maryland
health services
cost review commission

596th Meeting of the Health Services Cost Review Commission
June 8, 2022

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

EXECUTIVE SESSION
11:30 am

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on May 11, 2022
2. Docket Status – Cases Closed

   2594A – Johns Hopkins Health System
   2595R – Johns Hopkins Hospital

3. Docket Status – Cases Open

   2587R – Tidal Health- Peninsula Regional
   2588R - Carroll Hospital
   2589R – Shady Grove Adventist Hospital
   2596N -UM Emergency Center at Queenstown
   2597A - Johns Hopkins Health System
   2598A - Johns Hopkins Health System

4. Final CRISP Funding – FY 2023
5. Final Update Factor – FY 2023
6. Final Recommendation on Nurse Support Program I Renewal
7. Final Recommendation on Changes to Clinic Relative Value Units
8. Draft Revenue Reform Recommendation
9. Uncompensated Care Report – FY 2023
10. Policy Update and Discussion

a. Workgroup Update

11. Maryland Patient Safety Center Report on 2022 Activities

12. Hearing and Meeting Schedule

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MINUTES OF THE
595th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
May 11, 2022

Chairman Adam Kane called the public meeting to order at 11:33 a.m. Commissioners Joseph Antos, PhD, Victoria Bayless, Stacia Cohen, James Elliott, M.D., Maulik Joshi, DrPH, and Sam Malhotra were also in attendance. Upon motion made by Commissioner Cohen and seconded by Commissioner Elliot, the meeting was moved to Closed Session. Chairman Kane reconvened the public meeting at 1:14 p.m.

REPORT OF MAY 11, 2022 CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the May 11, 2022, Closed Session.

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

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

ITEM II
CASES CLOSED

2590A- Johns Hopkins Health System
2591A- Johns Hopkins Health System
2592A- Johns Hopkins Health System
2593A- Johns Hopkins Health System

ITEM III
OPEN CASES

2595R- Johns Hopkins Bayview Medical Center

On April 6, 2022, Johns Hopkins Bayview Medical Center ("JHBMC," or "the Hospital") submitted a partial rate application to the Commission requesting its Partial Day Clinic (PDC) rate center be combined with the Clinic (CL) rate center effective July 1, 2022.

This request is revenue neutral and will not result in any additional revenue for the Hospital. The consolidation of these clinics will provide consistency in billing and reporting. The Hospital's currently approved rates and the new proposed rate are as follows:

	Volumes	Revenues	Unit Rates
Partial Day Clinic (PDC)	19,620	$ 1,652,440	$84.22
Clinic (CL)	2,198,952	$72,262,344	$32.86
Combined Rate (CL)	2,218,572	$73,914,784	$33.32

Staff recommendation is as follows:

1. That the Hospital be allowed to collapse its PDC rate center into its CL rate center;
2. That a CL rate of $33.32 per RVU be approved effective July 1, 2022; and
3. That no change be made to the Hospital's Global Budget Revenue for CL services.

Commissioners voted unanimously in favor of Staff's recommendation.

ITEM IV
PRMC FULL RATE REVIEW UPDATE

Katie Wunderlich, Executive Director, reported that Staff met with the representatives from TidalHealth Peninsula Regional ("Hospital") to resolve the issues with the Hospital's full rate application.

Steve Leonard stated that the Hospital is still not in agreement with Staff's recommendation.

Staff and the Hospital agreed to continue discussions until May 20th. Both parties also agreed to extend the 150 day time for review to August 3rd.

Chairman Kane recommended that the Staff and Hospital go to a Public Hearing if no agreement is reach by May 20th.

Commissioner voted unanimously to approve Chairman Kane's recommendation.

ITEM V
FY2021 HOSPITAL FINANCIAL CONDITION REPORT PRESENTATION

Ms. Amanda Vaughan, Associate Director, Financial Data Administration, presented a summary of the FY 2021 Hospital Financial Condition Report

Maryland hospitals' gross regulated revenues increased by 8.67 percent from $17.3B in FY 2020 to $18.8 in FY 2021. Net regulated revenues also increased from $14.5B in FY 2020 to $15.9B in FY 2021, an increase of 9.66 percent. Regulated profit margins also increased from 7.76 percent in FY 2020 to 9.70 percent in FY 2021. Margin on Total Operations increased from 2.01 percent in FY 2020 to 4.01 percent in FY 2021. Total Profit Margin increased from 1.70 percent in FY 2020 to 10.83 percent in FY 2021.

ITEM VI
DRAFT RECOMMENDATION ON THE UPDATE FACTOR FOR FY 2023

Mr. Jerry Schmith, Principal Deputy Director, Revenue and Regulation Compliance, presented staff's draft recommendation for the Update Factors for FY 2023 (See "Draft Recommendation for the Update Factors for FY 2023" available on the HSCRC website).

Staff updates hospitals' rates and approved revenues on July 1st for inflation as well as settling all adjustments from the prior year. Calculation of the update factors for RY 2022 generally follows the approaches established in prior years. Staff has taken into consideration the extraordinary circumstances of the COVID-19 response in the development of the update factor. Staff plans to continue to work with all stakeholders to develop and adapt existing policies in specific ways to address the COVID-19 crisis.

In considering the system-wide update for RY 2022, Staff sought to achieve balance among the following objectives:

1. Meeting the requirements of the TCOC Model:
    a) Savings Test: Maryland must reach $300M in annual savings to Medicare by 2023.
    b) Guardrail Test: Maryland TCOC growth may not exceed that of the nation by more than 1.00 percent in any year.
2. Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes.
3. Ensuring that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the TCOC Model.
4. Incorporating quality performance programs.
5. Ensuring that healthcare remains affordable for all Maryland residents.

Hospital revenue is divided into two categories:

- Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority. The proposed update factor for hospitals under Global Budget Revenues 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 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 based on those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital. The proposed update factor for these hospitals is strictly related to price, not volume.

For RY 2022, Staff proposed an update of 2.07 percent per capita for global revenue hospitals and an update of 2.37% for non-global revenue hospitals.

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

- **Adjustment for Inflation (3.64 percent):** The gross inflation allowance is calculated using 91.2 percent of Global Insight's First Quarter 2022 market basket growth of 3.80 percent with 8.80 percent of the capital growth index change of 2.20 percent. The adjustment for inflation includes 3.90 percent for wage and compensation. A portion of the 3.66 inflation allowance (0.02 percent) will be allocated to hospitals to more accurately provide revenues for increases in outpatient oncology and infusion drugs. This drug cost adjustment is further discussed below.

- **Outpatient Oncology and Infusion Drugs (0.02 percent):** The rising cost of drugs, particularly of new physician-administered oncology and infusion drugs in the outpatient setting led to the creation of separate inflation and volume adjustment for these drugs. Not all hospitals provide these services, and some hospitals have a much larger proportion of costs allocated. To address this situation, in Rate Year 2016, staff began allocating a specific part of the inflation adjustment to funding increases in the cost of drugs, based on the portion of each hospital's total costs that comprised these types of drugs.

  In addition to the drug inflation allowance, the HSCRC provides a utilization adjustment for these drugs. Half of the estimated cost changes due to usage or volume changes are recognized as a onetime adjustment and half are recognized as a permanent adjustment. This process is implemented separately from this Update Factor so only the inflation portion is addressed herein. Starting in 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. Rate Year 2023 continues this practice. While volume continues to grow for these drugs, staff analysis shows that the price per drug of the drugs covered has stabilized and the need for a higher inflation rate on this component of spending has been mitigated. This trend was recognized in Rate Year 2021 through a lowering of the drug inflation factor from 10 percent to 6 percent. Staff reviewed trends from 2018 to 2021 and determined that price and mix trends remain well below prior years. Therefore, staff is proposing a 1 percent drug inflation factor for RY 2023, which calculates to 0.02 percent that will be earmarked for outpatient oncology and infusion drugs.

- **Care Coordination / Population Health (-0.03 percent):** There were several programs for which the Commission provided funding aimed at Care Coordination and Population Health in RY 2022 hospital revenues. These programs include Regional Partnership Catalyst Programs for Diabetes and Behavioral Health, Maternal and Child Health Improvement Fund Assessment, Population Health Workforce Support for Disadvantaged Areas, and transition funding for Regional Partnership Legacy Grants. These funds were provided to hospitals on a one-time basis. For this reason, you will see a reversing out grant funding in RY 2022 of -0.22 percent. RY 2023 funding is expected to be approximately 0.20 percent and includes continued funding for Diabetes and Behavioral Health, as well as Maternal and Child Health.

- **Adjustments for Volume (-0.12 percent):** The Maryland Department of Planning's estimate of population growth for CY 2022 is -0.12 percent. For RY 2023 the staff is proposing to use the value of the Department of Planning CY 2022 growth estimate for the Demographic Adjustment in keeping with the prior year methodologies.

- **Low-Efficiency Outliers:** The Integrated Efficiency policy outlines a methodology for determining inefficient hospitals in the TCOC Model. This policy will utilize the Inter-Hospital cost comparisons to compare relative cost-per case efficiency. This policy will also use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance relative to national benchmarks for each service area in the State. The above evaluations are then used to withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals, which will be available for redistribution to relatively efficient hospitals. Due to the confounding impact that the COVID-19 pandemic has had on data, staff will not implement an efficiency policy effective July 1, 2022, but is assessing if a mid-year efficiency policy that addresses COVID concerns could be utilized in January 2023.

- **Set-Aside for Unforeseen Adjustments:** The intention of the set-aside is to use these funds for potential Global Budget Revenue enhancements and other potentially unforeseen requests that may occur at hospitals. Due to Model year test constraints for CY 2022, staff is not recommending a set-aside at this time.

- **Complexity and Innovation (formerly Categorical Cases) (0.14 percent):** The prior definition of categorical cases included transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spin Raza 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 case mix 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, 2019, 2020, and 2021. Based on this analysis, staff concluded that the historical average growth rate was 0.54 percent, which equates to a combined state impact of 0.14 percent for the RY 2023 Update Factor.

- **Net Quality & PAU Savings Reduction (- 0.43 percent)**: The statewide RY 2023 PAU savings adjustment, of -0.32 percent, is calculated based on update factor inflation and demographic adjustment applied to CY 2021 PAU performance

  These pay-for-performance programs include Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Quality Based Reimbursement program (QBR).

Over the past several months, staff has worked with the Performance Measurement Workgroup to assess potential modifications to the underlying measurements and methodologies for the RY 2023 pay-for-performance programs due to the confounding effects of the COVID public health emergency. While many workgroup members supported staff's guiding principle to adjust or not adjust for COVID in a uniform fashion across the three core quality programs, other workgroup members remain concerned about the overall deterioration in revenue adjustments relative to RY 2022.

Staff noted that the recently released proposed rule for the Hospital Inpatient Prospective Payment System (IPPS) outlined that various components of the federal value-based purchasing programs will not be included in the federal RY 2023 payment program due to data validity concerns. Specifically, the proposed rule may make the Hospital Value-Based Purchasing (HVBP) program and the Hospital Acquired Conditions Reduction Program (HACRP) revenue neutral for federal RY 2023. These programs are analogous to the QBR and MHAC programs, respectively.

Given the uncertainty of the federal programs, that are the basis for the required at-risk in programs in Maryland, staff is recommending that Quality programs in the RY 2023 Update Factor remain to be determined and that any adjustments determined through further engagement of the Performance Measurement Workgroup be implemented in January rate orders. Depending on the final IPPS rule, which will not be promulgated until after the start of the State fiscal year, staff may revise its recommendations to align with federal guidance. Similarly, if the final IPPS rule recommends any changes to the Hospital Readmissions Reduction Program (HRRP), which is the analog for RRIP, staff will potentially modify revenue adjustments for this program as well.

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

These include:

- Uncompensated Care (UCC): The proposed uncompensated care adjustment for RY 2023 will be -0.43 percent. The amount in rates was 4.65 percent in RY 2022, and the proposed amount for RY 2023 is 4.22 percent, a decrease of -0.43 percent.

- Deficit Assessment: The legislature did not propose a further reduction to the Deficit Assessment in RY 2023, and as a result, this line item is 0.00 percent.

The Medicare Financial 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 the 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 summed to determine total hospital savings. The TCOC Model requires that the State reach an annual total cost of care 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 overtime 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 2021 estimated performance, staff calculates that Maryland hospitals have exceeded the TCOC Model's annual savings requirement of $222 million for performance year three (CY 2021). However, while the State has favorable savings for CY 2021, guardrail performance when compared to the nation is expected to be unfavorable, with Maryland growing faster than the nation in 2021. Final CY 2021 data is in the process of being reconciled and approved with CMS and will be released at a later date, but staff anticipate that the State will miss the guardrail target by greater than 0.5 percent. 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.

In past years, staff compared Medicare growth estimates to the all-payer spending limits, to estimate that Model savings and guardrails were being met. Prior to the pandemic staff established an approach whereby prior year national trend was used to estimate national trend. However due to the ongoing COVID-19 pandemic and the related uncertainty and volatility, staff created an alternative approach to measure projected savings and compliance with the Total Cost of Care guardrails in RY 2022. For RY 2023 staff is using a similar approach as the prior year trend is, once again, not likely to be an accurate reflection of future trends.

Staff draft recommendations are as follows:

For Global Revenues Hospitals:

- Provide an overall increase of 2.76 percent for revenue (including a net change to uncompensated care) and 2.89 percent per capita for hospitals under Global Budgets. In addition, the staff is proposing to split the approved revenue into two targets, a midyear target, and a year-end target.

  Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

- Provide all hospitals a base inflation increase of 3.66 percent and apply 0.02 percent of this total inflation allowance based on each hospital's proportion of drug cost to total cost, thereby adjusting hospitals' budgets more equitably for increases in drug prices and high-cost drugs.

- Staff be tasked with developing, by November 2022, in accordance with the parameters outlined in this recommendation, a new recommendation to the Commission containing a general policy for adjusting for variations between the actual inflation and estimated inflation in future update factors or determining such a policy is not needed. In addition, if applicable, the recommendation may include a specific adjustment for cumulative variances from RY 2014 to RY 2022, based on the newly developed general policy, to be implemented in rates on 1/1/2023.

For Non-Global Revenue Hospitals including psychiatric hospitals and Mt. Washington Pediatric Hospital:

- Provide an overall update of 3.66 percent for inflation.
- Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

Kevin Sowers, President, Johns Hopkins Health System; Dr. Mohan Suntha, CEO, University of Maryland Medical System; Bob Atlas, President & CEO, Maryland Hospital Association; and Tom Kleinhanzl, President & CEO, Frederick Health, delivered a joint provider response to the RY 2023 Rate Update Proposal.

The group asserted that the proposed update factor does not provide the necessary funding required for hospitals to keep up with the unprecedented reliance on agency nurses, retention and recruitment of full-time staff, and other inflation currently being experienced. Acknowledging that the State must adhere to the Guardrail and Savings Tests, they maintained that the proposed revenue updates are not enough to withstand these increasing cost pressures.

Commissioner Elliott asked if physician shortages in Maryland are nearly as severe as nursing shortages.

Mr. Sowers responded that physician retention in Maryland is below the national average.

Dr. Suntha added that it is very challenging to recruit physicians from other states and that the pandemic has only worsened these pressures.

No Commissioner action is required since this is a draft recommendation.

ITEM VII
FINAL HOSPITAL PAYMENT PLANS GUIDELINES

Ms. Megan Renfrew, Associate Director of External Affairs, presented the Staff's guidelines for Hospital Payment Plans (see "Final Guidelines for Hospital Payment Plans, Per Chapter 770 of 2021" available on the HSCRC website).

Md. Code Health General §19-214 requires that hospitals provide financial assistance to low-income patients and follow rules around medical debt collection that are designed to protect patients. In 2021, the

legislature changed the medical debt requirements, including a requirement that HSCRC develop guidelines for hospitals that requiring that payment plans be income based (Chapter 770, 2021).

Chapter 770 required that the HSCRC seek input from stakeholders in drafting these guidelines. Accordingly, the HSCRC formed a Workgroup on Hospital Payment Plan Guidelines, which met three times between January and February of 2022 to review guidelines originally drafted by HSCRC staff, in collaboration with staff from the Office of the Commissioner of Financial Regulation (OCFR). Workgroup members and members of the public were also invited to submit written comments on the draft guidelines. In April, staff presented draft guidelines to the Commission and solicited public comments. HSCRC and OCFR staff revised the draft guidelines presented based on the comments received in April and the discussion in the April Commission meeting.

HSCRC staff is working on additional documents to provide further guidance for hospitals on implementation of Chapter 770, including a Frequently Asked Questions document, which is being developed in conjunction with OCFR. In addition, HSCRC staff plan to update the Special Audit Procedures to reflect the new requirements in Chapter 770.

Chapter 770 required that these guidelines include:

1. The amount of medical debt owed to the hospital
2. The duration of the payment plan based on a patient's annual gross income
3. Guidelines for requiring appropriate documentation of income level
4. Guidelines for the payment amount, that:
    a) may not exceed 5% of the individual patient's federal or State adjusted gross monthly income
    b) shall consider financial hardship, as defined in § 19–214.1(a) of the Health – General Article
5. Guidelines for:
    a) the determination of possible interest payments for patients who do not qualify for free or reduced–cost care, which may not begin before 180 days past the due date of the first payment
    b) a prohibition on interest payments for patients who qualify for free or reduced– cost care
6. Guidelines for modification of a repayment plan that does not create a greater financial burden on the patient
7. A prohibition on penalties or fees for prepayment or early payment

In developing these guidelines, HSCRC staff balanced a number of different policy goals. In general, HSCRC sought to focus on the requirements of Health General §19-214.2, as amended by Chapter 770 (2021). This contained the potential scope of the guidelines.

Under the law, income-based payment plans are now required to be offered to all patients, regardless of income. In developing these guidelines, HSCRC staff sought to balance providing protections to the low-

and moderate-income patients who will most benefit from these protections, while trying to minimize the burden on other patients.

HSCRC staff also worked to ensure that the guidelines provide patients with all the protections required by law while continuing to require that hospitals seek payment from patients who can pay their bills. This balance is intended to avoid unnecessary increases in uncompensated care costs.

Staff recommends that the Commission vote to adopt the hospital payment guidelines. The guidelines will be incorporated by reference into COMAR 10.37.10.

Commissioner Antos expressed concerns that the responsibility of communicating medical debt payments between hospitals falls on the patient; current practices do not make a patient's outstanding debts owed to other hospitals readily available.

Ms. Renfrew assured that Staff is working on amendments to future iterations of the payment plan guidelines to help solve this issue.

Brett McCone, Senior Vice President of Health Care Payment at Maryland Hospital Association, presented counter arguments to Staff's recommendation. Allowing patients and hospitals to negotiate payment plan installments would allow for more flexibility. Mr. McCone stated that uncompensated care would increase as a result of the proposed guidelines. He explained that the longer the terms of debt the less likely the debt will be paid.

Commissioners voted unanimously to approve Staff's recommendation.

ITEM VIII
PROPOSED AMENDMENTS – MEDICAL DEBT REGULATIONS

Regulations

Proposed Action

Patient Rights and Obligations; Hospital Credit and Assistance Policies – COMAR 10.37.10.26

The purpose of this action is to amend COMAR 10.37.10.26, which requires that hospitals provide financial assistance to low-income patients and follow rules around medical debt collection that are designed to protect patients. In 2021, the legislature changed the medical debt requirements, including a requirement that HSCRC develop guidelines for hospitals that require that payment plans be income based with legislation enacted in the 2021 Maryland legislative session (House Bill 565, Chapter 770), now codified at Health General Article ("HG"), §19-214.2, Annotated Code of Maryland.

Brett McCone, on behalf of the Maryland Hospital Association requested that the Commission allow for greater flexibility that would permit hospitals to offer payment plans agreed by patients that would exceed the 5% limitation of the new law.

The Commission voted unanimously to forward the proposed amendments to the AELR Committee for review and publication in the Maryland Register, which will also allow for written public comments.

ITEM IV
NURSING WORKFORCE SUPPORT INITIATIVE

Ms. Claudine Williams, Deputy Director, Clinical Data Administration, presented the final recommendation for the Nurse Support Program II (NSP II) FY 2023 Competitive Institutional Grants and a draft recommendation for permanent renewal and future funding of the Nurse Support Program 1 (See "Nurse Support Program II Competitive Grants Program Review Panel and Faculty Workgroup Statewide Initiative Recommendations for FY 2023" and Nurse Support Program 1 Draft Recommendation for Permanent Renewal and Future Funding" on the HSCRC website).

The HSCRC has funded programs to address cyclical nursing workforce shortages since 1986. In July 2001, the HSCRC implemented the hospital-based NSP I to address the nursing shortage impacting Maryland hospitals. Since that time, the NSP I completed three five-year program evaluation cycles, with the next renewal due by June 30, 2022.

The HSCRC established the NSP II on May 4, 2005, to increase Maryland's academic capacity to educate nurses. Provisions included a continuing, non-lapsing fund with a portion of the competitive and statewide grants earmarked for attracting and retaining minorities in nursing and in nurse faculty careers in Maryland. The Commission approved funding of up to 0.1 percent of regulated gross hospital revenue to increase nursing graduates and mitigate barriers to nursing education through institutional and faculty-focused statewide initiatives. Maryland Higher Education Commission (MHEC) was selected by the HSCRC to administer the NSP II programs as the coordinating board of higher education. After the conclusion of the first ten years of funding, the HSCRC continued to renew the NSP II funding, through June 30, 2025.

The HSCRC staff presents the following draft recommendations for the NSP I program:

1) Continue the NSP I as an ongoing program with permanent funding that does not require renewal. The NSP I staff will provide annual reports on the funded activities and accomplishments.

2) Consider increasing funding in future years from 0.1 percent to 0.2 percent of total patient revenue for each NSP program to further address the impact of the pandemic on the nursing workforce. For FY 2023, the staff recommends that the Commission prioritize additional funding to support workforce initiatives such as those included in the NSP I and II initiatives.

3) Charge the NSP I and II Advisory Committee to investigate other potential sources of funding from new legislation that can support nursing initiatives.

No Commission Action is require as this is a draft recommendation.

HSCRC and MHEC staff recommend the following thirteen proposals presented for the FY 2023 NSP II Competitive Institutional Grants Program.

FY 2023 Recommendations for Funded Proposals

Proposal	School	Total Funding Request
NSP II-23-101	Allegany College of Maryland	$749,215
NSP II-23-104	Anne Arundel Community College	$444,652
NSP II 23-110	Salisbury University	$617,392
NSP II 23-111	Towson University	$1,258,176
NSP II 23-112	University of Maryland	$742,510
NSP II 23-201	Coppin State University	$25,535
NSP II 23-202	Howard Community College	$83,575
NSP II 23-203	Johns Hopkins University	$55,029
NSP II 23-204	Notre Dame of Maryland University	$10,172
NSP II 23-205	Prince George's Community College	$46,350
NSP II 23-206	Towson University	$27,000
NSP II 23-207	Washington Adventist University	$16,161
NSP II 23-208	Wor-Wic Community College	$26,080
Total		$4,101,847

Commissioners voted uniamously to approve Staff's recommendation.

ITEM X
DRAFT RECOMMENDATION ON ONGOING SUPPORT OF CRISP IN FY 2023

Craig Behm, Executive Director, Chesapeake Regional Information System for our Patients (CRISP) presented the draft recommendations for FY 2023 funding to support Health Information Exchange (HIE) Operations and CRISP (See "Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 2023 Funding to Support HIE Operations and CRISP Reporting Services" on the HSCRC website).

Over the past ten years, the Commission has approved funding to support the general operations of the CRISP HIE and reporting services through hospital rates.

Beginning in FY 2020, HSCRC assumed full responsibility for managing the CRISP assessment, 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. Starting in FY 2023, CRISP's reimbursement from the HSCRC will be provided in two tranches: one relating to state match funding of core HIE operational costs and the other related to Reporting and Program Administration. This change is made to allow CRISP to recover operational reimbursement from the HSCRC in a timelier fashion.

HSCRC funding has been used to obtain federal matching funds throughout the history of the program. The federal match is obtained through the program outlined below. The HITECH IAPD program was previously the source of most federal funding, and it was terminated September 30, 2021. Funding has now moved to the MES program described below. The MES program requires 25 percent match for ongoing programs versus the 10 percent in place under IAPD.

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, the draft recommendation identifies the following amounts of State-supported funding for fiscal year (FY) 2023 to the CRISP:

- Direct funding and matching funds under Medicaid Enterprise System (MES) Federal Programs for Health Information Exchange (HIE) operations and infrastructure ($2.5 million)

- Direct funding and Medicaid Enterprise System (MES) matching funds for reporting and program administration related to population health, the Total Cost of Care Model, and hospital regulatory initiatives ($3.8 million). Staff propose using $1.5 million of accumulated reserves to reduce the revenue generated through rates for FY2023 to $2.3 million for this component.

Therefore, Staff recommends that the HSCRC provide funding to CRISP totaling $4.8 million for FY 2023, a decrease of $4.4 million (48 percent) from FY 2022. The remainder of CRISP's Maryland funding is derived from user fees, federal matching funds and the Maryland Department of Health (MDH).

The significant decrease in the funding level is driven by 2 factors:

a. The change in federal matching rules anticipated in the prior year's recommendation (that required more State funding) did not occur, resulting in a significant reduction in the required funding for FY 2023, and

b. The use of $1.5 million in reserves related to accumulated CRISP funding from prior years (due to better than expected federal match) to offset the current request. Without the use of these reserves, this year's request would have been $6.3 million, reflecting a moderate increase over the approximately $6 million anticipated in FY 2022 spending. Staff note the net request of $4.8 million is the lowest amount in CRISP funding since the Maryland Health Insurance Plan (MHIP) funding was terminated in FY 2020.

No Commission action is necessary as this is a draft recommendation.

ITEM XI
DRAFT RECOMMENDATION ON REVISIONS AND UPDATE TO CLINIC RELATIVE VALUE UNITS

Mr. William Hoff, Chief Audit & Compliance, presented Staff's draft recommendation on changes to the Relative Value Units (RVUs) for Clinic (CL) (see "Draft Recommendation on Changes to the Relative Value Units for Clinic Effective July 1, 2022" on the HSCRC website).

On November 16, 2020, the HSCRC staff convened a workgroup to review and initiate changes to the Clinic RVUs and guidelines for the Clinic rate center. The members of this workgroup included Hospitals, Maryland Hospital Association, Insurance Companies, and Hospital Consultants. These changes were initiated for the following reasons:

1. Staff is progressively standardizing RVUs for all ancillary and outpatient rate centers using national CPT code definitions and MPFS cost weights, consistent with the strategy that staff is executing over time for all services.
2. RVUs standardization using the Medicare Physician Fee Schedule weights, updating new codes, and removing inactive codes from Appendix D of the Commission's Accounting and Budget Manual.
3. Assignment of RVUs procedures that are being reported as "By Report."
4. The nature of the clinic visits has changed over time. Clinic visits now focus primarily on chronic conditions, specialized services, and behavioral health.
5. The Clinic Rate Center generates the largest number of consumer complaints. This is principally because the price of a clinic visit is generally more expensive than a visit to a doctors' office.

Clinic services include diagnostic, preventive, therapeutic, rehabilitative, and educational services provided to non-emergent outpatients in a regulated setting. On rare occasions, clinic services may be provided to inpatients; for example, if specialized staff from the clinic must provide care to an inpatient at the patient's bedside.

Surgical procedures, diagnostic tests and other services that are better described in a separate cost center, such as Labor and Delivery, Electroencephalography, Echocardiography, Interventional Cardiology, Laboratory, Lithotripsy, Occupational Therapy, Operating Room, Physical Therapy, Radiation Therapy, Radiology, or 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/or non-surgical procedure(s).

Staff draft recommendation is as follows:

1. The HSCRC staff recommends that the Commission approve the revisions to the RVU scale for the Clinic Rate Center. The revisions are specific to the Chart of Account and Appendix D of the Accounting and Budget Manual (Attachment 1- Chart of Account). These revised RVUs are based on MPFS weights and were reviewed by a workgroup facilitated by the HSCRC staff;

2. The RVU scale was updated to reflect linkages of RVUs to the CPT codes to reflect: the changes in clinical practices, and to link charging guidelines for Clinic services to the national definition, consistent with the HSCRC plan to adopt MPFS RVUs where possible and

3. The new and updated RVUs should be effective July 1, 2022. The conversion of the Clinic RVUs will be revenue neutral to the overall Hospital Global Budget Revenues.

No Commission action is necessary as this is a draft recommendation.

ITEM XII
POLICY UPDATE AND DISCUSSION

Model Monitoring

Ms. Caitlin Cooksey, Deputy Director of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 12 months ending December 2021. Maryland's Medicare Hospital spending per capita growth was favorable when compared to the nation. Ms. Cooksey noted that Medicare Nonhospital spending per-capita was trending unfavorably for both Part A and Part B when compared to the nation. Ms. Cooksey noted that Medicare Total Cost of Care (TCOC) spending per-capita was unfavorable when compared to the nation. Ms. Cooksey noted that the Medicare TCOC guardrail position is .72% above the nation through December. Ms. Cooksey noted that Maryland Medicare hospital and non-hospital growth through December shows a run rate erosion of $83,908,000.

Workgroup Update

Ms. Wunderlich presented a workgroup update on the activities of the standing workgroups.

- Performance Measurement Workgroup
    a) Evaluate appropriate COVID related changes for FY 2023
    b) RY 2024 Readmission Reduction Incentive Program
    c) Expanding Potential Avoidable Utilization quality programs into the ER

- Payment Models Workgroup
    a) RY 2023 Update Factor
    b) Draft recommendation May
    c) Final recommendation June

- Total Cost of Care Workgroup – Next meeting on May 18th
    a) Revenue for Reform
    b) Market Shift

ITEM XIII
HEARING AND MEETING SCHEDULE

June 8, 2022 Times to be determined - Go to Webinar

July 13, 2022 Times to be determined - Go to Webinar

There being no further business, the meeting was adjourned at 4:04 pm.

Closed Session Minutes
of the
Health Services Cost Review Commission

May 11, 2022

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

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

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

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

The Closed Session was called to order at 11:33 a.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

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

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

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

Item One

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

Item Two

Amanda Vaughn, Associate Director, Medical Economics & Data Analytics, updated the Commission on the year-to-date hospital profit margins and volumes through March 2022.

Item Three

Mr. Will Daniel, Deputy Director, presented an overview of total national inflation and health care price growth.

Item Four

Ms. Wunderlich updated the Commission on the recent meeting with CMMI concerning current Model issues and the next phase of the Model.

The Closed Session was adjourned at 12:56 p.m.

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF May 31, 2022

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

Docket Number	Hospital Name	Date Docketed	Purpose	Analyst's Initials	File Status
2587R	Tidal Health Pennisula Regional	2/25/2022	FULL	JS/AP	OPEN
2588R	Carroll Hospital	3/14/2022	DEF/MSG	WN	OPEN
2589R	Shady Grove Adventist Medical Center	3/16/2022	CAPITAL	JS/AP	OPEN
2596N	UM Shore Emergency Center at Queenstown	4/29/2022	MRI-Rebundled	WH	OPEN
2597A	Johns Hopkins Health System	5/18/2022	ARM	DNP	OPEN
2598A	Johns Hopkins Health System	5/31/2022	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

Proceeding 2588R – LifeBridge Carroll Hospital Center

- On April 14, 2022, Carroll Hospital Center (“the Hospital”) submitted a partial-rate application to the Commission requesting that its July 1, 2022, Medical Surgical Acute (MSG) and Definitive Observation (DEF) approved rates be combined effective July 1, 2022.
- The Hospital wishes to combine these two centers because of the lack of difference in care for DEF and MSG services.

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

1. That the Hospital be allowed to collapse its DEF rate into its MSG rate;
2. That a MSG rate of $1,480.51 per day be approved effective July 1, 2022; and
3. That no change be made to the Hospital’s Global Budget Revenue for MSG services.

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF THE	*	**COST REVIEW COMMISSION**	
LIFEBRIDGE HEALTH	*	**DOCKET:**	**2022**
CARROLL HOSPITAL CENTER	*	**FOLIO:**	**2398**
WESTMINSTER, MARYLAND	*	**PROCEEDING:**	**2588R**

Staff Recommendation
June 8, 2022

Introduction

On April 14, 2022, Carroll Hospital Center ("the Hospital") submitted a partial-rate application to the Commission requesting its Definitive Observation (DEF) rate center be combined with its Medical Surgical Acute (MSG) rate center effective July 1, 2022.

Staff Evaluation

The Hospital wishes to combine these two centers because of the lack of difference in care for DEF and MSG services.

Service	Service Unit	Unit Rate	Projected Volumes	Approved Revenue
Medical Surgical Acute	Patient Days	$1,676.82	18,073	$30,306,651
Definitive Observation	Patient Days	$1,216.59	13,443	$16,354,395
Proposed Combined MSG	Patient Days	$1,480,51	31,516	$46,660,046

Recommendation

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

1. That the Hospital be allowed to collapse its DEF rate into its MSG rate;

2. That a MSG rate of $1,480.51 per day be approved effective July 1, 2022; and

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

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UM SHORE EMERGENCY QUEENSTOWN

Proceeding 2596N- Partial Rate Application

Introduction

On April 29, 2022, UM Shore Emergency Center at Queenstown ("SMCQ"), submitted a partial rate application to the Commission to establish a new rebundled rate for MRI services effective July 1, 2022.

SMCQ provides no MRI services on site. Establishing a rebundled MRI rate will allow SMCQ to bill the patient for all services provided in their episode of care and eliminate the need to be billed separately by the offsite MRI provider.

The Hospital provided projected costs associated with the MRI services and requested a rate of $11.32 per RVU, while the statewide median rate for MRI is $11.78 per RVU.

Recommendation

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

1. That the rebundled MRI rate of $11.32 per RVU be approved effective July 1, 2022;

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

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

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF THE	*	**COST REVIEW COMMISSION**	
UM SHORE EMERGENCY	*	**DOCKET:**	**2022**
QUEENSTOWN	*	**FOLIO:**	**2406**
QUEENSTOWN, MARYLAND	*	**PROCEEDING:**	**2596N**

Staff Recommendation
June 8, 2022

Introduction

On April 29, 2022, UM Shore Emergency Center at Queenstown ("SMCQ," or the "the Hospital"), a member of the University of Maryland Medical System ("UMMS"), submitted a partial rate application to the Commission to establish a new rebundled rate for MRI services effective July 1, 2022.

Background

SMCQ provides no MRI services on site. Currently, registered SMCQ outpatients that require MRI services must be discharged and directed to a nearby unregulated provider, who provides and bills the patient for their services. The patient must then return and reregister at SMCQ. Establishing a rebundled MRI rate will allow SMCQ to bill the patient for all services provided in their episode of care and eliminate the need to be billed separately by the offsite MRI provider.

Staff Evaluation

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. The Hospital provided projected costs associated with the MRI services and requested a rate of $11.32 per RVU, while the statewide median rate for MRI is $11.78 per RVU.

Recommendation

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

1. That the rebundled MRI rate of $11.32 per RVU be approved effective July 1, 2022;

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

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

IN RE: **THE APPLICATION FOR**	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2022**
SYSTEM	*	**FOLIO:**	**2407**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2597A**

Staff Recommendation

June 8, 2022

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on May 18, 2022, on behalf of its member Hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for joint replacement and joint replacement consult services, hip and knee replacement, Cardiovascular, CART-T, and Spine surgery with Carrum Health, Inc. The System requests that the approval be for a period of one year beginning July 1, 2022.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff found that the activity under this arrangement has been positive and believes that the arrangement can continue to be successful.

VI. STAFF RECOMMENDATION

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

IN RE: **THE APPLICATION FOR**	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2022**
SYSTEM	*	**FOLIO:**	**2408**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2598A**

Staff Recommendation

June 8, 2022

INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on May 31, 2022 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) for an alternative

method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to add outpatient joint replacement services to the global rate arrangement approved for bariatric surgery, bladder surgery, anal rectal surgery, cardiovascular services, joint replacement surgery, pancreas surgery, spine surgery, thyroid surgery, parathyroid surgery, solid organ and bone marrow transplants, and Executive Health services, eating disorder, gender affirming surgery, and gall bladder surgery with Assured Partners. The Hospitals request that the approval be effective July 1, 2022.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination to add outpatient joint replacement services to bariatric surgery, bladder surgery, anal rectal surgery, cardiovascular services, joint replacement surgery, pancreas surgery, spine surgery, thyroid surgery, parathyroid surgery, solid organ and bone marrow transplants, and Executive Health services, eating disorder, gender affirming surgery, and gall bladder surgery approved effective July 1, 2022. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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RY 2023 - Final Staff Recommendation for Ongoing CRISP Funding

June 8, 2022

HSCRC Staff Funding Recommendation

Direct HIE Operations	$2,500,000
Reporting and Program Administration	$3,800,000
Maryland Total	**$6,300,000**
Reserves	*$1,500,000*
Funding Request	**$4,800,000**

Maryland Revenue	Hospital Rates	Federal Funds	User Fees	MDH	Total
HIE Operations	$2.5M	$9.0M	$5.0M	$0.3M	**$16.8M**
Reporting and Program Admin	$3.8M	$8.0M	----	$2.3M	**$14.1M**
Other Non-HSCRC Programs	----	$1.6M	$0.3M	$0.9M	**$2.7M**
Total Funding	**$6.3M**	**$18.6M**	**$5.3M**	**$3.4M**	**$33.6M**
Percent of Total	*19%*	*55%*	*16%*	*10%*	*100%*

Note: This schedule does not include CRISP projects anticipated to be funded entirely by MDH or federal grants

Key Takeaways:

1. Direct HIE Operations funding is consistent with prior years and allows CRISP to continue to build and support infrastructure aligned with the Total Cost of Care Model.
2. Reporting and Program Administration will continue to enable population reports, regulatory programs, and related care interventions.
3. User Fees are growing as a share funds; the CRISP Board recently raised rates on payers for the first time.
4. New reports and services that were brought online for Regional Partnerships, Care Redesign Programs, and CTIs are steady-state operations, meaning that future funding increases will be moderate.

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Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 2023 Funding to Support HIE Operations and CRISP Reporting Services

Final Recommendation

June 8, 2022

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

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Table of Contents

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List of Abbreviations

CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for Our Patients
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
MDH	Maryland Department of Health
MHCC	Maryland Health Care Commission
MHIP	Maryland Health Insurance Plan
MES	Medicaid Enterprise System
TCOC	Total Cost of Care

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Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
To fund and sustain a robust Health Information Exchange, CRISP, for activities related to the HSCRC and the Maryland Model Model.	Include an assessment in hospital rates to generate funding to support CRISP projects and operations to further the goals of the Maryland Model	Hospitals benefit from CRISP programs and pay a separate user fee. This assessment is a pass through and has no impact on hospitals.	CRISP provides vital coordination and reporting that allow hospitals and other Maryland providers to enhance the quality and cost effectiveness of the care provided.	Provider reporting supported by CRISP will collect data on social determinants of health and disparities in health outcomes.

Summary of the Recommendation

No comments were received on the draft recommendation and this final recommendation is unchanged from the draft.

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 recommendation identifies the following amounts of State-supported funding for fiscal year (FY) 2023 to the Chesapeake Regional Information System for our Patients (CRISP):

- Direct funding and matching funds under Medicaid Enterprise System (MES) Federal Programs for Health Information Exchange (HIE) operations and infrastructure ($2.5 million)
- Direct funding and Medicaid Enterprise System (MES) matching funds for reporting and program administration related to population health, the Total Cost of Care Model, and hospital regulatory initiatives ($3.8 million). Staff propose using $1.5 million of accumulated reserves to reduce the revenue generated through rates for FY2023 to $2.3 million for this component.

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

Therefore, Staff recommends that the HSCRC provide funding to CRISP totaling $4.8 million for FY 2023, a decrease of $4.4 million (48 percent) from FY 2022. As a result, the HSCRC will be funding approximately 19 percent of CRISP's Maryland funding, compared to budgeted 31 percent in FY 2022 (as federal funding was never lowered, actual FY22 share is closer to the FY23 budgeted of 19 percent). The remainder of CRISP's Maryland funding is derived from user fees, federal matching funds and the Maryland Department of Health (MDH).

The significant decrease in the funding level is driven by 2 factors: (1) the change in federal matching rules anticipated in the prior year's recommendation (that required more State funding) did not occur, resulting in a significant reduction in the required funding for FY 2023, and (2) the use of $1.5 million in reserves related to accumulated CRISP funding from prior years (due to better than expected federal match) to offset the current request. Without the use of these reserves, this year's request would have been $6.3 million, reflecting a moderate increase over the approximately $6 million anticipated in FY 2022 spending.

Staff note the net request of $4.8 million is the lowest amount in CRISP funding since the Maryland Health Insurance Plan (MHIP) funding was terminated in FY 2020.

Background – Past Funding

Over the past ten 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, Last 10 Years

CRISP Budget: HSCRC Funds Received	
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
FY 2021	$5,170,000
FY 2022	$9,240,000

User fees generated by payers have historically been a small share of total CRISP revenue and remained unchanged since inception. In FY2022, the CRISP Finance Committee approved an increase of $300,000 in payer fees, which now represents 10% of user fee revenue.

Funding Through Hospital Rates

Beginning in FY 2020, HSCRC assumed full responsibility for managing the CRISP assessment, 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. Starting in FY 2023, CRISP's reimbursement from the HSCRC will be provided in two tranches: one relating to state match funding of core HIE operational costs and the other related to Reporting and Program Administration. This change is made to allow CRISP to recover operational reimbursement from the HSCRC in a timelier fashion.

Funding Through Federal Matching

HSCRC funding has been used to obtain federal matching funds throughout the history of the program. The federal match is obtained through the program outlined below. The HITECH IAPD program was previously the source of most federal funding, and it was terminated September 30, 2021. Funding has now moved to the MES program described below. The MES program requires 25 percent match for ongoing programs versus the 10 percent in place under IAPD

Medicaid Enterprise System (MES) Matching Funds

MES is a federal program designed to promote effective care for Medicaid beneficiaries through investments in information technology infrastructure. Medicaid benefits from CRISP's data sharing and reporting initiatives through the care management and cost control initiatives facilitated for all Medicaid patients under CRISP all-payer activities and for dual-eligible patients under CRISP's Medicare activities.

Activities funded under this element of the assessment include point-of-care and other provider data sharing initiatives, and CRISP reporting tools utilizing the Medicare claims and the HSCRC's hospital case mix data. Hospitals, the HSCRC, and other stakeholders use CRISP reporting from these datasets to manage and track progress under several HSCRC programs and enable hospitals to identify and pursue care efficiency initiatives.

Under MES, 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.

Other Funding

CRISP's Maryland activities are also financed through user fees paid by hospitals and payers as well as funding received from MDH (See Table 2). Payer user fees have historically been a small share of total CRISP revenue and remained unchanged since inception. In FY2022, the CRISP Finance Committee approved an increase of $300,000 in payer fees, which now represents 10% of user fee revenue.

Description of Activities Funded

Activities funded directly by this assessment and from earned federal matching fall into the two categories described below. The descriptions below outline, in general terms, the programs for which funds will be used. Staff will direct funding to specific programs within the general parameters described.

Category 1: HIE Operations Funding and Infrastructure

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. MDH made extensive use of CRISP's capabilities during the COVID crisis.

The total amount of funding recommended by staff for FY 2022 for the HIE function is $2.5 million.

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

Category 2: Reporting and Program Administration Related to Population Health, the Total Cost of Care Model, and Hospital Regulatory Initiatives

These initiatives were designed to reduce health care expenditures and improve outcomes for all Marylanders. Many of these programs focus on unmanaged high-needs Medicare patients and patients dually eligible for Medicaid and Medicare, consistent with the goals of Maryland's All-Payer Model. These initiatives encourage collaboration between and among providers, provide a platform for provider and patient engagement, and allows for confidential sharing of information among providers. To succeed under the Total Cost of Care (TCOC) Model, providers will need a variety of tools to manage high-needs and complex patients that CRISP is currently working to develop and deploy.

