maryland
health services
cost review commission

x621st Meeting of the Health Services Cost Review Commission

June 14, 2024

(The Commission will begin in public session at 11:00am for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 12:00pm)

CLOSED SESSION
11:00am

1. Discussion on Planning for Model Progression - Authority General Provisions Article, §3-103 and §3-104
2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

PUBLIC MEETING
12:00 pm

1. Review of Minutes from the Public and Closed Meetings on May 8, 2024

Informational Subjects

2. Presentation on Overdose in Maryland

Specific Matters

3. Docket Status – Cases Closed

   2645A Johns Hopkins Health System

4. Docket Status – Cases Open

   2646N UM Shore Medical Center at Easton
   2647A Johns Hopkins Health System
   2648N Johns Hopkins Hospital
   2649A Johns Hopkins Health System
   2651A Johns Hopkins Health System

Subjects of General Applicability

5. Report from the Executive Director
   a. EDDIE Update
   b. Update: Community Benefit Reporting Instructions

c. Facility Fee Workgroup

6. Final Recommendation: RVU Updates
7. Final Recommendation: CRISP Funding - FY 2025
8. Final Recommendation: Update Factor - FY 2025
9. Hearing and Meeting Schedule

MINUTES OF THE 620th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION May 8, 2024

Chairman Joshua Sharfstein called the public meeting to order at 12:05 p.m. In addition to Chairman Sharfstein, in attendance were Commissioners Joseph Antos, PhD, James Elliott, M.D., Adam Kane, Ricardo Johnson, and Maulik Joshi. Commissioner Nicki McCann, J.D, attended virtually. Upon motion made by Commissioner Joshi and seconded by Commissioner Johnson, the Commissioners voted unanimously to go into Closed Session. The Public Meeting reconvened at 1:10 p.m.

REPORT OF MAY 8, 2024, CLOSED SESSION

Paul Katz, Analyst, External Affairs and Policy, summarized the items discussed at the May 8, 2024, Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE APRIL 10, 2024, PUBLIC MEETING AND CLOSED SESSION

The Commission voted unanimously to approve the minutes of the April 10, 2024, Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM II
QUEEN ANNE'S COUNTY MOBILE INTEGRATED COMMUNITY HEALTH PROGRAM

Dr. Joseph Ciotola and Jared Smith presented an update on the Queen Anne's County Mobile Integrated Community Health Program (see "Queen Anne's County Mobile Integrated Community Health Pioneering Solutions for Enhanced Care" available on the HSCRC website).

Queen Anne's County, Maryland, does not have a hospital to provide emergency services, emergency department visits, and hospital admission. The Queen Anne's County Mobile Integrated Community Health (MICH) Program was created in 2014.

Program participants receive visits from these members of the MICH team:

- Department of Health community health nurse
- Department of Emergency Services paramedic
- University of Maryland Shore Regional Health at Easton Pharmacist

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- Peer support specialist if needed.
- License addictions counselor if needed.

MICH received a three-year grant from CareFirst, which allowed the program to add a telehealth component in 2016. MICH also receives funding from other grants, partnering hospital systems, local funding, and in-kind services.

The MICH program is available to adults who are considered high-risk for frequent use of emergency services, emergency department visits, and hospital readmissions or to any adult found to have unmet social or healthcare needs. Services to these participants include:

- Education about specific medical conditions
- Fall risk assessments.
- Home safety checks
- Nutrition status (if someone has enough nutritious food)
- Social support evaluation
- Substance use risk analysis.

Referrals to the MICH may be identified through 911 calls or other sources. Participation in the program is voluntary and there is no fee for this service. Eligibility for the MICH program is for adults 18 and over who live in Queen Anne's County. A member of MICH team will contact patients to arrange an appointment for a home visit.

Between July 2016 and March 2024, the program made 1,098 patient contacts. This resulted in a reduction in emergency department and inpatient visits and costs. The average patient contact per year is approximately 150 patients. The average medications provided per patient is 10 and the number of comorbidities per patient is 6. The median age of the patients is 71 years old with 75% of patients over age of 65. Total average cost per year for the program is around $500,000.

ITEM III
INNOVATION COMPETITION – HSCRC & MARYLAND DEPARTMENT of HEALTH PARTNERSHIP

Dr. Laura Herrera Scott, Secretary of Health, Maryland Department of Health and Dr. Jon Kromm, Executive Director, presented an update on the Advancing All-Payor Health Equity Approaches and Development (AHEAD) Program partnership between the HSCRC and Maryland Department of Health (MDH) (see "Promoting Innovation in Care Delivery" available on the HSCRC website).

AHEAD is a state total cost of care (TCOC) model that seeks to drive state and regional health care transformation and multi-payer alignment, with the goal of improving the total health of a state population and lowering costs across all payers, including Medicare, Medicaid, and private coverage. The model aims to support the delivery of high-quality care, improved population health, greater care coordination, and advanced health equity by supporting underserved patients. AHEAD aims to increase resources

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available to participating states to improve the overall health of their population, support primary care, and transform health care in their communities.

HSCRC/MDH is looking to kickstart an innovation ideas contest to recruit ideas for innovation in care, coordination, and payment. Winning ideas will be presented to the MDH and HSCRC leadership for discussion and consideration. Ideas may or may not prove feasible and appropriate for implementation. An idea that is not possible now may be worth pursuing later in the model. HSCRC/MDH will start by tapping into the intellectual capital of our state and asking what might be possible.

The AHEAD innovation ideas contest process is as follows

- Step 1: A public call for judges. The goal will be a diverse set of judges from multiple perspectives.
- Step 2: Development of rules for the contest. MDH and HSCRC will set the rules for 3 categories: innovation in care, innovation in coordination, and innovation in payment. To support specific problem solving, HSCRC will make information available for specific care and payment challenges, such as pediatric asthma, sickle cell disease, emergency department utilization, and post-acute care
- Step 3: Administration of the contest
- Step 4: Cash prizes, expected to be funded by the Abell Foundation and Horizon Foundation.

ITEM VI
UPDATE: REVENUE FOR REFORM

Erin Schurmann, Chief, Provider Alignment and Special Project, presented an update on the Revenue for Reform for Year 1 and revisions to be made in Year 2 (see "Revenue for Reform Update Year 2 Revisions & Next Steps" available on the HSCRC website)

Under Global Budget Revenue ("GBR") rate-setting methodologies, hospitals have retained significant revenue as volume declines, which results in higher charges for consumers. However, retained revenues are necessary to allow hospitals to invest in population health and other delivery system transformation. The Integrated Efficiency Policy addresses excessively high charges by withholding inflation from hospitals with excess costs relative to their peers. But currently, only traditional hospital costs are included in the Inter Hospital Cost Comparison (ICC). This potentially penalizes hospitals that have reinvested their retained revenues in population health management. The Revenue for Reform (RFR) policy is intended to safe harbor population health investments from the Integrated Efficiency Policy. The RFR policy will separate hospital expenditures into 'core hospital expenditures' and 'population health expenditures.' Expenditures must be net of any revenue received. RFR is intended to integrate community health spending directly into the hospital's global budgets. Currently, HSCRC policies (e.g., CTI, GBR, etc.) work for interventions that hospitals physically deploy within their hospitals/health systems. RFR is thus targeted at interventions physically deployed outside of the hospital.

The primary goal of the RFR policy is to:

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- Direct hospitals retained revenue to community-based population health investments and drive. population health improvement.
- Support projects that advance the goals of the TCOC Model to improve health equity, population health, and reduce total cost of care.
- Create a virtuous cycle between less need for hospital services and growing hospital investments in the community.

Year 1 strengths

- $26 million has been directed to community health and expanding/maintaining access to physicians in Baltimore County, the Eastern Shore, and the DC Metro region.
- Valuable dialogues about population health spending between health systems, HSCRC and Maryland Department of Health (MDH).
- Achievements made in Intervention goals are as follows:

  - Health Behaviors

    1. Reduced Substance use disorder and overdose deaths.
    2. Increase patient-self management of chronic diseases.
    3. Reduce diabetes incidence through exercise and education.

  - Social and Economics

    1. Increase job opportunities.
    2. Expand supportive services for victims of partner violence.
    3. Reduce health disparities in the LGBTQIA population.
    4. Increase SDOH screening and community referral partners.

  - Clinical Care (non-hospital based)

    1. Increase the number of primary care providers
    2. Expand Telehealth
    3. Expand access to post-acute care for uninsured population.
    4. Reduce childhood asthma ED visits through mobile health

  - Physical Environment

    1. Expand on permanent housing services
    2. Expand temporary housing for high needs patients with housing instability or no housing

Challenges for Year 1 are as follows:

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- While $26 million across nine hospitals was approved for investment, this was out of a potential $43 million which means that $17 million was not invested into health population intervention.
- Community Health

    - ➢ It was unclear how hospital applications connected to broader population health strategies.
    - ➢ Measuring impact will be difficult because there were not consistent impact measures used across programs.
    - ➢ The level of cost reporting was insufficient to understand the full use of funding.
    - ➢ There is potentially duplicative funding for programs also supported by MDH.
    - ➢ Some long-standing interventions have not shown outcomes to date.

- Physician Spending

    - ➢ It was unclear how hospital applications connected to broader access strategies.
    - ➢ Substantial variability in amount of funding proposed per practitioner and patient served.
    - ➢ The level of cost reporting was insufficient to understand the full use of funding.

- MDH and HSCRC should provide more effective guidance on specific projects that would be high value investments.
- The application would benefit from more guidance on the details required, evaluation criteria, cost reporting, and required data analyses.
- Staff discussed proposed adaptations for Year 2 which will offer three tracks to hospitals.
    - Track 1 - Community Health interventions that:
        - Address the top drivers of avoidable utilization, readmissions, and/or total cost of care, and also align with the hospital CHNA or CDC Healthy People 2030.
        - Fit clearly into an overall population health strategy by the hospital.
        - Have clearly defined populations and outcome measures, with the HSCRC & MDH recommended common measures as appropriate.
        - Involve trusted community partners as appropriate for the project.
        - Have a viable plan for assessing results.
        - HSCRC and MDH will request a broader view of financial needs of programs.
        - HSCRC and MDH will review and approve/reject applications.
    - Track 2 – Physician Spending
        - Support primary care, mental health, and dental providers in HPSAs and MUAs.
        - Fit clearly into an overall provider access strategy by the hospital.
        - HSCRC and MDH will request a broader view of financial needs of practices.

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        - Additional review will be applied to funding per practitioner and/or patient panel to assure that expenses are reasonable.
        - HSCRC and MDH will review and approve/reject applications.
    - Track 3 - Pre-approved community partnerships
        - Selected by a committee of HSCRC & MDH, based on proven experience implementing effective population health interventions.
        - If there are insufficient Track 1 and 2 investments, hospitals will be directed to invest in Track 3.
- Staff indicated that they would return in the July 2024 meeting with a policy development plan for FY 2026.

ITEM V
PRESENTATION BY THE MARYLAND HOSPITAL ASSOCIATION: HOSPITALS & NURSE EDUCATION

Ms. Jane Krienke, Senior Analyst, Government Affairs, Maryland Hospital Association, presented an update on the challenges impacting the state's nursing workforce and the value of the Nurse Support Program II (NSP II) (see "Hospitals & The Significance of Nurse Education" available on the HSCRC website").

ITEM VI
FINAL RECOMMENDATION: NURSE SUPPORT PROGRAM II GRANTS – FY2025

Ms. Laura Schenk, NSP II Grant Administrator, and Ms. Kim Ford, Assistant Grant Administrator, Maryland Higher Education Commission, presented the final recommendation for the Nurse Support Program II (NSP II) FY 2024 Competitive Institutional Grants (See "Nurse Support Program II Competitive Grants Program Review Panel Recommendations for FY 2025" available on the HSCRC website).

The HSCRC initiated nurse education support funding (formerly titled the Nurse Education Support Program or NESP) in 1986 through the collaborative efforts of hospitals, payers, and nursing representatives. In 2000, HSCRC implemented the Nurse Support Program I (NSP I) to address the issues of recruiting and retaining nurses in Maryland hospitals. In 2005, seventy-nine percent (79 percent) of the RN programs reported that they had met or exceeded their enrollment capacity. The shortage of qualified nursing faculty was identified as the fundamental obstacle to expanding the enrollments in nursing programs, thereby exacerbating the nursing shortage. The HSCRC proactively created NSP II to address the barriers to nursing education through statute with the Annotated Code of Maryland, Education Article § 11-405 Nurse Support Program Assistance Fund. The HSCRC established the NSP II on May 4, 2005, to increase Maryland's academic capacity to educate nurses.

NSP II is distinct from, and in addition to, the NSP I hospital-specific program but shares a mutual goal to increase the number of nurses in Maryland hospitals. NSP II focuses on expanding the capacity to educate more nurses through increasing faculty and strengthening nursing education programs at Maryland institutions. Provisions included a continuing, non-lapsing fund with a portion of the competitive and

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statewide grants earmarked for attracting and retaining minorities in nursing and in nurse faculty careers in Maryland. The Commission approved funding of up to 0.10 percent of regulated gross patient revenue to increase nursing graduates and mitigate barriers to nursing education through institutional and faculty-focused statewide initiatives. MHEC was selected by the HSCRC to administer the NSP II programs as the coordinating board of higher education. After the conclusion of the first ten years of funding, the HSCRC continued to renew the NSP II funding, through June 30, 2025.

FY 2024 Recommendation for Funded Proposal

Proposal	School	Total Funding Request
NSP II-25-101	Allegany College of MD	$ 913,019
NSP II 25-104	Frostburg State University	2,150,127
NSP II 25-105	Hagerstown Community College	1,656,426
NSP II 25-106	Johns Hopkins University	443,693
NSP II 25-109	Notre Dame of MD University	15,256
NSP II 25-111	Salisbury University	142,764
NSP II 25-112	University of Maryland, Baltimore	480,907
NSP II 25-113	University of Maryland, Baltimore	1,173,229
NSP II 25-115	University of Maryland, Baltimore	75,764
NSP II 25-201	Anne Arundel Community College	50,000
NSP II 25-202	Allegany College of MD	34,560
NSP II 25-203	Carroll Community College	49,975
NSP II 25-204	Chesapeake College	7,460
NSP II 25-205	Coppin State University	64,260
NSP II 25-206	Frostburg State University	44,417
NSP II 25-207	Harford Community College	48,995
NSP II 25-208	McDaniel College	18,186
NSP II 25-209	Montgomery College	1,566,000
NSP II 25-210	Montgomery College	48,762
NSP II 25-211	Notre Dame of MD	49,827
NSP II 25-213	Prince George's Community College	50,000
NSP II 25-214	Salisbury University	50,000
NSP II 25-215	Towson University	50,000
NSP II 25-216	Johns Hopkins University	813,518
NSP II 25-217	University of Maryland, Baltimore	484,805
5 NSP II 25-218	University of Maryland, Baltimore	756,346
NSP II 25-219	University of Maryland, Baltimore	1,846,767
	TOTAL	13,085,063

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

ITEM VII
REPORT FROM THE EXECUTIVE DIRECTOR

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Dr. Kromm stated that the Hospital's Financial Condition Reports are available online.

Dr. Kromm also stated that beginning in October the HSCRC is requiring hospitals to submit sexual orientation and gender identifying data to the Commission. He noted that Staff will be conducting virtual training for the new data request on May 27th and June 7th.

Model Monitoring

Deon Joyce, Chief of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 12 months ending December 2023. The data showed that Maryland's Medicare Hospital spending per capita growth was unfavorable when compared to the nation. Ms. Joyce stated that Medicare Nonhospital spending per-capita was unfavorable when compared to the nation. Ms. Joyce noted that Medicare TCOC spending per-capita was unfavorable when compared to the nation. Ms. Joyce stated that the Medicare TCOC guardrail position is 1.81% below the nation through December, and that Maryland Medicare hospital and non-hospital growth through December shows a savings of $204,936,000.

Update on Hospital Reimbursement Law Implementation

Megan Renfrew, Deputy Director of Policy and Consumer Protection, presented an update on Hospital Free Care Reimbursement Law (see "Hospital Free Care Reimbursement Law Implementation" available on the HSCRC website").

ITEM VIII
ACCOUNTING and BUDGET MANUAL UPDATES

Wayne Nelms, Assistant Chief, Audit & Integrity, presented an update on the modernization of the HSCRC Accounting and Budget Manual (see " Update to the Accounting and Budget Manual" available on the HSCRC website).

In August 2023, the HSCRC engaged I3 Healthcare Consulting to assist with an Annual Filing Modernization (AFM) initiative. The overall goal of this project is to obtain additional information about the operational costs at regulated hospitals to better improve HSCRC oversight, as well as streamline the documentation and collection of this information. Part of AFM project is to update and modernize the HSCRC Accounting and Budget Manual (Budget Manual).

The current version of the Budget Manual was created in the late 1970s. Since that time, there have been revisions but not a complete overhaul. The objective of is to modernize the manual by first removing information which is no longer relevant; adding new content and improving the way readers of the manual view and query its content. At this time, HSCRC has removed outdated content and revised other portions of the manual.

A summary of these changes are as follows:

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- Removed general accounting principles;
- Removed instructions for establishing an accounting system;
- Updated and added Cost Center information; List of Updates (continued) (Bdget
- Updated mailbox addresses;
- Removed reports no longer relevant;
- Updated instructions;
- Updated checklists;
- Added and updated hospital names, financial and Medicare identification numbers

ITEM IX
DRAFT RECOMMENDATION: RELATIVE VALUE UNITS UPDATES

Mr. William Hoff, Chief Audit & Compliance, presented Staff's draft recommendation on changes to the Relative Value Units (RVUs) for Speech Therapy (STH) and Audiology (AUD) Recommendation on Changes to the Relative Value Units for Clinic Effective July 1, 2024" on the HSCRC website).

On October 24, 2023, the HSCRC staff convened a workgroup to review and initiate changes to the STH & AUD RVUs and the guidelines for these rate centers. The members of this workgroup included Hospitals, Maryland Hospital Association, Insurance Companies, and Hospital Consultants. These changes were initiated for the following reasons:

1. They standardize RVUs using the Medicare Physician Fee Schedule (MPFS) weights; they update new codes using national CPT code definitions; and they remove inactive codes from Appendix D of the Commission's Accounting and Budget Manual.
2. They assign RVUs procedures that are currently being reported as "By Report."
3. They update the RVUs to reflect how STH/AUD services have changed over time. These visits now focus primarily on optimizing a patient's physical function in everyday, meaningful life activities, preventing disability, and maintaining health.

Staff's draft recommendation is as follows:

1. That the Commission approves the revisions to the RVU scale for the STH & AUD Rate Centers. The revisions are specific to the Chart of Accounts and Appendix D of the Budget Manual. These revised RVUs are based on MPFS weights and were reviewed by a workgroup facilitated by the HSCRC staff;
2. That the RVU scale be updated to reflect linkages of RVUs to the CPT codes to incorporate the changes in STH & AUD practices. The RVU scale was also updated to link charging guidelines for STH & AUD services to the national definition, consistent with the HSCRC's plan to adopt MPFS RVUs where possible;
3. That the new and updated RVUs be effective July 1, 2024, and that the conversion of the STH & AUD RVUs be revenue neutral to the overall Hospital Global Budget Revenues; and
4. That revisions to Appendix-D and the Chart of Accounts for Medical Supplies Sold be effective July 1, 2024.

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No Commissioner action is necessary as this is a draft recommendation.

ITEM X
DRAFT RECOMMENDATION: CRISP FUNDING – FY 2025

Mr. Craig Behm, President & CEO, and Megan Priolo Executive Director, Chesapeake Regional Information System for our Patients (CRISP) presented the draft recommendations for FY 2025 funding to support Health Information Exchange (HIE) Operations and CRISP (See "Maryland's Statewide Health Information Exchange (HIE), the Chesapeake Regional Information System for our Patients: FY 2025 Funding to Support HIE Operations and CRISP Reporting Services" on the HSCRC website).

Beginning in FY 2020, HSCRC assumed full responsibility for managing the CRISP assessment, previously shared with MHCC. CRISP-related hospital rate assessments are paid into an HSCRC fund, and the HSCRC reviews the invoices for approval of appropriate payments to CRISP. This process which includes bi-weekly update meetings, monthly written reports, and auditing of the expenditures, has created transparency and accountability. Starting in FY 2023, CRISP's reimbursement from the HSCRC was provided in two tranches: one relating to state match funding of core HIE operational costs and the other related to Reporting and Program Administration. This change is being made to allow CRISP to recover operational reimbursement from the HSCRC in a timelier fashion.

HSCRC funding has been used to obtain federal matching funds throughout the history of the program. The federal match is obtained through the program outlined below. The Health Information Technology for Economic and Clinical Health Act (HITECH) Implementation Advance Planning Document (IAPD) program was previously the source of most federal funding, and it was terminated September 30, 2021. Funding has now moved to the Medicaid Enterprise System (MES) program. The MES program requires a 25 percent match for ongoing programs versus the 10 percent in place under IAPD.

MES is a federal program designed to promote effective care for Medicaid beneficiaries through investments in information technology infrastructure. Medicaid benefits from CRISP's data sharing and reporting initiatives through the care management and cost control initiatives facilitated for all Medicaid patients under CRISP all-payer activities and for dual-eligible patients under CRISP's Medicare activities.

Activities funded under this element of the assessment include point-of-care and other provider data sharing initiatives, and CRISP reporting tools utilizing the Medicare claims and the HSCRC's hospital case mix data. Hospitals, the HSCRC, and other stakeholders use CRISP reporting from these datasets to manage and track progress under several HSCRC programs and enable hospitals to identify and pursue care efficiency initiatives.

In accordance with its statutory authority to approve alternative methods of rate determination consistent with the Total Cost of Care Model and the public interest,1 this recommendation identifies the following amounts of State-supported funding for fiscal year (FY) 2025 to the Chesapeake Regional Information System for our Patients (CRISP):

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- Direct funding and matching funds under MES Federal Programs for HIE operations and infrastructure ($3,080,000)

- Direct funding and MES matching funds for reporting and program administration related to population health, the Total Cost of Care Model, and hospital regulatory initiatives ($6,340,000). Staff propose using $1,000,000 of accumulated reserves to reduce the revenue generated through rates for FY2025 to $5,340,000 for this component.

Therefore, Staff recommends that the HSCRC provide funding to CRISP totaling $8,420,000 for FY 2025. As a result, the HSCRC will be funding approximately 20 percent of CRISP's Maryland funding, compared to budgeted 15 percent in FY 2024. The increase in funding from $4,800,000 to $8,420,000 is related to a change in the requirements to obtain Federal matching funds as described below and a reduction in the amount drawn from accumulated reserves from $1,700,000 to $1,000,000 as those reserves are spent down. The increase in the share of CRISP funding being paid through hospital rates also relates to the Federal funding change. The remainder of CRISP's Maryland funding is derived from user fees, federal matching funds and the Maryland Department of Health.

No Commission action is necessary as this is a draft recommendation.

ITEM XI
UPDATE: EMERGENCY DEPARTMENT WAIT TIMES

Emergency Department Dramatic Improvement Effort:

Geoff Dougherty, Deputy Director, Population-Based Methodologies, Analytics and Modeling, presented, the monthly update on the Emergency Department Dramatic Improvement Effort (EDDIE) Performance for April (see "Emergency Department Dramatic Improvement Effort" available on the HSCRC website).

Dr. Dougherty stated that Staff received April data from 41 out of 44 hospitals. The results of the data show the following:

- Emergency Department (ED) Median wait times in April show a slight increase when compared to March's data.

Dr. Dougherty stated that the April turnaround data was not provided. Results will be included in next month's report.

Multi-Visit Patient Policy:

Oseizame Emasealu presented an update on the Emergency Department Multi- Visit Program (MVP) (see Update: Emergency Department Multi-Visit Program" available on the HSCRC website").

The MVP Program timeline is as follows:

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- CY2021: The Commission asked staff to develop a policy providing hospital payment incentives for reduction of avoidable Emergency Department (ED) utilization.
- CY 2022: Performance Measurement Workgroup was convened to evaluate policy options for the reduction of ED potentially avoidable utilization.

    - Stakeholders recommended the development of policy focused on ED multi-visit patients (MVPs).

- CY23: Staff developed MVP measure, placed into monitoring status, began providing monthly reports to hospitals on CRISP portal.
- February 2024: The Commission asked staff to provide information on proposed or ongoing MVP intervention programs at the hospital EDs.

MVPs are patients with four or more ED visits in a calendar year at any hospital, regardless of their disposition. Most MVPs visited one or two hospitals during the year for all of their care. When those visits involved multiple hospitals, the hospitals tended to be within the same health system.

The takeaway from the MVP survey (program) are as follows.

- Less than half of the state hospitals have an established MVP program.
- While hospitals have invested in care management, MVPs are a unique population that can benefit from specialized programs. Resources committed to MVP are not in line with the size of the problem and potential ROI from addressing it
- No uniformity in defining and identifying MVPs.
- No clear outcome measurement metrics
- Global budgets alone have not compelled the hospitals to significantly address multi-visit patients
- Thus, the staff is working on an updated recommendation for building a policy around MVP's and will be back to the Commission shortly.

ITEM XII
DRAFT RECOMMENDATION: UPDATE FACTOR – FY 2025

Mr. Jerry Schmith, Principal Deputy Director, Hospital Rate Revenue and Regulations, Mr. William Henderson, Principal Deputy Director, Medical Economics & Data Analytics, and Mr. Allan Pack, Principal Deputy Director, Quality and Population Based Methodologies, presented staff's draft recommendation for the Update Factors for FY 2024 (See "Draft Recommendation for the Update Factors for FY 2025" available on the HSCRC website).

The Maryland Health Services Cost Review Commission (HSCRC or Commission) updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy-related adjustments, other adjustments related to performance, and settlements from the prior year. For this upcoming fiscal year in the development of the update factor, the HSCRC is considering the impact

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recent inflationary trends have had on the healthcare industry. As in all the HSCRC policies, this draft recommendation strives to achieve a fair and equitable balance between providing sufficient funds to cover operational expenses and necessary investments, while keeping the increase in hospital costs affordable for all payers.

In considering the system-wide update for the hospitals with global revenue budgets under the Total Cost of Care Model, Staff sought to achieve balance among the following conditions:

- Meeting the requirements of the Total Cost of Care Model agreement, including achieving $336 million in annual Medicare savings by the end of CY 2024;
- Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes;
- Ensuring that hospitals have adequate resources to invest in care coordination and population health strategies necessary for long-term success under the Total Cost of Care Model;
- Incorporating quality performance programs; and
- Ensuring that healthcare remains affordable for all Marylanders.

To meet the ongoing requirements of the Model, HSCRC will need to continue to ensure that state-wide hospital revenue growth is in line with the growth of the economy. The HSCRC will also need to continue to ensure that the Medicare TCOC Savings Requirement is met. The approach to developing the RY 2025 annual update is outlined in this report, as well as Staff's estimates on calendar year Model tests.

Hospital revenue is divided into two categories:

- Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority. The proposed update factor for hospitals under Global Budget Revenues is a revenue update. A revenue update incorporates both price and volume adjustments for hospital revenue under Global Budget Revenues. The proposed update should be compared to per-capita growth rates, rather than unit rate changes.

- Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland and, thus, Medicare does not pay based on those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital. The proposed update factor for these hospitals is strictly related to price, not volume.

HSCRC Staff accounted for several factors that are central provisions to the update process and are linked to hospital costs and performance. These include:

- **Adjustment for Inflation (3.15):** The gross inflation allowance is calculated using 91.2 percent of Global Insight's Fourth Quarter 2023 market basket growth of 3.20 percent with 8.80 percent of the capital growth index change of 2.60 percent. The adjustment for inflation includes 4.00

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percent for wage and compensation. Staff anticipates that the gross blended statistic of 3.15 percent will change once Global Insight releases its First Quarter 2024 book, which is historically the basis for the Commission's Update Factor recommendation. Due to the delayed release of the book, staff did not reflect the updated market basket growth statistics in the Draft Recommendation but will update the Final Recommendation in line with historical practice.

- **Additional Inflations Support (0.65):** Staff recommend providing an additional 0.65 percent to account for historical underfunding of inflation. It should be noted that this allowance follows several guiding principles including considering historical overfunding allowances, allowing for two-sided risk, utilizing multi-year solutions to ensure savings targets are met, and establishing formulaic methods for hospital and payer predictability. Using these principles, Staff developed a methodology that calculates a five-year cumulative value of under or over funding. Staff then notes the maximum risk tolerance, which is the max 5-year overfunding in any given year since 2014, i.e., the cumulative overfunding value that the Commission allowed without revising future funded inflation downwards. In effect, Staff are creating a risk corridor by which the Commission would not adjust future inflation if the variance between actual inflation and funded inflation was within 1.18 percent. Conversely, if the variance between actual inflation and funded inflation is within 1.18 percent, this methodology would not recommend any adjustments, as that level of variance was "tolerated" in prior years.

- **Outpatient Oncology and Infusion Drugs (0.10):** The rising cost of drugs, particularly of new physician-administered oncology and infusion drugs in the outpatient setting led to the creation of separate inflation and volume adjustment for these drugs. Not all hospitals provide these services, and some hospitals have a much larger proportion of costs allocated. To address this situation, in Rate Year 2016, staff began allocating a specific part of the inflation adjustment to funding increases in the cost of drugs, based on the portion of each hospital's total costs that comprised these types of drugs.

  In addition to the drug inflation allowance, the HSCRC provides a utilization adjustment for these drugs. Half of the estimated cost changes due to usage or volume changes are recognized as a one-time adjustment and half are recognized as a permanent adjustment. This process is implemented separately from this Update Factor so only the inflation portion is addressed herein.

  Starting in Rate Year 2021, Staff began using a standard list of drugs based on criteria established with the industry in evaluating high-cost drug utilization and inflation. This list was used to calculate the inflation allowance as well as the drug utilization adjustment component of funding for these high-cost drugs. Rate Year 2024 continues this practice. Price inflation on these drugs declined considerably starting in the late-2010s. In response to this trend Staff gradually lowered the drug inflation amount from 10 percent down to 0 percent over the period from RY 2019 to RY 2023 based on data from RY 2018 to RY 2022. Starting in RY 2022 the price inflation began to accelerate again, and this trend accelerated into RY 2023. While staff have previously evaluated providing hospital specific inflation, historically, all hospitals have received an equal drug inflation because analysis has shown the experienced inflation was relatively consistent across hospitals. However, the inflation beginning in 2022 appears to be concentrated in the more

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specialized drugs that are primarily delivered by academic institutions. Therefore, staff is recognizing this new round of inflation by recommending a small increase from 0 percent to 2.5 percent for all hospitals but a larger increase for just the academic centers of 7.5 percent. The 5 percent point gap reflects the observed gap between academic and non-academic trends in 2022 and 2023.

Care Coordination / Population Health (-0.07): There were several grant programs aimed at Care Coordination and Population Health in RY 2024 hospital revenues. These programs include Regional Partnership Catalyst Programs for Diabetes and Behavioral Health, and Maternal and Child Health Improvement Fund Assessment. These funds were provided to hospitals on a one-time basis. For this reason, Staff is reversing out grant funding in RY 2024 of -0.21 percent. RY 2025 funding is expected to be approximately 0.14 percent and includes continued funding for Behavioral Health and Maternal and Child Health.

Adjustments for Volume (0.25%): Staff are proposing a population growth estimate of 0.25 percent for RY 2025 (July 1, 2022 to June 30, 2023), which is based on the Maryland Department of Planning's estimate for 2023 over the projected value noted in 2022.2 For RY 2025 the staff is proposing to use Claritas' projected CY 2024 growth estimate for distributing the Demographic Adjustment at a zip code level, in keeping with the prior year methodologies.

Low-Efficiency Outliers (0.00%): The Integrated Efficiency policy outlines a methodology for determining inefficient hospitals in the TCOC Model. This policy will utilize the Inter-Hospital cost comparisons to compare relative cost-per-case efficiency. This policy will also use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance relative to national benchmarks for each service area in the State. The above evaluations are then used to withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals, which will be available for redistribution to relatively efficient hospitals or potentially for reinvestment through the proposed Revenue for Reform policy. Staff has earmarked 0 percent reduction for this item, because low-efficient hospitals are encouraged to buyout of their reductions through investments in Revenue for Reform and if buyouts do not occur, relatively efficient hospitals can petition the Commission for funding that is withheld from relatively inefficient hospitals.

Set-Aside for Unforeseen Adjustments (0.15): The intention of the set-aside is to use these funds for potential Global Budget Revenue enhancements and other potentially unforeseen requests that may occur at hospitals. Staff is recommending 0.15 percent for RY 2025. Staff will work to define hardship to better distribute this funding source.

- **Complexity and Innovation (formerly Categorical Cases) (-0.01%):** The prior definition of categorical cases included transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spinraza cases. However, the definition, which was based on a preset list, did not keep up with emerging technologies and excluded various types of cases that represent greater complexity and innovation, such as extracorporeal membrane oxygenation cases and ventricular assist device cases. Thus, the HSCRC Staff developed an approach to provide a higher variable

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cost factor (100 percent) for drugs and supplies, 50 percent for all other charges) to in-state, inpatient cases when a hospital exhibits dominance in an ICD-10 procedure codes and the case has a case mix index of 1.5 or higher. Staff used this approach to determine the historical average growth rate of cases deemed eligible for the complexity and innovation policy and evaluated the adequacy of funding of these cases relative to prospective adjustments provided to Johns Hopkins Hospital and University of Maryland Medical Center from RY 2017 to RY 2023. Based on this analysis, staff concluded that the historical average growth rate was 0.35 percent, which equates to a combined state impact of - 0.01 percent for the RY 2025 Update Factor.

- **PAU Redistribution (0.00%):** For RY 2025, Staff is proposing to continue utilizing the PAU Shared Savings program, as the policy 1) has successfully generated a 3:1 investment on the Infrastructure Funding that was put into rates to spur improvements in care management and 2) has recognized that hospitals in a fixed revenue model do not have the same opportunity to improve profitability by reducing avoidable utilization, i.e., the range in hospital revenue attributable to readmissions and avoidable admissions is large. However, Staff are concerned that the current construct of the program, which reduces inflation and population funding for readmissions and avoidable admissions in perpetuity so as to generate Model savings, is potentially problematic, because it may cause access issues for hospitals with low levels of potentially avoidable utilization. Thus, Staff are proposing to discontinue the inflation and population reduction through the PAU Shared Saving Program. The PAU value for RY 2025 is -0.37 percent. The proposed refinement to this methodology would be revenue-neutral to the State, and for this reason the value represented is 0 percent.

- **Quality Scaling Adjustments (-0.04)**: The quality pay-for-performance programs include Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP) including the Disparity Gap Incentive, and Quality Based Reimbursement Program (QBR). . Preliminary QBR adjustments will be implemented with the July rate orders and adjustments will be made in the January rate orders to reflect the full measurement period. The January QBR adjustments may also include changes to the preset revenue adjustment scale to reflect reduced performance standards in line with lower scores nationally, as approved in the RY 2025 final policy. The current revenue adjustments across the three programs are -0.12 percent (with preliminary QBR). The Update Factor recommendation reflects the reversal of the prior year's Quality adjustments of 0.08 percent.

- **Capital Funding and Estimated Increase for Full Rate Applications (0.17%)**: Preliminary modeling indicates that efficient hospitals may be entitled to approximately $36.5 million through the Full Rate Application Policy. This value is subject to change based on quality assurance reviews of Inter-hospital Cost Comparison (ICC) methodology and the Market shift Policy, which has an effect on the final revenues evaluated in the ICC. Staff, with input from Stakeholders, will work to determine how this funding should be distributed and any considerations that may accompany such a decision.

- **Transformation Funding (0.09%)** One of the paths to success under global budgets is to find innovative solutions that avert the need for traditional hospitalization. While significant progress

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has been 13 made in averting these admissions Staff believe there is an opportunity to accelerate these efforts through targeted investment in transformative solutions that may be too expensive or speculative to be funded in the normal course of business. For example, hospital-at-home approaches in rural areas could reduce cost, while also eliminating the travel burden on patients, but can't be tested at scale and therefore require extra investment to develop a proof of concept. The Transformation Fund will provide approximately $20 M to match investments committed by hospitals or other entities to pursue these transformative ideas. The funding shall be awarded based on a competitive process to be administered by HSCRC staff as an extension of the Care Transformation Initiative program; both Maryland hospitals and other entities, in partnership with a Maryland hospital, will be eligible. Staff shall select at most 3 proposals based on documented criteria that will include but not be limited to (1) degree of innovation and risk involved (i.e. why the approach is hard to implement in the absence of this funding), (2) speed of implementation, (3) the share of funding provided by the applicant versus requested from the State, (4) likelihood of scalability and (5) estimated long-term impact on lowering total cost of care and/or increasing quality. The impact in RY 2025 is approximately 0.09 percent; however, this funding will not be available for award before January 2025 and will be input into rates at that time. For this reason, staff are not including this line item in the calculation of calendar year 2024 growth or projections of calendar year 2024 savings.

Staff requests that Commissioners consider the following draft recommendations:

For Global Revenues:

1. Provide all hospitals with a base inflation increase of 3.15 percent, with an additional 0.65 percent for additional revenue support based on historic underfunding of inflation.

2. Provide an overall increase of 4.38 percent for revenue (including a net increase to uncompensated care) and 4.12 percent per capita for hospitals under Global Budgets. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of the revenue will be applied to the year-end target. Staff are aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

1. Provide an overall update of 3.15 percent for inflation.

2. Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing.

No Commission action is necessary as this is a draft recommendation.

ITEM XIII

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CLOSED CASES

2630R UM Shore Medical Center at Easton- Case Withdrawn

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ITEM XIV
OPEN CASES

2645A Johns Hopkins Health System- Accarent Health ARM approved.
2646N UM Shore Medical Center at Easton- No action needed at this time.

ITEM XV.
HEARING AND MEETING SCHEDULE

June 14, 2024,	Times to be determined- 4160 Patterson Ave HSCRC Conference Room
July 10, 2024,	Times to be determined- 4160 Patterson Ave. HSCRC Conference Room

There being no further business, the meeting was adjourned at 5:12 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission

May 8, 2024

Chairman Sharfstein stated reasons for Commissioners to move into administrative session pursuant to 3-103, 3-104, and 3-305 of the General Provisions Article. Regarding the TCOC Model Monitoring agenda item, Chairman Sharfstein stated that monitoring the TCOC Model and its contractual requirements is sensitive in nature and necessary for administering the Model successfully without the potential for disrupting the regular functions of the rate setting system. Total Cost of Care data is not complete until the performance year is over. Regarding the FY 2024 Hospital Unaudited Financial Performance agenda item, Chairman Sharfstein stated that information is based on unaudited data and not the official measure of hospital financial performance. Hospital financial performance is a critical factor in the Commission's ability to meet the tests of the Model. When looking at hospital financial performance from the vantage point of unaudited data, we cannot be certain that accurate conclusions can be drawn. The Commission also obtained legal counsel.

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

The Administrative Session was called to order by motion at 12:05 p.m.

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

In attendance representing Staff were Jon Kromm, Jerry Schmith, Allan Pack, William Henderson, Claudine Williams, Deb Rivkin, Cait Cooksey, Geoff Doeherty, Megan Renfrew, Erin Schurmann, Christa Speicher, Bob Gallion, and Paul Katz.

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

Item One

William Henderson, Director, Medical Economics & Data Analytics, updated the Commission and the Commission discussed Maryland Medicare Fee-For-Service TCOC versus the nation.

Item Two

Mr. Henderson briefly updated the Commission on the hospitals' unaudited financial performance through January 2024.

Item Three

The Commission was updated on legal matters by counsel.

The Administrative Session was adjourned at 12:50 p.m.

Overdose in Maryland
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Opportunities for Health Systems

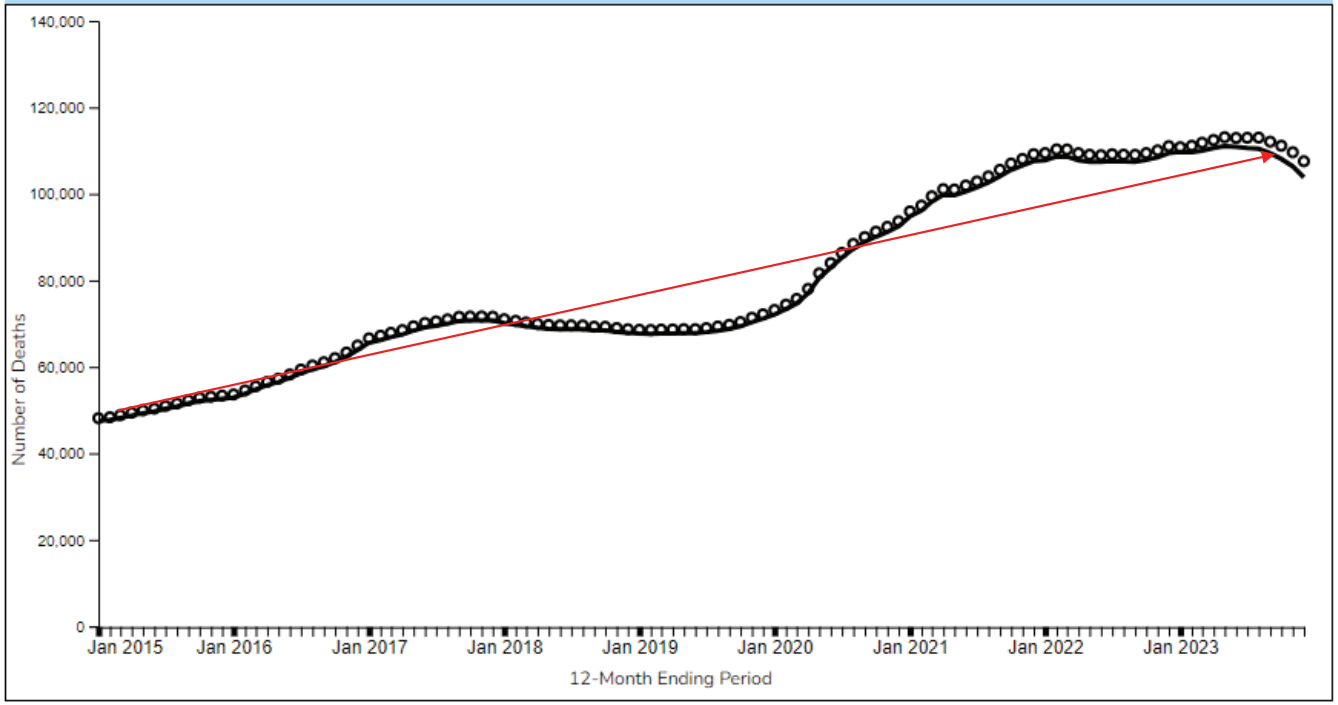
Olivia K. Sugarman, PhD, MPH
Postdoctoral Fellow
Johns Hopkins Bloomberg School of Public Health

Presentation to the Health Services Cost Review Commission
June 14, 2024

National Overdose Trends

Based on data available for analysis on: May 5, 2024

Figure 1a. 12 Month-ending Provisional Counts of Drug Overdose Deaths: United States

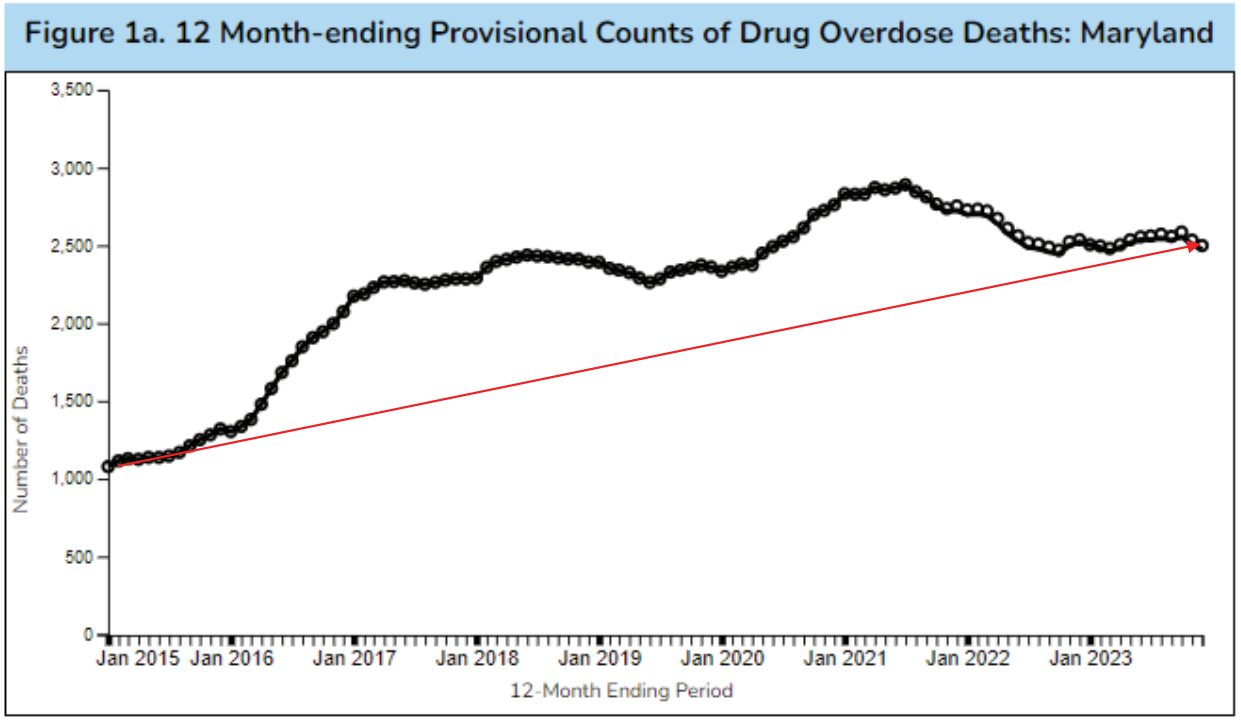


107,543 overdose deaths in 2023

- ~47,523 in 2014

(Ahmad et al. 2024)

Overdose in Maryland



2,476 overdose deaths in 2023

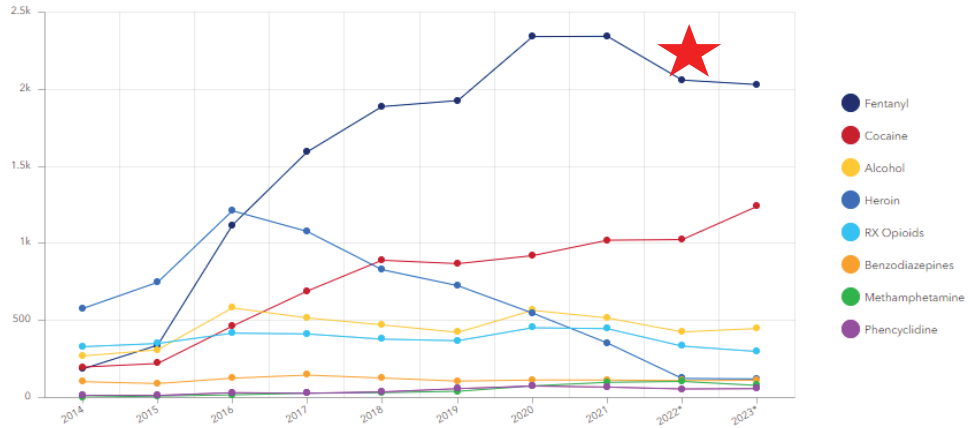
More than doubled since 2014

- 129% increase
- 1,078 in 2014

(Ahmad et al. 2024)

Key details about overdoses in Maryland

Chart 5: Annual Fatal Overdoses by Substance (2014 - 2023*)



- Fentanyl present in 81% of overdoses in 2023
- Overdose mortality rates higher in Non-Hispanic Black vs. White people
  - 57.3 vs 43.9 per 100,000
- Highest rates in Baltimore City, Cecil County, Dorchester County (Maryland Vital Statistics, 2023)

(Maryland's Office of Overdose Response, 2024)

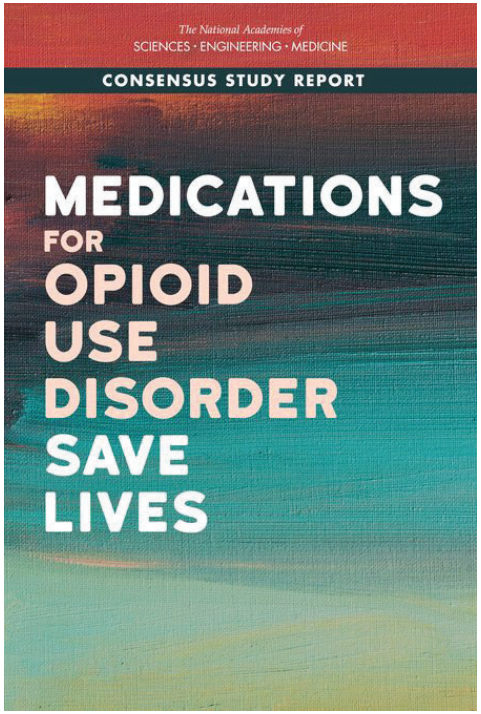
Beyond Fatal Overdoses in Maryland

- **13.1%** increase in ED visits for non-fatal opioid overdoses
  - 9,714 in 2023 v. 8,589 in 2022 (Maryland's Office of Overdose Response, 2024)
- This is an undercount for drug-related ER visits
  - Cellulitis from skin infections, injection drug use
  - Endocarditis

Tools to prevent overdose

Role of treatment in overdose prevention

- Medications for opioid use disorder are the gold standard treatment for opioid use disorder (National Academies of Sciences Engineering and Medicine, 2019)
  - FDA approved medications: Buprenorphine, methadone, naltrexone
- Medications are effective
  - Maryland study – medications for opioid use disorder cut fatal opioid overdose risk **by 82%** (Krawczyk et. al, 2020)
- Few people with opioid use disorder receive medication
  - ~42% in Maryland (Krawczyk et. al, 2022)
- Medical training gaps in how to use medications for opioid use disorder (Accreditation Council for Graduate Medical Education, 2023)



Roles for Medical Professionals and Health Systems

What can medical professionals and health systems do to prevent overdose?

- Start treatment with methadone or buprenorphine in ER, wards, link to treatment (D'Onofrio et al., 2015)
- Provide naloxone, a life-saving opioid reversal agent (Centers for Disease Control and Prevention, 2024)
- Refer people to harm reduction programs (Substance Abuse and Mental Health Services Administration, 2024)

Study

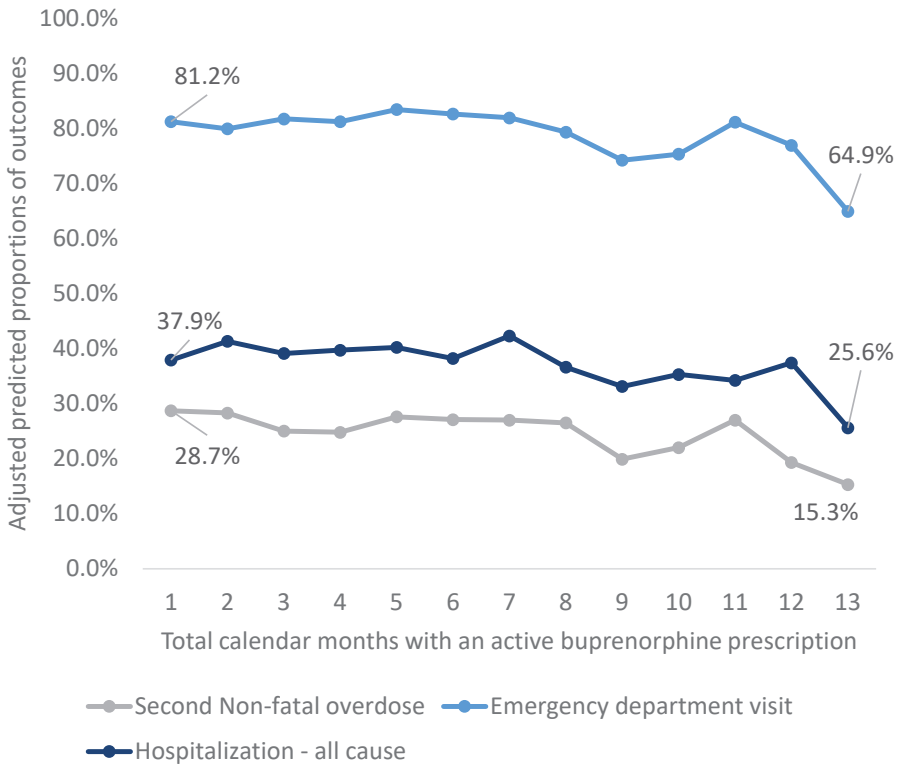
Buprenorphine retention study

What's the benefit of receiving and staying on buprenorphine after an overdose?

