maryland
health services
cost review commission

627th Meeting of the Health Services Cost Review Commission

January 8, 2025

(The Commission will begin in public session at 12:00 pm for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 pm)

CLOSED SESSION
12:00 pm

1. Update on Administration of Model - 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 December 11, 2024 and December 19, 2024

Informational Subjects

2. Presentation by Johns Hopkins on Implementation of a Comprehensive Hospital-Based Addiction Program

Specific Matters

For the purpose of public notice, here is the docket status.

Docket Status – Cases Closed

2662A Johns Hopkins Health System
2663A Johns Hopkins Health System
2664A Johns Hopkins Health System
2665A Johns Hopkins Health System
2666A University of Maryland Medical Center
2634A University of Maryland ARM with Cigna - Extension Request

3. Docket Status – Cases Open

2667A University Of Maryland Medical Center
2668R Johns Hopkins Howard County Medical Center

Subjects of General Applicability

4. Report from the Executive Director

a. Opportunity for Public Comment on HSCRC Volume Policies
b. Model Monitoring

5. Final Recommendation: High Cost Drug Funding Approach

6. Draft Recommendation: ED Best Practices Incentive Policy & ED Wait Times Activities

7. Hearing and Meeting Schedule

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MINUTES OF THE 626th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION DECEMBER 11, 2024

Chairman Joshua Sharfstein called the public meeting to order at 12:00 p.m. In addition to Chairman Sharfstein, in attendance were Commissioners James Elliott, M.D., Ricardo Johnson, Maulik Joshi, DrPH., Adam Kane, J.D., Nicki McCann, J.D., and Farzaneh Sabi, M.D. Upon motion made by Commissioner Sabi and seconded by Commissioner Elliott, the Commissioners voted unanimously to go into Closed Session. The Public Meeting was reconvened at 12:38 p.m.

REPORT OF NOVEMBER 13, 2024, CLOSED SESSION

Mr. William Hoff, Chief of Audit and Integrity, summarized the items discussed on December 11, 2024, in the Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM NOVEMBER 13, 2024, PUBLIC MEETING AND CLOSED SESSION

Upon motion made by Commissioner McCann and seconded by Commissioner Sabi, the Commission voted unanimously to approve the minutes of November 13, 2024, for the Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM II
GILCHRIST HEALTH ON HOSPICE AND PALLIATIVE CARE IN MAYRLAND

Ms. Catherine Hamel, M.A., President of Gilchrist Health, Dr. Lakshmi Vaidyanathan, M.D, Section Chief Palliative Care and Dr. Stephanie Carpenter, M.D., Medical Director, presented and update on the future of palliative and hospice care in Maryland. (see "Gilchrist Health on Hospice and Palliative Care in Maryland" available on the HSCRC website).

Established in 1994, Gilchrist has grown to become Maryland's largest provider of geriatric, palliative, and hospice care. Dr. Vaidyanathan noted that hospice care has proven to significantly improve the quality of life for patients and their families. By addressing physical, emotional, and spiritual needs, hospice care can alleviate suffering, reduce hospitalization, and provide peace of mind.

Despite its benefits, hospice utilization in Maryland lags the national average. Maryland's underutilization of hospice services results in a significant number of individuals who could benefit from these services going without. By increasing awareness, reducing barriers to care, and advocating for policies that

support hospice and palliative care, stakeholders can improve patient outcomes, reduce healthcare costs, and alleviate the burden on families and caregivers.

No action is necessary on this agenda item.

ITEM III
CLOSED CASES

2660A	Johns Hospkins Health System
2661A	Johns Hospkins Health System

ITEM IV
OPEN CASES

2662A	Johns Hospkins Health System
2663A	Johns Hospkins Health System
2664A	Johns Hospkins Health System
2665A	Johns Hospkins Health System
2666A	University of Maryland Medical Center

ITEM V
2634A UNIVERSITY OF MARYLAND ARM WITH CIGNA EXTENSION REQUEST

Mr. Chris Konsowski, Chief, Hospital Rate Regulation, presented the hospital's request for extension (see "2634A University of Maryland ARM with Cigna Extension Request").

On August 14, 2024, in accordance with the authority granted by the Commission, staff approved a three (3) month extension of the Commission's approval of the alternative rate arrangement between the University of Maryland Medical Center (UMMC) and Cigna Health Corporation (Cigna) (Proceeding 2634A). The extension expires on December 31, 2024. However, UMMC and Cigna have not completed negotiations to renew the arrangement and requested an additional three-month extension.

Staff recommend that the Commission grant UMMC's request for an additional three-month extension of its approval until March 31, 2025. If the negotiations are not completed before the expiration of this extension, the arrangement shall end, and no further services shall be provided under the arrangement until a new application is submitted and approved.

Chairman Sharfstein requested a motion to adopt the staff recommendation. Commissioner Kane moved to approve the staff recommendation, seconded by Commissioner Joshi. **The motion passed unanimously in favor of the staff's recommendation.**

ITEM VI
REPORT FROM THE EXECUTIVE DIRECTOR

Staff Announcements

Dr. Joh Kromm, Executive Director, announced the onboarding of the following staff.

Ms. Janice Lepore joined the staff as the Chief of Policy and Government Affairs. Ms. Lapore is an accomplished clinical psychologist with over 15 years of experience in behavioral health, complemented by a strong background in policy and government affairs at the local, state and federal levels.

The External Affairs and Special Projects team also welcomed two new interns. Mr. Siam Muquit is pursuing his MD at the Johns Hospkins University School of Medicine and an MPH at the Bloomberg School of Public Health. Ms. Luwam Gebreyesus is a public health professional with expertise in data management, quality improvement, and policy development. She is pursuing an MPH at the Bloomberg School of Public Health.

Model Monitoring

Ms. Deon Joyce, Chief, Hospital Rate Regulation, reported on the Medicare Fee-for-Service (FFS) data for the seven (7) months ending August 2024. The data showed that Maryland's Medicare Hospital spending per capita growth was favorable when compared to the nation. Ms. Joyce stated that Medicare non-hospital spending per capita and Total Cost of Care (TCOC) spending per capita were favorable when compared to the nation. Ms. Joyce stated that the Medicare TCOC guardrail is -1.81 percent below the nation through August, and that Maryland Medicare hospital and non-hospital growth through August resulted in savings of $117 million.

No action is necessary on this agenda item.

ITEM VII
FINAL RECOMMENDATION: QUALITY-BASED REIMBURSEMENT (QBR) POLICY

Dr. Alyson Schuster, Deputy Director, Quality Methodologies, and Ms. Dianne Feeney, Associate Director, Quality Initiatives, presented the staff's final recommendation on the Quality-Based Reimbursement (QBR) Policy (see "Final Recommendation: QBR Policy" available on the HSCRC website).

Ms. Feeney noted that staff received feedback from MHA and other hospitals regarding the challenges associated with the expedited digital measure submission requirements, which are more stringent than CMS. While staff recognize the importance of timely data for state improvement and hospital performance comparisons, staff understand the difficulties this poses.

To address this, staff propose a revised timeline that aligns with CMS for certain measures (e.g., severe obstetric complication measure, a crucial maternal health priority). This will allow for more robust risk adjustment and timely insights.

Regarding the reward/penalty cut point, staff have observed lower-than-anticipated national performance in recent years. To provide hospitals with better predictability, staff will analyze national performance after six months to offer a clearer indication of the year-end trajectory.

Ms. Feeney reviewed the staff's final recommendations for the QBR Policy as follows:

1. **Maintain Domain Weightings:** Retain the current weightings for person and community engagement, safety, and clinical care domains.
2. **Enhance Monitoring and Reporting**: Develop a timely follow-up measure for behavioral health and continue work on sepsis dashboards; explore timelier HCAHPS performance reporting in collaboration with HCAHPS experts.
3. **Address Digital Measure Challenges:** A two-pronged approach to recognize the varying capabilities of hospitals and vendors:
    - *Incentive for Timely Submission:* A $150,000 incentive for hospitals meeting the expedited timeline.
    - *Flexibility for Delayed Submission:* Hospitals unable to meet the expedited timeline can adhere to CMS's requirements without penalty, provided they submit the data.
    - *Non-Reporting Penalty:* Non-reporting will remain subject to a penalty.
4. **Earlier Cut Point Evaluation:** Evaluate the cut point earlier in the year to provide directional guidance to hospitals.

Ms. Tequila Terry, Senior Vice President, Care Transformation & Finance at Maryland Hospital Association and Mr. Brian Sims, Vice President, Quality & Equity at Maryland Hospital Association presented public comments in response to the staff's final recommendation.

Ms. Terry noted that MHA appreciated the opportunity to offer feedback on the staff recommendations for the QBR for rate year 2027 and expressed gratitude to the HSCRC staff for their partnership and collaboration with the industry. MHA generally agrees with the staff's QBR recommendations; however, they would like to highlight some concerns with the timeline for Implementing Electronic Clinical Quality Measures and aligning Maryland's Hospital QBR policy with the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) model requirements.

Mr. Simms stated three key issues arise from the misalignment of timelines:

1. **Increased Financial Burden**: The accelerated timeline, which significantly diverges from the CMS federal timeline, necessitates costly customized EHR development efforts for many Maryland hospitals. This imposes substantial vendor expenses and diverts valuable resources

from other critical priorities. Additionally, hospitals will incur significant costs for additional staffing and administrative burdens, further straining their already stretched operations.

2. **Exacerbated Financial Strain**: Maryland hospitals are already operating under tight financial constraints. The accelerated timeline introduces additional financial stress, potentially impacting their ability to deliver high-quality patient care.

3. **Disrupted Quality Improvement Efforts**: While we value the potential benefits of digital quality measurement, accelerating the implementation timeline may hinder ongoing quality improvement initiatives. This could compromise hospitals' ability to prioritize patient care and achieve optimal outcomes.

MHA stated that while they appreciate HSCRC's willingness to consider the concerns raised, including the proposed incentive for compliance, it does not adequately address the fundamental issue of undue burden on hospitals. MHA believes that this could undermine both clinical operations and patient care.

Furthermore, MHA emphasized the importance of aligning Maryland's hospital quality program with the AHEAD model which they stated is crucial to ensure consistency between hospital-specific, state-specific, and federal requirements.

MHA urged the Commission to reconsider the accelerated timeline for QBR development and align it with CMS requirements. Additionally, MHA advocated for careful synchronization of Maryland's hospital quality program with the requirements and goals of the AHEAD model.

Chairman Sharfstein inquired if the revised proposal allows hospitals to follow either the CMS timeline or an accelerated timeline, with an incentive of $150,000 for meeting the latter.

Mr. Simms stated that MHA appreciates the recent development of this incentive and the accommodating stance taken by staff, however, the feedback MHA has received from hospitals indicated that the incentive will not fully address the financial burdens and other administrative burdens, such as filing extenuating circumstances exemptions (ECE).

Dr. Schuster countered that hospitals are not required to submit an ECE if they decide to submit on the CMS timeline, however, hospitals must notify staff of what is being reported and when.

Ms. Feeney clarified that the $150,000 incentive figure was not arbitrarily chosen. Staff consulted with small hospitals who confirmed that this amount would cover their expenses. Staff also considered full-time equivalent (FTE) costs, vendor fees, and other incremental costs beyond CMS requirements. More importantly, this amount applies per hospital within a system. So, for example, UMMS would receive $150,000 multiplied by seven, and Hopkins would receive $150,000 multiplied by four. Ms. Feeney emphasized there was no penalty for submitting data on a delayed timeline and clarified that the ECE process (modeled after CMS) can only be used for issues beyond the control of the hospital (e.g., submission issues at CMS or weather-related disruptions) and cannot be used to vendor issues.

Dr. Sharfstein asked for an explanation of the specific benefits and advantages of the expedited reporting option, particularly considering the additional incentives offering.

Ms. Feeney stated that staff has leveraged Calendar Year (CY) 2024 data submitted currently through the eCQM vendor, Medisolv, to produce hospital-specific performance reports. This data is being made available to hospitals on the vendor platform, enabling them to assess their individual performance and identify system-wide trends. Furthermore, staff are compiling and analyzing statewide performance data to provide comprehensive insights. By offering this timely information, staff aim to empower hospitals to benchmark their performance, identify areas for improvement, and implement necessary changes throughout the year.

Chairman Sharfstein requested a motion to adopt the staff recommendation. Commissioner Joshi moved to approve the staff recommendation, seconded by Vice Chairman Elliott. **The motion passed unanimously in favor of the staff's recommendation.**

ITEM VIII
DRAFT RECOMMENDATION: MEDICARE PERFORMANCE ADJUSTMENT (CY2025/FY2027 PAYMENT)

Mr. William Henderson, Principal Deputy Director, Medical Economic and Data Analytics presented the staff's draft recommendation for CY 2025 Medicare Performance Adjustment (MPA Year 7) (see "Draft Recommendation for Medicare Performance Adjustment, Calendar Year 2025" available on the HSCRC website).

The Medicare Performance Adjustment (MPA) is a required element for the Total Cost of Care Model ("the Model") and is designed to increase the hospital's individual accountability for total cost of care (TCOC) in Maryland. Under the Model, hospitals bear substantial TCOC risk in the aggregate. However, for the most part, the TCOC is managed on a statewide basis by the HSCRC through its GBR policies. The MPA was intended to increase a hospital's individual accountability for the TCOC of Marylanders in their service area.

The MPA includes three components:

1. **Traditional Component:** Holds hospitals accountable for the Medicare TCOC of an attributed patient population.
2. **Reconciliation Component:** Rewards hospitals for Care Transformation Initiatives (CTIs); and
3. **Savings Component:** Allows the Commission to adjust hospital rates to achieve the Medicare savings targets.

The Traditional Component is governed via annual updates to the MPA policy adopted by the Commission. Reconciliation and Savings Components are governed via the MPA Framework. The Components are added together and applied as a discount or inflator to the amount that Medicare pays on each claim submitted by the hospital.

Mr. Henderson reviewed staff's final recommendation for MPA Year 7, which includes modifications to two Components as follows:

1. **MPA Traditional Component:** Replicating the Commission-approved retroactive adjustments to correct the MPA saving targets to reflect information available on non-claims-based payments (NCBPs) going forward, beginning in CY 2025, using the approach staff utilized for prior years.
2. **MPA Framework Reconciliation Component:** Effective July 1, 2025, apply a tiered CTI Offset for all hospitals that mirrors the Traditional MPA Scaled Growth Adjustment to provide greater protection for hospitals with less opportunity, without eliminating the incentive for all hospitals to drive savings. Given the State's current favorable savings position, the revision would also apply retrospectively for CTIs initiated on July 1 of CYs 2022, 2023, 2024 (CTI Years 2 through 4), only for hospitals where the change would have a positive impact on total payments (quintiles 1 and 2).

The Savings Component will remain unchanged from the prior year. Staff aims to maintain the current MPA methodology with minor modifications in 2024 while preparing for a more substantial review and potential updates in 2025. This ensures that the MPA framework remains aligned with evolving healthcare priorities and the implementation of the AHEAD model.

Commissioner McCann requested clarification on how hospitals can keep 100 percent of their CTI savings. Mr. Henderson responded that the Offset is subtracted from the scored savings, thus no hospital would truly keep 100 percent of savings.

Commissioner Elliott asked whether there were any exclusions from CTIs. Mr. Henderson responded except for ESRD patients, all beneficiaries that meet the individual criteria for CTIs are included.

Commissioner McCann inquired about the best performing CTIs. Mr. Henderson described staff plans to present CTI results in a future Commission meeting.

Mr. Henderson recapped the feedback received on several key areas as well as the staff's response. There was strong support for the relatively straightforward and uncontroversial change of incorporating NCBPs. Regarding the CTIs, there was a notable division of opinion on the attainment policy, particularly among hospitals operating in different quintiles. While hospitals in lower quintiles expressed enthusiasm for the proposed changes, hospitals in higher quintiles raised concerns about potential equity challenges and the impact on higher-cost areas. However, there was strong consensus among stakeholders to limit the CTI policy changes to future periods and minimize changes to the policy during active and enrolled performance periods. Stakeholders also voiced support for revising the MPA attribution and continued concerns about the MPA results misaligning with TCOC savings results.

Staff believes the proposed attainment provisions are a reasonable compromise and agrees to limit the policy changes to future periods, except for a one-time, retroactive adjustment. Staff is in support of revisiting the MPA attribution but will defer significant changes until 2026 to align with AHEAD implementation. Staff notes that although the TCOC model savings test and MPA savings measurement

are designed differently, the addition of NCBP to the MPA savings will partially address this concern and there may be some work that can be done under the AHEAD model to align them further.

Mr. Henderson reviewed three key areas for future focus that staff identified through the feedback process:

1. **Revisiting the MPA Attribution Method:** Staff will explore alternative methods for determining hospital-beneficiary associations, particularly in urban areas where geographic proximity may not accurately reflect actual delivery networks.

2. **Updating Quintile Benchmarks:** Staff plan to update the quintile benchmarks in conjunction with the upcoming benchmarking review to ensure that they accurately reflect current hospital performance.

3. **Adjusting the CTI Offset:** Staff will consider a more flexible approach to the CTI offset, potentially tying it to the overall savings performance to allow for greater variability in the offset amount.

Chairman Sharfstein inquired on the future areas of focus, specifically, the potential of expanding CTI to include all payers. Mr. Henderson noted there will be significant challenges related to claims data. This data is crucial for scoring non-hospital savings, a fundamental component of the original program. To facilitate this, the payer would require a mechanism, such as the MPA, to transmit these savings to the hospital. HSCRC will have to think about how this will work under the current rate setting system. Another factor to consider is the demographic composition of Medicare beneficiaries. Their increased clinical complexity compared to commercial patients makes it easier to identify and analyze statistically significant cohorts. Commercial payers may encounter challenges in finding similar opportunities, especially in terms of discharge-related savings. While the current CTI program primarily focuses on Medicare, all payers indirectly benefit as hospitals tend to apply these interventions across all payer populations. However, there's potential to further emphasize conditions not primarily covered by Medicare. The HSCRC is open to collaborating with other payers interested in this effort.

Commissioner McCann proposed exploring the possibility of establishing a learning collaborative focused on identifying successful strategies within the CTI, as pinpointing effective strategies through the data can be challenging. Mr. Henderson stated that there is already an official Learning Collaborative in place, led by Ms. Jessica Heslop from CRISP. She will be presenting in February about their work in this area.

No action is necessary on this agenda item.

ITEM IX
DRAFT RECOMMENDATION: NURSE SUPPORT PROGRAM II RENEWAL AND PROGRESS REPORT

Ms. Erin Schurmann, Associate Director, Strategic Initiatives, and her colleagues at the Maryland Higher Education Commission, Ms. Kim Ford and Ms. Laura Schenk, presented the draft recommendation for the Nurse Support Program II Renewal (see "Nurse Support Program II Renewal" available on the HSCRC website). This report and its recommendations are jointly submitted by the staff of the Maryland Higher Education Commission (MHEC) and the HSCRC.

Ms. Schenk described the conceptual framework of the NSP II program with the goal of bolstering Maryland's nursing schools' capacity to produce more nurses for the state's healthcare settings, including hospitals and other facilities. The program aims to achieve this through the core NSP II initiatives outlined in the framework. Another critical component of the framework is the integration of education and practice. Hospitals and nursing schools share mutual goals: hospitals require nurses, and schools need hospitals for clinical training. This interconnectedness is essential for driving healthcare improvement and transformation at the state level.

Ms. Schurmann and Ms. Schenk presented the staff's draft recommendations for NSP II funding renewal:

1. **Permanent Funding with Annual Reporting:** Staff recommend transitioning NSP II to permanent funding with annual performance reports. This aligns with the structure of NSP I and offers several benefits including increased oversight from the Commission through more frequent reporting, enhanced institutional grant planning by providing a more stable funding environment, and fostering innovation and attracting diverse proposals through an ongoing competitive program.
2. **Prioritizing Health Equity and Community/Population Health:** Staff propose adding new funding initiatives to prioritize education that prepares nurses to address health equity and practice in community and population health settings, consistent with the AHEAD model.
3. **Aligning with NSP I to Retain Graduates:** Staff recommend aligning NSP II with NSP I to focus on retaining graduates in Maryland. This includes building pathways to nursing that address vacancies and understaffed specialties, such as primary care and community health, as well as promoting curriculum updates to strengthen Evidence-Based Practice (EBP) and Competency-Based Education (CBE) to reduce learning gaps and increase retention of new graduates.
4. **Promoting underrepresented groups in nursing:** Staff recommend leveraging existing funding mechanisms, such as the competitive institutional grants program and faculty-focused initiatives, to identify new opportunities to fund underrepresented groups in nursing.
5. **Expanding and improving data collection and analysis.** Specific recommendations include mandating data submission from all nursing schools to gain a comprehensive understanding of statewide activities; enhancing data collection on new graduate employment in Maryland; and improving data collection and analysis on underrepresented groups in nursing.

Comments on the staff recommendation is due January 15, 2025. No action is necessary on this agenda item.

ITEM X
FINAL RECOMMENDATIONS: 2025 FUNDING FOR AHEAD PREPARATION

Dr. Jon Kromm, Executive Director, presented the staff final recommendation for the 2025 Funding for AHEAD Preparation. (see "Final Recommendation for the 2025 Funding for AHEAD Preparation" available on the HSCRC website).

Dr. Kromm summarized the relevant activities of the last meeting. The Commission authorized the expansion of the Set-Aside Program and approved an MPA adjustment. Additionally, staff proposed a significant rate increase, contingent on the development of specific initiatives.

Staff has received a wide range of feedback from various stakeholders on the proposed rate increase. Payers expressed concerns about potential cost increases for members. Local health departments and community health representatives supported investments in population health. Hospitals, while generally supportive of rate increases, had diverse opinions on how funds should be allocated. Some advocated direct funding, while others suggested using the funds to support specific initiatives like workforce development and capital investments.

Considering this feedback, staff has determined that there isn't sufficient consensus among stakeholders regarding the specific initiatives or programs that should be funded to justify a rate increase and subsequent aggregation of funds. However, staff has identified several key areas where we can make significant progress:

1. **Workforce Initiatives:** Staff recognize the pressing need to address workforce costs, particularly physician compensation. Staff will work with stakeholders to develop strategies to mitigate these costs and ensure a sustainable healthcare workforce.
2. **Population Health:** Staff is committed to supporting the development of a Population Health Trust to drive innovation and improve health outcomes.
3. **Flexibility with Projects that Align with the AHEAD Model**: Staff is interested in developing programs in four focus areas:
    - *Innovative Delivery Models:* Staff will explore opportunities to support innovative delivery models, such as risk-based care models, cross-hospital platform investments, and the inclusion of all-payers in the CTI Framework with opportunities for matched funding.
    - *Investment in the National Capital Region:* Staff could develop and provide funding for efforts to improve healthcare access and health outcomes in Prince George's County.
    - *Medicare Advantage:* Staff will collaborate with Medicare Advantage plans and hospitals to identify strategies to improve alignment and drive value-based care.
    - *Graduate Medical Education:* Within its review of GME spending policies, the HSCRC could provide additional support for initiatives addressing critical healthcare needs in Maryland.

Dr. Kromm reviewed staff's final recommendation to support these initiatives, as follows:

1. **An annual rate increase of $50 million, effective January 1, 2025, on a permanent, all-payer basis.** The increased revenue is intended to support hospital staffing needs particularly through increases to regulated margins to offset unusual pressure on the costs of physician support experienced over the past few years. This investment in the hospital workforce will bolster access to acute care services across the state, improve hospital throughput, and support hospital efforts to reduce emergency department length of stay.
2. **Required hospital reporting of detailed strategies used to recruit and retain hospital staff and manage staffing costs by July 2025.** This information will be used to inform policy development, involving payers and clinicians, to support hospital workforce and access to acute care services in Maryland related to these and other funding efforts.
3. **Direct $25 million in one-time rate increases to the Population Health Trust.** The Commission will provide specific directions for the funding contingent on the establishment of the necessary funding vehicle by the Maryland General Assembly. The rate increase is only for CY 2025 and will sunset at the end of the year if the Commission takes no further action.

Staff believe this approach balances immediate needs with long-term goals. By focusing on workforce, population health, and innovative delivery models, staff can position Maryland as a leader in healthcare transformation.

Commissioner McCann inquired about the breadth and depth of the workforce challenge statewide. Dr. Kromm stated that the staff is primarily focused on understanding the most complex aspect of workforce costs, physician compensation. To address this, staff has collaborated with numerous hospitals statewide to enhance cost reporting. This initiative is crucial, as physician compensation is not subject to regulation, and historical data is limited. While initial data has been collected and findings will be shared soon, the staff is still working to standardize the reporting of physicians' costs.

Regarding other workforce components, staff has a solid grasp of costs and historical trends. However, staff recognize the interconnectedness of these components. Unregulated cost pressure (e.g., physician compensation) impacts the overall hospital workforce and can exacerbate regulated cost pressures. While staff has a strong understanding of certain workforce cost elements, staff is actively working to gain a comprehensive view of the entire picture.

Ms. Melony Griffith, President and CEO and Ms. Tequila Terry, Sr. Vice President, Care Transformation, both from the Maryland Hospital Association (MHA), joined Mr. Arin Foreman, Vice President, Deputy Chief of Staff from CareFirst BlueCross BlueShield (CareFirst) to present public comments in response to the staff's final recommendation.

Ms. Griffith stated she appreciated the recognition of the need for permanent funding to address workforce challenges. Hospitals and health systems are committed to improving community health by providing equitable access to high-quality care. However, hospitals are facing rising costs for both products and services, as well as the delivery of care itself, and the $50 million adjustment may not be sufficient to fully offset these increased costs. As outlined in her previous comment letters and testimony,

including the collaboration with national expert Liz Sweeney, many hospitals and health systems are grappling with significant increases in exposure expenses since January 2020.

Ms. Terry described several cost drivers that are significantly impacting Maryland hospitals, resulting in a deferment of needed capital investments and compromising long-term patient care and facility maintenance. MHA's survey of member hospitals revealed widespread deferral of essential purchases, including medical equipment, facility upgrades, and IT infrastructure. Additionally, hospitals must contend with growing healthcare needs of an aging population, increasing payer denials, cybersecurity threats, supply chain disruptions, and unfunded mandates like the RSV vaccine for newborns.

To address these pressing needs, the MHA proposes a 2.7 percent rate increase in January, generating an additional $410 million in net revenue for hospitals. This permanent increase, applicable to both GBR and non-GBR hospitals, would help mitigate the broad-based cost pressures affecting all healthcare providers. To ensure the sustainability of Maryland's healthcare system, MHA urges the Commission to adopt a more robust funding approach. A significant permanent increase in hospital rates, exceeding the proposed $50 million, would better equip hospitals to provide quality care to all Marylanders.

Mr. Foreman stated CareFirst oppose the staff's proposal to increase rates by $50 million in January 2025 for physician support. CareFirst is troubled by the evolution of the proposal, which initially began as a $330 million initiative, focused on population health needs, and likely through a fund and application-based process. However, it has evolved into a $50 million permanent physician cost offset proposal. Physician costs have been a recurring issue in recent years, especially as health system investments have grown significantly since the implementation of GBRs. While CareFirst understands that these investments may have led to financial pressure and are sometimes necessary for hospital operations, a blanket rate increase of $50 million is not an effective solution and lacks the necessary rigor.

A more appropriate approach would involve thorough data collection, benchmarking, and consideration of stakeholder perspectives and input. This would ensure that any policy changes incentivize behaviors that contribute to the model's goals. The staff's recommendation, however, simply cites inadequate Medicare rates as the primary driver of physician losses and proposes a funding subsidy without a clear understanding of the underlying issues. Mr. Foreman noted that crucial questions remain unanswered, such as which specialties are experiencing losses and whether the proposed investments are appropriate. The $50 million figure appears arbitrary and lacks a targeted approach.

Commissioner Kane asked the panel to respond to the other priority funding areas, such as the investment in the Population Health Fund, the PG County, or Medicare Advantage initiatives. Ms. Terry indicated that more information is needed on the four initiatives before MHA provide substantive feedback. However, hospitals and health systems support strategies to improve population health broadly and many of them are using retained revenue to invest and support population health initiatives. Mr. Foreman agrees there had been underinvestment in PG County, and CareFirst is aligned with several of the areas of focus, however, there needs to be a more thorough vetting process.

Commissioner Johnson stated there should be a benchmark against which to measure current trends. He is hesitant to approve mid-year changes. Such adjustments can significantly impact both consumers and

employers. Although he understands the concerns, he believes a more comprehensive approach is necessary. Additionally, these types of adjustments are typically addressed within the update factor. Therefore, he sees no reason to deviate from our current process.

Commissioner McCann appreciated the valuable insights shared by MHA and CareFirst and hospitals are facing significant challenges. However, she believes it is crucial to ensure that any policy solution truly addresses the root of the problem. A $50 million allocation may not be sufficient to solve the complex issues at hand. Therefore, she proposes that the Commission defer this funding and conduct a comprehensive review to identify the most effective long-term solutions.

Commissioner Sabi stated this is a complex issue with numerous variables and varying impacts across different hospitals. Workforce shortages can significantly contribute to longer ED wait times, increased length of stay, and other bad health outcomes. While this funding may not fully address these challenges, it will provide valuable insights into specific hospital needs. By requiring hospitals to identify and report on their workforce deficiencies, the Commission can gain a better understanding of the scope of the problem and hold them accountable for addressing these critical issues. Ultimately, this investment will improve patient care and system efficiency.

Concurring with Commissioner McCann, Commissioner Joshi stated that this proposal does not constitute a comprehensive policy solution. However, he believes the $50 million allocation addresses a substantial need in the current climate. Transparency regarding the specific allocation and implementation of these funds is crucial. Additionally, engaging in broader policy discussions are essential for long-term solutions. Therefore, he supports both the $50 million allocation and the $25 million initiative. While the latter may lack specific details, it represents a necessary step forward in our efforts.

Regarding the proposed $25 million allocation, Commissioner McCann believes this amount should be considered seed money, signaling a larger, ongoing commitment from the state. Given the state's current fiscal challenges, she worries that relying solely on the rate setting system to fund the Population Health Trust Fund sets a dangerous precedent. As the Commission expands this model beyond hospitals, the state assumes significant responsibility and should contribute accordingly to the Population Health Trust Fund. She questions the urgency of voting on $25 million today and proposes waiting for the legislation to be finalized, which will clarify the fund's purpose, contributors, and potential impact. Only then can the Commission make an informed decision.

Commissioner Johnson added that the Commission can request information from hospitals and analyze programmatic solutions without the $50 million. The Commission does not know for sure whether this funding will specifically impact workforce issues or more broadly hospital margin or general financial issues. He is in favor of a more tailored solution.

Chairman Sharfstein agreed with Commissioner Joshi that the $50 million is a step toward a more comprehensive policy solution to a problem where there is consensus that it needs to be addressed.

Commissioner Elliott also agreed with $50 million as a starting point and would be in favor of holding some of the funding while staff investigates the scope of the issue.

Commissioner Kane stated he believes the Commission faces a significant policy challenge: reconciling the established inflation calculation methodology with the emerging issue of savings over target. While the latter may or may not be directly linked to inflation, it's undoubtedly tied to Medicare utilization trends relative to the nation. The Commission needs a clear framework to address both these issues simultaneously. Currently, the discourse around MPAs and additional savings seems disjointed and lacks a cohesive policy direction. While he fully empathizes with workforce needs, he fears that the ad-hoc approach may ultimately undermine patient care in Maryland. Instead of focusing on incremental solutions, the Commission should prioritize addressing fundamental policy questions such as what constitutes a financially stable hospital system, is inflation being calculated correctly, and how should the Commission interpret savings that are not directly tied to core inflation but rather to Medicare utilization growth. By addressing these core issues, the Commission can establish a more sustainable and effective policy framework that benefits Maryland's patients.

Chairman Sharfstein requested a motion to adopt the staff recommendation. Vice Chairman Elliott moved to approve the staff recommendation, seconded by Commissioner Joshi. In favor were Commissioners Joshi, Sabi, Elliott and Chairman Sharfstein. The opposite were Commissioners Kane, McCann and Johnson. **The motion passed in favor of the staff's recommendation**.

ITEM XI
FINAL RECOMMENDATION: OUT OF STATE, DEREGULATION, AND REPATRIATION VOLUME POLICIES

Mr. Allen Pack, Principal Deputy Director, Quality and Population-Based Methodologies presented the staff's final recommendations for the Out-of-State Deregulation and Repatriation of Volume Policies (see "Out-of-State, Deregulation, and Repatriation Volume Policies" available on the HSCRC website).

Mr. Pack reviewed all the volume policies that HSCRC has implemented to adjust global budgets in response to anticipated demographics changes, other volume patterns, and observed market shifts in services. He also reviewed the revised timeline for the volume workgroup, which had been delayed due to staff development of the repatriation policy, as well as an example of how the new volume repatriation policy would work.

Mr. Pack described the deregulation, repatriation, and out-of-state volume methodologies and their underlying rationale. Repatriation is defined as the cross-border movement of Maryland residents from out-of-state hospital facilities to Maryland regulated facilities. Expatriation is defined as the cross-border movement of Maryland residents from regulated Maryland hospital facilities to out-of-state hospital facilities. HSCRC can adjust a hospital's global budget revenue (GBR) if the percentage of out-of-state volume changes materially during the term of the agreement. A few hospitals have already requested GBR adjustments due to material out-of-state volume changes.

Mr. Pack reviewed the primary concerns raised by the workgroup, including the reliance on Medicare TCOC data, variations in hospital cost structures impacting efficiency and retained revenue levels, and volume fluctuations beyond hospital control. He outlined staff's proposed approaches to address these

concerns, the methodology used to assess the materiality threshold, and an evaluation of how the volume policies appropriately funded hospital volume in the All-Payer and TCOC Models.

The Volume Scorecard indicates that the population-based volume policies are effectively funding overall volume changes across the system. This affirms staff's belief that there is no need to modify the underlying methodologies. While there may be some unfunded volume at the service line level due to new services, staff has flexibility to address these concerns through additional volume policies. Staff cautions against any perceived funding misallocation suggested by the Volume Scorecard, as redistribution is being addressed annually through the formulaic methodologies of Potentially Avoidable Utilization (PAU), Integrated Efficiency, and Full Rate Application policies.

Mr. Pack reviewed the staff's final recommendation for the out-of-state deregulation, and repatriation volume policies as follows:

1. **Establish a Deregulation policy** based on the methodology outlined herein that will result in negative revenue adjustments to hospitals' global budgets.
2. **Establish a Repatriation policy** based on the methodology outlined herein that will result in positive (repatriation) and negative (expatriation) revenue adjustments to hospitals' global budgets.
3. **Establish an Out-of-State policy** based on the methodology outlined herein that will result in positive and negative revenue adjustments to hospitals' global budgets.
4. **Implement Deregulation and Expatriation during the next available rate issuance** on a one-time basis, negative out-of-state adjustments on a permanent basis, when the following materiality thresholds are met:
    A. The adjustment exceeds 3 percent of the hospital's GBR, *or*
    B. The adjustment exceeds 3 percent of the associated service line revenue

    Note: All Planned Deregulations should still be reported to the Commission in conformance with the GBR agreement and adjusted accordingly.
        - If deregulation methodology indicates a potential deregulation that varies from planned deregulation to more than 10 percent, staff may consider revising the deregulation adjustment
5. **Implement Repatriation during the next available rate issuance** on a one-time basis, positive Out-of-State adjustments on a permanent basis, when the following materiality thresholds are met:
    A. The adjustment exceeds 1 percent of the hospital's GBR, *or*
    B. The adjustment exceeds 1 percent of the associated service line revenue
6. **Implement Deregulation, and Repatriation/Expatriation adjustments on a permanent basis** for one year following the initial revenue adjustment to allow for potential backfilling and/or dissipation. Hospitals can provide additional information to contest the volume finding, but will have the burden of proof, and HSCRC staff will be final arbiters of this decision.

Mr. Pack added the following amendment to the staff recommendations:

7. **Delay implementation of new volume policies until July 2025** to ensure adequate time for hospitals to review staff findings and for staff to facilitate a holistic discussion of all volume policies with Commissioners.

Commissioner Kane inquired about the magnitude of the proposed policies. Mr. Pack answered that it was a movement of $18 million.

