maryland
health services
cost review commission

592nd Meeting of the Health Services Cost Review Commission
February 9, 2022

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

EXECUTIVE SESSION
11:30 am

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

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

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on January 12, 2022

2. Docket Status – Cases Closed
   2569N – Greater Baltimore Medical Center
   2578A – University of Maryland Medical Center
   2579A – John Hopkins Health System

3. Docket Status – Cases Open
   2580R – Brook Lane Hospital
   2581A – John Hopkins Health System
   2540A - John Hopkins Health System

4. Policy Update and Discussion

   a. Model Monitoring
   b. Legislative Update
   c. Workgroup Update
   d. Outcomes-Based Credit Update

5. Hearing and Meeting Schedule

MINUTES OF THE
591st MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
January 12, 2022

Chairman Adam Kane called the public meeting to order at 11:33 a.m. Commissioners Joseph Antos, PhD, Victoria Bayless, Stacia Cohen, James Elliott, M.D., and Maulik Joshi, DrPH were also in attendance. Upon motion made by Commissioner Antos and seconded by Commissioner Elliott, the meeting was moved to Closed Session. Chairman Kane reconvened the public meeting at 1:22 p.m.

REPORT OF JANUARY 12, 2022 CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the January 12, 2022 Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE DECEMBER 8, 2021 CLOSED SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the December 8, 2021 Public meeting and Closed Session.

ITEM II
CASES CLOSED

2573A- University of Maryland Medical Center
2574A- Johns Hopkins Health System
2575A- Johns Hopkins Health System
2576A- Johns Hopkins Health System
2577A- Johns Hopkins Health System

ITEM III
OPEN CASES

2569N- Greater Baltimore Medical Center

On August 20, 2020 Greater Baltimore Medical Center (“GBMC”, or “the Hospital") received an approved Certificate of Need (CON) to construct a three-story, 106,083 square foot expansion in front of the main lobby. The addition will include two thirty-bed nursing units. The project will also renovate about 11,600 square feet. This project is part of GBMC’s Master Facility Plan which aims to update the Hospital’s acute care facilities in line with standards while also remaining consistent with modern Facility Guidelines Institute standards. In concert with the approval of the CON and to ensure GBMC can update and modernize their facilities with today’s standards, the Hospital is requesting gross capital funding in the amount of $2,231,584 as part of the Commission’s capital funding policy.

Under the HSCRC's historical capital methodology, GBMC's request would have been capped at the 50/50 blend of a hospital's capital cost share (inclusive of the new request's first year estimated depreciation and interest costs) and the peer group average capital cost share, and that value would be scaled for cost per case efficiency. Using the recently updated HSCRC capital methodology, the capital request from GBMC will continue to be capped at the 50/50 blend of the hospital's capital cost share (inclusive of the new request's annualized estimate for depreciation and interest) and the peer group average, and that value will be scaled for cost per case efficiency, total cost of care efficiency, current levels of potentially avoidable utilization, and excess capacity.

The final two steps of the methodology are to remove costs associated with excess capacity, as defined by reductions in bed days from 2010 to 2018, and to mark up these cost-based figures for uncompensated care and the governmental payer differential. GBMC experienced a reduction of 2,772 bed days since 2010; however, the reduction occurred exclusively during the 2010 to 2014 time period when the Commission had an 85 percent volume variable system, i.e. 85 percent of the revenue associated with volume reductions was removed from the hospitals permanent revenue base, so there is no adjustment for excess capacity. The Hospital's markup in Fiscal Year 2022 was 1.1013; therefore, the capital allotment GBMC is eligible for is $2,037,583.

Lastly, since the Commission has not been able to update its efficiency methodologies beyond annual filing statistics from RY 2019 due to the confounding effects of the COVID-19 public health emergency, staff has a methodology that is one year in arrears from the typical implementation of its capital policy. As such, staff is recommending applying an additional year of inflation to the eligible capital funding to bring it closer in alignment with current year dollars. The $2,037,583 will be inflated by 2.96% that was provided in the RY2020 Update Factor, which yields a final permanent revenue adjustment of $2,097,895.

Staff recommends a permanent adjustment of $2,097,895 be provided to GBMC when the project is completed and the new site is available for use. This opening date of this project is anticipated to become effective on July 1, 2023.

The Commission voted unanimously to approve Staff's recommendation.

ITEM IV
HSCRC RESPONSE TO SURGE

Ms. Katie Wunderlich, Executive Director, presented an overview of the HSCRC's response to the COVID-19 pandemic (see "HSCRC Response to Surge") available on the HSCRC website.

Due to the continued COVID-19 surge, Staff proposed the following revisions to the COVID-19 Surge Policy for FY22.

- An accelerated release of the FY21 $124 million funding undercharge for January 2022 rate orders
- Delays in policy implementation including changes to the Readmissions Reduction Program, Revenue for Reform policy approval and implementation

- Suspension of all future workgroup meetings
- Extension of the Population Health Reporting and Community Benefit Reporting deadlines to March 1, 2022.

Given the ongoing challenges presented by the continue surge in COVID cases, Staff recommends refining the policy to supplement traditional GBR and COVID surge reimbursement. Staff recommends working with stakeholders to bring specific policy guidance to the Commission for review and approval in late Spring 2022 with a reconciliation at the end of the fiscal year and surge funding included in the January 2023 rate orders. The intent is to reimburse hospitals for high COVID volumes that result in total volumes beyond those covered under their GBR and not otherwise reimbursed. Specific considerations will include:

- Focus funding for hospitals with higher than typical COVID volumes
- Focus funding for hospitals with higher than typical total volumes where COVID is a significant contributor to the higher volumes
- Focus funding on COVID cases where a patient is being treated for COVID as the primary diagnosis, as opposed to all those with COVID exposure (the original policy used the more generous definition)
- Reduce funding for offsetting alternative sources of funding such as Provider Relief Fund (PRF) funds.

ITEM V
HOSPITAL REQUEST FOR MID-YEAR RATE UPDATE

Mr. Bob Atlas, President & CEO, Maryland Hospital Association (MHA), Mr. Tom Kleinhanzl, President & CEO, Frederick Health, Ms. Kristen Pulio, Chief Financial Officer, Adventist Healthcare, and Brett McCone, SVP of Health Care Payment, MHA, presented the Commission with Maryland Hospitals' request for an increase in the mid-year rate update.

MHA and its member hospitals urged the Commission to raise RY 2022 hospital rates for GBR and non-GBR hospitals by 65 basis points on January 1, 2022. MHA asserts that the request is due to the following pressures currently being experienced by Maryland hospitals:

- 2022 inflation is more than 25% higher than was estimated at the time of the update:

    a. According to data from MHA surveys, hospitals have given, or plan to offer, more than $170 million in RY 2022 permanent salary increases. These amounts are required to retain staff in the face of poaching by staffing agencies providing pay that can reach 3 to 4 times regular wages.
    b. Year-to-date RY 2022 contract labor costs averaged nearly $58 million per month or $650 million annually.
    c. These costs are 300% higher than $210 million in RY 2019, and the increment alone equates to 2.4% of all statewide patient revenues.

- Hospital margins are deteriorating rapidly:

a. In October, the median hospital operating margin was -2.1%. The median for RY 2021 was 3.4% and has since declined from the September median of 0.6%.
b. Hospitals in Maryland have more limited opportunities to recoup lost margin, for example

    - Hospitals outside of Maryland contract with health insurers for defined periods, those hospitals can attempt to renegotiate higher payment rates.
    - Hospitals outside of Maryland also can drive marginal revenue through volume increases.
    - Other states have also shared with hospitals some of the COVID-19 relief dollars they received from the federal government.

- The tight labor market is straining hospital services:

    a. Several hospitals have or will curtail scheduled procedures due to staffing limitations. Vital affected services include operating rooms, cardiac catheterization laboratories, labor and delivery inductions, and more.
    b. Medical/surgical and intensive care units are persistently running at an extended capacity of 85% or higher. That can result in inefficient operations and longer turnover times. In extreme circumstances, hospitals are forced to take inpatient beds offline due to staffing shortages.
    c. Emergency department wait times are getting longer, for both patients waiting to be diagnosed and patients waiting to be moved from the ED to an inpatient or observation bed. These circumstances directly result from limited staff both in EDs and on nursing floors.
    d. Many hospitals cite a sharp increase in ED yellow and red alert hours, well above pre-pandemic levels.
    e. Maryland hospitals continue their commitment to invest in improving the population's health or transforming care. However, these dire circumstances threaten that work through staffing pressures and the need to protect financial positions. Hospitals' core mission is to provide acute care, emergency, and outpatient services to their patients. If resources are limited, Maryland hospitals will only meet the core mission, resuming non-core investments only when new funds become available

Chairman Kane expressed appreciation to all hospital staff and MHA for their continued support in the field during this challenging time and ongoing crisis.

Chairman Kane asked why hospitals would pay such high agency costs.

Ms. Pulio replied that hospitals have not been able to hire clinical staff since before the pandemic and have no choice but to hire agency staff to staff units.

Chairman Kane asked Ms. Pulio to explain why hospitals did not use Provider Relief Funds (PRFs) received for recruiting.

Ms. Pulio explained that PRF funds were used to pay for one-time impacts of COVID-19 and that the staffing shortages have persisted, causing permanent, long-term consequences.

Chairman Kane asked Ms. Pulio to discuss some of the differences between challenges experienced at Adventist's Howard University Hospital (HUH), located in DC, and Adventist facilities in Maryland.

Ms. Pulio stated that HUH received two grants from the district and federal funding, unlike Maryland.

Chairman Kane asked if any of HUH's commercial payers increased funding to combat the crisis.

Ms. Pulio stated that HUH has a much smaller commercial population than Adventist facilities in Maryland.

Ms. Pulio shared that HUH is in constant conversation with commercial payers to discuss rates, and HUH also receives an additional 20% DRG payment for COVID patients in the Medicare population.

Chairman Kane stated that the Commission needs to consider the funding already provided, including GBR and PRF funds, and that undercharges will help cope with extraordinary expenses. He added that the Commission would continue to monitor hospital costs as we move forward.

Commissioner Antos stated that one aspect to consider is that the Commission projects inflation in June, which they now realize they underestimated for RY 2022.

Commissioner Antos proposed that the HSCRC provide advance funding for a portion of the inflation currently being experienced and settle up via the FY2023 Update Factor.

Ms. Wunderlich stated that she wanted to remind the Commission that when the RY 2022 Update Factor was projected last June, the HSCRC added a one-time permanent adjustment for anticipated inflation onto the projection, and that the Commission can always choose to smooth adjustments out over a more extended period.

Commissioner Cohen agreed with Commissioner Antos' suggestion. However, she reminded the Commissioners that historically, the HSCRC has not adjusted future Update Factors due to overestimating inflation in the prior year's Update Factor. Therefore, she believes the Commission needs to be consistent with how they think about modifying Update Factors in the future in cases of both over and underestimating inflation.

Chairman Kane stated that several months of declining margin have occurred. He is not sure that 65 basis points will provide enough support. He suggested providing $100 million to hospitals now and then removing it from the Update Factor in July.

Commissioner Cohen asked Chairman Kane the reasoning behind the funding of $100 million.

Chairman Kane replied that the request for 65 basis points was received before the current COVID surge began which likely increased the amount of funding needed. Additionally, he stated that neither the HSCRC nor the hospital industry could accurately predict the exact amount needed, so the $100 million in funding will hopefully act as a bridge to get hospitals through July.

The Commissioners voted unanimously to approve the proposal to make a one-time increase to RY 2022 hospital rates for GBR and non-GBR hospitals of $100 million on January 1, 2022, and to remove the $100 million adjustment from hospital rates on July 1, 2022. In addition, the $100 million would be offset against the inflation portion of the Update Factor for the first half of rate year 2023 and then be added back in January of 2023.

ITEM VI
FINAL RECOMMENDATION ON MARYLAND HOSPITAL ACQUIRED CONDITIONS FOR RY 2024

Dr. Alyson Schuster, Deputy Director, Quality Methodologies, presented the final recommendation for the Maryland Hospital Acquired Conditions Program for Rate Year 2024 (see "RY 2024 Final Recommendation for the Maryland Hospital Acquired Conditions Program") available on the HSCRC website

The quality programs operated by the HSCRC, including the Maryland Hospital Acquired Conditions (MHAC) program, are intended to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance.

The MHAC program is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time.

