maryland
health services
cost review commission

629th Meeting of the Health Services Cost Review Commission

March 12, 2025

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

CLOSED SESSION
12:00 pm

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on February 12, 2025

Specific Matters

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

Docket Status – Cases Closed

2. Docket Status – Cases Open

2668R Johns Hopkins Howard County Medical Center
2669A Johns Hopkins Health System
2670A University of Maryland Medical Center

Informational Subjects

1. Presentation: Advancing Innovation in Maryland (AIM) Winners

CAPABLE and Neighborhood Nursing
Sarah L. Szanton, PhD, RN, FAAN, Johns Hopkins School of Nursing

Tele-dizzy

David E. Newman-Toker, MD, PhD, Johns Hopkins School of Medicine

Subjects of General Applicability

3. Report from the Executive Director
    a. Model Monitoring
    b. Deregulation Oversight Overview
    c. Legislative Update

4. Final Recommendation: ED Best Practices Incentive Policy & ED Wait Times Activities

5. Draft Recommendation: Maryland Hospital Acquired Conditions (MHAC) Policy for RY 2027

6. AHEAD Public Testimony

7. Hearing and Meeting Schedule

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STAFF RECOMMENDATION RE: Alternative Method of Rate Determination

Johns Hopkins Health System, MARCH 12, 2025

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2025
SYSTEM	*	FOLIO:	2479
BALTIMORE, MARYLAND	*	PROCEEDING:	2669A

I. INTRODUCTION

On January 29, 2025, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System is requesting approval to continue to participate in a global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplant services. The Hospitals request that the Commission approve the arrangement for one year beginning March 1, 2025.

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The 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' application for an alternative method of rate determination with Aetna Health, Inc. for solid organ and bone marrow transplant services for one-year beginning March 1, 2025. The Hospitals must file a renewal application annually for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the 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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Final Recommendations on Hospital Best Practice Policy for Rate Year 2027

March 12, 2025

This document contains the staff final recommendations for RY 2027.

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Table of Contents

List of Abbreviations

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

POLICY OVERVIEW

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

Final Recommendations

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

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    a. For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice. Weighting of tiers will be determined in Year 2 (RY 2028) after Year 1 (RY 2027) data is collected and analyzed.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2027.
    a. Failure to implement and report data to the Commission by October 2025 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2026.
3. We propose that subsequent rate years will have +/-0.25 percent inpatient hospital revenue at risk tied to performance on these best practice metrics but intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

INTRODUCTION

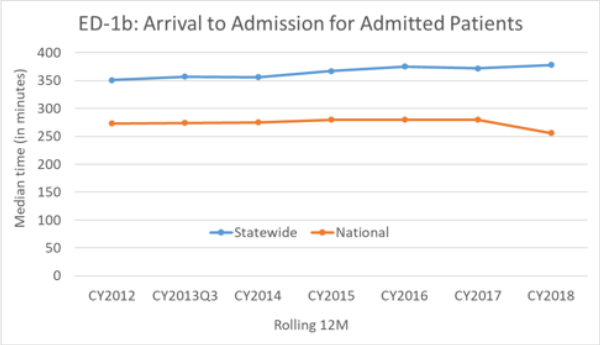
Maryland hospitals are funded under a population-based revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under the All-Payer Model agreement with the Centers for Medicare & Medicaid Services (CMS) beginning in 2014, and continuing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

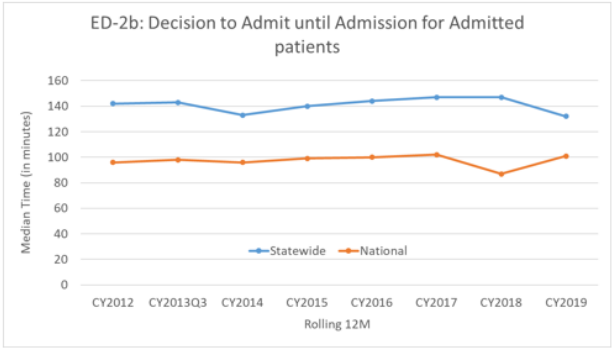
The Hospital Best Practice Policy is a new program that is being proposed for Commissioner consideration. The Best Practice Policy would be one of several quality pay-for-performance initiatives that provide +/- revenue at risk for hospitals to improve and maintain high-quality patient care and value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

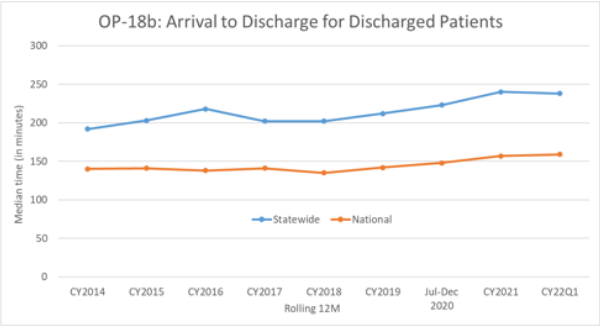
BACKGROUND

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

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





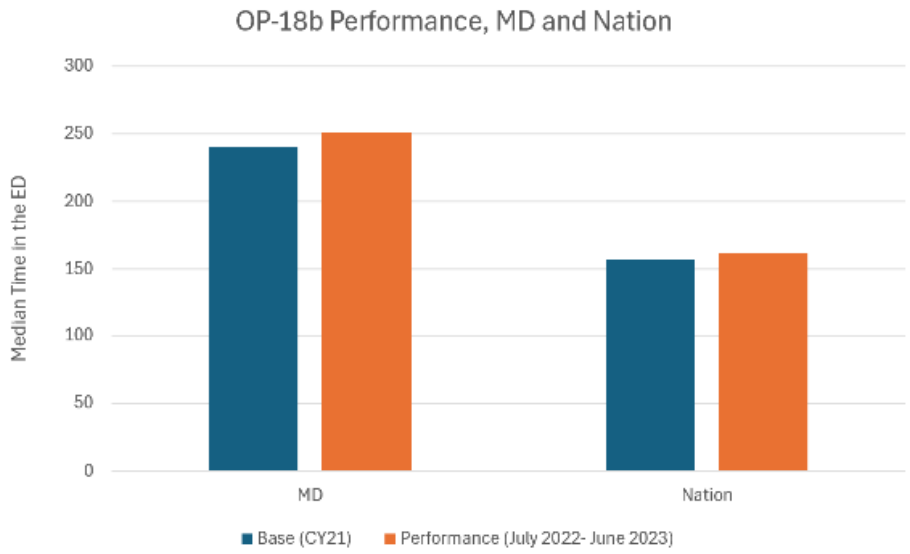


Measure ID	Measure Definition
ED-1	Median time from ED arrival to departure for admitted patients
ED-2	Median admit decision time to ED departure time for admitted patients
OP-18	Median time of ED arrival to departure for discharged patients

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

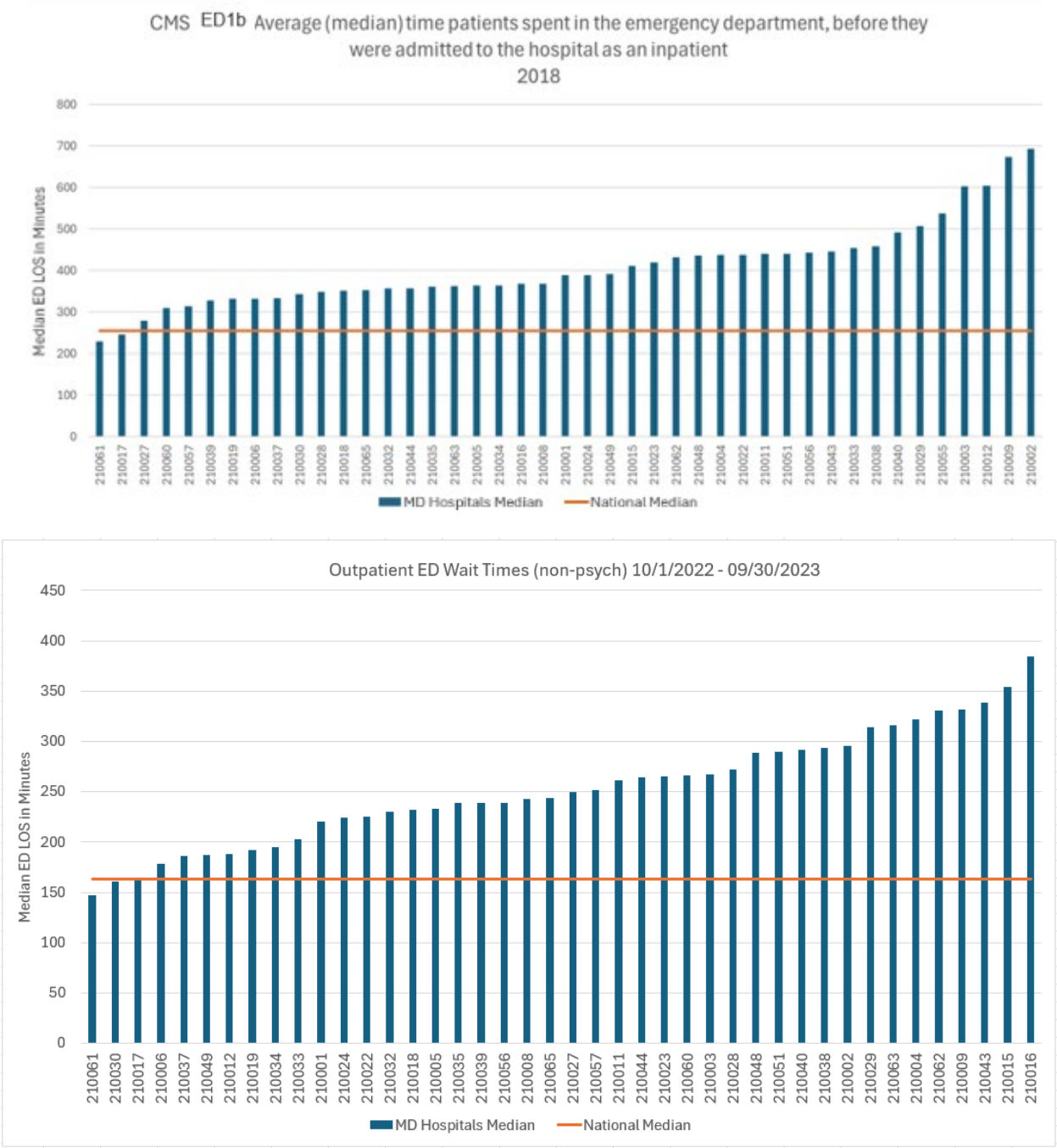
[1] Under alternative payment models, such as hospital global budgets or other hospital capitated models, some stakeholders have voiced concerns that there may be an incentive to reduce resources that lead to ED-hospital throughput issues.

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



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

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



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

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

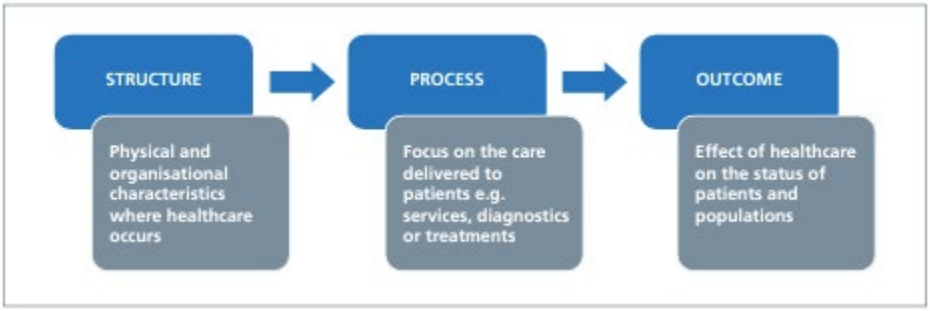
POLICY DEVELOPMENT AND IMPLEMENTATION

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

Policy Origins

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

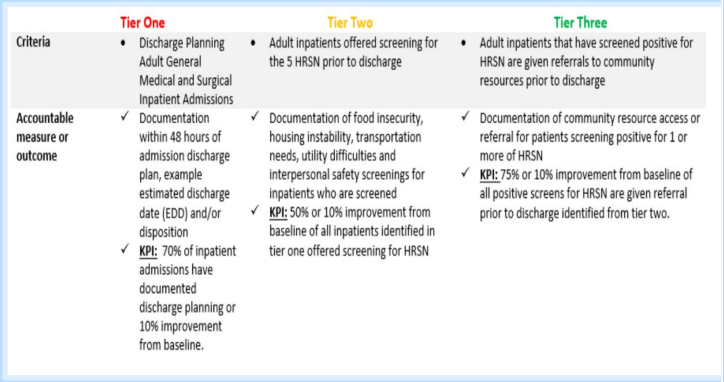
Figure 4. The Donabedian model for quality of care

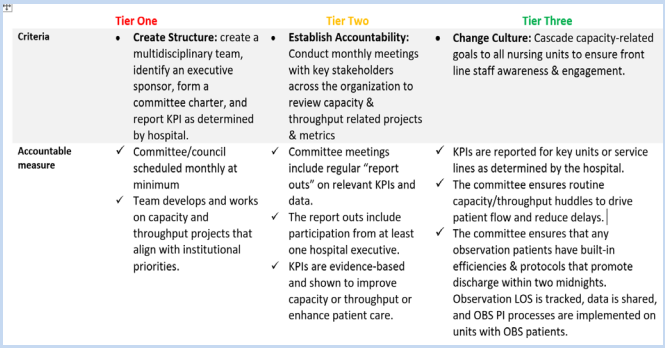


Stakeholder Process and Selected Best Practices

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

Figure 1. ED-Hospital Throughput Best Practices

Best Practice	Measures	Points (0-10 scale)
Interdisciplinary Rounds & Early Discharge Planning		Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points
Bed Capacity Alert System	**Tier 1**: Organization establishes one or more capacity metrics, examples could include: total number of patients in hospital, % hospital beds occupied, % of ED border c/w overall ED beds, NEDOC score, other hospital defined metrics. **Tier 2**: Organization establishes a bed capacity alert process (aka surge plan) driven by capacity metrics that triggers defined actions to achieve expedited throughput. Actions could include: Enhanced inpatient huddles to expedite discharges, rapid admission order turnarounds, hospitalist care in the ED, executive escalation, opening surge units, etc. **Tier 3**: Organization quantitatively demonstrates consistent activation of surge plans in response to bed capacity triggers. Internal metrics to be hospital defined and specific to hospital surge protocol. Examples could include: #/% of protocol activations, % discharges by specific time- maybe 1 p.m. and/or 3 p.m., etc.	Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points
Standardized Daily/Shift Huddles	The AHRQ defines a huddle as a short, standing meeting that is typically used in clinical settings to quickly share important information and touch base with a team, typically held at the beginning of each workday or shift. **Tier 1:** Implementation of, at minimum, daily huddles utilizing a multidisciplinary team approach with a focus on throughput and discharges. KPI: Multidisciplinary daily huddles are being completed at X frequency as defined by each organization. **Tier 2:** Tier 1 requirements with the addition of a standardized infrastructure (standard scripting, documentation, and/or use of huddle boards). Tier 2 would also include an escalation process for addressing clinical and/or non-clinical barriers to discharge or throughput. **Tier 3:** Tier 1 and Tier 2 requirements, with the addition of monitoring and reporting of key performance indicators (KPIs) as drivers of process improvement r/t throughput. Example KPIs could include but are not limited to, percent of discharge orders written by noon, or percent patients leaving the facility by a designated time as determined by each facility.	Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points

Best Practice	Measures	Points (0-10 scale)
Expedited Care Intervention (Expediting team, expedited care unit)	**Many best practices are proven to reduce Hospital Length of Stay and Boarding. Select one or more of the expediting practices listed below:** • Nurse Expediter • Discharge Lounge • Observation Unit (ED or Hospital based) • Provider Screening in Triage / Early Provider Screening Process • Dedicated CM and/or SW Resources in the ED **Tier 1:** Implement/Expand one (1) expedited care practice from the list above and report KPI as determined by the hospital. For example, LWBS, Inpatient LOS, Door to Provider Time, etc. **Tier 2:** Implement/Expand two (2) expedited care practices from the list above and report KPI for each practice as determined by the hospital. **Tier 3:** Implement/Expand three (3) expedited care practices from the list above and report KPI as determined by the hospital.	Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points
Patient Flow Throughput Performance Council		Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points
Clinical Pathways & Observation Management	**Tier 1: Design and Implement Intervention** Hospitals will select and implement a clinical pathway tailored to a specific patient population. This clinical pathway should be based on the facility's unique patient needs and can incorporate existing pathways if already in place. **Tier 2: Develop Data Infrastructure** Hospitals will establish robust data collection and analysis systems to monitor and evaluate outcomes. These systems should emphasize comparing the effectiveness of inpatient and ambulatory management strategies for the selected patient population, enabling data-driven decision-making and continuous improvement. **Tier 3: Demonstrate Improvement** Hospitals will demonstrate a measurable decrease in unwarranted clinical variation and/or measurable improvement in outcomes specific to their chosen intervention.	Tier 1 earns 0-2 points Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) Tier 3 earns up to 4 additional points

The initial proposal under consideration for the Best Practice policy was additional revenue at risk for performance on best practices for CY 2025. However, the work needed to refine the tiers and develop data collection is substantial. Furthermore, given concerns about the time it took to develop the ED LOS measure and incentive

concurrent to its use, staff believe additional time is needed to do this well. Finally, stakeholder engagement has been exceptional during this process and should be commended by providing this additional time for hospitals to develop the data collection needed to measure the tiers. Staff recommend that RY 2027 be focused on refinement and implementation of best practice measures, workflow redesign, and report development and validation. Therefore, RY 2027 efforts will be focused on development of the Best Practice tiers and data collection, and no revenue be tied to performance on the best practice measures for RY2027. There will be a 0.1 percent all-payer, IP revenue, accountability penalty tied to best practice implementation and data submission, meaning a penalty would be assessed if a hospital did not report data by October 2025 for its two selected best practices. Staff intend to continue the refinement of the best practices measures and tiers throughout RY 2027.

Stakeholder Feedback

The Best Practice subgroup has representation from all hospitals/health systems, as well as MHA and several other agencies and organizations. The subgroup members have been very engaged and actively involved in the development of the best practice recommendations. Overall, stakeholders have expressed support for the Best Practice Policy. The following has been called out in comment letters:

- Consideration of the effort required for data collection and reporting, allowing flexibility across health systems for alignment of measures with specific organizational opportunities
- Encourage flexible reporting timelines
- Request to shift data reporting deadline from October 2025 to December 2025
- Request for consideration of justifiable reporting delays in hospitals that are making a good faith effort in implementing best practices that may fall outside of the extraordinary circumstances exception policy. Noted above: We will follow our extraordinary circumstances exception policy to address any unforeseen events (i.e. cyberattack, natural disaster, etc.).
- Hospitals have been investing significant resources to implement initiatives directed at optimizing throughput and decreasing both IP and ED LOS. They ask that we also support and lead efforts to address external factors driving throughput and boarding issues related to an increased need for behavioral health and substance use disorder care, primary care, chronic condition management and complex post-acute care, as well as prior authorization delays and payer denials.
- Suggestions to also consider concurrent evaluation of other measures in the context of ED Wait Times, throughput and patient outcomes including: post-acute facility capacity, ambulatory and telemedicine care access related to ED wait times and hospital throughput, Left without being seen (LWBS), length of stay (stratified by discharge location and other factors), readmissions, 30-day mortality and patient experience
- Stakeholders also note external drivers of throughput issues including workforce challenges, supply delays, and capacity constraints across the continuum of care. Stakeholders support and in many instances volunteer to assist with efforts to address these external challenges, including engagement with legislators to facilitate meaningful actions.
- Request consideration of the +/- 0.25% revenue at risk in future years. Note: Policy indicates we will evaluate year 1 results before determining revenue at risk for subsequent years

HSCRC Response to Stakeholder Feedback

- The HSCRC staff support flexibility of measure reporting across health systems to allow for targeted efforts at each hospital. This flexibility is reflected in the measures in the final draft recommendation.

- HSCRC supports flexible reporting timelines and would support a data reporting timeline that would request preliminary data reporting as data is available in CY2025 with a requirement to have a data submission by December 2025.
- As reflected in the policy, regarding justifiable reporting delays, HSCRC will follow our extraordinary exception policy to address any unforeseen events. HSCRC will consider each request for delayed reporting outside of this policy on a case-by-case basis.
- HSCRC staff supports the requested focus on external drivers of ED LOS and ED Wait Times, and are working with the ED Wait Time Reduction Commission and designated subgroups to address external factors driving: throughput and boarding issues related to an increased need for behavioral health and substance use disorder care, primary care, chronic condition management and complex post-acute care, as well as prior authorization delays and payer denials.
- External drivers related to capacity across the continuum of care, supplies, external throughput challenges, and workforce issues will be evaluated by the HSCRC staff in partnership with the ED Wait Time Reduction Commission and designated representatives from hospital and other health care organizations on the Capacity, Operations and Staffing Subgroup of the ED WTR Commission.
- HSCRC staff agree with the suggestion to concurrently evaluate other measures in the context of ED Wait Times, throughput and patient outcomes, including: post-acute facility capacity, ambulatory and telemedicine care access related to ED wait times and hospital throughput, Left without being seen (LWBS), length of stay (stratified by discharge location and other factors), readmissions, 30-day mortality and patient experience.
    - HSCRC staff and the ED WTR Data Subgroup have begun analyses focused on capacity and LOS and are in agreement with analysis of the other measures noted above in the comments.
    - Regarding the post-acute facility capacity and care transitions, legislative partners have volunteered to help facilitate collaboration between HSCRC, ED WTR Commission and hospitals and post-acute partners and support data analysis. We anticipate moving forward with this collaboration during this legislative session.
- HSCRC staff believes the request for consideration of the +/- 0.25 % revenue at risk for subsequent years has been addressed, as the policy notes that we will evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

Final Recommendations

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

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of six Hospital Best Practices that are designed to improve the emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    a. For each best practice identified, three weighted tiers were developed with corresponding measures that reflect the fidelity and intensity of each best practice.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2027.
    a. Failure to implement and report data to the Commission by October 2025 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2026. We will follow our extraordinary circumstances exception policy to address any unforeseen events (i.e. cyberattack, natural disaster, etc.).

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

APPENDIX A: HSCRC EFFORTS TO ADDRESS ED LENGTH OF STAY

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

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

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

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

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

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

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

Additional Initiatives: Emergency Department Dramatic Improvement Effort (EDDIE)

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

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

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

Additional Initiatives: ED Potentially Avoidable Utilization

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

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

Additional Initiatives: Legislative Workgroup

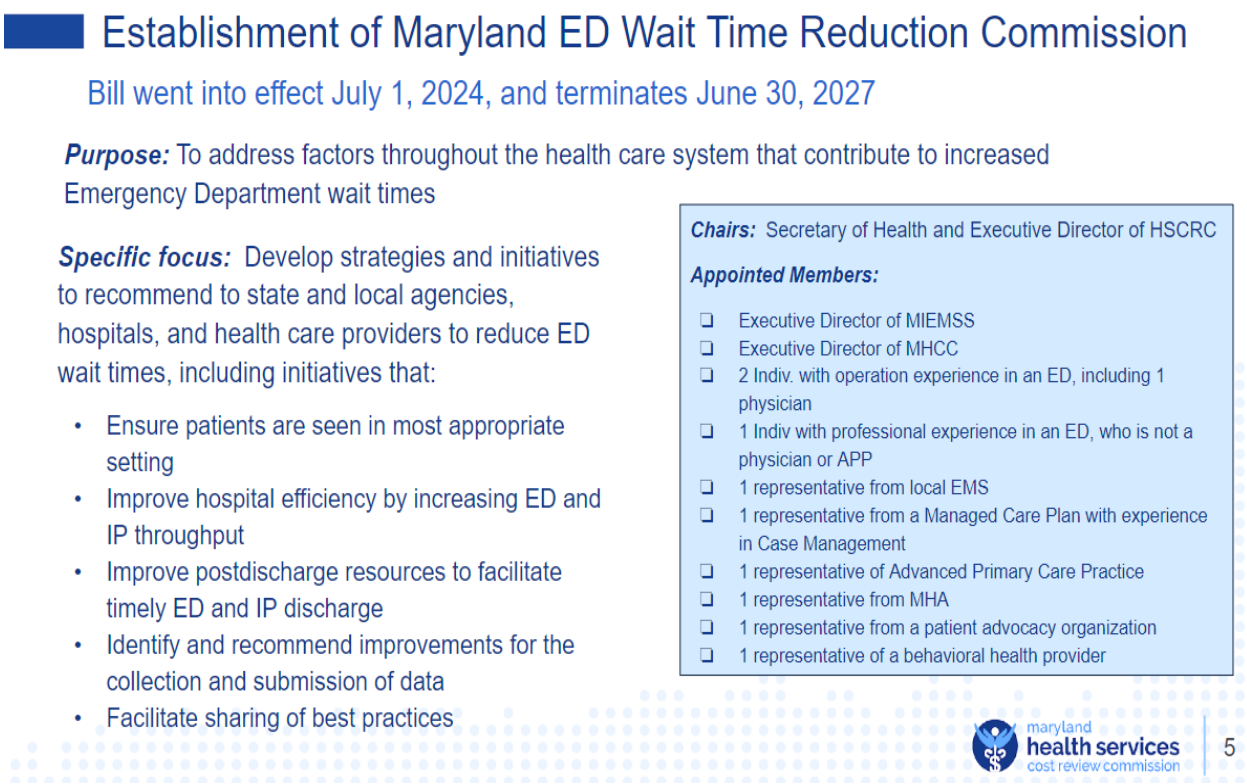
In early 2023, the Maryland General Assembly passed legislation establishing the Task Force on Reducing Emergency Department Wait Times to study best practices for reducing emergency department wait times; and requiring the Task Force to report its findings and recommendations to the Governor and the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

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

New Commission: Maryland Emergency Department Wait Time Reduction Commission

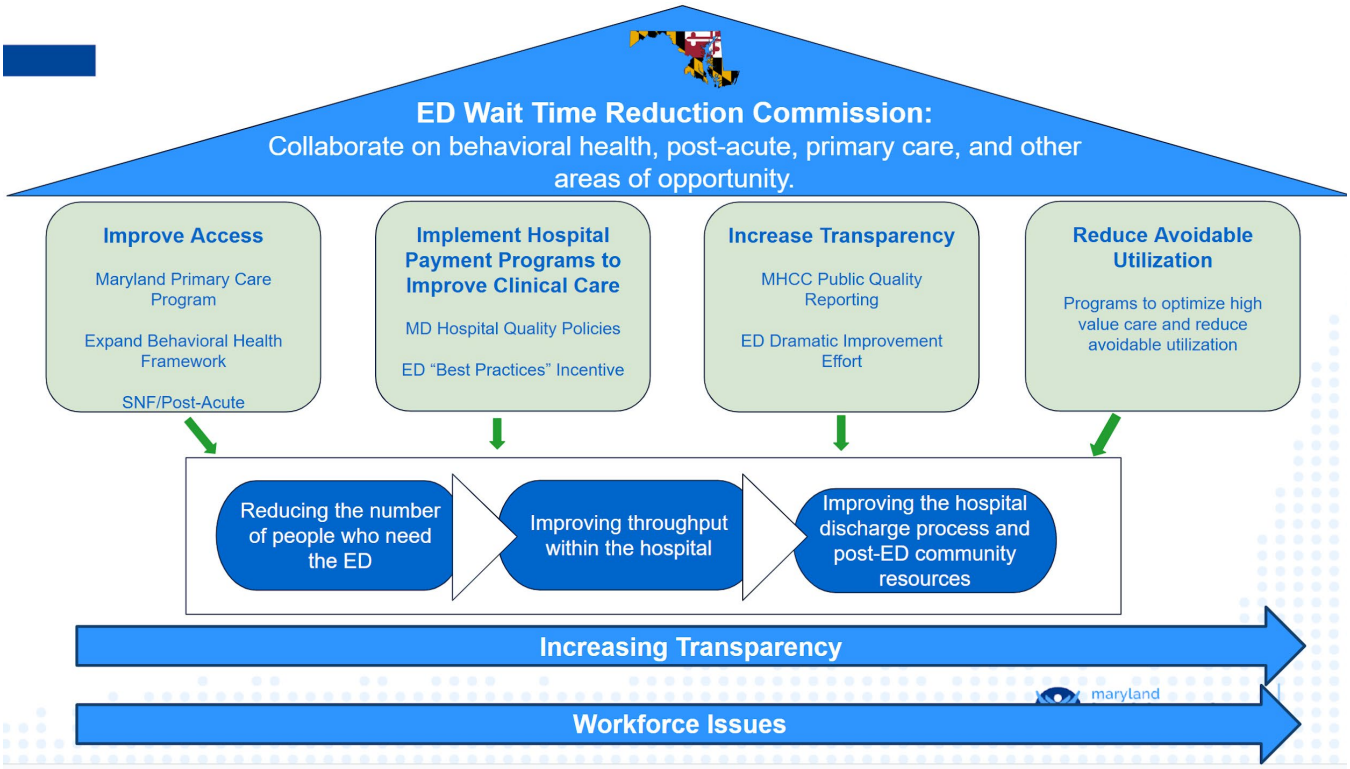
In the 2024 General Assembly session, legislation was passed establishing the ED Wait Times Reduction Commission, which went into effect on July 1, 2024. Figure E1 provides details on the ED Commission purpose, specific tasks, and member representation on the ED Commission.

Figure E1. ED Wait Time Commission Description



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

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



ED Wait Time Reduction Commission Subcommittees

Access to Non-Hospital Care

- Integrate and optimize best practices and data analytics for advanced primary care, specialty care, home health, post-acute care, and ancillary services in an effort to reduce avoidable ED and hospital utilization and improve care transition workflows throughout the continuum of care.
- Meetings every six to eight weeks.

Data Subcommittee

- Identify different data sources across healthcare platforms to include ambulatory, acute care, post-acute care, and third-party data. Will support the strategic data-driven priorities of the ED Wait Time Reduction Commission
- Meetings every six to eight weeks

ED Hospital Throughput Best Practices

- Develop a set of hospital best practices and scoring criteria to improve overall hospital throughput and reduce ED length of stay, advise on revenue at-risk and scaled financial incentives, and provide input on data collection and auditing.
- Meetings every four weeks.

Hospital Capacity, Operations & Staffing

- Subgroup will convene in April 2025.
- Planned focus of the subgroup is to assess access and capacity across the State, collaborate with commercial payers, Medicare, and Medicaid, and optimize workforce development opportunities.
- Meetings every four to six weeks.

Peninsula Regional 100 East Carroll Street Salisbury, MD 21801

(410) 546-6400

January 17, 2025

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

Dear Dr. Kromm,

We are writing to provide comments on the Emergency Department (ED) and Hospital Throughput Best Practices Draft Policy. We strongly support pilots to study ways to improve healthcare delivery and patient experience and outcomes for all patients.

As the Chief Nursing Executive and former ED nurse and director for twenty years, I have had the honor of contributing to the hard work and dedication of the ED team at TidalHealth. The efforts that have been made to enhance patient throughput and overall ED operations have been extensive, and I am incredibly proud of the strides that have been made.

The TidalHealth ED has implemented initiatives to enhance throughput including but not limited to interdisciplinary rounds on boarding patients, an internal department capacity management plan that has been presented on the national stage at the 2023 Emergency Nurses Association Conference in San Diego, CA, twice daily capacity huddles with leadership from both hospitals in our system, treatment of lower acuity patients in non-traditional care spaces while having efforts to maintain privacy and remain HIPAA compliant, a hospital wide throughput team that examines throughput challenges in both inside and outside the walls of the hospital, establishing the role of throughput nurse and many others. Our efforts have been successful because of the collaborative nature of the relationship between staff, physicians and advanced practice professionals and our dedication to our community.

Our performance because of these initiatives speaks for itself. TidalHealth is ranked eighth in overall throughput in the state and ranked first in similar high volume EDs. Our EMS median offload time is 7.3 minutes for the past six months for an average of almost 1600 arrivals per month. TidalHealth Peninsula Regional ED's average rate of patients who leave without being seen is under 3%.

We will continue our work as we believe in a culture of teamwork, innovation and continuous improvement and always challenge ourselves to better serve our community. As we continue to learn ways to improve and work to develop payment policies, we need to ensure we don't penalize Hospitals unfairly and differences are considered and adjusted for in the policies.

With this policy, the bed capacity in certain areas of the State and the close proximity to other hospitals has an impact and should be considered. We also should make sure that Hospitals that already perform well compared to their peers are not financially penalized for their good work.

We believe there are other factors and we want to work with the team as they develop the payment policy.

We appreciate the opportunity to submit our comments and we look forward to working with you to study the impact of the process measure adoptions on delivery of care.

Sincerely,

Angela Brittingham DNP, MS, RN, CEN, CPEN, NEA-BC, CPHQ
Vice President and Chief Nursing Officer

Cc:
Joshua Sharfstein, Chair HSCRC
Dr. James Elliott, Commissioner
Richardo Johnson, Commissioner
Dr. Maulik Joshi, Commissioner
Adam Kane, Commissioner
Nicki McCann, Commissioner
Dr. Farzaneh Sabi, Commissioner
Alyson Schuster Deputy Director, Quality Methodologies, HSCRC
Alan Pack,Principal Deputy Director, Quality and Population Based Methodologies, HSCRC Kathy Talbot, Vice President of Finance and Chief Revenue Integrity Officer

February 19, 2025

Joshua Sharfstein, MD
Chairperson, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dr. Sharfstein,

On behalf of the Johns Hopkins Health System (JHHS), we appreciate the opportunity to provide input on the Emergency Department Best Practices Incentive Policy. We agree that Emergency Department wait times are important drivers for patient safety and patient satisfaction and that the wait times in Maryland and the nation must be significantly reduced.

Numerous community, payer, post-acute capacity, and hospital drivers contribute to prolonged Emergency Department wait times, particularly in a "post"-pandemic world with higher rates of mental health illness, substance use, and increased incidence of chronic diseases. We appreciate the HSCRC's commitment to understand all of these drivers and to incentivize implementation of actionable processes that may reduce Emergency Department wait times. In pursuit of understanding these numerous drivers, JHHS also encourages staff to concurrently evaluate post acute facility capacity, ambulatory and telemedicine care access in relation to ED wait times and hospital throughput. Tracking the number of and length of stay of patients who are in our hospitals waiting for a post-acute care facility is an important indicator of a bottleneck in our shared delivery system.

JHHS encourages staff to also measure outcomes such as left before being seen, patient satisfaction, and complementary measures—such as 30-day mortality and subsequent length of stay or readmission—in order to develop a comprehensive, data-informed approach to Emergency Department wait times.

We appreciate that there is adequate time to collect data and performance, as the data will help identify not only opportunities for improvement on ED wait times, but also the other pressures impacting ED wait times. We are supportive of the approach as it exists today, though do recognize that the staff recommendation may need to be revisited once the data is collected and analyzed.

JHHS applauds HSCRC staff's collaborative, front-line clinician supported approach in developing appropriate best practices and tiered incentives. Emergency Department Wait times remain a challenging problem in Maryland and the nation, and we look forward to continued partnership with the HSCRC to further understand and mitigate this important issue.

Sincerely,

Peter Hill, MD
Senior Vice President Medical Affairs
Johns Hopkins Health System

cc: Josh Sharfstein, MD, Chairman Maulik Joshi, DrPH
James Elliott, MD, Vice Chairman Farzaneh Sabi, MD
Nicki McCann, JD Ricardo Johnson
Adam Kane Jonathan Kromm, Executive Director

Maryland
Hospital Association

February 19, 2025

Alyson Schuster, Ph.D.
Deputy Director, Quality Methodologies

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

Dear Dr. Schuster:

On behalf of the Maryland Hospital Association (MHA) and our member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) hospital best practices draft policy proposal aimed at incentivizing the implementation and optimization of best practices to improve hospital throughput and reduce emergency department (ED) wait times.

MHA and its members share the HSCRC's commitment to improving patient flow and reducing ED length of stay (LOS), recognizing that timely patient movement is essential for quality care, patient safety, and operational efficiency. Maryland hospitals have been actively engaged in efforts to enhance throughput and alleviate bottlenecks in the care continuum. Many of these efforts are already demonstrating promising results, and we appreciate HSCRC's recognition of the ongoing work by hospital leaders, frontline staff, and key stakeholders to address these challenges.

While we support the intent of this policy to drive system-wide improvements, we encourage HSCRC to carefully consider the broader systemic factors contributing to ED crowding and throughput inefficiencies, many of which fall outside of hospital control. Workforce shortages, supply and prior authorization delays limiting access to post-acute care, and community-based alternatives to hospitalization are significant constraints that must be addressed in parallel with hospital-driven initiatives. Sustainable improvements require a holistic approach involving hospitals, payers, emergency medical services, post-acute facilities, primary care, and community-based organizations.

We offer the following considerations regarding the draft policy proposal:

Refining the Best Practice Specifications

We appreciate the hard work of the Emergency Department Hospital Best Practice Subgroup over the past year. We encourage HSCRC to engage further with hospitals to refine the

specifications, ensuring that the selected practices are evidence-based, adaptable across diverse hospital settings, and aligned with ongoing hospital initiatives.

The proposed three-tiered weighting system should be developed with clear, achievable metrics that reflect realistic implementation timelines and acknowledge the varying levels of hospital resources.

Hospital Selection and Implementation Requirements

Allowing hospitals to select two best practices for implementation is a reasonable approach. We urge HSCRC to consider flexible implementation timelines, recognizing that some best practices may require significant operational changes or infrastructure investments.

While we acknowledge the need for accountability, we are concerned that the proposed 0.1% penalty for non-implementation and reporting by October 2025 does not account for external barriers to meeting the reporting deadline. We recommend that HSCRC establish an alternative pathway for hospitals demonstrating good-faith efforts toward implementation but facing justifiable delays.

Future Performance-Based Incentives

We appreciate HSCRC's willingness to evaluate the impact of the policy in the first year before finalizing the financial implications for subsequent years. However, we urge HSCRC to assess hospital performance within the broader context of external constraints. Factors such as patient acuity trends, regional variations in post-acute care availability, and emergency medical services transport issues should be accounted for when determining hospital performance expectations.

Rather than imposing a strict 0.25% at-risk revenue model in subsequent years, we recommend a phased approach that prioritizes technical assistance, peer learning, and collaborative problem solving before implementing financial penalties.

Maryland hospitals remain committed to working alongside HSCRC and other stakeholders to improve hospital throughput and reduce ED wait times. We urge HSCRC to ensure that policy incentives are designed to support hospitals in overcoming systemic barriers rather than imposing undue penalties that will not address the full scope of challenges. We appreciate the opportunity to provide feedback and look forward to continued collaboration on this important issue.

Sincerely,

Brian Sims
Vice President, Quality & Equity

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

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Draft Recommendation for the Maryland Hospital Acquired Conditions Program for Rate Year 2027

March 12, 2025

This document contains staff draft recommendations for the RY 2027 Maryland Hospital Acquired Conditions Program. Comments are due on Wednesday, March 21, 2025 and may be submitted to hscrc.quality@maryland.gov.

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Table of Contents

List of Abbreviations

AHRQ	Agency for Health Care Research and Quality
APR-DRG	All Patients Refined Diagnosis Related Groups
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
DRG	Diagnosis-Related Group
FFY	Federal Fiscal Year
FY	State Fiscal Year
HAC	Hospital-Acquired Condition
HAI	Hospital Associated Infection
HSCRC	Health Services Cost Review Commission
ICD	International Statistical Classification of Diseases and Related Health Problems
MHAC	Maryland Hospital-Acquired Condition
NHSN	National Healthcare Safety Network
NQF	National Quality Forum
PMWG	Performance Measurement Work Group
POA	Present on Admission
PPC	Potentially Preventable Complication
PSI	Patient Safety Indicator
QBR	Quality-Based Reimbursement
RY	Rate Year
SIR	Standardized Infection Ratio
SOI	Severity of Illness
TCOC	Total Cost of Care
VBP	Value-Based Purchasing
YTD	Year to Date

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Key Methodology Concepts and Definitions

Potentially preventable complications (PPCs): 3M originally developed 65 PPC measures, which are defined as harmful events that develop after the patient is admitted to the hospital and may result from processes of care and treatment rather than from the natural progression of the underlying illness. PPCs, like national claims-based hospital-acquired condition measures, rely on **present-on-admission codes** to identify these post-admission complications.

At-risk discharge: Discharge that is eligible for a PPC based on the measure specifications

Diagnosis-Related Group (DRG): A system to classify hospital cases into categories that are similar clinically and in expected resource use. DRGs are based on a patient's primary diagnosis and the presence of other conditions.

All Patients Refined Diagnosis Related Groups (APR-DRG): Specific type of DRG assigned using 3M software that groups all diagnosis and procedure codes into one of 328 All-Patient Refined-Diagnosis Related Groups.

Severity of Illness (SOI): 4-level classification of minor, moderate, major, and extreme that can be used with APR-DRGs to assess the acuity of a discharge.

APR-DRG SOI: Combination of Diagnosis Related Groups with Severity of Illness levels, such that each admission can be classified into an APR-DRG SOI "cell" along with other admissions that have the same Diagnosis Related Group and Severity of Illness level.

Case-Mix Adjustment: Statewide rate for each PPC (i.e., normative value or "norm") is calculated for each diagnosis and severity level. These **statewide norms** are applied to each hospital's case-mix to determine the expected number of PPCs, a process known as **indirect standardization**.

Observed/Expected Ratio: PPC rates are calculated by dividing the observed number of PPCs by the expected number of PPCs. Expected PPCs are determined through case-mix adjustment.

Diagnostic Group-PPC Pairings: Complications are measured at the diagnosis and Severity of Illness level, of which there are approximately 1,200 combinations before one accounts for clinical logic and PPC variation.

Zero norms: Instances where no PPCs are expected because none were observed in the base period at the Diagnosis Related Group and Severity of Illness level.

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Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effects on Health Equity
The quality programs operated by the Health Services Cost Review Commission, including the Maryland Hospital Acquired Conditions (MHAC) program, are intended to drive improvements in patient outcomes and to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care on an all-payer basis. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance.	The MHAC program is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time.	The MHAC policy currently holds 2 percent of inpatient hospital revenue at-risk for complications that may occur during a hospital stay as a result of treatment rather than the underlying progression of disease. Examples of the types of hospital acquired conditions included in the current payment program are respiratory failure, pulmonary embolisms, and surgical-site infections.	This policy affects a hospital's overall GBR and so affects the rates paid by payers at that particular hospital. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.	Historically the MHAC policy included the better of improvement and attainment, which incentivized hospitals to improve poor clinical outcomes that are often emblematic of disparities. The protection of improvement has since been phased out to ensure that poor clinical outcomes and the associated health disparities are not made permanent, which is especially important for a measure that is limited to in-hospital complications. In the future, the MHAC policy may provide direct hospital incentives for reducing disparities, similar to the approved readmission disparity gap improvement policy. Also for future consideration is inclusion of electronic Clinical Quality Measures to address areas such as maternal complications, which disproportionately impact lower income, minority patients.

Recommendations

The MHAC policy was redesigned in Rate Year (RY) 2021 to modernize the program for the new Total Cost of Care Model.[1] The RY 2021 policy approach to performance assessment, scoring, and conversion of scores to revenue adjustments has been maintained through RY 2026. This RY 2027 draft recommendation maintains the Potentially Preventable Complication (PPC) measures used for RY 2026 and also presents potential options for updating the methodology to address small cell size concerns, as well as the scaling to determine revenue adjustments. Specifically, the policy provides validity and reliability analysis results, hospital-level and statewide scores and revenue adjustments for the current methodology that scores hospitals on each PPC individually compared to an option that scores hospitals based on a PPC composite measure. While small hospitals initially raised concerns about small cell sizes, staff proposes the Commission consider adopting this new scoring methodology for all hospitals based on the findings outlined in this policy. Last, staff also propose potential changes for how scores are converted to revenue adjustments.

The draft recommendations for the RY 2027 Maryland Hospital Acquired Conditions (MHAC) program are as follows:

1. Use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.
    a. Maintain a focused list of PPCs in the payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
    b. Assess monitoring PPCs based on clinical recommendations, statistical characteristics, and recent trends to prioritize those for future consideration for updating the measures in the payment program.
    c. Engage hospitals on specific PPC increases as indicated/appropriate to understand trends and discuss potential quality concerns.
2. Assess performance using more than one year of data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs). The performance period for small hospitals will be CYs 2024 and 2025.
3. Assess hospital performance based on statewide attainment standards.
4. Consider options for determining hospital scores:
    a. Option1 (current methodology): Score hospital performance on each PPC individually

[1] See the RY 2021 policy for detailed discussion of the MHAC redesign, rationale for decisions, and approved recommendations.

weighted by Solventum (3M) cost weights as a proxy for patient harm. Hospitals are only assessed on the PPCs that meet minimum volume criteria.[2]

b. Option 2 (staff proposal): Score hospital performance on a PPC composite that includes all payment PPCs weighted by hospital specific expected volume and Solventum (3M) cost weights as a proxy for patient harm[3]

5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent. Consider the following options for the revenue adjustment scale:
    a. Option 1 (current methodology): Linear scale that ranges from 0 to 100 percent and includes a 10 percentage point hold harmless zone. The cut point for penalties and rewards is determined by centering the no harmless zone around the average hospital MHAC score as determined through prospective modeling.
    b. Option 2 (staff proposal): Continuous linear scale that ranges from 0 to 100 percent without a hold harmless zone. The cut point for penalties and rewards is average hospital MHAC score as determined through prospective modeling.
    c. (New proposal for either option): Retrospectively assess the average hospital MHAC scores and propose to the Commissioners that the cutpoint be modified if the actual average score is more than +/- 10 percent different from the prospectively modeled average MHAC score.
6. Going forward, consider other candidate measures/measure sets that may be important for assessing hospital avoidable, harmful complications and appropriate for use in the program, e.g., digitally specified measures.

Introduction

Maryland hospitals are funded under a population-based revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under the All-Payer Model agreement with the Centers for Medicare & Medicaid Services (CMS) beginning in 2014, and

[2] Hospitals must have at least 20 at-risk and 2 expected PPCs in the two year base period used to calculate Statewide normative values (i.e., statewide PPC rate for each diagnosis and severity of illness level). This criteria means that not all hospitals are assessed on all Payment PPCs; in RY 2026 some hospitals were assessed on as few as 3 PPCs (on average hospitals were assessed on X number of PPC categories)

[3] Hospitals without any at-risk or expected for a specific PPC would not be assessed on that PPC. The two maternity related PPCs are dropped for hospitals without this service line, but almost all other Payment PPCs are included for all hospitals at this time weighted by the hospital volume.

continuing under the current Total Cost of Care (TCOC) Model agreement, which took effect in 2019. Under the global budget system, hospitals are incentivized to shift services to the most appropriate care setting and simultaneously have revenue at risk in Maryland's unique, all-payer, pay-for-performance quality programs; this allows hospitals to keep any savings they earn via better patient experiences, reduced hospital-acquired infections, or other improvements in care. Maryland systematically revises its quality and value-based payment programs to better achieve the state's overarching goals: more efficient, higher quality care, and improved population health. It is important that the Commission ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Commission's quality programs reward quality improvements and achievements that reinforce the incentives of the global budget system, while guarding against unintended consequences and penalizing poor performance.

The Maryland Hospital Acquired Conditions (MHAC) program is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time. The program currently holds 2 percent of hospital revenue at-risk for hospital acquired complications that may occur during a hospital stay as a result of treatment rather than the underlying progression of disease. Examples of the types of hospital acquired conditions included in the current payment program are respiratory failure, pulmonary embolisms, and surgical-site infections.

For MHAC, as well as the other statewide hospital quality programs, annual updates are vetted with stakeholders and approved by the Commission to ensure the programs remain aggressive and progressive with results that meet or surpass those of the national CMS analogous programs (from which Maryland must receive annual exemptions). With the onset of the Total Cost of Care Model Agreement, each Quality program was overhauled to ensure they support the goals of the Model. For the MHAC policy, the overhaul was completed during 2018, which entailed an extensive stakeholder engagement effort. The major accomplishments of the MHAC program redesign were focusing the payment incentives on a narrower list of clinically significant complications, moving to an attainment only system given Maryland's sustained improvement on complications, adjusting the scoring methodology to better differentiate hospital performance, and weighting complications by their associated cost weights as a proxy for patient harm. The redesign also assessed how hospital performance is converted to revenue adjustments, and ultimately recommended maintaining the use of a linear revenue adjustment scale with a hold harmless zone.

For this RY 2027 MHAC draft policy, staff proposes maintaining the current focused list of payment PPCs and suggests consideration of potential changes to calculate hospital scores and applying revenue

adjustments to address small cell size concerns that particularly impact small hospitals; the potential changes entail the use of a composite measure to calculate all hospital scores, and updating the revenue adjustment scaling approach. The Assessment section of this draft includes an evaluation of PPCs in the payment program as well as those in "monitoring" status using the RY 2026 current MHAC methodology. This draft recommendation does not propose moving any complication categories from monitoring to payment. However, the Assessment section does provide analyses to evaluate the current methodology versus using a composite score, and includes a discussion of options for updating revenue adjustment scaling.

Background

Exemption from Federal Hospital-Acquired Condition Programs

The Federal Government operates two hospital complications payment programs, the Deficit Reduction Act Hospital Acquired Condition program (DRA-HAC), which reduces reimbursement for hospitalizations with inpatient complications, and the HAC Reduction Program (HACRP), which penalizes hospitals with the highest rates of complications. Detailed information, including HACRP complication measures, may be found in Appendix I. Also, it should be noted that the CMS Value-Based Purchasing program and the analogous Quality Based Reimbursement program contain a safety domain that assess hospital acquired complication measures.

Because of the State's unique all-payer hospital model and its global budget system, Maryland does not directly participate in the federal pay-for-performance programs. Instead, the State administers the Maryland Hospital Acquired Conditions (MHAC) program, which relies on quality indicators validated for use with an all-payer inpatient population. However, the State must submit an annual report to CMS demonstrating that Maryland's MHAC program targets and results continue to be aggressive and progressive, i.e., that Maryland's performance meets or surpasses that of the nation. Specifically, the State must ensure that the improvements in complication rates observed under the All-Payer Model through 2018 are maintained throughout the TCOC model. Based on performance to date, CMS has granted Maryland exemptions from the federal pay-for-performance programs (including the HAC Reduction Program) each year through Federal Fiscal Year 2025.

Overview of the MHAC Policy

The MHAC program, first implemented for Rate Year 2011, is based on a classification system developed by 3M Health Information Systems (3M), now Solventum. To identify potentially preventable complications

(PPCs), the system uses the present-on-admission (POA) variable for eligible secondary diagnosis codes available in claims data to identify conditions not POA. The PPC system originally comprised specifications for 65 PPCs,[4] defined as harmful events that develop after the patient is admitted to the hospital and may result from processes of care and treatment rather than from the natural progression of the underlying illness. For example, the program holds hospitals accountable for venous thrombosis and sepsis that occur during inpatient stays. These complications can lead to 1) poor patient outcomes, including longer hospital stays, permanent harm, and death; and 2) increased costs. Thus, the MHAC program is designed to provide incentives to improve patient care by adjusting hospital budgets based on PPC performance.

Current MHAC Methodology

Figure 1 provides an overview of the three steps in the Rate Year 2026 MHAC methodology (also see Appendix II) that converts hospital performance to standardized scores, and then payment adjustments, as outlined below:

Step 1. For the PPCs identified for payment, clinically-determined global and PPC-specific exclusions, as well as volume based hospital-level exclusions are identified to ensure fairness in assignment of complications.

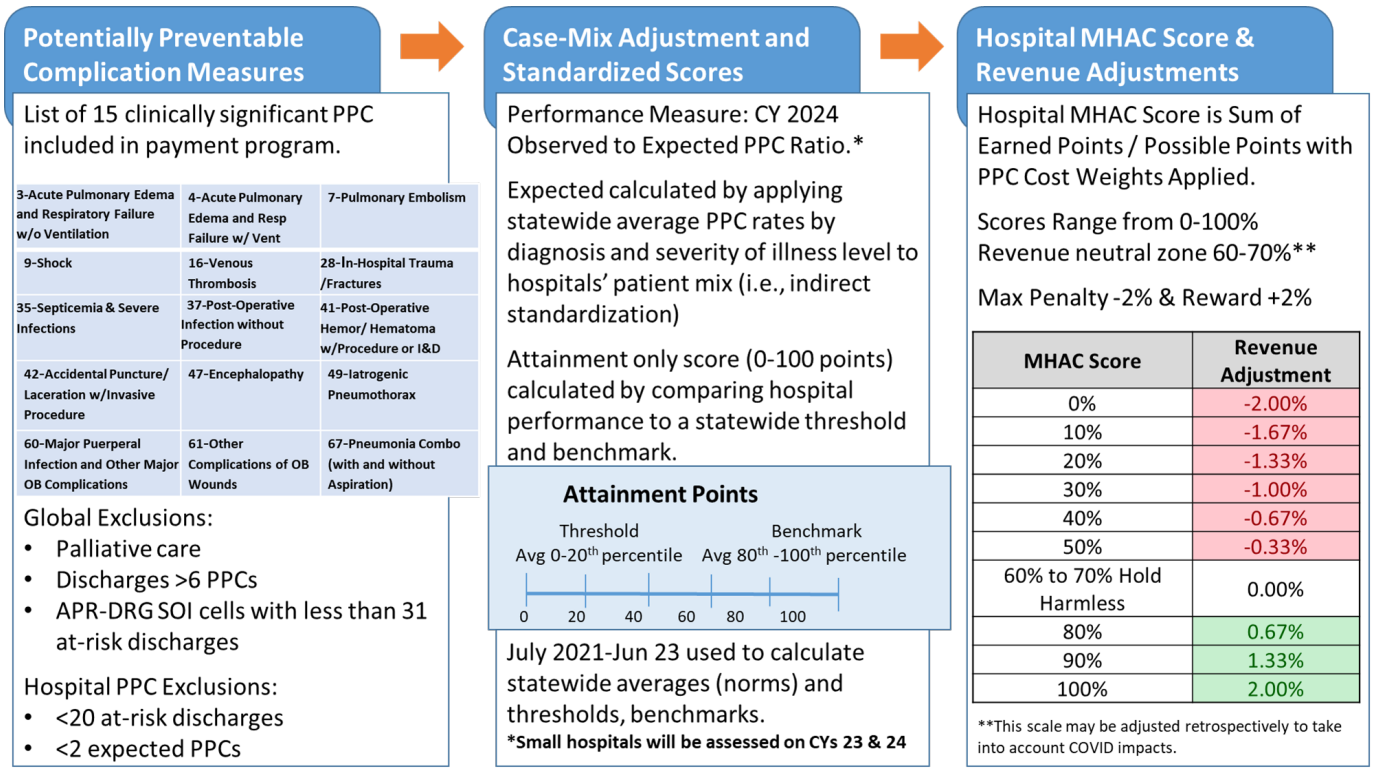
Step 2. Case-mix adjustment is used to calculate observed to expected ratios that are then converted to a standardized point score (from 0-100 points) based on each hospital's attainment levels using a similar scoring methodology that is used for CMS Value-Based Purchasing and Maryland QBR program.

Step 3. Overall hospital scores are then calculated by taking the points for each PPC and multiplying by the 3M PPC cost weights, then summing numerator (points scored) and denominator (possible points) across the PPCs to calculate a percent score. A linear point scale set prospectively is then used to calculate the revenue adjustment percent. This prospective scaling approach differs from national programs that relatively rank hospitals after the performance period.

[4] In RY 2020, 45 out of 65 PPCs or PPC combinations were included in the program as 3M had discontinued some PPCs and others were deemed not suitable for a pay-for-performance program. The re-designed RY 2021 policy reduced the PPCs assessed to a focused list of 14 PPCs that were clinically actionable and had higher rates and greater variation across hospitals, and/or were clinically significant. In RY 2025, the policy was updated to include PPC 47 Encephalopathy, so there are now 15 payment PPCs.

Additionally, the HACRP differs in that it provides no opportunity for rewards and reduces payments by 1 percent for hospitals in the worst-performing quartile.

Figure 1. Overview Rate Year 2026 MHAC Methodology



Assessment

This section provides an overview of the statewide PPC trends—for those used for payment, under monitoring, and overall (comprising a total of 58 PPCs)–using the current RY 2026 methodology. Following the results to date, this section provides analyses that evaluate the validity and reliability of hospital scores using the current methodology that scores hospitals on each PPC individually compared to options that score hospitals based on a PPC composite measure. Lastly, this section provides modeled revenue adjustments for hospitals based on both scoring methods as well as additional options for scaling rewards and penalties.

Statewide PPC Performance Trends

Performance trends to date provided below use the RY 2026 methodology, illustrating Maryland's continued improvement under the program.

Complications Included in Payment Program

Under the All-Payer Model, Maryland hospitals saw a dramatic decline in complications and, as a State, well exceeded the requirement of a 30 percent reduction by the end of CY 2018. These reductions were achieved through clinical quality improvement, as well as improvements in documentation and coding.

As mentioned previously, the MHAC redesign assessed which PPCs should be included in the pay-for-performance program based on criteria developed by the Clinical Adverse Events Measures (CAEM) subgroup that are outlined in the "Monitored Complications" section below.

Under the TCOC Model, Maryland must maintain these improvements by not exceeding the CY 2018 PPC rates for complications included in the payment program. Figure 2 below shows the statewide observed to expected (O/E) ratio from 2018 through September CY 2024.[5] The O/E ratio presents the count of observed PPCs divided by the calculated number of expected PPCs (which is generated using statewide normative values applied to the case-mix of discharges a hospital experiences). An O/E Ratio of greater than 1 indicates that a hospital experienced more PPCs than expected, and conversely, an O/E Ratio less than one indicates that a hospital experienced fewer PPCs than expected. Figure 2 below also indicates how Maryland is performing relative to CY 2018, which is the time period that will be used to assess any backsliding on performance.[6] Specifically, there has been a 40.9 percent decrease in the ratio based on the most recent data available (CY 2018 YTD O/E ratio = 1.15 and CY 2024 YTD O/E ratio = 0.68).

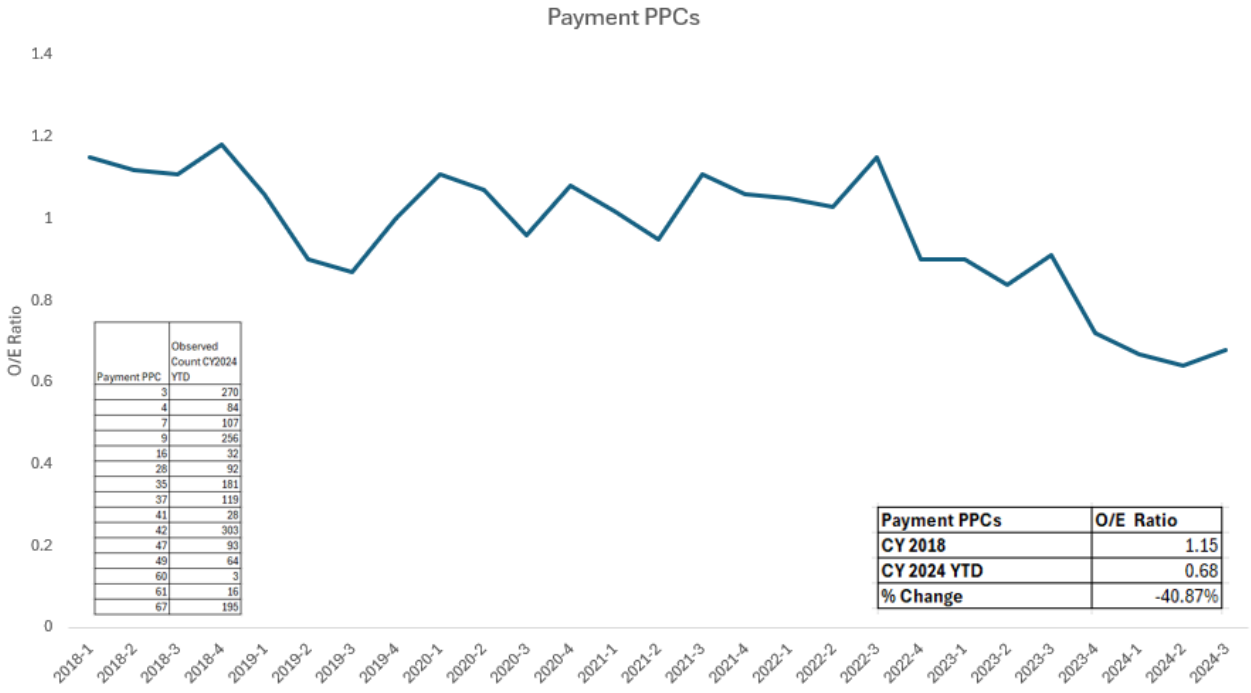
PPCs in the MHAC payment program include:

3 Acute Pulmonary Edema and Resp Failure w/o Ventilation
4 Acute Pulmonary Edema, Resp Failure w/ventilation
7 Pulmonary Embolism
9 Shock
16 Venous Thrombosis
28 In-Hospital Trauma and Fractures
35 Septicemia & Severe Infections
37 Post-Operative Infection & Deep Wound Disruption Without Procedure

[5] Staff notes that, consistent with federal policies during the COVID Public Health Emergency, PPC data from January-June 2020 will not be used for assessing quality of care.
[6] Beginning in v38 of the 3M PPC grouper, COVID exclusions vary by PPC.

41 Peri-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D
42 Accidental Puncture/ Laceration During Invasive Procedure
47 Encephalopathy
49 Iatrogenic Pneumothorax
60 Major Puerperal Infection and Other Major Obstetric Complications
61 Other Complications of Obstetrical Surgical & Perineal Wounds
67 Pneumonia Combo (with and without aspiration)

Figure 2. Payment Program PPCs Observed to Expected Ratios by Quarter CY 2018 to CY 2024 YTD Through September

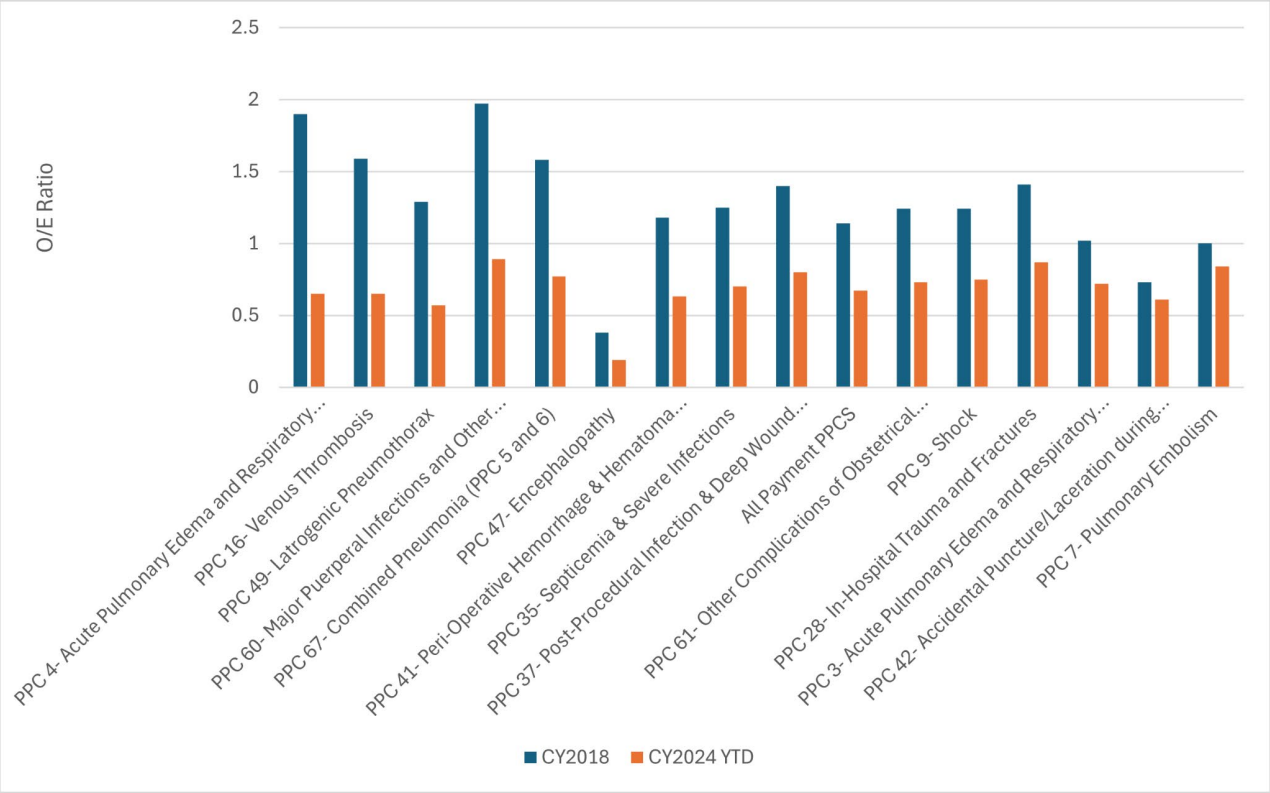


Payment PPC	Observed Count CY2024 YTD
3	270
4	84
7	107
9	256
16	32
28	92
35	181
37	119
41	28
42	303
47	93
49	64
60	3
61	16
67	195

Payment PPCs	O/E Ratio
CY 2018	1.15
CY 2024 YTD	0.68
% Change	-40.87%

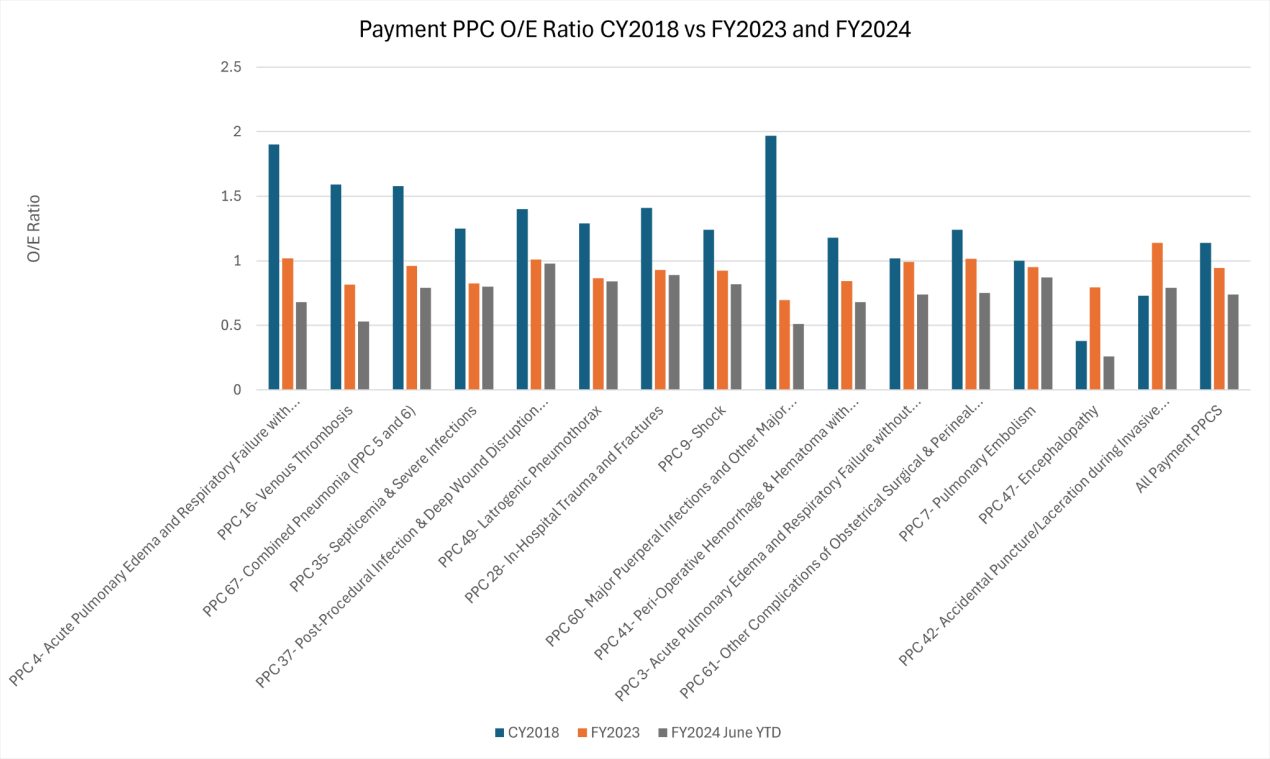
In terms of specific improvements among the 15 payment PPCs, Figure 3 shows the O/E ratios for CY 2018 and CY 2024 YTD, sorted from greatest percent decrease (on the left). The three PPCs with the greatest decreases (improvements) include PPC 4- Acute Pulmonary Edema and Respiratory Failure with Ventilation, PPC16- Venous Thrombosis, and PPC 67- Combined Pneumonia.

