific ways to address the COVID-19 crisis

At this time, the staff requests that Commissioners consider the following final recommendations:

a) Provide an overall increase of 3.52 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.35 percent per capita revenue increase for hospitals under Global Budgets, as shown in Table 2.

b) Provide an overall increase of 2.77 percent to the rates of hospitals not under Global Budgets (freestanding psychiatric hospitals and Mt. Washington Pediatric Hospital).

c) Continue to work with all stakeholders to address specific COVID-19 issues such as anticipated hospital undercharges, the challenge of maintaining affordability in a time of economic crisis and the need to ensure sufficient ongoing health system liquidity.

d) The Total Cost of Care Contract and the Commission's mandate both assume that hospital rate increases maintain the affordability of care for all Marylanders. This responsibility has been acknowledged through a cumulative test against a static historic average Gross State Product (GSP) in the Total Cost of Care contract, and more recently through a comparison to recent GSP in the FY20 and FY21 Update Factor Recommendations and the acknowledgement of maintaining growth below GSP in the MPA Framework and Capital Policies approved by the Commission. However, none of these policies create an active, defined method for evaluating the affordability of hospital rates against GSP. In addition there are inconsistencies in the calculations required under the guardrail tests in the Medicare total cost of care contract and the Commission's approach to rate setting. To address these issues the Commission should task staff with:

    i) Developing, by December 31st 2020, in conjunction with industry, a recommendation for evaluating future update factors against GSP, over the most recent 1 to 5 years, as a proxy for affordability. The recommendation should include both (1) a methodology for identifying the affordability standard and (2) policies for adjusting the update factor should the inflation provided differ from the affordability standard in future years, in order to maintain long-term affordability.

ii) Preparing in the same timeframe, in conjunction with industry, a report discussing how Maryland hospital rates relate to the premiums paid for commercial insurance as maintaining the affordability of healthcare for Marylanders also requires that hospital rates are translated into affordable premiums,

iii) Working with CMS to assess the feasibility of converting the Medicare guardrails to a Fiscal Year basis and utilizing retrospective Medicare growth rates in Medicare tests in a way that recognizes multiple years of results.

Introduction & Background

The Maryland Health Services Cost Review Commission (HSCRC or Commission) updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy related adjustments, other adjustments related to performance, and settlements from the prior year. For this upcoming fiscal year, the HSCRC is considering the extraordinary circumstances of the COVID-19 response in the development of the update factor. Specifically, while staff will implement any and all adjustments that had a performance period prior to the onset of COVID-19 pandemic in the United States (e.g. CY 2019 Market Shift, RY 2021 Readmissions Reduction Incentive Program), staff will not reduce inflation or anticipated utilization growth (related to general population growth) due to total cost of care performance, both the cumulative savings test and the annual total cost of care guardrail tests.

Staff recognizes that this approach could result in less than favorable Maryland Medicare performance in CY 2020. However, given Maryland's overall Medicare savings in the Total Cost of Care contract to date (approximately $335 million relative to an contractually obligated value of $300 million by 2023), and Maryland's positive performance in the total cost of care guardrail the last two years (1.3% under in 2018, 0.3% in 2019), staff believes the proposed update factor will provide greater certainty to an industry in the midst of a pandemic while not jeopardizing the continuance of the Total Cost of Care Model.

If the 1% guardrail threshold is triggered, the reason is likely due to the extraordinary circumstances of COVID-19, which will necessitate a request to exercise the exogenous factor clause in the Total Cost of Care contract. Finally, staff would note that while the proposed test of assessing projected Maryland total cost of care growth to prior year national growth reduces many uncertainties in the annual update factor formulation, it has a potential flaw if multiple years of unforeseen positive performance relative to national Medicare compound, and then this accumulation of savings relative to the nation is not accounted for in future update factors. As such, staff proposes to convene a workgroup to establish a more permanent benchmark for assessing Medicare total cost of care growth that complies with the tenets of the Total Cost of Care contract and responsibly credits hospitals for continued Medicare savings. Staff will also endeavor to create a defined method for assessing the affordability of healthcare in Maryland, one that creates an active, defined method for evaluating the affordability of hospital rates against GSP.

In July 2018, CMS approved a new 10-year Total Cost of Care (TCOC) Model Agreement for Maryland, which began January 1, 2019. Under the new TCOC Model, the State committed to continue to limit the growth in hospital costs in line with economic growth, reach an annual Medicare total cost of care savings

rate of $300 million by 2023 ("the Medicare TCOC Savings Requirement"), continue quality improvements, and improve the health of the population. To meet the ongoing requirements of the Model, HSCRC will need to continue to ensure after the COVID-19 crisis abates that state-wide hospital revenue growth is in line with the growth of the economy. The HSCRC will also need to continue to ensure that the Medicare TCOC Savings Requirement is met. The approach to ensure that the RY 2021 annual update is in line with these Model requirements is outlined in this report.

Update Factors are Revenue Updates

It is important to note that the proposed update factor is a revenue update. A revenue update incorporates both price and volume adjustments for hospital revenue under Global Budget Revenues. The proposed update should be compared to per capita growth rates, rather than unit rate changes.

Hospital Revenue Types Included in this Recommendation

There are two categories of hospital revenue:

1. Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority.

2. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland and, thus, Medicare does not pay on the basis of those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital.

This recommendation proposes Rate Year (RY) 2021 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Final Update Factors Recommendations

For RY 2021, HSCRC staff is proposing an update of 3.35 percent per capita for global revenues and a rate update of 2.77 for non-global revenues. These figures are described in more detail below.

Calculation of the Inflation/Trend Adjustment

For hospitals under both revenue types described above, the inflation allowance is central to HSCRC's calculation of the update adjustment. The inflation calculation blends the weighted Global Insight's Fourth Quarter 2019 market basket growth estimate with a capital growth estimate. For RY 2021, HSCRC staff combined 91.20 percent of Global Insight's Fourth Quarter 2019 market basket growth of 2.90 percent with 8.80 percent of the capital growth estimate of 1.40 percent, calculating the gross blended amount as a 2.77 percent inflation adjustment.

Update Factor Recommendation for Non-Global Budget Revenue Hospitals

For non-global budget hospitals (psychiatric hospitals and Mt. Washington Pediatric Hospital), HSCRC staff normally applies the FFY 2021 Inpatient Psychiatric Facilities Medicare productivity reduction of 0.40 percent to the inflation adjustment. This productivity offset is usually made for expected

improvements that could reasonably be expected with allowed volume growth. Since volumes are not growing due to COVID 19, staff recommends suspending this adjustment for this year only.

Table 1

	Global Revenues	Psych & Mt. Washington	
Proposed Base Update (Gross Inflation)	2.77%	2.77%	
Productivity Adjustment		-0.40%	(SUSPENDED)
Proposed Update	2.77%	2.77%	

Update Factor Recommendation for Global Budget Revenue Hospitals

In considering the system-wide update for the hospitals with global revenue budgets under the TCOC Model, HSCRC staff sought to achieve balance among the following conditions:

- Meeting the requirements of the Total Cost of Care Model agreement;
- Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes;
- Ensuring that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the Total Cost of Care Model; and
- Incorporating quality performance programs.

As shown in Table 2, after accounting for all known changes to hospital revenues, HSCRC staff estimates net revenue growth (before accounting for changes in uncompensated care and assessments) of 3.49 percent and per capita growth of 3.32 percent for RY 2021. After accounting for changes in uncompensated care and assessments, the HSCRC estimates net revenue growth at 3.52 percent with a corresponding per capita growth of 3.35 percent for RY 2021.

Staff needs to split the annual Rate Year revenue into six month targets to calculate financial tests, which are performed on Calendar Year (CY) results. Consistent with the past several years, the staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target for the calendar year calculation, with the full amount of RY 2021 estimated revenue used to evaluate the Rate Year year-end target. Of note, there are a few hospitals that do not follow this seasonal pattern, particularly Atlantic General Hospital. Thus, HSCRC staff will adjust the revenue split to accommodate their normal seasonality.

Net Impact of Adjustments

Table 2 summarizes the net impact of the HSCRC staff's final recommendation for inflation, volume, Potentially Avoidable Utilization (PAU) savings, uncompensated care, and other adjustments to global revenues. Descriptions of each step and the associated policy considerations are explained in the text following the table.

Table 2

Balanced Update Model for RY 2021			
Components of Revenue Change Link to Hosptial Cost Drivers /Performance			
			Weighted Allowance
Adjustment for Inflation (this includes 3.10% for compensation)			2.64%
- Rising Cost of Outpatient Oncology Drugs			0.13%
Gross Inflation Allowance	**A**		**2.77%**
Care Coordination/Population Health			
- Regional Partnership Grant			0.19%
Total Care Coordination/Population Health	**B**		**0.19%**
Adjustment for Volume			
-Demographic /Population			0.16%
-Transfers			
-Drug Population/Utilization			
Total Adjustment for Volume	**C**		**0.16%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.25%
- Low Efficiency Outliers	E		0.00%
- Capital Funding	F		0.03%
- Complexity & Innovation	G		0.10%
-Reversal of one-time adjustments for drugs	H		-0.03%
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.34%**
Quality and PAU Savings			
-PAU Savings	J		-0.28%
-Reversal of prior year quality incentives	K		0.19%
-QBR, MHAC, Readmissions			
-Current Year Quality Incentives	L		0.11%
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**0.02%**
Total Update First Half of Rate Year 21			
Net increase attributable to hospitals	N =	Sum of A + B + C + I + M	3.49%
Per Capita First Half of Rate Year (July - December)	O =	(1+N)/(1+0.16%)	3.32%
Adjustments in Second Half of Rate Year 21			
-Oncology Drug Adjustment	P		0.00%
-QBR	Q		0.00%
Total Adjustments in Second Half of Rate Year 21	**R =**	**P + Q**	**0.00%**
Total Update Full Fiscal Year 21			
Net increase attributable to hospital for Rate Year	S =	N + R	3.49%
Per Capita Fiscal Year	T =	(1+S)/(1+0.16%)	3.32%
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care, net of differential	U		0.12%
-Deficit Assessment	V		-0.09%
Net decreases	W =	U + V	0.03%
Total Update First Half of Rate Year 21			
Revenue growth, net of offsets	X =	N + W	3.52%
Per Capita Revenue Growth First Half of Rate Year	Y =	(1+X)/(1+0.16%)	3.35%
Total Update Full Rate Year 21			
Revenue growth, net of offsets	Z =	S + W	3.52%
Per Capita Fiscal Year	AA =	(1+Z)/(1+0.16%)	3.35%

Central Components of Revenue Change Linked to Hospital Cost Drivers/Performance

HSCRC staff accounted for a number of factors that are central provisions to the update process and are linked to hospital costs and performance. These include:

- **Adjustment for Inflation:** As described above, the inflation factor uses the gross blended statistic of 2.77 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's Fourth Quarter 2019 market basket growth of 2.90 percent with 8.80 percent of the capital growth index change of 1.40 percent. The adjustment for inflation includes 2.90 percent for compensation. A portion of the 2.77 inflation allowance (0.13 percent) will be allocated to hospitals in order to more accurately provide revenues for increases in outpatient oncology drugs. This drug cost adjustment is further discussed below.

- **Rising Cost of New Outpatient Drugs:** The rising cost of drugs, particularly of new physician-administered outpatient infusion and oncology drugs in the outpatient setting, continues to be a concern among hospitals, payers, and consumers. Not all hospitals provide these services and some hospitals have a much larger proportion of costs allocated. To address this situation, staff began allocating a specific part of the inflation adjustment to fund increases in the cost of drugs in RY 2016, based on the portion of each hospital's total costs that were comprised of drug costs. In RY 2020 this was refined to focus increases on the hospitals with the high-cost, outpatient infusion and oncology drugs that drive the overall drug inflation.

  In addition to the drug inflation allowance, in RY 2017, HSCRC initiated a utilization adjustment for changes in use of high cost oncology and infusion drugs. The adjustment for change in use is made utilizing information from the HSCRC's Casemix dataset and a supplemental report provided by the hospitals for a list of specified outpatient medications. Half of the estimated cost changes due to usage or volume changes are recognized as a one-time adjustment and half are recognized as a permanent adjustment.

  For Rate Year 2021, staff began using a standard list of drugs based on criteria established with the industry in evaluating high cost drug utilization and inflation. This list was used to calculate the inflation allowance as well as the drug utilization adjustment component of funding for these high cost drugs.

- **Care Coordination / Population Health:** In November 2019, The Commission approved 0.25 percent of RY 2021 hospital revenue for funding streams that focus on Diabetes & Management and Behavioral Health Crisis Program. The 0.25 percent will be reduced by 0.06 percent from unspent funds from prior rate years reducing the grant funding to 0.19 percent.

- **Adjustments for Volume:** The Maryland Department of Planning's estimate of population growth for CY 2020 is 0.16 percent. For RY 2021, the staff are proposing recognizing the full value of the 0.16 percent growth for the Demographic Adjustment to hospitals in keeping with prior year norms.

- **Set-Aside for Unforeseen Adjustment:** Staff recommends a 0.25 percent set-aside for unforeseen adjustments during RY 2021.

- **Capital Funding:** Suburban Hospital received approval in 2015 for a Certificate of Need (CON) totaling $200 million to replace and renovate the Hospital facility. The Commission approved a $7.7 million capital adjustment as part of Suburban's Full Rate Application in RY2020. The hospital received $2.6 million for this adjustment in RY2020. The remaining $5.1 million of the capital adjustment is included in RY2021. To account for the remaining capital adjustment 0.03 percent is included in the update factor for RY2021.

- **Categorical Cases:** The prior definition of categorical cases included transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spinraza cases. However, the definition, which was based on a preset list, did not keep up with emerging technologies and excluded various types of cases that represent greater complexity and innovation, such as extracorporeal membrane oxygenation cases and ventricular assist device cases. Thus, the HSCRC staff developed an approach to provide a higher variable cost factor (100% for drugs and supplies, 50% for all other charges) to in-state, inpatient cases when a hospital exhibits dominance in an ICD-10 procedure codes and the case has a casemix index of 1.5 or higher. Staff used this approach to determine the historical average growth rate of cases deemed eligible for the complexity and innovation policy and evaluated the adequacy of funding of these cases relative to prospective adjustments provided to Johns Hopkins Hospital and University of Maryland Medical Center in RY 2017, 2018 and 2019. Based on this analysis, staff concluded that the historical average growth rate was 0.43 percent, which equates to a combined state impact of 0.10 percent for the RY 2021 Update Factor.

- **Quality Scaling Adjustments:** The RY 2020 adjustments have been restored in the base for the Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Quality Based Reimbursement (QBR) adjustment. New adjustments are reflected in staff's recommendation. The amount for RRIP and MHAC, is 0.41 percent of total permanent revenue. CMS provides data for the Quality Based Reimbursement (QBR) adjustment. Due to the data delivery schedule, HSCRC does not have the final data available to calculate the QBR adjustment at this time. HSCRC expects the QBR adjustment to be approximately -0.32 percent of total permanent revenue, based on the changes in Commission policy and preliminary modeling.

- **PAU Savings Reduction:** The statewide RY 2021 PAU savings adjustment is now calculated based on update factor inflation and demographic adjustment applied to CY 2019 PAU revenue. RY 2021 PAU savings adjustment represents the change between RY 2020 and RY 2021. Previous years of PAU savings adjustments are not reversed out.

Central Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements

In addition to the central provisions that are linked to hospital costs and performance, HSCRC staff also considered revenue offsets with neutral impact on hospital financial statements. These include:

- **Uncompensated Care (UCC):** The proposed increase in uncompensated care adjustment for RY 2021 will be 0.12 percent. The amount in rates was 4.26 percent in RY 2020, and the proposed amount for RY 2021 is 4.38 percent.
- **Deficit Assessment:** The legislature reduced the deficit assessment by $15 million in RY 2021, and as a result, this line item is -0.09 percent.

Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers. These additional variables include one-time adjustments, revenue and rate compliance adjustments and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

PAU Savings Updated Methodology

The PAU Savings Policy prospectively reduces hospital global budget revenues in anticipation of volume reductions due to care transformation efforts. Starting in RY 2020, the calculation of the statewide value of the PAU Savings is included in the Update Factor Recommendation; however, a PAU measurement report was presented separately to the Commission in March.

Starting in RY 2020, the incremental amount of statewide PAU Savings reductions is determined formulaically using inflation and demographic adjustment applied to the amount of PAU revenue (see Table 3). This will result in a RY 2021 PAU savings reduction of -0.28 percent statewide, or $49,415,935. Hospital performance on avoidable admissions per capita and sending readmissions estimated revenue determines each hospital's specific PAU savings reduction.

Table 3

Statewide PAU Reduction		**Value**
RY 2020 Total Estimated Permanent Revenue	A	17,648,548,348
RY 2021 Inflation Factor (preliminary)	B	2.72%
Total RY20 PAU $	C	$1,844,766,206
RY 2021 Revenue Adjustment $	D=B*C	-$50,177,641
Ry 2021 Revenue Adjustment %	E=round(D/A)	-0.28%
RY 2021 Revenue Adjustment $ - Rounded	F = E*A	$49,415,9354

*Does not include revenue from Grace, UM-Laurel, or free standing EDs.

Consideration of Total Cost of Care Model Agreement Requirements & National Cost Figures

As described above, the staff proposal increases the resources available to hospitals to account for rising inflation, population changes, and other factors, while providing adjustments for performance under quality programs. Additionally, based on staff calculations, the proposed update falls within the financial parameters of the TCOC Model agreement requirements. The staff's considerations in regards to the TCOC Model agreement requirements are described in detail below.

Medicare Financial Test

Based on the staff's calculations, the proposed update keeps Maryland within the constraints of the TCOC Model's Medicare savings test. This test requires the Model to generate $300 million in annual Medicare fee-for-service (FFS) savings in total cost of care expenditures (Parts A and B) by 2023. The TCOC Model Medicare Savings Requirement is different from the previous All-Payer Model Medicare savings requirement in several ways. First, as previously discussed, Maryland's Total Cost of Care Model Agreement progresses to setting savings targets based on total costs of care, which includes non-hospital cost increases, as opposed to the hospital only requirements of the All-Payer Model. This shift ensures that spending increases outside of the hospital setting do not undermine the Medicare hospital savings resulting from Model implementation. Additionally, the change to total cost of care focuses hospital efforts and initiatives across the spectrum of care and creates incentives for hospitals to coordinate care and to collaborate outside of their traditional sphere for better patient care. Secondly, the All-Payer Model Savings Requirement was a *cumulative* savings test, where the savings for each year relative to the base period were added up to determine the total *hospital* savings. The TCOC Model requires that the State reach *annual* savings of $300 million relative to the national growth rate by 2023, relative to a 2013 base year. Thus, there must be sustained improved performance over time to meet the new TCOC Medicare Savings Requirements. The new TCOC Model contains specific annual Medicare Savings Requirements for each year. Based on the CY 2019 performance, staff calculates that Maryland hospitals have exceeded the TCOC Model's annual Savings Requirement of $120 million for performance year one (CY 2019), reaching approximately $335 million in savings. However, similar to the All-Payer Model, there are TCOC growth guardrails. Maryland's Medicare TCOC growth may not exceed the national Medicare TCOC growth rate in any two successive years and Maryland may not exceed the national growth rate by more than one percent in any year. Corrective actions are required if these limits are exceeded.

The growth in Medicare expenditures in Maryland outside of hospitals continues to exceed the national growth rate. Under the All-Payer Model, the HSCRC built a conservative approach to estimating variations in hospital cost growth. For the Total Cost of Care Model, HSCRC staff proposes to extend this approach to evaluating variations in Total Cost of Care performance. This revised approach will be discussed in the following section.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

In order to ensure Model savings and guardrails are being met, staff compared Medicare growth estimates to the all-payer spending limits. Because the actual revenue resulting from updates in RY 2020 affect the CY 2020 results, staff must convert the recommended RY 2021update to a calendar year growth estimate. Table 4 below shows the current revenue projections for CY 2020 to assist in estimating the impact of the recommended update factor together with the projected RY 2019 results. The overall increase from the bottom of this table is used in Table 5a.

Table 4

Estimated Position on Medicare Target		
Actual Revenue CY 2019		17,895,385,316
Adjust for MU Change 1/31/19-6/30/19		106,559,120
Adjusted Actual Revenue CY 2019		18,001,944,436
Step 1:		
Estimated Approved GBR RY 2020		18,383,120,012
Actual Revenue 7/1/19-12/31/19		9,015,458,624
Approved Revenue 1/1/20-6/30/20	A	**9,367,661,388**
Step 2:		
Estimated Approved GBR RY 2021		19,029,783,082
Permanent Update		3.52%
Step 3:		
Estimated Revenue 7/1/20-12/31/20(after 49.73% & seasonality)		9,463,511,127
Estimated Undercharge Percentage**		(101,259,569)
Projected Revenue 7/1/20-12/30/20	B	**9,362,251,557**
Step 4:		
Estimated Revenue CY 2020	**A+B**	**18,729,912,945**
Increase over CY 2019 Revenue		4.04%

Steps to explain Table 4 are described as below:
The worksheet begins with actual revenue for CY 2019. This revenue is adjusted for the impact of the "Differential Adjustment" that was made on July 1, 2019 and not included in the first six months of actual revenue from January 1, 2019 to June 30, 2019.

· Step 1: The table uses the estimated approved global budget revenue for RY 2020 and actual revenue for the last six months for CY 2019 to calculate the projected revenue for the first six months of CY 2020 (i.e. the last six months of RY 2020).

· Step 2: This step shows the estimated RY 2021 global budget revenue based on the information that staff have available to date. The permanent update over RY 2019 of 3.52 percent represents the portion of the RY 2021 update provided during the calendar year 2020, as shown in Table 2.
· Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2021 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2021 and estimated undercharge adjustment.
· Step 4: This step shows the resulting estimated revenue for CY 2020 and then calculates the increase over actual CY 2019 Revenue.

In prior year updates, Maryland obtained calendar year Medicare fee-for-service growth estimates from the CMS Office of the Actuary. The projected per capita amount for Medicare Parts A and B for CY 2020 is 4.28 percent. However, due to the variability in the estimates from actual performance, particularly with estimates beyond the current year, staff is again proposing using actual national Medicare FFS total cost of care growth from the previous calendar year moving forward in our guardrail and savings test, absent large policy changes that would suggest significantly different growth estimates. National Medicare FFS total cost of care growth for CY 2019 was 3.84 percent, shown in line A of Table 5a and 5b.

During CY 2014-CY 2019, all-payer growth outpaced Medicare growth on a per capita basis and in the updates staff adjusted the all-payer growth limit using the difference in Medicare and all-payer per capita growth to estimate the implied limit for Medicare.

For the purposes of evaluating the maximum all-payer spending growth that will allow Maryland to meet the per capita Medicare FFS target, the Medicare target must be translated to an all-payer growth limit. There are several ways to calculate the difference between Medicare FFS and all-payer growth rates using recent data trends. A consultant to CareFirst developed a “conservative difference statistic" that reflected the historical increase in Medicare per capita spending in Maryland relative to all-payer per capita spending growth. This conservative statistic has been updated each year using data provided by HSCRC. For the RY 2021 update, CareFirst and HSCRC staff calculated a difference of 0.95 percent, which used a five-year average difference between Maryland Medicare and all-payer claims reduced by the average annual absolute variance.

Maryland Medicare total cost of care cannot exceed national Medicare total cost of care growth by one percent in any single year and cannot exceed the national growth by any amount in two consecutive years; these are known as ‘total cost of care guardrails.’ In an effort to ensure that Maryland does not exceed the national Medicare growth rate in CY 2020, staff modeled the impact of excess non-hospital growth on the maximum hospital update that could be provided. This calculation assesses Medicare growth in unregulated settings and factors this excess growth into allowable hospital rate increases for RY 2021. Staff modeled non-hospital excess growth, inclusive of a conservative factor of -0.92 percent, which was calculated by taking a two year average of non-hospital excess growth and additionally accounting for the absolute average variance to provide conservatism.

In prior years the staff has included a 0.50 percent reduction in the Medicare Growth target to ensure the State achieves savings under the All-Payer Model. Again this year we have omitted that adjustment in

both tables 5a and 5b. Starting with RY 2020 this target adjustment is no longer necessary, as the Commission approved the MPA Framework in the fall of 2019. The MPA Framework provides a vehicle for achieving savings on a Medicare-only basis if needed to meet contract targets.

The first scenario, shown in Table 5a, calculates savings using the calendar year growth calculated in Table 4. The second scenario, shown in Table 5b calculates savings for the second half of the fiscal year. (January 2021 to June 2021.)

Table 5a – Using Calendar Year Growth Estimate

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare TCOC Growth (CY2019 3.84%)	A	3.84%		
Savings Goal for FY 2021	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	3.84%		
Conversion to All-Payer				
Actual statistic between Medicare and All-Payer *with conservatism*		0.95%	**Recommendation:**	**Savings:**
Excess Growth for Non-Hospital Cost Relative to the Nation *with conservatism*		-0.92%		
Net Difference Statistic Related to Total Cost of Care	D	0.03%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**3.87%**	**3.88%**	**0.00%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.16%)-1	F	**4.04%**	**4.04%**	**0.00%**

Table 5b – Using Second Half of Rate Year Growth Estimate

Maximum Increase that Can Produce Medicare Savings				
Medicare				
Medicare TCOC Growth (CY 2019 3.84%)	A	3.84%		
Savings Goal for RY 2021	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	3.84%		
Conversion to All-Payer				
Actual statistic between Medicare and All-Payer *with conservatism*		0.95%	**Recommendation:**	**Savings:**
Excess Growth for Non-Hospital Cost Relative to the Nation *with conservatism*		-0.92%		
Net Difference Statistic Related to Total Cost of Care	D	0.03%		
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**3.87%**	**3.20%**	**0.67%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.16%)-1	F	**4.04%**	**3.37%**	**0.67%**

Staff also modeled the growth and compared it to economic growth in Maryland as measured by the State Gross Domestic Product (State GDP, which was previously called the Gross State Product (GSP)). The purpose of this modeling is to ensure that healthcare remains affordable in the state. Staff calculated the compounded annual growth rate (CAGR) for three years using the most updated State GDP numbers available. (CY16-CY19). The 3-year CAGR calculation shows a per capita amount of 3.39 percent. Staff compared that number to the calendar year increase shown in Table 6 to evaluate whether the update provided in this final recommendation would maintain growth in line with economic growth. The chart below shows this comparison.

Table 6 – Using Calendar Year Growth Estimate

Maximum Increase that Maintains Affordability				
State Gross Domestic Product per Capita (3 year CAGR 3.39%)	A	3.39%	**Recommendation:**	**Savings:**
Savings Goal for FY 2021	B	0.00%		
Maximum growth rate that will achieve savings (A+B)	C	**3.39%**	**3.88%**	**-0.49%**
Conversion to total All-Payer revenue growth (1+C)*(1+0.16%)-1	D	**3.56%**	**4.04%**	**-0.49%**

While the Update Factor proposed for RY 2021 exceeds the 3-year CAGR, it should be noted that the Update Factor last year was 0.42 percent below the 3-year CAGR calculation.

