maryland
health services
cost review commission

**585th Meeting of the Health Services Cost Review Commission**
**June 9, 2021**

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

**EXECUTIVE SESSION**
**11:30 am**

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

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

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

**PUBLIC MEETING**
**1:00 pm**

1. Review of Minutes from the Public and Closed Meetings on May 12, 2021

2. Docket Status – Cases Closed
   2553A - Johns Hopkins Health System
   2554A - Johns Hopkins Health System
   2556A - Johns Hopkins Health System

3. Docket Status – Cases Open
   2555N -UM Shore Medical Center at Easton
   2557A - Johns Hopkins Health System
   2558N – Adventist HealthCare Rehabilitation - Rockville Campus
   2559N – Adventist HealthCare Rehabilitation – White Oak Campus
   2560N – Johns Hopkins Bayview Medical Center
   2561N – Sheppard and Enoch Pratt Hospital

4. Final Recommendation on the Update Factor for FY 2022

5. Final Recommendation on Integrated Efficiency Policy

6. Final Recommendation on Ongoing Support of CRISP in FY 2022

7. Final Recommendation on the Maryland Patient Safety Center for FY 2022

8. Final Recommendation on Community Benefits Reporting Guidelines

9. Policy Update and Discussion
    a. Model Monitoring
    b. Community Vaccination Program Update
    c. UCC Report (Materials Only)

10. Hearing and Meeting Schedule

**Closed Session Minutes**
**of the**
**Health Services Cost Review Commission**

**May 12, 2021**

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

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

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

3. 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 11:03 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 Bayless, Cohen, Colmers, Elliott, and Mohaltra.

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

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

## Item One

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

## Item Two

Katie Wunderlich, Executive Director, presented and the Commission discussed a framework for strengthening the Total Cost of Care (TCOC) Model and potential areas of focus.

Ms. Wunderlich reported that the Commission has engaged a vendor to assist with strategic planning.

**Item Three**

Will Daniels, Associate Director-Payment Reform and Provider Alignment outlined a framework for the development of a potential global budget for the provision of Emergency Medical Services.

The Closed Session was adjourned at 1:01 p.m.

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**MINUTES OF THE**
**584th MEETING OF THE**
**HEALTH SERVICES COST REVIEW COMMISSION**
**May 12, 2021**

Chairman Adam Kane called the public meeting to order at 11:03 p.m. Commissioners Joseph Antos, PhD, Victoria Bayless, Stacia Cohen, John Colmers, James Elliott, M.D. and Sam Malhotra were also in attendance. Upon motion made by Commissioner Colmers and seconded by Commissioner Elliott, the meeting was moved to Closed Session. Chairman Kane reconvened the public meeting at 1:13 p.m.

## REPORT OF MAY 12, 2021 CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the May 12, 2021 Closed Session.

## ITEM I
## REVIEW OF THE MINUTES FROM THE APRIL 14, 2021 CLOSED SESSION AND PUBLIC MEETINGS

The Commissioners voted unanimously to approve the minutes of the April 14, 2021 public meeting and Closed Session minutes.

## ITEM II
## CASES CLOSED

## ITEM III
## OPEN CASE

2553A- Johns Hopkins Health System
2554A- Johns Hopkins Health System
2555N- University of Maryland Shore Medical Center at Easton
2556N- University of Maryland Medical System

## ITEM IV
## FINAL RECOMMENDATION ON MATERNAL AND CHILD HEALTH FUNDING PROGRAM

Ms. Erin Schurmann, Chief, Provider Alignment & Special Projects, presented Staff's final recommendation on the Maternal and Child Health Funding Program (see "Final Recommendation on Use of Maternal and Child Funding" available on the HSCRC website).

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

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

In November 2019, the Commission approved a five-year investment of 0.25 percent of statewide all-payer hospital revenue (approximately $45 million annually) to support the population health goals of SIHIS through the Regional Partnership Catalyst Program. 80 percent of this approved amount was allocated to two funding streams dedicated to the State's identified key population health priorities: diabetes and opioid use. The State had not yet selected its third population health priority, so 20 percent ($10 million annually) of the approved funding was set aside for a future funding stream. Given that the State had not yet selected a third population health priority, the first year of funding was re-directed to address the public health emergency through the COVID-19 Long-Term Care (LTC) Partnership Program which ends June 30, 2021.

Staff recommends issuing the remaining 20 percent allocated to the third population health funding stream for maternal and child health investments. While Staff developed a competitive bid process for the diabetes and behavioral health funding streams under the Regional Partnership Catalyst Program, Staff recommends directing the third funding stream to investments led by Medicaid and the Prevention and Health Promotion Administration, in conjunction with the Medicaid HealthChoice MCOs. This funding will scale existing statewide evidence-based programs and promising practices and support the expansion of new services for mothers and children. Additionally, using the funding in this manner will also create an opportunity for the State to receive federal match funding, nearly doubling the investment. Funds

would be added to hospitals' annual rates as temporary adjustments through a uniform, broad-based assessment for four years.

- FY 2022 (July 2021 – June 2022)
- FY 2023 (July 2022 – June 2023)
- FY 2024 (July 2023 – June 2024)
- FY 2025 (July 2024 – June 2025)

Staff proposes an 80/20 funding split between Medicaid and the Prevention and Health Promotion Administration (PHPA) under which $8 million would be issued to Medicaid and $2 million would be issued to PHPA annually.

Medicaid - $8 million

a) Home Visiting Services Pilot Expansion
b) Reimbursement for Doula Services
c) CenteringPregnancy
d) HealthySteps
e) Maternal Opioid Misuse (MOM) Model Expansion

PHPA- $2 million

a) Asthma Home Visiting Program
b) Eliminating Disparities in Maternal Health Initiatives

Stakeholder comments are as follows:

Stakeholder Comment 1: Hospitals and the private sector need to be engaged more proactively.

Staff agrees that hospitals are important partners in the spectrum of care for pregnant women and children. Staff has identified opportunities where hospitals, MCOs, and community partners can collaborate to maximize the success of these programs and improve care for the target population which is discussed later in this recommendation. Additionally, only MCOs that are hospital-owned are eligible for funding.

Staff identified four key areas where hospitals can actively engage to support the programs proposed for funding in this recommendation.

1. Identification and Referrals: Hospitals can support early identification of pregnancy for MCOs and provide referrals for care which will promote prenatal care earlier in

pregnancy. Timely engagement in prenatal care is one of the keys to preventing severe maternal morbidity. Historically, reliance on administrative data (i.e., claims and encounters) to identify pregnancy was too late for payers and other entities to encourage prenatal care early in pregnancy. In addition to early identification of pregnancy, hospitals can identify children with moderate to severe asthma and refer to the State's home-visiting program and community-based programs to address childhood asthma.

2. Infrastructure and Policy Support: Hospitals also have opportunities to promote innovative policies and provide needed infrastructure for the programs recommended for funding.

3. Implementation Workgroup: The State will form a workgroup to support the implementation of the programs and initiatives recommended for funding. The workgroup would include representatives from hospitals, MCOs, and key partners engaged in these programs.

4. Community-Based Interventions: Community-based organizations implementing PHPA initiatives must collaborate with local hospitals and health systems.

Stakeholder Comment 2: Hospital rate-setting dollars should not be used to supplant state funding.

Staff agrees that this recommendation should not be used to justify supplanting State funds. Staff believes that this recommendation and the language in the 2021 BRFA have created very narrow parameters for use of these funds.

Stakeholder Comment 3: HSCRC and MDH should include maintenance of effort language in the MOU they develop.

Staff plans to include maintenance of effort language in the MOU with MDH to support programs and interventions described in the recommendation. Staff will include language in the MOU on the following provisions:

- Duration of the agreement
- Maintenance of effort for interventions covered in this recommendation
- A framework for operating a workgroup to engage hospitals, MCOs, and other partners to support the funded programs.
- Impact measure framework that aligns with SIHIS goals and focuses on health disparities.
- Continuation of funding linked to achievement of SIHIS goals for targeted populations.

Stakeholder Comment 4: The recommendation should narrow the focus of the programs.

Staff recommends funding the programs as proposed. The evidence-based programs and promising practices put forth for funding were selected because they have demonstrated positive health outcomes for patients and are narrowly focused to support the MCH goals under SIHIS.

Stakeholder Comment 5: Funded programs should include an intentional focus on diversity, equity, and inclusion.

Staff agrees that funded programs should be culturally competent to optimize care for the target populations. Additionally, the programs proposed were intentionally selected to support State efforts to reduce healthcare disparities for each of the SIHIS MCH goals.

Stakeholder Comment 6: Impact measures should align with other programs, where possible

Staff agrees that increased alignment will support ongoing efforts to build shared goals and focus stakeholder attention on SIHIS population health goals. As part of the MOU, Staff will include language to align impact measures with SIHIS goals and address health disparities. HSCRC and MDH staff will look to align impact measures with other programs, where possible.

Staff makes the following final recommendations:

1) Approve the use of the $10 million in reserved annual Regional Partnership Catalyst Program funding to support the third SIHIS population health priority area, maternal and child health, for four years (FY 2022 – FY 2025).
2) Authorize funding to be applied to annual hospital rates through a broad-based, uniform assessment on hospitals for transfer to the Maternal and Child Health Population Health Improvement Fund which will sunset in 2025.
3) Authorize HSCRC Staff to enter an MOU with MDH to establish the terms and conditions of administration of the Maternal and Child Health Population Health Improvement Fund.
4) Approve the use of $8 million annually by Medicaid to support the following initiatives and programs:

    - Home Visiting Services pilot expansion
    - Reimbursement for doula services;
    - CenteringPregnancy, a clinic-based group prenatal care model;
    - Healthy Steps, a clinic-based intensive prenatal and postpartum case management framework; and

- Maternal Opioid Misuse (MOM) model expansion.

5) Approve the use of $2 million annually by PHPA to support the following initiatives and programs:

   - Asthma Home Visiting Program
   - Eliminating Disparities in Maternal Health Initiative

6) Require an annual report from MDH on use of funds, engagement with hospitals, and progress towards SIHIS goals.

Commissioner Colmers thanked Staff for being responsive to the comments made at the last meeting and moved for approval of the recommendation.

Commissioner Bayless asked whether this is a continuation of existing work or new programs.

Ms. Tricia Roddy, Director of Innovation, Research, and Development, Maryland Medicaid, said the funding does not supplant existing State funds. For example, she said, the State does not cover doula services; this funding would allow Medicaid to cover those services. There is also a small home visiting program in place now, and local health departments must fund the State portion.

Ms. Traci La Valle, Senior Vice President of Quality & Health Improvement, Maryland Hospital Association, thanked Staff for allocating funds earmarked for regional partnerships. She said it would help the State achieve population health goals. Ms. LaValle expressed support for the small, but important changes to the final recommendation, specifically the annual report to demonstrate the impact of funding and the maintenance of effort language in the memorandum of understanding between HSCRC and the Maryland Department of Health (MDH) to ensure the programs continue at the end of the four years.

Commissioner Cohen asked Ms. Roddy to share results and early evidence of the existing programs at an upcoming meeting.

Commissioner voted unanimously in favor of Staff's recommendation.

## ITEM V
## FINAL RECOMMENDATION ON NURSE SUPPORT PROGRAM II FOR FY 2022

Ms. Claudine Williams, Deputy Director, Clinical Data Administration and, Ms. Peggy Daw, Grant Administrator at the Nurse Support Program II at the Maryland Higher Education Commission (MHEC), presented the final recommendation for the Nurse Support Program II (NSP II) FY 2022 Competitive Institutional Grants (See "Nurse Support Program II Competitive Grants Program Review Panel and Faculty Workgroup Statewide Initiative Recommendations for FY 2022" on the HSCRC website).

The HSCRC implemented the hospital-based Nurse Support Program I (NSP I) to address the nursing shortage impacting Maryland hospitals. Since that time, the NSP I completed three, five-year program evaluation cycles. The most recent renewal was approved on July 12, 2017 to extend the funding until June 30, 2022.

The HSCRC established the NSP II in May 2005 to increase Maryland's capacity to educate nurses. Provisions are included for a continuing, non-lapsing fund, with a portion of the competitive statewide grants to attract and retain minorities in nursing and nurse faculty careers in Maryland. The Commission approved funding of up to 0.1 percent of regulated gross hospital revenue to increase the number of nursing graduates and mitigate barriers to nursing education through institutional and faculty-focused initiatives. The HSCRC selected the Maryland Higher Education Commission (MHEC) to administer the NSP II programs as the higher education coordinating board.

In 2012, the NSP II program was modified to support new and existing nursing faculty development through doctoral education grants. Additionally, there were revisions to the Graduate Nurse Faculty Scholarship, including renaming the nurse educator scholarship in honor of Dr. Hal Cohen and sunsetting the living expense grant component. After the first ten years of funding in 2015, the HSCRC renewed funding through June 2020 and then for another five-year term through June 2025.

In 2021, the proportion of Bachelor of Science in Nursing (BSN) or higher-prepared nurses in Maryland increased to 67.1 percent, with continued steady progress towards the goal of 80.0 percent by 2025. Presently, Maryland ranks as the fourth highest in the nation in percent of BSN or higher prepared nurses. Maryland leads its neighboring states of Virginia, Delaware, West Virginia, and Pennsylvania in this measure by 10 to 15 percent.

The Competitive Institutional Grants Program builds educational capacity. It increases the number of nurse educators in order to supply hospitals and health systems with well-prepared nurses. The FY 2022 NSP II Review Panel was composed of nine members with backgrounds in healthcare, regulation, nursing education, and hospital administration.

Staff Recommendation #1: Funding recommended NSP II programs

HSCRC and MHEC staff recommend the following seven proposals for the FY 2022 NSP II Competitive Institutional Grants Program for a total of $6.6 million.

- Community College of Baltimore County First Semester Experience and Mentorship Program- Increasing Enrollments and Graduation $656,907.
- Coppin State University Implementation of Doctoral Education Advancement (IDEA) through the BSNDNP $983,146.
- Salisbury University Fast Track to a BSN: Expanded Opportunities for 1st and 2nd degree students $986,344.
- Stevenson University Enhancing Clinical Education Through Partnerships $587,359.
- University of Maryland School of Nursing Preparing Clinical Faculty $700,000.
- University of Maryland School of Nursing Academic-Practice: Pilot DEU Model $282,124.
- University of Maryland School of Nursing Academic-Practice Partnership-Clinical Nurses competing higher degrees- RNBSN-MSN $2,471,019.

Staff Recommendation #2: Include all NSP I and II hospitals, health systems, and affiliated facilities as approved service agreement sites and grandfather all nurse educators into 1:1 service.

HSCRC and MHEC Staff recommend the inclusion of all NSP I and NSP II hospitals, health systems and their affiliates as approved NSP II service agreement sites for nurse educators prepared through the Cohen Scholars. The Staff developed a master listing of participant hospitals and affiliates to guide service requirements. Any current recipient who is in the service period and not working in an eligible position will be advised of other opportunities and given a reasonable amount of time to enter one of the eligible educator positions.

In addition, Staff recommend approving the NSP II Faculty Workgroup recommendations for all past Hal and Jo Cohen Graduate Nurse Faculty Scholars to be grandfathered into the current 1:1 service agreement, for equitable, clear, and consistent guidance and administration of the Cohen Scholars program.

Commissioner Malhotra asked whether the seven programs were existing or new. Ms. Daw said the programs are not new but are focused on expanding enrollment.

Commissioner Elliott expressed support for NSP and noted that the seven approved programs will improve quality of care and prepare participants for the new NCLEX-RN Board of Nursing Exam.

The Commission voted to approve Staff's recommendation.

## ITEM VI
## DRAFT RECOMMENDATION ON THE UPDATE FACTOR 2022

Mr. Jerry Schmith, Principal Deputy Director, Revenue and Regulation Compliance, presented staff's draft recommendation for the Update Factors for FY 2022 (See "Draft Recommendation for the Update Factors for FY 2022" 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 approaches established in prior years. Staff is considering 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 conditions:

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.

There are two categories of hospital revenue:

- 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.

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: The inflation factor uses the gross blended statistic of 2.37 percent.

- Rising Cost of New Outpatient 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.

  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 2022 continues this practice.

- Care Coordination / Population Health: There were several grant programs aimed at Care Coordination and Population Health in RY 2021 hospital revenues. These programs include Long Term Care Grants, Medicare Advantage Program Grant Funding, and Regional Partnership Funding for Behavioral Health, Regional Partnership Funding for Diabetes Prevention and Management. These funds were provided to hospitals on a one-time basis. For this reason, there is a reversing out of grant funding in RY 2021 of -0.33 percent. Regional Partnership funding for Behavioral Health and Diabetes Prevention and Management is part of a 5-year program. Included in this adjustment is funding for the proposed Maternal Child Health initiatives, pending Commission approval at the May 2021 Commission meeting. RY 2022 funding is expected to be approximately 0.14 percent.

- 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. The amount under review for RY22 as determined by the Integrated Efficiency policy is approximately $19.9 million or a -0.10 percent reduction from the update. This withhold is subject to revisions based on updated data and Commission approval.

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

- Set-Aside for Unforeseen Adjustment: Staff recommends a 0.10 percent set-aside for unforeseen adjustments during RY 2021. 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.

- Complexity and Innovation (previously known as Categorical Cases): Staff concluded that the historical average growth rate was 0.39 percent, which equates to a combined State impact of 0.10 percent for the RY 2021 Update Factor.

- Quality Scaling Adjustments: Staff and hospital stakeholders expressed concerns about using CY 2020 data for the RY 2022 hospital quality pay-for-performance programs due to the COVID-19 public health emergency and data reliability and validity concerns. These pay-for performance programs include Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Quality Based Reimbursement program (QBR). Staff proposed to CMMI that the State should be allowed to re-use RY 2021 revenue adjustments and apply these adjustments for RY 2022. This request was approved by CMMI.

- PAU Savings Reduction: The statewide RY 2022 PAU savings adjustment is now calculated based on update factor inflation and demographic adjustment applied to CY 2019 PAU revenue. RY 2022 PAU savings adjustment represents the change between RY 2021 and RY 2022. Previous years of PAU savings adjustments are not reversed out.

In past years, Staff compared Medicare growth estimates to the all-payer spending limits to estimate whether the State has met the TCOC Model Savings and Guardrail Tests. Due to the ongoing COVID-19 pandemic and the volatility of the current landscape, Staff created an alternative approach to measure projected savings and compliance with the TCOC Model Tests.

As the tests are calculated on a calendar year basis, Staff must convert RY 2022 approved revenue to a calendar year growth estimate.

Staff estimated CY 2021 hospital charges by adding approved revenues for the first half of CY 2021 and estimated approved revenues for the second half of CY 2021 based on the current Update Factor recommendation of 2.37 percent. Staff then adjusted for undercharges in FY 2020 and the first half of FY 2021 and CARES Provider Relief Funds (PRF) Reconciliation. Ultimately, Staff determined that the revised estimate of CY 2021 revenue ($19.16B) would represent an 8.47 percent increase over CY 2020 actual revenue ($17.66B), or 8.38 percent without adjusting for population growth.

Staff also estimated TCOC growth for Maryland and the nation in four buckets: Part A hospital, Part B hospital, Part A non-hospital, and Part B non-hospital. To project CY 2021 growth in the nation, Staff calculated the average trend from CY 2017 to CY2019 and then trended CY 2019 data forward by two years to remove the impacts of COVID-19. Staff used the same approach to estimate non-hospital Part A and Part B for Maryland. Using this approach, Maryland projects to be below the nation by 0.10 percent. The analysis assumes that Medicare growth equals all-payer growth and does not predict pent-up demand or change in healthcare utilization patterns.

Finally, Staff compared the growth in Maryland hospital charges from CY 2018 through CY 2021 to the increase in Maryland Gross State Product (GSP) from CY 2017 through CY 2020 (the most recent period available). Staff determined that the three-year compound annual growth rate (CAGR) in GSP was 3.17 percent, while the three-year CAGR in Maryland hospital charges was 3.29 percent.

Staff presented two proposed methodologies on GBR reconciliation during the February 2021 Public Meeting. Stakeholders raised concerns with portions of the methods, particularly with the timing of settlement, the allocations of regulated CARES Act Funding, and the shifting of funds between entities within the same system.

Through collaboration with the Payment Model Workgroup, Staff has developed a revised approach for GBR settlement. Under Staff's revised direction, the process limits recoveries of COVID Relief Funding provided by the Commission. Staff will define COVID Relief Funding provided by the Commission as the sum of:

- Corridor relief provided in FY 2020 Q4,
- Funding provided under the COVID-19 Surge Funding Policy, and
- Allowance provided for net incremental COVID expenses, as defined by Staff.

Under the revised approach, allocated PRF will be calculated as the actual CARES PRF received by the hospital, times the more generous of the hospital's FY 2019 ratio of regulated to total revenue and the FY 2019 statewide ratio of regulated to total revenue.

Staff's revised approach for GBR reconciliation is as follows:

1. If the sum of FY 2020 actual charges and allocated PRF Funding exceed the FY 2020 GBR, remove from the hospital's future rates the lesser of:

    a) The amount of COVID Relief Funding provided by the Commission.
    b) The amount by which FY 2020 actual charges plus allocated PRF Funding exceed FY 2020 GBR,

2. If the sum of FY 2020 actual charges and allocated PRF is less than the FY 2020 GBR, add to the rates the amount of the shortfall.

The approach described above remains the same as the "alternative approach" presented during the February 2021 Public Meeting except that:

- it is limited to FY 2020,
- it is at a hospital-level ,
- the methodology for allocating PRF has been revised as described above,
- the COVID-19 Surge Funding Policy and Net Excess COVID Expenses are included as Commission-provided COVID Relief.

Before accounting for the COVID-19 Surge Funding Policy and Net Excess COVID Expenses, the revised methodology results in a net statewide increase of $46M, which would be applied to rates on July 1, 2021. However, the HSCRC provided $97M of preliminary relief in hospitals' January 1, 2021 Rate Orders. As a result, the net impact of the methodology is a recovery of $51M, which will be implemented over the last six months of the calendar year.

Based on the currently available data and the Staff’s analyses to date, the Staff provides the following draft recommendations for the RY 2022 update factors.

For Global Revenues Hospitals:

1. Provide an overall increase of 2.23 percent for revenue (net of uncompensated care offset) and 2.07 percent per capita for hospitals under Global Budgets. 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.

2. Allocate 0.23equality percent of the total inflation allowance based on each hospital's proportion of drug cost to the total cost to adjust hospital's revenue budgets more equitably for increases in drug prices and high-cost drugs.
3. Adjust rates effective July 1, 2021, over a 6-month window, to implement the reconciliation of CARES PRF and HSCRC support for Rate Year 2020 as described in this recommendation. The general impact of this proposal is that:

    - For hospitals where the sum of actual charges and PRF is less than their fiscal year 2020 approved Global Budget Revenue the adjustment would add the shortfall, net of any preliminary amount already provided in the January 1st, 2021 rate order, to their July 1, 2021 rate order.
    - For hospitals where the sum of actual charges and PRF is greater than their fiscal year 2020 approved Global Budget Revenue the adjustment would subtract from the lessor of the excess or the COVID corridor relief provided by the Commission (as defined in the body of the draft recommendation) from the July 1,2021 rate order.
    - Staff recommends that the Commission guarantee RY 2021 Global Budget Revenues for hospitals and implement a similar reconciliation policy as outlined above to maintain financial stability for hospitals, given that the COVID pandemic continues to have an impact on health care delivery in RY 2021.

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

1. Provide an overall update of 2.37 percent for inflation.
2. Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

Commissioner Antos asked whether the demographic adjustment accounts for population aging.

Mr. Schmith stated that aging and other demographic changes in the population are not considered at the state level. Mr. Schmith added that the Demographic and Population Adjustment would vary slightly at the hospital level to reflect changes in the hospital's service area population and demographics.

Commissioner Bayless asked how the proposed rate year 2022 update compares to the prior year.

Mr. Schmith said last year's approved revenue growth was 3.52%, primarily because cost inflation was 2.77%.

Commissioner Bayless stated that hospitals are experiencing significant cost inflation in 2021, primarily in hospital staff costs due to the COVID-19 pandemic.

Commissioner Bayless noted that although funding was available during the pandemic, hospitals continue to experience inflation, with costs well above pre-pandemic levels.

Mr. Schmith said HSCRC is examining total cost growth and hospital operating margins in RY 2021.

Commissioner Cohen asked Mr. Schmith if the 2022 proposed update reflects HSCRC Staff's historical approach.

Mr. Schmith said that the proposed update is consistent with HSCRC Staff's approach in prior years.

Ms. Katie Wunderlich, Executive Director observed that the HSCRC deviated from the historical Medicare growth comparison because of COVID-19.

Chairman Kane suggested that in the future the HSCRC will need to develop a policy to address annual under and overcharges as it affects future revenues.

## ITEM VII
## DRAFT RECOMMENDATION ON ONGOING SUPPORT OF CRISP FOR RY 2022

Mr. William Henderson, Principal Deputy Director, Medical Economics & Data Analytics and, Mr. Craig Behm, Executive Director, Chesapeake Regional Information System for our Patients (CRISP) presented the draft recommendations for FY 2022 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 2022 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.

In December 2013, the Commission authorized Staff to provide continued funding support for CRISP for FY 2015 through 2019 without further Commission approval if the amount did not

exceed $2.5 million in any year. Since FY 2020, when Maryland Health Insurance Plan (MHIP) funding terminated, requests have exceeded that amount and require Commission approval.

The Commission approved a total of $5.17 million in funding through hospital rates in FY 2021 to support the HIE and Implementation Advanced Planning Document (IAPD), Integrated Care Network (ICN) projects, and Medicaid Management Information System initiative activities for the Commission. This funding represents approximately 24 percent of CRISP's Maryland funding. The remainder of CRISP's Maryland funding is from user fees, Federal matching funds, and the Maryland Department of Health (MDH).

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, this draft recommendation identifies the following amounts of State-supported funding for FY 2022 to CRISP:

Direct funding and matching funds under Medicaid Enterprise System (MES) Federal Programs for Health Information Exchange (HIE) operations and infrastructure ($2,500,000)

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 ($6,740,000)

Therefore, the staff recommends the HSCRC provide funding to CRISP totaling $9,240.000, an increase of $4,070,000 (79 percent) from FY 2021. This amount represents approximately 31 percent of CRISP's Maryland funding, compared to 24 percent in FY 2021. The remainder of CRISP's Maryland funding is derived from user fees, Federal matching funds and the Maryland Department of Health (MDH). The significant increase in the funding level is driven by 3 factors:

- the roll-out of new programs under the Total Cost of Care Model,
- the switch from a 10 percent State match to earn Federal funds to a 25 percent State match, as funding moves from the HITECH IAPD to MES, and most significantly,
- a change in Federal matching rules that allocates Federal responsibility based on the number of beneficiaries rather than the number of providers participating in Medicaid programs.

The $4,070,000 increase in HSCRC funding correlates to only a 7-percentage point increase in the HSCRC's share of funding (from 24 to 31 percent) because, simultaneously, CRISP has experienced a significant expansion in its MDH-funded public health related work. To minimize the funding required, CRISP has reduced the proposed FY 2022 budget by approximately 18 percent from projected FY 2021 levels.

Staff's draft recommendation is for the Commission to approve a total of $9,240,000 in funding through hospital rates in FY 2022 to support the HIE and continue the investments made in the Total Cost of Care Model initiatives through both direct funding and obtaining Federal MES matching funds. Recommended funding is as follows.

| | |
|---|---|
| Health Information Exchange Assessment | $2,500.000 |
| Reporting and Program Administration | 6,740,000 |
| Total | 9,240,000 |

Commissioner Colmers asked Mr. Behm to elaborate on the increase in the other funding category, and the implications if CRISP did not receive the full requested funding.

Mr. Behm noted that other funding supports public health utilities that cannot easily be replicated. He said if the total funding request were not granted, CRISP would still be able to support core HSCRC analytical functions, but since the additional funding covers requested enhancements that cannot be subsidized CRISP could support fewer public health projects.

Commissioner Elliott asked Mr. Behm to comment on CRISP's ability to maintain the security of protected health information.

Mr. Behm noted the security budget has almost doubled because CRISP follows best practices, added enhancements, and conducts ample testing to ensure health information is protected.

Commissioner Cohen asked Mr. Behm whether changes in State and federal matching funds will continue to impact CRISP in future years.

Mr. Behm said in the past, Maryland benefited by investing State dollars that garnered federal matching funds. He projected that State Medicaid funds would be needed in the future. He observed that a general funding pool would be needed to support public health activities. Mr. Behm stated that he expected that federal funding programs to emerge after the COVID-19 pandemic to support HIEs given the recognition of their importance.

Chairman Kane asked whether the increase in funding was related to total cost of care activities.

Mr. Behm explained that the HSCRC and hospitals require services that go beyond the scope of HSCRC 's core funding. These services are intended to reduce total cost of care, they include collection of social determinants of health data and secure texting programs. Mr. Behm stated that funding from the public health sector would be needed to support future enhancement requests.

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

## ITEM VIII
## DRAFT RECOMMENDATION ON THE MARYLAND PATIENT SAFETY CENTER FOR FY 2021

Ms. Diane Feeney, Associate Director, Quality Initiatives, and Dr. Blair Eig, President and CEO, the Maryland Patient Safety Center (MPSC) presented Staff's draft recommendation on the funding of the Maryland Patient Safety Center for FY 2022 (see "Draft Recommendation on Continued Financial Support for The Maryland Patient Center for FY 2022" on the HSCRC Website)

In 2004, the HSCRC adopted recommendations to provide seed funding for the MPSC through hospital rates, with the initial recommendations funding 50 percent of the budgeted costs of the MPSC. In FY 2021, HSCRC funds accounted for 13 percent of MPSC's total budget. FY 2022 represents the last year of unrestricted funding for MPSC, as it will transition to a self-sustaining resource moving forward.

Under the TCOC Model, it is increasingly important that patient safety and quality of care improve across all care settings. The key stakeholders that are involved with the MPSC include hospitals, patients and families, physicians, long-term care and post-acute providers, ambulatory care providers, and pharmacy – all groups that are critical to the success of the TCOC Model. To achieve mutual healthcare goals for these stakeholders, MPSC prioritizes the Center's collaborations with Maryland's key health policy agencies including the Maryland Department of Health (MDH), the Maryland Health Care Commission (MHCC), the HSCRC and the Office of Health Care Quality (OHCQ). The MPSC is in a unique position in the State to develop and share best practices among these key stakeholder  avoiding duplicative efforts and reducing costs. MPSC is also favorably positioned to act as a convener for hospital and non-hospital providers in Maryland to support provider sharing of best practices and disseminate data that will help them succeed under the TCOC Model. It is imperative that MPSC partner closely with those private sector providers, including hospitals, nursing homes, and skilled nursing facilities, to continue this important work once the HSCRC funding has ended. Indeed, as evidenced by this report, MPSC has positioned itself as a resource to hospitals and LTC providers and as such have been awarded additional partnership funds directly by hospitals.

Key current MPSC hospital and non-hospital projects that particularly align with the TCOC model goals include:

- HRSA Maryland Maternal Health Innovation Grant (known as MDMOM)

MPSC has recruited all 32 birthing hospitals in the State into their program, which provides implicit bias trainings to care providers at these hospitals. This training program is critical to improving maternal mortality and morbidity and reducing health disparities. This work directly aligns with the SIHIS goal of reducing disparities in severe maternal morbidity (SMM).

- Clean Collaborative Phase III for Long Term Care
  Last year, due to the devastation nursing homes faced during the COVID PHE, the Commission voted to provide restricted funding to MPSC to initiate an 18-month collaborative for ten LTCs across the state. Among the goals were to reduce Emergency Department visits and hospital readmissions. Following recruitment and ramp-up, data collection began in October 2020. Early results are provided later in this report, but trends are demonstrating a reduction in infection related ED visits and hospital admissions, and therefore the total cost of care.

- Clean Collaborative Phase IV: HSCRC Hospital Partnership Grants with Long Term Care— Recognizing the value of Phases I and II of the MPSC Clean Collaborative, three hospital systems have partnered with MPSC and are currently working with fourteen LTC partners under the HSCRC Partnership Grants. While it is very early in the data collection process which began in December 2020, early results look promising in reducing infection related ED visits and hospital admissions as well as impacting the reduction of COVID -19 positivity rates in residents and staff at the participating LTC facilities.

The HSCRC collaborates with MPSC on projects as appropriate and reviews an annual briefing on the progress of the MPSC in meeting its goals, as well as an estimate of expected expenditures and revenues for the upcoming fiscal year. Based on both the FY 2021 project outcomes and the projected FY 2022 budget, staff makes recommendations to the Commission regarding the continued financial support of the MPSC. In 2019, the Commission approved a recommendation to decrease the funding by 25% each subsequent year from the 2019 levels such that HSCRC funding would conclude after FY 2022. In May 2021, the HSCRC received the MPSC program plan update for FY 2022. The MPSC is requesting a total of $123,028 in unrestricted funding, a 75 percent decrease over the FY 2019 budget, and representing 7 percent of the total MPSC 2022 budget, consistent with the Commission's intent to reduce State funds over time and encourage a sustainable business model for the MPSC.

In addition to the $123,028, MPSC is proposing that the Commission consider two options: the first is a request for restricted funding to complete the Clean Collaborative PHASE III with LTC that HSCRC funded in FY 2021, in the amount of $125K; the second is funding to convene an additional LTC Clean Collaborative with a new cohort of ten LTC facilities in the amount of

$275K. The restricted funding request for FY 2022 ranges from $125K-$400K from the HSCRC and is detailed in the Budget sub-section under the Assessment section. Currently, Staff is not recommending funding for the Phase V LTC Clean Collaborative. Instead, MPSC should pursue direct funding with hospitals and LTC facilities to disseminate best practices around infection control that can lead to better health outcomes and lower ED utilization.

HSCRC Staff provides the following draft recommendations for the MPSC funding policy for FY 2022:

1. Consistent with prior Commission recommendations, the HSCRC should reduce the amount of unrestricted funding support for the MPSC in FY 2022 by 75 percent from the FY 2019 HSCRC unrestricted grant amount of $492,075. The result is an adjustment to hospital rates in the amount of $123,028.

2. To receive funding from the hospital rate setting system, the MPSC should continue to report annually at a minimum on data that it has collected from hospitals and other facilities that participate in its quality and safety initiatives and should demonstrate, to the extent possible, the ways in which MPSC initiatives are producing measurable gains in quality and safety at participating facilities.

3. MPSC requests additional funding from HSCRC that will be restricted for targeted projects that align with the statewide TCOC Model's quality and safety goals, and which the Commission can consider on a case-by-case basis.

    a) For FY 2022, Staff recommends that the HSCRC fund an additional $125,000 for the 18-month Clean Collaborative Phase III for Long-Term Care project completion, which began and was funded in FY 2021.

4. The MPSC should continue to pursue strategies to achieve long-term sustainability through other sources of revenue, including identifying other provider groups that benefit from MPSC programs, as FY 2022 will be the final year of unrestricted funding from the HSCRC.

Chairman Kane asked what organization would own the intellectual property at the end of the Long-Term Care Clean Collaborative Program.

Dr. Eig said MPSC provides data to all participating long-term care facilities, and other consultants as allowed.

Commissioner Bayless encouraged MPSC to focus future opportunities on alignment with SIHIS goals.

Dr. Eig said MPSC has been engaging with the State during the past fiscal year on the four SIHIS population health goals: maternal equity, childhood asthma, opioids, and diabetes disparities.

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

## ITEM IX
## DRAFT RECOMMENDATION FOR THE COMMUNITY BENEFIT REPORTING

Mr. Willem Daniel, Deputy Director, Payment Reform & Provider Alignment, presented Staff's draft recommendation on Community Benefits Reporting Guidelines (see "Draft Recommendation for the Community Benefit Reporting" available on the HSCRC website).

Hospitals are required to analyze their community's health needs. This assessment must include members of the community. Staff believes that hospitals generally engage in an extensive process with community members when writing their Community Health Needs Assessment (CHNA). However, the extensiveness of those efforts may vary by hospital. Additionally, hospitals are not required to report the portion of community benefit spending directed to CHNA initiatives. Currently, Community Benefit Reporting requirements mandate that hospitals report the spending in high-level categories, such as "Mission-Driven Health Services" or "Charity Care." These categories are not detailed enough to allow the HSCRC, other policymakers, or the public to identify spending directed to community health needs.

Staff draft recommendation is as follows:

Chapter 437 of 2020 (SB 774 and HB 1169) directed the HSCRC to include additional information in hospitals' reporting of community health needs. Accordingly, Staff recommends updating the Community Benefit Reporting Guidelines to require hospitals to report:

1. Which members of the community helped the hospital to develop its Community Health Needs Assessment.
2. Initiatives the hospital performed addressing unmet needs of their community and the costs of those initiatives.

## ITEM X
## FY 2020 HOSPITAL FINANCIAL CONDITION REPORT PRESENTATION

Ms. Amanda Vaughan, Associate Director, Financial Data Administration, presented a summary of the FY 2020 Hospital Financial Condition Report

Despite experiencing a drop in volumes due to COVID-19 in the last four months of FY 2020 and the State mandate to cease all elective and non-urgent medical procedures and appointments from March 24, 2020, through May 7, 2020, Maryland hospitals' median operating margin was 2.19 percent, compared to the national median of 0.30 percent. This difference was due partly to the Commission's actions for COVID-19 relief, and the Federal CARES Act Funding received by hospitals. Maryland hospitals' gross regulated revenues declined by 0.57 percent from $17.4B in FY 2019 to $17.3B in FY 2020. Net regulated revenues also declined from $14.8B in FY 2019 to $14.5B in FY 2020, a decline of 2.03 percent. Regulated profit margins also declined from 8.09 percent in FY 2019 to 7.76 percent in FY 2020.

## ITEM XI
## FINAL RECOMMENDATION ON TERMINATION OF COVID-19 SURGE FUNDING POLICY

Ms. Wunderlich presented Staff's final recommendation on termination of COVID-19 Surge Funding Policy.

On April 30, 2020, the Commissioners approved the COVID-19 Surge Funding Policy in an emergency effort to provide hospitals with additional funding beyond GBR, to the extent that COVID-19 cases caused them to exceed GBR. Under this policy, the funding was equal to the amount by which standard COVID-19 and non-COVID charges exceeded the original GBR. In September, Staff determined that no hospital met these conditions and required no additional funding in RY 2020.

During the September 2020 Public Meeting, HSCRC Staff recommended, and Commissioners approved, the suspension of the COVID-19 Surge Funding Policy. At that time, hospitals were experiencing a substantial return of elective volumes and a decline in COVID-19 cases. Following the vote, Staff and Commissioners agreed that the Commission would revisit the policy in the future, should Maryland experience another surge in COVID-19 cases.

During the December 2020 Public Meeting, Commissioners voted to reinstate the COVID-19 Surge Funding Policy, retroactive to November 1, 2020. At the time, COVID-19 cases and hospitalizations experienced another surge in the State.

Staff continued tracking Statewide COVID-19 volumes and vaccinations and determined that due to the reduction in COVID cases and return of elective volumes, the HSCRC should suspend the policy as of April 30, 2021. Staff will calculate the amount of COVID-19 Surge Funding due

to hospitals for the period from November 1, 2020, through April 30, 2021, and share the results with the industry. Staff notes that any funding provided through the COVID 19 Surge Funding Policy will impact FY 2020 GBR reconciliation calculations.

Staff's final recommendation is as follows:

Given the return of non-COVID volumes, increased vaccinations, and the relatively low rate of new COVID-19 cases, Staff recommends termination of the COVID-19 Surge Funding Policy as of April 30, 2021. Furthermore, Staff recommends adjusting hospital rates consistent with the relevant policies once final data from November 1, 2020, through April 30, 2021, is available. Should COVID-19 cases spike in the State, the Commission can revisit the COVID-19 Surge Funding Policy in the future.

Chairman Kane asked whether the COVID-19 Surge Funding Policy should be kept open perpetually.

Ms. Wunderlich replied that the policy's purpose was to allow hospitals to be reimbursed for extraordinary volumes, but that overall, the idea is contrary to the GBR system.

Ms. Wunderlich explained that Staff believes the policy should only be in place during COVID-19 spikes.

Commissioner Elliott asked if Staff had identified a specific trigger for when the policy should be terminated or reinstated.

Ms. Wunderlich responded that there was no particular trigger, but that Staff closely monitors COVID-19 volumes and would request to reinstate the policy should a significant spike occur.

The Commission voted to approve Staff's final recommendation.

## ITEM XII
## POLICY UPDATE

### Model Monitoring

Ms. Caitlin Cooksey, Chief, Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 12 months ending December 2020. Maryland's Medicare Hospital spending per capita growth was mixed for the past twelve months with December being favorable when compared to the nation. Ms. Cooksey noted that Medicare TCOC spending per capita was trending unfavorably for the past several months with December being favorable. Nonhospital

spending per capita in Maryland is trending close to the nation thru October. Maryland's Medicare Part A nonhospital spending is favorable. Medicare Part B nonhospital spending is mixed when compared to the nation thru December.

## ITEM X
## HEARING AND MEETING SCHEDULE

June 9, 2021 Times to be determined, 4160 Patterson Avenue
HSCRC Conference Room

July 14, 2021 Times to be determined, 4160 Patterson Avenue
HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:46 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 JUNE 2, 2021

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

| Docket Number | Hospital Name | Date Docketed | Decision Required by: | Rate Order Must be Issued by: | Purpose | Analyst's Initials | File Status |
|---|---|---|---|---|---|---|---|
| 2555N | University of Maryland Shore Medical Center at Easton | 4/27/2021 | 5/27/2021 | 9/14/2021 | I/P PSYCH SERVICES | WH | OPEN |
| 2557A | Johns Hopkins Health System | 5/27/2021 | N/A | N/A | ARM | DNP | OPEN |
| 2558N | Adventist HealthCare Rehabilitation-Rockville Campus | 5/27/2021 | 6/26/2021 | 10/24/2021 | RDL | WH | OPEN |
| 2559N | Adventist HealthCare Rehabilitation-White Oak Campus | 5/27/2021 | 6/26/2021 | 10/24/2021 | RDL | WH | OPEN |
| 2560N | Johns Hopkins Bayview Medical Center | 5/28/2021 | 6/27/2021 | 10/25/2021 | CHRONIC & REHAB. | WH | OPEN |
| 2561N | Sheppard and Enoch Pratt Hospital | 6/1/2021 | 6/30/2021 | 10/28/2021 | CAT | WH | OPEN |

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

| | | | |
|---|---|---|---|
| **IN RE: THE APPLICATION FOR** | * | **BEFORE THE MARYLAND HEALTH** | |
| **ALTERNATIVE METHOD OF RATE** | * | **SERVICES COST REVIEW** | |
| **DETERMINATION** | * | **COMMISSION** | |
| **JOHNS HOPKINS HEALTH** | * | **DOCKET:** | **2021** |
| **SYSTEM** | * | **FOLIO:** | **2367** |
| **BALTIMORE, MARYLAND** | * | **PROCEEDING:** | **2557A** |

**Staff Recommendation**

**June 9, 2021**

## I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on May 27, 2021 on behalf of its member hospitals (the Hospitals), requesting approval to continue to participate in a global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplant services. The Hospitals request that the Commission approve the arrangement for one year beginning July 1, 2021.

.

## II. OVERVIEW OF APPLICATION

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

## III. FEE DEVELOPMENT

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

## IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

## V. STAFF EVALUATION

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

slightly unfavorable. The Hospitals report that they have renegotiated reimbursement to mitigate losses. Therefore, staff believes that the Hospitals can achieve favorable experience under this arrangement.

## VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one-year period beginning July 1, 2021. The Hospitals must file a renewal application annually for continued participation.

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

maryland
health services
cost review commission

# Final Integrated Efficiency Recommendation

June 9, 2021

# Overview of Comments Received on Draft Integrated Efficiency Policy Recommendation

- Following the first draft recommendation, staff received comment letters from five stakeholders and several verbal comments from Commissioners.

| | |
|---|---|
| **Maryland Hospital Association** | **Luminis Health** |
| **Johns Hopkins Health System** | **CareFirst** |
| **University of Maryland Medical System** | |

- Following the second draft recommendation, staff received comment letters from eleven stakeholders.

| | |
|---|---|
| **Maryland Hospital Association** | **Luminis Health** |
| **Johns Hopkins Health System** | **Greater Baltimore Medical Center** |
| **University of Maryland Medical System** | **Ascension Saint Agnes Hospital** |
| **LifeBridge Health System** | **Mercy Medical Center** |
| **Medstar Health Inc.** | **Tidal Health Peninsula Regional** |
| **Western Maryland Medical Center** | |

# Comments on the Draft Integrated Efficiency Policy

| Topics | MHA | JHHS | UMMS | Luminis | LB | GBMC | WMHC | St. Agnes | Mercy | Tidal | MedStar | Meritus | CareFirst | Commissioners |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ICC Technical Adjustment (DSH) | | | | | | | ✓ | | | | | | | |
| ICC Peer Groups | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | | |
| ICC Performance Improvement | ✓ | | | | | | | | | | | | ✓ | |
| Allowed Interns & Residents | ✓ | | | ✓ | | | | | | ✓ | | ✓ | | |
| Special Adjustments | | | ✓ | | | | | | | | ✓ | | | |
| Initial TCOC Benchmarking Concerns | ✓ | ✓ | ✓ | ✓ | | | ✓ | | | ✓ | ✓ | ✓ | | |
| Price in TCOC Benchmarking | | | ✓ | ✓ | | | | | | | | | | |
| TCOC Attainment & Improvement | | ✓ | ✓ | ✓ | | | | | | | | | | |
| TCOC Attribution | | | | | | ✓ | | | ✓ | | | | | |
| Implementation Timeline | | | | | ✓ | | | | | | ✓ | | ✓ | ✓ |
| Scaling Approach | ✓ | ✓ | ✓ | ✓ | | | | | | | | | ✓ | ✓ |
| Weighting of TCOC | | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | ✓ | | | |
| Diminished All-Payer Focus | | ✓ | | ✓ | | | | | | | | | | ✓ |
| Revenue Neutrality | ✓ | ✓ | | | | | | | | | | | ✓ | ✓ |
| Rebasing Global Budget Volumes | ✓ | ✓ | ✓ | | | | | | | | | ✓ | | |
| Revenue for Reform | ✓ | | ✓ | | | | | | | | ✓ | ✓ | ✓ | ✓ |

# ICC Technical Adjustments (DSH) & Staff Response

| Topic | WMHC |
|---|---|
| Modify Poor Share Variable in DSH Adjustment | The current measure [of poor share] is based on the percent of hospital revenue from Medicaid for inpatient and outpatient services for Maryland residents where Medicaid is either the primary or secondary payer. We ask that this measure be expanded to include out-of-state residents as well, given that the population served is still poor with the same general health characteristics as their Maryland counterparts.<br><br>We would also ask the measure include patients with Medicare as a primary payer but charity as a secondary payer, reflecting the low-income status of these elderly patients who do not currently qualify for Medicaid. |

- Staff agrees with the first suggested technical adjustment of adding Medicaid out-of-state to the poor share variable that is being proposed, in lieu of peer groups, as a means to calculate the direct risk adjustment of serving a lower socioeconomic population.
  - Represents similar population that is agnostic to patient's home residence
  - DSH coefficient is reduced to $63.14 per case as opposed to previously calculated value of $69.14 per case.
    - $R^2$ (explanatory power of poor share variable in ICC performance) is 50.8% versus 52.08%
  - Limited impact on results; Correlation (R) = .9980
    - See Appendix for Revised Results
- Staff does not concur with request to include Medicare as primary payer and charity as secondary payer
  - Does not necessarily represent a lower socioeconomic population, as reduced cost care can be provided to patients up to 500% of FPL
  - Staff's poor share variable is meant to serve as a proxy for indigent care. It will not capture all populations that are more expensive, hence the regression based approach.
  - CMS has not extended its stratifications/risk adjustments to include Medicare individuals outside of the dual eligible population

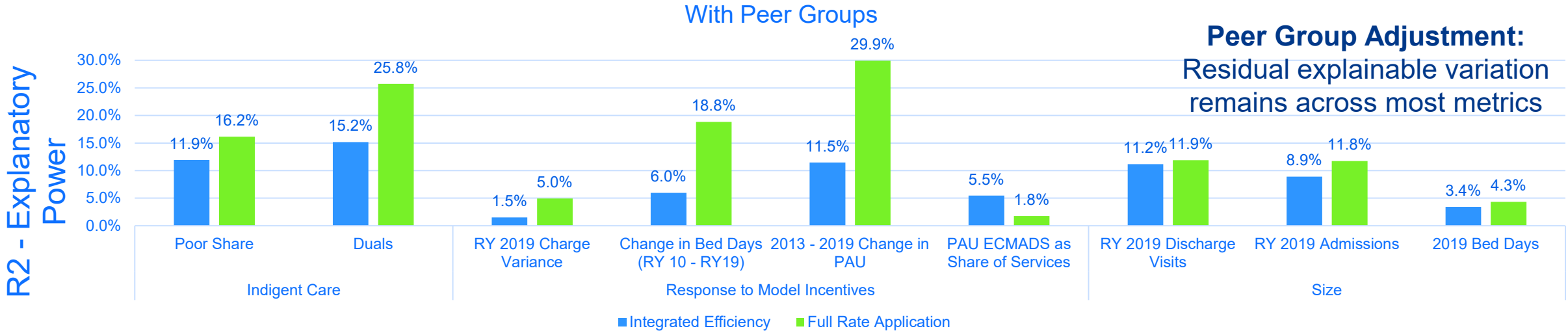
# ICC Peer Groups

| MHA | JHHS | UMMS | Luminis | Lifebridge | WMHC & Tidal | St. Agnes | Mercy | Meritus |
|---|---|---|---|---|---|---|---|---|
| The analysis focused on the cost factors peer groups were originally intended to address, including indigence of the patient population, urbanicity, and hospital teaching status.<br><br>Although many cost factors and their associated variables were tested, additional elements have been posited to influence ICC performance. The Commission should further evaluate the efficacy of the alternative and peer group approaches by testing factors including, but not limited to, geography, technology, and case mix index. | JHHS would ask that HSCRC staff continue to work with hospitals to better understand these factors and delay the implementation of the peer groups until such analysis can be found. | While the Commission staff have put forward a very thorough and thoughtful proposal, we view this proposal as one possible solution out of many, and we do not yet know if it is the best solution.<br><br>We therefore propose that a decision to move to a statewide peer group be delayed to allow time to explore alternative peer group options and adjustments. | Luminis believes a prudent approach would be to make the necessary, straightforward changes to the peer groups now (such as moving urban hospitals into the urban group and moving hospitals with newly established teaching programs into the teaching program, and dedicating more time to determining its handling of new teaching programs and vetting the proposed socioeconomic adjustor. | Because of the amount of variability the elimination of peer groups creates, and importance that ensuring a direct disproportionate share adjustment appropriately reflects the associated costs with providing care, we believe it would be prudent for the HSCRC to continue to explore alternatives before adopting no statewide peer groups.. | While we understand HSCRC's rationale for the potential elimination of peer groups, any shift away from this historic policy needs to adequately account for socioeconomic factors inherent in measuring the relative efficiency of hospitals.<br><br>These issues are particularly prevalent in more rural areas of the state that do not have the infrastructure and resources of more urbanized areas. | Eliminating peer groups entirely requires full confidence that direct adjustments to capture such issues as socioeconomic disparity are fully and precisely captured. Saint Agnes commends the work done by HSCRC staff to reintroduce a DSH-like measure as a thoughtful start to the necessary process of appropriately quantifying the impact of socioeconomic disparities on hospital costs. | Mercy's concern is the new regression does not adequately account for the direct and indirect cost of providing services in Baltimore. | Meritus agrees with this analysis and supports the elimination of the traditional peer grouping logic from the efficiency policy. However, we echo the comments of the MHA that further evaluation of additional cost factors and their influence on ICC performance is needed. |

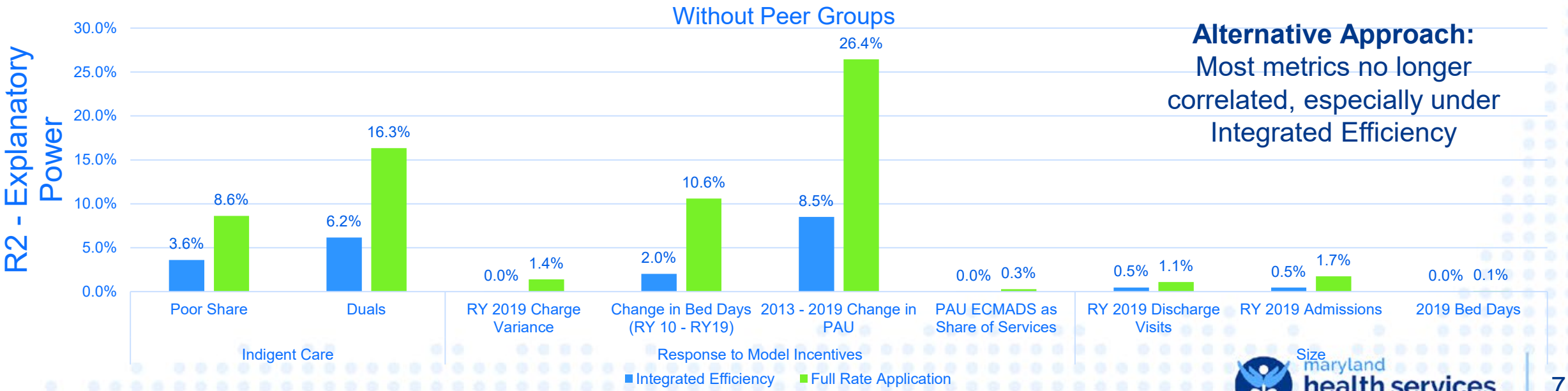
# Staff Responses: ICC Peer Groups

- Staff agree with the concern expressed in many of the comment letters that a movement away from peer groups should evaluate cost elements that may influence ICC performance.
- Staff would note though that:
  - The peer groups should chiefly adjust for their stated purpose: indigent care and teaching status. While peer groups accomplish these goals, staff's alternative approach is more effective
  - Additional analysis of other cost factors have shown no material, statistically significant relationship between ICC Performance and factors for which hospitals should be held harmless.
  - Moreover, in nearly all cases the influence cost factors have on ICC performance was reduced by the introduction of the alternative approach of abandoning peer groups and directly risk adjusting for indigent care (see appendix B for additional results – casemix, trauma, high tech, labor market, payermix, unique service lines).
- For these reasons, staff recommends adopting the direct risk adjustment approach for indigent care.
  - Staff does not recommend waiting to make the transition until the "best solution" is developed, as it is not clear if one exists and all analyses indicate the alternative approach is methodologically superior to peer groups.
  - Staff likewise disagree with idea of just transitioning hospitals from one peer group to another within the existing peer group framework, because a) it is not clearly evident what hospitals should transition, especially for the urban peer group, and b) these new peer group assignments will not effectively reduce risk adjust for indigent care with the same precision as a direct risk adjustment.

# Staff Responses: ICC Peer Groups cont.




**Peer Group Adjustment:**
Residual explainable variation remains across most metrics




**Alternative Approach:**
Most metrics no longer correlated, especially under Integrated Efficiency

# TCOC Technical Concerns & Staff Response

| Topic | WHMC & Tidal |
|---|---|
| Labor Market Adjustment | Medicare payments are generally adjusted for the wage index to reflect differences in wages across areas.<br><br>Without adjusting for the wage index, Maryland hospitals with patients in counties compared to low wage markets face a standard where Medicare prices may be as much as 35% below the national average while high wage markets may be 91% more. |
| Normalization Adjustments | The [demographic] normalization involves an adjustment from a regression model based on two measures: a measure of deep poverty level and the county's median income. The regression model explains only 13% of the variation in TCOC per Medicare fee-for-service beneficiary in the 650 counties used in the benchmark process (based on the model's adjusted R-Squared), but is nonetheless used for the normalization.<br><br>The second adjustment, however, for median income also increase the comparison benchmark that results in a more favorable comparison for the hospital. Hence, the staff's proposed policy is to provide a more generous assessment of a hospital's relative efficiency because it's patients are in high-income areas.<br><br>The result is a real redistribution of resources away from hospitals serving poor patients to those in affluent communities. |

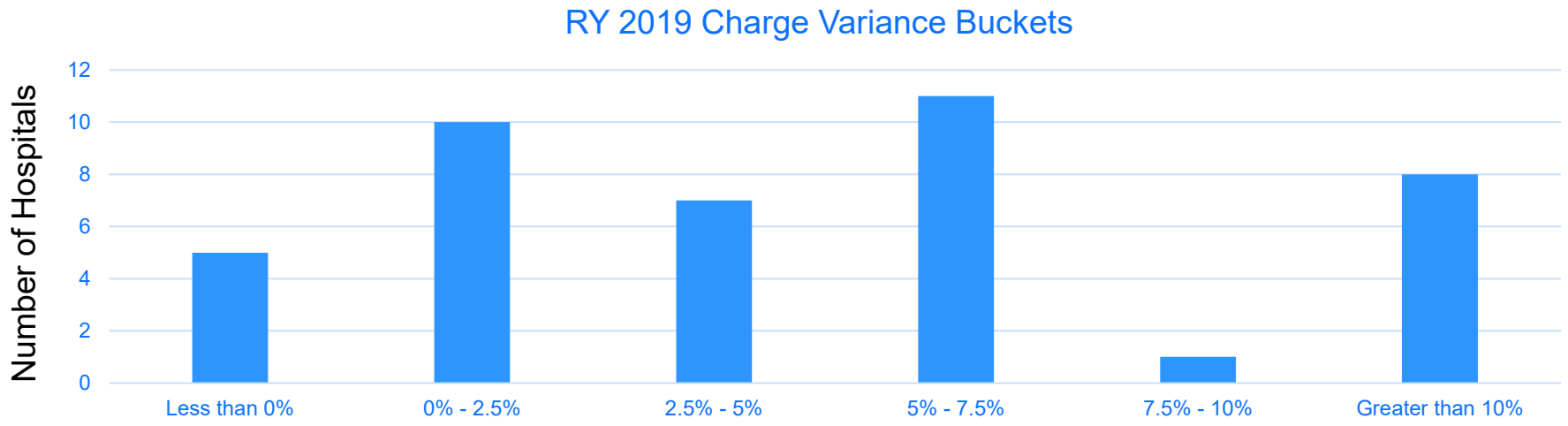
- Regional Price Parity, a measure of prices was used in selecting benchmark areas.
- Medicare Wage Indexes have been criticized by Maryland hospitals due to there dependence on reporting which Maryland hospitals are not focused.
- Staff disagree with notion that an adjustment for deep poverty and median income necessarily redistributes resources away from hospitals serving poor communities.
  - An adjustment for deep poverty purposefully attempts to account for the higher than anticipated costs in a lower socioeconomic area and the likely reason the $R^2$ is low (but still statistically significant) is because staff first selected peer geographies and then ran a regression to normalize for residual cost variation. If no peer selection was performed, the $R^2$ would theoretically be much higher.
  - The adjustment for Median Income, at least to some degree, does what a wage index adjustment would do in favoring areas with higher wages and therefore incomes. Also, there is extensive evidence that higher income areas do experience higher utilization and prices, particularly in the commercial population, and therefore higher benchmarks would be expected.
- A thorough review of the TCOC results does demonstrate that various low income parts of the State (e.g. Easton) are not adversely affected by the benchmarking methodology, but staff will continue to refine the methodology with stakeholders to ensure that it yields fair and reasonable results.