- Who: 41,558 Adult Maryland residents who had a non-fatal overdose between 2016 – 2021
- What: Buprenorphine retention within 1 year of non-fatal overdose
- Why: Look at effect on risk of having a second non-fatal overdose, ER visit, hospitalization within 1 year

The effect of buprenorphine retention

- **5,439** people got buprenorphine within 1 year after non-fatal overdose
- This was only 13% of 41,558 index non-fatal overdoses
- **Buprenorphine retention lowered odds of adverse outcomes**
- An additional month of buprenorphine reduces odds of…
  - Second Non-fatal overdose by **4.7%**
  - ED visit (all-cause) by **5.3%**
  - Hospitalization (all-cause) by ~ **3.9%**



Key takeaways

- Few people in Maryland receive a gold standard treatment.
- Buprenorphine not only reduces overdose, it also reduces ER visits and hospitalizations.

Health systems have major potential to combat overdoses by initiating medications for opioid use disorder, establishing referrals and treatment programs for retention.

Thank you!

Questions?

Contact info:
osugarm1@jh.edu

Website:
www.oliviaksugarman.com

Scan for paper

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Hospitals-Opioid Overdose and Opioid-Related Emergency Medical Conditions Treatment Act HB 1155-SB1071

Eric Weintraub, MD
Professor of Psychiatry
Director, Division of Addiction Research & Treatment
University of Maryland School of Medicine

UNIVERSITY of MARYLAND
SCHOOL OF MEDICINE

HB 1155-SB1071

Summary: Each hospital must have the **protocols** and capacity to treat a patient who presents in a **hospital ED** for care and treatment of an opioid-related overdose or opioid-related emergency medical condition **with a medication for OUD** if the treatment occurs as recommended by the treating health care practitioner and is **voluntarily** agreed to by the patient

A hospital must possess at least **one formulation of each U.S. Food and Drug Administration-approved full and partial opioid agonist used for the treatment of OUD (methadone, buprenorphine).**

Before discharging a patient who is diagnosed with an OUD or administered or prescribed medication for OUD, a hospital must (1) make a **referral** of the patient to an appropriate provider or facility for a timely appointment, when possible, to voluntarily continue treatment in the community and (2) **work with peer support professionals**, as available, or other resources to assist the patient in accessing the identified treatment services.

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HB 1155-SB1071 Implementation

Effective date 1/25/25

A protocol established by a hospital must include: any Maryland Department of Health requirement regarding prescribing opioid agonist treatment

Hospitals must develop **uniform practices** for the following:

1. **screening and diagnosing** specified individuals who present with an OUD based on the criteria in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders;
2. **offering and administering opioid agonist medication** to treat an opioid-related overdose or OUD;
3. To identify community-based treatment services that are appropriate for:

   (i) treating opioid use disorder

   (ii) assisting patients to voluntarily access ongoing community-based treatment at discharge

maryland
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Open Cases Overview

June 14 , 2024

Open Cases

- 2646N: UM Shore Medical Center at Easton - Partial Rate Application for Capital - **Draft Presentation 6/14**
- 2647A: Johns Hopkins Health System - ARM - Health Design Plus - *cardiovascular, joint replacement procedures, bypass, cardiac cath, defibrillators, PCI, cardiac valves, TAVRs and oncology evaluation services* - **Approved for 1 year**
- 2648N: Johns Hopkins Hospital - Partial Rate Application - **No action needed at this time**
- 2649A: Johns Hopkins Health System - ARM - One Team Health - *cardiovascular services, spine surgery, CAR-T and certain cancer and bone marrow transplants* - **Approved for 1 year**
- 2651A: Johns Hopkins Health System - ARM - Global Medical Management, Inc. - *cardiovascular services, kidney transplant services, bone marrow transplants and spine procedures* - **Approved for 1 year**

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Easton Capital Recommendation

June 14 2024

Executive Overview

1. Funding Request
2. Consideration of Capital policy modifications
3. How the Modifications Impact UM SRH at Easton
4. Linkage of funding request tied to
    a. TCOC accountability and
    b. Population health investments

Background

- As part of University of Maryland Shore Regional Health's (UM SRH) effort to rationalize acute care delivery on the Eastern Shore, they have requested $18.6 million for a $539 million capital replacement project at Easton Hospital
  - Will offset 42% of the estimated depreciation and interest costs
  - Additional support is derived from $39M in cash, $50 million in philanthropy, $100 million in state funding, and approximately $18 million in interest income.
- While this project is relatively expensive, it does represent a wholesale replacement of a facility that
  - Was largely constructed over 50 plus years ago (between 1955 and 1975)
  - Has cost premiums associated with "ruralness" and post COVID inflation
  - Right sizes the physical capacity of Easton Hospital, the final remaining general acute care facility in the mid-shore

Beds	Physical Capacity	Current Licensed Capacity	CON Approved Physical Capacity
MSGA	*120*	*72*	*86*
Obstetric	*13*	*13*	*11*
Pediatric	*5*	*3*	*1*
Psychiatric	*12*	*10*	*12*
Subtotal Acute	***150***	***98***	***110***
Rehab	*15*	*20*	*12*
Subtotal Inpatient	***165***	***118***	***122***
Dedicated Observation	***0***	0	25
Total Inpatient and Observation Beds	***165***	***118***	***147***

Breakdown of Request

- The capital funding request of $18.6M consists of 3 components:

Item	Incremental Funding ($Millions)	Cumulative Funding ($Millions)	Notes
Capital Policy Output	$3.8	$3.8	Represents the value that UM SRH at Easton is entitled to under the existing capital policy
Capital Policy Output with New Methodology Considerations	$8.1	$11.9	UM SRH at Easton has requested that cost premiums related to the "ruralness" of the project (e.g., installation of utilities on farmland) and quantifiable inflation related to COVID be passed through the capital policy without qualification
Additional Funding Request	$6.7	$18.6	Represents an amount equivalent to the restoration of savings that was derived from converting UM SRH at Dorchester from an acute care facility to a Free Standing Medical Center

Capital Policy

- Capital policy builds off historical Commission methodology
  - Averages hospital's capital costs, inclusive of new project, and statewide peer group
  - Adjusts for hospital cost per case efficiency through ICC
- New methodology approved in December 2019 also accounts for:
  - Total cost of care
  - Current levels of potentially avoidable utilization,
  - Excess capacity

Capital Methodology Steps

Steps	Additional Commentary
Step 1: Determine Capital Cost of New Project	Requires final determination from MHCC on allowed capital project size and verified useful life and interest rate values
Step 2: Determine Eligible Capital Cost	Calculated by averaging hospital's capital costs, inclusive of the new project, and statewide peer group
Step 3: Efficiency Adjustment	Scales capital projects from 0-100% based on ranked efficiency in hospital cost per case and TCOC (each ranking worth ~2%)
Step 4: PAU Adjustment Credit	Provides additional funding to hospital if they demonstrate low levels of avoidable utilization and thus have more limited room for improvement in profitability
Step 5: Excess Capacity Adjustment	Reduces available funding if hospital has had significant volume declines since 2014 because the hospital should be able to contribute to capital by reducing fixed costs,
Step 6: Check against Maximum Depr & Interest	Policy caps available funding at 100% depreciation, 70% interest to require hospitals to fund a portion of project out of capital reserves or philanthropy
Step 7: Provide Markup	Revenue is marked up for uncompensated care and governmental discounts

- Policy has been successfully used to adjudicate capital requests from Suburban Hospital, Adventist Shady Grove Medical Center, and Greater Baltimore Medical Center.

New Methodology Consideration: Ruralness

- UM SRH noted in its application that building in a rural environment brings both land development and labor workforce issues that are different from building in a more heavily populated geography.
- This is evident given:
  - Last major rural capital project in Maryland, Western Maryland Hospital Center, had first year depreciation and interest of 19.49 percent versus a statewide average of 8.36 percent.
  - Last five major hospital capital projects approved through the CON process, only one of them did MHCC identify as having building and site multipliers
- In light of this cost premium, UM SRH requests that the that $40.1 million in unique cost multipliers be passed through the 50/50 blend in the Step 2 of the capital methodology without qualification

Site Preparation & Building Costs Premiums in Recent Major Capital Projects MHCC-Approved CONs

		Recent Major Capital Replacements				
	Easton	Shady Grove	GBMC	Suburban	WOMC	UM Capital Region
Site Multipliers						
Premium due to abnormal labor shortages/remote areas	2,664,598	-	-	-	-	-
Premium for minority business enterprise	1,090,430	-	-	-	-	1,798,368
Premium for prevailing wage	2,664,598	-	-	-	-	724,871
Total Site Multipliers	6,419,626	-	-	-	-	2,523,239
Building Multipliers						
Premium due to abnormal labor shortages/remote areas	12,998,316	-	-	-	-	-
Premium for prevailing wage	12,998,316	-	-	-	-	19,232,575
Premium for minority business enterprise	8,570,914	-	-	-	-	9,115,520
Total Building Multipliers	34,567,546	-	-	-	-	28,348,095
Total Site Prep and Building Premiums	**$40,987,172**	-	-	-	-	**$30,871,334**
Percent of Total Project Costs	7.7%	0.0%	0.0%	0.0%	0.0%	4.0%

New Methodology Consideration: Inflation

- UM SRH also noted in its application that supply chain and inflationary issues have increased the magnitude of cost required to undertake this capital project
  - Total project size increased by $190M (54%) from 2016 to 2023
- Inflationary cost increases are evident given staff's analysis of Easton's 2016 and 2023 CON
  - New construction costs increased by $91M (49%); $63M (69%) of the cost increase was attributable to inflation
  - Producer Price Index by Commodity Construction (PPIC) indicates that over 7 years the price per square foot increased by 6.53% per year (56% total); actual CON increased by 3.74% per year (29% total) - well above inflation for capital in Update Factor
- In light of this cost premium, UM SRH requested that $35.3 million of the $63.1 million HSCRC has determined is attributable to recent inflationary be passed through the 50/50 blend in the Step 2 of the capital methodology without qualification

Recommendation on New Methodology Considerations

- Staff agrees with these requests because MHCC has:
  - Approved the entire $540 million capital project and
  - Has not directed the HSCRC to exclude any cost multipliers and/or exemptions from capital rate support calculations.
- The capital policy never contemplated:
  - Unique rural cost multipliers that would not be accounted for in statewide average capital cost share statistics and/or
  - Differentially higher capital costs because of labor premiums and supply chain disruption.
- Moving forward, staff recommend that:
  - All exclusions and multipliers that are approved as part of the total capital project through the CON process be passed through the capital policy without qualification and
  - Staff assess the applicability of statewide average depreciation and interest statistics to specific requests and propose alternative calculations if appropriate.

Additional Funding Request

- In 2020, UM SRH discussed with HSCRC staff the concept of transitioning UM SMC Dorchester from a full-service hospital to an FMF and redirecting the resulting GBR savings to the UM SMC at Easton capital project
- HSCRC staff expressed a willingness to consider such an arrangement, subject to Commissioner approval. However, when UM SMC at Dorchester transitioned from an acute care facility to an FMF in November 2021, HSCRC staff removed $6.7 million in system savings, citing the lack of an active, docketed CON project
- As UM SMC at Easton's replacement and relocation capital project is now underway, UM SRH is resubmitting its request to use the GBR capacity generated from the UM SMC at Dorchester FMF transition to contribute to covering 16% of the capital costs of the UM SMC at Easton replacement and relocation project

Details of Additional Funding Request

- Potential evaluation
  - Two-sided risk structure; Range of potential funding outcomes: $0 - $6.70M
  - Geographic/community-based care CTI thematic area
- Expected outcome
  - Geographic TCOC improvement vs. agreed upon base period for 5-county Mid-Shore
  - At least dollar for dollar savings, i.e., $6.7 million, to be achieved within a reasonable time frame, e.g., 7 years of the start of the new hospital, and relative to a reasonable established target
  - In year 1, total cost of care for Medicare recipients in the 5-county region is at least $1 million better than agreed upon benchmark, which grows to $6.7 million per year better than the target in year 7.
  - If target savings are not achieved, then rates are lowered to recoup the difference. For example, if only $500K saved in year 1, reduction in $500K in rates in year 2. An additional $2 million will still be expected in year 2.
  - After year 10, risk structure sunsets and three year average TCOC savings run rate is permanently reflected in UM SMC in Easton's rate structure (not to exceed $6.7 million).

Details of Additional Funding Request cont.

- Risk reduction provision
  - UM SRH will have an opportunity to reduce half of the TCOC risk if two conditions are met:
    - Investments in enhanced access (UMMS is indicating that at least $3.5 million will be spent annually)
    - Progress on key community health improvement indicators are met
      - Examples:
        1. Lives touched/encounters in non-hospital setting
        2. Number connected to services addressing social needs
        3. Number connected to outreach programs
        4. Emergency department admissions per capita
        5. Avoidable admissions per capita
        6. Readmissions performance at SRH hospitals
- Staff recommend that the Commission approve the additional $6.7 million in system savings, contingent on an executed contract between UM SRH and the HSCRC that codifies expected deliverables and associated KPI's/expected outcomes.

Draft Recommendations

1. All exclusions and multipliers that are approved as part of the total capital project through the CON process should be passed through the capital policy without qualification and staff should assess the applicability of statewide average depreciation and interest statistics to specific requests and propose alternative calculations if appropriate.
   a. Given the implications this will have on the capital policy moving forward, staff ask for public comment on this proposal by June 21, 2024 and that Commissioners use this commentary when considering this alteration to the capital policy in a subsequent Commission meeting.
2. A permanent adjustment of $11,890,372, per the capital methodology, to be provided to UM SMC at Easton when the capital project is completed and the new site is available for use.
   a. The opening date of this project is anticipated to become effective on July 1, 2029.
3. A permanent adjustment of $6,700,000, which will provide funding equivalent to the facility conversion of UM SMC at Dorchester, to be provided to UM SMC at Easton when the capital project is completed and the new site is available for use.
   a. The funding will be contingent on UM SRH executing a contract with the HSCRC that that links the funding, as indicated above, to total cost of care, investments in care transformation, and key performance indicators.
   b. The final contract will be subject to Commission approval.

IN RE: THE PARTIAL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
SHORE REGIONAL	*	DOCKET: 2024
HEALTH SYSTEM, INC	*	SUBMISSION DATE: April 18, 2024
MEDICAL CENTER AT EASTON	*	FOLIO: 2456
EASTON, MARYLAND.	*	PROCEEDING: 2646N

* * * * * * * * * * * * *

STAFF RECOMMENDATION

June 14, 2024

Introduction

On January 18, 2024 UM Shore Medical Center at Easton (UM SMC at Easton or the Hospital) received an approved Certificate of Need (CON)[1] to replace the existing facility, the majority of which was built between 1955 and 1975,[2] with a 407,872 square foot hospital that will be relocated to an undeveloped 200-acre site located at 10000 Longwoods Road in Easton, Talbot County, approximately 3 miles from the existing campus. The proposed replacement hospital will include 110 acute care beds, 12 special hospital rehabilitation beds, and 25 observation beds. The Hospital will also include an emergency department (ED) with 27 treatment spaces and three behavioral health holding rooms, regulated outpatient clinics, a full-service laboratory, and space for administrative and education functions.

The estimated project cost is $539,558,871 for the relocation and replacement of UM SMC Easton, which will equate to annual depreciation and interest of $44,733,329. UM SMC Easton proposes to finance the project with approximately $39 million in cash, $50 million in philanthropy, $333 million in proceeds from debt financing, $100 million in state funding,[3] and approximately $18 million in interest income.

In concert with the approval of the CON and to ensure UM SMC Easton can update and modernize their facilities with today's standards, the Hospital is requesting gross capital funding in the amount of $18.6 million, $11.9 million as part of the Commission's capital funding policy and $6.7 million from prior system savings that was generated by converting the medical facility in Cambridge from an acute care hospital to a freestanding medical facility in 2021. UM SMC at Easton has put forward a proposal that link the $6.7 million restoration to trends in total cost of care and key metrics developed during a community planning process, as described later in this memo. This agreement will require a future executed contract with the HSCRC.

[1] https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/2024_decisions/con_shore_easton_2463_rpt_20240118.pdf

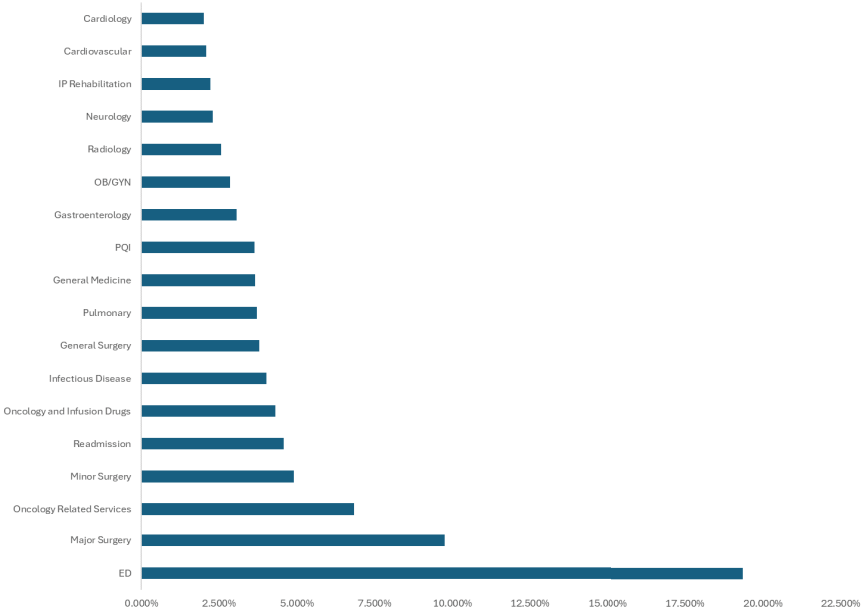
[2] See Appendix A for UM SMC at Easton Facility by Year of Construction

[3] The State has already provided $40 million and has noted in its publications that it has committed a total of $100 million to the project - https://dbm.maryland.gov/budget/Documents/operbudget/2025/proposed/FY2025MarylandStateBudgetHighlights.pdf (Page 21)

Background

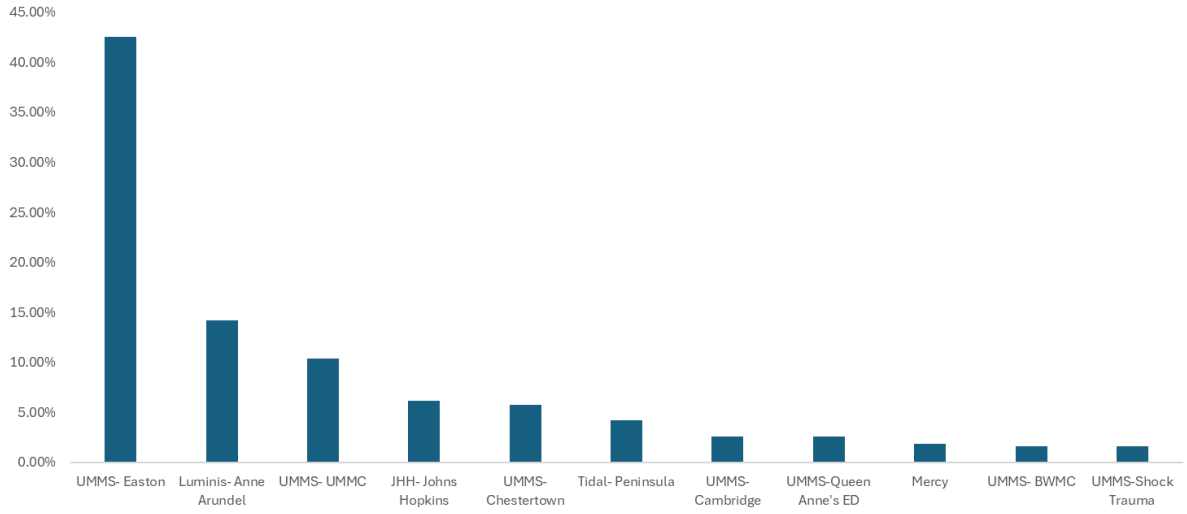
UM Shore Regional Health (UM SRH) is a regional, not-for-profit, healthcare network formed on July 1, 2013, through the consolidation of two UMMS partner entities, the Shore Health System ("UM SHS", comprised of UM SMC at Easton, its two Freestanding Medical Facilities, or "FMFs" at Cambridge and Queen Anne's), and Chester River Health. The UM SRH network is the primary provider for the Mid-Shore region, which includes Caroline, Dorchester, Kent, Queen Anne's and Talbot counties, providing 53 percent of hospital-based services to residents of the five counties in Fiscal Year 2023, of which UM SMC at Easton compromised 80 percent.[4] UM SRH includes UM SMC at Easton, the regional hub for hospital-based services, UM SMC at Chestertown, a Rural Hospital Model, two FMFs (UM Shore Emergency Center at Queenstown and UM SMC at Cambridge), as well as a number of ambulatory centers offering specialty care, primary care, behavioral health, rehabilitation, diagnostic services, and urgent care located in each of the five counties.

Table 1a. UM Shore Health System Fiscal Year 2023 Service Line Distribution in Five County Service Area
(ECMADS; excludes services comprising less than 2% of service delivery)



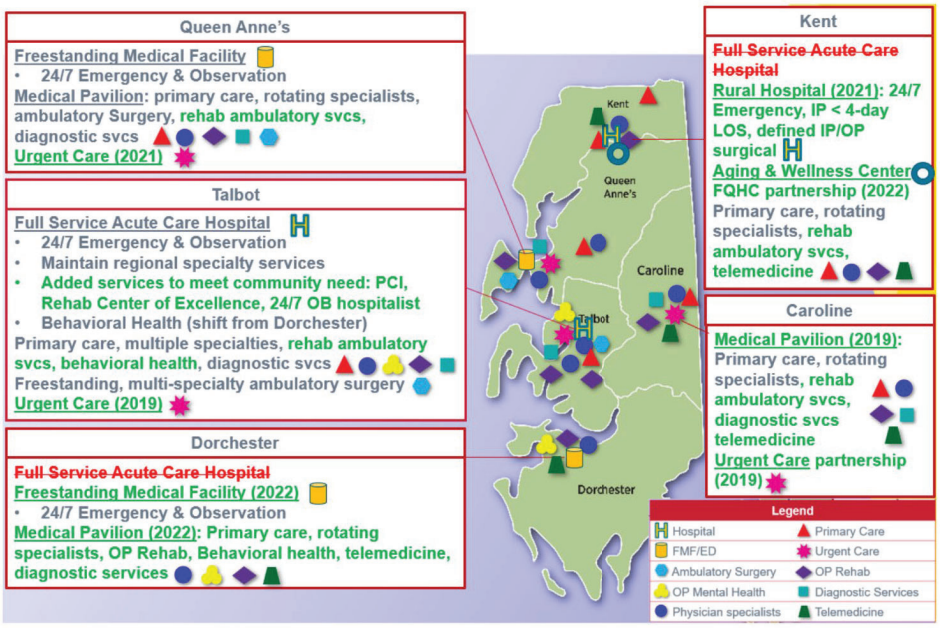
[4] Share is calculated using Commission's casemix adjusted measure of inpatient and outpatient services, equivalent casemix adjusted discharges (ECMADS). UM SHS' share of unadjusted discharges and outpatient visits in the five upper shore counties is significantly higher (71 percent in Fiscal Year 2023). The divergence between the two shares, ECMADS vs unadjusted discharges/visits, is largely driven by UM SHS' larger proportion of services that are provided to emergency room patients (37 percent of discharges/visits versus statewide average of 27 percent).

Table 1b. UM Shore Health System Fiscal Year 2023 Market Share in Five County Service Area (ECMADS; excludes hospitals comprising less than 1% of service delivery)



UM SRH's relatively large, preexisting footprint in the Mid-Shore and the incentives of the TCOC Model have allowed the system to functionally redesign the healthcare system in its five county service area, thereby eliminating excess fixed costs and improving unnecessary utilization metrics as well as a total cost of care (see table 2 for care delivery redesign)

Table 2 UM Shore Regional Health System Redesigned Care Delivery for the Mid-Shore[5]



[5] Source: UM SMC at Easton Partial Rate Application

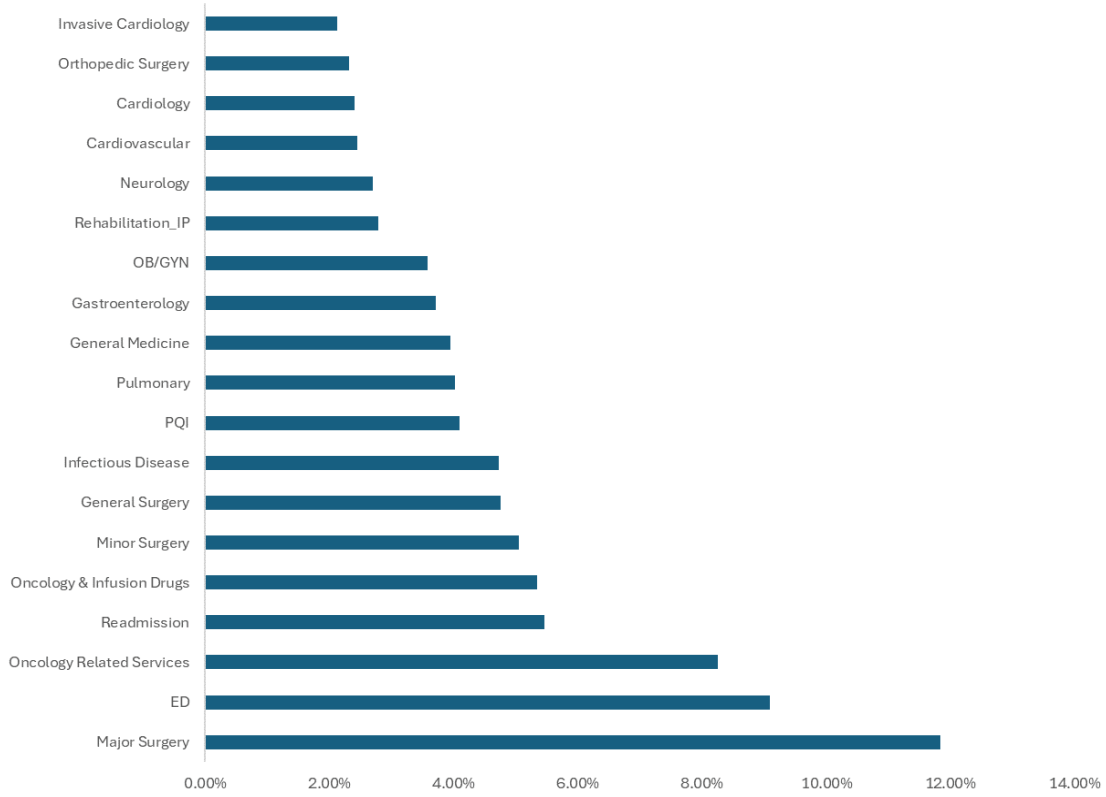
According to the Hospital, because of this redesign UM SRH has meaningfully impacted avoidable hospital utilization since Calendar Year 2016, (all numbers exclude COVID-impacted time periods of Calendar Years 2020/2021):

1) 10% less Emergency Department ("ED") utilization (FY2019 vs. FY2015)
2) 21% reduction in readmissions vs. 8% Statewide (CY2019 vs. CY2016),
3) Casemix-adjusted readmission rate that was 21% below the State average in CY2019
4) 48% fewer discharges for ambulatory-sensitive conditions (CY2019 vs. CY2015)
5) 20+% reduction in overall Medical Surgical Acute Average Daily Census (including observation) (CY2019 vs. CY2015)

In terms of total cost of care, UM SMC at Easton and UM SMC at Chestertown rank 18th and 12th respectively on the Medicare FFS Total Cost of Care attainment metric used in the most recent *Integrated Efficiency* policy and 18th and 7th respectively on Medicare FFS improvement since 2019 (UM SRH's freestanding facilities at Queenstown and Cambridge are not included in the reported measures). According to HSCRC's TCOC Benchmarking methodology from 2019 to 2021 Shore generated $7.5 million of total cost of care savings across Medicare and Commercial populations above the statewide average improvement, $5 million and $2.5 million respectively.

UM SMC at Easton, which is the UM SRH's intended medical hub for its system's acute services, is a not-for-profit 118-licensed bed hospital, serving residents of the 5 county Mid-Shore region since 1915. The Hospital provides specialty services including cancer care, stroke care, cardiovascular and pulmonary services, minimally invasive robotic assisted surgery, telemedicine, kidney transplant and vascular access clinics, general surgery, urology, OB/GYN, otolaryngology, orthopedics and joint replacement services, neurosurgery, diabetes management, wound care, rehabilitation, behavioral health, digestive health, sleep disorders, palliative care, and home health care.

Table 3. UM SMC at Easton Fiscal Year 2023 Service Line Distribution in Five County Service Area (ECMADS; excludes services comprising less than 2% of service delivery)



UM SMC at Easton's current licensed bed capacity of 118 is significantly below its current physical capacity of 165. 37 semi private rooms in the existing hospital, which the Hospital indicates do not meet current standards of care, account for some of this excess in physical capacity, as often patients cannot share a room due to a patient's isolation status, gender, or acuity level.[6] This disparity between physical beds and licensed beds creates operational and cost inefficiencies. The proposed capital project "right sizes" the facility by establishing physical capacity at 122 for inpatient services with no semi private rooms and an additional 25 beds for dedicated observation.

[6] "In the last two decades the majority of hospital physical plant modernization and expansion projects reviewed by the Commission have included the transition of semi-private to private room capacity. Often these hospitals also maintain semi-private rooms that, operationally, become single occupancy rooms" - STATE HEALTH PLAN FOR FACILITIES AND SERVICES: ACUTE CARE HOSPITAL SERVICES (page 3) https://dsd.maryland.gov/regulations/artwork/10241001.pdf

Table 4. UM SMC at Easton Bed Capacity Statistics

Beds	Physical Capacity	Current Licensed Capacity	CON Approved Physical Capacity
MSGA	*120*	*72*	*86*
Obstetric	*13*	*13*	*11*
Pediatric	*5*	*3*	*1*
Psychiatric	*12*	*10*	*12*
Subtotal Acute	***150***	***98***	***110***
Rehab	*15*	*20*	*12*
Subtotal Inpatient	***165***	***118***	***122***
Dedicated Observation	***0***	0	25
Total Inpatient and Observation Beds	***165***	***118***	***147***

The project contemplates an 11% decrease in physical Medical Surgical Acute Adult and Pediatric beds compared to the historic bed complement across SMC Easton and Dorchester (prior to transitioning to an FMF), and according to the MHCC recommendation on the CON, the proposed bed capacity aligns with current volumes plus population estimates put forward by UM SRH, which project that the mid-shore will grow by 0.9 percent to 1.0 percent annually for Fiscal Year 2023 through Fiscal Year 2032. HSCRC staff were at first concerned that this projection was potentially aggressive since total population growth from 2010 to 2020 was 1.66 percent. However, after accounting for the aging of the population using the age weights from the Commission's Demographic Adjustment policy, which recognizes expected hospital use rates due to the aging of the population, staff calculated a compound annual growth rate of 1.59 percent, suggesting the projections are reasonable.[7] The Hospital does not expect that the proposed physical capacity, relative to current licensed capacity, will yield any changes in the hospital's market share, as the growth is in line with anticipated demographic changes. However, UM SMC at Easton does anticipate in 2029, when the replacement hospital opens, that the market share for adult psychiatric patients will increase by 6.9 percent, leading to 83.5 percent market share, because the Hospital will be able to admit patients previously referred to Delaware.[8]

Additionally, volumes in the Fiscal Year 2023 Experience Report already justify the contemplated 87 MSGA/Pediatric beds and 25 observation beds, meaning UM SMC at Easton will have to offset anticipated population growth with reductions in avoidable utilization and/or length of stay.

[7] See Appendix B for age adjusted population modeling.

[8] "The capacity constraints and staffing limitations UM SMC Easton experienced in FY 2022 resulted in 121 patients being referred to hospitals in Delaware" - https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_con/documents/2024_decisions/con_shore_easton_2463_rpt_20240118.pdf (Page 119)

Table 5. UM SMC at Easton MSGA Patient Days and Observation Days in Fiscal Year 2023

	FY2023 Days	Proposed Beds
Med/Surg ICU	2,333	
Med/Surg	21,797	
MSGA Days	24,130	
MSGA ADC	66	
Occupancy	80%	
Needed MSGA Beds	**83**	**87**
Pediatric Days	99	
Pediatric ADC (Days/365)	0.3	
Occupancy	80%	
Needed Pediatric Beds	**0.3**	**1**
Observation hours	223,395	
Observation Days (Hours/24)	9,308	
Observation ADC (Days/365)	**26**	**25**

Source: HSCRC FY2023 Experience Reports

Hospital Capital Methodology Request

The HSCRC staff reviewed the hospital's capital request under partial rate application standards. In October 2003, the Commission adopted the staff's recommendation permitting rate increases for major projects approved through a CON under an alternative partial rate application process. The partial rate application process builds on the Inter-Hospital Cost Comparison (ICC) standard methodology, but with adjustments. HSCRC staff updated its approach to capital requests to include evaluations of total cost of care efficiency, current levels of potentially avoidable utilization, and excess capacity, in addition to the historical analyses of capital cost efficiency and cost per case efficiency. This updated methodology was approved at the December 11, 2019 Commission meeting, and thus far has been successfully used to adjudicate capital requests from Suburban Hospital, Adventist Shady Grove Medical Center, and Greater Baltimore Medical Center.

The Hospital's partial rate application requests that the HSCRC grant a revenue increase to fund projected incremental capital costs associated with the regulated portion of the project. The CON includes projected average annual interest cost of $16,772,329 and first year depreciation cost of $27,961,000 for a total of $44,733,329 in annual capital cost.

The Hospital is requesting approximately 42 percent of the $44.7 million ($11.9 million as part of the Commission's capital funding policy and $6.7 million from prior system savings that were generated by converting the medical facility in Cambridge from an acute care hospital to a freestanding medical facility in 2021), which, if approved, will be added to rates at the time of the opening of the new facility and will effectively increase the rate structure of UM SMC at

Easton by ~6 percent. The request for significantly less than 100 percent depreciation and 70 percent interest, which is the maximum available in the capital policy, reflects UM SMC at Easton's acknowledgement of the scaling in the capital financing methodology.

Under the HSCRC's historical capital methodology, UM SMC at Easton's request would have been capped at the 50/50 blend of a hospital's capital cost share (inclusive of the new request's first year estimated depreciation and interest costs) and the peer group average capital cost share, and that value would be scaled for cost per case efficiency. Using the HSCRC capital methodology adopted in December 2019, the capital request from UM SMC at Easton will continue to be capped at the 50/50 blend of the hospital's capital cost share (inclusive of the new request's annualized estimate for depreciation and interest) and the peer group average, and that value will be scaled for cost per case efficiency, total cost of care efficiency, current levels of potentially avoidable utilization, and excess capacity.

Table 6. Capital Methodology Steps

Steps	Additional Commentary
Step 1: Determine Capital Cost of New Project	Requires final determination from MHCC on allowed capital project size and verified useful life and interest rate values
Step 2: Determine Eligible Capital Cost	Calculated by averaging hospital's capital costs, inclusive of the new project, and statewide peer group
Step 3: Efficiency Adjustment	Scales capital projects from 0-100% based on ranked efficiency in hospital cost per case and TCOC (each ranking worth ~2%)
Step 4: PAU Adjustment Credit	Provides additional funding to hospital if they demonstrate low levels of avoidable utilization and thus have more limited room for improvement in profitability
Step 5: Excess Capacity Adjustment	Reduces available funding if hospital has had significant volume declines since 2014 because the hospital should be able to contribute to capital by reducing fixed costs,
Step 6: Check against Maximum Depr & Interest	Policy caps available funding at 100% depreciation, 70% interest to require hospitals to fund a portion of project out of capital reserves or philanthropy
Step 7: Provide Markup	Revenue is marked up for uncompensated care and governmental discounts

Step 1: The first step of the capital methodology determines the allowed, regulated portion of UM SMC at Easton's capital project, per MHCC, which is $539,558,871. Additionally, staff confirms that the project has an annualized depreciation figure of $27,961,00[9] and an annualized interest figure of $16,772,329 on a 30-year loan with a 5.00 percent interest rate.[10]

Combined, the depreciation and interest bring the Hospital's current capital cost share of 8.43 percent to 26.62 percent, an increase of 18.19 percentage points (or $15,206,457 to $59,939,786).

[9] See Appendix C for an itemization of the useful life of each capital

[10] See rate assumption as per page 42 of the Capital Rate Application, which is consistent with that used in the CON application dated January 6, 2023.

Staff are concerned about the relatively large share of total costs being devoted to capital costs that this project contemplates, i.e., 26.62 percent versus a statewide average of 7.64 percent. However, there are several additional factors that should be considered when determining the reasonableness of the project size:

1) The projected use rates and bed capacity that were approved by MHCC align with current volumes and reasonable projections of population growth, as discussed in the *Background* section, and MHCC has confirmed that the project's cost per square foot for the replacement hospital is $46.87 per square foot less than the Marshall Valuation Service ("MVS") benchmark for Class A, good quality construction, which is the industry standard for capital cost benchmarking.
2) A component of the large capital share is due to UM SRH's purposeful consolidation of facilities in the Eastern Shore. Specifically, inpatient services have been centralized at UM SMC at Easton while:
    a) The hospital in Cambridge was converted to a freestanding medical facility in 2021, thus eliminating its delivery of inpatient services, and
    b) Chestertown was reengineered to provide services under a critical access hospital model, which necessitates maintaining average daily census less than 96 hours and has effectively reduced Chestertown's licensed bed capacity from 41 at the start of the All-Payer Model to 5 in Fiscal Year 2024.

    Given this consolidation, staff, purely for analytical purposes, have assessed the depreciation and interest as a percent of total UM SRH costs to recognize the regional consolidation the system has embarked upon. This analysis, inclusive of the allowed consideration for unique cost multipliers that will be discussed below, indicates that while still high (21.1 percent), the costs associated with capital as a percentage of total hospital costs are more reasonably related to statewide values once these considerations are accounted for.

3) As outlined in the MHCC recommendation and HSCRC analyses of cost inflation, approximately $76.3 million in the $540 million capital project are fairly unique to UM SMC at Easton's capital project (as compared to the prevailing experience in the State), and thus are not reflected in the statewide average capital cost share that is utilized in Step 2 of the capital methodology.
    a) First, building in a rural environment brings both land development and labor workforce issues that are different from building in a more heavily populated geography. This is evident given that the last major rural capital project in Maryland, Western Maryland Hospital Center which opened on November 21, 2009 had first year depreciation and interest of 19.49 percent versus a statewide average of 8.36 percent. Additionally, of the last five major hospital capital projects approved through the CON process, only one of them did MHCC identify

as having building and site multipliers, and this particular facility (University of Maryland Capital Regional Medical Center) was almost funded entirely by State and county revenue transfers, not a rate enhancement through HSCRC capital methodologies. As noted in Table 7 below, due to the rural nature of UM SMC at Easton, it had cost multipliers that were equivalent to 7.7 percent of its project versus 4 percent for University of Maryland Capital Regional Medical Center and 0 percent for all other recently evaluated hospitals.

Table 7. Site Preparation & Building Costs Premiums in Recent Major Capital Projects MHCC-Approved CONs[11]

		Recent Major Capital Replacements				
	Easton	Shady Grove	GBMC	Suburban	WOMC	UM Capital Region
Site Multipliers						
Premium due to abnormal labor shortages/remote areas	2,664,598	-	-	-	-	-
Premium for minority business enterprise	1,090,430	-	-	-	-	1,798,368
Premium for prevailing wage	2,664,598	-	-	-	-	724,871
Total Site Multipliers	6,419,626	-	-	-	-	2,523,239
Building Multipliers						
Premium due to abnormal labor shortages/remote areas	12,998,316	-	-	-	-	-
Premium for prevailing wage	12,998,316	-	-	-	-	19,232,575
Premium for minority business enterprise	8,570,914	-	-	-	-	9,115,520
Total Building Multipliers	34,567,546	-	-	-	-	28,348,095
Total Site Prep and Building Premiums	**$40,987,172**	-	-	-	-	**$30,871,334**
Percent of Total Project Costs	7.7%	0.0%	0.0%	0.0%	0.0%	4.0%

b) Second, supply chain and inflationary issues have inherently increased the magnitude of cost required to undertake such a project. HSCRC's analysis of cost increases, which utilized the St. Louis Federal Reserve capital inflation indices,[12] indicates that of the $91.2 million escalation in construction costs between UM SMC at Easton's 2023 CON and UM SMC at Easton's 2016 CON application, $63.1 million of that escalation is related to inflation (with $28M of the escalation related to relocating 29 total beds – 17 MSGA and 12 Psych – from UM SMC at Dorchester as it transitioned to an FMF).

[11] Source: UM SMC at Easton Partial Rate Application

[12] https://fred.stlouisfed.org/tags/series?t=capital%3Bgoods%3Binflation

Table 8. Analysis of Construction Cost Escalation
2016 vs. 2023 CON

Impact of Inflation upon 2016 CON:
Producer Price Index by Commodity Construction (PPIC)

	2016	PPIC 2016	PPIC 2023	2016 Inflated	2023	Variance
Gross Costs	$187,014,795	113.400	176.527	$291,121,347	$278,183,562	-4.4%
Sq. Ft.	354,643				407,872	15.0%
Gross/SF	$527.33	113.400	176.527	$820.89	$682.04	-16.9%

Impact of Deflation upon 2023 CON:
Producer Price Index bt Commodity Construction (PPIC)

	2023	PPIC 2016	PPIC 2023	2023 Deflated	2016	Variance
Gross Costs	$278,183,562	113.400	176.527	$178,703,631	$187,014,795	-4.4%
Sq. Ft.	407,872				354,643	15.0%
Gross/SF	$682.04	113.400	176.527	$438.14	$527.33	-16.9%

Therefore: Cost estimates did not rise as much as index would suggest

Cost Escalation due to Inflation	$63,099,383	69.2%
Cost Escalation due to size	$28,069,384	30.8%
Construction Cost Escalation	$91,168,767	100.0%

UM SMC at Easton has requested that $40.1 million in unique cost multipliers outlined in Table 7 and $35.3 million of the $63.1 million HSCRC has determined is attributable to recent inflationary trends in Table 8 (for a total of $76.3 million) should be passed through the 50/50 blend in the Step 2 of the capital methodology without qualification, similar to how the Commission adjusts for other costs beyond a hospital's control, e.g., labor market in efficiency policies or graduate medical education in TCOC assessments.

Staff agrees with these requests because MHCC has approved the entire $540 million capital project and has not directed the HSCRC to exclude any cost multipliers and/or exemptions from capital rate support calculations. Moreover, the capital policy never contemplated unique rural cost multipliers that would not be accounted for in statewide average capital cost share statistics nor did the policy anticipate that hospitals, recapitalizing in a post-pandemic time period, would have differentially higher capital costs because of labor premiums and supply chain disruption. Moving forward, staff recommend that all exclusions and multipliers that are approved as part of the total capital project through the CON process be passed through the capital policy without qualification and that staff assess the applicability of statewide average depreciation and interest statistics to specific requests and propose alternative calculations if appropriate.

Step 2: Averaging the requested capital share of 26.62 percent to the peer group average of 7.64 percent, per Step 2 of the capital methodology, yields an allowed capital cost share of 17.13 percent, which equates to a 8.70 percentage point increase in capital costs, or $19,154,648.

However, given staff's recommendation to pass through without qualification $76.3 million of the capital project due to unique cost drivers, staff ran two capital models that will then be combined in the final step:

1. the first model (the "pass through model") calculates depreciation of $3,952,679 and interest of $2,371,003 on a project size of $ 76,274,200, which when inflated to the 2029 (the year of the facility opening) and marked up for uncompensated care and government discounts, equals $8,522,602; this proposed funding is carried to the final step without further adjustment as Staff is recommending special treatment for this funding.
2. the second model, which is $463,284,671 and, unlike the pass through model, will run through all of the additional steps of the capital methodology, yields depreciation of $ 24,008,321, interest of $14,401,325, and a requested capital cost share of 24.50 percent.

Averaging the requested capital cost share of model two of 24.50 percent to the peer group average of 7.64 percent, per Step 2 of the capital methodology, yields an allowed capital cost share of 16.07 percent, which equates to a 7.64 percentage point increase in capital costs, or $16,776,520.

Step 3: After a figure is derived in Step 2 for model 2 described above, the capital methodology then scales the result in Step 3 by the *Integrated Efficiency* of hospital cost per case and total cost of care, which is a relative ranking of hospitals that provides approximately 2 percent for each additional increase in ranking. In the case of UM SMC at Easton, which is the 3rd best hospital in the fifth quintile of performance, the hospital is entitled to 18 percent of the allowed capital cost share, or $2.9 million.

Step 4: The capital methodology provides a credit to hospitals that have lower levels of PAU, as defined by 30-day readmissions and avoidable admissions for PQIs. UM SMC at Easton's performance is in the middle of the second quintile of performance and better than the state average performance (15.6 percent compared to the statewide average of 16.15 percent), thus earning a credit of $58,109 and bringing total funding to $3,040,602.

Step 5 The capital methodology removes costs associated with excess capacity, as defined by reductions in bed days from 2010 to 2023. UM SMC at Easton did not experience a reduction in bed days since 2010; thus, there is no adjustment for excess capacity and no change to total funding.

Step 6 In Step 6, staff review the project to determine if eligible funding exceeds 100 depreciation and 70 percent interest, which is equivalent to $34,089,249. Because eligible funding does not exceed that value, there is no change to total funding.

Step 7 The Hospital's markup in Fiscal Year 2024 was 1.1076; therefore, the capital allotment for UM SMC at Easton is eligible for under model 2 is $3,367,771. Combined with the value calculated under the pass through model ($8,522,602), the total capital allotment for the Hospital is $11,890,372. See table 9 below for an itemized schedule of the capital methodology.

Table 9. Capital Methodology Schedule

Algebra	Step	Model 1 (Pass Through Model)	Model 2	Total
	Capital Project Size	$76,274,200	$463,284,671	$539,558,871
A	Depreciation	$3,952,679	$24,008,321	$27,961,000
B	Interest	$2,371,003	$14,401,325	$539,558,871
C=A + B	Step 1: Determine Capital Cost of New Project	$6,323,682	$38,409,646	$44,733,329
	Step 2: Determine Eligible Capital Cost			
D	Current Hospital Capital Ratio	NA	8.43%	
E	Hospital Proforma Capital Ratio	NA	24.50%	
F	Peer Group Capital Ratio	NA	7.64%	
G=Avg(E,F)	Average of the Hospital and Peer Group	NA	16.07%	
H=G-D	Addditional Capital Funding %	NA	7.64%	
I	Addditional Capital Funding $	$7,694,657	$16,776,520	$24,471,177
	Step 3: Efficiency Adjustment			
J	Scaling due to Integrated Efficiency Peformance	NA	18%	
K=I x J	Qualifying Capital Cost After Efficiency Adjustment	$7,694,657	$2,982,492	$10,677,149
	Step 4: PAU Adjustment Credit			
L	Credit due to PAU Performace	NA	58,109	
M=K + L	Qualifying Capital Cost After PAU Adjustment	$7,694,657	$3,040,602	$10,735,258
	Step 5: Excess Capacity Adjustment			
N	Adjustment due to Bed Day Reduction	NA	0	
O=M + N	Qualifying Capital Cost After Excess Capacity Adjustment	$7,694,657	$3,040,602	$10,735,258
	Step 6: Check against Maximum Depr & Interest	NA	NA	
	Step 7: Provide Markup			
P	Estimated Markup	1.1076	1.1076	1.1076
Q=O x P	Additional Capital Funding	$8,522,602	$3,367,771	$11,890,372

Hospital Restoration of Funding Request

In 2020, UM SRH discussed with HSCRC staff the concept of transitioning UM SMC Dorchester from a full-service hospital to an FMF and prioritizing redirecting the resulting GBR savings to contribute to the UM SMC at Easton capital project, rather than generating system savings. HSCRC staff expressed a willingness to consider such an arrangement, subject to Commissioner approval. However, when UM SMC at Dorchester transitioned from an acute care facility to an FMF in November 2021, HSCRC staff removed $6.7 million in system savings, citing the lack of an active, docketed CON project.

As UM SMC at Easton's replacement and relocation capital project is now underway, UM SRH is resubmitting its request to use the GBR capacity generated from the UM SMC at Dorchester FMF transition to contribute to covering capital costs of the UM SMC at Easton replacement and relocation project, rather than system savings. Without this accommodation, the effective financing for this project from the capital policy alone would be 26 percent versus the 42 percent the Hospital is requesting.

Because UM SMC at Easton understands that this request is outside of the capital policy, it has put forward the following proposal to make the $6.7 million restoration, which will be used to fund 16 percent of the new facility's depreciation and interest, at risk for geographic TCOC improvement, as measured by the Care Transformation Initiative (CTI) policy framework:

1) Potential evaluation
    a) Two-sided risk structure
        i) Range of potential funding outcomes: $0 - $6.70M
    b) Geographic/community-based care CTI thematic area
    c) Risk structure tied to policies that are in effect upon activation of the funding (i.e., 2029)
        i) Ex: CTI for TCOC risk, Revenue for Reform for the buyout provision
2) Expected outcome
    a) Geographic TCOC improvement vs. agreed upon base period for 5-county Mid-Shore
        i) At least dollar for dollar savings, i.e., $6.7 million, to be achieved within a reasonable time frame, e.g., 7 years of the start of the new hospital, and relative to a reasonable established target
        ii) In year 1, total cost of care for Medicare recipients in the 5-county region is at least $1 million better than agreed upon benchmark, which grows to $6.7 million per year better than the target in year 7.
        iii) If target savings are not achieved, then rates are lowered to recoup the difference. For example, if only $500K saved in year 1, reduction in $500K in rates in year 2. An additional $2 million will still be expected in year 2.
        iv) After year 10, risk structure sunsets and three year average TCOC savings run rate is permanently reflected in UM SMC in Easton's rate structure (not to exceed $6.7 million).
3) Risk reduction provision
    a) UM SRH will have an opportunity to reduce of half of the TCOC risk if two conditions are met
        i) Investments in enhanced access are made (UMMS is indicating that at least $3.5 million will be spent annually), and
        ii) Progress on key community health improvement indicators are met
    b) The details of which investments to make and what the key improvement indicators are should be worked out through a community planning process, and reviewed and found to be appropriate by the Commission staff
    c) Examples of potential investments in enhanced access:
        i) Rural primary care residency program
        ii) Mobile Integrated Health/Community Health Workers
        iii) Community-based mental health services
        iv) Primary care community physicians
        v) Community physicians oriented to community needs
        vi) Chronic condition medical specialties – Cardiology, Pulmonary, Diabetes
    d) Examples of key performance indicators (KPI's):

i) Lives touched/encounters in non-hospital setting
ii) Number connected to services addressing social needs
iii) Number connected to outreach programs
iv) Emergency department admissions per capita
v) Avoidable admissions per capita
vi) Readmissions performance at SRH hospitals

Below is an outline of the potential risk arrangement which will be subject to further negotiation should Commissioners approve staff's recommendation to advance a contract negotiation with UM SRH:

Table 10. Potential TCOC At-Risk Schedule

Cumulative Evaluation ***Poor Performance*** *($ Millions)*	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Final Reconciliation (Year 11)	Total	Permanent Funding (Average of Last 3 Years)
Capital Installment	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7		$67	
Required Savings Relative to Baseline	$1	$2	$3	$4	$5	$6	$7	$7	$7	$7		$49	
Actual Savings	$1	$3	$2	$2	$5	$4	$0	$0	$0	$0		$17	$0
Annual Reconciliation				$0	($2)	$0	($2)	($7)	($7)	($7)	($7)	($32)	
Cumulative Reconciliation	$0	$0	$0	$0	($2)	($2)	($4)	($11)	($18)	($25)	($32)		

Cumulative Evaluation ***Excellent Performance*** *($ Millions)*	Year 1	Year 2	Year 3	Year 4	Year 5	Year 6	Year 7	Year 8	Year 9	Year 10	Final Reconciliation (Year 11)	Total	Permanent Funding (Average of Last 3 Years)
Capital Installment	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7	$6.7		$67	
Required Savings Relative to Baseline	$1	$2	$3	$4	$5	$6	$7	$7	$7	$7		$49	
Actual Savings	$1	$1	$2	$2	$5	$4	$5	$8	$9	$10		$47	$6.70
Annual Reconciliation				($2)	($2)	$0	($2)	($2)	$1	$2	$3	($2)	
Cumulative Reconciliation	$0	$0	$0	($2)	($4)	($4)	($6)	($8)	($7)	($5)	($2)		

Placing at risk a funding source for a major capital project's depreciation and interest is an unprecedented request, as the new facility is not an asset that can be easily liquidated if the Hospital fails to maintain enhanced access and/or performs poorly on expected TCOC improvement.

