maryland
health services
cost review commission

625th Meeting of the Health Services Cost Review Commission

November 13, 2024

(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 1:00pm)

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 October 9, 2024

Specific Matters

There will be no specific matters discussed during this meeting. For the purpose of public notice, here is the docket status.

Docket Status – Cases Closed

2658A Johns Hopkins Health System
2659A University of Maryland Medical Center

Docket Status – Cases Open

2660A Johns Hopkins Health System
2661A Johns Hopkins Health System

Subjects of General Applicability

2. External Presenters: Totally Linking Care – Crisis Services Expansion in Prince George's County under the Regional Partnership Catalyst Program

3. Report from the Executive Director
    a. Model Monitoring
    b. ED Wait Time Activities

4. Draft Recommendation: High-Cost Drug Funding Approach

5. Final Recommendation: MPA and Set Aside Policy Updates

6. Draft Recommendation: 2025 Funding for AHEAD Preparation

7. Hearing and Meeting Schedule

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Joshua Sharfstein, MD
Chairman

James N. Elliott, MD
Vice-Chairman

Ricardo R. Johnson

Maulik Joshi, DrPH

Adam Kane, Esq

Nicki McCann, JD

Farzaneh Sabi, MD

Jonathan Kromm, PhD
Executive Director

William Henderson
Director
Medical Economics & Data Analytics

Allan Pack
Director
Population-Based Methodologies

Gerard J. Schmith
Director
Revenue & Regulation Compliance

Claudine Williams
Director
Healthcare Data Management & Integrity

MINUTES OF THE 624th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION OCTOBER 9, 2024

Chairman Joshua Sharfstein called the public meeting to order at 11:43 a.m. In addition to Chairman Sharfstein, in attendance were Commissioners James Elliott, M.D., Ricardo Johnson, Maulik Joshi, DrPH., Adam Kane, J.D., Nicki McCann, J.D., and Farzaneh Sabi, M.D. Upon motion made by Commissioner Sabi and seconded by Commissioner Elliott, the Commissioners voted unanimously to go into Closed Session. The Public Meeting was reconvened at 1:07 p.m.

REPORT OF OCTOBER 9, 2024, CLOSED SESSION

Mr. William Hoff, Chief of Audit and Integrity, summarized the items discussed on October 9, 2024, in the Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE SEPTEMBER 11, 2024, PUBLIC MEETING AND CLOSED SESSION

Upon motion made by Commissioner Johnson and seconded by Commissioner Joshi, the Commission voted unanimously to approve the minutes of September 11, 2024, for the Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM II
CLOSED CASES

2655A	Johns Hopkins Health System
2656A	Johns Hopkins Health System
2657A	Johns Hopkins Health System

ITEM III
OPEN CASES

2658A	Johns Hopkins Health System
2659A	University of Maryland Medical Center

ITEM IV
NURSE SUPPORT PROGRAM II RENEWAL

Ms. Erin Schurmann, Associate Director, Strategic Initiatives, and her colleagues at the Maryland Higher Education Commission, Ms. Kim Ford and Ms. Laura Schenk, presented an update on the Nurse Support Program II Renewal (see "Nurse Support Program II Renewal" available on the HSCRC website).

Ms. Schurmann stated the NSP II funding is used to support nursing education initiatives at Maryland Schools of Nursing to increase educational capacity to meet the needs of the Maryland nursing workforce and improve the delivery and quality of care in all healthcare settings. The timeline updates are as follows:

- **December 2024:** Draft Recommendation on Program Renewal and Progress Report
- **January 2025:** Solicit formal public comments.
- **February 2025:** Final Recommendation - Commissioner vote
- **Existing funding ends:** June 30, 2025
- **If approved, renewed funding would begin:** July 1, 2025

The NSP II funded programs must align with one of seven NSP II initiatives. Programs submit annual progress reports on outcomes specific to the initiative goals. The progress report will include general metrics that are applicable for all initiatives (listed below) as well as outcome metrics specific to the funded initiative.

- Total amount ($) of funding awarded
- Distribution of awards to underrepresented groups of nursing
- Geographic distribution of awards

Dr. Shawna Mudd (Johns Hopkins School of Nursing) and Dr. Jacqueline Hill (Bowie State University) shared how their institutions benefited from the NSP II.

Dr. Mudd stated that the grants have funded development of new nursing programs at Johns Hopkins such as:

- pre-licensure nursing education, doctoral education (nurse anesthesia), post-master's nursing education (psychiatric mental health NP)
- Nurse educator preparation, preceptor education/training, faculty development
- Resilience training for nurses, faculty, students

Dr. Mudd also noted how the NSP II grant supported its goal to increase the number of primary care Nurse Practitioners (NPs) with the Nursing Advanced Practice Transitions (SNAPT)

program. Since 2021, they have been able to place 22 primary care NPs, who have all remained in the practice where they were initially placed. Currently, they have 18 applicants for a 5th cohort starting in Jan 2025, and will be expanding the program to include acute care NPs for placement in acute care settings.
Dr. Hill described how the New Nursing Faculty Fellowship (NNFF) improved the faculty retention rate at Bowie to 91 percent and increased the number of certified nurse educators from 0 to 11 in 3 years. These enhancements have resulted in a significant improvement in NCLEX passing rates, increasing from a low of 39 percent to currently exceeding 85 percent.
Commissioner McCann asked if the NSP II program could be used as a pipeline to develop home care nurses. Dr. Mudd stated the program has started a cohort for students in ambulatory care centers and in the community where they are needed.

Vice Chairman Dr. Elliott asked if the program included telehealth nursing. Dr. Mudd responded that telehealth is part of the competencies that are expected from their nurses, particularly for advanced practice.

Commissioner Kane requested additional information on the context of the outcomes that were presented and whether the goals are being met. Ms. Schurmann indicated that additional information on the process of goal setting and how outcomes are evaluated will be provided at the December meeting.

Chairman Sharfstein inquired about the effectiveness of the NSP II program in serving the needs of Marylanders and whether the NSP programs have flexibility to shift their focus from supporting general nursing education to specific nursing investments that are aligned to the needs of Maryland, particularly in response to the AHEAD Model. Dr. Hill agreed that the grant initiatives provide many opportunities to focus on areas that align with the Commission's interests.

Commissioner Joshi asked whether diversity of faculty and scholars is one of the goals of NSP. Ms. Schurmann indicated that her MHEC colleagues will be addressing that question later in the presentation.

Commissioner Johnson asked whether programs are funded 100 percent by the grant. Drs. Hill and Mudd indicated that NSP funds a portion of the costs. Dr. Sabi asked whether NPS is filling the gaps in hard-to-place departments (such as the ED and labor and delivery). Dr. Hill responded that they have an Advisory Board that provides guidance on the needs of the community hospitals.

Ms. Schurmann presented the conceptual framework for the NSP II program and requested feedback from Commissioners on the future direction of the program.

No action is necessary on this agenda item.

ITEM V
MARYLAND'S MATERNAL HEALTH STRATEGY AND ROLE OF HSCRC SUPPORT THROUGH THE MCH IMPROVEMENT FUND

Dr. Shelly Choo, M.D., MPH, Director, Bureau of Maternal and Child Health (MCH) and Ms. Laura Goodman, Deputy Director, Medicaid Office of Innovation, presented an update on the Maryland's Maternal Health Strategy and the role of HSCRC support through the MCH Improvement Fund (see "Maryland's Maternal Health Strategy and Role of HSCRC Support Through the MCH Improvement Fund" available on the HSCRC website).

Dr. Choo stated the Maryland Maternal Health Task Force was convened by the Maryland Department of Health (MDH) to address the needs of pregnant and postpartum women in Maryland. The objective of the Taskforce is to improve maternal health outcomes through improved maternal care before, during, and after pregnancy.

The 2024 State Health Improvement Plan (SHIP) prioritizes women's health by addressing maternal health outcomes through enhanced prenatal, perinatal, and postnatal care. Additionally, the plan aims to ensure that all women can attain and maintain optimal physical, mental, and emotional well-being, and have the autonomy to make informed decisions about their bodies, reproductive health, and sexual health.

Dr. Choo described the Women's Health Action Plan's focus on six key goals: 1) protect reproductive rights and expand access to reproductive health services, including abortion care; 2) advance birth equity, with a focus on Black maternal and infant health, through the perinatal continuum; 3) support behavioral health needs across the life course; 4) improve access to comprehensive high-quality somatic services through life courses; 5) increase place-based and community-centered approaches to promote health and prevent diseases; and 6) expand, support and diversify the perinatal workforce.

Dr. Choo and Ms. Goodman summarized the progress made to date in expanding federally funded coverage for postpartum and pregnant individuals who would be Medicaid-eligible but for their immigration status. They also discussed other maternal health initiatives that are funded by the Commission. Future priorities include enhanced data translation, deepening partnership with local health departments and communities, and ongoing health equity promotion. Chairman Sharfstein encouraged the presenters to consider additional initiatives that the Commission could strategically collaborate on with MDH that align with existing Commission priorities (i.e., maternal quality measures for hospitals).

No action is necessary on this agenda item.

ITEM VI
EMERGENCY DEPARTMENT WAIT TIME ACTIVITIES UPDATES

Ms. Tina Simmons, Associate Director for Quality Methodologies, presented and updated the Commission on Emergency Department (ED) wait time activities (see "Emergency Department Wait Time Activities" available on the HSCRC website).

Ms. Simmons described the work being done in the ED Hospital Best Practices Policy Development Subgroup to identify the best practice measures to improve ED wait times and provided examples of the best practices being reviewed. Staff are working on the ED Best Practices policy that will be presented to the Commission in November. Several Commissioners expressed concerns that the present best practices may not adequately address the throughput challenges currently facing hospitals. Staff noted that the review will focus on variations in hospital performance using best practices.

Adventist Presentation

Dr. Jim Rost, Chief Medical Officer of White Oak Medical Center (WOMC); Mr. Kevin Cargill, CPA, Chief Financial Officer of White Oak and Fort Washington Medical Center; Dr. Mary Kim, Vice President of Adventist HealthCare Primary Care and Population Health; and Ms. Katie Eckert, CPA, Vice President of Adventist HealthCare Reimbursement, Strategic Analytics & Operational Excellence presented an update to the Commission on the White Oak Medical Center ED throughput improvements (see "Adventist Presentation" available on the HSCRC website).

Dr. Rost acknowledged that a recent report in Becker ranked Adventist White Oak as the 8th hospital with the Longest ED Wait Time in the nation. He reiterated that the hospital continues to actively address this issue and look for additional opportunities for improvement. Dr. Rost reviewed an analysis of WOMC ED throughput metrics and described several initiatives that were implemented to address ED crowding. Mr. Cargill described WOMC's commitment to developing infrastructure for managing length of stay (LOS), which includes restructuring the throughput committee, establishing key performance indicators aligned with industry benchmarks, employing analytics for daily patient management, updating or creating patient management policies, and implementing initiatives to address identified issues. These initiatives positively impacted adult LOS, reducing it by 13 percent between August 2023 and July 2024. The hospital also increased the percentage of patients discharged by 11:00 am from 5 percent in late 2023 to 15 percent by April 2024. Dr. Kim presented the hospital's approach to population health management. This approach includes the Care Navigation program that focuses on

preventing Potentially Avoidable Utilization (PAU), optimizing discharge coordination with external providers, and coordinating care in the community. According to TCOC Maryland Primary Care Program (MDPCP) data, these interventions have resulted in consistently lower than Statewide benchmark rates of utilization for both ED visits and inpatient admissions within the population.

Ms. Eckert presented the WOMC ED throughput opportunity analysis, which highlighted a decline in per capita volumes despite an increase in ED visits, ranking WOMC among the nation's best. The analysis identified a need for bedded care and high-acuity outpatient care as key drivers of ED volumes, with waiting for an acute bed as a primary contributor to ED wait times. Furthermore, excessive inpatient length of stay (IP LOS) is primarily concentrated among patients discharged to other providers. The hospital particularly faces challenges with prolonged IP LOS for patients being transferred to skilled nursing facilities (SNFs) in the region.

No action is necessary on this agenda item.

ITEM VII
REPORT FROM THE EXECUTIVE DIRECTOR

CY 2023 Total Cost of Care (TCOC) Model Official Performance

Dr. Kromm informed the Commission that the State met all the targets and exceeded expectations for the Total Cost of Care (TCOC) Model Year 5 performance. (see "TCOC Model Saving Targets" available on the HSCRC website).

Model Monitoring

Ms. Deon Joyce, Chief of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 5 months ending June 2024. The data showed that Maryland's Medicare Hospital spending per capita growth was favorable when compared to the nation. Ms. Joyce stated that Medicare non-hospital spending per capita and TCOC spending per capita were favorable when compared to the nation. Ms. Joyce stated that the Medicare TCOC guardrail is -1.85 percent below the nation through June, and that Maryland Medicare hospital and non-hospital growth through May resulted in savings of $88.3 million.

Ahead Model Update

Dr. Kromm informed the Commission that although the State is projecting to be over the TCOC saving target in CY 2024, the pace of the savings will likely slow down during the last 6 months of the year. He stated that staff are working on a proposal to alleviate hospital concerns regarding cost needs within the system. However, two key considerations must be taken into account by Commissioners and stakeholders as they assess the staff proposal. The first consideration is operational. Traditionally, staff issue order rates twice a year (January and July). Off-cycle rate adjustments have several downstream consequences, including potential impacts on payers and out-of-pockets costs for patients, as well as operational issues for staff to execute

rate orders in a reasonable amount of time. The second consideration is the impact these adjustments will have on an all-payer basis. Staff aim to avoid unintended consequences, particularly impacts on public payer access to non-hospital services.
Chairman Sharfstein asked what's the process going forward. Dr. Kromm proposed taking comments from the Commissioners during the meeting then solicit feedback from stakeholders to get different perspectives to determine how to mitigate the cost drivers.
Commissioner Sabi stated hospitals are under pressure from physician specialty practices that are not willing to take calls for hospitals on an inpatient basis because the reimbursement is not sufficient. She recommended that staff consider the cost of physicians as an operational cost that is currently not being funded.
Vice Chairman Elliott suggested using the Set Aside Funds to address the hospitals' financial stress.
Commissioner Johnson noted that the data provided does not show an underlying infrastructure problem. However, for some hospitals, the data should be reviewed, and reinvestment should be made on a "as needed" basis.
Commissioner McCann asked what's the total amount being requested for funding the Set Aside Policy. She noted that the unaudited financial statements on the HSCRC website show more than half of the hospitals have a negative margin and it would make sense to take action to address some of the infrastructure problems the hospitals are facing.
Dr. Kromm stated the Set Aside funding request is $78M. However, the final amount is still to be determined.
Commissioner Joshi believes that all hospitals are struggling with physician workforce costs and infrastructure funding should be shared with everyone, not just those who meet the criteria for Set Aside funding.
Dr. Kromm noted the limitations of HSCRCs authority to directly take on physician costs.
Commissioner Kane noted his concerns about whether pegging rates to inflation is enough if Medicare and other payers are growing at rates above inflation. Additionally, investments in non-hospital services should be prioritized and considered.
Commissioner Johnson agreed that investment in primary care and Medicare Advantage should be considered and balanced with the impact on consumers.
No action is necessary on this agenda item.

ITEM VIII
FINAL RECOMMENDATION: CONFIDENTIAL DATA REQUEST

Chairman Sharfstein and Commissioner McCann were recused from the meeting for this item. The meeting was subsequently led by Vice Chairman Elliott.

Mr. Curtis Wills, Health Data Management Fellow, presented the Staff's recommendation on the Confidential Data Request submitted by Johns Hopkins University, Bloomberg School of Public

Health (see "Final Recommendation: Confidential Data Request" available on the HSCRC website).

Mr. Wills informed the Commission of the request to access the Statewide Confidential Hospital Discharge Data Sets (Inpatient), and Hospital Outpatient Data Sets (Outpatient) collected by the Health Services Cost Review Commission (HSCRC) to obtain information on clinical encounters, procedures, diagnoses, outcomes, and healthcare costs of the AIDS Linked to the Intravenous Experience (ALIVE) Study. This ongoing observational cohort study focuses on adults from the Baltimore area with a history of injection drug use.

The Review Committee voted unanimously to give Johns Hopkins University, Bloomberg School of Public Health, access to the Data. As a condition for approval, the applicant will be required to file annual progress reports to the HSCRC, detailing any changes in goals, design, or duration of the project; data handling procedures; or unanticipated events related to the confidentiality of the data. The applicant will submit a copy of the final report to the HSCRC for review prior to public release.

The Staff Recommendation is as follows:

1. HSCRC staff recommends that the request by Johns Hopkins University Bloomberg School of Public Health for the Data for Calendar Year 2014-2024 be approved.

2. This access will include limited confidential information for subjects meeting the criteria for the research.

Commissioner Johnson moved to approve the staff recommendation, and it was seconded by Commissioner Joshi. The motion passed unanimously in favor of the Staff's recommendation.

ITEM IX
DRAFT RECOMMENDATION: ARPA-H BCORE OUTCOME BUYER RECOMMENDATION

Chairman Sharfstein was recused from the meeting for this item. The meeting was led by Vice Chairman Elliott.

