

**610th Meeting of the Health Services Cost Review Commission
July 12, 2023**

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

**CLOSED SESSION
11:00 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 June 14, 2023
2. Docket Status – Cases Closed
2625A Johns Hopkins Medical System
3. Docket Status – Cases Open
2620T Howard County General Hospital
2622N MedStar St. Mary's Hospital
2626R Encompass Health Rehabilitation Hospital of Southern Maryland
4. Confidential Data Request by USOM, Department of Anesthesiology
5. Final Recommendation on Efficiency Policies
6. Regional Partnership - CY 2022 Report
7. Uncompensated Care Report - FY 2024
8. Policy Update and Discussion
 - a. ED Reporting Template Dashboard
 - b. NSP I Report - FY 2022 Activities
 - c. Maryland Model Performance CY22 - Update
9. Hearing and Meeting Schedule

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

AS OF JULY 3, 2023

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

Docket Number	Hospital Name	Date Docketed	Purpose	Analyst's Initials	File Status
2620T	Howard County General Hospital	4/6/2023	TEMPORARY	JS/AP	OPEN
2622N	MedStar St. Mary's Hospital	4/11/2023	OTH	WN	OPEN
2626R	Encompass Health Rehabilitation Hopsital od Southern Maryland	7/3/2023	FULL	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

IN RE: THE PARTIAL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF THE	*	COST REVIEW COMMISSION
MEDSTAR HEALTH	*	DOCKET: 2023
ST. MARY'S HOSPITAL	*	FOLIO: 2432
LEONARDTOWN, MARYLAND	*	PROCEEDING: 2622N

Staff Recommendation
July 12, 2023

Introduction

On April 6, 2023, MedStar St. Mary’s Hospital (“MSMH” or “the Hospital”), submitted a partial rate application requesting the creation of a new rate for Occupational Therapy (OT) services. The Hospital also requested an effective date of July 1, 2023 for OT services.

Staff Evaluation

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital’s projections. Based on the information received, the Hospital requested a OT rate of \$16.76. The statewide median rate is \$16.79.

<u>Service</u>	<u>Service Unit</u>	<u>Unit Rate</u>	<u>Projected Volumes</u>	<u>Approved Revenue</u>
Occupational Therapy	RVUs	\$16.76	53,319	\$893,626

Recommendation

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

1. That a rate of \$16.76 be approved effective July 1, 2023 for OT services;
2. That the OT rate center not be rate realigned until a full year of cost data has been reported to the Commission; and
3. That no change be made to the Hospital’s Global Budget Revenue for the OT services.



maryland
health services
cost review commission

**Final Staff Recommendation for a Request to Access
HSCRC Confidential Patient Level Data from
The University of Maryland School of Medicine (UMSOM)
Department of Anesthesiology.**

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

July 12, 2023

This is a final recommendation for Commission consideration at the July 12, 2023, Public Commission Meeting.

SUMMARY STATEMENT

The University of Maryland School of Medicine (UMSOM), Department of Anesthesiology, is requesting access to the Health Services Cost Review Commission (HSCRC) Confidential Inpatient and Outpatient Hospital Data (“the Data”), to evaluate the clinical and financial outcomes associated with the implementation of a statewide Critical Care Coordination Center (C4).

OBJECTIVE

Researchers aim to objectively study:

1. Efforts to address healthcare disparities throughout the state of Maryland specially for areas under-served;
2. Use of a public, safety-based, EMS agency/model to provide administrative control and direction for provision of critical care services under pandemic and non-pandemic conditions;
3. The importance of having a state-level intensive care physician who can provide medical direction for patients who are unable to be transferred from an emergency department (ED);
4. The effect of a Critical Care Coordination Center (C4) on ED crowding; and
5. How critical care, like trauma and cardiac/stroke cases, can be regionalized at a state level.

Project Investigators received approval from the Maryland Department of Health (MDH) Institutional Review Board (IRB) on September 29, 2022, and the MDH Strategic Data Initiative (SDI) office on October 28, 2022. The Data will not be used to identify individual hospitals or patients. The Data will be retained by UMSOM until June 14, 2024. At that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee (“the Review Committee”). The Review Committee is composed of representatives from HSCRC, the MDH Environmental Health Bureau. The role of the Review Committee is to determine whether the study meets the minimum requirements listed below and to make recommendations for approval to the HSCRC at its monthly public meeting.

1. The proposed study or research is in the public interest;
2. The study or research design is sound from a technical perspective;
3. The organization is credible;
4. The organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations; and
5. The organization has adequate data security procedures in place to ensure protection of patient confidentiality.

The Review Committee unanimously agreed to recommend that UMSOM be given access to the Data. As a condition for approval, the applicant will be required to file annual progress reports to the HSCRC, detailing any changes in goals, design, or duration of the project; data handling procedures; or unanticipated events related to the confidentiality of the data. Additionally, the applicant will submit a copy of the final report to the HSCRC for review prior to public release.

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by UMSOM for the Data for Calendar Year 2020 through 2023 be approved.
2. This access will include limited confidential information for subjects meeting the criteria for the research.



maryland
health services
cost review commission

Final Recommendation on Modifications to Efficiency Policies: Full Rate Application, Integrated Efficiency Methodology, and Capital Financing

July 12, 2023

This document contains the final staff recommendation for modifying the Commission's efficiency policies. Staff will request that Commissioners vote on these recommendations during the July Commission meeting.

Table of Contents

Key Methodology Concepts and Definitions	1
1. Policy Overview	2
2. Draft Recommendations	2
3. Introduction	3
3a. Hospital Cost per Case	5
3b. Total Cost of Care Per Capita	6
3c. Revenue for Reform	6
4. Policy Discussion	7
4a. Areas for Improvement	7
4b. Efficiency Implementation	19
5. Efficiency Assessment	24
5a. Full Rate Application Results	25
5b. Integrated Efficiency Results	29
6. Stakeholder Comments	30
6a. Philosophical Concerns - Defining Efficiency in Model	31
6b. Philosophical Concerns - Overlapping TCOC Risk	32
6c. Philosophical Concerns - Addressing Outliers	33
6d. Philosophical Concerns - Disproportionate Impact	34
6e. Responses to Staff Recommendations - Application of TCOC	35
6f. Responses to Staff Recommendations - Revenue for Reform	35
6g. Responses to Staff Recommendations - Productivity Adjustment	37
6h. Responses to Staff Recommendations - One-time adjustment	38
6i. Technical Considerations - Aligning Revenue and Volume	39
6j. Technical Considerations - Data Concerns with Efficiency Evaluation	40
6k. Technical Considerations - Data Concerns with Efficiency Evaluation	45
7. Final Recommendations	46

Appendix A. Detailed Description of Inter-Hospital Cost Comparison Methodology	48
Appendix B. Detailed Description of TCOC Benchmarking Assessment Methodology	51
Appendix C. Efficiency Matrix with Existing TCOC Benchmarks	54
Appendix D. Efficiency Matrix with MPA and MPA Analog Method	55
Appendix E. Efficiency Matrix with Better of Benchmarks & MPA and MPA Analog Method	56
Appendix F. ICC Statistical Significance Evaluation	57

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 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 of 2 percent. The term "Relative efficiency" is the difference between a hospital's actual revenue base and the ICC calculated cost base.
3. Productivity Adjustment – A percentage reduction applied to the peer group standard cost in the ICC evaluation (historically 2 percent) to ensure that hospitals do not acquire rate enhancement for merely demonstrating average cost performance and thus limited operational efficiency.
4. 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.
5. 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 weighted equally, and hospitals are arrayed into quartiles to determine overall efficiency.
6. Total Cost of Care (TCOC) Benchmark Performance – TCOC, an assessment of part A and B Medicare expenditures and all commercial expenditures excluding retail pharmacy, 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, benefit (commercial only) and demographic adjusted basis
7. Medicare Performance Adjustment (MPA) Method – An evaluation of Medicare TCOC that blends attainment and improvement by scaling the expected, cumulative improvement levels based on TCOC benchmark performance.
8. Medicare Performance Adjustment (MPA) Analog Method- An evaluation of Commercial TCOC that blends attainment and improvement by scaling the expected, cumulative improvement levels based on TCOC benchmark performance.

1. 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 and a proposed efficiency buyout if a hospital invests in population health.	Hospitals that run efficiently and effectively manage total cost of care in their service areas may 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 areas. 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. Additionally, allowing an efficiency buyout if a hospital invests in population health will likely improve health disparities in communities that have limited community investments.

2. Background and purpose of Recommendation

Since 2018, staff has been working with Commissioners and stakeholders to develop formulaic and transparent methodologies that: a) establish an absolute standard so that the Commission may reset a hospital's rate structure to align with its current services (Full Rate Application); b) identify and addresses relative efficiency performance in order to bring hospitals closer to peer average standards over time through scaled inflation (Integrated Efficiency Policy); and c) provide predictable rate updates for major new capital projects (Capital Financing Policy). These policies have built off traditional efficiency evaluations that the HSCRC has utilized over the course of all-payer rate setting in the State, but they also incorporated new, unprecedented evaluations of Total Cost of Care (TCOC) that better aligned the Commission's efficiency policies with the incentives of Maryland's TCOC Model. As a result, the policies allow the

Commission to adjust hospitals' permanent rate structures based on objective efficiency standards that balance hospital cost efficiency and TCOC effectiveness.

The efficiency policies have thus far been used successfully to adjudicate several full rate applications, capital rate applications, and GBR adjustments through the Integrated Efficiency policy. However, in line with the Commission's ethos to constantly refine and evolve its evaluations, staff is seeking modifications to the efficiency policies to:

- a) improve the application of TCOC evaluations,
- b) allow for Integrated Efficiency buyouts to directly incentivize population health investments,
- c) reinstitute a productivity adjustment that will ensure that only hospitals with demonstrated operational efficiency can access funding through a full rate application, and
- d) address underlying data challenges in the RY 2024 policies by making all efficiency adjustments one-time in nature.¹

Following a comment period and additional discussion from Commissioners and stakeholders, staff have revised the draft recommendations, as presented at the June 2023 Commission meeting, which will be discussed in full detail in the enclosed report.

3. 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 aggregate rates are set in reasonable relationship to aggregate costs; and that rates are set equitably and applied on an all-payer basis. The innovative TCOC agreement with the federal government focuses efforts on managing per capita rather than per unit cots, and to meet that focus, requires that the relative growth of per capita total health care spending in Maryland must meet certain standards.

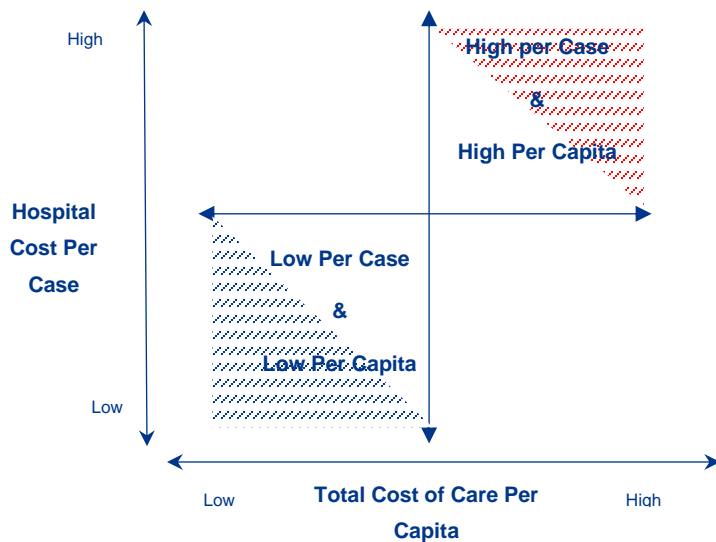
¹ Continued data challenges specific to RY 2024 efficiency analysis includes: Casemix adjusted weights that have not been updated to a post-COVID time period; Limited scoring of hospital deregulation adjustments; Ongoing service delivery disruption due to COVID, which affects both RY 2022 hospital volumes and CY 2021 TCOC metrics; and Unrealized Demographic Adjustment funding due to census catchup, which would have increased hospital profit margins.

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 full rate application methodology, the integrated efficiency methodology, and the capital financing methodology, in more general language. 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 current efficiency policies were 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*; a hospital that is successful in both dimensions could be considered to be “Efficient”. That is, they achieve technical efficiency without sacrificing the more important per capita goals. Those hospitals identified as particularly high in both these categories are considered presumptively Ineffective (red in the 2 X 2 diagram below), while those that are low in both these categories are presumptively Effective (blue below).

Presumptively Ineffective hospitals, which may have excessive retained revenue that is generating high hospital prices and bad TCOC outcomes, have restricted access to full rate and capital rate applications and are potentially not granted access to a portion of inflation as part of the Annual Update Factor. Presumptively Effective hospitals have greater access to full rate and capital rate applications and 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. Controlling TCOC is essential for the waiver to succeed and per unit efficiency in the absence of per capita efficiency is of little value to healthcare payers. At the same time, controlling hospital cost per case, in a responsible way, is a valuable tool in managing cost per capita and part of the Commission's mandate. Finding the right balance between these two

elements that tend to move in opposite directions is critical.² 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. Staff notes that the TCOC Model is an innovation focused on global budgets and not per case reimbursement and the Commission should be hesitant to implement policies that prioritize per case over per capita approaches. CMS has been reimbursing hospitals on a per case basis for many years and it has not proven effective in controlling spending on a per capita basis or addressing health equity or other community health concerns, hence the need for a global budget model.

3a. Hospital Cost per Case

The Commission has relied on the Inter-hospital Cost Comparison (ICC) methodology to evaluate an individual hospital's cost per case or technical efficiency. 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.

² As hospitals volumes fall as part of improving total cost of care, hospital unit rates increase under the GBR. Conversely historically hospitals have sought increased revenue and per unit efficiency by focusing on maximizing volumes rather than on focusing on maximizing the overall health of a community.

- Adjusting this standard cost per case back up to **approved total revenue** specific to each hospital.
- The approved revenue is compared to actual revenue to calculate the **relative efficiency of the hospital**.

These calculations are summarized in greater detail in Appendix A.

3b. 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 steps 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 Fee-for-Service and commercial insurance payers. It does not exist for Medicaid. The task is to find appropriate demographically similar 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 hospital's primary service area.
- **Adjust the data for differences** in Beneficiary Risk and Demographics and compare.

These calculations are summarized in detailed tables in Appendix B. Additional detail on the benchmarking approach can be found on the HSCRC website: [TCOC Workgroup](#)

3c. Revenue for Reform

Since 2013, most hospitals in the State that have operated under a global budget have been successful at reducing hospital utilization and therefore have generated retained revenues. While retained revenues are indicative of a hospital following the incentives of the Model and providing more effective care to their community, they will make a hospital more inefficient on a per case basis. Since hospitals do not incur variable costs on utilization that has been avoided, the revenue retained after a reduction in utilization will increase the hospital's regulated profit. And, since regulated profit is not included in the hospital's Approved Revenue, the impact of retained revenue on hospital utilization will be to increase the hospital's charge per case without

increasing the hospital's Approved Revenue. Thus, a hospital's retained revenue will make the hospital less efficient under the ICC evaluation.

This creates tension between the ICC and global budgets. Hospitals are supposed to generate retained revenues in order to invest in community and population health. But if they do so, they are considered inefficient and – under the Integrated Efficiency policy – are provided less inflation than peer institutions who may have ignored the model and made no effort to focus on community health. And perversely, a hospital that generates retained revenue and spends the entirety of that revenue on population health is considered equally inefficient as a hospital that generates retained revenue and does nothing productive with it.

The Revenue for Reform policy attempts to address this tension by allowing hospitals deemed to be inefficient to mitigate the inflationary reduction associated with the Integrated Efficiency Policy if the hospital uses the revenue to invest in community and population health. This policy proposal would mark the first direct incentive, other than grant funding, that the Commission would have to compel hospitals to invest in population health.

4. Policy Discussion

The following section discusses potential areas for improvement in the various efficiency methodologies, specifics behind each of the changes previewed above, and how each efficiency policy will be implemented.

4a. Areas for Improvement

Full Rate Application – TCOC Application & Productivity Adjustment

Over the last two years, numerous stakeholders and staff have raised concerns about the positive TCOC scaling in the FRA policy. Specifically, unlike the negative scaling in the FRA policy, a hospital only had to be better than its national benchmark geographies in order to improve its standing in a FRA; there was no consideration for improvement in TCOC. As a result, concerns were raised that TCOC “rewards” were due to geographic determinism, e.g., a hospital in a market that nationally would have had a more expensive hospital footprint and thus higher

TCOC might appear more efficient, even though no improvement on TCOC had occurred in Maryland since the start of the Model.

Providing a reward to a hospital under this scenario does not represent acknowledgement of any action the hospital may have taken to advance the health of the population, reduce utilization, and improve TCOC. While the TCOC reward does not determine the final hospital approved revenue, as TCOC scales the assessment from the ICC, in certain cases the reward was quite significant. *In light of this concern, staff recommend the following changes to the TCOC algorithm:*

Exhibit 1: Proposed Changes (in bold underline) to TCOC Algorithm in Full Rate Application

Prior TCOC Performance Standard for Scaling	Proposed TCOC Performance Standard for Scaling	Reward/Penalty Modification to ICC
Better than Medicare Benchmark	Better than Medicare Benchmark <u>and better than average State TCOC growth</u>	Reward
	Better than Medicare Benchmark and worse than average State TCOC growth	No action
Better than Medicare Benchmark AND Average of Top Half of Commercial Performance	Better than Medicare Benchmark AND Average of Top Half of Commercial Performance <u>and better than average State Commercial TCOC growth</u>	Additional Reward
	Better than Medicare Benchmark AND Average of Top Half of Commercial Performance and worse than average State Commercial TCOC growth	No action
Worse than Medicare Benchmark but better than average State TCOC growth	Worse than Medicare Benchmark but better than average State TCOC growth	No action
Worse than Medicare benchmark and worse than average State TCOC growth	Worse than Medicare benchmark and worse than average State TCOC growth	Penalty

Worse than Commercial Benchmark	Worse than Commercial Benchmark	Additional Penalty
All Rewards Capped so that a Hospital Does not Exceed Medicare Benchmark		

In addition to the TCOC scaling consideration staff have brought forward, Commissioners have raised concerns about the limited emphasis on operational efficiency in the FRA policy, i.e., the degree to which hospitals demonstrate that their inputs or costs are less expensive per output or hospitalization. This is a particularly salient point when regulated margins are suppressed statewide, because as statewide margins decrease, the standard for qualifying for rate enhancements in the ICC is lowered. This occurs because the ICC is effectively equal to a hospital's operational efficiency relative to the peer group cost standard LESS the profits stripped from a hospital LESS a productivity adjustment (if there is one in place). Thus, if regulated margins decrease across the board, then the degree to which a hospital must reduce its cost per case to qualify for a permanent, higher rate structure is attenuated.

When the Full Rate Application policy was first considered for adoption, average regulated margins were greater than 8 percent and the methodology incorporated a 2 percent productivity adjustment. In effect, hospitals had to demonstrate cost per case efficiency (or operational efficiency) that was greater than 10 percent of the peer group average to qualify for a rate enhancement. As such, the Commission recommended discontinuing the productivity adjustment because having to demonstrate operational efficiency that is greater than 10 percent of the peer group standard (8 percent profit PLUS a 2 percent productivity adjustment) was considered too significant to warrant a rate enhancement.

When margins are reduced the opposite is true: having to demonstrate an operational efficiency that is less than 8 percent of the peer group standard is not stringent enough, especially compared to historical expectations of relative operational efficiency (see Exhibit 2):

Exhibit 2: Historical Minimum Operational Efficiency Standard for Enhanced Rates

Fiscal Year	Regulated Margin	Productivity Adjustment	Effective Minimum Operational Efficiency Standard
FY2004	4.61%	2%	6.61%
FY2005	4.88%	2%	6.88%
FY2006	5.16%	2%	7.16%
FY2007	5.50%	2%	7.50%
FY2008	5.44%	2%	7.44%
FY2009	6.42%	2%	8.42%
FY2010	6.44%	2%	8.44%
FY2011	7.56%	2%	9.56%
FY2012	7.07%	2%	9.07%
FY2013	4.52%	2%	6.52%
FY2018	8.81%	Discontinued	8.81%
FY2022 (Current ICC Evaluation)	6.47%	0%	6.47%
2004-2013 Average	5.76%		7.76%

Failure to reinstate a productivity adjustment in RY 2024 would result in diminishing the minimum operational efficiency standard in HSCRC policies to a point not reached in the last twenty years of rate setting (6.47 percent operational efficiency standard vs. an average of 7.76 percent). Moreover, given that the margin erosion is due to various transient costs, such as length of stay increases and nurse agency costs, increasing approximately one quarter of the industry's rate structure based on potentially temporary phenomena is not an ideal policy outcome. *Thus, staff recommend using the statewide margin erosion to calculate the productivity adjustment each year such that rate enhancements are provided only for demonstrable cost efficiency. Specifically, the productivity adjustment would be equal to the variance between 8 percent (the historical minimum operational efficiency standard) and the average regulated margin for ICC evaluated hospitals. For RY 2024 efficiency policies, this would be equal to 1.53 percent (8 percent – 6.47 percent regulated profit = 1.53 percent). In years when the regulated margin is greater than 8 percent, there would be no productivity adjustment. As discussed in the Stakeholder Comment section, the addition of permanent rate increase from the demographic adjustment alters the final productivity adjustment from 1.53 percent to 0.34 percent.*

Integrated Efficiency – TCOC Application

While historical iterations of efficiency measures only considered hospital costs, under the TCOC Model any measure of efficiency should include an assessment of a hospital's total cost

of care performance. The current method for scaling annual inflation through the Integrated Efficiency policy incorporates a ranking system that evaluates hospital cost per case efficiency at 50 percent, Medicare TCOC attainment performance measured against national benchmark geographies at 25 percent, and Commercial TCOC attainment performance measured against national benchmark geographies at 25 percent.

The Commission adopted a TCOC benchmarking approach because prior improvement-only analyses were unreliable and did not recognize different opportunity levels in the Model due to varying historical TCOC effectiveness that predated global budgets. While statistical reliability and consideration for TCOC effectiveness improved under the benchmarking approach, numerous stakeholders expressed concern that the incentive was still not actionable, as the wide gulf in TCOC attainment assessments could not be closed in a short time period. Thus, hospitals expressed reluctance to make investments to improve TCOC that would ultimately still result in reduced inflation through the Integrated Efficiency policy because the benefits could not possibly accrue fast enough to improve the hospitals position, i.e., the efficiency incentive was not actionable.

The Medicare Performance Adjustment (MPA) similarly wrestled with this concern and elected to blend TCOC attainment with improvement by scaling the expected, cumulative improvement levels based on TCOC benchmark performance. In effect, hospitals that were historically more expensive in terms of TCOC had to grow at a slower rate than hospitals that were less expensive. Over time (15 years in the MPA), geographies will be aligned at similar attainment levels, but in the intermediate years there are improvement rewards that reward hospitals for making investments to reduce TCOC.

Staff recommend that the same method that is incorporated in the MPA should be used in the Integrated Efficiency policy. The benefit of this approach is that hospitals that generate TCOC savings in line with the Model's overarching incentives are not penalized with lower inflation; it is more reliable than year over year improvement assessments because it is cumulative; and, like the benchmarking analysis, it recognizes that various parts of the State do not need to improve

TCOC as fast as other parts of the State due to historically good performance in TCOC. *Staff also recommend this same approach should be used for Commercial TCOC.* For a description of the calculation, see the tables below:

Exhibit 3: MPA Method for Medicare TCOC in Integrated Efficiency

Step	MPA Approach	Medicare MPA Analog for IE
A	Calculate Variance from Benchmark in 2019	Same
B	Group hospitals into roughly even 5 groups based on performance in Step A	Same
C	Assign adjustment values to each group ranging from 0 (best performing group) to 1% (weakest group). Attainment-based adjustment value is used to adjust improvement targets in Step D. As additional years elapse the adjustment is compounded.	Same
D	Calculate performance as: Hospital Growth Since 2018 – (National Growth since 20198 – Step C Adjustment)	Same
E	Cap value in Step D at +/-3% and scale to 1% to calculate MPA reward or penalty.	Rank results from Step D and blend ranking 50%/50% with ICC

Exhibit 4: MPA Analog Method for Commercial TCOC in Integrated Efficiency

Step	MPA Approach in MC IE	MPA Analog for Commercial TCOC
A	Calculate Variance from Benchmark in 2018	Same
B	Group hospitals	Same
C	Assign adjustment values to each group ranging from 0 (best performing group) to 1% (weakest group). As additional years elapse the adjustment is compounded.	Assign adjustment values to each group ranging from -0.5% (best performing group) to 0.5% (weakest group). As additional years elapse the adjustment is compounded.
D	Calculate performance as: Hospital Growth Since 2018 – (National Growth since 2018 – Step C Adjustment)	Use MD average performance instead of National as standard for being above or below target.
E	Rank results from Step D and blend ranking 50%/50% with ICC	Same

The chief variance between the two methods (the Medicare MPA analog and the Commercial MPA analog) is the former expects improvement over time, hence why the average hospital has to perform better than the nation by 0.5 percent (halfway between 0 and 1 percent), and the latter does not expect any improvement, hence why the average hospital is expected to grow at the same rate as the statewide average. The reason for this divergence is simply because Maryland is less expensive than national peers with respect to Commercial TCOC; it is Medicare TCOC that needs to be reduced to come into line with national performance. That said, the Efficiency

Workgroup that debated these proposed adjustments strongly advocated that this phenomenon is largely driven by pricing differences in the State's all-payer rate setting system, which benefit all hospitals equally, so the Commission should not elect to just focus on Medicare TCOC and should instead stick with the Commission's guiding principle of developing policies on an all-payer basis.

The final concern raised by stakeholders during the Efficiency Workgroup sessions was whether the MPA and MPA analog methods did enough in the immediate years to recognize historical TCOC effectiveness, the degree to which hospitals are less expensive than their peers at the start of the Model. While this variance is certainly recognized over time as the MPA increases the expected rate of change by 1 percent per year (e.g., a historically expensive TCOC hospital will have to beat the nation by 1 percent in year one, 2 percent in year two,³ etc., while a historical inexpensive TCOC hospital will have to just stay in line with national growth), the expected rate of change is not demonstrably different for the first few years of the MPA implementation and thus understates the variation in attainment performance. *In light of this concern and in keeping with HSCRC Quality policies that address this issue by assessing the better of a hospital's attainment or improvement performance, staff recommend that hospitals in the Integrated Efficiency policy be evaluated under TCOC benchmarking and the MPA/MPA analog approach, and that the best ranking from either assessment be utilized in determining which hospitals will have their inflation scaled.*

Revenue for Reform – Directing Retained Revenue to Population Health Investments

Under current policy, the ICC compares a hospital's charge per case to its Hospital Approved Revenue. Since retained revenue generally results in higher regulated profits, retained revenue will make the hospital appear inefficient even if that retained revenue is being spent on productive population health investments that are in line with the purpose of the Maryland Model but not recorded in regulated cost centers (when these costs are not recorded as regulated costs they will appear as profits in the regulated entity).

³ Technically the impacts are compounded over time, so year 2 = 1.01 x 1.01 -1.

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

Under the Revenue for Reform policy proposal, Staff recommend that hospitals' Integrated Efficiency penalty be reduced by the amount of qualified population spending that the hospital demonstrates. For instance, if the hospital would have received a \$10 million dollar reduction in its Annual Update Factor because of having inflation withheld but had spent \$7 million in qualified population health spending, then the hospital would receive an efficiency cut of only \$3 million (\$10 million efficiency adjustment - \$7 million in a qualifying population health safe harbor).

As discussed above, Staff recommend exempting population health spending from Integrated Efficiency adjustments. Staff recommend establishing clear criteria for what qualifies for inclusion in the Revenue for Reform policy.

Staff recommend that any spending, net of offsetting revenue for that activity, that meets the following three criteria offset a hospital's Integrated Efficiency adjustment:⁴

⁴ Staff recommend that all qualifying spending be included in the Revenue for Reform policy but that future policies examine the relative efficiency of the population health investments. Staff do not believe that sufficient information is available to set targets on the expected impact of the hospital's population health investments. However, it is important to ensure that hospitals are accountable for actual improvements in population health, not just monetary expenditures. Once the hospitals' population health investments are cataloged, future policies should compare the relative effectiveness of similar population investments and established outcomes targets for population health interventions.

- 1) The investment must take place outside of the hospital itself. Activities that take place within the hospital are most likely targeted at patients currently in the hospital. These costs should be treated as part of the hospital's cost of a hospitalization and should not be safe harbored. For example, hospital-based care management programs are valuable but are part of the routine cost of a hospitalization and should be included in the evaluation of the hospital's cost per case. An intervention is considered to be 'outside of the hospital' if services are provided to beneficiaries off of the hospital's campus and recorded in unregulated or non-regulated⁵ cost centers, even if the intervention is deployed from the hospital.⁶ For example, a mobile integrated health program that treats patients at home would qualify even if the program's base of operations was in the hospital itself.
- 2) The investment must be on a non-physician cost (with the exception of the physician safe harbor below). Physician costs are obviously a critical component of many population health interventions. However, physicians are generally reimbursed for the services they provide. The reimbursement rate does not always cover the cost of providing those services, and health systems may need to invest in physician practices to develop a comprehensive strategy for managing the total cost of care. However, hospitals also spend money on physician practices for regular business reasons. Staff do not believe that there is currently an easy way to distinguish a 'business investment' from a 'population health investment.' Therefore, staff recommend excluding physician costs in this policy. For this purpose, physician costs will be excluded if the physicians are billing payers for services that they provide. If the staff of a program happen to be physicians but do not bill payers for services, their costs may be included.
- 3) The investment principally must be serving people who live within the hospital's primary service area. This will ensure that the retained revenues are retained in the community itself and not just the hospital. Investments that are made in an area outside of the hospital's service area are presumably made for other purposes – such as promoting the

⁵ Unregulated refers to business conducted by the regulated entity (the hospital) but not within their regulated cost structure and reported as unregulated in their HSCRC Annual Filing, non-regulated refers to business conducted by a parent or sister entity of the regulated entity which is not reported in the HSCRC Annual Filing.

⁶ Regulated safe harbors would render the Commission's ICC assessment meaningless, as revenue associated with regulated hospital costs would be earmarked as population health investments.

health system in an area with a more favorable payer mix – than the health of the hospital’s community.

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

1) Community Health Safe Harbor

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

- a) An unmet need included on the Community Health Needs Assessment (CHNA).
Hospitals are required to conduct a CHNA once every three years in which they: 1) assess the health of their community; and 2) identify the significant health needs of their community. In conducting the CHNA, hospitals must work collaboratively with members of their community and establish an implementation strategy that describes how the hospital intends to address each health need (or explains why it does not intend to address that need). Since hospitals are already required to establish an implementation plan for addressing the needs of the community, Staff believe spending on community health should be limited to needs identified on the CHNA to fall within this safe harbor.
- b) A need identified by the Centers for Disease Control and Prevention’s (CDC’s) Healthy People 2030 initiative. The CDC establishes national population health priorities; essentially, this is a community health needs assessment for the entire country. Staff believe that hospitals should be allowed to invest in national health priorities, even if their local community did not explicitly address or identify a particular health need.

Staff recommend that hospitals be required to describe their interventions and justify how the intervention is intended to impact one of the community or national health needs. Staff will assess whether the intervention is reasonably related to the community health need identified by the hospital. If the Staff does not believe the intervention to be reasonably related to an identified

community health need, then the costs of the intervention will not qualify. Staff recommend that only direct costs of patient care be included, but that a 25 percent overhead be included in the credit that the hospital receives.

2) Physician Spending Safe Harbor

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

3) Regional Entity Safe Harbor

Staff expect the majority of the hospital's interventions to fall within one of the two safe harbors described above. However, there may be cases where it is advantageous for hospitals that have overlapping service areas and community health needs to leverage their resources and partner with other organizations to solve regional population health issues.

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

demonstrate a commitment to improving population health in the region, and can attest to strong performance in improving health outcomes for the targeted populations.

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

Finally, consideration should be given to statewide strategies that promote population health. To the extent possible, spending plans associated with Revenue for Reform should be made in concert with existing State and local health departments so as not to duplicate or contradict other investments in the community.

4b. Efficiency Implementation

Full Rate Application – Resetting Hospital Rates Based on Current Service Delivery

The current process for full rate applications is outlined in Maryland statute (Health-General Article §19-222 and COMAR 10.37.10.03 et seq). The process allows hospitals to file for a change in its rate schedule that will be effective based on the date that the rate application notice specifies, which must be at least 30 days after the date on which the notice is filed.⁷

The Commission, upon receiving the full rate application, must review and act on the rate application within 150 days after the notice is filed and the application is docketed, unless both parties agree to postpone this deadline. This often may occur because the hospital has introduced in its rate application a methodology consideration that deviates from the approved policy and requires additional research⁸, e.g., new funding for graduate medical education, or because there is additional data, often proprietary in nature, that requires additional staff review.

If the Commission decides to hold a public hearing, the Commission must set a place and time for the hearing within 65 days of the filing notice. In the event of a hearing, the Commission

⁷ The HSCRC has also historically used the full rate application methodology to enter into spend-down arrangements with hospitals, whereby the Commission reduces an inefficient hospital's rate structure over a period of years.

⁸ Additional considerations, either to correct a data source or to consider a different methodological approach, are referred to as a Phase II assessment.

may suspend the effective date of any proposed change until 30 days after the hearing. Finally, if the Commission fails to complete the review of the rate application within 150 days, the change in rate structure will be effective to the date provided on the rate application notice.

Various stakeholders have complained that this process is potentially burdensome when a hospital qualifies for a rate enhancement under the existing Commission approved methodology. *As such, staff recommends that hospitals eligible for a rate enhancement through the full rate application policy in RY 2024 have that value built into rate orders with a July 1, 2023 effective date. A rate enhancement under the streamlined process will only be available provided: 1) the hospital agrees to the value established by the methodology; 2) no additional methodological considerations will be considered; and 3) the hospital must refrain from requesting additional funding until January 1, 2025.*

Integrated Efficiency - 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 they judge to be unnecessary outright, or by simply continuing to pursue additional volume growth beyond population and demographic driven changes.

Despite these complexities, the HSCRC must still establish aggregate charges that are reasonably related to aggregate 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 continue to recommend arraying hospitals into quartiles and focusing on outliers in the fourth quartile based on a weighting system of:*

- 1. Hospital cost per case efficiency rank, as measured by the ICC, at 50 percent*
- 2. Medicare TCOC performance rank, as measured by the better of a benchmark attainment assessment and the performance captured through the Medicare Performance Adjustment analog method (MPA) at 25 percent, and*
- 3. Commercial TCOC performance rank, as measured by the better of a benchmark attainment assessment and the performance captured through a Commercial MPA analog, at 25 percent.⁹*

This statewide weighting approach ensures that total cost of care strongly influences the efficiency analysis and ensures that hospitals with more favorable payer mixes, i.e., more commercial purchasers, are not artificially advantaged. Focusing this policy on the worst performers, such that hospitals in the worst quartile have a portion of their Annual Update Factor withheld, ensures that hospitals are not incentivized to reclaim lost volumes at their hospitals in order to improve cost per case efficiency.

Integrated Efficiency - 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 are developed. However, concerns regarding GBR enhancement requests 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.

⁹ Medicare and Commercial performance comprise an even share of the total cost of care evaluation (25% each) as both represent approximately the same share of hospital payments statewide.

Specifically, staff proposed and continues to recommend 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. 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, 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 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 and the funding derived from withholding inflation from hospitals in the worst quartile.

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

Capital Financing Policy – Partial Rate Applications

To avoid a large growth in capital costs and to ensure that hospitals utilize retained revenues related to avoided utilization to finance smaller projects, the Commission adopted a policy that restricted rate enhancements to projects whose value exceeded a material percentage of a hospital's permanent revenue base. Specifically, the policy maintains a threshold for a project to receive capital funding at 25 percent of the hospital permanent revenue for a hospital near or above the average hospital size (about \$300 million). The policy also increases the capital threshold by 0.10 percent for every million dollars that the hospital is below \$300 million. This equates to scaling from a threshold of 25 percent for a hospital with permanent revenue of \$300 million to a threshold of 50 percent for a hospital with permanent revenue of \$50 million. For example, a hospital with permanent revenue of \$200 million would have a capital threshold of 35 percent or \$70 million dollars. The table below shows the capital threshold and the threshold amounts in increments of \$50 million.

Exhibit 5: Capital Thresholds for Potential Rate Support

Permanent Revenue	Threshold for Capital Funding	Threshold Amount
> \$300,000,000	25.0%	\$75,000,000
\$250,000,000	30.0%	\$75,000,000
\$200,000,000	35.0%	\$70,000,000
\$150,000,000	40.0%	\$60,000,000
\$100,000,000	45.0%	\$45,000,000
< \$50,000,000	50.0%	\$25,000,000

Once a hospital meets the capital threshold criteria, staff recommend continuing to use the Commission’s capital financing model, which will consider: a) a hospital’s relative capital efficiency – the portion of total costs the hospital spends on capital; b) a hospital’s cost per case efficiency and TCOC effectiveness, as measured through the Integrated Efficiency policy; and c) a hospital’s level of potentially avoidable utilization and excess capacity.

Revenue For Reform – Approval Process for Hospital Safe Harbors

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

In August of 2023, staff will release an application template for hospitals to complete. This will include a list of the hospital’s interventions, which safe harbor they are applying for, and the amount of losses that they expect to incur over the following fiscal year on that intervention. By October 2023, staff will review the submissions and determine which interventions meet the requirements of the Revenue for Reform policy, described here. Interventions that meet the criteria will then be submitted to the Secretary of Health. If the Secretary or her designee deems the interventions to be a population health programs, then the cost of the approved interventions will be used to reduce any Integrated Efficiency Adjustment based on each ICC run. This will determine which hospitals are subject to the Integrated Efficiency reduction in Rate Year 2024.

In the fall of 2024, hospitals will be required to submit a cost accounting describing the costs actually incurred on their approved population health interventions. Staff anticipate start-up delays in any new community health investment, but to ensure that safe harbors are not provided erroneously, staff will penalize hospitals that take advantage of Revenue for Reform and do not

spend at least 80 percent of the stated community investment, inclusive of a 25 percent indirect cost rate (35 percent for the regional partnership). Failure to reach 80 percent of the community investment will result in:

- Removal of 100 percent of the variance between the actual spend and the 80 percent threshold on a permanent go forward basis.
- 105 percent of the variance between the actual spend and the 80 percent threshold on a one-time basis.

In subsequent years, staff will assume safe harbors will grow by the inflation provided in the Annual Update Factor and will increase the threshold for compliance to 95 percent.

