maryland
health services
cost review commission

576th Meeting of the Health Services Cost Review Commission
September 9, 2020

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

EXECUTIVE SESSION
11:30 am

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

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

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on June 10, 2020

2. Docket Status – Cases Closed
   2524A – Johns Hopkins Health System 2525A – Johns Hopkins Health System
   2564A – Johns Hopkins Health System 2574A – Johns Hopkins Health System

3. Docket Status – Cases Open
   2523N – McNew Family Health Center 2528A – Johns Hopkins Health System
   2529A – Johns Hopkins Health System 2530N – McNew Family Health Center

4. Medicare Performance Adjustment RY 2022 Executive Summary

5. Policy Update and Discussion

   a. Model Monitoring

   b. FY 2020 GBR Considerations

   c. COVID-19 Surge Policy Report

6. Long-Term Care Partnership Grant Program (Informational Only)
7. Legal Update
8. Hearing and Meeting Schedule

Closed Session Minutes
Of the
Health Services Cost Review Commission

July 8, 2020

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

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

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

The Closed Session was called to order at 11:42 p.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

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

In attendance via conference call representing Staff were Katie Wunderlich, Chris Peterson, Allan Pack, William Henderson, Alyson Schuster, Tequila Terry, Will Daniel, Joe Delenick, Claudine Williams, Amanda Vaughn, and Dennis Phelps.

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

Item One

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

Item Two

Tequila Terry, Deputy Director-Payment Reform and Provider Alignment, presented an overview of HSCRC's new visual identity project.

Item Three

Kate Wunderlich, Executive Director, updated the Commission and the Commission discussed surge Capacity Planning.

Item Four

Ms. Wunderlich presented to the Commission and the Commission discussed staff's suggestions on Strategic Priorities and Policy Development to evolve and improve the Total Cost of Care (TCOC) Model. The suggestions included care transformation, quality and population health, payment reform and provider alignment strategies, rate setting and financial methodology development, and long term transformation of the TCOC Model.

Ms. Wunderlich announced that Chris Peterson, Director-Payment Reform and Provider Alignment, was leaving the staff. Ms. Wunderlich and the Commissioners wished him well and thanked for his many Significant accomplishments relative to the development and implementation of the TCOC Model.

The Closed Session was adjourned at 1:02 p.m.

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MINUTES OF THE
575th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
July 8, 2020

Chairman Adam Kane called the public meeting to order at 11:42 am. Commissioners Joseph Antos, PhD, Victoria Bayless, Stacia Cohen, John Colmers, James Elliott, M.D., and Sam Malhotra were also in attendance. Upon motion made by Commissioner Antos and seconded by Commissioner Colmers, the meeting was moved to Closed Session. Chairman Kane reconvened the public meeting at 1:12 p.m.

REPORT OF JULY 8, 2020 CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the July 8, 2020 Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE JUNE 10, 2020 CLOSED SESSION AND PUBLIC MEETING

The Commissioners voted unanimously to approve the minutes of the June 10, 2020 Public Meeting and Closed Session minutes.

ITEM II
CASES CLOSED

2520A- University of Maryland Medical Center
2521A- University of Maryland Medical Center
2322A- Johns Hopkins Health System

ITEM III
TOTAL COST of CARE MODEL STATE ACTIVITIES UPDATE

Statewide Integrated Health Improvement Strategy

Ms. Tequila Terry, Deputy Director, Payment Reform and Provider Alignment, Ms. Anne Langley, Center for Population Health Initiative, Maryland Department of Health, and Mr. Steve Schuh, Executive Director, Maryland Opioid Command Center, Office of the Governor, presented an update on Statewide Integrated Health Improvement Strategy (see “Statewide Integrated Health Improvement Strategy” on the HSCRC website).

In December 2019, the State of Maryland and Centers for Medicare and Medicaid Services (CMS) signed a Memorandum of Understanding (MOU) agreeing to establish a Statewide Integrated Health Improvement Strategy (SIHIS). This initiative is designed to engage state agencies and private sector partners to collaborate and invest in improving health, addressing disparities, and reducing health care costs for Marylanders.

The guiding principles for the SIHIS are:

- Maximize the population health improvement opportunities made possible by the Total Cost of Care (TCOC) Model.
- Goals, measures, and targets should be specific to Maryland and established through a collaborative public process.
- Goals, measures, and targets should reflect an all-payer perspective.
- Goals, measures, and targets should capture statewide improvements, including improved health equity.
- Goals for the three domains of the integrated strategy should be synergistic and mutually-reinforcing.
- Measures should be focused on outcomes whenever possible; milestones, including process measures, may be used to signal progress toward targets.
- Maryland's strategy must promote public and private partnerships with shared resources and infrastructure.

The MOU requires the State to propose goals, measures, milestones, and targets in three domains by the end of CY 2020. The three domains are Hospital Quality, Transformation across the System, and Total Population Health. The Centers for Medicare and Medicaid Innovation (CMMI) has stated that in order for the TCOC Model to be made permanent, the State must sustain and improve high quality care under the population base hospital finance model, achieve annual cost saving targets, and achieve progress on the SIHIS.

Within the Total Population Health domain, the State has the option to identify three priority areas to focus on improving as part of the TCOC Model.

- The first statewide priority area is diabetes, which was identified by the Maryland State Secretary of Health. Further information on this statewide priority and Maryland's Statewide Diabetes Action Plan is available on the MDH website.
- The second statewide priority area is opioids, which was identified by the Lieutenant Governor through the Maryland Heroin and Opioid Emergency Task Force. This initiative is being led by the Opioid Operational Command Center (OOCC).
- The State also has the option of identifying a third population health focus by December 31, 2020.

The State must set targets and demonstrate progress in each of the three domains. CMMI will review data through CY 2021 to make decisions about making the TCOC Model permanent. The HSCRC Performance Measurement Workgroup will be responsible for domain one (Hospital Quality). Domain two (Transformation across the System) will be the responsibility of both the HSCRC Performance Measurement Workgroup and the HSCRC Total Cost of Care Workgroup. Within domain three (Population Health), the Maryland Department of Health will be responsible for the Diabetes priority area, and the OOCC will be responsible for the Opioid priority area.

Staff intend to present milestones and targets to the Commissioners during the October 14th Public Meeting and to present the proposal to the Commissioners during the December 9th Public Meeting. The SIHIS proposal is due to CMS on December 31st.

Chairman Kane asked whether the priority areas are separate from the incentives the GBR methodology would be expected to produce.

Ms. Terry stated that they are indeed separate, particularly domains two and three, which are not limited to hospital providers.

Commissioner Colmers questioned to what extent the initiatives should focus on Medicare versus other populations, given that CMS' main focus will be on Medicare patients.

Ms. Terry responded that domain three (Population Health) is intended to look at health challenges of all Maryland citizens, not just in the Medicare population.

Ms. Langley updated the Commission on the efforts to coordinate state activities to prevent and control diabetes. A Diabetes Target Measures Work Group will be convene to generate and evaluate a panel of potential measures. The group will include representatives from the hospital industry, MDH, CRISP, the American Diabetes Association, payers, the clinician community, diabetes specialists, and other experts. The goal is to align activities and select clinically relevant measures that improve health outcomes.

Mr. Schuh updated the Commission on the Opioid Operational Command Center (OOCC). OOCC was created by Governor Larry Hogan in 2017 to coordinate the statewide response to the opioid crisis. The OOCC will lead the population health priority on opioid screening, prevention, and treatment. OOCC will draw strategies and potential measures from its strategic plan, the Maryland Inter-Agency Opioid Coordinating Plan. Mr. Schuh will vet potential measures with the state partner group, composed of State Agencies and other stakeholders including MHA and with the HSCRC.