Based on broad program participation, including non-hospital providers, and the ability to secure federal match funds, these programs will be funded through a combination of assessments and federal matching funds. This recommendation covers three components:

(1) Funding for population health and cost and quality management reporting in support of HSCRC regulations and the TCOC Model

(2) Funding for program administration related to programs under the TCOC Model

(3) Funding for innovative reporting initiatives such as enhanced data on social determinants of health and the integration of electronic health record data into statewide hospital quality measurement

The total amount of funding recommended by staff for FY 2021 for the activities described above is $3.8 million.

Staff Recommendation

Staff is recommending the Commission approve a total of $4.8 million in funding through hospital rates in FY 2023 to support the HIE and continue the investments made in the TCOC Model initiatives through both direct funding and obtaining federal MES matching funds. Staff anticipates actual CRISP spending of $6.3 million but proposes to use $1.5 million of prior reserves, limiting the actual assessment to $4.8 million.

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

Table 2. FY 2023 Recommended Rate Support for CRISP as a share of estimated total Maryland Funding

FY 2023 Project Name	Hospital Rates	Federal Budgeted Funding	User Fees	Maryland Department of Health	Maryland Total
HIE Operations	$2,500,000	$9,016,000	$5,005,000	$297,000	$16,818,000
Reporting and Program Administration	$3,800,000	$8,010,000	$0	$2,264,000	$14,074,000
Other non-HSCRC programs	$0	$1,578,000	$275,000	$857,000	$2,710,000
Total Funding	**$6,300,000***	**$18,604,000**	**$5,280,000**	**$3,418,000**	**$33,602,000**
% Of Total	**19%**	**55%**	**16%**	**10%**	**100%**

*Note: Prior to reduction for use of accumulated reserves to reduce FY2023 assessment.

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RY 2023 Final Update Factor Recommendation

June 8, 2022

Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
The annual update factor is intended to provide hospitals with reasonable changes to rates in order to maintain operational readiness while also seeking to contain the growth of hospital costs in the State. In addition, the policy aims to be fair and reasonable for hospitals and payers.	The final recommendation provides an annual update factor of 3.38 percent per capita, a revenue increase of 3.25 percent for hospitals under Global Budgets. This policy also provides an inflation increase of 3.66 percent for hospitals not under Global Budgets which includes psych hospitals and Mt. Washington Pediatrics. The updates for GBR hospitals and specialty hospitals include an additional 0.40 percent for inflation catch up.	The annual update factor provides hospitals with permanent and one-time adjustments to their respective rate orders for RY 2023. The update includes changes for inflation, high-cost drugs, care coordination, complexity and innovation, quality, uncompensated care, and others as deemed necessary.	One of the tenets of the update factor determination is to contain the growth of costs for all payers in the system and to ensure that the State meets its requirements under the Medicare Total Cost of Care Agreement.	The annual update factor contains the growth of costs for all payers and also reflects ongoing investments in population health and health equity through the Regional Partnership programs. The update factor also reflects quality measures, including within hospital disparities, that aim to improve health disparities across the State.

HSCRC Update Factor Evaluation

Funded Inflation vs Actual Inflation

	RY 2020	RY 2021	RY 2022	Cumulative Growth
Funded Inflation	2.96%	2.77%	2.57%	8.53%
Actual Inflation	2.31%	2.01%	4.42%	8.98%
	0.65%	0.76%	-1.85%	-0.40%

Table 3 – Page 8 of Final Recommendation

Update Factor Recommendation for Global and Non-Global Budget Revenue

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.66%	3.66%
Inflation Catch-Up	0.40%	0.40%
Productivity Adjustment	N/A	SUSPENDED
Proposed Inflation Update	4.06%	4.06%

Table 1 – Page 5 of Final Recommendation

After review of inflation over the course of the pandemic from RY 2020 - RY 2022, staff have determined that hospitals have been underfunded by approximately 0.40 percentage points.

Update Factor Recommendation for Global Budget Revenues

Table 2 – Page 7 of Final Recommendation

Balanced Update Model for RY 2023			
Components of Revenue Change Link to Hospital Cost Drivers /Performance			
			Weighted Allowance
Adjustment for Inflation (this includes 4.80% for wages and compensation)			3.64%
- Outpatient Oncology Drugs			0.02%
-Inflation Catch Up			0.40%
Gross Inflation Allowance	**A**		**4.06%**
Care Coordination/Population Health			
- Reversal of One-Time Grants			-0.22%
- Regional Partnership Grant Funding RY23			0.20%
Total Care Coordination/Population Health	**B**		**-0.03%**
Adjustment for Volume			
-Demographic /Population			-0.12%
-Transfers			
-Drug Population/Utilization			
Total Adjustment for Volume	**C**		**-0.12%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.10%
- Low Efficiency Outliers	E		0.00%
- Capital Funding	F		0.00%
- Complexity & Innovation	G		0.14%
-Reversal of one-time adjustments for drugs	H		-0.04%
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.20%**
Quality and PAU Savings			
-PAU Savings	J		-0.32%
-Reversal of prior year quality incentives -QBR, MHAC, Readmissions	K		-0.11%
-Current Year Quality Incentives	L		0.00%
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**-0.43%**
Total Update First Half of Rate Year 23			
Net increase attributable to hospitals	**N =**	Sum of A + B + C + I + M	**3.68%**
Per Capita First Half of Rate Year (July - December)	**O =**	(1+N)/(1-0.12%)	**3.81%**
Adjustments in Second Half of Rate Year 23			
-Oncology Drug Adjustment	P		0.00%
-Current Year Quality Incentives	Q		TBD
Total Adjustments in Second Half of Rate Year 23	**R =**	P + Q	**0.00%**
Total Update Full Fiscal Year 23			
Net increase attributable to hospital for Rate Year	**S =**	N + R	**3.68%**
Per Capita Fiscal Year	**T =**	(1+S)/(1-0.12%)	**3.81%**
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care, net of differential	U		-0.43%
-Deficit Assessment	V		0.00%
Net decreases	**W =**	U + V	**-0.43%**
Total Update First Half of Rate Year 23			
Revenue growth, net of offsets	**X =**	N + W	**3.25%**
Per Capita Revenue Growth First Half of Rate Year	**Y =**	(1+X)/(1-0.12%)	**3.38%**
Total Update Full Rate Year 23			
Revenue growth, net of offsets	**Z =**	S + W	**3.25%**
Per Capita Fiscal Year	**AA =**	(1+Z)/(1-0.12%)	**3.38%**

Table 5– Page 14 of Final Recommendation

Estimated Position on Medicare Test		
Actual Revenue CY 2021		18,951,788,063
Step 1:		
Approved GBR RY 2022		19,638,102,984
Actual Revenue 7/1/21-12/31/21		9,501,433,932
Approved Revenue 1/1/22-6/30/22		10,136,669,052
FY22 Undercharge in First Half of CY22		(125,000,000)
Anticipated Revenue 1/1/22-6/30/22	**A**	**10,011,669,052**
Step 2:		
Approved GBR RY 2022		19,638,102,984
Reverse One Time Extraodinary Adjustments:		(189,274,421)
Adjusted GBR RY 2022		19,448,828,563
Projected Approved GBR RY 2023		20,081,373,781
Permanent Update RY 2023		3.25%
Adjusted Change from GBR RY 2022		2.26%
Step 3:		
Estimated Revenue 7/1/22-12/31/22 (after 49.73% & seasonality)		9,986,467,181
CARES Act $ Payback		-
FY23 Inflation Advance Payback		(98,505,808)
FY21 Undercharge Release in Second Half of CY22		95,754,888
Projected Revenue 7/1/22-12/30/22	**B**	**9,983,716,261**
Step 4:		
Estimated Revenue CY 2022	**A+B**	**19,995,385,313**
Increase over CY 2021 Revenue		5.51%

CY 22 Projected Impact to Waiver Tests

Guardrail Test

Scenario 1: 2021 Trended Forward based on 2017-2019 Trends

Scenario 1 Guardrail Projections			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,742	$11,974	Predicted Variance
YOY Growth	4.99%	3.88%	1.12%

TCOC Savings Test Using Scenario 1

Scenario 1 Savings Projections	
2021 Savings (Run Rate)	$338 M
2022 Annual Dissavings	-$110 M
2022 Savings (Run Rate)	$228 M
2022 Savings with One-Time Revenue Adjustments Removed	$263 M

Tables 6a and 7a : Pages 16 and 18 of Final Recommendation

CY 22 Projected Impact to Waiver Tests

Guardrail Test

Scenario 2: 2021 Trended Forward based on 2015-2019 Trends

Scenario 2 Guardrail Projections			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,696	$11,850	Predicted Variance
YOY Growth	4.64%	2.80%	1.84%

TCOC Savings Test Using Scenario 2

Scenario 2 Savings Projections	
2021 Savings (Run Rate)	$338 M
2022 Annual Dissavings	-$192 M
2022 Savings (Run Rate)	$146 M
2022 Savings with One-Time Revenue Adjustments Removed	$181 M

Tables 6b and 7b : Pages 16 and 18 of Final Recommendation

CY 22 Projected Impact to Waiver Tests

Guardrail Test
Scenario 3: OACT Projections
CY 2022

Scenario 3 Guardrail Projections			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,927	$12,345	Predicted Variance
YOY Growth	6.41%	7.10%	-0.69%

Projected CY22 National Total Cost Growth

TCOC Savings Test Scenario 3

Scenario 3 Savings Projections	
2021 Savings (Run Rate)	$338 M
2022 Annual Savings	$72 M
2022 Savings (Run Rate)	$410 M

Tables 6c and 7c : Pages 17 and 18 of Final Recommendation

Final Recommendations

For Global Revenues:

- (a) Provide all hospitals a base inflation increase of 3.66 percent and apply 0.02 percent of this total inflation allowance based on each hospital's proportion of drug cost to total cost, thereby adjusting hospitals' budgets more equitably for increases in drug prices and high-cost drugs. Furthermore, provide an additional 0.40 percent to account for the underfunding of inflation through the pandemic from FY 2020 - FY 2022

- (b) Provide an overall increase of 3.25 percent for revenue (including a net change to uncompensated care) and 3.38 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target.

  Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

Final Recommendations

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

- (a) Provide an overall update of 3.66 percent for inflation and an additional 0.40 percent to account for the underfunding of inflation through the pandemic for FY 2020-FY2022.
- (b) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

Comment Letter Overview

Stakeholder Comments

MHA submitted a proposal that outlined the requested increase of their members. The following hospitals also submitted comment letters in support of MHA's letter: Luminis Health, University of Maryland Medical System, Johns Hopkins Health System, Holy Cross Health, MedStar Health, Ascension St. Agnes , and Sheppard Pratt.

Stakeholder Comments

MHA Position – Rate year 2023 requests

1. Fully fund FY 2023 inflation – *3.66%*

1. Make the $100 million (0.5%) advance funding permanent and require no repayment

1. Modify PAU savings adjustment to reduce takeaway

1. Limit uncompensated care funding reduction

1. Monitor inflation and Model performance; **add funding Jan. 1, 2023**

Stakeholder Comments

Medicaid – Rate year 2023 requests

1. Maryland can't risk becoming subject to a corrective action plan for failing to meet the TCOC Model Guardrail test

2. Medicaid does not agree with MHA's comment that the $100 million inflation advance should be made permanent and should not be paid back

3. Medicaid served as a safety net during the pandemic, absorbing an increase of 20 percent increase in coverage and agrees that the UCC adjustment is appropriate

Stakeholder Comments

CareFirst Position – Rate year 2023 requests

1. Increasing hospital rates has a significant and direct impact on Maryland residents and employers

2. Mid-year adjustments to hospital rates have directly impacted Medicaid MCOs and Medicare Advantage plans

3. Staff should revise its assumptions for Maryland's non-hospital spending and hospital undercharges

4. While Staff should seek to fund cost inflation at Maryland's hospitals, Staff should develop a plan to identify savings in the system to enable Maryland to pass its savings test requirements

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health services
cost review commission

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cost review commission

Final Recommendation for the Update Factors for Rate Year 2023

June 8, 2022

Table of Contents

List of Abbreviations

ACA	Affordable Care Act
CAGR	Compounded Annual Growth Rate
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
MHAC	Maryland Hospital Acquired Conditions
MPA	Medicare Performance Adjustment
MPA-SC	Medicare Performance Adjustment - Saving Component
OACT	Office of the Actuary
PAU	Potentially avoidable utilization
QBR	Quality Based Reimbursement
RRIP	Readmission Reduction Incentive Program
RY	Rate year, which is July1 through June 30 of each year
TCOC	Total Cost of Care
UCC	Uncompensated care

Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
The annual update factor is intended to provide hospitals with reasonable changes to rates in order to maintain operational readiness while also seeking to contain the growth of hospital costs in the State. In addition, the policy aims to be fair and reasonable for hospitals and payers.	The final recommendation provides an annual update factor of 3.38 percent per capita, a revenue increase of 3.25 percent for hospitals under Global Budgets. This policy also provides an inflation increase of 3.66 percent for hospitals not under Global Budgets which includes psych hospitals and Mt. Washington Pediatrics. The updates for GBR hospitals and specialty hospitals include an additional 0.40 percent for inflation catch up.	The annual update factor provides hospitals with permanent and one-time adjustments to their respective rate orders for RY 2023. The update includes changes for inflation, high-cost drugs, care coordination, complexity and innovation, quality, uncompensated care, and others as deemed necessary.	One of the tenets of the update factor determination is to contain the growth of costs for all payers in the system and to ensure that the State meets its requirements under the Medicare Total Cost of Care Agreement.	The annual update factor contains the growth of costs for all payers and also reflects ongoing investments in population health and health equity through the Regional Partnership programs. The update factor also reflects quality measures, including within hospital disparities, that aim to improve health disparities across the State.

Summary

The following report includes the final recommendation for the Update Factor for Rate Year (RY) 2023. 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 continues to create significant uncertainty and will likely drive large, short, and long-term changes in the healthcare industry. Staff plans to continue to work with all stakeholders to develop and adapt existing policies in specific ways to address the COVID-19 crisis and its lingering effects on healthcare in the State of Maryland. As with all HSCRC policies, the aim is equity and fairness for all hospitals and payers that balances the need to provide sufficient resources for operational readiness and necessary investment, while simultaneously ensuring affordability and slowing the growth of healthcare costs.

Staff requests that Commissioners consider the following final recommendations:

For Global Revenues:

(a) Provide all hospitals a base inflation increase of 3.66 percent and apply 0.02 percent of this total inflation allowance based on each hospital's proportion of drug cost to total cost, thereby adjusting hospitals' budgets more equitably for increases in drug prices and high-cost drugs. Furthermore, provide an additional 0.40 percent to account for the underfunding of inflation through the pandemic from FY 2020 - FY 2022.

(b) Provide an overall increase of 3.25 percent for revenue (including a net change to uncompensated care) and 3.38 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target.

Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

(a) Provide an overall update of 3.66 percent for inflation and an additional 0.40 percent to account for the underfunding of inflation through the pandemic for FY 2020-FY2022.

(b) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

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. As in all the HSCRC policies, this final recommendation strives to achieve a fair and equitable balance between providing sufficient funds to cover operational expenses and necessary investments, while keeping the increase in hospital costs affordable for all payers.

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. It is worth mentioning that Maryland has already

met the 5-year total cost of care savings requirement under the Total Cost of Care Agreement, but this progress must be sustained through 2023 as the savings requirement is not a cumulative test.

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 develop the RY 2023 annual update is outlined in this report, as well as staff's estimates on calendar year Model tests.

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. The proposed update factor for hospitals under Global Budget Revenues 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.

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 based on those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital. The proposed update factor for these hospitals is strictly related to price, not volume.

This recommendation proposes Rate Year (RY) 2023 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Final Update Factors Recommendations

For RY 2023, HSCRC staff is proposing an update of 3.38 percent per capita for global budget revenues and an update of 4.06 percent for non-global budget 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 First Quarter 2022 market basket growth estimate with a capital growth estimate. For RY 2023, HSCRC staff combined 91.20 percent of Global Insight's First Quarter 2022 market basket growth of 3.80 percent with 8.80 percent of the capital growth estimate of 2.20 percent, calculating the gross blended amount as a 3.66 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 proposes applying the inflation adjustment of 3.66 percent. The pandemic's effect on hospitals continues to result in historically low volumes. For this reason, HSCRC staff propose to withhold the productivity adjustment from this year's gross blended inflation amount. It is important to note that these hospitals receive an adjustment based on their actual volume change, rather than a population adjustment. HSCRC staff continues to include these non-global budget hospitals in readmission calculations for global budget hospitals and may implement quality measures for these hospitals in future rate years. After review of inflation over the course of the pandemic from RY 2020 - RY 2022, staff have determined that hospitals have been underfunded by approximately 0.40 percentage points. That amount has been added to the inflation amount outlined in Table 1 below. Table 3 outlines this inflation catch up in more detail.

Table 1

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.66%	3.66%
Inflation Catch-Up	0.40%	0.40%
Productivity Adjustment	N/A	SUSPENDED
Proposed Inflation Update	4.06%	4.06%

Update Factor Recommendation for Global Budget Revenue Hospitals

In considering the system-wide update for the hospitals with global revenue budgets under the Total Cost of Care 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;
- Incorporating quality performance programs; and
- Ensuring that healthcare remains affordable for all Marylanders.

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 3.68 percent and per capita growth of 3.81 percent for RY 2023. After accounting for changes in uncompensated care and assessments, the HSCRC estimates net revenue growth at 3.25 percent with a corresponding per capita growth of 3.38 percent for RY 2023.

To measure the proposed update against financial tests, which are performed on Calendar Year results, staff split the annual Rate Year revenue into six-month targets. Staff intends to 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 2023 estimated revenue used to evaluate the Rate Year year-end target. HSCRC staff will adjust the revenue split to accommodate their normal seasonality for hospitals that do not align with the traditional seasonality described above.

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 2023

Components of Revenue Change Link to Hospital Cost Drivers /Performance

			Weighted Allowance
Adjustment for Inflation (this includes 4.80% for wages and compensation)			3.64%
- Outpatient Oncology Drugs			0.02%
- Inflation Catch Up			0.40%
Gross Inflation Allowance	**A**		**4.06%**
Care Coordination/Population Health			
- Reversal of One-Time Grants			-0.22%
- Regional Partnership Grant Funding RY23			0.20%
Total Care Coordination/Population Health	**B**		**-0.03%**
Adjustment for Volume			
-Demographic /Population			-0.12%
-Transfers			
-Drug Population/Utilization			
Total Adjustment for Volume	**C**		**-0.12%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		0.10%
- Low Efficiency Outliers	E		0.00%
- Capital Funding	F		0.00%
- Complexity & Innovation	G		0.14%
-Reversal of one-time adjustments for drugs	H		-0.04%
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.20%**
Quality and PAU Savings			
-PAU Savings	J		-0.32%
-Reversal of prior year quality incentives	K		-0.11%
-QBR, MHAC, Readmissions			
-Current Year Quality Incentives	L		0.00%
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**-0.43%**
Total Update First Half of Rate Year 23			
Net increase attributable to hospitals	**N =**	Sum of A + B + C + I + M	**3.68%**
Per Capita First Half of Rate Year (July - December)	**O =**	(1+N)/(1-0.12%)	**3.81%**
Adjustments in Second Half of Rate Year 23			
-Oncology Drug Adjustment	P		0.00%
-Current Year Quality Incentives	Q		TBD
Total Adjustments in Second Half of Rate Year 23	**R =**	P + Q	**0.00%**
Total Update Full Fiscal Year 23			
Net increase attributable to hospital for Rate Year	**S =**	N + R	**3.68%**
Per Capita Fiscal Year	**T =**	(1+S)/(1-0.12%)	**3.81%**
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care, net of differential	U		-0.43%
-Deficit Assessment	V		0.00%
Net decreases	**W =**	U + V	**-0.43%**
Total Update First Half of Rate Year 23			
Revenue growth, net of offsets	**X =**	N + W	**3.25%**
Per Capita Revenue Growth First Half of Rate Year	**Y =**	(1+X)/(1-0.12%)	**3.38%**
Total Update Full Rate Year 23			
Revenue growth, net of offsets	**Z =**	S + W	**3.25%**
Per Capita Fiscal Year	**AA =**	(1+Z)/(1-0.12%)	**3.38%**

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

HSCRC staff accounted for several 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 3.66 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's First Quarter 2022 market basket growth of 3.80 percent with 8.80 percent of the capital growth index change of 2.20 percent. The adjustment for inflation includes 3.90 percent for wages and compensation. A portion of the 3.66 inflation allowance (0.02 percent) will be allocated to hospitals to more accurately provide revenues for increases in outpatient oncology and infusion drugs . This drug cost adjustment is further discussed below. After further evaluation of inflation during the course of the pandemic, hospitals have been underfunded for RY 2020-RY2022 by approximately 0.40 percent. The details of this calculation can be reviewed in Table 3 below.

Table 3

	RY 2020	RY 2021	RY 2022	Cumulative Growth
Funded Inflation	2.96%	2.77%	2.57%	8.53%
Actual Inflation	2.31%	2.01%	4.42%	8.98%
	0.65%	0.76%	-1.85%	-0.40%

- **Outpatient Oncology and Infusion Drugs:** The rising cost of drugs, particularly of new physician-administered oncology and infusion drugs in the outpatient setting led to the creation of separate inflation and volume adjustment for these drugs. Not all hospitals provide these services, and some hospitals have a much larger proportion of costs allocated. To address this situation, in Rate Year 2016, staff began allocating a specific part of the inflation adjustment to funding increases in the cost of drugs, based on the portion of each hospital's total costs that comprised these types of drugs.

  In addition to the drug inflation allowance, the HSCRC provides a utilization adjustment for these drugs. 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. This process is implemented separately from this Update Factor so only the inflation portion is addressed herein.

  Starting in 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. Rate Year 2023 continues this practice. While volume continues to grow for these drugs, staff analysis shows that the price per drug of the drugs covered has stabilized and

the need for a higher inflation rate on this component of spending has been mitigated. This trend was recognized in Rate Year 2021 through a lowering of the drug inflation factor from 10 percent to 6 percent. Staff reviewed trends from 2018 to 2021 and determined that price and mix trends remain well below prior years. Therefore, staff is proposing a 1 percent drug inflation factor for RY 2023, which calculates to 0.02 percent that will be earmarked for outpatient oncology and infusion drugs.

- **Care Coordination / Population Health:** There were several grant programs aimed at Care Coordination and Population Health in RY 2022 hospital revenues. These programs include Regional Partnership Catalyst Programs for Diabetes and Behavioral Health, Maternal and Child Health Improvement Fund Assessment, Population Health Workforce Support for Disadvantaged Areas, and transition funding for Regional Partnership Legacy Grants. These funds were provided to hospitals on a one-time basis. For this reason, you will see a line in Table 2 reversing out grant funding in RY 2022 of -0.22 percent. RY 2023 funding is expected to be approximately 0.20 percent and includes continued funding for Diabetes and Behavioral Health, as well as Maternal and Child Health.

- **Adjustments for Volume:** The Maryland Department of Planning's estimate of population growth for CY 2022 is -0.12 percent. For RY 2023 the staff is proposing to use the value of the Department of Planning CY 2022 growth estimate for the Demographic Adjustment in keeping with the prior year methodologies.

- **Low-Efficiency Outliers:** The Integrated Efficiency policy outlines a methodology for determining inefficient hospitals in the TCOC Model. This policy will utilize the Inter-Hospital cost comparisons to compare relative cost-per case efficiency. This policy will also use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance relative to national benchmarks for each service area in the State. The above evaluations are then used to withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals, which will be available for redistribution to relatively efficient hospitals. Due to the confounding impact that the COVID-19 pandemic has had on data, staff will not implement an efficiency policy effective July 1, 2022, but is assessing if a mid-year efficiency policy that addresses COVID concerns could be utilized in January 2023.

- **Set-Aside for Unforeseen Adjustments:** Staff recommends 0.10 percent set-aside to use for potential Global Budget Revenue enhancements and other potentially unforeseen requests that may occur at hospitals.

- **Complexity and Innovation (formerly 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, 2019, 2020, and 2021. Based on this analysis, staff concluded that the historical average growth rate was 0.54 percent, which equates to a combined state impact of 0.14 percent for the RY 2023 Update Factor.

- **PAU Savings Reduction:** The statewide RY 2023 PAU savings adjustment, of -0.32 percent, is calculated based on update factor inflation and demographic adjustment applied to CY 2021 PAU performance
- **Quality Scaling Adjustments:** These pay-for-performance programs include Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Quality Based Reimbursement program (QBR).

  Over the past several months, staff have worked with the Performance Measurement Workgroup to assess potential modifications to the underlying measurements and methodologies for the RY 2023 pay-for-performance programs due to the confounding effects of the COVID public health emergency. While many workgroup members supported staff's guiding principle to adjust or not adjust for COVID in a uniform fashion across the three core quality programs, other workgroup members remain concerned about the overall deterioration in revenue adjustments relative to RY 2022.

  Staff note that the recently released proposed rule for the Hospital Inpatient Prospective Payment System (IPPS) outlines that various components of the federal value-based purchasing programs will not be included in the federal RY 2023 payment program due to data validity concerns. Specifically, the proposed rule may make the Hospital Value-Based Purchasing (HVBP) program and the Hospital Acquired Conditions Reduction Program (HACRP) revenue neutral for federal RY 2023. These programs are analogous to the QBR and MHAC programs, respectively.

  Given the uncertainty of the federal programs, which are the basis for the required at-risk in programs in Maryland, staff are recommending that Quality programs in the RY 2023 Update Factor remain to be determined and that any adjustments determined through further engagement of the Performance Measurement Workgroup be implemented in January rate orders. Depending on the final IPPS rule, which will not be promulgated until after the start of the State fiscal year, staff may revise its recommendations to align with federal guidance. Similarly, if the final IPPS rule recommends any changes to the Hospital Readmissions Reduction Program (HRRP), which is the analog for RRIP, staff will potentially modify revenue adjustments for this program as well.

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 a neutral impact on hospital financial statements. These include:

- **Uncompensated Care (UCC):** The proposed uncompensated care adjustment for RY 2023 will be -0.43 percent. The amount in rates was 4.65 percent in RY 2022, and the proposed amount for RY 2023 is 4.22 percent, a decrease of -0.43 percent.
- **Deficit Assessment:** The legislature did not propose a further reduction to the Deficit Assessment in RY 2023, and as a result, this line item is 0.00 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 RY2020, the calculation of the statewide value of the PAU Savings was included in the Update Factor Recommendation; however, a PAU measurement report was presented separately to the Commission in March of 2019.

For RY 2023, the incremental amount of statewide PAU Savings reductions is determined formulaically by using inflation and the demographic adjustment applied to the amount of PAU revenue (see Table 4). This will result in a RY 2023 PAU savings reduction of -0.32 percent statewide, or $60,153,549. Hospital performance on avoidable admissions per capita and 30 day readmissions, the latter of which is attributed to the index hospital, determines each hospital's share of the statewide reduction.

Table 4

Statewide PAU Reduction	Formula	Value
RY 2022 Total Estimated Permanent Revenue*	A	$18,797,984,034
RY 2023 Inflation Factor**	B	3.52%
CY 2019 Total Experienced PAU $	C	$1,719,724,282
RY 2023 Proposed Revenue Adjustment $	D = B*C	-$60,534,295
RY 2023 Proposed Revenue Adjustment %	E = D/A	-0.32203%
RY 2023 Adjusted Proposed Revenue Adjustment %	F = ROUND(E)	**-0.32%**
RY 2023 Adjusted Proposed Revenue Adjustment $	G = F*A	**-$60,153,549**
Total PAU %	H	9.77%
Total PAU $	I = A*H	$1,835,962,632
Required Percent Reduction PAU	J = G/I	-3.28%

*Does not include revenue from McCready, or freestanding EDs.

** Inflation factor is subject to revisions related to updated data and Commission approval

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. Staff's considerations regarding the TCOC Model agreement requirements are described in detail below.

Medicare Financial 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 the 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 summed to determine total *hospital* savings. The TCOC Model requires that the State reach an annual total cost of care 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 overtime 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 2021 estimated performance, staff calculates that Maryland hospitals have exceeded the TCOC Model's annual savings requirement of $222 million for performance year three (CY 2021). However, while the State has favorable savings for CY 2021, guardrail performance when compared to the nation is expected to be unfavorable, with Maryland growing faster than the nation in 2021. Final CY 2021 data is in the process of being reconciled and approved with CMS and will be released at a later date, but staff anticipate that the State will miss the guardrail target by greater than 0.5 percent. 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.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

In past years, staff compared Medicare growth estimates to the all-payer spending limits, to estimate that Model savings and guardrails were being met. Prior to the pandemic staff established an approach whereby prior year national trend was used to estimate national trend. However due to the ongoing COVID-19 pandemic and the related uncertainty and volatility, staff created an alternative approach to measure projected savings and compliance with the Total Cost of Care guardrails in RY 2022. For RY 2023 staff is

using a similar approach as the prior year trend is, once again, not likely to be an accurate reflection of future trends.

Actual revenue resulting from RY 2022 updates affect the CY 2022 results. As a result, staff must convert the recommended RY 2022 update to a calendar year growth estimate. Table 4 below shows the current revenue projections for CY 2022 to assist in estimating the impact of the recommended update factor together with the projected RY 2023 results. The overall increase from the bottom of this table is used in Tables 6a-6c.

Table 5

Estimated Position on Medicare Test		
Actual Revenue CY 2021		18,951,788,063
Step 1:		
Approved GBR RY 2022		19,638,102,984
Actual Revenue 7/1/21-12/31/21		9,501,433,932
Approved Revenue 1/1/22-6/30/22		10,136,669,052
FY22 Undercharge in First Half of CY22		(125,000,000)
Anticipated Revenue 1/1/22-6/30/22	**A**	**10,011,669,052**
Step 2:		
Approved GBR RY 2022		19,638,102,984
Reverse One Time Extraodinary Adjustments:		(189,274,421)
Adjusted GBR RY 2022		19,448,828,563
Projected Approved GBR RY 2023		20,081,373,781
Permanent Update RY 2023		3.25%
Adjusted Change from GBR RY 2022		2.26%
Step 3:		
Estimated Revenue 7/1/22-12/31/22 (after 49.73% & seasonality)		9,986,467,181
CARES Act $ Payback		-
FY23 Inflation Advance Payback		(98,505,808)
FY21 Undercharge Release in Second Half of CY22		95,754,888
Projected Revenue 7/1/22-12/30/22	**B**	**9,983,716,261**
Step 4:		
Estimated Revenue CY 2022	**A+B**	**19,995,385,313**
Increase over CY 2021 Revenue		5.51%

Steps to explain Table 5 are described as below:

The table begins with actual revenue for CY 2021.

Step 1: The table uses global revenue for RY 2022 and actual revenue for the last six months for CY 2021 to calculate the projected revenue for the first six months of CY 2022 (i.e., the last six months of RY

2022). Hospitals currently project they will not be able to charge all of RY 2022 revenue by the end of the Rate Year, the estimated shortfall is $125 million (the RY 2022 Undercharge). The RY 2022 Undercharge is either (a) forfeited as penalties or (b) deferred and added to revenue as a catch-up in the first half of CY 2023, or some combination of the two, with the actual result varying by hospital. Under either scenario it does not impact CY 2022 revenue and is therefore subtracted in Step 1.

Step 2: This step begins with the approved revenue for RY 2022 and reverses out the extraordinary one-time adjustments from RY 2022 that were a result of the COVID-19 pandemic. These one-times include: RY 2020 GBR settle up, RY 2021 price variance, COVID surge funding, and RY 2023 advanced inflation funding. The result is an adjusted RY 2022 GBR. The proposed update of 3.25 percent, as shown in Table 2, is then applied to the adjusted RY 2022 GBR amount to calculate the projected revenue for RY 2023.

Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2023 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2023. Additionally, staff applied the RY 2023 Advanced Inflation payback and release of the remaining RY 2021 undercharge to determine the projected revenue for the final six months of the calendar year.

Step 4: This step shows the resulting estimated revenue for CY 2022 and then calculates the increase over actual CY 2021 Revenue. The CY 2022 increase based on this year's recommended update is 5.51 percent. The 5.51 percent is used to estimate CY 2022 hospital spending per capita for Maryland in our guardrail calculation, which is explained next in this policy.

Consistent with prior commitments, staff are reviewing an additional wave of Covid surge funding for RY22 and expense funding for RY20 and RY21. At this time, it is not recommended that any funding be added in July. Staff will work with stakeholders to refine the methodology for the COVID wave that occurred in RY 2022. Any additional funding would be implemented at a later date and will consider the impact on calendar year guardrail tests.

Staff modeled three different scenarios to project the CY 2022 guardrail position. Each scenario is described in more detail below. The one data element that is constant in each scenario is Maryland hospital growth. Because global budget revenues are a known data element, staff applied the estimated CY 2022 growth of 5.51 percent, shown in Table 5 to Maryland hospital spending per capita from 2021. The Maryland hospital growth estimate takes into account available hospital specific factors, such as the estimated RY 2022 Undercharge, remaining RY 2021 undercharge release and advanced inflation payback. Tables 6a-6c below show the results of these analyses. These analyses assume that Medicare growth equals All-Payer growth.

Scenario 1, shown in Table 6a, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. This takes the average trend from 2017 to 2019 and trends the data forward using 2021 as the base. This is a similar trend that staff used to predict 2021 growth, with an updated base.

Table 6a

Scenario 1 Guardrail Projections			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,742	$11,974	Predicted Variance
YOY Growth	4.99%	3.88%	1.12%

Scenario 2, shown in Table 6b, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. Scenario 2 takes the average trend from 2015 - 2019 and trends the data forward using 2021 as the base. This is the most conservative estimate of the three scenarios. Staff added this scenario because the trend used in Scenario 1 proved to be higher than actual trend in CY 2021 and resulted in an overestimate of national growth. Utilizing a longer period to establish the "typical" trend results in a lower trend estimate, as the more recent 2017 to 2019 period utilized in Scenario 1 was a relatively high trend window.

Table 6b

Scenario 2 Guardrail Projections			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,696	$11,850	Predicted Variance
YOY Growth	4.64%	2.80%	1.84%

Scenario 3, shown in Table 6c, utilizes the 2022 projection as published by the Office of the Actuary which is predicted to be 7.10 percent for 2022. The non-hospital portion of Maryland estimate utilizes the OACT growth prediction of 7.1 percent. The draft recommendation used a national growth estimate of 5 percent. Staff derived that amount by using figures provided in the National Health Estimate (NHE) tables. The 5 percent matched OACT figures for CY 2023. After further review and discussion with OACT, 7.1 percent is the best growth estimate to use for CY 2022. . Hospital and non-hospital is not broken out in the updates provided to staff. Staff believes 7.1 percent is the best estimate to use, but have some concerns that this may be too low of a growth to use for Maryland non-hospital because Maryland has historically trended higher than the nation. There is considerable variation among staff's three national trend forecasts - high (7.10 percent) and low (2.8 percent). This illustrates considerable uncertainty about how health care costs

will "bounce back" as the healthcare market incorporates the COVID-19 pandemic window into the future patterns of care.[1]

Table 6c

Scenario 3 Guardrail Projections			
	Maryland	US	
2021	$13,088	$11,527	
2022	$13,927	$12,345	Predicted Variance
YOY Growth	6.41%	7.10%	-0.69%

In addition to modeling the CY 2022 guardrail position, staff also modeled estimated savings under each scenario. The savings target for CY 2022 is $267 million. Achieving an annual run rate of $267 million in CY 2022 is crucial as we move to the next phase of Model negotiations because this year will serve as the basis for the federal government's evaluation of the Model. Tables 7a-7c below highlight our annual savings or dissavings and anticipated 2022 run rate under each scenario.

Scenario 1 and Scenario 2 estimate that Maryland would miss the savings target for CY 2022, while under Scenario 3 Maryland would achieve the target. This range of outcomes illustrates the considerable uncertainty in the national projections. Staff want to note that there are significant negative consequences to missing the savings target in CY 2022.

Of note, the final line item in Table 7a and Table 7b estimate CY2022 savings if we applied the MPA-SC (Medicare Performance Adjustment - Savings Component) to the Medicare portion of the remaining undercharge that will be released in July rate orders. Staff believe that invoking this option would be a path of last resort. In addition, staff believes that the only revenue that would be appropriate to have this applied to would be one-time revenue adjustments, as application to permanent revenue would undercut the all-payer nature of the Model.

[1] During the workgroup process around this recommendation hospital stakeholders suggested using the US Per Capita Cost trends used to project Medicare Advantage increases. This methodology estimates a much higher 9 percent growth for the nation for CY 2022. Staff have concerns about differing from the national estimate that is provided by OACT, which the HSCRC has used as a reference in past years, given that these are projections and there is considerable uncertainty regarding the likely bounce back. As discussed above the approach used in Scenario 1 proved to be an overestimate in CY 2021.

Table 7a

Scenario 1 Savings Projections	
2021 Savings (Run Rate)	$338 M
2022 Annual Dissavings	-$110 M
2022 Savings (Run Rate)	$228 M
2022 Savings with One-Time Revenue Adjustments Removed	$263 M

Table 7b

Scenario 2 Savings Projections	
2021 Savings (Run Rate)	$338 M
2022 Annual Dissavings	-$192 M
2022 Savings (Run Rate)	$146 M
2022 Savings with One-Time Revenue Adjustments Removed	$181 M

Table 7c

Scenario 3 Savings Projections	
2021 Savings (Run Rate)	$338 M
2022 Annual Savings	$72 M
2022 Savings (Run Rate)	$410 M

Staff also modeled the growth and compared it to economic growth in Maryland as measured by the Gross State Product. 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 GSP numbers available (CY18-CY21). The 3-year CAGR calculation shows a per capita amount of 2.22 percent. Staff then compared that number to the 3-year CAGR for Hospital Acute Charges using (CY18-CY22). Staff was able to estimate CY 2022 charges using the proposed RY 2023 update factor. The CAGR for hospital charge growth equated to 3.59 percent. Staff also calculated a 5-year CAGR calculation, shown in Table 8b. The difference between 5 years of Gross State Product and Hospital Acute charges show a variance of 0.69 percent. The charts below show these comparisons. While unfavorable, staff would note that given the volatility in the economy over the past few years and the extraordinary actions the

Commission and the Federal government took to provide more funding to hospitals during the COVID public health emergency, this analysis should be considered with caution. Moreover, given the unprecedented increases in inflation over the past year that have yet to prove temporal, staff do not believe it is prudent to use prior affordability assessments as a hard cap on global budget revenue allotments in RY 2023.

Table 8a

GSP (2018 - 2021)	Hospital Charges (2019-2022)	Variance
2.22%	3.77%	1.55%

Table 8b

GSP (2016 - 2021)	Hospital Charges (2017-2022)	Variance
2.52%	3.21%	0.69%

Medicare's Proposed National Rate Update for FFY 2023

CMS released its proposed rule for the change to the Inpatient Prospective Payment System's (IPPS) payment rate on April 18, 2022. In the proposed rule, CMS would increase rates by approximately 3.20 percent which includes a market basket increase of 3.10 percent, a productivity reduction of -0.40 percent, and a legislative increase of 0.50 percent. This proposed increase will not be finalized until August 2022 and will not go into effect until October 1, 2022. This also does not take into account volume changes, nor does it take into account projected reductions in Medicare disproportionate share hospital (DSH) payments and Medicare uncompensated care payments as well as potential reductions for additional payments for inpatient cases involving new medical technologies and Medicare Dependent Hospitals.

Inflation Reconciliation Proposal

Staff's draft recommendation of the update factor utilized a lower national growth projection. The final recommendation utilizes an updated growth projection for CY 2022. After further review of inflation funding, staff determined that hospitals have been underfunded over the course of the pandemic by approximately 0.40 percent. As a result of these two changes, staff has updated the recommendation to include an additional 0.40 percent for inflation reconciliation to be added on July 1, 2022. At this time staff do not recommend providing any additional inflation beyond the 0.40 percent in this rate year, as it would not be tied to any methodological approach. Staff are committed to continuing to monitor inflation and review Maryland growth compared to the nation for the remainder of the calendar year. In addition, now that this type of adjustment has been incorporated into the process, Staff recommend the Commission consider this retroactive evaluation every year and apply an adjustment to current year inflation if the variation is material, regardless of the direction of the adjustment

The annual update factor relies on an estimate of the inflation for the future period being funded. As a result, the approved Update Factor could over- or under-fund inflation for a given period versus the actual experience for that period.

The Commission has not historically adjusted for this because amounts are often small and adjusting inflation for prior estimation error would add additional complexity to the update factor process, it is likely that under- and over-estimates will cancel out over time, and the Commission's mandate is to provide financial stability and not a margin guarantee. Therefore, it is not necessary to exactly fund inflation in every period, as hospitals can bear some risk for variations between funding and inflation.

Hospital stakeholders have argued that because the inflation estimate used in the RY 2022 update factor was a significant underestimate of actual inflation the Commission should depart from historic practice and provide additional inflation, a "catch-up", in RY 2023, in order to fund full inflation on a permanent basis.

The Commission and staff have been watching inflation and wage and labor cost pressures carefully. In response to concerns raised by the hospital field around rising labor costs, the Commission advanced a one-time increase of $100 million in January 2022, and accelerated the release of prior year undercharges. Additionally, the Governor also made available $30 million to hospitals to support unusually high workforce costs. Finally, an additional $50 million is anticipated to be awarded from the State to hospitals in RY 2023 to further cover workforce demands that have sustained through the year. While these are one-time adjustments to hospital rates, they do provide financial support to hospitals in the short term until more is understood about the permanency of those labor cost increases.

While staff acknowledge that the shortfall of permanent inflation for RY 2022 was much more significant than the variance in prior years, staff are not recommending the Commission reverse historic practice and adopt a catch-up adjustment greater than .40 percent as of July 1, 2022, because of the availability of extraordinary one-time funding available to hospitals in RY 2022 as mentioned above, pressure on the Medicare guardrail and savings tests documented above, as well as uncertainty surrounding national growth trends.

Instead, staff recommend that the Commission direct staff to convene a stakeholder workgroup and report back to the Commission in November 2022 on (a) a policy for addressing differences between actual and estimated inflation in future update factors within the parameters outlined below (or that such a policy is not required) and (b) a recommendation to the Commission for a reconciliation inflation adjustment for experience through RY 2022 to be applied to hospital rates on January 1, 2023, consistent with the policy developed under item (c), and with the State's savings position and other factors considered in the typical annual update factor process. Staff's bias is that such an adjustment is appropriate but the feasibility of providing such adjustment and the size of the adjustment will depend on the State's savings position, national growth rates and the policy parameters described for the general policy and that by waiting for January 1, 2023, to apply any adjustment the Commission will have better information on these factors.

The possible parameters for the general policy described in (a) above are:

1. That any policy is two-sided and would apply to both over and underestimates of inflation
2. That any policy looks at cumulative inflation over or under funding since 2013, including consideration of the impact of the PAU inflation adjustment, the infrastructure funding and other permanent funding adjustments as applicable
3. That any policy would have a materiality provision such that an adjustment would only apply when the cumulative under or overfunding of inflation reached a specified threshold (e.g., 0.75 percent)

Stakeholder Comments

In a series of meetings beginning in early CY 2022, HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed RY 2023 update.