Figure 3. Payment Program PPC Observed to Expected Ratios CY 2018 and CY 2024 September YTD



Staff also analyzed payment PPC changes for FYs 2023 and 2024 compared to the base period of CY 2018 as illustrated in Figure 4 below. The overall PPC O/E ratios show a steadily declining trend across the three time periods; from FY2023 to FY2024 all payment PPCs showed a decrease in the O/E ratios (improvement).

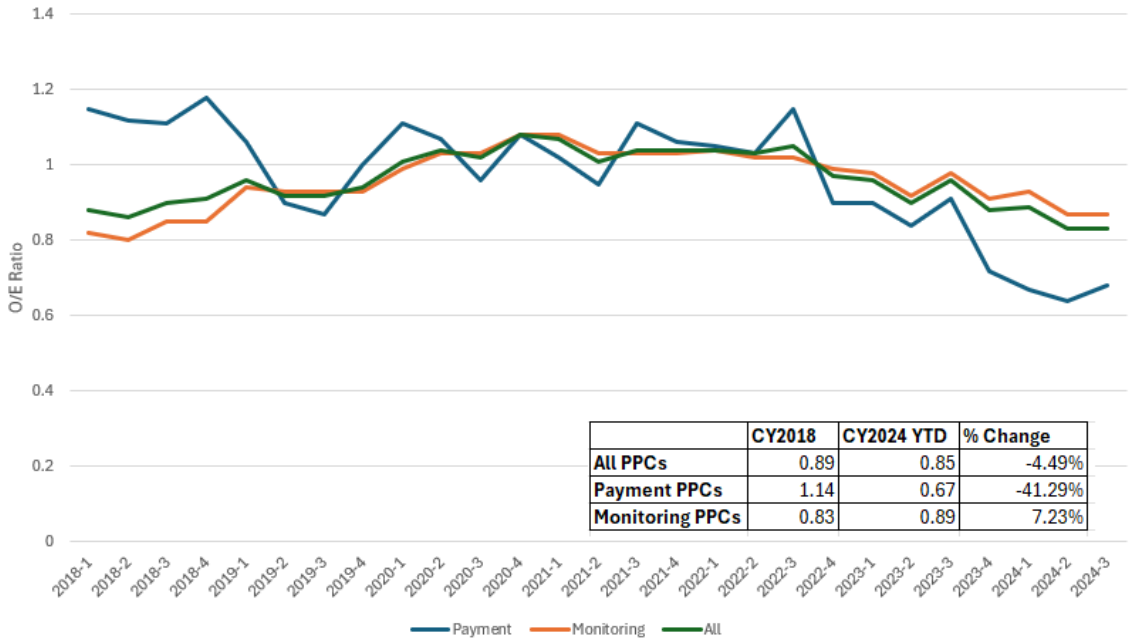
Figure 4. Payment Program PPC Observed to Expected Ratio Trends; CY 2018, FY 2023, and FY 2024



Monitored Complications

In addition to focusing on a narrowed list of PPCs for payment, as stated previously, the RY 2021 MHAC policy following the program redesign included a recommendation to monitor the remaining PPCs. Staff fulfills this recommendation by monitoring all PPCs that are still considered clinically valid by 3M, and distinguishing between “Monitoring” and “Payment” PPCs. The overall PPC trend across all 56 (payment and monitored) PPCs shows that there has been a decrease in the overall statewide O/E ratio from 0.89 in CY 2018 to 0.85 in CY 2024 YTD through September; the minimal improvement in overall performance is the result both of increases in some of the PPCs under monitoring status and reductions in the payment program PPCs, as illustrated in Figure 5 below. As also illustrated, the monitored PPC trends have increased from 0.83 as of 2018 to 0.89 in YTD 2024 with the highest O/E ratios experienced from Q3 2020 to Q1 2021 during the COVID peak period.

Figure 5. PPC O/E RatioTrends CY 2018 Qtr 1 Through CY 2024 Qtr 3



	CY2018	CY2024 YTD	% Change
All PPCs	0.89	0.85	-4.49%
Payment PPCs	1.14	0.67	-41.29%
Monitoring PPCs	0.83	0.89	7.23%

To support determinations on whether to move monitored PPCs into the payment program, staff considers several factors identified by the Clinical Adverse Events Measures (CAEM) subgroup which was convened when the MHAC program was re-designed for RY 2021. These include:

- PPC Data Analysis/Statistics: greater than 50% increase in O/E ratio compared to 2018, rate per 1,000 generally 0.5 or above, volume of observed events 100 or above (over two years), significant variation across hospitals, O/E ratios less than .85 and greater than 1.15, and at least half of the hospitals are eligible for the PPC.
- Additional Considerations: PSI overlap, clinical significance, potential influence of coding practices/changes, opportunity for improvement/actionability, impact on all-payers.

Based on staff evaluation of the monitored PPCs vetted with the PMWG, staff does not recommend moving any monitored PPCs into the payment program for RY 2027. Appendix III provides the statewide percentage changes in the O/E ratios for the monitored PPCs from 2018 to 2024 YTD through September sorted by the observed PPCs with the largest increases.

Stability of Case-Mix Adjusted PPC Rates and Scoring

Small Cell Size Considerations

Statistical issues of measurement validity and reliability related to small cell sizes impact all hospitals but are amplified for small hospitals. The current MHAC program addresses small cell size concerns in two ways: 1) All hospitals are excluded from being assessed on a PPC if they do not meet the minimum criteria of 2 expected PPCs and 20 admissions at-risk for a PPC; and 2) Small hospitals (those with less than 21,500 at-risk or 22 expected PPCs across all payment PPCs) are assessed using two years of data. Currently in RY 2026, only 4 hospitals are assessed on all of the 15 PPCs in the MHAC program and 5 hospitals are considered small hospitals by the criteria outlined above.

Despite the Commission's best efforts to address small cell size concerns, one relatively small hospital has requested changes to the MHAC policy that would better balance the tradeoff between incenting greater year over year performance across all in-hospital complications and concerns of statistical instability for PPC evaluations amongst small hospitals. In advance of the RY 2026 Policy, the hospital expressed their concerns that they had in previous years been eligible for PPC 35-Sepsis but had the previous year seen their expected rate drop below 2, rendering them ineligible for inclusion of this PPC in their MHAC score. They noted further that the PPC was serious and highly amenable to interventions which they had identified and implemented; however, with the minimum expected criteria of 2, their performance on PPC 35 is not counted or recognized in their score. Staff did not remove the inclusion requirement of 2 expected PPCs, as there was concern over the potential instability of the measurement with very low numbers of events. Further, the hospital was concerned that they were measured on two years of performance, vs. one year, as a small hospital.

As Maryland hospitals continue to improve on payment PPCs, small cell size issues are also impacting larger hospitals (i.e., non-small hospitals). The current approach of having minimum criteria for at-risk and expected is designed to increase validity and reliability. However, over time, hospitals may be assessed on fewer PPC measures, effectively reducing the comprehensiveness of the program and failing the crucial test of content validity, the degree to which a measure captures the concept it is intended to measure. Thus, staff assessed methods to evaluate the PPCs through updates to the MHAC methodology aimed at better addressing small cell size issues and related statistical reliability and validity. Among the methods considered were Bayesian smoothing[7], an approach used by CMS for the same concerns, and composite

[7] Under this Bayesian smoothing approach, a hospital's smoothed O/E ratio for each PPC measure equals the sum of a) the hospital's O/E ratio for the PPC measure times the reliability of the PPC measure at the hospital and b) one

measurement, i.e., evaluating all PPCs as one measurement as opposed to evaluating each PPC unto itself.. Results of the modeling to address small cell sizes were presented to the PMWG during the RY 2026 policy development process. Initial concerns regarding Bayesian smoothing were that, despite improved statistical reliability, small hospitals' evaluations and financial penalties/rewards would be driven by the statewide average as opposed to the hospital's' performance, which additionally could reduce the incentive for small hospitals to improve since their score would be based on other hospitals. For these reasons, staff focused its attention on the composite measurement approach in RY 2027.

Potential PPC Composite Score Options to Improve Statistical Measurement

During the RY 2027 MHAC updating process, concerns were again raised regarding the current MHAC methodology by PMWG members and other hospital stakeholders and included the following:

- Hospital performance may be based on a small subset of PPCs, as few as two or three of the 15 PPC measures for small hospitals.
- PPC measure reliability is low for some of the PPCs.
- Scores for hospitals defined as small tend to be at the high or low ends of performance.
- Two years of data in the measurement period for small hospitals (vs. one year for other hospitals) means that one year of performance will be counted in two consecutive Rate Year scores under the program.

Working with Mathematica Policy Research (MPR), staff assessed and presented options for developing a PPC composite to address these issues. Specifically, three potential composite methodologies were modeled and compared to the current MHAC methodology. Similarities and differences from the current methodology in the steps for calculating hospital composite scores are outlined in Figure 6 below.

Figure 6. Summary of MHAC Score Calculation Steps for Current Methodology vs Models

minus the reliability of the PPC measure at the hospital times the statewide O/E ratio for the PPC measure. If the reliability of a PPC measure is 1.00 at the hospital, then the hospital's smoothed O/E ratio equals the hospital's O/E ratio and is not affected by the statewide average. If the reliability of a PPC measure is 0.00 at a hospital, then the hospital's smoothed O/E ratio equals the statewide average.

1-3

Calculation Steps	Current Methodology	PPC Composite Option 1	PPC Composite Option 2	PPC Composite Option 3
PPC Exclusion Criteria	Exclude PPC measures with <2 expected PPCs or <20 at risk discharges	Exclude PPCs with 0 at-risk discharges		
PPC Measure "Volume" Weights	PPC measures not weighted by volume	PPC measures with greater expected PPCs at hospital receive a larger weight	PPC measures with more at-risk discharges at hospital receive larger weight	PPC measures with more observed PPCs across Maryland hospitals receive a larger weight
PPC Measure 3M Cost Weights	PPC measures are weighted by 3M Cost Weights			
Benchmarks and Thresholds	For each of the 15 payment PPCs, calculate a benchmark and threshold	Calculate a benchmark and threshold for the PPC Composite		

As shown in Figure 6 above, the current methodology and the three composite options staff assessed all have different approaches to PPC measure volume weights. While all of the methods tested maintain the use of the Solventum (3M) cost weights as a proxy for patient harm, the composite methodologies differ in that the hospitals are scored on the PPC measure composite as opposed to being scored on each individual PPC and the PPC exclusion logic for the current methodology excludes far more PPC's.

In order to evaluate the current methodology and potential composite score options, staff assessed the content validity, predictive validity, and reliability of each method. Content validity refers to the degree to which a measure captures the concept it is intended to measure. The intention of the MHAC Program is to evaluate Maryland hospitals based on their performance on the 15 payment PPCs, so methodologies that evaluate Maryland hospitals on all 15 payment PPCs would have the highest content validity. The composite methodologies tested evaluate Maryland hospitals on payment PPC measures with greater than 0 at-risk discharges, resulting in very high content validity, even for the smallest hospitals (Figure 7).

Figure 7. Content Validity Current Methodology Versus Composite Options

Hospital Category*	Number of Hospitals	Average Number of PPC Measures Evaluated	
		Current Methodology	Composite Methodology
Small Hospitals	5	3.6	13.2
Medium Hospitals	15	11.0	14.5
Large Hospitals	21	13.8	15

*Hospital category definitions are based on FY 2024 data. Small hospitals had less than 21,500 at-risk discharges or 22 expected PPCs; medium hospitals had between 60,000 and 150,000 at-risk discharges; large hospitals had greater than 150,000 at-risk discharges.

As previously stated, the current methodology evaluates Maryland hospitals on PPC measures for which the hospital has at least two expected PPCs, resulting in fewer PPC measures being evaluated, especially for small and medium hospitals. As illustrated in Figure 7 above, the five small Maryland hospitals are evaluated on an average of 13.2 payment PPC measures under the composite methodologies compared with 3.6 payment PPC measures under the current methodology. The 15 medium Maryland hospitals are evaluated on an average 14.5 payment PPC measures under the composite methodologies compared with 11.0 payment PPC measures under the current methodology. In addition to improving content validity, evaluating small hospitals on almost all of the 15 payment PPCs under the composite methodologies lessens the degree to which one observed PPCs on one payment PPC measure can have a drastic negative impact on a small hospital's MHAC revenue adjustment in consecutive rate years.

Reliability refers to the consistency of a measure and thus its dependability in assessing the performance of an intervention versus random variation.. Staff assessed the reliability of PPC measures and PPC composite values using the Morris signal-to-noise method under which a score of 1.00 indicates a perfect signal of hospital performance without noise (i.e., perfect reliability) and a score of 0 indicates no signal of hospital performance and all noise (i.e., worst reliability). Staff consider reliability above 0.50 to be acceptable but would hope the MHAC methodology could achieve an average reliability across Maryland hospitals of 0.75 or higher. The current methodology achieves reliability generally somewhat below the desired minimum of 0.50, with the average reliability across FY 2021 to FY 2024 being 0.39. Composite

Options 1, 2, and 3 all yield substantially higher reliability than the current methodology, especially Composite Option 1 with an average reliability of 0.76 across FY 2021 to FY 2024 (Figure 8).

Figure 8. Average Reliability Across Maryland Hospitals using a 1-year Performance Period by Methodology

Performance Period	Current Methodology*	Composite Option 1	Composite Option 2	Composite Option 3
FY 24	0.24	0.61	0.48	0.54
FY 23	0.38	0.81	0.63	0.68
FY 22	0.50	0.81	0.70	0.76
FY 21	0.42	0.80	0.62	0.72
Average	**0.39**	**0.76**	**0.61**	**0.68**

Based on the results of reliability and validity analyses of the current methodology versus the composite options presented above and also detailed in Appendix IV, **staff supports consideration of Option 1 to replace the current methodology**.

Hospital Scores and Revenue Adjustments

The hospital MHAC scores are calculated based on 1) hospital performance on each payment PPC measure relative to the PPC measure's benchmark and threshold (current methodology) or 2) hospital performance on the PPC composite relative to the PPC composite benchmark and threshold (staff proposal). Hospital MHAC scores are then converted to revenue adjustments using a prospectively determined revenue adjustment scale, which allows hospitals to track their progress throughout the performance period. Since the program redesign, the scale has remained the same–that is, it ranges from 0 to 100 percent with a hold-harmless zone between 60 and 70 percent. Should Commissioners approve staff's proposal to move to a PPC composite measurement, staff is proposing to adopt a continuous linear revenue adjustment scale that ranges from 0 to 100 percent without a hold harmless zone, using average hospital MHAC score as determined through prospective modeling as the cutpoint for rewards and

penalties. Staff believes there is no longer a need for a hold harmless zone because the composite methodology achieves a highly reliable measurement of hospital performance on payment PPC measures. Figure 9 provides the estimated revenue adjustments statewide under the current methodology and Composite Option 1, with and without a hold harmless zone. This prospective modeling is not actual values for any rate year, and may be updated in the final policy with more recent data that has the same gap between the base and performance period. For this modeling, the average MHAC score was 75 percent so this was used to determine the cut point between penalties and rewards.

The estimated statewide aggregate penalties and aggregate rewards were one and a half to two times larger, respectively, under Composite Option 1 than the Current Methodology (Figure 1). Net revenue adjustments increased from $11.8 million under the Current Methodology to $25.5 million under the Composite Option 1 with no hold harmless zone (staff proposal). Hospitals' estimated revenue adjustments under the Current Methodology and Composite Option 1 were highly correlated (0.83 with no hold harmless zone and 0.85 with a hold harmless zone).

Figure 9. Statewide Aggregate Revenue Adjustments Under Current Methodology and Composite Option 1

	Current Methodology		**Composite Option 1**	
Statewide Revenue Adjustments	No Hold Harmless Zone	Hold Harmless Zone	No Hold Harmless Zone	Hold harmless Zone
Aggregate Net Revenue Adjustment	$11,816,553	$9,289,553	$25,518,286	$22,286,597
Aggregate Penalties	-$23,903,863	-$16,502,774	-$35,931,679	-$29,594,430
Penalties: % of inpatient spending	-0.20%	-0.14%	-0.30%	-0.25%
Aggregate Rewards	$35,720,416	$25,792,327	$61,449,965	$51,881,027
Rewards: % of inpatient spending	0.30%	0.22%	0.52%	0.44%

Appendix V contains the by-hospital MHAC scores and estimated hospital revenue adjustments under the current methodology and Composite Option 1. Staff is also considering an option to retrospectively assess the average hospital MHAC scores and propose to the Commission that the cut point be modified if the actual average MHAC score is more than +/- 10 percent different from the prospectively modeled average MHAC score.

Recommendations

This RY 2027 draft recommendation maintains the measures used for RY 2026 but presents potential options for updating the methodology using composite scores, to address concerns of small cell sizes and those raised by small hospitals; results of the composite models will be presented in the final policy.

The draft staff recommendations for the RY 2027 Maryland Hospital Acquired Conditions (MHAC) program are as follows:

1. Use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.
    a. Maintain a focused list of PPCs in the payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
    b. Assess monitoring PPCs based on clinical recommendations, statistical characteristics, and recent trends to prioritize those for future consideration for updating the measures in the payment program.
    c. Engage hospitals on specific PPC increases as indicated/appropriate to understand trends and discuss potential quality concerns.
2. Assess performance using more than one year of data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs). The performance period for small hospitals will be CYs 2024 and 2025.
3. Assess hospital performance based on statewide attainment standards.
4. Consider options for determining hospital scores:
    a. Option1 (current methodology): Score hospital performance on each PPC individually weighted by Solventum (3M) cost weights as a proxy for patient harm. Hospitals are only assessed on the PPCs that meet minimum volume criteria.[8]

[8] Hospitals must have at least 20 at-risk and 2 expected PPCs in the two year base period used to calculate Statewide normative values (i.e., statewide PPC rate for each diagnosis and severity of illness level). This criteria means that not all hospitals are assessed on all Payment PPCs; in RY 2026 some hospitals were assessed on as few as 3 PPCs (on average hospitals were assessed on X number of PPC categories)

   b. Option 2 (staff proposal): Score hospital performance on a PPC composite that includes all payment PPCs weighted by hospital specific expected volume and Solventum (3M) cost weights as a proxy for patient harm[9]

5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent. Consider the following options for the revenue adjustment scale:
   a. Option 1 (current methodology): Linear scale that ranges from 0 to 100 percent and includes a 10 percentage point hold harmless zone. The cut point for penalties and rewards is determined by centering the no harmless zone around the average hospital MHAC score as determined through prospective modeling.
   b. Option 2 (staff proposal): Continuous linear scale that ranges from 0 to 100 percent without a hold harmless zone. The cut point for penalties and rewards is average hospital MHAC score as determined through prospective modeling.
   c. (New proposal for either option): Retrospectively assess the average hospital MHAC scores and propose to the Commissioners that the cutpoint be modified if the actual average score is more than +/- 10 percent different from the prospectively modeled average MHAC score.
6. Going forward, consider other candidate measures/measure sets that may be important for assessing hospital avoidable, harmful complications and appropriate for use in the program, e.g., digitally specified measures.

[9] Hospitals without any at-risk or expected for a specific PPC would not be assessed on that PPC. The two maternity related PPCs are dropped for hospitals without this service line, but almost all other Payment PPCs are included for all hospitals at this time weighted by the hospital volume.

Appendix I. Background on Federal Complication Programs

The Federal Government operates two hospital complications payment programs, the Deficit Reduction Act Hospital Acquired Condition program (DRA-HAC) and the HAC Reduction Program (HACRP), both of which are designed to penalize hospitals for post-admission complications.

Federal Deficit Reduction Act, the Hospital-Acquired Condition Present on Admission Program

Beginning in Federal Fiscal Year 2009 (FFY 2009), per the provisions of the Federal Deficit Reduction Act, the Hospital-Acquired Condition Present on Admission Program was implemented. Under the program, patients were no longer assigned to higher-paying Diagnosis Related Groups if certain conditions were acquired in the hospital and could have reasonably been prevented through the application of evidence-based guidelines.

Hospital-Acquired Condition Reduction Program

CMS expanded the use of hospital-acquired conditions in payment adjustments in FFY 2015 with a new program, entitled the Hospital-Acquired Condition Reduction Program, under the authority of the Affordable Care Act. That program focuses on a narrower list of complications and penalizes hospitals in the bottom quartile of performance. Of note, as detailed in Figure 1 below, all the measures in the Hospital-Acquired Condition Reduction Program are used in the CMS Value Based Purchasing program, and the National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures are also used in the Maryland Quality Based Reimbursement (QBR) program.

Figure 1. CMS Hospital-Acquired Condition Reduction Program (HACRP) FFY 2024 Measures

Recalibrated Patient Safety Indicator (PSI) measure:^ ● PSI 03 – Pressure Ulcer Rate ● PSI 06 – Iatrogenic Pneumothorax Rate ● PSI 08 – In-Hospital Fall with Hip Fracture Rate ● PSI 09 – Perioperative Hemorrhage or Hematoma Rate ● PSI 10 – Postoperative Acute Kidney Injury Requiring Dialysis Rate ● PSI 11 – Postoperative Respiratory Failure Rate ● PSI 12 – Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate ● PSI 13 – Postoperative Sepsis Rate ● PSI 14 – Postoperative Wound Dehiscence Rate ● PSI 15 – Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate
Central Line-Associated Bloodstream Infection (CLABSI)^*
Catheter-Associated Urinary Tract Infection (CAUTI)^*
Surgical Site Infection (SSI) – colon and hysterectomy^*
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia^*
Clostridium Difficile Infection (CDI)^*

^Recalibrated PSI Composite Measures included in the CMS VBP Program beginning FFY 2023. * National Healthcare Safety Network (NHSN) Healthcare-Associated Infection (HAI) measures included in both the CMS VBP and Maryland QBR Programs

For more information on the DRA HAC program POA Indicator, please refer to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index

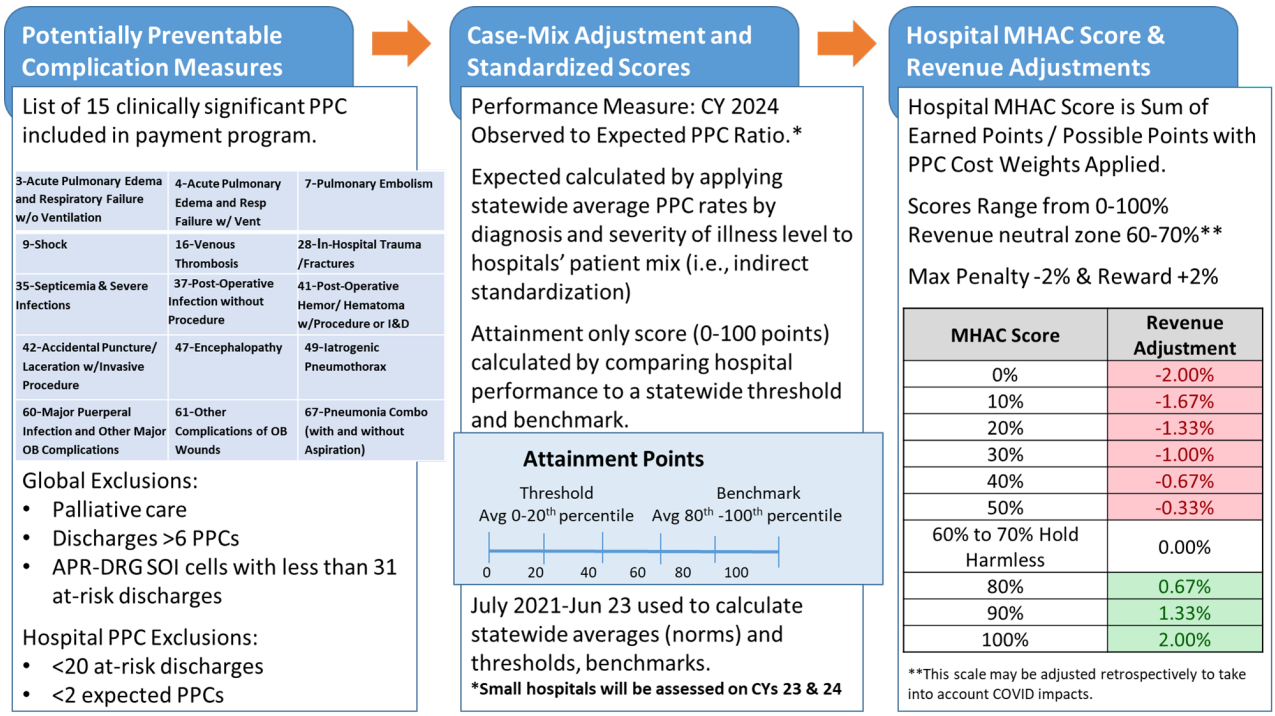
For more information on the DRA HAC program, please refer to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/FAQ-DRA-HAC-PSI.pdf

For more information on the HAC Reduction program, please refer to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program

Appendix II: RY 2026 MHAC Program Methodology

Figure 1 below provides a summary overview of the approved RY 2026 MHAC methodology.

Figure 1. Overview of RY 2026 Approved MHAC Methodology



Performance Metric

The methodology for the MHAC program measures hospital performance using the Observed (O) /Expected (E) ratio for each PPC. Expected number of PPCs are calculated using historical data on statewide PPC rates by All Patient Refined Diagnosis Related Group and Severity of Illness Level (APR-DRG SOI). See below for details on how the expected number of PPCs are calculated for each hospital.

Observed and Expected PPC Values

The MHAC scores are calculated using the ratio of $Observed : Expected$ PPC values.

Given a hospital's unique mix of patients, as defined by APR-DRG category and Severity of Illness (SOI) level, the HSCRC calculates the hospital's expected PPC value, which is the number of PPCs the hospital would have experienced if its PPC rate were identical to that experienced by a normative set of hospitals.

The expected number of PPCs is calculated using a technique called indirect standardization. For illustrative purposes, assume that every hospital discharge is considered “at-risk” for a PPC, meaning that all discharges would meet the criteria for inclusion in the MHAC program. All discharges will either have no PPCs, or will have one or more PPCs. In this example, each discharge either has at least one PPC, or does not have a PPC. The unadjusted PPC rate is the percent of discharges that have at least one PPC.

The rates of PPCs in the normative database are calculated for each diagnosis (APR-DRG) category and severity level by dividing the observed number of PPCs by the total number of admissions. The PPC norm for a single diagnosis and severity level is calculated as follows:

Let:

N = norm

P = Number of discharges with one or more PPCs

D = Number of “at-risk” discharges

i = A diagnosis category and severity level

$$N_i = \frac{P_i}{D_i}$$

In the example, each normative value is presented as PPCs per discharge to facilitate the calculations in the example. Most reports will display this number as a rate per one thousand discharges.

Once the normative expected values have been calculated, they can be applied to each hospital. In this example, the normative expected values are computed for one diagnosis category and its four severity levels.

Consider the following example in Figure 2 for an individual diagnosis category.

Figure 2. Expected Value Computation Example for one Diagnosis Category

A Severity of illness Level	B At-risk Discharges	C Observed Discharges with PPCs	D PPCs per discharge (unadjusted PPC Rate)	E Normative PPCs per discharge	F Expected # of PPCs	G Observed: Expected Ratio
			= (C / B)	(Calculated from Normative Population)	= (B x E)	= (C / E) rounded to 4 decimal places
1	200	10	.05	.07	14.0	0.7143
2	150	15	.10	.10	15.0	1.0000
3	100	10	.10	.15	15.0	0.6667
4	50	10	.20	.25	12.5	0.8000
Total	**500**	**45**	**.09**		**56.5**	**0.7965**

For the diagnosis category, the number of discharges with PPCs is 45, which is the sum of discharges with PPCs (column C). The overall rate of PPCs per discharge in column D, 0.09, is calculated by dividing the total number of discharges with PPCs (sum of column C) by the total number of discharges at risk for PPCs (sum of column B), i.e., 0.09 = 45/500. From the normative population, the proportion of discharges with PPCs for each SOI level for that diagnosis category is displayed in column E. The expected number of PPCs for each severity level shown in column F is calculated by multiplying the number of at-risk discharges (column B) by the normative PPCs per discharge rate (column E). The total number of PPCs expected for this diagnosis category is the expected number of PPCs for the severity levels.

In this example, the expected number of PPCs for the APR DRG category is 56.5, which is then compared to the observed number of discharges with PPCs (45). Thus, the hospital had 11.5 fewer observed discharges with PPCs than were expected for 500 at-risk discharges in this APR DRG category. This difference can be expressed as a percentage difference as well.

All APR-DRG categories and their SOI levels are included in the computation of the observed and expected rates, except when the APR-DRG SOI level has less than 30 at-risk discharges statewide.

PPC Exclusions

Consistent with prior MHAC policies, the number of at-risk discharges is determined prior to the calculation of the normative values (hospitals with <10 at-risk discharges are excluded for a particular PPC) and the normative values are then re-calculated after removing PPCs with <2 complication expected. The following exclusions will also be applied:

For each hospital, discharges will be removed if:

- Discharge is in an APR-DRG SOI cell has less than 31 statewide discharges.
- Discharge has a diagnosis of palliative care (this exclusion may be removed in the future once POA status is available for palliative care for the data used to determine performance standards); and
- Discharge has more than 6 PPCs (i.e., a catastrophic case, for which complications are probably not preventable).

For each hospital, PPCs will be removed if during the base period:

- The number of cases at-risk is less than 20; and
- The expected number of PPCs is less than 2.

The PPCs for which a hospital will be assessed are determined using the base period data and not reassessed during the performance period. This is done so that scores can be reliably calculated during the performance period from a pre-determined set of PPCs. The MHAC summary workbooks provide the excluded PPCs for each hospital.

Combination PPCs

Based on clinical input and 3M recommendation, starting in RY 2021 two pneumonia (PPC 5 Pneumonia & Other Lung Infections & PPC 6 Aspiration Pneumonia) PPCs were combined into single pneumonia PPC and the 3M cost weight is a simple average of the two PPC cost weights.

Hospital Exclusions

Acute care hospitals that do not have sufficient volume to have at least 15 at-risk and 1.5 expected for any payment program PPC are excluded from the MHAC policy.

Benchmarks and Thresholds

For each PPC, a threshold and benchmark value are calculated using the determined base period data. In previous rate years when improvement was also assessed, the threshold was set at the statewide median

of 1 and the benchmark was the O/E ratio for the top performing hospitals that accounted for 25% of discharges. For RY 2021 under an attainment only methodology, staff adapted the MHAC points system to allow for greater performance differentiation by moving the threshold to the value of the observed to expected ratio at the 10th percentile of hospital performance, moving the benchmark to the value of the observed to expected ratio at the 90th percentile of hospital performance, and assigning 0 to 100 points for each PPC between these two percentile values.

Attainment Points (possible points 0-100)

If the PPC ratio for the performance period is greater than the threshold, the hospital scores zero points for that PPC for attainment.

If the PPC ratio for the performance period is less than or equal to the benchmark, the hospital scores a full 100 points for that PPC for attainment.

If the PPC ratio is between the threshold and benchmark, the hospital scores partial points for attainment. The formula to calculate the Attainment points is as follows:

- Attainment Points = [99 * ((Hospital's performance period score - Threshold)/ (Benchmark – Threshold))] + 0.5

Calculation of Hospital Overall MHAC Score

To calculate the final score for each hospital, the attainment points earned by the hospital and the potential points (i.e., 100) for each PPC are multiplied by the 3M cost weights. Hospital scores across PPCs are calculated by summing the total weighted points earned by a hospital, divided by the total possible weighted points (100 per PPC * 3M cost weight).

RY 2025 Update: Small Hospital Methodology

Hospital-specific PPC inclusion requirements were updated for the RY 2025 policy, i.e., all hospitals are required to have at least 20 at-risk discharges and 2 expected PPCs in order for a particular PPC to be included in the payment program. Because of the volatility in performance scores for smaller hospitals, the Commission also approved the following policy updates in RY 2025:

> "Establish small hospital criteria for assessing performance under the MHAC policy based on the number of at-risk discharges and expected PPCs (i.e., small hospitals are those with less than staff are proposing for RY 2026 to modify the methodology slightly to make the performance standards less sensitive to potential outliers by averaging the worst and best performing hospitals (as

opposed to taking a single value at a given percentile). This methodology is more in line with the CMS VBP program approach to setting the benchmark. Staff explored a couple of options and suggests averaging the 20 percent of O/E ratios of the worst and best performing hospitals results, which results in similar benchmark and threshold values as compared to the current method but avoids the cliff effects of using a single percentile. 21,500 at-risk discharges and/or 22 expected PPCs across all payment program PPCs) as opposed to the number of PPC measure types, and for hospitals that meet small hospital criteria, increase reliability of score by using two years of performance data to assess hospital performance (i.e., for RY 2025 use CY 2022 and 2023). “

RY 2026 Update: Calculating Performance Standards

Staff modified the methodology slightly to make the performance standards less sensitive to potential outliers by averaging the worst and best performing hospitals (as opposed to taking a single value at the 90th and 10th percentile). This updated methodology is more in line with the CMS VBP program approach to setting the benchmark. Staff explored a couple of options and determined that averaging the 20 percent of O/E ratios of the worst and best performing hospitals results yields similar benchmark and threshold values compared to the previous method but avoids the cliff effects of using a single percentile.

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Appendix III: Monitoring PPCs

The table below shows the monitored PPCs' O/E ratios for CY 24 YTD (through September) and the percent changes in the observed-to-expected ratio from CY 2018.

Monitoring PPC	2018 O/E	2024 YTD O/E	2018-2024 % Change
2:Extreme CNS Complications	1.82	0.82	-55.19%
21: Clostridium Difficile Colitis	1.31	0.73	-44.50%
25: Renal Failure with Dialysis	1.19	0.68	-43.37%
45: Post-Procedure Foreign Bodies	0.79	0.52	-34.51%
29:Poisonings due to Anesthesia	0.88	0.61	-30.88%
10: Congestive Heart Failure	0.82	0.58	-28.67%
65:Urinary Tract Infection without Catheter	1.11	0.80	-27.62%
66: Catheter-Related Urinary Tract Infection	1.02	0.74	-26.95%
39:Reopening Surgical Site	1.08	0.85	-20.91%
14: Ventricular Fibrillation/Cardiac Arrest	0.84	0.74	-11.31%
33: Cellutis	0.92	0.90	-2.49%
11: Acute Myocardial Infarction	0.96	0.95	-0.95%
54: Infections due to Central Venous Catheters	0.85	0.88	3.58%
18: Major Gastrointestinal Complication with Transfusion or Significant Bleeding	0.52	0.60	14.66%
24: Renal Failure without Dialysis	0.81	0.96	17.77%
40: Peri-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc	0.82	0.97	18.76%
20: Other Gastrointestinal Complications without Transfusion or Significant Bleeding	0.69	0.88	28.36%
44: Other Surgical Complication- Mod	0.63	0.81	29.38%
8: Other Pulmonary Complications	0.72	0.95	31.05%
23: GU Complications Except UTI	0.61	0.84	38.07%
1:Stroke & Intracranial Hemorrhage	0.68	0.95	40.57%
48: Other Complications of Medical Care	0.57	0.80	40.77%
19:Major Liver Complications	0.69	0.98	41.55%
26: Diabetic Ketoacidosis & Coma	0.59	0.88	47.97%
50: Mechanical Complication of Device, Implant & Graft	0.56	0.84	50.35%
15: Peripheral Vascular Complications Except Venous Thrombosis	0.53	0.80	50.68%
34: Moderate Infections	0.60	0.92	52.77
13: Other Cardiac Complications	0.57	0.87	52.96%

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Monitoring PPC	2018 O/E	2024 YTD O/E	2018-2024 % Change
64: Other In-Hospital Adverse Events	0.49	0.77	58.40%
27:Post-Hemorrhagic & Other Acute Anemia with Transfusion	0.72	1.16	61.66%
52:Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection	0.67	1.09	63.24%
17: Major Gastrointestinal Complications without Transfusion or Significant Bleeding 0	0.67	1.09	63.24%
38: Post-Operative Wound Infection & Deep Wound Disruption with Procedure	1.24	2.07	67.39%
53:Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infusions	0.54	0.92	69.77%
51: Gastrointestinal Ostomy Complications	0.47	0.88	87.51%
59: Medical & Anesthesia Obstetric Complications	0.48	0.99	106.96%
31: Decubitus Ulcer	0.35	0.87	147.91%
30: Poisonings due to Anesthesia	**0 observed**	**0 Observed**	
32: Transfusion Incompatibility Reaction	**0 observed**	**0 Observed**	

Appendix IV. Composite Options Testing Results

As shown in the equation below, PPC Composite Option 1 is calculated as the sum of the hospital's observed PPCs times the 3M Cost Weight for each payment PPC measure divided by the sum of the hospital's expected PPCs times the 3M Cost Weight for each payment PPC measure.

$$PPC\ Composite_j = \frac{\left(\sum_{i=1}^{15} ObservedPPC_{ij} * 3MCostWeight_i\right)}{\left(\sum_{i=1}^{15} ExpectedPPC_{ij} * 3MCostWeight_i\right)}$$

PPC Composite Option 1 does not explicitly weight PPC measures by volume, but PPC measures with higher expected PPCs receive more weight. The expected PPCs for a PPC measure increases as the volume of at-risk discharges increases.

As show in the equation below, PPC Composite Option 2 is calculated as the sum of the hospital's observed-to-expected (O/E) ratio for each payment PPC measure, weighted by the PPC measure's 3M Cost Weight and hospital's volume of at-risk discharges for the given PPC measure.

$$PPC\ Composite_j = \sum_{i=1}^{15} \left(\frac{Observed\ PPCs_{ij}}{Expected\ PPCs_{ij}}\right) * \left(\frac{Volume_{ij} * 3MCostWeight_i}{\sum_{i=1}^{15} Volume_{ij} * 3MCostWeight_i}\right)$$

As shown in the equation below, PPC Composite Option 3 is calculated as the sum of hospital's O/E ratio for each payment PPC measure, weighted by the PPC measure's 3M Cost Weight and the proportion of observed payment PPCs statewide for the given PPC measure.

$$PPC\ Composite_j = \sum_{i=1}^{15} \left(\frac{Observed\ PPCs_{ij}}{Expected\ PPCs_{ij}}\right) * \left(\frac{StateProportion_i * 3MCostWeight_i}{\sum_{i=1}^{15} StateProportion_i * 3MCostWeight_i}\right)$$

For example, if there were 10,000 observed PPCs across the 15 payment PPC measures across Maryland hospitals and there were 1,000 observed PPCs for a given payment PPC measure, then the statewide proportion would be 0.10 for the PPC measure.

Staff used data from FY 2018 through FY 2024 to model six iterations of Maryland hospital results under each composite option and the current methodology (Figure I). To inform decision making, staff assessed the content validity, predictive validity, and reliability of each composite option and the current methodology across the six iterations of results.

Figure I. Performance Periods for Each Iteration of MHAC Results

Iteration	Small Hospital Performance Period	Non-Small Hospital Performance Period
1	FY 2023- FY 2024	FY 2024
2	FY 2022- FY 2023	FY 2023
3	FY 2021- FY 2022	FY 2022
4	FY 2020- FY 2021	FY 2021
5	FY 2019- FY 2020	FY 2020
6	FY 2018- FY 2019	FY 2019

Notes: 1) A base period of FYs 2021 and FY 2022 was used for each iteration to keep PPC measure O/E ratios and PPC composite values on the same scale to facilitate comparisons across iterations. 2) Small hospitals were identified as having <21,500 at-risk discharges or <22 expected PPCs during the base period.

Content validity refers to the degree to which a measure captures the concept it is intended to measure. The intention of the MHAC Program is to evaluate Maryland hospitals based on their performance on the 15 payment PPCs, so methodologies that evaluate Maryland hospitals on all 15 payment PPCs would have the highest content validity. The composite methodologies evaluate Maryland hospitals on payment PPC measures with greater than 0 at-risk discharges, resulting in very high content validity even for the smallest hospitals (Figure 2). The current methodology only evaluates Maryland hospitals on PPC measures for which the hospital has at least two expected PPCs, resulting in fewer PPC measures being evaluated especially for small and medium hospitals. The five small Maryland hospitals are evaluated on an average of 13.2 payment PPC measures under the composite methodologies compared with 3.6 payment PPC measures under the current methodology. The 15 medium Maryland hospitals are evaluated on an average of 14.5 payment PPC measures under the composite methodologies compared with 11 payment PPC measures under the current methodology. In addition to improving content validity, evaluating small hospitals on almost all of the 15 payment PPCs under the composite methodologies lessens the degree to which one observed PPCs on one payment PPC measure can drastically negatively impact a small hospital's MHAC revenue adjustment in consecutive rate years.

Figure 2. Content Validity Current Methodology Versus Composite Options

Hospital Category*	Number of Hospitals	Average Number of PPC Measures Evaluated	
		Current Methodology	Composite Methodology
Small Hospitals	5	3.6	13.2
Medium Hospitals	15	11.0	14.5
Large Hospitals	21	13.8	15

Predictive validity refers to the extent that past performance is predictive of future performance. Staff calculated correlations in hospitals' PPC composite values across iterations to assess predictive validity. A measure can be considered to have sufficient predictive validity if adjacent performance periods have moderately to highly correlated and correlations get smaller as the distance between performance periods increases. All composite options demonstrated sufficient predictive validity, but Composite Option 1 demonstrated slightly higher correlations across iterations of results (Figure 3).

Figure 3. Average Correlations of Composite Values Composite Options

Distance Between Performance Periods	Composite Option 1	Composite Option 2	Composite Option 3
1 Year Apart	0.61	0.57	0.53
2 Years Apart	0.40	0.34	0.28
3 Years Apart	0.31	0.23	0.27
4 Years Apart	0.13	0.10	0.10

Reliability refers to the degree to which a measure captures the underlying quantity the measure is intended to capture. Staff assessed the reliability of PPC measures and PPC composite values using the Morris signal-to-noise method under which a score of 1.00 indicates a perfect signal of hospital performance without noise (i.e., perfect reliability) and a score of 0 indicates no signal of hospital performance and all noise (i.e., worst reliability). Staff consider reliability above .50 to

be acceptable but would hope the MHAC methodology could achieve an average reliability across Maryland hospitals of 0.75 or higher. The current methodology achieves reliabilities generally somewhat below the desired minimum reliability of 0.50, with the average reliability across FY 2021 to FY 2024 being 0.39 (Figure 4). Options 1, 2, and 3 all yield substantially higher reliabilities than the current methodology, especially Composite Option 1 with an average reliability of 0.76 across FY 2021 to FY 2024.

Figure 4. Average Reliability Across Maryland Hospitals using a 1-year Performance Period by Methodology

Performance Period	Current Methodology*	Composite Option 1	Composite Option 2	Composite Option 3
FY 24	0.24	0.61	0.48	0.54
FY 23	0.38	0.81	0.63	0.68
FY 22	0.50	0.81	0.70	0.76
FY 21	0.42	0.80	0.62	0.72
Average	**0.39**	**0.76**	**0.61**	**0.68**

Note: Reliability was calculated using a one-year performance period for all hospitals. Two years of performance data are used to assess reliability for small hospitals, so the actual average reliability across Maryland hospitals is slightly higher than represented in Figure 10.
**For the Current Methodology, staff calculated average reliability across payment PPC measures with two or more expected PPCs during the performance period.*

Average reliability dipped lower across methodologies when using FY 2024 as the performance period. As rates of observed PPCs continue to decrease across Maryland hospitals over time, PPC measure and PPC composite reliability could decrease. Staff will continue to monitor PPC measure and PPC composite reliability and consider using two years of performance period data for all hospitals if reliability when using one year of performance period data continues to decrease. Figure 5 below shows that PPC measure and PPC composite reliability is notably higher when using a two-year performance period for all hospitals and above 0.75 for Composite Option 1 for the FY 2024-2023 performance period.

Figure 5. Average Reliability Across Maryland Hospitals using a 2-year Performance Period by Methodology

Performance Period	Current Methodology*	Composite Option 1	Composite Option 2	Composite Option 3
23-24	0.33	0.78	0.68	0.71
22-23	0.50	0.86	0.76	0.80
21-22	0.54	0.87	0.76	0.81

Performance Period	Current Methodology*	Composite Option 1	Composite Option 2	Composite Option 3
20-21	0.47	0.85	0.71	0.77
Average	**0.46**	**0.84**	**0.73**	**0.77**

**For Current Methodology, calculated average reliability across payment PPCs with two or more expected PPCs during performance period.*

When examining small hospitals only, the composite options have drastically higher reliability than the current methodology (Figure 6). When using two years of data, the average reliability across small hospitals using Composite Option 1 is greater than the minimum reliability of 0.50 but somewhat lower for Composite Option 2 and Composite Option 3 and much lower under the current methodology.

Figure 6. Average Reliability Across Small Maryland Hospitals using a 1-year, 2-year, and 3-year Performance Period by Methodology

Performance Period	Current Methodology*	Composite Option 1	Composite Option 2	Composite Option 3
One Year (FY24)	0.13	0.28	0.14	0.18
Two Years (FY23-24)	0.19	0.51	0.32	0.34
Three Years (FY22-24)	0.32	0.66	0.43	0.41
One Year (FY23)	0.20	0.46	0.26	0.29
Two Years (FY22-23)	0.45	0.67	0.41	0.42
Three Years (FY21-23)	0.41	0.73	0.46	0.45

**For Current Methodology, calculated average reliability across payment PPCs with two or more expected PPCs during performance period.*

Aside from assessing validity and reliability of the composite methodologies, staff also examined hospital level results to understand the implications of the different weights each composite methodology puts on each payment PPC measure. As shown in Figure 7 below, the weight put on each PPC measure can vary notably across composite methodologies. In this hypothetical example, the given hospital has a very similar number of at-risk discharges for PPC measures 28 and 42 and therefore both have volume weights of 12.7% under Composite Option 2. However, PPC 42 has almost twice as many expected PPCs as PPC 28 (10.2 versus 5.4) so PPC 42 receives roughly twice the weight as PPC 28 under Composite Option 1. Reliability tends to increase as the number of expected PPCs at a hospital increases and the weight Composite Option 1 puts on each PPC measure is based on the number of expected PPCs at the hospital, offering a

plausible explanation for why Composite Option 1 demonstrated consistently higher reliabilities than the other composite options. Composite Option 3 also yields high reliability levels across iterations, but staff anticipate hospitals may perceive this methodology to be less fair than Composite Option 1 because the weight put on payment PPC measures is based on statewide proportion of expected PPCs instead of hospital-specific percentage of expected PPCs. Across Maryland hospitals and payment PPC measures, the average difference between the proportion of observed PPCs statewide and hospital-specific percentage of expected PPCs was about 3 percentage points (e.g., 3% compared with 6%), thus confirming that the Composite Option 3 methodology could be considered less representative of hospital-specific performance or less fair. This average difference also could explain why reliabilities across iterations were somewhat lower for Composite Option 3 than Composite Option 1.

Figure 7. MHAC Composite Weighting Hypothetical Example

PPC Measure	At-risk discharges	Expected PPCs	Pct. of hospital's expected PPCs (Composite Option 1)	Pct. of hospital's at-risk discharges (Composite Option 2)	Proportion of statewide observed PPCs (Composite Option 3)	3M Cost Weight
28	20,270	5.4	2.4%	12.7%	4.8%	0.45
42	20,294	10.2	4.5%	12.7%	7.3%	0.50

Appendix V: Hospital MHAC Scores and Revenue Adjustments

Figures 1 and 2 below show hospitals' MHAC scores and revenue adjustments without a hold harmless zone and with a hold harmless zone, respectively. These MHAC scores and estimated revenue adjustments are not actual values for any rate year because staff used FY data periods for testing purposes, not calendar year data periods.

Figure 1. Revenue Adjustments using Current Methodology Versus Composite Option 1 (FY 2024, No Hold Harmless Zone)

Hospital ID	Current Methodology MHAC Score	Current Methodology Revenue Adjustment (%)	Current Methodology Revenue Adjustment ($)	Composite Option 1 MHAC Score	Composite Option 1 Revenue Adjustment (%)	Composite Option 1 Revenue Adjustment ($)
210001	63%	-0.33%	-$829,111	74%	-0.14%	-$355,688
210002	61%	-0.38%	-$5,628,094	55%	-0.62%	-$9,109,788
210003	56%	-0.51%	-$1,592,906	59%	-0.52%	-$1,602,995
210004	66%	-0.25%	-$1,032,564	58%	-0.54%	-$2,247,955
210005	54%	-0.57%	-$1,445,227	55%	-0.62%	-$1,574,268
210008	55%	-0.54%	-$1,194,250	59%	-0.52%	-$1,142,916
210009	59%	-0.44%	-$7,914,269	50%	-0.74%	-$13,532,989
210011	78%	0.21%	$537,644	85%	0.53%	$1,345,252
210012	79%	0.29%	$1,517,346	94%	1.41%	$7,324,387
210015	91%	1.27%	$4,715,776	100%	2.00%	$7,437,246
210016	87%	0.94%	$2,290,181	95%	1.51%	$3,666,063
210017	71%	-0.12%	-$33,867	100%	2.00%	$579,764
210018	65%	-0.28%	-$265,076	69%	-0.27%	-$256,215

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Hospital ID	Current Methodology MHAC Score	Current Methodology Revenue Adjustment (%)	Current Methodology Revenue Adjustment ($)	Composite Option 1 MHAC Score	Composite Option 1 Revenue Adjustment (%)	Composite Option 1 Revenue Adjustment ($)
210019	79%	0.29%	$1,024,331	86%	0.63%	$2,193,940
210022	57%	-0.49%	-$1,217,879	50%	-0.74%	-$1,856,209
210023	76%	0.05%	$178,088	80%	0.04%	$137,544
210024	72%	-0.09%	-$241,946	81%	0.14%	$363,065
210027	91%	1.27%	$2,325,533	100%	2.00%	$3,667,597
210028	85%	0.78%	$783,993	86%	0.63%	$629,171
210029	76%	0.05%	$228,357	67%	-0.32%	-$1,495,495
210032	83%	0.62%	$523,759	88%	0.82%	$697,445
210033	63%	-0.33%	-$535,789	70%	-0.24%	-$393,477
210034	87%	0.94%	$1,209,103	100%	2.00%	$2,564,689
210035	78%	0.21%	$205,942	67%	-0.32%	-$309,334
210037	64%	-0.30%	-$373,936	80%	0.04%	$46,212
210038	65%	-0.28%	-$387,515	70%	-0.24%	-$339,289
210039	77%	0.13%	$104,975	88%	0.82%	$665,552
210040	94%	1.51%	$2,432,386	100%	2.00%	$3,217,228
210043	89%	1.11%	$3,599,390	94%	1.41%	$4,594,690
210044	78%	0.21%	$556,659	76%	-0.09%	-$239,795
210048	67%	-0.22%	-$491,074	62%	-0.44%	-$974,957
210049	72%	-0.09%	-$213,902	93%	1.31%	$3,110,205
210051	74%	-0.04%	-$69,761	84%	0.43%	$804,923
210056	88%	1.02%	$1,911,451	90%	1.02%	$1,901,168
210057	95%	1.59%	$5,321,585	100%	2.00%	$6,679,462
210058	100%	2.00%	$1,619,362	100%	2.00%	$1,619,362
210060	62%	-0.36%	-$134,334	59%	-0.52%	-$195,694
210061	76%	0.05%	$22,959	65%	-0.37%	-$174,189
210062	70%	-0.14%	-$302,363	86%	0.63%	$1,320,723
210063	87%	0.94%	$2,758,580	97%	1.71%	$4,990,062

Hospital ID	Current Methodology MHAC Score	Current Methodology Revenue Adjustment (%)	Current Methodology Revenue Adjustment ($)	Composite Option 1 MHAC Score	Composite Option 1 Revenue Adjustment (%)	Composite Option 1 Revenue Adjustment ($)
210064	83%	0.62%	$420,894	72%	-0.19%	-$130,426
210065	94%	1.51%	$1,432,122	100%	2.00%	$1,894,215

Figure 2. Revenue Adjustments using Current Methodology Versus Composite Option 1 (FY 2024, Hold Harmless Zone)

Hospital ID	Current Methodology MHAC Score	Current Methodology Revenue Adjustment (%)	Current Methodology Revenue Adjustment ($)	Composite Option 1 MHAC Score	Composite Option 1 Revenue Adjustment (%)	Composite Option 1 Revenue Adjustment ($)
210001	63%	-0.21%	-$530,069	74%	-0.02%	-$41,812
210002	61%	-0.27%	-$3,935,499	55%	-0.53%	-$7,746,084
210003	56%	-0.41%	-$1,266,440	59%	-0.42%	-$1,295,643
210004	66%	-0.13%	-$517,951	58%	-0.45%	-$1,843,845
210005	54%	-0.47%	-$1,186,294	55%	-0.53%	-$1,338,606
210008	55%	-0.44%	-$965,640	59%	-0.42%	-$923,777
210009	59%	-0.32%	-$5,892,829	50%	-0.66%	-$12,002,209
210011	78%	0.00%	$0	85%	0.05%	$126,199
210012	79%	0.00%	$0	94%	1.22%	$6,330,993
210015	91%	1.08%	$4,021,354	100%	2.00%	$7,437,246
210016	87%	0.67%	$1,635,013	95%	1.35%	$3,278,651
210017	71%	0.00%	$0	100%	2.00%	$579,764
210018	65%	-0.15%	-$147,473	69%	-0.15%	-$144,660
210019	79%	0.00%	$0	86%	0.18%	$629,157
210022	57%	-0.38%	-$950,014	50%	-0.66%	-$1,646,244
210023	76%	0.00%	$0	80%	0.00%	$0
210024	72%	0.00%	$0	81%	0.00%	$0
210027	91%	1.08%	$1,983,087	100%	2.00%	$3,667,597

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Hospital ID	Current Methodology MHAC Score	Current Methodology Revenue Adjustment (%)	Current Methodology Revenue Adjustment ($)	Composite Option 1 MHAC Score	Composite Option 1 Revenue Adjustment (%)	Composite Option 1 Revenue Adjustment ($)
210028	85%	0.47%	$471,265	86%	0.18%	$180,428
210029	76%	0.00%	$0	67%	-0.20%	-$963,443
210032	83%	0.26%	$224,630	88%	0.44%	$372,818
210033	63%	-0.21%	-$342,542	70%	-0.12%	-$201,608
210034	87%	0.67%	$863,206	100%	2.00%	$2,564,689
210035	78%	0.00%	$0	67%	-0.20%	-$199,283
210037	64%	-0.18%	-$224,911	80%	0.00%	$0
210038	65%	-0.15%	-$215,590	70%	-0.12%	-$173,843
210039	77%	0.00%	$0	88%	0.44%	$355,770
210040	94%	1.39%	$2,232,123	100%	2.00%	$3,217,228
210043	89%	0.88%	$2,856,278	94%	1.22%	$3,971,520
210044	78%	0.00%	$0	76%	0.00%	$0
210048	67%	-0.10%	-$213,061	62%	-0.34%	-$745,070
210049	72%	0.00%	$0	93%	1.09%	$2,581,289
210051	74%	0.00%	$0	84%	0.00%	$0
210056	88%	0.78%	$1,446,767	90%	0.70%	$1,305,821
210057	95%	1.49%	$4,975,104	100%	2.00%	$6,679,462
210058	100%	2.00%	$1,619,362	100%	2.00%	$1,619,362
210060	62%	-0.24%	-$90,209	59%	-0.42%	-$158,172
210061	76%	0.00%	$0	65%	-0.26%	-$122,293
210062	70%	-0.01%	-$24,252	86%	0.18%	$378,744
210063	87%	0.67%	$1,969,413	97%	1.61%	$4,710,074
210064	83%	0.26%	$180,513	72%	-0.07%	-$47,838
210065	94%	1.39%	$1,314,212	100%	2.00%	$1,894,215

Adventist HealthCare

February 3, 2025

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 comment on HSCRC policies that support the goals of the AHEAD Model and other related priorities.

Optimizing Maryland HSCRC Policies to Ensure Access to Medically Necessary Care

While volume, quality, and other HSCRC policies could benefit from refinement, 90% of Hospital Global Budget Revenues ("GBR") remain tied to three primary drivers:

1. Base Hospital GBR revenues set at the inception of the Maryland Model in 2014
2. Annual Inflation and Demographic Adjustments
3. Market Shift Adjustments

Numerous other annual HSCRC policy adjustments exist, but they have an immaterial impact to the big picture, influencing ~10% or less of GBR. Our comments focus on fundamental gaps in Maryland's HSCRC policy framework related to these core components that currently prevent funding for medically necessary care. Prioritizing these changes will have the greatest impact on strengthening the Maryland model in preparation for AHEAD.

1. Fund Medically Necessary Acute Care

Current HSCRC policies incentivize reducing all hospital volumes, including medically necessary care. When volume decreases, hospitals retain ~50% of the reimbursement for those cases. However, when volume grows due to population increases or the chronic needs of the community, hospitals receive far less financial support. As a result, there is no policy incentive to provide medically necessary care beyond an established GBR, as the current framework does not fully cover these costs.

In theory, the Demographic policy should fund the growth of medically necessary care, but it reimburses only a fraction of that growth. For example:

- In FY25, only 0.25% of the statewide 4.25% age-adjusted demographic growth was funded. This equates to ~$40M in annual gross revenues for Adventist HealthCare, more than 2x its CY24 operating margin.
- Since FY2015, only 4.22% of the 11.63% statewide age-adjusted demographic growth was funded leaving a -7.41% gap in funding for hospitals since FY2015. This equates to ~$75M in annual gross revenues for Adventist HealthCare, more than 4x its CY24 operating margin.

The combination of financial incentives to reduce volume and an insufficient Demographic adjustment makes it impossible in areas of the state with high growth to ensure access to medically necessary care. This forces hospitals to ration care—even when that care is medically necessary—to maintain financial solvency within GBR limits.

Proposed Policy Solutions

- **Tie incremental demographic funding to population metrics** such as per capita use rates.
    - As long as per capita use rates remain low, funding should have limited constraints to ensure access and prevent harm.
- **Introduce a demographic adjustment booster** for hospitals in extreme percentiles of utilization.
    - **Collectively, the following metrics indicate limited access to medically necessary care despite overall low utilization.**
        - Montgomery County (population: 1 million) has a Medicare admission rate per capita comparable to Chautauqua, Kansas (population: 3,500), placing it in the lowest 17% of U.S. counties.
        - Montgomery County Medicare emergency department (ED) utilization rate ranks in the lowest 7% of US counties, comparable to Kodiak, Alaska (population: 13,000).
        - Maryland ranks 47th in the Nation with lowest hospital beds per capita.
        - White Oak Medical Center has the 8th longest ED wait time in the United States
    - Additional funding would expand access without jeopardizing financial targets, leveraging excess savings from strong Medicare Total Cost of Care (TCOC) performance.

2. Fund Medically Necessary "Potentially Avoidable" Acute Care

HSCRC defines "avoidable utilization" (PAU) narrowly and does not reimburse hospitals for any incremental growth in these cases, as they are stripped from the Market Shift, Demographic, and Efficiency policies. While a strong PAU policy is necessary for a population-based reimbursement system, these cases are only "potentially" avoidable**.**

By the time a 50-year-old patient arrives at the emergency room with severe hypertension and a stroke, the care is medically necessary. Yet, under HSCRC's current framework, the hospital receives zero reimbursement for treating a new PAU patient and bears 100% financial risk.

By contrast, under Medicare IPPS, hospitals are at risk for up to 3% of reimbursement for readmissions. The disparity is clear:

- **Medicare IPPS risk is too low** to incentivize meaningful change.
- **HSCRC's PAU policies are too extreme**, jeopardizing access to medically necessary care.

Additionally, PAU funding was built into hospital budgets based on 2013 volumes and has not been adjusted since, despite significant shifts in population, demographics, and patient preferences. The current policy framework lacks safeguards to ensure PAU patients receive medically necessary care.

Proposed Policy Solutions

- **Implement a short-term fix by releasing demographic adjustments** to provide immediate funding for medically necessary care.
- **Modify PAU policies for a long-term solution**, adjusting the at-risk amount to 50% for incremental PAU cases.
    - This would continue to hold hospitals accountable for avoidable care while ensuring funding for truly necessary cases.

3. Fix Base Hospital Rate Inequities to Ensure Regional Access

Base hospital rates were inequitably set at the Maryland Model's inception, favoring regions with more infrastructure and higher initial GBR contracts. While Maryland operates an all-payer system, ensuring that all patients pay the same rate for a specific procedure at a specific hospital, the price of the same procedure varies significantly across Maryland hospitals.

For example, White Oak Medical center's base rates are on average -13% below the statewide average which equates to ~$24M in annual GBR. This is just one example of baked in inequities that have compounded over time, limiting infrastructure growth in underserved areas like Fort Washington, Prince Georges and White Oak, Montgomery.

Proposed Policy Solutions

- Use incremental funding from excess savings or targeted update factors to rebalance resources without reducing funding for hospitals with higher rates.
- Implement a targeted booster for hospitals in underserved areas to ensure equitable funding and expand access to medically necessary care. GBR per capita could be used to measure equitable investment.

4. Implement Regional Planning and Align MHCC & HSCRC Policies

HSCRC policies rely heavily on statewide averages, which mask geographic disparities in access and funding. A regional planning approach would better address these gaps by analyzing per capita GBR and redirecting resources to underserved areas.

Additionally, there is a critical misalignment between MHCC (which licenses hospital beds) and HSCRC (which funds them). Currently, MHCC's dynamic licensing process increases bed licensure based on prior-year census, while HSCRC does not adjust funding accordingly. As a result, White Oak Medical Center is licensed for more beds than it physically has, operating at full capacity since its opening in 2019 without a proportional increase in funding to open access to meet the demand.

Proposed Policy Solutions

- **Align MHCC bed licensing with HSCRC funding**, ensuring that financial resources match patient demand and support hospitals where they are most needed.
- **Convert all HSCRC policies to a regional view** to better direct resources and ensure equitable access to care.

Conclusion

By addressing these core policy areas—funding medically necessary care, correcting base rate inequities, and implementing regional planning—the Maryland HSCRC model can be significantly strengthened. These targeted changes are essential to ensuring access to medically necessary care and preparing for the AHEAD Model.