Staff recognize the concern that missed performance metrics may cause margin erosion and liquidity deterioration. However, given the UM SRH's demonstrated ability to rationalize its acute care service delivery and improve upon avoidable utilization metrics and total cost of care, staff recommend that the Commission approve the restoration of the $6.7 million in system savings, contingent on an executed contract between UM SRH and the HSCRC that codifies expected deliverables and associated KPI's/expected outcomes. UMMS financial reserves would serve as the backstop for the project. The final contract will be subject to Commission approval.

Staff Recommendation

Based on the analysis described in the prior sections of this document, staff recommend the following:

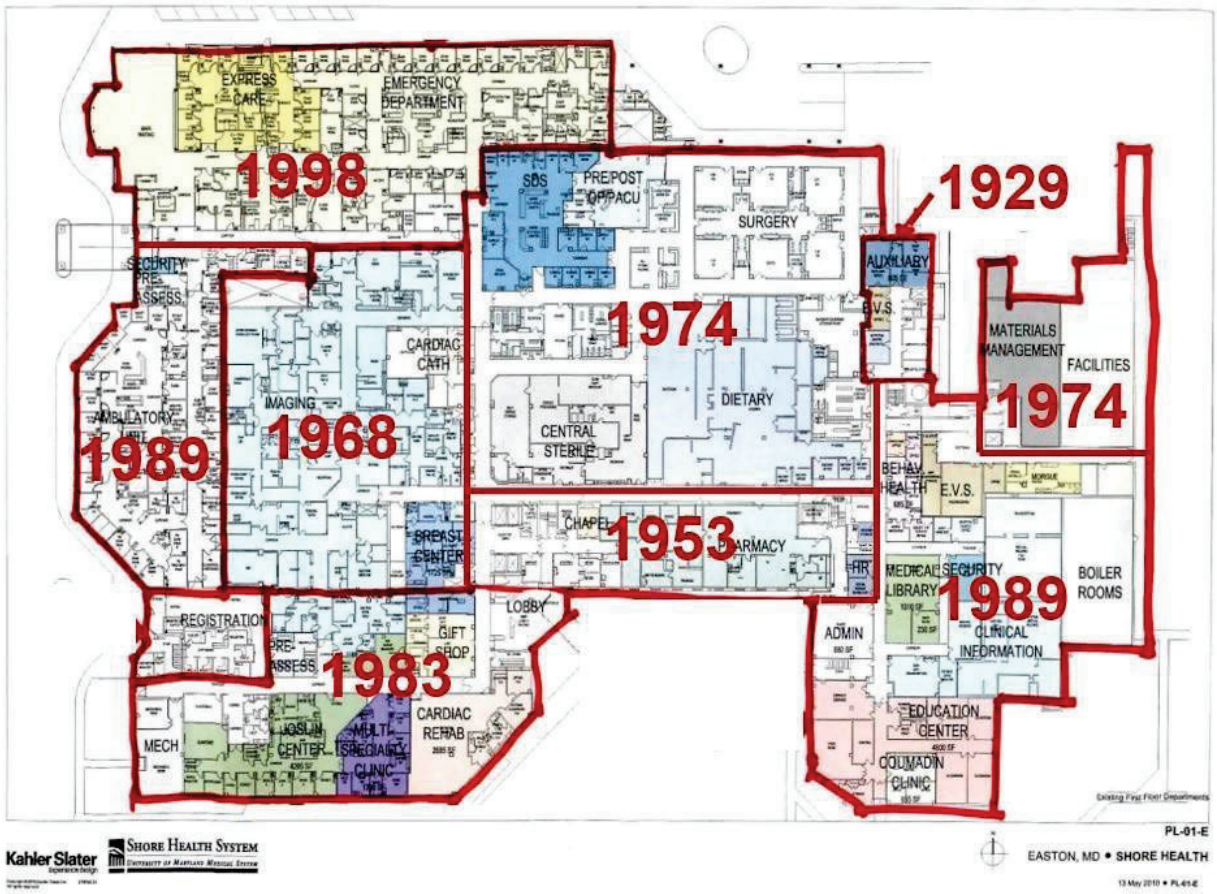
1) All exclusions and multipliers that are approved as part of the total capital project through the CON process should be passed through the capital policy without qualification and staff should assess the applicability of statewide average depreciation and interest statistics to specific requests and propose alternative calculations if appropriate. Given the implications this will have on the capital policy moving forward, staff ask for public comment on this proposal by June 21, 2024 and that Commissioners use this commentary when considering this alteration to the capital policy in a subsequent Commission meeting.

2) A permanent adjustment of $11,890,372, per the capital methodology, to be provided to UM SMC at Easton when the capital project is completed and the new site is available for use. The opening date of this project is anticipated to become effective on July 1, 2029.

3) A permanent adjustment of $6,700,000, which will restore funding related to the facility conversion of UM SMC at Dorchester, to be provided to UM SMC at Easton when the capital project is completed and the new site is available for use. The funding will be contingent on UM SRH executing a contract with the HSCRC that that links the funding, as indicated above, to total cost of care, investments in care transformation, and key performance indicators. The final contract will be subject to Commission approval.

Appendices

Appendix A, Current UM SMC at Easton Facility by Year of Construction:



Appendix B, Age Adjusted Population Modelling

"	A	B	C	D=B*C	E
Cohort	2020 Census	Age Cost Weights from Demographic Adjustment Policy	2010-2020 year Growth Rate	Age Adjusted 10 year Growth Rate	Age Adjusted Population Growth
0 to 4	10,735	0.6416	-10.47%	-6.72%	(721)
5 to 14	25,040	0.1395	-7.09%	-0.99%	(248)
15 to 44	71,774	0.6026	-3.36%	-2.03%	(1,454)
45 to 54	26,728	0.9082	-20.16%	-18.31%	(4,894)
55 to 64	32,753	1.4633	17.72%	25.93%	8,492
65 to 74	25,118	2.0882	36.90%	77.05%	19,354
75 to 84	13,487	2.8283	34.49%	97.56%	13,157
85+	4,688	2.8550	17.35%	49.52%	2,322
Total	210,323			17.12%	36,008
CAGR				1.59%	

Appendix C, UM SMC at Easton CON Project Depreciation Detail by Use of Funds ($'s in thousands)

	Uses of Funds	Useful Life (Years)	Annual Depreciation
Design	27,213	40.0	680
Land	2,465	-	-
Land improvement	41,409	30.0	1,380
Building construction & infrastructure	308,607	40.0	7,715
Information technology	30,711	5.5	5,584
Equipment / furnishings	54,350	5.5	9,882
Contingency	13,725	32.0	429
Subtotal	**$ 478,480**	**18.6**	**$ 25,670**
CON prep / consultants	8,100	32.0	253
Capitalized interest & borrowing fees	52,978	26.0	2,038
Total uses of funds	**$ 539,558**	**19.3**	**$ 27,961**

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

June 14, 2024

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

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2457
BALTIMORE, MARYLAND	*	PROCEEDING:	2647A

I. INTRODUCTION

Johns Hopkins Health System ("System') filed an application with the HSCRC on May 24, 2024, on behalf of its member hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global price arrangement for cardiovascular, joint replacement procedures, bypass, cardiac cath, defribillators, PCI, cardiac valves, TAVRs and oncology evaluation services with Health Design Plus, Inc. The System requests approval of the arrangement for a period of one year beginning May 1, 2024.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the new global rates for solid organ transplants 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 Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in

payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC 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 favorable. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for participation in an alternative method of rate determination for cardiovascular, joint replacement procedures, bypass, cardiac cath, defibrillators, PCI, cardiac valves, TAVRs and oncology evaluation services for a one-year period commencing May 1, 2024, and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU"). The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

June 14, 2024

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2459
BALTIMORE, MARYLAND	*	PROCEEDING:	2649A

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Johns Hopkins Health System

June 14, 2024

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ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2461
BALTIMORE, MARYLAND	*	PROCEEDING:	2651A

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Emergency Department Dramatic Improvement Effort (EDDIE)

June Commission Meeting

Emergency Department Initiatives

- HSCRC staff have been working on the following:
  - Finalized data submission requirements for ED LOS data for QBR
  - Meeting with subgroup to develop ED LOS incentive for QBR
  - Internal planning for ED Wait Time Commission, which will include:
    - Hospital ED Best Practices Incentive
    - Statewide Best Practices Implementation
  - Continue work on policy for Multi-Visit Patients
  - EDDIE data continues to be collected (see appendix for May data)

Appendix

EDDIE Overview

- Maryland has underperformed most other states on ED throughput measures since before the start of the All-Payer model
- EDDIE is a Commission-developed quality improvement initiative that began in June 2023 with two components:

EDDIE: Improved ED Experience for Patients

Quality Improvement

- Rapid cycle QI initiatives to meet hospital set goals related to ED throughput/length of stay
- Learning collaborative
- Convened by MHA

Commission Reporting

- Public reporting of monthly data for three measures
- Led by HSCRC and MIEMSS

ED Length of Stay and EMS Turnaround Data

- Monthly, unaudited data on ED length of stay for May 2024 was received from 43 out of 44 hospitals (IP and OP data).
- There was a decrease in Median Wait Times in May compared to April.
    - May Average Median Wait Time:

ED1a: 555.2 minutes **ED1b: 542.7 minutes** **ED1c: 758.2 minutes**

    - 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) and the data have NOT been audited by the HSCRC; data can be used for trending purposes within the hospital.
- EM turnaround time data shows minimal movement of hospitals across categories for May 2024, with one hospital improving in performance and three

See Appendix for graphs and data for all measures

May 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

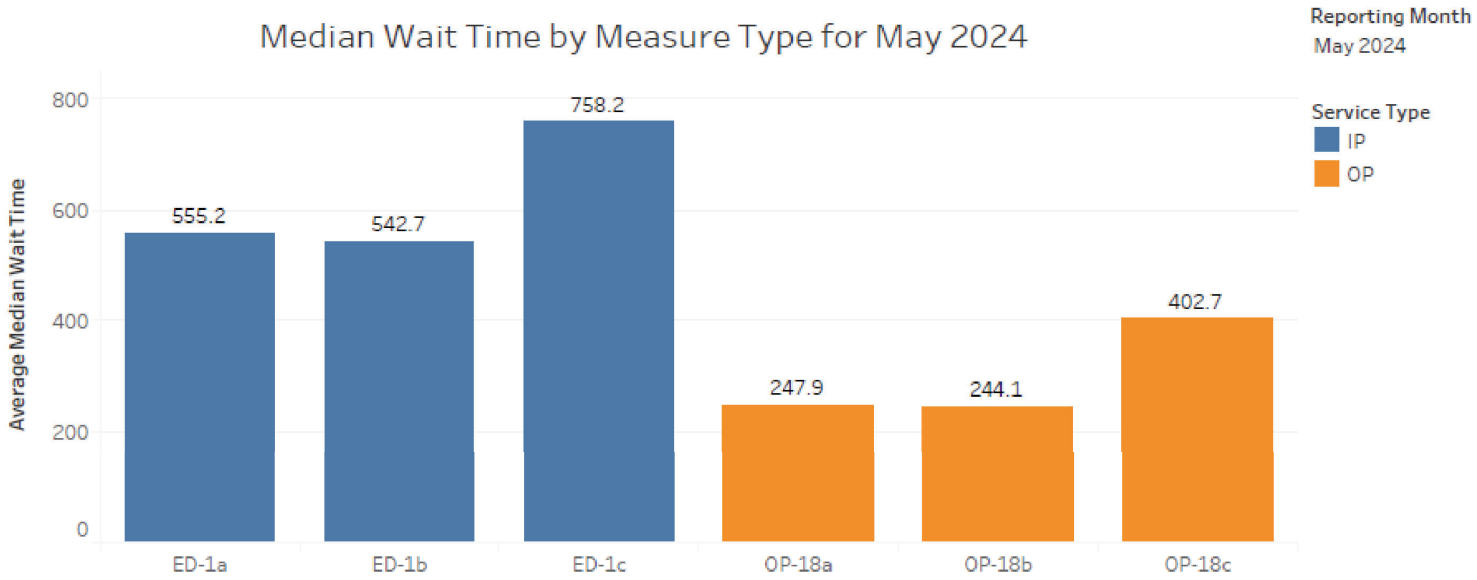
May data received for 39 out of 40 hospitals

- 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:

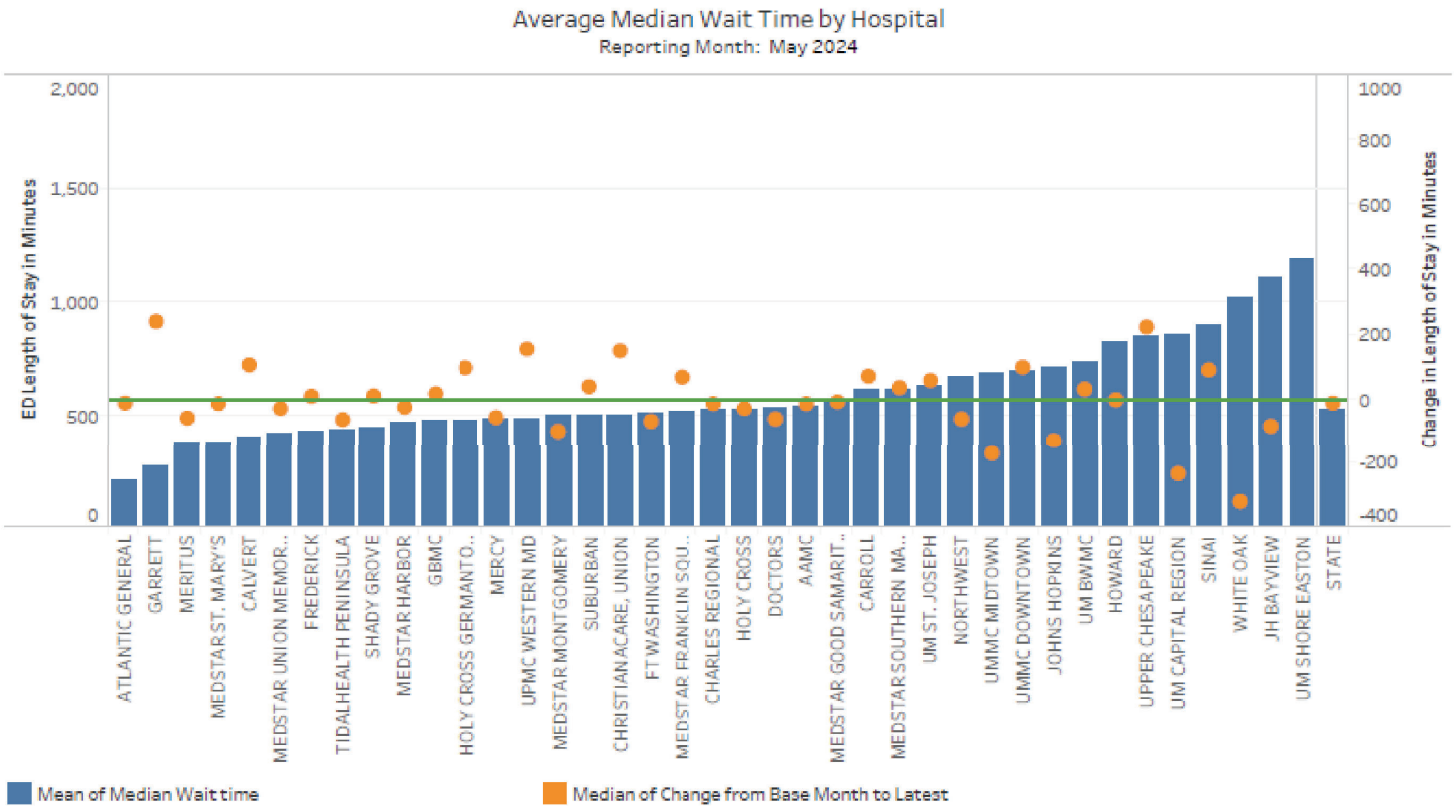
- Starting with February data, CRISP automated several new types of graphs/charts to illustrate EDDIE data using Tableau.
- Rolling median (June-Latest Month) and change from June/first month provided
- Latest month grouped by CMS ED volume category (Volume data is from CMS Care Compare or imputed by 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

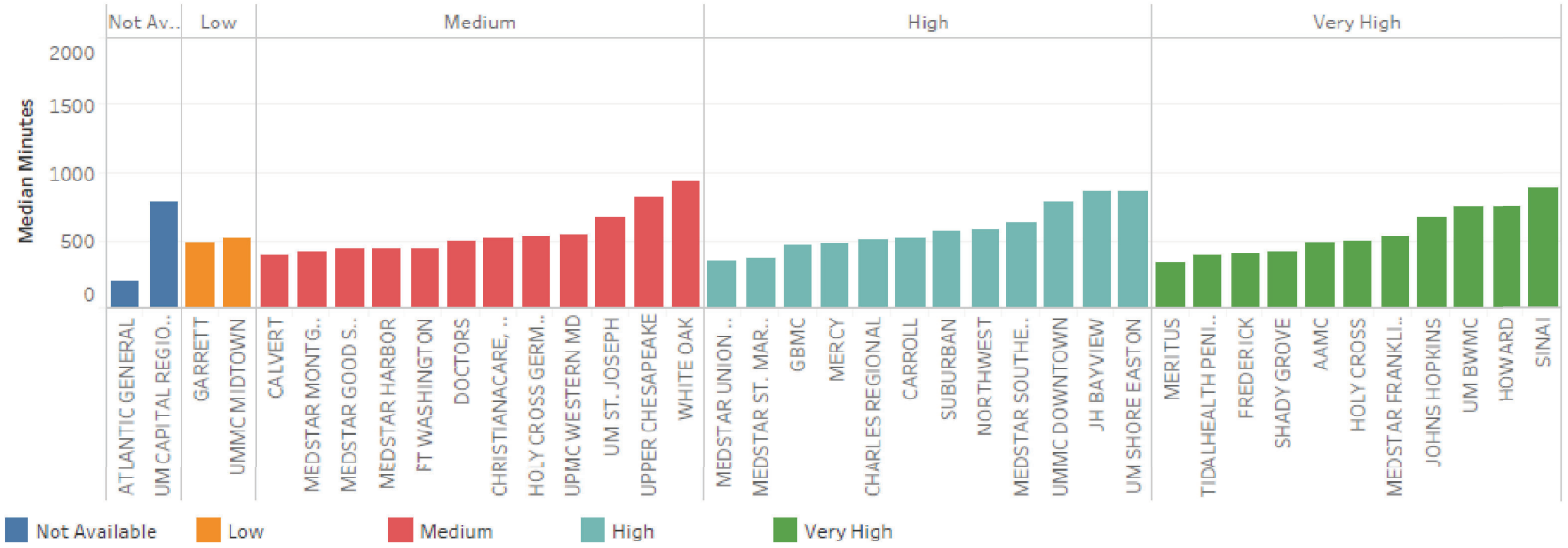


ED 1a: ED Arrival to Inpatient Admission

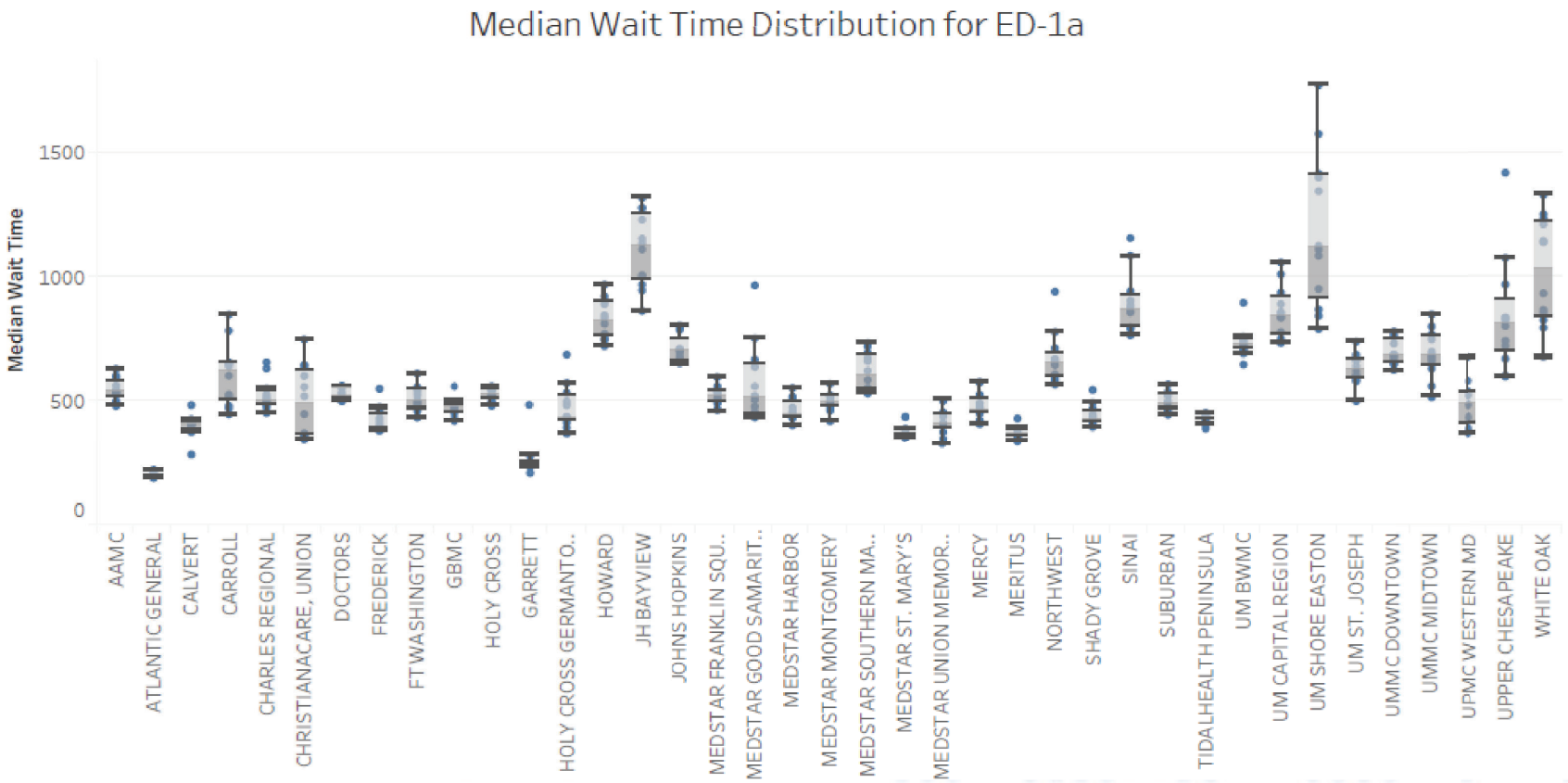
Measure
ED-1a



ED 1a: ED Arrival to Inpatient Admission Time
Latest Month Median By Volume--Latest Month



ED 1a: ED Arrival to Inpatient Admission



ED 1a: ED Arrival to Inpatient Admission

Heat Graph:
Colors are relative to June/first month reported.

Red = higher wait time
Green = lower wait time

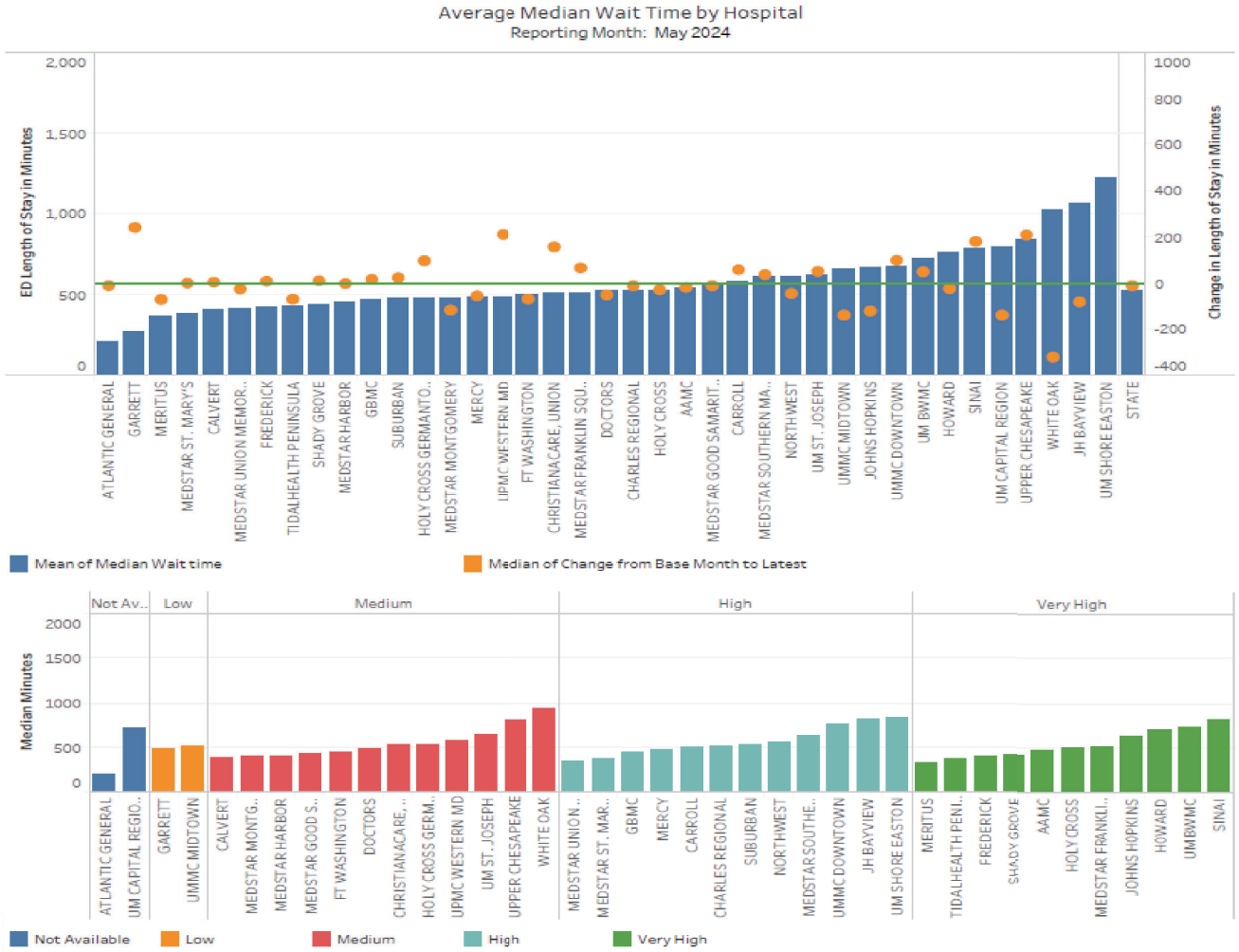
Average Median Wait Time All Hospitals for ED-1a

Measure
ED-1a

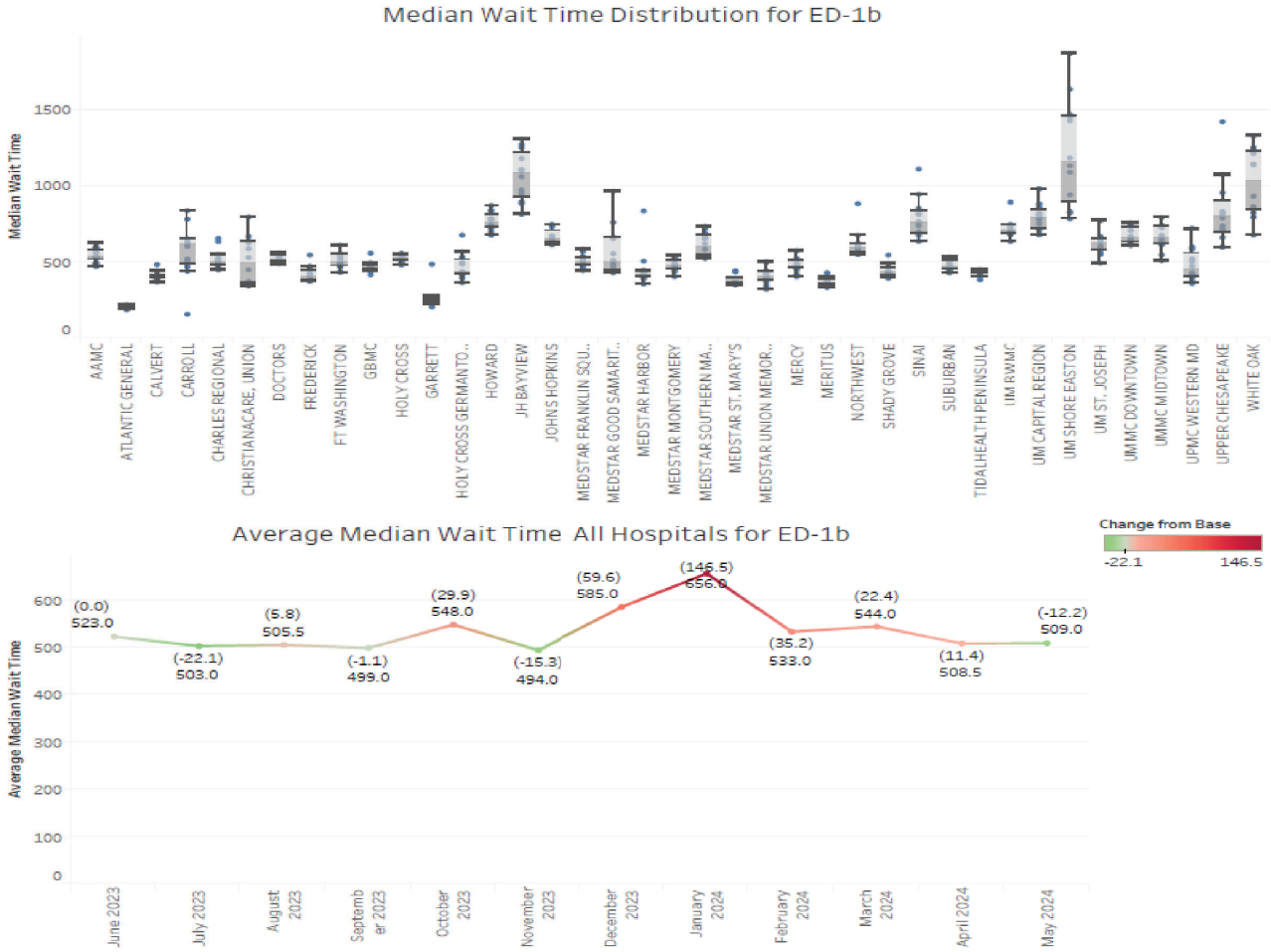
Change from Base
-610 819

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
AAMC	493	532	540	534	563	601	629	597	530	544	501	480
ASCENSION SAINT AGNES	601	564	545	574	641	576	755	772	684	694	742	
ATLANTIC GENERAL	210	218	221	212	195	189	216		190	191	199	199
CALVERT	282	383	411	425	405	409	484	426	408	402	375	389
CARROLL	447	527	481	640	602	470	654	848	656	649	783	519
CHARLES REGIONAL	527	486	497	453	492	455	508	656	631	551	475	514
CHRISTIANACARE, UNION	369	351	370	343	360	448	641	601	645	557	748	520
DOCTORS	561	514	537	503	559	529	555	559	513	512	500	500
FREDERICK	392	388	382	395	416	432	464	550	476	381	386	402
FT WASHINGTON	503	434	488	493	550	539	611	460	476	556	524	435
GARRETT			244		246	244	277	254	231	237	207	485
GBMC	439	467	456	475	482	420	476	559	497	474	454	457
HOLY CROSS	524	481	540	513	547	518	546	559	496	524		496
HOLY CROSS GERMANTO..	435	393	428	369	483	414	573	687	499	437		533
HOWARD	748	770	765	834	968	921	902	889	721	845	811	747
JH BAYVIEW	945	1,007	1,153	968	1,135	1,276	1,229	1,277	1,315	1,001	1,110	862
JOHNS HOPKINS	794	680	652	697	704	708	661	804	786	710	663	666
MEDSTAR FRANKLIN SQUA..	463	467	493	492	532	509	560	596	539	512	537	532
MEDSTAR GOOD SAMARIT..	441	479	522	456	559	506	667	965	752	637	442	434
MEDSTAR HARBOR	458	553	474	518	513	402	441	457	436	437	432	434
MEDSTAR MONTGOMERY	518	461	486	495	525	497	505	569	518	480	471	419
MEDSTAR SOUTHERN MA..	585	544	539	530	542	554	660	738	695	673	719	622
MEDSTAR ST. MARY'S	380	351	362	354	362	382	436	437	363	372	390	367
MEDSTAR UNION MEMORI..	375	456	412	326	407	400	504	500	439	410	446	347
MERCY	526	577	575	407	450	423	466	492	461	476	463	470
MERITUS	393	370	354	386	379	345	368	430	370	354	354	335
NORTHWEST	645	778	669	566	602	608	661	940	713	593	668	584
SHADY GROVE	408	427	446	435	545	494	428	437	403	470	396	419
SINAI	796	796	877	861	764	856	791	1,155	1,085	942	904	887
SUBURBAN	527	462	467	480	537	469	499	521	497	445	475	567
TIDALHEALTH PENINSULA		453	448	447	432	430	445	450	438	406	424	390
UM BWMC	711	740	691	708	717	647	756	895	758	731	725	743
UM CAPITAL REGION	1,010	853	858	751	890	734	835	1,057	936	838	736	778
UM SHORE EASTON	1,399	951	1,344	1,414	1,109	789	1,574	1,770	1,084	1,124	843	868
UM ST. JOSEPH	604	600	641	667	687	499	621	739	580	585	672	663
UMMC DOWNTOWN	680	625	648	688	658	650	670	768	687	758	721	780
UMMC MIDTOWN	685	849	800	658	768	560	698	677	748	669	631	516
UPMC WESTERN MD	383	430	438	481	522	523	489	676	580	392	368	539
UPPER CHESAPEAKE	598	669	599	834	801	968	1,075	1,417	721	741	834	822
WHITE OAK	1,251	865	1,143	855	1,328	1,210	794	825	677	1,233	1,138	932

ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric



ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric



ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric

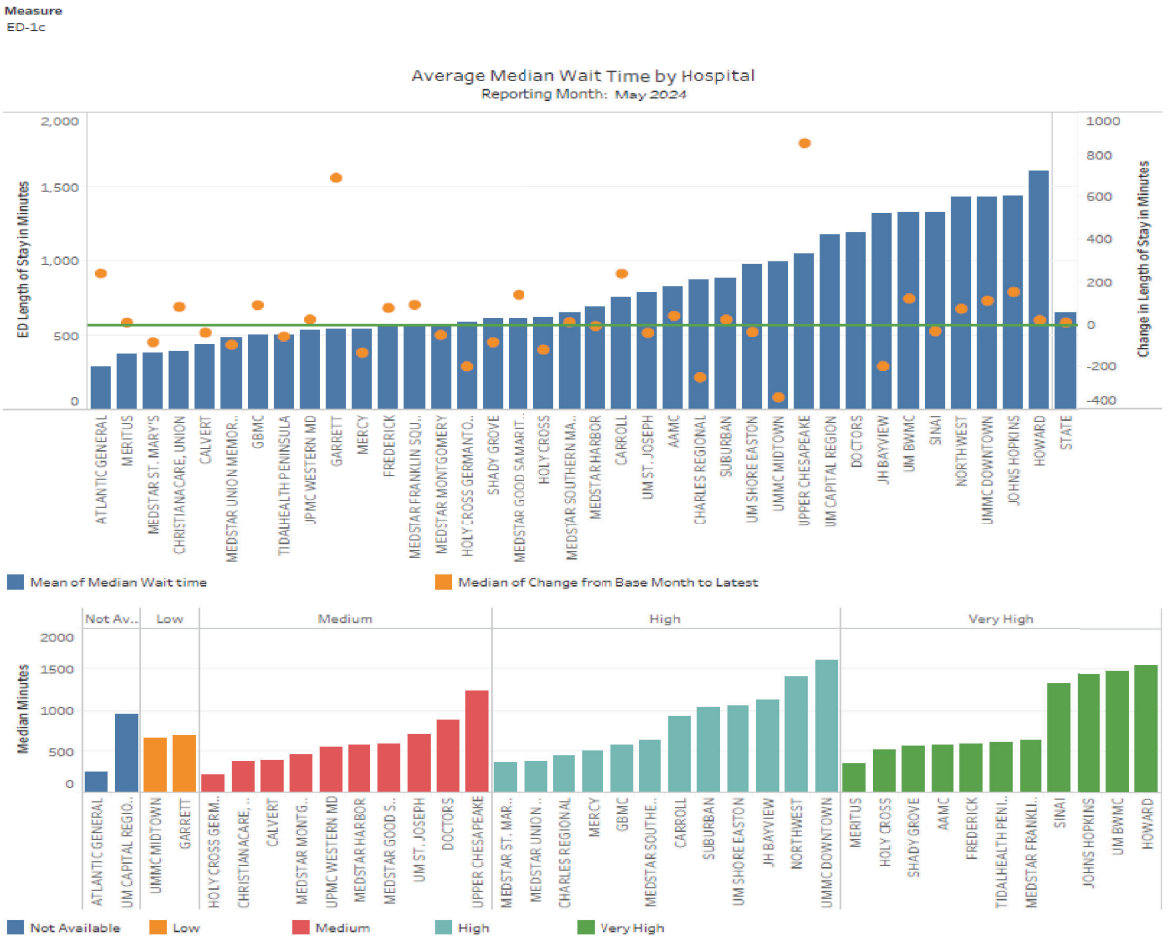
Average Median Wait Time All Hospitals for ED-1b

Measure
ED-1b

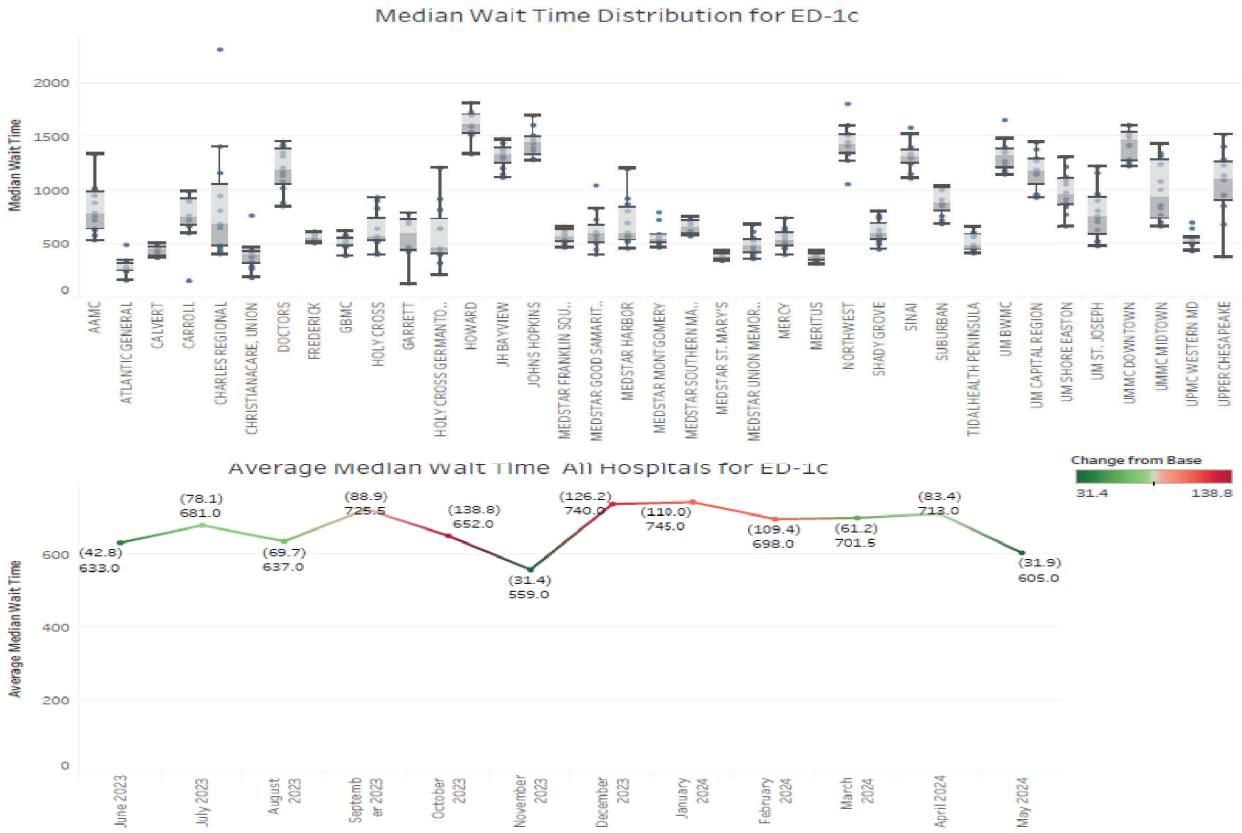
Change from Base
-668 822

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
AAMC	488	527	536	529	565	597	623	591	528	539	495	471
ASCENSION SAINT AGNES	599	563	541	573	641	576	755	772	683	694	741	
ATLANTIC GENERAL	209	203	222	212	195	189	216		190	190	199	199
CALVERT		386	403	420	390	408	484	443	404	395	369	391
CARROLL	441	520	470	623	603	158	653	837	648	648	782	500
CHARLES REGIONAL	526	484	499	449	489	456	507	656	634	551	474	516
CHRISTIANACARE, UNION	372	351	370	343	356	450	640	627	669	588	795	530
DOCTORS	541	503	525	499	559	523	547	543	510	509	489	491
FREDERICK	388	376	378	391	410	427	458	546	472	375	379	397
FT WASHINGTON	503	434	488	493	550	539	611	469	476	556	524	435
GARRETT			244		246	244	277	255	227	236	206	486
GBMC	438	467	455	475	481	417	476	558	496	475	454	455
HOLY CROSS	524	482	540	513	544	518	546	557	495	524		496
HOLY CROSS GERMANTO..	435	396	427	365	487	414	568	677	498	436		533
HOWARD	722	734	729	776	871	839	836	785	676	785	741	699
JH BAYVIEW	895	951	1,107	885	1,097	1,250	1,179	1,270	1,307	973	1,059	815
JOHNS HOPKINS	746	631	613	650	672	652	617	744	732	667	623	626
MEDSTAR FRANKLIN SQUA..	445	471	492	484	516	471	570	585	538	492	522	512
MEDSTAR GOOD SAMARIT..	440	474	512	449	556	494	654	965	761	664	442	430
MEDSTAR HARBOR	407	506	424	835	391	357	399	447	416	432	415	406
MEDSTAR MONTGOMERY	520	459	478	477	525	438	490	540	495	454	448	404
MEDSTAR SOUTHERN MA..	584	542	536	525	540	533	654	735	691	668	720	622
MEDSTAR ST. MARY'S	368	350	362	356	362	385	436	443	361	366	390	369
MEDSTAR UNION MEMORI..	367	442	397	321	398	389	498	503	434	413	425	342
MERCY	523	576	574	404	450	421	464	490	461	476	462	469
MERITUS	404	371	357	386	377	341	368	430	364	352	347	334
NORTHWEST	595	676	613	558	575	561	600	883	624	549	609	551
SHADY GROVE	408	424	446	434	546	493	427	437	397	468	395	419
SINAI	638	636	759	699	675	765	737	1,110	945	852	814	819
SUBURBAN	510	441	445	457	516	455	485	506	474	429	456	534
TIDALHEALTH PENINSULA		452	446	447	429	430	447	448	437	405	423	383
UM BWMC	684	704	681	683	699	635	740	893	747	721	698	734
UM CAPITAL REGION	859	752	781	714	809	683	793	981	882	821	679	721
UM SHORE EASTON	1,452	941	1,468	1,428	1,182	784	1,634	1,867	1,089	1,132	823	832
UM ST. JOSEPH	598	562	641	656	640	494	607	771	583	550	669	650
UMMC DOWNTOWN	658	610	625	669	636	622	651	747	662	742	707	758
UMMC MIDTOWN	647	792	735	614	742	547	676	664	726	640	617	509
UPMC WESTERN MD	373	417	411	473	599	503	430	722	520	394	360	585
UPPER CHESAPEAKE	599	662	598	831	789	956	1,074	1,421	717	739	826	809
WHITE OAK	1,251	865	1,142	855	1,328	1,212	795	825	677	1,233	1,138	932

ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric



ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric



ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric

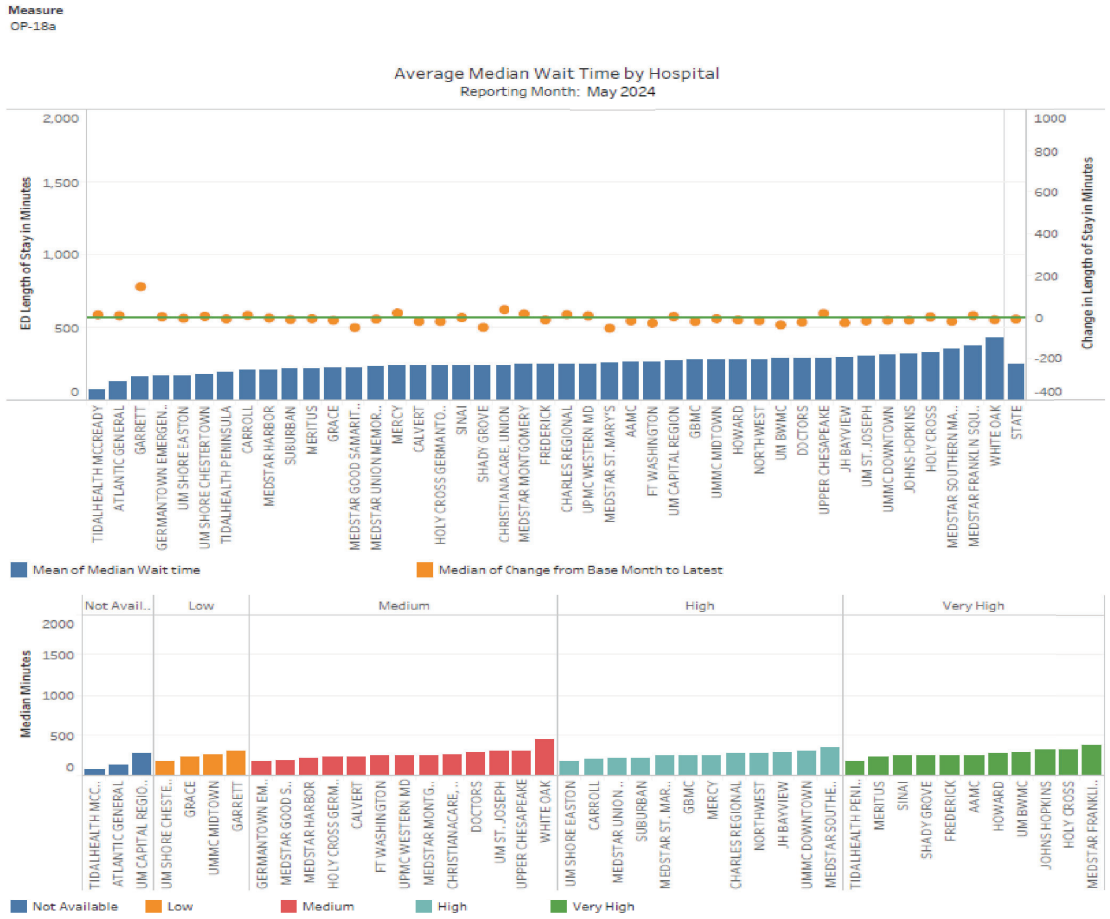
Average Median Wait Time All Hospitals for ED-1c

Measure
ED-1c

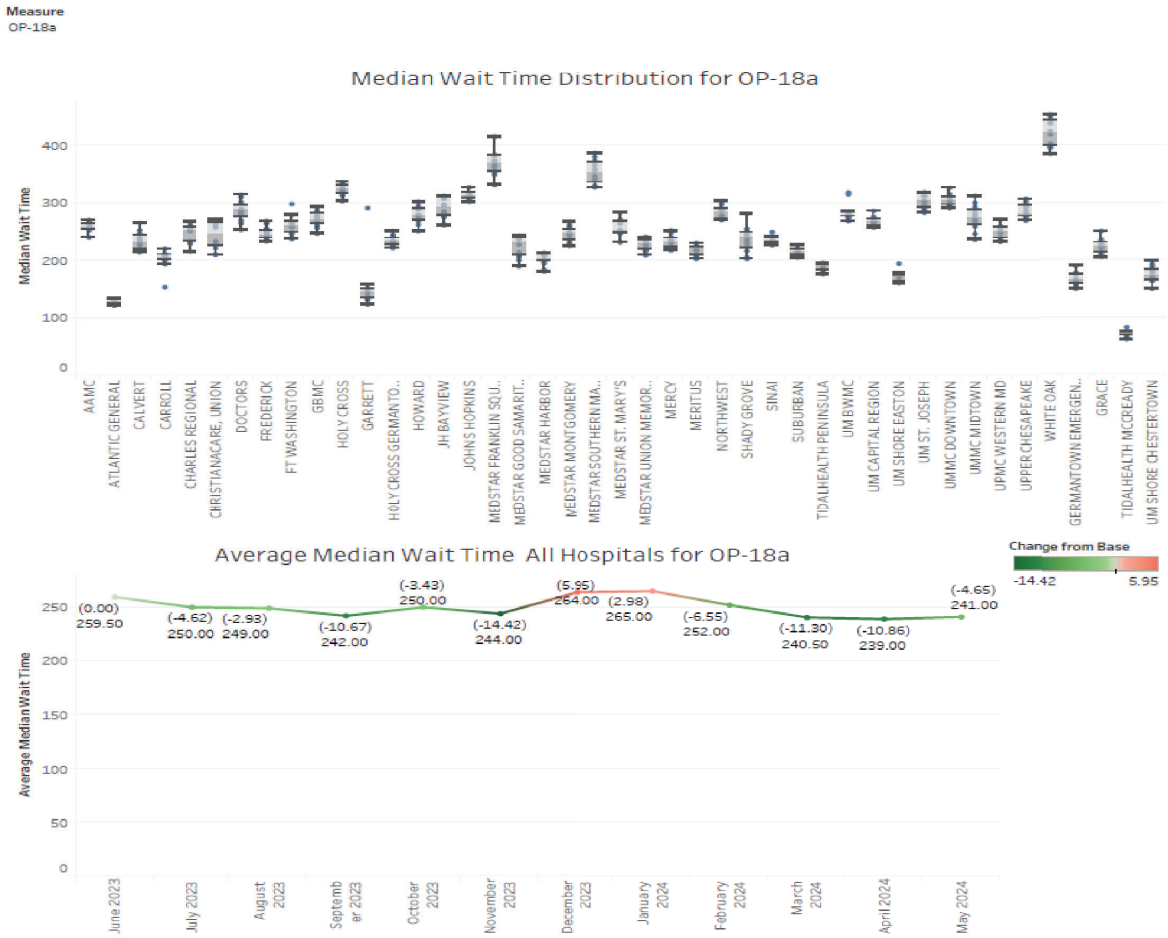
Change from Base
-564 2,701

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
AAMC	535	883	719	643	1,335	951	1,009	1,017	757	790	629	578
ASCENSION SAINT AGNES	755	939	631	691	652	531	682	745	698	574	839	
ATLANTIC GENERAL		345	160	262	286	490	255			254		242
CALVERT	425	379	457	471	508	427	501	369	449	458	393	385
CARROLL	665	667	764	893	598	156	724	988	989	717	924	906
CHARLES REGIONAL	682	678	487	810	1,407	406	1,161	647	466	2,311	946	436
CHRISTIANACARE, UNION	290	184	268		424	422	764	431	463	388	331	375
DOCTORS	1,414	1,316	1,167	1,019	1,418	1,453	1,347	1,208	1,134	850	1,079	881
FREDERICK	506	517	540	514	613	534	586	609	613	557	514	586
GARRETT							470	717	428	786	131	691
GBMC	480	387	479	476	508	526	498	621	578	471	398	573
HOLY CROSS	642	416	518	568	903	559	532	933	831	400		526
HOLY CROSS GERMANTO..	410	320	643	400	412	458	1,208	919	643	818		215
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
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
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
MEDSTAR FRANKLIN SQUA..	532	465	500	532	627	662	469	642	542	583	589	627
MEDSTAR GOOD SAMARIT..	446	502	590	549	608	522	827	1,045	725	577	401	588
MEDSTAR HARBOR	577	868	923	1,199	806	520	695	531	603	458	540	572
MEDSTAR MONTGOMERY	512	472	498	532	531	722	550	795	588	568	579	465
MEDSTAR SOUTHERN MA..	609	575	586	573	601	714	683	717	754	722	713	622
MEDSTAR ST. MARY'S	434	356	356	339	359	374	415	379	376	430	396	353
MEDSTAR UNION MEMORI..	464	681	473	358	475	431	612	470	530	407	553	371
MERCY	622	648	738	490	458	531	518	556	398	456	577	492
MERITUS	329	344	317	385	423	395	363	434	397	362	413	340
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
SHADY GROVE	633	805	526	760	450	573	592	497	739	594	589	552
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
SUBURBAN	1,000	849	875	865	1,029	718	868	760	912	686	1,040	1,025
TIDALHEALTH PENINSULA		659	490	441	473	415	415	567	440	596	465	605
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
UM CAPITAL REGION	1,379	1,445	1,189	1,169	1,299	1,191	1,147	1,272	1,146	931	959	950
UM SHORE EASTON	1,085	974	769	1,304	875	842	917	1,121	661	878	1,215	1,052
UM ST. JOSEPH	739	1,159	627	899	1,216	520	756	473	516	961	806	702
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
UMMC MIDTOWN	1,001	1,341	1,431	1,078	1,317	664	1,238	698	767	830	855	661
UPMC WESTERN MD	513	520	508	510	525	484	560	640	695	437	428	539
UPPER CHESAPEAKE	377	1,135	679	1,513	948	1,283	1,096	848	1,096	953	1,404	1,231
WHITE OAK			2,701									