5. Efficiency Assessment

In this section, staff provides the results of the Full Rate Application and Integrated Efficiency policies using RY 2023 revenue, RY 2022 volumes for the ICC, as well as results for 2021 Medicare and Commercial Total Cost of Care performance. Staff will not provide modelling on the Capital Rate Application policy, as that requires knowledge of a proposed capital project. Staff will also provide revised results in the Stakeholders' comment section to reflect modifications staff made to the methodology because of comment letters.

For the Full Rate Application policy, staff will present models that reflect the existing methodology for scaling TCOC performance and the proposed methodology that limits rewards to hospitals that have demonstrated excellent performance in attainment and improvement. Additionally, staff will reflect both models with and without a productivity adjustments in the ICC.

For Integrated Efficiency, staff will present models that array hospitals into quartiles using a weighting system of 50% ICC, 25% Medicare TCOC, and 25% Commercial TCOC. Staff will present the Integrated Efficiency models under: a) the existing methodology that does not consider TCOC improvement; b) a proposed methodology that uses the MPA Method to blend TCOC attainment and improvement for Medicare and Commercial; and c) a model that utilizes the better of attainment and MPA attainment/improvement. ***Based on this analysis and the Commission vote on the underlying methodology, staff will ultimately recommend that the***

hospitals in the worst quartile of performance have a portion of their Medicare and Commercial RY 2024 Update Factor withheld, effective July 1, 2023.

5a. Full Rate Application Results

As noted above, staff will first provide modelling results with and without the proposed modification to TCOC scaling in the FRA. It should be noted that additional considerations are noted in the Stakeholder Comment Section that affect these results. See below:

Exhibit 6: Full Rate Application Results Under Current and Proposed TCOC Scaling Methods, inclusive of 1.53 Percent Productivity Adjustment (\$ Millions)

HOSP id	Hospital Name	RY 2023 Permanent Revenue (inclusive of CY 2022 MS & RY23 DA Reversal)	GBR \$ Change Based on Hospital Approved Revenue Before TCOC Analyses	Current Methodology			Proposed Methodology		
				TCOC Effect on Rate Applications	Full Rate Application Recommendation (\$ Change)	Full Rate Application Recommendation (% Change)	TCOC Effect on Rate Applications	Full Rate Application Recommendation (\$ Change)	Full Rate Application Recommendation (% Change)
210001	Meritus Medical Center	\$420.9	\$41.5	-\$3.4	\$38.0	9.0%	-\$3.4	\$38.0	9.0%
210002	University of Maryland Medical Center	\$1,776.6	-\$111.1	-\$4.1	-\$115.2	-6.5%	-\$4.1	-\$115.2	-6.5%
210003	Prince Georges Hospital Center	\$369.6	-\$86.2	-\$0.6	-\$86.8	-23.5%	-\$0.6	-\$86.8	-23.5%
210004	Holy Cross Hospital	\$558.0	\$16.2	\$6.6	\$22.7	4.1%	\$0.0	\$16.2	2.9%
210005	Frederick Memorial Hospital	\$397.8	-\$42.7	\$0.0	-\$42.7	-10.7%	\$0.0	-\$42.7	-10.7%
210006	Harford Memorial Hospital	\$115.0	-\$12.7	\$0.0	-\$12.7	-11.0%	\$0.0	-\$12.7	-11.0%
210008	Mercy Medical Center	\$633.8	-\$71.0	-\$6.0	-\$76.9	-12.1%	-\$6.0	-\$76.9	-12.1%
210009	Johns Hopkins Hospital	\$2,809.8	-\$204.1	-\$4.6	-\$208.7	-7.4%	-\$4.6	-\$208.7	-7.4%
210011	St. Agnes Hospital	\$474.2	-\$69.5	-\$1.8	-\$71.4	-15.1%	-\$1.8	-\$71.4	-15.1%
210012	Sinai Hospital	\$915.4	-\$199.4	-\$9.8	-\$209.2	-22.9%	-\$9.8	-\$209.2	-22.9%
210015	MedStar Franklin Square Hospital Center	\$626.7	\$3.1	\$0.0	\$3.1	0.5%	\$0.0	\$3.1	0.5%
210016	Washington Adventist Hospital	\$339.0	-\$39.1	-\$4.6	-\$43.7	-12.9%	-\$4.6	-\$43.7	-12.9%
210017	Garrett County Memorial Hospital	\$78.0	\$9.3	\$1.2	\$10.5	13.4%	\$1.0	\$10.3	13.3%
210018	MedStar Montgomery Medical Center	\$202.1	-\$24.6	\$11.3	-\$13.3	-6.6%	\$3.4	-\$21.2	-10.5%
210019	Peninsula Regional Medical Center	\$524.1	\$27.2	\$0.0	\$27.2	5.2%	\$0.0	\$27.2	5.2%
210022	Suburban Hospital	\$392.8	-\$51.3	\$49.2	-\$2.1	-0.5%	\$0.0	-\$51.3	-13.1%
210023	Anne Arundel Medical Center	\$725.9	-\$49.8	\$22.6	-\$27.2	-3.8%	\$6.1	-\$43.8	-6.0%
210024	MedStar Union Memorial Hospital	\$474.6	-\$40.5	-\$5.8	-\$46.3	-9.7%	-\$5.8	-\$46.3	-9.7%
210027	Western Maryland Regional Medical Center	\$363.8	-\$17.8	-\$0.5	-\$18.3	-5.0%	-\$0.5	-\$18.3	-5.0%
210028	MedStar St. Mary's Hospital	\$214.1	\$6.4	\$0.0	\$6.4	3.0%	\$0.0	\$6.4	3.0%
210029	Johns Hopkins Bayview Medical Center	\$761.8	-\$109.0	-\$5.6	-\$114.5	-15.0%	-\$5.6	-\$114.5	-15.0%
210030	University of Maryland Shore Medical Center at Chestertown	\$55.5	-\$19.2	\$0.0	-\$19.2	-34.6%	\$0.0	-\$19.2	-34.5%
210032	Union Hospital of Cecil County	\$192.4	-\$26.0	-\$2.9	-\$28.9	-15.0%	-\$2.9	-\$28.9	-15.0%
210033	Carroll Hospital Center	\$267.5	-\$37.5	\$0.0	-\$37.5	-14.0%	\$0.0	-\$37.5	-14.0%
210034	MedStar Harbor Hospital Center	\$203.7	\$0.0	-\$1.2	-\$1.2	-0.6%	-\$1.2	-\$1.2	-0.6%
210035	University of Maryland Charles Regional Medical Center	\$175.2	\$0.9	\$0.0	\$0.9	0.5%	\$0.0	\$0.9	0.5%
210037	University of Maryland Shore Medical Center at Easton	\$269.4	-\$54.7	-\$0.6	-\$55.3	-20.5%	-\$0.6	-\$55.3	-20.5%
210038	University of Maryland Medical Center Midtown Campus	\$257.7	-\$48.2	-\$2.9	-\$51.1	-19.8%	-\$2.9	-\$51.1	-19.8%
210039	Calvert Memorial Hospital	\$173.5	-\$19.5	\$6.9	-\$12.6	-7.3%	\$6.6	-\$12.9	-7.4%
210040	Northwest Hospital Center	\$294.5	-\$43.9	-\$3.3	-\$47.3	-16.1%	-\$3.3	-\$47.3	-16.1%
210043	University of Maryland Baltimore Washington Medical Center	\$492.4	-\$30.2	-\$4.0	-\$34.2	-6.9%	-\$4.0	-\$34.2	-6.9%
210044	Greater Baltimore Medical Center	\$472.5	-\$44.6	\$0.0	-\$44.6	-9.4%	\$0.0	-\$44.6	-9.4%
210048	Howard County General Hospital	\$343.4	-\$2.8	\$11.1	\$8.2	2.4%	\$4.7	\$1.8	0.5%
210049	Upper Chesapeake Medical Center	\$357.3	-\$21.3	-\$2.2	-\$23.5	-6.6%	-\$2.2	-\$23.5	-6.6%
210051	Doctors Community Hospital	\$282.6	-\$21.9	\$14.0	-\$8.0	-2.8%	\$1.0	-\$21.0	-7.4%
210056	MedStar Good Samaritan Hospital	\$299.8	-\$20.9	-\$3.7	-\$24.6	-8.2%	-\$3.7	-\$24.6	-8.2%
210057	Shady Grove Adventist Hospital	\$500.0	-\$64.1	\$21.8	-\$42.3	-8.5%	\$0.0	-\$64.1	-12.8%
210058	University of Maryland Rehabilitation & Orthopaedic Institute	\$134.6	-\$32.3	-\$9.8	-\$42.1	-31.3%	\$1.0	-\$31.2	-23.2%
210060	Fort Washington Medical Center	\$64.8	-\$9.4	-\$3.7	-\$13.2	-20.3%	-\$3.7	-\$13.2	-20.3%
210061	Atlantic General Hospital	\$123.3	\$1.7	\$0.0	\$1.7	1.4%	\$0.0	\$1.7	1.4%
210062	MedStar Southern Maryland Hospital Center	\$307.0	-\$39.1	\$11.8	-\$27.3	-8.9%	\$0.1	-\$39.0	-12.7%
210063	University of Maryland St. Joseph Medical Center	\$445.9	-\$26.3	\$0.0	-\$26.3	-5.9%	\$0.0	-\$26.3	-5.9%
210065	Holy Cross Germantown	\$137.5	\$6.1	\$1.4	\$7.5	5.5%	\$0.0	\$6.1	4.4%
	Total	\$19,024.4	-\$1,578.4	\$76.7	-\$1,501.7	-7.9%	-\$47.4	-\$1,625.7	-8.5%
	Total for Rate Enhancements Only	\$3,201.1	\$109.5	\$16.8	\$126.3	3.9%	\$2.3	\$111.7	3.5%

The difference between the two methods for TCOC scaling are slight, as the overall rate enhancements for hospitals that would be eligible for funding decreases from \$126.3 million under the current methodology to \$111.7 million under the proposed methodology. The lion's share of the variance is driven by Holy Cross and Howard County General hospitals, which are both less expensive than national peers in TCOC but have not fared as well on TCOC growth

since the start of the TCOC Model. Holy Cross Hospital has grown 16.07 percent since 2018 vs. a statewide average of 14.19 percent for Medicare TCOC and 25.69 percent vs 16.74 percent for Commercial, which effectively eliminates all positive TCOC rewards. Howard County General Hospital still earned positive TCOC scaling under the proposed methodology change because it is both cheaper than national benchmark geographies and it has grown less than the statewide average. In both cases, however, the delta (12.41 percent vs a statewide average of 14.19 percent for Medicare & 15.39 vs 16.74 percent for Commercial) was less significant than the current attainment-only methodology for positive TCOC scaling.

Staff have similarly modelled the current and proposed methodology without a productivity adjustment to the ICC, as the currently policy does not include one. However, given suppressed margins impedes the ICC's ability to determine demonstrable operational efficiency, particularly if the margin erosion is transient, staff strongly urges Commissioners to consider reinstating the productivity adjustment.

Exhibit 7: Full Rate Application Results Under Current and Proposed TCOC Scaling Methods, not inclusive of Productivity Adjustment (\$ Millions)

HOSP id	Hospital Name	RY 2023 Permanent Revenue (inclusive of CY 2022 MS & RY23 DA Reversal)	GBR \$ Change Based on Hospital Approved Revenue Before TCOC Analyses	Current Methodology			Proposed Methodology		
				TCOC Effect on Rate Applications	Full Rate Application Recommendation (\$ Change)	Full Rate Application Recommendation (% Change)	TCOC Effect on Rate Applications	Full Rate Application Recommendation (\$ Change)	Full Rate Application Recommendation (% Change)
210001	Meritus Medical Center	\$420.9	\$46.7	-\$3.4	\$43.2	10.3%	-\$3.4	\$43.2	10.3%
210002	University of Maryland Medical Center	\$1,776.6	-\$99.6	-\$4.1	-\$103.7	-5.8%	-\$4.1	-\$103.7	-5.8%
210003	Prince Georges Hospital Center	\$369.6	-\$83.2	-\$0.6	-\$83.7	-22.7%	-\$0.6	-\$83.7	-22.7%
210004	Holy Cross Hospital	\$558.0	\$22.6	\$6.6	\$29.1	5.2%	\$0.0	\$22.6	4.0%
210005	Frederick Memorial Hospital	\$397.8	-\$38.3	\$0.0	-\$38.3	-9.6%	\$0.0	-\$38.3	-9.6%
210006	Harford Memorial Hospital	\$115.0	-\$11.6	\$0.0	-\$11.6	-10.0%	\$0.0	-\$11.6	-10.0%
210008	Mercy Medical Center	\$633.8	-\$64.4	-\$6.0	-\$70.3	-11.1%	-\$6.0	-\$70.3	-11.1%
210009	Johns Hopkins Hospital	\$2,809.8	-\$181.8	-\$4.6	-\$186.3	-6.6%	-\$4.6	-\$186.3	-6.6%
210011	St. Agnes Hospital	\$474.2	-\$65.2	-\$1.8	-\$67.0	-14.1%	-\$1.8	-\$67.0	-14.1%
210012	Sinai Hospital	\$915.4	-\$192.3	-\$9.8	-\$202.2	-22.1%	-\$9.8	-\$202.2	-22.1%
210015	MedStar Franklin Square Hospital Center	\$626.7	\$9.7	\$0.0	\$9.7	1.5%	\$0.0	\$9.7	1.5%
210016	Washington Adventist Hospital	\$339.0	-\$35.5	-\$4.6	-\$40.1	-11.8%	-\$4.6	-\$40.1	-11.8%
210017	Garrett County Memorial Hospital	\$78.0	\$10.3	\$1.2	\$11.5	14.7%	\$1.0	\$11.4	14.6%
210018	MedStar Montgomery Medical Center	\$202.1	-\$22.4	\$11.3	-\$11.1	-5.5%	\$3.4	-\$19.0	-9.4%
210019	Peninsula Regional Medical Center	\$524.1	\$33.6	\$0.0	\$33.6	6.4%	\$0.0	\$33.6	6.4%
210022	Suburban Hospital	\$392.8	-\$46.8	\$49.2	\$2.4	0.6%	\$0.0	-\$46.8	-11.9%
210023	Anne Arundel Medical Center	\$725.9	-\$41.4	\$22.6	-\$18.8	-2.6%	\$6.1	-\$35.3	-4.9%
210024	MedStar Union Memorial Hospital	\$474.6	-\$35.6	-\$5.8	-\$41.4	-8.7%	-\$5.8	-\$41.4	-8.7%
210027	Western Maryland Regional Medical Center	\$363.8	-\$13.7	-\$0.5	-\$14.2	-3.9%	-\$0.5	-\$14.2	-3.9%
210028	MedStar St. Mary's Hospital	\$214.1	\$9.0	\$0.0	\$9.0	4.2%	\$0.0	\$9.0	4.2%
210029	Johns Hopkins Bayview Medical Center	\$761.8	-\$102.6	-\$5.6	-\$108.2	-14.2%	-\$5.6	-\$108.2	-14.2%
210030	University of Maryland Shore Medical Center at Chestertown	\$55.5	-\$18.8	\$0.0	-\$18.8	-33.9%	\$0.0	-\$18.8	-33.8%
210032	Union Hospital of Cecil County	\$192.4	-\$24.1	-\$2.9	-\$27.0	-14.0%	-\$2.9	-\$27.0	-14.0%
210033	Carroll Hospital Center	\$267.5	-\$34.6	\$0.0	-\$34.6	-12.9%	\$0.0	-\$34.6	-12.9%
210034	MedStar Harbor Hospital Center	\$203.7	\$2.1	-\$1.2	\$0.9	0.4%	-\$1.2	\$0.9	0.4%
210035	University of Maryland Charles Regional Medical Center	\$175.2	\$3.0	\$0.0	\$3.0	1.7%	\$0.0	\$3.0	1.7%
210037	University of Maryland Shore Medical Center at Easton	\$269.4	-\$52.1	-\$0.6	-\$52.7	-19.6%	-\$0.6	-\$52.7	-19.6%
210038	University of Maryland Medical Center Midtown Campus	\$257.7	-\$46.3	-\$2.9	-\$49.2	-19.1%	-\$2.9	-\$49.2	-19.1%
210039	Calvert Memorial Hospital	\$173.5	-\$17.6	\$6.9	-\$10.7	-6.2%	\$6.6	-\$11.0	-6.3%
210040	Northwest Hospital Center	\$294.5	-\$41.1	-\$3.3	-\$44.4	-15.1%	-\$3.3	-\$44.4	-15.1%
210043	University of Maryland Baltimore Washington Medical Center	\$492.4	-\$24.6	-\$4.0	-\$28.6	-5.8%	-\$4.0	-\$28.6	-5.8%
210044	Greater Baltimore Medical Center	\$472.5	-\$39.1	\$0.0	-\$39.1	-8.3%	\$0.0	-\$39.1	-8.3%
210048	Howard County General Hospital	\$343.4	\$1.5	\$11.1	\$12.6	3.7%	\$4.7	\$6.2	1.8%
210049	Upper Chesapeake Medical Center	\$357.3	-\$17.0	-\$2.2	-\$19.2	-5.4%	-\$2.2	-\$19.2	-5.4%
210051	Doctors Community Hospital	\$282.6	-\$19.0	\$14.0	-\$5.1	-1.8%	\$1.0	-\$18.1	-6.4%
210056	MedStar Good Samaritan Hospital	\$299.8	-\$17.8	-\$3.7	-\$21.5	-7.2%	-\$3.7	-\$21.5	-7.2%
210057	Shady Grove Adventist Hospital	\$500.0	-\$58.7	\$21.8	-\$36.9	-7.4%	\$0.0	-\$58.7	-11.7%
210058	University of Maryland Rehabilitation & Orthopaedic Institute	\$134.6	-\$31.3	-\$9.8	-\$41.1	-30.6%	\$1.0	-\$30.3	-22.5%
210060	Fort Washington Medical Center	\$64.8	-\$8.7	-\$3.7	-\$12.5	-19.3%	-\$3.7	-\$12.5	-19.3%
210061	Atlantic General Hospital	\$123.3	\$3.3	\$0.0	\$3.3	2.7%	\$0.0	\$3.3	2.7%
210062	MedStar Southern Maryland Hospital Center	\$307.0	-\$35.9	\$11.8	-\$24.1	-7.9%	\$0.1	-\$35.8	-11.7%
210063	University of Maryland St. Joseph Medical Center	\$445.9	-\$20.8	\$0.0	-\$20.8	-4.7%	\$0.0	-\$20.8	-4.7%
210065	Holy Cross Germantown	\$137.5	\$7.9	\$1.4	\$9.3	6.8%	\$0.0	\$7.9	5.7%
Total		\$19,024.4	-\$1,392.3	\$76.7	-\$1,315.6	-6.9%	-\$47.4	-\$1,439.7	-7.6%
Total for Rate Enhancements Only		\$3,797.5	\$102.9	\$64.8	\$167.7	4.4%	\$1.1	\$150.8	4.0%

As expected, the same hospitals that were eligible for a rate enhancement under the modelling with a productivity adjustment qualify for a rate enhancement when there is not a productivity adjustment but to a larger degree. The rate enhancements for these ten hospitals increases from \$111.7 million (with a productivity adjustment and the newly proposed TCOC scaling approach) to \$150.8 million. Additionally, two hospitals that were not eligible with a productivity

adjustment qualify when it is suspended, Medstar Harbor and Suburban, albeit the latter still does not qualify under the new TCOC scaling approach.

5b. Integrated Efficiency Results

For Integrated Efficiency, staff will provide results that incorporate three TCOC modelling approaches with the ICC at 50% of the evaluation: 1) TCOC under the current TCOC benchmarking approach; 2) TCOC under the MPA analog methods; and 3) TCOC assessed by the better of option 1 and 2.¹⁰ Staff will not provide modelling with and without a productivity adjustment in the ICC, as Integrated Efficiency is a relative ranking policy and thus a straight percentage reduction to ICC Approved Revenue across all hospitals will have no impact on rankings.

Exhibit 8: Integrated Efficiency Modelling Under 3 TCOC Evaluations

Hospital	Hospital Name	Model 1: Current Methodology		Model 2: Methodology + MPA + Commercial Option 1 (MPA Analog)		Model 3: Better of Model 1 & 2 TCOC (Better of Benchmarks and MPA Approach)	
		Reduction \$	Reduction %	Reduction \$	Reduction %	Reduction \$	Reduction %
210048	Howard County General Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210065	Holy Cross Germantown	\$0	0.0%	\$0	0.0%	\$0	0.0%
210004	Holy Cross Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210062	MedStar Southern Maryland Hospital Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210051	Doctors Community Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210043	University of Maryland Baltimore Washington Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210017	Garrett County Memorial Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210035	University of Maryland Charles Regional Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210028	MedStar St. Mary's Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210019	Peninsula Regional Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210001	Meritus Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210015	MedStar Franklin Square Hospital Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210049	Upper Chesapeake Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210023	Anne Arundel Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210034	MedStar Harbor Hospital Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210027	Western Maryland Regional Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210039	Calvert Memorial Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210061	Atlantic General Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210009	Johns Hopkins Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210011	St. Agnes Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210056	MedStar Good Samaritan Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210006	Harford Memorial Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210044	Greater Baltimore Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210018	MedStar Montgomery Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210002	University of Maryland Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210033	Carroll Hospital Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210063	University of Maryland St. Joseph Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%
210005	Frederick Memorial Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210060	Fort Washington Medical Center	\$0	0.0%	\$505,716	0.8%	\$0	0.0%
210022	Suburban Hospital	\$0	0.0%	\$4,378,518	1.1%	\$0	0.0%
210016	Washington Adventist Hospital	\$0	0.0%	\$5,101,506	1.5%	\$2,180,607	0.6%
210057	Shady Grove Adventist Hospital	\$0	0.0%	\$5,295,541	1.1%	\$0	0.0%
210024	MedStar Union Memorial Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%
210003	Prince Georges Hospital Center	\$0	0.0%	\$0	0.0%	\$2,377,394	0.6%
210030	University of Maryland Shore Medical Center at Chestertown	\$644,793	1.2%	\$402,182	0.7%	\$669,458	1.2%
210058	University of Maryland Rehabilitation & Orthopaedic Institute	\$1,505,424	1.1%	\$2,400,257	1.8%	\$2,272,374	1.7%
210032	Union Hospital of Cecil County	\$2,649,272	1.4%	\$0	0.0%	\$850,970	0.4%
210008	Mercy Medical Center	\$2,999,744	0.5%	\$0	0.0%	\$2,548,218	0.4%
210038	University of Maryland Medical Center Midtown Campus	\$3,104,801	1.2%	\$3,016,596	1.2%	\$3,522,894	1.4%
210037	University of Maryland Shore Medical Center at Easton	\$3,129,138	1.2%	\$0	0.0%	\$1,841,004	0.7%
210040	Northwest Hospital Center	\$4,434,958	1.5%	\$2,133,964	0.7%	\$3,552,121	1.2%
210029	Johns Hopkins Bayview Medical Center	\$8,521,562	1.1%	\$2,122,942	0.3%	\$6,737,729	0.9%
210012	Sinai Hospital	\$22,449,385	2.5%	\$22,449,385	2.5%	\$22,449,385	2.5%
	Subtotal	\$49,439,076		\$47,806,606		\$49,002,155	

¹⁰ For results inclusive of each efficiency evaluation score, please see Appendices A through C.

While the results are fairly similar across the 3 models for various hospitals, there are some notable changes in the inflation values that will be potentially withheld. For example, Union of Cecil Hospital will incur a 1.4 percent reduction (\$2.6 million) under the current methodology that incorporates TCOC benchmarks as the only TCOC evaluation. This is driven by Cecil's Commercial TCOC attainment performance, which is the 5th worst in the State. However, under the MPA Analog Methods, Cecil does not incur a reduction because it is growing significantly slower than the Statewide average in commercial TCOC (5.2 percent from 2018-2021 versus 16.74 percent statewide; the second best in the State), and under the better of attainment and improvement, Cecil effectively reduces its inflation by two thirds. This type of improvement is exactly why staff are proposing to amend the TCOC evaluation to account for improvement over time, thus further incentivizing hospitals to reduce TCOC.

Similarly, Tidal Health Peninsula Regional Medical Center has higher Medicare TCOC relative to national benchmark peers and slightly higher than state peers (12.53 percent higher than the Medicare benchmark versus the statewide average of 9.9 percent); however, its performance in Medicare improvement since 2018 is the third best in the State, thus supporting its case to acquire increased rate enhancements through the Commission's efficiency policies.

6. Stakeholder Comments

Staff received 10 comment letters containing a broad array of topics that covered the following thematic areas: 1) Philosophical Concerns; 2) Responses to Staff Recommendations; and 3) Technical Considerations.

The commenters were as follows:

Exhibit 9: List of Stakeholders that Submitted Comment Letters



**List of
Stakeholders**

Adventist Healthcare
Maryland Hospital Association
CareFirst
Mercy Medical Center
Holy Cross Health
MedStar Health
Johns Hopkins Health System
University of Maryland Medical
System
Lifebridge Health
Tidal Health

Staff will respond to each comment area raised, often by multiple stakeholders, starting more broadly and working to greater specificity.

6a. Philosophical Concerns - Defining Efficiency in Model

Both CareFirst and MHA expressed concern about the underlying efficiency evaluation for different reasons:

- CareFirst postulated that “greater clarity regarding the individual cost categories making up a hospital’s structure could create an opportunity to base the efficiency policy on the relative percentages those cost categories make up of each hospital’s budget,” which admittedly would require “...more concrete guidance in an enhanced annual filing.” This concern stems from the fact that under the current ICC, “...a hospital with 15% overhead and a hospital with 30% overhead could score similarly in the cost per case calculation.”
- MHA noted in a long-term workgroup, stakeholders should “determine if using equivalent case mix adjusted discharges to calculate permanent revenue in the Inter-hospital Cost Comparison is appropriate in a population-based payment system.”

Staff Response:

Staff appreciates stakeholders’ concern that the ICC does not identify individual excess cost categories, as is done with a Medical Loss Ratio (MLR) approach, but would note that MLR works more readily in the insurance market because non-overhead expenses, i.e., medical

claims, are deemed reasonable. Given State law requires that the Commission ensure that all costs are reasonable, this method may not work as well for hospital efficiency analyses.

Staff is particularly concerned about the ICC in a population-based system, but until the field and Commissioners generally agree to pursue changes to Maryland statute, staff cannot advance a policy that fails to assess that:

*“(1) The total costs of all hospital services offered by or through a facility are reasonable;
(2) The aggregate rates of the facility are related reasonably to the aggregate costs of the facility;”*

6b. Philosophical Concerns - Overlapping TCOC Risk

Several commenters expressed concern about the overlapping TCOC risk in the Efficiency policies:

- MHA noted in a long-term workgroup, stakeholders should “Address overlap of TCOC risk among HSCRC payment policies.”
- Adventist is “concerned that the proposed ICC policy cannot be properly evaluated without consideration of the to-be-determined deregulation adjustments and the CTI payment policy as all three policies have a significant impact on hospitals in RY24.”
- CareFirst, Johns Hopkins, and Mercy Hospital noted that it understood/appreciated why Staff is balancing the cost per case metric with TCOC performance metrics.

Staff Response:

Staff sympathize with Adventist’s concern about additional revenue adjustments from non-efficiency policies, especially ones that evaluate TCOC, but Commissioners have made clear their desire for such a policy and it is required that Staff have a Full Rate Application approach in place when the Full Rate Application moratorium expires on June 30th.

Moreover, controlling TCOC is essential for the waiver to succeed and per unit efficiency, in the absence of per capita efficiency, is of little value to healthcare payers. Thus, TCOC evaluation in the Commission’s efficiency policies is essential.

Staff appreciates CareFirst's, Johns Hopkins', and Mercy's recognition that the Commission has to balance both evaluations of efficiency in its Full Rate and Integrated Efficiency policies

6c. Philosophical Concerns - Addressing Outliers

Two commenters opined on efficiency “outliers” and how to address them:

- Lifebridge noted that “given the design of the Interhospital Cost Comparison (ICC) there was the likelihood of a hospital becoming "stuck"... [and] the latest ICC modeling continues to suggest that even with the \$13.2 million of already removed permanent revenue and the potential of another \$22.5 million for fiscal year 24, a substantial revenue reduction would still be required for Sinai to not be deemed as a 4th quartile inefficient performer.”
- Johns Hopkins noted that “historically, HSCRC efficiency policies have been used to identify outliers in the system and provide a way for those outliers to be brought back towards the statewide average via rate actions. JHHS believes that the current proposal of utilizing the quartile ranking continues to support this concept, which we believe is appropriate.”

Staff Response:

Staff appreciate Johns Hopkins comment that HSCRC efficiency policies have historically been used to bring “outliers” in line with the statewide average, and would note that an expansion of the current quartile ranking approach, e.g., the bottom half, would expand the definition of outliers from typical historical practice.

Staff recognizes Lifebridge’s concern about the potential magnitude of the policy if it is utilized in subsequent years, but staff note that multiple policy elements have been introduced to mitigate this concern including revisions to TCOC scoring and the opportunity for Revenue for Reform buy outs. Stakeholders are welcome to suggest additional enhancements for future policy updates.

6d. Philosophical Concerns - Disproportionate Impact

University of Maryland Medical System has expressed concern about the disproportionate negative impact the current policy results have on rural and safety net hospitals. To that end, UMMS is requesting that the Commission complete another evaluation of the disproportionate share hospital (DSH) adjustment as well as other components of the methodology such as the resident cap.

MHA and Lifebridge have similarly expressed a desire to explore alternatives to the DSH adjustment and to re-evaluate the peer group comparisons, which previously were used to address higher costs related to socioeconomic disadvantaged patients

Staff Response:

Promoting health equity for all Marylanders, especially in underserved communities, is a core aim of the Model; as such, staff continually evaluates policy tools to ensure that appropriate accommodations are made to support health equity. Staff have evaluated the Efficiency policies and conclude the following:

Staff have repeatedly shown there is no statistically significant relationship between measures of socioeconomic disadvantage (poor share, ADI, dual eligibles, etc.,) and ICC performance (see appendix F).

Of the 43 hospitals evaluated, only 3 are rural and are negatively affected by the proposed Integrated Efficiency policy while 4 rural hospitals are eligible for rate enhancements under the Full Rate Application policy.

Additionally, the inclusion of the Revenue for Reform buy out would enable safety net hospitals to retain revenue to be redeployed for community and social needs that better serve a vulnerable population.

Of the remaining 6-8 hospitals that may incur a penalty under the Integrated Efficiency policy, only one hospital would be considered a safety net hospital.

6e. Responses to Staff Recommendations - Application of TCOC

All letters (CareFirst, JHHS, MHA, Mercy, and UMMS) that addressed staff's recommendation to incorporate TCOC attainment and improvement in the Full Rate Application and Integrated Efficiency policy supported the proposal.

JHHS, while supportive of the staff's proposal, raised one concern: "We do have concerns in the Full Rate Application Methodology, that hospitals that have some of the lowest TCOC in the state still must reduce their TCOC faster than the statewide average improvement. We believe that staff should consider a modification to that methodology to allow for some lower threshold for hospitals with the lowest TCOC in the state."

Staff Response:

Staff appreciate all stakeholders that opined on the proposed modification and characterized it as an improvement to the efficiency methodologies. While staff are sympathetic to JHHS' concern that low TCOC hospitals are not necessarily rewarded in the Full Rate Application policy, staff would note that the point of scaling a hospital's ICC evaluation by its performance in TCOC is to recognize actions taken during the course of the Model to affect TCOC. While staff recognized this for downside risk when first promulgating the policy in 2021, staff failed to recognize this for upside risk, thereby creating an asymmetrical policy. Staff is correcting this error with broad support of stakeholders in this policy recommendation.

6f. Responses to Staff Recommendations - Revenue for Reform

All letters (CareFirst, JHHS, MHA, and UMMS) that addressed staff's recommendation to incorporate a population health buyout provision for the Integrated Efficiency policy expressed support for the proposal.

- Ex: UMMS wrote: "By providing these facilities with an opportunity to retain revenue, the offset option allows hospitals to keep revenue where it is needed most and re-invest in activities that would directly benefit the health of the population."

Stakeholders did bring up some additional considerations:

- MHA “suggest modifying the full rate application to include population health investments as phase II adjustments.” If the Commission does not advance this proposal, “such investments would not be recognized for efficient hospitals, creating inequities across policies.”
- CareFirst noted that “We view the qualifying population health investment buyout from inflationary reductions as an introduction to more significant policy enhancement in this space.”
- JHHS “believe[s] that there should be some limit to how much of the dollars identified through the Efficiency Policy can be offset”, and “...the policy as drafted does not address retained revenue that has accumulated since the inception of GBR. The Regional Entity Safe Harbor should be explored as an opportunity to redirect retained revenue that should but have not been invested in population health programs”

Staff Response:

Staff appreciate all stakeholders support of the proposed Revenue for Reform policy.

Staff disagree with MHA’s assertion that population investments should be considered in Phase II negotiations with staff during full rate applications. This proposal overlooks that a) the Full Rate Application is to reset hospital rates for current acute care services - it is not a process for simply seeking additional seed funding - and b) staff has already allowed low cost hospitals to access additional funding for population health investments through the Integrated Efficiency policy.

Staff understand CareFirst and JHHS’ concern that additional retained revenue should be dedicated to population health investments, but would note that more work needs to be done to define and quantify all retained revenue, and all necessary hospital investments, e.g., physician subsidies, should be ascertained before requiring larger investments from retained revenue.

6g. Responses to Staff Recommendations - Productivity Adjustment

All hospital stakeholders that addressed the policy decision of a productivity adjustment disagreed with staff's recommendation. CareFirst supported it.

- CareFirst noted that “Over the last four years, roughly a quarter of hospitals would have qualified under these criteria each year. Thus, the 8% baseline does not require an unreasonable level of performance; it is attainable.”
- All hospital stakeholders echoed Holy Cross' assertion that productivity adjustment was suspended in January of 2021 “until the staff could develop an “allowed unregulated subsidy” to account for population health investments including physician costs.”
- Holy Cross, MHA, and Tidal Health also asserted that the reduced margins in RY 2022 are not due to operational inefficiencies, but rather underfunding of inflation.

Staff Response:

Staff appreciate CareFirst's support and insightful observation that over the last four years more than 25% of the hospitals have had operational efficiency that exceeds the standard staff has put forth. This standard is not “simply a tool to make qualification for rate relief more difficult,” as suggested by Holy Cross and Tidal Health, but rather a safeguard against providing rate enhancements for average cost performance, as was the previous justification for the 2% productivity adjustment.

Staff do not agree with the assertion that margin erosions in RY 2022 are due to underfunding of inflation. Cumulative inflation was underfunded by only approximately 1%, and there has been significant increases in length of stay and use of agency nurses, which are potentially indicative of operational inefficiency.

It is also important to note that all hospitals have measures of retained revenue that have likely not been converted into retained earnings, i.e., they are additional operational efficiencies that hospitals could achieve under this system by eliminating fixed costs. Finally, the Commission just made a determination about appropriate funding of inflation in the

Update Factor; it is not the function of the Full Rate Application to undo this judgement on a broad basis.

Staff does, however, concur that the productivity adjustment was suspended, not terminated, so that staff could develop a potential allowed unregulated subsidy for necessary physician subsidies and population health investments. But, the original genesis for the suspension was Commissioners' concerns that requiring hospitals to achieve more than 10% operational efficiency was too stringent a standard, a situation that is addressed by Staff's proposal.

Additionally, the work to quantify potential unregulated subsidies has been delayed because hospitals repeatedly expressed not having capacity during the pandemic to develop additional policies and reporting structures.

The final recommendation in January of 2021 required the Commission to temporarily suspend the productivity adjustment and that "staff will report back to the Commission with a proposed substitute for that temporary removal no later than July of 2023." Staff believe it has complied with its mandate and that the Commission should adopt its proposed, empirically-based substitute for a productivity adjustment.

6h. Responses to Staff Recommendations - One-time adjustment

Holy Cross, MHA, and Tidal Health disagreed with staff's recommendation to implement all efficiency adjustments in RY 2024 on a one-time basis; JHHS, MedStar, and UMMS supported it but the latter two did note that there should be a pathway to permanent rate increases, i.e., filing a full rate application.

Holy Cross and Tidal Health likened this proposal to an extension of the full rate moratorium and have notes that staff's concerns over case weights, deregulation adjustments, and the demographic adjustment "are based on policy decisions and have not been equitably applied across policies." For example, the Commission has implemented marketshift, the demographic adjustment, the MPA and CTIs.

MHA noted that under this proposal "Hospitals eligible for permanent rate relief may be reluctant to make permanent decisions, like raising nursing wages, if ongoing dollars are not

guaranteed.” Additionally, “If HSCRC wants to delay permanent rate adjustments because volumes are not stable, then it must follow its rule making process and propose to extend the moratorium via regulation, which MHA does not support.”

Staff Response:

Staff appreciates UMMS’, JHHS’, and MedStar’s recognition that the data volatility in this period is potentially problematic.

Staff notes that the MPA and CTI’s are one-time adjustments, and that the marketshift adjustment is less confounded by the data issues Staff raised so the data considerations are less impactful

Staff are sympathetic to MHA’s position that hospitals cannot make permanent investment decisions based on one-time revenue and also agree that the Commission would need to extend the moratorium period to prevent hospitals from filing a full rate application to access permanent changes to rate structures, which they are likely to do because of the role this policy plays in investment decisions. For those reasons, staff has revised the policy recommendation to:

Implement all efficiency adjustments in RY 2024 on a permanent basis in July 2023 rate orders, contingent on hospitals, which are receiving rate enhancements, agreeing not to a file a full rate application until January 2025. However, Staff reserves the right to re-evaluate revenue in RY 2025, subject to approval by Commissioners, for hospitals receiving a permanent adjustment, if efficiency evaluations change materially over the next year due to movements in the data as results stabilize post-pandemic.

6i. Technical Considerations - Aligning Revenue and Volume

Adventist expressed concern about the mismatch between revenue and volume in the ICC.

- “While in most years, the six months difference between the calendar year-based market shift revenue adjustment and the fiscal year-based volumes used in the ICC are immaterial, many hospitals, experienced significant volume fluctuation in volume during the July-December 2022 time period, driving large market shift adjustments.”

- “Adventist believes that the Staff should bring the underlying ICC volumes forward to CY 2022 to match the revenue adjustments reflected in the CY 2022 market shift adjustment in the draft policy.”

Staff Response:

Staff agrees with Adventist’s concern but would note that arguably the most important statistic in the ICC is regulated profit margin, which cannot be ascertained from CY 2022 for the vast majority of hospitals and allows the Commission to develop a cost per case standard.