The MHAC policy currently holds 2 percent of inpatient hospital revenue at-risk for complications that may occur during a hospital stay as a result of treatment rather than the underlying progression of disease. Examples of the types of hospital acquired conditions included in the current payment program are respiratory failure, pulmonary embolisms, and surgical-site infections.

This policy affects a hospital's overall GBR and so affects the rates paid by payers at that particular hospital. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.

Historically the MHAC policy included the better of improvement and attainment, which incentivized hospitals to improve poor clinical outcomes that are often emblematic of disparities. The protection of improvement has since been phased out to ensure that poor clinical

outcomes and the associated health disparities are not made permanent, which is especially important for a measure that is limited to in-hospital complications. In the future, the MHAC policy may provide direct hospital incentives for reducing disparities, similar to the approved readmission disparity gap improvement policy.

Stakeholder input and concerns are as follows:

MHA is concerned about the recommendation to update the PPC measures included in the payment program. MHA acknowledge concern but believe more time is needed to assess factors driving increases. (i.e., reduce focus on coding/documentation vs. poor clinical care)

CareFirst is concerned regarding monitoring trends and wants timely changes to reverse deterioration in performance that may negatively impact patient care and raise concerns with CMMI.

Staff is concerned with increases in monitoring PPCs and the impact on patient care. For RY 2024, staff proposes to do additional analytics on which hospitals/systems are driving statewide increases and to engage these hospitals to understand trends and discuss quality concerns vs. coding and documentation changes. Furthermore, the HSCRC recognizes the burden hospitals are under during the current COVID surge and do not want to further burden hospitals with additional measures at this time.

Staff's final recommendations for the RY 2024 Maryland Hospital Acquired Conditions (MHAC) program are as follows:

1. Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.

    - Maintain a focused list of PPCs in the payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
    - Assess monitoring PPCs based on clinical recommendations, statistical characteristics, and recent trends to prioritize those for future consideration for updating the measures in the payment program.
    - Engage hospitals on specific PPC increases to understand trends and discuss potential quality concerns.

2. Use more than one year of performance data for small hospitals (i.e., less than 20,000 at-risk discharges and/or 20 expected PPCs). The performance period for small hospitals will be CY 2021 and 2022.
3. Continue to assess hospital performance on attainment only.
4. Continue to weigh the PPCs in the payment program by 3M cost weights as a proxy for patient harm.
5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent and continuous linear scaling with a hold harmless zone between 60 and 70 percent.

6. Adjust retrospectively the RY 2024 MHAC pay-for-performance program methodology as needed due to the COVID-19 Public Health Emergency and report any changes to the Commissioners.

The Commissioners voted unanimously in favor of Staff's recommendation.

ITEM VII
POLICY UPDATE AND DISCUSSION

Model Monitoring

Ms. Caitlin Cooksey, Deputy Director of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 9 months ending September 2021. Maryland's Medicare Hospital spending per capita growth was trending close to the nation, with the past several months being favorable. Ms. Cooksey noted that Medicare Nonhospital spending per-capita was trending unfavorably for both Part A and Part B when compared to the nation. Ms. Cooksey noted that Medicare Total Cost of Care (TCOC) spending per-capita was unfavorable with the past two months trending close when compared to the nation. Ms. Cooksey noted that the Medicare TCOC guardrail position is 1.11% above the nation thru September. Ms. Cooksey noted that Maryland Medicare hospital and non-hospital growth thru September shows a run rate erosion of $92,181,000.

CRISP Learning Collaborative

Ms. Wunderlich noted that CRISP Learning Collaborative with American Institute for Research and IMPAQ International entitled "Maryland Model Analytics- Evaluation of the Care Transformation Initiatives Program: Pre-implementation Report" is part of the Commission packet.

Care Transformation Initiatives (CTIs) are a key component of Maryland's TCOC Model. These voluntary initiatives allow hospitals and health systems to test innovations that address specific clinical and population needs and promote efficient use of health care resources. Hospitals whose initiatives produce savings will be rewarded with a positive payment adjustment. By testing and evaluating the results of hospitals' care transformation efforts, the State hopes to identify and disseminate best practices for improving care and reducing costs.

IMPAQ is conducting a two-part evaluation of the CTI program. This report includes findings from the pre-implementation phase of the program. After the first performance period ends in 2022, we will conduct a second evaluation. In this first phase, we conducted a mixed-methods evaluation of the CTI program to: (1) describe how hospitals designed their CTIs; (2) identify areas of spending that are (or are not) addressed by CTIs; (3) assess how CTIs align with published research on care transformation; and (4) describe the extent to which CTIs address socioeconomic status and race and ethnicity.

Workgroup Update

M. Wunderlich stated that all workgroup activities will be suspended until the beginning of February due to ongoing COVID cases, except one workgroup that will continue to work on payment plan guidelines.

Staff Update

Ms. Wunderlich announced that Ms. Tequila Terry, Principal Deputy Director of Payment Reform and Stakeholder Alignment, will be leaving the Commission to join CMMI. Ms. Wunderlich thanked Ms. Terry for all her dedicated work at the Commission admirably serving the citizens of Maryland.

ITEM VIII
HEARING AND MEETING SCHEDULE

February 9, 2022	Times to be determined - Go to Webinar
March 9, 2022	Times to be determined – Go to Webinar

There being no further business, the meeting was adjourned at 3:01 pm.

Closed Session Minutes
of the
Health Services Cost Review Commission

January 12, 2022

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

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

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

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

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

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

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, Cait Cooksey, Bob Gallion, and Dennis Phelps.

Also attending via conference call were Eric Lindemann, Commission Consultant, Stan Lustman, Commission Counsel, and Benjamin Quintanilla, Nurse Support Program Coordinator.

Item One

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

Item Two

William Henderson, Director-Medical Economics & Data Analytics, updated the Commission and the Commission discussed hospitals' financial condition through November 2021.

Item Three

Claudine Williams, Deputy Director-Medical Economics & Data Analytics, introduced Benjamin Quintanilla, Nurse Support Program Coordinator, who presented an overview of the Commission's Nurse Support Programs, as well as potential future recommendations to address the nursing shortage.

Item Four

Katie Wunderlich, Executive Director, and staff briefly discussed current adjustments to rate corridors associated with hospital undercharges.

The Closed Session was adjourned at 1:11 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 January 31, 2022

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
2580R	Brook Lane Hospital	12/7/2021	1/6/2022	5/6/2022	FULL	JS/AP
2581A	Johns Hopkins Health System	1/26/2021	N/A	N/A	ARM	DNP

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

File Status
OPEN
OPEN

IN RE: THE FULL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
BROOK LANE HEALTH	*	DOCKET: 2021
SERVICES - HAGERSTOWN	*	FOLIO: 2390
HAGERSTOWN, MARYLAND.	*	PROCEEDING: 2580R

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STAFF RECOMMENDATION

February 9, 2022

List of Abbreviations

CON	Certificate of Need
ECMAD	Equivalent Case-Mix Adjusted Discharge
EIPA	Equivalent Inpatient Admission
EIPD	Equivalent Inpatient Day
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commissions
ICC	Interhospital Cost Comparison
MHCC	Maryland Health Care Commission
PAU	Potentially Avoidable Utilization
TCOC	Total Cost of Care

Key Methodology Concepts and Definitions

Certificate of Need (CON): With certain exceptions, a CON is required to build, develop, or establish a new healthcare facility, move an existing facility to another site, change the bed capacity of a healthcare facility, change the type or scope of any health care service offered by a healthcare facility, or make a healthcare facility capital expenditure that exceeds a threshold established in Maryland statute. The Maryland CON program is intended to ensure that new healthcare facilities and services are developed in Maryland only as needed and that, if determined to be needed, that they are: the most cost-effective approach to meeting identified needs; of high quality; geographically and financially accessible; financially viable; and will not have a significant negative impact on the cost, quality, or viability of other health care facilities and services.

Equivalent Case-mix Adjusted Discharges (ECMADS): Often referred to as case-mix, ECMADS are a hospital 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.

Interhospital 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 hospital's 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 ranging from 0 percent to 4.5 percent depending on the peer group. The term "Relative efficiency" is the difference between a hospital's actual revenue base and the ICC calculated cost base.

Payer Differential: The HSCRC has employed a differential, whereby public payers (Medicare and Medicaid) pay 7.7 percent (previously 6 percent, prior to July 1, 2019) less than other payers. Commercial payers also pay approximately 2 percent less than billed charges for prompt pay practices.

Potentially Avoidable Utilization (PAU): PAU is the measurement of hospital care that is unplanned and may be prevented through improved care, care coordination, or effective community-based care. PAU includes readmissions and hospital admissions for ambulatory-care sensitive conditions as defined by the Agency for Healthcare Research and Quality's Prevention Quality Indicators (PQIs) measurement approach. PAU may be expressed as a percent of hospital revenue received from PAU events at that hospital or the rate of PAU events for a hospital's attributed population.

Total Cost of Care (TCOC) Model: The agreement between the State of Maryland and the federal government, which obligates the state to obtain certain levels of health care savings to the federal Medicare program (along with other requirements) through State flexibility provided

through the agreement. For example, Medicare participates in the State's system for all-payer hospital global budgets.

Overview

Brook Lane Health Services - Hagerstown ("Brook Lane," or "the Hospital") submitted a full rate application on December 7, 2021, requesting an increase to its permanent revenue totaling $2.1 million, an 8.7 percent increase over Brook Lane's approved revenue base that was effective for the one-year period from July 1, 2021 through June 30, 2022. The statute requires that the effective date of the newly proposed rates be no sooner than 30 days from the filing of the full rate application. However, in this instance both staff and hospital have been working on this application since July 2021. Given the special nature of this hospital, the staff requests that the Commission waive the 30-day requirement and allow for an effective date of December 1, 2021.

The rate application requested increase (8.7 percent) is related to the efficiency of the Hospital's costs relative to Maryland peers, a methodology established during the full rate determination for Sheppard Pratt Hospital. The requested revenue increases are exclusive of HSCRC-approved adjustments, including: the update factor, productivity adjustments, market shift adjustments, demographic adjustments, quality adjustments, population health, and other routine adjustments.

HSCRC staff docketed Brook Lane's full rate application on December 7, 2021.

Request for General Revenue Increase

Brook Lane justifies the requested $2.1 million in additional operating revenue based on its objective to achieve a viable and sustainable operating margin, which decreased from 1.5 percent in Fiscal Year 2014 to -3.7 percent in Fiscal Year 2019.[1] Several cost increases over and above inflation provided in the annual Update Factor contribute to the need for additional revenue:

1. Additional staffing related to increased patient acuity --$2.2 million
2. Increased Depreciation and Interest Costs – $702 thousand
3. Increased Insurance Expenditures (other than malpractice) -- $58 thousand

Additional requests included in the Brook Lane application that are inclusive of the $2.1 million in additional operating revenue are as follows:

1) Brook Lane requested that the rate increase become effective December 1, 2021.

2) Brook Lane requested that the rate application be effectuated in the same manner as the Sheppard Pratt rate application, which accounted for:

[1] Regulated margin was -2.8 percent in Fiscal Year 2020, but due to the COVID Public Health Emergency analyses were restricted to Fiscal Year 2019 and prior years.

a) Inflation for Fiscal Year 2020 and 2021 since the Maryland cost comparison model utilized Fiscal Year 2019 costs to remove the confounding elements of the COVID public health emergency; and

b) A markup[2] to rates to recognize that the effective rate increase will not be equal to the rate determination made by the Commission since Medicare does not pay HSCRC-approved rates at the Hospital.

Background

Full Rate Applications

In January 2018, the Commission updated its regulations for full rate applications to incorporate new requirements for efficiency. In January of 2021, the Commission approved a policy to evaluate full rate applications. The revised methodology utilizes updated but historical evaluations of hospital cost-per-case efficiency and incorporates new measures of efficiency based on the move from volume-based payments under the charge-per-case system, employed prior to 2014, to a per-capita system with value-based requirements.

Due to the unique nature of Brook Lane, which is a psychiatric facility in the State and is not part of Global Budget Revenue methodologies, the evaluation contained in this recommendation addresses cost per unit.[3] Staff believes the cost-per-case efficiency methodology is an effective tool for assessing general acute care facilities, but is concerned that the requisite casemix methodology is not sufficient to determine varying levels of acuity for facilities, such as Brook Lane or Sheppard Pratt Hospitals that serve patients exclusively with behavioral health needs.[4]

Background on Brook Lane

Brook Lane is a private mental health inpatient facility with 57 beds located in Hagerstown,

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[2] Markup in rates is a historical rate setting mechanism that supports the funding of uncompensated care as well as the discounts individual payers are afforded for promptly paying and for avoiding bad debts.