OP18a: ED Arrival to Discharge Time by Month



OP18a: ED Arrival to Discharge Time by Month



OP18a: ED Arrival to Discharge Time by Month

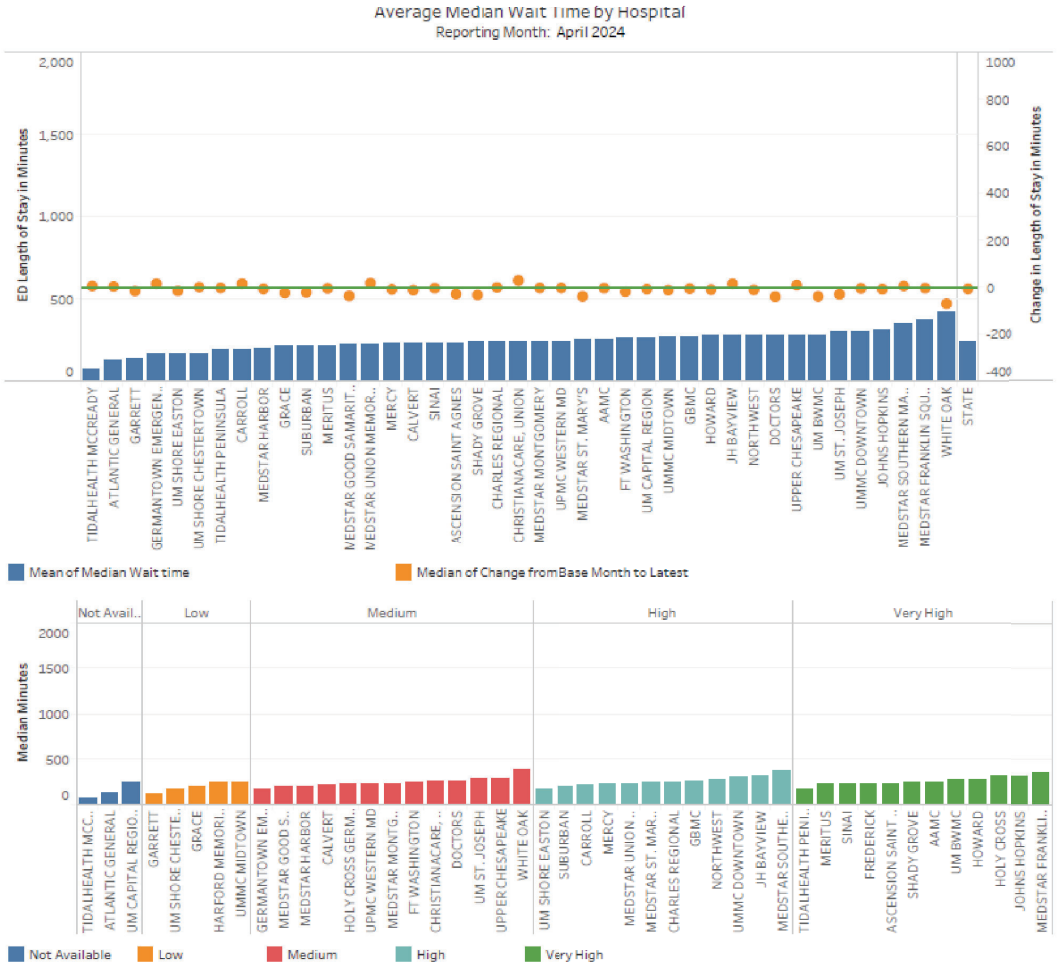
Average Median Wait Time All Hospitals for OP-18a

Measure
OP-18a

Change from Base
-79.0 147.0

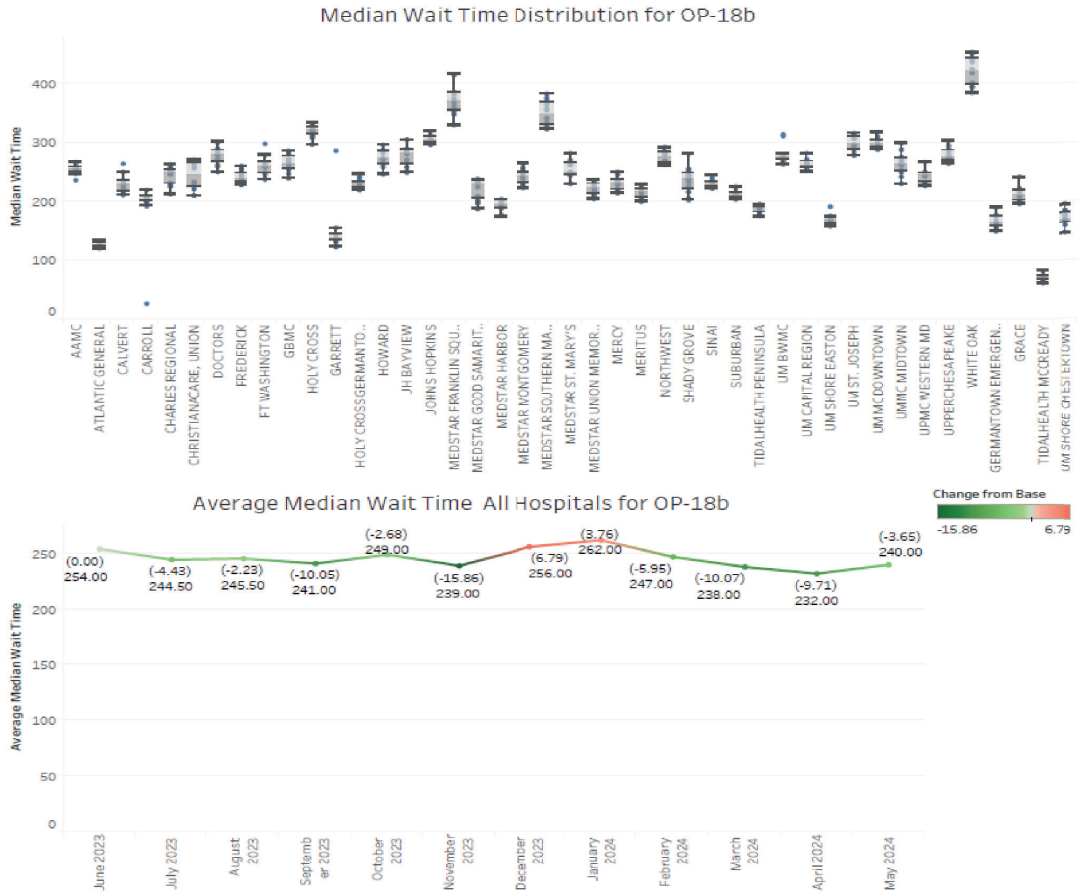
Hospital Name	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..	January 2024	February 2024	March 2024	April 2024	May 2024
AAMC	258.0	255.0	260.0	254.0	266.0	263.0	271.0	268.0	256.0	258.0	253.0	241.0
ASCENSION SAINT AGNES	261.0	238.0	236.0	243.0	220.0	226.0	239.0	238.0	232.0	227.0	233.0	
ATLANTIC GENERAL	124.0	127.0	131.0	133.0	128.0	123.0	134.0		125.0	122.0	128.0	132.0
CALVERT	247.0	229.0	240.0	233.0	253.0	235.0	266.0	218.0	215.0	216.0	220.0	227.0
CARROLL	194.0	203.0	201.0	201.0	221.0	154.0	212.0	209.0	211.0	209.0	210.0	203.0
CHARLES REGIONAL	254.0	253.0	232.0	216.0	230.0	234.0	258.0	261.0	252.0	258.0	253.0	267.0
CHRISTIANACARE, UNION	229.0	234.0	222.0	211.0	211.0	234.0	271.0	265.0	272.0	258.0	260.0	266.0
DOCTORS	311.0	288.0	280.0	265.0	281.0	285.0	315.0	302.0	290.0	254.0	270.0	288.0
FREDERICK		249.0	248.0	236.0	240.0	244.0	265.0	269.0	256.0	234.0	240.0	237.0
FT WASHINGTON	268.0	238.0	262.0	247.0	260.0	259.0	299.0	280.0	266.0	259.0	250.0	240.0
GARRETT			145.0		150.0	147.0	158.0	134.0	132.0	138.0	124.0	292.0
GBMC	267.0	257.0	261.0	273.0	279.0	266.0	287.0	276.0	294.0	294.0	266.0	247.0
GERMANTOWN EMERGEN..	162.0	156.0	159.0	150.0	167.0				190.0	175.0	178.0	165.0
GRACE	236.0	251.0	226.0	221.0	228.0	206.0	233.0	227.0	209.0	215.0	212.0	222.0
HOLY CROSS	320.0	304.0	335.0	333.0	327.0	314.0	329.0	337.0	324.0	315.0		322.0
HOLY CROSS GERMANTO..	242.0	227.0	252.0	233.0	235.0	228.0	245.0	234.0	226.0	227.0		222.0
HOWARD	290.0	290.0	303.0	252.0	275.0	263.0	296.0	280.0	271.0	269.0	280.0	278.0
JH BAYVIEW	312.0	312.0	308.0	281.0	283.0	262.0	264.0	298.0	276.0	297.0	313.0	286.0
JOHNS HOPKINS	328.0	319.0	318.0	309.0	312.0	303.0	305.0	313.0	311.0	309.0	319.0	315.0
MEDSTAR FRANKLIN SQUA..	357.0	373.0	382.0	365.0	374.0	385.0	416.0	416.0	332.0	350.0	355.0	365.0
MEDSTAR GOOD SAMARIT..	239.0	237.0	244.0	228.0	239.0	207.0	239.0	241.0	215.0	210.0	201.0	190.0
MEDSTAR HARBOR	213.0	213.0	211.0	202.0	214.0	181.0	196.0	200.0	184.0	202.0	203.0	210.0
MEDSTAR MONTGOMERY	232.0	226.0	247.0	238.0	259.0	246.0	262.0	268.0	249.0	244.0	229.0	249.0
MEDSTAR SOUTHERN MA..	367.0	344.0	331.0	328.0	340.0	329.0	388.0	381.0	358.0	360.0	374.0	348.0
MEDSTAR ST. MARY'S	284.0	269.0	272.0	251.0	254.0	249.0	265.0	265.0	252.0	233.0	247.0	232.0
MEDSTAR UNION MEMORI..	218.0	227.0	230.0	221.0	241.0	219.0	241.0	235.0	229.0	217.0	236.0	210.0
MERCY	232.0	241.0	231.0	219.0	218.0	222.0	233.0	249.0	236.0	237.0	225.0	253.0
MERITUS	225.0	207.0	207.0	221.0	211.0	203.0	225.0	231.0	221.0	218.0	221.0	219.0
NORTHWEST	288.0	291.0	304.0	279.0	291.0	290.0	299.0	272.0	271.0	273.0	277.0	272.0
SHADY GROVE	282.0	256.0	252.0	242.0	247.0	246.0	238.0	217.0	203.0	206.0	228.0	234.0
SINAI	232.0	240.0	250.0	232.0	233.0	233.0	243.0	236.0	229.0	232.0	227.0	231.0
SUBURBAN	227.0	216.0	227.0	217.0	219.0	210.0	209.0	214.0	213.0	206.0	208.0	217.0
TIDALHEALTH MCCREADY			62.0	73.0	83.0	67.0	75.0	68.0	74.0	70.0	69.0	74.0
TIDALHEALTH PENINSULA		184.0	190.0	196.0	195.0	191.0	192.0	184.0	190.0	182.0	182.0	177.0
UM BWMC	316.0	319.0	285.0	282.0	277.0	280.0	278.0	272.0	269.0	276.0	278.0	280.0
UM CAPITAL REGION	265.0	277.0	271.0	265.0	269.0	260.0	287.0	274.0	262.0	259.0	258.0	269.0
UM SHORE CHESTERTOWN	169.0	175.0	164.0	180.0	193.0	150.0	189.0	199.0	180.0	164.0	168.0	174.0
UM SHORE EASTON	178.0	165.0	172.0	174.0	163.0	161.0	178.0	195.0	164.0	173.0	164.0	174.0
UM ST. JOSEPH	313.0	305.0	313.0	319.0	319.0	291.0	318.0	302.0	295.0	287.0	284.0	296.0
UMMC DOWNTOWN	310.0	312.0	306.0	299.0	292.0	293.0	304.0	316.0	327.0	298.0	303.0	296.0
UMMC MIDTOWN	266.0	294.0	277.0	279.0	270.0	237.0	301.0	313.0	284.0	270.0	247.0	260.0
UPMC WESTERN MD	233.0	236.0	248.0	250.0	272.0	260.0	259.0	256.0	256.0	250.0	238.0	240.0
UPPER CHESAPEAKE	278.0	280.0	278.0	270.0	280.0	282.0	308.0	303.0	294.0	277.0	287.0	297.0
WHITE OAK	455.0	404.0	420.0	397.0	452.0	402.0	426.0	445.0	439.0	397.0	386.0	444.0

OP18b: ED Arrival to Discharge Time - Non-Psychiatric



OP18b: ED Arrival to Discharge Time - Non-Psychiatric

Measure
OP-18b



OP18b: ED Arrival to Discharge Time - Non-Psychiatric

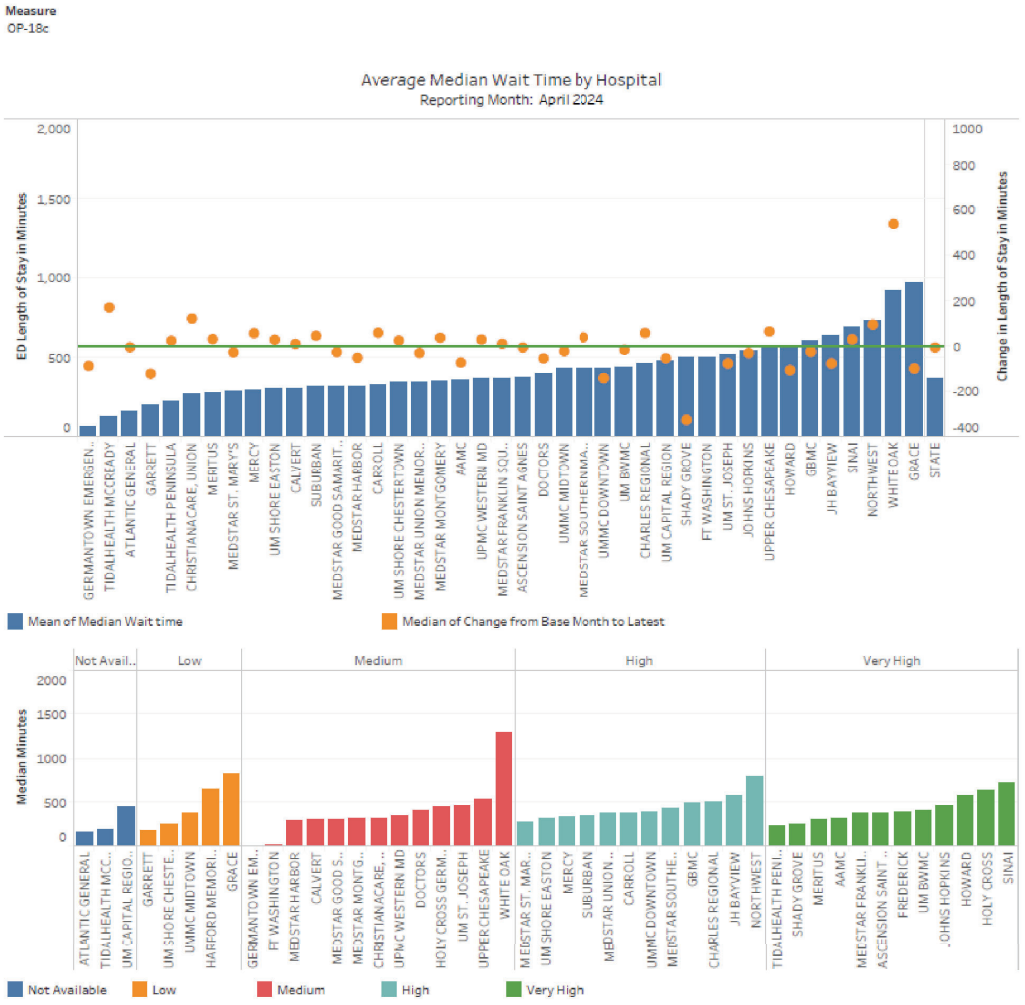
Average Median Wait Time All Hospitals for OP-18b

Measure
OP-18b

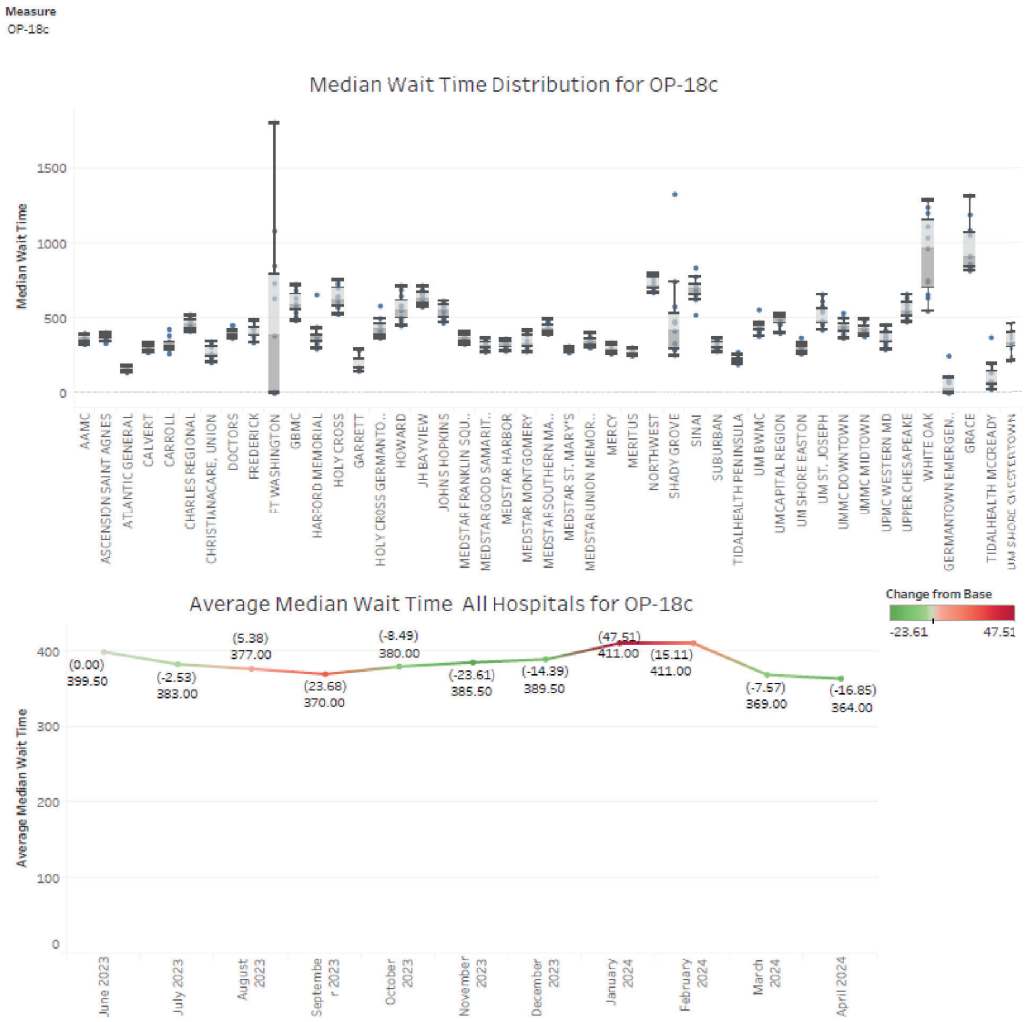
Change from Base
-166.0 149.0

Hospital Name	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..	January 2024	February 2024	March 2024	April 2024	May 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
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	
ATLANTIC GENERAL	123.0	126.0	130.0	132.0	127.0	122.0	134.0		124.0	121.0	127.0	132.0
CALVERT		229.0	237.0	231.0	251.0	233.0	265.0	216.0	212.0	212.0	218.0	224.0
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
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
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
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
FREDERICK		246.0	245.0	232.0	235.0	239.0	256.0	261.0	251.0	229.0	234.0	233.0
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
GARRETT			138.0		145.0	144.0	156.0	133.0	132.0	137.0	123.0	287.0
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
GERMANTOWN EMERGEN..	162.0	156.0	159.0	150.0	167.0				190.0	175.0	178.0	165.0
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
HOLY CROSS	315.0	298.0	330.0	328.0	324.0	309.0	326.0	334.0	322.0	313.0		320.0
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
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
TIDALHEALTH MCCREADY			62.0	73.0	83.0	66.0	75.0	67.0	73.0	70.0	68.0	74.0
TIDALHEALTH PENINSULA		184.0	190.0	195.0	196.0	190.0	191.0	183.0	190.0	181.0	182.0	176.0
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
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
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
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
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
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
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
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
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
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

OP18c: ED Arrival to Discharge Time by Month



OP18c: ED Arrival to Discharge Time by Month



OP18c: ED Arrival to Discharge Time by Volume Psychiatric ED Visits

Average Median Wait Time All Hospitals for OP-18c

Measure
OP-18c

Change from Base
-729 1,

Hospital Name	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..	January 2024	February 2024	March 2024	April 2024
AAMC	394	383	353	385	393	372	363	349	344	330	322
ASCENSION SAINT AGNES	379	342	389	330	371	384	387	391	402	365	373
ATLANTIC GENERAL	164	179	175	151	156	136	158		171	149	159
CALVERT		282	302	302	318	270	328	283	301	307	292
CARROLL	322	423	323	260	296	339	325	329	286	320	381
CHARLES REGIONAL	444	433	419	453	476	487	475	414	521	410	502
CHRISTIANACARE, UNION	202	236	238	260	253	250	237	341	306	316	324
DOCTORS	451	363	389	393	380	397	404	447	411	389	397
FREDERICK		343	335	376	426	395	435	484	433	396	
FT WASHINGTON	729	847	1,078	0	0	0	0	1,801	629	381	6
GARRETT			288		288	167	154	144	166	169	167
GBMC	506	681	587	631	534	714	592	586	576	723	482
GERMANTOWN EMERGEN..	87	69	0	0	0				246	105	0
GRACE	912	845	1,083	1,313	1,187	909	859	837	833	1,050	814
HARFORD MEMORIAL	325	375	292	347	380	387	437	371	654		
HOLY CROSS	751	609	726	701	586	642	524	577	569	633	
HOLY CROSS GERMANTO..	579	496	386	364	426	434	383	406	415	454	
HOWARD	687	445	503	550	571	496	549	714	644	479	582
JH BAYVIEW	659	678	714	598	635	684	630	593	601	574	583
JOHNS HOPKINS	496	488	583	595	564	540	612	598	508	550	466
MEDSTAR FRANKLIN SQUA..	353	365	337	324	328	370	405	406	398	366	364
MEDSTAR GOOD SAMARIT..	324	333	292	314	364	285	337	351	315	273	298
MEDSTAR HARBOR	333	336	322	346	361	279	316	330	297	310	282
MEDSTAR MONTGOMERY	276	320	302	345	386	309	392	416	322	396	313
MEDSTAR SOUTHERN MA..	390	426	422	399	467	432	479	491	398	412	429
MEDSTAR ST. MARY'S	302	293	310	271	289	295	297	290	293	269	275
MEDSTAR UNION MEMORI..	401	332	307	325	359	299	359	346	342	303	371
MERCY	276	302	287	274	289	275	269	324	326	258	333
MERITUS	269	251	246	262	266	301	284	293	256	283	300
NORTHWEST	700	776	698	767	677	669	713	739	680	776	795
SHADY GROVE	574	294	741	1,323	466	411	288	330	478	288	250
SINAI	692	672	648	717	622	518	698	659	833	773	722
SUBURBAN	300	322	359	299	362	300	291	308	295	277	346
TIDALHEALTH MCCREADY			24	52	140	369	74	133	74	37	195
TIDALHEALTH PENINSULA		202	225	254	189	270	227	208	197	226	226
UM BWMC	413	469	377	446	420	446	553	443	440	434	397
UM CAPITAL REGION	508	473	488	522	406	491	514	465	397	497	455
UM SHORE CHESTERTOWN	214	313	411	329	382	293	363	411	459	324	239
UM SHORE EASTON	276	265	330	314	275	258	307	366	274	307	304
UM ST. JOSEPH	537	656	548	611	576	451	469	479	420	471	461
UMMC DOWNTOWN	531	419	448	500	416	365	443	450	455	363	391
UMMC MIDTOWN	398	440	420	483	379	390	426	492	444	416	376
UPMC WESTERN MD	309	415	289	398	337	399	353	349	451	372	338
UPPER CHESAPEAKE	473	556	526	495	482	585	657	634	611	525	538
WHITE OAK	748	655	545	1,198	963	634	737	1,237	1,032	1,109	1,286

EMS Turnaround Times: May Performance

- 25 hospitals reported the 90th percentile of turnaround time was <=35 minutes
  - Net decrease of 1 Hospital from last month
- 24 hospitals reported the 90th percentile of turnaround time was 35-60 minutes
  - Net increase of 1 Hospital from last month
- 3 hospitals reported the 90th percentile of turnaround time was over 60 minutes
  - Net increase of 1 Hospital from last month
- Hospitals with improving performance
  - (Average to high performing): Anne Arundel Medical Center
  - (Low performing to average): N/A
- Hospitals with declining performance
  - (High performing to average): CalvertHealth Medical Center, Suburban
  - (Average to low performing) : St. Agnes Hospital

EMS Turnaround Times: May 2024 Performance

90th Percentile: 0-35 Minutes

Anne Arundel Medical Center+
Atlantic General Hospital
Cambridge Free-Standing ED
Chestertown
Frederick Health Hospital
Garrett Regional Medical Center
Germantown Emergency Center
Good Samaritan Hospital
Grace Medical Center
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 Hospital
Union Memorial Hospital
Upper Chesapeake Health Aberdeen
Walter Reed National Military Medical Center
Western Maryland

>35 Minutes

Baltimore Washington Medical Center
Bowie Health Center
CalvertHealth Medical Center-
Carroll Hospital Center
Charles Regional
Doctors Community Medical Center
Easton
Fort Washington Medical Center
Franklin Square
Greater Baltimore Medical Center
Harbor Hospital
Howard County Medical Center
Johns Hopkins Bayview
Johns Hopkins Hospital ADULT
Laurel Medical Center
Mercy Medical Center
Midtown
Northwest Hospital
Sinai Hospital
St. Joseph Medical Center
Suburban Hospital -
University of Maryland Medical Center
Upper Chesapeake Medical Center
White Oak Medical Center

>60 Minutes

Capital Region Medical Center
Southern Maryland Hospital
St. Agnes Hospital -

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

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Hospital Community Benefit Reporting Instructions Workgroup: Update

June 14, 2024

Hospital Community Benefit Reporting Instructions Workgroup

- Workgroup focused on updating reporting instructions in two areas.
- Members:
  - Hospitals & MHA, local health departments, insurers, & consumer advocates.
- Timeline
  - Three meetings: April 17; May 1; and May 15.
  - Written comment period through May 31.
  - Next Step: Update reporting instructions for FY 24.
  - July 1: Final reporting instructions released.

Updates to Reporting Instructions

- Indirect Cost Ratios
  - Hospitals will continue to report indirect cost ratios to Maryland in the same manner they report to IRS. HSCRC will correct references to Schedule M in the reporting instructions, which should improve reporting consistency. HSCRC will continue to post the reports submitted by hospitals publicly.
  - HSCRC will include analysis in the HSCRC annual summary community benefits report that compares hospitals using standardized indirect cost ratios to allow comparison between hospitals.
  - Outcome balances alignment of Maryland Reporting with IRS Reporting and analytic goals.
- CHNA- Aligned Spending-
  - HSCRC will clarify reporting instructions for this reporting area.
  - Goal is to achieve better consistency & comparability in hospital submitted data.

Questions?

Megan Renfrew

Deputy Director, Policy and Consumer Protection

megan.renfrew1@maryland.gov

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Facility Fee Study & Workgroup

June 14, 2024

Background: 2020-2023

- 2020 law requires hospitals to provide notices of facility fees (e.g. HSCRC regulated charges) in the outpatient clinic rate center.
  - Inform patients that they may receive bills for both facility and professional fees.
  - Provides an estimate of the fee amount (the total charge, not the out-of-pocket amount).
  - Inform patients that that care may be less expensive outside of the hospital.
- HSCRC also redistributed rates, so that charges in the clinic rate center were lower (making charges in other rate centers higher).
- Patients continue to complain about the cost of facility fees.
- Concern: Do notices cause patients to cancel appointments and defer care, especially Medicaid beneficiaries and other low-income patients?

Background: 2024

The Office of the Attorney General introduced Legislation to expand notice to-

- All outpatient rate centers; and
- In-state outpatient facilities run by out-of-state hospitals.

The bill was amended.

- The notice continues to apply only to HSCRC's outpatient clinic rate center.
- HSCRC is required to conduct a study.

Facility Fee Study & Reports

HSCRC is required to submit reports in 2024 and 2025.

2024

- Analysis of the impact of expanding the facility fee notice to beyond the outpatient clinic rate center on consumers, providers, and payers.
- Recommendation for requiring the facility fee notice for all outpatient services, including services provided by out–of–state hospitals at outpatient locations in the State.
- Preliminary report on other findings and recommendations.

2025

Findings and recommendations on:

- the costs underlying hospital outpatient facility fees and the drivers of hospital facility costs that are unique to hospitals;
- the impact of hospital facility fee charges for hospitals, payers, and consumers;
- Alternative approaches to facility fees that would protect consumers from high facility fee bills, maintain access to health care services, and address health equity concerns; and
- Related topics

Facility Fee Study: Workgroup

Ad-Hoc Workgroup

HSCRC will use an ad-hoc workgroup to meet the legal requirement to consult with stakeholders on the study.

Charge

The workgroup will provide advice to the HSCRC on the study and any recommendations to the legislature.

Key Principles

- Provide effective notice to patients on cost exposure & protect consumers from high facility fee bills.
- Maintain access to health care services & minimize deferral of necessary care by consumers.
- Address health equity concerns.
- Consider the impact of policy changes on consumers, hospitals, and payers.

Question: Feedback on the principles?

Facility Fee Study Workgroup Members

Required members:

- Maryland Department of Health,
- Maryland Insurance Administration,
- Health Education and Advocacy Unit, Office of the Attorney General,
- Hospitals, including an out–of–state hospital providing services to patients in facilities in the State,
- Representatives of physician practices that provide services in hospital outpatient settings,
- Health care payers,
- Consumer advocacy groups, and
- Employer groups.

HSCRC may also ask other experts to participate.

Do you have suggestions for other experts for staff to consider?

Facility Fee Study: Timeline

2024

Summer –

- Procurement activities
- Convene workgroup
- Draft report
- Research and analysis

Fall –

- Staff provide preview of report findings and recommendations in October Commission meeting
- Staff submit report (due 12/1/24)

2025

Workgroup & analysis activities continue

Summer – Draft report

Fall –

- Staff provide preview of report findings and recommendations in October Commission meeting
- Staff submit report (due 12/1/25)

Thank you!

Megan Renfrew

Deputy Director, Policy and Consumer Protection, HSCRC

megan.renfrew1@maryland.gov

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2024-2025 Facility Fee Workgroup Charter

Workgroup Responsibilities

Maryland law[1] requires the Health Services Cost Review Commission (HSCRC) to consult with multiple State Agencies and other stakeholders on a study on facility fees. HSCRC is convening this workgroup to provide advice to the HSCRC on the study and any related recommendations to the legislature.

The Workgroup's discussions shall help inform HSCRC's development on two reports to the legislature, due December 1, 2024, and December 1, 2025. These reports are described below.

HSCRC Facility Fee Study and Reports

HSCRC is required to conduct a study on facility fees and submit reports in 2024 and 2025.

2024:

- Consider the impact of expanding the facility fee notice requirement on consumers, including Medicaid recipients and consumers with recurring appointments, with consideration given to the impact on providers and payers.
- Make recommendations for the application of the outpatient facility fees notice requirement to apply to all outpatient services, including services provided by out–of–state hospitals at outpatient locations in the State.
- Make a preliminary report on other findings and recommendations (see below)

2025: Provide findings and recommendations on:

- the nature of costs underlying hospital outpatient facility fees and how similar costs are recovered in other health care settings;
- the drivers of hospital facility costs that are unique to hospitals and are not reflected in other health care settings;
- the magnitude and impact of hospital facility fee charges for hospitals, payers, and consumers;
- industry practices for seeking authority for an outpatient location to be approved as "at the hospital" and thereby subject to rate regulation;
- alternative mechanisms or revisions to the billing of the facility fees that would allow hospitals to recover costs while protecting individual consumers from high facility fee bills, maintaining access to health care services, and addressing health equity concerns;
- the interaction of the alternative mechanisms or revisions studied under item (5) of this subsection with the State's Total Cost of Care model obligations to the federal

[1] Chapter 142 (2024), Laws of Maryland

government, including any impact on Medicare total cost of care savings if outpatient facility fees are eliminated or reduced;

- the impact of the alternative mechanisms or revisions studied under item (5) of this subsection on Medicaid, Medicare, and commercial insurance, including consumer out–of–pocket costs, with a particular focus on the interaction with high–deductible commercial insurance products;
- published material on efforts in other states, by federal Medicare and Medicaid regulatory agencies, and by national advocacy organizations related to the regulation or minimization of facility fees, and the potential effects that similar efforts may have on health care costs in the State, including consumers' out–of–pocket costs;
- the regulation of fees charged by out–of–state hospital outpatient facilities located in the State; and
- the effectiveness of the notice of hospital outpatient facility fees that is provided to consumers.

Guiding Principles
The workgroup will consider the following principles in its work:

- Provide effective notice to patients on cost exposure & protect consumers from high facility fee bills.
- Maintain access to health care services & minimize deferral of necessary care by consumers.
- Address health equity concerns.
- Consider the impact of policy changes on consumers, hospitals, and payers.

Workgroup Meetings
All meetings of the Workgroup are open to the public. Reasonable notice of all meetings, stating the time and place, shall be given to each Member by email. Reasonable notice of all meetings shall be provided to the public by posting on the HSCRC website: https://hscrc.maryland.gov/Pages/Workgroups-Home.aspx.

Order of Business
Generally, the agenda/order of business at meetings of the Workgroup shall be as follows:

(a) Calling the meeting to order;
(b) Consideration of the topic/questions presented to the Workgroup;
(c) Public comments; and
(d) Adjournment.

Quorum
A simple majority of the Members shall constitute a quorum at any meeting for the conduct of the business of the Workgroup.

Participation in Meetings
Members will attend meetings via web conference. Members participating by such means shall count for quorum purposes, and their support for recommendations shall be included so long as their participation is included in attendance.

Membership.
By law, the workgroup will include members from the Maryland Health Services Cost Review Commission, the Maryland Department of Health, the Maryland Insurance Administration, the Health Education and Advocacy Unit within the Office of the Attorney General, hospitals (including an out–of–state hospital providing services to patients in facilities in the State) representatives of physician practices that provide services in hospital outpatient settings, health care payers, consumer advocacy groups, and employer groups. HSCRC may also ask other experts to participate.

Chair and Staff
HSCRC will chair and provide staff support for the workgroup.

Timeline (Tentative)

May - July 2024	Recruit members and hold the first workgroup meeting.
July - November 2024	Workgroup meetings provide input for 2024 report. Staff draft and submit 2024 report
September 2024 - December 2025	Workgroup convenes at least quarterly on the study. Staff draft and submit the final report.

Final Recommendation: RVUs Updates

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Background

The proposed changes were sent out to all hospitals for comments. The comment period closed on May 15, 2024, with one comment received from St. Agnes Hospital.

> "The hospital recommended the Speech-Language Evaluation, and the Speech-Language Treatment relative values units be similar or have equal values."

Staff responded that the workgroup used the Medicare Physician Fee Schedule weights to determine the RVUs values of each procedure, and the methodology was consistent with all conversions.

Hospitals were required to calculate a conversion factor to assure no change in the hospital revenues because of this RVU conversion. Hospitals will begin using these revised RVUs effective July 1, 2024.

Staff Recommendation

1. That the Commission approves the revisions to the RVU scale for the STH & AUD Rate Centers. The revisions are specific to the Chart of Accounts and Appendix D of the Accounting and Budget Manual (Attachment 1- Chart of Accounts). These revised RVUs are based on MPFS weights and were reviewed by a workgroup facilitated by the HSCRC staff;

2. That the RVU scale be updated to reflect linkages of RVUs to the CPT codes to incorporate the changes in STH & AUD practices. The RVU scale was also updated to link charging guidelines for STH & AUD services to the national definition, consistent with the HSCRC's plan to adopt MPFS RVUs where possible (Attachment 2 – Appendix D);

3. That the new and updated RVUs be effective July 1, 2024, and that the conversion of the STH & AUD RVUs be revenue neutral to the overall Hospital Global Budget Revenues; and

4. That revisions to Appendix-D and the Chart of Accounts for Medical Supplies Sold be effective July 1, 2024.

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Changes to Relative Value Units for Speech (STH) & Audiology (AUD) Effective July 1, 2024

Final Staff Recommendation

June 14, 2024

This document contains the final staff recommendation for changes to Relative Value Units for Speech & Audiology services effective July1, 2024, ready for Commission discussion and vote.

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Table of Contents

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Definitions

Current Procedural Terminology (CPT) codes – Describe medical, surgical, and diagnostic services.

Health Care Common Procedure Coding System (HCPCS) – Codes based on the CPT to provide standardized coding when healthcare is delivered.

Relative Value Units (RVUs) – A standard unit of measure. A value or weight assigned to a specific service based on relative resources used for that service relative to other services.

Medicare Physician Fee Schedule (MPFS) – The Centers for Medicare and Medicaid Services ("CMS") use the MPFS for reimbursement of physician services, comprised of resources costs associated with physician work, practice expense, and professional liability insurance.

Background

On October 24, 2023, the HSCRC staff convened a workgroup to review and initiate changes to the STH & AUD RVUs and the guidelines for these rate centers. The members of this workgroup included Hospitals, Maryland Hospital Association, Insurance Companies, and Hospital Consultants. These changes were initiated for the following reasons:

1. They standardize RVUs using the Medicare Physician Fee Schedule weights; they update new codes using national CPT code definitions; and they remove inactive codes from Appendix D of the Commission's Accounting and Budget Manual.
2. They assign RVUs procedures that are currently being reported as "By Report."
3. They update the RVUs to reflect how STH/AUD services have changed over time. These visits now focus primarily on optimizing a patient's physical function in everyday, meaningful life activities, preventing disability, and maintaining health.

Speech-Language Pathology

Speech-Language Pathology services, which are required to be implemented or supervised by a licensed speech-language pathologist, include but are not limited to diagnostic assessment and evaluation, treatment, and continued evaluation/periodic re-evaluation.

Diagnostic assessment and evaluation include clinical appraisal of speech (articulation, voice, fluency, motor speech disorders), deglutition (clinical bedside dysphagia exams and instrumental dysphagia assessments, such as flexible endoscopic examination of swallowing or modified barium swallow studies), language competencies (expressive and receptive language domains), and underlying processes (speech perception, visual perception, motor skills, cognitive skills, memory, attention, etc.) through standardized and informal tests, and hearing screening. Treatment includes planning and conducting treatment programs on an individual or group basis, to develop, restore, improve, or augment functional skills of persons disabled in the processes of speech, deglutition, language and/or underlying processes. Continued evaluation/periodic re-evaluation includes both standardized and informal procedures to monitor progress and verify status.

Additional activities may include, but are not limited to, preparation of written diagnostic evaluative and special reports; provisions of extensive counseling and guidance to individuals and their families; and maintaining specialized equipment utilized in evaluation and treatment such as assistive communication devices and speech prostheses.

Other considerations for both STH & AUD.

1. Routine supply cost is included in the HSCRC rate per RVU.
2. Non-routine supply and disposable medical supplies costs are billable as MSS.
3. Durable Medical Equipment (DME) for inpatient services is billable as MSS. However, DME provided to outpatients is not regulated by HSCRC, and all applicable payer DME billing requirements would apply.

Audiology

Audiology diagnoses hearing loss, identifies auditory disorders, and determines the possible etiology of auditory disorders.

Conducted evaluations include, case history (including previous assessments and diagnoses, diagnostic impressions, and management planning); physical examination of the ears and cranial nerve function, gait, and posture; qualitative and/or quantitative classification of communication abilities; assessment and impact of tinnitus and/or decreased sound tolerance; behavioral (psychometric or psychophysical), physical, and electrophysiological tests of hearing, auditory function, balance and vestibular function, and auditory processing that result in the formation of a diagnosis and subsequent management and treatment planning.

Audiologists collaborate with other healthcare providers, patients, and their caregivers to integrate information, test results, and treatment recommendations to develop a comprehensive needs assessment for medical, educational, psychosocial, vocational, or other services. They also design and implement

programs to prevent the onset or progression of hearing loss and identify individuals exposed to potentially adverse conditions.

Methodology

The STH & AUD RVUs were developed with the aid of an industry task force working in conjunction with HSCRC staff. The descriptions of the new codes in Appendix D of the Accounting and Budget Manual were obtained from the 2024 edition of the CPT manual and the 2024 edition of the HCPCS. In assigning RVUs, the group used the 2024 MPFS released November 2023, and then assigned using the following protocol.

The proposed RVUs were based on the MPFS Non-Facility (NON-FAC) Practice Expense (PE) RVUs. When there was a Technical (TC) modifier line item, that value was used. To maintain whole numbers in Appendix D, the RVUs were multiplied by ten and rounded to the nearest whole number, where values less than X.5 the RVUs were rounded down and all other values were rounded up.

1. For RVUs utilizing the methodology described above, the rationale in the table of RVUs is noted as MPFS.
2. For RVUs where the calculated RVU appeared too high (because it included significant equipment or other overhead and non-staff costs associated with it) or too low (because it did not reflect the facility resources associated with the service), the proposed RVUs were modified.
3. For RVUs without a NON-FAC PE RVU value in the MPFS, the underlying rationale for the RVU has been noted in the table of RVUs.
4. Unlisted services or services rarely performed have been designated as By Report (BR). RVUs for BR services are to be assigned based on relative RVU value of similar services.
    a. The BR methodology for each code must be documented and readily available in the event of an audit.

Comments and Responses

The proposed changes were sent to all hospitals for comments. The Comment period closed on May 15, 2024, with one comment received from St. Agnes Hospital. The hospital was concerned that the proposed swallowing evaluation and swallowing treatment evaluation values should both be similar and have equal RVUs values. Staff responded that the workgroup used the Medical Physician Fee Schedule weights to determine the RVUs values of each procedure, and the methodology was consistent with all conversions.

Hospitals were required to calculate a conversion factor to assure no change in the hospital revenues because of this RVU conversion. Hospitals will begin using these revised RVUs effective July 1, 2024.

maryland
health services
cost review commission

Recommendation

1. That the Commission approves the revisions to the RVU scale for the STH & AUD Rate Centers. The revisions are specific to the Chart of Accounts and Appendix D of the Accounting and Budget Manual (Attachment 1- Chart of Accounts). These revised RVUs are based on MPFS weights and were reviewed by a workgroup facilitated by the HSCRC staff;

2. That the RVU scale be updated to reflect linkages of RVUs to the CPT codes to incorporate the changes in STH & AUD practices. The RVU scale was also updated to link charging guidelines for STH & AUD services to the national definition, consistent with the HSCRC's plan to adopt MPFS RVUs where possible (Attachment 2 – Appendix D);

3. That the new and updated RVUs be effective July 1, 2024, and that the conversion of the STH & AUD RVUs be revenue neutral to the overall Hospital Global Budget Revenues; and

4. That revisions to Appendix-D and the Chart of Accounts for Medical Supplies Sold be effective July 1, 2024.

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

ACCOUNT NUMBER	COST CENTER TITLE
7550	Speech Therapy

The Speech Therapy (ST) relative value units (RVUs) were developed with the aid of the industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions in this section of Appendix D were obtained from the 2024 edition of the Current Procedural Terminology (CPT) manual, and the 2024 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2024 Medicare Physician Fee Schedule (MPFS) released December 15, 2023, and then assigned using the following protocol. For the new 2024 CPT codes we used the 2024 Medicare Physician Fee Schedule (MPFS) released December 13, 2023.

RVU Assignment Protocol

RVUs were proposed based on the Medicare Physician Fee Schedule (MPFS) Non-Facility (NON-FAC) Practice Expense (PE) RVUs. When there is a Technical Component (TC) modifier line item, that value is used. To maintain whole numbers in Appendix D, RVUs were multiplied by ten and rounded to the nearest whole number, where values less than X.5 were rounded down and all other values were rounded up. For example, treatment of speech CPT of 92507 has a NON-FAC PE RVU of 0.94. 0.94 * 10 = 9.4. 9.4 rounded = 9. 9 is the proposed RVU.

1) For RVUs utilizing the methodology described above, the rationale in the table of RVUs is noted as MPFS.

2) For RVUs where the calculated RVU appeared too high (because it included significant equipment or other overhead and non-staff costs associated with it) or too low (because it did not properly reflect the facility resources associated with the service), the proposed RVU was modified as noted in the table of RVUs.

a. 92521 Evaluation of speech fluency did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92522 Evaluation of speech sound production which is 13 RVUs.

b. 92537 Caloric vestibular test, bithermal did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92540 basic vestibular evaluation which is 17 RVUs.

c. 92538 Caloric vestibular test, monothermal did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it would be equal to half of CPT 92537 Caloric vestibular test, bithermal rounded down which is 17 divided by 2= 8.5 rounded down to 8.

d. 92550 Tympanometry and reflex threshold measurements did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and

resources involved that it is a combination of CPT 92567 Tympanometry (3 RVUs) and CPT 92568 Acoustic reflex testing (2 RVUs) = 5 RVUs.

e. 92557 Comprehensive audiometry threshold did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it is a combination of CPT 92553 Pure tone audiometry (13 RVUs) and CPT 92556 Speech audiometry threshold (13 RVUs) = 26 RVUs.

f. 92579 Visual reinforcement audiometry did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92552 Pure tone audiometry which is 11 RVUs.

g. 92588 Distortion product evoked otoacoustic emissions, comprehensive did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it should be set at double CPT 92587 Distortion product evoked otoacoustic emissions, limited 3*2 = 6 RVUs.

h. 92611 Motion Fluoroscopic evaluation did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it would be equal to half of CPT 92612 Flexible endoscopic evaluation 46 divided by 2 = 23 RVUs.

i. 97129 Mirror PT/OT- Therapeutic interventions, initial 15 minutes did not seem reasonable in comparison to other codes. It was determined to mirror 97110 (Therapeutic Exercises) and 97112 (neuromuscular re-ed) which are both 4 RVUs.

j. 97130 Mirror PT/OT- Therapeutic interventions, additional 15 minutes did not seem reasonable in comparison to other codes. It was determined to mirror 97110 (Therapeutic Exercises) and 97112 (neuromuscular re-ed) which are both 4 RVUs.

3) For RVUs without a NON-FAC PE RVU value in the MPFS, the underlying rationale for the RVU has been noted in the table of RVUs.

a. 92630 Auditory rehabilitation, prelingual did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92626 Evaluation of auditory function which is 12 RVUs.

4) For RVUs converting CPT non-time-based codes time-based codes. The time increment selected was 15 minutes. The 15-minute increments used in this Appendix D are subject to the Medicare 8-minute rule. The phrase *"(per HSCRC: each 15 minutes)"* has been added to the CPT description for emphasis.

a. 97150 Therapeutic procedures, group it was determined to use the MPFS RVU of 2 as the base and then double for each 15-minute increment.

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

Time	RVU
08-22 MINUTES	2
23-37 MINUTES	4
38-52 MINUTES	6
53-67 MINUTES	8

5) Unlisted services or services rarely performed have been assigned as By Report (BR). Similar logic should be utilized to assign RVUs to any services that are not found or BR.

•If there are no MPFS RVUs for a service, mirror an existing code that has similar facility resources or mirror an existing code that has similar facility resources with adjustments if needed (for example, if a BR service is slightly less resource intensive than an existing service, the RVU can be lower). The BR methodology for each code must be documented and readily available in the event of an audit.

Other considerations:

1. Routine supply cost is included in the HSCRC rate per RVU.
2. Non-routine supply (such as TEP, passey-muir speaking valve) and disposable medical supplies costs are billable as MSS.
3. Durable Medical Equipment (DME) for inpatient services is billable as MSS. However, DME provided to outpatients are not regulated by HSCRC, and all applicable payor DME billing requirements would apply.
4. The CPT codes reviewed account for most services provided in ST. There are some CPT codes not listed and new codes may be added in the future. These codes should be considered as “by report” by the individual institution and use the RVU assignment protocols listed above.
5. CPT codes are in a process of constant revision and as such providers should review their institution’s use of CPT codes and stay current with proper billing procedures.
6. Time increments used in this section of Appendix D are for direct patient time. Direct patient time spent evaluating and treating the patient is billable. Time spent on set-up, documentation of service, conference, and other non-patient contact is not reportable or billable.
7. It is expected and essential that all appropriate clinical documentation be prepared and maintained to support the services provided.