Medicare's Proposed National Rate Update for FFY 2021

On May 11, 2020, CMS released its proposed rule for the change to the Inpatient Prospective Payment System's (IPPS) payment rate. The proposed increase to the Operating Rate is 3.1%. However, other adjustments to payments would lower the payment increase to 1.6%. The proposed Outpatient Prospective Payment (OPPS) payment rate is 2.5%.Combined, these two payment rates are approximately equivalent to a 1.9% increase for hospital payments, which is the analog to the HSCRC Update Factor. These increase are proposed and will not be finalize until August 2020 and will not go into effect until October 1, 2020. This also does not take into account volume changes.

Stakeholder Comments

HSCRC staff received and reviewed comments from Maryland Hospital Association (MHA), Johns Hopkins Health Systems (JHHS), University of Maryland Medical System (UMMS,) MedStar Health, Mt Washington Pediatrics Hospital, Sheppard Pratt, CareFirst and Transit Health & Welfare Fund. Stakeholders expressed concern over the following aspects of the Draft Recommendation:

- Creating an update that creates Medicare dissavings in CY 2020
- Creating an update that is unaffordable relative to Gross State Product (GSP) growth
- Creating a hard cap test for the update factor based on GSP
- Continuing the Potentially Avoidable Utilization (PAU) shared savings adjustment
- Implementing a Productivity Adjustment for Non GBR Hospitals
- Creating a clear plan to use federal relief funding in determining hospital revenues moving forward

Comment: While generally supportive of the Draft RY 2021 Update Factor recommendation, CareFirst and the Transit Health and Welfare Fund expressed concerns regarding Maryland losing ground against national Medicare, as measured by the annual total cost of care (TCOC) saving test (projected dissaving's of .34%). These stakeholders were similarly concerned that the proposed update would exceed staff's measure of affordability, namely an evaluation of projected growth relative to a three year average growth in Growth State Product (projected dissavings of .64%).

Response: Staff shares the concern about the projected dissavings in the various tests that are employed to ensure the Update Factor is reasonable and affordable. In the draft recommendation, staff tried to strike a balance between providing an update that allowed hospitals to adequately respond to cost pressures, especially as volume dissipated due to the COVID-19 pandemic, and protecting the public from large price increases in the midst of a faltering economy.

Staff believes a projected dissavings of .34% in TCOC is still in keeping with the TCOC test, as the State has had two consecutive years of savings relative to national Medicare growth and the projected dissavings does not exceed 1%. That said, staff has reviewed the various adjustments made to the update factor and the TCOC test to better ensure there are no projected Medicare dissavings. Staff conducted this review because the formulaic approach outlined in the RY 2020 Update Factor asserted that in the absence of an automatic 0.50% offset to ensure Medicare savings, which instead has been replaced by the Medicare Performance Adjustment Savings Component, staff would not put forward an all-payer update that creates dissavings to Medicare. Moreover, given the relatively low proposed rule of 1.9% for Medicare IPPS/OPPS in fiscal year 2021, staff thought it important to ensure the Update Factor did not result in Medicare TCOC dissavings.

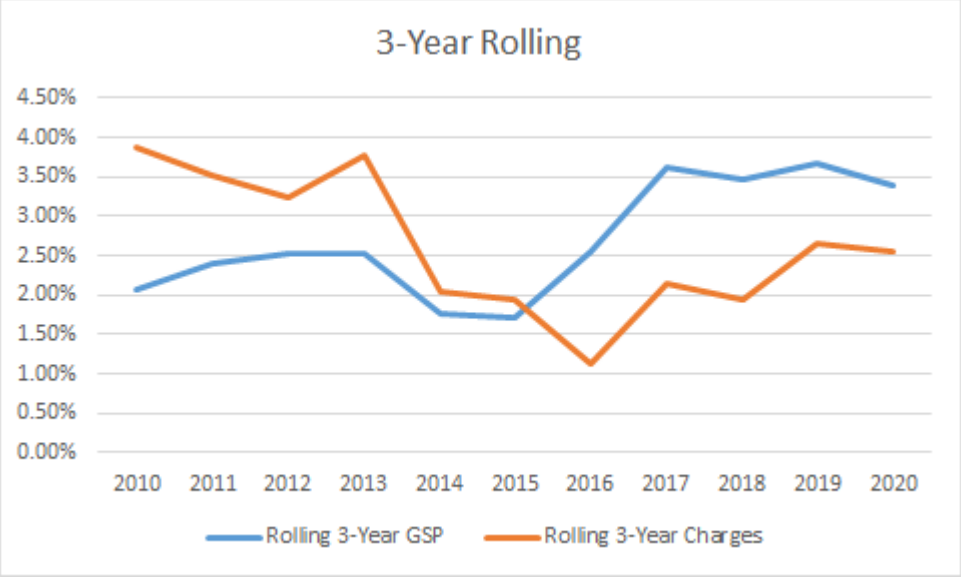
Specifically, staff proposed two changes to the Draft Update Factor Recommendation:

1) Implementing the Quality Based Reimbursement (QBR) program effective July 1, 2020 as opposed to January 1, 2020. In addition to reducing projected dissavings in CY 2020, this approach represents a methodological improvement because consumers will receive a more similar price for hospital services throughout the fiscal year. Staff believe this approach, which relies on quarterly estimates for QBR is acceptable, as the variance between estimates based on 9 months of data and the actual QBR adjustment has been minimal (at the statewide and hospital level) and will be reconciled in the January 1st mid-year rate orders, if necessary.

2) Reassessing the non-hospital excess cost calculation to exclude 2015 through 2017 from the average, because non-hospital dissavings have exhibited a much lower trend in recent years. This adjustment will have no impact to hospitals or payers but, upon further review, is more indicative of anticipated non-hospital dissavings, which have slowed in 2018 and 2019. The conservative factor in the non-hospital excess cost calculation, which is a measure of average absolute deviation, still utilizes all five years of data (2015-2017), as this statistic is more meaningful if it includes multiple variables that deviate from the average.

While the inclusion of these adjustments result in no Medicare TCOC dissavings, there are still projected dissavings relative to staff's measure of affordability, namely three year compound annual GSP growth. With these adjustments, the dissavings relative to GSP goes from .64% to .49% for CY 2020. Staff are

concerned about this outcome but note that hospital expenditure growth has been well below the 3.58% annual growth rate required in the All-Payer and Total Cost of Care contracts and hospital expenditure growth has lagged behind GSP growth in recent years, as evidenced by the table below:



Additionally, the Update Factor, recommended and approved, for FY 2020 was 0.42% below the 3 year average GSP. Given the adjustments staff has proposed and the positive performance of hospital charges relative to recent GSP growth, staff do not recommend any further modifications to the update factor recommendation.

Comment: The Maryland Hospital Association, Johns Hopkins Health System and University of Maryland Medical System all expressed concern about creating a new Gross State Product test for the Update Factor that would be binding or a "hard cap."

Response: Staff remain concerned that while the Total Cost of Care Contract and the Commission's mandate both assume that hospital rate increases maintain the affordability of care for all Marylanders, there is no policy to create an active, defined method for evaluating the affordability of hospital rates against GSP. In addition there are inconsistencies in the calculations required under the guardrail tests in the Medicare total cost of care contract and unnecessary complexities related to assessing calendar year performance with a fiscal year update. To address these concerns, staff feel it is important to convene a workgroup to discuss the various tests included in the annual Update Factor.

Comment: The Maryland Hospital Association, MedStar Health and the University of Maryland Medical Center expressed concern over the continued implementation of the Potentially Avoidable Utilization (PAU) shared savings adjustment in RY 2021. Specific arguments included that the global budgets already have the incentive to reduce PAU, PAU is included in multiple methodologies and is potentially over utilized, Maryland's overall Medicare use rate is below the national average, and it is unclear how patient utilization patterns will change, especially since "volumes have dropped significantly as a result of the COVID-19 pandemic and Potentially Avoidable Volumes have largely been eliminated." Carefirst, conversely, is in support of the PAU adjustment.

Response: Staff continues to believe the PAU adjustment is necessary to incentivize hospitals to continue to reduce avoidable utilization, and given the projected tightness of our various tests (Medicare guardrail and GSP growth), this adjustment is necessary to not backslide in Medicare and to keep healthcare affordable in Maryland. It is important to note that our comparison values for these tests are last year's figures, which will not include the unprecedented declines staff anticipates in national Medicare figures and Maryland gross state product.

Staff also recognizes that Maryland hospitals have made significant improvements in reducing potentially avoidable utilization, as evidenced by the fact that the overall Maryland Medicare use rate is below the national average, Medicare readmissions are slightly better than the national average, and on a risk adjusted basis (age and gender adjusted), Maryland in 2019 was 5% below 2016 national norms for avoidable admissions (PQIS) - this last relative statistic changes to Maryland being 13% over 2016 national norms when observation over 24 hours is included. Given the incentives of the Model, which no other hospital system in the country has to the same degree, staff believe it is important to continue to incentivize reductions in PAU that move Maryland well beyond national average performance.

Finally, staff would note that a fundamental hallmark of the All-Payer and Total Cost of Care Model is to reinforce the primary incentives of the model(s) in multiple methodologies, in this case reducing potentially avoidable utilization. PAU is included in the Demographic Adjustment as means to redistribute the availability of funding for anticipated utilization growth related to changes in the population of Maryland and it is also included in the Market Shift Adjustment methodology to ensure that hospitals receive a reward, i.e. full retention of revenue, when PAU is reduced. Adding PAU to the update factor to ensure that inflation is not provided for readmissions and avoidable admissions is yet another example of reinforcing one of the primary incentives of the Total Cost of Care Model.

Comment: Mt Washington Pediatrics Hospital and Sheppard Pratt Hospital both requested that the productivity adjustment of 0.40 percent for non-GBR hospitals be removed from the Update Factor Recommendation.

Response: The 0.40 percent productivity offset is normally applied to the estimated inflation provision to recognize productivity gains from expected volume growth. A review of each hospital’s current volumes show a large decline probably due to COVID-19. Therefore, staff has recommended to suspend this adjustment for FY 2021.

Comment: Transit Health & Welfare Fund expressed that they would like to see a clear plan to address the possibility that hospital revenue from payers and additional federal and/or state COVID-19 relief funds might exceed hospital expenses.

Response: Staff will be engaging industry over the next few months to refine the State’s response to the COVID-19 pandemic and the implications it has for our hospital industry. Specific topics will include: identifying all federal funding provided in response to COVID-19; reducing RY 2020 guaranteed income, which was not charged due to volume dissipation, by federal relief dollars dedicated to offset regulated hospital losses; calculating all capital surge expenditures and potentially creating an indemnification program for those expenses in line with the directive from the Maryland Secretary of Health, and implementing at a future date an efficiency policy that can transition hospitals to a post-COVID market.

Recommendations

Based on the currently available data and the staff's analyses to date, the HSCRC staff provides the following final recommendations for the RY 2021 update factors.

a) Provide an overall increase of 3.52 percent for revenue (inclusive of an uncompensated care increase and deficit assessment reduction), resulting in a 3.35 percent per capita revenue increase for hospitals under Global Budgets, as shown in Table 2.

b) Provide an overall increase of 2.77 percent to the rates of hospitals not under Global Budgets (freestanding psychiatric hospitals and Mt. Washington Pediatric Hospital).

c) Continue to work with all stakeholders to address specific COVID-19 issues such as anticipated hospital undercharges, the challenge of maintaining affordability in a time of economic crisis and the need to ensure sufficient ongoing health system liquidity.

d) The Total Cost of Care Contract and the Commission's mandate both assume that hospital rate increases maintain the affordability of care for all Marylanders. This responsibility has been acknowledged through a cumulative test against a static historic average Gross State Product (GSP) in the Total Cost of Care contract, and more recently through a comparison to recent GSP in the FY20 and FY21 Update Factor Recommendations and the acknowledgement of maintaining growth below GSP in the MPA Framework and Capital Policies approved by the Commission. However, none of these policies create an active, defined method for evaluating the affordability of hospital rates against GSP. In addition there are inconsistencies in the calculations required under the guardrail tests in the Medicare total cost of care contract and the Commission's approach to rate setting. To address these issues the Commission should task staff with:

    i) Developing, by December 31st 2020, in conjunction with industry, a recommendation for evaluating future update factors against GSP, over the most recent 1 to 5 years, as a proxy for affordability. The recommendation should include both (1) a methodology to determine the affordability standard and (2) policies for adjusting the update factor should the inflation provided differ from the affordability standard in future years, in order to maintain long-term affordability.

    ii) Preparing in the same time frame, in conjunction with industry, a report discussing how Maryland hospital rates relate to the premiums paid for commercial insurance as maintaining the affordability of healthcare for Marylanders also requires that hospital rates are translated into affordable premiums,

    iii) Working with CMS to assess the feasibility of converting the Medicare guard rails to a Fiscal Year basis and utilizing retrospective Medicare growth rates in Medicare tests in a way that recognizes multiple years of results.

Maryland
Hospital Association

May 21, 2020

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

Dear Chairman Kane:

On behalf of the Maryland Hospital Association's 61 member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) rate year 2021 annual payment update. Hospitals acknowledge the efforts of commission staff and the careful consideration of the payment update by the commissioners. We are proud of Maryland's unique rate-setting system and HSCRC staff's actions during this unprecedented time.

Health care affordability is an important policy consideration, but we strongly oppose setting a concrete growth limit. HSCRC should appropriately judge whether the annual revenue increase is reasonable, including comparing the projected outcome to different measures. The contract with the federal government sets an overall limit, and staff recommends a reasonable amount for the commission approval. There is no reason to set a hard threshold to adjust the annual revenue update up or down if Maryland continues to beat its contractual requirements. **The commission should reject this recommendation.**

Exclude the productivity offset for the psychiatric and specialty hospitals. Including the rate year 2021 proposal**,** the update factor for these hospitals has been reduced almost 4% since 2015. Like all health care providers, these hospitals face challenging circumstances. For rate year 2021, they should be granted full inflation.

Eliminate the potentially avoidable utilization (PAU) savings adjustment. Global budgeted revenue (GBR) targets account for all volume, even potentially avoidable utilization. Hospitals have every incentive to eliminate PAU, not only because of GBR, but because PAU is considered in several other methodologies. Maryland's overall Medicare hospital use rates are below the national rates. There is no reason to remove additional dollars from the annual revenue update.

Please see the attachment (pages 3-5, plus exhibits) for further articulation of these points.

We look forward to discussing the update at the May 28 meeting of the Payment Models Work Group and at HSCRC's public meeting June 10, as we continue to work together on behalf of the people and communities we serve.

Sincerely,

Brett McCone, Senior Vice President

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
James Elliott, M.D.
Stacia Cohen
Sam Malhotra
Katie Wunderlich, Executive Director
Jerry Schmith, Principal Deputy Director

Enclosure

A new GSP target is not required to adjust the annual payment update

All-payer, per capita hospital spending in Maryland is affordable, and hospitals support HSCRC maintaining affordability. It is not clear why HSCRC staff ask the "commission to task the staff" with setting a new gross state product (GSP) comparison measure, coupled with a concrete policy to adjust the update factor to the measure. This approach would deviate from HSCRC's longstanding approach, that provided we meet our contractual and legal requirements, HSCRC sets reasonable annual payment updates to ensure health care is affordable. Every year, hospitals, health plans, and other stakeholders work with HSCRC staff through a public process to consider all impacts before making an informed recommendation to adjust hospital revenues.

The contract defines affordability to be growth below 3.58% per year, compounded since the 2013 base period. This was the agreed target in the original All-Payer Contract and the subsequent Total Cost of Care Contract. This limit was chosen, and agreed to, because it used a long period to compute the average and the compounded nature allowed for fluctuation up or down each year. Establishing an annual target that does not allow the commissioners to judge reasonableness given the circumstances at the time is not appropriate, for several reasons.

1. **A concrete limit removes HSCRC's flexibility—one of the hallmarks of our system.** HSCRC has always considered targets when making policy. Affordability now is no different. HSCRC might use a variety of measures to determine what is affordable, including GSP, cost inflation, health insurance premiums and other factors. Most important is that staff maintains the ability to recommend what they believe to be appropriate without being tied to an absolute standard.

   HSCRC staff can recommend annual revenue updates that fall below the contractual standard. During the first six years of the model, the HSCRC approved cumulative per capita revenue growth of 21.15%, *before reductions for uncompensated care and pass throughs*, well below the allowable cumulative limit of 27.92%. Net of reductions in uncompensated care and the deficit assessment, HSCRC approved a cumulative increase of 16.63%. During the same period, actual revenue per capita grew just 14.17%. All-payer spending per capita growth is 2.46% below the approved all-payer per capita growth rate. (See Exhibit 1.)

2. **Using GSP to measure annual affordability raises data accuracy concerns.** In fact, the GSP measure in the staff recommendation is GSP per capita. The GSP data reflect Maryland's economic output, a projection from the US Bureau of Economic Analysis. This figure can fluctuate more than 2 percentage points annually. The population is from the Maryland Department of Planning, which is projected using 10-year interval census data and expected trends. Using this type of data to create an annual limit, without using a much longer calculation window or allowing for multiple years of growth, is very problematic.

3. **Maryland's hospital spending is affordable.** As we presented last year and updated this year, figures from the Health Care Cost Institute (HCCI) show Maryland's commercially insured hospital spending per capita to be among the lowest in the nation. According to HCCI, Maryland's inpatient spending per person is the 3rd lowest in the nation and Maryland's outpatient hospital spending per person is the 2nd lowest in the nation. (See Exhibit 2). When non-hospital spending is included, Maryland is 5th lowest. (See Exhibit 3.) From 2013 to 2018, Maryland's inpatient hospital spending per person grew at just above half (54%) of the national

rate and outpatient hospital spending per person grew at just above one-third (36%) of the national rate. (See Exhibit 4.)

4. **Fixing the annual revenue growth to GSP would invariably lead to a one-way door**. If GSP growth exceeded inflation and other adjustments, it is not likely HSCRC staff would recommend, nor would commissioners approve, an amount up to the standard. Other stakeholders would question the need to raise hospital prices beyond the arbitrary figure. Yet establishing a "concrete policy for adjusting the update factor" could easily be used to lower the annual revenue update down to GSP in the name of affordability. This is another reason to support multiple affordability measures and considered judgment by commissioners when deciding the update every year.

5. **Health plan premium growth should be considered, but not linked to a GSP standard.** Hospitals agree, and we've supported this position for several years. HSCRC's effort to understand the relationship between hospital spending and health plan premium growth should not hinge on setting a new GSP target. The first six years of all-payer model spending results demonstrate successful performance.

6. **A revenue update is a much tighter control than a price update.** Maryland's hospitals benefit greatly from our global budgeting and rate setting system. Maryland's hospitals adopted value-based payments and fixed global budgets to reduce potentially avoidable utilization. The global budget—an annual "fixed" amount of revenue—guarantees affordability and stability. HSCRC retaining annual judgment over the fixed amount is paramount in the system.

Health care affordability is of concern to all Marylanders. All Maryland hospitals respect, appreciate, and value this concern. There are multiple ways to measure affordability, and any standard should be considered over a long period. There is no need for HSCRC staff to create a concrete policy for adjusting the update. We may not always agree, but hospitals trust HSCRC staff to recommend and commissioners to approve reasonable revenue updates yearly and over the long term.

Exclude the productivity offset for the psychiatric and specialty hospitals

Like other Maryland hospitals, the two psychiatric hospitals, BrookLane and Sheppard Pratt, and Mt. Washington Pediatric Hospital, are facing financial challenges during the COVID pandemic. Unlike other Maryland hospitals, these hospitals are not subject to fixed revenues under global budgets. However, they will face the same cost inflation.

Historically, the annual payment update, in this case a price update, was reduced by amounts for productivity and other factors. From rate year 2015 through the rate year 2021 proposal, the psychiatric and specialty hospital update was reduced by almost 4%, or approximately 20% of the cumulative amount during that seven-year period. For rate year 2021, we ask HSCRC to forgo any productivity adjustment and give these three hospitals full inflation.

Eliminate the potentially avoidable utilization savings adjustment

No PAU savings adjustment should be taken for rate year 2021. Over the first six years of the Model, Maryland hospitals held hospital spending per capita below the targeted growth rate and substantially below the historical trend. To date, the commission removed almost 2% from hospital revenues as extra

payer savings. Health plans, other payers, and providers other than hospitals are less likely to work on measures to produce savings if their savings are guaranteed in the hospital rate setting system.

HSCRC changed its approach to PAU savings in 2020. We understand HSCRC staff's logic to remove inflation from volumes that are potentially avoidable as an incentive for hospitals to lessen avoidable utilization. Hospitals must and will continue to reduce avoidable utilization. However, Maryland's inpatient Medicare utilization per 1,000 beneficiaries is now below the national average. To achieve this good result, Maryland lowered inpatient admissions that were avoidable, beyond the definition of PAUs.

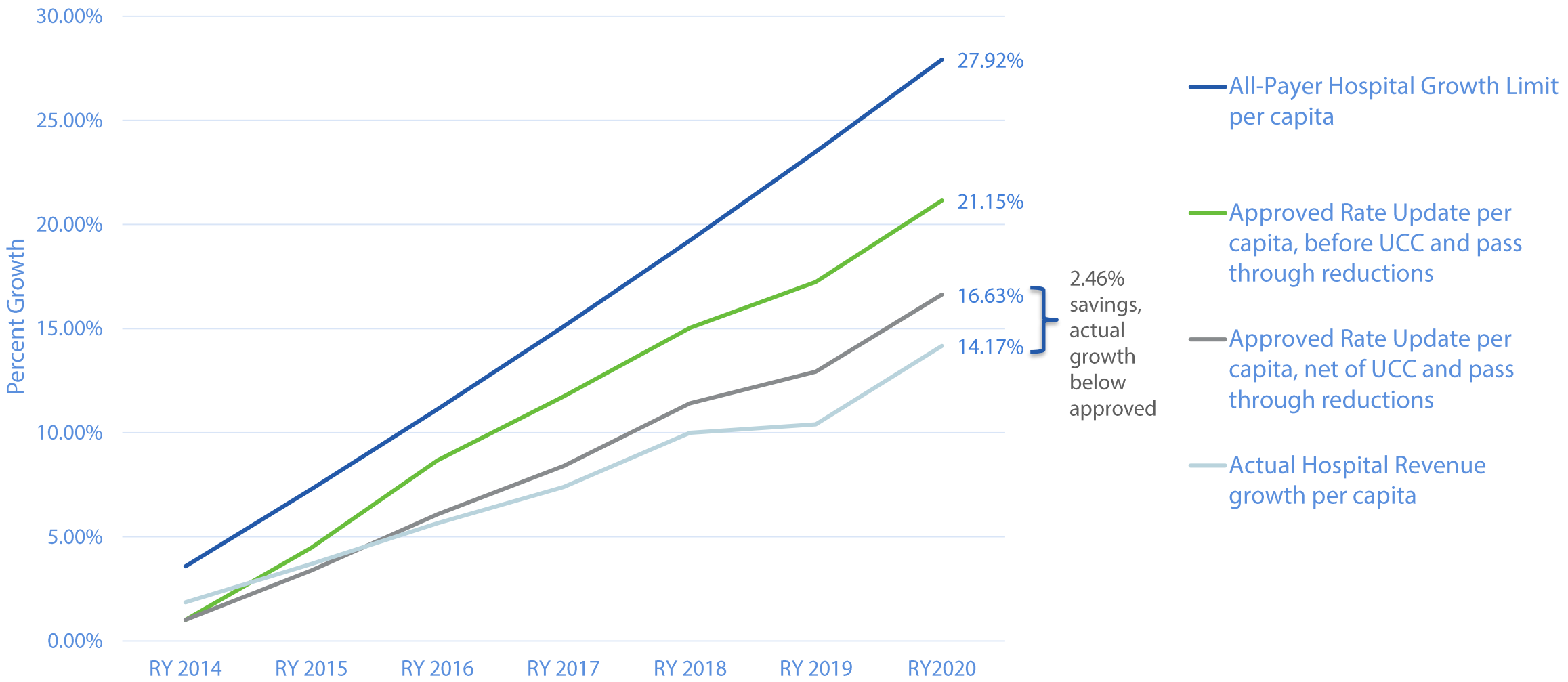
Taking an explicit reduction for PAU savings is duplicative. Incentives to reduce PAU already are woven into many HSCRC methodologies as either an explicit adjustment or a financial reward for overall improvement. Examples include:

- Reducing age-weighted use rates in the demographic adjustment to reduce PAU incentives
- Financial rewards under the Medicare Performance Adjustment (MPA) for reducing unnecessary Medicare use, including PAU; financial penalties if service use rises relative to the targeted trend
- Providing separate rewards for reducing readmissions, one of the two PAU measures, under the Readmission Reduction Incentive Program (RRIP)

In addition to the foundational reasons, the COVID-19 pandemic is changing care delivery. Hospitals expect very little PAU at the end of rate year 2020 and into rate year 2021 because overall utilization is dramatically lower. Like many HSCRC methodologies, the amount applied prospectively is based on a historical period—in this case, calendar year 2019. Because of the pandemic, hospitals and other health care providers are delivering care in radically different ways, reducing PAU. HSCRC could eliminate the adjustment with the expectation that PAU will be lower, reducing the adjustment in a future period.