# Implementation Timeline & Staff Response

| LifeBridge | MedStar | CareFirst |
|---|---|---|
| The volume data used to calculate the ICC comparison is from fiscal year 2019. Understanding the inability to utilize data from fiscal year 2020 given the COVID pandemic, we believe facilities may be experiencing different levels of current volume activity when compared to fiscal year 2019 data, and that the changes in volume may be permanent moving forward as activities return to normal.<br><br>Waiting for more current data will ultimately produce a more accurate result for any ICC methodology adopted. In the interim, the HSCRC maintains the ability to implement relative efficiency controls through control of volume-based corridors and associated restrictions to revenue | We recognize these recommendations include several material changes in historical methodology, such as removing peer groups, reducing IME credit for non- AMC's, and introducing a Medicare/Commercial TCOC benchmark. These methodological changes have created a significant change in hospital performance against the efficiency metric and may impact performance under other methodologies as well.<br><br>As HSCRC and the hospitals continue to review and offer improvements to methodology, consideration should be given to phasing-in methodology changes to allow for monitoring and adjustment. | CareFirst noted that an efficiency methodology be implemented as soon as possible to ensure that individual hospital costs do not become unreasonable relative to their competitors. |

- Staff acknowledges that the proposed Integrated Efficiency policy for RY 2022 does incorporate several new modifications to the underlying methodologies and appreciates all the work industry has done to improve the policy while also heroically responding to the public health emergency.
- However, staff would note that with the exception of TCOC benchmarks, an alternative to ICC peer groups, special adjustments for Chestertown Hospital, and the alternative scaling approach, which was unanimously supported by stakeholders, these modifications, e.g. an updated indirect medical education risk adjustment, have been reviewed for more than one year and reflected in prior iterations of this policy.
  - All modifications brought forward in the last year have gone through various workgroup processes.
- Staff would also note that while LifeBridge's comment that relative efficiency has been maintained through control of volume-based corridors is correct, these corridors have, in recent years, been more limited in incentivizing reductions in avoidable utilization because corridors are topping off (see next slide). Furthermore, without implementing an efficiency policy that withholds inflation, thereby driving less variation in efficiency outcomes, staff would not support rebasing volumes in RY 2022 rate orders to CY 2019 volumes, as requested by numerous stakeholder comment letters.

# Implementation Timeline & Staff Response cont.




- Finally, staff would point out that while COVID will undoubtedly affect volumes for years to come and may yield a “new normal” that is different by hospital, there has not been an efficiency policy that scales inflation in the GBR era and there has been rather strong correlation in year over year ICC results (RY19-RY20 - R=.9072), suggesting that relative efficiency has been fairly stable as the Commission has not yet addressed divergences in efficiency in our Model(s).

# Weighting of TCOC & Staff Response

| Topic | WMHC & Tidal | Mercy | MedStar | JHHS | Luminis |
|---|---|---|---|---|---|
| 50/50 Weighting of ICC & TCOC | Hospitals on average in Maryland contribute about half of the TCOC for Medicare beneficiaries. The remainder is out of the direct control of the hospital. While the model provides incentives to coordinate across the healthcare spectrum of services other providers are still largely paid on a fee-for-service basis…<br><br>Hence, the use of 50% of the TCOC benchmarks for determining relative efficiency seems excessive. Hospital revenue is being placed at risk beyond the ability for the hospital to control the performance in the market | At 50%, the policy significantly over weights the share of TCOC relative to individual efficiency, far beyond national programs and commercial payers. | The Medicare and Commercial Total Cost of Care Benchmarking is a significant new measure that will most likely require adjustment over time as HSCRC and the hospitals continue to review and understand the results.<br><br>Historically, when new measures of significance were introduced, the Commission often implemented a phased-in approach. We recommend increasing the weighting of this measure in stages over the next several years (i.e. 25% in FY22, 50% in FY23) given both the newness of the measure and to ensure that it aligns with the model and other policies. | | |
| 50/50 Weighting of Med/CO TCOC | | | | Not considering the significant payor mix differences in Maryland's hospitals could have an unintended consequence of disadvantaging a hospital based on payor mix | Concerned that the policy assumes a 50/50 attainment measurement mix between Medicare and Commercial payers, not taking into account the significant payer mix differences in Maryland's hospitals. |

# Staff Response: Weighting of TCOC

- Staff's acknowledges various hospital's concern that weighting TCOC as 50% of the Integrated Efficiency policy is significant since hospitals are accountable for TCOC but not directly responsible for it. Staff would note though that:
  - Emphasizing cost per case efficiency in a TCOC Model could lead to perverse outcomes that undermine the central incentive of the Model to improve the health of the population and reduce potentially avoidable utilization
  - Hospitals have far greater influence on Medicare TCOC when associated professional claims are considered (~70%)
  - Readjusting the weighting as outlined by Medstar in a phased in approach, i.e. 25% TCOC in RY 2022, would have limited effect on the Integrated Efficiency results:
    - Correlation (R) between Efficiency Matrix with 50/50 weighting & 75% ICC/25% TCOC = .918; all but one hospital (WMHC) would remain in the penalty zone;
    - Staff would be concerned moving beyond 75% ICC weighting given incentives of the Model, i.e. this is a TCOC Model
  - For these reasons, staff recommend maintaining the 50/50 weighting of the ICC and TCOC

- Staff's weighting of Medicare and Commercial TCOC performance at 50% each for the 50% TCOC component of the policy (i.e. 25% for each TCOC assessment) was purposeful.
  - Given the all-payer nature of Maryland hospital rate setting that advantages commercial payers relative to national peers, and disadvantages Medicare, AND the fact that price is not removed from the benchmarks, the 50/50 weighting for all hospitals ensures that no hospital has an advantage due to its unique payor mix in an all-payer state
  - Specifically, hospitals with larger commercial shares in richer areas are not artificially advantaged
  - Potential downside to this approach is if a hospital has a low, unrepresentative share of an individual payer that then comprises 25% of the efficiency assessment
    - Analysis of CY 2019 Hospital Payer Mix indicates that no hospitals fall below 2 standard deviations in Medicare or Commercial payer shares relative to the statewide average.
    - Very low coefficient of variation for Medicare (.28) and Commercial (.16) payer mix corroborate the idea that there is limited variation

# Rebasing Global Budget Volumes & Staff Response

| MHA | JHHS | UMMS | Meritus |
|---|---|---|---|
| MHA asks the HSCRC to set annual unit rates using volumes from the most recent 12-month period preceding the rate order, citing the complexity of measuring monthly rate compliance and adjusting unit rates, as well as the reduced need for maintaining 2013 volumes once the efficiency policy is implemented. | JHHS believes that if the staff recommendation is approved that staff should set annual unit rates using volumes from the most recent 12-month period preceding the rate order. We appreciate the need to hold hospitals accountable to GBR targets, and the efficiency policy will reduce overall GBR revenues for outlier hospitals | UMMS fully supports the Commission's proposal to rebase rate order volumes using FY19 data. GBR rate orders were first established in 2014 volume levels and those volumes have since only been adjusted for targeted policies and only by modest amounts. Continuing to utilize outdated volume levels creates an added level of administrative burden on both the hospitals and Commission staff in order to continually request corridor adjustments. Rate order volume was fixed in the beginning of the new model to ensure significant shifts in volume and pricing could be evaluated, as the Commission did not have another mechanism at the time to monitor such changes. Now that the Commission has an integrated efficiency model, we feel that it is no longer necessary to hold volume constant on hospital rate orders. | Meritus agrees with MHA's position, which is also supported by Commission staff, to re-base hospital volumes to the 2019 period to accurately reflect hospital price per unit in the ICC. |

- Staff are supportive of rebasing global budget volumes should an efficiency policy be implemented
  - Stakeholders are right about administrative concerns regarding corridor compliance
  - Rebasing volumes will increase the incentive to reduce avoidable utilization, especially for hospitals that are or are approaching corridor limits
  - Thus, staff are advancing the following recommendation in the RY 2022 Integrated Efficiency Policy recommendation
    - **If inflation is withheld in RY 2022 Update Factor based on relative efficiency policy, update volumes for RY 2022 rate orders to reflect CY 2019 volumes with 5 percent corridors. This limit may be extended to 10 percent at the discretion of the HSCRC staff if the Hospital presents satisfactory evidence that it would not otherwise be able to achieve its approved total revenue for the Rate Year.**
  - Staff, however, does not support rebasing each year based on the most recent 12 month period, as requested by MHA and JHHS for the following reasons:
    - The permanent effects of COVID have not yet been settled and the Commission should consider accruing savings to payers if utilization remains far below historical norms, which an annual rebasing policy will not allow
    - The Integrated Efficiency policy only makes negative adjustments to hospitals in the fourth quartile, i.e. it is not a broad based scaling policy, so rebasing all hospitals' volumes each year seems inconsistent with the proposed reach of the efficiency policy
    - Corridors are the Commission's best analytic to determine deregulation of services, which the Commission must defund in the GBR in order to avoid "double billing," and rebasing each year will make it difficult for staff to use this analytical tool

# Final Recommendations

1) Formally adopt policies to

- Determine hospitals that are relatively inefficient;
- Evaluate Global Budget Revenue enhancement requests using the criteria identified above;

2) Use the Inter-Hospital Cost Comparison, including its supporting methodologies to compare relative cost-per-case for the above evaluations;

- Abandon ICC peer groups and adopt a direct regression based risk adjustment for indigent care cost variation that will be applied to all efficiency policies

3) Use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance for the above evaluations;

4) Withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals based on criteria described herein

5) Use set aside outlined in the Annual Update Factor and funding secured from withholds from outlier hospitals to fund potential Global Budget Revenue enhancement requests.

6) If inflation is withheld in RY 2022 Update Factor based on relative efficiency policy, update volumes for RY 2022 rate orders to reflect CY 2019 volumes with 5 percent corridors. This limit may be extended to 10 percent at the discretion of the HSCRC staff if the Hospital presents satisfactory evidence that it would not otherwise be able to achieve its approved total revenue for the Rate Year.

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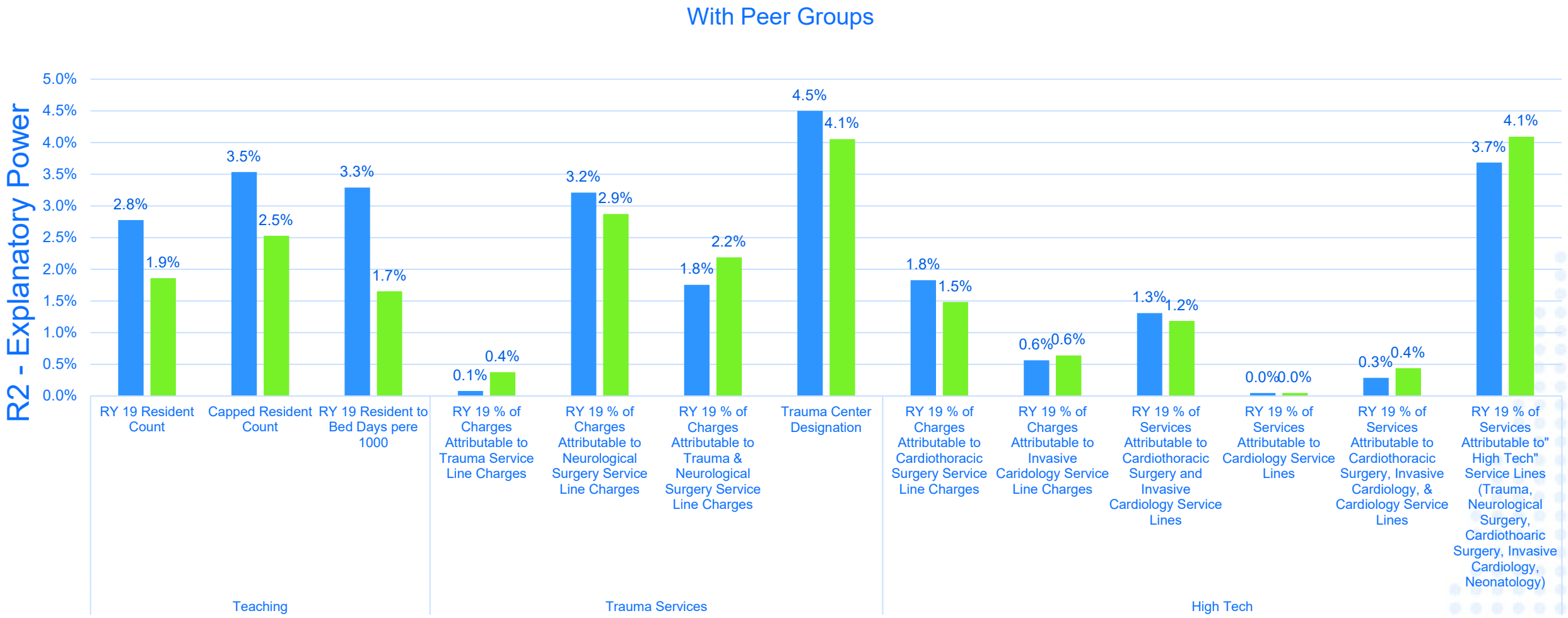
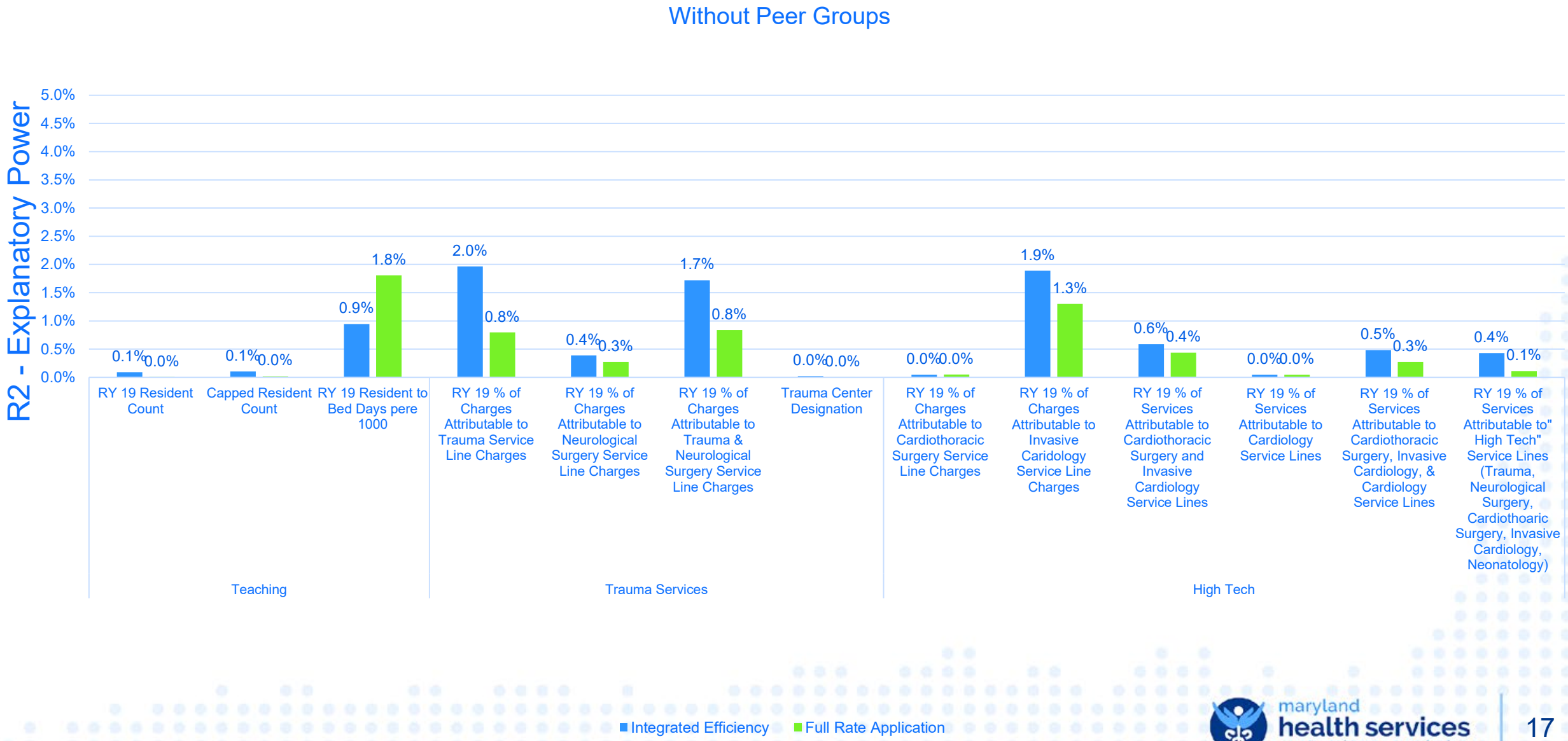
# Appendices

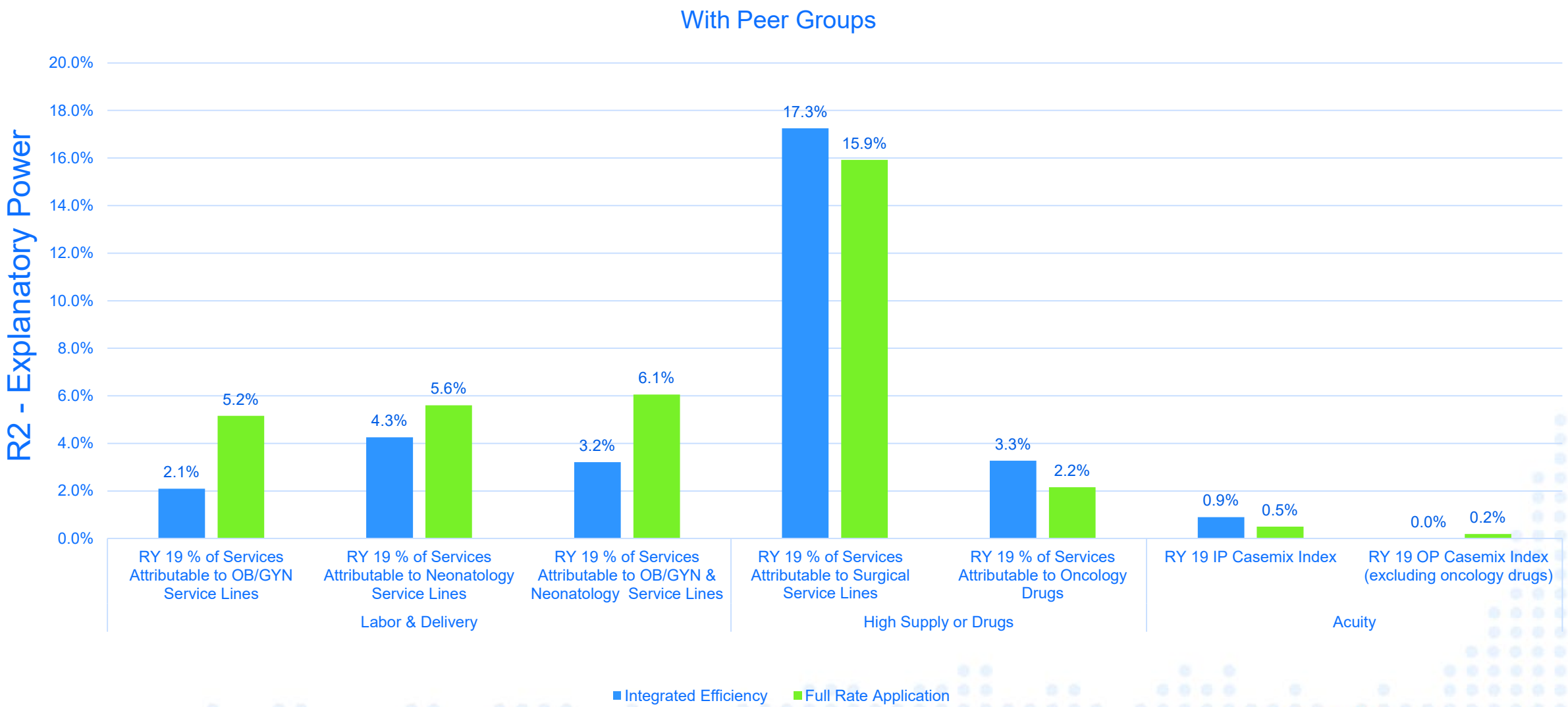
# Appendix 1a – Cost Factors Affecting ICC Results



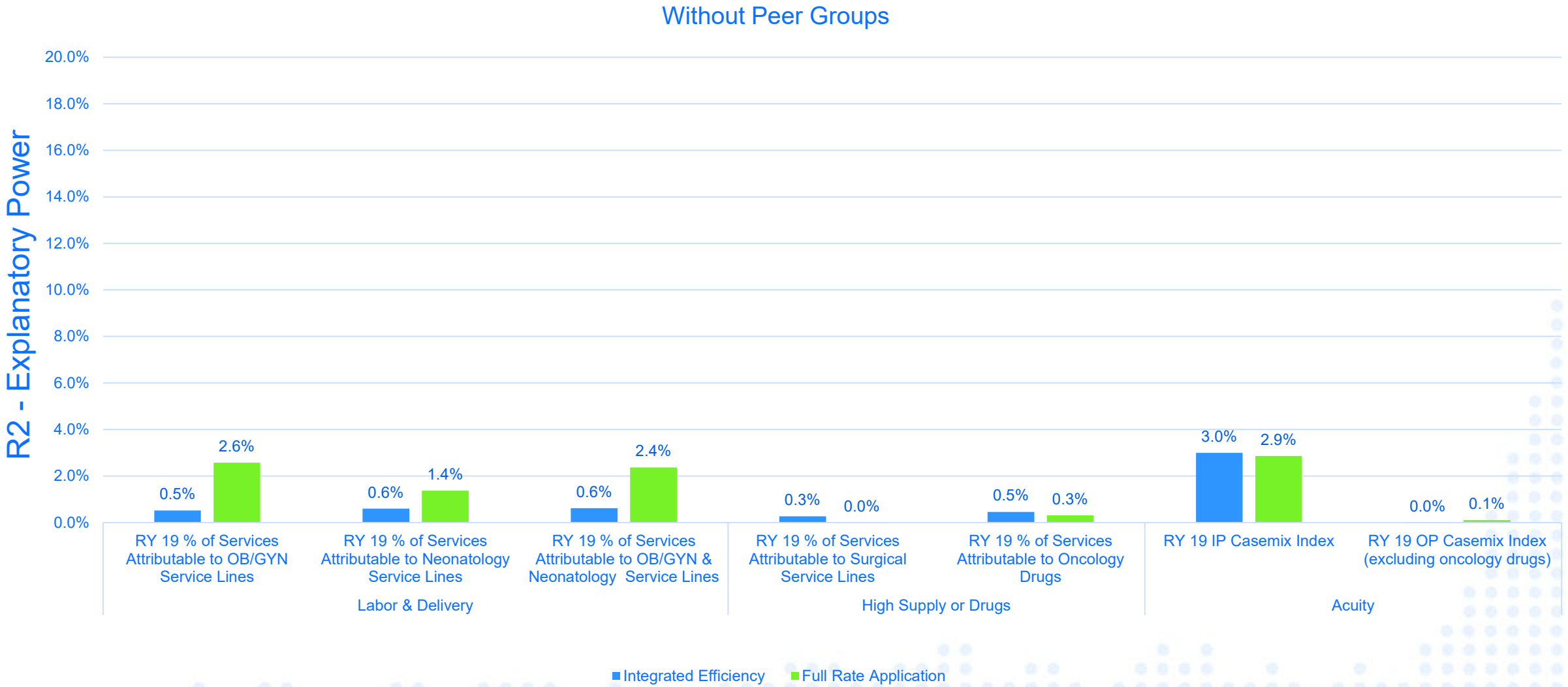
# Appendix 1b – Cost Factors Affecting ICC Results



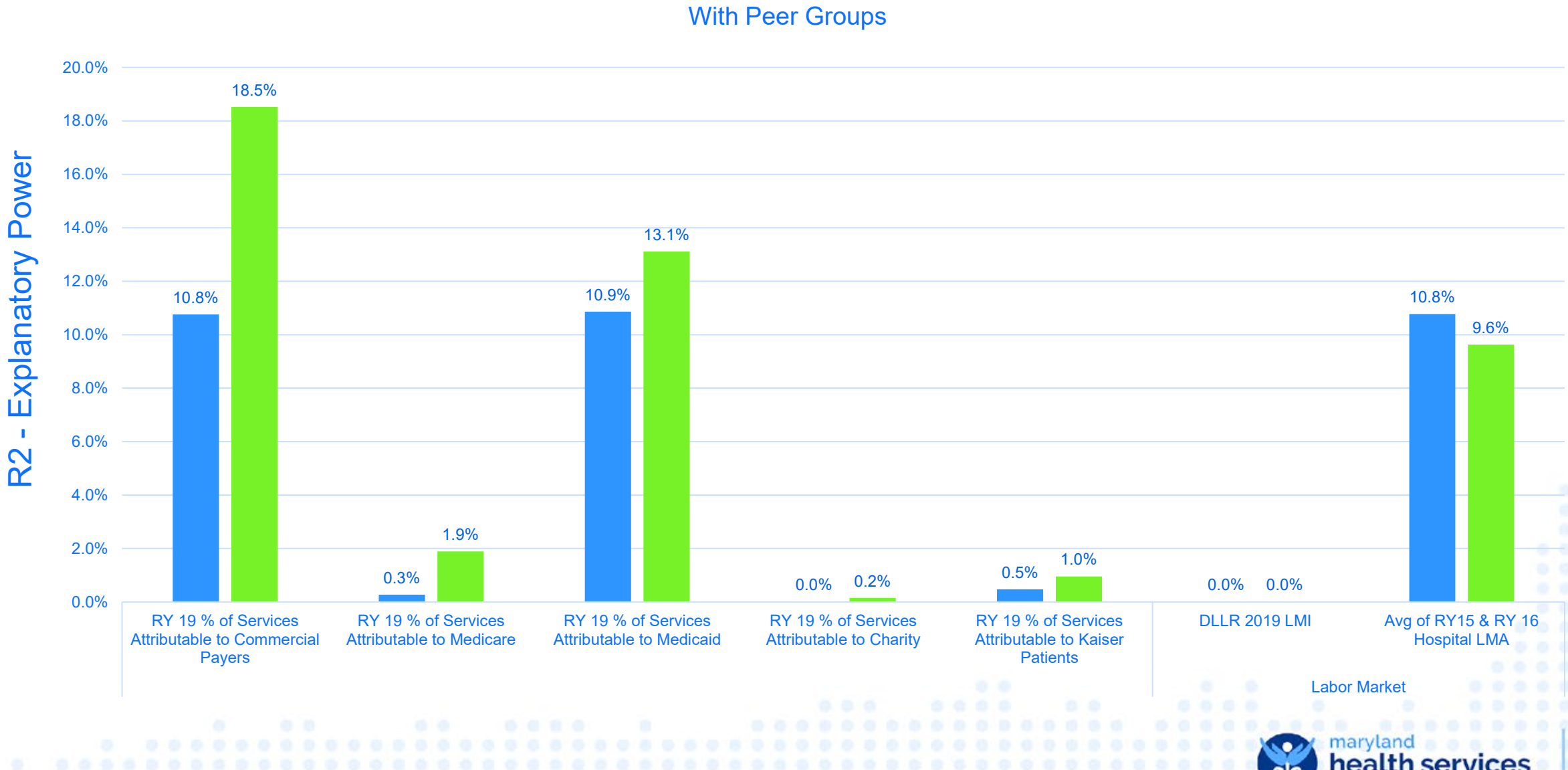
# Appendix 1c – Cost Factors Affecting ICC Results



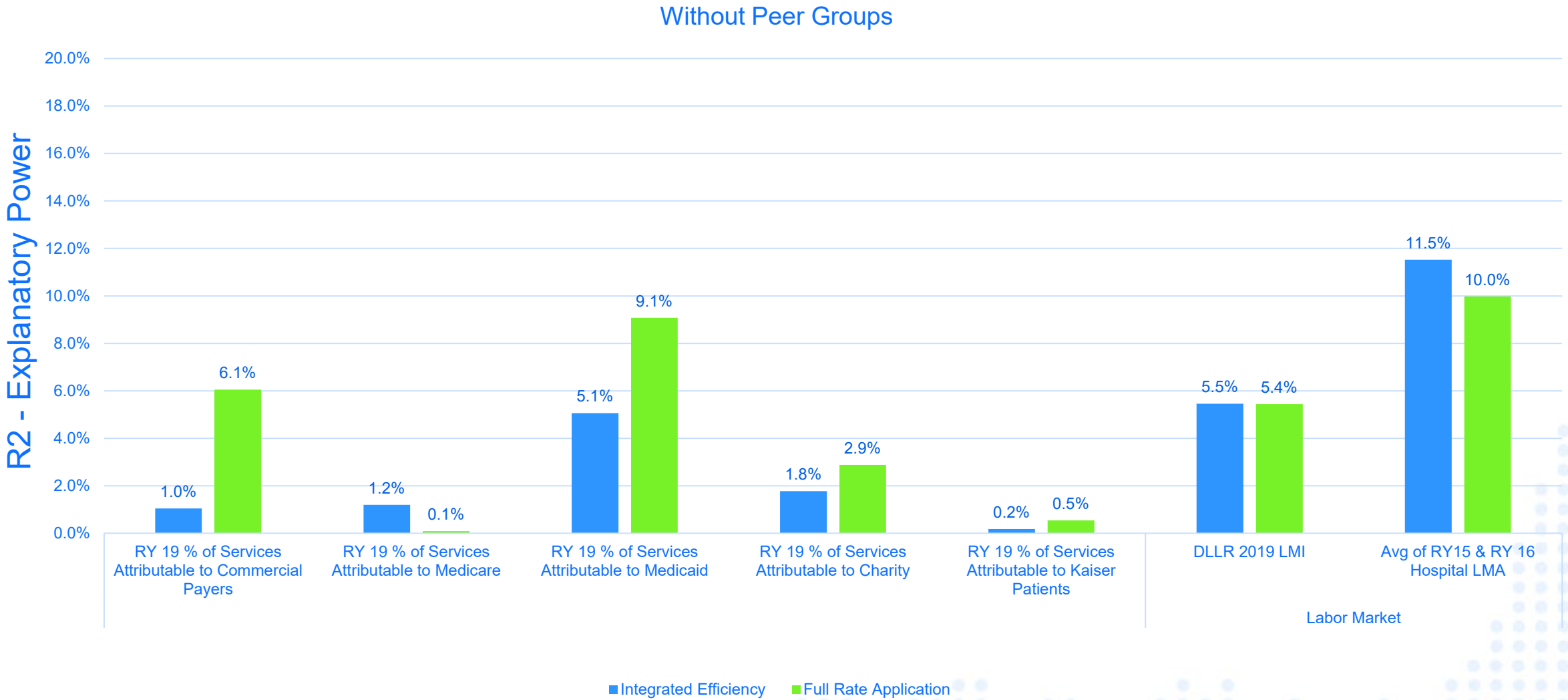
# Appendix 1d – Cost Factors Affecting ICC Results



# Appendix 1e – Cost Factors Affecting ICC Results



# Appendix 1f – Cost Factors Affecting ICC Results



# Appendix 2: ICC Performance Improvement & Staff Response

| MHA | JHHS | CareFirst |
|---|---|---|
| A guiding principle of the policy is HSCRC's statutory mandate to ensure hospital costs are reasonable and charges are reasonably related to costs. Under the Inter-hospital Cost Comparison (ICC) methodology, hospitals cannot make management decisions that will affect the policy outcome because revenues and adjustment factors are fixed. Under the "Revenue for Reform" proposal, hospitals could quantify, and possibly boost, resources they invest to transform care. The hospital field understands the statutory requirement. HSCRC might further opine on what hospitals can achieve to improve policy results. | JHHS believes that HSCRC staff should include clear policy goals and objectives for the efficiency policy. We believe for an efficiency policy to be effective, hospitals need to understand what actions a hospital can take in order to improve their positions in the rankings. | In the past, similar threshold policies [worst quartile and an outlier on price] created a "stuck hospital" phenomenon where there was little opportunity for hospitals to get to the next level. As part of an ongoing evaluation, Staff should consider whether this phenomenon is occurring under the new policy. |

- Staff agrees with stakeholder's concern regarding performance improvement, as any good policy must create clear incentives, and staff likewise appreciates MHA's acknowledgement that the Commission must still adhere to its statutory mandate to ensure hospital costs are reasonable and charges are reasonably related to costs.
- Staff would note there are several ways hospitals in a fixed revenue environment can improve in the ICC while not compromising TCOC performance, including:
  - Reducing Potentially Avoidable Utilization, which receives direct credit in the ICC
  - Providing medically necessary care, often more acute in nature
  - Repatriating volume lost to non-Maryland facilities
  - Demonstrating performance as a center of excellence, which allows the exporting of Maryland hospital services to non-Maryland residents
  - Reducing cost per case, which admittedly is partially offset by the ICC profit strip
  - Repurposing retained revenue to care transformation initiatives, which admittedly is not yet eligible for credit in the ICC, i.e. Revenue for Reform
  - The redistributive nature of the policy will also improve hospital's performance
- Staff will continue to assess the degree to which hospitals are "stuck" under this policy and will modify the policy in the future if it continues to ensnare hospitals in perpetual inflation reductions that cannot be avoided by performance improvement in the ICC or TCOC.

# Appendix 3: ICC Allowed Interns & Residents & Staff Response

| MHA | Luminis | Tidal | Meritus |
|---|---|---|---|
| Adjustments to hospital revenue for medical education costs are based on the number of interns and residents as of 2011. Since then, hospitals began new residency programs. HSCRC should periodically assess adjustments for medical education based on program changes. | The current measure of relative hospital cost efficiency, the ICC, does not account for the costs associated with newly established graduate medical education programs. This is particularly impactful at Anne Arundel Medical Center, where our program, with 48 residents for FY 22 and growing to 76 residents by FY 24 is unaccounted for in the calculation. This program carries a significant cost, with direct medical education (DME) and indirect medical education (IME) costs estimated to be $225,000 per resident. While we recognize that HSCRC staff has stated that it is evaluating its handling of new programs, an ICC that does not account for the DME and IME costs related to this program is not a comprehensive picture of AAMC's relative cost-efficiency position. | The current policy also does not adequately reflect the reality of teaching programs within the state and is inconsistent with CMS reimbursement policies or these programs. The current policy limits the number of residents to the amount included in the FY 2011 Efficiency Methodology and does not reflect residents associated with new programs. This has the effect of reducing the ability of hospitals to increase residency placements and expand teaching programs. | Investments by hospitals in establishing new teaching programs are effective in addressing identified physician shortages, improving access to care, and ultimately improving the health of the people of Maryland. We ask Commission staff to consider providing ICC adjustments to account for the costs of residency programs established since 2011 that are linked to addressing issues with access to care and physician shortages. |

- Staff agrees that the current cost associated with the residency program at AAMC is significant and that the current policy of not funding new residency programs in accordance with CMS' graduate medical education policy is inconsistent with CMS' reimbursement policies.
- However, staff would note that:
  - There is significant supply of physicians and funded residency slots relative to the rest of the nation; moreover, retention of trained residents is low (~30%)
  - Not all Maryland residency programs currently in existence receive IME and DME credit for each resident, e.g. 318 of UMMC's 843 residents are not recognized in the ICC
  - Not all CMS reimbursement methodologies and their associated outcomes are desirable
    - Resident counts have been frozen since 1996 and only altered by various redistribution schemes; RY 2022 proposed IPPS rule does indicate 1,000 new slots will be added at 200 per year in RY 2023
    - "As an "entitlement" system… a community with no GME can build a very large multihospital GME system with a high cap fully funded by Medicare. The specialty mix of that system may have nothing to do with state/local needs for physicians. This is happening particularly in urban communities with new medical schools" – American Academy of Family Physicians
- Staff has completed a supply and demand analysis with its contractor Mathematica Policy Research and does plan to convene a workgroup in the Summer to develop an allowed residents policy that takes into account physician supply by region and specialty

# Appendix 4: ICC Special Adjustments & Staff Response

| Topic | Medstar |
|---|---|
| Revenue for Reform Pilot | Given the importance of care management to the success of the Maryland GBR model, we support the "Revenue for Reform" Concept that would allow hospitals to retain funding to reinvest in approved reform efforts. To ensure transparency and equity, we recommend developing this policy before approving revenue for reform special adjustments. |
| Critical Access Hospital Adjustment | If the HSCRC removes peer groups, we would recommend not making any new special designations or adjustments until a formal process and policy is developed and approved that would evaluate other categories of cost that may be unique in certain types of providers |

- Staff agrees that all adjustments, specific to one hospital or broadly applied, should be evaluated in consultation with workgroups and then made available to all hospitals that meet the criteria for that adjustment
- Staff would note specific to the critical access hospital adjustment provided to Chestertown Hospital that the Maryland State Legislature authorized a report by the Maryland Health Care Commission and its contractor NORC that concluded that Chestertown is a unique rural healthcare delivery system in an otherwise urbanized state and that "rural hospitals require solutions that are tailored to community needs and built around sustainable services."
  - Staff would further note that this critical access designation was discussed in 2 workgroup meetings and outlined in a public meeting for Commissioner consideration.
- Commissioners requested of staff during the November 2020 Commission meeting a pilot of the Revenue for Reform program, which staff extended to Chestertown, since the rural healthcare delivery reforms, including mobile integrated homes and the proposed Aging and Wellness Center, were outlined in the NORC Report.

# Appendix 5a: TCOC Benchmarking

| Topic | MHA | JHHS | UMMS | WMHC & Tidal | MedStar | Luminis | Meritus |
|---|---|---|---|---|---|---|---|
| Appropriate Vetting | Since March 2020, hospitals re-allocated resources and staff to respond to the COVID-19 pandemic. When the methodology was introduced in August 2020, key hospital stakeholders were unable to review and thoroughly vet the methodology. Acknowledging the burden on hospitals, Commissioners extended the vetting period until six months after the surge recedes. Unfortunately, hospitals were still responding to surge events as recently as the last half of April. | The benchmarking methodology needs further evaluation by the hospital industry and Commissioners, including the longer-term cost savings target proposed by staff. | We support MHA's proposal to vet the TCOC benchmarking methodology further. As stated in their letter, the ongoing COVID pandemic has continued to require a re-allocation of resources to support hospital operations and has resulted in few resources to evaluate changes in HSCRC methodologies. The on-going public health emergency has not allowed hospitals adequate time and resources to evaluate and understand such a complex analysis and feel that more time to vet the methodology is warranted | | The Medicare and Commercial Total Cost of Care Benchmarking is a significant new measure that will most likely require adjustment over time as HSCRC and the hospitals continue to review and understand the results.<br><br>Historically, when new measures of significance were introduced, the Commission often implemented a phased-in approach. We recommend increasing the weighting of this measure in stages over the next several years (i.e. 25% in FY22, 50% in FY23) given both the newness of the measure and to ensure that it aligns with the model and other policies. | The open and transparent workgroup process has eroded over time as much of the detail for developing and applying methodologies is not publicly documented and requires persistent discussion with the staff to obtain the details of relevant calculations when a hospital wishes to replicate the work | Meritus agrees with the Maryland Hospital Association's ("MHA") position that further vetting of the Commercial and Medicare benchmarking methodology is needed prior to the FY2023 policy recommendation. |
| Winners and Losers | | | Hospitals located in wealthier jurisdictions tend to have better TCOC results while hospitals serving poor rural or urban jurisdictions perform poorly<br><br>Border hospitals tend to perform better in the Medicare benchmarking due to the number of patients who seek care outside Maryland at lower payment rates | The staff presentation of the integrated efficiency policy notes the desire to redistribute resources within the system from poor performers to excellent performers. But the results of the policy appear to penalize small rural providers and reward hospitals in relatively affluent suburban areas. | | This policy has clear winners (Montgomery, Howard, Anne Arundel County) and losers (Baltimore City/County, Eastern Shore, other rural areas).<br><br>Hospitals that are primarily compared to counties and MSAs on the East or West coast do relatively well, while hospitals compared to those in the rest of the country fare far worse. | |

# Appendix 5b: Staff Responses: TCOC Benchmarking

- Staff recognized that the release of the final benchmarks was delayed as part of the slowdown due to the COVID crisis. However:
  - Fundamental process has been discussed for almost 2 years and peer groups and preliminary results were released in late 2019. Peer groups have not changed, and results were similar to those in the final version.
  - Final version was released August 31, 2020 including extensive supporting data and documentation.
- Due to the delay in Integrated Efficiency policy, per Commissioners' directive, revenue adjustments based on this methodology will be made in July of 2021, giving hospitals sufficient time to understand the payment implications of the benchmarking.
- Staff agrees that unintentionally punishing poorer areas is not a desirable outcome. However, the benchmarking methodology includes extensive risk / demographic adjustments.
  - There are areas that are both economically disadvantaged and include inefficient hospitals.
  - Claiming that the risk / demographic adjustment is insufficient because it results in an unfavorable comparison for some urban or rural hospitals is begging the question. Moreover, this concern is a broad criticism that does not recognize that urban hospitals and small rural hospitals are not monolithic entities with the same performance in the benchmarking analysis, e.g. St. Agnes, Calvert and Eastong fare quite well

# Appendix 5c: Staff Responses: TCOC Benchmarking cont.

| TCOC Per Capita | Unadjusted TCOC | Risk Adj. TCOC with Deep Poverty Adj. | Benchmark w. Median Income |
|---|---|---|---|
| Baltimore City | $16,504 | $16,625 | $13,080 |
| Baltimore County | $14,060 | $17,379 | $13,394 |
| Montgomery County | $10,931 | $14,437 | $10,530 |
| Baltimore City over Montgomery | 51.0% | 15.2% | 24.2% |
| Baltimore County over Montgomery | 28.6% | 20.4% | 27.2% |

Montgomery County begins with a highly significant per capita cost advantage. Risk adjustment, peer group selection and the deep poverty demographic adjustment eliminates about 60% of Baltimore City and 25% of Baltimore County differences.

Baltimore City and County are similar after these adjustments which would be expected.

Median income adjustment adds about 8 points back to reflect higher DC area costs not already reflected in the benchmark.

# Appendix 6: Price Inclusion in TCOC Benchmarks & Staff

| University of Maryland Medical System | Luminis |
|---|---|
| The inclusion of price in the benchmark analysis skews results and tends to place urban and suburban areas at a disadvantage.<br><br>Utilization performance should be considered as an alternative to measuring performance to eliminate some of the price disparity caused by our all-payer model | The benchmark comparison should be limited to utilization variances since price is addressed through the ICC calculation. Measuring only utilization would eliminate priced differences due to the Maryland All Payer model.<br><br>Limiting price considerations in the benchmarks may also eliminate some of the inequities resulting from the construction of the national peer groups. |

- Staff do not agree with the Luminis comment that price is addressed through the ICC calculation. While it is true that the ICC measures cost per hospital case and is therefore a good proxy for hospital prices, it does not address pricing variation for total cost of care.
- Measuring price in the context of TCOC differentiates between good price inefficiency that lowers TCOC by reinvesting retained revenue in efforts to reduce TCOC and bad price inefficiency, which results from a failure to capture and reinvest costs released by lower volumes.
  - The ICC methodology by itself does not differentiate between the two and risks rewarding the latter behavior.
  - The same advantage exists for TCOC measurements in comparing two price efficient hospitals
- Assessing just utilization as an efficiency outcome is fraught with issues as well because there is not currently an optimal level of utilization, especially for areas with lower socioeconomic populations.

# Appendix 7: TCOC Attainment and Improvement & Staff

| University of Maryland Medical System | Johns Hopkins Health System | Luminis |
|---|---|---|
| TCOC measure should include both attainment and improvement, similar to the approach taken with the quality policies | Only measuring growth or only measuring attainment could disadvantage hospitals with very low TCOC relative to peers or hospitals that have shown reductions to TCOC but have not yet reached a benchmark. | Any benchmarking methodology needs to provide for both an attainment and improvement measure. This is consistent with the approach of other HSCRC programs such as the Readmissions Reduction Incentive Program |

- Staff remains concerned about the reliability of TCOC improvement statistics to determine relative efficiency for the following reasons:
  - Improvement analysis is inappropriate in a relative efficiency analysis that redistributes revenue among hospitals
    - Hospitals with smaller attributed TCOC dollars have very unstable growth statistics
    - It adds additional complexity that may not differentiate hospitals rank order substantively
    - Inclusion of TCOC growth would likely require additional, perhaps arbitrary weighting in the Efficiency Matrix
  - Penalties are scaled so a poor attainment hospital receives a penalty that is likely minimal versus their attainment shortfall.
  - As long as the hospital improves, they will have plenty of time to “escape” the penalty before the impact becomes material
  - In lieu of relative efficiency assessment, improvement could be considered as an exemption from a penalty

# Appendix 8:TCOC Attribution & Staff Response

| GBMC | Mercy |
|---|---|
| GBMC is concerned that the broad nature of the county-based TCOC benchmarking metric, combined with GBMC's relatively low market share in a highly saturated market, means that the metric [TCOC based on PSAP] is neither reflective of GBMC's actual TCOC performance nor within GBMC's control to impact the result. | Mercy strives to reduce overall TCOC, specifically focused on patients seeking services at Mercy. Without a direct link between patients and the TCOC measurement, it is unclear how hospitals in urban settings are able to directly impact TCOC performance. |

- Staff acknowledge that it will be harder for hospitals in a "highly saturated market" to directly impact TCOC performance in isolation, but staff would note that:
  - There is strong correlation between TCOC performance as measured by a geographic attribution and the attribution outlined in the Medicare Performance Adjustment (MPA).
  - The MPA attribution is complicated and cannot be adopted for the commercial TCOC evaluation (25% of Integrated Efficiency Policy)
  - HSCRC has funded regional partnership grants to incentivize hospitals and other healthcare providers to collaborate on improving population health and TCOC outcomes across broader geographies
  - 50% of the Integrated Efficiency Policy is ICC performance, which is hospital specific and allows hospitals in saturated markets to differentiate themselves by competing for medically necessary volume
- For these reasons, staff does not support the use of an alternative attribution methodology

# Appendix 9: Scaling Approach & Staff Response

| MHA | JHHS | UMMS | Luminis | CareFirst | Commissioners |
|---|---|---|---|---|---|
| Removing the one standard deviation ICC threshold reduces the cliff effect observed in the previous approach.<br><br>However, arraying hospitals into quartiles based on performance will always present some type of cliff effect for hospitals that are closely ranked. Hospitals that repeatedly fall within the worst quartile will have a portion of their inflation permanently removed each year, potentially leading to unintended adverse consequences. The Commission should periodically evaluate this impact, in addition to the sliding scale of withheld inflation. | The modified approach is consistent with other HSCRC measurement policies and helps minimize any "cliff" effects that a policy could cause.<br><br>Additionally, it provides appropriate incentives by emphasizes TCOC performance and cost per case efficiency in determining a hospitals position and subsequent penalty | The previous proposal was an 'all or nothing' approach whereby hospitals were either penalized by the maximum amount or not at all, which created a cliff effect.<br><br>The new approach aligns more consistently with the scaling approaches adopted within many other policies, such as the quality programs and MPA. We feel the revised scaling approach put forward by the staff provides the appropriate incentives and equally emphasizes both TCOC performance and cost per case efficiency in determining a hospital's penalty (or reward). | A continuous scaling logic (rather than just addressing outliers) may better address the apparent inequity between rural/urban hospitals, may reduce the extent to which this policy penalizes smaller hospitals that operate on thin margins, and more appropriately penalize hospitals with retained revenue that do not look inefficient largely due to geographic location, while also more aggressively addressing the variation in the system. | The approach of quartiles and one standard deviation on the ICC is called into question given the small size of the revenue withheld from hospitals in this policy. While the ICC distribution does represent a normal distribution, that does not imply that costs below the mean plus one standard deviation are reasonable.<br><br>Therefore, CareFirst recommends that these thresholds continue to be evaluated over time to ensure that they are truly capturing the outlier hospitals. | Commissioners likewise share CareFirst's concerns that the policy does not remove more revenue and believe hospitals are inappropriately incentivized by the policy to maintain cost per case variation up to one standard deviation from average performance. Moreover, Commissioners expressed concerns about the cliff effect of using a one standard deviation rule and withholding the same revenue percentage among all outlier hospitals despite gradations in performance in the worst quartile. |

- Given Commissioners' concerns over the cliff effect and the lack of recognition of performance variation in the worst quartile, staff has put forward in the revised recommendation a continuous scaling approach that will withhold revenue for all hospitals in the worst quartile
  - This was unanimously supported by stakeholder comment letters
  - Staff will continue to review the appropriateness of this scaling logic in concert with all other methodological reviews required of this policy

# Appendix 10: Diminished All Payer Focus & Staff Response

| Johns Hopkins Health System | Luminis | Commissioners |
|---|---|---|
| The goal of driving Medicare to national benchmarks while preserving Commercial rates that are nearly 25% below the nation is counter to the All Payer Model and reduces the value of the Waiver. Methodologies that would eliminate the difference would preserve the problems of the national Medicare fee-for-service system while constraining hospitals from charging rates to commercial payers in line with the nation. | The benchmarks focus on Medicare and not All Payer targets:<br><br>The goal of driving Medicare to national benchmarks while preserving Commercial rates that are nearly 25% below the nation is counter to the All Payer Model and eliminates the value of the Waiver.<br><br>Methodologies that would eliminate the difference would preserve the problems of the Medicare fee-for-service system (inpatient rates barely above breakeven and outpatient rates that do not cover costs) while constraining hospitals from charging rates to commercial payers in line with the nation. | Some Commissioners have noted generally that the all-payer aspect of the Model, which has been a hallmark of the hospital payment system in Maryland for over forty years, must be underscored in all policies. |

- Staff agrees that the Model and all its supporting methodologies/policies should reflect an all-payer perspective.
- Staff would note though that comparing hospitals to a TCOC benchmark average and then relatively ranking hospitals based on percentage variation from that benchmark in order to scale inflation does not eliminate the higher governmental reimbursement for hospitals in Maryland.
  - Future policies that use TCOC benchmark performance as a defined attainment standard will need additional scrutiny to ensure the all-payer tenets of the Model are not compromised.
  - It should also be noted that currently it is not possible to create an all-payer total cost of care assessment due to the dearth of national Medicaid cost data.

# Appendix 11: Revenue Neutrality & Staff Response

| Maryland Hospital Association | Johns Hopkins Health System | CareFirst | Commissioners |
|---|---|---|---|
| We agree that if revenues are reduced for high-cost hospitals (as HSCRC defines such), the full sum of this reduction should be available to be redistributed within the system. None should be withheld. | JHHS believes that the efficiency policy should be revenue neutral on a statewide basis. If high cost hospital's revenues are reduced, the full sum of this reduction should be available within the system and no portion should be withheld. | Dollars derived from withholding the update factor from poor performing outlier hospitals should be passed along as savings to purchasers of hospital care who have been paying more for those inefficient services. | Various Commissioners have noted that staff should consider using the efficiency assessments and the associated policy to accrue system savings. |

- Staff still holds that the policy is not the means by which system savings should be generated.
  - Its purpose is to correct maldistribution of global budget revenue in the Model, i.e. to redistribute all revenue removed from inefficient hospitals to efficient hospitals
  - Savings have been realized and should continue to be generated through the combination of the GBR incentives and the Annual Update Factor Policy, which on a statewide basis holds hospitals accountable for Medicare total cost of care and hospital affordability, while not upending the central incentive of the Model to reduce avoidable utilization.
- Staff remain concerned about purchasers paying more for inefficient services but would note that the current cost sharing concern for purchasers is restricted to Medicare Outpatient coinsurance, as that is the only purchaser with cost sharing arrangements that incurs higher required payments relative to national peers.
  - Future policy development should focus on alleviating cost sharing concerns by revising reimbursement methodologies that do not upend the central incentive of the Model to reduce avoidable utilization
- Staff, therefore, strongly recommend maintaining revenue neutrality in this policy.
  - If Commissioners do not concur with staff's recommendation, staff would ask Commissioners to consider savings generated by this policy in the various total cost of care and affordability tests employed in the Annual Update Factor Policy.

# Appendix 12: Revenue for Reform & Staff Response

| MHA | UMMS | CareFirst | Meritus | Commissioners |
|---|---|---|---|---|
| HSCRC introduced the Revenue for Reform concept, proposing a safe harbor for care transformation investments and other spending expected to lower avoidable service use.<br><br>Valuing the proposed interventions to compare among hospitals will require well-vetted criteria. It is imperative that HSCRC staff work with stakeholders to implement a sound methodology. Allowing ample time for stakeholder recommendations will culminate in a formal recommendation to the Commission that will stand up in practice. | UMMS is committed to continued investments in community-based services through the utilization of safe harbored GBR revenue. The safe harbor revenue provides a pathway for Shore Health to improve cost efficiency, generate retained revenue, and redeploy that revenue to meet community needs without negatively impacting its position on the Integrated Efficiency Metric. | The rapid growth in unregulated costs and losses over the course of the past five years is unsustainable and continues to be funded by increased regulated profits. Increased reporting requirements and transparency are critical so that HSCRC Staff can ascertain which unregulated operations are contributing to the goals of the model.<br><br>Hospitals cannot be given credit for the work they are doing in their unregulated operations until the full picture is understood, especially since they are now a major cost driver in the system. | Approval of [Revenue for Reform] interventions should not be limited to only inefficient hospitals. Meritus also stresses the need for well-vetted and uniform criteria that will be used in the HSCRC evaluation of proposed intervention.<br><br>We also would like to express reservations in the HSCRC making value judgements on which hospital population health interventions will qualify for approval or not under the Revenue for Reform proposal. The patient population of a rural sole community provider may require drastically different interventions than the patient population of an urban regional hospital in order to maximize improvements in health. Meritus asks Commission staff to be cognizant of this in developing their criteria for approval to insure equity in the policy. | Various Commissioners have expressed concerns that the largest source of unregulated losses, physician subsidies, are necessary to operate a hospital, and the current regulatory authority of the HSCRC has prevented the Commission from appropriately accounting for a key component of hospital operations.<br><br>Other Commissioners have also expressed a desire to quantify what regulated margins are subsidizing, especially with regards to potential safe harbors in the Revenue for Reform concept.<br><br>Finally, several Commissioners have urged staff to establish evaluations of appropriate levels of overhead. |

- Staff remain committed to establishing a reporting and auditing function for quantifying costs intrinsic to a hospital's operations and in line with the TCOC Model (both regulated and unregulated). The degree to which these costs are deemed appropriate and therefore eligible for credit in an efficiency assessment will need to need to be determined with industry input and with directives from Commissioners.
- Staff have convened two workgroups to help facilitate the onboarding of Revenue for Reform: one to assess the process of reporting community health initiatives; one to assess how best to include Revenue for Reform safe harbors into the ICC
- Staff believes that while establishing methodologies for capturing appropriate levels of overhead is necessary and important, it cannot be done "…until the full picture is understood."

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# Final Recommendation on Integrated Efficiency Policy for RY 2022: Withholding Inflation for Relative Efficiency Outliers and Potential Global Budget Revenue Enhancements

June 9, 2021

This document contains the final staff recommendation for creating an Integrated Efficiency Policy for the purposes of withholding inflation for inefficient hospitals and awarding Global Budget Revenue enhancements for high performing hospitals.

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# Key Methodology Concepts and Definitions

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

2. Inter-hospital Cost Comparison (ICC) Standard – Each hospital's ICC revenue base is built up from a peer group standard cost, with adjustments for various social goods (e.g., trauma costs, residency costs, uncompensated care mark-up) and costs beyond a hospitals control (e.g. differential labor market costs) that are not included in the peer group standard. The revenue base calculated through the ICC does not include profits. Average costs are reduced by a productivity factor of 2 percent. The term "Relative efficiency" is the difference between a hospital's actual revenue base and the ICC calculated cost base.

3. Volume Adjusted Inter-hospital Cost Comparison (ICC) - A version of the ICC that incorporates hospitals' reduction in potentially avoidable utilization, as defined by the Potentially Avoidable Utilization Shared Savings Program and additional proxies for avoidable utilization. Volumes from this analysis, both negative and positive, amend a hospital's final ICC calculated cost base – not the peer group cost standard - as well as the hospital's position relative to the ICC Cost Standard.

4. Efficiency Matrix – A combined ranking of a hospital's performance in the Inter-hospital Cost Comparison and Total Cost Care. Total Cost of care is measured by comparing the per capita cost of care in a hospital's service area to matched national Medicare and Commercial benchmarks on a risk-adjusted basis. Both measures are weighting equally and hospitals are arrayed into quartiles to determine overall efficiency.