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
31575	Laryngoscopy, flexible; diagnostic	28	Non-Time Based	MPFS
31579	Laryngoscopy, flexible or rigid telescopic, with stroboscope	38	Non-Time Based	MPFS
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual	9	Non-Time Based	MPFS
92508	Treatment of speech, language, voice, communication, and/or auditory processing disorder; group, 2 or more individuals	4	Non-Time Based	MPFS
92511	Nasopharyngoscopy with endoscope (separate procedure)	29	Non-Time Based	MPFS
92519	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; cervical (cvemp) and ocular (ovemp)	15	Non-Time Based	MPFS
92520	Laryngeal function studies (i.e., aerodynamic testing and acoustic testing)	18	Non-Time Based	MPFS
92521	Evaluation of speech fluency (e.g., stuttering, cluttering)	13	Non-Time Based	Mirror CPT 92522 Based on resources
92522	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria)	13	Non-Time Based	MPFS
92523	Evaluation of speech sound production (e.g., articulation, phonological process, apraxia, dysarthria); with evaluation of language comprehension and expression (e.g., receptive and expressive language)	29	Non-Time Based	MPFS
92524	Behavioral and qualitative analysis of voice and resonance	13	Non-Time Based	MPFS
92526	Treatment of swallowing dysfunction and/or oral function for feeding	12	Non-Time Based	MPFS
92537	Caloric vestibular test with recording, bilateral; bithermal (i.e., one warm and one cool irrigation in each ear for a total of four irrigations)	17	Non-Time Based	Mirror CPT 92540 Based on resources

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92538	Caloric vestibular test with recording, bilateral; monothermal (i.e., one irrigation in each ear for a total of two irrigations)	8	Non-Time Based	Set at half of CPT 92537 (rounded down) Based on CPT Description and resources
92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording	17	Non-Time Based	MPFS
92542	Positional nystagmus test, minimum of 4 positions, with recording	4	Non-Time Based	MPFS
92546	Sinusoidal vertical axis rotational testing	35	Non-Time Based	MPFS
92550	Tympanometry and reflex threshold measurements	5	Non-Time Based	Combination of CPT 92567 (3) + 92568 (2) Based on CPT Description and resources
92552	Pure tone audiometry (threshold); air only	11	Non-Time Based	MPFS
92553	Pure tone audiometry (threshold); air and bone	13	Non-Time Based	MPFS
92555	Speech audiometry threshold	8	Non-Time Based	MPFS
92556	Speech audiometry threshold; with speech recognition	13	Non-Time Based	MPFS
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	26	Non-Time Based	Combination of CPT 92553 (13) + CPT 92556 (13) Based on CPT Description and resources
92567	Tympanometry (impedance testing)	3	Non-Time Based	MPFS
92568	Acoustic reflex testing, threshold	2	Non-Time Based	MPFS
92579	Visual reinforcement audiometry (vra)	11	Non-Time Based	Mirror CPT 92552 Based on resources

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92582	Conditioning play audiometry	24	Non-Time Based	MPFS
92584	Electrocochleography	23	Non-Time Based	MPFS
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	3	Non-Time Based	MPFS
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report	6	Non-Time Based	Set at double CPT 92587 Based on resources
92597	Evaluation for use and/or fitting of voice prosthetic device to supplement oral speech	8	Non-Time Based	MPFS
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	24	Non-Time Based	MPFS
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	17	Non-Time Based	MPFS
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	22	Non-Time Based	MPFS
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	14	Non-Time Based	MPFS
92605	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	9	Time-Based	MPFS
92606	Therapeutic service(s) for the use of non-speech-generating device, including programming and modification	9	Non-Time Based	MPFS

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92607	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; first hour	18	Time-Based	MPFS
92608	Evaluation for prescription for speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)	7	Time-Based	MPFS
92609	Therapeutic services for the use of speech-generating device, including programming and modification	15	Non-Time Based	MPFS
92610	Evaluation of oral and pharyngeal swallowing function	12	Non-Time Based	MPFS
92611	Motion fluoroscopic evaluation of swallowing function by cine or videorecording	23	Non-Time Based	Set at half of CPT 92612 Based on resources
92612	Flexible endoscopic evaluation of swallowing by cine or video recording	46	Non-Time Based	MPFS
92614	Flexible endoscopic evaluation, laryngeal sensory testing by cine or video recording	31	Non-Time Based	MPFS
92616	Flexible endoscopic evaluation of swallowing and laryngeal sensory testing by cine or video recording	47	Non-Time Based	MPFS
92618	Evaluation for prescription of non-speech-generating augmentative and alternative communication device, face-to-face with the patient; each additional 30 minutes (list separately in addition to code for primary procedure)	3	Time-Based	MPFS
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	8	Non-Time Based	MPFS
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour	12	Time-Based	MPFS

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92630	Auditory rehabilitation; prelingual hearing loss	12	Non-Time Based	Mirror CPT 92626 Based on resources
92650	Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis	6	Non-Time Based	MPFS
92651	Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report	15	Non-Time Based	MPFS
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report	18	Non-Time Based	MPFS
92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report	14	Non-Time Based	MPFS
92700	Unlisted otorhinolaryngological service or procedure	By Report	Non-Time Based	Unlisted Code
95992	Canalith repositioning procedure(s) (e.g., epley maneuver, semontmaneuver), per day	5	Non-Time Based	Mirror PT/OT
96105	Assessment of aphasia (includes assessment of expressive and receptive speech and language function, language comprehension, speech production ability, reading, spelling, writing, e.g., by boston diagnostic aphasia examination) with interpretation and report, per hour	11	Time-Based	MPFS
96110	Developmental screening (e.g., developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument	3	Non-Time Based	MPFS

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
96112	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; first hour	10	Time-Based	MPFS
96113	Developmental test administration (including assessment of fine and/or gross motor, language, cognitive level, social, memory and/or executive functions by standardized developmental instruments when performed), by physician or other qualified health care professional, with interpretation and report; each additional 30 minutes (list separately in addition to code for primary procedure)	6	Time-Based	MPFS
96125	Standardized cognitive performance testing (e.g., ross information processing assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report	13	Time-Based	MPFS
97110	Therapeutic procedure, 1 or more areas, each 15 minutes; therapeutic exercises to develop strength and endurance, range of motion and flexibility	4	Time-Based	Mirror PT/OT
97112	Therapeutic procedure, 1 or more areas, each 15 minutes; neuromuscular reeducation of movement, balance, coordination, kinesthetic sense, posture, and/or proprioception for sitting and/or standing activities	5	Time-Based	Mirror PT/OT

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
97129	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; initial 15 minutes	4	Time-Based	Mirror PT/OT
97130	Therapeutic interventions that focus on cognitive function (e.g., attention, memory, reasoning, executive function, problem solving, and/or pragmatic functioning) and compensatory strategies to manage the performance of an activity (e.g., managing time or schedules, initiating, organizing, and sequencing tasks), direct (one-on-one) patient contact; each additional 15 minutes (list separately in addition to code for primary procedure)	4	Time-Based	Mirror PT/OT
97150	Therapeutic procedure(s), group (2 or more individuals) (per HSCRC: each 15 minutes)	2 +	Non-Time Based	Mirror PT/OT (Starting with 2 and then doubling based on time)
97530	Therapeutic activities, direct (one-on-one) patient contact (use of dynamic activities to improve functional performance), each 15 minutes	7	Time-Based	Mirror PT/OT
97550	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; initial 30 minutes	6	Time-Based	MPFS

STANDARD UNIT OF MEASURE REFERENCES
SPEECH THERAPY (ST)

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
97551	Caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face; each additional 15 minutes (list separately in addition to code for primary service)	2	Time-Based	MPFS
97552	Group caregiver training in strategies and techniques to facilitate the patient's functional performance in the home or community (e.g., activities of daily living [adls], instrumental adls [iadls], transfers, mobility, communication, swallowing, feeding, problem solving, safety practices) (without the patient present), face to face with multiple sets of caregivers	4	Time-Based	MPFS
97760	Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes	9	Time-Based	Mirror PT/OT
97761	Prosthetic(s) training, upper and/or lower extremity(ies), initial prosthetic(s) encounter, each 15 minutes	7	Time-Based	Mirror PT/OT
97763	Orthotic(s)/prosthetic(s) management and/or training, upper extremity(ies), lower extremity(ies), and/or trunk, subsequent orthotic(s)/prosthetic(s) encounter, each 15 minutes	11	Time-Based	Mirror PT/OT

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

ACCOUNT NUMBER	COST CENTER TITLE
7580	AUDIOLOGY

The Audiology relative value units (RVUs) were developed with the aid of the industry task force under the auspices of and approved by the Health Services Cost Review Commission. The descriptions in this section of Appendix D were obtained from the 2024 edition of the Current Procedural Terminology (CPT) manual, and the 2024 edition of the Healthcare Common Procedure Coding System (HCPCS). In assigning RVUs the group used the 2023 Medicare Physician Fee Schedule (MPFS) released December 15, 2022, and then assigned using the following protocol. For the new 2024 CPT codes we used the 2024 Medicare Physician Fee Schedule (MPFS) released December 13, 2023.

RVU Assignment Protocol

RVUs were proposed based on the Medicare Physician Fee Schedule (MPFS) Non-Facility (NON-FAC) Practice Expense (PE) RVUs. When there is a Technical Component (TC) modifier line item, that value was used. To maintain whole numbers in Appendix D, RVUs were multiplied by ten and rounded to the nearest whole number, where values less than X.5 were rounded down and all other values were rounded up. For example, basic vestibular evaluation CPT of 92540 has a NON-FAC PE RVU of 1.69. 1.69 * 10 = 16.9. 16.9 rounded = 17. 17 is the proposed RVU.

1) For RVUs utilizing the methodology described above, the rationale in the table of RVUs is noted as MPFS.

2) For RVUs where the calculated RVU appeared too high (because it included significant equipment or other overhead and non-staff costs associated with it) or too low (because it did not properly reflect the facility resources associated with the service), the proposed RVU was modified as noted in the table of RVUs.

a. 92537 Caloric vestibular test, bithermal did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92540 basic vestibular evaluation which is 17 RVUs.

b. 92538 Caloric vestibular test, monothermal did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it would be equal to half of CPT 92537 Caloric vestibular test, bithermal rounded down which is 17 divided by 2= 8.5 rounded down to 8.

c. 92550 Tympanometry and reflex threshold measurements did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it is a combination of CPT 92567 Tympanometry (3 RVUs) and CPT 92568 Acoustic reflex testing (2 RVUs) = 5 RVUs.

d. 92557 Comprehensive audiometry threshold did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources

involved that it is a combination of CPT 92553 Pure tone audiometry (13 RVUs) and CPT 92556 Speech audiometry threshold (13 RVUs) = 26 RVUs.

e. 92570 Acoustic immittance testing did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it is a combination of CPT 92567 Tympanometry (3 RVUs) and CPT 92568 Acoustic reflex testing (2 RVUs) plus 2 RVUs for decay testing= 7 RVUs.

f. 92579 Visual reinforcement audiometry did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92552 Pure tone audiometry which is 11 RVUs.

g. 92588 Distortion product evoked otoacoustic emissions, comprehensive did not seem reasonable in comparison to other codes. It was determined that based on the CPT description and resources involved that it should be set at double CPT 92587 Distortion product evoked otoacoustic emissions, limited 3*2 = 6 RVUs.

3) For RVUs without a NON-FAC PE RVU value in the MPFS, the underlying rationale for the RVU has been noted in the table of RVUs.

a. 92630 Auditory rehabilitation, prelingual did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92626 Evaluation of auditory function which is 12 RVUs.

b. 92633 Auditory rehabilitation, postlingual did not seem reasonable in comparison to other codes. It was determined to mirror CPT 92626 Evaluation of auditory function which is 12 RVUs.

4) Unlisted services or services rarely performed have been assigned as By Report (BR). Similar logic should be utilized to assign RVUs to any services that are not found or BR.

•If there are no MPFS RVUs for a service, mirror an existing code that has similar facility resources or mirror an existing code that has similar facility resources with adjustments if needed (for example, if a BR service is slightly less resource intensive than an existing service, the RVU can be lower). The BR methodology for each code must be documented and readily available in the event of an audit.

Other considerations:

1. Routine supply cost is included in the HSCRC rate per RVU.
2. Non-routine supply costs and disposable medical supplies are billable as M/S supplies.
3. Durable Medical Equipment (DME) for inpatient services is billable as M/S supplies. However, DME provided to outpatients are not regulated by HSCRC, and all applicable payor DME billing requirements would apply.

4. The CPT codes reviewed account for most services provided in audiology. There are some CPT codes not listed and new codes may be added in the future. These codes should be considered as "by report" by the individual institution and use the RVU assignment protocols listed above.
5. CPT codes are in a process of constant revision and as such providers should review their institution's use of CPT codes and stay current with proper billing procedures.
6. Time increments used in this section of Appendix D are for direct patient time. Direct patient time spent evaluating and treating the patient is billable. Time spent on set-up, documentation of service, conference, and other non-patient contact is not reportable or billable.
7. It is expected and essential that all appropriate clinical documentation be prepared and maintained to support services provided.

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92511	Nasopharyngoscopy with endoscope (separate procedure)	29	Non-Time Based	MPFS
92512	Nasal function studies (e.g., rhinomanometry)	0	Non-Time Based	Zero RVUs. Not SLP/AUD.
92516	Facial nerve function studies (egg, electroneuronography)	17	Non-Time Based	MPFS
92517	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; cervical (cvemp)	15	Non-Time Based	MPFS
92518	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; ocular (ovemp)	15	Non-Time Based	MPFS
92519	Vestibular evoked myogenic potential (vemp) testing, with interpretation and report; cervical (cvemp) and ocular (ovemp)	15	Non-Time Based	MPFS
92537	Caloric vestibular test with recording, bilateral; bithermal (i.e., one warm and one cool irrigation in each ear for a total of four irrigations)	17	Non-Time Based	Mirror CPT 92540 Based on resources
92538	Caloric vestibular test with recording, bilateral; monothermal (i.e., one irrigation in each ear for a total of two irrigations)	8	Non-Time Based	Set at half of CPT 92537 (rounded down) Based on CPT Description and resources

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92540	Basic vestibular evaluation, includes spontaneous nystagmus test with eccentric gaze fixation nystagmus, with recording, positional nystagmus test, minimum of 4 positions, with recording, optokinetic nystagmus test, bidirectional foveal and peripheral stimulation, with recording, and oscillating tracking test, with recording	17	Non-Time Based	MPFS
92541	Spontaneous nystagmus test, including gaze and fixation nystagmus, with recording	3	Non-Time Based	MPFS
92542	Positional nystagmus test, minimum of 4 positions, with recording	4	Non-Time Based	MPFS
92544	Optokinetic nystagmus test, bidirectional, foveal or peripheral stimulation, with recording	2	Non-Time Based	MPFS
92545	Oscillating tracking test, with recording	2	Non-Time Based	MPFS
92546	Sinusoidal vertical axis rotational testing	35	Non-Time Based	MPFS
92547	Use of vertical electrodes (list separately in addition to code for primary procedure)	3	Non-Time Based	MPFS
92548	Computerized dynamic posturography sensory organization test (cdp-sot), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report	7	Non-Time Based	MPFS
92549	Computerized dynamic posturography sensory organization test (cdp-sot), 6 conditions (i.e., eyes open, eyes closed, visual sway, platform sway, eyes closed platform sway, platform and visual sway), including interpretation and report; with motor control test (mct) and adaptation test (adt)	6	Non-Time Based	MPFS

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92550	Tympanometry and reflex threshold measurements	5	Non-Time Based	Combination of CPT 92567 (3) + 92568 (2) Based on CPT Description and resources
92551	Screening test, pure tone, air only	0	Non-Time Based	Zero RVUs. Screening/No Charge/Part of Clinic Visit performed during visit
92552	Pure tone audiometry (threshold); air only	11	Non-Time Based	MPFS
92553	Pure tone audiometry (threshold); air and bone	13	Non-Time Based	MPFS
92555	Speech audiometry threshold	8	Non-Time Based	MPFS
92556	Speech audiometry threshold; with speech recognition	13	Non-Time Based	MPFS
92557	Comprehensive audiometry threshold evaluation and speech recognition (92553 and 92556 combined)	26	Non-Time Based	Combination of CPT 92553 (13) + CPT 92556 (13) Based on CPT Description and resources
92558	Evoked otoacoustic emissions, screening (qualitative measurement of distortion product or transient evoked otoacoustic emissions), automated analysis	1	Non-Time Based	Typically used for newborn screenings. See DEL rate center when appropriate.
92562	Loudness balance test, alternate binaural or monaural	14	Non-Time Based	MPFS
92563	Tone decay test	10	Non-Time Based	MPFS
92565	Stenger test, pure tone	6	Non-Time Based	MPFS
92567	Tympanometry (impedance testing)	3	Non-Time Based	MPFS
92568	Acoustic reflex testing, threshold	2	Non-Time Based	MPFS
92570	Acoustic immittance testing, includes tympanometry (impedance testing), acoustic reflex threshold testing, and acoustic reflex decay testing	7	Non-Time Based	Combination of CPT 92567 (3) + 92568 (2) + 2 RVUs for decay testing

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92571	Filtered speech test	9	Non-Time Based	MPFS
92572	Staggered spondaic word test	14	Non-Time Based	MPFS
92575	Sensorineural acuity level test	6	Non-Time Based	MPFS
92576	Synthetic sentence identification test	12	Non-Time Based	MPFS
92577	Stenger test, speech	6	Non-Time Based	MPFS
92579	Visual reinforcement audiometry (vra)	11	Non-Time Based	Mirror CPT 92552 Based on resources
92582	Conditioning play audiometry	24	Non-Time Based	MPFS
92583	Select picture audiometry	16	Non-Time Based	MPFS
92584	Electrocochleography	23	Non-Time Based	MPFS
92587	Distortion product evoked otoacoustic emissions; limited evaluation (to confirm the presence or absence of hearing disorder, 3-6 frequencies) or transient evoked otoacoustic emissions, with interpretation and report	3	Non-Time Based	MPFS
92588	Distortion product evoked otoacoustic emissions; comprehensive diagnostic evaluation (quantitative analysis of outer hair cell function by cochlear mapping, minimum of 12 frequencies), with interpretation and report	6	Non-Time Based	Set at double CPT 92587 Based on resources
92590	Hearing aid examination and selection; monaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital
92591	Hearing aid examination and selection; binaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital
92592	Hearing aid check; monaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92593	Hearing aid check; binaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital
92594	Electroacoustic evaluation for hearing aid; monaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital
92595	Electroacoustic evaluation for hearing aid; binaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital
92596	Ear protector attenuation measurements	6	Non-Time Based	MPFS
92601	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; with programming	24	Non-Time Based	MPFS
92602	Diagnostic analysis of cochlear implant, patient younger than 7 years of age; subsequent reprogramming	17	Non-Time Based	MPFS
92603	Diagnostic analysis of cochlear implant, age 7 years or older; with programming	22	Non-Time Based	MPFS
92604	Diagnostic analysis of cochlear implant, age 7 years or older; subsequent reprogramming	14	Non-Time Based	MPFS
92620	Evaluation of central auditory function, with report; initial 60 minutes	14	Time-Based	MPFS
92621	Evaluation of central auditory function, with report; each additional 15 minutes (list separately in addition to code for primary procedure)	3	Time-Based	MPFS
92622	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; first 60 minutes	11	Time-Based	MPFS
92623	Diagnostic analysis, programming, and verification of an auditory osseointegrated sound processor, any type; each additional 15 minutes (list separately in addition to code for primary procedure)	3	Time-Based	MPFS
92625	Assessment of tinnitus (includes pitch, loudness matching, and masking)	8	Non-Time Based	MPFS

STANDARD UNIT OF MEASURE REFERENCES
AUDIOLOGY

CODE	DESCRIPTION	RVU	CATEGORY	RATIONALE
92626	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); first hour	12	Time-Based	MPFS.
92627	Evaluation of auditory function for surgically implanted device(s) candidacy or postoperative status of a surgically implanted device(s); each additional 15 minutes (list separately in addition to code for primary procedure)	3	Time-Based	MPFS
92630	Auditory rehabilitation; prelingual hearing loss	12	Non-Time Based	Mirror CPT 92626 Based on resources
92633	Auditory rehabilitation; postlingual hearing loss	12	Non-Time Based	Mirror CPT 92626 Based on resources
92650	Auditory evoked potentials; screening of auditory potential with broadband stimuli, automated analysis	6	Non-Time Based	MPFS
92651	Auditory evoked potentials; for hearing status determination, broadband stimuli, with interpretation and report	15	Non-Time Based	MPFS
92652	Auditory evoked potentials; for threshold estimation at multiple frequencies, with interpretation and report	18	Non-Time Based	MPFS
92653	Auditory evoked potentials; neurodiagnostic, with interpretation and report	14	Non-Time Based	MPFS
92700	Unlisted otorhinolaryngological service or procedure	By Report	Non-Time Based	Unlisted Code
V5240	Dispensing fee, contralateral routing system, binaural	0	Non-Time Based	Zero RVUs, Typically Non-Hospital

SECTION 200
CHART OF ACCOUNTS

7580 AUDIOLOGY

Function

The Audiology cost center provides and coordinates services to person's age newborns through geriatrics. Audiology evaluates individuals with auditory and vestibular complaints or symptoms (including, but not limited to, impaired hearing, tinnitus, dizziness, imbalance, sound intolerance, delayed speech and language, auditory processing problems, poor educational performance, or failed hearing and/or balance screening results), and aid in the diagnosis of vestibular disease/falls risk leading to vestibular rehabilitation. Audiology diagnoses hearing loss, identifies auditory disorders, and determines the possible etiology of auditory disorders.

Conducted evaluations include, case history (including previous assessments and diagnoses, diagnostic impressions, and management planning); physical examination of the ears and cranial nerve function, gait, and posture; qualitative and/or quantitative classification of communication abilities; assessment and impact of tinnitus and/or decreased sound tolerance; behavioral (psychometric or psychophysical), physical, and electrophysiological tests of hearing, auditory function, balance and vestibular function, and auditory processing that result in the formation of a diagnosis and subsequent management and treatment planning.

Audiologists collaborate with other healthcare providers, patients and their caregivers to integrate information, test results, and treatment recommendations to develop a comprehensive needs assessment for medical, educational, psychosocial, vocational, or other services. They also design and implement programs to prevent the onset or progression of hearing loss and identify individuals exposed to potentially adverse conditions.

Description

This cost center contains the direct expenses incurred in maintaining an Audiology program. The expense related to the sale of hearing aids and disposable medical supplies must not be included here but accounted for in the Medical Supplies Sold cost center. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), supplies, purchased services, other direct expenses and transfers.

Standard Unit of Measure: Relative Value Units

Audiology Relative Value Units (RVU) as determined by the Health Services Cost Review Commission. (See Appendix D of this manual.) Relative Value Units for unlisted services or procedures should be estimated based on other comparable modalities or procedures.

Data Source

The **number** of RVU shall be obtained from an actual count maintained by the Audiology Cost Center.

Reporting Schedule

Schedule D - Line D43

7110 MEDICAL SUPPLIES SOLD
7111 Medical Supplies-Billable
7112 Medical Supplies-Non-Billable

Description

The Medical Supplies Sold cost center is used for the accumulation of the invoice cost of all disposable medical and surgical supplies and equipment used in daily hospital service centers, ambulatory service centers and certain ancillary service centers (Labor and Delivery and Delivery Services, Account 7010, Operating Room, Account 7040, Ambulatory Surgery, Account 7050, Speech-Language Pathology, Account 7550, and Audiology, Account 7580, Interventional Radiology/Cardiovascular, Account 7310, Occupational Therapy, Account 7530, and Physical Therapy, Account 7510). The invoice/inventory cost of non-chargeable disposable supplies and equipment issued by the Central Services and Supplies cost center (Account 8460) to patient care cost centers shall be maintained in this cost center. If such items are purchased by the patient care cost center, the invoice cost of preparing and issuing medical and surgical supplies and equipment must be accumulated in the Central Services and Supplies cost center (Account 8460). The cost of reusable (non-disposable) medical and surgical supplies must be accounted for in the Central Services and Supplies cost center (Account 8460). The applicable portion of such overhead will be allocated to this cost center during the cost allocation process.

Standard Unit of Measure: Equivalent Inpatient Admissions (EIPA)

Gross Patient Revenue x Inpatient Admissions (excl. nursery)
Gross Inpatient Revenue

Data Source

Gross Patient Revenue and Gross Inpatient Revenue shall be obtained from the General Ledger. Inpatient Admissions shall be obtained from daily census counts.

Reporting Schedule

Schedule D - Line D26

7550 SPEECH-LANGUAGE PATHOLOGY

Function

The Speech-Language Pathology cost center provides evaluation and treatment to persons with impaired speech, language, cognitive-communication, or swallowing function. Speech-Language Pathology includes evaluation, treatment, and establishing plans of care to address areas of need. Specific Speech-Language Pathology services, which shall be implemented or supervised by a licensed speech-language pathologist, include but are not limited to diagnostic assessment and evaluation, treatment, and continued evaluation/periodic re-evaluation.

Diagnostic assessment and evaluation includes clinical appraisal of speech (articulation, voice, fluency, motor speech disorders), deglutition (clinical bedside dysphagia exams and instrumental dysphagia assessments, such as flexible endoscopic examination of swallowing or modified barium swallow studies), language competencies (expressive and receptive language domains), and underlying processes (speech perception, visual perception, motor skills, cognitive skills, memory, attention, etc.) through standardized and informal tests, and hearing screening. Treatment includes planning and conducting treatment programs on an individual or group basis, to develop, restore, improve or augment functional skills of persons disabled in the processes of speech, deglutition, language and/or underlying processes. Continued evaluation/periodic re-evaluation includes both standardized and informal procedures to monitor progress and verify current status.

Additional activities may include but are not limited to preparation of written diagnostic evaluative and special reports; provisions of extensive counseling and guidance individuals and their families; and maintaining specialized equipment utilized in evaluation and treatment such as assistive communication devices and speech prostheses.

Description

This cost center contains the direct expenses incurred in maintaining a Speech-Language Pathology Cost Center. Any expenses related to the sale of speech prostheses or other communication aids and disposable medical supplies must not be included here but accounted for in Medical Supplies Sold cost center. Included as direct expenses are salaries and wages, employee benefits, professional fees (non-physician), non-medical supplies, purchased services, other direct expenses, and transfers.

Standard Unit of Measure: Relative Value Units (RVU)

Speech- Language pathology RVUs as determined by the Health Services Cost Review Commission. (See Appendix D of this manual.) Relative Value Units for unlisted modalities or for procedures should be estimated based on other comparable modalities or procedures.

Data Source

The number of Relative Value Units shall be the actual count maintained by the Speech-Language Pathology cost center.

Reporting Schedule

Schedule D - Line D41

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Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 2024 Funding

Final Recommendation

June 14, 2024

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

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Table of Contents

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List of Abbreviations

AHEAD	Advancing All-Payer Health Equity Approaches and Development Model
CMS	Centers for Medicare & Medicaid Services
CRISP	Chesapeake Regional Information System for Our Patients
CRS	CRISP Reporting Services
EQIP	Episode Quality Improvement Program
FY	Fiscal year
HIE	Health information exchange
HITECH	Health Information Technology for Economic and Clinical Health Act
HSCRC	Health Services Cost Review Commission
IAPD	Implementation Advanced Planning Document
MDH	Maryland Department of Health
MHCC	Maryland Health Care Commission
MHIP	Maryland Health Insurance Plan
MES	Medicaid Enterprise System
TCOC	Total Cost of Care

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Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
To fund and sustain a robust Health Information Exchange, CRISP, for activities related to the HSCRC and the Maryland Model.	Include an assessment in hospital rates to generate funding to support CRISP projects and operations to further the goals of the Maryland Model	Hospitals benefit from CRISP programs and pay a separate user fee. This assessment is a pass through and has no impact on hospitals.	CRISP provides vital coordination and reporting that allow hospitals and other Maryland providers to enhance the quality and cost effectiveness of the care provided.	Provider reporting supported by CRISP will collect data on social determinants of health and disparities in health outcomes in order to further the goals of improved health equity under the Model.

Summary of the Recommendation

This final recommendation is the same as the draft recommendation submitted in May. No comments were received.

In accordance with its statutory authority to approve alternative methods of rate determination consistent with the Total Cost of Care Model and the public interest,[1] this recommendation identifies the following amounts of State-supported funding for fiscal year (FY) 2025 to the Chesapeake Regional Information System for our Patients (CRISP):

- Direct funding and matching funds under Medicaid Enterprise System (MES) Federal Programs for Health Information Exchange (HIE) operations and infrastructure ($3,080,000)
- Direct funding and Medicaid Enterprise System (MES) matching funds for reporting and program administration related to population health, the Total Cost of Care Model, and hospital regulatory initiatives ($6,340,000). Staff propose using $1,000,000 of accumulated reserves to reduce the revenue generated through rates for FY2025 to $5,340,000 for this component.

Therefore, Staff recommends that the HSCRC provide funding to CRISP totaling $8,420,000 for FY 2025. As a result, the HSCRC will be funding approximately 20 percent of CRISP's Maryland funding, compared to budgeted 15 percent in FY 2024. The increase in funding from $4,800,000 to $8,420,000 is related to a

[1] MD. CODE ANN., Health-Gen §19-219(c).

change in the requirements to obtain Federal matching funds as described below and a reduction in the amount drawn from accumulated reserves from $1,700,000 to $1,000,000 as those reserves are spent down. The increase in the share of CRISP funding being paid through hospital rates also relates to the Federal funding change. The remainder of CRISP's Maryland funding is derived from user fees, federal matching funds and the Maryland Department of Health (MDH).

This recommendation continues the approach used in prior years of spending down reserve funds accumulated due to a better than anticipated Federal match, but the amount pulled from reserves has been reduced to retain greater reserves for potential unanticipated costs related to the State's expected participation in the Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model model.

This recommendation also approves funding for a practice transformation grant program in support of Episode Quality Improvement Program.

Background – Past Funding

Over the past ten years, the Commission has approved funding to support the general operations of the CRISP HIE and reporting services through hospital rates as shown in Table 1.

Table 1. HSCRC Funding for CRISP HIE and Reporting Services, Last 10 Years

CRISP Budget: HSCRC Funds Received	
FY 2013	$1,313,755
FY 2014	$1,166,278
FY 2015	$1,650,000
FY 2016	$3,250,000
FY 2017	$2,360,000
FY 2018	$2,360,000
FY 2019	$2,500,000
FY 2020	$5,390,000
FY 2021	$5,170,000
FY 2022	$9,240,000
FY 2023	$4,800,000
FY 2024	$4,800,000
FY 2025	$8,420,000

The funding request for FY 2025 is similar to that for FY 2022 which is when the State first anticipated a change in the Federal matching requirements. That change did not materialize at that time.

Funding Through Hospital Rates

Beginning in FY 2020, HSCRC assumed full responsibility for managing the CRISP assessment, previously shared with MHCC. CRISP-related hospital rate assessments are paid into an HSCRC fund, and the HSCRC reviews the invoices for approval of appropriate payments to CRISP. This process – which includes bi-weekly update meetings, monthly written reports, and auditing of the expenditures – has created transparency and accountability. Starting in FY 2023, CRISP's reimbursement from the HSCRC was provided in two tranches: one relating to state match funding of core HIE operational costs and the other related to Reporting and Program Administration. This change is made to allow CRISP to recover operational reimbursement from the HSCRC in a timelier fashion.

Funding Through Federal Matching

HSCRC funding has been used to obtain federal matching funds throughout the history of the program. The federal match is obtained through the program outlined below. The HITECH IAPD program was previously the source of most federal funding, and it was terminated September 30, 2021. Funding has now moved to the MES program described below. The MES program requires 25 percent match for ongoing programs versus the 10 percent in place under IAPD

Medicaid Enterprise System (MES) Matching Funds

MES is a federal program designed to promote effective care for Medicaid beneficiaries through investments in information technology infrastructure. Medicaid benefits from CRISP's data sharing and reporting initiatives through the care management and cost control initiatives facilitated for all Medicaid patients under CRISP all-payer activities and for dual-eligible patients under CRISP's Medicare activities.

Activities funded under this element of the assessment include point-of-care and other provider data sharing initiatives, and CRISP reporting tools utilizing the Medicare claims and the HSCRC's hospital case mix data. Hospitals, the HSCRC, and other stakeholders use CRISP reporting from these datasets to manage and track progress under several HSCRC programs and enable hospitals to identify and pursue care efficiency initiatives.

Under MES, state funds are eligible for either a 90 percent match for new reporting initiatives or a 75 percent match for ongoing reporting. The assessment funding will provide the State's portion of this match as well as the State's Fair Share amount. The Fair Share represents the amount that benefits Medicaid before considering the federal and state match. Starting in FY 2024 the methodology for calculating the State's Fair Share amount was changed resulting in a greater portion being borne by the State and driving the increase in this assessment.

Other Funding

CRISP's Maryland activities are also financed through user fees paid by hospitals and payers as well as funding received from MDH (See Table 2). Payer user fees have historically been a small share of total CRISP revenue and have remained unchanged since inception. In FY2022, the CRISP Finance Committee approved an increase of $300,000 in payer fees, which now represents 15% of user fee revenue.

Description of Activities Funded

Activities funded directly by this assessment and from earned federal matching fall into the two categories described below. The descriptions below outline, in general terms, the programs for which funds will be used. Staff will direct funding to specific programs within the general parameters described.

Category 1: HIE Operations Funding and Infrastructure

The value of an HIE rests in the premise that more efficient and effective access to health information will improve care delivery while reducing administrative health care costs. The General Assembly charged the MHCC and HSCRC with the designation of a statewide HIE.[2] In the summer of 2009, MHCC conducted a competitive selection process which resulted in awarding state designation to CRISP, and HSCRC approved up to $10 million in startup funding over a four-year period through Maryland's unique all-payer hospital rate setting system. CRISP maintained designation through multiple renewal processes, with the most recent occurring in 2022 HSCRC's annual funding for CRISP is illustrated in Table 1 above.

The use of HIEs is a key component of health care transformation, enabling clinical data sharing among appropriately authorized and authenticated users. The ability to exchange health information electronically in a standardized format is critical to improving health care quality and safety.

Many states, along with federal policy makers, look to Maryland as a leader in HIE implementation. CRISP continues to build the infrastructure necessary to support existing and future use cases and to assist HSCRC in administering per-capita and population-based payment structures under the Total Cost of Care Model. A return on the State's investment is demonstrated through implementation of a robust technical platform that supports innovative use cases to improve care delivery, increase efficiencies in health care, and reduce health care costs. MDH made extensive use of CRISP's capabilities during the COVID crisis.

The total amount of funding recommended by Staff for FY 2025 for the HIE function is $3,080,000.

[2] MD. CODE ANN., Health-Gen §19-143(a).

Category 2: Reporting and Program Administration Related to Population Health, the Total Cost of Care Model, and Hospital Regulatory Initiatives

These initiatives were designed to reduce health care expenditures and improve outcomes for all Marylanders. Many of these programs focus on unmanaged high-needs Medicare patients and patients dually eligible for Medicaid and Medicare, consistent with the goals of Maryland's All-Payer Model. These initiatives encourage collaboration between and among providers, provide a platform for provider and patient engagement, and allows for confidential sharing of information among providers. To succeed under the Total Cost of Care (TCOC) Model, providers will need a variety of tools to manage high-needs and complex patients that CRISP is currently working to develop and deploy.

Based on broad program participation, including non-hospital providers, and the ability to secure federal match funds, these programs will be funded through a combination of assessments and federal matching funds. This recommendation covers three components:

(1) Funding for population health and cost and quality management reporting in support of HSCRC regulations and the TCOC Model;

(2) Funding for program administration related to programs under the TCOC Model; and

(3) Funding for innovative reporting initiatives such as enhanced data on social determinants of health and the integration of electronic health record data into statewide hospital quality measurement

For FY2025 the CRISP program administration work will include the implementation of a practice transformation grant program in support of a wide range of EQIP entities for EQIP participation. This program was identified, based on stakeholder feedback, as a way to encourage smaller practices to participate in EQIP and to improve readiness for EQIP engagement. Under this program CRISP shall award up to $8,000,000 of grants to practices who participate in EQIP and have a demonstrated need for practice support, based on guidelines developed by CRISP and approved by HSCRC staff. Staff recommends funding for the grants be provided using the Medicare Performance Adjustment Reconciliation Component, this CRISP assessment would only fund the administration of the program. Working with CRISP Staff will provide an update on this program during the Fall of 2024.

The total amount recommended by Staff for FY 2025 for the activities described above is $5,340,000

Staff Recommendation

Staff is recommending the Commission approve a total of $8,420,000 in funding through hospital rates in FY 2025 to support the HIE and continue the investments made in the TCOC Model initiatives through both direct funding and obtaining federal MES matching funds. Staff anticipates actual CRISP spending of

$9,420,000 but proposes to use $1,000,000 of prior reserves, limiting the actual assessment to $8,420,000. Staff also recommend funding the EQIP practice transformation grants via the Medicare Performance Adjustment Reconciliation Component.

Table 2 shows the funding through hospital rates and the federal match that will be generated from the MES funding as well as the user fee and MDH funding.

Table 2. FY 2025 Recommended Rate Support for CRISP as a share of estimated total Maryland Funding

Project Name	Hospital Rates	Budgeted Federal Funding	User Fees	Maryland Department of Health	Maryland Total
HIE Operations	$3,080,000	$9,830,000	$5,746,000	$3,020,000	$21,676,000
Reporting and Program Administration	$6,340,000	$10,306,000	$0	$4,270,000	$20,916,000
Other non-HSCRC programs	$0	$2,760,000	$0	$1,230,000	$3,990,000
Total Funding	**$9,420,000***	**$22,896,000**	**$5,746,000**	**$8,520,000**	**$46,582,000**
% Of Total	**20%**	**49%**	**13%**	**18%**	**100%**

*Note: Prior to reduction for use of accumulated reserves to reduce FY2025 assessment.

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Update Factor Final Recommendation

June 14, 2024

STAKEHOLDERS' COMMENTS

Comment Letters Received

Letters were received from:

- Maryland Hospital Association (MHA)
- University of Maryland Medical Systems
- LifeBridge Health
- Tidal Health
- Ascension Saint Agnes
- Sheppard Pratt
- Mount Washington Pediatrics
- Atlantic General
- MedStar Health
- CareFirst
- Adventist Healthcare
- Holy Cross Health
- Johns Hopkins Health System*

Comments generally focused on 7 areas:

1. Fund Current Inflation
2. Catch Up Methodology
3. Revised PAU Policy
4. Clarification of Set-Aside
5. Outpatient Oncology & Infusion Drugs
6. Retained Revenue
7. Support Inflation for Specialty Hospitals

* comment letter not submitted on time

Draft Recommendation

The draft recommendation reflected inflation from Global Insight's 4th Quarter 2023 book and additional inflation support based on five years of cumulative underfunding using 2019 as a base.

Draft Recommendation Inflation Breakdown	
Adjustment for Inflation (4th Quarter Book)	**3.05%**
Additional Inflation Support	**0.65%**
Outpatient Oncology Drugs	**0.10%**
Gross Inflation Allowance	**3.80%**
PAU Shared Savings	**0%**

1. RY2025 Update Factor Comments: Fund Current Inflation

- All Hospitals requested that the Commission fund current inflation to 3.24%, reflecting data from Global Insight's First Quarter 2024 book.

HSCRC Staff Response: Staff agree to update current inflation to Global Insight's First Quarter 2024 book to reflect 3.24%. This new value is reflected in the Final Recommendation. The update will have an effect on TCOC savings and the magnitude of any catch up inflation value.

Draft Recommendation: Inflation Catch Up Methodology

- Staff believe a review of underfunded inflation is warranted, but any adjustments for underfunding of inflation should have the following guiding principles:
  - Consider historical overfunding allowances
  - Allow for two-sided risk
  - Utilize multi-year solutions to ensure savings tests are met
  - Establish formulaic methods that are predictable to hospitals and payers
- Staff's proposed methodology takes these guiding principles into account:
  - Establishes the cumulative overfunding value that the Commission allowed without revising future funded inflation downwards (1.18%), i.e., the two-sided risk corridor or max tolerance.
  - Evaluates current 5 year over/underfunding through 2023 (2.16%)
  - Reconciles current over/underfunding to two-sided risk corridor
  - Yields additional inflation of 0.98%

	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023
Funded Inflation	1.65%	2.40%	2.40%	1.92%	2.68%	2.32%	2.96%	2.77%	2.57%	4.06%
Actual Inflation	1.75%	1.84%	1.66%	2.29%	2.48%	2.40%	2.31%	2.37%	4.79%	5.09%
(Under)/Over Funding	(0.10%)	0.56%	0.74%	(0.37%)	0.20%	(0.08%)	0.65%	0.40%	(2.22%)	(1.03%)
5 Year Cumulative Difference	(0.10%)	0.45%	1.18%	0.82%	1.01%	1.03%	1.12%	0.78%	(1.00%)	**(2.16%)**
Max Tolerance **(A)**	1.18%				Absolute of 5 Year Cumulative 2018-2023 **(B)**			2.16%		
Max Funding Solution **C = B-A**					**0.98%**					

- All additional inflation values still need to be considered against required savings

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2. RY2025 Update Factor Comments: Inflation Catch-Up Methodology

- CareFirst suggests that there should be no additional funding provided in RY 2025 because the catch up methodology doesn't account for prior overfunding
  - Hospitals have been "cumulatively overfunded by more than $1 billion above actual inflation"
- If any catch up inflation is provided in RY 2025, CareFirst suggests targeting additional funding to invest in reducing statewide maternal mortality rate by 50% over 5 years. In addition, CareFirst suggests providing 0.1% funding in rates paid via an assessment to MHA to create a Maternal Quality Care Collaborative.
  - If improvements are not made over 5 years, the additional funding provided for this effort should be removed from rates.

HSCRC Staff Response: HSCRC staff agree that the catch up methodology should account for prior overfunding and thus are amending the staff recommendation to utilize a 2014 baseline. Staff, however, do not agree with CareFirst's assessment of cumulative overfunding, as it takes into account cash reserves and fails the typical regulatory standard of making adjustments in a prospective manner. Moreover, this same approach was not taken into account when resolving the census forecasting error in the Demographic Adjustment, which would have showed significant, negative impacts to cash reserves.

Lastly, while staff appreciate CareFirst's novel proposal to address maternal mortality. This type of coordinated policy action could be supported by the proposed population health provision, which will be further vetted with a technical workgroup and other key stakeholders, most notably the Department of Health.

2. RY2025 Update Factor Comments: Inflation Catch-Up Methodology

- All Hospitals are in support of a catch-up methodology to address the underfunding of inflation that has occurred in RY 2022 and RY 2023. MHA and it's member hospitals request that half of the 2.34% totaling 1.17% be funded in RY 2025 and the remainder be funded in RY 2026. The 2.34% is based on a 5 year cumulative growth calculation which considers RY 2020- RY2024. In addition, any correction for overfunded inflation be limited to 0.5% per year and not be applied if savings exceed the Medicare target. If adjustments exceed 0.5%, they should be spread over multiple years to ensure financial stability and predictability.
    - Request for additional funding to address underfunded inflation in FY25. They propose targeting this funding to efficient hospitals and scaling a portion to limit growth for "Low-Efficiency Outliers". *(Tidal Health)*

HSCRC Staff Response: HSCRC staff believe there needs to be a catch up methodology that can be used moving forward, but disagree on the approach proposed by the MHA and it's member hospitals.

a) *Calculation of over/(under)funding should go back to 2014 and calculate cumulative funding through 2023. Staff do not agree that 2024 should be included in the calculation of funding since that period is not considered 'final'.*
b) *There must be two-sided risk and overfunding should have the same corridor as underfunding. The impact to consumers, as well as hospitals, must be considered in this methodology.*
c) *Any catch up inflation will be applied to all hospitals equitably.*
d) *Additional inflation values still need to be considered against required savings.*

2. Updated Inflation Methodology

Inflation Catch-Up Methodology

Max Tolerance =	1.00%					1.00%							
HSCRC Scenario/Table 1 - Inflation Resolved after First Policy Year	**Historical**										**Projected**		
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
HSCRC Funded Inflation	1.65%	2.40%	2.40%	1.92%	2.68%	2.32%	2.96%	2.77%	2.57%	4.06%	3.24%	3.24%	3.24%
Actual Inflation	1.75%	1.84%	1.66%	2.29%	2.48%	2.40%	2.31%	2.37%	4.79%	5.09%	3.15%	3.24%	3.24%
Actual Inflation Correction												1.00%	0.00%
(Under)/Over Funding	-0.10%	0.55%	0.73%	-0.36%	0.20%	-0.08%	0.64%	0.39%	-2.12%	-0.98%	0.09%	1.00%	0.00%
Cumulative Difference (2019 Base)						(0.08%)	0.56%	0.95%	(1.19%)	(2.16%)	(2.07%)	-1.09%	-1.09%
Cumulative Difference (2014 Base)	(0.10%)	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	(0.19%)	(1.17%)	(1.08%)	-0.09%	-0.09%
Guardrail/Tolerance **(A)**										1.00%	1.00%	1.00%	1.00%
Cumulative Difference with Anticipated Inflation Correction (2014 Base) **(B)**	(0.10%)	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	(0.19%)	(1.17%)	(0.09%)	(0.09%)	(0.09%)
Calculated Inflation Correction (C) = (A+1)/(B+1)-1)									**1% for stub period**	1.00%	0.00%	0.00%	0.00%
Inflation Adjusted Update											3.24%	4.24%	3.24%

Changes to Catch Up Inflation Methodology:

- 2014 baseline (1.17% underfunding) in lieu of 2019 baseline (2.16% underfunding)
- 1% funding to be provided in RY 2025
- Risk corridor changed from 1.18% to 1% for future evaluations

Draft Recommendation: PAU

Staff proposed to continue utilizing the PAU Shared Savings program in order to recognize differential opportunities in a fixed revenue model; however, Staff are recommended that the PAU Shared Savings program should not be used to generate Model savings, as the policy has already generated a 3:1 investment on the Infrastructure Funding that was put into rates to spur improvements in care management and future reductions may cause access issues, especially for hospitals with low levels of readmissions and avoidable admissions.

- (0.37%) PAU Reduction, 0.00% Statewide Impact

Staff also recommended the following:

1) An analysis to be funded out of hospital rates of activities of current interventions to reduce PAU; 2) Establishment of a single point of executive accountability for the PAU reduction strategy; and 3)Agreement to engage in future analyses of PAU performance.

3. RY2025 Update Factor Comments: PAU

- Various Commissioners expressed concern that under the new methodology, select hospitals will receive a reward, i.e., a net increase to their revenue base, and it is unclear if the hospitals have done anything to warrant such a reward
- Almost all hospitals are in support of adjusting the PAU savings methodology to better reflect hospitals' ability to influence their rates while funding full inflation. They also support maintaining incentives for care transformation and seek clarification on certain aspects of the staff recommendation.
    - Medstar agrees with Staff's draft recommendation that an analysis to be funded out of hospital rates and activities of current interventions to reduce PAU, an establishment of a single point of executive accountability for the PAU reduction strategy, and an agreement to engage in future PAU performance analyses. They further emphasize the need for additional analyses to acknowledge that not all PAU volume is avoidable.

HSCRC Staff Response: Staff ran several analyses to see if there was a relationship between the rewards in the new PAU methodology and improvement in PAU performance over the course of the Model. While there were occurrences where hospitals have clearly demonstrated improvement and are in a position to get a reward (e.g., Garrett Regional Medical Center, MedStar St. Mary's, Chestertown Hospital), there was not a statistically significant relationship across the entire industry. Similarly, hospitals attainment performance at the start of the Model was not correlated with the current reward structure, suggesting that the proposed methodology captures both hospitals that had excellent performance at the start of the Model but have not necessarily decreased PAU (e.g., Holy Cross) and hospitals that have improved under the Model. In light of this finding, staff recommend amending the PAU Shared Savings policy to cap rewards for hospitals to 0%. In addition to a single point of accountability, hospitals would need to submit a plan for Commission approval to reduce PAU or maintain low rates of PAU.

Staff appreciates the hospital support to amend the PAU policy and to review PAU performance over the course of the Model. If approved by the Commission, staff will utilize a portion of the set aside ($500k-$1M) to contract a vendor to begin analyses of PAU performance before the start of next calendar year.

4. RY2025 Update Factor Comments: Set Aside Funding

- Several hospitals express concerns about the estimate of set-aside funding, emphasizing the need for transparency and clear criteria for distribution.
  - Support the commission's proposal but stress the importance of developing fair criteria for accessing these funds *(UMMS & LifeBridge)*
    - One hospital specifically cited concerns over using cash-on-hand to determine financial hardship, stating it can be misleading when establishing need. *(LifeBridge)*
  - Suggestion to prioritize funding for "High-Efficiency Outliers" before other requests. *(Tidal Health)*
  - Opposed increasing set aside funding, citing concerns about creating incentives and impacting inflation funding for all hospitals. *(MedStar)*

HSCRC Staff Response: Given the relatively strong support to establish criteria for distributing set aside funding, and yet no proposals for what the criteria should be (other than removal of a cash consideration), staff are putting forward the proposal from the draft recommendation with one amendment. Staff also share MedStar's concerns that increasing the set aside could crowd out potential inflation for all hospitals and could increase the likelihood of a woodwork effect, i.e., hospitals request funding purely because there is available revenue. For these reasons, staff do not believe that the funding for the set aside should be larger and again notes the need for sufficient gatekeeper tests to access funding for financial hardship, similar to what is utilized in the Integrated Efficiency policy.

1) *The below criteria must be met to provide funding to hospitals with a clear financial hardship:*
   - *Below State Average Operating Margin, and Regulated Operating Margin decline of more than 3 percent, and Total Operating Margin decline of more than 1 percent*
   - *Or 125 days cash on hand*
   - *Or two consecutive years of negative Cash Flow from Operations (on the regulated entity)*
2) *The Commission will create a process where the set aside is distributed through a competitive process*
   - *Twice per year (depending on funding availability) hospitals submit applications citing either relative efficiency performance or financial hardship and the details of their revenue request*
   - *Staff provide recommendations in subsequent meeting*
   - *Commissioners vote on requests*
   - *Hospital must submit a corrective action plan approved by their Board*

Draft Recommendation: Outpatient Oncology and Infusion Drugs

- Staff have previously evaluated providing hospital specific inflation, historically, all hospitals have received an equal drug inflation because analysis has shown the experienced inflation was relatively consistent across hospitals.

- The inflation beginning in 2022 appears to be concentrated in the more specialized drugs that are primarily delivered by academic institutions. Therefore, staff is recognizing this new round of inflation by recommending a small increase from 0 percent to 2.5 percent for all hospitals but a larger increase for just the academic centers of 7.5 percent. The 5 percent point gap reflects the observed gap between academic and non-academic trends in 2022 and 2023.

5. RY2025 Update Factor Comments: Outpatient Oncology and Infusion Drugs

- Hospitals have seen a significant rise in pharmaceutical costs that exceed core inflation. There is concern about the differing treatment for Academic Medical Centers. Hospitals are requesting that there should be no distinction in inflation rates and that any substantial changes in inflation or cost increases should be thoroughly evaluated before being implemented long-term. The impact of this funding on non-academic hospital rates means that fewer hospitals are able to provide care in to the community. Hospitals suggest that high-cost drug cases should be funded outside of the GBR and operated on a fee-for-service basis.