Just as in Maslow's hierarchy of needs, broader population health goals cannot be achieved from hospitals until medically necessary acute care is adequately funded.

Adventist appreciates the opportunity to provide comment. Direct answers to the specific itemized questions are included below and reinforce our recommended prioritized changes.

Katie Eckert

Katie Eckert, CPA

Senior Vice President, Strategic Operations

Adventist HealthCare

cc: Joshua Sharfstein, MD
Farzaneh Sabi, MD
James N. Elliott, MD
Ricardo R. Johnson
Maulik Joshi, DrPH
Adam Kane, Esq
Nicki McCann, JD

1. **Ensuring High Value Care**. A core goal under AHEAD is to bring innovative and affordable care models to the state that improve the health of Marylanders.

   a. Over the past decade, hospitals have used the flexibility of global budgets, to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. *To further drive this work, how can the payment system better recognize effective efforts?*

   Just as in Maslow's hierarchy of needs, broader population health goals cannot be achieved from hospitals until medically necessary acute care is adequately funded.

   b. Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. *How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?*

   Align MHCC bed licensing with HSCRC funding, ensuring that financial resources match patient demand and support hospitals where they are most needed.

   Convert all HSCRC policies to a regional view to better direct resources and ensure equitable access to care.

   c. Numerous organizations and approaches have documented how the fee-for-service system generates low value care. Maryland does not necessarily perform well on these metrics despite the different hospital financial incentives. See for example the Lown Institute analysis of Unnecessary Back Surgery in which Maryland is average: https://lownhospitalsindex.org/unnecessary-back-surgery/. *How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care?*

   Ensure that medically necessary care is funded before further incentivizing new ways to reduce volumes which could further exacerbate areas of the state without access to medically necessary care.

   d. The Health Services Cost Review Commission policies provide an added incentive to reduce "potentially avoidable utilization" as defined by readmissions and PQIs. *Given answers to the questions above, should the HSCRC consider alternative or complementary approaches?*

   Yes, because the current policy framework lacks safeguards to ensure PAU patients receive medically necessary care. See comments in letter for policy recommendations.

   e. Do hospitals have planning needs to support innovative and affordable care models? If so, what are those needs, and how might the HSCRC support them?

   A first step to help hospitals would be to implement coordinated regional planning for MHCC and HSCRC. A key area of concern is the critical misalignment between MHCC (which licenses hospital beds) and HSCRC (which funds them). Currently, MHCC's dynamic licensing process increases bed licensure based on prior-year census, while HSCRC does not adjust funding accordingly.

2. **Improving Access to Care.** Another goal of AHEAD is for Marylanders to be able to receive the right care in the right location at the right time. This requires many steps, including appropriate hospital budgeting, sufficient investment outside of hospitals and effective oversight in those other levels of care.

   a. Currently, access to needed care in Maryland is assessed through a series of individual measures, including ED wait times, hospital beds per capita, avoidable admissions per capita, and others. This disjointed approach cannot account for the complex relationship of these access measures to one another. *How can the Commission and partner agencies develop more useful measures of needed access that support prioritization of funding and rationalization of existing investments?*

   HSCRC should look at all volumes on a per capita basis to identify gaps in the throughput continuum. Admissions, observation cases and outpatient-in-a-bed all reflect bedded care. Notably, admissions per capita are not listed in 2a metrics. Overly focusing on "avoidable" care to the detriment of "medically necessary care" has led to gaps in access. Additionally, all metrics should be reviewed on a regional basis so that the state average does not mask regional inequities.

   b. Reducing ER wait times is a state priority. *Should the HSCRC consider payment policy to slow the rate of volume declines in specific health systems for specific services related to ER wait times?*

   Yes. The State must ensure access to medically necessary care. Underfunding this access is one of the key drivers of long ER wait times in the State.

   c. As patients move from one hospital to another within specific service lines, there is an adjustment made to both hospitals' budgets. *What, if any, changes are appropriate to HSCRC's policies for this market shift to support access to needed care without abandoning population-based payment and creating an excessive financial incentive for hospital-based treatment?*

   Currently, the Market Shift policy pays up to a 50% variable cost factor for volume (VCF) growth/decline however not all service lines operate at a 50% VCF. Modifying the policy to use a service line specific VCF will results in more accurate funding shifts for volumes. Additionally, moving to a county or regional analysis would more closely algin with a regional planning approach to healthcare access. Finally, PAU volumes under the current Market Shift policy are removed and not reimbursed. By providing $0 reimbursement for PAU cases, this sets up a barrier to access to care.

   c. Hospital global budgets are adjusted every year for statewide population growth. *How, if at all, should this adjustment be changed or focused to promote the goals of the model for access to care, cost control, and population health?*

   Since FY2015, only 4.22% of the 11.63% statewide age-adjusted demographic growth was funded leaving a -7.41% gap in funding for hospitals. This must be corrected to fund medically necessary care. See comment letter for recommendations.

d. *Recognizing that effective hospitals can provide greater access to care, what are key domains and metrics that should be used to assess the effectiveness of hospitals? Should national comparisons be used to evaluate metrics such as length of stay, utilization per capita and administrative costs?*

Yes, but this cannot be done in isolation. For example, hospital excess ER wait times are in direct correlation to low acute care capacity. Individual metrics cannot be used in isolation to measure the performance of a healthcare or hospital system. Hospital performance expectations should be adjusted accordingly for gaps in the State's infrastructure.

3. **Other topics**. There are several cross-cutting policy areas that could also be addressed in 2025. a. Physician costs. Hospital-based physician charges to individual patients is outside the authority of the HSCRC.
   a. *With costs of hospital-based physicians rising out of proportion to insurance reimbursements, what policy changes should be considered by HSCRC, and, more broadly, by the state? What, if any, special considerations should be made for physician costs in academic health systems, recognizing the role of existing funding for graduate medical education?*

Traditional mechanisms to cover physician market costs include expanding services to increase volumes and negotiating higher rates with commercial payers. These tools do not exist for Maryland hospitals. In the absence of these tools its appropriate to fund a portion of the cost to retain hospital-based providers in GBR in order to ensure access to care. Like IME/GME residency funding, HSCRC could provide a component in GBR for hospital based.

   b. Facility conversions. *Should the HSCRC consider facilitating the conversion of hospitals with declining numbers of patients and high market-level capital costs to free-standing medical facilities or other lower acuity providers?* Such a step could be designed to increase funding for hospitals seeing more patients as well as permit the restructuring of services at the conversion facilities to meet community needs. If so, what policies should guide this process?

Yes. A model like Dynamis' Healthy Villages could be used to advance ambulatory and community care. See Kaufman Hall's article "A Different Way of Thinking About Hospital Closures".

   c. Percentage of revenue under global budgets. Under the TCOC Model, the HSCRC was allowed to exclude up to 5 percent of in-state revenue from population-based methodologies, which the Commission utilized to ensure the delivery of high-cost outpatient drugs through the CDS-A policy. Under the AHEAD Model, this exclusion increases to 10 percent. *What additional volumes should the Commission consider using fee-for-service methodologies for, e.g., expanded quaternary definitions or hospital at home?*

The HSCRC could consider paying volumes on a fee-for-service real-time basis for hospitals in services areas with low use rate per capita. Under a certain threshold, the risk of restricting access is greater than the risk of growing volumes.

4. *What other major changes to policies under the Maryland Model of population-based payment should be considered?* Please be as specific as possible.

Funding medically necessary care, correcting base rate inequities, and implementing regional planning are essential to ensuring access to medically necessary care and preparing for the AHEAD Model.

Aledade

Good evening,

Below you will find Aledade's answers to the questions contained in the request for comment on the AHEAD model recently announced by HSCRC.

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

a. *Over the past decade, hospitals have used the flexibility of global budgets to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. To further drive this work, how can the payment system better recognize effective efforts?*

Hospital management is largely focused on treatment over prevention, overlooking the actors best positioned to make substantive impacts on highlighted criteria: primary care. Primary care is not only more cost-effective but also leads to better health outcomes. Emphasizing hospital based treatment incentivizes intervention after the point at which the cost of care expands significantly. Instead, HSCRC should work to further integrate primary care into the existing TCOC model and the forthcoming AHEAD model by ensuring interoperability with programs such as MSSP and MDPCP. Interoperability would ensure primary care's ability to participate in HSCRC's processes as efficiently and effectively as possible. Parallel to this, mandated investment by commercial providers would change the economics of primary care and allow for the stabilization of current capacity and set the foundation for future expansion. Despite being the foundation of our health care system, primary care currently receives only 7¢ of every health care dollar. As a result primary care suffers from severe underinvestment resulting in reducing capacity and causing increased hospital utilization across the board. This recommended one-two punch would effectively reduce the exposure of hospitals to the expansion of utilization of their expensive care while simultaneously supporting the long-term viability of the most cost effective form of care ensuring that all boats rise across the health care ecosystem.

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b. Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?

Nationwide studies have shown that the best programs for reducing cost of care focus on integrating multiple systems together to deliver valuable, high quality care over fee for service. The future successful operation of HSCRCs models is incumbent on identifying the areas where interoperability eases the process of care and ensuring that all levels of health care are working effectively to reduce instances of chronic illness and disease. Identifying opportunities to integrate fragmented care into holistic systems emphasizing value base care would go a long way toward ensuring the long term success of Commission's goals. Additionally exploring opportunities to emphasize programmatic interoperability and the long term survival of primary care would form a foundation for future investments to intervene in the most severe cases of inefficiency.

c. Numerous organizations and approaches have documented how the fee-for-service system generates low value care. Maryland does not necessarily perform well on these metrics despite the different hospital financial incentives. See for example the Lown Institute analysis of Unnecessary Back Surgery in which Maryland is average: https://lownhospitalsindex.org/unnecessary-back-surgery/. How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care?

The root cause of low-value, fee-for-service care is the economic incentives structure that keeps it viable; to reduce its instance, rewarding value is key. Through the forthcoming AHEAD model HSCRC should prioritize payments focused on results over services delivered. MSSP has demonstrated in primary care that coordinated care with an emphasis on value reduces instances of chronic disease, increases positive outcomes, and reduces cost. Across Maryland primary care physicians already have a track record of success leveraging well integrated programmatic support, through MSSP and MDPCP, to achieve the transition to value based care. By opening pathways to financial stability that emphasise outcomes over services, HSCRC would influence the clinical decision making present at every level of care. Furthermore, by ensuring that primary care is included in this process and emphasising programmatic interoperability, HSCRC would move the critical point of intervention back to the space where it is most easily and effectively managed on a cost basis.

d. The Health Services Cost Review Commission policies provide an added incentive to reduce "potentially avoidable utilization" as defined by readmissions and PQIs. Given answers to the questions above, should the HSCRC consider alternative or complementary approaches?

It is readily apparent that adequate primary care capacity represents the best path forward for reducing overall utilization. The emphasis on using hospitals as the mechanism to reduce rates of hospitalization is addressing the problem after it has already arisen. To reduce overall rates of utilization an adequate network of primary care must be in place. Primary care is best positioned to manage the long term care of patients to prevent the development of chronic illnesses and control the spread of diseases that result in hospital admissions. Ensuring its long term success is, therefore, critical to the successful reduction of utilization rates across the board. Currently the economic environment for primary care is extremely difficult. Low reimbursement rates from commercial providers, reduced reimbursements from the federal government, and poor interoperability between support programs force primary care providers to make difficult choices. Reducing the economic barriers to practice operations through mandated commercial investment, expanded interoperability of support programs, and closer integration with the existing TCOC infrastructure would ensure long term viability. Programs such as MSSP and MDPCP have already demonstrated the value of primary care in reducing utilization. Further integration with the state's programs and agreements with CMS would allow for better upstream intervention in developing health issues and reduced instances of hospitalization.

We appreciate the opportunity to submit our comments and look forward to the opportunity to testify on the 12th. In the meantime please let me know if there is anything else that I can do to help.

Sincerely,

Will London

Senior Policy Analyst

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Ascension
Saint Agnes

February 3, 2025

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, I am writing today to respond to the request for comments from the Health Services Cost Review Commission (HSCRC) regarding potential changes to policies as the State of Maryland prepares to begin the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model.

In addition to the answers to the specific questions posed by the HSCRC, Ascension Saint Agnes would like to encourage the HSCRC to focus on the following policy and funding priorities:

- **Demographic policy**. The current demographic policy does not adequately account for the aging of the population, underfunding hospitals based on the expected increases in utilization.
- **Market shift policy**. The current policy does not appropriately account for and fund shifts in patient movement nor does it appropriately differentiate the variable costs across service lines. Ascension Saint Agnes is also concerned that the current policy does not account for events outside of the hospital's control such as the cyberattack that occurred in 2024.
- **Physician investments**. While Ascension Saint Agnes understands the potential statutory limits of the HSCRC to fund physicians directly, current policies do not account for the increasing expenses being required to adequately staff the physician enterprise, both to operate the hospital and a robust ambulatory network to support population health efforts.

Below are answers to the specific questions raised by the HSCRC:

- **Over the past decade, hospitals have used the flexibility of global budgets to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. To further drive this work, how can the payment system better recognize effective efforts?**

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For each of the payment programs established by the HSCRC, there needs to be a clear connection between hospital action and reward or penalty. Some of the existing programs such as the Medicare Performance Adjustment (MPA) do not have a clear line to accountability between actions in the span of control of the hospitals and the corresponding financial impact. This leads to lack of engagement from the hospitals and highly variable results amongst them year over year.

- **Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?**

  Ascension Saint Agnes continues to be supportive of the investments that have been made in the state's Health Information Exchange (HIE), CRISP, as having one data utility to route clinical information amongst hospitals and provide program performance data has been critical. Ascension Saint Agnes would encourage the HSCRC to review any investments in additional data tools on a statewide basis through this lens, providing equitable access for all users, rather than each individual system or hospital separately investing in disparate tools.

- **Numerous organizations and approaches have documented how the fee-for-service system generates low value care. Maryland does not necessarily perform well on these metrics despite the different hospital financial incentives. See for example the Lown Institute analysis of Unnecessary Back Surgery in which Maryland is average: https://lownhospitalsindex.org/unnecessary-back-surgery/. How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care?**

  The HSCRC could take the following concrete steps to partner with hospitals and physicians to address low-value care:
  - Convene a stakeholder group to review the data, by hospital, for low value care to determine the areas of greatest opportunity. This group would be tasked with identifying best practices to reduce this type of care and make recommendations to the HSCRC regarding financial incentives that could be used to drive positive change.
  - Partner with the hospitals to reform the medical malpractice climate in Maryland. Defensive medicine is a reality in the state and is a factor in the ordering of potentially unnecessary or duplicative tests, etc.

- **The HSCRC policies provide an added incentive to reduce "potentially avoidable utilization" as defined by readmissions and PQIs. Given answers to the questions above, should the HSCRC consider alternative or complementary approaches?**

  The readmissions program is an example of one where there are specific interventions that hospitals can pursue to make positive improvement with clear financial rewards or penalties. It is also all payer, allowing broad based interventions for all patients. The HSCRC should

endeavor to reform or eliminate existing policies that cannot clearly tie hospital behavioral change to an impact on metrics.

Hospitals are currently penalized for moving care to lower cost, more appropriate settings which is just as meaningful as managing potentially avoidable utilization. The deregulation incentives should be revisited to ensure care is provided in the most appropriate setting without risk of excessive reductions to regulated revenue.

- **Do hospitals have planning needs to support innovative and affordable care models? If so, what are those needs, and how might the HSCRC support them?**

  Given the significant excess savings currently being generated by the Model, there is an opportunity to provide start-up funding for hospital programs that demonstrate an opportunity to significantly improve quality or reduce total cost of care. These funds could also be used to target specific performance improvement activities such as length of stay and Emergency Department (ED) throughput.

  One of the challenges with previous funding of these types of initiatives is that the funding is temporary, even if the intervention has proven successful. The HSCRC should consider funding these initiatives permanently if they are achieving the results outlined in the initial proposal.

- **Currently, access to needed care in Maryland is assessed through a series of individual measures, including ED wait times, hospital beds per capita, avoidable admissions per capita, and others. This disjointed approach cannot account for the complex relationship of these access measures to one another. How can the Commission and partner agencies develop more useful measures of needed access that support prioritization of funding and rationalization of existing investments?**
  The Model has successfully reduced hospital utilization, but these reductions have not been consistent across hospitals and have not drawn an effective distinction between positive reductions (Potentially Avoidable Utilization) vs negative reductions (restricting access to the community). The HSCRC should consider a more refined approach to utilization reductions, rewarding hospitals for reducing unnecessary care while adequately funding (at least covering the cost) medically necessary care.

- **Reducing ER wait times is a state priority. Should the HSCRC consider payment policy to slow the rate of volume declines in specific health systems for specific services related to ER wait times?**

  Stabilizing the financial performance of hospitals is one straightforward way to ensure EDs are staffed appropriately for the demand.

- **As patients move from one hospital to another within specific service lines, there is an adjustment made to both hospitals' budgets. What, if any, changes are appropriate to HSCRC's policies for this market shift to support access to needed care without abandoning**

population-based payment and creating an excessive financial incentive for hospital-based treatment?

The current market shift methodology doesn't recognize the varying degrees of variable cost across different service lines. This is one adjustment that could be incorporated to ensure the cost of shifting volume is covered. It's important to note that this does not provide a strong incentive to grow volume to grow margin like the rest of the country, only to ensure that hospitals do not incur financial losses by providing medically necessary care due to patient choice.

- **Hospital global budgets are adjusted every year for statewide population growth. How, if at all, should this adjustment be changed or focused to promote the goals of the model for access to care, cost control, and population health?**

  The current demographic adjustment does not adequately account for the aging of the population, thereby underfunding hospitals for expected increases in acute care utilization. This aspect of the current policy needs to change to provide appropriate funding to hospitals, without which hospitals will be unable financially to commit significant resources to population health initiatives.

- **Recognizing that effective hospitals can provide greater access to care, what are key domains and metrics that should be used to assess the effectiveness of hospitals? Should national comparisons be used to evaluate metrics such as length of stay, utilization per capita and administrative costs?**
  The current Integrated Efficiency Policy is not an accurate measure of the efficiency of hospitals. Two of the measures utilized, comprising 50% of the total ranking, are measuring the total cost of care for Medicare and Commercial members. As discussed earlier, these measures are difficult to impact for a single hospital, particularly year over year.

  In addition, the policy does not drive behavioral change. Once in the bottom quartile, the hospital has limited options to improve performance, including increasing volume, which is counter to the goals of the HSCRC. A new policy is needed which accurately measures the efficiency and effectiveness of hospitals,

- **Physician costs. Hospital-based physician charges to individual patients is outside the authority of the HSCRC. With costs of hospital-based physicians rising out of proportion to insurance reimbursements, what policy changes should be considered by HSCRC, and, more broadly, by the state? What, if any, special considerations should be made for physician costs in academic health systems, recognizing the role of existing funding for graduate medical education?**

  Physician costs are a necessary and required expense to run an acute care hospital, however the regulatory system has not kept pace with changing physician coverage models, with community physicians no longer rounding on patients in hospitals to the extent they once did. Although lacking clear statutory authority, the HSCRC has already recognized that rate regulated revenue can be used to pay physicians as the Revenue for Reform policy

specifically calls out physician expenses as an approved use. The HSCRC needs to develop a methodology that acknowledges the costs needed for physician coverage in hospital rates.

- **Facility conversions. Should the HSCRC consider facilitating the conversion of hospitals with declining numbers of patients and high market-level capital costs to free-standing medical facilities or other lower acuity providers? Such a step could be designed to increase funding for hospitals seeing more patients as well as permit the restructuring of services at the conversion facilities to meet community needs. If so, what policies should guide this process?**

  Freestanding Medical Facilities (FMFs) are an effective care delivery solution for rationalizing excess acute services yet ensuring emergency and other needed ancillary services are available to communities. The HSCRC should revisit its incentives for how hospitals evaluate transitioning acute facilities to FMFs, particularly for those hospitals that are part of larger, Maryland-based health systems.

- **Percentage of revenue under global budgets. Under the TCOC Model, the HSCRC was allowed to exclude up to 5 percent of in-state revenue from population-based methodologies, which the Commission utilized to ensure the delivery of high-cost outpatient drugs through the CDS-A policy. Under the AHEAD Model, this exclusion increases to 10 percent. What additional volumes should the Commission consider using fee-for-service methodologies for, e.g., expanded quaternary definitions or hospital at home?**

  Obstetrics and newborn services are not service lines that hospitals should be expected to manage under a population-based payment model, as the model is meant to reduce unnecessary utilization which doesn't apply to these services. These services should be carved out and handled on a fee-for-service basis.

Thank you again for the opportunity to provide comments. If you have any questions, please do not hesitate to contact me.

Sincerely,

Beau Higginbotham
President & CEO

cc: Dr. Laura Herrera-Scott, Secretary, Maryland Department of Health
Dr. Joshua Sharfstein, Chairman
Dr. James Elliott, Vice Chairman
Ricardo Johnson
Dr. Maulik Joshi

Adam Kane
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February 3, 2025

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

Dear Executive Director Kromm:

CareFirst BlueCross BlueShield ("CareFirst") appreciates the opportunity to comment in response to the Health Services Cost Review Commission's (HSCRC) call for comments related to policy changes and investments to maximize Maryland's success.

Marylanders would benefit from a healthy Medicare Advantage market

Medicare Advantage (MA) has become a primary source of health insurance coverage for the elderly nationally. It provides robust benefits and is resourced to actively manage care for beneficiaries, unlike the Medicare Fee for Service program. HSCRC has discussed the interplay between the model and the federal MA program, which inadvertently distorts payment and holds back the market from its potential. If high value care and access are HSCRC priorities entering the AHEAD model, Medicare Advantage should be viewed as an asset and helpful tool in achieving better outcomes across those domains. HSCRC can correct the model's impact on the MA market and, as a result, put population health interventions into the market driving down low value care. CareFirst would happily work with HSCRC on a solution.

Global budgets should not exist without service and access standards

The state should develop a data-driven perspective on the service needs within communities. This would help guide investment decisions and put patients at the center of the conversation. There has been a lot of angst in the industry caused by the movement of patients throughout the system, hospitals' differing responses to the incentives of the model, and whether the appropriate amount of revenue was transferred between hospitals. HSCRC should develop standards that accompany global budgets (i.e. hospital must maintain X staffed beds), just like any other contract, and those standards should be informed by service needs in community.

The state's standards on access should cut across the delivery system and not stop at hospital services. They should leverage data to determine where investments are most needed to provide access to communities and conversely where investments would be duplicative and unproductive. This would require considering nuances and defining what adequate access looks like – for example, does a physician's office offer evening or weekend access? Do they accept Medicaid patients? Do they offer online scheduling? How far out is the next available appointment? This level of sophistication acknowledges that setting up physical space is not enough to constitute patient-friendly access.

Value-based care remains an underutilized opportunity

Many of HSCRC's questions focused on high and low value care, which can be addressed through more robust value-based care arrangements than the ones in market today. HSCRC should push for value-based arrangements between payers and various provider types while continuing to promote multi-payer alignment. For example, we believe there is an opportunity to leverage the flexibility afforded to Maryland through the model to test an expanded version of global budgets that allows some hospitals to voluntarily take accountability for the total cost of care of all patients in their community.

HSCRC should also push for health systems to create innovative value-based partnerships with other provider types to address some of the length of stay issues contributing to long emergency department wait times. Value-based care can help with fiscal stewardship in optimizing current bed capacity.

HSCRC does not regulate physician costs

While we understand hospitals have made tremendous investments in unregulated physicians, some of which are necessary to sustain core hospital operations, we do not believe it is within the HSCRC's statutory mandate to fund these costs. As long as health systems are billing separately for physician services, and comprehensive physician investment data is not collected and critically analyzed, there is no place for HSCRC to consider policy changes that address these costs.

We appreciate the opportunity to comment on these questions that demonstrate staff is putting a great deal of effort into their policy calendar at this inflection point in the model. CareFirst looks forward to engaging with staff and industry stakeholders to shape appropriate policies that center patients and drive improvements in access, affordability, outcomes, and equity.

Sincerely,

Arin D. Foreman
Vice President, Deputy Chief of Staff
CareFirst BlueCross BlueShield
1501 S. Clinton Street
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February 3, 2025

Jonathan Kromm, PhD, MHS
Executive Director
Health Services Cost Review Commission
Submitted via email to hscrc.care-transformation@maryland.gov

RE: *HSCRC Opportunity for Comment* on the AHEAD Model

Dear Executive Director Kromm:

The Chesapeake Regional Information System for our Patients ("CRISP"), the state designated health information exchange ("HIE") and health data utility ("HDU") for Maryland, appreciates the opportunity to comment on HSCRC's questions related to the implementation of the AHEAD model. While CRISP does not have written comments to offer on questions related to policy design or payment methodology, we do want to take this opportunity to express our continued support and partnership as the state moves toward the AHEAD model.

As it relates to the creation and investment in common utilities to enhance care and health outcomes, CRISP is honored to serve as both the state-designated HIE and HDU for Maryland. CRISP's vision is to advance health and wellness by deploying health information technology solutions adopted through cooperation and collaboration. To that end, CRISP is able to build on existing technology infrastructure and reporting tools that have developed collaboratively over the past decade and serve as a common utility to provide reports or other technology-based tools to help enhance care and health outcomes.

As it relates to the development of useful access measures that also prioritize funding requirements and the best use of existing initiatives, CRISP is prepared to leverage its expertise in data collection, normalization, and reporting. We are happy to leverage and enhance existing reporting tools to support the state in its ability to analyze data trends across a broad array of health care providers and places of service.

CRISP leads the nation with innovation in reuseable data exchange with robust governance. CRISP has significant experience connecting unique data sets from multiple sources to create usable tools for clinicians, public health agencies and care coordinators across multiple settings. Our tools are leveraged throughout Maryland including use at the point of care, care coordination, population health reporting, program administration, and public health. Our CRISP Reporting Services (CRS) offers a robust suite of reports where users can access claims data to evaluate population health trends and performance. Our CRS and Program

Administration teams have partnered with HSCRC for years to provide technical assistance in addition to reports to all Maryland hospitals. We also partner with other state agencies such as MDPCP and Medicaid to provide comprehensive reporting for primary care providers and Managed Care Organizations. Both teams work closely with their state counterparts to regularly enhance and perfect the tools provided to make sure we are continually meeting market needs.

CRISP is eager to support HSCRC in data, reporting and technology tool needs that may arise as a result of this request for comments. CRISP highly values its relationship with the HSCRC and the Maryland healthcare community. As we engage throughout the country, there is no doubt Maryland is leading the way in innovation with advanced cost and quality initiatives in health care. We look forward to continuing to support Maryland in its leadership role, and we look forward to working together to implement these ground-breaking initiatives. CRISP stands ready to support the HSCRC and the Maryland healthcare community with the AHEAD model.

Sincerely,

Megan Priolo, DrPH, MHS
Vice President & Executive Director, CRISP Maryland

GBMC HealthCare System

Greater Baltimore Health Alliance
Greater Baltimore Medical Center
Gilchrist Hospice Care

John B. Chessare, M.D., MPH, FACHE
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January 31, 2025

Maryland Health Services Cost Review Commission

Dear Commissioners:

Please accept these three ideas in response to your call for comments on policy changes and investments that would help with the implementation of the AHEAD model.

Funding Provider Organizations to Drive Improved Health Outcomes and Patient Experience while Reducing Cost and Improving the Joy of Care

The definition of maximum value in healthcare is the best health outcome and care experience at the lowest cost. In Maryland and especially within the City of Baltimore, there is a huge opportunity to improve the health outcome and care experience and reduce the cost of those with chronic disease. The population is ageing and therefore the burden of chronic disease is growing rapidly, unfortunately, the system is not structured to drive maximum value.

Acute care hospitals are constructed to safely deliver babies, to do high end surgery, and to rescue those with acute illness and then return them to the community. Hospitals are not structured to manage the health of a population of chronically ill people and keep them from requiring acute rescue. The Affordable Care Act brought us the notion of "accountability" and the concept of the Accountable Care Organization. CMS and the Innovation Center now have good evidence that these physician-led organizations can and do drive greater value. In the absence of a clinical team that is accountable along with the patient for driving the best outcome and reducing non-value care, patients, especially those from historically underserved communities, are left to fend for themselves, with nowhere to turn until they get to a point of acute need where they present to an emergency department and often get admitted to the hospital because the ED clinicians are reluctant to discharge them without a clinician who will assume the accountability for their care.

The Maryland Primary Care Model is an excellent first step in building an accountable system. Now that it will include Medicaid as a payor, more accountable relationships will be built with chronically ill and marginalized individuals. To make faster progress, however, more resources must be applied to the creation of accountable care organizations or their

equivalents in multi-specialty group practices that are incentivized to drive value and move into underserved neighborhoods. This will only happen if funding is moved to capitation per individual served, with financial incentives for value performance.

Adding more revenue to the system does not improve the value equation, however. The good news is that especially in the City of Baltimore, we have excess hospital capacity. While the state of Maryland average of 2.0 beds per thousand residents is below the national average of 2.35 beds per thousand residents, in the City of Baltimore we have 6.1 beds per thousand residents.

We know that some patients come from all over the world to get care in Baltimore's outstanding academic medical centers, so Baltimore should have more than the statewide average of beds. However, we believe that we could close some of the beds and use some of the savings to incentivize the creation of accountable physician-led clinical groups. This will require new authority within the HSCRC or the creation of a new entity, to close hospital capacity and effectively move the funds to the accountable clinician groups. Organizations that saw a reduction in beds could be given a "right of first refusal" to create accountable provider organizations that would move into underserved communities in the city.

An innovative move of this nature will require strong leadership for change. In the absence of a redesign of this nature, the HSCRC should explore other means to move resources to those ready to be held accountable to better manage those with chronic disease and drive better health outcomes, better care experience at lower cost with more joy for those providing the care, the so-called quadruple aim of U.S. healthcare.

Creating Standard Work to Reduce Waste in the Transition from Inpatient to Post-Acute Care

A second suggestion to create more value in Maryland's healthcare system is to standardize the mechanics of transition from inpatient units to extended care facilities. Today, no two post-acute facilities have the same procedure for accepting admission. As an example, some facilities use the term "accepted" to mean they are ready to take the patient, and others use the term "accepted" to mean that the patient will be welcome sometime in the future when a bed becomes available. GBMC is now working with several post-acute providers to design a transition process that will move patients when they are ready and a bed is available, without the over-processing and rework loops that are now prevalent. This design could be extended to all post-acute facilities in the State.

Increasing Access to Palliative Care to Reduce Non-value Added Admissions at End of Life

A third suggestion is to create robust palliative medicine services at Maryland hospitals to give patients symptom relief and better options as they approach the end of life. Creating a proposal for this initiative is underway between GBMC/Gilchrist and Commission staff.

Thank you for your time and consideration.

Sincerely,

John B. Chessare MD

John B. Chessare MD, MPH

HOLY CROSS HEALTH
A Member of Trinity Health

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February 3, 2025

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

Dear Dr. Kromm,

On behalf of Holy Cross Health, I am writing to provide comments to the Health Services Cost Review Commission (HSCRC) regarding policy priorities to prepare for participation in the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model.

Holy Cross Health believes the following policy and funding priorities are most critical to address as the HSCRC reviews feedback from the industry:

- **Demographic policy -** The current policy does not appropriately fund hospitals because it does not adequately adjust for the aging of the population. This limits the funding hospitals need to address the increases in acute care utilization that will occur as the population ages.

- **Physician losses -** The dynamics of the physician workforce within the hospital have changed dramatically since the HSCRC was created, yet the statutory authority and policies have not been updated to reflect these changes. Hospitals do not have sufficient funding to absorb the increasing financial losses resulting from maintaining adequate physician coverage within the hospital and also invest in ambulatory practices to meet the goals of the Model.

- **Market shift policy -** The current policy underfunds hospitals and is not consistent with other policies whereby funding follows the patient/person. Incentives can be maintained that do not reward volume growth while ensuring that hospitals receive the necessary revenue to care for patients.

Below are Holy Cross Health's comments to specific questions raised by the HSCRC:

Ensuring High-Value Care

- **Over the past decade, hospitals have used the flexibility of global budgets, to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. To further drive this work, how can the payment system better recognize effective efforts?**

  The HSCRC should give hospitals funding to support innovative population health pilot

programs and provide ongoing funding for successful ones. Hospital rates can be used to fund hospital-community partnerships that can reduce total cost of care (TCOC) beyond hospital savings. Two examples of successful programs include:

- The Wellness and Independence for Seniors at Home (WISH) program was one of the first programs developed by Montgomery County's Nexus Montgomery Regional Partnership. It was very successful in reducing TCOC for vulnerable seniors, but the savings could not be attributed to specific hospitals, so hospitals were not able to continue the program when the HSCRC funding ended.

- The Skilled Nursing Facility (SNF)-Real Time partnership generated benefits that were system-wide but couldn't be tied to specific hospital readmission savings.

In addition, the Medicare Performance Adjustment (MPA) should be adjusted to be program-specific vs. broad-based so that hospitals can influence the results and be held accountable for performance. The MPA as it stands today does not create or incent hospital-specific action.

- **Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?**

  The HSCRC can encourage and fund pilot programs to test common utilities and then deploy those that work systemwide. The Hospital-SNF partnership that tested the Real Time data monitoring system in 10 SNF's was a good example of this that led to Medicaid offering it to all SNFs.

  The HSCRC could work with CRISP (Chesapeake Regional Information System for our Patients) to expand its functionality to better incentivize physician utilization. CRISP's role could also be expanded to provide hospitals with more data and analytics regarding performance improvement opportunities.

- **Numerous organizations and approaches have documented how the fee-for-service system generates low value care. Maryland does not necessarily perform well on these metrics despite the different hospital financial incentives. See for example the Lown Institute analysis of Unnecessary Back Surgery in which Maryland is average. How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care?**

  Financial support for development of hospital/system-owned physician practices may help to shift provider incentives from a fee-for-service (FFS) mindset to a TCOC management perspective because the upside (and downside) opportunities are substantially higher than the FFS opportunity of a standalone practice. Aligning the incentives between physicians and hospitals can promote greater collaboration and focus on reducing certain types of low value care as identified in the study.

- **The HSCRC policies provide an added incentive to reduce "potentially avoidable utilization" as defined by readmissions and PQIs. Given answers to the questions above, should the HSCRC consider alternative or complementary approaches?**

  The HSCRC should consider demonstration projects between hospitals and SNFs to reduce readmissions and other avoidable utilization. This may require seeking Centers for Medicare and Medicaid Services (CMS) waivers or other authority to pay SNFs differently and better align them with the Model.

  The HSCRC should also evaluate the list of PQIs to determine whether hospitals can truly influence and be held accountable for preventing them, e.g. diabetic amputations are often a result of the life-time effect of health behaviors and socioeconomic conditions and cannot be solved by hospital interventions alone.

- **Do hospitals have planning needs to support innovative and affordable care models? If so, what are those needs, and how might the HSCRC support them?**

  Support for capital investments is needed to ensure that hospitals can care for patients, both inside and outside of the hospital. Many hospitals have had to defer needed capital improvements or expansions due to limited resources.

<u>Improving Access to Care:</u>

- **Currently, access to needed care in Maryland is assessed through a series of individual measures, including ED wait times, hospital beds per capita, avoidable admissions per capita, and others. This disjointed approach cannot account for the complex relationship of these access measures to one another. How can the Commission and partner agencies develop more useful measures of needed access that support prioritization of funding and rationalization of existing investments?**

  The HSCRC should convene a multi-stakeholder workgroup to set high level goals and measures that align different provider types across the continuum. These policies need to be flexible to drive performance.

  Aligning providers across the continuum will likely necessitate payment changes, data reporting, regulatory mandates or other requirements on non-hospital providers such as primary care, urgent care, and post-acute. Using post-acute as an example, the current regulatory construct allows them to utilize insurance denials or other tactics to reject patient discharges, negatively impacting hospital length of stay and contributing to ED wait times.

- **As patients move from one hospital to another within specific service lines, there is an adjustment made to both hospitals' budgets. What, if any, changes are appropriate to HSCRC's policies for this market shift to support access to needed care without abandoning population-based payment and creating an excessive financial incentive for hospital-based treatment?**

The HSCRC should modify the market shift calculation to recognize a greater share of variable costs by evaluating costs on a service line basis and simplifying the geographic definitions. The current zip code methodology does not sufficiently capture shifts in volume between hospitals.

- **Hospital global budgets are adjusted every year for statewide population growth. How, if at all, should this adjustment be changed or focused to promote the goals of the model for access to care, cost control, and population health?**

  The demographic adjustment should be revised to ensure that a hospital's age-adjusted growth is fully funded so hospitals have sufficient resources to cover the higher cost of caring for an aging and generally sicker population. Holy Cross Health recommends, as part of the annual payment update for Rate Year 2026, that the limit on age-adjusted growth be removed and a long-term plan be developed to review the demographic characteristics of the population and risk adjust for more complicated populations such as hospitals with high catchment areas/referrals from LTAC, SNF, and Rehab facilities.

  Consideration should also be given for hospitals with higher uninsured patient populations as access to outpatient care for preventative and post-hospitalization care is markedly limited. Similarly, care for patients with a high level of social needs and/or limited English proficiency also takes longer and impacts ED and inpatient length of stay, which isn't currently accounted for in payment policies.

Other Topics:

- **Physician costs - Hospital-based physician charges to individual patients is outside the authority of the HSCRC. With costs of hospital-based physicians rising out of proportion to insurance reimbursements, what policy changes should be considered by HSCRC, and, more broadly, by the state? What, if any, special considerations should be made for physician costs in academic health systems, recognizing the role of existing funding for graduate medical education?**

  Physician salaries are rising out of proportion to insurance reimbursements. The cost to compensate physicians for taking call is steadily rising because they can make more money outside of the acute care setting. In addition, the availability of physicians in Maryland is decreasing secondary to competition from nearby markets (DC, VA, PA, DE) where they are compensated higher. In markets, like Holy Cross Health's, with a significant number of uninsured patients, physicians are unable to recoup professional fees for their services which requires hospitals to provide a stipend/bridge the gap for the care they provide in the hospital. The state needs to allocate more funds for uninsured patients for emergent care.

  Payers need to fairly compensate physicians for the care they provide. The low payer reimbursement in Maryland is a significant driver of the financial losses that hospitals are sustaining to maintain the physician enterprise.

  The HSCRC should pursue two potential avenues for addressing this issue:

  - Include hospital-based physician costs that are not otherwise offset by

revenue as a regulated, essential hospital cost and fund through hospital rates.

- Pursue legislation to mandate a floor for commercial payer reimbursement to ensure that physicians can remain financially stable in Maryland and to limit the subsidies that hospitals are providing.

Thank you for the opportunity to provide comments on these important policy matters.

Sincerely,

Julie D. Keese

Julie D. Keese
Vice President and Chief Financial Officer
Holy Cross Health, Inc.

cc: Dr. Laura Herrera-Scott, Secretary, Maryland Department of Health
Dr. Joshua Sharfstein, HSCRC Chairman
Dr. James Elliott, HSCRC Vice Chairman
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi
Andre (Dre) Boyd Sr., Regional President & CEO, Trinity Health MidAtlantic and Holy Cross Health

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February 3, 2025

Jonathan Kromm, PhD
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
(transmitted via email)

Dear Dr. Kromm,

On behalf of Luminis Health, we appreciate the opportunity to provide comments on Maryland's transition to the Advancing All-Payor Health Equity Approaches and Development (AHEAD) Model. While we support the AHEAD goals, ten years into global budgets and five years into the Total Cost of Care (TCOC) model, there are unintended consequences now threatening hospital financial viability. To sustain high-quality care and meet AHEAD's goals, key policies and practices must be revised and addressed, including:

- **Market Shift and Volume Recognition**. Luminis Health experienced $12.2M in volume growth from CY23Q1Q2 to CY24Q1Q2 but will receive only $1.1M in market shift funding—just 9% of actual growth. We support the recommendation articulated by the Maryland Hospital Association (MHA) to review the Variable Cost Factor (VCF) at the service line level and to shift away from ZIP code-based calculations to more accurately reflect real volume changes.

- **Age-Adjusted Demographic Growth Funding**. Maryland has experienced a 40% increase in the 65+ population in the past decade. The demographic adjustment fails to account for Maryland's aging population, leading to a cumulative statewide underfunding of $7.4B since FY16. This must be corrected to ensure hospitals can sustain access and invest in population health programs.

- **Integrated Efficiency Accuracy**. The current policy continuously awards the hospitals in the top quartile while reducing revenue for those in the bottom quartile, with limited ability for hospitals to positively impact their ranking.

- **Recognition of Hospital-Based Physician Expenses**. Luminis Health's hospital-based physician costs have risen 68% since FY20, straining resources. These expenses are directly linked to the quality and delivery of 24/7 hospital care and therefore should be considered under GBR.

- **Payor Accountability**. Rising payor denials are straining operations, with Luminis Health's denial write-offs increasing from 1.5% to 4.6% of gross revenue ($49.6M) since FY19, while revenue cycle and appeal costs have surged 152%.

The cumulative impact of these policy shortfalls has left growing hospitals in financial peril. Emergency Department (ED) overcrowding has negative impacts on ED wait time, bed capacity, patient safety, and patient experience when not appropriately addressed in a hospital's global budget. Hospitals maintaining access and experiencing increases in medically necessary care are impacted by these challenges disproportionately compared to hospitals that are treating less patients. Luminis Health has incurred an $8.8M operating loss through December 2024 on a consolidated basis – our fourth consecutive year of negative operating margins. Several HSCRC policies restrict our ability to maintain financial sustainability, particularly the items noted above as well as the lack of Global Budget Revenue (GBR) support for new graduate medical education (GME) programs, and much needed behavioral health services.

The Medicare FFS cumulative *excess savings* (i.e. above established targets) under the TCOC model from 2019-2024 exceed $1B. This number is substantially higher on an all-payor basis. These dollars could have been invested in hospitals that maintain community access, meet patient demand, and fund broader population health initiatives. While there has been some reduction in utilization statewide, most of the savings have been the result of rate suppression (across all payors) and payor denials (commercial, Medicare Advantage and Medicaid MCOs). Rate suppression and denials do not improve population health or reduce disparities in care and outcomes.

Ensuring High-Value Care

Hospitals need financial flexibility to invest in innovative population health solutions. Over the past decade, Luminis Health has aligned with the goals of the Model, the Statewide Integrated Health Improvement Strategy (SIHIS), and the Governor's healthcare vision by investing in programs such as:

- Maternal Health - Centering Pregnancy Program; new access points in Prince George's County
- Behavioral Health (BH) - Luminis Integrated Teen Experience; increased adult psychiatric bed capacity and BH urgent care and walk-in clinics
- Luminis Health-Gilchrist Life Care Institute (hospice and palliative care joint venture)
- Post-acute/Skilled Nursing Facility (SNF) partnerships
- Colo-rectal, prostate and breast cancer screening and early intervention
- Diabetes Prevention Program
- Advanced Medicine and Transitional Care Clinics (opening access to hospital and ED discharged patients)
- Mobile Integrated Community Health
- Remote patient home monitoring for chronically ill patients

Many of these initiatives (and others) were recently enumerated in our response to the HSCRC's call to inventory population health programs. Continued support for these and future investments — such as Hospital at Home, ambulatory palliative care, hospice, and home care —require sustainable funding. The AHEAD model's success hinges on population health initiatives – but these cannot be supported while health systems operate at a financial loss or have insufficient margins to reinvest in the organization.

Improving Access to Care

The HSCRC should prioritize funding programs that align with the Maryland Health Improvement Plan, especially in behavioral health and women's health. Rising medical malpractice insurance costs, particularly in OB, deter needed service expansion. For example, Luminis Health's associated premiums and reinsurance expenses have increased 157% since FY20, far exceeding inflationary adjustments. In 2023, Luminis Health Doctors Community Medical Center (LHDCMC) opened an inpatient behavioral health unit aligned with state priorities yet was denied GBR funding. Given the lack of margin produced by these two service lines, it is not a coincidence that BH and OB are among the most frequently closed clinical programs nationally. Policies must evolve to ensure equitable funding for essential services.

Current policies on Potentially Avoidable Utilization (PAU) funding are overly restrictive and limit hospitals' ability to improve access to care. The three major volume policies – market shift, demographic, and integrated efficiency – all exclude this volume, failing to account for medically necessary care provided by hospitals, often to patients presenting to the emergency departments.

Addressing Emergency Department Overcrowding

ED overcrowding is exacerbated by inadequate primary care reimbursement, incentivizing payors to route patients to hospital EDs where payments are capped under GBR. Meanwhile, Luminis Health has made substantial strides in reducing diversion hours and improving Emergency Medical Services (EMS) transfer times. Being efficient at managing an overcrowded ED has resulted in increased EMS arrivals, further exasperating the ED volume challenges. Payor accountability is critical to resolving this crisis.

Recognizing Hospital-Based Physician Costs & GME

Hospital-based physician costs are essential to acute care hospital operations. Gone are the days of private practice physicians making daily rounds and being on-call around the clock. Commercial payor professional fees have been studied exhaustively and place Maryland in the lowest decile nationally. Hospitals need rate support for these services.

Maryland must align with national standards by establishing a dedicated funding mechanism for GME programs. To date, Luminis Health has invested $103M in GME with no GBR support, despite its critical role in addressing physician shortages and maintaining access to care.

Reforming Integrated Efficiency
The Integrated Efficiency policy fails to recognize chronic underfunding in Maryland hospitals. With 19 hospitals operating at a loss and more than $1B in excess Medicare savings generated largely through rate suppression, the methodology requires recalibration to prioritize hospital solvency.

Payor Accountability & Their Role in the Model
Under the waiver, Maryland hospitals have lost leverage with insurance companies that benefit from favorable "all payor" rates set by the HSCRC. Hospitals face numerous, burdensome payment policies that can be unilaterally modified by insurers. While some insurers are provider-owned, others are large national corporations focused on profits. The HSCRC must ensure hospitals receive value in exchange for these rates, possibly by establishing consistent payment policies across all payors or reducing the number of participating payors. Additionally, Managed Medicaid Plans should be monitored and reassessed regularly. The HSCRC and policymakers need to redefine the role of payors in Maryland's system to ensure they add value rather than creating inefficiency and higher costs, which is critical for the success of AHEAD.

Conclusion
Rising costs, growing demand, and limited funding have driven many Maryland hospitals into financial turmoil, threatening access to care. The AHEAD model needs to strike a balance between fiscal sustainability and its goals of access, quality, and equity. The excess savings generated under the model provide the HSCRC with the opportunity to take immediate action on the issues outlined in this letter. For issues outside the scope of HSCRC, we urge legislative collaboration and support.

We look forward to the opportunity to testify at the February 12th public meeting and future collaboration with the HSCRC to strengthen Maryland's healthcare landscape. As always, we are available for any questions you may have.

Sincerely,

Victoria W. Bayless
Chief Executive Officer

Stephanie K. Schnittger
Chief Financial Officer

cc:
Laura Herrera-Scott, MD, Secretary, Maryland Department of Health
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Homam Ibrahim
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Suite 403
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February 3, 2025

Health Services Cost Review Commission

4160 Patterson Avenue

Baltimore, MD 21215

Subject: Comments on HSCRC policies and Their Impact on Patient Access to life-saving procedures and Innovation

Dear Members of the Health Services Cost Review Commission,

I appreciate the opportunity to provide comments regarding the HSCRC policies and their impact on patient access to care, innovation, and life-saving procedural volume restrictions.

As a physician who recently relocated from New York to practice in Maryland, I have witnessed firsthand how the limitations imposed by the GBR model significantly affect access to life-saving cardiovascular procedures.

I have reviewed the HSCRC letter with great interest, particularly the figure summarizing the AHEAD vision. A central word in the figure—inside a red arrow spanning all AHEAD columns—is accountability. I could not agree more; accountability is the cornerstone of any healthcare policy. However, despite this emphasis, I have yet to find a single study evaluating GBR's accountability. The few available studies on GBR's effects on cost saving are retrospective and suffer from significant methodological flaws. Furthermore, the HSCRC letter does not mention any funding or funding opportunities to rigorously assess the GBR's value or its impact on healthcare in Maryland.

Maryland has a unique opportunity to guide the nation in determining the most effective payment model. While fee-for-service is not the answer, we also cannot claim that GBR is the optimal solution, as we lack the necessary data to support its foundational objectives.

As an interventional cardiologist specializing in valve disease, I can attest that the current model deprives Maryland residents of life-saving and medically necessary valve procedures.

Aortic stenosis, one of the most common and deadly valve diseases, has treatment options ranging from open-heart surgery to minimally invasive transcatheter procedures—both of which are proven to be life-saving interventions.

In 2023**, 48% of patients nationwide** with symptomatic severe aortic stenosis were referred to a specialist for treatment. In contrast, during the same time frame, **only 31% of patients in Montgomery County** received such referrals. This stark disparity should prompt us to critically evaluate whether the Maryland model truly serves the best interests of its residents.

While the GBR model has successfully controlled healthcare costs and promoted preventive care initiatives, it has also introduced unintended consequences that hinder access to innovative and life-saving treatments. The cap on procedural volumes creates a restrictive environment where hospitals face financial penalties for exceeding their allocated budgets, even when providing essential, life-saving procedures such **as Transcatheter Aortic Valve Replacement (TAVR) and Transcatheter Edge-to-Edge Repair (TEER). This is unfortunately not sustainable.**

In my clinical experience, the constraints of GBR have directly resulted in delays and denials of care for patients requiring advanced cardiovascular procedures. Hospitals in Maryland, particularly those with high procedural demand, often lack the infrastructure to support growing medical needs of their communities. This results in an alarming trend—patients being referred to neighboring states where procedural caps are not imposed. Consequently, Maryland residents must travel long distances to access the care they need, which contradicts the GBR's intended goal of improving patient-centered healthcare delivery.

Additionally, the GBR model stifles medical innovation. As new, evidence-based interventions become available, hospitals struggle to adopt these advancements due to budgetary restrictions. Unlike fee-for-service models that incentivize the adoption of cutting-edge procedures, Maryland's payment system discourages hospitals from expanding their service offerings. This places Maryland at a disadvantage compared to other states, where patients have access to a broader range of emerging technologies and treatment options.

Furthermore, while the GBR system has been in place for over a decade, there remains a significant lack of data demonstrating its effectiveness in improving patient access to specialized care. While cost containment is a key priority, it should not come at the expense of timely and equitable access to essential medical treatments. Future policy refinements should consider mechanisms that allow hospitals to provide medically necessary

procedures without financial penalties and foster an environment where innovation can thrive.

I urge the HSCRC to evaluate these concerns seriously and consider reforms that will balance cost control with improved patient access and innovation. As Maryland embarks on the AHEAD Model, it is crucial to ensure that financial structures do not create barriers to care or drive patients out of state for treatment. Thank you for your time and consideration of these pressing issues.

Moving forward, the HSCRC should consider reforms that:

1. **Support greater procedural flexibility**—hospitals should not be penalized for providing proven life-saving interventions. A Hybrid model between GBR and fee-for-service may be warranted for life saving highly innovative procedures that otherwise will not be offered under the current model. Alternatively, exclusions from the cap requirements of certain rapidly growing life-saving procedures should be considered.
2. **Incorporate mechanisms for innovation**—new life saving treatments should be incentivized, not restricted. Incentives for new service liens providing life-saving procedures.
3. **Fund independent research**—a comprehensive evaluation of GBR's impact on access to specialized care is essential. Specifically for marginalized populations.

Sincerely,

Homam Ibrahim, MD, FACC, FSCAI

Director, Structural Heart Disease

Director, Cardiovascular Research

Adventist Healthcare

JOHNS HOPKINS
MEDICINE

February 3, 2025

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

Dear Dr. Kromm,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input as the State prepares to move into the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. Over the past five years, JHHS has engaged in extensive collaboration and policy discussion with the Health Services Cost Review Commission (HSCRC), and has previously responded to many of the questions posed for this comment period, particularly within the whitepapers JHHS has shared with HSCRC and Maryland Department of Health (MDH) leadership. These whitepapers are included here along with previously shared comment letters for additional consideration. As highlighted in these comment letters and whitepapers, JHHS believes the below priority issues must be resolved before the State is prepared to move into the AHEAD model, and proposes the following potential solutions.

1. **Adequate funding for quaternary and tertiary care delivery and growth.**

   Trending of financial information since the inception of global budget revenue (GBR) indicates that Maryland hospitals are falling behind national hospitals in terms of recapitalization, adoption of new technologies, and the expansion of complex tertiary and quaternary care service lines. According to Vizient 10-year projections, virtually all inpatient growth—both in the state of Maryland and nationally—is projected to be in high-CMI and tertiary and quaternary care, an area exclusive to academic medical centers (AMCs) and advanced community hospitals.

   Despite this trend and these projections, the percent growth in total staffed acute beds at JHH grew 5% from 2015-2022, vs. the National AMC total growth of 10%. Maryland's AMCs are not keeping pace nationally with quaternary and tertiary volume growth.

   The model must preserve Marylanders' access to critical lifesaving care and curative therapies that can only be safely and effectively delivered by AMCs. GBR and current volume policies

create significant pressures to limit access to these key services based on a rationing of fiscal reserves to cover less intensive levels of care. Given the population-based payment flexibilities granted under the State's AHEAD agreement, JHHS urges the Commission to develop a policy that excludes these critical services from GBR and adequately funds AMC-level care.

2. **Adequate funding for medically necessary care.**

   During the last 10 years of GBR, the state saved $1B over stated targets, which can be considered underfunding of the industry. While the goal of the Model is to reduce avoidable or unnecessary utilization, this statement is optimistic and based on data provided, unattainable due to clinical necessity. As in any capped system, fixed payments provide strong incentives to reduce all utilization, not just avoidable utilization. Data shows that to be the case in Maryland, therefore, strong oversight (market or regulatory) is necessary to guarantee that hospitals continue to provide necessary services for the patients in their service area, and that these necessary services are appropriately funded. As some hospitals respond to the incentives of the system by reducing capacity and in turn, utilization, other hospitals then absorb this volume and deliver this necessary care; these hospitals should not be penalized for providing needed care. Under the current HSCRC policies and methodologies, an empty bed is more financially valuable than a staffed bed with a patient in it – this dynamic must change.

   JHHS recommends that the HSCRC appropriately fund this medically necessary care by ensuring core volume policies provide sufficient funding to cover the cost of doing that work. This means that the demographic adjustment appropriately accounts for expected changes due to aging of the population (and that those funds are directed to the hospitals that are taking on the burden of doing that work), and that the market shift adjustment yields a variable cost factor that is appropriate to the care being provided. This can differ dramatically by service line, for patients moving from one hospital to a different hospital. There are some high-cost service lines such as neurology and cardiac surgery that likely demand a higher variable cost factor so that the hospital gaining market shift receives more revenue to support a higher cost service.

   The HSCRC must ensure there are guidelines to identify concerning trends as some hospitals respond to the incentives of the model as they exist today. This includes shifting volumes to out of state providers, deregulating care without disclosure to the HSCRC, lower acuity care being provided in hospitals designed to handle the highest acuity and therefore lowering access for patients with significantly complicated care needs, and redesigning major clinical offerings that greatly reduce or expand access that result in patient displacement in the marketplace or transfer limitations.

3. **Addressing excess capacity and related retained revenues to support community and population health.**

   The success of the Demonstration Model in reducing acute care volumes resulted in some hospitals operating at a lower census and sub-optimal efficiency in Baltimore City, both on operating and clinical quality levels. In any other state, these hospitals would close, effectively right-sizing capacity in the area. However, the model has protected these hospitals from closures, and as a result, significant funding is retained in facilities with limited value, efficiency, and quality of care.

Simultaneously, increasing funding for population health resources is critical to the model, however, to assume that these programs will be funded through PAU volume savings dramatically underestimates the level of funding and time horizon required for significant improvements in population health status. It is also important to note that population health initiatives must involve collaboration and support across hospital systems, non-hospital providers, and state and local governments. The data demonstrates that the biggest impact to population health can be achieved within Baltimore City, but cannot be driven by just one hospital. This work requires partnerships.

JHHS recommends that the State establish a process to evaluate capacity in a semi-regular basis, make recommendations on reductions or increases in capacity, and develop incentives for implementation; through this process, the State can redirect funding currently retained in low capacity facilities towards needed capacity expansion, population and community health initiatives. In collaboration with the Maryland Health Care Commission in their role as the authority over Certificate of Need, this extensive public process should examine the utilization and cost of hospital services, the financial health of the facilities themselves, and the long-term bed need by region and across the state based on future demographic projections. This process would allow for long-term planning to take place in an open, transparent, and thoughtful manner, rather than relying solely on ad hoc policies to drive the necessary changes.

The whitepapers that follow outline the above model distortions and proposed solutions in more detail. Additionally, JHHS offers the following feedback on the HSCRC's proposed questions:

1. **C/D: How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care? Given answers to the questions above, should the HSCRC consider alternative or complementary approaches to PAU policies?**

   Currently, the approach to PAUs does not encourage collaboration to improve the health of a population in order to reduce PAU. For example, if Hospital A eliminates a program and those patients are then seen at Hospital B, Hospital B is penalized for any PAUs associated with this new volume. However, the responsibility for health improvement for this set of patients should lie with Hospital A, who is not getting penalized for this PAU, and instead rewarded with retained revenue for shedding this volume. A revised approach would create accountability for PAU and incent hospitals to work more collaboratively to care for a geographic population.

   JHHS encourages the HSCRC to develop a stakeholder process to develop a more focused and effective approach to current PAU policies. In coordination with staff, this group would be tasked with establishing an accountability mechanism through specific measures in a select number of categories. Subsequently, the HSCRC should consider developing policies to incentivize the activities and initiatives that impact those select measures.

2. **B: Should the HSCRC consider payment policy to slow the rate of volume declines in specific health systems for specific services related to ED wait times?**

   The concern remains that the emphasis on volume reduction is leading to reduced access to care, not simply the elimination of avoidable or unnecessary utilization. Over the course of GBR, and during this period of volume decline, statewide ED yellow diversion hours increased by

27.2% per year, suggesting a loss of access to care since the inception of GBR. With the exception of a decrease in yellow alerts in CY2017, there has been an increasing trend since 2013. Of note, the year after the inception of GBR, yellow alerts more than doubled in 2014 (8,208 hours).

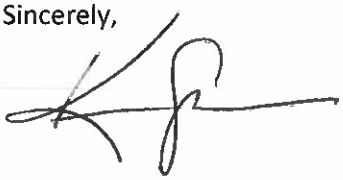
Instead of payment policy to slow the rate of volume decline for specific services related to ED wait times the HSCRC should develop policies that adequately fund medically necessary care. Adequately funding medically necessary care would allow hospitals to invest in staffing beds as needed.

2. **E. Recognizing that effective hospitals can provide greater access to care, what are key domains and metrics that should be used to assess the effectiveness of hospitals? Should national comparisons be used to evaluate metrics such as length of stay, utilization per capita and administrative costs?**

   JHHS believes that the HSCRC should engage the industry in developing a data-driven, commonly accepted definition of "effective" hospitals in the context of broader value-based goals of the AHEAD Model (high-value care, fairness in access to care, and equitable outcomes) and that efficiency metrics should hold hospitals directly accountable to that definition. As it stands, the current efficiency metric does not accomplish this goal. A process to define "effective" that engages the industry as partners in that definition, and a comprehensive re-thinking of the efficiency metric on those terms is needed.

JHHS appreciates the Commission's attention to the important feedback of the industry, and looks forward to resolution of the above model distortions and key issues prior to entering into the AHEAD 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: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott, Vice Chairman
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi
Jon Kromm

The following documents are included here, and reflect JHHS's concerns and recommendations related to the questions posed for comment.

Whitepaper	Date
Reforming Maryland's Model	04/2023
Volume Distortion Analysis	08/2024

Comment Letter	Date
Revenue for Reform Comment Letter #1	12/2021
Revenue for Reform Comment Letter #2	05/2022
Revenue for Reform Comment Letter #3	06/2022
Summary of Kevin Sowers HSCRC Testimony	10/2022
Potential Corrective Action Comment Letter #1	10/2022
Potential Corrective Action Comment Letter #2	11/2022
Total Cost of Care Model Progression - Physician Engagement & Alignment Workgroup Comments	04/2023
Total Cost of Care Model Progression - Cost-containment and Financial Targets Comment Letter	05/2023
FY24 Update Factor Comments	05/2023
Efficiency Policy Comment Letter	06/2023
Emergency Department Dramatic Improvement Effort Comment Letter	07/2023
MPA & CTI Comments	10/2023
MPA Comments	12/2023
JHHS AHEAD Comments	12/2023
Emergency Department Potentially Avoidable Utilization (ED PAU) Policy Comments	01/2024
FY25 Update Factor Comments	05/2024
AHEAD Priorities Comment Letter	06/2024
MPA & CTI Comments	06/2024
Financial Hardship Request Process Comments	09/2024
Emergency Department Best Practices Policy Comments	09/2024
Quality Based Reimbursement Emergency Department Length of Stay Policy Comments	09/2024
Excess Savings Comments	10/2024
Deregulation, Repatriation and Out of State Volume Policy Comments	10/2024
AHEAD Preparation Funding Comments	12/2024
Outpatient High-Cost Drug Funding Comments	12/2024

Global Budgets and Total Cost of Care: Reforming Maryland's Model

Whitepaper

April 2023

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Introduction

Since the introduction of the Maryland Demonstration model and Global Budget Revenue (GBR) in 2014, the payment system and regulatory structure for Maryland's hospitals has fundamentally evolved, moving from a pure fee-for-service system to one that attempts to align payment policies with the goals of driving value, improving health, and reducing cost. Although significant strides have been made to reduce unnecessary utilization, improve readmissions and hospital-acquired conditions, and move care to more cost efficient and clinically appropriate non-hospital settings, the system must evolve over time to adapt to changes in the healthcare environment and capitalize on key lessons learned.

After eight years of fixed hospital revenues under GBR, a number of critical distortions have arisen that jeopardize the long-term success and viability of the Model. Some of these are unintended consequences of policy decisions while others reflect a fundamental misalignment between the stated goals of policy makers and the operational realities experienced by the hospital field. These issues impact the hospital field broadly and, in some instances, the Academic Medical Centers (AMC) in particular.

The purpose of this paper, offered jointly by the Johns Hopkins Health System (JHHS) and the University of Maryland Medical System (UMMS), is to explore some of the challenges with the current Model while providing thoughtful, actionable recommendations for future improvements. The recommendations will likely require changes to the agreement with the Center for Medicare and Medicaid Innovation (CMMI), policy changes at the Maryland Department of Health (MDH), including the Health Services Cost Review Commission (HSCRC) and Maryland Health Care Commission (MHCC), and include other policy and funding levers that State and local government could utilize to best support the overarching goals of the Model.

JHHS and UMMS recognize that many of these issues are complex in nature and that any policy changes need to be thoroughly vetted and nuanced to meet the needs of all stakeholders – policy makers, hospitals, payers, clinical leaders, and community providers. Furthermore, we recognize that many of these challenges are exacerbated by the impact of the pandemic, ongoing staffing shortages, and struggling hospital performance across the country. We believe, however, that certain fundamental changes to the current Model need to be considered to promote its long-term success.

Guiding Principles

When the Maryland General Assembly (MGA) established the HSCRC in the 1970s, it articulated four key rate setting principles:

- Efficiency
- Access for all
- Equity among payers
- Solvency for all efficient and effective hospitals

JHHS and UMMS have consistently advocated for these principles over the years, both through policy and legislation. We believe that these core principles remain relevant in a healthcare environment that has fundamentally changed since the inception of the Maryland Model:

- Hospitals have moved away from traditional fee-for-service in favor of fixed revenue GBRs

- Managed Care Organizations (MCO) are now responsible for the large majority of Medicaid beneficiaries
- Commercial health plans have expanded in size and scope, with benefit design concepts, such as high deductible and value-based plans, that change the ways in which patients access care
- State and local governments, specifically local health departments, have stepped back from their traditional roles as safety net providers, depending upon hospitals and other private providers to step into the gap
- The public mental health system, particularly for inpatient care, has largely disappeared over the past 20 years, with the expansion of community-based services not keeping up with demand
- The pandemic has exacerbated the country's mental health crisis, placing even greater demands on hospitals
- CMMI, created as part of the Affordable Care Act in 2011, continues to push greater accountability for cost and quality onto providers, including increasing expectations for providers to address the social determinants of health

Building upon the foundational rate setting principles, and incorporating these changes in the healthcare landscape, JHHS and UMMS established the following guiding principles to inform its findings and recommendations:

- A key strength of the Model is its all-payer nature, reflecting a focus on equitable access and care for all patients, regardless of payer or ability to pay
- Hospitals have an obligation to meet the needs of the communities that they serve, including providing access to medically necessary care
- The financial incentives of the Model should reward cost-efficient providers that provide high-quality care to patients
- Regulatory programs need to have distinct criteria and rules that are objectively developed and uniformly enforced, with exceptions only being granted to address emergent and unforeseen events
- Regulatory constructs should contemplate and account for unique hospital circumstances, rather than strict application of across-the-board methodologies. Rural providers, providers with safety net functions, and AMCs have fundamental differences that must be reflected in policies and methodologies.
- State and local governments, including their budgeted priorities, initiatives, and policy objectives, should be leveraged to support the overarching goals of the Model

Issues with the Current Model

JHHS and UMMS remain committed to providing care of the highest quality and safety standards to all patients and have shown our commitment to the Maryland TCOC Model, integrating the goals and incentives of the model to transform the way our member organizations interact with the many communities they serve:

- Building a patient support and population health management infrastructure through significant investments in case management, care coordination, social work, navigators, and community outreach
- Building an integrated delivery model that improves access to care while reducing reliance on hospital-based services with investments in mental health, mobile integrated health, high-risk clinics, post-acute care, urgent care, primary care, and home care.