Commissioner Johnson asked what the magnitude be without the materiality threshold. Mr. Pack explained that it would differ by policy but altogether there is about $139 million in out-of-state decline.

Commissioner Joshi wanted clarification on what the moratorium would mean for policy implementation. Mr. Pack answered that all adjustments would apply in July, then annually going forward.

Mr. Arin Foreman, Vice President, Deputy Chief of Staff of CareFirst BlueCross BlueShield (CareFirst) and Mr. Kevin Sowers, President of Johns Hopkins Health System (JHH) and Executive Vice President of Johns Hopkins Medicine (JHM) presented public comments in response to the staff's final staff recommendation.

Mr. Foreman stated CareFirst is generally supportive of the proposed policies, as it formalizes the rate adjustment work that has historically been conducted informally on a deregulation and out-of-state volume basis. Transparency and documented rules are critical in a system that governs over $20 billion in consumer payments. The policies provide a detailed, formulaic approach to identify and adjust revenue as volume moves within or out of our system.

However, CareFirst finds the proposed materiality thresholds problematic. A significant source of concern for all stakeholders has been the revenue associated with volume movement in the system and there are fewer and fewer opportunities to drive affordability through traditional savings levers. Applying a discount on revenue during rate adjustments may be overly conservative, potentially compromising rate integrity and further exacerbating existing concerns about the relationship between volume and revenue. Finally, CareFirst agrees with other stakeholders that the current volume policies are not perfect. However, the intent is to formalize existing practices and continue to refine the volume policies.

Mr. Sowers stated that JHH supports the current model and its focus on quality outcomes and cost containment. He said that Johns Hopkins Health System remains committed to providing care to Maryland residents. However, JHH believes the demographics of the state have shifted, and healthcare innovation has led to increased demand for complex care. The expansion of Medicaid has also contributed to a larger patient population. The hospitals operate at high occupancy rates (compared to national benchmarks) and have had to turn away numerous complex care patients due to capacity constraints. The emergency departments are also experiencing significant volume increases. JHH feels that these factors necessitate a review of the current policies to avoid hindering access to care.

JHH consistently advocated for policy changes since 2020, as evidenced by letters to the Commission and white papers. While the focus on population health and health equity is commendable, the Commission

must not overlook the critical role of acute and complex care, especially as the baby boomer generation ages. The aging population drives the increasing demand for tertiary and quaternary care. The current policies that incentivize reduced volume hinder JHH ability to meet this demand and can penalize hospitals for providing more complex care, which can negatively impact patient access. JHH is concerned about the potential for ED diversions and reduced access to care due to capacity constraints. JHH is eager to collaborate with the HSCRC to address these policy issues and developed white papers with data-driven recommendations to improve the current system. JHH supports the amendment proposed by Mr. Pack, which would allow for the establishment of a workgroup comprising hospital representatives and staff to explore the integration of all volume policies as the state moves forward with the AHEAD model.

Commissioner Kane asked Mr. Sowers how he would define necessary and unnecessary utilization, as without resolving that question, we cannot fully understand whether we are funding utilization growth appropriately. Mr. Sowers responded that the Medicare savings well above the set targets may be indicative that unnecessary volume was pushed out of hospitals. He agrees that some lower utilization can be moved to deregulated space, but not all volume is bad and need to be removed.

Ms. Tequila Terry, Sr. Vice President, Care Transformation; Mr. Patrick Carlson, Vice President, Health Care Payment; and Ms. Kelly Bender, Director, Strategic Analytics of the Maryland Hospital Association (MHA) presented public comments in response to the staff's final recommendation.

Mr. Terry stated the continued success of the Maryland model, the ability of the hospitality sector to meet the care needs of patients and community members, and the financial health of hospitals are all contingent upon robust volume policies with adequate funding. As outlined in the HSCRC recommendation, the proposed policies aim to address deregulation, repatriation, and out-of-state volumes, specifically targeting volume shifts not covered by other policies. While MHA acknowledges the progress made, their members continue to grapple with certain details within the proposed policies. A more comprehensive review of existing policies is necessary to ensure that all relevant volume issues are addressed.

MHA agrees with the staff's proposed amendment to delay the implementation of these policies, allowing for a more thorough examination of their specific elements. This delay would also provide an opportunity to reassess the Commissions overall approach to volume policies, aiming to reduce complexity and enhance predictability. Hospitals just recently received revised results from the methodology adjustments proposed in the final draft recommendation. This underscores the need for adequate time to assess and validate the impact of such changes. Delayed implementation would facilitate this process, and MHA encourage a delayed vote.

Ms. Bender noted, as outlined in MHA comment letter, they identified several areas in the proposed policies that may require further refinement. Firstly, regarding the repatriation policy, there is a concern that extrapolating Medicare data to all payers could lead to inaccurate results, particularly for service lines with low Medicare volume, such as obstetrics or newborn care. This could potentially hinder deregulation efforts. MHA recommend modifying the methodology to prevent unreasonable outcomes. Secondly, the interaction between the policies presents complexities. Hospitals may face overlapping penalties from

both the repatriation and deregulation policies, especially for service lines impacted by other policy changes. While MHA appreciate the staff's efforts to address some of these policy interaction complexities, further examination is necessary to ensure the deregulation methodology accurately captures the volume shift to the deregulated setting.

Mr. Carlson stated MHA would like to expand the discussion beyond the three proposed policies to address the need for comprehensive changes to existing policies governing market shifts and demographic growth. As detailed in the formal comment letter, MHA believes significant improvements are necessary in two specific areas, the Market Shift methodology and the Demographic Adjustment. For Market Shift, MHA advocates for a revised methodology that recognizes a greater proportion of costs as variable, ensuring more accurate funding, and urges the Commission to consider a broader geographic approach for tracking market shifts to capture a more comprehensive picture of these changes. Regarding the Demographic Adjustment, MHA believes applying an efficiency adjustment that aligns with unadjusted state population projections underfunds critical services necessary for an aging population and recommends a revision to sufficiently account for this demographic reality. Any methodology addressing volume changes, including the proposed three policies or others like the Market Shift methodology and the Demographic Adjustments, must be compatible and produce predictable results with minimal complexity.

MHA commends the Commission's work on formulating these recommendations and recognizes the staff's acknowledgment of the need for systematic policy updates, particularly regarding variable cost factors. However, MHA encourages thorough consideration and careful adoption and implementation of any new policies. MHA requests ample time and opportunity to ensure these changes are implemented effectively.

Chairman Sharfstein asked Mr. Carlson if the next step is to develop a strategy based on these principles, or does MHA have a specific approach in mind to address the volume challenges. Mr. Carlson stated that MHA has engaged in internal discussions with the hospital field to explore potential refinements to the current approach for funding volume changes in response to market shifts. MHA believes the current 50 percent variable cost factor is a somewhat blunt instrument and they are exploring methodologies that could leverage the cost reports and service-line data to more accurately account for funding shifts. MHA has begun to share these ideas with staff and looks forward to a deeper dive into these options.

Additionally, MHA is questioning the rationale behind the current efficiency adjustment and age-adjusted growth funding. The Commission needs to ensure that the funding mechanisms align with real-world utilization rates and the actual resources required to serve patients. While the hospitals have the tools to meet the growth rate targets, tying these to economic growth metrics that may not directly correlate with healthcare costs and resource needs could be counterproductive. MHA believes these three policy areas are interconnected and require a comprehensive review to ensure consistency and avoid overlapping or conflicting approaches to volume allocation.

Dr. Sabi stated that it is evident that significant changes have occurred in the healthcare landscape over the past decade. Factors such as Kaiser Permanente's patient movement strategies and evolving healthcare demands have impacted hospital volumes. While it's disheartening to prioritize empty beds over patient

care, this reality underscores the need for a comprehensive and strategic approach. Rather than incremental adjustments, the Commission must consider a more radical solution. This involves a collaborative effort among hospitals to identify areas of excess capacity and increased need. Difficult decisions may be necessary regarding the allocation and reallocation of resources, including the addition or removal of beds. To address these challenges effectively, the Commission must acknowledge the impact of Medicaid expansion, the Affordable Care Act, increased patient demand, and the pandemic. A collective effort, involving open dialogue and compromise among healthcare providers, is essential to ensure appropriate access and care for patients. This may require significant time and effort, but it is a necessary step towards a more sustainable and patient-centered healthcare system.

Commissioner Kane stated that some policies, particularly Market Shift, is solely a hospital issue and he invites the MHA to come back next month with a proposal to address the movement of revenue among their members. On the Demographic Adjustment, there is confusion as to what the adjustment is funding. The policy needs to be more focused and transparent about the purpose and impact.

Chairman Sharfstein stated he appreciated the point made by Dr. Sabi on bed capacity. It's a complex issue with multiple factors to consider. In the case of RSV, for instance, preventing severe illness could lead to fewer hospitalizations overall. This raises questions about how the Commission value such preventative measures in reimbursement models. He did not suggest a definitive answer, but rather encouraged a thoughtful discussion of the trade-offs involved.

Mr. Pack continued his presentation and provided an overview of the Volume Scorecard, which calculates all the changes that occurred since the start of the original model in 2014 through 2023. The purpose is to demonstrate the extent to which the Commission has funded volume changes. This analysis doesn't imply that all volume policies are working optimally, as there may be unintended consequences that require further investigation. However, staff believes this analysis provides valuable insights.

Mr. Pack highlighted stakeholder feedback on the Volume Scorecard. Some stakeholders, such as CareFirst and MedStar, acknowledged the significant effort invested in this analysis. MedStar, while supportive of the volume scorecard concept, expressed concerns about its potential use in rate-setting decisions. Staff want to reiterate that the scorecard was intended solely as an analytical tool to inform potential modifications to future volume policies.

A common criticism was the need for independent validation. While staff understand this concern, staff believe several factors mitigate the need for external validation and a comprehensive approach ensures a fair and accurate accounting of volume changes:

1. **Independent Entity:** The HSCRC is an independent entity with no incentive to manipulate the scorecard to its advantage.
2. **Multiple Internal Analyses:** Multiple HSCRC staff members have conducted similar analyses, yielding consistent results.
3. **External Consultant Validation:** Independent consultants engaged by hospitals have also conducted their own analyses, confirming our findings.

4. **Availability of Hospital Data:** Staff regularly provide hospitals with relevant data, including market shift, demographic, and savings policy results. The only exception is miscellaneous adjustments, which are typically negotiated and reflected in rate orders, and are verified by an outside consultant.

Many stakeholders raised concerns about the core volume policies (demographic adjustment and market shift), particularly the variable cost factor and unrealized age-adjusted population growth. While staff has explored differential variable cost factors in the past, the analysis consistently points to a 50 percent estimate. Staff recognized the complexity of these issues and the need to balance various factors, including ensuring appropriate funding for patient care, incentivizing population health management, and avoiding capricious treatment of hospitals.

Commissioner McCann acknowledged the effort put into the Volume Scorecard, however, but questioned its value as it does not directly influence hospital operations or decision-making. Additionally, historical data, such as underfunded and overfunded areas from 2014, may not accurately reflect the current financial challenges faced by hospitals in 2024. She agrees with staff to periodically review these policies. Given the dynamic nature of value-based models, the Commission must adapt to evolving circumstances. To allow time for a comprehensive review of all the volume policies, she proposes delaying the approval of these three volume policies until a comprehensive review is conducted in July.

Dr. Kromm noted that he concurs with the points regarding the limitations of using the Scorecard over an extended period. It may not be the ideal tool for precise rate-setting or future policy determinations; however, it does provide valuable insights into the cumulative impact of various factors on a hospital's revenue base. By examining the entire revenue lifecycle, from inception to the present, staff can assess whether the total revenue aligns with the overall value provided.

Chairman Sharfstein summarized the argument for proceeding with the proposed changes to facilitate the review process. By incorporating these changes into the review, staff would have a clearer understanding of how the Commission intends to address the ongoing shifts. This would allow staff to conduct a more informed and integrated review without delaying the process. In essence, adopting the proposed changes could serve as a catalyst, propelling staff towards a more comprehensive examination of volume policies. On the other hand, he also recognizes the merit of postponing implementation. This approach would provide flexibility, ensuring that the changes align with the outcome of the review. If the review leads to significant alterations in volume policies, the proposed changes may no longer be necessary.

Commissioner Joshi agrees with the 6-month implementation delay and the points made by Mr. Sowers. He suggested that staff and the hospital field use the 6-month delay to do a comprehensive review and return in June 2025 with a finalized policy for Commission vote.

Commissioner Kane expressed uncertainty about the necessity of addressing this issue, citing the relatively low financial stakes associated with the policies under consideration. Mr. Pack countered that any potential modifications to the Demographic Adjustment and Market Shift should not impact on the three policies currently before the Commission and approving the policies now would help the policy making process. Mr. Pack is worried about staff bandwidth to do a wholesale overhaul if the

Demographic Adjustment and Market Shift policies in addition to a comprehensive review of all volume policies in the next 6 months.

Dr. Kromm reiterated that no modifications will be implemented prior to the policy's effective date in July. Subsequent adjustments will encompass the entire applicable timeframe. Staff acknowledged that out-of-state volume will be factored into the equation. If the policy is finalized in July, staff could retroactively compensate for the preceding 18 months, potentially resulting in substantial financial benefits to hospitals.

Chairman Sharfstein requested a motion to adopt the staff recommendation, as amended with an implementation delay until July 2025. Vice Chairman Elliott moved to approve the staff recommendation, seconded by Commissioner Sabi. **The motion passed unanimously in favor of the staff's recommendation.**

ITEM XII
HEARING AND MEETING SCHEDULE

January 8, 2025, Time to be determined
4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:40 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission

December 11, 2024

Chairman Sharfstein stated reasons for Commissioners to move into administrative session under the Authority General Provisions Article §3-103 and §3-104 for the purposes of discussing the administration of the Model.

Upon motion made in public session, Chairman Sharfstein called for adjournment into closed session:

The Administrative Session was called to order by motion at 12:00 pm.

In addition to Chairman Sharfstein, in attendance were Commissioners Elliott, Kane, Johnson, Joshi, McCann and Sabi.

In attendance representing Staff were Jon Kromm, Jerry Schmith, William Henderson, Geoff Dougherty, Allen Pack, Alyson Schuster, Cait Cooksey, Bob Gallion, Megan Renfrew, Erin Schurmann, and William Hoff.

Also attending were Assistant Attorneys General Stan Lustman and Ari Elbaum, Commission Counsel.

Item One

William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, updated the Commission, and the Commission discussed the TCOC model monitoring.

Item Two

Mr. Henderson updated the Commission, and the Commission discussed the FY 2024 Hospital Unaudited Financial Performance.

The Closed Session was adjourned at 12:20pm.

PUBLIC MINUTES
MINUTES OF THE 627th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
DECEMBER 19, 2024

Chairman Joshua Sharfstein called the public meeting to order at 9:00am. In addition to Chairman Sharfstein, in attendance were Commissioners James Elliott, M.D., Ricardo Johnson, Maulik Joshi, DrPH., Adam Kane, J.D., Nicki McCann, J.D., and Farzaneh Sabi, M.D. Upon motion made by Commissioner Joshi and seconded by Commissioner Elliott, the Commissioners voted unanimously to go into Closed Session. The Public Meeting was reconvened at 10:24 a.m.

ITEM TWO - Staff Projects Update

Item 2A - Access Measurement
Allan Pack gave a presentation on access to care, as part of a discussion to talk about healthcare access barriers and the Commission's interest to ensure that Maryland's healthcare ecosystem ensures access to care for Marylanders.

Mr. Pack stated that there is no singular method to measure Maryland's healthcare access need or performance. He stated that there is a need to create an Access Framework that can identify the potential for latent demand, support execution of the AHEAD model and help with informed decision-making, resulting in better care access for patients.

Mr. Pack also stated current volume policies identify micro-level changes that are necessary for making precise adjustments at the hospital-level. Mr. Pack stated that there is also a need to more proactively diagnose and understand utilization at a broader, more macro-level which can help further inform policies and measure additional access components.

Mr. Pack directed Commissioner attention to a slide listing global budget volume policies and incentives which included:

- Demographic adjustment
- Market shift
- Out of State
- Deregulation
- Repatriation
- Complexity and Innovation
- CDS-A

Mr. Pack then prompted discussion to ask if there are questions about volume policies or any analyses that would be helpful for informing future discussions.

Commissioner Kane suggested that a key question to address is how to reduce unnecessary utilization without first defining what constitutes "necessary" or "unnecessary" care. Chairman Sharfstein discussed the importance of defining unnecessary utilization with input from the industry, emphasizing not all cases are avoidable but principles can be established. Commissioner Sabi described the "carrot and stick" approach wherein the HSCRC policies and Model use penalties and rewards to influence improvements in population health.

Commissioner McCann stated that beyond access, the Commission needs to determine whether reductions in utilization are leading to improvements in outcomes. Chairman Sharfstein asked how the HSCRC incentivizes and rewards improvements in outcomes that result from reductions in utilization.

Executive Director Kromm stated that this would be challenging to take on from a clinical perspective and that identifying key outcomes will give us a sentinel view of utilization and that access will be a key outcome to evaluate this. Commissioner Kane said that if the system has finite resources and they are not appropriately directed there is a risk of compromising access to care.

Chairman Sharfstein stated that the Commission will be talking more about review of volume policies in 2025.

Mr. Pack gave a brief review of the benefits of a diagnostic monitoring tool to assess HSCRC policies.

Mr. Pack discussed indicators that the HSCRC should look for in terms of understanding access barriers.

- Provider shortages across Primary Care, Surgery, Behavioral Health Support Staff (e.g., Techs and Aides)
- Distance to care setting and wait time to treatment
- Utilization by care type and inpatient length of stay and excess days
- Capacity and availability across care types
- Adoption of alternative care types for appropriate populations such as telehealth for behavioral health

Mr. Pack presented a theoretical case study that showed that access barriers can directly impact patient experience and health outcomes. The case study provided an example of how there may be poor quality of care and follow-up, insufficient providers, or capacity, and a greater need to think through addressing social determinants of health and social factors.

Mr. Henderson stated a need to look beyond acute settings of care and a need to look at the system as a whole, and the HSCRC’s limitation to evaluate non-acute settings.

Commissioner Sabi expressed concern that the HSCRC currently only has visibility into the Medicare data and is blind to what happens outside the hospital system. She suggested exploring potential collaboration with the Maryland Insurance Administration (MIA), which has more detailed data on these areas. Executive Director Kromm confirmed ongoing discussions with MIA but noted that MIA also challenges in measuring access effectively. While MIA looks at trends related to rates, they don't capture utilization. MHCC focuses on capacity but noted a gap across state agencies in terms of measuring access.

Commissioner Elliot pointed out that the PQI (Prevention Quality Indicator) outcome measure can identify the presence of a problem but does not explain the underlying causes and stressed the need to evaluate quality from both outpatient and acute care perspectives. Mr. Pack mentioned that while PQIs could be used to penalize hospitals, they may also reflect broader systemic issues. These issues may span across the entire healthcare system and not be limited to individual hospitals. Chairman Sharfstein provided the example of asthma, emphasizing that most asthma cases in acute settings are preventable. He discussed the tension between wanting to provide access for sick patients while also investing in upstream prevention. He highlighted the need to fund both prevention efforts to reduce asthma and care for children in acute settings.

Commissioner Kane noted that just because a bed or service is unavailable, it does not mean there is no funding through global budgets. He also noted that access issues could extend across multiple hospitals, presenting an attribution problem across regulated entities.

Commissioner Elliott inquired whether volume policies could be adjusted to account for hospitals with disproportionately high PQIs. Executive Director Kromm responded that incorporating PQIs into a volume policy would create a complex policy structure. He suggested that this issue could also be addressed through quality programs and stressed the importance of first establishing a clear understanding of the problem and identifying access constraints before integrating this into policy frameworks.

ITEM 2B - Annual Filing Modernization

Mr. Henderson presented an update on the annual filing modernization project, focusing on improving the collection of physician spending data and understanding financial data related to physicians in hospitals.

- There was an increase in physician spending from $338.3M to $1.08B.
- Hospitals report net losses, and there is a need for clearer guidelines to improve comparability in reporting revenue and spending.
- The project is expected to provide more comprehensive data on physician spending, especially on regulated spending.
- A refined schedule will be shared at the May Commission meeting, with plans to use the data starting in January 2026.

Chairman Sharfstein asked about the extent to which the data could inform policy changes. Mr. Henderson explained that the data will help improve how to communicate externally, particularly because there is currently an incomplete picture of physician spending on hospitals. Executive Director Kromm emphasized that before discussing the potential impact on authority or policies, it's essential to first gather the complete picture of the data, which is the current focus. He highlighted two key aspects of parsing physician costs: by service provided and the method of payment.

Commissioner Joshi noted that "same-store" physician costs are increasing at an alarming rate. Commissioner Sabi stated that from the hospital perspective, hospitals feel like they are being held hostage by the need to pay competitive market rates to physicians and suggested that creating transparency would help level the playing field.

Executive Director Kromm inquired about what is being collected regarding insurance reimbursement. Mr. Henderson responded that insurance reimbursement is part of hospital revenue but noted that it depends on how the hospital attributes the payments. Commissioner Sabi noted that while commercial rates have increased, Medicare and Medicaid reimbursement rates have remained stagnant.

ITEM 2C - Facility Fees

Dr. Hendson gave an update on the facility fee report and noted that the legislature is particularly interested in facility fees. The HSCRC is required to provide a report containing recommendations related to expanding the outpatient facility fee notice to all outpatient services. The 2024 report will be submitted in December. The associated workgroup met 3 times and had an opportunity to provide written comment on an early draft of the report and recommendations.

Staff noted two key issues and recommendations.

- Expand Notices: Because notices are limited to the HSCRC-regulated outpatient clinic, many consumers do not receive notices. The report recommends expanding the notice requirements to most hospital outpatient services, but delaying expansion until after the 2026 legislative session, so legislators can respond to the 2025 study findings on the effectiveness of facility fee notices.
- Medicaid Patients: The current notice includes the estimated full hospital charge (not the patient's out-of-pocket cost), is written at a 12th grade reading level, and requires health insurance literacy. Some patients, including Medicaid patients may cancel their appointments due to sticker shock. The report recommends amending the law to clarify that hospitals do not need to provide notices to Medicaid beneficiaries.

Staff will be required to report in 2025 on the evaluation of the effectiveness of facility fee notices; the impact of facility fees on patients, payers, and hospitals; and recommendations related to alternative approaches to facility fees such as reducing or eliminating facility fees. Currently, Hilltop Institute is assisting with workgroup management and reports and there are

two procurements in process. Staff have started conducting research and will begin financial analytics once a procurement is in place. The facility fee workgroup membership was updated to reflect the 2025 scope and meetings will start in January.

There being no further business, the meeting was adjourned at 11:24 a.m.

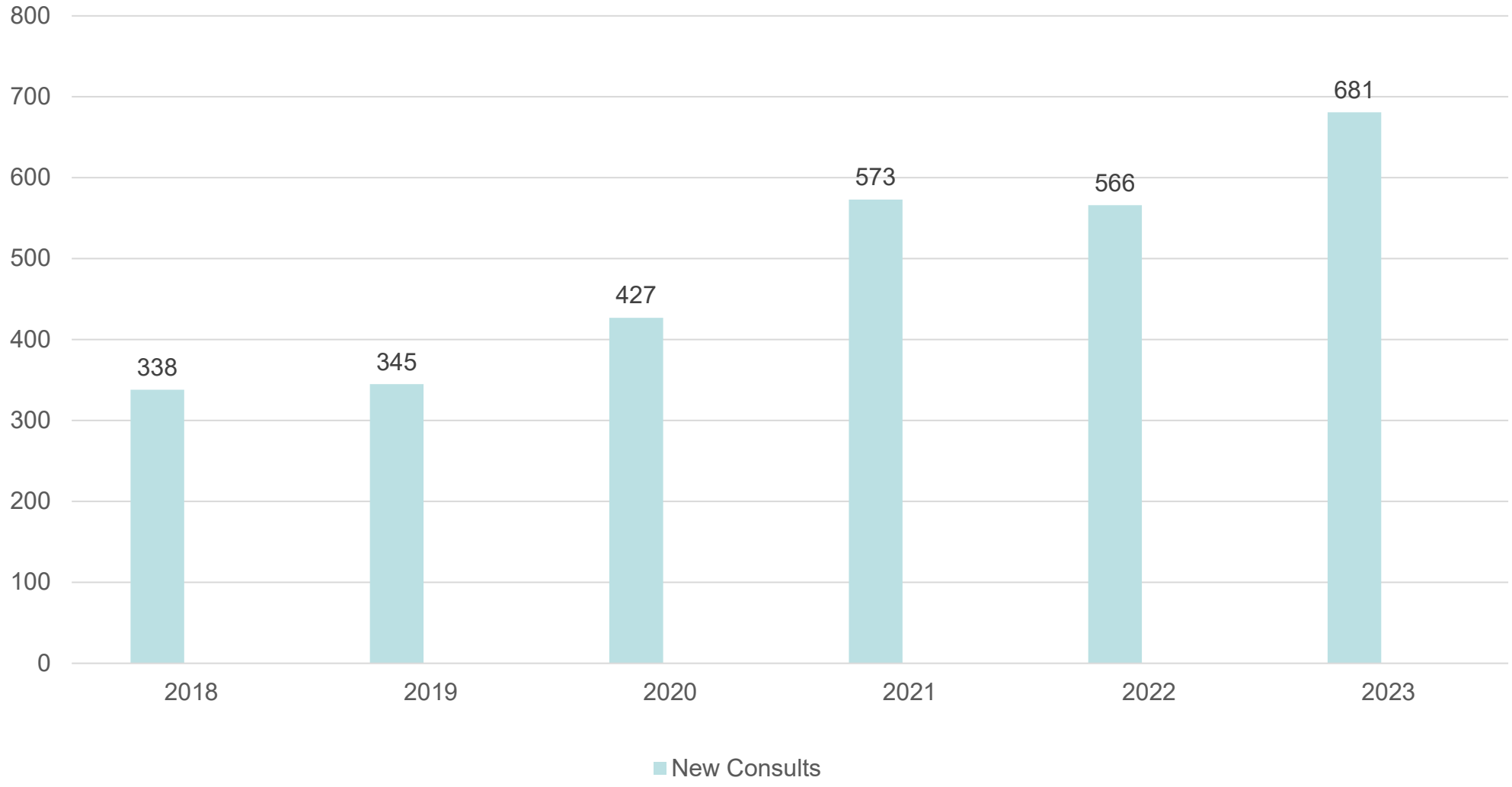
Implementation of a comprehensive hospital-based addiction program

January 8, 2025

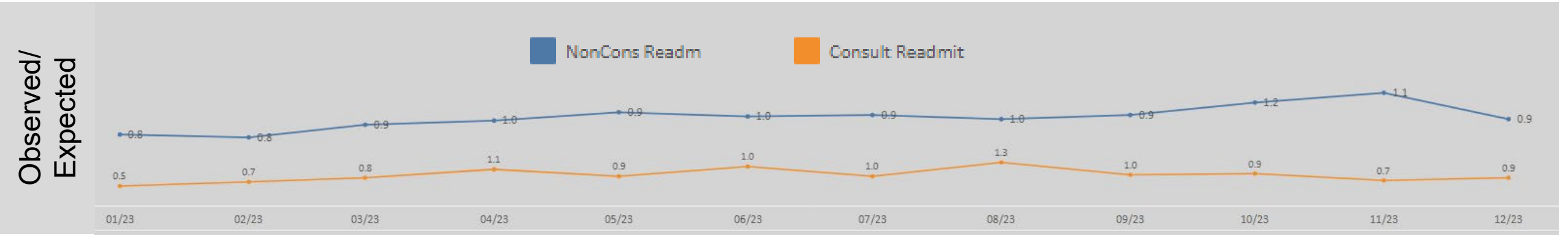
Created standards of care- JHH and JHBMC

- Implemented **dual-level, hospital-wide addiction medicine consult services** with health behavioral specialists (HBS)/peer recovery coaches (PRC), nurse practitioners, pharmacists and physicians (faculty and fellow)
- Routinely offer **linkage to treatment and initiation of buprenorphine and methadone** to qualified patients in the **Emergency Department (ED) and all inpatient units**
- JHM credentialed as an “Opioid Overdose Response Program” by the State of Maryland- JHH and JHBMC received Level 1 status from Baltimore City Health Department (**ED naloxone kit dispensing**)
- Implemented **methadone take home dispensing** for appropriate patients in Emergency Departments and inpatients units
- Treatment of alcohol withdrawal using standardized order sets
- Aftercare/bridge clinic at JHH- can see hospital discharges seen by consult service, including patients that were started on buprenorphine, independent of insurance

Growth in Annual Consult Volumes JHBMC

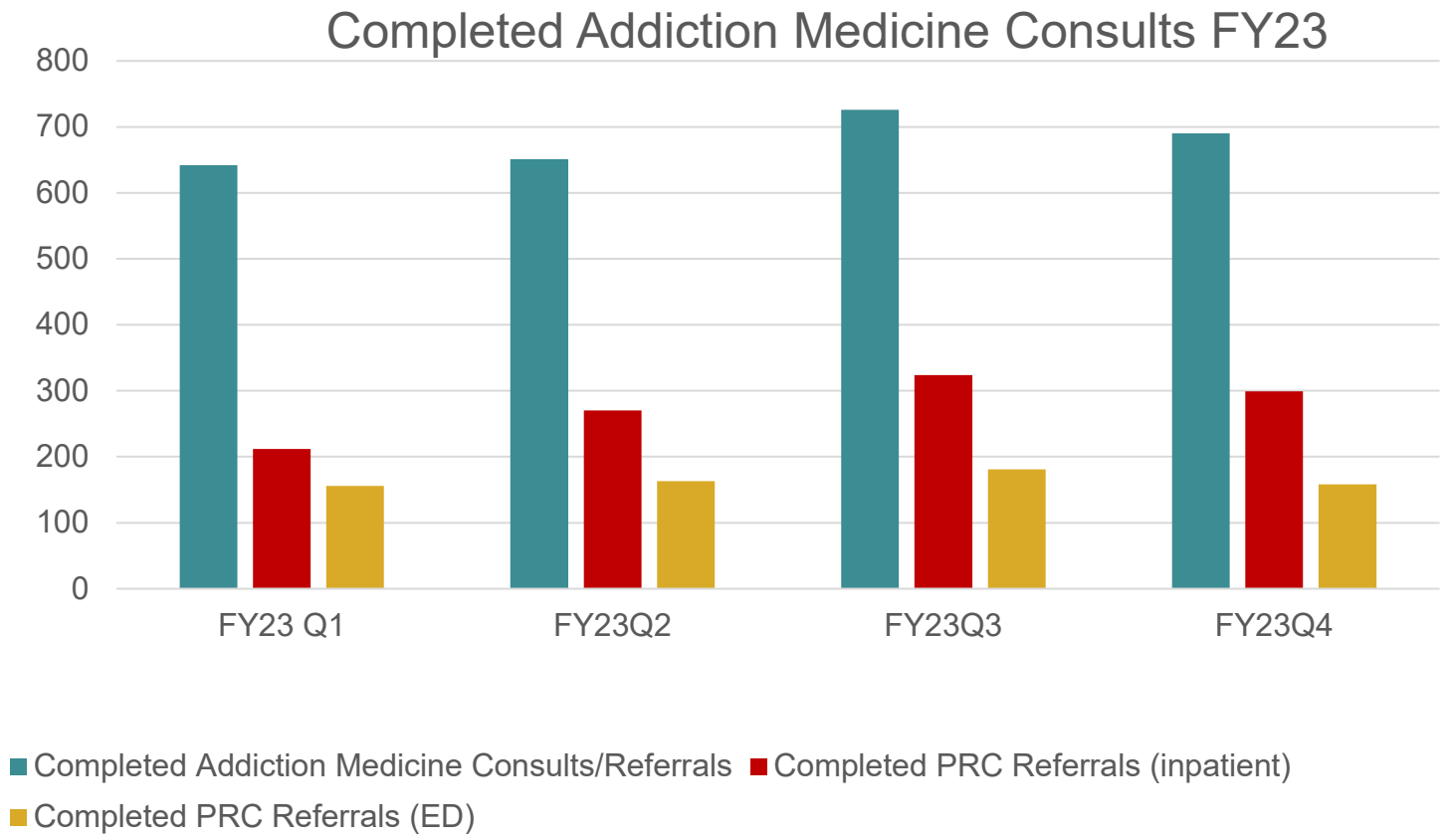


Decreased All-Cause Readmissions for Patients with SUD Seen by JHBMC Addiction Consult Service in 2023

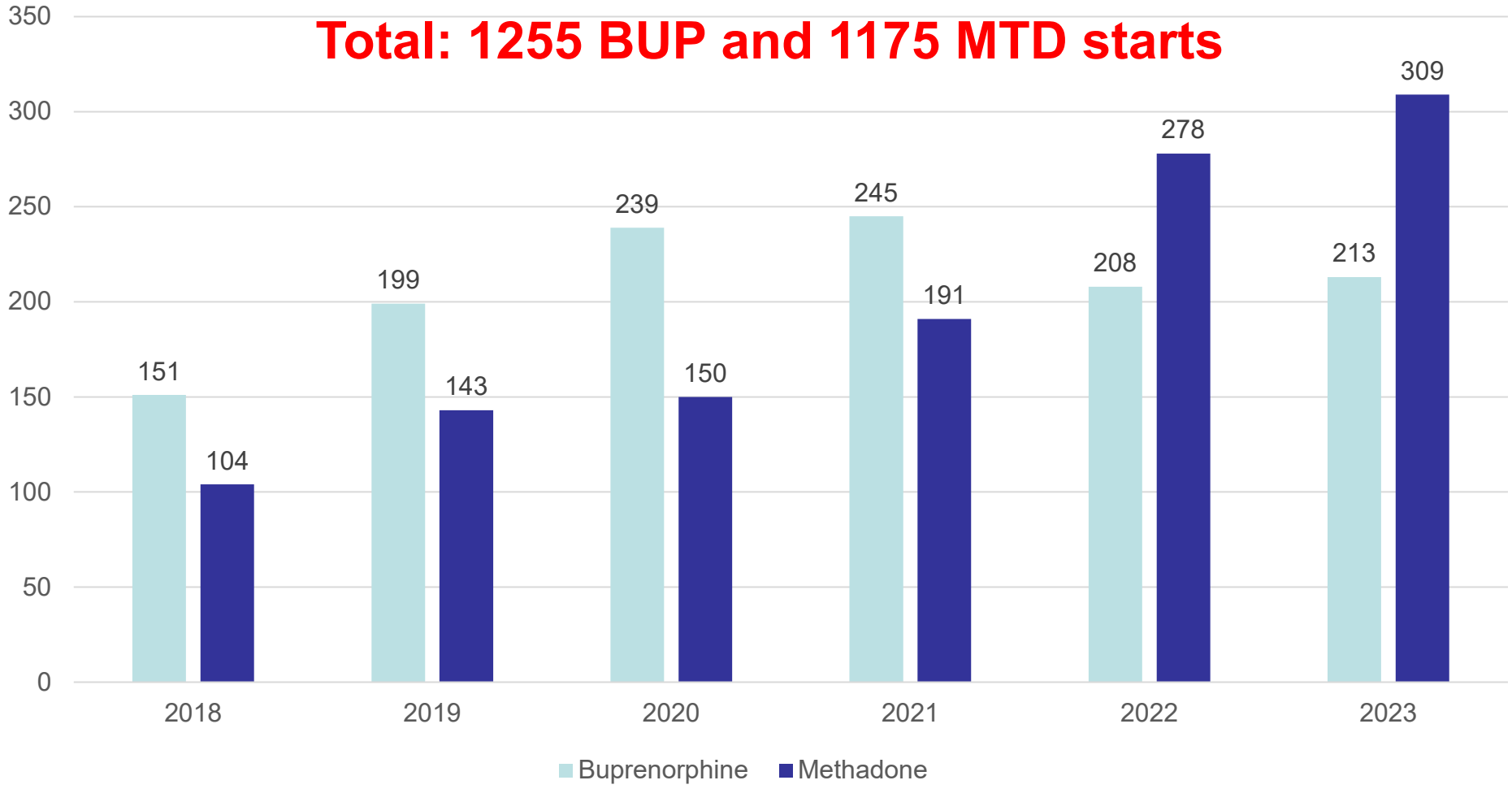


- Consistent trend of decreased readmissions for patients with SUD seen by addiction consult service
- Data Source: 2023 all-cause 30-day readmissions across state of Maryland (HSCRC dataset)

JHH Addiction Medicine Consultation Volume



Medication for Opioid Use Disorder Initiation at JHBMC 2018-2023



Methadone for Home- November 2022- April 2024

- **Total requests received:**
  - BMC ED: 23
  - BMC IP: 152
  - JHH ED: 22
  - JHH IP: 281

- **Total requests approved:** 439 (92%)

- **Total approved, dispensed requests:** 420 (88%)

- **Total doses dispensed:** 934 doses (days)
  - 1-day supplies: 76 (76 doses)
  - 2-day supplies: 174 (348 doses)
  - 3-day supplies: 170 (510 doses)

Innovative Care Initiatives

- Ongoing partnership to improve SUD care at Skilled Nursing Facilities (SNF)
  - Partnership with BD Health Services to continue methadone at SNF after start in hospital
  - ID partnerships for OPAT (outpatient IV antibiotics) after discharge

What practices should be adopted statewide

- Hospital-based addiction medicine consult services
- Standardized treatment of alcohol withdrawal
- Initiation of MOUD (methadone and buprenorphine) in all inpatient and ED settings with direct linkage to continued care using Peer Recovery support

maryland
health services
cost review commission

Application for an Alternative Method of Rate Determination

University of Maryland Medical Center

January 8, 2025

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IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
UNIVERSITY OF MARYLAND MEDICAL	*	DOCKET:	2024
CENTER	*	FOLIO:	2477
BALTIMORE, MARYLAND	*	PROCEEDING:	2667A

I. INTRODUCTION

On December 23, 2024, University of Maryland Medical Center ("Hospital") filed a renewal application for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital is requesting approval to continue to participate in a global price arrangement with OptumHealth Care Solutions, Inc. for solid organ transplant and blood and bone marrow transplants. The Hospital requests that the Commission approve the arrangement for one year beginning January 1, 2025.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University of Maryland Faculty Physicians, Inc. ("FPI"), which is a subsidiary of the University of Maryland Medical System. FPI will continue to manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been unfavorable. According to the Hospital, the losses under this arrangement can attributed to several extraordinary outlier cases. Staff believes that absent these cases, the Hospital can again achieve favorable experience under this arrangement. However, if the experience under the arrangement during the next year continues to be unfavorable, staff will not recommend further approval.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination with OptumHealth Care Solutions, Inc. for solid organ transplant and blood and bone marrow transplants for one-year beginning January 1, 2025. The Hospital must file a renewal application annually for continued participation.