However, Staff propose to amend the process:

Utilize the RY 2022 volumes and the marketshift adjustment attributable to the first six months of CY 2022, thereby matching the volume and revenue.

6j. Technical Considerations - Data Concerns with Efficiency Evaluation

Holy Cross and Tidal Health expressed that the potential data issues in efficiency policies were due to Commission policy decisions. Staff believes most of these contentions are inaccurate; however, Staff agree with one data concern raised in the Tidal Health letter.

Inaccurate - “When the Commission updated case weights in March 2023 to reflect the impact of an updated APR-DRG grouper version, it elected to use a pre-COVID volume period (CY2019) in lieu of a more current time period (CY2022). “

Staff Response:

This assertion suggests a lack of understanding of HSCRC data delays and the weight development process. Normally, CY data is not available to the Commission until 4 months after the year end, i.e. April. This year, due to data delays from Holy Cross, the data was not available until May. Typically, the weight development takes three to six months to program and validate, thus making use of CY 2022 data for efficiency adjustments in RY 2024 a virtual impossibility.

Inaccurate - “Hospitals are required to notify the HSCRC of changes in service offerings or when services are shifted to or from a hospital-based setting. The policy statement by the staff assumes

that hospitals have not been compliant with HSCRC requirements or that staff have not made adjustments for disclosed shifts of services. The breadth of this issue has not been quantified, yet the staff recommendation seeks to further delay rate relief for low-cost hospitals based on an unknown potential impact.”

Staff Response:

Again, this assertion suggests a lack of understanding of what constitutes a deregulation adjustment and the evidentiary burden to implement a deregulation adjustment. Deregulation can occur if a hospital actively engages in moving services to an unregulated setting, but it can also occur if contractual providers elect to no longer refer patients to a hospital, the latter of which does often occur and is more difficult for the hospital to recognize in real time. Additionally, the HSCRC could not base its deregulation adjustments on CY 2021 data due to the significant declines experienced across all sites of service in that calendar year. Finally, the Commission only has access to Medicare TCOC claims data in real time, thus extrapolation, which is prone to protest, is required to adjudicate deregulation adjustments with hospitals.

Accurate – “The Staff was also concerned about the impact of the Demographic Adjustment catch-up; however the Commission voted to restore the demographic adjustment and therefore these amounts can be reflected in the updated ICC calculation.”

Staff Response:

Staff agrees that since the Commission has elected to approve the full catch-up for 2010-2020 census, staff can update the ICC, thus ensuring that hospitals are not paid for population growth twice, once through the Demographic Adjustment, and once through an efficiency evaluation that had not yet scored funding for population growth.

As such, staff have incorporated the following changes to the ICC

- *Changing the permanent revenue assessed in the ICC to account for the Demographic Adjustment catch-up.*

- *Restating the profit margin statistic under a pro forma assumption that all demographic adjustment funding, should it have been provided in prior years, would have altered profitability.*
- *Revising the productivity adjustment from 1.53 percent to .34 percent given the pro forma profit statistic is now 7.66 percent versus 6.46 percent.*

Due to this rather substantive change and the change staff made to better line up revenue and volume in the ICC, per Adventist's request, staff have remodeled the efficiency policies with these technical adjustments. See below for revised results:

Exhibit 10: Full Rate Application Results Under Current and Proposed TCOC Scaling Methods, inclusive of .34 Percent Productivity Adjustment (\$ Millions)

HOSP id	Hospital Name	RY 2023 Permanent Revenue (inclusive of CY 2022 MS & RY23 DA Reversal)	GBR \$ Change Based on Hospital Approved Revenue Before TCOC Analyses	Current Methodology			Proposed Methodology		
				TCOC Effect on Rate Applications	Full Rate Application Recommendation (\$ Change)	Full Rate Application Recommendation (% Change)	TCOC Effect on Rate Applications	Full Rate Application Recommendation (\$ Change)	Full Rate Application Recommendation (% Change)
210001	Meritus Medical Center	\$420.9	\$39.2	-\$3.4	\$35.7	8.5%	-\$3.4	\$35.7	8.5%
210002	University of Maryland Medical Center	\$1,776.6	-\$133.3	-\$4.1	-\$137.4	-7.7%	-\$4.1	-\$137.4	-7.7%
210003	Prince Georges Hospital Center	\$369.6	-\$84.1	-\$0.6	-\$84.7	-22.9%	-\$0.6	-\$84.7	-22.9%
210004	Holy Cross Hospital	\$558.0	\$3.9	\$6.6	\$10.5	1.9%	\$0.0	\$3.9	0.7%
210005	Frederick Memorial Hospital	\$397.8	-\$54.8	\$0.0	-\$54.8	-13.8%	\$0.0	-\$54.8	-13.8%
210006	Harford Memorial Hospital	\$115.0	-\$15.7	\$0.0	-\$15.7	-13.7%	\$0.0	-\$15.7	-13.7%
210008	Mercy Medical Center	\$633.8	-\$69.4	-\$6.0	-\$75.4	-11.9%	-\$6.0	-\$75.4	-11.9%
210009	Johns Hopkins Hospital	\$2,809.8	-\$216.0	-\$4.6	-\$220.6	-7.9%	-\$4.6	-\$220.6	-7.9%
210011	St. Agnes Hospital	\$474.2	-\$67.1	-\$1.8	-\$68.9	-14.5%	-\$1.8	-\$68.9	-14.5%
210012	Sinai Hospital	\$915.4	-\$188.3	-\$9.8	-\$198.2	-21.6%	-\$9.8	-\$198.2	-21.6%
210015	MedStar Franklin Square Hospital Center	\$626.7	\$2.5	\$0.0	\$2.5	0.4%	\$0.0	\$2.5	0.4%
210016	Washington Adventist Hospital	\$339.0	-\$38.6	-\$4.6	-\$43.2	-12.7%	-\$4.6	-\$43.2	-12.7%
210017	Garrett County Memorial Hospital	\$78.0	\$9.6	\$1.2	\$10.8	13.8%	\$1.0	\$10.6	13.6%
210018	MedStar Montgomery Medical Center	\$202.1	-\$22.0	\$11.3	-\$10.7	-5.3%	\$3.4	-\$18.6	-9.2%
210019	Peninsula Regional Medical Center	\$524.1	\$28.9	\$0.0	\$28.9	5.5%	\$0.0	\$28.9	5.5%
210022	Suburban Hospital	\$392.8	-\$54.5	\$49.2	-\$5.3	-1.4%	\$0.0	-\$54.5	-13.9%
210023	Anne Arundel Medical Center	\$725.9	-\$53.7	\$22.6	-\$31.1	-4.3%	\$6.1	-\$47.6	-6.6%
210024	MedStar Union Memorial Hospital	\$474.6	-\$41.1	-\$5.8	-\$46.9	-9.9%	-\$5.8	-\$46.9	-9.9%
210027	Western Maryland Regional Medical Center	\$363.8	-\$14.1	-\$0.5	-\$14.6	-4.0%	-\$0.5	-\$14.6	-4.0%
210028	MedStar St. Mary's Hospital	\$214.1	\$6.3	\$0.0	\$6.3	2.9%	\$0.0	\$6.3	2.9%
210029	Johns Hopkins Bayview Medical Center	\$761.8	-\$119.0	-\$5.6	-\$124.6	-16.4%	-\$5.6	-\$124.6	-16.4%
210030	University of Maryland Shore Medical Center at Chestertown	\$55.5	-\$20.8	\$0.0	-\$20.8	-37.4%	\$0.0	-\$20.7	-37.4%
210032	Union Hospital of Cecil County	\$192.4	-\$25.8	-\$2.9	-\$28.7	-14.9%	-\$2.9	-\$28.7	-14.9%
210033	Carroll Hospital Center	\$267.5	-\$39.1	\$0.0	-\$39.1	-14.6%	\$0.0	-\$39.1	-14.6%
210034	MedStar Harbor Hospital Center	\$203.7	-\$0.9	-\$1.2	-\$2.1	-1.0%	-\$1.2	-\$2.1	-1.0%
210035	University of Maryland Charles Regional Medical Center	\$175.2	-\$0.7	\$0.0	-\$0.7	-0.4%	\$0.0	-\$0.7	-0.4%
210037	University of Maryland Shore Medical Center at Easton	\$269.4	-\$49.2	-\$0.6	-\$49.8	-18.5%	-\$0.6	-\$49.8	-18.5%
210038	University of Maryland Medical Center Midtown Campus	\$257.7	-\$45.1	-\$2.9	-\$48.0	-18.6%	-\$2.9	-\$48.0	-18.6%
210039	Calvert Memorial Hospital	\$173.5	-\$19.9	\$6.9	-\$13.0	-7.5%	\$6.6	-\$13.3	-7.7%
210040	Northwest Hospital Center	\$294.5	-\$43.3	-\$3.3	-\$46.6	-15.8%	-\$3.3	-\$46.6	-15.8%
210043	University of Maryland Baltimore Washington Medical Center	\$492.4	-\$36.9	-\$4.0	-\$40.9	-8.3%	-\$4.0	-\$40.9	-8.3%
210044	Greater Baltimore Medical Center	\$472.5	-\$50.3	\$0.0	-\$50.3	-10.7%	\$0.0	-\$50.3	-10.7%
210048	Howard County General Hospital	\$343.4	-\$6.3	\$11.1	\$4.8	1.4%	\$4.7	-\$1.6	-0.5%
210049	Upper Chesapeake Medical Center	\$357.3	-\$22.7	-\$2.2	-\$25.0	-7.0%	-\$2.2	-\$25.0	-7.0%
210051	Doctors Community Hospital	\$282.6	-\$35.2	\$14.0	-\$21.3	-7.5%	\$1.0	-\$34.3	-12.1%
210056	MedStar Good Samaritan Hospital	\$299.8	-\$19.8	-\$3.7	-\$23.5	-7.8%	-\$3.7	-\$23.5	-7.8%
210057	Shady Grove Adventist Hospital	\$500.0	-\$65.5	\$21.8	-\$43.7	-8.7%	\$0.0	-\$65.5	-13.1%
210058	University of Maryland Rehabilitation & Orthopaedic Institute	\$134.6	-\$33.4	-\$9.8	-\$43.2	-32.1%	\$1.0	-\$32.4	-24.0%
210060	Fort Washington Medical Center	\$64.8	-\$9.6	-\$3.7	-\$13.4	-20.7%	-\$3.7	-\$13.4	-20.7%
210061	Atlantic General Hospital	\$123.3	\$2.2	\$0.0	\$2.2	1.8%	\$0.0	\$2.2	1.8%
210062	MedStar Southern Maryland Hospital Center	\$307.0	-\$39.6	\$11.8	-\$27.8	-9.1%	\$0.1	-\$39.5	-12.9%
210063	University of Maryland St. Joseph Medical Center	\$445.9	-\$23.3	\$0.0	-\$23.3	-5.2%	\$0.0	-\$23.3	-5.2%
210065	Holy Cross Germantown	\$137.5	\$7.6	\$1.4	\$9.1	6.6%	\$0.0	\$7.6	5.5%
	Total	\$19,024.4	-\$1,659.2	\$76.7	-\$1,582.5	-8.3%	-\$47.4	-\$1,706.6	-9.0%
	Total for Rate Enhancements Only	\$3,025.9	\$93.8	\$16.8	\$110.6	3.7%	-\$2.4	\$97.7	3.2%

Because the Commission has not yet approved Staff's proposed approach to reinstating a productivity adjustment, staff have modelled the full rate application methodology without a .34 percent productivity adjustment as well:

Exhibit 11: Full Rate Application Results Under Current and Proposed TCOC Scaling Methods, not inclusive of Productivity Adjustment (\$ Millions)

HOSP ID	Hospital Name	RY 2023 Permanent Revenue (inclusive of CY 2022 MS & RY23 DA Reversal)	GBR \$ Change Based on Hospital Approved Revenue Before TCOC Analyses	Current Methodology			Proposed Methodology		
				TCOC Effect on Rate Applications	Full Rate Application Recommendation (\$ Change)	Full Rate Application Recommendation (% Change)	TCOC Effect on Rate Applications	Full Rate Application Recommendation (\$ Change)	Full Rate Application Recommendation (% Change)
210001	Meritus Medical Center	\$420.9	\$40.3	-\$3.4	\$36.9	8.8%	-\$3.4	\$36.9	8.8%
210002	University of Maryland Medical Center	\$1,776.6	-\$130.8	-\$4.1	-\$134.9	-7.6%	-\$4.1	-\$134.9	-7.6%
210003	Prince Georges Hospital Center	\$369.6	-\$83.5	-\$0.6	-\$84.0	-22.7%	-\$0.6	-\$84.0	-22.7%
210004	Holy Cross Hospital	\$558.0	\$5.3	\$6.6	\$11.9	2.1%	\$0.0	\$5.3	1.0%
210005	Frederick Memorial Hospital	\$397.8	-\$53.8	\$0.0	-\$53.8	-13.5%	\$0.0	-\$53.8	-13.5%
210006	Harford Memorial Hospital	\$115.0	-\$15.5	\$0.0	-\$15.5	-13.4%	\$0.0	-\$15.5	-13.4%
210008	Mercy Medical Center	\$633.8	-\$68.0	-\$6.0	-\$73.9	-11.7%	-\$6.0	-\$73.9	-11.7%
210009	Johns Hopkins Hospital	\$2,809.8	-\$211.1	-\$4.6	-\$215.6	-7.7%	-\$4.6	-\$215.6	-7.7%
210011	St. Agnes Hospital	\$474.2	-\$66.1	-\$1.8	-\$68.0	-14.3%	-\$1.8	-\$68.0	-14.3%
210012	Sinal Hospital	\$915.4	-\$186.8	-\$9.8	-\$196.6	-21.5%	-\$9.8	-\$196.6	-21.5%
210015	MedStar Franklin Square Hospital Center	\$626.7	\$4.0	\$0.0	\$4.0	0.6%	\$0.0	\$4.0	0.6%
210016	Washington Adventist Hospital	\$339.0	-\$37.8	-\$4.6	-\$42.4	-12.5%	-\$4.6	-\$42.4	-12.5%
210017	Garrett County Memorial Hospital	\$78.0	\$9.8	\$1.2	\$11.0	14.1%	\$1.0	\$10.8	13.9%
210018	MedStar Montgomery Medical Center	\$202.1	-\$21.5	\$11.3	-\$10.2	-5.0%	\$3.4	-\$18.1	-9.0%
210019	Peninsula Regional Medical Center	\$524.1	\$30.3	\$0.0	\$30.3	5.8%	\$0.0	\$30.3	5.8%
210022	Suburban Hospital	\$392.8	-\$53.5	\$49.2	-\$4.3	-1.1%	\$0.0	-\$53.5	-13.6%
210023	Anne Arundel Medical Center	\$725.9	-\$51.8	\$22.6	-\$29.2	-4.0%	\$6.1	-\$45.7	-6.3%
210024	MedStar Union Memorial Hospital	\$474.6	-\$40.0	-\$5.8	-\$45.8	-9.6%	-\$5.8	-\$45.8	-9.6%
210027	Western Maryland Regional Medical Center	\$363.8	-\$13.2	-\$0.5	-\$13.7	-3.8%	-\$0.5	-\$13.7	-3.8%
210028	MedStar St. Mary's Hospital	\$214.1	\$6.8	\$0.0	\$6.8	3.2%	\$0.0	\$6.8	3.2%
210029	Johns Hopkins Bayview Medical Center	\$761.8	-\$117.6	-\$5.6	-\$123.1	-16.2%	-\$5.6	-\$123.1	-16.2%
210030	University of Maryland Shore Medical Center at Chestertown	\$55.5	-\$20.7	\$0.0	-\$20.7	-37.2%	\$0.0	-\$20.7	-37.2%
210032	Union Hospital of Cecil County	\$192.4	-\$25.3	-\$2.9	-\$28.2	-14.7%	-\$2.9	-\$28.2	-14.7%
210033	Carroll Hospital Center	\$267.5	-\$38.5	\$0.0	-\$38.5	-14.4%	\$0.0	-\$38.5	-14.4%
210034	MedStar Harbor Hospital Center	\$203.7	-\$0.5	-\$1.2	-\$1.7	-0.8%	-\$1.2	-\$1.7	-0.8%
210035	University of Maryland Charles Regional Medical Center	\$175.2	-\$0.2	\$0.0	-\$0.2	-0.1%	\$0.0	-\$0.2	-0.1%
210037	University of Maryland Shore Medical Center at Easton	\$269.4	-\$48.6	-\$0.6	-\$49.2	-18.3%	-\$0.6	-\$49.2	-18.3%
210038	University of Maryland Medical Center Midtown Campus	\$257.7	-\$44.6	-\$2.9	-\$47.5	-18.4%	-\$2.9	-\$47.5	-18.4%
210039	Calvert Memorial Hospital	\$173.5	-\$19.5	\$6.9	-\$12.6	-7.3%	\$6.6	-\$12.9	-7.4%
210040	Northwest Hospital Center	\$294.5	-\$42.6	-\$3.3	-\$46.0	-15.6%	-\$3.3	-\$46.0	-15.6%
210043	University of Maryland Baltimore Washington Medical Center	\$492.4	-\$35.7	-\$4.0	-\$39.6	-8.0%	-\$4.0	-\$39.6	-8.0%
210044	Greater Baltimore Medical Center	\$472.5	-\$49.1	\$0.0	-\$49.1	-10.4%	\$0.0	-\$49.1	-10.4%
210048	Howard County General Hospital	\$343.4	-\$5.3	\$11.1	\$5.7	1.7%	\$4.7	-\$0.7	-0.2%
210049	Upper Chesapeake Medical Center	\$357.3	-\$21.8	-\$2.2	-\$24.0	-6.7%	-\$2.2	-\$24.0	-6.7%
210051	Doctors Community Hospital	\$282.6	-\$34.6	\$14.0	-\$20.6	-7.3%	\$1.0	-\$33.6	-11.9%
210056	MedStar Good Samaritan Hospital	\$299.8	-\$19.1	-\$3.7	-\$22.8	-7.6%	-\$3.7	-\$22.8	-7.6%
210057	Shady Grove Adventist Hospital	\$500.0	-\$64.3	\$21.8	-\$42.5	-8.5%	\$0.0	-\$64.3	-12.9%
210058	University of Maryland Rehabilitation & Orthopaedic Institute	\$134.6	-\$33.2	-\$9.8	-\$43.0	-31.9%	\$1.0	-\$32.2	-23.9%
210060	Fort Washington Medical Center	\$64.8	-\$9.5	-\$3.7	-\$13.2	-20.4%	-\$3.7	-\$13.2	-20.4%
210061	Atlantic General Hospital	\$123.3	\$2.5	\$0.0	\$2.5	2.0%	\$0.0	\$2.5	2.0%
210062	MedStar Southern Maryland Hospital Center	\$307.0	-\$38.8	\$11.8	-\$27.1	-8.8%	\$0.1	-\$38.8	-12.6%
210063	University of Maryland St. Joseph Medical Center	\$445.9	-\$22.1	\$0.0	-\$22.1	-5.0%	\$0.0	-\$22.1	-5.0%
210065	Holy Cross Germantown	\$137.5	\$8.0	\$1.4	\$9.4	6.9%	\$0.0	\$8.0	5.8%
Total		\$19,024.4	-\$1,617.7	\$76.7	-\$1,541.0	-8.1%	-\$47.4	-\$1,665.1	-8.8%
Total for Rate Enhancements Only		\$3,025.9	\$101.8	\$16.8	\$118.7	3.9%	-\$2.4	\$104.8	3.5%

For the Integrated Efficiency policy, staff will also provide the all 3 iterations of the policy (Model 1 – with TCOC benchmarks, Model 2 – with MPA analogs, and Model 3 – the better of Model 1 and Model 2), but it should be noted that given the overwhelming support for using both attainment and improvement, Model 3 is the version of the policy the Commissioners should consider:

Exhibit 12: Integrated Efficiency Modelling Under 3 TCOC Evaluation

Hospital Name	Model 1: Current Methodology		Model 2: Methodology + MPA + Commercial Option 1 (MPA Analog)		Model 3: Better of Model 1 & 2 TCOC (Better of Benchmarks and MPA Approach)		
	Reduction \$	Reduction %	Reduction \$	Reduction %	Reduction \$	Reduction %	Reduction %
Howard County General Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Holy Cross Germantown	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Holy Cross Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
MedStar Southern Maryland Hospital Center	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Doctors Community Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
University of Maryland Baltimore Washington Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Garrett County Memorial Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
University of Maryland Charles Regional Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
MedStar St. Mary's Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Peninsula Regional Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Meritus Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
MedStar Franklin Square Hospital Center	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Upper Chesapeake Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Anne Arundel Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
MedStar Harbor Hospital Center	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Western Maryland Regional Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Calvert Memorial Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Atlantic General Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Johns Hopkins Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
MedStar Good Samaritan Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Harford Memorial Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Greater Baltimore Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
MedStar Montgomery Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Carroll Hospital Center	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
University of Maryland St. Joseph Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Frederick Memorial Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Suburban Hospital	\$0	0.0%	\$3,502,814	0.9%	\$0	0.0%	0.0%
Shady Grove Adventist Hospital	\$0	0.0%	\$4,180,691	0.8%	\$0	0.0%	0.0%
MedStar Union Memorial Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Union Hospital of Cecil County	\$2,814,851	1.5%	\$0	0.0%	\$1,005,692	0.5%	0.5%
Washington Adventist Hospital	\$0	0.0%	\$5,101,506	1.5%	\$2,180,607	0.6%	0.6%
University of Maryland Medical Center	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
Mercy Medical Center	\$1,363,520	0.2%	\$0	0.0%	\$1,019,287	0.2%	0.2%
Fort Washington Medical Center	\$0	0.0%	\$505,716	0.8%	\$0	0.0%	0.0%
University of Maryland Shore Medical Center at Chestertown	\$644,793	1.2%	\$402,182	0.7%	\$669,458	1.2%	1.2%
University of Maryland Shore Medical Center at Easton	\$3,129,138	1.2%	\$0	0.0%	\$1,841,004	0.7%	0.7%
University of Maryland Rehabilitation & Orthopaedic Institute	\$1,505,424	1.1%	\$2,400,257	1.8%	\$2,272,374	1.7%	1.7%
Prince Georges Hospital Center	\$0	0.0%	\$0	0.0%	\$2,377,394	0.6%	0.6%
St. Agnes Hospital	\$0	0.0%	\$0	0.0%	\$0	0.0%	0.0%
University of Maryland Medical Center Midtown Campus	\$2,883,029	1.1%	\$2,729,301	1.1%	\$3,315,665	1.3%	1.3%
Northwest Hospital Center	\$3,674,680	1.2%	\$1,149,057	0.4%	\$2,841,697	1.0%	1.0%
Johns Hopkins Bayview Medical Center	\$8,521,562	1.1%	\$2,122,942	0.3%	\$6,737,729	0.9%	0.9%
Sinai Hospital	\$22,449,385	2.5%	\$22,449,385	2.5%	\$22,449,385	2.5%	2.5%
Subtotal	\$46,986,382		\$44,543,850		\$46,710,293		

6k. Technical Considerations - Data Concerns with Efficiency Evaluation

Mercy Hospital has introduced two potential modifications to the efficiency evaluation, namely:

- Revising the influence that reductions to potentially avoidable utilization has on the ICC;
- and
- Moving away from strict ordinal ranking in the Integrated Efficiency Policy.

Staff Response:

Staff believe both of these proposals are reasonable and should be addressed in a long term workgroup engagement on the efficiency policies.

7. Final Recommendations

As aforementioned in the Draft Recommendations section, staff have amended the final recommendations due to Stakeholder comments, specifically the alignment of volume and revenue assessed in the ICC and the accounting of the Demographic Adjustment catch-up that was voted on during the June Commission meeting. The final recommendations are as follows:

- 1) Provide TCOC Adjustments in the Full Rate Application policy based on a hospital's positive performance in attainment AND improvement.
 - a. Positive rewards for Medicare TCOC will be provided to hospitals that perform better than the Medicare Benchmark and grow slower than the average State Medicare TCOC.
 - b. Positive rewards for Commercial TCOC will be provided to hospitals that perform better than the Medicare benchmark, better than the average of top half of commercial TCOC benchmarks and are growing slower than the average State Commercial TCOC.
 - c. All other existing TCOC aspects of the Full Rate Application analysis will remain the same, including capping all rewards so that a hospital does not exceed its Medicare Benchmark
- 2) Utilize a revised TCOC assessment for the Integrated Efficiency policy that considers both attainment and improvement performance.
 - a. Medicare TCOC performance will be based on the better of a benchmark attainment assessment and improvement performance captured through a metric analogous to the Medicare Performance Adjustment method (MPA)
 - b. Commercial TCOC performance will be based on the better of a benchmark attainment assessment and improvement performance captured through a Commercial TCOC assessment analogous to the Medicare MPA approach.
- 3) Amend a hospital's penalty under the Integrated Efficiency Policy to reflect the amount of eligible qualifying population health investments it makes. Qualifying population health investments should not be subject to inflationary reductions, as outlined in the Integrated Efficiency policy.
 - a. Qualifying population health investments should meet all of the following (the specifics of these conditions are explained in much greater detail below and this additional detail would be used to govern admitted investments):

- i. Non-physician community spending in the hospital's primary service area incurred outside of the regulated space and cost accounting, net of revenue generated for those services,
 - ii. Spending that meets one of three following criteria:
 1. An initiative that is intended to address an unmet health need identified on either the hospital's Community Health Needs Assessment or the Centers for Disease Control and Prevention's Health People 2030 Initiative; or
 2. Spending on primary care (as defined by the Maryland Primary Care Program), mental health, or dental providers that are located in a Medically Underserved Area; (note this is an exception to item non-physician condition in i above) or
 3. Spending on a regional entity to improve population health.
- 4) Reinstatement of a productivity adjustment in the Inter-hospital Comparison (ICC) equivalent to the variance between the historical operational efficiency standard of 8 percent and the statewide regulated margin for ICC evaluated hospitals.
- 5) All RY 2024 efficiency adjustments will be processed as permanent adjustments
 - a. Hospitals eligible for a rate enhancement through the full rate application policy in RY 2024 can access funding through a streamlined process if the hospital agrees to: the value established by the methodology, no additional methodological considerations will be considerations; and the hospital will not file any subsequent rate request until January 1, 2025.
 - b. However, Staff reserves the right to re-evaluate revenue in RY 2025, subject to approval by the Commission, for hospitals receiving a permanent adjustment, if efficiency evaluations change materially over the next year due to movements in the data as results stabilize post-pandemic.

Appendix A. Detailed Description of Inter-Hospital Cost Comparison Methodology

Part A: Calculation of Standard Cost Per Case for Comparison Group			
Step	Efficiency Policy		Description
Step 1 Remove Items not related to the permanent Cost basis			
1a	FRA, IE, Cap	Permanent Revenue	Remove from actual revenue the impact of current one-time adjustments that are not associated with volumes in rates.
1b	FRA, IE, Cap	Markup	Remove approved markup for payer differential, uncompensated care, and other similar factors.
Step 2 Convert from Price to Cost by stripping Margins			
2a	FRA, IE, Cap	Profit	Remove hospital-specific current regulated profit in order to bring revenue to approximation of costs.
Step 3 Remove “Public Good” items for which hospitals are credited (medical education, higher wage market, more challenging socioeconomic environment)			
3a	FRA, IE, Cap	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.
3b	FRA, IE, Cap	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.
3c	FRA, IE, Cap	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.
3d	FRA, IE, Cap	Make direct adjustment for impact of poverty on cost.	Directly estimate through a multi-year regression the effect on hospital costs of treating a higher share of poor patients – one of the major reasons for the peer groups.
Step 4: Convert to Standard Cost Per Case			
4a	FRA, IE, Cap	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).

Part A: Calculation of Standard Cost Per Case for Comparison Group			
Step	Efficiency Policy		Description
4b	FRA, IE, Cap	Standard Cost Per Case	This is calculated at the individual hospital level but aggregated to create Standard Cost per Case for a comparison group. The group would either be the peer group or the statewide standard depending on the decision on the Policy Choice above. Currently there are only two peer groups, academic and non-academic

Part B: Calculation of Hospital Approved Revenue			
Step	Efficiency Policy		Description
Step 1: Establish hospital cost base at the standard cost per case			
1a	FRA, IE, Cap	Standard Cost per Case	Begin with Standard Cost per Case calculated above.
1b	FRA	Productivity Adjustment	Historically, the ICC removed a 2% uniform productivity adjustment from a hospital's Approved Revenue. This was discontinued when the Full Rate Application policy was approved by the Commission in January of 2021. Staff are proposing reinstating the Productivity Adjustment, but the value would be determined by subtracting the statewide average regulated margin from 8%, which is the historical minimum operational efficiency standard to access additional funding through a full rate application. – See pg. 10
1c	FRA	Volume	Multiply by hospital specific volume measured in ECMADs.
1d	IE, Cap	Volume (adjusted)	Multiply by hospital specific volume. In the Integrated Efficiency and Capital Financing policies, 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). No such adjustment is made in the FRA policy because the point of that policy is to reset a hospital's rate structure to in line with its current services.
Step 2: Convert to hospital specific cost value by adding back "Public Goods"			

Part B: Calculation of Hospital Approved Revenue			
Step	Efficiency Policy		Description
2a	FRA, IE, Cap	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.
2b	FRA, IE, Cap	Labor Market	Readjust standard labor costs to the hospital-specific labor market described above.
2c	FRA, IE, Cap	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.
2d	FRA, IE, CAP	DSH	Make direct adjustment for impact of poverty on cost.
Step 3: Convert from Cost to Charges			
3a	FRA, IE, Cap	Markup	Add back hospital-specific approved markup for payer differential, uncompensated care, and other similar factors.
3b	FRA, IE, Cap	Hospital Approved Revenue	

Part C: Calculation of Hospital Relative Efficiency			
Step	Efficiency Policy		Description
Step 1: Compare Actual to Standard			
1a	FRA, IE, Cap	Actual hospital permanent revenue v. Hospital Approved Revenue from 3b in Part B	Compare actual Permanent Revenue to Hospital Approved Revenue and express as percentage above or below the standard.
Step 2: Manipulate as appropriate for applicable policy			
2a	FRA	ICC and non-ICC revenues	Various revenues not evaluated in the ICC, e.g., oncology drugs, are passed through without efficiency evaluation and added to the Hospital Approved Revenue calculated under Step 1. This revenue is then scaled using the TCOC results cited below.
2b	IE, CAP	Rank	Rank order hospitals from most to least efficient. These results will be combined with the TCOC results below to produce a composite score.

Appendix B. Detailed Description of TCOC Benchmarking Assessment Methodology

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. ¹¹
	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 Metropolitan Statistical Area (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.
	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. ¹² This is similar to the approach the HSCRC has used in calculating the Medicare Performance Adjustment (MPA).

¹¹ The technique is called: “K-nearest neighbor.”

¹² 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.

Convert Geographic Benchmarks to Hospital Benchmarks

	Step		Description
	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 zip code, allocate costs and beneficiaries to each hospital in accordance with its primary service areas. ¹³
	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	Efficiency Policy		Description
1	FRA, IE, Cap	Medical Education	Remove estimated medical education costs from all data – Medicare and commercial, Maryland and Benchmark.
2	FRA, IE, Cap	Risk adjustment	Separately risk adjust Medicare and commercial data.
3	FRA, IE, Cap	Benefit adjustment (Commercial only)	Account for differences in commercial benefit plans by area. Richer plans result in higher utilization.
4	FRA, IE, Cap	Demographic Adjustment	Calculated separately for Medicare and commercial. Demographic factors adjusted are Median Income and Deep Poverty.
5	FRA, IE, Cap	Compare	Compare hospital to benchmark and express as % above or below
6a	FRA	Scale standardized hospital approved revenue established in the ICC	Currently, the FRA negatively scales Hospital Approved Revenue if the hospital is worse than its benchmark peers and is growing faster than statewide average TCOC growth rate. The policy also positively scales hospitals' standardized hospital approved revenue if it is better than its benchmark peers. Staff propose that the policy maintain symmetry such that TCOC rewards can only be accessed if the hospital's TCOC is better than the benchmark and growing slower than the statewide average TCOC growth rate. - See pg. 8
6b	IE, Cap	Rank	Currently, Integrated Efficiency and the Capital Financing Policy rank order hospitals on Medicare and Commercial benchmark standards. Staff are recommending supplementing the current TCOC benchmark assessment with an improvement analysis consistent with that utilized in the Medicare Performance

¹³ Ibid.

Adjust the data for differences and compare			
Step	Efficiency Policy		Description
			Adjustment (both for Medicare and Commercial). Additionally, staff are recommending that a better of attainment, as measured through the TCOC benchmarks, and improvement, as measured through the MPA method, be utilized to determine relative TCOC effectiveness. These results will be combined with the hospital efficiency results above to produce a the Effectiveness score. – See pg. 11

Appendix C. Efficiency Matrix with Existing TCOC Benchmarks

HOSP id	Hospital Name	2021 Volume Adjusted ICC Result	ICC Rank (50%)	2021 Medicare TCOC Relative to Benchmark	2021 Medicare TCOC Rank (25%)	2021 Commercial TCOC Relative to Benchmark	2021 Commercial TCOC Rank (25%)	Total Rank Points (Low Score is Better)
210048	Howard County General Hospital	1.67%	9	-3.21%	9	-24.78%	1	14
210065	Holy Cross Germantown	1.43%	11	-2.90%	10	-23.14%	4	18
210004	Holy Cross Hospital	3.78%	6	-2.15%	11	-15.91%	15	19
210035	University of Maryland Charles Regional Medical Center	1.46%	10	1.02%	13	-17.83%	12	23
210028	MedStar St. Mary's Hospital	6.18%	4	2.02%	14	-12.80%	25	24
210019	Peninsula Regional Medical Center	7.94%	3	12.53%	21	-13.57%	23	25
210017	Garrett County Memorial Hospital	14.04%	1	-5.07%	6	2.39%	42	25
210051	Doctors Community Hospital	-8.97%	22	-5.72%	4	-24.70%	2	25
210018	MedStar Montgomery Medical Center	-9.51%	24	-8.35%	2	-21.75%	7	29
210043	University of Maryland Baltimore Washington Medical Center	-6.34%	16	11.66%	20	-18.42%	11	32
210062	MedStar Southern Maryland Hospital Center	-9.85%	26	-5.27%	5	-22.01%	6	32
210001	Meritus Medical Center	10.44%	2	15.77%	26	-8.22%	35	33
210022	Suburban Hospital	-11.20%	31	-17.04%	1	-24.08%	3	33
210023	Anne Arundel Medical Center	-9.62%	25	-4.74%	8	-20.66%	9	34
210049	Upper Chesapeake Medical Center	-3.36%	12	18.01%	30	-15.47%	16	35
210057	Shady Grove Adventist Hospital	-11.92%	32	-6.73%	3	-21.53%	8	38
210002	University of Maryland Medical Center	-5.93%	15	23.70%	34	-15.33%	17	41
210015	MedStar Franklin Square Hospital Center	3.63%	7	19.81%	31	-8.16%	36	41
210034	MedStar Harbor Hospital Center	3.84%	5	26.60%	40	-11.21%	31	41
210005	Frederick Memorial Hospital	-10.04%	27	2.27%	15	-17.73%	13	41
210027	Western Maryland Regional Medical Center	-4.34%	13	13.16%	23	-10.54%	34	42
210039	Calvert Memorial Hospital	-16.28%	36	-4.77%	7	-22.35%	5	42
210061	Atlantic General Hospital	2.79%	8	24.67%	37	-10.59%	33	43
210009	Johns Hopkins Hospital	-7.96%	21	21.84%	33	-16.18%	14	45
210006	Harford Memorial Hospital	-6.85%	18	14.37%	25	-11.67%	29	45
210044	Greater Baltimore Medical Center	-6.95%	20	13.55%	24	-11.91%	28	46
210060	Fort Washington Medical Center	-10.20%	28	2.49%	16	-13.91%	20	46
210011	St. Agnes Hospital	-9.19%	23	17.44%	29	-15.04%	19	47
210063	University of Maryland St. Joseph Medical Center	-6.89%	19	15.78%	27	-11.50%	30	48
210024	MedStar Union Memorial Hospital	-6.69%	17	20.99%	32	-10.79%	32	49
210056	MedStar Good Samaritan Hospital	-4.47%	14	28.94%	42	-6.83%	37	54
210003	Prince Georges Hospital Center	-20.45%	40	6.08%	19	-19.02%	10	55
210016	Washington Adventist Hospital	-13.80%	34	2.57%	17	-13.45%	24	55
210033	Carroll Hospital Center	-12.75%	33	12.55%	22	-13.61%	21	55
210008	Mercy Medical Center	-10.42%	29	24.55%	36	-12.06%	26	60
210029	Johns Hopkins Bayview Medical Center	-13.89%	35	25.68%	38	-11.97%	27	68
210058	University of Maryland Rehabilitation & Orthopaedic Institute	-27.66%	42	23.70%	34	-15.33%	17	68
210030	University of Maryland Shore Medical Center at Chestertown	-29.33%	43	-0.05%	12	-5.67%	38	68
210037	University of Maryland Shore Medical Center at Easton	-19.50%	39	5.05%	18	-5.28%	40	68
210038	University of Maryland Medical Center Midtown Campus	-18.03%	38	26.03%	39	-13.58%	22	69
210032	Union Hospital of Cecil County	-17.82%	37	16.65%	28	-5.44%	39	71
210040	Northwest Hospital Center	-10.55%	30	29.31%	43	-2.44%	41	72
210012	Sinai Hospital	-21.61%	41	26.80%	41	3.15%	43	83