MHA submitted a proposal that outlined the requested increase of their members. The following hospitals also submitted comment letters in support of MHA's letter: Luminis Health, University of Maryland Hospital System, Johns Hopkins Health System, Holy Cross Health, MedStar, St. Agnes, and Sheppard Pratt. MHA's request in their official comment letter did not differ from their request from their comments during Payment Models. Comments are outlined below with staff's response in italics:

1. Fund IHS Market's RY2023 cost inflation, expected to be at least 3.58%
   Staff agree and have updated our tables and projections to include the release of the First Quarter Book from Global Insights. The inflation amount of 3.66 percent is reflected in this recommendation.
2. Make the $100 million advance funding permanent, requiring no repayment
   Staff does not agree. This advance was always intended and communicated that it was to be paid back. In addition, hospitals have received $80 million from the Governor over the last two fiscal years. The advance amount of $100M was not based on any specific inflation information. Staff have proposed an adjustment based on an analysis of historic inflation data and staff does not believe making a temporary, stopgap, advance permanent is appropriate in lieu of or in addition to an inflation adjustment based on a reasonable methodology.
3. Modify the savings adjustment for potentially avoidable utilization (PAU): A) Set rewards and penalties around a base of 0 percent, measuring year-over-year change; B) Set a statewide average benchmark as hold harmless floor, and apply adjustments to hospitals that exceed the benchmark; and C) Use a national benchmark to set a PAU savings target
   Staff believe that the proposal has merit since global budgets already have an incentive to reduce PAU and PAU inflation cannot theoretically be defunded in perpetuity without adversely affecting core inflation for non-PAU services. However, this assertion rests on the notion that hospitals, primarily due to the incentives of the global budgets, have successfully eliminated almost all avoidable utilization, even independent of the current definition of PAU (30 day readmissions and acute exacerbations of chronic conditions). To date, no data has been provided to suggest that Maryland has grossly surpassed current national performance on current definitions of PAU or other definitions not yet reflected in payment policy (excess imaging, canonical examples of low value care - knee arthroscopy for individuals with osteoarthritis, etc). Therefore, to discontinue the

PAU savings adjustment, especially in a year where TCOC guardrails and savings are a concern, does not seem prudent, but staff defer to the judgment of the Commission.

4. Limit the projected reduction in uncompensated care funding
   Staff do not agree. The uncompensated care policy has historically relied on a retrospective statistic of uncompensated care to determine funding. This approach has provided higher than anticipated levels of uncompensated care as the Affordable Care Act and other factors, e.g. lower unemployment, steadily reduced charity care and bad debts. Thus, staff do not believe it is appropriate to stray from policy in this year purely based on the assertion that uncompensated care will increase due to sunsetting federal stimulus payments. Furthermore, staff believe that the large decline in UCC levels may be due to changing practice patterns that result in an increased utilization of telemedicine, urgent care centers, and other alternatives to emergency room care. As such, staff do not support this request because UCC levels may not rebound.
5. Monitor inflation and Model performance for six months and adjust rates effective January 1, 2023, if conditions permit.
   Staff are committed to working with a workgroup to determine if any additional funding will be appropriate on January 1. Our proposal is outlined in this recommendation, but staff would note additional inflation in RY 2023 is unlikely since the Final Recommendation outlines an additional .40 percent increase to recognize recent underfunding of actual inflation.

In addition to the request outlined above, MHA proposed using a much higher national growth estimate when trending forward 2022. These growth rates of 9 percent were mentioned earlier in this recommendation. *Staff do not believe it is appropriate to stray away from the OACT for the national growth projection and the internal projection approaches based on recent trends used in prior years. Office of Actuary projections are projected for Fee-for-Service. The USPCC projections cited by MHA are used in projection MA (Medicare Advantage) increases. In addition, staff have had conversations with the Office of the Actuary to determine the most appropriate source to use when determining projected cost growth for the following year. It was determined through those conversations that the growth projections provided by the Office of the Actuary for the President's Budget are the most appropriate projections to use.*

Medicaid provided comments that supported staff's draft recommendation for three main reasons:

1. Maryland can't risk becoming subject to a corrective action plan for failing to meet the TCOC Model Guardrail test.
   Staff agrees. In the penultimate year of this demonstration it is incredibly important to ensure that the update remains within the bounds of projected calendar year growth. Staff has worked hard during this process to determine the appropriate national growth projection and will not recommend an update that does not provide some cushion.
2. Medicaid does not agree with MHA's comment that the $100 million inflation advance should be made permanent and should not be paid back.
   Staff agrees.
3. Medicaid served as a safety net during the pandemic, absorbing an increase of 20 percent increase in coverage and agrees that the UCC adjustment is appropriate.
   Staff agrees.

CareFirst agreed with staff's draft recommendation, but had several concerns, which are outlined below.

1. CareFirst noted that any increase as a result of the Update Factor gets passed on to employers. In addition, they expressed concern that mid-year rate increases can't be accounted for in MA and MCO plans.
   Staff recognizes the concerns it may place on payers by having mid year rate increases. We understand that RY21 was a significant increase at mid-year and do try to limit such increases. Staff have revised our proposal to provide a fixed increase as of July 1, thereby significantly reducing the likelihood of providing additional inflation in January.
2. CareFirst expressed concern that two of the guardrail/run rate scenarios that staff created project Maryland to grow faster than the Nation, explicitly stating concerns over staff's non-hospital projection. It was also noted that the undercharge assumption may not carry forward to June. It was urged that staff pressure test these assumptions prior to finalizing the recommendation.
   Staff created over 10 different guardrail and savings scenarios while evaluating potential guardrail positions. The three that were presented were the most realistic outcomes based on extensive review of data and past trends. The biggest obstacle to overcome each Update Factor season is projecting what will happen with national growth. Staff have had conversations with the Office of the Actuary to determine the most appropriate growth estimate and determined that the projections from the President's Budget are the best estimate. In addition, staff recognize that there are a number of factors that impact this year's update, including the projected FY 2021 undercharge. Staff are releasing the final recommendation with updated undercharge projections with data through April 2021.
3. CareFirst noted that staff's 'affordability' test comparing three years of hospital charge growth to a three-year GSP trend yields unfavorable results. The impact of which gets passed on to employers and health plans.
   As noted above, staff would note that given the volatility in the economy over the past few years and the extraordinary actions the Commission and the Federal government took to provide more funding to hospitals during the COVID public health emergency, this analysis should be considered with caution.

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 2023 update factors.

For Global Revenues:

(a) Provide all hospitals a base inflation increase of 3.66 percent and apply 0.02 percent of this total inflation allowance based on each hospital's proportion of drug cost to total cost, thereby adjusting hospitals' budgets more equitably for increases in drug prices and high-cost drugs.

Furthermore, provide an additional 0.40 percent to account for the underfunding of inflation through the pandemic from FY 2020 - FY 2022

(b) Provide an overall increase of 3.25 percent for revenue (including a net change to uncompensated care) and 3.38 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target.

Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

(a) Provide an overall update of 3.66 percent for inflation and an additional 0.40 percent to account for the underfunding of inflation through the pandemic for FY 2020-FY2022.

(b) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

Appendix A: Reconciliation of Set Aside for RY 21 and RY 22

As part of the RY 2022 recommendation, Commissioners requested that staff provide a reconciliation of previous years set aside funding. Below is an overview of this request for RY 21 and RY 22.

Distribution of Set Aside for RY 2021			
RY 2021 GBR Revenue		$19,105,021,605	
Set Aside %		0.25%	
Set Aside $		$47,762,554	
Hospital	**Set Aside $ Value**	**Set Aside %**	**Reason**
Mercy	$15,000,000	0.08%	Integrated Efficiency
Suburban	$11,933,939	0.06%	Integrated Efficiency/Capital
Shock Trauma	$2,564,524	0.01%	Shock Trauma Standby
Anne Arundel	$5,270,679	0.03%	Cardiac Program Funding
Statewide	$13,291,872	0.07%	Statewide Vaccination Adj.
Total	$48,061,024	0.25%	

Distribution of Set Aside for RY 2022			
RY 2022 GBR Revenue		$19,638,102,984	
Set Aside %		0.25%	
Set Aside $		$49,095,257	
Hospital	**Set Aside $ Value**	**Set Aside %**	**Reason**

Fort Washington	$6,253,680	0.03%	Integrated Efficiency
Howard County	$12,500,000	0.06%	Integrated Efficiency
Holy Cross	$8,704,705	0.04%	Integrated Efficiency
Anne Arundel	$1,364,501	0.01%	Cardiac Program Funding
Garrett	$2,072,192	0.01%	New Services: LIT, Pain Mgmt, Pop Heath.
Dorchester	$3,400,000	0.02%	Integrated Efficiency
Sinai	$5,500,000	0.03%	Integrated Efficiency (one-time)
PRMC	9,300,179	0.05%	Population Health, Behavioral Health, & Integrated Efficiency
Total	$49,095,257	0.25%	

Maryland
Hospital Association

May 18, 2022

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 60 member hospitals and health systems, we offer our comments on the Health Services Cost Review Commission's (HSCRC) July 1, 2022 annual payment update draft recommendation. MHA appreciates HSCRC's support during the past two years and our collaboration to secure Maryland's Total Cost of Care Model.

We are eager to join with the Commission in devising a fair annual payment update for rate year (RY) 2023. MHA's April 22 position paper respectfully asked HSCRC to:

1) Fund IHS Markit's RY2023 cost inflation, now 3.66%
2) Make the $100 million advance funding permanent and not require repayment
3) Modify the savings adjustment for potentially avoidable utilization
4) Limit the projected reduction in uncompensated care funding
5) Monitor inflation and Model performance for six months and raise rates January 1, 2023

As has become abundantly clear in recent months, Maryland hospitals today face extraordinary financial challenges. They have a profound need for an adequate rate update. And yet, **the difference between our request and staff's recommendation is just 0.86%**. Small as that figure is, it will truly help hospitals that are struggling both to keep core operations going and to invest in advancing the health of their communities.

We understand that the Commission must balance hospitals' intensifying financial pressures against the Medicare spending growth constraints in calendar year (CY) 2022. In that regard, we ask HSCRC to use the most up-to-date source available for national Medicare total cost of care growth comparisons. HSCRC staff and MHA both are relying upon numbers produced by the Centers for Medicare and Medicaid Services (CMS) Office of the Actuary. Staff's reference number is from National Health Expenditures (NHE) estimates that CMS actuaries calculated using data from 2019. However, in April, using data from 2021, CMS projected national Medicare fee-for-service spending growth for CY 2022 that is nearly double the NHE estimate.

Even if one were to apply a conservative adjustment to the freshest figure, **there is ample room for HSCRC to grant MHA's request without any risk of breaching the guardrail.**

Supporting information that supplements our April 22 paper is attached.

These extraordinary times call for extraordinary measures. HSCRC staff's draft recommendation adheres to the traditional approach. Other than adjusting for Medicare's actions on quality policy, it relies on mostly retrospective measures that do not capture the massive cost growth happening right now.

Even if the Commission accepts MHA's proposal, the situation at present is so volatile that **we must also ask you to commit to raise rates further in January 2023** if (a) Maryland's CY2022 performance on the guardrail test is favorable and (b) cumulative 2022-23 actual inflation proves to be at least 0.75% above the inflation the Commission provides for July 1.

What the hospital field is asking of the Commission is fair and reasonable. It will balance hospitals' needs for adequate revenue with the state's need—which hospitals support emphatically—to stay within Model contract parameters.

MHA and all our members sincerely appreciate the HSCRC's partnership as we continue to work together on behalf of the people and communities we serve.

Sincerely,

Bob Atlas
President & CEO

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

Information and Supporting Rationale

A. HSCRC's Medicare Guardrail Estimate Is Too Conservative

We make our requests fully knowing that Maryland's CY 2022 Medicare growth presents a challenge. MHA agrees that HSCRC should use a CMS source to project national Medicare total cost of care growth. In our position paper, MHA cited the Medicare fee-for-service per capita spending growth in CMS's 2023 Medicare Advantage (MA) final rate notice as the appropriate comparison.[1] The rate notice uses newer data than the National Health Expenditure (NHE) report HSCRC staff have cited.

In the 2023 rate notice, CMS's Office of the Actuary (OACT) projected 9.4% CY 2022 growth in Medicare Part A and Part B spending per beneficiary. MHA has confirmed with OACT that the MA rate notice fee-for-service projections reflect claims experience through September 30, 2021, and cash activity through December 31, 2021.[2] OACT also confirmed that their NHE estimates used the 2021 Medicare Trustees Report which reflects data only through 2019.

HSCRC's draft recommendation repeatedly cites the Medicare guardrail as the reason HSCRC cannot fund additional inflation—or, to state it more precisely, to fund inflation that the Commission did not fund fully in RY2022.

MHA has applied conservative assumptions to OACT's 9.4% figure to produce an adjusted growth rate projection of 7.1%. Even this lower figure allows room for MHA's July 1 requests.

Maryland's Model contract sets limits on growth of Medicare spending per beneficiary. The contract also has a combined all-payer annual hospital spending per capita growth limit of 3.58% compounded. Since 2013, all-payer hospital spending per capita has grown 15.14%, less than 2% per year, and less than half the limit of 32.50%. If HSCRC is concerned about CY2022 Medicare growth, it should implement the Medicare Performance Adjustment - Savings Component and **deliver direct savings to Medicare** in the form of lower payments.

B. Fund RY2023 Inflation; Make $100 Million Advance Permanent; Boost Rates January 1

1) Inflation continues to mount. In our position paper, Maryland hospitals strongly urged the Commission to raise the proposed rate update to account for the unprecedented and permanent inflation that is straining hospitals and health systems. We appreciate that HSCRC has proposed to fully fund market basket inflation of 3.66%. This is helpful step toward a stable future.

RY2022 inflation is now 4.42%, fully 1.85 percentage points or 72% higher than HSCRC's RY2022 factor of 2.57%. Adding the 0.5% advance to 2.57% would bring that factor to 3.07%,

[1] Though this is CMS's annual revision in Medicare managed care capitation rates, tables II-2 and II-3 project fee-for-service growth, used by CMS to project service use in capitation rate development.
[2] https://www.cms.gov/files/document/narrative-supporting-2023-growth-rate.pdf, pp. 1-2

still 1.35 percentage points and 43% below measured RY2022 inflation. Making the 0.5% permanent does not add new money to the system, it simply avoids the payback. Put another way, making this amount permanent fills slightly more than one-fourth of the last year's inflation shortfall. This is a balanced and reasonable request.

In granting the $100 million advance, commissioners expected RY2023 inflation to soar, allowing HSCRC to cover the advance. The 3.66% forecast is significant, though it is muted since RY2023 inflation is now projected *off a much higher RY2022 base*. Making 0.5% permanent partially offsets this difference.

MHA generally agrees with HSCRC's approach to raising rates January 1, and HSCRC should only adjust for extreme differences. We ask HSCRC to commit to boosting rates January 2023 if the following criteria are met.

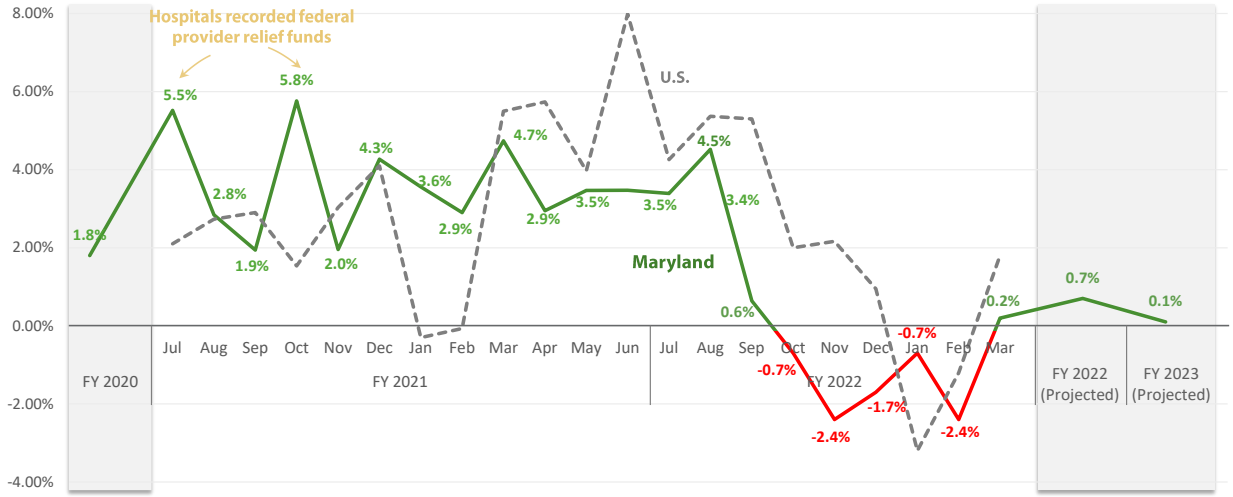
a) Maryland's CY2022 Model performance is favorable, and

b) Actual cumulative 2022-23 inflation proves to be at least 0.75% above the level provided.

MHA and member hospitals will participate in any work group HSCRC may use to discuss this is issue. We ask that commissioners receive regular reports in the second half of CY2022, and we welcome the opportunity to discuss this matter with commissioners at any point prior to January 1.

2) Hospital margins remain weak as cost pressures grow; margins would be even lower without one-time support. As shown in the chart below, the median hospital operating margin in March 2022 was a scant 0.2%, after five straight months of operating losses.

Hospital Operating Margins



More important, the financial pain continues. MHA has polled members and found Maryland hospitals are projecting median year-end RY2022 margin of just 0.7% and their RY2023 budgets will yield a mere 0.1% operating margin. These figures are well below both recent years' performance and the HSCRC's targeted operating margin of 2.75%.

Maryland's rate setting system continues to afford hospitals a degree of financial stability. We are grateful that HSCRC, combined with significant federal relief funds, served as shock absorbers in during 2020 and 2021. RY2022 figures reflect at least $200 million of one-time inflows, including prior year undercharges and the remnants of federal relief. With costs unchanged, absent these one-time infusions, CYTD 2022 financial performance would be much worse. In effect, the help hospitals got in the last two years masks the need for permanent inflation support.

For example, hospitals in one health system are projected to finish the twelve months ending June 2022 with a $6 million net income, a slightly positive operating margin of 0.7%. Excluding federal relief funds that were exhausted earlier in the year, the hospitals would combine to lose $25 million, a nearly 3% operating loss.

New data from national consultants Kaufman Hall, McKinsey and Premier, Inc. support the need for permanent revenue solutions as labor costs continue to rise.

- Kaufman Hall's May 2022 Flash Report shows hospital labor costs have jumped 30% nationally since 2019.[3]
- McKinsey's May 11 report shares its survey results, with 29% of responding nurses indicating they are likely to leave their patient care role.[4] By 2025, McKinsey projects a nationwide nursing shortage of 200,000 to 450,000 nurses.
- Premier, Inc's data shows a real increase in hospital labor wages of 16.5% in the end of 2020, remarkably consistent with MHA's labor survey showing nursing and nursing assistant rates climbing 16% to 18%.[5]

3) The labor market continues to constrain hospital services. The staffing crisis is very real, and it threatens hospitals' ability to operate services at normal capacity to serve our patients. Some recent service impact examples include:

- Despite heroic efforts, many hospitals have had to temporarily close inpatient beds when staff were not available. As a result, emergency department throughput is thwarted, extending wait times and causing service delays.

[3] https://www.kaufmanhall.com/sites/default/files/2022-05/KH-NHFR-Special-Report-2.pdf
[4] https://www.mckinsey.com/industries/healthcare-systems-and-services/our-insights/assessing-the-lingering-impact-of-covid-19-on-the-nursing-workforce?utm_source=newsletter&utm_medium=email&utm_campaign=newsletter_axiosvitals&stream=top
[5] https://premierinc.com/newsroom/blog/pinc-ai-data-cms-data-underestimates-hospital-labor-spending

- Several hospitals have been forced to scale back operating room availability, impacting the community.
- One hospital has had to reassign staff from outpatient services focused on population health—like wound care, cardiopulmonary rehabilitation, and even behavioral health—to fill core, beside acute services.

Maryland hospitals are committed to Model goals of improving population health and transforming care. However, as shown in the examples and in many other stories, hospitals are forced to focus on keeping up core mission capabilities while eyeing the future.

C. Mitigating the RY2023 Uncompensated Care (UCC) Impact

Our April 22 position paper gave a detailed rationale to lessen the 0.43% UCC impact. MHA proposes to reduce the estimated impact by half, sharing the cash implications evenly between hospitals and insurers.

HSCRC's UCC policy self-adjusts over time. However, in certain instances, HSCRC has prospectively lowered UCC for expected savings. Though HSCRC did not initially reduce UCC funding when coverage expanded under the Affordable Care Act (ACA), it prospectively reduced funding in year 2, as UCC began to fall from 7% to 4.5% of statewide revenues.

As of this writing, 2023 hospital write-off data are not available to model 2023 UCC policy options. MHA's proposal to offset the UCC reduction by half still lowers payments by 0.22%. After assessing 2022 actual results, this adjustment can be removed in the future.

D. Potentially Avoidable Utilization (PAU) Savings Adjustment

HSCRC staff acknowledges that MHA's PAU savings proposal has merit. MHA agrees and is committed to work with HSCRC staff to explore different options to reimagine the policy. An empirically based approach would compare Maryland's performance to targets using national benchmarks. Should Maryland exceed the benchmark, the negative policy impact should be reduced.

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

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

May 17, 2022

Chairman Kane,

On behalf of the Medicaid program at the Maryland Department of Health (the Department), I am writing to communicate the Department's full support of the Health Services Cost Review Commission's (HSCRC) staff recommendation for the rate year (RY) 2023 rate update factor. Our full support centers around three key points.

First, Maryland cannot risk becoming subject to a corrective action plan for failing to meet the Total Cost of Care (TCOC) Model's guardrail tests as it prepares to enter negotiations with the Center for Medicare and Medicare Innovation (CMMI). The growth guardrail test requires Maryland not to grow faster than the national Medicare rate. Maryland exceeded the national Medicare growth guardrail in calendar year (CY) 2021. If Maryland exceeds the national rate of growth in CY 2022, the state will be subject to a corrective action plan under the TCOC Model. Current projections predict another unfavorable performance for CY 2022 for the Medicare growth test, as well as for achieving the savings target of $267 million. Based on the staff's analysis, the proposed rate increase for RY 2023 provides the best assurance that Maryland meets these tests.

Staff analyses on the health of the hospitals' financial condition showed generous operating and profit margins in 2021. Absent approval of the staff recommendation as currently written, CMMI is likely to ask why Maryland was not able to achieve the growth and savings targets and why these monies should not be used to achieve CY 2022 targets. The pandemic affected all states; Maryland is not unique in its struggles with the pandemic and should be able to meet the national Medicare growth rate test.

Second, in addition to other positive adjustments, the Maryland Hospital Association (MHA) has proposed making permanent the one-time, $100 million inflation advance provided in January 2022. This is contrary to the HSCRC's agreement that the

$100 million would be repaid. MHA has stated that if these positive adjustments cause Maryland to fail its savings or guardrail tests, the Medicare Performance Adjustment can be used to adjust Medicare rates on the backend to bring the state into compliance. This is a direct violation of the Medicaid Upper Payment Limit test. Federal rules do not permit Medicaid to pay more than Medicare. This test is applied whether the adjustment to rates occurs upfront or on the backend. The same adjustment to Medicare must be made to Medicaid. Additionally, this deviation from all-payer rates does not align with the central tenet of the Total Cost of Care Model.

Third, in its testimony during the presentation of the draft recommendation, MHA asserted that the Medicaid redetermination process after the federal public health emergency ends necessitates an upward adjustment to uncompensated care. Maryland Medicaid now provides insurance coverage to over 1.7 million Maryland residents. Before the pandemic, Maryland Medicaid covered roughly 1.4 million. Maryland Medicaid served as the safety net during the pandemic, absorbing an over 20-percent increase in insurance coverage. The 0.20-percentage-point increase in uncompensated care for RY 2021 cited a slowing of the decrease in the uninsured population. Based on the extraordinary growth in Medicaid coverage, the FY 2021 increase was not necessary and should be adjusted downward as the staff recommends.

The Department has been closely following analyses that predict the federal public health emergency may extend past the 2022 midterm elections. If these predictions are accurate, Maryland Medicaid will not start redeterminations until early 2023. Once initiated, redeterminations will occur over a 12-month period. The staff's downward adjustment is appropriate at this time and should be reviewed again next year.

Thank you again for the opportunity to provide comments. If you have additional questions, please do not hesitate to contact me or Tricia Roddy, Deputy Medicaid Director.

Sincerely,

Steven R. Schuh
Deputy Secretary for Health Care Financing and
Director of Medicaid

David Schwartz
Vice President
Public Policy & Federal Affairs

CareFirst BlueCross BlueShield
840 First Street, NE
Washington, DC 20065
Tel. 202-680-7433

May 18, 2022

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

Dear Chairman Kane:

CareFirst BlueCross BlueShield (CareFirst) appreciates this opportunity to comment on the Draft Recommendation for the Update Factor for Rate Year 2023. We recognize the Staff is balancing significant competing priorities including (1) funding cost inflation in global budgets to accommodate hospitals' exposure to labor pressures, (2) recognizing the healthcare affordability crisis faced by Maryland residents and employers amidst a challenging economic environment, and (3) meeting a required Total Cost of Care (TCOC) Model Medicare savings test and guardrail on which the state performed poorly in 2021.

CareFirst sympathizes greatly with the hospital industry as they navigate the nursing shortage that has been exacerbated by the pandemic. We recognize the impact this has had on financials and operations, and we are committed to being a part of solving this problem at its root cause in collaboration with the state, HSCRC, and hospitals. We have already been working on this issue in all three of our jurisdictions. In Maryland, we testified in support of two bills this past legislative session. The first establishes a Commission to Study the Health Care Workforce Crisis in Maryland, which will collect and analyze data to identify both short and long-term solutions that address root causes. The second establishes the Maryland Loan Assistance Repayment program for Nurses and Nursing workers. In Washington, DC, we recently sponsored, and our Chief Executive Officer moderated, the DC Chamber's Health Policy forum, which focused on the future of DC's healthcare workforce as well as solutioning for capacity and pipeline challenges. In Virginia, CareFirst actively engages with and currently chairs the advisory board for the Governor's Health Science Academy at Alexandria City High School, which is focused on graduating students into three healthcare paths.

We are prioritizing this issue and will continue devoting people and resources toward solving its root causes. **We do not believe permanent hospital rate enhancement is a solution** to the core problem, and we urge HSCRC to consider who that would impact.

Impact on Maryland Residents, Employers, and Plans

Two-thirds of CareFirst's Maryland business is covered by self-insured plans, meaning that as healthcare costs rise, employers feel it directly since they take full risk for the cost of their employees' care. Many of these businesses are already dealing with significant price inflation in gas, housing, and food and beverage costs. Healthcare costs are usually employers' second

largest expense, and they are increasingly searching for relief in a number of ways, including (1) engaging companies to assist employees in finding efficient care alternatives, (2) seeking point solutions that promise to impact particular conditions, and/or (3) relying on provider profiling to

identify lower cost, high performing providers.

Recently, significant mid-year adjustments were applied to Maryland hospitals' rates, including rate corridor expansions, GBR additions of prior year undercharges, and an advance on inflation earlier this year. These mid-year adjustments have direct impacts on Maryland residents with benefit plans that apply coinsurance in the hospital setting. At CareFirst, roughly 43% of Maryland-based individual members are in plans with inpatient coinsurance.

These mid-year increases also cannot be accounted for by Medicare Advantage (MA) plans, which lock rates with bids submitted in June for the upcoming year, or by Medicaid Managed Care Organizations (MCOs), which lock rates in September. We know HSCRC is aware MA plans in Maryland are already underfunded by the national payment methodology that does not contemplate the impact of Maryland's all-payer rate-setting.

For these reasons, **we have concerns about Staff's recommendation to develop a new policy to adjust inflation in January** if the gap between funded and actual inflation surpasses a determined threshold.

Medicare Guardrail Projections

CareFirst took note of two assumptions in Staff's projection of guardrail and savings test performance that inherently adopt risk. The first is the expectation in the guardrail projection scenarios that Maryland's non-hospital spending growth trajectory will equal that of the nation. Given Maryland has a history of non-hospital spending growth outpacing the nation, it seems an average of Maryland-specific non-hospital spending growth over a reasonable recent period would be a more realistic expectation.

The second risk is the assumption the undercharge of $178 million through December 2021 will carry forward to June 2022. It is possible hospitals will charge at the top of their allowable rate corridors in the final quarter of the year to eliminate or reduce undercharges at year-end. In fact, it was reported by Staff at the May HSCRC public meeting this figure has already reduced to $150 million.

Both assumptions could be significantly underestimating Maryland's TCOC growth in Calendar Year 2022, which the industry and HSCRC need clarity on to understand how the recommended update factor positions the state on the guardrail test. **We urge Staff to pressure-test and adjust these assumptions before making a final recommendation**.

Affordability

Finally, Staff recently built into the update factor process an affordability analysis of their projected update. The 2020 Final Recommendation for the Medicare Performance Adjustment Framework stated that one of the principles for setting the update factor should be that "hospital spending growth continues to grow less than the Gross State Product." Despite this principle, this year's Staff recommendation yields an unfavorable result in that hospital charge growth exceeds the three-year GSP trend. This is indicative of how Maryland residents and employers are being impacted, which is troubling in a state with a unique model focused controlling health care cost growth.

Conclusion

We understand and agree with the need to fund cost inflation at Maryland's hospitals, but we believe a few critical items need to be addressed between the draft and final update factor recommendations.

1. We believe **a closer look at Maryland's non-hospital spending growth and undercharge position is necessary** to solidify the TCOC growth projections and understand the state's guardrail positioning.
2. If by funding cost inflation, the recommendation still projects tripping guardrails in 2022, we believe **there needs to be a plan to identify where savings will come from** outside of the update factor to ensure Maryland meets the TCOC Model's savings test requirements.
3. Staff should **reconsider its recommendation to develop a process for adjusting inflation in January** given the unbudgeted impact on employers and health plans.

Thank you again for the opportunity to comment today. We look forward to continuing collaborative discussions with Staff and the industry as this draft progresses toward a final recommendation.

Sincerely,

David Schwartz

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

MedStar Health

10980 Grantchester Way
Columbia, MD 21044
410-772-6500 PHONE
410-715-3754 FAX
medstarhealth.org

May 18, 2022

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

Dear Chairman Kane:

On behalf of MedStar Franklin Square Hospital, MedStar Good Samaritan Hospital, MedStar Harbor Hospital, MedStar Montgomery Medical Center, MedStar St. Mary's Hospital, MedStar Southern Maryland Hospital, and MedStar Union Memorial Hospital, we write to support the hospital field's July 1, rate request.

Throughout the pandemic Maryland hospitals have supported our communities and partnered with the state and the HSCRC to rise to the challenge to expand access to care, increase testing and distribute the vaccine to deliver on our mission to save lives, and we were glad to do it.

Now more than two years since the pandemic began, the impacts of this extended crisis on the healthcare workforce across the country and in the state of Maryland are greater than we could have imagined. The accumulation of months of stress has led to burnout and a higher number of nurses leaving the acute care setting or the profession. As a result, nursing turnover and vacancy rates have increased after each surge and our nursing vacancy rate is now more than 2.5 times higher than it was prior to the pandemic. To respond to the increased demand for nurses, we have adjusted wages, instituted special pay programs to encourage nurses to take additional shifts, and increased our utilization of agency nurses. Agency rates remain high based on the increased demand. Since not enough nurses are available, we have increased recruitment of patient care technicians and medical assistants to supplement the nurse staffing to continue to deliver safe and appropriate patient care. This increased demand has in turn driven up the market compensation for medical assistants, patient care technicians, respiratory therapists, and other clinical positions. These market forces have resulted in an increase in FY22 YTD personnel costs per adjusted admission of more than 30% when compared to FY19.

Cost increases extend beyond personnel with supply chain challenges, and other inflationary pressures. These expense increases have been significantly detrimental to hospital finances and have resulted in operating losses in our Maryland hospital operations. The expense pressure and inflationary increases are projected to continue in FY23. In addition, pandemic disruptions have created other operations challenges. Below are the some of the additional specific operational challenges that we are facing:

- Increase in food, drug, supplies, and delivery/freight costs
- Delays in receiving supplies and equipment causing increases in repair costs while waiting for new items
- Increase in behavioral health patients that require 1:1 attention and additional resources
- Delays in placement of patients due to Post Acute staffing challenges
- Reduction in Baltimore jobs program funding for peer recovery coaches and community health workers

While the health care industry's requested FY23 rate update will not fully alleviate these unavoidable cost increases, it is greatly needed as part of the solution. Thank you for your consideration of this request and please reach out should you have any questions.

Sincerely,

Brad S. Chambers
Senior Vice President & Chief Operating Officer, Baltimore Region, MedStar Health
President, MedStar Good Samaritan Hospital
President, MedStar Union Memorial Hospital

Stuart M. Levine, MD
President, MedStar Franklin Square Medical Center
And Senior Vice President, MedStar Health

Jill Donaldson, FACHE
President, MedStar Harbor Hospital
And Senior Vice President, MedStar Health

T.J. Senker, FACHE
President, MedStar Montgomery Medical Center and
Senior Vice President, MedStar Health

Stephen T. Michaels, M.D.
Stephen T. Michaels, MD, FACHE
President, MedStar Southern Maryland Hospital Center and
Senior Vice President, MedStar Health

Mimi Novello, MD, MBA, FACEP
President and Chief Medical Officer,
MedStar St. Mary's Hospital and
Senior Vice President, MedStar Health

cc: Katie Wunderlich, Executive Director
Joseph Antos, PhD
Maulik Joshi, DrPH
Sam Malhotra
Victoria W. Bayless
James Elliott, M.D.
Stacia Cohen, RN, MBA
Bob Atlas, MHA President & CEO

May 18, 2022

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

Dear Chairman Kane:

On behalf the Johns Hopkins Health System (JHHS) and our four Maryland hospitals, thank you for the opportunity to provide input on the staff recommendation on the payment update. JHHS supports the hospital industry's position. As noted by JHHS President Kevin Sowers during the May Commission meeting, many hospitals are facing unprecedented challenges. In his testimony, Mr. Sowers specifically spoke to financial and staffing pressures as well as actions our hospitals are taking to reduce costs.

JHHS greatly appreciates the actions taken by the HSCRC and state and federal governments to support hospitals throughout the COVID pandemic. However, this relief was generally "one-time" funding and with its discontinuation, many Maryland hospitals are struggling. At JHHS, three of our four Maryland hospitals are projecting a negative operating margin. The financial situation is severe enough that two of the JHHS Maryland hospitals will have to borrow money to meet cash flow needs.

Staffing and nursing agency spend is one of the biggest contributors to financial challenges. Healthcare, and in particular, hospital care, is a 24/7 operation with specific staffing needs. Hospitals that operate at capacity have no option but to take immediate action to stabilize the workforce. The expected nursing agency spend for our four Maryland hospitals over fiscal 2022 and 2023 is $469 million. In addition, JHHS invested $56 million in salary adjustments to recruit and retain all staff at our Maryland hospitals.

The health care and workforce landscape are forever altered by the COVID pandemic. Care models must be redesigned – but this is a long-term strategy. JHHS, and our four Maryland hospitals, have taken immediate action to address cost pressures through $210 million in

performance improvement actions. However, even in light of these actions and the proposed update, three of our Maryland hospitals are still facing negative operating margins.

JHHS recognizes that the HSCRC must balance the targets of the Total Cost of Care Agreement with the needs of the industry. We appreciate the sensitives to both the guardrails and the overall savings target. However, if the savings target is of such significant concern, there are actions the state can take to both support hospitals and protect the target. Hospital rates include 3-4% for items that are passed through the hospital rate structures and do not drop to the bottom line. **Reduction or elimination of some or all of these pass throughs would improve the performance against the guardrail.**

JHHS also recognizes that hospitals across the country are facing similar challenges and these cost pressures are not unique to Maryland, however we have tolerated modest margins in the past with the knowledge that Maryland's rate setting system offers a safety net in difficult times.

Thank you for the opportunity to share comments and concerns both written and at the Commission meeting. We greatly appreciate the HSCRC's transparent process in the development and approval of the payment update. JHHS supports the payment update proposal by MHA and the hospital field, however if this proposal cannot be accepted due to the Agreement constraints, other actions can be taken to stabilize hospitals experiencing the greatest cost pressures.

Sincerely,

Ed Beranek

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

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

Sheppard Pratt

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

May 18, 2022

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

Dear Chairman Kane:

On behalf of Sheppard Pratt, I write to support the hospital field's July 1, rate request.

Sheppard Pratt has a projected loss of ($12.1m) through the end of Fiscal Year 2022. This includes one-time HHS funding of $1m and additional one-time support through the state to maintain capacity. While we continue to manage COVID outbreaks on our inpatient units, the primary challenge in this current year is due to workforce shortages impacting Sheppard Pratt. Sheppard Pratt has had to rely on costly staffing agencies due to high turnover. Nursing agency expenses alone are a staggering $13.2m to the organization and over a 300% increase from prior year.

Based on our inability to staff programming, we have been forced to take several hospital beds offline for a portion of the year. In addition, we have five Day Hospital and Intensive Outpatient programs closed due to staff shortages as well as five at significantly reduced capacity. These program closures have the potential to impact Emergency Departments and other psychiatric inpatient units due to lack of other inpatient and outpatient services.

Sheppard Pratt is working to address staffing shortages by increasing compensation for existing staff and new nurses. To retain and recruit, we are increasing compensation by 20% in some cases. In addition, overtime is incredibly high with overtime labor accounting for 10% of all labor hours which is causing staff burnout. Sheppard Pratt is considering reductions to other mission-driven services to attempt to manage the operating losses.

Thank you for your consideration. Please call me with any questions.

Sincerely,

Harsh Trivedi, MD, MBA

cc: Katie Wunderlich, Executive Director
Joseph Antos, PhD
Maulik Joshi, DrPH
Sam Malhotra
Victoria W. Bayless
James Elliott, M.D.
Stacia Cohen, RN, MBA
Bob Atlas, MHA President & CEO

6501 N. Charles Street, Baltimore, MD 21204 • PHONE: 410.938.3401 • FAX: 410.938.3450 • htrivedi@sheppardpratt.org

HOLY CROSS HEALTH

1500 Forest Glen Road
Silver Spring, MD 20910-1484
301-754-7000
HolyCrossHealth.org

May 18, 2022

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

Dear Mr. Kane,

On behalf of Holy Cross Health, I am writing in support of the proposed July 1, 2022 rate request submitted by the Maryland Hospital Association on behalf of Maryland hospitals.

As you are aware, the past two years have posed a variety of significant and escalating challenges as Maryland hospitals continue to fight the impact of COVID-19 on the health of our community and our own financial wellbeing. The financial impact is severe as costs have risen exponentially driven by skyrocketing inflation and unprecedented spikes in labor availability and cost. Hospitals, including both within the Holy Cross Health system, are facing substantial operating income declines and overall losses. Through April 2022, Holy Cross Health has reported a financial loss of $4.3 million. This loss would have been $7.6 million YTD April 2022 were it not for $3.3 million of provider relief funds. Those one-time funds only lessened our losses and will not support our ongoing needs. This performance is a dramatic decline from our FY21 operating income of $49.2 million which also included substantial support from provider relief funds (PRF) totaling $31.3 million. If we remove the PRF from our FY21 operating income, our financial performance would have been much lower at $17.1 million. Comparing this year over year financial performance after eliminating the one-time PRF funding, our operating income is projected to decline by $24.7 million. The FY 2021 operating performance of $17.1 million, while positive, leaves little opportunity for reinvestment in focus areas that support lowering the total cost of care and ensuring access and efficiency of and in operations. With the continued challenges facing us on the labor front and rising inflation pressures, we are projecting a continued loss in FY23 totaling $10.0 million despite implementing initiatives to curb costs in all areas throughout our system. FY 2022 losses and even further loss in FY 2023 are crippling to Holy Cross Health and jeopardizes our position as an exceptional high quality, low cost, efficient and accessible provider of community-based hospital services.

Throughout the pandemic years, Holy Cross Hospital and Holy Cross Germantown Hospital both grew in comparison to the market at large and to hospitals in the region. Individuals who neglected care during the pandemic are seeking innovative treatments in our hospitals, while those who had emergent needs, including women needing a care partner for their birthing plans never stopped coming through our doors. We have remained open and have not delayed or deferred service offerings. The very real challenge to our operating performance today is driven by the dramatic increase in labor costs and supply chain cost escalations. A prominent driver of labor costs is the overall growth in compensation rates for nurses and essential clinical resources. At the height of the pandemic, meeting the needs of the community required us to pay two to three times market rate for nursing and ancillary caregivers. With high burnout and enticing financial opportunities presented, a significant number of our clinical colleagues have left Holy Cross Health to take positions with the contract agencies who offering premium dollars to fill market vacancies. While this significant turnover continues to

occur and premium dollars are spent on labor, Holy Cross built retention programs that offer bonus pay, wage adjustments and supportive benefits. Many colleagues have taken advantage of these offerings, but too few to impact the overall deficit caused by the significant wage increases necessary for us to remain competitive in the market.

Holy Cross Health has taken significant action to address attract and fill vacancies while implementing initiatives to retain current colleagues. We reviewed market compensation and instituted substantial adjustments multiple times this fiscal year and are continuing to review and adjust rates as necessary to address turnover and attract new colleagues. We implemented a retention program for those positions that are particularly difficult to recruit and established an in-house agency to offer a flexible work option for those seeking non-benefit-eligible positions. We are working closely with local colleges to effectively recruit and transition new nurse graduates into vacancies within our organization and providing the essential support to allow for their successful transition. We are also exploring the recruitment of foreign trained nurses to supplement our recruitment needs long term and exploring alternate staffing models to provide greater support for our front-line care givers and allow our nursing teams to work at the top of their licenses. These initiatives are essential for addressing our labor challenges but the growth in costs is creating a significant drain in our operating performance. Labor costs now comprise 60% of our net operating revenue compared to 52% in prior year and our overall compensation rates have risen over 14% from prior year.

The lack of recognition for the tremendous costs burden fails to recognize hospitals that have given so much and is forcing us to reassess and, potentially scale back, vital resources and investments made to support the transformation of care delivery under the Total Cost of Care model.

The challenges we are facing today are unprecedented and requires careful consideration as we look to continue the high-quality, accessible and efficient care that leads to improvement in and lowering of the total cost of care. Thank you for this opportunity to share the challenges we are facing in managing through these turbulent times and we appreciate your consideration of these challenges as you deliberate the update factor.

Sincerely,

Anne D. Gillis
Chief Financial Officer

Cc: Joseph Antos, Ph.D., Vice Chairman
James N. Elliott, M.D.
Sam Malhotra
Stacia Cohen, R.N.
Maulik Joshi, DrPH
Victoria W. Bayless
Katie Wunderlich, Executive Director
Norvell "Van" Coots, M.D, Pres and CEO, Holy Cross Health

Luminis Health℠

2001 Medical Parkway
Annapolis, Md. 21401
LuminisHealth.org

May 16, 2022

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

Dear Chairman Kane:

I write to support the hospital field's July 1 rate request on behalf of Luminis Health.

Luminis Health recorded an operating margin loss of $48.6M vs. a budgeted margin loss of $1.4M for the nine months ending March 31, 2022. The projected full fiscal year 2022 operating margin is a loss of $58.9M vs. a budgeted loss of $4.9M. The projected operating margin loss of $58.9M represents an operating margin of (5.2%) vs. a budgeted margin of (0.4%), significantly below FY21 and FY20 operating margins of 2.0% and 0.6%, respectively. Additionally, as we continue to lose non-recurring revenue streams, such as CARES funding ($7M received in FY22), labor shortages coupled with premium agency rates, and supply chain disruptions, we are budgeting an operating margin loss of $18M. The budgeted operating margin loss of $18M represents an operating margin of (1.5%).

As with most health systems across the nation, staffing challenges have impacted the level and quality of services across Luminis Health. Emergency room diversions have remained elevated year over year, resulting from reduced staffing, and have been a driver in poor throughput and the inability to open additional inpatients beds. Additionally, the downstream effect of lower inpatient beds has also negatively impacted Luminis Health's operating room capacity. The nursing staff has also taken on duties in other departments, specifically tasks customarily performed by Respiratory Therapy and Phlebotomy. Medical length of stay has increased year over year, partially due to the increased number of inexperienced and agency staff. There has been a significant increase of inductions on hold in Labor and Delivery because of staffing issues. Maintaining adequate levels of scarce clinical talent has made focusing on and funding population health, community health, and care transformation investments problematic.

