maryland
health services
cost review commission

623rd Meeting of the Health Services Cost Review Commission

September 11, 2024

(The Commission will begin in public session at 11:30 am for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00pm)

CLOSED SESSION
11:30 am

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 July 10, 2024

Informational Subjects

2. Presentation from Green and Healthy Homes Initiative

Specific Matters

3. Docket Status – Cases Closed

   2646N UM Shore Medical Center at Easton
   2652A Johns Hopkins Health System
   2653A Johns Hopkins Health System
   2654A Johns Hopkins Health System
   2618A Johns Hopkins Health System - Request for Extension

4. Docket Status – Cases Open

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

Subjects of General Applicability

5. HCAHPS Presentation
6. Report from the Executive Director
   a. AHEAD Model Update

b. Update on Advancing Innovation in Maryland Contest
c. Model Monitoring
d. Emergency Department Initiatives Update
e. Hospital Reimbursement Project Update
f. Set Aside Update
g. Fall Preview

7. Update on Accounting and Budget Manual
8. Hearing and Meeting Schedule

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MINUTES OF THE
622nd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
July 10, 2024

Chairman Joshua Sharfstein called the public meeting to order at 12:08 p.m. In addition to Chairman Sharfstein, in attendance were Commissioners James Elliott, M.D., Ricardo Johnson, Maulik Joshi, Adam Kane, Nicki McCann, J.D., and Farzaneh Sabi, M.D. Upon motion made by Commissioner Johnson and seconded by Commissioner Elliott, the Commissioners voted unanimously to go into Closed Session. The Public Meeting reconvened at 1:10 p.m.

Dr. Farzaneh (Fazi) Sabi, M.D

Chairman Sharfstein congratulated Dr. Farzaneh Sabi on her appointment to the Commission as a new Commissioner. Dr. Sabi expressed her gratitude for the appointment. She is a board-certified OB-GYN, and an associate Medical Director at the Mid-Atlantic Permanente Medical Group.

Dr. James Elliott, M.D

Chairman Sharfstein announced that Dr. James Elliott will serve as the new Vice Chairman. He has been on the Commission since 2018 and is a board-certified Pathologist at Doctors Community Hospital.

STAFF UPDATE

Dr. Jon Kromm, Executive Director, announced the retirement of Mr. Dennis Phelps, Deputy Director, Audit and Integrity after 47 years of dedicated service to the Commission and to the people of Maryland. Mr. Jerry Schmith and Mr. Stan Lustman paid tribute to Mr. Phelps for his innumerable contributions over the years.

Chairman Sharfstein along with Dr. Kromm presented a crystal plaque to Mr. Phelps in recognition of his years of devoted service. Mr. Phelps acknowledged the recognition and expressed his gratitude and appreciation for the Staff and the Commission.

Dr. Kromm also announced the impending retirement of Chris O'Brien on July 30, 2024.

REPORT OF JULY 10, 2024, CLOSED SESSION

Mr. William Hoff, Chief of Audit and Integrity, summarized the items discussed at the July 10, 2024, Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE JUNE 14, 2024, PUBLIC MEETING AND CLOSED SESSION

Upon Motion made by Vice Chairman Elliott and seconded by Commissioner Kane, the Commission voted unanimously to approve the minutes of the June 14, 2024, Public Meeting and Closed Session and to unseal the Closed Session minutes.

ITEM II
ARPA-H PROPOSAL PRESENTATION

Ms. Martha Jurczak, Director of Business Development at the University of Maryland School of Medicine introduced the two presenters. Dr. Amenda Rosencrans is an Assistant Professor of Medicine at Johns Hopkins University and Clinical Chief of Health Care, and Dr. Daniel Gingold, Professor of Emergency Medicine at the University of Maryland School of Medicine, Medical Director of the Baltimore City Mobile Integrated Healthcare Community Paramedics Program, and Deputy Medical Director for Population Health at the Baltimore City Fire Department.

Dr. Rosencrans presented an overview of the Advance Research Project Agency for Health (ARPA-H). This coalition is developing a strategic plan to reduce opioid overdose in Baltimore City and hopes to submit this plan to ARPA-H for funding opportunities. ARPA-H is committed to advancing health outcomes for all, supporting innovative solutions to a broad range of health challenges such as opioid overdose, and paving the way for life-saving treatments. Through these funding opportunities, health accelerators develop collaborative groups who develop a specific intervention plan. They work to raise funding upfront to support the plan and develop contractual relationships with outcome buyers who can invest in the sustainability of that plan. The funding is to support the EMS calls for opioid overdose in the jurisdiction in which they are working. ARPA-H will invest if metrics are achieved over 3 years up to $15M in the plan with the goal of a 2 to one match from outcome buyers to support the program.

Dr. Gingold stated that the collaborative is also interested in increasing the ability to impact opioid use disorder at the time of a specific crisis, especially when patients call 911.

Vice Chairman Elliott asked if there were other programs that focus on opioid overdose or similar issues.

Dr. Rosencrans stated that the program is building on what is already in place. The program is starting a citywide and systemic effort to invest in the model infrastructure to support it over time.

Commissioner Johnson asked Dr. Rosencrans to talk a little more about her work and who were the other outcome buyers.

Dr. Rosencrans stated that they have had conversations with payers that administer both government programs, private insurance products, trade organizations, and pharma companies.

Chairman Sharfstein asked Dr. Kromm if the Commission staff would be open to exploring a potential role and providing an assessment and potentially some options.

ITEM III
OPEN CASES
2646N-UM SHORE MEDICAL CENTER AT EASTON

Dr. Jon Kromm, Executive Director, presented and updated the UM Shore Medical Center at Easton Capital Funding Request (see "Staff Recommendation Shore Regional Health System, Inc. Medical Center at Easton" available on the HSCRC website).

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

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

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

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

Based on the analysis above, staff recommend the following:

1. All exclusions and multipliers that are approved as part of the total capital project through the CON process should be passed through the capital policy without qualification, and staff should assess the applicability of statewide average depreciation and interest statistics to specific requests and propose alternative calculations if appropriate.

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

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

Commissioner Joshi asked Dr. Kromm when the key performance indicators will be defined.

Dr. Kromm responded that the general framework can be done within a few months; however, the key performance indicators will start in 2030.

Chairman Sharfstein noted that during the last meeting, there was a discussion about a community planning process that would help define the investment and the key performance indicators.

Dr. Kromm responded it was part of the recommendation, and that the Hospital has a community planning process in place. The Commission will work with the Hospital to adjust and make sure that it is specifically defined in the plan.

Mr. Kenneth Kozel, President and Chief Executive Officer of University of Maryland Shore Regional Health, clarified that the opening date of the project is summer of 2028 not July 1, 2029.

Commissioner Kane noted that the hospital physical plan needs a replacement, and that the Commission should address the following:

- Capital policy and its related issues.
- What is the expected contribution of hospitals and the systems to replacement of capital projects.

- Combined with its integrated efficiency in the buyout, how does that compete with the desire for hospitals to invest in non-hospitals services.
- What is the rate capacity that is needed to service the new principal and interest payment.
- The Commission must consider how to finance future projects and what the obligations of the hospitals are going to be, in addition to having to manage through presumably much higher capital costs in the future.

Chairman Sharfstein stated he appreciated the new facility in the context of improving healthcare and ultimately reducing costs for the 5 counties that are involved. It is also a challenge for both UMMS and Staff to be able to see that kind of commitment all the way through. He requested a briefing sometime before January 1, 2029, as to how the project is progressing, the community planning, and how it fits into the overall strategy to control cost.

Commissioner Johnson concurred with Commissioner Kane. He noted that the capital load on this project being 3 times other projects in the State is concerning, given that the cost for consumers will be increased. Additionally, he noted a few concerns that he has had that have been discussed; however, as the Commission reviews the capital policy, hopefully, it will tackle some of his concerns. From a governance perspective, he feels the Commission gives too much deference to Maryland Health Care Commission (MHCC) and noted that we should be in collaboration with but not always deferring to their assessment.

Dr. Kromm acknowledged and concurred with Commissioner Johnson's comments. He noted that as Staff develops new policy, there will be a thorough understanding of what is the obligation of the hospital as well as what is passed through to rates. As we move forward and these cost increases, Staff will have to balance what is within the Capital Policy. Staff will also have to work with and coordinate with MHCC to make decisions. These discussions will be part of the capital policy.

Vice Chairman Elliott asked what is the company cost multiplier premium to minority business enterprise? What does that mean, how much is it, and is it a minority business enterprise premium?

Dr. Kromm acknowledged in the CON approval, that there was a cost amount multiplier identified for minority business involvement in this project. He asked Mr. Kozel to elaborate. Mr. Kozel could not recall the amount or the percentage. Commissioner Ellott recalled it was $9M -$9.5M attributed. He wanted to know the purpose of this amount.

Commissioner Johnson stated he assumed it would be harder to find minority businesses. However, the cost multiplier will still be met for having minority businesses, and there would be potentially a higher cost, because they are farther away.

Mr. Kozel concurred with Commissioner Johnson and stated what they traditionally have seen on the shore with other projects. Specifically, that it is more difficult to find minority owned business, and costs are more expensive to attract minority owned business. However, their intent is to still achieve that percentage target.

Commissioner Joshi made a motion to approve the staff recommendation, and it was seconded by Vice Chairman Elliott. The motion passed unanimously in favor of the Staff's recommendation.

Chairman Sharfstein acknowledged the presence of Senator Stephen S. Hershey, Jr., representing District 36 and Senator Johnny Mautz, representing District 37, thanking them for their interest and their presence.

Senator Hershey thanked Mr. Kozel for being so instrumental in helping the community with rural healthcare delivery on the Eastern Shore. He also wanted to thank the Commission, MHCC, the people in Annapolis and the Governor especially who contributed a hundred million dollars to this project. Senator Mautz also expressed his thanks and appreciation.

2618A-JHHS-REQUEST FOR EXTENSION

Chairman Sharfstein and Commissioner McCann recused themselves from this agenda item and left the room during the discussion and vote.

Vice Chairman Elliott acknowledged Mr. Konsowski and stated that Ms. Trisha Frick and Mr. Ed Beranek were online and available for comments.

Mr. Chris Konsowski, Chief, Hospital Rate Regulation, presented the Staff's final recommendation on JHHS' request for extension (see Staff recommendation "JHHS-Request for Extension" available on the HSCRC website).

Background

On February 9, 2024, in accordance with the authority granted by the Commission, staff approved a 3-month extension of the Commission's approval of the alternative rate arrangement between the Johns Hopkins Health System (JHHS) and Cigna Health Corporation (Cigna), Proceeding 2618A. The extension expires on June 30, 2024. However, JHHS and Cigna have not completed negotiations to extend the arrangement.

Request

JHHS requests that the Commission extend its approval for an additional two months, to August 31, 2024, to complete negotiations.

Findings
Staff found that the experience under the current arrangement has been favorable.

Staff Recommendation
Staff recommends that the Commission grant JHHS' request for a two-month extension of its approval, with the condition that if the negotiations are not completed before the expiration of this extension, that the arrangement end, and that no further services be provided under the arrangement until a new application is approved.

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

ITEM IV
REPORT FROM THE EXECUTIVE DIRECTOR

Dr. Kromm informed the Commission that CMMI has approved Maryland's entry into the Ahead program which means the following:

1. Maryland has access to funding for implementation work.
2. Negotiation will start on the new parameters of the Ahead model.

He will update the Commission on the negotiation.

EMERGENCY DEPARTMENT INITIATIVES UPDATE

Dr. Alyson Schuster, Deputy Director, Quality Methodologies, Ms. Tina Simmons, Associate Director for Quality Methodologies, and Ms. Damaria Smith, Fellow, Quality Initiatives, presented and updated the Emergency Department Initiatives. (see "Emergency Department Initiatives Updates" available on the HSCRC website).

EMERGENCY DEPARTMENT (ED) WAIT TIME REDUCTION COMMISSION

Ms. Simmons updated the Commissioners on the establishment of Maryland ED Wait Time Reduction Commission. The Bill to establish this commission went into effect July 1, 2024, and terminates June 30, 2027.

Purpose: To address factors throughout the health care system that contribute to increased ED wait times

Specific Focus:
Develop strategies and initiatives to recommend to state and local agencies, hospitals and health care providers reducing emergency department wait times, including initiatives that:

- Ensure that patients are seen in the most appropriate setting to reduce unnecessary use of ED.
- Improve Hospital efficiency by increasing ED and Inpatient throughput.
- Improve post discharge resources to facilitate timely ED and inpatient discharges.
- Identify and recommend improvement for the collection and submission of data that is necessary to monitor and reduce ED wait times.
- Facilitate the sharing of best practices for reducing ED wait time.

Annual Legislative Reports will be due on 11/01/2025 and 11/01/2026.

Staff believe the new commission will focus on looking at statewide interventions as well as hospital interventions. The statewide interventions will be driven by collaboration on behavioral health, post-acute, access to primary care, as well as on-going analysis of capacity concerns across the system. The hospital specific focus is being looked at as pre and post hospital opportunities that are within the hospital span of control. For example, hospital efficiency impacts throughput and capacity as well as integration of population healthcare and primary care integration. So, while the ED Commission will direct state level intervention and may advise on hospital level interventions, the HSCRC will still approve all hospital performance and payment policy.

Commissioner McCann asked what the difference between an advanced primary care practice and a primary care practice is?

Ms. Simmons stated that there is an advanced primary care practice model that integrates the care coordination and the care transition components, which has all the components of the Maryland primary care model.

Chairman Sharfstein noted that the legislation gives the authority to the Commission to request data from many different entities. He stated that this is an enormous opportunity to use this authority across the spectrum of things – i.e., to better understand what is happening on the primary care side and the long -term care side that takes care of patients

Ms. Simmons noted that data sharing and transparency are going to be critical to driving these initiatives.

EDDIE UPDATE

Ms. Damaria Smith, Fellow, Quality Initiatives, updated the Commission on the June data 2024 report which included the 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

- This data should be considered preliminary given timeliness of the data (i.e., the hospitals must turn in the data by the first Friday of the new month)
- This data is 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

She indicated that the data should be considered preliminary given the timeliness of the data (i.e., the hospitals must turn in the data by the first Friday of the new month), and the data has not been audited by the HSCRC; however, the data can be used for trending purposes within the hospital. EMS turnaround time data shows minimal net movement of hospitals across categories for June 2024, with four hospitals improving in performance and five hospitals declining in performance

Ms. Simmons noted after a review of the EDDIE data that 7 hospitals were identified that had consistently high ED length of stay. These hospitals received requests for an improvement plan for internal process to improve the ED length of stay and throughput initiatives. These plans were received from the 7 hospitals. The next step is to include collaborative review of the data and performance improvement plans with these hospitals, as well as collaboration with all hospitals as the ED Best Practices Advisory Subgroup is established.

Commissioner Sabi stated that part of the focus on the ED wait time should also include the unintended consequences, diversions, the admission rate in the ED, and the number of patients who leave the ED without being seen and then return at another time.

UPDATE: QBR ED-1 INCENTIVE DEVELOPMENT SUBGROUP UPDATE

Dr. Schuster updated the Commissioners on the QBR ED LOS Development. (see "QBR ED-1 Incentive development subgroup Update" available on the HSCRC website).

HSCRC staff recommend a statewide goal of 30% for ED LOS for admitted patients. For hospital payment policy, however, there needs to be a clear statewide improvement target to improvement range.

Attainment & Risk-Adjustment

- Staff concur that risk-adjustment for factors outside of hospitals' control would be appropriate for attainment.
    - Staff propose adding attainment in future years as better data becomes available.
- Staff believe for improvement, risk-adjustment would only be needed if there was significant change from 2023 to performance year, and that risk-adjustment for factors highly correlated with ED LOS may reduce improvements. The impact is currently being evaluated.
    - Stakeholders remain concerned that for improvement, risk adjustment is important.
- Stakeholder suggestions for factors to risk-adjust include:
    - Average case-mix of hospitals
    - Percent discharged to SNFs
    - Occupancy
    - Hospital Length of Stay

HSCRC Staff Priorities/Next Steps:

- Assist hospitals with Data Submission Requirements for ED LOS data elements
- Finalize QBR measure incentive development for CY 2024 (i.e., improvement target, risk-adjustment)
- Continue recruitment for ED Wait Time Reduction Commission members
- Finalize workplan and recruit members for Hospital Best Practices subgroup
- Continue with monthly EDDIE data collection and public reporting
- Review performance improvement initiatives with hospitals that have highest and lowest ED LOS

Commissioner Joshi thanked the Staff for their hard work. He noted that focusing on non-psychiatric admitted patients as a start makes a lot of sense. However, for the 1st year there should be no risk adjustment since it is already July. He stated his view on improvement and attainment, reward those who are both improving as well as attaining. Start simple, just take the top 20% of attainment, and anyone who improved 10%. The goal should be to help all hospitals.

Dr. Schuster indicated she appreciates pragmatism and wanted to recognize that it will be difficult to build a measure while we are asking hospitals to perform to a measure.

Commissioner McCann noted that she appreciated Commissioner Joshi's point around keeping the level of risk adjustment simple. Because we are halfway through the year and going through the process will create more uncertainty in the long term.

Vice Chairman Elliott commended the team for doing a terrific job. He noted that the measure that will perform worst, ED arrival time to departure time for discharged patient (OP18B), is excluded as a measure. He asked that the staff reconsider the inclusion of OP18B. Additionally,

he stated that if there were a 30% improvement as target measure, Maryland will still be performing worse than the nation.

Commissioner McCann also agreed with Commissioner Sabi on the importance of focusing on the ED wait time and the unintended consequences. She asked that one of the priorities next steps include Staff developing a measure to make sure that these policies that are not seeing improvement at the cost of patient access, patient care, increased diversion and less availability be modified.

Chairman Sharfstein asked if we have information on patients leaving against medical advice (AMA) or leaving without being seen?

Dr. Schuster noted that a discharged disposition on the case mix data indicates where the patients were discharged and one of the options were leaving AMA. The CMS data is done at the state and hospital level. This data has a 9-month delay.

ITEM V
HOSPITAL COMMUNITY BENEFIT REPORTING
PROPOSED CHANGES TO REGULATIONS

Ms. Megan Renfrew, Deputy Director, Policy and Consumer Protection, presented Hospital Community Benefit Reporting Proposed Changes to Regulation. (see "Hospital Community Benefit Reporting Proposed Changes to Regulation" available on the HSCRC website).

Ms. Renfrew proposed edits to COMAR 10.37.01.03 (edits identified in italics).
(1) Beginning on December 15, 2009, each nonprofit hospital shall submit the Annual Nonprofit Hospital Community Benefit Report to the Commission by **[**December 15 of every calendar year**]** *the date prescribed by the Commission* in the format prescribed by the Commission.

(2) Hospitals shall complete the report based on actual data covering the reporting period of the previous July 1 through June 30 *or other time as specified by the Commission*.

(3) The Commission shall provide instructions for completing the report **[**in its "Accounting and Budget Manual for Fiscal and Operating Management"**]** *on its public website*.

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 VI
DEVELOPMENT PLAN: REVENUE FOR REFORM-FY2026

Ms. Erin Schurmann, Chief, Provider Alignment & Special Projects, provided an update on the Revenue for Reform FY 2026 Policy Development Plan (see "Revenue for Reform" available on the HSCRC website).

Background

Revenue for Reform is a component of the Integrated Efficiency policy, which Commissioners approved in July 2023.

The primary goals of the Revenue for Reform policy are to:

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

Revenue for Reform integrates community health spending directly into hospital global budgets, thereby creating a sustainable funding stream for community and population health investments.

Guiding Principles for Revenue for Reform Updates:

- Aligns with Statewide and Regional Priorities
- Reflects Community and Patient Need
- Equity-Centered Strategy
- Efficient and High-Value Investments
- Standardized Approach to Measuring Impact
- Meaningful Collaboration with Community Partners
- Reflect Long-Term, Strategic Vision of Community Health Improvement
- Enables All-Payer Opportunities
- Drives Innovation in Care Delivery to Create High-Value Care

No Commission action was required on this agenda item.

ITEM VII
HEARING AND MEETING SCHEDULE

August 14, 2024,	The August Commission meeting has been cancelled.
September 11, 2024,	Time to be determined-4160 Patterson Ave. HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:50 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission

July 10, 2024

Chairman Sharfstein stated reasons for Commissioners to move into administrative session pursuant to 3-103, 3-104 and 3-305(b)(7) of the Authority General Provisions Articles for the purposes of discussing the administration of the Model, and a legal update on a recent Supreme Court decision.

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

The Administrative Session was called to order by motion at 12:08 p.m.

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

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

Joining by Zoom: Deb Rivkin

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

Item One

Stan Lustman, Assistant Attorney General, updated the Commission on a recent Supreme Court decision.

Item Two

William Henderson, Principal Deputy Director, updated the Commission, and the Commission discussed the TCOC Model monitoring and the on FY24 Hospital Unaudited Financial Performance

The Closed Session was adjourned at 12:43 p.m.

Whole House Model for Home Repair: Impacts on Health and Healthcare

Ruth Ann Norton, President and CEO
Green & Healthy Homes Initiative
September 11, 2024

Mission

GHHI is dedicated to addressing the social determinants of health and the advancement of racial and health equity through the creation of healthy, safe and energy efficient homes. By delivering a standard of excellence in its work, GHHI aims to eradicate the negative health impacts of unhealthy housing and unjust policies for children, seniors and families to ensure better health, economic and social outcomes in historically disinvested communities – with an emphasis on communities of color.

Accomplishments

$650 million raised and +45 pieces of legislation passed to support health and equity in housing.

Architect of the most health protective lead laws in the nation, leading to a 99% reduction in lead poisoning in Maryland. Policies have been replicated around the country.

Leading healthy housing convener at the local (over 75 partnering jurisdictions), state and national levels.

Field leader in alignment of housing with other sectors such as healthcare, energy, and education.

National leader in innovative financing models for healthy homes including designing the first Pay for Success model with Medicaid paying for outcomes.

Leading healthy homes programs contracted by Medicaid MCOs and ACOs. Supports other contracted programs by demonstration of Medicaid and Hospital Community Benefits investments.

Housing Quality and Health

Home repairs and remediation of home hazards are evidence-based interventions that improve health outcomes and address health inequities in disadvantaged communities.

GHHI has decades of experience addressing housing quality deficiencies that directly affect health:

- **Asthma Triggers**
- **Lead-Based Paint** and childhood lead poisoning
- **Fall & Injury Prevention** for older adults and children
- **Fossil Fuel Appliances** and Indoor Air Quality

Housing Quality and Health: Evidence Base

A strong evidence base demonstrates the efficacy of healthy housing interventions. Examples of key studies:

- **Asthma remediation:** Crocker, D. D., Kinyota, S., Dumitru, G. G., Ligon, C. B., Herman, E. J., Ferdinands, J. M., ... & Task Force on Community Preventive Services. (2011). Effectiveness of home-based, multi-trigger, multicomponent interventions with an environmental focus for reducing asthma morbidity: a community guide systematic review. American journal of preventive medicine, 41(2), S5-S32.

  A review of 20 home-based asthma programs found their multicomponent interventions (education, home modification, and/or supplies) to reduce asthma acute care visits by .57 visits per year. Informed national asthma guidelines.

- **Lead hazard control:** Gould, E. (2009). Childhood lead poisoning: conservative estimates of the social and economic benefits of lead hazard control. Environmental health perspectives, 117(7), 1162-1167.

  Seminal study quantifies the value of lead hazard control, including value of improved health outcomes.

- **Fall prevention modifications:** Gillespie, L. D., Robertson, M. C., Gillespie, W. J., Sherrington, C., Gates, S., Clemson, L., & Lamb, S. E. (2012). Interventions for preventing falls in older people living in the community. Cochrane database of systematic reviews, (9).

  Systematic review finds strong evidence that home modifications reduce trip hazards and risk of falling.

- **Indoor air quality and gas stoves:** Lebel, E. D., Finnegan, C. J., Ouyang, Z., & Jackson, R. B. (2022). Methane and NO x emissions from natural gas stoves, cooktops, and ovens in residential homes. Environmental science & technology, 56(4), 2529-2539.

  Study finds that just a few minutes of gas stove usage can release enough NOx to surpass the national 1-hour air quality standard.

Housing Quality and Asthma

The National Institutes of Health has established that control of environmental triggers is a vital component to guidelines-based asthma care.

- Examples of home asthma triggers include mold, dust, pest allergens, extreme heat, and extreme cold. Photos (right) from GHHI home assessments.
- Evidence shows that exposure to asthma triggers can result in exacerbations and preventable ED visits, hospitalization, and other medical events.
- Research indicates that 40% of asthma is attributable to environmental factors (Lanphear et al 2001).
- Analysis of healthcare records showed that GHHI's asthma program led to 35% reduction in Medicaid costs over 12 months.
- GHHI analysis links household fossil fuel appliance emissions (especially from gas stoves) to asthma-related ED visits, hospitalizations, and all-cause mortality.

Housing Quality and Childhood Lead Poisoning

- It is well documented that childhood lead exposure leads to cognitive and behavioral deficits
- Programs that identify and remediate home-based lead hazards ensure that children grow up health and ready to achieve their fullest potential in the classroom and in life.
- Homes built before 1978 are most at risk of containing lead-based paint.
- Every $1 investment in lead paint hazard control results in $17-$221 of economic and social benefits, including healthcare savings. (Gould 2009)

Housing Quality and Fall Prevention

- Research shows that multifactorial aging-in-place models, including those that incorporate home modifications, lead to reductions in medical utilization.
- 54% of fatal falls occur in the home (Home Safety Council).
- GHHI analysis of Tennessee Medicaid claims data shows that on average, a person's total cost of care will increase by over $40,000 in the two years after hospitalization for a fall; home modifications can help to prevent these costs and delay admission to nursing facilities.
- Independent analysis of GHHI fall prevention intervention shows that every $1 invested results in $1.80 in benefits (2019 Housing Upgrades to Benefit Seniors-HUBS report).

Example modifications: walk-in shower, anti-slip floor, grab bars, offset hinges for bathroom door

Green & Healthy Homes Initiative®

Example Projects with Healthcare

Wellpoint Health Plan
Maryland

- GHHI contracts with WellPoint Medicaid MCO to provide home-based asthma intervention.
- Includes home visiting education, home assessment, supplies.
- Program began as HUD grant; analysis by Wellpoint showed 35% reduction in total cost of care

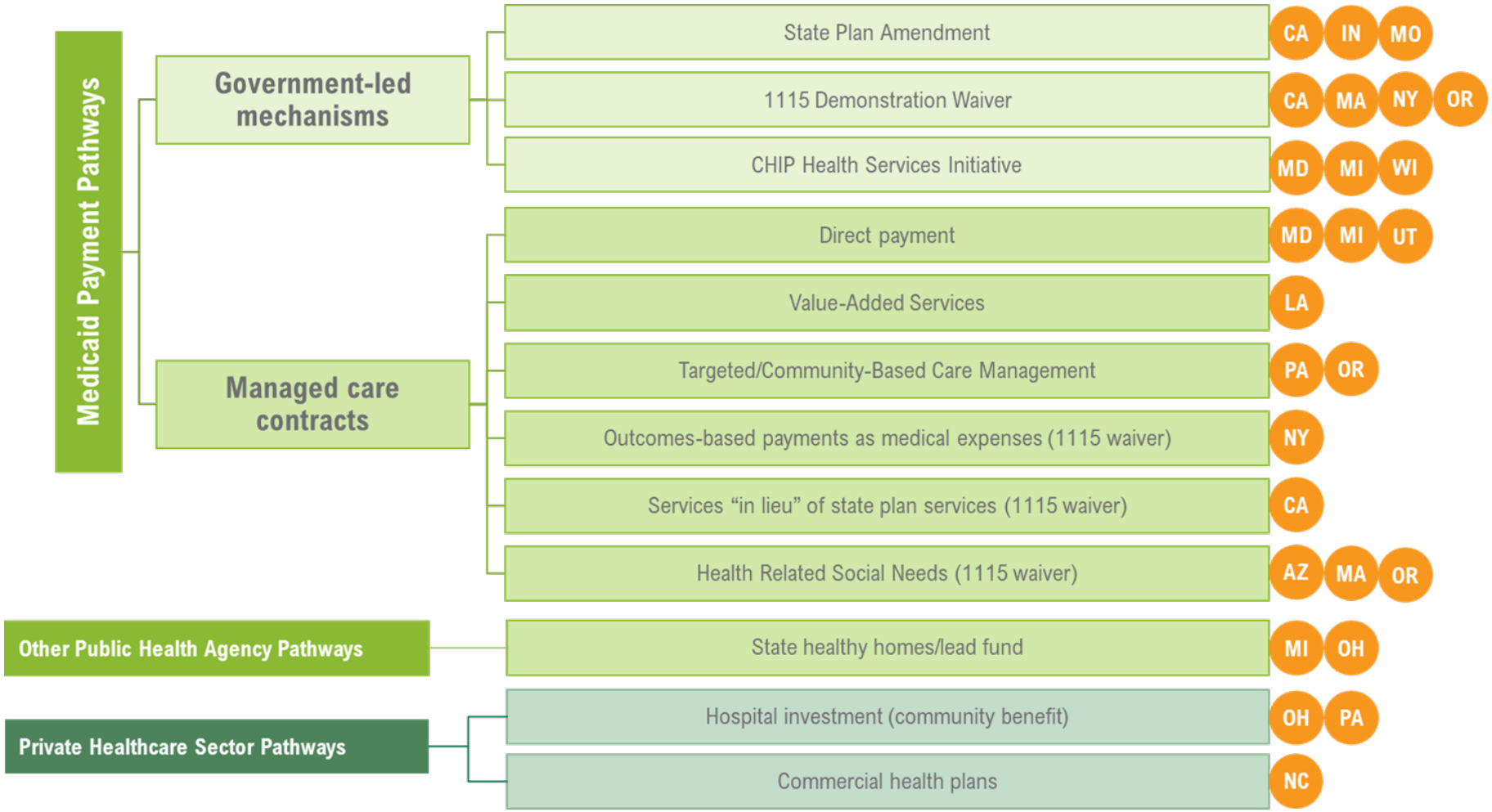
Penn Medicine Health System
Lancaster, PA

- Penn Medicine Lancaster General Health (LGH) was first hospital system in US to fully fund lead hazard control- $50M over 10 years. Estimated 2,800 homes
- GHHI manages program on behalf of LGH, braiding other program funding with LGH investment and other local programs.