Mr. William Henderson, Principal Deputy Director, Medical Economics and Data Analytics along with Dr. Amanda Rosecrans, Assistant Professor at Johns Hopkins University School of Medicine, and Clinical Chief of Mobile Clinical Service, Baltimore City Health Department; Martha Jerzak, MFA, Assistant Dean for Business and Economic Development at the University of Maryland School of Medicine; Dr. Lucy Willson, Professor and Graduate Program Director of Public Policy at the University of Maryland Baltimore County (UMBC); and Dr. Eric Weintraub,

Professor and Co-Director, Kahlert Institute for Addiction Medicine at the University of Maryland, School of Medicine presented the Staff's draft recommendations for the HSCRC to act as an Outcome Buyer for the ARPA-BCORE Program (see "Draft Recommendation: ARPA-H BCORE Outcome Buyer Recommendation" available on the HSCRC website). Staff are looking for an indication from Commissioners that Staff can submit a letter of intent to with the BCORE application for ARPA-H funding, ahead of the final recommendation in December.

Dr. Rosecrans presented an overview of the Advance Research Project Agency for Health (ARPA-H) HEROES Program. BCORE, a coalition of organizations working to reduce opioid overdoses in Baltimore City, is developing a strategic plan and intends to apply for funding through an ARPA-H grant. ARPA-H is a research funding agency that supports innovative solutions to a broad range of health challenges such as opioid overdose and paving the way for life-saving treatments. BCORE is actively seeking upfront funding to support its strategic plan and establish contractual relationships with buyers, like the HSCRC, who can invest in the plan's long-term sustainability. The funding is to support a variety of initiatives to address opioid overdose in Baltimore City and ultimately reduce the number of EMS encounters for fatal and non-fatal overdose (OD) by 10 percent, compared to the national average. If this metric is met, ARPA-H will invest up to $15 million, over 3 years, with the expectation of a 2 to 1 match from outcome buyers to support the program. The program has already obtained a commitment of $10 million from Baltimore City.

The draft staff recommendation is as follows:

- HSCRC agrees to become an "outcomes buyer" and provide payments to BCORE based on an agreed upon outcome measure.
    - Contingent upon acceptance of BCORE's application by ARPA-H
    - Measure will be based on healthcare spending by Baltimore City residents directly or indirectly related to an ED visit with an opioid-related diagnosis. Staff to work with BCORE to finalize measurements.
    - Payment set at 30 percent of valued savings.
    - Payment was capped at $15 M over 3 years (likely starting in FY 2026)

Mr. Henderson announced that public comments are due by October 23, 2024, with the final recommendation scheduled for the December meeting.

Commissioner Johnson asked who was providing the upfront funding for the program. Dr. Rosecrans stated that the City of Baltimore is contributing $10 million, with at least $5 million upfront.

Commissioner Johnson also inquired whether the $15 million investment by HSCRC will be paid by payers through rates. Mr. Henderson stated that it could come through an assessment or other means.

Commissioner McCann stated her support for the program and asked if opioid use disorder counts as PAU. Mr. Pack responded that opioid use disorder does not count toward a hospital's PAU metric, however, it may still count as a readmission.

Commissioner Joshi asked if the funding for this program would come from the Baltimore City hospitals. Mr. Henderson stated that it has not been determined, however that will be considered. No action is necessary on this agenda item.

ITEM X
FINAL RECOMMENDATION: COMMUNITY BENEFITS REPORTING REGULATIONS

Mr. Zachary Starr, Policy and Government Affairs Intern, and Ms. Megan Renfrew, Deputy Director, Policy and Consumer Protection, presented the Community Benefits Reporting Regulations (see "Community Benefits Reporting Regulations" available on the HSCRC website).

The final recommendation is unchanged from the draft recommendation. Staff did not receive any comments letters.

Mr. Starr presented the Staff's final recommendation to propose amendments to the existing regulations. These amendments would provide the Commission with flexibility in determining due dates for hospitals to submit their annual reports on community benefit activities and would simplify access to the submission instructions for these reports. The amendments were published as proposed regulations in the Maryland Register on August 23, 2024. HSCRC did not receive any public comments by September 23, 2024, deadline.

A Commission vote is required to finalize the regulation.

Commissioner Johnson moved to approve the staff recommendation, and it was seconded by Commissioner Sabi. The motion passed unanimously in favor of the Staff's recommendation.

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

Mr. Allen Pack, Principal Deputy Director, Quality and Population-Based Methodologies presented the Staff's draft recommendations for the out-of-state deregulation and repatriation of volume policies (see "Out-of-State, Deregulation, and Repatriation Volume Policies" available on the HSCRC website).

Mr. Pack reviewed all the volume policies that HSCRC has implemented to adjust global budgets in response to anticipated demographics changes, other volume patterns, and observed market shifts in services. He also reviewed the revised timeline for the volume workgroup, which

had been delayed due to staff development of the repatriation policy, as well as an example of how the new volume repatriation policy would work.

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

Mr. Pack reviewed the primary concerns raised by the workgroup, including the reliance on Medicare TCOC data, variations in hospital cost structures impacting efficiency and retained revenue levels, and volume fluctuations beyond hospital control. He outlined staff's proposed approaches to address these concerns, the methodology used to assess the materiality threshold, and an evaluation of how the volume policies appropriately funded hospital volume in the All-Payer and TCOC Models. The Volume Scorecard indicates that the population-based volume policies are effectively funding overall volume changes across the system. This affirms staff's belief that there is no need to modify the underlying methodologies. While there may be some unfunded volume at the service line level due to new services, staff have flexibility to address these concerns through additional volume policies. Staff cautions against any perceived funding misallocation suggested by the Volume Scorecard, as redistribution is being addressed annually through the formulaic methodologies of PAU, Integrated Efficiency, and Full Rate Application policies.

The draft staff recommendations are as follows:

- Establish a Deregulation policy based on the methodology outlined herein that will result in negative revenue adjustments to hospitals' global budgets.
- Establish a Repatriation policy based on the methodology outlined herein that will result in positive (repatriation) and negative (expatriation) revenue adjustments to hospitals' global budgets.
- Establish an Out-of-State policy based on the methodology outlined herein that will result in positive and negative revenue adjustments to hospitals' global budgets.
- Implement Deregulation, and Expatriation, the next available rate issuance on a one-time basis, negative Out-of-State adjustments on a permanent basis, when the following materiality thresholds are met:
    - The hospital is in the worst quartile of the most recently published Integrated Efficiency policy, *OR*

    - The adjustment exceeds 3 percent of the hospital's GBR, *OR*
    - The adjustment exceeds 3 percent of the associated service line revenue
    - All Planned Deregulations should still be reported to the Commission in conformance with the GBR agreement and adjusted accordingly.
        - If deregulation methodology indicates a potential deregulation that varies from planned deregulation by more than 10 percent, staff may consider revising the deregulation adjustment
- Implement Repatriation at the next available rate issuance on a one-time basis, positive Out-of-State adjustments on a permanent basis, when the following materiality thresholds are met:
    - The adjustment exceeds 1 percent of the hospital's GBR, *OR*
    - The adjustment exceeds 1 percent of the associated service line revenue
- Implement Deregulation, and Repatriation/Expatriation adjustments on a permanent basis for one year following the initial revenue adjustment to allow for potential backfilling and/or dissipation. Hospitals can provide additional information to contest the volume finding, but will have the burden of proof, and HSCRC staff will be final arbiters of this decision.
- Recognize the staff's approach to evaluating the over/under funding of volume in Commission's volume policies

Commissioner McCann clarified that not all volume is inherently negative, and that for certain services, volume can contribute to quality and efficiency. She questioned the apparent disconnect between staff's assertion that volumes are adequately funded and the fact that many hospitals are reporting negative operating margins, even as the TCOC savings target is exceeded.

Mr. Pack explained that the Volume Scorecard provides a simplified view of the aggregate impact of volume and revenue adjustments, compared to the complexity of the underlying policies. He acknowledged that the profit margins referenced were from a period of high inflation, which was subsequently addressed by a 1 percent rate increase. Since then, margins have improved significantly. Additionally, staff observed significant unexplained increases in the length of stay, which hospitals have been actively addressing.

Dr. Kromm added that the Scorecard merely reflects the cumulative impact of the policies to date. Further refinements to the volume policy are necessary to address identified gaps.

Commissioner Johnson inquired about the methodology for assessing materiality and questioned why annual reconciliation isn't considered for smaller variances. Mr. Pack explained that the predictability of global budget revenue is beneficial, as some fixed costs associated with these volumes should not be removed from the system. The 3 percent threshold was selected because

once the variance reaches 5 percent, hospitals are constrained by the GBR corridor policy. Additionally, staff employ the 3 percent threshold in other methodologies.

Commissioner McCann inquired about the frequency of hospital requests to exceed the 5 percent threshold in 2024. Mr. Jerry Schmith, Principal Deputy Director, RR acknowledged that such requests are occasionally approved. Before granting approval, staff investigate the underlying reasons for the temporary rate increase, such as patient shifts or deregulation.

No action is necessary on this agenda item.

ITEM XII
DRAFT RECOMMENDATION: QBR POLICY

Dr. Alyson Schuster, Deputy Director, Quality Methodologies, and Ms. Dianne Feeney, Associate Director, Quality Initiatives, presented the Draft Recommendation on the Quality-Based Reimbursement (QBR) Policy (see “Draft Recommendation: QBR Policy” available on the HSCRC website).

Ms. Feeney reported that there were no methodological changes to the Quality-Based Reimbursement (QBR) program for Rate Year (RY) 2027. However, she provided updates to the specifications for Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) and Timely Follow-up (TFU) measures, as well as an update from the HCAHPS Learning Collaborative.

Dr. Schuster reviewed the QBR Policy and Emergency Department (ED) LOS Measurement Development Timeline and the rationale for including ED LOS in the QBR program for CY 2024. She also described the ED LOS measure that was developed to reduce the median time for non-psychiatric patients between ED Arrival to physical departure from the ED. Dr. Schuster reviewed an example of the QBR scoring. It should be noted that during the annual evaluation of the reward/penalty scale for the performance period, HSCRC staff determined that an adjustment is needed and are recommending lowering the penalty cut point from 41 to 32 percent, based on National performance. This results in a net statewide penalty reduction of over $42 million and reduces the total number of penalized hospitals from 36 to 24.

Dr. Schuster reviewed the recommendations for CY 2025 implementation of the QBR program, including adding the ED1b to the QBR Person and Community Engagement (PCE) Domain, developing a risk-adjusted ED LOS measure for attainment, setting improvement targets based on the Statewide Improvement Goal that will be established by the ED Wait Time Reduction Commission, and considering whether observation stays exceeding 24 hours should be treated as inpatient admissions.

Dr. Schuster provided a brief update on the collection of Digital Quality measures for CY 2024 and 2025. Unlike CMS, which collects data annually, HSCRC collects these measures quarterly.

The draft staff recommendations are as follows:

- Maintain Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 60 percent, Safety (NHSN measures) - 30 percent, and Clinical Care - 10 percent.
    - Within the PCE domain, weigh the measures as follows:

i. HCAHPS Top Box	33.33 Percent
ii. HCAHPS Consistency:	16.67 percent
iii. HCAHPS Linear:	16.67 percent
iv. Timely Follow-Up for Medicare:	5.56 percent
v. Timely Follow-Up for Medicaid:	5.56 percent
vi. Disparities in Medicare Timely Follow-Up:	5.56 percent
vii. Emergency Department Length of Stay:	16.67 percent

    - Within the Safety domain, weigh each of the six measures equally (i.e., 30 percent divided by number of measures).
    - Within the Clinical Care domain, weight the inpatient and 30-day mortality measure equally (i.e., 10 percent divided by two measures).
- With regard to monitoring reports to track hospital performance:
    - Consider the feasibility of developing a Timely Follow-Up for Behavioral Health measure.
    - Disseminate Sepsis Dashboard.
    - Develop tools to monitor HCAHPS performance by patient and hospital characteristics.
- Implement an HCAHPS learning collaborative with hospitals.
- Continue collaboration with CRISP and other partners on infrastructure to collect hospital Electronic Clinical Quality Measures (eCQM) and Core Clinical Data Elements (CCDE) for hybrid measures.
- Continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) and maintain the pre-set revenue adjustment scale of 0 to 80 percent with cut-point at 41 percent.
    - Retrospectively evaluate 41 percent cut point using more recent data to calculate national average score for RY 2026 and RY 2027.
    - Based on concurrent analysis of national hospital performance, adjust the RY25 QBR cut point to 32 percent to reflect the impact of using pre-COVID performance standards and to ensure that Maryland hospitals are penalized or rewarded relative to national performance.

Commissioner Joshi asked whether it is possible to consider a midyear evaluation of the cut point. Dr. Schuster responded that Staff typically cannot do the final adjustments until January due to delays in receiving the data, but once we have 2 quarters of complete data, staff could easily rerun the cut point analysis.

Chairman Sharfstein inquired about the process for considering new measures in the QBR program in light of the AHEAD model initiatives. Dr. Schuster explained that the reason for minimal changes to the program in the recommendation is to allow staff time to develop the best approach to implementing this program under the AHEAD model and to focus on addressing ED throughput through the Best Practices Policy. Staff would appreciate input on potential new measures to integrate into their development work. Staff develop a process to seek public input on any measures developed through a separate draft staff recommendation or via the QBR policy.

Vice Chairman Elliott inquired whether there are plans to expand the Timely Follow-Up measure to include all patients, rather than just Medicare beneficiaries. Dr. Schuster explained that Medicaid patients are included but measured separately. Commercial payers are currently excluded from this measure due to data limitations. Staff are open to incorporating commercial payers in the future.

No action is necessary on this agenda item.

ITEM XIII
SET-ASIDE FOLLOW-UP

Ms. Caitlin Cooksey, Deputy Director, Hospital Rate Regulation, presented stockholder comments related to the Set Aside policy (see "Set Aside Follow-Up" available on the HSCRC website).

Ms. Cookey updated the Commission on the feedback received from hospitals regarding the Set Aside Policy. A common concern was that the funding should be allocated based on need and merit. A specific concern raised was that policy's gatekeeper criteria excluded hospitals with below-average margins and operating losses relative to RY 2022. While staff do not believe the criteria was arbitrary, they recognize hospitals with consistently negative regulated and total margins, despite recent improvement, could be considered financially distressed. Staff is considering amending the "gatekeeper criteria" for hospitals with below average regulated margins and negative total margins over the past 3 years to qualify for the Set Aside funds, regardless of the any changes in profitability in the last three years. Staff requested that Commissioners provide guidance on additional criteria and requirements for funding.

Ms. Cooksey explained the revised hospital eligibility and the process of evaluating funding requests, based on the feedback received from MHA and hospitals.

This item will require Commission action.

Commissioner Kane asked whether the test will be at a hospital or system level. Mr. Pack indicated that the analysis of margins will be at the hospital level, however the data on days cash-on-hand will be analyzed at a system level.

Chairman Sharfstein inquired whether staff had considered using hospitals' corrective action plans to enhance their score. Ms. Cooksey responded that the staff is open to evolving the evaluation process to be more objective and would consider future changes in collaboration with stakeholders. Mr. Pack added that some hospitals requesting funds through this policy are relatively efficient and are not required to submit corrective action plans, making it challenging to compare them to less efficient hospitals.

Commissioner McCann inquired about the requirement for 125 days cash-on-hand for system hospitals and indicated that it seemed quite low. Mr. Henderson responded that most bond covenants require only 75 days cash-on-hand, and the state average is approximately 80-150 days. Additionally, the Commission has flexibility to raise hospital rates if levels drop too low.

Regarding funding requirements and commitments to suspend variable executive compensation, Chairman Sharfstein suggested that the corrective action plan should address executive compensation without mandating specific outcomes. This would allow Staff to assess the issue while acknowledging potential variability among hospitals.

Commissioner Kane inquired whether the corrective action plan is intended to describe a hospital's overall financial situation or how the hospital would utilize the Set Aside funds. Mr. Pack clarified that the corrective action plan is designed for hospitals to outline their overall financial health and describe strategies for reducing costs to mitigate future funding needs.

Chairman Sharfstein asked for a motion to approve the Staff proposal on the financial assessment for eligibility and requirements for funding.

Commissioner Sabi moved to approve the staff proposal, and it was seconded by Commissioner Joshi. The motion passed unanimously in favor of the Staff’s recommendation.

ITEM XIV
HEARING AND MEETING SCHEDULE

November 13, 2024, Time to be determined-4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 5:15 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission

October 9, 2024

Chairman Sharfstein stated reasons for Commissioners to move into administrative session under the Authority General Provisions Article §3-103, and §3-104 for the purposes of discussing the administration of the Model and providing an update on the FY24 monthly hospital unaudited financial performance.

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

The Administrative Session was called to order by motion at 11:43 a.m.

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

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

Also attending were Assistant Attorney's General Stan Lustman and Ari Elbaum, Commission Counsel.

Item One

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

Item Two

William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, updated the Commission, and the Commission discussed the FY24 Hospital Unaudited Financial Performance.