- Engaging communities in evidence-based care management to deliver value in terms of outcomes and community needs.
- Expanding partnerships with community organizations and investing in community-based initiatives to address identified community needs: community outreach, workforce development, place-based investments, and social determinants of health.
- Impacting health disparities and prioritizing equity.

While we remain committed to the overarching goals of the Model, the challenges outlined below represent a necessary evolution of the model's financial and care delivery incentives to position the Model for sustained, long-term success. The challenges with the current Model have arisen in part due to decisions made during the development and early implementation of GBR and in part because of policy decisions that have been made over the course of the Model. This is understandable as the purpose of CMMI Demonstration Models is to test new payment types, learn what works and what needs improvement, and course correct along the way. Maryland needs to similarly recognize that although there have been many benefits of the current model, like all models it needs to evolve over time to address unintended consequences, negative incentives, and other issues that present themselves.

These challenges with the current model can be placed into two categories – those that impact all of Maryland's hospitals due to the uniform payment model and those that uniquely affect the AMCs.

Systemic Issues Impacting Hospitals

Retained Revenue

The policy intention of the Maryland Demonstration Model, first the All-Payer Model (2014-2018) and now the TCOC Model (2019-present), is to transition away from volume-based payment methodologies toward implementing financial incentives for hospitals to continually invest in community health and care transformation (moving from "volume" to "value"). For the first eight years of the Demonstration Model, the primary financial incentive has been the fixed revenue GBR. Under GBR, hospitals are provided a fixed annual revenue amount (initially based on 2013 volumes), with limited adjustments for both utilization increases and decreases. As utilization decreases, hospitals are allowed to "retain" this revenue, thereby generating savings to drive continuous investment in care transformation. Policies to date have focused on preserving hospitals' ability to retain revenue related to volume declines, providing a maximum incentive to reduce hospital-based utilization. The magnitude of the retained revenue that resulted from the GBR policy construct has been one of the most significant distortions in the Model prior to the pandemic (2014-2019), and factors such as the COVID-19 crisis, ongoing labor shortages, and eroding hospital financial performance have added complexity to this issue today.

For the six years prior to the onset of the pandemic (2014-2019), Maryland was able to achieve significant utilization declines, but both the drivers and value to the Model of those declines and the resulting retained revenue remains unclear. The HSCRC's current policies do not differentiate between health management and simply discontinuing services, and there is no data at this time to indicate that the bulk of hospital utilization declines prior to the pandemic were achieved through care transformation or investment in addressing community needs. Instead, all volume reductions are

rewarded as a positive outcome and there is limited accountability for continuously investing retained revenues in care transformation or improving health outcomes.

While this broad incentive to reduce all utilization and keep the revenue served as a critical mechanism to radically and fundamentally change hospital behavior in a short period of time over the early years of the Demonstration Model, allowing hospitals to retain all of the GBR savings in perpetuity regardless of utilization declines is counter to the ongoing goals of the Model and the stated policy positions of former CMMI and MDH leaders involved in the original design. After eight years of locking these revenues into increasingly price-inefficient facilities that are no longer providing the same level of care to the community, the State must grapple with the unintended consequences of doing so:

- Patients receiving care at low-volume hospitals receive inappropriately high bills.
- Revenue that could otherwise be used to invest in care transformation or to support the State's contractual obligation to achieve Medicare savings is instead unavailable as it covers the fixed costs of volumes that are no longer there.
- It limits the ability to invest in hospital services at the providers who are caring for the patients by providing inadequate annual rate updates that are spread across all hospitals, regardless of need, level of service, or investments in the community.
- Restricting access to this revenue only to the hospital that experienced the utilization declines limits the ability to make direct investments in communities with the highest priority needs, including Social Determinants of Health.

Since March 2020, the severe volume and cost disruption of the COVID-19 crisis as well as the ongoing staffing shortages and cost inflation issues serve as complicating factors for assessing retained revenue. While the general issue remains (hospitals are retaining revenues due to significant volume declines) and the same thoughts regarding retained revenues should apply eventually, we recognize that there is not yet a sufficient 12-month period to assess retained revenue issues from 2020 to today.

Excess Capacity

JHHS and UMMS recognize that rationalizing the hospital footprint by reducing excess hospital bed capacity to align with a redesigned care delivery model is an essential component of long-term success under a fixed revenue model. To its credit, UMMS serves as a leader in this area, redesigning care delivery by initiating plans to transition three acute hospitals to Freestanding Medical Facilities (FMF) where appropriate and implementing a rural hospital model on the mid-shore. While UMMS has made these efforts as part of its commitment to transform care delivery for the communities it serves, there are not direct mechanisms in place to ensure that this transformation occurs where needed.

For instance, the population of Baltimore City declined by more than 7% from 2013 (the base period for hospitals' GBR) and 2021. Not surprisingly, hospital-based volumes have decreased significantly, generating significant retained revenue among hospitals in Baltimore City. Baltimore City is over-bedded beyond the need for staffed hospital beds; however, the retained revenue keeps low-volume hospitals open that would have closed in the open market. There is a need to both periodically realign GBRs with current volumes and implement a process to facilitate right sizing hospital capacity over time. Otherwise, revenue that could be invested in continuous transformation is inefficiently covering the fixed costs of volume levels that no longer exist. While it is not the HSCRC's responsibility to close hospitals, it is its responsibility to appropriately align regulated payments with organizations that are serving patients in our communities.

By right-sizing capacity, we can create available funds that can be thoughtfully distributed to address (1) allowed retained revenue at hospitals (2) investments in care transformation and community health, and (3) contributions to savings requirements. A more equitable and logical way to meet community needs may be a policy that, if properly executed, provides for right-sizing capacity within the system, pooling a defined amount of those retained revenues, and using them to re-invest in care transformation. The HSCRC already executes the policy premise of realigning GBRs with the reduced services provided in its conversion of acute care hospitals to FMFs. When approving these new types of facilities, the HSCRC removed funding from the historic global budgets because the FMFs are providing less services than had previously been provided by their acute care hospital predecessors. The same should hold true for acute care hospitals that are providing less care than they once did.

Inadequate Focus on Population Health and Health Disparities

To date, the major incentives of the All-Payer and TCOC Models have been to (1) reduce hospital-based utilization with the intention of generating retained revenues available for reinvestment, and (2) establish broad accountability for TCOC per capita and change over time (often linked to TCOC for a specified geographic area). These incentives have changed hospitals' behavior in-terms of hospital-based utilization, created a source of funds for reinvestment, and introduced financial metrics linked to TCOC to ensure financial targets are achieved. However, policies to date do not adequately establish accountability for health outcomes or create adequate pathways for direct, differential investment of available funds into areas of highest need. Both the current agreement with CMMI and the State Integrated Health Improvement Strategy (SIHIS) establish a need for increased accountability to outcomes. Furthermore, CMMI's 10-year strategy refresh (October 2021) prioritizes accountable care models and advancing health equity among its strategic objectives. The CMMI 10-year strategy refresh also highlighted several "lessons learned" from various models that should inform our own considerations of Model Progression:

- **Ensure health equity is embedded in every Model** – this is not just a requirement to measure whether inequity exists. Maryland's model design should consider this as a mandate to identify inequities and make direct investments in eliminating them.
- **Streamline and reduce complexity to help scale what works –** Current HSCRC methodologies meant to incent TCOC improvement and care transformation tend to be both too many in number and have incentive pathways that are overly complex or carry a significant administrative burden to measure. The CMMI strategy refresh rightly points out that complexity of model design can be an impediment to care transformation. As the Maryland Model continues to progress, it should identify specific, easily measurable, and impactful outcomes, design clear incentives for hospitals to affect those outcomes, and make direct investments in improving outcomes where the most inequity exists.
- **Complexity of financial benchmarks that undermine model effectiveness –** HSCRC should evaluate the effectiveness of its broad TCOC metrics in achieving desired behavior changes and set benchmarks that maximize hospital participation while also sustainably generating savings.
- **Implement models that encourage lasting care transformation** – This means prioritizing health equity, outcomes, care transformation, and multi-stakeholder participation/collaboration in Model design.

It is essential that our State Model demonstrates the ability to make the differential investments required to impact health status in the communities with the most severe historical/structural disadvantages in the State. This is the definition of health equity. The strength of our demonstration model is that we have the ability to address this in a way that is unachievable under payment models in other States. We believe that current HSCRC policies do not adequately incent hospitals to invest significantly and collaboratively in community health programs. Although hospitals have invested in innovative programs to varying degrees, including those targeting social determinants of health, these have been difficult to scale and sustain over time. Considering the lack of regulatory or contractual requirements around the use of retained revenues, we are also concerned that overall investment in care transformation and community health initiatives both represents a small portion of overall retained revenue and is not adequately targeted toward the highest priority health inequities. Current policies, including the proposed Revenue for Reform policy, preserve an inequity of access to funding for investment at hospitals with the most retained revenues. There are likely more efficient, equitable, and targeted ways to ensure appropriate levels of investment for the highest priority health disparities in the State. Care transformation should be contemplated in terms of regional strategies that identify the highest priority community needs, and HSCRC policies should emphasize direct investment in addressing those needs as well as real accountability for improvement.

In addition, the lack of requirements regarding how GBR savings are to be spent, at least in part in the community, has led to some hospitals investing in services for more commercially insured and affluent populations outside of their primary service area. This is an unfortunate occurrence as these funds could have been better utilized to invest in community-based services in communities that most need them.

Lack of direct accountability for low intensity hospital-based care

As was discussed previously, the GBR model provides a broad incentive to reduce utilization and retain revenue, which has served as a critical mechanism to change hospital behavior around utilization management. However, policies to date have de-emphasized hospital-level accountability for utilization management in favor of broad incentives. As we are now in Year 10 of the Model, there are multiple areas where implementing more direct, hospital-level accountability will be required to drive continuous utilization improvement while also improving patient care and experience.

Price per case mix adjusted case

Price distortions are an inevitable outcome of the retained revenues under the GBR model described earlier. Without proper accountability for how retained revenue is utilized, the value of growing price per volume distortions at lower-volume hospitals is unclear. This has direct impact on patients who require hospital-level care, as patients at low volume hospitals will receive higher bills. These higher bills result in ever greater amounts of patient cost share, particularly for patients with high-deductible health plans.

Length of Stay (LOS)

A recent analysis by the Maryland Hospital Association (MHA) illustrates that LOS in Maryland is increasing compared to the nation. While the underlying causes may be difficult to discern, it is

true that the fixed revenue GBR has less clearly defined accountability for managing LOS at a case or DRG level than at a national level, which we are being benchmarked against.

Potentially Avoidable Utilization (PAU)

Since the implementation of GBR, hospitals with retained revenue have seen an overall decrease in volumes under GBR, not just avoidable volumes. There is no data at this time to indicate that hospitals with decreased volume and retained revenue have achieved that decrease by disproportionately impacting PAU.

Low Intensity Volume

In this context, "low intensity volume" can be defined as care that could be provided in a different setting or as care that could be avoided altogether. For purposes of this discussion, we have identified four different types of low intensity volume:

1. The first category includes urgent care and primary care-sensitive outpatient emergency department (ED) visits. This can be thought of as patients using the ED as a setting for primary care or disease management. The most important solution here is to connect residents of the local community to resources to actively manage their health.
2. The second category consists of ED admissions that do not require an academic setting, as these cases are less complex and do not require the highly specialized care that AMCs are uniquely positioned to deliver. These patients "vote with their feet" for necessary hospital care and present at AMC EDs, but a lower cost care setting should be available to these patients.
3. The third category includes patients using regulated outpatient services such as clinics, imaging, lab, screenings, endoscopies, and other lower intensity outpatient procedures.
4. The fourth category, which JHH has moved aggressively on since the opening of its Greenspring Station Ambulatory Surgery Center (ASC) in 2019, includes a mostly commercial, non-Baltimore City population that has traditionally travelled to JHH for elective outpatient procedures that could be served in an ASC.

For both JHHS and UMMS, even as low intensity volume is a lower percentage of total volume than most hospitals, there exists a certain amount of low intensity volume as a result of both our teaching mission and our role serving communities that have significant disparities. However, addressing low intensity volume to maximize our roles as hubs of clinical innovation and as tertiary/quaternary resources to the State and region is a high priority. We are committed to exploring the following potential solutions to address low intensity volume at Johns Hopkins Hospital (JHH) and the University of Maryland Medical Center (UMMC) over the coming months. JHH and UMMC aim to partner with the HSCRC to work through the various financial and regulatory barriers that may limit the viability of these approaches and strategies:

1. **Urgent Care Strategy for Baltimore City**: To effectively reduce low intensity volume in Baltimore City, there is a need for an urgent care strategy. Given the current Medicaid reimbursement rates, urgent care facilities in Baltimore City have not been financially viable. Therefore, there is no alternative venue for Medicaid patients in Baltimore City, and many

of these patients are then seen in EDs. In collaboration with other health systems and industry stakeholders, JHHS and UMMS would like to explore the development of a Baltimore City urgent care strategy focused on creating additional access to care for Medicaid patients in lower-cost settings. Considerations for this discussion should include patient copay and financial responsibility, triage strategies, funding mechanisms, payor contracting, education, social issues, and community need.

2. **Investigate alternative hospital-based sites for lower intensity clinical care:** Since FY2018, the UMMC undertook a conscious alignment of programs that includes the strategic transfer to the UMMC Midtown Campus (MTC) of acute inpatient, post-acute, and certain outpatient surgical and clinic services from UMMC. This alignment allows for growth of programs to meet community identified needs at Midtown and, at the same time, it also enhances timely access to UMMC for the vital tertiary/quaternary resources relied upon by the entire state and region. UMMC will continue to explore opportunities to leverage its alignment with MTC in this way. At JHH, there may some opportunity to move services currently provided at JHH to Johns Hopkins Bayview Medical Center (JHBMC). For various services, including obstetrics, prostate cancer, and thoracic surgery, volumes could be transferred to JHBMC if appropriate updates are made to facilities to support this shift of volume. JHH will examine this opportunity further along with the necessary financial and operational issues that must be resolved for the viability of this strategy.

3. **Expand Movement of Services to the Ambulatory Setting:** Both JHHS and UMMS aim to continue efforts to move services to ASCs where possible given the current staffing and reimbursement landscape. Similar to urgent care, Medicaid payment rates are a barrier to establishing ASCs in Baltimore City due to the payer mix.

4. **Hospital at Home**: JHHS has launched planning for implementation of an innovative care model developed at Johns Hopkins Medicine (JHM), referred to nationally as Hospital at Home. This care model aims to offer home-based acute care services to adult patients as a lower cost and often preferable alternative to traditional hospital services. Patients would be selected and triaged from the ED and admitted to a Hospital at Home bed or transferred from an inpatient facility-based setting to continue their hospital stay at home. This care setting would provide an alternative for hospital admission that does not require an academic setting. Hospital at Home also provides tremendous promise to reduce the total cost of care through decreased utilization of post-acute services when appropriate. While Hospital at Home is frequently misunderstood as home-based primary care or home care services, it is critical to note that Hospital at Home is an acute model serving patients who need an inpatient level of care.

   Hospital at Home would allow Maryland hospitals to provide acute care in a more cost-effective setting, but the currently proposed payment model for the program prevents Hospital at Home from being a financially feasible program for hospitals. JHHS would welcome the opportunity to work with the HSCRC to revise the proposed payment model for Hospital at Home in order to allow Maryland hospitals the opportunity to launch and scale these programs.

5. **Expanded Post-Acute Care Strategies**

AMC-Specific Challenges

AMCs are leading clinical and teaching institutions that are deeply embedded in their communities, providing tertiary and quaternary healthcare services for citizens across the region, specializing in the most complex and difficult diagnoses and treatments, educating the next generation of health professionals, and often serving as safety-net providers for their local communities. AMC research provides important new knowledge leading to advances in understanding and treatment of diseases, including conducting innovative clinical trials to quickly and safely make new treatments available. AMCs also stand on the country's frontline of defense in response to public health outbreaks, natural disasters, local crises, and responding to potential terrorist attacks. In the absence of high-end clinical services that are only available at the State's AMCs, Maryland residents would either not have access to these services or would be required to travel out-of-state to access them.

AMCs operate 71% of accredited level-one trauma centers and 98% of the nation's 41 comprehensive cancer center nationally. Research suggests that patients treated at AMCs have up to 20% higher odds of survival, compared to those treated at nonteaching hospitals, and the nation's medical schools conduct 55% of the extramural medical research supported by the National Institutes of Health (NIH).

In 2019, Johns Hopkins Technology Ventures' Technology Transfer group processed 443 reports of invention, secured 147 new U.S. patents and executed 116 new agreements. The office also consulted with dozens of inventors to analyze the market for, plan the development of, and secure funding for early-stage technologies. During Fiscal Year (FY) 2019, externally-funded spending at Johns Hopkins on research and related programs totaled nearly $3.4 billion. Johns Hopkins University led all U.S. institutions in total NIH funding in FY 2021. Although these grants are important to further the research objectives of AMCs, it is important to note that these dollars do not cover the total cost of the research enterprise.

In addition to their key role as leaders of clinical care and hubs for medical and scientific research and innovation, AMCs serve as a foundation and catalyst for economic development to the region and state. They employ thousands of professionals and staff, while often producing original products and technologies that benefit millions of people worldwide. In FY 2019, Johns Hopkins and its affiliates directly and indirectly accounted for more than 102,400 jobs in Maryland, including 54,623 people employed directly by Johns Hopkins at its various Maryland locations with a payroll of nearly $4.4 billion. In FY 2019, Johns Hopkins spent more than $1.3 billion on purchases of goods and services (including construction) from companies in Maryland, directly supporting 7,700 jobs in Maryland.

Due to the unique role and highly specialized services of AMCs, they have struggled in a few major areas under the broad-based GBR policies. Of particular, consistent concern is (1) the underfunding of high intensity, AMC-oriented clinical programs and (2) the limited ability for broad-based GBR volume reduction incentives to provide a pathway to contribute to investment in both the AMC mission (teaching, research, innovation) and in care transformation for typically high needs local populations. This experience under GBR represents a significant concern for both JHHS and UMMS in terms of the

ongoing sustainability of the Model. The below issues represent the most impactful and pressing concerns driving AMC performance in the Model.

Consolidation of highly tertiary, specialized clinical programs at AMCs and growth in those volumes as new therapies and treatments occur

Highly tertiary, specialty programs (such as Transplants, Hematology/Oncology, Neurosciences, Cardiovascular Services, and other specialty surgeries) are at the core of the research and innovation that occurs at AMCs and have grown differentially at AMCs over time. At AMCs, these programs are growing, while more community-oriented programs are declining in alignment with Model incentives. At other hospitals, even other teaching hospitals, these same services are behaving similarly to, not differentially from, other service lines.

The broad incentives and volume funding mechanisms under the GBR intentionally underfund costs associated with volume growth as a disincentive for hospitals to grow. Unfortunately, at the level of cost and growth that occurs differentially at AMCs in these AMC-oriented service lines, underfunding of cost growth is not a sustainable option to support these AMC-oriented programs.

Limited ability to generate sufficient contribution to continuous investment in research and innovation

In its effort to replace volume-based payment mechanisms with value-based mechanisms, the All-Payer Model and subsequent TCOC Model took the ambitious step of implementing fixed revenue GBRs and intentionally making it financially unfavorable to grow hospital-based volume while making it beneficial to reduce volumes. This kind of policy targets the lower value hospital-based volumes described above. Due to the program mix at AMCs, the major incentives of the GBR are less impactful. AMCs nationally are contributing to significant, continuous reinvestment in research and clinical innovation by making a margin on that same AMC-oriented volume. This reality, juxtaposed against the limited ability of the Maryland AMCs to maximize the incentives of the Demonstration Model due to program mix, places Maryland's AMCs at a disadvantage compared to their national peers.

While we support the goal of the Maryland Demonstration Model to move away from volume-based incentives, we also recognize the need to drive continual reinvestment in the academic mission. However, the GBR Model eliminated the traditional route to investment without implementing a pathway to generate contribution at the magnitude required to make necessary investments in supporting the academic mission. This in turn limits Maryland's AMCs' ability to maintain their position compared to peers.

Proliferation of Graduate Medical Education

The funding of Graduate Medical Education (GME) in the United States has evolved over several decades. Originally established to ensure an adequate supply of physicians with the expansion of health insurance due to the creation of Medicare in the mid-1960s, it has changed over time from a statutory and operational perspective. Unfortunately, policy and funding changes have not kept pace with the needs of the population, resulting in thousands of medical graduates each year unable to find a residency slot.

In Maryland, due in part to the unique hospital rate setting authority of the HSCRC, Maryland's hospitals have been funded differently in some ways and similarly in others compared to their national peers. Although funding categories for Direct Medical Education (DME) and Indirect Medical Education (IME) exist in both systems, the all-payer nature of Maryland's hospital payment system ensures that all payers are equitably contributing to the social benefits derived from GME.

The challenge remains, however, that the HSCRC has not articulated an updated policy to govern GME funding since 2002. During that time, Maryland's hospitals have all transitioned to the GBR model, community hospitals have been allowed to add residency programs without a clearly articulated policy to guide them, and new medical schools have been envisioned in the State. It is incumbent upon the HSCRC to revisit the issue of GME funding in Maryland and assess whether the existing GME infrastructure can or should accommodate newly established schools of medicine. The HSCRC should evaluate these circumstances with an eye toward creating a policy that appropriately funds physician training in Maryland, ensures specialty and geographic diversity, and promotes the tenets of the TCOC Agreement with CMS.

Recommendations

The following recommendations are being offered to generate additional dialogue and discussion with CMMI and State leadership on ways to improve the current model:

Statewide Policy Issues

1. **Retained revenue accumulated prior to the pandemic (from the inception of GBR in 2014 through 2019) must be addressed (1) to ensure that hospital revenue bases reflect changes in patient choice, movement and clinical delivery and (2) to ensure revenues related to volume declines over time are available for direct investment in health disparities as well as generating system savings.**
    a. While recent efforts to develop the Revenue for Reform policy would add certain requirements for hospitals to spend a portion of retained revenues, this remains a passive mechanism that still leaves significant revenues covering fixed costs for volumes that no longer exist at a hospital and limits the ability to make direct, differential investments into areas of highest need. We believe a more direct adjustment and redeployment of funds is a better approach to ensuring that retained revenue provides accretive value to the Model.

b. We recommend utilizing a consistent methodology for calculating retained revenues. The current retained revenue calculation socialized by the HSCRC is calculated at the unit rate level. This is inconsistent with the Equivalent Case Mix Adjusted Discharges (ECMAD) volume methodology used in the market shift policy and other HSCRC policies. HSCRC should maintain consistency across policies whenever possible.
c. Such a policy must include specific considerations, such as allowing hospitals to permanently retain a portion of revenue (and potentially retain a larger portion of PAU declines), requiring a certain amount of system savings, and defining how hospitals may access funds to invest in care transformation.
d. Adjustments would likely need to be implemented over a multi-year period to allow hospitals a runway to absorb reductions.

2. **Monitor current hospital performance with a goal of establishing an appropriate period to revisit retained revenues accumulated since 2020.**
    a. Hospitals find themselves in a unique financial circumstance due to (1) the extreme disruption of the COVID crisis that began in March 2020 and extended through the Omicron surge in the Winter and Spring of 2022 and (2) the ongoing, extended impact of inflationary pressure, escalation of labor costs, and labor shortages.
    b. We recognize that assessing retained revenue during this period is significantly complicated by these factors and are wary of making permanent adjustments related to this period at this time.
    c. Eventually, retained revenue should be evaluated along the principles outlined in Recommendation 1 above once an evaluation period is established.

3. **Redesign volume methodologies going forward**
    a. While current policies have achieved a significant change in hospital mindset in a short period of time, 100% retention of revenue related to volume declines in perpetuity is not a viable policy.
    b. Current incentives to reduce utilization (market shift policy) go too far, incenting hospitals to reduce or eliminate access
        i. For PAU-related retained revenues: Any retained revenues associated with a reduction in PAUs should be protected at 100%, as this is consistent with the intent of the new model and also with other HSCRC methodologies. To ensure incentives are appropriately aligned with other HSCRC policies, these revenues should be fully protected.
        ii. Adjust the market shift policy to better account for volume changes by including differential variable cost factors depending on the service. The market shift policy is currently focused on patient movement from hospital to hospital, but this is only a small part of the full picture of volume shift. The policy therefore misses significant portions of patient choice and movement and is not as timely as needed.

4. **Establish a periodic rebalancing mechanism to adjust hospital GBRs to reflect changes in patient movement and clinical delivery. This could be done in different ways:**

a. Sync unit rates with GBR on a regular basis, effectively lowering rates at hospitals with retained revenue over time. This could be a phased approach to reduce a hospital's GBR where appropriate.
b. Implement limitations on rate corridors for hospitals who have not reached GBR for two consecutive years, and potentially remove half of the difference from the following year's GBR. This would allow retained revenues to be intentionally removed from the system through an appropriate, phased, and measurable process that continues to provide the incentive to lower total cost of care.

5. Establish a process to evaluate capacity on a semi-regular basis, make recommendations on reductions in capacity, and develop incentives for implementation.

a. MDH should undertake an extensive public process to examine the utilization and cost of hospital services, the financial health of the facilities themselves, and the long-term bed need by region and across the state based on future demographic projections. This process would allow for long-term planning to take place in an open, transparent, and thoughtful manner, rather than relying solely on ad hoc policies to drive the necessary changes.

6. Implement policies that make hospitals directly accountable for low intensity care

a. Create a regional approach to PAUs in order to further the focus on population health-driven strategies**.** Currently, the approach to PAUs does not encourage collaboration to improve the health of a population in order to reduce PAU. For example, if Hospital A eliminates a program and those patients are then seen at Hospital B, Hospital B is penalized for any PAUs associated with this new volume. However, the responsibility for health improvement for this set of patients should lie with Hospital A, who is not getting penalized for this PAU, and instead rewarded with retained revenue for shedding this volume. This approach would create accountability for PAU and incent hospitals to work more collaboratively to care for a geographic population.

b. HSCRC should implement stronger incentives to reduce excess utilization due to LOS. Accountability for length of stay management is currently limited to the broad incentive to reduce utilization under the fixed revenue GBR. We do not have direct reward/penalty incentives around length of stay built into our model. Implementing strong, direct accountability for length of stay aligns with the goals of the model.

c. Increase Medicaid rates for non-hospital services such as urgent care and ambulatory surgery centers to divert inpatient utilization and still generate substantial savings to Medicaid**.** By increasing Medicaid reimbursement and making the urgent care and ASC settings financially viable for providers, low intensity patients would have an alternative to the ED that currently does not exist. We are open to exploring options to make this proposal cost-neutral to Medicaid.

7. **Leverage the unique capability of the Maryland model to develop distinct funding mechanisms for investment in care transformation and community health, particularly in areas of highest need.**
    a. As funding sources are "stuck" at hospitals with volume declines, there remains inequitable or unavailable funding for direct investment to address the most pressing health disparities.
    b. There must be mechanisms that enable direct, differential investment in providers and programs that serve the State's most disadvantaged populations.
    c. For example, Baltimore City needs a more impactful and scalable high-utilizer strategy, utilizing lessons learned from successful national programs. We would like to develop an innovative approach that focuses on the systemic and root causes of health disparities. We propose a phased, multi-stakeholder approach that addresses SDOH, including affordable housing.

8. **Evaluate Model incentives and how they apply to areas where a "one-size-fits-all" approach may not sufficiently support long-term success.**
    a. Distinct policy considerations may be required in areas where standard incentives have either limited impact or do not adequately account for specific needs.
    b. Acknowledging the different mission and program mix of the academic medicine model.
    c. Accounting for rural communities where low population density may mean traditional approaches to volume and efficiency are insufficient to support necessary programs and care delivery models.
    d. Supporting safety net programs and ensuring differential investment in areas of highest need.

9. **Evaluate the current quality and patient safety program to ensure the metrics are actionable, impactful, and promote the overall success of the Model.**
    a. While there is a need to align with CMS requirements regarding the quality and patient safety program, Maryland should be innovative in how it approaches the type, number, and incentives/penalties of the metrics utilized to the extent possible.
    b. Any metrics selected should be appropriate for the hospital to impact, be easily measurable in near real-time to gauge performance, and have clear lines of accountability.
    c. Maryland should also explore aligning quality metrics across providers and health plans, each impacting its own specific part of the care continuum that when broadly constructed will have the greatest impact on the chronic condition or other measurable goal.

AMC-specific Issues

1. **The drug funding mechanics in the current Complexity and Innovation policy should apply to high-cost outpatient drugs (100% VCF funding of change – up and down – in cost plus markup).**

a. For AMCs, where high-cost outpatient drugs represent more than 40% of total drug spend, 50% funding of change in cost plus markup via the Cost of Drugs Sold Adjustment (CDS-A) is not a viable methodology.
b. This is an issue of rapidly increasing importance due to the proliferation of innovative drugs and therapies since FY2021. While high-cost outpatient drug cost plus markup at JHH and UMMC grew by $4M annually in FY 2018 to FY 2020, the two AMCs have collectively experienced $18M+ growth in each of FY 2021 and FY 2022 and expect growth in the coming years to expand beyond $20M annually.
c. Funding only 50% of cost growth at this magnitude has a potentially devastating effect at AMCs, particularly as the HSCRC reduces the differential inflation funding it provides for high-cost drugs. Excluding outpatient drugs from the Complexity and Innovation policy and subjecting them to the current CDS-A mechanism guarantees a shortfall of funding for the great majority of new and innovative drugs and therapies and puts the Maryland AMCs at a significant disadvantage nationally.
d. While the underfunding of costs is an issue that the HSCRC may consider addressing Statewide, its disproportionate impact at AMCs makes an AMC-solution a minimum requirement. Applying the volume funding mechanism defined in the Complexity and Innovation Policy to these high-cost drugs would resolve the issue.

2. **A cost coverage volume model, such as the funding mechanism defined in the Complexity and Innovation Policy should be applied to the high-acuity, AMC-oriented clinical programs that serve as the foundation of research and clinical innovation.**
    a. Transplants, Hematology, Oncology, Cardiovascular Services, Neurosciences, Neonatology, Extracorporeal Membrane Oxygenation (ECMO), certain surgical specialties (such as Ear, Nose, and Throat (ENT), Thoracic Surgery, and Vascular Surgery) represent an AMC's core clinical programs in terms of research and innovation.
    b. While the current Complexity and Innovation Policy utilizes a cost coverage volume funding mechanism, it identifies a limited number of specific inpatient procedures (it excludes all inpatient cases with Case Mix Index (CMI) <1.5, does not recognize any drugs and therapies that are not associated with a procedure, and excludes outpatient entirely) that represent only about 10% of an AMC's volume.
    c. The HSCRC should apply exclusion criteria for participation in this cost coverage mechanism. However, if the AMC exclusion criteria are met, the cost coverage volume funding mechanism should apply to entire clinical programs both inpatient and outpatient, rather than attempting to identify specific inpatient volumes within those programs. It is the entire program that supports the research, innovation, and teaching cost structure within it, not the limited set of inpatient procedures that are unique to AMCs.

3. **Beyond applying a cost coverage model to AMC-oriented volumes (including innovative drugs and therapies), AMCs require an additional or alternate, value-based pathway to invest in both their academic mission and care transformation.**
    a. The major incentives of the GBR are less impactful at AMCs because the community-oriented, lower intensity volumes that are targeted by GBR policies and have been a

significant driver of improved financial performance at community hospitals represent a much smaller proportion of an AMC's business.

b. While we have proposed cost coverage volume funding models on AMC-oriented clinical programs above, AMCs nationally are contributing to significant, continuous reinvestment in research and clinical innovation by making a margin on that same AMC-oriented volume. This reality, juxtaposed against the limited ability of the Maryland AMCs to maximize the incentives of the Demonstration Model due to program mix, represents a differential advantage that AMCs have nationally.
c. While we support the goal of the Maryland Demonstration Model to move away from volume-based incentives, we recognize the need to drive continual reinvestment in the academic mission. For this reason, we would propose a development of a value-based mechanism that replaces the national volume-based mechanism but provides access to a similar level of contribution.

4. There is an increasing need for thoughtful policies around the proliferation of GME programs.

a. HSCRC should review residency slots across the State periodically and provide funding in rates for existing residency slots. HSCRC should remove the cap on residents in place since 2011, evaluate current funding levels, and provide funding equivalent to the current resident levels.
b. HSCRC should review the adequacy of the current funding levels for DME for existing programs prior to funding new programs.
a. HSCRC GME funding policy should evaluate need for newly established programs. We are concerned that the growth in medical schools within the state will create a scenario that will restrict the clinical placements of existing schools of medicine. New residency programs should be complementary to, not compete with, existing residency programs, and newly established residency programs should not be automatically funded without a demonstration of need.
b. HSCRC/MHCC should periodically assess physician supply/population projections/need.
c. HSCRC should explore options to reduce the rate variation caused by having large teaching programs.
d. HSCRC/MHCC should advocate for programs to attract and retain physicians, particularly in underserved areas (such as loan forgiveness).

August 16th, 2024

The Need for Maryland Model Policy Refinement

Executive Summary

Maryland continues to be a leader nationally in the development and implementation of Alternative Payment Models (APM) for hospital global budgets, including the All-Payer and Total Cost of Care (TCOC) Models with the Center for Medicare and Medicaid Innovation (CMMI) over the past decade. Like all CMMI Demonstration Models, Maryland's Model was based on a series of policy assumptions that would either be proven or disproven over time. Policy changes, based on data and experience, would allow the Model to build upon its successes while addressing unintended consequences.

Unfortunately, these necessary and anticipated course corrections have not kept pace with the demonstrated, objective outcomes of the Maryland Model to date. Unintended consequences have negatively impacted patient access and quality of care and need to be addressed.

Policy Assumption	**Unintended Consequence**
The structure of the hospital global budgets will provide financial incentives for hospitals to reduce *potentially avoidable utilization (PAU).*	The Model provides incentives to reduce *all hospital utilization*, including medically necessary care. Since 2014, non-PAU spending decreased by 4.5% while PAU spending increased by 3.8%, demonstrating that Maryland's hospitals have disproportionately reduced necessary care.
Reimbursing hospitals for a fraction of the cost of providing additional care will reduce the incentive to provide unnecessary care to patients.	The fractional reimbursement doesn't cover the cost of providing medically necessary care, disincentivizing maintained or increased access. For example, $120 million growth in tertiary/quaternary care at Academic Medical Centers, 2014–2023 received less than $50M funding through market shift policy.
The Academic Medical Centers (AMCs) have the same opportunity as community hospitals to reduce unnecessary utilization and should therefore be under hospital global budgets.	Much of the care provided by AMCs is highly specialized, innovative, higher cost, and is not available at community hospitals. Reducing access to these types of services as envisioned by global budgets results in restrictions to patient access. For example, inpatient growth in the most complex cancer cases is projected to be 20%+

	over the next 10 years. Within Maryland, inpatient cancer care admissions for Maryland residents declined -16% for Maryland hospitals from CY19-CY23, while surrounding states saw growth in cancer admissions.
Hospitals will achieve reduced utilization through meaningful investments in population and community health, generating financial margin for the hospital to allow for additional reinvestment.	Hospitals implemented population health programs to varying degrees, but most of the reductions in utilization and subsequent hospital savings have been generated by reducing inpatient bed and Emergency Department (ED) capacity, regardless of patient need. This has resulted in Maryland having the longest ED wait times in the country. Several Baltimore City hospitals have seen a 20+% reduction in ED volumes since 2014 even as ED wait times have increased. The greatest reductions have been in areas with historic health disparities. Statewide there have been limited investments in population health. Instead, some hospitals have invested in Medicare Advantage plans and access points, including urgent care centers, in more affluent areas outside of their immediate communities. These investments are inconsistent with, and at times contrary to, the goals of the Model.
Health systems will naturally rationalize their hospital and service delivery footprint, reducing excess capacity and producing savings for the Model.	None of the health systems in the state has completely closed a hospital and there are several examples of system hospitals significantly reducing inpatient volumes to a point that would be financially unsustainable in the rest of the country. Several Baltimore City hospitals have 20+% less licensed beds than they did in 2014, yet their global budgets have remained largely intact, eliminating the incentive to repurpose these facilities into other health care delivery models, including freestanding medical facilities.

The Model as it exists today focuses primarily on utilization reduction and cost savings, reflecting the priorities of previous state and federal administrations. Moving forward, adding a focus on health equity, improved community health and advancing innovation – all priorities championed by the current state

and federal administrations – will greatly enhance the Model's positive impact on the health of Marylanders.

Understanding and adjusting the Model over time becomes even more important as Maryland moves into the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. This moment presents an opportunity to set financial and clinical goals for the state and Maryland's hospitals to achieve over the next decade. In addition to negotiating key contractual provisions with CMMI as part of Maryland's participation in AHEAD, it is critical that the Health Services Cost Review Commission (HSCRC) revise current policies to ensure that incentives are in place to promote improved patient access and quality, provide appropriate funding for the provision of medically necessary care, and fundamentally transform the delivery system.

To achieve the above goals, the following recommendations should be implemented by the HSCRC, either through contractual changes with CMMI or policy changes at the state level:

- **Enable AMCs to provide complex, specialized care that Marylanders need and deserve by removing tertiary and quaternary care from global budget restraints.** The HSCRC should seek to strike a balance between creating financial incentives for AMCs to reduce unnecessary utilization and improve the health of the local communities they serve, while simultaneously ensuring that the Model is not limiting access to highly specialized clinical treatments that have the ability to improve and save the lives of Maryland's residents.

- **Ensure adequate reimbursement for medically necessary care by allowing funds to "follow the patient."** The HSCRC should revise current policies to shift funding amongst hospitals based on patient choice, eliminating the financial penalty for hospitals treating patients that choose to receive treatment at their facility.

- **Develop policies and financial incentives that differentiate between unnecessary hospital utilization and medically necessary care.** Policies need to be enhanced to provide a more nuanced approach to differentiate between types of volume. This differentiation can provide clearer incentives for reducing PAU while eliminating incentives to reduce access to medically necessary care.

- **Develop a monitoring framework that prevents restrictions in access to care or identifies them for regulatory action**. The HSCRC should develop an oversight model whereby hospitals are encouraged to shift services based on patient choice, are provided financial incentives to provide treatment in the most cost and clinically effective settings, and are penalized for unreasonably restricting patient access.

- **Develop a process to address excess hospital capacity to ensure resources are allocated to best meet community needs.** Maryland needs a process to identify hospitals with excess capacity and to develop a plan to repurpose those captive funds. This process could result in funding being removed from under-utilized hospitals to invest in health resources for the local

communities, shifting funds to hospitals to reflect patient movement, or generating savings to the health care system, including savings to the Maryland Medicaid program to support priority areas in the state budget. The process should ensure that the local community is still adequately served, even if inpatient capacity and funding is reduced. Any impact to hospital staff could also be mitigated by repurposing existing funds for other health care services, either in the community or at other local hospitals, providing for additional employment opportunities.

Maryland has a unique opportunity, based on over a decade of experience, to make changes to the Model that will positively impact Maryland's residents. By using data and experience to improve the Model over time, Maryland can ensure that patients have access to leading clinical innovations, timely and quality care, and be a leader nationally.

Overview of the Maryland Demonstration Model

Maryland's All-Payer Model was designed to change the economic incentives for hospitals in their delivery of patient care, shifting from an emphasis on the volume of services provided under fee-for-service (FFS) payments to fixed payments for the care of the population in the hospital's service area. The volume based FFS incentives in the state were in part responsible for relatively high utilization of hospital services in the state.

To meet the requirements of the All-Payer Model, the state directly addressed the volume-based incentives that remained under the state's rate-setting model. The state had experimented with population-based payments for ten rural hospitals to stabilize volatile revenue prior to the All-Payer Model and chose to use this tool to implement the waiver model. This approach was expanded to include the rest of the hospitals in the state, shifting most of the state's hospital revenue to the Global Budget Revenue (GBR) system.[1]

The policies under the All-Payer Model and its successor, the Total Cost of Care (TCOC) model, are intended to:

- Provide a fixed annual budget to cover the expected cost of services for the patients receiving hospital services, known as GBR.
- Fund 50% of the incremental cost of changes in volume associated with demographic change, market shift, and approved changes in services – incremental funding should cover the added cost of patient care without providing added margin for the hospital to avoid incentives to capture volume.
- Encourage the elimination of potentially avoidable utilization (PAU) by allowing hospitals to keep revenue associated with reductions in readmissions and patient quality indicators (PQI) that are ambulatory sensitive conditions that may be avoided with better use of primary care.
- Generate sufficient margins to fund replacement capital and new technology to update hospital services over time.
- Fund population health activities that ultimately improve patient health and reduce the demand for hospital services, particularly through revenue retained from the reduction of PAUs (although this last item was not stated explicitly as a goal of the Model initially).

While the intentions of the Model are outlined above, distortions in practice exist such as:

1. In most examples, the market shift adjustment funds less than 50% variable cost factor when hospitals gain market share of non-PAU volumes, and conversely, leave more than 50% variable cost factor in GBR of hospitals that lose volume, thus creating distortions for both hospitals.
2. While the goal of the Model is to reduce avoidable or unnecessary utilization, this statement is optimistic and at times unattainable due to clinical necessity. ***As in any capped system, fixed***

[1] While hospitals were not required to participate in the GBR payment methodology, nonparticipation would have resulted in low inflationary updates for hospitals continuing under FFS payments. Given positive incentives to assist with the conversion and the restricted revenue for nonparticipation, all Maryland hospitals chose to accept hospital global budgets under GBR.

payments provide strong incentives to reduce all utilization, not just avoidable utilization. Strong oversight (market or regulatory) is necessary to guarantee that hospitals continue to provide necessary services for the patients in their service area.

3. Trending of financial information since the inception of GBR indicates that Maryland hospitals are falling behind national hospitals in terms of recapitalization, adoption of new technologies, and the expansion of complex tertiary care service lines.

4. Increasing funding of population health resources is critical to the model, however, to assume that these programs will be funded through PAU volume savings dramatically underestimates the level of funding and time horizon required for significant improvements in population health status. It is also important to note that population health initiatives must involve collaboration across hospital systems, non-hospital providers, and state and local governments.

The GBR Framework

Hospital budgets were originally established under the All-Payer Model using Fiscal Year (FY) 2013 as the base year, the last year before the implementation of the GBR. Revenue was established in line with the hospital's unit rates, the usual basis for rate setting under all payer rate regulations. Some hospitals negotiated adjustments to their revenue based on their individual circumstances, but statewide, this new base was the starting point for evaluating Model performance beginning in FY2014.

Moving forward, hospitals charge patients based on actual utilization. If volumes rise, hospitals lower their prices per unit rate charged because their revenue for the year is fixed – there is no additional revenue available due to rising volumes. As volumes decline, hospitals raise their unit rates to be able to hit their revenue target. Essentially, the state maintains a FFS billing system for services with a revenue cap imposed on its charging ability.

The Health Services Cost Review Commission (HSCRC) has established limits to this charging flexibility. Hospitals are allowed to modify prices within a 5% corridor unilaterally, but the HSCRC will allow hospitals to change prices up to 10% with approval. This approach serves as an implicit limit to the reduction in volume – if volumes drop too far, hospitals will not be able to fully charge their assigned budget. ***Of note, the HSCRC readjusted the volume base of some hospitals in 2018, negating the intent and value of the 5-10% corridor.***

Annual Adjustments to the GBR

For the GBR methodology to be sustainable, there must be a process to update the budget for changes in market conditions. A hospital's GBR may be modified annually due to certain volume adjustments that account for changes in PAU, demographics, patients choosing different hospitals for services, and hospitals expanding into new service lines or contracting existing service lines. Specifically, these adjustments fall into four categories: **PAU Adjustment, Demographic Adjustment, Market Shift Adjustment, and New Services or Service Closure Adjustment**.

PAU Adjustment: While the expectation is not that all PAU can be eliminated, generally the HSCRC expects hospitals to adopt clinical practices that provide higher quality and improve coordination across the clinical spectrum to avoid readmissions to acute care or to prevent unnecessary hospitalizations. The HSCRC staff defined PAU as 30-day unplanned hospital readmissions and PQIs, conditions that are potentially avoidable with appropriate use of primary care and chronic disease management. To the degree that hospitals can work with their partners to improve care coordination and reduce PAU cases, the hospital is able to keep its global budget associated with this volume, providing a strong economic incentive to avoid these cases.[2] ***Within the current demonstration model, HSCRC policies penalize hospitals in multiple ways for PAU volumes. While the industry focuses on reducing PAU volumes, a subset of these patients require care that is unavoidable and costs significant resources. Consider a diabetic patient with significant co-morbidities presenting in the emergency room with significant foot ulcers that ultimately require amputation of the foot. Hospitals must care for these patients while continuing to focus on strategies that reduce long-term complex comorbidities that increase utilization.***

Demographic Adjustment*:** The demographic adjustment accounts for changes in the demand for services associated with changes in the size and characteristics of the population served by hospitals within their primary service area. As implemented by the HSCRC staff, the demographic adjustment is age-adjusted for individual hospitals, but the results are scaled across hospitals so that the state population growth is accounted for without an age adjustment for the state. The demographic funding is allocated across all hospitals within the given service area in proportion to the existing distribution of existing market share. ***While the demographic adjustment is the HSCRC's proxy for population change which defines volume growth within a market, this adjustment is made to hospitals whether the hospital's GBR volumes have increased or decreased, resulting in additional revenue for patient care that does not exist.

Market Shift Adjustment*:** The market shift adjustment is designed to reallocate revenue from one hospital to another within the system as patients move across hospitals for care. This feature is designed to replicate the function of a market, but in a way that will not incentivize hospitals to seek additional volume to enhance their financial performance. The market shift is designed to identify changes in the volume of specific services within hospitals in each market and to reallocate revenue to cover the incremental cost of those services. The hospital that loses the volume will have its budget reduced to reflect the lower volume it is treating while retaining part of the revenue to recognize the fixed costs facing the facility. The HSCRC has set the incremental, or variable, cost factor (VCF) at 50 percent of the hospital's approved revenue for the case. The losing hospital keeps 50 percent of the revenue while the acquiring hospital receives 50 percent. ***While 50% of the approved revenue for the case is the intent of the policy, the VCF is often variable, often less than 50% or more than 50%. The retention of revenue is designed to recognize the fixed cost of hospital care in the short run, but HSCRC policy does not specify any time frame for ending this revenue retention, even though costs are fully variable in the long run. As stated previously, the result of the market shift and demographic adjustments is often

[2] The HSCRC has included annual reductions in the annual update factor to capture some of the savings (whether they materialized or not).

retained revenues in hospitals with low volumes and marginal clinical quality which would be subject to closure in the rest of the country.

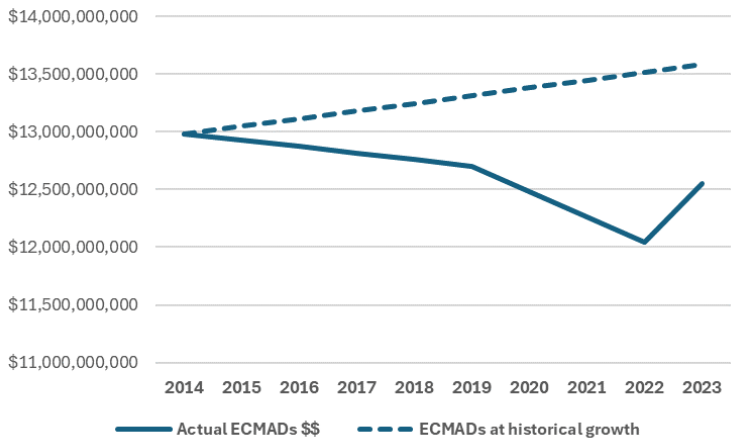
New Service or Service Closure Adjustment*:** The HSCRC addresses services changes through GBR adjustments on an *ad hoc* basis. Generally, if a hospital offers new services, the HSCRC staff has approved GBR adjustments to recognize the incremental cost of those services, generally funding them at 50 percent of the anticipated volume. For service closures, the HSCRC staff has allowed partial revenue to be retained and requires that hospitals inform the HSCR when services are closed or deregulated for budgets to be adjusted, although enforcement of deregulatory announcements is difficult and often occurs with a substantial lag. ***Policies governing service line additions or closures need review. Funding for service line additions does not incorporate the upfront fixed costs. Removal of funding for service line closures is challenging and occurs with a substantial lag.

Issue #1: Misaligned Incentives on Funding of Volume Shifts over Time

Policies associated with the Model cause concern with how hospitals view fluctuations in volume. Hospitals may avoid all volume growth, rather than focusing on reductions in PAU, or on more efficient care delivery in lower acuity settings. The polices that allow hospitals to shed any volume and retain revenue indefinitely traps funds for patient care that no longer exists and simultaneously penalizes other hospitals that continue to provide clinical care by underfunding this clinically appropriate volume.

The combination of reducing PAU volume and restricting non-PAU volume reduced volume growth (in $$) in the state from 2014-2023. Prior to the introduction of GBR methodology in 2014, volume growth averaged 0.5 – 1.0% per year. Since 2014, volume has grown -0.4% per year through 2019. From 2019 to 2022 volumes declined -1.8%, assisted by COVID. Volumes increased post-pandemic 4.2% from 2022 – 2023.

Table 2: Total Maryland Volume (in dollars)
2014- 2023



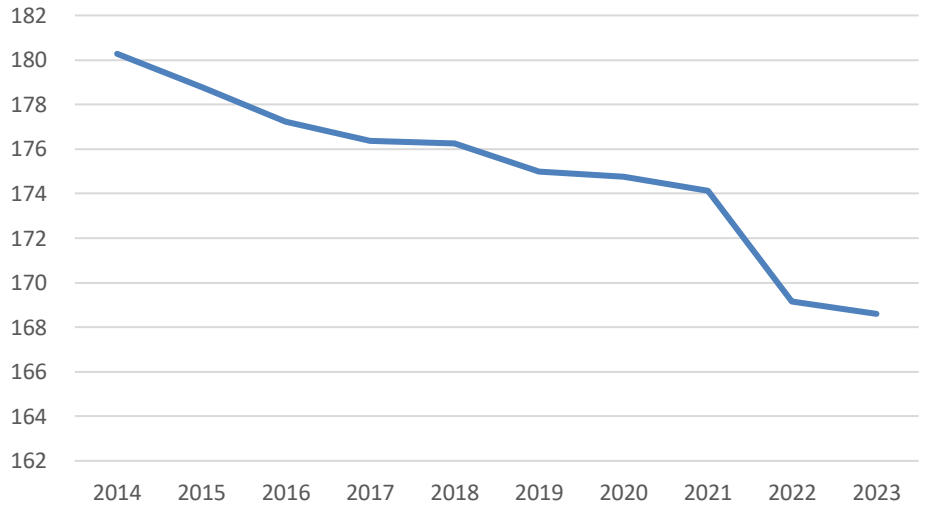
Source: HSCRC Inpatient and Outpatient Abstract Data. Trends in total volume dollars calendar years 2014, 2019, 2022 and 2023; in-state volume only

The change in growth rates from 2014 to 2023 generated a cumulative savings to Medicare of more than $433MM. While this trend has appeared to reduce volume growth in the Maryland market, additional analytics are necessary to rule out patients seeking care in other states and the potential closure of needed clinical service lines within Maryland.

The HSCRC uses Equivalent Case-Mix Adjusted Discharges ("ECMADs") as a measure of volume for Maryland hospitals. ECMADs include case mix adjusted discharges, equivalent outpatient case-mix adjusted visits, and inpatient weights that reflect resource demands and relative complexity. The higher the intensity of the case, the higher the level of ECMADs associated with it.

The increase in cumulative savings between 2014 to 2023 corresponds to a decrease in acute care ECMAD volumes during the same time period.

Table 3: Statewide ECMAD Volume/1,000 Population 2014- 2023

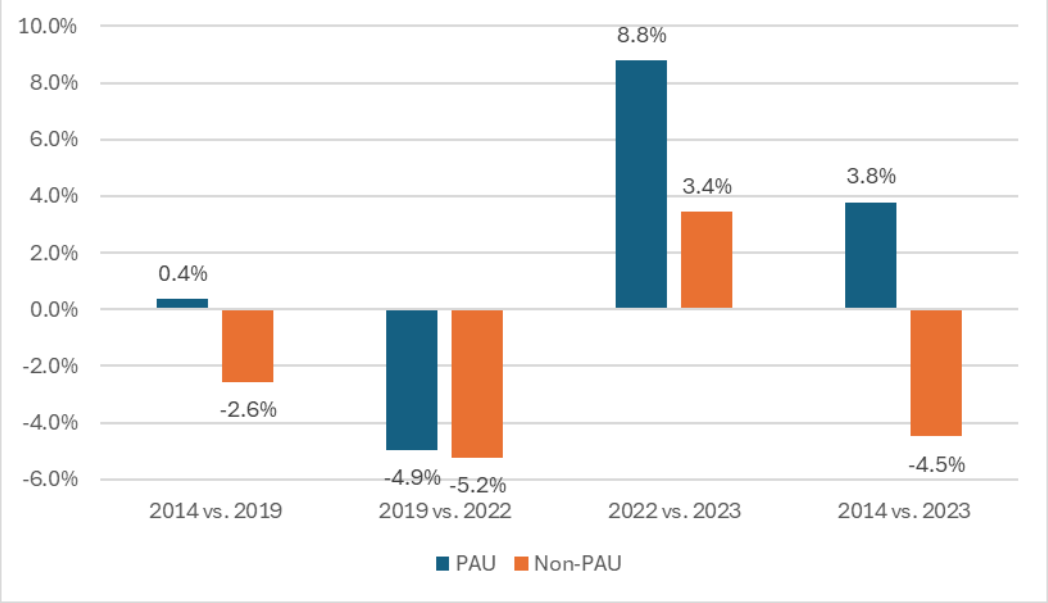


Source: HSCRC Inpatient and Outpatient Abstract Data, Claritas; excludes Oncology

When compared to statewide population growth, ECMAD growth declined faster than population growth from 2014 to 2023.

Changes in ECMAD volumes between 2014 to 2023 vary when looking at PAU vs. non-PAU volumes. Overall, non-PAU volume in dollars declined by -4.5% while PAU volume in dollars increased by 3.8% from 2014 to 2023. Prior to COVID, both PAU and non-PAU volumes declined. PAU volume grew post COVID between 2022 and 2023 due to patients receiving less care for chronic conditions during COVID leading to increased acuity and acute care needs. The overall volume change in dollars over that period was -3.3%.

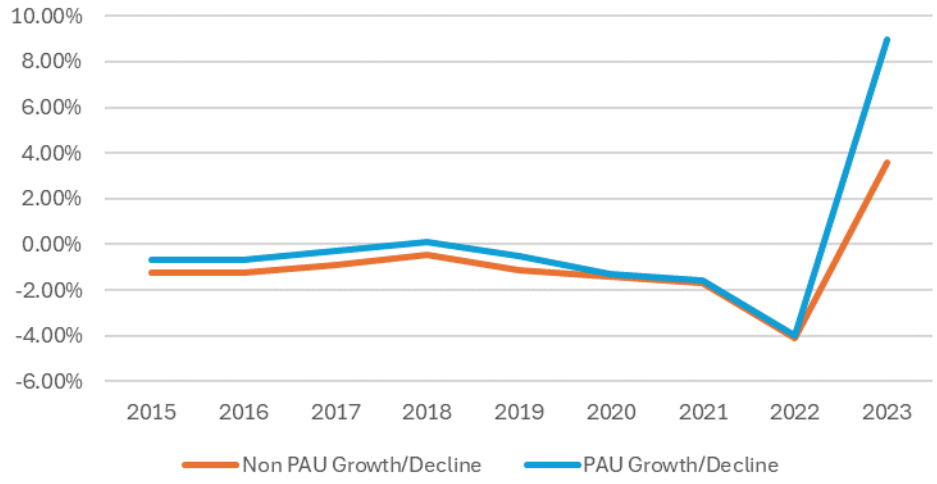
Table 4: Statewide ECMAD Volume Change: PAU vs. Non-PAU 2014-2023



Source: HSCRC Inpatient and Outpatient Abstract Data, Instate Only, Excludes Chronic, Specialty Hospitals, OP Oncology Drugs and Related Services, Categorical and Innovation

From 2014 to 2023, PAU volumes increased while non-PAU volumes declined.

Table 5: Statewide Change in ECMAD PAU vs. Non-PAU per 1,000 Population 2015-2023

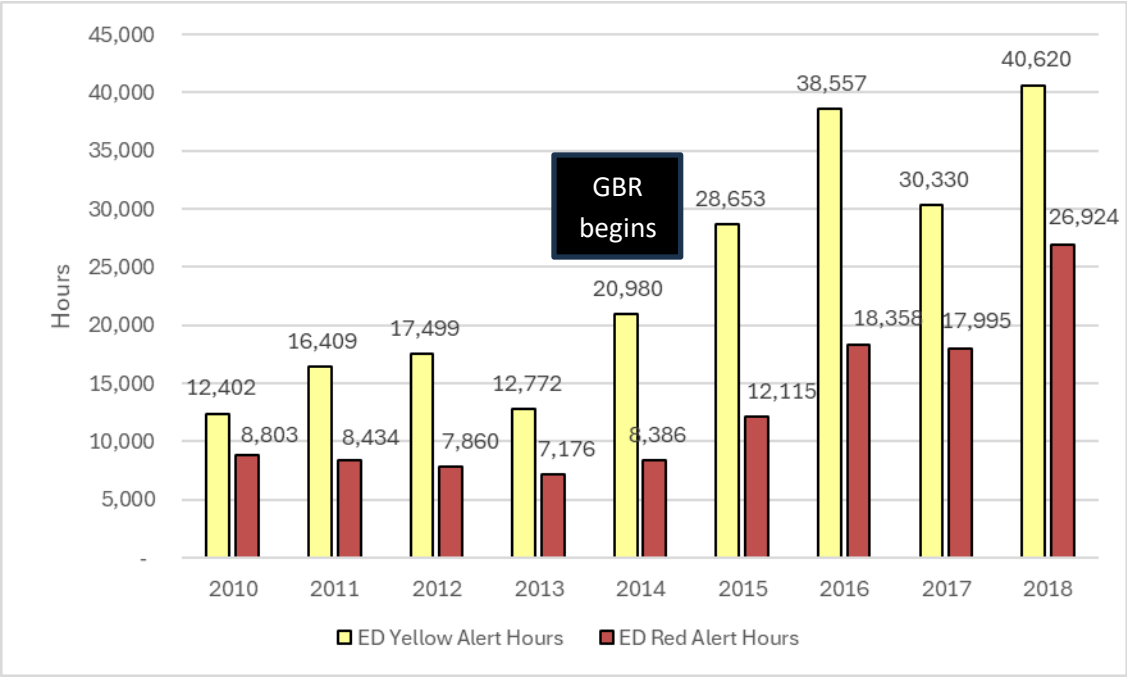


Source: HSCRC Inpatient and Outpatient Abstract Data, Claritas; excludes Oncology

Both PAU and non-PAU ECMAD growth per capita declined or remained flat from 2015-2022. PAU and non-PAU ECMAD volumes experienced post-pandemic growth from 2022-2023.

The concern remains that the emphasis on volume reduction is leading to reduced access to care, not simply the elimination of avoidable or unnecessary utilization. Over the course of GBR, and during this period of volume decline, statewide emergency department (ED) yellow diversion hours increased by 27.2% per year, suggesting a loss of access to care since the inception of GBR. With the exception of a decrease in yellow alerts in Calendar Year (CY) 2017, there has been an increasing trend since 2013. Of note, the year after the inception of GBR, yellow alerts more than doubled in 2014 (8,208 hours).

Table 6: Statewide Emergency Department Yellow Alert Diversion Hours 2010-2018, 2023



	ED Yellow Alert Hours	yoy % Change
2013	12,772	
2014	20,980	64.3%
2015	28,653	36.6%
2016	38,557	34.6%
2017	30,330	-21.3%
2018	40,626	33.9%
2023	175,920	

Source: MIEMSS database

Over the course of GBR, and during this period of volume decline, statewide emergency department yellow diversion hours increased by 27.2% per year, suggesting a loss of access to care since the inception of GBR.

Since the inception of GBR in 2014, volumes declined for EDs and inpatient services in Baltimore County and Baltimore City, particularly at community hospitals. Baltimore area hospitals experienced the largest ED volume reductions, compared to the state-wide average reduction of -19%.

Table 7: Baltimore City and Baltimore County ED Volume % Change CY14-CY23

Hospital	State Rank: % Decline	CY14 – CY23 % Volume Change	CY23 % of IP Via ED
JHBMC	42	-8%	64%
JHH	38	-11%	44%
UM – St. Joseph	30	-17%	53%
Sinai	24	-22%	59%
St. Agnes	23	-23%	65%
MS – Union Memorial	15	-27%	72%
Northwest	15	-28%	83%
MS - Harbor	13	-29%	64%
MS- Good Samaritan	11	-33%	80%
UMMC	8	-34%	47%
MS – Franklin Square	7	-37%	62%
Mercy	5	-39%	24%
Grace	4	-39%	0%
UM - Midtown	2	-47%	64%

Source: HSCRC Hospital Data

The Hospital Throughput Workgroup report found that limited hospital capacity was a key driver of extended ED wait times. Within Maryland, most community hospitals have significantly reduced staffed beds, leaving the Academic Medical Centers (AMC) to provide all levels of needed care for area patients and beyond.

Table 8: Emergency Department Average Wait Times

State	ED Avg Wait Time (min)	Min Over National Avg	Rank
Virginia	170	8	36th
Pennsylvania	182	20	41st
Maryland	247	85	50th
Nation	**162**	**-**	

Source: CMS (Data.CMS.gov)

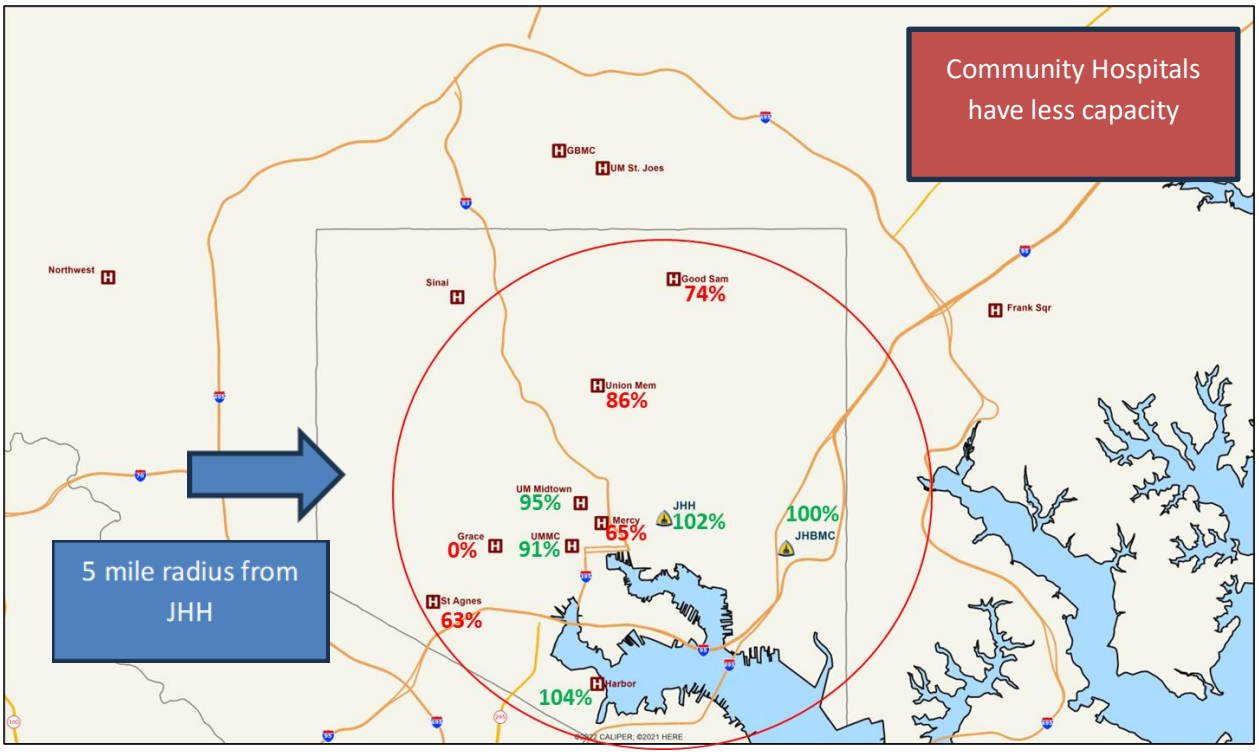
Despite an increase in ED yellow diversion hours, Maryland hospitals continue to have the longest ED wait times in the nation, 85 min greater than the national average.

When the focus shifts from statewide to the Baltimore region, there have been significant volume shifts between hospitals, ultimately resulting in a decline in licensed and staffed beds. Baltimore hospitals have shed over 400 inpatient medical/surgical/gynecological/addictions (MSGA) beds since GBR began, with most of the beds located at community hospitals. From 2013 to 2024, psychiatric bed capacity expanded, while MSGA, Obstetrics, and Pediatric licensed beds declined. Johns Hopkins Hospital (JHH) has more licensed beds than 2013, suggesting volume growth, and more licensed beds than physical capacity.