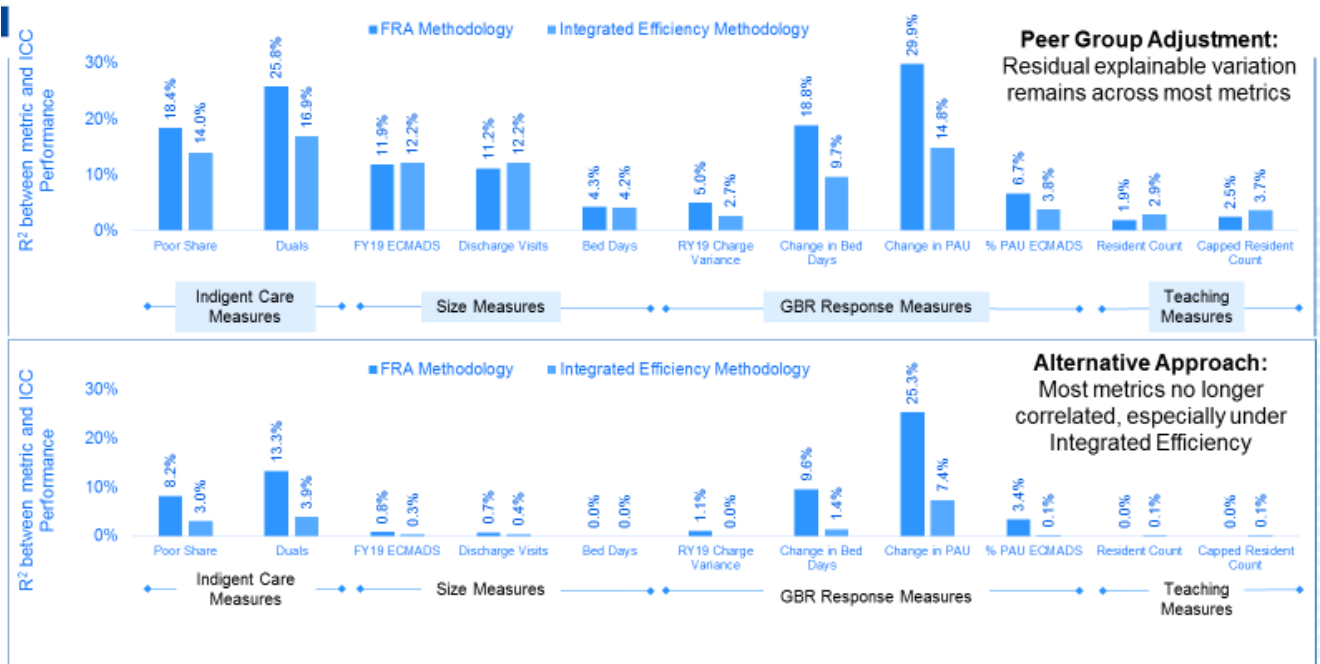
Appendix D. Efficiency Matrix with MPA and MPA Analog Method

HOSP id	Hospital Name	2021 Volume Adjusted ICC Result	ICC Rank (50%)	2021 MPA Method	2021 Medicare TCOC Rank (25%)	2021 Commercial MPA Analog Method	2021 Commercial TCOC Rank (25%)	Total Rank Points (Low Score is Better)
210017	Garrett County Memorial Hospital	14.04%	1	9.92%	6	4.65%	1	5
210019	Peninsula Regional Medical Center	7.94%	3	8.17%	3	12.79%	15	12
210028	MedStar St. Mary's Hospital	6.18%	4	12.70%	13	9.87%	8	15
210035	University of Maryland Charles Regional Medical Center	1.46%	10	7.60%	2	13.73%	20	21
210027	Western Maryland Regional Medical Center	-4.34%	13	15.68%	20	5.75%	4	25
210015	MedStar Franklin Square Hospital Center	3.63%	7	13.51%	14	15.04%	27	28
210048	Howard County General Hospital	1.67%	9	12.41%	12	14.89%	25	28
210001	Meritus Medical Center	10.44%	2	17.01%	27	14.91%	26	29
210061	Atlantic General Hospital	2.79%	8	8.63%	4	21.74%	39	30
210043	University of Maryland Baltimore Washington Medical Center	-6.34%	16	16.33%	24	11.01%	10	33
210034	MedStar Harbor Hospital Center	3.84%	5	18.89%	33	14.56%	24	34
210049	Upper Chesapeake Medical Center	-3.36%	12	16.01%	21	14.52%	23	34
210056	MedStar Good Samaritan Hospital	-4.47%	14	19.69%	35	6.42%	5	34
210063	University of Maryland St. Joseph Medical Center	-6.89%	19	14.26%	17	13.96%	21	38
210004	Holy Cross Hospital	3.78%	6	16.32%	23	25.44%	41	38
210024	MedStar Union Memorial Hospital	-6.69%	17	21.50%	36	7.13%	6	38
210044	Greater Baltimore Medical Center	-6.95%	20	14.20%	16	14.08%	22	39
210006	Harford Memorial Hospital	-6.85%	18	10.75%	9	19.63%	34	40
210009	Johns Hopkins Hospital	-7.96%	21	24.26%	40	5.43%	3	43
210039	Calvert Memorial Hospital	-16.28%	36	7.55%	1	11.83%	13	43
210011	St. Agnes Hospital	-9.19%	23	16.08%	22	13.45%	19	44
210002	University of Maryland Medical Center	-5.93%	15	24.45%	41	13.11%	17	44
210065	Holy Cross Germantown	1.43%	11	18.40%	32	20.06%	35	45
210051	Doctors Community Hospital	-8.97%	22	13.76%	15	17.28%	31	45
210023	Anne Arundel Medical Center	-9.62%	25	11.82%	10	18.64%	33	47
210033	Carroll Hospital Center	-12.75%	33	12.39%	11	12.99%	16	47
210005	Frederick Memorial Hospital	-10.04%	27	9.35%	5	20.51%	36	48
210018	MedStar Montgomery Medical Center	-9.51%	24	10.46%	8	27.40%	42	49
210008	Mercy Medical Center	-10.42%	29	22.90%	37	10.26%	9	52
210032	Union Hospital of Cecil County	-17.82%	37	17.96%	30	5.21%	2	53
210062	MedStar Southern Maryland Hospital Center	-9.85%	26	16.70%	26	16.01%	28	53
210003	Prince Georges Hospital Center	-20.45%	40	15.51%	19	11.09%	11	55
210037	University of Maryland Shore Medical Center at Easton	-19.50%	39	15.07%	18	12.66%	14	55
210029	Johns Hopkins Bayview Medical Center	-13.89%	35	23.14%	38	9.61%	7	58
210030	University of Maryland Shore Medical Center at Chestertown	-29.33%	43	10.40%	7	16.55%	30	62
210040	Northwest Hospital Center	-10.55%	30	18.35%	31	18.07%	32	62
210060	Fort Washington Medical Center	-10.20%	28	24.16%	39	16.43%	29	62
210057	Shady Grove Adventist Hospital	-11.92%	32	17.70%	28	21.33%	37	65
210022	Suburban Hospital	-11.20%	31	16.35%	25	29.27%	43	65
210038	University of Maryland Medical Center Midtown Campus	-18.03%	38	24.83%	43	11.36%	12	66
210016	Washington Adventist Hospital	-13.80%	34	17.89%	29	23.77%	40	69
210058	University of Maryland Rehabilitation & Orthopaedic Institute	-27.66%	42	24.45%	41	13.11%	17	71
210012	Sinai Hospital	-21.61%	41	19.38%	34	21.43%	38	77

Appendix E. Efficiency Matrix with Better of Benchmarks & MPA and MPA Analog Method

HOSP id	Hospital Name	2021 Volume Adjusted ICC Result	ICC Rank (50%)	2021 Medicare TCOC Rank - Better Of (25%)	2021 Commercial TCOC Rank - Better Of (25%)	Total Rank Points (Low Score is Better)
210017	Garrett County Memorial Hospital	14.04%	1	6	1	5
210019	Peninsula Regional Medical Center	7.94%	3	3	15	12
210048	Howard County General Hospital	1.67%	9	9	1	14
210028	MedStar St. Mary's Hospital	6.18%	4	13	8	15
210035	University of Maryland Charles Regional Medical Center	1.46%	10	2	12	17
210065	Holy Cross Germantown	1.43%	11	10	4	18
210004	Holy Cross Hospital	3.78%	6	11	15	19
210027	Western Maryland Regional Medical Center	-4.34%	13	20	4	25
210051	Doctors Community Hospital	-8.97%	22	4	2	25
210061	Atlantic General Hospital	2.79%	8	4	33	27
210015	MedStar Franklin Square Hospital Center	3.63%	7	14	27	28
210001	Meritus Medical Center	10.44%	2	26	26	28
210018	MedStar Montgomery Medical Center	-9.51%	24	2	7	29
210049	Upper Chesapeake Medical Center	-3.36%	12	21	16	31
210043	University of Maryland Baltimore Washington Medical Center	-6.34%	16	20	10	31
210062	MedStar Southern Maryland Hospital Center	-9.85%	26	5	6	32
210022	Suburban Hospital	-11.20%	31	1	3	33
210034	MedStar Harbor Hospital Center	3.84%	5	33	24	34
210023	Anne Arundel Medical Center	-9.62%	25	8	9	34
210056	MedStar Good Samaritan Hospital	-4.47%	14	35	5	34
210024	MedStar Union Memorial Hospital	-6.69%	17	32	6	36
210005	Frederick Memorial Hospital	-10.04%	27	5	13	36
210006	Harford Memorial Hospital	-6.85%	18	9	29	37
210057	Shady Grove Adventist Hospital	-11.92%	32	3	8	38
210063	University of Maryland St. Joseph Medical Center	-6.89%	19	17	21	38
210044	Greater Baltimore Medical Center	-6.95%	20	16	22	39
210009	Johns Hopkins Hospital	-7.96%	21	33	3	39
210039	Calvert Memorial Hospital	-16.28%	36	1	5	39
210002	University of Maryland Medical Center	-5.93%	15	34	17	41
210011	St. Agnes Hospital	-9.19%	23	22	19	44
210060	Fort Washington Medical Center	-10.20%	28	16	20	46
210033	Carroll Hospital Center	-12.75%	33	11	16	47
210008	Mercy Medical Center	-10.42%	29	36	9	52
210032	Union Hospital of Cecil County	-17.82%	37	28	2	52
210016	Washington Adventist Hospital	-13.80%	34	17	24	55
210003	Prince Georges Hospital Center	-20.45%	40	19	10	55
210037	University of Maryland Shore Medical Center at Easton	-19.50%	39	18	14	55
210029	Johns Hopkins Bayview Medical Center	-13.89%	35	38	7	58
210040	Northwest Hospital Center	-10.55%	30	31	32	62
210030	University of Maryland Shore Medical Center at Chestertown	-29.33%	43	7	30	62
210038	University of Maryland Medical Center Midtown Campus	-18.03%	38	39	12	64
210058	University of Maryland Rehabilitation & Orthopaedic Institute	-27.66%	42	34	17	68
210012	Sinai Hospital	-21.61%	41	34	38	77

Appendix F. ICC Statistical Significance Evaluation



June 13, 2023

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

Dear Katie –

I want to express the on-going concern of LifeBridge Health of the Integrated Efficiency Policy. A review of the advance materials for the public meeting on June 14th indicates Sinai Hospital being identified with a \$22.5 million penalty. While the broader discussion will include the potential for an ability to reduce the penalty through qualifying population health expenditures, whether the Revenue for Reform component will be approved as proposed and the ultimate magnitude of the LifeBridge population health investment that would be deemed as qualifying remain uncertain.

Our concerns are not new, and we have discussed them on multiple occasions, noting specifically our belief that the disproportionate share adjustment does not adequately measure the real cost of providing care to a dis-advantaged population and that the differences in cost per Medicaid beneficiaries based on geography – with Baltimore City being notably higher – are meaningful and not fully captured through the existing adjustments.

In a discussion on March 29th, 2022, we noted the concern that given the design of the Interhospital Cost Comparison (ICC) there was the likelihood of a hospital becoming “stuck” and noted that Sinai would have, at that time, needed a revenue reduction of \$111.3 million to move from its position to simply the 3rd quartile (see attached slide). While we debated if \$111.3 million was the precise amount, staff openly acknowledged its belief that the amount was likely to be in the \$75 million - \$80 million range. The latest ICC modeling continues to suggest that even with the \$13.2 million of already removed permanent revenue and the potential of another \$22.5 million for fiscal year 24, a substantial revenue reduction would still be required for Sinai to not be deemed as a 4th quartile inefficient performer.

The following table reflects the regulated profit for Sinai hospital dating back to fiscal year 2021. We remove the portion of the Grace Medical revenue stream which reflects the direct investment by LifeBridge in the West Baltimore community, and which the HSCRC treats as a safe-harbor within the Efficiency Policy measurement, in order to more accurately reflect the real operating margin. In addition, we have projected fiscal year 24 layering in the current identified revenue reduction from the Staff recommendation and another \$50 million of additional revenue reduction that could occur in fiscal

CARE BRAVELY

year 25 and later to model an overall efficiency policy reduction of an estimated \$86 million, reflecting an amount consistent with our discussions as being necessary to move from the 4th to 3rd quartile.

	<u>FY21</u>	<u>FY22</u>	<u>FY23 (1)</u>	<u>FY24 (2)</u>	<u>FY25+ (3)</u>
Regulated Operating Margin	\$110,117	\$110,344	\$53,115	\$53,115	\$53,115
Removal of Grace Safe-Harbor	(\$27,300)	(\$27,300)	(\$27,300)	(\$27,300)	(\$27,300)
FY24 Efficiency Policy	\$0	\$0	\$0	(\$22,500)	(\$22,500)
Reversal of Prior Year GBR	\$0	\$0	\$0	(\$6,500)	(\$6,500)
Settlements					
Projected Future Efficiency Policy	\$0	\$0	\$0	\$0	(\$50,000)
Revenue Reductions					
Adjusted Regulated Operating Margin	\$82,817	\$83,044	\$25,815	(\$3,185)	(\$53,185)

(1) Annualized using YTD April FSA submission


(2) Proforma considering removal of identified efficiency policy penalty + one-time settlements included in FY23

(3) Proforma considering an additional \$50 million GBR reduction to future fiscal years

While Sinai has begun to achieve some significant savings through its now longer than 12-month performance improvement engagement, the projections identify an unsustainable progression in regulated operating margin. Specifically, the removal of nearly 75% of its annual inflation adjustment in combination with the reversal of \$6.5 million of prior year GBR settlements in fiscal year 24 results in a regulated operating margin loss. Should future efficiency policy reductions of at least another \$50 million occur, Sinai may experience regulated losses in excess of \$50 million and be unable to effectively fund operations. At the same time, we have already placed on hold the renovation of the Sinai Hospital bed tower, a project we viewed as essential given facility age and condition.

Although we understand the intent of HSCRC Staff to create objective formulaic methodologies as a basis to make hospital revenue adjustments, we continue to believe the Integrated Efficiency Policy in its proposed form has the ability to reduce a hospital's revenue beyond retained savings from volume reductions even when considering possible credits of qualifying population health expenditures.

Sincerely,



David Krajewski

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

CC:

Allan Pack
Principal Deputy Director

Adam Kane, Esq.
HSCRC Chairman

Efficiency Policy Concerns

- LifeBridge believes the existing methodology allows for a hospital to be “stuck” in the highest quartile with limited ability to make operational decisions that improve position to the ICC statewide average
 - Using the existing methodology (without updates to IME and DSH coefficients) and holding TCOC peer comparisons constant, Sinai would need an estimated \$111.3 million permanent GBR reduction to move out of the highest quartile
- Methodology creates financial instability for LifeBridge in numerous ways including the commitment to investment in required campus facility renovation
- Revenue for Reform considerations are likely to be insufficient to move a hospital outside the highest quartile



June 21, 2023

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

Dear Ms. Wunderlich,

Adventist Healthcare would like to provide comment regarding the draft Integrated Efficiency Policy (“ICC”) recommendation. In short, we support the Maryland Hospital Association’s comment letter on the draft ICC. However, Adventist has a technical concern that we would like to raise and a larger concern with the current HSCRC payment policy framework that is important to decisions on the draft ICC.

A. Draft Integrated Efficiency Policy Technical Consideration

Our understanding is that FY2022 volumes are the basis for the Integrated Efficiency policy, however Staff has included the CY2022 market shift as a revenue adjustment to the ICC. While in most years, the six months difference between the calendar year-based market shift revenue adjustment and the fiscal year-based volumes used in the ICC are immaterial, many hospitals, experienced significant volume fluctuation in volume during the July-December 2022 time period, driving large market shift adjustments.

For a hospital like Adventist White Oak, for example, the mismatch of volume and revenue for a period of significant growth is potentially the difference between being penalized or avoiding penalty. Adventist believes that the Staff should bring the underlying ICC volumes forward to CY2022 to match the revenue adjustments reflected in the CY2022 market shift adjustment in the draft policy.

B . Policy Framework Concern for Predictable, Stable Revenues

At present, the field is navigating the unpredictability of three significant payment policies for RY24: the draft ICC Efficiency Policy, to-be-determined deregulation adjustments and the CTI payment policy. To only evaluate an individual payment policy without the broader policy context, risks understating the predictability of the environment hospitals are using to make decisions which could undermine long-term investments necessary to transform care.



Predictable, stable revenues are foundational to the model. This is even more critical as hospitals navigate long-term investments in infrastructure to improve population health. Temporary adjustments or unknown adjustments create an unstable operating environment that limits a hospital's ability to plan and make operational decisions that extend beyond a twelve-month period.

Adventist is concerned that that the proposed ICC policy cannot be properly evaluated without consideration of the to-be-determined deregulation adjustments and the CTI payment policy as all three policies have a significant impact on hospitals in RY24.

We understand that there is no formal comment period open for the CTI policy. However, the proposal to make the RY24 ICC adjustments temporary or abstain from subsequent rate relief in RY24 should be framed as part of the larger lens of payment policy instability of which the CTI policy is a large concern.

The Year 1 CTI program results re-align approximately 1.6% of Medicare revenues (\$129M) and .65% of all payer GBR. The Year 1 CTI policy result exceeds the RY24 annual adjustment for PAU savings (.38%), net quality programs (.57%) and revenue realignment under the Market Shift policy (.53%).

Given the significant realignment of revenue, Adventist has provided comprehensive written feedback for consideration and review prior to the proposed July 1, 2023 CTI Year 1 implementation in a separate letter for Staff and Commission consideration.

Sincerely,



Kristen Pulio
Senior Vice President and Chief Financial Officer
Adventist HealthCare

cc: Adam Kane, Allan Pack





June 21, 2023

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

Dear Ms. Wunderlich,

Adventist Healthcare would like to provide recommendations regarding the Care Transformation Initiatives (CTI) program administered by the Health Services Cost Review Commission (HSCRC) and Year 1 results. We appreciate HSCRC Staff's efforts to date on this new complex policy and look forward to collaborating with Staff on refinements.

We understand that there is no formal comment period open for the CTI policy. However, given that the open comment period was over a year ago without final Year 1 results on a new policy, Adventist would like to provide feedback prior to implementation into rates. We appreciate that Staff plan to review analysis of the Year 1 results at the 6/28/23 Total Cost of Care ("TCOC") Workgroup meeting but this will not leave enough time for meaningful stakeholder engagement before the proposed application to 7/1/23 claims 2 days later.

The Year 1 CTI program results re-aligns approximately 1.6% of Medicare revenues (\$129M) and .65% of all payer GBR. The Year 1 CTI policy result exceeds the RY24 annual adjustment for PAU savings (.38%), net quality programs (.57%) and revenue realignment under the Market Shift policy (.53%). Given the significant realignment of revenue, Adventist wants the opportunity to provide comprehensive written feedback for consideration and review prior to the proposed July 1, 2023 implementation.

Adventist Healthcare's feedback and recommendations are focused in two areas:

1. Policy changes to the CTI program
2. Recommendations for Year 1 results in payment policy

1. Policy changes to the CTI program

Adventist Healthcare recognizes and appreciates that the HSCRC staff are currently working on a series of policy changes to present to the Commissioners over the summer, with the goal of implementing them for the FY 2023 performance period. To support the work of the staff,



Adventist Healthcare is providing the following policy recommendations for your consideration in the implementation of Year 1 results and future program design:

A. Carve out pandemic related utilization “savings” from CTI payment policy results

For Year 1 of the CTI program, the base period pre-dates covid (2016/2017) and the performance period overlapped with the most severe COVID surge in Maryland (July 2021-June 2022) (See Appendix enclosure). Starting in 2020, due to pandemic rationed access to care, utilization plummeted in Maryland and the Nation. Maryland leadership (Governor’s office & Health Secretary) asked providers to only deliver essential care. Non-essential services (such as primary care and ambulatory surgical activity) were asked to close and loan staff and equipment to surge sites throughout the State. At one point, a Maryland executive order to stop elective surgeries was in effect. Even when the executive order was released, Hospitals were strongly encouraged to self-ration to not necessitate another executive order closing services. So even though the executive order to stop services was temporary, hospitals actively self-rationed access to care in order to avoid the thread of executive order closures during the performance period.

Maryland law was more aggressive during the pandemic than other States in mandating closures, vaccinations and masking. The result of this was an even sharper decline in non-essential utilization in Maryland relative to the Nation during this time that resulted in significant Model savings during CY2021. This was identified as the key driver of CY2020-2021 savings as presented in HSCRC’s TCOC workgroup meetings analyzing the savings drivers during this period (see enclosures). There are several implications of pandemic volume reduction for the Year 1 CTI results:

- **Episodic-based CTIs were limited in their ability to generate savings in Year 1.** In American Institutes for Research’s Year 1 report for CRISP, they found that *“CTIs with a low number of episodes are unlikely to generate significant total cost of savings because of the limited patient volume; higher patient volume is necessary for generating large savings”*. Furthermore, *“seventy-five percent of CTIs had fewer episodes during the performance year than at baseline... A lower number of episodes may be attributed to less health care utilization during the COVID-19 pandemic or overlapping episodes for a single patient, which would cause the second episode to be dropped from the CTI program...”* COVID-19 patients were also excluded from CTIs which further reduced the population of patients eligible for a potential episode. Consequently, reduced volumes during the performance period handicapped the ability of episodic CTIs to generate savings since they needed an initiating visit to trigger an episode.
- **Panel/Geography-based CTIs were optimized in their ability to generate savings in Year 1.** Panel/Geography-based CTIs did not require a triggering event, rather, TCOC for the targeted population was in scope. Therefore, during a period of suppressed non-essential care, we would expect significant savings relative to a “normal” base period. This panned out in the Year 1 performance with just 10 of 66 successful CTIs generating more than 50% of the savings due to panel-based primary care. An analysis of ECMAD declines relative to panel/geographic CTI savings



also suggests a strong correlation of pandemic-suppressed volumes to panel/geography CTI savings.

Therefore, it's imperative to understand what of the CTI savings generated in July 2021-June 2022 are due pandemic-related declines rather than clinical transformation. As it stands now, the current policy assumes 100% of the CTI savings are a result of clinical transformative efforts as no adjustment has been made for pandemic-related reduction in volumes.

- B. Reconcile to retained revenues.** Hospitals that generated retained revenue during the pandemic could potentially be paid twice for the avoided volumes if they also had a successful CTI. The CTI program pays a hospital for its CTI savings which were generated from reduced utilization. Hospital GBR retained revenues are generated when a hospital is allowed to raise its rates to due to reduced utilization. Policy alignment should be considered to avoid duplicative payment for avoided utilization. One example of potential policy alignment could be the use of CTI results to support Revenue-for-Reform safe harbors through a direct link to CTI measured outcomes.
- C. Reconcile to TCOC performance.** CTIs are a mechanism to document clinical interventions to reductions in TCOC. But just because a hospital didn't submit a CTI, doesn't mean that it wasn't actively engaging on activities to reduce TCOC. However, because of limited resources during the pandemic and the newness of the CTI program, a hospital may not have filed CTI paperwork or selected the most advantageous CTI to showcase their TCOC efforts.

Year 1 CTIs were submitted during an extremely resource constrained time- the height of the pandemic (2020-2021). The American Institutes for Research report on Year 1 noted that *"CTIs that could not be adequately redesigned [due to COVID-19 challenges such as staffing, personal protective equipment and shift to telemedicine] were pulled back when the pandemic hit"*. Also, the report noted the *"complex cost methodology"* and data lags/limitations as *"key barriers"* to designing successful CTIs. The report even went as far as to recommend that *"HSCRC and CRISP should consider targeted technical assistance to hospitals to help them"* design CTIs to quantify savings. Adventist commends HSCRC Staff and CRISP for the increased resources and assistance to hospitals however, this was not in place at the level it is now when CTIs were submitted for Year 1.

Additionally, because the CTI program is claims based, it excludes TCOC initiatives that cannot fit into the limited claims-based definitions of the CTIs. The result is that a *random sampling* of initiatives is captured by the CTI payment policy for Year 1. Hospitals could be very successful under their TCOC performance but look bad on their CTIs. Or they could look good on their CTIs but perform poorly on TCOC. But since there is no connection to TCOC performance, the program risks moving funds around the State for only interventions that could be captured in claims and were submitted with limited resources during the height of the pandemic. In effect, the policy rewards hospitals who "submitted their paperwork" without checking to see if they actually reduced TCOC. This conversely defunds initiatives that could not be captured in the CTI policy through the revenue neutral assessment to fund the savings rewards in rates.



- D. Reconcile to the model definition of savings.** The Model savings test measures Maryland performance on TCOC vs. the Nation. The CTI program only measure MD vs. MD performance. If Maryland's performance improves, but not better than the Nation, then it doesn't generate "savings" under the Model test. Therefore, it's possible that the sampling of initiatives that generate "savings" under the CTI policy may not generate Model "savings" as they are defined differently. Additionally, since CTI savings are risk adjusted and the Model savings are not, CTI savings could result in more revenue re-distributed across the state than actual Model savings generated by the initiatives. The result is a payment policy that moves funding around the State for initiatives that do not directly drive Model performance.
- E. Implement a cap on the downside risk for hospitals.** The current CTI program does not have a cap on the downside risk for hospitals to pay into the savings pool, creating financial uncertainty for hospitals. In fact, the Year 1 results to realign \$129M is more than the most recent Market Shift results of \$106M. Predictability and a cap, like other HSCRC programs, is essential for hospitals to estimate the magnitude of the associated risk. Such a stop-loss provision would bring this policy in-line with the core Model tenant of predicable, stable revenues. We appreciate that the Staff have already included this issue on their list of refinements.
- F. Assess the proportionality of the penalty and reward by hospital.** The program currently distributes the risk for the savings pool by percentage of statewide Medicare revenue. This potentially creates a disproportionate amount of risk for some hospitals, particularly safety net providers. Similarly, based on the number of patients, not all hospitals have an equal ability to generate savings. The more volumes in a CTI, the lower the savings threshold making it easier to generate savings. The savings threshold ranges from 1-15% with access to the lower threshold based on higher volumes. This disproportionately impacts stand-alone hospitals or smaller health systems because they don't have a level playing field with larger systems in accessing a lower savings threshold. The American Institutes for Research report noted the linkage of scale to ability to generate material savings "*CTIs with a large number of episodes and performance costs below target are necessary for generating significant savings*".

Additionally, because the CTI program is revenue neutral, all hospitals pay into a pool to cover the cost of the statewide savings. This is in effect a "tax" to hospitals. A hospital must generate enough CTI savings to cover its "tax" for statewide hospital savings. This could potentially create unintended consequences with larger health systems able to generate more savings so that smaller or standalone hospitals are not able to generate enough savings to offset their "tax" or benefit from the program. AHC recommends a review of the "effective tax rate" for the savings pool to ensure no disproportionate impact to safety net and smaller hospitals and health systems.

- G. Consider requiring each hospital to participate in each thematic area, creating equity across the hospitals and providing a statewide view of hospital performance.** Currently participation in thematic areas is variable by hospital. By requiring a submission in each thematic area, the HSCRC would have a more holistic review of hospital interventions and accompanying performance. This



would make the calculation of “savings” less tied to who submitted their paperwork and easier to identify patterns and trends to normalize the savings calculation for just clinical interventions. This would also move the policy to being comprehensive instead of a just a sampling of interventions.

H. Consider excluding the COVID performance period consistent with other HSCRC payment policies.

Due to the volatility of the COVID time period, several payment policies were suspended including QBR, MHAC, Market Shift and full rate applications. Staff also noted in the November 2022 TCOC workgroup, “*considerable volatility in TCOC in 2020, 2021, and 2022 makes...analysis over any period complex*”. Because CTI measures avoided utilization, carving out COVID cases is not sufficient to account for the pandemic impact with this policy. To account for the pandemic impact on CTI savings, we would need to add back to the performance year for artificially suppressed volumes due to the pandemic. Not adjusting the performance period attributes 100% of the CTI savings to clinical interventions without accounting for the pandemic related decline in utilization.

2. Recommendations for Year 1 results in payment policy

Adventist Healthcare is concerned that the results from the Year 1 CTI program have not undergone a comprehensive review since RY22 policy results were just finalized in May. Staff plan to review analysis of the Year 1 results at the 6/28/23 TCOC Workgroup meeting but this will not leave enough time for meaningful stakeholder engagement before the proposed application to 7/1/23 rates 2 days later.

Before finalizing the results and assessing the rewards and penalties for Year 1, we would recommend the following minimum analyses be completed:

- **Analysis to carve out the “savings” due to pandemic volume disruption**
- **Analysis to review the equity of the effective tax rate on hospitals to pay for state-wide savings share.**

Given the policy challenges, AHC recommends one of three courses of action to mitigate concerns in the policy:

1. Do not attach revenue or penalties to the Year 1 CTI results given the complications outlined.
2. Handicap the Year 1 CTI results by 50% (or other factor) to mitigate for the pandemic performance period and potential policy refinements.
3. Delay the implementation of the Year 1 CTI results and make the results contingent on a robust analytical review and any resulting modifications. The payment changes go through the MPA and not the annual rate order so they can be implemented when ready.



Conclusion

Adventist Healthcare appreciates the significant efforts to date on this policy and understand it's importance within the Maryland Model policy framework. Adventist Healthcare appreciates the opportunity to provide feedback and recommendations to the HSCRC staff and would welcome a meeting to discuss them further.

Sincerely,



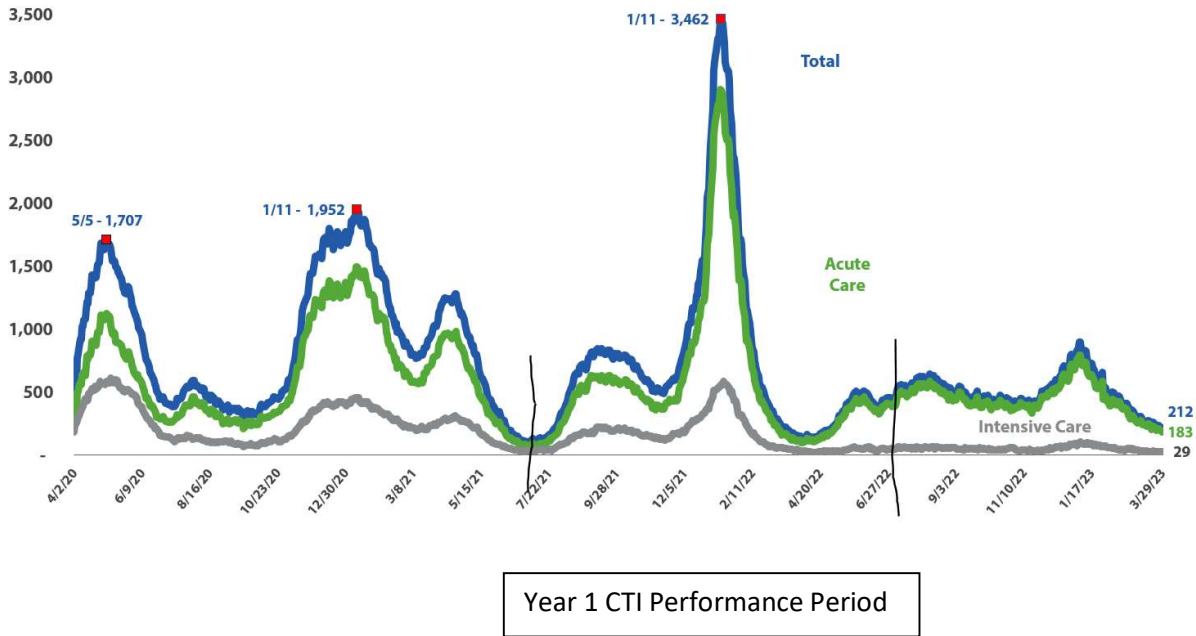
Katie Eckert, CPA
Vice President, Reimbursement and Strategic Analytics
Adventist HealthCare

cc: Adam Kane, Willem Daniel

Enclosures: Appendix, American Institutes for Research Report, TCOC materials



STATEWIDE COVID-19 HOSPITAL INPATIENTS



i. 11/2022 HSCRC TCOC Workgroup

1. “Considerable volatility in TCOC in 2020, 2021, and 2022 makes 2022 analysis over any period complex”
2. “US claims’ utilization has been historically low in 2022 and well under any forecasts (e.g. OACT)”

ii. 8/2022 HSCRC TCOC Workgroup

1. “Both Maryland and National utilization remain very depressed versus pre-pandemic levels”
2. “Both MD and the Nation remain significantly below Pre-pandemic levels. • In 2019 MD was around 80% of the 2013 level utilization, the nation around 90%. • YTD 2022 the nation is below the 70% and MD almost 60%”



David Schwartz
Vice President
Public Policy & Federal Affairs



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

June 21, 2023

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 on Modifications to Efficiency Policies.

Defining Efficiency

The efficiency policies aim to differentiate between hospitals operating efficiently and inefficiently. Hospitals' retention of revenue as volumes have declined has increased charges per case and it is increasingly unclear whether hospitals in this system are cost effective with their operations. It seems the first step in this endeavor should be to define what it means to be efficient and inefficient. The Staff's recommendation scores hospitals based on their cost per case, but also blends that with a measurement of performance on an attributed population's Medicare and Commercial total cost of care (TCOC). The Staff proposes the use of a TCOC measurement that contemplates both attainment of a certain level of TCOC and improvement in that metric over a period.

Cost Per Case Efficiency

While both hospital cost per case and attributed TCOC performance are worthwhile metrics, and may suffice for now, we believe the system would benefit from a greater understanding of hospital cost structures. Right now, the efficiency policy's consideration of hospital cost per case uses an aggregate cost number and does not consider the individual underlying cost categories. Typically, conversations around efficiency contemplate administrative overhead directly. In its current form, a hospital with 15% overhead and a hospital with 30% overhead could score similarly in the cost per case calculation since it uses a total cost figure in the numerator. It is our understanding that in order to contemplate cost categories in the policy, the HSCRC would need to issue more concrete guidance in an enhanced annual filing, so we would support that effort to arrive at a more accurate measurement of efficiency in a future iteration of these policies.

Further, with no required standard approach to cost allocation among hospital inpatient, outpatient, and physician enterprise operations, the overhead and profitability of regulated versus unregulated activity may not be consistently reported from hospital to hospital. This makes comparisons across regulated entities impossible for Staff to assess. In some cases, overhead costs allocated to Maryland hospitals may be shared with and between entities located outside of

Maryland, making their actual results even more opaque to Staff dedicated to overseeing global budgets.

We understand the legacy cost per case comparative efficiency policy used in a global budget environment can present disincentives to volume reduction. Further, we understand that is why Staff is balancing the cost per case metric with TCOC performance metrics. However, we wonder if greater clarity regarding the individual cost categories making up a hospital's structure could create an opportunity to base the efficiency policy on the relative percentages those cost categories make up of each hospital's budget. Suppose a hospital is the most expensive (inefficient) in a cost per case comparison, but at 15% administrative overhead, they rank lowest in the state as they are investing more in population health and quality improvement initiatives. As we seek to unearth which hospitals are truly most efficient, we believe this nuance should be considered.

Attainment and Improvement

Given the information the HSCRC currently has, we believe there is merit to balancing the cost per case efficiency measure with a TCOC measure and we think including both Medicare and Commercial makes good sense. We agree with the Staff's recommendation to use both attainment and improvement criteria, consistent with several other HSCRC policies over the years.

Qualifying Population Health Investment Criteria

We appreciate the Staff bringing back elements of the revenue for reform policy in the qualifying population health investments criteria. We were very supportive of the revenue for reform policy and believe this is only a fraction of what should be incorporated as we mature our model. With over \$600 million of retained revenue in global budgets intended to be reinvested in population health programs, it is the HSCRC's job to appropriately govern that funding on behalf of Marylanders. As such, HSCRC should understand the quantifiable impact of activities on the targeted populations, rather than crediting budget dollars dedicated to activities.

To date, the Model's success has been measured based on a few hospital quality metrics and two main financial metrics. With retained revenues already distributed and growing, we have an opportunity to collect data and incentivize coordinated community investment and programming. Today, without accountability attached to those dollars, we lack visibility into how the money is being invested and any impact it is driving. With greater accountability, we can ensure this large allotment of funding is being appropriately invested in ways that benefit the community and serves all populations, especially those in greatest need. We view the qualifying population health investment buyout from inflationary reductions as an introduction to more significant policy enhancement in this space. Hopefully, this will enable us to begin having more serious conversations about the haves and have-nots, progress on improving health outcomes, and how dollars and resources align with community needs.

Productivity Adjustment

We agree with Staff's proposal to reinstate the productivity adjustment equivalent to the variance between the historical operational efficiency standard of 8% and the statewide regulated margin. This standard is both consistent with historical precedent and reasonable in the context of determining permanent rate enhancements. Over the last four years, roughly a quarter of hospitals would have qualified under these criteria each year. Thus, the 8% baseline does not require an unreasonable level of performance; it is attainable.

Thank you again for the opportunity to comment on the Draft Recommendation on Modifications to Efficiency Policies. We look forward to continued work with the Staff and our industry partners on this important topic.

Sincerely,

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

David Schwartz

June 21, 2023

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

Dear Ms. Wunderlich,

On behalf of Holy Cross Health, we are writing to provide comments on the draft recommendation presented by the staff of the Health Services Cost Review Commission (HSCRC) on the updated Integrated Efficiency Policy. We appreciate the staff's dedication and hard work put into this policy over the past several years and respectfully request consideration of our comments as the policy is reviewed and evaluated.

The draft recommendation as currently proposed by HSCRC would:

- Provide Total Cost of Care (TCOC) Adjustments in the Full Rate Application (FRA) policy based on a hospital's positive performance in attainment and improvement.
- Utilize a revised TCOC assessment for the Integrated Efficiency Policy that considers both attainment and improvement performance.
- Amend a hospital's penalty under the Integrated Efficiency Policy to reflect the amount of eligible qualifying population health investments it makes.
- Reinstate a productivity adjustment in the Inter-hospital Comparison (ICC) equivalent to the variance between the historical operational efficiency standard of 8 percent and the statewide regulated margin for ICC evaluated hospitals.
- For Rate Year (RY) 2024 only, all efficiency adjustments will be processed as one-time adjustments, i.e., the adjustments will be reversed out in RY 2025 and will be replaced with permanent adjustments based off of RY 2023 volumes and Calendar Year (CY) 2022 TCOC performance. This adjustment is recommended because there are continued challenges with the underlying data needed to make the RY 2024 evaluation.