[3] The units used in the analysis include admissions, equivalent inpatient discharge, equivalent inpatient admission, patient days, hours, relative value units, gross square feet, patient meals, pounds of laundry, and hours worked.

[4] Brook Lane's volume is not included in the development of equivalent casemix adjusted discharges or ECMADS, the Commission's casemix methodology, because the Hospital is not affected by financial methodologies that utilize ECMADS. Thus, applying casemix weights from this methodology would be inappropriate, especially given the differential overhead levels at general acute care facilities and psychiatric facilities. Moreover, of the $453 million in statewide inpatient psych services used in casemix weight development, of which there are 60 APR-DRG SOI cell combinations; $4.8 million are in APR-DRG SOI cells that have fewer than 30 cases;,$1.6 million are in cells that required use of national weights due to small cell size;,$13.8 million are in cells defined as teaching dominance where academic medical centers constitute more than 70 percent of cases;,$33.9 million are in cells that had highly variable charge per case statistics defined by a coefficient of variation greater than 0.90; and $20.1 million are deemed outlier charges and not included in weight development (not all mutually exclusive).

Maryland. Over 50 percent of the inpatient services provided are in the Child and Adolescent Units at the Hospital. Brook Lane also works with various Partial Hospital Programs that are associated with schools. The Hospital's total approved revenue for Fiscal Year 2021 was $23,278,579. In FY 2019, approximately 1 percent of its revenues came from Baltimore City; 1 percent came from Baltimore County; 5 percent came from central Maryland Counties; 16 percent came from out-of-state residents; and the remaining 77 percent was derived from all other counties in Maryland, suggesting Brook Lane is a statewide resource.[5]

From Fiscal Years 2014 through 2019, Brook Lane had an average total operating margin of 1.7 percent based upon its annual filing of schedule RE, which includes both regulated and unregulated operations, specifically the combined operating margins measured: $352 thousand (1.5%) in FY 2014; $867 thousand (3.3%) in FY 2015; $1.6 million (5.1%) in FY 2016; $1.2 million (3.6%) in FY 2017; $116 thousand (0.5%) in FY 2018; and -$773 thousand (-3.7%) in FY 2019.

Staff Analyses

HSCRC staff has reviewed costs, financial trends, system financial statements, unregulated losses, volume trends, and quality performance. Recently, HSCRC staff collaborated with Brook Lane and its consultants to assess Fiscal Year 2019 cost per unit relative to Maryland hospital peers. While the basis for staff's recommendation is the assessment of cost per unit relative to Maryland hospital peers, staff also conducted a separate cost analysis of Brook Lane's costs relative to national psychiatric facility peers based on the Fiscal Year 2019 Medicare cost report to support the rate recommendation described herein.

Financial Background and Performance

Hospital Rate History

Brook Lane is not a GBR hospital. The HSCRC regulates the rates of Brook Lane because it is a Maryland licensed hospital and because two thirds of its revenue are not from public payer reimbursements.[6] Since Fiscal Year 2014 Brook Lane has received the following adjustments:

[5] Source: HSCRC hospital discharge data, Fiscal Year 2019

[6] Md. Health-General Code Ann., Sections 19-211 and 19-220, http://www.dsd.state.md.us/comar/comarhtml/10/10.37.03.10.htm

Table 1. Brook Lane Adjustments, July 1, 2014-2020

	Year Beginning July 1,						
Component:	2014	2015	2016	2017	2018	2019	2020
Update Factor Inflation	1.80%	2.70%	2.70%	2.80%	2.68%	2.57%	2.96%
Productivity/ACA		-0.70%	-0.80%	-0.75%	-0.40%	-0.80%	-0.50%
Infrastructure		0.30%	0.30%				
PAU	NA	NA	NA	NA	NA	NA	NA
Net Permanent Adjustment	**1.80%**	**2.30%**	**2.20%**	**2.05%**	**2.28%**	**1.77%**	**2.46%**
Net Quality Adjustments	NA	NA	NA	NA	NA	NA	NA
Uncompensated Care Funding	3.25%	3.47%	4.24%	4.64%	5.27%	4.53%	4.22%
Mark Up Change	-0.81%	3.55%	1.03%	1.74%	-3.27%	3.88%	-0.45%

HSCRC staff has also worked with Brook Lane during the COVID Public Health Emergency to provide temporary enhanced rates in order to provide financial stability.

Revenue Growth & Cost Growth

Brook Lane's regulated gross revenue has increased by $8 million or 55 percent from Fiscal Year 2014 to Fiscal Year 2019. During this same period, the State offset the annual update factor amount for non-GBR hospitals by a productivity adjustment. Non-GBR hospitals are under a 100 percent variable cost factor system because unlike GBR hospitals, there is no incentive to reduce volume; therefore, the Hospital should become more efficient and profitable as volumes increase and reimbursement is not scaled for covered fixed costs. In addition, Brook Lane is not included in some of the volume incentives GBR hospitals were held to, which was the rationale for the productivity offset. The 2019 annual compounded impact (from 2014 through 2019) of these adjustments was a reduction in 2019's revenue of approximately $789 thousand in permanent revenue. During this same time, however, inpatient days grew by 37 percent, which offset the productivity adjustment by a decrease of 3.5 percent.[7] This increase in inpatient days occurred even though admissions grew by just 4 percent from 1,677 to 1,746, due in large part to better care coordination and care moving to the most appropriate setting. It also suggests that acuity of patients at Brook Lane has increased since 2014.

[7] The Update Factor Offsets total -3.45 percent from FY2014-FY2019 as shown in Table 2.

Table 2. Brook Lane Update Factor Impact FY 14-FY 20

Fiscal Year	Gross Update Factor	Offset	Population Health Infrastructure	Net Update	Total Net Revenue (in thousands)	Compounded Impact of Offset (in thousands)
2019	2.57%	-0.80%	0.00%	1.77%	22,563	789
2018	2.68%	-0.40%	0.00%	2.28%	22,853	612
2017	2.80%	-0.75%	0.00%	2.05%	21,984	498
2016	2.70%	-0.80%	0.30%	2.20%	20,804	313
2015	2.70%	-0.70%	0.30%	2.30%	17,202	120
2014	1.80%	0.00%	0.00%	1.80%	14,513	-

According to operating margin data submitted by Brook Lane, the Hospital has seen significant margin erosion since 2014. Overall margin at Brook Lane (combined regulated and unregulated) decreased from 1.5 percent in 2014 to -3.7 percent in 2019. This amounts to a $1.1 million dollar margin deterioration since 2014. 2020 is not accounted for in this comparison due to the confounding factors associated with the COVID-19 pandemic

As reflected in Table 2, the cumulative loss in revenues from 2014 through 2019 attributable to the offset to the annual update factor totals $2.332 million. As per review of the audited financial statements, the balance sheet reflects a decline in current assets between 2014 and 2019 of $1.290 million. Although cash and other current assets are highly liquid and subject to material changes, it is reasonable to attribute part of the measured decline in current assets to the effects of the repeated annual offset.

Brook Lane has experienced growth in operating cost beyond that anticipated by the provision of the annual update factor.

Table 3. Brook Lane Cost Escalation Exceeds Update Factor Expectation ($ Thousands)

Regulated Operating Expenses 2014	$14,386.7
Cumulative Update Factor 2015 – 2019	1.1419
Regulated Operating Expenses 2014 stated in 2019 $s	$16,429.8
Regulated Operating Expenses 2019	$19,934.8
Cost Escalation beyond Update Factor Expectation	$ 3,505.0

Breakdown of Material Costs Escalations:

	2014 Exp.	As Updated	2019 Exp.	Beyond
Payroll/Benefits/Agency RNs	$10,529.6	$12,024.1	$14,272.6	$2,248.5
Depreciation & Amortization	$ 531.5	$ 606.9	$ 1,130.3	$ 523.4
Interest Expense	$ 91.4	$ 104.4	$ 282.8	$ 178.4
Insurance (other than malpractice)	$ 42.2	$ 48.2	$ 106.4	$ 58.2
Other				$ 496.5
Total Cost Escalations beyond Update Factor Expectation				$3,505.0

The most significant cost pressure experienced by Brook Lane has been acuity-related labor premiums. Annual filing data from the C & D schedules shows FTEs increased by 31 from 2014 to 2019, which is an increase of 20.9 percent. During this same time, using Equivalent Inpatient Day data divided by Equivalent Inpatient Admission data as a measure of acuity, days per admission rose by 31.4 percent, which suggests Brook Lane did indeed experience higher intensity cases.

Table 4. Brook Lane's FTE Increase and Acuity Increase 2014-2019.

	2014	**2015**	**2016**	**2017**	**2018**	**2019**
FTEs	148	152	182	169	181	179
YOY Increase		2.7%	19.7%	-7.1%	7.1%	-1.1%
Cumulative Increase		2.7%	22.9%	14.2%	22.3%	**20.9%**
EIPD/EIPA	7.41	8.03	8.20	8.45	8.97	9.74
YOY Increase		8.4%	2.1%	3.0%	6.2%	8.6%
Cumulative Increase		8.4%	10.7%	14.0%	21.1%	**31.4%**

Maryland Cost Comparison Model

HSCRC staff, in conjunction with Brook Lane, developed an alternative cost model to the standard Inter-Hospital Comparison methodology. The Maryland cost comparison model that was developed first established criteria for Maryland peers. First, to be considered comparable to Brook Lane, general acute care facilities had to have at least 20 percent of their inpatient revenue related to acute inpatient psychiatric services, as defined by the service line IP psych in the market shift methodology. Second, additional exclusions were applied: a) hospitals deemed high tech, i.e., with 5 percent or more of its charges attributable to cardiothoracic surgery, invasive cardiology, and cardiology service lines, were excluded; b) hospitals with higher supply costs, i.e., with 25 percent or more of hospital charges attributable to surgical service lines were excluded ; and c) hospitals with high drug costs, i.e., with 5 percent or more of their charges attributable to the oncology drug service line in the market shift methodology, were excluded. This exercise resulted in 6 hospitals selected as Brook Lane peers:

Table 5. List of Maryland Peer Hospitals

Adventist HealthCare Shady Grove Medical Center	MedStar Harbor Hospital Center
Northwest Hospital	UM Harford Memorial Hospital
UM Midtown	UM Shore Dorchester

While these hospitals did provide better comparability to Brook Lane by eliminating unique costs that Brook Lane does not incur (e.g., supply costs for transaortic valve replacements), HSCRC staff also worked with the Hospital to adjust for the higher overhead costs incurred at general acute care facilities. Specifically, the Maryland cost comparison model discounted all overhead cost centers for Brook Lane's Maryland peers by the differential overhead these hospitals incur for medical/surgical inpatient discharges versus psychiatric inpatient discharges. In effect, the costs for the patient related overhead (e.g., dietary services, laundry) for Brook Lane's selected peers were reduced by 34.1 percent, and other overhead costs (e.g., general accounting, medical records) were reduced by 48 percent. Without this adjustment, the Maryland cost comparison model would have indicated Brook Lane's costs were 412 percent more efficient than otherwise determined.