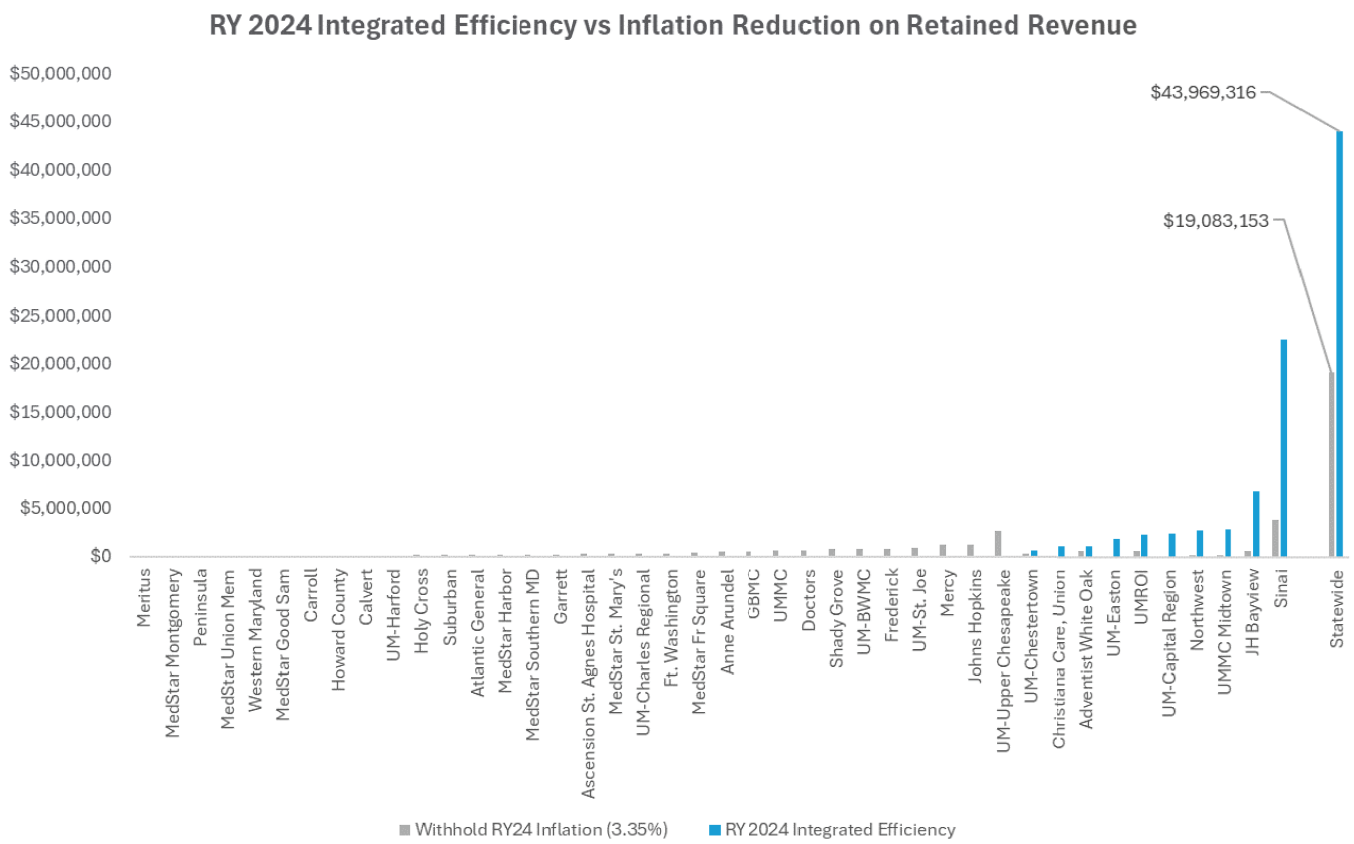
HSCRC Staff Response: The distinction in inflation rates between Academic Medical Centers and other hospitals was based on a thorough evaluation of the data. Academic medical centers have experienced higher cost growth over recent years and the proposed differential inflation rates reflects that. It is also consistent with the guidelines established in prior years when Staff noted that differential inflation rates could be used if trends diverged between hospitals. Prior to this year the data has not indicated for this adjustment. Staff agrees that a review of the policies related to high cost drug would be appropriate and plans to initiate a review during FY 2025.

6. RY2025 Update Factor Comments: Retained Revenue

- During the presentation of the Draft Recommendation of the Update Factor, Commissioners raised concerns regarding the funding of inflation on retained revenue. It was suggested that inflation should only be funded on the portion of revenue not related to retained revenue or scaled to accommodate retained revenue at the hospital.

HSCRC Staff Response: Staff disagree with this idea. The GBR rewards hospitals by allowing them to retain revenue as volumes decline (at 50% VCF). This incentive is fundamental to the Model to ensure that there is funding available in hospitals to invest in population health, physicians and other opportunities that will improve total cost of care in their service areas. The side effect of too much retained revenue, is that a hospital may operate inefficiently, which is why the Integrated Efficiency Policy was created and approved by the Commission in April of 2021. This policy is the mechanism by which retained revenue should be addressed and have that revenue removed from the system. Removing retained revenue from all hospitals rather than just outliers, as currently outlined in the policy may disincentivize hospitals to manage total cost of care and invest in their service area.

6. To Retain or not to Retain?



Defunding inflation on retained revenue versus implementing Integrated Efficiency has three central flaws:

1. It achieves less in savings and/or opportunity for reinvestment ($19.1M versus $43.9M in RY 2024)
2. It broadly distributes the reduction to most all hospitals, thus reducing the impetus to transform care delivery
3. It upends the central incentive of the Model

"The largest incentives in the MD TCOC Model are the all-payer hospital global budgets. At the start of each year, HSCRC sets a budget across all payers for each hospital in the state. These budgets, which continue from MDAPM, encourage hospitals to reduce avoidable hospital use by improving beneficiaries' health or shifting care to lower-acuity settings"

https://www.cms.gov/priorities/innovation/data-and-reports/2024/md-tcoc-1st-progress-rpt, page ES-2

1) Retained revenue is calculated on a per case basis, assuming a 50% variable cost factor
2) Retained revenue calculations include revenue adjustments related to marketshift, demographic adjustment, PAU shared savings, out-of-state volume adjustments, deregulation, and other miscellaneous volume adjustments
3) Retained revenue calculations exclude oncology drugs, chronic cases, and cases eligible under the Complexity and Innovation policy

Draft Recommendation: Specialty Hospital Update

Draft Recommendation Inflation Breakdown: Specialty Hospitals	
Inflation	**3.15%**
Productivity Adjustment	**Suspended**
Additional Inflation Support	**0.00%**
Gross Inflation Allowance	**3.15%**

7. RY2025 Update Factor Comments: Non-GBR Hospitals

- Non-GBR hospitals should receive full inflation and an additional adjustment for underfunded inflation in FY 2025, equivalent to GBR hospitals. As downstream providers with low volumes still below CY 2019 levels, they struggle to maintain positive margins and required staffing.

HSCRC Staff Response: HSCRC Staff agree to include the catch up inflation value of 1.00 percent in the Final Recommendation. Volumes remain low compared to 2019 at the specialty hospitals, but demand remains high. Specialty hospitals experience the same inflationary pressures as acute hospitals. The cost pressures, specifically, specialized staffing needs make it difficult for these hospitals to fill vacancies and as a result are these hospitals utilizing agency staffing in higher levels. These hospitals represent an important component of the overall delivery system in Maryland and ensuring continued access to these services is crucial.

8. Population Health Consideration

- Commissioners expressed concerns that reducing the system-wide inflation reduction for PAU would reduce the incentive for hospitals to improve or sustain efforts to reduce PAU.
- CareFirst also indicated that an increased portion of the Update Factor should be directed to population health improvement efforts.
- As such, 0.19% of the Update Factor (equivalent to half of the proposed modification to the PAU reduction), will be clawed back in the in the January rate orders if the following conditions are not met:
  - A plan, subject to Commission approval, for population health improvement aligned with statewide priorities
  - This will be evaluated in future years if there is not demonstrated improvement in the proposed initiative

Population Health Management Plans

- Hospitals will be required to submit a population health management plan.
- The plan should, at a minimum,
  1) identify at least 3 conditions driving avoidable utilization, readmissions, and/or cost within their hospital,
  2) describe programs, initiatives, and interventions intended to address the conditions identified, as well as the resources committed to these efforts;
  3) specify participation in statewide efforts to address core population health goals, such as reducing maternal mortality and overdose;
  4) provide performance improvement indicators and outcomes for the identified conditions and programs, including, as appropriate, measures related to equity.

Timing

- Staff will host a subgroup of Payment Models to discuss both the (1) Population Health Management Plans and (2) Revenue for Reform FY 2026 revisions.
- Subgroup Details
  - Open call for members in July/August
  - Host 1-2 meetings in late August and September
- Final standards for Population Health Management Plans released to the hospital field by October 15.
- Plans from hospitals due mid-December.
- HSCRC will classify plans into meets standards or does not meet standards. Those hospitals without plans that meet standards will have the additional funding removed through a clawback.
- Hospitals will be notified by February 1, 2025.

Key Considerations

Subject to discussion in the subgroup, we anticipate that the standards will:

- Require the appointment of a responsible executive.
- Encourage use of Milliman's MedInsight Value-Based Care Insights (VBCI) tool to identify clinically defined subpopulations with improvement opportunity.
- Anticipate the use of CRISP to measure key population health goals.
- Define a minimum amount of specific population health management investments, at least the scale of the revenue in this provision of the Update Factor.
- Include specifying partnerships with outpatient providers, community-based organizations and public health departments to achieve population health goals.
- Include the potential for investments in social contributors to health.
- Additional workgroup feedback will be needed to refine an approach to setting improvement targets.

Final Recommendation

The final recommendation reflects changes due to Commissioner and stakeholder feedback

Summary of Changes between Draft & Final Recommendations		
GBR Hospitals	**Draft Recommendation**	**Final Recommendation**
Adjustment for Inflation (4th Quarter Book)	3.05%	3.14%
Additional Inflation Support	0.65%	1.00%
Outpatient Oncology Drugs	0.10%	0.10%
Gross Inflation Allowance	3.80%	4.24%
PAU Shared Savings	0.00%	-0.02%
Non-GBR Hospitals		
Inflation	3.15%	3.24%
Productivity Adjustment	Suspended	Suspended
Additional Inflation Support	0.00%	1.00%
Gross Inflation Allowance	3.15%	4.24%

Update Factor Discussion

Balanced Update Model for RY 2025					
Components of Revenue Change Link to Hospital Cost Drivers /Performance					
			Weighted Allowance	All Payer Revenue Increase {Millions}	Medicare Revenue Increase {Millions}
Adjustment for Inflation (this includes 4.00% for Wages and Salaries)			3.14%	$664.2	$219.2
- Additional Inflation Support			1.00%	$211.6	$69.8
- Outpatient Oncology Drugs			0.10%	$21.4	$7.1
Gross Inflation Allowance	**A**		**4.24%**	**$897.1**	**$296.1**
Care Coordination/Population Health					
- Reversal of One-Time Grants			-0.21%	-$45.1	-$14.9
- Grant Funding RY25: RP for Behavioral Health & Maternal and Child Health			0.14%	$29.7	$9.8
Total Care Coordination/Population Health	**B**		**-0.07%**	**-$15.4**	**-$5.1**
Adjustment for Volume					
-Demographic /Population			0.25%	$52.9	$17.5
-Drug Population/Utilization			0.00%	$0.0	$0.0
Total Adjustment for Volume	**C**		**0.25%**	**$52.9**	**$17.5**
Other adjustments (positive and negative)					
- Set Aside for Unknown Adjustments	D		0.15%	$31.7	$10.5
- Low Efficiency Outliers/Revenue for Reform	E		0.00%	$0.0	$0.0
- Complexity & Innovation	F		-0.01%	-$3.1	-$1.0
-Reversal of one-time adjustments for drugs	G		-0.10%	-$21.9	-$7.2
-Capital Funding & Estimated Increase for Full Rate Applications	H		0.17%	$36.5	$12.0
Net Other Adjustments	**I =**	**Sum of D thru H**	**0.20%**	**$43.2**	**$14.3**
Quality and PAU Savings					
-PAU Redistribution (-.38%)	J		-0.02%	-$5.05	-$1.7
-Reversal of prior year quality incentives -QBR, MHAC, Readmissions	K		0.08%	$17.6	$5.8
-Current Year Quality Incentives	L =		-0.12%	-$25.2	-$8.3
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**-0.06%**	**-$12.7**	**-$4.2**
Total Update First Half of Rate Year					
Net increase attributable to hospitals	**N=**	Sum of A + B + C	**4.56%**	**$965.2**	**$318.5**
Per Capita	**O=**	(1+N)/(1+0.25%)	**4.30%**		
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements					
-Uncompensated care, net of differential	P		0.14%	$29.6	$9.8
-Deficit Assessment	Q		0.00%	$0.0	$0.0
Net decreases	**R =**	P + Q	**0.14%**	**$29.6**	**$9.8**
Total Update First Half of Rate Year 25					
Revenue growth, net of offsets	**S =**	N + R	**4.70%**	**$994.8**	**$328.3**
Per Capita Revenue Growth	**T =**	(1+S)/(1+0.25%)	**4.44%**		
Adjustments in Second Half of Rate Year					
- Transformation Funding			0.09%	$20.0	$6.6
Total Adjustments Second Half of Rate Year	**U**		**0.09%**	**$20.0**	**$6.6**
Total Update Full Rate Year					
Revenue growth, net of offsets	**V =**	S + U	**4.80%**	**$1,014.8**	**$334.9**
Per Capita Revenue Growth	**W =**	(1+V)/(1+0.25%)	**4.53%**		

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Estimated Position on Medicare Test		
Actual Revenue January - June 2023		10,280,594,777
Actual Revenue July-December 2023		10,452,399,742
Actual Revenue CY 2023		20,732,994,519
Step 1:		
Approved GBR RY 2024		21,159,064,172
Actual Revenue 7/1/23-12/31/23		10,452,399,742
Approved Revenue 1/1/24-6/30/24		10,706,664,430
Projected FY24 GBR Compliance		0
Anticipated Revenue 1/1/24-6/30/24	**A**	**10,706,664,430**
Expected Revenue Growth 1/1/24-6/30/24		**4.14%**
Step 2:		
Final Approved GBR RY 2024		21,159,064,172
Reverse All Payer Rate Reduction:		20,000,000
Final Adjusted GBR Base for RY 2025		21,179,064,172
Projected Approved GBR RY 2025		22,174,807,962
Permanent Update RY 2025		4.70%
Step 3:		
Estimated Revenue 7/1/24-12/31/24 (after 49.73% & seasonality)	**B**	**11,027,531,999**
Expected Revenue Growth 7/1/24 - 12/31/24		***5.50%***
Step 4:		
Estimated Revenue CY 2024	**A+B**	**21,734,196,430**
Increase over CY 2024 Revenue		**4.83%**
Per Capita Increase over CY 2024		**4.57%**

CY 24 Guardrail Scenario 1: 2023 Trended forward at 2017 - 2019 Trend

Scenario 1 Guardrail Projections			
	Maryland	US	
2023	$14,058	$12,526	
2024	$14,708	$13,006	Predicted Variance
YOY Growth	4.6%	3.8%	0.8%
Estimated CY2024 Savings Run Rate			$404.6 M

CY 24 Guardrail Scenario 2: 2023 Trended forward at 2015 - 2019 Trend

Scenario 2 Guardrail Projections			
	Maryland	US	
2023	$14,058	$12,526	
2024	$14,633	$12,875	Predicted Variance
YOY Growth	4.1%	2.8%	1.3%
Estimated CY2024 Savings Run Rate			$339.0M

CY 24 Guardrail Scenario 3: 2023 Trended forward at 2022 - 2023 Trend

Scenario 3 Guardrail Projections			
	Maryland	US	
2023	$14,058	$12,526	
2024	$14,888	$13,178	Predicted Variance
YOY Growth	5.9%	5.2%	0.7%
Estimated CY2024 Savings Run Rate			$427.5 M

Final Recommendations

For Global Revenues:

- Provide hospitals with a base inflation increase of 3.24 percent, inclusive of differential inflation for oncology drugs for academic (7.5 percent) and community (2.5 percent) hospitals, and an additional 1.0 percent for cumulative underfunding of inflation since 2014.
- Provide overall increase of 4.80 percent for revenue (4.54 percent per capita for hospitals under Global Budgets)
- Adoption of catch-up inflation methodology to use in RY 26 and beyond. Includes:
  - Two-sided risk, 1.00 percent risk corridor, and recognition that all additional inflation values will be considered against required savings
- Establishment of criteria for distribution of set-aside funding. Includes following criteria and process:
  - Clear financial hardship criteria: Below State Average Annual Operating Margin, Annual Regulated Operating Margin decline of more than 3 percent, and Annual Total Operating Margin decline of more than 1 percent; OR 125 days cash on hand (actual or projected); OR Two Consecutive Years of negative Cash Flow from Operations (on the regulated entity).
  - Competitive process that requires a corrective action plan for improved financial operations and is subject to Commission approval.
- Amend PAU Shared Savings policy; statewide impact is equal to -0.02 percent and cap rewards for hospitals to 0.0 percent.
  - To ensure there is no backsliding, an analysis will be funded out of hospital rates, each hospital will have to establish a single point of executive accountability and all hospitals must agree to engage in future PAU performance analyses.
- Hospitals are required to submit a population health improvement plan.
  - The plan should, at a minimum, (1) identify at least 3 conditions driving avoidable utilization, readmissions, and/or cost within their hospital, (2) describe programs, initiatives, and interventions intended to addressing the conditions identified; (3) specify participation in statewide efforts to address core population health goals and; (4) provide performance improvement indicators and outcomes for the identified conditions and programs, including, as appropriate, measures related to equity.
  - Failure to submit a population health plan will result in a takeback of 0.19 percent of inflation removed in the January rate updates.

Final Recommendations

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

- Provide an overall update of 3.24 percent for inflation, with an additional 1.0 percent for additional revenue support based on cumulative underfunding of inflation since 2014.
- Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing.

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Final Recommendation for the Update Factors for Rate Year 2025

June 14, 2024

This document reflects the Final Recommendation for the RY25 Update Factor that was approved at the Commission on June 14, 2024.

Table of Contents

List of Abbreviations

CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFS	Fee-for-service
FY	Fiscal Year
FFY	Federal fiscal year refers to the period of October 1 through September 30
GBR	Global Budget Revenue
GSP	Gross State Product
HSCRC	Health Services Cost Review Commission
MHAC	Maryland Hospital Acquired Conditions
PAU	Potentially Avoidable Utilization
QBR	Quality-Based Reimbursement
RRIP	Readmission Reduction Incentive Program
RY	Rate year, refers to the period of July 1 through June 30 of each year
TCOC	Total Cost of Care
UCC	Uncompensated Care

Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers / Consumers	Effects on Health Equity
The annual update factor is intended to provide hospitals with reasonable changes to rates in order to maintain operational readiness while also seeking to contain the growth of hospital costs in the State. In addition, the policy aims to be fair and reasonable for hospitals and payers.	The final recommendation provides an annual update factor of 4.53 percent per capita, a revenue increase of 4.80 percent for hospitals under Global Budgets. This policy also provides an inflation increase of 4.24 percent for hospitals not under Global Budgets, which includes psychiatric hospitals and Mt. Washington Pediatrics.	The annual update factor provides hospitals with permanent and one-time adjustments to their respective rate orders for RY 2025. The update includes changes for inflation, high-cost drugs, care coordination, complexity and innovation, quality, uncompensated care, and others as deemed necessary.	One of the tenets of the update factor determination is to contain the growth of costs for all payers in the system and to ensure that the State meets its requirements under the Medicare Total Cost of Care Agreement. Applied to all payers in the system, the update factor determination ensures that the increases to hospital rates borne by all purchasers of hospital services, including consumers, is reasonable and affordable.	The annual update factor contains the growth of costs for all payers and reflects ongoing investments in population health and health equity. The update factor also reflects quality measures, including within hospital disparities, that aim to improve health disparities across the State.

Executive Summary

The following report includes a final recommendation for the Update Factor for Rate Year (RY) 2025. This update is designed to provide hospitals with reasonable inflation to maintain operational readiness and to keep healthcare affordable in the State of Maryland.

This recommendation generally follows approaches established in prior years for setting the update factors. As with all HSCRC policies, the aim is equity and fairness for all hospitals and payers that balances the need to provide sufficient resources for operational readiness and necessary investment, while simultaneously ensuring affordability for consumers and purchasers of hospital services, as well as meeting all of the State's contractual obligations with the federal government.

Staff requests that Commissioners consider the following final t recommendations:

For Global Revenues:

(a) Provide all hospitals with gross inflation increase of 3.24 percent, with an additional 1.00 percent for additional revenue support based on historic underfunding of inflation.

(b) Provide an overall increase of 4.80 percent for revenue (including a net increase to uncompensated care) and 4.53 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

(c) Adoption of a catch-up inflation methodology to use in RY 26 and beyond. This methodology, outlined in this report, would include: two-sided risk to ensure hospitals and consumers are equally considered, a 1.00 percent risk corridor to ensure that inflation reconciliations are only performed when there are material variances, and recognition that all additional inflation values will be considered against required savings.

(d) Establishment of criteria for distribution of set-aside funding. Staff propose the following criteria must be met to provide funding to hospitals with a clear financial hardship: Below State Average Annual Operating Margin, Annual Regulated Operating Margin decline of more than 3 percent, and Annual Total Operating Margin decline of more than 1 percent; or 125 days cash on hand (actual or projected); or Two Consecutive Years of negative Cash Flow from Operations (on the regulated entity). The Commission will create a process where the set aside will be distributed through a competitive exercise and require a corrective action plan for improved financial operations.

(e) Amend the PAU Shared Savings policy so that statewide impact is equal to -0.02 percent and then cap rewards for hospitals to 0.0 percent. To ensure there is no backsliding in statewide performance, an analysis will be funded out of hospital rates to assess current interventions to reduce PAU, each hospital will have to establish a single point of executive accountability for their PAU reduction strategy, and all hospitals must agree to engage in future PAU performance analyses.

(f) To ensure continued focus on population health within the State and ensure Hospitals are fully engaged in population health efforts, Hospitals will be required to submit a population health improvement plan. The plan should, at a minimum, (1) identify at least 3 conditions driving avoidable utilization, readmissions, and/or cost within their hospital, (2) describe programs, initiatives, and interventions intended to addressing the

conditions identified; (3) specify participation in statewide efforts to address core population health goals, such as reducing maternal mortality and overdose; (4) provide performance improvement indicators and outcomes for the identified conditions and programs, including, as appropriate, measures related to equity.

Staff will convene a workgroup to refine this approach. Failure to submit a population health plan that successfully addresses the conditions outlined above and discussed in the workgroup, will result in a take back of 0.19 percent of inflation removed in the January rate updates.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

(a) Provide an overall update of 3.24 percent for inflation, with an additional 1.0 percent for additional revenue support based on cumulative underfunding of inflation since 2014.

(b) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing.

Introduction & Background

The Maryland Health Services Cost Review Commission (HSCRC or Commission) updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy-related adjustments, other adjustments related to performance, and settlements from the prior year. For this upcoming fiscal year in the development of the update factor, the HSCRC is considering the impact recent inflationary trends have had on the healthcare industry. As in all the HSCRC policies, this final recommendation strives to achieve a fair and equitable balance between providing sufficient funds to cover operational expenses and necessary investments, while keeping the increase in hospital costs affordable for all payers.

In July 2018, CMS approved a new 10-year Total Cost of Care (TCOC) Model Agreement for Maryland, which began January 1, 2019. The TCOC Model requires that the State reach an annual total cost of care savings of $408 million relative to the national growth rate by 2026, relative to a 2013 base year. In addition, the State committed to continue to limit the growth in hospital costs in line with economic growth, continue quality improvements, and improve the health of the population. The annual savings target for CY 2024 is $336 million.

To meet the ongoing requirements of the Model, HSCRC will need to continue to ensure that state-wide hospital revenue growth is in line with the growth of the economy. The HSCRC will also need to continue to ensure that the Medicare TCOC Savings Requirement is met. The approach to developing the RY 2025 annual update is outlined in this report, as well as Staff's estimates on calendar year Model tests.

Hospital Revenue Types Included in this Recommendation

There are two categories of hospital revenue:

1. Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority. The proposed update factor for hospitals under Global Budget Revenues is a revenue update. A revenue update incorporates both price and volume adjustments for hospital revenue under Global Budget Revenues. The proposed update should be compared to per capita growth rates, rather than unit rate changes.

2. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland, and, thus, Medicare does not pay based on those rates. This includes freestanding psychiatric hospitals and Mount Washington Pediatric Hospital. The proposed update factor for these hospitals is strictly related to price, not volume.

This recommendation proposes Rate Year (RY) 2025 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

Overview of Final Update Factors Recommendations

For RY 2025 HSCRC staff is proposing an update of 4.53 percent per capita for global budget revenues and an update of 3.24 percent for non-global budget revenues. These figures are described in more detail below.

Calculation of the Inflation/Trend Adjustment

For hospitals under both revenue types described above, the inflation allowance is central to HSCRC's calculation of the update adjustment. The inflation calculation blends the weighted Global Insight's Firs Quarter 2024 market basket growth estimate with a capital growth estimate. For RY 2025, HSCRC Staff combined 91.20 percent of Global Insight's First Quarter 2024 market basket growth of 3.30 percent with 8.80 percent of the capital growth estimate of 2.60 percent, calculating the gross blended amount as a 3.24 percent inflation adjustment. Global Insights has not yet released its CY 2024 First Quarter book, which historically is the reference staff use to determine annual inflation.

Consideration of Hospital Financial Condition

Hospital industry representatives have raised concerns over hospital financial performance in several forums. Staff recognize that recent Fiscal Years have been more financially challenging for hospitals than prior years and that several hospitals are challenged to meet their system debt service coverage ratios. Staff's review of audited hospital financial data shows that profits on regulated activities remained unchanged, from 6.46 percent of regulated net operating revenue in

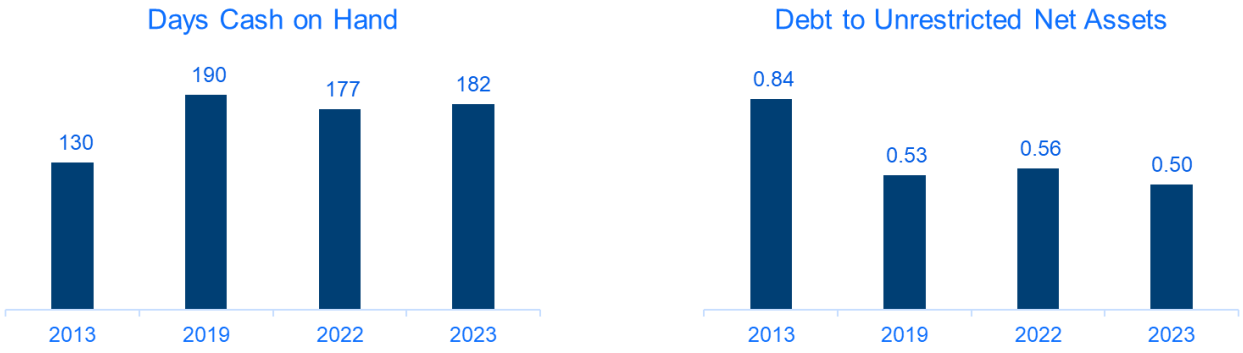
RY 2022 to 6.60 percent of regulated net operating revenue in RY 2023. Profits on hospital operations, which include profits and losses from regulated and unregulated day-to-day activities, decreased from 0.77 percent of total net operating revenue in RY 2022 to 0.01 percent of total net operating revenue in RY 2023.

Unaudited data received by the HSCRC shows that fiscal year-to-date RY 2024 regulated margins through February are 5.90 percent, although that is below last year's audited amount of 6.60 percent, unaudited regulated margins are typically understated, and staff anticipate fiscal year end audited regulated RY 2024 margins will be at or above RY 2023.

Unaudited data received by the HSCRC shows that fiscal year-to-date RY 2024 total operating margins through February are 1.31 percent, an improvement over the break-even results for RY 2023. Unaudited and audited total operating margins are typically consistent. While average margins are positive, the median unaudited total operating margin for year-to-date RY 2024 is approximately break-even meaning half of all hospitals are losing money. These losses are concentrated among smaller, independent hospitals resulting in the median under-performing the average.

Despite relatively weak financial performance in RY 2023 and, to a lesser extent year-to-date RY 2024, hospital balance sheets, on average, remain stronger than they were prior to GBRs. Figure 1 shows days cash on hand and debt to unrestricted net asset ratio for Maryland domiciled health systems as of June 30, 2013 (pre-GBR), 2019 (pre-pandemic), 2022, and 2023 (most recent years)[1].

Figure 1: Balance Sheet Metrics



Staff generally review industry wide values in assessing financial condition but note that statewide strength does not mean individual hospitals do not have significant challenges. Despite the

[1] Days cash on hand reflects the number of days of cash operating expenses an organization could pay with its unrestricted cash and investments. Debt to Unrestricted Net Assets measures how much debt an organization carries relative to its total balance sheet. Balance sheet metrics are reported at a system level as debt and cash are typically managed at a system level. Only primarily Maryland-domiciled systems are included to avoid swamping the statistics with the results of large national systems that have limited representation in Maryland.

overall balance sheet strength, if operating margins continue to be weak, as in recent fiscal years, select hospitals may experience worsening financial conditions.

Update Factor Recommendation for Non-Global Budget Revenue Hospitals

For non-global budget hospitals (psychiatric hospitals and Mt. Washington Pediatric Hospital), HSCRC Staff proposes applying the inflation adjustment of 3.24 percent, with an additional 1.0 percent for additional revenue support based on cumulative underfunding of inflation since 2014, and continuing suspension of the productivity reduction. The pandemic's effect on hospitals continues to result in volume declines compared to the pre-pandemic period. It is important to note that these hospitals receive an adjustment based on their actual volume change, rather than a population adjustment. HSCRC staff continues to include these non-global budget hospitals in readmission calculations for global budget hospitals and may implement quality measures for these hospitals in future rate years. Hospitals not under Global Budget revenues are provided updates similar to what is proposed nationally. Staff are not recommending providing them with additional inflation support but do recommend withholding the productivity adjustment. These hospitals are volume variable and have the ability to grow volumes to increase revenues.

Table 1: Base Inflation Inputs

	Global Revenue	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.24%	3.24%
Productivity Adjustment	N/A	SUSPENDED
Additional Inflation Support	1.00%	1.00%
Proposed Inflation Update	4.24%	4.24%

Update Factor Recommendation for Global Budget Revenue Hospitals

In considering the system-wide update for the hospitals with global revenue budgets under the Total Cost of Care Model, HSCRC staff sought to achieve balance among the following conditions:

- Meeting the requirements of the Total Cost of Care Model agreement, including achieving $336 million in annual Medicare savings by the end of CY 2024;

- Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes;
- Ensuring that hospitals have adequate resources to invest in care coordination and population health strategies necessary for long-term success under the Total Cost of Care Model as well as framework for doing so;
- Incorporating quality performance programs; and
- Ensuring that healthcare remains affordable for all Marylanders.

As shown in Table 2, after accounting for all known changes to hospital revenues, HSCRC staff estimates revenue growth for the full rate year to be 4.80 percent with a corresponding per capita growth rate of 4.53 percent.

The revenue growth that will impact CY 2024 is expected to be 4.70 percent with a corresponding per capita growth of 4.44 percent. The 4.70 percent revenue growth will be used to measure the proposed update against financial tests, which are performed on Calendar Year results, Staff split the annual Rate Year revenue into six-month targets. Staff intends to apply 49.73 percent of the Total Approved Revenue to determine the mid-year target for the calendar year calculation, with the full amount of RY 2025 estimated revenue used to evaluate the Rate Year year-end target. HSCRC staff will adjust the revenue split to accommodate their normal seasonality for hospitals that do not align with the traditional seasonality described above.

Net Impact of Adjustments

Table 2 summarizes the net impact of the HSCRC Staff's final recommendation for inflation, volume, Potentially Avoidable Utilization (PAU) savings, uncompensated care, and other adjustments to global revenues. Descriptions of each step and the associated policy considerations are explained in the text following the table.

Table 2: Update Factor Schedule

Balanced Update Model for RY 2025					
Components of Revenue Change Link to Hospital Cost Drivers /Performance					
			Weighted Allowance	All Payer Revenue Increase {Millions}	Medicare Revenue Increase {Millions}
Adjustment for Inflation (this includes 4.00% for Wages and Salaries)			3.14%	$664.2	$219.2
- Additional Inflation Support			1.00%	$211.6	$69.8
- Outpatient Oncology Drugs			0.10%	$21.4	$7.1
Gross Inflation Allowance	**A**		**4.24%**	**$897.1**	**$296.1**
Care Coordination/Population Health					
- Reversal of One-Time Grants			-0.21%	-$45.1	-$14.9
- Grant Funding RY25: RP for Behavioral Health & Maternal and Child Health			0.14%	$29.7	$9.8
Total Care Coordination/Population Health	**B**		**-0.07%**	**-$15.4**	**-$5.1**
Adjustment for Volume					
-Demographic /Population			0.25%	$52.9	$17.5
-Drug Population/Utilization			0.00%	$0.0	$0.0
Total Adjustment for Volume	**C**		**0.25%**	**$52.9**	**$17.5**
Other adjustments (positive and negative)					
- Set Aside for Unknown Adjustments	D		0.15%	$31.7	$10.5
- Low Efficiency Outliers/Revenue for Reform	E		0.00%	$0.0	$0.0
- Complexity & Innovation	F		-0.01%	-$3.1	-$1.0
-Reversal of one-time adjustments for drugs	G		-0.10%	-$21.9	-$7.2
-Capital Funding & Estimated Increase for Full Rate Applications	H		0.17%	$36.5	$12.0
Net Other Adjustments	**I =**	**Sum of D thru H**	**0.20%**	**$43.2**	**$14.3**
Quality and PAU Savings					
-PAU Redistribution (-.38%)	J		-0.02%	-$5.05	-$1.7
-Reversal of prior year quality incentives	K		0.08%	$17.6	$5.8
-QBR, MHAC, Readmissions					
-Current Year Quality Incentives	L =		-0.12%	-$25.2	-$8.3
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**-0.06%**	**-$12.7**	**-$4.2**
Total Update First Half of Rate Year					
Net increase attributable to hospitals	**N=**	Sum of A + B + C + I + M	**4.56%**	**$965.2**	**$318.5**
Per Capita	**O=**	(1+N)/(1+0.25%)	**4.30%**		
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements					
-Uncompensated care, net of differential	P		0.14%	$29.6	$9.8
-Deficit Assessment	Q		0.00%	$0.0	$0.0
Net decreases	**R =**	P + Q	**0.14%**	**$29.6**	**$9.8**
Total Update First Half of Rate Year 25					
Revenue growth, net of offsets	**S =**	N + R	**4.70%**	**$994.8**	**$328.3**
Per Capita Revenue Growth	**T =**	(1+S)/(1+0.25%)	**4.44%**		
Adjustments in Second Half of Rate Year					
- Transformation Funding			0.09%	$20.0	$6.6
Total Adjustments Second Half of Rate Year	**U**		**0.09%**	**$20.0**	**$6.6**
Total Update Full Rate Year					
Revenue growth, net of offsets	**V =**	S + U	**4.80%**	**$1,014.8**	**$334.9**
Per Capita Revenue Growth	**W =**	(1+V)/(1+0.25%)	**4.53%**		

Central Components of Revenue Change Linked to Hospital Cost Drivers/Performance

HSCRC Staff accounted for several factors that are central provisions to the update process and are linked to hospital costs and performance. These include:

- **Adjustment for Inflation:** As described above, the inflation factor uses the gross blended statistic of 3.24 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's First Quarter 2024 market basket growth of 3.30 percent with 8.80 percent of the capital growth index change of 2.60 percent. The adjustment for inflation includes 4.00 percent for wage and compensation.

- **Additional Inflations Support:** Staff recommend providing an additional 1.00 percent to account for historical underfunding of inflation. Staff are utilizing the RY 2014 to RY 2023 time period for this review. The RY 2024 period has not been included in this review, as it still requires 4 more quarters of data to be deemed complete. Cumulative underfunding from RY 2014 through RY 2023 is 1.17 percent. Utilizing a 2019 baseline, the cumulative underfunding is 2.16 percent, which is largely driven by underfunding of 2.12 percent in RY 2022 and -0.98 percent in RY 2023. By way of comparison, the largest year for overfunding of inflation was RY 2016 when the Commission overfunded by 0.73 percent. Given the significant underfunding that has occurred in the last two fiscal years and because staff is advancing a methodology that in future years would formulaically reconcile inflation if there is a material difference between actual inflation and funded inflation, Staff propose providing 1.00 percent additional for catch up inflation in the RY 2025 recommendation. Staff note, however, that it is imperative that any additional inflation value be considered against required savings, both the Medicare TCOC savings test and the all-payer per capita growth test.

  Moving forward, Staff recommend adoption of a catch-up methodology that will be utilized in the RY 2026 Update Factor and beyond. This methodology is outlined in Table 3 below. It allows for a two-sided risk corridor of 1.00 percent on all future evaluations of cumulative over or underfunding by which the Commission would adjust future inflation if the variance between actual inflation and funded inflation was greater than 1.00 percent. Conversely, if the variance between actual inflation and funded inflation is within 1.00 percent, this methodology would not recommend any adjustments, as that level of variance was "tolerated" in prior years. It should be noted that this methodology follows several guiding principles including: considering historical overfunding allowances, allowing for two-sided risk, utilizing multi-year solutions to ensure savings targets are met, and establishing formulaic methods for hospital and payer predictability.

Table 3: Inflation Risk Corridor Methodology

Inflation Catch-Up Methodology

Max Tolerance =	1.00%					1.00%							
HSCRC Scenario/Table 1 - Inflation Resolved after First Policy Year	Historical										Projected		
Year	**2014**	**2015**	**2016**	**2017**	**2018**	**2019**	**2020**	**2021**	**2022**	**2023**	**2024**	**2025**	**2026**
HSCRC Funded Inflation	1.65%	2.40%	2.40%	1.92%	2.68%	2.32%	2.96%	2.77%	2.57%	4.06%	3.15%	3.24%	3.24%
Actual Inflation	1.75%	1.84%	1.66%	2.29%	2.48%	2.40%	2.31%	2.37%	4.79%	5.09%	3.15%	3.24%	3.24%
Actual Inflation Correction												1.00%	0.00%
(Under)/Over Funding	-0.10%	0.55%	0.73%	-0.36%	0.20%	-0.08%	0.64%	0.39%	-2.12%	-0.98%	0.00%	1.00%	0.00%
Cumulative Difference (2019 Base)						(0.08%)	0.56%	0.95%	(1.19%)	(2.16%)	(2.16%)	-1.18%	-1.18%
Cumulative Difference (2014 Base)	(0.10%)	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	(0.19%)	(1.17%)	(1.17%)	-0.18%	-0.18%
Guardrail/Tolerance **(A)**										1.00%	1.00%	1.00%	1.00%
Cumulative Difference with Anticipated Inflation Correction (2014 Base) **(B)**	(0.10%)	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	(0.19%)	(1.17%)	(0.18%)	(0.18%)	(0.18%)
Calculated Inflation Correction (C) = (A+1)/(B+1)-1)								**1% for stub period**		1.00%	0.00%	0.00%	0.00%
Inflation Adjusted Update											3.15%	4.24%	3.24%

- **Outpatient Oncology and Infusion Drugs:** The rising cost of drugs, particularly of new physician-administered oncology and infusion drugs in the outpatient setting led to the creation of separate inflation and volume adjustment for these drugs. Not all hospitals provide these services, and some hospitals have a much larger proportion of costs allocated. To address this situation, in Rate Year 2016, staff began allocating a specific part of the inflation adjustment to funding increases in the cost of drugs, based on the portion of each hospital's total costs that comprised these types of drugs.

  In addition to the drug inflation allowance, the HSCRC provides a utilization adjustment for these drugs. Half of the estimated cost changes due to usage or volume changes are recognized as a one-time adjustment and half are recognized as a permanent adjustment. This process is implemented separately from this Update Factor so only the inflation portion is addressed herein.

  Starting in Rate Year 2021, Staff began using a standard list of drugs based on criteria established with the industry in evaluating high-cost drug utilization and inflation. This list was used to calculate the inflation allowance as well as the drug utilization adjustment component of funding for these high-cost drugs. Rate Year 2024 continues this practice. Price inflation on these drugs declined considerably starting in the late-2010s. In response to this trend Staff gradually lowered the drug inflation amount from 10 percent down to 0 percent over the period from RY 2019 to RY 2023 based on data from RY 2018 to RY 2022. Starting in RY 2022 the price inflation began to accelerate again, and this trend accelerated into RY 2023. While staff have previously evaluated providing hospital specific inflation, historically, all hospitals have received an equal drug inflation because analysis has shown the experienced inflation was relatively consistent across hospitals. However, the inflation beginning in 2022 appears to be concentrated in the more

specialized drugs that are primarily delivered by academic institutions. Therefore, staff is recognizing this new round of inflation by recommending a small increase from 0 percent to 2.5 percent for all hospitals but a larger increase for just the academic centers of 7.5 percent. The 5 percent point gap reflects the observed gap between academic and non-academic trends in 2022 and 2023.

- **Care Coordination / Population Health:** There were several grant programs aimed at Care Coordination and Population Health in RY 2024 hospital revenues. These programs include Regional Partnership Catalyst Programs for Diabetes and Behavioral Health, and Maternal and Child Health Improvement Fund Assessment. These funds were provided to hospitals on a one-time basis. For this reason, you will see a line in Table 2 reversing out grant funding in RY 2024 of -0.21 percent. RY 2025 funding is expected to be approximately 0.14 percent and includes continued funding for Behavioral Health and Maternal and Child Health.

- **Adjustments for Volume:** Staff are proposing a population growth estimate of 0.25 percent for RY 2025 (July 1, 2022 to June 30, 2023), which is based on the Maryland Department of Planning's estimate for 2023 over the projected value noted in 2022.[2] For RY 2025 the staff is proposing to use Claritas' projected CY 2024 growth estimate for distributing the Demographic Adjustment at a zip code level, in keeping with the prior year methodologies.

- **Low-Efficiency Outliers:** The Integrated Efficiency policy outlines a methodology for determining inefficient hospitals in the TCOC Model. This policy will utilize the Inter-Hospital cost comparisons to compare relative cost-per-case efficiency. This policy will also use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance relative to national benchmarks for each service area in the State. The above evaluations are then used to withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals, which will be available for redistribution to relatively efficient hospitals or potentially for reinvestment through the proposed Revenue for Reform policy. Staff has earmarked 0 percent reduction for this item, because low-efficient hospitals are encouraged to buyout of their reductions through investments in Revenue for Reform and if buyouts do not occur, relatively efficient hospitals can petition the Commission for funding that is withheld from relatively inefficient hospitals.

- **Set-Aside:** The intention of the set-aside is to use these funds for 1) Global Budget Revenue enhancements for relatively efficient hospitals that qualify under the Integrated Efficiency policy and 2) unforeseen events that occur at hospitals with a financial hardship, regardless of efficiency (e.g., cyberattacks). Staff is recommending 0.15 percent for RY 2025. In an effort to create transparency and equity, Staff propose that the following criteria must be met in order for a hospital to be deemed to have a financial hardship:

[2] https://planning.maryland.gov/MSDC/Pages/s2_estimate.aspx

Below State Average Annual Operating Margin, Annual Regulated Operating Margin decline of more than 3 percent from one year to the next, and Annual Total Operating Margin decline of more than 1 percent from one year to the next; or 125 days cash on hand (actual or projected); or Two Consecutive Years of negative Cash Flow from Operating Activities (on the regulated entity).[3] In addition, Staff propose that the Commission create a process where the set aside is distributed through a competitive exercise that includes: applications from hospitals citing either relative efficiency performance or financial hardship and the details of their request (Hospitals in financial hardship must also submit a corrective action plan approved by their Board), a recommendation from Staff in a subsequent Commission meeting, and a formal vote from Commissioners on the hospital requests that comports with the overall value established in the set-aside.

- **Complexity and Innovation (formerly Categorical Cases):** The prior definition of categorical cases included transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spinraza cases. However, the definition, which was based on a preset list, did not keep up with emerging technologies and excluded various types of cases that represent greater complexity and innovation, such as extracorporeal membrane oxygenation cases and ventricular assist device cases. Thus, the HSCRC Staff developed an approach to provide a higher variable cost factor (100 percent for drugs and supplies, 50 percent for all other charges) to in-state, inpatient cases when a hospital exhibits dominance in an ICD-10 procedure codes and the case has a casemix index of 1.5 or higher. Staff used this approach to determine the historical average growth rate of cases deemed eligible for the complexity and innovation policy and evaluated the adequacy of funding of these cases relative to prospective adjustments provided to Johns Hopkins Hospital and University of Maryland Medical Center from RY 2017 to RY 2023. Based on this analysis, staff concluded that the historical average growth rate was 0.35 percent, which equates to a combined state impact of -0.01 percent for the RY 2025 Update Factor.

- **PAU Redistribution:** For RY 2025, Staff is proposing to continue utilizing the PAU Shared Savings program, as the policy 1) has successfully generated a 3:1 investment on the Infrastructure Funding that was put into rates to spur improvements in care management and 2) has recognized that hospitals in a fixed revenue model do not have the same opportunity to improve profitability by reducing avoidable utilization, i.e., the range in hospital revenue attributable to readmissions and avoidable admissions is large. However, Staff are concerned that the current construct of the program, which reduces inflation and population funding for readmissions and avoidable admissions in perpetuity

[3] Days cash on hand will be evaluated at a system level. As regulated entities do not routinely submit stand alone Statements of Cash Flows, applicants for the set aside will be responsible for providing a Statement of Cash Flows for the two relevant periods to the HSCRC to document negative results on the cash flow measure. Such statements need not be audited but the HSCRC will review to ensure it is consistent with audited financial information.

to generate Model savings, is potentially problematic, because it may cause access issues for hospitals with low levels of potentially avoidable utilization. Thus, Staff are proposing to discontinue the inflation and population reduction through the PAU Shared Saving Program. The PAU value for RY 2025 is -0.38 percent. The proposed refinement to this methodology in the draft recommendation was that it be revenue-neutral to the State; however, given Commissioner concerns that the policy may reward hospitals that have not improved PAU performance under the Model , staff are amending the recommendation so that rewards for individual hospitals are capped at 0.0 percent, and for this reason, the value represented on Table 2 is -0.02 percent.

- **Quality Scaling Adjustments:** The quality pay-for-performance programs include Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP) including the Disparity Gap Incentive, and Quality Based Reimbursement Program (QBR). Preliminary QBR adjustments will be implemented with the July rate orders and adjustments will be made in the January rate orders to reflect the full measurement period. The January QBR adjustments may also include changes to the preset revenue adjustment scale to reflect reduced performance standards in line with lower scores nationally, as approved in the RY 2025 final policy. The current revenue adjustments across the three programs are -0.12 percent (with preliminary QBR). The Update Factor recommendation reflects the reversal of the prior year's Quality adjustments of 0.08 percent.

- **Capital Funding and Estimated Increase for Full Rate Applications:** Preliminary modeling indicates that efficient hospitals may be entitled to approximately $40 million through the Full Rate Application Policy. This value is subject to change based on updates to commercial TCOC data that will not be available until July, as well as quality assurance reviews of the Inter-hospital Cost Comparison (ICC) methodology. Hospitals eligible for a rate enhancement through the full rate application policy in RY 2025 can access funding through a streamlined process if the hospital agrees to: the value established by the methodology (no additional methodological considerations will be contemplated); and the hospital will not file any subsequent rate request until January 1, 2026.

- **Transformation Funding:** One of the paths to success under global budgets is to find innovative solutions that avert the need for traditional hospitalization. While significant progress has been made in averting these admissions Staff believe there is an opportunity to accelerate these efforts through targeted investment in transformative solutions that may be too expensive or speculative to be funded in the normal course of business. For example, hospital-at-home approaches in rural areas could reduce cost, while also eliminating the travel burden on patients, but can’t be tested at scale and therefore require extra investment to develop a proof of concept. The Transformation Fund will provide approximately $20 M to match investments committed by hospitals or other entities to pursue these transformative ideas. The funding shall be awarded based on a competitive process to be administered by HSCRC staff as an extension of the Care Transformation

Initiative program; both Maryland hospitals and other entities, in partnership with a Maryland hospital, will be eligible. Staff shall select at most 3 proposals based on documented criteria that will include but not be limited to (1) degree of innovation and risk involved (i.e. why the approach is hard to implement in the absence of this funding), (2) speed of implementation, (3) the share of funding provided by the applicant versus requested from the State, (4) likelihood of scalability and (5) estimated long-term impact on lowering total cost of care and/or increasing quality. The impact in RY 2025 is approximately 0.09 percent; however, this funding will not be available for award before January 2025 and will be input into rates at that time. For this reason, staff are not including this line item in the calculation of calendar year 2024 growth or projections of calendar year 2024 savings.

Central Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements

In addition to the central provisions that are linked to hospital costs and performance, HSCRC staff also considered revenue offsets with a neutral impact on hospital financial statements. These include:

- **Uncompensated Care (UCC):** The proposed uncompensated care adjustment for RY 2025 will be 0.14 percent. The amount in rates was 4.35 percent in RY 2024, and the proposed amount for RY 2025 is 4.49 percent, an increase of 0.12 percent. The final statewide UCC amount is subject to some variability based on updated December annual filing submissions and UCC Fund reserve levels.
- **Deficit Assessment:** This line item is 0 percent, the Legislature approved a funding level of $294,825,000, which is the same as previous years.

Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers. These additional variables include one-time adjustments, revenue and rate compliance adjustments and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

PAU Redistribution - Updated Methodology

The PAU Savings Policy prospectively reduces hospital global budget revenues in anticipation of volume reductions due to care transformation efforts. Starting in RY 2020, the calculation of the statewide value of the PAU Savings was included in the Update Factor Recommendation; however, a PAU measurement report was presented separately to the Commission in March of 2019.

For RY 2025, the incremental amount of statewide PAU Savings reductions is determined formulaically by using inflation and the demographic adjustment applied to the amount of PAU revenue (see Table 4). This will result in a RY 2025 permanent PAU savings reduction of -0.38

percent statewide, or $77,272,272 Hospital performance on avoidable admissions per capita and 30-day readmissions, the latter of which is attributed to the index hospital, determines each hospital's share of the statewide reduction.

Table 4: PAU Shared Savings Adjustment

Statewide PAU Reduction	Formula	Value
RY 2023 Total Estimated Permanent Revenue	A	$20,539,088,163
RY 2024 Inflation Factor**	B	3.49%
CY 2022 Total Experienced PAU $	C	$2,214,105,206
RY 2024 Proposed Revenue Adjustment $	D = B*C	-$77,272,272
RY 2024 Proposed Revenue Adjustment %	E = D/A	-0.37622%
RY 2024 Adjusted Proposed Revenue Adjustment %	F = ROUND(E)	**-0.380000%**
RY 2024 Adjusted Proposed Revenue Adjustment $ *	G = F*A	**-$78,048,535**
Total PAU %	H	10.77%
Total PAU $	I = A*H	$2,213,052,684
Required Percent Reduction PAU	J = G/I	-3.53%

*Does not include revenue from McCready, or freestanding E.Ds.
** Inflation factor is subject to revisions related to updated data and Commission approval

As previously noted, Staff are proposing to continue utilizing the PAU Shared Savings program in order to recognize differential opportunities in a fixed revenue model; however, Staff are recommending that the PAU Shared Savings program should not be used to generate Model savings, as the policy has already generated a 3:1 investment on the Infrastructure Funding that was put into rates to spur improvements in care management and future reductions may cause access issues, especially for hospitals with low levels of readmissions and avoidable admissions.

Staff believe this change to the PAU policy is an important step forward but have concerns that it could potentially reduce focus on avoidable admissions. As a result, staff are recommending the following: 1) An analysis to be funded out of hospital rates of activities of current interventions to reduce PAU; 2) Establishment of a single point of executive accountability for the PAU reduction strategy; and 3) Agreement to engage in future analyses of PAU performance.

Change in Differential

In December 2022 the Commission voted, and CMMI subsequently approved, an increase of 1 percent to the public payer differential, from 7.7 percent to 8.7 percent, effective April 1, 2023, to June 30, 2024. The public payer differential will revert to 7.7 percent, effective July 1, 2024. The overall impact to hospitals will be revenue-neutral, however, hospital markups, rates, and GBRs will be adjusted to account for the updated public payer payment. The adjustments will be hospital specific, as they are based on the percentage of services attributable to public payers.

Consideration of Total Cost of Care Model Agreement Requirements & National Cost Figures

As described above, the Staff proposal increases the resources available to hospitals to account for rising inflation, population changes, and other factors, while providing adjustments for performance under quality programs. Staff's considerations regarding the TCOC Model agreement requirements are described in detail below.

Medicare Financial Test

This test requires the Model to generate $336 million in annual Medicare fee-for-service (FFS) savings in total cost of care expenditures (Parts A and B) by the end of CY 2024. The TCOC Model Medicare Savings Requirement is different from the previous All-Payer Model Medicare Savings requirement in several ways. First, as previously discussed, Maryland's Total Cost of Care Model Agreement progresses to setting savings targets based on total costs of care, which includes non-hospital cost increases, as opposed to the hospital-only requirements of the All-Payer Model. This shift ensures that spending increases outside of the hospital setting do not undermine the Medicare hospital savings resulting from Model implementation. Additionally, the change to the total cost of care focuses hospital efforts and initiatives across the spectrum of care and creates incentives for hospitals to coordinate care and to collaborate outside of their traditional sphere for better patient care.

Secondly, the All-Payer Model Savings Requirement was a *cumulative* savings test, where the savings for each year relative to the base period were summed to determine total *hospital* savings. The TCOC Model requires that the State reach an annual total cost of care savings of $408 million relative to the national growth rate by 2026, relative to a 2013 base year. Thus, there must be continued improved performance overtime to meet the 2026 TCOC Medicare Savings Requirements. In addition, the State has begun planning for the next phase of the TCOC Model. This will likely occur under CMS's new multi-state model known as AHEAD.[4] The State expects to have further savings targets beyond the $408 million under the new model and it is important that State enters these negotiations in a strong position versus current savings targets.

Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

In past years, Staff obtained calendar year growth estimates for Medicare Fee-for-Service growth from the Office of the Actuary. Staff then converted these estimates to an All-Payer value by calculating a difference statistic, to estimate that Model savings and guardrails were being met. Prior to the pandemic staff established an approach, whereby the prior year national trend was used as the stand-in to estimate national trends. However, due to the ongoing COVID-19 pandemic and the related uncertainty and volatility, Staff created an alternative approach to measure projected savings and compliance with the Total Cost of Care guardrails for RY 2023. For RY 2025 Staff are using a combination of these approaches. Scenario 3 represents the prior

[4] https://hscrc.maryland.gov/Pages/ahead-model.aspx

year trend test used prior to the pandemic; the other two scenarios are similar to those used in the more recent Update Factor recommendations.

Actual revenue resulting from RY 2025 updates affects the CY 2024 results. As a result, Staff must convert the recommended RY 2025 update to a calendar year growth estimate. Table 5 below shows the current revenue projections for CY 2024 to assist in estimating the impact of the recommended update factor together with the projected RY 2025 results. The overall increase from the bottom of this table is used in Tables 6a-6c.

Table 5: CY 2024 Global Budget Revenue Estimate

Estimated Position on Medicare Test		
Actual Revenue January - June 2023		10,280,594,777
Actual Revenue July-December 2023		10,452,399,742
Actual Revenue CY 2023		20,732,994,519
Step 1:		
Approved GBR RY 2024		21,159,064,172
Actual Revenue 7/1/23-12/31/23		10,452,399,742
Approved Revenue 1/1/24-6/30/24		10,706,664,430
Projected FY24 GBR Compliance		0
Anticipated Revenue 1/1/24-6/30/24	**A**	**10,706,664,430**
Expected Revenue Growth 1/1/24-6/30/24		**4.14%**
Step 2:		
Final Approved GBR RY 2024		21,159,064,172
Reverse All Payer Rate Reduction:		20,000,000
Final Adjusted GBR Base for RY 2025		21,179,064,172
Projected Approved GBR RY 2025		22,174,807,962
Permanent Update RY 2025		4.70%
Step 3:		
Estimated Revenue 7/1/24-12/31/24 (after 49.73% & seasonality)	**B**	**11,027,531,999**
Expected Revenue Growth 7/1/24 - 12/31/24		***5.50%***
Step 4:		
Estimated Revenue CY 2024	**A+B**	**21,734,196,430**
Increase over CY 2024 Revenue		**4.83%**
Per Capita Increase over CY 2024		**4.57%**

Steps to explain Table 5 are described as below:

The table begins with actual revenue for CY 2023.

Step 1: The table uses global revenue for RY 2024 and actual revenue for the last six months for CY 2023 to calculate the projected revenue for the first six months of CY 2024 (i.e., the last six months of RY
2024). Hospitals currently project they will be able to charge all of RY 2024 revenue, for this reason, staff have kept the projected RY 2024 compliance line at zero.

Step 2: The final approved GBR for RY 2024 is $21,159,064,172. This step applies the proposed update of 4.70 percent, as shown in Table 2, to the RY 2024 GBR amount to calculate the projected revenue for RY 2025.

Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2025 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2025

Step 4: This step shows the resulting estimated revenue for CY 2024 and then calculates the increase over actual CY 2023 Revenue. The CY 2024 increase based on this year's recommended update is 4.83 percent. The 4.83 percent is used to estimate CY 2024 hospital spending per capita for Maryland in our guardrail and savings policy, which is explained in the next section.

Staff modeled three different scenarios to project the CY 2024 guardrail position. Each scenario is described in more detail below. The one data element that is constant in each scenario is Maryland hospital growth. Because global budget revenues are a known data element, Staff applied the estimated CY 2024 growth of 4.83 percent, shown in Table 5 to Maryland hospital spending per capita from 2023. These analyses assume that Medicare growth equals All-Payer growth.

Scenario 1, shown in Table 6a, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. This takes the average trend from 2017 to 2019 and trends the data forward using 2023 as the base.

Table 6a: TCOC Estimate (Scenario 1)

Scenario 1 Guardrail Projections			
	Maryland	US	
2023	$14,058	$12,526	
2024	$14,708	$13,006	Predicted Variance
YOY Growth	4.6%	3.8%	0.8%
Estimated CY2024 Savings Run Rate			$404.6 M

Scenario 2, shown in Table 6b, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. Scenario 2 takes the average trend from 2015 - 2019 and trends the data forward using 2023 as the base. This is the most conservative estimate of the three scenarios as average national trends for that period were low. Utilizing a longer period to establish the “typical” trend results in a lower trend estimate, as the more recent 2017 to 2019 period utilized in Scenario 1 was a relatively high trend window.

Table 6b: TCOC Estimate (Scenario 2)

Scenario 2 Guardrail Projections			
	Maryland	US	
2023	$14,058	$12,526	
2024	$14,633	$12,875	Predicted Variance
YOY Growth	4.1%	2.8%	1.3%
Estimated CY 2024 Savings Run Rate			$339.0 M

Scenario 3, shown in Table 6c, utilizes Medicare fee-for-service per capita data for Maryland and the nation broken out into four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) which are then added together to calculate a total per capita estimate. Scenario 3 takes the trend from the prior period (2022-2023) and trends the data forward using 2023 as the base. This approach is consistent with the pre-pandemic approach of using the prior

year trend to guide current-year savings targets. This approach results in a slightly higher estimate of national trends and slightly larger projected savings than Scenario 2.

Table 6c: TCOC Estimate (Scenario 3)

Scenario 3 Guardrail Projections			
	Maryland	US	
2023	$14,058	$12,526	
2024	$14,888	$13,178	Predicted Variance
YOY Growth	5.9%	5.2%	0.7%
Estimated CY 2024 Savings Run Rate			$427.5 M

In addition to modeling the CY 2024 guardrail position, Staff also modeled estimated savings under each scenario; these are shown in each table above. The guardrail can not be above the Nation by 1 percent in any year or above the Nation by any percent in two consecutive years. The guardrail position in CY 2023 was below the Nation, so Maryland is not at risk of tripping the guardrail two years in a row. In addition, the estimated savings for CY 2023 is projected to be $504 million, although this amount won't be final until it is confirmed by CMS. The savings target for CY 2024 is $336 million.

In all three above scenarios, Maryland is set to achieve the savings target for CY 2024 with varying degrees of cushion. In the most conservative scenario, shown in Table 6b, estimated savings are projected to achieve $339 million in savings, which is $3 million more than the target for CY 2024. This scenario also exceeds the guardrail by 0.3 percent, because Maryland is expected to grow faster than the Nation by 1.3 percent. It is important to note that savings are closely monitored during the year and the Commission has time to take action to correct the course should a small shortfall materialize. Staff note that the projections released by OACT also suggest higher trends into 2024 nationally that would yield higher savings.

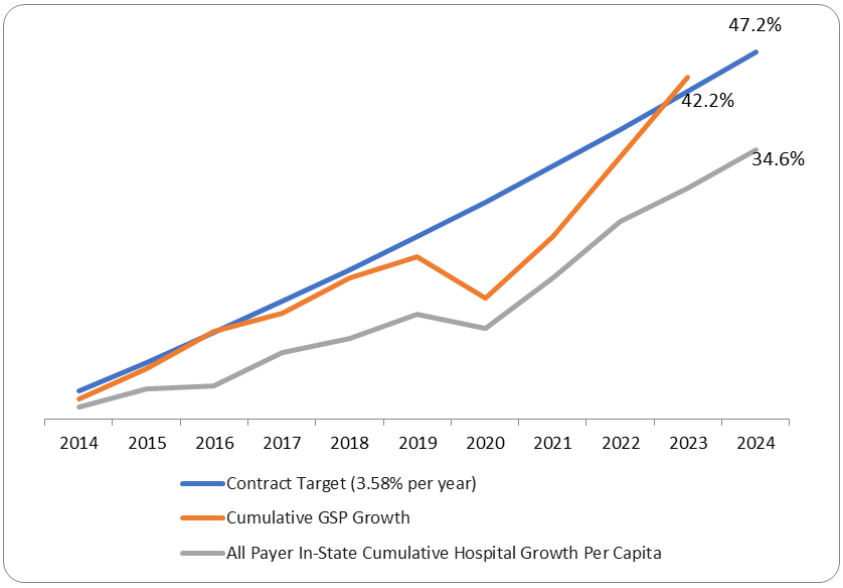
In all three scenarios presented the range in savings varies between $339.0 million to $427.5 million which is a $88.5 million dollar spread. The average of these three scenarios is $390.3 million.

All-Payer Affordability

Under the Total Cost of Care Contract all-payer test, all-payer in-state hospital charge growth cannot grow at above 3.58 percent per annum over the life of the contract (3.58 percent was intended as an approximation of typical per annum Gross State Product (GSP) growth). As shown

in Table 7 the cumulative value of this target through CY 2024 is 47.2 percent. Actual all-payer in-state hospital charge growth through CY 2024 is 29.8 percent, inflating this to 2024 using the recommended update factor on a per capita basis yields 34.6 percent. This means that Maryland is approximately 13 percentage points below this target, as seen in Figure 2. Staff also notes that all-payer in-state hospital charges are not just well below the all-payer target but also below the actual cumulative GSP growth through 2023 of 42.2 percent, which is an indication of the savings generated by the Model that accrue to all payers and consumers.

Figure 2
Affordability Scorecard – Cumulative GSP Test with CY 2024 Projection



Staff also compared the all-payer in-state hospital charges to economic growth in Maryland as measured by the GSP for the most recent 5 years. The purpose of this modeling is to ensure that healthcare remains affordable in the State, for this purpose Staff believes it is not sufficient to only look at the cumulative test embedded in the Total Cost of Care Contract. Therefore, Staff calculated the cumulative growth for five years using the most updated State GSP numbers available (CY19-CY23). The 5-year calculation shows a cumulative per capita growth of 21.8 percent. Staff then compared that number to the 5-year cumulative growth in in-state acute hospital charges using (CY20-CY24). Staff was able to estimate CY 2024 charges using the proposed RY 2024 update factor. The cumulative growth for in-state hospital charges also equated to 18.7 percent, meaning the recommended update factor would keep the cumulative in-state hospital charge less than the GSP growth over a 5-year window.

Medicare's Proposed National Rate Update for FFY 2025

CMS released its proposed rule for the Inpatient Prospective Payment System's (IPPS) payment rate on April 10, 2024. In the proposed rule, CMS would increase rates by approximately 2.60 percent which includes a market basket increase of 3.00 percent, and a productivity reduction of -0.40 percent. This proposed increase will not be finalized until August 2024 and will not go into effect until October 1, 2024. This also does not take into account volume changes, nor does it take into account projected reductions in Medicare disproportionate share hospital (DSH) payments and Medicare uncompensated care payments as well as potential reductions for additional payments for inpatient cases involving new medical technologies and Medicare Dependent Hospitals.

Stakeholder Comments

Staff worked with the Payment Models Workgroup to review and provide input on the proposed RY 2025 update. Comments generally focused on 7 areas: fund current inflation, catch up methodology, revised PAU policy, clarification of set-aside, outpatient oncology & infusion drugs, retained revenue and support inflation for Specialty Hospitals.

MHA submitted a proposal outlining the increase for its member hospitals, while CareFirst submitted a letter suggesting that an increased portion of the Update Factor should be directed to population health improvement efforts. In addition to MHA and CareFirst's letter, the following hospitals submitted comments: University of Maryland Medical System, John Hopkins Health system, Holy Cross Health, MedStar Health, Tidal Health, Adventist HealthCare, Sheppard Pratt, Mount Washington Pediatric Hospital, LifeBridge Health, Atlantic General, and Ascension St. Agnes. The request and comments outlined by MHA, CareFirst, and echoed by member hospitals are outlined below with staff's response in italics:

1. **Fund Current Inflation:**
    a. All hospitals requested that the commission fund current inflation to 3.24% reflecting data from Global Insight's First Quarter 2024 book.

HSCRC Staff Response: Staff agree to update current inflation to Global Insight's First Quarter 2024 book to reflect 3.24%. This new value will be reflected in the Final Recommendation. The update will have an effect on TCOC savings and the magnitude of any catch-up inflation value.

2. **Inflation Catch-Up Methodology:**
    a. Carefirst suggests that:
        i. There should be no additional funding provided in RY 2025 because the catch-up methodology doesn't account for prior overfunding. Hospitals have been "cumulatively overfunded by more than $1 billion above actual inflation"

ii. If any catch up inflation is provided in RY 2025, CareFirst suggests targeting additional funding to invest in reducing statewide maternal mortality rate by 50% over 5 years. In addition, CareFirst suggests providing 0.1% funding in rates paid via an assessment to MHA to create a Maternal Quality Care Collaborative. If improvements are not made over 5 years, the additional funding provided for this effort should be removed from rates.

HSCRC Staff Response: HSCRC staff agree that the catch-up methodology should account for prior overfunding and thus are amending the staff recommendation to utilize a 2014 baseline. Staff, however, do not agree with CareFirst's assessment of cumulative overfunding, as it takes into account cash reserves and fails the typical regulatory standard of making adjustments in a prospective manner. Moreover, this same approach was not taken into account when resolving the census forecasting error in the Demographic Adjustment, which would have shown significant, negative impacts to cash reserves.
Lastly, while staff appreciate CareFirst's novel proposal to address maternal mortality. This type of coordinated policy action could be supported by the proposed population health provision, which will be further vetted with a technical workgroup and other key stakeholders, most notably the Department of Health.

b. All Hospitals are in support of a catch-up methodology to address the underfunding of inflation that has occurred in RY 2022 and RY 2023. MHA and its member hospitals request that half of the 2.34% totaling 1.17% be funded in RY 2025 and the remainder be funded in RY 2026. The 2.34% is based on a 5-year cumulative growth calculation which considers RY 2020- RY2024. In addition, any correction for overfunded inflation be limited to 0.5% per year and not be applied if savings exceed the Medicare target. If adjustments exceed 0.5%, they should be spread over multiple years to ensure financial stability and predictability.
    i. Request for additional funding to address underfunded inflation in FY25. They propose targeting this funding to efficient hospitals and scaling a portion to limit growth for "Low-Efficiency Outliers". (Tidal Health)

HSCRC Staff Response: HSCRC staff believe there needs to be a catch-up methodology that can be used moving forward but disagree on the approach proposed by the MHA and its member hospitals.

a) Calculation of over/(under)funding should go back to 2014 and calculate cumulative funding through 2023. Staff do not agree that 2024 should be included in the calculation of funding since that period is not considered 'final'.
b) There must be two-sided risk and overfunding should have the same corridor as underfunding. The impact to consumers, as well as hospitals, must be considered in this methodology.
c) Any catch-up inflation will be applied to all hospitals equitably.

d) Additional inflation values still need to be considered against required savings.

3. PAU:

a) Various Commissioners expressed concern that under the new methodology, select hospitals will receive a reward, i.e., a net increase to their revenue base, and it is unclear if the hospitals have done anything to warrant such a reward.

b) Almost all hospitals are in support of adjusting the PAU savings methodology to better reflect hospitals' ability to influence their rates while funding full inflation. They also support maintaining incentives for care transformation and seek clarification on certain aspects of the staff recommendation.

i) Medstar agrees with Staff's draft recommendation that an analysis be funded out of hospital rates and activities of current interventions to reduce PAU, an establishment of a single point of executive accountability for the PAU reduction strategy, and an agreement to engage in future PAU performance analyses. They further emphasize the need for additional analyses to acknowledge that not all PAU volume is avoidable.

HSCRC Staff Response: Staff ran several analyses to see if there was a relationship between the rewards in the new PAU methodology and improvement in PAU performance over the course of the Model. While there were occurrences where hospitals have clearly demonstrated improvement and are in a position to get a reward (e.g., Garrett Regional Medical Center, MedStar St. Mary's, Chestertown Hospital), there was not a statistically significant relationship across the entire industry. Similarly, hospitals attainment performance at the start of the Model was not correlated with the current reward structure, suggesting that the proposed methodology captures both hospitals that had excellent performance at the start of the Model but have not necessarily decreased PAU (e.g., Holy Cross) and hospitals that have improved under the Model. In light of this finding, staff recommend amending the PAU Shared Savings policy to cap rewards for hospitals to 0%. In addition to a single point of accountability, hospitals would need to submit a plan for Commission approval to reduce PAU or maintain low rates of PAU.

Staff appreciates the hospital's support to amend the PAU policy and to review PAU performance over the course of the Model. If approved by the Commission, staff will utilize a portion of the set aside ($500k-$1M) to contract a vendor to support efforts to better understand and reduce PAU in Maryland.

4. Set Aside Funding:

a. Several hospitals express concerns about the estimate of set-aside funding, emphasizing the need for transparency and clear criteria for distribution.

i. Support the commission's proposal but stress the importance of developing fair criteria for accessing these funds (UMMS & LifeBridge). One hospital specifically cited concerns over using cash-on-hand to determine financial hardship, stating it can be misleading when establishing need. (LifeBridge)

ii. Suggestion to prioritize funding for “High-Efficiency Outliers” before other requests. (Tidal Health)
iii. Opposed increasing set aside funding, citing concerns about creating incentives and impacting inflation funding for all hospitals. (MedStar)

HSCRC Staff Response: Given the relatively strong support to establish criteria for distributing set aside funding, and yet no proposals for what the criteria should be (other than removal of a cash consideration), staff are putting forward the proposal from the draft recommendation with one amendment. Staff also share MedStar's concerns that increasing the set aside could crowd out potential inflation for all hospitals and could increase the likelihood of a woodwork effect, i.e., hospitals request funding purely because there is available revenue. For these reasons, staff do not believe that the funding for the set aside should be larger and again note the need for sufficient gatekeeper tests to access funding for financial hardship, similar to what is utilized in the Integrated Efficiency policy.

1) *The below criteria must be met to provide funding to hospitals with a clear financial hardship:*
    - *Below State Average Operating Margin, and Regulated Operating Margin decline of more than 3 percent, and Total Operating Margin decline of more than 1 percent*
    - *Or 125 days cash on hand*
    - *Or two consecutive years of negative Cash Flow from Operations (on the regulated entity)*

2) *The Commission will create a process where the set aside is distributed through a competitive process*
    - *Twice per year (depending on funding availability) hospitals submit applications citing either relative efficiency performance or financial hardship and the details of their revenue request*
    - *Staff provide recommendations in subsequent meeting*
    - *Commissioners vote on requests*
    - *Hospital must submit a corrective action plan approved by their Board*

5. Outpatient Oncology and Infusion Drugs:

a. Hospitals have seen a significant rise in pharmaceutical costs that exceed core inflation. There is concern about the differing treatment for Academic Medical Centers. Hospitals are requesting that there should be no distinction in inflation rates and that any substantial changes in inflation or cost increases should be thoroughly evaluated before being implemented long-term. The impact of this funding on non-academic hospital rates means that fewer hospitals are able to provide care to the community. Hospitals suggest that high-cost drug cases should be funded outside of the GBR and operated on a fee-for-service basis.

HSCRC Staff Response: The distinction in inflation rates between Academic Medical Centers and other hospitals was based on a thorough evaluation of the data. Academic medical centers

have experienced higher cost growth over recent years and the proposed differential inflation rates reflect that. It is also consistent with the guidelines established in prior years when Staff noted that differential inflation rates could be used if trends diverged between hospitals. Prior to this year the data had not indicated for this adjustment. Staff agrees that a review of the policies related to high-cost drugs would be appropriate and plans to initiate a review during FY 2025.

6. **Retained Revenue:**
    a. During the presentation of the Draft Recommendation of the Update Factor, Commissioners raised concerns regarding the funding of inflation on retained revenue. It was suggested that inflation should only be funded on the portion of revenue not related to retained revenue or scaled to accommodate retained revenue at the hospital.

HSCRC Staff Response: Staff disagree with this idea. The GBR rewards hospitals by allowing them to retain revenue as volumes decline (at 50% VCF). This incentive is fundamental to the Model to ensure that there is funding available in hospitals to invest in population health, physicians and other opportunities that will improve total cost of care in their service areas. The side effect of too much retained revenue is that a hospital may operate inefficiently, which is why the Integrated Efficiency Policy was created and approved by the Commission in April of 2021. This policy is the mechanism by which retained revenue should be addressed and have that revenue removed from the system. Removing retained revenue from all hospitals rather than just outliers, as currently outlined in the policy may disincentivize hospitals to manage total cost of care and invest in their service area.

7. **Non-GBR Hospitals:**
    a. Non-GBR hospitals should receive full inflation and an additional adjustment for underfunded inflation in FY 2025, equivalent to GBR hospitals. As downstream providers with low volumes still below CY 2019 levels, they struggle to maintain positive margins and required staffing.

HSCRC Staff Response: HSCRC Staff agree to include the catch-up inflation value of 1.00 percent in the Final Recommendation. Volumes remain low compared to 2019 at the specialty hospitals, but demand remains high. Specialty hospitals experience the same inflationary pressures as acute hospitals. The cost pressures, specifically, specialized staffing needs make it difficult for these hospitals to fill vacancies and as a result are these hospitals utilizing agency staffing in higher levels. These hospitals represent an important component of the overall delivery system in Maryland and ensuring continued access to these services is crucial.

In addition to the 7 general comment areas, concerns were raised pertaining to Population Health Considerations. Commissioners expressed concerns that reducing the system-wide inflation reduction for PAU would reduce the incentive for hospitals to improve or sustain efforts to reduce PAU. CareFirst also indicated that an increased portion of the Update Factor should be directed to population health improvement efforts. As such, staff are considering a withhold of 0.19% of the

Update Factor (equivalent to half of the proposed modification to the PAU reduction), which would be released to each hospital in the January rate orders once the following conditions are met:

1. A plan, subject to Commission approval, for population health improvement aligned with statewide priorities.
2. The withhold will be evaluated in future years if there is not demonstrated improvement in the proposed initiative.

Recommendations

Based on the currently available data and the Staff's analyses to date, the HSCRC Staff provides the following final recommendations for the RY 2025 update factors.

For Global Revenues:

(a) Provide all hospitals with gross inflation increase of 3.24 percent, with an additional 1.00 percent for additional revenue support based on historic underfunding of inflation.

(b) Provide an overall increase of 4.80 percent for revenue (including a net increase to uncompensated care) and 4.53 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of the revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

(c) Adoption of a catch-up inflation methodology to use in RY 26 and beyond. This methodology, outlined in this report, would include: two-sided risk to ensure hospitals and consumers are equally considered, a 1.00 percent risk corridor to ensure that inflation reconciliations are only performed when there are material variances, and recognition that all additional inflation values will be considered against required savings.

(d) Establishment of criteria for distribution of set-aside funding. Staff propose the following criteria must be met to provide funding to hospitals with a clear financial hardship: Below State Average Annual Operating Margin, Annual Regulated Operating Margin decline of more than 3 percent, and Annual Total Operating Margin decline of more than 1 percent; or 125 days cash on hand (actual or projected); or Two Consecutive Years of negative Cash Flow from Operations (on the regulated entity). The Commission will create a process where the set aside will be distributed through a competitive exercise and require a corrective action plan for improved financial operations.

(e) Amend the PAU Shared Savings policy so that statewide impact is equal to -0.02 percent and then cap rewards for hospitals to 0.0 percent. To ensure there is no backsliding in statewide performance, an analysis will be funded out of hospital rates to

assess current interventions to reduce PAU, each hospital will have to establish a single point of executive accountability for their PAU reduction strategy, and all hospitals must agree to engage in future PAU performance analyses.

(f) To ensure continued focus on population health within the State and ensure Hospitals are fully engaged in population health efforts, Hospitals will be required to submit a population health improvement plan. The plan should, at a minimum, (1) identify at least 3 conditions driving avoidable utilization, readmissions, and/or cost within their hospital, (2) describe programs, initiatives, and interventions intended to addressing the conditions identified; (3) specify participation in statewide efforts to address core population health goals, such as reducing maternal mortality and overdose; (4) provide performance improvement indicators and outcomes for the identified conditions and programs, including, as appropriate, measures related to equity.

Staff will convene a workgroup to refine this approach. Failure to submit a population health plan that successfully addresses the conditions outlined above and discussed in the workgroup, will result in a takeback of 0.19 percent of inflation removed in the January rate updates.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

(a) Provide an overall update of 3.24 percent for inflation, with an additional 1.0 percent for additional revenue support based on cumulative underfunding of inflation since 2014.

(b) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing.

As a result of action taken by the Commission at its public meeting of June 14, 2024, the Commission approved this Staff Final Recommendation.

Comment Letters

Letters were received from:

- Maryland Hospital Association (MHA)
- University of Maryland Medical Systems
- LifeBridge Health
- Tidal Health
- Ascension Saint Agnes
- Sheppard Pratt
- Mount Washington Pediatrics
- Atlantic General
- MedStar Health
- CareFirst
- Adventist Healthcare
- Holy Cross Health
- Johns Hopkins Health System

Maryland
Hospital Association

May 15, 2024

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) staff recommendation regarding the annual update factor. MHA welcomes the opportunity to comment on this important issue and is committed to working collaboratively with Commissioners and staff to develop the final recommendation in June.

MHA and its members appreciate the time, effort, and partnership of the HSCRC staff as the draft recommendation was developed and staff's recognition of the significant financial pressures Maryland hospitals face. After reviewing the staff recommendation, MHA proposes the following for the final recommendation in June.

- **Fund current inflation.** MHA respectfully requests the staff recommendation to fund current inflation at 3.15% be updated to 3.24%, reflecting data from Global Insight's First Quarter 2024 book.

- **Provide half of historic underfunded inflation (2.34%) in rate year (RY) 2025 and the other half in RY 2026.** MHA recognizes that it is not possible to include the full amount of underfunded inflation in a single update and remain within the Total Cost of Care (TCOC) Model savings target. Therefore, MHA respectfully requests HSCRC include an additional 1.17% in the update factor for RY 2025 to reflect half of the historic underfunding of inflation over the past several years, with a commitment to restore the remainder in RY 2026.

- **Provide the same rate increase for underfunded inflation to the specialty hospitals.** MHA respectfully requests specialty hospitals also receive a rate increase in recognition of underfunded inflation.

- **Overfunding of inflation correction.** MHA appreciates the HSCRC staff's willingness to consider establishing a policy to correct for years when inflation is overestimated but respectfully requests that any correction in any given year be limited to .5% and that it not be applied if there are savings over the Medicare savings target. If the methodology to correct for overfunded inflation requires an adjustment in excess of .5%, an adjustment

- should be spread out over multiple years to enable stability and predictability for hospital financial operations and planning.

- **Set aside funding for unforeseen adjustments.** MHA respectfully disagrees with the estimate of set-aside funding available for hospital-specific rate adjustments and would encourage HSCRC to provide additional information on the process to determine current and future requests from hospitals.

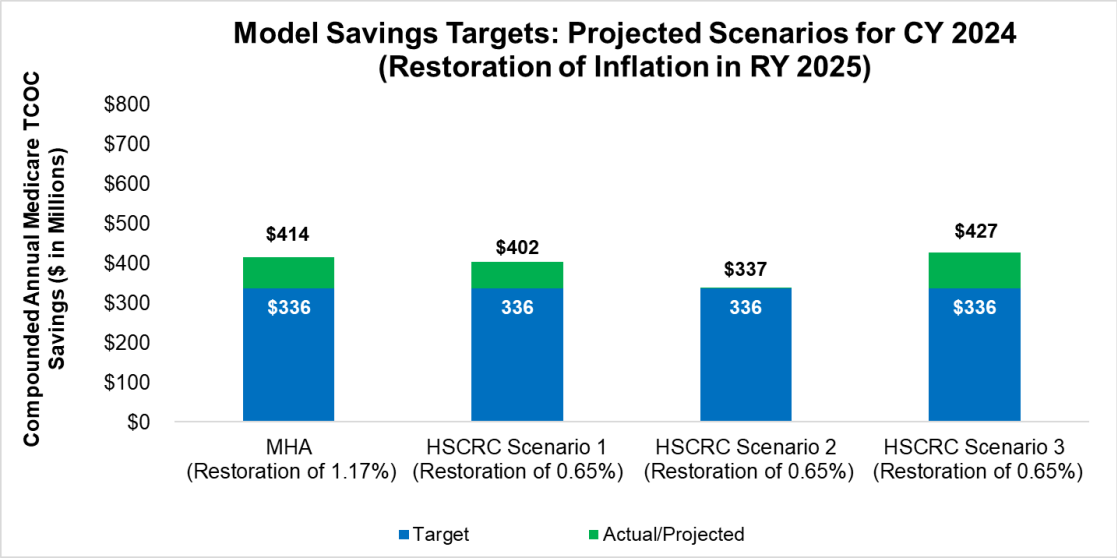
- **Potentially Avoidable Utilization (PAU) policy change.** MHA concurs with the staff recommendation to modify the current PAU shared savings adjustment but requests additional clarity on key provisions.

Additional Update Factor Due to Historic Unfunded Inflation

In developing estimates for a range of potential update factors, HSCRC staff modeled a series of scenarios based on historic and/or current trends. Although the majority of these scenarios demonstrate HSCRC could provide a more robust update factor, HSCRC staff decided to err on the side of the most conservative estimates to ensure Maryland met its obligations under the TCOC Model to achieve $336 million in savings by the end of calendar year (CY) 2024.

While MHA understands the desire to be more conservative, MHA believes a .65% increase for historic underfunding of inflation as currently recommended is significantly below what is warranted by the current savings target estimates and does not recognize the historic TCOC Model excess savings. Figure 1 below compares the savings estimates as prepared by HSCRC staff, including the assumptions for each.

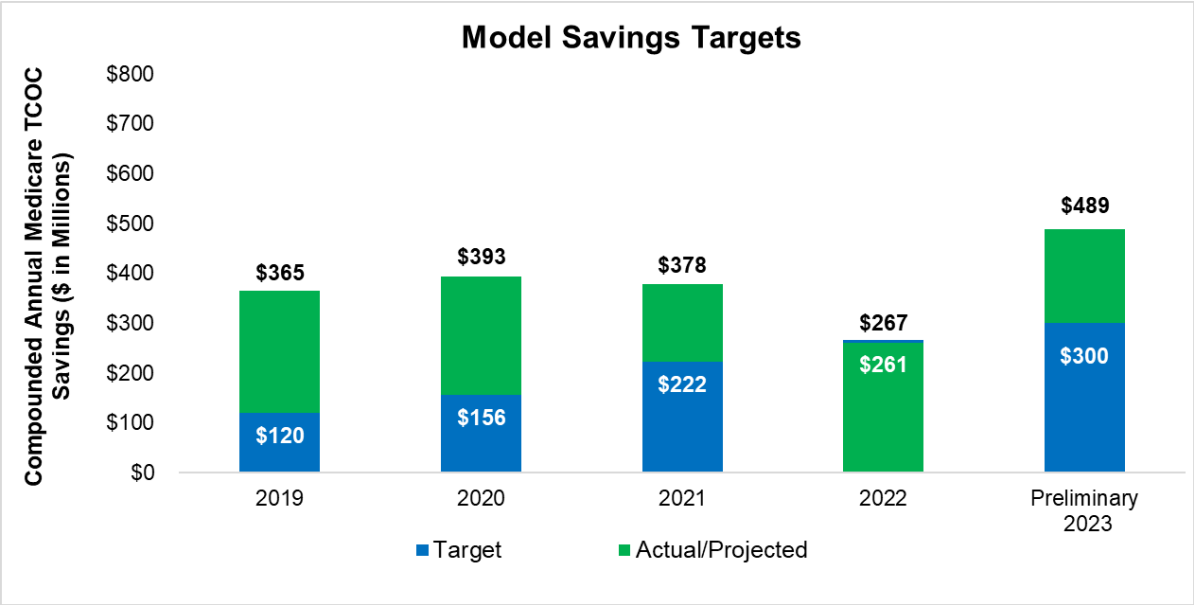
Figure 1: HSCRC Staff Savings Estimates Scenarios



Using Scenario 2 as the recommendation's basis does not reflect the dramatic change that has occurred since the COVID-19 pandemic. Staff acknowledges this in the recommendation, remarking that using 2015-2019 as the historic trend to determine the current one is "the most conservative estimate of the three scenarios as average national trends for that period were low." Staff also acknowledges this differs from the "pre-pandemic approach of using the prior year trend to guide current-year savings targets." Scenario 3 strikes the appropriate balance between using more recent data, consistent with prior practice, while still achieving significant savings.

Relying on overly conservative estimates continues a trend that resulted in significant excess savings year over year. Figure 2 below demonstrates that over the past several years, the TCOC Model generated a cumulative excess savings of over $500 million.

Figure 2: Annual Savings Generated by the TCOC Model, 2019-2023



These excess savings have accrued to the benefit of the governmental and commercial payers, artificially and unnecessarily limiting investments that could have been made by the hospitals in population health programs, innovative clinical treatments, or routine capital improvements.

Unlike the significant benefits that payers realized due to these excess savings, hospitals remained at risk for any projected or actual underperformance in meeting the annual savings target. As recently as 2022, hospitals were subject to a system correction factor due to concerns that Maryland would miss the savings target and trigger a corrective action plan from the Centers for Medicare & Medicaid Services Innovation Center. These concerns later proved to be unfounded, and HSCRC, to its credit, rescinded the rate reductions implemented as part of the system correction factor.

This episode, however, highlights the one-sided nature of the current TCOC Model where hospitals are financially penalized for Model underperformance yet are not financially rewarded for overperformance. This is the opposite dynamic for payers as they are protected on the downside yet receive a financial windfall on the upside. HSCRC's goal should be to provide sufficient funding for hospitals to invest in new services and reinvest in existing ones by hewing as close to the annual savings target as possible and not creating savings well over what is contractually required.

Additional Inflation for Specialty Hospitals

The current staff recommendation provides full inflation, which is currently 3.15% and is expected to be 3.24% based on the data from Global Insight's First Quarter 2024 book, for specialty hospitals, in line with what is being provided to acute care hospitals. The recommendation, however, does not extend the additional underfunding of inflation to the specialty hospitals. MHA firmly supports the restoration of underfunded inflation to both the acute care and specialty hospitals as the specialty hospitals have experienced the same challenges with increased labor expenses, supply chain issues, and other inflationary pressures negatively impacting their financial performance. MHA also believes treating specialty hospitals the same, particularly psychiatric hospitals, is consistent with the spirit and intent of the Mental Health Parity and Addiction Equity Act.

Overfunding Inflation Correction Corridor

MHA agrees in establishing a consistent policy to address over and underfunding of inflation on a go-forward basis. MHA recommends, however, that a correction for overinflation not be applied if the state is meeting the TCOC Model targets. This is consistent with the field's position that HSCRC should endeavor to remain as close to the target as possible each year without over generating savings. It is critical to maintain stable hospital finances and not cause dramatic swings in revenue, particularly based on retrospective data, therefore MHA respectfully recommends the following elements to the proposed policy:

- Any correction for overinflation be limited to .5% in a given year. Any correction for overinflation that is warranted under the methodology proposed by HSCRC staff that would exceed .5% should be spread out over multiple years to provide stability and predictability in hospital financial operations and planning.

- A multi-year trend be utilized to estimate any inflation correction to smooth the potential volatility over time. This is consistent with MHA's position on the RY 2025 update factor in only requesting that half of underfunded inflation be funded this year, with the other half being included in RY 2026.

- Consider adopting a policy for future rate years that avoids annual adjustments for over and underfunding inflation and, instead, adjusts on a two or three-year interval. Hospitals

would benefit from avoiding a whipsaw effect that could result in instability of financial operations and planning.

Set-Aside Funding for Unforeseen Adjustments

Consistent with previous years' recommendations on the update factor, staff included $30 million as a set aside for unforeseen adjustments to hospital-specific global budgets. It is unclear how this estimate was determined, and MHA believes it underestimates the funding that is potentially available to address individual issues hospitals present for HSCRC's consideration.

At the May meeting, HSCRC staff presented the latest Medicare savings estimates for CY 2023—now estimated to be about $473 million with some non-claims adjustments still to be made—indicating $173 million in excess savings beyond the CY 2023 target. While MHA recognizes the savings will be reduced based on CY 2024 activity, including the RY 2025 update factor, it is likely there will still be significant savings beyond the $336 million CY 2024 requirement based on HSCRC's shared savings model estimates. MHA believes any savings beyond the contractually required savings target should not only be available for correcting historic underfunding of inflation, but also be potentially available for appropriate adjustments to hospital global budgets.

MHA encourages HSCRC to develop a process to review these letters objectively, transparently, and expeditiously, providing a forum for hospitals to engage with the staff and Commissioners and an opportunity for fair consideration of the issues raised.

PAU Shared Savings Policy Change

MHA appreciates HSCRC staff's willingness to reconsider the design of the PAU Shared Savings policy and agrees that ongoing PAU reductions can have the unintended consequence of limiting patient access. Although supportive of the staff recommendation, MHA requests additional information on the following components:

- "An analysis to be funded out of hospital rates of activities of current interventions to reduce PAU
- Establishment of a single point of executive accountability for the PAU reduction strategy
- Agreement to engage in future analyses of PAU performance"

MHA welcomes the opportunity to work together to further define and develop these additional aspects of the recommendation.

Conclusion

MHA is sincerely appreciative of the thoughtful approach the HSCRC staff took to develop the recommendation for the annual update factor and respectfully requests that additional

consideration be given to restoring half of the underfunded inflation this year with a commitment to include the remaining amount in the RY 2026 update.

Thank you for the chance to comment on this critical issue. If you have any questions, please do not hesitate to contact me.

Sincerely,

Melony G. Griffith
President & CEO

cc: Joshua Sharfstein, M.D., Chair
Joseph Antos, Ph.D., Vice Chair
James Elliott, M.D.
Ricardo R. Johnson
Maulik Joshi, DrPH
Adam Kane
Nicki McCann, JD

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

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

CORPORATE OFFICE

May 15, 2024

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

RE: UMMS Comment Letter on Draft Staff Recommendation for the FY 2025 Update Factor

Dear Jon:

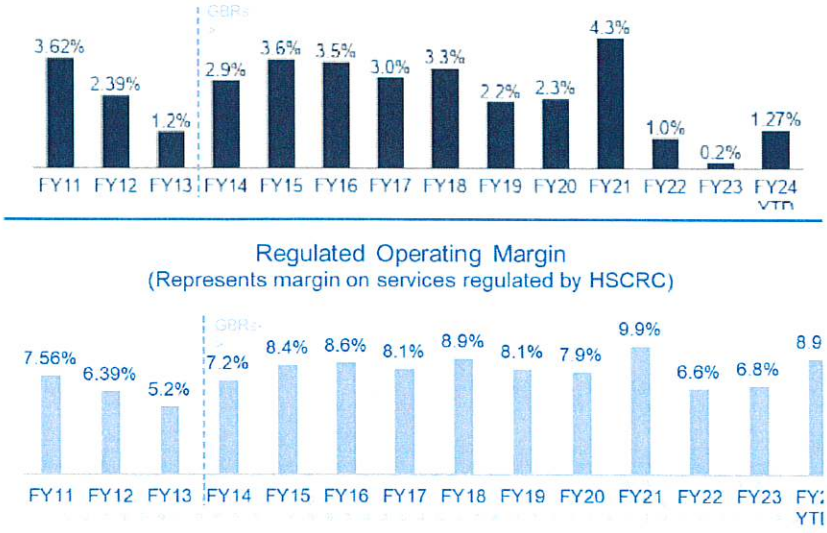
On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, we are submitting comments in response to the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Update Factor for Rate Year 2025.

We appreciate the time spent by Commission Staff in developing and vetting this proposal with the industry. We would like to address specific adjustments proposed in the balanced Update and offer our support of the points outlined in MHA's comment letter.

Industry Effects of Underfunding Inflation

The continuing pressures of actual inflation, coupled with the underfunding of inflation in hospital revenues, has caused a significant plunge in hospital margins. Regulated margins fell from 9.90% in FY 2021 to 8.9% through YTD December 2024. Total operating margins during that time declined to a loss of

1.27%, up slightly from the average of 0.6% over the two years prior as shown in the chart below.



These low margins have required all hospitals, including UMMS, to make very difficult decisions and implement significant cost cutting measures to maintain operating solvency. UMMS is also deferring programmatic investments, replacement of capital and equipment, and spending initiatives for innovative patient care delivery. Despite performance improvement initiatives and deferred spending, UMMS is projecting an FY 2024 operating margin significantly lower than targeted margins needed to fund capital. This trend is continuing into our FY 2025 operating budget.

Model Considerations and Projections

Commission staff have put forward four different projection models, as they have done each year when determining the appropriate update factor. Historically, commission staff have argued that all four models, ranging in their levels of conservatism, must meet the required savings target. This approach has yielded nearly $200M in excess savings from 2019 through 2021. UMMS contends that this approach is overly conservative and should be adjusted determining the affordability of the update factor. UMMS acknowledges that the need to achieve the agreed upon savings target is of paramount concern, but the industry cannot afford to continue to receive lower that necessary inflation adjustments and operate with razor thin margins due to ongoing forecast errors.

UMMS Position on the FY2025 Update Factor Proposal

UMMS would propose an update factor that recognizes both realities of Total Cost of Care Model performance and ongoing hospital cost pressures.

1. IHS has recently updated the inflation forecast to 3.24%, up from the prior quarter's estimate of 3.15%. UMMS believes this should be the starting point of any update factor calculations as to avoid adding to the state's unfunded inflation problem.
2. We ask that the Commission consider that not all forecasts for expected fee-for-service Medicare per beneficiary growth need to achieve the targeted savings, only those that are most likely scenarios. Ensuring that the most unlikely scenarios also meet the model test is part of the reason we have underfunded inflation for the past several years.
3. We request that hospitals get some relief from the underestimate of inflation. We agree with MHA's request that the HSCRC provide hospitals with half of the inflation underfunding or 1.17%. Additionally, we feel the remaining 1.17% should be restored in FY 2026 rates.
4. We support MHA's position to change the inflation correction corridor to 0.5% and to consider the model performance in adjusting for over or underfunding of inflation. We also agree that should the model performance be favorable, over-funding should not be required to be repaid.
5. We support and appreciate the commission staff's proposal to adjust the PAU savings methodology. This revised methodology more appropriately adjusts for the variation in a hospital's ability to influence their hospital specific PAU rates while funding full inflation, allowing for hospitals to continue to fund necessary programs that support access for patients with chronic conditions.
6. We support the commission staff's proposal to provide a set aside for hardship fund that is open to all hospitals. UMMS agreed with MHAs position that it is necessary for the commission to work with the industry to develop the criteria for accessing these funds.
7. We fully support both the differential drug cost inflation and establishment of a special drug tier in the CDS-A policy that would provide full cost funding for specific drugs.
8. We ask that specialty hospitals be provided full inflation and the same 1.17% additional unfunded inflation in rates for FY 2025. While it is true these hospitals are volume variable, many facilities are downstream providers for acute hospital volume, which is still below CY 2019 levels. Until acute volume recovers, these hospitals will continue to struggle to achieve positive margins with required staffing levels.

Summary

This proposal offers a realistic structure to help cover cost pressures and allow hospitals to begin re-investing in their facilities while balancing the State's commitments to expected performance under the Model. Creating excess savings based upon underfunding hospital cost inflation is not a tenable way to continue the model. As we look forward to the AHEAD model, it seems reasonably appropriate to re-evaluate the way in which we are funding hospital inflation to ensure a more balanced approach. We appreciate your consideration of this proposal. Please contact me if you have any questions.

Sincerely,

Mohan Suntha, MD, MBA
President and Chief Executive Officer
University of Maryland Medical System

cc: Dr. Joshua Sharfstein, Chairman
Joseph Antos, PhD, Vice Chairman
James Elliott, M.D.
Nicki McCann, JD
Maulik Joshi, DrPH
Ricardo R. Johnson
Adam Kane
Allan Pack, Principal Deputy Director
Jerry Schmith, Principal Deputy Director
Joe Hoffman, UMMS, Interim CFO
Alicia Cunningham, UMMS, SVP

LIFEBRIDGE HEALTH

May 15, 2024

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

Dear Jon,

The hospitals collectively continue to operate in a challenging environment with respect to volume and labor demands, escalating inflationary pressures on supplies and pharmaceuticals and need to keep-up with required capital investments, resulting in on-going pressure to operating margin performance. While work continues on the Update Factor, we did want to acknowledge our appreciation of the Staff's consideration for both prior year underfunded inflation and the change in the Potentially Avoidable Utilization (PAU) shared Savings adjustment within this year's recommendation.

At the same time, we wanted to also voice our concern regarding requirements being considered of unique hospital requests as part of the "Set Aside", specifically the criteria of financial hardship to include a liquidity measure of less than 125 days cash-on-hand. Cash is not accounted for in a standardized manner throughout Maryland's hospitals. Some Systems record cash within a Parent entity or academic structure as opposed to an individual hospital. In addition, within Systems that maintain comprehensive continuum- of- care providers that include unregulated services, the ability to distinguish a hospital's cash related to regulated services becomes difficult. Lastly, philanthropy efforts could be mitigated if donors are understanding that contributions may influence regulatory outcomes and a hospital's ability to actively work with the HSCRC. We are ultimately understanding of a hospital's burden-of-proof for establishing a one-time rate relief request but believe an overall cash threshold can be misleading in establishing need.

As always, we respect the work of the Commission as it establishes an annual revenue increase while balancing all other elements of Maryland's unique reimbursement model.

Sincerely,

David Krajewski
Executive Vice President and Chief Financial Officer, LifeBridge Health
President, LifeBridge Health Partners

TidalHealth™

Peninsula Regional

100 East Carroll Street
Salisbury, MD 21801

(410) 546-6400

May 14, 2024

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

Dear Jon:

TidalHealth appreciates the opportunity to comment on the Health Services Cost Review Commission's ("HSCRC") draft staff recommendation for the Fiscal Year 2025 Update Factor. The HSCRC has the important duty to consider changes to the staff recommendation to fully account for inflation underfunding as well as **to provide additional funding/enhancements for efficient Hospitals**. Both are critically important, and we hope you will strongly consider the following changes to the draft staff recommendation:

(1) Inflation

We support MHA's request to provide additional funding to the industry to account for underfunded inflation. We believe, given the substantial impact of the underfunding over the last couple of years, that full underfunding should be provided in fiscal year 2025. **We believe a portion of this additional inflation funding should be targeted to support efficient hospitals.** We continue to strongly support scaling a portion of the update to limit the continued growth for hospitals that HSCRC considers as "Low-Efficiency Outliers."

(2) Outpatient Oncology and Infusion Drugs

A significant portion of total expenses relates to pharmaceutical costs. We have seen significant increases that are way above core inflation. We are concerned with this carve out treatment for Academic Medical Centers. We request that there not be a differential in inflation and that additional evaluation of inflation/cost increases be performed before a significant change is made that will carry well into the future. If we are starting to scale inflation, even if just for Oncology and Infusion drugs, we should consider scaling the overall update based on a hospital's efficiency. Carving out a portion of hospital business and not linking it to any type of efficiency is not equitable and redistributes money from community hospitals to Academic Medical Centers.

(3) Low Efficiency Outliers and Set Aside for Unforeseen Adjustments

We believe that we need to utilize and enhance current policy to determine who receives additional funding. The Integrated Efficiency Policy should be the basis to determine GBR enhancements and the hospitals that are "High-Efficiency Outliers" should have priority access to funding before other requests are considered.

As we have stated in the past, our recommendations continue to be guided by a strong belief that there is inherent inequity within the Maryland model. While we respect the original guiding principles of the model allowing hospitals to retain revenue in the case of successful population health efforts, on-going cumulative dollars embedded in hospital costs and charges to consumers has caused major inequities and does not provide funding that moves forward access and equity to the communities we serve.

Thank you, again, for the opportunity to comment, and I am available should you have any questions.

Sincerely,

Stephanie Gary
Vice President and Chief Financial Officer

cc: Dr. Joshua Sharfstein, Chair, HSCRC
Dr. Joseph Antos, Vice Chair, HSCRC
Dr. James Elliott, Commissioner, HSCRC
Ricardo Johnson, Commissioner, HSCRC
Dr. Maulik Joshi, Commissioner, HSCRC
Adam Kane, Commissioner, HSCRC
Nicki McCann, Commissioner, HSCRC
Melony G. Griffith, Chief Executive Officer, MHA
Steven Leonard, Chief Executive Officer, TidalHealth

Ascension
Saint Agnes

May 15, 2024

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

Dear Dr. Kromm,

On behalf of Ascension Saint Agnes (ASA), I am writing today to provide comments on the Health Services Cost Review Commission's (HSCRC) staff recommendation for the Fiscal Year (FY) 2025 annual payment update. I appreciate the time that you and your staff dedicated to the thoughtful analysis and recommendations.

ASA, like our peers around the state, continues to experience the inflationary pressures of the COVID pandemic that fundamentally reset our expense base. Coupled with the underfunding of actual inflation, these twin pressures have resulted in significant challenges as we seek to invest in clinical programs, expand ambulatory access, and implement needed infrastructure upgrades.

While ASA recognizes and appreciates the staff's recommendation to partially restore some of the underfunded inflation, there is still significant savings in excess of the Model savings target that could be available to hospitals to allow for needed investments. Based on information shared at the May Commission meeting, the HSCRC could provide additional inflation beyond the 0.65% and still be well within the range to achieve the savings target for Calendar Year 2024. Given the financial position of Maryland's hospitals, and the recognition that they have been underfunded over the past several years, ASA would encourage the staff to increase the inflation funding available in the final recommendation in June.

Overall, ASA supports the position of the Maryland Hospital Association for the FY 2025 update as outlined below:

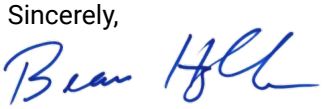
- **Fund base inflation of 3.15%**
- **Restore half of underfunded inflation (1.17%)** with a commitment to fund the other half in the FY 2026 annual payment update
- **Limit the inflation correction factor to 0.5%** and only apply it if the state is not meeting the Medicare savings target

Ascension Saint Agnes
900 S. Caton Avenue
Baltimore, MD 21229
667-234-3162

- **Revise the Potentially Avoidable Utilization (PAU) policy** in recognition of the significant savings that have been generated since the inception of the Model.

Thank you again for the opportunity to comment.

Sincerely,



Beau Higginbotham
President & CEO

cc: Dr. Josh Sharfstein, Chairman
Dr. Joseph Antos, Vice Chairman
Dr. James Elliott
Dr. Maulik Joshi
Ricardo Johnson
Adam Kane
Nicki McCann

Sheppard Pratt

May 2, 2024

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

Dear Mr. Kromm:

In its draft recommendation for the proposed update factor for RY2025, the HSCRC staff has recommended an update factor for the Global Budget Revenue (GBR) hospitals along with a different, lower update factor for the non-GBR hospitals in the State. For RY 2025, HSCRC staff is proposing an update of 3.15% per capita for non-global revenues without additional inflation support. This letter, written on behalf of Sheppard Pratt, requests that the HSCRC provide an update factor to the non-Global Budget Hospitals of 4.32% to cover underfunded inflation.

Hospitals under Global Budget Revenues are under the HSCRC's full rate-setting authority, and the Commission sets rates for all payers. For specialty hospitals not covered under the waiver, the HSCRC sets the rates paid by non-governmental payers and purchasers. Where CMS has not waived Medicare's rate-setting authority to Maryland, Medicare does not pay based on those rates. Medicaid also does not pay regulated rates. Hospitals falling in this category include freestanding psychiatric hospitals and Mount Washington Pediatric Hospital.

In the staff recommendation for the non-GBR hospital update factor, the HSCRC staff proposes suspending the productivity adjustment to the inflation update but does not include additional inflation support. The proposal is summarized in the table below, from the staff proposal.

	Psych & Mt. Washington
Proposed Base Update (Gross Inflation)	3.15%
Productivity Adjustment	SUSPENDED
Additional Inflation Support	N/A
Proposed Inflation Update	3.15%

The Commission began providing lower update factors to the non-waiver hospitals with the FY2013 update factor. At that time, the Commission decided to reduce the update factor with a productivity adjustment of 0.5 percentage points below the market basket of 2.59%, leaving an update of 2.09%. While there was no stated justification beyond the imposition of a productivity

Sheppard Pratt

factor, the apparent implication was that the non-waiver hospitals were not constrained by the terms of the waiver and in later years by the incentives of the Global Budget Revenue model.

