State of Maryland
Department of Health

Adam Kane
Chairman

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Vice-Chairman

Victoria W. Bayless

Stacia Cohen

John M. Colmers

James N. Elliott, M.D.

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Katie Wunderlich
Executive Director

Allan Pack, Director
Population Based
Methodologies

Chris Peterson, Director
Payment Reform &
Provider Alignment

Gerard J. Schmith, Director
Revenue & Regulation
Compliance

William Henderson, Director
Medical Economics &
Data Analytics

570th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
April 16, 2020

PUBLIC SESSION
11:30am

1. **Open Cases**

   2520R – Holy Cross Germantown Hospital **2521R – Holy Cross Hospital**

2. **Overview of HSCRC Action Plan to Address COVID-19**

3. **Draft Recommendation on COVID Surge Funding**

EXECUTIVE SESSION
12:30pm

1. Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104

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

IN RE: THE PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF THE	*****	**COST REVIEW COMMISSION**	
HOLY CROSS	*****	**DOCKET:**	**2020**
GERMANTOWN HOSPITAL	*****	**FOLIO:**	**2330**
GERMANTOWN, MARYLAND	*****	**PROCEEDING:**	**2520R**

Staff Recommendation

April 16, 2020

Introduction

On March 20, 2020 Holy Cross Germantown Hospital ("the Hospital") submitted a partial rate application to the Commission requesting that it's July 1, 2020, Medical Surgical Acute (MSG) and Definitive Observation (DEF) approved rates be combined effective July 1, 2020.

Staff Evaluation

This rate request is revenue neutral and will not result in any additional revenue for the Hospital. The Hospital wishes to combine these two centers, because the patients in both units are cared for in the same area and have similar nurse staffing ratios. The Hospital's currently approved rates and the new proposed rate are as follows:

	Current Rate	Budgeted Volume	Approved Revenue
Medical Surgical Acute	$ 1,301.68	6,964	$ 9,064,281
Definitive Observation	$ 1,433.36	6,678	$ 9,571,510
Combined Rate Proposed	$ 1,366.14	13,641	$ 18,635,791

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That the Hospital be allowed to collapse its DEF rate into its MSG rate;

2. That a MSG rate of $1,366.14 per day be approved effective July 1, 2020; and

3. That no change be made to the Hospital's Global Budget Revenue for MSG services.

IN RE: THE PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF THE	*****	**COST REVIEW COMMISSION**	
HOLY CROSS	*****	**DOCKET:**	**2020**
HOSPTIAL	*****	**FOLIO:**	**2331**
SILVER SPRING, MARYLAND	*****	**PROCEEDING:**	**2521R**

Staff Recommendation

April 16, 2020

Introduction

On March 20, 2020 Holy Cross Hospital ("the Hospital") submitted a partial rate application to the Commission requesting that it's July 1, 2020, Medical Surgical Acute (MSG) and Definitive Observation (DEF) approved rates be combined effective July 1, 2020.

Staff Evaluation

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	Current Rate	Budgeted Volume	Approved Revenue
Medical Surgical Acute	$1,143.44	53,202	$ 60,833,122
Definitive Observation	$ 1,520.36	10,830	$ 16,465,210
Combined Rate Proposed	$ 1,207.19	64,032	$ 77,298,332

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That the Hospital be allowed to collapse its DEF rate into its MSG rate;