In September 2021, driven by the challenges faced by workforce competition, Luminis Health received Board approval to invest $29M in employee wage and benefits optimization programs. The investments included but were not limited to nursing retention bonuses, salary market adjustments, the implementation of a $17/hour living wage across the enterprise, and an R.N. college loan repayment program. Luminis Health has also experienced higher than average contract labor costs. Contract labor hourly rates have risen from $72 in FY19 to $174 in October 2021 (a 142% increase) and are still rising. Moreover, contract labor expense has grown from $23.3M in FY20 to $38.1M in FY21 and is projected to exceed $70.0M in FY22.

We hope you consider the wage pressures and the impact on care quality and delivery across the Maryland health systems in the July 1 rate order.

I appreciate your consideration. Please call me with any questions.

Sincerely,

Kevin L. Smith
Chief Financial Officer

cc: Katie Wunderlich, Executive Director
Joseph Antos, PhD
Maulik Joshi, DrPH
Sam Malhotra
Victoria W. Bayless
James Elliott, M.D.
Stacia Cohen, RN, MBA
Bob Atlas, MHA President & CEO

Ascension
Saint Agnes

May 18, 2022

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

Dear Chairman Kane,

On behalf of Ascension Saint Agnes Hospital, I write to support the hospital field's July 1st rate request.

Ascension Saint Agnes is experiencing unprecedented staffing challenges, wage pressures and rising costs for supplies and services. For the period July through the end of April 2022, Ascension Saint Agnes has an operating margin of 0.0% and projects an operating margin for fiscal 2022 year end of 0.7%. Commission action in January including approval of the 0.5% midyear advance funding and expansion of unit rate corridors has been critical for Ascension Saint Agnes to respond to rapidly increasing cost inflation and wage pressure in fiscal year 2022. For fiscal year 2023, Ascension Saint Agnes is projecting 0.35% operating margin. The erosion from fiscal year 2022 is driven primarily by rising labor costs and lower regulated revenue due to lower unit rate corridors. Ascension Saint Agnes has experienced a year-over-year increase in salary and wages per equivalent discharge and supply expense per equivalent discharge of 11.6% and 5.4%, respectively. Commission action to approve the hospital field's July 1st rate request will provide much needed financial support to respond to the rising costs.

Staffing shortages at Ascension Saint Agnes are leading to significant throughput issues in the emergency department, critical care, and med/surg nursing units. Emergency department red and yellow alerts (a good indicator of emergency department crowding) is currently running 390% over pre-pandemic levels for the ten months ending April 2022. Emergency department overcrowding is causing increased wait times, delays in treatment, delays in recognizing serious

Ascension Saint Agnes
900 S. Caton Avenue
Baltimore, MD 21229
667-234-3114

medical issues, increased ambulance wait times and increased violence towards staff members due to the long wait time.

Ascension Saint Agnes has taken significant action over the past year to access the workforce and respond to the rapidly rising cost of labor. Ascension Saint Agnes currently has a nursing vacancy rate of 30% and a voluntary turnover rate of 25%. Contract labor and temporary staffing costs for the ten months ended April 2022 have increased $19.2m (532% increase) over the same 10-month period last year. An increase in contract labor and temporary staffing utilization means loss of permanent staff which causes inconsistencies in care teams and inconsistent adherence to policies and procedures including initiatives to improve quality and patient experience. To stabilize its workforce in response to the higher contract labor and temporary staffing utilization, Ascension Saint Agnes has invested $10.9m into permanent wage increases (representing a 6.3% increase in non-physician salary expense) to attract and retain employed personnel.

Thank you for your consideration. Please call me with any questions.

Regards,

Edward Lovern
President & CEO

cc: Katie Wunderlich, Executive Director
Joseph Antos, Ph.D.
Maulik Joshi, Dr.P.H.
Sam Malhotra
Victoria W. Bayless
James Elliott, M.D.
Stacia Cohen, RN, MBA
Bob Atlas, MHA President & CEO

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

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

CORPORATE OFFICE

May 18, 2022

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

RE: UMMS Comment Letter on Draft Staff Recommendation for the FY 2023 Update Factor

Dear Katie:

On behalf of the entire University of Maryland Medical System, including all of our employees, and especially our care givers, we appreciate the extraordinary efforts of the HSCRC in providing the entire industry with resources and numerous flexibilities that have allowed us to continue to provide the world class care that we are so committed to delivering to our patients and communities.

Now as we begin to move forward in a COVID-modified environment, we are facing unprecedented labor shortages and cost inflation pressures. Some of these pressures are likely temporary, however, it is unclear about how long they will persist. In other areas, particularly regarding structural labor rates, we have had to make numerous permanent increases to our wages and benefit design.

As you are aware, the US economy is experiencing the largest increase in inflation in recent memory. Inflation is rising at rates last experienced with the oil crisis of the 1970s. Much recent debate has centered around the likely persistence of this inflationary trend – is it temporary or will it persist?

It is well documented that forecasts often lag turning points in economic activity. During a period of rising inflation, status quo models often miss the factors contributing to growth and continue to forecast increases well below those experienced for some time into the future. For Maryland hospitals, the implication is that costs would continue to rise well beyond the allowed increases based on the annual update factor.

The purpose of this letter is to discuss the adequacy of the preliminary update to rates proposed by the HSCRC staff, based on the current edition of the Medicare Market basket and the IHS Markit model for Rate Year 2023.

Cost Pressures at the University of Maryland Medical System

This general rise in prices is exerting operational and financial pressures on hospitals. While prices for all items are rising, the rising cost of labor is most impactful as there has been a fundamental shift in the labor market creating staffing shortages and permanent pressure on wages. These labor market changes necessitated swift action and UMMS moved quickly to make investments into our workforce including both one-time investments such as retention bonuses and over $68 million in permanent wage increases. The financial consequences of these investments are exacerbated by increases in the cost of agency staff needed to fill vacancies in critical clinical positions. In FY 2022 UMMS is projected to spend over $200 million in agency costs, more than four times the amount budgeted. Agency employees cost substantially more than employed staff. While the use of agency employees reflects a temporary circumstance in the hospital labor market, the situation is not necessarily short term. The impact of the lingering effects of the pandemic, workforce investments, one-time and permanent, and the unprecedented agency cost, is a FY 2022 projected breakeven operating margin which is far below annual budget goals.

Adding to this higher permanent FY 2022 cost, UMMS is expecting continued and increasing cost pressure in FY 2023 due to growth in inflation and the need for additional workforce investments. The FY 2023 budget includes the continuation of higher than normal agency usage, although lower than FY 2022, and the need for additional permanent wage and salary increases. To mitigate the impact of both FY 2022 and FY 2023 budgeted cost growth, UMMS is implementing $125 million in cost reductions through performance improvement initiatives - $50 million in agency cost and $75 million in other cost savings through such initiatives as a nursing care model changes and overall productivity improvements. In addition to targeting cost reductions, UMMS is also deferring programmatic investments, replacement of capital and equipment, and spending initiatives for innovative patient care delivery. Despite performance improvement initiatives and deferred spending, UMMS is budgeting an operating margin significantly lower than targeted margins needed to fund capital.

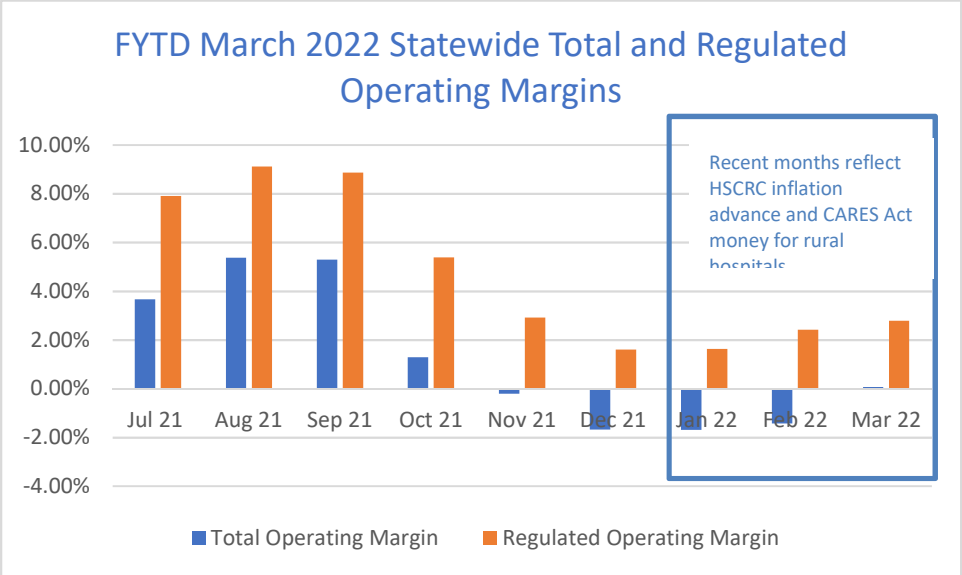
Industry Effects of Underfunding in FY2022

In addition to the prospective pressures of current inflation, the HSCRC update factor for Fiscal Year 2022 was well below actual inflation and is a compounding factor in the pressures UMMS is experiencing on its operating margins.

- For FY 2022, the approved update factor was 2.44% while actual inflation is projected at 3.9% by IHS Market forecast of the CMS market basket. Given the recent experience with the growth of the price indexes mentioned above, this gap could continue to increase.
    - Of specific concern is the CMS market basket assumptions regarding growth in labor costs. The market basket uses the Employment Cost Index, which is forecast for FY 2022 at 4.1%. This is

expected to rise to 5.4% in the next projection. However, alternative measures such as BLS's Average Hourly Earnings for hospital workers is rising at 7.8% and expected to peak at 9.7% in 2022. This rapid growth is echoed by a newly released Kaufman Hall report that estimates that labor costs for hospitals have risen by more than one-third since the onset of the pandemic.

- The results of this underfunding manifests itself in declining margins in preliminary data for FY 2022 to date. Regulated margins fell from 8.86% in September 2021 to 1.60% in December 2021 and total operating margins declined to a loss of 1.70% in December. Regulated operating margins have started to improve with the $100 million in advanced funding approved by the Commission and total operating margins are currently at breakeven. The results are shown in the chart below:



Per the recent HSCRC staff analysis, cumulatively, the annual update factor had overfunded inflation for the industry in the aggregate by 0.5 percentage points prior to FY 2022, but the 2022 underfunding clearly dwarfs that previous experience and is an outlier in forecast errors for recent years. Given the magnitude of the underfunding, it is not surprising that hospital margins have dropped precipitously.

The $100 million advance on the FY 2023 update factor increase appears to have stabilized the decline, as shown in the graph above. However, this advance of one-time money that is scheduled for recoupment is unlikely to offer sustained relief for long given that inflation numbers have continued to rise at an increasing rate:

- The Bureau of Economic Analysis (BEA) announced the PCE Index for March 2022 grew at 6.6% on an annual basis, which continued to increase over the 6.3% reported for the previous month. This increase in the rate of price growth suggests that the current price pressures have not yet peaked.
- According to BLS, producer prices for final demand increased 11.0% from April 2021 to April 2022. The Increase has been 10.0% the previous month.

- The Consumer Price Index rose 8.3% from April 2021 to April 2022, following a 12-month increase of 8.5% in March 2022.
- Medicare actuaries forecast that Medicare per capita costs will rise 9.4% in 2022.

Demonstration Model Considerations

The State has committed to $300 million in annual savings to Medicare Part A and B by the end of 2023 as a condition of the TCOC Model. To date, the State has exceeded the savings target, but the staff announced that position has eroded in recent months. Hospitals were running below the national growth rate, but non-hospital costs were growing faster than the national rate of growth.

Additionally, the guardrail position for CY 2021 over the same time the previous year was positive, which indicates as second consecutive year of growth beyond the national average. The anomalous conditions related to the pandemic have made comparisons to the national performance problematic. Clearly, the HSCRC has a difficult task to manage the system's performance under the Demonstration Model with providing sufficient revenue for hospitals to cover the rising costs of providing patient care. UMMS is fully committed to the success of the Demonstration Model and only asks that the HSCRC consider the extreme operating pressures that the industry is currently trying the manage.

A Proposal for the FY 2023 Update Factor

Given the new information regarding the cumulative savings erosion and the fact that inflationary pressures appear to be still increasing, UMMS would propose an update factor that recognizes both realities of Demonstration Model performance and labor cost pressures.

The current adjustment for inflation included in the staff's preliminary balanced update model for FY 2023 currently stands at 3.66% but given the fact that the IHS forecast has undershot recent forecasts for inflation (as have most forecasting models for the current fiscal year), updated models may show higher market basket forecasts.

1. We ask that the Commission consider alternative forecasts for expected fee-for-service Medicare per beneficiary growth in FY 2023. Given the CMS actuary's forecast of 9.4% per beneficiary fee-for-service growth for the Medicare Advantage update, the projection in the staff recommendation may be excessively conservative. While it is necessary to balance the needs of patients, payers, and providers, the financial pressures from volatile and rising input prices layered on top of an emerging post-pandemic environment have placed considerable stress on hospitals and health systems. It is necessary to substantially cover expected cost increases if the hospital system is to continue to meet the demands placed upon it by patients and policymakers.
2. We request that hospitals get some relief from the underestimate of inflation for FY 2022. We ask that the HSCRC forgive the payback of the $100 million advance from FY 2023 rates and keep this revenue as part of the permanent rate base. This approach effectively provides .50% of permanent funding for FY 2022 underfunded inflation. While this approach does not fully cover the

underestimate of FY 2022 inflation, this effort to relieve hospitals is balanced with the need to meet the state's commitments under the Demonstration Model. We would also request the HSCRC reevaluate the remaining underfunded FY2022 inflation for inclusion in rates as early as January 1, 2023 or at a future date dependent upon positive performance to the Total Cost Care savings target.

3. To avoid a repeat of FY 2022's underfunding in FY 2023, we suggest an update factor that recognizes full funding of expected inflation for FY 2023. This may require a reassessment at midyear to understand where cost growth stands in January 2023, given the volatility of the current economic environment.

Summary

While this proposed structure does not make hospitals whole with respect to rising costs, it offers a more realistic structure to cover cost pressures while balancing the State's commitments to expected performance under the Demonstration Model. We recognize this is a very difficult decision with numerous countervailing pressures. Maintaining a strong hospital industry given the stresses of the past two years must be a priority of any Demonstration Model as we work to care for the citizens of Maryland while bending the cost growth curve. We appreciate your consideration of this proposal. Please contact me if you have any questions.

Sincerely,

Mohan Suntha, MD, MBA

President and CEO
University of Maryland Medical System

cc: Adam Kane, Esq. Chairman
Joseph Antos, PhD, Vice Chairman
Victoria W. Bayless
James Elliott, M.D.
Maulik Joshi, DrPH
Stacia Cohen, RN, MBA
Sam Malhotra
Jerry Schmith, Principal Deputy Director
Michelle Lee, UMMS, CFO
Alicia Cunningham, UMMS, SVP

maryland
health services
cost review commission

Nurse Support Program I

Draft Recommendations for Permanent Renewal and Future Funding

June 8, 2022

This document contains the final staff recommendations for permanent renewal of the NSP I program.

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

maryland
health services
cost review commission

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Introduction

Maryland's unique Nurse Support Program I (NSP I) was designed to address the short-and long-term issues of recruiting and retaining nurses in acute care hospitals. Approximately $245 million in NSP I funds have been provided to hospitals in rates to support the NSP I initiatives since it was implemented in June 2001.

In 2010, the Institute of Medicine (IOM) published a groundbreaking report which laid out eight (8) recommendations to address the increasing demand for high quality and effective healthcare services and provided an action-oriented blueprint for the future of nursing. The HSCRC incorporated four of the recommendations into the scope of the NSP I program:

- *IOM Recommendation 3:* Implement nurse residency programs
- *IOM Recommendation 4:* Increase the proportion of nurses with a baccalaureate degree to 80 percent by 2020
- *IOM Recommendation 6:* Ensure that nurses engage in lifelong learning
- *IOM Recommendation 7:* Prepare and enable nurses to lead change to advance health

Incorporating the four (4) recommendations from the IOM, the NSP I program focuses on three (3) main areas to provide support and training for Maryland nurses:

1. *Education and Career Advancement*. This area includes initiatives that increase the number of advanced degree nurses, preparing them as future leaders; recruitment and retention of newly licensed nurses through nursing residency programs, and supporting nursing students and experienced RNs who are re-entering the workforce after an extended leave.
2. *Patient Quality and Satisfaction.* This area includes lifelong learning initiatives such as certification and continuing education linked to improved nursing competency and patient outcomes.
3. *Advancing the Practice of Nursing.* These activities in this area advance the nursing practice, for example, nurse-driven evidenced-based research; innovative

organizational structures for clinical nurses to have a voice in determining nursing practice, standards, and quality of care; and American Nurses Credentialing Center's (ANCC) Magnet®, and Pathway to Excellence programs demonstrating nursing excellence.

With input from the NSP I Advisory Committee, staff developed nursing and organizational metrics to assess hospitals' progress in achieving these program aims. This report provides the results of NSP I initiatives since the last report to the Commission in FY 2016, through FY 2021, including program achievements and recommendations for increased funding.

NSP I Accomplishments (FY 2017 – 2021)

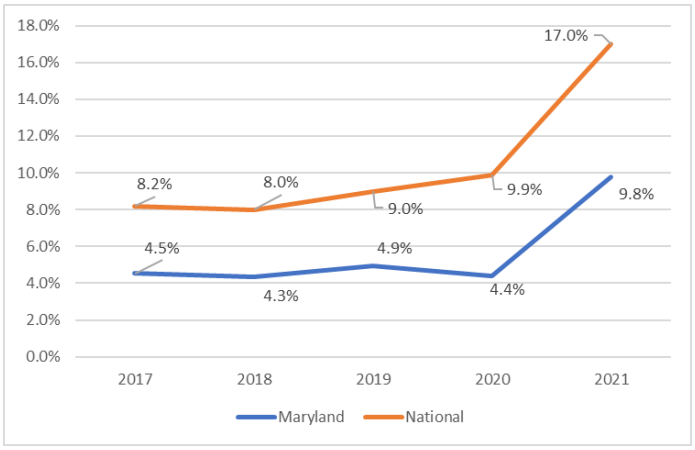
Maintained Low Vacancy and Retention Rates Compared to Nation

Prior to the pandemic (between 2017 and 2019), Maryland was experiencing notably lower vacancies rates (4.6 percent) compared to the nationally (8.4 percent) (NSI, 2022). All national statistics cited for vacancies and retention data are derived from the *National Health Care Retention and RN Staffing Report*, an annual survey of approximately 192 facilities from 32 states, and is published by the Nurse Solution, Inc.

Although the success cannot solely be attributed to NSP I, programs that are funded by the NSP (including nurse residency programs (NRP), continuing education, leadership development and shared governance, preceptorship, and mentorship) are known to attract and retain nurses (Lee, 2008; Trofino, 2003). Not unexpectedly, vacancy rates increased sharply during the height of the pandemic in 2021, both in Maryland and nationally. Despite the challenges, Maryland’s average vacancy rates (9.8 percent) remained well below the national average (17 percent) (Graph1).

The vacancy rates reported in this paper differ from vacancy rates being reported by the Maryland Hospital Association. In order to compare to the national data, the number of nursing positions include part-time and per diem staff. The vacancy rates excluding part-time and per diem is closer to 8.5 percent between FYs 2017- 2020.

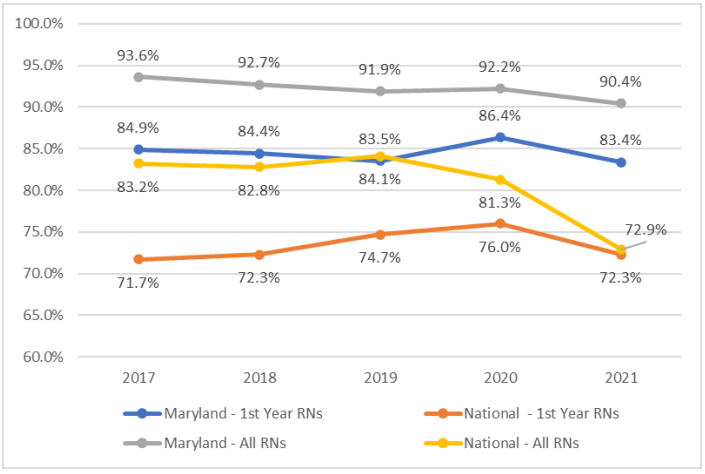
Graph 1. Registered Nurse Vacancy Rates: Maryland vs Nation, 2017 - 2021



Source: Maryland: NSP I Annual Report Data; National: NSI National Healthcare Retention Report

Nursing retention in Maryland has remained above 90 percent since FY 2017, ranging from 94 percent to 90 percent in 2021 (Graph 2). In Maryland, the average post-COVID retention rate was 91 percent, compared to the national average of 77 percent (falling from 83 percent pre-COVID). For first year RNs, the retention rates for Maryland hospitals averaged 85 percent, compared to 73 percent nationally (Graph 2). The retention rates pre versus post-COVID did not change as significantly in Maryland.

Graph 2. First Year and All Registered Nurse Retention Rates: Maryland vs Nation, 2017 - 2021



Source: Maryland: NSP I Annual Report Data; National: NSI National Healthcare Retention Report

Maintained Retention Rates for First Year Nurses with Nurse Residency Programs

Nurse residency programs (NRPs) have been instrumental in retaining first year nurses in Maryland and the success of the program is evidenced by retention rates that are higher than the nation. The purpose of the NRP is to build upon nursing school's foundational knowledge to smoothly transition new nurses into professionals and retain them in the workforce. Nurse residency programs for newly licensed RNs builds confidence and improves their organization, management, communication, and clinical skills (Wagner, 2020). Maryland is the first, and one of three states in the US, to have all acute care hospitals fund and offer nurse residency programs (NRPs) for new nurse graduates.

Additionally, NRPs reduce hospital costs associated with attrition (National Academies of Sciences, Engineering and Medicine, 2015). High retention rates result in significant cost savings to hospitals; the average cost to replace one RN ranges from $40,038 to upwards of $88,000 (NSI, 2021; Jones, 2008). Prior to the coronavirus pandemic, Maryland hospitals overall retained more than 88 percent of their new to practice nurses annually (Graph 2) compared to an average of 76 percent nationally (NSI, 2022). Moreover, hospital leaders and nurse residents report they are more confident and competent after completing their 12-month nurse residency program, resulting in better-prepared nurses and significant hospital cost savings.

Increased the Number of Certified and Specialty Care Nurses

The NSP I program funds initiatives that support courses and the associated costs to obtain and maintain certification. Certification offers patients and families the validation that the nurse caring for them has demonstrated the experience and knowledge in the complex specialty of critical care (American Association of Critical-Care Nurses, 2022). The number of certified nurses increased by 10 percent between FYs 2017 and 2021.

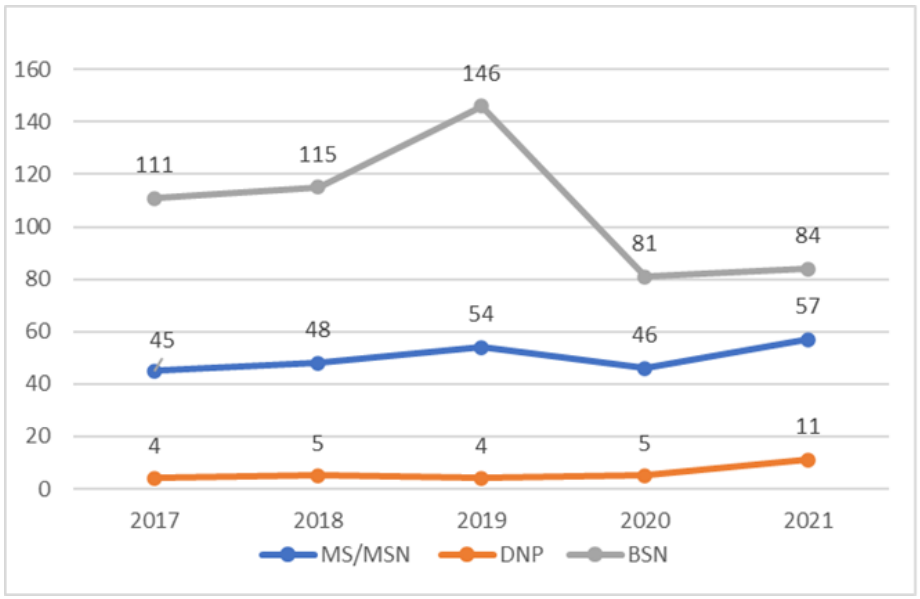
The aim of Transition-to-Specialty Care programs is to address hard-to-fill specialty clinical and critical leadership roles. Specialty care nurses, which include nurses working in hard-to-fill areas such as ICU, Psych and ED, were especially desirable during the

pandemic when these nurses were of critical need. More than 6,100 newly licensed and experienced nurses participated in NSP I funded programs, with average completion rates of 89 percent.

Increased the Number of Nurses with BSN and Advanced Degrees

RNs are in new and expanded roles to provide care across the healthcare continuum with increased focus on health disparities. According to *The Future of Nursing 2020-2030* report, it is imperative for RNs to achieve higher levels of education, as "*nurses play multiple roles in acute care, community, and public health settings, through which they can influence the medical and social factors that drive health outcomes, health equity, and health care equity…Nurses have a critical role to play in achieving the goal of health equity, but they need robust education, supportive work environments, and autonomy*" (National Academy of Sciences, 2021).

Graph 3. Maryland Registered Nurses by NSP I-Funded Degree Type, FY 2017- 2021



Between 2017 and 2021, 27% increase in MS/MSN grads vs 24% decline in BSN grads

Source: NSP I Annual Report Data

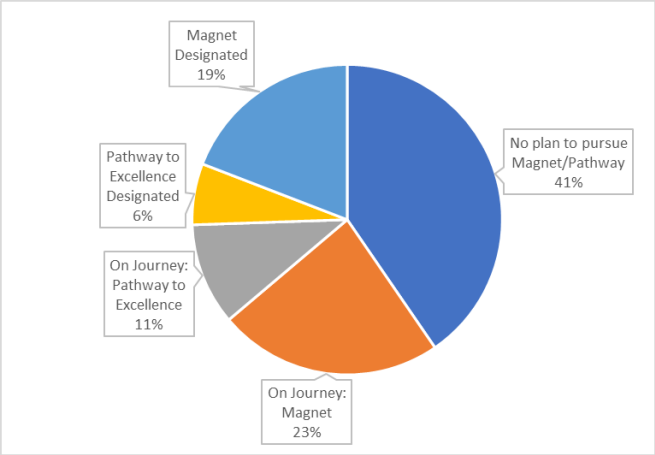
Strong research evidence has linked lower mortality rates, fewer medication errors, and positive outcomes to nurses prepared at the baccalaureate and graduate degree levels (IOM, 2011). Quality patient care hinges on a well-educated, highly functioning, motivated nursing workforce. The IOM Future of Nursing 2010 report called for 80 percent

of RNs to hold a BSN degree by 2020 and a doubling of doctoral-prepared RNs. In 2019, the Commission approved the staff recommendation to amend the goal for Maryland to "80 Percent BSN by 2025", and the Nurse Support Program II (NSP II) has made steady progress toward that goal. In FY 2021, 67 percent of RNs in Maryland hold a BSN or higher (Final NSP II FY 2023 Report, 2022). Through the NSP I funds, there was a 27 percent increase in the number of hospital-based nurses holding BSN and Advanced degrees between 2017-2019 (Graph 3).

Advanced the Practice of Nursing

The American Nurses Credentialing Center (ANCC) Magnet® Recognition Program recognizes healthcare organizations for quality patient care, nursing excellence, and innovation in professional nursing practice. Between FYs 2017 and 2021, nine (9) hospitals in Maryland have successfully achieved Magnet® and three (3) have achieved Pathway to Excellence® designation with funding from the NSP I program (Graph 4). Sixteen (16) hospitals are pursuing either Magnet® or Pathway to Excellence® designation in FY 2021.

Graph 4. Percent of Maryland Hospitals by ANCC Status, FY 2021



Source: NSP I Annual Report Data

Enhanced Diversity in the Nursing Workforce

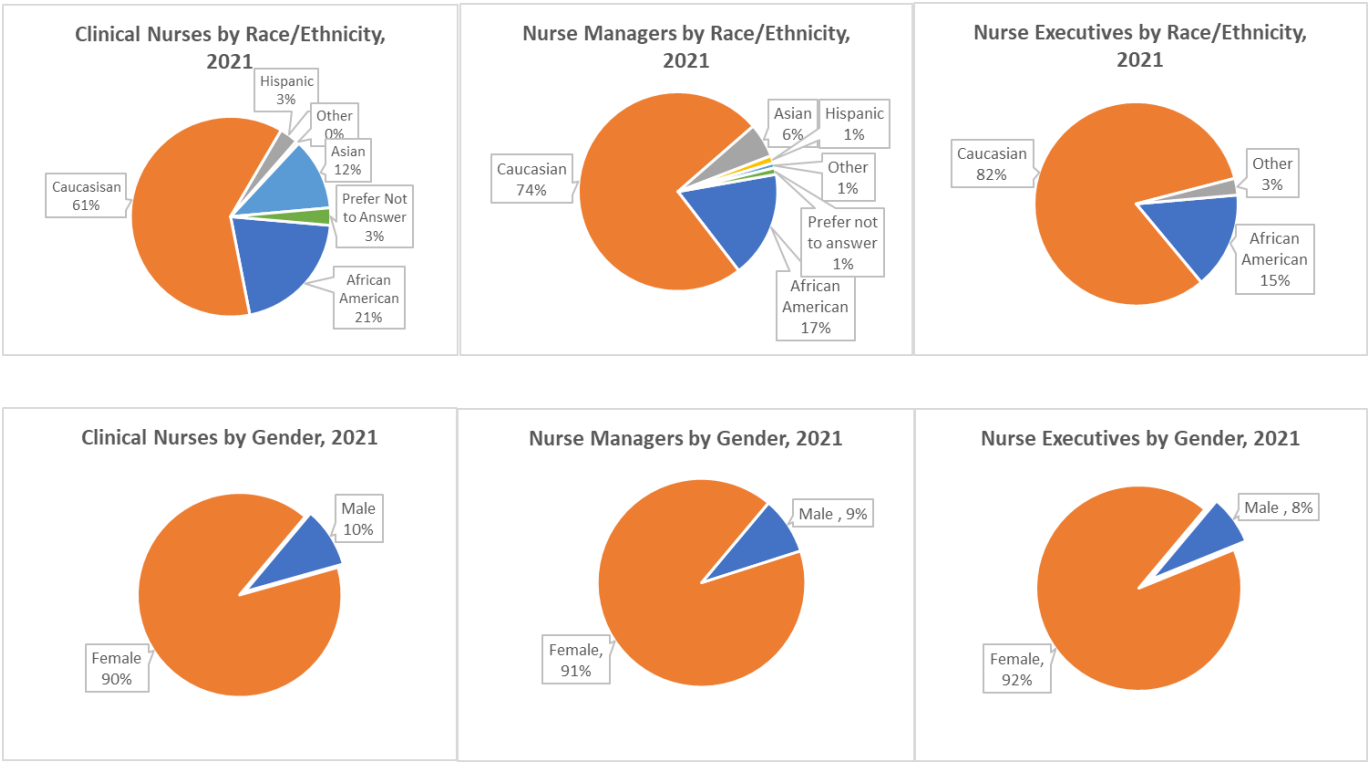
According to the American Association of Colleges of Nursing, "*Though nursing has made great strides in recruiting and graduating nurses that mirror the patient*

population, more must be done before adequate representation becomes a reality. The need to attract students from underrepresented groups in nursing – specifically men and individuals from African American, Hispanic, Asian, American Indian, and Alaskan native backgrounds - is a high priority for the nursing profession" (2019). As the spotlight has grown on health disparities, the need for providers who look like the patients they are serving has become an important mission for nursing schools and should extend to post graduation as well.

Nationally, 27 percent of RNs are from racial and ethnic minority groups (HRSA, 2019). The HSCRC began collecting data for all clinical nurses, nurse managers and nurse executives employed at Maryland hospitals in FY 2020 (Graph 5). Overall, 36 percent of clinical RNs are represented by ethnic and racial minorities in FY 2021. For Nurse Managers and Executives, ethnic and racial minorities account for 25 and 17 percent, respectively. Similar to the nation, where the percentage of male nurses was around 12 percent in 2021, nurses in Maryland are overwhelmingly female, regardless of position (Graph 5) (BLS, 2021).

The inclusion of minority and male nurses in clinical and management roles is crucial to addressing health disparities. Several studies have concluded that minority nurses leaders are in better positions to "influence resource allocation and the recruitment and retention of a diverse workforce…[as well as] shape organizational and national policies aimed at eliminating health disparities" (Philips and Malone, 2014). Increasing the number of minorities in nursing, especially in leadership positions, is an area of opportunity for the NSP I program to address in the coming years.

Graph 5. Demographics for Clinical Nurses, Nurse Managers and Nurse Executives in Maryland, FY 2021



Source: NSP I Annual Report Data

Impact of COVID on the Nursing Workforce

Nursing Burnout

As illustrated in Graphs 1 and 2 above, vacancy rates increased, and retention suffered in the wake of the COVID pandemic. The repeated surges of COVID made the situation dire for healthcare personnel, increasing burnout and moral distress among nurses (Yang and Mason, 2022). In a recent survey of 2,000 nursing staff, the Maryland Nursing Workforce Center (MNWC) found that over 40 percent of respondents experienced moderate to severe stress, were unable to control worrying, felt hopeless, and had little pleasure in usual things. Close to 50 percent of respondents indicated that they had symptoms of burnout, felt anxious, and had experienced sleep disturbances. Furthermore, about 62 percent of nurses felt their physical health and safety were compromised without their consent, and more than 60 percent indicated an intent to leave

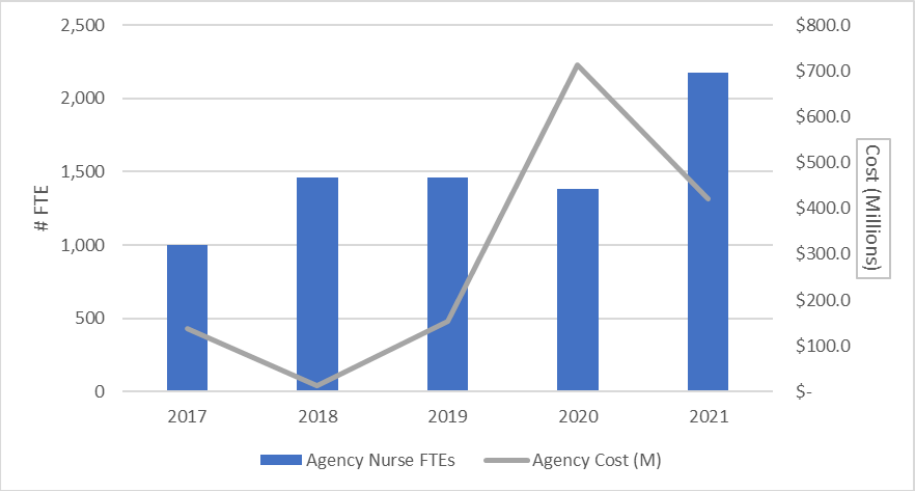
their current nursing job (MNWC, 2021). These findings are echoed in across the nation (Hansen and Tuttas, 2021)

Increased Reliance on Agency Nurses

Anecdotally, nurses were leaving their positions to go to competing hospitals for signing bonuses, or to agencies for better pay, better hours, and less stress (Vesoulis and Abrams, 2022). The increase in agency nurses and the resulting high turnover, creates additional burdens on staff nurses as they must constantly orient the new people. In discussions with nurses from various roles, the main complaint regarding agency nurses is they are paid significantly more than staff nurses but not responsible for regulatory reporting and other burdens that are placed on staff nurses.

As more nurses leave hospitals for agencies, a costly feedback loop is created as hospitals rely more on agencies to backfill the reduction in the workforce. The pandemic exacerbated costs to a high of $713 million (Graph 6) in Maryland, as reported to the HSCRC in the FY 2020 NSP Annual Reports. Nationally, most hospitals are not anticipating reducing their reliance on agency nurses, while costs continue to increase (NSI, 2022). Several organizations, including the American Hospital Association and the American Health Care Association/National Center for Assisted Living (the major nursing home trade group) are requesting Congressional intervention to help prevent the travel agencies “from exploiting our organizations’ desperate need for health care personnel” (Vesoulis and Abrams, 2022).

Graph 6: Maryland Hospital Agency FTEs and Costs, FY 2017-2021



Source: NSP I Annual Report Data

Addressing the root cause of nurse dissatisfaction is complicated. In addition, the nursing profession faces significant shortages due to an aging workforce, increasingly aging population, nurse burnout, violence in the workplace and other region-specific issues (Haddad et al.,2022). However, there are identified strategies that can reduce turnover, according to an article by the American Sentinel College of Nursing & Health Sciences at Post University (The Sentinel Watch, 2020):

- Reducing overtime and eliminating mandatory overtime.
- Developing shared governance programs that give nurses a voice in scheduling, workflows, and hospital policies.
- Ensuring adequate nurse staffing levels and supporting acuity-based staffing tools.
- Recognizing nurses' need for work-life balance.
- Encouraging and developing a workplace culture of collaboration between nurses and physicians.

Historically, the NSP program has funded similar initiatives, but staff analysis has shown hospitals have shifted their funding priorities. The share of spending on programs for entry-level nurses (such as NRP) increased from 30 percent to 55 percent, compared to spending on programs for experienced nurses (such as continuing education and

Advanced Degrees) that declined from 45 percent to 26 percent. Increasing the amount of NSP funding would allow hospitals to continue to sustain the progress that has been made with new nurses, while making an important investment in experienced nurses.

Future Funding Considerations

To address the issues that have come to the forefront during the pandemic, the NSP I and NSP II Advisory Committee suggest that the two programs be expanded to meet the current demands. With an additional 0.1 percent in funding, the Advisory Committee recommends the following:

- Increasing funding for proven initiatives (as described above) that have shown to increase retention and reduce vacancies.
- Develop initiatives to address health disparities by increasing the number of minorities and men in all nursing roles. Specifically, NSP I programs can implement initiatives to:
    - Increase the number of minority and male mentors and preceptors
    - Increase the number of minority and male nurses in leadership positions.
    - Develop recruitment strategies to target racial/ethnic minorities, particularly in areas with high minority populations.
- Carve out funding specifically aimed at Licensed Practical Nurses (LPN) for internal and external continuing education, leadership/preceptor/mentorship programs, as well as funding advanced nursing degrees and specialty practice programs.
- Funding additional NSP II initiatives that were described in the NSP II FY 2023 Staff Recommendation.

This year, the Maryland legislature passed several bills that focus on the ongoing crisis in the healthcare workforce broadly, though there are several bills that specifically address the issues in nursing. Staff recommends tasking the NSP I and II Advisory Committee with exploring how hospitals and nursing schools can access potential funding through the following legislation:

- **HB 625 / SB 440** (*Commission to Study the Health Care Workforce Crisis in Maryland – Establishment*): Establishes a Commission to study the health care workforce crisis.
- **HB 1208** (*Health Occupations - Health Care Workforce Expansion*): Requires the State Board of Nursing to evaluate the workforce based on data from nursing certificate renewals and promulgate regulations related to requirements for CNAs. Also provides tax benefits for certain activities (such as nurses who act as preceptors to train nurses).
- **SB 518 / HB 821** (*Career Pathways for Health Care Workers Program*): Creates a program in the Department of Labor that provides matching grants to employers for training programs attended by healthcare workers and requires the Governor to provide at least $1M for the program in the budget.
- **SB 696 / HB 975** (*Maryland Loan Assistance Repayment for Nurses and Nursing Workers - Program Establishment and Funding*): Establishes a Maryland Loan Assistance Repayment Fund for Nurses and "Nursing Workers". $400K is provided per year for this fund.

Staff Recommendations

The HSCRC staff present the following recommendations for the NSP I program:

1) Continue the Nurse Support Program I (NSP I) as an ongoing program with permanent funding that does not require renewal. The NSP I staff will provide annual reports on the funded activities and accomplishments.
2) Consider increasing funding in future years from 0.1 percent to 0.2 percent of total patient revenue for each NSP program to further address the impact of the pandemic on the nursing workforce in FY 2024.
3) Charge the NSP I and II Advisory Committee to investigate other potential sources of funding from new legislation that can support nursing initiatives.

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maryland
health services
cost review commission

FINAL STAFF RECOMMENDATION

Changes to Relative Value Units for Clinic

Background

- The proposed changes to Relative Value Units for Clinic were sent to all Hospitals for comments. The comment period closed on May 18, 2022. There were no comments received.

- Hospitals were required to calculate a conversion factor to assure no change in the Hospitals' revenue as a result of this RVU conversion.

- Hospitals will begin using these revised RVUs effective July 1, 2022.

Recommendation

1. The HSCRC staff recommends that the Commission approve the revisions to the RVU scale for the Clinic Rate Center. The revisions are specific to the Chart of Account and Appendix D of the Accounting and Budget Manual. These revised RVUs are based on MPFS weights and were reviewed by a workgroup facilitated by the HSCRC staff;

2. The RVU scale was updated to reflect linkages of RVUs to the CPT codes to reflect; the changes in clinical practices, and to link charging guidelines for Clinic services to the national definition, consistent with the HSCRC plan to adopt MPFS RVUs where possible; and

3. The new and updated RVUs should be effective July 1, 2022. The conversion of the Clinic RVUs will be revenue neutral to the overall Hospital Global Budget Revenues.

Final Staff Recommendation
Changes to Relative Value Units for Clinic
Effective July 1, 2022

June 8, 2022

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 the changes to the Relative Value Units for Clinic services effective July 1, 2022, ready for Commission action.

Comments

The proposed changes were sent to all Hospitals for comments. The comment period closed on May 18, 2022. There were no comments received.

Hospitals were required to calculate a conversion factor to assure no change in the Hospitals' revenue as a result of this RVU conversion. Hospitals will begin using these revised RVUs effective July 1, 2022.

Definitions

Current Procedural Terminology (CPT) codes – describe medical, surgical, and diagnostic services.

Health Care Common Procedure Coding System (HCPCS) – codes based on the CPT to provide standardized coding when healthcare is delivered.

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.

Medicare Physician Fee Schedule (MPFS) – The Centers for Medicare and Medicaid Services ("CMS") use the MPFS for reimbursement of physician services, comprised of resources costs associated with physician work, practice expense, and professional liability insurance.

Background

On November 16, 2020, the HSCRC staff convened a workgroup to review and initiate changes to the Clinic RVUs and guidelines for the Clinic rate center. The members of this workgroup included Hospitals, Maryland Hospital Association, Insurance Companies, and Hospital Consultants. These changes were initiated for the following reasons:

1. Staff is progressively standardizing RVUs for all ancillary and outpatient rate centers using national CPT code definitions and MPFS cost weights, consistent with the strategy that staff is executing over time for all services.

2. RVUs standardization using the Medicare Physician Fee Schedule weights, updating new codes, and removing inactive codes from Appendix D of the Commission's Accounting and Budget Manual.

3. Assignment of RVUs procedures that are being reported as "By Report."

4. The nature of the clinic visits has changed over time. Clinic visits now focus primarily on chronic conditions, specialized services, and behavioral health.

5. The Clinic Rate Center generates the largest number of consumer complaints. This is principally because the price of a clinic visit is generally more expensive than a visit to a doctor's office.

Clinic services include diagnostic, preventive, therapeutic, rehabilitative, and educational services provided to non-emergent outpatients in a regulated setting. On rare occasions, clinic services may be provided to inpatients; for example, if specialized staff from the clinic must provide care to an inpatient at the patient's bedside.

Surgical procedures, diagnostic tests and other services that are better described in a separate cost center, such as Labor and Delivery, Electroencephalography, Echocardiography, Interventional Cardiology, Laboratory, Lithotripsy, Occupational Therapy, Operating Room, Physical Therapy, Radiation Therapy, Radiology, or 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/or non-surgical procedure(s).