Commissioner Malhotra asked whether the OOCC has begun gathering data to determine where resources should be deployed.

Mr. Schuh responded that the OOCC is currently gathering that data with the intention of identifying any gaps or surplus of treatment delivery capacity in each county in the State.

Maryland Primary Care Program

Dr. Howard Haft, Executive Director. Maryland Primary Care Program (MDPCP), provided an update on MDPCP activities.

MDPCP is a voluntary program open to all qualifying Maryland primary care providers which provides funding and support for the delivery of advanced primary care throughout the State. The MDPCP supports the overall health care transformation process and allows primary care providers to play an increased role in illness prevention, management of chronic disease, and the prevention of unnecessary hospital utilization.

As of CY 2020 Quarter 2, MDPCP has approximately 2,000 aligned providers (up from 1,500 in 2019) and 347,000 Medicare Fee for Service beneficiaries attributed (up from 220,000 in 2019). Currently, MDPCP is working with the Advisory Council and CMMI to develop an optional track three proposal modeled after Primary Care First. MDPCP is also further embracing data driven care by utilizing data tools to reduce avoidable hospital utilization and unnecessary Emergency Department (ED use. Finally, MDPCP is working to manage population health during COVID-19 by assisting in statewide testing of primary care patients and focusing on improving access to care through telehealth**.**

Commissioner Elliott asked whether there was any data that links enhanced access to primary care and avoidable utilization.

Dr. Haft responded that enhanced access to primary care is principal driver in reducing avoidable utilization. Data on the availability of primary care is used to predict where avoidable utilization would is likely to occur, which can be addressed by care interventions.

Commissioner Bayless asked Dr. Haft if there was anything that has surprised or disappointed him so far in the program.

Dr. Haft replied that he has been surprised by the overwhelmingly positive response from the physicians and level of engagement. Dr. Haft stated that he has been disappointed by the failure to receive credible data in a timely fashion.

Chairman Kane asked how many of the MDPCP physicians are health system aligned or owned. Dr. Haft responded that approximately 50 percent of the physicians are health system aligned or owned.

Chairman Kane then asked whether there was a difference between independent and hospital aligned/owned practices in terms of resources in already in place at the onset of the program, and in the outcomes of independent and hospital aligned/owned practices.

Dr. Haft replied that the best performers are the small, independent, highly engaged practices.

Commissioner Cohen asked if shifts in risk scores were being tracked, since care management fees are dependent on risk scores.

Dr. Haft responded that they are currently being tracked.

Commissioner Cohen requested that Dr. Haft include risk score data in future presentations to the Commission.

Care Redesign Programs and Care Transformation Initiatives

Mr. Willem Daniel, Deputy Director, Payment Reform and Provider Alignment, presented Staff's update on the Care Redesign Program (CRP) and Care Transformation Initiative (CTI) programs (See "CTI Update" on the HSCRC website).

CRP was created to allow hospitals to make gain sharing payments to nonhospital providers. CTIs were created in order to address some of the limitations with the CRP. Under CTI, hospitals are able to define their own CTI population, rather than following CMS definitions. Hospitals will also receive 100 percent of the Total Costs of Care savings that they produce under CTI, and are not required to make incentive payments. Finally, CTI seeks to minimize the administrative burden by not requiring any reporting beyond defining the CTI population.

The CTI policy incentivizes hospitals to manage the total cost of care of the selected population. Hospitals receive 100 percent of the achieved savings on beneficiaries in their defined population. The savings are calculated by comparing the total cost of care of the included beneficiaries to similar beneficiaries in a prior year. Payments are offset by revenue reduction across all non-participating hospitals in the State in order to incentivize participation by all hospitals. The CTI process will also allow the Commission to calculate the Return on Investment (ROI) on interventions, which will help illustrate the TCOC Model's care transformation impact to CMMI.

The following five CTI thematic areas have been identified to-date:

- Care Transitions (Target Population: Patients discharged from the hospital)
- Palliative Care (Target Population: Patients seen at the hospital who have a serious diagnosis)
- Primary Care (Target Population: Patients seen by primary care practices)
- Community Care (Target Population: Patients residing in Skilled Nursing Facilities or assisted living facilities)
- Emergency Care (Target Population: Patients seen at the ED but not admitted to the hospital)

The CTI policy is scheduled to begin on January 1, 2021. The original policy was delayed by 6 months due to the COVID virus state of emergency. Final implementation protocols will be due in October of 2020. The first performance period will be calendar year 2021 with payments made beginning July 2022. New CTI Thematic Areas can be developed throughout CY 2022. Staff will also explore additional methodologies to set a target price like the MA or PACE benchmarks so that measures will be developed to report the amount that hospitals spend on their CTIs. These costs can be used to calculate an ROI on their interventions. These costs can be included in the Inter-hospital Cost Comparison methodology to incorporate population health spending into our efficiency policies. Development of the next CTI Thematic Areas and methodologies will continue through 2021.

Commissioner Elliott asked if there is an overlap between the primary care thematic area of the CTI program and MDPCP.

Mr. Daniel responded that there is some overlap. Mr. Daniel also stated that the CTI policy has more total cost of care risk/reward than MDPCP, but has fewer restrictions on individual practices use of care management fees.

Chairman Kane asked what the magnitude of yearly revenue moved around by the CTI program is expected to be.

Mr. Daniel replied that the expected amount would depend on expected savings and success. Mr. Daniel stated that some of the interventions would already be mature, and thus expected to yield higher savings, while new interventions would likely see a ramp-up period before achieving substantial savings.

Commissioner Kane suggested that Staff should spend more time thinking about the magnitude of savings, since the program would require a lot of work for hospitals.

Ms. Katie Wunderlich, Executive Director, stated that Staff addresses the magnitude of the targets for each thematic area and noted that the administrative burden of the CTI program is much lower than that of the CRP program.

ITEM IV
COVID-19 LONG-TERM CARE PARTNERSHIP UPDATE

Ms. Terry presented the Staff's update on the COVID-19 Long Term Care Partnership Grant program
(see" COVID-19 Long Term Care Partnership Grant Program" on the HSCRC website).

The COVID-19 Long Term Care Partnership (LTC) Grant Program is intended to foster collaboration between hospitals, long-term care facilities, and other congregate living facilities that serve vulnerable populations during the COVID-19 crisis. Under the LTC Grant Program, hospitals and their long-term care/congregate living partners will collaborate on best practices to reduce the spread of COVID-19 in these settings through a focus on patient management, infection prevention, and infection control The grant program is intended to be a one-year program starting July 1, 2020 and ending June 30, 2021. Grant awards will be issued in order of receipt until the statewide approved funding limit of $10 million has been met. The grant program is being funded by the previously unallocated 3rd funding stream of the Regional Partnership Catalyst Grant Program.

In order to eligible for the LTC grants:

- Hospitals must partner with at least one licensed long-term care and/or congregate living facility that services vulnerable populations and is operating in Maryland
- Hospitals should work with partners that are in the same geographic areas and with whom they have a "911 relationship" with to handle the majority of emergencies.
- As of the application date, hospitals must have a collaboration agreement with the long-term care/congregate living facility that is currently operating in Maryland to be eligible for grant funding.
- Applications must include a list of strategies that will be implemented to address COVID-19 patient management, infection prevention, and infection control.
- Details about arrangements for resource sharing, financial payments, and/or in-kind support must be disclosed in the applications.

Staff's recommendation is that the Commissioners delegate authority to Staff to evaluate applications submitted for funding and to make award determinations up to the approved limit of $10M, and that Staff work with one or more Commissioners during the process.

Commissioner Antos questioned whether the grant funding would be for one year from the approval of the application, or be retroactive to July 1, 2020.