EXHIBIT 1:

HSCRC APPROVED GROWTH IS BELOW THE CONTRACT LIMIT

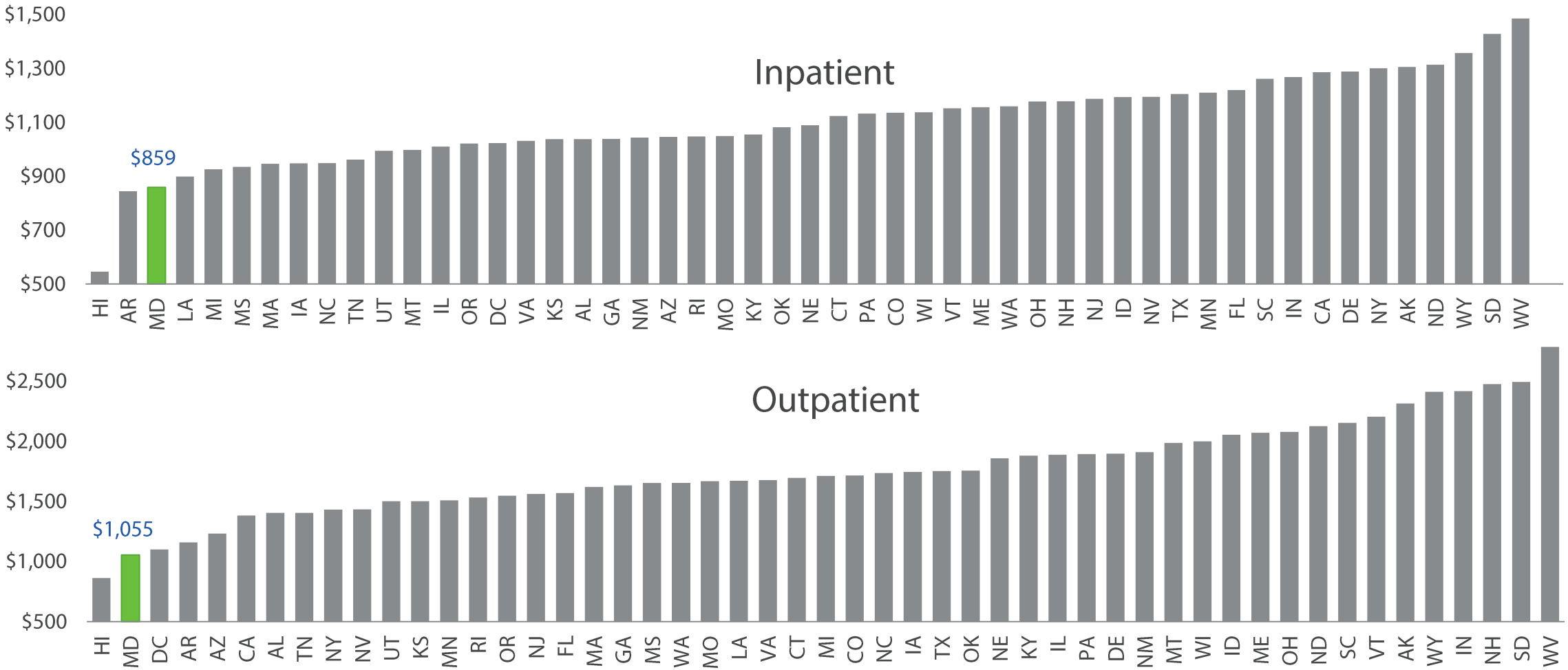


Source: The Health Care Cost Institute Health Care Cost and Utilization Report 2017 and 2018, compares per person spending across the U.S. by service categories and growth in spending between 2013-2018; the report is based on 40 million claims from Aetna, Humana, Kaiser, and United Healthcare for individuals up to age 65 with employer-sponsored coverage

EXHIBIT 2

MARYLAND SECOND, THIRD LOWEST IN THE U.S.

HOSPITAL, PER PERSON COMMERCIAL SPENDING, BY STATE, 2018



Source: The Health Care Cost Institute Health Care Cost and Utilization Report 2017 and 2018, compares per person spending across the U.S. by service categories and growth in spending between 2013–2017 and 2014-2018; the report is based on 40 million claims from Aetna, Humana, Kaiser, and United Healthcare for individuals up to age 65 with employer-sponsored coverage

EXHIBIT 3

MARYLAND AMONG THE LOWEST IN THE U.S.

TOTAL HOSPITAL AND NON-HOSPITAL, PER PERSON COMMERCIAL SPENDING, BY STATE, 2018

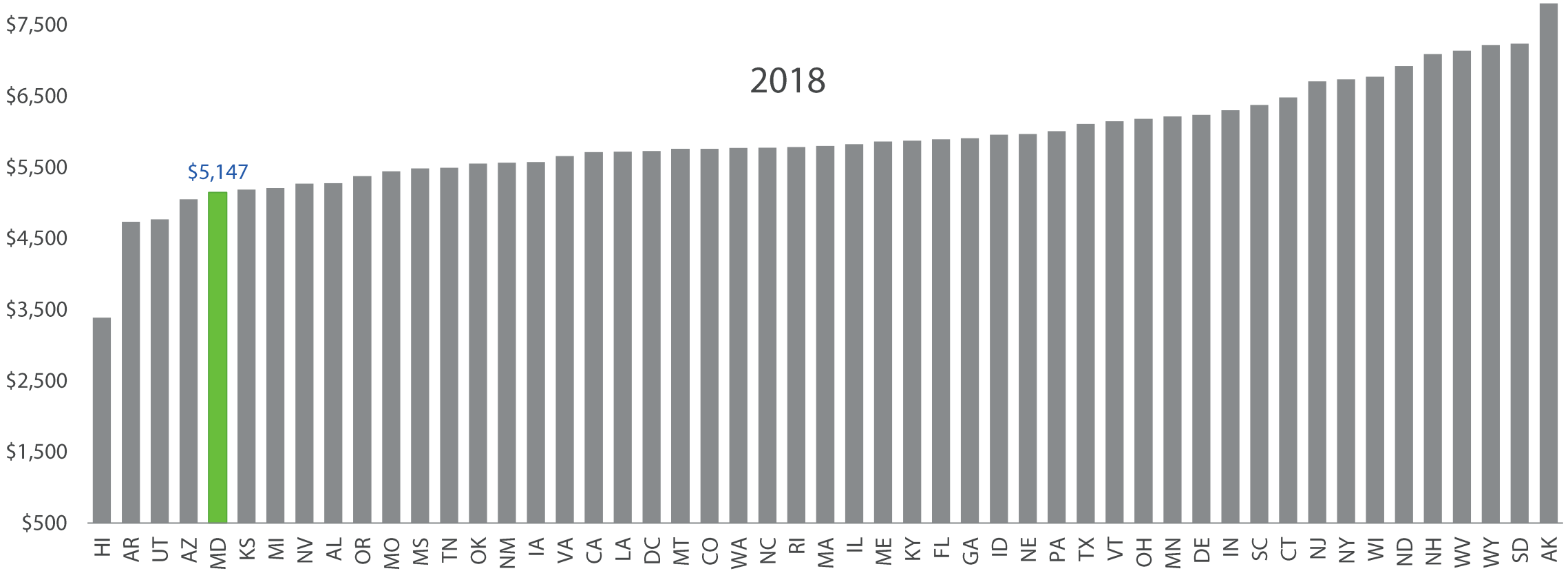


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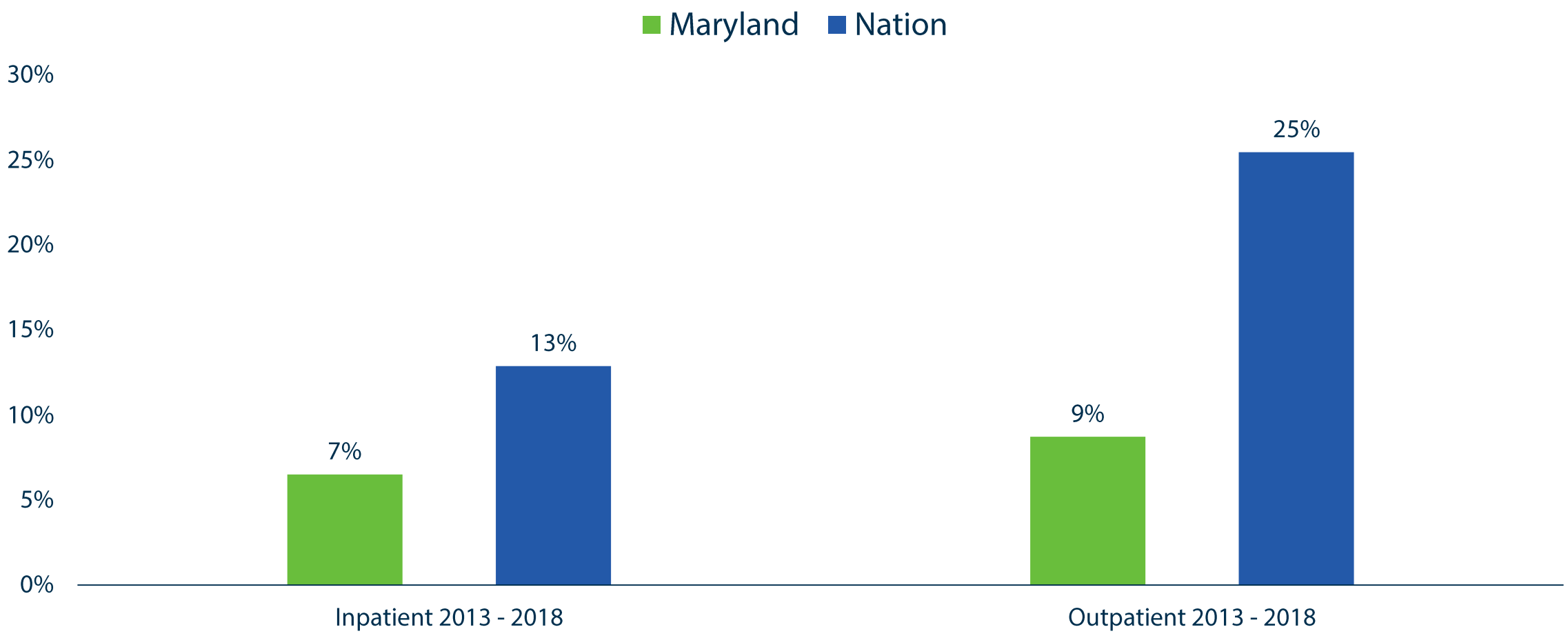
EXHIBIT 4:

MARYLAND HOSPITAL SPENDING GROWTH FAR BELOW THE NATION

HOSPITAL, PER PERSON COMMERCIAL SPENDING GROWTH



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May 21, 2020

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

Dear Mr. Kane:

Thank you for the opportunity to provide CareFirst's comments on the HSCRC Staff's "Draft Recommendation for the Update Factors for Rate Year 2021" which will be applied to hospital rates effective July 1, 2020. We recognize the HSCRC Staff's effort to take a balanced, transparent approach in reviewing the key issues involved in this year's update to hospital rates. While the potential impacts of COVID-19 remain a continuing concern, we agree with Staff's approach to leave that factor out of the update analysis, since the update is permanent and carries forward into all future years' revenue updates.

Overall, we are supportive of the Staff's recommendation; however, we have some concerns as well as additional perspectives noted below.

We are concerned that the proposed updates yield a result that both causes Maryland to lose ground against the national total cost of care (TCOC) savings test (Maryland's 4.03% per capita vs. Nation's 3.68% per capita) and fails the affordability test (Maryland projected hospital growth of 4.03% per capita vs. State Gross Domestic Product (GDP) growth of 3.39%). The affordability test relies on State Gross Domestic Product (GDP) and uses the compound annual growth rate (CAGR) from the most recent three-year period. While CareFirst recognizes that one of Staff's recommendations is to determine how best to utilize State GDP or other factors in policy moving forward, it's difficult to endorse a recommendation that fails both tests.

With that said, we recognize that much of the update factor recommendation has become formulaic and based on previously agreed upon policies. We believe this is important as it promotes predictability, transparency, and objectivity in the process. Part of the rationale for this year's more generous update is that the state flipped from a statewide negative to positive quality adjustment, which is an indication that collective performance is improving – something we should be proud of. We also recognize that the calendar year tests described above incorporate six months of activity that has already been approved and implemented. The true impact on the upcoming rate year is expected to be 3.33% per capita. If this figure were compared to the TCOC savings test (3.68% Nation) and affordability test (3.39%), it would yield savings for the state and be deemed affordable. While this calls into question what was approved last year, it's quite possibly an issue of data availability at that time, as well as using projected figures in the FY2020 update as opposed to the most recent year of Medicare Fee-For-Service (FFS) TCOC growth, which has been corrected in this FY2021 update.

Of critical importance, we support the Potentially Avoidable Utilization (PAU) adjustment, which removes inflation on PAU volume remaining in the hospital. Over the years, a significant amount of permanent Global Budgeted Revenue (GBR) rate dollars (around $1 billion since FY2014) have been attributed to care transformation and it is essential to provide a return on that investment. While the current PAU savings policy is based on 30-day readmissions and Prevention Quality Indicators (PQI) for adults, we commend the Commission's efforts to expand the scope of PAU to prevention indicators for pediatrics, and eventually potentially avoidable emergency department visits. In a model that strives to

remove avoidable utilization from the hospital setting, it is both intuitive and logical to discontinue inflation on the avoidable utilization that remains in the hospital.

We also agree with and appreciate the Staff's commitment to an affordability measure. The incorporation of a State GDP guideline for affordability into the update factor recommendation has enhanced the process and made it more complete. We recognize the need to build this into the policy thoughtfully, especially given the expected upcoming volatility in GDP with the impacts of COVID-19. We have learned that unforeseen events can impact our methodologies in ways we were not anticipating and we look forward to working with all stakeholders on achieving the existing goal of ensuring that health care cost increases are affordable to those who pay the bill at the end of the day – individuals, businesses, and communities.

We respectfully request that Staff include in their final recommendation a recap of each of the update factors since FY2014, demonstrating how these update factors have indeed been conservative. Staff often reminds industry stakeholders not to look for marginal cost savings on individual transactions that occur over the course of a year. For example, upon a hospital's deregulation of services, Staff does not prioritize the accrual of savings but allows hospitals to retain 50% of the revenue in their GBR in addition to the unregulated charges they will collect moving forward. Staff reasons that about half of the hospital's costs are variable and they need that charge capacity in order to continue their investments in population health and care transformation. Instead, Staff points to the update factor as the major healthcare cost savings mechanism in today's system. In an environment where the HSCRC sets rates for hospitals but is held accountable for total cost of care, lower update factors are the primary driver of system savings on healthcare. It would be helpful to understand what update factors since FY2014 would have been if we were in a fee-for-service (non-GBR) regulated system with a 50% variable cost factor. What has the impact of TCOC tests been on update factors? What offsets have been applied to update factors because of this system that have yielded healthcare cost savings to the public? This is an opportunity to ensure all stakeholders understand the HSCRC's approach to healthcare system savings.

Finally, we note that Staff has expressed an interest in studying the relationship between hospital costs in Maryland and commercial premiums in Maryland. This is something we have already begun to study and despite Maryland hospital costs only being a part of the equation, we are committed to leading that discussion so that there is a broader sense of understanding in the industry. We are committed to the population health and affordability goals of the TCOC model and will continue to invest our resources and efforts towards the same goals.

Thank you again for this opportunity to comment on the Draft Recommendation. We support the transparent and formulaic development of the annual update. We appreciate the efforts of the Staff to ensure savings and affordability for Maryland consumers, and we urge the Staff to place further emphasis on efficiency in upcoming years. We understand there are a lot of moving variables in the system currently as the pandemic continues. As such, we recognize and agree with the Chairman's comments at the Public Meeting on May 13, 2020, which stated that we will need to monitor closely Medicare spending nationally and how it compares to spending in Maryland.

Sincerely,

Maria Harris Tildon

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

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May 21, 2020

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

Dear Chairman Kane:

On behalf of the Johns Hopkins Health System (JHHS) and its 4 Maryland Hospitals, we are writing to comment on the Health Services Cost Review Commission's (HSCRC) Staff Recommendation on the Rate Year 2021 Annual Payment Update. We acknowledge the efforts of commission staff and the careful consideration of the payment update by the commissioners. JHHS generally supports the staff recommendation for the FY 2021 Update Factor but has concern with one particular component of the recommendation.

Health care affordability is an important policy consideration, but we strongly oppose setting a concrete growth limit**.** HSCRC should appropriately judge whether the annual revenue increase is reasonable, including comparing the projected outcome to different measures. The contract with the federal government sets an overall limit, and staff recommends a reasonable amount for commission approval. There is no reason to set a hard threshold to adjust the annual revenue update up or down if Maryland continues to meet its contractual requirements.

A new Gross State Product (GSP) target is not required to adjust the annual payment update.

All-payer, per capita hospital spending in Maryland is affordable, and JHHS supports HSCRC maintaining affordability. We do not understand the need to set a new gross state product (GSP) comparison measure, coupled with a concrete policy to adjust the update factor to the measure. This approach would deviate from HSCRC's longstanding approach that HSCRC sets reasonable annual payment updates to ensure health care is affordable.

Over the years, the HSCRC has developed a method to work with hospitals and other stakeholders through a public process to consider all impacts before making an informed recommendation to adjust hospital revenues.

The contract defines affordability to be growth below 3.58% per year, compounded since the 2013 base period. This was the agreed target in the original All-Payer Contract and the subsequent Total Cost of Care Contract. This limit was chosen, and agreed to, because it used a long period to compute the average and the compounded nature allowed for fluctuation up or down each year. Establishing an annual target that does not allow the commissioners to judge reasonableness given the circumstances at the time is not appropriate.

The HSCRC has always considered targets when making policy. Affordability now is no different. The HSCRC might use a variety of measures to determine what is affordable, including GSP, cost inflation, health insurance premiums and other factors. Most important is that staff maintains the ability to recommend what they believe to be appropriate without being tied to an absolute standard.

If GSP growth exceeded inflation and other adjustments, it is not likely HSCRC staff would recommend, nor would commissioners approve, an amount up to the standard. Other stakeholders would question the need to raise hospital prices beyond the arbitrary figure. Yet establishing a "concrete policy for adjusting the update factor" could easily be used to lower the annual revenue update down to GSP in the name of affordability. This is another reason to support multiple affordability measures and commissioner judgement when deciding the update every year.

Health care affordability is of concern to all Marylanders. JHHS respects, appreciates, and values this concern. There are multiple ways to measure affordability, and any standard should be considered over a longer period. There is no need for HSCRC staff to create a concrete policy for adjusting the update using GSP.

We thank you for this opportunity to provide our comments on this very important matter.

Sincerely,

Ed Beranek

Ed Beranek
Vice President, Revenue Management and Reimbursement
Johns Hopkins Health System

cc: Katie Wunderlich, Executive Director
Jerry Schmith, Principal Deputy Director

MedStar Health

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medstarhealth.org

Susan K. Nelson
Executive Vice President and
Chief Financial Officer

May 22, 2020

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

Dear Katie:

On behalf of MedStar Health System and our Maryland Hospitals, I am writing to comment on the Staff's Draft Recommendation for Rate Year 2021.

We are all in the midst of the most significant public health crisis of our lifetimes. These are truly unprecedented times and the disruption and future uncertainties are more significant as a result. Undoubtedly, innovation and transformation will emerge out of the COVID-19 pandemic and will have lasting impact on health care long into the future. However, in fiscal year 2021 the challenges associated with COVID-19 will continue and health care providers will be focused on caring for patients with COVID-19, caring for patients whose care was delayed during the crisis and transitioning to the "New Normal" as it takes shape out of the pandemic disruption. Significant operational and financial challenges will carryover into rate year 2021 as we work our way through the crisis and learn to return to "normal" operations while COVID-19 is still prevalent. Supply shortages, clinical staff shortages, testing needs, space constraints as new safety measures are put in place, and preparations for a potential second surge are all examples of continuing challenges that come with a financial burden. More than ever, we need an update factor for rate year 2021 that is both fully reflective of inflation and population growth.

We appreciate the HSCRC staff's support during this difficult crisis. We agree with the HSCRC staff recommendation with one important adjustment. We recommend removing the Shared Savings/Potentially Avoidable Utilization Adjustment for the Rate Year 2021 update factor. Volumes have dropped significantly as a result of the COVID-19 pandemic and any Potentially Avoidable Volumes have been largely eliminated. It is unclear how patient utilization patterns and health care provider delivery approaches will be impacted in the future. Suspending the PAU reduction to the update factor in Rate Year 2021 will allow time for data collection on new utilization patterns and will provide support for health care providers during this period of significant uncertainty. The information from Rate Year 2021 can then be used to understand the best approach moving forward.

We would like to thank the HSCRC and staff for their engagement and support of hospitals during this unprecedented time. We appreciate the opportunity to comment and look forward to the continued partnership.

Sincerely,

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

cc: Adam Kane, Esq. Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
James Elliott, M.D.
Stacia Cohen, RN, MBA
Sam Malhotra
Kathy Talbot, VP Rates & Reimbursement, MedStar Health

Mt. Washington Pediatric Hospital
Where Children Go to Heal and Grow

An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

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

May 21, 2020

Mr. Kane,

We would like to take the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) rate year 2021 annual payment update recommendation for Mt. Washington Pediatric Hospital. The COVID-19 pandemic has significantly decreased both volumes and revenue, with the downturn expected to continue into FY 2021. Unlike the GBR hospitals, MWPH does not have the flexibility to recoup this lost revenue next year.

MWPH occupies a unique niche in the Maryland healthcare continuum. As a lower-cost post-acute provider, the hospital helps reduce overall expense by treating medically-appropriate patients who transfer from a NICU or PICU. For this reason, it was exempted from the GBR system.

Volume declines in FY2020 have essentially erased the last several years of modest volume growth. Recent events have impacted hospitals across Maryland including MWPH. With the advent of the COVID-19 pandemic, inpatient admissions and average daily census have decreased 6%, outpatient visits have decreased by 25%, and revenue is projected to decrease by 13%. Rehabilitation admissions have seen the largest decrease, from an average of six per month to just one in April. The reduction in non-emergency surgeries and, presumably, a decrease in trauma due to stay-at-home orders have reduced the demand for pediatric rehabilitation. These conditions are likely to remain in place well into FY 2021.

For FY 2021, volume is not likely to rebound and MWPH faces significant financial challenges. We expect this volume decrease to continue into FY 2021, as families with vulnerable children may be particularly hesitant to venture out for medical care. Additionally, as families become used to the convenience of remote care, more service will transition to non-regulated telehealth, further reducing MWPH's revenue. It will be crucial for MWPH to preserve its ability to serve patients whose insurance will not cover telehealth, or whose conditions preclude remote services.

MWPH does not have the protection that the GBR hospitals have. As a non-GBR hospital, MWPH does not have the ability to recoup FY20 undercharges in FY21. As such, the hospital is not likely to recover lost revenues in FY 2021. The rate of hospitalization for children with COVID-19 is much lower than that for adults, and is therefore not likely to lead to a "surge" of patients needing services. Although the hospital has benefited financially from keeping the revenue from 100% of its volume variance in prior years, its growth has been modest and related to the needs of transferring hospitals to move patients to a lower level of care. It cannot strategically grow volume in the way that an acute care hospital can.

Mt. Washington Pediatric Hospital

Where Children Go to Heal and Grow

An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

Mt. Washington serves a unique patient population.
Admissions to Mt. Washington reduce overall hospital costs in Maryland, as patients are moving from more expensive acute care to a less expensive post-acute setting. In addition to reducing the cost per day of care, transferring patients to MWPH opens NICU and PICU beds for the infants and children who need them.

Although its rate structure is linked to the state's psychiatric hospitals, Mt. Washington is different. MWPH has almost no patients that are covered by Medicare. Over the past three years, annual Medicare revenue averaged just $87,000 per year.

While the productivity adjustment serves as an incentive to move services to the most appropriate and efficient care setting, Mt. Washington IS that setting for the medically complex children it admits. The hospital's work is already overseen by insurers, who typically review inpatient cases weekly or bi-weekly to assure that inpatient stays do not last longer than is medically necessary. The 0.4% productivity adjustment would not serve to limit length of stay or readmissions. Instead, it would only limit the number of patients MWPH could serve, leaving the state to pay higher costs in acute care settings.

For these reasons, MWPH requests that it receive the full 2.77% rate increase, without a productivity adjustment.

Thank you for your consideration.

Sincerely,

Mary Miller

Mary Miller, CFO

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
James Elliott, M.D.
Bob Atlas, President and CEO, MHA
Alicia Cunningham, Sr. VP, UMMS
Stacia Cohen
Sam Malhotra
Katie Wunderlich, Executive Director
Jerry Schmith, Principal Deputy Director
Sheldon Stein, CEO, MWPH

Sheppard Pratt

Harsh K. Trivedi, M.D., M.B.A.
President & Chief Executive Officer

May 21, 2020

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

Dear Ms. Wunderlich:

In its draft recommendation for the proposed update factor for RY2021, the HSCRC staff has recommended an update factor for the Global Budget Revenue (GBR) hospitals along with a different, lower update factor for the non-GBR hospitals in the State. For RY 2021, HSCRC staff is proposing an update of 3.33 percent per capita for global revenues and an update of 2.37 percent for non-global revenues. This letter, written on behalf of Sheppard Pratt, requests that the HSCRC provide an update factor to the non-Global Budget Hospitals of 2.77% to cover full inflation as measured by the market basket.

As the staff recommendation notes, hospitals under Global Budget Revenues are under the HSCRC's full rate-setting authority, and the Commission sets rates for all payers. For specialty hospitals not covered under the waiver, the HSCRC sets the rates paid by non-governmental payers and purchasers. Where CMS has not waived Medicare's rate-setting authority to Maryland, Medicare does not pay based on those rates. Hospitals falling in this category include freestanding psychiatric hospitals and Mount Washington Pediatric Hospital.

In the staff recommendation for the non-GBR hospital update factor, the HSCRC staff proposes applying the FFY 2021 Inpatient Psychiatric Facilities Medicare productivity reduction of 0.40 percentage points to the inflation adjustment. When subtracting this productivity adjustment from the gross blended inflation adjustment of 2.77 percent growth results in a proposed update of 2.37 percent. The proposal is summarized in Table 1 below, from the staff proposal.

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Table 1

	Global Revenues	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	2.77%	2.77%
Productivity Adjustment		-0.40%
Proposed Update	2.77%	2.37%

The Commission began providing lower update factors to the non-waiver hospitals with the FY2013 update factor. At that time, the Commission decided to reduce the update factor with a productivity adjustment of 0.5 percentage points below the market basket of 2.59%, leaving an update of 2.09%. While there was no stated justification beyond the imposition of a productivity factor, the apparent implication was that the non-waiver hospitals were not constrained by the terms of the waiver and in later years by the incentives of the Global Budget Revenue model. Continuing in a fee-for-service environment was an apparent justification for a productivity adjustment.

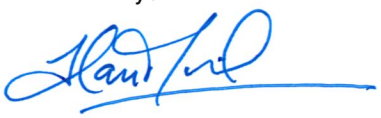
These negative adjustments have continued since the FY2013 rate year, and the cumulative effect of these diminished updates are substantial. From FY2013 through FY2020, the cumulative effect of these reductions is 5.7% of the revenue base, based on the quantity of services provided in FY2013 as the base year. The productivity factor is put into place with the presumption that providers will drive volume growth to improve margins. However, Sheppard Pratt's inpatient volumes have been steady since FY2013 and Sheppard Pratt has shifted care to lower level settings where appropriate. This has occurred while our hospital has supported the acute care hospital system in Maryland with behavioral health services that are critical services in supporting population health improvement activities.

According to HSCRC's Disclosure Reports, gross patient revenue for all acute hospitals increases increased by 14.6% from FY2013 through FY2019. For the same time period, gross patient revenue for Sheppard Pratt increased 15.9%. While our revenue growth has slightly exceeded that of the acute care hospitals, that similar rate of growth has come without the protection of global budgets from decreased revenue when we engage in population health improvement activities that have the potential to reduce volume.