Methodology

Clinic RVUs were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of the new codes in Appendix D of the Accounting and Budget Manual were obtained from the 2022 edition of the CPT manual and the 2022 edition of the HCPCS. In assigning RVUs, the group used the 2022 MPFS released December 15, 2021, and then assigned using the following protocol.

The proposed RVUs were based on the MPFS Non-Facility (NON-FAC) Practice Expense (PE) RVUs. When there was a Technical Component (TC) modifier line item, that value was used. To maintain whole numbers in Appendix D, the RVUs were multiplied by ten and rounded to the nearest whole number, where values less than X.5 the RVUs were rounded down and all other values were rounded up.

1) For RVUs utilizing the methodology described above, the rationale in the table of RVUs is noted as MPFS.

2) For RVUs where the calculated RVU appeared too high (because it included significant equipment or other overhead and non-staff costs associated with it) or too low (because it did not properly reflect the facility resources associated with the service), the proposed RVUs were modified.

3) For RVUs without a NON-FAC PE RVU value in the MPFS, the underlying rationale for the RVU has been noted in the table of RVUs.

4) Unlisted services or services rarely performed have been designated as By Report (BR). RVUs for BR services are to be assigned based on relative RVU value of similar service.

- The BR methodology for each code must be documented and readily available in the event of an audit.

Recommendation

1. The HSCRC staff recommends that the Commission approve the revisions to the RVU scale for the Clinic Rate Center. The revisions are specific to the Chart of Account and Appendix D of the Accounting and Budget Manual (Attachment 1- Chart of Account). These revised RVUs are based on MPFS weights and were reviewed by a workgroup facilitated by the HSCRC staff;

2. The RVU scale was updated to reflect linkages of RVUs to the CPT codes to reflect; the changes in clinical practices, and to link charging guidelines for Clinic services to the national definition, consistent with the HSCRC plan to adopt MPFS RVUs where possible (Attachment 2 – Appendix D); and

3. The new and updated RVUs should be effective July 1, 2022. The conversion of the Clinic RVUs will be revenue neutral to the overall Hospital Global Budget Revenues.

Account Number 6720

Clinic services include diagnostic, preventive, therapeutic, rehabilitative, and educational services provided to non-emergent outpatients in a regulated setting. On rare occasions, clinic services may be provided to inpatients; for example, if specialized staff from the clinic must provide care to an inpatient at the patient's bedside.

Surgical procedures, diagnostic tests and other services that are better described in a separate cost center, such as Labor and Delivery, Electroencephalography, Echocardiography, Interventional Cardiology, Laboratory, Lithotripsy, Occupational Therapy, Operating Room, Physical Therapy, Radiation Therapy, Radiology, or 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/or non-surgical procedure(s).

Approach

Clinic Relative Value Units (RVUs) were developed with the aid of an industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions of the codes in this section of Appendix D were obtained from the 2022 edition of the Current Procedural Terminology (CPT) manual and the 2022 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2022 Medicare Physician Fee Schedule (MPFS) released December 15, 2021, and then assigned using the following protocol.

RVU Assignment Protocol

RVUs were proposed based on the Medicare Physician Fee Schedule (MPFS) Non-Facility (NON-FAC) Practice Expense (PE) RVUs. When there is a Technical Component (TC) modifier line item, that value was used. To maintain whole numbers in Appendix D, RVUs were multiplied by ten and rounded to the nearest whole number, where values less than X.5 were rounded down and all other values were rounded up. For example, the psychotherapy CPT of 90832 shown below has a NON-FAC PE RVU of 0.48. 0.48 * 10 = 4.8. 4.8 rounded = 5. 5 is the proposed RVU.

HCPCS	MOD	DESCRIPTION	NON-FAC PE RVU
90832		Psytx w pt 30 minutes	0.48

Here is another example where there is a TC modifier. In this case, the Corneal Topography CPT of 92025 shown below has a NON-FAC PE RVU for TC modifier of 0.50. 0.50 * 10 = 5.0. 5.0 rounded = 5. 5 is the proposed RVU.

HCPCS	MOD	DESCRIPTION	NON-FAC PE RVU
92025		Corneal topography	0.70
92025	TC	Corneal topography	0.50
92025	26	Corneal topography	0.20

1) For RVUs utilizing the methodology described above, the rationale in the table of RVUs is noted as MPFS.
2) For RVUs where the calculated RVU appeared too high (because it included significant equipment or other overhead and non-staff costs associated with it) or too low (because it did not properly reflect the facility resources associated with the service), the proposed RVU was modified as noted in the table of RVUs.
3) For RVUs without a NON-FAC PE RVU value in the MPFS, the underlying rationale for the RVU has been noted in the table of RVUs.
4) Unlisted services or services rarely performed have been assigned as By Report (BR). Similar logic should be utilized to assign RVUs to any services that are not found or BR.
    - If there are no MPFS RVUs for a service, mirror an existing code that has similar facility resources or mirror an existing code that has similar facility resources with adjustments if needed (for example, if a BR service is slightly less resource intensive than an existing service, the RVU can be lower). The BR methodology for each code must be documented and readily available in the event of an audit.

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 (such as nurses, medical technicians, residents, and other staff employed by the hospital clinic). The time does not necessarily have to be face-to-face with the patient, but the patient must be present in the department, except during specific times when telehealth (i.e., virtual) services are permitted. The time spent by physicians, and other non-physician providers (NPP), 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 each 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 (when not separately charged), family support, patient teaching, and transportation of patients requiring 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 of 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
- 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

TELEMEDICINE

Per the May 4, 2020, HSCRC memo:
https://hscrc.maryland.gov/Documents/TELEHEATH%20MEMO%20AND%20ADDENDUM.pdf

For services provided real-time in an audio-visual format or for telephonic/audio only services when an audio-visual format is not accessible by the patient: where the service is provided by non-physician providers who cannot bill a professional fee for their services; where the service provided utilizes the same staffing structure as face-to-face; and where the only difference is that the patient is at home vs. at the hospital receiving services; in these instances, hospitals are to use the existing Appendix D to report and charge for the service with the exact same RVUs and pricing as face-to-face visits.

In instances where a patient receives the telehealth services from an outside provider who bills a professional fee for the services rendered, such as a physician, the hospital shall not report nor charge an E/M visit or charge for other services, procedures, or therapies provided to the patient by non-physician clinicians who cannot bill a professional fee. The only instance when a hospital clinic fee or other fee for telehealth services can be charged is when the only telehealth services rendered are those provided solely by providers that cannot bill for their service

Until the end of the federal public health emergency (PHE), the temporary guidance provided related to telemedicine services will remain in effect. At the conclusion of the federal PHE, additional guidance will be provided to hospitals regarding the reporting of these services.

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. 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 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 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	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 assigned RVUs.

Consultation codes (such as CPT 99242) or prolonged E/M codes (such as CPT 99354) are for professional services and should not be used for facility services. Only E/M codes (99202-99215 and G0463) should be used for facility E/M visits.

If codes for preventive (such as CPT 99387) or other specific services will be used, the RVUs should be based on the minute-to-RVU logic shown above. For example, if CPT 99387 typically takes 45 minutes, then 4 RVUs should be used, etc. Codes are noted as "E/M" on the table of RVUs if they are to be based on the minute-to-RVU logic above.

Code	Description	RVU	Rationale
G0101	Cervical or vaginal cancer screening; pelvic and clinical breast examination	1	Based on prior BR
G0463	Hospital outpatient clinic visit for assessment and management of a patient	E/M	Match RVUs as stated above
Q0091	Screening Papanicolaou smear, obtaining, preparing and conveyance of cervical or vaginal smear to laboratory	0	Included as an E/M component
Q0111	Wet mounts, including preparations of vaginal, cervical, or skin specimens	LAB	Report in Lab rate center

PART II: SERVICES AND NON-SURGICAL PROCEDURES

Each section includes tables with CPT codes, descriptions, and RVU values. This manual is not meant to give direction or interpretation to Medicare or other payer billing or coding rules. Moreover, it is the goal of every work group that recommends revisions to RVUs that the revised system may be as impervious as possible to future changes in billing rules and correct coding guidelines. Codes below are grouped in subsections and are in CPT code order with numeric and new technology codes listed before alpha-numeric codes. COVID-19 related services are listed at the end.

When a service has By Location (BL) instead of a relative value unit (RVU) assigned to it, this means that the service may be provided in multiple areas of the hospital based on hospital protocols, patient condition, and other factors. The RVU for the service should be assigned based on the respective rules for the location. For example, and the list below is not all-inclusive:

- If the service is provided in an Operating Room (OR), OR minutes should be used.
- If the service is provided in an Imaging Suite, Interventional Radiology Cardiovascular (IRC) minutes should be used.
- If the service is provided in an outpatient clinic or other outpatient area where scheduled services are provided that is not an operating room or imaging suite, Operating Room-Clinic (ORC) minutes should be used. For any services where ORC minutes are indicated, but the hospital does not have an ORC rate, the hospital should report the service under the Clinic (CL) rate center using a BR RVU.

TRANSFUSIONS

RVUs for transfusion of blood or blood components (36430) will be assigned based on 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 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).

Code	Description	RVU	Rationale
36430	Transfusion, blood, or blood components, first hour (0-90 min)	11	MPFS
36430	Transfusion, blood or blood components, two hours (91-150 min)	16	MPFS base RVU plus add-on of 5 RVUs for each additional hour (11 was slightly less than prior value

Code	Description	RVU	Rationale
			of 12 and add-on of 5 is slightly less than prior add-on of 6)
36430	Transfusion, blood or blood components, three hours (151-210 min)	21	MPFS base plus add-on of 5 RVUs for each additional hour
36430	Transfusion, blood or blood components, four hours (211-270 min)	26	MPFS base plus add-on of 5 RVUs for each additional hour
36430	Transfusion, blood or blood components, five hours (271-330 min)	31	MPFS base plus add-on of 5 RVUs for each additional hour
36430	Transfusion, blood or blood components, six hours (331-390 min)	36	MPFS base plus add-on of 5 RVUs for each additional hour
36430	Transfusion, blood or blood components, seven hours (391-450 min)	41	MPFS base plus add-on of 5 RVUs for each additional hour
36430	Transfusion, blood or blood components, eight hours (451-510 min)	46	MPFS base plus add-on of 5 RVUs for each additional hour
36455	Exchange transfusion, blood; other than newborn	21	Resources like 180 minutes of blood transfusion

VENOUS PROCEDURES

RVUs for therapeutic apheresis and photopheresis were based on prior established By Report RVUs in use by hospitals and kept consistent with the Outpatient Prospective Payment System (OPPS) relationship weights. Note that these services are NOT the same as pheresis services that appear in the LAB rate center.

Code	Description	RVU	Rationale
36511	Therapeutic apheresis; for white blood cells	50	Prior BR average RVUs
36512	Therapeutic apheresis; for red blood cells	50	Prior BR average RVUs
36513	Therapeutic apheresis; for platelets	50	Prior BR average RVUs
36514	Therapeutic apheresis; for plasma pheresis	50	Prior BR average RVUs
36516	Therapeutic apheresis; with extracorporeal immunoadsorption, selective adsorption or selective filtration and plasma reinfusion	150	Base code for apheresis adjusted based on OPPS relationship (weight of CPT 36516 approximately 3x weight of CPT 36511)

Code	Description	RVU	Rationale
36522	Photopheresis, extracorporeal	150	Consistency with CPT 36516
36591	Collection of blood specimen from a completely implantable venous access device	8	MPFS
36592	Collection of blood specimen using established central or peripheral catheter, venous, not otherwise specified	9	MPFS
36593	Declotting by thrombolytic agent of implanted vascular access device or catheter	10	MPFS
38205	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; allogeneic	9	MPFS
38206	Blood-derived hematopoietic progenitor cell harvesting for transplantation, per collection; autologous	9	MPFS

IMMUNIZATIONS

Code	Description	RVU	Rationale
90460	Immunization administration through 18 years of age via any route of administration, with counseling by qualified health care professional; first or only component of each vaccine or toxoid administered	3	MPFS
90471	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); 1 vaccine (single or combination vaccine/ toxoid)	3	MPFS
90472	Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); each additional vaccine (single or combination vaccine/ toxoid)	2	MPFS
90473	Immunization administration by intranasal or oral route; 1 vaccine (single or combination vaccine/ toxoid)	3	MPFS
90474	Immunization administration by intranasal or oral route; each additional vaccine (single or combination vaccine/ toxoid)	2	MPFS
G0008	Administration of influenza virus vaccine	3	Consistency with CPT 90471

Code	Description	RVU	Rationale
G0009	Administration of pneumococcal vaccine	3	Consistency with CPT 90471
G0010	Administration of hepatitis B vaccine	3	Consistency with CPT 90471

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 Service 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.

Code	Description	RVU	Rationale
90785	Interactive complexity	1	MPFS
90791	Psychiatric diagnostic evaluation	12	MPFS
90792	Psychiatric diagnostic evaluation with medical services	15	MPFS
90832	Psychotherapy, 30 minutes with patient	5	MPFS
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service	5	MPFS
90834	Psychotherapy, 45 minutes with patient	6	MPFS
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service	6	MPFS
90837	Psychotherapy, 60 minutes with patient	9	MPFS
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service	9	Consistency with CPT 90837
90839	Psychotherapy for crisis; first 60 minutes	9	MPFS
90840	Psychotherapy for crisis; each additional 30 minutes	5	MPFS
90845	Psychoanalysis	6	MPFS
90846	Family psychotherapy (without the patient present), 50 minutes	4	MPFS
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes	4	MPFS

Code	Description	RVU	Rationale
90849	Multiple-family group psychotherapy	4	MPFS
90853	Group psychotherapy (other than of multiple-family group)	2	MPFS
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services	2	MPFS
90865	Narcosynthesis for psychiatric diagnostic and therapeutic purposes (e.g., sodium amobarbital (Amytal) interview)	BR	No volumes
90875	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 30 minutes	5	MPFS
90876	Individual psychophysiological therapy incorporating biofeedback training by any modality (face-to-face with the patient), with psychotherapy (e.g., insight oriented, behavior modifying or supportive psychotherapy); 45 minutes	10	MPFS
90880	Hypnotherapy	8	MPFS
90882	Environmental intervention for medical management purposes on a psychiatric patient's behalf with agencies, employers, or institutions	0	Not a hospital service
90885	Psychiatric evaluation of hospital records, other psychiatric reports, psychometric and/or projective tests, and other accumulated data for medical diagnostic purposes	0	Not a hospital service
90887	Interpretation or explanation of results of psychiatric, other medical examinations and procedures, or other accumulated data to family or other responsible persons, or advising them how to assist patient	0	Not a hospital service
90889	Preparation of report of patient's psychiatric status, history, treatment, or progress (other than for legal or consultative purposes) for other individuals, agencies, or insurance carriers	0	Not a hospital service
G0176	Activity therapy, such as music, dance, art, or play therapies, not for recreation, related	PDC	Report in PHP rate center

Code	Description	RVU	Rationale
	to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)		
G0177	Training and educational services related to the care and treatment of patient's disabling mental health problems, per session (45 minutes or more)	PDC	Report in PHP rate center
G2067	Medication assisted treatment, methadone; weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)	BR	Services may vary by hospital
G2068	Medication assisted treatment, buprenorphine (oral); weekly bundle including dispensing and/or administration, substance use counseling, individual and group therapy, and toxicology testing, if performed (provision of the services by a Medicare-enrolled Opioid Treatment Program)	BR	Services may vary by hospital
H0001	Alcohol and/or drug assessment	12	Consistency with CPT 90791
H0004	Behavioral health counseling and therapy, per 15 minutes	3	Based on prior BR
H0005	Alcohol and/or drug services; group counseling by a clinician	2	Consistency with CPT 90853
H0015	Alcohol and/or drug services; intensive outpatient (treatment program that operates at least 3 hours/day and at least 3 days/week and is based on an individualized treatment plan), including assessment, counseling, crisis intervention, and activity therapies or education	6	Consistency with CPT 90853 x 3hrs
H0016	Alcohol and/or drug services; medical/somatic (medical intervention in ambulatory setting)	9	Based on prior BR
H0020	Alcohol and/or drug services; methadone administration and/or service (provision of the drug by a licensed program)	9	Based on prior BR
H0032	Mental health service plan development by non-physician	PDC	Report in PHP rate center

Code	Description	RVU	Rationale
H0035	Mental Health Partial Hospitalization, treatment, less than 24 hours	PDC	Report in PHP rate center
H0047	Alcohol and/or other drug abuse services, not otherwise specified	BR	Unlisted service

BIOFEEDBACK TRAINING

No RVUs were assigned to these services (e.g., CPT 90901. 90912, and 90913). These services are reportable via the rehabilitation (Physical and Occupational Therapy) rate centers.

OPHTHALMOLOGY

Ophthalmology is a section where the MPFS RVUs for many services included equipment and overhead and required adjustment.

Code	Description	RVU	Rationale
92002	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; intermediate, new patient	4	Based on E&M value
92004	Ophthalmological services: medical examination and evaluation with initiation of diagnostic and treatment program; comprehensive, new patient, 1 or more visits	4	Based on E&M value
92012	Ophthalmological services: medical examination and evaluation with initiation or continuation of diagnostic and treatment program; intermediate, established patient	4	Based on E&M value
92014	Ophthalmological services: medical examination and evaluation with initiation or continuation of diagnostic and treatment program; comprehensive, established patient, 1 or more visits	4	Based on E&M value
92015	Determination of refractive state	2	MPFS
92018	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other	OR	Report in OR rate center

Code	Description	RVU	Rationale
	manipulation to facilitate diagnostic examination; complete		
92019	Ophthalmological examination and evaluation, under general anesthesia, with or without manipulation of globe for passive range of motion or other manipulation to facilitate diagnostic examination; limited	OR	Report in OR rate center
92020	Gonioscopy	4	MPFS
92025	Computerized corneal topography, unilateral or bilateral, with interpretation and report	5	MPFS
92060	Sensorimotor examination with multiple measurements of ocular deviation (e.g., Restrictive, or paretic muscle with diplopia) with interpretation and report	8	MPFS
92065	Orthoptic training	10	MPFS
92071	Fitting of contact lens for treatment of ocular surface disease	4	MPFS
92081	Visual field examination, unilateral or bilateral, with interpretation and report; limited examination (e.g., Tangent screen, Autoplot, arc perimeter, or single stimulus level automated test, such as Octopi 3 or 7 equivalent)	5	MPFS
92082	Visual field examination, unilateral or bilateral, with interpretation and report; intermediate examination (e.g., at least 2 isopters on Goldmann perimeter, or semiquantitative, automated suprathreshold screening program, Humphrey suprathreshold automatic diagnostic test, Octopus program 33)	8	MPFS
92083	Visual field examination, unilateral or bilateral, with interpretation and report; extended examination (e.g., Goldmann visual fields with at least 3 isopters plotted and static determination within the central 30 deg, or quantitative, automated threshold perimetry, Octopus program G-1, 32 or 42, Humphrey visual field analyzer full threshold programs 30-2, 24-2, or 30/60-2)	11	MPFS

Code	Description	RVU	Rationale
92100	Serial tonometry with multiple measurements of intraocular pressure over an extended time period with interpretation and report, same day (e.g., diurnal curve or medical treatment of acute elevation of intraocular pressure)	2	Based on hospital BR as MPFS value is equipment intense
92132	Scanning computerized ophthalmic diagnostic imaging, anterior segment, with interpretation and report, unilateral or bilateral	4	MPFS
92133	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; optic nerve	4	MPFS
92134	Scanning computerized ophthalmic diagnostic imaging, posterior segment, with interpretation and report, unilateral or bilateral; retina	5	MPFS
92136	Ophthalmic biometry by partial coherence interferometry with intraocular lens power calculation	6	MPFS
92201	Ophthalmoscopy, extended; with retinal drawing and scleral depression of peripheral retinal disease (e.g., for retinal tear, retinal detachment, retinal tumor) with interpretation and report, unilateral or bilateral	3	MPFS
92202	Ophthalmoscopy, extended; with drawing of optic nerve or macula (e.g., for glaucoma, macular pathology, tumor) with interpretation and report, unilateral or bilateral	2	MPFS
92229	Imaging of retina for detection or monitoring of disease; point-of-care automated analysis and report, unilateral or bilateral	2	Based on hospital BR as no MPFS value
92230	Fluorescein angioscopy with interpretation and report	0	Not a hospital service
92235	Fluorescein angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral	4	Based on hospital BR as MPFS value is equipment intense
92240	Indocyanine-green angiography (includes multiframe imaging) with interpretation and report, unilateral or bilateral	2	Based on hospital BR as MPFS value is equipment intense

Code	Description	RVU	Rationale
92242	Fluorescein angiography and indocyanine-green angiography (includes multiframe imaging) performed at the same patient encounter with interpretation and report, unilateral or bilateral	6	Based on hospital BR as MPFS value is equipment intense
92250	Fundus photography with interpretation and report	5	MPFS
92260	Ophthalmodynamometry	4	MPFS
92265	Needle oculoelectromyography, 1 or more extraocular muscles, 1 or both eyes, with interpretation and report	12	MPFS
92270	Electro-oculography with interpretation and report	20	MPFS
92273	Electroretinography (ERG), with interpretation and report; full field (i.e., ffERG, flash ERG, Ganzfeld ERG)	27	MPFS
92274	Electroretinography (ERG), with interpretation and report; multifocal (mfERG)	16	MPFS
92283	Color vision examination, extended, e.g., anomaloscope or equivalent	13	MPFS
92284	Dark adaptation examination with interpretation and report	13	MPFS
92285	External ocular photography with interpretation and report for documentation of medical progress (e.g., close-up photography, slit lamp photography, goniophotography, stereophotography)	6	MPFS
92286	Anterior segment imaging with interpretation and report; with specular microscopy and endothelial cell analysis	5	MPFS
92287	Anterior segment imaging with interpretation and report; with fluorescein angiography	14	Based on hospital BR as MPFS value is equipment intense
92499	Unlisted ophthalmological service or procedure	BR	Unlisted service
95930	Visual evoked potential (VEP) checkerboard or flash testing central nervous system except glaucoma, with interpretation and report	EEG	Report in EEG rate center

OTORHINOLARYNGOLOGIC SERVICES

Code	Description	RVU	Rationale
92504	Binocular microscopy	7	MPFS
92511	Nasopharyngoscopy with endoscope	SLP	Report in Speech Language Pathology rate center

REHABILITATION SESSIONS AND OTHER SERVICES

Code	Description	RVU	Rationale
93668	Peripheral arterial disease (PAD) rehabilitation, per session	4	MPFS
93702	Bioimpedance spectroscopy (BIS), extracellular fluid analysis for lymphedema assessment(s)	PT/OT	Report in PT/ OT rate center
93750	Interrogation of ventricular assist device (VAD), in person, with qualified health care professional analysis of device parameters (e.g., drivelines, alarms, power surges), review of device function (e.g., flow and volume status, septum status, recovery), with programming, if performed, and report	EKG	Report in EKG rate center
93793	Anticoagulant management for a patient taking warfarin, must include review and interpretation of a new home, office, or lab international normalized ration (INR) test result, patient instructions, dosage adjustment (as needed), and scheduling of additional test(s), when performed	E/M	Align with E&M RVUs
93797	Qualified health care professional services for outpatient cardiac rehabilitation; without continuous ECG monitoring (per session)	3	MPFS
93798	Qualified health care professional services for outpatient cardiac rehabilitation; with continuous ECG monitoring (per session)	5	MPFS
94625	Qualified health care professional services for outpatient pulmonary rehabilitation; without continuous oximetry monitoring (per session)	15	MPFS
94626	Qualified health care professional services for outpatient pulmonary rehabilitation;	16	MPFS

Code	Description	RVU	Rationale
	with continuous oximetry monitoring (per session)		
0358T	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report	1	Based on hospital BR as no MPFS value
G0237	Therapeutic procedures to increase strength or endurance of respiratory muscles, face to face, one on one, each 15 minutes (includes monitoring)	3	MPFS
G0238	Therapeutic procedures to improve respiratory function, other than described by G0237, one on one, face to face, per 15 minutes (includes monitoring)	3	MPFS
G0239	Therapeutic procedures to improve respiratory function or increase strength or endurance of respiratory muscles, two or more individuals (includes monitoring)	4	MPFS
G0422	Intensive cardiac rehabilitation; with or without continuous ECG monitoring with exercise, per session	3	Consistency with CPT 93797
G0423	Intensive cardiac rehabilitation; with or without continuous ECG monitoring without exercise, per session	5	Consistency with CPT 93798

ALLERGY TESTING/IMMUNOTHERAPY

Code	Description	RVU	Rationale
95004	Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests	1	MPFS
95017	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with venoms, immediate type reaction, including test interpretation and report, specify number of tests	2	MPFS
95018	Allergy testing, any combination of percutaneous (scratch, puncture, prick) and intracutaneous (intradermal), sequential and incremental, with drugs or biologicals, immediate type reaction, including test	5	MPFS

Code	Description	RVU	Rationale
	interpretation and report, specify number of tests		
95024	Intracutaneous (intradermal) tests with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests	2	MPFS
95027	Intracutaneous (intradermal) tests, sequential and incremental, with allergenic extracts for airborne allergens, immediate type reaction, including test interpretation and report, specify number of tests	1	MPFS
95028	Intracutaneous (intradermal) tests with allergenic extracts, delayed type reaction, including reading, specify number of tests	4	MPFS
95044	Patch or application test(s) (specify number of tests)	1	MPFS
95052	Photo patch test(s) (specify number of tests)	2	MPFS
95056	Photo tests	BR	No volumes
95060	Ophthalmic mucous membrane tests	BR	No volumes
95065	Direct nasal mucous membrane test	8	MPFS
95076	Ingestion challenge tests (sequential and incremental ingestion of test items, e.g., food, drug, or other substance); initial 120 minutes of testing	19	MPFS
95079	Ingestion challenge test (sequential and incremental ingestion of test items, e.g., food, drug, or other substance); each additional 60 minutes of testing	10	MPFS
95115	Professional services for allergen immunotherapy not including provision of allergenic extracts; single injection	0	Not a hospital service
95117	Professional services for allergen immunotherapy not including provision of allergenic extracts; 2 or more injections	0	Not a hospital service
95180	Rapid desensitization procedure, each hour (e.g., insulin, penicillin, equine serum)	19	MPFS
95199	Unlisted allergy/clinical immunologic service or procedure	BR	Unlisted service

ENDOCRINOLOGY

Code	Description	RVU	Rationale
95249	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; patient-provided equipment, sensor placement, hook-up, calibration of monitor, patient training, and printout of recording	**7**	Equipment intense; OPPS APC weight more appropriate
95250	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; qualified health care professions (office) provided equipment, sensor placement, hook-up, calibration of monitor, patient training, removal of sensor, and printout of recording	**7**	Consistency with CPT 95249, patient vs provider equipment not a factor
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation, and report	0	Not a hospital service

ELECTROMYOGRAPHY

No RVUs were as assigned to these services (e.g., CPT 95874). These services are reportable via the Electroencephalography (EEG) rate center.

GENETIC COUNSELING

Code	Description	RVU	Rationale
96040	Medical genetics and genetic counseling services, each 30 minutes face-to-face with patient/family	2	Service equivalent to E/M charges, various increments determined value

PSYCHOLOGICAL ASSESSMENTS, TESTING, AND INTERVENTIONS

Code	Description	RVU	Rationale
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning, and judgement, [e.g., acquired knowledge,	8	MPFS

Code	Description	RVU	Rationale
	attention, language, memory, planning, and problem solving, and visual spatial abilities]), by qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour		
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning, and judgement, [e.g., acquired knowledge, attention, language, memory, planning, and problem solving, and visual spatial abilities]), by qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour	5	MPFS
96125	Standardized cognitive performance testing (e.g., Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	SLP or PT/OT	Report in SLP or PT/OT rate center
96130	Psychological testing evaluation services by qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour	8	MPFS
96131	Psychological testing evaluation services by qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour	6	MPFS
96132	Neuropsychological testing evaluation services by qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical	12	MPFS

Code	Description	RVU	Rationale
	decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour		
96133	Neuropsychological testing evaluation services by qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; each additional hour	9	MPFS
96136	Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method; first 30 minutes	7	MPFS
96137	Psychological or neuropsychological test administration and scoring by qualified health care professional, two or more tests, any method; each additional 30 minutes	7	MPFS
96138	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; first 30 minutes	10	MPFS
96139	Psychological or neuropsychological test administration and scoring by technician, two or more tests, any method; each additional 30 minutes	10	MPFS
96146	Psychological or neuropsychological test administration, with single automated, standardized instrument via electronic platform, with automated result only	1	MPFS
96156	Health behavior assessment, or re-assessment (i.e., health-focused clinical interview, behavioral observations, clinical decision making)	6	MPFS
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes	4	MPFS
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes	1	MPFS
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes	1	MPFS

Code	Description	RVU	Rationale
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes	1	MPFS
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes	4	MPFS
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes	2	MPFS
96170	Health behavior intervention, family (without the patient present), face-to-face; initial 30 minutes	7	MPFS
96171	Health behavior intervention, family (without the patient present), face-to-face; each additional 15 minutes	3	MPFS

DRUG ADMINISTRATION AND DELIVERY

Code	Description	RVU	Rationale
95990	Refilling and maintenance of implantable pump or reservoir for drug delivery, spinal (intrathecal, epidural) or brain (intraventricular), includes electronic analysis of pump, when performed	6	Equipment intense; RVU is in line with prior By Report values
96360	Intravenous infusion, hydration; initial, 31 minutes to 1 hour	8	MPFS
96361	Intravenous infusion, hydration; each additional hour	3	MPFS
96365	Intravenous infusion, for therapy, prophylaxis, or diagnosis; initial, up to 1 hour	18	MPFS
96366	Intravenous infusion, for therapy, prophylaxis, or diagnosis; each additional hour	4	MPFS
96367	Intravenous infusion, for therapy, prophylaxis, or diagnosis; additional sequential infusion of a new drug/substance, up to 1 hour	7	MPFS
96368	Intravenous infusion, for therapy, prophylaxis, or diagnosis; concurrent infusion	4	MPFS

Code	Description	RVU	Rationale
96369	Subcutaneous infusion for therapy or prophylaxis; initial, up to 1 hour, including pump set-up and establishment of subcutaneous infusion site(s)	18	Consistency with CPT 96365
96370	Subcutaneous infusion for therapy or prophylaxis; each additional hour	4	Consistency with CPT 96366
96371	Subcutaneous infusion for therapy or prophylaxis; additional pump set-up with establishment of new subcutaneous infusion site(s)	6	Consistency with CPT 95990
96372	Therapeutic, prophylactic, or diagnostic injection; subcutaneous or intramuscular	2	MPFS
96373	Therapeutic, prophylactic, or diagnostic injection; intra-arterial	4	MPFS
96374	Therapeutic, prophylactic, or diagnostic injection; intravenous push, single or initial substance/drug	10	MPFS
96375	Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of a new substance/drug	4	MPFS
96376	Therapeutic, prophylactic, or diagnostic injection; each additional sequential intravenous push of the same substance/drug provided in a facility	1	MPFS
96377	Application of on-body injector (includes cannula insertion) for timed subcutaneous injection	4	MPFS
96401	Chemotherapy administration, subcutaneous or intramuscular; non-hormonal anti-neoplastic	7	Drug intense; OPPS APC weight more appropriate
96402	Chemotherapy administration, subcutaneous or intramuscular; hormonal anti-neoplastic	7	Drug intense; OPPS APC weight more appropriate
96405	Chemotherapy administration; intralesional, up to and including 7 lesions	7	Drug intense; OPPS APC weight more appropriate
96406	Chemotherapy administration; intralesional, more than 7 lesions	7	Consistency with CPT 96405
96409	Chemotherapy administration; intravenous, push technique, single or initial substance/drug	10	Consistency with CPT 96374
96411	Chemotherapy administration; intravenous, push technique, each additional substance/drug	4	Consistency with CPT 96375

Code	Description	RVU	Rationale
96413	Chemotherapy administration, intravenous infusion technique; up to 1 hour, single or initial substance/drug	18	Consistency with CPT 96365
96415	Chemotherapy administration, intravenous infusion technique; each additional hour	4	Consistency with CPT 96366
96416	Chemotherapy administration, intravenous infusion technique; initiation of prolonged chemotherapy infusion (more than 8 hours), requiring use of a portable or implantable pump	18	Consistency with CPT 96413
96417	Chemotherapy administration, intravenous infusion technique; each additional sequential infusion (different substance/drug), up to 1 hour	1	Consistency with CPT 96376
96420	Chemotherapy administration, intra-arterial; push technique	BL	Invasive service
96422	Chemotherapy administration, intra-arterial; infusion technique, up to 1 hour	BL	Invasive service
96423	Chemotherapy administration, intra-arterial; infusion technique, each additional hour	BL	Invasive service
96425	Chemotherapy administration, intra-arterial; infusion technique, initiation of prolonged infusion (more than 8 hours), requiring the use of a portable or implantable pump	BL	Invasive service
96440	Chemotherapy administration into pleural cavity, requiring and including thoracentesis	BL	Invasive service
96446	Chemotherapy administration into peritoneal cavity via indwelling port or catheter	BL	Invasive service
96450	Chemotherapy administration, into CNS (e.g., intrathecal), requiring and including spinal puncture	BL	Invasive service
96521	Refilling and maintenance of portable pump	6	Consistency with CPT 95990
96522	Refilling and maintenance of implantable pump or reservoir for drug delivery, systemic (e.g., intravenous, intra-arterial)	6	Consistency with CPT 95990
96523	Irrigation of implanted venous access device for drug delivery systems	3	Based on hospital BR as MPFS value is equipment intense

Code	Description	RVU	Rationale
96542	Chemotherapy injection, subarachnoid or intraventricular via subcutaneous reservoir, single or multiple agents	6	Based on hospital BR as MPFS value is too high
96549	Unlisted chemotherapy procedure	BR	Unlisted service
C8957	Intravenous infusion for therapy/ diagnosis; initiation of prolonged infusion (more than 8 hours), requiring use of portable of implantable pump	18	Consistency with CPT 96413
G0498	Chemotherapy administration, intravenous infusion technique; initiation of infusion in the office/clinic setting using office/clinic pump/supplies, with continuation of the infusion in the community setting (e.g., home, domiciliary, rest home or assisted living) using a portable pump provided by the office/other outpatient setting, includes follow up office/other outpatient visit at the conclusion of the infusion	18	Consistency with CPT 96416
0537T	Chimeric antigen receptor T-cell (CAR-T) therapy; harvesting of blood-derived T lymphocytes for development of genetically modified autologous CAR-T cells, per day	0	Bundled service with the biologic
0540T	Chimeric antigen receptor T-cell (CAR-T) therapy; CAR-T cell administration, autologous	18	Consistency with CPT 96413
0662T	Scalp cooling, mechanical; initial measurement and calibration of cap	9	Based on hospital BR as no MPFS value
0663T	Scalp cooling, mechanical; placement of device, monitoring, and removal of device	12	Based on hospital BR as no MPFS value

PHOTODYNAMIC THERAPY/DERMATOLOGY

Code	Description	RVU	Rationale
96567	Photodynamic therapy by external application of light to destroy premalignant lesions of the skin and adjacent mucosa with application and illumination/activation of photosensitive drug(s), per day	BR	No volumes

Code	Description	RVU	Rationale
96570	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); first 30 minutes	3	MPFS
96571	Photodynamic therapy by endoscopic application of light to ablate abnormal tissue via activation of photosensitive drug(s); each additional 15 minutes	2	MPFS
96900	Actinotherapy (ultraviolet light)	7	MPFS
96902	Microscopic examination of hairs plucked or clipped by the examiner (excluding hair collected by the patient) to determine telogen and anagen counts, or structural hair shaft abnormality	2	MPFS
96904	Whole body integumentary photography, for monitoring of high-risk patients with dysplastic nevus syndrome or a history of dysplastic nevi, or patients with a personal or familial history of melanoma	6	Based on hospital BR as MPFS value is equipment intense
96910	Photochemotherapy; tar and ultraviolet B (Goeckerman treatment) or petrolatum and ultraviolet B	2	Based on hospital BR as MPFS value is equipment intense
96912	Photochemotherapy; psoralens and ultraviolet A (PUVA)	2	Based on hospital BR as MPFS value is equipment intense
96913	Photochemotherapy (Goeckerman and/or PUVA) for severe photoresponsive dermatoses requiring at least 4-8 hours of care under direct supervision of the physician (includes application of medication and dressings)	BR	No volumes
96920	Laser treatment for inflammatory skin disease (psoriasis); total area less than 250 sq cm	BR	No volumes
96921	Laser treatment for inflammatory skin disease (psoriasis); 250 sq cm to 500 sq cm	BR	No volumes
96922	Laser treatment for inflammatory skin disease (psoriasis); over 500 sq cm	BR	No volumes
96999	Unlisted special dermatological service or procedure	BR	Unlisted service

ACTIVE WOUND CARE MANAGEMENT

No RVUs were as assigned to these services (e.g., CPT 97597). These services are reportable via the rehabilitation (Physical and Occupational Therapy) rate centers. Clinic staff costs should be reallocated to the therapy rate centers for appropriate matching of revenue and expense.

MEDICAL NUTRITION THERAPY AND DIABETES MANAGEMENT

Code	Description	RVU	Rationale
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes	5	MPFS
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes	5	MPFS
97804	Medical nutrition therapy; group (2 or more individuals), each 30 minutes	2	MPFS
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes	7	MPFS
G0109	Diabetes outpatient self-management training services, group session (2 or more), per 30 minutes	2	MPFS
G0270	Medical nutrition therapy: reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen, (including additional hours needed for renal disease), individual, face to face with the patient, each 15 minutes	5	MPFS
G0271	Medical nutrition therapy: reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition, or treatment regimen, (including additional hours needed for renal disease), group (2 or more individuals), each 30 minutes	2	MPFS
0403T	Preventative behavior change, intensive program of prevention of diabetes using a standardized diabetes prevention program curriculum, provided to individuals in a group setting, minimum 60 minutes, per day	4	Consistency with CPT G0109 x2

ACCUPUNCTURE AND CHIROPRACTIC

Code	Description	RVU	Rationale
97810	Acupuncture, 1 or more needles; without electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	5	MPFS
97811	Acupuncture, 1 or more needles; without electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)	3	MPFS
97813	Acupuncture, 1 or more needles; with electrical stimulation, initial 15 minutes of personal one-on-one contact with the patient	7	MPFS
97814	Acupuncture, 1 or more needles; with electrical stimulation, each additional 15 minutes of personal one-on-one contact with the patient, with re-insertion of needle(s)	5	MPFS
98925	Osteopathic manipulative treatment (OMT); 1-2 body regions involved	4	MPFS
98926	Osteopathic manipulative treatment (OMT); 3-4 body regions involved	6	MPFS
98927	Osteopathic manipulative treatment (OMT); 5-6 body regions involved	7	MPFS
98928	Osteopathic manipulative treatment (OMT); 7-8 body regions involved	8	MPFS
98929	Osteopathic manipulative treatment (OMT); 9-10 body regions involved	9	MPFS
98940	Chiropractic manipulation treatment (CMT); spinal, 1-2 regions	3	MPFS
98941	Chiropractic manipulation treatment (CMT); spinal, 3-4 regions	4	MPFS
98942	Chiropractic manipulation treatment (CMT); spinal, 5 regions	5	MPFS
98943	Chiropractic manipulation treatment (CMT); extraspinal, 1 or more regions	3	MPFS

EDUCATION AND TRAINING

Code	Description	RVU	Rationale
98960	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; individual patient	7	Consistency with CPT G0108
98961	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 2-4 patients	2	Consistency with CPT G0109
98962	Education and training for patient self-management by a qualified, nonphysician health care professional using a standardized curriculum, face-to-face with the patient (could include caregiver/family) each 30 minutes; 5-8 patients	2	Consistency with CPT G0109

NON-FACE-TO-FACE AND NON-MEDICAL SERVICES

Code	Description	RVU	Rationale
98966	Telephone assessment and management service provided by a qualified nonphysician heath care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion	0	Professional service
98967	Telephone assessment and management service provided by a qualified nonphysician heath care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or	0	Professional service

Code	Description	RVU	Rationale
	procedure within the next 24 hours or soonest available appointment: 11-20 minutes of medical discussion		
98968	Telephone assessment and management service provided by a qualified nonphysician heath care professional to an established patient, parent, or guardian not originating from a related assessment and management service provided within the previous 7 days nor leading to an assessment and management service or procedure within the next 24 hours or soonest available appointment: 21-30 minutes of medical discussion	0	Professional service
98970	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes	0	Professional service
98971	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes	0	Professional service
98972	Qualified nonphysician health care professional online digital assessment and management, for an established patient, for up to 7 days, cumulative time during the 7 days; 21 or more minutes	0	Professional service
98975	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); initial set-up and patient education on use of equipment	5	MPFS
98976	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor respiratory system, each 30 days	0	Not a regulated service
98977	Remote therapeutic monitoring (e.g., respiratory system status, musculoskeletal system status, therapy adherence, therapy	0	Not a regulated service

Code	Description	RVU	Rationale
	response); device(s) supply with scheduled (e.g., daily) recording(s) and/or programmed alert(s) transmission to monitor musculoskeletal system, each 30 days		
98980	Remote therapeutic monitoring treatment management services, qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; first 20 minutes	0	Not a regulated service
98981	Remote therapeutic monitoring treatment management services, qualified health care professional time in a calendar month requiring at least one interactive communication with the patient or caregiver during the calendar month; each additional 20 minutes	0	Not a regulated service
99078	Qualified health care professional qualified by education, training, licensure/regulation (when applicable) educational services rendered to patients in a group setting (e.g., prenatal, obesity, or diabetic instructions)	0	Not a regulated service
99441	Telephone evaluation and management service by a qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 5-10 minutes of medical discussion	0	Professional service
99442	Telephone evaluation and management service by a qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest	0	Professional service

Code	Description	RVU	Rationale
	available appointment: 11-20 minutes of medical discussion		
99443	Telephone evaluation and management service by a qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment: 21-30 minutes of medical discussion	0	Professional service
G2010	Remote evaluation of recorded video and/or images submitted by an established patient (e.g., store and forward), including interpretation with follow-up with the patient within 24 business hours, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment	0	Not a regulated service
G2012	Brief communication technology-based service, e.g., virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to a E/M service or procedure within the next 24 hours or soonest available appointment, 5-10 minutes of medical discussion	0	Not a regulated service

SUBSTANCE ABUSE SERVICES

Code	Description	RVU	Rationale
99406	Smoking and tobacco use cessation counseling visit; intermediate, greater than 3 minutes up to 10 minutes	2	MPFS

Code	Description	RVU	Rationale
99407	Smoking and tobacco use cessation counseling; intensive, greater than10 minutes	3	MPFS
99408	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; 15 to 30 minutes	0	Not a regulated service
99409	Alcohol and/or substance (other than tobacco) abuse structured screening (e.g., AUDIT, DAST), and brief intervention (SBI) services; greater than 30 minutes	0	Not a regulated service

COVID-19-RELATED CODES

Codes will continue to be added as COVID-19 treatments are identified.