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

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Executive Director's Report

Volume Policy Discussion

January 8, 2025

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Advancing Innovation in Maryland (AIM)

January 8, 2025

Christa Speicher

What is AIM?

- Advancing Innovation in Maryland (AIM) is a contest that seeks to surface ideas for potential implementation to advance Maryland's unique healthcare model, which has the goals of improved patient care and health outcomes, greater equity, and affordability.
- AIM is supported by a public-private partnership involving the Maryland Department of Health (MDH), the Health Services Cost Review Commission (HSCRC), and local foundations.
- Three categories of ideas:
  - Innovative Interventions: Ideas for interventions that a hospital can implement, by themselves or in coordination with community partners;
  - Innovative Collaborations: Ideas for programs or platforms that the hospital system as a whole or in a region can implement, by itself or in coordination with community partners; and
  - Innovative Payment Approaches: Ideas for payment innovations that the Health Services Cost Review Commission can implement.

Submissions and Judges

- We received 41 unique submissions on a wide range of ideas
- Judging panel reviewed each submission
  - Sharon Neely, Maryland Medicaid
  - Magaly Rodriguez de Bittner, University of Maryland School of Pharmacy
  - Sean Cavanaugh, Aledade
  - Niharika Khanna, University of Maryland School of Medicine
  - Scott Afzal, Independent Health Tech Executive
  - Tequila Terry, Maryland Hospital Association
  - Nicholas Stine, University of California - Berkeley Haas School of Business
  - Pamela Edison,

Winners and next steps

- Judges chose 10 unique winning ideas across the three categories
- All contributors have been notified
- Formal announcement will be made later this month
- In-person event will be in February
- Winners will present their ideas at upcoming commission meetings in 2025

Ensuring High Value Care.

A core goal under AHEAD is to bring innovative and affordable care models to the state that improve the health of Marylanders.

- Using the flexibility of global budgets, hospitals have established programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. To further drive this work, how can credit for such efforts be better recognized by the payment system?
- Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?
- Numerous organizations and approaches have documented how the fee-for-service system generates low value care. Maryland does not necessarily perform well on these metrics despite the different hospital incentives. How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care?
- The Health Services Cost Review Commission policies provide an added incentive to reduce "potentially avoidable utilization" as defined by readmissions and PQIs. Given answers to the questions above, should the HSCRC consider alternative or complementary approaches?
- Do hospitals have planning needs to support innovative and affordable care models? If so, what are those needs, and how might the HSCRC support them?

Improving Access to Care.

Another goal of AHEAD is for Marylanders to be able to receive the right care in the right location at the right time. This requires appropriate hospital budgeting as well as investments and oversight in other levels of care.

- Currently, access to care in Maryland is assessed through a series of individual measures, including ED wait times, hospital beds per capita, avoidable admissions per capita, and others. This disjointed approach cannot account for the relationship of these access measures to one another. How can the Commission and partner agencies develop more useful measures of access that support prioritization of funding and rationalization of existing investments?
- Reducing ER wait times is a state priority. Should the HSCRC consider payment policy to slow the rate of volume declines in specific health systems for specific services related to ER wait times?
- As patients move from one hospital to another within specific service lines, there is an adjustment made to both hospitals' budgets. What, if any, changes are appropriate to HSCRC's policies for this market shift to support access to needed care without abandoning population-based payment and creating an excessive financial incentive for hospital-based treatment?
- Hospital global budgets are adjusted every year for statewide population growth. How, if at all, should this adjustment be changed or focused to promote the goals of the model for access to care, cost control, and population health?
- Recognizing that effective hospitals can provide greater access to care, what are key domains and metrics that should be used to assess the effectiveness of hospitals? Should national comparisons be used to evaluate metrics such as length of stay, utilization per capita and administrative costs?

Other Topics

- There are several cross-cutting policy areas that could also be addressed in 2025.
  - **Physician costs.** Hospital-based physician charges have not been regulated by the HSCRC. With costs of hospital-based physicians rising out of proportion to insurance reimbursements, what policy changes should be considered by HSCRC, and, more broadly, by the state? What, if any, special considerations should be made for physician costs in academic health systems, recognizing the role of existing funding for graduate medical education?
  - **Facility conversions.** Should the HSCRC consider facilitating the conversion of facilities with declining numbers of patients and high market-level capital costs from hospitals to free-standing medical facilities or other lower acuity providers? Such a step could be designed to increase funding for hospitals seeing more patients as well as permit the restructuring of services at the conversion facilities to meet community needs. If so, what policies should guide this process?
  - **Percentage of revenue under global budgets.** Under the TCOC Model, the HSCRC was allowed to exclude up to 5 percent of in-state revenue from population-based methodologies, which the Commission utilized to ensure the delivery of high-cost outpatient drugs through the CDS-A policy. Under the AHEAD Model, this exclusion increases to 10 percent. What additional volumes should the Commission consider using fee-for-service methodologies for, e.g., expanded quaternary definitions or hospital at home?
- What other major changes to policies under the Maryland Model of population-based payment should be considered?

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Update on Medicare FFS Data & Analysis

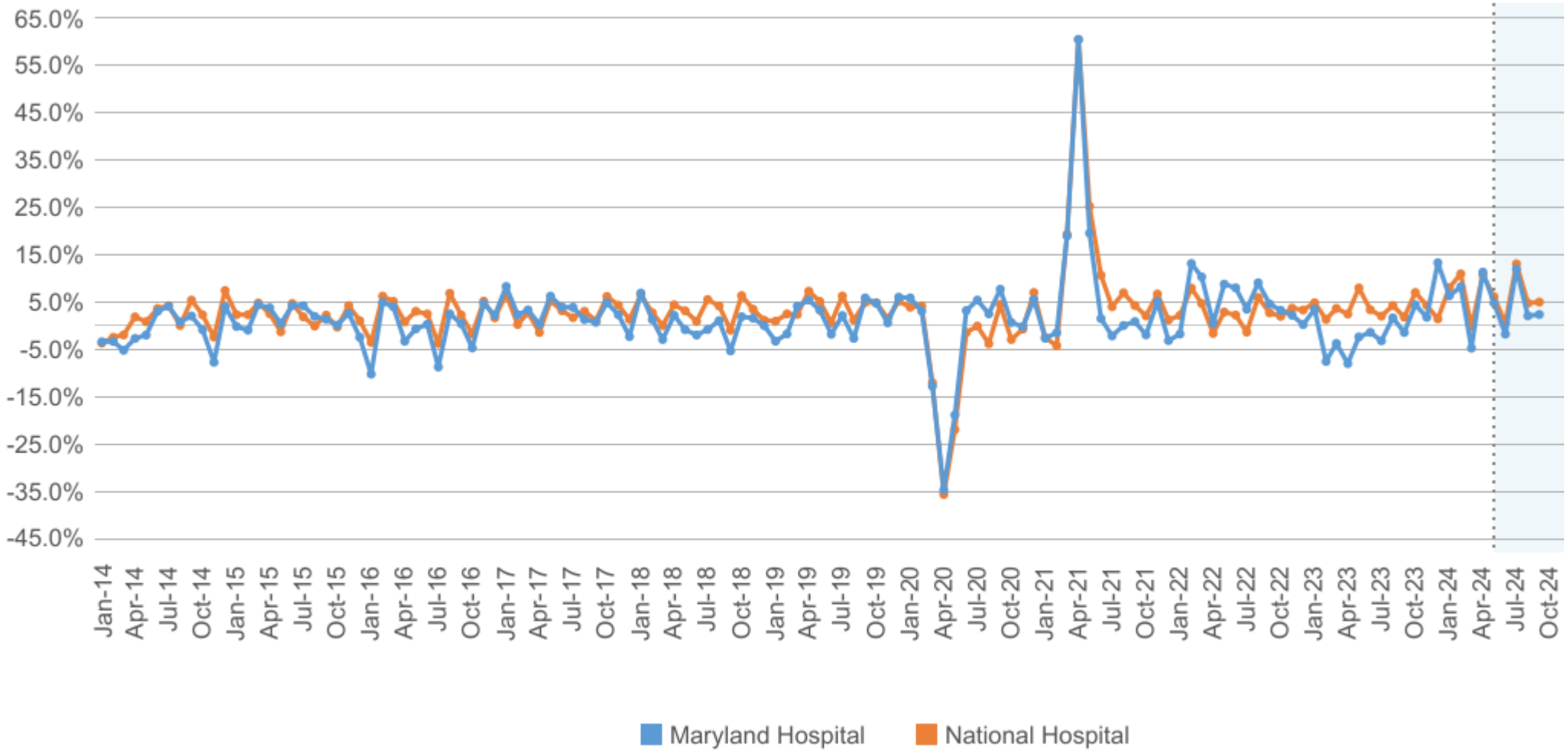
January 2025 Update

Data through September 2024, Claims paid through November 2024

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

Medicare Hospital Spending per Capita

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



CY16 has been adjusted for the undercharge.

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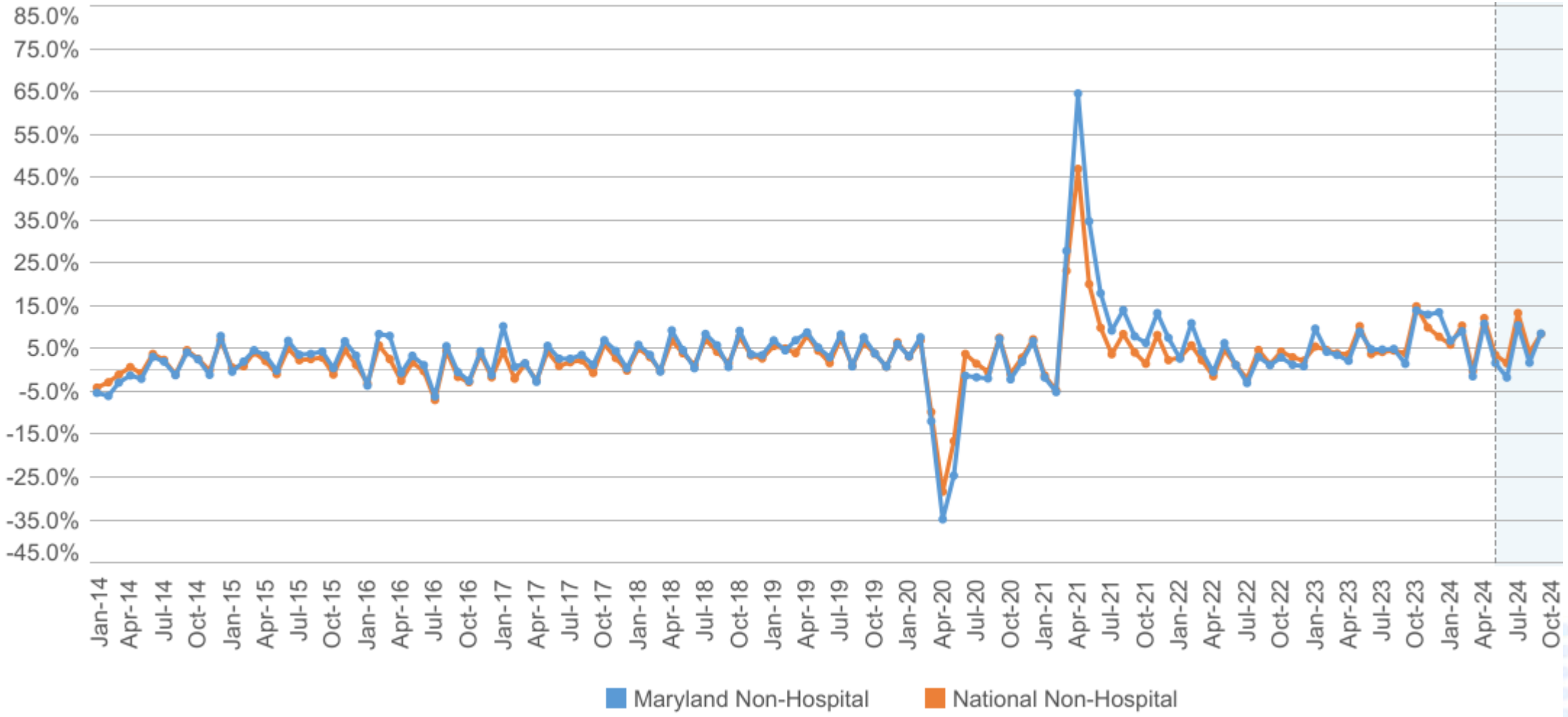
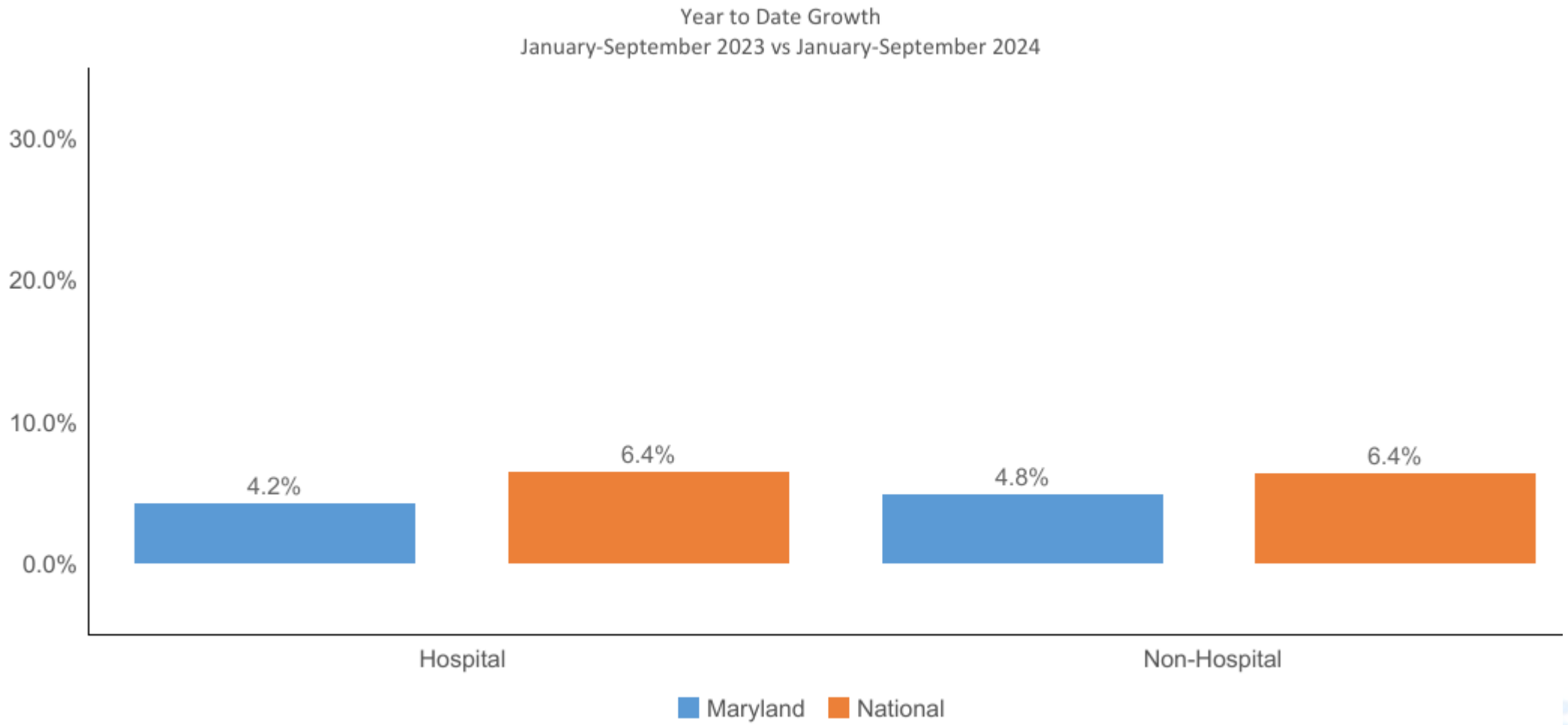
Medicare Non-Hospital Spending per Capita

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

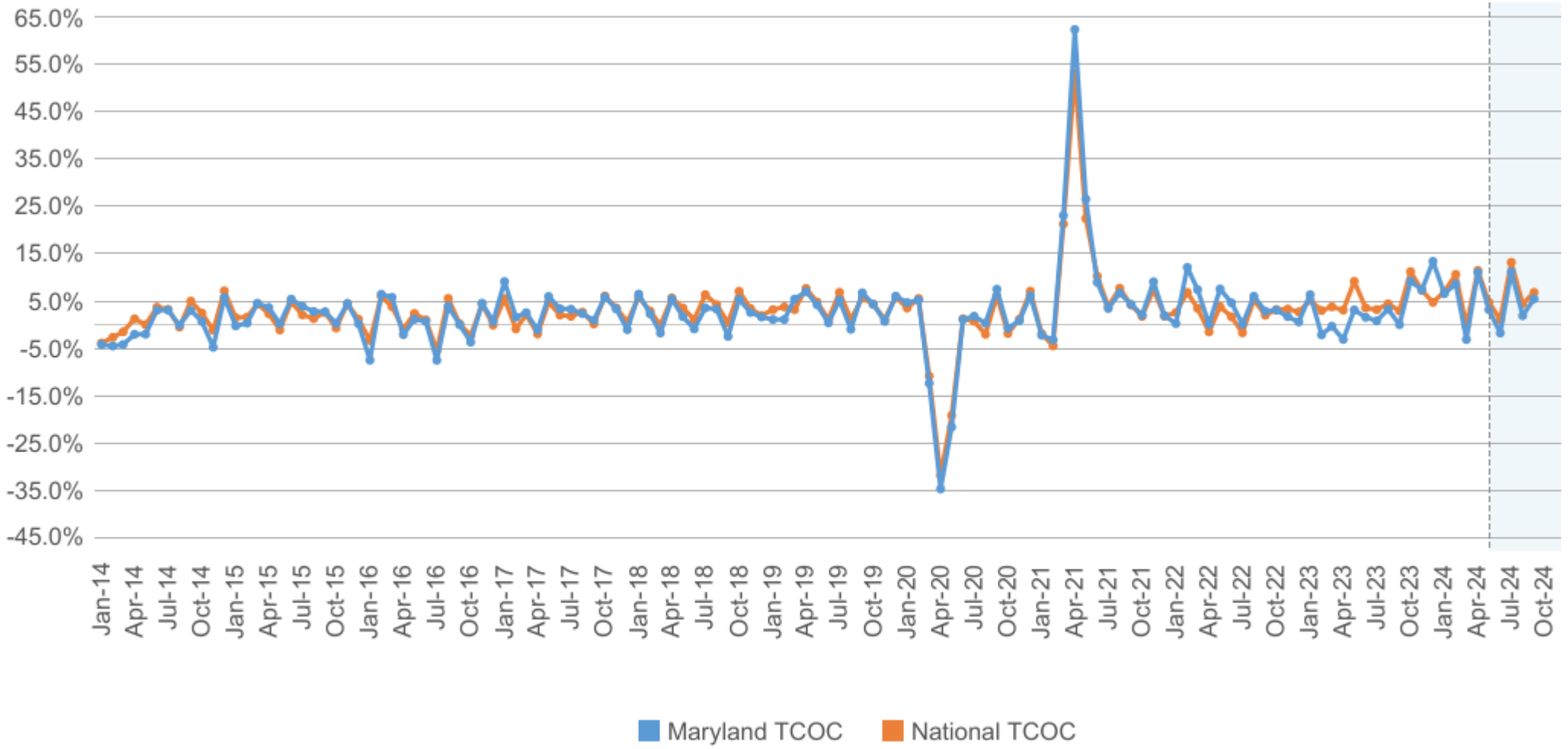


Medicare Hospital and Non-Hospital Payments per Capita



Medicare Total Cost of Care Spending per Capita

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



CY16 has been adjusted for the undercharge

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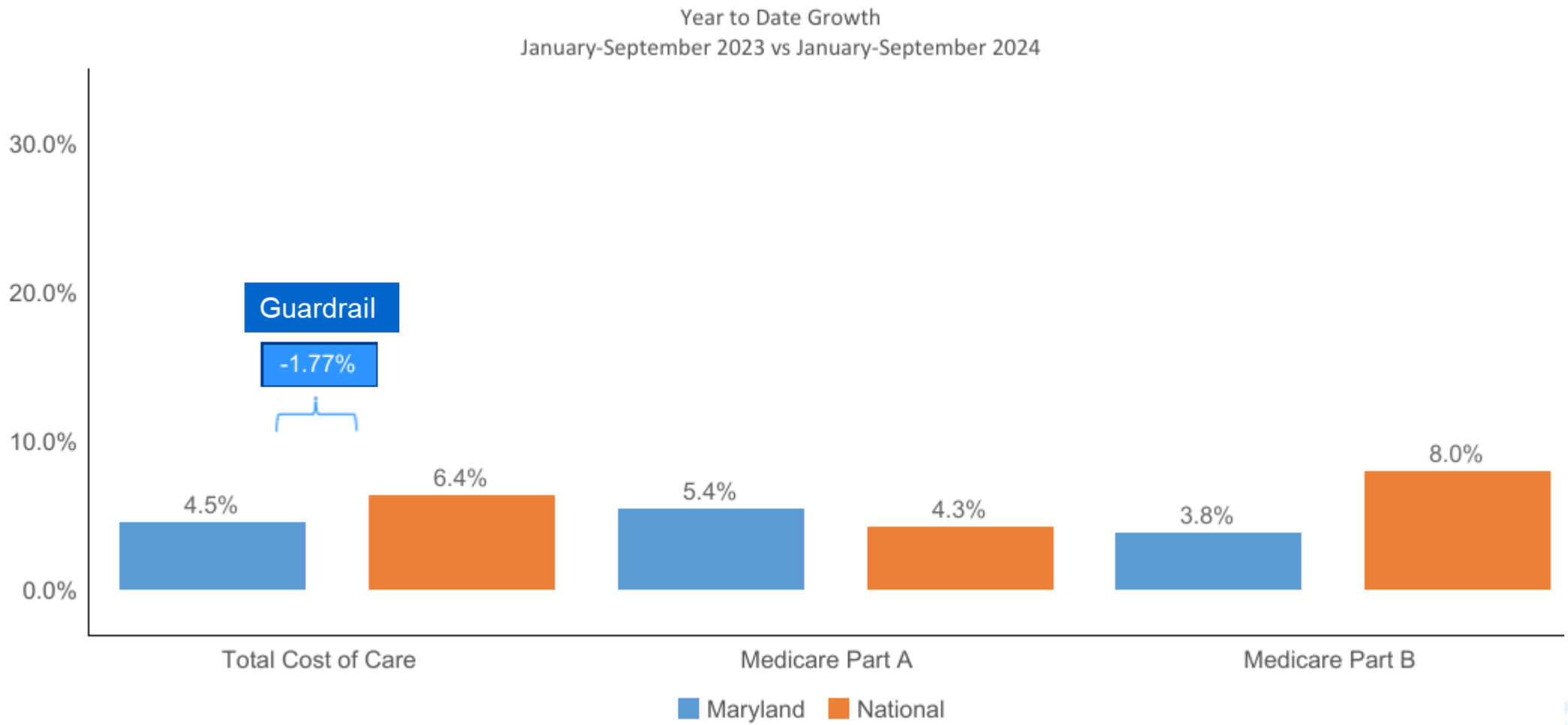
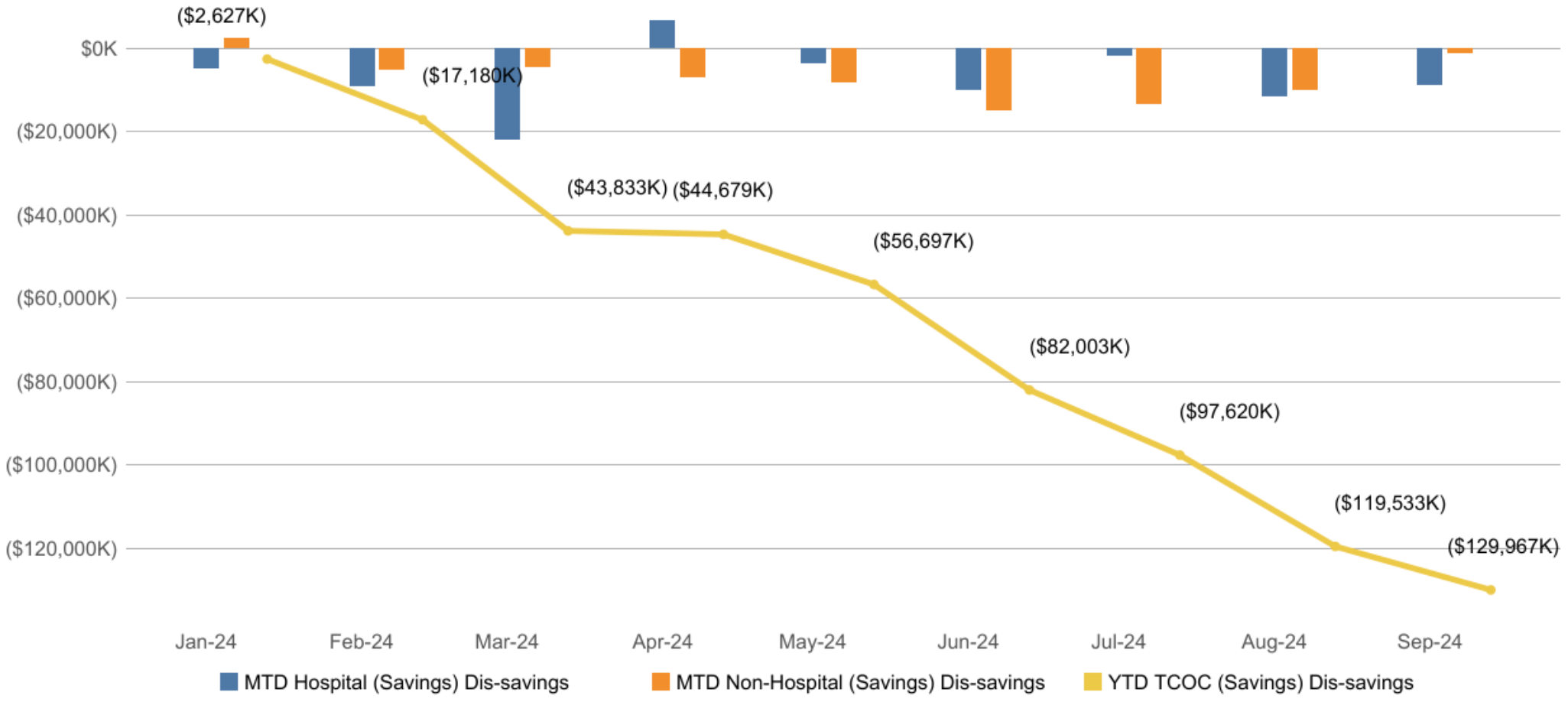
Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through September 2024



Final Recommendation on High-Cost Drugs

Introduction

- HSCRC Staff are proposing to change the method of reimbursing high-cost drugs from the current approach to one that provides 100% cost reimbursement for the direct cost of the covered drugs.
  - High-cost drugs are already exempted from population-based methodologies under the TCOC contract (2% of 5% allowed, allowance will go to 10% under AHEAD).
  - Staff believe now is an opportune time to change from the current complex policy to a simpler approach.
- Five Comment Letters were received: MHA, Tidal, UMMS, JHHS and MedStar

Draft Policy Recommendation

To simplify the CDS-A policy, Staff propose to make it more directly volume variable as follows (New/Changed Elements, prior to comment letters on draft policy):

1. Continue to identify high-cost drugs for volume-based funding based on criteria set by Staff in consultation with industry stakeholders
2. Continue to conduct an audit of reported volumes to ensure volume-based reimbursement is fairly stated.
3. Change volume funding to 100% of measured cost change, per the annual audit, effective 1/1 each year.
4. Implement a provisional adjustment period for each year, at the end of the year based on the first 6 months of data to smooth the impact of increased adjustment size.
    a. Provisional adjustment period will be directly calculated by staff using Casemix data, excluding drugs with outlier dosage counts. No manual adjustments will be made.
    b. Provisional adjustment will be temporary only, final adjustment derived from the audit will supersede the provisional adjustment and all amounts will be trued up to the final audit.
5. Set the drug component of inflation in the update factor to only reflect any price inflation not captured during the volume adjustment; inflation on drugs will primarily be provided through the volume adjustment
6. Implement a new annual report, produced by a consultant, to identify hospital efficiency in controlling CDS-A drug costs and assess penalties, up to 20% of drug cost, to hospitals that are not meeting target goals.
7. Hospitals will continue to be expected to “tier” charges for drugs. Staff will periodically evaluate hospital tiering of drug prices to ensure high-cost drugs are not being loaded with proportionate overhead, resulting in unfair costs to consumers.
8. Continue to audit data reported in Casemix to validate amounts reported and gather appropriate ASP and 340B price data.

Recap of Comment Letters

- Letters were supportive of the policy change to 100% reimbursement.
- Comments in 3 categories:
  - Implementation considerations – no changes to the proposed policy
  - Potential Policy changes – no changes to the proposed policy
  - Policy clarifications – some changes to the proposed policy

Recap of Comment Letters - Implementation Considerations

- Comments relating to implementation of the policy:
  - MHA asked for clarification of the process for reviewing drug tiering noted in item 7 of the recommendation. UMMS suggested a more comprehensive review of how overhead is applied to drugs.
  - MHA asked for clarification on how the policy will be implemented operationally, at a rate center level.
  - MedStar raised concerns about the time and effort involved in adding NDC to the casemix data but were supportive of the concept.
- Staff Response
  - The drug tiering requirement has been in place for some time. Staff acknowledge that the approach may need refreshing. Staff plan to share an analysis of current outcomes this spring and will work with the industry to refine and clarify the policy and allow a period for compliance before further review.
  - Staff acknowledge the concerns and will work with industry through existing workgroups and processes to address the issues highlighted in the comment letters.

Recap of Comment Letters – Potential Policy Changes

- Comments discussing potential policy changes:
  - MHA did not support a suggestion made during the draft recommendation discussion for the Commission to implement proactive review of drug efficacy and value. MHA felt hospitals were in the best position to complete this review.
  - TidalHealth raised concerns that the focus on volume changes could underfund price inflation on drugs and suggested a hospital should receive the higher of inflation or CDS-A adjustment in their drug funding.
  - UMMS believes the Commission should give consideration to hospitals who are negatively impacted by the change in methodology and ensure that any negative adjustments for FY 2024 do not underfund growing expenses that hospitals may be experiencing in FY 2025.
- Staff Response:
  - Staff agree with MHA that hospitals are in the best position to review drug appropriateness on a prospective basis. Staff do not believe they have the expertise or bandwidth, at this time, to support such a review. Staff will work with the report consultant to accelerate the timeliness of any recommendations so hospitals can quickly focus on any areas of concern.

Recap of Comment Letters – Potential Policy Changes

- Staff Response continued:
  - Staff believes the existing proposal fully funds drug inflation and the funding of greater of inflation or CDS-A drug changes is not merited:
    - inflation based on non-CDS-A drugs is covered in the update factor
    - same-drug price inflation based on CDS-A drugs will be covered under the update factor in accordance with the proposed policy
    - a significant portion of drug price inflation is switching to new drugs, as this is considered a volume change under the policy and volume changes are always funded at the most recent price, this inflation is covered under the volume elements of this policy.
  - Staff believe switching to 100% of drug cost will lead to both positive and negative adjustments and this is the intent of the policy. Since most changes are implemented on a retrospective basis hospitals should have adequate time to plan for changes. Also, the change recommend on the next slide will allow hospitals to access funding for cost increases more rapidly.

Recap of Comment Letters – Policy Clarifications

- Comments leading to changes in the recommendation:
  - MHA, TidalHealth, UMMS, JHHS and MedStar asked for clarification around the proposed future penalties and the process for assessing and applying them. UMMS raises concerns that the approach may not have been fully vetted with industry.
  - MHA, JHHS and UMMS supported the implementation of an additional optional rate adjustment, beyond the standard January 1 and July 1 adjustments, as discussed during the presentation of the draft recommendation. They suggested the use of a % rather than dollar threshold to be eligible for this adjustment.
- Staff Response
  - Staff clarified the policy on proposed penalties:
    - Proposal is penalties would apply to 20% of the relevant CDS-A drug cost
    - 20% was intended to establish an order-of-magnitude expectation. Staff acknowledge that additional clarification is required on these penalties but believes that will be easier to establish once initial reporting work is completed. Therefore, Staff has revised the recommendation to require an additional Commission review and vote prior to the implementation of any penalties.

Recap of Comment Letters – Policy Clarifications

- Staff Response continued:
  - Based on industry support Staff has amended the proposal to include an additional March 1 drug volume funding update based on a hospital's projection of their current fiscal year cost.
    - Update would be voluntary, and projection would be subject to staff review.
    - Changes would still be offset against the final adjustment based on the audit.
    - Change has no impact on the total funding provided. It accelerates increases in drug funding from July 1 of the next fiscal year to March 1 of the current fiscal year.
  - This change was included as industry requested that it was important to the management of their finances.
    - Previously standard rate updates have been limited to Jan 1 and June 1, a March 1 update is new and adds complexity to the system.
    - Because the update is voluntary it will likely result in only positive adjustments to funding (negative updates will occur later when formulaic adjustments are made)
    - Shifting retrospective funding adjustment forwards does not have any policy impact. However, many policies have retrospective adjustments, if funding timing is to become a routine consideration, then Staff believes the Commission should also evaluate the role of carried investment balances in funding hospitals, particularly related to income timing issues.