Finally, the FFY2021 CMS Preliminary Rule for Inpatient Psychiatric Facilities (IPF) proposes a market basket factor based on the 2016-based IPF market basket of 3.0 percent less the economy-wide productivity factor of 0.4 percentage points as required by law. This yields a proposed federal IPF update of 2.6 percent. The HSCRC staff proposal mixes the IPF productivity adjustment with a lower acute care hospital update factor of 2.77%. This suggests that the logic of the productivity factor as applied in the context of Maryland rate-setting is misapplied, and each additional year that this adjustment is applied compounds the problem.

We respectfully request that the Commission provide the non-GBR hospitals an update factor at the full market basket without the proposed productivity adjustment. We appreciate your consideration of our request. Please contact me if you have any questions.

Sincerely,



Harsh K. Trivedi, MD, MBA
President & Chief Executive Officer

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Adam Kane, Esq., Chairman
Health Services Cost Review Commission
4160 Patterson Ave.
Baltimore, MD 21215

May 21, 2020

Dear Chairman Kane:

Thank you for allowing me this opportunity to offer comments on the draft update factor recommendation. I am the Executive Director of the Transit Employees Health & Welfare Fund and the newly formed Transit Employees Retiree Health Plan. The funds are governed by boards of trustees representing the management of the Washington Metropolitan Area Transit Authority and ATU Local 689. I represent those who provide a significant percentage of the money that goes to the hospitals and physicians in this state: the employees who sacrifice wages for benefits and who pay at the point of service, and the employers who routinely see the cost of health care rising faster than any other cost of doing business. This is a voice that is not represented on the commission and is barely represented in the relevant work groups.

These are perilous times and not just for the hospital industry and the fearless employees who must keep themselves and the public safe and healthy. These are also perilous times for the hundreds of thousands of Marylanders who have lost their jobs, and sadly, with those jobs, their health insurance. These are perilous times for the many businesses, including some physician practices, that face bankruptcy or extinction. This is not the time to quibble over a few basis points in an update factor. For that reason, I do not oppose the recommendation in the staff report for rate year 2021.

Nevertheless, I do want to raise some points of concern.

First, I would hope that his year's disregard of the Medicare cost savings target and the affordability tests will be an anomaly and a concession to the current unusual economic circumstances because of the COVID-19 pandemic. I am particularly concerned by a presumption that since we have already hit our Medicare savings target for 2023 there is little

pressure to continue saving. Imagine a private enterprise that hits its five-year revenue target in the second year and decided it did not need to grow anymore.

Second, I would like to see a clear plan that anticipates the possibility that the combination of hospital revenue from payers and additional federal and/or state COVID-19 relief funds might exceed hospital expenses. If so, how will that additional revenue flow back to private payers?

Sincerely,

James L. McGee, CEBS
Executive Director

JLM/jm

UNIVERSITY of MARYLAND MEDICAL SYSTEM

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Corporate Finance

May 22, 2020

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

RE: Rate Year 2021 Draft Update Factor Staff Recommendation

Dear Chairman Kane:

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, we are submitting comments in response to the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Update Factors for Rate Year 2021. We appreciate the time spent by Commission Staff in developing and vetting this proposal with the industry. We support the staff's proposal to fund full market basket inflation, as it is a necessary component to ensure that hospitals remain financially sound. Additionally, we appreciate the Commission and Staff support in developing and approving an Innovation Policy. We do, however, have concerns regarding specific adjustments proposed in the Staff Recommendation and offer our support of the issues outlined in MHA's comment letter.

Additional GSP comparison measure is not needed

We agree with the points raised by MHA on this topic. The agreement with CMMI outlies clear guidelines for success under the new model and the current parameters of the model have generated lower rates of growth for healthcare services benefiting all payers. The contract defines affordability to be growth below 3.58% per year. The limit was chosen, and agreed to, because it used a long period to compute the average and the compounded nature allowed for fluctuation up or down each year. There are multiple ways to measure affordability, and any standard should be considered over a longer period. There is no need for HSCRC staff to create a concrete policy for adjusting the update using GSP and establishing an annual target that does not allow the commissioners to judge reasonableness given the circumstances at the time is not appropriate.

UMMS supports the Staff's recommendation to evaluate how Maryland hospital rates relate to premiums paid for commercial insurance. This is an important step in maintaining healthcare affordability. We view this work as separate and distinct, and not related to a GSP annual target.

PAU Savings adjustment should be eliminated

UMMS supports the MHA's position of removing the PAU adjustment in the annual rate update. UMMS hospitals have demonstrated a marked decline in the volume of PAU cases over the term of the new model. Nearly all of the HSCRC financial methodologies already provide limits or reductions for PAU volume. When compounded, not only are hospitals not funded for incremental PAU cases, but we are actually paying a penalty for having them at all. We would remind the staff and commissioners that not all PAU is truly avoidable, and while opportunities exist within hospitals to further reduce PAU, our facilities cannot continue these significant efforts without a funding source. Since multiple incentives already exist within other policies to limit the amount of PAU, and given that hospitals have demonstrated significant efforts in reducing this volume, we feel that yet another reduction for PAU savings is unwarranted.

Eliminate the productivity offset for specialty hospitals.
Including the rate year 2021 proposal**,** the update factor for these hospitals has been reduced almost 4% since 2015. Like all health care providers, these hospitals face challenging circumstances. For rate year 2021, full inflation should be granted.

Thank you for the opportunity to provide our comments on this very important matter.

Sincerely,

Alicia Cunningham

Alicia Cunningham
Senior Vice President, Corporate Finance & Revenue Advisory Services

cc: Katie Wunderlich, Executive Director
Jerry Schmith, Principal Deputy Director
Mohan Suntha, MD, UMMS CEO
Michelle Lee, UMMS CFO

Final Recommendation:
Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 2021 Funding to Support HIE Operations, CRISP Reporting Services and the ICN Project

May 13, 2020

Health Services Cost Review Commission

4160 Patterson Avenue
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This is a final recommendation for Commission consideration at the June 13, 2020 Commission Meeting.

Table of Contents

LIST OF ABBREVIATIONS

BRFA	Budget Reconciliation and Financing Act
CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for Our Patients
CRP	Care Redesign Program
CRS	CRISP Reporting Services
FY	Fiscal year
HIE	Health information exchange
HITECH	Health Information Technology for Economic and Clinical Health Act
HSCRC	Health Services Cost Review Commission
IAPD	Implementation Advanced Planning Document
ICN	Integrated Care Network
MDH	Maryland Department of Health
MHCC	Maryland Health Care Commission
MHIP	Maryland Health Insurance Plan
MMIS	Medicaid Management Information Systems
PDMP	Prescription Drug Monitoring Program

OVERVIEW AND RECOMMENDATION

In accordance with its statutory authority to approve alternative methods of rate determination consistent with the Total Cost of Care Model and the public interest,[1] this final recommendation identifies the following amounts of State funding support for fiscal year (FY) 2021 to the Chesapeake Regional Information System for our Patients (CRISP):

- Health Information Exchange (HIE) operations ($1,500,000)
- Implementation Advanced Planning Document (IAPD) matching funds ($1,000,000)
- Integrated Care Network (ICN) Program Support ($1,110,000)
- Medicaid Management Information System (MMIS) matching funds ($1,560,000)

Therefore the recommendation is that the HSCRC provide total funding of $5,170,000 to CRISP. This reflects a decrease of $220,000 from FY 2020 funding of $5,390,000.

This funding represents approximately 24 percent of CRISP's Maryland funding, excluding the Prescription Drug Monitoring Program which has its own funding source. The remainder of CRISP's Maryland funding is from user fees and Federal matching funds. This equivalent value was 23 percent in the prior year. The HSCRC assessment request is 14 percent of total CRISP funding for FY 2021, when funding from other states is included.

While this assessment declined slightly, overall CRISP activities will continue to expand because ongoing operating costs for HIE services continue the planned shift to user fees resulting in an overall increase in CRISP operating capacity. CRISP, in partnership with Medicaid, also continues to leverage federal funding through IAPD and MMIS matching grants.

However, the HITECH IAPD funding used to drive much of the CRISP project development is terminating September 30, 2021. Sustainable operations funding for these activities is available through the Federal MMIS program with an increase in State matching from 10 percent to 25 percent. As a result, the total funds requested for matching has increased for FY 2021 and is likely to continue to increase in FY 2022.

In recognition of this future funding change, CRISP is focusing FY 2021 on achieving operational efficiencies with a goal of maximizing current investments.

[1] MD. CODE ANN., Health-Gen §19-219(c).

BACKGROUND – PAST FUNDING

Over the past nine years, the Commission has approved funding to support the general operations of the CRISP HIE and reporting services through hospital rates as shown in Table 1.

Table 1. HSCRC Funding for CRISP HIE and Reporting Services, FYs 2010-2019

CRISP Budget: HSCRC Funds Received	
FY 2010	$4,650,000
FY 2011	No funds received
FY 2012	$2,869,967
FY 2013	$1,313,755
FY 2014	$1,166,278
FY 2015	$1,650,000
FY 2016	$3,250,000
FY 2017	$2,360,000
FY 2018	$2,360,000
FY 2019	$2,500,000
FY 2020	$5,390,000

In December 2013, the Commission authorized staff to provide continued funding support for CRISP for FYs 2015 through 2019 without further Commission approval as long as the amount does not exceed $2.5 million in any year. Since FY 2020, when Maryland Health Insurance Plan (MHIP) funding terminated, requests have exceed that amount and require Commission approval.

FY 2020 FUNDING THROUGH HOSPITAL RATES

Beginning in FY 2020, when MHIP funding was no longer available, HSCRC assumed full responsibility for managing the CRISP assessment where it was previously shared with MHCC. CRISP-related hospital rate assessments are paid into an HSCRC fund, and the HSCRC reviews the invoices for approval of appropriate payments to CRISP. This process, which includes bi-weekly update meetings, monthly written reports, and auditing of the expenditures, has created transparency and accountability. The remaining section details the infrastructure and support that will be funded in FY 2021 through the hospital rate setting system.

HIE Operations Funding

The value of an HIE rests in the premise that more efficient and effective access to health information will improve care delivery while reducing administrative health care costs. The General Assembly charged the MHCC and HSCRC with the designation of a statewide HIE.[2] In the summer of 2009, MHCC conducted a competitive selection process which resulted in awarding state designation to CRISP, and HSCRC approved up to $10 million in startup funding over a four-year period through Maryland's unique all-payer hospital rate setting system. CRISP maintained designation through multiple renewal processes, with the most recent occurring in 2019. HSCRC's annual funding for CRISP is illustrated in Table 1 above.

The use of HIEs is a key component of health care transformation, enabling clinical data sharing among appropriately authorized and authenticated users. The ability to exchange health information electronically in a standardized format is critical to improving health care quality and safety.

Many states, along with federal policy makers, look to Maryland as a leader in HIE implementation. CRISP continues to build the infrastructure necessary to support existing and future use cases and to assist HSCRC in administering per-capita and population-based payment structures under the Total Cost of Care Model. A return on the State's investment is demonstrated through implementation of a robust technical platform that supports innovative use cases to improve care delivery, increase efficiencies in health care, and reduce health care costs.

The total amount of funding recommended by staff for FY 2021 for the HIE function is $1,500,000.

Implementation Advanced Planning Document (IAPD) Matching Funds

In addition to its role in HIE among providers, CRISP is also involved in health care transformation activities related to HSCRC, MHCC, and the Maryland Department of Health (MDH). In its collaboration with the Medicaid program, uniform and broad-based funding through hospital rates can also be used to leverage federal financial participation under the Health Information Technology for Economic and Clinical Health (HITECH) Act, known as IAPD funding. Under the HITECH Act, the Centers for Medicare & Medicaid Services (CMS) may approve states for Medicaid Electronic Health Record Incentive Program funding, and states receive a 90 percent federal financial participation match for expanding HIE through September, 2021. This request will enable CRISP (working with MDH) to obtain federal funding. IAPD funding allows CRISP (working with MDH) to qualify for funding to implement use cases that complement ICN activities.

[2] MD. CODE ANN., Health-Gen §19-143(a).

In FY 2021, the State's match of $1.0 million will leverage $9.0 million in federal funds for a variety of initiatives. Activities enabled through IAPD that enhance the point of care delivery include encounter notification services, practice-level advanced-implementation support, ambulatory integration, hospital integration, and image exchange. Common infrastructure activities include data routing and consent management, technical infrastructure and operations expense, and data architecture. Finally, there are a number of public health reporting initiatives as well, including public health use case management, electronic lab reporting, MDH interface development and validation, and CMS Clinical Quality Measures reporting.

The total amount of funding recommended by staff to obtain IAPD matching funds for FY 2021 is $1,000,000. As discussed above, this funding source will end after FY 2021 and CRISP anticipates moving this funding to the MMIS grant described below.

ICN Project Support

The ICN initiatives were designed to reduce health care expenditures and improve outcomes for unmanaged high-needs Medicare patients and patients dually eligible for Medicaid and Medicare, consistent with the goals of Maryland's All-Payer Model. The ICN initiative encourages collaboration between and among providers, provides a platform for provider and patient engagement, and allows for confidential sharing of information among providers. To succeed under the new Total Cost of Care Model, providers will need a variety of tools to manage high-needs and complex patients that CRISP is currently working to develop and deploy.

The initial intent was to transition funding for the administration of ICN projects to user fees, a process that began in FY 2019. Operating the core HIE infrastructure built as a result of the ICN project will transition as planned. However, based on broad program participation, including non-hospital providers, and the ability to secure federal match funds, program administration will be funded through a combination of assessments and federal matching funds. This recommendation covers three components that are not currently funded by user fees: (1) funding of operations for ICN-related HIE services remaining to transition to user fee funding, (2) funding for enhancements to current administrative processes, and (3) funding for ICN-related reporting that is broadly supporting transformation under the Total Cost of Care Model. The existing programs recommended for funding are:

- Point of care tools for providers and care managers. Funding for these tools is scheduled to transfer to 100 percent CRISP user fee funding by FY 2022.
- Program Administration and ICN-related reporting for initiatives related to care redesign under the Total Cost of Care Model.

The enhancements recommended for funding include developing and implementing streamlined administrative procedures and support for enhanced knowledge sharing tools in support of existing and future care redesign programs.

Starting in FY 2021 CRISP intends to offer hospitals a discount on user fees in return for meeting defined standards for submission of data to CRISP. CRISP and HSCRC believe full

hospital compliance with these requirements drives significant value to the healthcare system. This FY 2021 proposal anticipates some user fee collection reductions as a result of this program.

If CRISP is unable to meet compliance goals through fee reduction incentives in FY 2021, staff recommend that, in the future, the Commission consider assessing non-compliance penalties under the Commission's regulatory authority because even limited non-compliance erodes the value of the data collected and the investment made by the rest of the system.

Last year's request included transitional funding for the period prior to anticipated MMIS matching funds on October 1, 2019. The MMIS funds were approved as expected, at which point eligible reporting was funded under the MMIS section of this recommendation.

The total amount of funding recommended by staff for FY 2021 for ICN Project Support is $1,110,000. Approximately $300,000 of the funding is for remaining activities already scheduled to transition to user fee funding in future fiscal years.

Medicaid Management Information Systems (MMIS) Matching Funds

A major component of the ICN project is the reporting provided by CRISP to hospitals, the HSCRC and other system stakeholders from both Medicare and All-Payer sources. In FY 2020 CRISP transitioned funding for this reporting, previously funded by MHIP dollars, to matching grants under the Federal MMIS program. MMIS is a Federal program designed to promote effective care for Medicaid beneficiaries through investments in information technology infrastructure. Medicaid benefits from CRISP's reporting initiatives through the care management and cost control initiatives facilitated for all Medicaid patients under CRISP all-payer reporting and for dual-eligible patients under CRISP's Medicare reporting.

Reporting funded under this element of the assessment includes CRISP reporting tools utilizing the Medicare claims and the HSCRC's hospital Casemix data set. CRISP reporting from these datasets are used by hospitals, the HSCRC and other stakeholders to manage and track progress under a number of HSCRC programs and enable hospitals to identify and pursue care efficiency initiatives.

In FY 2020 CRISP was able to transition funding to the MMIS grant faster than anticipated in the FY 2020 assessment request. In addition, the implementation of certain reporting initiatives was delayed as a result of the COVID crisis and other program changes. As a result of these two factors, there was a balance remaining from the FY 2020 funding, which will be retained by the HSCRC and disbursed to CRISP as relevant projects are completed.

Under MMIS, state funds are eligible for either a 90 percent match for new reporting initiatives or a 75 percent match for ongoing reporting. The assessment funding will provide the State's portion of this match. Approximately $640,000 relates to maintaining existing reporting infrastructure and is therefore eligible for a 75 percent match. Approximately $170,000, relates to new reporting initiatives, which are eligible for a 90 percent match. In addition, as HITECH

IAPD funds are matched at the higher rate, as projects shift from IAPD to MMIS, additional funding is required from the state. Therefore, approximately $750,000 is required to maintain the core HIE infrastructure upon which the reporting relies, such as the master person index.

The total amount of funding recommended by staff for FY 2020 for to obtain Federal MMIS matching funds is $1,560,000.

RECOMMENDATION

Staff is recommending the Commission approve a total of $5,170,000 in funding through hospital rates in FY 2021 to support the HIE and IAPD initiative activities and continue the investments made in the ICN initiatives through both direct funding and obtaining Federal MMIS matching funds.

Table 2 shows the recommended funding through hospital rates and the federal match that will be generated from the IAPD and MMIS funding as well as the user fee funding.

Table 2. FY 2021 Recommended Rate Support for CRISP as a share of total non-PDMP related Maryland Funding

FY 2021 Project Name	Hospital Rates	Federal Budgeted Funding	User Fees	Total
HIE Operations	$1,500,000	$0	$4,380,000	$5,880,000
IAPD Match	$1,000,000	$9,000,000	$0	$10,000,000
ICN Project Support	$1,110,000	$0	$0	$1,110,000
MMIS Match	$1,560,000*	$3,204,000**	$0	$4,764,000
Total Funding	**$5,170,000**	**$12,204,000**	**$4,380,000**	**$21,754,000**
% of Total	**24%**	**56%**	**20%**	**100%**

*Includes match funds for population health reporting and non-reporting operations

**Only includes MMIS operations funding related to population health reporting

Final Recommendations on Continued Financial Support for the Maryland Patient Safety Center for FY 2021

June 10, 2020

Health Services Cost Review Commission
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This is a final staff recommendation for consideration and vote at the June 10, 2020 public Commission meeting.

Table of Contents

LIST OF ABREVIATIONS

Delmarva	Delmarva Foundation for Medical Care
FY	Fiscal Year
HQI	Hospital Quality Initiative
HSCRC	Health Services Cost Review Commission
LTC	Long Term Care
MAPSO	Mid-Atlantic Patient Safety Organization
MDH	Maryland Department of Health
MHA	Maryland Hospital Association
MHCC	Maryland Health Care Commission
MPSC	Maryland Patient Safety Center
NAS	Neonatal Abstinence Syndrome
OHCQ	Office of Health Care Quality
RFP	Request for Proposals
TCOC	Total Cost of Care

INTRODUCTION

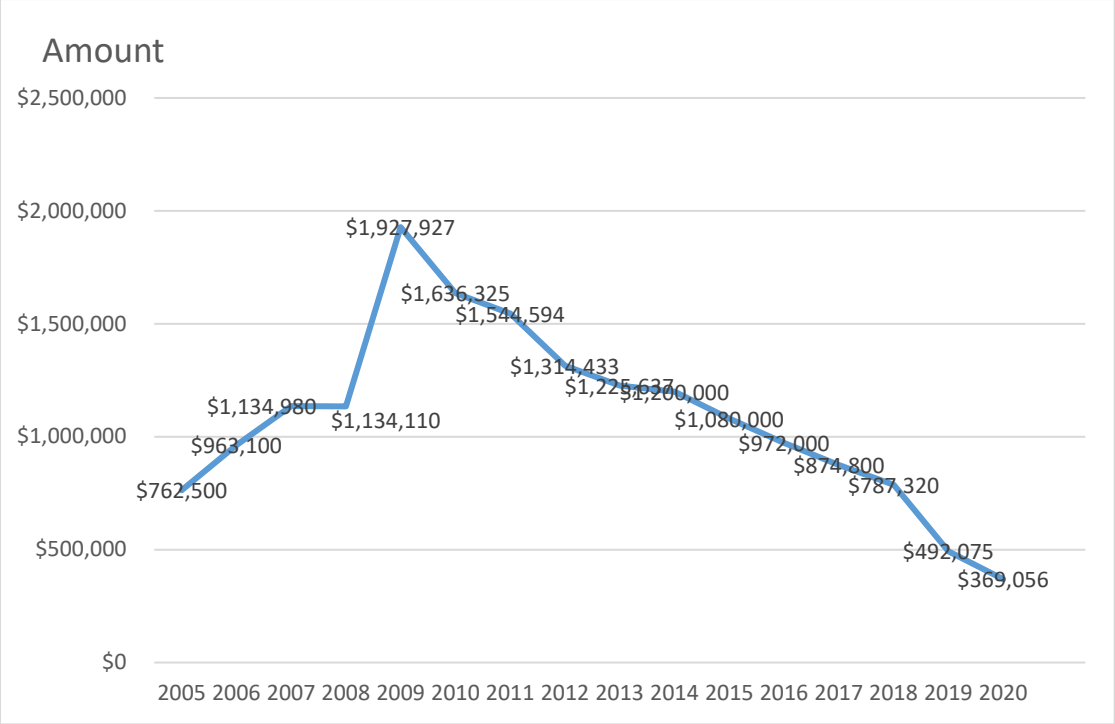
In 2004, the Maryland Health Services Cost Review Commission (HSCRC or Commission) adopted recommendations to provide seed funding for the Maryland Patient Safety Center (MPSC) through hospital rates. The initial recommendations funded 50 percent of the reasonable budgeted costs of the MPSC. In FY 2020, HSCRC-dedicated funds accounted for 20 percent of MPSC's total budget. The proposed support for MPSC in FY 2021 represents 14.5 percent of the total budget. The HSCRC collaborates with MPSC on projects as appropriate, receives an annual briefing and documentation on the progress of the MPSC in meeting its goals, as well as an estimate of expected expenditures and revenues for the upcoming fiscal year. Based on the annual budget item information provided by the MPSC and staff experience, staff makes recommendations to the Commission regarding the continued financial support of the MPSC.

Under the Total Cost of Care Model (TCOC Model), it is increasingly important that safety and quality is improved across all care settings. The key stakeholders that are involved with the MPSC include hospitals, patients, physicians, long-term care and post-acute providers, ambulatory care providers, and pharmacy – all groups that are critical to the success of the TCOC Model. To achieve mutual healthcare goals for these stakeholders, MPSC notes that it is critical (and should be prioritized) that the Center also collaborates with Maryland's key health policy agencies including the Maryland Department of Health (MDH), the Maryland Health Care Commission (MHCC), HSCRC and the Office of Health Care Quality (OHCQ). The MPSC is in a unique position in the State to develop and share best practices among these key stakeholders. It is also favorably positioned to act as a convener for hospital and non-hospital providers in Maryland to support provider sharing of best practices and disseminate data that will help them succeed under the TCOC Model.

As noted in the MPSC December 2019 report to MHCC, without the centralization of activities from a trusted patient safety center, Maryland healthcare facilities would be left to experiment and duplicate efforts in their patient safety strategies. This added cost is avoided through regular communication with patient safety officers across the state to share best practices, resources and consultation and coaching from the MPSC.

Over the past 16 years, the HSCRC included an adjustment to the rates of eight Maryland hospitals to provide funding to cover the costs of the MPSC. Funds are transferred biannually, by October 31 and March 31 of each year. Although funding increased between FY 2005 and FY 2009, the level of HSCRC support has declined each year since FY 2009, consistent with the original intent to scale back State-funded support. **Figure 1** below shows the funding level the HSCRC's in support of the MPSC.

Figure 1. HSCRC Unrestricted Funds Supporting MPSC FY2005-FY2020



In April 2020, the HSCRC received the MPSC program plan update for FY 2021. The MPSC is requesting a total of $246,056 in funding support from the HSCRC for FY 2021, a 50 percent decrease over the FY 2019 budget, consistent with the Commission's intent to reduce State funds over time and encourage a sustainable business model for the MPSC.

BACKGROUND

The 2001 General Assembly passed the Patients' Safety Act of 2001,[1] charging the Maryland Health Care Commission (MHCC)—in consultation with the Maryland Department of Health (MDH)—with studying the feasibility of developing a system for reducing the number of preventable adverse medical events in Maryland, including a system of reporting such incidences. The MHCC subsequently recommended the establishment of the MPSC to improve patient safety in Maryland.

In 2003, the General Assembly endorsed this concept by including a provision in legislation to allow the MPSC to have medical review committee status, thereby making the proceedings, records, and files of the MPSC confidential and not discoverable or admissible as evidence in any civil action.[2]

[1] Chapter 318, 2001 Md. Laws.
[2] MD. **CODE**. ANN., Health-Gen. § 1-401(b)(14);(d)(1).

The MHCC selected the Maryland Hospital Association (MHA) and the Delmarva Foundation for Medical Care (Delmarva) through the State's Request for Proposals (RFP) procurement process to establish and operate the MPSC in 2004, with an agreement that the two organizations would collaborate in their efforts. MHA and Delmarva jointly operated the MPSC from 2004 to 2009. The MPSC was then reorganized as an independent entity and was re-designated by the MHCC as the State's patient safety center starting in 2010 for two additional five-year periods with an expiration in April 2020, following an extension from the December 2019 date. An RFP process was conducted by MHCC in the first quarter of 2020, and MHCC again selected and re-designated MPSC as the State's patient safety center for a five-year period through 2025.

ASSESSMENT

Strategic Priorities and Partnerships

The MPSC's vision is to be a center of patient safety innovation, convening healthcare providers to accelerate understanding of, and implement evidence-based solutions for preventing avoidable harm. Its mission is to make healthcare in Maryland the safest in the nation.

The MPSC's goals are to:

- Eliminate preventable harm for every patient, with every touch, every time;
- Develop a shared culture of safety among patient care providers; and,
- Be a model for safety innovation in other states.

To accomplish its vision, mission, and goals, the MPSC established and continues to build new strategic partnerships with an array of key private and public organizations. The organizations represent a broad array of interests and expertise, including policymakers and providers across the continuum of healthcare quality, safety, and learning and education.