Code	Description	RVU	Rationale
0001A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; first dose	3	Consistency with CPT 90471
0002A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; second dose	3	Consistency with CPT 90471
0003A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; third dose	3	Consistency with CPT 90471
0004A	Immunization administration by intramuscular injection of severe acute	3	Consistency with CPT 90471

Code	Description	RVU	Rationale
	respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 30 mcg/0.3mL dosage, diluent reconstituted; booster dose		
0011A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; first dose	3	Consistency with CPT 90471
0012A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; second dose	3	Consistency with CPT 90471
0013A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 100 mcg/0.5mL dosage; third dose	3	Consistency with CPT 90471
0021A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free, 5x1010 viral particles/0.5mL dosage; first dose	3	Consistency with CPT 90471
0022A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, chimpanzee adenovirus Oxford 1 (ChAdOx1) vector, preservative free,	3	Consistency with CPT 90471

Code	Description	RVU	Rationale
	5x1010 viral particles/0.5mL dosage; second dose		
0031A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5mL dosage; single dose	3	Consistency with CPT 90471
0034A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, DNA, spike protein, adenovirus type 26 (Ad26) vector, preservative free, 5x1010 viral particles/0.5mL dosage; booster dose	3	Consistency with CPT 90471
0041A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 mL dosage; first dose	3	Consistency with CPT 90471
0042A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, recombinant spike protein nanoparticle, saponin-based adjuvant, preservative free, 5 mcg/0.5 mL dosage; second dose	3	Consistency with CPT 90471
0051A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3mL dosage, tris-sucrose formulation; first dose	3	Consistency with CPT 90471
0052A	Immunization administration by intramuscular injection of severe acute	3	Consistency with CPT 90471

Code	Description	RVU	Rationale
	respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3mL dosage, tris-sucrose formulation; second dose		
0053A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3mL dosage, tris-sucrose formulation; third dose	3	Consistency with CPT 90471
0054A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARSCoV-2) (coronavirus disease [COVID-19]) vaccine, mRNALNP, spike protein, preservative free, 30 mcg/0.3mL dosage, tris-sucrose formulation; booster dose	3	Consistency with CPT 90471
0064A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.25mL dosage; booster dose	3	Consistency with CPT 90471
0071A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2mL dosage, diluent reconstituted, tris-sucrose formulation; first dose	3	Consistency with CPT 90471
0072A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10	3	Consistency with CPT 90471

Code	Description	RVU	Rationale
	mcg/0.2mL dosage, diluent reconstituted, tris-sucrose formulation; second dose		
0073A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 10 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation: third dose	3	Consistency with CPT 90471
0081A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation: first dose	3	Consistency with CPT 90460
0082A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 3 mcg/0.2 mL dosage, diluent reconstituted, tris-sucrose formulation: second dose	3	Consistency with CPT 90460
0094A	Immunization administration by intramuscular injection of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) (coronavirus disease [COVID-19]) vaccine, mRNA-LNP, spike protein, preservative free, 50 mcg/0.5 mL dosage, booster dose	3	Consistency with CPT 90471
M0220	Injection, tixagevimab and cilgavimab, for the pre-exposure prophylaxis only, for certain adults and pediatric individuals (12 years of age and older weighing at least 40kg) with no known sars-cov-2 exposure, who either have moderate to severely compromised immune systems or for who vaccination	4	Consistency with CPT 96372 X 2

Code	Description	RVU	Rationale
	with any available covid-19 vaccine is not recommended due to a history of severe adverse reaction to a covid-19 vaccine(s) and/or covid-19 component(s), includes injection and post administration monitoring		
M0222	Intravenous injection, bebtelovimab, includes injection and post administration monitoring	18	Consistency with CPT 96365
M0240	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring, subsequent repeat doses	22	Consistency with CPT 96365 plus CPT 96368
M0243	Intravenous infusion or subcutaneous injection, casirivimab and imdevimab includes infusion or injection, and post administration monitoring	22	Consistency with CPT 96365 plus CPT 96368
M0245	Intravenous infusion, bamlanivimab and etesevimab, includes infusion and post administration monitoring	22	Consistency with CPT 96365 plus CPT 96368
M0247	Intravenous infusion, sotrovimab, includes infusion and post administration monitoring	18	Consistency with CPT 96365
M0249	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, first dose	0	Inpatient procedure
M0250	Intravenous infusion, tocilizumab, for hospitalized adults and pediatric patients (2 years of age and older) with covid-19 who are receiving systemic corticosteroids and require supplemental oxygen, non-invasive or invasive mechanical ventilation, or extracorporeal membrane oxygenation (ECMO) only, includes infusion and post administration monitoring, second dose	0	Inpatient procedure

GASTROENTEROLOGY

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

PART III: SURGICAL PROCEDURES

Any surgical procedures performed in a clinic should be reported via the Operating Room-Clinic (ORC) cost center, and associated surgical costs allocated to the ORC 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), 91000 to 91299 (gastroenterology), and 93000 to 93050 (cardiography).

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 IRC procedures have surgical CPT codes are defined in the IRC rate center with RVUs. Hospitals should continue to report using those IRC RVUs until instructed otherwise.

- *Laboratory*-Venipuncture/Capillary punctures. These procedures are 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.

CAPTURING MINUTES FOR SURGICAL PROCEDURES PERFORMED IN CLINIC

The counting of minutes for surgical procedures performed in clinics is different than the rules in the operating room Chart of Accounts [See Operating Room Chart of Accounts.]

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 like 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. 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

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

STANDARD UNIT OF MEASURE REFERENCES

6720 CLINIC SERVICES

Function

Clinics provide organized diagnostic, preventive, curative, rehabilitative, and educational services on a scheduled basis to ambulatory patients. Additional activities include, but are not limited to the following:

Participating in community activities designed to promote health education; assisting in administration of physical examinations and diagnosing and treating ambulatory patients having illnesses which respond quickly to treatment; referring patients who require prolonged or specialized care to appropriate other services; assigning patients to doctors in accordance with clinic rules; assisting and guiding volunteers in their duties; making patients' appointments through required professional service functions.

Description

The cost centers contain the direct expenses incurred in providing clinic services to ambulatory patients. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies (non-medical-surgical), purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Number of Relative Value Units

Clinic Relative Value Units as developed by the Health Services Cost Review Commission. A count of visits must also be maintained and reported on Schedule V2. Visits made by clinic patients to ancillary cost centers are not included here but are accumulated in the appropriate ancillary cost center.

Data Source

The number of Relative Value Units shall be the actual count maintained by the formally organized clinic within the hospital.

Reporting Schedule

Schedule D - Line D19

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Revenue for Reform

Draft Recommendation

June 2022

This document contains the draft staff recommendations for a Revenue for Reform adjustment to the ICC for RY 2023. Written comments from the public will be received through June 17, 2022.

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Draft Recommendations for Revenue for Reform Policy

Staff recommend the following revisions to the Integrated Efficiency policy:

1. A hospital's penalty under the Integrated Efficiency Policy should be lowered by the amount of qualifying population health investments they make. Qualifying population health investments should also not be subject to inflationary reductions, as outlined in the Integrated Efficiency policy.

2. Qualifying population health investments should be limited to the following:

    a. Community spending in the hospital's primary service area, net of revenue generated for those services, (e.g. outside of the hospital's regulated space).

    b. Non-physician costs (except as described below).

    c. Spending that meets one of three following criteria:

        i. An initiative that is intended to address an unmet health need identified on either the hospital's Community Health Needs Assessment or the Centers for Disease Control and Prevention's Health People 2030 Initiative; or

        ii. Spending on primary care, mental health, or dental providers that are located in a Medically Underserved Area; or

        iii. Spending on regional entity to improve population health.

3. Beginning in Rate Year 2025, hospitals will be spent down to remove 50% of their retained revenues or their expected population health spending unless that hospital has made qualifying population health investments in that amount. Staff recommends that:

    a. Retained revenue be measured by multiplying their charge variance by their eligible revenues; and

    b. Establishing a minimum expected community health spending equal to the 75% percentile of all hospitals retained revenues (approximately 1% of the hospitals eligible revenues).

The following discussion provides rationale and detail for each of these recommendations.

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
Under the GBR, hospitals can retain revenues from reduced utilization. These retained revenue can be reinvested in the community to improve population health. To date, hospital spending on population health has been limited.	Penalties under the Integrated Efficiency Policy should be reduced by the amount that hospitals spend on population health. In 2025, 50% of unused retained revenues, not directed toward community health spending outlined in the policy, should be removed from hospitals' GBR.	Hospitals that have not spent their retained revenues on community and population health will be spent down to an appropriate standard, beginning in RY 2025.	Consumers will benefit from additional population health spending. Payers will benefit if population health investments prove effective at reducing unnecessary utilization and improving health status.	Hospital's investments will be directed towards their community. Hospitals will not be able to use their retained revenues to invest in wealthy / healthier markets. This will increase population health spending in underserved areas.

Background and Purpose

Since the beginning of the All-Payer Model in 2014, the State has been successful at meeting its financial obligations to CMS as a result of the Global Budget Revenue (GBR) system for hospital payment. The GBR provides hospitals with a revenue target that is relatively invariant to hospital utilization. This reimbursement system rewards hospitals for reducing unnecessary utilization because the revenue that had been associated with that utilization is retained by the hospital under the GBR.

Retained revenues have two purposes under the GBR system. First, retained revenues are used to support hospital financial stability, since per capita revenue is taken out of the system. The Total Cost of Care (TCOC) Model commits the State to reducing Medicare TCOC by $300 million by 2023. If overall utilization remained constant, then the reductions in per capita revenues would necessitate reductions in the price per case. In turn, this would put pressure on hospitals' margins. Under the GBR system, a hospital's retained revenues from reduced utilization are used to 'cushion' hospital finances from overall per capita revenue reductions. In this regard, the GBR system has been remarkably successful. Per capita Medicare costs have declined by more than $300 million relative to the nation, but per capita utilization has declined significantly and consequently regulated hospital margins have been relatively stable.

The second purpose of retained revenues is to invest in the health of Marylanders. The fee-for-service system is a 'sick-care system' meaning that the majority of spending is directed to treating patients after they become sick. Under the GBR, hospitals have an incentive to invest in the care that keeps patients healthy. Under the GBR, retained revenues are not linked to a particular hospitalization episode and can therefore be reinvested in interventions that keep patients healthy and out of the hospital. The extent to which hospitals' retained revenues have been used for this purpose is unknown. The HSCRC has not made

a systematic attempt to catalog the monies spent by hospitals on population health. While some laudable initiatives have been well-publicized by hospitals and the media, the total amount of population health spending remains unknown.

Assessing the extent to which retained revenues are used for population health is critical to the long-term success of the Maryland Model. Not only is it critical to sustain utilization reductions under the GBR, but the HSCRC's assessment of hospitals cost-efficiency currently does not incorporate the amount of population health spending. This creates a tension between the Integrated Efficiency policy, which aims to correct any maldistribution in the Model, and the purposes of the GBR. Resolving this tension is necessary to ensure that hospitals are equitably reimbursed while at the same time ensuring that hospitals are able to succeed under the GBR.

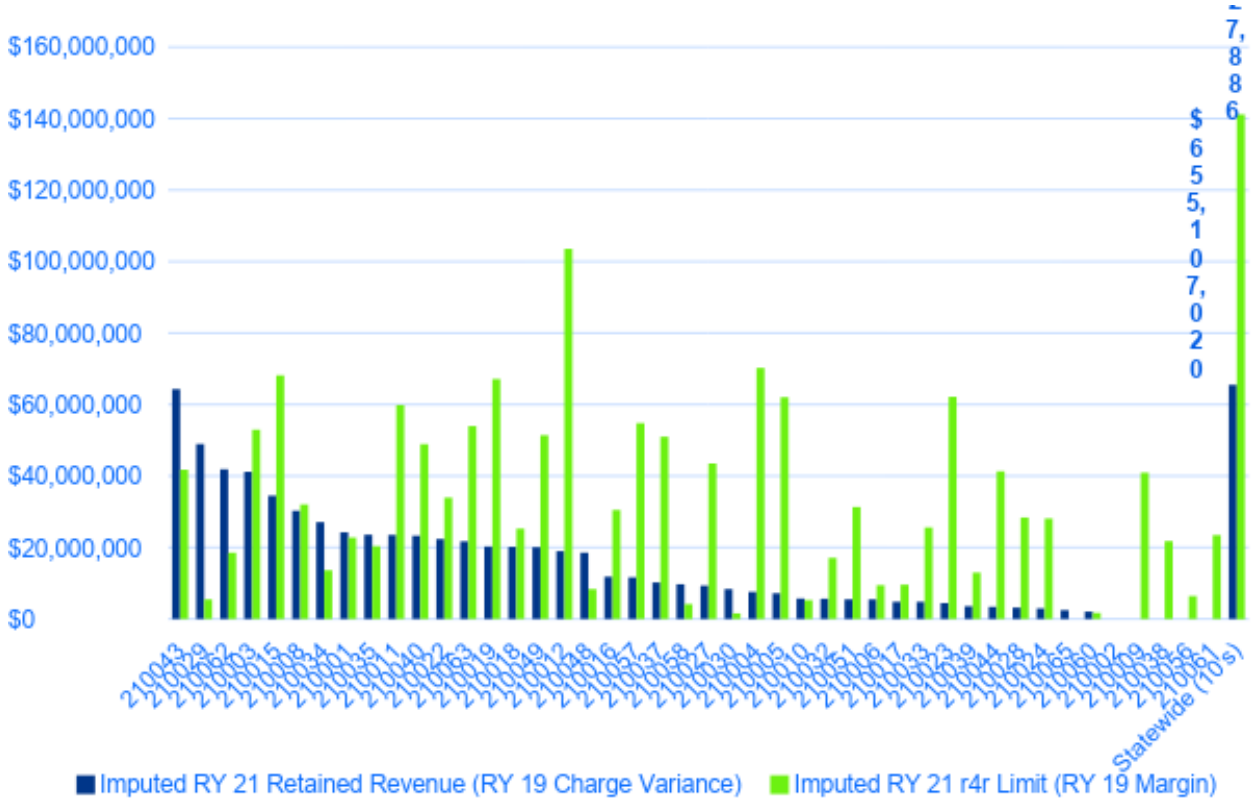
Quantification of Retained Revenue

Since 2013, most hospitals in the State have been successful at reducing hospital utilization and therefore generating retained revenues. Staff estimated the magnitude of the retained revenues in the State by multiplying the hospital's charge variation by the hospital's permanent revenue. The charge variation is the amount by which a hospital increased or decreased their charges relative to their rate order. The rate order is based on 2013 revenues and volumes, plus inflation.[1] So the difference between the charged amount and the rate order is an approximation of the revenues retained on volume decreases relative to 2013. There are other changes included in rates – capital spending, full rate orders, etc. – so using rate variances is only an approximation of the retained revenues but it does represent the best translation of volume declines into retained dollars available.

Staff calculation of retained revenue in the State is shown in Figure 1. Statewide, hospitals have generated approximately $655 million of retained revenues. For comparison purposes, hospital regulated margin is also shown. On a statewide basis retained revenues are about 47% of regulated margin but the distribution of retained revenues is unequal. In general, hospitals that have been relatively successful at reducing utilization have more retained revenues than hospitals that have not significantly utilization.

[1] In RY 2022, volumes were rebased to their 2019 levels. For this analysis, Staff used the charge variance as of 2019. This both measures the impact of utilization relative to 2013 and avoids the period during which the COVID-19 pandemic had a significant impact on hospital utilization.

Figure 1: Retained Revenues and Regulated Margin



Tension with the ICC

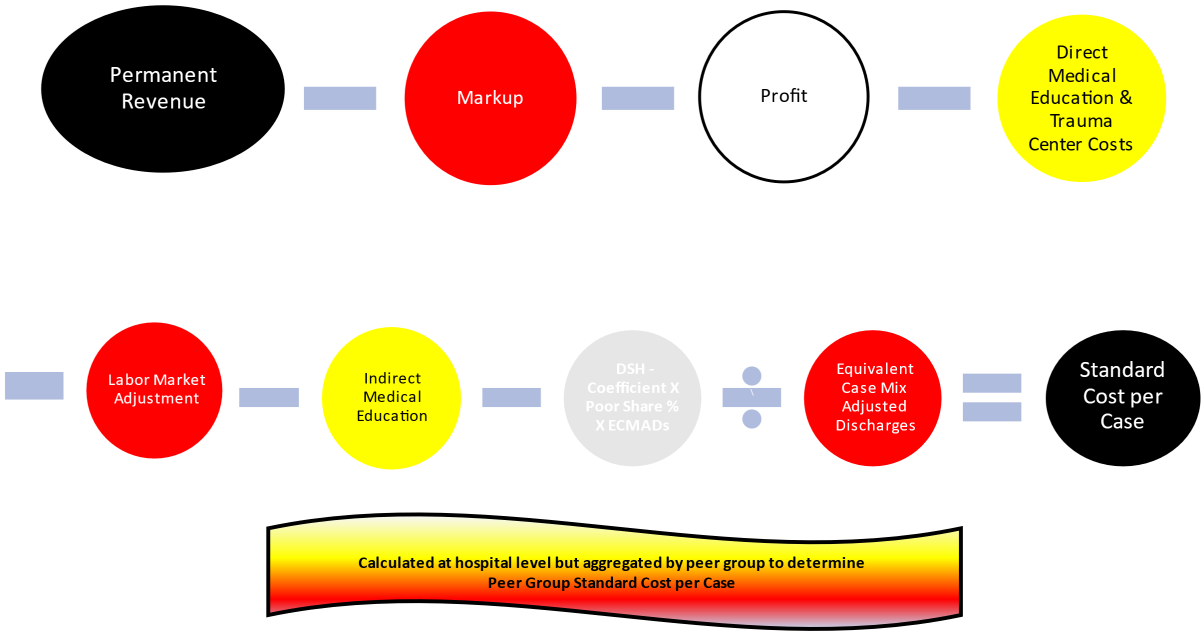
In October of 2019, the Commission approved a policy for assessing hospital's relative cost-efficiency using the Inter-Hospital Cost Comparison (ICC) methodology.[2] In brief, the ICC compares a hospital's charge per case to the hospital's Approved Revenue, which is calculated based on a Peer Group Standard Cost Per Case. In essence, the Commission assesses a hospital's efficiency by comparing the charge per case at the hospital to the charge per case at the hospital's peer institutions, after controlling for the impact of exogenous facts and profit as explained below.

The peer group standard is calculated by taking the charge per case at a hospital's peer institutions and subtracting: 1) costs that are outside of the hospital's control such as impact of geographic variation in labor costs and to remove the markup on charges due to uncompensated

[2] https://hscrc.maryland.gov/Documents/October%202019%20Public%20Post-Meeting%20Materials.pdf

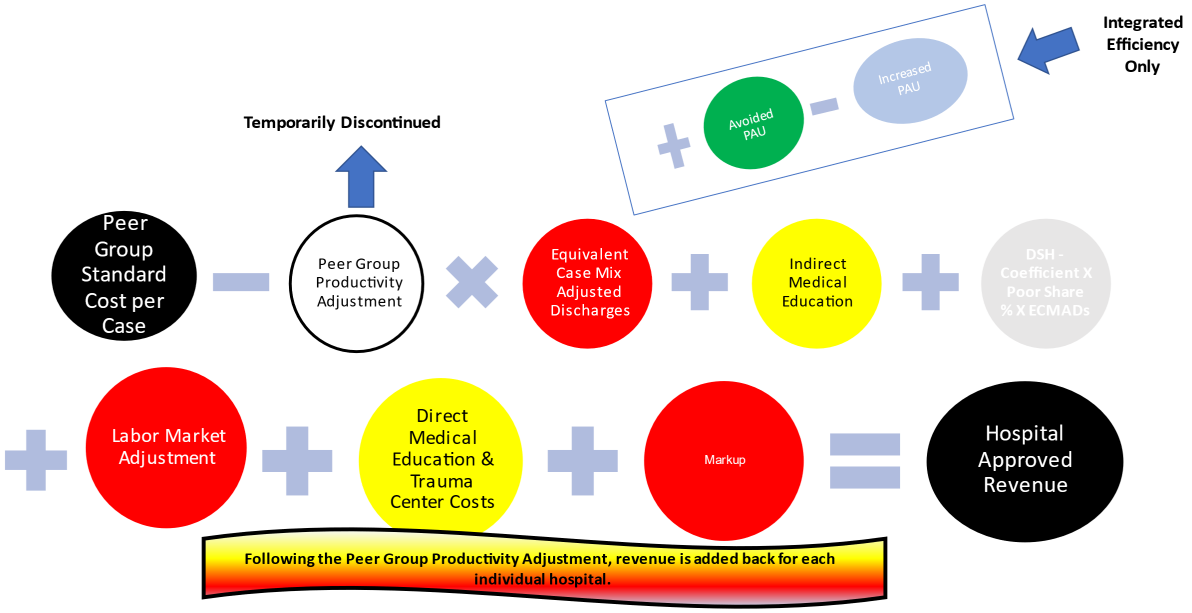
care costs and the payer differential; 2) the cost of 'social goods' (such as graduate medical and trauma center costs); and 3) hospital regulated profit. This peer group standard represents the minimum level of charges necessary to support hospital operations.

Figure 2: Illustration of the Peer Group Standard Cost Per Case



The hospital's Approved Revenue is equal to the Peer Group Standard plus the allowances made in other HSCRC policies for the hospital's geographic labor market, its medical education costs, etc. An illustration of the methodology to calculate the hospital's Approved Revenue is shown in Figure 3 below.

Figure 3: Illustration of the Hospital Approved Revenue



In general, retained revenues will make a hospital more inefficient relative to its Approved Revenue. Since hospitals do not incur variable costs on utilization that has been avoided, the revenue retained after a reduction in utilization will increase the hospital's regulated profit. And since regulated profit is not included in the hospital's Approved Revenue, the impact of retained revenue on hospital utilization will be to increase the hospitals charge per case without increasing the hospitals Approved Revenue. Thus, a hospital's retained revenue will make the hospital less efficient under the ICC evaluation.

This creates a tension between the ICC and the GBR. Hospitals are supposed to generate retained revenues in order to invest in community and population health. But if they do so, they are considered inefficient and – under the Integrated Efficiency policy – are provided less inflation than peer institutions. And perversely, a hospital that generates retained revenue and spends the entirety of that revenue on population health is considered equally inefficient as a hospital that generates retained revenue and does nothing productive with it.

Revenue for Reform Recommendations

Revenue for Reform and the ICC

Under current policy, the ICC compares a hospital's charge per case to its Approved Revenue. Since retained revenue generally results in higher regulated profits, retained revenue will make the hospital appear inefficient even if that retained revenue is being spent on productive population health investments that are in line with the purpose of the Maryland Model.

Under current policy, Staff calculate the ICC for all hospitals in the State prior to the Annual Update Factor. Hospitals are ranked based on the ratio of their charges to Approved Revenue. The amount by which the hospitals is over (under) their Approved Revenue is the amount by which they are considered inefficient (efficient). For example, a hospital with $130 million in charges and $100 million in Approved Revenue would be considered 30% inefficient. Hospitals are then ranked from most efficient to least efficient. Hospitals do not receive the Medicare and Commercial portion of the annual update factor if they are in the bottom quartile of hospitals.

In the Revenue for Reform Policy, Staff recommend that hospitals' Integrated Efficiency penalty be reduced by the amount of qualified population spending that the hospital demonstrates. For instance, if the hospital would have received a $10 million dollar reduction in their annual update factor as a result of having inflation withheld but had spent $7 million in qualified population health spending, then the hospital would receive an efficiency cut of only $3 million ($10 million efficiency adjustment - $7 million in a qualifying population health safe harbor).

Systematic Spend Downs of Unused Retained Revenue

Since the beginning of the All-Payer Model, hospitals have generated substantial retained revenue but investment in population health has been limited. The Commission required hospitals to report their population health investments as of 2019 and found approximately $200 million of population health investments, most of that associated with hospital-based care management programs. This raises two policy concerns: 1) the overall level of investment in population health is less than desired; and 2) there are distributional issues if some hospitals are doing a disproportionate amount of the population health work. Both concerns are due to retained revenue that has not been reinvested in population health.

In order to address these concerns, Staff recommend reducing hospital's GBR by 50% of the hospital's retained revenue minus whatever spending the hospital has made in population health.

Currently, the Integrated Efficiency policy withholds a portion of the annual Update Factor to hospitals that are considered outliers relative to their Approved Revenue and TCOC performance. This is intended to put hospitals on a path towards converging with their peers. Once hospitals can reduce their Integrated Efficiency penalty by investing in population health, Staff expect hospitals to begin redirecting their retained revenue into population health interventions. However, the magnitude of these Integrated Efficiency cuts is relatively small and therefore the speed of convergence is relatively slow.

Additionally, there are some hospitals that have not generated retained revenues under the model. Staff are concerned that these hospitals have not kept up with the rest of the State in removing low-value hospital utilization. Failing to reduce utilization has two consequences: 1) it makes it more difficult to achieve the statewide savings targets; and 2) it limits the amount of revenues available to invest in the population health of their communities.

In order to speed the reinvestment of hospital's retained revenue into population health, Staff recommend reducing hospital's GBR by 50% of that hospitals retained revenue or by 1% of a hospital's qualifying revenues, whichever is larger. Staff recommend hospitals spend at least 1% of their qualifying revenues on population because this is the 75th percentile of statewide retained revenues. Staff believe that the 75th percentile of utilization reductions are feasible for all hospitals.

However, Staff recognize that some types of utilization are more difficult to avoid than other types of utilization. Staff recognize that the expected population health be applied to hospital revenues excepting for innovation (as defined by the innovation policy), categorical exclusions (transplants, etc.), and transfers. These types of cases are not expected to be avoided and thus will not contribute to retained revenues. For example, if a hospital's GBR is $1 billion but $200 million is associated with categorical exclusions, transfers, etc., then the hospital would be expected to spend 1% of only $800 in revenues.

Staff recommend beginning this systematic spend down in RY 2025 because some time is needed for both hospitals and the HSCRC to determine which population health investments qualify for inclusion. Further, hospitals that have under invested in population health can use the time to redirect their retained revenue.

Qualifying Population Health Investments

As discussed above, Staff recommend exempting population health spending from the integrated efficiency adjustment and the GBR spenddown. However, a clear and universal definition of population health investment does not exist. Therefore, Staff recommend establishing clear criteria for what qualifies for inclusion in the Revenue for Reform policy.

Staff recommend that any spending, net of offsetting revenue for that activity, that meets the criteria offset the hospitals integrated efficiency adjustment, provided that it does not exceed the hospitals regulated margin. Spending in excess of the regulated margin would indicate an unsustainable investment and should not be encouraged. Moreover, it would render the Commission's ICC assessment meaningless, as revenue associated with regulated hospital costs would be earmarked as population health investments.

Staff recommend that all qualifying spending be included in the Revenue for Reform policy but that future policies examine the relative efficiency of the population health investments. Staff do not believe that sufficient information is available to set targets on the expected impact of the hospital's population health investments. However, it is important to ensure that hospitals are accountable for actual improvements in population health, not just monetary expenditures. Once the hospitals' population health investments are cataloged, future policies should compare the relative effectiveness of similar population investments and established outcomes targets for population health interventions.

Staff recommend that all population health investments should meet the following three criteria:

1. The investment must take place outside of the hospital itself. Activities that take place within the hospital are most likely targeted at patients currently in the hospital. These costs should be treated as part of the hospital's cost of a hospitalization and should not be safe harbored. For example, hospital-based care management programs are valuable but are part of the routine cost of a hospitalization and should be included in the evaluation of the hospital's cost per case. An intervention is considered to be 'outside of the hospital' if services are provided to beneficiaries off of the hospital's campus, even if the intervention is deployed from the hospital. For example, a mobile integrated health program that treats patients at home would qualify even if the program's base of operations was in the hospital itself.
2. The investment must be on a non-physician cost (with the exception of the physician safe harbor below). Physician costs are obviously a critical component of many population health

interventions. However, most physician services are reimbursed for the services they provide. The reimbursement rate does not always exceed the cost of providing those services and health systems may need to invest in physician practices in order to develop a comprehensive strategy for managing the total cost of care. However, hospitals also spend money on physician practices for regular business reasons. Staff do not believe that there is an easy way to distinguish a 'business investment' from a 'population health investment.' Therefore, staff recommend excluding physician costs.[3] For this purpose, physician costs will be excluded if they are billing payers for services that they provide. If the staff of a program happen to be physicians but do not bill payers for services, their costs may be included.

3. The investment must be primarily serving people who live within the hospital's primary service area. This will ensure that the retained revenues are retained in the community itself and not just the hospital. Investments that are made in an area outside of the hospital's service area are presumably made for other purposes – such as promoting the health system in an area with a more favorable payer mix – than the health of the hospital's community. Exceptions may be made but would face a higher bar (described in the catch all safe harbor below).

The criteria above are intended to ensure that qualifying investments are based in the community and are not part of the hospital's routine business operations. In order to ensure that community-based investments are spent on population health, Staff recommends that the spending must fall into one of the following three safe harbor categories.

Community Health Safe Harbor

In order to ensure that the hospital's interventions are intended to improve the health of its community, the intervention must be 'reasonably related' to a community health need identified on one of the following:

- An unmet need included on the Community Health Needs Assessment (CHNA). Hospitals are required to conduct a CHNA once every three years in which they: 1) assess the health of their community; and 2) identify the significant health needs of their community. In conducting the CHNA, hospitals must work collaboratively with members of their community and establish an implementation strategy that describes how the hospital intends to address each health need (or explains why they do not intend to address that

[3] Staff believe that integrating non-hospital providers into the Model should be a high priority for the commission. But alternative policies, such as developing capitation-like arrangements for health system would be a more productive avenue.

need). Since hospitals are already required to establish an implementation plan for addressing the needs of the community, Staff believe spending on community health should be limited to needs on the CHNA.

- A need identified by the Centers for Disease Control and Prevention (CDC)'s Healthy People 2030 initiative. The CDC establishes national population health priorities; essentially, this is a community health needs assessment for the entire country. Staff believe that hospitals should be allowed to invest in the national health priorities, even if their local community did not address or identify a particular health need.

Staff recommend that hospitals be required to describe their interventions and justify how the intervention is intended to impact one of the community or national health needs. Staff will assess whether the intervention is reasonably related to the community health need identified by the hospital. If the Staff does not believe the intervention to be reasonably related to an identified community health need, then the costs of the intervention will not qualify. Staff recommend that only direct costs of patient care be included, but that a 25% overhead be included in the credit that the hospital receives.

Physician Spending Safe Harbor

Staff recommend that hospitals be allowed to subsidize physicians in areas that do not have sufficient access. Hospitals may invest in primary care, mental health, or dental providers in areas that the Agency for Health Care Research and Quality (AHRQ) has identified as a Medically Underserved Area. These are areas that have fewer physicians per capita than would be expected, adjusted for the percent of the population living below the poverty rate, the percent of the population that is older than 65, and the infant mortality rate. Spending on specialists other than primary care, mental health, or dental providers would not be allowed and spending on those specialties outside of Medically Underserved Areas would not be allowed. Staff recommend that only direct costs of patient care be included, but that a 25% overhead be included in the credit that the hospital receives.

Regional Entity Safe Harbor

Staff expect the majority of the hospital's interventions to fall within one of the two safe harbors described above. However, there may be cases where it is advantageous for hospitals that have

overlapping service areas and community health needs to leverage their resources and partner with other organizations to solve regional population health issues.

Staff recommend allowing hospitals to form a regional entity to develop population health partnerships, strengthen population health infrastructure, and improve community health outcomes. The regional entity will comprise multiple hospitals and one or more community partners. The community partner must be an organization that has an established presence in the region and has the capacity to implement population health interventions or to scale existing interventions. Interventions and spending are not restricted to CHNA focus areas. The community partner should also be located in the primary service area of the regional entity, demonstrate a commitment to improving population health in the region, and can attest to strong performance in improving health outcomes for the targeted populations.

Hospitals must demonstrate that community partners have a credible governance structure and commitment to community health objectives. The Regional Entity will propose a board of directors which will oversee the business and affairs of the entity and have the authority to establish policies and regulations for the management and operation of the Regional Entity and its programs, initiatives, and services. A majority of the board must be unaffiliated with the hospital entity and a majority of the board members must have demonstrated public health knowledge and experience. The board of directors must also include two community members who are one of the following: 1) A member of the local Health Improvement Coalition or Health Department; 2) A long-term resident of the community; 3) A member of the target population; 4) Members approved by the HSCRC. The hospitals must propose an executive director who is not otherwise an employee of a hospital in the state of Maryland; and is a demonstrated expert in public, population, or community health.

Staff recommend that hospitals submit a governance structure and staff planning to the HSCRC. HSCRC will review and approve or reject the board composition, prior to approving any safe harbors. The hospitals must submit any change in board composition to the HSCRC for review and approval. Staff also recommend that hospitals be required to describe their interventions and justify how the intervention is intended to impact population health in the region. If Staff does not believe the population health intervention can be reasonably implemented and improve population health outcomes, then the costs of the intervention will not qualify. Hospitals must submit their

budget (including the programs and community health focus areas) to the HSCRC annually for review, along with the proposed safe harbor amounts.

Additionally, staff recommend that hospitals which contribute to a revenue entity be given credit for the additional indirect costs. Staff recommend that the hospitals safe harbor be equal to 135% of the direct, rather than 125% of the direct costs as in the other two safe harbor.

Approval Process for Hospital Safe Harbors

Staff recommend that the Revenue for Reform policy be implemented as follows:

1. In July of 2022, staff will release an application template for hospitals to complete. This will include a list of the hospital's interventions, which safe harbor they are applying for, and the amount of losses that they expect to incur over the following fiscal year on that intervention.
2. By October 2022, staff will review the submissions and determine which interventions meet the requirements of the Revenue for Reform policy, described here. The cost of the approved interventions will be used to reduce any Integrated Efficiency Adjustment based on each ICC run. This will determine which hospitals are subject to the Integrated Efficiency cut in the Rate Year 2023 and 2024.
3. In the fall of 2023, hospitals will be required to submit a budget describing the costs actually incurred on their approved population health interventions. Staff believe that it is important to ensure hospitals meet their promised population health spending.

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Rate Year 2023 Uncompensated Care Policy

June 8, 2022

Prudence Akindo — Chief, Financial Methodologies (CPBM)

What is Uncompensated Care (UCC) in Maryland?

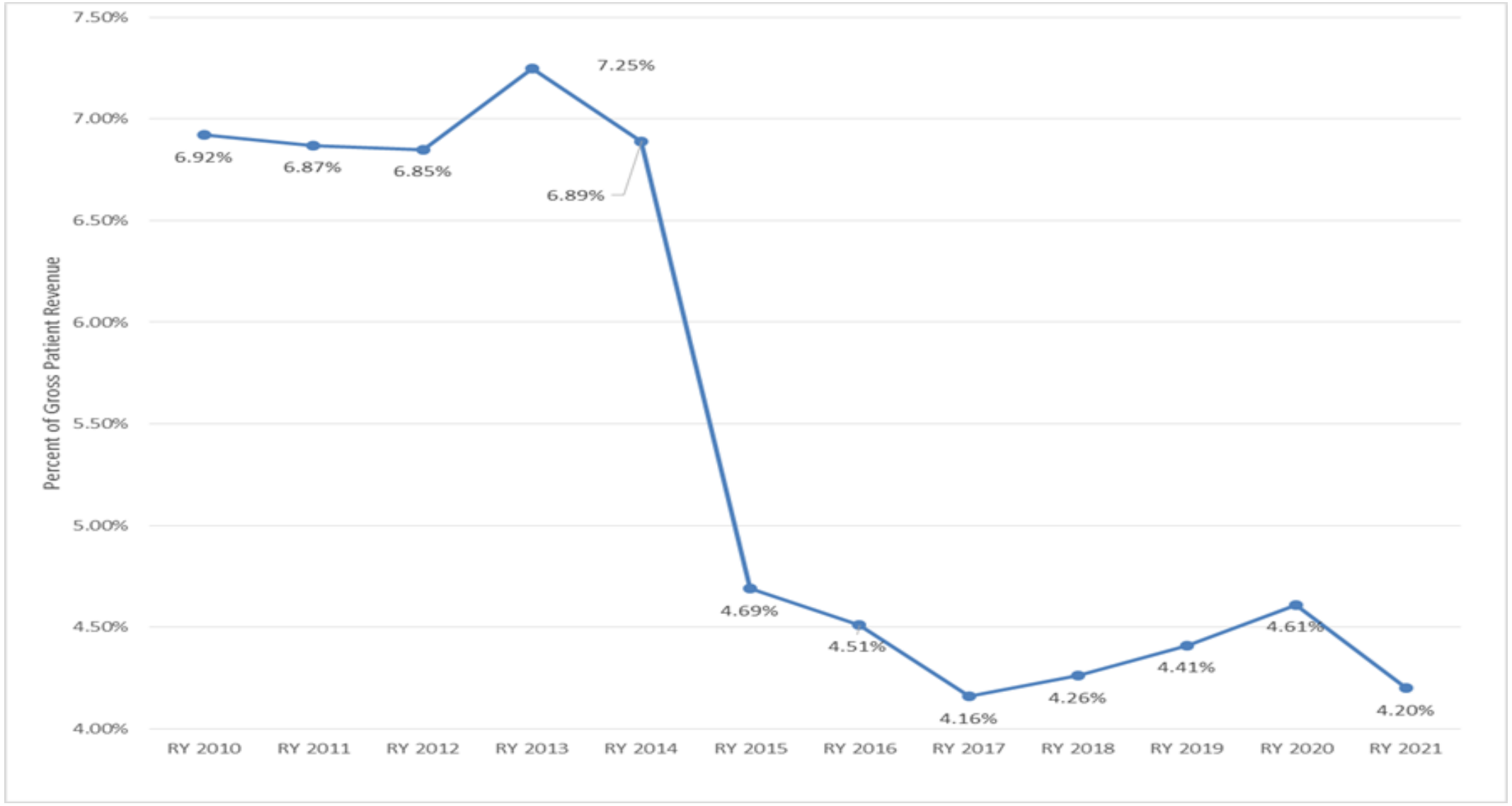
- Uncompensated Care (UCC) includes bad debt and charity care
- Funding is determined prospectively in rates
  - Based on the prior year's actual statewide experience
  - Redistribution of uncompensated care funding is based on hospital prior year actual and predicted levels of uncompensated care
- By recognizing reasonable levels of bad debt and charity care in hospital rates:
  - The State enhances access to hospital services for patients who otherwise, cannot afford to pay for them; and
  - Hospitals equally share the burden of uncompensated care

Results of the Model

- The RY 2023 Statewide UCC amount that will be built into rates is 4.20 percent, which is the equivalent of the RY 2021 Actual UCC and not dissimilar from prior years, e.g. RY 2017 was 4.16 percent

- Under the current HSCRC policy, UCC above the statewide average is funded by a statewide pooling system. 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
  - For RY 2023, 26 hospitals are expected to withdraw from the pool, while 17 will be expected to pay into the pool

Actual Statewide UCC in Rates (RY 2010 – RY 2021)



RY 2021 Decrease in UCC

- RY2021 decline in statewide UCC is largely driven by significant declines in ED utilization by commercial patients (52 percent among patients that had a write-off; the highest among major payer types)

	CHARITY/SELF PAY			COMMERCIAL			MEDICAID			MEDICARE			OTHER		
Site of Service	**% Change FY18-19**	**% Change FY19-20**	**% Change FY20-21**	**% Change FY18-19**	**% Change FY19-20**	**% Change FY20-21**	**% Change FY18-19**	**% Change FY19-20**	**% Change FY20-21**	**% Change FY18-19**	**% Change FY19-20**	**% Change FY20-21**	**% Change FY18-19**	**% Change FY19-20**	**% Change FY20-21**
ED	7.97%	-9.63%	-42.24%	-8.51%	-20.56%	-52.03%	9.68%	-9.36%	-31.93%	-5.24%	-17.65%	-35.22%	7.14%	-8.64%	-64.41%
IP	34.99%	2.55%	-11.65%	-6.70%	-11.73%	-24.91%	0.51%	4.21%	-45.53%	-0.95%	-1.99%	-26.23%	12.86%	0.52%	-30.77%
OP	32.64%	-1.90%	-11.92%	-7.98%	-22.24%	-19.89%	14.34%	-26.23%	-19.30%	-10.65%	-21.03%	-26.86%	-30.61%	-6.35%	-42.15%
Grand Total	**16.57%**	**-6.61%**	**-29.51%**	**-8.15%**	**-20.41%**	**-35.42%**	**9.45%**	**-9.59%**	**-31.82%**	**-7.37%**	**-16.74%**	**-29.54%**	**-4.91%**	**-7.16%**	**-53.32%**

- Staff predicts that this trend will continue into the RY2022 and RY 2023 UCC Policy calculations due to
  - Reduced ED utilization; and
  - The protections put in place by the state to ensure coverage and patient access to care, most notably through the suspension of Medicaid eligibility redeterminations

- If UCC normalizes and trends back upwards, future iterations of the UCC policy will provide an enhanced UCC markup in rates in line with the most recent UCC actual, as per the design of the policy

Future Considerations

- Staff is evaluating the possibility of using multi-year actual UCC averages in lieu of the one year figures to do the 50/50 blend
  - Using multiple years of history will make the statistic more stable, especially as the effects of the Affordable Care Act implementation appear to have dissipated
  - Staff also believes that the use of multi-year averages will help control for anomalies, such as the effects of Covid-19 on hospital Utilization

- Staff is considering this change for the RY 2024 UCC Policy, upon stakeholder input and commission approval

Appendix

The UCC Methodology

Multi step process which includes:

1. Statewide Actual UCC in All-Payer Hospital Rates

   Determining the statewide actual UCC based on the prior year's bad debt and charity care as reported on the Revenue and Expense (RE) Schedules

2. Hospital Distribution to/from UCC Fund

   The UCC Fund is used to redistribute funds from hospitals with lower rates of UCC to hospitals with higher rates of UCC. Steps to calculate each hospital's UCC payment is as follows:

   i. Hospital-Specific Actual UCC

      Using gross patient revenue, bad debt and charity as reported on the hospitals' annual financial filings for the previous year, an actual UCC Value is determined for each hospital

   ii. Hospital-Specific Predicted UCC

      Using a logistic regression model to predict a patient's chance of having UCC based on the area deprivation index (ADI), payer type, and site of service, a predicted value of UCC is produced for each hospital

   iii. Blended Actual and Predicted UCC

      Blending half of the Actual UCC (from step 2(i)) and half of the Predicted UCC (from step 2(ii)), the UCC percent is determined for each hospital

   iv. Determining hospital contribution/withdrawals

      Hospitals draw funds from the pool should they experience UCC greater than the statewide average and pay into the pool should they experience UCC lesser than the statewide average

Rate Year 2023 Uncompensated Care Report

June 8, 2022

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 2023 Uncompensated Care Policy. There are no proposed changes in methodology and thus no need for a formal Commission vote at this time.

Table of Contents

INTRODUCTION

Recognizing the financial burden hospitals take on when providing quality care to patients who cannot pay for it, the HSCRC factors in the cost of Uncompensated Care (UCC) into the rates the Commission sets for hospitals.[1] 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 amount of funding that will be made available for the UCC pool, the latter of which ensures the burden of uncompensated care is shared equitably across all hospitals.

Uncompensated Care (UCC) is hospital care provided for which no compensation is received, typically a combination of charity care and bad debt.

Charity Care

Charity care services are "those Commission regulated services rendered for which payment is not anticipated".[2] Charity care is provided to patients who lack health care coverage or whose health care coverage does not pay the full cost of the hospital bill. There are two types of charity care that may occur across all payers:

1. **Free care** is care for which the patient is not responsible for any out-of-pocket expenses for hospital care. Hospitals are required statutorily to provide free care to patients with a household income less than 200% of the FPL.[3]
2. **Reduced-cost care** is care for which the patient is only responsible for a portion of out-of-pocket expenses and is required for patients with household income between 200 and 300% of the FPL.[4] Reduced-cost care is also required for patients that have a financial hardship[5] and have household incomes below 500% of the FPL. Financial hardship is defined by statute as medical debt, incurred by a household over a 12-month period, which exceeds 25% of household income.[6] There is no prescribed discount that hospitals must provide to patients between 200% and 500% of the FPL. Per statute "if a patient is eligible for reduced-cost medically necessary care, the hospital shall apply the reduction that is most favorable to the patient."[7]

Bad Debt

The other type of Hospital UCC is bad debt, which is for "Commission regulated services rendered for which payment is anticipated and credit is extended to the patient" but the payment is not made. Unpaid cost share for patients that do not meet the free thresholds can be charged as bad debt after the hospital makes a reasonable attempt to collect those charges.[8] However, there

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[1] Maryland has a unique all-payer rate setting system for hospitals, administered by the HSCRC. Acute general hospitals in Maryland must charge patients (and insurers) the rate set by the HSCRC for health care services.