Final Policy Recommendation

To simplify the CDS-A policy, Staff propose to make it more directly volume variable as follows (New/Changed Elements, prior to comment letters, Comment letter impact):

1. Continue to identify high-cost drugs for volume-based funding based on criteria set by Staff in consultation with industry stakeholders
2. Continue to conduct an audit of reported volumes to ensure volume-based reimbursement is fairly stated.
3. Change volume funding to 100% of measured cost change, per the annual audit, effective 1/1 each year.
4. Implement two provisional adjustments for each year, one on March 1st and one on July 1st, to smooth the impact of the increased adjustment size:
    a) The March 1st adjustment will be voluntary and based on a projection of current year spending prepared by the hospital. To be eligible for this funding adjustment the projection must show a cost increase above a minimum threshold established by staff and be subject to staff review and approval.
    b) The July 1st adjustment will be automatic and based on the first 6 months of data from the prior fiscal year. The adjustment will be directly calculated by staff using Casemix data, excluding drugs with outlier dosage counts. No manual adjustments will be made to this adjustment. The impact of any adjustment made in the prior March 1st adjustment will be deducted.
    c) Provisional adjustments will be temporary only, final adjustment derived from the audit will supersede the provisional adjustment and all amounts will be trued up to the final audit.

Final Policy Recommendation, Continued

To simplify the CDS-A policy, Staff propose to make it more directly volume variable as follows (New/Changed Elements, prior to comment letters, Comment letter impact):

5. Implement a new annual report, produced by a consultant, to identify hospital effectiveness in managing CDS-A drugs and assess penalties of 20% of relevant CDS-A drug costs, to hospitals that are not meeting target goals. Prior to the implementation of any penalties a revised version of this policy will be developed, with stakeholder input, that specifies in greater detail the approach for any penalties assessed.
6. Hospitals will continue to be expected to "tier" charges for drugs. Staff will periodically evaluate hospital tiering of drug prices to ensure high-cost drugs are not being loaded with proportionate overhead, resulting in unfair costs to consumers.
7. Continue to audit data reported in Casemix to validate amounts reported and gather appropriate ASP and 340B price data.

Appendix

Annual Evaluation Report Outline and Impact

- Report would be compiled by a consultant with expertise in Pharmacoeconomics and other relevant topics. HSCRC has enlisted the assistance of the Prescription Drug Affordability Board (PDAB) in managing the report.
- Report would assess the following regarding high-cost drugs:
  - Place of service use rates.
  - Generic and biosimilar use rates.
  - Adoption of new drugs.
  - Acquisition pricing
- Report will allow the HSCRC to evaluate whether:
  - The policy change has impacted the efficiency of high-cost drug utilization in Maryland.
  - There are additional opportunities for improved utilization efficiency.
  - Efficacious new drugs are being adopted in at a rate at or better than the nation.
- First report would be released in late CY25 based on FY25 data to assess the baseline and observe any initial impacts from this change. Report would then be release annually thereafter.

Criteria for Drugs to be Treated under CDS-A Policy

The state-wide list is composed of Billed High-Cost Physician-Administered Outpatient Infusion, Chemotherapy, & Biological Oncology Drugs meeting all the following criteria:

- 3M's EAPG Class Code of VII or higher in either of the past two fiscal years (to reference relatively high cost per patient visit), and
- State-wide case-mix charges in either of the past two fiscal years of $2 million or greater (to reference relatively high-cost utilization), and
- Market share by point of service of less than 90% at physicians' offices (to minimize inclusion of drugs best served outside of a hospital setting), and
- An Ambulatory Payment Classification - OPPS Payment Status Indicator of G or K, Paid under OPPS/Separate APC payment (to preclude drugs packaged under other charge codes), and
- Inclusion of alternate codes for same listed drug (so to capture brand, generic, biologic, biosimilar, replacement, discontinued and temporary codes)

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Proposed Revisions to Outpatient High-Cost Drug Funding Policy

Final Recommendation

January 8th, 2025

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List of Abbreviations

340B	340B Drug Pricing Program[1]
AHEAD	States Advancing All-Payer Health Equity Approaches and Development Model
ASP	Average Sales Price[2]
Casemix	Patient-level discharge data submitted by hospitals to the HSCRC
CDS-A Drugs	Cost of Drugs Sold - Audit[3]
CMS	Centers for Medicare & Medicaid Services
GBR	Global Budget Revenue
NDCs	National Drug Codes
TCOC	Total Cost of Care Model

[1] The 340B Program requires pharmaceutical companies participating in Medicaid to provide outpatient drugs to clinics that serve certain low-income patients at significantly reduced prices.
[2] Medicare pays for certain Part B drugs through Average Sales Price (ASP) methodology. Most separately payable drugs and biologics are paid at a rate of ASP plus 6% according to CMS
[3] CDS-A stands for Costs of Drugs Sold – Audit and refers to the statewide list of high-cost physician-administered outpatient drugs meeting certain defined inclusion criteria, these criteria are listed in Appendix A. These drugs are subject to an annual audit to validate reported amounts and ensure appropriate funding.

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
Simplify the current policy to ensure high-cost drugs are adequately funded by making the policy more directly volume variable and reducing complexity in the decision-making process	Adjust volume funding to 100% of measured cost change from the audit and introduce a new annual evaluation report and penalties to maintain hospital incentives for cost efficiency	Hospitals would be 100% reimbursed for changes in high-cost drug volumes. Hospitals would be subject to an annual report to monitor the use of Part B drugs and potential penalties for inefficient cost management.	Annual report would allow HSCRC to monitor hospitals and ensure Part B drugs are efficiently managed to maximize value to payers and consumers	Shifting to 100% volume-based funding will help ensure the availability of life saving treatments regardless of insurance status, location or other demographic characteristics

Summary of the Recommendation

Currently, certain high-cost physician-administered drugs, known as “CDS-A drugs”, are financed via a special funding provision outside of the Global Budget Revenue (GBR) process that is 50% inflation-based and 50% volume-based. HSCRC Staff propose shifting the current CDS-A drug funding policy to 100% volume-based funding in order to simplify the policy and make funding more representative of actual costs at a hospital level. A new report would be instituted to monitor the impact of the changes on the cost of these drugs in Maryland.

Comment letters received were generally supportive of the major change anticipated by this policy. Based on the specific feedback, Staff have made some clarifying revisions to the policy which are outlined in the next section. The Recommendation section has been revised to reflect these changes. The Background and other informational portions of this recommendation are unchanged from the draft policy.

Summary of Comment Letters and Resulting Changes to the Proposed Policy

Overview

Comment letters were received from the Maryland Hospital Association, University of Maryland Medical System (UMMS), Johns Hopkins Health System (JHHS), Tidal Health and MedStar Health. The letters were all generally supportive of the proposed policy but raised a number of concerns about the implementation:

- MHA, TidalHealth, UMMS, JHHS and MedStar asked for clarification around the proposed future penalties and the process for assessing and applying them. UMMS raises concerns that the approach may not have been fully vetted with industry.
- MHA asked for clarification of the process for reviewing drug tiering noted in item 7 of the recommendation. UMMS suggested a more comprehensive review of how overhead is applied to drugs.
- MHA did not support a suggestion made during the draft recommendation discussion for the Commission to implement proactive review of drug efficacy and value. MHA felt hospitals were in the best position to complete this review.
- MHA asked for clarification on how the policy will be implemented operationally, at a rate center level.
- MedStar raised concerns about the time and effort involved in adding NDC to the casemix data but were supportive of the concept.
- TidalHealth raised concerns that the focus on volume changes could underfund price inflation on drugs and suggested a hospital should receive the higher of inflation or CDS-A adjustment in their drug funding.
- UMMS believes the Commission should give consideration to hospitals who are negatively impacted by the change in methodology and ensure that any negative adjustments for FY 2024 do not underfund growing expenses that hospitals may be experiencing in FY 2025.

- MHA, JHHS and UMMS supported the implementation of an additional optional rate adjustment, beyond the standard January 1 and July 1 adjustments, as discussed during the presentation of the draft recommendation. They suggested the use of a % rather than dollar threshold to be eligible for this adjustment.

Staff appreciate the commenters' general support for the proposed changes, the sections below discuss the comments received. Items where Staff are proposing a change to the policy are discussed first and then Staff's responses to other comments.

Clarification Regarding the 20% Penalty

As discussed in the Commission presentation and during the workgroup, shifting to a cost-based reimbursement system (which is the effect of this proposal) always raises the risk that cost control will no longer be prioritized by the funded organization. Staff included the 20% penalty as they felt it was important to create an "order-of-magnitude"-type reference point for potential penalties as the Commission enters this new territory.

Staff continue to believe this consideration is important but agree with commenters that (1) there was some inconsistency in description of the penalties in the original recommendation and (2) there is a lack of specificity around exactly how this will be implemented. In response to item 1, Staff clarified this final recommendation to more clearly state that the 20% is a percent of relevant CDS-A drug costs. On item 2, Staff purposely provided little specificity on the implementation as the report process has not yet been defined and it is unclear how targeted the reporting will be or what issues will be discovered. Therefore, Staff does not believe it is feasible to lay out greater detail at this time. Instead, Staff have revised this recommendation to specify that Staff will submit a revised recommendation to the Commission with greater detail on penalty parameters prior to the implementation of any penalties.

Staff also note that the report proposed in this recommendation was intended to address both the risk of poor cost control as well as the risk of lagging drug adoption. The language has been revised to clarify that penalties could be applied in either case.

Additional Voluntary Adjustment Date

At the request of the industry, during the presentation of the draft recommendation, Staff proposed an additional provision which would provide an accelerated update to drug funding for hospitals on March 1st of each year, in addition to those outlined in the draft recommendation, which follow the current July 1st and January 1st standard. A number of commenters were supportive of this recommendation.

Therefore, Staff have revised the recommendations in this policy to provide an option for hospitals to prepare and submit to Staff a projection of CDS-A drug costs for the current year and receive an update to funding, based on their projection, effective March 1st of that year. To be eligible for this funding adjustment the projection must show a cost increase above a minimum threshold established by staff and be subject to staff review and approval. Any funding received under this approach will be deducted from the future standard adjustments received under the base policy. Staff will work with industry to develop the specific process for the adjustment.

This approach will not change the amount of total funding received, because all changes to drug funding are made retrospective to their effective date, but it would accelerate the funding of some of current year cost growth from the next fiscal year to March 1 to June 30 of the current fiscal year.

Staff note this change adds complexity to the system. While HSCRC gives weight to operational simplicity in policy development, this change was recommended by industry stakeholders as important to the management of their finances. Also, because the adjustment is voluntary, only increases will be funded, whereas all other elements of the policy are simultaneously implemented whether positive or negative.

As noted above, the change does not have any impact on the total funding received by hospitals but does allow them to (1) reduce the impact on cash reserves of the gap between the time drug costs are incurred and funded and (2) better match the expense and income related between periods. Staff does not believe either of these

criteria have a strong policy impact as most Maryland hospitals are allowed to carry cash and investment balances many times greater than the drug costs increases they face. Further, the periods in which income and losses are recorded by not-for-profit institutions has less significance for public reporting requirements. Staff do believe that in the future, if the timing of income recognition is to be a significant element in policy evaluation, the Commission should also consider including hospital investment income as an element in policy development–particularly if the accommodation adds administrative complexity

Staff Response on Other Comments

Drug Rate Tiering: The expectation for hospitals to follow this practice has been well established, however, Staff recognize it has not been a subject to review of late. Staff are completing some initial analysis and intend to work with industry starting in the spring to review this topic. The initial work will focus on understanding current policy and practice and working with industry to refine and implement the existing guidance, no punitive action is expected in the near term. As part of the review of the Annual Filing Staff are also reviewing the overhead assignment process.

Prospective Review of Drug Selection: Staff agree with the commenter that primary responsibility for selecting the appropriate drugs should lie with the hospital. Staff are also concerned that they do not have sufficient bandwidth or expertise to support hospitals on a prospective basis. Staff will work with the selected report consultant to accelerate the timeliness of any recommendations so that hospitals can focus quickly on any areas of concern.

Policy Operationalization: Staff recognize industry concerns about the details of policy implementation (e.g. addition of NDC to Casemix). Staff will work with industry on the various operational considerations raised and believe established processes are sufficient to address these concerns.

Inflation Funding: Staff believe drug price inflation is sufficiently addressed through three elements of proposed and existing policies: (1) Inflation based on non-CDS-A drugs is covered in the update factor, (2) same-drug price inflation based on CDS-A

drugs will be covered under the update factor in accordance with this policy[4], (3) a significant portion of drug price inflation is actually switching to new drugs, as this is considered a volume change under the policy and volume changes are always funded at the most recent price, this inflation is covered under the volume elements of this policy. As a result, staff do not believe providing funding at the higher of CDS-A or inflation is needed.

Consideration to Hospitals Who are Negatively Impacted: The proposed policy provides funding at 100% of drug cost effective with Fiscal Year 2024, Staff do not believe any hospitals are negatively impacted by this change in a way unrelated to their drug cost experience but as noted above will work with the industry on operational details.

Background

In HSCRC's rate setting process, certain high-cost drugs paid under the medical benefit, also known as Medicare Part B drugs, are subject to special funding provisions outside of the Global Budget Revenue process. These drugs are referred to as "CDS-A drugs" and include high cost, physician-administered, outpatient, oncology and infusion drugs as well as biologics. CDS-A drugs are determined annually based on a set of criteria established by staff in consultation with industry stakeholders. The current criteria can be found in Appendix A. Currently hospitals are funded for CDS-A Drug cost changes via two pathways: 50% of funding comes from volume adjustments and the other 50% comes from the prospective price inflation factor, which is applied to CDS-A Drugs during the update factor. The current CDS-A approach was implemented in 2016 to recognize high Part B drug trends. The high-cost drug trends decreased later in the decade but began to accelerate again in Fiscal Year 2023 - the Staff expects this acceleration will continue into Fiscal Year 2024. Implementing this policy was necessary as these disproportionate trends were not being addressed by standard GBR policies. The policy was intended to provide extra funding for hospitals experiencing high-cost drug trends while still controlling spending on these drugs. In addition to clinical benefits for patients,

[4] Staff track same-drug price trends as part of the CDS-A policy evaluation and it is typically very limited, most inflation results from the adoption of new drugs.

high-cost drugs should reduce the need for acute hospitalization and other expensive services and therefore their adoption is strongly aligned with the goals of the Maryland Model.

Current Policy

Overview

Hospitals currently receive funding for CDS-A drugs via a 50/50 blend of specific volume-based funding and across the board inflation funding. Volume-based funding is provided either at Medicare's "Average Sales Price" (ASP) or 340B pricing, depending on whether a hospital qualifies for the 340B program. Volume adjustments are based on Casemix reporting and validated by staff via an audit process to ensure hospitals' volumes are appropriately reported.

Inflation funding is included in the annual Update Factor. Amounts are estimated by staff based on historical data and applied to each hospital's CDS-A drug spending. Since the inflation factor is prospective, it is estimated using data from two years prior, so funding tends to lag behind the actual inflation trends under the current policy.

The intention behind this two-lever policy was to incentivize hospitals to manage the high cost of administering these drugs:

- Hospitals that move to lower cost drugs benefit by retaining 50% of the drug cost in their GBR.
- Hospitals can also benefit by "beating" the average prospective inflation by negotiating prices with suppliers. However, 340B prices generally start lower and these participating hospitals may have less opportunity to negotiate.
- Hospitals absorb 50% of volume increases; therefore, a hospital that fails under the prior bullets will lose money under the policy.

The current approach operates under the assumptions that every hospital will have an equal opportunity of success under this policy and that the impact of new high-cost drugs would be evenly distributed because the inflation factor is set on a statewide basis.

Even though HSCRC has provided different inflation factors for academic hospitals[5], it would not be operationally feasible to accurately estimate hospital specific inflation factors for every hospital; therefore, differential inflation experience will never be fully captured under the current policy.

The funding described in this section pertains only to the direct costs of acquiring the covered drugs. It does not impact the funding provided for the administration of drugs or hospital overhead (i.e. a $10,000 increase in funding under this policy increases total funding by only $10,000, there are no additional overhead loads). An important component of current policy is that hospitals are expected to "tier" their charges so that the loads applied to high-cost drugs are less than those applied to lower cost drugs, in percentage terms, as the cost of administration and overhead does not increase proportionally with the drug cost. Staff intend to continue this expectation and increase oversight to ensure it is applied.

Policy Impact

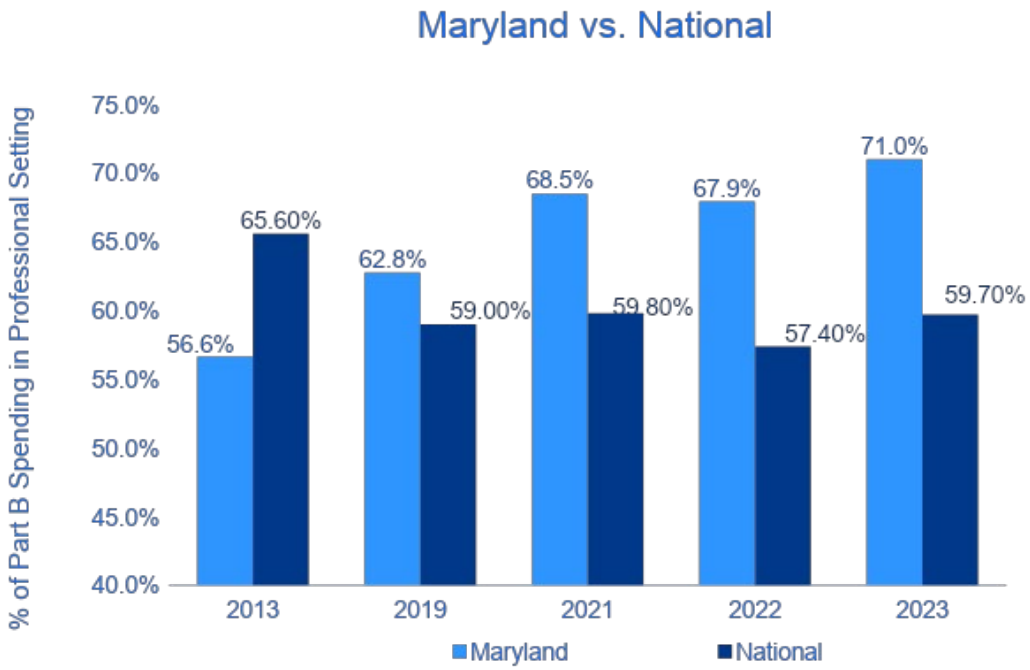
In FY23, HSCRC estimated that the average hospital was overfunded by 0.4% of total GBR based on the two-pathway drug funding approach, with the median hospital being overfunded by an estimated 0.24%.

Maryland has been successful in shifting administration of Part-B drugs to the professional setting rather than the hospital. In 2023, 71.0% of Part-B spending was in the non-hospital setting (that is drugs were billed as professional rather than facility claims), compared to 59.7% for the nation as a whole, which effectively reversed the site of care shares that existed prior to global budgets in 2013 (see Figure 1). Staff estimate that the Part B place of service changes generated Medicare run rate savings of ~$180 million dollars since 2013 under the Total Cost of Care Model (TCOC Model)[6].

[5] In 2024, HSCRC provided a separate inflation factor for academic hospitals due to differing inflation trends. This had not been done previously

[6] *CDS-A Drugs are billed under Medicare Part B and therefore are part of the model savings test. See July 2025 TCOC workgroup materials for further information on model savings. (https://hscrc.maryland.gov/Pages/hscrc-tcoc.aspx)*

Figure 1: Maryland Model Impact on Part B Drugs



Issues with current funding approach

Both the inflation and the volume lever cause challenges for providing accurate funding. While the current approach does vary based on volume, the combination of prospective inflation and 50% volume funding do not reliably match the actual hospital experience. Even if funding is accurate at the statewide level, variation in cost and volume at the hospital level will result in over/underfunding for individual hospitals. Hospitals facing the highest cost pressures are the most likely to be underfunded.

The prospective inflation factor is unlikely to be accurate given the rapidly changing nature of the CDS-A drug market and the two-year data lag. This volatility in the market creates a funding stream at the statewide level that lags the actual needs of hospitals, causing overfunding in times of slow drug cost growth, and under funding in times of high drug cost growth.

Additionally, changes in drug mix receive overlapping funding, as they are considered in both the volume and inflation adjustments. The complexity of this two-track funding policy creates confusion and results in suboptimal decision making, and shifting to a one-track approach would give stakeholders a clearer understanding of the funding approach.

Case for Changes to Cost Reimbursement

Staff believe that now is an appropriate time to change this policy. Currently, hospitals are appropriately funded for CDS-A drugs through FY2023, which means that this policy can be modified without requiring adjustment to current funding levels. The current two-tiered structure makes it difficult to project how these two funding streams will interact in any given situation. This complexity makes it difficult for the HSCRC to administer, hospitals to operationalize, and also risks creating confusion at hospitals about how drug costs will be reimbursed which could adversely impact appropriate adoption of new drugs. Additionally, there are indications that cost growth is shifting primarily towards a small volume of high-cost drugs administered at select hospitals, which the current approach is poorly equipped to handle.

The CDS-A approach is already a volume variable component in GBRs as scored under the TCOC Model[7]. Therefore, making changes to it does not impact that test. However, the current policy has been effective in generating total cost of care savings, which HSCRC should strive to maintain under any proposed policy change.

Staff Recommendation

To simplify the CDS-A policy, HSCRC Staff propose to make it more directly volume variable. This policy will consist of the following components:

[7] Under the TCOC Model Maryland is required to "ensure that 95 percent of all 17 Regulated Revenue for Maryland residents is paid according to a Population-Based Payment methodology". The CDS-A drug funding policy does not meet this standard and is therefore scored against the 5% exception under this provision. It accounts for approximately 2% of total charges.

1. Continue to identify high-cost drugs for volume-based funding based on criteria set by Staff in consultation with industry stakeholders (see Appendix A for current criteria)
2. Continue to conduct an audit of reported volumes to ensure volume-based reimbursement is fairly stated
3. Change volume funding to 100% of measured cost change, per the annual audit, effective 1/1 each year.
4. Implement two provisional adjustments for each year, one on March 1st and one on July 1st, to smooth the impact of the increased adjustment size:
    a. The March 1st adjustment will be voluntary and based on a projection of current year spending prepared by the hospital. To be eligible for this funding adjustment the projection must show a cost increase above a minimum threshold established by staff and be subject to staff review and approval.
    b. The July 1st adjustment will be automatic and based on the first 6 months of data from the prior fiscal year. The adjustment will be directly calculated by staff using Casemix data, excluding drugs with outlier dosage counts. No manual adjustments will be made to this adjustment. The impact of any adjustment made in the prior March 1st adjustment will be deducted.
    c. Provisional adjustments will be temporary only, final adjustment derived from the audit will supersede the provisional adjustment and all amounts will be trued up to the final audit.
5. Set the drug component of inflation in the update factor to only reflect any price inflation not captured during the volume adjustment;[8] inflation on drugs will primarily be provided through the volume adjustment
6. Implement a new annual report, produced by a consultant, to identify hospital effectiveness in managing CDS-A drugs and assess penalties of 20% of

[8] If the price of a drug changes and there is no volume change, the volume adjustment will not capture that inflation; therefore, a small allowance is needed in the Update Factor for this impact.

relevant CDS-A drug costs, to hospitals that are not meeting target goals. Prior to the implementation of any penalties a revised version of this policy will be developed, with stakeholder input, that specifies in greater detail the approach for any penalties assessed. Further details are outlined below.

7. Hospitals will continue to be expected to "tier" charges for drugs. Staff will periodically evaluate hospital tiering of drug prices to ensure high-cost drugs are not being loaded with proportionate overhead, resulting in unfair costs to consumers.
8. Continue to audit data reported in Casemix to validate amounts reported and gather appropriate ASP and 340B price data.

Staff recommend implementing the revised policy retrospectively for FY2024, effective 1/1/2025. As volume adjustments under this policy were always implemented retrospectively, HSCRC Staff believe it is appropriate to implement in FY25 for FY24. Policy timelines can be found in Appendix B.

New Reporting Requirements

In order to maintain incentives to appropriately control cost growth of CDS-A drugs under this new policy, HSCRC proposed additional reporting requirements via an annual report. 100% volume-based cost reimbursement does not provide the same incentives to manage costs effectively as the current policy. Therefore, the HSCRC will contract for an annual report to monitor the State's use of Part B drugs both in terms of cost management and adoption of effective new drugs. If this report finds an erosion in the appropriateness of Maryland spend, GBR reductions equal to 20% of relevant CDS-A drug costs will be assessed on a statewide, regional, or hospital basis, depending on the extent of the concern. However, prior to the implementation of any penalties a revised version of this policy will be developed, with stakeholder input, that specifies in greater detail the approach for any penalties assessed. This annual report would become the basis for these and any future policy changes.

The annual report will be compiled by a consultant with a background in Pharmaeconomics and other relevant topics. HSCRC has enlisted the Prescription Drug Affordability Board (PDAB) to aid us by managing this report. The report will focus on the following factors regarding high-cost drugs:

- Place of service use rates
- Generic and biosimilar use rates
- Adoption rate of new drugs
- Acquisition pricing

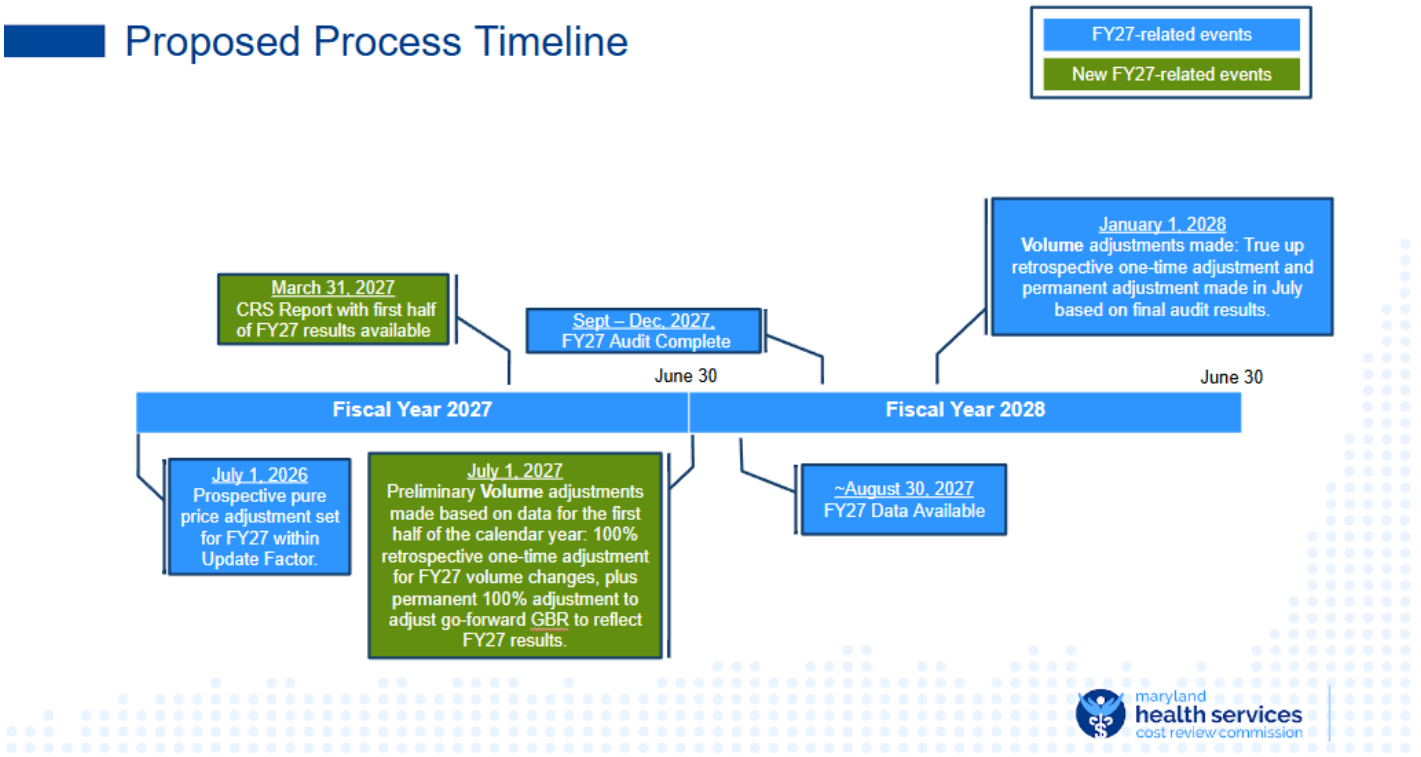
This report will allow the HSCRC to effectively evaluate whether the policy change is impacting the efficiency of high-cost drug utilization in Maryland and examine additional opportunities for improved utilization efficiency and effectiveness. In the new report, Staff will require NDCs to be collected as part of Casemix data. HSCRC expects that the first report will be released in late CY2025 based on FY25 data to assess the baseline metrics and initial impacts of this policy change. The report would be released annually thereafter.

Appendix A: Criteria for Drugs to be Treated under CDS-A Policy

The state-wide list is composed of Billed High-Cost Physician-Administered Outpatient Infusion, Chemotherapy, & Biological Oncology Drugs meeting all the following criteria:

- 3M's EAPG Class Code of VII or higher in either of the past two fiscal years (to reference relatively high cost per patient visit), and
- State-wide case-mix charges in either of the past two fiscal years of $2 million or greater (to reference relatively high-cost utilization), and
- Market share by point of service of less than 90% at physicians' offices (to minimize inclusion of drugs best served outside of a hospital setting), and
- An Ambulatory Payment Classification - OPPS Payment Status Indicator of G or K, Paid under OPPS/Separate APC payment (to preclude drugs packaged under other charge codes), and
- Inclusion of alternate codes for same listed drug (so to capture brand, generic, biologic, biosimilar, replacement, discontinued and temporary codes)

Appendix B: Policy Timeline



Note: Graphic does not reflect March 1st voluntary adjustment.

MedStar Health

8094 Sandpiper Circle
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Nottingham, MD 21236

MedStarHealth.org

November 27, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Executive Director Kromm,

On behalf of MedStar Health System (MedStar) and its seven Maryland hospitals, I write in support of the proposed changes to the Health Services Cost Review Commission (HSCRC)'s high-cost drug funding policy, known as CDS-A, presented during the November 13, 2024 HSCRC public session. HSCRC staff's recommendation to change the CDS-A policy to provide 100% cost reimbursement for the direct cost of the drugs covered under it eliminates some of the complexity associated with funding hospitals for these high-cost but critical drugs and is a prudent action to take as Maryland prepares for the start of the AHEAD model in 2026.

While overall supportive of HSCRC staff's recommendation, MedStar does however have concerns regarding the proposed annual report to monitor the State's use of Medicare Part B drugs. As described in the staff's recommendation, this report is intended to highlight any erosion in the efficiency of Maryland spending compared to 2023 levels. HSCRC staff is proposing to use this report to reduce hospital GBRs by up to 20% of CDS-A spending if there is a determination that erosion has occurred, and additionally, use the report for future policy changes. While MedStar agrees that changing the CDS-A policy to fund 100% of drug cost does not maintain the same incentives for hospitals to manage costs effectively, we are concerned about the vague definition of 'efficiency' as it relates to the utilization of these drugs. Given the magnitude of a 20% GBR adjustment for hospital revenue, MedStar suggests that HSCRC staff more clearly define how efficiency will be measured and who they intend to contract with to ensure the report is completed by an organization with the appropriate expertise. Additionally, the requirement that NDCs be collected as part of hospital case mix data will require hospitals and health systems to devote a significant amount of time to revising data submission systems and processes. While we understand the importance of collecting this data, MedStar encourages staff to establish deadlines for this requirement that are in line with the effort required.

MedStar looks forward to the final Staff Recommendation at the December 2024 Commission meeting. If you would like to discuss this matter further or have any questions, please do not hesitate to contact me.

Sincerely,

Mike Wood
Vice President, Revenue Management & Reimbursement
MedStar Health

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi

Maryland
Hospital Association

Dec. 6, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm,

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am writing to comment on the Health Services Cost Review Commission (HSCRC) draft recommendation to shift the current CDS-A drug funding policy to a 100% volume-based funding model.

MHA supports the proposed policy change, which aims to more accurately reflect actual acquisition costs for high-cost drugs. We support the proposed alternative option that would allow hospitals to access an interim update in the current fiscal year, on March 1, based on projected spending. This approach supports financial stability by aligning cost increases with the corresponding revenue within the same fiscal year. HSCRC should consider whether a percentage-based threshold, rather than a dollar amount threshold, would be more appropriate for determining access to an earlier interim update for smaller hospitals.

Before finalizing the policy, MHA asks that HSCRC address the following proposed policy elements to ensure it is effective and implementable.

- **Penalties for Not Meeting Target Goals**. Clarification is needed regarding the drug cost target goals and assessment of penalties if hospitals do not meet the target based on findings in a new annual report. The proposal suggests that an erosion in the efficiency of Maryland spending from 2023 levels would be the basis for assessing a penalty. Under the proposal, global budget revenue (GBR) reductions "equal to 20% of CDS-A spending" would be assessed on a statewide, regional, or hospital basis. The proposal also states that penalties would be assessed to hospitals not meeting target goals "up to 20% of drug cost." As proposed, there is uncertainty about whether the penalty would be calculated as up to 20% of the specific drug cost that is off target or as a reduction in the GBR equal to 20% of all CDS-A spending. Additionally, we request more details on how these penalties will be assessed, including whether they will apply to specific drugs or drug classes and how they will be allocated at the statewide, regional, or hospital level, and urge the HSCRC to outline the specific metrics and criteria a consultant will use to evaluate utilization efficiency under the new reporting requirement for CDS-A drugs.

- **Drug Charge Tiering Oversight.** During the November HSCRC public meeting, the need for drug tiering oversight was discussed. We ask for clarification on the

requirements for tiering drug overhead costs and how tiering expectations will align with current drug charges and cost requirements. Tiering requirements must be clear before implementing any evaluation or other oversight measure.

- **Proactive Drug Review.** A suggestion was made to implement a proactive drug review process to assess the clinical efficacy and value of high-cost drugs before approving them for funding under the policy for CDS-A drugs during the November HSCRC meeting. Hospitals are in the best position to perform this type of evaluation through pharmacy and therapeutics committees and other processes already in place to ensure high-value drugs.

- **Operational Considerations.** MHA encourages HSCRC to consider practical operational implications to ensure smooth implementation of this policy. Specifically, we request clarification on how rate center adjustments will be made under the new policy.

In conclusion, we support the transition to a 100% volume-based funding approach for CDS-A drugs. We look forward to working with HSCRC to ensure that the policy appropriately funds and provides access to high-cost drugs in a manner that can be easily operationalized.

We appreciate the opportunity to provide feedback on this important matter. Should you have any questions, please feel free to reach out to me.

Sincerely,

Patrick D. Carlson

Patrick D. Carlson
Vice President, Health Care Payment

cc: Dr. Laura Herrera-Scott, Secretary, Maryland Department of Health
Dr. Joshua Sharfstein, Chair
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi

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JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

December 9, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm,

Thank you for the opportunity for Johns Hopkins Health System (JHHS) to provide comments to the Health Services Cost Review Commission (HSCRC) on the Draft Recommendation for Proposed Revisions to the Outpatient High-Cost Drug Funding Policy.

JHHS appreciates the HSCRC's willingness to continue to review and better align polices under the current model as the industry evolves and innovates. We are generally very supportive of the staff recommendation, specifically:

- We support 100% funding for high-cost drugs, especially as the cost of many of these drugs continues to increase. It is important that hospitals receive adequate funding for these lifesaving drugs.

- We support a provisional adjustment period but believe funding should flow into hospital rates in the year that the increase in expense is occurring. Many high-cost drugs are increasingly used to treat various conditions, and some are now curative for patients who previously would have suffered from chronic conditions, in turn significantly increasing the expense of delivering these treatments. Given this expense increase, we strongly believe that it is important for the revenues to match expenses in the same fiscal period.

- We are also supportive of implementing this change with the 1/1/25 rate order as this is consistent with the way the policy is currently applied.

The recommendation also lays out new reporting requirements and possible associated penalties. We believe that more information is required to ensure hospitals fully understand these new requirements and assure that they are reasonably aligned with good patient care as well as the

intent of the model. We are also concerned about the intent of the penalties being considered since we are talking about only covering the actual cost of the drug.

JHHS appreciates the opportunity to comment on the Outpatient High-Cost Drug Funding Policy. We look forward to working with staff to continue to review polices to better align them under the current system.