MPSC Members and Partnerships

As of fiscal year ending 2020, MPSC has 45 paid member facilities (increased from 42 from last year), including 43 hospitals, one long-term care facility, one rehabilitation hospital; membership fees provide the largest portion of MPSC's FY20 annual revenue. Paid membership provides member organizations with unlimited staff participation at education sessions and conferences free of charge or at a reduced rate (Six Sigma and Lean for Healthcare). Patients and family participation in MPSC initiatives is actively sought. Patients and families are represented by two board members and patients and/or family members are sought to provide their perspective to MPSC collaboratives and projects.

With regard to expanding membership to non-hospital entities, MPSC notes that they actively seek membership from non-hospital organizations by offering in-person educational programs and webinars free of charge[3]. MPSC has recently begun negotiating with Federally Qualified

[3] In 2019 these efforts included Patient Safety Foundations for Long Term Care and Patient Safety Principles to Implement QAPI, and RCA for LTC webinar.

Health Centers regarding potential membership. Through their efforts to engage non-hospital members, MPSC notes that:

- Non-hospital budgets are limited for participation in quality and patient safety programs.
- Financial incentives are different for non-hospital organizations, presenting additional challenges in engaging participation.

The **Mid-Atlantic Patient Safety Organization (MAPSO)**, a component of the MPSC, includes **43 members** representing hospitals and long-term care facilities. **Membership is separate from MPSC and is free of charge.** The primary activities of the MAPSO are to improve patient safety and healthcare quality by collecting adverse event reports and holding Safe Tables for members. Safe Tables are a forum conducted under the federal law establishing Patient Safety Organizations (PSOs), such as MAPSO, at which healthcare professionals convene and have open dialogues about patient safety and quality issues. Frank and transparent discussions are encouraged in these legally and privileged settings held for MAPSO member organizations only. MAPSO has held one Safe Table in October 2019, and due to the pandemic cancelled the second for April 2020. To assure confidentiality of discussion these are not held virtually or via conference call. MAPSO has collected, analyzed and trended over 23,000 adverse events from 13 facilities in the last 12 months.

The MPSC identifies 15 strategic partners in FY 2020:

- **Qlarant** – Maryland QIO
- **Alliance for Innovation in Maternal Health -** National alliance promoting maternal and infant health
- **Health Facilities Association of Maryland -** A leader and advocate for Maryland's long-term care provider community
- **Maryland Healthcare Education Institute** – The educational affiliate of the Maryland Hospital Association
- **Maryland Hospital Association** - The advocate for Maryland's hospitals, health systems, communities, and patients before legislative and regulatory bodies
- **MedChi -** Statewide professional association for licensed physicians
- **CRISP -** Regional health information exchange (HIE) serving Maryland and the District of Columbia
- **Society to Improve Diagnosis in Medicine -** National non-profit that catalyzes and leads change to improve diagnosis and eliminate harm
- **Maryland Ambulatory Surgical Association -** The state membership association that represents ambulatory surgery centers (ASCs) and provides advocacy and resources to assist ASCs in delivering high quality, cost-effective ambulatory surgery to the patients they serve
- **Johns Hopkins School of Medicine / The Armstrong Institute for Patient Safety and Quality** – The patient safety center within Johns Hopkins Medicine
- **MedStar Health**

- **MD RxALI**
- **Johns Hopkins Bloomberg School of Public Health**
- **Lifespan**
- **State entities -** HSCRC, MHCC, MDH, OHCQ

Educational Programs and Conferences

Safety Tools Education

Customized educational programs for MPSC members are driven by changing needs of members and the healthcare industry. In FY 2020 the following educational programs were offered, however the COVID-19 pandemic forced the postponement or cancellation of nearly all of the spring 2020 programs. Some have been postponed until June 2020, while others have been cancelled for spring but are planned to be offered again in the fall of 2020. This year as a result of the pandemic attendance dropped from over 500 registrants for educational programs in FY 2019 to 246 registrants for FY 2021. Educational programs offered included:

- Root Cause Analysis (RCA)
- Failure Modes and Effects Analysis (FMEA)
- Patient Safety Foundations
- TeamSTEPPS® Train the Trainer
- Six Sigma for Healthcare
- Lean for Healthcare
- Appreciative Inquiry
- Human Factors Engineering
- Patient Safety Principles for QAPI Implementation (Free for LTCs)
- Treatment of Opioid Use Disorder: A Buprenorphine Waiver Qualifying Course (offered in partnership with the American College of Gynecologists and the American Association of Addiction Medicine)

Safety Conferences

The **Annual Patient Safety Conference** has grown from 1,200 to 1,500 registrants annually.

- Participants from acute care hospitals, long term care, rehabilitation hospitals, ambulatory surgery centers, state agencies, quality improvement organizations
- Continuing education credits are provided for multiple specialties.
- The spring 2020 conference was postponed due to the COVID-19 pandemic and rescheduled to September 9, 2020 with over 1400 already registered. MPSC will also hold the planned FY 2021 conference as usual in the spring of 2021.

The **Medication Safety Conference draws** 200 to 500 registrants annually and is held in the fall. There were 242 in attendance at the October 30, 2019 conference.

- Participants include medication safety officers, pharmacists, quality improvement professionals, other disciplines
- Continuing education credits are provided.
- MPSC plans to hold the FY 2021 conference in November 2020

FY 2020 Maryland Patient Safety Center Activities, Accomplishments, Initiatives and Outcomes

MPSC initiatives have engaged providers in hospitals, long-term care facilities, and ambulatory care facilities, as well as patients and consumers. MPSC uses a collaborative model to bring together providers from across the care spectrum to learn best practices to improve care and outcomes. MPSC uses the Berkley Research Group to verify and analyze data collected from hospitals and other providers participating in MPSC initiatives as well as to provide return on investment figures. Highlights from FY 2020 are provided below

Collaborative Sustainability and Return on Investments

Reducing First Time Cesarean Sections – A two- year collaborative conducted from June 2016 to June 2018 with sustainability data collected for 18 months following the completion of the collaborative through December of 2019. Thirty-one of Maryland's thirty-two birthing hospitals participated and achieved an aggregate decrease of primary c-sections of 5.1% during the collaborative period with an estimated cost savings of $1,294,936. During the period of sustainability there was an additional reduction of 2.5% from the last quarter of the collaborative, resulting in a post collaborative cost savings of $1,375,582.
Total savings for this collaborative is $2,670,518 (Source: BRG).

Improving Care to Improve Outcomes: Neonatal Abstinence Syndrome Collaborative-
A two-year collaborative conducted from October 2016 to September 2018 with a sustainability period post collaborative from October 2018 to September 2019. During the collaborative period three metrics were assessed:

1. ***LOS for all newborns with a diagnosis of NAS (ICD10 96.1)-***
   The LOS of stay for all infants did not show a statistically significant reduction during the collaborative, however, the LOS for infants treated in NICUs pharmacologically did decrease by 3 days with a cost savings of $3,427,373 during the collaborative period. MPSC has received two quarters of data from MDH for the sustainability period, but that reflects a further savings of $1,765,242 for a total thus far of $5,192,615.
2. ***Rate of transfers out of the birth hospital for newborns with NAS (ICD10 96.1)-***
   Transfers of newborns with NAS decreased by 57% during the collaborative period demonstrating efforts by the birth hospitals to employ the best practice of keeping the mother baby dyad together. This provides an estimated cost savings in ground transport fees of $87,472. In the first two quarters of the four quarter sustainability periods transfers decreased another 5% for an estimated cost savings of $36, 878 in ground ambulance transport for a total of $124,350.
3. ***Readmissions of infants age 3 days to 30 days for NAS (ICD 10 96.1)-***
   There were not enough infants readmitted with a diagnosis of NAS to provide data.

Total estimated cost savings for this collaborative is $5,316,965 (Source: BRG).

MPSC notes that the Perinatal and Neonatal list servs established under the above collaboratives remain very active as a resource to the maternal infant health community and are utilized extensively to share information, resources and best practices.

Additional FY 2020 Initiatives and Activities

In addition to the above collaboratives, MPSC engaged in the following activities and initiatives in FY 2020:

Opioid Education for Consumers – In response to the statewide opioid addiction epidemic, the MPSC partnered with MHA and MedChi in 2018 to conduct a patient-centered statewide public awareness education for consumers on opioid use. In FY 2020 MPSC also joined with the Rx Abuse Leadership Initiative (RALI) of Maryland, an alliance of more than 20 local, state and national organizations committed to finding solutions to end the opioid crisis in Maryland. MPSC has continued to provide this consumer education in FY 2020, however COVID-19 has also impacted this effort. Plans are now underway to make this education available virtually.

Diagnostic Errors: A study group exploring the role of MPSC in the emerging work on diagnostic errors has been convening quarterly. As a result, MPSC has taken on a consulting role with MedStar, which was awarded an AHRQ grant to develop a new TeamSTEPPS® module to improve communication among the healthcare team in ambulatory settings to improve diagnosis. This consultative invitation is a result of Maryland's long history of provision of TeamSTEPPS® training and early work convening experts in improving diagnosis. In addition, MPSC was one of the earliest organizational members of the Society to Improve Diagnosis in Medicine (SIDM).

HRSA Maryland Maternal Health Innovation Grant: MPSC was named as a sub-awardee in the Johns Hopkins Bloomberg School of Public Health $10.3 million five year HRSA grant to improve maternal health in Maryland. The project is known as MDMOM (www.mdmom.org). MPSC, through its strong relationships with the Maryland hospitals, and the birthing hospitals especially, will leverage those relationships to facilitate implicit bias training, training on stigma associated with opioid use disorder in pregnancy and quality improvement training for hospital maternal units. In FY 2020 MPSC conducted a needs assessment survey with a 100% return rate from the birthing hospitals related to the previously mentioned topics. With this information work is now in progress to select models and /or vendors and develop an implementation plan to start training in the second grant year beginning October 1, 2020.

Patient Safety Officer Forums and PSO list serv: MPSC convene quarterly forums for patient safety officers, quality improvement staff, risk managers and any others interested in patient safety across the state. The forums are two hours in length and provide the opportunity for topic driven exchange of issues of interest to this group. Offered as an in- person meeting but a conference call line is established as well. The MPSC manages a PSO list serv that supports this group and is an active means for quick exchange of best practices, ideas and concerns across the state. Participants are from acute care, long term care, specialty hospitals and state entities such as OHCQ.

Care Alerts Collaborative– This grant between MPSC and CRISP is in its final year. In FY 2020, the role of MPSC was to review activities and quality of alerts by those making entries. These were analyzed, reviewed and action recommendations made and provided to CRISP quarterly.

Caring for the Caregiver – MPSC has implemented the Caring for the Caregiver program, a partnership with the Armstrong Institute, in 42 organizations across the country. The Caring for the Caregiver program provides training to organizations that assists them in establishing a peer responder program to provide immediate, confidential, "psychological first aid" and emotional support to "second victims" following work-related traumatic events. MPSC expects to close FY 2020 with $392,000 in gross sales, of which MPSC will receive $110,000.

Patient Safety Certification and Organization Specific Education– MPSC implemented the Patient Safety Certification Education in one long term care facility this past fiscal year. MPSC provided patient safety champion training at the organization in three 5- week sessions for a total of 78 staff at the facility. The organization reports that as result they have implemented an adverse event reporting system, created a Patient Safety Committee, begun patient safety leadership rounds, implemented a "Good Catch" program and plan to do a culture of safety survey. This resulted in $14,000 in gross sales in FY 2020.

Patient and Family Advisory Councils for Quality and Safety (PFACQS) – MPSC and MedStar Health have engaged in a partnership to provide consultation and education to organizations to assist them in the creation of councils that embody partnership and open communication with diverse patient populations and patient families to improve quality and safety. This partnership was kicked off in January 2020.

Activities initiated FY 2020 in Response to COVID-19 Pandemic

In an effort to provide the healthcare community with support and resources related to the COVID-19 pandemic MPSC has initiated the following:

Caring for the Caregiver– Through this program MPSC is assisting organizations and healthcare peers to respond to caregivers in distress by sharing a series of interventions on social media from the internationally recognized Caring for the Caregiver: Implementing RISE program. Additionally, MPSC is providing a FREE copy of the full training manual for the program to organizations upon request.

PFACQS – MPSC recognizes that as a result of COVID-19 some patients are anxious, ill, and possibly facing death while separated from their loved ones. This has resulted in healthcare providers engaging in tough conversations with families in untraditional ways. Strategies for successful decision-making, communication, and patient experience have been challenged. MPSC in collaboration with the MedStar Institute for Quality and Safety is presenting a one-hour live webinar discussion on ideas and resources to effectively engage patients, families and the patient and family advisory council during these difficult times.

FY 2021 Projected Budget

MPSC expects to continue the work of the following initiatives, programs, education, and conferences in FY 2021 with the requested $246,056:

- Mid-Atlantic PSO
- Safety Tools Education
- Safety Conferences
- Opioid Education for Consumers
- Diagnostic Errors
- Maryland Maternal Health Innovation program- implicit bias, etc training
- PFACQS
- Patient Safety Officer Forums
- Patient Safety Certification
- Caring for the Caregiver

MPSC anticipates increased revenue from membership, and sales of the Caring for the Caregiver Program. Program sales for PFACQS are projected and some grant funding has been obtained. These amounts are reflected in the FY 2021 proposed budget Version A outlined in Figure 2 below, including potential funds from the HSCRC. Consistent with FY 2020, the majority of the revenue anticipated in FY 2021 is derived from membership dues and conference revenue. In FY 2010, HSCRC funding accounted for 20 percent of its operating expenses. If approved, the FY 2020 HSCRC funding will account for approximately 14.5% percent of the total MPSC expenses.

MPSC notes that the HSCRC funds in addition to the other revenue currently identified would not support other important projects MPSC is ready and able to do in FY 2021 that targets Safety in Long Term Care (LTC) facilities in the state; these new projects are described following Figure 2 below.

Continuing to diversify the revenue stream for MPSC is crucial to the long-term sustainability of the Center in order to create stability in fiscal planning and to move away from the reliance on rate setting funds.

Figure 2. Proposed MPSC Revenue and Expenses Version A

Maryland Patient Safety Center, Inc.		
Statement of Income and Expenses		
Working Copy for FY 2021 (Version A)		
		DRAFT
		Rev. 05-01-20
	FY 2020	**FY 2021**
Description	**Budget**	**Budget**
Beginning Restricted Fund Balance as of July 1	-	-
Restricted Grant Revenue-MDH	200,000	-
Restricted Grant Revenue-Care First	159,500	-
Restricted Grant Revenue-HRSA	-	**36,600**
Net Assets Released from Restriction-Care First	(156,167)	-
Net Assets Released from Restriction-MDH	(200,000)	-
Net Assets Released from Restriction-HRSA		**(36,600)**
Change in Restricted Net Assets	3,333	-
Ending Restricted Fund Balance as of June 30	3,333	-
Unrestricted Funds as of July 1		
Board-Designated Operating Reserve	174,344	**174,344**
Unrestricted Net Assets	1,552,078	**1,576,700**
Total Unrestricted Funds as of July 1	1,726,422	**1,751,044**
Revenue		
HSCRC Funding	369,056	**246,056**
Membership Dues	400,000	**503,650**
Education Session Revenue	19,750	**18,800**
Annual Patient Safety Conference Revenue	200,000	**175,500**
Medsafe Revenue	10,000	**24,000**
Caring for HC/Rise Program Sales	175,000	**392,000**
Sales - Patient Safety Certification	100,000	-
Sales - Team STEPPS	125,000	-
Sales - Lean Daily Management	25,000	-
Care Alerts Collaborative Revenue	8,494	-
Net Assets Released from Restriction	356,167	**36,600**
Total Revenue	1,788,467	**1,396,606**
Expenses		
Administration	409,646	**447,780**
Education Sessions	32,750	**27,400**
Patient Safety	287,500	**418,700**
Medication Safety	21,500	**139,400**
Caring for HC	158,457	**347,579**
Safe Sleep	156,167	-
Certification	90,733	**55,300**
Team STEPPS	130,191	-
Lean Daily Management	33,908	-
MidAtlantic PSO	34,500	**96,800**
Perinatal/Neonatal Collaboratives	200,000	-
OB Hemmorrhage	58,000	-
Care Alerts	8,494	-
PFAQS	-	**52,033**
Joy & Meaning	15,000	-
Diagnosis Errors	66,900	**47,900**
Maternal Health	-	**38,900**
Opioid Safety	60,100	**35,400**
Total Expenses	1,763,846	**1,707,192**
Change in Unrestricted Net Assets	24,622	**(310,586)**
Restricted Funds as of June 30	3,333	-
Board-Designated Operating Reserve as of June 30	174,344	**174,344**
Unrestricted Fund Balance as of June 30	1,576,700	**1,266,114**
Total Ending Fund Balances	1,754,377	**1,440,458**

FY 2021 Additional Budget Requests/Proposals

In consideration of the tremendous patient safety needs identified with the COVID-19 pandemic, MPSC is proposing the new initiatives described below and requesting the additional funding amounts identified to implement them.

Clean Collaborative for Long Term Care: Over the past decade, substantial scientific evidence has accumulated indicating that contamination of environmental surfaces plays a key role in the transmission of several healthcare-associated pathogens. Figure 3 below provides the findings of a study confirming that the SARS-CoV-2 virus can live on surfaces for hours to 3 days. In light of the current SARS-CoV-2 challenges surrounding the high rates of infection and death in LTC, by providing LTC with tools to establish cleaning and disinfection procedures and access to technologies to substantiate validation of cleanliness, this time is now.

Figure 3. SARS CoV Surfaces Life

Media	SARS-CoV-1	SARS-CoV-2
Aerosols	3 hours	3 hours
Plastic	72 hours	72 hours
Stainless Steel	48 hours	48 hours
Cardboard	8 hours	24 hours
Copper	8 hours	4 hours

Gamble, A., Williamson, B.N., et al. (2020) Aerosol and surface stability of SARS-CoV-2 as compared with SARS-CoV-1. New England Journal of Medicine, Correspondence nejm.org.

Leaping off the successes of Clean Collaborative Phases 1 and 2 MPSC previously conducted, the Clean Collaborative for LTC will focus the scope of the collaborative specifically to the needs of long-term care. The purpose of the collaborative is to: (1) identify best practices for cleaning and disinfecting hard and soft surface areas throughout the facility (specifically a concern in the current COVID-19 pandemic) and (2) to educate and promote best management practices via webinars, collaborative calls, face to face meetings and onsite consultation and evaluation. Through collection of quantitative data on a monthly basis each facility will be able to respond to and evaluate changes in products, frequency and cleaning practices in their facility. The long- term benefits expected are a decrease in HAIs, implementation of best practices in the facility, decreases in hospital admissions for HAI, and prevention of, and rapid response to, possible future infection outbreaks. In addition, per the collaborative participant agreement, all participating facilities will be able keep the validation technology, following the collaborative, a key component of a comprehensive cleaning validation program.

To assist LTCs to have the greatest impact on infection prevention related to cleaning and disinfecting healthcare surface areas, MPSC is proposing to facilitate an 18-month collaborative. MPSC will provide a subject matter experts and experienced infection preventionists to consult and evaluate through site visits with participating facilities. Estimated collaborative cost: $275,000 Year 1; $150,000 Year 2 (FY 2022).

Total additional request for FY 2021: $275,000

Decreasing racial disparities in healthcare collaborative: The experience of the COVID-19 pandemic has vividly highlighted the racial disparities in healthcare. MPSC proposes implementing a two-year collaborative pilot that will enroll ten hospitals to participate in selection of a diagnosis to explore, noting disparity in clinical outcomes. MPSC will provide developed Implicit Bias training and obtain, analyze and report back to facilities their data and analysis compared to the pilot aggregate with the intended goal of improving the disparity outcomes for that specific diagnosis and population. Costs would include staff time, cost of online training, development of data portal for reporting and generation of reports, development of tools and subject matter expert consultation. Expected total cost for the planning, development implementation of the project: Year 1 (planning): $125,000; Year 2 (Implementation): $250,000; Year 3 (Implementation and close out): $175,000.

Total additional request FY 2021: $125,000

Caring for the Healthcare Provider in LTC: MPSC is proposing development of a program specifically designed for LTC staff who have suffered tremendous stress in the COVID-19 environment. MPSC would like to convene focus groups to identify the support LTC staff need, challenges to leadership, and identification of solutions to support, empower and heal. Year 1 cost: $50,000

Total additional FY 2021 request: $50,000

Figure 4 below presents revised revenues and expenses with the optional projects outlined above included.

Figure 4. Proposed Revised MPSC Revenue and Expenses with Optional Projects Version B

Maryland Patient Safety Center, Inc.		
Statement of Income and Expenses		
Working Copy for FY 2021 (Version B)		**DRAFT Rev. 05-01-20**
Description	**FY 2020 Budget**	**FY 2021 Budget**
Beginning Restricted Fund Balance as of July 1	-	**-**
Restricted Grant Revenue-MDH	200,000	**-**
Restricted Grant Revenue-Care First	159,500	**-**
Restricted Grant Revenue-HRSA	-	**36,600**
Restricted HSCRC Funding-Clean Collaborative		**275,000**
Restricted HSCRC Funding-Racial Disparities		**125,000**
Restricted HSCRC Funding-Caring for Long Term Care		**50,000**
Net Assets Released from Restriction-Care First	(156,167)	**-**
Net Assets Released from Restriction-MDH	(200,000)	**-**
Net Assets Released from Restriction-HRSA		**(36,600)**
Net Assets Released from Restriction-Clean Collaborative		**(275,000)**
Net Assets Released from Restriction-Racial Disparities		**(125,000)**
Net Assets Released from Restriction-Caring for Long Term Care		**(50,000)**

Maryland Patient Safety Center, Inc.		
Statement of Income and Expenses		
Working Copy for FY 2021 (Version B)		**DRAFT Rev. 05-01-20**
Description	**FY 2020 Budget**	**FY 2021 Budget**
Change in Restricted Net Assets	3,333	**-**
	-	**-**
Ending Restricted Fund Balance as of June 30	3,333	**-**
Unrestricted Funds as of July 1		
Board-Designated Operating Reserve	174,344	**174,344**
Unrestricted Net Assets	1,552,078	**1,576,700**
Total Unrestricted Funds as of July 1	1,726,422	**1,751,044**
	-	**-**
Revenue		
HSCRC Funding	369,056	**246,056**
Membership Dues	400,000	**503,650**
Education Session Revenue	19,750	**18,800**
Annual Patient Safety Conference Revenue	200,000	**175,500**
Medsafe Revenue	10,000	**24,000**
Caring for HC/Rise Program Sales	175,000	**392,000**
Sales - Patient Safety Certification	100,000	**-**
Sales - Team STEPPS	125,000	**-**
Sales - Lean Daily Management	25,000	**-**
Care Alerts Collaborative Revenue	8,494	**-**
Net Assets Released from Restriction	356,167	**486,600**
	-	**-**
Total Revenue	1,788,467	**1,846,606**
Expenses		
Administration	409,646	**410,880**
Education Sessions	32,750	**27,400**
Patient Safety	287,500	**406,500**
Medication Safety	21,500	**114,900**
Caring for HC	158,457	**347,579**
COVID19-Clean Collaborative	-	**275,000**
COVID19-Racial Disparities	-	**125,000**
COVID19-Caring for LTC	-	**50,000**
Safe Sleep	156,167	**-**
Certification	90,733	**54,000**
Team STEPPS	130,191	**-**
Lean Daily Management	33,908	**-**
MidAtlantic PSO	34,500	**81,500**
Perinatal/Neonatal Collaboratives	200,000	**-**
OB Hemmorrhage	58,000	**-**

Maryland Patient Safety Center, Inc.		
Statement of Income and Expenses		
Working Copy for FY 2021 (Version B)		**DRAFT Rev. 05-01-20**
Description	**FY 2020 Budget**	**FY 2021 Budget**
Care Alerts	8,494	**-**
PFAQS	-	**48,633**
Joy & Meaning	15,000	**-**
Diagnosis Errors	66,900	**47,900**
Maternal Health	-	**38,900**
Opioid Safety	60,100	**35,400**
	-	**-**
Total Expenses	1,763,846	**2,063,592**
Change in Unrestricted Net Assets	24,622	**(216,986)**
	-	**-**
Restricted Funds as of June 30	3,333	**-**
Board-Designated Operating Reserve as of June 30	174,344	**174,344**
Unrestricted Fund Balance as of June 30	1,576,700	**1,359,714**
Total Ending Fund Balances	1,754,377	**1,534,058**

MPSC Return on Investment

As noted in the last several Commission recommendations, the HSCRC provides funding for the MPSC with the expectation that there will be both short- and long-term reductions in Maryland healthcare costs, particularly related to such outcomes as reduced mortality rates, lengths of stay, patient acuity, and malpractice insurance costs. Working with BRG this past year, as noted above, the MPSC has demonstrated estimated cost avoidance/ savings for the neonatal and perinatal collaboratives conducted 2016-2019 of $7,987,143.

Additional data on all of the MPSC's programs is needed to ensure that the limited dollars available for MPSC funding creates meaningful improvements in quality and outcomes at facilities in Maryland to achieve the goals of the Total Cost of Care Model. The MPSC should continue to report results from its initiatives to HSCRC staff.

STAKEHOLDER COMMENTS AND STAFF RESPONSES

Staff received ten comment letters/emails in support of the draft recommendation, and in particular, in support of the optional LTC Clean Collaborative funding. The individuals that submitted comments along with their organizations or affiliations are listed below.

- Joseph DeMattos, President and CEO, Health Facilities Association of Maryland
- Jack Gentry**,** Retired Police Officer, Baltimore City; Patient Advocate; MPSC Board Member
- Susan Glover, Senior VP Quality, Adventist HealthCare

- Deborah Graves, President, Levindale Geriatric Center; MPSC Board Member
- Kevin Heffner, President & CEO, LifeSpan Network; MPSC Board Member
- David Mayer, MD, Executive Director, MedStar Institute for Quality and Safety; MPSC Board Chairman
- Podge Reed, Jr., Former Hospital Administrator; Patient Advocate; MPSC Board Member
- Speaker Pro Tem Sheree Sample-Hughes, Maryland House of Delegates, District 37A; MPSC Board Member
- Nicole Stallings, Senior Vice President, Government Affairs, Maryland Hospital Association; MPSC Board Member
- Barbara Tachovsky, Former President, Mainline Hospitals, Paoli, PA; MPSC Board Member

Salient points made by many commenters are highlighted below.

- In light of the COVID-19 pandemic, many stakeholders expressed the urgent need for interventions focused on infection in nursing home and long-term care facilities, and noted that MPSC was able to start the project immediately if funded
- MHA notes that MHA and MPSC have worked closely to improve the quality and safety of health care in Maryland; further, MPSC has been instrumental in helping hospitals to change practices and drive better outcomes on some of the most pressing concerns in our state.
- The work of the MPSC, and in particular the proposed LTC Clean Collaborative, align with the goals of the TCOC model - improving quality and reducing costs through fewer infections and fewer hospital admissions.
- Several hospital stakeholders expressed interest in using the MPSC Clean Collaborative to further engage with post-acute care.
- Most commenters pointed to the early successes of the previous Clean Collaborative projects where participants achieved a significant decrease of 45% in the incidence of C-difficile infections.
- Patient advocates pointed to the need for high quality long-term care for many current or future patients.
- Speaker Pro Tem Sample-Hughes and Dr. David Mayer from Medstar note that MPSC is able to ensure consistency in training, education and coaching on measurement and results across the state as a coordinating organization.