Blue Cross Health Plan
North Carolina

- GHHI contracted with Blue Cross NC to build and manage state network of service providers to carry out pilot program.
- Delivered fall prevention intervention to over 460 members in 15 months.
- GHHI served as hub for intake, referrals, data sharing, and reporting.
- Outcomes evaluation in progress.

Reimbursement models



Ruth Ann Norton
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GHHInational

healthy_housing

Green & Healthy Homes Initiative®

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

September 11, 2024

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2465
BALTIMORE, MARYLAND	*	PROCEEDING:	2655A

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on June 26, 2024, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital ("the Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) and Johns Hopkins Employer Health Programs, Inc. for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to continue to participate in a global rate arrangement for Executive Health Services with Under Armour, Inc. for a period of one year beginning August 1, 2024.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full

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

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been favorable. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Executive Health Services with Under Armour for a one-year period commencing August 1, 2024. The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

September 11, 2024

IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2466
BALTIMORE, MARYLAND	*	PROCEEDING:	2656A

I. INTRODUCTION

On July 29, 2024, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System is requesting approval to continue to participate in a global price arrangement with Emerging Therapy Solutions formerly known as Life Trac (a subsidiary of Allianz Insurance Company of North America) for solid organ and bone marrow transplants and cardiovascular services, plus CAR-T services. The Hospitals request that the Commission approve the arrangement for one year beginning September 1, 2024.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

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

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been favorable. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, cardiovascular, and CAR-T services with Emerging Therapy Solutions for the period beginning September 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.

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Application for an Alternative Method of Rate Determination

Johns Hopkins Health System

September 11, 2024

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ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2024
SYSTEM	*	FOLIO:	2467
BALTIMORE, MARYLAND	*	PROCEEDING:	2657A

I. INTRODUCTION

On July 29, 2024, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System is requesting approval to continue to participate in a revised global price arrangement with Cigna Health Corporation for solid organ and bone marrow transplants and ventricular assist device (VAD) services. The Hospitals request that the Commission approve the arrangement for one year beginning September 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.

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VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services and VAD with Cigna Health Corporation services for the period beginning September 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.

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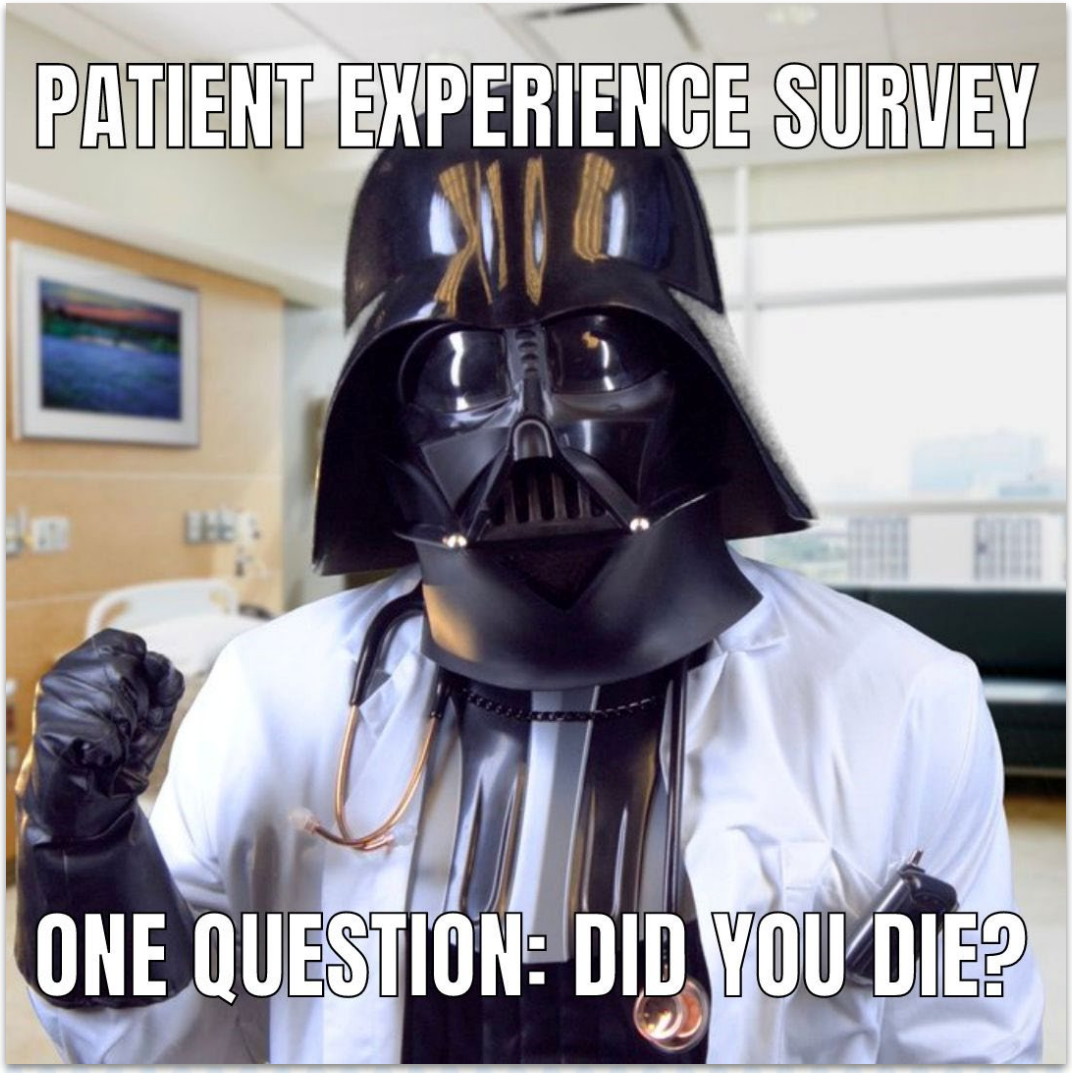
Improving Patient Experience in Maryland

Jonathan Sachs, MBA, FACHE, PCC

September 11, 2024

Perceptions of Patient Experience



Outline

1. Context: What is Patient Experience?
2. HCAHPS 101 with Upcoming Changes
3. New Ways to Understand Patient Preferences
4. Maryland Hospitals Can Improve HCAHPS Scores
5. MHA Learning Collaborative
6. Concluding Thoughts
7. Q&A

About Me - Professional

- Patient experience consultant with the HSCRC
- Chief Executive Officer for a Patient Experience Tech Startup
- Chief Experience Officer, Robert Wood Johnson University Hospital
- Vice President of Experience Transformation, Adventist HealthCare
- Executive Director of Urgent Care Operations, Adventist HealthCare
- Director of Public Policy, Adventist HealthCare
- Intern, US House Energy and Commerce Committee during the ACA
- MBA and BA, University of Maryland, College Park
- Fellow, American College of HealthCare Executives
- Certificate, Health Care Innovation, Stanford University

About Me - Personal

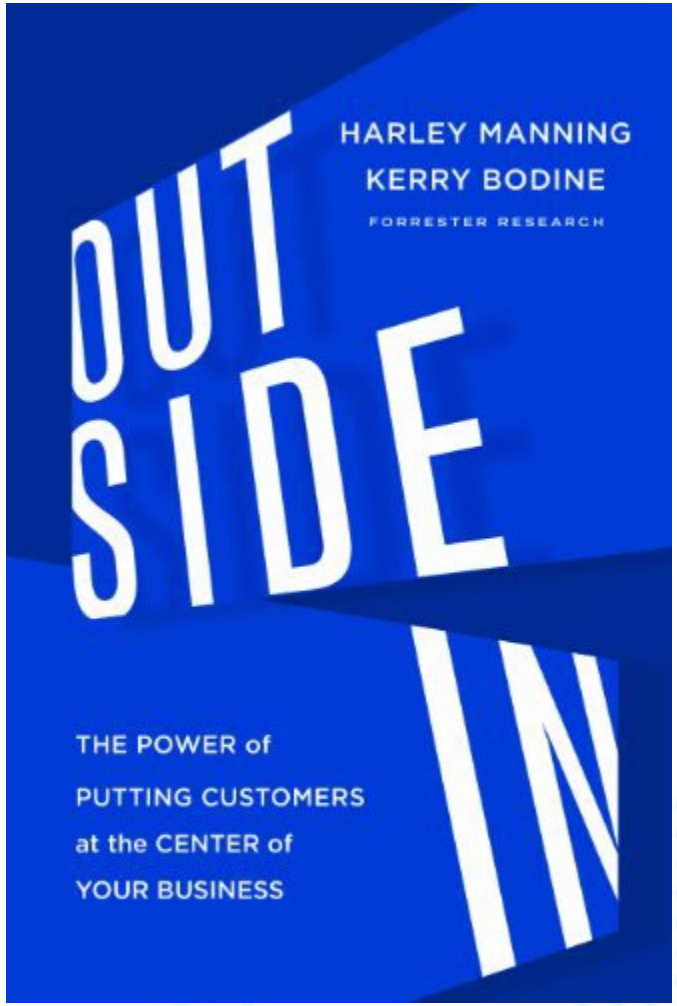
- Sister with Development Disabilities
- Son to both parents who have had invasive neurosurgery
- Family and friend to patients
- Advocate for patients
- Husband
- Father of two boys
- Proud resident of Baltimore County
- Proud to have been raised in Montgomery County

Setting the Context: What is Patient Experience

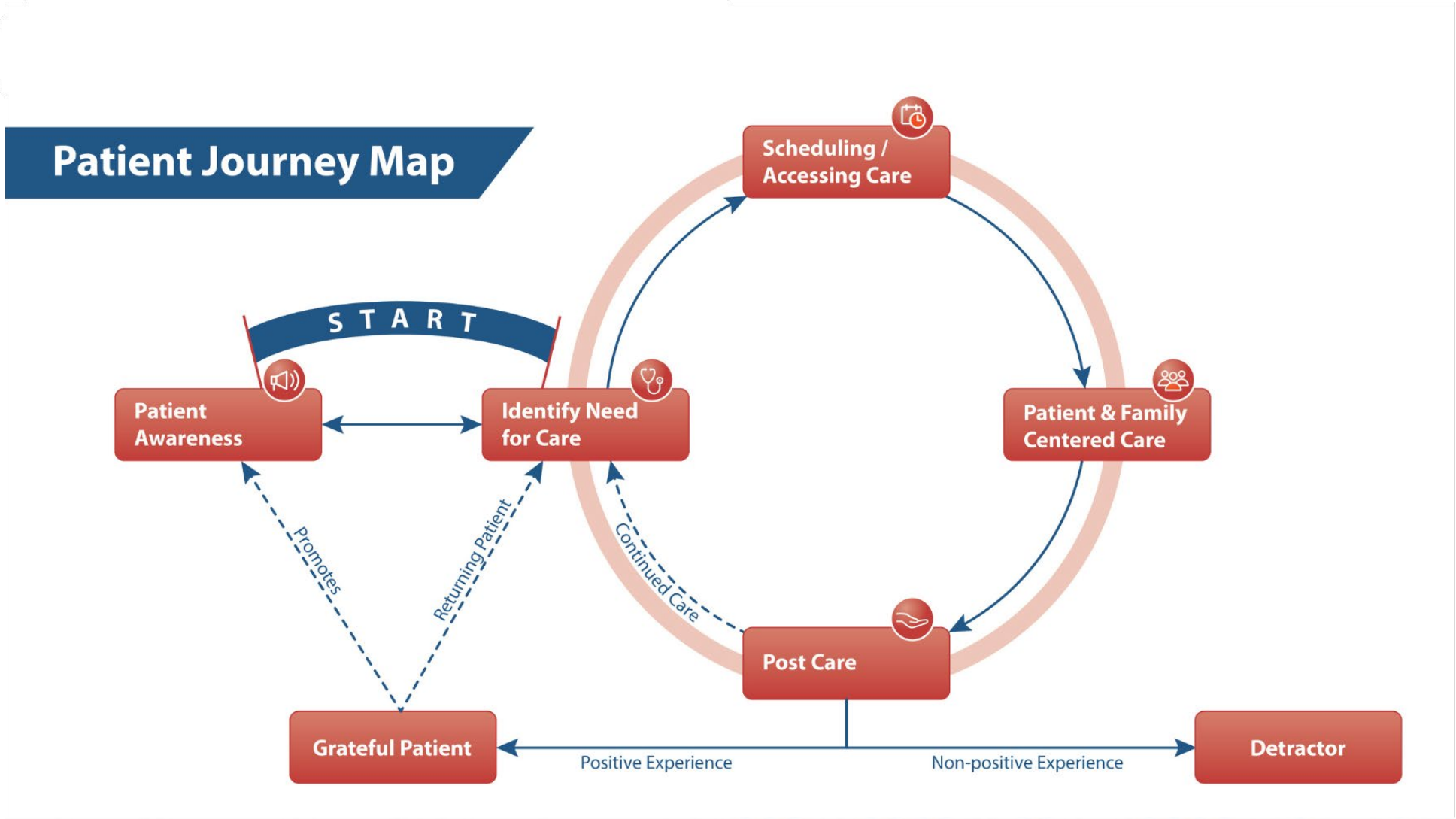
Outside In or Inside Out?

Outside In or Inside Out?

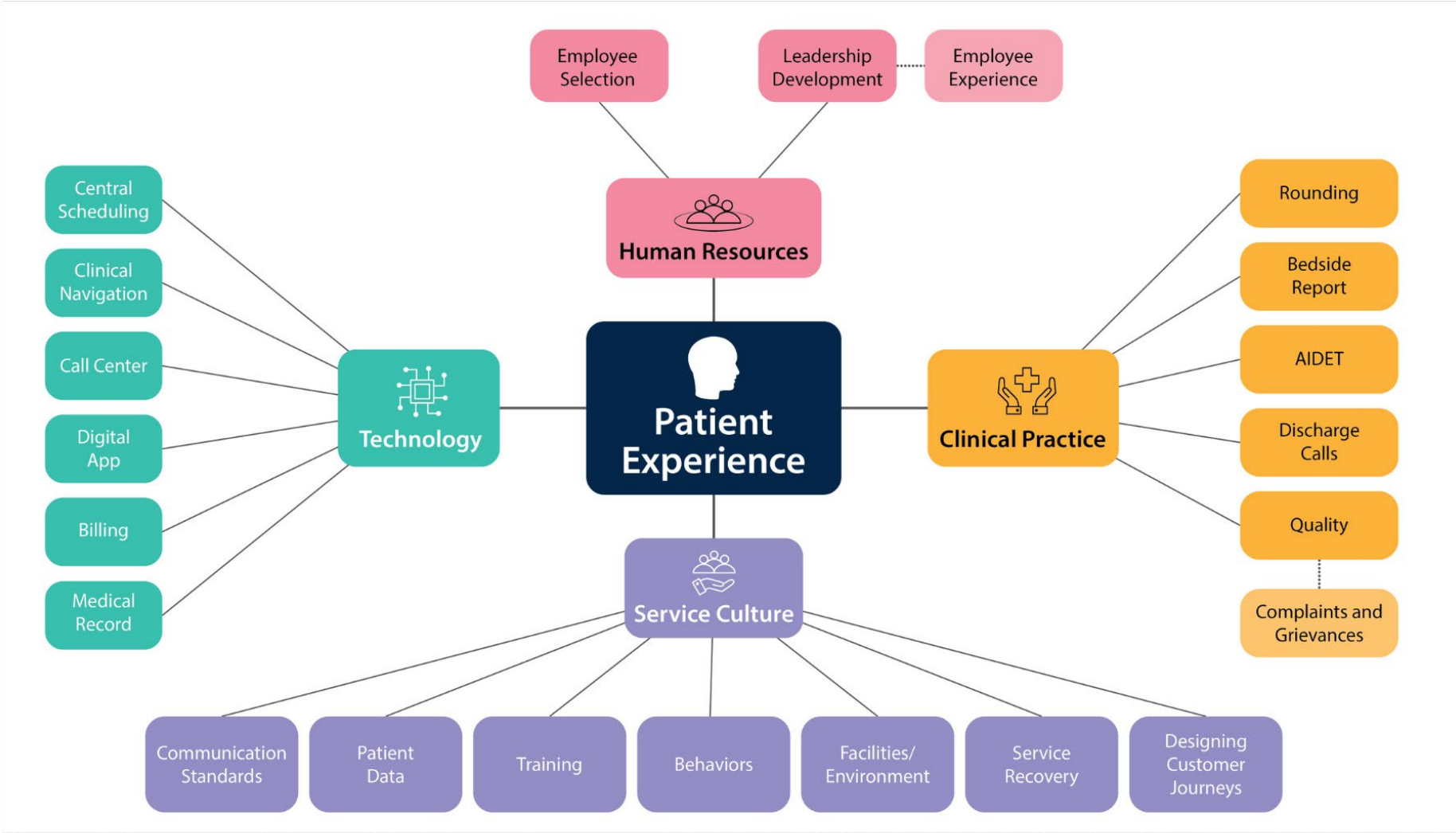
- Patient experience is how patients perceive their interactions with receiving care.
- Outside-In: Bringing the perspective of the patient to every decision we make.



Understanding the Patient Journey



What Must Come Together To Deliver A Positive Patient Exp?

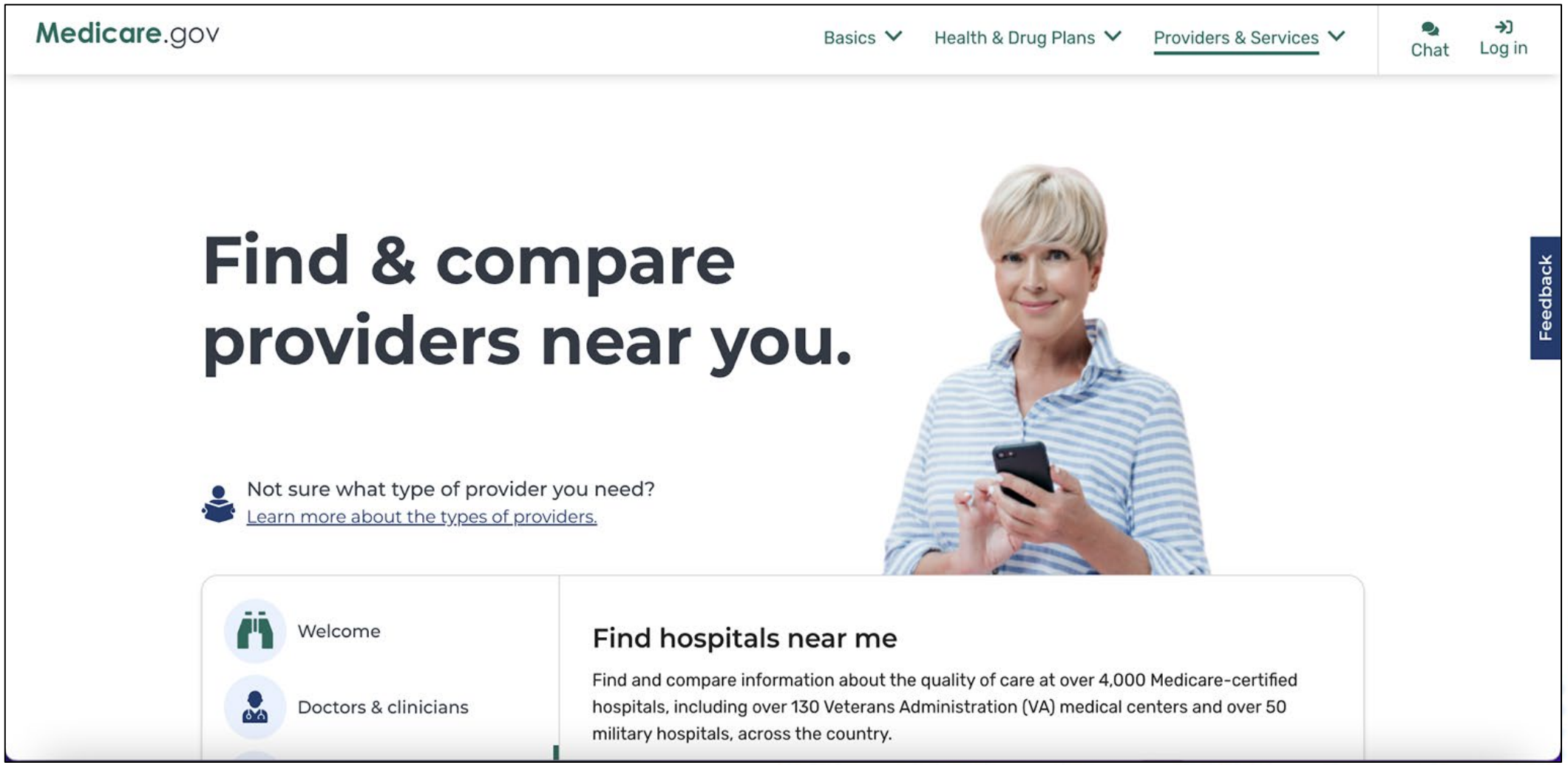


HCAHPS 101

HCAHPS Goals

1. The survey is designed to produce comparable data on patients' perspectives of care that allows objective and meaningful comparisons among hospitals on topics that are important to consumers.
2. Public reporting of the survey results is designed to create incentives for hospitals to improve their quality of care.
3. Public reporting serves to enhance public accountability in health care by increasing transparency.

How HCAHPS is Used



How HCAHPS is Used

1. **Northwest Hospital Center**

3.4 mi

ACUTE CARE HOSPITALS

5401 Old Court Road
Randallstown, MD 21133
(410) 521-2200

Overall star rating

Patient survey rating

Compare

2. **Sinai Hospital of Baltimore**

3.4 mi

ACUTE CARE HOSPITALS

2401 West Belvedere Avenue
Baltimore, MD 21215
(410) 601-5131

Overall star rating

Patient survey rating

Compare

How HCAHPS is Used

HCAHPS and Other Quality Measures

JGIM
JOURNAL OF GENERAL INTERNAL MEDICINE

Relationship Between Patient-Reported Hospital Experience and 30-Day Mortality and Readmission Rates for Acute Myocardial Infarction, Heart Failure, and Pneumonia

Ning Dong, MD, MS[1], Jonathan D. Eisenberg, MD[2], Kumar Dharmarajan, MD, MBA[3,4,5], Erica S. Spatz, MD, MHS[3,4], and Nihar R. Desai, MD, MPH[3,4]

Correlation Between Patient Experience and Outcome Measures

The HCAHPS overall satisfaction measures were inversely correlated with readmission rates for all three conditions assessed ($r = -0.22$ to -0.31, $p < 0.001$) (Table 1). The overall satisfaction measures were also inversely associated with mortality rates for AMI and PNA ($r = -0.10$ to -0.20, $p < 0.001$).

Maryland's Ranking – Overall Rating

46th

Source: hcahpsonline.org - 2023 Summary of HCAHPS Survey Results

Maryland's Ranking – Overall Rating

Top 5:

1. **IA**
2. **KS**
3. **NE**
4. **SD**
5. **MN**

Bottom 5:

49. NY
50. NJ
51. DC
52. PR
53. VI

Source: hcahpsonline.org - 2023 Summary of HCAHPS Survey Results

What HCAHPS Measures

- 22 Questions, followed by 7 demographic questions
- Typical scale:
  - Never - Usually - Sometimes - Always
- Domains:
  - Overall Rating
  - Communication with Nurses
  - Communication with Doctors
  - Responsiveness of Hospital Staff
  - Hospital Environment
  - Communication about Medicines
  - Communication about Pain***
  - Discharge Information
  - Care Transitions

**Omitted from QBR/VBP

What HCAHPS Measures

Domains	Questions
Doctor Communication	During this hospital stay, how often did doctors treat you with courtesy and respect?
	During this hospital stay, how often did doctors listen carefully to you?
	During this hospital stay, how often did doctors explain things in a way you could understand?
Responsiveness of Hospital Staff	During this hospital stay, after you pressed the call button, how often did you get help as soon as you wanted it?
	During this hospital stay, did you need help from nurses or other hospital staff in getting to the bathroom or in using a bedpan?
	How often did you get help in getting to the bathroom or in using a bedpan as soon as you wanted?

Top Box

YOUR CARE FROM NURSES

1. During this hospital stay, how often did nurses treat you with courtesy and respect?

1 ☒ Never
2 ☒ Sometimes
3 ☒ Usually
4 ☑ Always

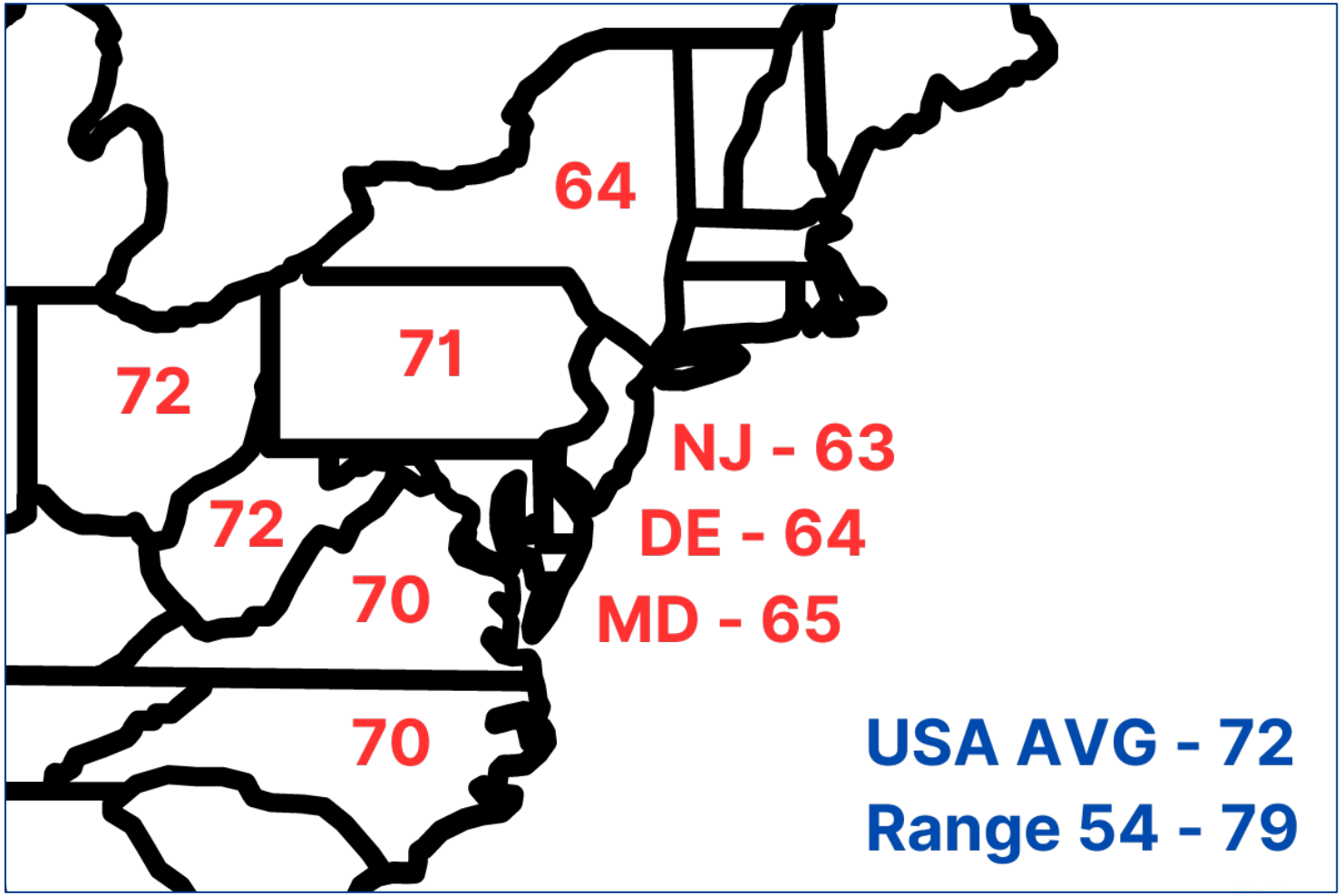
OVERALL RATING OF HOSPITAL

Please answer the following questions about your stay at the hospital named on the cover letter. Do not include any other hospital stays in your answers.