The final component of the Maryland cost comparison model was calculating the average cost per unit for the selected peers (inclusive of the overhead discount described above) and applying that to Brook Lane's units. This established cost base was compared to Brook Lane's actual costs to determine the efficiency of the Hospital. For a summary schedule of this analysis, see the table below:

Table 6. Summary of Maryland Cost Comparison Model

Berkeley Research Group
Brook Lane
Cost Comparison: Brook Lane vs. Psychiatry Hospitals
Fiscal Year 2019

	Peer Group Comparison Cost				Brook Lane Cost	Variance	
		Adjustment Factor for Psych Cost Intensity					
Description	FY 2019 C&D Comparison: Results	%	$	Adjusted Peer Group Comparison Costs	FY 2019 C&D Comparison: Results	Brook Land Favorable/ (Unfavorable)	% Favorable / (Unfavorable)
Plant Operations	$2,058,892	34.1%	($701,197)	$1,357,694	$790,000	$567,694	71.9%
Dietary Services	745,885	34.1%	(254,026)	491,859	576,700	(84,841)	(14.7%)
Purchasing and Stores	317,833	34.1%	(108,244)	209,588	0	209,588	0.0%
Pharmacy	475,477	34.1%	(161,933)	313,544	0	313,544	0.0%
Laundry and Linen	59,627	34.1%	(20,307)	39,320	42,300	(2,980)	(7.0%)
Social Services	198,404	34.1%	(67,570)	130,833	0	130,833	0.0%
Patient Care Overhead Total	$3,856,117		($1,313,279)	$2,542,838	$1,409,000	$1,133,838	80.5%
Hospital Administration	$4,186,627	48.0%	($2,007,717)	$2,178,910	$2,347,700	($168,790)	(7.2%)
Depreciation & Amortization	2,528,877	48.0%	(1,212,735)	1,316,142	895,900	420,242	46.9%
Long Term Interest	561,390	48.0%	(269,217)	292,173	282,800	9,373	3.3%
Housekeeping	4,293	48.0%	(2,059)	2,234	395,600	(393,366)	(99.4%)
Malpractice Insurance	535,341	48.0%	(256,726)	278,616	215,400	63,216	29.3%
Patient Accounts	787,426	48.0%	(377,614)	409,812	1,663,700	(1,253,888)	(75.4%)
General Accounting	590,149	48.0%	(283,009)	307,140	929,700	(622,560)	(67.0%)
Medical Staff Administration	341,225	48.0%	(163,636)	177,589	309,400	(131,811)	(42.6%)
Leases and Rentals	399,528	48.0%	(191,595)	207,932	0	207,932	0.0%
Medical Care Review	497,197	48.0%	(238,433)	258,764	298,100	(39,336)	(13.2%)
Medical Records	210,991	48.0%	(101,182)	109,809	392,700	(282,891)	(72.0%)
Other Insurance	63,666	48.0%	(30,531)	33,135	106,400	(73,265)	(68.9%)
Nursing Administration	1,241,765	48.0%	(595,494)	646,271	133,300	512,971	384.8%
Other Overhead Total	$11,948,475		($5,729,949)	$6,218,526	$7,970,700	($1,752,174)	(22.0%)
Overhead Total	$15,804,592		($7,043,228)	$8,761,364	$9,379,700	($618,336)	(6.6%)
Adult Psychiatry	$4,119,003	0.0%	$0	$4,119,003	$2,525,900	$1,593,103	63.1%
Child Psychiatry	6,082,547	(13.7%)	832,482	6,915,029	4,869,500	2,045,529	42.0%
Individual Therapy	0	0.0%	0	0	936,300	(936,300)	(100.0%)
Group Therapies	0	0.0%	0	0	165,600	(165,600)	(100.0%)
IP, Nursing, Obv Total	$10,201,550		$832,482	$11,034,032	$8,497,300	$2,536,732	29.9%
Electroencephalography	183	0.0%	0	183	1,000	(817)	(81.7%)
Radiology - Diagnostic	420	0.0%	0	420	1,700	(1,280)	(75.3%)
Electrocardiography	4,301	0.0%	0	4,301	4,100	201	4.9%
Laboratory Services	7,666	0.0%	0	7,666	134,300	(126,634)	(94.3%)
Psych. Day and Night Care	396,486	0.0%	0	396,486	475,700	(79,214)	(16.7%)
Electroconvulsive Therapy	330,300	0.0%	0	330,300	330,300	0	0.0%
Ancillary Total	$739,356		$0	$739,356	$947,100	($207,744)	(21.9%)
Total Direct Patient Care	$10,940,906		$832,482	$11,773,388	$9,444,400	$2,328,988	24.7%
Total Excluding Supplies and Drugs	$26,745,498		($6,210,746)	$20,534,752	$18,824,100	$1,710,652	9.1%

Due to the concern related to accurately assessing the efficiency of costs within the pharmacy rate center, which may reflect unique discounts not available to all hospitals, these costs were excluded from the Maryland cost comparison model and passed through without qualification

($856 thousand or 4 percent of Brook Lane's Fiscal Year 2019 cost base). This effectively reduced Brook Lane's favorable cost position from 9.1 percent efficient relative to Maryland peers to 8.7 percent.

The table below describes the results of the Maryland cost comparison model and the costs that were evaluated without qualification.

Table 7. Summary of Components of ICC Recommended Revenue for Sheppard Pratt Hospital

	Cost Assessed	Cost Change ($)	Approved Cost	Cost Change (%)
Maryland Cost Comparison Model	$18,824,100	$1,710,652	$20,534,752	9.1%
Pharmacy Rate Center	$856,600	$0	$856,600	0%
Total	**$19,680,700**	**$1,710,652**	**$21,391,352**	**$8.7%**

National Cost Comparison Model

Given the concerns about making a rate determination based on a comparison between Maryland general acute care facilities and a specialized psychiatric facility, HSCRC staff also collaborated with Brook Lane to assess the Hospital's efficiency to similar stand-alone psychiatric facilities across the country. Specifically, the national cost comparison model used Fiscal Year 2019 Medicare cost reports[8] and evaluated Brook Lane's costs per equivalent patient days (EIPDs)[9] relative to 11 psychiatric facilities from 8 different states. The final assessment determined that Brook Lane t was 5.6 percent efficient relative to its selected national peers - within a reasonable range of the 8.7 percent determined by the Maryland cost comparison model. Below, staff will outline the peer selection process and the underlying methodology for the national cost comparison model.

To select national peers, HSCRC staff and Brook Lane settled on the following criteria, which when applied resulted in no Medicare cost report variables demonstrating a statistically significant relationship with efficiency assessments:

- Comparable licensed beds (at least 35)
- Average length of stay greater than 6 days and less than 15 days

[8] CMS maintains the cost report data in the Healthcare Provider Cost Reporting Information System (HCRIS) https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports

[9] EIPDs are a long established measure that attempts to standardize inpatient and outpatient volume into a singular metric by multiplying the ratio of total revenue to inpatient revenue by a hospital's inpatient days.

- Average daily census greater than 20 and less than 70
- Medicare days between 6 and 25 percent of total hospital days
- Medicaid days between 10 and 45 percent of total hospital days
- Provides pediatric services
- Provides both inpatient and outpatient services

Once peer facilities were selected, staff did not use volumes derived from the Medicare Severity-Diagnosis Related Group (MS-DRG), because MS-DRGs do not adequately measure patient acuity in this context, which is evidenced by the fact that CMS pays a per diem amount under the Psych inpatient prospective payment system (IPPS) with adjustments for age, specific diagnoses, and length of stay. As such, staff utilized EIPDs, as discussed above. For a summary of the national cost comparison model, see table 8 below:

Table 8. Cost Comparison to National Peer Group Hospitals

ProvNo	Name	EIPDs	Licensed Beds	Average Daily Census	Average Length of Stay	% Medicare Day	% Medicaid Day	Total Reimb Costs per EIPDs	% of over/ under Average
214003	**Brook Lane**	**18,186**	**65**	**47**	**10**	**12.2%**	**41.7%**	**$1,021**	**(5.6%)**
264032	CenterPointe Hospital of Columbia	8,073	72	22	8	20.3%	27.7%	$1,153	**6.6%**
454134	Haven Behavioral Hospital of Frisco	13,335	70	35	7	19.1%	20.0%	$1,047	**(3.2%)**
054131	John Muir Behavioral Health Center	21,006	73	42	6	10.9%	26.0%	$1,713	**58.4%**
454124	Mesa Springs	38,767	72	60	7	6.8%	21.6%	$622	**(42.5%)**
204006	Northern Light Acadia Hospital	35,047	68	66	14	17.4%	35.9%	$1,303	**20.5%**
154057	Options Behavioral Health System	16,371	70	44	7	18.7%	21.7%	$609	**(43.6%)**
054096	Sutter Center for Psychiatry	29,968	73	53	7	13.1%	14.4%	$1,242	**14.8%**
144029	The Pavilion Behavioral Health System	25,320	72	62	7	7.6%	24.4%	$554	**(48.8%)**
374026	Tulsa Center for Behavioral Health	17,216	56	46	11	10.2%	10.4%	$558	**(48.4%)**
454131	Westpark Springs	23,640	72	51	8	14.5%	28.5%	$734	**(32.1%)**
524041	Willow Creek Behavioral Health	16,781	72	42	7	8.9%	15.2%	$813	**(24.8%)**
							Weighted Average	**$1,081**	

Cost Model Selection and Implementation

HSCRC staff supports Brook Lane's request to make a rate determination based on the Maryland cost comparison model because the analysis, which assesses cost for each hospital rate center using the relevant unit of measurement, is more thorough and less prone to acuity mismeasurement than the national cost comparison model that assesses total costs per EIPD. However, the full rate recommendation also outlined two additional requests that need to be considered:

1) Brook Lane requested that the rate increase become effective December 1, 2021;

2) Brook Lane requested that the rate application be effectuated in the same manner as the Sheppard Pratt rate application, which accounted for:

a) Inflation for Fiscal Year 2020 and 2021 since the Maryland cost comparison model utilized Fiscal Year 2019 costs to remove the confounding elements of the COVID public health emergency; and

b) A markup[10] to rates to recognize that the effective rate increase will not be equal to the rate determination made by the Commission since Medicare does not pay HSCRC-approved rates at the Hospital.

HSCRC staff agrees with the first consideration to implement a rate increase effective December 1, 2021, as staff has been working with Brook Lane since July to apply an alternative efficiency evaluation, and staff believes that the Hospital has demonstrated an immediate need for rate support due to its recent negative operating margins and efficient cost base.

HSCRC staff also agrees with the second consideration that any cost assessment based on a prior year needs to be inflated to current year costs and supports the request to have a markup to rates that recognizes the historical revenue increases that have been built into rates to account for Medicare's lower reimbursement levels. As such, HSCRC staff recommends applying the 8.7 percent favorable cost performance to the Hospital's Fiscal Year 2022 permanent revenue base of $23,984,920. This would yield an increase of $2,084,838, of which $1,530,380 would be collected, since Medicare does not pay Commission-approved rates at Brook Lane; therefore, the effective revenue increase would be 7.4 percent. This effective revenue increase is also more closely aligned with the favorable cost performance of 5.6 performance outlined in the national cost comparison model above.

For a summary of Brook Lane's effective revenue increase and the HSCRC staff recommendation, see the table below:

[10] Markup in rates is a historical rate setting mechanism that supports the funding of uncompensated care as well as the discounts individual payers are afforded for promptly paying and for averting bad debts.

Table 9. Summary of Brook Lane's Effective Revenue Increase Per HSCRC Recommendation

	FY2022 Permanent Revenue				Projected Net Patient Revenue			Variance	
Payer Mix	Payer Mix[1]	Charges	Payer Discount	Net Revenue	Charges	Payer Discount	Net Revenue	Charges	Net Revenue
Ratio of Medicare Charges	16.1%	$3,859,174	30.0%	$2,701,422	$4,194,614	35.6%	$2,701,422	$335,440	$0
Ratio of Medicaid I/P Charges	43.6%	10,457,425	6.0%	9,829,980	11,366,387	6.0%	10,684,404	908,962	854,425
Ratio of Medicaid O/P Charges	2.6%	621,209	46.0%	335,453	675,205	50.3%	335,453	53,996	-
Ratio of Blue Cross I/P Charges	17.6%	4,218,947	2.3%	4,124,021	4,585,659	2.3%	4,482,482	366,712	358,461
Ratio of Blue Cross O/P Charges	1.7%	407,744	2.0%	399,589	443,185	2.0%	434,321	35,441	34,732
Ratio of HMO Charges to Total	0.0%	-	6.0%	-	-	6.0%	-	-	-
Deductibles Paid by Medicaid & Blue Cross	0.0%	-	2.0%	-	-	2.0%	-	-	-
Provision for Uncollectable Accounts:	4.6%	1,101,627	100.0%	-	1,197,381	100.0%	-	95,754	-
Provision for Other Payors:	13.8%	3,319,513	2.0%	3,253,123	3,608,046	2.0%	3,535,885	288,533	282,762
Total	100.0%	$23,984,920		$20,643,587	$26,069,696		$22,173,967	$2,084,838	$1,530,380
								8.7%	*7.4%*