Staff Response

Staff appreciates the comments provided by stakeholders and the collective support for MPSC and the proposed LTC Clean Collaborative that focuses on reducing infections in Skilled Nursing Facilities. In order to monitor the effectiveness of the proposed LTC Clean Collaborative were it to be funded, staff supports a focus on real time data collection on outcomes and on MPSC reporting to the Commission at regular intervals as the project progress over the next year.

RECOMMENDATIONS

Quality and safety improvements are the primary drivers to achieve the goals of reduced potentially avoidable utilization and reduced complications in acute care settings under the TCOC Model. For these reasons, it is important to continue to support hospitals in identifying and sharing best practices to improve patient quality and outcomes. Individual hospitals across the State are experimenting with strategies to improve care coordination, enhance processes for better care, and advance systems and data sharing to maximize the efficiency and effectiveness of care; the MPSC is in a unique position to convene healthcare providers and share best practices that have been identified through multi-provider collaborative testing and change. The key stakeholders that are involved with the MPSC include hospitals, patients, physicians, long-term care and post-acute providers, ambulatory care providers, and pharmacy – all groups that are critical to the success of the Total Cost of Care Model. The MPSC is in a favorable position in the State to develop and share best practices among this group of key stakeholders. To support the overall mission of the State, the MPSC should align initiatives with the broader statewide plan and activities for patient safety.

In light of the information presented above, HSCRC staff provides the following final recommendations for the MPSC funding support policy for FY 2021:

1. Consistent with the prior Commission recommendations, the HSCRC should reduce the amount of **unrestricted** funding support for the MPSC in FY 2021 by 25 percent from the FY 2019 HSCRC unrestricted grant amount of $492,075. The result is an adjustment to hospital rates in the amount of $246,056.
2. In order to receive future funding from the hospital rate setting system, the MPSC should continue to report twice annually on data that it has collected from hospitals and other facilities that participate in its quality and safety initiatives and demonstrate, to the extent possible, the ways in which MPSC initiatives are producing measurable gains in quality and safety at participating facilities.
3. Going forward, the HSCRC should decrease the amount of **unrestricted** support by 25 percent per year from the RY 2019 amount of $492,075 in order to achieve the goal of independent sustainability for MPSC, resulting in independent sustainability by FY 2023.
4. MPSC may request annually needed funding from HSCRC that will be **restricted for targeted projects** that align with statewide TCOC Model and quality and safety goals which the Commission will consider on a case by case basis.
    a. For FY 2021, HSCRC should fund an additional $275,000 for the Clean Collaborative for Long Term Care project through hospital rates.
5. The MPSC should continue to pursue strategies to achieve long-term sustainability through other sources of revenue, including identifying other provider groups that benefit from MPSC programs.

HFAM
Health Facilities Association of Maryland
Partners in Quality Care

May 20, 2020

Dianne Feeney
Associate Director, Quality Initiative
Health Services Cost Review Commission
4160 Patterson Ave
Baltimore, MD 21215

Dear Dianne,

As the President and CEO of the Health Facilities Association of Maryland (HFAM), I wish to communicate my strong support for the HSCRC project funding for the Maryland Patient Safety Center (MPSC) Clean Collaborative for Long Term Care (LTC).

As you may know, HFAM is oldest and largest nationally affiliated long-term and post-acute care providers association in Maryland. HFAM represents the majority of the 226 skilled nursing and rehabilitation centers in the state, as well as assisted living communities and affiliated businesses. HFAM members provide more than 6 million days of care across all payer sources annually to Marylanders most in need of person-centered, medical long-term and post-acute care.

The HSCRC project funding was requested at the May 13 HSCRC meeting. Several of our member facilities participated in the first phase of the MPSC Clean Collaborative from Spring 2016 to Spring 2017 and I am aware of MPSC's ability to implement successful collaboratives and am excited about the benefits that this collaborative could provide our facilities with a strong LTC focus.

As you know, our LTC community has been hard hit by the COVID-19 pandemic and an initiative that could provide infection prevention expertise, an environmental cleaning expert, and the tools to evaluate, trend, and implement improvement strategies would be both welcome and needed. An initiative that would focus on increasing cleanliness and decreasing facility acquired infections in LTC would affect readmissions rates to acute care, decrease the total cost of care and ultimately impact mortality related to those infections. MPSC has demonstrated the ability to implement such an initiative successfully and I am confident in their commitment and ability.

I strongly support this initiative, although the funding is limited to only ten facilities. I am confident that should this program receive funding that demonstrated results will indicate the need for expansion of the project further to more facilities.

Regards,

Joe DeMattos
President & CEO

601 Global Way, Suite 100-103 ▪ Linthicum, MD 21090 ▪ www.HFAM.org
410.290.5132 ▪ 301.490.8413 ▪ Toll Free: 1.877.LTC.HFAM

May 20, 2020

Ms. Dianne Feeney
HSCRC
VIA ELECTRONIC MAIL

Dear Dianne,

I am writing to express my strong support for the Maryland Patient Safety Center (MPSC) Clean Collaborative for Long Term Care proposal, a project for which funding was requested at the May 13 HSCRC meeting.

As CEO of LifeSpan Network, the largest senior services association in the region, as well as a MPSC board member, I am very familiar with the popularity and impact of LifeSpan's own Infection Control Certification Program for providers, and I believe that the Clean Collaborative program would complement the program in a significant and tangible way. We stand ready to support MPSC's efforts in this area in every way that we can.

Clean Collaborative for Long Term Care project comes at such a critical time as the COVID 19 incidence and mortality statistics demonstrate an urgent need to direct attention to our senior citizens and our nursing homes in Maryland. We already know that nursing homes are a key component in the continuum of care and infection rates, particularly related to COVID 19, impacts the total cost of care, readmission rates to acute care, and overall mortality. Striving for improved patient safety during COVID 19 requires that interventions come from many sources, and I am confident that the MPSC is well equipped to quickly implement a clean collaborative as it has successfully completed a similar initiative in the recent past.

I am hopeful that you will endorse the Long Term Care Clean Collaborative project as an initiative that will impact the total cost of care, decrease admissions, as well as mortality rates. At this time in our country, we must take special care to provide for the needs of our most vulnerable elderly population, and the Clean Collaborative is a step in the right direction in doing just that.

Thank you for your consideration of this important proposal. Looking forward to speaking with you again very soon.

Sincerely,

Kevin D. Heffner, MAGS
President

7090 Samuel Morse Drive, Suite 400, Columbia, MD 21046
410-381-1176 Fax 410-381-0240 www.LifeSpan-Network.org

Maryland
Hospital Association

May 20, 2020

Dianne Feeney
Associate Director, Quality Initiatives
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Feeney:

On behalf of the Maryland Hospital Association's (MHA) 61 member hospitals and health systems, it is my pleasure to submit this letter of support for staff's recommendation for the Maryland Patient Safety Center (MPSC) fiscal year 2021 funding. In addition to the unrestricted funding recommendation, MHA commends staff for their restricted funding recommendation for the Clean Collaborative for Long-Term Care.

This collabroative, which builds upon a previous effort involving hospitals and five nursing homes, addresses one of the most pressing patient safety needs identified during the COVID-19 pandemic: preventing and mitigating the spread of infection in long-term care facilities. Environmental infection control practices are essential to reduce the risk of the virus entering nursing centers and assisted living communities. The first two phases of the collaborative significantly improved infection rates, and I am confident this new collarboative will yield similar benefits.

Since the inception of MPSC, MHA and MPSC have worked closely to improve the quality and safety of health care in Maryland. MPSC has been instrumental in helping hospitals to change practices and drive better outcomes on some of the most pressing concerns in our state. We have every confidence that this collaborative will ignite similar outcomes within the long-term care community. Further, supporting the post-acute and long-term care community in this way will facilitate multi-sector participation in MPSC programs – a priority of the HSCRC.

MHA looks forward to continuing to work with MPSC and our post-acute and long-term care partners to advance the health of all Marylanders.

Sincerely,

Bob Atlas
President & CEO

Adventist HealthCare

820 West Diamond Avenue, Suite 600
Gaithersburg, MD 20878
www.AdventistHealthCare.com

May 22, 2020

Dianne Feeney
Associate Director, Quality Initiatives
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dianne Feeney:

On behalf of Adventist Healthcare and for our many healthcare workers who have benefited from the Maryland Patient Safety Center (MPSC), I am writing in support of the Long-Term Care Clean Collaborative.

Adventist Healthcare has a true appreciation for the MPSC's track record with infection prevention collaboratives in the acute and long-term care settings. I am confident that the MPSC will maintain a high level of integrity in the training, education, and coaching necessary to support this initiative. A decrease in infection rates associated with the long-term care setting will have a favorable impact on the total cost of care in Maryland due to a healthier long-term care population with decreased utilization of emergent and acute care services.

A senior infection preventionist and a consulting environmental expert are integral to the success of this collaborative to ensure that appropriate infection control methods are standardized and implemented among all participants. The ACME Co. monitoring technology will bolster data collection related to surface cleanliness. Finally, the MPSC is well positioned to serve as the coordinating body on this initiative.

Thank you for your consideration.

Sincerely,

Susan L Glover

Susan L. Glover, RN, MHA, FACHE
Senior Vice President, Chief Quality & Integrity Officer

cc: Barbara Epke, Interim President and CEO Maryland Patient Safety Center

Sheree Sample-Hughes
Legislative District 37A
Dorchester and Wicomico Counties

Speaker Pro Tem

Health and Government
Operations Committee

The Maryland House of Delegates
6 Bladen Street, Room 313
Annapolis, Maryland 21401
410-841-3427 · 301-858-3427
800-492-7122 *Ext.* 3427
Fax 410-841-3780 · 301-858-3780
Sheree.Sample.Hughes@house.state.md.us

THE MARYLAND HOUSE OF DELEGATES
Annapolis, Maryland 21401

May 26, 2020

Dianne Feeney
Associate Director, Quality Initiative
Maryland Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Feeney,

I am sending this correspondence to show my strong support for the Maryland Patient Safety Center's (MPSC) Clean Collaborative for Long Term Care proposal, a project for which funding was requested at the May 13th HSCRC meeting. We know that nursing homes are a key component in the continuum of care for our most vulnerable population. Infection rates, particularly related to COVID 19, impact the total cost of care, readmission rates to acute care, and overall mortality. Striving for improved patient safety during COVID 19 requires that interventions come from many sources. I am confident that the MPSC is well equipped to quickly implement a clean collaborative as they have successfully completed a similar initiative in the recent past. Personally, I know the importance of having an equipped staff coupled with a clean facility promotes environmental health as well as emotional well-being for seniors.

In 2016, MPSC launched a Clean Collaborative for Hospitals, Ambulatory Centers, and Nursing Homes, with five nursing homes participating. This year long project was followed by another phase of the project in 2018, with ultimate completion in 2019 with a significant decrease in the incidence of C-difficile at 45% for the participants. The collaborative focused on surface contamination, policies and procedures, as well as compliance. Serving on the board of the MPSC, I know that they are poised to initiate a clean collaborative tailored to the needs of nursing homes with this new proposal. As a coordinating organization they are able to ensure consistency in training, education and coaching on measurement and results across the State of Maryland. The funds requested will allow MPSC to provide a Senior Infection Prevention Expert and a Consulting Environmental Expert to ensure that appropriate infection control methods are defined for and followed by all participants. Nursing homes working with MPSC will be able to follow up with MPSC for sustainability of results.

Yours in Service,

Sheree Sample-Hughes
Speaker Pro Tem
Delegate, 37A Legislative District

Maryland

Dianne Feeney -MDH- <dianne.feeney@maryland.gov>

Clean collaborative

1 message

Jack Gentry <jackc.gentry@gmail.com> Wed, May 20, 2020 at 1:54 PM
To: Dianne.feeney@maryland.gov

Dear Ms. Feeney,

As an MPSC board member, I have seen the results of what this center does and have been impressed with their thorough and effective work.
The request they are making in reference to the Long Term Care Clean Collaborative is tailor-made for what the MPSC does. The idea of targeting ten long term care nursing facilities with an infection preventionist and an environmental consultant will primarily potentially save the lives of hundreds of residents of those facilities. They will also be a resource for education and training on a continuing basis. And as a bonus will save the state time, energy and money.
Your consideration of this funding is crucial for the safety and health of the patients of these ten facilities.

Sincerely,
Jack Gentry, member MPSC Board

Sent from my iPad

Maryland

Dianne Feeney -MDH- <dianne.feeney@maryland.gov>

Maryland Patient Safety Center Clean Collaborative Proposal

1 message

Deborah Graves <Dgraves@lifebridgehealth.org> Wed, May 20, 2020 at 2:18 PM
To: "dianne.feeney@maryland.gov" <dianne.feeney@maryland.gov>
Cc: "Epke, Barbara" <bepke@marylandpatientsafety.org>

Dear Dianne,

First, I hope this note finds you and yours doing and feeling well during this pandemic.

Thank you for your time in reading my note. I am the President of Levindale Hospital and Nursing Center and a SVP with LifeBridge Health. I joined the Maryland Patient Safety Center (MSPC) board just this month and I am thrilled to be able to share my support for the Long Term Care Clean Collaborative proposal.

This proposal could not come at a better time and, with the successful implementation experience of the MSPC, it is certain that it will be a success. We know that the majority of COVID 19 cases and deaths are associated with people – especially seniors – who live in congregate housing. By decreasing infection rates in long term care, the Clean Collaborative will positively impact the total cost of care in Maryland, through healthier nursing home residents, decreased emergency room visits, and decreased hospital admissions. Funding for this proposal is slated for a final vote at the June meeting of the HSCRC.

The proposal is tailored to the specific needs of nursing homes during COVID 19. The plan involves a small number of long-term care facilities (to begin), and includes a senior infection prevention consultant, an environmental consultant, and equipment for monitoring surface contamination. The support this team could provide – especially to smaller, less networked long-term care facilities – is enormous and needed. Attached to this plan is the ability for the MPSC to act as a coordinating body that will be able to follow up with participants which will create sustainability and thereby be of great value to the communities of Maryland.

Our senior citizens deserve this level of direct attention. I believe MPSC is the coordinating organization who can ensure consistency in training, education and coaching on measurements and results. I believe this because they have demonstrated success with the 2016 launch of the Clean Collaborative for Hospitals, Ambulatory Centers, and Nursing homes. This project saw a significant decrease in C-difficile across the board for all involved. With good training and stewardship, infections can be mitigated and contained.

I do hope that you will join me in endorsing the Long Term Care Clean Collaborative project. It is time that we all do more than acknowledge the problems associated with senior congregate housing. I feel this proposal is a great step toward providing decreased mortality and decreased total cost of care across Maryland.

Thank you for your time and consideration. Stay well.

All my best,

Deborah Graves

Deborah Graves

Senior Vice President, LifeBridge Health

President & COO, Levindale Hospital

2434 W. Belvedere Ave. | Baltimore, MD 21215
410.601.2204 office | 410.601.4313 fax
dgraves@lifebridgehealth.org

Maryland

Dianne Feeney -MDH- <dianne.feeney@maryland.gov>

LOS MPSC Proposal

1 message

David Mayer <david.mayer@patientsafetymovement.org> Tue, May 19, 2020 at 4:12 PM
To: "Dianne.feeney@maryland.gov" <Dianne.feeney@maryland.gov>, "Epke, Barbara" <bepke@marylandpatientsafety.org>

Dear Diane,

I am sending this email to show my strong support for the Maryland Patient Safety Center (MPSC) Clean Collaborative for Long Term Care proposal, a project for which funding was requested at the May 13 HSCRC meeting. As the current Board Chair of the MPSC, I regularly review project proposals, and the Clean Collaborative for Long Term Care project comes at such a critical time as the COVID 19 incidence and mortality statistics demonstrate an urgent need to direct attention to our senior citizens and our nursing homes in Maryland. We already know that nursing homes are a key component in the continuum of care and infection rates, particularly related to COVID 19, impacts the total cost of care, readmission rates to acute care, and overall mortality. Striving for improved patient safety during COVID 19 requires that interventions come from many sources, and I am confident that the MPSC is well equipped to quickly implement a clean collaborative as we have successfully completed a similar initiative in the recent past.

In 2016, we launched a Clean Collaborative for Hospitals, Ambulatory Centers, and Nursing Homes, with five nursing homes participating. This year long project was followed by another phase of the project in 2018, with ultimate completion in 2019 with a significant decrease in the incidence of C-difficile at 45% for the participants. The collaborative focused on surface contamination, policies and procedures, as well as compliance. We are poised to initiate a clean collaborative tailored to the needs of nursing homes with this new proposal, and as a coordinating organization MPSC is able to ensure consistency in training, education and coaching on measurement and results across the state. The funds requested will allow MPSC to provide a senior infection preventionist and a consulting environmental expert to ensure that appropriate infection control methods are defined for and followed by all participants. Nursing homes working with MPSC will be able to follow up with MPSC for sustainability of results.

I am hoping you will endorse the Long Term Care Clean Collaborative project as an initiative that will impact the total cost of care, decrease admissions, as well as mortality rates. In my roles as Executive Director of the MedStar Institute for Quality and Safety as well as CEO of the Patient Safety Movement Foundation, a global organization devoted to zero preventable deaths in healthcare, I can attest that all of us have neglected our elderly populations for too long from a quality and safety perspective. The MPSC can help start righting that and put MD on the map as a leader in safe, high quality nursing home care.

Thank you for your consideration.

All the best and please stay safe.

Regards,

Dave

Sent from Mail for Windows 10

Maryland

Dianne Feeney -MDH- <dianne.feeney@maryland.gov>

Clean Collaborative for Long Term Care

1 message

Podge Reed, Jr. <pmreed64@aol.com> Tue, May 19, 2020 at 10:46 AM
Reply-To: "Podge Reed, Jr." <pmreed64@aol.com>
To: dianne <.feeney@maryland.gov>
Cc: bepke@marylandpatientsafety.org

Dear Ms. Feeney - I serve as a patient advocate member of the Maryland Patient Safety Center Board (MPSC). As a patient advocate my focus is on the patient with specific interest in the patient experience when interacting with health care providers. As you are aware the MPSC completed a previous Clean Collaborative that involved hospitals and nursing home with positive results.

I was recently involved with my daughter in obtaining better nursing home care from her mother-in-law. Due to some medical issues it became apparent that her mother-in-law would need more focused nursing care related to a series of repeated infections. My daughter had to be a very active advocate with the staff to make sure these infections were properly treated. This Clean Collaborative initiative for nursing homes would improve the environment in which nursing home patients live; thereby, reducing infection rates and improving their quality of life.

Another reason I would recommend this program is that I am an active patient and will always be. As an lung transplant patient, I must maintain a suppress immune system. I realize that one day I could find myself in a long term care environment. It would be extremely important to me that I had access to a very clean environment in which to live and receive nursing home care.

I would recommend approval of this Clean Collaborative initiative.

Sincerely yours,

Podge M. Reed, Jr., MHA

Patient Advocate Member, MPSC

May 20, 2020

Ms. Dianne Feeney
Associate Director, Quality Initiative
Maryland Health Services Cost Review Commission

Dear Ms. Feeney,

Despite my long and diverse career in health care, I am still stunned to be experiencing the remarkable impact that the COVID-19 pandemic is leveling on our citizens. Those of us fortunate enough to be working in health care, however, are compelled to see the continuing threat as an opportunity to enhance our effort to care for and protect our community. The pandemic is widespread but long-term care facilities are experiencing a disproportionately significant negative impact.

As a board member on the Maryland Patient Safety Committee, I fully support the implementation of a project focused on improving the health and cleanliness issues of long-term care facilities. At, MPSC, we have had excellent outcomes with our Clean Collaborative focused primarily in hospitals. Our model for training, education, and measuring outcomes is in the record…it is outstanding. By coordinating, implementing and monitoring our successful strategies in the nursing home environments we can impact measurable improvements in health outcomes. That is our passionate goal!

The Clean Collaborative for long-term care will measure and address the specific needs and outcomes within nursing homes at this critical time. I am a confident supporter of this timely and focused project and I am very hopeful that the HSCRC will support this initiative at this critical time.

Sincerely,

Barbara J. Tachovsky

Final Staff Recommendation

Changes to Relative Value Units for Clinic Evaluation & Management (E&M) Effective July 1, 2020

June 10, 2020

Health Services Cost Review Commission

4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX (410) 358-6217

This document contains the final staff recommendation for changes to Relative Value Units for Clinic Evaluation & Management (E&M) effective July 1, 2020, ready for Commission discussion and vote.

Definitions

Current Procedural Terminology (CPT) codes – The medical service and procedure code used to bill for hospital outpatient services. The primary CPT codes used for billing Clinical Evaluation & Management codes are 99201-99205, 99211-99215, and G0463.

These codes provide the progressive levels of care for billing of Clinic services, based on the use of hospitals' resources in diagnosis and treatment of these patients.

Relative Value Units (RVUs) – A standard unit of measure. A value or weight assigned to a specific service based on relative resources used for that service relative to other services.

Introduction & Background

The Health Services Cost Review Commission (HSCRC, or Commission) is revising the Clinic Evaluation and Management (E&M) services charge structure. As a result of patient complaints, State legislators have contacted the HSCRC to evaluate the Clinic rate and its underlying components. In light of the concerns raised, the HSCRC has agreed to review and modify the rate structure. In the short term, staff will revise the Relative Value Unit (RVU) scale. The table below illustrates the RVUs reduction on higher level visit CPT codes and the charge per visit.

Impact of Proposed RVU Changes

Visit Code	2018 Visits	Current RVUs	Proposed RVUs	2018 Charges	Modeled Charges	2018 Charge Per Visit	Modeled Charge Per Visit
99202	27,671	4	3	$5,857,675	$4,045,403	$204	$148
99204	12,668	15	5	$10,389,654	$3,398,566	$783	$269
99205	912	18	6	$900,014	$294,013	$955	$327
99212	184,079	4	3	$40,813,087	$29,776,708	$204	$155
99213	113,550	7	4	$39,839,740	$22,525,035	$347	$203
99214	48,071	15	5	$33,932,441	$11,035,914	$727	$250
99215	4,162	18	6	$3,329,635	$1,177,296	$852	$286
G0463	62449			$13,593,903	$7,933,421	$204	

Hospitals were concerned about the feasibility of implementing a fixed RVU structure for HCPCS code G0463 that may be billed to Medicare as a replacement for any of the 5 E&M visit levels. A technical adjustment was made to HCPCS code G0463 to be used for Medicare billing with the above level's assigned RVUs.

Staff has determined that a significant reason for high Clinic E&M charges is that the rate setting methodology does not fully reflect the less intensive nature of Clinic services versus other hospital services. Additionally, the RVU range of the five E&M Visit Levels is too wide. Modifications to the methodology used to allocated overhead expenses is a long term undertaking; therefore, staff has decided that for Fiscal Year (FY) 2021, narrowing the range of the Visit Level RVUs, similar to Medicare's E&M RVU scale, coupled with a reduction in the amount of overhead allocated to Clinics, would result in a significant lowering of E&M RVUs. **The end result is expected to be a reallocation of approximately $60 million in Clinic revenue to other rate centers.**

Historically, this would be done in a revenue neutral fashion within a given rate center, i.e., increasing the unit rate as RVUs decline. The HSCRC plans to reallocate the revenues associated with the Clinic RVU reductions from the resulting compression to other rate centers. The proposed changes will result in a more reasonable clinic office visit fees, addressing concerns of patients, while having minimal impact on the distribution of charges across payers. These adjustments **will be revenue neutral to the overall GBR** and will be reflected in each hospital's FY 2021 rate order, effective July 1, 2020.

Comments and Responses:

The proposed changes were sent to all hospitals for comments. The comment period closed on May 18, 2020 with two comments received. If approved by the Commission, effective July 1, 2020, hospitals will begin using the revised 9 E&M CPT codes RVUs listed in this recommendation.

Maryland Hospital Association (MHA) and CareFirst BlueCross BlueShield (CareFirst)

Rationale for Change – MHA acknowledged that the proposed changes would flatten the RVU scale and reduce the charge per outpatient clinic visit at the higher end of the scale. The recommendation would also reclassify regulated charges away from the clinic rate center to other rate centers. MHA and CareFirst support these recommendations.

Concerns – Staff agreed to remove a fixed RVU value for HSCPC code G0463 and to leave instructions for assigning clinic RVUs unchanged in Appendix D of the Accounting and Budget Manual. MHA supports these revisions from the Draft Recommendation.

Carefirst raised concern about the temporary hold on rate realignment for the Clinic rate center. Staff will revisit the Clinic Rate Realignment in FY2021. CareFirst shared its support for the Draft Recommendation.

Final Recommendation

The HSCRC staff recommends that the Commission approve revisions to the Relative Value Unit (RVU) Scale for Clinic Evaluation & Management Current Procedural Terminology CPT codes. The revisions are specific to the Chart of Accounts and Appendix D of the Accounting and Budget Manual (Attachment 1).

The RVU scale was updated to reflect linkages of RVUs to the CPT codes and to link national guideline for Clinic E&M Services consistent with the HSCRC's plan to adopt national RVUs where possible. The Commission should adopt these new RVUs, effective July 1, 2020.

The Clinic E&M reset will be revenue neutral to the overall GBR and will be reallocating approximately $60 million in Clinic revenue to other rate centers.

Account Number 6720

OVERVIEW: REPORTING STRUCTURE FOR CLINIC SERVICES

DEFINITION OF CLINIC SERVICES

Clinic Services include diagnostic, preventive, therapeutic, rehabilitative, and educational services provided to non-emergent outpatients in a regulated setting. On rare occasions, clinic services will be provided to inpatients (Examples and discussion are included later in this document.)

Surgical procedures, diagnostic tests and other services that are better described in a separate cost center, such as Delivery, EEG, EKG, Interventional Cardiology, Laboratory, Lithotripsy, Occupational Therapy, Operating Room, Physical Therapy, Radiation Therapy, Radiology, Speech Therapy, are to be reported in those specific rate centers.

Clinic services may include either one or both of the following two components: an evaluation and management (E/M) visit, and non-surgical procedures. To report an E/M visit and a procedure on the same day, the E/M service must be separately identifiable. The Medicare definition of separately identifiable is included in the Evaluation and Management section.