Ms. Terry replied that the funding would be provided through hospital rates for one year as of July 1, 2020.

Commissioner Antos noted that hospitals would require time to strategize and prepare their applications.

Commissioner Antos then asked whether there was a connection between the LTC Grants and the Maryland Patient Safety Center (MPSC).

Ms. Terry responded that LTC activities could be aligned with those of MPSC, but that Staff would determine whether an application is requesting funding that would duplicate MPSC funding.

Chairman Kane emphasized that the LTC grants is not limited to non-profit organizations, and that if hospitals want to participate in multiple types of grants they are encouraged to do so.

Commissioners voted unanimously to approve Staff's recommendation.

ITEM V
FY 2019 COMMUNITY BENEFITS REPORT

Mr. Daniel, and Laura Spicer, Director, Health Reform Studies, Hilltop Institute, presented Staff's FY 2019 Community Benefit Report. (See "Maryland Hospital Community Benefit Report FY 2019).

The term community benefit refers to initiatives, activities, and investments undertaken by tax exempt hospitals to improve the health of the communities they serve. Maryland law defines community benefit as an activity that intends to address community needs and priorities primarily through disease prevention and improvement of health status. Examples of community benefit activities may include the following:

- Health services provided to vulnerable or underserved populations such as Medicaid, Medicare, or Maryland Children's Health Program participants
- Financial or in-kind support of public health programs
- Donations of funds, property, or other resources that contribute to a community priority
- Health care cost containment activities

- Health education, screening, and prevention services
- Financial or in-kind support of the Maryland Behavioral Health Crisis Response System

In 2001, the Maryland General Assembly passed House Bill 15 which required the HSCRC to collect community benefit information from individual hospitals and compile it into a statewide, publicly available Community Benefit Report (CBR). In response to this legislative mandate, the HSCRC initiated a community benefit reporting system for Maryland's nonprofit hospitals that included two components. The first component, the Community Benefit Collection Tool, is a spreadsheet that inventories community benefit expenses in specific categories defined by the HSCRC's Community Benefit Reporting Guidelines and Standard Definitions. These categories are similar but not identical to the federal community benefit reporting categories. The second component of Maryland's reporting system is the CBR narrative report. The HSCRC developed the Community Benefit Narrative Reporting Instructions to guide hospitals' preparation of these reports, which strengthen and supplement the quantitative community benefit data that hospitals report in their inventory spreadsheets.

In March 2020, the Maryland General Assembly passed Senate Bill 774, which amends the statutory requirements for hospital community benefit reporting. This bill requires the HSCRC to establish a Community Benefit Reporting Workgroup and adopt regulations recommended by the Workgroup regarding community benefit reporting. The bill also modifies the definition of community benefit and expands the list of items that hospitals must include in their CBR.

All 50 Maryland hospitals submitted FY 2019 CBRs, showing a total of $1.89 billion in community benefit expenditures, which is a slight increase over FY 2018 ($1.75 billion). The distribution of expenditures across community benefit categories remained similar to prior years, with mission-driven services accounting for the majority of expenditures. Expenditures as a percentage of operating expenses also slightly increased from FY 2018 (6.7 percent) to FY 2019 (7.4 percent).

The narrative portion of the CBR provides the HSCRC with richer detail on hospital community benefits and Community Health Needs Assessment (CHNA) activities beyond what is included in the financial report. Encouraging findings of the review include a senior-level commitment to community benefit activities and community engagement. For example, 90 percent of hospitals employed a population health director, and most reported that these staff members were involved in selecting the community health needs to target and in developing community benefit initiatives. Additionally, 87 percent of hospitals employ staff dedicated to community benefit. Community benefit initiatives frequently targeted diabetes treatment/prevention, which is consistent with needs identified in hospital CHNAs and the goals of the State's new Diabetes Action Plan.

The review also identified the following areas for improvement:

- Most, but not all, hospitals reported working with their local health department during the CHNA process. All hospitals are encouraged to include the local health departments in this process. Hospitals are also encouraged to improve visibility and reporting on CHNA activities
- Staff noted variation in the format and content of the hospitals' financial assistance policy documents. Standardization of these documents could provide greater clarity for consumers
- Only 13 hospitals reported collaborating with post-acute facilities in their community benefit initiatives. Greater collaboration with such facilities may help the State to achieve the new goals within the Total Cost of Care Model, which emphasizes collaboration with community-based providers to address population needs
- Inconsistencies and ambiguity in reporting on physician subsidies makes it difficult to tie these expenditures to needs specifically identified in the CHNA or to gaps in physician availability. Revisions to the reporting instructions will allow for more precise analyses in subsequent years

With the passage of Senate Bill 774 during the 2020 legislative session, the HSCRC Staff will work with stakeholders in the coming months to address these improvement areas, as well as the changes outlined in the bill. Corresponding changes will be made to next year's reporting tool.

Commissioner Colmers asked what the timing is regarding the State mandated changes.

Mr. Daniel replied that the legislation requires a plan to change the regulations, but does not directly state when this needs to be done. Mr. Daniel stated that the plan can be vague initially and then made more specific once Staff meets with a technical group to finalize the details.

Commissioner Bayless asked if there was an expected percent of spending associated with community benefit relative to the value of hospitals' tax-exempt status.

Mr. Daniel replied there is a general expectation for aggregate community benefit spending to exceed tax-exempt savings.

Ms. Bayless also asked what HSCRC staff intend to understand from the physician subsidy component of mission-driven services

Mr. Daniel said HSCRC staff intend to better understand unregulated spending, including how hospitals address access to physician services.

Commissioner Cohen questioned whether the Commission could shift from process-heavy reporting to a more outcomes based reporting in the future.

Mr. Daniel stated that Staff share Commissioner Cohen's view that the Commission should transition to more of a focus on outcomes in the reporting.

Chairman Kane questioned why HSCRC is responsible for the hospital community benefit reporting process and suggested MDH should be responsible, as he believes community benefit reporting is inconsistent with HSCRC's. legal mandates.

Ms. Wunderlich stated that coordination with MDH would be ideal, but HSCRC is legislatively required to manage this process.

Chairman Kane stated that efforts should be made to shift this work to MDH, as they are best suited to assess community benefit activities.

ITEM VI
POLICY UPDATE AND DISCUSSION

Ms. Wunderlich announced that Chris Peterson, Director, Payment Reform and Provider Alignment was leaving the staff to take a position with the MITRE Corporation. Ms. Wunderlich thank Mr. Peterson for his stellar service in the implementation of the TCOC Model over the years and for the invaluable contributions Mr. Peterson made in all areas of HSCRC focus.

CY 2019 Model Performance Overview

Ms. Wunderlich stated that the HSCRC received a letter affirming Maryland's performance against the TCOC Model. Ms. Wunderlich stated that according to the letter, Maryland met all model requirements for CY 2019. Maryland exceeded the CY 2019 target savings of $120M, with an actual savings of $340M. Since the TCOC Model allows the State to roll over half of CY 2019 excess savings to CY 2020, meaning that $110M in savings will be rolled forward to CY 2020. In addition, Ms. Wunderlich noted that Maryland's performance through March 2020 has been favorable.

Covid-19 Volume and Financial Trends

Mr. William Henderson Director, Medical Economics and Data Analytics, stated that for the two weeks ending June 14th, statewide inpatient revenue was 106.4 percent of historic levels, while statewide outpatient revenue was 85.2 percent of historic levels (up from 67 percent in the first two weeks of May). Mr. Henderson noted that the May statewide average daily census (ADC) of

COVID cases was approximately 22 percent of the May 2019 ADC, and that while several D.C. area hospitals were outliers, the majority of facilities experienced between 15 percent and 30 percent of their typical ADC in COVID cases.