Table 9: Baltimore City and County Hospitals Licensed Beds
FY23 Licensed Beds vs FY14 Licensed Beds

Hospital	2013 Total Licensed Beds	Change FY13 to FY24 MSGA	Obstetric	Pediatric	Psychiatric	2024 Total Licensed Beds	% Change 2013 to 2024
The Johns Hopkins Hospital	1,000	105	-	-	-	1,105	10.5%
University of Maryland Medical Center	800	(77)	-	1	(14)	710	-11.3%
MedStar Franklin Square Hospital	355	(5)	-	(9)	16	357	0.6%
Bayview Medical Center	355	8	5	(5)	-	363	2.3%
Greater Baltimore Medical Center	270	(42)	-	-	-	228	-15.6%
St. Joseph Medical Center	247	(25)	-	-	(1)	221	-10.5%
St. Agnes Hospital	287	70	2	17	48	424	47.7%
Northwest Hospital Center	225	(62)	-	-	35	198	-12.0%
MedStar Star Harbor Hospital	160	(48)	(10)	(5)	28	125	-21.9%
Sinai Hospital of Baltimore	426	(19)	2	(9)	24	424	-0.5%
MedStar Union Memorial Hospital	236	(20)	-	(1)	(26)	189	-19.9%
Mercy Medical Center	233	(103)	-	(1)	-	129	-44.6%
Medical Center Midtown Campus	155	(28)	(20)	-	9	116	-25.2%
Grace Medical Center	115	(83)	-	-	(32)	-	-100.0%
MedStar Good Samaritan Hospital	224	(73)	-	-	-	151	-32.6%
Total	**5,088**	**(402)**	**(21)**	**(12)**	**87**	**4,740**	**-6.8%**

Source: MHCC Licensed Acute Care Beds



Baltimore hospitals have shed over 400 MSGA beds since GBR began, with most of the beds located at community hospitals.

The change in licensed beds is driven by annual changes in acute inpatient volumes. The shift in volumes between 2014 and 2023 away from community hospitals in Baltimore City hospitals led JHH to be the largest recipient of volume shifts during this time.

Table 10: ECMAD Volume Shift: Baltimore City vs. Rest of State 2014-2023

ECMAD Volume Shift City Hospitals v. Rest of State	2014 - 2019	2019 -2022	2022 - 2023	Cumulative Shift 2014 - 2023
The Johns Hopkins Hospital	3,880	977	474	5,331
Mercy Medical Center	2,364	1,368	620	4,352
University of Maryland Medical Center	3,353	(1,716)	423	2,060
Johns Hopkins Bayview Medical Center	2,079	(174)	(149)	1,756
Rest of State	1,816	(1,326)	560	1,049
Lifebridge Levindale Hebrew Geriatric Center & Hospital	35	-	-	35
UM Rehabilitation & Orthopaedic Institute	(157)	(50)	(42)	(249)
MedStar Union Memorial Hospital	(1,471)	748	(605)	(1,327)
MedStar Harbor Hospital	(1,598)	130	(119)	(1,588)
St. Agnes Hospital	(2,533)	520	71	(1,942)
MedStar Good Samaritan Hospital	(2,938)	491	(251)	(2,699)
Grace Medical Center	(1,445)	(1,301)	(18)	(2,765)
Lifebridge Sinai Hospital	(3,384)	334	(965)	(4,015)

Source: HSCRC Market Shift files using non-confidential 'in-state' abstract data

JHH is the largest recipient of volume shifts between 2014 and 2023 in Baltimore City.

Issue #2: Misaligned incentives that allow hospitals that reduce services to keep financial resources, without appropriate accountability for the use of the retained revenue

These shifting volumes between hospitals under the GBR methodologies have not resulted in proportional shifts in revenue, given the HSCRC's methodologies that allow hospitals with declining volumes to retain 50 percent of revenue to cover fixed cost. The interaction of these methodologies has resulted in overfunding for hospitals dropping volume and underfunding for those showing growth as a general rule. Regulatory incentives designed to reward hospitals for avoiding unnecessary care through improved care management and improved population health management instead appear to reward hospitals reducing access to needed care and underfunding the hospitals treating those patients denied care elsewhere.

The following table shows the overfunding and underfunding status for hospitals in the Baltimore region. JHH appears to be penalized.

Table 11: In-State Only Retained Revenue
FY2014-CY2023

In State Volume Change and Funding through Policy
(Market Shift + Demographic + PAU Savings + Deregulation Adjustments)
FY2014 to CY2023

	Volume Change						Funding			
	2014-2019		2020-2023		Total 2014-2023		Expected 50% Funding	Actual Funding	Retained (Unfunded)	
	$$	%	$$	%	$$	%	$$	$$	$$	Percent of GBR
MedStar Harbor Hospital	($56.2 M)	-24%	($0.1 M)	0%	($56.3 M)	-24%	($28.2 M)	($18.8 M)	$9.4 M	4%
MedStar Good Samaritan Hospital	(83.7 M)	-23%	4.4 M	1%	(79.3 M)	-22%	(39.7 M)	(29.7 M)	10.0 M	3%
Sinai Hospital of Baltimore	(97.6 M)	-10%	(53.4 M)	-6%	(151.0 M)	-16%	(75.5 M)	(41.3 M)	34.2 M	4%
Ascension Saint Agnes Hospital	(62.4 M)	-12%	4.1 M	1%	(58.3 M)	-11%	(29.2 M)	(10.0 M)	19.2 M	4%
MedStar Union Memorial Hospital	(50.2 M)	-10%	(1.9 M)	0%	(52.1 M)	-10%	(26.1 M)	(10.4 M)	15.7 M	3%
UMMC Midtown Campus	(0.5 M)	0%	(9.7 M)	-4%	(10.2 M)	-4%	(5.1 M)	1.3 M	6.4 M	2%
University of Maryland Medical Center	65.1 M	4%	(68.7 M)	-4%	(3.6 M)	0%	(1.8 M)	9.8 M	11.6 M	1%
Johns Hopkins Bayview Medical Center, Inc.	38.8 M	5%	(28.5 M)	-4%	10.3 M	1%	5.2 M	15.8 M	10.7 M	1%
Mercy Medical Center	0.2 M	0%	16.9 M	3%	17.1 M	3%	8.6 M	31.0 M	22.5 M	3%
The Johns Hopkins Hospital	77.3 M	3%	35.5 M	1%	112.8 M	4%	56.4 M	30.7 M	(25.7 M)	-1%
Baltimore City Hospitals	**(169.2 M)**	**-2%**	**(101.4 M)**	**-1%**	**(270.6 M)**	**-3%**	**(135.3 M)**	**(21.6 M)**	**113.7 M**	**1%**
All other	(46.1 M)	0%	(72.7 M)	-1%	(118.8 M)	-1%	(59.4 M)	124.6 M	196.1 M	2%
Statewide	**($215.3 M)**	**-1%**	**($174.1 M)**	**-1%**	**($389.4 M)**	**-2%**	**($194.7 M)**	**$103.0 M**	**$309.8 M**	**2%**

Excludes out of state and outpatient high cost drugs.
Funding through volume policies only, special adjustments excluded.

Source: HSCRC abstract data

JHH has been underfunded by nearly $25.7 million over the FY2014-CY2023 model periods for in-state patient services.

Changes in volume for specific service lines demonstrate the shifts in service lines across hospitals. Orthopedic surgery, for example, shows declines in volume from Lifebridge Sinai Hospital & University of Maryland Medical Center (UMMC) with increases at JHH over the period of GBR.

Table 12: Baltimore City and Baltimore County Orthopedic ECMAD Volume FY2014-CY2023

Baltimore City + Baltimore County Orthopedic Surgery Volume	2014 Base ECMADs	Raw ECMAD Growth (Decline) 2014 - 2023
The Johns Hopkins Hospital	1,389	325
University of Maryland Medical Center	1,582	(139)
Lifebridge Sinai Hospital	2,954	(787)
MedStar Union Memorial Hospital	2,557	477
MedStar Harbor Hospital	698	(591)
MedStar Good Samaritan Hospital	1,235	(969)

Source: HSCRC abstract data

JHH is the recipient of Orthopedic volume growth in Baltimore City and Baltimore County between 2014 and 2023.

When comparing all service lines, JHH is the leader in raw ECMAD in Baltimore City and Baltimore County between FY2014 and CY2023, while other hospitals experienced volume declines.

Table 13: Baltimore City and Baltimore Service Line Sample ECMAD Volume Change FY2014-CY2023

Baltimore City + Baltimore County	All Service Lines		Medical (High Intensity)		Medical (Other)		Surgical (Other)	
	2014 Base ECMADs	Raw ECMAD +(-) 2014 - 2023	2014 Base ECMADs	Raw ECMAD +(-) 2014 - 2023	2014 Base ECMADs	Raw ECMAD +(-) 2014 - 2023	2014 Base ECMADs	Raw ECMAD +(-) 2014 - 2023
The Johns Hopkins Hospital	46,715	1,453	1,893	151	3,100	428	3,125	635
University of Maryland Medical Center	30,541	(549)	1,243	16	2,072	(120)	2,755	548
Lifebridge Sinai Hospital	34,292	(6,376)	1,673	(249)	2,816	(157)	2,671	(177)
MedStar Union Memorial Hospital	23,154	(4,670)	565	27	1,832	21	1,017	(276)
MedStar Harbor Hospital	4,935	(1,560)	155	30	493	(122)	330	(125)
MedStar Good Samaritan Hospital	19,719	(4,470)	711	(58)	2,439	(312)	1,211	374
	356,344	**(35,914)**	**13,366**	**(298)**	**32,701**	**(2,258)**	**24,599**	**1,939**

Source: HSCRC abstract data

In all service lines, JHH was the only hospital gaining ECMADs, while all other hospitals serving the area experienced declines, led by Lifebridge Sinai Hospital with a drop of nearly 6,400 ECMADs.

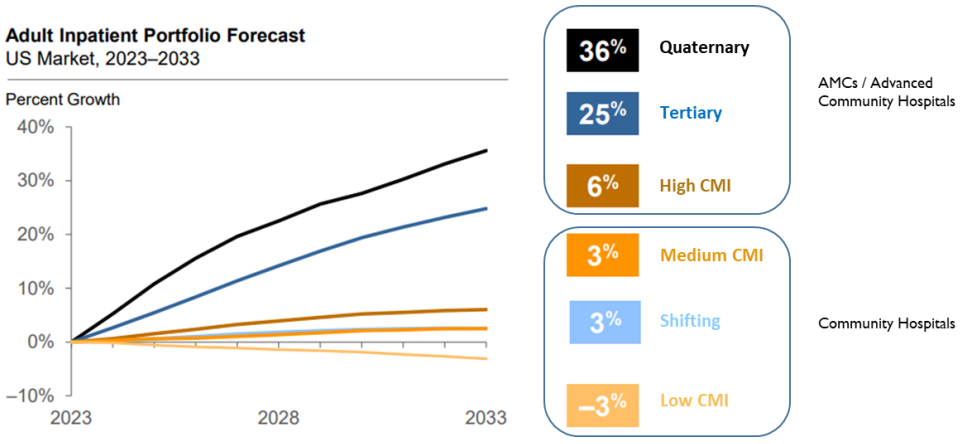
JHH saw increases in high intensity medical volume with Medstar Good Samaritan Hospital and particularly Lifebridge Sinai Hospital losing ECMADs. JHH and UMMC experienced increases in ECMADs in surgical cases, while the other hospitals in the market declined, led by MedStar Union Memorial Hospital and followed by Lifebridge Sinai Hospital. JHH gained ECMADs in other medical volume, while most hospitals serving Baltimore City and Baltimore County lost ECMADs, with Medstar Good Samaritan Hospital dropping about twice the ECMADs of the other hospitals.

Issue #3: Care is Shifting from Community Hospitals to AMCs

According to Vizient 10-year projections, virtually all inpatient growth, both in the state of Maryland and nationally, is projected to be in high-Case Mix Index (CMI) and tertiary and quaternary care, an area exclusive to AMCs and advanced community hospitals. Community hospitals are operating at a fraction of their fixed capacity and are projected to see fewer inpatients over time. Their long-term role in the care continuum is changing with a primary focus on outpatient care. AMCs are at full capacity and experiencing unique market demands, not experienced by community hospitals locally and nationally.

Table 14: Vizient 10-Year Projections by Inpatient Care Type
CY23 vs. CY33

JHH saw 16% growth in quaternary discharges FY18 – FY23.



Source: Vizient, Sg2, JHH CaseMix Data

According to Vizient 10-year projections, virtually all inpatient growth, both in the state of Maryland and nationally, is projected to be in high-CMI and tertiary care, an area exclusive to AMCs and advanced community hospitals.

JHH quaternary and tertiary volumes are growing below the national rate. While quaternary and tertiary volumes are rising nationally, the percent growth in total staffed acute beds at JHH grew 5% from 2015-2022, vs. the National AMC total growth of 10%. Of note, total staffed acute beds at UMMC declined 1% from 2015-2022. Maryland's AMCs are not keeping pace nationally with quaternary and tertiary volume growth.

Table 15: Total Staffed Acute Beds
CY15 vs. CY22

Hospital	2015 Staffed Beds	2022 Staffed Bed	% Growth
Hospital of The University of Pennsylvania	789	1,058	34.1%
Brigham and Women's Hospital	741	880	18.8%
UC San Francisco	740	861	16.4%
University of Chicago Medical Center	624	477	-23.6%
Duke University Hospital	905	1,024	13.1%
Yale New Haven Hospital	1,391	1,481	6.5%
New York Presbyterian Hospital	2,381	2,474	3.9%
Massachusetts General Hospital	1,016	1,038	2.2%
JHH	977	1,023	4.7%
UMMC	630	622	-1.3%
National AMC Total	82,899	91,200	10.0%
National non-AMC Total	792,748	771,739	-2.7%

Source: AHA Survey

Maryland's AMCs are not keeping pace nationally with quaternary and tertiary volume growth.

This reduction in beds at community hospitals provides less access points of care for Baltimore City and Baltimore County. Limited hospital capacity results in limited access for the acutely ill patients.

Table 16: JHH Hopkins Access Line Diversions
CY23

Clinical Service	# of Diversions
Internal Medicine	383
Neurosciences (non-Brain Tumor)	342
Pulmonary	232
Pediatrics	212
Gastroenterology	207
Brain Tumor	144
Oncology (Medical)	137
Cardiovascular	92
All Other	313
Total	**2,062**

Source: JHH HAL Database

The JHH Hopkins Access Line (HAL) diverted over 2,000 inpatient transfers in 2023 due to a lack of inpatient capacity. Most cases required complex specialty care.

As JHH accepts more of the Baltimore City/Baltimore County ED volumes and the growth in staffed beds continues to be below the national average, volumes from Maryland are leaving less availability for out of state quaternary and tertiary volumes. From CY14 to CY24 annualized, total out-of-state inpatients declined -43%.

Table 17: Trend of Non-Maryland Inpatients at JHH
CY14-CY24 Annualized

Discharges	2014	2015	2016	2017	2018	2019	2020	2021	2022	2023	2024 A	% Change
Domestic OOS	9,045	8,779	8,034	7,804	7,606	6,794	6,171	5,726	5,519	5,660	5,450	-40%
International OOS	919	1,077	990	702	611	489	537	252	250	264	229	-75%
Total OOS	**9,964**	**9,856**	**9,024**	**8,506**	**8,217**	**7,283**	**6,708**	**5,978**	**5,769**	**5,924**	**5,679**	-43%

Source: JHHS_HSCRC_ENC

Since GBR, JHH has less capacity for destination patients as it remains full of local patients.

As a result, JHH's AMC national peers are capturing this important rare and complex patient volume. The impact of this lost volume has detrimental financial implications for JHH and for Maryland. Minimum volume thresholds are imperative to guarantee a minimum level of quality of care. Without threshold volumes, quality outcomes will deteriorate. In addition, according to the JH Office of Government, Community and Economic Partnerships: Economic Impact Report, out of state patients have a meaningful impact on the regional and state-wide economy. In 2022, JHHS out of state visitors generated $62.3M.

Another consequence of shifting low intensity volumes to JHH is the underfunding of volume. Underfunding of volume manifests itself in the erosion of financial margin and the inability to reinvest in innovation and capital. Nationally, AMCs are making significant investments to provide advanced clinical technology and expand capacity for the growing number of complex patients. Beds are primarily growing in tertiary and specialty care, most notably in oncology, cardiovascular services, neurosciences, and pediatrics. If these issues are not addressed, there will be less specialized care in Maryland to meet the needs of the aging population and Maryland residents needing this level of care will likely have to travel out of state.

Table 18: Examples of Inpatient Expansion Nationally

Hospital	Project	Description
CHOP	New IP Tower / OP Tower	140 incremental beds $1.9B
Cincinnati Children's *	New IP Tower	225 incremental beds NA
Dana Farber *	New Cancer Hospital	300 incremental beds $1.7B
Massachusetts General *	New IP Tower (Cancer and CV)	94 incremental beds $1.9B
Mayo Clinic *	New IP Towers	148 incremental beds $5.5B
NYU Langone *	New Medical Center	140 incremental beds NA
UCSF	New IP Tower	180 incremental beds $2B+
Univ. of Chicago *	New Cancer Hospital	80 incremental beds $820M
Univ. of Kentucky *	New IP Tower / OP Tower	300 incremental beds $1B+

Note: Examples above are institutions in regional markets with similar long-term growth projections. *Denotes hospitals in states with CON regulations.
Source: Health system press releases and regional news outlets.

Maryland AMCs are falling behind regional and national competitors in complex care capacity.

The impact of higher low intensity volumes and the inability to expand beds at JHH is most notably seen in Pediatrics and Oncology.

Pediatrics

Locally and nationally, community hospitals are exiting the pediatric market as they see it as inefficient and a financial burden. Nationally, economics are driving the consolidation of inpatient beds as pediatrics inpatient volume requires high cost, specialized equipment and providers. Between 2008 and 2018, nationally, 19% of all pediatric inpatient units closed.[3] Maryland is not immune to this trend. In fact, this trend is accelerated in Maryland due to misaligned incentives.

[3] *Health Affairs* 2002 June 15: An Unexpected Shortage: Beds for Children, *Pediatrics*, 2021 July: Availability of Pediatric Inpatient Services in the US

Table 19: Licensed Pediatric Beds by Region
FY14, FY20, FY24

Jurisdiction/Region	FY14	FY20	FY24	% Change F14 to FY20	% Change F14 to FY24
Western Maryland	20	11	8	-45.0%	-60.0%
Montgomery County	59	21	19	-64.4%	-67.8%
Southern Maryland	23	19	17	-17.4%	-26.1%
Eastern Shore	20	15	13	-25.0%	-35.0%
All Areas Outside Central Maryland	122	66	57	-45.9%	-53.3%
Central Maryland	316	277	275	-12.3%	-13.0%
Maryland Total	**438**	**343**	**332**	***-21.7%***	***-24.2%***

Source: MHCC

Pediatric beds in Maryland declined -24.2% between FY14 and FY24.

Between FY12 and FY24, Maryland community hospitals steadily reduced pediatric inpatient capacity, shifting the volume to Maryland AMCs or out of the state. Licensed pediatric inpatient beds declined -21.7% (95 beds) between FY14 and F20, after the inception of GBR. Montgomery County experienced a -64.4% reduction in licensed pediatric beds compared to a -12.3% decline in the Central Maryland region from FY14 to FY20. Of note, Central Maryland contains the state's AMCs. From FY20-FY24 Maryland's licensed pediatric beds continued to decline, but at a slower rate, -3.2%. Since 2019, Calvert Health Medical Center, MedStar Harbor Hospital, MedStar Franklin Square Hospital, and University of Maryland Shore Regional Health at Chestertown closed inpatient pediatric units. Hospitals that reduced the inpatient pediatric program to a single bed include MedStar Union Memorial Hospital, University of Maryland Capital Region Medical Center, Meritus Medical Center, and Western Maryland Regional Medical Center. Today, only nine hospitals in the state have more than 5 pediatric beds.

Table 20: Inpatient Pediatric Admissions (non-ED): Maryland Residents 2019-2023

Hospital State	# Change in Inpatient Pediatric Admissions (non-ED) of Maryland Residents	% Change in IP Pediatric Admissions (non-ED) of Maryland Residents
MD	-933	-2%
DC	+101	+2%
PA	+44	+14%
VA	+320	+91%

Source: HSCRC, DCHA, VHI, and PA inpatient datasets

As licensed pediatric inpatient beds decline in Maryland, patient care for this population is migrating out to surrounding states.

The top conditions for which patients leave Maryland include Neonatal Intensive Care Unit (NICU), Pulmonary Medicine, Oncology, and Bariatric Surgery.

Table 21: Pediatric Inpatient Days at Maryland Hospitals FY2023

Hospitals	NICU		Behavioral Health		All Other	
	#	%	#	%	#	%
JHH and UMMC	35,451	29%	8,297	36%	48,417	72%
All Other Maryland Hospitals	85,516	71%	15,007	64%	19,088	28%
Hospital Total	**120,967**	**100%**	**23,304**	**100%**	**67,505**	**100%**

Note: Pediatric defined as 0-19
Source: HSCRC Inpatient Dataset FY23

For those pediatric inpatients that seek care in Maryland, in FY23 JHH and UMMC served ~72% of all pediatric non-NICU/Psychiatry patient days.

Cancer Care

Inpatient growth in the most complex cancer cases is projected to be 20%+ over the next 10 years. Within Maryland, inpatient cancer care admissions for Maryland residents declined -16% for Maryland hospitals from CY19-CY23, while surrounding states saw growth in cancer admissions.

Table 22: Inpatient Cancer Admissions (non-ED): Maryland Residents 2019-2023

Hospital State	# Change in Inpatient Cancer Admissions (non-ED) of Maryland Residents	% Change in IP Cancer Admissions (non-ED) of Maryland Residents
MD	-2,176	-16%
DC	-80	-4%
PA	+5	+4%
VA	+80	+50%

Source: HSCRC, DCHA, VHI, and PA inpatient datasets

Inpatient cancer care in Maryland is declining as patients seek treatment out of the state.

The top tumor types for which adult patients leave Maryland for care are bone marrow transplantation and hematologic malignancies.

Locally and nationally, community hospitals are exiting the inpatient cancer market as routine cancer treatment shifts to the outpatient setting and complex cases aggregate at National Cancer Institute (NCI) designated centers. Primary reasons for the consolidation include an increase in the complexity of cases and the associated high-cost, specialized equipment and providers needed to provide appropriate care. Examples of this care include cell and gene therapy and high intensity outpatient treatments.

Consolidation at cancer care centers is appropriate, but these centers require full reimbursement for operating costs and essential investments in technology and capacity. JHH's inpatient medical oncology beds have operated at 90%+ occupancy for the past several years, and FY24 year to date (YTD) March inpatient occupancy is 93.5%. An occupancy of 93.5% presents significant challenges such as regular bed shortages and staffing challenges. During this same period, Maryland community hospitals are reducing inpatient oncology volume, which allows them to keep retained revenue and avoid high-cost investments in inpatient treatments. Currently, Maryland AMCs care for 80% of inpatient chemotherapy patients, 68% inpatient head and neck malignancies, and 57% of hematologic malignancies.

Table 23: Cancer Inpatient Discharges at Maryland Hospitals
FY23

Hospitals	Chemotherapy		Head & Neck Surgery		Hematologic Malignancies	
	#	%	#	%	#	%
JHH and UMMC	712	80%	395	68%	825	57%
All Other Maryland Hospitals	180	20%	186	32%	610	43%
Hospital Total	**892**	**100%**	**581**	**100%**	**1,435**	**100%**

Source: HSCRC Inpatient Dataset,

Maryland AMCs care for most chemotherapy, head and neck surgery, and hematologic malignancy as Maryland community hospital volumes decline in these areas.

The funding for the movement of oncology cases from community hospitals to JHH does not allow for inpatient cancer care growth to compete nationally. Nationally, NCI comprehensive cancer centers are adding significant inpatient and hospital-based outpatient capacity. Major cancer care center expansion projects nationally include the Barnes-Jewish Siteman Cancer Center, Dana Farber, Memorial Sloan Kettering, Moffit Cancer Center, Ohio State- James Cancer Center, and the University of Chicago. In comparison, the JHH Sidney Kimmel Comprehensive Care Center Weinberg facility is over 20 years old.

Implications

This analysis demonstrates that the GBR system results in substantial shifts in volumes across the state, with reductions in volume within the hospital. The declines have not been uniform, and shifts in patient care have occurred among hospitals. Many hospitals with revenue reductions have kept a substantial share of their revenue base while treating fewer patients – a deliberate incentive built into the current GBR structure to provide incentives to move patient care from the hospital to lower acuity settings or to prevent the need for hospital services through improved care management and population health efforts.

The GBR policy is a blunt tool to achieve these refined goals. While the HSCRC has attempted to structure policies to encourage reductions in avoidable and unnecessary hospital utilization, the financial incentives tend to reward hospitals that reduce patient services – not just low value, avoidable, or unnecessary care. Some hospitals have aggressively reduced services by forgoing the renewal of physician contracts or removing service lines that require substantial ongoing investments. Some have moved services out of state or outside the hospital to nonregulated space to serve commercial patients primarily. While HSCRC policies reduce hospital GBRs for volumes that shift to other hospitals, hospitals that engage in these reductions retain revenue to cover their fixed costs, and other hospitals in their market pick up their patients at a fraction of the cost of providing the care.

Recommendations

As the Maryland Demonstration Model evolves under the AHEAD program, a series of refinements to the HSCRC GBR policies are necessary to address the distortions discussed in this paper. Specifically, the following adjustments are required to reduce perverse incentives and better align the foundation of the model with improved access, high quality care, hospital resource equity, and impact to Maryland's population health.

1. **Better alignment of revenues with patient choice of hospital – "Revenue follows the patient."**
    a. The HSCRC Market Shift adjustment must yield a net 50% variable cost factor, or whatever the proper fixed cost percentage is determined to be, for patients moving from one hospital to a different hospital.
        i. Hospitals should not be penalized for providing needed care.
        ii. All volumes should not be treated by the HSCRC as avoidable. Reducing PAU should continue to be the primary goal for utilization reduction.
        iii. The HSCRC must improve the monitoring of corporate integrity efforts to identify where hospitals are reacting to the incentives of the model in ways that harm access, efficiency, or quality. This includes shifting volumes to out of state providers, deregulating care without disclosure to the HSCRC, redesigning major clinical offerings that greatly reduce or expand access that result in patient dumping or transfer limitations.

2. **Exclusion of key tertiary and quaternary care from the constraints of the GBR.**
    a. Both JHH and UMMC must be allowed to offer critical lifesaving and curative therapies to citizens of Maryland. The GBR creates significant pressures to limit access to these key services based on a rationing of fiscal reserves to cover less intensive levels of care. Tremendous advances in therapeutic drugs and devices occur weekly. Many of these new biologic drugs offer curative solutions to advanced disability and life-limiting diseases.
    b. JHH and UMMC must be able compete nationally with other AMCs.
        i. Attract and retain top clinical and research talent.
        ii. Invest in new capital and innovative technologies.
        iii. Increase tertiary and quaternary volumes to improve clinical quality.
        iv. Sustain financial margins that support the tripartite goals of teaching hospitals.

3. **Address excess bed capacity in Maryland by geography.**
    a. The success of the Demonstration Model in reducing acute care volumes resulted in some hospitals operating at a lower census and sub-optimal efficiency in Baltimore City, both on operating and clinical quality levels.
    b. Timing is important in the context of the healthcare employment environment as providers are fervently searching to find clinical personnel. The patients displaced by hospital closures in Baltimore City would be absorbed by other providers. Associated job displacements would be redirected to other local hospitals in critical need of clinical resources.

c. The fixed cost savings from these hospital closures would likely fuel required system savings targets for many years.

Other Demonstration Model refinements are likely required; however, these categories address many of the current distortions in the model and ensure that the citizens of Maryland will have access to high quality advanced clinical care when needed. The HSCRC, MDH and CMMI must develop criteria to assess the health of Marylanders over the period of the model. We need meaningful measures to assure that the success of reduced costs reflect improvement in health and not rationing of care. Nothing less than appropriate refinement in these areas ought to be acceptable to the state regulators at the HSCRC.

GLOSSARY

- **Academic Medical Center (AMC):** A hospital affiliated with a medical school that provides advanced clinical care, conducts research, and educates healthcare professionals. AMCs often serve as referral centers for complex cases and play a key role in healthcare innovation and specialized care delivery, as well as serving as economic engines for the state. The HSCRC defines an AMC as a facility with 500 beds or more, affiliated with a school and has a higher Case Mix Index than 1.5. In Maryland only two hospitals meet this standard, The Johns Hopkins Hospital and University of Maryland Medical Center.
- **Alternative Payment Models (APM):** Payment approaches that move away from traditional fee-for-service structures, incentivizing providers to focus on the quality and effectiveness of care rather than the volume of services. APMs include models like global budgets, bundled payments, and shared savings programs, which encourage providers to reduce costs and improve patient outcomes.
- **Case Mix Index (CMI):** A measure representing the complexity and resource needs of a hospital's patient population. Higher CMI values indicate a higher proportion of complex, resource-intensive cases, impacting hospital reimbursement rates and budget allocations in models like the Maryland Model.
- **Center for Medicare and Medicaid Innovation (CMS Innovation Center):** Federal agency, established by the Affordable Care Act, under the Centers for Medicare and Medicaid Services (CMS) that supports the development and testing of innovative healthcare payment and service delivery models that aim to achieve better care for patients, better health for communities, and lower costs through improvement for the health care system. Maryland's All Payer Model, Total Cost of Care Model, and the States Advancing All Payer Health Equity Approaches and Development Models are administered by the CMS Innovation Center.
- **Demographic adjustment:** The demographic adjustment accounts for changes in the demand for services associated with changes in the size and characteristics of the population served by hospitals within their primary service area. As currently implemented in Maryland, the demographic adjustment is distributed to hospitals based on an expected age-adjusted growth rate within their given service area, but the results are scaled across hospitals so that state revenue growth is limited to population growth without an age adjustment. The demographic funding is allocated according to market share, meaning it expects all hospitals in a service area to experience demographic changes equally.
- **Equivalent Case-Mix Adjusted Discharges (ECMADs):** A standardized measure of both inpatient and outpatient hospital utilization adjusted for case mix, or the complexity of cases. ECMADs allow for consistent comparisons of hospital volume and performance by accounting for variations in the types of patients treated, supporting accurate budgeting and performance assessments.
- **Fee-for-service (FFS) payments:** A traditional payment model where providers are paid separately for each service they perform, such as exams, procedures, or tests.

- **Global Budget Revenue (GBR):** Payment methodology established by the Health Services Cost Review Commission as part of the agreement with the CMS Innovation Center that establishes a fixed global budget for hospital services, rather than traditional fee for service. Under this fixed revenue model, there are minimal revenue adjustments as volumes increase or decline.
- **Health Services Cost Review Commission (HSCRC):** State agency that oversees hospital rates for all patient care services at acute care hospitals in Maryland.
- **Inter-Hospital Cost Comparison (ICC):** A comparison of hospital charge per ECMAD, exclusive of hospitals' unique costs and allowed funding for social goods. Each hospital's ICC revenue base is built up from a peer group standard cost, with adjustments for social goods and costs beyond a hospital's control that are not included in the peer group standard.
- **Market Shift Adjustment:** The market shift adjustment is designed to reallocate revenue from one hospital to another within the state as patients move across hospitals for care. This feature is designed to replicate the function of a market, but in a way that will not incentivize hospitals to seek additional patient volume to enhance their financial performance. The market shift is intended to identify changes in the volume of specific services within hospitals in each market and to reallocate revenue to cover the incremental cost of those services. The market shift does not adjust for growth in volume, only the migration of patients from one hospital to another, if the migration can be tracked through the HSCRC's policies.
- **Maryland's Medicare Waiver**: Affects all patients, regardless of age or Medicare eligibility, treated in Maryland hospitals. Under the waiver's rules, every payor – whether an individual, Medicare, Medicaid, or a private insurer – pays the same charge for the same care at the same hospital, as set by the HSCRC.
- **Medical/Surgical/Gynecological/Addictions (MSGA) Beds**: Hospital beds designated for general medical, surgical, gynecological, and addiction-related care, excluding intensive or highly specialized care. MSGA beds support a broad range of inpatient services and are essential for accommodating routine hospitalizations. Effective use of MSGA beds is critical for managing capacity and controlling costs within the Maryland Model.
- **Patient Quality Indicators (PQIs)**: Measures that assess the quality of care management beyond the hospital walls by identifying potentially avoidable hospitalizations. PQIs highlight areas where improved primary or preventive care could reduce hospital admissions, making them an important tool in tracking hospital performance and identifying opportunities for care improvement.
- **Potentially Avoidable Utilization (PAU):** Readmissions and conditions where robust disease management in the "outside the walls of the hospital" setting can avoid future hospitalizations (such as diabetes, hypertension, heart failure).
- **Tertiary/Quaternary Care:** Advanced levels of medical care typically provided by specialized hospitals or academic medical centers. Tertiary care includes specialized consultative services, while quaternary care encompasses highly specialized, complex treatments (such as organ transplants or experimental therapies). Hospitals offering tertiary and quaternary care often act

as referral centers, providing complex care that goes beyond the capabilities of community hospitals.

- **Total Cost of Care (TCOC) Model:** Second phase of the Medicare waiver. As part of this Model, Maryland commits to saving $300 million in annual, total Medicare spending by the end of 2023, while also meeting hospital-based quality targets. The TCOC Model holds hospitals financially accountable for growth in all Medicare cost of care, including care outside the hospital. The TCOC Model will be replaced by the AHEAD Model.

JOHNS HOPKINS
MEDICINE

December 15, 2021

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

Dear Chairman Kane,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the draft recommendation for Revenue for Reform, which would classify certain non-hospital costs as allowed population health investments, creating safe harbors for retained revenues. The draft recommendation intends to provide hospitals with credit for investments that hospitals make in population health initiatives, and JHHS supports this intent. The implementation of Revenue for Reform would have been appropriate if implemented in 2014 with the launch of Global Budget Revenue Agreement. However, it is not clear why any hospital or health system has not to date robustly invested retained revenue in population health initiatives in the surrounding community since the HSCRC specifically states "GBR methodology is an extension of TPR methodology, which encourages hospitals to focus on population-based health management by prospectively establishing a fixed annual revenue cap for each GBR hospital." Any hospital or health system who has retained revenue that has not been invested in population health has simply been violating the goals and requirements of the Maryland Model. .Additionally, JHHS has specific concerns with the current proposed policy, as detailed below:

Methodology concerns

If the methodology is only applied to the lowest quartile hospitals, JHHS believes that this policy should not cause hospitals that are not in the lowest quartile to fall into the lowest quartile. Additionally, if the methodology is applied to all hospitals, there should be a standardized report for hospitals to provide the information used to adjust the efficiency results in an equitable manner.

Impact on consumers and hospitals

Revenue for Reform does not address some of the fundamental challenges with GBR, specifically its impact on consumers – patients who need hospital level of care. If excess revenue remains in the system, and volumes continue to decline, unit rates will continue to increase. Patients receiving care at

low volume hospitals will receive inappropriately high bills. This has an unfair impact on consumers, particularly as insurers continue to increase co-pays and deductibles.

Industry-wide savings targets under the Maryland Model will be increasingly hard to reach if all retained revenue is allowed to stay within the system. Any efficiency metric needs to address excess retained revenue and Revenue for Reform simply avoids difficult actions that must be taken to ensure the integrity of the Maryland Model.

Revenue for Reform, at this time, potentially rewards hospitals who may have reduced overall volumes under GBR, not just avoidable volumes. Data indicates that since the implementation of GBR, hospitals with retained revenue have seen an overall decrease in volume, not just potentially avoidable utilization (PAU). There is no data at this time to indicate that hospitals with decreased volume and retained revenue have achieved that decrease through population health investments – instead, this may have been achieved simply through the elimination or reduction of services. The Revenue for Reform policy may be rewarding those hospitals for inappropriate reduction of services. The HSCRC should develop a Revenue for Reform policy that only recognizes volume reductions associated with PAU or due to population health related programs (not all volume).

Unintended consequences

Revenue for Reform could also have the unintended consequence of disadvantaging some communities over others. As noted above, not all hospitals have retained revenue. Hospitals with retained revenue will be allowed to keep that revenue if they invest in population health initiatives in their communities. With the current draft recommendation, it remains unclear how the HSCRC will ensure that disadvantaged communities that surround hospitals without retained revenue are also supported with population health investments.

An additional unintended consequence of this policy relates to increasing concern about disproportionate population health initiatives being included in HSCRC rates, and the impact that this has on rate levels for value-based agreements. Revenue for Reform runs the risk of disproportionately disadvantaging hospitals with a larger population health footprint paid through rates. Given that some payor programs compare a specific payor to market rather than to themselves, the growth of HSCRC rates due to programs that do not relate to the value-based program does not promote progress in value-based work.

Proposed changes & additional considerations

To address the concerns noted above, JHHS proposes that the HSCRC considers revising the policy to reset hospital GBRs before implementing Revenue for Reform. A portion of the savings generated through a reset should be dedicated to a statewide fund that would be available on a need-based approach to serve communities most in need of population health investments. This equity-focused approach would ensure that these funds are made available to all communities, not just those communities located near hospitals with retained revenues. Under the current policy, communities like East Baltimore would not receive the level of investment that other communities receive, as the Johns Hopkins Hospital does not have retained revenues. By resetting GBRs before implementation of the policy, these communities would receive more equitable levels of investment to further our statewide population health goals.

While JHHS agrees with the intent of the Revenue for Reform policy, JHHS does not believe this policy can move forward in its current form without compromising consumers and equity for the reasons detailed above. JHHS appreciates the HSCRC's thoughtful consideration of the above concerns and comments related to the draft recommendation for Revenue for Reform, and thanks the HSCRC for their continued collaboration to improve population health.

Sincerely,

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

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
Katie Wunderlich
Maulik Joshi, DrPH
James Elliott, MD
Sam Maholtra

May 6, 2022

Willem Daniel
Deputy Director, Payment Reform
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Daniel,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the Health Services Cost Review Commission's (HSCRC) revised proposed Revenue for Reform policy. Revenue for Reform would require hospitals to demonstrate their investment in community-based efforts that address social determinants of health. As we stated in our December 15 comment letter, JHHS is supportive of the basic intention of the policy to require that some portion of retained revenues should be invested back into the community, in alignment with the goals of the Maryland Model.

Since the implementation of the Total Cost of Care (TCOC) Agreement, JHHS has developed several key population health initiatives that were highlighted as a community need through the Community Health Needs Assessment (CHNA). These initiatives include:

- Collaborating with Chase Brexton, a Federally Qualified Health Center (FQHC), to provide support for patients presenting to the Emergency Department with acute dental needs.
- Johns Hopkins Medicine partnered with Baltimore Medical System (BMS) to transition East Baltimore Medical Center to a FQHC with the goal of improving care for our local community and enhancing our ability to address key social determinants by expanding access and increasing behavioral health and other key wraparound services.
- Collaborating with the Helping Up Mission to provide housing, jobs, and supportive services for individuals in recovery for substance use disorder.
- Leading a coalition of hospitals to fund supportive housing services for high-utilizer patients in Baltimore City who are experiencing homelessness.
- Leading a coalition of hospitals to establish the Greater Baltimore Regional Integrated Crisis System.
- Implementing Journey to Better Health in Howard County, a faith health initiative, to address chronic disease in the community, especially in segments of the population that see disproportionate rates of diabetes, hypertension and obesity.

JHHS has consistently understood that the when the All-Payer Model transitioned to the TCOC Model, there was a greater expectation for the development of community and population-based health

improvement initiatives. The HSCRC, the Maryland Department of Health and the HSCRC invested significant time to develop the Maryland Population Health Improvement Plan. The Maryland Population Health Improvement plan, submitted to the Center for Medicare and Medicaid Innovation (CMMI) in December 2016, specifically notes, *"As the Maryland health care system increasingly migrates toward adopting public health approaches in order to meet the performance goals of the All-Payer Model, it requires that population health improvement beyond the clinical space to address all factors that determine health; the social determinants of health and health equity."*

Considering the effort and focus on transitioning the All-Payer Model to a population health model, it is unclear how any stakeholder in the Maryland Model could reasonably believe that all savings generated through utilization reduction would be retained on an ongoing basis rather than invested in population health strategies.

While supportive of the overall concept of Revenue for Reform, the concerns outlined in our original comment letter remain, specifically regarding consumer impact, retained revenue, excess capacity and unequitable distribution of resources. JHHS is providing additional feedback on various areas of the proposed recommendation as well as broader policy concerns.

Specific Policy Concerns

Buyout Methodology

JHHS agrees that the first two-year buyout methodology is a reasonable approach for hospitals facing efficiency penalties, as it essentially offers to redirect some portion of their retained revenue to appropriate investment in population health spending rather than losing the revenue. Some amount of retained revenues should be invested back into the community, as this has been the intent of the new model since its inception. This approach allows hospitals to choose to redirect retained revenues they would otherwise lose while ensuring these important investments are made in the health of our communities.

Retained Revenue Methodology

The December 15, 2021 JHHS comment letter addressed concerns that the Revenue for Reform policy was not aggressive enough in addressing retained revenue that has persisted and grown since the implementation of the Global Budget Revenue (GBR) model. HSCRC staff addressing this concern, stated that the goal of *"GBR is intended to incentivize reductions in utilization (not just Potentially Avoidable Utilization [PAU]). Rebasing hospitals that followed the incentives of the model would be a bait and switch."* The HSCRC position treats all utilization equally and fails to recognize the important distinction between providing medically necessary care versus making financial decisions to reduce services. It is crucial to note that volume reductions alone do not translate to more effective utilization of services. In reality, decreased volume alone may threaten patient access to quality care. The HSCRC currently has no benchmarks to determine if reduced volume is due to improved care, efficient care or just "rationing" of services. The Revenue for Reform policy may be rewarding those hospitals for inappropriate reduction of services.

JHHS advises that retained revenues be separated into two groups –PAU-related retained revenues and non-PAU-related retained revenues:

- **PAU-related retained revenues**: Any retained revenues associated with a reduction in PAUs should be protected at 100%, as this is consistent with the intent of the new model and also with other HSCRC methodologies. To ensure incentives are appropriately aligned with other HSCRC policies, these revenues should be fully protected and should not be subject to the requirements of Revenue for Reform.
- **Non-PAU related retained revenues**: As noted above, some hospitals may have generated volume reductions by shrinking or eliminating programs, in turn limiting patient access and causing subsequent volume increases at other hospitals. This does not align with the intent of the Maryland Model. To the extent hospitals have done this over the first 8 years of the model and have not invested those revenues in population health initiatives already, hospitals should not be able to retain this revenue.

Additionally, there must be a consistent methodology for calculating retained revenues. Currently, retained revenues are calculated at the unit rate level. This is inconsistent with the Equivalent Case Mix Adjusted Discharges (ECMAD) volume methodology used in the market shift policy and other HSCRC policies. To ensure better alignment with existing HSCRC methodologies, we urge staff to consider using a consistent methodology to calculate retained revenues.

JHHS recognizes the balance the HSCRC is trying to achieve in maintaining the incentives of the GBR and ensuring appropriate investments in population health. However, it is also important to note that the magnitude of retained revenue is inappropriate and should not be sustained. It locks revenue in increasingly inefficient and expensive facilities on a price per case basis, exposing patients to increasingly high bills that are only exacerbated by the shift of insurers of patients into high deductible health plans. Previous analysis has indicated approximately $600 million in retained revenue statewide. This significant amount of funding could annually support:

- 12 new elementary schools at $50 million for each school
- The purchase of 3,500 homes in Baltimore City at a median price of $167,000
- The elimination of the approximately 6,000 homeless[1] individuals in Maryland by providing them annual support of $100,000.

JHHS is not advocating against the goal of Revenue for Reform, or for the elimination of all retained revenue; however, an appropriate balance must be achieved.

Expected Population Health Spend

Different communities have different needs, as indicated by the various CHNAs. In addition, different types of hospitals have varying abilities to impact these different community needs. JHHS urges staff to move away from a one-size-fits-all approach to calculating the Expected Population Health Spend. Sole community/safety net hospitals, suburban hospitals, and academic medical centers (AMCs) are able to impact communities with different approaches and to varying degrees.

It is crucial to note that forcing all hospitals to spend 1% of their total revenue base as Expected Population Health Spend is a flawed concept. This approach assumes that all volumes can be managed under population health. It also assumes that all hospitals have an equal opportunity to do so. In this

[1] https://www.usich.gov/homelessness-statistics/md/

case, a one-size-fits-all approach could unduly penalize a hospital that is spending monies in other areas of need because they have no retained revenues.

If this methodology is adopted, it should only be applied to a portion of the revenues attributable to the populations the hospital serves. Given that certain volumes are carved out of the market shift methodology, staff should also consider carving these types of volumes out of the expected population health calculation. This would include the innovation adjustment, out-of-state volumes, PAUs, etc.

Qualifying Population Health Investments

JHHS generally supports the criteria outlined by the HSCRC as qualifying population health investments. An industry-wide focus on addressing issues identified in the CHNA creates an opportunity to address and improve social determinants of health strategies. There are many programmatic hospital-based investments, such as violence intervention, services for immigrant populations, and workforce development that JHHS believes should be included in the population health investment "safe harbor." We will continue to work with HSCRC staff to develop specific criteria that would categorize an investment as a population health initiative.

Broad Policy Concerns

How to incorporate an increasing expectation for spending on community-based programs in a constrained system

The increasing expectation for spending on community-based activities is a necessary and expected development within our TCOC policy. JHHS is concerned that the proposed policy favors hospitals with the most retained revenues while also creating a requirement to spend within their existing revenue structure at hospitals with limited retained revenue. As we consider the long-term viability of our Model JHHS believes that the growing distortions in the GBR, such as retained revenues and excess capacity, must be addressed to ensure rational and equitable access to available funds to invest in community health. JHHS is concerned that Revenue for Reform as currently constructed avoids difficult actions that must be taken to ensure the integrity of the Maryland Model.

Resetting Hospital GBRs

While generally supportive of the intention of the proposed Revenue for Reform policy to increase accountability for investing retained revenues in community-based activities, JHHS believes the concerns noted above and articulated by staff would be more adequately addressed by revising the policy to reset hospital GBRs before implementing Revenue for Reform. As we contemplate both increasing savings requirements and new expectations for investments of this type, we must consider the levers that we have to address the growing distortions in the GBR, including rebasing and addressing excess capacity in the system. Mechanisms such as these can create available funds that can be thoughtfully distributed to address (1) allowed retained revenue at hospitals (2) investing in care transformation, and (3) contributing to savings requirements. A more equitable and logical way to meet the community needs that are the stated goals of Revenue for Reform may be a policy that, if properly executed, provides for rebasing and addressing the excess capacity within the system, pooling a defined amount of those retained revenues, and using them to re-invest in care transformation. JHHS believes a thoughtful approach can strike a balance between preserving the volume incentives that drive TCOC savings in our system and meeting the increasing expectation to continually invest in care transformation.

Process to Identify Projected Bed Need Across the State

The State of Maryland would benefit from an open and robust discussion regarding the long-term bed need and sustainability of Maryland's hospitals. If the Maryland Model is ultimately successful and alternative models of care are scaled across the state, it will likely mean a reduction in the need for hospital-based inpatient services in the future.

Other states are taking similar approaches, initiating extensive public process to examine the utilization and cost of hospital services, the financial health of the facilities themselves, and the long-term bed need by region and across the state based on future demographic projections. A similar process in Maryland would allow for long-term planning to take place in an open, transparent, and thoughtful manner, rather than relying solely on the incentives in Revenue for Reform and other policies to drive the necessary changes.

JHHS recognizes the value of the intent of the proposed Revenue for Reform policy and appreciates staff's thoughtful consideration of the above comments. Though we agree that some retained revenues should be invested back into the community, we urge staff to ensure the methodology is appropriately adjusted to reflect alignment with the HSCRC's existing policies and with the intent of the Maryland Model. We look forward to continuing this important dialogue.

Sincerely,

Ed Beranek

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

June 23, 2022

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

Dear Ms. Wunderlich,

The Johns Hopkins Health System (JHHS) appreciates the opportunity to provide further input on the Health Services Cost Review Commission's (HSCRC) proposed Revenue for Reform policy. In its current form, the draft recommendation would require hospitals to demonstrate their investment in specific community-based initiatives, or potentially risk losing retained revenues. As we stated in our attached December 15 and May 6 comment letters, JHHS is supportive of the primary aim of the policy; it is necessary that that some amount of retained revenues are invested back into the community, in alignment with the goals of the Maryland Model. As the policy has evolved, the JHHS position remains consistent with our past comment letters. Specifically, JHHS notes:

- Policies must address retained revenue with a distinction between appropriate and inappropriate volume declines
- Hospitals without retained revenue cannot be held to a standard investment, particularly when these hospitals likely absorbed volume from other hospitals that simply shed volume
- Investing in community and population health initiatives is consistent with the goals of the Maryland Model.

JHHS understands the goal of the proposed Revenue for Reform policy, and agrees that some retained revenues must be addressed and reinvested back into the community. We urge the HSCRC to thoughtfully consider this policy's impact on and alignment with the HSCRC's existing policies and the intent of the Maryland Model.

Sincerely,

Ed Beranek

Ed Beranek
Vice President, Revenue Management & Reimbursement

Johns Hopkins Health System

Summary of Kevin Sowers Testimony on HSCRC Corrective Action Plan
HSCRC Commission Meeting
October 12, 2022

- JHHS supports the MHA position. The MHA position is a very balanced approach which looks to all stakeholders to contribute to achieving success of the Maryland Model.
    - Agree that COVID and its aftershock should be considered an exogenous factor because we would not be failing the targets if not for the pandemic.
    - Agree that some portion of the corrective action should be achieved through reductions to hospital Medicare rates.
        - The hospital industry has appropriately debated the nature of the rate reduction and has generally agreed to 75% of the rate reduction achieved through the efficiency policy and 25% achieved through rate reduction across all hospitals.
        - This process will require all hospitals to contribute to the solution
    - The HSCRC and hospital industry both are recognizing the need for a balanced approach towards corrective action - any drastic or aggressive actions should be avoided for now, until we have greater insight into the data and long-term Medicare growth.
    - However, taking incremental proactive action will signal to CMS how committed the state and hospital industry are to the success of the Maryland Model
- While JHHS supports the MHA position, we also urge the HSCRC to view the threat of corrective action as an opportunity evaluate the direction of the Maryland Model and numerous policies under the Model
    - JHHS has been very direct in voicing our concerns around retained revenue and excess capacity, particularly in Baltimore City
    - Allowing revenue to be retained within a hospital or health system indefinitely creates distortions within the overall system
        - Retained revenue creates artificially high charges at hospitals with low volume. These charges then become the burden of patients
        - Retained revenue makes long-term savings targets harder to achieve
        - Retained revenue creates perverse incentives for hospitals to arbitrarily reduce volumes and retain savings. Without clear and concrete guidance from the HSCRC on the nature of volume that *should* be reduced, some hospitals will succeed simply by eliminating services. When a hospital eliminates services, those patients either seek care at another hospital or they don't get the care they need. This is not behavior that should be financially rewarded
        - Retained revenue shields Maryland hospitals from actions and activity that is occurring in the hospital industry across the nation. As a health system with a national presence, JHHS is constantly evaluating market trends (the following is Vizient and Sg2 data that looks at market trends pre-COVID – 2015-2020)
            - Nationally staffed beds are declining at community hospitals while staffed beds at AMCs are growing
                - In Maryland staffed beds at community hospitals declined by 17% vs 3% decline nationally

        - Nationally AMC beds are growing by 9%, in Maryland AMC staffed beds remain stagnant
        - Nationally AMCs operate at 83% capacity and in Maryland JHH operates at over 90% capacity
    - Nationally, community hospitals are shrinking and the revenue from those hospitals is being shifted to the other hospitals providing medically necessary care for those patients. Yet in Maryland, this shrinkage is accelerated and most of the revenue remains with the hospitals who are closing beds
    - The Maryland Model should be used to support hospitals that either deliver medically necessary care or serve as a vital resource to a community – like in more rural areas – but the Maryland Model should not protect and insulate hospitals from bed declines that are either deliberate, or are not the result of health care transformation
- There is a need for stronger population health strategies to serve disparate communities.
    - The conversion of Bon Secours to Grace Medical serves as a strong example of how a hospital facility can be right sized to meet the needs of the community, while also allowing for strategic investments in the community
    - There are currently 10 acute care hospitals serving Baltimore City, which has a declining population. Baltimore City is over-bedded with significant retained revenue at hospitals with low occupancy rates.
    - A strong policy that reduces excess capacity or at least repurposes some retained revenue to support a coordinated population health approach could dramatically improve the overall health of high needs regions across the state.
    - Baltimore City -
        - Has a significantly higher rate of:
            - People living below the poverty line
            - Unemployment
            - Food insecurity
            - 43% of Baltimore City residents receive Medicaid vs. 23% statewide
        - There is a commonly referred to statistic in health care – 40% of an individual's health care costs are associated with the conditions they live in
        - If we are truly committed to recognizing the Maryland Model as a population health model then we need strong policies and collaborative approaches to addressing social determinants of health in areas like Baltimore City, where the need is much greater
        - No one hospital can achieve this transformation. It must be a collective effort and retained revenue represents an opportunity to both achieve savings and reinvest in our communities.
- JHHS believes there are fundamental issues with the Maryland Model's policies and methodologies that hinder the State and industry from achieving our goals and financial targets. We urge the HSCRC to consider intentional policies and strategies that address retained revenue, volume reduction and population health.

JOHNS HOPKINS
MEDICINE

October 7, 2022

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

Dear Chairman Kane,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the potential corrective actions that may be required if the State does not meet the savings targets required by the Waiver.

JHHS supports the Maryland Hospital Association (MHA) position regarding the potential corrective action steps, specifically the approach of consideration of exogenous factors, increasing the public payer differential, Medicaid deficit assessment relief and a reduction in hospital Medicare rates with the majority of the reduction achieved using the latest efficiency policy. This is a balanced approach that requires contributions from all stakeholders that benefit from the Maryland Model, including hospitals, commercial payers and the state of Maryland. This approach also reflects a thoughtful compromise across the hospital industry.

While JHHS is supportive of the MHA position, it is important to highlight that this approach towards corrective action does not solve the systemic problems within the Maryland Model and the Global Budget Revenue (GBR). Failing to meet the Medicare savings target presents Maryland with the opportunity to pursue a thoughtful evaluation of the policies within the Total Cost of Care Model that are improving patient care and those that are not.

JHHS has repeatedly raised the issue of retained revenue and the need for a rational population-based and clinical needs approach to bed capacity. There is a need for clear and updated policies and guidance on the impact of retained revenue on volume reduction. Data indicate that since the implementation of GBR, hospitals with retained revenue have seen an overall decrease in volume, not just potentially avoidable utilization (PAU). There is no data at this time to indicate that hospitals with decreased volume and retained revenue have achieved that decrease through population health investments – instead, this may have been achieved simply through the elimination or reduction of services. In order to achieve the goals of the model and deliver ongoing savings, the HSCRC must develop policies that –

instead of recognizing all volume reduction – only recognize volume reductions associated with PAU or due to population health related programs. Some HSCRC staff have publicly indicated that the Maryland Model and the GBR are designed to reward any volume reduction. This is a reckless policy perspective that offers to incent rationing of health care services. Additionally, given that Maryland is benchmarked against the national Medicare spend, with a requirement to ensure Medicare fee-for-service total cost of care grows less than the nation, the current approach to retained revenue is counter-productive. While in other states, hospitals with declining overall volumes may otherwise close, in Maryland they remain open, adding to the state's total cost of care and hindering progress on the benchmark.

JHHS, like many other hospital partners and policy makers, believes that the Maryland Model is intended to incentivize thoughtful investments in community and population health strategies that will produce the long-term outcome of reduced hospital utilization through lower rates of chronic conditions and improved health. There is a critical need to rebalance the system with longer-term policy corrections in order to achieve savings targets along with population health goals. JHHS remains firm in its belief that the goals of the model cannot be achieved over a 10-year period without directly reinvesting retained revenues in population health, creating quantifiable savings and investments. Population health investments should be strategic and regional with the initial focus on jurisdictions with higher rates of poverty and health disparities. As JHHS has noted in previous comment letters, industry-wide savings targets will be increasingly hard to reach if all retained revenue is allowed to stay within the system – however some portion of retained revenue should be redirected to targeted investments in population health that focus on social determinants of health in Maryland's most disadvantaged communities.

While JHHS believes that the exogenous factor of the pandemic is a reason for the miss of the savings target, we also believe there are fundamental issues with the Maryland Model's policies and methodologies that hinder the State and industry from achieving our goals and financial targets. In order to achieve these goals, it is necessary to implement longer-term policy corrections that address retained revenues and inappropriate volume reductions. JHHS appreciates the opportunity to comment on the potential corrective actions and longer-term policy corrections that may be required of the State and the industry.

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, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, R.N.
Katie Wunderlich
Maulik Joshi, Dr.P.H.
James Elliott, M.D.
Sam Maholtra

JOHNS HOPKINS
MEDICINE

November 28, 2022

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

Dear Chairman Kane,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the draft recommendation for adjusting for excessive Total Cost of Care (TCOC) growth in CY2022. JHHS appreciates the balanced approach that the Health Services Cost Review Commission (HSCRC) has taken with the draft recommendation. The approach leverages support for adjustments across all stakeholders that benefit from the Maryland Model, including hospitals, commercial payors and the state of Maryland. While JHHS is generally supportive of the HSCRC's draft recommendation, specific comments and concerns are noted below.

Staff recommends an all-payer rate reduction of 0.40% that will be taken from the January rate orders across the board

JHHS, and the majority of the hospital industry, supports a targeted approach to rate reductions, rather than across the board. The hospital industry developed a consensus position, recommending a reduction in hospital Medicare rates with the majority of the reduction achieved using the latest efficiency policy. This approach was proposed by Maryland Hospital Association (MHA) at the October meeting, and most of the Maryland hospitals supported this approach. Reducing rates based on the efficiency policy accounts for the fact that some hospitals are better positioned to sustain rate reductions than others. Less efficient hospitals have retained revenue and the industry recognizes that 75% of the rate reduction should come from inefficient hospitals and 25% from the remainder. JHHS would encourage the HSCRC to reconsider this aspect of the recommendation and instead honor the industry consensus to achieve the reductions in a targeted way, utilizing the HSCRC approved efficiency policy. We strongly encourage staff to adhere to existing policies. To change policy stances in response to a correction period causes us to pause in trying to understand the purpose of a policy that has been used in the past, but is now not considered by staff to be "accurate" or "relevant" to help address the issues before us. Constant policy changes that are not properly vetted with the industry undermines the stability of the Maryland Model.

We would also encourage the HSCRC to alter the all-payer rate reduction when the state is failing the Medicare targets – there is only a need reduce Medicare costs in Maryland in order to achieve compliance. The hospital industry is facing unprecedented labor and supply costs, with operating margins deteriorating significantly. Implementing an all-payer rate reduction will worsen hospital financial conditions, resulting in difficult decisions about staffing and services for some hospitals, while providing minimal targeted savings to address the Medicare issue directly. There is no need to reduce rates to all payers, particularly when commercial payers already receive the benefit of reduced hospital costs.

Staff recommends requesting an increase to the Public Payer Differential of 1% for the remainder of FY 2023 and the duration of FY 2024, contingent upon approval of the Center for Medicare and Medicaid Innovation (CMMI)

JHHS strongly supports using the differential as a temporary tool to reduce Medicare costs in Maryland. Insurers are the biggest benefactor of Maryland's all-payer system, resulting in hospitals costs to commercial payers that are on average 25% less than the nation. Expecting all stakeholders to contribute to corrective actions sends a strong message to state and federal policy makers, recognizing that success and failure of the Maryland model requires support, commitment, and sacrifice from all parties. Additionally, as more charity care and bad debt is associated with insured patients being enrolled in high-deductible health plans, revisiting and revising the differential may be sound public policy.

Staff recommends implementation of the Medicare Performance Adjustment Savings Component of $50 million

JHHS strongly supports using the Medicare Performance Adjustment Savings Component (MPA-SC) as a policy to bring Maryland cost growth in line with the nation. As noted earlier, JHHS believes that any reduction to hospital rates should be Medicare-only, and implemented based on the integrated efficiency policy, not across the board. The MPA-SC was developed and approved as a methodology to achieve the Medicare savings target if needed. The policy should be implemented now and used to mitigate across the board and all-payer reductions.

Additionally, given that there are various factors still in flux that will impact final model performance, JHHS believes the HSCRC should be cautious not to overcorrect with the adjustments under consideration. Of note, the actions inherent in the July 1, 2022 rate adjustments are not yet included in the data, and will have an impact on the state's final performance.

Staff recommends that the Commission send a formal request to the State to reduce the Medicaid Deficit Assessment by $50 million, contingent upon approval by the State Legislature

JHHS also supports this recommendation. Similar to the differential position, reducing the Medicaid Deficit Assessment demonstrates a multi-stakeholder commitment to protecting and preserving the Maryland Model, where all parties benefit. The staff recommendation notes that any

reduction to the Deficit Assessment is contingent upon approval by the State Legislature. However, a reduction to the remittance portion of the Deficit Assessment likely does not require any action by the Legislature. The laws governing the Medicaid Deficit Assessment were last revised by Chapter 16 of the Acts of 2019. The language currently states, "for fiscal year 2021 and each fiscal year thereafter, the budgeted Medicaid Deficit Assessment shall be $294,825,000." There is no reference in current law to a remittance portion, which is currently $56 million. In fact, any requirement for a remittance portion of the Medicaid Deficit Assessment was removed from law after 2016. In reviewing the law as it is currently written, the HSCRC and the Maryland Department of Health have the authority to abandon the remittance portion of the Medicaid Deficit Assessment so long as the total assessment remains as $294,825,000.

We appreciate concerns from the Maryland Medicaid program around long-term implications of this policy. However, the recommendation is a one-time only action, and is certainly justifiable when hospitals are experiencing unprecedented financial struggles and the Maryland Medicaid program is experiencing unprecedented financial surplus due to funds through the public health emergency.

Taking Corrective Actions Without Addressing Underlying Issues with the Model is Problematic

In addition to pursuing corrective action and as JHHS noted in our previous comment letter on potential corrective action, we also encourage the HSCRC and the industry to pursue a thoughtful evaluation of the policies within the TCOC Model that are improving patient care and those that are not. We must address the systemic problems within the Maryland Model and the Global Budget Revenue (GBR).

To this end, JHHS must reiterate our concerns around the issue of retained revenue and the need for a rational population-based and clinical needs approach to right-sizing bed capacity, especially in Baltimore City where the population has experienced a decline. There is a need for clear and updated policies and guidance on the impact of retained revenue on volume reduction. Data indicate that since the implementation of GBR, hospitals with retained revenue have seen an overall decrease in volume, not just potentially avoidable utilization (PAU). There is no data at this time to indicate that hospitals with decreased volume and retained revenue have achieved that decrease through population health investments – instead, this may have been achieved simply through the elimination or reduction of services:

- Recent Vizient and Sg2 data show that nationally, staffed beds at community hospitals declined by 3%, while Maryland has experienced a 17% decline in staffed beds at community hospitals. Simultaneously, AMC beds have grown 9% nationally, while in Maryland, AMC staffed beds remain stagnant.
- Nationally, community hospitals are shrinking; the revenue from these hospitals is being shifted to the hospitals that provide medically necessary care for those patients. However, in Maryland, this shrinkage is accelerated, while most of the revenue remains with the hospitals closing beds.
- Additionally, the population of Baltimore City is shrinking; the Baltimore City population was 576,498 in 2021, a 7.2% decrease from the population of 620,942 in 2010. As community hospitals are operating at a fraction of their fixed capacity and are projected

to see fewer inpatients over time, it is clear that their long-term role in the care continuum is changing.

- The Maryland Model should support hospitals that either deliver medically necessary care or serve as a vital resource to a community – like in more rural areas. The model should not protect and insulate hospitals from bed declines that are either deliberate or the result of population shifts.
- The HSCRC should investigate and explore potential regulatory opportunities regarding length of stay (LOS). The current regulatory environment in Maryland has resulted in challenges related to getting patients admitted into long-term care facilities, which in turn increases LOS, particularly for complex patients.
- The HSCRC should also explore regulatory opportunities related to skilled nursing facilities (SNFs). Due to low Medicare Advantage penetration in Maryland, there is very little utilization management, resulting in more SNF bed days in Maryland compared to the nation. This becomes a crucial consideration as we evaluate total cost of care performance compared to the nation.

In order to achieve the goals of the model and deliver ongoing savings, the HSCRC must develop policies that – instead of recognizing all volume reduction – only recognize volume reductions associated with PAU or due to population health related programs. Some HSCRC staff have publicly indicated that the Maryland Model and the GBR are designed to reward any volume reduction. This is a reckless policy perspective that offers to incent rationing of health care services. Additionally, given that Maryland is benchmarked against the national Medicare spend, with a requirement to ensure Medicare fee-for-service total cost of care grows less than the nation, the current approach to retained revenue is counter-productive. While in other states, hospitals with declining overall volumes may otherwise close, in Maryland they remain open, adding to the state's total cost of care, hindering progress on the benchmark, and limiting investments at hospitals still providing needed care to the community.