18. Using any number from 0 to 10, where 0 is the worst hospital possible and 10 is the best hospital possible, what number would you use to rate this hospital during your stay?

0 ☒ 0 Worst hospital possible
1 ☒ 1
2 ☒ 2
3 ☒ 3
4 ☒ 4
5 ☒ 5
6 ☒ 6
7 ☒ 7
8 ☒ 8
9 ☑ 9
10 ☑ 10 Best hospital possible

Maryland's Ranking – Overall Rating



Source: hcahpsonline.org - 2023 Summary of HCAHPS Survey Results

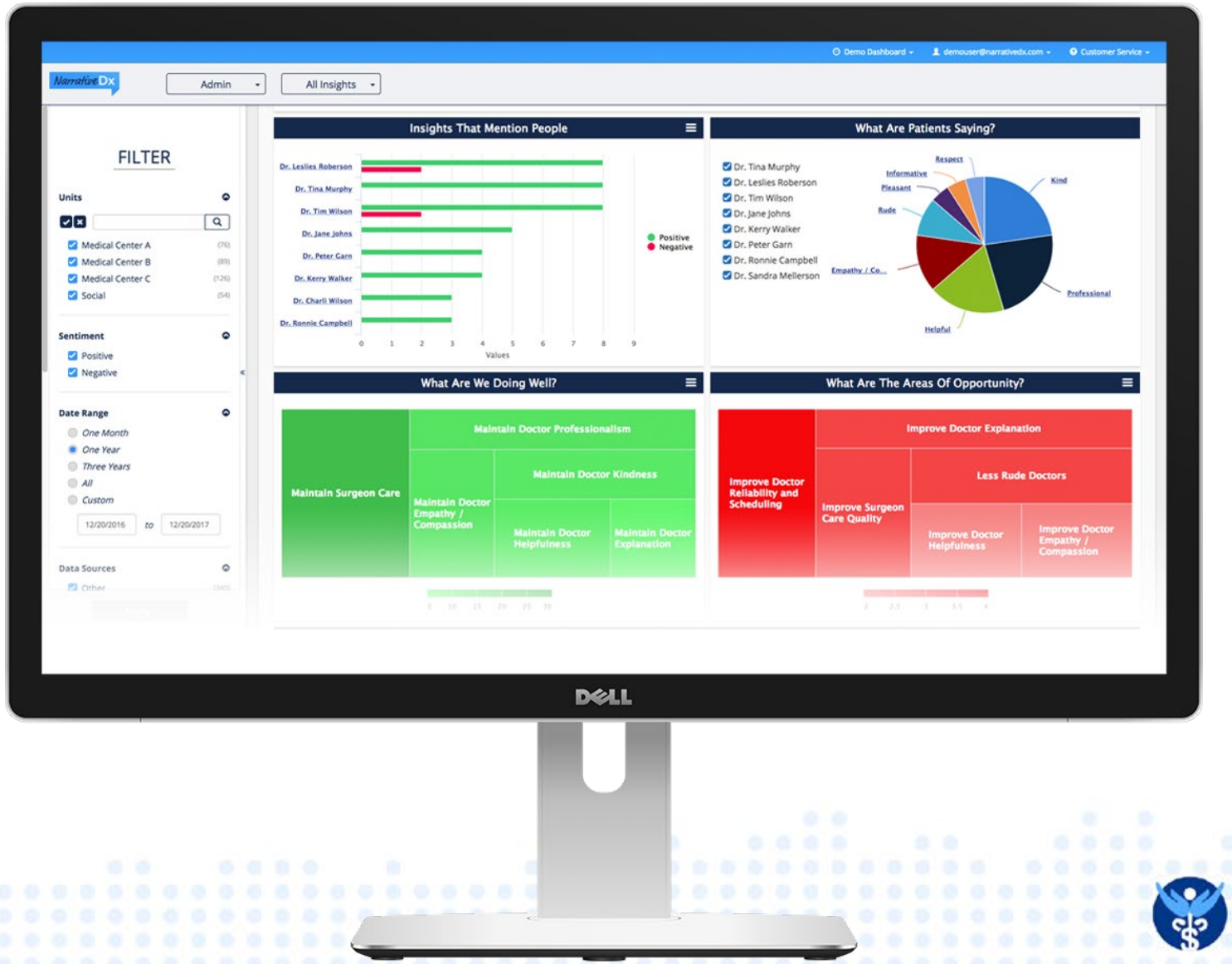
New Regulations from CMS

- "HCAHPS 2.0"
  - Coming January 1, 2025
- E-mail surveys
- Allow patient proxy
- Maximum 12 supplemental items
- Spanish language HCAHPS surveys to patients who note spanish language preference in the hospital

New Ways to Understand Patient Preferences

The Future of Patient Experience Measurement

Using AI and NLP to Understand Patient Comments

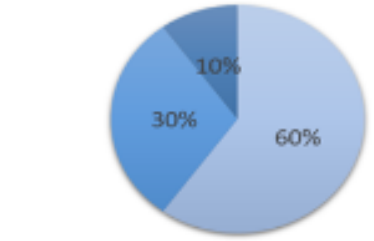


Maryland Hospitals Can Improve HCAHPS Scores

QBR Incentives for HCAHPS Performance

Performance Measures → **Standardized Measure Scores** → **Hospital QBR Score & Revenue Adjustments**

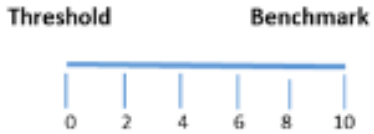
Domain and Measures:
Person and Community Engagement–
-8 HCAHPS categories;
-Timely Follow Up (TFU) Medicare and Medicaid & TFU Disparity Gap*
-ED LOS, admitted patients*
Safety— 6 Measures:
–5 CDC NHSN HAI Categories;
-AHRQ PSI 90 All-payer
Clinical Care–
--Mortality Inpatient, 30-day All-payer*



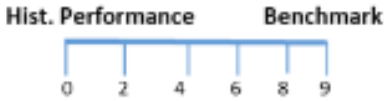
*New in RY 2026

Individual Measures are Converted to 0-10 Points:

Points for Attainment Compare Performance to a National Threshold (median) and Benchmark (average of top 10%)



Points for Improvement Compare Performance to Base (historical perf) and Benchmark



Final Points are Better of Improvement or Attainment

Hospital QBR Score is Sum of Earned Points / Possible Points with Domain Weights Applied

Scale Ranges from 0-80%

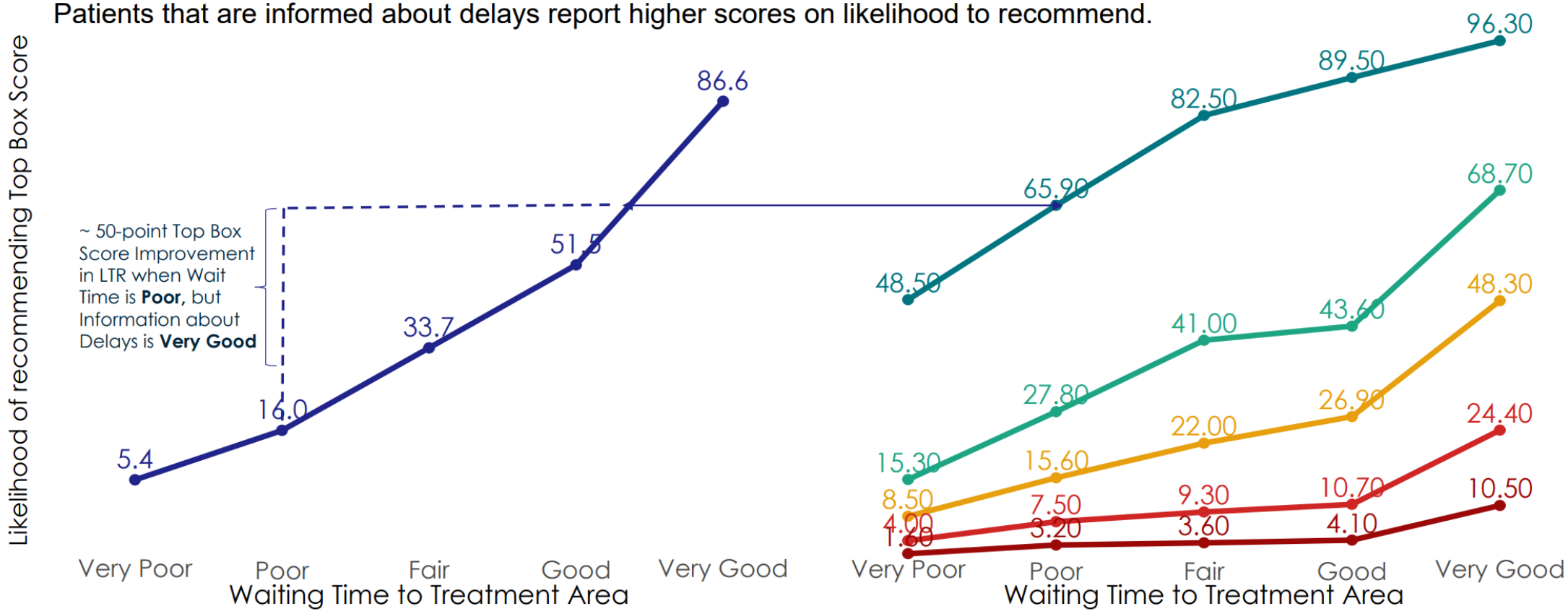
Max Penalty 2% & Reward +2%
(ALL HOSPITALS HAVE OPPORTUNITY TO EARN REWARD)

Abbreviated Pre-Set Scale	QBR Score	Financial Adjustment
Max Penalty	**0%**	**-2.00%**
	10%	-1.51%
	20%	-1.02%
	30%	-0.54%
Penalty/Reward Cutpoint	41%	0.00%
	50%	0.46%
	60%	0.97%
	70%	1.49%
Max Reward	**80%+**	**2.00%**

ED Wait Times

Impact of Perceptions of Wait Time/Informed about Delays on Emergency Department Likelihood to Recommend Scores

In 2023, Patients report higher scores related to likelihood to recommend with lower perceptions of wait times.
Patients that are informed about delays report higher scores on likelihood to recommend.

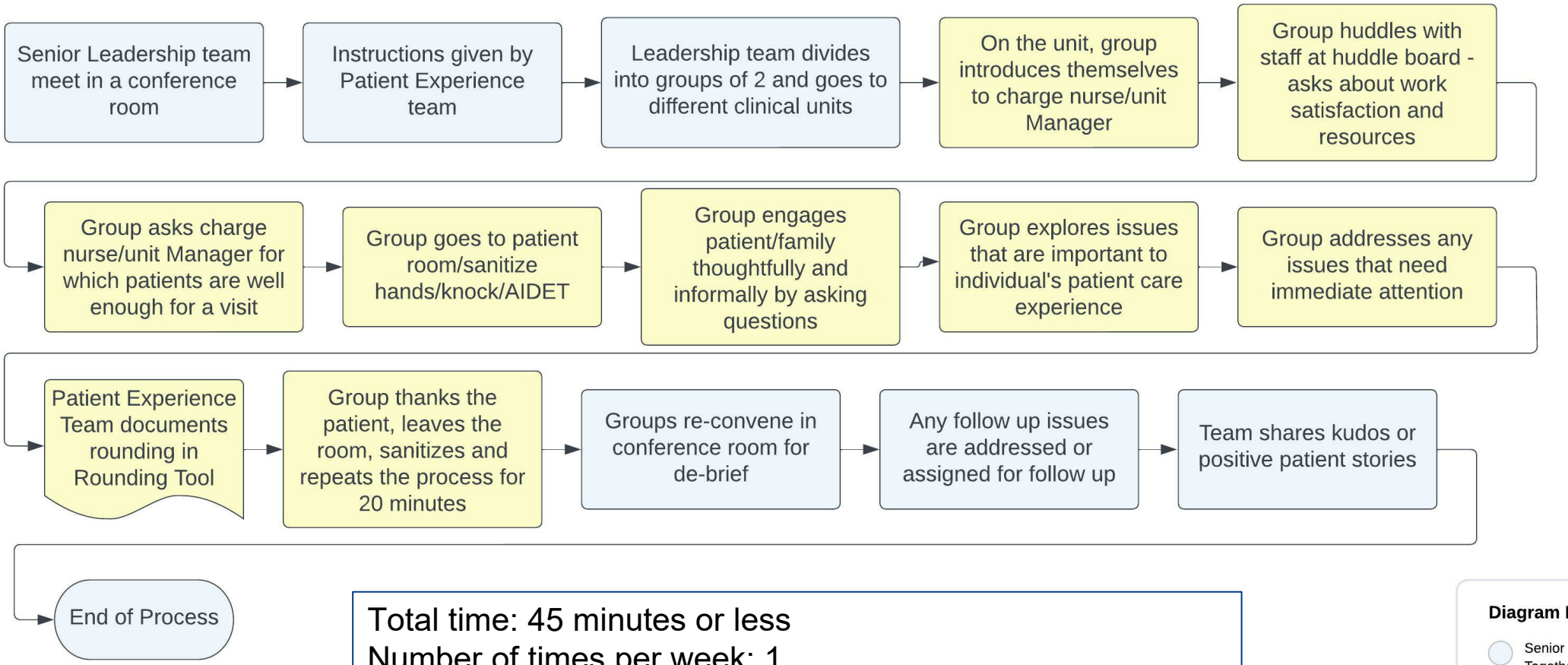


Approx 3.4M survey responses for 2023 CY "All PG Database"

Approx 1.6M survey responses for 2023 CY "All PG Database"

PressGaney

Best Practice to Improve HCAHPS Fast



Total time: 45 minutes or less
Number of times per week: 1
Total number of patient clinical inpatient units (HCAHPS):
-Adult: 34
-Peds: 5
-3 units/week = See patients in each unit about 4x per year

Best Practice to Improve HCAHPS Fast

Percentile Rank by Domain and Month

	Jan-23	Feb-23	Mar-23	Apr-23	2023 Year To Date
Overall Rating	**18**	**41**	**45**	**76**	**39**
Overall Rating n-size	*330*	*325*	*351*	*166*	*1,172*
Communication with Nurses	**25**	**61**	**36**	**63**	**42**
Communication with Nurses n-size	*335*	*332*	*365*	*167*	*1,199*
Communication with Doctors	**21**	**42**	**35**	**63**	**36**
Communication with Doctors n-size	*335*	*332*	*363*	*167*	*1,197*
Responsiveness of Hospital Staff	**23**	**54**	**51**	**47**	**43**
Responsiveness of Hospital Staff n-size	*302*	*304*	*335*	*153*	*1,094*

Data as of 5/11/2023

Learning Collaborative to Improve HCAHPS Scores

MHA Learning Collaborative

- Who:
  - Co-Lead with an MHA Representative
  - Hospital leaders responsible for HCHAPS Performance + National Survey Vendors
- What:
  - Compile and share best practices to help Maryland hospitals improve HCAHPS scores.
- How:
  - Analyze HCAHPS data
  - Sharing best practices, including from national experts
  - Quality improvement initiatives using PDSA cycles
- As a final work document, the learning collaborative will report findings to the HSCRC

Concluding Thoughts

Outline

1. Context: What is Patient Experience?
2. HCAHPS 101 with Upcoming Changes
3. AI Can Help Us Understand the Patient Experience
4. Using Technology for Data Analysis
5. Maryland Hospitals Can and Must Improve HCAHPS Scores
6. MHA Learning Collaborative
7. Concluding Thoughts
8. Q&A

Patient Experience is Part of the Care Plan

Question & Answer

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Report from Executive Director

September 11, 2024

Advancing Innovation in Maryland (AIM)

AIM Overview

- **Advancing Innovation in Maryland (AIM)** contest is a public-private partnership involving the Maryland Department of Health (MDH), the HSCRC, and local foundations.
- Goal is to surface ideas to support Maryland's unique health care model, which incentivizes better health, prevention of complications, and more efficient care.
- Contest will award cash prizes to individuals and organizations with ideas to promote improved population health and reduce overall health care costs for the state.
- Seeking ideas in three categories, all with the dual goal of improving health outcomes and promoting affordability:
  - **Innovative Interventions**: Ideas for interventions that a hospital can implement, by itself or in coordination with community partners.
  - **Innovative Collective Action:** Ideas for programs or platforms that require collective implementation by all hospitals within a region or statewide, by themselves, or in coordination with community partners.
  - **Innovative Payment Approaches**: Ideas for payment innovations that the Health Services Cost Review Commission can implement.
- In addition to the cash prizes, winning ideas will be presented to the Health Secretary and the Health Services Cost Review Commission for consideration.
- More information about the AIM contest, including a call for ideas, will be released in the coming weeks.

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Update on Medicare FFS Data & Analysis

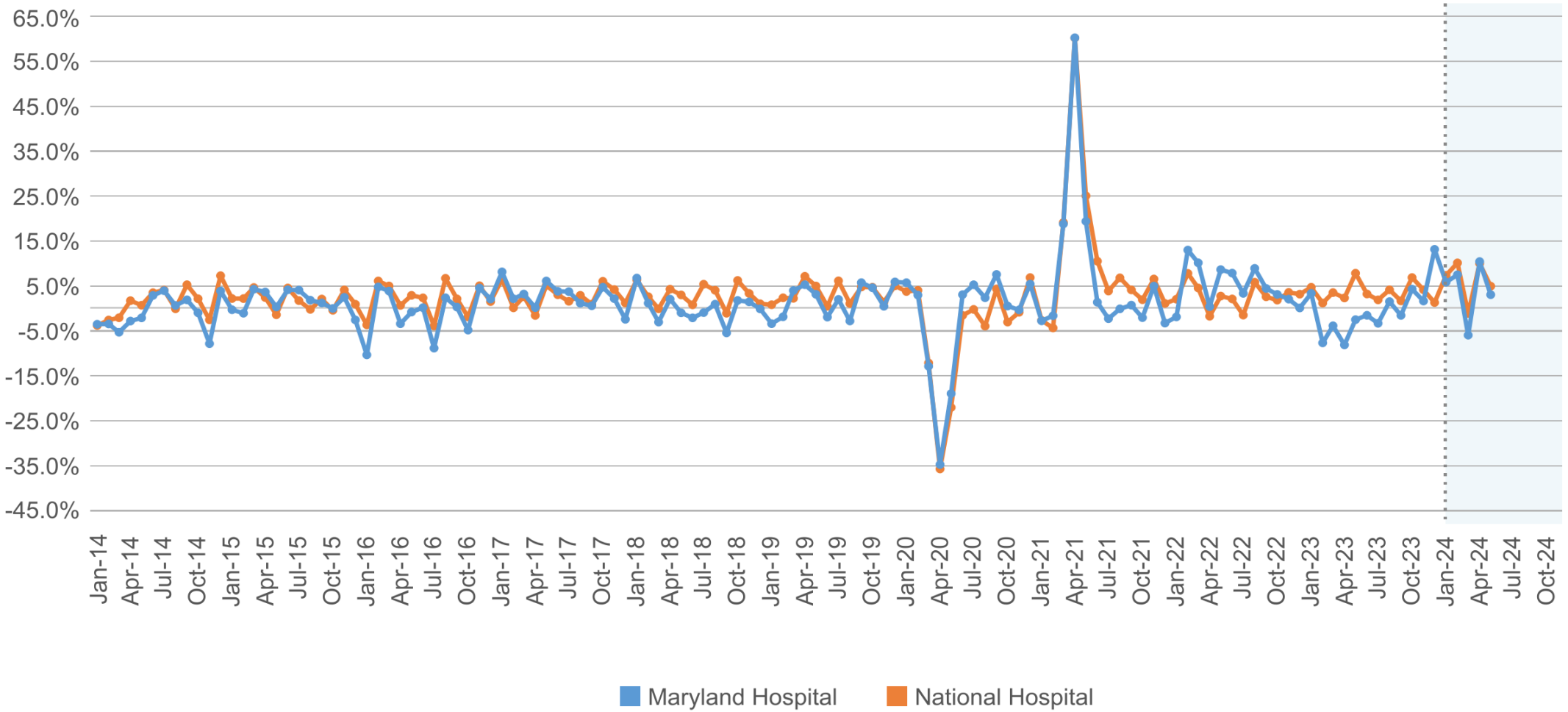
September 2024 Update

Data through May 2024, Claims paid through July 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)

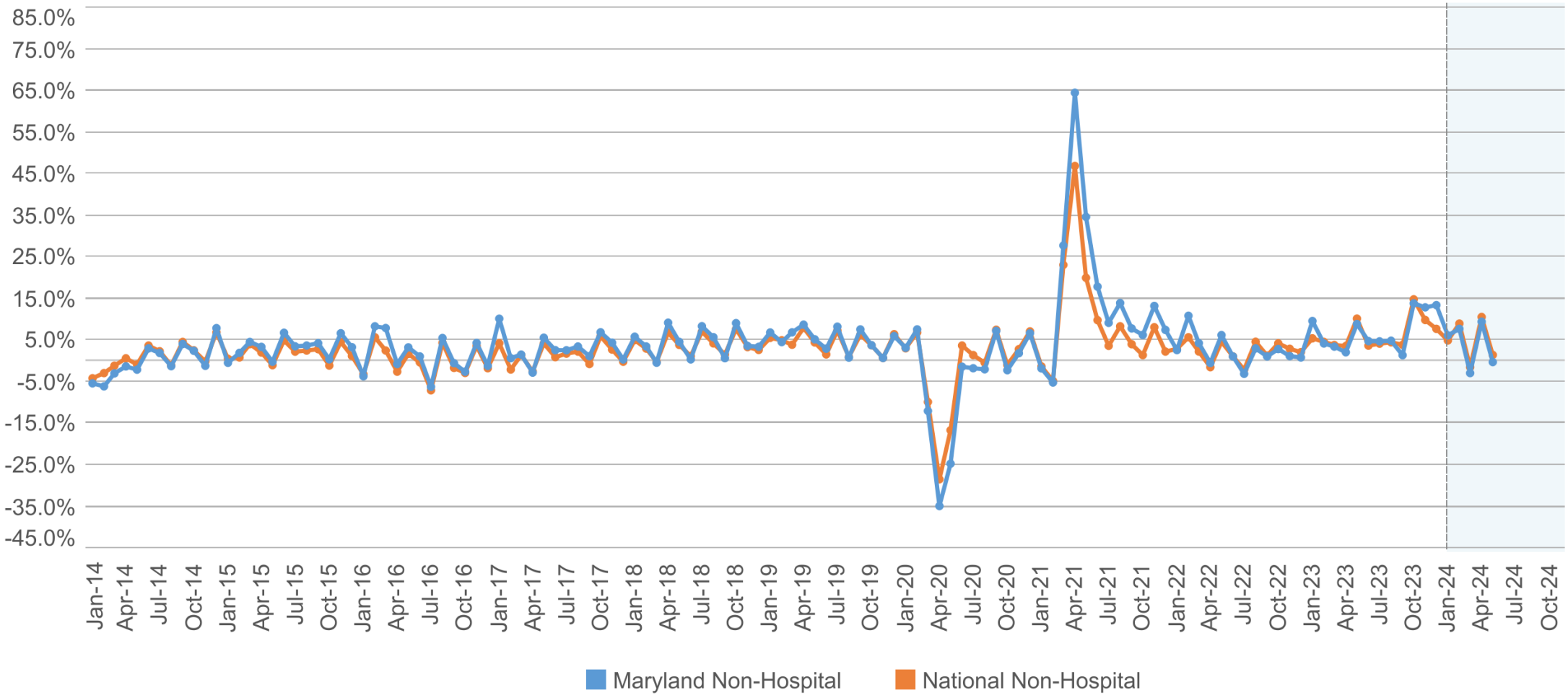


CY16 has been adjusted for the undercharge.