Holy Cross Health's concerns fall into two categories – policy and technical. From a policy perspective, Holy Cross health is deeply concerned with the proposed changes to the Full Rate Application process, including making changes to the ICC that have a one-time impact for RY 2024 but then have the potential to be reconsidered in RY 2025. This is essentially the equivalent of a moratorium extension on full rate applications and is in direct contradiction to the Commission and Staff's communicated position when we filed a request for temporary rate relief for Holy Cross Germantown Hospital. At the March 20, 2023 Commission meeting, we were assured our Full Rate Application would be expedited

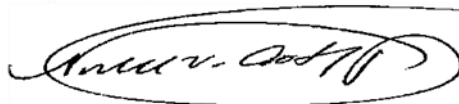
once the moratorium was lifted on July 1, 2023. The Full Rate Application moratorium was approved to address temporary concerns related to COVID which also impacted multiple HSCRC policies. With the moratorium expiring and the HSCRC resuming all normal adjustments, including quality adjustments based on results likely impacted by COVID, the Full Rate Application policy requires full restoration as occurring with the other policies.

In addition, the staff raises concerns about data issues for case weights, deregulation adjustments, and demographic adjustments, but does not acknowledge that these data concerns are based on policy decisions and have not been equitably applied across policies. The concerns related to COVID volume stability and TCOC metrics are being applied to the Integrated Efficiency Policy but HSCRC staff have made other permanent rate adjustments (market shift adjustments and demographic adjustments) with these same data. For example, the HSCRC has continued to use TCOC for the Medicare Performance Adjustment (MPA) and Care Transformation Initiatives (CTI) adjustments.

Holy Cross Health is also concerned with the staff recommendation to reinstitute a 1.5% productivity adjustment and linking it to erosion in hospital regulated profit levels. This is inconsistent with the previous position of the Commission in January 2021 where productivity adjustment was suspended until the staff could develop an “allowed unregulated subsidy” to account for population health investment including physician costs. The proposed policy also assumes that the erosion in hospital margins is due to operational inefficiencies. The majority of margin erosion across the State has been caused by a multi-year underfunding of inflation and unprecedented labor pressures driven by nursing and other staff shortages. The proposed productivity adjustment is not a measurement of operational efficiency but simply a tool to make qualification for rate relief more difficult.

Holy Cross Health continually strives to be an efficient provider of high-quality care to the communities that we are privileged to serve. Although we are overall supportive of a policy to drive efficient operations, we remain concerned with certain provisions in the draft staff recommendation. We would encourage the Commission to honor previous commitments that allow for the full rate application process to resume on July 1, 2023 without modification.

Sincerely,



Norvell V. Coots, M.D.
President and Chief Executive Officer



Anne D. Gillis
Chief Financial Officer

Ed Beranek
Vice President of Revenue Management
and Reimbursement
3910 Keswick Road
South Building / 4th Floor
Suite S-4200D
Baltimore, MD 21211
443-997-0631/FAX 443-997-0622
Jberane1@jhmi.edu



June 21, 2023

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

Dear Chairman Kane:

On behalf of the Johns Hopkins Health System (JHHS), representing our 4 Maryland hospitals, we appreciate the opportunity to comment on the commission's Draft Recommendation on Modifications to Efficiency Policies: Full Rate Application, Integrated Efficiency Methodology, and Capital Financing. First, we would like to thank staff for continuing to consider feedback from the industry in the revisions to HSCRC policies. 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 supports 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.

Policy Goals and Objectives, and Methodology Application

Historically, HSCRC efficiency policies have been used to identify outliers in the system and provide a way for those outliers to be brought back towards the statewide average via rate actions. JHHS believes that the current proposal of utilizing the quartile ranking continues to support this concept, which we believe is appropriate.

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.

Application of Efficiency Adjustment on a One-Time Basis

JHHS agrees with staff's concern regarding volume volatility using the COVID data period. Using this data period in methodologies that make permanent changes to hospital GBRs could be problematic. Applying the results on a one-time basis helps to lessen the potential permanent impact of using that data period. We would not want a policy in place that artificially reward or penalizes hospitals for a very disruptive data period.

Application of a Productivity Offset

JHHS understands the historical reasons for applying a productivity offset prior to the CY 2014 implementation of the Global Budget Revenue (GBR) methodology, however, it is not clear if such an adjustment is still valid under a fixed revenue model. When the productivity adjustment was suspended in the full rate application methodology, it was noted that the purpose of the suspension was to incorporate adjustments to regulated profits for both physician and population health expenditures. Since there have not been any adjustments made for these components, we believe that the productivity adjustment should continue to be suspended until those other adjustments can be made.

Inclusion of both attainment and improvement for both Full Rate Applications and Integrated Efficiency Policy

JHHS supports the staff's proposal to move to a TCOC measure that considers both attainment and improvement. In the Integrated Efficiency Policy, it is important to assure that funds are not taken from hospitals who have a high TCOC but have driven it down over time as they are moving in the right direction to achieve the goals of the TCOC system. We do have concerns in the Full Rate Application Methodology, that hospitals that have some of the lowest TCOC in the state still must reduce their TCOC faster than the statewide average improvement. We believe that staff should consider a modification to that methodology to allow for some lower threshold for hospitals with the lowest TCOC in the state.

Revenue for Reform Credit

JHHS supports the staff recommendation to allow for an offset to any inflation withhold for qualifying population health investments. We believe that a core principle of the TCOC system was for hospitals to reinvest GBR saving back into population health programs. However, we do believe that there should be some limit to how much of the dollars identified through the Efficiency Policy can be offset.

Additionally, the policy as drafted does not address retained revenue that has accumulated since the inception of GBR. The Regional Entity Safe Harbor should be explored as an opportunity to redirect retained revenue that should but have not been invested in population health programs. Accumulated retained revenue within a geographical region could support the launch and operations of a Regional Entity that addresses the social and medical needs of multi-visit patients within a region.

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

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

June 21, 2023

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

Dear Chairman Kane:

On behalf of MedStar Franklin Square Hospital, MedStar Good Samaritan Hospital, MedStar Harbor Hospital, MedStar Montgomery Medical Center, MedStar St. Mary's Hospital, MedStar Southern Maryland Hospital, and MedStar Union Memorial Hospital, we thank you for this opportunity to comment on the HSCRC's draft recommendation on Modifications to the Efficiency Policies.

Recognizing this policy is necessary to facilitate lifting the moratorium on Full Rate Applications on July 1, 2023, Medstar Health and its member hospitals generally support the HSCRC's draft recommendation. However, we offer the following comments on two of the specifics included within the recommendation.

One-Time Adjustments for FY2024

Given the financial pressures hospitals are experiencing, we appreciate the HSCRC Staff's proposal to allow hospitals eligible for a rate enhancement to access those funds through a streamlined process for Rate Year 2024. We also understand that once the moratorium on full rate applications is lifted, hospitals will be entitled to permanent rate relief through a full rate application process. We therefore believe preserving both options for Maryland hospitals during this period of time provides hospitals support during this challenging financial period and flexibility by allowing each organization to choose the approach that best meets their needs.

Productivity Adjustment

While we understand the thought process around the productivity adjustment as a way to require a certain level of "efficiency" in hospitals, we do not believe the productivity adjustment in its current form is appropriate for implementation in FY2024.

The productivity adjustment was suspended in FY2021 for good reasons. At that time, the suspension was put in place to account for investments made related to TCOC. Prior to that, the adjustment was considered temporary until a better understanding of physician expenses could inform the validity of the adjustment. Since that time, the policy has been updated to incorporate TCOC measures; however, there have been no updates related to physician expenses. The HSCRC does intend to better understand physician expenses; however, data related to physicians will not be captured until hospitals file the FY2024 Annual Filings, which is more than a year away.

We believe the reasons behind the suspension of the productivity adjustment in FY2021 were valid and are still applicable today. Therefore, we believe the implementation of the productivity adjustment for FY2024 is

unwarranted. We recommend the adjustment be evaluated during FY24 as part of the review & evolution of the entire Efficiency Policy, to ensure its future implementation is effective in achieving its intended goals.

We look forward to partnering with the HSCRC throughout the coming year to further enhance and evolve the Efficiency Policy.

Thank you for the opportunity to comment and please reach out should you have any questions.

Sincerely,

A handwritten signature in blue ink that reads "Susan K. Nelson". The signature is fluid and cursive, with the first name "Susan" being the most prominent part.

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

cc: Katie Wunderlich, Executive Director
Joseph Antos, PhD
Maulik Joshi, DrPH
Ricardo Johnson

Victoria W. Bayless
James Elliott, M.D.
Sam Malhotra



*A University
Affiliated
Center
Conducted
by the
Sisters
of Mercy*

June 20, 2023

Mr. Allan Pack
Principal Deputy Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Thank you for the continued effort to improve the efficiency methodology. Mercy understands, appreciates, and supports the objectives of rewarding efficient hospitals while increasing Total Cost of Care (TCOC) accountability at the hospital level. The proposed policy provides a comprehensive, reasonable approach to full rate applications and efficiency measurement.

There are several notable changes included in the proposed methodology that Mercy supports, including adding better of attainment vs. improvement, offering revenue for reform buyout options, and keeping any adjustments as one-time monies until the full COVID impact is flushed out.

In the spirit of continual policy improvement and ensuring equitable treatment across hospitals, **below are two suggested modifications** to the proposed methodology:

1. **PAU Adjusted Volumes** – Mercy understands the intent behind adjusting ICC volumes for PAU reductions under GBR, protecting hospitals who reduced PAU consistent with stated policy incentives. However, the adjustment as applied has an unintended consequence of negatively affecting hospitals with lower PAU reductions, even if they are already high performers in terms of PAU as a percentage of total volume. (Mercy has the lowest PAU percentage for any acute care hospital in the state, and the efficiency rank erodes due to PAU adjustments to volumes for other hospitals.) While Mercy agrees with the policy intention to give hospitals credit for PAU reductions in its efficiency assessment, Mercy believes that the execution should not adversely impact high performing hospitals for overall PAU attainment. There are two potential solutions to achieve this balance: a) incorporate a “better of attainment or improvement” logic in the PAU volume adjustment to align with the majority of other adjustments or b) treat the PAU credit as a protection or buy-down similar to the revenue for reform methodologies, rather than a direct adjustment to volume.

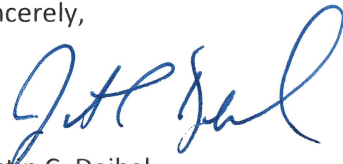


2. **Numeric ranking** – The summation of a straight numeric ranking for the three components of the efficiency methodology (ICC, Medicare TCOC, and Commercial TCOC) has the potential of over or under valuing small variances in performance. Mercy suggests a proportional ranking based on relative variance from best to worst.

Mercy also recognizes creating a uniform policy for 40+ hospitals inevitably poses challenges related to general fairness or treatment of outlier hospitals. Geographic attribution of TCOC accountability provides clear incentives for hospitals to affect the communities we serve, but in rare circumstances, the hospital's ability to impact performance data is outweighed by fractional market share in the primary service area. Mercy will continue to work with HSCRC staff to identify effective ways to measure and improve the care in the community around the hospital.

Thank you again for your dedication to improving the methodologies governing hospitals' rates.

Sincerely,



Justin C. Deibel
Executive Vice President & CFO

cc William Henderson
Willem Daniel
David Maine, M.D.
Elinor Petrocelli





Maryland
Hospital Association

June 21, 2023

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

Dear Chair Kane:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on the draft rate year (RY) 2024 Integrated Efficiency Policy recommendation, including other planned Health Services Cost Review Commission (HSCRC) analyses. Hospitals must be able to seek permanent rate relief from HSCRC, and the efficiency policy is important to lift the full rate application moratorium in RY 2024. Consistent with MHA's work group comments, HSCRC should assess all policies, including the efficiency policy, relative to our system's aims to create a more predictable and stable policy environment.

Lifting the Full Rate Application Moratorium to Provide Permanent Rate Relief

We understand HSCRC staff's reasoning for proposing full rate application settlements as one-time adjustments, yet we are concerned about the impact on future policy making. Hospitals eligible for permanent rate relief may be reluctant to make permanent decisions, like raising nursing wages, if ongoing dollars are not guaranteed. At the same time, hospitals should be free to use HSCRC's proposed approach to receive one-time funding, with a 2025 settle-up, provided they may still seek permanent rate relief.

HSCRC's full or permanent rate application moratorium ends July 1. After then HSCRC cannot prevent hospitals from seeking permanent rate relief through a full rate application. If HSCRC wants to delay permanent rate adjustments because volumes are not stable, then it must follow its rule making process and propose to extend the moratorium via regulation, which MHA does not support.

HSCRC also set aside 0.40% in the Annual Update Factor to settle full rate applications. This set aside was applied instead of potentially funding permanent inflation, increasing other amounts, or creating system savings—implying the monies ultimately will be permanent.

The proposal to apply full rate applications as one-time adjustments is inconsistent with the policy and other HSCRC rate adjustments. HSCRC staff cite falling profitability as the basis to permanently reestablish a productivity adjustment. Yet falling profitability occurred during the same period HSCRC cites as a concern. A portion of this period will affect permanent market

shift adjustments. While Medicare Performance Adjustment (MPA) and Care Transformation Initiatives (CTI) are not permanent revenue base adjustments, the same data were used to adjust annual hospital revenues.

The efficiency policy may be revised in 2024, changing any settle-up beyond volume alone. Traditionally, HSCRC has not retrospectively applied changes to its methodologies to settle full rate applications. The Commission should maintain the practice of setting policies prospectively, unless errors are identified, as in the case of the demographic adjustment.

The Productivity Adjustment Should Not be Reinstated

From HSCRC staff's 2021 recommendation, the productivity adjustment was suspended to account for Total Cost of Care (TCOC) Model (Model) investments outside of regulated hospital business. Prior to suspension, HSCRC staff recommended using the productivity adjustment as a *temporary measure* until additional reporting could provide a better understanding of physician costs intrinsic to the operations of acute care facilities and population health investments. HSCRC plans to recognize certain population health investments in the buyout provision, and HSCRC staff plan to revise the RY 2024 annual filings to better understand physician costs. Reinstating the productivity adjustment has the unintended consequence of requiring already efficient hospitals to become *even more efficient* to fund these costs.

At the April 12 HSCRC public meeting, commissioners directed staff to evaluate a measure for operational efficiency. The proposed approach is based on historical operating margins and a blanket 2% adjustment. It does not address the intent of commissioners' request to ensure both cost and price efficiency are evaluated as utilization declines.

The proposed measure does not account for reasonable margins in a global budget revenue (GBR) system. Hospital margins have eroded compared to pre-pandemic years. Regulated expenses rose during this period, primarily driven by agency costs and permanent salary adjustments. Whereas pre-COVID operating margins were offset by unregulated costs, erosion has occurred in all margins (see appendix). The data also shows that all other hospital costs declined despite inflation, showing *improved cost efficiency*.

Any further consideration of operational and administrative efficiency should occur only after a financial conditions assessment, understanding Maryland's position relative to the nation. If a measure is adopted, it should be well studied, as there is no rationale for the historical 2% adjustment.

With Proper Evaluation, Adopt a New Total Cost of Care Measurement Approach

HSCRC staff's recommendation to move to a Medicare Performance Adjustment (MPA)-like approach for both Medicare and commercial TCOC performance is appropriate, as there are concerns about the existing benchmarking methodology and national peer group comparisons. However, certain concerns about the MPA remain, including:

- Overlapping TCOC risk across HSCRC payment policies
- MPA's geographic attribution, which fails to recognize hospital efforts to manage TCOC

Although no methodology is perfect, the previous physician-linked methodology better captures hospital care transformation. The MPA approach for Medicare—in place since 2021—is more vetted. The commercial analog approach is only based on a 2018-2019 data period and is untested. For this reason, MHA supports a phased-in approach.

Implement Full Rate Application Algorithm, but Allow Population Health Investments

We support the revised algorithm for full rate application rewards and penalties, as it recognizes both total cost of care performance and improvement. We suggest modifying the full rate application to include population health investments as phase II adjustments. If HSCRC staff apply the logic for inefficient hospital “buy out,” then applications should follow suit. For example, an inefficient hospital making primary care investments in a medically underserved or health professional shortage area would have the costs considered in their revenue base. Such investments would not be recognized for efficient hospitals, creating inequities across policies.

Expand Revenue for Reform Spending for Community Needs and Behavioral Health

We appreciate staff broadening the physician spending category to align with primary care specialties and provider types included in the Maryland Primary Care Program. At the April 18 HSCRC Efficiency Work Group meeting, staff stated they would recommend broadening the community needs spending category to include costs that are recorded in the hospital but are community facing, like care navigation costs beyond traditional discharge planning. We suggest making this explicit in the final recommendation. We also recommend adding spending on behavioral health, which is a key concern of the Maryland Department of Health.

Long-Term Policy Considerations

MHA applauds the Commission for reviewing the policy in an iterative manner and looks forward to participating in the long-term work group, anticipated to begin in summer 2023. Based on field input, MHA suggests HSCRC:

- Address overlap of TCOC risk among HSCRC payment policies
- Review hospital-based physician costs
- Re-evaluate peer group comparisons
- Explore alternatives to the disproportionate share hospital (DSH) adjustment
- Determine if using equivalent case mix adjusted discharges to calculate permanent revenue in the Inter-hospital Cost Comparison is appropriate in a population-based payment system

We appreciate HSCRC's commitment to refining the policy and look forward to future engagement. If you have any questions about the recommendations outlined in this letter, please do not hesitate to contact me.

Sincerely,

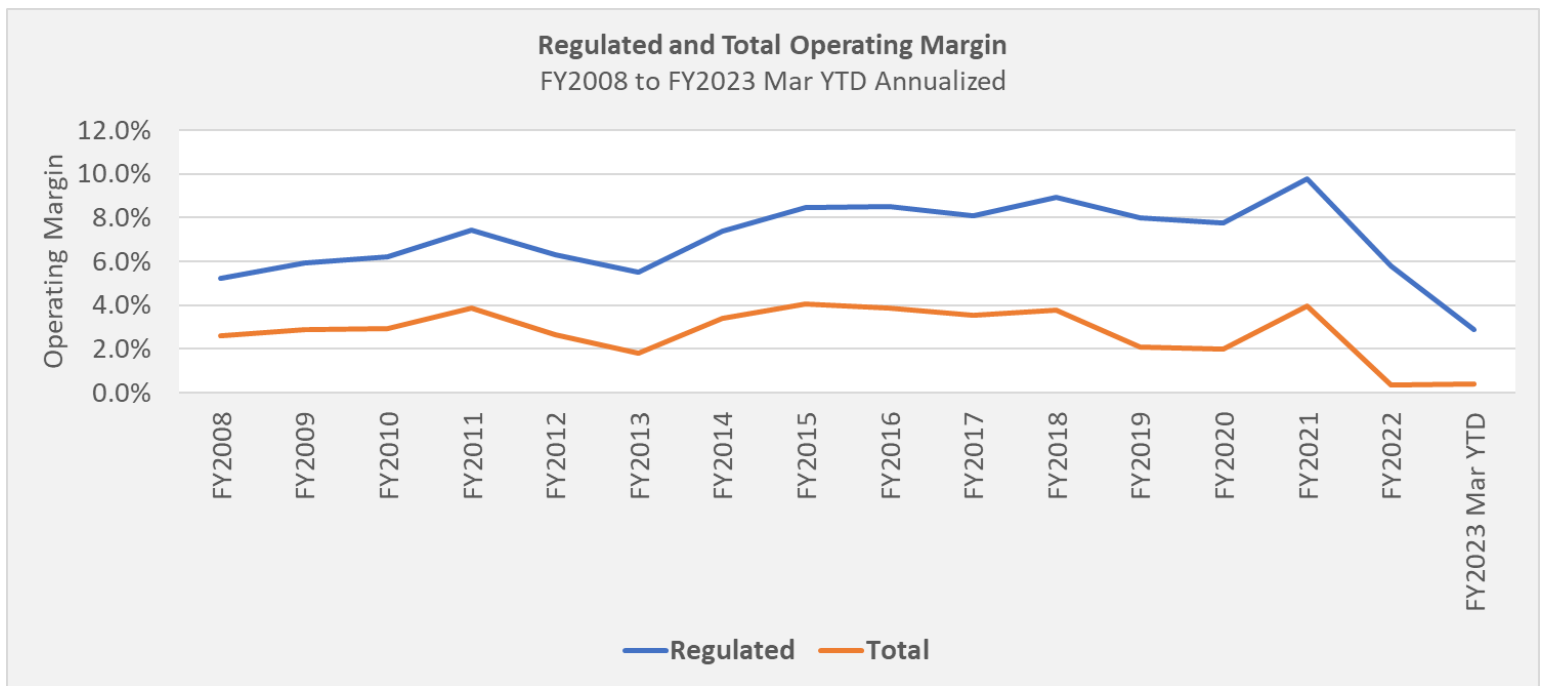


Brett McCone
Senior Vice President, Health Care Payment

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

Katie Wunderlich, Executive Director
Allan Pack, Principal Deputy Director
Jerry Schmith, Principal Deputy Director
William Henderson, Principal Deputy Director

Appendix I – Operating Margin Trends



Unregulated Subsidy (as Percent of Total Net Operating Revenue)	
FY2008-FY2013	-2.9%
FY2014-FY2017	-3.8%
FY2018-FY2022	-4.7%

June 21, 2023

O 410-543-7111
F 410-543-7102

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

Dear Ms. Wunderlich,

Thank you for the opportunity to comment on the draft recommendation by the staff of the Health Services Cost Review Commission (HSCRC or Commission) on the updated Efficiency Policies. TidalHealth appreciates the work of the staff and the ability of the industry to provide constructive feedback as part of the process.

As proposed by HSCRC, the draft recommendation would:

- Provide Total Cost of Care (TCOC) Adjustments in the Full Rate Application (FRA) policy based on a hospital's positive performance in attainment and improvement.
- Utilize a revised TCOC assessment for the Integrated Efficiency Policy that considers both attainment and improvement performance.
- Amend a hospital's penalty under the Integrated Efficiency Policy to reflect the amount of eligible qualifying population health investments it makes.
- Reinstate a productivity adjustment in the Inter-hospital Comparison (ICC) equivalent to the variance between the historical operational efficiency standard of 8 percent and the statewide regulated margin for ICC evaluated hospitals.
- For Rate Year (RY) 2024 only, all efficiency adjustments will be processed as one-time adjustments, i.e., the adjustments will be reversed out in RY 2025 and will be replaced with permanent adjustments based off of RY 2023 volumes and Calendar Year (CY) 2022 TCOC performance. This adjustment is recommended because there are continued challenges with the underlying data needed to make the RY 2024 evaluation.

TidalHealth has concerns with certain aspects of the proposed updates/staff recommendations, which we believe represents a significant departure from standard Commission practice. Our comments, in particular, focus on the last two bullet points raised above.

The proposed treatment of RY2024 rate relief represents an extraordinary change to the system used by the Commission in the past. To make changes to the ICC that have a one-time impact for RY 2024 only and are then open for reconsideration in RY 2025 can be argued to be a *de facto* extension of the moratorium on full rate reviews. The staff, however, has already encouraged hospitals with revenue issues (in either public meetings requesting temporary rates or in private meetings with hospital administrators and stakeholders) that hospitals seeking relief could avail themselves of the full rate review as the HSCRC's process for requesting a rate adjustment once the moratorium was lifted on July, 1, 2023. This recommendation would change the rules and deny hospitals the opportunity to resolve persistent issues with their current rate structure. It would essentially

turn full rate requests into temporary rate requests, subject to an undefined review the year after the rate relief was granted.

The staff cite data issues as a chief concern around the implementation of the ICC and Integrated Efficiency Policy, yet do not acknowledge that several of those issues – case weights, deregulation adjustments, and demographic adjustments – are based on policy decisions made by the Commission.

- When the Commission updated case weights in March 2023 to reflect the impact of an updated APR-DRG grouper version, it elected to use a pre-COVID volume period (CY2019) in lieu of a more current time period (CY2022).
- Hospitals are required to notify the HSCRC of changes in service offerings or when services are shifted to or from a hospital-based setting. The policy statement by the staff assumes that hospitals have not been compliant with HSCRC requirements or that staff have not made adjustments for disclosed shifts of services. The breadth of this issue has not been quantified, yet the staff recommendation seeks to further delay rate relief for low-cost hospitals based on an unknown potential impact.
- The Staff was also concerned about the impact of the Demographic Adjustment catch-up; however the Commission voted to restore the demographic adjustment and therefore these amounts can be reflected in the updated ICC calculation.

The Staff also cites concerns related to COVID volume stability and TCOC metrics applying to the Integrated Efficiency Policy when HSCRC staff have made other permanent rate adjustments (market shift adjustments and demographic adjustments) with these data.

- The price efficiency in the ICC is based on permanent revenue, which is then further adjusted to either reward or penalize hospitals for TCOC performance. The results of the FRA methodology are primarily driven by price efficiency, which is based on hospital approved permanent GBR; therefore, the results of the FRA should be permanent as well. (Of the 10 hospitals that qualify for rate relief, two receive an additional reward and one hospital is penalized due to TCOC performance.)
- The HSCRC has also continued to use TCOC for the Medicare Performance Adjustment (MPA) Care Transformation Initiatives (CTI) adjustments. Staff commented at the last TCOC workgroup meeting that COVID was not a driver of the CTI results based on their analysis.

The Integrated Efficiency is updated on an annual basis and therefore serves as a guardrail for the HSCRC to address individual hospital rate structures. A hospital's position in the Integrated Efficiency calculation has never been static, yet hospitals are supposed to be able to seek permanent rate relief or be subject to permanent rate reductions based on the results in any given year. The FRA moratorium was approved to address temporary concerns related to COVID that impacted multiple HSCRC policies. Now that the moratorium will expire on July 1st and the HSCRC has resumed all normal adjustments, the FRA policy needs to be restored as well to do what it is supposed to do – address individual hospital rate structures on a permanent basis. Resolution of revenue issues is, in particular, imperative for hospitals facing credit downgrades or violation of bond covenants, and one year of temporary relief is far from a permanent solution.

While not clear in the draft policy itself, Staff did suggest in the June meeting that the adjustment would only be one-time in nature if a hospital elected to use a yet to-be-determined "streamlined process" for accessing the value established by the FRA policy's methodology. In other words, a hospital could file a FRA and go through the normal process to obtain permanent relief. However, Staff implied that if a hospital was successful in obtaining permanent revenue through such a process (even if that took months to

complete), that Staff would simply recommend that the Commission open a rate review on the hospital in RY2025 to claw the money back if the updated methodology yields a different result, even if the hospital is efficient and even if the Commission declined to open rate reviews on inefficient hospitals. We believe that opening such a subsequent rate review would unfairly impede a hospital's attempt to do what it is legally entitled to do – that is, use the FRA process to resolve persistent issues with its rate structure on a permanent basis. We urge this Commission to reject Staff's proposal regarding the one-time nature of the FRA adjustments for RY2024. If the Commission declines to do so, then we respectfully request that the Commission clarify that hospitals may avail themselves of the regular FRA process to obtain a permanent adjustment in RY2024 without the threat of an immediate rate review proceeding in FY2025.

We also want to briefly comment on the reintroduction of a productivity adjustment. **In its most recent revision to the ICC methodology in January 2021, the staff recommended that the new efficiency standard not include a 2% productivity adjustment to recognize, at least until additional reporting could allow quantification, physician costs intrinsic to the operation of acute health care facilities and population health investments.** This was done in light of the investments and associated responsibilities that hospitals have under the TCOC model. The current staff recommendation, which reintroduces a productivity adjustment tied to regulated profit levels, is inconsistent with the previous position of the Commission. It also assumes that the erosion in hospital margins is due to operational inefficiencies, which is inaccurate. Hospitals in Maryland have been underfunded for inflation and have experienced unprecedented labor pressures driven by nursing and clinical staff shortages. The proposed productivity adjustment is not a measure of operational efficiency but simply a tool to make qualification for rate relief more difficult.

TidalHealth supports the concept of an Integrated Efficiency Policy, rewarding price efficient hospitals and providing financial incentives and penalties to drive accountability, particularly under the Global Budget Revenue model. As summarized above, however, we have concerns with certain aspects of the staff recommendation as currently proposed, which fundamentally limits a hospital's ability to seek permanent rate relief through the FRA process. FRAs have been an essential aspect of the rate setting process for hospitals to address their rate base. TidalHealth strongly urges that the Commission follow historical precedent and not change the nature of FRAs, especially in light of the dire financial challenges that hospitals continue to face.

Sincerely,



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



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

CORPORATE OFFICE

June 21, 2023

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

Re: Draft Recommendation on Modifications to Efficiency Policies

Dear Chairman Kane,

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

We support the Staff's proposal to further refine 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.

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 appropriateness of the Total Cost of Care (TCOC) measure and its application in the full rate application policy, allowing offsets to recognize investments in population health activities and recognition of continued disruption in hospital volume associated with the COVID pandemic.

UMMS would like to address the following areas of the Draft Recommendation on Modifications to Efficiency Policies:

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

Modification of the TCOC assessment to include both attainment and improvement for both Full Rate Applications and Integrated Efficiency Policy

UMMS supports the staff's proposal to move to a TCOC measure includes both attainment and improvement. This is a necessary step to recognize improvements made by hospitals who have historically been penalized for higher levels of total cost of care. Recognizing positive strides made by these hospitals is important to ensuring that funds are not taken from hospitals which need to continually invest in population health. Additionally, the shift to the better of improvement or attainment further aligns incentives in both financial and quality policies and creates consistency in their application.

Inclusion of a Population Health Investment Offset

UMMS supports the staff's proposal to include a provision to offset any inflation withhold with qualifying population health investments. The Integrated Efficiency policy currently recognizes regulated costs and profit, while many investments in population health occur outside the regulated facility and continue to go unrecognized. Many of the hospitals identified as inefficient are small rural or urban hospitals. These hospitals require some of the higher levels of population investment to ensure greater reductions or slower growth rates in total cost of care. By providing these facilities with an opportunity to retain revenue, the offset option allows hospitals to keep revenue where it is needed most and re-invest in activities that would directly benefit the health of the population instead of having that revenue go to system savings which does not help patients.

Setting Operational Efficiency Standard to 8% in Full Rate Applications

UMMS disagrees with the staff's proposal to include a productivity adjustment that would establish the operational efficiency for hospitals standard to be 8%. This standard was based upon historical data prior to the inception of a fixed revenue system. Fixed Revenue systems have not yet been thoroughly studied and as discussed in the Update Factor recommendation, a full financial condition study has not been completed since prior to the new model. It is unclear whether or not the historical profit and productivity standards are applicable in such a system. Furthermore, when suspending the productivity adjustment in the full rate application, it was noted that the purpose of the pause was to incorporate adjustments to regulated profits for both physician and population health expenditures. The staff recommendation as written does not include any adjustments for these items and until these adjustments are developed, the productivity adjustment is arbitrary and inaccurate. UMMS therefore believes that the productivity adjustment should remain paused until such time as these adjustments are incorporated into the full rate application policy.

Application of RY 2024 Efficiency Adjustments on a one-time basis

UMMS agrees with the staff's concerns regarding volume volatility and the impact of the Omicron surge on the stability of the data used in the application of permanent rate adjustments. UMMS is particularly concerned with both the FY2022 volume period used in the ICC (which includes the impact of Omicron) as well as the CY2021 period included in TCOC metrics (CY2021 was significantly impacted by COVID and has been excluded from most methodologies). It is clear from the significant swings in results year-to-year that these measurement periods are volatile. Additionally, the change to using CY 2021 in the TCOC metrics has caused significant swings to some hospitals' results, and UMMS is concerned that the implications of this change needs to be further evaluated and better understood. While UMMS has concerns about using these periods at all to make rate adjustments, applying the Efficiency and Full Rate Application results on a

Adam Kane, Esq.
June 21, 2023
Page 3

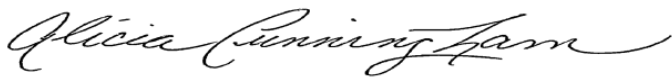
one-time basis is a thoughtful step to protect hospitals from being permanently impacted by temporary circumstances and disruptions. UMMS also agrees with the implementation of a streamlined approach for hospitals to access rate enhancements. As discussed, the proposed process allows the timeline and the cost of accessing these funds to be reduced considerably. However, UMMS believes that there should still be a pathway to permanent rate increases should individual hospitals believe that they are necessary and reasonable.

Additional Consideration

In addition to our thoughts about the aforementioned components of the efficiency policy recommendation, UMMS believes that there should be further evaluation done in FY 2024 around the disproportionate negative impact the current policy results are having on rural and safety net hospitals. More specifically, UMMS is requesting the HSCRC complete another evaluation of the DSH adjustment as well as other components of the methodology such as the resident cap.

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: Joseph Antos, PhD, Vice Chairman
Nikki McCann
Ricardo Johnson
Maulik Joshi, DrPH
James N. Elliott, MD
Joshua Sharfstein, MD

Allan Pack, Principal Deputy 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



maryland
health services
cost review commission

Regional Partnership Catalyst Program

Calendar Year 2022 Activities – Final Report

July 2023

Table of Contents

Introduction	1
Overview	1
Diabetes Prevention and Management Programs	2
Behavioral Health Crisis Programs	2
Summary of Awards	3
Year Two Diabetes Prevention and Management Activities	5
DPP Referral, Enrollment, and Retention Strategies	5
DPP Cohorts	6
DSMT/ES Expansion Strategies	7
Physician & Provider Engagement (DPP & DSMT/ES)	8
Impact Measures	8
DPP Referrals	8
DSMT/ES Participation	11
Billing & Sustainability (DPP & DSMT/ES)	12
Wraparound Services (DPP & DSMT/ES)	13
Diabetes Community Partner Collaboration (DPP & DSMT/ES)	14
Year Two Behavioral Health Crisis Services Activities	15
Crisis Center Activities and Progress	15
Care Traffic Control Activities and Progress	15
Mobile Crisis Team Activities and Progress	16
Behavioral Health Sustainability	17
Behavioral Health Community Partner Engagement	17
Catalyst Program Budget and Expenditures Summary	18
Catalyst Program Health Equity Efforts	20
Conclusion	21

Introduction

The Health Services Cost Review Commission (HSCRC) created the Regional Partnership Catalyst Program (Catalyst Program) to advance the population health and health equity goals of the Total Cost of Care (TCOC) Model and to encourage and support public-private partnerships that can create sustainable initiatives to improve the health of Marylanders. The Catalyst Program funds hospital-led teams to advance two population health priority areas that are part of the Statewide Integrated Health Improvement Strategy (SIHIS): (1) diabetes prevention and management and (2) behavioral health crisis services. Teams include neighboring hospitals and community organizations such as local health departments (LHDs), local behavioral health authorities (LBHAs), non-profit and social service organizations, and provider groups to develop and implement interventions. Goals of the Catalyst Program include:

- Partnerships and strategies that result in long-term improvement in the population health metrics of the TCOC Model;
- Increased number of prevention and management services for persons at risk for or living with diabetes;
- Reduced use of hospital emergency departments (EDs) for behavioral health and improved approaches for managing acute behavioral health needs;
- Integration and coordination of physical and behavioral health services to improve quality of care; and
- Engagement and integration of community resources into the transforming healthcare system.

The Catalyst Programs are also an important tool to advance goals of health equity for Marylanders. Provision of wraparound services to address social determinants of health (SDOH) is core to Regional Partnership programming. Regional Partnerships deploy community health workers (CHWs), patient navigators, care managers, and others to screen participants for SDOH needs and connect participants to resources. Regional Partnerships recognize that addressing SDOH and treating the whole patient is crucial to preventing diabetes or helping diabetic patients manage their disease. Additionally, Regional Partnerships are intentional in the selection of community-based partners to reflect the culture, language, and demographics of target populations to customize marketing materials and outreach strategies to engage patients. These activities are critical to address long-standing health disparities in the State and have been highlighted and promoted by the Regional Partnership programs.

For the period January 2021 through December 2025, the HSCRC has awarded \$157.6 million in cumulative funding through nine awards to eight Regional Partnerships.¹ The five-year cycle creates time to

¹ One Regional Partnership ended its participation in CY 2022.

build partnerships and infrastructure prior to implementing interventions. This report summarizes the activities in the second year of the five year cycle, CY 2022. As described in the enclosed report, Regional Partnerships have made significant progress in expanding service delivery in CY 2022 to stand up new programs across a large set of partners and different healthcare delivery systems. Although challenges continue to exist to recruit and maintain staff, navigate changing federal and state requirements, successfully implement billing and service reimbursement, and respond to the intensifying behavioral health needs of Marylanders, the Regional Partnerships cite an ongoing commitment to find creative solutions in order to improve health outcomes for participants in the respective programs. Importantly, Regional Partnerships will continue to promote provider awareness and build relationships with commercial insurers and Medicaid MCOs.

Overview

The Catalyst Program builds on the HSCRC's Regional Partnership Transformation Grant Program, launched in 2015 to reduce potentially avoidable utilization and per capita costs and demonstrate a positive return on investment through increased Medicare savings. The Regional Partnership Transformation Grant Program funded fourteen hospital-led partnerships, involving 41 of Maryland's acute care hospitals. Interventions were diverse, spanning behavioral health integration, care transitions, home-based care, mobile health, and patient engagement/education strategies focused on high-need and high-risk Medicare patients.

Subsequent to the Regional Partnership Transformation Grant Program's expiration in June 2020, the HSCRC established the Catalyst Program to enable hospital-led partnerships to continue to build infrastructure in support of the population health goals of the TCOC Model and SIHIS in a more focused manner. The Catalyst Program made awards under two funding streams: (1) diabetes prevention and management and (2) behavioral health crisis services. The Catalyst Program is based on the HSCRC philosophy of fostering collaboration among hospitals and community partners while creating infrastructure to disseminate evidence-based interventions.

Diabetes Prevention and Management Programs

Maryland needs significantly more diabetes prevention and management resources for the State's pre-diabetic population. The diabetes prevention and management funding stream supports Regional Partnerships implementing the Centers for Disease Prevention & Control (CDC) recommended Diabetes Prevention Program (DPP). DPP has shown long-term success in helping to prevent the onset of diabetes and promote weight-loss for those with pre-diabetes.

This funding stream also supports implementation of Diabetes Self-Management Training (DSMT) and Diabetes Self-Management Education and Support (DSMES). DSMT/ES provides lifestyle change help and

diabetes management curriculum to patients to help better control their Type II diabetes. Regional Partnerships under the Catalyst Program were required to achieve American Diabetes Association (ADA) or American Association of Diabetes Education (AADE) accreditation for their respective DSMT and DSMES programs, or partner with an accredited program.

Funding is available for wraparound services to bolster the impact of DPP and DSMT/ES. For example, Medical Nutrition Therapy (MNT) could be provided as a wraparound service for patients participating in DSMT/ES. It is provided by registered dietitians as an intensive, focused, and comprehensive nutrition therapy service. MNT delivered concurrently with DSMT/ES has been shown to increase the ability of patients to manage their diabetes. Additional wraparound services to support patient success in DPP and DSMT/ES include healthy food access, exercise programs, and transportation services to in-person classes.

