maryland
health services
cost review commission

581st Meeting of the Health Services Cost Review Commission
February 10, 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 January 13, 2020

2. Docket Status – Cases Closed

3. Docket Status – Cases Open

4. Staff Recommendation on ARM Extension of Approval

5. CARES Funding and COVID-19 Response

6. Policy Update and Discussion

    a. Model Monitoring
    b. Benchmarking Presentation
    c. Legislative Update

7. Hearing and Meeting Schedule

Closed Session Minutes
of the
Health Services Cost Review Commission

January 13, 2021

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

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

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

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

The Closed Session was called to order at 11:32 a.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

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

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

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

Item One

Katie Wunderlich, Executive Director, briefly summarized the recent meeting with Hospital CEOs concerning future strategies and initiatives to improve the delivery of health care in Maryland.

Item Two

Ms. Wunderlich updated the Commission and the Commission discussed proposals to help offset the disadvantages that Medicare Advantage Plans face operating in Maryland.

Item Three

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

Item Four

William Henderson, Director-Medical Economics & Data Analytics, briefly updated the Commission on policy concerns, i.e., the All-Payer system and the use of Total Cost of Care versus utilization in benchmarking. Mr. Henderson also discussed, in detail, the technical issue of benchmarks unintentionally favoring wealthy areas.

The Closed Session was adjourned at 1:05 p.m.

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MINUTES OF THE
580th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
January 13, 2021

Chairman Adam Kane called the public meeting to order at 11:02 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 1:15 p.m.

STAFF CHANGES

Ms. Katie Wunderlich, Executive Director, reported that Joe Delenick will be leaving the Commission. Both Ms. Wunderlich and Jerry Schmith, Director Revenue & Regulation Compliance, expressed appreciation for all his dedication and hard work.

Ms. Wunderlich introduced new Staff members Megan Renfrew and Zac Goldberg. Ms. Renfrew will be the Associate Director of External Affairs. Mr. Goldberg will be the Chief, Population Health.

REPORT OF JANUARY 13, 2021 CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the January 13, 2021 Closed Session.

REVIEW OF THE MINUTES FROM THE DECEMBER 9, 2020 CLOSED SESSION AND PUBLIC MEETING

The Commissioners voted unanimously to approve the minutes of the December 9, 2020 Public Meeting and Closed Session.

ITEM II
CASES CLOSED

2538A- University of Maryland Medical Center	2539A- University of Maryland Medical Center
2540A- Johns Hopkins Health System	2541A- Sheppard Pratt Hospital
2542A- University of Maryland Medical Center	2543A- Johns Hopkins Health System
2544A- Johns Hopkins Health System	2545A- Johns Hopkins Health System

ITEM III
OPEN CASES

2541N- Sheppard Pratt Hospital

On November 6, 2020, Sheppard and Enoch Pratt Hospital ("the Hospital") submitted a partial rate application to establish a new Transcranial Magnetic Stimulation (TMS) rate. The Hospital is the nation's largest private, nonprofit provider of mental health, substance use, special education, developmental disability, and social services. TMS, or repetitive TMS, is a noninvasive procedure used to treat some types of mood disorder, including treatment-resistant depression. The Hospital requests a treatment rate for TMS to be effective February 1, 2021.

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. The Hospital provided projected costs associated with the TMS expansion and requested a rate of $388.7266 per treatment. Based on the Centers for Medicare and Medicaid Services (CMS) and the Ambulatory Payment Classification (APC) rate structure, Staff determined that a TMS rate of $339.1538 is reasonable and appropriate.

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

1. That the TMS rate of $339.1538 per treatment be approved effective February 1, 2021;
2. That the TMS rate center not be rate realigned until a full year of cost data have been reported to the Commission; and
3. That the TMS services be subject to the application of the Approved Revenue and Unit Rate Policies.

Commissioners voted unanimously to approve Staff's recommendation.

2546N- Garrett Regional Medical Center

On December 3, 2020, Garrett Regional Medical Center ("the Hospital") submitted a partial rate application to establish a new Lithotripsy (LIT) rate. The Hospital is the sole community provider of nearly all outpatient diagnostic, inpatient, rehabilitation, and emergency medical services and is situated in the Appalachian Mountain. The Hospital requests a procedure rate for LIT to be effective February 1, 2021.

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 rate of $3,634 per procedure, while the statewide median rate for LIT services is $3,775.04 per procedure.

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

1. That the Commission waive COMAR 10.37.10.07, which requires that a hospital file a rate application for new service at least 60 days before its operational opening.
2. That the LIT rate of $3,634 per procedure be approved effective February 1, 2021;
3. That the LIT rate center not be rate realigned until a full year of cost data has been reported to the Commission; and
4. That no change be made to the Hospital's Global Budget Revenue for the LIT Services.

Commissioners voted unanimously to approve Staff's recommendation.

ITEM IV
FINAL RECOMMENDATION ON THE READMISSION REDUCTION INCENTIVE PROGRAM FOR RY 2023

Ms. Andrea Zumbrum, Chief, Quality Analysis and Reporting and Geoff Dougherty, Deputy Director, Population Based Methodologies, Analytics, and Modeling presented Staff's final recommendation on the Readmission Reduction Incentive Program (see "Final Recommendation for the Readmission Reduction Incentive Program for Rate Year 2023" available on the HSCRC website).

Since 2014, Maryland hospitals have been funded under a global budget system, which is a fixed annual revenue cap that is adjusted for inflation, quality performance, reductions in potentially avoidable utilization, market shifts, and demographic growth. Under the global budget system, hospitals are incentivized to transition services to the most appropriate care setting and may keep savings that they achieve via improved health care delivery (e.g., reduced avoidable utilization, such as readmissions or hospital-acquired infections). It is important that the Commission ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the HSCRC's Quality Programs reward quality improvements that reinforce the incentives of the global budget system, while penalizing poor performance and guarding against unintended consequences.

The Readmissions Reduction Incentive Program (RRIP) is one of several pay-for-performance initiatives that provides incentives for hospitals to improve patient care and value over time. The RRIP currently holds up to 2 percent of inpatient hospital revenue at-risk in penalties and up to 1 percent at-risk in rewards based on improvement and attainment in case-mix adjusted readmission rates. In addition, the RRIP is the first quality policy to provide incentives for reducing disparities by rewarding hospitals up to 0.5% of inpatient hospital revenue for reducing within-hospital disparities in readmissions.

The RRIP methodology evaluates all-payer, all-cause inpatient readmissions using the Chesapeake Regional Information System for our Patients (CRISP), and a unique patient identifier to track patients across Maryland hospitals. The readmission measure excludes certain types of discharges (such as planned readmissions) from consideration. Readmission rates are adjusted for case-mix using All-Patient Refined Diagnosis-related Group (APR-DRG) Severity of Illness (SOI). The policy determines a hospital's score and revenue adjustment by the better of improvement or attainment.

In CY 2019, Maryland improved upon its achievement of being at or below the national average Medicare FFS readmission rate. In CY 2018, Maryland had an unadjusted Medicare readmission rate of 15.40 percent, compared to the national rate of 15.45 percent. Through CY 2019, Maryland further improved its readmission rate, concluding the year with a rate of 14.94 percent compared to the national rate of 15.52 percent.

Maryland also improved its case-mix adjusted readmission rate in CY2019, concluding CY 2019 with an all-payer case-mix adjusted readmission rate of 11.37 percent, representing a 2.90 percent reduction from CY 2018.

Staff notes that, on September 2, 2020, The Centers for Medicare and Medicaid Services (CMS) published an Interim Final Rule (IFR) in response to the COVID-19 PHE. In this IFR, they announced that:

- CMS will not use CY Q1 or CY Q2 of 2020 quality data even if submitted by hospitals.
- CMS is still reserving the right to suspend application of revenue adjustments for FY 2022 for all hospital pay for performance programs at a future date in 2021; changes will be communicated through memos ahead of IPPS rules.

It is not known at this time if Maryland has flexibility in suspending its RY 2022 quality programs. However, the Center for Medicare and Medicaid Innovation (CMMI) has strongly suggested that the State must have quality program adjustments and has further suggested that the State pursue alternative strategies, such as reusing portions of CY 2019 data (as is being done for the Skilled Nursing Facility VBP program) to create a 12-month performance period.

Staff believes the most appropriate approach for the RRIP policy is to exclude the COVID-19 patients if any CY 2020 data is used. Staff will work to assess any case-mix adjustment and performance standard issues caused by the absence of COVID-19 patients in the base period. Staff will provide updates to the Commission in February, at the earliest, on the final decisions for any adjustments to the RY 2022 quality policies.

For RY 2023, the program will use v38 of the APR-DRG grouper: however, unlike the v38 Potentially Preventable Complications (PPC) grouper, this updated grouper does not make changes to the readmission flags to account for COVID-19. Staff will need to consider any additional modifications to address case-mix adjustment and performance standard concerns that may arise from inclusion of COVID-19 positive patients in the performance period, especially since COVID-19 cases were not part of the statewide normative values. Furthermore, based on stakeholder comments, analyses should be done on concerns over case-mix adjustment and performance standards for non-COVID patients.

Staff is presently working with CMMI to better understand the federal Hospital-Wide Readmission (HWR) measure. Staff believes that it may be advantageous to better understand the federal HWR measure, since it includes a risk-adjustment; The "Waiver Test" readmission rate for Maryland is presently an unadjusted readmission rate. This may present future challenges as Maryland reduces unnecessary utilization and simultaneously increases the case-mix index of remaining eligible discharges. Additionally, a Hybrid HWR Measure was adopted by CMS in 2018 as a voluntary measure under the Hospital Inpatient Quality Reporting Program. The Hybrid HWR Measure differs from the claims-based HWR Measure, as it merges Electronic Health Record (EHR) data elements with claims data to calculate the risk-standardized readmission rate. Staff will consider potential use(s) of the HWR/HWR Hybrid Measure in the future.

Staff will continue to work with Mathematica Policy Research (MPR) to operationalize an all-payer measure of Excess Days in Acute Care, which would incorporate admissions, observation stays, and ED visits within 30 days of an acute care discharge.

In response to Commissioners and stakeholders' comments Staff's Final Recommendation will include the following revisions:

- Exclude pediatric oncology cases from RRIP. While removing these cases has an immaterial impact, the measure update will further align oncology discharges with the readmission measure's intention.

- The maximum reward will be increased, from 1 percent of inpatient revenue to 2 percent of inpatient revenue. Staff appreciates the commitment to symmetry across the pay-for-performance quality programs. In prior years, RRIP was the only HSCRC quality pay-for-performance policy without symmetrical risk. Staff also acknowledge that asymmetrical risk added unnecessary complexity to the policy.

Staff recommendations are as follows:

1. Maintain the 30-day, all-cause readmission measure.
2. Remove pediatric oncology cases following the intention of the oncology readmission measure
3. Improvement Target - Maintain the RY 2022 approved statewide 5-year improvement target of -7.5 percent from 2018 base period.
4. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile statewide performance receive scaled rewards for maintaining low readmission rates.
5. For improvement and attainment, set the maximum reward hospitals can receive at 2 percent of inpatient revenue and the maximum penalty at 2 percent of inpatient revenue.
6. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap measure over 8 years (>=15.91 percent reduction in disparity gap measure 2018 to 2021), capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years (>=29.29 percent reduction in disparity gap measure 2018 to 2021).
7. Continue development of an all-payer Excess Days in Acute Care measure to account for readmission, emergency department, and observation revisits post-discharge.
8. Adjust the RRIP pay-for-performance program methodology as needed due to the COVID-19 Public Health Emergency and report to Commissioners as follows:
    - For RY 2022 (CY 2020 performance period)
        - Exclude COVID-19 positive cases from the program.
        - Exclude the data for January to June 2020; evaluate whether to use the final six months of 2020 or whether to use a prior time period.
        - Evaluate case-mix adjustment and performance standards concerns arising from use of a pre-COVID time period to determine normative values.
    - For RY 2023 (CY 2021 performance period)
        - Include COVID-19 cases but retrospectively assess any case-mix concerns
        - Retrospectively evaluate case-mix adjustment and performance standards concerns arising from inclusion of COVID-19 patients and the use of a pre-COVID time period to determine normative values.

Commissioner Colmers expressed concern about the reliability of the data used to evaluate hospitals' success in reducing within-hospital readmission disparities. He specifically questioned whether there is sufficient data integrity in coding of patient race by hospitals.

Mr. Dougherty replied that Staff has assessed the data and does not believe that there is systematic miscoding of race at the hospital-level.

Chairman Kane questioned whether the disparity measure's complexity would negatively impact a hospital's ability to implement specific interventions to reduce its readmissions disparity.

Mr. Dougherty explained that the interventions would likely not be affected by the complexity of the measure. Mr. Dougherty stated that the RRIP policy would incentivize hospital to address: health literacy issues; increase access to PCP follow-ups, and increasing access to transportation as interventions that would help reduce readmissions disparities.

Brian Sims, Director of Quality & Health Improvement, MHA, discussed steps that MHA has taken to identify strategies for addressing readmissions disparities. Mr. Sims reiterated MHA's stance to suspend all performance-based adjustments for RY 2022 due to COVID-19 related data issues.

Commissioner Bayless reminded Commissioners that all Maryland hospitals took the American Hospital Association (AHA) Equity of Care Pledge. Ms. Bayless noted that one element of the Pledges, is a commitment to improving the collection of data on race. Commissioner Bayless encouraged MHA to remind hospitals of this and the other elements of the Pledge.

Commissioners voted unanimously to approve Staff's recommendation.