Total Cost of Care Performance

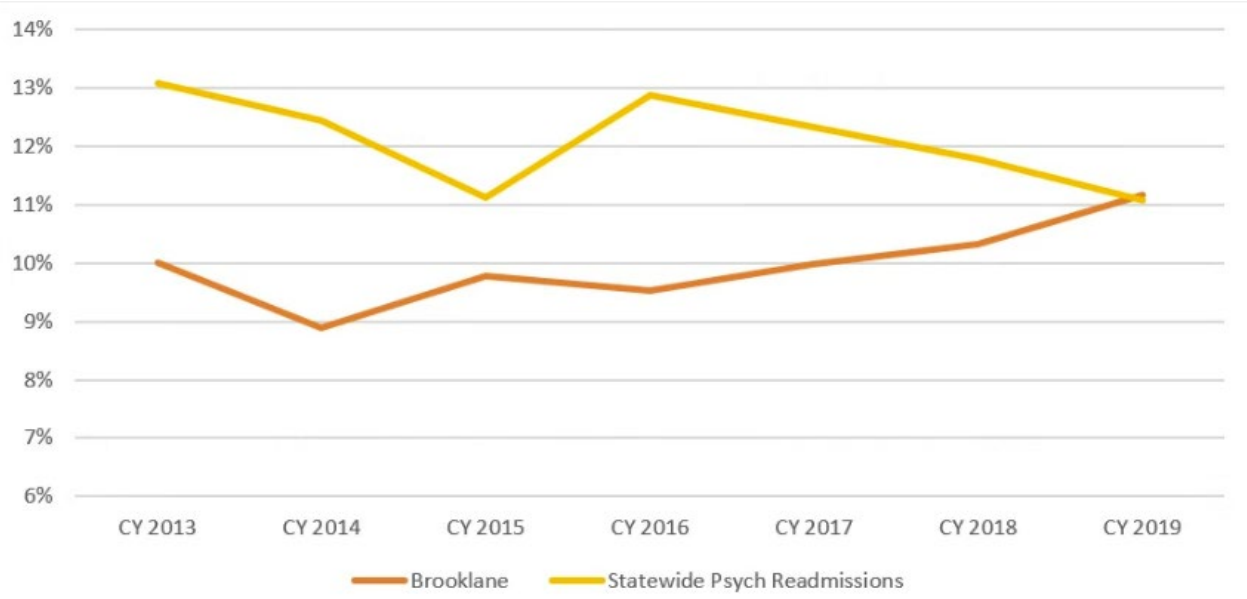
Under a per-capita model, a hospital's efficiency may not be adequately measured by cost-per-case measures. In order to consider how the cost per-capita performance might alter the results from a hospital cost efficiency analysis, the HSCRC also evaluates Total Cost of Care (TCOC) performance. Exceptional TCOC performance might allow for a revenue increase in the results from a hospital cost efficiency analysis, while poor results might suggest reductions from a hospital cost efficiency analysis.

In the case of Brook Lane, HSCRC staff did not attempt to assess its TCOC performance because it is not a hospital that participates in the population-based methodologies that underpin the TCOC Model, e.g., Global Budget Revenue, Demographic Adjustment, Market Shift, Potentially Avoidable Utilization Shared Savings, and the Medicare Performance Adjustment. Nor will the impact of this rate determination affect Medicare TCOC because Medicare does not pay HSCRC-approved rates at the Hospital.

Quality Performance

Similar to TCOC performance, the HSCRC staff cannot fully evaluate quality performance, as Brook Lane does not participate in the Commission's pay for performance quality programs under its unique service delivery model. However, in our all-payer Readmission Reduction Incentive Program (RRIP), we include psychiatric hospitals to account for any readmissions from an acute hospital to a psychiatric hospital. Thus, we can evaluate Brook Lane's case-mix adjusted readmission rate. As shown in Table 10, staff concluded that Brook Lane outperformed the State on psychiatric readmissions from 2013 to 2018. In 2019, Brook Lane performed on par

with the statewide readmission rate due to statewide reductions and even though the Hospital has no financial incentive to reduce readmissions. Moreover, since 2013, Brook Lane has maintained a lower readmission rate relative to the rest of the State despite the acuity increases the Hospital experienced, as documented in Table 4 above:



Recommendation

HSCRC staff recommends that the Commission:

1) Approve a general revenue increase request of $2,084,838 effective December 1, 2021, because the Hospital has demonstrated cost efficiency and a revenue structure that is insufficient to support the underlying cost base. Since Medicare does not pay HSCRC-approved rates at Brook Lane, the expected net amount of this increase is estimated to be approximately $1,530,380.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2022**
SYSTEM	*	**FOLIO:**	**2391**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2581A**

Staff Recommendation

February 9, 2022

I. INTRODUCTION

On January 26, 2022, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval to continue to participate in a revised global price arrangement with Life Trac (a subsidiary of Allianz Insurance Company of North America) for solid organ and bone marrow transplants and cardiovascular services. The Hospitals request that the Commission approve the arrangement for one year beginning March 1, 2022.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payers, 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 that it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

The staff found that the experience under the arrangement has been favorable for the last year. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services and cardiovascular services for the period beginning March 1, 2022. The Hospitals must file a renewal application annually for continued participation.

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

RECOMMENDATION TO GRANT AN EXTENSION OF APPROVAL OF THE ALTERNATIVE METHOD OF RATE DETERMINATION (ARM) ARRANGEMENT BETWEEN JOHNS HOPKINS HEALTH SYSTEM AND THE BLUE DISTINCTION CENTERS FOR TRANSPLANTS

February 9, 2022

Background

Effective December 9, 2020, a one-year approval was granted for the renewal of an alternative rate arrangement (ARM) between the Johns Hopkins Health System (JHHS) and Blue Distinction Center for Transplants for the provision of solid organ and blood and bone marrow services.

In October of 2021, JHHS requested and was granted a three-month extension of the approval for the ARM arrangement with Blue Distinction Center for Transplants to provide time to complete renegotiation of the arrangement.

Request

On January 26, 2022, JHHS requested an additional one-month extension, to March 31, 2022, to finalize negotiations on the ARM arrangement with Blue Distinction Center for Transplants.

Findings

Staff found that the experience for ARM arrangement between the JHHS and Blue Distinction Center for Transplants has been favorable for the last twelve months.

Recommendation

Since the authority granted to staff to extend Commission approval on ARM arrangements is limited to three months, staff recommends that the Commission approve JHHS's request for an additional one-month extension, to March 31, 2022, of Commission approval for the ARM arrangement between the JHHS and Blue Distinction Center for Transplants.

maryland
health services
cost review commission

Update on Medicare FFS Data & Analysis

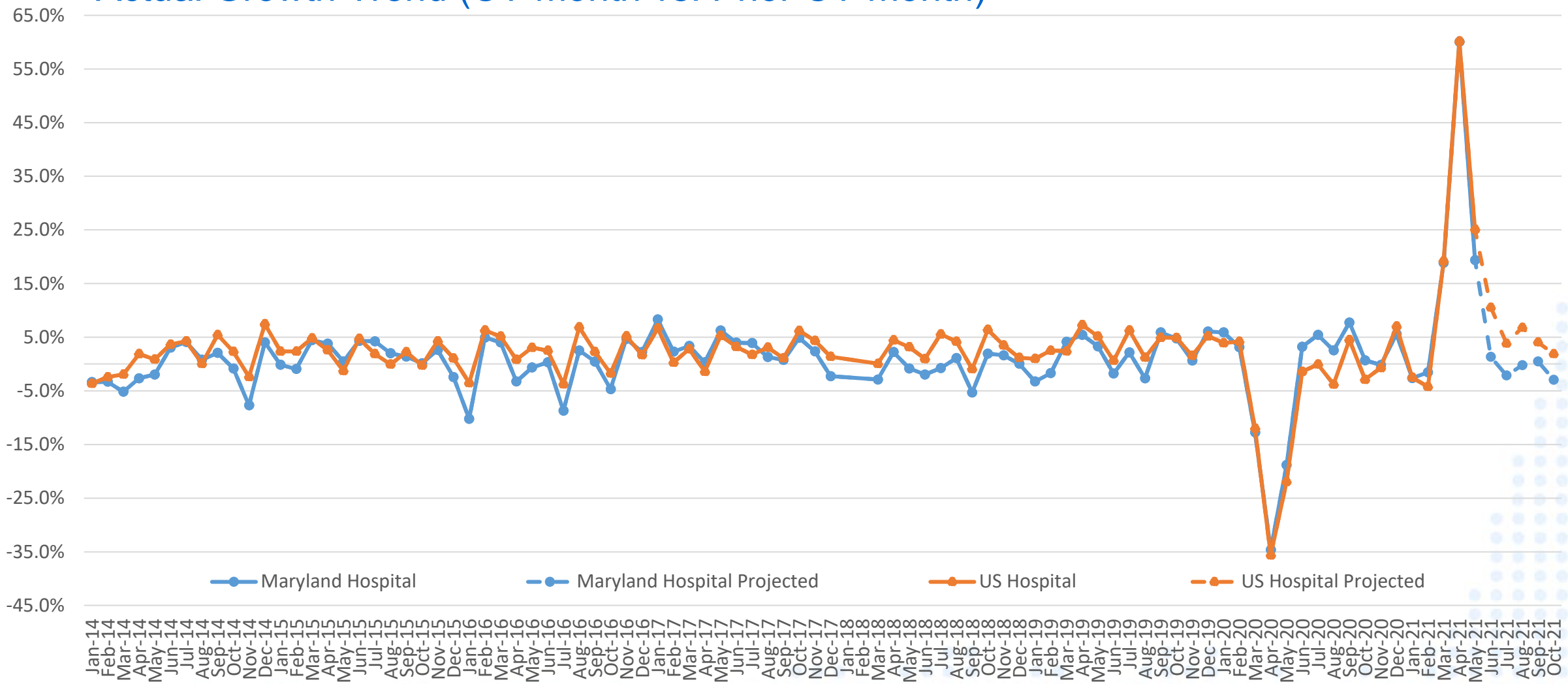
February 2022 Update

Data through October 2021, Claims paid through December 2021

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

Medicare Hospital Spending per Capita

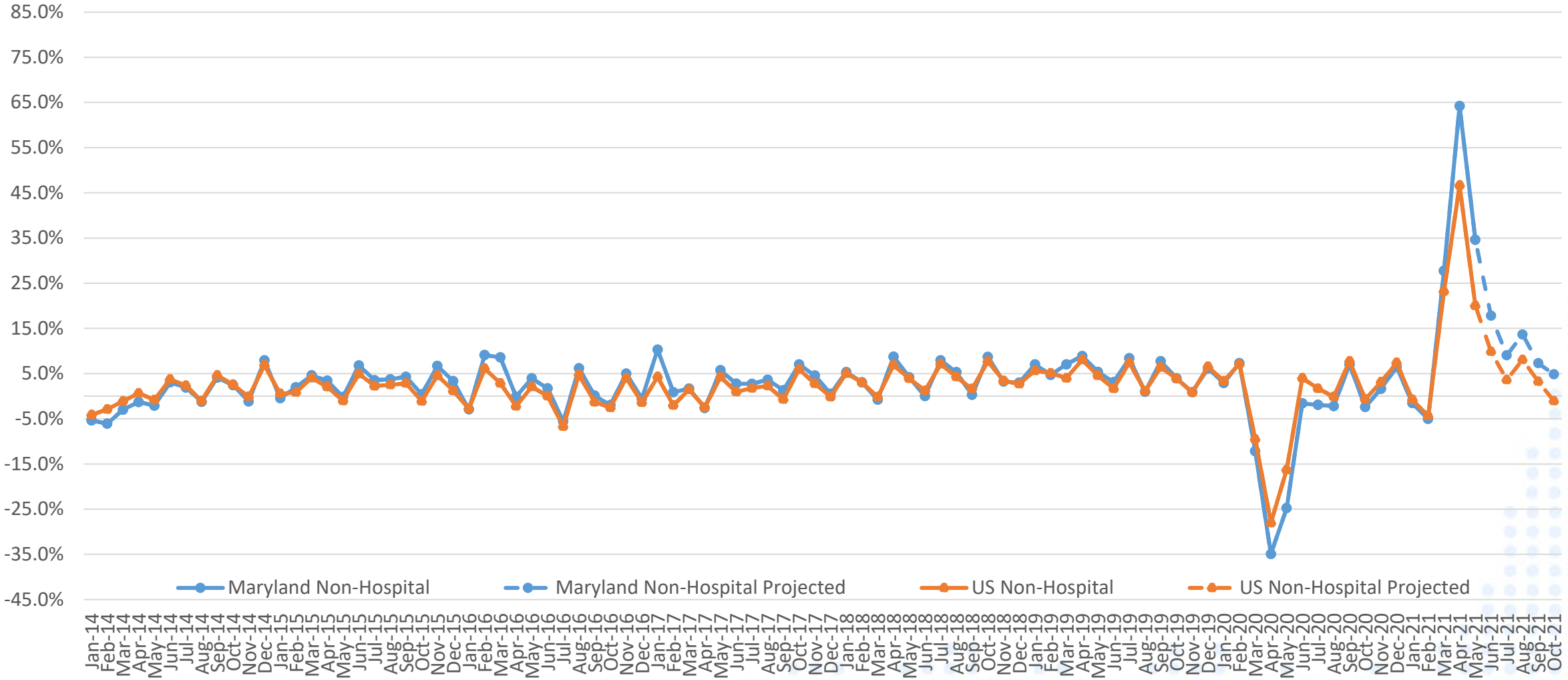
Actual Growth Trend (CY month vs. Prior CY month)