Sincerely,

Ed Beranek

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

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi
William Henderson

TidalHealth™

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December 9, 2024

Jon Kromm, PhD
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215 re

Dear Dr. Kromm,

We are writing to submit several comments on the recommended changes to the CDS-A Drug Funding Policy. We are in support of enhanced funding for high-cost drugs shifting from 50% to 100% volume-based funding with the following considerations:

(1) Making sure that future update factors still appropriately fund all hospitals pharmacy inflation by making sure certain hospitals are not penalized by redirecting funding to only high-cost drugs with volume changes. This could be done by providing the higher of drug inflation or the CDS-A formula.

(2) We do believe and agree that monitoring growth in funding will be important as to ensure that the new policy addresses inadequate level of drug funding but does not have other unintended consequences. We do not agree that a penalty should be put in place without clarity on what specifically would drive a penalty application.

(3) While this policy is being refined and other policies are being reviewed to provide enhanced funding for areas that drive significant cost growth (i.e. capital and volume), we continue to support and champion the need for a GME Policy for Rural Communities as it will be a significant cost pr4ssure but is needed to provide the gaps in physician coverage. The AHEAD Model reduces the amount of dollars required under the Global Budget and consideration/funding outside of the GBR should be given to address unique issues facing rural communities that cause access barriers and equitable care.

We appreciate the opportunity to submit our comments.

Sincerely,

Kathy Talbot

Kathy Talbot
Associate Vice President of Finance

Cc:
Joshua Sharfstein, Chair HSCRC
Dr. James Elliott, Commissioner
Richardo Johnson, Commissioner
Dr. Maulik Joshi, Commissioner
Adam Kane, Commissioner
Nicki McCann, Commissioner
Dr. Farzaneh Sabi, Commissioner
William Henderson

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CORPORATE OFFICE

December 9, 2024

Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: UMMS Comment Letter Regarding Proposed Revisions to Outpatient High-Cost Drug Funding Policy

Dear Jon:

On behalf of the University of Maryland Medical System (UMMS) and its member hospitals, we are writing today in response to the Commission's Proposed Revisions to Outpatient High-Cost Drug Funding Policy. UMMS supports the Commission's proposal to fully fund the expense associated with high-cost outpatient drugs. As an industry, we are seeing an acceleration in the development and use of high-cost drugs, biologics and cell therapies and the commission's proposal provides much needed funding to support the delivery of new technology and advanced care to the citizens of Maryland. While we are generally supportive of the proposed funding approach, we would also like to address some areas of concern in the policy as written.

FY 2024 Implementation

Given the rising costs of emerging high-cost drugs and biologics, UMMS supports implementing changes to the CDS-A policy in a timely manner. The Commission should give consideration to hospitals who are negatively impacted by the change in methodology and ensure that any negative adjustments for FY 2024 do not underfund growing expenses that hospitals may be experiencing in FY 2025.

Timing of Mid-Year Adjustments

UMMS supports the continuation of a July 1 mid-year CDS-A funding adjustment with an additional provision that additional funding may be given in March should a hospital's actual experience exceed a certain threshold. We agree with MHA that this threshold should be set as a percentage of cost rather than a specific dollar amount. This is especially important as the average cost and number of new biologics and cell therapies coming into the market are on the rise, causing significant strains on hospital margins.

Part B Drug Use Monitoring

UMMS has concerns regarding the application of penalties on hospitals for shifts in the site of service for infusions. The Commission should vet new policies or methodologies which have implications on hospital revenue with the industry prior to putting the policy forward for approval. Hospitals were not afforded the

opportunity to comment on this new addition and are uncomfortable supporting this undefined portion of the CDS-A drug funding policy without industry vetting of the methodology.

Drug Pricing

Given the concerns raised related to markups on high-cost drugs, UMMS suggests the Commission convene an industry workgroup to develop a more reasonable and consistent approach to establishing overhead amounts for supplies and drugs. Disproportionate overhead amounts contribute to the higher markups required to maintain unit rate compliance.

We appreciate the opportunity to provide feedback on the Proposed Revisions to Outpatient High-Cost Drug Funding Policy. Please let us know if you have any additional questions.

Sincerely,

Alicia Cunningham
SVP, Reimbursement & Revenue Advisory Services
University of Maryland Medical System

cc: Joshua Sharfstein, MD Chairman
James Elliott, MD, Vice Chairman
Adam Kane
Maulik Joshi, DrPH
Ricardo R. Johnson
Nicki McCann, JD
Farzaneh (Fazi) Sabi, MD
William Henderson, Principal Deputy Director

maryland
health services
cost review commission

Emergency Department and Hospital Throughput Best Practices Draft Policy

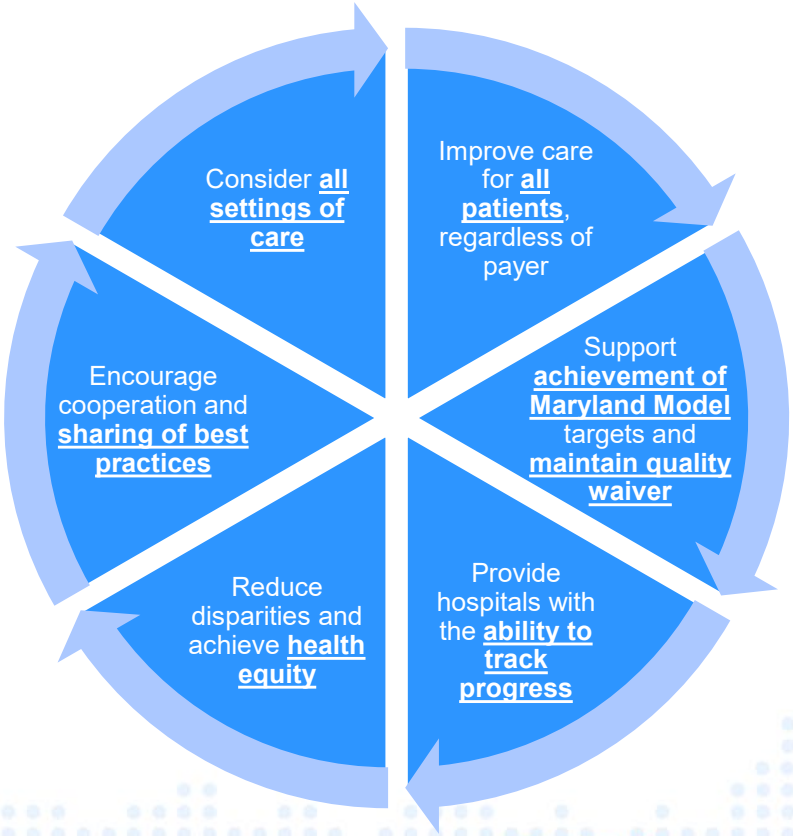
January 8, 2025

HSCRC Quality Program Goals

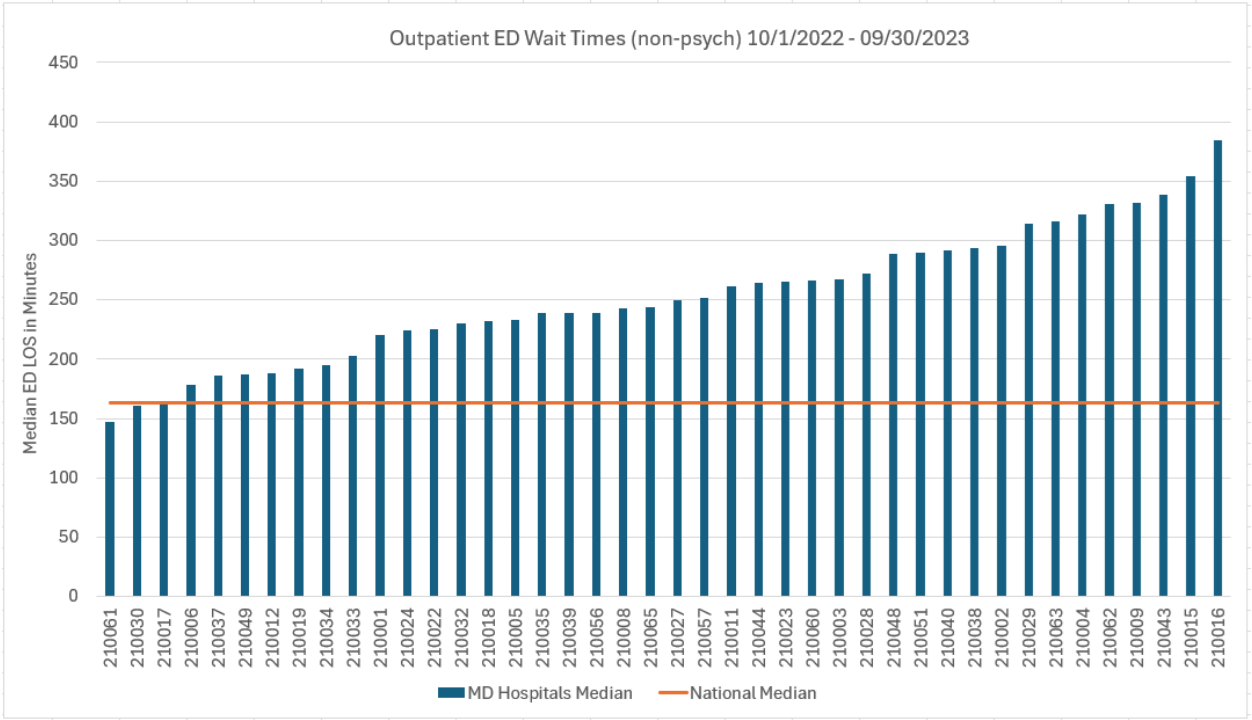
- **Implement standardized pay-for-performance programs** that reward or penalize hospitals based on patient outcomes;
- Utilize **a broad set of quality measures** that appropriately reflects the delivery of quality health care services provided at Maryland hospitals;
- **Provide timely and accurate year-to-date reports** on quality performance using hospital case-mix data and other data sources;
- Align the incentives for enhancing health care quality in the hospital setting with **broader State health initiatives**.

HSCRC Quality Program Guiding Principles

- The mission of the HSCRC Quality Program is to create all-payer financial incentives for Maryland hospitals to provide efficient, high quality patient care, and to support delivery system improvements across the State.



Why Focus on Emergency Department Length of Stay?



maryland health services cost review commission

ED Best Practices Incentive Policy Development

Commission leadership directive: Identify 3-5 best practice measures that will constitute a +/- 1% revenue at risk program for CY 2025 performance.

Policy Goal:

- Develop structural or process measures that will address systematically longer ED length of stay (LOS) in the State.
- Promote adoption of hospital best practices by providing GBR financial incentives.
- Align hospital initiatives with the goals of the ED Wait Time Reduction Commission.

Steps

1. **Finalize a set of hospital best practices and tiers to improve overall hospital throughput and reduce ED length of stay**
2. **Develop data collection and auditing**

RY 2027/CY 2025

3. **Implement statewide monitoring reports**
4. Propose RY 2028 policy with revenue at-risk and scaled financial incentives

The Donabedian Model for Quality of Care

Types of Best Practices

ED-Hospital Best Practices Policy

QBR Policy

10% on IP ED LOS

Draft Recommendations For RY 2027 (CY 2025 Performance Period)

Final Policy
February 2025

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    - For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice.

2. Require hospitals to select two Best Practices to implement and report data on for RY 2027.
    - Failure to implement and report data to the Commission by October 2025 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2026.

3. We propose that subsequent rate years will have 0.25 percent inpatient hospital revenue at risk tied to performance on these best practice metrics but intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

Final Six Best Practices Selected

Each hospital will select 2 interventions from the 6 interventions below:

- Interdisciplinary Rounds
- Bed capacity Alert Process
- Standard Daily/Shift Huddles
- Expedited Care Bucket (inclusive of expediting team, rapid medical evaluation team, rapid medical evaluation unit and patient observation management)
- Patient Flow Throughput PI Council
- Establishing Clinical Pathways

Examples of Best Practice Measures and Tiers

Best Practice	Measures (EXAMPLE ONLY--Still in development)	Points (0-10 scale)
Interdisciplinary Rounds	**Tier 1**: Interdisciplinary Rounds piloted with a target of x% on at least 1 unit **Tier 2:** Interdisciplinary Rounds implemented on X additional units AND documentation of discharge planning initiated Day 1 **Tier 3**: Leadership involvement in Interdisciplinary Rounds OR Documentation of prior auth for post-acute placement by x timeframe; specialist consults completed within 24 hours of order, etc.	**Tier 1** earns 0-2 points **Tier 2** earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) **Tier 3** earns up to 4 additional points
Bed Capacity Alert System	**Tier 1:** Bed capacity Alert triggered at a certain surge level, alert goes to all inpatient and outpatient areas And triggers mandatory leadership huddles **Tier 2:** Bed capacity alert includes non-hospital partners (outpatient providers, local post-acute facilities) **Tier 3:** Leverage Access centers and CRISP to facilitate most appropriate patient placement; potentially partner with MIEMSS long-term	**Tier 1** earns 0-2 points **Tier 2** earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) **Tier 3** earns up to 4 additional points
Standardized Daily/Shift Huddles	**TBD—**tier development and metrics in process, initial discussions focused on integrating ED census, wait time etc. into huddles, as well as linkage to interdisciplinary rounds	**Tier 1** earns 0-2 points **Tier 2** earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) **Tier 3** earns up to 4 additional points

Examples of Best Practice Measures and Tiers

Expedited Care Intervention (Expediting team, expedited care unit)	**Proposal 1: select one or more of multiple expediting practices** **Nurse expediter** **Tier 1:** Designated RN for admission/discharge planning/coordination **Tier 2:** Tier 1 & x% decrease in discharge order to discharge time for D/C to Home pts **Tier 3:** Tier 1 & 2 plus (x+5% decrease in discharge order time for D/C to Home **Discharge Lounge** **Tier 1:** Designated clinical space & staff to discharge patients from a Discharge lounge **Tier 2:** Tier 1 & (x%) decrease to discharge order to discharge time **Tier 3:** Tier 1, 2 & (x+5%) decrease in discharge order to discharge time **Observation Unit** **Tier 1:** Dedicated clinical space and staffing for short stay patients **Tier 2**: Tier 1 & Decrease in Total Obs (ED Obs & Hospital Obs) LOS **Tier 3:** Tier 1 & 2 & (x+5%) Decrease in Total Obs LOS **Proposal 2: Develop/ implement processes & specific metrics, mandatory sharing across hospitals and reporting to HSCRC; define targets over CY25 in order to prevent unintended consequences**	**Tier 1** earns 0-2 points **Tier 2** earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) **Tier 3** earns up to 4 additional points
Patient Flow Throughput Performance Council	**Tier 1**: Established Patient Flow Throughput Performance Council with front-line and leadership representation, meets at least monthly **Tier 2:** Council tracks and implements specific interventions targeted at decreasing inpatient LOS **Tier 3:** Leadership has strategic goals for each department tied to patient flow throughput	**Tier 1** earns 0-2 points **Tier 2** earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) **Tier 3** earns up to 4 additional points
Clinical Pathways/Observation Management	**TBD: currently focused on evidence-based pathways that facilitate care across the continuum with overarching goal of enhancing and expediting care** **Example**: Chest pain protocol that leverages nurse driven protocol and/or expedited evaluation in an outpatient setting if clinically appropriate & expedited protocol for inpatients.	**Tier 1** earns 0-2 points **Tier 2** earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points)

Benefits of Best Practices Proposal

- Increased focus on ED & Hospital Throughput
- Significant collaboration within and across hospitals
- Foundation for Quality Improvement Partnership

Next Steps

- Continue development of measure definition, tiers, and targets with hospital groups
- Comment period through 1/17
- Final policy presented to HSCRC Commission on 2/12

Recap: Draft Recommendations For RY 2027 (CY 2025 Performance Period)

Final Policy
February 2025

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    - For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice.

2. Require hospitals to select two Best Practices to implement and report data on for RY 2027.
    - Failure to implement and report data to the Commission by October 2025 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2026.

3. We propose that subsequent rate years will have 0.25 percent inpatient hospital revenue at risk tied to performance on these best practice metrics but intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

maryland
health services
cost review commission

Draft Recommendations on Hospital Best Practice Policy for Rate Year 2027

January 8, 2025

This document contains the staff draft recommendations for RY 2027. Comments are due by noon 1/17/2025 and may be submitted to hscrc.quality@maryland.gov.

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

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List of Abbreviations

AHEAD	State's Advancing All-Payer Health Equity Approaches and Development Model
APR DRG	All Patient Refined Diagnosis Related Group
CDC	Centers for Disease Control & Prevention
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis-Related Group
eCQM	Electronic Clinical Quality Measure
ED	Emergency Department
ED-1 Measure	Emergency Department Arrival to Departure for Admitted Patients
ED-2 Measure	Time of Order to Admit until Time of Admission for ED Patients
EDDIE	Emergency Department Dramatic Improvement Effort
FFY	Federal Fiscal Year
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HSCRC	Health Services Cost Review Commission
LOS	Length of Stay
MIEMSS	Maryland Institute for Emergency Medical Services Systems
NHSN	National Health Safety Network
PQI	Prevention Quality Indicators
QBR	Quality-Based Reimbursement
RY	Maryland HSCRC Rate Year (Coincides with State Fiscal Year (SFY) July-Jun; signifies the timeframe in which the rewards and/or penalties would be assessed)
VBP	Value-Based Purchasing

POLICY OVERVIEW

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/ Consumers	Effect on Health Equity
The quality programs operated by the Health Services Cost Review Commission, including the Best Practices policy, are intended to promote quality improvement and ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model and subsequent AHEAD model (Maryland Model), do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Maryland Model while guarding against unintended consequences and penalizing poor performance. The objective of implementing a Hospital Best Practice Policy is to track and incentivize hospitals to implement and strengthen operational structures and processes, which are designed to provide high quality, evidence-based care to all patients, at all times.	The Best Practice policy is a newly proposed pay-for-performance quality initiative that provides incentives for hospitals to improve and maintain high-quality patient care and value within a global budget framework. For Year 1, RY 2027, we propose to focus on best practices related to hospital throughput, that should ultimately reduce ED LOS. Specifically, during Year 1, HSCRC staff will collaborate with hospitals to finalize the best practices and tiers, develop infrastructure for data collection, and disseminate statewide monitoring reports to track performance. Hospitals will be expected to participate in the implementation of best practices and submission of data for tracking by an agreed upon deadline to avoid an "accountability" penalty of 0.1 percent of all-payer, Inpatient revenue. This penalty will be applicable to any hospital that does not implement and report on the selected best practices. This approach will allow sufficient time to establish workflows, report development, and validate data collection mechanisms. This Best Practice policy will initially focus on ED-Hospital Throughput Best Practices but is written with the intention of developing and standardizing best practices for various clinical processes and operations as appropriate.	For program Year 1, RY 27, hospitals will be required to implement or strengthen best practices designed to improve patient care and throughput and report data to the HSCRC to track intensity and fidelity to the best practices. For Year 1, there is no revenue at risk associated with performance. There will be an accountability penalty for not reporting on best practice measures. This penalty will be 0.1% of all-payer, inpatient revenue, to be assessed in the January 2026 rate update. We will follow our extraordinary circumstances exception policy to address any unforeseen events (i.e. cyberattack, natural disaster, etc.). For program Year 2, RY 28, we recommend 0.25% inpatient revenue at risk associated with performance on designated best practice measures. This will be reassessed at the end of Year 1 after evaluating the impact of the best practices	This policy ensures that the quality of care provided to consumers is evidence-based and patient-centered. by incentivizing specific types of best practices to address areas of concern. Hospitals that do not participate in implementation and data tracking of best practices, will be penalized through their Global budget. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.	There is currently not a health equity measure in the Best Practice policy, but we can stratify data collected to evaluate for health disparities. Health equity incentives could be integrated in a subsequent rate year. Standardization of Best Practices across all patients should better ensure that all patients receive the same evidence-based interventions. By focusing on structures and processes, this program will allow all hospitals the potential to earn rewards regardless of the types of patients served or other barriers that hospitals may face that may also impact outcomes such as ED LOS. Going forward, HSCRC staff will continue to analyze disparities and propose incentives for reducing them in the program.

Draft Recommendations

This document puts forth for consideration the RY 2027 (CY 2025 performance period) draft policy recommendations on hospital best practices:

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    a. For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2027.
    a. Failure to implement and report data to the Commission by October 2025 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2026.
3. We propose that subsequent rate years will have 0.25 percent inpatient hospital revenue at risk tied to performance on these best practice metrics but intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

INTRODUCTION

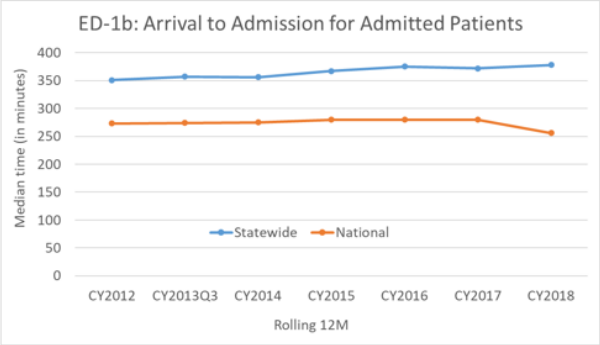
Maryland hospitals are funded under a population-based revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under the All-Payer Model agreement with the Centers for Medicare & Medicaid Services (CMS) beginning in 2014, and continuing under the current Total Cost of Care (TCOC) Model agreement, which took effect in 2019 and will transition to the AHEAD Model in 2026. Under the global budget system, hospitals are incentivized to shift services to the most appropriate care setting and simultaneously have revenue at risk under Maryland's unique, all-payer, pay-for-performance quality programs; this allows hospitals to keep any savings they earn via better patient experiences, reduced hospital-acquired infections, improved emergency department length of stay, or other improvements in care. Maryland systematically revises its quality and value-based payment programs to better achieve the state's overarching goals: more efficient, higher quality care, and improved population health. It is important that the Commission ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Commission's quality programs reward quality improvements and achievements that reinforce the incentives of the global budget system, while guarding against unintended consequences and penalizing poor performance.

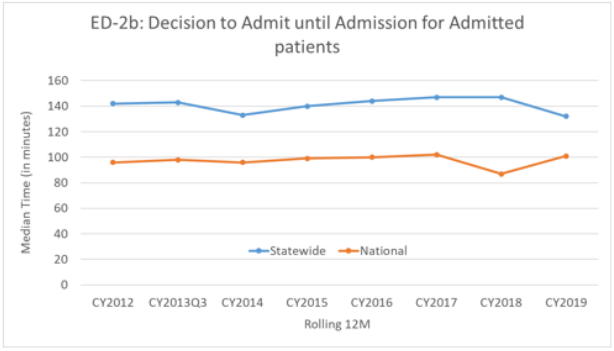
The Hospital Best Practice Policy is a new program that is being proposed for Commissioner consideration. The Best Practice Policy would be one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time. However, unlike other quality policies that primarily focus on outcomes of care, the Best Practice policy would specifically provide incentives tied to the structure and process of care delivery in Maryland hospitals. During this initial year, the policy will incentivize hospitals to improve upon ED and hospital throughput to address the long ED LOS experienced by patients in Maryland. Specifically, the commission will refine a set of up to six best practices for RY 2027 and require hospitals to select and report data on two best practices by the latter part of CY 2025. If data is not submitted by hospitals in Year 1, an accountability penalty will be implemented. After the initial year focused on development, implementation and reporting, the program will have a designated percentage of inpatient hospital revenue at-risk based on performance on best practice measures. In addition to this Best Practice policy, the RY 2027 Quality-Based Reimbursement Policy, which was approved at the December 2024 Commission meeting, has a financial incentive tied ED LOS. The ED-Hospital Throughput best practice measures are process and structural measures aligned to support the outcome measure, ED LOS, in the QBR program.

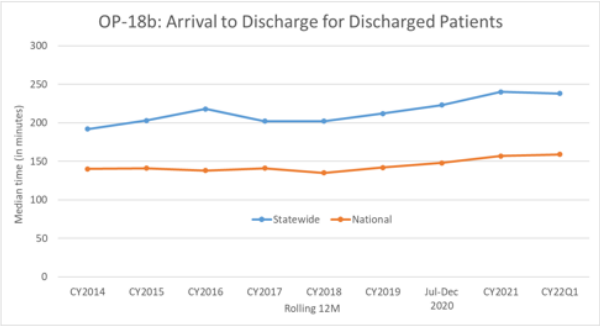
BACKGROUND

ED length of stay (LOS)--i.e., wait times–has been a significant concern in Maryland, predating Maryland's adoption of hospital global budgets instituted in 2014,[1] with multiple underlying causes and potential negative impacts (e.g., poorer patient experience, quality, care outcomes). Thus, the Commission approved the addition of an ED wait time or length of stay (LOS) measure in the RY 2026 QBR program and voted to continue its inclusion in RY 2027. Previously published and available data on CMS Care Compare reveals Maryland's poor performance compared to the Nation on both inpatient and outpatient ED measures (i.e., higher wait times for both those admitted to the inpatient hospital and those discharged home), as shown in Figure 1.

Figure 1. Emergency Department Performance on CMS ED Wait Time Measures





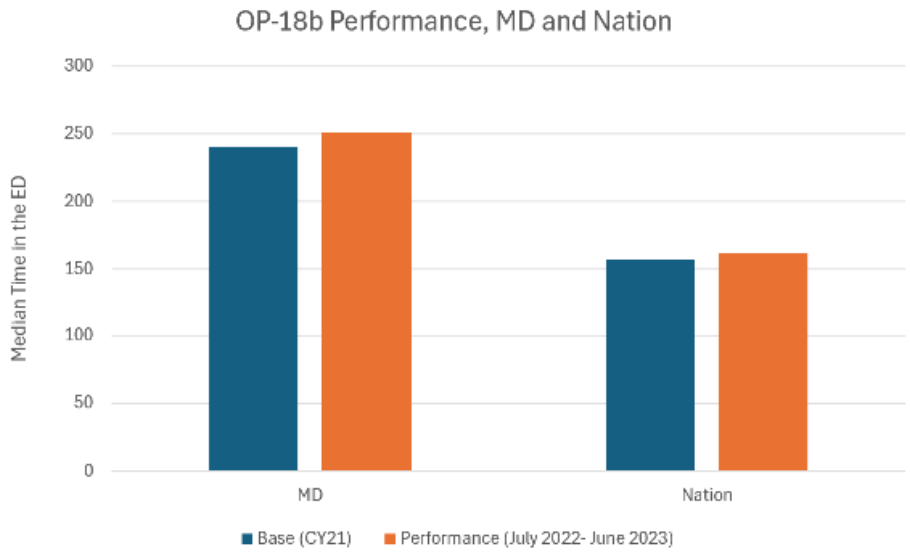


Measure ID	Measure Definition
ED-1	Median time from ED arrival to departure for admitted patients
ED-2	Median admit decision time to ED departure time for admitted patients
OP-18	Median time of ED arrival to departure for discharged patients

As illustrated in Figure 2 below, based on the most current data available, the OP-18b wait time for discharged patients has increased slightly for both Maryland and the Nation from the base to the performance year, and Maryland wait times continue to be significantly above those of the Nation for both the base and performance years.

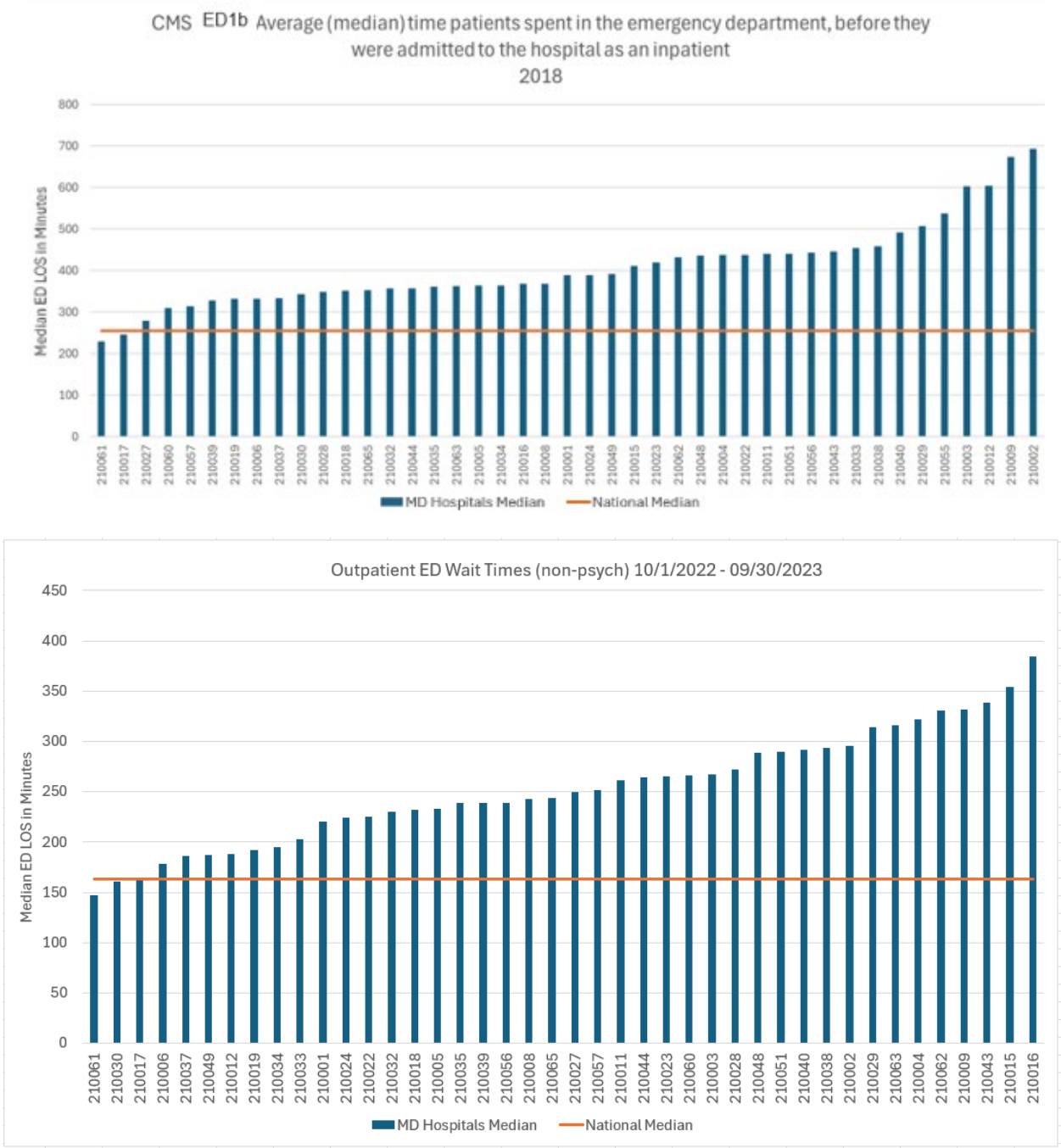
[1] Under alternative payment models, such as hospital global budgets or other hospital capitated models, some stakeholders have voiced concerns that there may be an incentive to reduce resources that lead to ED-hospital throughput issues.

Figure 2. Maryland and National Performance on ED Wait Times for Discharged Patients



Furthermore, all but a couple of hospitals in Maryland perform worse than the national average. Figure 3, shows the ED length of stay for non-psychiatric patients who are admitted (ED1b) for 2018 (last year this was reported) and for those who are discharged home (OP-18b) using the most recently available data.

Figure 3. Maryland by Hospital and National Performance on ED Wait Times



Based on these results, staff believes all hospitals in Maryland have an opportunity to improve ED LOS through incentives on Best Practices and the outcome. Furthermore, there has been increased public scrutiny on Maryland's ED Wait times, which have been consistently higher than all other states for the past decade. Several initiatives have been underway over the last two years to analyze Maryland's ED length of stay and promote improvement (e.g., MHA Legislative Taskforce, EDDIE). In the 2024 Maryland General Assembly Session, a new

ED Wait Time Reduction Commission was established. The ED Commission is co-chaired by the HSCRC Executive Director and staffed by the HSCRC. The ED Commission will work on hospital and wider access issues to improve hospital throughput and will develop a state goal for improvement in ED wait times. The development of Best Practices focused on ED-Hospital Throughput is one of the specific goals outlined by the ED Wait Time Reduction Commission. Appendix A provides additional background on initiatives that the HSCRC and hospitals have undertaken to address this issue.

POLICY DEVELOPMENT AND IMPLEMENTATION

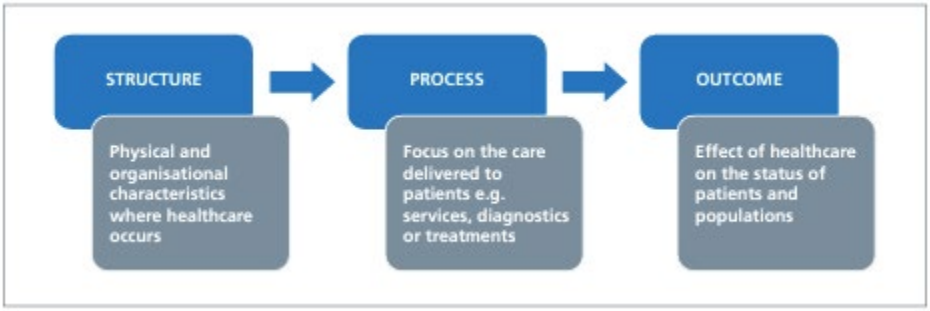
In this section, staff provides an overview of work done during CY 2024 to develop this Best Practice Policy. This includes discussion on why the Commission should develop incentives related to structure and process measures, description of stakeholder engagement, as well as an outline of the six best practices that have been selected and examples of tiers for assessing the intensity and fidelity to the best practices. The section concludes with next steps and draft recommendations for input.

Policy Origins

The Donabedian model of quality of care assesses three components as shown in Figure 4. While most current pay for performance incentives are focused on outcomes (i.e., mortality, complications, readmissions), structure and process measures are important to measure to understand how changes in quality actually occur and are still required for some areas by CMS (e.g., attestation measures for health equity). There are several additional reasons why incentivizing structure and process measures should be considered in the case of ED LOS improvement. First, given that the ED LOS data collection and measure development is still underway, staff are hesitant to put additional revenue at risk on the outcome measure at this time. Second, the changes that can occur within a hospital to impact ED LOS may not be sufficient to improve the State's rankings nationally by themselves. This is because ED and hospital throughput is impacted by access to outpatient primary care, specialty care, behavioral health, and post-acute care. Third, there may be ways to reduce ED LOS to earn an incentive that would not result in better care to patients and these unintended consequences could be avoided by providing incentives to focus hospitals on better care delivery through optimization of known best practices. Hospitals in the State have engaged willingly in this work thus far, and will be held accountable in RY 2027 if they do not submit data showing their commitment to this work. Thus, staff feels that the current revenue at-risk on the outcome through QBR is sufficient at this time, but that more can be done to improve the care received by patients through ensuring best practices such as the ones identified below, are implemented well for all patients, at all times. By developing tiers and measures to assess the intensity and fidelity to these best practices, the State has a unique opportunity to improve more than just ED LOS. Thus, staff believe a mix of incentives on

structure, process, and outcomes is appropriate and could be more impactful than simply adding more revenue to outcomes alone.