2. That a MSG rate of $1,207.19 per day be approved effective July 1, 2020; and

3. That no change be made to the Hospital's Global Budget Revenue for MSG services.

April 16, 2020

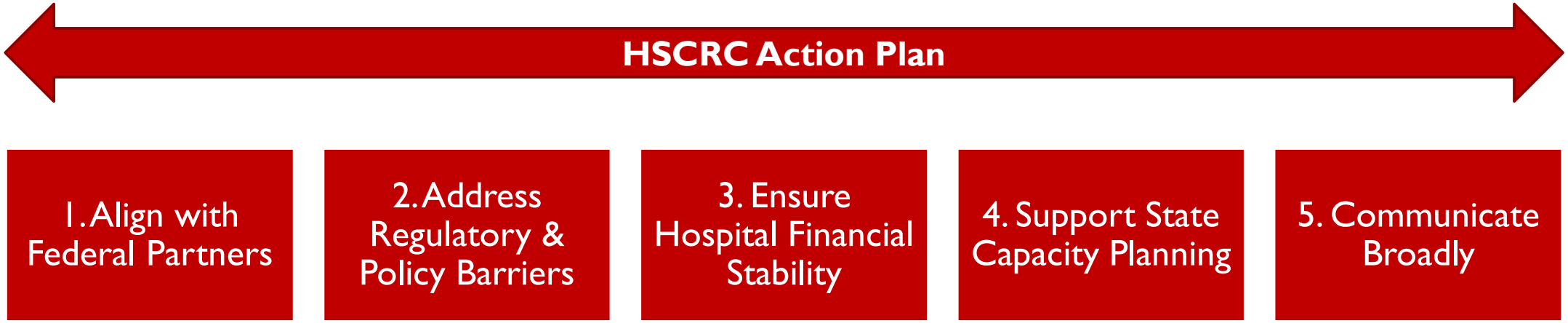
COVID-19:
Overview of HSCRC Action Plan

Katie Wunderlich
Health Services Cost Review Commission

HSCRC Action Plan

COVID-19: Overview of HSCRC Action Plan

- As Maryland prepares for care of individuals affected by COVID-19, HSCRC staff have developed an action plan to ensure hospitals have the funding needed to combat the virus during the trough, surge, and post-surge phases.



1. Align with Federal Partners

HSCRC is working closely with federal partners to ensure Maryland hospitals have access to federal relief aid to combat COVID-19 and to assure compliance with the Total Cost of Care Contract.

Congress

- Worked with Maryland's federal delegation to secure an amendment to the CARES Act to ensure Maryland and its hospitals would be eligible for relief funding
- Will continue to monitor federal relief legislation to ensure that Maryland has access to any future federal aid

CMS

- Received a Quality Program waiver allowing hospitals to submit late or forgo submission of CMS quality data for October 2019 to June 2020
- Received approval to suspend the use of data from January 2020 to June 2020 for all quality revenue adjustments
- Communicating regularly with CMMI team on any additional considerations needed under our TCOC Contract to address the unique challenges posed by COVID-19

2. Address Regulatory & Policy Barriers

HSCRC has modified/suspended policies and established new mechanisms to aid hospitals in preparing for the potential increase in patients affected by COVID-19.

Waived "At the Hospital" Regulations	• Waived regulations in order to give hospitals more flexibility to move regulated services out of the hospital to make room for COVID-19 inpatient expansion
Enabled Telehealth	• Approved a telehealth policy to enable critical hospital services to be delivered safely and to allow providers to recover professional fees for telehealth services.
Suspended Certain Efficiency & Volume Policies	• Suspended efficiency policies, including the withholding of portions of the RY 2021 update factor related to the Integrated Efficiency policy • Suspended RY 2021/CY 2020 Market Shift Adjustments that overlap with COVID-19 period • Suspended evaluations of Complexity and Innovation during the COVID-19 response period
Eliminated Non-Critical Reporting	• Modified or suspended non-critical quality reporting and other data collection/reporting

3. Ensure Hospital Financial Stability

HSCRC is working to establish policies, modify rate setting methodologies, and identify all available funding to support hospitals during the COVID-19 pandemic.