## Policy Overview

| Policy Objective | Policy Solution | Effect on Hospitals | Effect on Payers/Consumers | Effect on Health Equity |
|---|---|---|---|---|
| The GBR approach explicitly rewards hospitals by allowing them to retain revenue as volume declines. While this incentive remains fundamental to the model, it has the potential side effect of masking hospitals that operate inefficiently. | This policy penalizes significantly inefficient hospitals and rewards significantly efficient ones by evaluating them on a normalized cost per case basis. To avoid penalizing hospitals that are effectively reinvesting savings from lower utilization in improving population health, the cost per case measure is balanced with a measure of total cost of care. | Hospitals that run efficiently and effectively manage total cost of care in their service areas will be entitled to additional revenue. Those that are inefficient and are not effectively managing total cost of care will lose revenue. Only clear outliers will be impacted, most hospitals will not be affected. | By incenting both efficiency and effective total cost of care management, this policy will control unit level cost inflation faced by the direct healthcare consumer while also improving the effectiveness of the healthcare delivery for all residents. | Through this policy, hospitals are evaluated, in part, on total cost of care, thereby incentivizing hospitals to improve care coordination and non-hospital investments in their service area. An increased focus on total cost of care can help to improve access and quality of care for residents in the hospital's service area. Although this does not directly effect health equity, the investments that are made in the community can indirectly improve health disparities. |

## Recommendations

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

In July 2019, a staff draft recommendation was brought before the Commission. During the course of review following the publication of the July draft recommendation, a number of concerns were identified by staff, Commissioners, and stakeholders regarding: a) the casemix

adjustment for rehabilitation cases; b) use of a growth calculation in lieu of a benchmark attainment analysis for total cost of care performance; c) the appropriateness of current peer groups in the hospital cost per case efficiency assessment and d) general concerns that the policy should identify larger amounts of inappropriately retained revenue.

Commissioners at the October and November 2020 Commission meetings also expressed concern that the designation of hospitals as outliers based on a one standard deviation hospital pricing rule created an undesirable cliff effect, especially when the penalty was not scaled to reflect gradations in hospital performance. Commissioners also noted a desire to expedite the use of staff's proposed Revenue for Reform concept that allows hospitals to have safe harbors for hospital revenue, i.e., revenue that is used for specific care transformation efforts at the hospital that could be excluded from efficiency analyses. Finally, staff also noted that an additional risk adjustment for hospitals deemed similar to critical access hospitals would be included in future iterations of the Integrated Efficiency Policy.

In light of all of these issues, staff has: a) implemented a change to its casemix adjustment that reduces the variability of rehabilitation case groupings; b) incorporated total cost of care benchmark performance into efficiency evaluations; c) reviewed the effectiveness of ICC peer groups and recommended an alternative approach; d) arrayed hospitals into quartiles instead of quintiles and incorporated Commercial benchmark performance to expand the extent of revenue redistributed through this policy; e) proposed a scaling approach that penalizes all hospitals in the worst quartile but on a sliding scale basis; f) reflected a pilot Revenue for Reform safe harbor; and g) proposed a critical access hospital adjustment. As such, staff is presenting the following recommendations for Commission approval:

1) Formally adopt policies to
    a. Determine hospitals that are relatively inefficient;
    b. Evaluate Global Budget Revenue enhancement requests using the criteria identified above;
2) Use the Inter-Hospital Cost Comparison, including its supporting methodologies to compare relative cost-per-case for the above evaluations;
    a. Abandon ICC peer groups and adopt a direct regression based risk adjustment for indigent care cost variation that will be applied to all efficiency policies

3) Use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance for the above evaluations;
4) Withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals based on criteria described herein;
5) Use set aside outlined in the Annual Update Factor and funding secured from withholds from outlier hospitals to fund potential Global Budget Revenue enhancement requests.
6) If inflation is withheld in RY 2022 Update Factor based on relative efficiency policy, update volumes for RY 2022 rate orders to reflect CY 2019 volumes with 5 percent corridors. This limit may be extended to 10 percent at the discretion of the HSCRC staff if the Hospital presents satisfactory evidence that it would not otherwise be able to achieve its approved total revenue for the Rate Year.

## Introduction

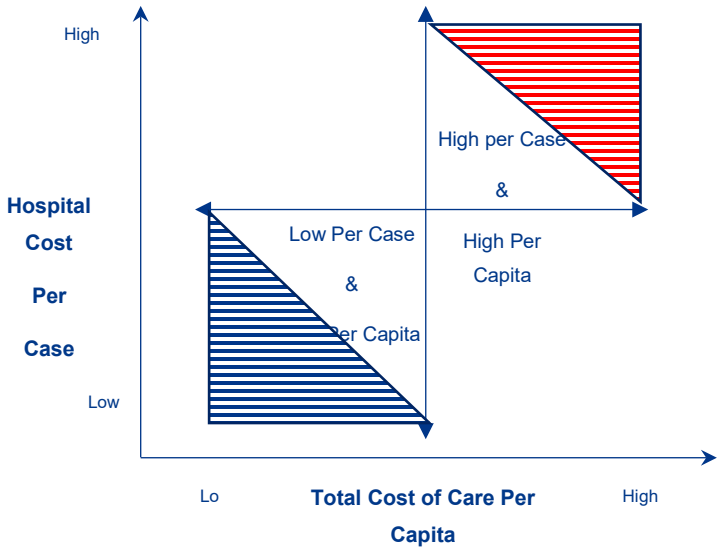
The goals of the HSCRC and the Total Cost of Care (TCOC) agreement are relatively straight forward. The Commission's enabling statute requires that hospital costs are reasonable; that rates are set in reasonable relationship to costs; and that rates are set equitably and applied on an all-payer basis. The TCOC agreement with the federal government requires that the relative growth of per capita total health care spending in Maryland must meet certain standards.

The policies and the methodologies adopted by the Commission to achieve its goals, however, are anything but straight forward. These approaches are complex in part because the economics of health care and health services are technical and complex.

This section of the policy proposal is an attempt to describe the integrated efficiency methodology in more general language and to point to sections of this Final Recommendation on Integrated Efficiency Policy for RY 2022 and the related appendix which describe these approaches in necessarily more precise terms. The intent is to use this primer to paint the broad overview and to provide context to the more technical aspects of the policy.

The integrated efficiency policy is established by the HSCRC to **simultaneously** evaluate whether hospitals are "technically efficient" on a ***cost per case*** basis AND are effective in controlling ***total cost per capita.*** Those hospitals identified as particularly high in both these categories are considered presumptively inefficient (red in the 2 X 2 diagram below), while those that are low in both these categories are presumptively efficient (blue below). Presumptively inefficient hospitals are not granted access to a portion of inflation as part of the annual update

factor. They are free to file a rate application if they so desire. Presumptively efficient and effective hospitals are granted the opportunity to request slightly higher revenue through an expedited adjustment to their GBR agreement.




The simultaneous nature of this comparison is important. Clearly, controlling TCOC is essential in order for the waiver to succeed. At the same time, controlling hospital cost per case is central to the mission of the Commission. Finding the right balance between these two elements that tend to move in opposite directions is critical.[1] The remainder of this section identifies the steps taken to calculate Maryland hospitals' values equitably along these dimensions and to establish the thresholds that determine high and low performance along both.

## A. Hospital Cost per Case

The Commission has relied on the Inter-hospital Cost Comparison (ICC) methodology to evaluate individual hospital's cost per case or technical efficiency. (See overview of ICC methodology). Although it involves complex calculations, the ICC process can be seen in three basic calculations:

- Adjusting all hospitals' permanent revenue to produce a **standard cost per case** for the comparison group. – See Table 7;
- Adjusting this standard cost per case back up to **approved total revenue** for each hospital. – See Table 10; and
- The approved revenue is compared to actual revenue to calculate the **relative efficiency of the hospital** – See Tables 12a and 12b.

[1] As hospitals volumes fall as part of improving total cost of care, hospital unit rates increase under the GBR.

These calculations are summarized in the following tables with references to sections in the Policy Paper with more detail.

| Calculation of Standard Cost Per Case for Comparison Group | | |
|---|---|---|
| Step | | Description |
| 1 | Permanent Revenue | Remove from actual revenue the impact of current one-time adjustments in rates. – **See p. 13.** |
| 2 | Markup | Remove approved markup for payer differential, uncompensated care, and other similar factors. |
| 3 | Profit | Remove hospital-specific current regulated profit in order to bring revenue to approximation of costs. **See p. 25.** |
| 4 | Direct Medical Education | Remove the direct expenses associated with medical education – capping the number of residents to the levels in 2011 and the costs to the statewide average cost per resident. **See p. 20** |
| 5 | Indirect Medical Education | Adjust hospital costs for the estimated marginal impact on costs of operating a teaching program. This adjustment is separately calculated for major academic hospitals and other teaching hospitals and inflated to current year. **See p. 21.** |
| 6 | Labor Market | Adjust the portion of hospital costs associated with differences in the labor market in which the hospital operates. Use hospital wage and salary data for two groups – Montgomery and Prince George's Counties, where wages are higher than Maryland's average, and a second grouping of all other hospitals. **See p. 21.** |
| Policy Choice | Retain peer groups or, alternatively, make direct adjustment for impact of poverty on cost. | The HSCRC has traditionally made this calculation by groups of peer hospitals. The policy paper introduces an approach that directly estimates the effect on hospital costs of treating a higher share of poor patients – one of the major reasons for the peer groups. **See p. 22.** |
| 7 | Volume | Divide by volume, which is measured by ECMADs – a statistic that incorporates the difference in the types of cases (discharges/visits) a hospital treats (case-mix adjusted) and incorporates both inpatient and outpatient activity (equivalent). |
| 8 | Standard Cost Per Case | This is calculated at the individual hospital level but aggregated to create Standard Cost per Case for comparison group. The group would either be the peer group or the statewide standard depending on the decision on the Policy Choice above. |

| Calculation of Hospital Approved Revenue | | |
|---|---|---|
| Step | | Description |
| 1 | Standard Cost per Case | Begin with Standard Cost per Case calculated above. |
| 2 | Productivity adjustment | Remove 2% uniform productivity adjustment. |
| 3 | Volume (adjusted) | Multiply by hospital specific volume. Adjust hospital volume to reflect steps hospital has taken (or not) to remove potentially avoidable utilization (PAU). This step protects hospitals that have eliminated PAU (and have higher cost per case as a result) and penalizes hospitals that have added PAU (and have lower cost per case as a result). **See p. 26.** |
| 4 | Indirect Medical Education | Add back in hospital specific indirect medical education/ Separately calculated for major academic hospitals and other teaching hospitals and inflated to current year. |
| 5 | Labor Market | Readjust standard labor costs to the hospital-specific labor market described above. |
| 6 | Direct Medical Education | Add back the hospital specific direct expenses associated with medical education – capping the number of residents in most cases to the levels in 2011 and the costs to the statewide average cost per resident. |
| 7 | Markup | Add back hospital-specific approved markup for payer differential, uncompensated care, and other similar factors. |
| 8 | Hospital Approved Revenue | |

| Calculation of Hospital Relative Efficiency | | |
|---|---|---|
| Step | | Description |
| 1 | Actual v. Standard | Compare actual Permanent Revenue to standardized Hospital Approved Revenue and express as percentage above or below the standard. |
| 2 | Rank | Rank order hospitals from most to least efficient. These results will be combined with the TCOC results below to produce a composite score. |

### B. Total Cost of Care Per Capita

The evaluation of the TCOC attributed to a hospital is likewise complex, but it involves several basic steps. These are separately performed against a benchmark standard for the payer categories for which the Commission has comparable information on total health care spending.

Such data exists for Medicare and commercial insurance payers. It does not exist for Medicaid. The task is to find appropriate geographic areas in the country to compare to Maryland areas; attribute the geographic data on total costs to individual hospitals; and adjust the data to make fair comparisons. Once those steps are accomplished an aggregate TCOC comparison can be made.

- **Establish Benchmark Groups** for each Maryland geography for Medicare and Commercial populations using national data from similar locations.
- **Convert Geographic Benchmarks** into Hospital-specific Benchmarks assigning weights based on a hospitals' primary service area.
- **Adjust the data for differences** in Beneficiary Risk and Demographics and compare.

As before, these calculations are summarized in the following tables with references to sections in the Policy Paper with more detail.

| Establish Benchmarks for Medicare and Commercial Populations | | | |
|---|---|---|---|
| | Step | | Description |
| Medicare | 1 | Claims data | Medicare TCOC claims data for Maryland is collected by county. Data is for Medicare Part A and Part B only. |
| | 2 | Data on area characteristics | Potential benchmark Medicare counties are identified for comparison based on population density, size and other demographic factors. |
| | 3 | Identify cohorts | 20 county cohorts identified for 5 largest Maryland counties using a statistical technique that finds 20 US counties that have values closest to each of the 5 largest counties and 50 county cohorts identified for remaining Maryland counties.[2] |
| | 4 | Calculate County Benchmark | Simple average of benchmark cohort values for Medicare TCOC per capita. |
| Commercial | 1 | Claims data | National commercial claims data is not available at the county level, but at the MSA level. Maryland commercial claims data is available at the county level. For comparison purposes, Maryland data is aggregated to MSA level, but excludes non-Maryland residents from the MSA. |
| | 2 | Data on area characteristics | Potential benchmark commercial MSAs are identified for comparison based on population density, size and other demographic factors. |

[2] The technique is called: "K-nearest neighbor."

| Establish Benchmarks for Medicare and Commercial Populations | | | |
|---|---|---|---|
| | Step | | Description |
| | 3 | Identify cohorts | 20 MSA cohorts are identified for each Maryland MSA using a statistical technique that finds 20 US MSAs that have values closest to each of the Maryland MSAs.[2] |
| | 4 | Calculate benchmark | Simple average of benchmark values. |

| Convert Geographic Benchmarks to Hospital Benchmarks | | | |
|---|---|---|---|
| | Step | | Description |
| Medicare | 1 | Calculate a hospital specific TCOC | Using Maryland Medicare data by zip code, allocate costs and beneficiaries to each hospital in accordance with its primary service area.[3] This is similar to the approach the HSCRC has used in calculating the Medicare Performance Adjustment (MPA). |
| | 2 | Calculate benchmark TCOC for each hospital | Using the corresponding benchmark for each county, calculate each hospital's benchmark weighted by Medicare beneficiaries allocated to its primary service area. |
| Commercial | 1 | Calculate a hospital specific TCOC | Using Maryland commercial data by county, allocate costs and beneficiaries to each hospital in accordance with its primary service area.[4] |
| | 2 | Calculate benchmark TCOC for each hospital | Using the corresponding benchmark for each county, calculate each hospital's benchmark allocated to its primary service area. |

| Adjust the data for differences and compare | | |
|---|---|---|
| Step | | Description |
| 1 | Medical Education | Remove estimated medical education costs from all data – Medicare and commercial, Maryland and Benchmark. |
| 2 | Risk adjustment | Separately risk adjust Medicare and commercial data. |
| 3 | Benefit adjustment (Commercial only) | Account for differences in commercial benefit plans by area. Richer plans result in higher utilization. |
| 4 | Demographic Adjustment | Calculated separately for Medicare and commercial. Demographic factors adjusted are Median Income and Deep Poverty. |
| 5 | Compare | Compare hospital to benchmark and express as % above or below |

[3] Shared zip codes are split among hospitals based on ECMAD share, and any unassigned zip codes are assigned to a hospital based on travel distance.
[4] Shared counties are split among hospitals based on ECMAD share.

| Adjust the data for differences and compare | | |
|---|---|---|
| Step | | Description |
| 6 | Rank | Rank order hospitals on Medicare and commercial standards. These results will be combined with the hospital efficiency results above to produce a composite score |

## Background

### Efficiency Tools

While staff has utilized the ICC and various total cost of care analyses to support Commission proposals to modify hospitals' global revenues outside of a full rate application,[5] thereby implicitly approving these efficiency tools through adjudication, no formal policies that address scaling of inflation or global budget modifications are currently in place. It is important that formal policies reflective of all methodology enhancements are approved by the Commission to provide greater clarity to the industry and to allow for the Commission's methodologies to be more formulaic and uniform in their application.

In terms of the ICC, staff did not materially change the methodology from what was presented to the Commission in November of 2017. The ICC still currently places hospitals into peer groups based on socioeconomic factors and teaching status and then develops a peer group cost average, devoid of unique hospital cost drivers (e.g., labor market, casemix) and various social goods (e.g., residency programs), to ultimately build up hospital revenue for each hospital based on the calculated peer group cost average. The difference between a hospital's evaluated revenue and its revenue calculated from the ICC cost standard is the measure of a hospital's relative cost-per-case efficiency. As aforementioned, staff has also included in this report a slightly different ICC assessment that removes peer groups and directly risk adjusts for indigent care.

Additional modifications to the November 2017 ICC include modifying the casemix methodology that governs the singular volume statistic used in the ICC, creating a differential cost estimate for indirect medical education costs of major academic medical centers versus other residency programs, limiting the resident and intern cost strip to the State average cost per

[5] Anne Arundel Medical Center, Garret Regional Medical Center, UMMC Midtown Hospital, Bayview Hospital

resident, updating the input values to reflect RY 2020 revenue and RY 2019 casemix volume, and adjusting the ICC for changes in Volume, all of which will be discussed in greater detail in the *ICC Calculation* section below.

As for Medicare total cost of care, staff originally had two established tools for analysis: total cost of care growth relative to 2013 (the base year for the All-Payer Model) based on a strictly geographic attribution; and total cost of care growth relative to 2015 based on the attribution in the Medicare Performance Adjustment (MPA), which incorporates patient and physician matching. Although both of these approaches yield similar results when the performance period is the same, both have limitations in determining absolute efficiency because both are dependent upon the date by which growth is evaluated, i.e., the base year, and typically growth calculations are not as reliable year over year as attainment analyses. For these reasons, staff has developed total cost of care "attainment" benchmark calculations into the final efficiency determinations, inclusive of Commercial performance, that will be discussed in the Overview of the *Total Cost of Care Calculation* section.

## Efficiency Implementation

### Withholding Inflation from Outlier Hospitals

In prior applications of the HSCRC efficiency methodologies, hospitals' revenues were reduced under spend-down agreements if they were deemed to have cost-per-case beyond a set level. In another application of efficiency measures, hospitals with favorable hospital cost-per-case positions were given higher annual updates than those hospitals with poor relative cost-per-case. However, all of these prior iterations of efficiency analyses were based on fee-for-service mechanisms and did not have to account for relative cost efficiency in a per capita system. In a per capita system, a hospital aligned with the TCOC Model will reduce utilization by improving the health of the population, retain a portion of the revenue associated with the reduced utilization, and potentially appear to be less cost efficient in a cost-per-case analysis. Moreover, hospitals can confound this analysis in the global revenue era by reducing utilization through shifting services to non-hospital providers (referred to as deregulation), eliminating services outright, or by simply continuing to pursue additional volume growth beyond population and

demographic driven changes. Despite these complexities, the HSCRC must still establish charges that are reasonably related to costs, which in turn should be reasonable themselves, while also properly incentivizing hospitals to reduce unnecessary utilization and total cost of care.

For these reasons, staff cannot evaluate hospital cost-per-case or total cost of care analyses independently, and any combination of tools will not precisely identify hospitals' efficiency ranking, especially near the mid-range of performance. Thus, staff will focus this policy on the worst quartile and recommend that hospitals in this quartile have a portion of their Annual Update Factor withheld, based on a 50/50 weighting of a Volume adjusted cost-per-case and geographic Medicare and Commercial total cost of care attainment calculations.

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

**Global Budget Revenue Enhancements**

Staff's original efficiency proposals limited the application of the policy to poor performing outlier hospitals. Positive revenue adjustments would be addressed through an additional policy on the evaluation of rate applications once total cost of care benchmarks were developed. However, concerns regarding GBR enhancement requests have prompted staff to also outline a methodology for evaluating excellent performing hospitals and describe a process by which additional revenue may be requested outside of a full rate application.

Specifically, staff proposed that all GBR revenue enhancements outside of a full rate application be limited to hospitals that are among the best performers in cost-per-case, as measured by a Volume Adjusted ICC, and Medicare and Commercial total cost of care, using a geographic benchmark attainment analysis. This evaluation mirrors the analysis performed for determining poor performing outliers. For hospitals to receive a GBR enhancement outside of a full rate review, they must be in the best quartile of performance as evaluated in the Efficiency Matrix and must be better than one standard deviation from average Volume Adjusted ICC performance (1.05 times the ICC standard), which indicates potential insolvency. Further, a hospital that

qualifies for a GBR enhancement must submit a formal request to the HSCRC that outlines either: a) how a previous methodology disadvantaged the hospital; or b) a spending proposal that aligns with the aims of the Total Cost of Care (TCOC) Model. Total revenue enhancements will be capped by the funding made available by the set aside in the Annual Update Factor approved by the Commission each year (.25% or ~$45 million in RY 2021) and the funding derived from withholding inflation from hospitals in the worst quartile.

This process and proposed budget cap does not restrict hospitals from submitting a formal rate application request.

## Overview of Efficiency Calculations

### Overview of ICC Calculation

The general steps for the ICC calculation, consistent with prior practices, are as follows:

1. Calculate approved permanent revenue for included volume as measured by Equivalent Case Mix Adjusted Discharges (ECMADs) that will be evaluated in the ICC methodology. This excludes the hospital revenues for one-time temporary adjustments and assessments for funding Medicaid expansion, Medicaid deficits and user fees, such as fees that support the operations of the HSCRC.

2. Permanent revenues are adjusted for social goods (e.g., medical education costs) and for costs that take into consideration factors beyond a hospital's control (e.g., labor market areas as well as markup on costs to cover uncompensated care and payer differential).

3. Hospitals are divided into peer groups for comparison, recognizing that specific adjustments may not fully account for cost differences. The adjusted revenue per ECMAD is compared to other hospitals within the peer group to assess relative adjusted charge levels. The peer groups are:

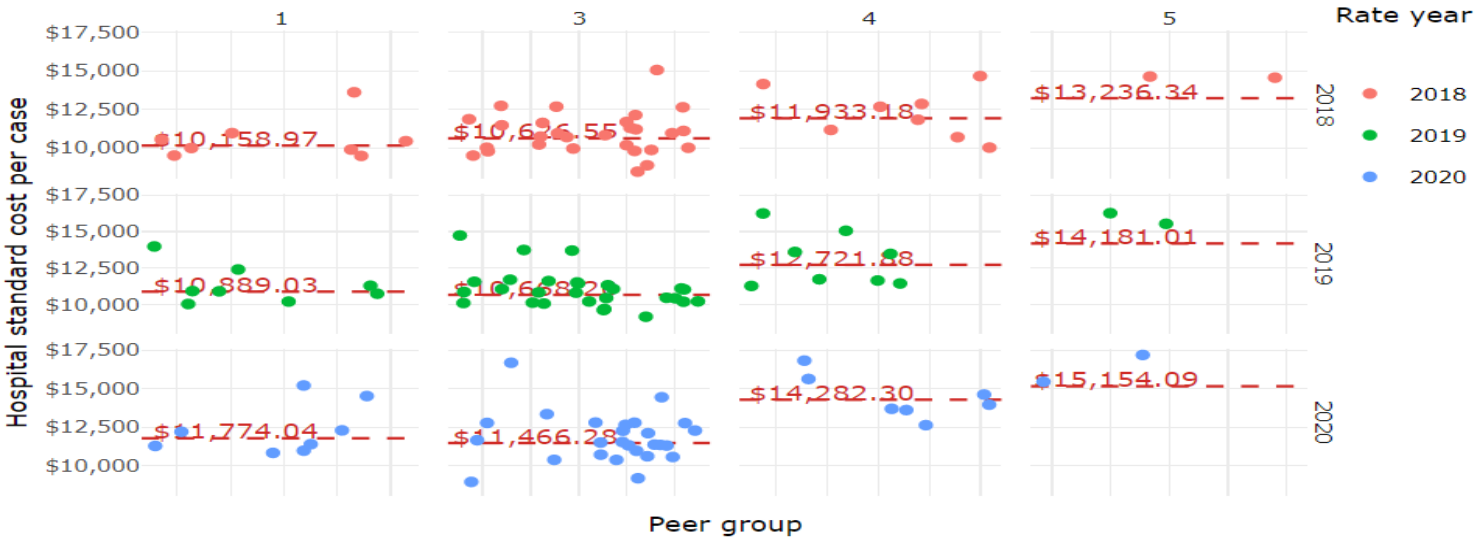
- Peer Group 1 (Non-Urban Teaching)
- Peer Group 3 (Suburban/Rural Non-Teaching)
- Peer Group 4 (Urban Hospitals)

- Peer Group 5 (Academic Medical Center Virtual, which overlaps with peer group 4)

Staff have also developed an alternative approach, whereby all peer groups, save Peer Group 5, are eliminated and instead direct adjustments are made through a regression to account for the intended purposes of the peer groups, most notably added costs related to teaching and to a greater extent serving a lower socioeconomic population or indigent care.

Staff arrived at this alternative approach due to many industry requests to assess the validity of the peer groups and because analysis of the peer groups indicated that there was greater variation in terms of cost per case within the peer group than across peer groups, which is not ideal for an adjustment that aims to align hospitals with similar characteristics and therefore similar cost profiles. This is best demonstrated graphically in Table 1 below, which shows that: a) hospital cost per case variation is greater in the smaller peer groups (Peer Group 1and Peer Group 4); b) cost per case performance in many cases tends to be more similar across peer groups than within peer groups; and c) variation with the peer groups is growing larger over time, which is another imprecision associated with peer groups since they do not automatically update, and yet there are ongoing changes in the patient population and market.

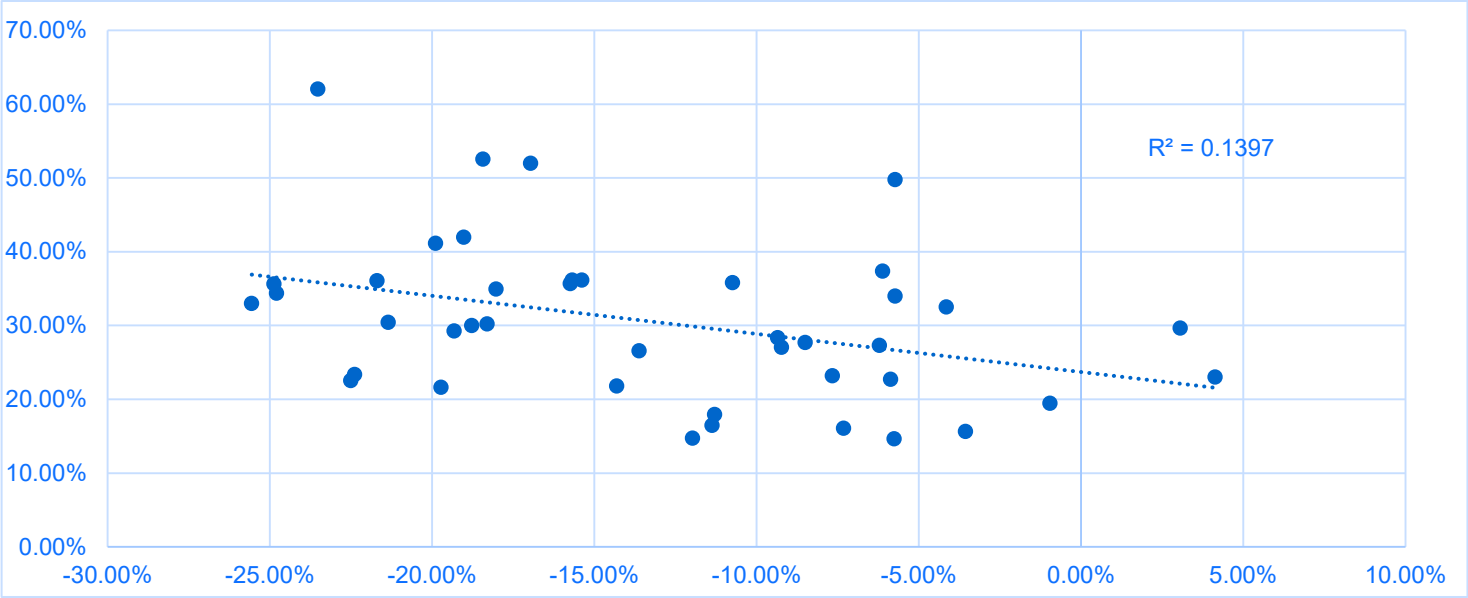
**Table 1: Hospital Cost Per Case Variation (RY 2018 ICC – RY 2020 ICC)**




The second concern about the current peer group design was that there remained a statistically significant relationship between levels of indigent care and ICC performance after application of the peer groups, indicating the peer groups had not fully addressed the residual cost variation for which they were intended. Specifically, staff noted that poor share (the percent of hospital revenue attributable to Medicaid, dual eligibles, and charity care) as well as the percent of revenue attributable to dual eligibles by itself had a small but not insignificant bearing on ICC performance when the historical peer groups were retained and indigent care was not adjusted for directly, as evidenced by a R2 of 0.1397 and a p value less than .05.[6]

[6] R2 denotes the extent to which a given set of variables in a regression explains variation in results or outcomes; the larger the R2 the higher the percentage of variation is explained. The complementary measures of p value indicate the extent to which the variables in the regression are not random. Typically p values less than .1 indicate the independent variables in the regression are not random and exert meaningful influence on the outcome.

**Table 2: Correlation between Integrated Efficiency ICC Performance & Poor Share Percentage**




Conversely, the alternative approach of consolidating Peer Groups 1, 3 and 4 and directly risk adjusting for indigent care resulted in an elimination of the statistically significant relationship between indigent care and ICC performance, which will be discussed in greater detail in subsection *D. Disproportionate Share Hospital (DSH) Adjustment.*

4. There are two additional steps to convert revenues to cost. The first additional adjustment is to remove profits from regulated services from the adjusted revenues (profit strip henceforth). The second is to make a productivity adjustment to the costs. These two adjustments are made to allow for consideration of efficient costs for purposes of rate setting.

5. After applying the calculated peer group cost average to each hospital, all costs that were removed in Step 2 (social goods and factors beyond a hospital's control) are added back to each hospital to build revenue up to the ICC calculated value. The profit strip and productivity adjustment outlined in Step 4 are not added back to a hospital's revenue. The difference between the ICC calculated value and the revenue included in the ICC evaluation, as described in Step 1, is the measure of a hospital's relative efficiency in relation to the ICC Cost Standard.

For a graphic outline of this process(not inclusive of staff's alternative approach outlined in Table 7 to directly risk adjust for indigent care in lieu of using peer groups), please see Tables 3a and 3b.

**Table 3a: Overview of ICC Cost Comparison Calculation Determining Peer Group Cost-per-case (Stripping Down)**

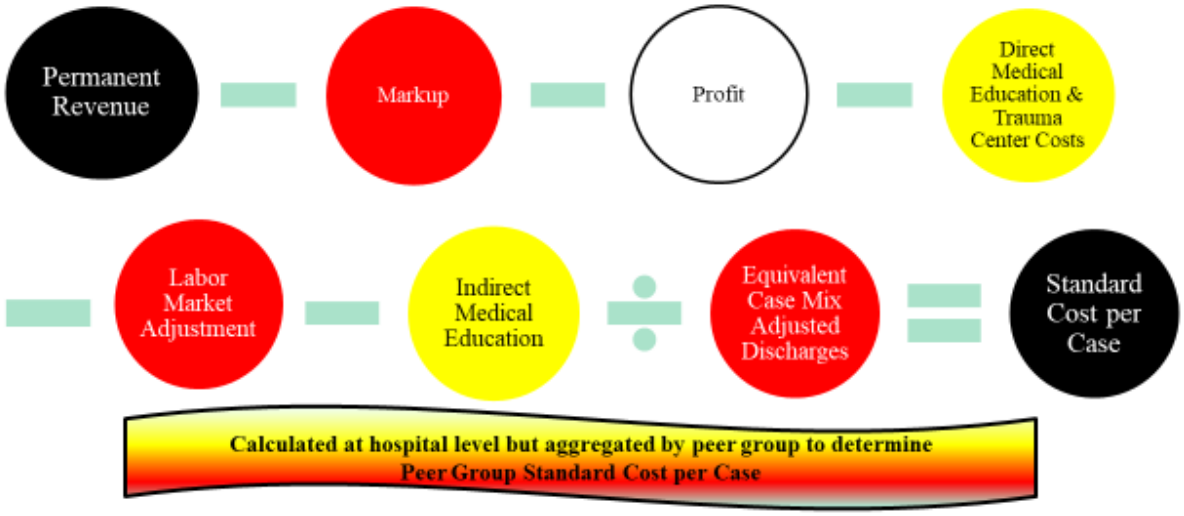
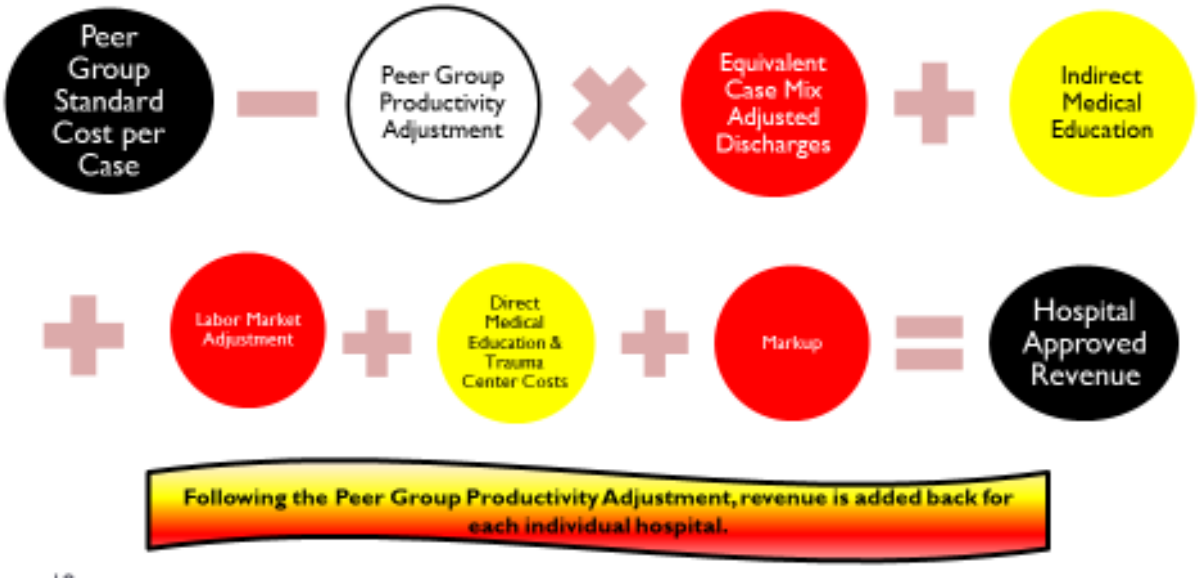


**Table 3b: Overview of ICC Cost Comparison Calculation Determining Total Revenue (Building Back Up)**




**Proposed Changes to ICC Methodology**

The following section outlines the proposed changes to the ICC relative to the methodology in effect in 2011.

**Step 1- Calculate Permanent Revenue**

A. Outpatient Drug Overhead Adjustment

As described in Appendix 1, staff has concluded its work in developing weights on outpatient cases, particularly cases that are subject to cycle billing and are ubiquitous across multiple outpatient settings. Staff did not develop usable weights for oncology and infusion drugs because these costs are highly variable by hospital due to various discounts that only certain hospitals receive, e.g., 340b discounts, and therefore do not offer a reliable efficiency comparison. As such, staff excluded oncology drugs from the cost-per-case/visit comparisons but retained the charges/cost constituting drug overhead, especially since the magnitude of drug overhead allocations are not uniform across hospitals. In the HSCRC rate setting calculations, a

significant portion of costs continues to be allocated based on "accumulated costs." This process is allocating too much overhead to outpatient biological drugs, and staff has concluded that this allocation distorts cost comparisons.[7]

B. Revenue for Reform Safe Harbor

In response to Commissioner requests to expedite the use of staff's proposed Revenue for Reform concept, whereby hospital revenue is placed into safe harbors, i.e., it is not assessed in efficiency analyses if the revenue subsidizes care transformation, staff has put into the modelling for this iteration of the Integrated Efficiency Policy a pilot safe harbor for Chestertown Hospital. Specifically, a portion of revenue has been removed from the ICC and any potential scaling adjustments in the Efficiency Matrix in recognition of Chestertown's intent to divert inpatient hospital revenue to rural health transformation, including an Aging and Wellness Center.

Staff does not recommend including any additional safe harbors until the Revenue for Reform Policy is officially promulgated, at which point a reporting and auditing function for safe harbors will be outlined.

**Step 2- Adjustments to Revenue**

Adjustments to revenue along with changes to each adjustment methodology are proposed by staff below:

A. Medical Education Costs

Consistent with past practices, direct medical education costs, including nurse and other training as well as graduate medical education (GME) costs, are stripped from the permanent revenues using amounts reported in hospitals' annual cost filings. HSCRC policies limited recognition of growth in residencies beginning in 2002, unless increases in residencies were approved through a rate setting process, consistent with Medicare policies that also limit recognition of growth in

[7] Medicare adds six percent to average sales price to pay for overhead on physician administered drugs that are not bundled into a visit cost, while non-governmental payers use a somewhat higher overhead figure on top of average sales price in their payment formulation. It is likely that HSCRC will need to change its overhead allocation and rate setting formulation for these biological and cancer drugs in the near term as costs continue to escalate. In the meantime, staff recommends retaining the overhead related revenues/costs in revenues evaluated under ICC charge-per case/visit comparisons.

residencies. For the proposed ICC formulation, the staff is limiting the counts and costs used in the GME calculations based on the number of residents and interns that were included in the 2011 regression. Moreover, staff is capping direct medical education costs for hospitals to no more than the average direct cost per resident statewide, which in the RY 2019 annual filing was $132,803.

Over the years, the calculation of indirect medical education ("IME") costs has been difficult. In 2011, the HSCRC reached a calculation after much debate of an IME allowance per resident of $230,746. Staff believed this figure was too high for those hospitals that are not major academic medical centers with high ratios of residents per bed. As such, staff worked with a contractor to create a nationally calibrated two-peer-group model to determine major academic indirect medical education costs versus the IME costs per resident of other teaching hospitals.[8] The criteria staff used for defining these two peer groups were as follows:

**Table 4 Criteria used to define teaching intensity hospital peer groups**

| Teaching intensity | Major AMC | Number of beds | IRB ratio |
|---|---|---|---|
| High | Yes | 500 or more | 0.60 or higher |
| Moderate to Low | No | Fewer than 500 | 0.03 to 0.60 |

Source: AAMC website and HCRIS, 2013-2015.
AAMC = American Association of Medical Colleges; AMC = academic medical center; HCRIS = Hospital Cost Reporting Information System

IRB ratio=Number of Interns and Residents/beds

Using the most recent three years of national hospital data (2013–2015) from the Hospital Cost Reporting Information System[9] and a regression that controlled for the other factors commonly

[8] Several studies also show that major teaching hospitals (sometimes, though not always, defined as academic medical centers or AMCs) have higher IME costs than non-major teaching hospitals. In its 2007 Report to Congress, MedPAC (2007) reported separate IME cost estimates for AMCs and other teaching hospitals. The results showed a stronger relationship to cost in AMCs than in other teaching hospitals. The IME cost estimate for major AMCs (2.6 percent) was nearly double the estimate for other teaching hospitals (1.5 percent). Nguyen and Sheingold (2011) also reported that the impact of teaching intensity on costs was higher among large urban hospitals than other hospitals. They found that costs per case for large urban hospitals increased 1.4 percent for every 10 percent increase in the ratio of residents to beds, compared with a 1.1 percent increase over all teaching hospitals.
[9] All Medicare-certified institutional providers are required to submit an annual cost report to a Medicare administrative contractor, which serves as the basis for the Hospital Cost Reporting Information System database. The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center, in total and for Medicare.

associated with costs, such as hospitals' average patient severity and indigent care burden[10], it was determined that IME costs among high-teaching intensity hospitals are $302,887 and $110,875 for low- and moderate-teaching intensity hospitals combined. These values were inflated from the 2015 analysis to be equivalent to RY 2020 dollars.

**Future development work may result in different allowed resident counts, but the methodologies for determining the cost per resident for direct and indirect medical education will remain the same.**

**Table 5 Estimated IME costs, by hospital peer group, 2013–2015**

| Teaching intensity | IME coefficient ($) | Standard error | P-value | 95 percent confidence interval | |
|---|---|---|---|---|---|
| All | 230,675*** | 11,753 | 0.000 | 207,639 | 253,711 |
| High[a] | 192,012*** | 41,873 | 0.000 | 109,942 | 274,082 |
| Moderate and low (omitted group) | 110,875*** | 17,216 | 0.000 | 77,132 | 144,619 |

Sources: HCRIS, 2013–2015; IPPS Impact File, 2013–2015.

Notes: The results are based on 124 hospitals in the high-teaching intensity group, 510 hospitals in the moderate-teaching intensity group, and 1,006 hospitals in the low-teaching intensity group.

[a] To calculate the marginal effect for these groups, add the estimated IME coefficient with the estimated IME coefficient for the omitted group within a given model. Estimated IME costs for high-teaching intensity hospitals in the two-peer group model are $302,887.

***Significantly different from zero at the .01 level, two-tailed t-test.

HCRIS = Hospital Cost Reporting Information System; IPPS = inpatient prospective payment system.

B. Labor Market Adjustment

In the prior ICC, the labor market adjustment was constructed using an HSCRC wage and salary survey that was based on two weeks of pay and included fringe benefits and contract labor. Each hospital was provided with a unique labor market adjustor that was more indicative of a hospital's ability or decision to pay salaries as opposed to the cost pressures hospitals face in

[10] Several variables (including hospitals' case-mix index, wage index, census region, and urban or rural designation) were derived from the IPPS Impact File, which CMS uses to estimate payment impacts of various policy changes in the IPPS proposed and final rules.

various labor markets, and there were concerns about the consistency and accuracy of reported benefit levels and their impact on the measured wage levels. Staff suspended the wage and salary survey submission for 2017 and intends to replace this survey data with data that better accounts for labor costs hospitals cannot control. One potential solution is to utilize CMS's nationally reported data. Although this national CMS data is available historically, HSCRC staff has not had the opportunity to audit the data, and there may be reporting errors. Staff and MHA have stressed the importance of accurate data in the 2017 reports to Medicare.

While staff will continue to use the HSCRC wage and salary survey in its formulation of the ICC until a new labor data source is available, it proposed in the 2018 ICC formulation to eliminate hospital specific adjustments for most hospitals. Specifically, the ICC will use two sets of hospital groupings, with the first set of grouping for Prince George's County and Montgomery County where wages are higher than Maryland's average, and a second grouping of all other hospitals.

C. Capital Cost Adjustment

Previously, there was a capital cost adjustment for differences in capital costs, which was being phased out over time. The time has elapsed, and there is no longer an adjustment for capital cost differences.

D. Disproportionate Share Hospital (DSH) Adjustment

In the 2011 analysis, staff made an adjustment to charges for patients considered to be poor, in consideration of the cost burden that those patients may place on hospitals with higher levels of indigent care. Prior calculations utilized the percentage of Medicaid, charity pay, and self-pay, referred to as poor share, as an independent variable in a multi-variate regression to determine this cost burden.

Staff discontinued this adjustment and instead retained peer groups, most notably Peer Group 4 (the urban peer group), because the peer group design and direct risk adjustment for indigent care were duplicative and disadvantaged hospitals, not part of the urban peer group, with similar levels of indigent care. Since this discontinuation, stakeholders have continued to raise concerns

that while the peer group assignments and indigent care are duplicative, there is variation in patient populations outside of the urban peer group that are not adequately addressed with the current ICC evaluation.

As such, staff engaged Mathematica Policy Research in developing a new DSH adjustment once it was determined that the peer groups in their current configuration (and in many other configurations based on cluster analyses) did not adequately address residual cost variation related to indigent care. The alternative approach built off the discontinued regression that utilized poor share as an independent variable because it demonstrated the greatest influence on ICC performance once peer groups were removed. Staff further added to the regression by controlling for Baltimore city hospitals, as staff was concerned that indigent care, as the last remaining adjustment in the ICC, was capturing other cost variation, likely due to actual inefficiency, e.g. excess capacity. Finally, staff identified slight volatility in the regression's annual coefficients and thus advanced the idea of using a regression that calculated indigent care cost per 1% of poor share over a three year ICC assessment, thereby smoothing out any instability in the DSH adjustment.

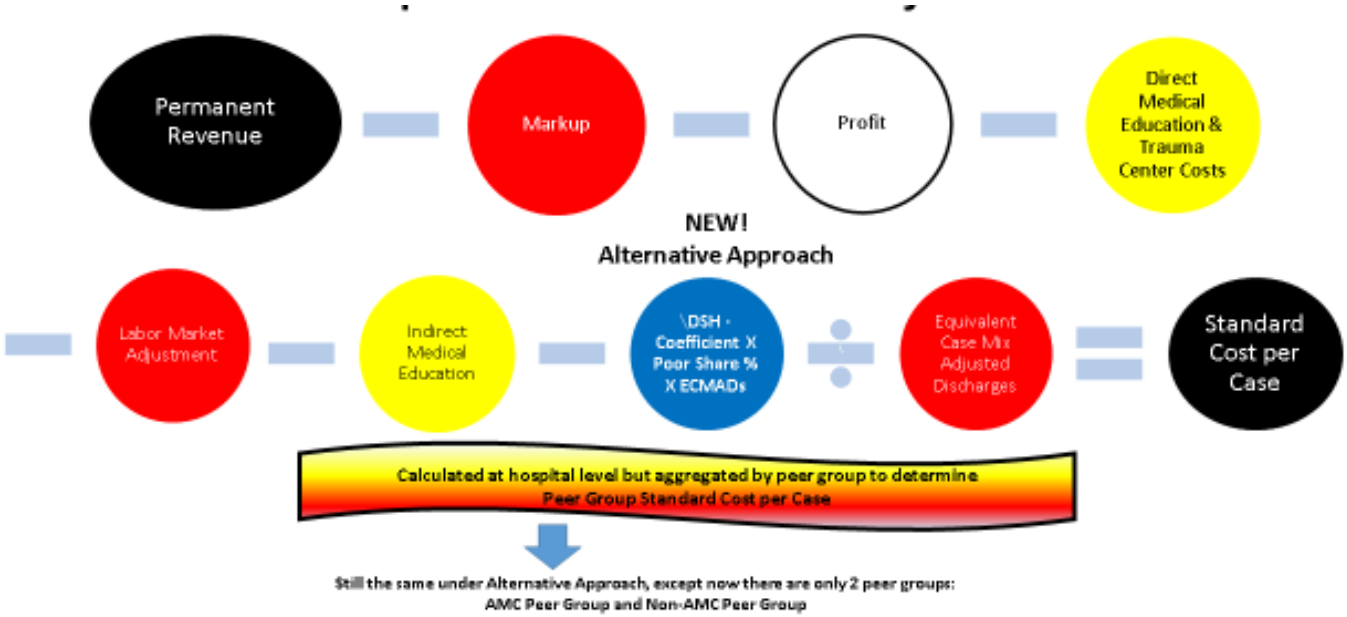
**Table 6 DSH Adjustment Based on 3 Year ICC Assessment Poor**

| | RY18-RY20 |
|---|---|
| Poor Share (DSH Adjustment) | 6,314.39*** |
| Metropolitan Indicator | 1,103.34** |
| Constant | 9,076.45*** |
| Observations | 41 |
| R2 | 0.51 |

*Note:* $^{*}p<0.1$; $^{**}p<0.05$; $^{***}p<0.01$

After calculating the poor share coefficient of $6,314, staff incorporated it directly into the ICC by multiplying it by a hospital's poor share percentage and its ECMADS when developing the peer group cost per case, which is a statewide peer group, save the academic medical centers, in the alternative approach. For a graphical demonstration of this see table 7 below:

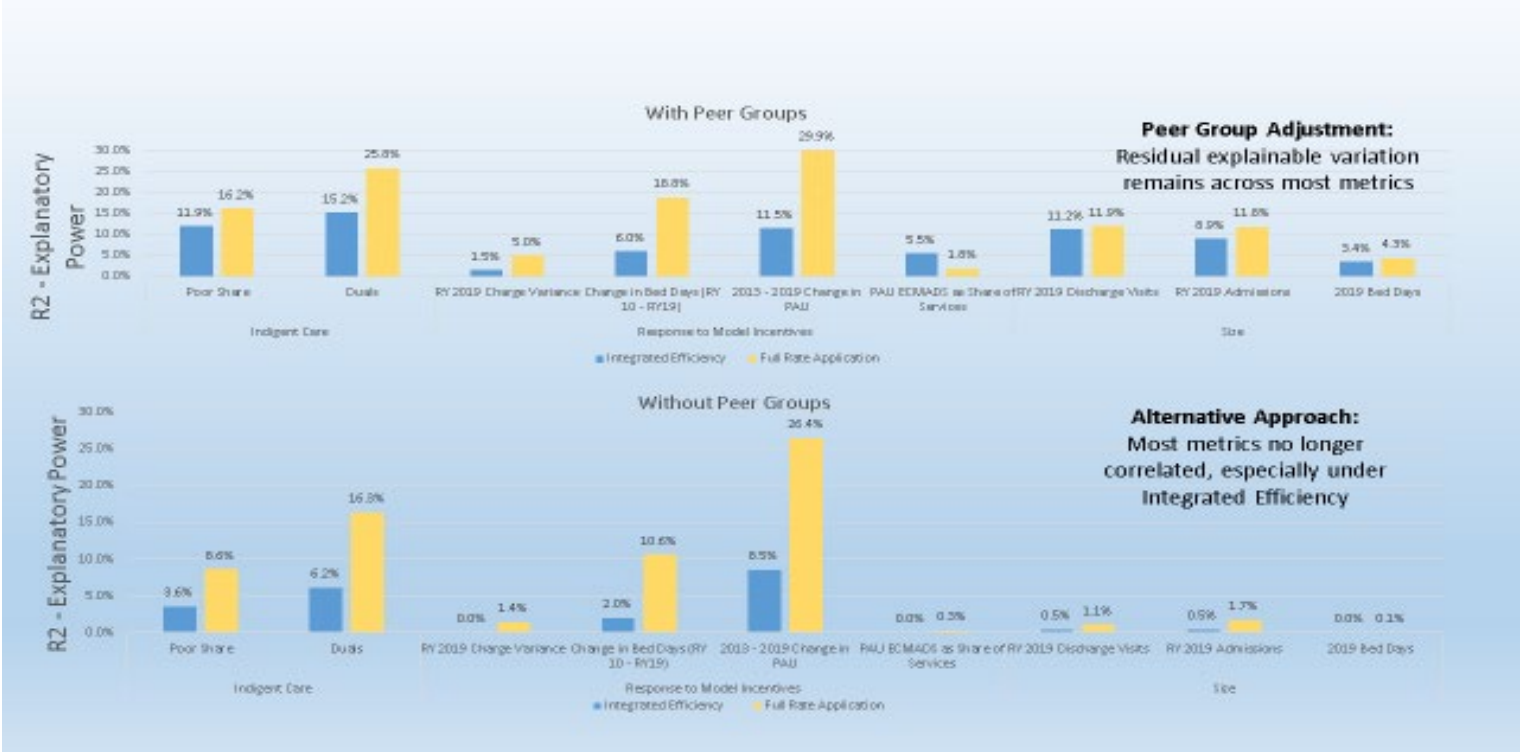
**Table 7: Overview of ICC Cost Comparison Calculation Determining Peer Group Cost-per-case with DSH Cost Strip (Stripping Down)**




Similar to other cost strips (e.g., labor market, indirect medical education), the DSH adjustment is built back into a hospital's revenue base once the standard cost per case is developed.

Finally, to determine the efficacy of the alternative approach, staff ran final correlations to evaluate if the relationship between indigent care and ICC performance was reduced, ideally to a point where it was no longer statistically significant. In this exercise, staff also evaluated other hospital characteristics that stakeholders expressed concern over, most notably charge variance – the degree to which a hospital must change its charges to align the GBR to current service volume and which serves as a measure of TCOC Model incentives. In all cases, the relationship between indigent care and these other statistics of interest weakened under the alternative approach, and in the ICC used in the Integrated Efficiency Methodology the relationship between indigent care and ICC performance was not statistically significant:

**Table 9: Residual Variation As Measured by $R^2$ with Other Metrics**




Due to the sensitivity of the peer group risk adjustment, staff has reflected in the *Efficiency Assessment* section results of the Integrated Efficiency Methodology with peer groups and with the alternative approach. Based on the workgroup process and stakeholder comment letters, staff has put forward in this policy the recommendation to abandon ICC peer groups and adopt a direct regression based risk adjustment for indigent care cost variation that will be applied to all efficiency policies.

**Step 3 Productivity and Cost Adjustments**

A. Profits

Staff has retained the same adjustment used to remove profits from the ICC costs, which has been used historically. Consistent with the statutory authority of HSCRC, the Commission does not regulate professional physician services. The adjustment removes profits for regulated services and does not incorporate subsidies or losses for professional physician services.

B. Productivity Adjustment

In prior iterations of this policy, staff recommended using an alternative approach to calculate the productivity adjustment. The excess capacity adjustment, which was formulated based on the declines in patient days (including observation cases >23 hours) from 2010 through 2018 in each peer group as well as the change in outpatient surgery days with a length of stay greater than 1 from 2013 to 2017, produced varying levels of required increased productivity for each peer group, which staff believed was a methodological improvement to the historical 2 percent productivity adjustment employed across the board. However, given further review based on the final promulgation of the Major Capital Financing policy that also uses this calculation on a hospital specific basis, staff has determined that the excess capacity calculation should not be used to determine a peer group productivity adjustment due to the 85 percent variable cost factor in place from 2010 to 2014, which made the calculation overestimate the level of productivity expected of each peer group. Thus, staff is recommending returning to the historical 2 percent productivity adjustment. This approach varies from the final approved policy for Full Rate Applications, which temporarily discontinued the use of a productivity adjustment, but because the Integrated Efficiency Policy is a relative ranking methodology and all hospitals incur the same productivity adjustment, the retention of a 2 percent productivity adjustment does not affect results.

**Step 4- Building up a Hospital's Permanent Revenue**

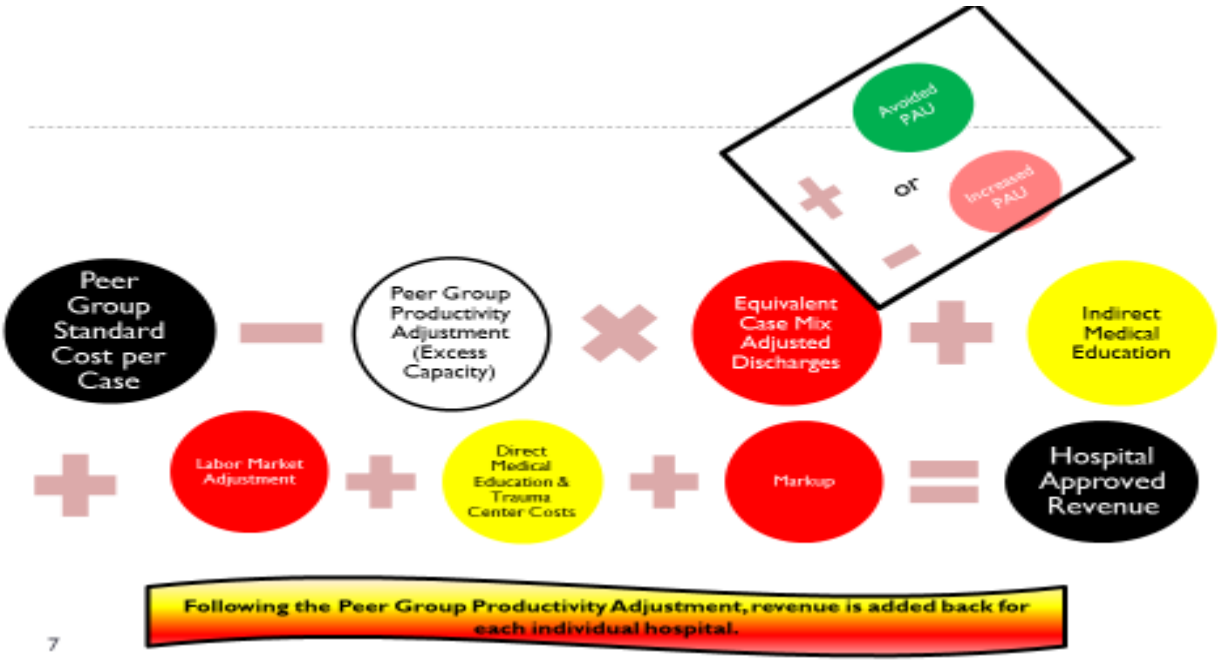
A. Volume Adjustment

In iterations of the ICC that relatively rank hospitals for the purpose of identifying inefficient hospitals, staff proposes to volume adjust the ICC because there exists an inverse correlation of (.53), whereby reductions in potentially avoidable utilization result in worse ICC performance. To correct for this, growth rates for potentially avoidable utilization, as defined by the PAU Shared Savings program,[11] will be assessed from CY 2013 to RY 2019. The inverse of PAU

[11] In the PAU Shared Savings program, there are two volume measurements: readmissions that are specified as 30-day, all-payer, all-cause readmissions at the receiving hospital with exclusions for planned admissions; and hospitalizations for ambulatory-care sensitive conditions as determined by the Agency for Health Care Research and Quality's Prevention Quality Indicators (PQIs).

growth rates, both positive and negative, will be multiplied by a hospital's PAU ECMADS, thereby adding or subtracting volume used in the final calculation of a hospital's ICC approved revenue. That is, if a hospital reduced PAU over the course of the All-Payer Model, the volume will be added to its evaluation, thereby making the hospital appear more efficient in a cost-per-case analysis. Conversely, if a hospital increased PAU, volume will be removed from the ICC evaluation, thereby making the hospital less efficient.

**Table 10: Overview of ICC Cost Comparison Calculation Determining Total Revenue (Building Back Up) with Volume Adjustment**




This PAU volume adjustment in concert with the alternative approach to ICC peer groups is also what ensures that there is no statistically significant relationship between indigent care and ICC performance, as evidenced by Table 9.