Mr. Henderson stated that the FY 2020 undercharge is now expected to fall in the range of $0.97B to $1.1B, before accounting for Federal funding. A $1B undercharge represents a 5.5 percent undercharge at full GBR. Mr. Henderson stated that as of May 15, the total amount of federal funding received by Maryland hospitals was $546M, $487M for regulated activities and $59M for unregulated activities.

ITEM IX
HEARING AND MEETING SCHEDULE

September 9, 2020	HSCRC Conference Room Times to be determined, 4160 Patterson Avenue
October 14, 2020	HSCRC Conference Room Times to be determined, 4160 Patterson Avenue

There being no further business, the meeting was adjourned at 4:20 p.m.

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF AUGUST 31, 2020

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials
2523N	McNew Family Health Center	6/1/2020	9/9/2020	12/29/2020	PTH & STH	WH
2528A	Johns Hopkins Health System	8/19/2020	N/A	N/A	ARM	DNP
2529A	Johns Hopkins Health System	8/24/2020	N/A	N/A	ARM	DNP
2530N	McNew Family Health Center	8/26/2020	9/25/2020	1/23/2021	AMB & ANCILARIES	WH

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

File Status
OPEN
OPEN
OPEN
OPEN

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IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF THE	*	**COST REVIEW COMMISSION**	
J. KENT McNEW	*	**DOCKET:**	**2020**
FAMILY MEDICAL CENTER	*	**FOLIO:**	**2333**
ANNAPOLIS, MARYLAND	*	**PROCEEDING:**	**2523N**

Staff Recommendation
September 9, 2020

Introduction

On June 1, 2020, J. Kent McNew Family Medical Center ("the Hospital") submitted a partial rate application to establish both a new Physical Therapy (PTH) rate and a new Speech Therapy (STH) rates. The Hospital requested that the rates be set at the statewide median per RVU and be effective July 1, 2020. The J. Kent McNew Family Medical Center was opened by Anne Arundel Medical Center in the spring of this year as a stand-alone mental health facility that provides both inpatient and outpatient mental health services. It includes an acute inpatient mental health unit, a psychiatric day hospital (also referred to as a partial hospitalization program), and intensive outpatient treatment.

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 its projections. Therefore, staff requested that the Hospital submit to the Commission projected cost and statistical data for the requested new PTH and STH services. Based on the information received, it was determined that the PTH rate based on the Hospital projection data would be $14.05 per RVU, while the statewide median rate for PTH services is $14.23 per RVU. The STH rate based on the Hospital projection data would be $12.28, while the statewide median rate for STH services is $11.72.

	Estimated Annual Volume (RVUs)	FY20 Statewide Median Rate	Estimated Revenue at FY20 Rates
Physical Therapy	425	$14.05	$5,971
Speech Therapy	155	$11.72	$1,816

Recommendation

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

1. That the Commission waive its requirement (COMAR 10.37.10.07) that a hospital file a rate application at least 60 days before the operational opening of a new hospital, a revenue center, or a new service;

2. That the PTH rate of $14.05 per RVU be approved effective July 1, 2020;

3. That the STH rate of $11.72 per RVU be approved effective July 1, 2020; and

4. That the PTH and STH rate centers not be rate realigned until a full year of cost data have been reported to the Commission.

Preview of the MPA Recommendation

Overview of the Medicare Performance Adjustment (MPA) Policy

- CMS requires the HSCRC to attribute patients to hospitals in Maryland and hold hospitals accountable for their attributed beneficiaries.
  - Under current policy, beneficiaries are attributed to hospitals using a tiered attribution algorithm.
  - Tiered attribution is necessary because 95% of all beneficiaries in the State must be attributed to some hospital.
  - Hospitals win or lose based on whether their attributed costs grow faster or slower than national growth – a discount factor.
- Staff and the TCOC Workgroup reviewed the existing MPA Policy, focusing on three things:
  1. Improvements in the MPA attribution
  2. Modifications to the financial methodology
  3. Assessing the interaction between the CTI and MPA polices.

Review of MPA Attribution Method

- Staff and hospitals are concerned about the complexity of the MPA attribution.
  - The complexity of the attribution algorithm makes it difficult to determine whether TCOC results are due to a hospital's performance or due to churn in the attribution algorithm.
  - Attribution based on plurality of physician services provided to beneficiaries was incorporated in order match ACO and programs but results in substantial churn.
- In order to simplify the attribution algorithms, staff compared different MPA attribution algorithms under three criteria:
  - 1) How much TCOC is the hospital responsible for as compared to their revenue; 2) What percentage of the beneficiaries' care is provided by their attributed hospital; and 3) What percentage of the hospital's services are provided to attributed beneficiaries.
  - Pure geographic attribution did at least as well as all other attribution algorithms (except for the Academic Medical Centers)
- Therefore, staff intends to recommend moving to geographic attribution.

Review of Financial Benchmarking

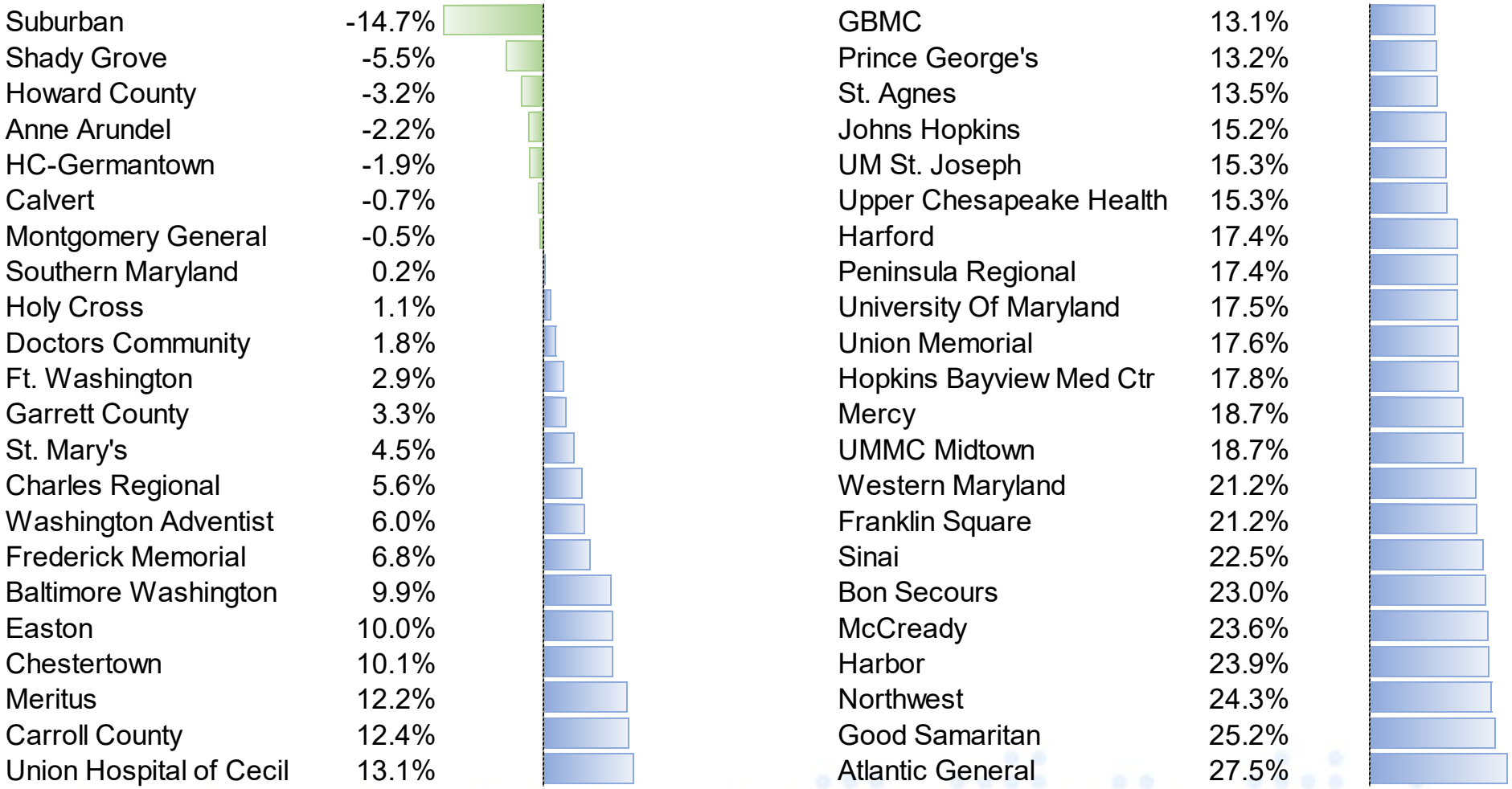
- Benchmarking to national growth rate also makes the MPA policy unpredictable and potentially volatile.
  - Comparing hospitals to a national year over year growth rate makes it hard for hospitals to know how much improvement is required for them to be successful.
  - Year over year variation can result in hospitals frequently flipping from winners to losers and back from year to year.
- Hospitals have suggested moving to an attainment standard rather than an improvement standard for the MPA.
  - A TCOC per capita target based on a comparison to the hospital's comparison group costs.
  - The benchmark would grow at the national growth rate but the TCOC target would be relatively stable over time.
- Staff intends to recommend moving to an attainment target for the MPA.