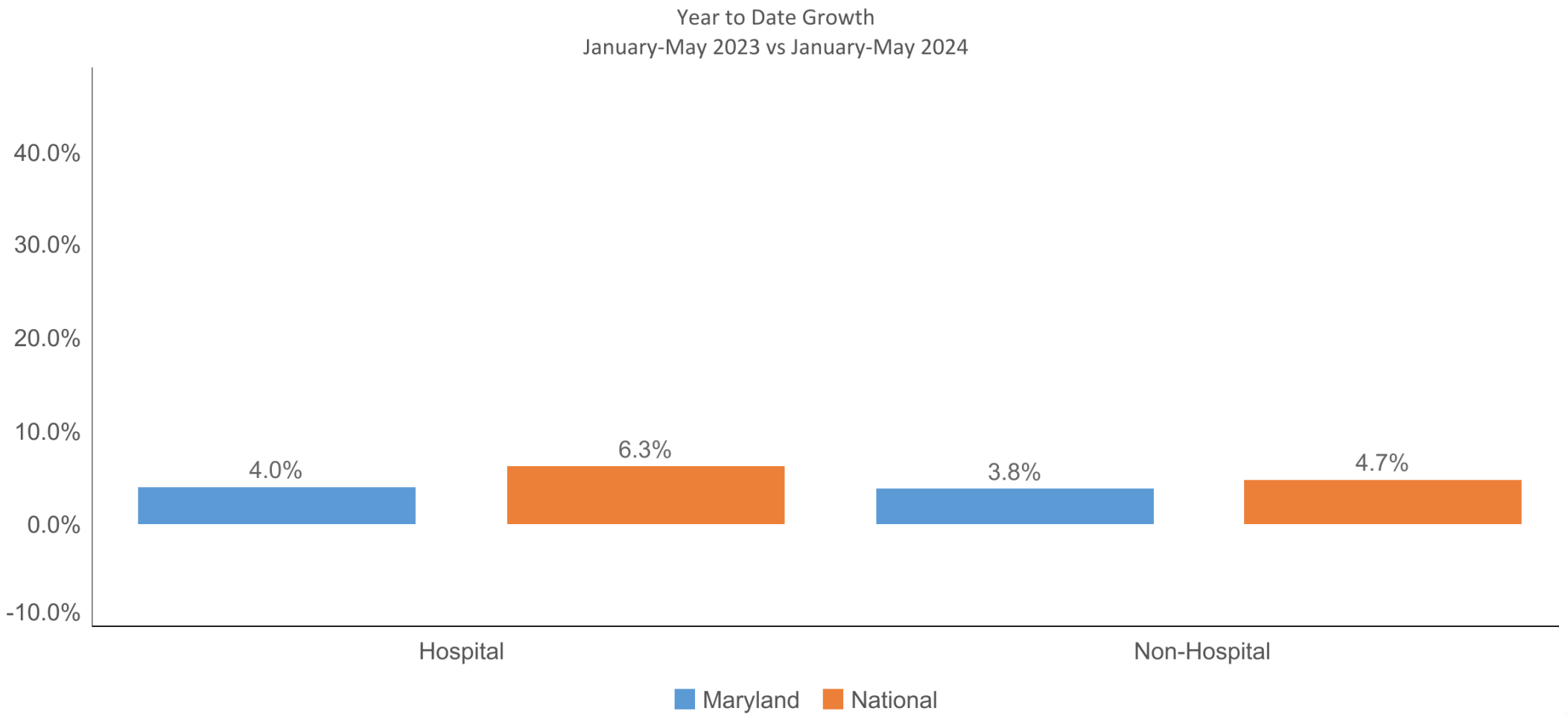
maryland health services cost review commission

Medicare Non-Hospital Spending per Capita

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

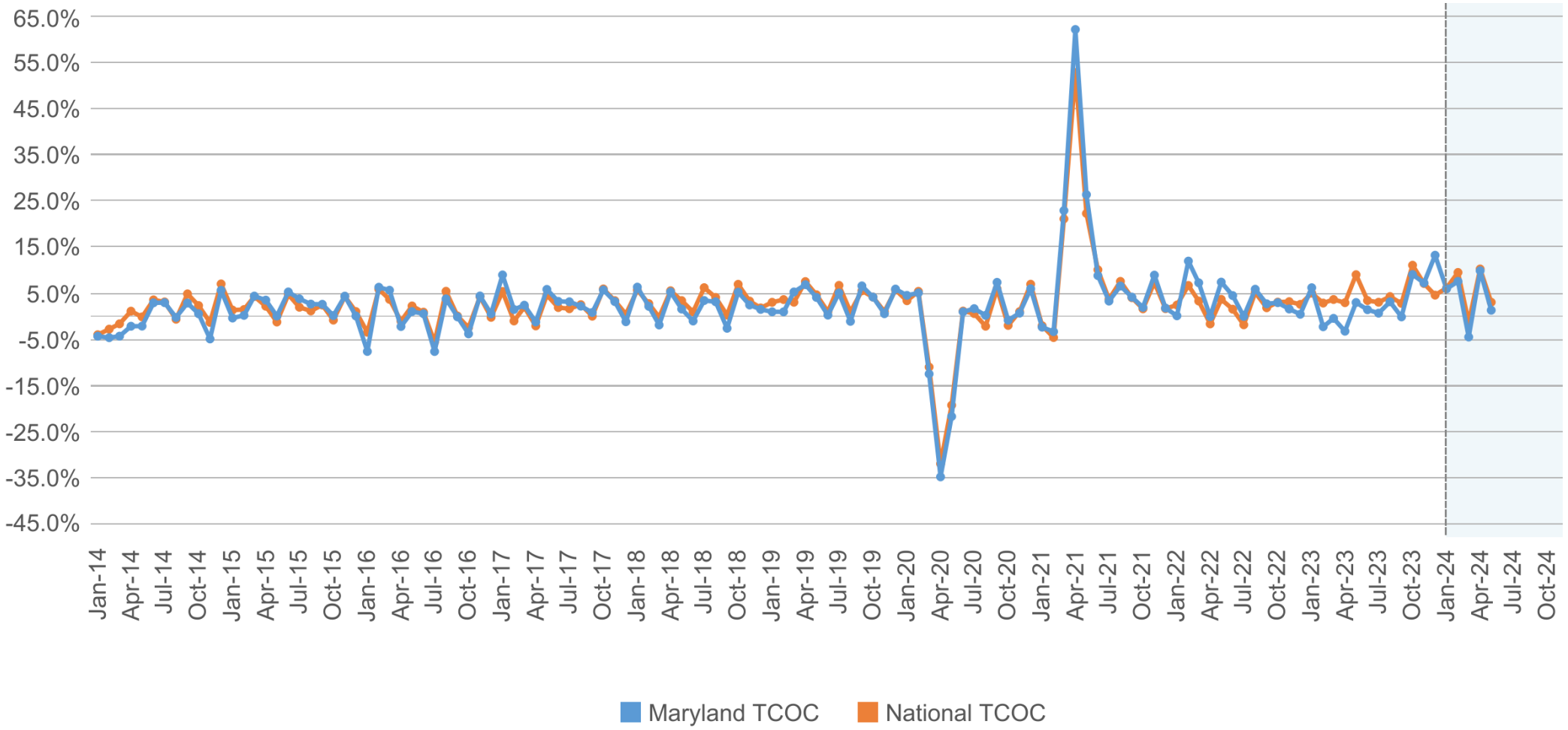


Medicare Hospital and Non-Hospital Payments per Capita



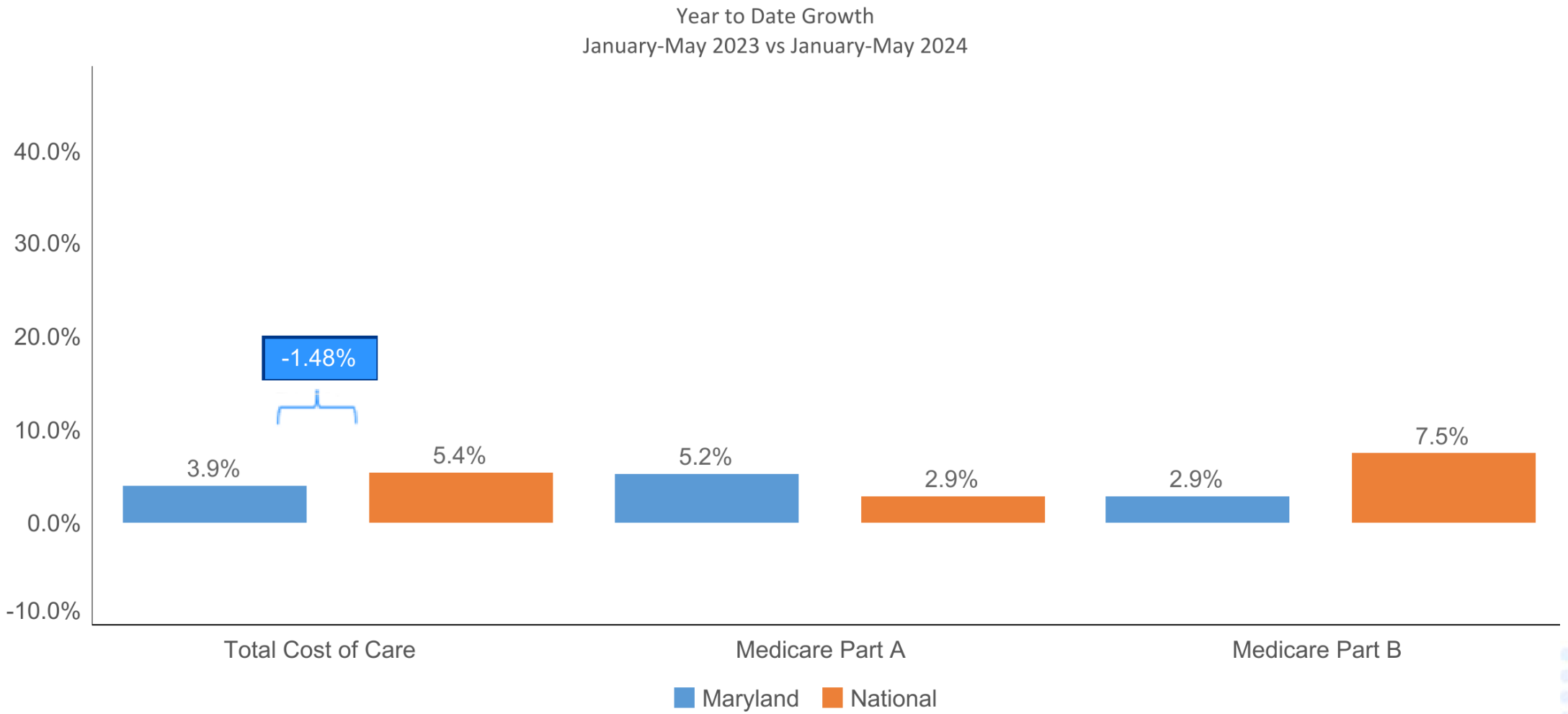
Medicare Total Cost of Care Spending per Capita

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



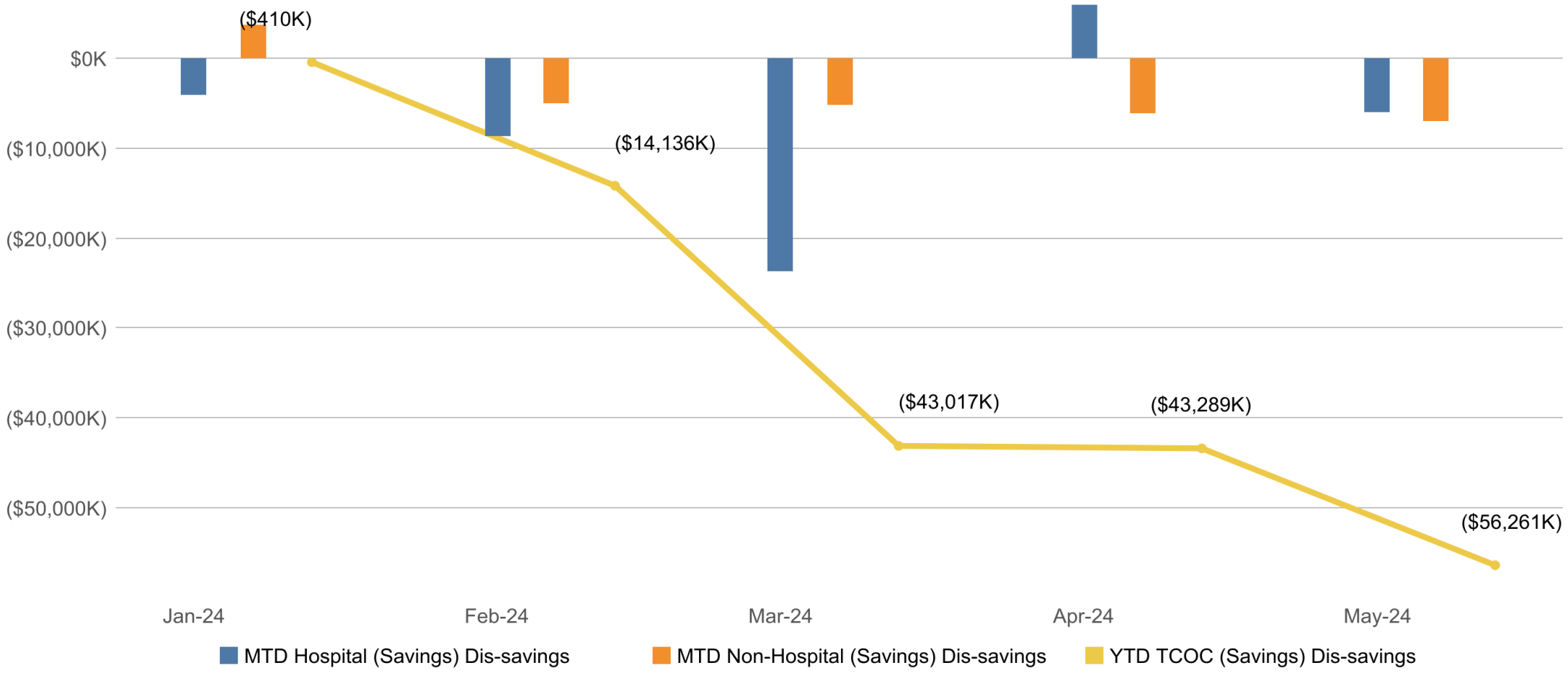
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through May 2024



maryland
health services
cost review commission

Emergency Department Initiatives Update

September Commission Meeting

Today's Presentation

- Emergency Department Wait Time Reduction Commission
- Best Practices Incentive Policy
- ED QBR Performance Standards and Data Collection Update
- EDDIE Updates (in Appendix)

Establishment of Maryland ED Wait Time Reduction Commission

Bill went into effect July 1, 2024, and terminates June 30, 2027

Annual Reports due Nov 2025 and Nov 2026

Purpose: To address factors throughout the health care system that contribute to increased Emergency Department wait times

Specific focus: Develop strategies and initiatives to recommend to state and local agencies, hospitals, and health care providers to reduce ED wait times, including initiatives that:

- *Ensure patients are seen in most appropriate setting*
- *Improve hospital efficiency by increasing ED and IP throughput*
- *Improve postdischarge resources to facilitate timely ED and IP discharge*
- *Identify and recommend improvements for the collection and submission of data*
- *Facilitate sharing of best practices*

Commission Appointed Members

Chairs:

Secretary of Health –**Laura Herrera Scott, MD, MPH**

Executive Director of HSCRC–**Jon Kromm, PhD**

Appointed Members:

- ❑ Executive Director of MIEMSS–**Ted Delbridge, MD**
- ❑ Executive Director of MHCC–**Wynee Hawk, RN, JD**
- ❑ 1 Indiv. with operation leadership experience in an ED (physician)–**Dan Morhaim, MD**
- ❑ 1 Indiv. with operation leadership experience in an ED (physician)–**Neel Vibhakar, MD**
- ❑ 1 Indiv with operations leadership experience in an ED (non-physician or APP)– **Barbara Maliszewski, RN**
- ❑ 1 representative from local EMS–**Danielle Knatz**
- ❑ 1 representative from a Managed Care Plan –**Amanda Bauer, DO**
- ❑ 1 representative of Advanced Primary Care Practice–**Mary Kim, MD**
- ❑ 1 representative from MHA–**Andrew Nicklas, JD**
- ❑ 1 representative from a patient advocacy organization–**Toby Gordon, ScD**
- ❑ 1 representative of a behavioral health provider–**Jonathan Davis, LPC**

ED Wait Time Reduction Commission:

Collaborate on behavioral health, post-acute, primary care, and other areas of opportunity.

Improve Access

Maryland Primary Care Program

Expand Behavioral Health Framework

SNF/Post-Acute

Hospital Payment Programs to Improve Clinical Care

MD Hospital Quality Policies

ED "Best Practices" incentive

Increase Transparency

MHCC Public Quality Reporting

ED Dramatic Improvement Effort

Reduction in Avoidable Utilization

Programs to optimize high value care and reduce avoidable utilization

Reducing the number of people who need the ED

Improving throughput within the hospital

Improving the hospital discharge process and post-ED community resources

maryland health services cost review commission

ED Best Practice Incentive Update

ED Best Practices Incentive Policy Development

Draft Policy November 2024
Final Policy January 2025

Objective:

- Develop process or structural measures that will address systematically longer ED length of stay (LOS) in the State.
- Will incentivize hospital best practices, as well as alignment with EDDIE and the ED Wait Time Reduction Commission.

Description:

- Subgroup will advise on the development of 3-5 measures that will constitute a +/- 1% revenue at risk program for CY 2025 performance.
- Repurposing QBR ED Subgroup 2 to assist with this development, as well as other experts.
- Next Meeting: 9/27/2024 10 am - noon

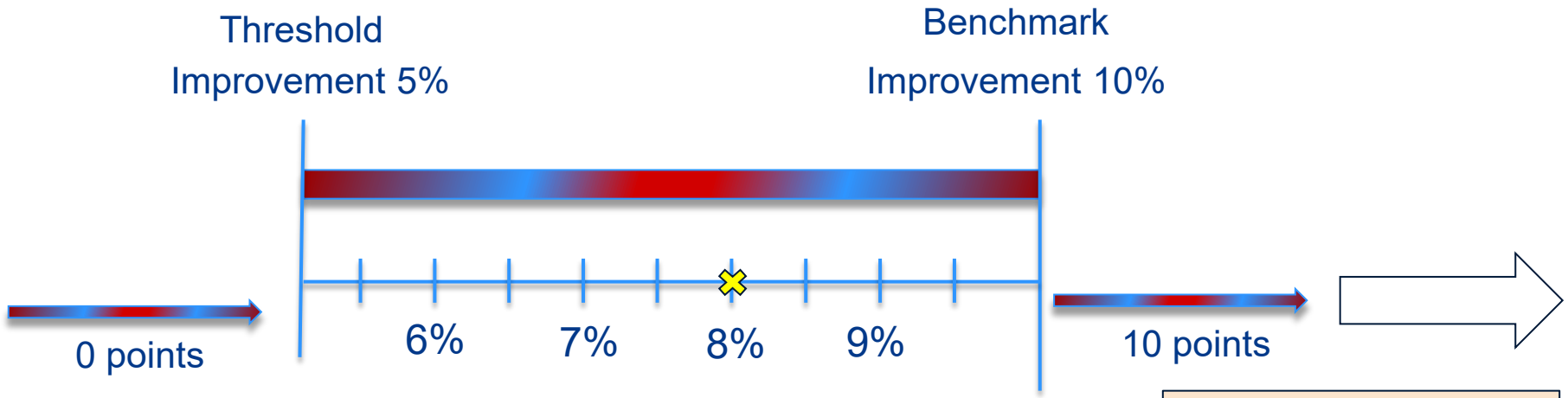
ED QBR Performance Standards and Data Collection Update

QBR ED LOS Incentive CY 2024

- Incentive measures improvement from CY 2023 to CY 2024
- **Measure:** Percent change in the median time from ED arrival to physical departure from the ED for patients admitted to the hospital
- **Population:** All non-psychiatric ED patients who are admitted to Inpatient bed and discharged from hospital during reporting period
- **Scoring:** Use attainment calculation for percent change to convert improvement into a 0 to 10 point score (see next slide)
- **Data:** Ad hoc data submissions of time stamps to merge in with case-mix data
- **Statewide Goal:** TBD by ED Wait Time Reduction Commission

QBR Performance Standards

Performance Standard Options:
Option 1: Set 5% threshold and 10% benchmark for all hospitals (example below)
Option 2: Tier threshold and benchmark based on CY 2023 performance (best 1/3rd of hospitals: 0-5%; middle 1/3rd: 5-10%; lowest 1/3rd: 10-15%



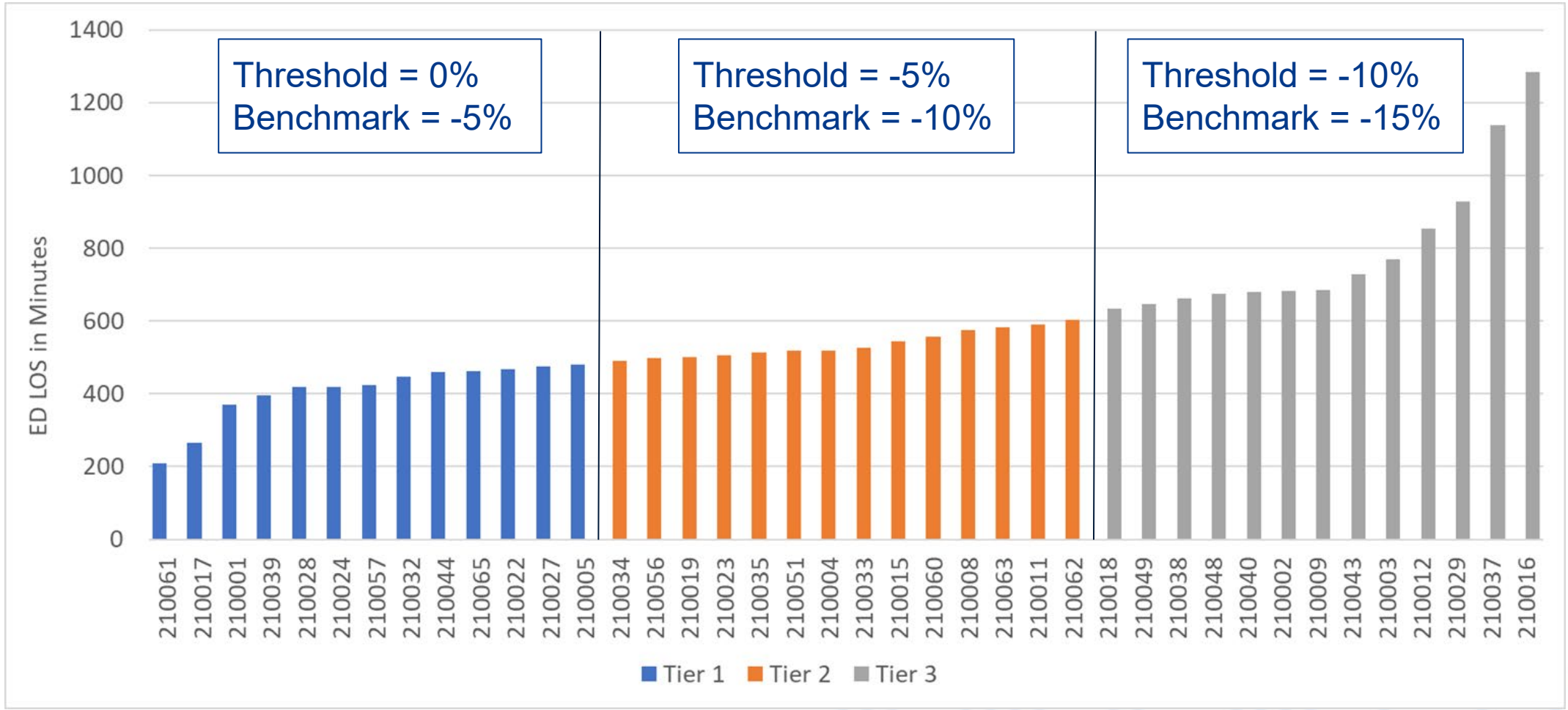
Hospital Improvement = 8.0%
Calculates to a score of 6 out of 10

Scores are summed across QBR measures and weighted to get total hospital score

QBR Revenue Adjustment Scale

Abbreviated Pre-Set Scale	QBR Score	Financial Adjustment
Max Penalty	0%	-2.00%
	10%	-1.51%
	20%	-1.02%
	30%	-0.54%
Penalty/Reward Cutpoint	41%	0.00%
	50%	0.46%
	60%	0.97%
	70%	1.49%
Max Reward	80%+	2.00%

Tiered Performance Standards



QBR ED LOS Data Collection Update

- Deadline to submit patient level data was extended to 9/13
- HSCRC staff and hMetrix are following up with hospitals with low match rates between the adhoc ED LOS data file and case mix data. Reasons for lack of matches includes:
  - Difference in admission dates
  - Patients who came to ED but Left without Being Seen do not have case mix data
  - Duplicates
  - Truncated MRNs
- Staff should have processed data by end of September

Appendix

EDDIE Update

August 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 44 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:

- Starting with February data, CRISP automated several new types of graphs/charts to illustrate EDDIE data using Tableau.
- Rolling median (June 2023-Latest Month) and change from June 2023/first month provided
- Latest month grouped by CMS ED volume category (Volume data is from CMS Care Compare or imputed by hospital, volume categories were recently updated on CMS Care Compare.)
- Graphs have not been QAed by hospitals due to fast turnaround time

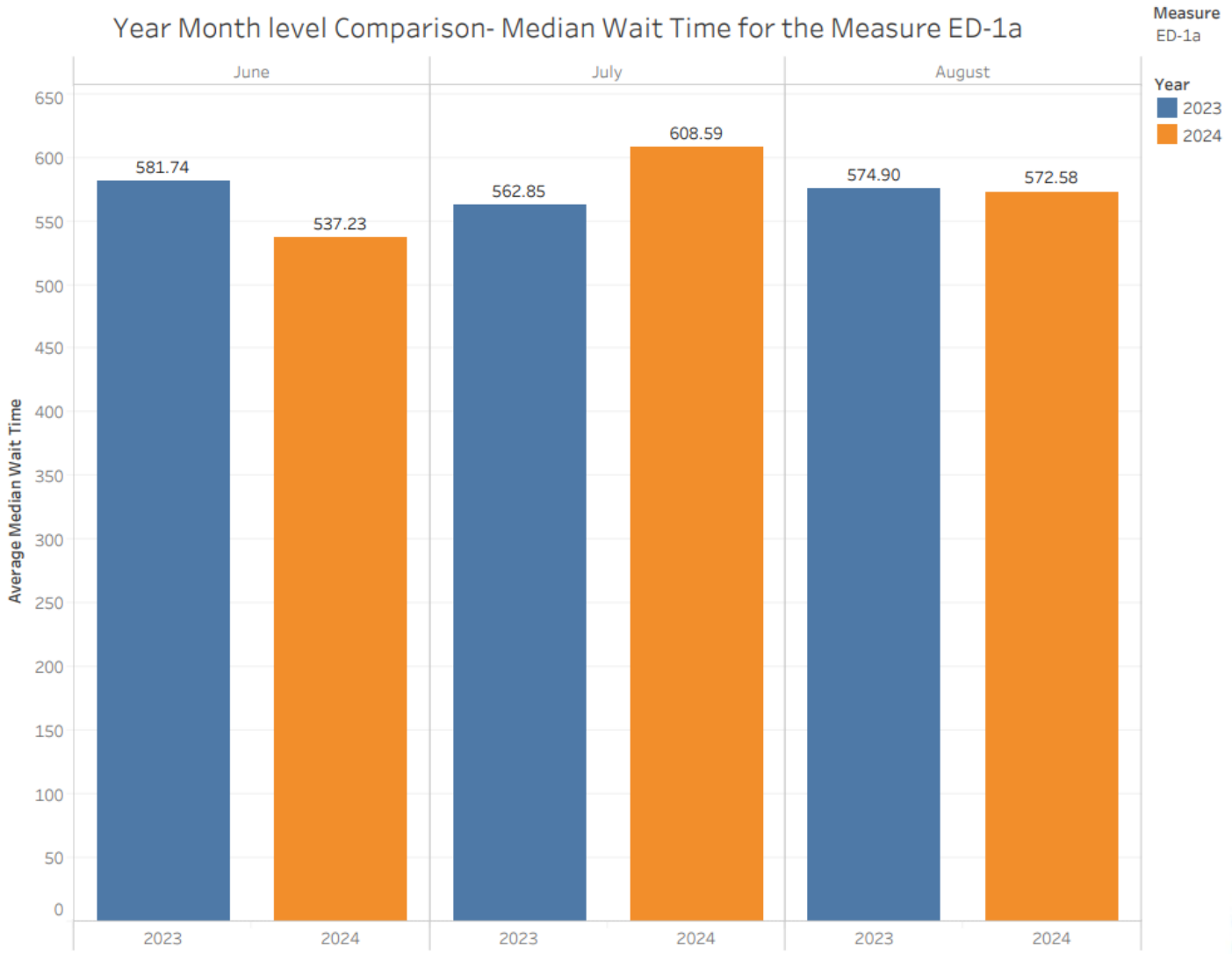
ED Length of Stay and EMS Turnaround Data

- Monthly, unaudited data on ED length of stay for August 2024 was received from 44 out of 44 hospitals (IP and OP data).
- There was a decrease for ED1a, ED1b, and ED1c in Median Wait Times in August compared to July.
    - August Average Median Wait Time:

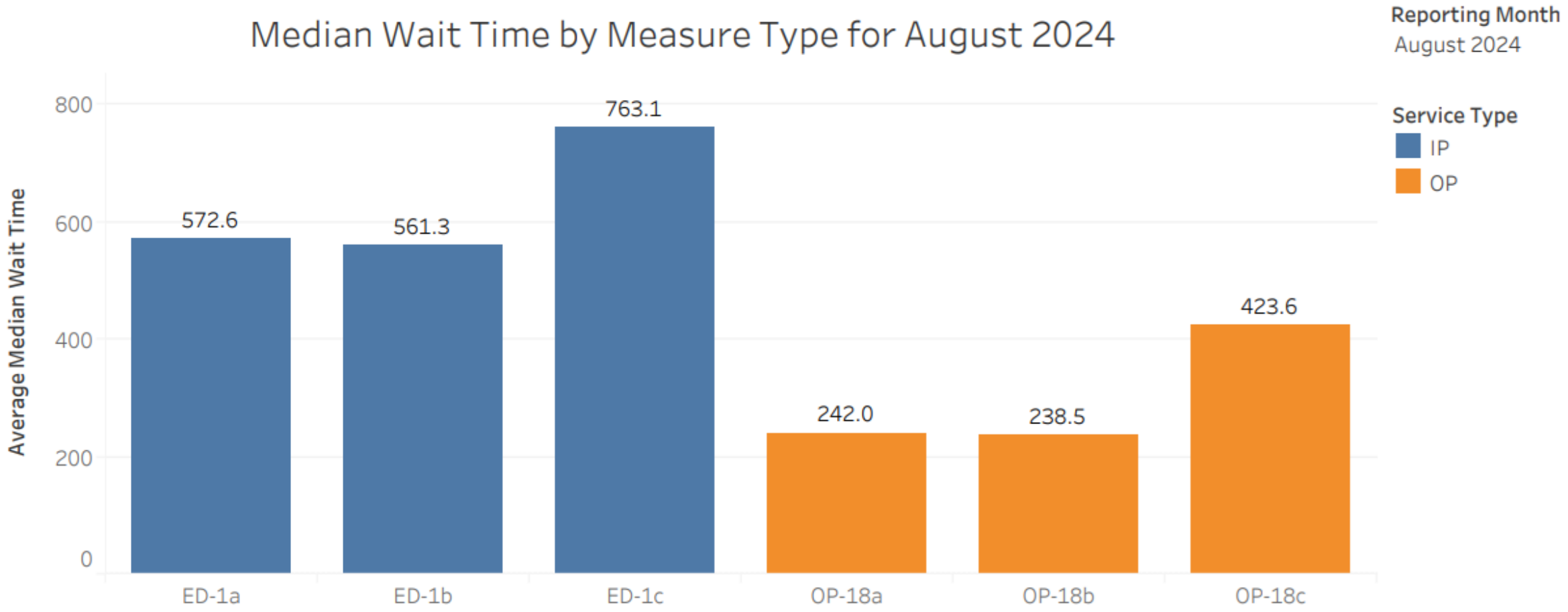
ED1a: 572.6 minutes **ED1b: 561.3 minutes minutes** **ED1c: 763.1**

    - These data should be considered preliminary given timeliness of the data (i.e., the hospitals must turn in by the first Friday of new month) and the data have NOT been audited by the HSCRC; data can be used for trending purposes within the hospital.
- EMS turnaround time data shows notable net movement of hospitals across categories for August 2024, with four hospitals improving in performance and six hospitals declining in performance

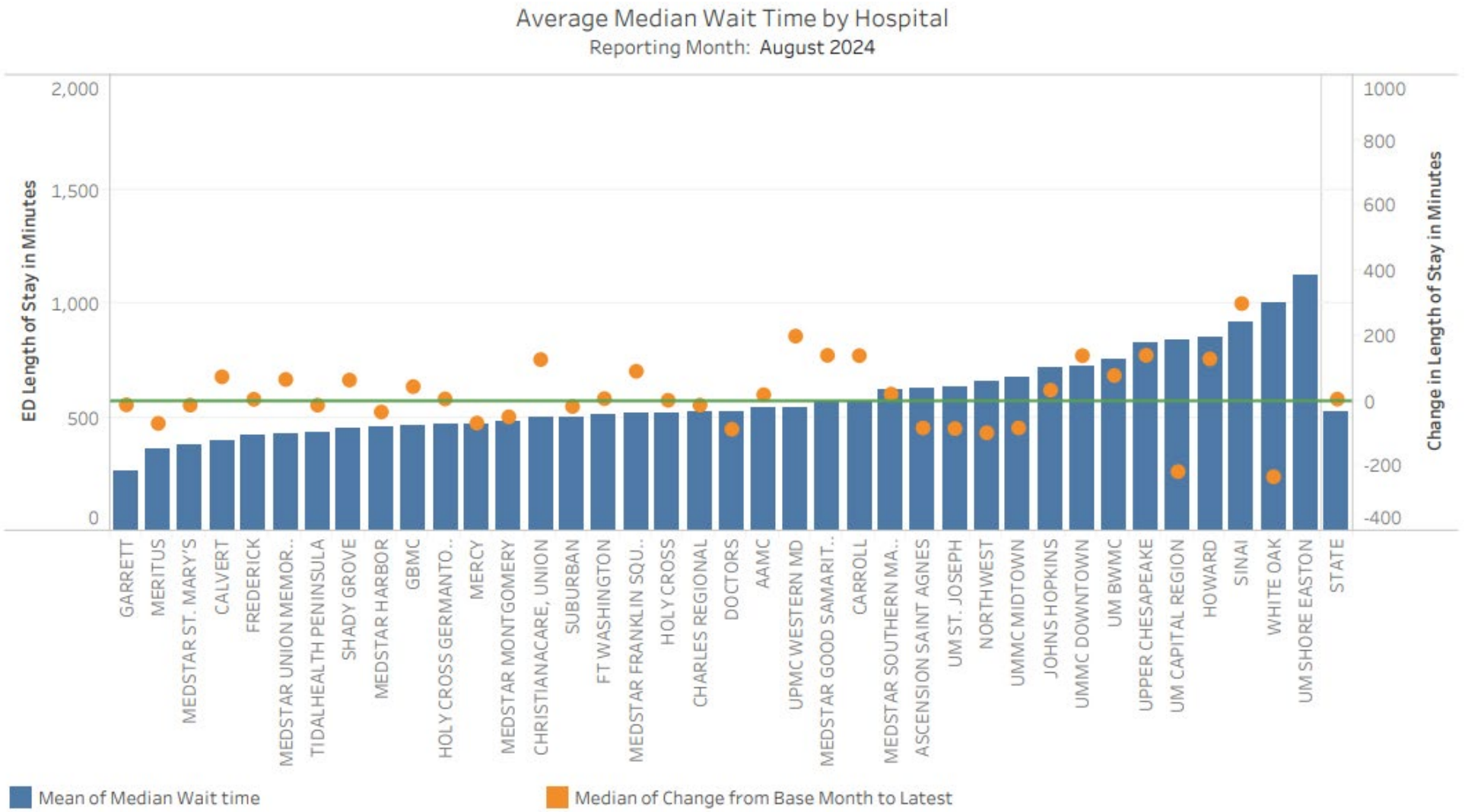
Monthly Results 2023 vs. 2024



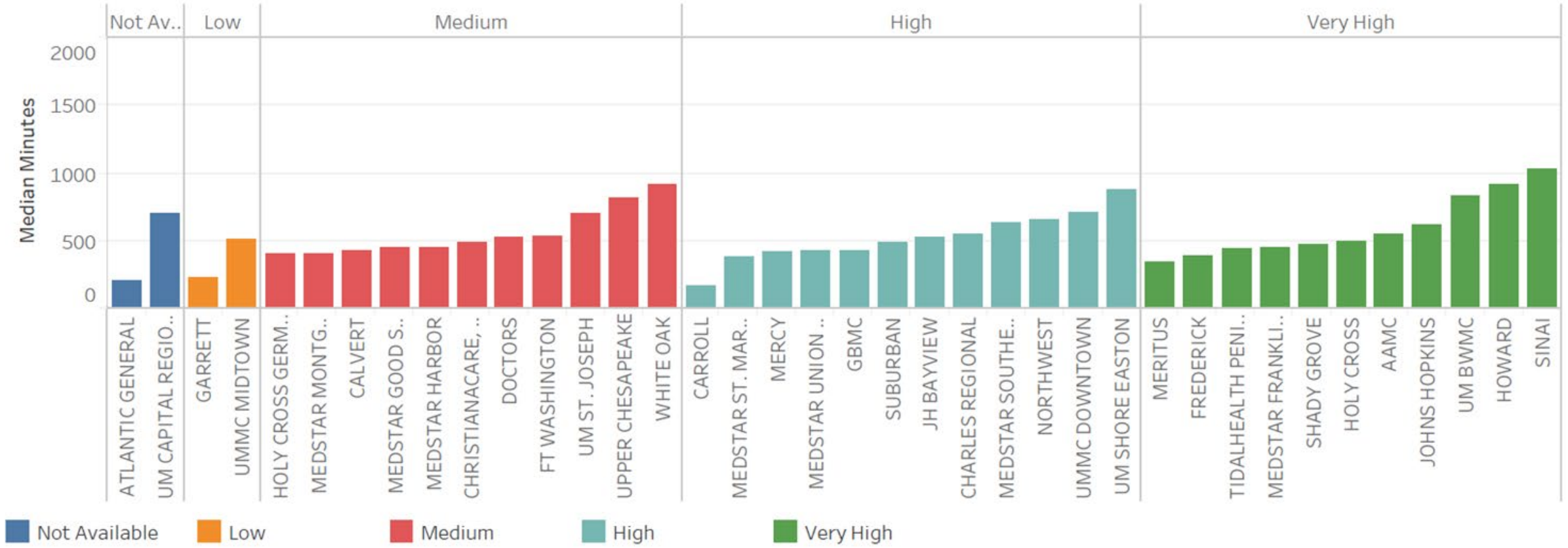
ED Median Wait Time



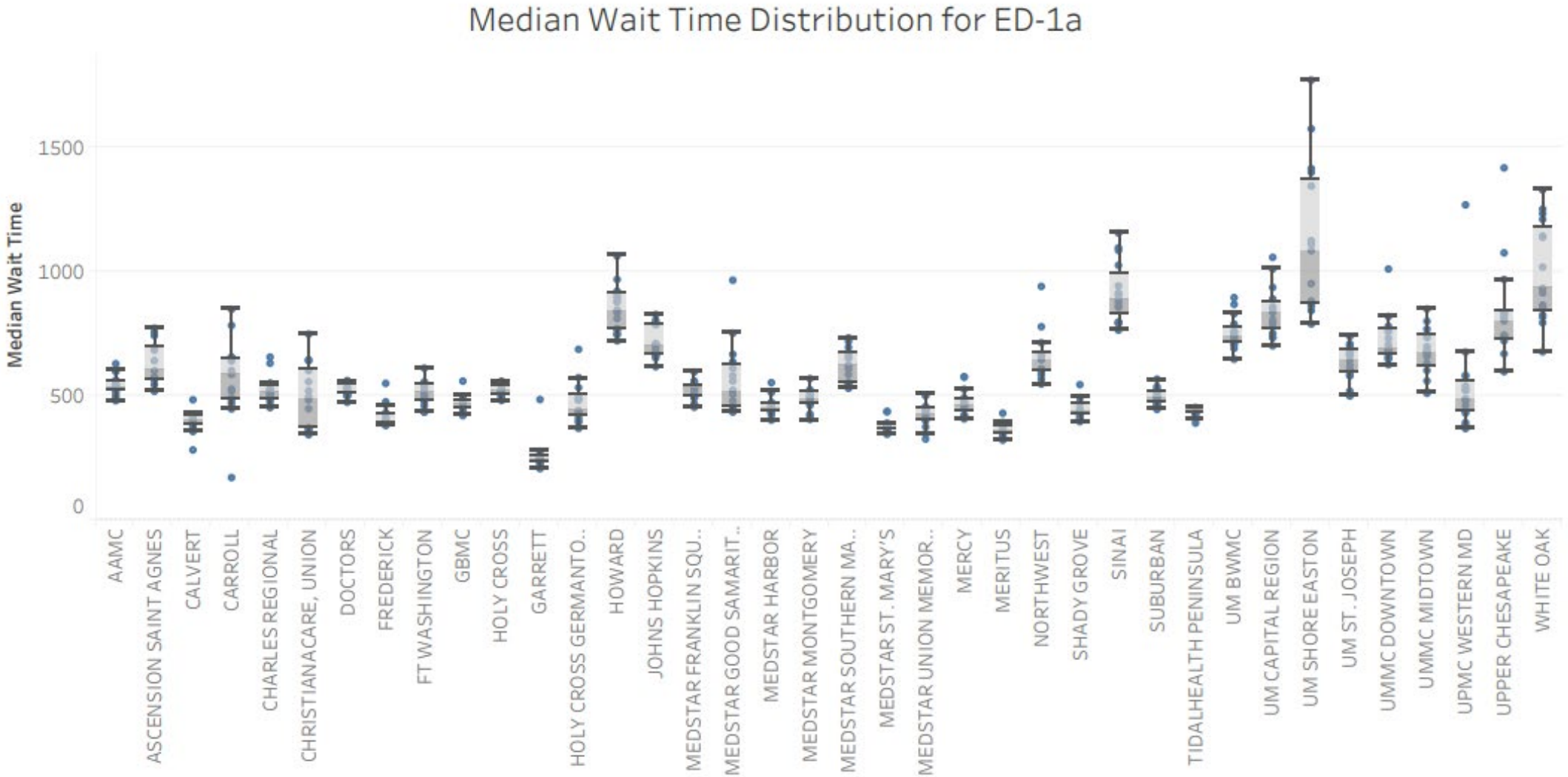
ED 1a: ED Arrival to Inpatient Admission



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



ED 1a: ED Arrival to Inpatient Admission



ED 1a: ED Arrival to Inpatient Admission

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

Red = higher wait time
Green = lower wait time

Average Median Wait Time All Hospitals for ED-1a

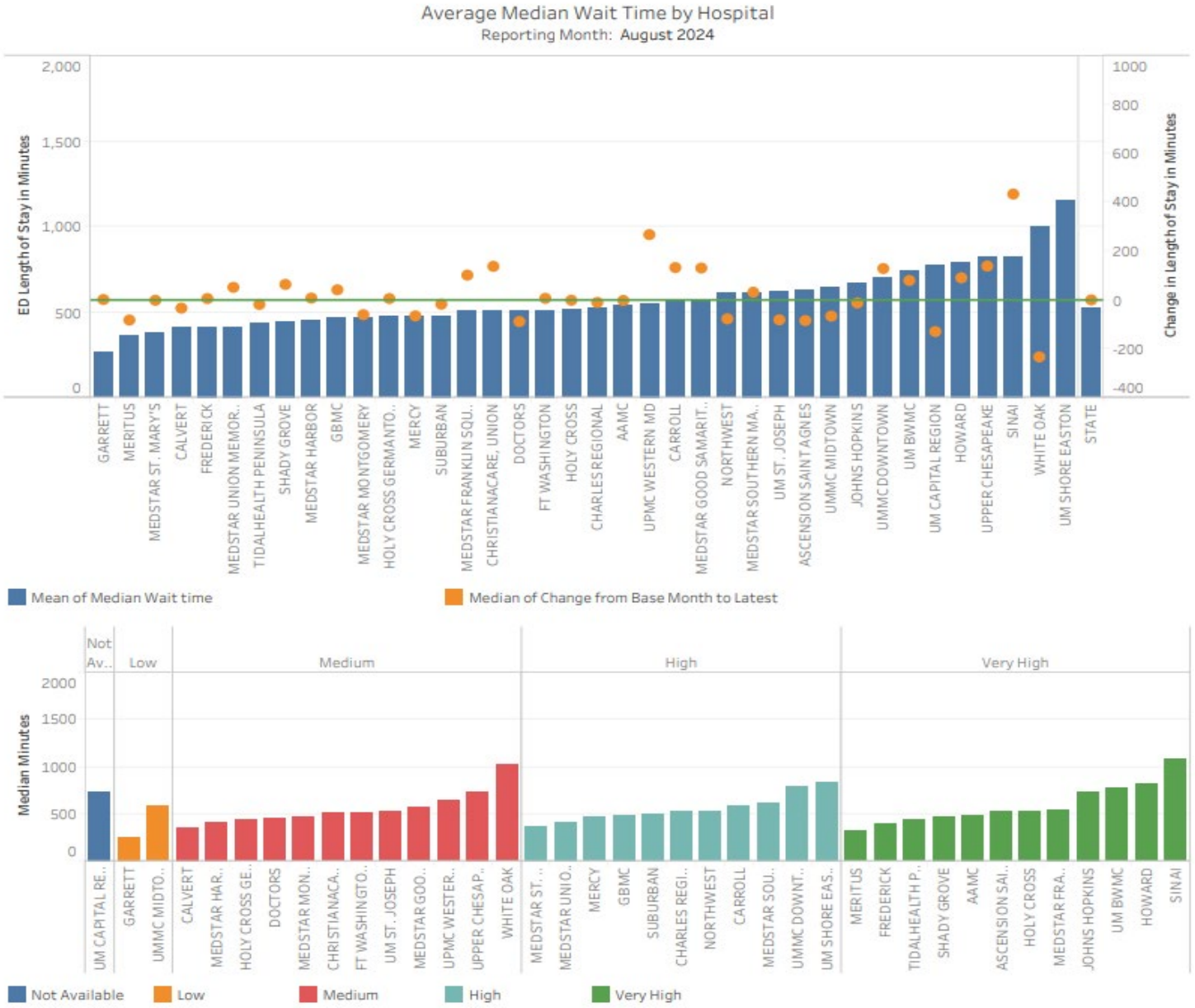
Measure
ED-1a

Change from Base
-610 885

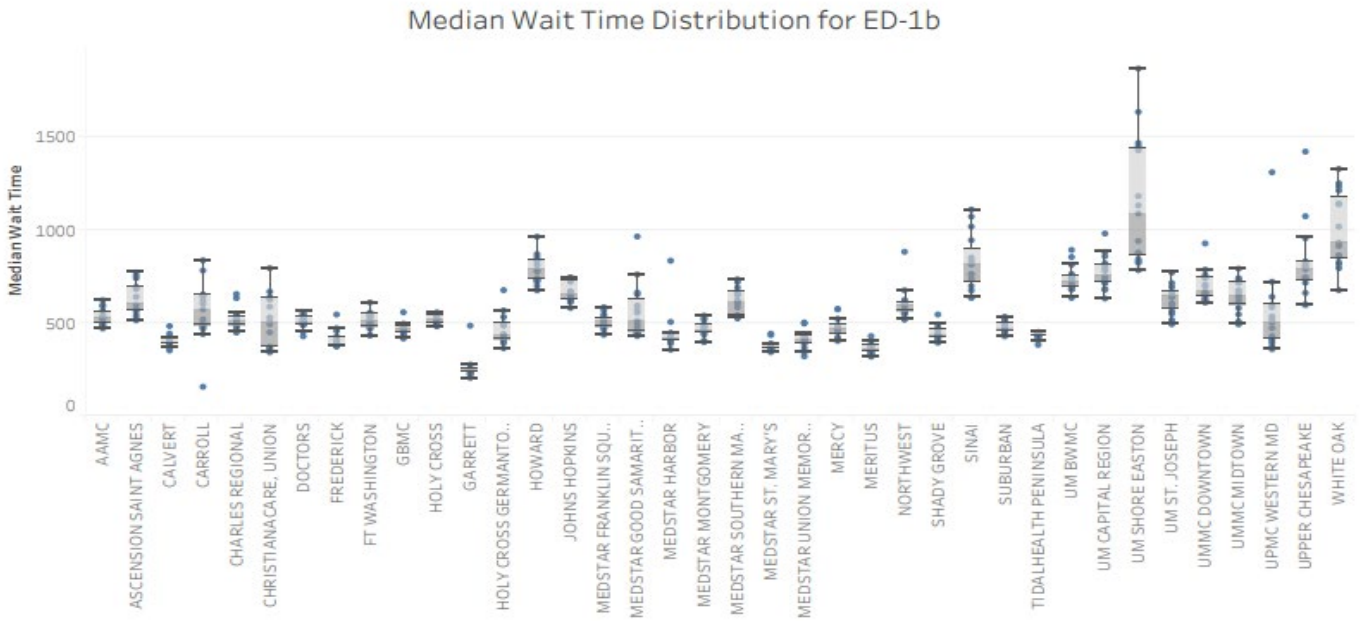
Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024
AAMC	493	532	540	534	563	601	629	597	530	544	501	480	550	521	512
ASCENSION SAINT AGNES	601	564	545	574	641	576	755	772	684	694	742			524	518
ATLANTIC GENERAL	210	218	221	212	195	189	216		190	191	199	199	200	210	
CALVERT	282	383	411	425	405	409	484	426	408	402	375	389	423	395	356
CARROLL	447	527	481	640	602	470	654	848	656	649	783	519	171	493	586
CHARLES REGIONAL	527	486	497	453	492	455	508	656	631	551	475	514	548	526	514
CHRISTIANACARE, UNION	369	351	370	343	360	448	641	601	645	557	748	520	483		496
DOCTORS	561	514	537	503	559	529	555	559	513	512	500	500	522	509	474
FREDERICK	392	388	382	395	416	432	464	550	476	381	386	402	395	391	397
FT WASHINGTON	503	434	488	493	550	539	611	460	476	556	524	435	536	553	510
GARRETT			244		246	244	277	254	231	237	207	485	223	257	232
GBMC	439	467	456	475	482	420	476	559	497	474	454	457	428	425	483
HOLY CROSS	524	481	540	513	547	518	546	559	496	524		496	498	501	526
HOLY CROSS GERMANTO..	435	393	428	369	483	414	573	687	499	437		533	401	483	441
HOWARD	748	770	765	834	968	921	902	889	721	845	811	747	915	1,062	877
JH BAYVIEW	945	1,007	1,153	968	1,135	1,276	1,229	1,277	1,315	1,001	1,110	862	522	1,110	
JOHNS HOPKINS	794	680	652	697	704	708	661	804	786	710	663	666	617	790	827
MEDSTAR FRANKLIN SQUA..	463	467	493	492	532	509	560	596	539	512	537	532	454	532	554
MEDSTAR GOOD SAMARIT..	441	479	522	456	559	506	667	965	752	637	442	434	450	610	581
MEDSTAR HARBOR	458	553	474	518	513	402	441	457	436	437	432	434	451	466	424
MEDSTAR MONTGOMERY	518	461	486	495	525	497	505	569	518	480	471	419	405	427	469
MEDSTAR SOUTHERN MA..	585	544	539	530	542	554	660	733	695	673	719	622	624	651	606
MEDSTAR ST. MARY'S	380	351	362	354	362	382	436	437	363	372	390	367	382	345	367
MEDSTAR UNION MEMORI..	375	456	412	326	407	400	504	500	439	410	446	347	425	455	441
MERCY	526	577	575	407	450	423	466	492	461	476	463	470	417	419	458
MERITUS	393	370	354	386	379	345	368	430	370	354	354	335	338	322	324
NORTHWEST	645	778	669	566	602	608	661	940	713	593	668	584	651	608	547
SHADY GROVE	408	427	446	435	545	494	428	437	403	470	396	419	469	468	472
SINAI	796	796	877	861	764	856	791	1,155	1,085	942	904	887	1,025	914	1,095
SUBURBAN	527	462	467	480	537	469	499	521	497	445	475	567	485	490	510
TIDALHEALTH PENINSULA		453	448	447	432	430	445	450	438	406	424	390	434	441	440
UM BWMC	711	740	691	708	717	647	756	895	758	731	725	743	830	868	789
UM CAPITAL REGION	1,010	853	858	751	890	734	835	1,057	936	838	736	778	701	806	793
UM SHORE EASTON	1,399	951	1,344	1,414	1,109	789	1,574	1,770	1,084	1,124	843	868	877	881	861
UM ST. JOSEPH	604	600	641	667	687	499	621	739	580	585	672	663	701	709	519
UMMC DOWNTOWN	680	625	648	688	658	650	670	768	687	758	731	780	705	1,010	819
UMMC MIDTOWN	685	849	800	658	768	560	698	677	748	669	631	516	510	734	602
UPMC WESTERN MD	383	430	438	481	522	523	489	676	580	392	368	539	461	1,268	582
UPPER CHESAPEAKE	598	669	599	834	801	968	1,075	1,417	721	741	834	822	811	744	738
WHITE OAK	1,251	865	1,143	855	1,328	1,210	794	825	677	1,233	1,138	932	914	817	1,018

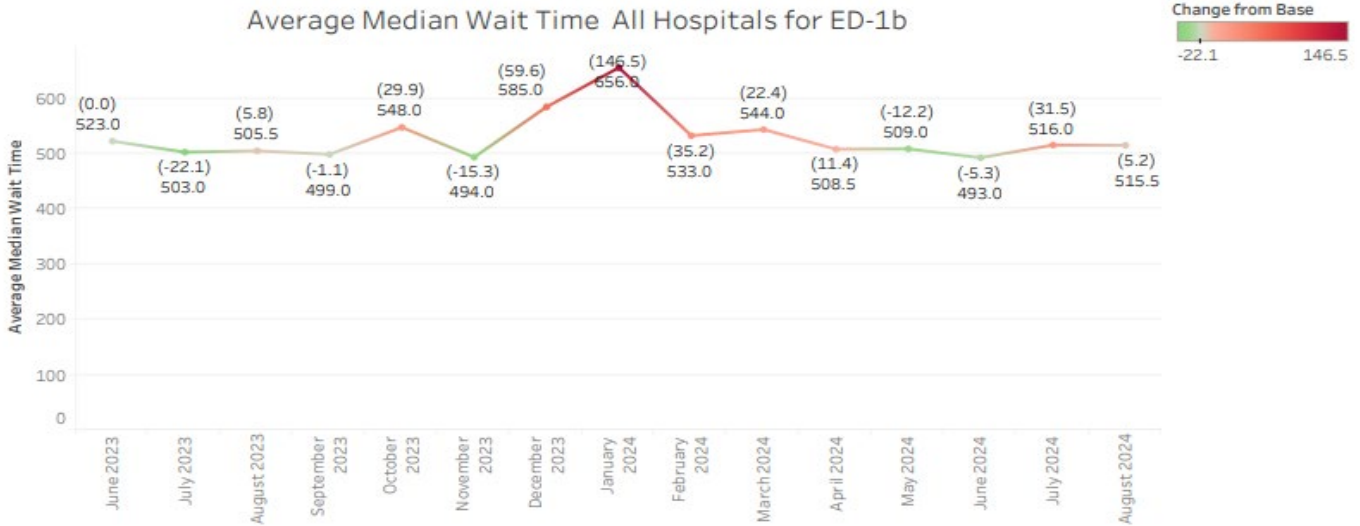
Western Maryland did submit data but not in time for inclusion

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



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





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

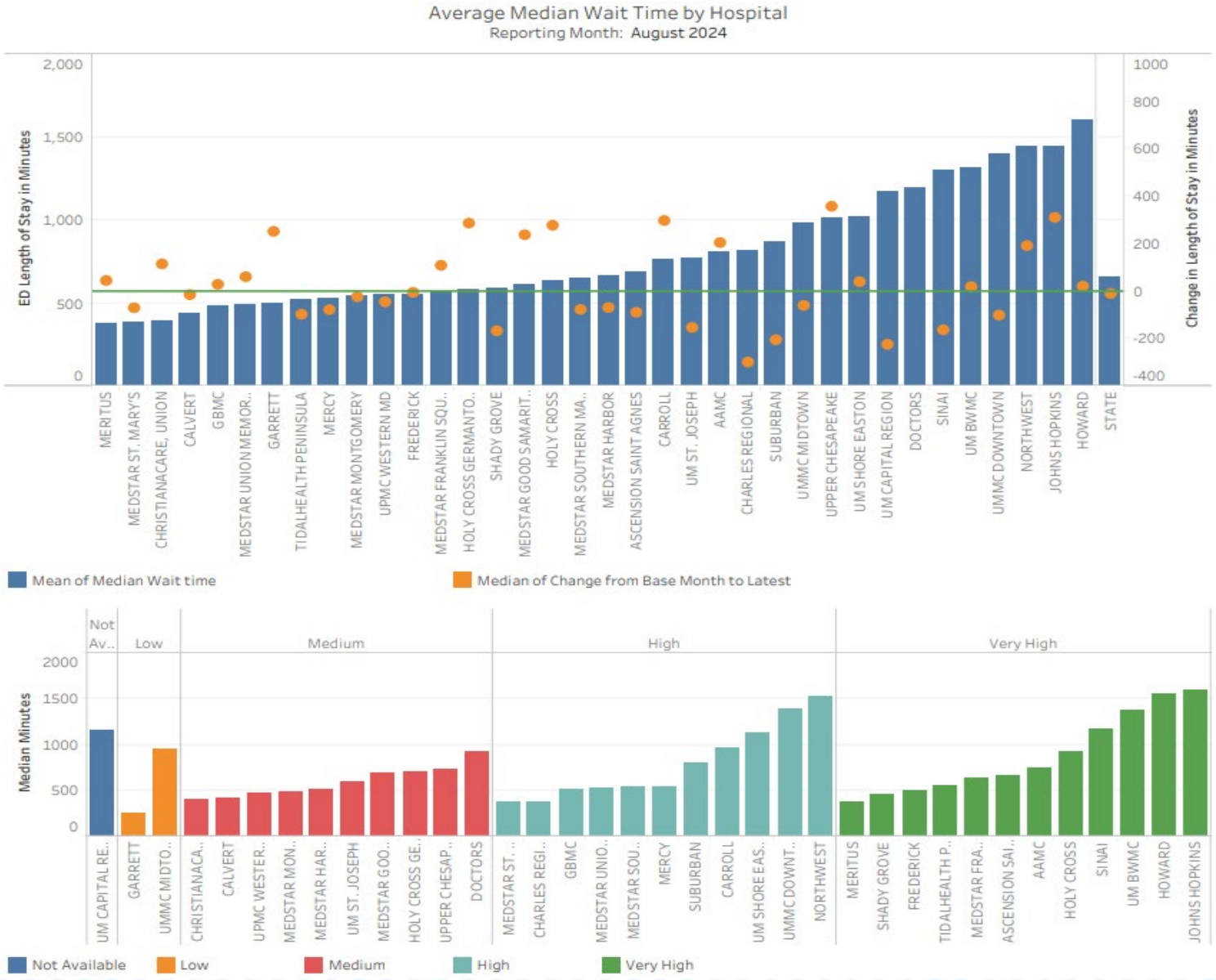
Average Median Wait Time All Hospitals for ED-1b