ITEM V
FINAL FULL RATE REVIEW METHODOLOGY

Mr. Allan Pack, Director, Population Based Methodologies, presented Staff's final Full Rate Review Policy (see "Final Recommendation on Full Rate Application Policy" available on the HSCRC website)

In November 2015, full rate reviews were suspended to allow development of tools and methodologies consistent with the new All-Payer Model. Regulations were introduced at the September 2017 Commission meeting that updated filing requirements for full rate reviews and the moratorium on full rate reviews was lifted in November of 2017. At the November 2017 Commission meeting, Staff put forward a final recommendation to the cost-per-case and per visit analysis - the Inter-hospital Cost Comparison (ICC) methodology, which is a tool that HSCRC

staff proposed to continue using in evaluating hospitals' cost-per-case efficiency. At that time, Staff recommended that the Commission defer formal adoption of an efficiency methodology because more work was required to develop additional efficiency tools, namely total cost of care analyses. Also, Staff set out, with support of a technical workgroup, to refine the case-mix methodology that serves as the basis for the volume statistic used in the ICC to evaluate cost-per-case efficiency, in accordance with Commission priorities.

While Staff has utilized the ICC and various Total Cost of Care (TCOC) growth analyses to support Commission proposals to modify certain hospitals' global revenues, thereby implicitly approving these efficiency tools through adjudication, no formal policies are currently in place. It is important that formal policies reflective of all methodology enhancements are approved by the Commission to provide greater clarity to the industry and to allow for the Commission's methodologies to be more formulaic and uniform in their application.

Staff did not materially change the ICC methodology from what was presented to the Commission in November of 2017. The ICC still places hospitals into peer groups based on geography/urbanicity and teaching status and then develops a peer group cost average, devoid of unique hospital cost drivers (e.g. labor market, case mix) and various social goods (e.g.. residency programs), to ultimately build up hospital revenue for each hospital based on the calculated peer group cost average. The difference between a hospital's evaluated revenue and its revenue calculated from the ICC cost standard is the measure of a hospital's cost-per-case efficiency.

Staff has also developed TCOC "attainment" benchmarks calculations into the final efficiency determinations. The TCOC benchmarks assess both Medicare and Commercial TCOC performance.

While staff believe the efficiency methodologies and implementation proposal are sound, staff acknowledges that more work will have to be done to refine and improve the ICC and TCOC analyses.

Mr. Pack noted that the current process for full rate applications as outlined in Maryland statute allows hospitals to a file for a change in its rate schedule that will be effective at least 30 days after the docketing of the application. Upon receiving the full rate application, the Commission must review and act on the rate application within 150 days after the application is docketed, unless both parties agree to postpone this deadline. 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 docketing date. If a hearing is held the Commission may suspend the effective date of any proposed change in rates until 30 days after the hearing. Finally, if the Commission fails to complete the review of the rate application within 150 days, the requested change in rate

structure will be effective on the hospital's initially proposed effective date as it appeared on the application.

Due to the alacrity with which decisions on rate applications must be made, there are two concerns this policy would like to address, namely the implications rate enhancements have on TCOC savings tests and the utilization of staff resources.

Therefore, in this context, Staff recommends the following options for administering a global budget enhancement should Commissioners approve one through the full rate application process:

- Provide the revenue increase immediately because there are no potential concerns about TCOC performance.
- Provide revenue increase immediately but concurrently reduce inflation across the board for all hospitals due to TCOC performance.
- Provide a portion of revenue increase immediately and provide remaining revenue at semiannual milestone (Jan or July 1st) when TCOC can be accounted for.
- Delay revenue increase to semi-annual milestone (Jan or July 1st) when TCOC can be accounted for.

Staff believes the efficiency methodologies and the implementation proposal are sound; however, staff acknowledges that additional work will be required to refine and improve the ICC and TCOC analyses. Staff has identified the following future work streams for enhancing the efficiency methodologies:

A. Short term - Staff is engaging an outside contractor to review the validity of its ICC peer groups to consider potential modifications and to also consider using a statewide regression analysis to account for additional cost variation that the peer groups ostensibly address, namely costs associated with teaching, urbanicity, and rurality, the latter of which is not currently addressed in the ICC. This task should be completed in January 2021 and can be accounted for in future full rate application recommendations.
B. Short term – Staff is also engaging an outside contractor to review the adequacy of current physician supply by specialty by region. This analysis will incorporate out-year demand projections, inclusive of Maryland's role as a net exporter of medical professionals, and will be used to determine the allowed residents in the ICC analysis. This task should be completed in January 2021 and can be accounted for in future full rate application recommendations.
C. Short term – Staff is also engaging in a process to review the benchmarking methodology with stakeholders in an effort to increase understanding and transparency of the methodology. Should any inconsistencies or inaccuracies be uncovered during this

review, staff would make the appropriate changes and account for those changes in a future full rate application recommendation.

D. Medium term - Staff will work to include national analyses that were completed for inpatient efficiency evaluations of the State's two major academic medical centers. Staff plans to complement these analyses by incorporating them into an outpatient-only ICC that will effectively evaluate the State's two academics both on a national level for inpatient services and on a Maryland peer group level for outpatient services. Completion of this task is contingent upon submission from Johns Hopkins Hospital and University of Maryland Medical Center, per the agreement put forward in the Innovation Policy and prior Update Factor recommendations. This task should be completed in the summer of 2021.
E. Long term - Staff will continue the work to quantify the investments hospitals are making in unregulated settings that are in line with the incentives of the TCOC Model, thereby providing a path for hospitals to acquire credit in the ICC evaluation when retained revenues are used to improve health outcomes.

The final Staff Recommendation is as follows:

1. Formally adopt policies described herein to assess cost per case efficiency and TCOC efficiency to determine the rate structure for hospitals11 should:
    a) A hospital requests a full rate application; or
    b) HSCRC open a full rate review of a hospital;
2. Use the ICC, including its supporting methodologies to compare cost-per-case for the above evaluations;
3. Use TCOC measures with a geographic attribution to evaluate per capita cost performance for the above evaluations;
4. Allow Staff to include in full rate application recommendations the following:
    a) Implementation date for global budget enhancement that considers and comports with the State's TCOC savings tests; and
    b) Hospital specific, mutually agreed upon moratorium on full rate applications that extends beyond the regulatory limits. COMAR 10.37.10.03 allows a hospital to file a full rate application at any time provided there is no pending hospital-instituted case before the Commission or if the subject hospital has not obtained permanent rates through the issuance of a Commission rate order within the previous 90 days.

Commissioner Cohen expressed concerns regarding the temporary suspension of the 2% productivity adjustment.

Commissioner Colmers echoed Ms. Cohen's concern, and requested that Staff identify a specific timeframe for proposing an alternative to the productivity adjustments.

Mr. Pack stated that Staff hoped to better understand the unregulated investments hospitals are making once they have reviewed the hospital's RY 2022 Annual Filings. The Commissioners agreed to vote on a revised final recommendation, which stated that the productivity adjustment suspension is temporary and that Staff will propose an alternative to Commissioners' productivity adjustment no later than July 2023.

Commissioner Bayless questioned whether the ICC calculation should include a reasonable level of profit.

Mr. Pack replied that until Staff better understands the necessary level of unregulated costs (including physician subsidies and care transformation expenses), it would be difficult to quantify an appropriate level of profit.

Commissioner Bayless also raised concerns with the language in Staff's recommendation concerning a mutually agreed upon moratorium following the filing of a full rate review. Commissioner Bayless expressed discomfort with the proposed language, which conflicts with COMAR regulations.

Mr. Pack agreed to strike the moratorium language and include a statement that Staff will present a revision to COMAR, increasing the statutory moratorium following full rate review from 90 days to a period of one to two years.

Chairman Kane clarified that the purpose of the moratorium is to discouraged repetitive and frivolous full-rate applications. Chairman Kane noted that the moratorium would not prevent informal discussions concerning revenue adjustments between hospitals and Staff.

Mr. Arin Foreman, CareFirst, Senior Director Regulatory Affairs, questioned the reason for Staff's recommendation to remove the 2% productivity adjustment.

Mr. Brett McCone, Senior Vice President, Health Care Payment, MHA, expressed support for HSCRC's recommendation to remove the 2 % productivity adjustment. Mr. McCone questioned the need for a moratorium on the filing of full rate applications. Mr. McCone was concerned that a hospital may be forced to accept the moratorium as part of an agreement with staff. Mr. McCone reiterated the need to review the benchmarking methodology and address peer groups and medical education funding.

Based on Commissioners and stakeholders comments, the following revisions will be added to Staff's recommendation:

The removal of the language that the 2% productivity adjustment is temporary, and Staff will return to the Commission with an alternative to the productivity adjustment no later than July 2023.

Staff will present a revision of COMAR regulations regarding the statutory moratorium period following a full rate review within an appropriate timeframe.

Commissioners unanimously voted in favor of the revised Staff recommendation.

ITEM VI
POLICY UPDATE AND DISCUSSION

Model Monitoring

Ms. Caitlin Cooksey, Chief, Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 8 months ending September 2020. Maryland's Medicare Hospital spending per capita growth was unfavorable when compared to the nation. Ms. Cooksey noted that Medicare TCOC spending per capita was trending unfavorably for the past 3 months. Nonhospital spending per capita in Maryland is trending close to the nation thru August. Maryland's Medicare Part A nonhospital spending is favorable. Medicare Part B nonhospital spending is mixed when compared to the nation thru August. Based on August results, $3,200,000 has been added to our run rate.

ITEM VII
LEGAL UPDATE

Regulations

Final Action

Uniform Accounting and Reporting System for Hospitals and Related Institutions COMAR 10.37.01.02

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. This action was proposed for adoption in the Maryland Register on October 23, 2020 and will become effective with Commission today on February 8, 2021.

The Commission voted unanimously to approve final adoption of the proposed amendment to COMAR 10.37.01.02.

ITEM VIII
HEARING AND MEETING SCHEDULE

February 10, 2021

March 10, 2021

There being no further business, the meeting was adjourned at 3:58 p.m.

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Recommendation to Grant an Extension of Approval of the Alternative Method of Rate Determination (ARM) Arrangement Between University of Maryland Medical Center and Optumhealth Care Solutions, Inc.

February 10, 2021

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

Background

Effective November 1, 2019, a one-year approval was granted for the renewal of an alternative rate arrangement (ARM) between the University of Maryland Medical Center (UMMC) and OptumHealth Care Solutions, Inc. for the provision of solid organ and blood and bone marrow services.

In October of 2020, UMMC requested and was granted a three-month extension of the approval for the ARM arrangement with OptumHealth Care Solutions, Inc.to provide time to complete renegotiation of the arrangement.

Request

On January 20, 2021, UMMC requested a second three-month extension, to April 30, 2021, to finalize negotiations on the ARM arrangement with OptumHealth Care Solutions, Inc.

Findings

Staff found that the experience for ARM arrangement between the University of Maryland Medical Center (UMMC) and OptumHealth Care Solutions, Inc. has been favorable for the last twelve months.

Recommendation

Since the authority granted to staff to extend Commission approval on ARM arrangements is limited to three months, staff recommends that the Commission approve UMMC's request for an additional three-month extension, to April 30, 2021, of Commission approval for the ARM arrangement between the University of Maryland Medical Center (UMMC) and OptumHealth Care Solutions, Inc.

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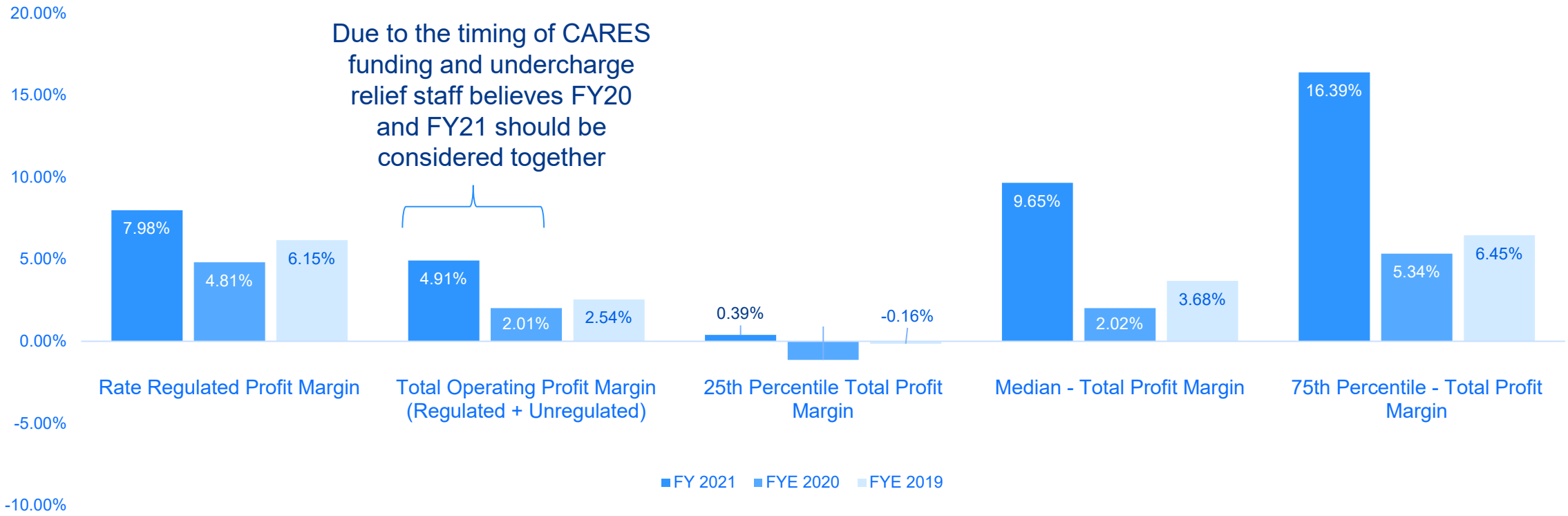
CARES Funding Policy Update

February 10, 2021

Introduction

- The Commission has been providing ongoing guidance about its approach to setting hospital rates during the COVID crisis
- Intent is to provide final guidance for the 18 months ended 12/31/20 shortly so hospitals can have certainty moving forward
- Today's goal is to discuss the proposed staff approach and an alternative to allow for Commissioner questions and discussion. The two alternatives are provided to frame the conversation.
- The Commission will accept written comment letters through 2/24 and will allow those submitting comment letters to testify verbally during the March Commission meeting.
- The second half of FY21 will not be addressed, due to the ongoing nature of the crisis, although it is likely a similar approach will be taken.