Stage 1

Capacity Expansion

- **Issue:** Hospitals need capital to fund expansion activities for the anticipated surge of patient volume
- **HSCRC Solution:**
  - MHHEFA Bond Funding
- **Other Solutions:**
  - Federal CARES Act Relief Funding
  - FEMA funding

Volume Trough

- **Issue:** Hospitals' liquidity is negatively affected due to low patient volumes associated with social distancing & cancellation of elective procedures
- **HSCRC Solutions:**
  - Expanded Corridor Relief
  - Suspended Undercharge Penalties and allowance to recoup FY 20 undercharge in future fiscal years
- **Other Solutions:**
  - Payer Sponsored Advance Working Capital Programs

Stage 2

Volume Surge

- **Issue:** Patient volumes are projected to spike due to increased hospitalizations. Plan action to address the surge if patient levels exceed hospital GBRs
- **HSCRC Solution:**
  - COVID Surge Policy (*under development*)

Hospital Financial Stability: MHHEFA Bond Funding

- Maryland's COVID-19 projections indicate additional hospital beds will be needed across the State
- HSCRC is working to ensure capital is available to fund the expansion of existing or new hospital care sites associated with COVID-19 that receive an Emergency Certificate of Need designation
- To enable access to capital, HSCRC is exploring bond funding through Maryland Health and Higher Educational Facilities Authority (MHHEFA)
  - MHHEFA Bond funding can be used for the purchase, demolition, construction, renovation, upgrade and equipping of facilities
  - Capital costs associated with COVID-19 can be amortized capital costs over several years
  - The repayment of the bonds will be guaranteed by the hospital rate-setting system
  - If federal relief funds become available after the bonds are issued, the State will use any available federal funds to pay down principal and interest.

Hospital Financial Stability: CARES Act Relief Funding

$100B Public Health & Social Services Fund from HHS Secretary to Providers

- Purpose
  - To remain available until expended, to prevent, prepare for, and respond to coronavirus, domestically or internationally, for necessary expenses to reimburse, through grants or other mechanisms, eligible health care providers for health care related expenses or lost revenues that are attributable to coronavirus.
  - Funds may not be used to reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse
- HSCRC Consideration
  - Federal relief funds received by hospitals must be netted against any undercharge in FY 20 that is carried over into future fiscal years

$25B+ Federal Emergency Assistance from FEMA through HHS to Applicants

- Purpose:
  - To reimburse "eligible emergency protective measures taken to respond to the COVID-19 emergency at the direction or guidance of public health officials" and that is not otherwise reimbursed by another federal agency
- Increases federal support to HHS in its role as the lead federal agency for the federal government's response to COVID-19
- Maryland hospitals are encouraged to apply through the Maryland Emergency Management Agency

Hospital Financial Stability: Corridor Relief & Undercharge Policies

To provide liquidity and financial stability to hospitals as the COVID-19 pandemic continues, the HSCRC has taken the following steps:

Corridor Relief

- Expanded charging capacity for hospitals from March 1st until June 30th (the greater of 10% or 5 percentage points from current charging variance as of March 1, 2020);
- Staff will evaluate corridors each week to determine if further charging variance is required.
- Corridor expansions above 10% or 5 percentage points from current variance will be reviewed on a case by case basis
- Corridor expansion can be considered in FY 21 should volume trough continue due to COVID-19 in order to stabilize prices and enable hospitals to recoup undercharges from the previous year

Undercharge Policies

- Waived penalties related to RY 2020 global budget undercharges
- Allowed hospitals to accrue revenues not charged in the final four months of FY 2020 to be recouped in future fiscal years
- Any federal funds received in FY 20 will reduce the total undercharge carried forward to FY 21

Hospital Financial Stability: COVID Surge Policy

The surge in COVID cases was not built into hospitals' Global Budget Revenue (GBR) and is not preventable volume (potentially avoidable utilization) by the medical system. Hospitals should not be expected to manage the costs of treating COVID within a fixed revenue system. Therefore,

- HSCRC is developing a policy to add additional revenue to the hospital's GBR to treat the surge in COVID cases, if needed.

- Simultaneously, the volume of non-COVID cases is declining as hospitals cancel elective surgeries and the public implements social-distancing practices.