Measure
ED-1b

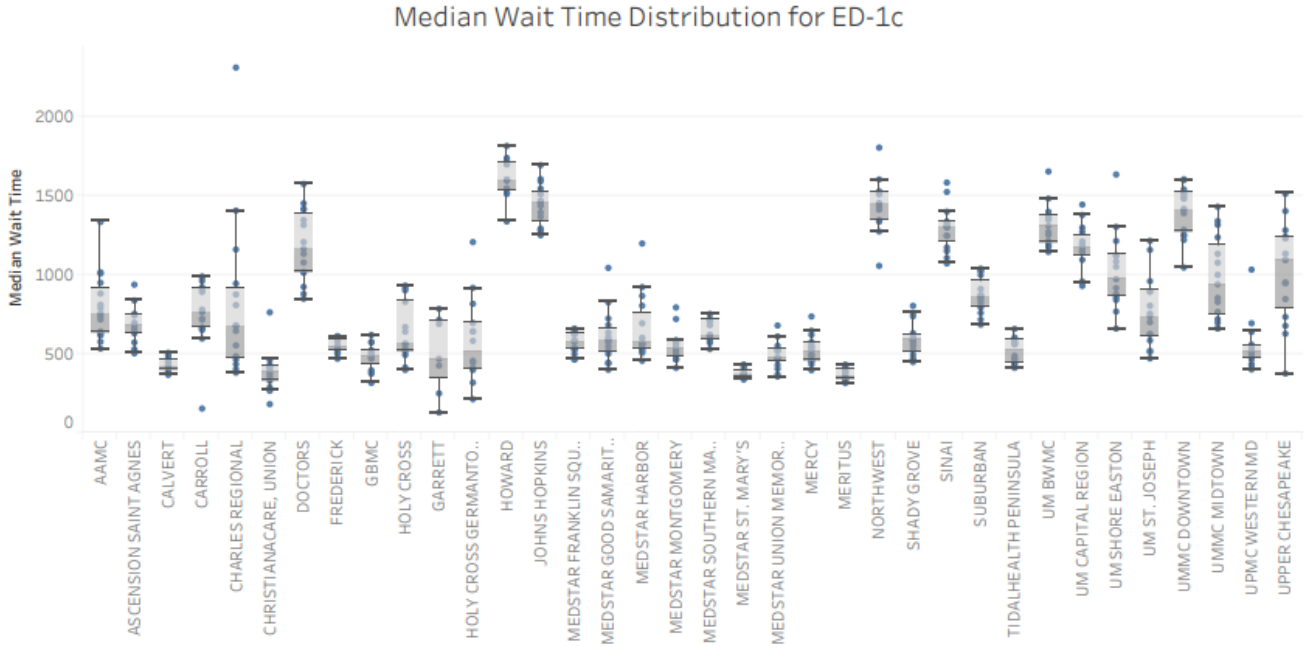
Change from Base
-668 937

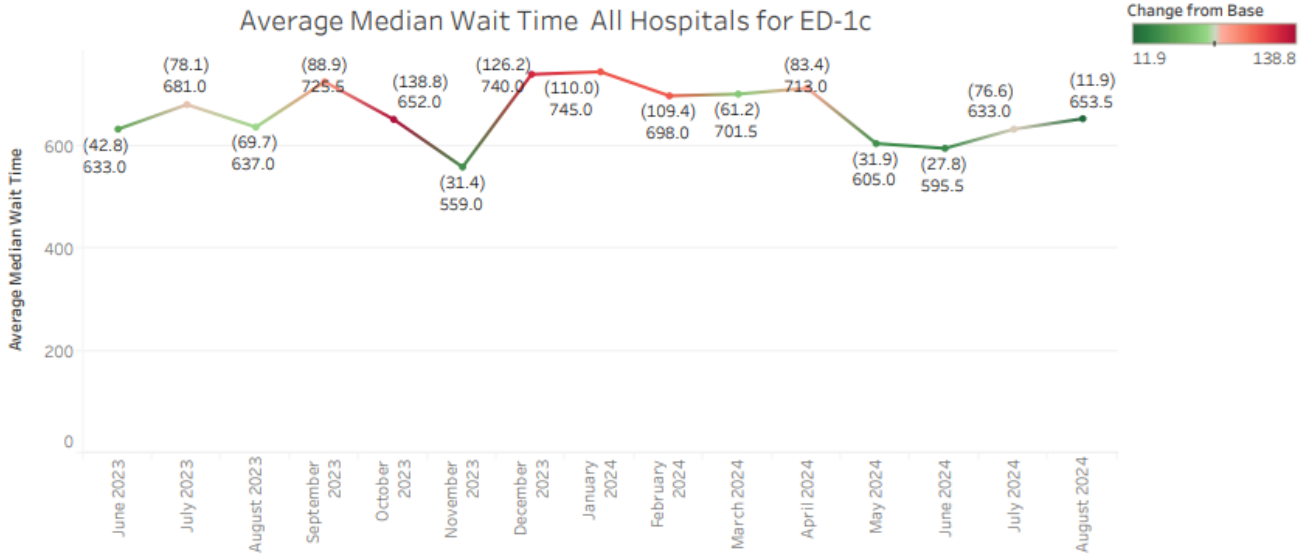
Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024
AAMC	488	527	536	529	565	597	623	591	528	539	495	471	528	508	486
ASCENSION SAINT AGNES	599	563	541	573	641	576	755	772	683	694	741			525	515
ATLANTIC GENERAL	209	203	222	212	195	189	216		190	190	199	199	199	210	
CALVERT		386	403	420	390	408	484	443	404	395	369	391	407	392	353
CARROLL	441	520	470	623	603	158	653	837	648	648	782	500	480	487	574
CHARLES REGIONAL	526	484	499	449	489	456	507	656	634	551	474	516	544	526	516
CHRISTIANACARE, UNION	372	351	370	343	356	450	640	627	669	588	795	530	493		510
DOCTORS	541	503	525	499	559	523	547	543	510	509	489	491	429	493	453
FREDERICK	388	376	378	391	410	427	458	546	472	375	379	397	390	381	394
FT WASHINGTON	503	434	488	493	550	539	611	469	476	556	524	435	536	553	510
GARRETT			244		246	244	277	255	227	236	206	486	223	256	246
GBMC	438	467	455	475	481	417	476	558	496	475	454	455	429	427	480
HOLY CROSS	524	482	540	513	544	518	546	557	495	524		496	499	500	523
HOLY CROSS GERMANTO..	435	396	427	365	487	414	568	677	498	436		533	398	488	441
HOWARD	722	734	729	776	871	839	836	785	676	785	741	699	855	964	813
JH BAYVIEW	895	951	1,107	885	1,097	1,250	1,179	1,270	1,307	973	1,059	815	1,117	1,085	
JOHNS HOPKINS	746	631	613	650	672	652	617	744	732	667	623	626	581	722	734
MEDSTAR FRANKLIN SQUA..	445	471	492	484	516	471	570	585	538	492	522	512	437	516	547
MEDSTAR GOOD SAMARIT..	440	474	512	449	556	494	654	965	761	664	442	430	450	594	571
MEDSTAR HARBOR	407	506	424	835	391	357	399	447	416	432	415	406	436	445	415
MEDSTAR MONTGOMERY	520	459	478	477	525	438	490	540	495	454	448	404	398	402	460
MEDSTAR SOUTHERN MA..	584	542	536	525	540	533	654	735	691	668	720	622	604	652	616
MEDSTAR ST. MARY'S	368	350	362	356	362	385	436	443	361	366	390	369	385	344	367
MEDSTAR UNION MEMORI..	367	442	397	321	398	389	498	503	434	413	425	342	410	435	419
MERCY	523	576	574	404	450	421	464	490	461	476	462	469	416	417	458
MERITUS	404	371	357	386	377	341	368	430	364	352	347	334	339	320	322
NORTHWEST	595	676	613	558	575	561	600	883	624	549	609	551	600	559	518
SHADY GROVE	408	424	446	434	546	493	427	437	397	468	395	419	465	468	472
SINAI	638	636	759	699	675	765	737	1,110	945	852	814	819	1,018	834	1,072
SUBURBAN	510	441	445	457	516	455	485	506	474	429	456	534	457	472	493
TIDALHEALTH PENINSULA		452	446	447	429	430	447	448	437	405	423	383	429	440	434
UM BWMC	684	704	681	683	699	635	740	893	747	721	698	734	813	855	764
UM CAPITAL REGION	859	752	781	714	809	683	793	981	882	821	679	721	632	740	730
UM SHORE EASTON	1,452	941	1,468	1,428	1,182	784	1,634	1,867	1,089	1,132	823	832	878	875	843
UM ST. JOSEPH	598	562	641	656	640	494	607	771	583	550	669	650	715	694	517
UMMC DOWNTOWN	658	610	625	669	636	622	651	747	662	742	707	758	697	928	787
UMMC MIDTOWN	647	792	735	614	742	547	676	664	726	640	617	509	493	716	581
UPMC WESTERN MD	373	417	411	473	599	503	430	722	520	394	360	585	536	1,310	641
UPPER CHESAPEAKE	599	662	598	831	789	956	1,074	1,421	717	739	826	809	803	747	738
WHITE OAK	1,251	865	1,142	855	1,328	1,212	795	825	677	1,233	1,138	932	914	817	1,018

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



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





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

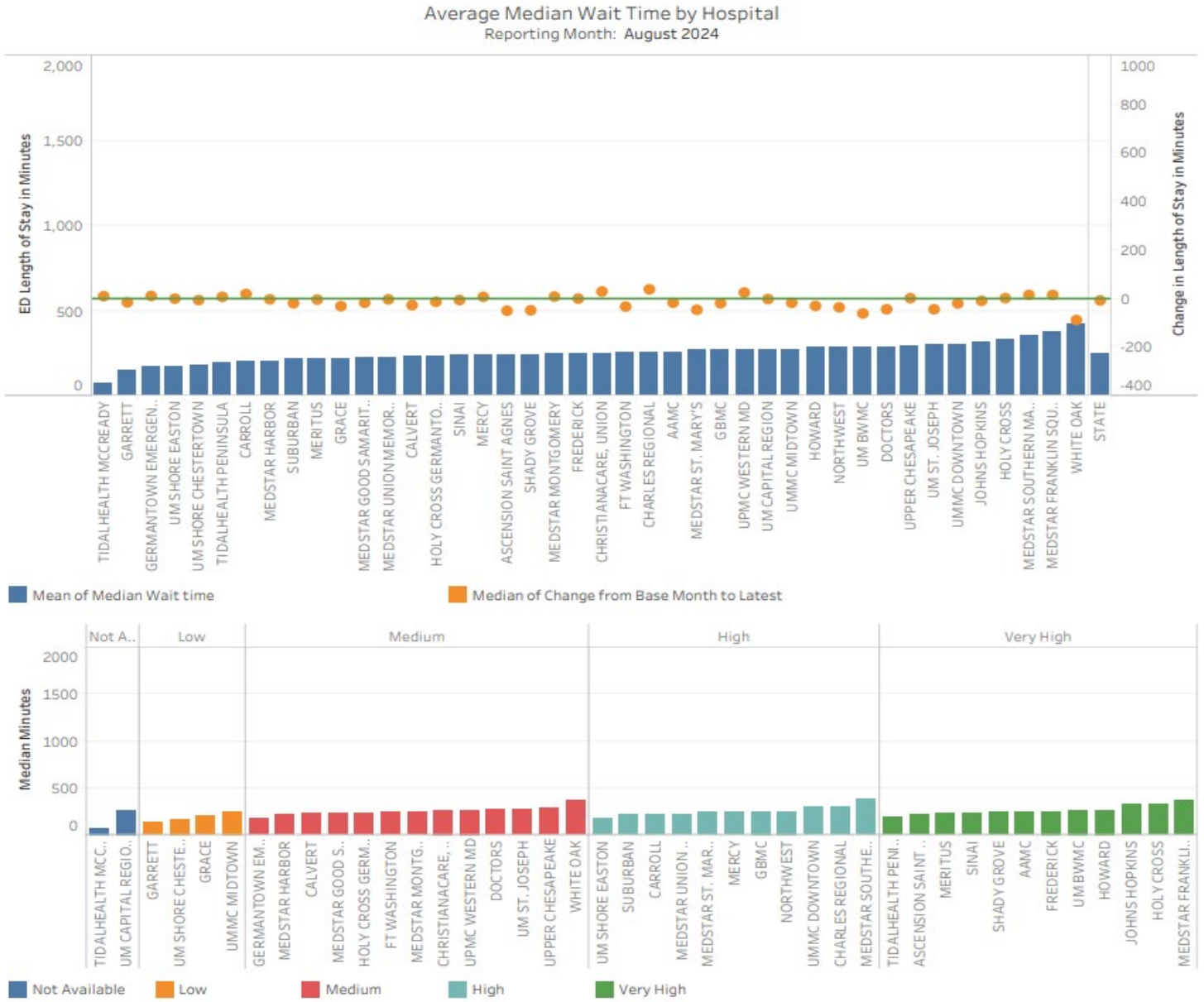
Average Median Wait Time All Hospitals for ED-1c

Measure
ED-1c

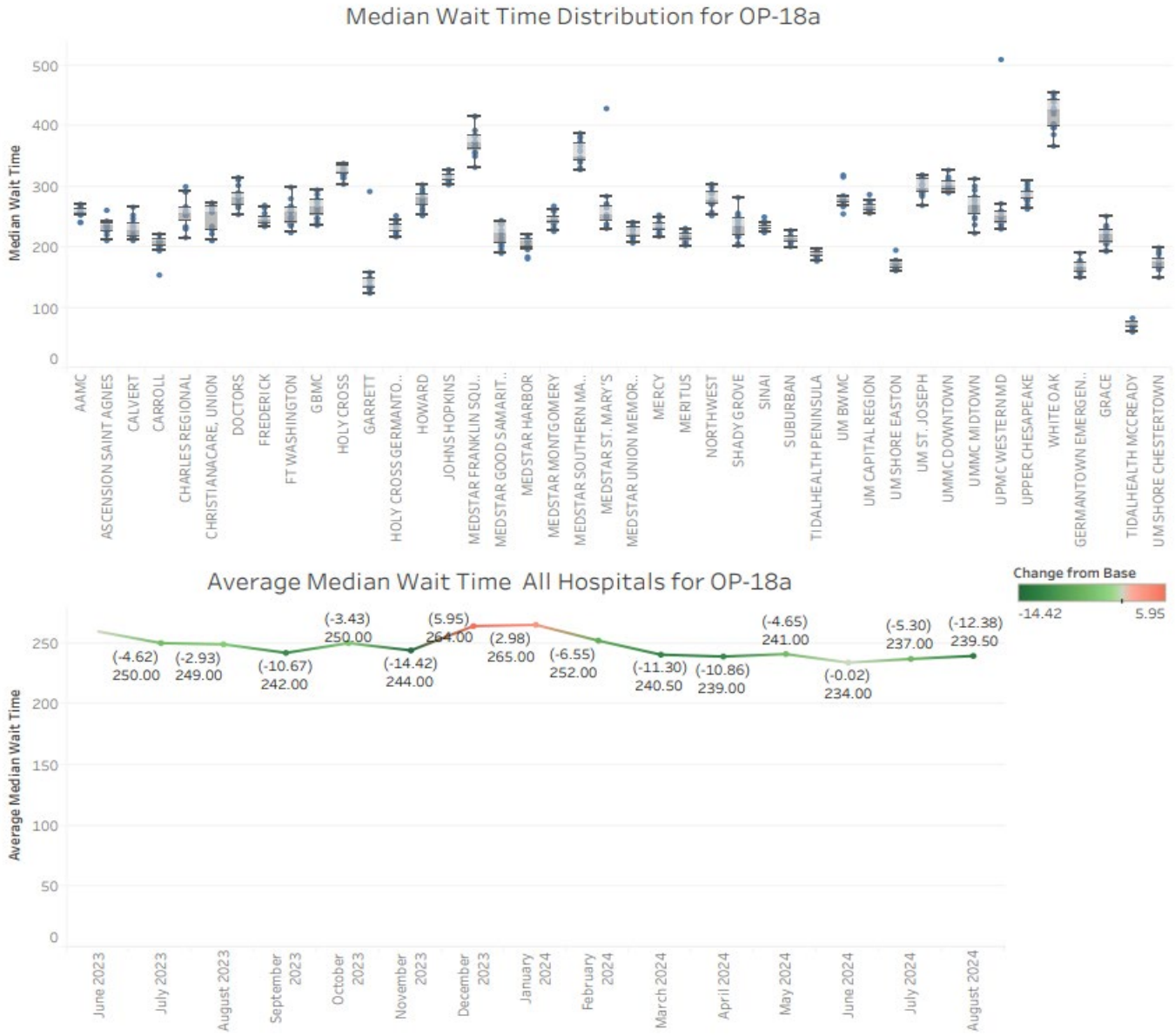
Change from Base
-564 2,701

Hospital Name	June 2023	July 2023	August 2023	September 2023	October 2023	November 2023	December 2023	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024
AAMC	535	883	719	643	1,335	951	1,009	1,017	757	790	629	578	812	618	740
ASCENSION SAINT AGNES	755	939	631	691	652	531	682	745	698	574	839			505	666
ATLANTIC GENERAL		345	160	262	286	490	255			254		242	210	322	
CALVERT	425	379	457	471	508	427	501	369	449	458	393	389	490	427	410
CARROLL	665	667	764	893	598	156	724	988	989	717	924	906	652	781	963
CHARLES REGIONAL	682	678	487	810	1,407	406	1,161	647	466	2,311	946	436	555	877	383
CHRISTIANACARE, UNION	290	184	268		424	422	764	431	463	388	331	375	355		405
DOCTORS	1,414	1,316	1,167	1,019	1,418	1,453	1,347	1,208	1,134	850	1,079	881	1,575	1,015	925
FREDERICK	506	517	540	514	613	534	586	609	613	557	514	586	471	606	501
GARRETT							470	717	428	786	131	691			252
GBMC	480	387	479	476	508	526	498	621	578	471	398	573	376	318	509
HOLY CROSS	642	416	518	568	903	559	532	933	831	400		526	495	671	920
HOLY CROSS GERMANTO..	410	320	643	400	412	458	1,208	919	643	818		215	584	447	697
HOWARD	1,524	1,512	1,338	1,597	1,699	1,602	1,701	1,815	1,728	1,519	1,603	1,547	1,598	1,740	1,545
JH BAYVIEW	1,309	1,205	1,440	1,376	1,383	1,394	1,475	1,316	1,348	1,147	1,294	1,115	1,431	1,214	
JOHNS HOPKINS	1,281	1,294	1,284	1,510	1,458	1,470	1,453	1,606	1,694	1,396	1,368	1,436	1,251	1,546	1,592
MEDSTAR FRANKLIN SQUA..	532	465	500	532	627	662	469	642	542	583	589	627	531	577	641
MEDSTAR GOOD SAMARIT..	446	502	590	549	608	522	827	1,045	725	577	401	588	441	637	684
MEDSTAR HARBOR	577	868	923	1,199	806	520	695	531	603	458	540	572	562	561	508
MEDSTAR MONTGOMERY	512	472	498	532	531	722	550	795	588	568	579	465	413	468	488
MEDSTAR SOUTHERN MA..	609	575	586	573	601	714	683	717	754	722	713	622	710	617	532
MEDSTAR ST. MARY'S	434	356	356	339	359	374	415	379	376	430	396	353	351	374	364
MEDSTAR UNION MEMORI..	464	681	473	358	475	431	612	470	530	407	553	371	480	518	525
MERCY	622	648	738	490	458	531	518	556	398	456	577	492	464	435	544
MERITUS	329	344	317	385	423	395	363	434	397	362	413	340	337	348	374
NORTHWEST	1,337	1,510	1,454	1,058	1,435	1,275	1,347	1,523	1,805	1,343	1,604	1,413	1,518	1,450	1,529
SHADY GROVE	633	805	526	760	450	573	592	497	739	594	589	552	607	471	466
SINAI	1,337	1,336	1,108	1,400	1,248	1,151	1,299	1,248	1,584	1,309	1,525	1,308	1,073	1,310	1,174
SUBURBAN	1,000	849	875	865	1,029	718	868	760	912	686	1,040	1,025	804	830	795
TIDALHEALTH PENINSULA		659	490	441	473	415	415	567	440	596	465	605	581	565	562
UM BWMC	1,359	1,400	1,349	1,654	1,216	1,176	1,146	1,271	1,255	1,183	1,360	1,483	1,310	1,191	1,378
UM CAPITAL REGION	1,379	1,445	1,189	1,169	1,299	1,191	1,147	1,272	1,146	931	959	950	1,212	1,096	1,155
UM SHORE EASTON	1,085	974	769	1,304	875	842	917	1,121	661	878	1,215	1,052	857	1,635	1,125
UM ST. JOSEPH	739	1,159	627	899	1,216	520	756	473	516	961	806	702	626	893	586
UMMC DOWNTOWN	1,491	1,410	1,419	1,222	1,510	1,519	1,541	1,249	1,599	1,253	1,286	1,605	1,047	1,482	1,390
UMMC MIDTOWN	1,001	1,341	1,431	1,078	1,317	664	1,238	698	767	830	855	661	721	1,134	941
UPMC WESTERN MD	513	520	508	510	525	484	560	640	695	437	428	539	403	1,034	468
UPPER CHESAPEAKE	377	1,135	679	1,513	948	1,283	1,096	848	1,096	953	1,404	1,231	1,243	629	735
WHITE OAK			2,701												