Figure 4. The Donabedian model for quality of care



Stakeholder Process and Selected Best Practices

Staff formed an ED Subgroup in February 2024 to develop the ED LOS measure and incentive methodology for the RY 2026 QBR policy. By the fall of 2024, staff transitioned this subgroup to work on the development of ED and Hospital Best Practices to improve throughput and reduce ED LOS. This was also aligned, as mentioned above, with the ED Wait Time Reduction Commission's legislative mandate to focus on the sharing of best practices. Since September 2024, there have been eight subgroup meetings to collect, discuss, and select the proposed best practices. Specifically, the subgroup vetted over thirty best practice suggestions and narrowed down the list to six and proposed that hospitals be expected to implement or improve upon two best practices during CY 2025. While there were several discussions on whether to select two best practices that all hospitals must uniformly implement, hospitals felt strongly that options were needed since certain types of best practices may be more or less effective in different settings; additionally, since hospitals were engaged in the selection of the best practice options, and will be engaged in developing and finalizing the measures and the tiers for each of the options, the staff felt that providing choices would best maintain collaboration and address the variation in hospital settings. However, the selection of the number of best practice options, requirements for implementation, and focus of the best practices can change over time as this policy evolves. Figure 1 provides an overview of the six best practices for ED-Hospital Throughput. In addition, examples of how the best practices could be measured and tiered (i.e., assessed on intensity and fidelity) are provided. The idea would be that in future years hospitals would earn points based on the measures and could earn more points for higher intensity or fidelity to the best practice, as opposed to an all or nothing incentive. ***All measures and tiers listed below are examples. As the subgroup continues to meet and finalize measure and tier development, the table will be updated. Final measures and tiers will be presented in the final policy recommendations.***

Figure 1. ED-Hospital Throughput Best Practices

Best Practice	Measures (EXAMPLE ONLY--Still in development)	Points (0-10 scale)
Interdisciplinary Rounds	• Tier 1: Interdisciplinary Rounds piloted with a target of x% on at least 1 unit • Tier 2; Interdisciplinary Rounds implemented on X additional units AND documentation of discharge planning initiated Day 1 • Tier 3: Leadership involvement in Interdisciplinary Rounds OR Documentation of prior auth for post-acute placement by x timeframe; specialist consults completed within 24 hours of order, etc.	• Tier 1 earns 0-2 points • Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) • Tier 3 earns up to 4 additional points
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Best Practice	Measures (EXAMPLE ONLY--Still in development)	Points (0-10 scale)
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Clinical Pathways/Observation Management	• TBD: currently focused on evidence-based pathways that facilitate care across the continuum with overarching goal of enhancing and expediting care • Example: Chest pain protocol that leverages nurse driven protocol and/or expedited evaluation in an outpatient setting if clinically appropriate, also expedited protocol for admitted patients.	• Tier 1 earns 0-2 points • Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) • Tier 3 earns up to 4 additional points

Staff had originally planned to propose additional revenue at risk for performance on best practices for CY 2025 but the work needed to refine the tiers and develop data collection is substantial. Furthermore, given concerns about the time it took to develop the ED LOS measure and incentive concurrent to its use, staff believe additional time is needed to do this well. In addition, stakeholder engagement has been exceptional during this process and should be commended by providing this additional time for hospitals to develop the data collection needed to measure the tiers. Staff recommends that RY 2027 be focused on refinement and implementation of best practice measures, workflow redesign, and report development and validation. Therefore, staff recommends that RY 2027 efforts be focused on development of the Best Practice tiers and data collection, but that no revenue be tied to performance on the best practice measures for RY2027. Specifically, staff have proposed a 0.1 percent all-payer, IP revenue, accountability penalty tied to best practice implementation and data submission, meaning a penalty would be assessed if a hospital did not report data by October 2025 for its two selected best practices. Staff intends to continue the refinement of the best practices and development of measures to define tiers, as well as address other feedback, between the draft and the final policy.

Draft Recommendations

This document puts forth for consideration the RY 2027 (CY 2025 performance period) draft policy recommendations on hospital best practices:

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).

    a. For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2027.
    a. Failure to implement and report data to the Commission by October 2025 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2026. We will follow our extraordinary circumstances exception policy to address any unforeseen events (i.e. cyberattack, natural disaster, etc.).
3. We propose that subsequent rate years will have 0.25 percent inpatient hospital revenue at risk tied to performance on these best practice metrics but intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

APPENDIX A: HSCRC EFFORTS TO ADDRESS ED LENGTH OF STAY

Concerns about unfavorable ED throughput data have been shared by many Maryland stakeholders, including the HSCRC, the MHCC, payers, consumers, emergency department and other physicians, hospitals, the Maryland Institute of Emergency Medical Services Systems, and the Maryland General Assembly, with around a dozen legislatively mandated reports on the topic since 1994, including the Maryland General Assembly Hospital Throughput Work Group Final Report in March 2024.

Historically, the HSCRC has taken several steps to address emergency department length of stay concerns. However, in the past few years, the COVID public health emergency and its effects on inflation and labor have had particularly significant negative impacts on hospitals and other care settings that patients may use after receiving hospital care (e.g., nursing homes), further exacerbating pressures on emergency departments.

Previously, the HSCRC included ED LOS measures in the QBR program for two years. In RY 2020 (CY 2018 measurement period), the QBR Program introduced the use of the two CMS inpatient ED wait time measures (chart abstracted measures: ED-1 and ED-2) as part of the QBR Person and Community Engagement (PCE) domain because of the high correlation between ED wait times and HCAHPS performance (also in the PCE domain and on which the state also performs poorly). CMS retired ED-1 after CY 2018 and ED-2 after CY 2019 necessitating both measures' removal from the QBR program after only two years. Overall, ED LOS improved (i.e., ED LOS time went down) for more than half the hospitals when the measures were in QBR, although some of the improvements were minimal. With the retirement of the chart-abstracted ED LOS measures, the HSCRC continued to work to find a way to collect the data and include the results in QBR.

More recently, staff collaborated with CRISP and their contractor to collect the electronic Clinical Quality Measure (eCQM) ED-2 (Order of admission to admit time) for CYs 2022-2023. However, analyses of the ED-2 eCQM found that there are a significant number of hospitalizations (>50,000 statewide) that are dropped from the ED measure due to an exclusion for stays where the patient spends more than one hour in observation care. Furthermore, CMS discontinued this eCQM measure in CY 2024, rendering it not feasible for hospitals to continue to report the eCQM at this time for use in the QBR program.

To determine the direction for inclusion of an ED throughput measure in the RY 2026 QBR policy that would begin with CY2024 performance, the Commission considered several measurement options proposed by staff as well as other initiatives underway to address this issue going forward.

Ultimately, the Commission approved inclusion of ED 1-like measure in the RY 2026 QBR program to be finalized during CY 2024 and that would not require additional Commission approval. In working with ED Subgroup stakeholders in early 2024, staff selected a measure that mirrors the CMS ED1 measure, with specifications aligned with those of The Joint Commission as much as possible; the initial measure collection and submission is through an ad hoc electronic data pull for all patients that will be submitted on an ongoing basis eventually

through the existing HSCRC case mix data submission process; the initial ad hoc electronic data pull and submission includes data from CY 2023 to serve as the performance baseline period, and from January through March 2024. Hospitals also provided an ad hoc submission in December 2024 that will correct any previously submitted data and provide data from April through September 2024; beginning with data from October 2024 going forward, the ED measure data elements will be included as part of the standard case mix submission process. The ED1 LOS measure captures the time of emergency department arrival to the time of physical departure from the emergency department for patients admitted to the facility. The population is all ED patients (pediatrics and adults) admitted to an inpatient (IP) bed and discharged from the hospital during the reporting period.

Additional Initiatives: Emergency Department Dramatic Improvement Effort (EDDIE)

In June of 2023, Commissioner Joshi convened HSCRC, MIEMSS, MHA, and MDH to propose the EDDIE project with the goal of reducing the time patients spent in the emergency department and pushed the HSCRC staff and MHA to begin this project immediately (i.e., not wait until next policy year) given the importance of this issue. The EDDIE project focuses on short-term, rapid-cycle improvement in ED patient experience by collecting and publicly reporting on ED performance data and fostering a quality improvement process to address those metrics.

Specifically, starting in July 2023, hospitals are submitting data on measures that mirror the CMS ED 1 and OP 18 CMS measures on a monthly basis in accordance with an excel reporting template along with a memo provided by HSCRC staff that contains reporting instructions and high-level specifications. The HSCRC has requested that the measures submitted be stratified by behavioral health based on initial ICD codes. Additionally, the HSCRC has developed a reporting process by which MIEMSS provides monthly reporting on EMS turnaround times by hospital. This will provide hospital accountability for improving efficiency in handoffs by EMS personnel, which will in turn improve EMS unit availability and decrease response times.

The HSCRC and MIEMSS are supporting this work by collecting and publicly reporting hospital ED wait times at monthly Commission meetings. The intent is to provide a mechanism for Commission monitoring of timely ED performance data that brings on-going attention to this issue through public reporting, provides an opportunity for the Commission to recognize and learn from high performers, and to track the hospitals performance improvement efforts relative to their aim statements. Once hospitals have submitted CY 2023 and CY 2024 patient level data, the staff will ask the Commissioners whether EDDIE data submissions are still needed.

Additional Initiatives: ED Potentially Avoidable Utilization

In CY 2021, Commissioners asked staff to evaluate expansion of potentially avoidable utilization (PAU) to emergency department utilization. Staff recommendations initially focused on high volume and low acuity chief complaint encounters (e.g., ear pain, dental problems) based on analysis of 2.4M ED observations with triage ratings. With workgroup/stakeholder vetting, this project was re-focused on multi-visit patients in the ED with >3

ED visits (statewide) in a 12-month period. A hospital monitoring program with reporting through CRISP has been established in CY 2023, with plans to consider a payment policy for CY 2025. A draft ED PAU policy will be presented at the November 2024 commission meeting.

Additional Initiatives: Legislative Workgroup

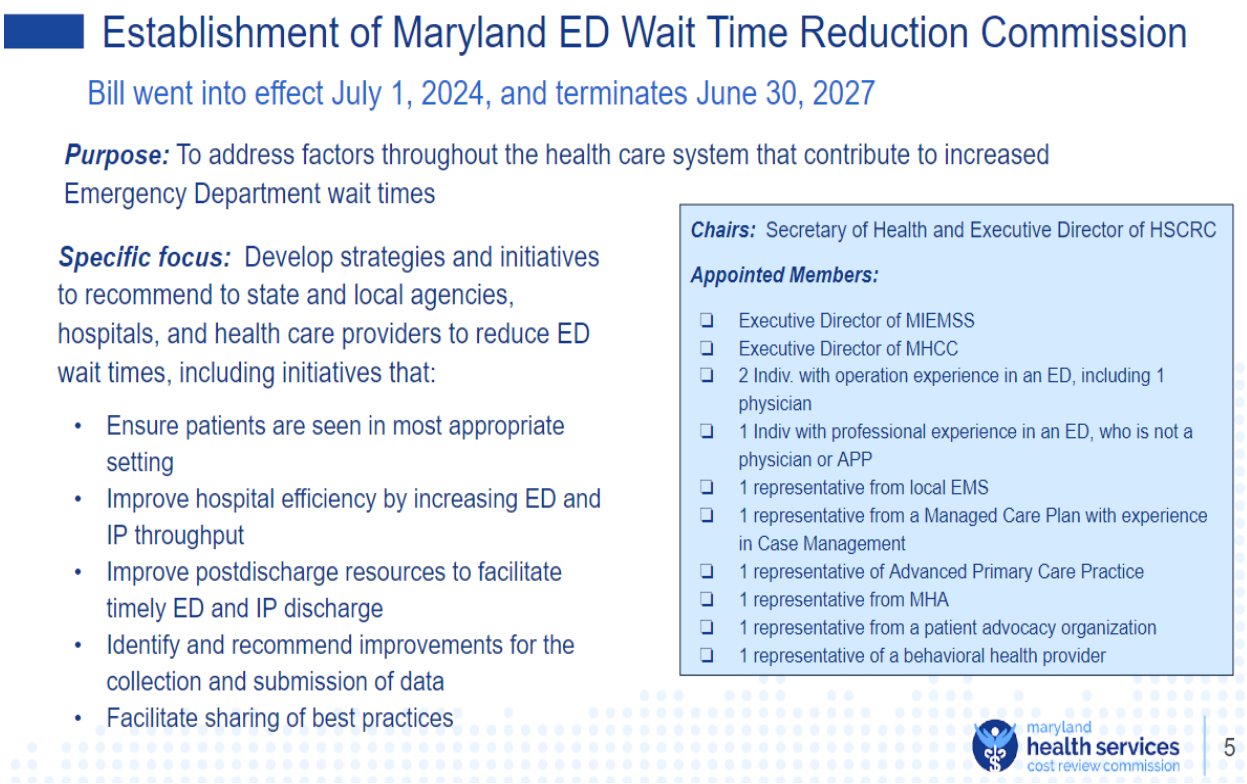
In early 2023, the Maryland General Assembly passed legislation establishing the Task Force on Reducing Emergency Department Wait Times to study best practices for reducing emergency department wait times; and requiring the Task Force to report its findings and recommendations to the Governor and the General Assembly by January 1, 2024. In response, MHA, with co-chair Dr. Ted Delbridge, executive director of Maryland Institute for Emergency Medical Services Systems (MIEMSS), led a multi-stakeholder work group, the Hospital Throughput Work Group, aimed at making recommendations to improve the patient journey in Maryland.

Members included hospital representatives, legislators, the HSCRC, the MHCC, the state Department of Health, patient advocates and emergency department and behavioral health providers. The Task Force was charged with making legislative, regulatory and/or policy recommendations in a report. The Maryland General Assembly Hospital Throughput Work Group Final Report was submitted in March 2024. The HSCRC staff was an active participant in the Task Force and believe that inclusion of an ED length of stay measure in QBR will be consistent with any policy recommendations designed to improve ED length of stay and hospital throughput (i.e., a payment incentive should bolster performance improvement and not hinder other policy recommendations).

New Commission: Maryland Emergency Department Wait Time Reduction Commission

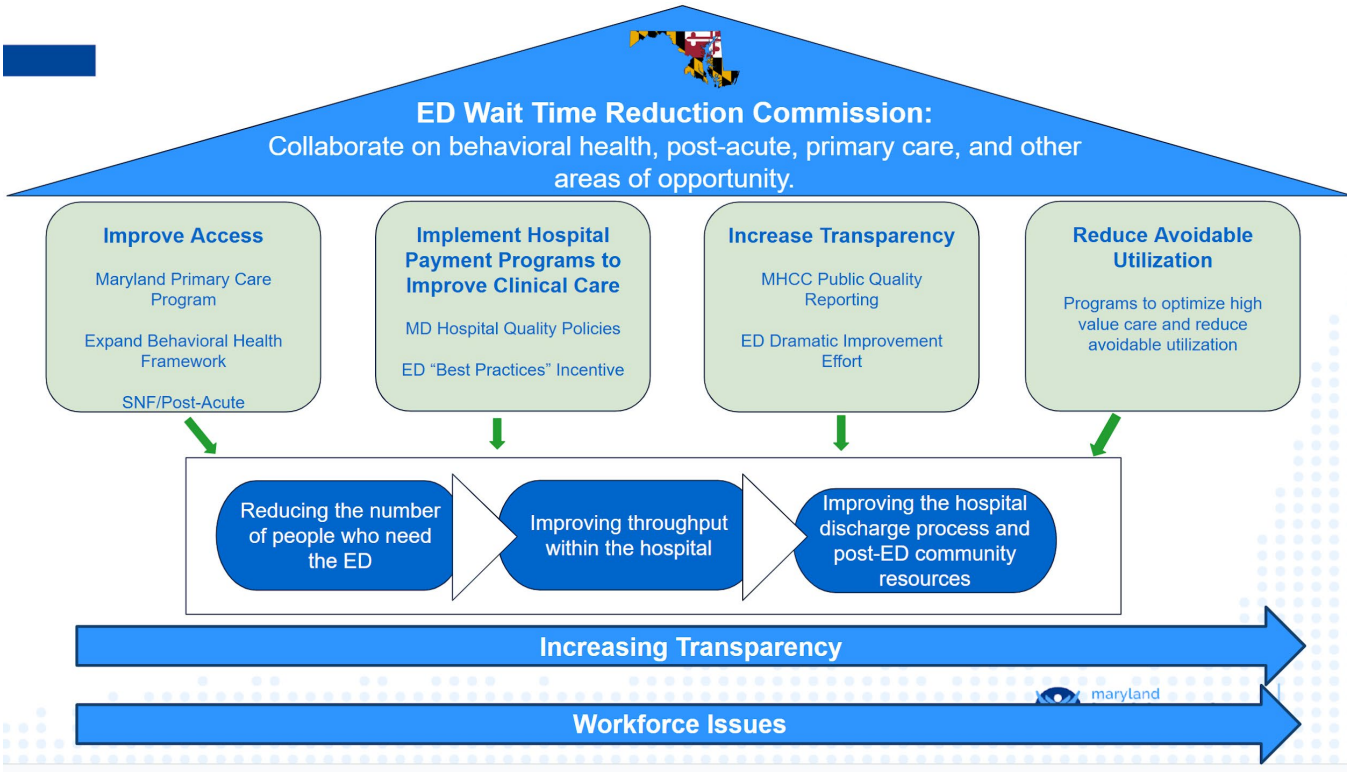
In the 2024 General Assembly session, legislation was passed establishing the ED Wait Times Reduction Commission, which went into effect on July 1, 2024. Figure E1 provides details on the ED Commission purpose, specific tasks, and member representation on the ED Commission.

Figure E1. ED Wait Time Commission Description



The ED Commission's work aligns with many of the current HSCRC policies and those under development. These policies, shown in Figure E2, are designed to address ED and hospital throughput by reducing the number of people who need ED services, improving ED and hospital throughput, and improving the hospital discharge process and community resources. The ED Commission will address state-level opportunities related to access to hospital and community-based services that impact ED wait times, such as access to behavioral health care, post-acute/SNF beds, and primary care. The ED Commission will also support hospital best practices to address ED wait times and throughput across Maryland hospitals. The ED Commission members have been appointed and the first meeting occurred in October 2024. Four subgroups have been established and are reporting up through the ED Wait Time Reduction Commission, including the ED Hospital Throughput Best Practices subgroup, which also reports up through the HSCRC Commission as it relates to hospital policy.

Figure E2. ED Wait Time Commission and Other Initiatives to Reduce ED Wait Times



maryland
health services
cost review commission

Emergency Department Initiatives Update

January Commission Meeting

Status Updates

1. QBR Policy:
   - Hospitals are submitting ad hoc data for April-September 2024 (and resubmitting CY 2023-March 2024 as needed) by 1/17/25
   - Staff have been vetting measure specifications for CY 2024 with PMWG; will begin work on CY 2025 measure and targets

2. ED Best Practices subgroup continues to meet and anticipate final policy at February Commission meeting
   - Draft recommendations on Hospital Best Practice policy for RY27 released on 1/8/25
   - Best Practice Subgroup meetings scheduled for 1/10/25 and 1/30/25

3. ED Wait Time Reduction Commission meeting will be held on 1/22/25
   - Access to Non-Hospital Care and Data subgroups meetings will be held in February

Appendix

December Data 2024 Reporting

Monthly, public reporting of three measures:

- ED1-like measure: ED arrival to inpatient admission time for all admitted patients
- OP18-like measure: ED arrival to discharge time for patients who are not admitted
- EMS turnaround time (from MIEMSS): Time from arrival at ED to transfer of patient care from EMS to the hospital

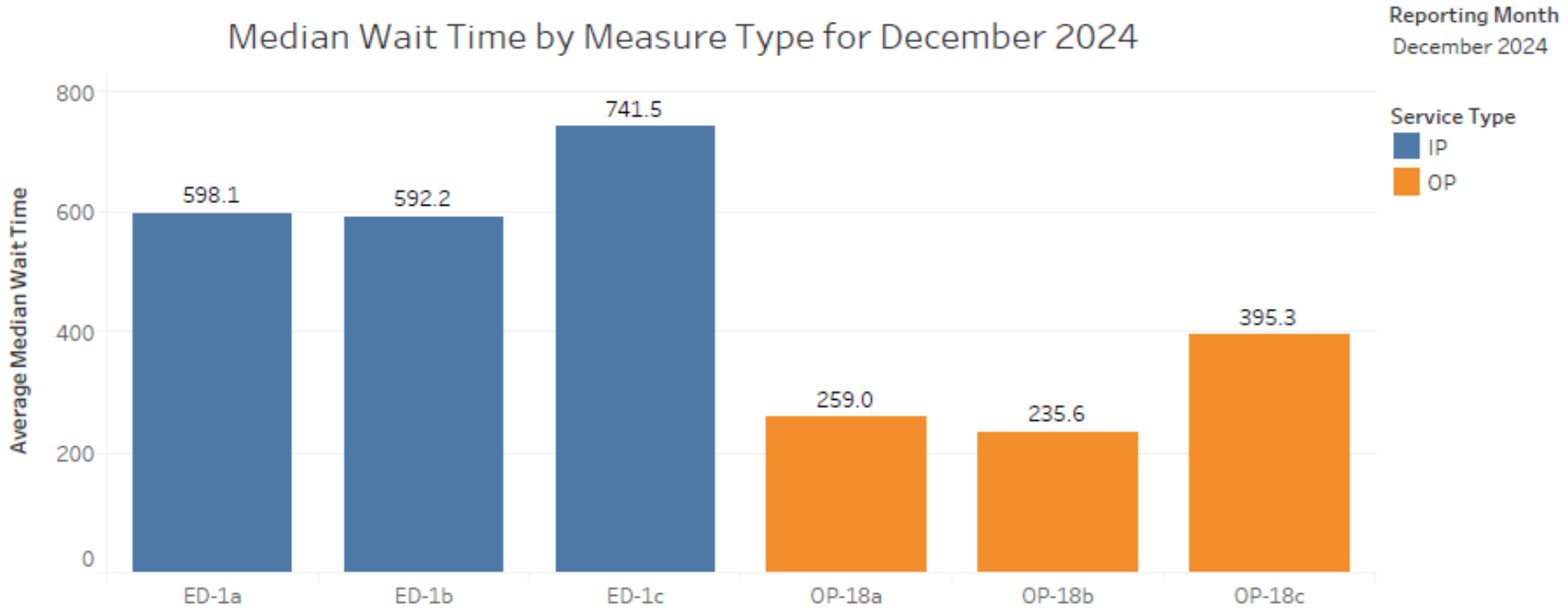
Data received for 41 out of 44 hospitals

- These data should be considered preliminary given timeliness of the data (i.e., the hospitals must turn in by the first Friday of new month)
- These data are being collected for hospital quality improvement and have NOT been audited by the HSCRC; data can be used for trending purposes within the hospital
- Data may be updated over time if issues are identified or specifications change

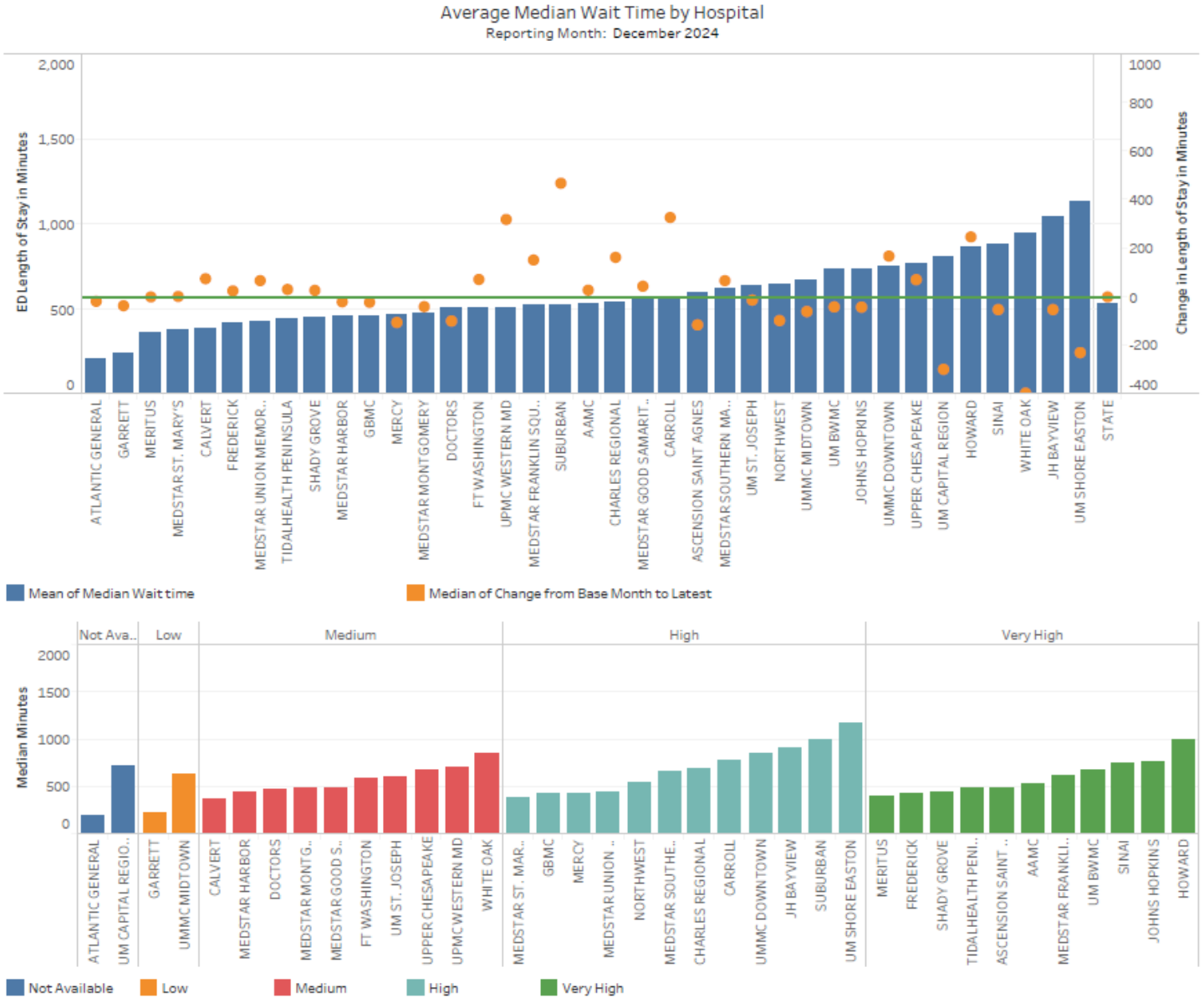
Graphs:

- Rolling median (June 2023-Latest Month) and change from June 2023/first month provided
- Latest month grouped by CMS ED volume category (Volume data is from CMS Care Compare or imputed by hospital, volume categories were recently updated on CMS Care Compare.)
- Graphs have not been QAed by hospitals due to fast turnaround time

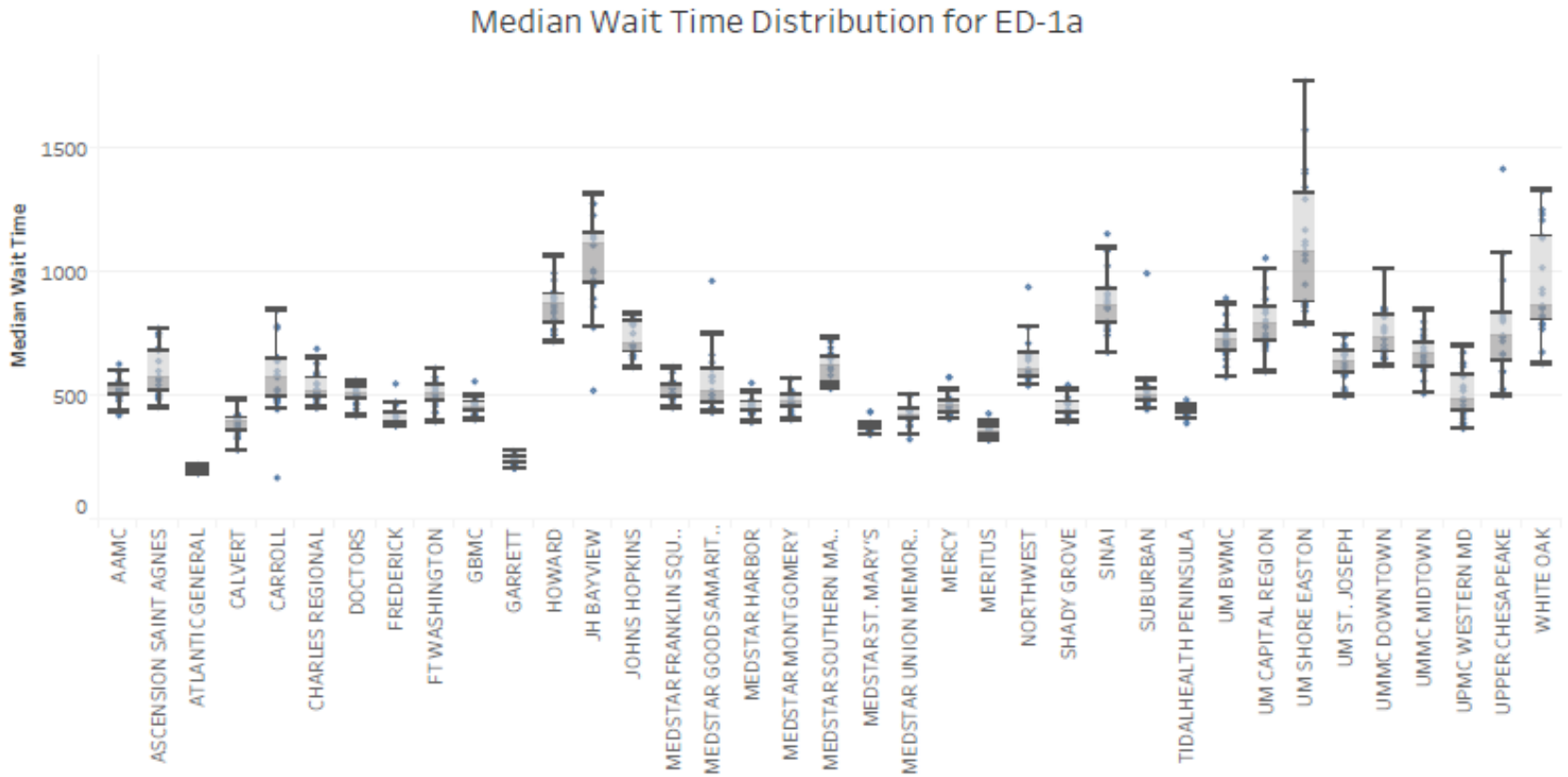
ED Median Wait Time



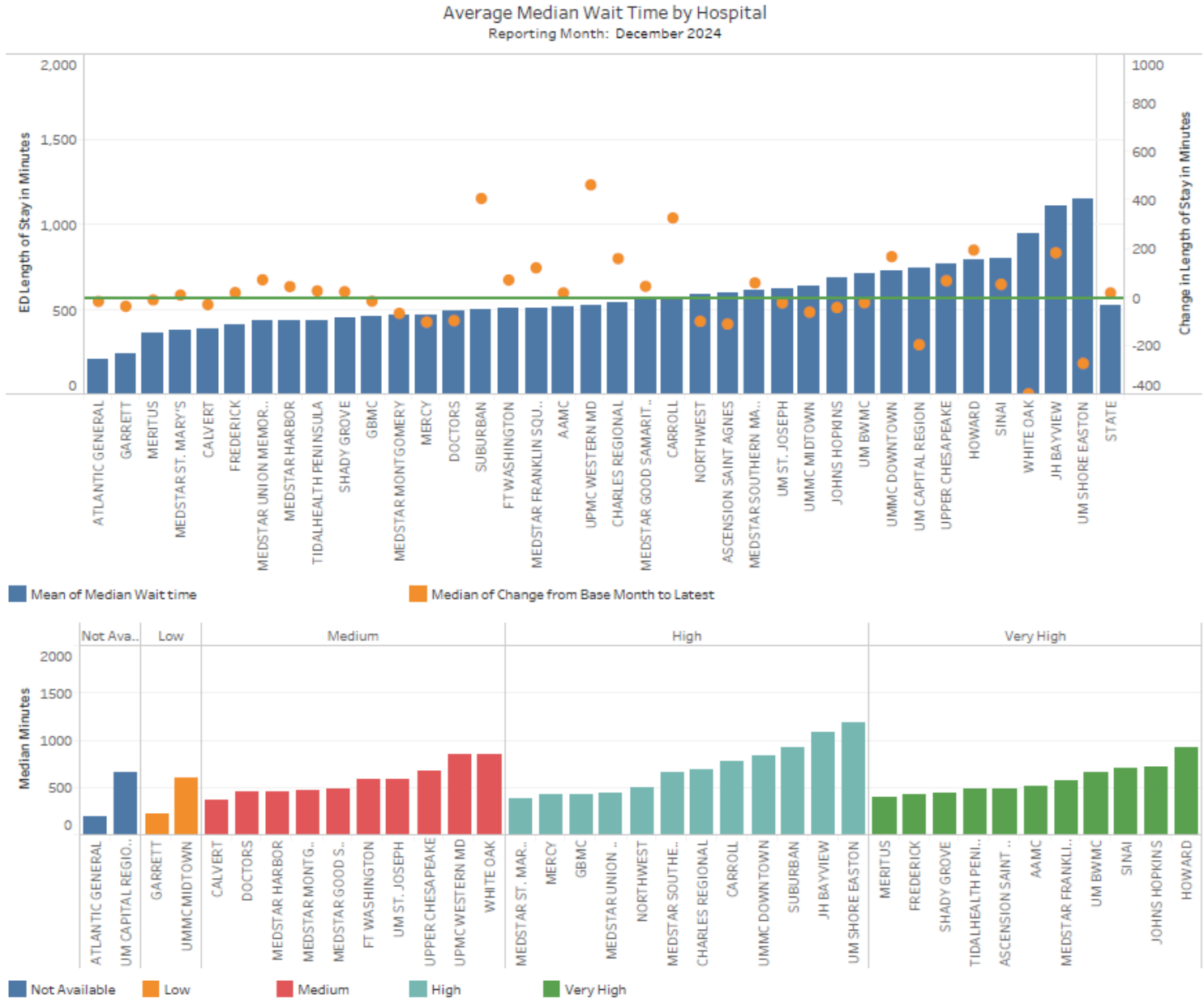
Ed1a Update


Average Median Wait Time by Hospital
Reporting Month: December 2024
ED Length of Stay in Minutes
Change in Length of Stay in Minutes
ATLANTIC GENERAL
GARRETT
MERITUS
MEDSTAR ST. MARY'S
CALVERT
FREDERICK
MEDSTAR UNION MEMOR..
TIDALHEALTH PENINSULA
SHADY GROVE
MEDSTAR HARBOR
GBMC
MERCY
MEDSTAR MONTGOMERY
DOCTORS
FT WASHINGTON
UPMC WESTERN MD
MEDSTAR FRANKLIN SQU..
SUBURBAN
AAMC
CHARLES REGIONAL
MEDSTAR GOOD SAMARIT..
CARROLL
ASCENSION SAINT AGNES
MEDSTAR SOUTHERN MA..
UM ST. JOSEPH
NORTHWEST
UMMC MIDTOWN
UM BWMC
JOHNS HOPKINS
UMMC DOWNTOWN
UPPER CHESAPEAKE
UM CAPITAL REGION
HOWARD
SINAI
WHITE OAK
JH BAYVIEW
UM SHORE EASTON
STATE
Mean of Median Wait time
Median of Change from Base Month to Latest
Not Ava..
Low
Medium
High
Very High
Median Minutes
Not Available
Low
Medium
High
Very High