[2] HSCRC Accounting and Budget Manual Section 100, "Accounting Principles and Concepts", p. 39, August 2008, Available at: https://hscrc.maryland.gov/Documents/Hospitals/Compliance/AccountingBudgetManual/2018/SECTION-100-FINAL-08-01-10.pdf

[3] Md. Code, § 19-214.1(b)(2) (i) of the Health General Article

[4] COMAR 10.37.10.26 A-2 (2)(a)(ii)

[5] Md. Code, § 19-214.1(a)(2) of the Health General Article

[6] Md. Code, § 19-214.1(b)(4) of the Health General Article

[7] Md. Code, § 19-214.1(b)(5) of the Health General Article

[8] Bad debt includes unpaid cost share expenses reduced by a reduced-cost care discount for patients eligible for reduced-cost care. The HSCRC requires hospitals to make "a reasonable collection effort" before writing-off bad debt. HSCRC Accounting and Budget Manual Section 100, "Accounting Principles and Concepts", p. 39, August 2008, Available at:

are several reasons that a hospital may not include bad debts into uncompensated care, most notably denials.[9]

HSCRC's UCC policy assures access to hospital services in the State for those patients who cannot readily pay for them and equitably distributes the burden of uncompensated care costs across all hospitals and all payers. This approach ensures that hospitals with high volumes of low-income patients are not at a financial disadvantage.

For RY 2023, the determined UCC amount to be built into rates for Maryland hospitals is 4.20 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 UCC methodology is a cornerstone of the HSCRC's all payer system. In addition to equitably supporting financial assistance for low income patients, the policy incentivizes hospitals to responsibly collect payments from patients and payers who can afford to pay. This prevents UCC costs from rising too quickly, protecting the sustainability of the UCC fund, which in turn ensures that UCC funding remains available for those who truly need it while constraining growth of health care rates for all patients and payers.[10]

The HSCRC prospectively calculates the amount of uncompensated care provided in hospital rates at each regulated Maryland hospital using a multi-step process:

1. **Statewide Actual UCC in All-Payer Hospital Rates:** HSCRC builds UCC funding into hospital rates based on the total amount of charity care and bad debt reported by all acute hospitals for the previously completed fiscal year. The UCC markup to hospital rates is based on statewide actual UCC, expressed as a percent of gross patient revenue, and is applied uniformly to acute care hospital rates statewide. For example, in RY 2023,

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https://hscrc.maryland.gov/Documents/Hospitals/Compliance/AccountingBudgetManual/2018/SECTION-100-FINAL-08-01-10.pdf

[9] These include: a) Contractual allowances and adjustments associated with Commission approved differentials—i.e., prompt payment, SAAC, and the differential granted to Medicare and Medicaid.; b) Administrative, Courtesy and Policy Discounts and Adjustments - These include, but are not limited to, reductions from established rates for courtesy discounts, employee discounts, administrative decision discounts, discounts to patients not meeting charity policy guidelines, undocumented charges and, payments for services denied by third party payers; c) Charges for medically unnecessary hospital services;). Charges written off that are not the result of a patient's inability to pay or where the hospital has not expended a reasonable collection effort - 08/01/08 SECTION 100 ACCOUNTING PRINCIPLES AND CONCEPTS I

[10] Other states have struggled to maintain sustainable uncompensated care funds. One example is New Jersey. H S Berliner, S Delgado, "The rise and fall of New Jersey's uncompensated care fund", J Am Health Policy. Sep-Oct 1991;1(2):47-50. https://pubmed.ncbi.nlm.nih.gov/10112731/.

HSCRC staff will use RY 2021 statewide UCC experience of 4.20 percent to determine the UCC amount built into all hospital rates.

2. **Hospital Payments or Contributions to the UCC Fund**
   The UCC Fund is used to redistribute funds from hospitals with lower rates of UCC to hospitals with higher rates of UCC.

   i. **Hospital-Specific Actual UCC:** HSCRC uses gross patient revenue as reported on the hospitals' annual financial filings for the previous year to determine the hospital-specific actual UCC for each hospital[11]. (See Appendix II).

   ii. **Hospital-Specific Predicted UCC:** This step involves use of a logistic regression model to predict the UCC. HSCRC allows a 9-month runout period for charity care and bad debt Write-Off reporting. This means hospitals have 9 months from the end of a fiscal year to report charity care and bad debt that occurred in that fiscal year in their Write-Off data submissions to the Commission. HSCRC then uses that amount to predict the UCC amount built into hospital rates for the next fiscal year using area deprivation Index (ADI),[12] payer type, and site of care as independent variables in the logistic regression. 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. Incorporating predicted UCC into the methodology provides hospitals with a financial incentive to collect payments so that UCC does not rise too quickly and UCC funds remain available for those who truly need it. Because UCC is paid by patients and insurers through rates, uncontrolled increases in UCC could increase hospital rates for everyone.

   iii. **Blended Actual and Predicted UCC:** The HSCRC calculates a 50/50 blend between the hospital-specific actual UCC (described in step i) and the hospital-specific predicted UCC (described in step ii). All individual hospital values for payment or withdrawal from the UCC Fund are then normalized to ensure that the UCC fund is redistributive in nature. (See Appendix I).

   iv. **Determining hospital contribution/withdrawals:** The 50/50 blend (step iii) for each hospital is subtracted from the amount of state-wide actual UCC funding provided in rates (step 1) and multiplied by the hospital's global budget revenue (GBR) to determine how much each hospital will either withdraw from or pay into the statewide UCC Fund. The Fund is the mechanism through which HSCRC ensures the burden of uncompensated care is shared by all hospitals. Specifically, if a hospital's 50/50 blend is less than the statewide average UCC rate (determined in step 1), the hospital will pay into the UCC Fund. Conversely, if a

[11] Before ACA, HSCRC based the Actual UCC included in pool funding calculations on a 3-year rolling average. This smooths the year over year hospital-specific changes in UCC. In anticipation of large decreases in UCC in 2014, HSCRC adjusted their policy to use 1 year of data, to avoid carrying over higher UCC amounts

[12] "The Area Deprivation Index ...allows for rankings of neighborhoods by socioeconomic disadvantage in a region of interest …. including] factors for...income, education, employment, and housing quality." https://www.neighborhoodatlas.medicine.wisc.edu/

hospital's 50/50 blend is greater than the statewide average UCC rate, the hospital will withdraw from the Fund.

Exhibit 1: UCC Methodology Example ($ Millions)

		Step 1		Step 2 (i)	Step 2 (ii)	Step 2 (iii)	Step 2 (iv)
	A	B	C = A X B	D	E	F = Avg D & E	G = (F-B) X A
	GBR	**Prior Year Statewide UCC Rate**	**UCC Funding Provided in Rates**	**Prior Year Hospital-Specific UCC Rate**	**Predicted Hospital-specific UCC Rate**	**Hospital-Specific 50/50 Blend**	**(Payment) or Withdrawal from UCC Fund**
Hospital A	$300	5%	$15	3%	4%	3.50%	($4.50)
Hospital B	$300	5%	$15	7%	6%	6.50%	$4.50

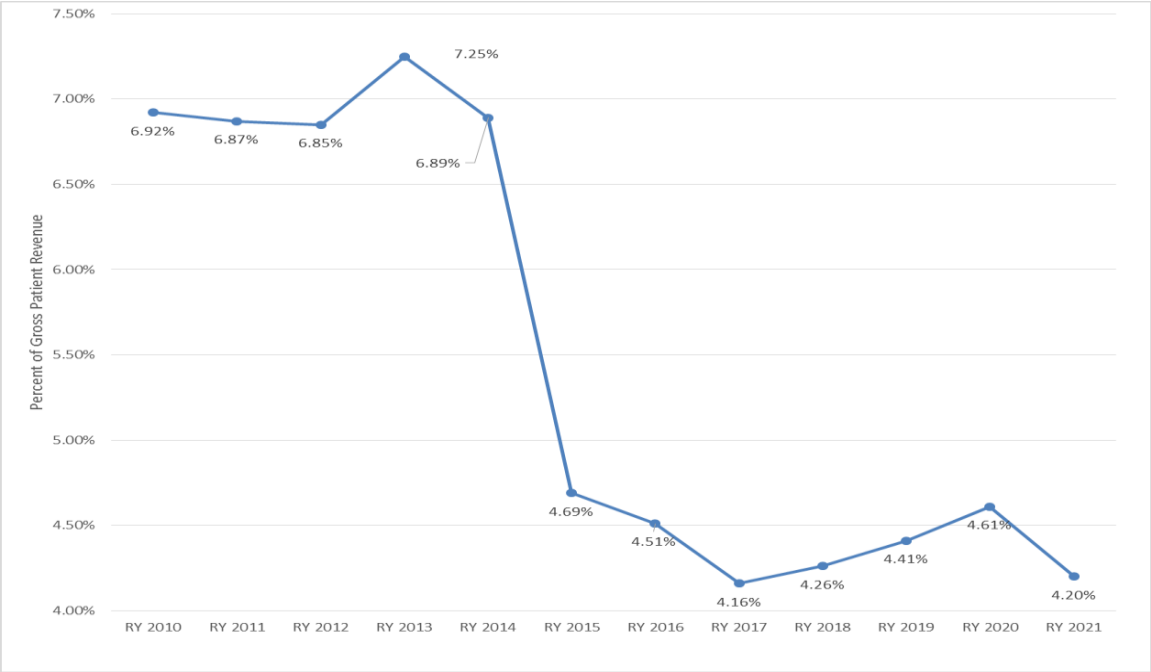
ASSESSMENT

Based on RY 2021 audited reports, the HSCRC has determined that the percentage of UCC to incorporate in hospitals' rates in order to fund the UCC pool is 4.20 percent, 0.41 percentage points lower than last year's UCC rate of 4.61 percent. The graph below shows the changes in Actual Statewide UCC incorporated in hospital rates since RY 2010. 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.[13] Based on the Census Bureau's American Community Survey, Kaiser Family Foundation estimates Maryland's uninsured rate to have decreased to 5.9 percent as of 2019;[14] however, as the RY17 to RY20 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 dissipated.

[13] http://www.marylandhbe.com/fewer-marylanders-without-health-coverage-census-bureau-reports/

[14] 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

Exhibit 2: Actual Statewide UCC in Rates (RY 2010 – RY 2021)



Additional analyses indicate that the RY2021 decline in statewide UCC is driven in part by significant statewide declines in hospital utilization most likely to result in UCC; with declines in ED utilization being the biggest driver (See Exhibit 3 and 4 below). The HSCRC's model to predict UCC is based on the patients' payer type, ADI and site of service, and the probability of a patient subsequently deemed as having UCC is historically highest amongst commercial patients presenting though the ED. Thus, the significant declines in ED utilization by commercial patients having a write-off to UCC (52 percent; the highest among major payer types) subsequently results in declines in UCC and reduces the ED utilization's share of total hospital services resulting in UCC. With the ongoing effects of the pandemic still looming, most notably reduced ED utilization, and the protections put in place by the state to ensure coverage and patient access to care, most notably through the suspension of Medicaid eligibility redeterminations, staff predicts that this trend will continue into the RY2022 and RY 2023 UCC Policy calculations. If UCC normalizes and trends back upwards, future iterations of the UCC policy will provide an enhanced UCC markup in rates in line with the most recent UCC actual, as per the design of the policy.

Exhibit 3: Percent Change from FY18 – FY21 by Site of Service and Payer for Patients with Write-Off to UCC

	CHARITY/SELF PAY			COMMERCIAL			MEDICAID			MEDICARE			OTHER		
Site of Service	**% Change FY18-19**	**% Change FY19-20**	**% Change FY20-21**	**% Change FY18-19**	**% Change FY19-20**	**% Change FY20-21**	**% Change FY18-19**	**% Change FY19-20**	**% Change FY20-21**	**% Change FY18-19**	**% Change FY19-20**	**% Change FY20-21**	**% Change FY18-19**	**% Change FY19-20**	**% Change FY20-21**
ED	7.97%	-9.63%	-42.24%	-8.51%	-20.56%	-52.03%	9.68%	-9.36%	-31.93%	-5.24%	-17.65%	-35.22%	7.14%	-8.64%	-64.41%
IP	34.99%	2.55%	-11.65%	-6.70%	-11.73%	-24.91%	0.51%	4.21%	-45.53%	-0.95%	-1.99%	-26.23%	12.86%	0.52%	-30.77%
OP	32.64%	-1.90%	-11.92%	-7.98%	-22.24%	-19.89%	14.34%	-26.23%	-19.30%	-10.65%	-21.03%	-26.86%	-30.61%	-6.35%	-42.15%
Grand Total	16.57%	-6.61%	-29.51%	-8.15%	-20.41%	-35.42%	9.45%	-9.59%	-31.82%	-7.37%	-16.74%	-29.54%	-4.91%	-7.16%	-53.32%

Exhibit 4: Site of Service Shares for Patients with Write-Off to UCC

Site of Service	RY 2018	RY 2019	RY 2020	RY 2021
ED	54.3%	54.5%	54.4%	50.2%
IP	8.6%	8.8%	9.6%	10.2%
OP	37.1%	36.8%	36.0%	39.6%

IMPLEMENTATION

Based on the preceding analysis, HSCRC staff will implement the following for RY 2023:

1. Decrease the statewide UCC provision in rates from 4.61% to 4.20% effective July 1, 2022.
2. Continue to use the regression modeling approach approved by the Commission at the June 2016 meeting.
3. Continue to do 50/50 blend of RY2021 audited UCC levels and RY2021 predicted UCC levels to determine hospital-specific adjustments for the UCC Fund.

COVID-19 IMPLICATIONS

In CY 2020, 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 dissipated. Staff also believes that the use of multi-year averages will help control for anomalies such as the effects of Covid-19 on hospital Utilization. Staff however has halted further work on this and other policy development to allow the hospitals sufficient bandwidth to respond to the pandemic. Staff plans to resume evaluation of the multi-year blend on actuals for the RY 2024 UCC policy.

Staff was also concerned about the impact of COVID-19 on the RY2021 Write-off data used to predict RY 2023 UCC. To ensure that the data was reliable and accurate, staff performed various statistical and trend analyses on the data and found that the data is significantly correlated to data used in prior year UCC calculations, thereby suggesting the data is reliable. (See appendix III).

Staff will also like to acknowledge that while specialty care sites were opened to handle added volumes brought on by COVID-19 at the height of the pandemic, such as Laurel Hospital and The Baltimore Convention Center, these sites of care are not included with current UCC calculations, as the UCC borne by these facilities are covered by the State and these facilities will not continue to operate in the capacity they did during the public health emergency.

Appendix I. Hospital Uncompensated Care Provision for RY 2023

HOSPID	HOSPNAME	FY2022 GBR Permanent Revenue	FY 2021 UCC Based on FY 2022 GBR Permanent Revenue	FY 2021 Percent UCC from the RE Schedule	Percent Predicted UCC (Adjusted)	Predicted UCC Amounts (Based on FY 2022 GBR Permanent Revenue)	50/50 Blend Percent	50/50 Blend Adjusted to FY 2021 UCC Based on FY 2022 GBR Permanent Revenue Level	Percent UCC
210001	Meritus Medical Cntr	$414,702,125	$ 20,651,004	4.98%	4.86%	$ 20,162,634	4.92%	$ 22,921,540	**5.53%**
210002	UMMC	$1,762,263,450	$ 67,865,990	3.85%	2.51%	$ 44,306,079	3.18%	$ 62,997,485	**3.57%**
210003	UM-Prince George's Hospital	$360,327,339	$ 37,867,023	10.51%	4.93%	$ 17,750,048	7.72%	$ 31,235,366	**8.67%**
210004	Holy Cross	$566,608,070	$ 39,504,563	6.97%	4.81%	$ 27,235,202	5.89%	$ 37,482,034	**6.62%**
210005	Frederick Memorial	$378,562,405	$ 15,963,062	4.22%	3.31%	$ 12,545,894	3.77%	$ 16,011,049	**4.23%**
210006	UM-Harford Memorial	$113,970,044	$ 7,325,922	6.43%	3.39%	$ 3,867,974	4.91%	$ 6,286,657	**5.52%**
210008	Mercy Medical Cntr	$620,468,373	$ 29,031,401	4.68%	3.35%	$ 20,776,792	4.01%	$ 27,973,014	**4.51%**
210009	Johns Hopkins	$2,798,682,521	$ 65,233,712	2.33%	2.52%	$ 70,630,416	2.43%	$ 76,303,294	**2.73%**
210010	UM-SRH at Dorchester	$20,791,578	$ 1,480,641	7.12%	6.29%	$ 1,306,959	6.70%	$ 1,565,557	**7.53%**
210011	St. Agnes Hospital	$469,325,568	$ 20,640,411	4.40%	5.50%	$ 25,822,761	4.95%	$ 26,094,401	**5.56%**
210012	Sinai Hospital	$917,237,944	$ 30,265,551	3.30%	3.05%	$ 27,944,338	3.17%	$ 32,691,531	**3.56%**
210015	MedStar Franklin Square	$611,317,028	$ 20,110,400	3.29%	3.19%	$ 19,516,057	3.24%	$ 22,254,802	**3.64%**
210016	Washington Adventist Hospital	$321,314,660	$ 24,245,108	7.55%	3.49%	$ 11,218,111	5.52%	$ 19,916,666	**6.20%**
210017	Garrett Co Memorial	$70,456,150	$ 4,315,701	6.13%	6.13%	$ 4,319,463	6.13%	$ 4,849,636	**6.88%**
210018	MedStar Montgomery	$190,272,080	$ 7,491,143	3.94%	1.78%	$ 3,386,671	2.86%	$ 6,109,140	**3.21%**
210019	Peninsula Regional	$502,552,923	$ 18,099,584	3.60%	4.64%	$ 23,342,162	4.01%	$ 23,274,294	**4.63%**
210022	Suburban	$376,087,520	$ 14,298,615	3.80%	1.57%	$ 5,922,584	2.69%	$ 11,356,523	**3.02%**
210023	Anne Arundel Medical Cntr	$706,611,415	$ 18,069,162	2.56%	1.90%	$ 13,392,344	2.23%	$ 17,669,245	**2.50%**
210024	MedStar Union Memorial	$455,550,559	$ 13,719,467	3.01%	3.53%	$ 16,096,954	3.27%	$ 16,745,341	**3.68%**
210027	Western Maryland	$442,114,709	$ 19,658,351	4.45%	6.31%	$ 27,887,291	5.38%	$ 26,702,333	**6.04%**
210028	MedStar St. Mary's	$198,569,196	$ 5,867,698	2.95%	2.28%	$ 4,522,814	2.62%	$ 5,835,465	**2.94%**
210029	JH Bayview	$760,736,567	$ 34,155,762	4.49%	4.30%	$ 32,717,834	4.40%	$ 37,557,196	**4.94%**
210030	UM-SRH at Chestertown	$55,479,928	$ 3,276,629	5.91%	3.51%	$ 1,947,173	4.71%	$ 2,933,764	**5.29%**

210032	Union Hospital of Cecil Co	$176,995,571	$ 11,548,612	6.52%	3.23%	$ 5,708,465	4.88%	$ 9,691,829	**5.48%**
210033	Carroll Co Hospital Cntr	$249,918,479	$ 7,987,395	3.20%	2.26%	$ 5,654,440	2.73%	$ 7,661,455	**3.07%**
210034	MedStar Harbor Hospital Cntr	$205,614,800	$ 8,075,101	3.93%	4.70%	$ 9,668,532	4.31%	$ 9,965,085	**4.85%**
210035	UM-Charles Regional	$165,219,509	$ 10,019,384	6.06%	3.35%	$ 5,543,033	4.71%	$ 8,740,082	**5.29%**
210037	UM-SRH at Easton	$255,848,352	$ 9,574,657	3.74%	2.70%	$ 6,895,702	3.22%	$ 9,249,996	**3.62%**
210038	UMMC - Midtown	$341,725,972	$ 17,258,289	5.05%	3.97%	$ 13,577,472	4.51%	$ 17,317,817	**5.07%**
210039	Calvert Health Med Cntr	$164,614,286	$ 4,137,092	2.51%	1.95%	$ 3,208,087	2.23%	$ 4,125,161	**2.51%**
210040	Northwest Hospital Cntr	$289,860,605	$ 14,885,928	5.14%	3.76%	$ 10,890,287	4.45%	$ 14,476,302	**4.99%**
210043	UM-BWMC	$480,654,281	$ 26,315,560	5.47%	2.50%	$ 12,002,672	3.99%	$ 21,520,083	**4.48%**
210044	GBMC	$490,075,990	$ 15,896,550	3.24%	2.29%	$ 11,225,955	2.77%	$ 15,232,398	**3.11%**
210048	Howard County General	$331,665,468	$ 14,650,318	4.42%	2.21%	$ 7,337,433	3.31%	$ 12,348,645	**3.72%**
210049	UM-Upper Chesapeake	$343,612,512	$ 19,415,563	5.65%	2.34%	$ 8,033,497	3.99%	$ 15,415,796	**4.49%**
210051	Doctors Community	$278,725,839	$ 13,140,414	4.71%	3.74%	$ 10,425,017	4.23%	$ 13,234,693	**4.75%**
210056	MedStar Good Samaritan	$321,621,636	$ 12,519,934	3.89%	3.93%	$ 12,633,778	3.91%	$ 14,126,695	**4.39%**
210057	Shady Grove Adventist Hospital	$498,926,118	$ 31,254,800	6.26%	3.47%	$ 17,302,774	4.87%	$ 27,270,649	**5.47%**
210060	Fort Washington Medical Center	$61,378,051	$ 4,519,868	7.36%	4.79%	$ 2,942,818	6.08%	$ 4,191,154	**6.83%**
210061	Atlantic General	$116,767,136	$ 4,375,748	3.75%	3.55%	$ 4,140,340	3.65%	$ 4,782,760	**4.10%**
210062	MedStar Southern MD	$295,292,257	$ 13,323,871	4.51%	2.85%	$ 8,406,003	3.68%	$ 12,203,817	**4.13%**
210063	UM-St. Joseph Med Cntr	$418,215,972	$ 15,461,763	3.70%	2.34%	$ 9,768,008	3.02%	$ 14,169,411	**3.39%**
210065	HC-Germantown	$125,846,870	$ 8,424,608	6.69%	5.53%	$ 6,960,533	6.11%	$ 8,640,522	**6.87%**
	Total	**$ 18,726,581,857**	**$ 781,922,352**	**4.17%**	**3.23%**	**$ 608,943,405**	**3.71%**	**$ 781,130,683**	**4.17%**

Note: Levindale, UMROI, and UM-Shock Trauma are not included in this analysis. If included, the actual UCC from RY 2021 RE Schedule would be 4.20%. This rate of 4.20% is what is built into rates.

Appendix II. Actual UCC Summary Statistics

The table below shows the Actual UCC Statewide and by hospital between RY 2021 and RY 2020– it does not reflect predicted UCC rates.

Hospital Name	RY2021 % UCC	RY 2020 % UCC	Variance Over/Under
Meritus Medical Cntr	4.98%	5.19%	-0.21%
UMMC	3.85%	3.91%	-0.06%
UM-Prince George's Hospital	10.51%	8.79%	1.72%
Holy Cross	6.97%	7.95%	-0.98%
Frederick Memorial	4.22%	4.52%	-0.30%
UM-Harford Memorial	6.43%	6.55%	-0.12%
Mercy Medical Cntr	4.68%	5.14%	-0.46%
Johns Hopkins	2.33%	3.04%	-0.71%
UM-SRH at Dorchester	7.12%	6.12%	1.00%
St. Agnes Hospital	4.40%	5.39%	-0.99%
Sinai Hospital	3.30%	4.12%	-0.82%
MedStar Franklin Square	3.29%	3.72%	-0.43%
Washington Adventist	7.55%	6.71%	0.84%
Garrett Co Memorial	6.13%	6.55%	-0.42%
MedStar Montgomery	3.94%	3.69%	0.25%
Peninsula Regional	3.60%	4.13%	-0.53%
Suburban	3.80%	3.95%	-0.15%
Anne Arundel Medical Cntr	2.56%	3.28%	-0.72%
MedStar Union Memorial	3.01%	3.01%	0.00%
Western Maryland	4.45%	4.79%	-0.34%
MedStar St. Mary's	2.95%	3.51%	-0.56%
JH Bayview	4.49%	5.21%	-0.72%
UM-SRH at Chestertown	5.91%	6.15%	-0.24%
Union Hospital of Cecil Co	6.52%	6.02%	0.50%
Carroll Co Hospital Cntr	3.20%	3.48%	-0.28%
MedStar Harbor Hospital Cntr	3.93%	4.97%	-1.04%
UM-Charles Regional	6.06%	6.22%	-0.16%
UM-SRH at Easton	3.74%	3.50%	0.24%
UMMC - Midtown	5.05%	4.45%	0.60%
Calvert Health Med Cntr	2.51%	3.17%	-0.66%
Northwest Hospital Cntr	5.14%	6.52%	-1.38%
UM-BWMC	5.47%	5.72%	-0.25%
GBMC	3.24%	2.93%	0.31%
Howard County General	4.42%	5.24%	-0.82%
UM-Upper Chesapeake	5.65%	6.02%	-0.37%

Doctors Community	4.71%	6.86%	-2.15%
MedStar Good Samaritan	3.89%	4.52%	-0.63%
Shady Grove	6.26%	6.47%	-0.21%
UM-ROI	3.70%	3.95%	-0.25%
FT. Washington	7.36%	7.30%	0.06%
Atlantic General	3.75%	5.64%	-1.89%
MedStar Southern MD	4.51%	4.93%	-0.42%
UM-St. Joseph Med Cntr	3.70%	3.70%	0.00%
Levindale	6.10%	4.80%	1.30%
HC-Germantown	6.69%	8.68%	-1.99%
UM-Shock Trauma	6.20%	6.28%	-0.08%
Total	**4.20%**	**4.61%**	**-0.41%**

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

Appendix III. Write-off Data Analyses

		RY 2021		RY 2020		RY 2019	
HOSPID	**Hospital Name**	**Total Charge**	**PREDICTED UCC**	**Total Charge**	**PREDICTED UCC**	**Total Charge**	**PREDICTED UCC**
210001	Meritus	$ 429,296,231	$ 20,753,055	$ 362,989,191	$ 19,737,440	$ 369,036,976	$ 18,134,597
210002	UMMC	$ 1,680,523,275	$ 42,009,833	$ 1,555,084,757	$ 39,831,911	$ 1,523,304,722	$ 38,806,181
210003	UM-PGHC	$ 342,841,275	$ 16,792,269	$ 341,318,592	$ 25,884,428	$ 324,900,507	$ 23,651,869
210004	Holy Cross	$ 557,655,797	$ 26,651,889	$ 511,271,415	$ 31,506,521	$ 518,520,703	$ 36,298,525
210005	Frederick	$ 382,396,332	$ 12,600,617	$ 359,679,258	$ 17,816,086	$ 352,965,587	$ 18,341,972
210006	UM-Harford	$ 108,950,161	$ 3,676,501	$ 100,457,116	$ 4,082,797	$ 107,480,496	$ 4,624,593
210008	Mercy	$ 619,672,235	$ 20,631,691	$ 548,551,614	$ 21,549,321	$ 553,175,818	$ 21,313,358
210009	Johns Hopkins	$ 2,752,683,753	$ 69,073,011	$ 2,453,860,252	$ 77,749,259	$ 2,460,960,900	$ 74,202,193
210010	UM-Dorchester	$ 37,159,450	$ 2,322,510	$ 38,406,151	$ 1,883,237	$ 45,223,858	$ 2,314,568
210011	St. Agnes	$ 434,651,035	$ 23,778,427	$ 419,501,571	$ 23,171,568	$ 429,347,315	$ 20,409,003
210012	Sinai	$ 890,925,821	$ 26,987,789	$ 818,167,825	$ 29,860,158	$ 786,008,811	$ 27,144,657
210013	Grace Medical center	$ 35,924,820	$ 4,269,837	$ 69,512,240	$ 3,574,000	$ 112,480,475	$ 4,908,287
210015	MedStar Fr Square	$ 604,008,549	$ 19,172,671	$ 588,927,594	$ 21,459,424	$ 555,859,990	$ 20,641,056
210016	Adventist White Oak	$ 339,081,563	$ 11,770,837	$ 305,251,723	$ 15,375,366	$ 283,496,544	$ 18,617,983
210017	Garrett	$ 65,957,527	$ 4,020,585	$ 59,760,227	$ 3,313,803	$ 65,237,466	$ 3,339,540
210018	MedStar Montgomery	$ 189,151,497	$ 3,347,508	$ 184,111,749	$ 6,464,645	$ 179,659,293	$ 6,979,742
210019	Peninsula	$ 505,015,288	$ 23,322,642	$ 457,824,421	$ 20,278,255	$ 456,040,357	$ 19,145,025

210022	Suburban	$ 370,346,576	$ 5,798,886	$ 321,763,218	$ 11,652,972	$ 336,195,043	$ 12,930,829
210023	Anne Arundel	$ 697,354,673	$ 13,141,459	$ 639,384,460	$ 23,102,385	$ 638,915,947	$ 21,982,738
210024	MedStar Union Mem	$ 453,561,747	$ 15,935,199	$ 429,931,609	$ 14,546,466	$ 421,430,297	$ 15,662,050
210027	Western Maryland	$ 352,856,671	$ 22,130,114	$ 337,971,374	$ 15,363,115	$ 336,104,673	$ 14,850,446
210028	MedStar St. Mary's	$ 207,204,990	$ 4,692,572	$ 199,340,963	$ 7,533,670	$ 190,651,240	$ 7,309,126
210029	JH Bayview	$ 743,246,969	$ 31,783,180	$ 654,894,625	$ 31,784,940	$ 676,879,971	$ 33,226,513
210030	UM-Chestertown	$ 42,056,371	$ 1,467,622	$ 41,883,891	$ 1,809,240	$ 46,771,763	$ 1,951,437
210032	ChristianaCare, Union	$ 179,194,497	$ 5,746,397	$ 163,599,167	$ 8,504,136	$ 163,540,394	$ 7,340,949
210033	Carroll	$ 250,444,673	$ 5,634,001	$ 231,088,487	$ 8,487,669	$ 234,141,186	$ 8,301,971
210034	MedStar Harbor	$ 199,952,253	$ 9,348,597	$ 184,401,953	$ 8,143,593	$ 188,013,249	$ 8,530,979
210035	UM-Charles Regional	$ 169,142,509	$ 5,642,257	$ 155,083,766	$ 7,883,030	$ 154,875,318	$ 7,461,752
210037	UM-Easton	$ 247,794,590	$ 6,640,513	$ 238,382,456	$ 6,893,256	$ 230,782,936	$ 7,624,533
210038	UMMC Midtown	$ 221,889,769	$ 8,765,812	$ 198,376,019	$ 6,565,622	$ 216,362,184	$ 7,733,089
210039	Calvert	$ 163,431,696	$ 3,166,860	$ 156,986,093	$ 5,713,463	$ 152,440,161	$ 5,948,940
210040	Northwest	$ 272,444,317	$ 10,177,517	$ 266,740,312	$ 12,536,995	$ 270,436,111	$ 14,110,094
210043	UM-BWMC	$ 476,591,102	$ 11,833,276	$ 438,316,007	$ 16,079,520	$ 446,838,259	$ 16,705,835
210044	GBMC	$ 524,457,618	$ 11,944,947	$ 470,195,108	$ 16,421,310	$ 476,405,568	$ 16,595,959
210048	Howard County	$ 318,841,236	$ 7,013,460	$ 300,110,296	$ 11,314,679	$ 307,874,351	$ 13,533,347
210049	UM-Upper Chesapeake	$ 346,058,239	$ 8,044,495	$ 311,152,323	$ 10,502,966	$ 323,542,686	$ 11,231,490
210051	Doctors	$ 252,300,061	$ 9,382,765	$ 255,559,577	$ 13,947,959	$ 256,571,881	$ 14,478,704
210056	MedStar Good Sam	$ 287,291,214	$ 11,220,812	$ 267,313,912	$ 10,472,083	$ 258,232,394	$ 10,783,231
210057	Shady Grove	$ 496,288,718	$ 17,113,067	$ 458,711,466	$ 23,043,892	$ 445,836,157	$ 24,062,522
210060	Ft. Washington	$ 63,360,503	$ 3,020,528	$ 61,224,082	$ 4,618,514	$ 51,952,283	$ 4,574,910
210061	Atlantic General	$ 122,092,827	$ 4,304,468	$ 106,773,194	$ 5,540,541	$ 110,346,276	$ 5,714,101
210062	MedStar Southern MD	$ 297,180,588	$ 8,411,470	$ 281,748,091	$ 11,856,408	$ 273,982,766	$ 10,949,621
210063	UM-St. Joe	$ 417,568,750	$ 9,697,222	$ 372,785,338	$ 12,770,361	$ 389,641,461	$ 15,918,298
210065	HC-Germantown	$ 131,726,680	$ 7,244,156	$ 119,287,524	$ 9,113,579	$ 110,764,041	$ 9,383,182
Total	**Statewide**	**$ 18,280,574,451**	**$ 590,483,324**	**$ 16,837,681,008**	**$ 679,740,581**	**$ 16,918,700,246**	**$ 696,044,899**
			RY2021 - 2020	**RY2021 - 2019**	**RY2020 - 2019**		
	Total Charge Correlation		**99.93%**	**99.93%**	**99.94%**		
	Predicted UCC Correlation		**96.87%**	**95.90%**	**99.34%**		

MARYLAND

PATIENT SAFETY CENTER

May 2022

HSCRC Update

Table of Contents

Introduction

The Maryland Patient Safety Center (MPSC) is an independent not-for-profit organization committed to improving patient safety across all aspects of healthcare. The Center serves as a resource not only in Maryland but in the surrounding region of Washington, DC, northern Virginia, Delaware, West Virginia, and eastern Pennsylvania.

MPSC's mission is simple yet profound: Keeping Maryland Healthcare safe. To accomplish this, MPSC's vision is to be a model of patient safety innovation and implementation, convening providers, patients and families across the healthcare continuum to prevent avoidable harm and provide safe and equitable healthcare for all. MPSC engages a growing number of healthcare providers from around the state through ongoing initiatives, including education and training, safety culture collaboratives, special projects, research, and near miss reporting. As a result of their participation, health care providers, working with patients and their families, discover and create new ways to deliver improved care in Maryland.

MPSC maintains a relentless pursuit of innovative solutions to eliminate harm within the healthcare community. In its seventeen-year history, MPSC, its partners and providers have seen measurable improvements. MPSC has raised awareness among health care professionals about safety strategies that dramatically transform culture. Topics continue to include leadership and innovation in clinical information technology, human factors engineering and quality and safety tools, such as Lean/Six Sigma and Root Cause Analysis. Registration was 278 for the November 2021 Annual MPSC Medication Safety Conference and 675 for the March 2022 Annual MPSC Patient Safety Conference. The November conference was held virtually due to the COVID-19 pandemic, but the April conference was held in person in Baltimore with appropriate infection control precautions, our first in-person conference in 2 ½ years.

Under Maryland's Total Cost of Care (TCOC) Model for healthcare, it is increasingly important that safety and quality are continuously improved across all care settings. The key stakeholders involved with MPSC include hospitals, patients, physicians, long-term care and post-acute providers, and ambulatory care providers – all groups that are critical to the success of the TCOC Model. To achieve mutual health care goals for these stakeholders, MPSC has collaborated with Maryland's key health policy agencies including MDH, MHCC, HSCRC and OHCQ to establish and achieve these goals.

MPSC continues to serve as a trusted patient safety center to assist Maryland healthcare facilities in efforts to develop and implement patient safety strategies. MPSC conducts regular communication with patient safety officers, as well as leaders in patient and family engagement and peri- and neonatal services across the state to share best practices, resources and consultation, and coaching in order to improve safety and reduce cost and redundancy.

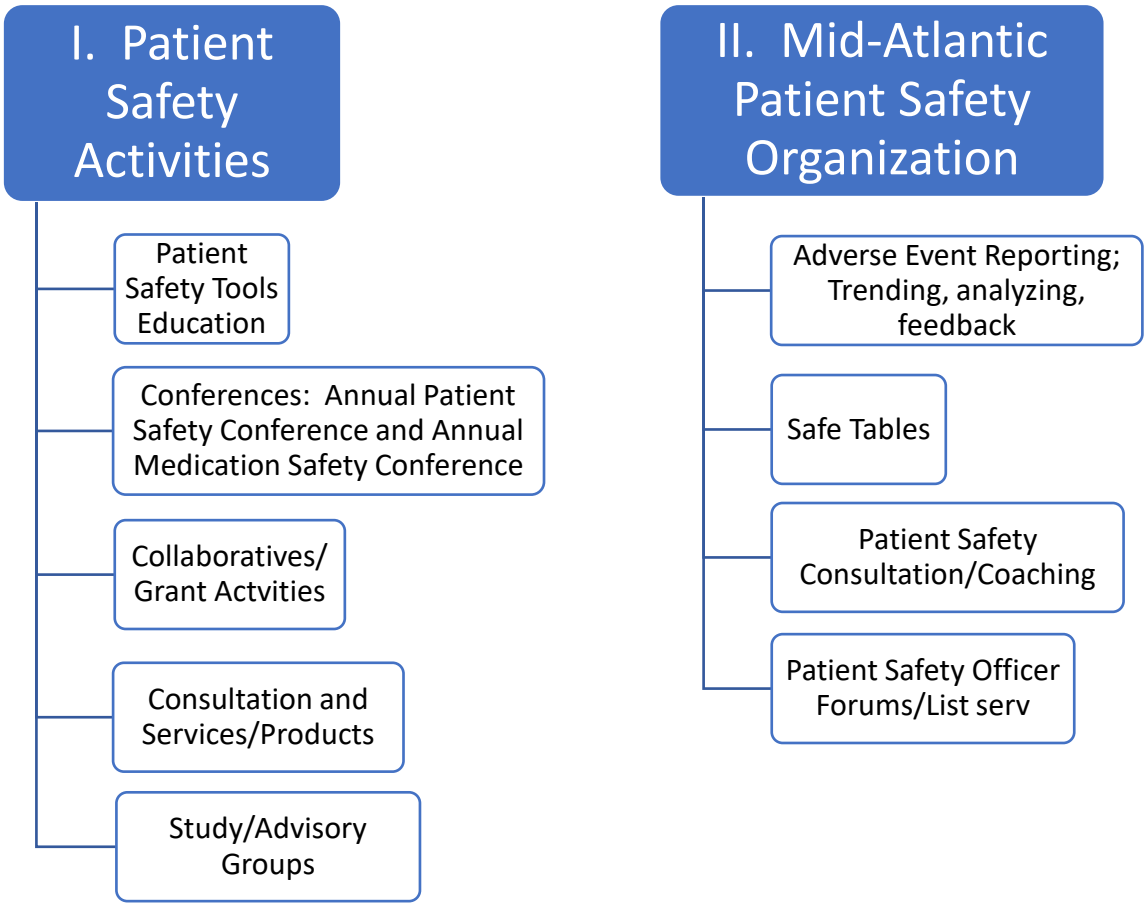
This report provides the HSCRC a summation of MPSC activities from December 2021 through May 2022.

Structure and Activities

MPSC conducts activities to improve patient safety and manages the federally listed Mid-Atlantic Patient Safety Organization (MAPSO). MAPSO received its current 3-year relisting from the federal Agency for Health Care Research and Quality (AHRQ) in September 2020, expiring December 9, 2023. The structure and activities of MPSC are noted below and will be described further in detail.

Structure and Activities of

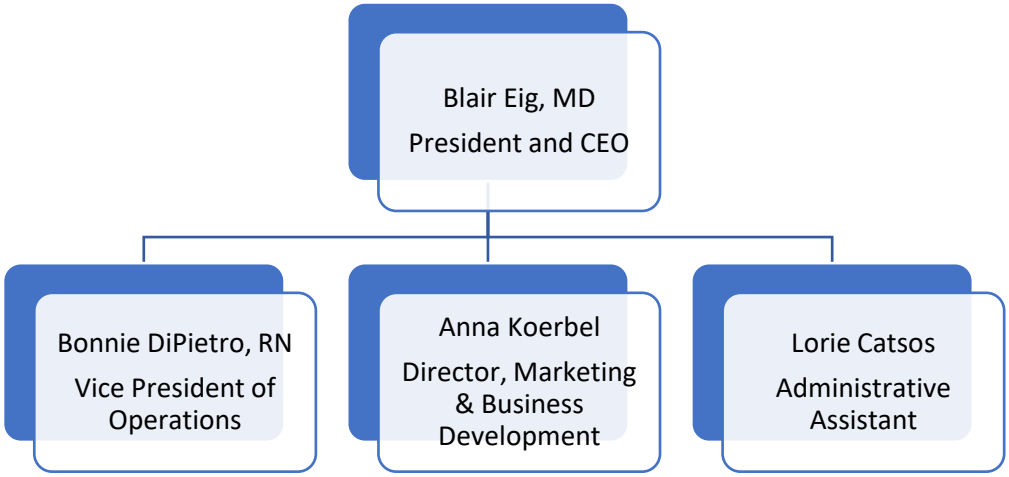
Maryland Patient Safety Center



Staff

MPSC employs four full time staff including the President and CEO, Vice President of Operations, Director of Business Development and Marketing and an Administrative Assistant. Blair Eig, MD, a board-certified pediatrician, and former Chief Medical Officer for Holy Cross Health in Montgomery County, took over as President and CEO on June 1, 2020. He has maintained the Center's focus on collaborative safety projects and education, with an emphasis on healthcare equity, support for the resiliency of healthcare workers, expanding the center's activities into the outpatient setting and patient safety issues associated with the COVID-19 pandemic.

Maryland Patient Safety Center Staff



Membership

- Forty-nine (49) paid member facilities including 45 acute care hospitals, three rehabilitation hospitals, three long term care facilities, and one addiction recovery center
- Barriers to widespread non-hospital MPSC memberships:
  - Non-hospital budgets are limited for participation in quality and patient safety programs, so MPSC continues to seek funding to support collaboratives and programs targeting these facilities, such as nursing homes during the current COVID-19 pandemic.
  - Financial incentives are different for non-hospital organizations, presenting additional challenges in engaging participation.
- Patients and family participation in MPSC initiatives will continue to be actively sought. Patients and families are represented by three MPSC board members and patients and/or family members are sought to provide their perspective to our collaboratives.
- 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)

- Membership fees currently provide the largest portion of MPSC's annual revenue but will be significantly supplemented by state general funds in the coming year (see below).

I. State Funding

Since its inception MPSC has been funded through the Health Services Cost Review Commission, membership fees and program sales. Due to the discontinuation of HSCRC funding in FY2023, state funding was sought through legislative action this past session. A funding bill was cross-filed by Speaker Pro Tem Sample-Hughes in the House of Delegates and Senator Augustine in the Senate, and with support from many state healthcare organizations, the Maryland Hospital Association and the MHCC, the legislation was passed. In addition, the governor added this funding to the FY23 supplemental state budget, assuring that the funding will start in FY23 and continue annually. This funding guarantees that MPSC will have the resources necessary to carry out its mission of keeping Maryland healthcare safe going forward.

II. Administrative Summary, December 2021 through May 2022

Re-designation of the Maryland Patient Safety Center as Maryland's Patient Safety Center

MPSC received a 5-year re-designation from the Maryland Health Care Commission in April 2020. As part of this re-designation, MPSC provides a written report twice a year to MHCC to update the commission on its activities. In addition, a MHCC commissioner, Marcia Boyle, joined the MPSC board in September 2020.

MPSC Board Development

The MPSC board provides a broad representation from Maryland healthcare, government and community including two members of the State legislature and a commissioner from the MHCC. One of the major activities for the MPSC board is the ongoing review and update of the center's strategic plan and its Mission, Vision and Goals for the next 5 years.