- HSCRC will seek to balance the trough and the surge in volumes in order to:
  - Ensure that hospital revenues are stable and predictable during the volume trough
  - Ensure that hospitals have sufficient revenues to treat COVID cases
  - Ensure that resources and revenues for volume that has dissipated can be repurposed for COVID cases

4. Support State Capacity Planning

- HSCRC Staff have been active in the State Surge Activation Planning Team
  - Modeling Patient Volumes
  - Tracking and Reporting Emergency CON Funding Needs
  - Rate Setting Support for Baltimore Convention Center & Alternative Sites
  - Interpreting Federal Relief Packages & Identifying Funding Sources

5. Communicate Broadly

- HSCRC staff developed a broad communications plan intended to share key information about actions taken to prepare for the COVID-19 crisis, HSCRC policy decisions, and the most current information from State planning activities to help hospitals address the crisis.
  - Address hospital concerns and questions about planning
  - Advocate for engagement, resources, and/or support with legislators and federal agencies
  - Offer HSCRC policy expertise during the crisis
  - Inform the public about State activities underway
  - Highlight the strength and flexibility of the Model to respond to emergencies

- HSCRC staff has issued frequent communications to hospitals to ensure immediate policy questions related to COVID-19 are addressed
  - A dedicated webpage was established to centralize all communications related to COVID-19

- HSCRC staff proactively sent information to State legislators, DLS, partner agencies about actions we were taking to address COVID-19.

Physician Support

- HSCRC is concerned with the financial state of physician practices that have lost volume during the quarantine phase of COVID-19. Physicians are an important component of the healthcare system and relief efforts should consider physician needs
  - The HSCRC does not have rate-setting authority for physicians
  - The TCOC contract prohibits the HSCRC from directly regulating or approving any rates or bundles for physicians
  - The TCOC contract does allow for voluntary participation in programs that are approved by CMS, but not feasible during an emergency
- Although HSCRC can not set rates for physicians, staff will encourage hospitals to partner with and support physician practices (both owned and community-based practices)
- HSCRC Staff have been actively advocating for physician support from the private payers and Medicaid
- Physicians now have access to Advanced Payment Programs (loans) from:
  - Medicare
  - CareFirst
  - UnitedHealthcare
- Under the federal CARES Act, grants are also available for physicians

Draft Recommendation
COVID Surge Financing

April 16, 2020

Policy Problem and Draft Recommendation

- The surge in COVID cases was not built into hospitals' global budget revenue (GBR) and is not preventable volume by the medical system. Hospitals should not be expected to manage the costs of treating COVID within a fixed revenue system.
- Therefore, Staff is proposing a policy to:
  - Add additional revenue to the hospital's GBR to treat the surge in COVID cases, if needed
  - Use revenues from dissipated non-COVID volume to backfill a surge in COVID volume
- Specifically, the Draft Recommendation seeks to ensure that hospitals have sufficient revenue to address a possible surge in COVID cases by:
  - Modifying the hospitals' FY2020 and FY2021 global budget revenue (GBR) to include additional revenue if COVID cases cause the hospital to exceed its GBR; and
  - Adding any amounts related to COVID cases that exceed the hospital's original GBR as a one-time adjustment to the GBR

Summary of the Proposed COVID Financing Policy

- In order to guarantee hospitals sufficient revenues to accomplish those objectives, staff recommends:
  - Hospitals receive the existing GBR; **and,**
  - **IF NECESSARY,** hospitals receive additional revenue if the hospitals exceeds the GBR because of additional COVID cases
- Specifically, the FY2020 and FY2021 GBR will be equal to Non-COVID GBR + COVID Funding, where:
  - Non-COVID GBR = FY2020 or FY2021 Original GBR
  - COVID Funding = The greater of:
    - $0
    - COVID Standardized Charges – (GBR – Non-COVID Standardized Charges)
- COVID and Non-COVID costs will be assessed using standardized rates.
  - COVID and Non-COVID Standardized Charges will be calculated by multiplying the rate center units for cases with a COVID ICD10 code and all other ICD10 codes by the rate on the hospitals most recent rate order
  - The rate orders is used so that hospitals do not have to reduce charges in order to be in compliance with their GBR as COVID cases surge
- This policy would only be in effect for the duration of the COVID crisis.