DPP and DSMT/ES offer Regional Partnerships a pathway to sustainability via Medicare, Medicaid and/or commercial payer reimbursement. However, Medicare billing requires suppliers to make substantial investments in certification, training, and administration. Catalyst Program funding helps build this infrastructure by supporting start-up costs, including recruitment, training, and certification.

Behavioral Health Crisis Programs

The TCOC Model incentivizes reductions in unnecessary emergency department (ED) and hospital utilization. Across Maryland, hospitals cite opioid use disorder and inadequate access to acute mental health services as contributors to ED overcrowding. Maryland currently lacks sufficient infrastructure needed to divert behavioral health crisis needs from EDs and inpatient settings to more appropriate community-based care. Community-based organizations often do not receive reimbursement for crisis management services and struggle to provide the capacity needed in Maryland.

The behavioral health crisis services funding stream supports development and implementation of infrastructure and interventions consistent with the “Crisis Now: Transforming Services is Within Our Reach” action plan developed by the National Action Alliance for Suicide Prevention. Regional Partnerships are implementing one or more of the following:

- **Air Traffic Control (ATC) Capabilities with Crisis Line Expertise.**² The ATC model is based on always knowing the location of an individual in crisis and verifying hand-offs to the next provider. The model creates a hub for deployment of mobile crisis services and access to other services such as crisis stabilization. The model’s essential components include qualified crisis call centers and 24/7 clinical coverage with a single point of contact for a defined region.

² ATC is also referred to as “Care Traffic Control” by one Regional Partnership.

- **Community-Based Mobile Crisis Teams.**³ Mobile crisis services deploy real-time professional and peer intervention to the location of a person in crisis. They are intended to avoid unnecessary ED use and hospitalization.
- **Stabilization Centers.** Crisis stabilization services provide 24-hour observation and supervision at a sub-acute level to prevent or ameliorate behavioral health crises and/or address acute symptoms of mental illness. Settings are small and home-like relative to institutional care.

Summary of Awards

The HSCRC awarded a cumulative \$157.6 million through nine awards to eight Regional Partnerships for the five-year period of January 2021 through December 2025. Five of the nine awards fall under the diabetes prevention and management funding stream. These awards total \$78.5 million and involve 24 hospitals. They span Western, Central, and Southern Maryland as well as the Capital Region. Three of the nine awards fall under the behavioral health crisis services funding stream. These three awards total \$79.1 million and involve 24 hospitals. They span Central Maryland, portions of the Capital Region, and the Lower Eastern Shore. A summary of awards is shown in Table 1 below.

³ Mobile Crisis Teams (MCT) are also referred to as Mobile Response Teams (MRT).

Table 1. Summary of Regional Partnership Catalyst Program Awards, CY 2021 – CY 2025

	Regional Partnership	Counties/ Region	Award	Participating Hospitals
Diabetes Prevention and Management	Baltimore Metropolitan Diabetes Regional Partnership	<ul style="list-style-type: none"> ● Baltimore City 	\$43,299,986	<ul style="list-style-type: none"> ● JH Bayview Medical Center ● Howard County General Hospital ● Johns Hopkins Hospital ● Suburban Hospital ● UMMC ● UMMS Midtown
	Western Regional Partnership	<ul style="list-style-type: none"> ● Allegany ● Frederick ● Washington 	\$15,717,413	<ul style="list-style-type: none"> ● Frederick Health ● Meritus Medical Center ● UPMC Western Maryland
	Nexus Montgomery⁴	<ul style="list-style-type: none"> ● Montgomery 	\$4,121,123	<ul style="list-style-type: none"> ● Holy Cross Germantown ● Holy Cross Hospital ● Shady Grove Medical Center ● White Oak Medical Center
	Totally Linking Care (TLC)	<ul style="list-style-type: none"> ● Charles ● Prince George's ● St. Mary's 	\$7,379,620	<ul style="list-style-type: none"> ● Adventist -Fort Washington Medical Center ● Luminis Doctors Community Hospital ● MedStar St. Mary's ● MedStar Southern Maryland ● UM Capital Region Health ● UM Laurel Regional Medical Center
	Saint Agnes and Lifebridge	<ul style="list-style-type: none"> ● Baltimore City ● Baltimore County 	\$5,962,333	<ul style="list-style-type: none"> ● Ascension St. Agnes ● Sinai Hospital ● Grace Medical Center
	Full Circle Wellness	<ul style="list-style-type: none"> ● Charles 	\$2,054,382	<ul style="list-style-type: none"> ● UM Charles Regional Medical Center
Behavioral Health Crisis Services	Greater Baltimore Region Integrated Crisis System (GBRICS)	<ul style="list-style-type: none"> ● Baltimore City ● Baltimore County ● Carroll ● Howard 	\$44,862,000	<ul style="list-style-type: none"> ● Bayview Medical Center ● Carroll Hospital ● Grace Medical Center ● Greater Baltimore Medical Center ● Howard County General ● Johns Hopkins Hospital ● Ascension St. Agnes ● Sinai ● MedStar Franklin Square ● MedStar Good Samaritan ● MedStar Harbor ● MedStar Union Memorial ● Mercy ● Northwest ● University Maryland Medical Center ● UM Midtown ● UM St. Joseph Medical Center

⁴ Program participation ended in 2022.

Totally Linking Care (TLC)	<ul style="list-style-type: none"> • Prince George's 	\$22,889,722	<ul style="list-style-type: none"> • Adventist Fort Washington Medical Center • MedStar Southern Maryland • UM Laurel Medical Center • UM Capital Region Health
Tri-County Behavioral Health Engagement (TRIBE)	<ul style="list-style-type: none"> • Lower Eastern Shore 	\$11,316,332	<ul style="list-style-type: none"> • Atlantic General Hospital • TidalHealth - Peninsula Regional Medical Center
Total Awards		\$157,602,911	

Year Two Diabetes Prevention and Management Activities

DPP Referral, Enrollment, and Retention Strategies

During CY 2022, Regional Partnerships took a range of actions to promote DPP referral, enrollment, and retention. They made progress in expanding DPP capacity for underserved populations in particular, for example by targeting zip codes with no prior DPP, expanding cohorts at senior centers and assisted living facilities to engage older adults, and hiring bilingual coaches to expand Spanish-language DPP. Continued hiring of coaches, CHWs, and administrative support staff is a strategy reported by multiple Regional Partnerships.

Referral efforts are multipronged. Regional Partnerships are enhancing electronic health records (EHRs) to facilitate DPP referral and enrollment from within the hospital, for example with DPP referrals in after visit summaries and automated patient messages and provider prompts. In addition, Regional Partnerships work with community providers, and community-based organizations to identify participants and address barriers to care. This includes implementing technology solutions to reach community partners outside of the health system EHR. Outreach at community events and direct to consumer public marketing campaigns—including flyers, direct mail, media advertisements, and QR codes—are also referral sources, as are MCOs.

MCOs fulfill different roles in Regional Partnership referral processes. For some Regional Partnerships, MCOs are a key source of referrals, and they partner closely during outreach events to provide participant education. Other Regional Partnerships are in the process of building contracts with MCOs and understanding credentialing processes for DPP providers. Suggestions from Regional Partnerships include streamlining MCO credentialing processes. Table 2 shows CY 2022 MCO engagement with Regional Partnerships.

Table 2. CY 2022 MCO Engagement

Managed Care Organization (MCO)	Regional Partnerships Engaged
Aetna Better Health	3
Amerigroup	2
CareFirst	2
Jai Medical Systems	1
Maryland Physicians Care	3
Priority Partners	2

Source: Regional Partnership Annual Reporting, CY 2022

Regional Partnerships report that once individuals are identified and referred, enrollment proves challenging. Regional Partnerships deploy multiple touchpoints and different approaches to bridge the gap, for example shifting from phone calls to text messaging and purchasing smartphones for coaches to facilitate text communication. Individuals are reluctant to answer phone calls from unrecognized numbers.

During enrollment, Regional Partnerships engage participants in different formats depending on the preferences of the participant, with individual, group, in-person, and virtual methods. Regional Partnerships recognize that participants in virtual classes may fall outside of target zip codes.

To promote participant retention in DPP, coaches send encouraging messages and reach out to participants who miss classes. Participants are assessed for any barriers that might prevent participation. Regional Partnerships also provide participant incentives for reaching milestones. Examples include Weight Watchers memberships and functional tools such as scales and cooking equipment. Regional Partnerships make healthy food available to some participants, for example through Food as Medicine initiatives or grocery store raffles. Regional Partnerships are also focusing on retention of staff and coaches, for example through purposeful team communication and unification of mission. Regional Partnerships describe recruitment and retention of staff as a challenge. One Regional Partnership has successfully recruited staff from outside of Maryland through conference networking.

DPP Cohorts

Table 3 shows DPP Cohorts for CY 2021 – 2022. Regional Partnerships supported 163 total cohorts in 2022 that were either run by the hospital or partner community organizations. 119 cohorts began in 2022, while 44 cohorts that began in 2021 concluded. Two Regional Partnerships also ensured cohorts were more accessible to participants by providing interpreters and classes in English and Spanish. Cohort sizes can vary in size based on delivery format (i.e. in-person or virtual), location, and available staffing. In general, smaller cohort sizes allow for more personalized contact between lifestyle coaches and participants which supports program retention and maximizes patient success in the program.

Table 3. DPP Cohorts, CY 2021-2022

Regional Partnership	2022 (New Cohorts)	2021 (Cohorts Ending)
Baltimore Metropolitan Diabetes Regional Partnership	36	7
Full Circle Wellness	9	7
Saint Agnes and Lifebridge	8	6
Totally Linking Care (TLC)	24	17
Western Regional Partnership	42	7
Total	119	44

Source: Regional Partnership Annual Reporting, CY 2022

DSMT/ES Expansion Strategies

Regional Partnerships are focusing on referral and enrollment efforts as well as increasing the reach of classes to expand DSMT/ES. They cite success in participants meeting their goals for A1C improvement and self-selected behavioral goals.

Referral and enrollment strategies include strengthening relationships with referring providers. Regional Partnerships are increasing the presence of DSMT/ES educators in primary care and endocrinology practices to facilitate cross-referral and engaging participants in familiar settings. Another strategy is embedding DSMT staff in the population health team for integration between inpatient and ambulatory services. Regional Partnerships are targeting potential participants through the EHR and standardizing workflows among care management teams to address gaps in care. EHR enhancements facilitate participant identification, referral, care coordination, and resource navigation. Regional Partnerships are expanding their focus beyond Medicare, offering DSMT/ES as a standard of care for all patients particularly amidst transitions of care. In addition to encouraging provider referrals and EHR identification, Regional Partnerships are promoting DSMT/ES through community-based marketing and recruitment.

Despite these various strategies, engagement of participants in DSMT/ES continues to be challenging. Regional Partnerships cite low referral rates by providers, in addition to barriers such as cost-sharing faced by patients. For Medicare FFS beneficiaries, there is a cost share requirement which can become cost-

prohibitive for patients, particularly if DSMT is performed in a regulated setting.^{5 6} Patient financial responsibility depends on the location of where DSMT/ES is provided and any supplemental benefits the beneficiary may have in addition to Medicare coverage.

Regional Partnerships are expanding the number and nature of DSMT/ES classes, with more sites and larger spaces, in-person and virtual, one-on-one and group, and hybrid offerings. The expansion of classes allows for participants to receive education earlier in their diagnoses. Classes are being offered on evenings and weekends to meet the scheduling needs of participants under age 65 who balance work and caregiving activities. In addition, classes are offered in English and Spanish. DSMT/ES expansion has been facilitated by the hiring of new staff during CY 2022, including class teachers and registered dietitians to lead the nutrition components of DSMT and provide MNT.

Physician & Provider Engagement (DPP & DSMT/ES)

When a provider has a meaningful conversation with the patient about enrolling in DPP or DSMT/ES, the patient is more likely to participate. Accordingly, Regional Partnerships are continuing to conduct a range of physician and provider engagement activities for both DPP and DSMT/ES. Outreach methods differ for hospital-affiliated versus community-based providers. For hospital-affiliated providers, engagement activities center on EHR tools, regular outreach meetings, and messages from leadership. Some Regional Partnerships focus only on hospital-affiliated providers and MDPCP partners, for example by working with MDPCP managers to identify patients and collaborating with MDPCP to provide warm introductions and ongoing support to providers and CTOs. Other Regional Partnerships engage community-based providers with educational visits to offices, information about the CRISP referral tool, EHR optimization offerings, and the availability of paper referrals. In addition, Regional Partnerships offer educational road shows and CME modules for both categories of providers. Despite the various provider engagement efforts, Regional Partnerships note the challenges of recruiting hospital-affiliated and community-based providers to make referrals.

Impact Measures

DPP Referrals

HSCRC set a goal for Regional Partnerships to refer five percent of their prediabetic patient population to DPP in 2022. Referrals are measured in targeted ZIP codes that were self-selected by Regional Partnerships in their 2020 proposals. There is a significant number of referrals being generated outside of targeted ZIP codes that HSCRC does not give credit for in reporting since measurement is ZIP code-based.

⁵ The deductible and coinsurance of 20 percent of the Medicare-allowed amount applies to DSMT.

⁶ Centers for Medicare and Medicaid Services. *Medicare Learning Network Fact Sheet - Medicare Diabetes Self-Management Training*. May 2022. <https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/DSMT-Fact-Sheet-909381.pdf>

The numbers shown in Table 4 are therefore a lower-bound of referrals and actual performance exceeds the reported amounts.

In 2022, Regional Partnerships referred a total of 7,224 patients to DPP in designated ZIP codes. Referrals to DPP are inclusive of all-payers (Medicare, Medicaid, commercial, self-pay, uninsured) and are self-reported by Regional Partnerships monthly.

Table 4. All-Payer Referrals to Diabetes Prevention Programs, CY 2022

Regional Partnership	Target	Actual ⁷	% of CY22 Target Achieved
Baltimore Metropolitan Diabetes Regional Partnership	1,969	2,976	151.1%
Full Circle Wellness	579	609.5	105.3%
Saint Agnes and Lifebridge	542	788	145.4%
Totally Linking Care (TLC)	1,911	1,634.5	85.5%
Western Regional Partnership	1,124	1,216	108.2%
Statewide Total	6,125	7,224	118%

Source: CRISP Regional Partnership Monitoring Dashboard, Hospital Self-Reported Data

HSCRC is continuing to use all-payer referrals as performance metric in CY 2023 and is monitoring Medicare and Medicaid claims to evaluate DPP enrollment. Progress to establish new billing processes for DPP has been slower than anticipated. All Regional Partnerships are expected to provide reports on billing progress this summer. Staff will be reviewing these plans and will ask for corrective action plans for Regional Partnerships where progress is still lacking.

On an all-payer basis, statewide cumulative enrollment in DPP has steadily increased since the Catalyst Program began in 2021 and is currently outpacing the nation (Table 5 and Figure 1). This data is based on CDC programmatic data that is provided to the State on a quarterly basis and is inclusive of all DPP in the State, not solely RP-attributed DPP. Based on data through January 2023, Maryland has experienced a 172.6 percent increase in DPP enrollments per 100k since 2018. This rate of change is faster than the nation overall, which has experienced a 96.4 percent increase over the same period.

Table 5. Cumulative DPRP Enrollment Rate per 100K Compared to National Average, 2018 - January 2023

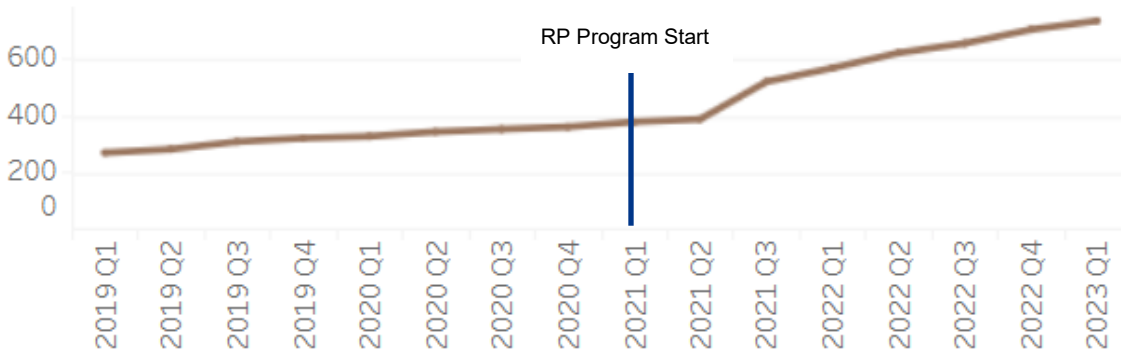
2018 Baseline	Most Recent Rolling 12 Months	Percent Change	National Comparison Change
---------------	-------------------------------	----------------	----------------------------

⁷ Regional Partnerships that serve the same ZIP code split credit for referrals which accounts for 0.5 values.

Rates per 100K (MD)	269.9	735.7	172.6%	96.4%
Rates per 100K (Nation)	358.0	763.2	113.2%	

Source: CRISP SIHIS Directional Indicators Dashboard, CDC Programmatic Data

Figure 1. Cumulative DPRP Enrollment Rate per 100K Compared to National Average, 2018-January 2023



Source: CRISP SIHIS Directional Indicators Dashboard, CDC Programmatic Data

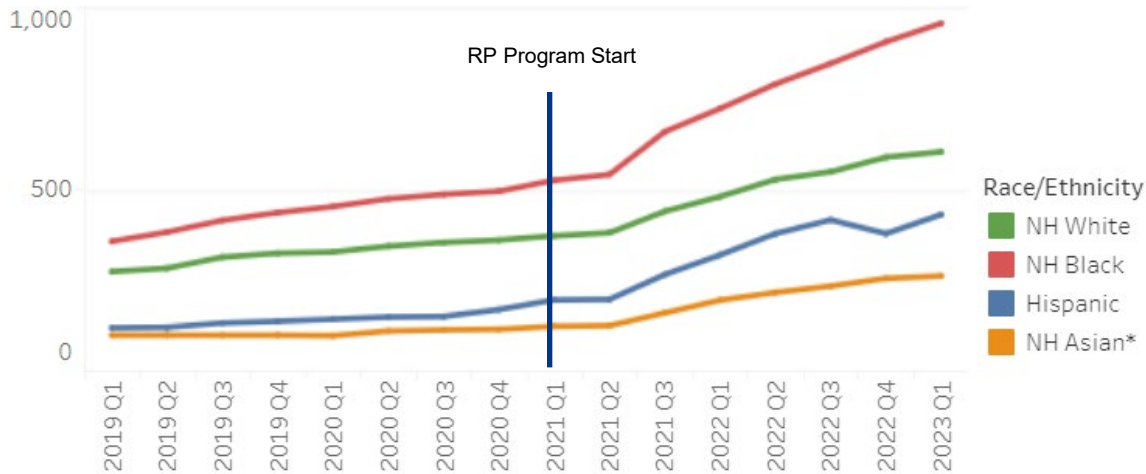
The State is also able to monitor DPRP enrollment by race and ethnicity, as shown in Table 6 and Figure 2, and is seeing marked improvements in enrollment across all races and ethnicities.

Table 6. Cumulative DPRP Enrollment Rates per 100K by Race/Ethnicity, 2018-January 2023

Race/Ethnicity	2018 Baseline	Most Recent Rolling 12 Months	Percent Change
NH White	276.2	604.1	118.7%
NH Black	359.0	955.8	166.2%
Hispanic	122.5	432.6	253.2%
NH Asian	102.1	264.2	158.7%
Statewide Total	269.9	735.7	172.6%

Source: CRISP SIHIS Directional Indicators Dashboard, CDC Programmatic Data

Figure 2. Cumulative DPRP Enrollment Rates per 100K by Race/Ethnicity, 2018-January 2023



Source: CRISP SIHIS Directional Indicators Dashboard, CDC Programmatic Data

As shown above, NH Black enrollment in DPP is outpacing NH White enrollment. There is room for improvement on DPP enrollment for the Hispanic and NH Asian population, although enrollment is growing faster for those populations than NH White.

DSMT/ES Participation

The HSCRC monitored Medicare DSMT claims in CY 2022 and found that volumes remained below initial expectations when the program launched. Many Regional Partnerships had not fully established billing operations for expanded DSMT programs in 2022 and were continuing to rebuild programs after DSMT volumes declined during the pandemic. Additionally, a great deal of DSMT/ES is reimbursed by commercial payers, but HSCRC does not currently measure commercial DSMT/ES claims and Medicaid does not provide coverage for DSMT/ES. Overall, DSMT claims for RP-attributed Medicare beneficiaries increased by 186 percent between CY 2021 and CY 2022 (Figure 3 and Table 7). Regional Partnerships are expected to aggressively grow their DSMT claims in CY 2023 as billing processes are put into place and volumes continue to rebound from 2020 lows due to the pandemic. Additionally, the Medicare cost-sharing requirement for patients continues to be a barrier to participation.

Figure 3. RP-Attributed Medicare Beneficiaries with DSMT Claims, CYs 2019-2022

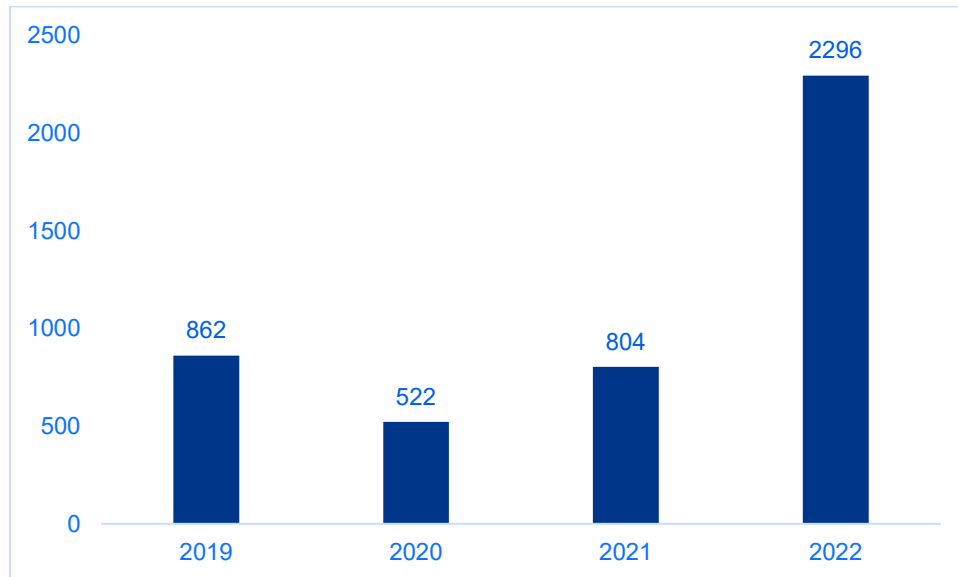


Table 7. RP-Attributed Medicare Beneficiaries with DSMT Claims, CY 2021-CY 2022

Regional Partnership	CY 2021	CY 2022	% Change 2021 to 2022
Baltimore Metropolitan Diabetes Regional Partnership	332	1513	356%
Full Circle Wellness	166	185	11%
Saint Agnes and Lifebridge	228	358	57%
Totally Linking Care (TLC)	68	85	25%
Western Regional Partnership	10	155	1450%
Statewide Total	804	2296	186%

Source: CCLF Data

The State also receives annual reports from the CDC on DSMES participation, based on data reported by the ADA and Association of Diabetes Care and Education Specialists (ADCES), as shown in Table 8. This data is inclusive of billed and non-billed DSMES. Since 2019, Maryland has seen 69 percent growth in DSMES participants through 2021, compared to 7 percent growth nationally.⁸

⁸ 2022 DSMES Data will be available in late summer 2023.

Table 8. DSMES Participation Growth, Maryland vs. Nation, 2019-2021

State	2019 Encounters	2020 Encounters	2021 Encounters	Percent Growth
Maryland	11,403	11,705	19,270	69%
Nation	975,417	928,895	1,042,253	7%

Source: American Diabetes Association (ADA) and Association of Diabetes Care and Education Specialists (ADCES)

Billing & Sustainability (DPP & DSMT/ES)

The ability to bill Medicare and Medicaid for reimbursement of DPP and DSMT/ES creates a pathway to sustainability for Regional Partnerships. During CY 2022 Regional Partnerships made progress towards billing. In CY 2022, eight DPP suppliers billed Medicare and/or Medicaid, although the majority of Regional Partnership's DPP providers did not. One Regional Partnership plans on having an additional 21 DPP providers begin billing Medicare in 2023. One Regional Partnerships is also working on creating an administrative umbrella hub arrangement for billing—this approach accommodates DPP suppliers by not requiring a transfer of recognition to an umbrella hub provider organization.

Some Regional Partnerships' DSMT/ES providers have been billing Medicare and commercial payers for some time. All Regional Partnerships are committed to having all of their DSMT/ES providers billing Medicare in CY 2023. Regional Partnerships note that to be financially viable, programs need to bill payers beyond Medicare, and generate revenue from other services such as MNT and glucose monitoring. They also point to differences operating in regulated versus unregulated spaces, noting that regulated rates have associated cost-sharing for Medicare patients that can be cost-prohibitive.

Wraparound Services (DPP & DSMT/ES)

Provision of wraparound services to address social drivers of health (SDOH) is core to Regional Partnership programming. Regional Partnerships deploy CHWs, patient navigators, care managers, and others to screen participants for SDOH need and connect participants to resources. Support is available in English and Spanish. Regional Partnerships also screen participants for depression to connect them to resources as needed.

During CY 2022, Regional Partnerships offered the following wraparound services shown in Table 9 to DPP participants. These services that are supported by vendors and collaborators allow for participants' needs to be met and help remove barriers related to social determinants of health.

Table 9. CY 2022 Wraparound Services (DPP & DSMT)

Wraparound Service	Count of Regional Partnerships
Food Access	5
Transportation	5
Exercise	4
Medical Nutritional Therapy	4
Remote Patient Monitoring	2
Mobile Integrated Health	1
Medication Management	1
Financial Assistance	1

Source: Regional Partnership Annual Reporting, CY 2022

Regional Partnerships describe multiple efforts to address food access, starting with screening. Questions are now asked about “challenges purchasing *healthy* food” as opposed to “challenges purchasing food” to understand when participants lack physical or financial access to healthy food (even though fast food may be accessible). One survey showed that close to half of participants have trouble buying fruits and vegetables due to access or cost. From this survey, 56 percent of respondents having trouble getting food are African-American, pointing to health disparities.

Solutions to provide healthy food include food delivery to participants’ homes, a virtual supermarket concept, and partnering with supermarkets and others on healthy food access programs. Regional Partnerships are also partnering with community- and faith-based organizations to provide cooking classes and demonstrations.

Regional Partnerships are addressing transportation through the provision of Lyft rides and connecting participants to existing non-emergency transportation providers. To promote exercise, Regional Partnerships offer participants gym memberships through the YMCA or County parks and recreation facilities, fitness instruction (including virtual), and Fitbit activity trackers.

Diabetes Community Partner Collaboration (DPP & DSMT/ES)

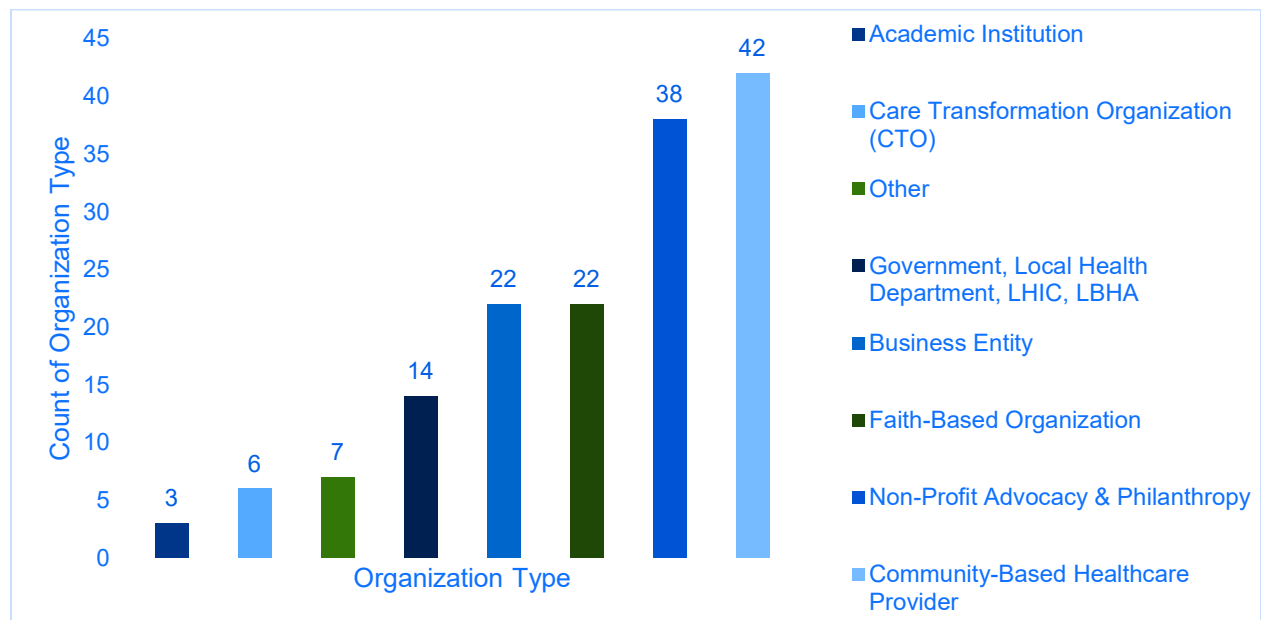
The development of partnerships for long-term improvements in population health, and engagement and integration of community resources in the healthcare system are core goals of the Catalyst Program. During CY 2022, Regional Partnerships convened and attended community events with partners to reach potential participants outside of the healthcare setting who may be missed in other marketing efforts. The community events also enable Regional Partnerships to build relationships with other community attendees.

In CY 2022, Regional Partnerships also worked with community partners to provide ongoing education about diabetes prevention and management, and to establish in-person classes, for example at faith-based

organizations, apartment complexes, and senior settings. Regional Partnerships also worked closely with community partners to meet participants' SDOH needs, for example food access.

Figure 4 shows the breadth of Regional Partnerships' community partners for diabetes prevention and management. There are a total of 154 community partner organizations across the five Regional Partnerships. The two most common types of organizations are community-based healthcare providers and non-profit advocacy or philanthropy organizations.

Figure 4. CY 2022 Diabetes Program Community Partners



Source: Regional Partnership Annual Reporting, CY 2022

Year Two Behavioral Health Crisis Services Activities

Open Access and Crisis Center Activities and Progress

Regional Partnerships made significant progress on crisis center activities in Year Two. TRIBE opened both of its sites with Monday through Friday hours (8am to 8pm and 8am to 4:30pm). Crisis center visits increased monthly at both primary and secondary sites, and by the end of the calendar year both centers had a combined total volume of 1460 visits. Both sites integrate primary telehealth services as needed. Staff assess for and coordinate SDOH and substance use disorder needs. One of the two sites embeds peer support on site. The Regional Partnership continually monitors service delivery data to address priority needs. Given staff strain of walk-in hours with no scheduled times for intakes, the Regional Partnership is identifying better triage processes. The need for bolstered security was also addressed in CY 2022.

TLC projects to open its 23-hour Crisis Stabilization Center in the summer of 2023 with capacity to serve 16 individuals. During CY 2022 all contracts were signed and the Regional Partnership continues to meet regularly with key stakeholders to align with local and State requirements.

GBRICS is expanding access to immediate-need behavioral health services through its Open Access Pilot project, with two pilot cohorts of five and thirteen pilot sites. Both cohorts are now offering appointments. The project provides technical assistance, training, and seed funding to the sites to implement or expand open access appointments. In the last quarter of CY 2022, pilot sites received 155 patients. During CY 2022, a vendor was selected through competitive procurement to provide technical assistance. The Regional Partnership has worked with the care traffic control software to create an outpatient referral tool for the 988 Regional Call Center to send referrals to pilot sites for individuals in immediate need of outpatient behavioral health appointments which should grow patient volumes at Open Access pilot sites. The main source of referrals is each site's marketing efforts, as well as a widely shared resource guide and listing on the 988helpline.org website. An evaluation of the Open Access Pilot will provide information on why some sites have a low volume of referrals.

Care Traffic Control Activities and Progress

Significant progress was made on care traffic control and open access activities. The 988 Regional Call Center for Central Maryland went live in April 2023, establishing a regional Care Traffic Control system by implementing a single hotline for substance use and mental health crisis calls. It averages 55 calls per day, an increase from the number of calls to separate 988 operators prior to implementation. Work completed during CY 2022 included competitively procuring a vendor contract to operate the 988 Regional Call Center and negotiating the MOU. The contract is held by three organizations. It was challenging to identify and implement one phone system that worked for all three organizations, accommodating both cloud-based and hard-wired phone systems. An outpatient scheduling module was also completed. Dozens of staff have been trained in using the new system, including on risk assessments, mobile crisis team dispatch, and the bed registry. To market the new 988 Regional Call Center in preparation of its launch, GBRICS worked with over 100 community outreach partners to distribute marketing materials, disseminated materials and information through the 988helpline.org website, and had a paid media campaign across central Maryland.

Progress was made on enhancing the Prince George's County Response System via technology. During CY 2022, TLC implemented system integration between the 988 Call Center with the mobile response team dispatch module. To advance implementation, in October 2022 the Regional Partnership implemented the dispatch pilot with the Prince George's County Health Department serving as dispatchers to the mobile crisis team. In addition, a 911-988 diversion pilot was rolled out in Prince George's County in October 2022. This includes set-up protocols, call handling criteria, and outcomes measurement. The Regional

Partnership is currently developing standard operating procedures for referring crisis calls to mobile crisis teams.

Mobile Crisis Team Activities and Progress

Mobile crisis team response volume grew dramatically over CY 2022 to divert patients from the ED who do not require a high-level intervention. In Prince George's County, TLC is funding four operating mobile crisis teams. They work in close collaboration with law enforcement and EMS, with standard operating procedures around scene sharing and best practice protocols for the emergency crisis continuum. In October 2022 the Regional Partnership changed the mobile crisis team business model to be standalone, as opposed to part of the call center. This change was motivated by regulation and reimbursement requirements. The change also facilitated the mobile crisis team's increasing workforce. Incorporating dispatch into the mobile crisis team system increased coordination of services. The new standalone mobile crisis team can now receive calls directly instead of having to be routed through the 988 Call Center. After launching the new mobile response times in Fall 2022, in-person and virtual interactions with patients in crisis increased significantly. In CY 2022, monthly dispatches increased from 11 in January to 240 in December, totaling 1178 dispatches. A total number of 1751 patients were served by mobile response teams in CY 2022, growing from 52 in January to 432 in December.

In Central Maryland, several mobile crisis teams went live in May 2023, with more launching in summer 2023 as staff are hired. During CY 2022 GBRICS issued two awards to fund mobile crisis teams. This adds five teams: two shifts seven days per week plus a part-time shift for Baltimore City and Baltimore County coverage; and two shifts seven days per week plus a part-time shift for Howard and Carroll Counties plus additional coverage for Baltimore County. Additional work in CY 2022 included developing protocols on integrating peers into mobile response staffing, responding to third party callers, providing voluntary transportation for higher levels of care, and creating triage process around inclusion of medical or law-enforcement support.

Behavioral Health Sustainability

During CY 2022 Regional Partnerships advanced the sustainability of Catalyst Program behavioral health initiatives. Beginning in CY 2021, Regional Partnerships coordinated with the broad-based effort to establish a statewide mechanism to fund 988 in Maryland. The "Fund Maryland 988 Campaign" brings together more than 70 partner organizations to establish a Maryland 988 Trust Fund. The campaign advocated for legislation during the 2022 and 2023 General Assembly sessions to lay the groundwork for sustainable funding. In 2022, the General Assembly passed legislation to establish a 988 Trust Fund and appropriated \$5.5 million for the 988 Lifeline in FY2023. During the 2023 Maryland General Assembly, legislators passed Senate Bill 3/House Bill 271 which require the Governor to appropriate \$12 million for the

Trust Fund in the FY 2025 annual budget bill. With continued funding support, the 988 Trust Fund has the potential to financially support crisis services across the state in the long run.

Regional Partnerships are taking action to ensure the programs they implement are aligned with sources of funding for long term sustainability. For example, one 988 Regional Call Center structured its dispatch team to align with the bundled payment structure proposed by Maryland Medicaid to tap into a sustainable revenue source through claims reimbursement. Regional Partnerships are working on an ongoing basis to develop performance metrics for initiatives, ensuring accountability and fidelity to support sustainability.

Behavioral Health Community Partner Engagement

Regional Partnerships recognize the value of conducting meaningful, multi-sector input, as well as the significant dedicated effort it requires. They continued developing and expanding community partnerships in CY 2022. These relationships are vital to communicating the availability of new Catalyst Program services to the public. Regional Partnerships involve local government entities to ensure Catalyst Program efforts complement existing initiatives to develop behavioral health crisis service infrastructure. Key public entities included local government, public safety agencies, and LBHAs.

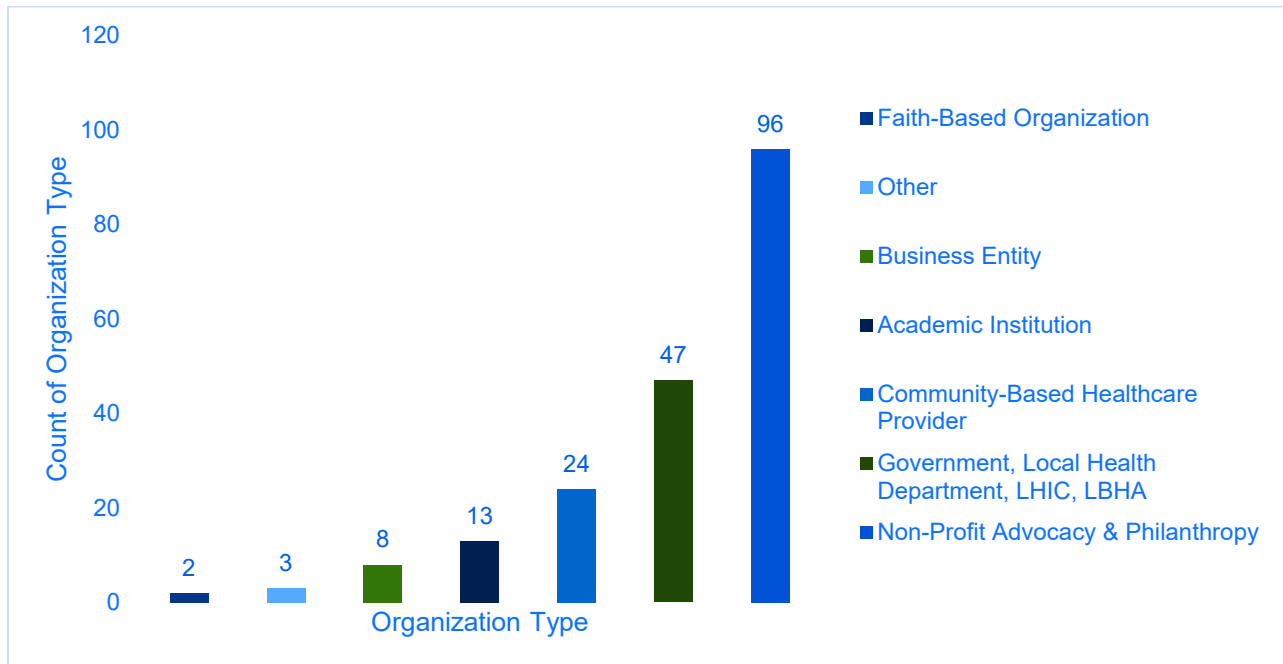
Regional Partnerships have formal governance entities intentionally structured to engage a diverse group of stakeholders in guiding the overall strategy, implementation, and sustainability of initiatives. Collaborations helped for example to achieve continuity of care with warm handoffs for patients in crisis, collaboration on individualized patient treatment plans, and support in develop of crisis stabilization center policies and procedures.