Overview of the Revised MPA Approach

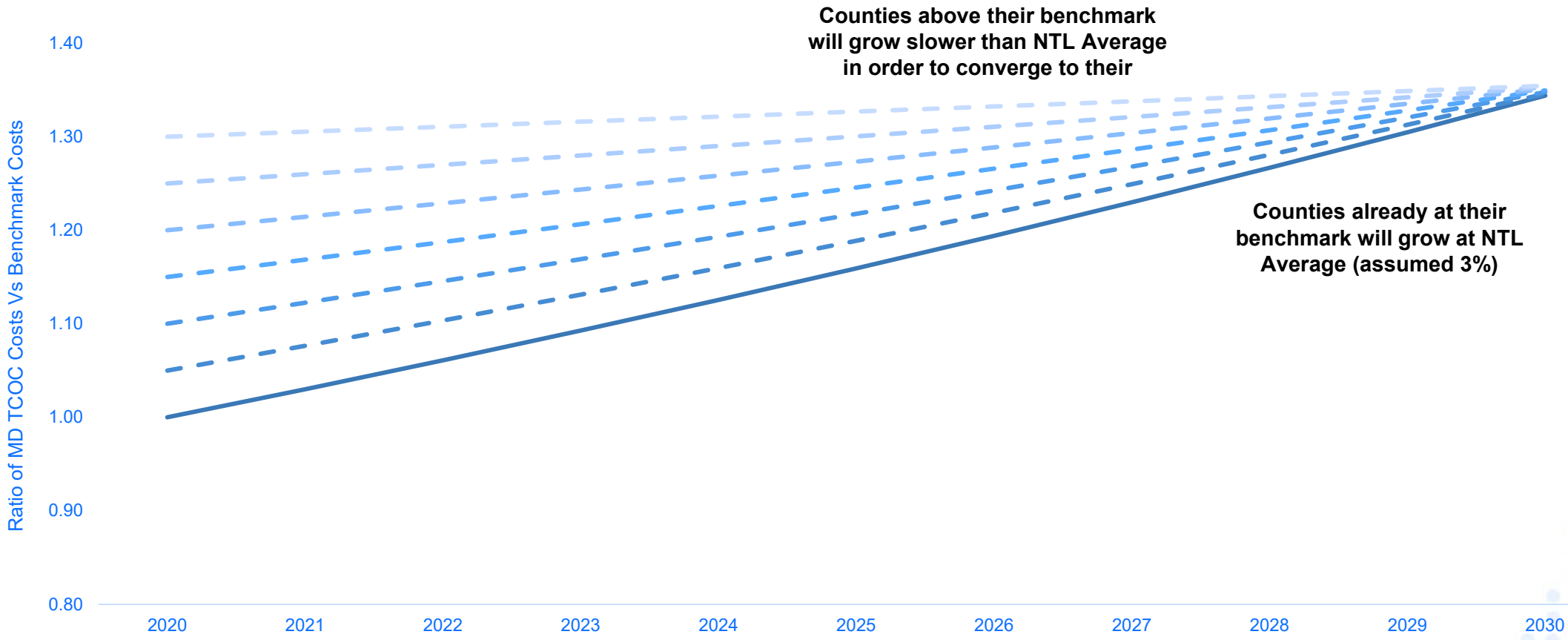
1. Create a hospital's TCOC per capita for their MPA attributed beneficiaries.
   A. The MPA beneficiaries are attributed based on the hospital's share of ECMADs in their PSAP zip codes.
   B. The same approach is used for the hospital benchmark analysis.
2. Determine the TCOC Growth Rate Adjustment for the hospital.
   A. Hospital's geographic TCOC is compared to their benchmark counties.
   B. The growth rate adjustment is determined by amount the hospital's geographic TCOC is greater / less than their benchmark counties.
3. Set the hospital's MPA Target based on their prior year target and a growth rate factor.
   A. For the 2021 MPA, the 'prior year MPA target' will be equal to the hospital's 2020 geographic TCOC.
   B. Going forward, the MPA target grows by the growth rate factor.
   C. Each year the growth rate factor is equal to the national growth rate – the TCOC growth rate adjustment.
4. Calculate the hospitals reward / penalty by taking the difference between their geographic TCOC and the MPA Target.
   A. Scale the difference based on quality and MPA revenue at risk.
   B. The MPA will be applied to the hospitals claims as a discount in the following fiscal year.

MC Benchmarking Results, % Above (Below) Benchmark

2018, Risk and Demographic Adjusted, Blended Statewide: 8.6%



Convergence to the Benchmark Costs



Attainment Adjusted MPA Growth Targets

Assuming $800 M over 10 years is the right target

- Hospitals' MPA performance target would be set so that hospital converge to their benchmark by 2030.
- Hospitals and TCOC workgroup members discussed whether eliminating excess Medicare costs is the right objective.
- Staff intends to recommend an attainment approach regardless of what the target would be.
- For example, setting a target that eliminates half of the Medicare excess costs would result in a more gradual growth rate adjustment.