Alignment of MPSC Goals with Maryland State Agencies

MPSC continues to work closely with Maryland State Agencies – MDH, MHCC, HSCRC and OHCQ – to align its activities and goals with the state's. This has gained increased urgency during the current

COVID-19 pandemic. Elsewhere in this report is a more extensive discussion of the major MPSC initiatives that have been involved in the pandemic response:

- Clean Collaborative in Long Term Care – An infection prevention collaborative in 24 nursing homes across the state, funded by HSCRC grants to MPSC or through hospital system community partnerships.
- Caring for the Caregiver – In collaboration with the Armstrong Institute for Patient Safety and Quality at Johns Hopkins, MPSC coordinates a national program of support for the resiliency of health care workers in all health care settings.
- Health Equity – In collaboration with the Maryland Hospital Association and Dr. Nicole Rochester, MPSC created a series of seminars for Maryland hospitals discussing racial bias in healthcare and COVID-19 vaccine hesitancy in communities of color. Since May of 2021, we have been working with an advisory group of local experts on an initiative to combat racial disparities in maternity care. This ***B.I.R.T.H. Equity Maryland*** project will deliver webinars, point of care tools and a library of resources to non-obstetric providers and patients alike on racial bias in healthcare and how to recognize and treat the complications of pregnancy in a timely fashion. The webinars kicked off the pilot group phase of the project in May 2022.

In addition to these collaboratives, MPSC is involved in many other statewide healthcare issues through consultation, education and/or collaboratives. These include:

- Opioid education
- Maternal healthcare improvement
- Patient safety in long term care (including assisted living)
- Diagnostic errors

Development of Partnerships

With limited MPSC resources, developing partnerships has been key to expanding key products. Our longest standing partnership, the *Caring for the Caregiver: Implementing RISE* program with the Johns Hopkins Armstrong Institute for Patient Safety and Quality, has been extremely successful with 51 contracts sold nationally and internationally — bringing together 92 hospitals, four provider groups, three veterinary groups, one State Department of Public Health, and one School of Nursing in our *Caring for the Caregiver Partner Network.* The COVID-19 pandemic has shone a new light on the importance of healthcare provider wellbeing, so we expect this resource to continue to sell. While membership dues are a key financial resource for MPSC, contracts from these partnerships also bring to MPSC important revenue. We continue to develop our partnership with the MedStar Institute for Quality and Safety (MIQS) for the Patient and Family Advisory Council for Quality (PFACQS) program as it recognizes the importance of including patients and families in quality improvement and patient

safety projects to improve outcomes. We know that patients and families bring a unique firsthand perspective of performance gaps within our healthcare institutions.

COVID-19

The advent of COVID-19 changed MPSC priorities. In addition to the grant funded collaboratives mentioned later, we have evolved our learning modalities and now provide remote E-learning and other capabilities to bring education to caregivers who may not be able to leave work or to congregate on site. We developed several COVID-19 related activities:

- Frequent patient safety newsletters including resources
- Free of charge Caring for the Caregiver Manual to allow self-guided interventions for caregivers in healthcare (130+ copies distributed throughout the world)
- Two webinars dedicated to Patient and Family Engagement with continuing education for Patient Experience professionals:
    - “Patient and Family Engagement During COVID-19”
    - "Exploring the Role of Patient and Family Advisory Councils (PFAC) in a COVID-Shaped World”
    - Recordings of these webinars remain available on our website at no cost.
- E-learning modules on opioids, Appreciative Inquiry, Data Visualization, and Performance Improvement
- Web-based seminars for Root Cause Analysis, Lean, Six Sigma and other safety/quality tools
- Increase in the use of the Patient Safety Officer Listserv, with questions posted to the data base daily on such topics as COVID testing for labor and delivery and policy issues such as visitation during COVID.
- MPSC completed a four-part Vaccine Hesitancy in Communities of Color Series. Targeting hospitals, long-term care organizations and all healthcare providers, we reached over 700 attendees to present information on the root causes of hesitancy among Black and Brown communities and strategies to increase vaccine acceptance. Recordings of these webinars remain available on our website at no cost.

III. Patient Safety Center Activities

MPSC Patient Safety Tools Education

- The demands of COVID-19 continued to affect the number of registrants to the educational offerings this past year, but a slight increase was noted with 250 registrants this past year.

- Classes scheduled between December 2021 and June 2022 have continued to require presentation in a virtual format because of COVID-19 limitations to in-person gatherings. These include:
    - Root Cause Analysis (RCA)
    - Human Factors
    - Lean for Healthcare
    - Identification and Assessment of Elder Abuse
- Appreciative Inquiry and a Performance Improvement series, including Change Management and Process Maps, are now offered in an enduring education format - accessible to registrants 24/7 to take when convenient.
- A five module Data Visualization course is now also offered as an e-learning program available 24/7 with 8.0 continuing education credits for Public Health professionals.
- Opioid Awareness: What you need to know (for consumers) previously presented in community settings is now moved to e-Learning.
- Through a partnership with RxALI MD, MPSC also offers the RALI Cares Virtual Experience for free on our website.

MPSC Conferences

MPSC Annual Patient Safety Conference: I thought we fixed that: Chronic issues in patient safety

- The MPSC 2022 Annual Patient Safety Conference was provided in-person on March 4, 2022 .
- 675 registered for the conference
- Participants from across healthcare attended - acute care hospitals, long term care, rehabilitation hospitals, ambulatory surgery centers, state agencies and quality improvement organizations.
- A panel of internationally known patient safety experts provided the opening keynote discussion and laid the foundation for the day by discussing where we have been and how so much more needs to be done for patient safety.
- Other presentations throughout the day equipped participants with new strategies to address age old patient safety topics that continue to be issues for healthcare.
- Five (5.0) continuing education credits for seven clinical disciplines were offered.

Medication Safety Conference:

- The 2021 annual medication safety conference was held virtually on November 5, 2021. The topic was *Medication Safety in Transitions of Care: Getting it Right.*
- 287 registered for the conference
- Attendees included medication safety officers, pharmacists, quality improvement professionals, physicians and other disciplines.
- The keynote address was given by Robert Campbell from The Joint Commission on the current medication reconciliation standards and the revisions that have been made to the standard over time.
- Five (5.0) continuing education credits were awarded for five disciplines.

Initiatives

Improving Diagnosis

- MPSC participated as an expert consultant to the MedStar Quality Improvement Program on an AHRQ grant to develop a TeamSTEPPS® module to improve diagnosis in ambulatory settings. The work was submitted to AHRQ, was piloted across the country and is now available on the AHRQ website for dissemination. It will be offered this fall as a course by MPSC.
- MPSC remains active with the Society for Improvement in Diagnostic Medicine.

Health Equity

- **COVID-19 Vaccine Acceptance Among Communities of Color**
  MPSC, in partnership with the Maryland Hospital Association, offered a complimentary series of webinars featuring nationally recognized local pediatrician and expert in patient advocacy and healthcare inequities, Nicole Rochester, MD. Dr. Rochester focused on addressing the systemic racism and the healthcare disparities that have led to a current state of medical mistrust among minority communities and a hesitancy to accept the COVID-19 vaccine. She presented thoughtful and practical methods for building vaccine acceptance among the Black and Brown communities -- both in the public and among healthcare providers -- and introduced local healthcare-community partnerships as successful models for improvements. The series received over 700 unique registrants and the recordings of all four sessions remain available for viewing on the MPSC website along with helpful resource guides.
- **B.I.R.T.H. Equity Maryland: Breaking Inequality Reimagining Transformative Healthcare**
  With the leadership and support of an advisory group comprising local experts in the fields of maternal health, emergency medicine, family practice, racial bias and health care inequities, MPSC, in partnership with the Maryland Hospital Association, has created educational tools to address the substantial disparity in maternal morbidity rate for black mothers in Maryland - a central focus of the Maryland Statewide Integrated Health Improvement Strategy, or SIHIS. A gap has been identified relative to racial equity in maternal health training for non-obstetric providers and patients. The work of the advisory group began on May 6, 2021, and the pilot sites started to implement the work on May 9, 2022. MPSC received a grant from the Baltimore-based France-Merrick Foundation to fund implementation at five pilot sites:
    - University of Maryland Baltimore Washington Medical Center Emergency Department
    - Mercy Medical Center Emergency Department
    - Baltimore Health Start
    - Comprehensive Women's Health Primary Care
    - University of Maryland BWMC Hanover Primary Care

MPSC Statewide Patient Safety Officer Forums

- All hospitals are required by the Joint Commission to designate a patient safety officer.
- MPSC convened two virtual one-hour PSO Forums between December 2021 and May 2022. All were held via Zoom and attended by patient safety officers, risk managers, quality improvement staff at hospitals and long-term care facilities.
- The PSO list serv has continued to be utilized weekly, and at times daily to connect the above individuals via e-mail for sharing of policies, procedures, and best practices; over 150 individuals participate in the list serv.
- Networking among patient safety officers is a result of the forums and coaching.
- The forums and listserv are open to all who are interested in patient safety.
- MPSC has continued to provide coaching and consultation to individuals in the group when requested.

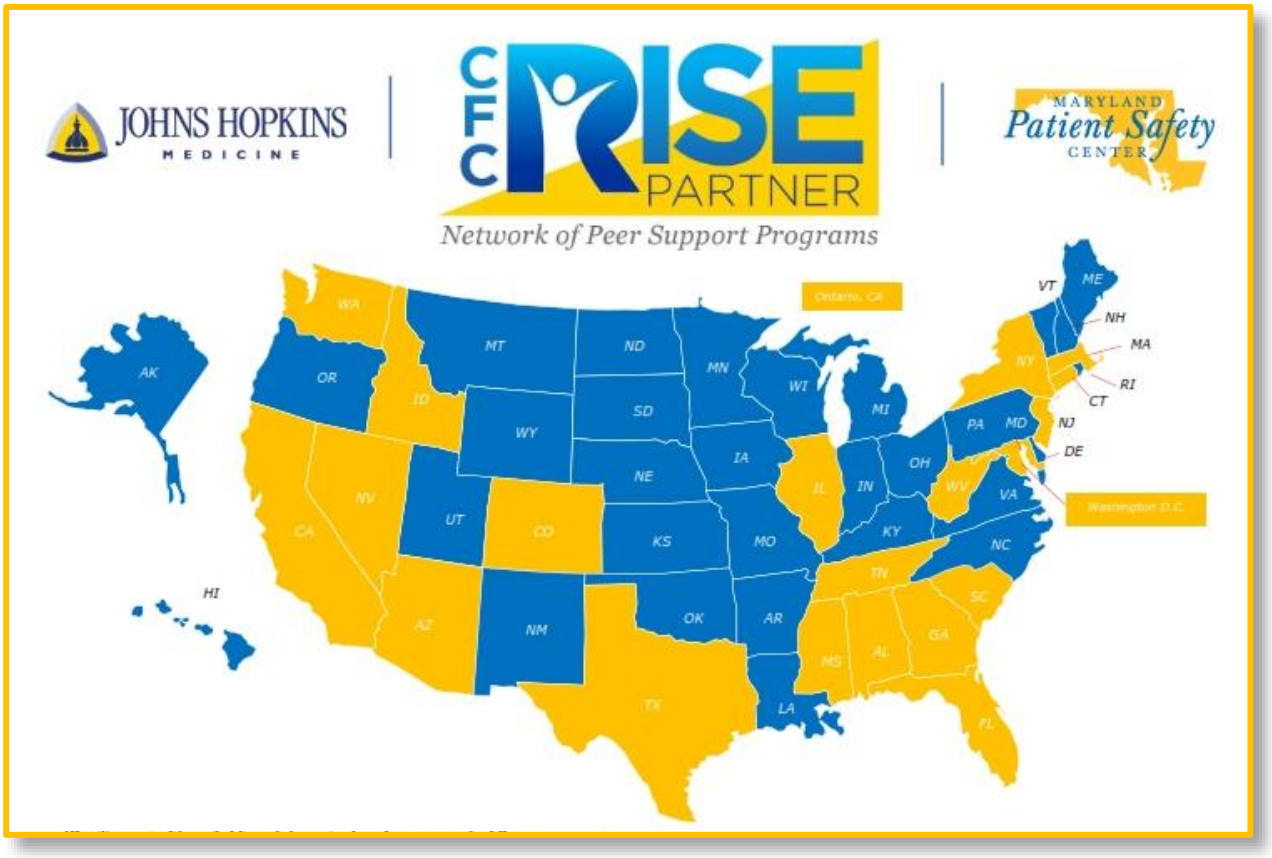
MPSC Revenue Generating Consultation Services and Products

Patient Safety Education and Certification

This program utilizes collegial collaboration, classroom instruction and practical application methodology, facilitated by a consulting team with expertise in patient safety, performance improvement and regulatory requirements. Goals are to improve the organization's culture of safety. The training is now available in a virtual format, but activity is slowed due to the COVID-19 pandemic.

Caring for the Caregiver: Implementing RISE

Now a six-year long partnership with the Johns Hopkins Armstrong Institute for Patient Safety and Quality, MPSC handles all marketing, contracts, administrative work, and sustainability for this program. Currently MPSC has contracted with 55 hospitals and/or healthcare systems, creating the *CFC/RISE Partner Network*—a group of 92 hospitals, four provider groups, three veterinary groups, one State Department of Public Health, and one School of Nursing. This group provides shared and experiential learning opportunities, along with inspirational ideas and encouragement.



At the onset of the pandemic, MPSC began temporarily offering a complimentary copy of the Peer Responder Basic Training Manual to requesting individuals and hospitals, accompanied by a letter from our partners, the Johns Hopkins Medicine training team. The goal is to share basic information on effective and efficient peer support to meet the immediate need in hospitals across the country. To date, over 130 copies have been distributed to healthcare organizations across the world.

Training has continued through a virtual platform. We can reach large audiences nationwide with great success.

We persist in gathering a robust list of sales leads, although hospital budgets for program purchases have been negatively impacted by the pandemic. We feel confident that the need and the interest remain high and that our training opportunities will be widespread. To meet the projected incoming demand, MPSC has established expansion opportunities:

1. **Regional training support -** MPSC has onboarded a representative from Denver Health and Hospital Authority, as well as a representative from St. Jude Children's Research Hospital, who oversee very successful Caring for the Caregiver programs at their institutions. Both will work as a local support person for new contracts sold in their regions, handling coaching sessions and helping with the training sessions.

2. **Online Learning -** MPSC and Johns Hopkins University have executed a contract with Siemens Healthineers to develop online learning modules for *Caring for the Caregiver: Implementing RISE*. Development is underway and when complete will transition the two days of live training into 10 online learning modules available for purchase through Siemens. This will not only allow for a lower cost option requiring significantly less resource allocation but will also market the *Caring for the Caregiver* program to hundreds of thousands of Siemens users worldwide.

3. **HRSA Grant on Healthcare Worker Wellbeing -** MPSC has a supportive role in a recent grant awarded to Johns Hopkins Medicine for RISE training. MPSC will oversee training at two rural hospitals in Maryland in 2022 and at participating Community Based Organizations in the two years to follow.

Patient and Family Advisory Council on Quality and Safety (PFACQS®) Update with seminar

The PFACQS® Program, in collaboration with the Center for Engaging Patients as Partners at the MedStar Institute for Quality and Safety, has been designed to help organizations take their patient and family engagement strategies to the next level with a focus on improving outcomes, reducing costs, promoting transparency and reinforcing staff joy and meaning in healthcare work. While the COVID-19 pandemic has affected utilization and expansion of Advisory Councils, we expect that the PFACQS® program will effect change in the following areas:

- Patient-provider partnerships
- Addressing racial disparities in healthcare through a diverse and inclusive PFAC
- Patient and family engagement during the COVID era and utilizing patient and family advisors to assist with post-COVID transformation of care (i.e., telemedicine, delayed diagnosis with reluctance to seek care, etc.)

Online learning

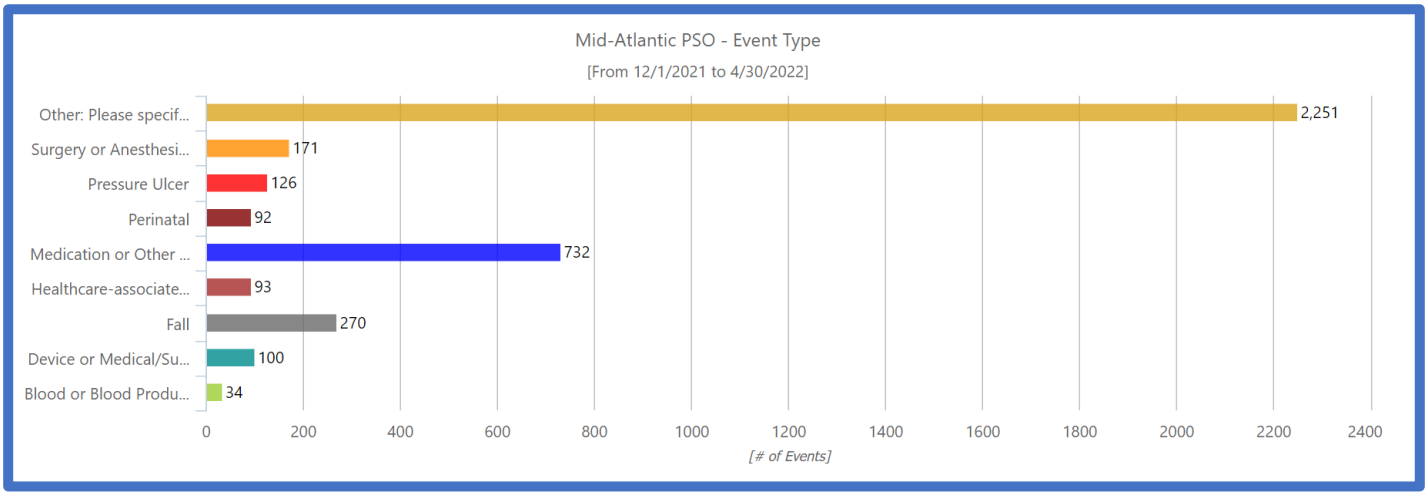
MPSC currently offers four e-learning courses for healthcare professionals:

- ***Data Visualization: From Spreadsheet to Story***, a five module Step-by-Step Guide to Communicating Health Data that offers a hybrid learning experience for healthcare professionals desiring to bring data to life through engaging and meaningful messages.
- ***Performance Improvement: Change Management***, helps hospitals and practices achieve their organizational goals with minimal pushback or resistance to adopting changes to processes, policies, technology, or even the people that provide the care.
- ***Performance Improvement: Process Maps***, a simple, but powerful and effective tool that is widely leveraged today in Lean Six Sigma to provide insight into a process.
- ***Appreciative Inquiry,*** a self-guided, one-hour class providing a foundational knowledge on AI, introducing the methodology as a tool to enhance the culture of patient safety at the unit and organizational levels, and demonstrate the principles of AI and its application.

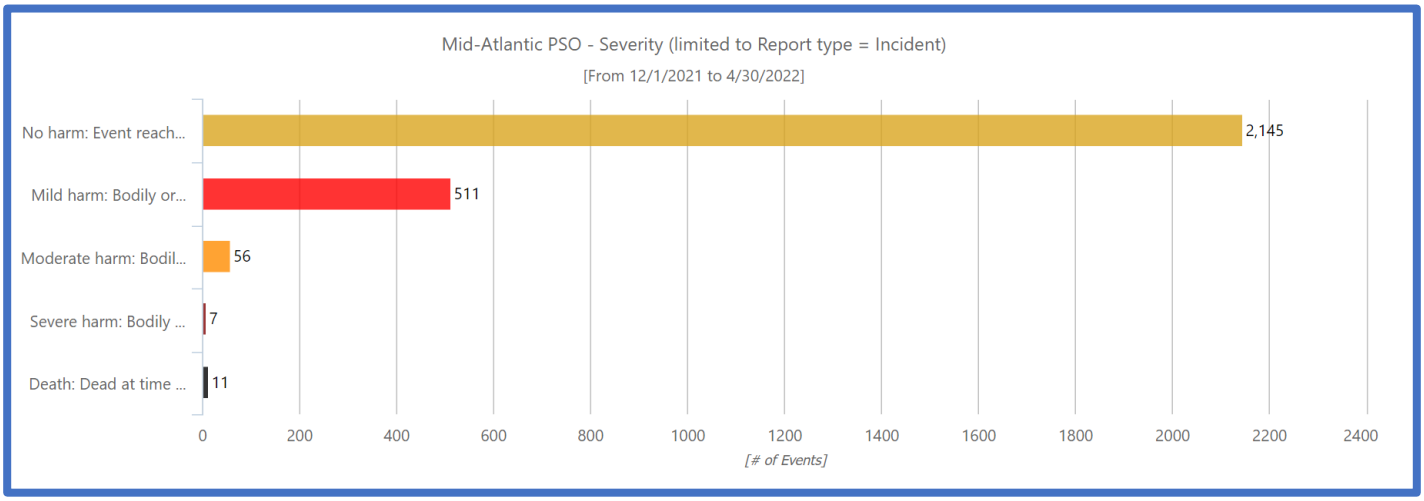
IV. Mid-Atlantic Patient Safety Organization

Mid-Atlantic PSO: The PSO currently has 42 members. Below is a breakdown of the safety event trends for the past year. Safe Tables continue to be highly valued by the Mid-Atlantic PSO members. In April 2022 a virtual Safe Table conducted. The Maryland Department of Health Office of Health Care Quality identified that serious insulin errors were on the rise and joined us with 40 MAPSO members to discuss insulin solutions and best practices.

Mid-Atlantic PSO Adverse Events by Type
December 2021 to April 2022



Mid-Atlantic PSO Adverse Events by Severity
December 2021 to April 2022



V. Grants and Consulting

Clean Collaborative Phase III

The COVID-19 pandemic highlighted the importance of facility surface cleanliness and infection prevention measures in our state's long-term care facilities. With designated funding approved through hospital rates by HSCRC for ten LTCs, MPSC began an 18-month collaborative with those facilities to reduce infection-related ED visits and hospital admissions, and COVID, MRSA and C-Difficile rates. Data collection ended in March 2022, and we are in the process of an in-depth analysis, comparing self-reported infection data with Medicare claims data provided to us from CRISP. We do not expect to have all the CRISP data until December 2022 and will provide a full final analysis and report of the work in early 2023. Preliminary data is provided in Attachment 1. Data demonstrated that Relative Light Units, a measure of i surface cleanliness, improved in the facilities and a reduction of ED visits and hospital admissions for MRSA, C-Difficile, wound infections and COVID-19 was also seen. Two of the ten facilities withdrew from the collaborative before it was completed, and one facility did not submit infection data in April 2021.

The following facilities participated in Phase III:

Facility	County
Orchard Hill	Baltimore County
Keswick	Baltimore City
Egle	Alleghany County
SagePoint	Charles County
Charlotte Hall (Veterans)	St. Mary's County
Lorien Columbia	Howard County
Clinton	Prince George's County
Birch Manor	Carroll County
Salisbury Genesis	Wicomico County
Hebrew Home	Montgomery County

Clean Collaborative Phase IV:

The Clean Collaborative Phase IV was a partnership with three hospital systems, recipients of HSCRC hospital partnership grants to reduce COVID rates in residents and staff in partner LTCs. MPSC consulted with the partner hospitals to work with their partnered LTCs. The hospitals were Anne Arundel Medical Center, Doctors Hospital (both part of Luminis Health) and Frederick Health. The work concluded in November 2021.

Clean Collaborative Phase IV-Hospital LTC Community Partnership grants participants:

Hospital	Facility Partner	County
Doctors Hospital	Doctors Nursing Care	Prince George's
Anne Arundel Medical Center	Crofton Nursing Care	Anne Arundel
	Fairfield	Anne Arundel
	FutureCare Chesapeake	Anne Arundel
Frederick Health	Ballenger Creek	Frederick
	Buckingham's Choice	Frederick
	Citizen's	Frederick
	Frederick Health and Rehab.	Frederick
	Glade Valley- withdrew	Frederick
	Homewood	Frederick
	Northampton	Frederick
	St. Joseph Ministries- closed	Frederick
	Vindobona- withdrew	Frederick
	Lorien Mt. Airy	Frederick

The goals of both the Clean Collaborative Phase III and Phase IV were as follows:

1. Decrease the average Relative Light Units on specified surfaces in participating facilities
2. Decrease rate of facility acquired COVID-19, MRSA and C-Difficile in participating facilities
3. Decrease ED visits for infection related diagnoses in participating facilities
4. Decrease ED hospital admissions for diagnoses in participating facilities

- **MD MOM:** MPSC is a partner in the five-year $10.3 million HRSA grant to the Johns Hopkins Bloomberg School of Public Health for the MD Maternal Health Innovation Program. MPSC is a sub-awardee and is facilitating implicit/unconscious bias training, quality improvement training and training in substance use disorder in pregnancy and consultation to birthing hospitals.

- **Healthcare Worker Wellbeing:** MPSC is a partner in a $2.7 million HRSA grant to Johns Hopkins Medicine to facilitate widespread R.I.S.E (Resilience in Stressful Events) training in multiple sites of care throughout Maryland.

- **B.I.R.T.H. Equity Maryland:** MPSC was awarded a grant from Baltimore-based France-Merrick Foundation to fund the first round of pilot sites in non-obstetric provider education on Bias in Maternal Healthcare

- **Neonatal Abstinence Syndrome Collaborative:** this collaborative concluded in 2018, and a paper on the successful outcomes in reducing separation of mothers and babies has been accepted for publication to the American Journal of Perinatology.

- **Maryland Department of Health, Maternal Mortality Review Committee (MMRC):** MPSC was recently (May) awarded a grant to manage the operations of the MMRC for the next two fiscal years.

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VI. Future Considerations

- Improving care transitions
- Antibiotic Stewardship in Primary Care
- Telemedicine safety
- Clean Collaborative on soft surfaces in LTC
- Statewide disclosure model, such as CANDOR
- Addressing racial disparities in healthcare through programmatic peer support

VII. Strategic Partners

- **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
- **LifeSpan Network –** The largest senior care provider association in the Mid-Atlantic region
- **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 Medicine & The Armstrong Institute for Patient Safety and Quality** – The patient safety center within Johns Hopkins Medicine
- **MedStar Health**
- **State entities -** HSCRC, MHCC, MDH, OHCQ
- **Centers for Disease Control and Prevention**
- **Clemson University**

ATTACHMENT 1

The Clean Collaborative

Phase III: Long Term Care

HSCRC Funded

October 2020 to March 2022

Hypothesis – Proper cleaning and disinfection of surfaces areas facility-wide, along with quantifiable validation of disinfection methods, will assist healthcare environmental service managers and infection preventionists in reducing healthcare associated infections (HAIs).

Background

The Health Services Cost Review Commission (HSCRC) COVID-19 provided designated funding, through adjusted hospital rates of specific hospitals, to Maryland Patient Safety Center (MPSC) to recruit ten Long Term Care (LTC) facilities to collaborate on data sharing, infection prevention and control, resource sharing, and patient management strategies to reduce the spread of COVID-19 in these settings.

Utilizing the framework and successes of the Clean Collaborative Phases 1 and 2 previously conducted, MSPC offered participation in a collaborative LTC facilities across Maryland is to: (1) identify best practices for cleaning and disinfecting hard surface areas throughout the facility (specifically a concern in the COVID-19 pandemic) and (2) to educate and promote best cleaning and disinfection practices via webinars, collaborative calls, face-to-face meetings and onsite consultation and evaluation. Through collection of monthly quantitative data, 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 include:

- HAI reduction
- Improved implementation of cleaning and disinfection best practices within the facility
- Reduction in Emergency Department visits and hospital admissions related to HAI
- Prevention and rapid response to possible future infection outbreaks
- Participating LTC facilities will utilize cleaning validation technology and reports as part of a comprehensive cleaning validation program

Methodology

MPSC recruited LTCs to participate in a facilitate an 18-month collaborative to improve cleaning and disinfection. Nineteen facilities applied to participate, and ten were chosen considering diversity in geographic location in the state, size of facility and ownership. MPSC provided a subject matter expert in cleaning and disinfection (CleanHealth Environmental) and an experienced infection preventionist (Mayoryk Consulting Services) for consultation and evaluation through site visits and individual consultation with participating facilities. Quality assurance and performance improvement strategies were also provided.

The Clean Collaborative sought to improve facility cleanliness as a means of reducing HAIs through:

1. Identification of best management practices (BMPs) for cleaning and disinfecting surface areas
2. Educating and promoting BMPs via webinars and factsheets
3. Improving cleanliness of the facility
4. Reducing surface-transmitted facility acquired infections
5. Reducing ED visits and hospitalizations for infections

In alignment with CDC recommendations for conducting an Environmental Hygiene Cleaning and Monitoring Program, the Clean Collaborative employed adenosine triphosphate (ATP) system monitoring verification technology**.** The ATP monitoring devices were provided to the ten facilities at no charge by ACME Paper and Supply Company.

During the Clean Collaborative participants agreed to input quantitative data monthly for 18 months utilizing the ATP device, which uploaded the data to the cloud. In addition, each facility agreed to submit HAI data monthly to MPSC (See Appendix 1). The Clean Collaborative project team collected, analyzed, and graphically depicted and reported aggregate and facility-specific data to the facility team leads.

Participants

Ten long-term facilities agreed to participate in the Clean Collaborative Phase III as follows:

1. Birch Manor Center for Rehabilitation and Healthcare- Sykesville, MD, Carroll County
2. Charlotte Hall Veteran's Home- Charlotte Hall, MD, St. Mary's County
3. Clinton Healthcare Center- Clinton, MD, Prince George's County
4. Egle Nursing and Rehabilitation Center- Lonaconing, MD, Alleghany County
5. Hebrew Home of Greater Washington- Rockville, MD, Montgomery County
6. Keswick Multi-Care Center- Baltimore, MD, Baltimore City
7. Lorien Columbia- Columbia, MD, Howard County
8. Orchard Hill Rehabilitation and Healthcare Center- Towson, MD, Baltimore County
9. Sagepoint Senior Living Services- LaPlata, MD, Charles County
10. Salisbury Rehabilitation and Nursing Center- Salisbury, MD, Wicomico County

All ten facilities began the collaborative strongly and submitted most of the required data. Turnover, surges in COVID infections and staffing issues throughout the 18 months impacted the ability of some facilities to

remain engaged. Two facilities withdrew (Birch Manor and Orchard Hill) and one facility never submitted infection data sufficient to analyze (Salisbury).

Despite the challenges mentioned above, and the burdens that the COVID-19 pandemic itself placed on healthcare staffing, recruitment, and reporting requirements, seven facilities continued to report and collect surface samples over the 18-months. Calls and webinars were recorded for participants to view later and to share with their teams in staff meetings when convenient for the facility.

Activities and Participation

The Collaborative kick off webinar was held on September 4, 2020 from 830a to 10:45a. Ten facilities participated. Collaborative calls were scheduled every month for the six months, and every other month thereafter.

Collaborative Calls were held as follows, with participation as noted:

DATE	Time	# Participating partner LTCs
October 14, 2020	1:00pm-2:00pm	9
November 11, 2020	1:00pm-2:00pm	6
December 9, 2020	1:00pm-2:00pm	7
January 13, 2021	1:00pm-2:00pm	8
February 10, 2021	1:00pm-2:00pm	8
March 10, 2021	1:00pm-2:00pm	
May 12, 2021	1:00pm-2:00pm	6
July 28, 2021	1:00pm-2:00pm	5
September 8, 2021	1:00pm-2:00pm	8
November 19, 2021	1:00pm-2:00pm	5
January 12, 2022	1:00pm-2:00pm	4
March 9, 2022	1:00pm-2:00pm	4

Additionally, collaborative webinars were held and recorded to provide education as follows:

DATE	Time	Title
November 19, 2020	10:00a – 11:00a	Cleaning and Disinfection Basics
March 24, 2021	2:00p – 3:00p	Technologies for Healthcare
June 23, 2021	11:00a – 12:00p	ATP SureTrend Software: Pulling Valuable Reports
August 20, 2021	10:00a – 11:00a	Employee Recognition and Engagement
December 15, 2021	11:00a – 12:00p	Soft Surfaces: What we don't know could hurt us
March 23, 2022	1:00p – 2:00p	Sustaining Change: What? you mean I am not done?

The program requested the collection of one-hundred swabs from specific locations monthly. The results uploaded to the ATP device cloud (see Appendix 1 for locations). Relative Light Unit (RLU) data was calculated which provided results and benchmark data of surface cleanliness. For the facility's data to be included in the aggregate data monthly, a minimum of 90 swabs each month from the listed locations were required. As previously mentioned, the program requested that participating LTCs provided infection data monthly to allow for an analysis of ED visits, hospitalizations, and HAIs of specific surface transmitted infections, as well as COVID-19 case counts.

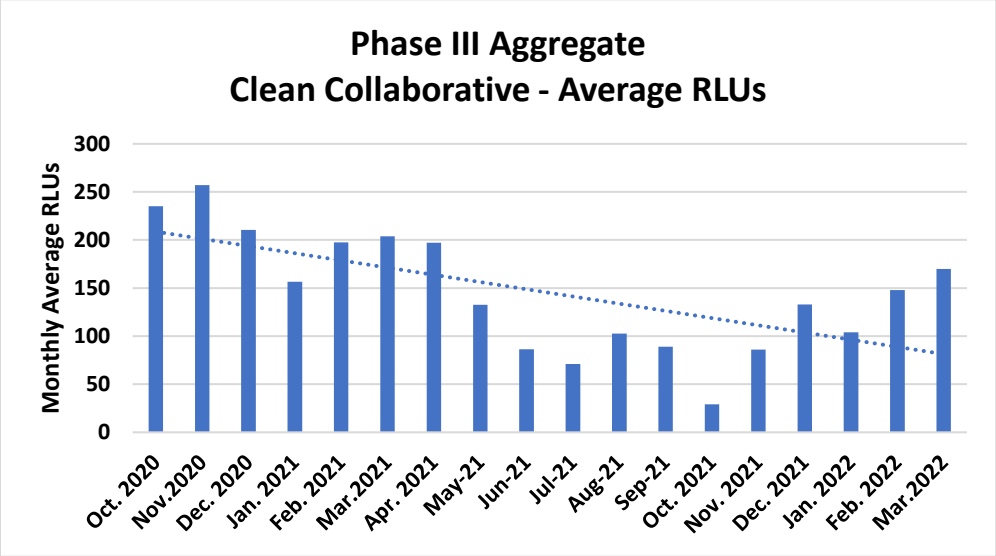
Sufficient data was submitted by the facilities as follows:

Month	RLU data- # LTCs	Infection Data- #LTCs
Oct. 2020	9	9
Nov. 2020	10	9
Dec. 2020	10	9
Jan. 2021	9	9
Feb. 2021	10	9
Mar 2021	10	7
Apr. 2021	10	7
May. 2021	8	7
Jun. 2021	8	7
Jul. 2021	9	7
Aug. 2021	9	7
Sep. 2021	9	7
Oct. 2021	7	7
Nov. 2021	8	7
Dec. 2021	8	7
Jan. 2022	8	7
Feb.2022	7	7
Mar.2022	8	6

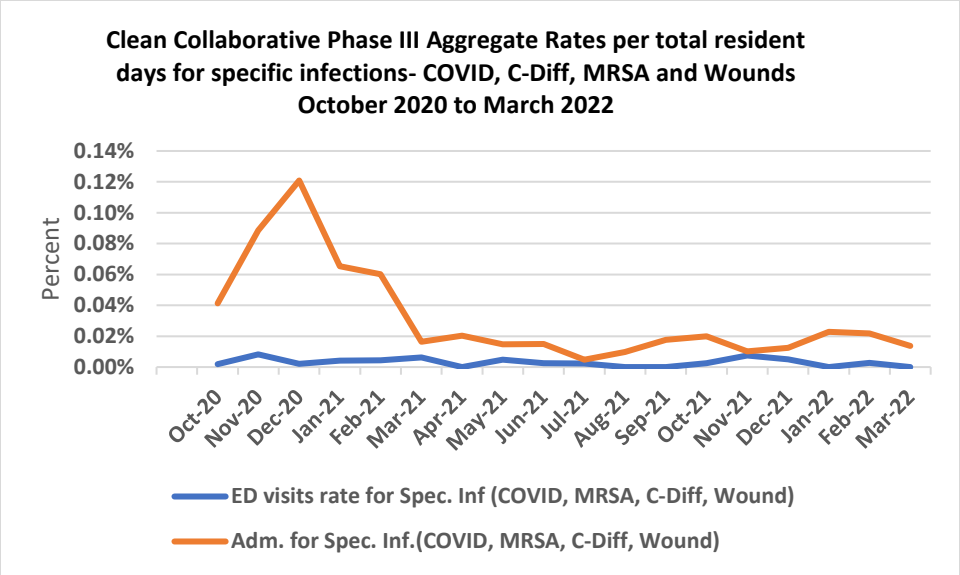
Results

As the COVID-19 pandemic evolved, The Centers for Disease Control and Prevention (CDC) released an update stating that the danger of contracting COVID-19 from surface transmission (indirect contact) was low, compared with direct contact, droplet transmission, or airborne transmission. Despite the low risk of transmission from surfaces, the program continued to collect and monitor healthcare acquired COVID-19 cases and healthcare acquired MRSA and *C-difficile*. As expected, the COVID surges and variant changes impacted the rates of facility acquired COVID, as did the administration of COVID vaccines to LTC residents and staff.

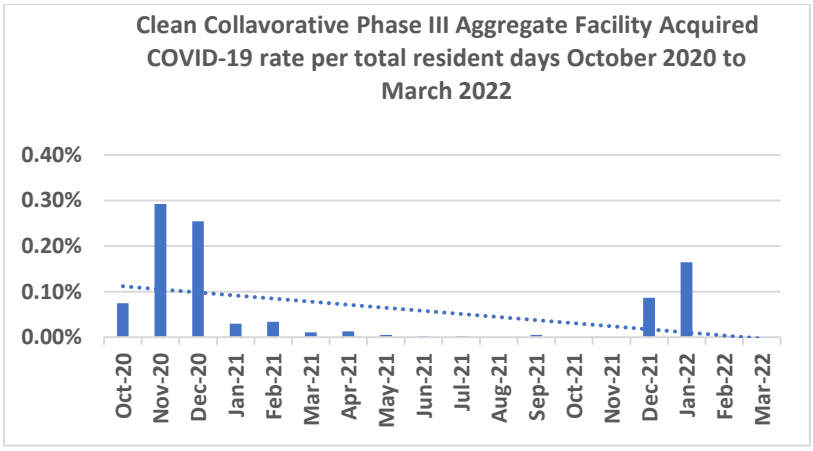
As previously mentioned, RLUs provide a quantitative measure of surface cleanliness. The LTC's aggregate data was only analyzed for those facilities that provided 90 or more of the required 100 samples. Preliminary data is provided below, which demonstrates reduction in the average RLUs for the participants, indicating improved surface cleaning and disinfection. Individual blinded facility analysis data will be forthcoming in the final report.

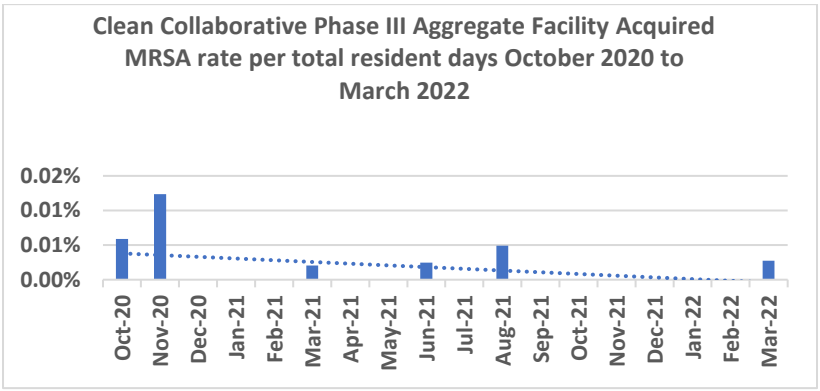


As an aggregate, the preliminary data for Phase III participants also demonstrates a decrease in hospital admissions for surface transmitted infections and for COVID-19, while ED visits for the same infections remained flat.



The aggregate rate of specific facility acquired infections trended down for the facilities that reported as demonstrated below.





Preliminary Conclusions: MPSC Clean Collaborative Phase III – Long Term Care kicked off with ten long term care facilities to conduct a collaborative designed to improve surface cleanliness, reduce ED visits and hospital admissions for infections, and decrease specified surface transmitted infections (*C-difficile* and MRSA) and COVID-19 rates. Data was self-reported by the facilities. Challenges over the one-year project included withdrawal of facilities (2), and project and facility administrative leadership turnover in the facilities. Staffing challenges during the COVID-19 pandemic included shortages and illness of facility staff, as well as the evolving demands to manage the pandemic for residents and staff. Obtaining RLUs sampling data each month and infection data monthly was a challenge, but eight of the ten original facilities submitted enough RLU data for analysis for the entire project, while 7 facilities submitted most of the required infection data for the 18-months (one of those 7 lost their team lead and thus submission of the final month of infection data). Preliminary data for the aggregate surface cleanliness appears to have been reduced substantially and hospital admissions for specific infections appears to have declined. Additionally, reported facility acquired COVID-19, C-Difficile and MRSA rates declined. Medicare claims data for the participating facilities will be provided by CRISP for a more in-depth analysis, and BRG has been engaged to provide an analysis for the collaborative for us. We expect a final analysis to be completed and available and reported in early 2023.

APPENDIX 1

THE CLEAN COLLABORATIVE

FACT SHEET: SAMPLE COLLECTION

Thank you for your participation in the ***Maryland Patient Safety Center (MPSC) Clean Collaborative***. Per the Participation Agreement, sample collection and data entry using ATP technology is a required component of the collaborative. MPSC offers the following additional information regarding the sample collection protocol, as follows:

Sampling locations

Sampling locations was determined, based on industry guidelines, including the CDC Environmental Checklist (http://www.cdc.gov/hai/toolkits/Evaluating-Environmental-Cleaning.html), which identifies high-touch room surfaces. In addition, a limited number public area surfaces, are also be included, as defined below.

	High-touch Room Surfaces	**Long Term Care # per month**
1	Bed rails / controls	4
2	Tray table	4
3	Call box / button	4
4	Telephone	4
5	Bedside/end table handle/pull	4
6	Chair	4
7	Room sink	4
8	Room light switch	4
9	Room inner door knob	4
10	Bathroom inner door knob / plate	4
11	Bathroom light switch	4
12	Bathroom handrails by toilet	4
13	Bathroom sink	4
14	Toilet seat	4

15	Toilet flush handle	4
16	Window sill	4
	Other High Touch Areas	
17	Arm of shower chair	4
18	Nurses station phone receiver (part you talk into)	4
19	Nurse station counter top	4
20	Mobile glucometer	4
21	Housing/ canister of portable thermometer	4
22	Portable BP or Vital sign unit-push handle	4
23	Facility information desk	4
24	Staff breakroom table	4
25	Staff breakroom chair	4

Number of samples to be collected

Note that facilities are required to collect a **minimum** of 100 surface area location samples, per month, over the course of 12 months. The high-touch room surfaces should be collected right after the room has been cleaned, while the public area surfaces and mobile equipment are to be done at random times. The precise location of the 4 samples of each surface (i.e. the bed rail room locations) as well as when the samples will be collected over the course of the month are within the discretion of the facility.

Who should collect the samples each month?

Trained Staff. The trained staff must be a staff member or volunteer who is able to measure cleanliness using the ATP technology. Trained Staff must be trained to fully understand the specific procedures of the sample collection and data entry processes. Such training is provided by MPSC via onsite meetings and webinars, which Trained Staff will be required to attend.

It is suggested that the facility consider several job categories when selecting the Trained Staff such infection preventionists, facilities staff, dietary staff, light duty staff, volunteers, transporters, and pastoral care, among others. **Environmental Services staff are restricted from collecting the samples.**

Should you have any additional questions, please contact Bonnie DiPietro, Director of Operations with the Maryland Patient Safety Center at bdipietro@marylandpatientsafety.org or 410-540-5095.

maryland
health services
cost review commission

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: June 8, 2022

RE: Hearing and Meeting Schedule

July 13, 2022 To be determined - GoTo Webinar

August 10, 2022 To be determined - GoTo Webinar

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

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