These negative adjustments continued through FY2020, and the cumulative effect of these diminished updates are substantial. From FY2013 through FY2020, the cumulative effect of these reductions is >6% of the revenue base, based on the quantity of services provided in FY2013 as the base year. The productivity factor is put into place with the presumption that providers will drive volume growth to improve margins. HSCRC has recognized in recent years that this limits providers ability to maintain access to services and has suspended the productivity adjustments which has allowed Sheppard Pratt to not lose additional ground on reimbursement.

In rate year FY25, the exclusion of the specialty hospitals from the underfunded inflation adjustment is especially concerning. Demand for psychiatric services has never been higher and Sheppard Pratt provides services that are unique in the market to an underserved, chronically acute population. Sheppard Pratt has experienced rising cost pressures over the past several years like the other Maryland hospitals and health systems. In many ways, Sheppard Pratt is less equipped than other health systems to manage the same cost pressures due to lower reimbursement for behavioral health services and receiving reduced reimbursement from our largest payers, Medicaid and Medicare. Labor and benefit costs drive the greatest expense increases, and the broader workforce environment leaves Sheppard Pratt with higher position vacancies and dependent on higher levels of agency staffing than ever before. This has limited capacity of services in recent years. Sheppard Pratt remains focused on maintaining services and staffing levels that support the broader community, including the acute care hospital systems in Maryland. Providing rate updates to Sheppard Pratt that are below the GBR hospitals creates a reimbursement parity issue that will be compounded over time, and which is not in alignment with the state's focus on creating access to behavioral health services.

We respectfully request that the Commission provide the non-GBR hospitals an update factor equivalent to the GBR hospitals. We appreciate your consideration of our request. Please contact me if you have any questions.

Sincerely,

Kelly Savoca
Senior Vice President and Chief Financial Officer

Mt. Washington Pediatric Hospital
Where Children Go to Heal and Grow
Est. 1922
An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

May 15, 2024

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

RE: UMMS Comment Letter on Draft Staff Recommendation for the FY 2025 Update Factor

Dear Mr. Kromm,
On behalf of Mt. Washington Pediatric Hospital, I am submitting comments in response to the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Update Factor for Rate Year 2025.

The current HSCRC recommendation provides an update factor of 3.15% for Mt. Washington Pediatric and the other specialty hospitals, but none of the additional inflation support that the global revenue hospitals are to receive.

I am writing to ask that Mt. Washington be provided full inflation and the 1.17% additional unfunded inflation in rates for FY 2025. While it is true the hospital is volume variable, it is a downstream provider for acute hospital volume, which is still below CY 2019 levels. Until acute volume recovers, Mt. Washington will continue to struggle to achieve positive margins while maintaining required staffing levels.

At the same time, Mt. Washington is subject to the same inflationary pressures as the global revenue hospitals, for labor and for other resources.

For these reasons, we request that Mt. Washington Pediatric Hospital receive the same additional inflation support as the global revenue hospitals.

Mt. Washington Pediatric Hospital
Where Children Go to Heal and Grow
Est. 1922
An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

I appreciate your consideration of this proposal. Please contact me if you have any questions.

Sincerely,

Scott Klein, MD, President and CEO
Mt. Washington Pediatric Hospital

Cc: cc: Dr. Joshua Sharfstein, Chairman
Joseph Antos, PhD, Vice Chairman
James Elliott, M.D.
Nicki McCann, JD
Maulik Joshi, DrPH
Ricardo R. Johnson
Adam Kane
Allan Pack, Principal Deputy Director
Jerry Schmith, Principal Deputy Director
Joe Hoffman, UMMS, Interim CFO
Alicia Cunningham, UMMS, SVP

ATLANTIC
GENERAL HOSPITAL
care.givers

May 15, 2024

Sent via email

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

Dear Dr. Kromm,

On behalf of Atlantic General Hospital (AGH), I am writing to provide comments on the recommendation by the staff of the Health Services Cost Review Commission (HSCRC) for the Fiscal Year (FY) 2025 annual payment update. AGH appreciates the thoughtful approach that the staff have taken in developing the recommendation.

These continue to be challenging times for Maryland's hospitals financially as we recover from the pandemic. Increases in staffing and other expenses have fundamentally changed the financials of operating a hospital, with limited ability to generate additional revenue to compensate for these changes. As an independent community hospital serving the lower Eastern Shore, AGH is disproportionately impacted by these changes unlike some of our larger health system peers. The recognition of these challenges by the HSCRC in providing a sufficient FY 2025 update is critical to maintaining a financially viable organization that is able to reinvest in clinical services for the community.

AGH supports the position of the Maryland Hospital Association for the FY 2025 update as outlined below:

- **Fund base inflation of 3.15%**
- **Restore half of underfunded inflation (1.17%)** with a commitment to fund the other half in the FY 2026 annual payment update
- **Limit the inflation correction factor to .5%** and only apply it if the state is not meeting the Medicare savings target
- **Revise the Potentially Avoidable Utilization (PAU) policy** in recognition of the significant savings that have been generated since the inception of the Model.

In addition to supporting MHA's position, Atlantic General Hospital would also encourage the HSCRC to allow hospitals who qualify for rate relief under a Full Rate Application and who are willing to take the formulaic answer to be permitted to have an expedited review process similar to what occurred last year. The expedited process eliminated the administrative burden associated with a full rate application for both the hospital and HSCRC Staff. The filing requirements for a full rate application serve as a barrier for rate relief for an independent community hospital with already limited resources.

Thank you again for the opportunity to comment.

Sincerely,

Donald R. Owrey, FACHE
President and CEO
Atlantic General Hospital

cc: Dr. Josh Sharfstein, Chairman
Dr. Joseph Antos, Vice Chairman
Dr. James Elliott
Dr. Maulik Joshi
Ricardo Johnson
Adam Kane
Nicki McCann
James Kanuch, VP Finance Atlantic General Hospital

MedStar Health

10980 Grantchester Way
Columbia, MD 21044
8th Floor
P 410-772-6927
MedStarHealth.org

Susan K. Nelson
Executive Vice President and
Chief Financial Officer

May 15, 2024

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

Dear Executive Director Kromm,

On behalf of MedStar Health System (MedStar) and its seven Maryland hospitals, thank you for the opportunity to comment and provide input on the Health Services Cost Review Commission's (HSCRC) July 1, 2024, annual payment update draft staff recommendation. MedStar appreciates the collaborative work undertaken by HSCRC staff to bring this recommendation forward and their recognition of the significant financial challenges Maryland hospitals are currently facing. MedStar is supportive of staff's intent to fully fund hospitals for inflation and population change, two key pillars of the Maryland Global Budget Revenue system. To achieve this goal MedStar proposes the following revisions to the staff recommendation.

MedStar supports MHA's recommendation to fund current inflation of 3.24% and provide half of historic 2.34% underfunded inflation in rate year (RY) 2025 as well as the other half in RY2026.

MedStar requests that staff update the recommendation to fund current inflation at 3.24% reflecting data from Global Insight's First Quarter 2024 book. This is consistent with previous annual update recommendations which have been updated to include the most recent published inflation data.

MedStar appreciates staff recognition that hospitals have been underfunded for inflation in recent years and their recommendation to build in an additional 0.65% of inflation support into the RY2025 update factor. However, this additional support does not provide the level of funding required for the cost increases experienced by hospitals since the onset of the pandemic and is based on an overly conservative savings target projection. Since 2019, hospitals have absorbed significant permanent cost pressures including clinical staff salary increases and supply cost increases that have caused an erosion of operating margins and a reduction in cash reserves. MedStar appreciates staff must balance ensuring that Maryland meets its model obligations with providing hospitals a reasonable update for inflation. However, given the current overachievement of model savings performance, we believe there is room to provide hospitals with a greater level of support for inflation. With financial pressures as they are, Maryland hospitals need the commission to consider a less conservative projection of future model savings when evaluating the inflation support for

FY25 & beyond. As such, MedStar echoes and supports the request made by the Maryland Hospital Association to provide an additional 1.17% of inflation in RY2025 and 1.17% of inflation in RY2026.

MedStar supports MHA's recommendation to limit inflation overfunding correction in any given year to 0.50% and do not apply inflation overfunding correction as calculated if Maryland is meeting or exceeding Medicare savings targets.

MedStar agrees with staff's proposed methodology to establish a consistent policy to calculate inflation over/under funding and any potential inflation funding corrections. While we agree that the methodology needs to apply in both underfunding and overfunding scenarios, MedStar has concerns regarding the impact of an inflation reduction in any given year due to the unsustainably thin operating margins of hospitals and health systems in Maryland. To maintain financial stability and predictability for hospitals which enables hospitals and health systems to reinvest in patient care and population health, MedStar recommends that any correction for over funded inflation be limited to 0.5% in any given year and that any correction for over funded inflation greater than 0.5% be spread over multiple years.
Further, MedStar believes that any adjustment for inflation overfunding be guided ultimately by the goals of the Maryland TCOC model in achieving the required annual Medicare savings target. If the state is meeting the TCOC Model targets, MedStar recommends that a correction for over funded inflation not be applied for any given year.

Consistent with MHA's recommendation, Medstar supports the idea of improving transparency and the process for distributing set-aside funding. Medstar disagrees with increasing this funding above the $31.7M proposed by staff in the draft recommendation.

MedStar supports the creation of a process with increased structure and transparency for distributing the set aside and providing funding to hospitals when unique or unanticipated circumstances arrive. MedStar does have concerns regarding the set aside, namely:

1. Discussion during the May 8, 2024, meeting about a need to increase the set-aside in order to respond to a number of individual hospital requests unrelated to price efficiency, capital expenditure, or unanticipated cost increases (i.e. cyber-attacks)
2. The criteria proposed by staff may create perverse incentives for hospitals to pursue additional funding through the set-aside for unfunded inflation or volume growth rather than utilizing appropriate channels.

Inherently, increasing the amount of funding for the set-aside provision in the update factor reduces the provision intended to fund inflation at all Maryland hospitals. At a time when Maryland hospitals are underfunded for inflation by 2.34% since the onset of the COVID-19 pandemic and under acute financial stress, MedStar does not believe it is prudent to increase the allocation of funding for the set-aside which will financially benefit a select few hospitals to the detriment of all hospitals. Given these concerns, MedStar recommends that no additional funding be allocated for the set-aside provision above the $31.7M (0.15%) that HSCRC staff has carefully estimated and included in the draft recommendation.

Redesigning the PAU shared Savings Policy to be revenue neutral is a welcome step and further evaluation of the policy going forward is warranted.

MedStar is very supportive of the staff recommendation to revise the PAU Shared Savings Policy to eliminate a net revenue reduction from the Maryland healthcare system while maintaining the incentive to reduce PAU patient volume. To date, $600M of revenue has been taken out of the Maryland hospital system

and further reductions may pose healthcare access challenges. MedStar believes it is important to maintain these incentives that reward hospitals who invest in care transformation and are successful in creating alternative care pathways that keep patients out of the hospital that do not require acute hospital-based care. MedStar seeks clarification regarding the additional components of the staff recommendation including:

1. An analysis to be funded out of hospital rates of activities of current interventions to reduce PAU.
2. Establishment of a single point of executive accountability for the PAU reduction strategy
3. Agreement to engage in future analyses of PAU performance.

While MedStar is likely supportive of these three additional recommendations as it aligns with work already undertaken by the health system, MedStar strongly believes any additional analyses regarding PAU performance needs to acknowledge that not all PAU volume is avoidable.

Exempting hospital retained revenue from inflation updates is contradictory to the incentives and purpose of the Maryland Total Cost of Care Model.

Although not included in the staff recommendation, during the public meeting on May 8, 2024, there was significant discussion regarding hospital retained revenues and potentially not updating these revenues for inflation. MedStar strongly opposes this notion. The idea of removing inflation on retained revenue is misaligned with the incentives built into the Maryland TCOC model and the agreements made between the hospitals and the state at the implementation of Global Budget Revenue. A core tenant of the model is that hospitals, in exchange for predictable and stable updates to hospital revenues annually, can keep the revenue associated with reductions in unnecessary utilization and redeploy this 'retained revenue' to invest in improved care infrastructure and population health. Hospitals and health systems will not be able to continue to make these investments at scale if inflation funding is cut off while costs in these areas continue to accelerate.

Further, the HSCRC has for years worked collaboratively with stakeholders to develop several policies to address any misallocation of revenue in hospital global budgets and provide both revenue enhancements and revenue reductions to individual hospital global budgets when warranted for price inefficiency or volume shifts (i.e market shift, integrated efficiency, de-regulation, etc.). Any action taken to address what is perceived as a misallocation of retained revenue in the Maryland hospital system should be done through these existing policies by continued engagement with stakeholders and HSCRC staff rather than through the update factor process which is solely intended to provide a reasonable update to hospital rates in line with experienced inflation growth.

In summary:

1. MedStar agrees with MHA's request to fully fund inflation estimated at 3.24%.
2. MedStar requests additional inflation support of 1.17% in FY2025 and 1.17% in FY2026 due to historical underfunding of inflation in alignment with MHA's request
3. MedStar echoes the recommendation made by MHA that any correction of inflation overfunding be limited to 0.5% in any given year and not be implemented if Maryland is meeting or exceeding the savings test.
4. MedStar echoes the support expressed by MHA of improving transparency and the process used for distributing the funds in the set aside, however, MedStar disagrees and recommends that no further funding be allocated for the set aside above $31.7M (0.15%).

5. MedStar, in alignment with the industry, strongly supports the proposed revisions to the PAU Shared Savings policy and seeks clarification regarding the additional recommendations proposed by staff.
6. MedStar strongly disagrees with the concept of not applying inflation increases to hospital retained revenue as it contradicts the incentives of the Maryland model.

MedStar and its member hospitals appreciate the HSCRC staff's work on the update factor and the open conversation with the field throughout the process. Thank you for considering this request and please do not hesitate to reach out should you have any questions or a need to discuss this matter further. We look forward to the final staff recommendation at the June 2024 Commission meeting.

Sincerely,

Susan Nelson
Chief Financial Officer
MedStar Health

cc: Joshua Sharfstein, M.D., Chair
Joseph Antos, PhD, Vice Chair
Adam Kane
James Elliott, MD
Maulik Joshi, DrPH
Ricardo R. Johnson
Nicki McCann, JD

CareFirst BlueCross BlueShield
10455 Mill Run Circle
Owings Mills, MD 21117-5559
carefirst.com

May 15, 2024

Dear Chairman Sharfstein,

CareFirst BlueCross BlueShield ("CareFirst") appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) draft recommendation for the annual payment update for rate year (RY) 2025. We are grateful for the thoughtful work by the Commissioners and staff. Finding the right balance between Medicare savings required by the Total Cost of Care Model, financial stability for hospitals, and affordability for Maryland consumers is complex and challenging but critically important. Unfortunately, the RY25 Update Factor Recommendation misses the mark.

Hospitals do not need catch-up inflation because they are already cumulatively overfunded by more than $1 billion above actual inflation

Hospitals already have received significant overfunding for inflation, and the proposed update does not account for this overfunding. It is true that actual inflation exceeded the amounts funded in RY 2022 and RY 2023, and there has been some temporary financial strain on the hospital industry. But the long-term trends are exactly the opposite – since the inception of the all-payer model and global budgets, funded inflation exceeded the actual rate of inflation by more than $1 billion, as shown in the table below. In all prior years, the HSCRC allowed overfunding to accumulate rather than removing funding in excess of inflation. Hospitals used the excess funding to build up financial reserves to cushion against a day when actual inflation exceeds funded inflation. Now that the day has arrived, instead of turning to those reserves, staff is proposing additional relief through rates.

This is deeply unfair to consumers who are being forced to pay for inflation several times over. While the HSCRC focuses on setting hospital rates, the impact of every rate increase on insurance premium payers - hard working Marylanders striving to ensure they can afford the cost of accessing care - should not be dismissed. **For these reasons, CareFirst opposes the proposed catch-up inflation adjustment of 0.65% in the draft recommendation.**

RY2013 Gross Patient Revenue (regulated services)	$ 15,264,777,897

	RY2014	RY2015	RY2016	RY2017	RY2018	RY2019	RY2020	RY2021	RY2022	RY2023
Funded Inflation	1.65%	2.40%	2.40%	1.92%	2.68%	2.32%	2.96%	2.77%	2.57%	4.06%
Gross Patient Revenue @ Funded Inflation *($ in millions)*	$15,516	$15,889	$16,270	$16,583	$17,027	$17,422	$17,938	$18,435	$18,909	$19,676
Actual Inflation	1.75%	1.84%	1.66%	2.29%	2.48%	2.40%	2.31%	2.37%	4.79%	5.09%
Gross Patient Revenue @ Actual Inflation *($ in millions)*	$15,532	$15,818	$16,080	$16,449	$16,856	$17,261	$17,660	$18,078	$18,944	$19,908
Difference	-0.10%	0.56%	0.74%	-0.37%	0.20%	-0.08%	0.65%	0.40%	-2.22%	-1.03%
(Under) / Over Funding *($ in millions)*	$ (15)	$71	$190	$134	$171	$161	$278	$357	$ (35)	$ (232)
Difference since 2013	-0.10%	0.45%	1.18%	0.82%	1.01%	0.93%	1.58%	1.97%	-0.19%	-1.17%
Accumulation of (Under) / Over Funding *($ in millions)*	**$ (15)**	**$56**	**$246**	**$380**	**$551**	**$712**	**$991**	**$1,347**	**$1,312**	**$1,079**

Commission did not true-up inflation | Staff proposing true-up inflation

CareFirst's alternative recommendation

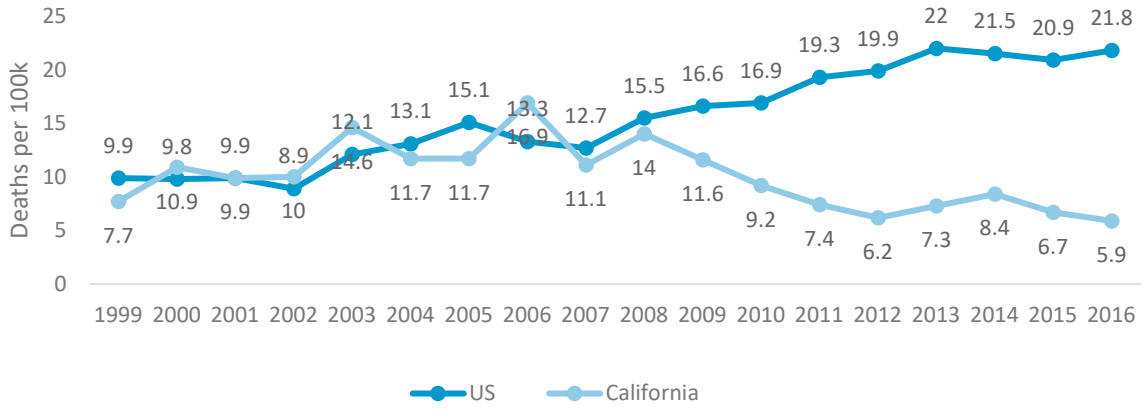
If the HSCRC asks consumers to pay more despite historical overfunding, CareFirst believes any additional funding given to hospitals should provide some benefit to the public. The State and hospital industry began the important work of improving maternal care through the Statewide Integrated Health Improvement Strategy (SIHIS). In 2021, the HSCRC approved $40 million to be spent on improving maternal care between 2022 and 2025 through a regional partnership program. The State has failed to meet its SIHIS goals, and by a large margin. Instead of a targeted 7.5% reduction in Severe Maternal Morbidity (SMM) events, **the actual rate has increased by 32.8%.**[1] While HSCRC listed a variety of reasons the rate may have increased, they ultimately noted "many SMM events are preventable, and recent analysis of Maryland SMM events found that approximately one third could have been averted by changes to clinician-, system-, and/or patient-level factors". Marylanders deserve better.

To address this important issue, we offer the following as an alternative to Staff's proposed catch-up inflation adjustment:

1. The HSCRC should provide 0.5% in additional rates (in lieu of catch-up inflation) for hospitals to invest in reducing the statewide maternal mortality rate by 50% over five years while also eliminating the disparities in maternal mortality between White and Black mothers.
2. The HSCRC should provide 0.1% in additional rates to be paid via an assessment to the Maryland Hospital Association ("MHA") for the purpose of creating a Maternal Quality Care Collaborative that will conduct maternal safety and quality assessments, monitor initiatives, and track progress across the State.
3. If the industry fails to meet these targets within 5 years, or in any given year fails to reduce maternal mortality by at least 10% and disparities by at least 20%, the HSCRC should reclaim the 0.5% additional funding.

This is an audacious goal but not an impossible one. Between 2008 and 2013, California cut its maternal mortality rate in half (as shown in the chart below). This success was not due to expensive new technologies or innovative drugs. Rather, it was driven by four things: 1) using public health data to identify the largest causes of maternal mortality; 2) mobilizing a broad coalition of stakeholders to develop toolkits addressing causes; 3) developing of a rapid-cycle data system to track outcomes; and 4) focusing clinical attention on quality improvement.[2] These measures are well within the capability of Maryland hospitals.

Figure 1: Maryland Maternal Mortality Ratio in US and California, 1999-2016

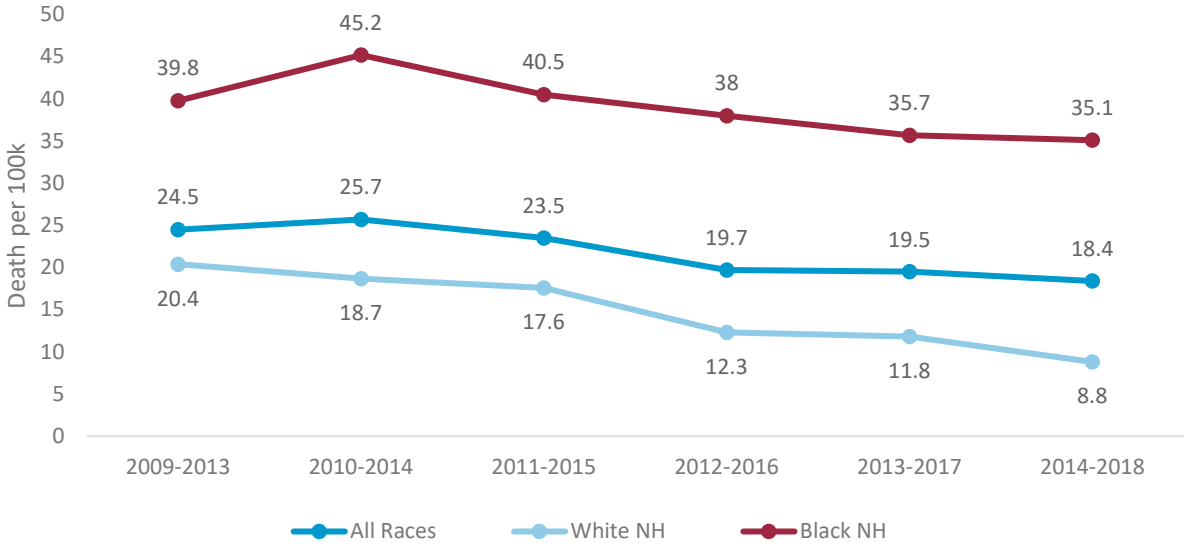


Source: California Pregnancy Mortality Surveillance System. (2021). California Pregnancy-Related Deaths, 2008-2016.

[1] Health Services Cost Review Commission (2024). Annual Report: Statewide Integrated Health Improvement Strategy.
[2] Addressing Maternal Mortality And Morbidity In California Through Public-Private Partnerships | Health Affairs

The HSCRC should also use this opportunity to draw attention to the serious racial disparities that exist in Maryland's maternal mortality rate. While the State has made some progress reducing the maternal mortality rate over the past decade, the average rate remains far too high and substantial racial disparities remain. Racial disparities grew during this period, as shown in the chart below.

Figure 2: Maryland Maternal Mortality Ratio, 5-Year Rolling Average



Source: Maryland Department of Health. 2020 Annual Report Health – General Article §§13-1207—13-1208 and §13-1212.

We appreciate the opportunity to comment on this important proposal. If the HSCRC is committed to charging consumers more to give hospitals additional money, it should be used to drive accountability for fixing this tragic – and preventable – crisis.

Sincerely,

Arin D. Foreman
Vice President, Deputy Chief of Staff
CareFirst BlueCross BlueShield
1501 S. Clinton Street
Baltimore, MD 21224

Adventist HealthCare

May 15, 2023

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

Dear Mr. Kromm

Adventist HealthCare ("AHC") appreciates the opportunity to provide comments on the draft Update Factor for fiscal year 2025. Like many hospitals in the state, we are at a critical juncture for our health system and need collaboration and support from the Health Services Cost Review Commission ("HSCRC") to provide stability. We have endured multiple years of suppressed operating margins because we have absorbed significant cost disruptions alongside significant volume pressures since the onset of the COVID-19 pandemic without adequate reimbursement. These pressures have created an untenable situation that may undermine the goals of the Total Cost of Care Model ("the Model") and exacerbate health disparities that exist in our state.

We hope you will take these recommendations seriously and consider them in the spirit of collaboration with which they are intended, as we all seek to build a stronger and more sustainable healthcare system in Maryland.

I. Adequately and Equitably Fund Inflation

A. The historic underfunding of inflation should be fully corrected.

AHC supports funding current inflation of 3.24% consistent with Global Insight's first Quarter 2024 book, plus half of historic unfunded inflation of 2.34% at 1.17% in RY25 and the remainder in RY26. While AHC appreciates the multiple savings target scenarios prepared by Staff, they are overly conservative and artificially limit the window to correct historic underfunding.

In the unlikely event that Maryland's savings performance does not continue to outperform the nation, there are multiple policy levers the HSCRC can use to course correct as evidenced by successful actions taken in CY 2023. Given that the statewide hospital mean for operating margins has been 0% or negative since 2022, this is not the time to risk under funding rates.

For example, AHC's operating margin had been stable for many years leading into COVID but despite expense reductions on an already efficient operation, margins have eroded beginning in 2022 and continued to erode in 2023 and through the second quarter of 2024. This is due to volume increases driving up expenses and inflation outpacing revenue increases.

- Comparing 2023 to 2019:
  - Salaries and benefits expenses outpaced revenue growth by 3.3%
  - Total labor expenses outpaced revenue growth by 5.34%
  - Total expenses outpaced revenue growth by 2.47%
  - Physician subsidy expenses outpaced revenue growth by 27%

B. The policy of inflation correction for overfunding should be limited and tied to Savings Test performance.

AHC appreciates HSCRC staff's maturation of the inflation funding policy. Prior to the global pandemic, stable inflation did not generate the unpredictable growth we've experienced since 2022 and it's appropriate to mature our policies for unforeseen events since the inception of the Model. However, AHC recommends that any correction for overinflation be limited to -.5% in any given year and should not be applied in a year with excess Medicare Savings. In an environment that does not fund real-time volume growth, it's paramount to ensure stable, prospective inflation funding. Should overfunding occur and if the Medicare Savings test is not in jeopardy, then the claw back of overfunded inflation can be administered over multiple years to smooth the volatility of funding for hospitals. Without prospective funding stability, AHC cannot make long-term decisions and is forced into a reactive, one-year planning cycle that undermines long-term sustainability. Since market-shift and other policies provide delayed funding for retrospective volume performance, we should balance this with policies that are prospective and quick to fund on the upswing with a measured reduction on the downswing.

C. AHC does not support funding high-cost drugs for academic health centers by defunding inflation from community hospitals.

The proposed high-cost drug policy carves out incremental high-cost drug funding for academic health centers from the statewide inflation update. It means that AHC must give up approx. $800,000 of the inflation update to divert to academic high-cost drugs. AHC strongly supports access-to-care for all patients and agrees that life-saving therapeutics should be made available to those who need it. However, funding this out of non-academic hospital rates means that Adventist has $800,000 less to provide hospital care in our community. While the proposed policy appears to solve an access-to-care problem for patients who require high-cost-drugs, it exacerbates an access-to-care crisis in our service area of Montgomery and Prince George's County as it simply squeezes the balloon moving the problem to non-academic hospitals.

As documented in multiple communications to HSCRC staff, White Oak Medical Center ("WOMC") and Fort Washington Medical Center (FWMC) have experienced extreme volume pressures since CY2022. Daily, since 2022, WOMC has operated at 100%+ occupancy. On a typical weekday, 50%-60% of our 32 ED treatment spaces are occupied by a patient who has already been identified for admission but lacks an available bed to accommodate that admission. As a result, in CY2023, WOMC spent 70% of available hours in the year on red alert, 8x the amount of time spent on red alert in CY2019. And nearly 50% of WOMC patients come from Prince George's County due to the radical shortage of high-quality healthcare in that region. Thankfully, WOMC's high volumes earned additional bed capacity under the 140% rule from the MHCC and an expansion project on the 8th floor is underway, even without a

commitment from the HSCRC to fund these beds long term. Therefore, AHC may end up building these beds and filling them with patients, and yet not get reimbursed for the care we provide in them despite earning the beds from another state agency based on our volumes.

Due to the shortage of acute care beds in Prince Georges County, the Maryland Department of Health placed 16 trailer beds on the FWMC campus in 2020 to ensure adequate access to care. These beds remain in active use on the campus, as this additional space continues to be critically necessary to meet the demand for care in the community.

This lack of capacity has had a devastating impact on our ED wait times and acute length of stay ("LOS"). While WOMC and FWMC have managed their LOS to better than the state average for patients we can discharge-to-home, patients who require a discharge to another setting (specialized acute care, quaternary care, rehabilitation, SNF and Home Health) have seen severity adjusted LOS double due to the severe lack of access to post-acute care in our service area. This LOS gap on discharge-to-home vs. discharge-to-other-care-setting has worsened by over 30% since pre-pandemic. Not surprisingly, this care pipeline pinch has backed-up into our emergency rooms resulting in some of the longest ED wait times in the State.

To this day, WOMC has not received capital or permanent funding for the 8th floor expansion at WOMC and FWMC has not received permanent funding for the 16 additional beds placed on our campus – both critical to ensuring access to care in our community. Removing funding from AHC hospitals when we are seeing a demand for care that already exceeds our capacity in order to fund the high-cost drug policy as proposed will only exacerbate access to care issues within our community. It may solve one problem, but it will definitely create another one in its stead.

D. We recommend that high-cost drug cases be funded outside of GBR and on a fee-for-service basis.

As we prepare to move to the AHEAD Model, there are foundational fractures in HSCRC policy that must be corrected to ensure the sustainability of the Model. This is one of those break points. How many of the academic patients receiving the high-cost drugs are Medicare patients? Is the Savings Test materially impacted by carving this out? While the current contract requires 95% of hospital revenues to be under a population methodology, how much room is left to fund these life-saving drugs without defunding community hospital care? These are the questions that should be answered before a policy decision reinforces the precedent of defunding community care that is already in crisis.

II. Addressing Systemic Inequities within the Model Framework

Adventist Healthcare is not overfunded by the volume payment policies. HSCRC staff have presented that Maryland hospitals are "over funded" by HSCRC volume policies by $500M+ and specifically that AHC is overfunded by approx. $50M. This is concerning rhetoric that ignores the fiscal reality of many hospitals in Maryland and assumes that prices were set appropriately at the inception of GBR in 2014. There are several flaws in the volume funding logic, with the two most alarming being 1) inequitable base

GBR prices set at the inception of the model and 2) exclusion of reimbursement for physician subsidies from payment policy.

A. Base hospital prices and base GBRs were not set equally at the inception of the Model, baking in regional inequities that have compounded over the last ten years.

At the inception of GBR, historic inequities were baked into the Model's foundation. Communities with less hospital infrastructure received less funding. This was never corrected and has been exacerbated over the last ten years by the impact of year-over-year update factor compound growth, grossly distorting and entrenching historic inequities. Prince George's County is the perfect example. The county faces significant, systemic healthcare disparities, lacking access to healthcare resources across the board from inpatient hospital-based care to outpatient community physicians. Although the model was designed to incentivize hospitals to invest in community-based care, the initial GBR rates never accounted for the historic inequities that existed in Prince Geoge's County and the higher level of investment it would require to address these issues. Rather, the rates were set based on the existing inequitable foundation. This error compounded over time, further entrenching historically disadvantaged populations. Decades of marginalization were baked into the starting GBRs for Prince George's County forcing over 40% of the population to seek care outside the county. This underinvestment has led to higher incidences of chronic disease per capita. Similarly, while Montgomery County is generically assumed to be "wealthy", there are pockets of deep deprivation most notably in our service area at WOMC as evidenced by our uninsured, underinsured, undocumented and governmental patient mix. By locking-in already disadvantaged communities into lower reimbursement rates, current policies make it near impossible to close the gap and improve health outcomes.

- **Reimbursement per ECMAD ranges from $26,000 to $8,000 across the State creating an inequity of +44% to -55% range around the Statewide average of $18,000** (CY23 Jan-Jun Market Shift). (Table 1)
    - WOMC and FWMC reimbursement per ECMAD is below the State average (-4% WOMC and -13% FWMC). Incremental annual revenue of moving to the State average would be $11.6M at WOMC and $6.4M at FWMC.
    - Looking at University of Maryland Capital Region's (Cap Region) rates that are 23% above the State average the gap is even bigger. The incremental annual revenue at Cap Region's rate would be $76.1M at WOMC and $17.7M at FWMC. We recognize that Cap Region's teaching status garners incremental reimbursement, but we would not expect to see this level of inequity. We compare WOMC to Cap Region's rate structure given that approx. 50% of WOMC's volumes come from Prince George's County.

An independent State commissioned study quantified the hospital price inequity for Baltimore vs. Adventists' service area as a staggering $400M annually in excess revenue accrued to the Baltimore region simply due to price inequities. The Abt study compared the Baltimore Region to Montgomery, Prince George's and Anne Arundel County as a cohort to quantify the difference in per-capita costs of care between the two regions. After adjusting for differences in risk and utilization patterns, it concludes that for employer-sponsored health insurance, the Baltimore region spends over $135M

annually more than the cohort region simply because of higher hospital prices in Baltimore. The report also quantified this for Medicare FSS IP Hospital spend and estimates over $300M excess in Baltimore. Combined, the isolated excess spend in Baltimore for higher hospital prices is nearly $400M+ annually compared to our service area. This is a staggering inequity and a direct consequence of neglected price parity in the Maryland Model. (Enclosure 1, Abt Associates 2022 report, Health Care Costs in Baltimore Relative to Other Urban Areas in Maryland)

B. HSCRC payment polices do not cover the cost for physicians and therefore must be factored in as "unfunded" expenses against HSCRC staff's "over funded" calculations.

While it may be true that at the inception of HSCRC regulation in the 1970s professional billing covered the cost of physicians, this is no longer the case. The business model shifted decades ago, and this is not unique to Maryland; it is a national phenomenon. Physician subsidies for hospital-based care are a necessary cost of a hospital- otherwise there would be no physicians to care for the patients. These costs are not included in HSCRC staff's "overfunding" calculations.

Outside of Maryland, hospital's address this by 1) cross-subsidization in commercial rates 2) margin generating volume growth 3) payer regulation. In Maryland, we have eliminated the first two options and in effect have eliminated the third as we have the lowest professional reimbursement rates in the country guaranteeing the largest physician subsidies anchored to hospitals in the Nation.

This has left hospitals no-recourse to reimburse physician subsidies that at AHC have grown 27% above funded inflation. This is another foundational breakpoint for the sustainability of the Model. In the past year Staff have initiated looking at physician costs, however the timetable just to study these costs- not necessarily take policy action- is three years. AHC has grave concerns that this will not be timely enough to address this systemic underfunding that threatens the solvency of hospitals in Maryland.

Continued assertions that hospitals are over-funded will undermine the urgency needed to address these systemic issues that are now at a breakpoint for our service area. We recognize that it will take time to resolve concerns within the Model policy framework and that some of these changes may need to be made under the transition to the AHEAD model. However, AHC has significant concerns regarding regional inequities within the Model and that flaws within initial GBR calculations and the drastic increase in the cost of physician subsidies disadvantage community hospitals and threaten the sustainability of the Model.

We see the potential of the Model and want to be collaborative partners in building the future of Maryland healthcare, especially as we serve two of the most populous counties in the state. But, providing healthcare must be sustainable and the Model's must be equitable, supporting all hospitals and communities.

In Conclusion

Given the extreme excess savings of over $100M in 2024 and the deteriorating financial conditions of hospitals due to funding gaps, Adventist Healthcare respectfully requests that the Update Factor for FY25 provide:

- Current inflation of 3.24%
- Half of historic unfunded inflation of 2.34% at 1.17% in RY25 and the remainder in RY26
- Elimination of academic high-cost drug funding out of community hospital inflation update

Thank you for the opportunity to provide comment and collaborate on the RY25 Update Factor recommendation.

Sincerely,

Terry Forde
President and Chief Executive Officer
Adventist HealthCare

Kristen Pulio
Senior Vice President and Chief Financial Officer
Adventist HealthCare

cc: Joshua Sharfstein, MD
Joseph Antos, PHD
James N. Elliott, MD
Ricardo R. Johnson
Maulik Joshi, DrPH
Adam Kane, Esq
Nicki McCann, JD

Attachments:

Enclosure 1: Abt Associates 2022 report, Health Care Costs in Baltimore Relative to Other Urban Areas in Maryland

Table 1
Statewide Charge per ECMAD
CYTD January-June 2023 Market Shift

	CY22 Discharges	CY23 Discharges	ECMAD CY22	ECMAD CY23	Total Charge CY22	Total Charge CY23	CY22 Chg/ ECMAD	CY23 Chg/ ECMAD	Rank (CY23 chg/ecmad)	Above (below statewide avg) - CYTD23 June	Above (below) statewide Avg % - CYTD23 June
UMMS- UMMC	175,373	182,599	32,138	33,124	$827,519,624	$859,044,757	$ 25,749	$ **25,934**	1	7,892	44%
UMMS- Midtown	45,828	47,109	4,406	4,440	$90,196,804	$108,262,060	$ 20,471	$ **24,386**	2	6,344	35%
UMMS- Chestertown	16,546	17,003	966	984	$24,412,203	$23,841,565	$ 25,279	$ **24,233**	3	6,190	34%
UMMS- UMROI	19,535	19,661	2,510	2,609	$54,276,977	$60,937,515	$ 21,623	$ **23,360**	4	5,318	29%
Lifebridge- Grace	11,223	11,523	655	687	$16,719,189	$15,884,951	$ 25,539	$ **23,124**	5	5,081	28%
Lifebridge- Sinai	109,903	107,769	16,747	16,231	$381,283,919	$372,580,337	$ 22,767	$ **22,954**	6	4,912	27%
JHH- Johns Hopkins	349,116	361,675	43,307	44,376	$954,119,910	$1,001,991,521	$ 22,031	$ **22,580**	7	4,537	25%
UMMS- Capital Region	21,043	22,999	6,568	7,441	$164,173,666	$164,833,095	$ 24,995	$ **22,151**	8	4,109	23%
JHH- Bayview	163,605	169,339	14,620	15,286	$282,395,902	$299,887,790	$ 19,316	$ **19,619**	9	1,576	9%
MedStar- Good Sam	47,167	50,272	6,587	6,658	$122,812,622	$128,489,877	$ 18,643	$ **19,299**	10	1,256	7%
MedStar- Harbor	26,944	27,054	4,668	4,590	$85,056,627	$87,831,225	$ 18,221	$ **19,134**	11	1,092	6%
MedStar- Union Mem	42,674	43,300	11,458	11,235	$206,244,029	$208,106,376	$ 17,999	$ **18,523**	12	480	3%
Luminis- Doctors	26,555	28,181	6,101	6,540	$102,172,988	$119,539,016	$ 16,746	$ **18,279**	13	236	1%
Saint Agnes	70,491	76,528	10,547	11,226	$198,078,125	$205,111,355	$ 18,781	$ **18,271**	14	229	1%
Adventist- Shady Grove	57,594	61,755	12,295	12,336	$211,040,538	$223,761,732	$ 17,164	$ **18,140**	15	97	1%
UMMS- Harford	19,081	19,717	2,452	2,579	$47,391,186	$46,687,773	$ 19,324	$ **18,103**	16	61	0%
Lifebridge- Northwest	37,032	36,545	6,442	6,671	$121,132,628	$118,557,467	$ 18,805	$ **17,773**	17	(270)	(1%)
Adventist- White Oak	24,411	26,185	7,894	7,853	$139,984,601	$135,894,971	$ 17,732	$ **17,305**	18	(737)	(4%)
MedStar- Southern MD	28,171	28,137	6,938	7,368	$127,352,784	$126,273,949	$ 18,356	$ **17,139**	19	(904)	(5%)
UMMS- Easton	38,354	42,063	6,421	7,014	$128,688,258	$117,183,903	$ 20,041	$ **16,707**	20	(1,335)	(7%)
GBMC	73,441	72,537	13,855	13,344	$223,268,462	$222,263,468	$ 16,115	$ **16,657**	21	(1,386)	(8%)
UMMS- Laurel	10,904	11,399	888	960	$15,703,500	$15,886,740	$ 17,688	$ **16,545**	22	(1,498)	(8%)
Mercy	142,780	146,685	16,599	17,570	$277,404,660	$290,369,576	$ 16,712	$ **16,527**	23	(1,516)	(8%)
MedStar- Franklin Square	91,942	97,552	15,244	15,530	$254,975,928	$252,859,409	$ 16,726	$ **16,282**	24	(1,761)	(10%)
ChristianaCare, Union	37,102	35,669	4,103	3,900	$61,877,071	$63,314,111	$ 15,081	$ **16,233**	25	(1,810)	(10%)
Lifebridge- Carroll	32,299	34,785	6,471	6,745	$106,448,281	$108,160,059	$ 16,451	$ **16,035**	26	(2,008)	(11%)
Frederick	43,891	51,460	10,118	10,785	$167,950,163	$170,537,055	$ 16,599	$ **15,812**	27	(2,230)	(12%)
Adventist-Ft. Washington	9,325	9,995	1,418	1,380	$27,778,515	$21,722,026	$ 19,590	$ **15,736**	28	(2,306)	(13%)
UMMS- BWMC	65,245	72,372	12,604	13,545	$218,015,234	$212,474,830	$ 17,298	$ **15,686**	29	(2,356)	(13%)
Western Maryland	50,526	51,695	7,329	7,193	$109,728,623	$112,493,547	$ 14,972	$ **15,639**	30	(2,404)	(13%)
Calvert	31,075	32,165	4,243	4,339	$70,123,903	$67,526,613	$ 16,529	$ **15,562**	31	(2,480)	(14%)
UMMS-Bowie ED	9,124	10,413	545	620	$8,012,228	$9,551,098	$ 14,692	$ **15,409**	32	(2,633)	(15%)
UMMS- Charles	31,785	32,566	5,011	4,982	$74,428,397	$76,462,792	$ 14,854	$ **15,348**	33	(2,695)	(15%)
MedStar- Montgomery	29,959	33,207	5,035	5,520	$78,506,154	$83,943,626	$ 15,592	$ **15,207**	34	(2,835)	(16%)
Trinity - Holy Cross	56,854	54,007	14,498	14,777	$248,085,340	$223,624,105	$ 17,112	$ **15,133**	35	(2,909)	(16%)
JHH- Suburban	29,759	33,597	9,910	10,406	$161,038,301	$154,410,640	$ 16,251	$ **14,838**	36	(3,204)	(18%)
UMMS-Upper Chesapeake	63,945	66,697	10,260	10,689	$160,525,065	$157,885,628	$ 15,646	$ **14,771**	37	(3,271)	(18%)
UMMS- St. Joe	44,855	45,191	11,721	13,663	$188,612,854	$201,316,087	$ 16,092	$ **14,734**	38	(3,308)	(18%)
Tidal- Peninsula	72,889	77,000	12,660	13,049	$184,917,118	$191,528,385	$ 14,606	$ **14,677**	39	(3,365)	(19%)
Luminis- Anne Arundel	121,642	105,940	20,764	20,563	$300,753,213	$298,067,393	$ 14,484	$ **14,495**	40	(3,547)	(20%)
JHH- Howard County	46,301	49,280	10,447	10,589	$156,287,829	$152,179,713	$ 14,960	$ **14,371**	41	(3,671)	(20%)
Meritus	53,337	57,392	10,378	10,462	$138,547,932	$148,613,131	$ 13,350	$ **14,205**	42	(3,837)	(21%)
Garrett	23,894	23,086	1,830	1,817	$21,397,185	$25,742,670	$ 11,695	$ **14,169**	43	(3,874)	(21%)
UMMS- Cambridge	7,743	8,596	430	493	$9,275,618	$6,950,450	$ 21,581	$ **14,099**	44	(3,943)	(22%)
MedStar- St. Mary's	44,402	46,202	6,324	6,355	$89,769,236	$88,853,221	$ 14,196	$ **13,981**	45	(4,061)	(23%)
Atlantic General	26,309	26,824	2,747	2,866	$38,561,014	$38,226,641	$ 14,039	$ **13,336**	46	(4,706)	(26%)
Trinity - Holy Cross Germantown	19,057	19,642	4,193	4,614	$65,483,092	$57,817,911	$ 15,616	$ **12,531**	47	(5,511)	(31%)
Adventist- Germantown ED	9,788	10,771	582	649	$7,986,426	$8,027,607	$ 13,720	$ **12,378**	48	(5,664)	(31%)
Tidal- McCready	9,158	9,700	272	284	$2,467,014	$2,515,255	$ 9,063	$ **8,856**	49	(9,186)	(51%)
UMMS-Queen Anne's ED	7,819	7,737	470	468	$3,625,423	$3,819,960	$ 7,717	$ **8,166**	50	(9,876)	(55%)
Grand Total	**2,627,796**	**2,713,576**	**424,670**	**437,406**	**$7,756,606,361**	**$7,891,844,980**	**$ 18,265**	$ **18,042**			

HOLY CROSS HEALTH
A Member of Trinity Health

1500 Forest Glen Road
Silver Spring, MD 20910-1484
301-754-7000
HolyCrossHealth.org

May 15, 2024

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

Dear Dr. Kromm,

Thank you for the opportunity to provide comments on the recommendation by the staff of the Health Services Cost Review Commission (HSCRC) for the Fiscal Year (FY) 2025 annual payment update. We appreciate the time and effort that the staff put into the recommendation, including the recognition that underfunding inflation over the past several years needs to be addressed.

Like our colleagues across the state, Holy Cross Health (HCH) has experienced significant financial challenges over the past several years related to the inflationary impact of the COVID pandemic. The underfunding of actual inflation in previous years' annual payment updates has only compounded these challenges. HCH appreciates the recognition by the HSCRC staff that this underfunding of inflation should begin to be addressed in the FY 2025 update, but we would encourage the staff to provide additional funds consistent with the significant savings that are being generated above and beyond the contractual requirements of the Model.

HCH supports the position of the Maryland Hospital Association for the FY 2025 update as outlined below:

- **Increase base inflation from 3.15% to 3.24%** reflecting recent data from Global Insight's First Quarter 2024.
- **Restore half of underfunded inflation (1.17%)** with a commitment to fund the other half in the FY 2026 annual payment update.
- **Limit the inflation correction factor to 0.5%** and only apply it if the state is not meeting the Medicare savings target.
- **Revise the Potentially Avoidable Utilization (PAU) policy** in recognition of the significant savings that have been generated since the inception of the Model.

In addition to supporting MHA's position, Holy Cross Health would also encourage the HSCRC to allow hospitals who qualify for rate relief under the Full Rate Application policy and who are willing to accept the formulaic answer to be permitted to have an expedited review and administrative pathway to accessing the funding at the beginning of FY 2025, as occurred last year. This reduced the administrative burden on both sides while allowing for additional GBR funding for efficient hospitals that met the stringent criteria for rate relief.

Thank you again for the opportunity to comment.

Sincerely,

Julie D. Keese

Julie D. Keese
Vice President and Chief Financial Officer

cc: Dr. Joshua Sharfstein, Chairman
Dr. Joseph Antos, Vice Chairman
Dr. James Elliott
Dr. Maulik Joshi
Ricardo Johnson
Adam Kane
Nicki McCann
Douglas Strong, Interim CEO, Holy Cross Health, Inc.

JOHNS HOPKINS
MEDICINE

May 15, 2024

Joshua Sharfstein, M.D.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Sharfstein,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the staff recommendation for the Fiscal Year (FY) 2025 payment update. JHHS appreciates the challenges the Health Services Cost Review Commission (HSCRC) faces in balancing the financial strains of hospitals with ensuring the model savings targets are met.

JHHS's comments and recommendations are outlined below.

Inflation Update

JHHS is appreciative of the inclusion of the 3.15% inflation increase in FY 2025 but believe the number should be updated to reflect the current inflation of 3.24% found in the recently released Global Insight's First Quarter 2024 book. This is consistent with prior years update factor. We are also appreciative of the recommendation by the staff to include an additional .65% in recognition of past years' underfunding of inflation. JHHS would encourage the HSCRC, however, to provide additional funding beyond the staff recommendation.

Based on the latest estimates shared at the May Commission meeting, the state is currently achieving savings in excess of $173m beyond the $300m Calendar Year (CY) 2023 target. These savings are accruing to the benefit of the payers without any accountability for how this financial windfall benefits consumers. These are funds that could alternatively be used to recapitalize aging facilities, invest in population health programs, or address significant labor pressures in the hospitals. Although the staff is naturally conservative in their savings estimates, each of the scenarios shared except one demonstrated significant savings for CY 2024 beyond the contractual target.

JHHS would propose three specific changes to the staff recommendation:

1. **Provide an additional 1.17% for inflation**. The cumulative underfunding of inflation over the past several years is 2.34%. Although JHHS believes that this funding should be fully restored,

we recognize the need to balance providing additional funding to hospitals while meeting the Medicare savings target. Half of underfunded inflation should be included in the FY 2025 update with a commitment to include the other half in FY 2026.

2. **Eliminate a pre-defined and limited set-aside.** The set-aside in the draft recommendation is an arbitrary estimate that doesn't reflect the needs of the hospitals or the significant savings that the state is currently generating. Rather than a specific set-aside that artificially limits the funding available to hospitals, any savings in excess of the target should be viewed as potentially available to address appropriate hospital funding requests.
3. **Eliminate inflation on retained revenues.** Consistent with past positions of JHHS, we continue to encourage the HSCRC to eliminate inflation on retained revenues. The update factor should be used to provide inflation on actual expenses incurred by the hospital to care for patients, not to inflate expenses that no longer exist because patient volumes aren't present. The current methodology continues to lock revenue into increasingly price inefficient facilities for care that no longer exists, rather than providing funding to recognize changes in patient movement.

Potentially Avoidable Utilization (PAU) Shared Savings

JHHS supports the staff recommendation on changes to the PAU Shared Savings policy given the significant savings that the policy has generated since the inception of Global Budget Revenue (GBR).

Transformation Funding

JHHS supports the creation of a $20m pool of funds to be used for innovative initiatives. For years, JHHS has engaged the HSCRC in an attempt to fund a hospital-at-home program, consistent with trends nationally. The hospital at home program has the potential to reduce low-intensity care currently provided within JHHS and provide a better patient experience. JHHS encourages the HSCRC to include hospital at home as the type of program that could be funded out of the new Transformation Funding pool.

High-Cost Drugs

JHHS supports the staff recommendation to differentially fund high-cost drugs that are utilized at the Academic Medical Centers (AMC). JHHS would encourage the staff to continue working with the AMCs to ensure that high-cost drugs are being adequately funded and not continue a system whereby the AMCs are faced with the choice of either providing life-saving care at a significant financial loss or reducing access.

Recommendations

Given the economic climate and the challenges currently faced by the healthcare industry, JHHS believes a more nuanced and balanced approach to the update factor is required. For the reasons outlined above, hospitals should not receive inflation on retained revenue, as this is funding volumes that do not exist. Additionally, given the significant savings that the state is generating in excess of the contractual target, there are ample funds available to restore half of the unfunded inflation from the past several years.

Thank you for the opportunity to share comments and feedback. JHHS greatly appreciates the HSCRC's transparent process in the development and approval of the payment update and looks forward to continued collaboration in pursuit of the goals of the Maryland Model.

Sincerely,

Kevin Sowers, M.S.N., R.N., F.A.A.N.
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

cc: Joseph Antos, Vice Chairman

Dr. James Elliott

Ricardo Johnson

Dr. Maulik Joshi

Adam Kane

Nicki McCann

Jon Kromm

maryland
health services
cost review commission

TO:
HSCRC Commissioners

FROM:
HSCRC Staff

DATE:
June 14, 2024

RE:
Hearing and Meeting Schedule

July 10, 2024 To be determined - Zoom

August 14, 2024 To be determined - Zoom

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.