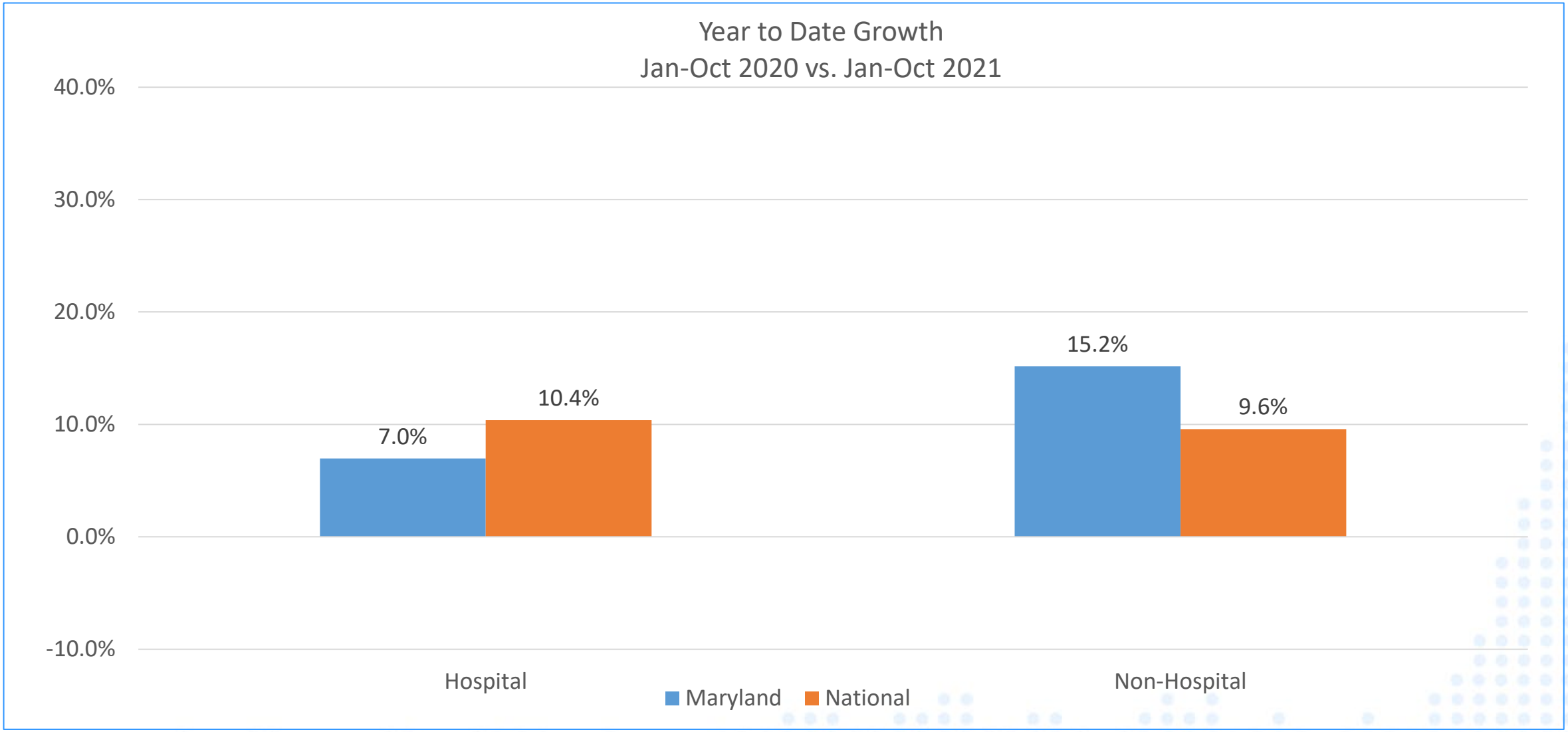
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

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



Medicare Total Cost of Care Payments per Capita



Medicare Total Cost of Care Spending per Capita

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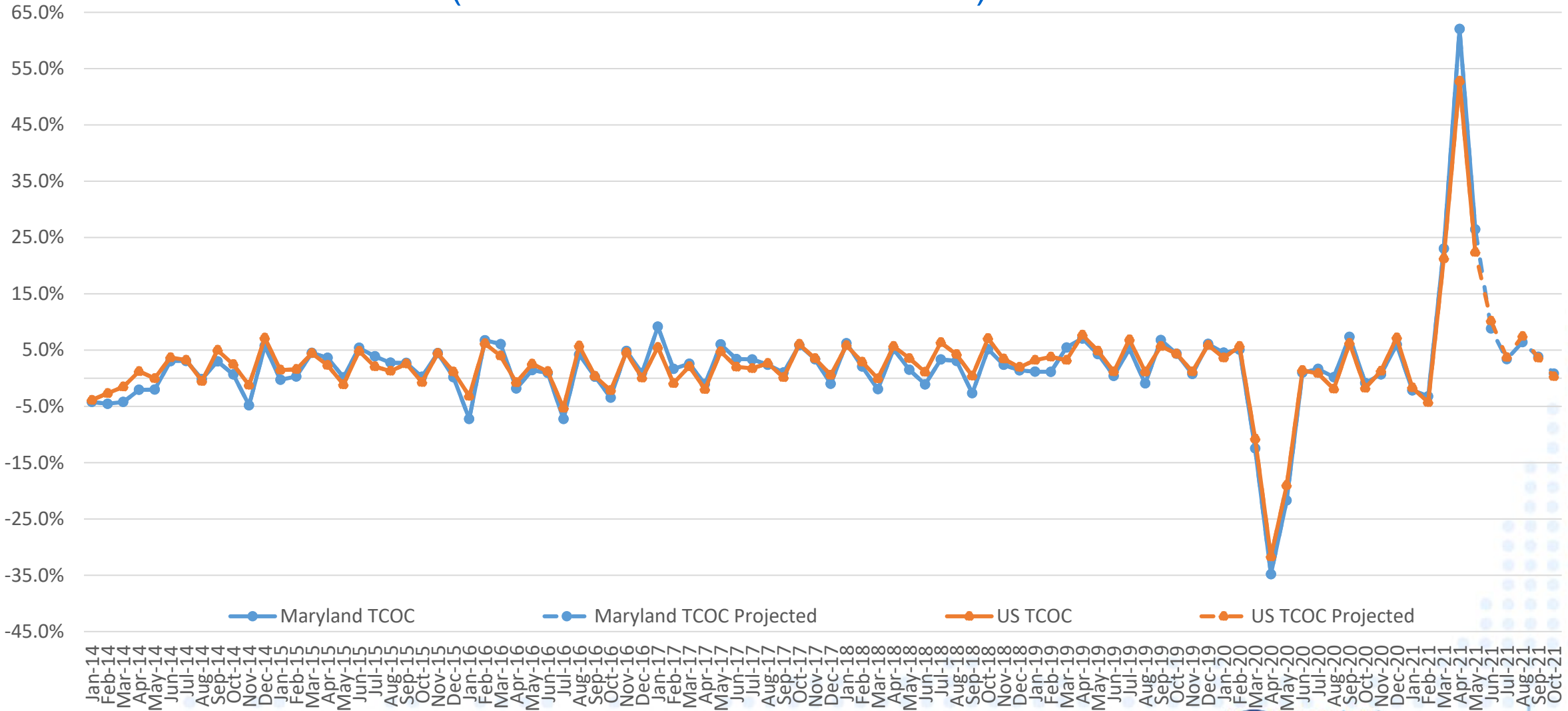

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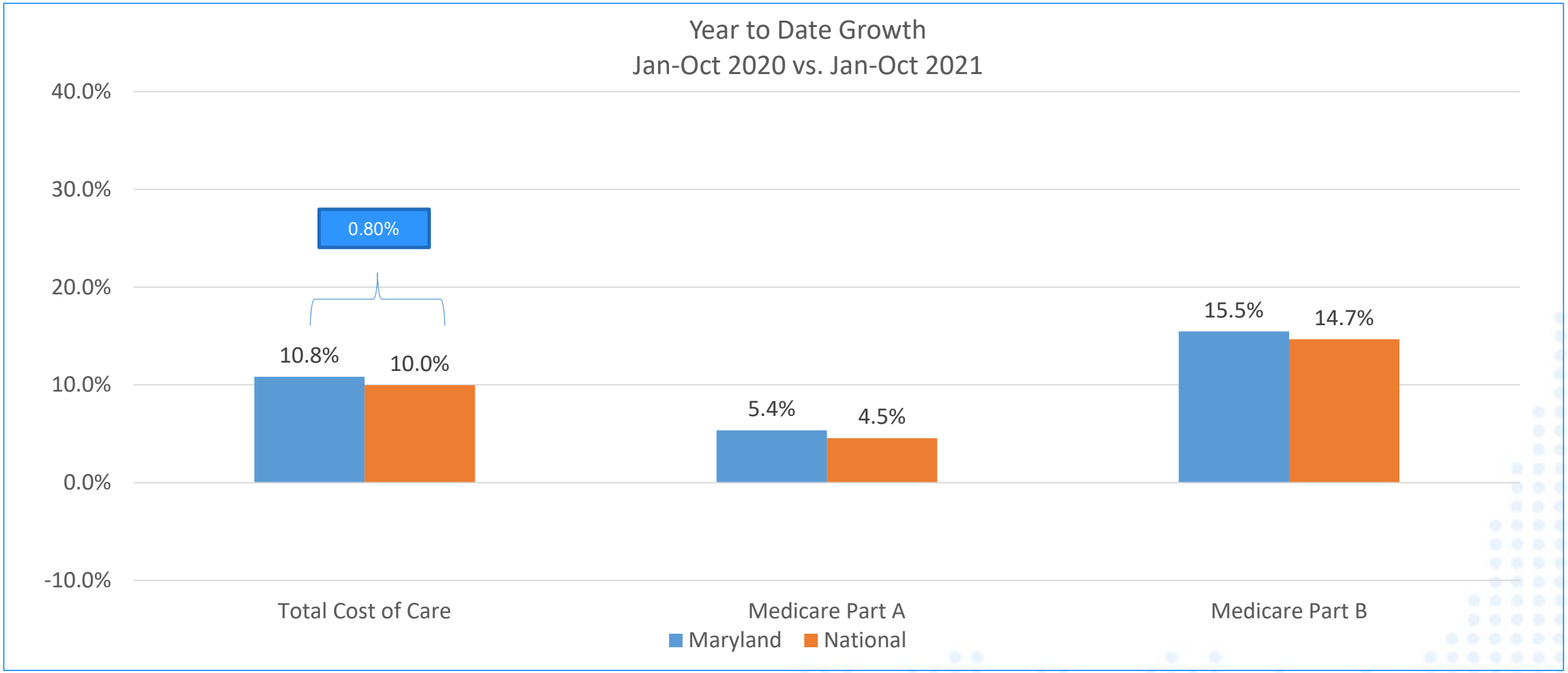
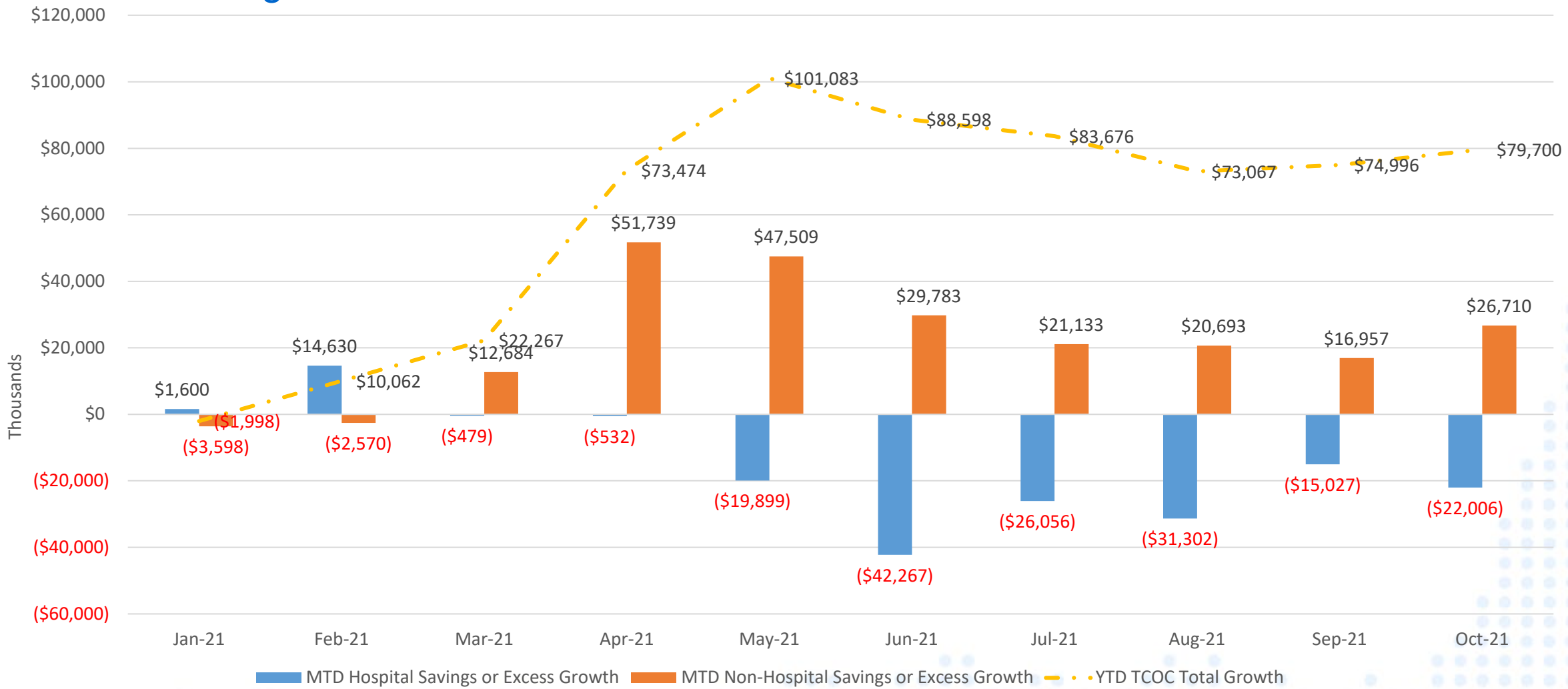
Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through October 2021