RVU ASSIGNMENT OF CLINIC VISITS

The relative value units (RVUs) for the evaluation and management portion of a clinic visit are based on a 5-point visit level scale, while the RVUs for non-surgical procedures are specified by procedure. The development of the RVU values for each component will be explained in more detail in subsequent paragraphs. Clinic procedures considered surgery are to be reported via operating room minutes. The definition of surgical procedures will be explained in more detail later in this section.

RVUs were assigned based on clinical care time (CCT), as described in the E/M section, with a rule of 5 minutes of CCT per 1 RVU. This same logic should be applied to any services that are “by report”.

PART 1: EVALUATION AND MANAGEMENT (E/M) COMPONENT

CLINICAL CARE TIME

The evaluation and management portion of the clinic visit is based on a 5-point visit level scale. The amount of clinical care time provided to the patient during the E/M portion of the visit determines the visit level. Clinical care time is the combined total amount of time that each non-physician clinician spends treating the patient. The time does not necessarily have to be face-to-face with the patient, but the patient must be present in the department. The time spent by physicians, and other –physician providers, who bill professionally for their services is not included. It is possible for

multiple clinic personnel to be providing CCT to the same patient simultaneously. Therefore, in a given time interval, the hospital may record and report CCT greater than the actual clock time that as elapsed.

Both direct and indirect patient care may be included in CCT. Direct patient care will always be included in CCT. Indirect patient care may be included when the skills of a clinician are required to provide the care. Direct patient care includes tasks or procedures that involve face-to-face contact with the patient. These tasks may include: specimen retrieval, administration of medications, family support, patient teaching, and transportation of patients requiring a nurse or other clinical personnel whose cost is assigned to the Clinic. Indirect patient care includes tasks or procedures that do not involve face-to-face contact with the patient, but are related to their care. These tasks may include: arranging for admission, calling for lab results, calling a report to another unit, documentation of patient care, and reviewing prior medical records.

EXAMPLES OF SERVICES INCLUDED IN E/M COMPONENT

The following are examples of services performed by nursing and other clinical staff that may be included in CCT provided during the E/M portion of a clinic visit. The list is not all-inclusive and is only meant as a guide.

- Patient evaluation and assessment
- Patient education and skills assessment
- Patient counseling
- Patient monitoring that does not require equipment or a physician order (different from observation)
- Skin and wound assessment
- Wound cleansing and dressing changes
- Application of topical medications
- Transporting a patient, when it requires the skill of a clinician
- Coordination of care and discharge planning that requires the skill of a clinician

EXAMPLES OF SERVICES EXCLUDED FROM E/M COMPONENT

Services that do not require the skills of a clinician should be excluded from CCT. Examples of excluded activities are listed below. The list is not all-inclusive and is only meant as a guide.

- Patient waiting time
- All time spent on the phone with a payer
- Time spent securing payment authorization
- Chart set-up, room preparation
- Appointment setting
- Calling in prescriptions and entering orders and/or charges

PROFESSIONAL SERVICES ONLY VISIT

In instances where a patient sees only an *outside provider,* the hospital may only report a Level one E/M visit regardless of the amount of time a patient spends with the outside provider. An outside provider is a physician or other provider who bills professionally and is not included on the hospital's wage and salary reporting schedule. A level one E/M visit may also be reported when a patient is seen by clinic personnel and CCT totals 1-10 minutes, as per the E/M visit level guidelines below.

INTERNAL GUIDELINES

The RVUs for each visit level remain the same across every clinic. However, each clinic within a hospital is expected to develop and maintain a set of internal guidelines to standardize the amount of CCT required to perform common E/M services in the particular clinic. Hospitals are expected to conduct in-service programs to assure that new and existing clinic staff understand the guidelines and apply them fairly and consistently. The over-riding consideration is that there must be a "reasonable" relationship between the intensity of resource use and the assigned visit level.

The clinic's internal guidelines should include a typical time range for all of the commonly performed services in that clinic. The time range allows for the circumstances of the visit and judgment of the clinician, while maintaining a degree of uniformity among clinicians. The guidelines are not expected to dictate a definitive time value for every service that could be performed in a clinic. Instead their purpose is to provide an average time frame for commonly performed procedures. The format and content are at the facility's discretion. For example, taking vital signs: 5 minutes.

VISIT LEVELS

The minutes and RVUs for each of the five levels of an E/M visit are:

	New/Established	Minutes	RVUs
Level 1	99201/99211	0–10	2
Level 2	99202/99212	11–25	3
Level 3	99203/99213	26–45	4
Level 4	99204/99214	46–90	5
Level 5	99205/99215	>90	6

HCPCS code G0463 can be used for Medicare billing with the above levels assigned RUVs.

NEW VS. ESTABLISHED

The 2000 Federal Register defines a new vs. an established patient by whether or not the patient has an established medical record. Patients with a previously established medical record are considered established whether or not it is their first visit to a specific clinic.

SEPARATELY IDENTIFIABLE

To ensure uniform reporting by all Maryland hospitals, it is important to recognize when an E/M visit should be reported separately from a procedure or other E/M services. This manual is not meant to provide guidance on how to bill services or to interpret Medicare rules. Medicare discusses the term "separately identifiable" in Program Memorandum Transmittals AA-00-40 and A-01-80. Providers who want additional guidance or examples may check with their Medicare Administrative Contractor or other payor representative.

PART II: SERVICES AND NON-SURGICAL PROCEDURES

Each section includes tables with CPT codes, descriptions, and RVU values. It is prefaced with any information, coding guidelines, etc. that were used in setting the RVUs for each area. This manual is not meant to give direction or interpretation to Medicare billing or coding rules. Moreover, it is the goal of every work group that recommends revisions to RVUs that the revised system be as impervious as possible to future changes in billing rules and correct coding guidelines.

BACKGROUND INFORMATION ON DRUG ADMINISTRATION SERVICES

This manual is not meant to give direction or interpretation to Medicare billing or coding rules. However, substantial information on the current coding guidelines for injections, transfusions, and infusions is being included here because of the frequent changes and clarifications to coding guidelines for these services. The information is included to document the rules in place at the time the RVUs were developed and to provide rationale for the relative values. The Clinic RVU work group assigned RVUs to transfusions, infusions, and related drug administrations with the following information in mind.

VASCULAR ACCESS DEVICES

There are several codes related to vascular access devices, however, only 36593, "declotting-thrombolytic agent of vascular access device or catheter", is routinely and frequently performed in clinics. It was assigned an RVU value of 9. The insertion of non-tunneled central venous catheters (36555 and 36556) are performed and reported more frequently in interventional cardiology than in clinics, although a few hospitals routinely perform those procedures in clinics. After considering the options, the group decided that RVUs for the insertion of non-tunneled central venous catheters

(36555 and 36556) in the clinic would be reported via operating room minutes. (See the Surgical Procedures section of this appendix for further information.) The remaining CPT codes related to vascular access devices (36557-36620) are routinely performed in the IVC or operating room suite, and therefore, should not be assigned clinic RVUs. Any of these procedures that are performed in the clinic will be reported through the operating room cost center.

INJECTIONS

Are injections billed per injection, or per drug?

After substantial discussion, the work group agreed that injectable drugs are charged per injection when splitting a dosage is ordered and documented. The following examples were cited for further clarification.

- *If two drugs are mixed into one syringe/injection based* on nursing guidelines or standards of practice (such as Phenagran and Demerol), one unit/injection should be billed.

- *If two drugs cannot be administered together and require separate injections, two units of service may be billed, but the documentation should denote that these were separately administered based on the time injected. (Note: hospitals should avoid split drugs just for the sake of billing twice.)*

- *If an order is written as "10 mg morphine" and staff titrates it as 2 mg x 5 separate injections before the pain is relieved-the facility still can bill only one unit.*

- *If an order is written as "10 mg of morphine" and staff titrates 2 mg x 5 injections with no relief, and then the doctor orders an "additional 6 mg of morphine" and staff titrates 2 more injections of 2 mg prior to pain relief (14 mg total now administered)-two units/injections may be billed (7 actual injections performed).*

- *If an order is written as "10 mg of morphine" and staff titrates 2 mg x 5 injections with no relief, and then the doctor orders "5 mg of Torodol" and staff injects all 5 mg with pain relief-2 injections may be billed (one for each drug).*

If an order is written for an IM injection of Gentamycin, 160 mg. And a nurse administers it in a split 80 mg. IM dose, it should be billed as one unit of 90772 (IM injection). If it was ordered to be titrated in two 80 mg. doses, it could be billed as two units of 9077288. Hospitals may have specific physician-approved hospital policies that specify circumstances under which a dose is titrated. For example, "if a patient weights less than X, titrate IM injections over X mg. into multiple injections of not more than X mg." In this case, charge and bill for each IM injection.

TRANSFUSIONS

Transfusion of blood or blood components (36430) will be internally stratified by the number of hours. Stratifying by the number of units transfused was rejected because the resources consumed in the transfusion of units vary by patient diagnosis and type of product. The first hour of transfusion is weighted heavier than subsequent hours to include the staff's time preparing and assessing the patient prior to and at the conclusion of the transfusion. The timing of the transfusion begins and ends with the start and stop of the transfusion, and/or resolution of any reaction to the blood product. Any fraction of the first hour can be reported as a full hour, subsequent hours are subject to simple rounding rules i.e., must be 30 minutes or more.

INFUSIONS

Infusion coding is currently divided into chemotherapy and non-chemotherapy, and first hour and each additional hour. The first hour of infusion is weighted heavier than subsequent hours to include the staff's time preparing, educating and assessing the patient prior to and at the conclusion of the infusion. The timing of the infusion begins and ends with the start and stop of the infusion. The treatment of a reaction to a chemotherapy infusion should not be included in the timing of the infusion. A hospital that believes time resolving a reaction should be accounted for may consider whether those services are separately identifiable and warrant an E/M code. Education including discussion of the management of side effects is included in the value of chemotherapy infusions.

For further clarification, providers are encouraged to consult with their Medicare Administrative Contractor or other payor representative.

DRUG ADMINISTRATION SERVICES

IMMUNIZATIONS

36430	Transfusion, blood or blood components, first hour (0-90 min)	12
36430	Transfusion, blood or blood components, two hours (91-150 min)	18
36430	Transfusion, blood or blood components, three hours (151-210 min)	24
36430	Transfusion, blood or blood components, four hours (211-270 min)	30
36430	Transfusion, blood or blood components, five hours (271-330 min)	36
36430	Transfusion, blood or blood components, six hours (331-390 min)	42
36430	Transfusion, blood or blood components, seven hours (391-450 min)	48
36430	Transfusion, blood or blood components, eight hours (451-510 min)	54
36591	Collection of blood specimen from a completely implantable venous Access device	6
36593	Declotting by thrombolytic agent of implanted VAD or cath	9

IMMUNIZATIONS

90465	Immuniz. <8 y/o, percut, intraderm, IM, subq, first	2
+90466	Immuniz. <8 y/o, ea. additional, per day	1
90467	Immuniz. <8 y/o, intranasal or oral, first	2
+90468	Immuniz. <8 y/o, intranasal or oral, ea. additional	1
90471	Immuniz. percut, intraderm, IM, subq, first	2
+90472	Immuniz. ea. Additional, per day	1
90473	Immuniz. intranasal or oral, first	2
+90474	Immuniz. intranasal or oral, ea. additional	1

NON-CHEMOTHERAPY INJECTIONS AND INFUSIONS

90760	IV infusion, hydration; initial, 31 minutes to 1 hour	12
+90761	IV infusion, hydration; ea add'l hr	6
90765	IV infusion, for therapy, prophylaxis, or diagnosis, initial, up to 1 hr	12
+90766	IV infusion, ea add'l hr	6
+90767	IV infusion, add'l sequential infusion up to one hour	6
+90768	IV infusion, concurrent infusion	1
90769	SubQ infusion for therapy or prophylaxis, initial, up to 1 hr, including pump set-up and establishment of subQ infusion site(s)	By Report
+90770	SubQ infusion for therapy or prophylaxis, ea add'l hr	By Report
+90771	SubQ infusion for therapy or prophylaxis, add'l pump set-up and establishment of new subQ infusion site(s)	By Report
90772	Therapeutic, prophylactic, or diagnostic injection, subQ, or IM	3
90773	Therapeutic, prophylactic, or diagnostic injection, intraarterial	By Report
90774	Therapeutic, prophylactic, or diagnostic injection, IV push, single or initial substance/drug	6
+90775	Therapeutic, prophylactic, or diagnostic injection, IV push, ea add'l IV push of a new substance/drug	3
+90776	Therapeutic, prophylactic, or diagnostic injection, ea add'l sequential IV push of the same substance/drug provided in a facility single or initial substance/drug	By Report
90779	Unlisted ther, prophyl, or dx IV or IA injection or infusion	By Report

CHEMOTHERAPY INFUSIONS

RVUs are "By Report" for several services that are performed infrequently within the state.

96401	Chemotherapy admin, subQ or IM, non-hormonal anti-neoplastic	6
96402	Chemotherapy admin, subQ or IM, hormonal anti-neoplastic	6
96405	Chemotherapy admin, intralesional, 1-7 lesions	By Report
96406	Chemotherapy admin, Intralesional, 8+ lesions	By Report
96409	Chemotherapy admin, IV push, single or initial substance/drug	6
+96411	Chemotherapy admin, IV push, ea add'l substance/drug	3
96413	Chemotherapy admin, IV infusion, up to one hour, single or initial	18
+96415	Chemotherapy, IV infusion, ea add'l hour	9
96416	Chemotherapy, IV infusion initiation of prolonged infusion, >8hrs, with port or implantable pump	By Report
+96417	Chemotherarpy, IV Infusion, ea add'l sequential infusion, up to 1 hr	9
96420	Chemotherapy, intra-arterial, push	By Report
96422	Chemotherapy, intra-arterial, infusion, up to 1 hr	By Report
+96423	Chemotherapy, intra-arterial infusion, ea add'l hr	By Report
96425	Chemotherapy, intra-arterial infusion, initiation of prolonged infusion,>8 hrs, with port or implantable pump	By Report
96440	Chemother into pleural cavity, w/ thoracentesis	By Report
96445	Chemo into peritoneal cavity, w peritoneocent.	By Report
96450	Chemo into CNS, intrathecal, w/ spinal puncture	By Report
96521	Refill and maintenance of portable pump	By Report
96522	Refill and maintenance of implantable pump	By Report
96523	Irrigation of implanted venous access device for drug delivery	3
96542	Chemo inject, subarach or intraventric, subq reserv.	By Report
96549	Unlisted chemotherapy procedure	By Report

PSYCHIATRY (EXCLUDES PARTIAL HOSPITALIZATION- PHP)

In instances where a patient only sees an outside provider who bills professionally, the hospital may only report two RVUs regardless of the amount of time a patient spends with the outside provider. Two RVUs corresponds to a level one E/M visit that is used to report the facility component of an E/M visit when a clinic patient is seen only by an outside provider. (*See Professional Services Only Visit under Part II: E/M Component.)* The following RVUs are to be assigned only when the service is performed by a non-physician provider who does not bill professionally for the service.

90791	Psychiatric diagnostic evaluation (no medical services)	12
90792	Psychiatric diagnostic evaluation (with medical services)	18
90785	Interactive complexity (add-on code)	By Report
	Psychotherapy	
90832	Psychotherapy, 30 minutes	6
90833	Psychotherapy, 30 minutes (add-on code to E&M code)	6
90834	Psychotherapy, 45 minutes	9
90836	Psychotherapy, 45 minutes (add-on code, to E&M code)	9
90837	Psychotherapy, 60 minutes	12
90838	Psychotherapy, 60 minutes (add-on code to E&M code)	12
90839	Psychotherapy for crisis, first 60 minutes	12
90840	Psychotherapy for crisis, each additional 30 minutes (add on code)	6
90853	Group Psychotherapy (other than that of multi-family)	3
90845	Psychoanalysis	By Report
90846	Family psychotherapy w/o patient	10
90847	Family psychotherapy w/ patient	10
90849	Multiple family group psychotherapy	By Report
90853	Group psychotherapy	3
	Other	
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes	By Report
90870	Electroconvulsive therapy (ECT), single seizure. Performed and reported in OR	
90875	Individual psychophysiolog ther-biofdbk w/ psychotherapy, 20-30 min	6
90876	Individual psychophysiolog ther-biofdbk w/ psychotherapy, 45-50 min	10
90880	Hypnotherapy	By Report
90882	Environmental intervention for med management	By Report
90885	Psychiatric eval of records, reports & tests for diagnosis	By Report
90887	Interpret of psych or med exams & data to family	By Report
90889	Prep of report of pt status, hx, tx, or progress	By Report
90899	Unlisted psychiatric service or procedure	By Report

BIOFEEDBACK TRAINING

RVUs were left as “by report” as these services are not routinely performed in the Clinic setting.

These services are also reportable via the rehabilitation rate centers.

90901	Biofeedback training, any modality	By Report
90911	Biofeedback training, perineal muscles	By Report

OPHTHALMOLOGY

COMPREHENSIVE VS. INTERMEDIATE

In deciding whether to code an ophthalmologic exam as comprehensive vs. intermediate, the direction in the most recent CPT manual should be consulted. RVUs were set with the following distinction in mind: a comprehensive visit includes treatment, whereas, an intermediate visit does not.

92002	Ophthalmol svcs, medical exam, intermed, new pt.	4
92004	Ophthalmol svcs, medical exam, comprehensive, new pt.	6
92012	Ophthalmol svcs, medical exam, intermed, estab pt.	3
92014	Ophth svcs, medical exam, comprehensive, estab pt.	4
92015	Determination of refractive state	2
92018	Ophthal exam under gen anesth, complete	By Report
92019	Ophthal exam under gen anesth, limited	By Report
92020	Gonioscopy	By Report
92060	Sensorimotor exam, interp and report	9
92065	Orthoptic &/or pleoptic training w/ med. Direction	6
92070	Fitting of contact lens, include. Lens supply	By Report
92081	Visual field exam, w/ interp & report, limited	2
92082	Visual field exam, w/ interp & report, intermed.	4
92083	Visual field exam, w/ interp & report, extended	6
92100	Serial tonometry, w/ interp & report	By Report
92120	Tonography w/ interp & report	By Report
92130	Tonography w/ water provocation	By Report
92135	Scanning computerized ophthalmic diagnostic imaging, posterior seg, w/ interp & report, unilateral	4
92136	Ophthalmic biometry, partial coherence interferometry	By Report
92140	Provocative tests for glaucoma, w/ interp & report	By Report
92225	Ophthalmoscophy, extended, interp & report, initial	By Report
92226	Ophthalmoscophy, extended, interp & report, subsequent	By Report
92230	Fluorescein angioscopy, w/ interp & report	By Report
92235	Fluorescein angiography, w/ interp & report	4
92240	Indocyanine-green angiography, w/ interp & report	2
92250	Fundus photography w/ interp & report	2
92260	Ophthalmodynamometry	By Report

92265	Needle oculoelectromyography, w/interp & repor	By Report
92270	Electro-oculomyography, w/interp & report	By Report
92275	Electro-retinography, 2/interp & report	By Report
92283	Color vision exam, extended	By Report
92284	Dark adaptation exam w/interp & report	By Report
92285	External ocular photography, w/interp & report 3	
92286	Special anterior segment photography, w/interp & report	By Report
92287	Ant. Segment photo, w/fluorescein angiography	By Report
92499	Unlisted Ophthalmological service or procedure	By Report

CARDIAC REHABILITATION

RVUs for caridac rehab were based on the principle of one RVU per five minutes of clinical care time, with the assumptions that services are usually provided in a group setting with a staff to patient ratio of 1:3, and sessions last 60-75 minutes.

93797	Physician services for cardiac rehab, without monitoring	0
93798	Physician services for cardiac rehab, continuous monitoring	5

ALLERGY TESTING/IMMUNOTHERAPY

RVUs were left as “by report” as these services are not routinely performed in the hospital setting.

95004	Percutaneous tests w/ allergenic extracts, immed type reaction, incl test interp & report by physician, specify # of tests	By Report
95010	Percutaneous tests, w/ drugs, biological, venom, immed. rxn	By Report
95015	Intracutaneous tests, w/ drugs, biologicals, venom, immed. rxn	By Report
95024	Intracutaneous/intradermal tests, w/ allergenic extracts, immed. Rxn, incl test interp & report by physician, specify # of tests	By Report
95027	Intracutaneous/intradermal tests, w/ allergenic extracts, airborne, immed. Rxn, incl test interp & report by physician, specify # of tests	By Report
95028	Intracutaneous tests, allergenic extracts, delayed rxn, + reading	By Report
95044	Patch or application tests	By Report
95052	Photo patch tests	By Report
95056	Photo tests	By Report
95060	Ophthalmic mucous membrane tests	By Report
95065	Direct nasal mucous membrane tests	By Report
95070	Inhalation bronchial challenge, w/ histamine or methacholine	By Report
95071	Inhalation bronchial challenge, w/ antigens or gases	By Report
95075	Ingestion challenge, sequential and incremental	By Report
95180	Rapid desensitization procedure, ea hour	By Report
95199	Unlisted allergy/clinical immunologic service or procedure	By Report

ENDOCRINOLOGY

RVUs were left as "by report" as these services are not routinely performed in the hospital setting.

95250	Glucose monitoring, up to 72 hours by continuous recording	By Report

PSYCHOLOGICAL TESTING

Some of the following CPTs may also be reported via the speech language pathology (STH) rate center using the RVUs defined in that rate center.

96101	Psyc Testing per hour of MD or Ph.D time, both face-to-face time to administer tests & interp & report prep time	12
96102	Psyc Testing w/ qualified health care professional interp & report, admin by tech, per hr of tech time, face-to-face	By Report
96103	Psyc Testing admin by computer, w/ qualified health care professional interp & report	By Report
96105	Assessment of aphasia12	
96110	Developmental testing	By Report
96111	Developmental testing, extended	By Report
96116	Neurobehavioral status exam	12
96118	Neropsych testing, per hr of MD or Ph.D, both face-to face time to administer tests & interp & report prep time	By Report
96119	Neuropsychological testing battery, admin. by technician, per hour	By Report
96120	Neuropsychological testing battery, admin. by computer, per hour	By Report
96125	Standardized cognitive performance testing, per hr, both Face-to-face time admin tests & interp & report prep time	By Report

PHOTODYNAMIC THERAPY/DERMATOLOGY

RVUs were left as "by report" as these services are not routinely performed in the hospital setting.

96567	Photodynamic therapy, external application of light	By Report
+96570	Photodynamic therapy, endoscopic application of light, 30 min	By Report
+96571	Photodynamic therapy, endoscopic, ea additional 15 min	By Report
96900	Actinotherapy	By Report
96902	Microscopic exam of hair–telogen and anagen counts	By Report
96910	Photochemotherapy, tar & UVB or petrolatum & UVB	By Report
96912	Photochemotherapy, psoralens & UVB	By Report
96913	Goeckerman &/or PUVA, severe, 4-8 hrs, direct superv.	By Report

96920	Laser treatment, <250 cm²	By Report
96921	Laser treatment, 250-500 cm²	By Report
96922	Laser treatment, > 500 cm²	By Report
96999	Unlisted special dermatological service or procedure	By Report

MEDICAL NUTRITION THERAPY

These services are currently not a facility benefit for Medicare purposes, but are routinely performed in the hospital clinic setting.

97802	Medical nutrition therapy, Individual, initial, ea 15 min	3
97803	Medical nutrition, Individual, re-assess, ea 15 min	3
97804	Medical nutrition, group, re-assess, ea 30 min	4
G0270	Medical nutrition therapy, Individual, ea 15 min	3
G0271	Medical nutrition therapy, group, ea 30 min	4

ACUPUNCTURE AND CHIROPRACTIC

RVUs were left as “by report” as these services are not routinely performed in the hospital setting.

97810	Acupuncture, 1 or more needles, 15 min	By Report
+97811	Acupuncture, 1 or more needles, addl 15 min	By Report
97813	Acupunct, 1 or more needle, w/elect. Stim, 15 min	By Report
+97814	Acupunct, 1 or more needle, w/ elect. Stim, addl 15 min	By Report
98925	Osteopathic manipulative trmt (OMT); 1-2 regions	By Report
98926	Osteopathic manipulative trmt (OMT); 3-4 regions	By Report
98927	Osteopathic manipulative trmt (OMT); 5-6 regions	By Report
98928	Osteopathic manipulative trmt (OMT); 7-8 regions	By Report
98929	Osteopathic manipulative trmt (OMT); 9-10 regions	By Report
98940	Chiropractic manipulation, spinal 1-2 regions	By Report
98941	Chiropractic manipulation, spinal 3-4 regions	By Report
98942	Chiropractic manipulation, spinal 5 regions	By Report
98943	Chiropractic manip, extraspinal 1 or more regions	By Report

DIABETES SELF MANAGEMENT TRAINING

G0108	Diabetes self management, Individual, 30 min.	6
G0109	Diabetes self management, group, 30 min.	3

SMOKING CESSATION

99406	Smoking/tobacco-use cessation counseling; intermediate, >3-10 min	2
99407	Smoking/tobacco-use cessation counseling; intensive, >10 min	9

ALCOHOL AND/OR SUBSTANCE (OTHER THAN TOBACCO) ABUSE

99408Alcohol and/or substance abuse structured screening and brief intervention services; 15-30 min	By Report
99409Alcohol and/or substance abuse structured screening and brief intervention services; >30 min	By Report

GASTROENTEROLOGY

All GI services (codes 91000-91299) will be reported through the operating room center. (See the Surgical Procedure section for more information.)

WOUND CARE

No new assignments were made for services performed in a wound care clinic. The following codes are not reportable in Clinic because they are already assigned in the Physical Therapy cost center: 97597, 97598, 97602, 97605, 97606, 0183T. The decision to use 1104X codes to describe excisional debridement should be made based on guidance from your Medicare Administrative Contractor or other payor representative.

PART III: SURGICAL PROCEDURES

Any surgical procedures performed in a clinic should be reported via the operating room cost center, and associated surgical costs allocated to the operating room rate center (excluding the exceptions listed in more detail below). Surgical procedures are defined as all procedures corresponding to CPT codes from 10000 to 69999 (surgery) and 91000 to 91299 (gastroenterology).

A few rate centers include a limited number of surgical procedures with CPT codes between 10000 and 69999 that have already been assigned RVUs relative to other procedures in that cost center. For the most part, the RVU values and reporting of these procedures will remain unchanged. The procedures and how they should be reported are:

- *Clinic*-Specimen Collection via VAD (CPT 36591), Declotting (CPT 36593), and Blood Transfusions (CPT 36430) have been assigned Clinic RVUs, and should be reported as clinic revenue.

  Delivery-Non-Stress Tests, amniocentesis, external versions, cervical cerclages, dilation and curettage/evacuation and curettage, hysterectomies, deliveries, etc. Continue to report via DEL by assigned RVUs.

Interventional Cardiology-certain IVC procedures have surgical CPT codes are defined in the IVC rate center with RVUs. Hospitals should continue to report using those IVC RVUs

- until instructed otherwise.