B. Critical Access Hospital (CAH) Adjustment

In recognition of the costs required to provide hospital care in rural areas, HSCRC staff proposes to add an additional risk adjustment for hospitals that would otherwise qualify as critical access hospitals. Based on analyses of hospital size, driving distance to the nearest facility, and low volume with short length of stay, staff has concluded that Chestertown Hospital should be

provided a Critical Access Hospital (CAH) Adjustment, i.e., an adjustment that benchmarks Chestertown Hospital's costs to similar national CAH's.[12] [13]

Following selection of peer hospitals, the CAH adjustment is based on straight average of cost centers from Medicare Cost Reports, excluding cost centers that represent services not provided (e.g., Psych, SNF). Casemix adjusted inpatient and outpatient discharges are then utilized to recognize differences in acuity and to scale the straight average method to the hospital's volume, which effectively weights the comparison. Then to convert the analysis to all-payer, a ratio of non-Medicare casemix index to Medicare casemix index is utilized, all of which will yield a predicted total cost standard based on national CAH benchmarks. Finally, staff adjusted the hospital's approved cost structure at the end of the ICC methodology so as not to affect Maryland peer group cost average, i.e., it functions as a final credit in ICC.

## Overview of Medicare Total Cost of Care Calculations

Consistent with the Total Cost of Care (TCOC) Model, the cost used in this evaluation will include all types of medical costs (including both hospital and non-hospital services) with the exception of retail pharmacy.

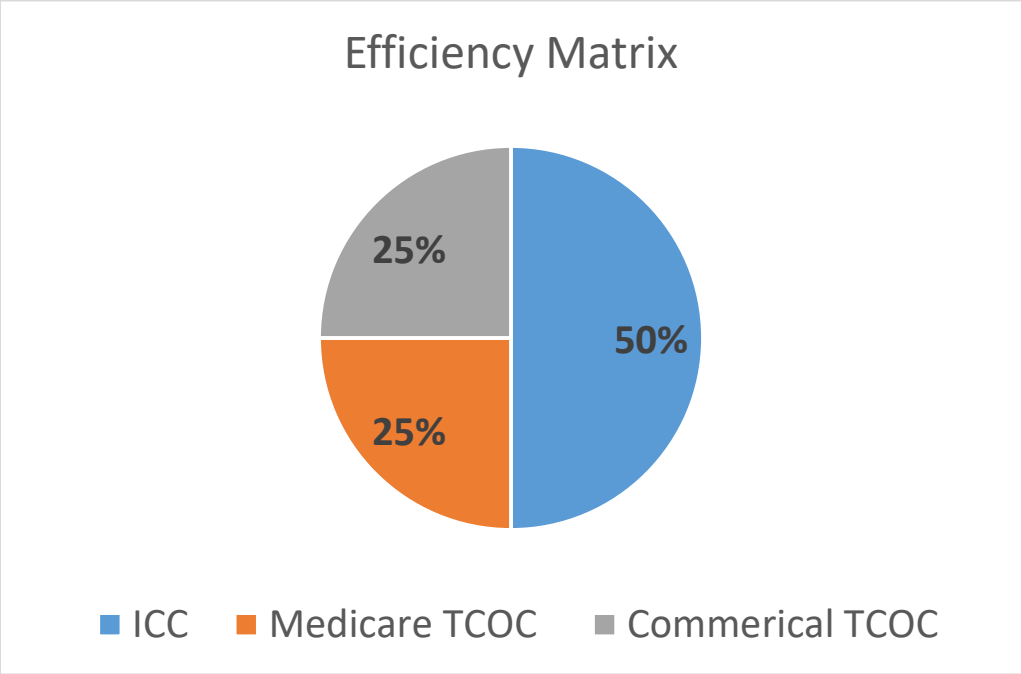
Hospitals' TCOC performance will be ranked by percentage variance from the Medicare benchmark performance (or average of similar demographic national peers), and this same approach will be applied to Commercial performance. The score from this ranking will be added to the ranking from the ICC and will comprise 50% of the evaluation – Medicare and

[12] Qualification for CAH classification nationally requires: a) Having 25 or fewer acute care inpatient beds; b) Being located more than 35 miles from another hospital; c) Maintaining an annual average length of stay of 96 hours or less for acute care patients; and d) Providing 24/7 emergency care services. Sixty-two percent of rural hospitals are paid as Critical Access Hospitals (CAH), comprising 35% of rural hospital payment for Medicare

[13] The criteria used for choosing peer CAH hospitals were as follows: flagged CAH's in national cost report database (~1,300 hospitals); established selection criteria, including: similar size; high quality; not financially distressed;, private, not for profit hospitals; similar wage levels--wage index of .85 or higher; and heavy Medicare mix--Medicare revenue is 30% or higher (24 hospitals); removed hospitals not available in American Hospital Directory data and hospitals that once swing beds were removed were too small for comparison (15 hospitals).

Commercial performance will comprise an even share of the total cost of care evaluation (25% each) as both represent approximately the same share of hospital payments statewide. This statewide weighting approach ensures that total of care is heavily influential to the efficiency analysis and ensures that hospitals with more favorable payer mixes, i.e., more commercial purchasers, are not artificially advantaged.

**Table 11: Efficiency Matrix Weighting**




**Geographic Attribution Approach**

For the purpose of this calculation, a hospital's attributed beneficiaries will be determined based on the Primary Service Area-Plus (PSAP) method used for the geographic attribution layer of the Medicare Performance Adjustment attribution approved by the Commission in November 2017. Under this approach, beneficiaries are attributed based on their zip code of residence. Zip codes are attributed to hospitals through three steps:

1. Costs and beneficiaries in zip codes listed as Primary Service Areas (PSAs) in the hospitals' GBR agreements are assigned to the corresponding hospitals. Costs and beneficiaries in zip codes claimed by more than one hospital are allocated according to the hospital's share on equivalent case-mix adjusted discharges (ECMADs) for inpatient

and outpatient discharges among hospitals claiming that zip code. ECMADs are calculated from Medicare FFS claims for the federal fiscal years 2014 and 2015.

2. Zip codes not claimed by any hospital are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if such zip code does not exceed 30 minutes' drive time from the hospital's PSA. Plurality is identified by the ECMAD of the hospital's inpatient and outpatient discharges during the attribution period.
3. Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.

**Medicare and Commercial Benchmark Methodologies**

A Medicare and a Commercial benchmark was calculated for each hospital. Each benchmark was developed in a three step process. Step 1 was to identify benchmark groups for each Maryland geography. Step 2 was to translate the geographic benchmarks into hospital-level benchmarks. Step 3 was to complete the cost comparison adjusting for beneficiary risk and demographics.

Detailed methodologies for each payer and additional data files related to the benchmarking process can be found in the Resources section of the Total Cost of Care Workgroup page on the HSCRC's website. The following is an abbreviated overview of these materials.

Step 1: Identify Benchmark Groups for each Maryland Geography

For Medicare benchmarking the geographic unit was a county. Due to limitations of the commercially available national data, the benchmark geographic unit was a Metropolitan Statistical Area. (MSA) However, in Maryland where more granular data is available through the Maryland Health Care Commission's Medical Claims Database (MCDB), Maryland counties were reorganized into a group of MSA-like cohorts such that all Maryland counties were included and no non-MD counties were included (this is not the case with standard MSAs).

Potential comparison geographies for each Maryland geography were narrowed based on population density and size. Various demographic factors were then calculated for every geographic unit within this narrowed selection. The demographic values used were intended to capture the health needs and economic situation of the geography. Factors related to health

system design like physician supply or provider concentration were explicitly excluded to avoid creating results that were biased by the nature of the delivery system.

A benchmark cohort was then developed for each Maryland geographic units (1 for Medicare and 1 for Commercial). The cohort was established based on selecting the 20 or 50 most statistically similar national geographies for each Maryland geography. The cohort includes 20 members for all Commercial areas and for 5 large Maryland counties for Medicare. (Anne Arundel, Baltimore City, Baltimore County, Montgomery County and Prince George's County). 50 member cohorts were used for Medicare for the remaining Maryland counties.

The cohort sizes were selected to balance the relative similarity of the included national geographies against the need for stable results over time. Medicare and Commercial benchmark cohorts are not identical as the same geographic unit was not used, but there is substantial overlap, and the selection metrics were identical except that payer mix was used in the Commercial selection but not in the Medicare selection.

Step 2: Translate Geographic Benchmarks into Hospital benchmarks

As the policy requires measuring performance at a hospital level, it was necessary to develop a hospital specific benchmark. This was done in three steps:

A. Calculate Maryland per capital total cost of care for each Maryland hospital based on its Primary Service Area Plus (PSAP). The PSAP is the service area selected by the hospital in their GBR agreement with any shared zip codes split based on ECMAD share and any unassigned zip codes assigned to a hospital based on travel distance. With these modifications, the PSAP methodology attributes 100% of Maryland's population to a hospital.

B. Calculate the benchmark by blending the relevant geographic benchmarks based on the distribution of the beneficiaries within the hospital's PSAP. For example, a hospital with 60% of its beneficiaries in geographic unit A and 40% in geographic unit B has a benchmark per capita total cost of care equal to 60% A and 40% B.

C. Adjust the Maryland and benchmark values using the adjustments described in Step 3 below to adjust for differences between the Hospital's PSAP demographics and those in the geographic units in its benchmark.

Step 3: Complete the Cost Comparison adjusting for Beneficiary Risk and Demographics

Per capita total cost of care is calculated for each Maryland hospital and its benchmark. For Medicare the paid amounts are used and for Commercial the allowed amount was used. For Medicare, the paid amount was utilized, as that is the amount for which Maryland is accountable under the Total Cost of Care Model. For Commercial, the allowed amount was utilized to remove the impact of varying cost sharing amounts across different commercial populations. The raw amounts are then adjusted as follows:

A. Medical Education costs were stripped from all values. Medical Education was removed so that Maryland hospitals would not be harmed or helped versus their benchmark cohort based on the level of medical education provided.

B. Risk adjustment is applied. Medicare risk adjustment is applied using Medicare Hierarchical Conditioning Categories (HCCs). Commercial risk adjustment is applied using HHS-HCC Platinum Risk Scores. Both these methodologies are publicly available validated risk adjustment methodologies. Age and sex are incorporated in these methodologies and therefore were not separately addressed.

C. (Commercial Only) Benefit adjustment is applied. While the use of allowed amounts removes the cost impact of member cost shares, it does not remove the utilization impact of varying cost shares. Generally, a plan with richer benefits will result in higher utilization. The benefit adjustment is intended to eliminate this impact from the comparison, so Maryland is not harmed or helped because of its commercial health plans having poorer or richer benefits. The adjustment resulted in a scaled index for each MSA reflecting the relative richness of benefits. This value is then used to remove the impact of benefit differential from the per capita total cost of care.

D. Demographic Adjustment was applied. A demographic adjustment was developed to better standardize for demographic factors beyond the control of the health system that impact cost of care. The adjustment was calculated separately for Medicare and Commercial, but in both cases was based on a regression of the risk and benefit adjusted total per capita cost of care against Median Income and Deep Poverty as reported by zip code in census data. The resulting regression coefficients were used to create a predicted value for each county, and the ratio of the actual value to the predicted value was used to adjust the risk and benefit-adjusted per capita total cost of care.

The values calculated can then be used to compare each hospital's per capita total cost of care to their peer average (or other comparison points derived from the benchmark cohort, e.g. 75$^{th}$ percentile) while removing the impact of medical education, beneficiary risk, benefits and demographics from the comparison.

## Efficiency Assessment

### Withholding Inflation from Outlier Hospitals

In this section, staff provides the results of the Volume Adjusted ICC for RY 2020 permanent revenue as well as results for 2018 Medicare and Commercial Total Cost of Care benchmark performance. Using these three statistics and weighting them respectively as 50%, 25%, and 25%, hospitals are arrayed into quartiles, such that hospitals in the bottom quartile will be considered to be the most costly relative to hospital peers. Based on this analysis, staff ultimately recommends that the remaining hospitals that are in worst quartile of performance, as outlined above should have a portion of their Medicare and Commercial RY 2022 update factor withheld, effective July 1, 2021.

### Global Budget Revenue Enhancements

In this section, the best performing quartile for Volume Adjusted ICC and Medicare Total Cost of Care growth from 2013 to 2018 is also listed. Staff removed hospitals that are not better than one standard deviation from average Volume Adjusted ICC performance or 1.05 times the ICC Cost Standard. The remaining hospitals will be considered favorably when submitting requests for GBR enhancements.

### ICC Results

As noted above, the difference between the Volume Adjusted ICC evaluated revenue figure, the revenue that was actually inputted into the ICC methodology, and the Volume Adjusted ICC calculated value is a hospital's measure of efficiency relative to the ICC cost standard. Table 12a (with peer groups) and Table 12b (without peer groups) below demonstrate this measure of efficiency as a percentage variance from the ICC standard. The table is ranked in order of most favorable to least favorable. Please note the results in table 12a have changed slightly because: a) staff has updated RY 2020 permanent revenue figures for hospitals that modifications to their rate structure after February of 2020; b) all revenue at Sinai Hospital associated with the Bon Secours transition was removed from the analysis, as this represented a prospective budget

amount with no associated volume – future years will include this revenue minus the agreed upon safe harbors; and c) staff included a critical access hospital adjustment and a pilot safe harbor for rural care transformation at Chestertown Hospital.

**Table 12a: RY 2020 Volume Adjusted ICC Efficiency Rankings (Percentage and Dollar)* Inclusive of Historical ICC Peer Groups**

| | Relative Efficiency to ICC Standard % | | Relative Efficiency to ICC Standard % |
|---|---|---|---|
| Garrett County Memorial Hospital | 4.14% | Western Maryland Regional Medical Center | -14.31% |
| Mercy Medical Center | 3.06% | St. Agnes Hospital | -15.38% |
| Atlantic General Hospital | -0.95% | MedStar Franklin Square Hospital Center | -15.68% |
| Suburban Hospital | -3.56% | Sinai Hospital | -15.74% |
| MedStar Union Memorial Hospital | -4.16% | Prince Georges Hospital Center | -16.96% |
| MedStar Harbor Hospital Center | -5.73% | University of Maryland Shore Medical Center at Chestertown | -18.01% |
| Fort Washington Medical Center | -5.73% | Shady Grove Adventist Hospital | -18.30% |
| Anne Arundel Medical Center | -5.76% | University of Maryland Shore Medical Center at Dorchester | -18.43% |
| Howard County General Hospital | -5.87% | Harford Memorial Hospital | -18.78% |
| Johns Hopkins Bayview Medical Center | -6.12% | MedStar Good Samaritan Hospital | -19.03% |
| Johns Hopkins Hospital | -6.22% | Doctors Community Hospital | -19.32% |
| Holy Cross Hospitals | -6.43% | Carroll Hospital Center | -19.73% |
| Greater Baltimore Medical Center | -7.32% | Washington Adventist Hospital | -19.89% |
| Peninsula Regional Medical Center | -7.66% | University of Maryland Shore Medical Center at Easton | -21.35% |
| University of Maryland Baltimore Washington Medical Cente | -8.50% | Northwest Hospital Center | -21.69% |
| MedStar St. Mary's Hospital | -9.24% | Calvert Memorial Hospital | -22.39% |
| Meritus Medical Center | -9.35% | MedStar Montgomery Medical Center | -22.51% |
| University of Maryland Medical Center | -10.74% | University of Maryland Medical Center Midtown Campus | -23.52% |
| Upper Chesapeake Medical Center | -11.30% | University of Maryland Rehabilitation & Orthopaedic Institute | -24.80% |
| University of Maryland St. Joseph Medical Center | -11.37% | Union Hospital of Cecil County | -24.87% |
| Frederick Memorial Hospital | -11.97% | MedStar Southern Maryland Hospital Center | -25.56% |
| University of Maryland Charles Regional Medical Center | -13.62% | | |

*Highlighted values represent hospitals that have an ICC calculated value better than one standard deviation of average performance, which would qualify these hospitals for a global budget revenue enhancement.

**Table 12b: RY 2020 Volume Adjusted ICC Efficiency Rankings (Percentage and Dollar)* Inclusive of Alternative Peer Groups Approach**

| | Relative Efficiency to ICC Standard % | | Relative Efficiency to ICC Standard % |
|---|---|---|---|
| Garrett County Memorial Hospital | 6.76% | Upper Chesapeake Medical Center | -11.57% |
| Fort Washington Medical Center | 2.45% | University of Maryland St. Joseph Medical Center | -12.38% |
| Atlantic General Hospital | -0.42% | Western Maryland Regional Medical Center | -12.73% |
| Holy Cross Hospitals | -2.49% | Shady Grove Adventist Hospital | -12.95% |
| University of Maryland Shore Medical Center at Dorchester | -2.92% | Harford Memorial Hospital | -13.55% |
| Howard County General Hospital | -3.64% | Frederick Memorial Hospital | -13.83% |
| Meritus Medical Center | -4.41% | Northwest Hospital Center | -13.99% |
| MedStar St. Mary's Hospital | -4.89% | Doctors Community Hospital | -14.45% |
| Peninsula Regional Medical Center | -5.25% | Johns Hopkins Bayview Medical Center | -14.51% |
| University of Maryland Baltimore Washington Medical Center | -6.16% | MedStar Union Memorial Hospital | -14.99% |
| Suburban Hospital | -7.36% | University of Maryland Shore Medical Center at Easton | -16.13% |
| Anne Arundel Medical Center | -7.80% | Union Hospital of Cecil County | -17.65% |
| Johns Hopkins Hospital | -7.87% | University of Maryland Shore Medical Center at Chestertown | -17.67% |
| MedStar Harbor Hospital Center | -9.25% | Carroll Hospital Center | -18.33% |
| St. Agnes Hospital | -9.61% | Prince Georges Hospital Center | -19.24% |
| University of Maryland Medical Center | -9.70% | MedStar Southern Maryland Hospital Center | -19.51% |
| Washington Adventist Hospital | -9.71% | Calvert Memorial Hospital | -20.27% |
| University of Maryland Charles Regional Medical Center | -9.72% | University of Maryland Rehabilitation & Orthopaedic Institute | -20.32% |
| MedStar Franklin Square Hospital Center | -9.84% | MedStar Montgomery Medical Center | -20.76% |
| Mercy Medical Center | -10.18% | University of Maryland Medical Center Midtown Campus | -22.31% |
| Greater Baltimore Medical Center | -10.69% | Sinai Hospital | -23.96% |
| MedStar Good Samaritan Hospital | -11.00% | | |

Highlighted values represent hospitals that have an ICC calculated value better than one standard deviation of average performance, which would qualify these hospitals for a global budget revenue enhancement.

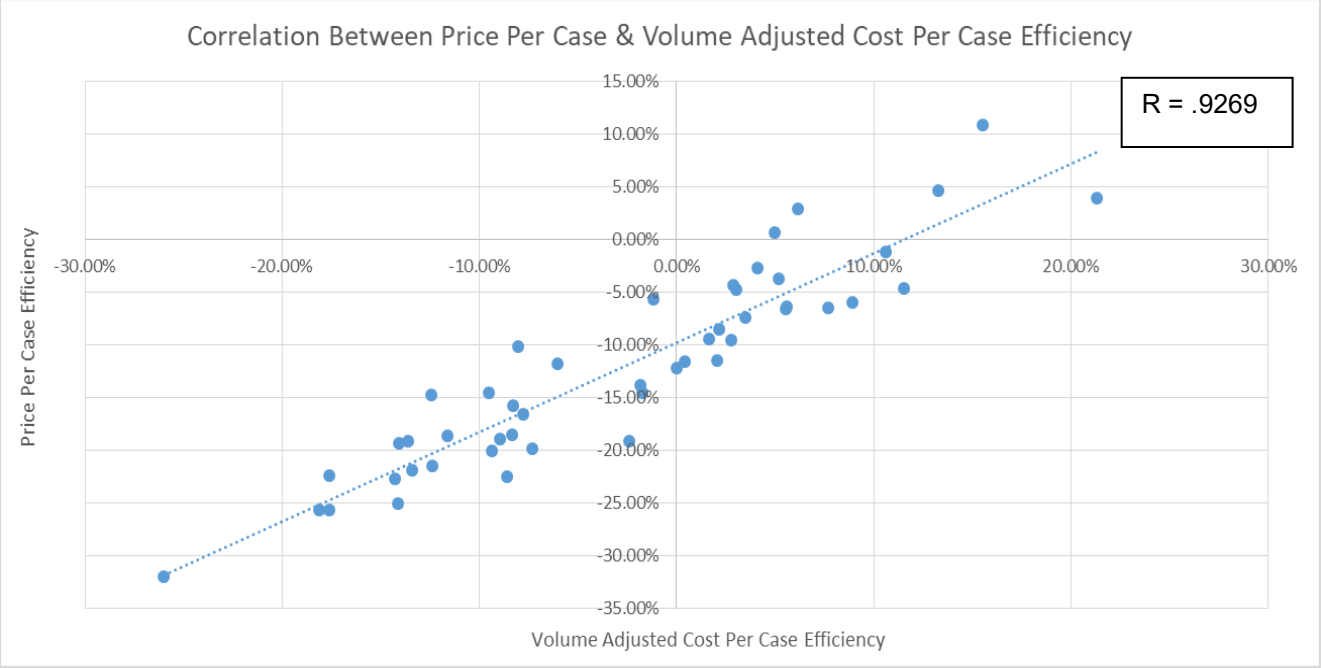
As shown in Table 12a and Table 12b, only two hospitals are deemed more efficient than the ICC cost standard, i.e., have a positive percentage variance, but it is important to note that this is because the ICC standard has become more difficult to attain, since hospital profits have improved under the All-Payer Model and Total Cost of Care Model. It is also important to note that this does not preclude best performing hospitals from qualifying for a GBR enhancement under the Integrated Efficiency Policy, as the standard for qualification based on ICC performance is being better than one standard deviation from average performance – 5 hospitals

meet the one standard deviation ICC rule in the version with peer groups and 7 hospitals meet the standard without peer groups.

While total profit margins are lower because of unregulated losses, most notably physician subsidies, staff has not made adjustments to the profits stripped from hospitals' revenue base to account for these losses. This is consistent with the statutory authority of HSCRC, as the Commission does not regulate professional physician services. Future work outlined in the *Future Policy Considerations* section below does indicate that staff will attempt in subsequent iterations of the ICC to credit unregulated losses that are in line with the incentives of the Total Cost of Care Model, but at this point staff will make no modifications.

Critics of the ICC have noted that not accounting for unregulated losses does not accurately portray the new costs associated with providing care in a population-based per capita model. Staff agrees with this concern but notes that this is why the implementation of the efficiency policy incorporates total cost of care performance and only removes funding from hospitals in the worst quartile. Regardless of any imprecision in the ICC methodology, hospital prices per case grew in the global revenue era as volumes have declined or remained static. This is an expected outcome similar to the rise in per diem payments when length-of-stay initially fell under the DRG system. To ensure that charges do not become unreasonably high, especially given Medicare outpatient coinsurance that is already high due to the all-payer rate setting nature of the system, staff recommends using the combination of cost-per-case analyses and total cost of care. Moreover, staff notes that there is a high degree of correlation between high priced hospitals and high cost hospitals, as determined by the ICC (R=.9269). This suggests that the hospitals identified in the outlier analysis are not just inefficient in costs relative to their peers, but that they are also receiving reimbursement commensurate with their higher costs (see Table 13 below for the correlation analysis).

**Table 13: Correlation between Hospital ICC Cost Efficiency and ICC Price Efficiency**




## TCOC Results

Using the geographic attribution described in the *Efficiency: Overview of Total Cost of Care Calculations* section, staff has determined that 7 hospitals perform better than their national geographic peers in Medicare total cost of care; 10 hospitals perform worse than national peers but better than average statewide performance relative to national benchmarks (11.5% statewide unweighted); and 26 hospitals perform worse than average statewide performance relative to national benchmarks. As one would expect due to the all-payer rate setting nature of the Maryland system, the results are quite different relative to national peers for commercial, as 40 hospitals perform better than national benchmarks, but quite interestingly the results on the two total cost of care metrics are correlated but not strongly (R = .5165). Table 14 below shows hospital total cost of care performance relative to national benchmarks, both in terms of percentage variance and statewide ranking based on percentage variance.

## Table 14: Hospital Attributed Total Cost of Care Growth Performance

| Hospital Name* | 2018 Medicare TCOC Relative to Benchmark | 2018 Medicare TCOC Rank | 2018 Commercial TCOC Relative to Benchmark | 2017 Commercial TCOC Rank |
|---|---|---|---|---|
| Suburban Hospital | -10.14% | 1 | -36.06% | 1 |
| MedStar Southern Maryland Hospital Center | -6.70% | 2 | -28.54% | 7 |
| Doctors Community Hospital | -4.86% | 3 | -31.06% | 6 |
| Fort Washington Medical Center | -3.80% | 4 | -21.35% | 23 |
| Howard County General Hospital | -2.22% | 5 | -32.32% | 3 |
| Shady Grove Adventist Hospital | -2.05% | 6 | -31.64% | 4 |
| Anne Arundel Medical Center | -1.33% | 7 | -31.15% | 5 |
| Washington Adventist Hospital | 2.03% | 8 | -26.22% | 11 |
| MedStar Montgomery Medical Center | 2.69% | 9 | -32.46% | 2 |
| Calvert Memorial Hospital | 2.86% | 10 | -26.77% | 9 |
| Holy Cross Hospitals | 2.89% | 11 | -28.02% | 8 |
| MedStar St. Mary's Hospital | 5.28% | 12 | -13.24% | 37 |
| Prince Georges Hospital Center | 5.39% | 13 | -22.23% | 20 |
| University of Maryland Charles Regional Medical Center | 6.02% | 14 | -21.83% | 22 |
| Garrett County Memorial Hospital | 7.79% | 15 | 3.01% | 43 |
| University of Maryland Baltimore Washington Medical Center | 10.19% | 16 | -24.27% | 15 |
| Frederick Memorial Hospital | 10.22% | 17 | -25.04% | 14 |
| University of Maryland Shore Medical Center at Dorchester | 11.60% | 18 | -23.21% | 17 |
| University of Maryland Shore Medical Center at Easton | 11.60% | 18 | -12.07% | 38 |
| University of Maryland Shore Medical Center at Chestertown | 13.29% | 20 | -12.02% | 40 |
| MedStar Union Memorial Hospital | 13.87% | 21 | -13.68% | 36 |
| St. Agnes Hospital | 14.13% | 22 | -23.55% | 16 |
| Greater Baltimore Medical Center | 14.37% | 23 | -20.28% | 26 |
| Johns Hopkins Hospital | 14.42% | 24 | -20.79% | 25 |
| Meritus Medical Center | 14.45% | 25 | -16.75% | 32 |
| Union Hospital of Cecil County | 15.43% | 26 | -3.56% | 42 |
| Carroll Hospital Center | 15.88% | 27 | -21.25% | 24 |
| University of Maryland St. Joseph Medical Center | 16.58% | 28 | -18.03% | 29 |
| University of Maryland Rehabilitation & Orthopaedic Institute | 16.60% | 29 | -26.77% | 9 |
| University of Maryland Medical Center | 16.60% | 29 | -25.70% | 12 |

| | | | | |
|---|---|---|---|---|
| **Johns Hopkins Bayview Medical Center** | 17.46% | 31 | -17.82% | 30 |
| **Mercy Medical Center** | 17.56% | 32 | -19.96% | 27 |
| **University of Maryland Medical Center Midtown Campus** | 19.01% | 33 | -23.21% | 17 |
| **MedStar Franklin Square Hospital Center** | 19.24% | 34 | -16.15% | 34 |
| **Upper Chesapeake Medical Center** | 19.30% | 35 | -22.89% | 19 |
| **MedStar Good Samaritan Hospital** | 20.32% | 36 | -9.88% | 41 |
| **Sinai Hospital** | 20.99% | 37 | -14.56% | 35 |
| **Peninsula Regional Medical Center** | 21.47% | 38 | -21.99% | 21 |
| **Harford Memorial Hospital** | 21.74% | 39 | -18.97% | 28 |
| **Northwest Hospital Center** | 23.86% | 40 | -16.30% | 33 |
| **Western Maryland Regional Medical Center** | 24.36% | 41 | -12.05% | 39 |
| **MedStar Harbor Hospital Center** | 27.59% | 42 | -25.13% | 13 |
| **Atlantic General Hospital** | 29.41% | 43 | -17.29% | 31 |

*Dorchester Hospital receives the same TCOC performance as Easton; UMROI receives the same TCOC performance as Midtown Hospital.

## Implementation of Efficiency Results

### Withholding Inflation from Outlier Hospitals

Staff recognizes that any combination of cost-per-case and total cost of care tools does not precisely identify a hospital's efficiency rank order, especially near the median of performance, and staff believes that implementation of an efficiency policy should align with historical HSCRC policies to focus on the tail ends of the distribution. Moreover, a central limitation in these analyses is that the total cost of care tools are Medicare and Commercial only.

Therefore, staff recommends weighting equally the two rankings from the Volume Adjusted ICC and geographic total cost of care benchmark performance to array hospitals into quartiles, such that hospitals in the bottom quartile will be considered the least efficient and hospitals in the top quartile will be considered the most efficient relative to hospital peers. Finally, staff recommends that the remaining hospitals, deemed inefficient as outlined above, should have the Medicare and Commercial portion of their annual update factor withheld on a sliding scale to recognize gradations in performance.

In reviewing the array of hospitals according to a 50/50 ranking of Volume Adjusted ICC and geographic total cost of care benchmark performance ranking, staff identified eleven hospitals

when using an ICC that maintained historical peer groups and ten hospitals when using staff's proposed alternative approach to adjusting for indigent care that would be subject to an inflation factor reduction[14] See Table 15a and 15b for results:[15]

**Table 15a: Inefficient Hospitals as Determined by ICC & Geographic TCOC Rankings (inclusive of existing peer groups) – Efficiency Matrix**

| Hospital Name | Volume Adjusted ICC Result | ICC Rank (50%) | 2018 Medicare TCOC Relative to Benchmark | 2018 Medicare TCOC Rank (25%) | 2018 Commercial TCOC Relative to Benchmark | 2017 Commercial TCOC Rank (25%) | Total Rank Points (Low Score is Better) |
|---|---|---|---|---|---|---|---|
| **MedStar Franklin Square Hospital Center** | **-15.68%** | 25 | 19.24% | 34 | -16.15% | 34 | 59 |
| **Carroll Hospital Center** | **-19.73%** | 34 | 15.88% | 27 | -21.25% | 24 | 60 |
| **University of Maryland Rehabilitation & Orthopedic Institute** | **-24.80%** | 41 | 16.60% | 29 | -26.77% | 9 | 60 |
| **Sinai Hospital** | **-15.74%** | 26 | 20.99% | 37 | -14.56% | 35 | 62 |
| **Western Maryland Regional Medical Center** | **-14.31%** | 23 | 24.36% | 41 | -12.05% | 39 | 63 |
| **University of Maryland Shore Medical Center at Easton** | **-21.35%** | 36 | 11.60% | 18 | -12.07% | 38 | 64 |
| **Harford Memorial Hospital** | **-18.78%** | 31 | 21.74% | 39 | -18.97% | 28 | 65 |
| **University of Maryland Medical Center Midtown Campus** | **-23.52%** | 40 | 19.01% | 33 | -23.21% | 17 | 65 |
| **MedStar Good Samaritan Hospital** | **-19.03%** | 32 | 20.32% | 36 | -9.88% | 41 | 71 |
| **Northwest Hospital Center** | **-21.69%** | 37 | 23.86% | 40 | -16.30% | 33 | 74 |
| **Union Hospital of Cecil County** | **-24.87%** | 42 | 15.43% | 26 | -3.56% | 42 | 75 |

[14] As is always the case, a hospital has a legal opportunity to contest a rate order through the Full Rate Review process, pursuant to Health-General Article §19-222 and COMAR 10.37.10.03 et seq.

[15] For the complete array of hospitals based on ICC ranking and TCOC ranking, see Appendix 5

**Table 15b: Inefficient Hospitals as Determined by ICC & Geographic TCOC Rankings (inclusive of alternative approach for indigent care) – Efficiency Matrix**

| Hospital Name | Volume Adjusted ICC Result | ICC Rank (50%) | 2018 Medicare TCOC Relative to Benchmark | 2018 Medicare TCOC Rank (25%) | 2018 Commercial TCOC Relative to Benchmark | 2017 Commercial TCOC Rank (25%) | Total Rank Points (Low Score is Better) |
|---|---|---|---|---|---|---|---|
| **University of Maryland Shore Medical Center at Easton** | -16.13% | 33 | 11.60% | 18 | -12.07% | 38 | 61 |
| **Johns Hopkins Bayview Medical Center** | -14.51% | 31 | 17.46% | 31 | -17.82% | 30 | 62 |
| **Carroll Hospital Center** | -18.33% | 36 | 15.88% | 27 | -21.25% | 24 | 62 |
| **Western Maryland Regional Medical Center** | -12.73% | 25 | 24.36% | 41 | -12.05% | 39 | 65 |
| **University of Maryland Shore Medical Center at Chestertown** | -17.67% | 35 | 13.29% | 20 | -12.02% | 40 | 65 |
| **Northwest Hospital Center** | -13.99% | 29 | 23.86% | 40 | -16.30% | 33 | 66 |
| **University of Maryland Medical Center Midtown Campus** | -22.31% | 42 | 19.01% | 33 | -23.21% | 17 | 67 |
| **Union Hospital of Cecil County** | -17.65% | 34 | 15.43% | 26 | -3.56% | 42 | 68 |
| **Sinai Hospital** | -23.96% | 43 | 20.99% | 37 | -14.56% | 35 | 79 |

Of these hospitals, one was removed from consideration because it already had a preexisting arrangement with the HSCRC to address its cost inefficiencies: University of Maryland Medical Center Midtown Campus. Also of note, seven of the eleven hospitals in Table 15a are deemed inefficient in Table 15b, suggesting rather strong alignment in the results. In fact, the correlation across all quartiles between both ICC assessments (without and without peer groups) is .70 and stronger still when the efficiency matrix scores inclusive of TCOC assessments are considered (R=.83).

For the remaining hospitals in Tables 15a and 15b, staff calculated a withholding from the RY 2022 Update Factor on a sliding scale basis. The withholding is calculated by multiplying the

inflationary factor of 2.15 percent [16] by the statewide share of hospital's revenue attributable to Medicare fee for service and commercial (73 percent) and then prorated by a hospital's point distance from the 3rd quartile. Under the peer group approach this would remove $16.6 million in inflation funding; the withhold increases slightly to $17.8 million under the alternative approach to adjusting for indigent care in lieu of peer groups.

Staff has included in the tables below a comparison between the new proposed scaling and the old scaling logic that removed the entire update factor for all hospitals in the worst quartile and worse than one standard deviation in the ICC..

**Table 16a: RY 2022 Update Factor Withhold for Inefficient Hospitals inclusive of existing Peer Groups – Total Potential Withhold of 1.57% (2.15% Update Factor X 73% of Revenue Attributable to Medicare and Commercial Payer Mix)**

| Worst Quartile Hospitals | Total Points (Efficiency Matrix) | Prior Scaling Policy (No Sliding Scale & One Standard Deviation Rule) | Prior Policy % Withhold | Prior Policy Withhold as % of RY 2019 Margin | New Scaling Policy (Scaling Entire Worst Quartile with Sliding Scale) | New Policy % Withhold | New Policy Withhold as % of RY 2019 Margin |
|---|---|---|---|---|---|---|---|
| **MedStar Franklin Square Hospital Center** | 59.0 | $0 | 0% | 0% | $497,732 | 0.09% | 1% |
| **Carroll Hospital Center** | 59.5 | $0 | 0% | 0% | $310,150 | 0.13% | 1% |
| **UMROI** | 60.0 | $2,006,985 | 1.57% | 57% | $222,998 | 0.17% | 6% |
| **Sinai Hospital** | 62.0 | $0 | 0% | 0% | $2,922,243 | 0.35% | 4% |
| **Western Maryland Regional Medical Center** | 63.0 | $0 | 0% | 0% | $1,476,407 | 0.44% | 4% |
| **Easton Hospital** | 64.0 | $3,578,271 | 1.57% | 8% | $1,192,757 | 0.52% | 3% |
| **Harford Memorial Hospital** | 64.5 | $0 | 0% | 0% | $615,294 | 0.57% | 8% |
| **Midtown Hospital** | 65.0 | $0 | 0% | 0% | $0 | 0.00% | 0% |
| **MedStar Good Samaritan Hospital** | 70.5 | $0 | 0% | 0% | $2,966,528 | 1.09% | 60% |
| **Northwest Hospital Center** | 73.5 | $4,303,359 | 1.57% | 11% | $3,705,670 | 1.36% | 9% |

[16] Current calculations for RY 2022 Update Factor indicate that general inflation for hospitals will be 2.14% and the Demographic Adjustment will be 0.01%.

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **Union Hospital of Cecil County** | 76.0 | $2,652,373 | 1.57% | 19% | $2,652,373 | 1.57% | 19% |
| **Total** | | **$12,540,988** | | | **$16,562,152** | | |

**Table 16b: RY 2022 Update Factor Withhold for Inefficient Hospitals with Alternative Approach to Peer Groups – Total Potential Withhold of 1.57% (2.15% Update Factor X 73% of Revenue Attributable to Medicare and Commercial Payer Mix)**

| Worst Quartile Hospitals | Total Points (Efficiency Matrix) | Prior Scaling Policy (No Sliding Scale & One Standard Deviation Rule) | Prior Policy % Withhold | Prior Policy Withhold as % of RY 2019 Margin | New Scaling Policy (Scaling Entire Worst Quartile with Sliding Scale) | New Policy % Withhold | New Policy Withhold as % of RY 2019 Margin |
|---|---|---|---|---|---|---|---|
| **University of Maryland Shore Medical Center at Easton** | 61.0 | $0 | 0% | 0% | $96,710 | 0.04% | 0% |
| **Johns Hopkins Bayview Medical Center** | 61.5 | $0 | 0% | 0% | $599,941 | 0.09% | 14% |
| **Carroll Hospital Center** | 61.5 | $3,721,798 | 1.57% | 17% | $201,178 | 0.09% | 1% |
| **Western Maryland Regional Medical Center** | 65.0 | $0 | 0% | 0% | $1,292,854 | 0.38% | 4% |
| **University of Maryland Shore Medical Center at Chestertown** | 65.0 | $0 | 0% | 0% | $195,309 | 0.38% | 16% |
| **Northwest Hospital Center** | 65.5 | $0 | 0% | 0% | $1,163,070 | 0.43% | 3% |
| **University of Maryland Medical Center Midtown Campus** | 67.0 | $0 | 0% | 0% | $0 | 0.00% | 0% |
| **Union Hospital of Cecil County** | 68.0 | $0 | 0% | 0% | $1,075,286 | 0.64% | 8% |
| **Sinai Hospital** | 79.0 | $13,150,094 | 1.57% | 16% | $13,150,094 | 1.57% | 16% |
| **Total** | | **$16,871,893** | | | **$17,774,443** | | |

## Global Budget Revenue Enhancements

As noted above, this recommendation also outlines the process by which hospitals will be evaluated when GBR enhancement requests are submitted to HSCRC staff. Specifically, for a hospital to receive a GBR enhancement, it must be in the best quartile of performance as evaluated in the Efficiency Matrix; it must be better than one standard deviation from average Volume Adjusted ICC performance (1.05 times the ICC standard); and it must submit a formal request to HSCRC staff that outlines either: a) how a previous methodology disadvantaged the hospital; or b) a spending proposal that aligns with the aims of the Total Cost of Care Model.

Because this recommendation still requires hospitals to submit a formal proposal to successfully receive a GBR enhancement, staff will not outline the exact amounts a hospital may receive under such a policy. However, in Tables 17a and 17b below, staff does identify the hospitals that currently would be eligible for a GBR enhancement:

**Table 17a: Hospitals Eligible for a GBR Enhancement in RY 2021 (with existing ICC peer groups)**

| Hospital Name | Volume Adjusted ICC Result | ICC Rank (50%) | 2018 Medicare TCOC Relative to Benchmark | 2018 Medicare TCOC Rank (25%) | 2018 Commercial TCOC Relative to Benchmark | 2017 Commercial TCOC Rank (25%) | Total Rank Points (Low Score is Better) |
|---|---|---|---|---|---|---|---|
| Suburban Hospital | -3.56% | 4 | -10.14% | 1 | -36.06% | 1 | 5 |
| Garrett County Memorial Hospital | 4.14% | 1 | 7.79% | 15 | 3.01% | 43 | 30 |
| Mercy Medical Center | 3.06% | 2 | 17.56% | 32 | -19.96% | 27 | 32 |
| MedStar Union Memorial Hospital | -4.16% | 5 | 13.87% | 21 | -13.68% | 36 | 34 |

**Table 17b: Hospitals Eligible for a GBR Enhancement in RY 2021 (with alternative proposal to adjusting for indigent care)**

| Hospital Name | Volume Adjusted ICC Result | ICC Rank (50%) | 2018 Medicare TCOC Relative to Benchmark | 2018 Medicare TCOC Rank (25%) | 2018 Commercial TCOC Relative to Benchmark | 2017 Commercial TCOC Rank (25%) | Total Rank Points (Low Score is Better) |
|---|---|---|---|---|---|---|---|
| **Howard County General Hospital** | -3.64% | 6 | -2.22% | 5 | -32.32% | 3 | 10 |
| **Holy Cross Hospitals** | -2.49% | 4 | 2.89% | 11 | -28.02% | 8 | 14 |
| **Fort Washington Medical Center** | 2.45% | 2 | -3.80% | 4 | -21.35% | 23 | 16 |
| **University of Maryland Shore Medical Center at Dorchester** | -2.92% | 5 | 11.60% | 18 | -23.21% | 17 | 23 |
| **Garrett County Memorial Hospital** | 6.76% | 1 | 7.79% | 15 | 3.01% | 43 | 30 |

## Stakeholder Comments and Staff Response

Following the first draft recommendation, staff received comment letters from five stakeholders and several verbal comments from Commissioners.

| | |
|---|---|
| **Maryland Hospital Association** | **Luminis Health** |
| **Johns Hopkins Health System** | **CareFirst** |
| **University of Maryland Medical System** | |

Following the second draft recommendation, staff received comment letters from twelve stakeholders.

| | |
|---|---|
| **Maryland Hospital Association** | **Luminis Health** |
| **Johns Hopkins Health System** | **Greater Baltimore Medical Center** |
| **University of Maryland Medical System** | **Ascension Saint Agnes Hospital** |
| **LifeBridge Health System** | **Mercy Medical Center** |
| **Medstar Health Inc.** | **Tidal Health Peninsula Regional** |
| **Western Maryland Medical Center** | **Meritus Health** |

The comments from stakeholders and Commissioners can be broadly categorized into 16 areas of concern.

| Topics | MHA | JHHS | UMMS | Luminis | LB | GBMC | WMHC | St. Agnes | Mercy | Tidal | MedStar | Meritus | CareFirst | Commissioners |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| ICC Technical Adjustment (DSH) | | | | | | | ✓ | | | | | | | |
| ICC Peer Groups | ✓ | ✓ | ✓ | ✓ | ✓ | | ✓ | ✓ | ✓ | ✓ | | ✓ | | |
| ICC Performance Improvement | ✓ | | | | | | | | | | | | ✓ | |
| Allowed Interns & Residents | ✓ | | | ✓ | | | | | | ✓ | | ✓ | | |
| Special Adjustments | | | ✓ | | | | | | | | ✓ | | | |
| Initial TCOC Benchmarking Concerns | ✓ | ✓ | ✓ | ✓ | | | ✓ | | | ✓ | ✓ | ✓ | | |
| Price in TCOC Benchmarking | | | ✓ | ✓ | | | | | | | | | | |
| TCOC Attainment & Improvement | | ✓ | ✓ | ✓ | | | | | | | | | | |
| TCOC Attribution | | | | | | ✓ | | | ✓ | | | | | |
| Implementation Timeline | | | | | ✓ | | | | | | ✓ | | ✓ | ✓ |
| Scaling Approach | ✓ | ✓ | ✓ | ✓ | | | | | | | | | ✓ | ✓ |
| Weighting of TCOC | | ✓ | | ✓ | | | ✓ | | ✓ | ✓ | ✓ | | | |
| Diminished All-Payer Focus | | ✓ | | ✓ | | | | | | | | | | ✓ |
| Revenue Neutrality | ✓ | ✓ | | | | | | | | | | | ✓ | ✓ |
| Rebasing Global Budget Volumes | ✓ | ✓ | ✓ | | | | | | | | | ✓ | | |
| Revenue for Reform | ✓ | | ✓ | | | | | | | | ✓ | ✓ | ✓ | ✓ |

Staff will address each category below:

| Topic | WMHC |
|---|---|
| **Modify Poor Share Variable in DSH Adjustment** | The current measure [of poor share] is based on the percent of hospital revenue from Medicaid for inpatient and outpatient services for Maryland residents where Medicaid is either the primary or secondary payer. We ask that this measure be expanded to include out-of-state residents as well, given that the population served is still poor with the same general health characteristics as their Maryland counterparts.<br><br>We would also ask the measure include patients with Medicare as a primary payer but charity as a secondary payer, reflecting the low-income status of these elderly patients who do not currently qualify for Medicaid. |

Staff agrees with the first suggested technical adjustment of adding Medicaid out-of-state to the poor share variable that is being proposed as a means to calculate the direct risk adjustment of serving a lower socioeconomic population (in lieu of peer groups). This represents a similar population to the one staff aims to address through the DSH adjustment, which should be agnostic to patient's home residence.

By taking this approach, the DSH coefficient is reduced to $63.14 per case as opposed to the previously calculated value of $69.14 per case. The $R^2$ (explanatory power of poor share variable in ICC performance) is 50.8% versus 52.08%, and it has a limited impact on results: Correlation (R) = .9980

Staff does not concur with request to include Medicare as primary payer and charity as secondary payer, because this population does not necessarily represent a lower socioeconomic population, as reduced cost care can be provided to patients up to 500% of FPL. Moreover, staff's poor share variable is meant to serve as a proxy for indigent care. It will not capture all populations that are more expensive, hence the regression based approach. Finally, staff would note that CMS has not extended its stratifications/risk adjustments to include Medicare individuals outside of the dual eligible population

| Topic | MHA | JHHS | UMMS | Luminis | Lifebridge | WMHC & Tidal | St. Agnes | Mercy | Meritus |
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| **ICC Peer Groups** | The analysis focused on the cost factors peer groups were originally intended to address, including indigence of the patient population, urbanicity, and hospital teaching status. Although many cost factors and their associated variables were tested, additional elements have been posited to influence ICC performance. The Commission should further evaluate the efficacy of the alternative and peer group approaches by testing factors including, but not limited to, geography, technology, and case mix index. | JHHS would ask that HSCRC staff continue to work with hospitals to better understand these factors and delay the implementation of the peer groups until such analysis can be found. | While the Commission staff have put forward a very thorough and thoughtful proposal, we view this proposal as one possible solution out of many, and we do not yet know if it is the best solution. We therefore propose that a decision to move to a statewide peer group be delayed to allow time to explore alternative peer group options and adjustments. | Luminis believes a prudent approach would be to make the necessary, straightforward changes to the peer groups now (such as moving urban hospitals into the urban group and moving hospitals with newly established teaching programs into the teaching program, and dedicating more time to determining its handling of new teaching programs and vetting the proposed socioeconomic adjustor. | Because of the amount of variability the elimination of peer groups creates, and importance that ensuring a direct disproportionate share adjustment appropriately reflects the associated costs with providing care, we believe it would be prudent for the HSCRC to continue to explore alternatives before adopting no statewide peer groups. | While we understand HSCRC's rationale for the potential elimination of peer groups, any shift away from this historic policy needs to adequately account for socioeconomic factors inherent in measuring the relative efficiency of hospitals. These issues are particularly prevalent in more rural areas of the state that do not have the infrastructure and resources of more urbanized areas. | Eliminating peer groups entirely requires full confidence that direct adjustments to capture such issues as socioeconomic disparity are fully and precisely captured. Saint Agnes commends the work done by HSCRC staff to reintroduce a DSH-like measure as a thoughtful start to the necessary process of appropriately quantifying the impact of socioeconomic disparities on hospital costs. | Mercy's concern is the new regression does not adequately account for the direct and indirect cost of providing services in Baltimore. | Meritus agrees with this analysis and supports the elimination of the traditional peer grouping logic from the efficiency policy. However, we echo the comments of the MHA that further evaluation of additional cost factors and their influence on ICC performance is needed. |

Staff agree with the concern expressed in many of the comment letters that a movement away from peer groups should evaluate cost elements that may influence ICC performance.

Staff would note though that the peer groups should chiefly adjust for their stated purpose: indigent care and teaching status. While peer groups accomplish these goals, staff's alternative approach is more effective.

Additional analysis of other cost factors have shown no material, statistically significant relationship between ICC Performance and factors for which hospitals should be held harmless.

Moreover, in nearly all cases the influence cost factors have on ICC performance was reduced by the introduction of the alternative approach of abandoning peer groups and directly risk adjusting for indigent care. For these reasons, staff recommends adopting the direct risk adjustment approach for indigent care.

Staff does not recommend waiting to make the transition until the "best solution" is developed, as it is not clear if one exists and all analyses indicate the alternative approach is methodologically superior to peer groups. Staff likewise disagree with idea of just transitioning hospitals from one peer group to another within the existing peer group framework, because a) it is not clearly evident what hospitals should transition, especially for the urban peer group, and b) these new peer group assignments will not effectively reduce risk adjust for indigent care with the same precision as a direct risk adjustment.

| Topic | MHA | JHHS | CareFirst |
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| **ICC Performance Improvement** | A guiding principle of the policy is HSCRC's statutory mandate to ensure hospital costs are reasonable and charges are reasonably related to costs. Under the Inter-hospital Cost Comparison (ICC) methodology, hospitals cannot make management decisions that will affect the policy outcome because revenues and adjustment factors are fixed. Under the "Revenue for Reform" proposal, hospitals could quantify, and possibly boost, resources they invest to transform care. The hospital field understands the statutory requirement. HSCRC might further opine on what hospitals can achieve to improve policy results. | JHHS believes that HSCRC staff should include clear policy goals and objectives for the efficiency policy. We believe for an efficiency policy to be effective, hospitals need to understand what actions a hospital can take in order to improve their positions in the rankings. | In the past, similar threshold policies [worst quartile and an outlier on price] created a "stuck hospital" phenomenon where there was little opportunity for hospitals to get to the next level. As part of an ongoing evaluation, Staff should consider whether this phenomenon is occurring under the new policy. |

Staff agrees with stakeholder's concern regarding performance improvement, as any good policy must create clear incentives, and staff likewise appreciates MHA's acknowledgement that the Commission must still adhere to its statutory mandate to ensure hospital costs are reasonable and charges are reasonably related to costs. Staff would note there are several ways hospitals in a

fixed revenue environment can improve in the ICC while not compromising TCOC performance, including:

- Reducing Potentially Avoidable Utilization, which receives direct credit in the ICC
- Providing medically necessary care, often more acute in nature
- Repatriating volume lost to non-Maryland facilities
- Demonstrating performance as a center of excellence, which allows the exporting of Maryland hospital services to non-Maryland residents
- Reducing cost per case, which admittedly is partially offset by the ICC profit strip
- Repurposing retained revenue to care transformation initiatives, which admittedly is not yet eligible for credit in the ICC, i.e. Revenue for Reform
- The redistributive nature of the policy will also improve hospital's performance

Staff will continue to assess the degree to which hospitals are "stuck" under this policy and will modify the policy in the future if it continues to ensnare hospitals in perpetual inflation reductions that cannot be avoided by performance improvement in the ICC or TCOC.

| Topic | MHA | Luminis | Tidal | Meritus |
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| **ICC Allowed Interns & Residents** | Adjustments to hospital revenue for medical education costs are based on the number of interns and residents as of 2011. Since then, hospitals began new residency programs. HSCRC should periodically assess adjustments for medical education based on program changes. | The current measure of relative hospital cost efficiency, the ICC, does not account for the costs associated with newly established graduate medical education programs. This is particularly impactful at Anne Arundel Medical Center, where our program, with 48 residents for FY 22 and growing to 76 residents by FY 24 is unaccounted for in the calculation. This program carries a significant cost, with direct medical education (DME) and indirect medical education (IME) costs estimated to be $225,000 per resident. While we recognize that HSCRC staff has stated that it is evaluating its handling of new programs, an ICC that does not account for the DME and IME costs related to this program is not a comprehensive picture of AAMC's relative cost-efficiency position. | The current policy also does not adequately reflect the reality of teaching programs within the state and is inconsistent with CMS reimbursement policies or these programs. The current policy limits the number of residents to the amount included in the FY 2011 Efficiency Methodology and does not reflect residents associated with new programs. This has the effect of reducing the ability of hospitals to increase residency placements and expand teaching programs. | Investments by hospitals in establishing new teaching programs are effective in addressing identified physician shortages, improving access to care, and ultimately improving the health of the people of Maryland. We ask Commission staff to consider providing ICC adjustments to account for the costs of residency programs established since 2011 that are linked to addressing issues with access to care and physician shortages. |

Staff agrees that the current cost associated with the residency program at AAMC is significant and that the current policy of not funding new residency programs in accordance with CMS' graduate medical education policy is inconsistent with CMS' reimbursement policies. However, staff would note that there is significant supply of physicians and funded residency slots relative to the rest of the nation. Moreover, retention of trained residents is low (~30%) and not all Maryland residency programs currently in existence receive IME and DME credit for each resident, e.g. 318 of UMMC's 843 residents are not recognized in the ICC.

Staff also notes that not all CMS reimbursement methodologies and their associated outcomes are desirable: a) Resident counts have been frozen since 1996 and only altered by various redistribution schemes - RY 2022 proposed IPPS rule does indicate 1,000 new slots will be added at 200 per year in RY 2023 b) "As an "entitlement" system… a community with no GME can build a very large multihospital GME system with a high cap fully funded by Medicare. The specialty mix of that system may have nothing to do with state/local needs for physicians. This is happening particularly in urban communities with new medical schools" – American Academy of Family Physicians

Finally, staff would note that it has completed a supply and demand analysis with its contractor Mathematica Policy Research and does plan to convene a workgroup in the Summer to develop an allowed residents policy that takes into account physician supply by region and specialty.

| Topic | Medstar |
|---|---|
| **Revenue for Reform Pilot** | Given the importance of care management to the success of the Maryland GBR model, we support the "Revenue for Reform" Concept that would allow hospitals to retain funding to reinvest in approved reform efforts. To ensure transparency and equity, we recommend developing this policy before approving revenue for reform special adjustments. |
| **Critical Access Hospital Adjustment** | If the HSCRC removes peer groups, we would recommend not making any new special designations or adjustments until a formal process and policy is developed and approved that would evaluate other categories of cost that may be unique in certain types of providers |

Staff agrees that all adjustments, specific to one hospital or broadly applied, should be evaluated in consultation with workgroups and then made available to all hospitals that meet the criteria for that adjustment.

Staff would note specific to the critical access hospital adjustment provided to Chestertown Hospital that the Maryland State Legislature authorized a report by the Maryland Health Care Commission and its contractor NORC that concluded that Chestertown is a unique rural healthcare delivery system in an otherwise urbanized state and that "rural hospitals require solutions that are tailored to community needs and built around sustainable services." Staff would further note that this critical access designation was discussed in 2 workgroup meetings and outlined in a public meeting for Commissioner consideration.

In terms of Revenue for Reform, Commissioners requested of staff during the November 2020 Commission meeting a pilot of the Revenue for Reform program, which staff extended to Chestertown, since the rural healthcare delivery reforms, including mobile integrated homes and the proposed Aging and Wellness Center, were outlined in the NORC Report.

| Topic | MHA | JHHS | UMMS | WMHC & Tidal | MedStar | Luminis | Meritus |
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| **Appropriate Vetting of TCOC Benchmarks** | Since March 2020, hospitals re-allocated resources and staff to respond to the COVID-19 pandemic. When the methodology was introduced in August 2020, key hospital stakeholders were unable to review and thoroughly vet the methodology. Acknowledging the burden on hospitals, Commissioners extended the vetting period until six months after the surge recedes. Unfortunately, hospitals were still responding to surge events as recently as the last half of April. | The benchmarking methodology needs further evaluation by the hospital industry and Commissioners, including the longer-term cost savings target proposed by staff. | We support MHA's proposal to vet the TCOC benchmarking methodology further. As stated in their letter, the ongoing COVID pandemic has continued to require a re-allocation of resources to support hospital operations and has resulted in few resources to evaluate changes in HSCRC methodologies. The on-going public health emergency has not allowed hospitals adequate time and resources to evaluate and understand such a complex analysis and feel that more time to vet the methodology is warranted | | The Medicare and Commercial Total Cost of Care Benchmarking is a significant new measure that will most likely require adjustment over time as HSCRC and the hospitals continue to review and understand the results. Historically, when new measures of significance were introduced, the Commission often implemented a phased-in approach. We recommend increasing the weighting of this measure in stages over the next several years (i.e. 25% in FY22, 50% in FY23) given both the newness of the measure and to ensure that it aligns with the model and other policies. | The open and transparent workgroup process has eroded over time as much of the detail for developing and applying methodologies is not publicly documented and requires persistent discussion with the staff to obtain the details of relevant calculations when a hospital wishes to replicate the work | Meritus agrees with the Maryland Hospital Association's ("MHA") position that further vetting of the Commercial and Medicare benchmarking methodology is needed prior to the FY2023 policy recommendation. |
| **Winners and Losers in TCOC Benchmarks** | | | Hospitals located in wealthier jurisdictions tend to have better TCOC results while hospitals serving poor rural or urban jurisdictions perform poorly<br>Border hospitals tend to perform better in the Medicare benchmarking due to the number of patients who seek care outside Maryland at lower payment rates | The staff presentation of the integrated efficiency policy notes the desire to redistribute resources within the system from poor performers to excellent performers. But the results of the policy appear to penalize small rural providers and reward hospitals in relatively affluent suburban areas. | | This policy has clear winners (Montgomery, Howard, Anne Arundel County) and losers (Baltimore City/County, Eastern Shore, other rural areas). Hospitals that are primarily compared to counties and MSAs on the East or West coast do relatively well, while hospitals compared to those in the rest of the country fare far worse. | |

Staff recognized that the release of the final benchmarks was delayed as part of the slowdown due to the COVID crisis. However, the fundamental process has been discussed for almost 2 years and peer groups and preliminary results were released in late 2019. Moreover, peer groups have not changed, and results were similar to those in the final version, which was released August 31, 2020 and included extensive supporting data and documentation.