The Closed Session was adjourned at 12:25 p.m.

maryland
health services
cost review commission

Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

November 13, 2024

maryland health services cost review commission

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2470
BALTIMORE, MARYLAND	*	PROCEEDING:	2660A

I. INTRODUCTION

On September 30, 2024, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Johns Hopkins Howard County Medical Center and Suburban Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospitals are requesting approval to continue to participate in a revised global price arrangement with the Priority Partners Managed Care Organization, Inc., the Johns Hopkins Employer Health Programs, Inc., and the Johns Hopkins Uniformed Services Family Health Plan for spine and bariatric surgery services. The Hospitals request that the Commission approve the arrangement for one year beginning November 1, 2024.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement

among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

Staff found that experience under this 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 for bariatric and spine surgery services with the Priority Partners Managed Care Organization, Inc., the Johns Hopkins Employer Health Programs, Inc., and the Johns Hopkins Uniformed Services Family Health Plan for the period beginning November 1, 2024. 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.

maryland
health services
cost review commission

Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

November 13, 2024

maryland
health services
cost review commission

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2471
BALTIMORE, MARYLAND	*	PROCEEDING:	2661A

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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 there was no activity under this arrangement for the prior year. However, staff believes that the Hospitals can 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 for cardiovascular services with Quality Health Management for the period beginning November 1, 2024. 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.

Health Services Cost Review Commission
November 13, 2024, Commission Meeting
Behavioral Health Regional Partnership Catalyst Program

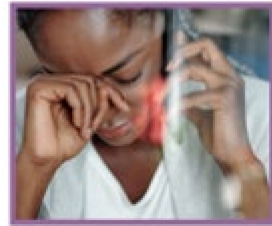
PRINCE GEORGE'S COUNTY'S TRANSFORMATIONAL APPROACH TO MENTAL HEALTH

Margaret Fowler
Executive Director
Totally Linking Care In Maryland

Carlos Mackall
Behavioral Health and Strategy Manager
Totally Linking Care In Maryland

Crisis Now Model:

Someone to Call

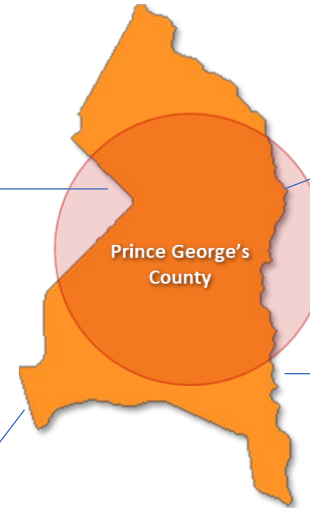


Someone to come to you

Somewhere to go

Totally Linking Care in Maryland

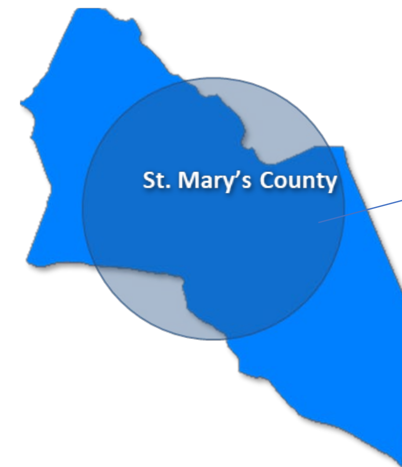
A nonprofit corporation of five hospitals that connects healthcare providers and programs with residents in Southern Maryland (Calvert County, Charles County, Prince George's County, and St. Mary's County). We believe that everyone deserves access to quality healthcare.



Members

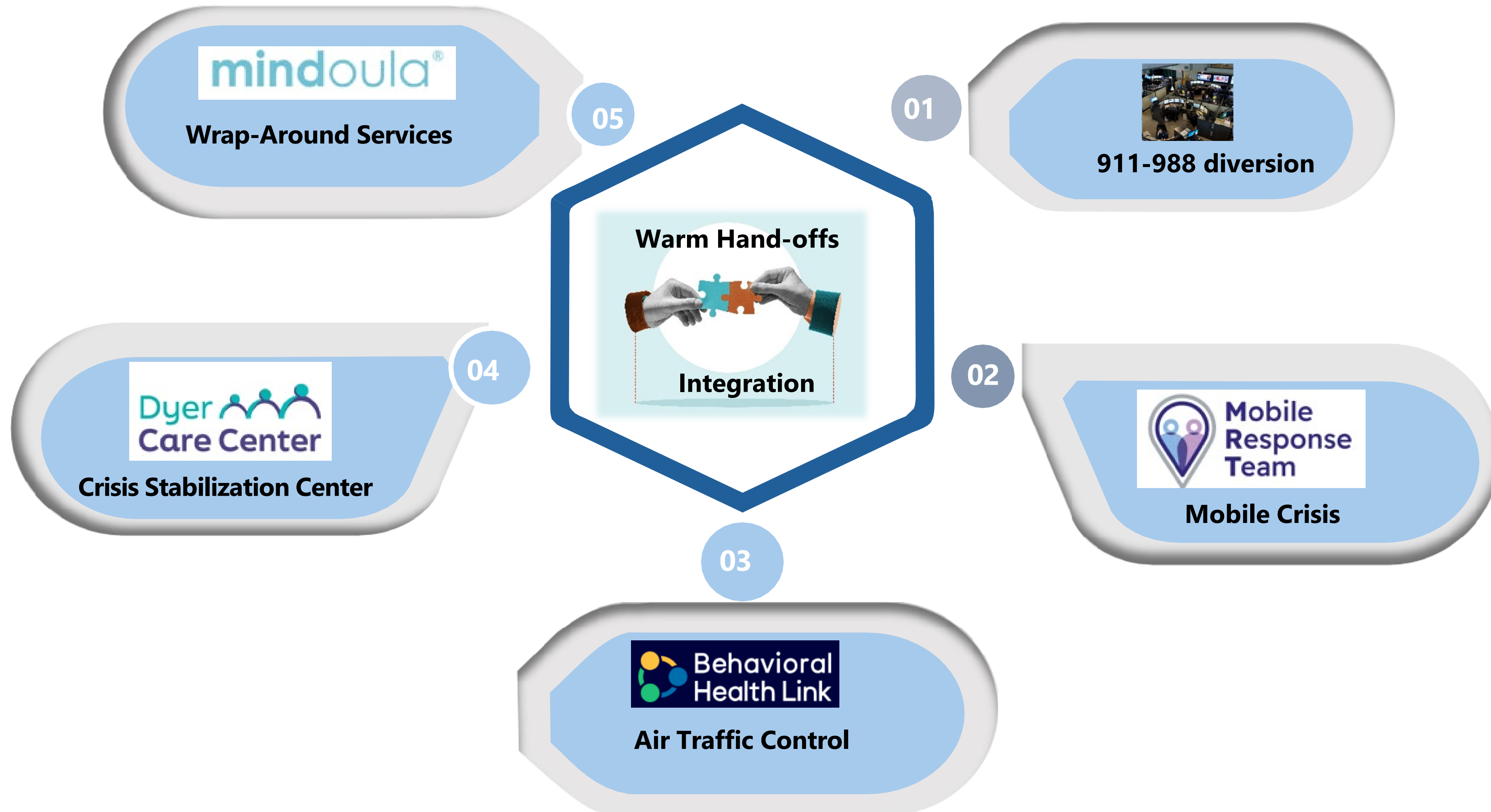
Mission

To improve the health of residents in Southern Maryland through meaningful partnership-led education, engagement, and empowerment.



Building a healthier, more equitable community

Behavioral Health Project Components



911 Diversion Pilot

Purpose: Prince George's County, Maryland aims to connect non-violent mental health distress 911 callers to behavioral health crisis responders (phone-based crisis hotline and mobile crisis field team), per the recommendations of its police reform working group.

Goal: To build a seamless integration and data collection platform to longitudinally track calls across the emergency crisis continuum and measure outcomes of these calls to reflect the impact on Police, Fire, EMS, Hospital Emergency Departments as well as the increased access to mental health services.

Monthly Diversion Workgroup & Case Review Meetings: Cross-agency working group, public Safety Agencies in the County: Office of Homeland Security (OHS), Police (PGPD), Fire/EMS, Sheriff's Office, Municipal Chiefs Association, 988, Mobile Response and Health Dept.

Pilot Data Collection: Manual Process Tracing   Average Monthly Calls 10-15   56.2% of those calls diverted

911-988 pilot project is a permanent program, operating 24/7. Longitudinal data tracking across entities in progress as we bring on BHL Call Center Module.

Crisis Now Model:

- ✓ Someone to Call
- ✓ Someone to come to you
- ✓ Somewhere to go

PRINCE GEORGE'S COUNTY'S TRANSFORMATIONAL APPROACH TO MENTAL HEALTH

With the increase in emergency behavioral health crises in our region, most law enforcement and other 911 responders struggle to provide best practices care because they may not have the training to handle behavioral/mental health issues. This is why Prince George's County is leading a transformational approach to mental health.

Through the behavioral health continuum, residents may receive treatment through four key programs to increase access to behavioral health services, help reduce the number of public safety personnel needed to respond to emergency crisis duties, and guide residents to the appropriate level of care.

GOES TO LOCATION OF CRISIS

Call 988, the National Suicide & Prevention Lifeline.

Call (301) 429-2185 for in-person emergency crisis assessment and intervention by a mental health clinician.

A 23-hour outpatient facility that provides emergency crisis stabilization for mental health, behavioral health, and substance abuse.

Offers 24/7 support and care to eligible patients facing chronic mental health, some physical health, and social well-being challenges that are referred from participating hospitals.

888-900-1257 info@tlc-md.org tlc-md.org

Mobile Response Team

✓ Someone to come to you

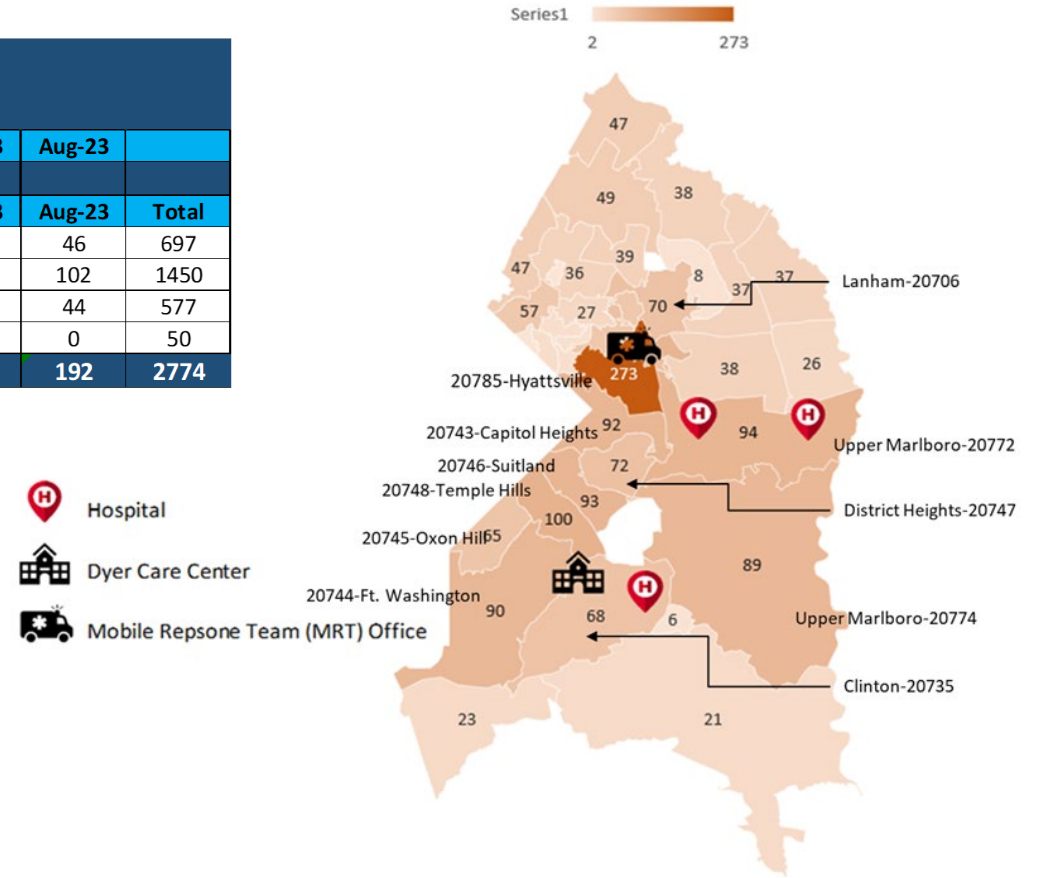
- Call Volume increase from CY22
- Now eight two-person teams
- Weekly Meeting for TA
- Robust Data Analysis

BHL Monthly Trend Dashboard CY 2024 - Rolling 12 Months

Data	Jul-24	Jun-24	May-24	Apr-24	Mar-24	Feb-24	Jan-24	Dec-23	Nov-23	Oct-23	Sep-23	Aug-23	
Dispatch Level													
	Jul-24	**Jun-24**	**May-24**	**Apr-24**	**Mar-24**	**Feb-24**	**Jan-24**	**Dec-23**	**Nov-23**	**Oct-23**	**Sep-23**	**Aug-23**	**Total**
Level 0 -	31	34	47	64	120	94	51	61	58	55	36	46	697
Level 1 -	100	100	134	149	147	140	146	109	110	94	119	102	1450
Level 2 -	70	81	80	62	44	39	20	21	38	48	30	44	577
Level 3 -	8	2	13	3	6	6	0	1	5	4	2	0	50
Grand T	209	217	274	278	317	279	217	192	211	201	187	192	2774

CrisisMind Monthly Report 2022

Referral Source	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	YTD
911	0	0	0	0	0	0	0	0	0				0
Police	1	0	0	0	0	3	43	76	98				221
Hotline	6	32	35	34	39	43	60	48	74				371
Local County Departments	5	0	0	0	0	0	0	0	0				5
General Public	0	0	0	0	0	0	0	0	0	169	205	194	0
Number of dispatches	11	32	35	34	39	46	103	124	172	140	205	194	1135



Air Traffic Control

BH Dashboard of MRT data

Integration of 911, 988 and MRT calls

MRT Data Driven Strategic Planning

Platform customization to align with State Data sets

Implementing BHL Call Center and Referral Modules

Duration Analysis Report for Dispatched and Completed Cases

Dispatched Average All Levels (Outliers Removed)	Jul-24	Jun-24	May-24	Apr-24	Mar-24	Feb-24	Jan-24
Time of Call to Arrived Avg	67.22	68.26	63.50	63.75	71.47	67.58	67.25
Time of Call to Episode Completed Avg	99.41	93.29	96.12	95.83	95.63	98.63	89.28
Pre-Dispatch to Episode Completed Avg	82.23	81.01	84.89	84.04	84.84	90.75	81.28

Dispatched Average All Levels (Outliers Removed)	Jul-24	Jun-24	May-24	Apr-24	Mar-24	Feb-24	Jan-24
Time of Call to Pre-Dispatch Avg	18.39	13.29	11.77	14.93	10.79	9.05	8.00
Pre-Dispatch and Dispatched Avg	14.15	16.17	14.30	17.47	20.12	25.37	24.84
In Transit Avg	34.73	39.38	37.97	33.46	40.55	33.70	34.42
Arrived to Episode Completed Avg	33.35	25.45	32.62	33.12	24.16	31.68	22.03

	Jul-24	Jun-24	May-24	Apr-24	Mar-24	Feb-24	Jan-24
Number of Total Cases	209	217	274	278	317	279	217
	Jul-24	Jun-24	May-24	Apr-24	Mar-24	Feb-24	Jan-24
Number of Dispatched Cases	131	136	170	167	123	74	78
	Jul-24	Jun-24	May-24	Apr-24	Mar-24	Feb-24	Jan-24
Number of Dispatched Cases with Outliers Removed	115	99	125	137	92	60	67
	Jul-24	Jun-24	May-24	Apr-24	Mar-24	Feb-24	Jan-24
Total Number of Outliers	19	20	19	25	17	19	14
	Jul-24	Jun-24	May-24	Apr-24	Mar-24	Feb-24	Jan-24
Total Number of Dispatched Outliers	18	16	16	23	12	11	8

Dispatched Average All Levels (Outliers Removed)	Jul-24	Jun-24	May-24	Apr-24	Mar-24	Feb-24	Jan-24
Time of Call to Pre-Dispatch Avg	**18.39**	**13.29**	**11.77**	**14.93**	**10.79**	**9.05**	**8.00**
Level 0 - Routine / Information-seeking Calls	16.50	9.67	17.60	11.00	11.20	4.00	13.50
Level 1 - Moderate / Resolution may Requiring Dispatch	23.73	14.58	13.72	17.82	9.72	5.70	7.65
Level 2 - Urgent / Requiring Dispatch	14.61	12.61	9.89	11.56	13.91	12.77	8.38
Level 3 - Imminent / Requiring Dispatch and Police Level	7.80	6.50	8.80	7.00	8.83	11.25	
Pre-Dispatch and Dispatched Avg	**14.15**	**16.17**	**14.30**	**17.47**	**20.12**	**25.37**	**24.84**
Level 0 - Routine / Information-seeking Calls	9.25	3.67	6.80	14.00	10.60	25.33	14.00
Level 1 - Moderate / Resolution may Requiring Dispatch	16.16	17.33	14.22	18.16	24.93	35.19	25.78
Level 2 - Urgent / Requiring Dispatch	13.72	16.33	15.57	17.06	11.43	16.50	23.31
Level 3 - Imminent / Requiring Dispatch and Police Level	4.40	5.00	11.30	17.00	14.83	16.75	
In Transit Avg	**34.73**	**39.38**	**37.97**	**33.46**	**40.55**	**33.70**	**34.42**
Level 0 - Routine / Information-seeking Calls	7.00	1.00	14.20	23.89	30.00	25.33	52.50
Level 1 - Moderate / Resolution may Requiring Dispatch	40.09	39.98	45.37	38.80	45.17	43.41	36.51
Level 2 - Urgent / Requiring Dispatch	32.65	41.29	32.39	27.26	30.43	25.58	25.75
Level 3 - Imminent / Requiring Dispatch and Police Level	28.80	37.00	41.10	28.50	43.50	27.25	