Example of COVID Funding

	Calculation	FY2020	FY2021
Original GBR	A	$360m	$384m
COVID Months	B	4	2
Prorated GBR	C = A x B/12	$120m	$64m
Non-COVID Volume	D	$60m	$32m
COVID Volume	E	$80m	$40m
COVID Financing	F = E - (C - D)	$20m	$8m
Total GBR	G = A + F	$380m	$392m

Updates on Process

- Based on feedback and suggestions from the industry, HSCRC staff is recommending several changes from the initial policy proposal discussed with the Payment Models Workgroup. Those changes are:
  - Allowing hospitals to pass through charges related to COVID cases instead of using a calculation based on ECMADs
  - Adding COVID costs to the GBR as they occur in FY2020 and FY2021 rather than waiting until after the COVID crisis
- This policy would apply only for the duration of the COVID crisis.
  - This policy does not grant any additional rate relief and hospitals are expected to adhere to their rate corridors for the duration of the COVID crisis
  - Any additional revenues added to GBR will be one-time funding in either FY2020 or FY2021
  - Any funds for COVID will be netted against federal bailout funds and the FY2020 GBR undercharge
- The HSCRC is requesting comments by April 24, 2020 and intends a final recommendation on April 30.

Draft Recommendation on COVID Surge Funding

April 16, 2020

Health Services Cost Review Commission

4160 Patterson Avenue

Baltimore, Maryland 21215

(410) 764-2605

FAX: (410) 358-6217

This document contains the draft recommendation for funding additional volume that occurs because of the COVID crisis. Public comments on this draft recommendation can be sent to the following email address hscrc.payment@maryland.gov and will be accepted through April 24, 2020.

Recommendations

To ensure that hospitals have sufficient revenue to address a possible surge in COVID cases, the HSCRC staff recommends:

- Modifying the hospitals' FY2020 and FY2021 global budget revenue (GBR) to include additional revenue if COVID cases cause the hospital to exceed its GBR;
- Adding any amounts related to COVID cases that exceed the hospital's original GBR as a one-time adjustment to the GBR.

Background

The COVID crisis has caused disruption throughout the hospital and healthcare industries. Hospital volumes have fallen significantly due to the cancelation of elective surgeries and the effects of social-distancing measures. Meanwhile, hospitals have begun to prepare for a potential surge in COVID cases that may result in a corresponding surge in hospitalizations.

Maryland's global budget system is a source of stability during this time. In other states, the dissipation of hospital volumes results in a reduction in hospital revenues at the same time that hospitals are incurring significant costs to prepare for COVID. The GBR system guarantees hospitals a greater degree of financial stability during the dissipation of volumes. The GBR is spread out over time and, therefore, income can be recaptured over a longer time horizon. The HSCRC is also monitoring hospital cash flows. Through other policies, such as expanding rate corridors (i.e. increasing charging capacity), the Commission can better ensure sufficient interim liquidity.

In normal times, the GBR is a revenue cap that disincentivizes hospitals from growing unnecessary volumes and limits revenues to population-related utilization growth. COVID cases are not preventable or avoidable and the FY2020 GBR did not include additional volumes for a pandemic such as COVID. If a large surge in COVID cases occurs, hospitals may find themselves with insufficient revenue in their original GBR.

This draft recommendation is designed to provide additional funding to hospitals that experience a surge in COVID cases. It is possible that the surge in COVID volume does not occur, in which case the HSCRC expects that the existing GBR will be sufficient to stabilize hospitals during the trough in volume caused by the cancelation of elective surgeries and other measures.