Hospital Performance vs. Benchmark	TCOC Growth Rate Adjustment (Replaces 0.33% in current calculation)
<0%	-0.0%
0-5%	-0.5%
5-10%	-1.0%
10-15%	-1.4%
15-20%	-1.8%
20-25%	-2.2%
25-30%	-2.6%

Review of the MPA and CTI Policy Overlaps

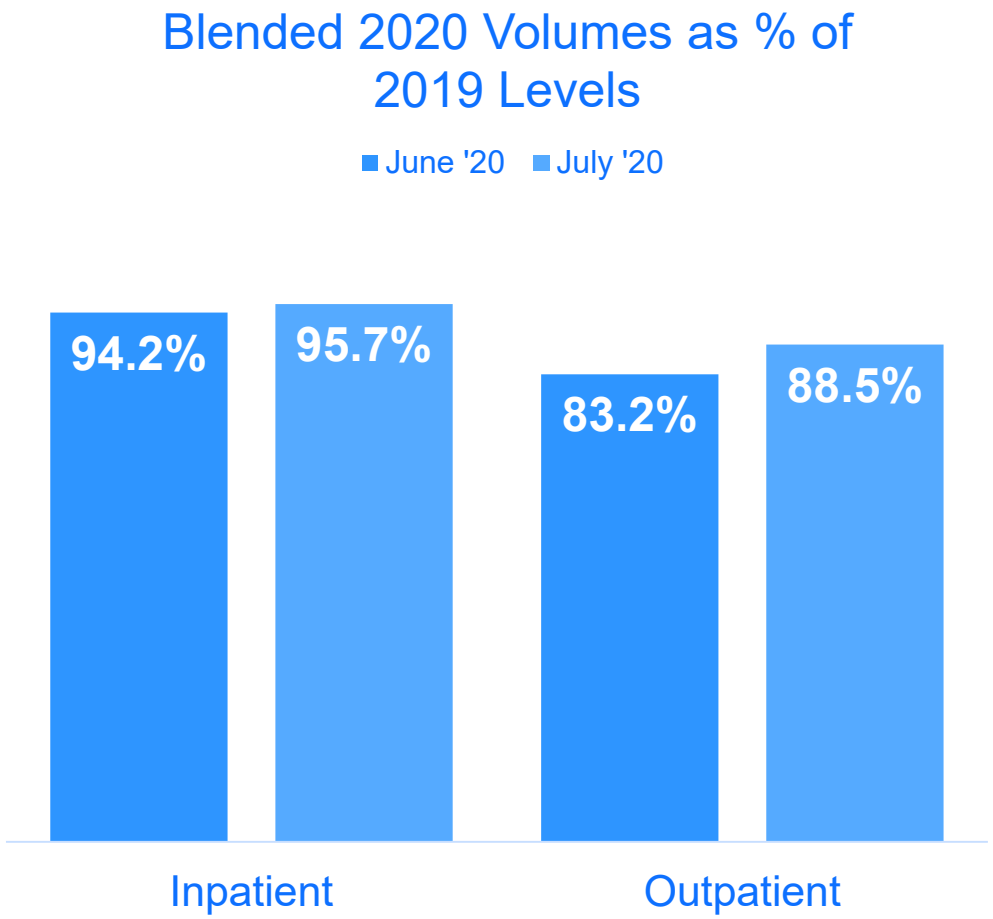
- The CTI and MPA potentially overlap since both policies attempt to measure how successful hospitals have been at reducing the TCOC of Medicare beneficiaries.
  - CTI measure hospitals on an improvement basis which could be complementary to the MPA.
  - The CTI attribution is better targeted since hospitals can define their own populations.
- Staff recommends allowing hospitals to ‘buy out’ of the traditional MPA by increasing their participation in the CTI.
  - Staff will measure the ratio of TCOC covered by a hospital’s CTI to the TCOC attributed to that hospital. The hospital’s MPA penalty will be reduced by that ratio.
  - For example, if the hospital had half as many dollars under the CTI as under MPA attribution then a hospital will receive only half of the MPA penalty they would have otherwise received.
  - Only negative results would be impacted so hospitals will still be rewarded for good attainment results.

Increased TCOC Accountability for MDPCP

- The MDPCP program provides investments to primary care practices and to hospitals that run Care Transformation Organizations (CTOs).
  - Currently, there is little accountability for a practice's success at reducing hospital utilization and total cost of care.
  - First year results from the MDPCP program indicated little impact on TCOC despite large investments of care management fees.
  - Significant results were not expected in the first year of the program, but it suggests the need for greater accountability on hospital-run CTO moving forward
- To increase accountability, HSCRC could require hospitals that participate in MDPCP to also participate in a primary care-based CTI.
  - If hospital run CTOs do not participate in the CTI then HSCRC will assess an MPA penalty equal to the amount of the care management fees their practices receive.
  - The CTI will reward hospitals for reducing the TCOC on MDPCP beneficiaries. Hospitals that succeed at reducing the TCOC will receive a positive MPA adjustment equal to the savings they produce.
  - Hospitals that are not successful will pay for the savings of successful hospitals.

COVID Funding Update

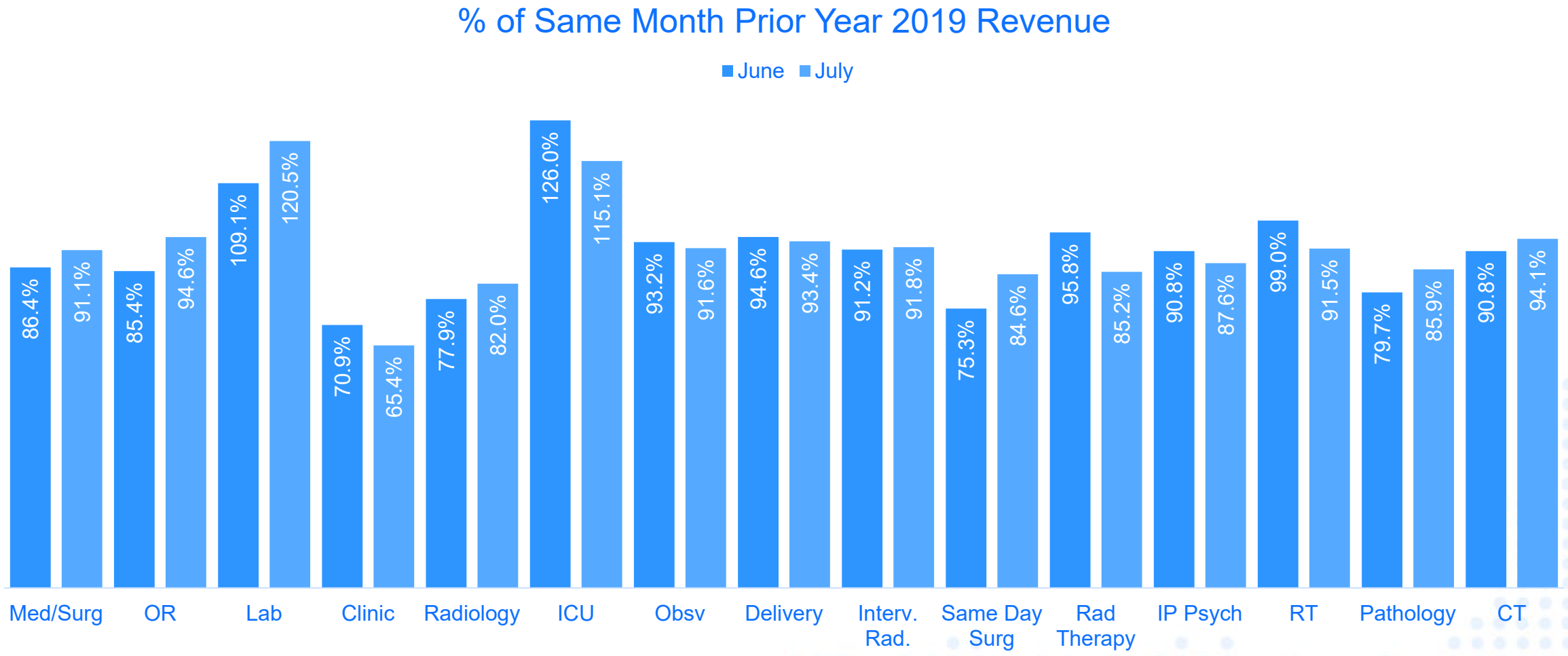
June and July 2020 Volumes are Close to Historic Levels



Source: HSCRC Financial reporting, volume relationship is calculated separately for each revenue center and then aggregated based on share of June 2019 total revenue. ED is excluded due to change in units on 7/1/19. Med Surg and Drugs excluded as units are not reported.