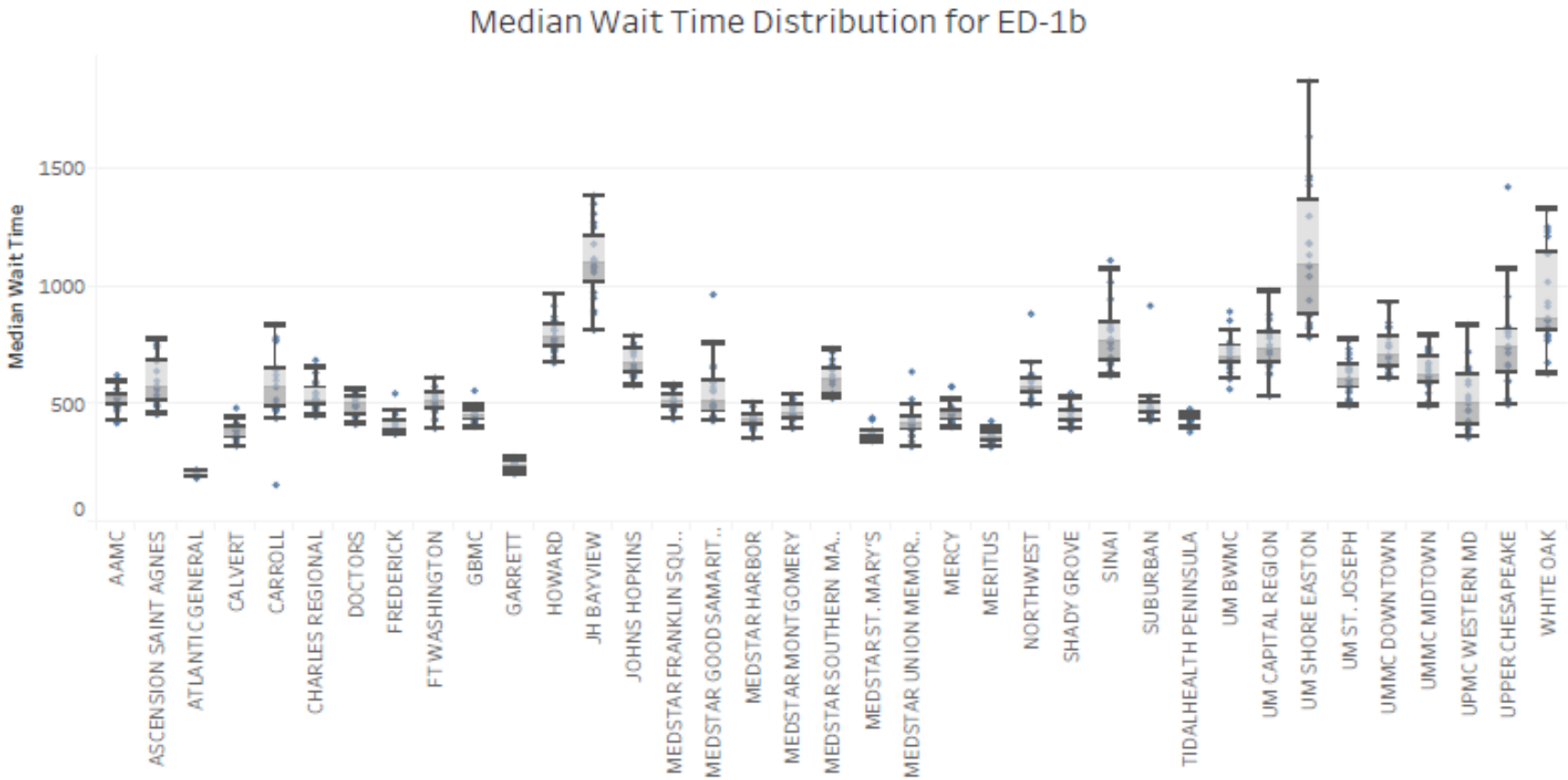
Ed1a Update


Median Wait Time Distribution for ED-1a
Median Wait Time
1500
1000
500
0
AAMC
ASCENSION SAINT AGNES
ATLANTIC GENERAL
CALVERT
CARROLL
CHARLES REGIONAL
DOCTORS
FREDERICK
FT WASHINGTON
GBMC
GARRETT
HOWARD
JH BAYVIEW
JOHNS HOPKINS
MEDSTAR FRANKLIN SQU..
MEDSTAR GOODSAMARIT..
MEDSTAR HARBOR
MEDSTAR MONTGOMERY
MEDSTAR SOUTHERN MA..
MEDSTAR ST. MARY'S
MEDSTAR UNION MEMOR..
MERCY
MERITUS
NORTHWEST
SHADY GROVE
SINAI
SUBURBAN
TIDALHEALTH PENINSULA
UM BWMC
UM CAPITAL REGION
UM SHORE EASTON
UM ST. JOSEPH
UMMC DOWNTOWN
UMMC MIDTOWN
UPMC WESTERN MD
UPPER CHESAPEAKE
WHITE OAK

Ed1b Update


Average Median Wait Time by Hospital
Reporting Month: December 2024
ED Length of Stay in Minutes
Change in Length of Stay in Minutes
Mean of Median Wait time
Median of Change from Base Month to Latest
Median Minutes
Not Ava..
Low
Medium
High
Very High
Not Available
Low
Medium
High
Very High

Ed1b Update


Median Wait Time Distribution for ED-1b
Median Wait Time
1500
1000
500
0
AAMC
ASCENSION SAINT AGNES
ATLANTIC GENERAL
CALVERT
CARROLL
CHARLES REGIONAL
DOCTORS
FREDERICK
FT WASHINGTON
GBMC
GARRETT
HOWARD
JH BAYVIEW
JOHNS HOPKINS
MEDSTAR FRANKLIN SQU..
MEDSTAR GOODSAMARIT..
MEDSTAR HARBOR
MEDSTAR MONTGOMERY
MEDSTAR SOUTHERN MA..
MEDSTAR ST. MARY'S
MEDSTAR UNION MEMOR..
MERCY
MERITUS
NORTHWEST
SHADY GROVE
SINAI
SUBURBAN
TIDALHEALTH PENINSULA
UM BWMC
UM CAPITAL REGION
UM SHORE EASTON
UM ST. JOSEPH
UMMC DOWNTOWN
UMMC MIDTOWN
UPMC WESTERN MD
UPPER CHESAPEAKE
WHITE OAK

Ed1b Update

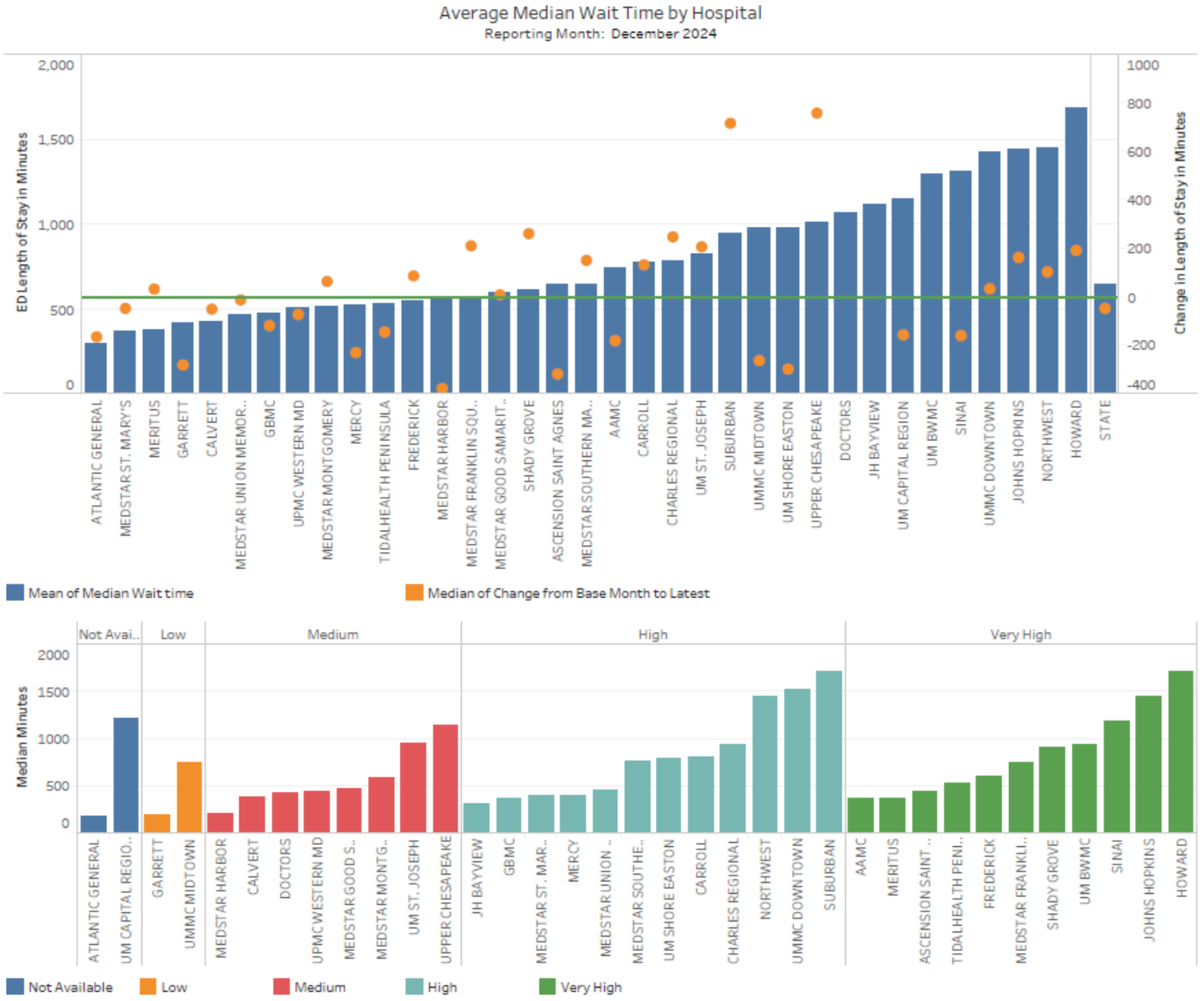
Average Median Wait Time All Hospitals for ED-1b

Measure
ED-1b

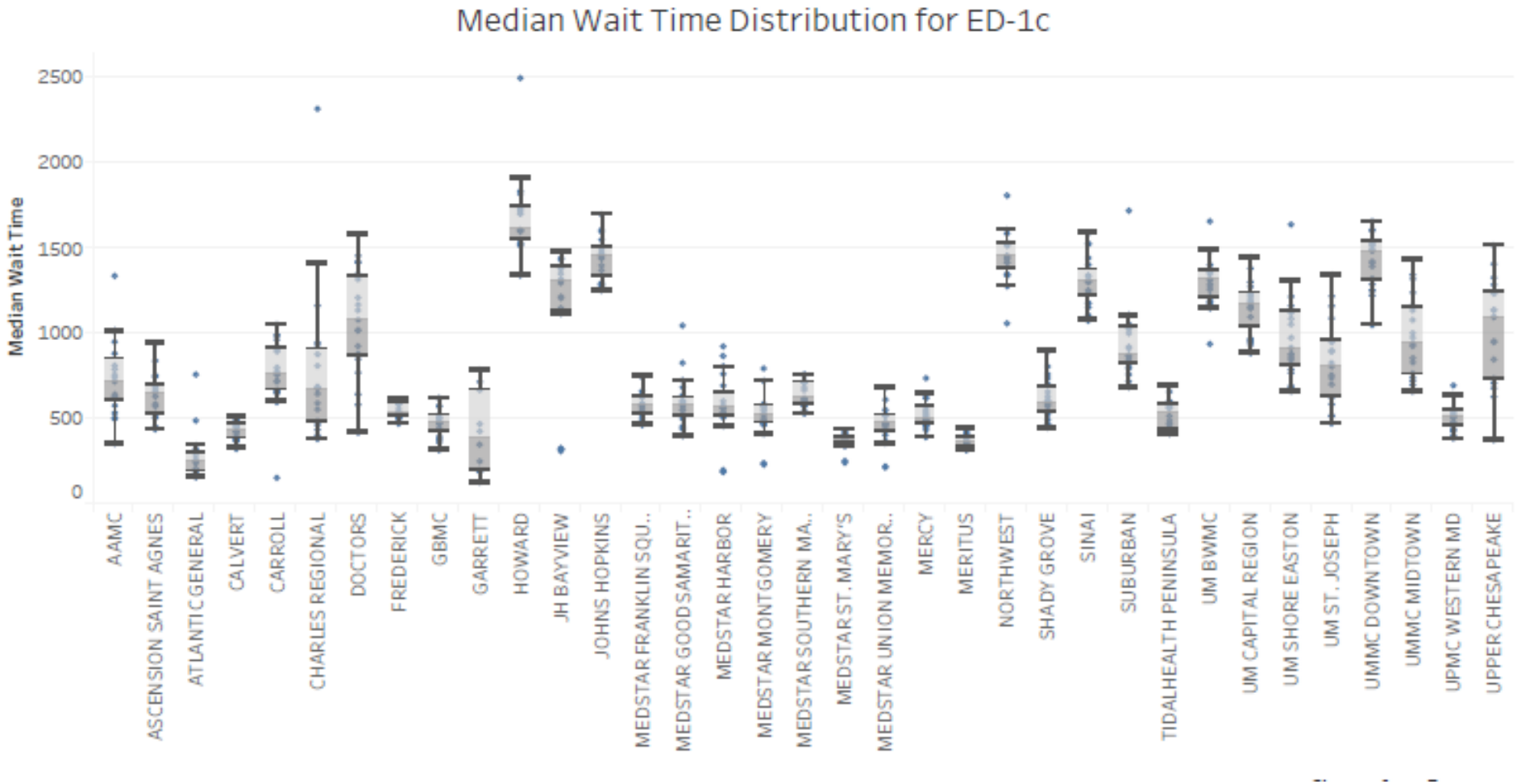
Change from Base
-668 822

Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024
AAMC	488	527	536	529	565	597	623	591	528	539	495	471	528	508	486	502	430	421	508
ASCENSION SAINT AGNES	599	563	541	573	641	576	755	772	683	694	741			525	515	503	495	457	491
ATLANTIC GENERAL	209	203	222	212	195	189	216		190	190	199	199	199	210	202	201	214	197	194
CALVERT		386	403	420	390	408	484	443	404	395	369	391	407	392	353	332	324	341	358
CARROLL	441	520	470	623	603	158	653	837	648	648	782	500	480	487	574	479	574	487	769
CHARLES REGIONAL	526	484	499	449	489	456	507	656	634	551	474	516	544	526	516	596	588	515	687
CHRISTIANACARE, UNION	372	351	370	343	356	450	640	627	669	588	795	530	493	445	510	491	488	509	
DOCTORS	541	503	525	499	559	523	547	543	510	509	489	491	429	493	453	449	415	431	447
FREDERICK	388	376	378	391	410	427	458	546	472	375	379	397	390	381	394	423	431	380	409
FT WASHINGTON	503	434	488	493	550	539	611	469	476	556	524	435	536	553	510	398	514	516	576
GARRETT			244		246	244	277	255	227	236	206	229	223	256	246	231	264	227	209
GBMC	438	467	455	475	481	417	476	558	496	475	454	455	429	427	480	459	444	405	424
HOLY CROSS	524	482	540	513	544	518	546	557	495	524		496	499	500	523	527	491		
HOLY CROSS GERMANTO..	435	396	427	365	487	414	568	677	498	436		533	398	488	441	453	400		
HOWARD	722	734	729	776	871	839	836	785	676	785	741	699	855	964	813	816	771	758	918
JH BAYVIEW	895	951	1,107	885	1,097	1,250	1,179	1,270	1,307	973	1,059	815	1,117	1,085	1,109	1,349	1,072	1,383	1,080
JOHNS HOPKINS	746	631	613	650	672	652	617	744	732	667	623	626	581	722	734	726	790	760	706
MEDSTAR FRANKLIN SQUA..	445	471	492	484	516	471	570	585	538	492	522	512	437	516	547	546	483	499	568
MEDSTAR GOOD SAMARIT..	440	474	512	449	556	494	654	965	761	664	442	430	450	594	571	556	592	497	487
MEDSTAR HARBOR	407	506	424	454	391	357	399	447	416	432	415	406	436	445	415	445	489	505	453
MEDSTAR MONTGOMERY	520	459	478	477	525	438	490	540	495	454	448	404	398	402	460	442	508	433	456
MEDSTAR SOUTHERN MA..	584	542	536	525	540	533	654	735	691	668	720	622	604	652	616	537	546	597	645
MEDSTAR ST. MARY'S	368	350	362	356	362	385	436	443	361	366	390	369	385	344	367	380	437	349	379
MEDSTAR UNION MEMORI..	367	442	397	321	398	389	498	503	434	413	425	342	410	435	419	638	522	367	441
MERCY	523	576	574	404	450	421	464	490	461	476	462	469	416	417	458	474	434	436	423
MERITUS	404	371	357	386	377	341	368	430	364	352	347	334	339	320	322	337	360	359	395
NORTHWEST	595	676	613	558	575	561	600	883	624	549	609	551	600	559	518	526	628	506	498
SHADY GROVE	408	424	446	434	546	493	427	437	397	468	395	419	465	468	472	474	524	429	433
SINAI	638	636	759	699	675	765	737	1,110	945	852	814	819	1,018	834	1,072	777	666	622	693
SUBURBAN	510	441	445	457	516	455	485	506	474	429	456	534	457	472	493	507	466	479	918
TIDALHEALTH PENINSULA		452	446	447	429	430	447	448	437	405	423	383	429	440	434	406	429	458	480
UM BWMC	684	704	681	683	699	635	740	893	747	721	698	734	813	855	764	654	606	565	664
UM CAPITAL REGION	859	752	781	714	809	683	793	981	882	821	679	721	632	740	730	627	658	536	666
UM SHORE EASTON	1,452	941	1,468	1,428	1,182	784	1,634	1,867	1,089	1,132	823	832	878	875	843	1,042	1,297	1,083	1,182
UM ST. JOSEPH	598	562	641	656	640	494	607	771	583	550	669	650	715	694	517	608	735	520	577
UMMC DOWNTOWN	658	610	625	669	636	622	651	747	662	742	707	758	697	928	787	825	786	846	827
UMMC MIDTOWN	647	792	735	614	742	547	676	664	726	640	617	509	493	716	581	590	603	624	588
UPMC WESTERN MD	373	417	411	473	599	503	430	722	520	394	360	585	536	655	641	659	473	396	837
UPPER CHESAPEAKE	599	662	598	831	789	956	1,074	1,421	717	739	826	809	803	747	738	498	514	523	669
WHITE OAK	1,251	865	1,142	855	1,328	1,212	795	825	677	1,233	1,138	932	914	817	1,018	631	770	784	856

Ed1c Update


Average Median Wait Time by Hospital
Reporting Month: December 2024
ED Length of Stay in Minutes
Change in Length of Stay in Minutes
ATLANTIC GENERAL
MEDSTAR ST. MARY'S
MERITUS
GARRETT
CALVERT
MEDSTAR UNION MEMOR..
GBMC
UPMC WESTERN MD
MEDSTAR MONTGOMERY
MERCY
TIDALHEALTH PENINSULA
FREDERICK
MEDSTAR HARBOR
MEDSTAR FRANKLIN SQU..
MEDSTAR GOOD SAMARIT..
SHADY GROVE
ASCENSION SAINT AGNES
MEDSTAR SOUTHERN MA..
AAMC
CARROLL
CHARLES REGIONAL
UM ST. JOSEPH
SUBURBAN
UMMC MIDTOWN
UM SHORE EASTON
UPPER CHESAPEAKE
DOCTORS
JH BAYVIEW
UM CAPITAL REGION
UM BWMC
SINAI
UMMC DOWNTOWN
JOHNS HOPKINS
NORTHWEST
HOWARD
STATE
Mean of Median Wait time
Median of Change from Base Month to Latest
Not Avai..
Low
Medium
High
Very High
Median Minutes
Not Available
Low
Medium
High
Very High

Ed1c Update


Median Wait Time Distribution for ED-1c
Median Wait Time
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1500
1000
500
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AAMC
ASCENSION SAINT AGNES
ATLANTIC GENERAL
CALVERT
CARROLL
CHARLES REGIONAL
DOCTORS
FREDERICK
GBMC
GARRETT
HOWARD
JH BAYVIEW
JOHNS HOPKINS
MEDSTAR FRANKLIN SQU..
MEDSTAR GOODSAMARIT..
MEDSTAR HARBOR
MEDSTAR MONTGOMERY
MEDSTAR SOUTHERN MA..
MEDSTAR ST. MARY'S
MEDSTAR UNION MEMOR..
MERCY
MERITUS
NORTHWEST
SHADY GROVE
SINAI
SUBURBAN
TIDALHEALTH PENINSULA
UM BWMC
UM CAPITAL REGION
UM SHORE EASTON
UM ST. JOSEPH
UMMC DOWNTOWN
UMMC MIDTOWN
UPMC WESTERN MD
UPPER CHESAPEAKE

Ed1c Update

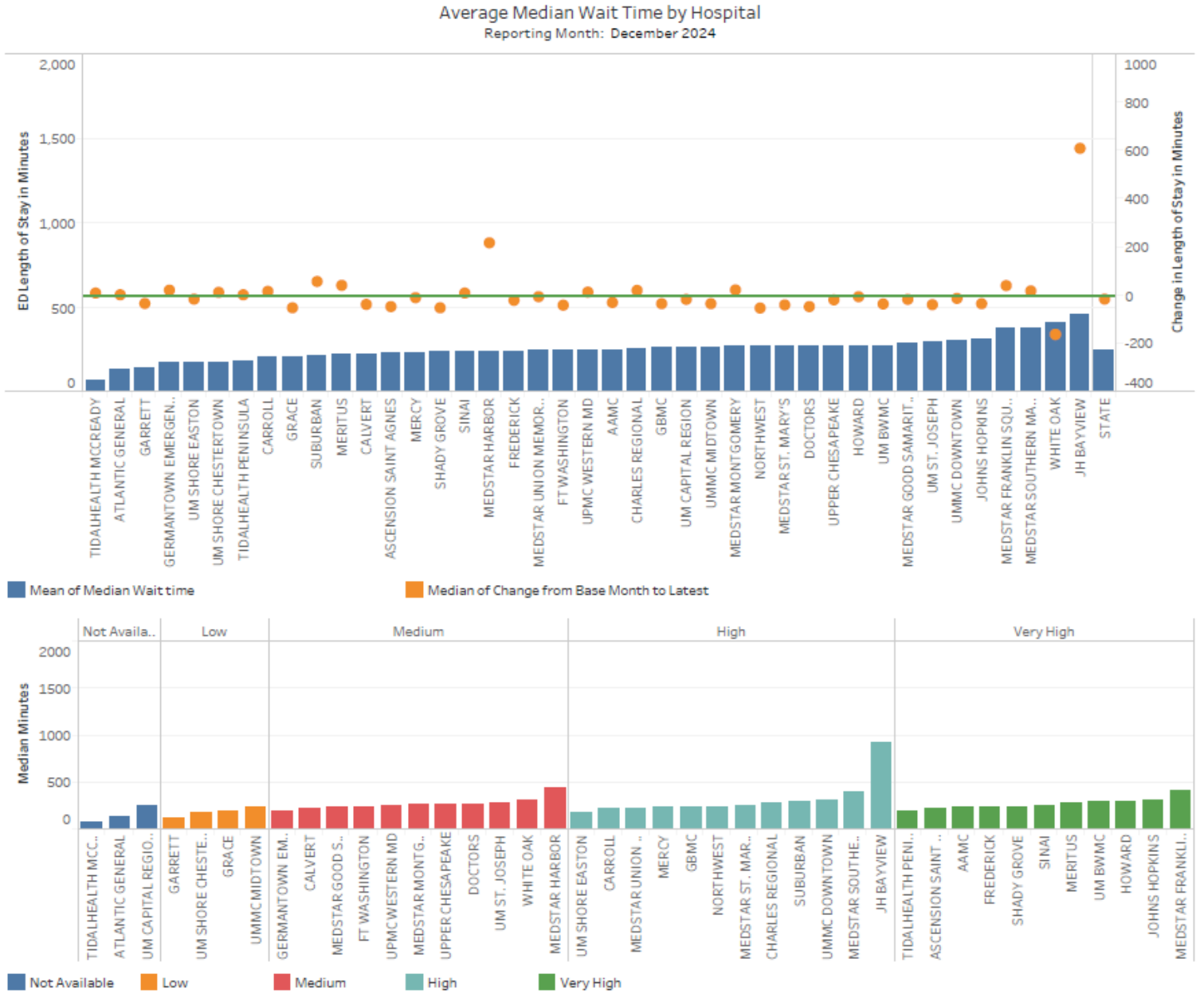
Average Median Wait Time All Hospitals for ED-1c

Measure
ED-1c

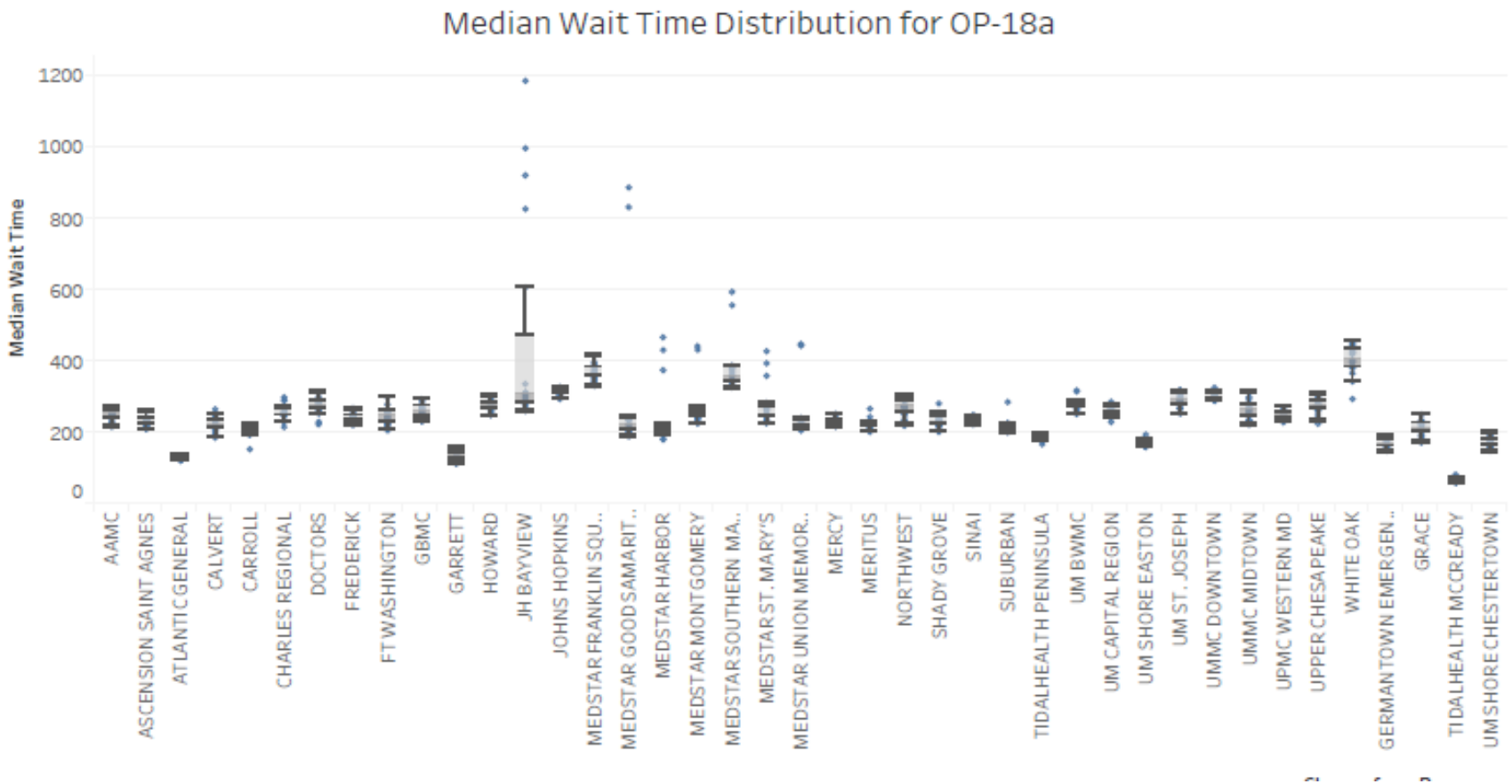
Change from Base
-997 1,629

Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024
AAMC	535	883	719	643	1,335	951	1,009	1,017	757	790	629	578	812	618	740	627	507	500	356
ASCENSION SAINT AGNES	755	939	631	691	652	531	682	745	698	574	839			505	666	587	523	454	439
ATLANTIC GENERAL		345	160	262	286	490	255			254		242	210	322	177	253	182	759	182
CALVERT	425	379	457	471	508	427	501	369	449	458	393	389	490	427	410	325	486	381	376
CARROLL	665	667	764	893	598	156	724	988	989	717	924	906	652	781	963	1,051	759	650	799
CHARLES REGIONAL	682	678	487	810	1,407	406	1,161	647	466	2,311	946	436	555	877	383	688	481	593	931
CHRISTIANACARE, UNION	290	184	268		424	422	764	431	463	388	331	375	355	340	405	296	369	343	
DOCTORS	1,414	1,316	1,167	1,019	1,418	1,453	1,347	1,208	1,134	850	1,079	881	1,575	1,015	925	770	644	583	420
FREDERICK	506	517	540	514	613	534	586	609	613	557	514	586	471	606	501	520	531	507	594
GARRETT							470	717	428	786	131	350			252	200	668		191
GBMC	480	387	479	476	508	526	498	621	578	471	398	573	376	318	509	445	619	483	363
HOLY CROSS	642	416	518	568	903	559	532	933	831	400		526	495	671	920	623	341		
HOLY CROSS GERMANTO..	410	320	643	400	412	458	1,208	919	643	818		215	584	447	697		444		
HOWARD	1,524	1,512	1,338	1,597	1,699	1,602	1,701	1,815	1,728	1,519	1,603	1,547	1,598	1,740	1,545	1,831	2,490	1,904	1,717
JH BAYVIEW	1,309	1,205	1,440	1,376	1,383	1,394	1,475	1,316	1,348	1,147	1,294	1,115	1,431	1,214	1,394	328	322	324	312
JOHNS HOPKINS	1,281	1,294	1,284	1,510	1,458	1,470	1,453	1,606	1,694	1,396	1,368	1,436	1,251	1,546	1,592	1,487	1,284	1,462	1,445
MEDSTAR FRANKLIN SQUA..	532	465	500	532	627	662	469	642	542	583	589	627	531	577	641	586	526	558	744
MEDSTAR GOOD SAMARIT..	446	502	590	549	608	522	827	1,045	725	577	401	588	441	637	684	556	600	602	456
MEDSTAR HARBOR	577	868	923	761	806	520	695	531	603	458	540	572	562	561	508	567	193	191	201
MEDSTAR MONTGOMERY	512	472	498	532	531	722	550	795	588	568	579	465	413	468	488	242	233	570	577
MEDSTAR SOUTHERN MA..	609	575	586	573	601	714	683	717	754	722	713	622	710	617	532	538	545	669	761
MEDSTAR ST. MARY'S	434	356	356	339	359	374	415	379	376	430	396	353	351	374	364	244	255	391	388
MEDSTAR UNION MEMORI..	464	681	473	358	475	431	612	470	530	407	553	371	480	518	525	222	217	523	453
MERCY	622	648	738	490	458	531	518	556	398	456	577	492	464	435	544	624	503	491	394
MERITUS	329	344	317	385	423	395	363	434	397	362	413	340	337	348	374	323	445	333	363
NORTHWEST	1,337	1,510	1,454	1,058	1,435	1,275	1,347	1,523	1,805	1,343	1,604	1,413	1,518	1,450	1,529	1,582	1,522	1,415	1,442
SHADY GROVE	633	805	526	760	450	573	592	497	739	594	589	552	607	471	466	658	705	609	895
SINAI	1,337	1,336	1,108	1,400	1,248	1,151	1,299	1,248	1,584	1,309	1,525	1,308	1,073	1,310	1,174	1,440	1,300	1,520	1,179
SUBURBAN	1,000	849	875	865	1,029	718	868	760	912	686	1,040	1,025	804	830	795	1,108	921	1,053	1,717
TIDALHEALTH PENINSULA		659	490	441	473	415	415	567	440	596	465	605	581	565	562	691	576	429	516
UM BWMC	1,359	1,400	1,349	1,654	1,216	1,176	1,146	1,271	1,255	1,183	1,360	1,483	1,310	1,191	1,378	1,288	1,319	1,365	938
UM CAPITAL REGION	1,379	1,445	1,189	1,169	1,299	1,191	1,147	1,272	1,146	931	959	950	1,212	1,096	1,155	1,234	884	968	1,224
UM SHORE EASTON	1,085	974	769	1,304	875	842	917	1,121	661	878	1,215	1,052	857	1,635	1,125	1,160	692	684	789
UM ST. JOSEPH	739	1,159	627	899	1,216	520	756	473	516	961	806	702	626	893	586	1,341	1,088	827	947
UMMC DOWNTOWN	1,491	1,410	1,419	1,222	1,510	1,519	1,541	1,249	1,599	1,253	1,286	1,605	1,047	1,482	1,390	1,653	1,539	1,319	1,526
UMMC MIDTOWN	1,001	1,341	1,431	1,078	1,317	664	1,238	698	767	830	855	661	721	1,134	941	925	975	1,163	740
UPMC WESTERN MD	513	520	508	510	525	484	560	640	695	437	428	539	403	517	468	552	556	386	442
UPPER CHESAPEAKE	377	1,135	679	1,513	948	1,283	1,096	848	1,096	953	1,404	1,231	1,243	629	735	1,325	734	708	1,136
WHITE OAK			2,701																

OP18a Update



OP18a Update



OP18a Update

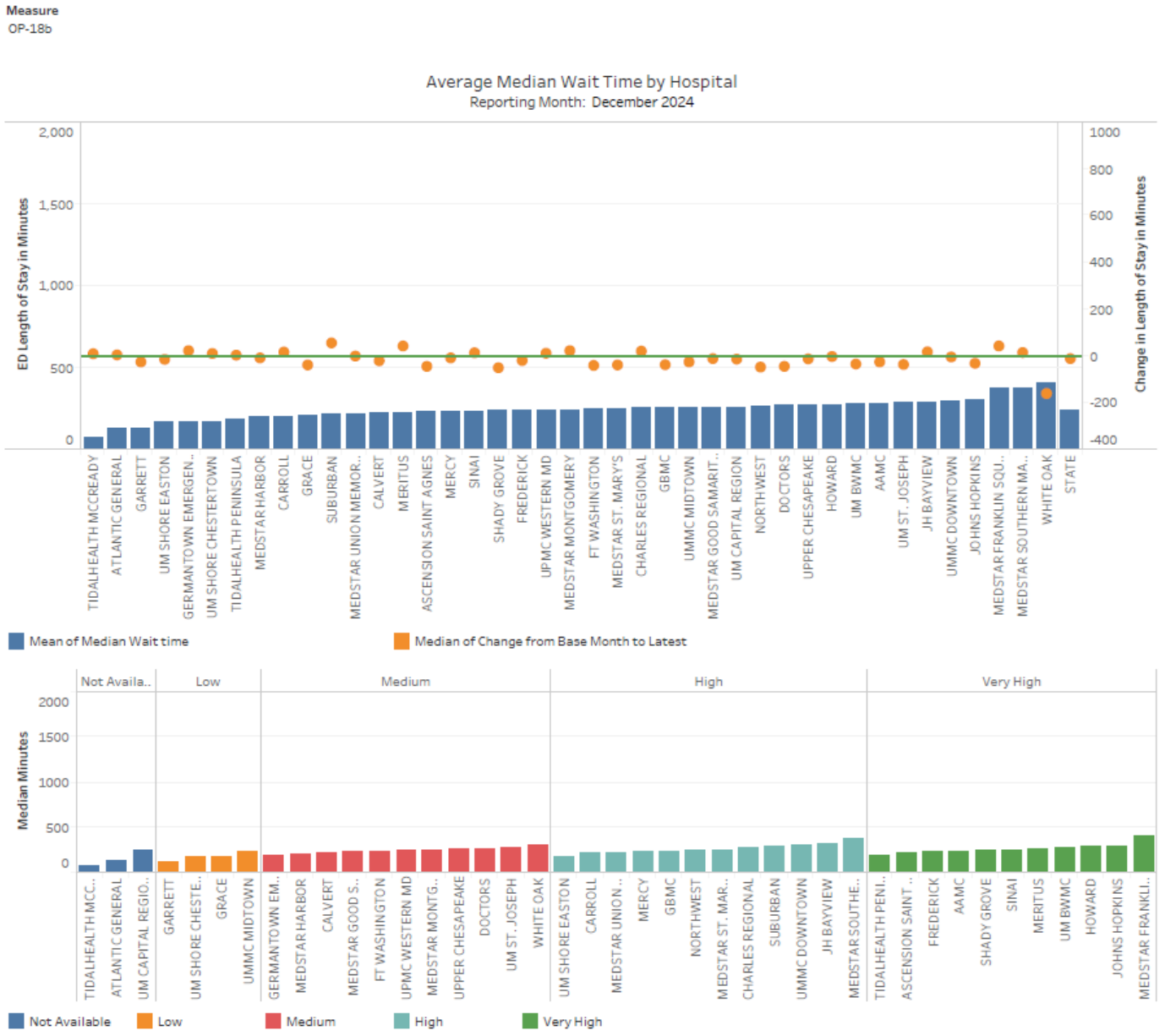
Average Median Wait Time All Hospitals for OP-18a