JHHS, like many other hospital partners and policy makers, believes that the Maryland Model is intended to incentivize thoughtful investments in community and population health strategies that will produce the long-term outcome of reduced hospital utilization through lower rates of chronic conditions, improved health, and addressing the underlying social determinants of health (SDOH). There is a critical need to rebalance the system with longer-term policy corrections in order to achieve savings targets along with population health goals. JHHS remains firm in its belief that the goals of the model cannot be achieved over a 10-year period without directly reinvesting retained revenues in population health, creating quantifiable savings and investments. Population health investments should be strategic and regional with the initial focus on jurisdictions with higher rates of poverty and health disparities. As JHHS has noted in previous comment letters, industry-wide savings targets will be increasingly hard to reach if all retained revenue is allowed to stay within the system. Locking retained revenue in facilities that no longer provide clinical care will also greatly limit the state's ability to invest in the types of transformative strategies that CMMI is expecting, namely housing and SDOH-focused interventions.

JHHS believes that corrective action needs to be pursued in order support the long-term viability of the Maryland Model. However, we also believe there are fundamental issues with the Maryland Model's policies and methodologies that hinder the State and industry from achieving our goals and financial targets. In order to achieve these goals, it is necessary to implement longer-term policy corrections that address retained revenues and inappropriate volume reductions. JHHS would

encourage the HSCRC to begin work in January to realign the existing incentives within the Model, with the goal of implementing a comprehensive approach that addresses the underlying challenges of the current Model and places Maryland on a stronger path to success.

JHHS appreciates the opportunity to comment on the draft recommendation and longer-term policy corrections that may be required of the State and the industry.

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, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, R.N.
Katie Wunderlich
Maulik Joshi, Dr.P.H.
James Elliott, M.D.
Sam Maholtra

April 12, 2023

James Elliott, M.D.
Commissioner; Chairman of Physician Engagement and Alignment Workgroup
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Elliott,

The Johns Hopkins Health System (JHHS) appreciates the opportunity to provide input on the draft Total Cost of Care Model Progression recommendations proposed by the Physician Alignment and Engagement workgroup. As outlined in the workgroup's draft recommendation letter, the discussions have centered on modifications to the Episode Quality Improvement Program (EQIP), the Maryland Primary Care Program (MDPCP), and new programs to engage specialty providers, such as behavioral health, emergency physicians, and hospital-based physicians.

JHHS has strong participation in EQIP, with providers currently enrolled in 15 episodes. While the program has potential, the performance data to date has been limited. The program began in January 2022; providers began to see the first quarter of performance data in late fall of CY22, and the data for half of the first performance year, CY22, remains incomplete and has not yet been released. Given the incomplete data, JHHS believes further assessment of the program is needed before the program can be relied upon as a cornerstone for the next phase of the model. For both EQIP and MDPCP, JHHS urges the Health Services Cost Review Commission (HSCRC) to exercise caution as they consider aggressively expanding programs for which outcomes and impact are not yet fully understood.

The Physician Alignment and Engagement workgroup has also discussed the concept of a Global Budget Revenue (GBR) model for emergency physicians in Maryland. This is a new concept that has not yet been fully internally vetted; however, the current GBR model creates many distortions in care delivery. For the six years prior to the onset of the pandemic (2014-2019), Maryland was able to achieve significant utilization declines, but both the drivers and value to the Model of those declines and the resulting retained revenue remains unclear. The HSCRC's current policies do not differentiate between health management and simply discontinuing services, and there is no data at this time to indicate that the bulk of hospital utilization declines prior to the pandemic were achieved through care transformation or investment in addressing community needs. Instead, **all** volume reductions are rewarded as a positive outcome and there is limited accountability for continuously investing retained revenues in care transformation or improving health outcomes. JHHS believes the distortions in the current GBR model must be addressed before the HSCRC can consider expanding the model to the Emergency Department or other areas.

JHHS appreciates the efforts of the workgroup to generate policy recommendations to promote physician alignment and engagement for the next phase of the Model. As the Total Cost of Care Progression discussions continue, JHHS looks forward to the opportunity to collaborate with the HSCRC and workgroups to further the goals of the Maryland Model.

Sincerely,

Nicki McCann, J.D.
Vice President, Provider/Payor Transformation
Johns Hopkins Health System

May 9, 2023

Will Daniel
Deputy Director, Payment Reform
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Daniel,

The Johns Hopkins Health System (JHHS) appreciates the opportunity to provide input on the draft Total Cost of Care Model Progression recommendations related to cost-containment and financial targets as discussed in the Total Cost of Care Workgroup.

Global Budget Revenue (GBR) 2.0

JHHS is supportive of the development of variations of GBR for different types of hospitals or different geographies of hospitals. GBR 2.0 is an example of this type of variation of GBR; JHHS is supportive of this recommendation if participation is purely voluntary and if participation is a fit for the hospital providing these services. Additionally, hospitals who elect not to participate should not be penalized through this policy or other related policies. JHHS also encourages the HSCRC to ensure effective safeguards are in place so GBR 2.0 does not create additional distortions in the model.

Supplemental Benefits

While using a portion of Medicare savings to provide supplemental benefits to Medicare beneficiaries is a worthy aspiration, this recommendation would use rate setting dollars to create an infrastructure that already exists through Medicare Advantage. If the goal is to create greater access to vision and dental benefits for Medicare beneficiaries, the state would be better served using these funds to supplement Medicare Advantage in Maryland. The concept of using savings under retained revenue for a dedicated purpose has merit and should be explored further. However, creating an infrastructure that is duplicative of Medicare Advantage is not the best use of resources.

The HSCRC should also consider the implications of linking additional benefits to savings; in the case where savings targets are potentially not met, these supplemental benefits would then be at risk, creating disruptions in care for patients and providers. Further, there is a level of complexity required to implement such a recommendation that is beyond the authority of the HSCRC. For these reasons, JHHS is not supportive of advancing this recommendation.

Reducing Cost Sharing

JHHS is not supportive of the concept of reduced Medicare cost sharing. JHHS agrees that the GBR effect and the increased burden for Medicare beneficiaries are distortions of the model; however, to address these distortions, JHHS believes the HSCRC should address retained revenue and excess capacity issues. This approach would more directly impact Medicare beneficiaries, and would be more effective for the model's long-term success. Additionally, significant contributors to price variability are the mid-year GBR targets and mid-year adjustments; this is within the scope of the HSCRC, and not the hospital industry.

JHHS appreciates the efforts of the workgroup to generate policy recommendations regarding cost-containment & financial targets for the next phase of the Model. As the Total Cost of Care Progression discussions continue, JHHS looks forward to the opportunity to collaborate with the HSCRC and workgroups to further the goals of the Maryland Model.

Sincerely,

Nicki McCann

Nicki McCann, J.D.
Vice President, Provider/Payer Transformation
Johns Hopkins Health System

Kevin W. Sowers, MSN, RN, FAAN

President
Johns Hopkins Health System

Executive Vice President
Johns Hopkins Medicine

May 24, 2023

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

Dear Chairman Kane,

On behalf the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the staff recommendation on the FY24 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.

Demographic adjustment

JHHS is in agreement with the staff's recommendation regarding the demographic adjustment. We believe that it is important, in a population health-based system/model to ensure that demographic changes are appropriately funded. JHHS thanks the HSCRC for their commitment to resolve any additional funding the Commission should provide to account for the ten-year forecasting error that occurred in the preceding decade and making sure hospitals are fully funded for demographic changes moving forward. We look forward to participating in those discussions and methodology development.

Lack of alignment with the purpose of the update factor

JHHS is concerned with the proposed recommendation, as it is not consistent with the purpose of the update factor as stated by the HSCRC, nor the goals of the Maryland Model. According to the draft recommendation, the purpose of the update factor is to "provide hospitals with reasonable inflation to maintain operational readiness and to keep healthcare affordable within the State of Maryland[1]." The recommendation as currently proposed is inconsistent with the purpose of the update factor.

[1] Health Services Cost Review Commission. (May 10, 2023). *Draft Recommendation for the Update Factors for RY 2024.*

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Generally, the update factor is applied evenly across all hospitals regardless of volume and capacity. Hospitals with low volume or retained revenue receive inflation beyond their operational needs. These hospitals receive inflation and funding for volumes, patients, and costs that do not currently exist.

Some stakeholders and staff believe inflation should be distributed evenly because retained revenues should be dedicated to population health investments. However, there are no data or outcomes to support that these investments have been made with retained revenues. Certain Baltimore City hospitals have the highest representation of retained revenue, yet represent some of the greatest health disparities in the state. Analysis of Baltimore City multi-visit patients indicates that 33,895 high utilizers[2] in Baltimore City represented 21% of unique patients from the city, and represented 57% of total hospital charges; this population generated $1.2B of the $2.2B of total hospital charges, with the most common chronic conditions being hypertension, chronic kidney disease, and mental health diagnoses, among others. Zip code analyses of Baltimore City demonstrate that the highest concentration of high utilizers and multi-visit patients can be found in zip codes that surround hospitals with retained revenues. There is no evidence that hospitals with retained revenue are engaged in meaningful population and community health strategies and investments.

This issue has compounded over time, and must be resolved over a number of years in order to stabilize the model. Fully inflating retained revenue for the period of 2014 through 2019 has contributed over $140M in excess cost to the Maryland Model, however applying a 50% variable cost factor would reduce the excess amount to $70M.

Impact on affordability for patients

Furthermore, the overfunding of inflation at hospitals with low volumes and retained revenues impacts affordability for patients who seek care at those hospitals; patient bills are inflated to ensure the hospital can then meet its global budget revenue (GBR). JHHS urges the HSCRC to continue to prioritize affordability for patients, and to consider the impact of this recommendation as proposed.

Funding of inflation

While historically this process may have worked well for the industry, hospitals are currently operating in extraordinary circumstances with unprecedented nursing and staffing costs due to COVID-19 and its ongoing impact. It is critical for hospitals providing medically necessary care to be appropriately funded for the previous two years. JHHS urges the HSCRC to provide further support to hospitals in these extraordinary circumstances. The HSCRC has expressed legitimate concerns that there must be a conservative approach to the update factor due to the need to achieve our model savings targets. However, there is sufficient capacity to provide a reasonable update factor that fully funds inflation for hospitals that are providing medically necessary care if strategies are pursued to address retained revenue.

Lack of alignment with the goals of the Maryland Model

[2] Defined as 3+ inpatient/emergency department/observation visits within the year; based on FY21 analysis

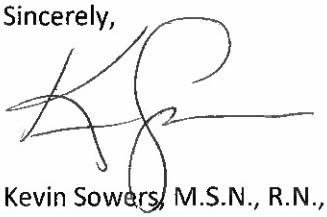
As proposed, the recommendation reflects the fundamental concerns that JHHS has repeatedly expressed regarding the direction and goals of the Maryland Model. As designed by CMMI, the model is intended to be a population health model in which targeted population health investments lead to improved health outcomes and reduced hospital utilization in certain diseases or communities, while controlling for cost and quality. However, as JHHS has previously noted, the model currently rewards any and all volume reduction, regardless of how this reduction was achieved. Hospitals that reduce or entirely eliminate services are rewarded, while hospitals that provide medically necessary care – or take on volume that was shed by other hospitals – are penalized. This approach does not align with the goals of the model, and the repeated application of inflation to retained revenues only serves to further the distortions that currently exist in the model.

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, because the hospital industry remains unstable and uncertain in the aftermath of the COVID-19 pandemic, retained revenue should be assessed for pre-COVID model performance years (2014-2019). JHHS believes that these recommendations will allow the HSCRC, the State, and the healthcare industry at large to further align with the total cost of care goals.

Thank you for the opportunity to share comments and concerns both written and at the Commission meeting. 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, Ph.D., Vice Chairman
Victoria W. Bayless
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June 21, 2023

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

Dear Chairman Kane:

On behalf of the Johns Hopkins Health System (JHHS), representing our 4 Maryland hospitals, we appreciate the opportunity to comment on the commission's Draft Recommendation on Modifications to Efficiency Policies: Full Rate Application, Integrated Efficiency Methodology, and Capital Financing. First, we would like to thank staff for continuing to consider feedback from the industry in the revisions to HSCRC policies. One of the hallmarks of the rate setting system has always been its evolutionary nature that allows the methodologies to continue to be refined as new information becomes available and the development of this policy has shown the staff's commitment to continuing that process.

JHHS supports the proposal to adjust hospital revenues for efficiency. We also believe that it is appropriate to have both a Price Efficiency metric as well as a Total Cost of Care (TCOC) metric included as part of the methodology. Measuring efficiency in a fixed revenue environment is challenging, and we appreciate the HSCRC staff's approach to balance price efficiency with hospital specific, per capita TCOC performance.

Policy Goals and Objectives, and Methodology Application

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

JHHS also believes that the efficiency policy should be revenue neutral on a statewide basis. If high-cost hospital's revenues are reduced, the full sum of this reduction should be available within the system and no portion should be withheld. We appreciate the HSCRC staff's consideration that allows low-cost outliers to apply for increases and other proposed uses of savings.

Application of Efficiency Adjustment on a One-Time Basis

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

Application of a Productivity Offset

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

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

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

Revenue for Reform Credit

JHHS supports the staff recommendation to allow for an offset to any inflation withhold for qualifying population health investments. We believe that a core principle of the TCOC system was for hospitals to reinvest GBR saving back into population health programs. However, we do believe that there should be some limit to how much of the dollars identified through the Efficiency Policy can be offset. Additionally, the policy as drafted does not address retained revenue that has accumulated since the inception of GBR. The Regional Entity Safe Harbor should be explored as an opportunity to redirect retained revenue that should but have not been invested in population health programs. Accumulated retained revenue within a geographical region could support the launch and operations of a Regional Entity that addresses the social and medical needs of multi-visit patients within a region.

Finally, we believe that this and all methodologies need to be reviewed and revisited on a regular basis to assure that the underlying methodologies are keeping in sync with the goals of the new model and to provide refinements where needed.

Thank you again for your consideration and thanks to the HSCRC staff for all of their efforts in crafting a policy on this very complex matter. If you have any questions, please feel free to contact me.

Sincerely,

Ed Beranek

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

July 6, 2023

Allan Pack, PhD
Principal Deputy Director, Quality Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dr. Pack,

On behalf of the Johns Hopkins Health System (JHHS), thank you for allowing input on the Emergency Department Dramatic Improvement Effort (EDDIE) proposal. Given that Emergency Department wait times across Maryland are among the highest in the nation, JHHS agrees that the root causes of these wait times must be understood and addressed. JHHS appreciates the opportunity to continue partnering with the HSCRC on issues that meaningfully improve the health and outcomes of Marylanders.

As proposed, the EDDIE initiative involves collecting data from each hospital on the following metrics:

- ED1 Median Time (in minutes) from ED Arrival to ED Departure for Admitted ED Patients
- OP-18 Median Time (in minutes) from ED Arrival to ED Departure for Discharged ED Patients
- EMS turnaround time – collected by MIEMSS

JHHS's comments and feedback are detailed below:

EMS turnaround time

We agree with the measure specification of the EMS turnaround time. Assuring timely transfer of care of emergently ill patients is essential to good clinical outcomes. Using the benchmark of 30 minutes to transfer 90% of patients was felt to be reasonable by our clinical experts. This measure also ensures that outlier events are not overweighted by using 90% of all cases as the threshold.

Behavioral Health

We agree with stratifying the ED-1 and OP-18 measure by behavioral health versus non-behavioral health patients. There are significant differences in availability of medical and behavioral health resources and it is important to understand the pressure points of each separately.

Metrics

JHHS suggests the incorporation of additional meaningful metrics that provide insight into the root causes of ED wait times. While the selected ED-related measures serve as a proxy for system throughput and capacity, these measures do not provide the complete picture. Consider other indicators of capacity to target for improvement such as inpatient length of stay (separated into patients discharged to home and post-acute care), length of time to admit a patient to a skilled nursing facility/nursing home, length of time to transfer patients to tertiary and quaternary care, length of time to place behavioral patients into a psychiatric inpatient bed, ICU or PACU boarding times, *et al.*

Implementation time

While we appreciate the urgency to understand this issue, 4-6 weeks may not be an adequate timeframe for hospitals to shift resources and re-invigorate EMR algorithms to report these measures. We encourage the HSCRC to solicit hospital feedback on a more reasonable timeframe.

Understanding root causes

JHHS shares the HSCRC's position that Maryland ED wait times must be addressed, and looks forward to collaborating on further understanding the drivers of ED wait times by using complementary measures. JHHS asks for help from the HSCRC in understanding the root cause of these wait times and not just improving our measurement of the symptoms. More specifically, we would like to ask the HSCRC to help evaluate:

- the correlation between ED wait times and inpatient bed availability
- the correlation between geographic area and ED wait time (suggesting there may be a greater need for regional resource investment outside of the ED). Our JHHS data suggests there is considerable variability in ED utilization in Baltimore City compared to outside the city.
- the correlation between ED wait time and regional population density
- the correlation between ED wait time and specific social determinants of health
- the correlation of Maryland ED wait times by region compared to national based on population per licensed inpatient beds.

Alignment of nomenclature

JHHS suggests that the HSCRC consider the framing and nomenclature related to ED wait time initiatives as this work continues. Framing our short-term efforts as the "ED Dramatic Improvement Effort" suggests that lengthy wait times are related to ED operations or structure when they are instead a proxy measure to upstream demand and capacity factors. JHHS suggests the name of this effort be revised to "Hospital Capacity & Occupancy Enhancement Throughput Initiative," or a similar name. We believe this better reflects where improvement is required to successfully impact wait times associated with ED visits or patient transfers among hospitals.

Long ED wait times cause patient harm, distress, dissatisfaction, and safety issues, stresses an already burdened clinical team, and impacts hospital performance. However, ED wait times are a composite endpoint of many healthcare and public health factors that cannot be solved by hospitals alone. It is imperative that there be a coordinated approach to improve ED utilization that addresses availability of behavioral health and substance abuse resources, availability of post-acute resources, housing and food insecurity resources, medication cost reform, length of stay issues, primary care and alternate provider sites that are available evenings and weekends, medical inpatient beds, as well as coordinated radiology and lab services so that patients can have a comprehensive timely evaluation. While reporting of wait measures may be a starting point for evaluation, focusing on emergency department measures alone will not solve many of the underlying issues. As discussions regarding wait time and capacity measurement continue, the input of the industry and clinical experts will be critical. We look forward to partnering with the HSCRC and other public health agencies to improve timely access and improved outcomes for Marylanders.

Sincerely,

Peter Hill, MD
Senior Vice President Medical Affairs
Johns Hopkins Health System

cc: Adam Kane, Esq., Chairman
Joseph Antos, PhD
Nicki McCann, JD
Ricardo Johnson, JD
Maulik Joshi, DrPH
James Elliott, MD
Joshua Sharfstein, MD

October 24, 2023

William Henderson
Principal Deputy Director, Medical Economics and Data Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Henderson,

On behalf the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the Medicare Performance Adjustment (MPA) and Care Transformation Initiatives (CTIs). JHHS's comments are outlined below.

1. Given the challenge of timeliness of data due to claims run out, JHHS agrees that it is difficult for hospitals to predict or adjust performance based on data. JHHS supports the recommendation to limit downside risk. A maximum liability threshold will support the longer-term stability of the program.
2. Under the current policy, hospitals with sizable Medicare revenues must generate significant numbers of episodes in their CTIs in order to hit the minimum savings rate and, therefore, perform well in the program. Further, any CTI savings are offset by a statewide MPA cut, which is also calculated based on a hospital's share of statewide Medicare revenue. The linkage of these policies to Medicare revenue disproportionately impacts the state's academic medical centers (AMCs) compared to others in the state, because AMCs receive patients from across the state due to the regional and national programs they support. This provides less opportunity to engage in and impact longitudinal care or outcomes for some patients who reside outside of the immediate area of the hospital.
3. JHHS encourages the HSCRC to apply learnings from evaluation of the first year of the program, and consider narrowing the thematic areas of the program and/or revise selection criteria to assist hospitals with program planning and guidance on future investments in population health.
4. Given the overlap with other policies, JHHS recommends that the HSCRC conduct an analysis to determine if payments are duplicated by the CTI process with other pay for performance programs.
5. A hospital's ability to influence the MPA remains unseen at this time. Therefore, JHHS believes the MPA risk should not be increased until there is further data and clarity on this issue.

JHHS appreciates the HSCRC's consideration of the above comments related to the MPA and CTIs, and looks forward to continued participation and collaboration on these programs.

Sincerely,

Ed Beranek

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

cc: Joshua Sharfstein, MD, Chairman
Joseph Antos, PhD
Nicki McCann, JD
Ricardo Johnson, JD
Maulik Joshi, DrPH
James Elliott, MD
Adam Kane, Esq.,

December 1, 2023

William Henderson
Principal Deputy Director, Medical Economics and Data Analysis
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Henderson,

On behalf the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the Medicare Performance Adjustment (MPA) CY2024 draft recommendation. JHHS's comments are outlined below.

Increasing revenue at risk to 2%

JHHS recognizes that this proposal to increase revenue at risk is moving forward at the request of the Centers for Medicare and Medicaid Innovation (CMMI). While the revenue at risk through the MPA may increase to 2%, the levers to meaningfully influence performance under the policy are not yet well understood by the industry, and the increased risk will not necessarily improve performance. JHHS encourages further communication with CMMI to ensure clarity that hospitals' ability to influence the MPA is currently limited. While the MPA aims to implement hospital accountability, the methodology and data challenges prevent the MPA from being a mechanism that truly impacts total cost of care.

Add population health measure

While JHHS appreciates the HSCRC's increased focus on meaningful population health interventions, the current proposal for an inpatient diabetes screening measure should be further considered and requires greater engagement and input from the clinical community. The inpatient screening measure proposal is significantly improved from the proposal to screen in the emergency department; however, many providers continue to express concern about the validity and efficacy of the measure. The inpatient screening measure offers tremendous promise to improve population health through identification of undiagnosed diabetes, yet there are legitimate concerns that without appropriate community resources to address diabetes, the screening measure will fall short of reaching full potential. If the opportunity to connect with community resources remains limited, the policy may also lead to overtesting and adding cost to the system without ensuring the value of testing for patients. JHHS recommends continued engagement with clinical experts to gain support and develop criteria around patients to be excluded from the measure as clinically appropriate, and understand any unintended consequences of putting

this proposal into operation may have on our systems. Efforts should continue to be invested to advance tools within CRISP to both monitor patients who have been tested and offer community resources available to help patients address their diabetes.

CTI Program Revision: Cap downside risk at 2.5%

JHHS is supportive of limiting the downside risk in the CTI program. JHHS appreciates staff's recognition that it is difficult for hospitals to predict or adjust performance given the challenge of timeliness of data due to claims run out. A maximum liability threshold will support the longer-term stability of the program.

CTI Program Revision: Reintroduce CTI buyout

JHHS agrees with staff's proposal to reintroduce the Care Transformation Initiatives (CTI) buyout. Given that hospitals implement targeted interventions for specified populations, JHHS appreciates that the buyout policy recognizes a hospital's greater ability to impact CTI populations.

Further, due to the complexity of the CTI methodology, JHHS encourages greater education on CTIs generally to allow for a deeper understanding of the policy within the industry.

Additional comments

Additionally, under the current CTI policy, hospitals with sizable Medicare revenues must generate significant numbers of episodes in their CTIs in order to hit the minimum savings rate and, therefore, perform well in the program. Further, any CTI savings are offset by a statewide MPA cut, which is also calculated based on a hospital's share of statewide Medicare revenue. The linkage of these policies to Medicare revenue disproportionately impacts the state's academic medical centers (AMCs) compared to others in the state, because AMCs receive patients from across the state and country due to the regional and national programs they support. This provides less opportunity to engage in and impact longitudinal care or outcomes for some patients who reside outside of the immediate area of the hospital.

JHHS appreciates the HSCRC's consideration of the above comments related to the CY2024 draft MPA recommendation, and looks forward to continued collaboration on these programs.

Sincerely,

Ed Beranek

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

cc: Joshua Sharfstein, MD, Chairman
Joseph Antos, PhD
Nicki McCann, JD
Ricardo Johnson, JD
Maulik Joshi, DrPH
James Elliott, MD
Adam Kane, Esq.,

December 1, 2023

Joshua Sharfstein, MD
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dr. Sharfstein,

The Johns Hopkins Health System (JHHS) appreciates the opportunity to provide comments as Maryland considers participation in the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. In alignment with the goals of the Maryland Model, the AHEAD Model seeks to improve the total health of a state population and lower costs across all payers. The AHEAD Model contains many components that build upon the tenets and structure of the Maryland Model, and offers the opportunity to translate learnings from Maryland to other states across the nation.

As the Center for Medicare and Medicaid Innovation (CMMI) plans to implement the AHEAD Model, and as Maryland considers the next phase of the Total Cost of Care Model, JHHS offers the attached whitepaper that comments on the current distortions that exist within the Maryland Model. In order for the AHEAD Model to successfully build upon the learnings from the Maryland Model, JHHS believes these distortions must be addressed, and offers recommendations in the attached.

JHHS looks forward to the evolving discussions about the future of healthcare delivery in Maryland, and further collaboration with the Health Services Cost Review Commission, the Maryland Department of Health, and stakeholders across the industry.

Sincerely,

Ed Beranek

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

cc: Adam Kane, Esq.
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James Elliott, MD
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*Reforming Maryland's Model Whitepaper was submitted along with this letter; see Whitepaper #1 from April 2023 in this document.

January 5, 2024

Geoff Dougherty
Deputy Director, Population Health
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Dougherty,

On behalf the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the Emergency Department Potentially Avoidable Utilization (ED PAU) policy. JHHS supports the concept of developing strategies and accountability for multi-visit patients (MVPs), and encourages the development of policies that align with the intent of the Maryland Model. JHHS's comments and concerns regarding the ED PAU recommendation are detailed below.

JHHS agrees that hospitals should be actively engaged in addressing the needs of multi-visit patients. However, JHHS is also concerned that the current recommendation is singularly focused on hospitals without any effort or intention to engage state and local government as well as Medicaid fee-for-service and Managed Care Organizations and insurers, who are paid to manage the care of the members they serve. Commercial insurers remain the biggest benefactors of the Maryland Model, and their contribution to issues such as ED PAU should be required and measured. Collaboration and accountability for MVPs should extend beyond hospitals alone to generate meaningful change and improvement for Marylanders. As noted by the HSCRC and Maryland Department of Health in the 2016 Population Health paper submitted to CMMI, socio-economic factors such as housing, employment and education account for 40% of health care cost and utilization. Hospitals alone cannot address the lack of focus and investment in these socio-economic factors.

Though the current recommendation is reward-only, it is also crucial to note that the policy as written may have unintended consequences that are similar to other distortions that exist under the Maryland Model. As JHHS has previously noted, the model currently rewards any and all volume reduction, and views all ED volume as addressable. However, there is and will continue to be some ED MVP utilization that is appropriate and medically necessary. Within the current model, hospitals that reduce or entirely eliminate services are rewarded, while hospitals that provide medically necessary care – or take on volume that was shed by other hospitals – are penalized. This approach does not align with the goals of the model, and could be further exacerbated by the ED PAU policy, as the proposed policy could potentially reward hospitals that limit access to care. Further, the policy does not recognize

patient preference and experience. JHHS's analyses reflect that some MVPs travel farther to seek care at specific hospitals, while others do not have the option to seek care elsewhere. JHHS urges staff to account for these additional distortions and considerations when revising the current ED PAU recommendation.

JHHS recommends that staff initiate an ED PAU policy that is limited and more intentionally focused on a single disease that truly represents avoidable care. This policy should require collaboration across multiple stakeholders, including hospitals, state and local government, commercial insurers, and MCOs. Additionally, hospitals should report on their strategies to address MVP utilization to ensure hospitals who may perform well under the policy are not achieving positive results by limiting access in order to decrease volumes. If the policy is more intentionally focused on addressable ED MVP volume, the HSCRC and the industry can then use lessons learned from the initial policy to address additional diseases or conditions in future years. While behavioral health represents the greatest opportunity to improve care for MVPs, it is important to note that the MCOs and hospitals have limited opportunity to improve care for this population under Maryland's existing Medicaid financing for behavioral health. Behavioral health is carved out of MCOs and generally "unmanaged" for the Medicaid population, which accounts for 40% of ED MVPs. Strategies to improve behavioral health care for MVPs should include a fully integrated Medicaid program.

JHHS appreciates the efforts and partnership of the HSCRC staff as the Commission and industry seek to develop intentional strategies to support the needs of multi-visit patients. While supportive of the intent of the policy, JHHS encourages a thoughtful approach to ensure new policy methodologies align with the goals of the Maryland Model, and looks forward to further discussion and collaboration on this policy.

Sincerely,

Peter Hill, MD
Senior Vice President - Medical Affairs
Johns Hopkins Health System

cc: Joshua Sharfstein, MD, Chairman
Joseph Antos, PhD
Nicki McCann, JD
Ricardo Johnson, JD
Maulik Joshi, DrPH
James Elliott, MD
Adam Kane, Esq.,

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

JOHNS HOPKINS
MEDICINE

June 5, 2024

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

Dear Dr. Kromm,

As the State of Maryland works with the Center for Medicare and Medicaid Innovation (CMMI) to negotiate Maryland's participation in the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model, Johns Hopkins Health System (JHHS) would like to outline specific critical issues which must be addressed for the future success of the Model. These are informed by our experience in the current model, discussions with key stakeholders within Maryland and around the country, and the requirements for the long-term sustainability of the healthcare delivery system for the citizens of Maryland.

For your reference, I have included a white paper JHHS previously submitted outlining specific issues with the current Model and making recommendations for improvement. Although JHHS believes each of these issues needs to be addressed, I am writing today to encourage the Health Services Cost Review Commission (HSCRC) to actively engage with JHHS and the broader hospital industry to improve the Model in three key areas prior to finalizing the new agreement with CMMI:

- Establishing a pathway for Maryland's Academic Medical Centers (AMC) that provide tertiary/quaternary care to operate sustainably and thrive under the Model
- Reforming the current volume policies of the HSCRC to support the provision of medically necessary care, and eliminate incentives that reward reductions in access to care
- Rebalancing captive revenue and eliminating excess capacity to promote a more financially sustainable system that better supports the needs of patients

Establishing a Pathway for Maryland's AMCs

Under the current Total Cost of Care (TCOC) Model, 95% of Medicare spending is required to be under a population-based payment model which historically has been met under the Global Budget Revenue (GBR) model. This requirement has placed unnecessary constraints on the growth of highly specialized clinical programs, providing a bifurcated choice for the AMCs to either limit access to care or incur significant financial losses to provide, develop, or expand it.

At their core, GBRs are designed to provide financial incentives to reduce unnecessary utilization. However, many of the services provided by AMCs – namely, highly specialized and complex procedures and treatments – however, cannot be reduced and in fact will need to be expanded with the aging of the population and the development of cutting-edge pediatric treatments. Restricting funding

for these services in Maryland will have the unintended consequence of denying local access for Maryland residents, forcing them to travel out of state for care or forgo it.

Recent data from Vizient demonstrated a 36% and 25% increase in need for inpatient quaternary and tertiary care, respectively, over the next decade, with a 3% decline in low case mix index cases. This aligns with significant growth in staffed beds at AMCs nationally since 2015, with AMC beds increasing 10%, most notably in cancer, cardiovascular services, neurosciences, and pediatrics. This same type of growth to meet patient need and demand is constrained and financially penalized under Maryland's current GBR model.

AHEAD provides a unique opportunity for the HSCRC to reset this requirement with CMMI, given that the financial methodology for AHEAD excludes specific services that are currently included in GBR. This should become the baseline for a new approach, even as JHHS would encourage the HSCRC to push for greater flexibility to carve out from GBR the tertiary and quaternary services provided only by AMCs.

Reforming Current Volume Policies

Over the past decade, the HSCRC has developed a series of policies meant to reward hospitals for reducing utilization and penalizing hospitals for growing it. Like all demonstration models, these policies should be refined over time to ensure that the outcomes being achieved are in line with the intent of the policies. Unfortunately, the current policies have caused a misalignment between patient movement and the resources required to care for them, providing financial incentives to restrict access to care rather than maintain or expand required clinical services. The American Hospital Association reports that post-COVID, 3% of community hospital beds have closed across the nation. In MD, it is reported that we have seen a 17% decrease in these beds, thus creating access issues and requiring patients to leave the State for services.

Some challenges with the current volume policies include:

- **Market shift does not cover the variable cost of services.** Although the policy asserts that variable cost will be funded at 50%, in practice it is significantly less once other adjustments are factored in. Even if the market shift were funded at 50%, in many cases it is unlikely that it would cover the total cost of delivering the care. While the initial intent was to reward organizations for decreasing utilization, over time it has led to the closure of beds and appropriate clinical services required in our communities. Organizations have been financially rewarded for limiting clinical services.
- **Deregulation has not been uniformly enforced.** The deregulation policy is meant to ensure that revenue follows the patient as services shift into the community and to protect payers from paying twice for the same service. This has not been enforced consistently, allowing hospitals to retain revenue for services they no longer provide in the hospital and receive payment again for providing the same service in the community. For example, movement of colonoscopies that used to be performed in a hospital but are now performed in a hospital-owned ambulatory surgery center off campus, without informing the HSCRC of the shift in site of service.
- **All volumes are the same.** As a policy objective, GBR is meant to focus on reducing unnecessary utilization, not all utilization. In practice, GBR and other HSCRC policies have rewarded hospitals that reduce access by allowing them to retain revenue while underfunding hospitals that have seen increased volumes due to patient movement and choice.

- **The financial incentive is to reduce access by closing beds.** Under a capped revenue system that does not allow for margin growth by increasing volumes, hospitals are provided significant financial incentives to reduce overall capacity by reducing staffed beds. This is counter to meeting the needs of patients, particularly in already underserved areas.

The HSCRC and hospital industry need to collaborate to ensure that the incentives of the Model produce the desired outcomes, that there is a clear line between action and result, and that patient access for appropriate required clinical care is maintained.

Rebalancing Captive Revenue and Reducing Excess Capacity

GBRs have remained largely static over the course of the Model, with annual adjustments to reflect inflation, market shift, and other volume and quality related changes over time. Despite Maryland being in the Model for over 10 years, including several years of the COVID-19 pandemic, there has not been a concerted effort to examine each of the hospital GBRs to determine if the revenue provided is still appropriate for the mix of services and patients.

The static nature of the GBRs runs counter to the tenets of patient choice as stipulated in other Centers for Medicare and Medicaid Services' programs (Money Follows the Person) and rewards hospitals in perpetuity for limiting access. By concentrating historic revenue permanently in facilities that provide a fraction of the care from pre-GBR, the policy is effectively limiting needed investments in patient care and maintaining hospitals that would otherwise have been forced to reimagine themselves as freestanding medical facilities or, in other states, closed. It is recognized that Baltimore City has the largest excess bed capacity and also the most retained revenue. In a time when significant investments are needed, not just in hospital-based clinical services but in the broader community to support the population health goals of the Model, the current policy restricts access to hundreds of millions of dollars that could be put to better use.

Conclusion

Although JHHS appreciates the significant work required by the HSCRC to negotiate and execute the AHEAD agreement by November, it is critically important to develop a parallel process to resolve these issues if we are going to be successful in the future Model. JHHS believes it is nearly impossible for it or any system to support the State's financial commitments without an understanding of if and how these issues will be addressed. It is in the interest of the State and Maryland's hospitals to work together to promote a system with clear incentives and outcomes that appropriately invests in clinical care, preserves access, and right-sizes the system over time.

JHHS welcomes the opportunity to collaborate with the HSCRC in the coming months on these important topics and looks forward to working with you on them.

Sincerely,

Kevin Sowers, M.S.N., R.N., F.A.A.N.
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

*Reforming Maryland's Model Whitepaper was submitted along with this letter; see Whitepaper #1 from April 2023 in this document.

June 2024

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

Dear Dr. Kromm,

I am writing on behalf of Johns Hopkins Health System (JHHS) to share our perspective on the Care Transformation Initiatives (CTI) program operated by the Health Services Cost Review Commission (HSCRC) and to offer recommendations for improvements to the program. JHHS appreciates the openness of you and your staff to review input from the hospital industry as you continue to refine existing programs and develop new ones.

As with other Center for Medicare and Medicaid Innovation (CMMI) Demonstration Models, Maryland's Total Cost of Care (TCOC) Model should learn from what has worked well, correct for unintended consequences, and continue to improve and promote programs that improve patient outcomes and reduce cost. As originally envisioned, the CTI program would allow hospitals to identify a specific cohort of patients based on a series of criteria that aligned with a clinical program, providing, at least in theory, a more direct tool to measure TCOC performance rather than solely relying on the Medicare Performance Adjustment (MPA). The financial risk to the hospitals was unclear at the outset given the level of unpredictability regarding the number of hospitals that would participate, the number of CTIs per hospital, and the performance of each of the CTIs.

Reforms to the CTI program are all the more important given the recent changes and performance of the MPA. For Calendar Year (CY) 2024, the amount of risk under the MPA doubled to 2%, with indications that CMMI may be interested in additional increases in the future. This is concerning given the volatility and uncertainty within the MPA, including the disconnect between the savings being generated under the Model and the penalties being applied to the hospitals. For CY 2023, the state generated almost $200 million in TCOC savings beyond the contractual target while the hospitals were penalized ~$24 million for TCOC performance. In addition to changes to the CTI program, the MPA must be examined to ensure that the reward and penalties are aligned with performance.

Maryland now has two years' worth of CTI performance data, allowing for enough experience to determine if certain changes need to be made to the program. Based on this experience, JHHS would like to offer the following recommendations to improve the CTI program:

1. **Institute a coding intensity adjustment cap from the baseline to the performance period.** In the current CTI program, coding changes are not capped from the baseline to the performance period. In Fiscal Year (FY) 2023, certain CTIs had a 20+% increase in

the risk score between the two periods, greatly increasing the TCOC savings that were generated. This lack of a cap is contrary to other TCOC value-based models, including the Medicare Shared Savings Program (MSSP) and commercial payer Accountable Care Organizations (ACO). Instituting a cap would ensure that any savings generated were largely the result of utilization or cost declines rather than coding adjustments.

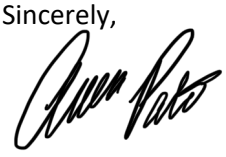
2. **Utilize a panel-based measurement approach rather than intent to treat.** Rather than measuring a hospital's performance based on the patients enrolled in a clinical program and receiving an intervention, the current CTI program measures the TCOC performance on all patients that meet the CTI criteria, regardless if the patient was enrolled in the clinical intervention. This does not consider the significant number of patients that refuse intervention. A panel-based measurement approach would directly identify patients enrolled in programs and allow for a more robust assessment of their effectiveness. Hospitals would still be incented to enroll as many patients as possible under a panel-based measurement approach to drive TCOC savings and maximize CTI performance.

3. **Reduce the amount of Medicare fee for service (FFS) revenue subject to the CTI savings pool.** CTIs are largely focused on interventions – such as primary care, care transitions, and palliative care – that reduce unnecessary utilization. However, the current CTI program distributes the amount that each hospital is required to contribute to the CTI savings pool based on the total amount of Medicare FFS revenue at that hospital, regardless of the mix of services being provided. The Academic Medical Centers (AMC) have large amounts of revenue that is related to tertiary and quaternary care (including transfers from other hospitals), greatly increasing their financial risk under the CTI program and limiting their ability to offset this risk by improving CTI performance by reducing unnecessary utilization. Similar to the HSCRC's policy that treats innovative care provided by the AMCs differently under the Model, the amount of Medicare FFS revenue measured for purposes of the CTI savings pool should be reduced for AMCs to reflect their unique and specialized role in the system.

Given that FY 2024 has not yet been finalized, and that even early results are still very preliminary due to episode lengths and claims runout, JHHS encourages the HSCRC to consider these programmatic changes for the current performance period.

Thank you for the opportunity to provide comments. If you have any questions, please do not hesitate to contact me.

Sincerely,



Aneena Patel, MHA
Director, Provider/Payor Transformation & Affiliations
Johns Hopkins Health System

September 16, 2024

Tina Simmons, MBA, BA, BSN, RN, LSSBBH, CPHQ
Associate Director, Quality Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Simmons,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the Health Services Cost Review Commission's (HSCRC) developing Emergency Department (ED) Best Practices policy. While JHHS agrees with the intent of the policy as it seeks to promote the adoption and expansion of processes aimed at reducing ED length of stay (LOS), JHHS notes the following comments and concerns.

Revenue at Risk

As currently drafted, the plan for this policy is to tie the best practice measures to 1% of inpatient hospital revenue. JHHS urges HSCRC staff to reconsider this percentage. While hospitals do maintain some degree of control over ED LOS and can engage in additional initiatives to improve performance and patient experience, there are a number of factors entirely out of hospitals' control that may impact performance on these measures. Hospitals should not be penalized over measures where control is limited.

The timeline for policy development is tight, and while gathering feedback from the industry in this expedited timeline is critical, this is a significant amount of revenue at risk for a measure developed in such a short time frame. It is necessary to craft these best practices and interventions while considering how to mitigate any harmful unintended consequences before implementing and potentially penalizing hospitals.

Potential Measures

JHHS proposes three categories of measures that could have the impact of improving ED utilization and throughput.

Capacity

1. *Length of Stay:* JHHS recommends a hospital LOS measure that is focused on a patient population for which hospitals have a degree of control over the outcome. This measure could apply to patients who are discharged to home, or patients under certain disease processes. We would suggest a metric tied to Observed over Expected (O/E LOS) for an agreed upon hospitalized patient population. Improvement and attainment targets can be set.
2. *Consistent Monitoring by HSCRC Staff of Staffed and Licensed Beds*: MHCC annual reporting of licensed beds is a good proxy for staffed beds on yearly basis, however some hospitals may reduce and flex up staff throughout the year. Greater transparency and monitoring of licensed, staffed and occupied beds are needed. Additionally global budgets should have greater alignment with licensed beds. Staff could consider a staffed beds measure as a best practice; This measure could include med/surg beds, intensive care unit beds, and potentially pediatric beds if applicable.
3. Related to 1 and 2, a measure which monitors ED boarding hours would be the important leading indicator of improved hospital capacity. Reducing boarding is demonstrated in the ED literature to directly correlate with improved ED LOS and improved ED efficiency.
4. Some measure that shows difficulty in discharge of inpatients such as number of denials to post-acute facilities (or perhaps certain categories of those denials).
5. Some additional best practice and related measures could include:
    - A fully staffed 24/7 observation unit
    - A staffed discharge lounge
    - Deployment (and associated cost) of tools to increase provider efficiency (e.g., scribes, AI notes, voice dictation)
    - Utilization of ED discharge planners
    - Utilization of Inpatient discharge planners + a measure of how many inpatient discharges were identified in the discharge planning portion of Epic for discharge 3 days in advance.
    - Best practices related to Discharge By Noon efforts (e.g., daily discharge labs starting at 5am, reporting DBN rates by unit)
    - In 2019, JHHS created a health system Best Practice Council, where ED leaders convene to develop system-wide policies and programs that optimize care delivery.

Appropriate Utilization

ED throughput can be modestly improved through the use of evidence based best practice guidelines. In 2017, Johns Hopkins Hospital embarked on an initiative to embed ED evidence-based care guidelines in the electronic medical record. To date they implemented 250 guidelines at the point of care, many system-wide. Designed by an interdisciplinary team, the guidelines direct best practice in accordance with current evidence, inform providers about appropriate use of tests, treatments and hospital admissions and include specific operational information to increase efficiency.

Appropriate Social Supports in the ED

Frequent utilization of the ED by individuals in need of social services in common. While these multi-visit patients have an impact on overall utilization, their contribution to ED wait times is minimal. With appropriate social supports in the ED, the multi-visit patients can be screened and discharged rapidly, however it is important to note that the social supports are addressing an unmet need in the community

and may indeed make the ED a more attractive destination for individuals who cannot access community-based resources. While the right thing to do by patient care, these resources may increase ED utilization. Examples include social work in the ED, peer recovery specialists, and other potential best practices where duration and amount would be established through HSCRC process and stakeholder engagement.

The above potential measures would require further consideration and input from industry stakeholders to ensure the policy approach is thoughtful and truly measures outcomes over which hospitals have a degree of control.

Additional Considerations

As JHHS has previously noted in multiple forums and comment letters, an evaluation of inpatient bed capacity should be considered as a key metric in improving ED LOS. ED wait times are generally a reflection of capacity constraints, not ED efficiency. The ability to improve ED LOS will be limited absent transparent evaluation and discussion of bed capacity and its distribution throughout the state and various policies that reward capacity reduction among hospitals.

Thank you for the opportunity to share feedback. JHHS appreciates the HSCRC's collaborative process in the development of these policies, and encourages staff to be thoughtful when determining these measures to ensure patients and providers do not face harmful unintended consequences. The misplaced focus on ED processes and measures as a means to address ED wait times has been distracting at best and dangerous at worst. Maryland is in the bottom of beds per capita in the nation. Under current HSCRC policies, an empty bed is more financially sustainable than a staffed bed. If the state and the HSCRC are truly committed to addressing ED wait times, JHHS strongly encourages swift and comprehensive changes to the current volume policies. Without these changes some hospitals will continue to adjust their staffed beds to meet budget targets, while hospitals who have maintained their commitment to patient care will have no opportunity to address ED length of staff. Continuation of the status quo will exasperate access to care challenges for Maryland citizens. JHHS looks forward to continued collaboration with the HSCRC in pursuit of improved quality, access, and patient experience for Marylanders.

Sincerely,

Peter M. Hill, MD, MS, FACEP
Senior Vice President of Medical Affairs
Johns Hopkins Health System
Associate Professor Emergency Medicine
Johns Hopkins School of Medicine

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott, Vice Chairman
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane

Nicki McCann
Dr. Farzaneh Sabi
Jon Kromm

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

September 10, 2024

Tina Simmons, MBA, BA, BSN, RN, LSSBBH, CPHQ.
Associate Director, Quality Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Simmons,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the Quality Based Reimbursement (QBR) Program's developing Emergency Department Length of Stay (ED LOS) policy.

The approved final recommendation for the QBR Program for RY2026 included an ED-1 EDDIE-like measure in the Patient and Community Engagement domain weighted at 10%; staff noted they would convene a technical workgroup in the first 6 months of the year and then retroactively apply this to the entire calendar year (CY2024). JHHS appreciates the HSCRC's efforts to work with hospital and industry stakeholders throughout the measurement development process; however, given that we are currently over 9 months into the calendar year, this retrospective application is no longer feasible. Hospitals have been in the measurement period for the majority of the calendar year while the policy is not yet finalized, meaning hospitals' ability to impact the measure has been limited.

JHHS proposes that staff consider creating a moderated LOS measure for the current calendar year while planning for the implementation of the full ED LOS measure and financial accountability metrics for C2025 or CY2026. For example, if a hospital performs 5% unfavorably on throughput, the loss would be capped at some amount, if around 0%, no penalty or reward, and if 5% favorable performance, a capped reward. This approach allows for some implementation of an accountability measure without unduly penalizing or rewarding hospitals for performance on a measure that remained unknown throughout the majority of the performance period.

Thank you for the opportunity to share feedback. JHHS appreciates the HSCRC's collaborative process in the development of the ED LOS measure, and looks forward to continued collaboration in pursuit of improved quality, access, and patient experience for Marylanders. JHHS continues to advocate for evaluation of bed capacity as a key metric in improving ED LOS. ED wait times are generally a reflection of capacity constraints, not ED efficiency. The ability to improve ED LOS will be limited absent transparent evaluation and discussion of bed capacity throughout the state and various policies that reward capacity reduction.

Sincerely,

Peter M Hill, MD, MS, FACEP
Senior Vice President of Medical Affairs
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Associate Professor Emergency Medicine
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cc: Dr. Joshua Sharfstein, Chairman

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September 26, 2024

Dr. Jon Kromm
Executive Director
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4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm,

Thank you for the opportunity for Johns Hopkins Health System (JHHS) to provide comments to the Health Services Cost Review Commission (HSCRC) on the process for hospitals that are experiencing financial hardship to apply for additional funding.

As we stated in our financial hardship request for JH Suburban Hospital, JHHS believes that significant, prolonged financial hardship is a justifiable reason to consider additional funding. In general, we agree with the HSCRC's intention to evaluate the driving issues for potential funding, particularly in an environment where we are generating savings well exceeding requirements. To the extent that hardship is linked to the volume pressure of maintaining access or meeting need, we must ensure that hospitals are adequately positioned to meet those needs and that we are not prioritizing excess savings over maintaining access to necessary care. We believe that some of these financial hardships are driven by HSCRC policies that are not operating as intended at an individual hospital level. If these policy issues are not addressed at the State level (prior to the movement into the AHEAD model) we will continue to have hospitals experiencing financial distress.

Policies should ensure that there is adequate reimbursement for medically necessary care by allowing funds to "follow the patient". They should differentiate between unnecessary hospital utilization and medically necessary care. The HSCRC should develop a monitoring framework that prevents restrictions in access to care or identifies them for regulatory action. They should also develop a process to address excess hospital capacity to ensure resources are allocated to best meet community needs. We would be happy to work with the industry and the HSCRC on the development of these policies.

As you consider how to address the many financial hardship requests, we believe that the available funding pool is defined by the room we have within our model targets to address

justified needs, and that we should **not** limit ourselves to temporary funding or arbitrary caps. Instead, financial hardship should be evaluated in the context of qualification (has the hospital shown it is experiencing financial hardship?) and merit (would we consider the driving issues as deserving of relief or funding?).

For the specific requests for comment, JHHS respectfully submits the following:

1. **What constitutes a minimally viable technical proposal?**
    a. **If hospitals reach the standard (i.e., they make it to step 3 of our process which evaluates need and oversight), should they automatically qualify for a portion of the set aside or should there be a minimum threshold in scoring?**

    In general, we view efforts to mathematically score financial hardship requests and predetermined algorithms for distributing hard-and-fast funding amounts as flawed approaches to reviewing financial hardship. If the HSCRC judges a hospital to have adequately demonstrated their financial hardship, either by utilizing the HSCRC's base criteria or by reasonably demonstrating its need, the stated drivers of that hardship should be evaluated on merit, with the goal of providing funding to address justified issues. Considering the significant excess savings currently being generated, the HSCRC has the flexibility to ensure an adequately funded hospital system. This includes addressing drivers of financial hardship that meet both qualification and merit thresholds.

2. **Should some criteria be weighted more favorably in the overall evaluation? For example, should hospital regulated margin be given more weight than total margin?**

    While total operating margin is considered the true metric of the financial health of the organization, it is important to consider the relationship between regulated margin and total margin. The GBR amounts are meant to cover the regulated operations of a hospital and if the GBR is failing to cover those operations, that certainly needs to be considered, especially if the hospital operates other operations not regulated by the HSCRC to help offset some of that shortfall. Likewise, if a hospitals operations are supported by their GBR as evidenced by a positive regulated margin, but other operations are consuming that profit and causing the total profit to be lower, the HSCRC should understand whether those other operations are a cost of doing business or a poor business decision. In our mind, any definition of financial hardship should include an evaluation of both regulated and total margin, both are important in assessing a hospital's financial hardship. Financial hardship associated with providing medically necessary care should be prioritized.

3. **Are there any suggestions for how to allocate the funding? For example, should funds be allocated based on evaluation score, margin and/or days cash on hand, total GBR, or a combination thereof?**

    We want to re-emphasize here that financial hardship requests should be evaluated based on qualification (has the hospital shown it is experiencing financial hardship?) and merit

(would we consider the driving issues as deserving of relief or funding?). We do view financial hardship as a justifiable reason to consider additional funding. However, we view setting arbitrary funding caps and mathematical approaches to distributing limited funds as a flawed approach. If a request has been deemed to meet qualification and merit thresholds, the HSCRC's guiding questions on funding should be (1) how much does the hospital need to address the issue? and (2) do we have the ability to provide that level of funding based on our current understanding of Waiver metrics? This approach is consistent with other evaluation pathways such as full rate applications and GBR enhancements. Given the current magnitude of Waiver savings, the HSCRC should prioritize addressing justified drivers of financial hardship and should not view itself as limited to $31 million of temporary funding.

4. **Should hospitals withhold executive bonuses as a prerequisite for set aside funding?**

   The HSCRC should prioritize evaluating financial hardship requests based on qualification and merit. If additional funding is deemed to meet those thresholds, it should be provided. Executive compensation is controlled by individual hospital boards, and we do not believe it can be handled from a legal perspective through a regulatory manner as it relates to this policy. It is likely that any such action would be met with legal challenges.

5. **Should hospital management be required to outline sustainable reductions in cost to offset funding priorities as a prerequisite for set aside funding?**

   HSCRC staff should evaluate the driving issues and logically assess whether permanent funds are justified or, alternatively, if only temporary funds will be provided with the expectation that the hospital generate sufficient operational efficiency to offset the loss of temporary funds over time. Most hospitals that would qualify for financial hardship are likely actively engaged in aggressive performance improvement initiatives to improve financial performance. A dollar-for-dollar cost reduction commitment should not be required to receive funding that is justified based on merit.

6. **Should hospitals need to make a pledge to not ask for funding for a specific period of time following fund allocations?**

   Once again, we do view financial hardship as a justifiable reason to consider additional funding. As with any funding tool, if a hospital receives sufficient funding to address the request, it is reasonable to set some limits on when the hospital can request further funding for that specific need or funding pathway. Otherwise, a hospital must have recourse if it disagrees with the HSCRC's recommendations.

Thank you again for the opportunity to provide comments on the set-aside process.

Sincerely,

Ed Beranek

Ed Beranek

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
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October 25, 2024

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

Dear Dr. Kromm,

Thank you for the opportunity for Johns Hopkins Health System (JHHS) to provide comments to the Health Services Cost Review Commission (HSCRC) on suggestions for revenue enhancements in rate year 2025 due to savings over administrative target.

Maryland's hospitals and health systems continue to struggle with rising expenses that have significantly increased since the beginning of the pandemic. The operating environment for hospitals and health systems has been difficult. Rising staffing, supply, and drug costs, combined with challenges in recruitment and retention along with many other issues have made this downturn more difficult than previous ones. Hospitals also continue to confront challenges due to rising costs of essential physician coverage and increases in medically necessary volumes at certain facilities.

As we stated in our previous comment letter, JHHS believes that significant, prolonged financial hardship is a justifiable reason to consider additional funding. In general, we agree with the HSCRC's intention to evaluate the driving issues for potential funding, particularly in an environment where we are generating savings well exceeding requirements. To the extent that hardship is linked to the volume pressure of maintaining access or meeting need, we must ensure that hospitals are adequately positioned to meet those needs and that we are not prioritizing excess savings over maintaining access to necessary care. As you consider how to address revenue enhancements in rate year 2025 due to savings over administrative target, we believe that the available funding pool should be defined by the room we have within our model targets to address justified needs, and that we should **not** limit ourselves to temporary funding or arbitrary caps. Instead, financial hardship should be evaluated in the context of qualification (has the hospital shown it is experiencing financial hardship?) and merit (would we consider the driving issues as deserving of relief or funding?).

For the specific requests for comment, JHHS respectfully submits the following:

Should any revenue enhancements due to savings over our administrative target be:

1. **Targeted to an increase in the Set Aside?**

   As mentioned in our previous letter, financial hardship requests should be evaluated based on qualification and merit. We do view financial hardship as a justifiable reason to consider additional funding. However, we view setting arbitrary funding caps and mathematical approaches to distributing limited funds as a flawed approach. If a request has been deemed to meet qualification and merit thresholds, the HSCRC's guiding questions on funding should be (1) how much does the hospital need to address the issue? and (2) do we have the ability to provide that level of funding based on our current understanding of Waiver metrics? This approach is consistent with other evaluation pathways such as full rate applications and GBR enhancements. Given the current magnitude of Waiver savings, the HSCRC should prioritize addressing justified drivers of financial hardship and should not view itself as limited to $31 million of temporary funding.

2. **Applied in a broad-based manner for costs drivers that are not currently funded in rates?**

   While we believe that all hospitals are experiencing cost pressures, we also recognize that not all are experiencing these pressures at the same level or for the same reason and therefore would be opposed to an across-the-board funding for all hospitals. We believe that any funding should be specifically directed to hospitals based on specific need. One potential methodology to do this would be based on an age specific demographic adjustment. The current demographic adjustment insufficiently accounts for age-adjusted growth by lowering the adjustment to align with unadjusted state projections for annual population change. The consequence is a reduction in growth from 4.25% to 0.25% in the current rate year. A rate increase could be applied to address the underfunding of age-adjusted demographic growth, a critical need for hospitals as Maryland's population ages. This would impact all hospitals but in a differential manner and could be done in an expeditious manner.

3. **Applied in a broad base manner for new costs that would be accretive to the goals of the TCOC Model?**

   JHHS believes that only after considering the current financial needs of hospitals should other costs be considered that do not currently exist within the system. It is important to deal with the industry's current financial issues before considering other funding. Only after those issues are addressed should additional programs be considered.

   Thank you again for the opportunity to provide comments on suggestions for revenue enhancements in rate year 2025 due to savings over administrative target. We are

committed to working with HSCRC staff on a sensible solution that addresses the current needs of the hospital industry.

Sincerely,

Ed Beranek

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

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
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JOHNS HOPKINS
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HEALTH SYSTEM

October 30, 2024

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

Dear Dr. Kromm,

Thank you for the opportunity for Johns Hopkins Health System (JHHS) to provide comments to the Health Services Cost Review Commission (HSCRC) on the Draft Recommendation for Deregulation, Repatriation and Out of State Volume Policies.

JHHS appreciates the HSCRC's willingness to continue to review polices that are out of alignment under the current system. While we understand the intent of each individual methodology laid out in the staff recommendation in a vacuum, we continue to believe that a more wholistic review of volume policy is necessary, through the lens of broader volume incentives and the behavioral economics that they create. JHHS has been consistent in its policy commentary that the existing volume policies need to better align revenue with the cost of providing medically necessary care. Without addressing volume policies in a comprehensive manner, including a review of the core market shift and demographic policies, we do not believe layering on even more policies to address shortfalls in these existing policies is the correct approach. We instead believe that volume policy should be reviewed more broadly, with a goal of simplifying the interaction between all of these methodologies and more directly aligning funding with the cost of providing medically necessary care.

The core existing market shift and demographic policies need important, unaddressed updates. The methodology needs to fund variable and fixed costs more precisely. Current methodology funds volume change at a 50% variable cost factor (VCF) across the board regardless of service mix. We have found that a 50% across the board VCF does not properly account for the real costs of providing care to certain types of patients. This can disadvantage a hospital that has service lines which carry a higher VCF like Oncology, Cardiac Services and Orthopedic Services. JHHS favors a methodology that recognizes a greater share of costs overall as variable by evaluating costs on a service line basis.

Current market shift methodology, which tracks shifts by ZIP code, does not sufficiently capture shifts. The ZIP code specific methodology does not account for patient movement over a broader geographic area. Use of broader geographic definitions could improve the methodology.

Additionally, the current methodology for demographic adjustments insufficiently accounts for age-adjusted growth, as mentioned in our previous letter. Lowering the adjustment to align with unadjusted state projections for annual population change has reduced the adjustment and substantially underfunded age adjusted demographic growth at a time when the state has higher utilization with an aging population. The current demographic adjustment allocates funding to hospitals whether or not they experience any actual use rate growth. This approach also needs to be reconsidered.

JHHS appreciates the opportunity to comment on volume policy changes. Volume policies must do a better job accounting for and funding volume changes. While the focus of the draft recommendation is on deregulation, repatriation, and OOS adjustments, we urge you to also consider the other volume policies, including market shift and demographic adjustment, that need improvement. Broad volume policy review is needed because market shift and demographic aren't working.

Sincerely,

Ed Beranek

Ed Beranek
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December 2, 2024

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

Dear Mr. Kromm,

On behalf of the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the draft recommendation for 2025 funding for AHEAD preparation. Staff recommends implementing a rate increase of 1.6% for 2025 hospital rates and redirecting these funds to further the goals of the AHEAD model; while encouraging to see that the HSCRC is taking steps to acknowledge that exceeding the savings target in any given year is not appropriate, JHHS believes the recommendation as drafted presents several challenges.

JHHS's concerns and comments are detailed further below.

Redirection of Funding

Excess savings represent a clear underfunding of Maryland hospitals, as also demonstrated by the deteriorating financial performance of Maryland hospitals. Therefore, the most productive use of these funds is to address this underresourcing by redirecting funds back to hospitals.

The draft recommendation also indicates that legislative action is required to capture and direct this funding. However, in light of the State's current fiscal challenges, there is considerable risk that any action to increase hospital rates for a dedicated purpose will be redirected to support shortfalls in the State's General Fund.

Further, according to the AHEAD agreement, the Population Health Trust is intended to be funded by a mix of both public and private sources. It is critical that the State also demonstrate its support for the AHEAD model by contributing to this fund. Without this financial commitment from both the State and the industry, a concerning precedent may be set for this fund to be solely supported through hospital rates.

New Programs to Address Health Cost and Delivery Challenges

While all areas of potential areas of investment noted in the draft recommendation are worth exploring, given the concerning fiscal situation of many Maryland hospitals, focus should be on addressing

challenges with current policies that underfund medically necessary care and overfund bed closures or capacity restriction. Any additional funding should be directed at hospitals that are providing medically necessary care. Statewide, over half of Maryland hospitals have recently reported negative operating margins in most quarters. This is an unsustainable position for Maryland hospitals, and must be addressed to adequately preserve access and care delivery in Maryland.

Comments on each area of potential investment are below.

1. *An all-payer value-based program, similar to the current Medicare Care Transformation Initiatives (CTI) program, to support clinical innovation and transformation to achieve better and more equitable health outcomes while maintaining affordability.*

   An all-payer value-based program would require significant long-term planning and evaluation. If this all-payer program is intended to be modeled after the current Medicare CTI program, there must be further evaluation of the current CTI program; until there are greater insights into how CTIs are driving performance or improving care, this program should not be expanded.

2. *Common platforms and efforts for the hospital system to improve efficiency and effectiveness of care.*

   The State and industry have already made significant investments in the State HIE, CRISP. Before moving forward with other common platforms and efforts, JHHS encourages staff and the industry to clearly identify and prioritize the currently unmet needs, and the likelihood that these potential common platforms and solutions will meet those prioritized needs. Further, this information and prioritization should be gathered through a process involving feedback from the industry and stakeholders to identify the most critical needs, and to clarify where further resources or efforts would most effectively meet those needs.

3. *Access expansions to meet latent demand for high-value clinical services across the healthcare system.*

   JHHS agrees that certain clinical care is undoubtedly underfunded in Maryland. However, this issue would be best addressed by adjustments to the state's existing volume policies. One-time funding will be insufficient to address various policies and methodologies that underfund medically necessary hospital-based services. Access challenges under the global budget construct should be addressed through a comprehensive review and evaluation of the existing volume policies.

4. *Global payment arrangements with hospitals that are working to improve health and lower costs in their geographic areas.*

   As JHHS has previously noted, there are many shortfalls that within the current global payment arrangements. These shortfalls are producing access to care challenges that are evident after a decade of global budgets and misaligned incentives. These challenges must first be addressed before these global payment arrangements could be further expanded. Any expansion of global

payment arrangements under the current methodologies will further erode access to healthcare throughout Maryland.

5. *Workforce investments, including but not limited to updates to the GME program.*

   The GME policy has not been revisited since before the implementation of global budgets, and likely requires some changes; however, these changes must be considered in a comprehensive and thoughtful manner, rather than addressed with one-time funding. A number of current workforce challenges would be best addressed through long-term policy solutions.

6. *Greater understanding of patient financial burdens with seed funding for new approaches to assistance.*

   The Maryland General Assembly has made significant changes to hospital financial assistance policies that mitigate the impact of medical costs on individual patients. If there are concerns that global budgets are having a disproportionate impact on certain patient populations, addressing these distortions directly through policy adjustments would be more impactful than a short-term funding solution that aims to mitigate the impact of GBR on these patient populations.

7. *Additional pay-for-performance programs with transformation or access impact*

   As noted throughout this comment letter, challenges and shortcomings of existing volume policies create transformation and access issues in Maryland. These issues would best be addressed through a comprehensive review of existing policies along with stakeholder engagement to improve the policies.

JHHS thanks the Commission and staff for the opportunity to provide comments and feedback on this recommendation. While JHHS agrees with the principle that excess savings are not appropriate and must be reinvested in the health of Marylanders, it is critical that this 2025 funding supports gaps in our current policies, particularly where medically necessary care is underfunded. Further, JHHS believes that because these issues are long-standing, the impact of a one-time investment will be limited. Meaningful solutions to these issues will require thoughtful, long-term solutions. JHHS looks forward to further collaboration with the HSCRC on further AHEAD planning that improves health and access for all Marylanders.

Sincerely,

Ed Beranek

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

cc: Dr. Joshua Sharfstein, Chairman

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December 9, 2024

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

Dear Dr. Kromm,

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

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

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

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

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

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

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

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

Sincerely,

Ed Beranek

Ed Beranek
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JOHNS HOPKINS
SCHOOL of NURSING

February 3, 2025

To: The Total Cost of Care Workgroup, Maryland Health Services Cost Review Commission (HSCRC)

From: Sarah Szanton, Dean, Johns Hopkins School of Nursing; Natalia Barolín, Sr. Health Policy Adviser, Johns Hopkins School of Nursing

Re: Comments on AHEAD Policy

Dear Colleagues,

Thank you for the opportunity to inform the policies for AHEAD implementation. We have provided a response to questions 1b and 2a below.

1. **Ensuring High Value Care**. A core goal under AHEAD is to bring innovative and affordable care models to the state that improve the health of Marylanders.

b. Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. *How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?*

Maryland communities, academic institutions and health systems have developed promising solutions; but they have not fulfilled their cost saving and equity potential due to policy gaps that undermine adoption across the state. The Advancing Innovation in Maryland (AIM) award is a good first step in identifying promising approaches for meeting the vision and goals under AHEAD. Community based interventions like Neighborhood Nursing and CAPABLE (both AIM Awardees) should be considered for HSCRC investment as a common utility to empower all Marylanders to achieve optimal health and well-being.