4-Hour Shift

- 12 AM-4 AM
- 12 PM-4 PM
- 4 AM-8 AM
- 4 PM-8 PM
- 8 AM-12 PM
- 8 PM-12 AM

8-Hour Shift

- 12 AM-8 AM
- 4 PM-12 AM
- 8 AM-4 PM

ReferralSourceType

- (blank)
- 988 Police Call
- Blank
- Bowie
- Capitol Heights
- Direct call from Department of Social Services
- Direct call from Fire/EMS
- Direct call from MRT of Another County
- Direct call from Police
- Direct call from Prince George's County resident
- Direct call from Resident from Another County
- Direct call from School
- District Heights
- Greenbelt
- Hyattsville
- Landover Hills
- Participant
- Provider
- Riverdale Park
- Seat Pleasant
- Upper Marlboro
- Warm transfer from CCSI (988 call or iMind email)

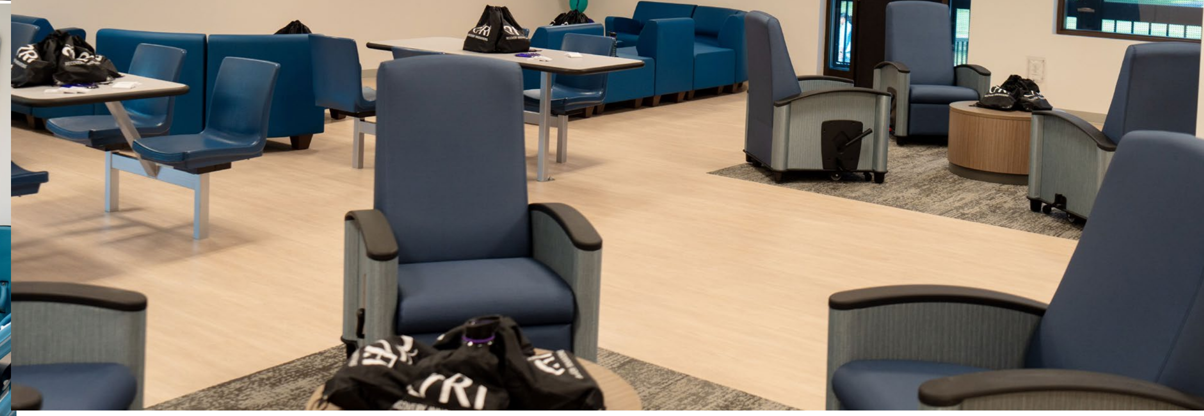
✓ Somewhere to go

The Dyer Care Center is a 23-hour outpatient facility in Prince George's County that provides emergency crisis stabilization for mental health, behavioral health, and substance abuse.

https://www.youtube.com/watch?v=Xm2ukCeu08I

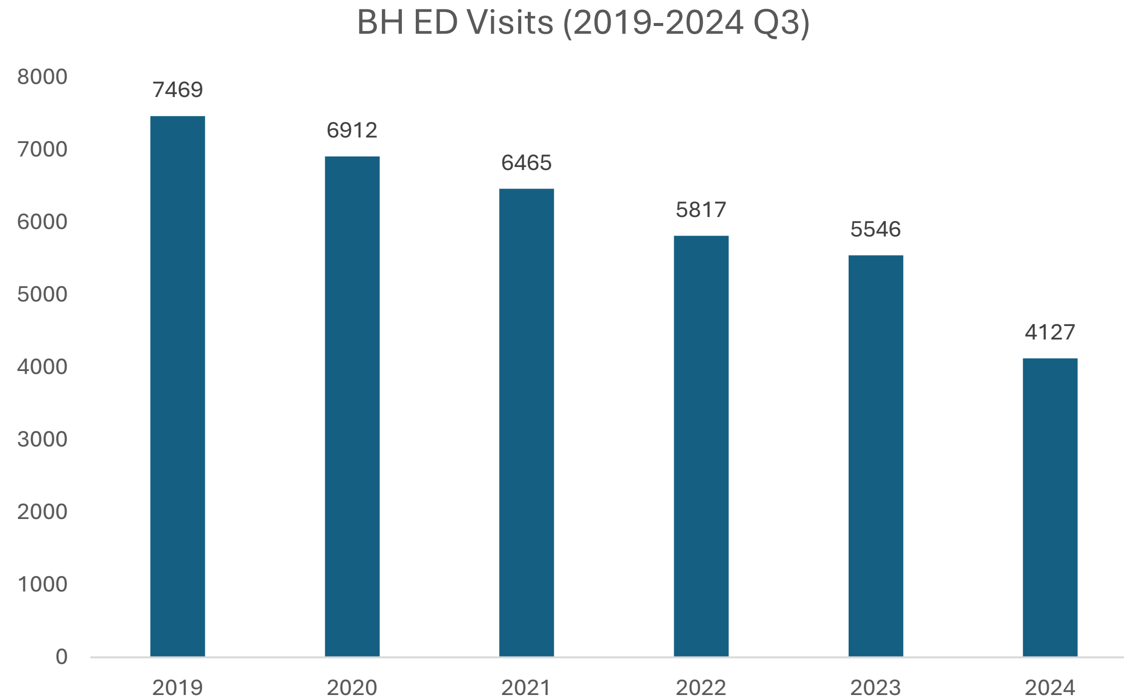
Dyer Care Center Ribbon Cutting Ceremony

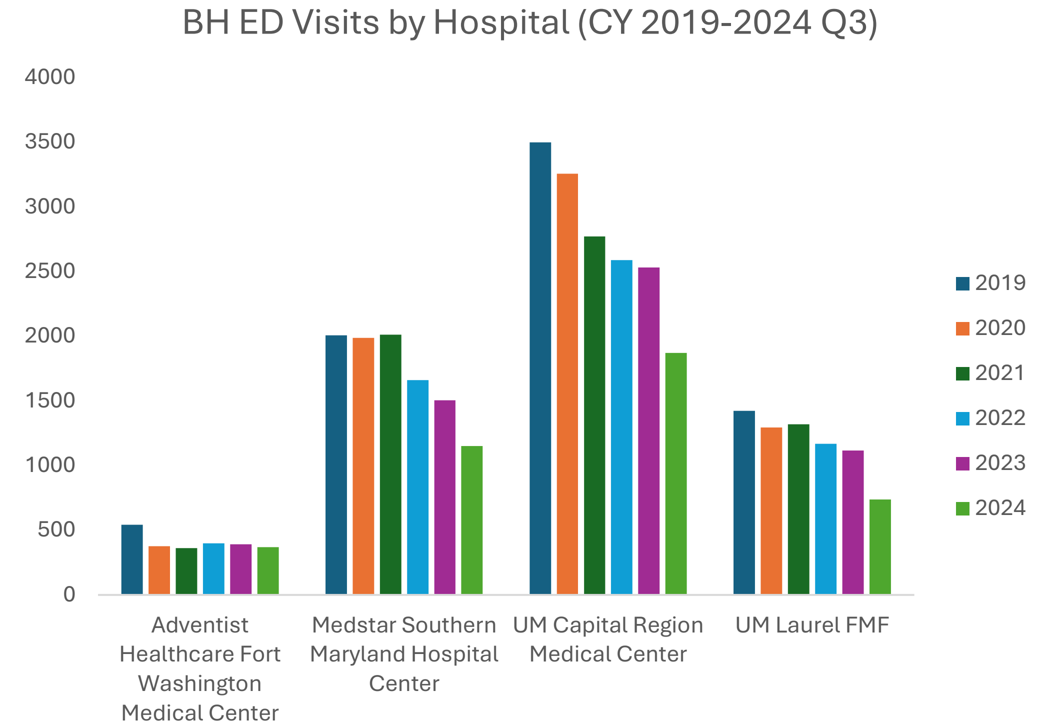
U&O Permit	16- chair facility	24/7/365 facility
Emergency Designation	JCAHO Accreditation	Permanent Licensure



Behavioral Health Emergency Department Utilization

- Behavioral Health Emergency Department Visits at TLC hospitals are declining against a 2019 baseline.





Source: CRISP Regional Partnership Dashboard, HSCRC Casemix Data

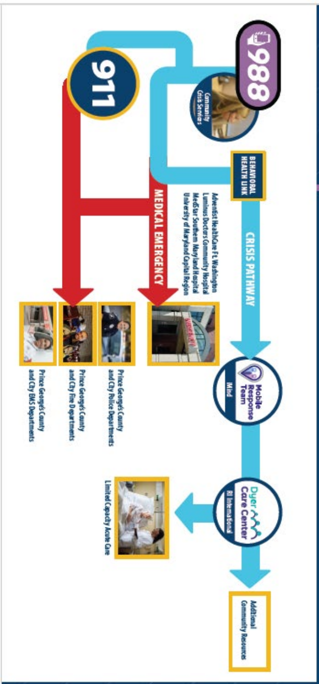
*TLC hospitals participating in Regional Partnership Catalyst Program are UM Capital Region including Laurel, Medstar Southern Maryland, Adventist Fort Washington Medical Center.

Mindoula Use

- High risk patients with history of readmission or ED use.
- 32-day post discharge services.
- Virtual behavioral health case management.

Participants Served April to June 2024

- 44% average reduction of BHU readmissions.
- 97% average enrollment in monthly cohorts.
- Program Expansion to include Dyer Care Center.



Crisis Continuum

Totally Linking Care in Maryland

TLC-MD

info@tlc-md.org

tlc-md.org

PRINCE GEORGE'S COUNTY'S TRANSFORMATIONAL APPROACH TO MENTAL HEALTH

Someone to call:

988

Someone to come to you:

Mobile Response Team

Somewhere to go:

Dyer Care Center

988

Mobile Response Team

Dyer Care Center

National Suicide & Crisis Lifeline

988 offers 24/7 access to crisis call specialists who are trained to de-escalate behavioral health crisis. Individuals can be connected to resources such as same:

- Day/next day behavioral health appointments and the Mobile Response Team.
- If public safety intervention is not required, residents can access services directly via calling, texting or chatting 988.
- Public safety officials can receive support from
- 988 crisis specialists by triaging a call and/or requesting resources.

In-person Emergency Crisis Intervention

MRT is an emergency behavioral health service that provides immediate response for anyone in Prince George's County who:

- is experiencing a mental health, substance use, or psychiatric distressed crisis
- may be a danger to self and/or others.
- is unwilling or unable to seek help for themselves

MRT will dispatch a two-person team to the caller's location for an in-person assessment and intervention as deemed necessary by mental health professionals.

Emergency Crisis Stabilization Facility

The Dyer Care Center (DCC) will be the first facility in Prince George's County, MD to provide short-term personalized emergency care to community members experiencing a mental health and/or substance use crisis. The emergency crisis stabilization center also serves the crucial purpose of diverting guests, whenever possible, away from emergency rooms, unneeded hospitalization, and potential incarceration.

The DCC is committed to both "rapid engagement" of anyone seeking care, and to creating a warm, welcoming, and trustworthy environment for care. Our peer support specialists and other staff are highly trained in the interpersonal, human dimensions of care.

988 | 301-429-2185 | 240-965-1715

Successes

- 911-988 Diversion Pilot made permanent
- Robust MRT Data used for Strategic Planning
- Opened Dyer Care Center
- Implemented Crisis Now Model
- Shared Marketing Resources

Mobile Response Team

If you are in a mental health emergency crisis and you are a resident of Prince George's County:

Call the Mobile Response Team (MRT) at **(301) 429-2185**

or the National Suicide and Crisis Lifeline at

988

and ask for MRT

OPEN 24 HOURS/DAY, 365 DAYS/YEAR

Prince George's County, MD Proud
Get to Know Us

CRISIS CONTINUUM
MAKING A DIFFERENCE

Totally Linking Care in Maryland
TLC-MD

Adventist HealthCare
Fort Washington Medical Center

University of Maryland
Capital Region Health

MedStar Southern Maryland
Hospital Center

Thank You For This Opportunity

Questions

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Update on Medicare FFS Data & Analysis

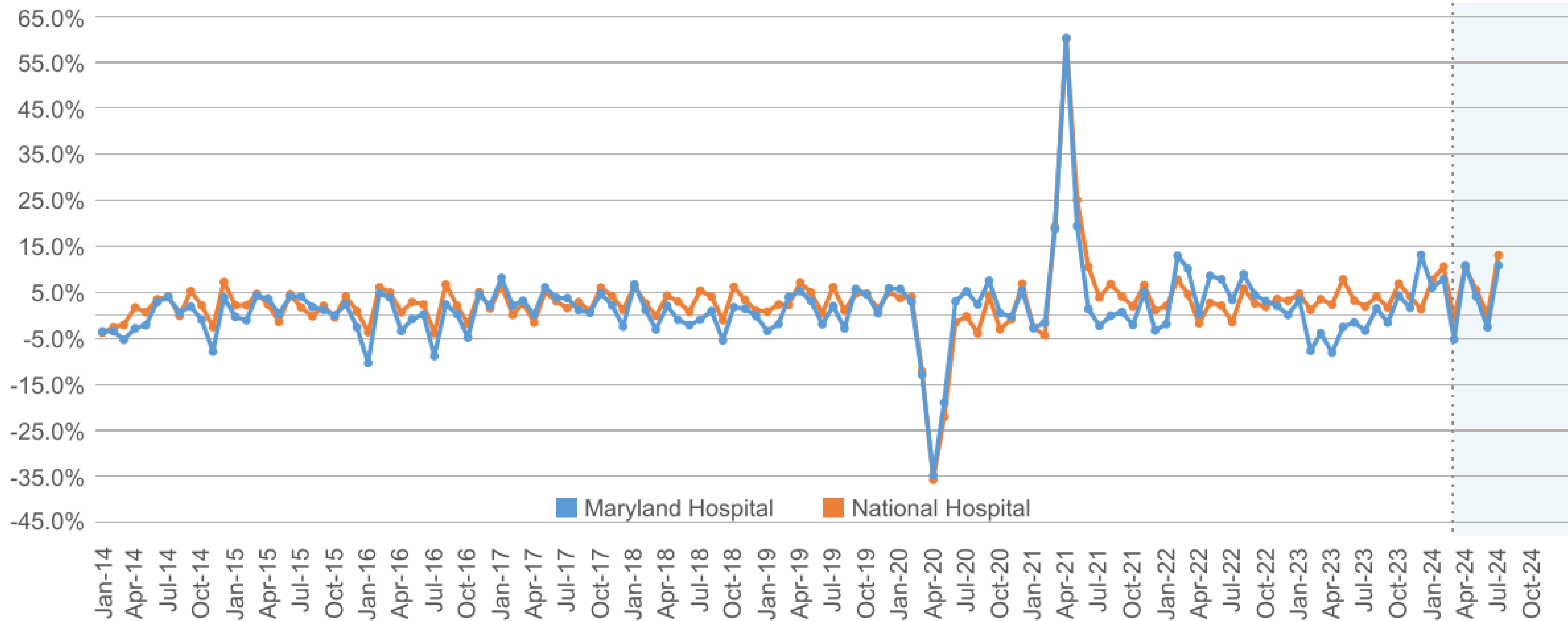
November 2024 Update

Data through July 2024, Claims paid through September 2024

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

Medicare Hospital Spending per Capita

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

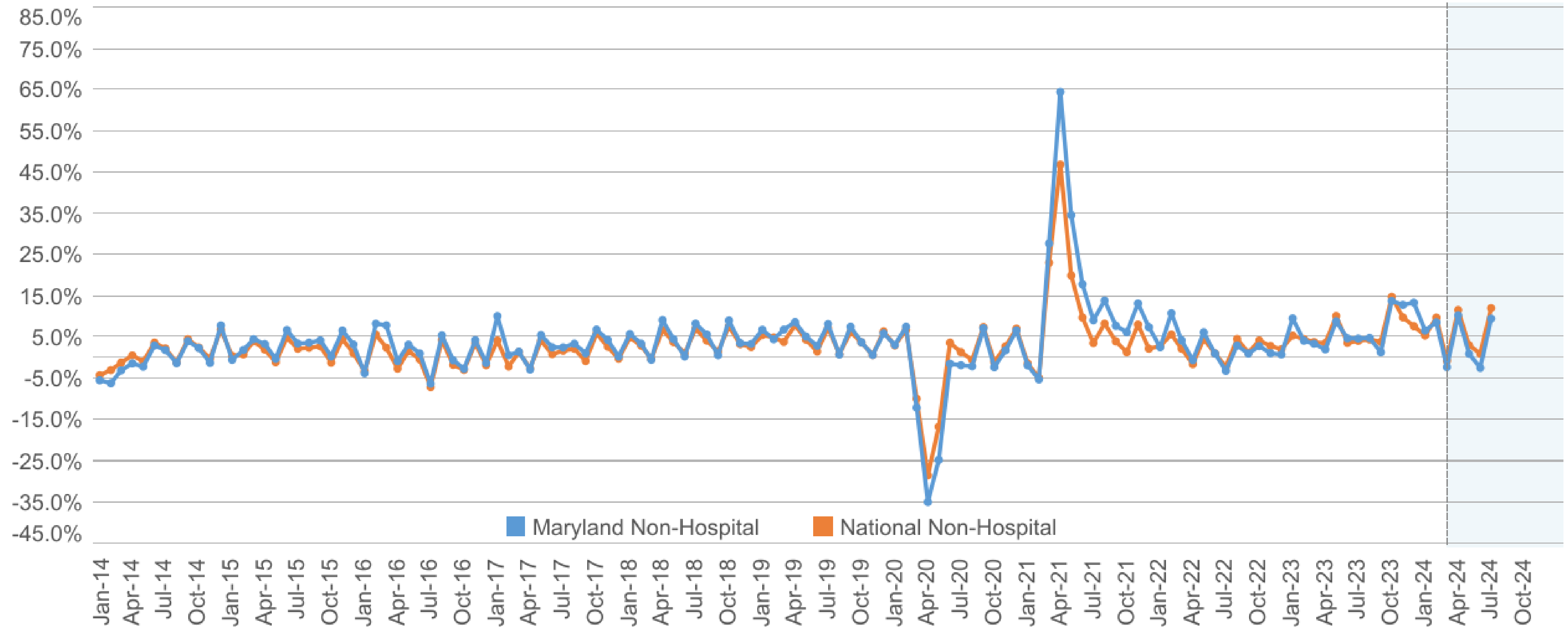


CY16 has been adjusted for the undercharge.