- For June and July 2020 hospital volumes were close to historic levels. With permitted corridor expansion revenue matched standard levels
- Simple average across hospitals yields similar results suggesting relatively even recapture.
- ED is excluded as June over June comparison is distorted by 7/19 RVU changes. July ED volumes were 75% of same time prior year.

June and July 2020 Volumes for Major Revenue Centers



Note: ED excluded due to change in RVUs as of 7/1/2019 resulting in inconsistent units.

Update on COVID-19 Surge Policy

- On April 30, 2020, the Commission approved a recommendation stating that hospitals would be funded beyond the GBR to the extent that COVID cases caused them to exceed the GBR.
- Under this recommendation, the funding was equal to the amount by which standard COVID and non-COVID charges exceeded the original GBR.
- Staff has completed this calculation and determined that for FY 2020 no hospital met these conditions, and no additional funding is required.
- Staff is recommending the termination of this policy due to the following:
  - The substantial return of elective volumes
  - The transition of COVID management to an ongoing part of operations
- The Commission can revisit this policy should COVID once again significantly impact elective volumes.

Staff Recommendation on Termination of COVID Surge Funding

Given the return of elective surgeries in June and the relatively low rate of new COVID cases, the staff recommends that the Commission determine the COVID Surge Policy to be terminated as of June 30, 2020, and that in accordance with the original policy there are no amounts due under this policy for FY2020.

Should COVID cases spike in the State, the Commission can revisit the COVID Surge Policy.

CARES Act and Federal Funding Introduction

- HSCRC has two sources of information on Federal COVID funds received:
  - A survey of hospitals performed by the HSCRC and attested to by hospital CFOs (Survey Report).
  - Federal reporting data (Federal Report) accessible at: https://data.cdc.gov/Administrative/HHS-Provider-Relief-Fund/kh8y-3es6.
    - The Federal Report only updates when hospitals attest to the funding received but is otherwise the most complete report available at an entity level.
    - As a result there may be some delay in the reporting and staff will continue to refresh these analyses as the Federal government updates this report
- These sources do not agree for some systems. Staff continues to work with hospitals to reconcile. For the current undercharge analyses the HSCRC is using the greater of these two amounts.
  - Where the Federal Report is lower than the Survey Report staff expect it is a function of timing and that as the Federal report is updated amounts will be more comparable. In these cases we have used the Survey Report.
  - Survey Report may be lower than the Federal Report depending what funding tranches hospitals included. Staffis working with the relevant hospitals. In these cases we have used the Federal Report.
- In addition to grant funding discussed above Maryland hospitals have received Federal loan funding of about $1.5 Billion.

CARES Act and Federal Funding ($ Millions)

Staff is currently estimating total Federal funding received by Maryland GBR hospitals of $851 M of which $809 M relates to regulated business.

Systems grouped by whether Survey Report was more or less than Federal Report (1)	Federal CARES Act per Federal Report (2)	Other Federal Funding per Survey Report (2)	Total Funding per Federal Report	Funding per Survey Report	Survey Report Higher (Lower) than Federal Report	Total Federal Funding Assumed	Regulated Funding Used in Undercharge Analysis (3)
Calculation	A	B	C = A+B	D	E = D – C	F = Greater of C and D	Regulated Portion of F
Survey Higher (6 Systems)	164.2	7.3	171.5	271.6	100.2	**271.6**	**252.9**
Equal (7 Systems)	58.5	4.0	62.6	63.2	0.6	**63.2**	**56.9**
Survey Lower (5 Systems)	504.2	11.7	515.9	392.9	(123.0)	**515.9**	**499.5**
Total	726.9	23.0	749.9	727.7	22.1	**850.7**	**809.4**

1. See discussion on prior slide.
2. Based on the documentation staff does not believe the Federal Report includes Sequestration or Uninsured funding, therefore these are derived from the HSCRC survey and shown in Column B.
3. This comparison is performed using total funding as Federal reporting does not segregate allocations to unregulated revenue within the same entity. For hospitals where the Survey Report more or the same as the Federal Report staff is using the reported regulated amount. For those underreporting versus the Federal report staff is using the Federal amount plus the uninsured and sequestration amount reported times the % regulated revenue. Staff are comparing survey reported allocation between regulated and unregulated to the revenue reported in schedule RE and review with hospitals when the allocation is materially different.

FY20 Undercharge Position ($ Millions)

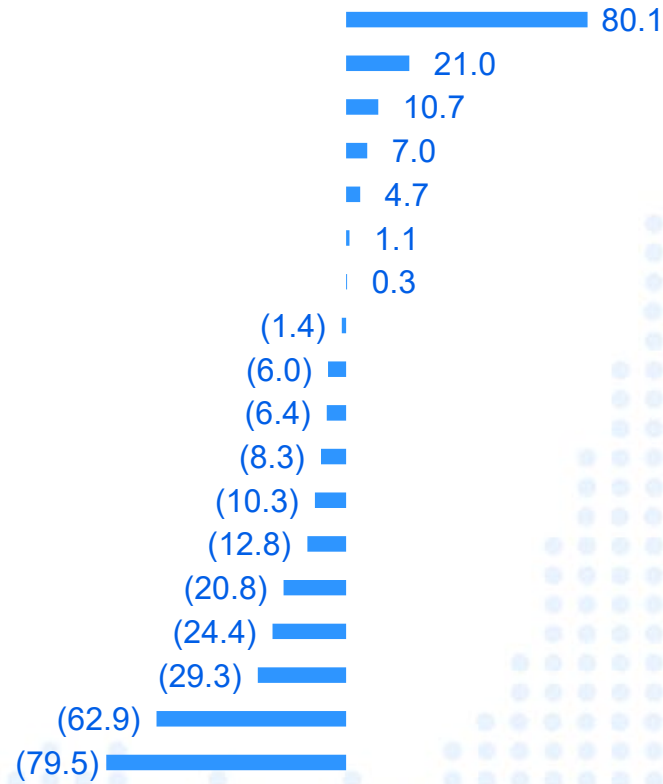
Staff estimates Maryland hospitals were collectively $137 M undercharged in FY20, but $262 M undercharged including only those with an undercharge.

By Undercharge Status

	System Count (1)	GBR	Revenue	Over (Under) Charge	Assumed Federal Funding (2)	Net Over (Under) Charge
Undercharged	11	13,162.0	12,365.3	**(796.7)**	534.7	**(262.1)**
Overcharged	7	5,211.1	5,061.4	**(149.7)**	274.7	**125.0**
Total	18	18,373.1	17,426.7	**(946.4)**	809.4	**(137.1)**

1. The HSCRC is planning to implement the undercharge policies at a system level as some hospitals chose to allocate their Federal funding disproportionally across their member hospitals.
2. See prior slide.

By system, Over (Under) Charged



Undercharge/Overcharge Recognition Guidance

- The HSCRC anticipates that any final overcharge will be recovered either by the Federal Government or the HSCRC.
  - Hospitals will only be able to retain those funds if their FY20 Annual Filings justify additional expenses.
  - Until FY20 Annual Filings are submitted and more information is available on Federal recovery the HSCRC will not recover any amounts.
  - Hospitals should not recognize this revenue in their financial statements in the meantime.
  - Hospitals that are in an undercharge position may not recover more than their undercharge, net of the regulated portion of CARES funding. Once FY20 cost reports are available additional amounts may be used to offset costs.
- As previously communicated, for FY21 Hospitals should eliminate COVID-related corridor expansion once their FY20 undercharge is recovered.
- Staff will issue a memo confirming this guidance and staff's understanding of each hospital's position as a follow-up to this discussion.

health services cost review commission

COVID-19 Long-Term Care Partnership Grant (LTC)
Approved Awards (as of 9/4/2020)

This one-year funding program is intended to foster collaboration between hospitals and long-term care facilities/other congregate living facilities that serve vulnerable populations during the COVID-19 crisis. Hospitals and their partners will collaborate on strategies to reduce the spread of COVID-19 in these settings.