Maryland's TCOC Model has saved Medicare billions of dollars and set the stage for the design of the AHEAD model to be implemented in Maryland and other states. Despite this success, Maryland's per capita health care spending increased by 40% over the past decade. And while racial and ethnic health disparities have improved in Maryland, large disparities remain for key health indicators, including infant mortality and preventable health care utilization. Under AHEAD, Maryland has the opportunity to adopt promising interventions that offer value and improved health outcomes but do not fit into traditional fee for service and the fragmented payor and policy environment. For example, HSCRC could consider using savings under AHEAD to cover Neighborhood Nursing for populations attributable to hospitals and health systems across Maryland. CAPABLE can be combined with Neighborhood Nursing for the appropriate populations. The JHSON is currently designing a program to integrate CAPABLE into

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Neighborhood Nursing to address the functional needs of Neighborhood Nursing clients. We have outlined both programs below:

- **CAPABLE (Community Aging in Place—Advancing Better Living for Elders)** is a person-directed, home-based falls prevention and rehabilitative health intervention that serves older adults who wish to remain in their homes as they age but face physical and functional challenges. It improves physical function, mental health and overall well-being while decreasing hospitalization, length of stay, readmission rates, and nursing home admissions. More than 15 years of clinical trials and implementation show that CAPABLE saves money and significantly reduces unnecessary hospitalization and nursing home admissions by alleviating disability, depression, and pain. Yet, current payment structures within Medicare and Medicaid in Maryland do not effectively address functional disability. Medicare focuses on acute and chronic illnesses, while Medicaid primarily supports custodial care for those with disabilities. CAPABLE enables older adults with disability to care for themselves rather than the custodial care of Medicaid. Other states are starting to cover CAPABLE through Medicaid waivers and New York is offering it through their Aging Master Plan funds.
- **Neighborhood Nursing** links every resident in a geographic area with a registered nurse (RN) and community health worker (CHW) who offer community and home-based services, disease and chronic illness management, and social care, reducing acute care utilization and improving engagement with marginalized, low-income Marylanders. The Neighborhood Nursing model is positioned to decrease spending, improve outcomes, and eliminate disparities. Current fee-for-service based payment structures and limited multipayer alignment for services outside of the hospital pose significant challenges to Neighborhood Nursing. Shared savings and/or pooled funds across payers can be used to support a program like Neighborhood Nursing that provides a common utility to deliver the right care in the right location at the right time across Maryland.

2. Improving Access to Care. Another goal of AHEAD is for Marylanders to be able to receive the right care in the right location at the right time. This requires many steps, including appropriate hospital budgeting, sufficient investment outside of hospitals and effective oversight in those other levels of care.

a. Currently, access to needed care in Maryland is assessed through a series of individual measures, including ED wait times, hospital beds per capita, avoidable admissions per capita, and others. This disjointed approach cannot account for the complex relationship of these access measures to one another. *How can the Commission and partner agencies develop more useful measures of needed access that support prioritization of funding and rationalization of existing investments?*

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In order to understand whether Marylanders are receiving the right care at the right location at the right time, Maryland must also measure indicators of whole person health and well-being as well as what matters to individuals, families, and communities. There is an increasing body of knowledge on person-centered measures that capture whole person health and well-being. For example, the journal Medical Care recently released a special edition on Measuring What Matters Most: Considering the Well-Being of the Whole Person in Health Care. HSCRC should conduct an analysis to determine the best measures to support community based whole person care and that support models that deliver this kind of care. And then support the use and implementation of the measures via the other policies defined in AHEAD.

Maryland is well positioned to lead with cutting-edge models that can reduce total cost of care, strengthen the health care system, and support meeting the SIHIS Domain goals. Hospitals, individual providers, provider practices, and payors are already struggling to figure out how to meet the requirements under AHEAD. HSCRC has the opportunity to identify and support innovative common utility programs that can relieve pressures off hospitals and help the state and all AHEAD participants meet the requirements of the model and improve the health and well-being for all Marylanders. The HSCRC should consider using shared savings and/or developing a pooled funding stream to support programs that can be utilized across AHEAD participants to maximize reach in Maryland. These funds could be used to support bundled payments for innovative interventions like CAPABLE or to support the implementation and spread of a model like Neighborhood Nursing across the state, agnostic of payor or provider.

We look forward to ongoing collaboration.

Sincerely,

Sarah L. Szanton, PhD, ANP, FAAN
Dean
Patricia M. Davidson Health Equity and Social Justice Endowed Professor

Natalia Barolín, BA, BSN, RN
Sr. Health Policy Adviser

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Submission from the Maryland Academy of Family Physicians

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

a. Over the past decade, hospitals have used the flexibility of global budgets, to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. *To further drive this work, how can the payment system better recognize effective efforts?*

The payment system should incentivize quality primary care rather than number of visits. However, complicated patients cannot always be quantified by risk scoring. Longer complicated visits for complicated issues should be compensated properly. Flat fee visit payments or full capitation would disincentivize quality chronic disease management. Payments to primary care physicians should include both prospective payments based on risk scoring but also proper reimbursement for care of complicated patients via E&M payments.

Additional programs that support food and activity would be helpful, such as those from Lifestyle Medicine. These programs need health coaches and nutritionist to support patients. Currently most programs only support dieticians for patients with hyperlipidemia and diabetes. Obesity is the major contributor to both of these diseases. We need ways to educate and support a whole-food plant-based diet.

- Personalized Plans: Tailor interventions to the individual's needs, preferences, and goals.
- Collaboration with Healthcare Providers: Work with doctors, dietitians, and fitness experts to ensure holistic care.
- Behavioral Changes: Use motivational interviewing, goal setting, and small achievable steps to foster long-term habits.

b. Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. *How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?*

Maryland should invest in programs that are already working well. For instance, the MDPCP program has a very good track record and has good support among its participants, particularly its use of coaches. This should be strengthened. Though there are health and access inequities in certain parts of the state, ALL parts of the state have a significant primary care shortage. Primary care needs to be strengthened in all parts of the state.

A statewide program for initiatives around food and activity would be well received and impactful. A program like Food is Medicine.

- Key Studies:
  - The Diabetes Prevention Program:
    - Showed that lifestyle changes (diet and exercise) can reduce the risk of Type 2 diabetes by 58% in high-risk individuals.
  - The Framingham Heart Study:
    - Found that physical inactivity, smoking, and poor diet significantly increase the risk of heart disease, while regular exercise and healthy eating reduce it by 30-50%.
  - The PURE Study:
    - Investigated the impact of diet and physical activity in different countries, showing how lifestyle choices influence global health. It found that improving diet and increasing physical activity reduced cardiovascular disease mortality by 40%.

c. Numerous organizations and approaches have documented how the fee-for-service system generates low value care. Maryland does not necessarily perform well on these metrics despite the different hospital financial incentives. See for example the Lown Institute analysis of Unnecessary Back Surgery in which Maryland is average:

https://lownhospitalsindex.org/unnecessary-back-surgery/. *How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care?*

> If physicians are incentivized to be able to educate and discuss options with patients, rather than forced to do 15 minute appointments, they will have the time to actually perform evidence based medicine per clinical guidelines. Currently physicians do not have the time to properly follow clinical guidelines due to their pay structure. The pay structure for primary care physicians should move away from RVUs and toward high quality care.
>
> Engage Primary Care Physicians earlier in the plan when specialists are involved. Finding ways to make sure that the specialist and the primary care physician are collaborating on the patients care.

d. The Health Services Cost Review Commission policies provide an added incentive to reduce "potentially avoidable utilization" as defined by readmissions and PQIs. *Given answers to the questions above, should the HSCRC consider alternative or complementary approaches?*

> Yes, physicians should be incentivized to follow clinical guidelines (and not punished). Any alternative or complementary approaches should be covered by insurance. Physicians and patients cannot avoid excess utilization when alternative and less expensive approaches are not available or covered by insurance.
>
> Consider measuring Transition of Care Management visits. This would encourage standard practices for patients to see their primary care physicians after a hospitalization or ER visit.

e. Do hospitals have planning needs to support innovative and affordable care models? If so, what are those needs, and how might the HSCRC support them?

> Planning needs are important and often restricted due to financial constraints. To encourage and support this work provided grants and additional reimbursement for new services would be beneficial. New alternative forms of reimbursement for health coaches and paying form group visits would be a good start. Identifying statewide resources for social determinants of health would also help. It is difficult to screen people for these issues when you do not have solutions to help them solve their problems.

Improving Access to Care. Another goal of AHEAD is for Marylanders to be able to receive the right care in the right location at the right time. This requires many steps, including appropriate hospital budgeting, sufficient investment outside of hospitals and effective oversight in those other levels of care.

a. Currently, access to needed care in Maryland is assessed through a series of individual measures, including ED wait times, hospital beds per capita, avoidable admissions per capita, and others. This disjointed approach cannot account for the complex relationship of these access measures to one another. *How can the Commission and partner agencies develop more useful measures of needed access that support prioritization of funding and rationalization of existing investments?*

> Focusing on access in the ambulatory care setting would be helpful. Measuring primary care offices on how long it takes to get an acute and TCM appointments can help ensure that patients get seen in the correct setting when needed. Having extended hours and weekend access is also very important and could be encouraged. Encouraging home visits for certain populations would also improve our current system. We need to make these types of visits accessible, and the state should help with funding to allow this type of work.

b. Reducing ER wait times is a state priority. *Should the HSCRC consider payment policy to slow the rate of volume declines in specific health systems for specific services related to ER wait times?*

c. As patients move from one hospital to another within specific service lines, there is an adjustment made to both hospitals' budgets. *What, if any, changes are appropriate to HSCRC's policies for this market shift to support access to needed care without abandoning population-based payment and creating an excessive financial incentive for hospital-based treatment?*

Coming up with a blended attribution would be helpful. Often patients are seen in one system, but their primary care provider is employed in another. Encouraging partnerships between organizations can create win-wins for both systems.

d. Hospital global budgets are adjusted every year for statewide population growth. *How, if at all, should this adjustment be changed or focused to promote the goals of the model for access to care, cost control, and population health?*

Systems receiving money (increased rates) for providing care in the city or other higher paying regions, should be held accountable for spending/investing this money in their geographic regions. Have we looked to see if the increase that one system gets over another shows proportionate investment in their communities?

Hospital global budgets should be adjusted by amount of administrative costs vs actual costs of medical care. Hospitals should be incentivized to partner with community primary care physicians and urgent care centers to improve access to care, cost control, and population health.

e. Recognizing that effective hospitals can provide greater access to care, what are key domains and metrics that should be used to assess the effectiveness of hospitals? Should national comparisons be used to evaluate metrics such as length of stay, utilization per capita and administrative costs?

See d. Access measures could be put into place (like TCM visits). We should first focus on the state/regional comparisons, and they later be compared to national results. Administrative costs should be the primary metric. Yes, national comparisons, as well as comparisons to other similar Mid-Atlantic states should be considered.

Other topics. There are several cross-cutting policy areas that could also be addressed in 2025.

a. Physician costs. Hospital-based physician charges to individual patients is outside the authority of the HSCRC. *With costs of hospital-based physicians rising out of proportion to insurance reimbursements, what policy changes should be considered by HSCRC, and, more broadly, by the state? What, if any, special considerations should be made for physician costs in academic health systems, recognizing the role of existing funding for graduate medical education?*

Hospital based physicians: Non-hospital based physicians are lower cost and their payments should be increased. Most of the "facility" pricing is likely going to administrative costs rather than compensation to physicians. HSCRC should institute policies on how much of the facility fee is actually going to administrative costs rather than staffing costs.

Academic health systems are vitally needed, primarily for primary care graduate medical education. Increased state funding should be given to primary care graduate medical education, particularly Family Medicine.

There should be a study done on physician reimbursement and how they correlate to inflation and insurance reimbursement. Maryland is consistently in the 49th or 50th position (last) and this is not sustainable to support the medical needs of the state. It is driving out some of the best talent to other states. One insurer is holding over 60% of the market and this needs to be looked at and reimbursement improved.

In addition, investment in Loan Assistance Repayment Program for Physicians (Physician LARP) is a powerful tool at the State's disposal to incentivize physicians to enter primary care and ensure patient access to physicians in every part of Maryland. Making sure there is a regular source of funding for this program will be a great value add to ensure a sufficient primary care workforce.

b. Facility conversions. *Should the HSCRC consider facilitating the conversion of hospitals with declining numbers of patients and high market-level capital costs to free-standing medical facilities or other lower acuity providers?* Such a step could be designed to increase funding for hospitals seeing more patients as well as permit the

restructuring of services at the conversion facilities to meet community needs. If so, what policies should guide this process?

Yes, this should be looked at. The number of people living in the city has decreased, yet we still have several hospital systems operating there. We also have hospitals in the county and city in very close proximity that are offering similar services. It seems there is an opportunity to decrease duplicative services.

c. Percentage of revenue under global budgets. Under the TCOC Model, the HSCRC was allowed to exclude up to 5 percent of in-state revenue from population-based methodologies, which the Commission utilized to ensure the delivery of high-cost outpatient drugs through the CDS-A policy. Under the AHEAD Model, this exclusion increases to 10 percent. *What additional volumes should the Commission consider using fee-for-service methodologies for, e.g., expanded quaternary definitions or hospital at home?*

4. *What other major changes to policies under the Maryland Model of population-based payment should be considered?* Please be as specific as possible.

Ensuring that payments are being shared with physicians should be considered. Many hospital systems are keeping the population health payments that they receive and not passing them on to the physician.

Any institution receiving Population based payments must be required to have a part of that payment go directly to primary care physicians. Maryland has the lowest compensation for physicians in the nation and Primary care physicians are among the lowest compensated physicians. In order to improve the primary care shortage in MD, we need to improve compensation for these advanced primary care services. The population based payment must also go to actual staffing rather than administrative costs. This requirement should also not be adding to administrative burden.

When population based payments are instituted. Primary care visits should still be well compensated and there should be no flat fee or capitation that would de-incentivize physicians from seeing complicated visits.

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February 3, 2025

Sent via email to hscrc.care-transformation@maryland.gov
Maryland Health Services Review Commission
Joshua Sharfstein, M.D., Chair
4160 Patterson Avenue
Baltimore, MD 21215

RE: Response to HSCRC's Request for Stakeholder Feedback

Dear Dr. Sharfstein & HSCRC Commissioners:

On behalf of our more than 1,600 physicians practicing in and/or residing in Montgomery County, Montgomery County Medical Society is pleased to respond to HSCRC's request for stakeholder feedback. Our members include physicians of all specialties, practice modes, and practice locations in the County, and we are committed to providing quality, accessible, equitable, and affordable healthcare for more than a million patients. We share our perspectives on behalf of our patients — the most important stakeholders — in mind.

We have worked collaboratively with MedChi, the Maryland State Medical Society, of which we are a chartered component, to share individual and collective physician concerns about the Total Cost of Care Model and now about AHEAD (States Advancing All-Payer Health Equity Approaches and Development) Model. **As part of our feedback (and attached to this communication) are MedChi's positions on Healthcare Transformation, Population Health & Primary Care Investment. We support these positions and encourage the HSCRC to give serious consideration to the recommendations contained in these documents.** These recommendations represent valuable insights into the challenges of providing patient care both in the hospital and outside the hospital and include proposed solutions.

There are several areas on which we want to provide additional feedback. These issues relate to significant concerns about the current Total Cost of Care (TCOC) Model. We want to ensure these issues are addressed and resolved and not repeated in the new AHEAD model.

At the foundation of our members' concern is that the focus on cost containment has adversely affected quality and access to care under the TCOC Model, and, if not addressed, will continue and be exacerbated in the new AHEAD model.

Moreover, the statement *"AHEAD envisions a health care system that empowers all Marylanders to achieve optimal health and well-being by ensuring high-value care, improving access to care, and promoting health equity"* assumes that there is a system of and infrastructure for care to be provided, and the health care workforce necessary for Marylanders to "achieve optimal health and well-being." While we agree that we need to strive toward this vision, we feel strongly that Maryland lacks a coordinated and collaborative effort to address the foundational needs and building blocks to achieve this stated vision.

Below we have categorized our feedback according to HSCRC's formal request. We recognize that some of the issues raised may not be the purview of the HSCRC; however, they directly or indirectly impact the success of the TCOC and AHEAD models and must be addressed by appropriate legislative and regulatory bodies. Given the complexity of the funding mechanisms of the TCOC, it is often difficult to determine the appropriate process through which to raise quality and access concerns and to explore solutions.

Ensuring High Value Care.

The HSCRC's focus is on ensuring "high value care." Containment of costs is important; however, not to the detriment of access to and/or quality of care. The methodology used by HSCRC and/or hospitals to measure quality of care is likely different from how physicians who admit or consult at Maryland hospitals and/or inpatients measure quality of care.

Metrics used by hospitals to measure quality of care are often patient satisfaction scores post-discharge, mortality rate, readmission rate, length of stay, compliance with clinical guidelines, infection rates, patient safety incidents, average cost per patient, bed occupancy rate, and healthcare effectiveness data and information set (HEDIS) scores. While important factors, quality of care is also impacted by:

- Inability of surgeons to schedule patients for procedures due to operating room suite closures attributed to staffing challenges or arbitrarily to diminish utilization and cost. Lack of access to surgical care negatively impacts patient care and the viability of surgical practice;
- Elimination of inpatient service lines which push patients to other hospitals in Maryland that provide the service, or into a community setting that isn't the most appropriate setting for that illness or disease treatment. The viability of such community providers is subject to market forces and reimbursement policy. Closure of outpatient services, such as dialysis, requires patients to drive long distances to receive care. In most physicians' opinions, these chronic diseases would best be treated in a community hospital for the best outcomes;
- Lack of call pay funding transparency. If used exclusively for hospital employed or contracted physicians to control costly admissions, access to cost effective, quality care provided to patients by outside specialists is undermined;
- Lack of adequate and adequately trained inpatient clinical staffing;[1]
- Unwillingness of hospitals to allow new and innovative treatments and surgical procedures because these treatments and procedures, while potentially financially profitable, could penalize hospitals under global budget models therefore denying access to such treatments or surgeries in Maryland; and
- Lack of adequate emergency room physician or hospitalist coverage to see patients resulting in additional patient care expenses from care provided by advanced practice providers and potentially greater liability;[2]

[1] Global Data for the Maryland Hospital Association, Maryland Nurse Workforce Projections: 2021-2035. June, 2022.

[2] Zarefsky, Mark. What's the cost of scope creep? Start counting in the millions. October 5, 2023, American Medical Association News Wire.

Bernard, M.D., Rebekah. The missing variable: The effect of physician replacements on healthcare spending. Medical Economics, August 3, 2021.

- Inability of patients and physicians to share their concerns about quality of and access to care because there is no third-party, nonbiased system for collecting and reviewing such data, and having findings addressed and factored into annual budget review.

These concerns, shared with us by our members out of concern for their patients, impact quality and cost and are unfortunately the symptoms of global budget cost constraints. We expect that many of these factors are not captured and are not a part of the HSCRC funding methodology as they are more qualitative than quantitative.

Furthermore, we have learned that many physicians and surgeons are admitting their patients to hospitals in DC and Northern Virginia to expedite patient care and diagnostic and surgical procedures. Our physician members have indicated that the care provided in those out-of-state hospitals is not affected by the cost-cutting decisions which are prevalent in Montgomery County and most of Maryland's community hospitals, including lack of access to OR suites, lack of innovative equipment and medications, and inadequate nursing and physician staffing. Contrary to HSCRC's effort to enhance health equity, patients in Maryland with Medicaid coverage are precluded from receiving care outside of the state and unable to access cutting edge technology which is offered outside of Maryland.

These issues are worsened by the increasing volume of patients in Montgomery County at approximately 20% greater than pre-COVID rates (as reported by Suburban Hospital to the HSCRC), and without adequate adjustment of rates to Montgomery County hospitals to compensate for increased patient utilization. We encourage the HSCRC to look at the current volume methodology and make appropriate changes to ensure Montgomery County hospitals are appropriately compensated for increases in utilization.

Recommendations:

1)Modify the volume formula to reflect increased population utilization and fund hospitals accordingly using the "money should follow the patient" strategy. Community hospitals cannot be expected to provide care to more Maryland residents without additional resources. Free standing medical facilities and other lower acuity providers cannot provide the same services of full-service inpatient hospitals at a time of increasing population growth.

2)Evaluate the current funding methodology which has resulted in perverse incentives which ration patient care.

3)Incentivize hospitals financially to improve their offering of innovative procedures and surgeries which improve health outcomes, including requiring hospitals to pay call coverage to independent specialists.

4)Develop an independent complaint reporting system which will encourage patients and clinicians to share their feedback and concerns about inpatient care, and create a multi-disciplinary, non-biased committee to assess trends and address these complaints with specific hospitals and/or initiate improvements in hospital funding for those facilities which address complaints effectively.

5)Evaluate the disproportionate funding to hospitals within Maryland and reallocate funding to community hospitals where there is increasing demand and the need for community-based primary care which will help to achieve the goals of AHEAD. While it is understandable that funding is needed in our tertiary care facilities and trauma centers, population health strategies and improved outcomes will result from greater funding to community hospitals and community-based physicians and other outpatient services.

6)Improve the transparency of HSCRC funding strategies. It is complex and not easily understood. The general public is unaware of hospital funding methodology in Maryland or the impact it may have on their medical care.

7)Develop a publicly available and consistently applied transparent rating system for hospital quality and efficiency accessible to patients, physicians and other providers to inform consumers of quality health care.

8)Incentivize quality primary care rather than the number of visits. Physicians who care for patients with complicated health conditions should be compensated properly for the time and resources required to treat a patient effectively.

9)Medicare has established a rating system for hospitals, nursing homes, physicians and many other facilities called Medicare Compare. According to the medicare.gov website, "Medicare Compare uses a methodology that primarily relies on standardized quality measures, including process measures (what a provider does), outcome measures (results of care), patient experience measures, and sometimes structural measures (characteristics of the provider or facility), all gathered from patient medical records, claims data, and standardized surveys to generate a comparative rating for healthcare providers, allowing patients to compare quality across different facilities and doctors on the Medicare website; this often takes the form of a star rating system, where higher stars indicate better quality." Maryland's rating system could be based on similar measures but also on emergency room efficiency, acquisition of innovative equipment, staffing, etc. This rating system needs to be publicized. Hospitals should strive to achieve the highest level of quality and efficiency.

10)Consider "medical loss ratio" type reporting for hospitals. Medical loss ratios are a significant aspect of the Affordable Care Act.[3] They have been implemented in Maryland to hold health insurance companies accountable for the amount spent on medical care of every premium dollar and expose the amount spent on non-medical care expenses. The "medical loss ratio" concept applied to hospitals could limit the amount spent on administrative salaries, marketing, and non-medical projects including the building of non-patient care facilities. Hospital global budgets should be adjusted by the amount of administrative costs vs. actual costs of medical care. Hospitals should be incentivized to partner with community primary care physicians and urgent care centers to improve access to care, cost control and population health. By reporting both the resources spent on administration and health care to the HSCRC, hospitals will be held accountable for the medical care they are providing and be incentivized to meet certain targets of care. National and regional comparisons of administrative costs should be considered.

11)The payment structure for primary care physicians should move away from RVUs and toward high-quality care to compensate for time and resources needed to effectively use clinical guidelines and patient education to improve patient care and outcomes.

Improving Access to Care.

"AHEAD envisions a health care system that empowers all Marylanders to achieve optimal health and well being by ensuring high-value care, improving access to care, and promoting health equity."

[3] Hall, Mark A. and McCue, Michael J. How the ACA's Medical Loss Ratio Rule Protects Consumers and Insurers Against Ongoing Uncertainty. Commonwealth Fund Issue Briefs. July 2, 2019.

The Total Cost of Care model and the new AHEAD model will require an adequate physician workforce, in both primary and specialty care, which currently does not exist, to manage and optimize outpatient care. While MCMS recognizes that the existence of an adequate physician workforce is not the domain of the HSCRC, in its absence we will continue to witness the inability of Marylanders to "receive the right care in the right location at the right time" which is a fundamental and necessary aspect for the AHEAD model success. Longstanding and well-known physician and nursing workforce shortages in Maryland continue to challenge health care delivery, and have been studied by the State legislature, but few concrete steps have been taken to address the deficiencies.[4]

This lack of access to primary and behavioral health care is an element in Maryland's current ranking of 50th with the longest Emergency Department waiting time in the nation, a dubious distinction which Marylanders have shouldered for the past number of years. [5]

Increasing use of observation status is recognized as a strategy to avoid compromising inpatient budget allocations of the TCOC model; however, observation status can contribute to clogged emergency rooms further exacerbating emergency wait times.

While MDPCP and other alternative payment models have demonstrated success in reducing cost and increasing value, there are still too many patients who have no access to primary care who may seek care in emergency rooms or urgent care centers or receive no treatment at all for chronic or acute conditions which result in costly hospital admissions. The Primary Care Model for patients with Medicaid will also make a difference; however, both rely on an adequate number of physician and advanced practice providers to participate in these care coordination programs. Effective strategies to ensure successful transitions of care from hospital to outpatient settings, continuity of care and "medical home models" have demonstrated considerable progress toward reducing hospital admissions.

A primary driver of diminishing supply of primary (and specialty) care physicians is the inability to sustain practices in Montgomery County and Maryland due to the unique private payor environment, with one dominant insurer, CareFirst, controlling the majority of non-Medicare individuals. Over 3.5 million patients are covered in the commercial insurance market by CareFirst, allowing the insurer to set lower prices, limit its provider panels, create its own network of practices (including the largest primary care practice in Montgomery County which has practice locations in D.C. and northern Virginia as well), and create cost-containing efforts that limit physician and patient access to care that would be considered routine.

By creating barriers to standard care, by requiring additional approvals called 'prior authorizations', physicians' time is used on needless red tape, when it could instead be used for patient care. By causing unnecessary delays,

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[4] Commission to Study the Health Care Workforce Crisis: Final Report 2022/23.

[5] Twenter, Paige. Maryland confronts nation's longest ED wait times. Beckers Hospital Review. January 22, 2025.

Olaniran, Christian and Baylor, Kaicey. Maryland has the longest emergency room wait times in the country. New legislation aims to change that. CBS News. January 22, 2025.

Health Management Associates. Maryland General Assembly Hospital Throughput Workgroup Report. March, 2024

which are not based on science, patients are forced to either forego medications (some of which they have been used successfully for years) or pay for them outside of insurance.

As a result, physicians are leaving Maryland and moving out of state to practice elsewhere where the payor environment is less hostile to benefit from more insurance competition and higher payment rates, closing their practices and/or merging into larger groups, transitioning to concierge or direct membership practices, seeking employment in other medical environments such as NIH and FDA, and/or simply retiring early. A direct result of continual frustration with the status quo is a high rate of burnout.

When payors report network adequacy measures, the numbers do not reflect the reality of the situation. To understand the extent of the access problem, all one needs to do is to call a medical practice and see how long it takes to get a new patient appointment.

MCMS is so concerned about this issue that we launched our own workforce survey in the fall of 2024. The findings are:

- 32 surveys received so far since survey was launched in late September which represents 164 clinicians including physicians and mid-levels and almost 38,000 patients under their direct care.
- 42% of primary care respondents report it takes 1-4 months to set up an appointment for an established patient for routine care. 44% of specialists report it takes 1-4 months for them to see an established patient.
- 67% of specialists note it takes 1-4 months to see a new patient. 1/3 of Primary care physicians report that it takes 1-4 months for a new patient.
- For a referral, 42% of primary care physicians note it takes 3 to more than 6 months to get a specialist appointment for their patients.
- 42% of primary care physicians who answered our survey plan to retire in the next 5 years. 39% of specialists will retire in the next 5 years. This means almost 10,000 primary care patients will have to find a new physician and almost 8,000 patients of retiring specialists will as well.

With all of these factors, Maryland has been ranked in one survey as the worst in which to practice Medicine and ranks 49th of 50 states in terms of physician payments by insurers.[6] Maryland is one of the few states where commercial insurance payments are **lower** than Medicare payments.

The answer is to make Maryland a more economically favorable environment where physicians choose to practice. The answer is not to expand scope of practice for advanced practice professionals which have been shown to increase cost and liability concerns.[7] Marylanders deserve to be treated by well-trained physicians. Physicians are most able to provide cost-effective quality care in the outpatient setting. Providing additional financial incentives to physicians to establish practices in Maryland, instead of hospitals, is what's needed to achieve "right care in the

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[6] DeSilva, Hayley. Lowest paying states for physicians. May 25, 2023.

Reynolds, Keith A. Best States to Practice. Physicians Practice. September 24, 2024. Slide 2.

[7] Zarefsky, Mark. What's the cost of scope creep? Start counting in the millions. American Medical Association News Wire. October 5, 2023.
Bernard, M.D., Rebekah. The missing variable: The effect of physician replacements on healthcare spending. Medical Economics, August 3, 2021.

right location at the right time" as physicians are familiar with their patients' healthcare needs and can more effectively coordinate their care to avoid unnecessary hospitalizations.

According to our workforce survey 71.4% of primary care physicians note that they have considerable trouble or it's almost impossible to recruit a new physician to join their practice, while 55.5% of specialists note the same concern. Inability to match competing compensation offers is the number one reason that it is difficult to recruit physicians to Montgomery County. According to several practices in Montgomery County, the only physicians who want to live in Maryland are those who have family connections, and it's our observation that these physicians often open practices in two or three jurisdictions – Maryland, Virginia and/or D.C. – once they recognize the economics of practice in Maryland are not sustainable given the high cost of practice and low commercial insurance payments.

Recommendations:

1)Expand facility fee payment policy to include additional medical care settings. By leveling the playing field, more cost-effective, high-quality care can be performed in the outpatient setting, including independent surgery centers and medical practices increasing patient access. HSCRC should institute policies to ensure the fees are supporting patient care.

2)Enhance access to and payment for remote patient monitoring for patients enrolled in MDPCP or Medicaid Primary Care Program. Remote patient monitoring has demonstrated success in management of the care for patients with long-term chronic conditions.

3)Create an environment which encourages, facilitates and rewards cooperation, not competition, among providers of care in the outpatient setting. Finding successful ways for hospitals and all physicians to align and work together to improve patient outcomes is critical. Acquisition of medical practices by hospitals often increases costs. Investing in independent primary care to improve outcomes through programs like MDPCP and the new Medicaid Primary Care Program are helpful to manage care at the local level, yet many physicians find that the administrative burdens of such programs limit their optimal success.

4)Create legislation that no payor operating in Maryland can pay less than Medicare to primary care and behavioral health physicians working exclusively in Maryland.

5)Expand Medicaid coverage and payments to be equivalent to Medicare for the Top 25 CPT codes in the outpatient setting. If the proposed budget for Maryland is approved, Medicaid E&M codes would once again be equivalent to Medicare. Unfortunately, patients have little or no access to medical or surgical care for chronic conditions.

6) Eliminate prior authorizations for all practices participating in MDPCP and the new Medicaid Primary care program. This would immediately increase interest in participation if administrative burdens could be reduced.

7)Eliminate duplicative credentialing requirements for participation in Medicare and Medicaid managed care plans (like Medicare Advantage) if clinicians are already credentialed by traditional Medicare and Medicaid. This will improve access and expedite care.

8)Enhance outreach services to and service for underserved communities by encouraging Medicaid to match the 10% incentive in payment to physicians who practice in Health Care Professional Shortage (HPSA) areas as designated by Medicare.

9)Encourage hospitals to collaborate with and support financially nonprofit clinics and organizations which provide medical care in the community to enhance outreach to underserved populations (e.g. Mobile Medical Care, Mercy Clinic, etc.)

10)Population-based payment methodology must include payments for care provided by community-based primary care physicians to ensure appropriate care for chronically ill patients to reduce hospital admissions.

Planning is underway to replicate the Maryland model to other states through the AHEAD Model. CMS's goal in the AHEAD Model is to "collaborate with states to curb health care cost growth, improve population health; and advance health equity." According to HSCRC, "The AHEAD Model is the multi-state CMMI model that builds upon the successes of the Maryland TCOC in reducing health care cost growth and improving statewide health care quality."

Physicians across the State have been raising concerns through our medical societies, and urgent action is needed. Access to care has been a longstanding goal for physicians, patients, elected officials, and other stakeholders. Access to high quality care provided by physicians is the mission of our state and local medical societies. Patient advocacy groups share our deep concern for the future of high-quality medical care in the state.

Montgomery County Medical Society and our members are available to participate with HSCRC to create solutions to the challenges faced by our physicians and patients.

Thank you again for the opportunity to provide feedback on behalf of our physician members and their patients.

Sincerely,

Brent Berger, M.D.
President

Aruna Nathan, M.D.
President-Elect

Angela Marshall, M.D.
Immediate Past President

MedStar Health

10980 Grantchester Way
Columbia, MD 21044

MedStarHealth.org

February 3, 2025

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

Dear Executive Director Kromm,

On behalf of MedStar Health Inc. (MedStar) and our seven Maryland acute care hospitals, we want to thank the Health Services Cost Review Commission (HSCRC) for the opportunity to provide comments on aspects of the Maryland Demonstration Model and how MedStar believes it could be improved as we transition to its next phase under the new AHEAD model. In addition to our direct responses to the questions posed by HSCRC staff below, we emphasize hospitals must be financially healthy and sufficiently resourced to support success under the AHEAD model. Currently, as MHA outlines in detail in their comments, hospitals in Maryland are not adequately funded to meet the baseline acute care needs of Maryland residents, invest in care transformation and population health, and make needed capital investments. To prepare for the AHEAD model, Maryland hospitals need policies to support the financial health of hospitals and access to care, address increasing payor denials (which have tripled since fiscal year 2013 and now represent $1.4B), and recognize the increasing costs of essential physicians necessary to operate a hospital and care for our communities.

1. **Ensuring High Value Care**
    a. Over the past decade, hospitals have used the flexibility of global budgets, to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. To further drive this work, how can the payment system better recognize effective efforts?

       Response:
       The current model can be improved in several areas for incentivizing innovative care models:

       Achievability and Timeliness. Operational decisions to invest in new programs are funded today and over several years before potential for incentive dollars is a possibility. This approach, combined with hospitals' financial pressures and thin margins, stifle innovation. An improved model would defray upfront risk and cost of innovation for hospitals and ensure incentive success is achievable, measurable, and timely. The

model must make short-term success achievable to stimulate innovation, then "on-ramp" risk and reward as programs scale. This is like recent developments in the MSSP ACO program to provide glidepaths and more opportunities for advanced payments.

Geographic attribution. Hospitals are limited in their ability to impact health by the individuals they touch. While hospitals have a clear role in the community and supporting the health of the communities they serve, the intended impact of these are broad and long term, so unlikely to yield direct returns through TCOC. In areas where there may be one hospital for a community, this may be more feasible, but in Baltimore City or other areas with multiple hospitals, it is not possible to geographically bound activities or the community served by initiatives – either those based in the hospital or community. Hospitals are uniquely positioned however to respond to patients with 1) high levels of acute care utilization, 2) that are from marginalized areas and may rely on the ED for primary care services (e.g. unhoused, SUD, undocumented), and 3) that may have been previously lost to longitudinal care (leading to their present exacerbation of an underlying chronic condition). We should design the system to specifically incentivize hospitals to capitalize on these strengths and attributes. Programs based on population attribution (e.g. MPA and PAU savings policy) should focus on patients that explicitly touch a facility or system. Other mechanisms exist for more global attribution through providers or organizations with clearer and longitudinal patient relationships – such as through primary care and MDPCP.

We would recommend a joint task force of staff and stakeholders with experience in policy incentive design meet to develop a policy structure that better recognizes effective efforts.

b. Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?

Response:

Given recent cutbacks in federal funding for social programming, especially for programs to support high risk populations, there will be substantial need among community-based organizations for new funding streams to support current programming. Creating a grants program for health-related programming could help fill this gap – or potentially transferring funding to established grant structures (e.g. MCHRC) to expand their pool of funding to support these programs without requiring development and execution of a new grant program. MedStar would encourage these grant programs and/or funding support to be implemented without adding to the financial burden of hospitals.

c. Numerous organizations and approaches have documented how the fee-for-service system generates low value care. Maryland does not necessarily perform well on these metrics despite the different hospital financial incentives. See for example the Lown Institute analysis of Unnecessary Back Surgery in which Maryland is average: https://lownhospitalsindex.org/unnecessary-back-surgery/. How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care?

Response:
Targeting low-value care is not a good strategy for model success under the current model incentives. Low value care metrics tend to have a narrow clinical definition sensitive to coding specificity, such that while clinical value is improved by avoiding low-value activities, the cost avoided is relatively negligible as a share of the total cost of care.

If it is a state priority to focus on clinically low value care, it should create specific, measurable incentives to promote focus on this. However, it is worth noting that given limited available bandwidth to focus on model objectives, it is unlikely that this is the highest yield focus for hospitals in achieving the model's statewide targets. Perhaps there is a lower-structure way to include this intent in the model, such as naming an annual low-value care goal and asking for qualitative reporting on best practices, in the current manner of the ED best practices policy being instituted currently.

d. The Health Services Cost Review Commission policies provide an added incentive to reduce "potentially avoidable utilization" as defined by readmissions and PQIs. Given answers to the questions above, should the HSCRC consider alternative or complementary approaches?

Response:
The current policy for PAU is of limited impact as it combines all PQIs and readmissions into a single number, then compares that number to the statewide average. A more meaningful policy would take PQIs related to a specific disease state, such as diabetes, and then provide a direct connection between year-over-year diabetes PQI volume and programming aimed at reducing the same. This could potentially take a CTI-like structure, except that the measure of interest would be PQI cost versus a calculated expected PQI cost for that population (rather than total cost in current CTI).

2. Improving Access to Care

c. As patients move from one hospital to another within specific service lines, there is an adjustment made to both hospitals' budgets. What, if any, changes are appropriate to HSCRC's policies for this market shift to support access to needed care without abandoning population-based payment and creating excessive financial incentive for hospital-based treatment?

Response:
MedStar is supportive of revisions to the market shift methodology to improve funding accuracy and more closely reflect the actual care seeking dynamics of patients in the healthcare market. To achieve this, MedStar would support a revision to the market shift methodology to use service line specific variable cost factors when calculating GBR shifts between hospitals instead of the flat 50% variable cost factor historically applied. Further, MedStar believes market shift calculations applied at the zip code level potentially excludes true volume shifts between facilities and would therefore support a further consolidation of geographic definitions when determining if shifts in the market have happened between hospitals.

d. Hospital global budgets are adjusted every year for statewide population growth. How, if at all, should this adjustment be changed or focused to promote the goals of the model for access to care, cost control, and population health?

Response:

In addition to funding year over year inflation, updating hospital global budgets for changes in population is a core tenant of Maryland's fixed hospital revenue system. However, the current HSCRC methodology used to adjust hospital global budgets for demographic changes falls short of meeting this tenant and has left Maryland's hospitals underfunded since fiscal year 2014. Through fiscal year 2025, age-adjusted population growth statewide has been 11.63% vs 4.22% of funding provided in hospital global budgets – a hospital funding shortfall worth approximately $1.6 billion. The underfunding of population growth/aging and the associated hospital utilization increase is driven by three factors:

- Use of age-adjusted population change to distribute funding amongst hospitals but capping funding at the Maryland Department of Planning population growth projection
- Adjustment to leave PAU volume growth caused by population growth unfunded in demographic methodology
- Use of a scaling factor for expected efficiencies to bring overall demographic funding to within the levels provided under the Model contract for population growth

MedStar encourages the HSCRC to revisit the methodology used to calculate global budget revenue adjustments for demographic changes to determine if it is still appropriate to cap age-adjusted population growth funding at the MDP population growth projection, lower funding to account for PAU volumes, and scale funding for expected efficiencies. As Maryland is exceeding its annual Medicare savings requirements, hospitals have been left significantly underfunded – in large part due to underfunding of population change. As we move into AHEAD, developing a more sustainable mechanism for funding population change needs to be a top priority of the HSCRC, however Medstar recognizes this policy revision will take considerable time to develop. Therefore, MedStar encourages the HSCRC to develop both a short-term solution to this underfunding challenge that helps alleviate the current financial challenges Maryland hospitals face, as well as a long-term solution for the AHEAD model.

e. Recognizing that effective hospitals can provide greater access to care, what are key domains and metrics that should be used to assess the effectiveness of hospitals? Should national comparisons be used to evaluate metrics such as length of stay, utilization per capita, and administrative costs?

Response:

MedStar is supportive of staff's efforts to study and determine the effectiveness of hospitals as it relates to access to care through the development of metrics and relevant benchmarking tools. Given the importance of such an evaluation and the potential financial implications as it relates to healthcare payment policy in Maryland, MedStar strongly recommends that the HSCRC develop a workgroup that includes stakeholders from across the industry to develop and refine key metrics to be used in this evaluation.

3. **Other Topics**
    a. Physician costs. Hospital-based physician charges to individual patients is outside the authority of the HSCRC. With costs of hospital-based physicians rising out of proportion to insurance reimbursements, what policy changes should be considered by HSCRC, and, more broadly, by the state? What, if any, special considerations should be made for physician costs in academic health systems, recognizing the role of existing funding for graduate medical education?

    Response:
    MedStar appreciates the HSCRC's recognition of the challenges Maryland hospitals are facing regarding increasing physician costs. To help alleviate the financial pressures hospitals are facing related to rising physician costs, one approach the HSCRC could consider would be the inclusion of costs associated with the physicians needed to operate a hospital in the inter-hospital cost comparison methodology – which is used to determine the appropriateness of a hospital's global budget revenue. Including some set of allowable physician costs in the ICC calculation would provide hospitals with 'credit' for the physicians needed to operate a hospital and potentially unlock additional GBR for qualifying hospitals.
    Additionally, MedStar believes that to truly solve the challenge of rising physician costs, action must be taken to address the acute physician shortage in Maryland, as well as nationally. For Maryland, MedStar would propose that the HSCRC engage in a collaborative effort to determine the root cause of physician retention issues and what actions can be taken to improve retention post-residency. This retention issue plays a key role in physician shortages and therefore, rising physician costs. Nationally, an overall physician shortage is projected to occur over the next decade of an estimated 150,000 doctors. This will require a substantial investment in training the next generation of physicians and Maryland must be a leader in this space. To this end, MedStar would suggest the HSCRC study the feasibility of expanding the amount of graduate medical education available in the state – at all training institutions.

    c. Percentage of revenue under global budgets. Under the TCOC Model, the HSCRC was allowed to exclude up to 5 percent of in-state revenue from population-based methodologies, which the Commission utilized to ensure the delivery of high-cost outpatient drugs through the CDS-A policy. Under the AHEAD Model, this exclusion increases to 10 percent. What additional volumes should the Commission consider using fee-for-service methodologies for, e.g., expanded quaternary definitions or hospital at home?

    Response:
    Excluding any growing service from GBR will inherently create greater challenges in meeting total cost of care targets under the new Model. Despite those challenges, MedStar is supportive of the evaluation of certain exclusions and strongly encourages the HSCRC to form a workgroup, dedicated solely to this topic, to accomplish this.

Again, we want to thank you for the opportunity to provide comments on the Maryland demonstration model and any policy changes that should be considered as the state transitions to the new AHEAD model beginning in 2026. Although the AHEAD model doesn't officially begin until 2026, MedStar believes that success under the model starts now. MedStar supports the HSCRC's efforts to prepare for what lies ahead. As the Maryland Hospital Association's comment letter states, the financial condition of Maryland Hospitals, the rising cost of physicians, and the increasing rate of denials are all

issues that need our collective attention in order to establish a solid starting point for the new model. As the HSCRC processes responses to these questions, MedStar would ask the HSCRC to maintain a transparent and evolving conversation with industry stakeholders through regular updates, workgroup creation and participation, and actively seeking stakeholder feedback on major policy changes and decisions.

If you have any questions or wish to discuss any of the above further, please do not hesitate to reach out.

Sincerely,

Susan K. Nelson

Susan Nelson
Executive Vice President & Chief Financial Officer
MedStar Health

Stephen Evans, MD
Executive Vice President, Medical Affairs & Chief Medical Officer
Medstar Health

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

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

February 3, 2025

Sent via email to hscrc.care-transformation@maryland.gov
John Kromm, PhD
Executive Director, HSCRC
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Comments on Policies and Investments to Further the AHEAD Model

Dear Executive Director Kromm:

MedChi, The Maryland State Medical Society (MedChi), appreciates the opportunity to comment on possible Health Services Cost Review Commission policy changes and investments that would further the goals of the AHEAD Model. We want to first thank HSCRC for its ongoing work on physician alignment programs, including the Maryland Primary Care Program and the Episode Quality Improvement Program (EQIP). These initiatives have demonstrated significant potential to strengthen physician engagement and improve patient outcomes. We also look forward to collaborating closely with you as Maryland develops the Medicaid Advanced Primary Care Program and other programs to further the goals of the AHEAD Model.

MedChi remains steadfast in advocating for the critical issues outlined in the three attached one-page documents. We would also like to highlight the importance of moving expeditiously on the following three issues:

1. **Patient Protections with a Focus on Equity**

   HSCRC should develop and enhance policies and investments prioritizing health equity, quality, and care for every patient in Maryland while also striving to avoid unintended consequences of incentive structures that may run counter to patient safety.

2. **Adjustment of Volume Policies**

   The current volume policies reward restricting access to care and fail to cover the costs of providing care to additional patients. Limitations within the global budget create disincentives for hospitals to invest in new and innovative technologies, such as robotic surgeries or other advanced procedures, because there is no additional funding to support these investments. These challenges have not only made Maryland's hospitals less competitive on a national level but have also aggravated Maryland's physician workforce shortage and have resulted in further inequalities in access to care for Maryland patients.

3. **Physician Payment**

   Maryland's commercial insurers benefit from the all-payer model because annual rate increases for hospitals are capped. Despite this favorable regulatory climate, Maryland's commercial insurers offer some of the lowest physician payment rates in the country, as evidenced

by a Maryland Health Care Commission (MHCC) study. These low payment rates are driving market inefficiencies and the viability of medical practices, which has resulted in an unsustainable health care environment.

We believe that meaningful solutions will require continued dialogue and partnership between stakeholders, including HSCRC, physicians, hospitals, and health care institutions. MedChi is committed to working in a collaborative and comprehensive manner to address these issues and work toward goals we all share: to improve health equity, quality, and care for all Marylanders.

We appreciate your consideration of these critical concerns and would also respectfully request to provide oral comments during the HSCRC meeting on February 12, 2025.

Sincerely,

Benjamin Lowentritt, M.D.

Immediate Past President
MedChi, The Maryland State Medical Society

cc: Dr. Laura Herrera-Scott, Secretary, Maryland Department of Health
Joshua Sharfstein, Chair, HSCRC
Dr. James Elliott, Vice Chair, HSCRC
Richardo Johnson, Commissioner, HSCRC
Dr. Maulik Joshi, Commissioner, HSCRC
Adam Kane, Commissioner, HSCRC
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Dr. Padmini Ranasinghe, President, MedChi, The Maryland State Medical Society
Gene Ransom, III, CEO, MedChi, The Maryland State Medical Society
Ashton DeLong, General Counsel, MedChi, The Maryland State Medical Society

Enclosures

MedChi
The Maryland State Medical Society

The AHEAD Model: HEALTHCARE TRANSFORMATION

The Goal

As Maryland's unique Total Cost of Care (TCOC) Model is expanded and improved upon with the new Advancing All-Payer Equity Approaches and Development (AHEAD) Model, it is necessary to ensure that incentive structures do not continue to create unintended impacts such as long ER wait times, health inequities, and lack of access to mental health and addiction treatment services.

Under the AHEAD Model, MedChi Believes That We Can Transform Healthcare By:

Savings Targets – The Money Should Follow the Patient

- The AHEAD Model should attribute savings to the Maryland patient and reward practitioners with those savings regardless of healthcare setting.
- The AHEAD Model should have a savings target that ensures regulated entities are funded appropriately for innovation and modernizing patient care and reduces funding for those regulated entities that do not invest in innovation and modernization of patient care.

Access to Specialty Care in Regulated Entities

For comprehensive and expeditious care, particularly in ERs, Maryland should set standards requiring regulated entities to have specialty physicians available to treat patients and reward regulated entities that meet such standards.

Increased Oversight

The AHEAD Model should redesign oversight of all regulated entities to protect patients and participating practitioners and entities against unintended consequences of the Model by:

- Creating a transparent appeal and grievance process for patients, physicians, and others who are adversely affected by activity incentivized by the Model.
- Requiring reporting from regulated entities demonstrate how specific interventions are designed to impact social determinants of health and the outcomes of those interventions.
- Designing a regulatory structure that provides regulators with the authority to make financial adjustments and take appropriate action against regulated entities who do not meet the goals of the Model or engage directly or indirectly in activities that limit access to quality healthcare. This regulatory structure should provide regulators with the flexibility to make real-time adjustments to meet the desired goals of the Model.
- Improving transparency on capital projects to avoid subsidizing projects that do not directly impact modernization of or increased access to patient care.

Transparency in Value-Based Programs

Further the goals of the AHEAD Model, all practitioners participating in value-based programs should have full transparency and access to all financial information and terms of the program including the Episode Quality Improvement Program, Care Transformation Initiatives Program, and Maryland Primary Care Program.

Payment Differentials Policy

Maryland should ensure that there is a clear policy around the use of payment differentials to ensure fair and timely payments to practitioners and regulated entities.

Payment Floors

To further increase access to healthcare and build Maryland's healthcare workforce, the AHEAD Model should provide the State with the authority to set transparent payment floors, adjusted annually, that require all payers participating in the AHEAD Model to pay physicians, healthcare practitioners, and regulated entities for care provided at or above the set payment floor.

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The AHEAD MODEL: POPULATION HEALTH

Improving Healthcare Under the AHEAD Model

Public Health Goals

The AHEAD Model should create quality measures that apply to all areas of care with a particular focus on health equity and that clearly align with the Statewide Integrated Health Improvement Strategy.

Preventative Health

The AHEAD Model should have additional measures and incentives for all practitioners to increase screening and prevention for various healthcare conditions with a targeted focus on promoting health equity.

Improve Care Innovation

- The AHEAD Model should continue to expand the Episode Quality Improvement Program (EQIP) and EQIP Primary Care Access Program to accelerate care resign to aid physician in further improving patient care, access to health care, and care management activities.
- The AHEAD Model should provide Maryland with the flexibility to explore and implement other value-based programs to increase quality and access to patient care such as physician-led Accountable Care Organizations or similar programs.

Improve the Healthcare Workforce

Maryland needs to expand its healthcare workforce, particularly in primary care. Maryland should use funds under the AHEAD Model to reward primary care physicians choosing to work Maryland. To further aid in meeting the AHEAD Model's goals, Maryland should also consider reducing barriers to licensure for physicians to practice in Maryland.

Loan Repayment

MedChi believes that the State should request that the AHEAD Model allow for the use of funds for loan repayment to attract physicians to come and stay in Maryland.

Graduate Medical Education Reform

MedChi believes that Maryland's graduate educate needs to be protected and promoted by augmenting the current funding mechanisms and adding a rural residency program to increase investment in residency and Maryland's future physicians.

Exogenous Factors

Maryland's current Total Cost of Care Agreement has a strong exogenous factor clause that includes a clause around defensive medicine, payment, and other important issues. This clause needs to be kept in any agreement concerning the AHEAD Model.

Transparency in Reporting

- The AHEAD Model should require increased reporting and transparency on the use of government funds for community benefit programs to ensure funds are being used to further the AHEAD Model's goals of health equity across the State.
- The AHEAD Model should require further reporting and transparency on the use of additional funds requested by regulated entities for physician payments to ensure that funds are used for their intended purpose.

Price Transparency

Maryland should request that the AHEAD Model provide for more transparency for patients regarding the pricing of services and products provided by regulated entities and collect the data on pricing in one readily accessible and user-friendly location.

Increased Access to CRISP and Other Databases

The AHEAD Model should provide physicians and other healthcare practitioners and entities with increased access to the State's health information exchange, Chesapeake Regional Information System for Our Patients (CRISP), Maryland's All Payer Claims Database, and other available data sources. By providing these Model participants with increased access, healthcare practitioners will be encouraged to be involved in the Model and be able to more actively further health equity. Maryland should also request funds to modernize these various data sources to increase user efficiency.

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mdafp MARYLAND ACADEMY OF FAMILY PHYSICIANS

MedChi The Maryland State Medical Society

THE AHEAD MODEL: PRIMARY CARE

About the AHEAD Model

The Centers for Medicare & Medicaid Services (CMS) has selected Maryland to implement the new States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model. With this selection, Maryland will move away from its current Total Cost of Care (TCOC) Model and continue to build on its state-wide efforts to improve health equity, quality, and access, and to control healthcare costs through the new AHEAD Model.

AHEAD Model Goals

The AHEAD Model Aims to:

- Improve the total health of a state population
- Expand health equity among all payers including Medicare, Medicaid, and private coverages
- Drive state and regional healthcare transformation and multi-payer alignment
- Increase resources available to participating states
- Support primary care and transform healthcare in communities

Prior to the AHEAD model, the State is Encouraged to:

Support and Prioritize the Maryland Primary Care Program (MDPCP) by:

- Improving and increasing enrollment opportunities, including a Medicaid program.
- Maintaining Care Transformation Organizations (CTOs), especially for small and mid-size practices.
- Using the Episode Quality Improvement Program (EQIP) as a wrap-around tool coordinating with MDPCP to target underserved areas.

Keep On-Ramp Track

MDPCP should keep an on-ramp track, so new practice sites may be added without risk.

Augment EQIP with Primary Care Bundles

MedChi and MDAFP strongly believe that we need to add several bundles targeted at primary care.

Expand MDPCP

To further advance the total health of all Marylanders and lower healthcare costs across all payers, MDPCP should be expanded to include Medicaid and private payers in the AHEAD Model.

Incorporate Transformation and MDPCP Gap Services

MDPCP will most likely not have open enrollment opportunities for 2025. MedChi and MDAFP strongly encourage incorporating a transformation role for EQIP primary care to get new practices into MDPCP once we have clarity on the future of the Maryland Model.

Develop an Accessible, Critical Primary Care Program

Using EQIP, a global budget program could be developed to provide accessible primary care for rural and urban settings with shortages. The cost could be covered by Medicaid and the HSCRC to improve outcomes, access, and population health. The program would target creating new pediatric and adult primary care services through a public-private partnership.

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Maryland
Hospital Association

February 3, 2025

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

Dear Dr. Kromm,

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am writing in response to the Health Services Cost Review Commission's (HSCRC) call for public comment on needed policy changes and investments to maximize Maryland's success as the state transitions to the AHEAD Model. We appreciate HSCRC's recognition that this is an opportune time to examine existing policies and implement changes to strengthen the Maryland Model.

The transition from the Total Cost of Care (TCOC) Model to the AHEAD Model brings us to an important moment in our ongoing effort to improve the health and wellbeing of Marylanders. Since the inception of the Maryland Model, Maryland hospitals have led the way in driving innovation through health care payment reform. Over the course of the All-Payer Model and the TCOC Model, hospitals generated $4.6 billion in Medicare savings through high-quality, efficient care delivery. Our hospitals reduced disparities in unplanned readmissions, preventable admissions, and timely follow-up both by race and for areas with challenging socio-economic conditions.

The AHEAD Model aims to build on this legacy with an even greater focus on population health and health equity and provides new opportunities to improve the health of all Marylanders. Hospitals will play a critical role in leading local interventions that focus on identifying populations that are most at risk for poor outcomes and developing targeted interventions that improve health. Our hospitals will also lead in the effort to improve health equity with each creating health equity plans that will demonstrate how equity is actively incorporated in hospital operations, strategies, and services. AHEAD includes important opportunities for hospitals to partner with other care providers across the care spectrum and, rightly, includes a focus on expanding access to primary care.

MHA Priorities

To be successful under AHEAD, hospitals must be financially healthy and sufficiently resourced to meet the baseline acute care needs of patients, invest in care transformation and population health, and make needed capital investments. ***The hospital field identified three top concerns***

that need to be addressed to support our mission of advancing health care and the health of all Marylanders: (1) policies to support the financial health of hospitals and access to care, (2) rising costs for essential physician coverage, and (3) payer denials and accountability.

Policies to Support the Financial Health of Hospitals and Access to Care

As we have highlighted over the past few months, Maryland hospitals and health systems have experienced challenging financial conditions since January 2020 as expenses have risen significantly. Maryland hospital system operating margins have been under pressure. In most quarters in the last three years, half or more of the systems have reported negative operating margins. Margins remain low with an average of just 0.3% in the third quarter of 2024, and margins lag when compared with other systems in the nation. Market experts estimate that nonprofit systems generally need a margin of 3% to sustain their missions. Since 2023, Maryland hospital systems have only reached this level once, and the average of the last 11 years was substantially lower at 1.6%.

Our hospital systems lag on other important financial performance measures as well. Due to operational uncertainty, hospitals deferred needed capital investments. In 2023, the average age-of-plant for Maryland hospitals was 13.2 years vs. 12.3 years nationally. Maryland hospital systems are below national benchmarks when comparing cash reserves to debt. Maryland also lags its peers in days cash on hand, an important liquidity measure. Labor and other cost pressures have been a challenge. From 2019 to 2023, labor costs grew by nearly 19%, outpacing the 14.2% increase in net regulated patient revenue. Staffing costs have increased to over 50% of total expenses, and the substantial labor cost increases are now a structurally high operating expense. Hospitals have seen an increase in financial losses due to costs to employ or contract with physicians. Low reimbursements do not cover the costs of these essential medical staff, and these losses have grown by 55% for all specialties in recent years.

When evaluating the financial health of hospital systems, one must look at the full spectrum of financial indicators. Credit ratings are just one measure of financial stability. Operating margins are a central metric, and when considering margins, the focus must be at a system level. The Maryland Model is a total-cost-of care model. When appropriate, hospitals are supposed to shift services to lower cost unregulated and non-hospital settings and enhance integration of care across the care continuum, including through investments outside of the hospital walls to enhance primary care, post-acute care, community care, and population health. Because our focus is on improving care in settings across the continuum of care, our financial measures must focus on hospital system level performance that includes margins on hospital and non-hospital services. An exclusive focus on regulated margins fails to account for these important aims. And there are hospital costs, like essential physician services, that are not covered under rates. Without considering total hospital system financial performance, one misses large cost drivers and loss leaders for hospitals. HSCRC must embrace a broader focus on a wholistic set of financial metrics to obtain a complete and honest picture of hospital sustainability.

The financial challenges of our hospitals have occurred when hospitals have been generating Medicare TCOC savings substantially more than what is required under the Total Cost of Care Model. For 2024, Maryland is on track to achieve more than $600 million in savings for

Medicare—well above the contractual target of $336 million. The estimated savings are well above the baseline for the start of AHEAD and the first-year target under the new model agreement where we must generate an estimated additional $16 million in savings above the baseline. Over the course of the TCOC Model, Maryland has generated more $1.1 billion in excess Medicare TCOC savings. The Maryland Model and HSCRC policies must achieve a balance of hospital sustainability, health access, and health equity with cost savings for payers and affordability for patients. The generation of substantial excess savings at time when hospitals have struggled is a sign of a Model that is out of balance. HSCRC policies and actions are not keeping up with the costs hospitals incur for providing care in their communities. This is leaving hospitals resource constrained at a time when hospitals need to be strengthened to perform successfully under the AHEAD Model beginning in 2026.

HSCRC policies and actions must enable hospitals to be financially sustainable and provide greater access to care in their communities. Changes to key policies must be made this year to better fund volume growth and shifts, inflationary and other cost pressures, and capital needs.

Needed Improvements to Volume Policies

It is imperative that volume policies ensure that hospitals receive adequate funding services. Changes are needed to the market shift policy and demographic adjustment so that they more precisely account for and sufficiently fund volume changes.

Market Shift

The existing policy governing market shifts funds volume changes at a 50% variable cost factor (VCF). MHA urges adoption of a methodology that recognizes a greater share of costs overall as variable by evaluating costs on a service line basis. MHA recommends an approach that would use the annual filing to calculate VCF percentages by rate center, apply the calculated rate center-specific VCFs to service line/rate center charges, and then calculate service line-specific VCFs to apply statewide. An optimal approach would capture as variable costs direct expenses and direct patient care overhead costs, resulting in an appropriately higher calculated average VCF. An exception could be considered for outpatient psychiatric services, a service line with relatively high fixed costs—a higher VCF could support growth and greater access to these services.

MHA also recommends modifying the geographic definitions used under the market shift methodology. The current methodology, which generally tracks shifts by ZIP code with exceptions for certain service lines that are under a county level approach, does not sufficiently capture shifts, and broader geographic definitions would improve the methodology. The change to a county or regional approach would be simpler than the existing methodology, result in a higher effective VCF, and potentially benefit hospitals experiencing unfunded volume growth. The county-level approach is used under the national AHEAD methodology, and the potential benefit to volume-growing hospitals may support efforts to address access challenges.

Demographic Adjustment

Maryland's population is aging and becoming more complex. By 2030, nearly 20% of our population is projected to be 65 or older—this is up from just 12% in 2010 and 16% in 2020. Our state is also confronting an increased burden of chronic disease. The number of individuals with three or more chronic conditions is projected to increase. The percentage of our population with prediabetes is projected to reach nearly 30%, and the percentage of our population with diabetes will reach more than 15%. Projected figures are even higher for seniors, with 51% having prediabetes and 26% with diabetes. Our aging population with more chronic conditions will have a higher need for health care services, and the demographic adjustment must be responsive to this need.

The current demographic adjustment methodology insufficiently accounts for age-adjusted population growth by lowering the adjustment so that it aligns with unadjusted state projections for annual population change. The methodology, which discounts potentially avoidable utilization (PAU) and age-adjusted growth by a per capita scaling factor, underfunds use-rate growth to achieve the contractual all-payer revenue limit. This approach acts as an additional constraint on growth beyond the PAU adjustment, unduly limits hospital resources, and exacerbates access challenges. For Rate Year (RY) 2025, the scaling factor reduced the adjustment from 4.25% to 0.25%. The cumulative impact of the underfunded growth has been substantial. From RY 2016 through RY 2025, the methodology has resulted in a cumulative underfunding of demographic growth by $7.4 billion.

MHA urges changing the methodology to discontinue the scaling factor so hospitals can receive more funding for use-rate growth. This change needs to be implemented in time to support growth in rate year 2025. MHA can support a two-pronged effort to (1) implement a more straightforward, implementable, modification to the age-adjusted approach for funding demographic growth in the near term, and (2) develop a more refined risk adjustment approach in the long term. The status quo is not sustainable, and imminent HSCRC action is needed.

Inflationary and Other Cost Pressures

In the post-COVID years, hospitals have been contending with inflationary cost pressures, and HSCRC policies have not provided sufficient funding to address these challenges. As noted above, staffing costs have been a significant cost driver and are now a structurally high operating expense. A reasonable annual payment update for Rate Year 2026 is essential to address the challenges and support hospital financial stability and access to care with the beginning of AHEAD.

Preliminary estimates have core inflation for Rate Year 2025 ending higher than projected (3.42% vs. 3.24%). The annual payment update for RY 2025 included an additional 1% for historic underfunding of inflation, an action that provided important support for our hospitals. But under HSCRC's methodology for calculating cumulative inflation over- or underfunding, hospitals are currently underfunded by a percentage that would fall within the inflation tolerance corridor of ±1%. The current methodology would yield no additional inflationary support allocated for RY 2026.

MHA urges changing the methodology so that annual update funding for Rate Year 2026 keeps pace with core inflationary pressures and includes additional support to address underfunded inflation. This could include narrowing inflation tolerance corridors that would yield an inflation catch up for the upcoming rate year.

Deferred Routine Capital Needs

As we highlighted in December, hospitals have deferred needed routine capital investments due to financial distress over the past several years. As noted above, Maryland hospitals have an older average age-of-plant than other hospitals nationwide. Continued deferral of these expenses due to insufficient funding from HSCRC places Maryland hospitals further behind their peers and poses long-term risks for patients.

In a recent survey of MHA member hospitals, all respondents reported deferring routine capital purchases over the last three years to mitigate financial risk from operating income uncertainty. These deferred purchases span a wide range of areas, but include routine patient care capital replacement, upgrade, and additional purchases, facility maintenance and renovations, and other non-patient care purchases, such as for information technology, office equipment, and parking needs. Hospitals also reported having emergency capital expenditures—an indicator of having to defer capital needs until it is unavoidable. HSCRC must revise policies so that hospitals have additional resources to address deferred capital needs. Hospitals need to address these needs to meet patients' baseline acute care needs. Facility renovation, routine equipment replacement, and investment in new technology play an important role in enhancing patient experience. Improvement in HCAHPs and quality scores depends on the ability of hospitals to make these needed investments.

Rising Costs for Essential Physician Coverage

Hospitals have seen an increase in financial losses due to costs to employ or contract with physicians. Hospitals require sufficient medical staff to perform the basic functions of providing care to patients, and the losses attributable to physician employment or contractual arrangements—termed physician subsidies—are largely unavoidable.

Low physician reimbursement from payers and an increase in private equity acquisitions of physician practices are driving up contractual costs to provide adequate coverage for the hospital. In 2017, the average private physician payment rate was 104% of Medicare, one of the lowest in the nation, and physician subsidies are on the rise. A growing number of hospitals are citing increased physician subsidies, specifically in the hospital- based specialties of anesthesia and radiology, when requesting rate increases. The entry of private equity into the physician market is a challenge. When private equity enters the market, physician costs increase, particularly in instances when a single firm controls more than 30% of the market.