Staff would also note that due to the delay in Integrated Efficiency policy, per Commissioners' directive, revenue adjustments based on this methodology will be made in July of 2021, giving hospitals sufficient time to understand the payment implications of the benchmarking.

Staff agrees that unintentionally punishing poorer areas is not a desirable outcome. However, the benchmarking methodology includes extensive risk / demographic adjustments. Claiming that the risk / demographic adjustment is insufficient because it results in an unfavorable comparison for some urban or rural hospitals is begging the question. Moreover, this concern is a broad criticism that does not recognize that urban hospitals and small rural hospitals are not monolithic entities with the same performance in the benchmarking analysis, e.g. St. Agnes, Calvert and Easton fare quite well.

| Topic | University of Maryland Medical System | Luminis |
|---|---|---|
| **Price Inclusion in TCOC Benchmarks** | The inclusion of price in the benchmark analysis skews results and tends to place urban and suburban areas at a disadvantage. Utilization performance should be considered as an alternative to measuring performance to eliminate some of the price disparity caused by our all-payer model | The benchmark comparison should be limited to utilization variances since price is addressed through the ICC calculation. Measuring only utilization would eliminate priced differences due to the Maryland All Payer model. Limiting price considerations in the benchmarks may also eliminate some of the inequities resulting from the construction of the national peer groups. |

Staff do not agree with the Luminis comment that price is addressed through the ICC calculation. While it is true that the ICC measures cost per hospital case and is therefore a good proxy for hospital prices, it does not address pricing variation for total cost of care.

Measuring price in the context of TCOC differentiates between good price inefficiency that lowers TCOC by reinvesting retained revenue in efforts to reduce TCOC and bad price inefficiency, which results from a failure to capture and reinvest costs released by lower volumes. The ICC methodology by itself does not differentiate between the two and risks rewarding the latter behavior.

Assessing just utilization as an efficiency outcome is fraught with issues as well because there is not currently an optimal level of utilization, especially for areas with lower socioeconomic populations.

| Topic | University of Maryland Medical System | Johns Hopkins Health System | Luminis |
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| **TCOC Attainment and Improvement** | TCOC measure should include both attainment and improvement, similar to the approach taken with the quality policies | Only measuring growth or only measuring attainment could disadvantage hospitals with very low TCOC relative to peers or hospitals that have shown reductions to TCOC but have not yet reached a benchmark. | Any benchmarking methodology needs to provide for both an attainment and improvement measure. This is consistent with the approach of other HSCRC programs such as the Readmissions Reduction Incentive Program |

Staff remains concerned about the reliability of TCOC improvement statistics to determine relative efficiency for the following reasons:

- Improvement analysis is inappropriate in a relative efficiency analysis that redistributes revenue among hospitals
- Hospitals with smaller attributed TCOC dollars have very unstable growth statistics
- It adds additional complexity that may not differentiate hospitals rank order substantively
- Inclusion of TCOC growth would likely require additional, perhaps arbitrary weighting in the Efficiency Matrix

Staff would also note that penalties are scaled so a poor attainment hospital receives a penalty that is likely minimal versus their attainment shortfall, and as long as the hospital improves, they will have plenty of time to "escape" the penalty before the impact becomes material.

| Topic | GBMC | Mercy |
|---|---|---|
| **TCOC Attribution** | GBMC is concerned that the broad nature of the county-based TCOC benchmarking metric, combined with GBMC's relatively low market share in a highly saturated market, means that the metric [TCOC based on PSAP] is neither reflective of GBMC's actual TCOC performance nor within GBMC's control to impact the result. | Mercy strives to reduce overall TCOC, specifically focused on patients seeking services at Mercy. Without a direct link between patients and the TCOC measurement, it is unclear how hospitals in urban settings are able to directly impact TCOC performance. |

Staff acknowledge that it will be harder for hospitals in a "highly saturated market" to directly impact TCOC performance in isolation, but staff would note that there is strong correlation between TCOC performance as measured by a geographic attribution and the attribution outlined in the Medicare Performance Adjustment (MPA). Moreover, the MPA attribution is complicated and cannot be adopted for the commercial TCOC evaluation (25 percent of Integrated Efficiency Policy)

Staff would also note that the HSCRC has funded regional partnership grants to incentivize hospitals and other healthcare providers to collaborate on improving population health and TCOC outcomes across broader geographies and that 50 percent of the Integrated Efficiency Policy is ICC performance, which is hospital specific and allows hospitals in saturated markets to differentiate themselves by competing for medically necessary volume. For these reasons, staff does not support the use of an alternative attribution methodology

| Topic | WHMC & Tidal |
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| **Labor Market Adjustment** | Medicare payments are generally adjusted for the wage index to reflect differences in wages across areas.<br><br>Without adjusting for the wage index, Maryland hospitals with patients in counties compared to low wage markets face a standard where Medicare prices may be as much as 35% below the national average while high wage markets may be 91% more. |
| **Normalization Adjustments** | The [demographic] normalization involves an adjustment from a regression model based on two measures: a measure of deep poverty level and the county's median income. The regression model explains only 13% of the variation in TCOC per Medicare fee-for-service beneficiary in the 650 counties used in the benchmark process (based on the model's adjusted R-Squared), but is nonetheless used for the normalization.<br><br>The second adjustment, however, for median income also increase the comparison benchmark that results in a more favorable comparison for the hospital. Hence, the staff's proposed policy is to provide a more generous assessment of a hospital's relative efficiency because it's patients are in high-income areas. The result is a real redistribution of resources away from hospitals serving poor patients to those in affluent communities. |

Staff note that Regional Price Parity, a measure of prices was used in selecting benchmark areas, and the Medicare Wage Indexes have been criticized by Maryland hospitals due to their dependence on reporting, which Maryland hospitals are not focused on.

Staff also disagree with notion that an adjustment for deep poverty and median income necessarily redistributes resources away from hospitals serving poor communities, as an adjustment for deep poverty purposefully attempts to account for the higher than anticipated costs in a lower socioeconomic area. Staff would also note that the likely reason the $R^2$ for deep poverty is low (but still statistically significant) is because staff first selected peer geographies and then ran a regression to normalize for residual cost variation. If no peer selection was performed, the $R^2$ would theoretically be much higher.

The adjustment for Median Income, at least to some degree, does what a wage index adjustment would do in favoring areas with higher wages and therefore incomes. Also, there is extensive evidence that higher income areas do experience higher utilization and prices, particularly in the commercial population, and therefore higher benchmarks would be expected.

Finally, a thorough review of the TCOC results does demonstrate that various low income parts of the State (e.g. Easton) are not adversely affected by the benchmarking methodology, but staff will continue to refine the methodology with stakeholders to ensure that it yields fair and reasonable results.

| Topic | LifeBridge | MedStar | CareFirst |
|---|---|---|---|
| **Implementation Timeline** | The volume data used to calculate the ICC comparison is from fiscal year 2019. Understanding the inability to utilize data from fiscal year 2020 given the COVID pandemic, we believe facilities may be experiencing different levels of current volume activity when compared to fiscal year 2019 data, and that the changes in volume may be permanent moving forward as activities return to normal. Waiting for more current data will ultimately produce a more accurate result for any ICC methodology adopted. In the interim, the HSCRC maintains the ability to implement relative efficiency controls through control of volume-based corridors and associated restrictions to revenue | We recognize these recommendations include several material changes in historical methodology, such as removing peer groups, reducing IME credit for non- AMC's, and introducing a Medicare/Commercial TCOC benchmark. These methodological changes have created a significant change in hospital performance against the efficiency metric and may impact performance under other methodologies as well. As HSCRC and the hospitals continue to review and offer improvements to methodology, consideration should be given to phasing-in methodology changes to allow for monitoring and adjustment. | CareFirst noted that an efficiency methodology be implemented as soon as possible to ensure that individual hospital costs do not become unreasonable relative to their competitors. |

Staff acknowledges that the proposed Integrated Efficiency policy for RY 2022 does incorporate several new modifications to the underlying methodologies and appreciates all the work industry has done to improve the policy while also heroically responding to the public health emergency. However, staff would note that with the exception of TCOC benchmarks, an alternative to ICC peer groups, special adjustments for Chestertown Hospital, and the alternative scaling approach, which was unanimously supported by stakeholders, these modifications, e.g. an updated indirect medical education risk adjustment, have been reviewed for more than one year and reflected in prior iterations of this policy. Also, all modifications brought forward in the last year have gone through extensive workgroup processes.

Staff would also note that while LifeBridge's comment that relative efficiency has been maintained through control of volume-based corridors is correct, these corridors have, in recent years, been more limited in incentivizing reductions in avoidable utilization because corridors are topping off. Furthermore, without implementing an efficiency policy that withholds inflation, thereby driving less variation in efficiency outcomes, staff would not support rebasing volumes in RY 2022 rate orders to CY 2019 volumes, as requested by numerous stakeholder comment letters.

Finally, staff would point out that while COVID will undoubtedly affect volumes for years to come and may yield a "new normal" that is different by hospital, there has not been an efficiency policy that scales inflation in the GBR era and there has been rather strong correlation in year over year ICC results (RY19-RY20 - R=.9072), suggesting that relative efficiency has been fairly stable as the Commission has not yet addressed divergences in efficiency in our Model(s).

| Topic | MHA | JHHS | UMMS | Luminis | CareFirst | Commissioners |
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| **Scaling Approach** | Removing the one standard deviation ICC threshold reduces the cliff effect observed in the previous approach. However, arraying hospitals into quartiles based on performance will always present some type of cliff effect for hospitals that are closely ranked. Hospitals that repeatedly fall within the worst quartile will have a portion of their inflation permanently removed each year, potentially leading to unintended adverse consequences. The Commission should periodically evaluate this impact, in addition to the sliding scale of withheld inflation. | The modified approach is consistent with other HSCRC measurement policies and helps minimize any "cliff" effects that a policy could cause. Additionally, it provides appropriate incentives by emphasizes TCOC performance and cost per case efficiency in determining a hospitals position and subsequent penalty | The previous proposal was an 'all or nothing' approach whereby hospitals were either penalized by the maximum amount or not at all, which created a cliff effect. The new approach aligns more consistently with the scaling approaches adopted within many other policies, such as the quality programs and MPA. We feel the revised scaling approach put forward by the staff provides the appropriate incentives and equally emphasizes both TCOC performance and cost per case efficiency in determining a hospital's penalty (or reward). | A continuous scaling logic (rather than just addressing outliers) may better address the apparent inequity between rural/urban hospitals, may reduce the extent to which this policy penalizes smaller hospitals that operate on thin margins, and more appropriately penalize hospitals with retained revenue that do not look inefficient largely due to geographic location, while also more aggressively addressing the variation in the system. | The approach of quartiles and one standard deviation on the ICC is called into question given the small size of the revenue withheld from hospitals in this policy. While the ICC distribution does represent a normal distribution, that does not imply that costs below the mean plus one standard deviation are reasonable. Therefore, CareFirst recommends that these thresholds continue to be evaluated over time to ensure that they are truly capturing the outlier hospitals. | Commissioners likewise share CareFirst's concerns that the policy does not remove more revenue and believe hospitals are inappropriately incentivized by the policy to maintain cost per case variation up to one standard deviation from average performance. Moreover, Commissioners expressed concerns about the cliff effect of using a one standard deviation rule and withholding the same revenue percentage among all outlier hospitals despite gradations in performance in the worst quartile. |

Given Commissioners' concerns over the cliff effect and the lack of recognition of performance variation in the worst quartile, staff has put forward in the revised recommendation a continuous scaling approach that will withhold revenue for all hospitals in the worst quartile. This was unanimously supported by stakeholder comment letters. Staff will continue to review the appropriateness of this scaling logic in concert with all other methodological reviews required of this policy

| Topic | WMHC & Tidal | Mercy | MedStar | JHHS | Luminis |
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| **50/50 Weighting of ICC & TCOC** | Hospitals on average in Maryland contribute about half of the TCOC for Medicare beneficiaries. The remainder is out of the direct control of the hospital. While the model provides incentives to coordinate across the healthcare spectrum of services other providers are still largely paid on a fee-for-service basis… Hence, the use of 50% of the TCOC benchmarks for determining relative efficiency seems excessive. Hospital revenue is being placed at risk beyond the ability for the hospital to control the performance in the market | At 50%, the policy significantly over weights the share of TCOC relative to individual efficiency, far beyond national programs and commercial payers. | The Medicare and Commercial Total Cost of Care Benchmarking is a significant new measure that will most likely require adjustment over time as HSCRC and the hospitals continue to review and understand the results. Historically, when new measures of significance were introduced, the Commission often implemented a phased-in approach. We recommend increasing the weighting of this measure in stages over the next several years (i.e. 25% in FY22, 50% in FY23) given both the newness of the measure and to ensure that it aligns with the model and other policies. | | |
| **50/50 Weighting of Med/CO TCOC** | | | | Not considering the significant payor mix differences in Maryland's hospitals could have an unintended consequence of disadvantaging a hospital based on payor mix | Concerned that the policy assumes a 50/50 attainment measurement mix between Medicare and Commercial payers, not taking into account the significant payer mix differences in Maryland's hospitals. |

Staff acknowledges various hospital's concern that weighting TCOC as 50% of the Integrated Efficiency policy is significant since hospitals are accountable for TCOC but not directly responsible for it. Staff would note though that emphasizing cost per case efficiency in a TCOC Model could lead to perverse outcomes that undermine the central incentive of the Model to improve the health of the population and reduce potentially avoidable utilization. Staff would

also note that hospitals have far greater influence on Medicare TCOC when associated professional claims are considered (~70 percent vs the frequently cited 55 percent)

Additionally, readjusting the weighting as outlined by Medstar in a phased in approach, i.e. 25 percent TCOC in RY 2022, would have limited effect on the Integrated Efficiency results: Correlation (R) between Efficiency Matrix with 50/50 weighting & 75 percent ICC / 25 percent TCOC = .918; and all but one hospital (WMHC) would remain in the penalty zone.

Finally, staff would be concerned moving beyond 75 percent ICC weighting given the incentives of the TCOC Model. Therefore, staff recommends maintaining the 50/50 weighting of the ICC and TCOC.

In terms of the weighting of Medicare and Commercial TCOC performance at 50 percent each for the 50 percent TCOC component of the policy (i.e. 25 percent for each TCOC assessment), staff notes that this was purposeful. Given the all-payer nature of Maryland hospital rate setting that advantages commercial payers relative to national peers, and disadvantages Medicare, AND the fact that price is not removed from the benchmarks, the 50/50 weighting for all hospitals ensures that no hospital has an advantage due to its unique payor mix in an all-payer state. Specifically, hospitals with larger commercial shares in richer areas are not artificially advantaged.

The potential downside to this approach is if a hospital has a low, unrepresentative share of an individual payer that then comprises 25 percent of the efficiency assessment. However, analysis of CY 2019 Hospital Payer Mix indicates that no hospitals fall below 2 standard deviations in Medicare or Commercial payer shares relative to the statewide average, and a very low coefficient of variation for Medicare (.28) and Commercial (.16) payer mix corroborate the idea that there is limited variation. Thus, staff does not support moving away from the equal weighting of Medicare and commercial TCOC.

| Topic | Johns Hopkins Health System | Luminis | Commissioners |
|---|---|---|---|
| **Diminished All Payer Focus** | The goal of driving Medicare to national benchmarks while preserving Commercial rates that are nearly 25% below the nation is counter to the All Payer Model and reduces the value of the Waiver. Methodologies that would eliminate the difference would preserve the problems of the national Medicare fee-for-service system while constraining hospitals from charging rates to commercial payers in line with the nation. | The benchmarks focus on Medicare and not All Payer targets:<br>The goal of driving Medicare to national benchmarks while preserving Commercial rates that are nearly 25% below the nation is counter to the All Payer Model and eliminates the value of the Waiver. Methodologies that would eliminate the difference would preserve the problems of the Medicare fee-for-service system (inpatient rates barely above breakeven and outpatient rates that do not cover costs) while constraining hospitals from charging rates to commercial payers in line with the nation. | Some Commissioners have noted generally that the all-payer aspect of the Model, which has been a hallmark of the hospital payment system in Maryland for over forty years, must be underscored in all policies. |

Staff agrees that the Model and all its supporting methodologies/policies should reflect an all-payer perspective. Staff would note though that comparing hospitals to a TCOC benchmark average and then relatively ranking hospitals based on percentage variation from that benchmark in order to scale inflation does not eliminate the higher governmental reimbursement for hospitals in Maryland.

Future policies that use TCOC benchmark performance as a defined attainment standard will need additional scrutiny to ensure the all-payer tenets of the Model are not compromised. It should also be noted that currently it is not possible to create an all-payer total cost of care assessment due to the dearth of national Medicaid cost data.

| Topic | Maryland Hospital Association | Johns Hopkins Health System | CareFirst | Commissioners |
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| **Revenue Neutrality** | We agree that if revenues are reduced for high-cost hospitals (as HSCRC defines such), the full sum of this reduction should be available to be redistributed within the system. None should be withheld. | JHHS believes that the efficiency policy should be revenue neutral on a statewide basis. If high cost hospital's revenues are reduced, the full sum of this reduction should be available within the system and no portion should be withheld. | Dollars derived from withholding the update factor from poor performing outlier hospitals should be passed along as savings to purchasers of hospital care who have been paying more for those inefficient services. | Various Commissioners have noted that staff should consider using the efficiency assessments and the associated policy to accrue system savings. |

Staff still holds that the policy is not the means by which system savings should be generated. Its purpose is to correct maldistribution of global budget revenue in the Model, i.e. to redistribute all revenue removed from inefficient hospitals to efficient hospitals.

Savings have been realized and should continue to be generated through the combination of the GBR incentives and the Annual Update Factor Policy, which on a statewide basis holds hospitals accountable for Medicare total cost of care and hospital affordability, while not upending the central incentive of the Model to reduce avoidable utilization.

Staff remain concerned about purchasers paying more for inefficient services but would note that the current cost sharing concern for purchasers is restricted to Medicare Outpatient coinsurance, as that is the only purchaser with cost sharing arrangements that incurs higher required payments relative to national peers.

Future policy development should focus on alleviating cost sharing concerns by revising reimbursement methodologies that do not upend the central incentive of the Model to reduce avoidable utilization. Staff, therefore, strongly recommend maintaining revenue neutrality in this policy. If Commissioners do not concur with staff's recommendation, staff would ask Commissioners to consider savings generated by this policy in the various total cost of care and affordability tests employed in the Annual Update Factor Policy.

| Topic | MHA | JHHS | UMMS | Meritus |
|---|---|---|---|---|
| **Rebasing Global Budget Volumes** | MHA asks the HSCRC to set annual unit rates using volumes from the most recent 12-month period preceding the rate order, citing the complexity of measuring monthly rate compliance and adjusting unit rates, as well as the reduced need for maintaining 2013 volumes once the efficiency policy is implemented. | JHHS believes that if the staff recommendation is approved that staff should set annual unit rates using volumes from the most recent 12-month period preceding the rate order. We appreciate the need to hold hospitals accountable to GBR targets, and the efficiency policy will reduce overall GBR revenues for outlier hospitals | UMMS fully supports the Commission's proposal to rebase rate order volumes using FY19 data. GBR rate orders were first established in 2014 volume levels and those volumes have since only been adjusted for targeted policies and only by modest amounts. Continuing to utilize outdated volume levels creates an added level of administrative burden on both the hospitals and Commission staff in order to continually request corridor adjustments. Rate order volume was fixed in the beginning of the new model to ensure significant shifts in volume and pricing could be evaluated, as the Commission did not have another mechanism at the time to monitor such changes. Now that the Commission has an integrated efficiency model, we feel that it is no longer necessary to hold volume constant on hospital rate orders. | Meritus agrees with MHA's position, which is also supported by Commission staff, to re-base hospital volumes to the 2019 period to accurately reflect hospital price per unit in the ICC. |

Staff are supportive of rebasing global budget volumes should an efficiency policy be implemented. Stakeholders are right about administrative concerns regarding corridor compliance and rebasing volumes will increase the incentive to reduce avoidable utilization, especially for hospitals that are or are approaching corridor limits. Thus, staff are advancing the following recommendation in the RY 2022 Integrated Efficiency Policy recommendation

**If inflation is withheld in RY 2022 Update Factor based on relative efficiency policy, update volumes for RY 2022 rate orders to reflect CY 2019 volumes with 5 percent corridors. This limit may be extended to 10 percent at the discretion of the HSCRC staff if the Hospital presents satisfactory evidence that it would not otherwise be able to achieve its approved total revenue for the Rate Year.**

Staff, however, does not support rebasing each year based on the most recent 12 month period, as requested by MHA and JHHS for the following reasons:

- The permanent effects of COVID have not yet been settled and the Commission should consider accruing savings to payers if utilization remains far below historical norms, which an annual rebasing policy will not allow.
- The Integrated Efficiency policy only makes negative adjustments to hospitals in the fourth quartile, i.e. it is not a broad based scaling policy, and so rebasing all hospitals' volumes each year seems inconsistent with the proposed reach of the efficiency policy
- Corridors are the Commission's best analytic to determine deregulation of services, which the Commission must defund in the GBR in order to avoid "double billing," and rebasing each year will make it difficult for staff to use this analytical tool

Delay provides benefits to policy development including: revised scaling approach; future removal of unreliable RY 2020 volume; and additional work on peer group and allowed medical residents in ICC methodology.

| Topic | MHA | UMMS | CareFirst | Meritus | Commissioners |
|---|---|---|---|---|---|
| **Revenue for Reform** | HSCRC introduced the Revenue for Reform concept, proposing a safe harbor for care transformation investments and other spending expected to lower avoidable service use. Valuing the proposed interventions to compare among hospitals will require well-vetted criteria. It is imperative that HSCRC staff work with stakeholders | UMMS is committed to continued investments in community-based services through the utilization of safe harbored GBR revenue. The safe harbor revenue provides a pathway for Shore Health to improve cost efficiency, generate retained revenue, and redeploy that revenue to meet community needs without negatively impacting its position on the | The rapid growth in unregulated costs and losses over the course of the past five years is unsustainable and continues to be funded by increased regulated profits. Increased reporting requirements and transparency are critical so that HSCRC Staff can ascertain which unregulated operations are contributing to | Approval of [Revenue for Reform] interventions should not be limited to only inefficient hospitals. Meritus also stresses the need for well-vetted and uniform criteria that will be used in the HSCRC evaluation of proposed intervention. We also would like to express reservations in the HSCRC making value judgements on which hospital population health interventions will qualify for approval or not under the Revenue for Reform proposal. The patient population of a rural sole | Various Commissioners have expressed concerns that the largest source of unregulated losses, physician subsidies, are necessary to operate a hospital, and the current regulatory authority of the HSCRC has prevented the Commission from appropriately accounting for a key component of hospital operations. Other Commissioners have also expressed a desire to quantify what regulated margins are subsidizing, especially with regards to potential |

| | | | | | |
|---|---|---|---|---|---|
| | to implement a sound methodology. Allowing ample time for stakeholder recommendations will culminate in a formal recommendation to the Commission that will stand up in practice. | Integrated Efficiency Metric. | the goals of the model. Hospitals cannot be given credit for the work they are doing in their unregulated operations until the full picture is understood, especially since they are now a major cost driver in the system. | community provider may require drastically different interventions than the patient population of an urban regional hospital in order to maximize improvements in health. Meritus asks Commission staff to be cognizant of this in developing their criteria for approval to insure equity in the policy. | safe harbors in the Revenue for Reform concept. Finally, several Commissioners have urged staff to establish evaluations of appropriate levels of overhead. |

Staff remain committed to establishing a reporting and auditing function for quantifying costs intrinsic to a hospital's operations and in line with the TCOC Model (both regulated and unregulated). The degree to which these costs are deemed appropriate and therefore eligible for credit in an efficiency assessment will need to need to be determined with industry input and with directives from Commissioners.

Staff have convened two workgroups to help facilitate the onboarding of Revenue for Reform: one to assess the process of reporting community health initiatives; one to assess how best to include Revenue for Reform safe harbors into the ICC

Staff believes that while establishing methodologies for capturing appropriate levels of overhead is necessary and important, it cannot be done "…until the full picture is understood."

## Future Policy Considerations

While staff believes the efficiency methodologies and implementation proposal are sound, staff acknowledges that additional work could further refine the ICC and total cost of care analyses. Staff describes below various work streams to improve the efficiency methodologies.

1) Medium term - Staff will work to include national analyses that were completed for inpatient efficiency evaluations of the State's two major academic medical centers. Staff

plans to complement these analyses by incorporating them into an outpatient-only ICC that will effectively evaluate the State's two academics both on a national level for inpatient services and on a Maryland peer group level for outpatient services. Completion of this task is contingent upon submission from Johns Hopkins Hospital and University of Maryland Medical Center, per the agreement proposed in the Innovation Policy and prior Update Factor recommendations.

2) Medium term – Staff is also engaging an outside contractor to review the adequacy of current physician supply by specialty by region. This analysis will incorporate out year demand projections, inclusive of Maryland's role as a net exporter of medical professionals, and will be used to determine the allowed residents in the ICC analysis.

3) Long term - Staff will continue the work to quantify the investments hospitals are making in unregulated settings that are in line with the incentives of the Total Cost of Care Model, thereby providing a path for hospitals to acquire credit in the ICC evaluation when retained revenues are used to improve health outcomes.

In terms of total cost of care, staff will focus on maintaining the total cost of care analyses and updating them each year with new data. Additionally, staff will explore developing Medicaid benchmark analyses, but it should be noted that data nationally on Medicaid total cost of care is far less robust than Medicare and commercial data.

Short and medium term adjustments to the ICC may have effects on hospitals' current efficiency rankings and whether a hospital is eligible for revenue adjustments in the Integrated Efficiency policy, although it should be noted that prior modernization efforts, such as the overhaul of the casemix methodology, did not substantially alter results. Nevertheless, Commissioners should consider this when determining the implementation date for the Integrated Efficiency policy.

## Recommendations

1) Formally adopt policies to
    a. Determine hospitals that are relatively inefficient;
    b. Evaluate Global Budget Revenue enhancement requests using the criteria identified above;
2) Use the Inter-Hospital Cost Comparison, including its supporting methodologies to compare relative cost-per-case for the above evaluations;
    b. Abandon ICC peer groups and adopt a direct regression based risk adjustment for indigent care cost variation that will be applied to all efficiency policies
3) Use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance for the above evaluations;
4) Withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals based on criteria described herein
5) Use set aside outlined in the Annual Update Factor and funding secured from withholds from outlier hospitals to fund potential Global Budget Revenue enhancement requests.
6) If inflation is withheld in RY 2022 Update Factor based on relative efficiency policy, update volumes for RY 2022 rate orders to reflect CY 2019 volumes with 5 percent corridors. This limit may be extended to 10 percent at the discretion of the HSCRC staff if the Hospital presents satisfactory evidence that it would not otherwise be able to achieve its approved total revenue for the Rate Year.

# Appendix 1: Revised Casemix Methodology Discussion

Fundamental to a sound efficiency methodology is a reliable volume statistic that accounts for acuity and expected cost differences, as not all services require the same level of care and resources. The HSCRC historically has had a reliable inpatient casemix adjusted volume statistic that outputs relative weights to measure the relative cost or resources needed to treat a mix of patients at a given Maryland hospital using specific APR-DRG/severity of illness levels.[17]

The calculation of relative weights used by Maryland hospitals, which in many respects is just creating ratios based on average charges (adjusted for price differences among hospitals), has been the following since the adoption of the APR-DRG Grouper in 2004 for all hospitals:

1) Use the outlier trim methodology to adjust charges for outlier cases so that the maximum charge equals the trim limit.
2) Calculate an average charge per case in each APR-DRG/severity category.
3) Calculate a statewide average charge per case (CPC).
4) Divide the cell average by the statewide average to generate the cell weight.
5) Calculate hospital-specific relative weights as follows:
    a) For each hospital i, calculate the average charge per case-mix adjusted discharge: C(i).
    b) For the state as a whole, calculate the average charge per case-mix adjusted discharge: C.
    c) For each hospital, calculate a standardizing factor: S(i) = C(i) / C.
    d) For each hospital, adjust its charges to the state level by dividing by S(i).
    e) Recalculate the case-mix weights using the standardized charges.

[17] At a summary level, the case-mix index (CMI), which is the average value of the relative weights for the patients at a given hospital, identifies how resource needs vary across groups of patients and hospitals.

f) Go back to step 6a and repeat until the changes in weights are minimal or non-existent.

7) Calculate the average weight per APR-DRG/severity category.

8) Adjust the weights in low volume cells (cells with less than 30 cases) by blending the average weight per APR-DRG/severity category in step 7 with the 3M National Relative Weights.

9) Adjust the weights to be monotonically increasing by severity of illness.

10) Normalize the weights to a statewide CMI of 1.00.

Despite the general consensus that the inpatient casemix methodology is sufficient, the HSCRC historically has had a less reliable outpatient casemix methodology. The first reason for this is because of cycle billed claims where unique hospital billing practices created inconsistent data for determining relative weights across hospitals. Additionally, procedures that can occur in multiple outpatient settings and are different in service intensity[18] were not separated from one another in weight development, thereby creating weights not indicative of the intensity of resources that must be applied in an emergency room versus a clinic..

These concerns mattered less for the first few years of the All-Payer model because the principal use of outpatient weights in HSCRC methodologies was the Market Shift Adjustment, a methodology that evaluates growth. If the inconsistent measurement were present in both the base and performance period for the Market Shift, the issue was of less concern as long as the billing method did not change at a hospital. However, because efficiency methodologies evaluate a single period of time and inter-hospital comparisons, the concerns over inconsistent and unreliable outpatient weights became more pressing once the moratorium on rate reviews was lifted in November of 2017.

[18] In the past, HSCRC applied special weighting differences on the coded severity levels 1 through 5 of an emergency room visits. However, multiple studies have documented coding variations and upcoding in the emergency room. As a result, HSCRC is using the standard method included in the outpatient grouper, which takes into account diagnoses and other coded information to assign emergency room cases to an EAPG. The EAPG grouper assigns medical cases based on diagnosis. In the most recent casemix iteration, HSCRC has separated emergency room and clinic cases to provide higher weights to emergency room cases given the higher resources that must be provided to patients presenting in the emergency room.

The Commission prioritized the need to develop a sufficient outpatient methodology for purposes of evaluating hospital cost efficiency and evaluating ongoing volume changes. Staff worked with industry and additional stakeholders to create a new outpatient weighting approach that utilized a similar methodology to the inpatients weighting system but also did the following:

(1) All claims, including cycle-billed claims (i.e., accounts where patients are billed monthly) were parsed out into visits, which allows accurate and consistent visit weights to be applied to oncology services, clinics, outpatient psychiatry, and physical therapy;

(2) Emergency room and clinic visits were given different weights, with higher weights allotted to emergency room patients, replacing an approach that used the same weight regardless of hospital site of service;

(3) All coded claims lines (i.e., all claims lines with a CPT or HCPCS code) were used to ensure more accurate weight development, replacing an approach where only 45 claim lines were used in weight development and Enhanced Ambulatory Patient Grouping ("EAPG")[19] assignment – possible because of enhanced computing power;

(4) Outpatient services within 5 days of one another that had similar care profiles were repackaged into visit episodes to ensure that all charges associated with an episode of care (e.g., supply charges for surgery) were not weighted independently of one another.

(5) Oncology and infusion drugs were removed from the oncology services portion of the claim, allowing oncology services to be weighted independent of oncology drugs, thereby allowing oncology services to be evaluated through Market Shift and oncology and infusion drugs to continue be evaluated through the CDS-A process.[20]

During the process of assessing the construct validity of new casemix methodology, the HSCRC employed Mathematica Policy Research (MPR). MPR concluded that improvements to the

[19] EAPGs are a 3M product, which results from the assignment of encounters to clinically meaningful outpatient groupings, similar to inpatient DRG groupings.

[20] The CDS-A accounts for usage changes in high cost oncology and infusion drugs, and provides a hospital specific adjustment based on 50 percent of estimated growth. The remainder of drug cost growth is provided through a targeted inflation adjustment. For additional detail on the new casemix methodology, please see Appendix 2.

casemix methodology resulted in better recognition of clinical severity, as evidenced by improved monotonicity and goodness of fit.

Specifically, to evaluate monotonicity, which means services of increasing complexity are assigned weights of increasing magnitude, MPR employed a clinical expert to conduct a review of the 564 EAPGs. The EAPGs were categorized and combined into 25 different clinically compatible service areas such as general medicine, gastroenterology, general surgery, and oncology. Within each service area, the EAPGs were then ranked by level of clinical complexity on a scale of 1 to 5, where 1 is least complex and 5 is most complex. For example, in the category of general medicine, a level one ranking includes vaccine administration and a level 5 ranking includes the treatment of AIDS. The rankings in each service area were then reviewed by another clinical expert to reach consensus. Then using a fixed effects regression, MPR evaluated the weighting difference from level 5 to level 1. Table A below demonstrates that for each level the weight is significantly higher than the weight in the level below:[21]

**Table A. Regression results for association between procedure groups and severity levels of ECMADs on EAPG weight (all ECMADs)**

| EAPG Weight | Number of EAPGs | Coefficient | Std Err | t | Difference | T of difference |
|---|---|---|---|---|---|---|
| Level 5 (omitted) | 79 | - | - | - | - | - |
| Level 4 | 110 | -0.435* | 0.133 | 3.27 | -0.435* | 3.27 |
| Level 3 | 149 | -0.936* | 0.127 | 7.36 | -0.501* | 4.09 |
| Level 2 | 179 | -1.506* | 0.125 | 12.02 | -0.570* | 4.66 |
| Level 1 | 189 | -1.873* | 0.123 | 15.20 | -0.367* | 3.28 |

EAPG = enhanced ambulatory patient grouping; ECMAD = equivalent casemix adjusted discharge; Std Err = standard error; T = T-statistic

* Significantly different than 0, p<.05

Finally, to evaluate goodness of fit or the predictive accuracy of the outpatient weights, MPR evaluated Winsorized charges, i.e., removing charges below the 5th percentile and above the 95th

[21] MPR also estimated the proportion of EAPGs with weights within the range predicted by their severity level (1-5). The weight falls in the correct range when the ECMAD for a given EAPG is within the bounds of the predicted severity level. They found that 45.5 percent of EAPG high type combinations were within those bounds. They found that 70.7 percent were within the ECMAD range including EAPGs one level lower and one level higher.

percentile, and determined that the R2 was .726, suggesting that the new weighting system had a very high degree of explanatory power.

## Appendix 2. Outpatient Casemix Methodology Steps

### A. Group and Assign Outpatient Records a Principal EAPG Type & APG High Type

- ***Step 1: Group Data***
  - Outpatient data grouped using the EAPG grouper version 3.12 (change from the EAPG grouper version 3.8 previously used)
    - An EAPG is identified for every CPT that is coded in the record
    - Medical visits also use ICD-10 diagnosis codes for grouping
    - Each record can contain hundreds of EAPGs

- ***Step 2: Exclude Observation Cases***
  - If the Observation Rate Center units in any outpatient visit record are greater than 23 hours, the entire record is excluded from the outpatient weight assignment calculation.
  - Future consideration may be given to maintaining outpatient visits greater than 23 hours in the outpatient data set when developing weights for purposes of the ICC

- ***Step 3: Assign Principal Record Type***
  - A principal EAPG Type is assigned to all records
    - HSCRC applies a hierarchy based on EAPG Type
      - Each CPT code is linked to an EAPG, and each EAPG is linked to an EAPG Type
  - The records are categorized by APG High Type and assigned in hierarchy as follows:
    - Type 2: Oncology Related Services
    - Type 8: Oncology Drugs
    - Type 5: Rehab and Therapy
    - Type 6: Psychiatric Visits
    - Type 4: ED Visits
    - Type 1: Significant Procedures

- ☐ Type 3: Non-ED Visits
- ☐ Type 7: Other Visits

☐ ***Step 4: Consolidating cases into records - for APG High Type Oncology Related Services (ORS)***

- ☐ All aggregated outpatient records per APG High Type are unbundled and parsed out by service dates
  - ☐ Each identified EAPG within the APG High Type has its own service date
  - ☐ Visits with a length of stay (LOS) 5 days or less are assigned the same service date as their corresponding APG High Type
- ☐ Consolidate into one record all EAPGs associated with ORS occurring on the same service date
- ☐ Determine the EAPG with the highest weight within the record (Previously calculated weights are used as the preliminary weight for assigning the high weight)
- ☐ The high weight EAPG is the High Weight EAPG (HIWTAPG)
- ☐ Consolidate into the record any ancillary EAPGs occurring on the same service date as the EAPG with the highest weight within the ORS
- ☐ Any ancillary EAPGs not occurring within the same service date as the high weight EAPG within the ORS is appended back into the outpatient records

☐ ***Step 5: Calculate the total charge***

- ☐ The sum of all EAPG charges in the ORS record
- ☐ The HIWTAPG assumes all charges associated with that record i.e. the total charge

☐ **Step 6: Apply the Trim Logic to the APG High Type by HIWTAPG (Expected Charge)**

- ☐ Trim logic = (the statewide average expected charge by HIWTAPG * 2) or the (the statewide average expected charge by HIWTAPG + 10,000); whichever is greater
- ☐ The expected charge is usually the total charge except where a trim is applied, then the trim charge becomes the expected charge
- ☐ (Step 1-6 is repeated for each APG High Type)

## B. Merge all datasets and Calculate expected charges to outpatient categories

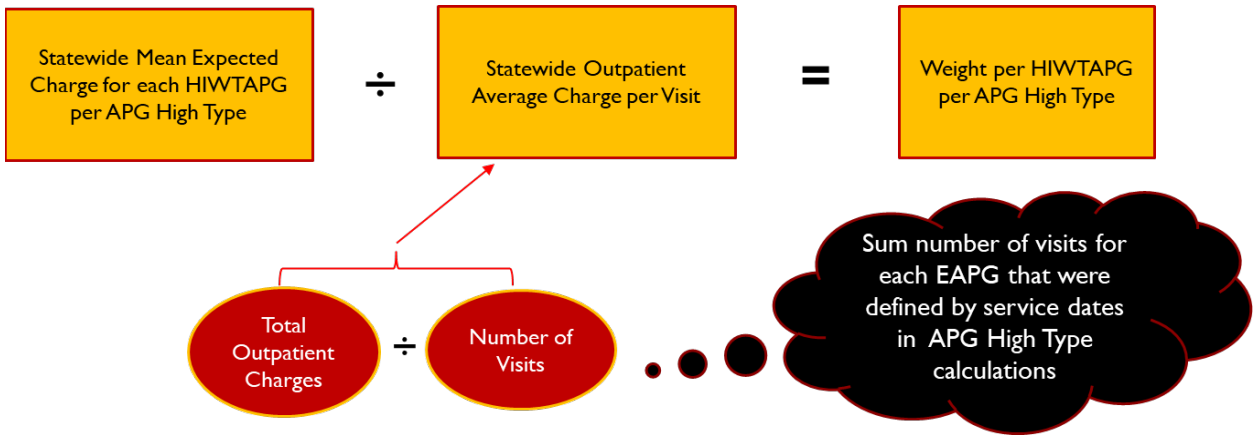
☐ ***Step 7: Merge all eight APG High Types and begin the iterative process of determining weights***

- ☐ **Step a: Calculate the statewide average charge per visit**

- The mean of all trimmed charges as determined by the trim logic

- ***Step b: Calculate the Mean Statewide Expected Charge by APG High Type and HIWTAPG***
  - The mean of expected charges across all hospitals by APG High Type and HIWTAPG

- ***Step 8: Calculate initial weights for each APG High Type and HIWTAPG***




- ***Step 9: Normalize the Hospital HIWTAPG Expected Charge about the Mean Expected Charge Per Hospital***
  - ***Calculate Hospital Specific Average charge and casemix index (CMI) and hospital specific charge adjustment factor***
    - ***Hospital Specific average charge divided by the hospital specific average CMI = Hospital specific expected charge***
    - ***Hospital specific expected charge divided by the statewide average charge (as determined in step 7a) = Hospital Specific adjustment factor***
    - ***Recalculate the total charge by dividing the initial trim charge by the hospital charge adjustment factor***
  - Perform 31 Iterations as shown above until convergence (hospital specific adjustment factor equals1.00)
  - The final iteration determines the statewide expected charge (as described in step 7b) used for the **final weight calculation** (repeat step 8)

- ***Step 10: Assign Principal Record Type by High Weighted EAPG***

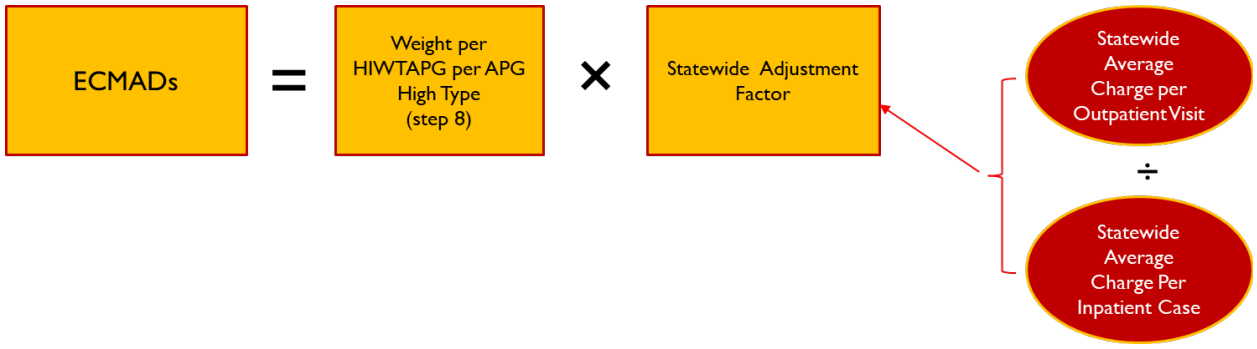
- ☐ This overrides step number 3 because in many instances lower acuity services or ancillaries will garner all of the charges associated with that record, most notably within the Significant Procedures High Type.

- ☐ Because weights are reassigned, they have to be checked again for monotonicity and normalized to 1.0.

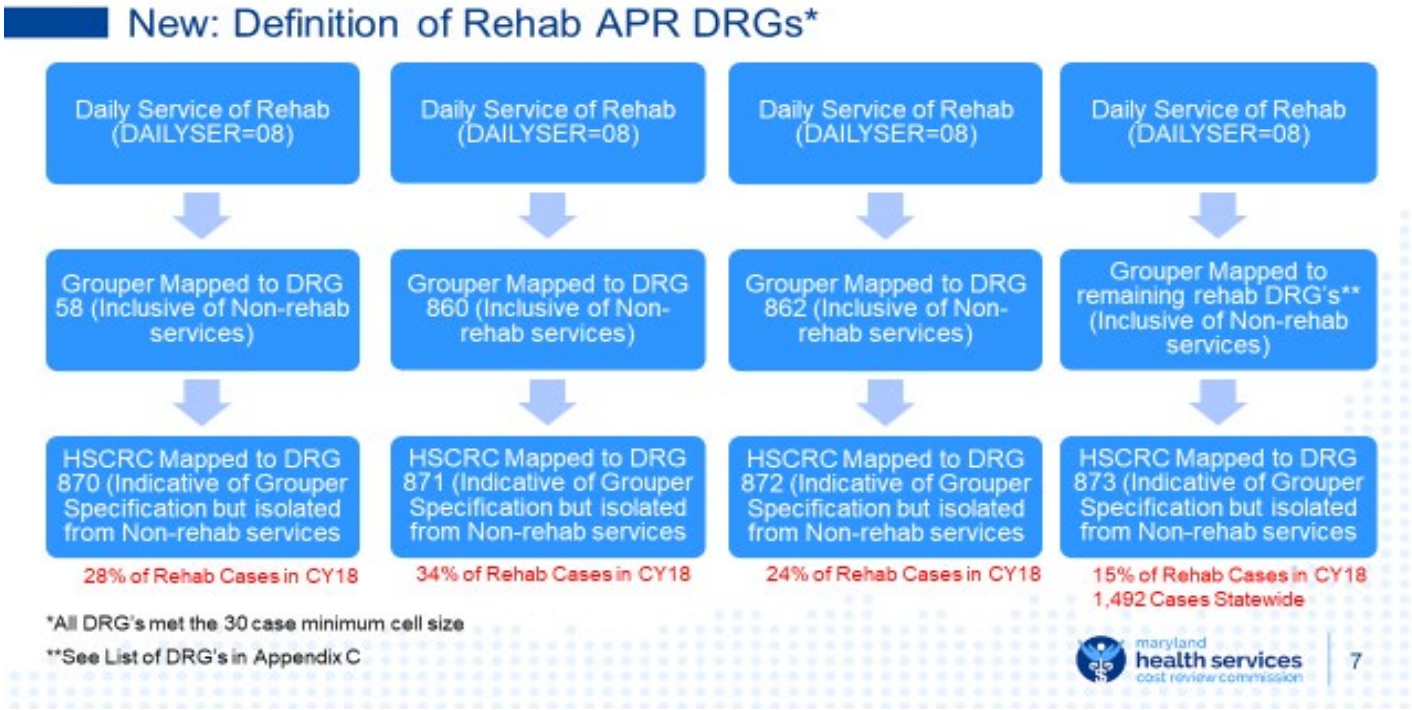
## C. Calculate ECMAD

☐ ***Step 11: Calculate the Statewide Adjustment Factor*** **= Outpatient Charge per visit divided by Average charge per Inpatient case**

- ☐ ECMAD is defined as the normalized weight from Step 16 multiplied by the Statewide Charge Ratio Adjustment Factor



# Appendix 3: Rehab Casemix Mapping and Reliability Results




| DRG | Severity Level | # of Cases | Average LOS | Average Charge | Coefficient of Variation |
|---|---|---|---|---|---|
| 58 - OTHER DISORDERS OF NERVOUS SYSTEM | 1 | 354 | 12 | $24,147 | 0.52 |
| 58 - OTHER DISORDERS OF NERVOUS SYSTEM | 2 | 1,331 | 14 | $28,866 | 0.57 |
| 58 - OTHER DISORDERS OF NERVOUS SYSTEM | 3 | 958 | 17 | $35,309 | 0.61 |
| 58 - OTHER DISORDERS OF NERVOUS SYSTEM | 4 | 93 | 18 | $40,232 | 0.74 |
| 860 - REHABILITATION | 1 | 214 | 8 | $18,310 | 0.51 |
| 860 - REHABILITATION | 2 | 1,403 | 9 | $20,070 | 0.54 |
| 860 - REHABILITATION | 3 | 1,376 | 13 | $28,295 | 0.71 |
| 860 - REHABILITATION | 4 | 340 | 19 | $41,478 | 0.84 |
| 862 - OTHER AFTERCARE & CONVALESCENCE | 1 | 404 | 11 | $21,732 | 0.46 |
| 862 - OTHER AFTERCARE & CONVALESCENCE | 2 | 1,197 | 12 | $26,037 | 0.59 |
| 862 - OTHER AFTERCARE & CONVALESCENCE | 3 | 657 | 13 | $30,003 | 0.71 |
| 862 - OTHER AFTERCARE & CONVALESCENCE | 4 | 77 | 15 | $35,958 | 0.64 |

maryland health services cost review commission

# Appendix 5a. Efficiency Matrix with Existing ICC Peer Groups

| Hospital Name | Volume Adjused ICC Result | ICC Rank (50%) | 2018 Medicare TCOC Relative to Benchmark | 2018 Medicare TCOC Rank (25%) | 2018 Commercial TCOC Relative to Benchmark | 2017 Commercial TCOC Rank (25%) | Total Rank Points (Low Score is Better) |
|---|---|---|---|---|---|---|---|
| Suburban Hospital | -3.56% | 4 | -10.14% | 1 | -36.06% | 1 | 5 |
| Howard County General Hospital | -5.87% | 9 | -2.22% | 5 | -32.32% | 3 | 13 |
| Anne Arundel Medical Center | -5.76% | 8 | -1.33% | 7 | -31.15% | 5 | 14 |
| Fort Washington Medical Center | -5.73% | 7 | -3.80% | 4 | -21.35% | 23 | 21 |
| Holy Cross Hospitals | -6.43% | 12 | 2.89% | 11 | -28.02% | 8 | 22 |
| Garrett County Memorial Hospital | 4.14% | 1 | 7.79% | 15 | 3.01% | 43 | 30 |
| University of Maryland Baltimore Washington Medical Center | -8.50% | 15 | 10.19% | 16 | -24.27% | 15 | 31 |
| Mercy Medical Center | 3.06% | 2 | 17.56% | 32 | -19.96% | 27 | 32 |
| MedStar Union Memorial Hospital | -4.16% | 5 | 13.87% | 21 | -13.68% | 36 | 34 |
| MedStar Harbor Hospital Center | -5.73% | 6 | 27.59% | 42 | -25.13% | 13 | 34 |
| Shady Grove Adventist Hospital | -18.30% | 29 | -2.05% | 6 | -31.64% | 4 | 34 |
| Johns Hopkins Hospital | -6.22% | 11 | 14.42% | 24 | -20.79% | 25 | 36 |
| Frederick Memorial Hospital | -11.97% | 21 | 10.22% | 17 | -25.04% | 14 | 37 |
| Greater Baltimore Medical Center | -7.32% | 13 | 14.37% | 23 | -20.28% | 26 | 38 |
| Doctors Community Hospital | -19.32% | 33 | -4.86% | 3 | -31.06% | 6 | 38 |
| University of Maryland Medical Center | -10.74% | 18 | 16.60% | 29 | -25.70% | 12 | 39 |
| Atlantic General Hospital | -0.95% | 3 | 29.41% | 43 | -17.29% | 31 | 40 |
| University of Maryland Charles Regional Medical Center | -13.62% | 22 | 6.02% | 14 | -21.83% | 22 | 40 |
| Johns Hopkins Bayview Medical Center | -6.12% | 10 | 17.46% | 31 | -17.82% | 30 | 41 |
| MedStar St. Mary's Hospital | -9.24% | 16 | 5.28% | 12 | -13.24% | 37 | 41 |
| St. Agnes Hospital | -15.38% | 24 | 14.13% | 22 | -23.55% | 16 | 43 |
| Peninsula Regional Medical Center | -7.66% | 14 | 21.47% | 38 | -21.99% | 21 | 44 |
| Prince Georges Hospital Center | -16.96% | 27 | 5.39% | 13 | -22.23% | 20 | 44 |
| Washington Adventist Hospital | -19.89% | 35 | 2.03% | 8 | -26.22% | 11 | 45 |
| MedStar Montgomery Medical Center | -22.51% | 39 | 2.69% | 9 | -32.46% | 2 | 45 |
| Meritus Medical Center | -9.35% | 17 | 14.45% | 25 | -16.75% | 32 | 46 |
| Upper Chesapeake Medical Center | -11.30% | 19 | 19.30% | 35 | -22.89% | 19 | 46 |
| University of Maryland Shore Medical Center at Dorchester | -18.43% | 30 | 11.60% | 18 | -23.21% | 17 | 48 |
| Calvert Memorial Hospital | -22.39% | 38 | 2.86% | 10 | -26.77% | 9 | 48 |
| MedStar Southern Maryland Hospital Center | -25.56% | 43 | -6.70% | 2 | -28.54% | 7 | 48 |
| University of Maryland St. Joseph Medical Center | -11.37% | 20 | 16.58% | 28 | -18.03% | 29 | 49 |
| University of Maryland Shore Medical Center at Chestertown | -18.01% | 28 | 13.29% | 20 | -12.02% | 40 | 58 |
| MedStar Franklin Square Hospital Center | -15.68% | 25 | 19.24% | 34 | -16.15% | 34 | 59 |
| Carroll Hospital Center | -19.73% | 34 | 15.88% | 27 | -21.25% | 24 | 60 |
| University of Maryland Rehabilitation & Orthopaedic Institute | -24.80% | 41 | 16.60% | 29 | -26.77% | 9 | 60 |
| Sinai Hospital | -15.74% | 26 | 20.99% | 37 | -14.56% | 35 | 62 |
| Western Maryland Regional Medical Center | -14.31% | 23 | 24.36% | 41 | -12.05% | 39 | 63 |
| University of Maryland Shore Medical Center at Easton | -21.35% | 36 | 11.60% | 18 | -12.07% | 38 | 64 |
| Harford Memorial Hospital | -18.78% | 31 | 21.74% | 39 | -18.97% | 28 | 65 |
| University of Maryland Medical Center Midtown Campus | -23.52% | 40 | 19.01% | 33 | -23.21% | 17 | 65 |
| MedStar Good Samaritan Hospital | -19.03% | 32 | 20.32% | 36 | -9.88% | 41 | 71 |
| Northwest Hospital Center | -21.69% | 37 | 23.86% | 40 | -16.30% | 33 | 74 |
| Union Hospital of Cecil County | -24.87% | 42 | 15.43% | 26 | -3.56% | 42 | 76 |

## Appendix 5b. Efficiency Matrix with Alternative Proposal to Adjust for Indigent Care

Maryland
Hospital Association

May 4, 2021

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 (MHA) 60 member hospitals and health systems, we commend the Health Services Cost Review Commission (HSCRC) for considering stakeholder input throughout the development of the integrated efficiency policy. We appreciate the opportunity to comment on the April 14 draft recommendation.

**ICC Policy Dictates Outcome**
A guiding principle of the policy is HSCRC's statutory mandate to ensure hospital costs are reasonable and charges are reasonably related to costs. Under the Inter-hospital Cost Comparison (ICC) methodology, hospitals cannot make management decisions that will affect the policy outcome because revenues and adjustment factors are fixed. Under the "Revenue for Reform" proposal, hospitals could quantify, and possibly boost, resources they invest to transform care. The hospital field understands the statutory requirement. HSCRC might further opine on what hospitals can achieve to improve policy results.

**Evaluate the Impact of Additional Variables on ICC Performance**
Several hospitals expressed the need to review longstanding peer groups. MHA appreciates the thorough analysis commissioned by HSCRC. The analysis focused on the cost factors peer groups were originally intended to address, including indigence of the patient population, urbanicity, and hospital teaching status.

Although many cost factors and their associated variables were tested, additional elements have been posited to influence ICC performance. The Commission should further evaluate the efficacy of the alternative and peer group approaches by testing factors including, but not limited to, geography, technology, and case mix index.

**Vet the Benchmarking Methodology Prior to the FY2023 Policy Recommendation**
Commercial and Total Cost of Care benchmarking accounts for 50% of hospitals' rankings in the efficiency matrix. Additionally, the benchmarking has been approved for use in the Medicare Performance Adjustment and was identified as a possible long-term Model savings target.

Since March 2020, hospitals re-allocated resources and staff to respond to the COVID-19 pandemic. When the methodology was introduced in August 2020, key hospital stakeholders were unable to review and thoroughly vet the methodology. Acknowledging the burden on hospitals, Commissioners extended the vetting period until six months after the surge recedes. Unfortunately, hospitals were still responding to surge events as recently as the last half of April.

Several hospitals are assessing the methodology. MHA and the hospital field will thoroughly review the methodology and provide comments to HSCRC staff over the next several months. Prior to the fiscal year 2023 policy recommendation, HSCRC should review methodology concerns with stakeholders and revise as necessary to limit unintended consequences.

**Use the Scale of Withheld Inflation Approach Over the One Standard Deviation Rule**
Consistent with concerns previously raised by Commissioners, removing the one standard deviation ICC threshold reduces the cliff effect observed in the previous approach. However, arraying hospitals into quartiles based on performance will always present some type of cliff effect for hospitals that are closely ranked. Hospitals that repeatedly fall within the worst quartile will have a portion of their inflation permanently removed each year, potentially leading to unintended adverse consequences. The Commission should periodically evaluate this impact, in addition to the sliding scale of withheld inflation.

**Evaluate the Impact of COVID on Hospital Performance**
MHA supports the staff recommendation to rebase hospital volumes to the 2019 period. The recommendation ensures the ICC methodology more accurately reflects hospital unit prices. As evidenced by the need to raise rate corridors during FY 2020 and 2021, COVID greatly impacted hospital volumes, which is not expected to completely subside in FY 2022. The Commission should monitor hospital performance over the next fiscal year and adjust for COVID-related volume effects as necessary.

**Establish a Robust Vetting Process for Revenue for Reform Credits**
HSCRC introduced the Revenue for Reform concept, proposing a safe harbor for care transformation investments and other spending expected to lower avoidable service use. Valuing the proposed interventions to compare among hospitals will require well-vetted criteria. It is imperative that HSCRC staff work with stakeholders to implement a sound methodology. Allowing ample time for stakeholder recommendations will culminate in a formal recommendation to the Commission that will stand up in practice.

**Other Policy Considerations**
Adjustments to hospital revenue for medical education costs are based on the number of interns and residents as of 2011. Since then, hospitals began new residency programs. HSCRC should periodically assess adjustments for medical education based on program changes.

Thank you for your commitment to a fair process and for your consideration of these critical policy implications. If you have any questions, please do not hesitate to contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

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

GBMC

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Greater Baltimore Medical Center
6701 N Charles Street
Baltimore, MD 21204

May 5, 2021

Dear Katie:

The purpose of this letter is to submit the following comments on behalf of Greater Baltimore Medical Center (GBMC) in response to the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Integrated Efficiency Policy.

As a general concept, GBMC is in support of the HSCRC's efforts to implement an Integrated Efficiency Metric that incorporates both price and Total Cost of Care (TCOC) into its measure of relative hospital efficiency. However, GBMC has concerns about the use of the geographic, attainment-based TCOC benchmark measure as its measure of relative hospital TCOC performance.