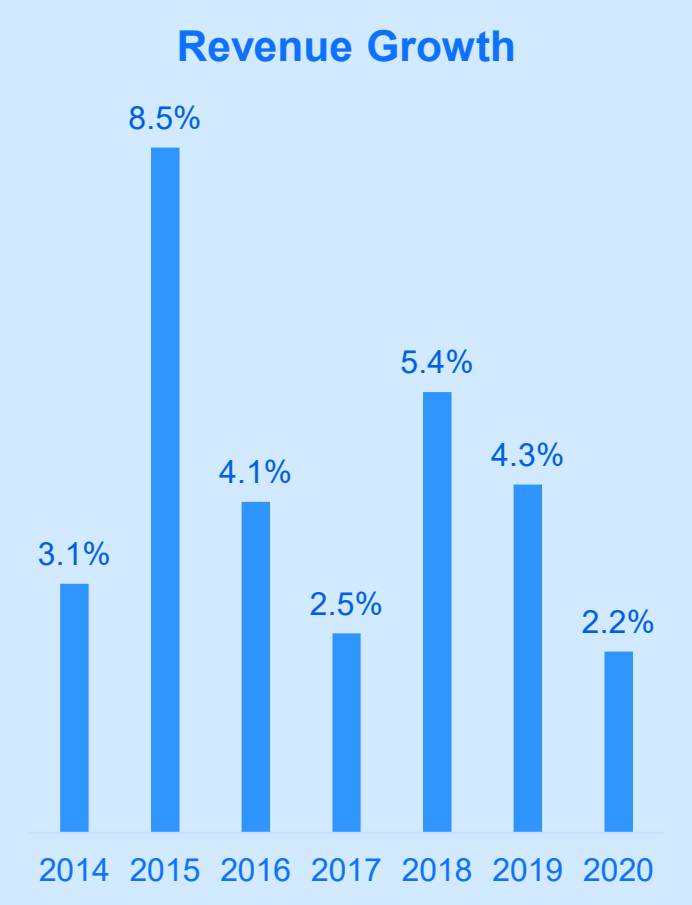
Profit Margins from Monthly Financial Statements July – December FY21 vs FYE 2020 & FYE 2019



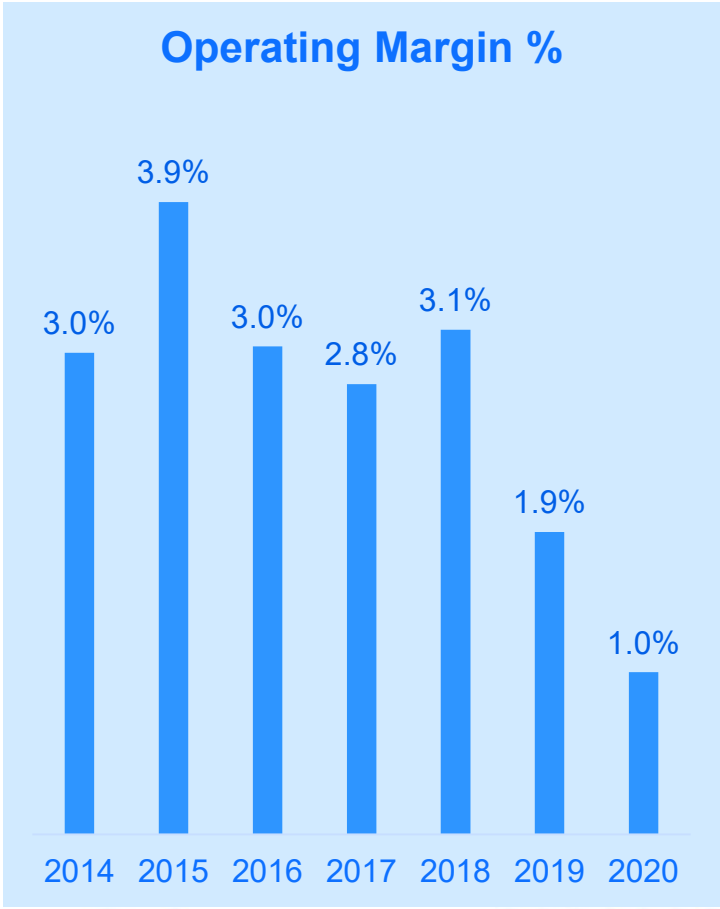
Total margins including non-operating are over 12% for YTD FY21 due to high unrealized investment gains. For FY20 they were approximately equal to Operating Margins and for FY19 they were about 1 point higher.

Source: Unaudited Monthly Financial reports. Annual Filings (which tie to audited financials) for FY20 and FY19 show higher regulated margins (7.9% and 7.7%) and but similar total margins (margin of 2.0% and 2.2%). These audited results include the freestanding ED's and are comprised of June YE hospitals only but these difference are not material..

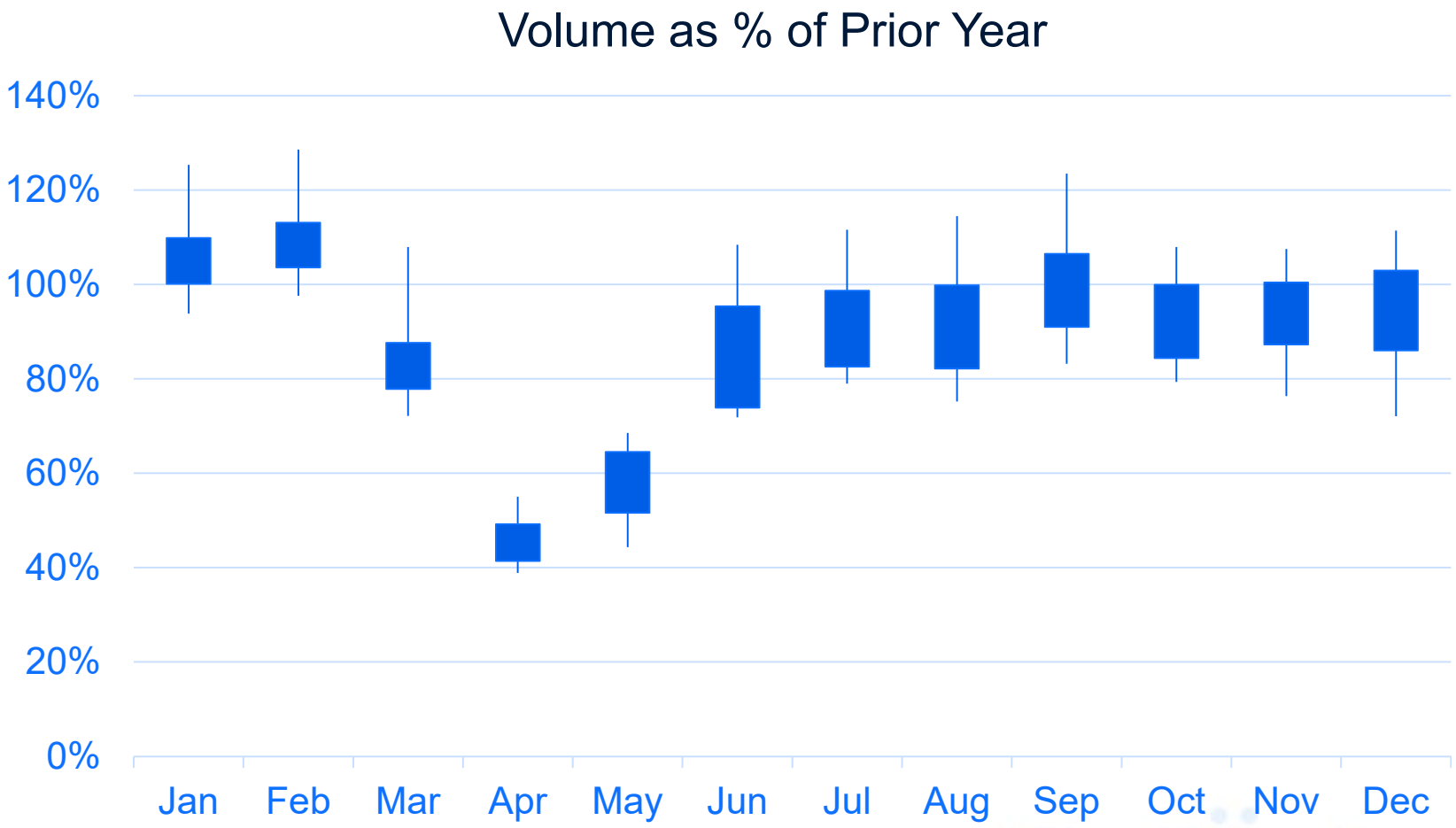
System Level Financials Through FY20



- Most Commission reporting focuses on the regulated hospital entities, but the Commission also collects audited financial statements from each health system.
- Staff consolidated these reports, the graphics show system level results updated for the most recent fiscal year (June year end entities only).
- FY20 Statewide system margins and revenue growth trailed prior years but both remain positive.

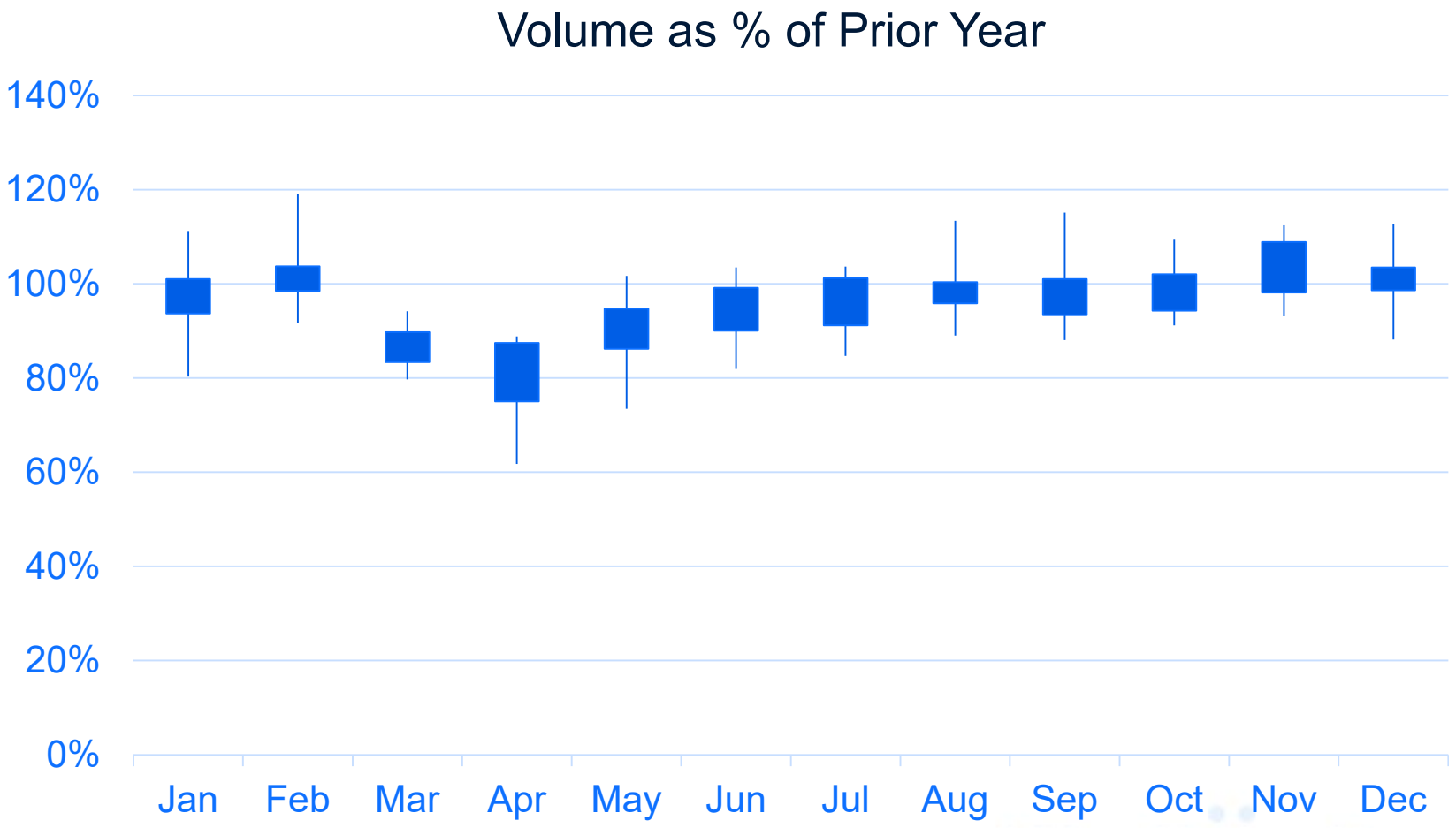


Outpatient Volumes by Month, CY 2020



- Volumes have been relatively constant since June. Greatest variation was in June during volume recovery.
- Line represents min and max value by system, box represents range from 25th to 75th percentile.
- Volumes are weighted across centers by prior year revenue. ER is excluded due to 7/1/19 RVU change.

Inpatient Volumes by Month, CY 2020

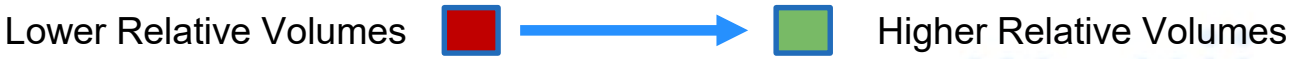


- IP Volumes are only slightly below prior year except for the Spring period.
- Line represents min and max value by system, box represents range from 25th to 75th percentile.
- Volumes are weighted across centers by prior year revenue.