Measure
OP-18a

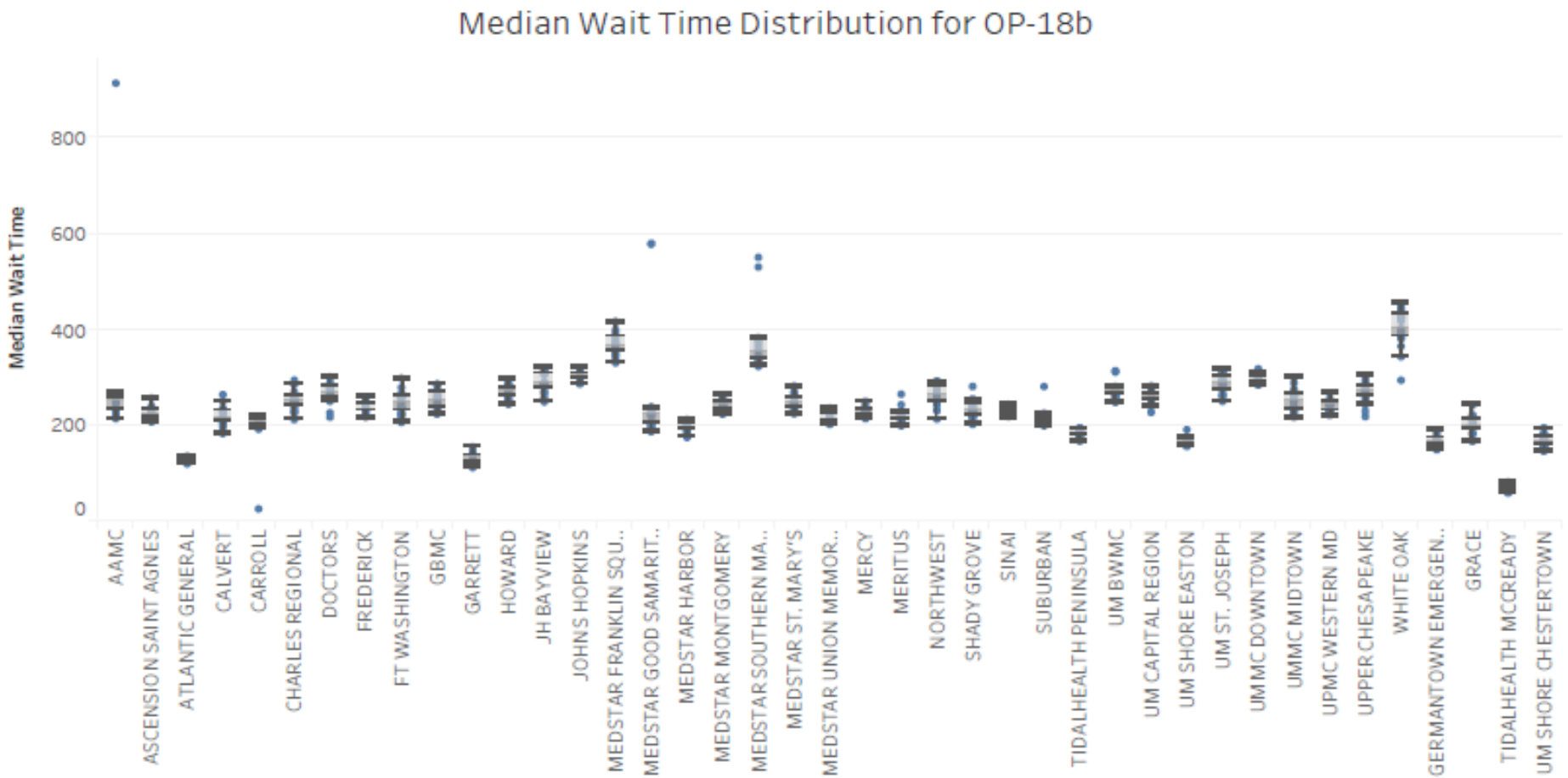
Change from Base
-160 875

Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024
AAMC	258	255	260	254	266	263	271	268	256	258	253	241	255	258	241	239	226	217	230
ASCENSION SAINT AGNES	261	238	236	243	220	226	239	238	232	227	233			237	211	219	222	212	216
ATLANTIC GENERAL	124	127	131	133	128	123	134		125	122	128	132	126	129	128	131	137	127	128
CALVERT	247	229	240	233	253	235	266	218	215	216	220	227	211	218	220	205	199	187	211
CARROLL	194	203	201	201	221	154	212	209	211	209	210	203	203	213	213	215	205	198	212
CHARLES REGIONAL	254	253	232	216	230	234	258	261	252	258	253	267	300	291	292	260	247	246	276
CHRISTIANACARE, UNION	229	234	222	211	211	234	271	265	272	258	260	266	273	244	258	240	239	250	
DOCTORS	311	288	280	265	281	285	315	302	290	254	270	288	270	272	267	273	224	231	266
FREDERICK		249	248	236	240	244	265	269	256	234	240	237	241	236	249	244	234	222	230
FT WASHINGTON	268	238	262	247	260	259	299	280	266	259	250	240	224	237	235	207	224	218	229
GARRETT			145		150	147	158	134	132	138	124	135	135	132	130	124	129	121	113
GBMC	267	257	261	273	279	266	287	276	294	294	266	247	236	241	248	254	233	234	234
GERMANTOWN EMERGEN..	162	156	159	150	167				190	175	178	165	171	161	173	178	173	167	185
GRACE	236	251	226	221	228	206	233	227	209	215	212	222	193	195	205	206	175	173	186
HOLY CROSS	320	304	335	333	327	314	329	337	324	315		322	338	320	322	303	310		
HOLY CROSS GERMANTO..	242	227	252	233	235	228	245	234	226	227		222	220	217	229	223	227		
HOWARD	290	290	303	252	275	263	296	280	271	269	280	278	282	283	260	250	271	259	286
JH BAYVIEW	312	312	308	281	283	262	264	298	276	297	313	286	607	304	337	1,187	828	998	922
JOHNS HOPKINS	328	319	318	309	312	303	305	313	311	309	319	315	327	311	319	315	302	297	295
MEDSTAR FRANKLIN SQUA..	357	373	382	365	374	385	416	416	332	350	355	365	367	393	372	360	345	341	399
MEDSTAR GOOD SAMARIT..	239	237	244	228	239	207	239	241	215	210	201	190	196	203	222	833	888	210	224
MEDSTAR HARBOR	213	213	211	202	214	181	196	200	184	202	203	210	210	220	210	204	376	468	432
MEDSTAR MONTGOMERY	232	226	247	238	259	246	262	268	249	244	229	249	247	246	240	443	433	256	256
MEDSTAR SOUTHERN MA..	367	344	331	328	340	329	388	381	358	360	374	348	345	348	382	595	558	343	387
MEDSTAR ST. MARY'S	284	269	272	251	254	249	265	265	252	233	247	232	429	231	238	360	395	227	246
MEDSTAR UNION MEMORI..	218	227	230	221	241	219	241	235	229	217	236	210	207	220	215	445	449	213	214
MERCY	232	241	231	219	218	222	233	249	236	237	225	253	234	233	239	233	226	222	224
MERITUS	225	207	207	221	211	203	225	231	221	218	221	219	219	213	221	228	245	221	268
NORTHWEST	288	291	304	279	291	290	299	272	271	273	277	272	271	258	252	250	237	220	237
SHADY GROVE	282	256	252	242	247	246	238	217	203	206	228	234	222	217	234	231	224	220	232
SINAI	232	240	250	232	233	233	243	236	229	232	227	231	224	231	226	238	238	244	243
SUBURBAN	227	216	227	217	219	210	209	214	213	206	208	217	201	209	208	213	206	205	286
TIDALHEALTH MCCREADY			62	73	83	67	75	68	74	70	69	74	73	60	72	62	63	71	73
TIDALHEALTH PENINSULA		184	190	196	195	191	192	184	190	182	182	177	185	183	191	178	168	179	188
UM BWMC	316	319	285	282	277	280	278	272	269	276	278	280	267	282	255	257	263	253	282
UM CAPITAL REGION	265	277	271	265	269	260	287	274	262	259	258	269	265	256	263	243	243	230	250
UM SHORE CHESTERTOWN	169	175	164	180	193	150	189	199	180	164	168	174	164	176	163	168	166	161	183
UM SHORE EASTON	178	165	172	174	163	161	178	195	164	173	164	174	167	174	178	174	166	161	164
UM ST. JOSEPH	313	305	313	319	319	291	318	302	295	287	284	296	293	291	269	268	267	254	276
UMMC DOWNTOWN	310	312	306	299	292	293	304	316	327	298	303	296	291	301	290	311	298	297	299
UMMC MIDTOWN	266	294	277	279	270	237	301	313	284	270	247	260	223	267	249	259	235	231	233
UPMC WESTERN MD	233	236	248	250	272	260	259	256	256	250	238	240	230	255	258	270	240	239	248
UPPER CHESAPEAKE	278	280	278	270	280	282	308	303	294	277	287	297	288	263	280	249	236	226	261
WHITE OAK	455	404	420	397	452	402	426	445	439	397	386	444	430	425	367	382	384	344	295

OP18b Update



OP18b Update



OP18b Update

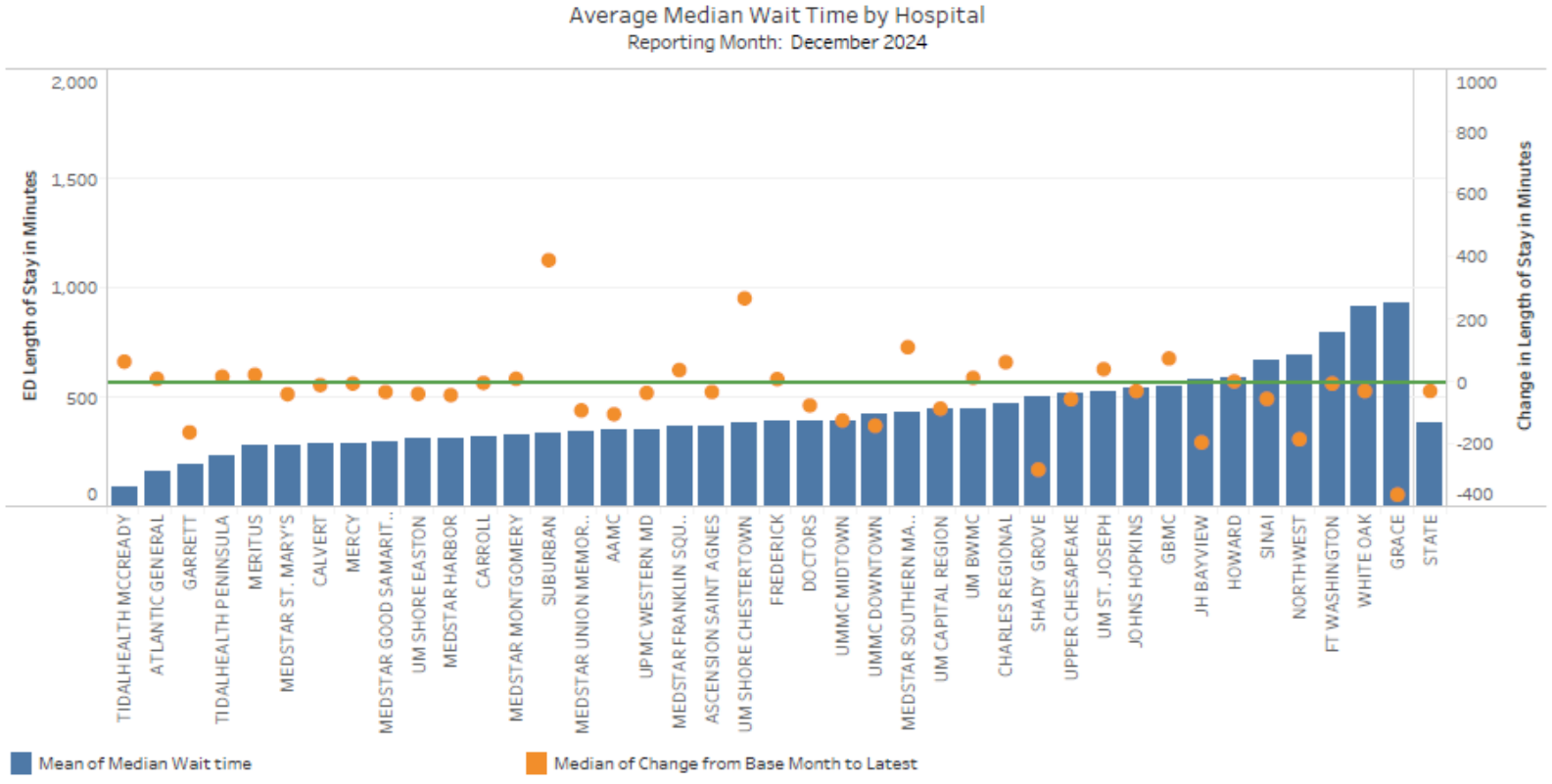
Average Median Wait Time All Hospitals for OP-18b

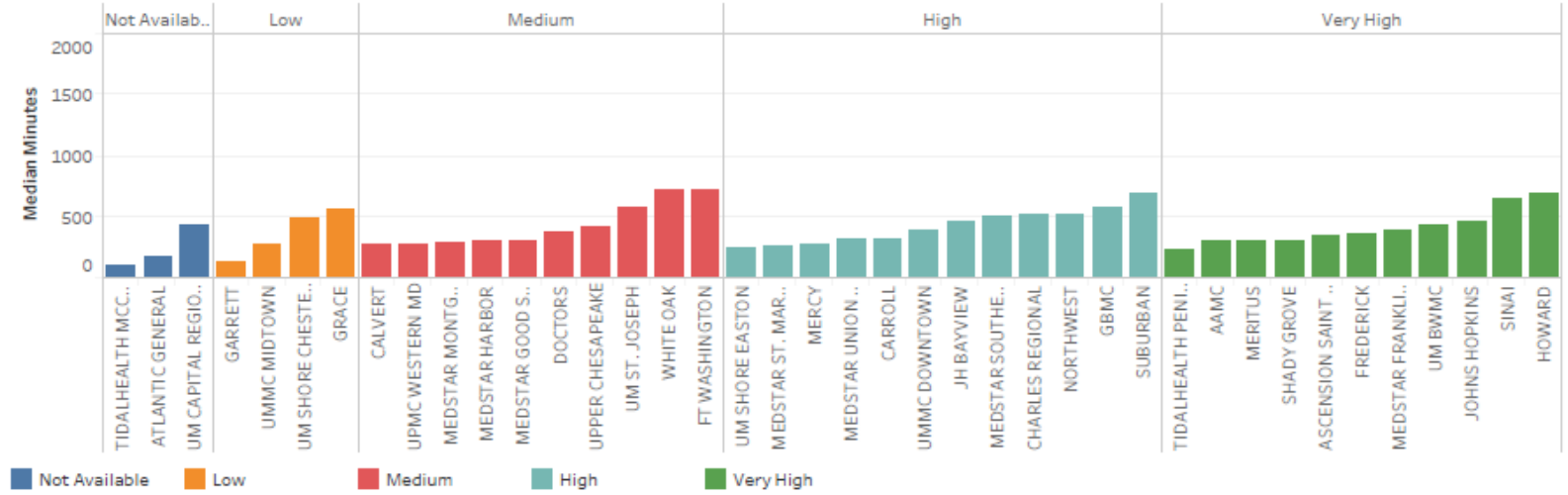
Measure
OP-18b

Change from Base
-166.0 660.0

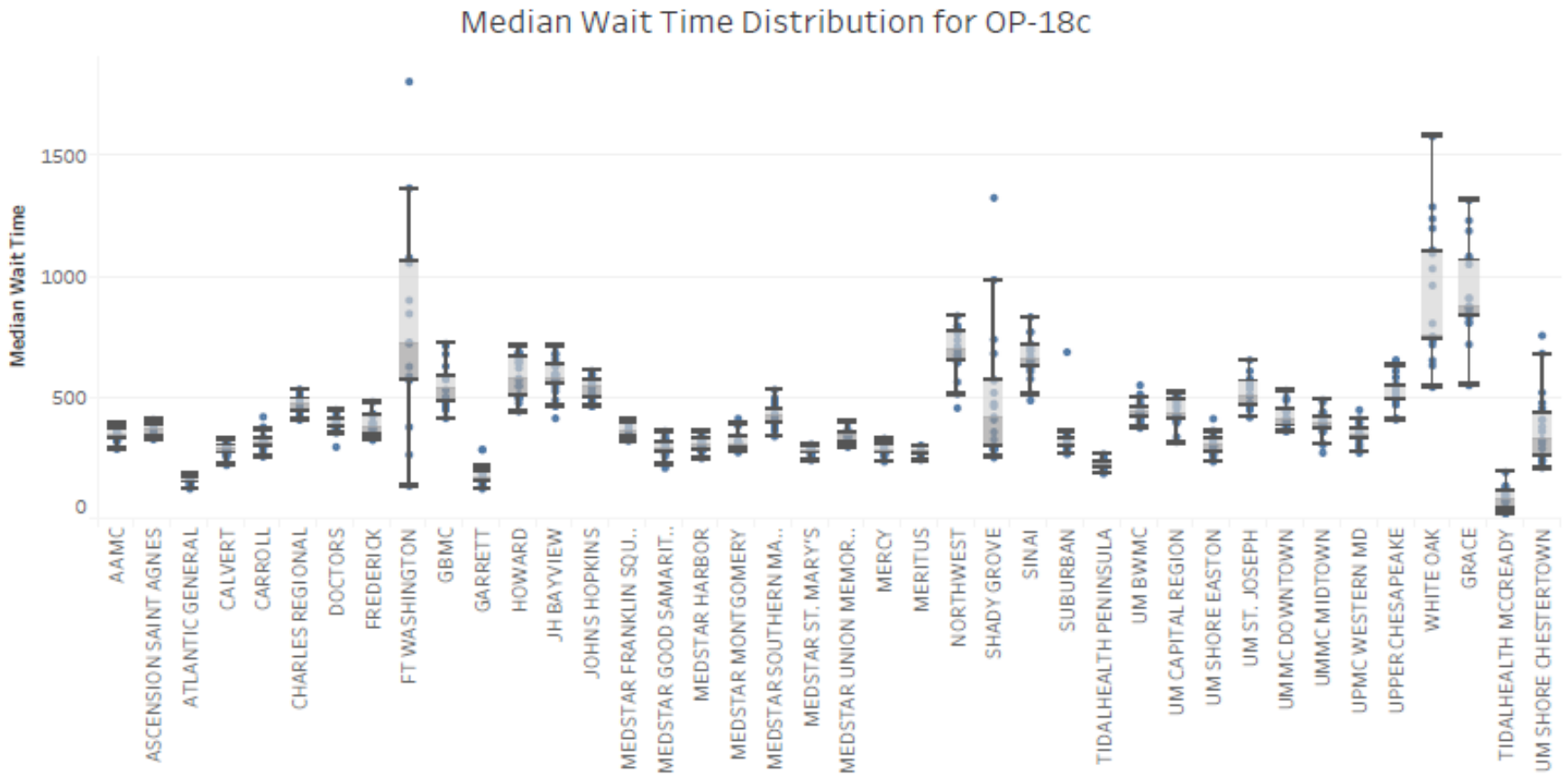
Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024
AAMC	254.0	251.0	257.0	248.0	256.0	260.0	268.0	266.0	254.0	259.0	251.0	237.0	914.0	254.0	234.0	235.0	223.0	215.0	229.0
ASCENSION SAINT AGNES	258.0	235.0	232.0	241.0	216.0	225.0	225.0	234.0	228.0	224.0	230.0			235.0	208.0	217.0	219.0	211.0	214.0
ATLANTIC GENERAL	123.0	126.0	130.0	132.0	127.0	122.0	134.0		124.0	121.0	127.0	132.0	125.0	128.0	127.0	130.0	137.0	127.0	128.0
CALVERT		229.0	237.0	231.0	251.0	233.0	265.0	216.0	212.0	212.0	218.0	224.0	209.0	216.0	218.0	204.0	197.0	184.0	209.0
CARROLL	193.0	201.0	200.0	201.0	220.0	27.0	210.0	207.0	209.0	207.0	209.0	202.0	202.0	212.0	213.0	214.0	203.0	197.0	210.0
CHARLES REGIONAL	250.0	247.0	230.0	213.0	226.0	232.0	255.0	259.0	247.0	253.0	250.0	264.0	295.0	287.0	287.0	256.0	240.0	242.0	271.0
CHRISTIANACARE, UNION	230.0	234.0	222.0	211.0	211.0	234.0	272.0	265.0	272.0	257.0	260.0	265.0	272.0	243.0	257.0	240.0	239.0	249.0	
DOCTORS	302.0	272.0	274.0	260.0	285.0	280.0	301.0	291.0	280.0	251.0	263.0	280.0	264.0	266.0	258.0	268.0	218.0	227.0	258.0
FREDERICK		246.0	245.0	232.0	235.0	239.0	256.0	261.0	251.0	229.0	234.0	233.0	235.0	229.0	244.0	239.0	232.0	218.0	227.0
FT WASHINGTON	268.0	238.0	261.0	247.0	260.0	259.0	299.0	280.0	265.0	259.0	250.0	240.0	224.0	237.0	235.0	207.0	224.0	217.0	228.0
GARRETT			138.0		145.0	144.0	156.0	133.0	132.0	137.0	123.0	134.0	134.0	130.0	131.0	122.0	127.0	120.0	113.0
GBMC	262.0	248.0	255.0	265.0	273.0	259.0	282.0	269.0	287.0	286.0	257.0	240.0	230.0	235.0	243.0	248.0	227.0	226.0	225.0
GERMANTOWN EMERGEN..	162.0	156.0	159.0	150.0	167.0				190.0	175.0	178.0	165.0	171.0	161.0	173.0				185.0
GRACE	220.0	243.0	218.0	209.0	212.0	199.0	223.0	215.0	200.0	203.0	197.0	210.0	185.0	185.0	197.0	198.0	168.0	169.0	182.0
HOLY CROSS	315.0	298.0	330.0	328.0	324.0	309.0	326.0	334.0	322.0	313.0		320.0	333.0	318.0	321.0	300.0	308.0		
HOLY CROSS GERMANTO..	237.0	224.0	248.0	232.0	232.0	225.0	242.0	230.0	223.0	226.0		220.0	219.0	215.0	227.0	220.0	225.0		
HOWARD	284.0	287.0	297.0	247.0	268.0	259.0	289.0	275.0	264.0	265.0	275.0	273.0	277.0	276.0	254.0	245.0	265.0	254.0	282.0
JH BAYVIEW	290.0	290.0	288.0	268.0	272.0	252.0	250.0	285.0	259.0	286.0	306.0	281.0	289.0	288.0	322.0	319.0	311.0	317.0	308.0
JOHNS HOPKINS	320.0	312.0	308.0	299.0	304.0	297.0	298.0	302.0	304.0	302.0	313.0	305.0	318.0	300.0	308.0	305.0	294.0	287.0	289.0
MEDSTAR FRANKLIN SQUA..	357.0	373.0	384.0	369.0	376.0	387.0	417.0	416.0	331.0	349.0	354.0	363.0	367.0	393.0	373.0	360.0	346.0	340.0	400.0
MEDSTAR GOOD SAMARIT..	234.0	231.0	239.0	225.0	234.0	202.0	237.0	238.0	210.0	208.0	198.0	188.0	190.0	200.0	220.0	580.0	579.0	207.0	223.0
MEDSTAR HARBOR	204.0	204.0	201.0	190.0	203.0	176.0	189.0	193.0	178.0	193.0	198.0	201.0	206.0	213.0	204.0	194.0	186.0	187.0	196.0
MEDSTAR MONTGOMERY	230.0	224.0	245.0	233.0	256.0	243.0	258.0	265.0	246.0	240.0	228.0	246.0	244.0	244.0	239.0	240.0	230.0	255.0	253.0
MEDSTAR SOUTHERN MA..	366.0	342.0	328.0	324.0	335.0	325.0	384.0	377.0	356.0	359.0	372.0	343.0	343.0	346.0	382.0	531.0	551.0	338.0	381.0
MEDSTAR ST. MARY'S	283.0	268.0	271.0	250.0	251.0	247.0	263.0	263.0	250.0	231.0	245.0	231.0	242.0	231.0	236.0	242.0	252.0	225.0	245.0
MEDSTAR UNION MEMORI..	211.0	221.0	226.0	218.0	235.0	215.0	237.0	232.0	225.0	212.0	230.0	205.0	203.0	214.0	210.0	216.0	214.0	208.0	211.0
MERCY	230.0	238.0	229.0	217.0	215.0	219.0	233.0	247.0	233.0	236.0	222.0	251.0	233.0	231.0	239.0	230.0	224.0	221.0	222.0
MERITUS	223.0	205.0	205.0	219.0	209.0	200.0	224.0	229.0	220.0	216.0	219.0	215.0	216.0	212.0	219.0	226.0	244.0	219.0	266.0
NORTHWEST	280.0	282.0	293.0	270.0	284.0	283.0	293.0	266.0	263.0	266.0	270.0	266.0	267.0	253.0	246.0	245.0	232.0	214.0	233.0
SHADY GROVE	282.0	256.0	252.0	241.0	247.0	245.0	238.0	217.0	203.0	206.0	227.0	234.0	222.0	217.0	234.0	231.0	223.0	220.0	232.0
SINAI	226.0	236.0	245.0	226.0	228.0	230.0	240.0	232.0	225.0	228.0	223.0	226.0	219.0	225.0	222.0	233.0	234.0	241.0	240.0
SUBURBAN	226.0	214.0	224.0	214.0	217.0	207.0	207.0	211.0	211.0	204.0	205.0	215.0	200.0	207.0	206.0	211.0	204.0	203.0	282.0
TIDALHEALTH MCCREADY			62.0	73.0	83.0	66.0	75.0	67.0	73.0	70.0	68.0	74.0	72.0	60.0	72.0	62.0	63.0	71.0	72.0
TIDALHEALTH PENINSULA		184.0	190.0	195.0	196.0	190.0	191.0	183.0	190.0	181.0	182.0	176.0	184.0	182.0	189.0	177.0	168.0	178.0	188.0
UM BWMC	312.0	315.0	282.0	279.0	271.0	277.0	274.0	269.0	264.0	273.0	274.0	277.0	263.0	278.0	253.0	251.0	258.0	249.0	278.0
UM CAPITAL REGION	261.0	273.0	267.0	260.0	264.0	256.0	283.0	270.0	259.0	253.0	254.0	267.0	263.0	253.0	260.0	241.0	241.0	228.0	248.0
UM SHORE CHESTERTOWN	166.0	171.0	160.0	176.0	184.0	147.0	185.0	196.0	177.0	161.0	167.0	167.0	162.0	170.0	159.0	164.0	160.0	157.0	177.0
UM SHORE EASTON	176.0	162.0	169.0	171.0	161.0	159.0	175.0	192.0	161.0	169.0	162.0	169.0	164.0	170.0	173.0	171.0	162.0	157.0	162.0
UM ST. JOSEPH	308.0	296.0	309.0	314.0	313.0	289.0	317.0	298.0	290.0	281.0	279.0	293.0	291.0	286.0	263.0	264.0	262.0	251.0	272.0
UMMC DOWNTOWN	301.0	306.0	298.0	293.0	289.0	290.0	299.0	311.0	319.0	294.0	297.0	292.0	285.0	294.0	287.0	307.0	293.0	292.0	297.0
UMMC MIDTOWN	254.0	276.0	267.0	265.0	262.0	231.0	289.0	300.0	271.0	263.0	243.0	251.0	218.0	262.0	239.0	254.0	229.0	225.0	229.0
UPMC WESTERN MD	229.0	232.0	246.0	244.0	268.0	249.0	251.0	249.0	247.0	244.0	227.0	234.0	222.0	248.0	247.0	256.0	231.0	232.0	241.0
UPPER CHESAPEAKE	269.0	275.0	272.0	265.0	275.0	276.0	304.0	296.0	285.0	269.0	279.0	290.0	283.0	257.0	273.0	244.0	230.0	219.0	257.0
WHITE OAK	455.0	403.0	419.0	395.0	452.0	402.0	426.0	444.0	438.0	396.0	386.0	443.0	429.0	425.0	366.0	382.0	383.0	344.0	295.0

OP18c Update





OP18c Update



OP18c Update

Average Median Wait Time All Hospitals for OP-18c

Measure
OP-18c

Change from Base
-590 1,072

Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024	September 2024	October 2024	November 2024	December 2024
AAMC	394	383	353	385	393	372	363	349	344	330	322	331		360	353	356	323	292	291
ASCENSION SAINT AGNES	379	342	389	330	371	384	387	391	402	365	373			346	360	339	411	344	347
ATLANTIC GENERAL	164	179	175	151	156	136	158		171	149	159	139	185	167	182	156	147	127	174
CALVERT		282	302	302	318	270	328	283	301	307	292	288	256	266	289	224	310	263	272
CARROLL	322	423	323	260	296	339	325	329	286	320	381	330	299	260	271	319	304	371	319
CHARLES REGIONAL	444	433	419	453	476	487	475	414	521	410	502	488	472	446	536	504	487	475	507
CHRISTIANACARE, UNION	202	236	238	260	253	250	237	341	306	316	324	345	287	277	308	270	236	275	
DOCTORS	451	363	389	393	380	397	404	447	411	389	397	432	386	380	299	414	357	369	376
FREDERICK		343	335	376	426	395	435	484	433	396	435	373	350	382	401	368	327	342	352
FT WASHINGTON	729	847	1,078					1,801	629	381		590	267	139	1,363	1,055	902	572	724
GARRETT			288		288	167	154	144	166	169	167	188	193	217	145	202	179	190	127
GBMC	506	681	587	631	534	714	592	586	576	723	482	417	463	498	462	488	452	484	581
GERMANTOWN EMERGEN..	87	69							246	105		18				178	173	167	
GRACE	912	845	1,083	1,313	1,187	909	859	837	833	1,050	814	872	1,074	877	876	1,230	808	721	552
HOLY CROSS	751	609	726	701	586	642	524	577	569	633		427	651	504	469	507	462		
HOLY CROSS GERMANTO..	579	496	386	364	426	434	383	406	415	454		429	313	411	420	535	454		
HOWARD	687	445	503	550	571	496	549	714	644	479	582	667	623	647	504	513	660	682	689
JH BAYVIEW	659	678	714	598	635	684	630	593	601	574	583	417	492	562	571	546	568	528	466
JOHNS HOPKINS	496	488	583	595	564	540	612	598	508	550	466	546	557	520	572	580	484	520	467
MEDSTAR FRANKLIN SQUA.	353	365	337	324	328	370	405	406	398	366	364	403	342	398	333	372	334	367	391
MEDSTAR GOOD SAMARIT..	324	333	292	314	364	285	337	351	315	273	298	259	280	291	305	222	212	274	292
MEDSTAR HARBOR	333	336	322	346	361	279	316	330	297	310	282	338	289	296	284	305	284	252	291
MEDSTAR MONTGOMERY	276	320	302	345	386	309	392	416	322	396	313	282	319	290	292	288	313	323	286
MEDSTAR SOUTHERN MA..	390	426	422	399	467	432	479	491	398	412	429	534	388	370	436	366	342	430	501
MEDSTAR ST. MARY'S	302	293	310	271	289	295	297	290	293	269	275	244	276	259	281	284	301	278	263
MEDSTAR UNION MEMORI..	401	332	307	325	359	299	359	346	342	303	371	359	320	357	346	351	316	318	310
MERCY	276	302	287	274	289	275	269	324	326	258	333	319	285	307	271	321	266	238	271
MERITUS	269	251	246	262	266	301	284	293	256	283	300	291	305	254	302	292	299	278	292
NORTHWEST	700	776	698	767	677	669	713	739	680	776	795	661	837	797	648	645	459	566	517
SHADY GROVE	574	294	741	1,323	466	411	288	330	478	288	574	255	522	423	265	986	361	683	294
SINAI	692	672	648	717	622	518	698	659	833	773	722	634	579	657	490	714	609	771	638
SUBURBAN	300	322	359	299	362	300	291	308	295	277	346	305	279	325	334	306	323	269	689
TIDALHEALTH MCCREADY			24	52	140	99	74	133	74	37	195	121	113	103	84	48	41	36	89
TIDALHEALTH PENINSULA		202	225	254	189	270	227	208	197	226	226	237	232	221	259	211	217	240	219
UM BWMC	413	469	377	446	420	446	553	443	440	434	397	404	516	442	451	437	499	481	426
UM CAPITAL REGION	508	473	488	522	406	491	514	465	397	497	455	425	436	407	411	430	341	320	423
UM SHORE CHESTERTOWN	214	313	411	329	382	293	363	411	459	324	239	757	244	523	683	221	263	247	481
UM SHORE EASTON	276	265	330	314	275	258	307	366	274	307	304	296	311	301	415	332	334	344	238
UM ST. JOSEPH	537	656	548	611	576	451	469	479	420	471	461	508	559	575	511	565	467	463	578
UMMC DOWNTOWN	531	419	448	500	416	365	443	450	455	363	391	376	399	491	374	409	404	377	391
UMMC MIDTOWN	398	440	420	483	379	390	426	492	444	416	376	398	313	361	364	403	399	307	275
UPMC WESTERN MD	309	415	289	398	337	399	353	349	451	372	338	367	325	348	351	352	345	303	274
UPPER CHESAPEAKE	473	556	526	495	482	585	657	634	611	525	538	498	495	494	505	494	411	474	418
WHITE OAK	748	655	545	1,198	963	634	737	1,237	1,032	1,109	1,286	750	1,575	746	746	807	1,095	753	719

EMS Turnaround Times: December Performance

- 23 hospitals reported the 90th percentile of turnaround time was <=35 minutes
- 24 hospitals reported the 90th percentile of turnaround time was 35-60 minutes
- 5 hospitals reported the 90th percentile of turnaround time was over 60 minutes
- Hospitals with improving performance
  - (Average to high performing): NA
  - (Low performing to average): NA
- Hospitals with declining performance
  - (High performing to average): Anne Arundel Medical Center, Bowie Health Center, Carroll Hospital Center, MedStar Franklin Square, Grace Medical Center, Union Hospital, Upper Chesapeake Medical Center
  - (Average to low performing): Doctors Community Medical Center, Fort Washington Medical Center, Howard County Medical Center

EMS Turnaround Times: December 2024 Performance

90th Percentile: 0-35 Minutes

Atlantic General Hospital
CalvertHealth Medical Center
Cambridge Free-Standing ED
Chestertown
Frederick Health Hospital
Garrett Regional Medical Center
Germantown Emergency Center
Good Samaritan Hospital
Holy Cross Germantown Hospital
Holy Cross Hospital
Johns Hopkins Hospital PEDIATRIC
McCready Health Pavilion
Meritus Medical Center
Montgomery Medical Center
Peninsula Regional
Queenstown Emergency Center
R Adams Cowley Shock Trauma Center
Shady Grove Medical Center
St. Mary's Hospital
Union Memorial Hospital
Upper Chesapeake Health Aberdeen
Walter Reed National Military Medical Center
Western Maryland

>35 Minutes

Anne Arundel Medical Center -
Baltimore Washington Medical Center
Bowie Health Center -
Carroll Hospital Center -
Charles Regional
Easton
Franklin Square -
Grace Medical Center -
Greater Baltimore Medical Center
Harbor Hospital
Johns Hopkins Bayview
Johns Hopkins Hospital ADULT
Laurel Medical Center
Mercy Medical Center
Midtown
Northwest Hospital
Sinai Hospital
St. Agnes Hospital
St. Joseph Medical Center
Suburban Hospital
Union Hospital -
University of Maryland Medical Center
Upper Chesapeake Medical Center -
White Oak Medical Center

>60 Minutes

Capital Region Medical Center
Doctors Community Medical Center -
Fort Washington Medical Center -
Howard County Medical Center -
Southern Maryland Hospital

maryland health services cost review commission

(+): Hospital improved by one or more categories; **(-)**: Hospital declined by one or more

maryland
health services
cost review commission

TO:
HSCRC Commissioners

FROM:
HSCRC Staff

DATE:
January 8, 2025

RE:
Hearing and Meeting Schedule

February 12, 2025 In person at HSCRC office and Zoom webinar

March 12, 2025 In person at HSCRC office and Zoom webinar

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

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