During CY 2022, one Regional Partnership issued a comprehensive community engagement report resulting from community roundtables and surveys. Key insights included the importance of overcoming skepticism toward the system of care and rebuilding trust with communities. This Regional Partnership also launched a 988 Community Ambassador program in CY 2022 to enlist community leaders in 988 education and outreach. Ambassadors represent leaders ranging from barbers to faith leaders.

Partner engagement also helped provide continuity of care amidst the changing behavioral health provider landscape. In CY 2022 a large mental health agency stopped providing services, creating treatment gaps. The Regional Partnership's crisis stabilization center worked with the LBHA to coordinate care and meet the needs of patients who had been left in the gap. Another example of collaborative partnership is between the Regional Partnership and the county school system and Board of Education to develop a referral pathway for high need students.

Figure 5 below shows the breadth of community partners in behavioral health crisis services Regional Partnerships. There were 193 community partners. The most prevalent category was 96 non-profit advocacy or philanthropy organizations. Local public entities comprised 47 community partners, followed by 24 community-based healthcare providers.

Figure 5. CY 2022 Behavioral Health Community Partners



Source: Regional Partnership Annual Reporting, CY 2022

Catalyst Program Budget and Expenditures Summary

Regional Partnership expenditures for CY 2022 are shown in Table 10. Total expenditures across all Regional Partnerships were approximately \$27.4 million. The largest category was workforce, with approximately \$12.3 million in expenditures. Approximately \$9.7 million was spent on other implementation activities, operations, and indirect costs; approximately \$1.3 million was spent on IT/technology, and approximately \$2.1 million was spent on wraparound services.

Table 10. Regional Partnership CY 2022 Expenditures

	Regional Partnership	Expenditures by Category	Total Expenditures
Diabetes Prevention and Management	Baltimore Metropolitan Diabetes Regional Partnership	<ul style="list-style-type: none"> Workforce expenditures: \$4,727,858 IT services: \$114,411 Wraparound services: \$126,501 Other implementation activities, operations, and indirect costs: \$2,009,579 	\$6,978,349
	Western Regional Partnership	<ul style="list-style-type: none"> Workforce expenditures: \$2,436,061.71 IT services: \$284,773.25 Wraparound services: \$424,585.33 Other implementation activities and indirect costs: \$323,768.34 	\$3,469,188.63
	Totally Linking Care	<ul style="list-style-type: none"> Workforce expenditures: \$257,218.67 IT services: \$262,515 Wraparound services: \$90,100.10 Other implementation activities and indirect costs: \$662,398.84 	\$1,272,232.61

	Saint Agnes and Lifebridge	<ul style="list-style-type: none"> • Workforce expenditures: \$552,894.52 • IT services: \$0 • Wraparound services: \$73,804.44 • Other implementation activities and indirect costs: \$41,652.39 	\$668,351.35
	Full Circle Wellness	<ul style="list-style-type: none"> • Workforce expenditures: \$218,837.07 • IT services: \$708.56 • Wraparound services: \$62,180.86 • Other implementation activities and indirect costs: \$181,770.36 	\$463,496.85
Behavioral Health Crisis Services	Greater Baltimore Region Integrated Crisis System	<ul style="list-style-type: none"> • Workforce expenditures: \$2,339,279.23 • IT services: \$326,000 • Wraparound services: \$964,169.35 • Other implementation activities and indirect costs: \$1,501,191 	\$5,130,639.58
	Totally Linking Care	<ul style="list-style-type: none"> • Workforce expenditures: \$395,917.85 • IT services: \$202,312.71 • Wraparound services: \$343,620 • Other implementation activities and indirect costs: \$6,554,030.14 	\$7,495,880.70
	Tri-County Behavioral Health Engagement (TRIBE)	<ul style="list-style-type: none"> • Workforce expenditures: \$1,350,597.49 • IT services: \$127,919.15 • Wraparound services: \$0 • Other implementation activities and indirect costs: \$406,523.96 	\$1,885,040.60
Total Expenditures			\$27,363,179.32

Source: Regional Partnership Annual Reporting, CY 2022

HSCRC staff is in the midst of conducting financial audits of all Regional Partnership spending to verify expenditures. As with all other special funding programs, any unspent funds are removed from hospital rates.

Catalyst Program Health Equity Efforts

Both the diabetes and behavioral health Regional Partnerships intentionally keep health equity at the forefront of activities. Regional Partnerships are purposeful in the selection of community-based partners to reflect the culture, language, and demographics of target populations and gain insight on how to best customize materials and activities for different cultures. For example, one Regional Partnership's 988 Community Ambassador Program is designed to build community trust through partnership with key community leaders. Ambassadors provide essential feedback on CALL 988 marketing and promotion strategies, ensuring incorporation of representative imagery and messaging.

Screening for SDOH is a core element of the Regional Partnerships. As a routine part of intake and throughout program activities, participants are assessed for a variety of SDOH and connected to available resources via teams including nurses, social workers, CHWs, and peer recovery specialists. One Regional Partnership is partnering with local ethnic grocers to offer healthy food vouchers and assess risk.

Regional Partnerships weave equity considerations into staffing and procurement considerations, for example to recruit diverse and bilingual staff. An increasing number of Spanish-speaking diabetes

educators have been hired to offer more DPP and DSMT/ES classes in Spanish. Regional Partnerships provide interpreter services and services for individuals with hearing impairment. Staffing strategies included hiring more community health workers reflective of communities served, pursuing grant funding to hire behavioral health peer support specialist, and developing mobile crisis leadership and service providers who are diverse with respect to gender, race, ethnicity, and sexual orientation given that culture matching can mitigate stigma mitigation and help build rapport in crisis situations.

Staff trainings include topics such as motivational interviewing, cultural humility, and anti-racism. Regional Partnerships also described their efforts to promote diversity through procurement, for example prioritizing organizations with strong connections to their local communities that incorporate feedback from the people they serve into their quality improvement efforts, value the roles of people with lived experience, and include small and grassroots efforts. Selecting locally owned minority businesses was another strategy reported.

Regional Partnerships conduct analyses to identify the specific areas and communities experiencing health disparities. This involves working with community partners to understand the root causes of disparities. Regional Partnerships prioritize historically excluded and marginalized communities for marketing and outreach, for example with health fairs and a mobile integrated health visitation program. Regional Partnerships designed their tracking systems to stratify populations by a variety of parameters to facilitate understanding of how services are reaching different populations.

Other health equity efforts address different modes of service delivery. For example, DPP classes were designed to be held virtually to remove transportation barriers and are offered both day and evening to increase accessibility to different populations. Regional Partnerships promote wholistic well-being. Examples include delivery of behavioral crisis center services through a behavioral health visit within the primary care office. In addition, Diabetes 101 was offered by a Regional Partnership as a free community workshop on basic diabetes education targeting the un- and underinsured.

Conclusion

During CY 2022 the Regional Partnerships made significant progress in expanding service delivery. Regional Partnerships tackled the complexity of standing up new programs across a large set of partners and different healthcare delivery systems. Looking ahead, Regional Partnerships highlighted some challenges, the most significant of which is recruiting and maintaining staff. Other challenges include navigation of changing federal and state requirements, technical barriers to billing and service reimbursement, and the intensifying behavioral health needs among children and youth which requires a different type of expertise than adults. Regional Partnerships will continue to promote provider awareness and build relationships with commercial insurers and Medicaid MCOs.

Rate Year 2024 Uncompensated Care Report

July 12, 2023

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

This document contains the staff report for RY 2024 Uncompensated Care Policy. There are no proposed changes in methodology and thus no need for a formal Commission vote at this time.

Table of Contents

INTRODUCTION	3
METHODOLOGY	4
ASSESSMENT	6
IMPLEMENTATION	8
COVID-19 IMPLICATIONS	8
Appendix I. Hospital Uncompensated Care Provision for RY 2024	9
Appendix II. Actual UCC Summary Statistics	11

Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
<p>The purpose of the Uncompensated Care (UCC) policy is to equitably share the financial burden of providing hospital care to patients that are uninsured or underinsured and cannot afford to pay for their care. By including this cost in statewide hospital rates, the HSCRC can ensure that all Marylanders can access care at all hospitals in Maryland.</p>	<p>Funding UCC in the State of Maryland is two fold.</p> <p>1). Through the UCC markup to hospital rates based on statewide Actual UCC, applied uniformly to acute care hospital rates statewide.</p> <p>For RY 2024, the determined UCC amount to be built into rates for Maryland hospitals is 4.29 percent.</p> <p>2). Hospital contributions to/from the UCC fund based on a 50/50 blend of Hospital-specific actual UCC and calculated predicted UCC rates.</p>	<p>Under the current HSCRC policy, UCC above the statewide average is funded by a statewide pooling system whereby regulated Maryland acute care 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.</p> <p>For RY 2024, 23 regulated acute care hospitals will pay into the pool while 19 will withdraw from the pool.</p>	<p>UCC is paid by patients and insurers through rates. Therefore, with the incorporation of predicted UCC, the policy incentivizes hospitals to responsibly collect payments from patients and payers who can afford to pay. This prevents UCC costs from rising too quickly, protecting the sustainability of the UCC fund, which in turn ensures that UCC funding remains available for those who truly need it while constraining growth of health care rates for all patients and payers.</p>	<p>The UCC policy represents an underlying historical tenet of health equity in the State, as it ensures that Marylanders, regardless of insurance status, can access care at any hospital and there is no need for public hospitals. All hospitals receive funding from all payers for uncompensated care costs. Hospitals with high volumes of low-income patients are not at a financial disadvantage compared to hospitals with higher income patients, allowing low-income patients to access care at any of the state's hospitals.</p>

INTRODUCTION

The Uncompensated Care Policy was created by the HSCRC to recognize the financial burden borne by hospitals from the continued provision of high quality hospital care to patients who cannot afford to pay for it and to create a financial reimbursement for the provision of

Uncompensated Care (UCC) into the rates the Commission sets for hospitals.¹ The UCC policy is a foundational element of equity built into the all-payer system and continued under the Total Cost of Care Model. The purpose of this report is to provide background 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 hardship⁵ 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 shares for patients that do not meet the free thresholds can be charged as bad debt after the hospital makes a reasonable attempt to collect those charges.⁸ However,

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

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

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

⁴ COMAR 10.37.10.26 A-2 (2)(a)(ii)

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

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

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

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

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 2024, the determined UCC amount to be built into rates for Maryland hospitals is 4.29 percent. Under the current HSCRC policy, UCC above the statewide average is funded by a statewide pooling system whereby regulated Maryland hospitals draw funds from the pool should they experience a greater-than-average level of UCC and pay into the pool should they experience a less-than-average level of UCC. This ensures that the cost of UCC is shared equally across all hospitals within the State.

METHODOLOGY

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

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

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

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

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

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

applied uniformly to acute care hospital rates statewide. For example, in RY 2024, HSCRC staff will use RY 2022 statewide UCC experience of 4.29 percent to determine the UCC amount built into all hospital rates.

2. **Hospital Payments or Contributions to the UCC Fund**

The UCC Fund is used to redistribute funds from hospitals with lower rates of UCC to hospitals with higher rates of UCC.

- i. **Hospital-Specific Actual UCC:** HSCRC uses gross patient revenue as reported on the hospitals' annual financial filings for the previous year to determine the hospital-specific actual UCC for each hospital¹¹. (See Appendix II).
- ii. **Hospital-Specific Predicted UCC:** This step involves use of a logistic regression model to predict UCC. HSCRC allows a 9-month runout period for charity care and bad debt Write-Off reporting. This means hospitals have 9 months from the end of a fiscal year to report charity care and bad debt that occurred in that fiscal year in their Write-Off data submissions to the Commission. HSCRC then uses that amount to predict the UCC amount built into hospital rates for the next fiscal year using area deprivation Index (ADI),¹² payer type, and site of care as independent variables in the logistic regression. An expected UCC dollar amount is calculated for every patient encounter. UCC dollars are summed at the hospital level, and summed UCC dollars are divided by hospital total charges to establish the hospital's estimated UCC level. Incorporating predicted UCC into the methodology provides hospitals with a financial incentive to collect payments so that UCC does not rise too quickly and UCC funds remain available for those who truly need it. Because UCC is paid by patients and insurers through rates, uncontrolled increases in UCC could increase hospital rates for everyone.
- iii. **Blended Actual and Predicted UCC:** The HSCRC calculates a 50/50 blend between the hospital-specific actual UCC (described in step i) and the hospital-specific predicted UCC (described in step ii). All individual hospital values for payment or withdrawal from the UCC Fund are then normalized to ensure that the UCC fund is redistributive in nature. (See Appendix I).
- iv. **Determining hospital contribution/withdrawals:** The 50/50 blend (step iii) for each hospital is subtracted from the amount of state-wide actual UCC funding provided in rates (step 1) and multiplied by the hospital's global budget revenue (GBR) to determine how much each hospital will either withdraw from or pay into the statewide UCC Fund. The Fund is the mechanism through which HSCRC ensures the burden of uncompensated care is shared by all hospitals. Specifically,

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

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

if a hospital's 50/50 blend is less than the statewide average UCC rate (determined in step 1), the hospital will pay into the UCC Fund. Conversely, if a hospital's 50/50 blend is greater than the statewide average UCC rate, the hospital will withdraw from the Fund.

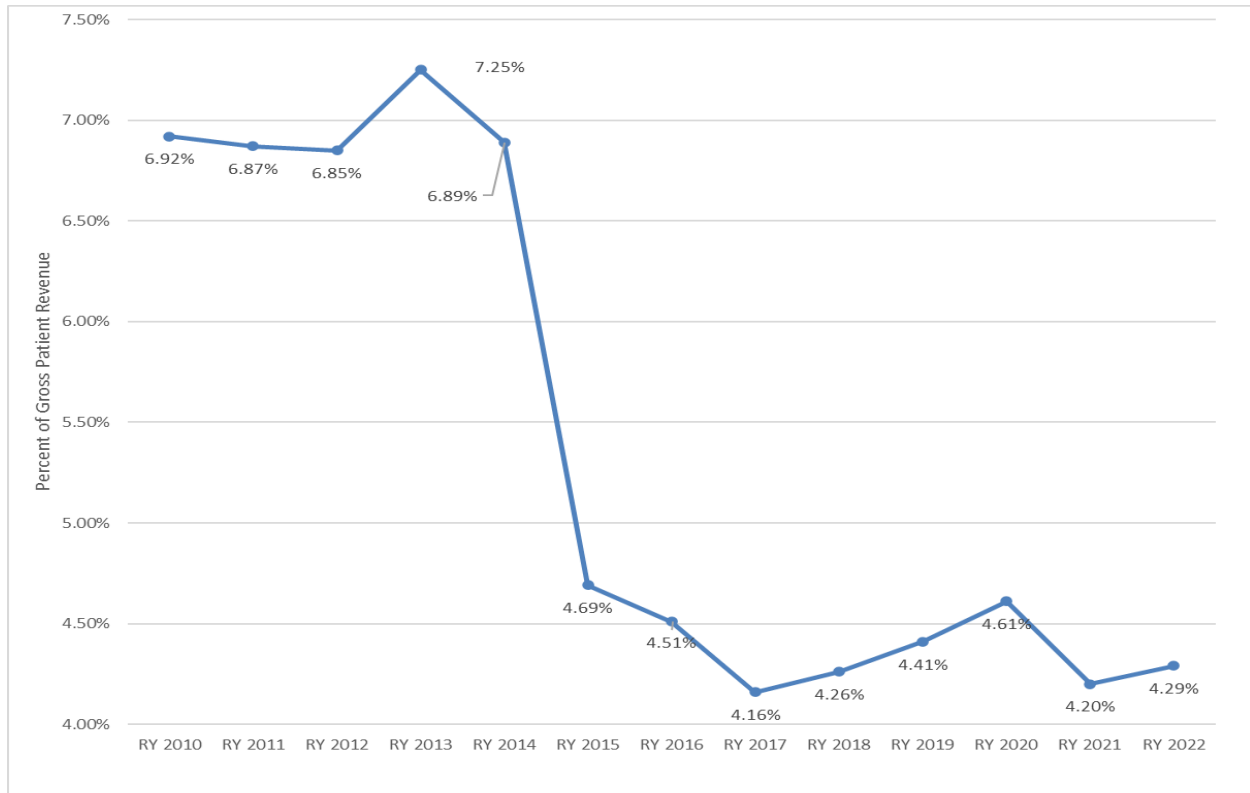
Exhibit 1: UCC Methodology Example (\$ Millions)

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

ASSESSMENT

Based on RY 2022 audited reports, the HSCRC has determined that the percentage of UCC to incorporate in hospitals' rates to fund the UCC pool is 4.29 percent, 0.09 percentage points higher than last year's UCC rate of 4.20 percent. The graph below shows the changes in Actual Statewide UCC incorporated in hospital rates since RY 2010. The slight uptick in UCC between RY 2021 and RY 2022 is driven by the increase in Emergency Department (ED) utilization as the COVID-19 Pandemic gradually phased out.

Exhibit 2: Actual Statewide UCC in Rates (RY 2010 – RY 2022)



Additional analyses to understand the downward trend in UCC in RY 2021 showed that the statewide UCC decline that year was driven in part by significant statewide declines in hospital utilization most likely to result in UCC; with declines in ED utilization being the biggest driver. RY 2022 shows a similar trend but in the opposite direction with ED utilization trending upwards (See Exhibit 3 and 4 below). The HSCRC’s model to predict UCC is based on the patients’ payer type, ADI and site of service, and the probability of a patient subsequently deemed as having UCC is historically highest amongst commercial patients presenting through the ED. Thus, the increase in ED utilization by commercial patients having a write-off to UCC (11 percent) subsequently results in the uptick in UCC and increases the ED utilization’s share of total hospital services resulting in UCC.

Exhibit 3: Percent Change from FY18 – FY22 by Site of Service and Payer for Patients with Write-Off to UCC

Site of Service	CHARITY/SELF PAY				COMMERCIAL				MEDICAID				MEDICARE				OTHER			
	% Change	% Change	% Change	% Change	% Change	% Change	% Change	% Change	% Change	% Change	% Change	% Change	% Change	% Change	% Change	% Change	% Change	% Change	% Change	% Change
	FY18-19	FY19-20	FY20-21	FY21-22	FY18-19	FY19-20	FY20-21	FY21-22	FY18-19	FY19-20	FY20-21	FY21-22	FY18-19	FY19-20	FY20-21	FY21-22	FY18-19	FY19-20	FY20-21	FY21-22
ED	8%	-10%	-42%	-1%	-9%	-21%	-52%	11%	10%	-9%	-32%	14%	-5%	-18%	-35%	-3%	7%	-9%	-64%	6%
IP	35%	3%	-12%	-18%	-7%	-12%	-25%	0%	1%	4%	-46%	17%	-1%	-2%	-26%	2%	13%	1%	-31%	-8%
OP	33%	-2%	-12%	3%	-8%	-22%	-20%	7%	14%	-26%	-19%	9%	-11%	-21%	-27%	2%	-31%	-6%	-42%	-26%
Total	17%	-7%	-30%	-1%	-8%	-20%	-35%	8%	9%	-10%	-32%	14%	-7%	-17%	-30%	1%	-5%	-7%	-53%	-5%

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

Site of Service	RY 2018	RY 2019	RY 2020	RY 2021	RY 2022
ED	54.3%	54.5%	54.4%	50.2%	50.9%
IP	8.6%	8.8%	9.6%	10.2%	9.8%
OP	37.1%	36.8%	36.0%	39.6%	39.3%

IMPLEMENTATION

Based on the preceding analysis, HSCRC staff will implement the following for RY 2024:

1. Increase the statewide UCC provision in rates from 4.20% to 4.29% effective July 1, 2023.
2. Continue to use the regression modeling approach previously approved by the Commission.
3. Continue to apply a 50/50 blend of RY2022 audited UCC levels and RY2022 predicted UCC levels to determine hospital-specific adjustments for the UCC Fund.

COVID-19 IMPLICATIONS

With the protections put in place by the state during the pandemic to ensure coverage and patient access to care most notably the suspension of Medicaid Eligibility Redeterminations, big declines in UCC in RY 2021 caused staff to predict similar trends for RY 2022 and RY 2023. However, this has not proven to be the case as UCC in RY 2022 showed a slight incline. In keeping with staff promise, future iterations of the UCC policy will provide an enhanced UCC markup in rates in line with the most recent UCC actual, as per the design of the policy.

In CY 2020, Staff began evaluating the possibility of using multi-year actual UCC averages in lieu of the one-year figures to do the 50/50 blend with predicted UCC from the regression. Staff believes that using two or more years of history will make the statistic more stable, especially as the declining trends due to the implementation of the Affordable Care Act appear to have dissipated. Staff also believes that the use of multi-year averages will help control for anomalies such as the effects of Covid-19 on hospital Utilization. Staff, however, have halted further work on this and other policy development to allow the hospitals sufficient bandwidth to respond to the pandemic. Staff plans to resume evaluation of the multi-year blend on actuals for the RY 2025 UCC policy.

Appendix I. Hospital Uncompensated Care Provision for RY 2024

HOSPID	HOSPNAME	FY2023 GBR Permanent Revenue	FY 2022 UCC Based on FY 2023 GBR Permanent Revenue	FY 2022 Percent UCC from the RE Schedule	Percent Predicted UCC (Adjusted)	Predicted UCC Amounts (Based on FY 2023 GBR Permanent Revenue)	50/50 Blend Percent	50/50 Blend Adjusted to FY 2022 UCC Based on FY 2023 GBR Permanent Revenue Level	Percent UCC
210001	Meritus Medical Cntr	\$443,254,882	\$ 20,339,157	4.59%	4.66%	\$ 20,665,404	4.63%	\$ 22,956,081	5.18%
210002	UMMC	\$1,871,729,866	\$ 73,036,719	3.90%	2.76%	\$ 51,743,580	3.33%	\$ 69,857,269	3.73%
210003	UM-Prince George's Hospital	\$389,829,607	\$ 57,441,972	14.74%	4.49%	\$ 17,518,548	9.61%	\$ 41,966,058	10.77%
210004	Holy Cross	\$590,003,012	\$ 43,984,177	7.45%	5.56%	\$ 32,820,831	6.51%	\$ 42,998,680	7.29%
210005	Frederick Memorial	\$420,197,912	\$ 17,190,531	4.09%	3.39%	\$ 14,264,262	3.74%	\$ 17,609,718	4.19%
210006	UM-Harford Memorial	\$120,311,054	\$ 7,873,582	6.54%	3.14%	\$ 3,781,579	4.84%	\$ 6,525,050	5.42%
210008	Mercy Medical Cntr	\$663,352,288	\$ 25,450,568	3.84%	3.63%	\$ 24,068,098	3.73%	\$ 27,722,635	4.18%
210009	Johns Hopkins	\$2,957,738,749	\$ 77,730,530	2.63%	2.91%	\$ 86,016,797	2.77%	\$ 91,672,653	3.10%
210011	St. Agnes Hospital	\$497,538,190	\$ 27,052,210	5.44%	6.05%	\$ 30,078,966	5.74%	\$ 31,984,439	6.43%
210012	Sinai Hospital	\$958,198,246	\$ 26,070,562	2.72%	3.05%	\$ 29,203,307	2.88%	\$ 30,944,641	3.23%
210015	MedStar Franklin Square	\$647,560,823	\$ 25,818,261	3.99%	3.40%	\$ 21,992,525	3.69%	\$ 26,766,492	4.13%
210016	Washington Adventist Hospital	\$357,809,663	\$ 30,180,030	8.43%	3.48%	\$ 12,465,815	5.96%	\$ 23,874,941	6.67%
210017	Garrett Co Memorial	\$79,922,950	\$ 5,181,330	6.48%	7.09%	\$ 5,664,608	6.79%	\$ 6,072,013	7.60%
210018	MedStar Montgomery	\$209,894,309	\$ 8,416,185	4.01%	2.11%	\$ 4,422,445	3.06%	\$ 7,187,606	3.42%
210019	Peninsula Regional	\$552,977,901	\$ 20,655,424	3.74%	4.66%	\$ 25,776,298	4.01%	\$ 25,994,434	4.70%
210022	Suburban	\$411,802,792	\$ 14,504,425	3.52%	2.19%	\$ 9,037,578	2.86%	\$ 13,179,805	3.20%
210023	Anne Arundel Medical Cntr	\$755,006,222	\$ 20,965,778	2.78%	1.95%	\$ 14,755,985	2.37%	\$ 19,998,548	2.65%
210024	MedStar Union Memorial	\$494,548,330	\$ 15,983,580	3.23%	4.06%	\$ 20,078,570	3.65%	\$ 20,189,111	4.08%
210027	Western Maryland	\$378,607,391	\$ 17,521,220	4.63%	6.55%	\$ 24,811,894	5.59%	\$ 23,699,861	6.26%
210028	MedStar St. Mary's	\$219,437,635	\$ 7,194,962	3.28%	2.18%	\$ 4,784,210	2.73%	\$ 6,706,445	3.06%

210029	JH Bayview	\$801,672,789	\$ 37,148,957	4.63%	5.03%	\$ 40,315,068	4.83%	\$ 43,367,625	5.41%
210030	UM-SRH at Chestertown	\$57,698,993	\$ 3,871,978	6.71%	3.85%	\$ 2,219,963	5.28%	\$ 3,410,525	5.91%
210032	Union Hospital of Cecil Co	\$193,877,039	\$ 9,638,733	4.97%	2.54%	\$ 4,918,870	3.75%	\$ 8,149,959	4.20%
210033	Carroll Co Hospital Cntr	\$268,940,103	\$ 7,235,586	2.69%	1.94%	\$ 5,204,436	2.31%	\$ 6,964,448	2.59%
210034	MedStar Harbor Hospital Cntr	\$214,544,707	\$ 10,311,515	4.81%	5.21%	\$ 11,185,746	5.01%	\$ 12,035,072	5.61%
210035	UM-Charles Regional	\$183,549,950	\$ 11,632,653	6.34%	3.71%	\$ 6,811,553	5.02%	\$ 10,325,844	5.63%
210037	UM-SRH at Easton	\$282,250,183	\$ 11,344,702	4.02%	2.52%	\$ 7,114,077	3.27%	\$ 10,334,002	3.66%
210038	UMMC - Midtown	\$268,995,697	\$ 14,782,063	5.50%	4.09%	\$ 11,013,046	4.79%	\$ 14,441,189	5.37%
210039	Calvert Health Med Cntr	\$178,132,879	\$ 4,435,539	2.49%	2.05%	\$ 3,647,192	2.27%	\$ 4,525,053	2.54%
210040	Northwest Hospital Cntr	\$308,413,899	\$ 10,194,088	3.31%	2.76%	\$ 8,506,532	3.03%	\$ 10,469,395	3.39%
210043	UM-BWMC	\$516,228,839	\$ 25,663,098	4.97%	2.27%	\$ 11,695,650	3.62%	\$ 20,915,001	4.05%
210044	GBMC	\$498,538,569	\$ 9,195,059	1.84%	2.37%	\$ 11,811,895	2.11%	\$ 11,760,578	2.36%
210048	Howard County General	\$360,257,158	\$ 13,285,496	3.69%	2.71%	\$ 9,779,672	3.20%	\$ 12,912,853	3.58%
210049	UM-Upper Chesapeake	\$373,198,865	\$ 18,787,835	5.03%	2.01%	\$ 7,507,687	3.52%	\$ 14,721,341	3.94%
210051	Doctors Community	\$299,866,966	\$ 19,356,399	6.45%	5.05%	\$ 15,144,009	5.75%	\$ 19,314,782	6.44%
210056	MedStar Good Samaritan	\$311,475,369	\$ 12,836,652	4.12%	4.37%	\$ 13,605,454	4.24%	\$ 14,803,405	4.75%
210057	Shady Grove Adventist Hospital	\$522,556,831	\$ 32,281,665	6.18%	3.04%	\$ 15,889,677	4.61%	\$ 26,968,347	5.16%
210060	Fort Washington Medical Center	\$67,020,261	\$ 4,718,044	7.04%	4.73%	\$ 3,170,255	5.89%	\$ 4,416,202	6.59%
210061	Atlantic General	\$127,713,601	\$ 3,510,528	2.75%	3.77%	\$ 4,815,582	3.26%	\$ 4,661,307	3.65%
210062	MedStar Southern MD	\$321,465,864	\$ 13,544,525	4.21%	2.75%	\$ 8,843,101	3.48%	\$ 12,533,536	3.90%
210063	UM-St. Joseph Med Cntr	\$466,947,045	\$ 17,258,104	3.70%	2.19%	\$ 10,219,139	2.94%	\$ 15,382,918	3.29%
210065	HC-Germantown	\$141,990,525	\$ 8,181,418	5.76%	5.08%	\$ 7,213,494	5.42%	\$ 8,618,721	6.07%
Statewide	Total	\$ 19,785,057,957	\$ 841,805,838	4.29%	3.40%	\$ 674,583,396	3.83%	\$ 848,938,585	4.29%

Appendix II. Actual UCC Summary Statistics

The table below shows the Actual UCC Statewide and by hospital between RY 2022 and RY 2021– it does not reflect predicted UCC rates.

HOSPID	HOSPNAME	RY2022 % UCC	RY2021 % UCC	Variance Over/Under
210001	Meritus Medical Cntr	4.59%	4.98%	-0.39%
210002	UMMC	3.90%	3.85%	0.05%
210003	UM-Prince George's Hospital	14.74%	10.51%	4.23%
210004	Holy Cross	7.45%	6.97%	0.48%
210005	Frederick Memorial	4.09%	4.22%	-0.13%
210006	UM-Harford Memorial	6.54%	6.43%	0.12%
210008	Mercy Medical Cntr	3.84%	4.68%	-0.84%
210009	Johns Hopkins	2.63%	2.33%	0.30%
210011	St. Agnes Hospital	5.44%	4.40%	1.04%
210012	Sinai Hospital	2.72%	3.30%	-0.58%
210015	MedStar Franklin Square	3.99%	3.29%	0.70%
210016	Washington Adventist	8.43%	7.55%	0.89%
210017	Garrett Co Memorial	6.48%	6.13%	0.36%
210018	MedStar Montgomery	4.01%	3.94%	0.07%
210019	Peninsula Regional	3.74%	3.60%	0.13%
210022	Suburban	3.52%	3.80%	-0.28%
210023	Anne Arundel Medical Cntr	2.78%	2.56%	0.22%
210024	MedStar Union Memorial	3.23%	3.01%	0.22%
210027	Western Maryland	4.63%	4.45%	0.18%
210028	MedStar St. Mary's	3.28%	2.95%	0.32%
210029	JH Bayview	4.63%	4.49%	0.14%
210030	UM-SRH at Chestertown	6.71%	5.91%	0.80%
210032	Union Hospital of Cecil Co	4.97%	6.52%	-1.55%
210033	Carroll Co Hospital Cntr	2.69%	3.20%	-0.51%
210034	MedStar Harbor Hospital Cntr	4.81%	3.93%	0.88%
210035	UM-Charles Regional	6.34%	6.06%	0.27%
210037	UM-SRH at Easton	4.02%	3.74%	0.28%
210038	UMMC - Midtown	5.50%	5.05%	0.44%
210039	Calvert Health Med Cntr	2.49%	2.51%	-0.02%
210040	Northwest Hospital Cntr	3.31%	5.14%	-1.83%
210043	UM-BWMC	4.97%	5.47%	-0.50%
210044	GBMC	1.84%	3.24%	-1.40%
210048	Howard County General	3.69%	4.42%	-0.73%
210049	UM-Upper Chesapeake	5.03%	5.65%	-0.62%
210051	Doctors Community	6.45%	4.71%	1.74%
210056	MedStar Good Samaritan	4.12%	3.89%	0.23%

210057	Shady Grove	6.18%	6.26%	-0.09%
210058	UM-ROI	3.78%	3.70%	0.08%
210060	FT. Washington	7.04%	7.36%	-0.32%
210061	Atlantic General	2.75%	3.75%	-1.00%
210062	MedStar Southern MD	4.21%	4.51%	-0.30%
210063	UM-St. Joseph Med Cntr	3.70%	3.70%	0.00%
210064	Levindale	5.11%	6.10%	-0.99%
210065	HC-Germantown	5.76%	6.69%	-0.93%
218992	UM-Shock Trauma	6.34%	6.20%	0.14%
	Total	4.29%	4.20%	0.09%

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



maryland
health services
cost review commission

Nurse Support Program I

Annual Report on FY 2022 Activities

July 2023

Table of Contents

Introduction	1
Background	1
FY 2022 Programs & Activities	2
Expenditures	4
Performance Results	5
Vacancy, Turnover, & Retention Rates	6
Certified and Specialty Care Nurses	Error! Bookmark not defined.
Continuing Education	9
Number of Nurses with BN and Advanced Degrees	10
Enhanced Diversity in the Nursing Workforce	11
Ongoing Challenges	13
Nursing Burnout	13
Increased Reliance on Agency Nurses	14
Conclusion	15

Introduction

Maryland's unique Nurse Support Program I (NSP I) was designed to address the short-and long-term issues of recruiting and retaining nurses in acute care hospitals. More than \$250 million in funds have been provided to hospitals in rates to support the NSP I initiatives since the program was implemented in June 2001. In May 2022, HSCRC Commissioners voted to approve NSP I as a permanent program with the requirement that HSCRC provide annual reports on funded activities and accomplishments. This report summarizes NSP I activities and performance against program metrics during Fiscal Year (FY) 2022.

Background

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

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

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

1. **Education and Career Advancement.** This area includes initiatives that increase the number of advanced degree nurses, preparing them as future leaders; recruitment and retention of newly licensed nurses through nursing residency programs, and supporting nursing students and experienced RNs who are re-entering the workforce after an extended leave.
2. **Patient Quality and Satisfaction.** This area includes lifelong learning initiatives such as certification and continuing education linked to improved nursing competency and patient outcomes.
3. **Advancing the Practice of Nursing.** These activities in this area advance the nursing practice, for example, nurse-driven evidenced-based research; innovative organizational structures for clinical nurses to have a voice in determining nursing practice, standards, and quality of care; and American Nurses Credentialing Center's (ANCC) Magnet®, and Pathway to Excellence programs demonstrating nursing excellence.

With input from the NSP I Advisory Committee, staff developed nursing and organizational metrics to assess hospitals' progress in achieving these program aims. Performance against those metrics is provided later in this report.

FY 2022 Programs & Activities

NSP I funds a core set of programs within all acute care hospitals that support the IOM recommendations outlined above. Hospitals select program priorities and implement one to several of the below programs to grow and advance their nursing workforce. Funded programs include:

1. **Continuing Education (Internal & External):** Funding supports education on a variety of subjects, including evidence-based practices, patient safety, disaster preparedness, quality indicators, patient experience, and workplace violence. These education opportunities may be offered internally within the hospital or externally through conferences hosted by leading organizations in the nursing field. Continuing education hours are increasingly provided online and are self-paced for participants.
2. **Leadership, Preceptorship, Mentorship Programs:** Funding supports regular training (e.g., workshops and quarterly education sessions) for nurses to develop key leadership skills necessary for building positive workplaces. These programs also provide coaching for nurses to become preceptors and mentors which are critical to new nurses and the nurse residency program. Additionally, funding may support preceptor and mentor positions. Funded mentor and preceptor roles may be of particular value to hospitals that have retiring nurses but want to retain their expertise as new staff are trained and grow in their roles.
3. **Nurse Residency Program for Newly Licensed Registered Nurses (RNs):** The Nurse Residency Program is a one-year program which provides the support, acquisition of knowledge, skills and attitudes necessary to successfully transition nursing students into clinical settings and develop core competencies in nursing. Nurse residents attend lectures from clinical experts, participate in one-to-one clinical preceptorship, and conduct a one-year research project to advance nursing. NRP is a critical program needed to guide acquisition of new competencies which are necessary to promote safe practice and individual growth and development of new nurses.
4. **Nursing Student Programs:** Funding may support tuition assistance for hospital employees pursuing nursing degrees towards RN licensure. Funding may also support externship programs for nursing students and short-term employment of nursing students.
5. **Professional Advancement Programs:** Funding can support the development or implementation of professional advancement programs.

6. **Professional Certification:** Funding supports tuition for certification preparatory courses, including specialty-specific certification programs. In addition to education programs, funding may provide reimbursement for certification exam fees.
7. **Projects to Build Nursing Science:** Funding supports research projects and assistance with evidence-based projects. This can include purchasing access to academic journals on nursing and the procurement of simulation equipment and training. Additionally, funding can support research coordinator positions to collaborate with nurse residents on building research skills, designing evidence-based projects, and other research-based learning endeavors. Funding may also be used to obtain external subject matter expertise. In many cases, hospitals set goals to publish research findings in peer-reviewed journals.
8. **RN Advanced Nursing Degree Programs:** NSP I funding provides tuition assistance for nurses pursuing advanced degrees, particularly BSNs and MSNs. In addition to tuition assistance, funding may also support one-on-one counseling, assistance with the application process, and other academic support for RNs pursuing advanced degrees.
9. **Shared Governance:** Funding supports nursing shared governance which is shared decision making between the bedside nurses and nurse leaders. Areas included in shared governance are decisions made on resources, nursing research/evidence-based practice projects, new equipment purchases, and staffing. This type of shared process allows for active engagement throughout the healthcare team, which promotes positive patient outcomes while creating a culture of positivity and inclusion that leads to greater job satisfaction.
10. **Transition to New Nursing Leadership Roles:** Funding supports formal leadership programs and bootcamps to build leadership competency for nurses that are new to leadership roles in the hospital.
11. **Transition to Specialty Practice Programs for Newly Licensed and Experienced RNs:** Funding supports learning programs and orientation transition programs for newly licensed or experienced RNs entering into specialty units and departments, including the emergency department (ED), intensive care unit (ICU), oncology (ONC), and operating room (OR).
12. **Nursing Excellence Programs:** Designation as a nursing center of excellence indicates the organization has created a “positive work environment allowing nurses to continually advance and flourish”. Programs include Magnet® and Pathway to Excellence®. NSP I supports nursing education about nursing excellence programs and innovative projects to achieve Magnet or Pathway to Excellence.