GBMC has prioritized its community health strategy throughout the duration of the Maryland Demonstration model, investing heavily in the patient-centered medical home and advanced primary care models. The impact of GBMC's community health and primary care physician strategy is reflected on the HSCRC's metrics that directly attribute physicians or episodes. On the Medicare Performance Adjustment (MPA), which directly attributes GBMC's employed primary care physicians and measures improvement over time, GBMC has been a top performer in the State, earning a maximum reward for the CY2019 performance period. On the Episode Care Improvement Program (ECIP), which links link payments across providers during a specified episode of care, GBMC was one of only two hospitals to receive an ECIP reward in FY2019.

These metrics show that GBMC has achieved success in meeting the goals of the TCOC model. GBMC has also achieved excellent results in quality by other metrics such as patient safety and HCAHPS scores. However, on more geographic-based TCOC metrics, GBMC has middling results, as its Primary Service Area Plus (PSAP) ranks slightly worse than average compared to both Medicare FFS and Commercial attainment benchmarks. This is because GBMC has a broad PSAP that covers significant portions of Baltimore County and Baltimore City. The county-based nature of the TCOC benchmarks, cannot precisely measure GBMC's positive impact on TCOC. GBMC is concerned that the broad nature of the county-based TCOC benchmarking

metric, combined with GBMC's relatively low market share in a highly saturated market, means that the metric is neither reflective of GBMC's actual TCOC performance nor within GBMC's control to impact the result.

For these reasons, GBMC is concerned that the geographic TCOC benchmarks would be a significant driver of GBMC's relative efficiency. GBMC believes the direct attribution of the MPA policy is a more precise measure of an individual hospital's impact on TCOC, particularly in counties with highly saturated hospital markets where hospitals have little overall control of the result.

Again, GBMC is committed to investing in community health and supports efforts to increase TCOC accountability under the TCOC Model. We appreciate the hard work that the staff has put into this proposal.

Sincerely,

Laurie R. Beyer, MBA, CPA
EVP/CFO of GBMC HealthCare, Inc.

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**Vice President of Revenue Management and Reimbursement**
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JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
HEALTH SYSTEM

May 5, 2021

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

Dear Ms. Wunderlich:

On behalf of the Johns Hopkins Health System (JHHS), representing our 4 Maryland hospitals, we appreciate the opportunity to comment on the commission's Revised Draft Recommendation on Integrated Efficiency Policy for RY 2022. First, we would like to commend the staff for continuing to consider feedback from the industry in the revisions to the policy. One of the hallmarks of the rate setting system has always been its evolutionary nature that allows the methodologies to continue to be refined as new information becomes available and the development of this policy has shown the staff's commitment to continuing that process.

JHHS continues to support the proposal to adjust hospital revenues for efficiency. We also believe that it is appropriate to have both a Price Efficiency metric as well as a Total Cost of Care (TCOC) metric included as part of the methodology. Measuring efficiency in a fixed revenue environment is challenging, and we appreciate the HSCRC staff's approach to balance price efficiency with hospital specific, per capita TCOC performance.

JHHS also believes that the efficiency policy should be revenue neutral on a statewide basis. If high cost hospital's revenues are reduced, the full sum of this reduction should be available within the system and no portion should be withheld. We appreciate the HSCRC staff's consideration that allows low cost outliers to apply for increases and other proposed uses of savings.

**Policy Goals and Objectives, and Methodology Application**

JHHS believes that HSCRC staff should include clear policy goals and objectives for the efficiency policy. We believe that for an efficiency policy to be effective, hospitals need to understand what actions a hospital can take in order to improve their position in the rankings.

**Modified Scaling Approach**

JHHS supports the modified scaling approach presented in the recommendation. The modified approach is consistent with other HSCRC measurement policies and helps minimize any "cliff" effects that a policy could cause. Additionally, it provides appropriate incentives by emphasizing both TCOC performance and cost per case efficiency in determining a hospitals position and subsequent penalty.

**Peer Groups**

JHHS supports the incorporation of an inpatient national peer group for both Maryland Academic Medical Centers (AMC). The AMCs have unique cist structures that should be compared to other like institutions. While we support the concept of the national peer group, we want to make sure that those comparisons are reasonable and also want to make sure that the results are properly integrated into the efficiency methodology. We are committed to working with HSCRC staff to analyze various data sources and methodologies that could be utilized in the creation and application of a national AMC peer group.

JHHS acknowledges that if there were a methodology that could directly adjust for all factors impacting a hospitals costs that there would no longer be a need for peer groups. We also realize that the current peer groups were initially developed almost 20 years ago. Many hospitals have changed since the initial creation of these groups. We appreciate all of the work that the staff has put into evaluating the current peer groupings but still believe that more analysis needs to be done to consider other factors that could be directly measured that the current peer groups help to adjust for in the methodology. JHHS would ask that HSCRC staff continue to work with hospitals to better understand these factors and delay the elimination of the peer groups until such analysis can be completed.

**Total Cost of Care**

JHHS agrees that TCOC is an important measure in the efficiency policy because the system incentives are population based. However, only measuring growth or only measuring attainment could disadvantage hospitals with very low TCOC relative to peers or hospitals that have shown reductions to TCOC but have not yet reached a benchmark. We believe that it would be appropriate to take both measures into consideration in this efficiency policy.

**Rebasing Rate Order Volumes**

JHHS supports the staff recommendation to rebase rate order volumes using FY 2019 data. If approved, the staff should set annual unit rates using volumes from the most recent 12-month period preceding the rate order. We appreciate the need to hold hospitals accountable to GBR targets, and the efficiency policy will reduce overall GBR revenues for outlier hospitals.

Finally, we believe that this and all methodologies need to be reviewed and revisited on a regular basis to assure that the underlying methodologies are keeping in sync with the goals of the new model and to provide refinements where needed.

Thank you again for your consideration and thanks to the HSCRC staff for all of their efforts in crafting a policy on this very complex matter. If you have any questions, please feel free to contact me.

Sincerely,

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

TidalHealth™

Executive Office

100 East Carroll Street
Salisbury, MD 21801

410-543-7111

May 4, 2021

Allan Pack, Principal Deputy Director
Population-Based Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

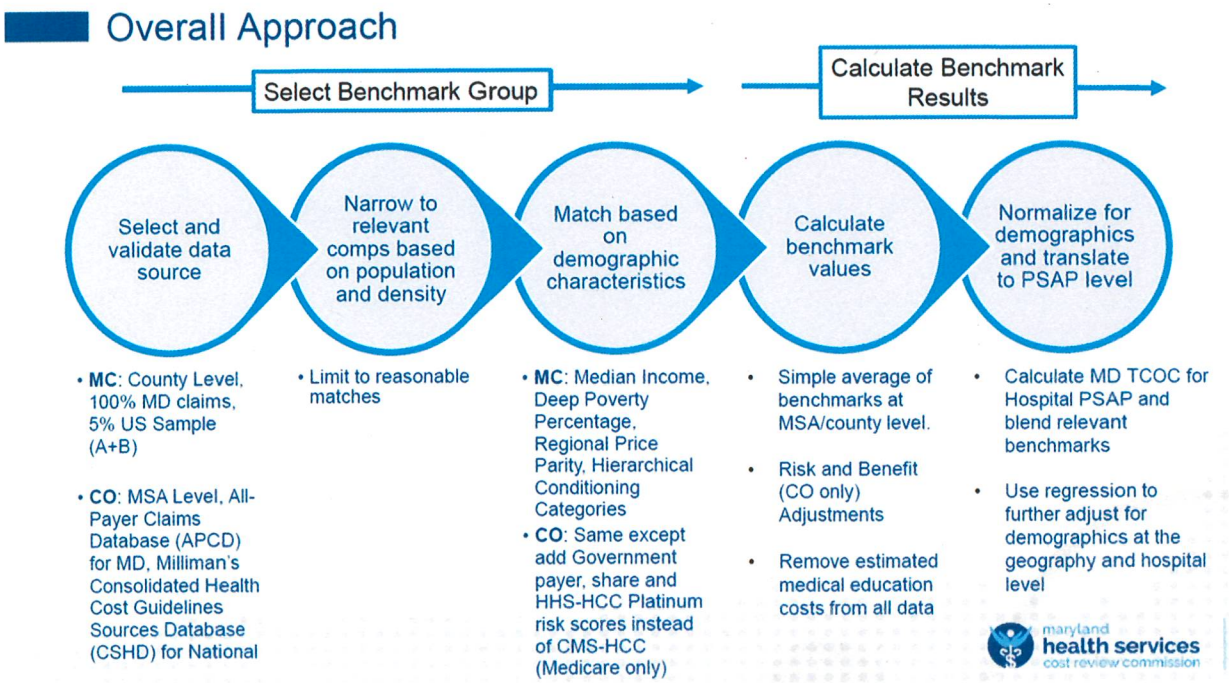
Dear Mr. Pack:

On behalf of TidalHealth Peninsula Regional, the purpose of this letter is to comment on the proposed Integrated Efficiency policy that is before the Commission at the June 2021 meeting.

**Total Cost of Care Benchmarks and Revenue Redistribution**

Recently the HSCRC announced the use of a methodology to develop benchmarks for TCOC performance based on county of beneficiary residence and for MSAs for commercial beneficiaries. These benchmarks were designed to compare total spending per beneficiary in similar jurisdictions elsewhere in the nation to judge the performance of the Maryland healthcare system. The staff incorporated these benchmarks into the Commission's MPA methodology for Medicare and had now proposed to further use the methodology in the Integrated Efficiency policy for hospitals.

The data and calculations for these adjustments were largely unfamiliar to the industry, so when the staff rolled out these complex adjustments, hospital representatives raised a variety of questions for clarification of the mechanics of the calculations as well as for a better understanding of the policy impact of these adjustments.



The staff presentation of the integrated efficiency policy notes the desire to redistribute the resources within the system from poor performers to excellent performers. But the results of the policy appear to penalize small rural providers and reward hospitals in relatively affluent suburban areas. While the staff has been forthcoming in providing the details of the policy and the included adjustments, the calculations are complex and detailed, and few understand the process outside of the staff and its contractors. The policy impact seems to result in a systematic bias based on these highly technical adjustments.

One source of this bias appears to be the lack of any adjustment for the price differences across the benchmark jurisdictions. Medicare payments are generally adjusted for the wage index to reflect differences in wages costs across areas. The HSCRC incorporates a wage adjustment into its own hospital efficiency methodology for that reason. However, the regression model used for normalizing the demographic variation in TCOC (see the last step in the chart above) does not make that adjustment across the benchmark counties prior to calculating the regression. But note: in Maryland, the wage index used in the efficiency methodology ranges from a low of 0.88 to a high of 1.06; in the 650 benchmark counties, the wage index ranges from a low of 0.65 to a high of 1.91. Without adjusting for the wage index, Maryland hospitals with patients in counties compared to low wage markets face a standard where Medicare prices may be as much as 35% below the national average while high wage markets may be 91% more. The consequence is that the benchmarks reflect differences in beneficiary utilization as well as differences in price. The consequences of this omission are important and require further examination to evaluate the equity of the proposed Integrated Efficiency model results.

Each adjustment has consequences. For example, in the last step of the benchmark calculation shown in the figure above, the benchmark is "normalized" for demographics. That normalization involves an adjustment from a regression model based on two measures: a measure of deep poverty and the county's median income. The regression model explains only about 13% of the variation in the TCOC per Medicare Fee-for-Service Beneficiary in the 650 counties used in the benchmark process (based on the model's adjusted R-squared), but it is nonetheless used for this normalization. The model's coefficients are used to generate adjustments that have substantial consequences – for hospitals with deep poverty, the adjustment results in a more generous benchmark, reflecting the likely need for resources need in treating poor populations. This result seems logical.

The second adjustment, however, for median income also increases the comparison benchmark that results in a more favorable comparison for the hospital. Hence, the staff's proposed policy is to provide a more generous assessment of a hospital's relative efficiency ***because its patients are in high-income areas.*** In fact, the credit attributed to this income adjustment is greater than the adjustment for deep poverty.

These detailed adjustments seem esoteric and are often passed over as hard-to-understand details, but they have real consequences. In this specific instance, hospitals serving the most affluent patients in the state benefit from a technical "normalization" designed to improve comparability across counties. The result, however, is a real redistribution of resources away from hospitals serving poor patients to those in affluent communities.

These issues deserve further consideration before TCOC benchmarks account for 50 percent of the Integrated Efficiency assessment. The Mathematica paper that develops the Medicare benchmark demonstrates considerable fragility of regression models, and we have several technical concerns about the resulting benchmark measure – particularly, that the TCOC is not adjusted by the Medicare Wage Index.

**Socioeconomic Concerns, Peer Groups, and the Poor Share Measure**

While we understand the HSCRC's rationale for the potential elimination of peer groups, any shift away from this historic policy needs to adequately account for the socioeconomic factors inherent in measuring the relative efficiency of hospitals. Hospitals located in socioeconomically disadvantaged areas, whether they be urban or rural settings, may lack critical infrastructure to assist in the management of the health of a population. In the absence of a sufficient primary care network in the community, for example, these hospitals may have to invest greater resources in care delivery models that place them at an efficiency-measured disadvantage from peers in more economically advantageous areas that do not have to make comparable investments. Additionally, hospitals in areas that have not had the advantage of capital and public health investments such as reliable transportation and school-based health centers will disproportionately have to invest in safety net services merely to try to maintain parity with more affluent peers. These investments, while necessary to care for the populations these hospitals serve, will appear to make the hospitals more inefficient. These socioeconomic factors need to be accounted for in any shift away from the current peer group methodology.

These issues are particularly prevalent in more rural areas of the state that do not have the infrastructure and resources of more urbanized areas. Often lacking in robust public health investments and encountering specific challenges such as greater geographic distances to travel for care, rural providers are uniquely challenged to manage the populations that they serve. This lack of concerted investment and resources often results in increased chronic conditions within the population, leading to additional healthcare utilization and potential negative health outcomes.

We support the staff's use of an indigence measure to capture the effect of treating relatively poor populations. We encourage continued work to recognize the complex links between healthcare spending and the socioeconomic conditions of the population that providers serve.

**Teaching Programs**

The current policy also does not adequately reflect the reality of teaching programs within the state and is inconsistent with CMS reimbursement policies for these programs. The current policy limits the number of residents to the amount included in the FY2011 Efficiency Methodology and does not reflect residents associated with new programs. This has the effect of reducing the ability of hospitals to increase residency placements and expand teaching programs.

Outside of Maryland, Medicare Graduate Medical Education (GME) Reimbursement is the primary source of funding for hospitals that participate in approved residency and fellowship training programs. Once approved by the Accreditation Council for GME (ACGME) for a specified number of positions, a new urban sponsoring institution has five years to fill those programs to the number dictated by the ACGME or request additional residency slots through the ACGME as desired. At the end of that five-year cap building period, the hospital will receive funding in perpetuity for the maximum number of residents training at the hospital during the cap building period. For new rural teaching hospitals, each individual program will have a 5-year window in which the hospital can grow that program to the number of positions approved by the ACGME in order to receive funding for that number of positions in perpetuity. These policies allow new programs to be approved and to be funded and not held to a cap established a decade ago.

We request that the Commission adopt the same approach in Maryland. The staff has noted that Maryland has more physicians than average for the state's population. However, rural providers within the state often find it difficult to recruit physicians to rural areas, creating specific areas of shortage. Given PRMC's specific needs for physician services in a Level III trauma center, the difficulties are particularly acute. To assist the Hospital with recruitment and to address the need for primary care and certain specialty physicians on the Eastern Shore,

PRMC intends to pursue Graduate Medical Education. We ask that the Commission (1) adopt the CMS approach that providers outside the state may use under CMS guidelines for new programs and (2) that the resulting program be recognized within the graduate medical education adjustments of the Integrated Efficiency policy.

**Appropriate Accountability**

The efficiency methodology establishes a presumptive cost per unit of care relative to a reasonable benchmark. The purpose is for the Commission to judge the needs of an applicant hospital based on rates sufficient for an efficient and effective hospital. That would imply that the hospital's own performance is the central issue in judging relative efficiency.

We understand the inclusion of TCOC as an element of hospital performance in measuring relative efficiency for establishing updates – the performance of the entire system is constrained by the need to meet the targets established under the Model. However, hospitals on average in Maryland contribute about half of the TCOC for Medicare beneficiaries. The remainder is out of the direct control of the hospital. While the Model provides incentives to coordinate across the healthcare spectrum of services, other providers are still largely paid on a fee-for-service basis – a direct conflict with the global budget incentive to reduce potentially avoidable utilization. Hence, the use of 50% of the TCOC benchmarks for determining relative efficiency appears excessive. Hospital revenue is being placed at risk beyond to ability of the hospital to control the performance in the market.

We are requesting that the weight of the TCOC attainment methodology be substantially reduced to allow additional review of the methodology based on the concerns addressed and to determine an appropriate weight of TCOC in the Integrated Efficiency Methodology.

**Conclusion**

With the turmoil introduced by the COVID-19, providers experienced substantial drops in volume early in the pandemic and now face an uncertain healthcare environment going forward. The subsequent response to changes in care have likely changed the practice of medicine in ways that are not fully understand at present. In this tumultuous environment, policy changes should not add to the uncertainty. The current proposal contains at its core well-intended modifications to improve existing HSCRC methodologies to address lingering issues with the current model, but to base revenue changes on the proposed TCOC benchmarks imposes permanent revenue changes based on information that may substantially misrepresent reality, with unintended outcomes for the poorest communities in the state.

We appreciate the hard work that the staff has put into this proposal, and we look forward to further working with you in the future to improve the quality, efficiency, and affordability of healthcare services in the communities we serve.

Please contact me if we can be of assistance.

Sincerely,

Steven E. Leonard, Ph.D., MBA, FACHE
President/CEO

UPMC LIFE CHANGING MEDICINE

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May 5, 2021

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

Dear Ms. Wunderlich:

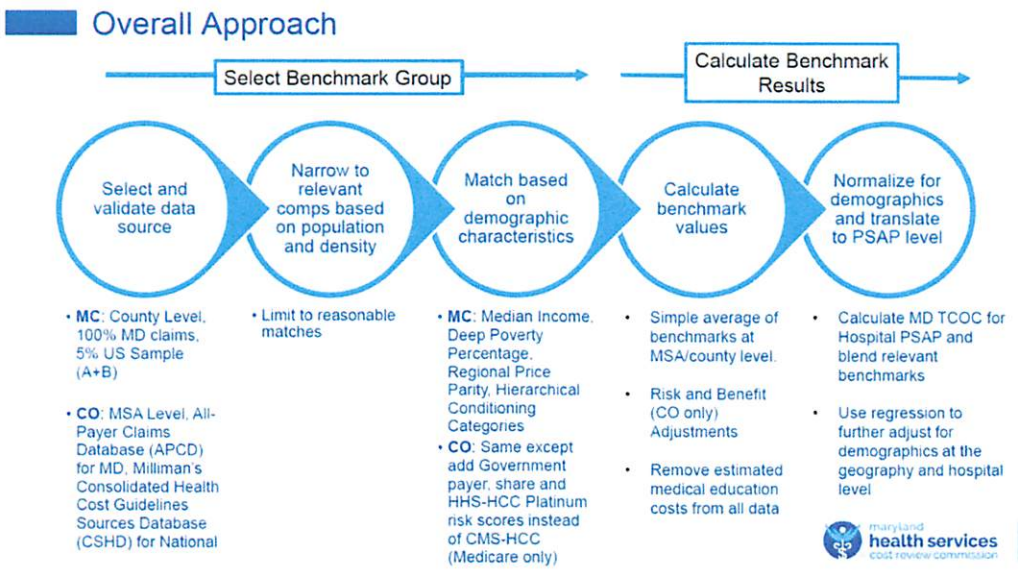
On behalf of UPMC Western Maryland, the purpose of this letter is to comment on the proposed Integrated Efficiency policy that is before the Commission at the June 2021 meeting.

**Total Cost of Care Benchmarks and Revenue Redistribution**

Recently the HSCRC announced the use of a methodology to develop benchmarks for TCOC performance based on county of beneficiary residence and for MSAs for commercial beneficiaries. These benchmarks were designed to compare total spending per beneficiary in similar jurisdictions elsewhere in the nation to judge the performance of the Maryland healthcare system. The staff incorporated these benchmarks into the Commission's MPA methodology for Medicare and had now proposed to further use the methodology in the Integrated Efficiency policy for hospitals.

The data and calculations for these adjustments were largely unfamiliar to the industry, so when the staff rolled out these complex adjustments, hospital representatives raised a variety of questions for clarification of the mechanics of the calculations as well as for a better understanding of the policy impact of these adjustments.

The staff presentation of the integrated efficiency policy notes the desire to redistribute the resources within the system from poor performers to excellent performers. But the results of the policy appear to penalize small rural providers and reward hospitals in relatively affluent suburban areas. While the staff has been forthcoming in providing the details of the policy and the included adjustments, the calculations are complex and detailed, and few understand the process outside of the staff and its contractors. The policy impact seems to result in a systematic bias based on these highly technical adjustments

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One source of this bias appears to be the lack of any adjustment for the price differences across the benchmark jurisdictions. Medicare payments are generally adjusted for the wage index to reflect differences in wages costs across areas. The HSCRC incorporates a wage adjustment into its own hospital efficiency methodology for that reason. However, the regression model used for normalizing the demographic variation in TCOC (see the last step in the chart above) does not make that adjustment across the benchmark counties prior to calculating the regression. But note: in Maryland, the wage index used in the efficiency methodology ranges from a low of 0.88 to a high of 1.06; in the 650 benchmark counties, the wage index ranges from a low of 0.65 to a high of 1.91. Without adjusting for the wage index, Maryland hospitals with patients in counties compared to low wage markets face a standard where Medicare prices may be as much as 35% below the national average while high wage markets may be 91% more. The consequence is that the benchmarks reflect differences in beneficiary utilization as well as differences in price. The consequences of this omission are important and require further examination to evaluate the equity of the proposed Integrated Efficiency model results.

Each adjustment has consequences. For example, in the last step of the benchmark calculation shown in the figure above, the benchmark is "normalized" for demographics. That normalization involves an adjustment from a regression model based on two measures: a measure of deep poverty and the county's median income. The regression model explains only about 13% of the variation in the TCOC per Medicare Fee-for-Service Beneficiary in the 650 counties used in the benchmark process (based on the model's adjusted R-squared), but it is nonetheless used for this normalization. The model's coefficients are used to generate adjustments that have substantial consequences – for hospitals with deep poverty, the adjustment results in a more generous benchmark, reflecting the likely need for resources need in treating poor populations. This result seems logical.

The second adjustment, however, for median income also increases the comparison benchmark that results in a more favorable comparison for the hospital. Hence, the staff's proposed policy is to provide a more generous assessment of a hospital's relative efficiency

***because its patients are in high-income areas.*** In fact, the credit attributed to this income adjustment is greater than the adjustment for deep poverty.

These detailed adjustments seem esoteric and are often passed over as hard-to-understand details, but they have real consequences. In this specific instance, hospitals serving the most affluent patients in the state benefit from a technical "normalization" designed to improve comparability across counties. The result, however, is a real redistribution of resources away from hospitals serving poor patients to those in affluent communities.

These issues deserve further consideration before TCOC benchmarks account for 50 percent of the Integrated Efficiency assessment. The Mathematica paper that develops the Medicare benchmark demonstrates considerable fragility of regression models, and we have several technical concerns about the resulting benchmark measure – particularly, that the TCOC is not adjusted by the Medicare Wage Index.

**Socioeconomic Concerns, Peer Groups, and the Poor Share Measure**

While we understand the HSCRC's rationale for the potential elimination of peer groups, any shift away from this historic policy needs to adequately account for the socioeconomic factors inherent in measuring the relative efficiency of hospitals. Hospitals located in socioeconomically disadvantaged areas, whether they be urban or rural settings, may lack critical infrastructure to assist in the management of the health of a population. In the absence of a sufficient primary care network in the community, for example, these hospitals may have to invest greater resources in care delivery models that place them at an efficiency-measured disadvantage from peers in more economically advantageous areas that do not have to make comparable investments. Additionally, hospitals in areas that have not had the advantage of capital and public health investments such as reliable transportation and school-based health centers will disproportionately have to invest in safety net services merely to try to maintain parity with more affluent peers. These investments, while necessary to care for the populations these hospitals serve, will appear to make the hospitals more inefficient. These socioeconomic factors need to be accounted for in any shift away from the current peer group methodology.

These issues are particularly prevalent in more rural areas of the state that do not have the infrastructure and resources of more urbanized areas. Often lacking in robust public health investments and encountering specific challenges such as greater geographic distances to travel for care, rural providers are uniquely challenged to manage the populations that they serve. This lack of concerted investment and resources often results in increased chronic conditions within the population, leading to additional healthcare utilization and potential negative health outcomes.

The HSCRC is evaluating revenue for reform which would hold hospitals harmless for investment of retained revenue in population health initiatives. The exact methodology has not been defined however we agree this adjustment is critical especially in areas treating patients in areas with health disparities.

We support the staff's use of a poor share measure to capture the effect of treating relatively poor populations. We encourage continued work to recognize the complex links between healthcare spending and the socioeconomic conditions of the population that providers serve.

In addition to continuing work related to addressing socioeconomic factors we request a technical adjustment to the current poor share measure. The current measure is based on the percent of hospital revenue from Medicaid for inpatient and outpatient services for Maryland residents where Medicaid is either primary or secondary payer. We ask that this measure be expanded to include out-of-state residents as well, given that the population served is still poor with the same general health characteristics as their Maryland counterparts. We would also ask that the measure include patients with Medicare as a primary payer but charity as a secondary payer, reflecting the low-income status of these elderly patients who do not currently qualify for Medicaid. These adjustments would more accurately reflect the poor populations treated by providers, especially those located near state borders.

**Appropriate Accountability**

The efficiency methodology establishes a presumptive cost per unit of care relative to a reasonable benchmark. The purpose is for the Commission to judge the needs of an applicant hospital based on rates sufficient for an efficient and effective hospital. That would imply that the hospital's own performance is the central issue in judging relative efficiency.

We understand the inclusion of TCOC as an element of hospital performance in measuring relative efficiency for establishing updates – the performance of the entire system is constrained by the need to meet the targets established under the Model. However, hospitals on average in Maryland contribute about half of the TCOC for Medicare beneficiaries. The remainder is out of the direct control of the hospital. While the Model provides incentives to coordinate across the healthcare spectrum of services, other providers are still largely paid on a fee-for-service basis – a direct conflict with the global budget incentive to reduce potentially avoidable utilization. Hence, the use of 50% of the TCOC benchmarks for determining relative efficiency appears excessive. Hospital revenue is being placed at risk beyond the ability of the hospital to control the performance in the market.

In addition, there is also a significant lag in the TCOC data used in the methodology. For example, the proposed Integrated Efficiency Methodology included TCOC data based on CY2018. If a hospital is subject to a rate reduction, it will take several years before the impact of the rate reduction or any other TCOC initiatives to be reflected in the TCOC attainment methodology. This may result in hospitals being subject to perpetual spenddown with minimal opportunity to improve the results.

We are requesting that the weight of the TCOC attainment methodology be substantially reduced to allow additional review of the methodology based on the concerns addressed and to determine an appropriate weight of TCOC in the Integrated Efficiency Methodology.

**Conclusion**

With the turmoil introduced by the COVID-19, providers experienced substantial drops in volume early in the pandemic and now face an uncertain healthcare environment going forward. The subsequent response to changes in care have likely changed the practice of medicine in ways that are not fully understood at present. In this tumultuous environment, policy changes should not add to the uncertainty. The current proposal contains at its core

well-intended modifications to improve existing HSCRC methodologies to address lingering issues with the current model, but to base revenue changes on the proposed TCOC benchmarks imposes permanent revenue changes based on information that may substantially misrepresent reality, with unintended outcomes for the poorest communities in the state.

We appreciate the hard work that the staff has put into this proposal, and we look forward to further working with you in the future to improve the quality, efficiency, and affordability of healthcare services in the communities we serve. Please contact me if we can be of assistance.

Sincerely,

Michele R. Martz
President, UPMC Western Maryland

LIFEBRIDGE HEALTH

May 5, 2021

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

Dear Katie –

On behalf of the LifeBridge Health System and its five member hospitals (Sinai, Northwest, Carroll, Grace and Levindale), the following comments are in response to the Efficiency Policy recommendation presented at the April 2021 Public Meeting.

LifeBridge has long understood the need for the HSCRC to measure relative efficiency, particularly given the time since inception of the fixed revenue model through Global Budget Revenues and changes in volume activity that have occurred since that time. Determining efficiency by measuring hospital performance against each other through peer comparisons has historically been a complicated, and often divisive issue, and we appreciate the amount of work that Staff – most notably Allan Pack – has committed to creating a comprehensive evaluation.

Nonetheless, we are concerned with moving forward beginning with Rate Year 2022 for the following reasons:

1. **Data Period and Pandemic State** – the volume data used to calculate the ICC comparison is from fiscal year 2019. Understanding the inability to utilize data from fiscal year 2020 given the COVID pandemic, we believe facilities may be experiencing different levels of current volume activity when compared to fiscal year 2019 data, and that the changes in volume may be permanent moving forward as activities return to normal. Waiting for more current data will ultimately produce a more accurate result for any ICC methodology adopted. In the interim, the HSCRC maintains the ability to implement relative efficiency controls through control of volume-based corridors and associated restrictions to revenue.

2. **Elimination of Peer Groups** – The current policy recommendation argues that the direct adjustments for disproportionate share and medical education are wholly sufficient in accounting for differences between all hospitals, outside of academic facilities for which a comparable peer group is still considered necessary. The elimination of peer groups is in stark contrast to long-standing position that the direct adjustments do not fully account for all differences across facilities, such as differences in geography, size, technology and complexity.

   While Staff continues to evaluate whether other variables outside of disproportionate share and medical education provide additional explanatory significance, the proposed elimination off peer groups creates substantial variability in relative performance when compared to an alternative that utilizes peer groups. Of particular concern is the sizeable deterioration in performance for many urban hospitals providing services in the most vulnerable communities. Significant investment is needed in order to provide these community members with comprehensive healthcare services and access to services beyond the hospital.

   Because of the amount of variability the elimination of peer groups creates, and importance that ensuring a direct disproportionate share adjustment appropriately reflects the associated costs with providing care, we believe it would be prudent for the HSCRC to continue to explore alternatives before adopting no statewide peer groups. Again, we believe the HSCRC has an ability to manage efficiency through a volume policy that can be enforced via corridor compliance.

We look forward to continuing to work collectively with the HSCRC to continue advancing Maryland's unique demonstration model. As always, should you wish to discuss this issue in greater detail, please do not hesitate to reach-out to us directly.

Sincerely,

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

CC: Adam Kane, Esq.
HSCRC Chairman

MedStar Health

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Kathy Talbot
Vice President

Rates and Reimbursement

May 5, 2021

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

Dear Ms. Wunderlich:

On behalf of MedStar Health, Inc. and our subsidiary Maryland hospitals, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft staff recommendation on the integrated efficiency policy for Rate Year 2022.

We recognize this was a tremendous amount of work for the HSCRC staff and we appreciate the detailed analysis incorporated in these draft recommendations. We offer the following comments that we hope you will strongly consider:

**Revenue for Reform Adjustments**
Given the importance of care management to the success of the Maryland GBR model, we support the "Revenue for Reform" Concept that would allow hospitals to retain funding to reinvest in approved reform efforts. We recognize HSCRC began gathering population health data and creating workgroups to inform future collection efforts that will assist in determining the efficiency "credit" that can be earned. Given the significance of these population health efforts to the future of the GBR model and also the related impact the revenue for reform adjustments may have on individual hospital performance, a formal policy is necessary to set standard criteria for revenue for reform adjustments. To ensure transparency and equity, we recommend developing this policy before approving revenue for reform special adjustments.

**Special Designations**
Federal Reimbursement Programs have different definitions that categorize hospitals, such as Critical Access Hospitals, Distinct Part Rehabilitation Units, and Large Urban Providers. This could be considered a similar approach to peer grouping to distinguish different characteristics that are unique in these types of providers. If the HSCRC removes peer groups, we would recommend not making any new special designations or adjustments until a formal process and policy is developed and approved that would evaluate other categories of cost that may be unique in certain types of providers.

**Medicare and Commercial Total Cost of Care Benchmarking**
The Medicare and Commercial Total Cost of Care Benchmarking is a significant new measure that will most likely require adjustment over time as HSCRC and the hospitals continue to review and understand the results. Historically, when new measures of significance were introduced, the Commission often implemented a phased-in approach. We recommend increasing the weighting of this measure in stages over the next several years (i.e. 25% in FY22, 50% in FY23) given both the newness of the measure and to ensure that it aligns with the model and other policies.

**Methodological Changes**
We recognize these recommendations include several material changes in historical methodology, such as removing peer groups, reducing IME credit for non- AMC's, and introducing a Medicare/Commercial TCOC benchmark. These methodological changes have created a significant change in hospital performance against the efficiency metric and may impact performance under other methodologies as well. As HSCRC and the hospitals continue to review and offer improvements to methodology, consideration should be given to phasing-in methodology changes to allow for monitoring and adjustment.

Thank you again for the opportunity to provide comments.

Sincerely,

Kathy Talbot

Kathy Talbot
Vice President
Rates and Reimbursement
MedStar Health, Inc.

cc: Adam Kane, HSCRC Chairman
Joseph Antos, Ph.D., HSCRC Vice Chairman
James N. Elliott, M.D., HSCRC Commissioner
Victoria W. Bayless, HSCRC Commissioner
Sam Malhorta, HSCRC Commissioner
Stacia Cohen, RN, HSCRC Commissioner
John M. Colmers, HSCRC Commissioner
Allan Pack, HSCRC Principle Deputy Director
Susan K. Nelson, Executive Vice President and CFO

Mercy
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May 5, 2021

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

Dear Chairman Kane,

Mercy commends you and your team for a thoughtful policy recommendation for hospital efficiency, and we appreciate the opportunity to provide comments.

While we agree with many of the conclusions drawn from the recommendation, the comments below focus on two areas where Mercy feels the proposed policy could be improved. Both reflect areas where efficient, urban hospitals may be disadvantaged having limited ability to influence relative efficiency, mainly due to geography.

**Total Cost of Care**

The policy is intended to "ensure that total of care is heavily influential to the efficiency analysis". Mercy agrees with the sentiment, but fears smaller, independent facilities will be disadvantaged in their ability to make a meaningful impact in urban areas, especially those dominated by large Academic Medical Centers. The concerns are:

- Weighting. At 50%, the policy significantly over weights the share of TCOC relative to individual hospital efficiency, far beyond national programs and commercial payers.
- Geographic attribution. Mercy strives to reduce overall TCOC, specifically focused on patients seeking services at Mercy. Without a direct link between patients and the TCOC measurement, it is unclear how hospitals in urban settings are able to directly impact TCOC performance.

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**Peer Groups & Urban Cost**

The policy removes peer groups and instead recommends "direct adjustments made through a regression to account for the intended purposes of peer groups". While we understand the HSCRC's concern regarding excess capacity, Mercy's concern is the new regression does not adequately account for the direct and indirect cost of providing services in Baltimore City. Examples of these cost include:

- Direct cost, such as security including K-9, required to ensure campus safety for patients, visitors and staff.
- Indirect cost associated with homelessness, wayfinding, advertising, wages, aged city infrastructure and consumer hesitancy.
- Capital cost to purchase, build, renovate and maintain facilities, included covered parking structures, which are land-locked. *(The capital adjustment has been removed from the current proposed policy)*.
- Medical liability cost are notoriously higher in urban jurisdictions, echoed by reinsurance providers continuously leaving the market and limiting exposures.

Again, we appreciate the ability to provide comment and hope the policy can continue to be refined over time.

Sincerely,

Justin Deibel
Executive Vice President & CFO, Mercy Health Services

Cc: Dr. David Maine, President & CEO MHS

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

Dear Chairman Kane:

On behalf of Meritus Health ("Meritus"), we thank the Health Service Cost Review Commission ("HSCRC" or the "Commission") staff for their work in developing the integrated efficiency policy and their commitment to responding to stakeholder input throughout the process. We appreciate the opportunity to comment on the Draft Recommendation on Integrated Efficiency presented at the April 14, 2021 HSCRC public session.

Meritus supports the development and implementation of a formulaic, transparent, and replicable policy that evaluates hospital efficiency and redistributes revenue from inefficient outliers to efficient outliers accordingly. Additionally, we are supportive of Staff's recommendation to measure hospital efficiency by blending a cost per case measure (ICC) with a measure of total cost of care (TCOC). Under the Maryland Total Cost of Care Model's fixed hospital revenue system (GBR), hospitals are incentivized to reduce utilization by allowing them to retain revenue as volumes decline. The incorporation of a TCOC metric in the policy will reward hospital's that reinvest this retained revenue into improving population health while penalizing hospital's that fail to do so. Balancing a hospital cost per case efficiency measure with a TCOC efficiency measure is needed to provide a more complete evaluation of hospital performance under a system that increasingly requires hospitals to have impact outside of their four walls. While supportive of the inclusion of a TCOC measure, Meritus agrees with the Maryland Hospital Association's ("MHA") position that further vetting of the Commercial and Medicare benchmarking methodology is needed prior to the FY2023 policy recommendation.

In response to stakeholder input, Commission staff evaluated the traditional peer groups used in the ICC methodology and determined that eliminating the peer groups and adopting a risk adjustment for indigent care cost addressed cost variations that are not a reflection of actual hospital performance. Meritus agrees with this analysis and supports the elimination of the traditional peer grouping logic from the efficiency policy. However, we echo the comments of the MHA that further evaluation of additional cost factors and their influence on ICC performance is needed. Additionally, Meritus agrees with MHA's position, which is also supported by Commission staff, to re-base hospital volumes to the 2019 period to accurately reflect hospital price per unit in the ICC.

***Revenue for Reform 'Safe Harbor'***

In the recent draft recommendations put forth before the commission, staff has expressed a desire to provide adjustments in the ICC to account for population health investments that providers make outside of HSCRC rate regulated space. Through the Efficiency Workgroup, HSCRC staff have introduced a "Revenue for Reform" concept as the mechanism by which to execute this policy refinement. This concept will allow hospitals to earmark a percentage of their GBR for investment in HSCRC approved population health interventions and have this earmarked revenue excluded from ICC analysis. Due to the relative nature of the efficiency policy ranking evaluation, any hospital that is allowed to improve their ICC performance through the "Revenue for Reform" safe harbor will impact the relative performance of every other hospital included in the methodology. As such approval of interventions should not be limited to only inefficient hospitals. Meritus also stresses the need for well-vetted and uniform criteria that will be used in the HSCRC evaluation of proposed intervention.

We also would like to express reservations in the HSCRC making value judgements on which hospital population health interventions will qualify for approval or not under the Revenue for Reform proposal. The patient population

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of a rural sole community provider may require drastically different interventions than the patient population of an urban regional hospital in order to maximize improvements in health. Meritus asks Commission staff to be cognizant of this in developing their criteria for approval to insure equity in the policy.

***Medical Education Costs***

The current ICC methodology provides adjustments to hospital revenue to account for the costs of medical education based on the number of residents and interns as of 2011. Meritus believes the HSCRC should update the ICC to account for appropriate teaching costs as new residency programs have been started at hospitals through the decade. We also would highlight that physicians are likely to practice medicine in the area where they completed their residency. As such, investments by hospitals in establishing new teaching programs are effective in addressing identified physician shortages, improving access to care, and ultimately improving the health of the people of Maryland. We ask Commission staff to consider providing ICC adjustments to account for the costs of residency programs established since 2011 that are linked to addressing issues with access to care and physician shortages.

Thank you again for your consideration and for Commission staff's continued efforts in developing this complex and comprehensive policy. We look forward to continuing to work collaboratively with staff and industry stakeholders in developing refinements to the Integrated Efficiency policy. If you have any questions, please feel free to contact me.

Sincerely,

Thomas T. Chan, CPA, MBA, FHFMA
Chief Financial Officer
Meritus Health

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Finance Shared Services

May 5, 2021

**Re: RY 2022 Revised Integrated Efficiency Policy Draft Recommendation**

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

Dear Katie:

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, we are submitting comments in response to the Health Services Cost Review Commission's (HSCRC) RY 2022 Revised Integrated Efficiency Policy Draft Recommendation.

We support the Staff's proposal to implement a standardized approach for evaluating hospital efficiency and adjusting hospital revenue. An efficiency policy is necessary to ensure that hospital costs remain reasonable and that health care is affordable in the state of Maryland. We believe the Inter-hospital Cost Comparison (ICC) and a per capita comparison measure are appropriate measures of efficiency.

Commission staff have put forward a thoughtful proposal regarding revisions to the Integrated Efficiency policy. The proposal addresses many of the concerns raised by hospitals regarding the previous staff recommendation, namely the application of scaling adjustments and the concern over the number of small rural hospitals identified as outliers.

UMMS supports the following areas of the RY 2022 Revised Integrated Efficiency Policy Draft Recommendation:

**Modified scaling approach for bottom quartile hospitals is more appropriate**

UMMS supports MHA's position that the modified scaling approach put forward by the Commission staff provides more fair and appropriate outcomes than the previously proposed scaling approach. The previous proposal was an 'all or nothing' approach whereby hospitals were either penalized by the maximum amount or not at all, which created a cliff effect. The new approach aligns more consistently with the scaling approaches adopted within many other policies, such as the quality programs and MPA. We feel the revised scaling approach put forward by the staff provides the appropriate incentives and equally emphasizes both TCOC performance and cost per case efficiency in determining a hospital's penalty (or reward).

**We support the concept of a National Peer Group for the AMCs**

UMMS supports the incorporation of an inpatient national peer group for both Maryland academic hospitals. Using a Maryland peer group of non-academic teaching hospitals for the AMCs has not provided the appropriate comparison of costs for these institutions. They are very unique in their cost structure and should be compared to other institutions with the similar costs. While we support the concept of national data for the AMCs, there are still many technical issues to be addressed in the methodology. We are committed to working through those issues with Commission staff and commit to completing this important work.

**Safe Harbor concept is a positive step toward recognizing Population Health investments**

UMMS would like to acknowledge the effort HSCRC staff has made to work with us to establish a GBR revenue base at Shore Medial Center – Chestertown that is meant to both sustain a baseline level of hospital-based operations and implement a non-hospital care delivery model designed to support community needs. UMMS views the HSCRC's establishment of a cost adjustor to the ICC as a critical consideration when evaluating the cost of providing essential hospital-based services at small, geographically isolated hospitals. UMMS is committed to continued investments in community-based services through the utilization of safe harbored GBR revenue. The safe harbor revenue provides a pathway for Shore Health to improve cost efficiency, generate retained revenue, and redeploy that revenue to meet community needs without negatively impacting its position on the Integrated Efficiency Metric.

**We support rebasing rate order volumes**

UMMS fully supports the Commission's proposal to rebase rate order volumes using FY19 data. GBR rate orders were first established in 2014 volume levels and those volumes have since only been adjusted for targeted policies and only by modest amounts. Continuing to utilize outdated volume levels creates an added level of administrative burden on both the hospitals and Commission staff in order to continually request corridor adjustments. Rate order volume was fixed in the beginning of the new model to ensure significant shifts in volume and pricing could be evaluated, as the Commission did not have another mechanism at the time to monitor such changes. Now that the Commission has an integrated efficiency model, we feel that it is no longer necessary to hold volume constant on hospital rate orders.

UMMS has concerns regarding the following areas of the RY 2022 Revised Integrated Efficiency Policy Draft Recommendation:

**Current peer groups should be retained for RY 2022 and options should be studied further**

UMMS agrees with the MHA position to further evaluate peer groups to determine the most appropriate way to evaluate hospital cost per case efficiency. Peer groups have long been an important component of the ICC and ROC methodology for many years. Peer groups have been relied upon to account for many factors contributing to a hospital's cost structure, including those that could not be well defined or quantified. This notion was even stated in the staff's draft ICC recommendation from October, 2019: 'Hospitals are divided into peer groups for comparison, recognizing that specific adjustments may not fully account for cost differences.' With this idea in mind, we believe any effort to modify peer groups should be undertaken carefully, ensuring any specific adjustments, including those related to indigent care, are extensively vetted with the industry. While the Commission staff have put forward a very thorough and thoughtful proposal, we view this proposal as one possible solution out of many, and we do not yet know if it is the best solution. We therefore propose that a decision to move to a statewide peer group be delayed to allow time to explore alternative peer group options and adjustments.

**Commission should consider a utilization TCOC Benchmark metric and further study results**

We support MHA's proposal to vet the TCOC benchmarking methodology further. As stated in their letter, the ongoing COVID pandemic has continued to require a re-allocation of resources to support hospital operations and has resulted in few resources to evaluate changes in HSCRC methodologies. The on-going public health emergency has not allowed hospitals adequate time and resources to evaluate and understand such a complex analysis and feel that more time to vet the methodology is warranted. We are committed to evaluating this methodology in depth over the course of the next several months in coordination with MHA and Commission staff. UMMS still has concerns regarding the influence of geography and price on the results and feels that an evaluation of a utilization-based methodology be considered, as expressed in our comment letter last year.

Thank you for the opportunity to provide feedback. We appreciate the HSCRC's continuous effort to evaluate and improve hospital reimbursement methodologies. If you have any questions, please do not hesitate to contact me.

Sincerely,

Alicia Cunningham

Senior Vice President, Corporate Finance & Revenue Advisory Services

cc: Adam Kane, Chairman
Joseph Antos, PhD, Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
John M. Colmers
James N. Elliott, MD
Sam Malhotra
Katie Wunderlich, Executive Director
William Henderson, Principal Deputy Director
Jerry Schmith, Principal Deputy Director
Mohan Suntha, MD, MBA, UMMS Chief Executive Officer
Michelle Lee, UMMS Chief Financial Officer

Ascension Saint Agnes

May 5, 2021

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

Dear Chairman Kane:

Ascension Saint Agnes Hospital (Saint Agnes) submits the following comments in response to the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Integrated Efficiency Policy.

Saint Agnes is committed to improving the health of the West Baltimore community and continues to take on a larger role in West Baltimore. The cost pressures inherent in serving an urban community with substantial disparities in terms of medical needs and social determinants of health, combined with the need to execute a robust population health strategy, represent significant challenges for the acute facilities serving those communities. As one of two facilities within Baltimore City that have not historically been defined as "urban" according to the HSCRC's current peer group definitions, we support the Staff's efforts to reevaluate its historic urban/non-urban peer groups, as well as efforts to quantify the impact of serving vulnerable populations and incorporate those effects into the HSCRC's measure of relative hospital efficiency.

Particularly since the elimination of the disproportionate share (DSH) measure from the Inter-Hospital Cost Comparison (ICC) in 2018, the recognition of the inherent issues with serving a community with such adverse socio demographic status has been entirely reliant upon the "urban" vs. "non-urban" peer group classification. Saint Agnes supports the HSCRC's efforts to quantify this impact on a hospital's operating structure and re-introduce adjustments that directly account for them in the ICC. Additionally, we understand the Staff's logic in its evaluation of peer groups that, if this socioeconomic impact is appropriately and accurately accounted for via direct adjustments to the ICC, it may eliminate the need for peer groups altogether.

Peer groups exist to capture cross-group differences that are not otherwise captured by direct adjustments to the ICC. Eliminating peer groups entirely requires full confidence that direct adjustments to capture such issues as socioeconomic disparity are fully and precisely captured. Saint Agnes commends the work done by HSCRC staff to reintroduce a DSH-like measure as a thoughtful start to the necessary process of appropriately quantifying the impact of socioeconomic disparities on hospital costs. Saint Agnes is committed to working with HSCRC staff to evaluate whether this adjustment appropriately captures the magnitude of a hospital's costs that directly result from serving

disparate populations and justifies elimination of the peer groups. For example, Saint Agnes has expressed in its discussions with HSCRC staff concerns around Medicaid denial rates, growing security costs, growing medical liability costs, staffing requirements to meet complex medical needs, and nurse salary issues.

Once again, Saint Agnes welcomes HSCRC staff's efforts to quantify the impact of serving populations with significant socioeconomic disparities into its relative hospital efficiency measures. Saint Agnes believes a process of evaluating whether that impact is sufficiently quantified by the proposed adjustment is key to determining whether complete elimination of peer groups is warranted and would happily support an ongoing effort to do so.

Sincerely,

Mitch Lomax
Chief Financial Officer
Ascension Saint Agnes

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

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# Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 2022 Funding to Support HIE Operations and CRISP Reporting Services

## Final Recommendation

June 9, 2021

No Comment Letters were received.

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# Table of Contents

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# List of Abbreviations

| | |
|---|---|
| BRFA | Budget Reconciliation and Financing Act |
| CMS | Centers for Medicare & Medicaid Services |
| CRISP | Chesapeake Regional Information System for Our Patients |
| CRP | Care Redesign Program |
| CRS | CRISP Reporting Services |
| EHR | Electronic Health Record |
| 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 |
| PDMP | Prescription Drug Monitoring Program |

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# Policy Overview

| Policy Objective | Policy Solution | Effect on Hospitals | Effect on Payers/Consumers | Effect on Health Equity |
|---|---|---|---|---|
| To fund Maryland's Health Information Exchange, CRISP, for activities related to the HSCRC and the Total Cost of Care Model. | Add an assessment to hospital rates that is then used to fund CRISP. | 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

This recommendation is identical to the draft recommendation and contains only minor corrections.

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) 2022 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 ($2,500,000)
- 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 ($6,740,000)

Therefore, the staff recommends the HSCRC provide funding to CRISP totaling $9,240.000, an increase of $4,070,000 (79 percent) from FY 2020. This amount represents approximately 31 percent of CRISP's Maryland funding, compared to 24 percent in FY 2021. The remainder of CRISP's Maryland funding is derived from user fees, Federal matching funds and the Maryland Department of Health (MDH).

The significant increase in the funding level is driven by 3 factors: (1) the roll-out of new programs under the Total Cost of Care Model, (2) the switch from a 10 percent State match to earn Federal funds to a 25 percent State match, as funding moves from the HITECH IAPD to MES (as described in last year's

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

recommendation), and most significantly (3) a change in Federal matching rules that allocates Federal responsibility based on the number of beneficiaries rather than the number of providers participating in Medicaid programs.

The $4,070,000 increase in HSCRC funding correlates to only a 7-percentage point increase in the HSCRC's share of funding (from 24 to 31 percent) because, simultaneously, CRISP has experienced a significant expansion in its MDH-funded public health related work. In order to minimize the funding required, CRISP has reduced the proposed FY 2022 budget by approximately 27 percent from projected FY 2021 levels.

# 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 2012** | $2,869,967 |
| **FY 2013** | $1,313,755 |
| **FY 2014** | $1,166,278 |
| **FY 2015** | $1,650,000 |
| **FY 2016** | $3,250,000 |
| **FY 2017** | $2,360,000 |
| **FY 2018** | $2,360,000 |
| **FY 2019** | $2,500,000 |
| **FY 2020** | $5,390,000 |
| **FY 2021** | $5,170,000 |

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

# Funding Through Hospital Rates

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

# 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 two programs outlined below. Beginning with the federal fiscal year starting October 1, 2021, the rules for obtaining these matches have changed from provider to beneficiary based. As a far higher percentage of providers participate in Medicaid than do State healthcare utilizers, this has reduced available Federal funding by approximately $10,000,000 on an annual basis. In addition, the HITECH IAPD program terminates September 30, 2021, moving more of the match into the MES program where the match required for ongoing programs is 25 percent versus the 10 percent from IAPD.

The two factors referenced in the prior paragraph drive the increase in the required HSCRC funding. The increase reflects the new share of programs run by the HSCRC under the Total Cost of Care Model. The lost match on general HIE operations will be funded by MDH, as these programs relate primarily to provider connectivity and other general public health initiatives.

## Implementation Advanced Planning Document (IAPD) Matching Funds

In addition to its role in HIE among providers, CRISP is also involved in health care transformation activities related to HSCRC, MHCC, and MDH. In its collaboration with the Medicaid program, uniform and broad-based funding through hospital rates can also be used to leverage federal financial participation under the Health Information Technology for Economic and Clinical Health (HITECH) Act, known as IAPD funding. Under the HITECH Act, the Centers for Medicare & Medicaid Services (CMS) may approve states for Medicaid Electronic Health Record Incentive Program funding, and states receive a 90 percent federal financial participation match for expanding HIE through September 30, 2021. This request will enable CRISP (working with MDH) to obtain federal funding. IAPD funding allows CRISP (working with MDH) to qualify for funding to implement HIE use cases.

Activities enabled through IAPD that enhance the point of care delivery include encounter notification services, practice-level advanced-implementation support, ambulatory integration, hospital integration, and image exchange. Common infrastructure activities include data routing and consent management, technical infrastructure and operations expense, and data architecture. Finally, there are a number of public health reporting initiatives as well, including public health use case management, electronic lab reporting, MDH interface development and validation, and CMS Clinical Quality Measures reporting.

As discussed above, this funding source will end after September 30, 2021 and CRISP anticipates moving this funding to the MES funding described below.

## 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 set. CRISP reporting from these datasets is used by hospitals, the HSCRC and other stakeholders to manage and track progress under a number of HSCRC programs and enable hospitals to identify and pursue care efficiency initiatives.

In FY 2021, CRISP was able to obtain funding under MES to a greater degree than anticipated in the assessment request. In addition, the implementation of certain reporting initiatives was delayed because of the COVID crisis and other program changes. As a result of these two factors, there was a funding balance remaining from FY 2021, which will be retained by the HSCRC and disbursed to CRISP as relevant projects are completed.

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.

# Description of Activities Funded

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

## 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.

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

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 2021 for the HIE function is $2,500,000.

## 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 new Total Cost of Care Model, providers will need a variety of tools to manage high-needs and complex patients that CRISP is currently working to develop and deploy.

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 Total Cost of Care Model

(2) Funding for program administration related to programs under the Total Cost of Care 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 $6,740,000.

In FY 2021, CRISP offered hospitals a discount on user fees in return for meeting defined standards for submission of data to CRISP. A total of 37 hospitals participated in the program and successfully improved their data feeds, thereby driving significant value to the healthcare system. Staff recommend that, in the

future, the Commission consider assessing non-compliance penalties under the Commission's regulatory authority because even limited non-compliance erodes the value of the data collected and the investment made by the rest of the system.

# Staff Recommendation

Staff is recommending the Commission approve a total of $9,240,000 in funding through hospital rates in FY 2022 to support the HIE and continue the investments made in the Total Cost of Care Model initiatives through both direct funding and obtaining Federal MES matching funds.

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

*Table 2. FY 2021 Recommended Rate Support for CRISP as a share of estimated total Maryland Funding*

| FY 2021 Project Name | Hospital Rates | Federal Budgeted Funding | User Fees | MDH | Total |
|---|---|---|---|---|---|
| HIE Operations | $2,500,000 | $2,580,000 | $4,400,000 | $2,920,000 | $12,400,000 |
| Reporting and Program Administration | $6,740,000 | $1,836,000 | $0 | $324,000 | $8,900,000 |
| Other non-HSCRC programs | $0 | $2,340,000 | $275,000 | $5,760,000 | $8,375,000 |
| **Total Funding** | **$9,240,000** | **$6,756,000** | **$4,675,000** | **$9,004,000** | **$29,675,000** |
| **% of Total** | **31%** | **23%** | **16%** | **30%** | **100%** |

# Final RY 2022 Funding Recommendation for the Maryland Patient Safety Center (MPSC)

June 9, 2021 Commission Meeting

maryland health services cost review commission

# MPSC Draft Recommendations Stakeholder Feedback

Ten commenters submitted letters supporting staff recommendations as well as additional funding for the Clean Collaborative Phase V; specific comments are listed below.

- **MPSC is successful convenor-** The center has demonstrated for many years the ability to bring all sectors of health care together within our state to improve the quality and safety of patient care.
- **COVID-19 pandemic response**- MPSC has established programs targeted at preventing infectious disease transmission in Long Term Care, supporting front-line hospital staff during stressful events (such as the pandemic) and addressing racial disparities in the delivery of care.
- **Clean Collaborative Phase III promising preliminary results-** Preliminary results have shown a decline in the incidence of infections and ED visits at the facilities and improvement in overall cleanliness; preventing these infections and the hospital visits associated with them is good healthcare.
- **Potential to reduce costs-** Reducing the incidence of LTC resident visits to Emergency Departments and hospital inpatient admissions is less expensive healthcare for the state, since preventing disease is less expensive than treating it, making it an overall good investment.

# MPSC RY 2022 Final Funding Recommendations

1. Consistent with prior Commission recommendations, the HSCRC should reduce the amount of **unrestricted** funding support for the MPSC in FY 2022 by 75 percent from the FY 2019 HSCRC unrestricted grant amount of $492,075. The result is an adjustment to hospital rates in the amount of $123,028.
2. As a condition of funding from the hospital rate setting system, the MPSC should continue to report annually on data that it has collected from hospitals and other facilities that participate in its quality and safety initiatives and should demonstrate, to the extent possible, the ways in which MPSC initiatives are producing measurable gains in quality and safety at participating facilities.
3. MPSC requests additional funding from HSCRC that will be **restricted for targeted projects** that align with the statewide TCOC Model's quality and safety goals, and which the Commission can consider on a case-by-case basis.

    a. For FY 2022, staff recommends that the HSCRC fund an additional $125,000 for the Clean Collaborative Phase III for Long-Term Care project completion, which began and was funded in FY 2021.

4. The MPSC should continue to pursue strategies to achieve long-term sustainability through other sources of revenue, including identifying other provider groups that benefit from MPSC programs, as FY 2022 will be the final year of unrestricted funding from the HSCRC.

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# Final Recommendation on Continued Financial Support for the Maryland Patient Safety Center for FY 2022

June 9, 2021

This is the final staff recommendation for vote at the June 9, 2021 Commission meeting.