A survey of MHA member hospitals found that in the last seven to 10 years, expenses and net losses for physician services have grown, particularly for certain specialties.[1] For all specialties,

[1] Survey base years differ due to respondent data availability.

losses have grown by 55% over the period. Increases were significant for a variety of specialties, including anesthesiology, hospitalists, and emergency medicine.

The current global budget and rate structure does not enable hospitals to cover the costs for these physician services that are essential to run a hospital. HSCRC must adopt a funding mechanism that enables hospitals to recover in rates expenditures for physician services that are not fully reimbursed by payers.

Payer Denials and Accountability

Maryland hospitals are confronting a significant challenge with payer denials. Denied cases have grown substantially since 2013, and this growth has accelerated in recent years. In particular, denied cases are increasing steeply in the emergency department and outpatient settings. Artificial intelligence (AI) claims analyzer technology has been contributing significantly to the increase.

From fiscal 2013 through 2024, the total dollar value of denials has more than tripled to $1.39 billion. In the last three years, denials by commercial payers have spiked, and denials for emergency department services, in particular, have risen 116%, and the dollar amount of denials up 117%. In fiscal year 2014, 13.2% of inpatient cases were denied—the highest level in six years. From fiscal 2019 through 2024, denied cases as a percentage of total outpatient services increased from 10.2% to 11.4%. Commercial payers were responsible for the largest percentage increase in outpatient denials with the percentage increasing from 8.5% to 12.5% of the total. And for commercial payers, denied cases for emergency department services increased from 6.1% to 15.2%. There has been a noteworthy increase in medically necessary denials for Medicare Advantage (232.5%) and commercial plans (79.1%). The overall denial rate for Medicaid managed care organizations has also been high over the last six years.

Denials can cause delays for patients receiving necessary care, and higher out-of-pocket costs resulting from claim denials can cause patients to defer care. Denied and delayed payment of claims is contributing to financial pressures on hospitals and operational uncertainty. Valuable staff and clinical resources are diverted to fight inappropriate claim denials.

We need a system for reviewing payer denials that refines data disclosures and ensures data integrity, enhances payer denial transparency, and reduces denial rates while examining factors that contribute to excessive denial rates, such as the use of AI in claims review and prior-authorization requirements. HSCRC can play an important role in supporting the collection and analysis of information on claim denials. MHA urges HSCRC to pursue policy development and levers that may address wrongful denials.

HSCRC Call for Input Categories

Regarding the specific areas of inquiry on which HSCRC has requested public input—high-value care, access to care, and other cross-cutting policies—MHA offers the following comments.

High Value Care

Ensuring that patients receive the right care at the right time and in the right setting is an important objective. MHA encourages language that reflects a focus on medical necessity, rather than terminology like "high value care" that may inadvertently suggest certain services lack value. A more precise framework for evaluating care appropriateness that centers on medical necessity will help hospitals provide high-quality, patient-centered care that best meets the needs of our communities.

MHA and our members recognize the importance of delivering high-quality, patient-centered care and offer the following considerations to ensure a framework that effectively supports hospitals in meeting these objectives:

- **Benchmarking Population Health Performance**: To measure progress toward high-quality, patient-centered care, there must be robust benchmarking of Maryland's population health performance. This should include an evaluation of how the state's policies under the TCOC Model have contributed to improved patient outcomes and care delivery. Establishing clear benchmarks in advance of the AHEAD Model will allow hospitals to track improvements and identify areas for further enhancement.

- **Program Funding Flexibility**: Sustainable, flexible funding mechanisms are essential to enable hospitals to launch, sustain, and scale chronic care management and population health initiatives. Providing financial support that can be adapted to evolving needs will help ensure that Maryland hospitals can continue their efforts to improve health outcomes while managing costs effectively.

- **CRISP Enhancements**: Real-time data analytics and reporting improvements through CRISP are necessary to align hospital efforts with statewide population health objectives. Investing in enhancements to data availability and usability will strengthen decision-making and allow for proactive interventions that improve patient care.

- **Increased Collaboration:** A stronger partnership among hospitals, physicians, and HSCRC is needed to refine policies and ensure alignment with the goals of the TCOC Model. Encouraging a collaborative approach to policy development and implementation will enhance the effectiveness of high-quality, patient-centered care strategies across the state.

- **Workforce Stability**: Maryland's physician workforce is essential to delivering high-quality, patient-centered care. Efforts to strengthen physician recruitment, retention, and reimbursement alignment with TCOC objectives must be prioritized to ensure stable and sustainable care delivery, particularly in underserved communities.

- **Person-Centered Care for Chronic Disease Management and Reduction of Inappropriate ED Use**: High-quality, patient-centered care should be rooted in person-centered strategies that prioritize patient engagement, self-management support, and

coordination of care. Focusing on person-centered approaches could improve chronic disease management and lead to better long-term health outcomes. Policies changes should be considered to influence patient behavior and lower inappropriate emergency department use.

Improving Access to Care

A framework for improving access to care should ensure that all Marylanders receive timely and necessary health care services. Establishing a clear, comprehensive framework for evaluating and supporting access to care is essential to ensure that Maryland hospitals can continue to meet the needs of the communities they serve. Central to any strategy to improve access to care is to embrace a focus on MHA's priorities shared above. This includes implementing policies to support the financial health of hospitals to ensure that our hospitals are resourced to meet patients' baseline acute care needs. It also includes improving volume policies to sufficiently fund demographic growth and market shifts. As HSCRC develops measures and policies to promote equitable, high-quality access to care statewide, we appreciate the opportunity to share additional key considerations from the hospital field:

Key Considerations for an Access-to-Care Framework:

1. **Establishing High-Level Measures:**
   To effectively support improved access, HSCRC should implement standardized, broadly applicable metrics that provide a comprehensive view of health care availability and utilization. These measures should account for differences such as geographic variations, workforce capacity, and patient acuity to ensure meaningful statewide assessment and prioritization of funding.

2. **Hospital Effectiveness in Access to Care:**
   A robust access framework should consider multiple factors that impact a hospital's ability to meet patient needs. Specifically, evaluations should include:

- The complexity and volume of patients served, including growing populations of older adults and patients with chronic conditions requiring specialized care.
- The availability of non-hospital health care resources, such as behavioral health services, post-acute care options, and primary care providers, which directly influence hospital capacity and patient throughput.
- The rising costs associated with recruiting and retaining both contracted and employed providers, particularly in regions with health care workforce shortages.

3. **Addressing Policy Barriers to Access through PAU Funding:**
   Current policies related to Potentially Avoidable Utilization (PAU) funding may be overly restrictive and could inadvertently limit hospitals' ability to improve access to care. For example, the market shift policy does not account for PAU. MHA encourages HSCRC to reevaluate these policies to ensure they promote, rather than hinder, access to high-quality care.

While long-term strategies are necessary to create sustainable access-to-care solutions, immediate interventions are also critical to addressing the urgent challenges hospitals face. In particular, refinements to the demographic adjustment and volume policies must be prioritized, as these directly impact hospitals' ability to respond to changes in patient populations and care demand. Hospitals must be equipped with policies that reflect real-time shifts in demographics and service utilization, allowing them to adapt and maintain high-quality care for their communities. Without these key adjustments, hospitals may struggle to manage increasing patient complexity and volume, undermining broader access-to-care goals.

Cross-Cutting Policies

We appreciate HSCRC's proactive approach in soliciting feedback on cross-cutting policy areas for 2025. We welcome the opportunity to share the field's perspectives on hospital-based physician costs, facility conversions, and consideration of services that should be excluded under the state's global budget framework:

Policy Changes to Address Costs for Hospital-Based Physicians

Hospitals depend on a stable and well-supported physician workforce to provide high-quality patient care 24/7/365. However, increasing physician costs present a challenge within the current reimbursement framework. As we discussed above, MHA urges HSCRC to recognize physician costs as an essential acute care hospital expense and to provide a means for hospitals to cover these in payment policies. HSCRC action should be part of a broader effort to evaluate Maryland's physician reimbursement levels compared to other states and address existing disparities that may affect physician recruitment and retention.

Conversion of Facilities to Freestanding Medical Facilities or Other Lower Acuity Providers

The question of facility conversion is complex and requires careful consideration of health care access, community needs, and financial sustainability. MHA members have a range of perspectives on HSCRC's role in these discussions but emphasize the following principles:

- Any policy approach should be guided by a data-driven process to assess the appropriate inpatient bed capacity needed across jurisdictions in the intermediate and long term.
- The hospital field supports preserving hospital and health system autonomy in making facility conversion decisions to ensure transitions align with community health care needs and financial sustainability.
- Future discussions should explore incentives that encourage hospitals to convert more freestanding medical facilities to increase capacity and access.

Percentage of Revenue Under Global Budgets

Members provided diverse feedback on which services should be excluded from the Global Budget Revenue model. Among the services mentioned, obstetric care, hospital-at-home, and

advanced diagnostic imaging (e.g., MRI) were highlighted as areas that may benefit from a more flexible reimbursement model.

Conclusion

The MHA vision for today and for the future is to have healthy hospitals and healthy communities. This is an important moment for the Maryland Model as we transition to the AHEAD Model. Our hospitals will be central in the effort to improve health quality, health equity, and population health. They must be empowered and resourced to meet the challenge of caring for Marylanders who are aging and have increasingly complex health needs. HSCRC must act swiftly to adopt and implement policies that will support hospital sustainability and enable our hospitals to meet baseline patient needs, invest in care transformation and population health, and make needed capital investments.

Thank you again for the opportunity to comment on these important matters. If you have any questions, please do not hesitate to contact me.

Sincerely,

Melony G. Griffith
President & CEO

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

CHESAPEAKE
PEDIATRIC DENTAL
GROUP

January 28, 2025

Re: Written Comment AHEAD

Dear Commission on HSCRC,

My name is Hakan Koymen and I am a pediatric dentist in the State of Maryland. I am writing during this period of “open comments” to discuss where pediatric dentistry will fit in the AHEAD Model. As a pediatric dentist, we see many young children with severe medical conditions, children with autism spectrum disorders, special needs, and/or generalized anxiety/ADHD that cannot be treated in the traditional dental setting or an Ambulatory Surgery Center (ASC). These children need to be seen under general anesthesia in a hospital setting to safely restore teeth with significant decay and extract those that are abscessed. In Maryland, there has been limited access to operating rooms for these cases because hospitals have been hesitant to provide valuable OR resources because the current payment model does not consider these dental cases.

With the AHEAD Model beginning in 2026, I feel that we have an opportunity to expand access to operating rooms for pediatric dental cases. My thought is that if you place pediatric dentistry in the “carve out” for AHEAD you would increase the number of hospitals that would be interested in seeing these children and we would create a situation where children of all socioeconomic strata, especially our most vulnerable children, would have equal opportunity for oral health. This would also significantly cut down costs for unnecessary ED visits for dental pain and abscesses which is where many of these children end up.

It also makes sense to put pediatric dentistry in the carve out, because our profession is not directly linked to the hospital. As dentists, we are not admitting children or providing comprehensive medical care to these children. They are being seen on an outpatient basis, and pediatric dentists are using the hospital to treat these children safely and once they are completed to continue their care outside of the hospital system.
Maryland has a history of bad outcomes due to dental neglect or the inability to have treatment performed in a timely manner. We only have to look as far as Deamonte Driver, who died of a dental abscess that went untreated because he couldn’t be seen by a provider. With the current difficulties of limited access to operating rooms to treat these children with severe dental disease and dental pain/abscesses, we are setting up for another preventable tragedy to effect one of the children in our State.

I believe that the introduction of AHEAD allows us a window of opportunity to treat our most vulnerable population in an equitable fashion as we open the door for more hospitals to see these children and get the care they desperately need, while at the same time reducing ED visits. I urge the Commission to strongly consider including pediatric dentistry in the AHEAD carve-out to ensure equitable access to critical oral healthcare for all Maryland children.

Sincerely,

Hakan Koymen, DDS, MS
Diplomate, American Board of Pediatric Dentistry
Dental Director, Maryland Healthy Smiles–SKYGEN

January 31, 2025

RE: HSCRC statement

Access to care

To Whom it May Concern:

I am not a subject matter expert, but I can offer an example of our inability to access a particular procedure in our community and state. My husband and I have lived in Montgomery County since 1986. We have always experienced excellent and accessible health care, that is until recently. In 2018, my husband Mike was diagnosed with minimal cognitive impairment, in 2020, Alzheimer's Disease and in 2021 Parkinsonism. He has a pacemaker. Over time, these diseases have progressed, particularly his right tremor, which impacts his quality of life. Our neurologist made us aware of a particular routine procedure, Focused Ultrasound, that has been very successful in eliminating tremor. With my husband's complex diagnosis, our neurosurgeon was unable to schedule this procedure in the State of Maryland due to the lack of access to specialized equipment. Ultimately, we have scheduled the procedure out of state, with a different neurosurgeon. The lack of access to treatment for this procedure, with a Maryland neurosurgeon, in the state of Maryland, was disappointing. It has created a significant delay in treatment for my husband and will require us to spend time, travel, and have an additional financial burden to access a treatment that could have been offered in Maryland. In the future, what is your plan for handling situations like ours? Please do not hesitate to reach out to me if you have additional questions about our experience.

Beth Matcham Shepherd

Michael Shepherd

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TidalHealth™

Executive

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February 3, 2025

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

Dear Dr. Kromm:

TidalHealth, Inc. ("TH") is responding to your request for comments related to Health Service Cost Review Commission ("HSCRC") policies that support goals of the AHEAD Model. We appreciate the opportunity, and we know that critical changes are needed so that the citizens of Maryland, regardless of where they live, have the needed access to healthcare services.

There are foundational issues that exist in the current Total Cost of Care Model that need to be fixed to ensure that we can meet what is required in the AHEAD Model, but most importantly, for us to be able to provide medically necessary care to our patients. These issues continue to be raised by us and others and without correcting the foundation will create major roadblocks for further improvement and meeting the goals of the AHEAD Model.

These foundational issues are around adequacy of the global budget revenue by recognizing full inflation and appropriate volume growth, while addressing inefficient Hospitals.

(1) Adequacy of the update factors given the rising cost pressures and increase in payor denial

The cost pressures referenced in the Maryland Hospital Association's letter related to growth in physician hospital-based subsidies. deferring capital needs, and increased payor denials is something we are experiencing, as well as other cost pressures. COVID funding masked the true financial picture and in FY26, we will need adequate funding for us to maintain a small operating profit. It is also necessary to proactively fund our GME program, as requested for several years, through a Rural GME Policy so we can plan and provide stabilization to our financial outlook.

Additionally, the HSCRC should move forward with the financial feasibility study that was supposed to be performed given the continued declines in hospital margins. The Industry has completed a financial feasibility study that shows unacceptable erosion in hospital financial performance.

(2) Fully recognizing demographic growth in methodologies

In FY 25, only .25% of the actual 4.25% of age adjusted population growth was funded statewide with TidalHealth Peninsula Regional Hospital("THPR") being funded only .38% of their actual 6.85% of age adjusted population growth. This is only a recent year example, but the cumulative impact is material.

This gap in funding significantly contributed to excess total cost of care savings. This has harmed the State as a whole, but certain areas of the State, like the Eastern Shore of Maryland, have been impacted more given their demographics. Current excess savings should be used to fund this differential, and policies should be revised to adequately fund for these changes going forward.

(3) Rebalancing the funding between efficient/non-efficient hospitals.

There is a wide disparity in base rates between hospitals. The cumulative funding difference between TidalHealth and other non-efficient Hospitals has created community inequities that should be corrected. Several recommendations would be:

(a) Create a standard base rate for all hospitals before add-ons, such as Graduate Medical Education, Labor Market differences, etc.
(b) Reduce excess Hospitals/Services in areas of the State by enforcing current policies and creating new policies that provide an equitable funding structure to free up funding to be redistributed; and
(c) Align HSCRC and Maryland Health Care Commission work around healthcare system needs to address adequacy of services in different counties and regions in the State.

We hope that the HSCRC will develop solutions to these on-going issues and not build on the current foundation to ensure that Marylanders regardless of where they live have access to their care needs and that Hospitals and providers caring for them receive equitable and appropriate funding levels. Attached is additional input to your specific questions.

Thank you again for providing us an opportunity to comment. We hope you take into consideration our on-going concerns.

Sincerely

Steve Leonard, President/CEO
TidalHealth Inc.

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

Attachment:

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

a. Over the past decade, hospitals have used the flexibility of global budgets, to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. To further drive this work, how can the payment system better recognize effective efforts? Medically necessary care needs to be adequately funded. Without adequate funds delay and rationing of care exists.

e. Do hospitals have planning needs to support innovative and affordable care models? If so, what are those needs, and how might the HSCRC support them? Our community needs assessment identifies our priorities and funding needs/models. Because of the prior work, TidalHealth Peninsula Regional has invested in a rural GME Program as a way to address physician shortages, access to care barriers, and the ability for patients to be cared for closer to home. These programs have attracted practicing Physicians to communities, as well as created a pipeline for the future. The HSCRC can support this by finalizing a Rural GME Policy.

2. Improving Access to Care. Another goal of AHEAD is for Marylanders to be able to receive the right care in the right location at the right time. This requires many steps, including appropriate hospital budgeting, sufficient investment outside of hospitals and effective oversight in those other levels of care.

d. Hospital global budgets are adjusted every year for statewide population growth. How, if at all, should this adjustment be changed or focused to promote the goals of the model for access to care, cost control, and population health? This was addressed in our letter, and we believe age adjusted population growth should be funded.

3. Other topics. There are several cross-cutting policy areas that could also be addressed in 2025.

a. Physician costs. Hospital-based physician charges to individual patients is outside the authority of the HSCRC. With costs of hospital-based physicians rising out of proportion to insurance reimbursements, what policy changes should be considered by HSCRC, and, more broadly, by the state? What, if any, special considerations should be made for physician costs in academic health systems, recognizing the role of existing funding for graduate medical education? HSCRC should fund GME in rural facilities and adopt the draft policy we shared to create needed stability as we build these Programs. HSCRC could provide a set funding level in the GBR based on provider specialty for hospital-based physicians and adjusted for payor-mix to adjust for lower payments by certain payors.

b. Facility conversions. Should the HSCRC consider facilitating the conversion of hospitals with declining numbers of patients and high market-level capital costs to

free-standing medical facilities or other lower acuity providers? Such a step could be designed to increase funding for hospitals seeing more patients as well as permit the restructuring of services at the conversion facilities to meet community needs. If so, what policies should guide this process? We agree that HSCRC should address Hospitals that have excess capacity and high costs. We believe that a majority of the Hospitals that have excess capacity are located in Baltimore City/County and as opposed to conversion, we believe that selective closing should be considered. We believe the current Integrated Efficiency Policy can be used to guide this process with rate reductions for high-cost hospitals.

c. Percentage of revenue under global budgets. Under the TCOC Model, the HSCRC was allowed to exclude up to 5 percent of in-state revenue from population-based methodologies, which the Commission utilized to ensure the delivery of high-cost outpatient drugs through the CDS-A policy. Under the AHEAD Model, this exclusion increases to 10 percent. What additional volumes should the Commission consider using fee-for-service methodologies for, e.g., expanded quaternary definitions or hospital at home? HSCRC should consider additional funding mechanisms for rural facilities given their large geographic coverage area to provide mobile/stationary clinics and home-based services not covered by Home Health, such as primary care, behavioral health, routine screenings, etc. The HSCRC could consider funding new technologies like the Center for Medicare and Medicaid Services.

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CORPORATE OFFICE

February 3, 2025

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

RE: Priority issues as Maryland prepares to enter the States Advancing All-Payer Health Equity Approaches and Development ("AHEAD") Model

Dear Dr. Kromm:

On behalf of the University of Maryland Medical System ("UMMS") and its member hospitals, I appreciate the opportunity to provide input on policy priorities as we prepare for the AHEAD Model. This truly is a critical period in terms of setting the foundational framework for the next ten years of our Model.

UMMS is committed to driving the AHEAD Model's goals of high-value care, fairness in access to care, and equitable outcomes in the communities we serve. Throughout our time on the Total Cost of Care Model, we have committed to being a leader in implementing valid, data-driven efforts to identify where disparities exist and work in partnership within our communities to design interventions to address them, directing differential effort toward our most underserved communities. We have built a robust data infrastructure and analytic process that target supports system-wide action plans that are developed and implemented at the hospital level, targeting leading health indicators such as severe maternal morbidity, unplanned readmissions, and diabetes.

The AHEAD Model's ambitious goals, combined with the Maryland Model's unique payment tools, represent a major opportunity to establish Maryland as a national leader in transformative care. UMMS has demonstrated its commitment to those goals through its efforts to date, but we cannot go further without the financial stability and policy foundation to do so. To truly work toward these goals, our Model must address the considerable financial pressures that continue to plague Maryland's hospitals. We have absorbed years of depressed operating performance, unable to invest in critical facility needs, program improvements, innovative technology, and population health strategies. The prolonged inability to make these investments absolutely puts us behind in AHEAD preparedness and produces unnecessary risk for Maryland citizens in terms of access to high quality hospital services. Considering the significant excess savings being generated by the Model, we certainly have the resources to address that risk.

Our hope is that the Commission's opportunity for comment kickstarts a process that delivers both the investment in resources and the policy evolution necessary to establish a solid foundation for long-term viability of AHEAD. Once again, the strength of our Model is we can address our problems in a way that is unachievable under payment models in other States.

UMMS is committed to being an active, engaged participant in this important work. While our complete responses to your questions are included with this letter, I consider the following to be the highest priorities for change. Addressing each of these issues is essential to putting the Model on a sustainable path to long-term success under AHEAD:

1. **Our payment model must evolve to better addresses the needs of Academic Medical Centers ("AMCs").** AMCs are leading clinical and teaching institutions that are deeply embedded in their communities, specializing in the most complex and difficult diagnoses and treatments, educating the next generation of health professionals, and advancing healthcare. AMC research provides important new knowledge leading to advances in understanding and treatment of diseases, including conducting innovative clinical trials to make new treatments available quickly and safely. Our Model must better support this vital role by carving tertiary and quaternary care out of GBR constraints and providing more funding pathways to drive continual reinvestment in the academic mission.

2. **Stabilize hospitals' current financial outlook and create mechanisms to better allow hospitals to share in the success of the Model.** Model savings, appropriately generated, represent the success of our collective efforts. We cannot continue to allow 100% of savings beyond Model targets to accrue to payer savings. Effective value-based models engage their provider partners in continuous transformation by allowing them to share in the successes, serving as a necessary source of financial stability and re-investment in model goals. I cannot emphasize enough that resource-starved hospitals will not achieve the transformation envisioned by AHEAD. Tools like the Medicare Performance Adjustment should be linked directly to Model performance and designed to allow hospitals to share both the benefits of Model success and accountability for poor performance, similar to an ACO shared savings structure nationally.

3. **We must address the issues with volume policy through the lens of access to care.** While we understand the Model's intentional linking of financial incentives to volume reduction and recognize that this has been a critical tool in terms of fundamentally changing the way hospitals think about volume, we also believe that providing appropriate resources for medically necessary care is essential to ensuring access to needed services. Our Model should always strive to generate savings through care transformation and population health improvement, rather than through underfunding of medically necessary care. There are several areas where volume policy refinement would significantly improve the Model's ability to achieve that goal. Specifically, a comprehensive review of the demographic and market shift policies is needed.

4. **We must define the driving characteristics of an effective hospital in the context of the AHEAD Model, and rethink the integrated efficiency policy, among others, on those terms.** The goals of high-value care, fairness in access to care, and equitable outcomes require significant, differential investment in our highest need communities. Hospitals in urban and rural communities must differentially invest in equitable access, quality care, and outcomes. This need for differential investment funds cannot be labelled as inefficiency. We absolutely need to engage in a process to define an "effective" hospital in the context of AHEAD goals and hold hospitals directly accountable to that definition. As it stands, with a bottom quartile overwhelmingly populated by urban and rural hospitals in high need communities, the current efficiency metric as designed acts as a barrier to investment in our communities of highest need and compounds with increased reporting/regulatory burden to these critical hospitals and communities.

5. **We must rethink the policy approach to population health accountability.** In our experience, implementing hospital-level accountability for transformation across a broad range of hospitals hinges on some important themes: data-driven accountability, maximizing engagement, translating broad-based goals into actionable performance, a root-cause analytic approach, and rewarding success. Too often the State's TCOC tools focus on identifying macro/population-level measures without translating these broad-based metrics to more specific measures that hospitals and providers understand how to engage in and contribute to progress. This lack of engagement stunts transformation and innovation but the HSCRC is designing policies still able to guarantee that savings goals are met. We strongly believe that change in the way we collectively approach policy making and tools available to support hospitals in this space is necessary for success. UMMS would fully engage in a multi-stakeholder evaluation of existing TCOC policies through this lens.

Because we serve so many communities in Maryland in so many ways, UMMS is deeply invested in the success of the Maryland Model, and I believe strongly that we must act to stabilize hospitals, evolve our policies, and position ourselves for a better future under AHEAD. As I said at the outset, this truly is a critical period in terms of setting the foundational framework for the next ten years of our Model. I am certain that if we do not take on these priorities, we will not achieve our goals. UMMS looks forward to collaborating with our State partners over the coming months on this important work.

Sincerely,

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

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

ATTACHMENT: UMMS Responses to HSCRC Call for Input

UMMS appreciates the HSCRC's request for input on policy evolution and investments needed to position Maryland for success under the AHEAD Model and strongly aligns with the industry's position outlined through MHA. We recognize that many of these questions pertain to broad questions of "how should we define?", "how can the system best support/engage?", and "what is the appropriate accountability tool?". When considering these questions, we believe that the key in many cases is to establish a data-driven, multi-stakeholder approach for established priorities whose intent is to define key indicators, partners, their roles in success, and agreed upon performance metrics. Along those lines, UMMS can offer the following input on the HSCRC's policy approach that apply broadly across the set of questions:

- **Identify and address the driving areas where under resourcing contributes to financial barriers to success.** UMMS absolutely agrees with the Maryland Hospital Association ("MHA") top concern that hospitals must come from a position of financial stability to maximally engage in the transformative goals of the AHEAD Model. Providing appropriate resources to ensure equitable access to medically necessary services, to address workforce shortage and inflationary pressures, and to address capital needs are core enabling factors for engaging in the more transformative goals of the Model. Policies such as the annual update factor, demographic adjustment, and capital funding policy should focus on providing sufficient resources to address needs.

- **Establish a data-driven, multi-stakeholder approach to policy building.** Many of the priorities contemplated by the questions would benefit considerably from convening stakeholders, including clinical and industry expertise, to engage in a data-driven process to identify specific drivers or indicators associated with the desired policy goal, defining the role of hospitals and providers in impacting those indicators, and designing performance measures that directly incent hospitals on those terms. To be successful, policies must engage providers in identifying goals, translate those broad goals into discreet, actionable performance metrics that hospitals and providers can engage in, and provide direct rewards for achievement. Once the policies are deployed, there should be an iterative learning system and support network at the State level to ensure hospitals do not need to duplicate policy resources internally and can focus on operationalizing the work. This process should be applied to many priority areas, including:
    - What signifies an effective hospital and designing efficiency metrics on those terms
    - Definitions and accountability for Potentially Avoidable Utilization ("PAU") and low-value care
    - Total cost of care and population health accountability tools, including AHEAD population health and equity measures
    - Ensuring volume policies promote equitable access to care

- **Avoid layering multiple policy incentives into single policies.** Instead, directly incent what you want through defined performance metrics, engaging stakeholders in the process of translating broad-based goals into specific performance expectations. It is better to have many directly incented things than

many things layered into one incentive. This disrupts the stakeholder's ability to engage in the incentive and translate into distinct actions.

Beyond those broadly applicable areas of input, UMMS offers the following responses to the HSCRC's questions around ensuring high-value care, improving access to care, and other topics.

Ensuring High Value Care: *A core goal under AHEAD is to bring innovative and affordable care models to the state that improve the health of Marylanders.*

a. *How can the payment system better recognize effective efforts to improve health?*
b. *How can the HSCRC best identify opportunities and support the development of such efforts?*
c. *How might the HSCRC work with hospitals, physicians, and other partners to reduce low-value care?*
d. *Should the HSCRC consider alternative or complementary approaches to PAU?*
e. *How might the HSCRC support planning needs to drive innovative and affordable care models?*

UMMS offers the following input on where the HSCRC's policy approach can evolve with the goal of creating a regulatory environment that fosters innovative and affordable care models to improve health:

- **Rethink the policy approach to population health accountability.** The State's TCOC tools tend to identify population-based measures without translating these broad-based metrics to discreet, actionable performance measures. In our experience, implementing hospital-level accountability for transformation across a broad range of hospitals hinges on some important themes: data-driven accountability, maximizing engagement, translating broad-based goals into actionable performance, a root-cause analytic approach, and rewarding success.

- **Think overtly about accountability and governance for non-hospital investments.** As goals expand outside the hospital regulatory system, accountability and governance must also be bolstered in these settings in a way that supports and integrates the hospital model with other pieces of the care continuum. Maryland hospitals have supported statewide investments in regional partnerships, MDPCP, Medicaid etc. and accountability for outcomes should be prioritized to ensure a collective and fair system of change.

- **Create tools to allow hospitals to share in the success of the Model as a source of continuous investment in transformation.** Excess savings beyond what the Model requires represent the success of our collective efforts. Effective value-based models engage their provider partners in continuous transformation by allowing them to share in the successes, serving as a necessary source of financial stability and re-investment in model goals. Specifically, the Medicare Performance Adjustment should be linked directly to Model performance and designed to allow hospitals to share both the benefits of Model success and accountability for poor performance and the CTI policy should consider payment of savings beyond a statewide neutral offset if the model performance is positive

- **Create tools to directly invest in efforts to achieve desired outcomes.** Leverage the unique payment mechanisms available to make direct investments in identified priorities. Hospitals need the ability to approach this work similarly to capital or grant planning, the permanent funding sources available to support five-to-ten-year plans to impact health outcomes.

- **Rethink the policy approach to Potentially Avoidable Utilization ("PAU").** In general, UMMS believes the HSCRC should de-emphasize "PAU in all policies" in favor of penalty/rewards directly linked to desired outcomes**.** The HSCRC should convene a multi-stakeholder group to identify specific volume types that the hospitals commit to positively impacting, define actionable performance measures, and assign performance accountability for hospitals on those terms. PAU and other methods of calculating 'waste' should also have robust clinical stakeholder input and leave room for specification and refinement to a Maryland context.

Improving Access to Care: *Another goal of AHEAD is for Marylanders to be able to receive the right care in the right location at the right time. This requires many steps, including appropriate hospital budgeting, sufficient investment outside of hospitals and effective oversight in those other levels of care.*

a. How can the HSCRC develop more useful measures of needed access?
b. Should the HSCRC consider policy to slow the rate of volume declines related to ER wait times?
c. What, if any, changes are appropriate to HSCRC's volume policies to support access to needed care?
d. How should the adjustment for statewide population growth be changed?
e. *Recognizing that effective hospitals can provide greater access to care, what are key domains and metrics that should be used to assess the effectiveness of hospitals?*

UMMS offers the following input on the HSCRC's policy approach to volume and access to care:

- **Use the 10% carve out to protect access for complex care (high-cost drugs, tertiary care, quaternary care), particularly at the Academic Medical Centers ("AMCs").** Our Model must support the vital role of AMC by carving tertiary and quaternary care out of GBR constraints and providing more funding pathways to drive continual reinvestment in the academic mission.

- **Volume policies should cover the cost of doing medically necessary work.** The financial impact each additional amount of work has on a hospital has a direct impact on access. If "doing more" of a necessary thing has a negative financial impact (instead of a neutral impact), the consequence is that the hospital is incented to restrict, not meet, access. Volume policies should fund the cost of doing medically necessary work, as long as it is within the expectation of year-over-year change. Covering the cost of doing medically necessary work supports access without abandoning population-based payment or creating an excessive financial incentive. Conversely, policies that intentionally underfund the cost of medically necessary care risk creating an adverse incentive to restrict access. UMMS believes the HSCRC should evaluate market shift and demographic policies through this lens

- **Define the driving characteristics of an effective hospital in the context of the AHEAD Model, and rethink hospital efficiency policies on those terms.** The goals of high-value care, fairness in access to care, and equitable outcomes require significant, differential investment in our highest need communities. Hospitals in urban and rural communities must differentially invest in access and outcomes, and yet, having higher GBRs makes them perform worse on the existing efficiency metric. UMMS agrees that we need to define an "effective" hospital in the context of AHEAD goals and hold hospitals directly accountable to that definition. As it stands, the current efficiency metric is not that solution and risks acting as a barrier to investment in our communities of highest need.

- **Do not layer other goals onto volume funding as gatekeepers to appropriate volume funding.** While issues such as ED wait times, low value care, and hospital effectiveness are appropriate priorities, they should be defined and incented directly based on valid performance measures.

Other topics: *There are several cross-cutting policy areas that could also be addressed in 2025.*

a. What, if any, special considerations should be made for physician costs?
b. Should the HSCRC consider facilitating the conversion of hospitals with declining numbers of patients and high market-level capital costs to free-standing medical facilities or other lower acuity providers?
c. What additional volumes should the Commission consider carving out of GBR?
d. What other major changes to policies under the Maryland Model of population-based payment should be considered? Please be as specific as possible.

Issues such as how to address the growing burden of physician costs, payer denials, facility conversions, and graduate medical education are important to the long-term success of our model and would benefit considerably from convening stakeholders to define the desired policy goals, evaluate policy options, and define how hospitals and providers would interact with them. UMMS encourages the HSCRC to engage stakeholders in discussions of these issues.

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Date January 31, 2025

RE: HSCRC Opportunity for Comment

To Whom It May Concern at Health Service Cost Review Commision:

The way these questions are posed distracts from what many providers see as problematic. As a neurosurgeon, my concerns differ from those of primary care. My practice depends on a robust inpatient system for high-quality treatment of complex diseases and injuries in Montgomery, Frederick, Howard, and Prince George's Counties. The global budgeting system is failing Maryland's patients. They should receive care close to home, not have to travel long distances. This system restricts hospital growth and the addition of vital technology, setting procedure limits based on cost rather than quality.

Various hospitals are indicating the need to limit certain surgeries due to their high cost. This affects access to care for patients with chronic diseases such as epilepsy, Parkinson's Disease, and essential tremor. While these treatments are expensive, they significantly enhance quality of life and increase productivity. Due to global budgeting that focuses on cost and volume rather than outcomes, care is being restricted, resulting in doctors referring patients out of state. The financial constraints on hospitals, which affect their ability to monitor quality and invest in programs to improve patient access and care quality, may eventually compel physicians and patients to seek alternatives elsewhere.

That all being said, I will attempt to address the questions that I believe I can.

1a. I am unsure of the validity of the premise only because I am not exposed to this part hospital programming and efforts. However, if there was a methodology that money spent on after discharge planning, physical therapy, adherence to medication, and ensuring outpatient follow up, could be discounted from the budget this might decrease financial strain. This encourages preventive care and helps prevent re-admission. It is my assumption that these programs can be use not only outside the GBR but be allowed to make money (home nurse visits, PT charges, remote patient monitoring).

1b. CRISP has been a tremendous help in ensuring that imaging studies and other tests do not get repeated, and that information is available from multiple sources to the providers. Expanding on this by incentivizing all systems, hospitals, labs, etc. in the MD, VA, DC, Delaware region participate would be helpful. Not all systems participate.

1c,d,e and beyond.

HSCRC has done a very poor job communicating with physicians directly and allowing us to understand "low value care" concerns. This is communicated only to hospitals. There seems to be an assumption that the hospitals are effectively communicating this to the physicians. This may be true in an employed model. However, many physicians in the state of Maryland are not employed by hospitals or large institutions. These physicians need effective

communication to what the state perceives to be low value care. This should be done in an evidence-based manner. I am somewhat dubious of the low back surgery example presented here. There were several assumptions made in the methodology. The first assumption is that the chart reviews adequately screened the exams and histories - were radicular symptoms or other "acceptable diagnoses" missed and should have been included? The second assumption is that the surgeries "didn't work." I see no review of the outcomes - improved Oswestry disability index (ODI) scores, decreased opiate use, return to work and independence. All of these have a positive impact on the individual as well as society. These "low value" procedures need better examination; the baby should not be thrown out with the bath water. That is to say that a surgery that might be costly, may have a considerable positive impact on the patient. Again, this is a case where the HSCRC places cost over outcomes. There must be a way to look at physician outcome based on length of stay, complication and outcome measures (opiate use, ODI, return to work, diminished physician visits, QOL measures). When a surgeon or facility is better than their peers or peer institutions or has a better reputation for a particular procedure or treatment protocol for a given disease or condition, more people will seek treatment there. This increase in volume may negatively impact the budget until adjustments are made. This penalizes the facility, prevents important reinvestment and growth. This seems counterintuitive to aims of the system. The HCSCRC needs to look not only at cost and volume, but outcomes and quality.

Beyond these questions I would like to address how this system impacts my patients, the patients of my peers and our practices. The GBR penalizing residents in areas where the local facility is not given the opportunity to invest and grow to serve their community. Hospitals must stay within budget and therefore cannot invest in new capital equipment or new technology to serve their local community. By consequence, residents need to travel outside their community for care. This migration is not just in state - many patients are seeking treatment in West Virginia, Virginia and the District of Columbia. These jurisdictions are not limited by the budget constraints of the HSCRC. Physicians seeking to use up-to-date, modern, or innovative equipment are stymied by the inability for hospitals to make money for reinvestment. These physicians are migrating out of the state to seek other to treat their patients. State funded or private, well-endowed universities have deeper pockets to fund these endeavors, but they are only located in Baltimore. Even the most well-endowed institution is using D.C. to offload patients for radiation treatment as this is outside the clutches of the global budget. Other larger healthcare systems transfer patients from their Maryland facilities to their D.C. counterparts to escape this system as well. This undercuts those facilities who are solely Maryland based. The cost of transfer should be part of the budgetary calculation, and these practices need monitoring. This practice pulls patients from their community and families when proximity for emotional support is paramount and an essential part of the healing process.

The goal of containing cost is laudable, but the methodology of the HSCRC has curtailed innovation of care, and Maryland community hospitals are being left behind. Residents in these communities are seeking care elsewhere and the physicians are seeking other facilities to render this care. The experiment of global budgeting has failed. When neighboring states have better opportunities, shorter wait times and more innovative care, the system does not work. I urge

the HSCRC to abandon the idea of Global Budgeting as method of cost containment. Seeking higher quality is more important than containing costs. Would you want your family to have the highest quality of care of least costly care? Not that these are mutually exclusive, but quality is more important than cost for those we love, right?

Sincerely,

Zachary T Levine MD FAANS
President Washington Brain & Spine Institute
Director of Neurosciences, Adventist Healthcare

Frederick Health

Frederick Health
400 West Seventh Street
Frederick, MD 21701
240-566-3300

February 4, 2025

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

Dear Dr. Kromm,

I am writing today to respond to the request for comments from the HSCRC to help guide policy prioritization as the state prepares to participate in the AHEAD Model.

Frederick Health encourages the HSCRC to focus on the following policy and funding priorities as it reviews the collective feedback of the industry. The HSCRC should commit to a timeline for addressing these major policy concerns prior to any hospital being asked to sign agreements to move to the AHEAD model. Frederick Health is requesting that the one-time set-aside funding that was recently added to stabilize the hospital's financial performance remain in rates until certain methodologies are considered and can be implemented including the following:

- **Physician subsidies**. Current HSCRC policies focus on the regulated margin of the hospital and do not consider the significant amount of funding that is needed to staff the hospital with physicians. Policies should be updated to allow for funding of physician costs that are critical to operating the hospital.
- **Demographic policy**. The HSCRC's current demographic policy does not adjust for the aging of the population, limiting necessary funding for hospitals based on the expected increases in utilization including potentially avoidable utilization volume as the population ages.
- **Capital policy.** The criteria to qualify for capital funding under the existing policy is too narrow and does not provide a path for Frederick Health to appropriately recapitalize an aging facility nor to ensure appropriate access to care for a growing population. The HSCRC should revise its current capital funding policy to account for other criteria such as Days Cash on Hand, Age of Plant, and Cash to Debt Ratio in assessing need.

The current model is generating significant excess savings (est. $600 - $650M for CY2024). These excess savings should be used first to ensure hospitals have sufficient funding for hospital operations before being used to fund population health initiatives.

Below are answers to specific questions raised by the HSCRC.

- **Physician costs. Hospital-based physician charges to individual patients is outside the authority of the HSCRC. With costs of hospital-based physicians rising out of proportion to insurance reimbursements, what policy changes should be considered by HSCRC, and, more**

broadly, by the state? What, if any, special considerations should be made for physician costs in academic health systems, recognizing the role of existing funding for graduate medical education?

Although the statutory authority of the HSCRC may not explicitly address physician expenses, Frederick Health believes that the HSCRC already has the statutory authority to treat a hospital's staffing costs related to hospital-based physicians just like any other hospital cost related to its regulated operations. This view in no way asks the HSCRC to review and set physician charges or to otherwise regulate physicians. Frederick Health is seeking consideration of hospital cost to ensure sufficient physician coverage for regulated hospital services, net of any corresponding off-setting professional revenue. Taking this position would allow the HSCRC to consider these costs when assessing whether a hospital's total regulated costs are reasonable and therefore, whether a hospital's regulated *revenue* is adequate. We believe the HSCRC relied upon this statutory authority most recently when it provided hospitals with an annual rate increase of $50 million to support hospital staffing needs, and as the HSCRC stated, was to offset unusual pressure on the costs of physician support experienced by hospitals over the past few years. While we were grateful for our portion of the $50 million, it does not come close to offsetting the substantial annual costs Frederick Health Hospital faces to ensure it has sufficient physician coverage to provide hospital-based services.

We ask the HSCRC to establish a physician cost policy to provide a funding mechanism to address hospitals' physician staffing costs. Until such a policy can be established, we ask the HSCRC take one or more of the following actions: (1) provide a more significant industry-wide funding increase; (2) allow the one-time money that was recently added through the set aside in order to stabilize the hospital's financial performance to remain in rates; and/or; (3) consider a financially distressed hospital's individual circumstances regarding hospital-based physician staffing costs when deciding upon new funding requests. As noted above, we believe the HSCRC has sufficient statutory authority to establish such a policy and to take such interim actions. If the HSCRC has relied on statutory authority different from that stated above to occasionally provide funding to hospitals to offset or otherwise be used to support physician costs (such as through the Revenue for Reform policy, in addition to the January 1st action described above), we respectfully request the HSCRC to so clarify and to rely on this alternative authority to provide a funding mechanism to help offset the substantial provider costs faced by hospitals. If, despite its prior actions, the HSCRC does not believe it has the authority to reimburse hospitals for the costs they incur to adequately staff the hospital, then the HSCRC should work with the Maryland General Assembly to secure the statutory authority it needs to do so. We would be happy to partner with the HSCRC in drafting legislation on this critical topic.

Furthermore, as a community hospital without a teaching program, we believe there is an inequity in the current system that favors teaching hospitals, which receive funding through graduate medical education (GME) dollars originally included in their hospital base rates for hospital-based physician coverage. This disadvantages community-based hospitals that currently have no means of recovering such costs. We suggest that the HSCRC calculate how much GME funding is included in GBR funding and provide a proportionate amount of funding to non-teaching hospitals across the state to fund hospital-based physician costs.

We further encourage Maryland to take a wholistic state-wide approach in order to stabilize the physician workforce, as Maryland is ranked 38th in the Best and Worst State for Doctors (2025)[1].

- **Hospital global budgets are adjusted every year for statewide population growth. How, if at all, should this adjustment be changed or focused to promote the goals of the model for access to care, cost control, and population health?**

  Frederick Health supports MHA's recommendation to change the demographic methodology to discontinue the existing scaling factor that lowers the adjustment so that it aligns with unadjusted state projections for annual population change. The HSCRC should implement a more straightforward, implementable modification to the age-adjusted approach for funding demographic growth for FY 2026 and develop a more refined risk adjustment approach in the long term.

  Policies need to recognize that patients will utilize more hospitals services as they age, and hospitals need to be appropriately funded for providing this additional care. This funding does not diminish the need to continue focusing efforts on implementing programs, such as palliative care, that may reduce additional utilization.

- **As patients move from one hospital to another within specific service lines, there is an adjustment made to both hospitals' budgets. What, if any, changes are appropriate to HSCRC's policies for this market shift to support access to needed care without abandoning population-based payment and creating an excessive financial incentive for hospital-based treatment?**

  While the Model is designed to reduce or eliminate the incentives to grow volume that exist in a fee for service system, it has overcorrected in current policies by underfunding hospitals that experience volume growth due to patient movement. The current market shift policy does not adequately reimburse hospitals for the variable cost of shifting volumes, penalizing hospitals that are providing necessary care to their communities.

  Frederick Health supports the recommendation by the Maryland Hospital Association to use the annual filing to calculate VCF percentages by rate center, apply the calculated rate center-specific VCFs to service line/rate center charges, and then calculate service line-specific VCFs to apply statewide. An optimal approach would capture as variable costs direct expenses and direct patient care overhead costs, resulting in an appropriately higher calculated average VCF. We would also support changing from a zip code level analysis to a county or regional one, similar to the national AHEAD methodology.

- **The HSCRC policies provide an added incentive to reduce "potentially avoidable utilization" as defined by readmissions and PQIs. Given answers to the questions above, should the HSCRC consider alternative or complementary approaches?**

  The HSCRC should continue to refine existing payment policies to ensure that the incentives or penalties are clearly aligned with specific clinical interventions that promote the reduction of

[1] https://wallethub.com/edu/best-and-worst-states-for-doctors/11376

unnecessary utilization and total cost of care, rather than macro-level incentives which are less likely to be successful. As these policies are developed it is critical that the HSCRC recognize it is not reasonable that all potentially avoidable utilization can be eliminated.

- **Do hospitals have planning needs to support innovative and affordable care models? If so, what are those needs, and how might the HSCRC support them?**

  The HSCRC is generating significant savings above what is required in the Model agreement. This provides an opportunity to utilize those funds to shore up hospital finances, creating the ability for those hospitals to invest in clinical programs which will accrue to the benefit of the Model. When hospital finances are stabilized, the HSCRC could consider a separate funding pool for these types of initiatives, with the funding being made permanent if the initiative is successful.

  Until our hospital finances are stabilized, we have no intention of investing in additional external innovation.

- **Over the past decade, hospitals have used the flexibility of global budgets, to establish programs to prevent illness, manage chronic disease, and support patients at home. Many opportunities for better management of chronic illness and prevention remain. To further drive this work, how can the payment system better recognize effective efforts?**

  Existing HSCRC programs should be modified to first identify metrics that hospitals can have a measurable impact on by implementing proven interventions, and then to create a reward and penalty structure that promotes the use of those interventions. The HSCRC could create a funding pool for initiatives that are likely to prevent unnecessary utilization and improve quality, however, unlike prior grant programs, these initiatives should be permanently funded if proven successful. Hospitals should also receive credit in HSCRC policies for successful programmatic investments to date.

  Until our hospital finances are stabilized, we have no intention of investing in additional external innovation.

- **Maryland has had a strong track record of statewide and regional investments to create common utilities to enhance care and health outcomes. How can HSCRC best identify these opportunities and what steps can the HSCRC take to support the development of such efforts?**

  Frederick Health would encourage the HSCRC to review the current administrative reporting requirements for hospitals before layering on additional tools. Standardizing data collection efforts could minimize duplication and eliminate staff time that would be better served treating patients.

  If additional initiatives are identified, the impact to community-based providers and organizations also needs to be assessed as they often have limited bandwidth to engage with multiple tools.

  That said, until our hospital finances are stabilized, we have not intention of investing in additional external innovation.

- **Numerous organizations and approaches have documented how the fee-for-service system generates low value care. Maryland does not necessarily perform well on these metrics despite the different hospital financial incentives. See for example the Lown Institute analysis of Unnecessary Back Surgery in which Maryland is average: https://lownhospitalsindex.org/unnecessary-back-surgery/. How might the HSCRC work with hospitals, physicians, and other partners to improve clinical decision making to reduce low-value care?**

  The HSCRC should convene stakeholders to better understand the various reasons why these procedures are being performed and alternative types of care are not being pursued. These reasons include lack of access, payer authorization barriers, concerns with patient satisfaction (patient needs vs patient wants), and a medical malpractice climate that promotes defensive medicine. Hospitals cannot solve these issues in isolation and will need to partner with the HSCRC to address them.

- **Currently, access to needed care in Maryland is assessed through a series of individual measures, including ED wait times, hospital beds per capita, avoidable admissions per capita, and others. This disjointed approach cannot account for the complex relationship of these access measures to one another. How can the Commission and partner agencies develop more useful measures of needed access that support prioritization of funding and rationalization of existing investments?**

  The HSCRC needs to recognize the significant barriers to discharging patients that exist and that are leading to longer lengths of stay for patients, many of which are largely outside of the hospital's control. These include limited availability of post-acute beds, both in the number available and the willingness of the post-acute providers to accept patients.

  A key component to make progress in this area is alignment and accountability for state agency partners that play a critical role in approving program eligibility, tracking referrals and placements, holding Medicaid Managed Care Organizations accountable, etc. The state cannot solely look to the hospitals to solve structural issues, many of which are multifaceted with a central role for the state to play.

- **Facility conversions. Should the HSCRC consider facilitating the conversion of hospitals with declining numbers of patients and high market-level capital costs to free-standing medical facilities or other lower acuity providers? Such a step could be designed to increase funding for hospitals seeing more patients as well as permit the restructuring of services at the conversion facilities to meet community needs. If so, what policies should guide this process?**

  Several hospitals in the state have been converted to Freestanding Medical Facilities (FMFs) but this has been on a case-by-case basis and driven by the individual hospital systems. The HSCRC, in partnership with the industry, could engage in a data-driven health needs planning process to determine what capacity may be needed by geography, allowing for a robust discussion about capital allocations and reinvestments in aging facilities.

- **What other major changes to policies under the Maryland Model of population-based payment should be considered? Please be as specific as possible.**

In addition to the focused suggestions on physician subsidies, and demographic and capital policy revisions, Frederick Health believes that the various quality programs need to be reviewed to align with the AHEAD model. For example, the HSCRC readmission policy should change from all-cause

to same-cause. Policy changes and attainment targets should be approved prior to the measurement period. Hospitals have made significant infrastructure investments to manage the various quality programs and thus rewards under these programs should be commensurate.

Thank you for the opportunity to respond to the request for comments. Frederick Health looks forward to working with the state as we move into the AHEAD Model, but wants to reemphasize that we cannot proceed without first addressing the significant financial challenges that hinder our ability to be successful.

Sincerely,

Tom Kleinhanzl
President & CEO

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

KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
Mid-Atlantic Permanente Medical Group
700-B 2nd Street NE, 5th Floor
Washington, DC 20002

February 7, 2025

Jonathan Kromm, PhD, Executive Director
Joshua Sharfstein, MD, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Executive Director Kromm and Chairman Sharfstein,

Thank you for the opportunity to comment on the Advancing All-Payer Health Equity Approaches and Development (AHEAD) model, the next phase of Maryland's unique hospital rate setting system. This is a pivotal time for the model and the state, and Kaiser Permanente is pleased to be among the stakeholders at the table to collaborate on a sustainable path forward. We share the goal of incentivizing effective integration of care that is designed to prevent illness, manage chronic diseases, and support patients across the care continuum.

Kaiser Permanente (KP) is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, provides and coordinates health care services for close to 800,000 members. In Maryland, we deliver care and coverage to approximately 450,000 members. KP provides inpatient care through strategic partnerships with 14 core hospitals. Inpatient care is delivered and coordinated by Mid-Atlantic Permanente physicians, supported by care transition coordinators and clinical pharmacists. It is through this integration with partner hospitals that improvements are realized in the average length of stay, quality of care, care coordination, patient satisfaction and patient outcomes.

It's important to note that a major driver of financial hardship for hospitals is the rapidly escalating workforce costs. Kaiser Permanente (KP) also faces these issues but remains committed to offering fair and market-competitive salaries and contracts with its providers. KP incurs rising costs in three primary ways: through the salaries and rates paid to its providers, payments for hospital services included in the established rates within the All-Payer model, and supplemental funds for specialty inpatient services not provided by KP's medical group. This situation places KP at a distinct disadvantage compared to other carriers in the state.

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[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.

Building on the innovations of Maryland's All-Payer model, AHEAD presents an opportunity to advance the value proposition of high-quality care in the most appropriate clinical setting. We believe that the Maryland approach to AHEAD model provides numerous opportunities to further refine and improve the management of complex patients.

Opportunities to Incentivize Care in Ambulatory Settings Under the AHEAD Model

Low-value care delivered in high-cost inpatient settings occurs because of the lack of appropriate access to services in ambulatory settings. These resources include primary care for preventative services and specialty care to manage chronic conditions as well as access to timely and available post-acute services like home health, respite care, palliative care, and hospice services. Building ambulatory care capacity in partnership with the AHEAD model is an opportunity to improve health and reduce utilization of care in high-cost settings.

To develop and sustain these ambulatory programs, we believe there is an opportunity to develop a joint pool of shared savings funded by initiatives like the Medicare Performance Adjustment (MPA), as a percentage of shared savings with CMS, can be established. Objective measures should be developed to assess these programs, ensuring that successful initiatives receive one-time investments for start-up funds and resources for sustainability. Measuring improvements in ED wait times from building more ambulatory capacity is one example, since patients who experience longer lengths of stay and face placement challenges, contributing to ongoing issues with extended emergency department wait times.

1. **Expand emergency medical services**

Maryland has piloted several emergency medical services programs in recent years, which could be expanded. Examples include the Alternate Destination Program and Mobile Integrated Health Programs proved essential during the COVID pandemic when resources were scarce. A 2019 report from the Maryland Health Care Commission (MHCC) and the Maryland Institute of Emergency Medical Services Systems (MIEMSS), required by Senate Bill 682 of 2018, outlined three EMS care models: EMS treat and release, EMS transport to alternative destinations, and EMS mobile integrated health (MIH) services. The report found that nearly 60 percent of EMS transports could be treated outside emergency rooms. However, these programs have faced major challenges, including regulatory and legislative barriers and financial constraints, which has thus far hindered widespread adoption.

2. **Improve and support post-acute services**

As part of KP's integrated delivery system and model of care, significant resources are directed to providing care in the ambulatory setting including home, virtual, medical office, outpatient urgent care and ambulatory surgery. As a result, KP members have a broader access to comprehensive outpatient services that are not in HSCRC rate set space. When inpatient services

are needed, our goal is to have our providers to care for our members throughout the care continuum. We accomplish this by consolidating care in our core hospitals.

Our ability to manage care through this structure is assuring consistent and reliable access to inpatient beds at core hospitals. While KP may advocate for reduced rates at these hospitals, KP does not want to place these hospitals at a financial disadvantage in the All-Payer model. We believe there is an opportunity for the Commission to consider alternative approaches to invest population health solutions for KP partner hospitals that could be leveraged as an investment to reduce the TCOC. We believe that such a model would allow for better integration and overall population health improvement for Marylanders in our care.
There are opportunities under AHEAD for the state to partner with integrated delivery systems like KP to participate in and support the development of robust post-acute care services including:

- **Access to affordable respite care.** Respite care helps prevent caregiver burnout and reduces the need for institutional placements. It offers a temporary solution for acute health crises, preventing emergency room visits. Key considerations include making respite care accessible and affordable, ensuring effective care coordination among providers, and tailoring programs to meet individual needs.[i]
- **Home health services.** Advances in home health services have recently been made to promote and safely delivery high quality medical care in the home setting. The adoption and acceptance of patients and their families to receiving medical care in the home setting significantly increased during the pandemic.[ii]
- **Palliative Care.** The role of palliative care has been long recognized as an important way of improving the quality of life for people with chronic conditions, including but not limited to cancer. [iii] Challenges still exist with engaging these services earlier in the course of illness, rather than waiting to discuss this option in a crisis setting when a patient is hospitalized. Resources to support robust palliative care programs are still limited.
- **Hospice Care.** Inconsistent and limited access to hospice care, especially in the home setting, is one of the drivers of avoidable hospital utilization and extended length of stay.[iv]
- **Telehealth.** Technologies like virtual urgent care and virtual acute care at home maintained appropriate care in ambulatory settings.

3. Incorporate Medicare Advantage into AHEAD

Nationally, access to and penetration of Medicare Advantage (MA) plans has increased. The majority (54%) of Medicare beneficiaries are now enrolled in a Medicare Advantage plan.[v] These plans often include additional benefits like prescription drugs, dental, vision, hearing, and wellness programs, making them a popular choice among beneficiaries.

In Maryland, the penetration of MA plans has been stifled due to lower reimbursement in a high-cost environment. Options to increasing access to MA plans include either improved revenue through benchmark adjustments, lower cost through rate relief, and access to care transformation initiatives and funding, currently only available to providers in traditional Medicare plans.

Kaiser Permanente is dedicated to providing high-quality, accessible, and affordable health care in Maryland and stands ready to work with you to build a care continuum that recognizes continuous improvement in quality and outcomes.

Thank you for consideration of our comments. Please contact Allison Taylor at (919) 818-3285 or allison.w.taylor@kp.org with questions.

Sincerely,

Isreal Rocha
Regional President
Kaiser Foundation Health Plan
Mid-Atlantic Region

Dr. Richard McCarthy
Executive Medical Director
Mid-Atlantic Permanente Medical Group

cc: Dr. James Elliott, Vice-Chairman
Ricardo Johnson
Maulik Joshi, DrPH
Adam Kane, Esq
Nicki McCann, JD
Dr. Farzaneh Sabi

[i] Yi, Yanling; Liu, Junxia; & Jiang, Ling. Does home and community-based services use reduce hospital utilization and hospital expenditure among disabled elders? Evidence from China. Front Public Health. 2023 Oct 25. Frontiers | Does home and community-based services use reduce hospital utilization and hospital expenditure among disabled elders? Evidence from China

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Dear Commission on HSCRC,

My name is Kristen Evans, and I am a pediatric dentist in Maryland. I am writing during this open comment period to address the role of pediatric dentistry in the AHEAD Model. Many of the children I treat have severe medical conditions, autism spectrum disorders, special needs, or anxiety/ADHD, making it impossible for them to receive care in a traditional dental setting or an Ambulatory Surgery Center (ASC). These children require treatment under general anesthesia in a hospital setting to safely address extensive decay and abscessed teeth. However, access to operating rooms for these cases in Maryland has been extremely limited, as hospitals are often reluctant to allocate OR resources due to the current payment model, which does not adequately support dental cases. A specific example is Sinai hospital of Baltimore under Lifebridge has reduced operating room time for dental practitioners by 25 percent over the last several years.

With the launch of the AHEAD Model in 2026, we have an opportunity to improve access to hospital-based care for pediatric dental patients. Including pediatric dentistry in the AHEAD Model's carve-out would encourage more hospitals to accommodate these children, ensuring that all—especially those most vulnerable—receive the critical oral healthcare they need. Additionally, this change would help reduce unnecessary emergency department visits and subsequent admissions for dental pain and infections, which many of these children currently experience due to lack of treatment options.

Pediatric dentistry is a logical fit for the carve-out because our profession operates independently of hospital systems. As dentists, we do not admit patients or provide ongoing medical care within hospitals. Instead, we utilize hospital resources to safely perform necessary dental procedures on an outpatient basis, allowing children to return to regular dental care outside the hospital setting.

Maryland has already witnessed the devastating consequences of limited access to dental care. The case of Deamonte Driver, who tragically died from an untreated dental abscess due to lack of timely treatment, and most recently Javion A. Fields who passed away while at an outpatient surgery center for dental treatment in Baltimore. These two children are a stark reminder of the urgent need for change. If we do not address the current challenges in accessing operating rooms, we risk another preventable tragedy affecting children in our state.

The implementation of AHEAD presents a crucial opportunity to ensure equitable treatment for Maryland's children while also reducing emergency department visits. I urge the Commission to include pediatric dentistry in the AHEAD carve-out so that all children, regardless of socioeconomic status, have access to vital dental care.

Sincerely,
Kristen Evans, DMD
Diplomate, American Board of Pediatric Dentistry
Public Policy Advocate, Maryland Academy Pediatric Dentistry

To: Chair Dr. Sharfstein and HSCRC Commissioners.
From: Dale Schumacher, MD, MPH, March 3, 2025

Medicare Spending Per Beneficiary (MSPB) Overview

At its January 8, 2025, meeting the Commissioners asked: how can the payment system better recognize effective efforts and identify objective criteria of utilization decline. The Commission also requested external comparison data. The Medicare Spending Per Beneficiary (MSPB) metric meets these criteria.

HISTORY MSPB

All states other than Maryland participate in Value Based MSPB reporting. The MSPB program was first implemented in CY 2014 and was publicly reported for each Hospital on Hospital Compare. *Because of Maryland's* ***unique non-DRG based rate setting,*** *MSPB reporting was not required. That policy changed in 2018 to include Maryland (80 FR 71297).* HSCRC uses 3M's APR-DRGs.

UTILITY AND REPORTS

MSPB is initiated using the index admission and includes claims data three days prior to admission and 30 days post discharge. The MSPB model has an indicator flag for an admission occurring in the prior 30 days prior index admission. Figure 1 is one of several revised reports provided by CMS.[1] The highlighted Hospital Specific Reports are particularly useful.

Table 1: Your Hospital's MSPB Measure

Table 2: A Summary of Your Hospital's MSPB Performance

Table 3: A Comparison of Your Hospital's MSPB Performance

Table 4: National Distribution of the MSPB Measure

Table 5: Detailed MSPB Spending Breakdown by Claim Type (see below)

Table 6: Detailed MSPB Episode Spending Breakdown by MDC

Overview of Supplemental Hospital-Specific Data Files

Each Hospital Specific Report (HSR) is accompanied by three supplemental hospital-specific data files:

1. Index Admission File: Presents all inpatient admissions for the individual hospital in which a beneficiary was discharged during the period of performance.

2. Beneficiary Risk Score File: Identifies beneficiaries and their health status based on the beneficiary's claims history in the 90 days prior to the start of an episode.

[1] CMS Reviewing Your FY 2025 Hospital VBP Program, Medicare spending Per Beneficiary Hospital Specific Report, June 5, 2024

To: Chair Dr. Sharfstein and HSCRC Commissioners.
From: Dale Schumacher, MD, MPH, March 3, 2025

3. Episode File: Shows the type of care, spending amount, and top five billing providers in each care setting for each MSPB episode.

Figure 1. Excerpt Table 5 from Example MSPB Report[2]

Table 5: Detailed Hospital VBP Program MSPB Hospital Spending Breakdowns by Claim Type

HOSPITAL NAME

Hospital Discharge Period: January 1, 2023 through December 1, 2023

Claim Type	Hospital Spending Per Episode [d]	Hospital Percent of Spending [e]	State Percent of Spending [f]	U.S. National Percent of Spending [g]
Total 3 Days Prior to Index Admission [a]	**$886**	**4.4%**	**3.1%**	**3.7%**
Home Health Agency	$6	0.0%	0.0%	0.1%
Hospice	$0	0.0%	0.0%	0.0%
Inpatient	$0	0.0%	0.0%	0.0%
Outpatient	$91	0.5%	0.5%	0.7%
Skilled Nursing Facility	$1	0.0%	0.0%	0.0%
Durable Medical Equipment	$10	0.0%	0.0%	0.0%
Carrier	$778	3.9%	2.5%	2.8%
Total During Index Admission [a] [b]	**$11,620**	**57.9%**	**53.4%**	**53.8%**
Home Health Agency	$0	0.0%	0.0%	0.0%
Hospice	$0	0.0%	0.0%	0.0%
Inpatient	$10,296	51.3%	47.0%	47.6%
Outpatient	$0	0.0%	0.0%	0.0%
Skilled Nursing Facility	$0	0.0%	0.0%	0.0%
Durable Medical Equipment	$29	0.1%	0.1%	0.1%
Carrier	$1,295	6.5%	6.3%	6.1%
Total 30 Days After Hospital Discharge [a] [b] [c]	**$7,563**	**37.7%**	**43.6%**	**42.6%**
Home Health Agency	$566	2.8%	2.6%	2.9%
Hospice	$289	1.4%	0.3%	0.8%
Inpatient	$2,033	10.1%	10.7%	14.5%

IMPLEMENTATION

This measure can be implemented to provide service line performance, a measure more recognizable by physicians as compared to population total cost of care measures. MSPB uses Medicare DRGs which provide national, state, and all hospital comparisons. The AHEAD program requires submission of Medicare claims sufficient for MSPB reporting. Implementation of MSPB should be straightforward.

In summary, MSPB provides external comparisons. Utilization can be linked to quality measures at the beneficiary level. These comparisons are accepted and understood by the physician community.[3] MSPB can complement EQIP. CMS routinely produces multiple MSPB reports so production costs are minimal and CMS or its contractors provide training for data interpretation. The HSCRC is encouraged to implement MSPB.

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[2] https://data.cms.gov/provider-data/topics/hospitals/payment-value-care

[3] Following comprehensive re-evaluation, the measure was re-endorsed in June 2021 by the consensus-based entity under contract with CMS. Following the re-endorsement, the re-evaluated measure was included in CMS's "List of Measures Under Consideration for December 1, 2021" (MUC2021-131) and then underwent review by a CBE-convened multistakeholder group then called the Measure Applications Partnership during the 2021-2022 cycle, where the measure received support for rulemaking.

maryland
health services
cost review commission

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: March 12, 2025

RE: Hearing and Meeting Schedule

April 9, 2025 In person at HSCRC office and Zoom webinar

May 14, 2025 In person at HSCRC office and Zoom webinar

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

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