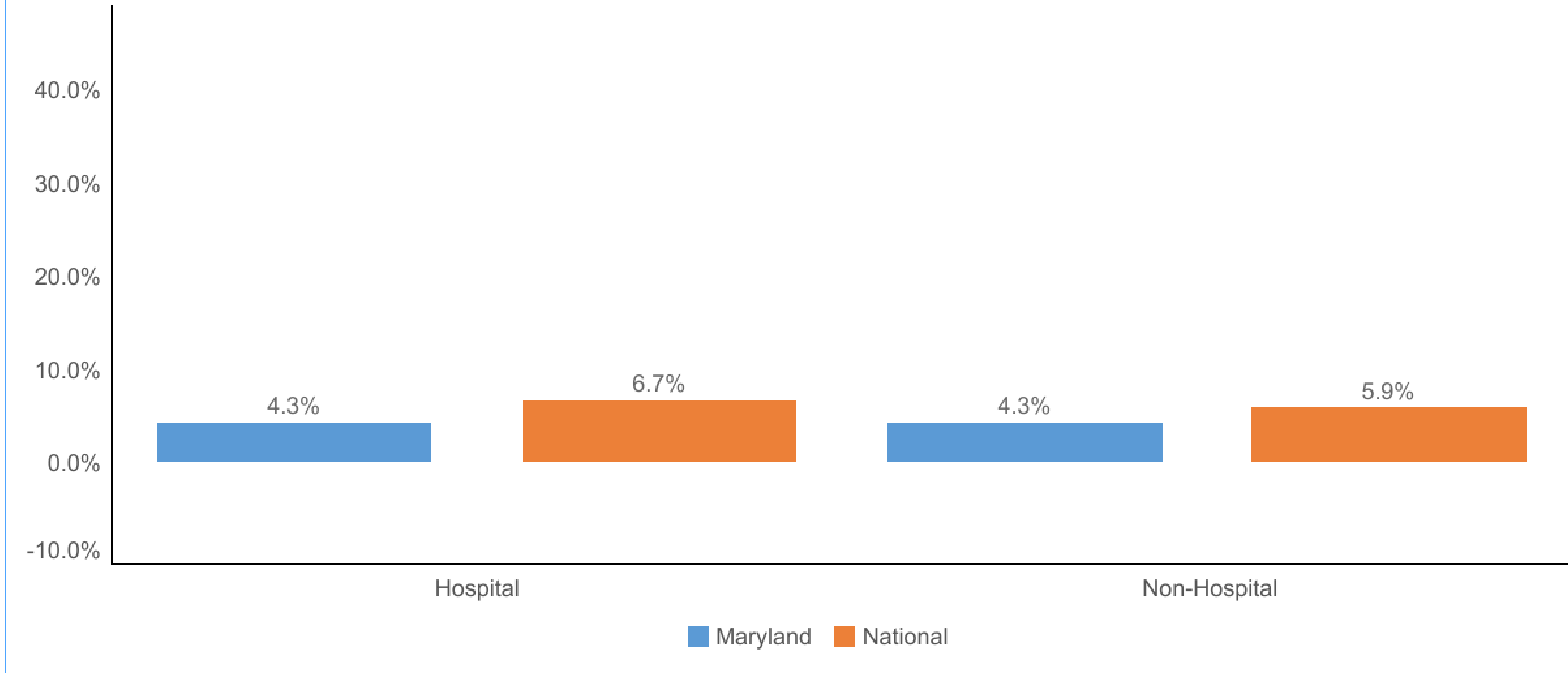
maryland health services cost review commission

Medicare Non-Hospital Spending per Capita

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

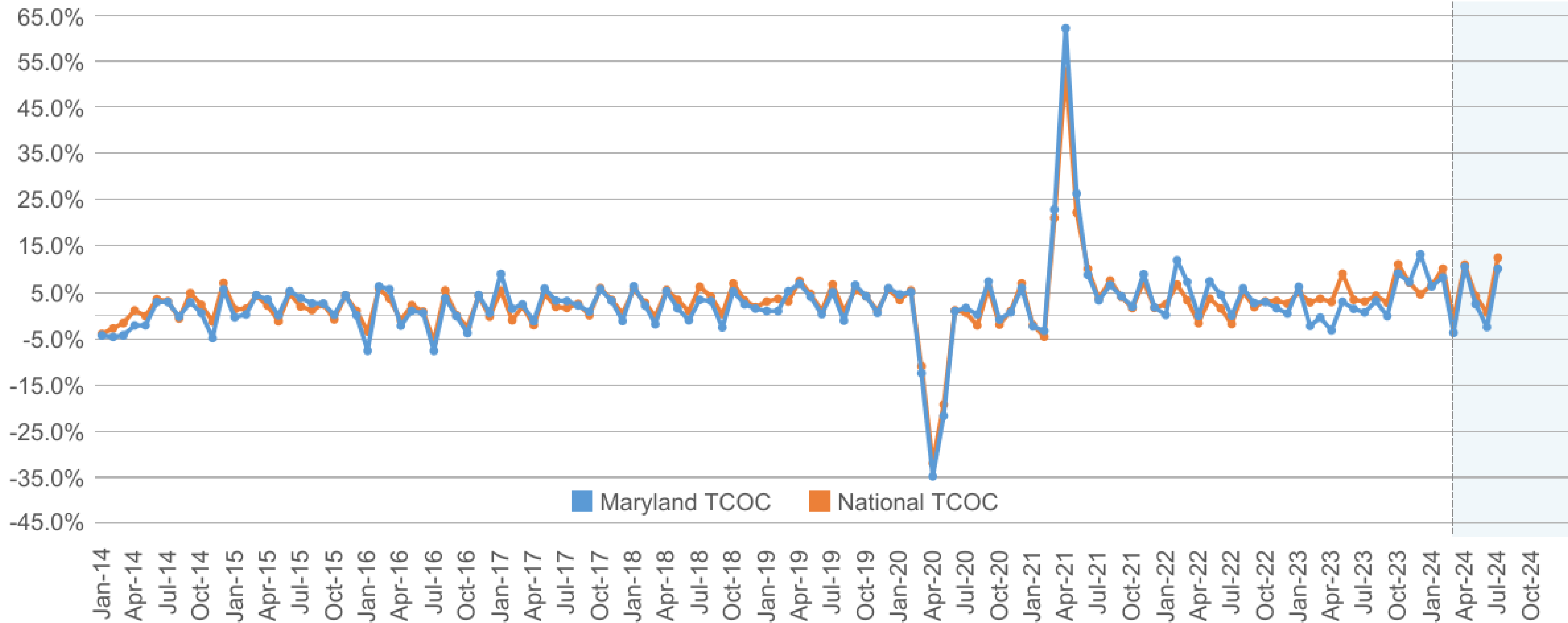


Medicare Hospital and Non-Hospital Payments per Capita



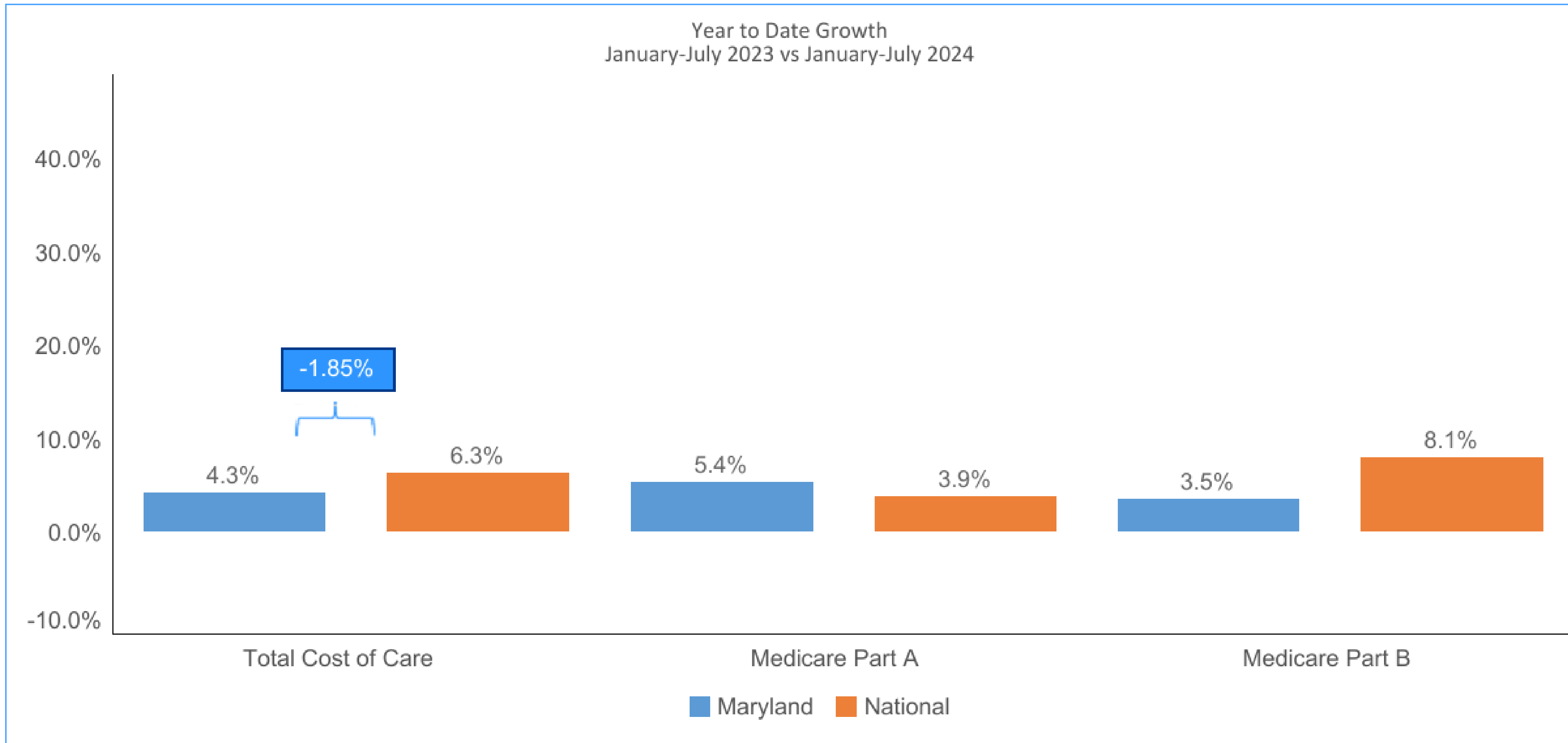
Medicare Total Cost of Care Spending per Capita

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



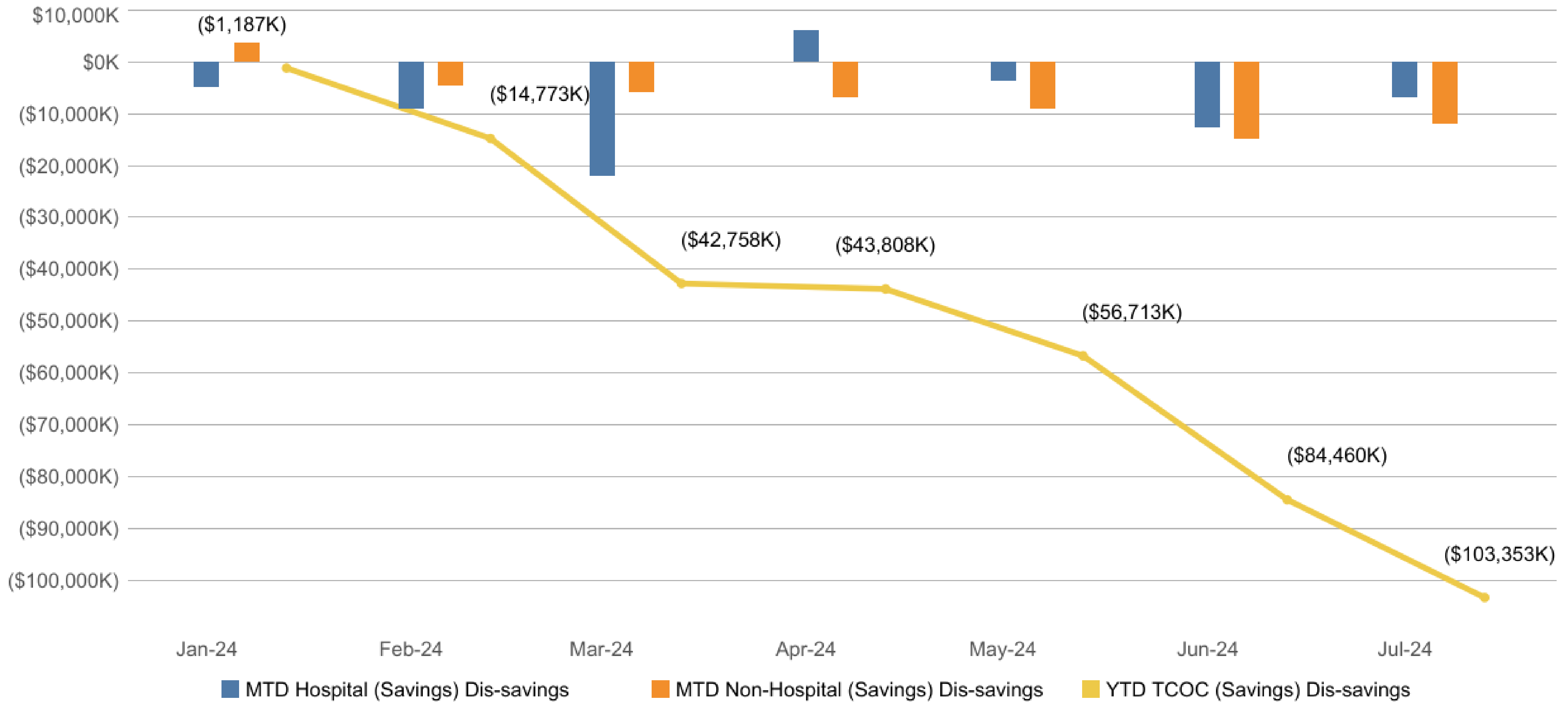
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through July 2024



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Emergency Department Initiatives Update

November Commission Meeting

Status Updates

1. EDDIE data collection continues but data visualizations were delayed this month (see EMS turnaround time in appendix)
2. QBR Policy:
    - Staff are working to calculate ED LOS for CY 2023 (base) using data submitted by hospitals
    - Minor changes proposed for final RY27 QBR policy; main focus is development of risk-adjusted ED LOS
3. ED Wait Time Reduction Commission held first meeting 10/23/24
    - Staff are currently focused on standing up subgroups
4. ED Best Practices subgroup continues to meet and anticipate draft policy at December Commission meeting

Appendix

October Data 2024 Reporting

Monthly, public reporting of three measures:

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

Data received for 43 out of 44 hospitals

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

Graphs:

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

EMS Turnaround Data

- EMS turnaround time data shows notable net movement of hospitals across categories for October 2024, with five hospitals improving in performance and three hospitals declining in performance

EMS Turnaround Times: October Performance

- 28 hospitals reported the 90th percentile of turnaround time was <=35 minutes
- 19 hospitals reported the 90th percentile of turnaround time was 35-60 minutes
- 5 hospitals reported the 90th percentile of turnaround time was over 60 minutes
- Hospitals with improving performance
  - (Average to high performing): CalvertHealth Medical Center, Grace Medical Center, Suburban Hospital, Union Hospital, Upper Chesapeake Medical Center
  - (Low performing to average): NA
- Hospitals with declining performance
  - (High performing to average): Carroll Hospital Center
  - (Average to low performing): Doctors Community Medical Center, White Oak Medical Center

EMS Turnaround Times: October 2024 Performance

90th Percentile: 0-35 Minutes

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

>35 Minutes

Baltimore Washington Medical Center
Carroll Hospital Center -
Charles Regional
Easton
Fort Washington Medical Center
Franklin Square
Good Samaritan Hospital
Greater Baltimore Medical Center
Harbor Hospital
Howard County Medical Center
Johns Hopkins Bayview
Johns Hopkins Hospital ADULT
Laurel Medical Center
Mercy Medical Center
Midtown
Sinai Hospital
St. Agnes Hospital
St. Joseph Medical Center
University of Maryland Medical Center

>60 Minutes

Capital Region Medical Center
Doctors Community Medical Center -
Northwest Hospital
Southern Maryland Hospital
White Oak Medical Center -

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

Draft Recommendation on High-Cost Drugs

Introduction

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

Review of Current Funding Approach

In HSCRC rate setting certain "High Cost" drugs that are drugs paid under the medical benefit (aka Part B drugs) are subject to a special funding provisions. Drugs under this policy are typically referred to as "CDS-A Drugs"[1] .