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Legislative Update

HSCRC February 2022 Commission Meeting

February 9, 2022

COVID-19 Impact: How will this session be different?

- Committee Briefings and Hearings
  - House: Virtual all session
  - Senate: Virtual through February 11; in-person starting February 14
- In-person floor sessions, floor sessions are live streamed
- Public access to legislative buildings

These policies are subject to change.

Legislative Priorities

- **Legislature:**
  - Redistricting
  - Distributing budget surplus
  - Planning for fall elections
- **HSCRC:** Bill to change the methodology for calculating the Commission's user fee assessment cap
- **HSCRC Stakeholders:** workforce, medical debt, and behavioral health

Staff Activities during Legislative Interim

- HSCRC submitted five legislative reports:
  - Independent Actuarial Analysis of Maryland's Hospital Medical Liability Climate (by Milliman), required by 2020 JCR
  - Evaluation of MDPCP, required by the 2021 JCR
  - Analysis of Hospital at Home in Maryland, required by the 2021 JCR
  - Analysis of Hospital Provision of Reduced-Cost Care and Collection Procedures, required by House Bill 565 (Ch. 770, 2021 Md. Laws)
  - Behavioral Health Emergency Department Wait Times and Service Improvements in Maryland, requested by HGO Committee
- Staff continue to work to implement House Bill 565 (Ch. 770, 2021 Md. Laws), related to medical debt and payment plans.

Staff Activities during 2022 Legislative Session

- HSCRC participated in briefings on:
  - Total Cost of Care Model for the House Health Government Operations (HGO) Committee
  - Behavioral Health Service Improvements for the HGO Public Health And Minority Health Disparities Subcommittee
- A joint briefing with four committees on medical professional liability included reference to Milliman's Independent Actuarial Analysis Report, submitted by HSCRC in 2021.

Budget

Bill #	Description
HB 300 SB 290	**Budget Bill for FY 2023 (The Governor's Budget)**

- HSCRC's Budget hearings will be held on:
  - February 14, 2022 – Health and Social Services Subcommittee of the Appropriations Committee (House)
  - February 17, 2022 – Health and Social Services Subcommittees of the Budget and Taxation Committee (Senate)

User Fee Bill

Bill #	Description	Position
HB 510 SB TBD	**Health Care Facilities – Health Services Cost Review Commission – User Fee Assessment**	Support

- Hearing dates are TBD
- Staff are engaging with key stakeholders
- MHCC also has a user fee bill this year (HB 353 / SB 253)

Medical Bill Reimbursement

Bill #	Description	Position
HB 694	**Hospitals – Financial Assistance – Medical Bill Reimbursement**	TBD, likely Letter of Information

- Seeks to require hospitals to provide refunds to patients who were eligible for free care but paid a bill in 2017-2021.
- Related to data analysis and modeling in a HSCRC report on potential future policy options related to financial assistance (required under HB 1420 (2020)).
- Hearing date is TBD

Questions?

Megan Renfrew

Associate Director of External Affairs

Center for Payment Reform and Provider Alignment

megan.renfrew1@maryland.gov

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Appendix

2022 General Dates of Interest

- **January 12 -** General Assembly convenes
- **Late January**
  - Budget bill introduced by Governor
  - Bill request guarantee date- last day legislators can request bill drafting
  - Final day for introduction of Administration bills (i.e. bills from the executive branch) without Senate Rules Committee Referral
  - Governor's State of the State Address (noon)
- **February 7 (Senate), 11 (House)-** Final day for introduction of bills without Rules Committee Referral
- **February 20 -** Green Bag appointments submitted by Governor
- **March 7 -** Final date for introduction of bills without suspension of Rules
- **March 21 -** Opposite Chamber Crossover Date
- **April 4 -** Budget bill to be passed by both chambers
- **April 11 -** Sine Die

2022 General Assembly: Key Facts

Senate

- President- Bill Ferguson (D-Baltimore City)
- 47 Senators--32 D; 15 R
- Key Committees for HSCRC's Work and Budget:
  - Finance – Chair Delores Kelley
  - Budget and Taxation - Chair Guy Guzzone

House of Delegates

- Speaker- Adrienne Jones (D-Baltimore County)
- 141 Delegates--99 D; 42 R
- Key Committees for HSCRC's Work and Budget:
  - Health and Government Operations (HGO) – Chair Shane Pendergrass
  - Appropriations – Chair Maggie McIntosh

Workgroup Updates

HSCRC Standing and Legislative Workgroups

- Standing Workgroups
  - Performance Measurement Workgroup
  - Payment Models Workgroup
  - Total Cost of Care Workgroup
  - Consumer Standing Advisory Committee
  - Care Transformation Steering Committee
- Stakeholder Groups
  - Secretary's Vision Group
  - Stakeholder Innovation Group
- Legislative Workgroups
  - Hospital Payment Plan Guidelines Workgroup (per Ch. 770 of 2021)

Outcome-Based Credit Review

Outcome-Based Credit (OBC) Purpose and Design

Purpose:

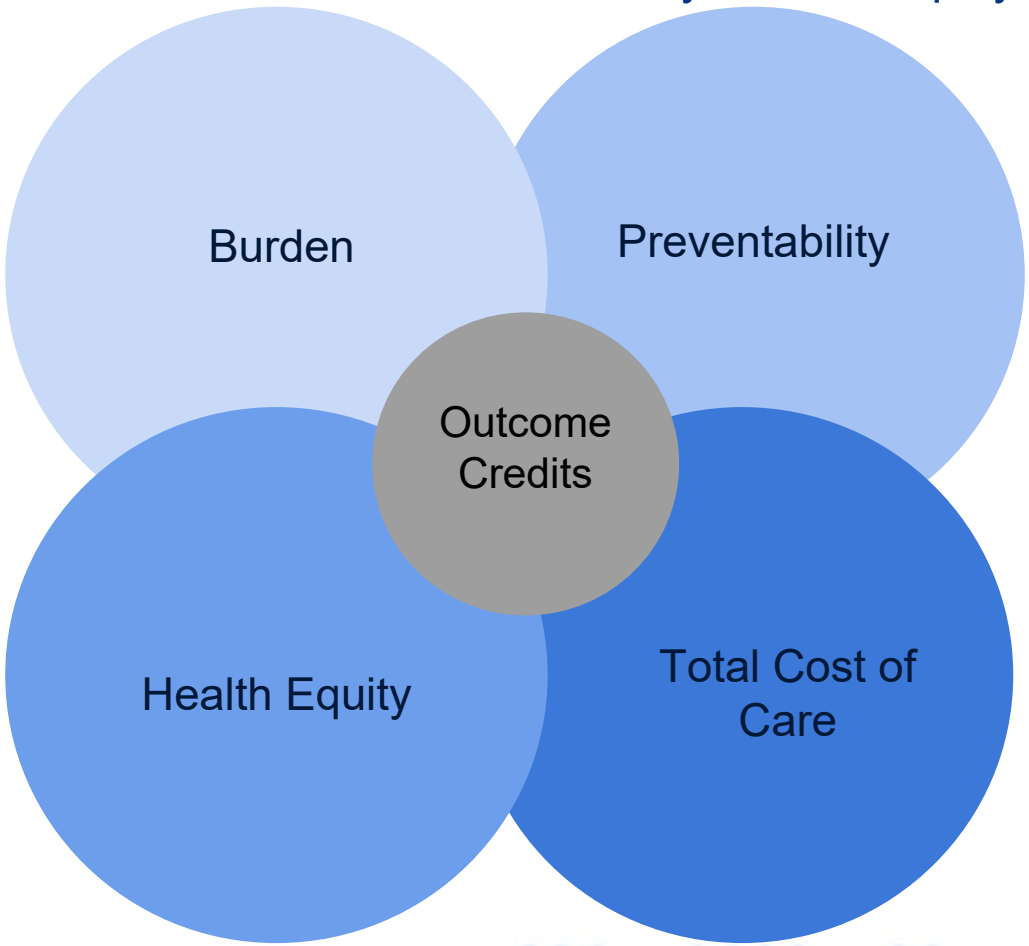
- Provide an opportunity to offset the State's TCOC with a credit for improvements in population health and promotes public/private collaboration on statewide priorities, with up-side only benefit
- OBC not directly linked to SIHIS, but intended to create momentum toward a limited series of population health goals

Design:

- Identify population health focus area
- Develop methodology for change over time in # of cases in Maryland vs. control group
- Measure annual # of cases prevented in MD
- Develop cost-per-case methodology
- Annual credit = cost per case x cases prevented

Selecting Outcome-Based Credits

Outcome Credits should be at the center of Burden, Preventability, Health Equity and Cost



Measuring Burden: Disability-Adjusted Life Years (DALYs)

Metrics: Disability-Adjusted Life Year (DALY)