Outpatient System-level Volume Variance, 2020

	Apr OP	May OP	Jun OP	Jul OP	Aug OP	Sep OP
System 1	-2%	0%	4%	13%	25%	7%
System 2	5%	4%	3%	-7%	-15%	-2%
System 3	-6%	-12%	-19%	-14%	-16%	-10%
System 4	5%	17%	16%	3%	1%	8%
System 5	-7%	-20%	-15%	-5%	-4%	-19%
System 6	7%	13%	17%	19%	14%	20%
System 7	9%	8%	16%	14%	8%	8%
System 8	-12%	-11%	-30%	-26%	-18%	-18%
All Non-System	6%	9%	21%	15%	14%	14%

- Amounts represent the percentage point difference between the system % of prior year volume and the state average
- Greatest variance in June and July. Variance tends to be consistent by system.
- IP Variances tend to be smaller.



Staff Proposed Settlement of FY20 and FY21 GBR

Approved Revenue	
Total FY20 and First Six Months of FY21 Charges inclusive of Approved Expanded Corridors	A
FY 20 Undercharge + FY 21 Undercharge for First Six Months	B
Impact of COVID on FY20 Expenses (1)	C
Impact of COVID on FY21 Expenses (1,2)	D
FY21 Funding Under Current COVID Surge Policy - if any (3)	E
Total Approved Revenue	F = A + B + C + D + E
Actual Revenue	
Actual Charges for FY20 and First Six Months of FY21	G
Regulated Portion of CARES funding (4)	H
Total Actual Revenue	I = G + H
Net Under (Over) Funding	J = F - I

- If analysis shows a net under funding hospital will be allowed to bill revenue in subsequent periods. If a net over funding hospitals will be required to reduce future charges to eliminate the over funding - earliest effective date is July 1, 2021.
- Some adjustments were made for hospitals that were undercharged in FY20 in the 1/1/21 rate orders. Any such adjustments will be offset against the July 1, 2021 rate order.
- If material CARES Act monies are subsequently recaptured by the Federal Government, the Commission will work with hospital to recover these funds through additional charges in subsequent rate years.

(1) Expenses will be assessed through aggregated annual filing analysis; will not calculate individual COVID related cost increases
(2) As these amounts will not be known until early FY22, final adjustment will likely be in the FY23 rate order.
(3) Calculated based on monthly assessments
(4) HSCRC will use amounts reported in Federal Reporting on the HHS Provider Relief Fund multiplied by the % of regulated revenue reported by the hospital entity in FY19. Hospital should submit separate reporting if that amount is not appropriate. HSCRC will also compare this amount to revenue reported in the annual filing.

Comparison of Staff Approach with Alternative Approach

- Under Staff's approach a hospital that receives more than their GBR and expenses from billed revenue and the regulated portion of the CARES funding would have all the excess removed in the next period (to the extent they did not have COVID expenses or COVID surge revenue).
- The industry has proposed an alternative approach in which the amount of funding removed in the next period is more limited. The following slides:
  - Show the estimated impact by system
  - Provide an example of how the approaches differ and the implications

Summary of Approach and Overcharges, 18 months ended 12/20

$ in Millions	Under Charge at Approved Rates	Under Charge with Standard Corridors*	Under Charge with COVID Corridors	Estimated CARES	**Staff Approach** Add'l (Reduced) Revenue	**Alternative Approach** Add'l (Reduced) Revenue
Luminis	$ (151)	$ (121)	$ (73)	$ 78	$ (5)	$ (5)
Adventist	(29)	3	(8)	92	(84)	-
Holy Cross	(38)	(14)	(24)	72	(48)	-
Johns Hopkins	(478)	(307)	(250)	244	6	6
LifeBridge	(204)	(145)	(93)	88	5	5
MedStar	(196)	(50)	(1)	169	(168)	(49)
Tidal	(45)	(28)	(25)	30	(5)	(3)
UMMS	(548)	(380)	(300)	297	3	3
All Other	(401)	(255)	(170)	156	14	14
Total	$ (2,090)	$ (1,296)	$ (943)	$ 1,227	$ (284)	$ (31)

- Excludes impact of any adjustment for surge or expense policy.
- Calculations assume the method is applied at a system level, applying the Alternative Approach at hospital level likely increase the benefit to hospitals.
- Amounts calculated on a statewide basis and may not reflect the facility-specific circumstances.
- CARES amounts reflect estimate as of 1/6/21 and are under revision.

* Equates to about 7% this reflects the amount hospital could charge under normal corridors, they typically charge 3-4%.

Example of Different Approaches

		Staff Proposal		Alternative Approach	
		Hospital A	Hospital B	Hospital A	Hospital B
A	Billed Revenue Before COVID Corridor Expansion	80	95	80	95
B	Corridor Expansion	5	5	5	5
C	Regulated CARES Funding (2)	10	10	10	10
D=A+B+C	Revenue Realized	95	110	95	110
E	Approved Revenue (1)	100	100	100	100
F=E-D	Under (Over) Funding	5	(10)	5	(10)
G	Increase (Reduction) to FY22 Revenue	5	(10)	5	(5)

Amounts reflect results for the 18 months ended 12/31/20

Determination of Item G

- Under Staff proposal the FY22 recovery is the amount needed to offset extra revenue in the 18 month window
- Under Alternative Approach the FY22 recovery is the amount needed to offset extra revenue in FY21 but capped at the amount of corridor expansion received.

- For a hospital that is below their approved revenue, the approaches yield identical results.
- For a hospital above the approved revenue, FY22 reductions will be less if the extra revenue is more than the corridor expansion.
- See the next slide for a discussion of the implication of these differences and the impact of potential Federal recoveries.

(1) Approved Revenue = GBR + COVID Expenses + COVID Surge Policy Funding
(2) CARES funding received by hospital allocated between regulated and unregulated based on historic revenue split.

Implication of Different Approaches

- The ultimate difference between the approaches varies depending on whether the Federal government recovers CARES funding equal to the excess on the prior slide.
  - We still await definitive guidance from the federal government on the use and documentation of CARES funding, as well as the reclamation process for funding already provided. In general, CARES revenue is intended to offset lost revenues and incremental expenses.
  - If recoveries are made, the approaches becomes the same. As under the Staff approach, the HSCRC would restore revenue lost due to Federal recovery in future periods.
  - If recoveries are not made the hospital is able to retain extra revenue under the Alternative approach that they would not retain under the Staff approach

Considerations for Staff Approach	Consideration for Alternative Approach
• Consistent with general policy, this approach sets hospital revenues equal to the approved Global Budget Revenue during the crisis period. Varying from that approach would create volume-based winners and losers which is inconsistent with the Model. • Hospital margins have remained generally consistent throughout the crisis, at a regulated, unregulated and system level. • HSCRC statute requires consideration of all sources of revenue.	• Without alternative guidance, hospitals must return funding to HHS that is not justified. It is far from certain that HHS would allow future period reductions as lost revenues. • Under Federal rules hospitals may legally share funding within their health system. They should be allowed to do so. • If hospitals can retain all CARES funding it may be used to offset other losses not subject to HSCRC support.

Next Steps

- Discuss Other considerations
  - Some hospitals have proposed using all system physician revenue in allocating funds between regulated and unregulated.
  - If the Alternative approach is followed Staff believe it should be implemented at a system level, otherwise systems will be able to earn additional payments for undercharges on one hospital while retaining overcharges on another.
- Written comment period through February 24, 2021
- Finalize approach at March Commission meeting
- Second half of FY21 (Jan to June)
  - Staff did not address the second half of FY21 due to uncertainty about COVID ongoing volume levels
  - Staff would likely recommend that the policies applied to FY20 and the first half of FY21 would be extended into the second half of FY21, which would include:
    - Guaranteeing the undercharge net of any additional Cares funding
    - Allowing increases in the GBR for documented expenses and funding under the COVID surge policy

Initial Review of COVID Expense Impact

Analysis of Annual Filing Data for COVID Impact on Costs

- HSCRC is in process of compiling FY2020 Annual Filing Data
  - Following slides are an initial summary of FY 20 Annual Filing for June YE Hospitals (~94% of Revenue)
- Analysis of COVID expenses will be done in the context of the annual filing because:
  - Creating COVID-specific expense report would create additional reporting burden and is unlikely to result in credible, comparable data across systems.
  - Staff believes incremental COVID-related expenses need to be evaluated in the context of other changes in cost.
- Goal will be to develop a generalizable approach to quantifying the impact of COVID on Hospital Costs. Towards this goal:
  - Staff will be reviewing the change in reported costs in total and per unit at both a summary and cost center.
  - Cost trend will be compared to historic trends.
  - Outlier cost center and hospitals will be evaluated.
  - COVID volumes as reported in casemix will also be considered.
- If hospitals wish to submit supplemental analyses on COVID expenses, Staff will also review this material. Any analysis submitted should focus on FY2020.

Initial Review of Expenses for FY20 (Regulated + Unregulated)

$ in millions	FY19	FY20	% Change
Net Patient Revenue	$14,770	$14,421	-2.4%
Other Operating Revenue	993	1,680	69.2%
Total Revenue	15,764	16,101	2.1%
Total Operating Expenses	15,420	15,772	2.3%
$ Margin	$344	$328	-4.4%
% Margin	2.2%	2.0%	

Increase relates to ~$700 M of CARES funding. Amount is consistent with HSCRC's review of audited financials. On Audited financials an additional $120 M is deferred and $500m was received after YE, which ties to HSCRC estimate of total receipts of $1.3 B

After CARES funding expenses increased generally in line with revenue. Incremental 0.2% equates to $30 M statewide. Results will vary by hospital

Patterns for unregulated margin were similar to the total margin, additional other operating revenue growth offset drops in net patient revenue resulting in a small improvement in margins.

Note: Annual Filings are still being reviewed and amounts may be subject to change, although not likely to be material..

Expense Growth by Cost Center, Major Direct Costs

- Most direct areas experienced declines as would be expected with the volume reductions.
- Largest declines in Outpatient services.
- Across all cost centers costs declined by 8.5% for FY20.
- For the year, OP volumes (excluding ER) were down about 11.4% and IP volumes by about 4.5%.

Cost Center	2020 Costs	2018	2019	2020
Medical Surgical Supplies	$1,074,680	0.5%	-0.5%	-15.4%
Medical Surgical Acute	$1,001,669	1.5%	6.3%	-1.5%
Drugs	$810,944	0.2%	2.2%	-5.6%
Operating Room	$528,498	-1.2%	1.1%	-7.8%
Laboratory Services	$487,224	2.3%	2.2%	-10.0%
Emergency Services	$444,763	-1.5%	4.8%	-3.8%
Medical Surgical ICU	$320,926	1.6%	1.8%	-2.4%
Clinic Services	$212,319	7.9%	0.1%	-8.3%
Radiology - Diagnostic	$189,197	-2.5%	1.3%	-6.3%
Observation	$160,270	6.1%	8.2%	-6.7%
Labor & Delivery Services	$150,416	1.0%	4.7%	-4.0%
Respiratory Therapy	$145,424	-3.8%	0.9%	-2.4%
Interventional Radiology/Cardi	$131,225	2.0%	10.8%	-13.2%
Psychiatric Acute	$126,217	3.2%	5.1%	-8.4%
Neonatal ICU	$113,605	5.4%	3.5%	-0.2%
Physical Therapy	$88,358	-1.5%	-0.7%	-8.9%
Same Day Surgery	$79,461	0.5%	-2.3%	-15.1%
Grand Total		0.3%	3.6%	-8.5%