1. Hospitals receive/lose funding for changes in volume in these drugs at 50% of the change in cost.
   a. Cost is defined as ASP or 340B, whichever is applicable (note funding impacted relates only to direct cost, no changes are made in indirect loads).
   b. Volumes are reported in Casemix and validated through an annual audit process completed in the 6 months after each fiscal year and settled on January 1st of the next fiscal year.
2. Hospitals are funded for the remaining 50% of cost changes through a prospective price inflation factor applied to CDS-A Drugs during the update factor.
   a. The inflation factor covers only price increases not volume, but it includes the impact of drug volume mix changes on price (which is also reflected in volume changes).
   b. The inflation factor is typically set industry-wide, although for FY25 a higher value was set for academic hospitals.
   c. Because it is prospective, the value must be estimated based on data from 2 years prior (FY25 prospective inflation was based on FY23 drug spending). As a result, prospective funding tends to lag actual trend.
3. Revenue adjustments resulting from this process are added to the total hospital GBR.
   a. Drugs are billed based on the ratio of revenue allocated to the drug cost center to the cost of the drug across all drugs (not just the CDS-A drugs).
   b. To avoid overburdening high-cost drugs with overhead loads hospitals are supposed to tier overhead based on the drug cost.

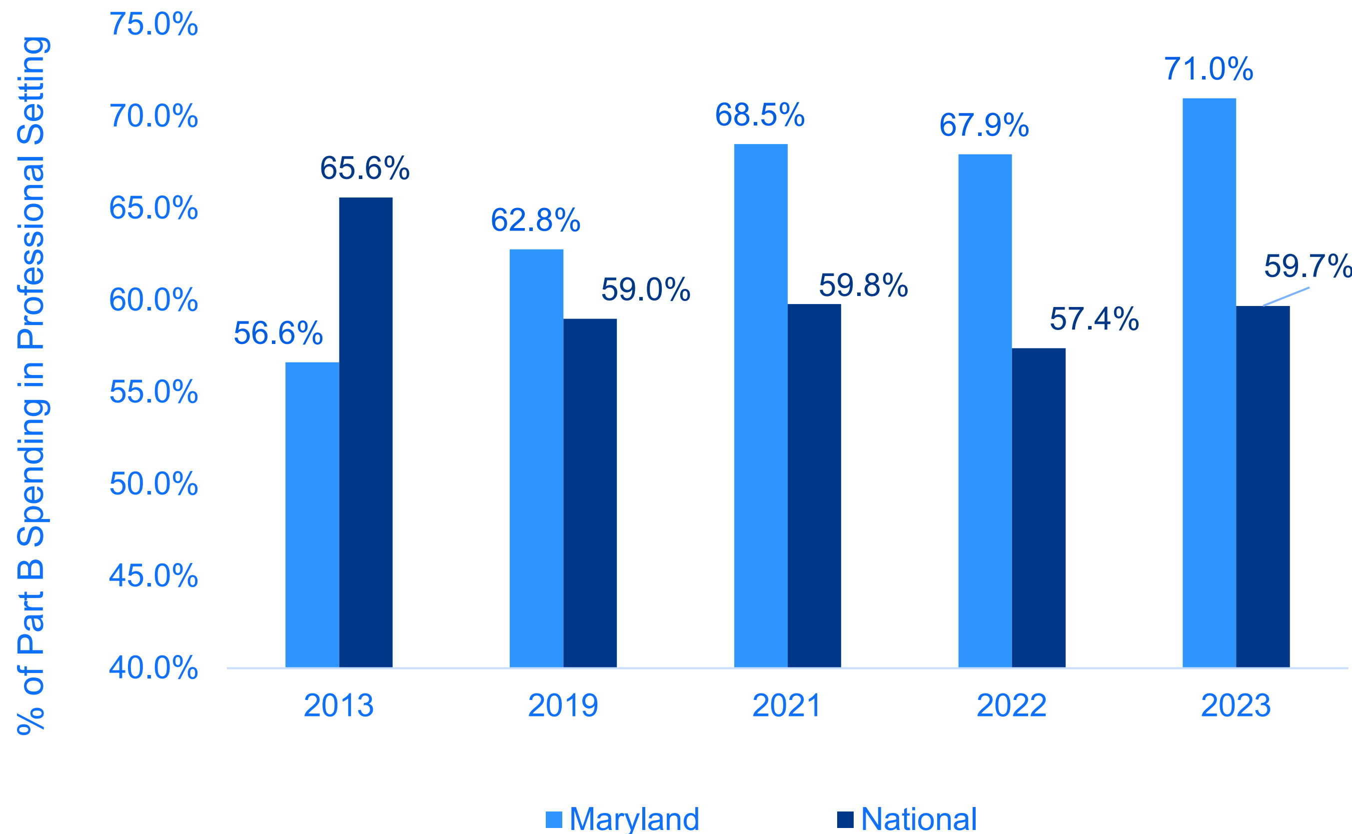
1. CDS-A stands for Costs of Drugs Sold – Audit and refers to the statewide list of physician administered outpatient drugs meeting certain defined inclusions criteria, these criteria are listed in Appendix A. These drugs are subject to an annual audit to validate reported amounts and ensure appropriate funding.

CDS-A Drug Trend, Actual Statewide Experience

- In 2023 CDS-A Drugs cost ~$380 M, which was about 40% of total statewide hospital drug costs
- CDS-A Approach was implemented in 2016 in response to high Part B drug trends.
- Trends mitigated later in the decade but have begun to accelerate again, particularly at the top end of the market.
- Staff expects trend acceleration seen in FY23 to continue into FY24.

	FY18	FY19	FY20	FY21	FY22	FY23
Volume	-12.5%	8.0%	7.2%	3.7%	3.9%	6.6%
Pure Price	-0.5%	-0.7%	1.1%	1.7%	1.5%	2.9%
Mix-Driven Price	18.3%	-3.7%	-5.3%	-1.3%	-2.0%	0.8%
Total	3.0%	3.3%	2.5%	4.1%	3.3%	10.5%

Outcomes - Model Has Achieved Significant Medicare Savings in Part B Drugs[1]



- During the past decade, Maryland's use of the professional setting has increased by almost 15% while the nation's decreased by about 6%. After a brief slow down during the pandemic the nation has gone back to the secular trend.
- On a PMPY basis Maryland has gone down from 19% greater than the nation to 2%.
- Estimate is that Part B place of service drove savings of ~$180 million dollars.
- Outside Maryland higher reimbursement in facility site of service discourages site of service shifts.

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

Case for Change

Staff believe we are at a tipping point for changing the policy:

- Hospitals are appropriately funded for the CDS-A Drugs through FY2023, this provides a window to change the funding approach.
- The current approach is complex, and it is hard to project how the two funding streams will interact to fund any given situation.
- There are indications that cost growth is moving to a small volume of very high-cost drugs, this is a situation which is poorly matched with the current approach.
- Given the CDS-A approach is already counted as a volume-variable component of the global budgets it would be simpler to make it directly volume variable.
- However, the current policy has been effective in driving Medicare savings, any policy change should look to maintain that advantage.

Reporting Strategy to Monitor Policy Impact

- As a 100% cost reimbursement policy does not maintain the same incentives to manage costs effectively the HSCRC is proposing to contract for an annual report to monitor the State's use of Part B drugs (see appendix).
  - If the report finds an erosion in the efficiency of Maryland spending from 2023 levels, GBR reductions equal to 20% of CDS-A spending will be assessed on a statewide, regional or hospital basis, depending on the extent of the erosion.
  - The report would become the basis for future policy changes.
- HSCRC intends to evaluate hospital tiering of drug prices over the coming year to ensure high-cost drugs are not being loaded with overhead on a $ for $ basis resulting in unfair costs to consumers.

Proposed Policy Recommendation

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

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

Potential Alternative for Interim Update

- Staff proposed the interim update for a fiscal year would be made on the following July 1 using annualized actual data for the first half of the fiscal year.
  - Follows current process of Jan 1 and July 1 rate updates
  - Update amount is determined objectively
- Industry proposed an additional option whereby hospitals with an expected increase of >$5 Million can access an earlier interim update on March 1 of the current fiscal year based on a projection of that year's spending
  - New curative, specialty drugs can cost > $1.0 M per dose, resulting in potentially significant volatility in cost experience during a year.
  - Accelerates recognition of cost increases into a hospital's current fiscal year matching the revenue with the year the expenses are incurred to avoid an impact to current year profitability.
  - Introduces interim rate update
  - Requires staff to review and negotiate projections from eligible hospitals
- Under either approach final adjustment is made on Jan 1 of following fiscal year based on actual costs.

Appendix

Annual Evaluation Report Outline and Impact

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

Criteria for Drugs to be Treated under CDS-A Policy

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

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

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Proposed Revisions to Outpatient High-Cost Drug Funding Policy

Draft Recommendation

November 13th, 2024

This is a draft recommendation for consideration by the Commission. Public comments must be received by November 27th, 2024, to william.henderson@maryland.gov

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List of Abbreviations

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

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

Policy Overview

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

Summary of the Recommendation

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

Background

In HSCRC’s rate setting process, certain high-cost drugs paid under the medical benefit, also known as Medicare Part B drugs, are subject to special funding provisions outside of the Global Budget Revenue process. These drugs are referred to as “CDS-A drugs” and include high cost, physician-administered, outpatient, oncology and infusion drugs as well as biologics. CDS-A drugs are determined annually based on a set of criteria established by staff in consultation with industry stakeholders. The current criteria can be found in Appendix A. Currently hospitals are funded for CDS-A Drug cost changes

via two pathways: 50% of funding comes from volume adjustments and the other 50% comes from the prospective price inflation factor, which is applied to CDS-A Drugs during the update factor. The current CDS-A approach was implemented in 2016 to recognize high Part B drug trends. The high-cost drug trends decreased later in the decade but began to accelerate again in Fiscal Year 2023 - the Staff expects this acceleration will continue into Fiscal Year 2024. Implementing this policy was necessary as these disproportionate trends were not being addressed by standard GBR policies. The policy was intended to provide extra funding for hospitals experiencing high-cost drug trends while still controlling spending on these drugs. In addition to clinical benefits for patients, high-cost drugs should reduce the need for acute hospitalization and other expensive services and therefore their adoption is strongly aligned with the goals of the Maryland Model.

Current Policy

Overview

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

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

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

- Hospitals that move to lower cost drugs benefit by retaining 50% of the drug cost in their GBR.

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

The current approach operates under the assumptions that every hospital will have an equal opportunity of success under this policy and that the impact of new high-cost drugs would be evenly distributed because the inflation factor is set on a statewide basis. Even though HSCRC has provided different inflation factors for academic hospitals[4], it would not be operationally feasible to accurately estimate hospital specific inflation factors for every hospital; therefore, differential inflation experience will never be fully captured under the current policy.

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

Policy Impact

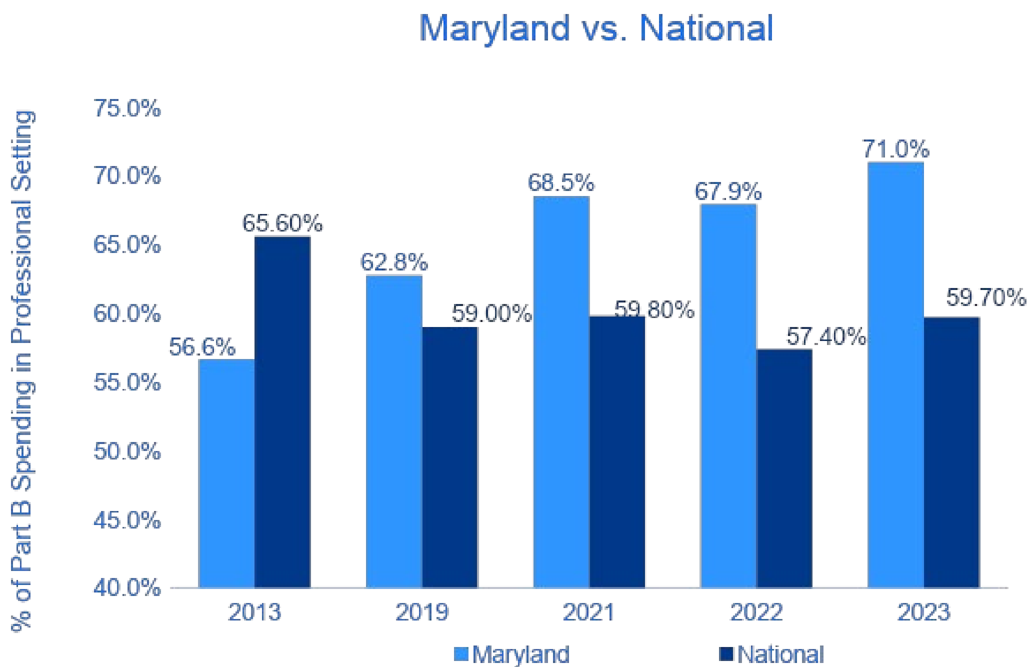
In FY23, HSCRC estimated that the average hospital was overfunded by 0.4% of total GBR based on the two-pathway drug funding approach, with the median hospital being overfunded by an estimated 0.24%.

Maryland has been successful in shifting administration of Part-B drugs to the

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

professional setting rather than the hospital. In 2023, 71.0% of Part-B spending was in the non-hospital setting (that is drugs were billed as professional rather than facility claims), compared to 59.7% for the nation as a whole, which effectively reversed the site of care shares that existed prior to global budgets in 2013 (see Figure 1). Staff estimate that the Part B place of service changes generated Medicare run rate savings of ~$180 million dollars since 2013 under the Total Cost of Care Model (TCOC Model)[5].

Figure 1: Maryland Model Impact on Part B Drugs



Issues with current funding approach

Both the inflation and the volume lever cause challenges for providing accurate funding. While the current approach does vary based on volume, the combination of

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

prospective inflation and 50% volume funding do not reliably match the actual hospital experience. Even if funding is accurate at the statewide level, variation in cost and volume at the hospital level will result in over/underfunding for individual hospitals. Hospitals facing the highest cost pressures are the most likely to be underfunded.

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

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

Case for Changes to Cost Reimbursement

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

The CDS-A approach is already a volume variable component in GBRs as scored under the TCOC Model[6]. Therefore, making changes to it does not impact that test. However, the current policy has been effective in generating total cost of care savings, which HSCRC should strive to maintain under any proposed policy change.

Staff Recommendation

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

1. Continue to identify high-cost drugs for volume-based funding based on criteria set by Staff in consultation with industry stakeholders (see Appendix A for current criteria)
2. Continue to conduct an audit of reported volumes to ensure volume-based reimbursement is fairly stated
3. Change volume funding to 100% of measured cost change, per the annual audit, effective 1/1 each year.
4. Implement a provisional adjustment period for each year, at the end of the year based on the first 6 months of data to smooth the impact of increased adjustment size.
    a. Provisional adjustment period will be directly calculated by staff using Casemix data, excluding drugs with outlier dosage counts. No manual adjustments will be made.
    b. Provisional adjustment will be temporary only, final adjustment derived from the audit will supersede the provisional adjustment and all amounts will be trued up to the final audit.

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

5. Set the drug component of inflation in the update factor to only reflect any price inflation not captured during the volume adjustment;[7] inflation on drugs will primarily be provided through the volume adjustment
6. Implement a new annual report, produced by a consultant, to identify hospital efficiency in controlling CDS-A drug costs and assess penalties, up to 20% of drug cost, to hospitals that are not meeting target goals. Further details are outlined below.
7. Hospitals will continue to be expected to “tier” charges for drugs. Staff will periodically evaluate hospital tiering of drug prices to ensure high-cost drugs are not being loaded with proportionate overhead, resulting in unfair costs to consumers.
8. Continue to audit data reported in Casemix to validate amounts reported and gather appropriate ASP and 340B price data.

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

New Reporting Requirements

In order to maintain incentives to control cost growth of CDS-A drugs under this new policy, HSCRC proposed additional reporting requirements via an annual report. 100% volume-based cost reimbursement does not provide the same incentives to manage costs effectively as the current policy. Under the proposed policy, HSCRC will contract for an annual report to monitor the State’s use of Part B drugs. If this report finds an erosion in the efficiency of Maryland spending from 2023 levels, GBR reductions equal to 20% of CDS-A spending will be assessed on a statewide, regional, or hospital basis,

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

depending on the extent of the erosion. This annual report would become the basis for future policy changes.