OP18a: ED Arrival to Discharge Time by Month



OP18a: ED Arrival to Discharge Time by Month



OP18a: ED Arrival to Discharge Time by Month

Average Median Wait Time All Hospitals for OP-18a

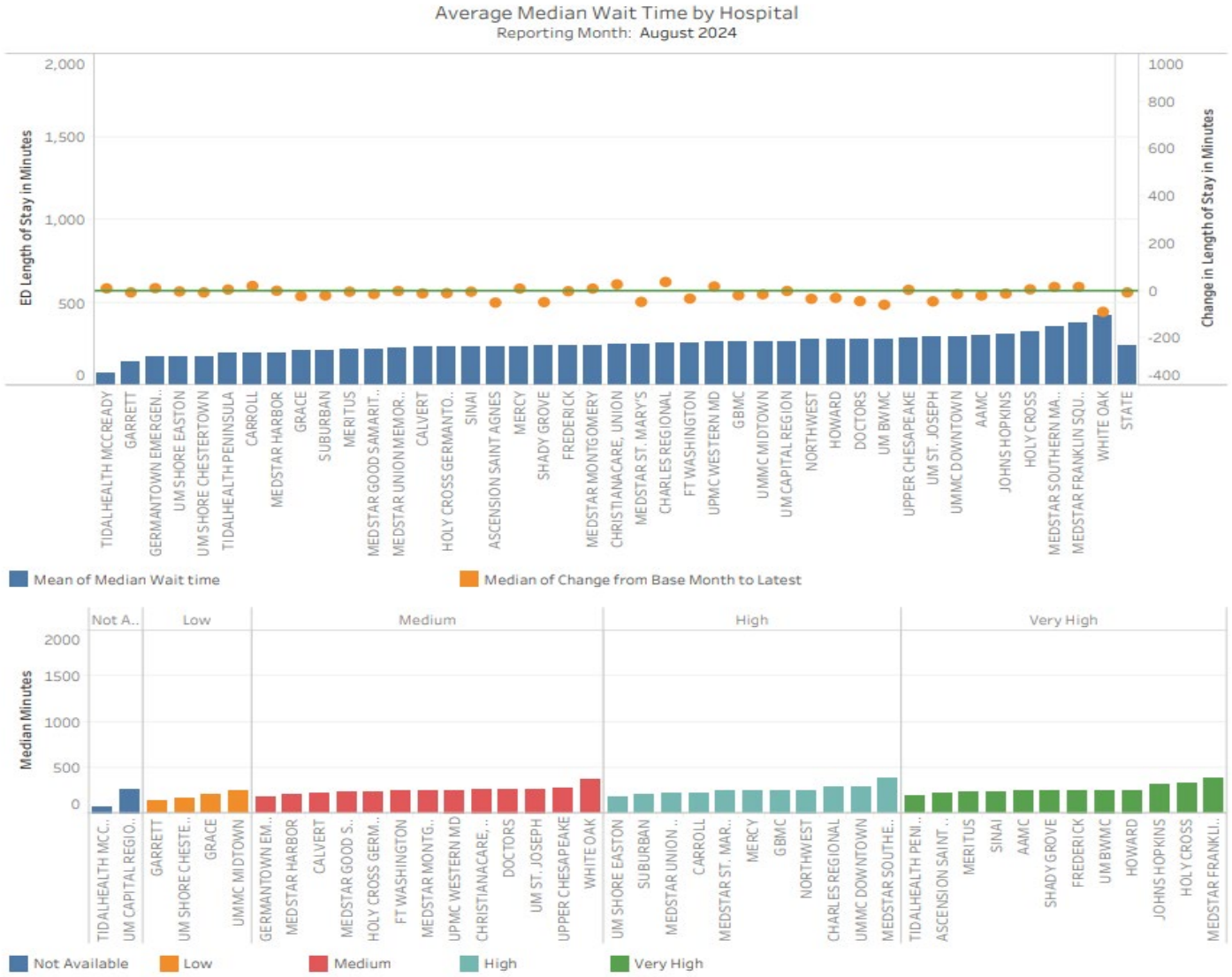
Measure
OP-18a

Change from Base
-88.0 295.0

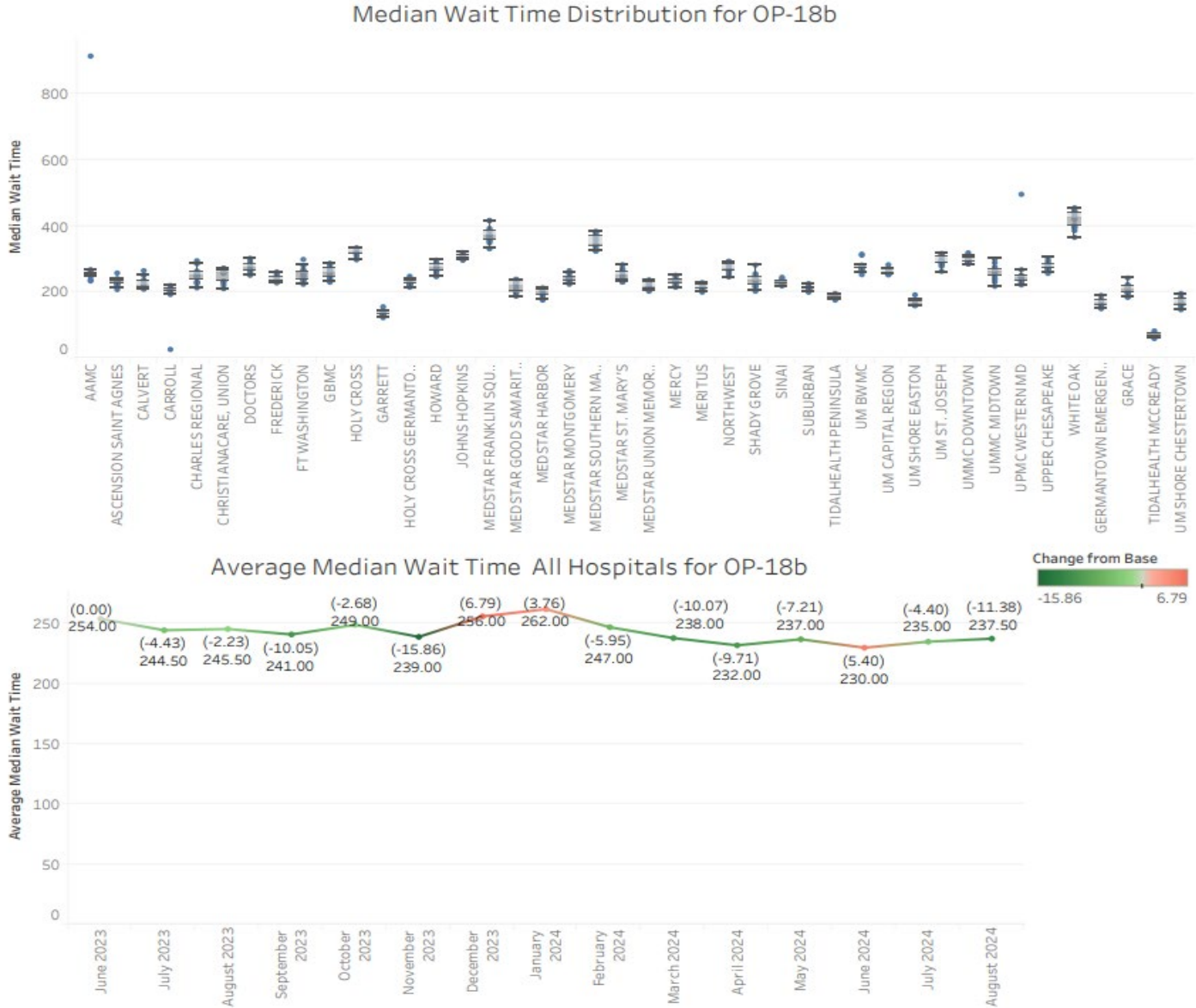
Hospital Name	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024
AAMC	258.0	255.0	260.0	254.0	266.0	263.0	271.0	268.0	256.0	258.0	253.0	241.0	255.0	258.0	241.0
ASCENSION SAINT AGNES	261.0	238.0	236.0	243.0	220.0	226.0	239.0	238.0	232.0	227.0	233.0			237.0	211.0
ATLANTIC GENERAL	124.0	127.0	131.0	133.0	128.0	123.0	134.0		125.0	122.0	128.0	132.0	126.0	129.0	
CALVERT	247.0	229.0	240.0	233.0	253.0	235.0	266.0	218.0	215.0	216.0	220.0	227.0	211.0	218.0	220.0
CARROLL	194.0	203.0	201.0	201.0	221.0	154.0	212.0	209.0	211.0	209.0	210.0	203.0	203.0	213.0	213.0
CHARLES REGIONAL	254.0	253.0	232.0	216.0	230.0	234.0	258.0	261.0	252.0	258.0	253.0	267.0	300.0	291.0	292.0
CHRISTIANACARE, UNION	229.0	234.0	222.0	211.0	211.0	234.0	271.0	265.0	272.0	258.0	260.0	266.0	273.0		258.0
DOCTORS	311.0	288.0	280.0	265.0	281.0	285.0	315.0	302.0	290.0	254.0	270.0	288.0	270.0	272.0	267.0
FREDERICK		249.0	248.0	236.0	240.0	244.0	265.0	269.0	256.0	234.0	240.0	237.0	241.0	236.0	249.0
FT WASHINGTON	268.0	238.0	262.0	247.0	260.0	259.0	299.0	280.0	266.0	259.0	250.0	240.0	224.0	237.0	235.0
GARRETT			145.0		150.0	147.0	158.0	134.0	132.0	138.0	124.0	292.0	135.0	132.0	130.0
GBMC	267.0	257.0	261.0	273.0	279.0	266.0	287.0	276.0	294.0	294.0	266.0	247.0	236.0	241.0	248.0
GERMANTOWN EMERGEN..	162.0	156.0	159.0	150.0	167.0				190.0	175.0	178.0	165.0	171.0	161.0	173.0
GRACE	236.0	251.0	226.0	221.0	228.0	206.0	233.0	227.0	209.0	215.0	212.0	222.0	193.0	195.0	205.0
HOLY CROSS	320.0	304.0	335.0	333.0	327.0	314.0	329.0	337.0	324.0	315.0		322.0	338.0	320.0	322.0
HOLY CROSS GERMANTO..	242.0	227.0	252.0	233.0	235.0	228.0	245.0	234.0	226.0	227.0		222.0	220.0	217.0	229.0
HOWARD	290.0	290.0	303.0	252.0	275.0	263.0	296.0	280.0	271.0	269.0	280.0	278.0	282.0	283.0	260.0
JH BAYVIEW	312.0	312.0	308.0	281.0	283.0	262.0	264.0	298.0	276.0	297.0	313.0	286.0	607.0	304.0	
JOHNS HOPKINS	328.0	319.0	318.0	309.0	312.0	303.0	305.0	313.0	311.0	309.0	319.0	315.0	327.0	311.0	319.0
MEDSTAR FRANKLIN SQUA..	357.0	373.0	382.0	365.0	374.0	385.0	416.0	416.0	332.0	350.0	355.0	365.0	367.0	393.0	372.0
MEDSTAR GOOD SAMARIT..	239.0	237.0	244.0	228.0	239.0	207.0	239.0	241.0	215.0	210.0	201.0	190.0	196.0	203.0	222.0
MEDSTAR HARBOR	213.0	213.0	211.0	202.0	214.0	181.0	196.0	200.0	184.0	202.0	203.0	210.0	210.0	220.0	210.0
MEDSTAR MONTGOMERY	232.0	226.0	247.0	238.0	259.0	246.0	262.0	268.0	249.0	244.0	229.0	249.0	247.0	246.0	240.0
MEDSTAR SOUTHERN MA..	367.0	344.0	331.0	328.0	340.0	329.0	388.0	381.0	358.0	360.0	374.0	348.0	345.0	348.0	382.0
MEDSTAR ST. MARY'S	284.0	269.0	272.0	251.0	254.0	249.0	265.0	265.0	252.0	233.0	247.0	232.0	429.0	231.0	238.0
MEDSTAR UNION MEMORI..	218.0	227.0	230.0	221.0	241.0	219.0	241.0	235.0	229.0	217.0	236.0	210.0	207.0	220.0	215.0
MERCY	232.0	241.0	231.0	219.0	218.0	222.0	233.0	249.0	236.0	237.0	225.0	253.0	234.0	233.0	239.0
MERITUS	225.0	207.0	207.0	221.0	211.0	203.0	225.0	231.0	221.0	218.0	221.0	219.0	219.0	213.0	221.0
NORTHWEST	288.0	291.0	304.0	279.0	291.0	290.0	299.0	272.0	271.0	273.0	277.0	272.0	271.0	258.0	252.0
SHADY GROVE	282.0	256.0	252.0	242.0	247.0	246.0	238.0	217.0	203.0	206.0	228.0	234.0	222.0	217.0	234.0
SINAI	232.0	240.0	250.0	232.0	233.0	233.0	243.0	236.0	229.0	232.0	227.0	231.0	224.0	231.0	226.0
SUBURBAN	227.0	216.0	227.0	217.0	219.0	210.0	209.0	214.0	213.0	206.0	208.0	217.0	201.0	209.0	208.0
TIDALHEALTH MCCREADY			62.0	73.0	83.0	67.0	75.0	68.0	74.0	70.0	69.0	74.0	73.0	60.0	72.0
TIDALHEALTH PENINSULA		184.0	190.0	196.0	195.0	191.0	192.0	184.0	190.0	182.0	182.0	177.0	185.0	183.0	191.0
UM BWMC	316.0	319.0	285.0	282.0	277.0	280.0	278.0	272.0	269.0	276.0	278.0	280.0	267.0	282.0	255.0
UM CAPITAL REGION	265.0	277.0	271.0	265.0	269.0	260.0	287.0	274.0	262.0	259.0	258.0	269.0	265.0	256.0	263.0
UM SHORE CHESTERTOWN	169.0	175.0	164.0	180.0	193.0	150.0	189.0	199.0	180.0	164.0	168.0	174.0	164.0	176.0	163.0
UM SHORE EASTON	178.0	165.0	172.0	174.0	163.0	161.0	178.0	195.0	164.0	173.0	164.0	174.0	167.0	174.0	178.0
UM ST. JOSEPH	313.0	305.0	313.0	319.0	319.0	291.0	318.0	302.0	295.0	287.0	284.0	296.0	293.0	291.0	269.0
UMMC DOWNTOWN	310.0	312.0	306.0	299.0	292.0	293.0	304.0	316.0	327.0	298.0	303.0	296.0	291.0	301.0	290.0
UMMC MIDTOWN	266.0	294.0	277.0	279.0	270.0	237.0	301.0	313.0	284.0	270.0	247.0	260.0	223.0	267.0	249.0
UPMC WESTERN MD	233.0	236.0	248.0	250.0	272.0	260.0	259.0	256.0	256.0	250.0	238.0	240.0	230.0	510.0	258.0
UPPER CHESAPEAKE	278.0	280.0	278.0	270.0	280.0	282.0	308.0	303.0	294.0	277.0	287.0	297.0	288.0	263.0	280.0
WHITE OAK	455.0	404.0	420.0	397.0	452.0	402.0	426.0	445.0	439.0	397.0	386.0	444.0	430.0	425.0	367.0

OP18b: ED Arrival to Discharge Time - Non-Psychiatric

Measure
OP-18b



OP18b: ED Arrival to Discharge Time - Non-Psychiatric



OP18b: ED Arrival to Discharge Time - Non-Psychiatric

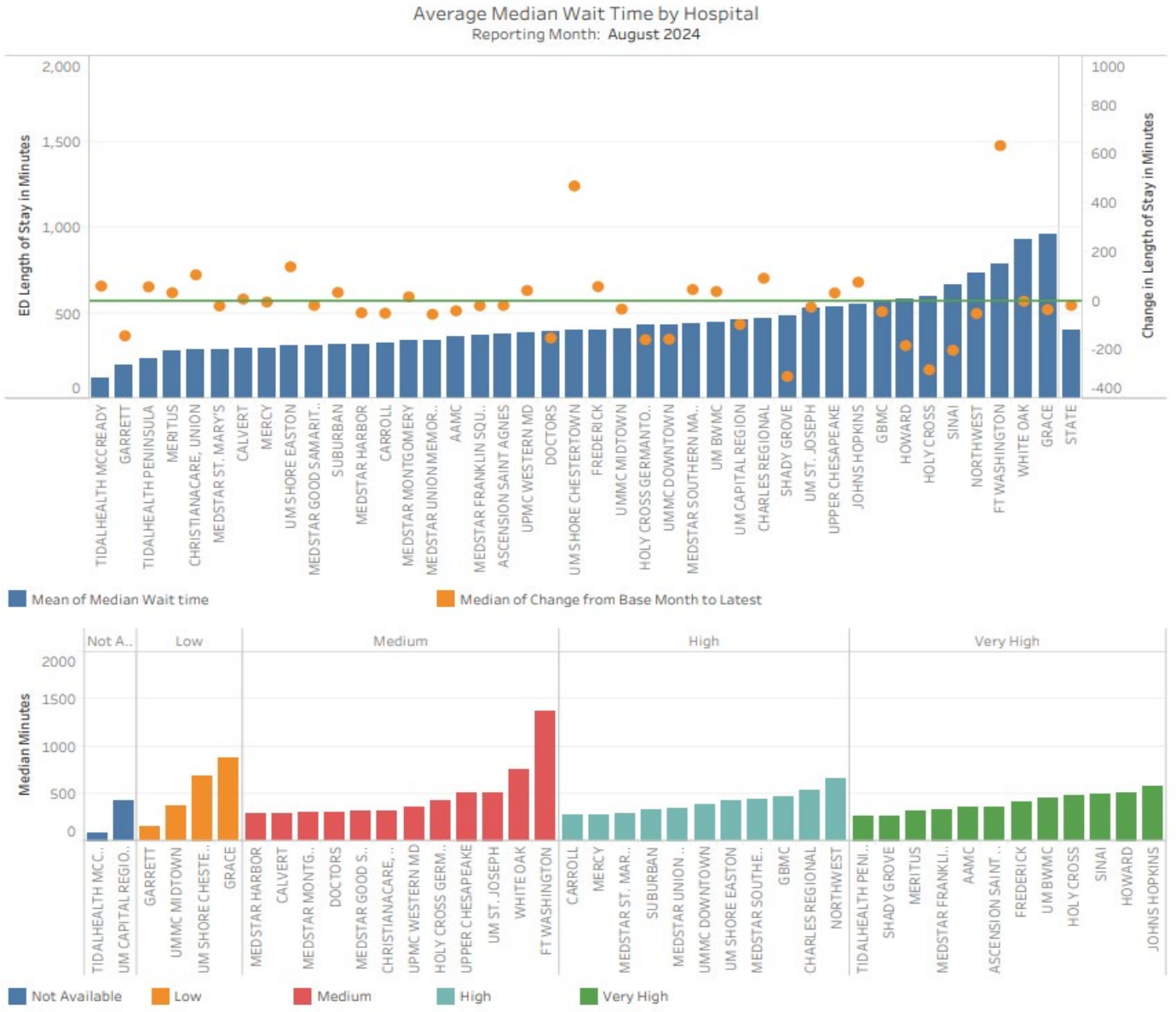
Average Median Wait Time All Hospitals for OP-18b

Measure
OP-18b

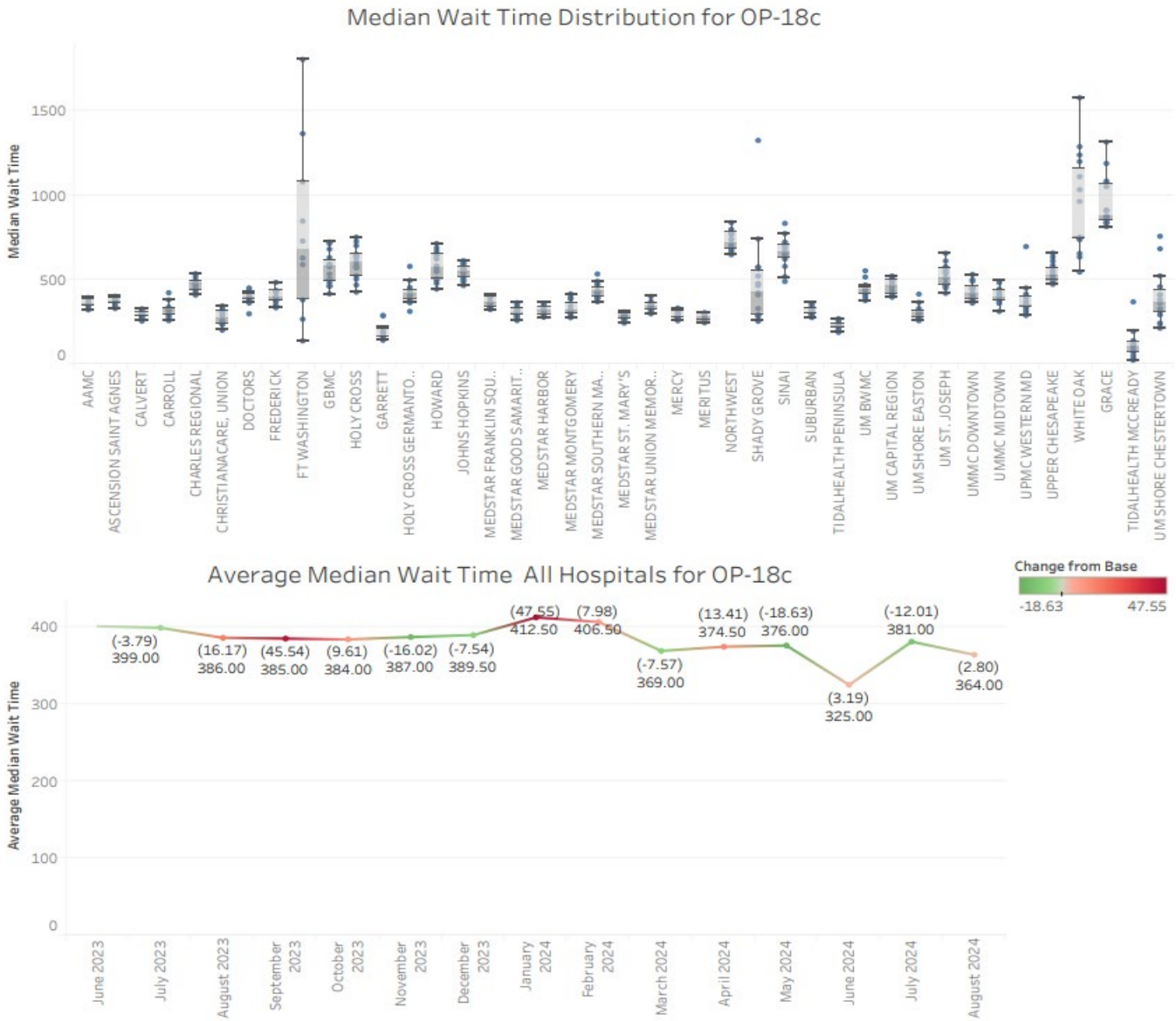
Change from Base
-166.0 660.0

Hospital Name	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024
AAMC	254.0	251.0	257.0	248.0	256.0	260.0	268.0	266.0	254.0	259.0	251.0	237.0	914.0	254.0	234.0
ASCENSION SAINT AGNES	258.0	235.0	232.0	241.0	216.0	225.0	225.0	234.0	228.0	224.0	230.0			235.0	208.0
ATLANTIC GENERAL	123.0	126.0	130.0	132.0	127.0	122.0	134.0		124.0	121.0	127.0	132.0	125.0	128.0	
CALVERT		229.0	237.0	231.0	251.0	233.0	265.0	216.0	212.0	212.0	218.0	224.0	209.0	216.0	218.0
CARROLL	193.0	201.0	200.0	201.0	220.0	27.0	210.0	207.0	209.0	207.0	209.0	202.0	202.0	212.0	213.0
CHARLES REGIONAL	250.0	247.0	230.0	213.0	226.0	232.0	255.0	259.0	247.0	253.0	250.0	264.0	295.0	287.0	287.0
CHRISTIANACARE, UNION	230.0	234.0	222.0	211.0	211.0	234.0	272.0	265.0	272.0	257.0	260.0	265.0	272.0		257.0
DOCTORS	302.0	272.0	274.0	260.0	285.0	280.0	301.0	291.0	280.0	251.0	263.0	280.0	264.0	266.0	258.0
FREDERICK		246.0	245.0	232.0	235.0	239.0	256.0	261.0	251.0	229.0	234.0	233.0	235.0	229.0	244.0
FT WASHINGTON	268.0	238.0	261.0	247.0	260.0	259.0	299.0	280.0	265.0	259.0	250.0	240.0	224.0	237.0	235.0
GARRETT			138.0		145.0	144.0	156.0	133.0	132.0	137.0	123.0	134.0	134.0	130.0	131.0
GBMC	262.0	248.0	255.0	265.0	273.0	259.0	282.0	269.0	287.0	286.0	257.0	240.0	230.0	235.0	243.0
GERMANTOWN EMERGEN..	162.0	156.0	159.0	150.0	167.0				190.0	175.0	178.0	165.0	171.0	161.0	173.0
GRACE	220.0	243.0	218.0	209.0	212.0	199.0	223.0	215.0	200.0	203.0	197.0	210.0	185.0	185.0	197.0
HOLY CROSS	315.0	298.0	330.0	328.0	324.0	309.0	326.0	334.0	322.0	313.0		320.0	333.0	318.0	321.0
HOLY CROSS GERMANTO..	237.0	224.0	248.0	232.0	232.0	225.0	242.0	230.0	223.0	226.0		220.0	219.0	215.0	227.0
HOWARD	284.0	287.0	297.0	247.0	268.0	259.0	289.0	275.0	264.0	265.0	275.0	273.0	277.0	276.0	254.0
JH BAYVIEW	290.0	290.0	288.0	268.0	272.0	252.0	250.0	285.0	259.0	286.0	306.0	281.0	289.0	288.0	
JOHNS HOPKINS	320.0	312.0	308.0	299.0	304.0	297.0	298.0	302.0	304.0	302.0	313.0	305.0	318.0	300.0	308.0
MEDSTAR FRANKLIN SQUA..	357.0	373.0	384.0	369.0	376.0	387.0	417.0	416.0	331.0	349.0	354.0	363.0	367.0	393.0	373.0
MEDSTAR GOOD SAMARIT..	234.0	231.0	239.0	225.0	234.0	202.0	237.0	238.0	210.0	208.0	198.0	188.0	190.0	200.0	220.0
MEDSTAR HARBOR	204.0	204.0	201.0	190.0	203.0	176.0	189.0	193.0	178.0	193.0	198.0	201.0	206.0	213.0	204.0
MEDSTAR MONTGOMERY	230.0	224.0	245.0	233.0	256.0	243.0	258.0	265.0	246.0	240.0	228.0	246.0	244.0	244.0	239.0
MEDSTAR SOUTHERN MA..	366.0	342.0	328.0	324.0	335.0	325.0	384.0	377.0	356.0	359.0	372.0	343.0	343.0	346.0	382.0
MEDSTAR ST. MARY'S	283.0	268.0	271.0	250.0	251.0	247.0	263.0	263.0	250.0	231.0	245.0	231.0	242.0	231.0	236.0
MEDSTAR UNION MEMORI..	211.0	221.0	226.0	218.0	235.0	215.0	237.0	232.0	225.0	212.0	230.0	205.0	203.0	214.0	210.0
MERCY	230.0	238.0	229.0	217.0	215.0	219.0	233.0	247.0	233.0	236.0	222.0	251.0	233.0	231.0	239.0
MERITUS	223.0	205.0	205.0	219.0	209.0	200.0	224.0	229.0	220.0	216.0	219.0	215.0	216.0	212.0	219.0
NORTHWEST	280.0	282.0	293.0	270.0	284.0	283.0	293.0	266.0	263.0	266.0	270.0	266.0	267.0	253.0	246.0
SHADY GROVE	282.0	256.0	252.0	241.0	247.0	245.0	238.0	217.0	203.0	206.0	227.0	234.0	222.0	217.0	234.0
SINAI	226.0	236.0	245.0	226.0	228.0	230.0	240.0	232.0	225.0	228.0	223.0	226.0	219.0	225.0	222.0
SUBURBAN	226.0	214.0	224.0	214.0	217.0	207.0	207.0	211.0	211.0	204.0	205.0	215.0	200.0	207.0	206.0
TIDALHEALTH MCCREADY			62.0	73.0	83.0	66.0	75.0	67.0	73.0	70.0	68.0	74.0	72.0	60.0	72.0
TIDALHEALTH PENINSULA		184.0	190.0	195.0	196.0	190.0	191.0	183.0	190.0	181.0	182.0	176.0	184.0	182.0	189.0
UM BWMC	312.0	315.0	282.0	279.0	271.0	277.0	274.0	269.0	264.0	273.0	274.0	277.0	263.0	278.0	253.0
UM CAPITAL REGION	261.0	273.0	267.0	260.0	264.0	256.0	283.0	270.0	259.0	253.0	254.0	267.0	263.0	253.0	260.0
UM SHORE CHESTERTOWN	166.0	171.0	160.0	176.0	184.0	147.0	185.0	196.0	177.0	161.0	167.0	167.0	162.0	170.0	159.0
UM SHORE EASTON	176.0	162.0	169.0	171.0	161.0	159.0	175.0	192.0	161.0	169.0	162.0	169.0	164.0	170.0	173.0
UM ST. JOSEPH	308.0	296.0	309.0	314.0	313.0	289.0	317.0	298.0	290.0	281.0	279.0	293.0	291.0	286.0	263.0
UMMC DOWNTOWN	301.0	306.0	298.0	293.0	289.0	290.0	299.0	311.0	319.0	294.0	297.0	292.0	285.0	294.0	287.0
UMMC MIDTOWN	254.0	276.0	267.0	265.0	262.0	231.0	289.0	300.0	271.0	263.0	243.0	251.0	218.0	262.0	239.0
UPMC WESTERN MD	229.0	232.0	246.0	244.0	268.0	249.0	251.0	249.0	247.0	244.0	227.0	234.0	222.0	496.0	247.0
UPPER CHESAPEAKE	269.0	275.0	272.0	265.0	275.0	276.0	304.0	296.0	285.0	269.0	279.0	290.0	283.0	257.0	273.0
WHITE OAK	455.0	403.0	419.0	395.0	452.0	402.0	426.0	444.0	438.0	396.0	386.0	443.0	429.0	425.0	366.0

OP18c: ED Arrival to Discharge Time by Month



OP18c: ED Arrival to Discharge Time by Month



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

Average Median Wait Time All Hospitals for OP-18c

Measure
OP-18c

Change from Base
-590 1,072

Hospital Name	June 2023	July 2023	August 2023	September 2..	October 2023	November 20..	December 20..	January 2024	February 2024	March 2024	April 2024	May 2024	June 2024	July 2024	August 2024
AAMC	394	383	353	385	393	372	363	349	344	330	322	331		360	353
ASCENSION SAINT AGNES	379	342	389	330	371	384	387	391	402	365	373			346	360
ATLANTIC GENERAL	164	179	175	151	156	136	158		171	149	159	139	185	167	
CALVERT		282	302	302	318	270	328	283	301	307	292	288	256	266	289
CARROLL	322	423	323	260	296	339	325	329	286	320	381	330	299	260	271
CHARLES REGIONAL	444	433	419	453	476	487	475	414	521	410	502	488	472	446	536
CHRISTIANACARE, UNION	202	236	238	260	253	250	237	341	306	316	324	345	287		308
DOCTORS	451	363	389	393	380	397	404	447	411	389	397	432	386	380	299
FREDERICK		343	335	376	426	395	435	484	433	396	435	373	350	382	401
FT WASHINGTON	729	847	1,078					1,801	629	381		590	267	139	1,363
GARRETT			288		288	167	154	144	166	169	167	188	193	217	145
GBMC	506	681	587	631	534	714	592	586	576	723	482	417	463	498	462
GERMANTOWN EMERGEN..	87	69							246	105		18			
GRACE	912	845	1,083	1,313	1,187	909	859	837	833	1,050	814	872	1,074	877	876
HOLY CROSS	751	609	726	701	586	642	524	577	569	633		427	651	504	469
HOLY CROSS GERMANTO..	579	496	386	364	426	434	383	406	415	454		429	313	411	420
HOWARD	687	445	503	550	571	496	549	714	644	479	582	667	623	647	504
JH BAYVIEW	659	678	714	598	635	684	630	593	601	574	583	417	492	562	
JOHNS HOPKINS	496	488	583	595	564	540	612	598	508	550	466	546	557	520	572
MEDSTAR FRANKLIN SQUA..	353	365	337	324	328	370	405	406	398	366	364	403	342	398	333
MEDSTAR GOOD SAMARIT..	324	333	292	314	364	285	337	351	315	273	298	259	280	291	305
MEDSTAR HARBOR	333	336	322	346	361	279	316	330	297	310	282	338	289	296	284
MEDSTAR MONTGOMERY	276	320	302	345	386	309	392	416	322	396	313	282	319	290	292
MEDSTAR SOUTHERN MA..	390	426	422	399	467	432	479	491	398	412	429	534	388	370	436
MEDSTAR ST. MARY'S	302	293	310	271	289	295	297	290	293	269	275	244	276	259	281
MEDSTAR UNION MEMORI..	401	332	307	325	359	299	359	346	342	303	371	359	320	357	346
MERCY	276	302	287	274	289	275	269	324	326	258	333	319	285	307	271
MERITUS	269	251	246	262	266	301	284	293	256	283	300	291	305	254	302
NORTHWEST	700	776	698	767	677	669	713	739	680	776	795	661	837	797	648
SHADY GROVE	574	294	741	1,323	466	411	288	330	478	288	574	255	522	423	265
SINAI	692	672	648	717	622	518	698	659	833	773	722	634	579	657	490
SUBURBAN	300	322	359	299	362	300	291	308	295	277	346	305	279	325	334
TIDALHEALTH MCCREADY			24	52	140	369	74	133	74	37	195	121	113	103	84
TIDALHEALTH PENINSULA		202	225	254	189	270	227	208	197	226	226	237	232	221	259
UM BWMC	413	469	377	446	420	446	553	443	440	434	397	404	516	442	451
UM CAPITAL REGION	508	473	488	522	406	491	514	465	397	497	455	425	436	407	411
UM SHORE CHESTERTOWN	214	313	411	329	382	293	363	411	459	324	239	757	244	523	683
UM SHORE EASTON	276	265	330	314	275	258	307	366	274	307	304	296	311	301	415
UM ST. JOSEPH	537	656	548	611	576	451	469	479	420	471	461	508	559	575	511
UMMC DOWNTOWN	531	419	448	500	416	365	443	450	455	363	391	376	399	491	374
UMMC MIDTOWN	398	440	420	483	379	390	426	492	444	416	376	398	313	361	364
UPMC WESTERN MD	309	415	289	398	337	399	353	349	451	372	338	367	325	696	351
UPPER CHESAPEAKE	473	556	526	495	482	585	657	634	611	525	538	498	495	494	505
WHITE OAK	748	655	545	1,198	963	634	737	1,237	1,032	1,109	1,286	750	1,575	746	746

EMS Turnaround Times: May Performance

- 22 hospitals reported the 90th percentile of turnaround time was <=35 minutes
- 25 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): Suburban Hospital
  - (Low performing to average): Baltimore Washington Medical Center, Doctors Community Medical Center, Fort Washington Medical Center
- Hospitals with declining performance
  - (High performing to average): CalvertHealth Medical Center, Franklin Square, Good Samaritan Hospital, Union Hospital
  - (Average to low performing) : St. Agnes Hospital, White Oak Medical Center

EMS Turnaround Times: August 2024 Performance

90th Percentile: 0-35 Minutes

Atlantic General Hospital
Cambridge Free-Standing ED
Chestertown
Frederick Health Hospital
Garrett Regional Medical Center
Germantown Emergency 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 Memorial Hospital
Upper Chesapeake Health Aberdeen
Walter Reed National Military Medical Center
Western Maryland

>35 Minutes

Anne Arundel Medical Center
Baltimore Washington Medical Center+
Bowie Health Center
CalvertHealth Medical Center-
Carroll Hospital Center
Doctors Community Medical Center +
Easton
Fort Washington Medical Center +
Franklin Square -
Good Samaritan Hospital -
Grace Medical Center
Greater Baltimore Medical Center
Harbor Hospital
Howard County Medical Center
Johns Hopkins Bayview
Johns Hopkins Hospital ADULT
Laurel Medical Center
Mercy Medical Center
Midtown
Northwest Hospital
Sinai Hospital
St. Joseph Medical Center
Union Hospital -
University of Maryland Medical Center
Upper Chesapeake Medical Center

>60 Minutes

Capital Region Medical Center
Charles Regional
Southern Maryland Hospital
St. Agnes Hospital -
White Oak Medical Center -

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

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Hospital Free Care Reimbursement Law Implementation

Update

Zach Starr, Intern, Policy and Government Affairs

September 11th, 2024

Overview of Law

HSCRC must coordinate with MDH, DHS, the Office of the Comptroller, HEAU, MSDE, and the Maryland Hospital Association (MHA) to develop a process that:

1. **Identifies** hospital **patients** who paid more than $25 for hospitals services provided in 2017-2021 who qualified for free care, using data from hospitals, the Comptroller, SNAP, Maryland's energy assistance program, and WIC;
2. **Provides reimbursement** from the hospital to the identified patients;
3. **Uses a "safe address"** to contact the patient if available; and
4. Ensure the state agencies **share and disclose** relevant information to the hospitals in compliance with state and federal law and **to the minimum extent necessary** to carry out the required process.