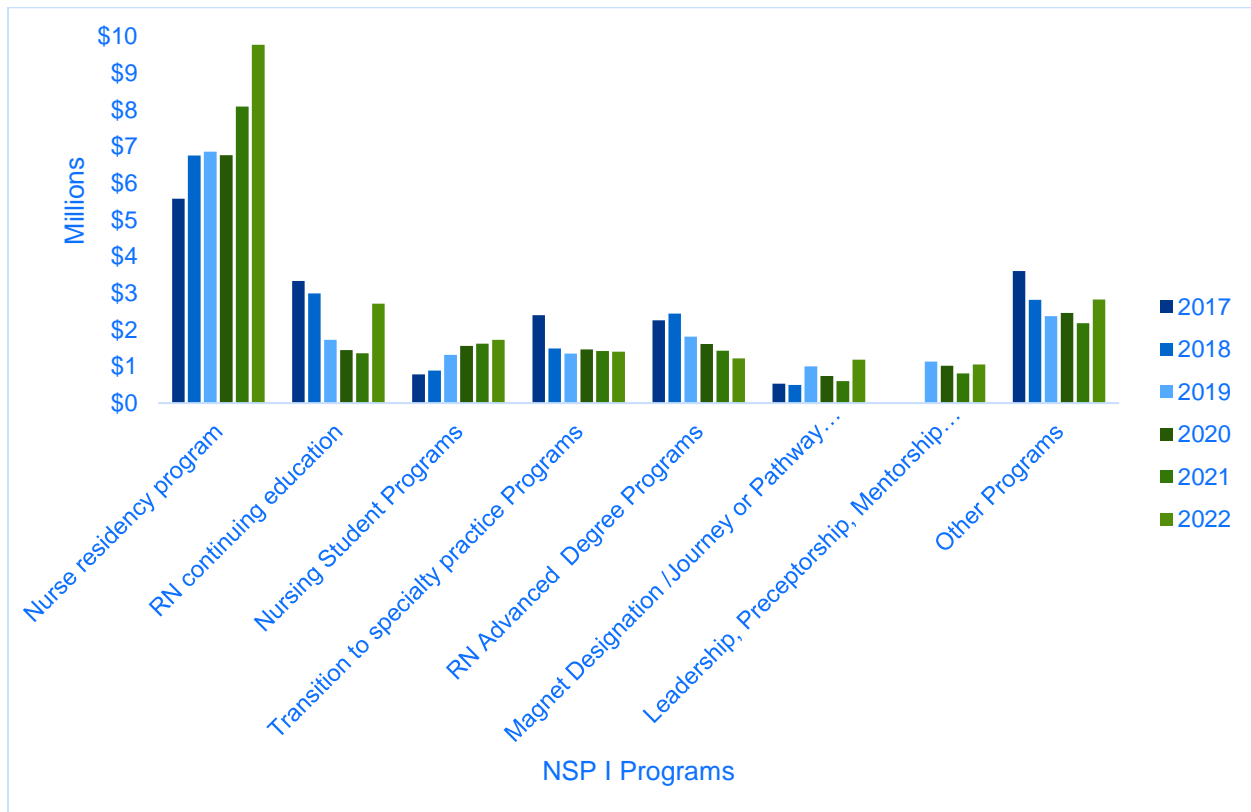
In FY 2022, all hospitals prioritized supporting new entrants to the nursing workforce by implementing a nurse residency program for newly licensed RNs. Additionally, many hospitals provided leadership, preceptorship, and mentorship programs, as well as nursing student programs. Professional advancement

was another key focus, as many hospitals funded continuing education and advanced degree programs for current staff. The collective focus on education and career advancement is expected given nursing workforce shortages and the urgent need to attract and retain new and experienced staff.

Expenditures

In FY 2022, HSCRC issued \$19.1 million in total funding to acute care hospitals. During FY 2020-FY 2022, NSP I participants were allowed to carry over unspent funds from prior years due to implementation delays and challenges caused by COVID-19. Hospitals spent approximately \$21.9 million using FY 2022 funds and COVID roll-over funding. The top funded programs in FY 2022 included 1) nurse residency programs, 2) RN continuing education, 3) nursing student programs, 4) transition to specialty practice programs, 5) RN advanced degree programs, 5) Magnet designation and Pathway to Excellence programs, and 6) leadership, preceptorship, and mentorship programs. Figure 1 and Table 1 show program expenditures from FY 2017 through FY 2022.

Figure 1. NSP I Program Expenditures, FY 2017 - 2022



Source: Hospital NSP I Annual Reports

Table 1. NSP I Program Expenditures, FY 2017 - 2022

NSP I Programs	2017	2018	2019	2020	2021	2022
Nurse residency program	\$5,574,572	\$6,754,291	\$6,860,202	\$6,764,270	\$8,095,171	\$9,775,301
RN continuing education	\$3,332,324	\$2,990,325	\$1,727,520	\$1,450,660	\$1,362,360	\$2,711,942
Nursing Student Programs	\$786,956	\$889,039	\$1,316,756	\$1,562,583	\$1,620,120	\$1,728,939
Transition to specialty practice Programs	\$2,397,140	\$1,494,908	\$1,354,607	\$1,460,928	\$1,420,664	\$1,402,766
RN Advanced Degree Programs	\$2,255,675	\$2,441,827	\$1,812,569	\$1,615,189	\$1,433,681	\$1,219,601
Magnet Designation /Journey or Pathway to Excellence	\$533,210	\$498,696	\$1,002,797	\$737,416	\$596,476	\$1,183,548
Leadership, Preceptorship, Mentorship Programs			\$1,133,456	\$1,021,250	\$809,386	\$1,051,685
Other Programs	\$3,607,854	\$2,815,687	\$2,373,633	\$2,456,528	\$2,177,543	\$2,823,986
Total Spending	\$18,487,731	\$17,884,773	\$17,581,540	\$17,068,824	\$17,515,401	\$21,897,768

Source: Hospital NSP I Annual Reports

Performance Results

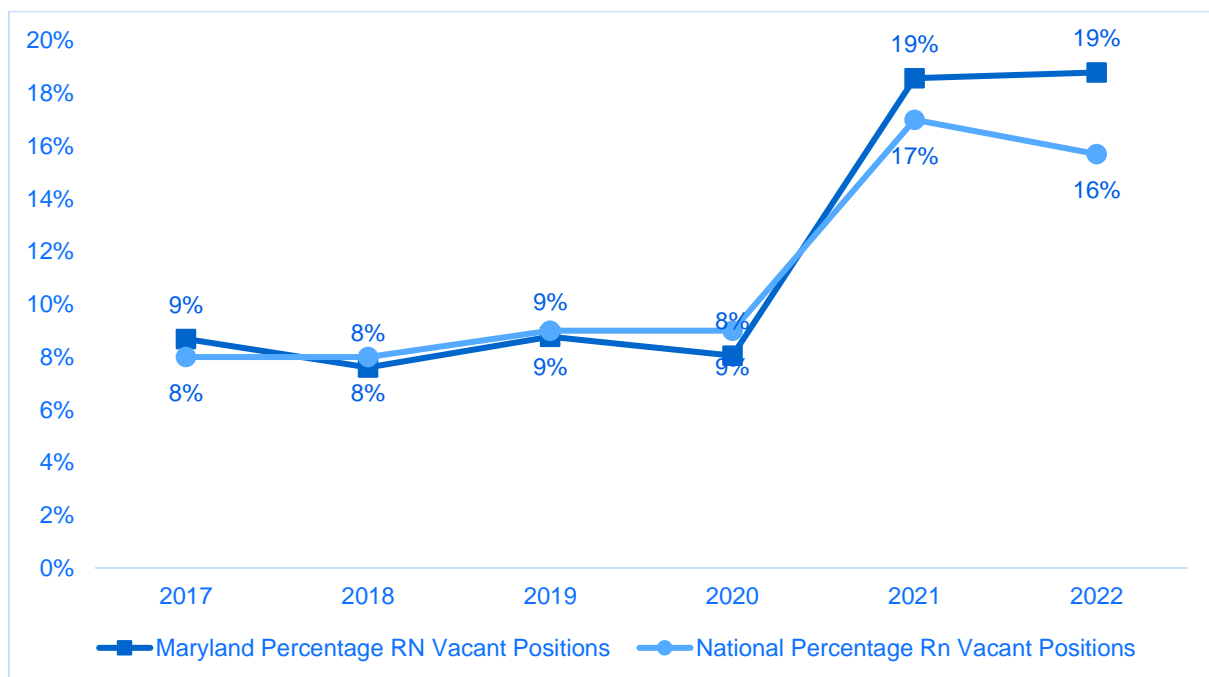
All participating hospitals submit data on a series of key metrics, which include, but are not limited to:

- Vacancy and Retention Rates
- Number of Nurses with BN and Advanced Degrees
- Enhanced Diversity

Vacancy, Turnover, & Retention Rates¹

Maryland hospital RN vacancy rate (19 percent) is currently above the nation (16 percent), which experienced a small decline in 2022 (Figure 2). The decrease in the national vacancy rate versus the stagnant vacancy rate in Maryland over the last two years may partially be attributed to difficulty in recruiting. The RN Recruitment Difficulty Index (RDI-RN) measures the average number of days hospitals take to recruit and hire an RN. According to National HealthCare Retention and RN Staff Report by Nursing Solutions Inc. (NSI), the North-East Region has the largest recruitment difficulty in the nation, taking 107 days on average to recruit and fill a position, whereas the national RDI-RN is 95 days.²

Figure 2. Registered Nurse Vacancy Rate in Hospitals, MD vs. Nation, 2017 - 2022



Source: Hospital NSP I Annual Reports, NSI Nursing Solutions

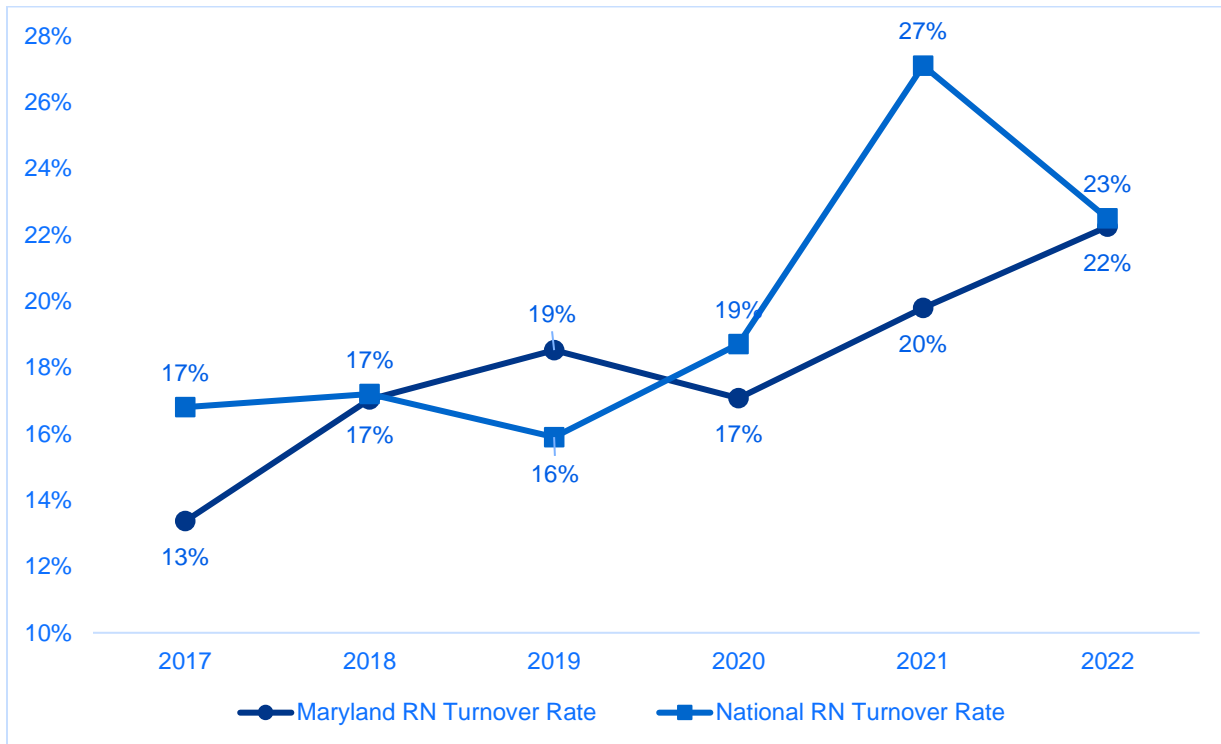
While Maryland's RN vacancy rate in FY 2022 was above the nation in FY 2022, the Maryland RN turnover rate remains below the nation, despite increases the prior two fiscal years, shown in Figure 3.

¹ All national statistics cited for vacancies and retention data are derived from the National HealthCare Retention and RN Staffing Report, which is an annual national survey of approximately 192 facilities from 32 states.

² Nursing Solutions Inc. (2023) 2023 NSI National Healthcare Retention and RN Staffing Report.

https://www.nsnursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf Accessed May 16, 2023.

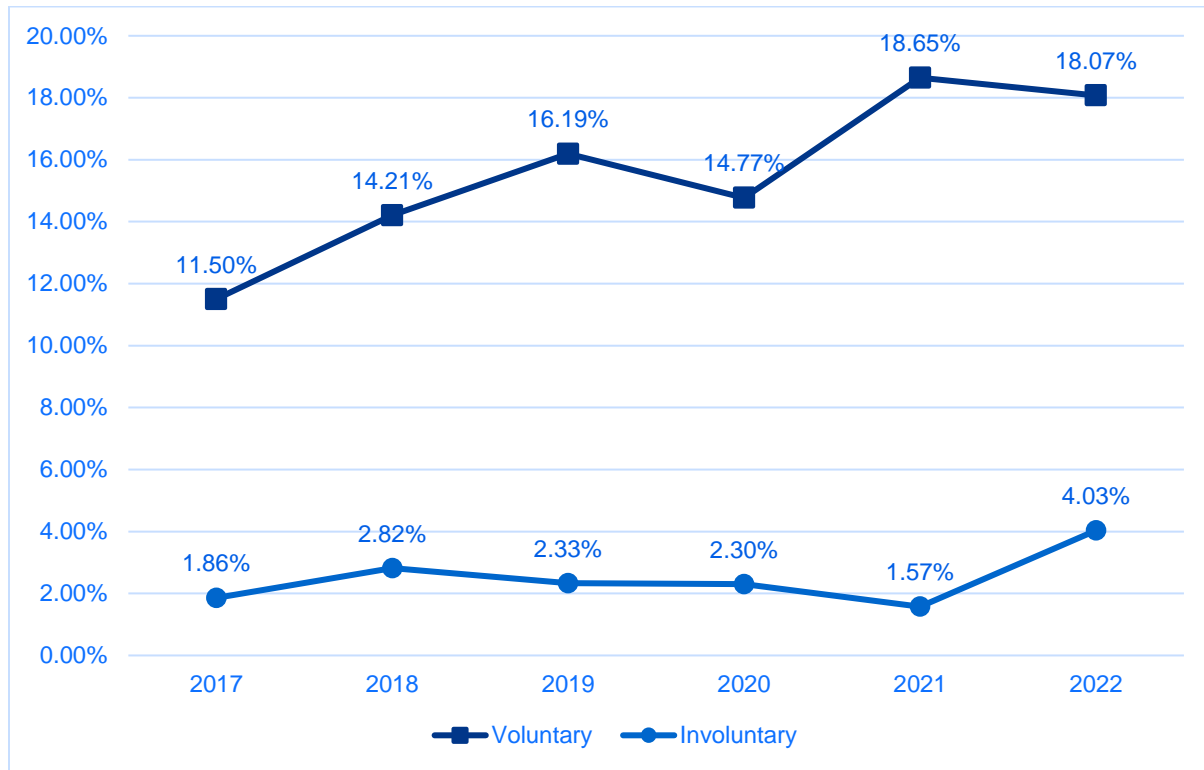
Figure 3. Hospital RN Turnover Rate, MD vs. Nation, FY 2017-FY 2022



Source: Hospital NSP I Annual Reports, NSI

As shown in Figure 4, voluntary departures in FY 2022 remained relatively stagnant since the prior year but have increased significantly since FY 2020. Involuntary terminations increased from 1.85 percent between FY 2017 and FY 2022, respectively, with the most significant increase between FY 2021 and FY 2022.

Figure 4. RN Turnover Rate, Voluntary & Involuntary, FY 2017 - FY 2022

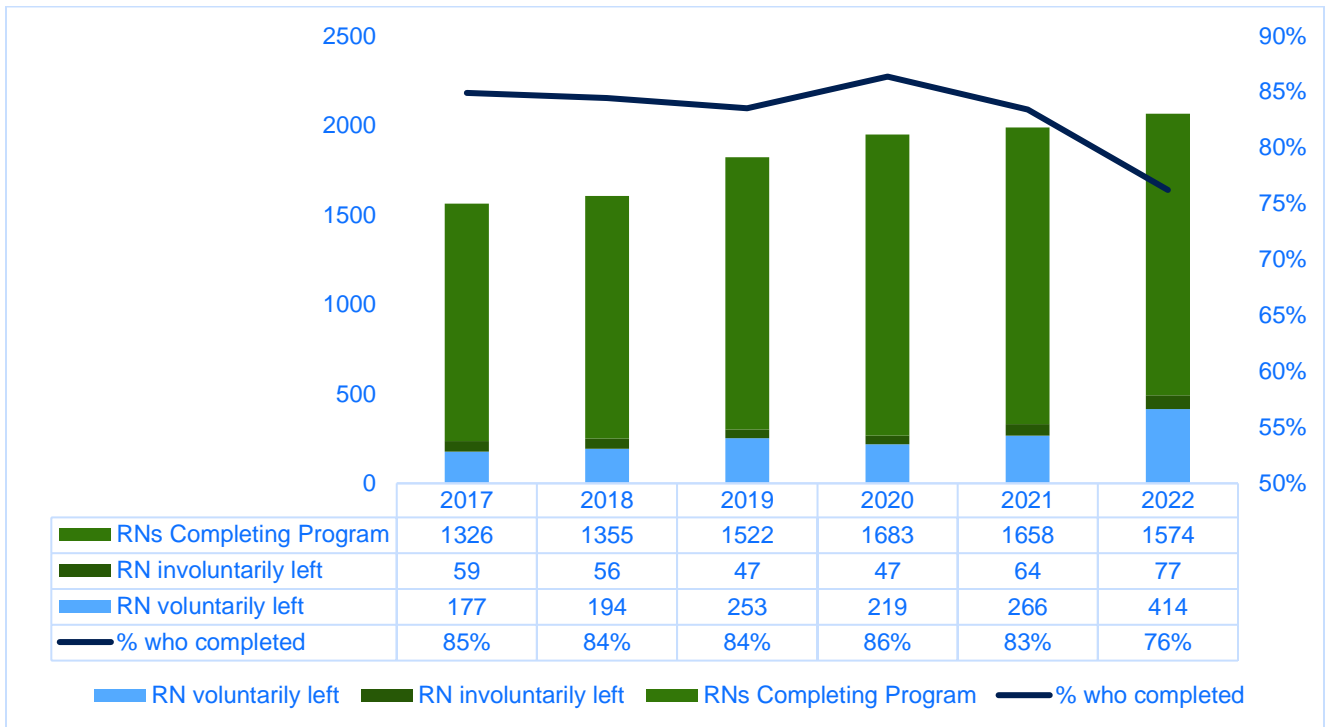


Source: Hospital NSP I Annual Reports

More insight is necessary to determine the growth of involuntary termination over the prior fiscal year, but improved educational programs and opportunities will likely provide significant value to help curtail this growth.

A key strategy to support new nurse retention is nurse residency programs. All NSP I hospitals implement nurse residency programs and report that they are an essential tool in training and retaining new nurses at hospitals. As shown in Figure 5, the completion rates for RNs completing residency programs declined by 7 percentage points to 76 percent in FY 2022, since the prior fiscal year.

Figure 5. RNs Participating and Completing Residency Program, FY 2017 -2022



The decline in completion rates is due primarily to growth in voluntary departures. Voluntary departures grew from 11 percent in FY 2017 to 20 percent in FY 2022. New nurses may be leaving for a variety of reasons including but not limited to: 1) opting to shift to travel jobs with higher pay, 2) shifting to positions in less stressful clinical settings, and 3) residual impacts of insufficient clinical training during the pandemic.

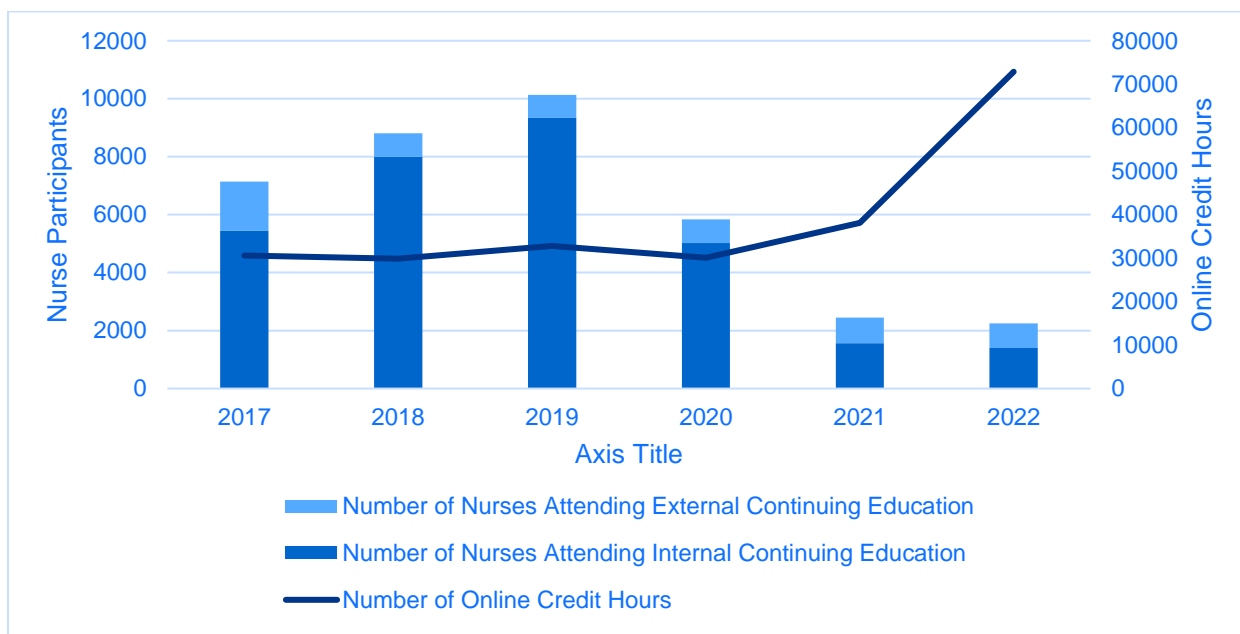
Many hospitals have cited the limited clinical experiences during nursing school as a key driver of the voluntary NRP departures. Safety concerns and the strain on hospital resources due to the pandemic necessitated halting on-site student clinical experiences in March 2020. To help address the impact of limited clinical training, Maryland hospitals and academics formed a committee to build a curriculum for a Transition to Nurse Residency Program (TNRP). The goal of TNRP is to restore the skills and competencies of new-to-practice nurses to pre-pandemic levels. The TNRP does not duplicate nor replace NRP; rather, it is a precursor to the NRP offered at onboarding and before new-to-practice nurses assume patient assignments. More than half of Maryland hospitals have implemented the program, and most are using NSP I funding to support it.

Continuing Education

Hospitals have reported a significant increase in the number of credit hours associated with continuing education. As shown in Table 1, funding for continuing education declined between FY 2017 (\$3.3 million) and FY 2021 (\$1.36 million) but increased by \$1.3 million in FY 2022 to \$2.7 million. Online credit hours in

FY 2022 increased significantly over the prior year, although the number of nurses participating decreased, potentially because of workforce shortages and that travel nurses are not eligible to participate in NSP I initiatives. The large growth in online credit hours can be attributed to an increased focus on in-house education as external opportunities were limited during the pandemic. Many external conferences that hospital nursing staff frequented prior to the pandemic have not resumed, so hospitals have reported increasing online education efforts.

Figure 6. Continuing Education Participants and Online Credit Hours, FY 2017 - 2022

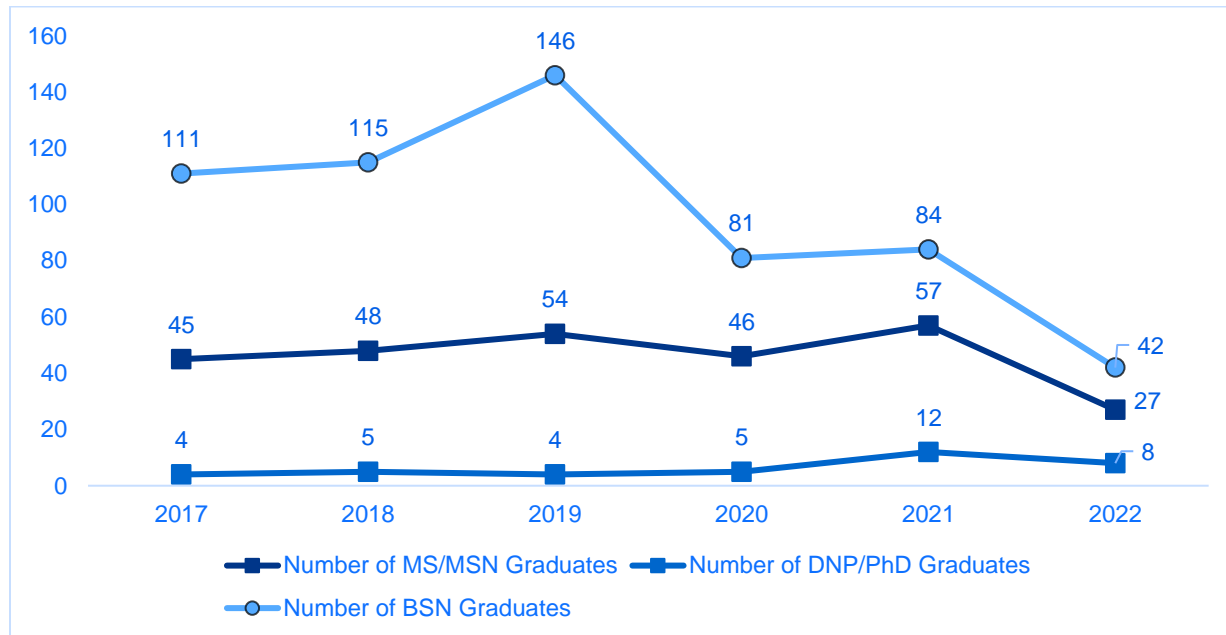


Number of Nurses with BN and Advanced Degrees

Another key goal of the IOM recommendations was to increase the number of nurses with advanced degrees. Strong research evidence has linked lower mortality rates, fewer medication errors, and positive outcomes to nurses prepared at the baccalaureate and graduate degree levels.³ Quality patient care hinges on a well-educated, highly functioning, motivated nursing workforce. Figure 7 shows the number of BSN, MS/MSN, and DNP/PhD degrees funded by NSP I between FY 2017 and FY 2022.

³ Institute of Medicine (US) Committee on the Robert Wood Johnson Foundation Initiative on the Future of Nursing, at the Institute of Medicine. *The Future of Nursing: Leading Change, Advancing Health*. Washington (DC): National Academies Press (US); 2011. 4, Transforming Education. Available from: <https://www.ncbi.nlm.nih.gov/books/NBK209885/>

Figure 7. NSP I Funded Degree Type, FY 2017 - 2022



Between 2017 and 2019, there was a 22 percent increase in the number of hospital-based nurses holding NSP I-funded BSN and Advanced degrees. However, the decline in advanced degrees that began in 2020 during the pandemic continued through FY 2022. As shown in Table 1, funding for advanced degrees has declined since FY 2017 as hospitals have prioritized attracting and retaining new staff through nurse residency and nursing student programs, and continuing education investments to retain existing staff. HSCRC will continue to monitor efforts around advanced degrees in FY 2023 to determine if this downward trend will continue or if investment in advanced degrees will begin to rebound to pre-pandemic levels. Anecdotally, some hospitals have reported that pursuit of advanced degrees is increasing in FY 2023. However, the State continues to make steady progress to the “80 Percent BSN by 2025” goals through the NSP II Program. In FY 2021, 67 percent of RNs in Maryland hold a BSN or higher.⁴

Enhanced Diversity in the Nursing Workforce

A key recommendation of IOM is to develop initiatives to address health disparities by increasing the number of minorities and men in all nursing roles. Specifically, NSP I programs can implement initiatives to:

- Increase the number of minority and male mentors and preceptors.
- Increase the number of minority and male nurses in leadership positions.

⁴ Health Services Cost Review Commission. (2023). *Nurse Support Program II Competitive Institutional Grants Program Recommendations for FY 2024*.

- Develop recruitment strategies to target racial/ethnic minorities, particularly in areas with high minority populations.

Based on reports submitted by hospitals, there is still significant progress to be made to increase the number of minorities and males in all nursing roles. As shown in Table 2, the number of males in all nursing roles (clinical nurse, nurse manager, nurse executive) has not changed significantly since FY 2020.

Table 2. Percent of Nursing Role by Gender, FY 2020 - 2022

	Gender	2020	2021	2022
Clinical Nurses	Male	9.38%	9.68%	10.15%
	Female	90.62%	90.32%	89.85%
Nurse Managers	Male	11.55%	9.32%	12.12%
	Female	88.45%	90.68%	87.88%
Nurse Executives	Male	15.32%	9.05%	13.30%
	Female	84.68%	90.95%	86.70%

Source: Hospital NSP I Reports

There have also not been significant changes in the race and ethnicity composition of nursing roles in Maryland hospitals either, as shown in Tables 3-5.

Table 3. Percent of Clinical Nurses by Race/Ethnicity, FY 2020 - 2022

	2020	2021	2022
NH Black	21.06%	20.53%	19.50%
NH White	62.01%	61.51%	60.45%
Hispanic	2.94%	2.98%	2.80%
Native American	0.37%	0.25%	0.23%
Pacific Islander	0.38%	0.26%	0.53%
Asian	11.16%	11.65%	11.43%
Prefer not to answer	2.08%	2.80%	5.06%

Source: Hospital NSP I Reports

Table 4. Percent of Nurse Managers by Race/Ethnicity, FY 2020 - 2022

	2020	2021	2022
NH Black	18.74%	17.33%	18.62%
NH White	73.81%	74.06%	68.49%

Hispanic	0.90%	1.18%	1.28%
Native American	0.13%	0.24%	0.13%
Pacific Islander	0.26%	0.59%	0.13%
Asian	5.26%	5.54%	7.53%
Prefer not to answer	0.90%	1.06%	3.83%

Source: Hospital NSP I Reports

Table 5. Nurse Executives by Race/Ethnicity, FY 2020 - 2022

	2020	2021	2022
NH Black	13.51%	15.09%	12.88%
NH White	83.33%	80.60%	77.68%
Hispanic	0.45%	1.29%	1.29%
Native American	0.45%	0.00%	0.86%
Pacific Islander	0.00%	0.00%	0.00%
Asian	2.25%	1.72%	1.72%
Prefer not to answer	0.00%	1.29%	5.58%

Source: Hospital NSP I Reports

As hospitals have struggled with nurse vacancy and retention, stagnant performance to increase diversity in the nursing force in Maryland hospitals is not wholly unexpected. Based on FY 2022 reporting, HSCRC staff has not seen robust efforts to increase male nursing staff and recruit racial/ethnic minorities, particularly in areas with high minority populations. HSCRC staff is encouraging hospitals to prioritize diversity in recruitment efforts to better reflect the composition of their communities in FY 2024 and will report on FY 2023 efforts next year.

Ongoing Challenges

Nursing Burnout

As illustrated in Figures 2-4 above, vacancy rates and retention continue to suffer in the wake of the COVID pandemic. In a 2021 survey of 2,000 nursing staff, the Maryland Nursing Workforce Center (MNWC) found that over 40 percent of respondents experienced moderate to severe stress, were unable to control worrying, felt hopeless, and had little pleasure in usual things. Close to 50 percent of respondents indicated that they had symptoms of burnout, felt anxious, and had experienced sleep disturbances. Furthermore, about 62 percent of nurses felt their physical health and safety were compromised without their consent,

and more than 60 percent indicated an intent to leave their current nursing job.⁵ These findings are echoed across the nation.⁶ Ongoing workforce shortages and lingering effects of COVID continue to exacerbate these challenges.

Increased Reliance on Agency Nurses

Anecdotally, nurses were leaving their positions to go to competing hospitals for signing bonuses, or to agencies for better pay, better hours, and less stress.⁷ The increase in agency nurses and the resulting high turnover, creates additional burdens on staff nurses as they must constantly orient the new people. In discussions with nurses from various roles, the main complaint regarding agency nurses is they are paid significantly more than staff nurses but not responsible for regulatory reporting and other burdens that are placed on staff nurses.

As more nurses leave hospitals for agencies, a costly feedback loop is created as hospitals rely more on agencies to backfill the reduction in the workforce. The pandemic exacerbated costs to \$713 million (Figure 8) in Maryland, as reported to the HSCRC in the FY 2020 NSP Annual Reports. Nationally, most hospitals are not anticipating reducing their reliance on agency nurses, while costs continue to increase.⁸ While there was a drop in agency costs in FY 2021, suggesting a potential return to pre-pandemic spending levels, hospitals reported a significant increase in FY 2022 to \$931 million as ongoing struggles with nursing workforce shortages continue.

⁵ University of Maryland School of Nursing – Maryland Nursing Workforce Center. (December 2021). Analysis of COVID-19's Impact on Maryland Nursing Workforce. <https://www.nursing.umaryland.edu/media/son/mnwc/MD-survey-of-post-COVID-workforce.pdf>

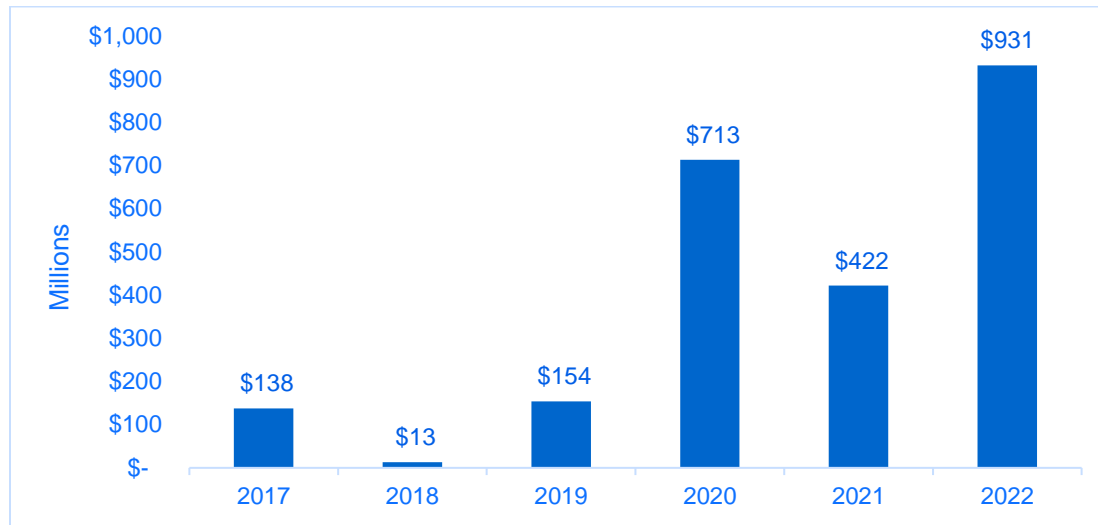
⁶ Hansen, A. and Tutas, C. (2021). Professional Choice 2020-2021: Travel Nursing Turns the Tide. [Article] www.nurseleader.com.

⁷ Vesoulis, Abby and Abrams, Abigail. Contract Nurse Agencies Are Making Big Money in the Age of COVID-19. Are They 'Exploiting' the Pandemic? Time.com, February 23, 2022. [Article]. <https://time.com/6149467/congress-travel-nurse-pay/> Accessed May 1, 2022.

⁸ Nursing Solutions Inc. (2023) 2023 NSI National Healthcare Retention and RN Staffing Report.

https://www.nsinursingsolutions.com/Documents/Library/NSI_National_Health_Care_Retention_Report.pdf Accessed May 16, 2023.

Figure 8. Nursing Agency Cost to Hospitals, FY 2017 - FY 2022



Source: Hospital NSP I Reports

The substantial growth in agency costs between FY 2021 and FY 2022 can partially be attributed to significant shortages during the second and third quarters of FY 2022 when the omicron variant of COVID-19 severely strained hospital resources. To bring this number down in FY 2023, hospitals have reported creating hospital or system-owned travel agencies which has mitigated some of the high costs associated with travel agencies.

Conclusion

The NSP I Program continues to be an important resource to acute care hospitals as they seek to retain nursing staff and grow leadership potential, expand educational opportunities, and advance the practice of nursing as a whole. HSCRC staff, with the guidance of the NSP I Advisory Committee, will work to identify areas of opportunities to support the nursing workforce in Maryland hospitals and further align with NSP II funded programs and initiatives. Additionally, based on available data presented in this report, there is a demonstrated need to increase funding for the NSP I program to support education and retention efforts and enhance diversity in the nursing workforce. In future years, staff will propose an increase in funding to expand or create new NSP I programs. HSCRC staff will continue to monitor NSP I activities through ongoing reporting, meetings with individual hospitals on program progress, and data monitoring.



TO: HSCRC Commissioners
FROM: HSCRC Staff
DATE: July 12, 2023
RE: Hearing and Meeting Schedule

Adam Kane, Esq
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

Stacia Cohen, RN, MBA

James N. Elliott, MD

Maulik Joshi, DrPH

Sam Malhotra

August 9, 2023 To be determined - GoTo Webinar

September 13, 2023 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.

Katie Wunderlich
Executive Director

William Henderson
Director
Medical Economics & Data Analytics

Allan Pack
Director
Population-Based Methodologies

Gerard J. Schmith
Director
Revenue & Regulation Compliance