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

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

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

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

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

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

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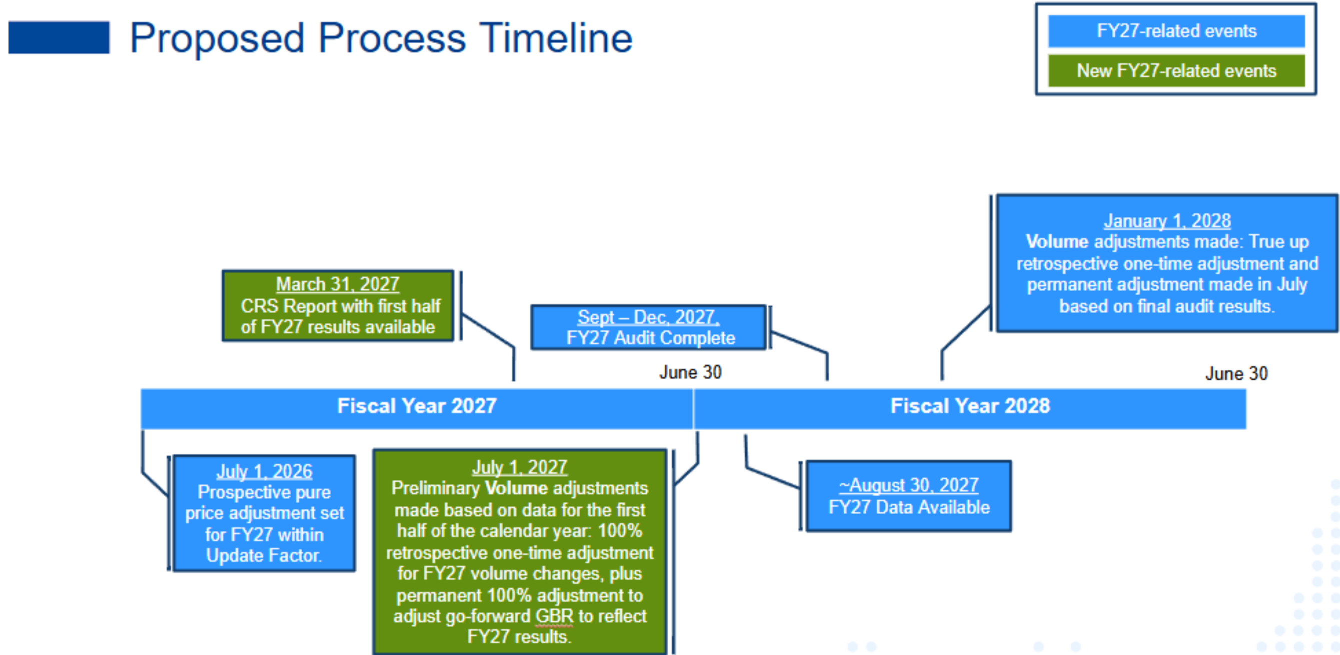
Appendix B: Proposed Process Timeline, FY27 Focused Example



MPA and Set Aside Policy Updates

Outline

1. Overview
2. HSCRC Call for Comments
3. Proposed Changes
4. Background
   - Set Aside
   - NCBP in MPA
   - Model Savings Position
5. Final Recommendation

Savings Over Target Overview

- In the October Commission meeting, Commissioners and Staff discussed the projected savings over the 2024 Medicare Fee-for-service target. During that conversation, the HSCRC committed to drafting a proposal for potentially increasing rates; reducing the expected savings over target over 2024 and 2025; and using additional revenue to strengthen the Model.

HSCRC Call for Comments

Following the discussion on savings over target in the October meeting, the HSCRC put out a call for comments on the following questions:

1. Targeted to an increase in the Set Aside?
   a. If yes, what should the total increase be and should there be any consideration for allocating additional funding separately for relatively efficient hospitals and hospitals that are currently undergoing a financial hardship, i.e., please indicate separate amounts for both sets of hospitals if you support this approach?

2. Applied in a broad-based manner for costs drivers that are not currently funded in rates?
   a. If yes, what are the cost drivers that all hospitals are experiencing and what is a reasonable total allotment for the system, i.e., please include a system wide cost estimate and support for that assertion?

3. Applied in a broad base manner for new costs that would be accretive to the goals of the TCOC Model?
   a. If yes, what are the costs that all hospitals could incur to improve Model performance (quality outcomes, utilization management, population health)?

Comments Received

1. Targeted to an increase in the Set Aside? If yes, what should the total increase be and should there be any consideration for allocating additional funding separately for relatively efficient hospitals and hospitals that are currently undergoing a financial hardship, i.e., please indicate separate amounts for both sets of hospitals if you support this approach?)

- Responses:
  - Hopkins and CareFirst emphasize that funding should be need-based and focus on individual hospital circumstances, particularly financial hardship, rather than applying a blanket-based allocation.
  - United Healthcare recommends maintaining the current schedule of rate adjustments, stressing that unanticipated increases could destabilize payers across commercial, Medicare Advantage, and Medicaid programs. They further emphasize that such disruptions would increase costs to consumers and negatively affect Medicaid MCOs. Furthermore, League of Life & Health Insurers of Maryland caution that raising rates without sufficient cost justification could lead to price-gouging and harm the long-term financial stability of Maryland's healthcare system.
  - Most hospitals commented that the set-aside funding should be increased to better address the growing financial needs across the system. Frederick Health, LifeBridge Health, and MedStar support directing a portion of revenue enhancements to this increase. St. Agnes and MedStar specifically advocate for a mid-year increase to address the current financial pressures.
  - Luminis, LifeBridge, and Adventist suggest that funding for relatively efficient hospitals should come from a separate pool, as their needs are different from those facing significant financial hardship, as their needs are different from those facing significant financial hardship. They argue that efficient hospitals have access to other funding sources and should not be prioritized for the same set-aside funding.
  - MHA recommends a hybrid approach that adds funding to the existing set-aside pool to meet unmet requests from hospitals in financial hardship and to allocate remaining funds to address broad-based cost drivers, which affect all hospitals to varying degrees.
  - MHA recommends that given the significant need a portion of funding generated from the rate increase should be added to the existing set aside funding to address unfunded requests that meet criteria. Furthermore, hospitals with higher financial need should receive priority for these additional funds.

Comments Received

2. Applied in a broad-based manner for costs drivers that are not currently funded in rates? If yes, what are the cost drivers that all hospitals are experiencing and what is a reasonable total allotment for the system, i.e., please include a system wide cost estimate and support for that assertion?

- Responses:
  - CareFirst cautions against broad-based funding increases, stressing that any funding should be justified and targeted. This aligns with the League of Life & Health Insurers, which expresses concerns about broad-based rate increases that could exacerbate costs for consumers and destabilize the healthcare system.
  - United Healthcare supports directing any savings to population health initiatives, particularly those aligned with the Statewide Integrated Health Improvement Strategy. They suggest using excess savings to support efforts that will improve population health outcomes, thus advancing health equity across the state. They also recommend positioning payers as key partners with hospitals and primary care providers to help achieve these goals. The League of Life & Health Insurers supports this view, advocating for innovative solutions focused on improving healthcare quality while managing costs, rather than simply increasing rates across the board.
  - Hospitals commented that certain cost drivers are insufficiently funded in current rate structures, particularly related to demographic changes, inflation, and aging population needs. Luminis, LifeBridge, and Frederick Health highlight the need for age-adjusted demographic adjustments to better reflect the true growth in healthcare demand. Adventist HealthCare further emphasizes that funding for the aging population is especially underfunded.
  - A few hospitals also highlight the growing costs associated with labor, supply, and drug expenses, which must be factored into future funding discussions (LifeBridge, Frederick Health). The general consensus is that addressing these unfunded cost drivers is a priority to maintain financial stability and continue delivering care.
  - MHA highlights the balance of funding generated by the rate increase should be allocated on a permanent basis to address key cost drivers such as rising labor costs, routine capital investments, and age-adjusted demographic growth and implementation should be quick. MHA proposes a 2.7% all-payer rate increase to address key cost drivers. This would generate an additional $410 million in net revenue for hospitals. Furthermore, funding should be allocated in a way that is transparent and minimally burdensome for hospitals and the HSCRC to administer.

Comments Received

3. Applied in a broad base manner for new costs that would be accretive to the goals of the TCOC Model? If yes, what are the costs that all hospitals could incur to improve Model performance (quality outcomes, utilization management, population health)?

- Responses:
  - CareFirst advocates for funding new initiatives that will improve healthcare affordability and help meet the overall goals of the TCOC model, but urges that these should not exacerbate financial difficulties for hospitals or families.
  - United Healthcare recommends investing in initiatives that advance population health and health equity, specifically in line with the goals of the AHEAD model. They advocate for investments that will improve health outcomes and help reduce health disparities. They also emphasize that payers should work closely with hospital groups and primary care providers to achieve these shared goals and improve the overall health of Marylanders.
  - The League of Life & Health Insurers emphasizes that any new initiatives should be carefully evaluated to avoid unnecessary cost increases or financial instability. They specifically caution against raising rates to allow hospitals to maximize revenue, particularly when margins are healthy, as this undermines the State's commitment to the Total Cost of Care Model and the HSCRC’s mandate. The League also warns that unsubstantiated cost increases could further jeopardize the TCOC Model and raise healthcare costs for consumers, small businesses, and taxpayers. They advocate instead for cost-control measures that prioritize quality and efficiency without burdening Maryland residents with higher rates.
  - Hospitals commented that financial stability should take precedence over funding new initiatives related to the TCOC model. Frederick Health, LifeBridge, and Hopkins caution against introducing new costs until set-aside funding and broader cost pressures are addressed.
  - Adventist HealthCare proposes using excess savings to address issues with the Care Transformation Initiative (CTI), particularly for areas like Montgomery County, which face challenges in meeting savings targets due to low Medicare usage.
  - St. Agnes supports the expansion of primary care through initiatives like EQIP, but only once financial stability is ensured.

Staff Recommendation for 2024

Staff recommend the Commission adjust two existing policies as follows:

1) increase the set aside provided in the Fiscal Year 2024 Update Factor Recommendation from 0.15% to 0.30%
2) retroactively correct the Medicare Performance Adjustment (MPA) savings target for Calendar Years 2020 to 2024 to reflect newly available information on non-claims-based payments resulting in a one-time increase to hospital rewards under this policy

Set Aside

- In June 2024 the Commission approved the FY25 Update Factor.
  - Set Aside of 0.15% (estimated at $31.7 million).
- In the FY25 Update Factor the Commission also directed staff to “create a process where the set aside will be distributed through a competitive exercise and require a corrective action plan for improved financial operations.”
  - Since June, staff have been working to gather information on hospital needs in accordance with that recommendation.
- To date staff have received requests totaling $181 million of which Staff believe approximately $81 million qualifies for eligibility, Staff believe the revised amount of $63.4 million is appropriate, as it would fund more than 75% of eligible requests.

Non-Claims-Based Payments (NCBPs)

- Traditional MPA: Target for measuring hospitals' performance is based on national Medicare per beneficiary growth consistent with the TCOC model savings target
- NCBP under MPA: Since 2020, the TCOC model savings target has gradually been adjusted to reflect the costs of certain national programs that are not paid via the standard claims reimbursement process. **Under this proposal the same adjustments would be applied to the MPA.**

Impact of NCBP on Traditional MPA per Beneficiary TCOC Growth Targets

Calendar Year	Target Used	Revised Target[5]	$ Impact
2020	-3.38%	-2.99%	$3.7 M
2021	8.96%	9.18%	$5.5 M
2022	2.84%	3.25%	$3.2 M
2023	5.36%	5.53%	$9.7M
2024[6]	TBD	TBD	TBD
Total through 2023	14.1%	15.4%	$22.2 M

Model Savings Position

- For Calendar Year 2023 CMS certified that under the TCOC Model Maryland achieved savings of $509 Million.
- Through July 2024 Maryland's savings have increased to approximately $600 million. This increase results from per beneficiary total cost of care growth of 4.3% in Maryland versus 6.3% nationally.
- Variance driven entirely by spending in the outpatient setting.
- Current $100 Million savings above target is split 50:50 between hospital-based and non-hospital based spending with the savings being driven by outpatient in both the hospital and non-hospital setting (inpatient is a slight headwind).

Final Recommendation

Staff recommend the Commission adjust two existing policies as follows:

1) increase the set aside provided in the Fiscal Year 2024 (FY24) Update Factor Recommendation from 0.15% to 0.30% (approximately $31.7 million on an all-payer basis).
2) retroactively correct the Medicare Performance Adjustment (MPA) savings target for Calendar Years 2020 to 2024 (CY2020 to CY2024) to reflect newly available information on non-claims-based payments resulting in a one-time increase to hospital rewards under this policy, costing an anticipated $22 million.

Both adjustments would be principally[1] one-time in nature.

- The Update Factor increase would only be effective for Fiscal Year 2025 (FY25) and would have to be renewed by the Commission beyond July 1, 2025.
- The MPA correction is a catch-up for a change in prior year rewards and is therefore one-time in nature. The cost of this change is borne only by Medicare.

Staff should work with industry and CMS to effect both these changes in CY24 to avoid creating disproportionate headwinds to CY25 savings. However, given their one time nature, the changes should be pursued even if they can't be fully implemented in CY24 due to operational limitations. Staff should also work to ensure that the resulting State Medicaid budget impact is offset.

1. Funding relating to hospitals qualifying for the set aside due to performance under the ICC policy would be permanent.

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MPA and Set Aside Policy Updates

Final Recommendation

November 13th, 2024

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List of Abbreviations

AHEAD	States Advancing All-Payer Health Equity Approaches and Development Model
CMS	Centers for Medicare & Medicaid Services
GBR	Global Budget Revenue
MPA	Medicare Performance Adjustment
NCBP	Non-Claim-Based Payment
TCOC	Total Cost of Care
TCOC Model	Total Cost of Care Model

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Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
Adjust the existing MPA and Update Factor Policies for specific purposes.	Two separate adjustments will be made: (1) an increase in the set aside provided in the Fiscal Year 2024 Update Factor Recommendation from 0.15% to 0.30% (2) a retroactive correction to the Traditional MPA savings target for calendar years 2020 to 2024 to reflect newly available information on non-claims-based payments resulting in a one-time increase to hospital rewards under this policy of approximately $22.0 M through 2023.	Hospitals would have more available funding based on need documented in the set aside process and/or the correction to the MPA calculation.	Set aside change will increase hospital costs for all payers in Fiscal Year 2025. MPA correction only impacts Medicare payments and does not impact other payers or Medicare or non-Medicare consumers.	No Impact

Summary of the Recommendation

Staff recommend the Commission adjust two existing policies as follows:

(1) increase the set aside provided in the Fiscal Year 2024 (FY24) Update Factor Recommendation from 0.15% to 0.30% (approximately $30 million on an all-payer basis, bringing the total set aside to $60 million).

(2) retroactively correct the Medicare Performance Adjustment (MPA) savings target for Calendar Years 2020 to 2024 (CY2020 to CY2024) to reflect newly available information on non-claims-based payments resulting in a one-time increase to hospital rewards under this policy (Currently estimated at approximately $22.0 M from Medicare only, through Calendar Year 2023, the final amount is contingent on review of the calculations by industry and CMS and policy requires CMS approval).

Both adjustments would be largely one-time[1] in nature and Staff will work with industry and CMS to implement them in CY24, but if that is not operationally feasible, they will be implemented in 2025 instead. These adjustments are possible due to Maryland's strong position in the Total Cost of Care Model savings test.

Background

Set Aside

In June 2024 the Commission approved the FY25 Update Factor. This included a Set Aside of 0.15% (estimated at $31.7 million). The Set Aside is routinely created during the update factor process to allow the HSCRC to meet unanticipated, documented funding needs of specific hospitals. The cost of the set aside is shared across all payers. In the FY25 Update Factor the Commission also directed staff to "create a process where the set aside will be distributed through a competitive exercise and require a corrective action plan for improved financial operations."[2] Since June Staff have been working to gather information on hospital needs in accordance with that recommendation. To date staff have received requests totaling $181 million of which Staff believe approximately $81million may merit funding, review is ongoing on this amount and staff believe the revised amount of approximately $60 million will be adequate. The delta between $81 million and $181 million is due to hospitals that did not meet the eligibility thresholds for funding and for items that cannot be funded by the Commission (i.e. Physicians).

Traditional Medicare Performance Adjustment

The traditional MPA is a program established under the TCOC Model whereby hospitals are at risk for up to 2% of Medicare revenue based on their performance managing TCOC risk for a set of attributed beneficiaries. This approach will continue under the new Advancing All-Payer Equity Approaches and Delivery Challenges Model

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[1]Hospitals can submit an application for set aside funding for financial hardship or efficiency. Hospitals that submit an application for efficiency receive permanent funding. Two hospitals submitted applications in FY25 under the efficiency criteria.

[2] See FY25 Update Factor Final Recommendation page 3 (pdf page 73) at June 2024 Commission Pre-Meeting Materials

(AHEAD). The specific provisions of this program can be found in the annual MPA recommendation to the Commission[3]. Changes to the MPA only impacts Medicare Trust Fund payments to hospitals and does not impact other payers or Medicare or non-Medicare consumers. The MPA policy is subject to annual approval by CMS and any changes to the policy require CMS approval.

Under the Traditional MPA the target for measuring hospitals' performance is based on national Medicare per beneficiary growth consistent with the TCOC Model savings target. However, since 2020, the TCOC Model savings target has gradually been adjusted to reflect the cost of certain national programs that are not paid via the standard claims reimbursement process. Known as non-claims-based payments (NCPBs), these payments typically relate to value-based programs. Because there are multiple programs, with varying levels of data available and significant data time lag these programs have only recently been fully reflected in the TCOC Model Savings Test.