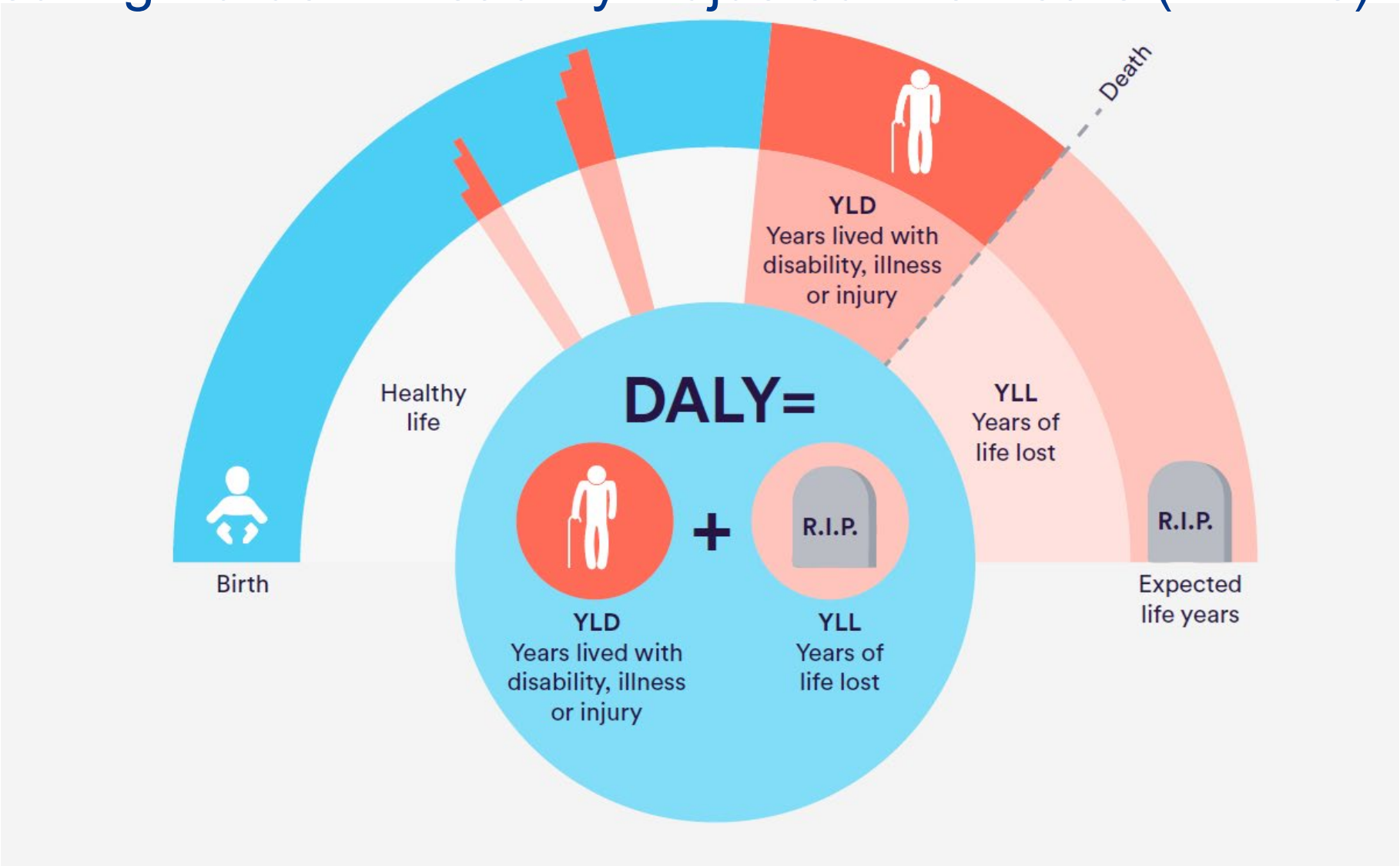
Quantifying the Burden of Disease from mortality and morbidity

Definition

One DALY can be thought of as one lost year of "healthy" life. The sum of these DALYs across the population, or the burden of disease, can be thought of as a measurement of the gap between current health status and an ideal health situation where the entire population lives to an advanced age, free of disease and disability.

Source: https://www.who.int/healthinfo/global_burden_disease/metrics_daly/en/

Measuring Burden: Disability-Adjusted Life Years (DALYs)



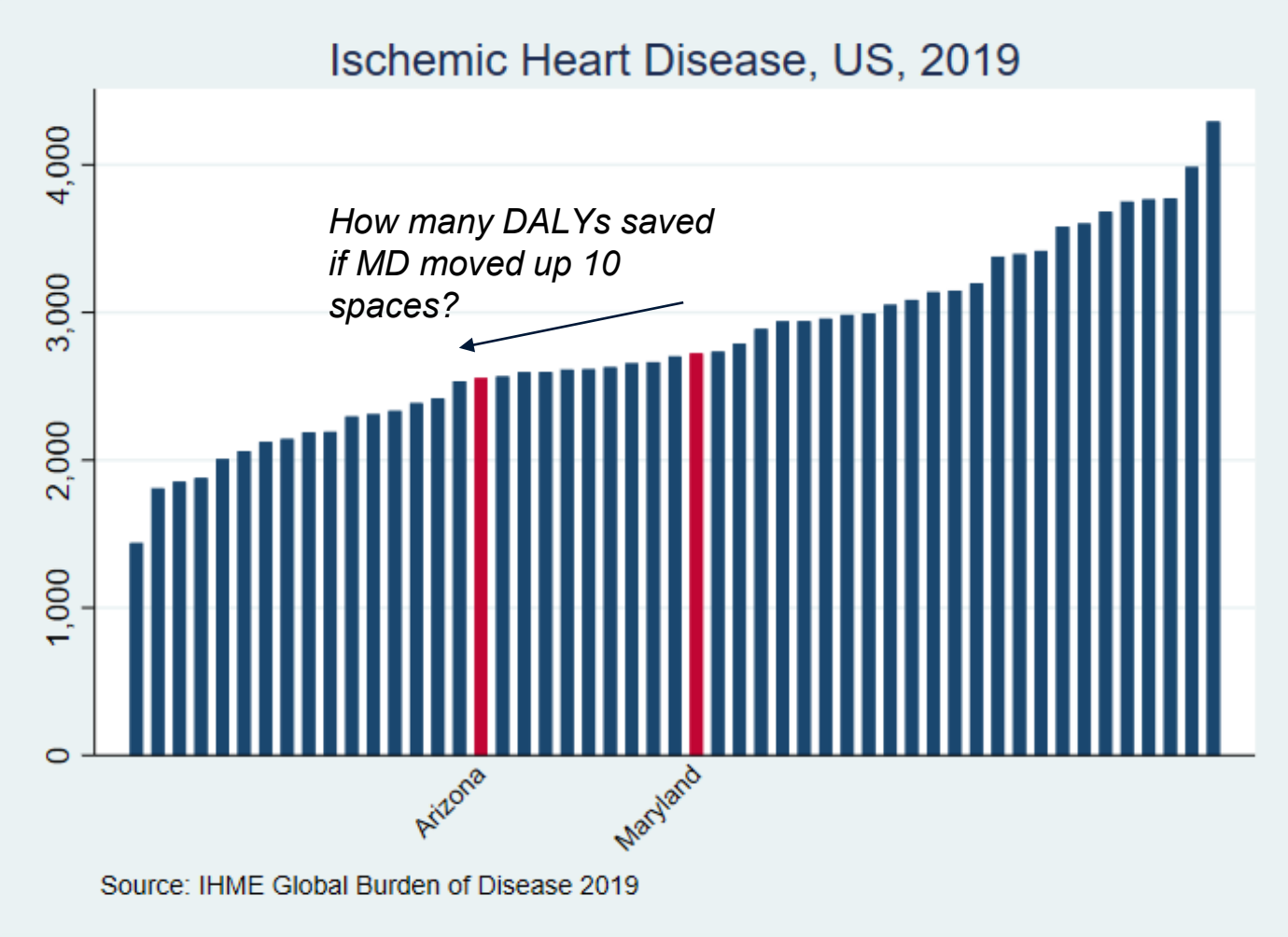
Source: Public Health England (2015). Reproduced by Nuffield Trust under Open Government Licence.

Measuring Preventable Burden

One way to gauge potential health improvement from interventions is to look at other states' performance:

1. **Rank:** rank states on DALYs per disease
2. **Calculate:** how many DALYs could Maryland save?
3. **Compare:** possible DALYs saved across diseases

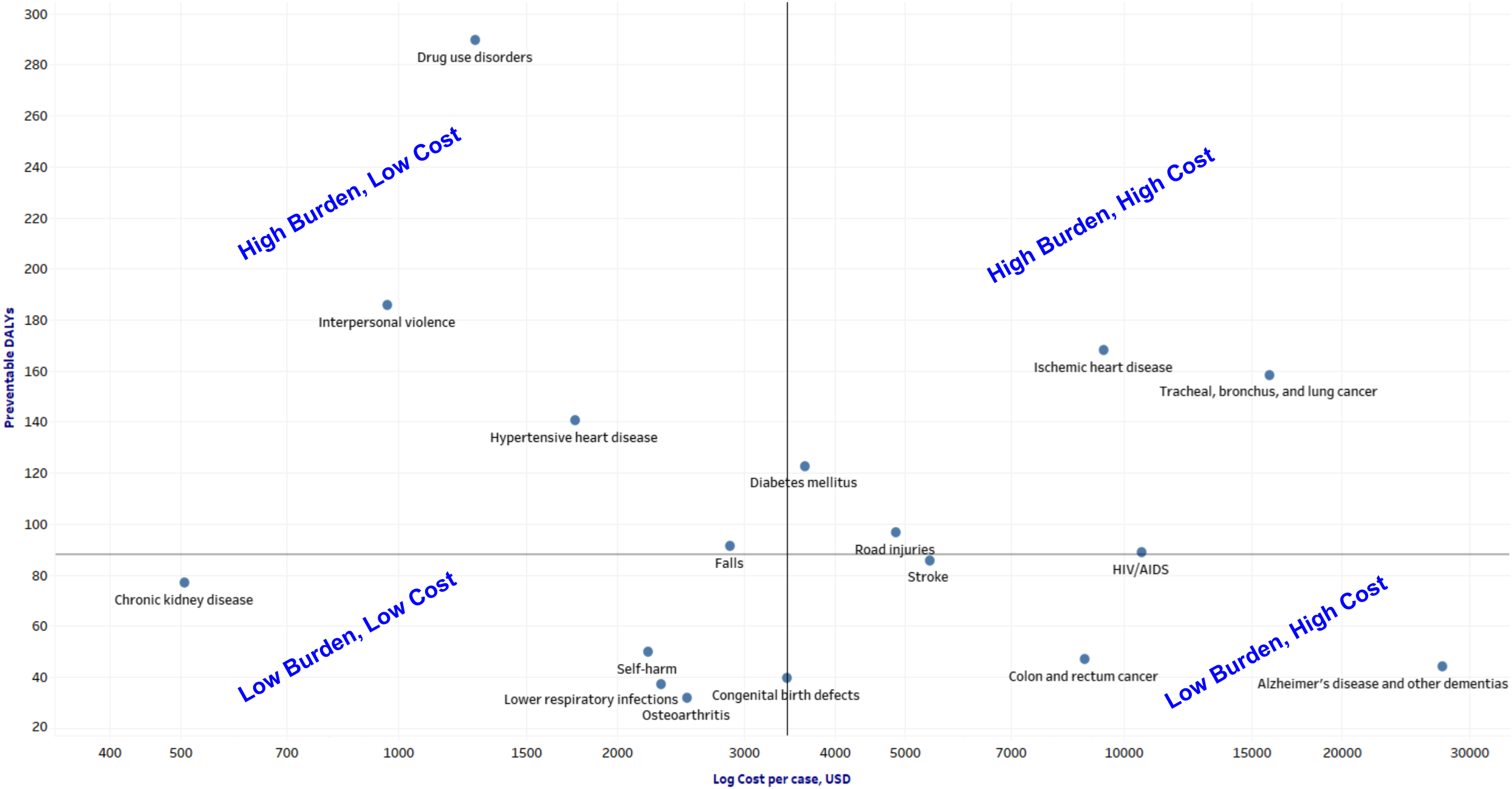
Example: Ischemic Heart Disease



How many DALYs saved if MD moved up 10 spaces?

- ➔ MD: 2,723 DALYs per 100k residents
- ➔ AZ: 2,555 DALYs per 100k residents
- ➔ Maryland could save nearly 170 DALYs per 100k residents by intervening on Ischemic Heart Disease

Preventable DALYs by Cost per Case



Diabetes Performance

- State submitted credit application in early January
- $5M credit earned to offset Maryland's CY 2021 TCOC savings
- CMMI currently validating performance analytics

Cases prevented per 10,000	1.36
MD population over 45 years old	2,576,359
Cases prevented	350
Credit per case	$14,512
2020 diabetes credit	$5,084,785

Credit Methodologies in Development

- Opioids
  - Initial program development focused on OUD incidence
  - Data issues resulted in switch to guidelines prescribing
  - Tentative CMMI submission in 2022 Q4
- Hypertension
  - Began work on cost methodology in November 2021

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TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: February 9, 2022

RE: Hearing and Meeting Schedule

March 9, 2022 To be determined - GoTo Webinar

April 13, 2022 To be determined - GoTo Webinar

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

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