## Table of Contents

# LIST OF ABBREVIATIONS

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

# POLICY OVERVIEW

| Policy Objective | Policy Solution | Effect on Hospitals | Effect on Payers/ Consumers | Effect on Health Equity |
|---|---|---|---|---|
| The final MPSC Recommendation seeks to continue funding the successful patient safety initiatives demonstrated in FY 2021. | The MPSC is part of a multi-pronged strategy to assess, target and improve Patient Safety. Interventions MPSC employs include learning on safety improvement methods, and collaborations among hospitals and other providers to improve safety. | The MPSC portfolio of initiatives involves working directly with hospitals on quality improvement training, collaboratives to implement best practices, caring for the caregiver, and convening hospitals with LTC partners to reduce infections and related outcomes such as readmissions to the hospital. | The MPSC funding supports continued work to engage patients and families and elected officials representing consumers in defining areas of concern where MPSC should work, and implementing Patient Family Advisory Committees, among other areas. | The MPSC work targets important areas for improving health equity that include such issues as improving COVID vaccine hesitancy among Black and Brown people and training perinatal providers on implicit bias and its negative effects, directly aligning with the SIHIS goal on reducing SMM outcomes. |

# RECOMMENDATIONS

HSCRC staff provides the following final recommendations for the MPSC funding policy for FY 2022:

1. Consistent with prior Commission recommendations, the HSCRC should reduce the amount of **unrestricted** funding support for the MPSC in FY 2022 by 75 percent from the FY 2019 HSCRC unrestricted grant amount of $492,075. The result is an adjustment to hospital rates in the amount of $123,028.
2. In order to receive funding from the hospital rate setting system, the MPSC should continue to report annually at a minimum on data that it has collected from hospitals and other facilities that participate in its quality and safety initiatives and should demonstrate, to the extent possible, the ways in which MPSC initiatives are producing measurable gains in quality and safety at participating facilities.
3. MPSC requests additional funding from HSCRC that will be **restricted for targeted projects** that align with the statewide TCOC Model's quality and safety goals, and which the Commission can consider on a case-by-case basis.
    a. For FY 2022, staff recommends that the HSCRC fund an additional $125,000 for the 18-month Clean Collaborative Phase III for Long-Term Care project completion, which began and was funded in FY 2021.
4. The MPSC should continue to pursue strategies to achieve long-term sustainability through other sources of revenue, including identifying other provider groups that benefit from MPSC programs, as FY 2022 will be the final year of unrestricted funding from the HSCRC.

# INTRODUCTION

In 2004, the Maryland Health Services Cost Review Commission (HSCRC or Commission) adopted recommendations to provide seed funding for the Maryland Patient Safety Center (MPSC) through hospital rates, with the initial recommendations funding 50 percent of the budgeted costs of the MPSC. In FY 2021, HSCRC funds accounted for 13 percent of MPSC's total budget. FY 2022 represents the last year of unrestricted funding for MPSC, as it will transition to a self-sustaining resource moving forward.

Under the Total Cost of Care Model (TCOC Model), it is increasingly important that patient safety and quality of care improve across all care settings. The key stakeholders that are involved with the MPSC include hospitals, patients and families, physicians, long-term care and post-acute providers, ambulatory care providers, and pharmacy – all groups that are critical to the success of the TCOC Model. To achieve mutual healthcare goals for these stakeholders, MPSC prioritizes the Center's collaborations with Maryland's key health policy agencies including the Maryland Department of Health (MDH), the Maryland Health Care Commission (MHCC), the HSCRC and the Office of Health Care Quality (OHCQ). The MPSC is in a unique position in the State to develop and share best practices among these key stakeholders, avoiding duplicative efforts and reducing costs. MPSC is also favorably positioned to act as a convener for hospital and non-hospital providers in Maryland to support provider sharing of best practices and disseminate data that will help them succeed under the TCOC Model. It is imperative that MPSC partner closely with those private sector providers, including hospitals, nursing homes, and skilled nursing facilities, in order to continue this important work once the HSCRC funding has ended. Indeed, as evidenced by this report, MPSC has positioned itself as a resource to hospitals and LTC providers and as such have been awarded additional partnership funds directly by hospitals.

Key current MPSC hospital and non-hospital projects that particularly align with the TCOC model goals include:

- **HRSA Maryland Maternal Health Innovation Grant (known as MDMOM)[1]—** MPSC has recruited all 32 birthing hospitals in the State into their program, which provides implicit bias trainings to care providers at these hospitals. This training program is critical to improving maternal mortality and morbidity and reducing health disparities in particular. ***This work directly aligns with the State Integrated Healthcare Improvement Strategy (SIHIS) goal of reducing disparities in severe maternal morbidity (SMM).***
- **Clean Collaborative Phase III for Long Term Care—** Last year, due to the devastation nursing homes faced during the COVID PHE, the Commission voted to provide restricted funding to MPSC to initiate an 18-month collaborative for ten LTCs across the state. Among the goals were to reduce Emergency Department visits and hospital readmissions. Following recruitment and ramp-up, data collection began in October 2020. Early results are provided later in this report, but trends are demonstrating a reduction in infection related ED visits and hospital admissions, and therefore the total cost of care.
- **Clean Collaborative Phase IV: HSCRC Hospital Partnership Grants with Long Term Care—** Recognizing the value of Phases I and II of the MPSC Clean Collaborative, three hospital systems have partnered with MPSC and are currently working with fourteen LTC partners under the HSCRC Partnership Grants. While it is very early in the data collection process which began in December 2020, early results look promising in reducing infection related ED visits and hospital admissions as well as impacting the reduction of COVID -19 positivity rates in residents and staff at the participating LTC facilities.

The HSCRC collaborates with MPSC on projects as appropriate and reviews an annual briefing on the progress of the MPSC in meeting its goals, as well as an estimate of expected expenditures and revenues for the upcoming fiscal year. Based on both the FY 2021 project outcomes and the projected FY 2022 budget, staff makes recommendations to the Commission regarding the continued financial support of the MPSC. In 2019, the Commission approved a recommendation to decrease the funding

[1] MPSC is a sub-awardee in the Johns Hopkins Bloomberg School of Public Health $10.3 million five-year HRSA grant to improve maternal health in Maryland.

by 25 percent each subsequent year from the FY 2019 levels such that HSCRC funding would conclude after FY 2022. In May 2021, the HSCRC received the MPSC program plan update for FY 2022. The MPSC is requesting a total of $123,028 in unrestricted funding, a 75 percent decrease over the FY 2019 budget, representing 7 percent of the total MPSC 2022 budget, consistent with the Commission's intent to reduce State funds over time and encourage a sustainable business model for the MPSC.

In addition to the $123,028, MPSC is proposing that the Commission consider two options: the first is a request for restricted funding to complete the Clean Collaborative PHASE III with LTC that HSCRC funded in FY 2021, in the amount of $125,000; the second is funding to convene an additional LTC Clean Collaborative with a new cohort of ten LTC facilities in the amount of $275,000. The restricted funding request from the HSCRC for FY 2022 ranges from $125,000-$400,000 and is detailed in the Budget sub-section under the Assessment section. At this time, staff is not recommending funding for the Phase V LTC Clean Collaborative. Instead, MPSC should pursue direct funding with hospitals and LTC facilities to disseminate best practices around infection control that can lead to better health outcomes and lower ED utilization.

# BACKGROUND

The 2001 General Assembly passed the Patients' Safety Act of 2001,[2] charging the Maryland Health Care Commission (MHCC)—in consultation with the Maryland Department of Health (MDH)—with studying the feasibility of developing a system for reducing the number of preventable adverse medical events in Maryland, including a system of reporting such incidences. The MHCC subsequently recommended the establishment of the MPSC to improve patient safety in Maryland.

In 2003, the General Assembly endorsed this concept by including a provision in legislation to allow the MPSC to have medical review committee status, thereby

[2] Chapter 318, 2001 Md. Laws.

making the proceedings, records, and files of the MPSC confidential and not discoverable or admissible as evidence in any civil action.[3]

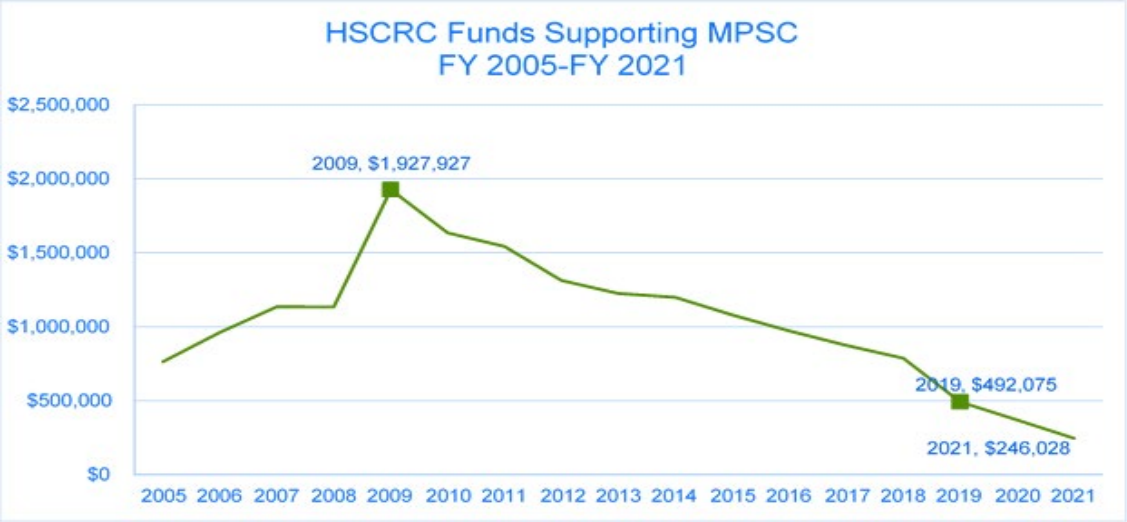
The MHCC selected the Maryland Hospital Association (MHA) and the Delmarva Foundation for Medical Care (Delmarva) through the State's Request for Proposals (RFP) procurement process to establish and operate the MPSC in 2004, with an agreement that the two organizations would collaborate in their efforts.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

Over the past 17 years, the HSCRC included an adjustment to the rates of eight Maryland hospitals to provide funding to cover the costs of the MPSC. Funds are transferred biannually. Although funding increased between FY 2005 and FY 2009, the level of HSCRC support has declined each year since FY 2009, consistent with the original intent to scale back State-funded support. In FY 2019, the Commission approved a recommendation to decrease the funding by 25% each subsequent year from the 2019 levels such that HSCRC funding would conclude after FY 2022. **Figure 1**

[3] MD. **CODE**. ANN., Health-Gen. § 1-401(b)(14);(d)(1).

below shows the HSCRC's funding level in support of the MPSC over time.

Figure 1. HSCRC Unrestricted Funds Supporting MPSC FY 2005-FY 2021




# ASSESSMENT

## Strategic Priorities and Partnerships

The MPSC's mission is **Keeping Maryland health care safe**. Its 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 health care to all.

The MPSC's goals are to:

- Achieve zero preventable harm across all levels of health care;
- Foster a shared culture of safety, compassion, and respect among all providers;
- Enhance patient experience by involving patients and families in all aspects of their care; and
- Support caregivers to ensure resiliency and prevent burnout.

To accomplish its mission, vision, and goals, the MPSC established and continues to build upon its strategic partnerships with an array of key private and public organizations.

## MPSC Members and Partnerships

As of FY 2021, MPSC has 50 paid member facilities (increased from 45 from last year), including 45 hospitals, two rehabilitation hospitals, one long-term care facility one ambulatory center, and one addiction recovery center. Additionally, MPSC provided 24 complimentary FY 2021 memberships to all Phase III and Phase IV Clean Collaborative long term care participants. Membership fees provide the largest portion of MPSC's FY21 annual revenue. Paid membership provides member organizations with unlimited staff participation at education sessions and conferences free of charge or at a significantly reduced rate (Six Sigma, Lean for Healthcare, and TeamSTEPPS® Master Trainer).

MPSC actively seeks patient and family participation in MPSC leadership and initiatives. Their perspective is included on a majority of collaboratives and projects. Patients and families are represented by two board members. In addition, the Maryland legislature is represented by two members of the board and the MHCC is represented by one board member.

With regard to expanding membership to non-hospital entities, MPSC notes that they actively seek membership from non-hospital organizations by offering in-person educational programs and webinars free of charge. MPSC has recently begun negotiating with Federally Qualified Health Centers regarding potential membership. Through their efforts to engage non-hospital members, MPSC notes that:

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

The **Mid-Atlantic Patient Safety Organization (MAPSO)**, a component of the MPSC, includes **43 members** representing hospitals and long-term care facilities. **Membership is separate from MPSC and is voluntary.** The primary activities of the MAPSO are to improve patient safety and healthcare quality by collecting adverse event reports and holding Safe Tables for members. Safe Tables are a forum conducted under the federal law establishing Patient Safety Organizations (PSOs),

such as MAPSO, at which healthcare professionals convene and have open dialogues about patient safety and quality issues. Frank and transparent discussions are encouraged in these legally and privileged settings held for MAPSO member organizations only. MAPSO held the last Safe Table in October 2019, and due to the pandemic has cancelled them since. AHRQ has provided guidance for virtual Safe Tables to assure confidentiality; a survey of members is currently underway to explore this option. MAPSO has collected, analyzed and trended over 96,000 adverse events from 13 facilities, with 15,000 in the last 12 months.

The MPSC identifies 15 strategic partners in FY 2021:

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

- **Lifespan**
- **State entities -** HSCRC, MHCC, MDH, OHCQ

## FY 2021 Maryland Patient Safety Center Activities and Accomplishments

MPSC initiatives have engaged providers in hospitals, long-term care facilities, and ambulatory care facilities, as well as patients and consumers. MPSC uses a collaborative model to bring together providers from across the care spectrum to learn best practices to improve care and outcomes. MPSC uses the Berkley Research Group to verify and analyze data collected from hospitals and other providers participating in MPSC initiatives, as well as to provide return on investment figures. Highlights from FY 2021 are provided below in the sections that follow

### Collaboratives

**Clean Collaborative Phase III for Long Term Care:** In consideration of SARS-CoV-2 challenges surrounding the high rates of infection and death in LTC facilities, MPSC used designated funding from HSCRC to initiate an 18-month collaborative for ten LTCs across the State. Nineteen LTC facilities applied, and the project had capacity for ten to participate. The collaborative provides the facilities with tools to establish cleaning and disinfection procedures, as well as access to technologies to substantiate validation of cleanliness. Using a collaborative model, the facilities share best practices, participate in educational webinars and collaborative calls. Data collection began in October 2020 and will be completed in March 2022, should the funding be approved to conclude the eighteen-month collaborative.

The goals of the collaborative are to:

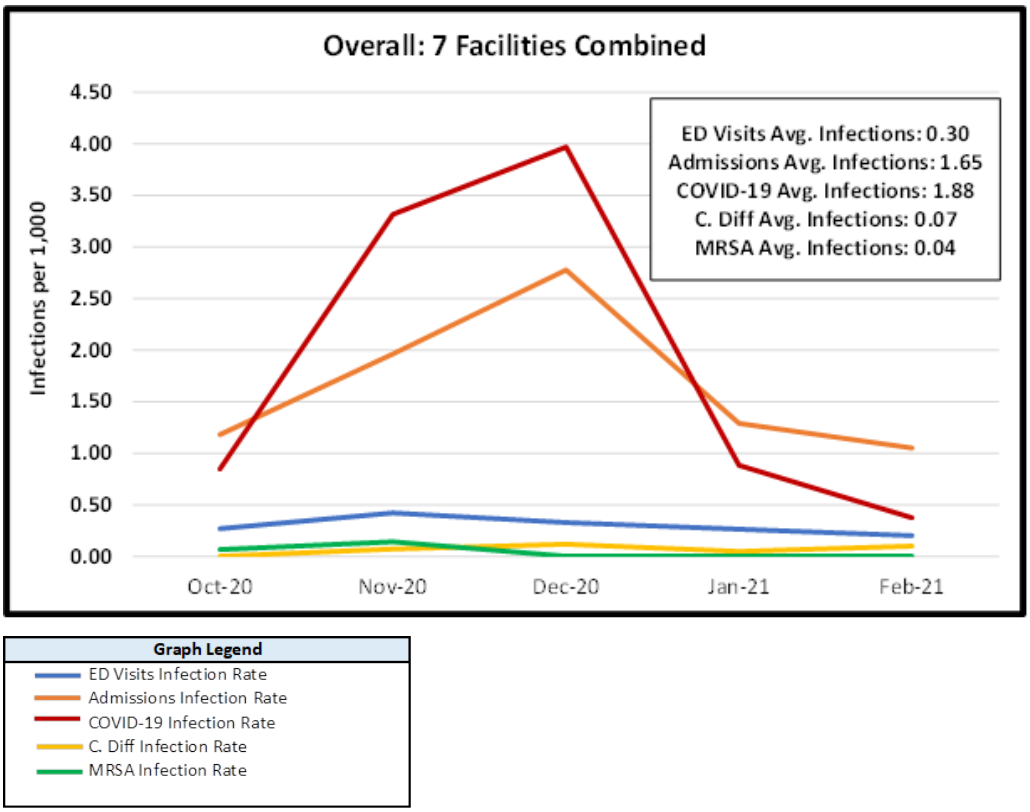
1. Reduce the collaborative average relative light units (measure of cleanliness) of specified surfaces sampled.
2. Reduce emergency department visits for infection-related diagnoses.
3. Reduce hospital admissions for infection-related diagnoses.

4. Reduce facility acquired cases of COVID-19, MRSA and C-Difficile

Results to date:

The Clean Collaborative Phase III outcome data is early in the collection process, but as illustrated in Figure 2 below, data from seven of the ten facilities shows promising trends in infection related ED visits and hospital admissions from October 2020 to February 2021. We expect CRISP to provide us with Medicare claims data for the ten participating facilities to compare this trend in June 2021.

**Figure 2: Clean Collaborative Phase III-LTC Infection related data N= 7 of 10**




**Clean Collaborative Phase IV: Hospital partnership grants with Long Term Care**

Three hospitals, recognizing the value and effectiveness of Phase I and II of the Clean Collaborative, partnered with MPSC to work with them on their applications and awards of HSCRC Hospital Partnership grants. Phase IV of the Clean Collaborative is the result of those partnerships. Frederick Health System (with 10 long-term care partnership facilities), Luminis Doctors Hospital (with one long-term care partner facility), and Luminis Anne Arundel Medical Center (with three LTC partners) have included MPSC's Clean Collaborative as a sub-awardee in their approved partnership grants. These facilities kicked off the project in November 2020 and began data collection for a one-year period in December 2020. Early data for these partnerships is also promising with the data we have from December 2020 to February 2021, but we do not yet have enough data to report.

## Additional FY 2021 Initiatives and Activities

In addition to the above collaboratives, MPSC engaged in the following activities and initiatives in FY 2021:

**Caring for the Caregiver: Implementing Resilience in Stressful Events (RISE) Program**– MPSC continues to grow participation in the program, a partnership with the Johns Hopkins Armstrong Institute. To date, domestic and international participants include 68 different hospitals, four provider groups, and one School of Nursing. The program provides training that assists in establishing a peer responder program to provide immediate, confidential, "psychological first aid" and emotional support to "second victims" following work-related traumatic events. MPSC closed FY 2020 with $431,000 in gross sales, of which MPSC will receive $172,400, and total gross sales for FY 2021 are projected around $300,000.

An economic evaluation of the cost benefit of the *Caring for the Caregiver: Implementing RISE* program was conducted by the Johns Hopkins Armstrong Institute for Patient Safety and Quality, MPSC's partner and subject matter experts for this program. The study found a net monetary benefit savings of $22,500 per nurse who initiated a peer support encounter through the program at a 1,000-bed hospital. These savings were determined to be 99.9% consistent on the basis of a probability sensitivity analysis with an impact that revealed a 1,000- bed hospital could save $1.81 million each year in personnel costs because of the program. Twenty-two Maryland hospitals have implemented Caring for the Caregiver. Based on the cited study, and averaging across the twenty-two hospitals participating in Maryland, a cost savings of approximately $10 million can be estimated for the state per year.[4]

While this study was specific to utilization by nurses, it is important to recognize that the *Caring for the Caregiver* program is not discipline specific. A 2018 article from the American Medical Association stated that the organizational cost of physician burnout

[4] Dane Moran, MPH,*† Albert W. Wu, MD,*† Cheryl Connors, MS,‡ Meera R. Chappidi, MPH,*†,Sushama K. Sreedhara, MBBS,† Jessica H. Selter, MD,* and William V. Padula, PhD. "Cost-Benefit Analysis of a Support Program for Nursing Staff", Journal of Patient Safety, Volume 00, Number 00, Month 2017

can range from $500,000 to more than $1 million per doctor.[5] This estimate includes recruitment, sign-on bonuses, lost billings and onboarding costs for replacement physicians. Providing programmatic peer support to physicians and other healthcare staff will generate additional attrition-related monetary benefit while also improving clinical effectiveness and reducing avoidable patient harm.

The rapid growth of this program has created unique opportunities to evolve. MPSC is in the process of developing an online *Caring for the Caregiver: Implementing RISE* training program through the internationally known Siemens Healthineers, and recently added a training partner from Denver Health to assist with expansion efforts in the Mountain Region and the West Coast.

**HRSA Maryland Maternal Health Innovation Grant—** MPSC was named as a sub-awardee in the Johns Hopkins Bloomberg School of Public Health $10.3 million five-year HRSA grant to improve maternal health in Maryland. The project is known as MDMOM (www.mdmom.org). MPSC, through its strong relationships with the Maryland birthing hospitals, will facilitate implicit bias training, training on stigma associated with opioid use disorder in pregnancy, and provide quality improvement training for hospital maternal units. In FY 2020 MPSC conducted a needs assessment survey with a 100% return rate from the birthing hospitals related to implicit bias and stigma. Eight hospitals began the training in February 2021. Phase IIA kicked off in April and Phase IIB will kick off in June.

**Opioid Education for Consumers—**In FY 2020 MPSC joined with the Rx Abuse Leadership Initiative (RALI) of Maryland, an alliance of more than 20 local, state and national organizations committed to finding solutions to end the opioid crisis in Maryland. MPSC continues to provide complimentary consumer education through our e-Learning platform.

[5] Source: https://www.ama-assn.org/practice-management/physician-health/how-much-physician-burnout-costing-your-organization ; last accessed 5/1/2021.

**Diagnostic Errors:** MPSC served as a consultant to MedStar, which was awarded an AHRQ grant to develop a new TeamSTEPPS® module to improve communication among the healthcare team in ambulatory settings to improve diagnosis. This consultative invitation is a result of Maryland's long history of provision of TeamSTEPPS® training and early work convening experts in improving diagnosis. In addition, MPSC was one of the earliest organizational members of the Society to Improve Diagnosis in Medicine (SIDM).

**Patient Safety Officer Forums and PSO list serv—** MPSC convenes quarterly forums for patient safety officers, quality improvement staff, risk managers, and others interested in patient safety across the State. The one-hour fora have been offered virtually every other month this year. These fora provide the opportunity for topic-driven exchange of ideas pertaining to issues of interest to this group. The MPSC manages a PSO list serv that supports this group and is an active means for quick exchange of best practices, ideas, and concerns across the State. Participants are from acute care, long term care, specialty hospitals, and State entities such as OHCQ.

**Patient Safety Certification and Organization Specific Education**– MPSC offers Patient Safety Certification and Education to healthcare organizations with facility specific consultation. Most recently (in 2020) **UM Capital Region Health** was certified for increasing near-miss reporting by 44%, decreasing serious adverse events by 80%, and reducing Hospital Acquired Infections (HAIs) by 67%.

**Patient and Family Advisory Councils for Quality and Safety (PFACQS®)** – The PFACQS® Program, a partnership between MPSC and MedStar Health, was 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 many healthcare systems have invested in patient and family advisory councils to ensure patient-centered care and patient satisfaction, very few have recognized the full potential of these councils to

improve core quality and safety measures as well as operational and financial performance.

## Activities initiated or Adapted in Response to COVID-19 Pandemic

In an effort to provide the healthcare community with support and resources related to the COVID-19 pandemic MPSC has initiated or adapted its initiatives as outlined below.

**Caring for the Caregiver: Implementing RISE**– MPSC shared a series of interventions on social media specific targeting COVID-19. Additionally, MPSC provided a FREE training manual with tips for effective and efficient peer support to organizations upon request; distributing over 130 copies worldwide.

**PFACQS® --**MPSC recognizes that as a result of COVID-19 some patients are anxious, ill, and possibly facing death while separated from their loved ones. This has resulted in healthcare providers engaging in tough conversations with families in untraditional ways. Strategies for successful decision-making, communication, and patient experience have been challenged. MPSC in collaboration with the MedStar Institute for Quality and Safety (MIQS) presented, “Patient and Family Engagement During COVID-19: What can we do? How can we help?” a complimentary one-hour live webinar discussion on ideas and resources to effectively engage patients, families and the patient and family advisory council during these difficult times. There were just over 330 registrants and the recorded session and resource guide remains available on the MPSC website.

MPSC and MIQS will offer another complimentary webinar on May 6, 2021 titled, “Exploring the Role of PFACs in a COVID-Shaped World”. An innovative panel of experts will discuss deploying Patient and Family Advisory Councils to address the post-COVID transformation of care including the needs of the long-haul COVID patient, the shift to Tele-health, visitations policies, behavioral healthcare needs exacerbated by the pandemic, and delayed diagnosis with reluctance to seek care.

**Vaccine Acceptance Among Communities of Color Series**—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 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 650 unique registrants representing more than 170 different organizations and the recordings of all three sessions remain available for viewing on the MPSC website along with attendant resource guides.

## Educational Programs and Conferences

### *Safety Tools Education*

Customized educational programs for MPSC members are driven by changing needs of members and the healthcare industry. In FY 2021 the following educational programs were offered virtually, in deference to realities during the COVID-19 pandemic. Educational programs via live webinars included:

- Root Cause Analysis (RCA)
- Failure Modes and Effects Analysis (FMEA)
- TeamSTEPPS® Train the Trainer
- TeamSTEPPS® Master Trainer
- Six Sigma Green Belt Certification
- Lean for Healthcare

Also, as a result of the pandemic, MPSC recognized a need for greater flexibility in learning opportunities and therefore implemented a new enduring education format through our e-Learning website, making the following courses accessible to registrants 24/7 to take when convenient:

- Appreciative Inquiry

- Opioid Education for Consumers
- Performance Improvement Series- 1. Change Management

***Safety Conferences***

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

- Participants from acute care hospitals, long term care, rehabilitation hospitals, ambulatory surgery centers, state agencies, quality improvement organizations
- Continuing education credits are provided for multiple specialties.
- The spring 2020 conference was postponed due to the COVID-19 pandemic and rescheduled to September 9, 2020, therefore two Annual Maryland Patient Safety Conferences were held during FY 2021:
  - September 9, 2020: 16th Annual Maryland Patient Safety Conference
    - "Putting the Patient at the Center of Patient Safety
    - 1645 registrants

  April 29, 2021: 17th Annual Maryland Patient Safety Conference

  "Healing Our Healer: Organizational solutions for safety and wellbeing"

  1140 registrants

The **Medication Safety Conference draws** 200 to 500 registrants annually and is held in the fall. There were 341 registrants for the November 13, 2020 virtual conference – "Facing the Challenges Unmasked by COVID-19".

- Participants include medication safety officers, pharmacists, quality improvement professionals, other disciplines
- Continuing education credits are provided.
- MPSC plans to hold the FY 2022 conference on November 5, 2021

## FY 2022 Projected Budget

MPSC expects to continue the work of the following initiatives, programs, education, and conferences in FY 2022 with the requested $123,028:

- Mid-Atlantic PSO

- Safety Tools Education
- Safety Conferences
- Opioid Education for Consumers
- Diagnostic Errors
- Maryland Maternal Health Innovation program- implicit bias, etc training
- PFACQS
- Patient Safety Officer Forums
- Patient Safety Certification/Education
- Caring for the Caregiver
- Health Equity – Maternal Health Equity and COVID vaccine hesitancy

MPSC anticipates increased revenue from membership and sales of the *Caring for the Caregiver Program*. Program sales for PFACQS® are projected and some grant funding has been obtained. Other grant opportunities will continue to be explored. These amounts are reflected in the FY 2022 proposed budget Version A outlined in Appendix A. Consistent with FY 2021, most of the revenue anticipated in FY 2022 is derived from membership dues and conference revenue. In consideration of the tremendous patient safety needs identified with the COVID-19 pandemic, MPSC is proposing in Version A of the budget that funding in the amount of $125,000 be designated and restricted to complete the 18-month *Clean Collaborative Phase III for Long Term Care*. This work is scheduled to be completed with data collection in March 2022.

Additionally, MPSC is ready and able to conduct projects in FY 2022, particularly on Infection Control and Prevention in LTC facilities throughout the State; these projects are described below in “FY 2022 Additional Budget Requests/Proposals”.

Should HSCRC elect not to fund the continuation of the *Clean Collaborative PHASE III for LTC* project, budget B in Appendix A is proposed.

### FY 2022 Additional Budget Requests/Proposals

In addition to the completion of the Clean Collaborative Phase III for LTC as included in Version A of the budget (Appendix A) above, MPSC is also requesting that there be designated funding for ten more LTC facilities- Clean Collaborative Phase V. This Phase will replicate the work of Phase III with ten additional LTC facilities to: (1) identify best practices for cleaning and disinfecting hard and soft surface areas throughout the facility and (2) to educate and promote best management practices via webinars, collaborative calls, face to face meetings and onsite consultation and evaluation. Through collection of quantitative data on a monthly basis each facility will be able to respond to and evaluate changes in products, frequency and cleaning practices in their facility.

Phase V will also be an 18-month collaborative if it is funded. MPSC will provide subject matter experts and an experienced infection preventionist to consult and evaluate through site visits with participating facilities. Estimated Phase V collaborative cost: $275,000 Year 1 (FY 2022); $125,000 Year 2 (FY 2023).

**Total additional request for FY 2022:**
**Clean Collaborative Phase III completion: $125,000**
**Clean Collaborative Phase V: $275,000**
**Total Restricted Funding requests: $400,000**

Budget Plan C (Appendix A) presents revised revenues and expenses with the optional projects outlined above included. Staff is not recommending HSCRC funding for this project. Instead, MPSC should pursue direct funding with hospitals and LTC facilities to disseminate best practices around infection control that can lead to better health outcomes and lower ED utilization.

## MPSC RETURN ON INVESTMENT

As noted in the last several Commission recommendations, the HSCRC provides funding for the MPSC with the expectation that there will be both short- and long-term

reductions in Maryland healthcare costs, particularly related to such outcomes as reduced mortality rates, lengths of stay, patient acuity, and malpractice insurance costs.

**Clean Collaborative Phase III for LTC**

Early data shows that the Clean Collaborative in LTC is reducing infection related ED visits and hospitalizations from our participating LTCs. Although, it is too early to quantify this ROI in dollars, as noted previously the early trend shows a reduction in infection related ED visits and hospital admissions, which impact the total cost of care.

**Clean Collaborative Phase IV: HSCRC Hospital Partnership Grants with Long Term Care**

As noted earlier, there is not enough data available yet, but early results look promising regarding a reduction in ED visits and hospitals admissions.

**Vaccine Hesitancy**

Addressing and acknowledging the underlying issues associated with COVD-19 vaccine hesitancy is an important step in restoring trust as we undertake a statewide vaccination campaign. Although the increases in healthcare workers and communities of color vaccine rates cannot be completely attributed to our educational offerings**, *MPSC work in this area has received overwhelming positive feedback from the 650 unique registrants representing more than 170 different organizations that participated*.**

**Caring for the Caregiver: Implementing RISE**

Johns Hopkins Medicine has shown that their RISE program saves $22,576.05 per nurse who uses the peer support system to handle a stressful event. The budget impact analysis revealed that a hospital could save US $1.81 million each year because of the *Caring for the Caregiver: Implementing RISE* program. (Journal of Patient Safety, 2017)**.**

Additionally, in a 2018 article from the American Medical Association, the organizational cost of physician burnout is quantified between $500,000 to more than $1 million per

doctor. This estimate includes recruitment, sign-on bonuses, lost billings and onboarding costs for replacement physicians.

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

# STAKEHOLDER FEEDBACK AND RESPONSES

HSRC staff received ten comment letters in response to the draft recommendations from the submitters listed below. Staff notes that the letters support staff's recommendations, and also add support for funding the Clean Collaborative Phase V for Long Term Care proposed by MPSC which replicates the Clean Collaborative Phase III work with 10 additional LTC facilities.

- Cherif Boutros, MD, MSc, FACS, FACG, Assoc. Prof. of Surgery, UMD School of Medicine, Medical Director, Tate Cancer CenterChief, Surgical Oncology, UMD Baltimore Washington Medical Center, MPSC Board member
- Barbara Epke, Former Vice President, LifeBridge Health, Inc. & Sinai Hospital of Baltimore, Vice Chair MPSC Board
- Badia Faddoul, DNP, RN, CCRN, CPHQ, Sr. Director of Quality and Safety, Johns Hopkins Home Care Group
- Kathy Graning, Vice President, Clinical Services, Keswick Manor, Clean Collaborative LTC Phase III participant
- Deborah Graves, President, Levindale Geriatric Center, MPSC Board member
- Kevin D. Heffner, President & CEO, LifeSpan Network
- Heather Kirby, Vice President of Integrated Care Delivery & Chief of Population Health, Frederick Health, Clean Collaborative Phase IV hospital and LTC partners participant
- Traci LaValle, Senior Vice President, Quality and Health Improvement , Maryland Hospital Association

- Del. Sheree Sample-Hughes, Maryland House of Delegates, District 37A, MPSC Board member
- Barbara Tachovsky, MSN, RN, NEA-BC, FACHE, Former President, Mainline Hospitals, Paoli, PA, MPSC Board member

Commenters' key reasons for supporting staff recommendations as well as additional funding for the Clean Collaborative Phase V are listed below.

**MPSC is a successful convenor-** The center has demonstrated for many years the ability to bring all sectors of health care together within our state to improve the quality and safety of patient care.

**COVID-19 pandemic response**- MPSC has established programs targeted at preventing infectious disease transmission in Long Term Care, supporting front-line hospital staff during stressful events (such as the pandemic) and addressing racial disparities in the delivery of care.

**Clean Collaborative Phase III promising preliminary results-** Preliminary results have shown a decline in the incidence of infections and ED visits at the facilities and improvement in overall cleanliness; preventing these infections and the hospital visits associated with them is good healthcare.

**Potential to reduce costs-** Reducing the incidence of LTC resident visits to Emergency Departments and hospital inpatient admissions is less expensive healthcare for the state, since preventing disease is less expensive than treating it, making it an overall good investment.

**STAFF RESPONSE**

Staff appreciates the comments in support of the work of the MPSC and HSCRC's FY 2022 recommendations to provide some unrestricted funding as well as funding for completing the Clean Collaborative Phase III for Long Term Care. Staff notes that the last year's recommendation was drafted in the midst of and in response to the COVID 19 pandemic as it was continuing to unfold and prior to the availability of vaccines. Staff applauds the early signs of success in both Clean Collaboratives Phases III (LTC) and IV (hospital and LTC partners). At this time, staff recommendations remain unchanged

from the draft recommendations. As always, the Commission has the option to amend the recommendations based on the stakeholder feedback above.

# RECOMMENDATIONS

Quality and safety improvements are the primary drivers to achieve the goals of reduced potentially avoidable utilization and reduced complications in acute care settings under the TCOC Model. MPSC has demonstrated value to Maryland hospitals, as demonstrated by the partnerships that they have formed. Individual hospitals across the State are experimenting with strategies to improve care coordination, enhance processes for better care, and advance systems and data sharing to maximize the efficiency and effectiveness of care; the MPSC is in a unique position to convene healthcare providers and share best practices that have been identified through multi-provider collaborative testing and change. The key stakeholders that are involved with the MPSC include hospitals, patients, physicians, long-term care and post-acute providers, ambulatory care providers, and pharmacy – all groups that are critical to the success of the Total Cost of Care Model. The MPSC is in a favorable position in the State to develop and share best practices among this group of key stakeholders. The MPSC should continue to consider alignment with the broader statewide plan for patient safety.

HSCRC staff provides the following final recommendations for the MPSC funding policy for FY 2022:

1. Consistent with prior Commission recommendations, the HSCRC should reduce the amount of **unrestricted** funding support for the MPSC in FY 2022 by 75 percent from the FY 2019 HSCRC unrestricted grant amount of $492,075. The result is an adjustment to hospital rates in the amount of $123,028.
2. As a condition of funding from the hospital rate setting system, the MPSC should continue to report annually on data that it has collected from hospitals and other facilities that participate in its quality and safety initiatives and should demonstrate, to the extent possible, the ways in which MPSC initiatives are producing measurable gains in quality and safety at participating facilities.

3. MPSC requests additional funding from HSCRC that will be **restricted for targeted projects** that align with the statewide TCOC Model's quality and safety goals, and which the Commission can consider on a case-by-case basis.
    a. For FY 2022, staff recommends that the HSCRC fund an additional $125,000 for the Clean Collaborative Phase III for Long-Term Care project completion, which began and was funded in FY 2021.
4. The MPSC should continue to pursue strategies to achieve long-term sustainability through other sources of revenue, including identifying other provider groups that benefit from MPSC programs, as FY 2022 will be the final year of unrestricted funding from the HSCRC.

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

Dear Ms. Feeney,

In my many years of experience as a hospital administrator in Maryland, quality and safety were at the top of the priority list in patient care. So valuable to me was the collaborative relationship between hospitals and the HSCRC, as both entities knew the value of safe, quality care as well as the impact of issues that threatened quality and safety. I am writing to you to show my strong support for the Maryland Patient Safety Center and its request for full funding for Fiscal Year 2022, which was presented at the May 12, 2021, HSCRC meeting.

The Maryland Patient Safety Center (MPSC) has demonstrated for many years the ability to bring all sectors of health care together within our state to improve the quality and safety of Maryland's patient care. In this difficult COVID-19 year, this collaboration and representation has been clear in MPSC's response to COVID-19, with programs targeted at preventing infectious disease transmission in Long Term Care, supporting frontline hospital staff during stressful events such as the pandemic, and addressing racial disparities in the delivery of care.

One of these programs, the Clean Collaborative Phase III in ten Maryland long term care facilities, was supported by a grant from the HSRC last year. The program educates nursing home staff in infection control and rigorous environmental cleaning in order to prevent the transmission of diseases such as C-difficile, MRSA and COVID -19. Preliminary results have shown a decline in the incidence of resident visits to hospital emergency departments, and inpatient admissions are being measured and will be reported in the coming months. Preventing infections as well as hospital visits associated with them is good care, but also is less expensive healthcare for the state, and a good investment for Maryland.

The MPSC has requested undesignated funding for FY 22, funding for the completion of the Clean Collaborative Phase III, and additional funding to initiate a new Clean Collaborative (Phase V) in ten more Maryland nursing homes. I strongly support this entire package of funding so that the MPSC can continue its work to decrease infections in more Maryland Long Term Care facilities, thereby saving overall healthcare cost and fulfilling the Center's mission of Keeping Maryland Healthcare Safe.

Sincerely,

*Barbara J. Epke*

Barbara J. Epke
Vice Chair, Maryland Patient Safety Center Board

Cc: Blair Eig, MD, President, MPSC

May 17, 2021

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

Dear Ms. Feeney,

After another amazing year of challenges in health care, the Maryland Patient Safety Center has again demonstrated its continuing, passionate commitment to bringing health care providers together to plan and implement strategies to improve quality and safety in health care. The COVID-19 pandemic provided additional challenges and the Center responded by targeting prevention of disease transmission in the vulnerable long-term care community. The focus on support of front-line staff became an ever-increasing challenge and area of focus as well as issues of racial disparities in care delivery.

Significant areas of attention and impact included the Clean Collaborative program, which has continued to grow and is increasingly important in this critical era. The focus on Clostridium difficile, MRSA and, of course, COVID-19 will continue. Results are impressive but the need for attention grows as COVID remains a dominant threat. This continued emphasis on disease prevention remains critical. Thus, it is not the time to lessen our focus on the valuable and productive investment that has been made.

The Maryland Patient Safety Center's request for undesignated funding for FY22 and funding for the Clean Collaborative Program's continued growth and effectiveness in Maryland nursing homes remain high priorities.

I urge you to support the entire package of funding for FY22 to continue the emphasis on decreasing infections in long-term care facilities while increasing successful outcomes at additional LTC sites. Savings in overall healthcare costs and safety and patient care will continue to be priorities and successful outcomes at the Maryland Patient Safety Center.

Thank you for your attention to this critical issue.

Sincerely,

Barbara Tachovsky

UNIVERSITY of MARYLAND

**CHERIF BOUTROS, MD, MSc, FACS**
Associate Professor of Surgery
University of Maryland School Of Medicine
Medical Director, Tate Cancer Center
Chief of Surgical Oncology
University of Maryland BWMC

29 S Greene Street, Baltimore 21201
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CBoutros@som.umaryland.edu

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

Dear Ms. Feeney,

I am writing to you to show my strong support for the Maryland Patient Safety Center and its full request for funding for Fiscal Year 2022 (FY22) presented at the May 12 Health Services Cost Review Commission meeting. The Maryland Patient Safety Center has demonstrated for many years the ability to bring all sectors of health care together within our state to improve the quality and safety of patient care. This has been quite evident this past year in its response to the COVID-19 pandemic, with programs targeted at preventing infectious disease transmission in Long Term Care. One of these programs, the Clean Collaborative Phase III in ten Maryland long term care facilities, was supported by a grant from the HSCRC last year.

The Maryland Patient Safety Center has requested undesignated funding for FY22 (which is to be phased out after this year), funding for completion of the Clean Collaborative Phase III as described above, and additional funding to initiate a new Clean Collaborative (Phase V) in 10 more Maryland nursing homes. I strongly support this entire package of funding so that the Maryland Patient Safety Center can continue its work to decrease infections in more Maryland Long Term Care facilities, thereby saving overall healthcare cost and fulfilling the center's mission of Keeping Maryland Healthcare Safe.

Sincerely,

Cherif Boutros, MD, MSc, FACS

Frederick Health

400 West 7th Street
Frederick, MD 21701

240.566.3679

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

May 13, 2021

Dear Ms. Feeney,

I am writing to you to show my strong support for the Maryland Patient Safety Center and its full request for funding for Fiscal Year 2022 (FY22) presented at the May 12 Health Services Cost Review Commission meeting. The Maryland Patient Safety Center has demonstrated for many years the ability to bring all sectors of health care together within our state to improve the quality and safety of patient care. This has been quite evident this past year in its response to the COVID-19 pandemic, with programs targeted at preventing infectious disease transmission in Long Term Care, supporting front-line hospital staff during stressful events (such as the pandemic) and addressing racial disparities in the delivery of care. One of these programs, the Clean Collaborative Phase IV, which is a part of our hospital partnership grant, is working with our partner LTCs to educate nursing home staff in infection control and rigorous environmental cleaning in order to prevent the transmission of infections such as Clostridium difficile, Methicillin Resistant Staphylococcus Aureus (MRSA) and COVID-19. Preliminary results have shown a decline in the incidence of these infections and improvement in overall cleanliness. The incidence of resident visits to Emergency Departments and hospital inpatient admissions are being measured and our early data indicates a decline in both. Obviously, preventing these infections and the hospital visits associated with them is good healthcare. But it is also less expensive healthcare for the state, since preventing disease is less expensive than treating it, making it an overall good investment.

The Maryland Patient Safety Center has requested additional funding to initiate a new Clean Collaborative (Phase V) in 10 more Maryland nursing homes. I strongly support this entire package of funding so that the Maryland Patient Safety Center can continue its work to decrease infections in more Maryland Long Term Care facilities, thereby saving overall healthcare cost and fulfilling the center's mission of Keeping Maryland Healthcare Safe.

Sincerely,

Heather Kirby
Vice President of Integrated Care Delivery &
Chief Population Health Officer

# Appendix A

## Maryland Patient Safety Center, Inc.

## Statement of Income and Expenses

**DRAFT**

**04-30-21**

**Working Copy for FY 2021 (Version A)Description**
**Beginning Restricted Fund Balance as of July 1**

| | FY 2021 Budget | FY 2022 Budget |
|---|---|---|
| | 3,575 | **48,300** |
| Restricted Grant Revenue-MDH | - | **-** |
| Restricted Grant Revenue-HRSA | 36,600 | **40,000** |
| Restricted HSCRC Funding-Phase III Clean Collaborative | 275,000 | **125,000** |
| Restricted HSCRC Funding-Phase IV Clean Collaborative | | **-** |
| Restricted HSCRC Funding-Phase V Clean Collaborative | | **-** |
| Net Assets Released from Restriction-MDH | - | **-** |
| Net Assets Released from Restriction-HRSA | ( 36,600 ) | **( 40,000 )** |
| Net Assets Released from Restriction-PH III Clean Collaborative | ( 275,000 ) | **( 125,000 )** |
| Net Assets Released from Restriction-PH IV Clean Collaborative | - | **( 48,300 )** |
| Net Assets Released from Restriction-PH V Clean Collaborative | - | **-** |
| **Change in Restricted Net Assets** | - | **( 48,300 )** |
| **Ending Restricted Fund Balance as of June 30** | 3,575 | **-** |
| **Unrestricted Funds as of July 1** | | |
| Board-Designated Operating Reserve | 174,344 | **-** |
| Unrestricted Net Assets | 1,576,700 | **1,485,859** |
| **Total Unrestricted Funds as of July 1** | 1,751,044 | **1,485,859** |
| **Revenue** | | |
| HSCRC Funding | 246,056 | **123,000** |
| Membership Dues | 503,650 | **518,000** |
| Fundraising Campaign Revenue | - | **4,000** |
| Education Session Revenue | 18,800 | **10,000** |
| Annual Patient Safety Conference Revenue | 175,500 | **115,000** |
| Medsafe Revenue | 24,000 | **7,000** |
| Caring for HC/Rise Program Sales | 392,000 | **275,000** |
| Sales - Team STEPPS | - | **3,000** |
| Other Grants & Contributions | - | **-** |
| Care Alerts Collaborative Revenue | - | **-** |
| Net Assets Released from Restriction | 311,600 | **213,300** |
| **Total Revenue** | 1,671,606 | **1,268,300** |
| **Expenses** | | |
| Administration | 416,980 | **456,720** |
| Education Sessions | 27,400 | **15,000** |
| Patient Safety | 421,800 | **331,800** |
| Medication Safety | 122,200 | **173,375** |
| Caring for HC | 348,979 | **276,300** |
| Certification | 54,000 | **36,500** |
| MidAtlantic PSO | 81,500 | **74,100** |
| PFAQS | 58,733 | **53,400** |
| Diagnosis Errors | 47,900 | **14,800** |
| Maternal Health | 38,900 | **42,900** |
| Opioid Safety | 43,400 | **28,400** |
| HSCRC Funding-Phase III Clean Collaborative | 275,000 | **146,200** |
| HSCRC Funding-Phase IV Clean Collaborative | - | **20,600** |
| HSCRC Funding-Phase V Clean Collaborative | - | **-** |
| **Total Expenses** | 1,936,792 | **1,670,095** |
| **Change in Unrestricted Net Assets** | ( 265,185 ) | **( 401,795 )** |
| **Ending Fund Balances:** | | |
| **Net Assets with Donor Restrictions - June 30** | 3,575 | **-** |
| **Net Assets with Board-Designated Restrictions - June 30** | 174,344 | **-** |
| **Net Assets without Donor or Board-Designated Restrictions - June 30** | 1,311,515 | **1,084,064** |
| **Total Ending Fund Balances** | 1,489,434 | **1,084,064** |

| **Note 1: FY22 Conference expenses of $258,820 have been prepaid. As a result, no additional cash output will be needed to cover these FY22 expenses. Please see the following calculation, reflecting the net unfunded change in net assets.** | |
|---|---|
| Total Budgeted Change in Net Assets without Restrictions | (401,795) |
| Less: Prepaid Conference Expenses | 258,820 |
| FY22 Unfunded Change in Net Assets | (142,975) |

# Maryland Patient Safety Center, Inc.
# Statement of Income and Expenses

**Working Copy for FY 2021 (Version B)**

**DRAFT**

**04-30-21**

| Description | FY 2021 Budget | FY 2022 Budget |
|---|---|---|
| **Beginning Restricted Fund Balance as of July 1** | - | **48,300** |
| Restricted Grant Revenue-MDH | - | **-** |
| Restricted Grant Revenue-HRSA | 36,600 | **40,000** |
| Restricted HSCRC Funding-Phase III Clean Collaborative | 275,000 | **-** |
| Net Assets Released from Restriction-MDH | - | **-** |
| Net Assets Released from Restriction-HRSA | ( 36,600 ) | **( 40,000 )** |
| Net Assets Released from Restriction-PH III Clean Collaborative | ( 275,000 ) | **-** |
| Net Assets Released from Restriction-PH IV Clean Collaborative | - | **( 48,300 )** |
| Net Assets Released from Restriction-PH V Clean Collaborative | - | **-** |
| **Change in Restricted Net Assets** | - | **( 48,300 )** |
| **Ending Restricted Fund Balance as of June 30** | - | **-** |
| **Unrestricted Funds as of July 1** | | |
| Board-Designated Operating Reserve | 174,344 | **-** |
| Unrestricted Net Assets | 1,576,700 | **1,485,858** |
| **Total Unrestricted Funds as of July 1** | 1,751,044 | **1,485,858** |
| **Revenue** | | |
| HSCRC Funding | 246,056 | **123,000** |
| Membership Dues | 503,650 | **518,000** |
| Fundraising Campaign Revenue | - | **4,000** |
| Education Session Revenue | 18,800 | **10,000** |
| Annual Patient Safety Conference Revenue | 175,500 | **115,000** |
| Medsafe Revenue | 24,000 | **7,000** |
| Caring for HC/Rise Program Sales | 392,000 | **275,000** |
| Sales - Team STEPPS | - | **3,000** |
| Other Grants & Contributions | - | **-** |
| Care Alerts Collaborative Revenue | - | **-** |
| Net Assets Released from Restriction | 311,600 | **88,300** |
| **Total Revenue** | 1,671,606 | **1,143,300** |
| **Expenses** | | |
| Administration | 416,980 | **459,920** |
| Education Sessions | 27,400 | **15,000** |
| Patient Safety | 421,800 | **328,700** |
| Medication Safety | 122,200 | **177,875** |
| Caring for HC | 348,979 | **275,500** |
| Certification | 54,000 | **43,500** |
| MidAtlantic PSO | 81,500 | **84,900** |
| PFAQS | 58,733 | **64,500** |
| Diagnosis Errors | 47,900 | **29,000** |
| Maternal Health | 38,900 | **42,900** |
| Opioid Safety | 43,400 | **33,600** |
| HSCRC Funding-Phase III Clean Collaborative | 275,000 | **-** |
| HSCRC Funding-Phase IV Clean Collaborative | - | **21,700** |
| HSCRC Funding-Phase V Clean Collaborative | - | **-** |
| **Total Expenses** | 1,936,792 | **1,577,095** |
| **Change in Unrestricted Net Assets** | ( 265,185 ) | **( 433,795 )** |
| **Ending Fund Balances:** | | |
| **Net Assets with Donor Restrictions - June 30** | - | **-** |
| **Net Assets with Board-Designated Restrictions - June 30** | 174,344 | **-** |
| **Net Assets without Donor or Board-Designated Restrictions - June 30** | 1,311,515 | **1,052,063** |
| **Total Ending Fund Balances** | 1,485,859 | **1,052,063** |

**Note 1: FY22 Conference expenses of $258,820 have been prepaid. As a result, no additional cash output will be needed to cover these FY22 expenses. Please see the following calculation, reflecting the net unfunded change in net assets.**

| | |
|---|---|
| Total Budgeted Change in Net Assets without Restrictions | (433,795) |
| Less: Prepaid Conference Expenses | 258,820 |
| FY22 Unfunded Change in Net Assets | (174,975) |

# Maryland Patient Safety Center, Inc.
# Statement of Income and Expenses

**Working Copy for FY 2021 (Version C)**

**DRAFT**

**04-30-21**

| Description | FY 2021 Budget | FY 2022 Budget |
|---|---|---|
| **Beginning Restricted Fund Balance as of July 1** | - | **48,300** |
| Restricted Grant Revenue-MDH | - | **-** |
| Restricted Grant Revenue-HRSA | 36,600 | **40,000** |
| Restricted HSCRC Funding-Phase III Clean Collaborative | 275,000 | **125,000** |
| Restricted HSCRC Funding-Phase V Clean Collaborative | - | **275,000** |
| Net Assets Released from Restriction-MDH | - | **-** |
| Net Assets Released from Restriction-HRSA | ( 36,600 ) | **( 40,000 )** |
| Net Assets Released from Restriction-PH III Clean Collaborative | ( 275,000 ) | **( 125,000 )** |
| Net Assets Released from Restriction-PH IV Clean Collaborative | - | **( 48,300 )** |
| Net Assets Released from Restriction-PH V Clean Collaborative | - | **( 275,000 )** |
| **Change in Restricted Net Assets** | - | **( 48,300 )** |
| **Ending Restricted Fund Balance as of June 30** | - | **-** |
| **Unrestricted Funds as of July 1** | | |
| Board-Designated Operating Reserve | 174,344 | **-** |
| Unrestricted Net Assets | 1,576,700 | **1,485,858** |
| **Total Unrestricted Funds as of July 1** | 1,751,044 | **1,485,858** |
| **Revenue** | | |
| HSCRC Funding | 246,056 | **123,000** |
| Membership Dues | 503,650 | **518,000** |
| Fundraising Campaign Revenue | - | **4,000** |
| Education Session Revenue | 18,800 | **10,000** |
| Annual Patient Safety Conference Revenue | 175,500 | **115,000** |
| Medsafe Revenue | 24,000 | **7,000** |
| Caring for HC/Rise Program Sales | 392,000 | **275,000** |
| Sales - Team STEPPS | - | **3,000** |
| Other Grants & Contributions | - | **-** |
| Care Alerts Collaborative Revenue | - | **-** |
| Net Assets Released from Restriction | 311,600 | **488,300** |
| **Total Revenue** | 1,671,606 | **1,543,300** |
| **Expenses** | | |
| Administration | 416,980 | **447,020** |
| Education Sessions | 27,400 | **15,000** |
| Patient Safety | 421,800 | **312,800** |
| Medication Safety | 122,200 | **161,275** |
| Caring for HC | 348,979 | **275,000** |
| Certification | 54,000 | **37,100** |
| MidAtlantic PSO | 81,500 | **71,400** |
| PFAQS | 58,733 | **54,300** |
| Diagnosis Errors | 47,900 | **10,600** |
| Maternal Health | 38,900 | **42,900** |
| Opioid Safety | 43,400 | **26,000** |
| HSCRC Funding-Phase III Clean Collaborative | 275,000 | **139,100** |
| HSCRC Funding-Phase IV Clean Collaborative | - | **13,700** |
| HSCRC Funding-Phase V Clean Collaborative | - | **63,900** |
| **Total Expenses** | 1,936,792 | **1,670,095** |
| **Change in Unrestricted Net Assets** | ( 265,185 ) | **( 126,795 )** |
| **Ending Fund Balances:** | | |
| **Net Assets with Donor Restrictions - June 30** | - | **-** |
| **Net Assets with Board-Designated Restrictions - June 30** | 174,344 | **-** |
| **Net Assets without Donor or Board-Designated Restrictions - June 30** | 1,311,515 | **1,359,063** |
| **Total Ending Fund Balances** | 1,485,859 | **1,359,063** |

**Note 1: FY22 Conference expenses of $258,820 have been prepaid. As a result, no additional cash output will be needed to cover these FY22 expenses. Please see the following calculation, reflecting the net unfunded change in net assets.**

| | |
|---|---|
| Total Budgeted Change in Net Assets without Restrictions | (126,795) |
| Less: Prepaid Conference Expenses | 258,820 |
| FY22 Unfunded Change in Net Assets | 132,025 |

KESWICK

*Right Care. Right Time. Right Place.*

May 14, 2021

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

Dear Ms. Feeney,

I am writing to you to show my strong support for the Maryland Patient Safety Center and its full request for funding for Fiscal Year 2022 (FY22) presented at the May 12 Health Services Cost Review Commission meeting. The Maryland Patient Safety Center has demonstrated for many years the ability to bring all sectors of health care together within our state to improve the quality and safety of patient care. This has been quite evident this past year in its response to the COVID-19 pandemic, with programs targeted at preventing infectious disease transmission in Long Term Care, supporting front-line hospital staff during stressful events (such as the pandemic) and addressing racial disparities in the delivery of care. One of these programs, the Clean Collaborative Phase III in ten Maryland long term care facilities, was supported by a grant from the HSCRC last year. Our organization is participating in this collaborate that educates nursing home staff in infection control and rigorous environmental cleaning in order to prevent the transmission of infections such as Clostridium difficile, Methicillin Resistant Staphylococcus Aureus (MRSA) and COVID-19. Preliminary results have shown a decline in the incidence of these infections and improvement in overall cleanliness. The incidence of resident visits to Emergency Departments and hospital inpatient admissions are being measured and our early data indicates a decline in both. Obviously, preventing these infections and the hospital visits associated with them is good healthcare. But it is also less expensive healthcare for the state, since preventing disease is less expensive than treating it, making it an overall good investment.

The Maryland Patient Safety Center has requested undesignated funding for FY22 (which is to be phased out after this year), funding for completion of the Clean Collaborative Phase III as described above, and additional funding to initiate a new Clean Collaborative (Phase V) in 10 more Maryland nursing homes. I strongly support this entire package of funding so that the Maryland Patient Safety Center can continue its work to decrease infections in more Maryland Long Term Care facilities, thereby saving overall healthcare cost and fulfilling the center's mission of Keeping Maryland Healthcare Safe.