Health General § 19-214.4, as amended by Chapter 310 (2023)

Progress and Key Events

February

Identified major operational challenges w/ the planned data sharing process.

Agreed on new approach: State Agencies would notify patients.

March-May

Developed an outline of a new process with input from stakeholders and legislators.

June

Draft contractual documents for hospitals and state agencies were released to stakeholders for public comment.

July

Comments identified a legal barrier* that specifically prohibits a process that includes State agencies notifying patients.

August

HSCRC met with legislators to notify them of the issue and develop a path forward for implementation.

Legislators agreed to meet with stakeholders and discuss potential 2025 legislation, workgroup members were notified of the barrier.

*Health General § 19-214.4(g)(3), as amended by Chapter 310 (2023)

Legal Barrier to Implementation - Overview

- Prohibitive legal language added in 2023:

  "The Office of the Comptroller, the Department of Human Services, the Department, the State Department of Education, the Commission, and each hospital may not implement the alternative approach included with Option 3 in the report identified under paragraph (2)(i) of this subsection".

- This "alternative" is the workflow that stakeholders agreed to in February.
- Hospitals and State agencies cannot sign contractual documents to commit to this process until this barrier is removed.

Health General § 19-214.4(g)(3), as amended by Chapter 310 (2023)

HSCRC, "Free Hospital Care Refund Process"

Expected Solution

- HSCRC expects legislators will schedule a meeting with stakeholders in the upcoming months to discuss possible 2025 legislation.
- HSCRC anticipates that a bill will be introduced in 2025 by one of the key legislators to solve this issue.
- Based on this expectation, HSCRC will continue to work with stakeholders this fall to prepare for implementation in the spring.
- The goal is to have contractual documents ready for signature by hospitals and state agencies as soon as the expected legislation becomes law.
- Based on this timeline, refunds will likely start going out to eligible patients in the second half of 2025.

Thank you!

- Megan Renfrew, Deputy Director, Policy and Consum
  - Megan.Renfrew1@Maryland.gov
  - 410-382-3855 (cell)
- Zach Starr, Intern, Policy and Government Affairs
  - zachary.starr@maryland.gov

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To: **HSCRC Commissioners**

From: **Megan Renfrew, Deputy Director, Policy and Consumer Protection**

Deb Rivkin, Director, Government Affairs

Date: **September 3, 2024**

Re: **Legality of the Proposed Reimbursement Process**

Background

Maryland law (the "Reimbursement Law") requires general acute care and chronic care hospitals to provide refunds to eligible patients (Health General §19-214.4). Patients who paid more than $25 for hospital services received in any year between 2017 and 2021 and were eligible, at the time of service, for free care from the hospital under Maryland's law related to hospital financial assistance (HG §19-214.1) are eligible for these refunds.

Issue

During the 2024 session, HSCRC staff worked with legislators and other stakeholders to address the workflow that HSCRC staff developed, with stakeholders, in 2023. These meetings lead to agreement on a new workflow. Under this workflow, state agencies, rather than hospitals, would send the letters to patients to notify them of the eligibility of the patient for a refund. Patients would then contact hospitals to confirm their eligibility for refunds. This process was chosen because it does not require the sharing of State data between state agencies, and it does not require the sharing of State agency data with hospitals. Hospitals, State agencies, and consumer advocates decided that this alternative approach was the most feasible option for implementing this law. Because HG § 19-214.4(d)(1) gives the Commission broad authority when implementing this law, we believed we had authority to make this change.

As the HSCRC worked with hospitals to implement the process we agreed on during the legislative session, stakeholders notified HSCRC that this process is prohibited by law. We've included a detailed description of this issue on the next page of this memo.

HSCRC informed key legislators of this issue in July. In order to fix this issue, interested legislators and stakeholders will need to introduce legislation in the 2025 session to remove the legal language that prohibits this process. In addition, the legislation will need to extend the

sunset date in the law beyond June 30th, 2025, to give the hospitals and state agencies sufficient time to implement the law.

Expected Process

HSCRC expects legislators will schedule a meeting with key stakeholders later this month to discuss possible 2025 legislation. HSCRC anticipates that a bill will be introduced in 2025 to solve this issue. Based on that expectation, HSCRC plans to continue to work with stakeholders to prepare for implementation of the bill over the next few months, with the goal of having contractual documents for state agencies and hospitals to sign as soon as the expected legislation becomes law.

Background

In 2022, the HSCRC produced a report titled “Free Hospital Care Refund Process” to outline the options available for implementing HG §19-214.4. In this report, three options for identifying eligible patients and distributing refunds were outlined.

The General Assembly mandated that Option 3 be implemented in HG § 19-214.4(g)(2). Option 3 requires State agencies and hospitals to identify patients eligible for refunds by starting with data from hospitals. This hospital data is then matched to State agency data to confirm. Hospitals would distribute a letter to notify that patient of their eligibility and instruct them on how to request a refund. Early in 2024, the HSCRC and other state agencies identified operational challenges to using option 3. These challenges were related to legal barriers to third-party access to state agency data. Hospitals and some state agencies rely on third-party contractors and software for operational tasks that are key to implementing this process.

During the 2024 legislative session, all interested parties, including State agencies, hospitals, and consumer advocates, met with you and agreed to develop a process that allows the State agencies to distribute letters to patients using hospital and State agency data. Hospitals, State agencies, and consumer advocates decided that this alternative approach is the most feasible option for implementing this law. We believed that the language below allowed HSCRC to make this change in the process.

HG § 19-214.4(d)(1): “The Commission may modify the process developed under subsection (a) of this section as necessary.”

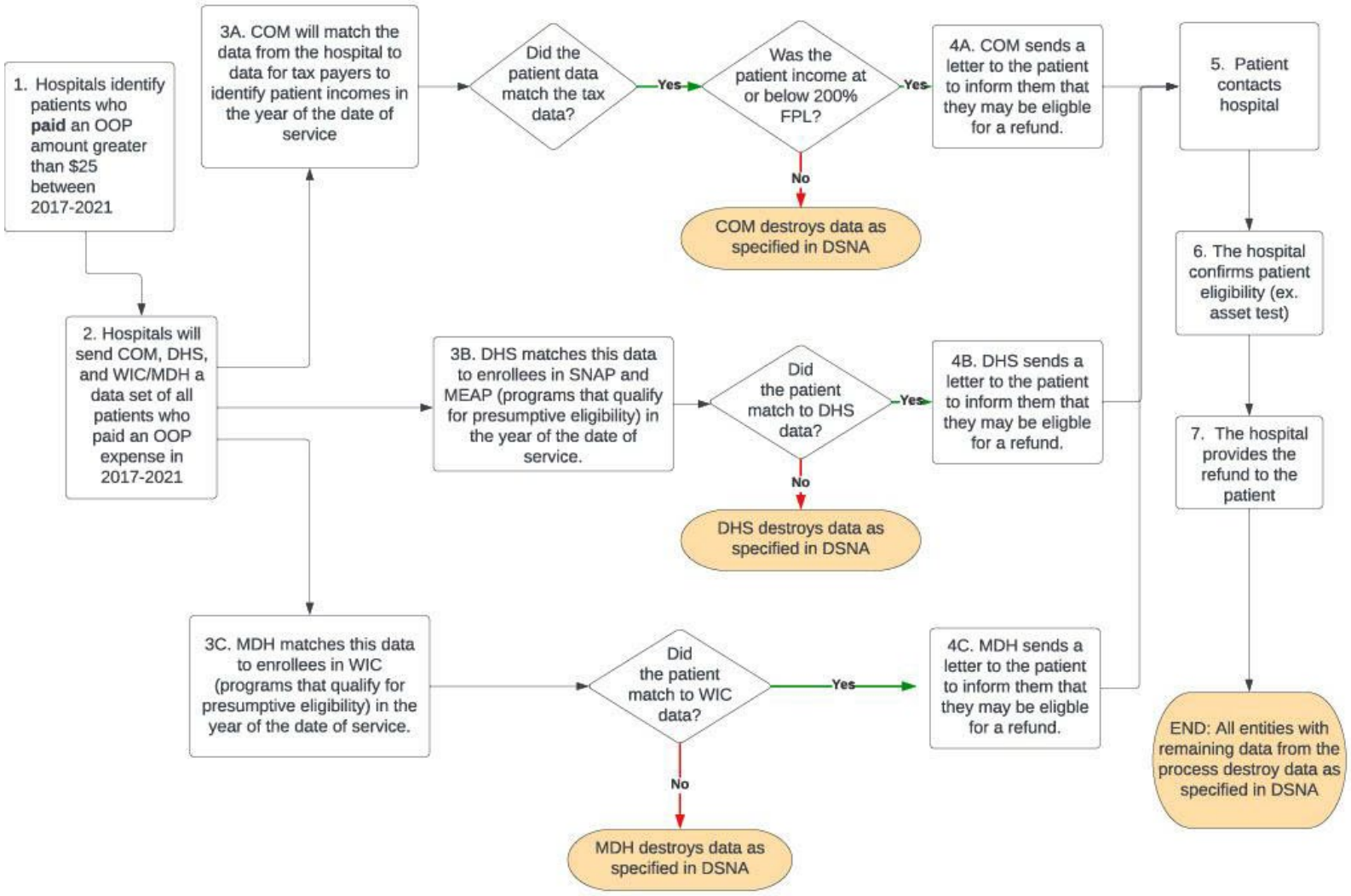
HSCRC worked closely with hospitals and other stakeholders to further develop this new process. We recently discovered that this process matches the description of a process that is *explicitly prohibited* by statute in HG § 19-214.4(g)(3).

“The Office of the Comptroller, the Department of Human Services, the Department, the State Department of Education, the Commission, and each hospital may not implement the alternative

approach included with Option 3 in the report identified under paragraph (2)(i) of this subsection"

This prohibition supersedes the Commission's authority to change the process in subsection (d)(1) of HG 19-214.4. The implementation of the hospital refunds cannot move forward since the process we agreed to during the legislative session is in violation of the law.

Appendix A: Current Workflow



Appendix B: Description of Option 3 and Alternative Approach - Excerpt from 2022 "Free Hospital Care Refund Process" Report

"Option 3: Start with Hospital Data

Under Option 3, the process starts with data from hospitals on patients who paid bills for services in the time period. This data would be combined with data from the Office of the Comptroller and DHS (and MDH and MSDE, if applicable) to identify patients who may be eligible for refunds for hospital financial assistance.

First, hospitals would identify all patients who paid an out-of-pocket expense for dates of service between 2017 and 2021. Each hospital will share an identifiable data set with the Office of the Comptroller that contains, for each patient, name, address in the year of the date of service, hospital name, the date of the hospital service, and other specified data elements specified to allow for data matching.

The Office of the Comptroller would match the hospital data with tax data and identify patients who received hospital services, paid out-of-pocket costs, and were at or below 200 percent FPL during the year of the service dates. After this matching process, the Office of the Comptroller would:

- send the data for those patients who were identified as having incomes at or below 200 percent FPL to the hospital;
- destroy data received from hospitals for patients over 200 percent FPL, as these patients likely do not qualify for free hospital care; and
- share with DHS (and MDH and MSDE, if applicable), identifiable data for patients that did not match to tax data that would contain, for each patient, name, address in the year of the date of service, hospital name, the date of the hospital service, and other specified data elements specified to allow for data matching.

The DHS (and MDH and MSDE, if applicable) would use the hospital data shared by the Office of the Comptroller for patients who paid a bill but did not match to tax data to match with enrollees in SNAP and Energy Assistance during the year of the service date. DHS (and MDH and MSDE, if applicable) would destroy data for patients who did not match. For patients that DHS (or MDH, or MSDE) identified as being enrolled in these programs, the applicable State agency would send that patient's data to the hospital. The hospital would then contact the patient to inform them that they may be due a refund. At the patient's request, the hospital would determine if the patient was eligible for free care and, if so, provide a refund.

An alternative approach would be for each of the State agencies above to send letters to the patients that may have qualified for financial assistance based on their income or program

enrollment. Patients would reach out to the hospitals to request a refund based on the letters received from the State agencies. Based on the letter, the hospital would determine if the patients were eligible for free care and provide a refund to those that overpaid. This alternative approach would minimize the sharing of State data with hospitals but not allow for the use of patient portals for those patients that use portals. As discussed above, patient portals are the preferred method for contacting patients. Hospitals expressed concerns that they will not be able to validate the authenticity of the letters that patients present to them related to potential eligibility for hospital refunds, since the hospitals will not have direct access to the information from the State agencies under this alternative approach."

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Set Aside Discussion

September 11, 2024

Overview

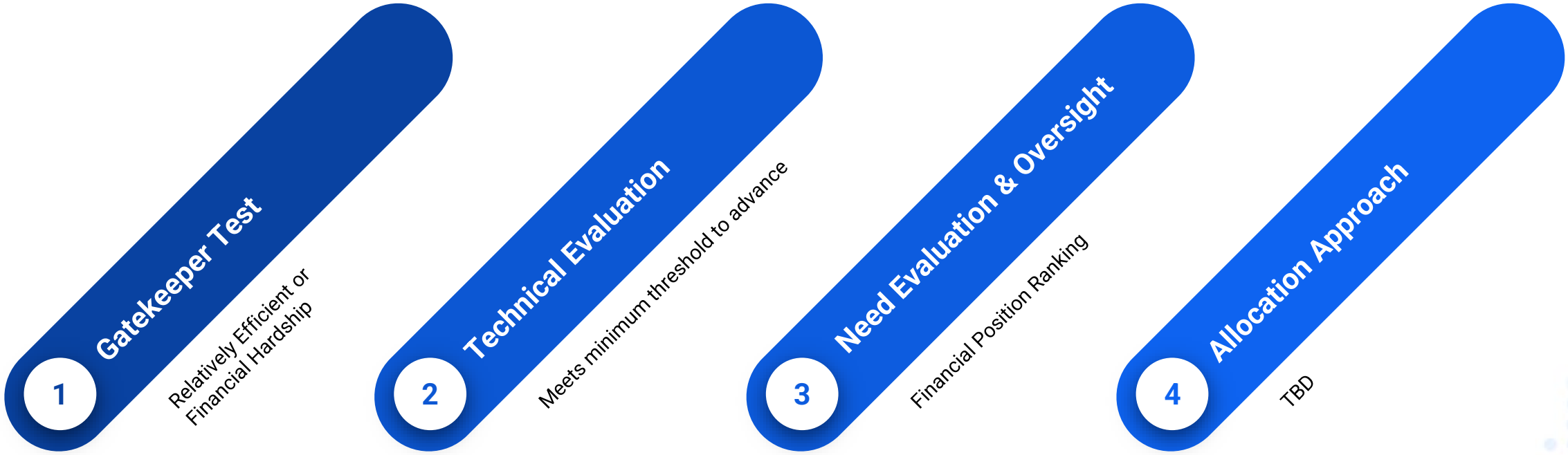
The intention of the set-aside is to use these funds for:

- Unforeseen events that occur at hospitals with a financial hardship, regardless of efficiency (e.g., cyberattacks)
- Enhancements for relatively efficient hospitals

Due to the volume of submissions & requested funding, staff would like Commissioners to weigh in on:

- Criteria for evaluation
- Weighting of evaluation criteria
- Evaluation responsibility

Process Overview



Scoring Rubric: Technical Evaluation

A) Financial Hardship Technical Evaluation

- Unforeseen and/or Preventable Ranking
  - *Is the request being made due to poor decision making/investments?*

A) Relative Efficiency Technical Evaluation

- Population Health Ranking
  - *Does the proposed intervention improve the health of the population?*
- Methodology Disadvantage Ranking
  - *How material is the adverse impact from a methodology?*

Scoring Rubric: Need Evaluation & Oversight

- Financial Assessment (e.g., 33 points)
  - FY24 Total Margin (Regulated + Unregulated)
    - Variance to Statewide Average
  - FY24 Regulated Margin
    - Variance to Statewide Average
  - Days Cash
    - Variance to Statewide Average

Potential Allocation Methodology

- Improvement Opportunities (e.g., 33 points)
  - Cost per ECMAD
    - Variance from Statewide Average
  - Overhead Cost per ECMAD
    - Variance from Statewide Average
  - Margin from Unregulated System Operations
    - Variance from Statewide Average
  - PAU
    - Variance from Statewide Average

- Oversight & Accountability (e.g., 33 points)
  - Controls to mitigate financial position
    - *How will hospital management find sustainable reductions in cost to offset funding priorities?*
  - Pledge/management commitment
    - *Should funding be conditional on a pledge to not repeat funding requests or reduce other administrative costs for the next 2 years?*

Discussion Topics for Commissioners

- What constitutes a minimally viable technical proposal?
- Should some criteria be weighted more favorably in the overall evaluation?
  - For example, should hospital regulated margin weigh more than total margin?
- Are there any suggestions for how to allocate the funding?
  - For example, should funds be allocated based on evaluation, margin and/or days cash on hand, or based on total GBR?
- Who should make initial and final assessment of proposals?

Next Steps

- Comment Period open through 9/26/2024

  hscrc.payment@maryland.gov

- Follow up October 9th Commission Meeting

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Fall 2024 Meetings Preview

September 11, 2024

October Meeting Topics

- External Presentations
  - Statewide Maternal and Child Health Strategy – Maryland Department of Health & Medicaid
- Reports & Updates
  - Nurse Support Program II – Program Renewal Update
  - Standard Executive Director Report Updates (Model Monitoring, ED Initiatives, etc.)
- Policies
  - Final Recommendation (Vote): Confidential Data Requests (1)
  - Draft Recommendation: Out of State and Deregulation Volume Policy
  - Draft Recommendation: Quality-Based Reimbursement (QBR) Policy
  - Draft Recommendation: Emergency Department Multi-Visit Patient Policy
  - *All Draft Recommendations will have final votes in December 2024.*

November Meeting Topics

- External Presentations
  - Totally Linking Care – Crisis Services Expansion in Prince George's County under the Regional Partnership Catalyst Program
- Reports & Updates
  - Statewide Community Benefits Report
  - Revenue for Reform Update
  - Standard Executive Director Report Updates (Model Monitoring, ED Initiatives, etc.)
- Policies
  - Draft Recommendation: Emergency Department Best Practices Incentive Policy
  - Draft Recommendation: Inpatient Diabetes Screening Policy
  - Draft Recommendation: Readmissions Reduction Incentive Program (RY 2027)
  - *All Draft Recommendations will have final votes in January 2025.*
- Regulations
  - Vote on final Community Benefits Reporting Regulations (proposed regs were on July agenda).

December Meeting Topics

- Reports and Updates
  - Standard Executive Director Report Updates (Model Monitoring, ED Initiatives, etc.)
- Policies
  - Final Recommendation: Out of State and Deregulation Volume Policy
  - Final Recommendation: Quality-Based Reimbursement (QBR) Policy
  - Final Recommendation: Emergency Department Multi-Visit Patient Policy
  - Draft Recommendation: Nurse Support Program II Renewal *(Final Vote in February 2025)*
  - Draft Recommendation: Medicare Performance Adjustment (CY 2025 Policy / FY 2027 Payment) (*Final Vote in March 2025)*

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Final Recommendation: Updates to the Accounting and Budget Manual

September 11, 2024

Agenda

- Background - Annual Filing Modernization Project
- Feedback from Stakeholders
- Staff Recommendation

Background – Annual Filing Modernization Project

The current version of the Accounting and Budget Manual was created in the late 1970s. In July 2023, Staff engaged I3 Healthcare Consulting to assist with an Annual Filing Modernization (AFM) initiative. The goal of this project is to obtain additional information about the operational costs at hospitals and to improve Staff oversight over compliance. The project also seeks to streamline the documentation and collection of this information. During Phase I, Staff removed outdated contents and revised the Manual.

Feedback from Stakeholders

These changes were shared with the Maryland Hospital Association (MHA) and the hospitals in the months of July and August 2024 for comments. The 30-day comment period ended August 16, 2024. Both MHA and Adventist HealthCare provided feedback as noted below.

MHA Comments:

In Appendix B, there were hospitals listed that were not updated to include the affiliated system in their name (e.g., Germantown and Suburban) – this may be something to check if the aim is standardization. Also, we noticed that Appendix C does not include the 340B rate centers.

Feedback from Stakeholders

HSCRC Response:

We added the affiliated systems names to all relevant hospitals in Appendix B. The 340 Rate Centers may be added to Appendix C during Phase II after additional information is evaluated by the AFM team.

Adventist Comments:

There is currently a mix of old and new names in Appendix B, and two Centers for Medicare & Medicaid Services (CMS) identification numbers are incorrect. You will notice both Shady Grove and Germantown Emergency share the same CMS identification number. You will also notice both Rehab locations share the same CMS identification numbers. The Financial identification numbers are different to accommodate separate HSCRC reporting, but in each of these cases the two reporting units are one entity for CMS.

Feedback from Stakeholders

HSCRC Response:

We updated the names of all Adventist HealthCare hospitals in Appendix B. In addition, we added a footnote to Appendix B to communicate that several of the CMS identification numbers are only for HSCRC reporting purposes.

Staff Recommendation

1. That the Commission approve the revisions of Phase I to the Accounting & Budget Manual. These revisions are to remove outdated contents and are part of the Annual Filing Modernization initiative.
2. That the updated revisions of Phase I of the Accounting & Budget Manual be effective October 1, 2024.

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Final Recommendation:

Updates to the Accounting and Budget Manual

September 11, 2024

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

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Background

The current version of the Accounting and Budget Manual was created in the late 1970s. In July 2023, Staff engaged I3 Healthcare Consulting to assist with an Annual Filing Modernization (AFM) initiative. The goal of this project is to obtain additional information about the operational costs at hospitals and to improve Staff oversight over compliance. The project also seeks to streamline the documentation and collection of this information. During Phase I, Staff removed outdated contents and revised the Manual. See revision items below:

Section 100 (Accounting Principles and Concepts)

- Removed general accounting principles.

Section 200 (Chart of Accounts)

- Removed instructions for establishing an accounting system; updated cost center information.

Section 300

- No change. This section will remain blank until the manual is finalized.

Section 400 (Reporting Requirements)

- Updated mailbox addresses; removed reports no longer relevant.

Section 500 (Reporting Instructions)

- Updated instructions; removed reports no longer relevant.

Section 600 (Reporting Schedule Checklist)

- Updated checklist; removed attestation form.

Section 700 / Appendix D (Standard Units of Measure)

- No changes.

Appendix A (Glossary of Terms)

- Removed List of Accounting Terms section.

Appendix B (Hospital List)

- Added and Updated hospital names, financial and Medicare identification numbers.

Appendix C (Center Codes)

- Added additional center codes.

Alternative Method of Rate Determination (ARM) Manual

- Removed language no longer relevant and added current policy.

Feedback from Stakeholders

These changes were shared with the Maryland Hospital Association (MHA) and the hospitals in the months of July and August 2024 for comments. The 30-day comment period ended August 16, 2024. Both MHA and Adventist HealthCare provided feedback as noted below.

MHA Comments:

In Appendix B, there were hospitals listed that were not updated to include the affiliated system in their name (e.g., Germantown and Suburban) – this may be something to check if the aim is standardization. Also, we noticed that Appendix C does not include the 340B rate centers.

HSCRC Response:

We added the affiliated systems names to all relevant hospitals in Appendix B. The 340 Rate Centers may be added to Appendix C during Phase II after additional information is evaluated by the AFM team.

Adventist Comments:

There is currently a mix of old and new names in Appendix B, and two Centers for Medicare & Medicaid Services (CMS) identification numbers are incorrect. You will notice both Shady Grove and Germantown Emergency share the same CMS identification number. You will also notice both Rehab locations share the same CMS identification numbers. The Financial identification numbers are different to accommodate separate HSCRC reporting, but in each of these cases the two reporting units are one entity for CMS.

HSCRC Response:

We updated the names of all Adventist HealthCare hospitals in Appendix B. In addition, we added a footnote to Appendix B to communicate that several of the CMS identification numbers are only for HSCRC reporting purposes.

Staff Recommendation

1. That the Commission approve the revisions of Phase I to the Accounting & Budget Manual. These revisions are to remove outdated contents and are part of the Annual Filing Modernization initiative.

2. That the updated revisions of Phase I of the Accounting & Budget Manual be effective October 1, 2024.

maryland
health services
cost review commission

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: September 11, 2024

RE: Hearing and Meeting Schedule

October 9, 2024 In person at HSCRC office and Zoom webinar

November 13, 2024 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.