Calculation of the GBR Add-on for COVID

Staff recommends that the FY2020 and FY2021 Global Budget Revenues (GBR) be modified to include additional funding for the treatment of COVID cases, if the volume of those COVID cases would cause the hospital to exceed its original GBR. Specifically, the FY2020 and FY2021 GBR will be equal to Non-COVID GBR plus COVID funding, where:

1. Non-COVID GBR = FY2020 or FY2021 Original GBR
2. COVID Funding = The greater of:
   A) $0
   B) COVID Standardized Charges – (GBR – Non-COVID Standardized Charges)

The COVID and non-COVID standardized charges will be assessed by counting the rate center units for cases with a COVID ICD-10 code and all other ICD-10 codes, respectively. The rate center units will then be multiplied by the relevant rates included on the hospitals' most recent rate order. Hospitals whose

volumes have increased would normally reduce charges to ensure they do not overcharge the GBR. Assessing the additional COVID revenues using the standardized rate on the rate order means that hospitals will not have to reduce charges as volumes rise due to the COVID surge.

The second part of this formula allows hospitals to pass through the additional charges related to COVID. The table below shows an example for a hospital with a GBR of $360 million, where $60 million of non-COVID volume has dissipated. In the first example, the hospital charges $80 million for COVID units (assessed at the standardized charges), which exceeds the revenue associated with dissipated volume ($60 million, again assessed at standardized charges) and thus the hospital receives a net COVID funding of $20 million. In the second example, the hospital charges only $20 million for COVID and the dissipated volume covers the additional COVID volume in its entirety. In this case, while the hospital receives no additional revenue, no revenue is removed from the hospital GBR either. According to the calculation formula, the hospital receives the greater of $0 or COVID Volume – (GBR – Non-COVID Volumes).

Table 1: Examples of Additional COVID Funding

	GBR	Non-COVID $	COVID $	Additional GBR Funding
Example 1	$360m	$300m	$80m	$80m – ($360m - $300m) = $20m
Example 2	$360m	$300m	$20m	$20m – ($360m - $300m) = – $40m[1]

[1] In this case, no revenue is subtracted from the GBR because the formula guarantees them COVID funding equal to the greater of $0 and the calculation above.

Timing and Implementation

This policy will be in effect for the duration of the COVID crisis, which began in March 2020 and will extend until the end of the State of Emergency, the resumption of elective surgeries, and/or a determination by the HSCRC. The HSCRC will publish a notification to the industry when the policy has expired. . The GBR will be prorated based on the duration of the fiscal year during which the COVID crisis was in effect. Prorated shares will be based on the share of the FY2019 GBR that was billed during the months in which the COVID crisis occurs. Prorating the GBR based on prior year charges is necessary to adjust for seasonal patterns in hospital utilization.

For example, if the COVID crisis extends from March to June of 2020, then the HSCRC will calculate the share of the hospitals' FY2019 charges that occurred between March and June of 2019 and apply that share to the hospitals' FY2020 annual GBR. The calculation described in the previous section will then proceed using the COVID and non-COVID volume that occur during the COVID crisis and the prorated GBR.

The additional COVID revenue will be assessed separately for FY2020 and FY2021, and the additional COVID revenues will be added to each hospital's annual GBR before calculating the annual GBR overcharge penalties. A hospital should not exceed its GBR, inclusive of the additional COVID revenues, and penalties will be assessed if the hospital exceeds the GBR plus allowed COVID Funding plus 0.5 percent. The table below shows the calculation for a hypothetical hospital.

Table 2: GBR Compliance Calculation

	Calculation	FY2020	FY2021
Original GBR	A	$360m	$384m
COVID Months	B	4	2
Prorated GBR	C = A x B/12	$120m	$64m
Non-COVID Volume	D	$60m	$32m
COVID Volume	E	$80m	$40m
COVID Financing	F = E - (C - D)	$20m	$8m
GBR Compliance	G = A + F	$380m	$392m

Additional Adjustments

The HSCRC will add additional revenue for the COVID cases prior to assessing the annual GBR compliance. To prevent double-payment to hospitals, that additional revenue may reduce the FY2020 undercharge that hospitals carry over into FY21, and may be reduced by emergency grant funds. The HSCRC will make those adjustments prior to assessing the GBR compliance. The adjustments may be applied to either FY2020 or FY2021 depending on when the assessments are made.