Expense Growth by Cost Area, Indirect Costs

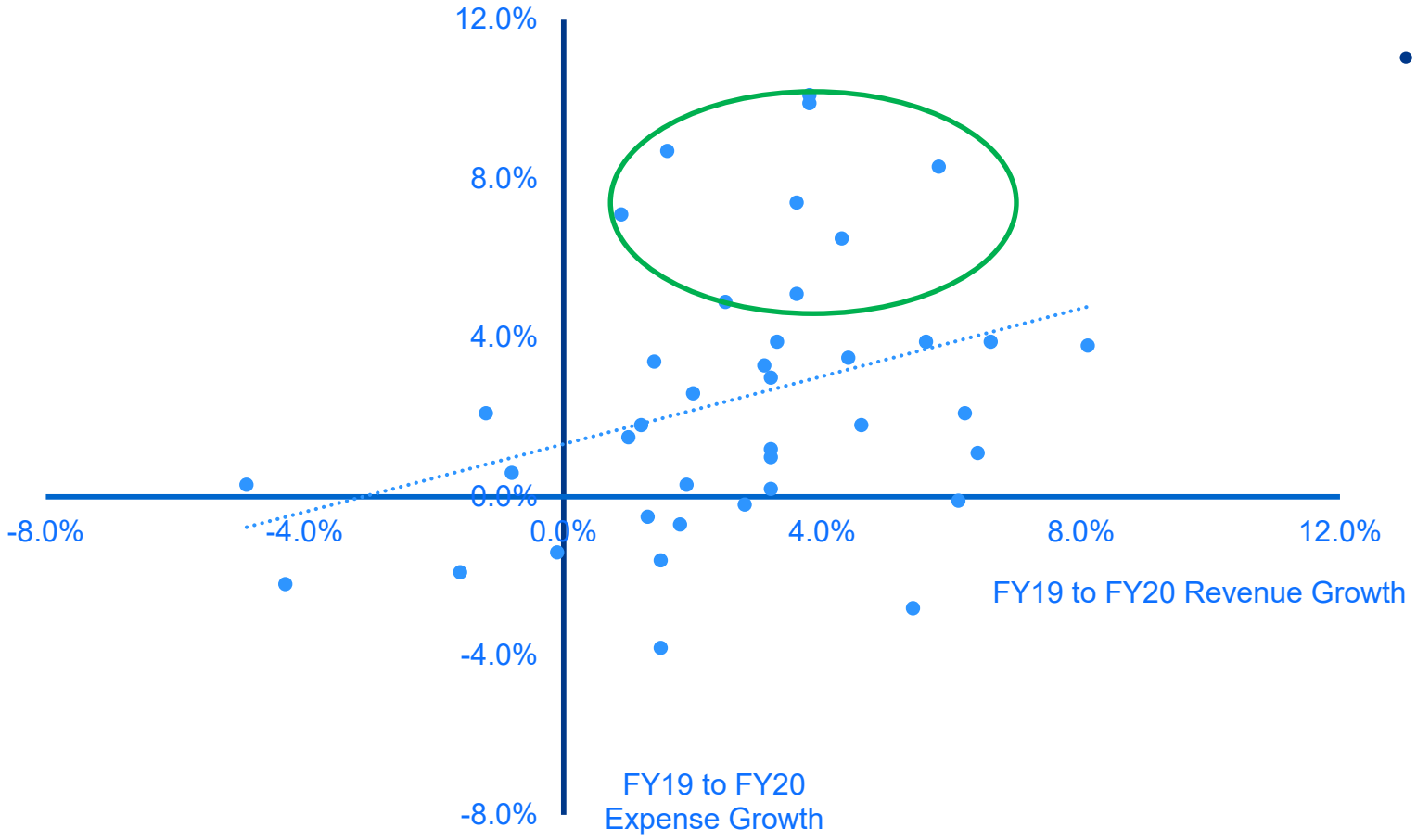
Cost Center	2020 Costs	2018	2019	2020
Hospital Admin	$1,224,106	4.2%	-3.2%	12.4%
Data Processing	$609,890	1.1%	8.8%	8.9%
Plant Operations	$547,881	4.8%	3.0%	-1.8%
Patient Accounts	$257,074	-2.7%	3.7%	-4.2%
Pharmacy	$256,154	2.3%	8.1%	1.5%
Housekeeping	$210,756	1.2%	1.4%	1.9%
Nursing Administration	$191,834	1.4%	1.7%	3.8%
General Accounting	$162,957	17.5%	2.4%	8.2%
Dietary Services	$122,186	4.0%	1.1%	1.6%
Central Services and Supply	$109,748	5.3%	7.5%	6.6%
Medical Records	$99,094	-8.1%	-7.2%	-7.7%
Social Services	$81,594	1.5%	10.1%	-1.2%
Medical Staff Administration	$71,198	13.5%	1.4%	-8.5%
Purchasing and Stores	$70,753	1.4%	-4.9%	6.9%
Laundry and Linen	$47,263	6.0%	1.8%	-4.4%
Organ Acquisition Overhead	$4,466	768.9%	20.0%	5.0%
Grand Total		3.2%	1.8%	4.8%

Sorted in descending order by size.

Cost Center	2020 Costs	2018	2019	2020
Depreciation & Amortization	$876,472	1.6%	3.6%	-0.2%
Malpractice	$252,693	29.7%	13.3%	21.0%
Interest - Long Term	$246,841	3.2%	3.4%	-10.7%
Leases & Rentals	$126,074	0.9%	4.2%	-4.9%
Medical Care Review	$114,082	2.2%	5.6%	3.1%
Other Insurance	$17,503	-8.9%	-9.3%	21.4%
Licenses	$14,061	14.7%	-4.9%	-3.5%
Unassigned Allocated to Unre..	$0	144.5%	-306.9%	-14.7%
Interest - Short Term	$-301	-8.4%	-71.0%	-125.1%
Grand Total		4.5%	4.5%	0.6%

- Generally, hospitals appear to have been able to lower costs in some areas to offset growth in others.
- High costs in Admin and Central Services likely reflect COVID related costs. However, hospitals held down growth in areas like Plant Operations, Social Services and Patient Accounts.

Revenue vs Expense Experience by Hospital



- Hospitals with differential expense growth, key questions to answer:
  - Did they have differential COVID volumes?
  - Does profile of expense match that would which would be expected to be driven by COVID?
  - Has hospital taken steps to realize cost savings as other hospitals did?

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Update on Medicare FFS Data & Analysis

February 2021 Update

Data through October 2020, Claims paid through December 2020

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

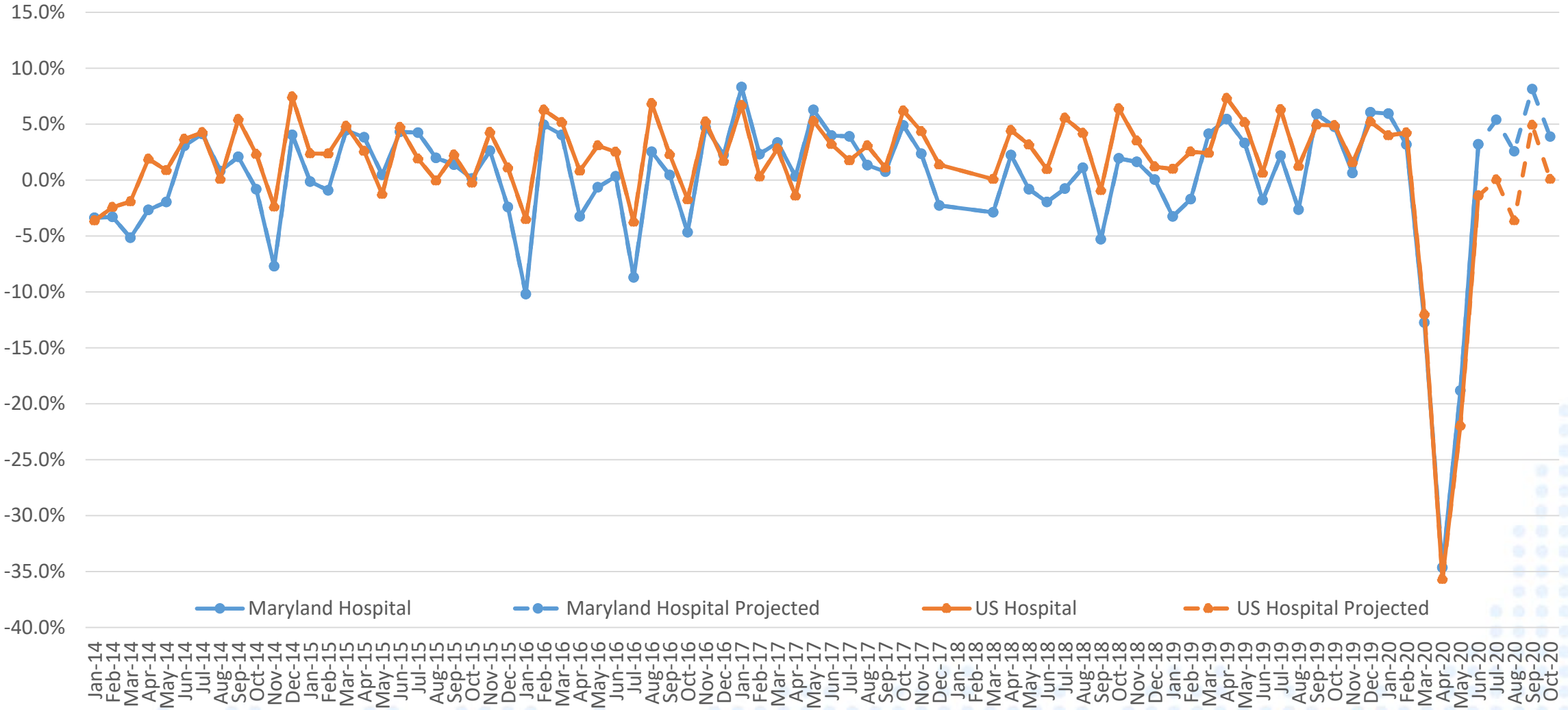
Note for CY 2016:

During the last six months of CY 2016 (July – December of 2016), Hospitals undercharged their Global Budget Revenue mid-year targets by approximately 1% ($25M dollars). The following slides have been adjusted to 'add back' the undercharge to the period of July – December 2016 to offset the decline in savings for January – June 2017.

Staff has noted which slides in the following presentation include the adjustment for the undercharge.

Medicare Hospital Spending per Capita

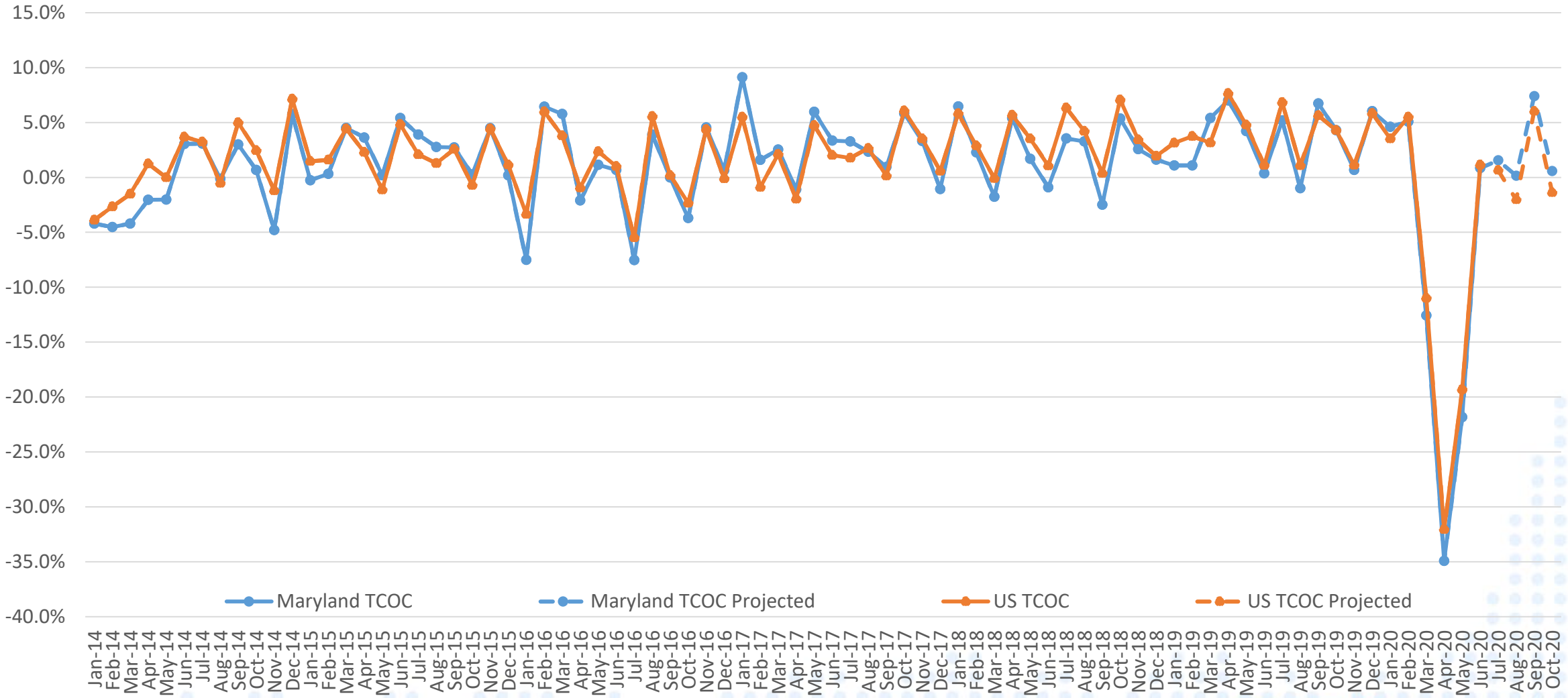
Actual Growth Trend (CY month vs. Prior CY month)



CY16 has been adjusted for the undercharge.

Medicare Total Cost of Care Spending per Capita

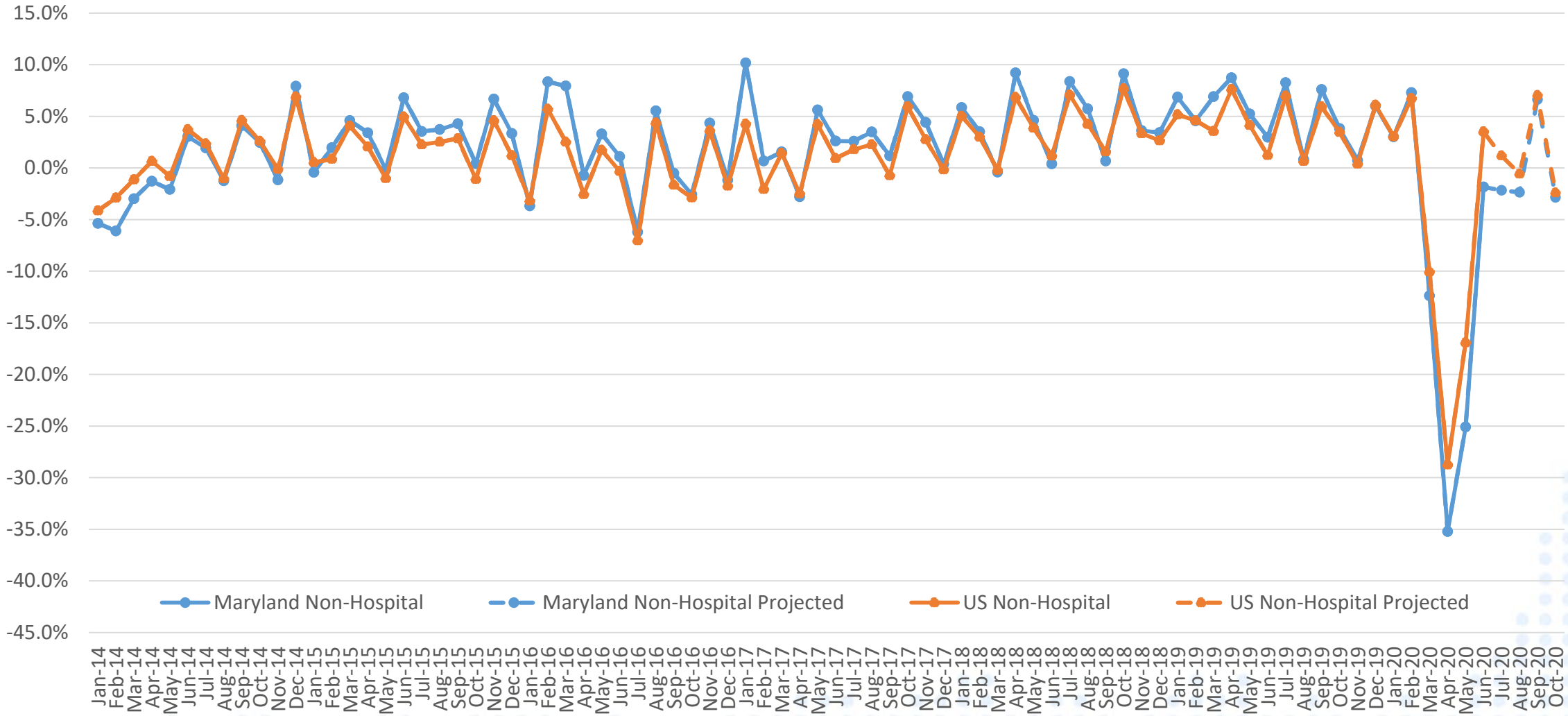
Actual Growth Trend (CY month vs. Prior CY month)