Sincerely,

Kathy Graning
Vice President, Clinical Services

LEVINDALE
*A LifeBridge Health Center*

Deborah Graves
President & Chief Operating Officer

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

Dear Ms. Feeney,

I was recently made aware that funding for the Maryland Patient Safety Center has been decreased for the next fiscal year. I am writing to you to show my strong support for the Maryland Patient Safety Center and its full request for funding for Fiscal Year 2022 (FY22) presented at the May 12 Health Services Cost Review Commission meeting. The Maryland Patient Safety Center has demonstrated for many years the ability to bring all sectors of health care together within our state to improve the quality and safety of patient care. This has been quite evident this past year in its response to the COVID-19 pandemic, with programs targeted at preventing infectious disease transmission in Long Term Care, supporting front-line hospital staff during stressful events (such as the pandemic) and addressing racial disparities in the delivery of care. One of these programs, the Clean Collaborative Phase III in ten Maryland long term care facilities, was supported by a grant from the HSCRC last year. The program educates nursing home staff in infection control and rigorous environmental cleaning in order to prevent the transmission of diseases such as Clostridium difficile, Methicillin Resistant Staphylococcus Aureus (MRSA) and COVID-19. Preliminary results have shown a decline in the incidence of these infections at the facilities and improvement in overall cleanliness. The incidence of resident visits to Emergency Departments and hospital inpatient admissions are being measured and will be reported in the coming months. Obviously, preventing these infections and the hospital visits associated with them is good healthcare. But it is also less expensive healthcare for the state, since preventing disease is less expensive than treating it, making it an overall good investment.

The Maryland Patient Safety Center has requested undesignated funding for FY22 (which is to be phased out after this year), funding for completion of the Clean Collaborative Phase III as described above, and additional funding to initiate a new Clean Collaborative (Phase V) in 10 more Maryland nursing homes. I strongly support this entire package of funding so that the Maryland Patient Safety Center can continue its work to decrease infections in more Maryland Long Term Care facilities, thereby saving overall healthcare cost and fulfilling the center's mission of Keeping Maryland Healthcare Safe.

Sincerely,

Deborah Graves

President, Levindale Hospital
SVP, LifeBridge Health

JUST A QUICK NOTE TO SAY HOW MUCH MY STAFF APPRECIATES THE MPSC EDUCATION AND AWARDS/NETWORKING OPPORTUNITIES. THEY ARE A MEANINGFUL WAY TO SHARE BEST PRACTICE & COMMON STORIES OF SUPPORT. PLEASE DO CONSIDER FULLY FUNDING THE MPSC

DO MY BEST -

May 13, 2021

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

Dear Ms. Feeney,

I am writing to you to show my strong support for the Maryland Patient Safety Center and its full request for funding for Fiscal Year 2022 (FY22) presented at the May 12 Health Services Cost Review Commission meeting. The Maryland Patient Safety Center has demonstrated for many years the ability to bring all sectors of health care together within our state to improve the quality and safety of patient care.

This has been quite evident this past year in its response to the COVID-19 pandemic, with programs targeted at preventing infectious disease transmission in Long Term Care, supporting front-line hospital staff during stressful events (such as the pandemic) and addressing racial disparities in the delivery of care. One of these programs, the Clean Collaborative Phase III in ten Maryland long term care facilities, was supported by a grant from the HSCRC last year. The program educates nursing home staff in infection control and rigorous environmental cleaning in order to prevent the transmission of diseases such as Clostridium difficile, Methicillin Resistant Staphylococcus Aureus (MRSA) and COVID-19. Preliminary results have shown a decline in the incidence of these infections at the facilities and improvement in overall cleanliness. The incidence of resident visits to Emergency Departments and hospital inpatient admissions are being measured and will be reported in the coming months. Obviously, preventing these infections and the hospital visits associated with them is good healthcare. But it is also less expensive healthcare for the state, since preventing disease is less expensive than treating it, making it an overall good investment.

The Maryland Patient Safety Center has requested undesignated funding for FY22 (which is to be phased out after this year), funding for completion of the Clean Collaborative Phase III as described above, and additional funding to initiate a new Clean Collaborative (Phase V) in 10 more Maryland nursing homes. I strongly support this entire package of funding so that the Maryland Patient Safety Center can continue its work to decrease infections in more Maryland Long Term Care facilities, thereby saving overall healthcare cost and fulfilling the center's mission of Keeping Maryland Healthcare Safe.

Sincerely,

Kevin D. Heffner, MAGS
President & CEO

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

Maryland
Hospital Association

May 17, 2021

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

Dear Ms. Feeney,

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, I urge you to fund the Maryland Patient Safety Center's full request of $523,000 in undesignated funds for fiscal year 2022. Increasing funding beyond the proposed $248,000 would allow state's patient safety organization to begin its Clean Collaborative with another 10 Maryland nursing homes. The Clean Collaborative improves infection control and rigorous environmental cleaning to prevent transmission of infectious diseases, such as Clostridium difficile, Methicillin Resistant Staphylococcus Aureus (MRSA), and COVID-19. All of these infections can result in unnecessary visits to the emergency department and other, more serious, outcomes. Preliminary results show a decline in these infections at the facilities and improvement in overall cleanliness.

As we enter the fourth year of the Total Cost of Care Model, stakeholders are coming together in ways that we have not before seen to do their part in improving care for Marylanders. The Maryland Patient Safety Center offered relevant, well-received programs for all sectors of health care to improve the quality and safety of patient care. Their timely response to support hospitals, nursing homes and others through the COVID-19 pandemic demonstrates the important role they play.

Sincerely,

Traci LaValle
Senior Vice President, Quality & Health Improvement

cc: Adam Kane, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
John M. Colmers
James N. Elliott, M.D.
Sam Malhotra
Katie Wunderlich, Executive Director

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

Speaker Pro Tem

Health and Government
Operations Committee

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

THE MARYLAND HOUSE OF DELEGATES
Annapolis, Maryland 21401

May 19, 2021

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

Dear Ms. Feeney,

I am pleased to support this initiative once again for the Maryland Patient Safety Center and its request for full funding in Fiscal Year 2022 (FY22) presented at the May 12th Health Services Cost Review Commission meeting. The Maryland Patient Safety Center has demonstrated for many years the ability to bring all sectors of health care together within our State to improve the quality and safety of patient care. This has been quite evident this past year in its response to the COVID-19 pandemic, with programs targeted at preventing infectious disease transmission in Long Term Care, supporting front-line hospital staff during stressful events (such as the pandemic) and addressing racial disparities in the delivery of care. One of these programs, the Clean Collaborative Phase III in ten Maryland long term care facilities, was supported by a grant from the HSCRC last year. The program educates nursing home staff in infection control and rigorous environmental cleaning in order to prevent the transmission of diseases such as Clostridium difficile, Methicillin Resistant Staphylococcus Aureus (MRSA) and COVID-19. Preliminary results have shown a decline in the incidence of these infections at the facilities and improvement in overall cleanliness. The incidence of resident visits to Emergency Departments and hospital inpatient admissions are being measured and will be reported in the coming months. Obviously, preventing these infections and the hospital visits associated with them is good healthcare. It is also less expensive healthcare for the State: since preventing disease is less expensive than treating it, making it an overall good investment.

The Maryland Patient Safety Center has requested undesignated funding for FY22 (which is to be phased out after this year). This funding will complete the Clean Collaborative Phase III, as described above, and additional funding to help initiate a new Clean Collaborative (Phase V) in 10 more Maryland nursing homes. I strongly support this entire package of funding so that the Maryland Patient Safety Center can continue its work to decrease infections in more Maryland Long Term Care facilities, thereby reducing overall healthcare costs and fulfilling the center's mission of "Keeping Maryland healthcare safe."

Yours in Service,

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

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HOME CARE GROUP

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

May 17, 2021

Dear Ms. Feeney,

I am writing to you to show my strong support for the Maryland Patient Safety Center and its full request for funding for Fiscal Year 2022 (FY22) presented at the May 12 Health Services Cost Review Commission meeting. The Maryland Patient Safety Center has demonstrated for many years the ability to bring all sectors of health care together within our state to improve the quality and safety of patient care. This has been quite evident this past year in its response to the COVID-19 pandemic, with programs targeted at preventing infectious disease transmission in Long Term Care, supporting front-line hospital staff during stressful events (such as the pandemic) and addressing racial disparities in the delivery of care. One of these programs, the Clean Collaborative Phase III in ten Maryland long term care facilities, was supported by a grant from the HSCRC last year. The program educates nursing home staff in infection control and rigorous environmental cleaning in order to prevent the transmission of diseases such as Clostridium difficile, Methicillin Resistant Staphylococcus Aureus (MRSA) and COVID-19. Preliminary results have shown a decline in the incidence of these infections at the facilities and improvement in overall cleanliness. The incidence of resident visits to Emergency Departments and hospital inpatient admissions are being measured and will be reported in the coming months. Obviously, preventing these infections and the hospital visits associated with them is good healthcare. But it is also less expensive healthcare for the state, since preventing disease is less expensive than treating it, making it an overall good investment.

The Maryland Patient Safety Center has requested undesignated funding for FY22 (which is to be phased out after this year), funding for completion of the Clean Collaborative Phase III as described above, and additional funding to initiate a new Clean Collaborative (Phase V) in 10 more Maryland nursing homes. I strongly support this entire package of funding so that the Maryland Patient Safety Center can continue its work to decrease infections in more Maryland Long Term Care facilities, thereby saving overall healthcare cost and fulfilling the center's mission of Keeping Maryland Healthcare Safe.

Sincerely,

Badia Faddoul, DNP, RN, CCRN, CPHQ
Maryland Patient Safety Board Member

Senior Director of Quality and Safety
Johns Hopkins Home Care Group
5901 Holabird Avenue, Suite A
Baltimore, MD 21224
(O) 410. 307 4598
bfaddou1@jhmi.edu

# Final Recommendation on Community Benefit Guidelines

maryland health services cost review commission

# Overview of the Recommendation

Chapter 437 of 2020 (SB774 and HB1169) directed the HSCRC to include:

1. A description of each hospital's process for soliciting input in the development of the community health needs assessment for the purpose of §501(r)(3) of the Internal Revenue Code; and
2. Recommendations for the Maryland Department of Health and the local health departments to assess the effectiveness of hospitals' community benefit spending to address the community health needs." (CH 437 of 2020)

Staff recommend updating the Community Benefit Reporting Guidelines to require hospitals to report:

1. Which members of the community helped the hospital to develop their Community Health Needs Assessment; and
2. The initiatives that the hospital performed to address the unmet community health needs of their community and the cost of those initiatives.

# Comments are Response

Staff received four comment letters (MHA, Medstar, JHHS, and CareFirst).

- The industry (MHA, Medstar, and Hopkins) requested that changes in the community benefit reports be made active for the FY2022 reports, instead of FY2021.
- CareFirst suggested that the Commission set standards for the indirect costs that can be reported as a community benefit.

Staff recommend making the community health needs assessment report optional for FY2021 and mandatory for FY2022. Staff will examine the reporting of indirect costs for future years.

maryland
health services
cost review commission

# Final Recommendation for the Community Benefit Reporting

June 9, 2021

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

# Policy Overview

| Policy Objective | Policy Solution | Effect on Hospitals | Effect on Payers/Consumers | Effect on Health Equity |
|---|---|---|---|---|
| This final recommendation seeks to improve the community benefit reporting guidelines in order to identify the amount hospitals spend on community health initiatives. | Hospitals will report the amount of funds spent on initiatives identified on their Community Health Needs Assessment. | There are no rate implications for hospitals with this final recommendation. | There are no implications for payers or consumers. | The HSCRC and the public will have a better insight into the community health spending and can analyze the impact of their spending on health equity. |

# Executive Summary

Staff recommend updating the community benefits reporting guidelines, pursuant to legislation passed in the 2020 General Assembly session, to include 1) an assessment of public engagement in the CHNA process; 2) a report on the amount the hospital spends to address their community health needs.

# Introduction & Background

Chapter 437 of 2020 (SB774 and HB1169) directed the Health Services Cost Review Commission (HSCRC) to form a Community Benefit Reporting Workgroup (Workgroup) to discuss the Community Benefit reporting process and the inclusion of community partners when conducting the hospital's Community Health Needs Assessment. The workgroup focused on two aspects of the community benefit reporting process:

> (1) a description of each hospital's process for soliciting input in the development of the community health needs assessment for the purpose of §501(r)(3) of the Internal Revenue Code; and
>
> (2) recommendations for the Maryland Department of Health and the local health departments to assess the effectiveness of hospitals' community benefit spending to address the community health needs." (CH 437 of 2020)

Based on the Workgroup's discussions, Staff recommend making the following changes to the community benefit reporting process.

# Recommendations for Community Benefit Reporting

Hospitals are required to conduct an analysis of their community's health needs. This assessment must include members of the community. Staff believe that hospitals generally engage in an extensive community engage process while writing their CHNAs. However, the extensiveness of those efforts may vary. Therefore, Staff recommend updating the reporting guidelines to require hospitals to describe those efforts. Additionally, hospitals do not currently report the portion of the community benefit spending that is directed to CHNA initiatives. Currently, community benefit reporting requirements require the hospitals to report spending in high-level categories, such as "Mission Driven Health Services" or "Charity Care." These categories are not detailed enough to allow the HSCRC, other policymakers, or the public to identify spending that is directed to community health needs. Staff recommends updating the community benefit reporting guidelines to link the hospital's community benefit reports with the hospital's CHNA initiatives.

1. Description of Hospital's Public Engagement Process

   Staff recommend including a description of the community's participation in the hospital's Community Health Needs Assessment. Under existing IRS regulations, hospitals are required to: "Solicit and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health" (IRS Section 501(r)(3)(B)). Staff worked with the Maryland Hospital Association and members of the Workgroup to identify eight best practices shown in Figure 1 below for hospitals to follow when developing their CHNA.

***Figure 1: Best Practices for Engaging Patients and Communities in the CHNA Process***


Staff recommend including a self-assessment in the community benefits reporting guidelines. Hospitals will be required to report the extent to which they performed these best practices. Hospitals will give themselves a rating on a scale of 1 to 6 based on a typology developed by the International Association for Public Participation (IAP2). The scale ranges from the hospital informing members of their community to the community itself driving the development of the Community Health Needs Assessment.

## 2. Assessing the Effectiveness of Hospitals' Community Benefit Spending to Address Community Health Needs

Staff recommend updating the community benefits reporting requirements to require hospitals to report the amount of their community benefit spending that was directed to addressing needs identified on their community health needs assessment. Under the HSCRC's current reporting guidelines, there is no way to accurately identify spending specifically made in response to a CHNA. Hospitals report aggregate community benefit spending categories that include spending on both local community health needs and other public health priorities. Thus, the HSCRC will update

reporting guidelines to identify community health needs spending among aggregate Community Benefit spending.

Hospitals will be required to disclose each priority area that they are focused on addressing with their community benefit spending. For example, a hospital may report that they are focused on reducing the incidence of diabetes in their local community as a priority area. The hospital will then report the target population and goals for that population. In other words, a hospital could focus on reducing incidence of diabetes by one percent among children aged 15 – 18 within ten years. The hospital will also annually report its progress to date in achieving those goals and other important programmatic information. Under each priority example, the hospital will have multiple initiatives that are expected to contribute to the overall priority area.

The hospitals will be required to report on every initiative created to support their community health needs priority areas and goals. This reporting will include detailed information at a line-item level so that the State can identify the community health initiatives that hospitals are engaged in. Initiatives that have full-time-equivalent (FTE)/staffing allocations or a programmatic budget are considered a 'Community Health Initiative', thus, will be reported as a line item. Finally, hospitals will be required to report the amount that they spent on each Community Health Initiative, as they do with the aggregate Community Benefit financials. Table 2 includes an example of the required information from each hospital's CHNA to be included in the Community Benefit reporting.

# Stakeholder Feedback

Staff received four comment letters (from the Maryland Hospital Association, the Johns Hopkins Health System, Medstar Health, and CareFirst) in response to the draft recommendation. Most stakeholders expressed support for aligning the community benefit reports with the community health needs initiatives. However, industry stakeholders requested that the change in the reporting guidelines become effective for the FY22 reports, which will be filed with the HSCRC in December of FY23. This timeline would allow hospitals to implement the changes in their own reporting systems and it would allow hospitals time to review the community benefit guidelines prior to submitting the first reports to the HSCRC. Stakeholders also noted that the disruption from COVID-19 would make it difficult to comply with changes to the community benefit reporting requirements. In light of these comments, Staff recommend that the requirement that hospitals report the amount of their community benefit spending directed to a community initiative be optional for FY21 and mandatory for FY22. This will allow hospitals to become familiar with the new reporting requirements and will provide more time for hospitals to implement the necessary changes to their own reporting systems.

CareFirst was supportive of the draft recommendation and also suggested that the HSCRC set standards for the indirect costs that hospitals can report as a community benefit. Staff believe that an analysis of indirect costs is worthwhile but do not recommend setting an indirect cost standard without careful study.

# Conclusion

Staff recommend updating the community benefits reporting guidelines to include 1) an assessment of public engagement in the CHNA process; and 2) a report on the amount the hospital spends to address their community health needs. Staff further recommends that the guidelines be optional for FY 2021 and mandatory starting in FY 2022 to allow hospitals to

Chapter 437 also required the HSCRC to make recommendations on how MDH and LHDs can utilize the data collected by the HSCRC to assess the portions of hospitals' community benefit spending deployed to address community health needs. Staff recommend updating the annual Nonprofit Hospital Community Health Benefit Report available to the legislature and members of the public to highlight the amount of spending that is directed towards the community local health needs. MDH and LHDs can use this information to assess the extent to which the hospital's spending aligns with the community's health needs.

Additionally, Chapter 437 also directed hospitals' Community Benefit reporting to include information on: 1) the gaps in provider availability in their community; 2) a description of hospital efforts to track and reduce health disparities; 3) a list of unmet community health needs. Staff believes this is already included in the community benefit report and additional changes are not necessary. Finally, Chapter 437 requires the hospitals to include a list of tax exemptions that the hospital claimed during the preceding tax year.

Finally, Staff recommend that the updated Community Benefit guidelines be optional for FY2021 and mandatory starting in FY2022. Data from the revised reporting requirements will be available in the fall of 2022.

Maryland
Hospital Association

May 19, 2021

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 (MHA) 60 member hospitals and health systems, we urge you to maintain the timeline for new hospital community benefit reporting requirements that was included in the December report of the Consumer Standing Advisory Committee (CSAC).

**We strongly urge HSCRC to maintain the original timeline and begin the new reporting requirements for the FY 2022 report. That would match what was initially communicated to CSAC and included in the report to legislators last December.**

The draft recommendation would make the new reporting requirements effective for the FY 2021 reports, due in just six months. This is a sudden, substantial change from the initial timeline. Throughout the better part of 2020 the CSAC met to consider how to satisfy the requirements of Chapter 437 of 2020. In our December 2020 comment letter we raised concerns regarding the limited resources available to comply with all the new requirements contemplated by Commission staff for the FY22 report which would be due in December 2022. We were therefore surprised to see that this timeframe was being accelerated to apply to the FY21 report.

Normally, hospitals would do everything to meet the adjusted timeline. COVID-19 response has made compliance impossible. This month is the first time in over a year that hospitals have seen a drop in COVID-19 patients. Meanwhile, they are still bringing vaccines out to underserved and hard-to-reach communities, determining how safely reinstate community programs and medical care, and working through the new care transformation report introduced last year. Further, while we appreciate the webinar series that was launched last week in partnership with Hilltop to detail the forthcoming changes, it has become apparent through confusing and at times contradictory staff presentations that the guidelines are not ready to be rolled out.

**Lack of Appropriate Notice**

The legislation does not mandate a timeframe in which these new reporting requirements must go into effect, so the change is unnecessary. Plus, the new timeline is inconsistent with what was discussed and agreed upon by the HSCRC.

Community benefit reporting is a time consuming, largely manual process for hospitals. This accelerated timeline and lack of clear and consistent guidance by the HSCRC and Hilltop does not give hospitals enough lead time.

The accelerated timeframe would require hospitals to follow new reporting requirements for activity from July 2020 through June 2021. This differs materially from the original direction. HSCRC and the workgroup, mandated by legislation passed in 2020, agreed that the new reporting requirements would go into effect on July 1, 2021, reflecting activity from July 2021 through June 2022. The first report covering the new requirements would be for FY 2022 and due in December 2022. HSCRC noted this in the report to the legislature in December 2020:

> *"Updated Community Benefit guidelines will go into effect for reporting on Fiscal Year 22 (beginning in July of 2021)."*

**Needlessly Burdensome**

MHA and our members appreciate the value of timely information. Nevertheless, HSCRC acknowledged early on that reporting burdens must be alleviated while operations were impacted by COVID-19. This new implementation timeline is not consistent with HSCRC's promise to accommodate hospitals impacted by the pandemic.

It should be noted that the Maryland General Assembly this session acknowledged the considerable amount of resources hospitals were dedicating to the ongoing COVID response and vaccination efforts and took action to extend the effective date of new reporting provisions accordingly.

The hospital personnel responsible for completing community benefit reports are over-extended. In addition to their normal workload, they are:

- Planning and executing large scale COVID-19 testing and vaccine events
- Working through challenges associated with the extensive data and reporting required by the state and federal governments concerning COVID-19 activities
- Navigating the constantly changing landscape of COVID-19 restrictions related to restarting community programs. Determining how to relaunch in-person events safely
- Reassessing focus areas through the Community Health Needs Assessments and accounting for changing needs due to the pandemic – particularly related to health disparities
- Working through the new care transformation report, first introduced last year.

Over the course of the first two webinars with Hilltop it was evident that staff unilaterally amended several items, changing them from what was approved by the CSAC. The net effect was to add to the reporting burden without giving a clear explanation of why provisions are being changed or added.

We hope HSCRC will quickly return to the initial timeline and allow the appropriate time for guideline development and implementation.

Please reach out if I can provide any additional details or answer any questions.

Sincerely,

Nicole Stallings
Senior Vice President, Government Affairs & Policy

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
John M. Colmers
James N. Elliott, M.D.
Sam Malhotra
Katie Wunderlich, Executive Director
Dennis Phelps, Deputy Director

**Maria Harris Tildon**
Executive Vice President
Public Policy & Government Affairs

**CareFirst BlueCross BlueShield**
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
Tel. 410-605-2591
Fax 410-505-2855

May 19, 2021

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

Dear Chairman Kane:

CareFirst BlueCross BlueShield appreciates the opportunity to comment on the "Draft Recommendation for the Community Benefit Reporting". We support the Draft Recommendation and hope community benefit reporting and transparency continues to progress into the future.

It has been over 10 years since the HSCRC overhauled the community benefit submission and reporting process. It is most relevant today with the State and hospitals needing to meet defined population health goals and with the potential for those goals to expand. Maryland has been a leader in community benefit reporting in the past, and to keep pace, the transparency sought by this recommendation is an excellent step toward improving reporting and awareness of how hospital expenditures are used to improve community and population health.

This recommendation combined with additional legislative changes adopted in 2020 (Chapter 437 of the 2020 Laws of Maryland) represent a good start in providing clarity to communities and consumers on how dollars associated with not-for-profit hospitals' tax-exempt status are used to help them and their health status. We support the recommendation as proposed and are offering below some thoughts on where the Staff might go next to continue to add meaning and value to the community benefit report.

- **Focus on Spending Net of Rate-Supported Programs** – The annual summary report of the Commission on community benefits highlights the total amount of community benefit spending and secondarily identifies the net spending (after considering amounts paid by payers through rates such as Uncompensated Care, Nurse Support, and Graduate Medical Education). To allow for better comparisons of hospitals to each other, or to hospitals in other states, it would be helpful to provide a greater focus on the net community benefit spending in the annual report of the Commission.

- **Set Standards for Indirect Costs** – In previous community benefit reports, some categories of community benefit spending have an indirect cost rate of 50% or more. In the interest of ensuring a reasonable amount of community benefit expenditures reach the targeted population directly, in the future the Commission could consider setting reasonable standards for indirect cost reporting in the community benefit reports. Recent

changes proposed by staff begin down this path by providing more detail on indirect cost expenditures and requiring separate line-items for indirect to direct cost ratios for hospital-based expenditures versus community-based expenditures.

CareFirst is encouraged by the community benefit changes proposed in the Draft Recommendation. We support the recommendation and are grateful for the opportunity to provide input. We look forward to working with you on continued development of the community benefit policy and reporting.

Sincerely,

Maria Harris Tildon

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

May 19, 2021

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

Dear Chairman Kane,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the updates to the Health Services Cost Review Commission (HSCRC) Community Benefit reporting guidelines. JHHS agrees with the critical need to engage community members in the Community Health Needs Assessment, and remains committed to continuing this practice in partnership with the HSCRC. We appreciate staff's dedication to a collaborative process throughout the development of these guidelines. With this in mind, JHHS does have concerns with the recent changes to the implementation deadline.

*Timeline Concerns*

In the December report to the legislature, the Consumer Standing Advisory Committee (CSAC) specified that the updated Community Benefit guidelines will go into effect for reporting on FY22, beginning in July of 2021. We have significant concerns regarding the advancement of the implementation timeline to FY21, as this accelerated timeline cannot be met in an appropriate and thoughtful manner. For successful implementation, each hospital must consider and implement the necessary changes as they progress through the FY22 reporting year. For example, JHHS will need to implement changes to reporting after individual consultation with over 100 program managers to discuss what additional details specific to their activities, and what reporting process changes, are needed to comply with the new requirements. Without an appropriate amount of time to ensure consistent collection of the highest quality data, the purpose of the reporting changes will not be met. An earlier implementation date could have the unintended impact of retroactive rule-making.

JHHS remains committed to investing in programs in collaboration with community residents, community leaders and community organizations that address the needs and priorities identified by community members. JHHS thanks the HSCRC for their collaboration on this important work.

Sincerely,

Nicki Sandusky McCann
Vice President, Provider/Payer Transformation
Johns Hopkins Health System

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
Katie Wunderlich
John M. Colmers
James Elliott, MD
Sam Maholtra

MedStar Health

8010 Corporate Drive, Suite O
Baltimore, MD 21236
410-933-2300 PHONE
410-933-2636 FAX
medstarhealth.org

Kathy Talbot
Vice President

Rates and Reimbursement

May 19, 2021

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

Dear Ms. Wunderlich:

On behalf of MedStar Health, Inc. and our subsidiary Maryland hospitals, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft staff recommendation on community benefit reporting.

We have the following comments:

(1) We request HSCRC maintain the FY 22 implementation timeline as MHA articulated in their comment letter. We are at the end of FY21 and these changes should be at the beginning of the fiscal year and not the end so hospitals have time to set–up new processes that might be required to better capture data requirements up-front.
(2) We request that Hospitals have the opportunity to formally comment on guidelines and the draft templates being developed to ensure that it is clear and understandable to all parties,
(3) We request that the December 15th due date be reviewed with the Annual filing and the new Population Health Report requirements to ensure that timing is aligned and does not create excess burden and duplication of work by hospital staff.

We look forward to our continued work with the HSCRC as we continue to look at opportunities to enhance community benefit reporting and show the work we are doing to support our communities.

Sincerely,

Kathy Talbot

Kathy Talbot
Vice President, Rates and Reimbursement
MedStar Health, Inc.

Meena Seshamani
Vice President, Clinical Care Transformation
MedStar Health, Inc.

Cc: Willem Daniel, Deputy Director, Payment Reform and Provider Alignment, HSCRC
Adam Kane, HSCRC Chairman
Joseph Antos, Ph.D., HSCRC Vice Chairman
James N. Elliott, M.D., HSCRC Commissioner
Victoria W. Bayless, HSCRC Commissioner
Sam Malhorta, HSCRC Commissioner
Stacia Cohen, RN, HSCRC Commissioner
John M. Colmers, HSCRC Commissioner

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# COVID-19 Community Vaccination Funding Program

# COVID-19 Community Vaccination Funding Program

- Maryland seeks to increase the statewide COVID-19 vaccination rate, particularly for underserved and vulnerable populations.
- Despite an unprecedented statewide effort to vaccinate all Marylanders, key challenges persist and threaten our ability to achieve community immunity.
  - Mass Vaccination Sites that are inaccessible for large portions of the State
  - Vaccine registration processes that are difficult for consumers to navigate
  - While vaccine supply has increased, consumer demand is declining
  - Many Mass Vaccination Sites are scaling back operations due to declining consumer demand
- Communities of color are disproportionately affected by these issues which exacerbates disparities
- To support the State's effort to increase vaccination rates, the Commission approved the "COVID-19 Community Vaccination Funding Program" that will run through the end of FY2022.
- The COVID-19 Community Vaccination Funding Program is intended to provide short-term funding to hospitals in order to allow for the optimization/expansion of their community-based vaccine dissemination strategies in areas with vaccine rates lower than the State average.

# Funding Overview

- The program is funding with the remainder of the set aside funds that the Commission allowed in the FY21 update factor ($12M).
- Any acute care hospital that is under HSCRC rate-setting authority was eligible to apply.
- Hospitals were encouraged to establish partnerships with local health departments, non-profits, faith-based entities and/or other community-based organizations.
- Hospitals volunteered for zip codes that have been identified by the Vaccination Equity Task Force (VETF) or in collaboration with Local Health Departments using CRISP data as disadvantaged, underserved, vulnerable, and/or hard-to-reach areas.

# Awardees

- The  HSCRC has awarded $12 million to 12 hospital systems in Maryland to expand hospitals' existing mobile and community-based vaccination programs and improve existing programs.
  - Atlantic General Hospital
  - Frederick Health
  - Greater Baltimore Medical Center
  - Holy Cross Hospital
  - Johns Hopkins Health System
  - LifeBridge Health and Ascension St. Agnes
  - Luminis Health
  - MedStar Health - Baltimore
  - MedStar Southern Maryland
  - Meritus Medical Center
  - University of Maryland Medical System

# Program Next Steps

- Projected Vaccine Administration
  - Hospitals have projected that nearly 300,000 vaccine doses will be issued
  - Hospitals communicate directly with MDH for vaccine supply.

- Statewide Coordination
  - Hospitals and HSCRC staff are participating in bi-weekly calls with the Governor's Office to ensure coordination with MDH and avoid duplication of efforts.

- Impact Measurement
  - Hospitals participating in the program will be required to provide data on their vaccination activities through HSCRC required monthly reporting
    - Type of vaccination events
    - # of vaccination events
    - Total # of doses issued by ZIP code
    - What is working, opportunities for improvement
  - HSCRC staff will monitor CRISP reporting on vaccination rates in targeted ZIP codes

# Awardees

| Hospital/Health System | Jurisdictions | ZIP Codes |
|---|---|---|
| Atlantic General Hospital | Worcester County | 21862, 21864, 21872, 21851, 21842, 21863, 21813, 21841, 21811 |
| Frederick Health | Frederick | 21701, 21702, 21703, 21704, 21710, 21716, 21727, 21754, 21755, 21758, 21769, 21770, 21771, 21773, 21774, 21777, 21778, 21780, 21788, 21793, 21798 |
| Greater Baltimore Medical Center | Baltimore City | 21202 |
| Holy Cross Hospital | Montgomery, Prince George's | 20705, 20770, 20784, 20785, 20866, 20868, 20901, 20902, 20903, 20904, 20906, 20910, 20912 |
| Johns Hopkins Health System | Baltimore City, Baltimore Co., Howard, Montgomery | 20723, 20794, 20814, 20815, 20817, 20850, 20852, 20854, 20874, 20878, 20902, 20904, 20906, 21043, 21044, 21045, 21046, 21075, 21202, 21205, 21213, 21219, 21222, 21224, 21231 |
| LifeBridge Health and Ascension St. Agnes | Baltimore City, Baltimore Co, Carroll | 21031, 21048, 21053, 21071, 21074, 21087, 21093, 21102, 21104, 21105, 21111, 21117, 21120, 21131, 21133, 21136, 21152, 21153, 21155, 21157, 21158, 21161, 21163, 21204, 21207, 21208, 21209, 21215, 21216, 21217, 21223, 21227, 21228, 21229, 21230, 21244, 21727, 21757, 21771, 21776, 21780, 21784, 21787,21791 |
| Luminis Health | Anne Arundel, Prince George's | 20706, 20711, 20743, 20769, 20770, 20784, 20785, 21401, 21403, 21409 |
| MedStar Health – Southern Maryland | St. Mary's, Prince George's | 20634, 20653, 2066, 20735, 20747 |
| MedStar Health – Baltimore | Baltimore City, Baltimore Co., Anne Arundel | 21206, 21213, 21218, 21220, 21221,21225, 21226, 21239 |
| Meritus Medical Center | Washington | 21711, 21713, 21719, 21722, 21733,21734, 21740, 21742, 21750, 21767, 21779, 21782, 21783, 21795 |
| University of Maryland Medical System | Baltimore City, Anne Arundel, Baltimore Co., Caroline, Charles, Dorchester, Harford, Kent, Queen Anne's, Prince George's | 20601, 20602, 20603, 20616, 20640, 20662, 21001, 21030, 21034, 21040, 21060, 21132, 21144, 21160, 21206, 21215, 21216, 21217, 21223, 21225, 21607, 21613, 21632, 21643, 21645, 21651 |

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# Rate Year 2022 Uncompensated Care Report

June 9, 2021

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

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# 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

[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

bad debt after the hospital makes a reasonable attempt to collect those charges.[8] However, there 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 2022, the determined UCC amount to be built into rates for Maryland hospitals is 4.61 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

[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: 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

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 five-step process:

1. **Statewide UCC:** HSCRC determines the statewide actual UCC based on the prior year's charity care and bad debt as a percentage of gross patient revenue as reported on the Hospitals' Revenue and Expense (RE) Schedules (e.g. Rate year (RY) 2022 UCC rates are based on the UCC percentage from the RY 2020 RE Schedules). The results from this computation determines the statewide UCC rate that will be built into the all-payer hospital rate structures., i.e. all hospital charges will be marked up to account for this statewide uncompensated care rate. Under this system, payers subsidize a share of uncompensated care that is equal to the payer's share of the market. It is important to note that only acute care hospitals are considered when determining the statewide UCC level. (See Appendix II).

2. **Hospital-Specific UCC:** HSCRC determines the hospital-specific actual UCC for each hospital based on the prior year's charity care and bad debt as a percentage of gross patient revenue as reported on the Revenue and Expense (RE) Schedules. (e.g. RY 2022 UCC uses the UCC percentage from the RY 2020 RE Schedules). (See Appendix II).

3. **Predicted Future UCC:** The third step uses a logistic regression model to predict the UCC for RY 2022. A regression is a statistical technique used when determining how much an output amount changes due to changes in multiple inputs. In this case, those inputs include: area deprivation Index (ADI), payer type, and site of care. An expected UCC dollar amount is calculated for every patient encounter. UCC dollars are summed at the hospital level, and summed UCC dollars are divided by hospital total charges to establish the hospital's estimated UCC level. This calculation creates a predicted UCC rate for each hospital. 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. (See Appendix II).

4. **Blended Actual and Predicted UCC:** The HSCRC calculates a 50/50 blend between the hospital- specific actual UCC (described in step 2 above) and the predicted UCC (described in step 3). This calculation serves to balance policy goals of reimbursing hospitals for UCC provided to low-income patients through the hospital's financial assistance policy while also incentivizing hospitals to minimize bad debt by encouraging reasonable activities to collect debt from patients who can afford to pay. (See Appendix I).

5. **Hospital Payments or Contributions to the UCC fund.** The 50/50 blend from step four for each hospital is subtracted from the amount of UCC funding provided in rates (calculated in

[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/.

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 a statewide UCC Fund. The UCC fund is the funding mechanism to ensure the burden of uncompensated care is shared equitably across all hospitals. Specifically, if a hospital has a UCC rate computed from the 50/50 blend that is less than the statewide average UCC rate from the prior fiscal year that was provided in rates to all hospitals, the hospital will pay into the UCC fund equal to the variance between the two statistics. Conversely, if a hospital has a 50/50 blend that is greater than the statewide average UCC rate, the hospital will receive funding equal to the variance between the two statistics.

**Exhibit 1: UCC Methodology Example ($ Millions)**

| | | Step 1 | | Step 2 | Step 3 | Step 4 | |
|---|---|---|---|---|---|---|---|
| | **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

The HSCRC must determine the percentage of UCC to incorporate in hospitals' rates in order to fund the UCC pool. Based on the FY 2020 audited reports, the statewide UCC rate is 4.61 percent, 0.20 percentage points higher than last year's UCC rate of 4.41 percent. According to the statistics published by the U.S. Census Bureau on September 16, 2015, the rate of Marylanders without health insurance decreased from 10.2 percent in 2013 to 7.9 percent in 2014.[11] Based on the Census Bureau's American Community Survey, Kaiser Family Foundation estimates Maryland's uninsured rate to have decreased to 6 percent as of 2018;[12] however, as the RY 2020 experience demonstrates, the continuing reductions in UCC that resulted from the implementation of the Affordable Care Act and the lowering of the uninsured population has slowed. For RY 2022, staff will provide a UCC rate of 4.61 percent in rates in keeping with prior year methodologies.

# IMPLEMENTATION

Based on the preceding analysis, HSCRC staff will implement the following for RY 2022:

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

[12] 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

1. Increase the statewide UCC provision in rates from 4.41% to 4.61% effective July 1, 2021.
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 FY20 audited UCC levels and FY2022 predicted UCC levels to determine hospital-specific adjustments for the UCC Fund.

# COVID-19 IMPLICATIONS

Early last year, Staff began evaluating the possibility of using multi-year actual UCC averages in lieu of the one year figures to do the 50/50 blend with predicted UCC from the regression. Staff believes that using two or more years of history will make the statistic more stable, especially as the declining trends due to the implementation of the Affordable Care Act appear to have slowed. However, with the onset of Covid-19, Staff halted further work on this and other policy development to allow the hospitals sufficient bandwidth to respond to the pandemic. With the pandemic still on-going, Staff plans to resume evaluation of the multi-year blend on actuals for the RY 2023 UCC policy.

Staff was also concerned about the impact of COVID-19 on the FY2020 Write-off data used to predict RY2022 UCC. To ensure that the data was reliable and accurate, staff performed various statistical and trend analyses on the data, the outcome of which leads staff to believe that the data is significantly correlated to data used in prior year UCC calculations (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.

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# Appendix I. Hospital Uncompensated Care provision FOR RY 2022

| HOSPID | HOSPNAME | FY2022 GBR Permanent Revenue | FY 2020 UCC Based on FY 2022 GBR Permanent Revenue | FY 2020 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 2020 UCC Based on FY 2022 GBR Permanent Revenue Level | Percent UCC |
|---|---|---|---|---|---|---|---|---|---|
| 210001 | Meritus Medical Cntr | $409,208,011 | $ 21,227,217 | 5.19% | 5.44% | $ 22,250,576 | 5.31% | $ 23,153,055 | 5.66% |
| 210002 | UMMC | $1,712,117,653 | $ 67,019,513 | 3.91% | 2.56% | $ 43,854,148 | 3.24% | $ 59,043,105 | 3.45% |
| 210003 | UM-Prince George's Hospital | $359,628,173 | $ 31,594,073 | 8.79% | 7.58% | $ 27,272,964 | 8.18% | $ 31,348,227 | 8.72% |
| 210004 | Holy Cross | $543,678,044 | $ 43,204,836 | 7.95% | 6.16% | $ 33,503,543 | 7.05% | $ 40,849,205 | 7.51% |
| 210005 | Frederick Memorial | $388,573,040 | $ 17,556,466 | 4.52% | 4.95% | $ 19,247,289 | 4.74% | $ 19,598,956 | 5.04% |
| 210006 | UM-Harford Memorial | $114,037,478 | $ 7,472,414 | 6.55% | 4.06% | $ 4,634,733 | 5.31% | $ 6,447,370 | 5.65% |
| 210008 | Mercy Medical Cntr | $604,003,988 | $ 31,026,006 | 5.14% | 3.93% | $ 23,727,714 | 4.53% | $ 29,157,779 | 4.83% |
| 210009 | Johns Hopkins | $2,710,191,648 | $ 82,384,244 | 3.04% | 3.17% | $ 85,870,983 | 3.10% | $ 89,600,280 | 3.31% |
| 210010 | UM-SRH at Dorchester | $47,896,448 | $ 2,930,569 | 6.12% | 4.90% | $ 2,348,591 | 5.51% | $ 2,811,290 | 5.87% |
| 210011 | St. Agnes Hospital | $458,016,938 | $ 24,698,447 | 5.39% | 5.52% | $ 25,299,001 | 5.46% | $ 26,624,940 | 5.81% |
| 210012 | Sinai Hospital | $901,651,842 | $ 37,117,410 | 4.12% | 3.65% | $ 32,907,022 | 3.88% | $ 37,289,830 | 4.14% |
| 210013 | Bon Secours Hospital | $42,591,769 | $ 1,840,957 | 4.32% | 5.14% | $ 2,189,873 | 4.73% | $ 2,146,521 | 5.04% |
| 210015 | MedStar Franklin Square | $599,770,894 | $ 22,339,505 | 3.72% | 3.64% | $ 21,854,534 | 3.68% | $ 23,534,474 | 3.92% |
| 210016 | Washington Adventist Hospital | $318,589,062 | $ 21,382,253 | 6.71% | 5.04% | $ 16,047,160 | 5.87% | $ 19,932,135 | 6.26% |
| 210017 | Garrett Co Memorial | $67,302,095 | $ 4,407,854 | 6.55% | 5.55% | $ 3,732,012 | 6.05% | $ 4,334,690 | 6.44% |
| 210018 | MedStar Montgomery | $188,495,772 | $ 6,960,277 | 3.69% | 3.51% | $ 6,618,580 | 3.60% | $ 7,231,094 | 3.84% |
| 210019 | Peninsula Regional | $506,778,910 | $ 20,923,926 | 4.13% | 4.43% | $ 22,446,579 | 4.01% | $ 23,095,921 | 4.56% |
| 210022 | Suburban | $370,693,880 | $ 14,641,420 | 3.95% | 3.62% | $ 13,425,044 | 3.79% | $ 14,946,121 | 4.03% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 210023 | Anne Arundel Medical Cntr | $715,249,436 | $ 23,427,209 | 3.28% | 3.61% | $ 25,843,555 | 3.44% | $ 26,237,962 | 3.67% |
| 210024 | MedStar Union Memorial | $450,005,129 | $ 13,562,387 | 3.01% | 3.38% | $ 15,225,641 | 3.20% | $ 15,330,373 | 3.41% |
| 210027 | Western Maryland | $357,775,195 | $ 17,145,931 | 4.79% | 4.55% | $ 16,263,334 | 4.67% | $ 17,791,301 | 4.97% |
| 210028 | MedStar St. Mary's | $202,851,623 | $ 7,127,580 | 3.51% | 3.78% | $ 7,666,348 | 3.65% | $ 7,878,151 | 3.88% |
| 210029 | JH Bayview | $744,561,141 | $ 38,813,885 | 5.21% | 4.85% | $ 36,136,854 | 5.03% | $ 39,913,216 | 5.36% |
| 210030 | UM-SRH at Chestertown | $56,037,287 | $ 3,444,151 | 6.15% | 4.32% | $ 2,420,618 | 5.23% | $ 3,123,142 | 5.57% |
| 210032 | Union Hospital of Cecil Co | $178,531,566 | $ 10,749,796 | 6.02% | 5.20% | $ 9,280,345 | 5.61% | $ 10,666,570 | 5.97% |
| 210033 | Carroll Co Hospital Cntr | $249,529,739 | $ 8,690,025 | 3.48% | 3.67% | $ 9,165,000 | 3.58% | $ 9,508,265 | 3.81% |
| 210034 | MedStar Harbor Hospital Cntr | $199,742,810 | $ 9,931,263 | 4.97% | 4.42% | $ 8,821,079 | 4.69% | $ 9,986,109 | 5.00% |
| 210035 | UM-Charles Regional | $169,302,105 | $ 10,530,821 | 6.22% | 5.08% | $ 8,605,759 | 5.65% | $ 10,190,727 | 6.02% |
| 210037 | UM-SRH at Easton | $243,411,788 | $ 8,517,245 | 3.50% | 2.89% | $ 7,038,688 | 3.20% | $ 8,283,938 | 3.40% |
| 210038 | UMMC - Midtown | $234,560,805 | $ 10,434,746 | 4.45% | 3.31% | $ 7,763,225 | 3.88% | $ 9,690,892 | 4.13% |
| 210039 | Calvert Health Med Cntr | $166,499,257 | $ 5,281,607 | 3.17% | 3.64% | $ 6,059,691 | 3.41% | $ 6,039,536 | 3.63% |
| 210040 | Northwest Hospital Cntr | $285,936,370 | $ 18,646,484 | 6.52% | 4.70% | $ 13,439,224 | 5.61% | $ 17,086,473 | 5.98% |
| 210043 | UM-BWMC | $482,519,388 | $ 27,591,914 | 5.72% | 3.67% | $ 17,701,110 | 4.69% | $ 24,119,712 | 5.00% |
| 210044 | GBMC | $515,319,556 | $ 15,101,534 | 2.93% | 3.49% | $ 17,997,257 | 3.21% | $ 17,625,966 | 3.42% |
| 210048 | Howard County General | $325,719,264 | $ 17,066,403 | 5.24% | 3.77% | $ 12,280,182 | 4.50% | $ 15,627,819 | 4.80% |
| 210049 | UM-Upper Chesapeake | $348,075,933 | $ 20,954,591 | 6.02% | 3.38% | $ 11,749,325 | 4.70% | $ 17,415,685 | 5.00% |
| 210051 | Doctors Community | $280,611,465 | $ 19,246,600 | 6.86% | 5.46% | $ 15,315,243 | 6.16% | $ 18,405,080 | 6.56% |
| 210056 | MedStar Good Samaritan | $285,942,380 | $ 12,930,514 | 4.52% | 3.92% | $ 11,201,857 | 4.22% | $ 12,851,115 | 4.49% |
| 210057 | Shady Grove Adventist Hospital | $489,441,390 | $ 31,650,044 | 6.47% | 5.02% | $ 24,587,645 | 5.75% | $ 29,948,031 | 6.12% |
| 210060 | Fort Washington Medical Center | $54,639,542 | $ 3,990,351 | 7.30% | 7.54% | $ 4,121,801 | 7.42% | $ 4,319,932 | 7.91% |
| 210061 | Atlantic General | $119,968,654 | $ 6,768,490 | 5.64% | 5.19% | $ 6,225,263 | 5.42% | $ 6,919,511 | 5.77% |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 210062 | MedStar Southern MD | $295,731,701 | $ 14,570,012 | 4.93% | 4.21% | $ 12,444,860 | 4.57% | $ 14,386,121 | 4.86% |
| 210063 | UM-St. Joseph Med Cntr | $412,479,912 | $ 15,251,020 | 3.70% | 3.43% | $ 14,130,162 | 3.56% | $ 15,646,243 | 3.79% |
| 210065 | HC-Germantown | $124,836,843 | $ 10,832,398 | 8.68% | 7.64% | $ 9,537,547 | 8.16% | $ 10,847,525 | 8.69% |
| | | | | | | | | | |
| | **Total** | **$ 18,332,505,926** | **$ 840,984,388** | **4.59%** | **4.04%** | **$ 738,251,960** | **4.31%** | **$ 840,984,388** | **4.59%** |

**Note:** Levindale, UMROI, and UM-Shock Trauma are not included in this analysis. If included, the actual UCC from RY 2020 RE Schedule would be 4.61%. This rate of 4.61% is what is built into rates.

# Appendix II. Actual UCC Summary Statistics

The table below presents the actual UCC change by hospital between FY 2019 and FY 2020– it does not reflect predicted UCC rates.

## Appendix II. Table 1. Actual UCC Change by Hospital, FY 2019-2020

| HOSPID | HOSPNAME | RY 2020 % UCC | RY 2019 % UCC | Variance Over/Under |
|---|---|---|---|---|
| 210001 | Meritus Medical Cntr | 5.19% | 4.61% | 0.58% |
| 210002 | UMMC | 3.91% | 4.20% | -0.29% |
| 210003 | UM-Prince George's Hospital | 8.79% | 8.84% | -0.05% |
| 210004 | Holy Cross | 7.95% | 8.36% | -0.41% |
| 210005 | Frederick Memorial | 4.52% | 4.65% | -0.13% |
| 210006 | UM-Harford Memorial | 6.55% | 6.45% | 0.10% |
| 210008 | Mercy Medical Cntr | 5.14% | 5.06% | 0.08% |
| 210009 | Johns Hopkins | 3.04% | 2.59% | 0.45% |
| 210010 | UM-SRH at Dorchester | 6.12% | 5.51% | 0.61% |
| 210011 | St. Agnes Hospital | 5.39% | 4.91% | 0.48% |
| 210012 | Sinai Hospital | 4.12% | 2.96% | 1.16% |
| 210013 | Bon Secours | 4.32% | 2.36% | 1.96% |
| 210015 | MedStar Franklin  Square | 3.72% | 3.50% | 0.22% |
| 210016 | Washington Adventist | 6.71% | 8.19% | -1.48% |
| 210017 | Garrett Co Memorial | 6.55% | 6.97% | -0.42% |
| 210018 | MedStar Montgomery | 3.69% | 3.43% | 0.26% |
| 210019 | Peninsula Regional | 4.13% | 3.79% | 0.34% |
| 210022 | Suburban | 3.95% | 3.60% | 0.35% |
| 210023 | Anne Arundel Medical Cntr | 3.28% | 2.71% | 0.57% |
| 210024 | MedStar Union Memorial | 3.01% | 2.98% | 0.03% |
| 210027 | Western Maryland | 4.79% | 5.36% | -0.57% |
| 210028 | MedStar St. Mary's | 3.51% | 4.47% | -0.96% |
| 210029 | JH Bayview | 5.21% | 5.20% | 0.01% |
| 210030 | UM-SRH at Chestertown | 6.15% | 5.39% | 0.76% |
| 210032 | Union Hospital of Cecil Co | 6.02% | 5.32% | 0.70% |
| 210033 | Carroll Co Hospital Cntr | 3.48% | 2.33% | 1.15% |
| 210034 | MedStar Harbor Hospital Cntr | 4.97% | 4.62% | 0.35% |
| 210035 | UM-Charles Regional | 6.22% | 5.26% | 0.96% |
| 210037 | UM-SRH at Easton | 3.50% | 3.39% | 0.11% |
| 210038 | UMMC - Midtown | 4.45% | 5.20% | -0.75% |

| | | | | |
|---|---|---|---|---|
| 210039 | Calvert Health Med Cntr | 3.17% | 4.27% | -1.10% |
| 210040 | Northwest Hospital Cntr | 6.52% | 5.06% | 1.46% |
| 210043 | UM-BWMC | 5.72% | 5.90% | -0.18% |
| 210044 | GBMC | 2.93% | 2.58% | 0.35% |
| 210045 | McCready Memorial | | 5.38% | -5.38% |
| 210048 | Howard County General | 5.24% | 4.08% | 1.16% |
| 210049 | UM-Upper Chesapeake | 6.02% | 4.13% | 1.89% |
| 210051 | Doctors Community | 6.86% | 7.27% | -0.41% |
| 210055 | UM-Laurel Regional | | 12.26% | -12.26% |
| 210056 | MedStar Good Samaritan | 4.52% | 4.46% | 0.06% |
| 210057 | Shady Grove | 6.47% | 5.16% | 1.31% |
| 210058 | UM-ROI | 3.95% | 4.49% | -0.54% |
| 210060 | FT. Washington | 7.30% | 8.31% | -1.01% |
| 210061 | Atlantic General | 5.64% | 4.74% | 0.90% |
| 210062 | MedStar Southern MD | 4.93% | 5.23% | -0.30% |
| 210063 | UM-St. Joseph Med Cntr | 3.70% | 3.86% | -0.16% |
| 210064 | Levindale | 4.80% | 4.68% | 0.12% |
| 210065 | HC-Germantown | 8.68% | 8.46% | 0.22% |
| 218992 | UM-Shock Trauma | 6.28% | 6.26% | 0.02% |
| **Total** | | **4.61%** | **4.41%** | **0.20%** |

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

# Appendix III. Write-off Data Analyses

| | | FY 2020 | | FY 2019 | |
|---|---|---|---|---|---|
| **HOSPID** | **Hospital Name** | **TOT_CHG** | **PREDICTED_UCC** | **TOT_CHG** | **PREDICTED_UCC** |
| 210001 | Meritus | $ 362,989,191 | $ 19,737,440 | $ 369,036,976 | $ 18,134,597 |
| 210002 | UMMC | $ 1,555,084,757 | $ 39,831,911 | $ 1,523,304,722 | $ 38,806,181 |
| 210003 | UM-PGHC | $ 341,318,592 | $ 25,884,428 | $ 324,900,507 | $ 23,651,869 |
| 210004 | Holy Cross | $ 511,271,415 | $ 31,506,521 | $ 518,520,703 | $ 36,298,525 |
| 210005 | Frederick | $ 359,679,258 | $ 17,816,086 | $ 352,965,587 | $ 18,341,972 |
| 210006 | UM-Harford | $ 100,457,116 | $ 4,082,797 | $ 107,480,496 | $ 4,624,593 |
| 210008 | Mercy | $ 548,551,614 | $ 21,549,321 | $ 553,175,818 | $ 21,313,358 |
| 210009 | Johns Hopkins | $ 2,453,860,252 | $ 77,749,259 | $ 2,460,960,900 | $ 74,202,193 |
| 210010 | UM-Dorchester | $ 38,406,151 | $ 1,883,237 | $ 45,223,858 | $ 2,314,568 |

| | | | | | |
|---|---|---|---|---|---|
| 210011 | St. Agnes | $ 419,501,571 | $ 23,171,568 | $ 429,347,315 | $ 20,409,003 |
| 210012 | Sinai | $ 818,167,825 | $ 29,860,158 | $ 786,008,811 | $ 27,144,657 |
| 210013 | Grace Medical center | $ 69,512,240 | $ 3,574,000 | $ 112,480,475 | $ 4,908,287 |
| 210015 | MedStar Fr Square | $ 588,927,594 | $ 21,459,424 | $ 555,859,990 | $ 20,641,056 |
| 210016 | Adventist White Oak | $ 305,251,723 | $ 15,375,366 | $ 283,496,544 | $ 18,617,983 |
| 210017 | Garrett | $ 59,760,227 | $ 3,313,803 | $ 65,237,466 | $ 3,339,540 |
| 210018 | MedStar Montgomery | $ 184,111,749 | $ 6,464,645 | $ 179,659,293 | $ 6,979,742 |
| 210019 | Peninsula | $ 457,824,421 | $ 20,278,255 | $ 456,040,357 | $ 19,145,025 |
| 210022 | Suburban | $ 321,763,218 | $ 11,652,972 | $ 336,195,043 | $ 12,930,829 |
| 210023 | Anne Arundel | $ 639,384,460 | $ 23,102,385 | $ 638,915,947 | $ 21,982,738 |
| 210024 | MedStar Union Mem | $ 429,931,609 | $ 14,546,466 | $ 421,430,297 | $ 15,662,050 |
| 210027 | Western Maryland | $ 337,971,374 | $ 15,363,115 | $ 336,104,673 | $ 14,850,446 |
| 210028 | MedStar St. Mary's | $ 199,340,963 | $ 7,533,670 | $ 190,651,240 | $ 7,309,126 |
| 210029 | JH Bayview | $ 654,894,625 | $ 31,784,940 | $ 676,879,971 | $ 33,226,513 |
| 210030 | UM-Chestertown | $ 41,883,891 | $ 1,809,240 | $ 46,771,763 | $ 1,951,437 |
| 210032 | ChristianaCare, Union | $ 163,599,167 | $ 8,504,136 | $ 163,540,394 | $ 7,340,949 |
| 210033 | Carroll | $ 231,088,487 | $ 8,487,669 | $ 234,141,186 | $ 8,301,971 |
| 210034 | MedStar Harbor | $ 184,401,953 | $ 8,143,593 | $ 188,013,249 | $ 8,530,979 |
| 210035 | UM-Charles Regional | $ 155,083,766 | $ 7,883,030 | $ 154,875,318 | $ 7,461,752 |
| 210037 | UM-Easton | $ 238,382,456 | $ 6,893,256 | $ 230,782,936 | $ 7,624,533 |
| 210038 | UMMC Midtown | $ 198,376,019 | $ 6,565,622 | $ 216,362,184 | $ 7,733,089 |
| 210039 | Calvert | $ 156,986,093 | $ 5,713,463 | $ 152,440,161 | $ 5,948,940 |
| 210040 | Northwest | $ 266,740,312 | $ 12,536,995 | $ 270,436,111 | $ 14,110,094 |
| 210043 | UM-BWMC | $ 438,316,007 | $ 16,079,520 | $ 446,838,259 | $ 16,705,835 |
| 210044 | GBMC | $ 470,195,108 | $ 16,421,310 | $ 476,405,568 | $ 16,595,959 |
| 210048 | Howard County | $ 300,110,296 | $ 11,314,679 | $ 307,874,351 | $ 13,533,347 |
| 210049 | UM-Upper Chesapeake | $ 311,152,323 | $ 10,502,966 | $ 323,542,686 | $ 11,231,490 |
| 210051 | Doctors | $ 255,559,577 | $ 13,947,959 | $ 256,571,881 | $ 14,478,704 |
| 210056 | MedStar Good Sam | $ 267,313,912 | $ 10,472,083 | $ 258,232,394 | $ 10,783,231 |
| 210057 | Shady Grove | $ 458,711,466 | $ 23,043,892 | $ 445,836,157 | $ 24,062,522 |
| 210060 | Ft. Washington | $ 61,224,082 | $ 4,618,514 | $ 51,952,283 | $ 4,574,910 |
| 210061 | Atlantic General | $ 106,773,194 | $ 5,540,541 | $ 110,346,276 | $ 5,714,101 |
| 210062 | MedStar Southern MD | $ 281,748,091 | $ 11,856,408 | $ 273,982,766 | $ 10,949,621 |
| 210063 | UM-St. Joe | $ 372,785,338 | $ 12,770,361 | $ 389,641,461 | $ 15,918,298 |

| | | | | | |
|---|---|---|---|---|---|
| 210065 | HC-Germantown | $ 119,287,524 | $ 9,113,579 | $ 110,764,041 | $ 9,383,182 |
| | | | | | |
| **Total** | **Statewide** | **$ 16,837,681,008** | **$ 679,740,581** | **$ 16,918,700,246** | **$ 696,044,899** |
| | | | | | |
| | **Total Charge Correlation** | **99.94%** | | | |
| | **Predicted UCC Correlation** | **99.34%** | | | |

maryland
health services
cost review commission

**TO**: HSCRC Commissioners

**FROM**: HSCRC Staff

**DATE**: June 9, 2021

**RE**: Hearing and Meeting Schedule

July 14, 2021 To be determined - GoTo Webinar

August 11, 2021 To be determined - GoTo Webinar

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

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