- *Laboratory*-Venipunctures/Capillary punctures. These procedures are considered to be part of the E/M component of a clinic visit. If a hospital chooses to code and report them separately in the clinic, the RVU is zero. If a phlebotomist comes to the clinic to do the procedure, the revenue and expenses are allocated to LAB.

- *Lithotripsy*-Procedures will continue to be reported in the LIT cost center as the number of procedures.

- *Occupational and Physical therapy*-Splinting, Strapping and Unna Boot application (CPT codes 29105-29590) continue to report with assigned PT/OT RVUs

- *Radiation Therapy*-Stereotactic Radiosurgery (61793). Continue to report with assigned RAT RVUs.

- *Speech Therapy*-Laryngoscopy (31579). Continue to report via STH by assigned RVUs.

- *Therapeutic apheresis*-Continue to report through LAB; RVUs are by report.

Non-physicians may perform procedures that will be reported as operating room revenue. The HSCRC acknowledged that it is appropriate for non-physicians to generate operating room minute charges as long as the clinician is providing services within the scope of his or her practice standards.

DOCUMENTING START AND STOP TIMES FOR SURGICAL PROCEDURES PERFORMED IN CLINIC

The definition of stop and start time for surgical procedures performed in clinics is the same definition as that used in the operating room Chart of Accounts that states:

> *Surgery minutes is the difference between starting time and ending time defined* as follows: *Starting time is the beginning of anesthesia administered in the operating room or the beginning of surgery if anesthesia is not administered or if anesthesia is administered in other than the operating room. Ending time is the end of the anesthesia or surgery if anesthesia is not administered. The time the anesthesiologist spends with the patient in the recovery room is not to be counted.*

Clinicians need to document procedure stop and start times in the medical record, unless the hospital is using average times. It is not necessary to keep a log similar to the one kept in the Operating Room (OR) to document the minutes of each procedure. Unlike in the OR, clinic staff may enter and leave the room during a procedure. This does not affect the calculation of procedure minutes. Please

reference additional information in this section regarding reporting of actual minutes (included vs. excluded minutes).

As an alternative to reporting actual minutes, hospitals may report procedures using average times that are "hard coded". To report average procedure times, hospitals should conduct time studies to find the average time it takes to perform common procedures and periodically verify these average times. Please reference additional information in this section regarding reporting of average minutes (included vs. excluded minutes).

ACTIVITIES INCLUDED IN PROCEDURE TIME

As stated above, the definition of procedure start and stop times for surgical procedures performed in the clinic is the same as the definition of procedure start and times for procedures performed in the operating room. However, for surgical procedures performed in the clinic, some activities that are integral to the procedure may not be typically thought of as included in the time of the procedure. The following lists of included and excluded activities are examples to guide the decision of which activities to include and exclude from the timing of surgical procedures performed in clinics. These lists are not all-inclusive but should be used as a guide when reporting minutes for these services.

INCLUDED ACTIVITIES

When the following activities are integral to a procedure, the time it takes to perform the activity should be included in the procedure time. These services are all above and beyond the actual performance of the surgical service, i.e. "cut to close". Many of these examples apply directly to wound care but should also be applied to all surgical procedures performed in the clinic. The overriding consideration is that the minutes associated with the procedure along with the minutes associated with clinical care time spent preparing the recovering the patient are reportable surgical minutes.

- Positioning of the patient in preparation for the procedure
- Removal of dressing/casting/Unna boot (i.e. whatever covers the wound)
- Cleansing of wound
- Wound measurement and assessment
- Applications of topical/local anesthetic
- Application of topical pharmaceuticals and dressing post procedure
- Monitored time when waiting for anesthetic to become effective
- Taking vital signs
- Monitored time when waiting for cast to dry

Monitored time post procedure when waiting for recovery from anesthetic

EXCLUDED ACTIVITIES

The time it takes to perform the following activities should not be included in the procedure time.

- Waiting time in general
- Teaching
- Non-monitored time when waiting for topical and/or local anesthetic to become effective
- Non-monitored time when waiting for cast to dry
- Non-monitored time post procedure when waiting for recovery from anesthetic

PART IV: MISCELLANEOUS INFORMATION

COUNTING CLINIC VISITS

The definition of a clinic visit follows the logic of the definition of a referred ambulatory visit. See Section 500 Reporting Instructions page 017 Schedule V2B columns 1 to 3. A patient who is seen in a clinic and receives an E/M service and/or non-surgical procedure is counted for one clinic visit. A patient who is seen in a clinic and receives a surgical procedure is counted as a surgery visit. A patient who is seen in a clinic and receives an E/M service plus a surgical procedure is counted as two visits-clinic and surgery. A patient receiving E/M services and/or non-surgical procedures in two different clinics is counted as two visits. Patients who are seen twice at the same clinic at two different times on one day for therapeutic or treatment protocol reasons are counted as having two visits. However, patients who are seen in the same clinic at two different times on one day because of scheduling difficulties would be counted as one visit. More information on counting visits is included in Part III: Surgical Procedures under the Same Day Surgery section and in Section 500 of this manual-Reporting Instructions for Schedule OVS.

Maria Harris Tildon
Executive Vice President
Marketing & Government Affairs

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May 21, 2020

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

Dear Mr. Kane:

CareFirst appreciates the opportunity to comment on the "Draft Recommendation on Changes to Relative Value Units for Clinic Evaluation & Management (E&M) Effective July 1, 2020". We thank the HSCRC Staff for making these recommended changes and we support the Draft Recommendation as proposed.

During the May Public HSCRC meeting, there was a discussion around the larger issue of rate realignment between inpatient and outpatient services. In 2012, HSCRC made a "temporary" emergency adjustment that shifted 25% of costs from inpatient-only rate centers to all other rate centers. The change was made at the time to provide room on the existing Waiver test until a new All-Payer Model agreement could be executed with CMS. This adjustment remains in place eight years later, causing inflated outpatient rates and inpatient rates that do not reflect actual costs.

In the spirit of this discussion, CareFirst supports the effort to reverse the 2012 realignment shift to re-establish cost integrity and rate fairness across inpatient and outpatient rates.

Again, we thank you for this opportunity to share our support and thoughts regarding this Draft Recommendation. We stand ready to work with you and all stakeholders on considering the larger issue of alignment between inpatient and outpatient costs and rates.

Sincerely,

Maria Harris Tildon

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

Maryland
Hospital Association

May 20, 2020

William Hoff
Chief, Audit and Compliance
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Hoff:

On behalf of the Maryland Hospital Association's 61 member hospitals and health systems, we offer our comments on the Health Services Cost Review Commission's (HSCRC) proposed relative value unit (RVU) revisions in the outpatient clinic rate center.

Hospital-based outpatient clinic services are an important component of our delivery system. As in other states, hospital-based clinics exist to provide specialized clinical services and to serve as a safety net so uninsured and underinsured patients have access to care.

The proposed changes would flatten the RVU scale and reduce the charge per outpatient clinic visit at the higher end of the scale. The recommendation would also reclassify regulated charges away from the clinic rate center to other rate centers. **Maryland's hospitals support these recommendations.**

Subsequent to the draft recommendation, HSCRC agreed to remove a fixed RVU value for billing code G0463 and to leave instructions for assigning clinic RVUs unchanged in Appendix D of the Accounting and Budget Manual. **We support these revisions from the draft recommendation.**

We appreciate HSCRC staff considering hospital field input, and Maryland's hospitals are pleased with the outcome. If you have any questions, please contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: Dennis Phelps, HSCRC
William Henderson, HSCRC
Karen Teague, HSCRC

Rate Year 2021 Uncompensated Care Report

June 10, 2020

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

This document contains the staff report for RY 2021 Uncompensated Care Policy. There are no proposed changes in methodology and thus no need for a formal Commission vote.

Table of Contents

INTRODUCTION

Uncompensated Care (UCC) is care provided for which no compensation is received, typically a combination of charity care and bad debt. Recognizing the financial burden hospitals take on when providing quality care to patients who cannot readily pay for it, the Maryland Health Services Cost Review Commission (HSCRC) factors in the cost of UCC into the State's hospital rate setting structure. This provision assures access to hospital services in the State for those patients who cannot readily pay for them and hospitals equally get credited for the care provided.

The purpose of this report is to provide background information on the UCC policy and to provide hospital-specific values for the UCC built into statewide rates as well as the UCC pool for rate year (RY) 2021. The HSCRC determines the total amount of UCC that will be placed in hospital rates for each year and the amount of funding that will be made available for the UCC pool. For RY 2021, the determined UCC amount to be built into rates for Maryland hospitals is 4.41 percent. Under the current HSCRC policy, UCC above the statewide average is funded by a statewide pooling system whereby regulated Maryland hospitals draw funds from the pool should they experience a greater-than-average level of UCC and pay into the pool should they experience a less-than-average level of UCC. This ensures that the cost of UCC is shared equally across all hospitals within the State.

METHODOLOGY

The HSCRC prospectively calculates the rate of uncompensated care at each regulated Maryland hospital using a three-step process:

1. The first step is to determine the actual UCC based on the prior year's bad debt and charity care as reported on the Revenue and Expense (RE) Schedules. Therefore, actual UCC percentages for RY 2021 is computed using bad-debt and charity care as a percentage of gross patient revenue from the RY 2019 RE Schedules. The results from this computation determines the statewide UCC rate that will be built into hospital rate structures. It is important to note that only acute care hospitals are considered when determining the statewide UCC level. All freestanding emergency centers, behavioral health and specialty hospitals are not considered in the determination of how much to fund UCC statewide. (See Appendix II Table 1).

2. The second step uses a logistic regression model to predict the UCC for RY 2021. A regression is a statistical technique used when determining how much an output amount changes due to changes in multiple inputs. In this case, those inputs include: area deprivation Index (ADI), payer type, and site of care. An expected UCC dollar amount is calculated for every patient encounter. UCC dollars are summed at the hospital level, and summed UCC dollars are divided by hospital total charges to establish the hospital's estimated UCC level. This calculation creates a predicted UCC rate for each hospital.

The logistic regression is limited to just acute care hospitals. UMROI, Levindale and Shock Trauma are also excluded from the regression due to the fact that these hospitals do not incorporate all of the input variables necessary to perform the regression as listed earlier in this section. (See Appendix I).

3. The third step involves performing a 50/50 blend between the actual UCC computed from the RE Schedules and the predicted UCC from the regression as a percent of hospital projected RY 2021 GBR. This action ensures that hospitals have an incentive to collect bad debts, as providing UCC at 100 percent of prior year actuals creates a moral hazard. The results of this calculation determines hospital-specific UCC levels in relation to the statewide UCC level determined in step 1. It is at this step where a determination is made as to how much each hospital will either withdraw from or pay into the UCC pool. (See Appendix I).

ASSESSMENT

The HSCRC must determine the percentage of UCC to incorporate in hospitals' rates in order to fund the UCC pool. Based on the RY 2019 audited reports, the statewide UCC rate was 4.41 percent, 0.15 percentage points higher than last year's UCC rate of 4.26 percent. According to the statistics published by the U.S. Census Bureau on September 16, 2015, the rate of Marylanders without health insurance decreased from 10.2 percent in 2013 to 7.9 percent in 2014.[1] Based on the Census Bureau's American Community Survey, Kaiser Family Foundation estimates Maryland's uninsured rate to have decreased to 6 percent as of 2018;[2] however, as the RY 2019 experience demonstrates, the continuing reductions in UCC that resulted from the implementation of the Affordable Care Act and the lowering of the uninsured population has slowed. For RY 2021, staff will provide a UCC rate of 4.41 percent in rates in keeping with prior year methodologies.

IMPLEMENTATION

Based on the preceding analysis, HSCRC staff will implement the following for RY 2021:

1. Increase the statewide UCC provision in rates from 4.26% to 4.41% effective July 1, 2020.

2. Continue to use the regression modeling approach approved by the Commission at the June 2016 meeting.

[1] http://www.marylandhbe.com/fewer-marylanders-without-health-coverage-census-bureau-reports/
[2] https://www.kff.org/other/state-indicator/total-population/?currentTimeframe=0&selectedRows=%7B%22states%22:%7B%22maryland%22:%7B%7D%7D%7D&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D

3. Continue to do 50/50 blend of FY19 audited UCC levels and FY2021 predicted UCC levels to determine hospital-specific adjustments.

FUTURE CONSIDERATIONS

Earlier this year, Staff began evaluating the possibility of using multi-year actual UCC averages in lieu of the one year figures to do the 50/50 blend with predicted UCC from the regression. Staff believes that using two or more years of history will make the statistic more stable, especially as the declining trends due to the implementation of the Affordable Care Act appear to have slowed. However, with the onset of Covid-19, Staff has halted further work on this and other policy development to allow the hospitals sufficient bandwidth to respond to the pandemic. Following the commissions protocol for policy creation and implementation, Staff will resume evaluation of the multi-year blend on actuals for the RY 2022 UCC policy, at which point staff will also address any implications from the federal CARES act funding that hospitals can avail themselves to for reimbursement of COVID-related treatment of the uninsured

Appendix I. Hospital Uncompensated Care provision FOR RY 2021

HOSPID	HOSPNAME	FY2021 GBR Permanent Revenue	FY 2019 UCC Based on FY 2021 GBR Permanent Revenue	FY 2019 Percent UCC from the RE Schedule	Percent Predicted UCC (Adjusted)	Predicted UCC Amounts (Based on FY 2021 GBR Permanent Revenue)	50/50 Blend Percent	50/50 Blend Adjusted to FY 2019 UCC Based on FY 2021 GBR Permanent Revenue Level	Percent UCC
210001	Meritus Medical Cntr	$ 396,672,128	$ 18,297,770	4.61%	4.91%	$ 19,492,598	4.76%	$ 19,494,212	4.91%
210002	UMMC	$ 1,662,265,601	$ 69,785,691	4.20%	2.55%	$ 42,346,209	3.37%	$ 57,843,392	3.48%
210003	UM-Prince George's Hospital	$ 353,143,106	$ 31,228,938	8.84%	7.28%	$ 25,707,853	8.06%	$ 29,370,921	8.32%
210004	Holy Cross	$ 530,249,154	$ 44,307,570	8.36%	7.00%	$ 37,119,564	7.68%	$ 42,004,297	7.92%
210005	Frederick Memorial	$ 373,830,810	$ 17,376,792	4.65%	5.20%	$ 19,426,241	4.92%	$ 18,984,894	5.08%
210006	UM-Harford Memorial	$ 111,520,291	$ 7,190,893	6.45%	4.30%	$ 4,798,414	5.38%	$ 6,184,700	5.55%
210008	Mercy Medical Cntr	$ 574,957,129	$ 29,093,472	5.06%	3.85%	$ 22,152,571	4.46%	$ 26,435,341	4.60%
210009	Johns Hopkins	$ 2,603,213,204	$ 67,311,289	2.59%	3.02%	$ 78,491,344	2.80%	$ 75,212,486	2.89%
210010	UM-SRH at Dorchester	$ 47,411,431	$ 2,610,210	5.51%	5.12%	$ 2,426,529	5.31%	$ 2,598,208	5.48%
210011	St. Agnes Hospital	$ 444,529,453	$ 21,819,305	4.91%	4.75%	$ 21,130,685	4.83%	$ 22,155,810	4.98%
210012	Sinai Hospital	$ 871,616,421	$ 25,771,915	2.96%	3.45%	$ 30,101,099	3.21%	$ 28,822,170	3.31%
210013	Bon Secours Hospital	$ 50,629,984	$ 1,194,898	2.36%	4.36%	$ 2,209,330	3.36%	$ 1,756,076	3.47%
210015	MedStar Franklin Square	$ 584,424,327	$ 20,455,548	3.50%	3.71%	$ 21,701,751	3.61%	$ 21,746,899	3.72%
210016	Washington Adventist Hospital	$ 308,889,863	$ 25,310,578	8.19%	6.57%	$ 20,285,630	7.38%	$ 23,520,866	7.61%
210017	Garrett Co Memorial	$ 64,923,243	$ 4,523,036	6.97%	5.12%	$ 3,323,455	6.04%	$ 4,047,623	6.23%
210018	MedStar Montgomery	$ 185,418,639	$ 6,367,928	3.43%	3.88%	$ 7,203,491	3.66%	$ 7,000,835	3.78%
210019	Peninsula Regional	$ 489,888,164	$ 18,557,642	3.79%	4.20%	$ 20,565,990	3.99%	$ 20,181,978	4.12%

210022	Suburban	$ 352,204,282	$ 12,663,912	3.60%	3.85%	$ 13,546,581	3.72%	$ 13,520,718	3.84%
210023	Anne Arundel Medical Cntr	$ 668,814,678	$ 18,105,021	2.71%	3.44%	$ 23,011,443	3.07%	$ 21,209,983	3.17%
210024	MedStar Union Memorial	$ 440,281,229	$ 13,107,508	2.98%	3.72%	$ 16,362,627	3.35%	$ 15,202,209	3.45%
210027	Western Maryland	$ 347,061,624	$ 18,617,971	5.36%	4.42%	$ 15,334,567	4.89%	$ 17,514,463	5.05%
210028	MedStar St. Mary's	$ 197,539,003	$ 8,833,992	4.47%	3.83%	$ 7,573,187	4.15%	$ 8,463,665	4.28%
210029	JH Bayview	$ 723,588,869	$ 37,642,784	5.20%	4.91%	$ 35,519,348	5.06%	$ 37,740,785	5.22%
210030	UM-SRH at Chestertown	$ 54,849,764	$ 2,955,731	5.39%	4.17%	$ 2,288,471	4.78%	$ 2,705,229	4.93%
210032	Union Hospital of Cecil Co	$ 174,088,858	$ 9,258,994	5.32%	4.49%	$ 7,814,445	4.90%	$ 8,807,357	5.06%
210033	Carroll Co Hospital Cntr	$ 244,045,385	$ 5,686,306	2.33%	3.55%	$ 8,653,145	2.94%	$ 7,397,026	3.03%
210034	MedStar Harbor Hospital Cntr	$ 196,848,325	$ 9,094,284	4.62%	4.54%	$ 8,931,865	4.58%	$ 9,298,813	4.72%
210035	UM-Charles Regional	$ 162,492,943	$ 8,541,349	5.26%	4.82%	$ 7,828,762	5.04%	$ 8,444,544	5.20%
210037	UM-SRH at Easton	$ 235,456,663	$ 7,989,170	3.39%	3.30%	$ 7,778,942	3.35%	$ 8,134,002	3.45%
210038	UMMC - Midtown	$ 228,986,072	$ 11,913,442	5.20%	3.57%	$ 8,184,284	4.39%	$ 10,367,440	4.53%
210039	Calvert Health Med Cntr	$ 159,336,602	$ 6,799,147	4.27%	3.90%	$ 6,218,072	4.08%	$ 6,714,950	4.21%
210040	Northwest Hospital Cntr	$ 281,304,485	$ 14,220,613	5.06%	5.22%	$ 14,677,155	5.14%	$ 14,906,952	5.30%
210043	UM-BWMC	$ 467,697,479	$ 27,615,024	5.90%	3.74%	$ 17,485,694	4.82%	$ 23,265,266	4.97%
210044	GBMC	$ 498,751,642	$ 12,884,594	2.58%	3.48%	$ 17,374,402	3.03%	$ 15,609,144	3.13%
210045	McCready Memorial	$ 5,652,059	$ 304,100	5.38%	6.35%	$ 358,702	5.86%	$ 341,908	6.05%
210048	Howard County General	$ 318,284,993	$ 13,001,466	4.08%	4.40%	$ 13,990,971	4.24%	$ 13,924,086	4.37%
210049	UM-Upper Chesapeake	$ 332,770,718	$ 13,742,814	4.13%	3.47%	$ 11,551,833	3.80%	$ 13,048,278	3.92%
210051	Doctors Community	$ 268,585,331	$ 19,513,544	7.27%	5.64%	$ 15,156,640	6.45%	$ 17,884,661	6.66%
210055	UM-Laurel Regional	$ 34,239,946	$ 4,198,572	12.26%	10.43%	$ 3,572,772	11.35%	$ 4,008,858	11.71%

210056	MedStar Good Samaritan	$ 278,617,567	$ 12,430,611	4.46%	4.18%	$ 11,634,472	4.32%	$ 12,414,006	4.46%
210057	Shady Grove Adventist Hospital	$ 480,905,268	$ 24,798,869	5.16%	5.40%	$ 25,955,261	5.28%	$ 26,181,586	5.44%
210060	Fort Washington Medical Center	$ 53,886,528	$ 4,478,927	8.31%	8.81%	$ 4,745,240	8.56%	$ 4,758,299	8.83%
210061	Atlantic General	$ 116,105,093	$ 5,504,651	4.74%	5.18%	$ 6,012,312	4.96%	$ 5,941,041	5.12%
210062	MedStar Southern MD	$ 288,479,390	$ 15,092,217	5.23%	4.00%	$ 11,528,974	4.61%	$ 13,732,577	4.76%
210063	UM-St. Joseph Med Cntr	$ 401,981,552	$ 15,497,093	3.86%	4.09%	$ 16,422,437	3.97%	$ 16,465,732	4.10%
210065	HC-Germantown	$ 121,010,475	$ 10,236,932	8.46%	8.47%	$ 10,251,190	8.47%	$ 10,568,826	8.73%
	Total	**$ 17,787,449,775**	**$ 775,933,113**	**4.36%**	**4.11%**	**$ 728,246,545**	**4.23%**	**$ 775,933,113**	**4.36%**

Note: Levindale, UMROI, and UM-Shock Trauma are not included in this analysis. If included, the actual UCC from RY 2019 RE Schedule would be 4.41%. This rate of 4.41% is what is built into rates.

Appendix II. UCC Summary Statistics

The table below presents the actual UCC change by hospital between FY 2018 and FY 2019– it does not reflect predicted UCC rates.

Appendix II. Table 1. Actual UCC Change by Hospital, FY 2018-2019

HOSPID	HOSPNAME	RY 2018 % UCC	RY 2019 % UCC	Variance Over/Under
210001	Meritus Medical Cntr	4.33%	4.61%	0.28%
210002	UMMC	4.10%	4.20%	0.10%
210003	UM-Prince George's Hospital	9.14%	8.84%	-0.30%
210004	Holy Cross	7.30%	8.36%	1.06%
210005	Frederick Memorial	4.34%	4.65%	0.31%
210006	UM-Harford Memorial	6.86%	6.45%	-0.41%
210008	Mercy Medical Cntr	4.41%	5.06%	0.65%
210009	Johns Hopkins	2.47%	2.59%	0.12%
210010	UM-SRH at Dorchester	5.60%	5.51%	-0.09%
210011	St. Agnes Hospital	5.03%	4.91%	-0.12%
210012	Sinai Hospital	3.52%	2.96%	-0.56%
210013	Bon Secours	2.13%	2.36%	0.23%
210015	MedStar Franklin Square	3.95%	3.50%	-0.45%
210016	Washington Adventist	7.02%	8.19%	1.17%
210017	Garrett Co Memorial	6.57%	6.97%	0.40%
210018	MedStar Montgomery	3.16%	3.43%	0.27%
210019	Peninsula Regional	3.49%	3.79%	0.30%
210022	Suburban	3.40%	3.60%	0.20%
210023	Anne Arundel Medical Cntr	2.80%	2.71%	-0.09%
210024	MedStar Union Memorial	3.59%	2.98%	-0.61%
210027	Western Maryland	4.99%	5.36%	0.37%
210028	MedStar St. Mary's	4.17%	4.47%	0.30%
210029	JH Bayview	5.14%	5.20%	0.06%
210030	UM-SRH at Chestertown	5.25%	5.39%	0.14%
210032	Union Hospital of Cecil Co	5.89%	5.32%	-0.57%
210033	Carroll Co Hospital Cntr	1.65%	2.33%	0.68%
210034	MedStar Harbor Hospital Cntr	4.26%	4.62%	0.36%
210035	UM-Charles Regional	5.35%	5.26%	-0.09%
210037	UM-SRH at Easton	3.59%	3.39%	-0.20%
210038	UMMC - Midtown	5.55%	5.20%	-0.35%
210039	Calvert Health Med Cntr	3.82%	4.27%	0.45%
210040	Northwest Hospital Cntr	4.33%	5.06%	0.73%
210043	UM-BWMC	6.05%	5.90%	-0.15%
210044	GBMC	2.25%	2.58%	0.33%

210045	McCready Memorial	5.78%	5.38%	-0.40%
210048	Howard County General	3.63%	4.08%	0.45%
210049	UM-Upper Chesapeake	2.92%	4.13%	1.21%
210051	Doctors Community	6.58%	7.27%	0.69%
210055	UM-Laurel Regional	9.55%	12.26%	2.71%
210056	MedStar Good Samaritan	4.16%	4.46%	0.30%
210057	Shady Grove	5.01%	5.16%	0.15%
210058	UM-ROI	5.07%	4.49%	-0.58%
210060	FT. Washington	9.89%	8.31%	-1.58%
210061	Atlantic General	4.95%	4.74%	-0.21%
210062	MedStar Southern MD	5.07%	5.23%	0.16%
210063	UM-St. Joseph Med Cntr	3.91%	3.86%	-0.05%
210064	Levindale	3.12%	4.68%	1.56%
210065	HC-Germantown	9.09%	8.46%	-0.63%
218992	UM-Shock Trauma	6.20%	6.26%	0.06%
Total		**4.26%**	**4.41%**	**0.15%**

Note: Free-Standing EDs, Behavior Health and Specialty Hospitals are not included in this analysis
Source: HSCRC RE Schedules

Appendix II. Table 2. UCC Write Off Distribution by Payer, RY 2019

The table below presents the UCC write off distribution by payer for services provided in FY 2019 based on the account-level information provided to the Commission. The largest contributor to UCC write off is from patients with a primary payer of charity care/self-pay at 33.98 percent of total UCC write off. Commercial payers and Medicare accounted for 30.25 and 17.13 percent of UCC, respectively.

UCC Write Off Distribution by Payer, RY 2019

Payer	Total Write Off	% of Total Write Off
Medicaid	$ 93,907,915	13.49%
Medicare	$ 119,201,202	17.13%
Other	$ 35,867,562	5.15%
Self-Pay/Charity	$ 236,496,607	33.98%
Commercial	$ 210,571,612	30.25%
Total	$ 696,044,899	100.00%

Source: 2019 UCC Write-off Data

Policy Update Report and Discussion

Staff will present materials at the Commission Meeting.

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Department of Health

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Vice-Chairman

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TO: **HSCRC Commissioners**

FROM: **HSCRC Staff**

DATE: **June 10, 2020**

RE: **Hearing and Meeting Schedule**

July 8, 2020	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
August 12, 2020	To be determined – 4160 Patterson Avenue HSCRC/MHCC Conference Room

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

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