Hospital(s)	Impact Area	Award Amount	Interventions Funded
1. Anne Arundel Medical Center (AAMC)	Anne Arundel County, Prince Georges County	$419,316	Funding will support a variety of interventions including case management and care coordination services, ongoing training and education, as well as data analytics and sharing. Funding will also support the implementation of Real Time software which will assist in managing patient information and provide analytics support to assist in clinical decision-making.
1. Doctors Community Hospital (DCH)	Prince Georges County	$571,554	Funding will support care coordination services and ongoing training and education. Funding will also support data analytics and sharing to improve patient management, care coordination, and discharge planning.
1. Frederick Health Hospital (FHH)	Frederick County, Carroll County	$ 1,108,460	Funding will support resource sharing, including an LTC facility support team staffed by resource nurses. Other shared resources include tele supportive services, as well as telehealth equipment and personal protective equipment. Additionally, funding will support ongoing training and education to partners.
1. Holy Cross Hospital 2. Holy Cross Germantown Hospital 3. Shady Grove Medical Center 4. White Oak Medical Center	Montgomery County	$1,209,000	Funding will support case management resources and the implementation of Real Time software. Through monitoring Real Time, case managers can identify potential cases of COVID-19 or other patients at risk of hospitalization. Case managers will support transitions of care for patients and monitor patients post-discharge to prevent potential readmissions.
1. Johns Hopkins Hospital 2. Johns Hopkins Bayview Medical Center 3. Howard County General Hospital 4. Suburban Hospital	Baltimore City, Baltimore County, Howard County, Montgomery County	$1,409,936	Funding will support telemedicine and remote patient monitoring (RPM) to improve patient outcomes, reduce unnecessary health care utilization and ensure effective patient care at long-term care facilities. ~~J~~HHS will also provide ongoing education and training support to partners.

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Lifebridge Health 1. Siani Hospital 2. Northwest Hospital 3. Carroll Hospital 4. Levindale Hospital 5. Grace Medical Center	Baltimore City, Baltimore County, Carroll County	$1,169,200	Funding will support targeted resource sharing and data analytics. Resource sharing interventions include telehealth, mobile health, and embedded clinicians and resource nurses. The grant will also support IT investments, including software to link EMRs to support post-acute transitions of care and care management activities.
MedStar 1. Good Samaritan Hospital 2. Franklin Square Hospital 3. Harbor Hospital 4. Montgomery Hospital 5. Union Memorial	Baltimore City, Baltimore County, Anne Arundel County, Montgomery County	$1,258,125	Funding will enhance telehealth connections to geriatrics and other specialty services, particularly to provide consults for geriatric patients who transition from hospital to SNF settings. Funding will also support data analytics work and provide performance management tools to improve quality outcomes.
1. Meritus Medical Center	Washington County	$ 274,951	Funding will support resource sharing and quality improvement consultation that includes a quality hotline to receive questions related to COVID-19, weekly calls and regular meetings with SNF partners to support quality assistance, as well as on-site support as needed.
1. Peninsula Regional Hospital	Somerset County, Wicomico County, Worchester County	$242,596.	Funding will support quality improvement initiatives and the development of an interdisciplinary education program to train staff on best practices for managing COVID-19. Funding will also support information sharing between partners related to COVID-19 challenges, as well as care transitions activities and technology platforms to support patient care management.

health services cost review commission

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University of Maryland Medical System (UMMS) 1. Baltimore Washington Medical Center 2. Charles Regional Medical Center 3. UM Medical Center 4. UM Midtown 5. Harford Memorial hospital 6. Prince Georges Hospital Center 7. Rehabilitation and Orthopedic Institute 8. Shore Medical Center Easton 9. Shore Medical Center Chestertown 10. St. Joseph Medical Center 11. Upper Chesapeake Medical Center	Anne Arundel County, Baltimore County, Baltimore City, Caroline County, Charles County, Harford County, Kent County, Prince Georges County, Queen Anne's County, Talbot County	$1,750,000	Funding will support the deployment of drop teams, resource nursing and education and training to partnering SNFs. With their funding, UMMS will also expand their supply chain for procuring PPE. UMMS will provide resource nurses to partners during the outbreak to implement interventions appropriate to control the spread of COVID-19 in the facility.
Western Maryland (WM)		$ 75,150	Funding will support an enhanced telehealth program to increase access to physician specialists in order to treat COVID-19 patients on-site and prevent unnecessary hospitalizations, where possible. WM and its partner will also participate in the Clean Collaborative with the Maryland Patient Safety Center.

MEMORANDUM

TO: Adam Kane, Chairman

FROM: Thomas Werthman, AAG, HSCRC

RE: Proposed Regulation for September 9, 2020 Meeting

DATE: August 31,, 2020

CC: Katie Wunderlich, Executive Director

Please be advised that the staff will be proposing an amendment to Commission regulation COMAR 10.37.01.02 at the September Public Meeting. This regulation concerns the Commission's Accounting and Budget Manual ("Manual") which has been incorporated by reference into the regulations. As occurs annually, the proposed regulation amendment represents the compilation of technical changes made to the Manual over the course of the year. This is supplement number 26. The staff is requesting that the Commission forward the amendment to the Maryland Register for publication and public comment. Following the comment period, staff will be bringing the amendment back to the Commission for final action.

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§19-207 and 19-215, Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulation **.02** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions**. This action was considered and approved for promulgation by the Commission at an open meeting held on September 9, 2020, notice of which was given through publication in the *Maryland Register*, under General Provisions Article, §3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about January 14, 2021.

Statement of Purpose

The purpose of this action is to update the Commission's manual entitled "Accounting and Budget Manual for Fiscal and Operating Management" (August, 1987), which has been incorporated by reference.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed regulation.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small business

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to William Hoff, Chief, Audit and Compliance, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or call 410-764-3448, or email to william.hoff@maryland.gov, or fax to 410-358-6217. Comments will be accepted through November 23, 2020. A public hearing has not been scheduled.

Adam Kane
Chair
Health Services Cost Review Commission

Part C

A. Fiscal Year in which regulations will become effective: FY 2021

B. Does the budget for fiscal year in which regulations become effective contain funds to implement the regulations?

NO

C If "yes", state whether general, special (exact name), or federal funds will be used:

D. If "no", identify the source(s) of funds necessary for implementation of these regulations:

No funds are needed to implement the regulations.

E. If these regulations have no economic impact under Part A, indicate reason briefly:

The regulations merely instruct hospitals on how to account for and report their expenses and revenue.

F. If these regulations have minimal or no economic impact on small businesses under Part B, indicate the reason and attach small business worksheet.

The regulations merely instruct hospitals on how to account for and report their expenses and revenues.

SMALL BUSINESS ANALYSIS WORKSHEET

Non-applicable

1a. Intended Beneficiaries.

1b. Intended Beneficiaries: Households..

1c. Intended Beneficiaries: Businesses.

2a. Other Direct or Indirect Impacts: Adverse.

2b. Other Direct or Indirect Impacts: Positive.

3. Long-Term Impacts.

4. Estimate of Economic Impact.

maryland
health services
cost review commission

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: September 9, 2020

RE: Hearing and Meeting Schedule

October 14, 2020 To be determined - 4160 Patterson Avenue
HSCRC/MHCC Conference Room

November 12, 2020 To be determined – 4160 Patterson Avenue
HSCRC/MHCC Conference Room

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

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