CY16 has been adjusted for the undercharge

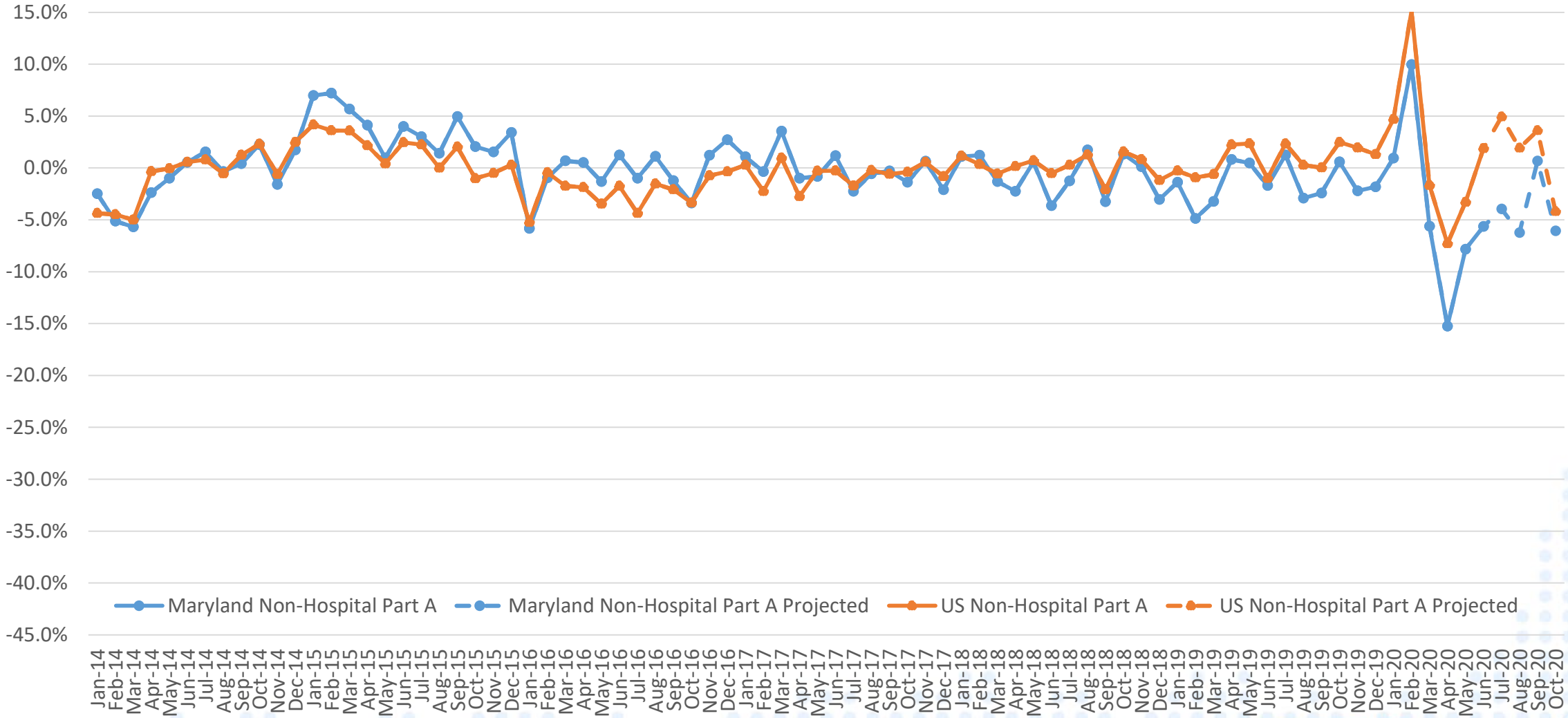
Non-Hospital Spending per Capita

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



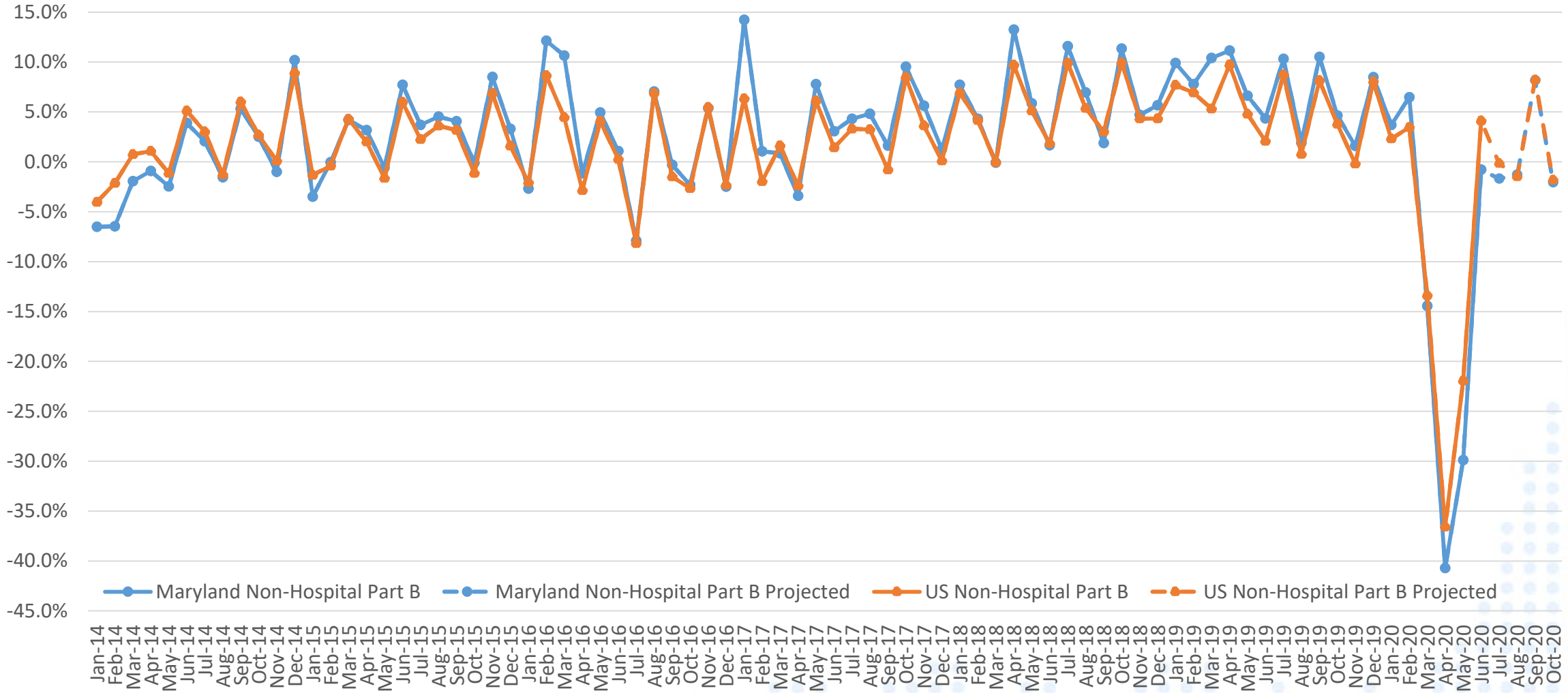
Non-Hospital Part A Spending per Capita

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



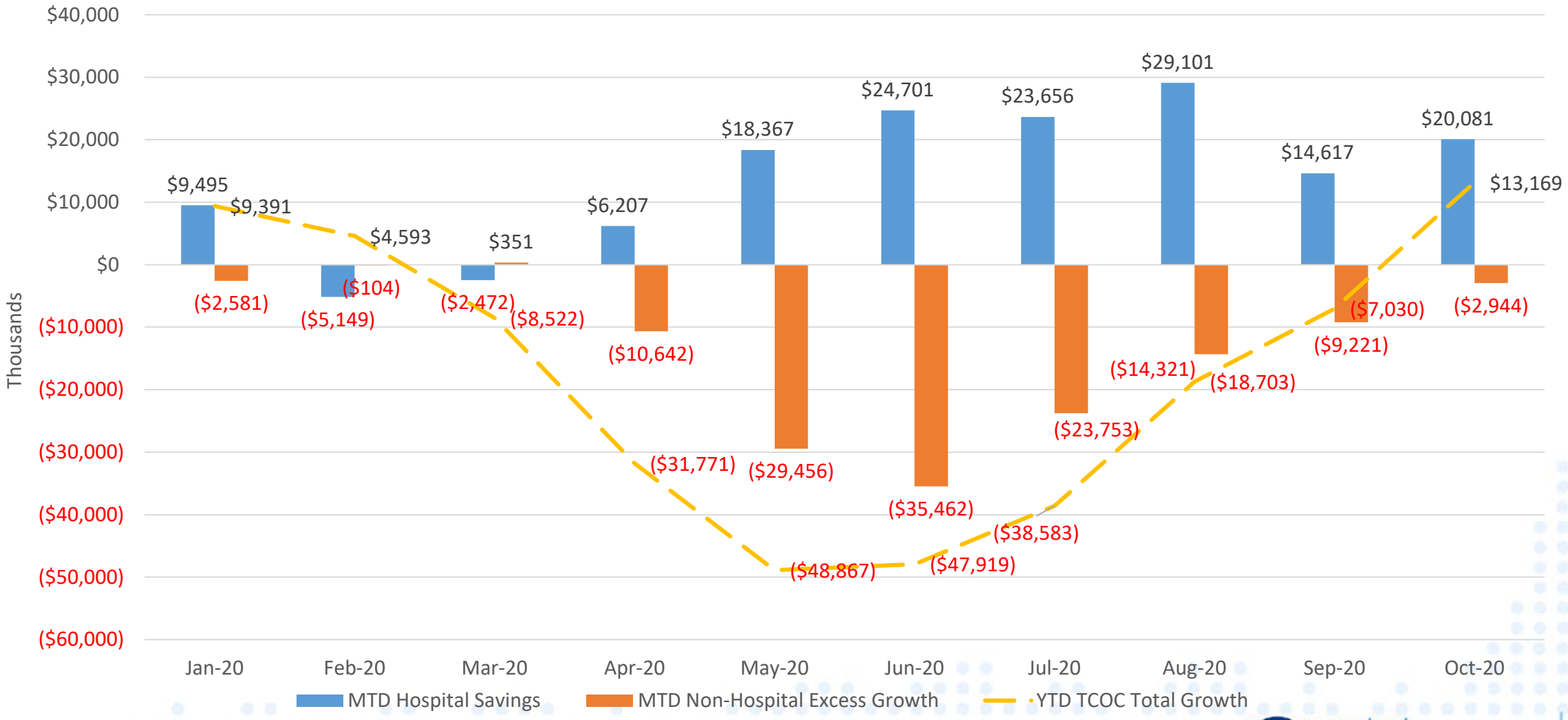
Non-Hospital Part B Spending per Capita

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



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through October 2020



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Benchmarking Overview

Benchmarking Overview

- Goal: Create a tool to allow the incorporation of Total Cost of Care (TCOC) benchmarks into appropriate methodologies at a granular level and guide the State on areas of strength and weakness in terms of cost and quality.
- Focus on Medicare (MC) fee-for-service and Commercial (CO) benchmarks of people younger than 65; will explore Medicaid and other areas in the future.

Applications of the Benchmarking

- Efficiency Policies and Full Rate Application policies under development.
- Target setting in MPA policy, effective 1/1/21.
- Readmission information was an input during target setting in Quality Process
- Care analytics and diagnostics:
  - Sharing data so industry can use the information to manage care and address gaps
  - HSCRC plans to continue to leverage the data
  - CRISP Learning Collaborative will be promoting additional detailed analysis

Determination of Evaluation Unit

Geographic Benchmarks

- Focus for this effort is member and beneficiary geography:
  - Geographies align best with per capita measures.
  - Selection of comparison group relies on measures available on a geographic basis.
  - Different site of service mixes makes it important to consider TCOC, not just hospital per capita costs.
  - Because most HSCRC methodologies are hospital based, they will have to determine a weighting approach to blend per capita results into each methodology.

- Peer geographies are established at a county level for Medicare and MSA level for CO.
  - Commercial is limited by data availability.