Because of these same limitations not all of these payments have been included in measuring performance under the Traditional MPA even as they were added to the TCOC Model savings test. The excluded payments add more to national costs than to Maryland costs, which means their exclusion results in harder growth targets under the Traditional MPA than the State faces under the TCOC Model test. Table 1 shows the Staff's estimate of the difference between the MPA targets used and the targets reflecting NCBP.

[3] The most recent MPA Recommendation can be found on pdf page 8 at March 2024 HSCRC Public Pre-Meeting Materials

Table 1: Impact of NCBP on Traditional MPA Per Beneficiary TCOC Growth Targets[4]

Calendar Year	Target Used	Revised Target[5]	$ Impact
2020	-3.38%	-2.99%	$3.7 M
2021	8.96%	9.18%	$5.5 M
2022	2.84%	3.25%	$3.2 M
2023	5.36%	5.53%	$9.7M
2024[6]	TBD	TBD	TBD
Total through 2023	14.1%	15.4%	$22.2 M

Model Savings Position

The funds for this spending are available because we are exceeding savings targets. For Calendar Year 2023 (CY23) CMS certified that under the TCOC Model Maryland achieved savings of $509 Million versus a target of $300 Million. During the Update Factor Staff estimated savings remaining approximately flat into 2024. However, through July 2024[7] (YTD CY24) Maryland's savings have increased to approximately $600 million. This increase results from per beneficiary total cost of care growth of 4.3% in Maryland versus 6.3% nationally. This variance is driven primarily by accelerations in

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[4] are estimates and are currently being reviewed by industry.
[5] For the purposes of this calculation the HSCRC is netting Maryland NCBPs against National and then adjusting the National trend. The TCOC Model savings test adjusts both Maryland and the Nation separately, Staff are proposing to use the alternative approach in the MPA to simplify they impact as the Maryland amounts are de minimis.
[6] The impact for Calendar Year 2024 is not yet known as the year is not yet complete and impact can vary with hospital performance. Staff anticipates an amount in the $5 to $10 million range, consistent with prior years.
[7] All CY24 amounts include 2 months run out and completion. All prior periods include 3 months run out. This approach is consistent with ongoing TCOC reporting methods.

national hospital spending and a slowing in Maryland non-hospital spending in comparison to the nation. Specifically:

- An increase in the national hospital per beneficiary growth to 6.7% in YTD CY24 compared to 3.7% for the same period in CY23 and average annual growth from 2013 to 2023 of 2.5%
- A reduction in Maryland non-hospital per beneficiary growth to 4.3% in YTD CY24 compared to 5.3% for the same period in CY23. For the same time period national non-hospital growth has gone up from 5.1% to 5.9%.

The $100 M extra savings accumulated year-to-date is split approximately 50:50 between hospital and non-hospital drivers. These adjustments have been identified for implementation in 2024 as it should be possible to implement them rapidly without significant disruption to the rate setting system. Making larger adjustments within 2024 would result in undesirably large variations in hospital rates and would be hard to operationalize.

Staff Recommendation

Staff recommend the Commission adjust two existing policies as follows:

(1) increase the set aside provided in the Fiscal Year 2024 (FY24) Update Factor Recommendation from 0.15% to 0.30% (approximately $30 million on an all-payer basis).

(2) retroactively correct the Medicare Performance Adjustment (MPA) savings target for Calendar Years 2020 to 2024 (CY2020 to CY2024) to reflect newly available information on non-claims-based payments resulting in a one-time increase to hospital rewards under this policy.

Both adjustments would be principally one-time in nature[8]. The Update Factor increase would only be effective for Fiscal Year 2025 (FY25) and would have to be renewed by the Commission beyond July 1, 2025.

[8] See footnote 1.

The MPA correction is a catch-up for a change in prior year rewards and is therefore one-time in nature. The cost of this change is borne only by Medicare. The impact as shown in Table 1 is an estimate and subject to review by industry and CMS. The impact of this recommendation is to include NCBP in the calculation of the MPA target rather than any specific dollar amount. This change is also contingent on approval by CMS, as with all MPA policy changes. This recommendation only addresses periods through CY24. Staff intend to include a similar recommendation in the CY25 MPA Recommendation covering future periods.

Staff should work with industry and CMS to effect both these changes in CY24 to avoid creating disproportionate headwinds to CY25 savings. However, given their one-time nature, the changes should be pursued even if they can't be fully implemented in CY24 due to operational limitations.

2025 Funding for AHEAD Preparation

Outline

1. Proposed Changes
2. Background
    - AHEAD & Population Health Trust
3. Availability of Funds/Savings Position
    - Model Savings
    - Contextual Factors
4. New Programs to Address Health Cost & Delivery Challenges
5. Final Recommendation

Proposed Changes

An increase of 1.6% to be implemented in hospital rates for 2025 to be collected by hospitals throughout 2025 and held to be directed to various purposes to prepare for the new model. The rate increase would sunset December 31, 2025, without further action from the Commission.

Background - AHEAD & Population Health Trust

AHEAD: Maryland will begin its new model implementation period on January 1, 2026. To ensure successful implementation, significant investment is necessary to accelerate healthcare transformation, bolster access to necessary services, and develop and launch a statewide population health strategy

Population Health Trust: Under the AHEAD agreement, the State committed to establishing a Population Health Trust comprised of public and private sources to support statewide population health improvement initiatives in alignment with the State's Health Equity Plan.

Model Savings Position

- For Calendar Year 2023 CMS certified that under the TCOC Model Maryland achieved savings of $509 Million.
- Through July 2024 Maryland’s savings have increased to approximately $600 million. This increase results from per beneficiary total cost of care growth of 4.3% in Maryland versus 6.3% nationally.
- Variance driven entirely by spending in the outpatient setting.
- Current $100 Million savings above target is split 50:50 between hospital-based and non-hospital based spending with the savings being driven by outpatient in both the hospital and non-hospital setting (inpatient is a slight headwind).
- As long as national trends remain high and Maryland non-hospital trends remain low, Staff expect the positive savings to continue into 2025 accumulating to as much as $650 or $700 million.

Various Considerations in Evaluating Savings Position

- The $509 million savings in 2023 will become the baseline for AHEAD starting in 2026 and should savings go below that level in the intervening years, they will have to be recovered to achieve 2026 targets.
- Savings are driven by high national hospital spending and low Maryland non-hospital spending. Both factors lie largely beyond the control of the Commission.
- YTD CY24 national hospital growth is very high compared to historical averages, and data reflects only 7 months of experience.
- FY25 Update Factor and reflected significant catch-up inflation while FY24 included significant demographic catch-up adjustments.
- CY23 savings of $509 million is consistent with model performance pre-pandemic, e.g. 2019 savings = $364 M
- All-payer performance may not mirror Medicare performance

New Programs to Address Health Cost & Delivery Challenges

Staff support investments in various health cost and delivery improvement programs to prepare for successful performance under the new model.

Creating an access and transformation fund that leverages the capabilities of hospitals as well as other participants in the system is the most productive way to use savings in excess of target. Staff have identified **7 areas of potential investment**:

1. An all-payer value-based program, similar to the current Medicare Care Transformation Initiatives program, to support clinical innovation and transformation to achieve better and more equitable health outcomes while maintaining affordability.
2. Common platforms and efforts for the hospital system to improve efficiency and effectiveness of care.
3. Access expansions to meet latent demand for high-value clinical services across the healthcare system.
4. Global payment arrangements with hospitals that are working to improve health and lower costs in their geographic areas.
5. Workforce investments, including but not limited to updates to the GME program.
6. Greater understanding of patient financial burdens with seed funding for new approaches to assistance.
7. Additional pay-for-performance programs with transformation or access impact.

Staff will work with stakeholders and the legislature to refine and prioritize this list before recommending final funding allocations to the Commission. Staff will also work to ensure that the resulting State Medicaid budget impact is offset.

Final Recommendation

Staff recommend the Commission increase rates as of January 1, 2025, for Calendar Year 2025 by **1.6 percent**, on an all-payer basis and with an offset to State Medicaid budget impacts, and that hospitals hold the revenues collected under this provision until directed to specific purposes by the Commission. Twenty percent of the funds held will be directed to the Population Health Trust, which the State agreed to establish under the AHEAD agreement, while the remaining eighty percent will be used to support access and transformation under the Model.

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2025 Funding for AHEAD Preparation

Draft Recommendation

November 13th, 2024

This is a draft recommendation for consideration by the Commission. Public comments must be received by November 27th, 2024, to hscrc.payment@maryland.gov

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List of Abbreviations

AHEAD	States Advancing All-Payer Health Equity Approaches and Development Model
CMS	Centers for Medicare & Medicaid Services
TCOC	Total Cost of Care
TCOC Model	Total Cost of Care Model

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
To prepare for successful implementation of the AHEAD model.	An increase of 1.6% will be implemented in hospital rates for 2025 to be collected by hospitals throughout 2025 and held to be redirected to various purposes to prepare for the AHEAD model as outlined in this recommendation. The rate increase would sunset December 31, 2025, without further action from the Commission.	Hospitals would gain directly when eligible for the additional funding and indirectly from strengthening of the Maryland model for AHEAD.	The rate increase will add to the costs for payers and consumers however payers and consumers will also benefit from the impact as the held funds are allocated to health improvement efforts and a successful launch of the AHEAD model	As one of the fundamental goals of AHEAD is increasing health equity, preparing for successful implementation will advance this goal.

Summary of the Recommendation

Staff recommend the Commission increase rates as of January 1, 2025, for Calendar Year 2025 by 1.6 percent, on an all-payer basis, and that hospitals hold the revenues collected under this provision until directed to specific purposes by the Commission to prepare for successful performance under the new Advancing All-Payer Equity Approaches and Development Model (AHEAD). Twenty percent of the funds held will be directed to the Population Health Trust the State agreed to establish under the AHEAD agreement and the remaining eighty percent will be used for new efforts related to AHEAD implementation as described in this recommendation.

The Commission will provide specific directions for the use of funds contingent on the establishment of necessary funding vehicles by the Maryland General Assembly. Additionally, an increase in the Maryland State Deficit Assessment will be necessary to offset the budgetary impact to Medicaid. The rate increase is only for calendar year 2025 and will sunset at the end of the year if the Commission takes no further action. Staff

believe there is sufficient room under the Total Cost of Care Model (TCOC Model) savings target to fund these efforts.

Background

AHEAD

The States Advancing All-Payer Health Equity Approaches and Development Model (AHEAD) is an 11-year multi-state total cost of care (TCOC) model administered by the Centers for Medicare and Medicaid Services (CMS). The Model seeks to drive state and regional healthcare transformation and multi-payer alignment to curb healthcare cost growth, improve population health, and advance health equity by reducing disparities in health outcomes across all payers including Medicare, Medicaid, and private coverage.

Maryland will begin its AHEAD implementation period on January 1, 2026. To ensure successful implementation, significant investment is necessary to accelerate healthcare transformation, bolster access to necessary services, and develop and launch an equity-centered population health strategy.

Population Health Trust

Under the AHEAD agreement the State committed to establishing a Population Health Trust comprised of public and private sources to support statewide population health improvement initiatives in alignment with the Statewide Health Equity Plan (HEP) and State Health Improvement Plan (SHIP). The Statewide HEP will be developed by the State and Maryland Commission on Health Equity (MCHE) and will serve as the foundation for all actions and investments under AHEAD. The plan is set to be finalized by July 2025 and will include quality and equity measures, along with performance targets for the State under the Model. It will address key areas such as chronic disease, behavioral health, healthcare access and utilization, population health, and the promotion of prevention and wellness. Maryland's SHIP has already established priorities, strategies, and targets aimed at improving health, based on needs identified in the State Health Assessment (SHA), which provides a comprehensive overview of the state's current health status.

Availability of Funds - Model Savings Position

For Calendar Year 2023 (CY23), CMS certified Maryland saving under the TCOC Model of $509 Million versus a target of $300 Million. During the Update Factor, Staff estimated savings remaining approximately flat into 2024. However, through July 2024[1] (YTD CY24) Maryland's savings have increased to approximately $600 million. This increase results from per beneficiary total cost of care growth of 4.3% in Maryland versus 6.3% nationally. This variance is driven primarily by accelerations in national hospital spending and a slowing in Maryland non-hospital spending in comparison to the nation. Specifically:

- An increase in the national hospital per beneficiary growth to 6.7% in YTD CY24 compared to 3.7% for the same period in CY23 and average annual growth from 2013 to 2023 of 2.5%
- A reduction in Maryland non-hospital per beneficiary growth to 4.3% in YTD CY24 compared to 5.3% for the same period in CY23. For the same time period, national non-hospital growth has gone up from 5.1% to 5.9%.

The $100 M extra savings accumulated year-to-date is split approximately 50:50 between hospital and non-hospital drivers. As long as national trends remain high and Maryland non-hospital trends remain low, Staff expect the positive savings to continue into 2025 accumulating to as much as $650 or $700 million.

While Staff believe Maryland will end Calendar Year 2025 well above the TCOC Model target of $372 million and, therefore, some actions to utilize savings above target are appropriate, Staff also note that there are several contextual factors to consider, and these informed the recommendation of a 1.6% increase.

- The $509 million savings in 2023 will become the baseline for AHEAD starting in 2026 and should savings go below that level in the intervening years, they will have to be recovered to achieve 2026 targets.

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[1] All CY24 amounts include 2 months run out and completion. All prior periods include 3 months run out. This approach is consistent with ongoing TCOC reporting methods.

- Savings are driven by high national hospital spending and low Marland non-hospital spending. Both factors lie largely beyond the control of the Commission.
- As noted in the bullet above, YTD CY24 national hospital growth is very high compared to historical averages, and data reflects only 7 months of experience
- YTD CY24 Maryland hospital growth of 4.3% is in line with projections made during the Update Factor and reflects both significant catch-up inflation adjustments made during that process and significant demographic catch-up adjustments made during the prior Update Factor.
- CY23 savings of $509 million represented a considerable acceleration from 2022 levels of $269 million, but when compared to pre-pandemic 2019 savings of $364 million are generally in line with the rate of savings accumulation ($60 M per year 2014 to 2019 versus $51 M per year 2014 to 2023). Therefore, 2023 savings levels when compared to 2022 should not be considered unusual within the longer-term view of the model but rather a correction from disruption triggered by the pandemic. Continued savings into 2025 would still be within the longer-term model trajectory.
- The performance on the TCOC Model savings test described above reflects only Medicare Fee-for-Service performance; to justify an all-payer rate increase, the Commission must assume other payers are seeing a similar benefit. Staff analysis has previously shown that TCOC Model has resulted in hospital cost growth below Gross State Product, so the correlation of Medicare performance with all-payer performance has a historical basis. However, due to data lags, Staff cannot demonstrate the same is true of the current savings over target.

New Programs to Address Health Cost and Delivery Challenges

In addition to providing funding for the Population Health Trust, Staff support investments in various health cost and delivery improvement programs to prepare for successful performance under AHEAD. Staff believe creating an access and transformation fund that leverages the capabilities of hospitals as well as other participants in the system, such as independent physician practices and not-for-profit community health organizations, is the most productive way to use savings in excess of target. Staff have identified 7 areas of potential investment:

1. An all-payer value-based program, similar to the current Medicare Care Transformation Initiatives program, to support clinical innovation and transformation to achieve better and more equitable health outcomes while maintaining affordability.
2. Common platforms and efforts for the hospital system to improve efficiency and effectiveness of care.
3. Access expansions to meet latent demand for high-value clinical services across the healthcare system.
4. Global payment arrangements with hospitals that are working to improve health and lower costs in their geographic areas.
5. Workforce investments, including but not limited to updates to the GME program.
6. Greater understanding of patient financial burdens with seed funding for new approaches to assistance.
7. Additional pay-for-performance programs with transformation or access impact.

Staff will work with stakeholders and the legislature to refine and prioritize this list before recommending final funding allocations to the Commission.

Staff Recommendation

Staff recommend the Commission increase rates as of January 1, 2025, for Calendar Year 2025 by 1.6 percent, on an all-payer basis, and that hospitals hold the revenues collected under this provision until directed to specific purposes by the Commission. Twenty percent of the funds held will be directed to the Population Health Trust, which the State agreed to establish under the AHEAD agreement, while the remaining eighty percent will be used for newly established programs as described in the prior section.

The Commission will provide specific directions for the use of funds after consultation with the Maryland State Legislature and the creation of the necessary funding vehicles.

To allow additional assessment of the State's savings position as the AHEAD model begins in 2026 and to provide time to work with stakeholders to clarify the use of funds, Staff recommend sunsetting this rate increase on December 31, 2025, unless the Commission acts to extend it.

To avoid increasing the cost to Medicaid under this proposal, Staff recommend an increase to the deficit assessment paid to Medicaid to offset the cost of this rate increase to the Maryland Medicaid program. Hospitals would pay this assessment out of a portion of the funds they are holding under this rate increase; this will avert any added costs to Medicaid without impacting hospitals or further increasing the cost of the rate increase to non-Medicaid payers.

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Revenue & Regulation Compliance

Claudine Williams
Director
Healthcare Data Management & Integrity

TO:	HSCRC Commissioners
FROM:	HSCRC Staff
DATE:	November 13, 2024
RE:	Hearing and Meeting Schedule

December 11, 2024	In person at HSCRC office and Zoom webinar
January 8, 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.