Data Sources

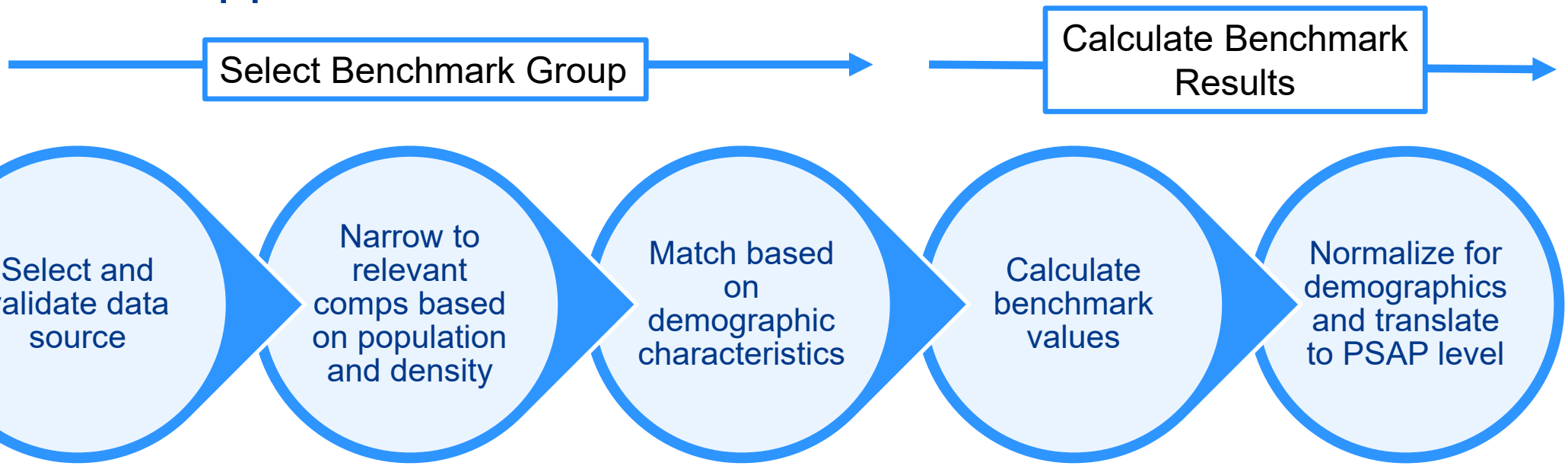
Medicare

- CCW Medicare Claims for A+B Beneficiaries, 100% available for MD, 5% sample for national data

Commercial

- MD - MD APCD collected by MHCC, also known as the Medical Claim Database
  - ERISA plans are not included in the APCD, and individuals are included.
  - Benchmarking excluded Kaiser and beneficiaries older than age 65.
  - It represents about 40% of MD beneficiaries. with these exclusions.
- National - Milliman's Consolidated Health Cost Guidelines Sources Database
  - ERISA plans are included but limited in number, and individuals are not included.
  - Benchmarking excluded beneficiaries older than age 65.
  - Reflects about 98 million commercial-insured people nationwide.

Overall Approach



- **MC**: County Level, 100% MD claims, 5% US Sample (A+B)
- **CO**: MSA Level, Medical Claims Database (MCDB) for MD, Milliman's Consolidated Health Cost Guidelines Sources Database (CSHD) for National

- Limit to reasonable matches

Ongoing work with payers to reconcile, may impact benchmark raise commercial costs to some degree (3-5%)

- **MC**: Median Income, Deep Poverty Percentage, Regional Price Parity, Hierarchical Conditioning Categories
- **CO**: Same except add Government payer, share and HHS-HCC Platinum risk scores instead of CMS-HCC (Medicare only)

- Simple average of benchmarks at MSA/county level.
- Risk and Benefit (CO only) Adjustments
- Remove estimated medical education costs from all data

- Calculate MD TCOC for Hospital PSAP and blend relevant benchmarks
- Use regression to further adjust for demographics at the geography and hospital level

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Recap of PMPM State Variation vs Benchmark

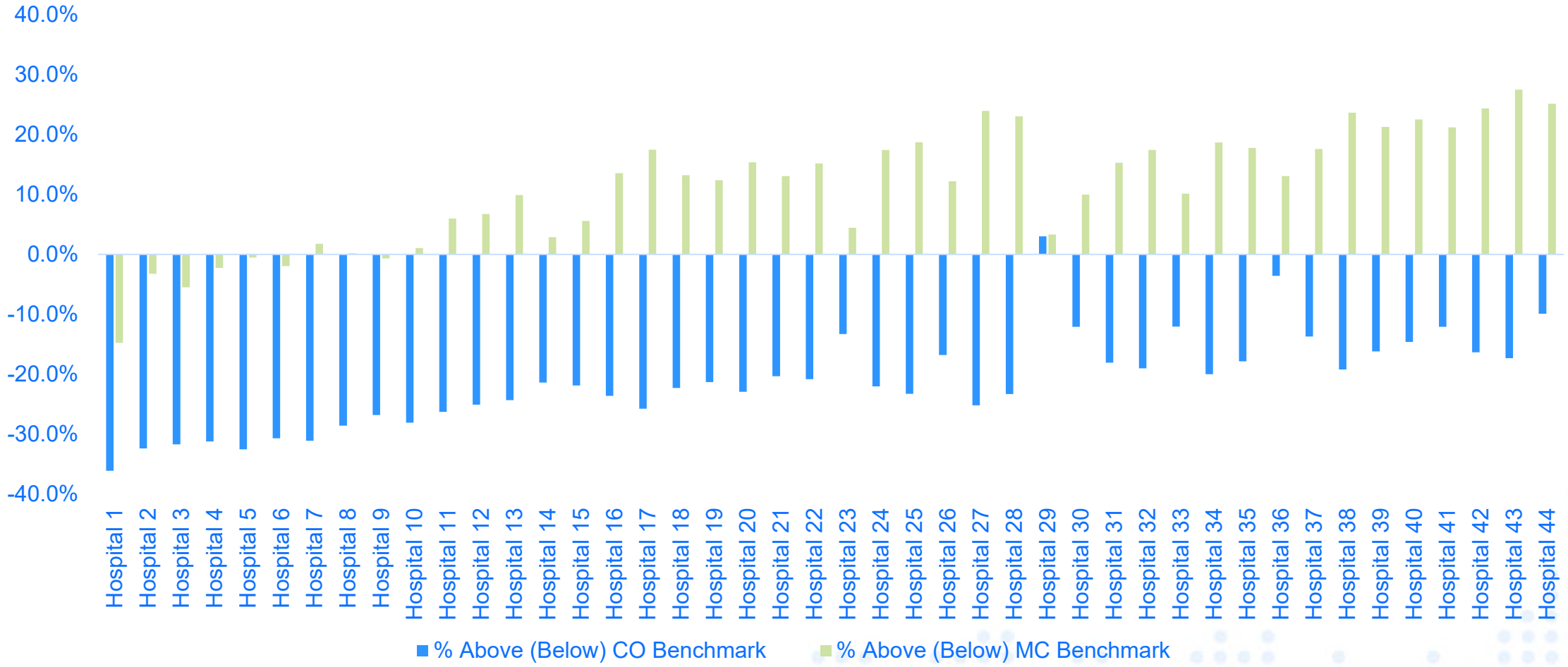
PMPM Higher (Lower) than Benchmark and % Variation by Bucket

	Commercial	Comment	Medicare	Comment
Inpatient	($19.04) (21.6%)	Commercial variations are primarily driven by unit cost somewhat offset by higher professional utilization. See note regarding commercial data reconciliation on prior slide.	$55.90 16.9%	Higher unit costs offset by favorable inpatient and outpatient utilization
Facility Outpatient	($44.30) (32.1%)		$36.99 19.9%	
Professional	$3.19 1.9%		$29.15 10.1%	
Post-Acute			($29.53) 19.3%	
Medical Education	($0.72)		($12.26)	See note below
Risk and Benefit Adjustment	($13.37)	The MD CO population evaluated was riskier and has higher benefits (maybe be population mix in data).	$7.50	The MD Medicare population is slightly less risky than the benchmark.
Demographics Adjustment	($21.10)	MD demographics are less favorable: mainly higher incomes correlate with higher costs.	($8.22)	
Total	($95.33)	Equate to 24.3 % favorable	$79.52	Equates to 8.6% unfavorable.

Note: Medical Education variance is exaggerated as national data includes only Indirect Medicare Education payments (IME) while Maryland claims include both IME and Direct Medical Education Amounts (DGME).

Benchmarking Results, Percentage Above (Below) Benchmark

2018, Risk and Demographic Adjusted, Blended Statewide: MC 8.6%, CO (24.3%)



Notes: Results are sorted by average rank on the two benchmarks. Commercial benchmark shown is the average of commercial benchmark. Efficiency policy will use the average of the top half of the benchmark (See discussion on slide 8).

Future Areas of Focus

- Data Set publicly available at
  - https://hscrc.maryland.gov/Pages/hscrc-tcoc.aspx
  - See August 2020 Benchmarking Materials link at the bottom of the page.
  - Files listed in Appendix of this presentation
- Updating CY19, expect data release to always be one full year behind due to delays in receiving Commercial data.
- HSCRC Completing Ongoing Review based on stakeholder feedback
  - Appropriate Risk/Demographic Adjustment
  - Impact of border-crossing

Baltimore vs Montgomery Medicare Benchmarking Comparison

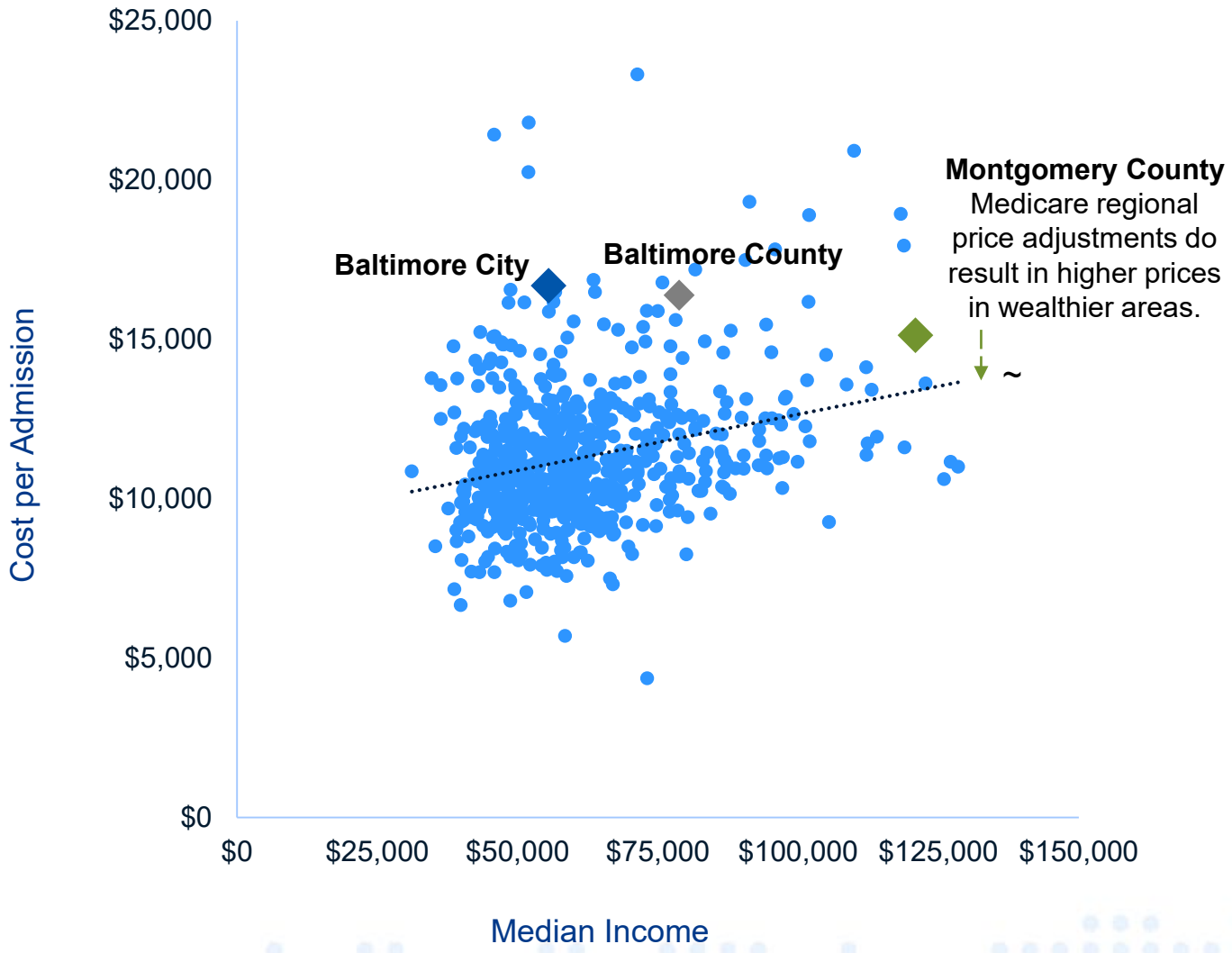
TCOC Per Capita	Unadjusted TCOC	Risk Adj. and Benchmark Adj. TCOC with Deep Poverty Adj.	Benchmark w. Median Income
Baltimore City	$16,504	$16,625	$12,911
Baltimore County	$14,060	$17,379	$13,222
Montgomery County	$10,931	$14,437	$10,394
Baltimore City over Montgomery	51.0%	15.2%	24.2%
Baltimore County over Montgomery	28.6%	20.4%	27.2%

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

Baltimore City and County are similar after these adjustments, which would be expected. A 15% difference is similar to that which can be derived from Medicare's standardized pricing files excluding regional price adjustments.

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

Medicare IP Cost per Admission vs Median Income



- Pale blue circles show relationship between Medicare IP cost per admit and Median income for each county included in the benchmarks
- Montgomery County (◆) unit costs are less inflated versus Median Income compare to versus Baltimore City (◆)
- This results in the positive adjustment to Montgomery county in the last step of the benchmarking process.
- Need to validate Montgomery income adjustment against Medicare adjusters and validate outlier status in the regression.

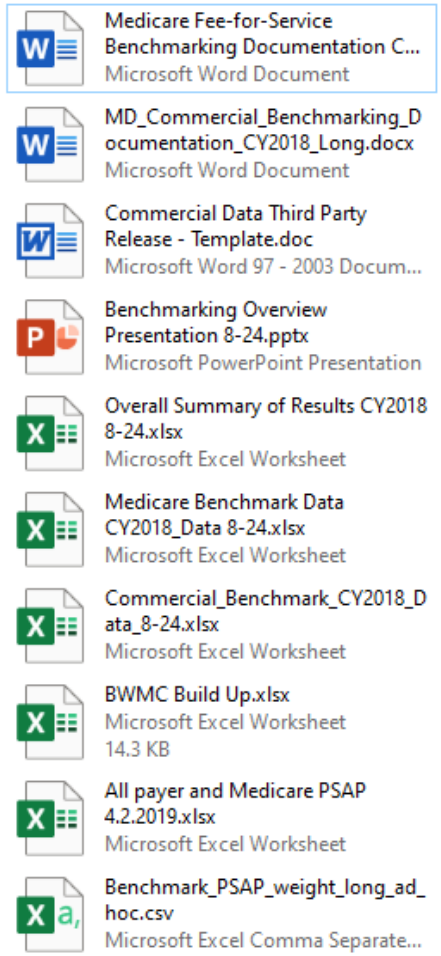
Appendix

Recap of Demographic Factors

	Medicare	Commercial
Factors used in narrowing potential matching populations for each MD geography	Urban/Rural Indicator Population Size Population Density	Population Size Population Density
Factors used in selecting matching national geographies for each MD geography	CMS - HCC Score Deep Poverty Percentage Median Income Regional Price Parity	HHS-HCC Platinum Risk Score Deep Poverty Percentage Median Income Regional Price Parity Percentage Spending from Government Payers
Factors used in risk adjusting and normalizing benchmark values to MD geography and MD Hospital-Attributed Population (parenthesis indicates level of detail at which value is mapped to a beneficiary)	CMS - HCC Score (Beneficiary) Deep Poverty Percentage (ZIP) Median Income (ZIP)	HHS-HCC Platinum Score (Beneficiary) Deep Poverty Percentage (County) Median Income (County) Benefit Levels (County)

Material Included in August 2020 Materials Zip

The first tab in most of the Excel files contains a directory to the other tabs.



1. Documentation for Medicare benchmarking process
2. Documentation for Commercial benchmarking process
3. Commercial data release template, see discussion on the next slide
4. This presentation
5. Summary of final benchmarking results currently being used
6. Medicare data, including MD and Benchmark summary and granular data
7. Commercial data, including MD and Benchmark summary data (see next slide)
8. Excel version of BWMC example shown in powerpoint presentation
9. Current ZIP-code-to-hospital PSAP attribution for both Medicare and All-Payer
10. Alternative presentation of Medicare Benchmark to PSAP mappings, see discussion in #6

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Legislative Update

HSCRC February 2021 Commission Meeting

February 10, 2021

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

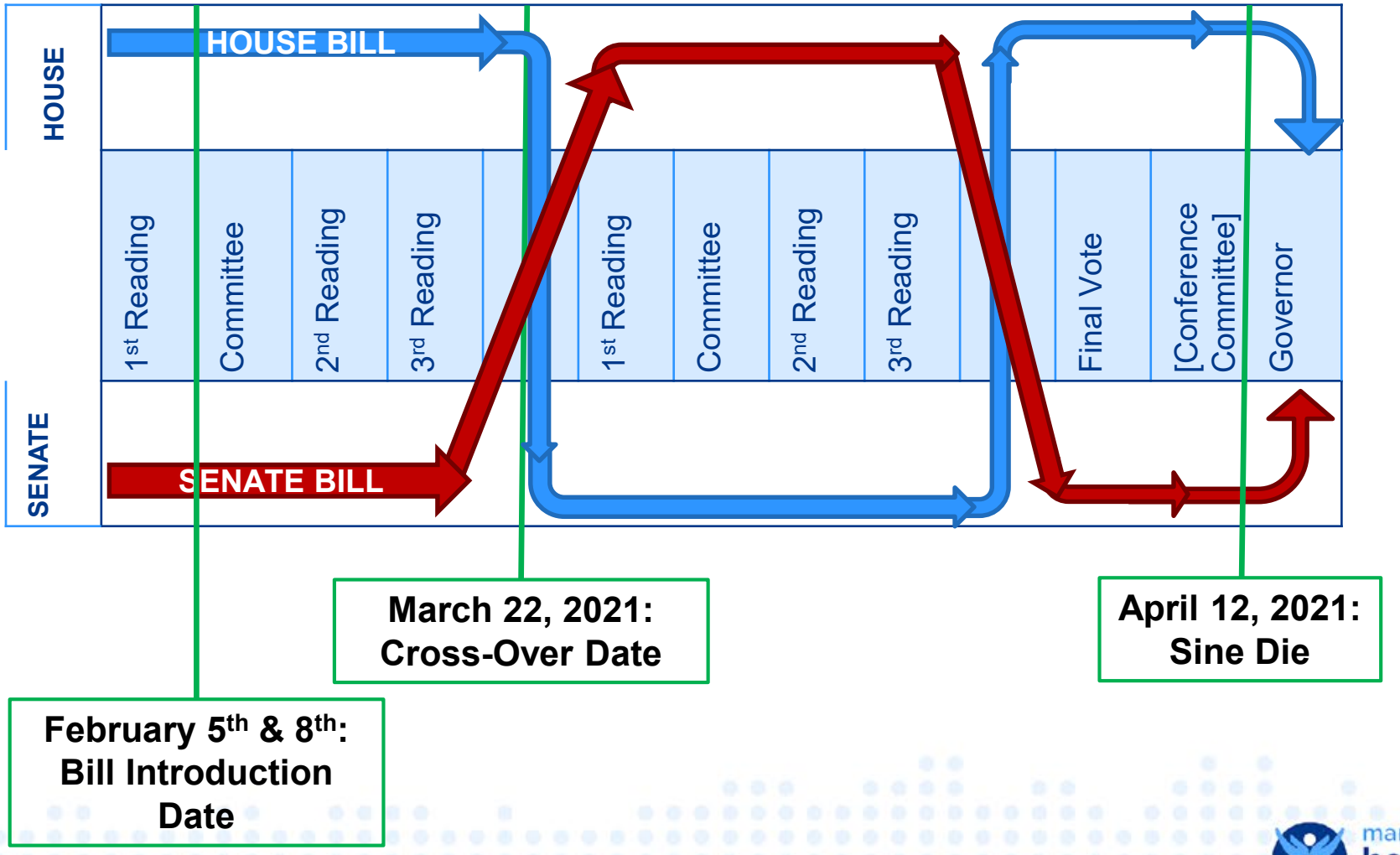
- Members are strongly encouraged to limit the number of bills introduced.
- Virtual committee briefings and hearings.
- Livestreaming of floor sessions
- Access to legislative buildings is restricted to Members, some staff, and limited members of press.
- Floor sessions are limited to 2 hours.
- Weekly schedule will be condensed, especially early in the session, to limit days members are on campus.

These policies are subject to change.

Overview of Staff Activity with General Assembly

- **Telehealth** and **health equity** are priority health-related issues for legislators this year.
- HSCRC staff have been in contact with stakeholders on the issues of **telehealth, medical debt, and financial assistance**.
- The HSCRC is working on a report, "*Analysis of the Impact of Hospital Financial Assistance Policy Options on Uncompensated Care and Costs to Payers*", mandated by House Bill 1420 (Ch. 470, 2020 Md. Laws)

Legislative Process



Budget

Bill #	Description	Position
HB 588	**Budget Bill for FY 2022 (The Governor's Budget)**	No Position - Monitor
HB 589 SB 493	**Budget Reconciliation and Financing Act of 2021**	No Position - Monitor

- HSCRC's Budget hearing will be held jointly with the Health and Social Services Subcommittees of the Appropriations Committee (House) and the Budget and Taxation Committee (Senate) on February 15, 2021
- HSCRC's is working with Department of Legislative Services budget analysts to prepare for the budget hearing

Telehealth Bills

Bill #	Description	Position
HB 123 SB 3	**Preserve Telehealth Access Act of 2021** • Requires Medicaid to provide medically necessary somatic, dental, or behavioral health services via telehealth. • Defines telehealth for Medicaid to include asynchronous and synchronous technology, audio-only, and remote patient monitoring. • Removes pre-PHE Medicaid telehealth limitations on where patients and providers are located. • Private insurers must reimburse for telehealth at the same rate and on the same basis as in person care and cover audio-only as telehealth; insurers cannot limit which providers can be reimbursed for telehealth beyond the limitations that apply to in person care.	No Position*
HB 731 SB 567	**Telehealth Services – Expansion** Lieutenant Governor's bill; same provisions as HB 123/SB 3.	No Position*
HB 551 SB 393	**Maryland Medical Assistance Program and Health Insurance – Coverage and Reimbursement of Telehealth Services** Bill is similar to HB 123/SB 3; focus on mental health and SUD services and practitioners.	No Position*

Medical Debt Bill

Bill #	Description	Position
HB 565 SB 514	**Health Facilities - Hospitals - Medical Debt Protection** • Establishes new reporting requirements on debt collection for hospitals • Prohibits hospitals from filing an action or handing collection activity over to a collection agency for a patient who owes less than $1000 • Prohibits hospitals from filing an action to collect a debt owed by an uninsured patient or a patient that has not been screened for financial assistance • Requires the HSCRC to submit an annual report to the legislature	Letter of Information with Amendment

Carefirst VBP

Bill #	Description	Position
HB 1021 SB 758	**Health Insurance – Two–Sided Incentive Arrangements and Capitated Payments – Authorization** • Allows for two-sided incentive arrangements between carriers and providers. • The arrangements hold the provider accountable for the cost of care for a population or the cost of an episode. • The risk is limited by the bill to 10% of total payments from the carrier to the provider and the arrangements must have more upside than downside risk. • Only physicians, groups of physicians, and group practices, ACOs, and similar entities are eligible for the arrangements. • Also allows primary care providers to enter capitated arrangements with self-insured groups without being regulated as insurance. • The self-insured groups can lease a carriers' network but must retain the obligation to provide covered benefits.	No Position

CRISP EHN and Nursing Home Data

Bill #	Description	Position
HB 1022 SB 748	**Public Health – State Designated Exchange – Clinical Information Sharing** *Electronic Health Networks (EHN)* • Requires EHNs to provide data on administrative transactions to the State-designated health information exchange (HIE) • The data must be used for public health and clinical purposes, such as informing ambulatory practices, urgent care centers, and hospitals about recent patient encounters. • EHNs may not charge providers or the HIE for the data. • The bill includes patient consent and communication requirements. *Nursing Homes* • MDH may require nursing homes to submit electronic clinical information to the State HIE. • The HIE can share the information with certain healthcare providers, government entities, and other HIEs. • The information can be used for state health improvement programs, mitigation of a public health emergency, or improvement of patient safety.	TBD

Questions?

Megan Renfrew

Associate Director of External Affairs

Center for Payment Reform and Provider Alignment

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Appendix

2021 General Dates of Interest

- **January 13 -** General Assembly convenes
- **Late January**
  - Budget bill introduced by Governor
  - Bill request guarantee date- last day legislators can request bill drafting
  - Final day for introduction of Administration bills (i.e. bills from the executive branch) without Senate Rules Committee Referral
  - Governor's State of the State Address (noon)
- **February 5th/8th -** Final day for introduction of bills without Rules Committee Referral
- **February 21 -** Green Bag appointments submitted by Governor
- **March 8 -** Final date for introduction of bills without suspension of Rules
- **March 22 -** Opposite Chamber Cross-over Date
- **April 5 -** Budget bill to be passed by both chambers
- **April 12 -** Sine Die

COVID-19 Operations

Senate

- 3 Stages depending on the amount of COVID-19 in members and staff.
  - Stage One: debate and voting are paused and all hearings occur virtually.
  - Stage Two: “floor” debate and voting in committee rooms to allow for more distance between lawmakers. No visitors to campus.
  - Stage Three: debate and voting on the Senate floor & limited office meetings (max two visitors, escorted into and out of Senate office buildings).
- Some Senators can vote from committee rooms.
- Senators and some staff will be tested 2x/week (other staff will be tested weekly). All Senators and staff will undergo health screenings each day they report to the Senate complex.

House of Delegates

- For floor debates and votes, members split into two groups, ½ on chamber floor and ½ in "chamber annex" (2 rooms in the House Office Building) connected via a live stream.
- Meetings in offices on campus are discouraged.

2021 General Assembly: Key Facts

Senate	House of Delegates
President- Bill Ferguson (D- Baltimore City)	Speaker- Adrienne Jones (D- Baltimore County)
47 Senators--32 D; 15 R	141 Delegates--98 D; 42 R; 1 vacant
Key Committees for HSCRC's Work and Budget: • Finance – Chair Delores Kelley • Budget and Taxation - Chair Guy Guzzone	Key Committees for HSCRC's Work and Budget: • Health and Government Operations (HGO) – Chair Shane Pendergrass • Appropriations – Chair Maggie McIntosh

The next HSCRC Public Meeting is March 10, 2021.

Policy Update Report and Discussion

Staff will present materials at the Commission Meeting.

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TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: February 10, 2020

RE: Hearing and Meeting Schedule

March 10, 2021 To be determined - GoTo Webinar

April 14, 2021 To be determined - GoTo Webinar

The Agenda for the Executive and Public Sessions will be available for your review the week prior to 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.