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606th Meeting of the Health Services Cost Review Commission
April 12, 2023

(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. 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
3. Update on Commission Response to COVID-19 Pandemic - Authority General Provisions Article, §3-103 and §3-104
4. Discussion on Bond Covenant Review - Authority General Provisions Article, §3-305(b)(5)(8)

PUBLIC MEETING
1:00 pm

1. Summary Statement of Closed Session
2. Review of Minutes from the Public and Closed Meetings on March 8 and March 20, 2023
3. Docket Status – Cases Closed
4. Docket Status – Cases Open
   - 2603R Luminis Anne Arundel Medical Center
   - 2608R Shady Grove Adventist Medical Center
5. Adoption of Proposed Regulations
   a. Accounting and Budget Manual: COMAR 10.37.01.02
   b. Regular Rate Applications, including the moratorium: COMAR 10.37.10.03; Commission Review of Established Rates: COMAR 10.37.10.04; Temporary Rate Applications: COMAR 10.37.10.05
6. Policy Update
   a. Legislative Update
   b. Model Monitoring
   c. Workgroup Review
7. Hearing and Meeting Schedule

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MINUTES OF THE
604th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
March 8, 2023

Chairman Adam Kane called the public meeting to order at 11:39 am. In addition to Chairman Kane, in attendance were Commissioners Joseph Antos, PhD, James Elliott, M.D., Maulik Joshi. Victoria Bayless and Sam Malhotra participated virtually. Upon motion made by Commissioner Joshi and seconded by Commissioner Elliott, the meeting was moved to Closed Session. Vice Chairman Antos reconvened the public meeting at 1:14p.m.

REPORT OF MARCH 8, 2023, CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the March 8, 2023, Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE FEBRUARY 8, 2023, CLOSED SESSION, AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the February 8, 2023, Public Meeting and Closed Session.

ITEM II
CLOSED CASES

ITEM III
OPEN CASES

2603R- Luminis Anne Arundel Medical Center
2608R- Shady Grove Adventist Medical Center
2614A- Johns Hopkins Health System
2615A- Johns Hopkins Health System
2616A- Johns Hopkins Health System
2617A- Johns Hopkins Health System
2618A- Johns Hopkins Health System

ITEM IV
CONFIDENTIAL DATA REQUEST

Ms. Claudine Williams, Deputy Director, Clinical Data Administration, presented staff's recommendation on granting the release of HSCRC confidential patient level data to Oregon Health & Science University/University of Utah Center for policy research in Emergency Medicine (see "Final Staff Recommendation or the Release of HSCRC Confidential Patient Level Data to Oregon Health & Science University/University of Utah Center for Policy Research in Emergency Medicine available on the HSCRC website).

The Oregon Health & Science University (OHSU) Center for Policy and Research in Emergency Medicine (CPR-EM)/University of Utah- National Emergency Medical Services Information System (NEMSIS) Technical Assistance Center (T.A.C.) is requesting access to Health Services Cost Review Commission (HSCRC) Inpatient and Outpatient Hospital data ("the Data"), for the following projects: 1. An evaluation of pediatric firearm injury risk prediction in children using emergency services in the US; 2. An evaluation of the National Pediatric Readiness Project (NPRP); and 3. Identifying ways to further improve pediatric outcomes and quality of care, and to examine the associated costs, all with national health policy implications.

The firearms injury prevention project will offer a direct benefit to Marylanders because the findings are likely to directly impact policy and decision-making around firearms injury prevention for children at the National, state, and local levels. The NPRP evaluation project will offer a direct benefit to Marylanders by exploring how the location of ED and hospital care for children may be directly associated with better or worse outcomes and quality of care; how an ED's "readiness" to treat pediatric patients affects outcomes by identifying a re-engineered, high-value emergency care system for injured children that optimizes quality, outcomes, and costs. Investigators received approval from the Maryland Department of Health (MDH) IRB on September 23, 2022, and the MDH Strategic Data Initiative (SDI) office on February 3, 2023. The Data will not be used to identify individual hospitals or patients. The Data will be retained by OHSU/Utah until June 30, 2025; at that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.

Staff Recommendation is as follows:

1. HSCRC staff recommends that the request by OHSU for the Data for Calendar Years 2018 through 2021, data be approved. Additionally, Staff recommends approval of OHSU's continued use of Calendar Years 2012 through 2017, previously approved at the HSCRC Public meeting on March 13, 2019.
2. This access will include limited confidential information for subjects meeting the criteria for the research.

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

ITEM V
OVERVIEW OF DEREGULATION PROCESS

Mr. Christopher Konsowski, Chief, Hospital Rate Regulation, presented an overview of the deregulation process. (see " Deregulation Process" available on the HSCRC website).

Deregulation is the movement of a hospital service from a regulated hospital space to unregulated space, most often an outpatient service. An outpatient service assumed to be regulated if it is performed in a building on the campus of a hospital.

Mr. Konsowski stated that deregulation is a desirable effect of the TCOC Model because it moves services to less costly settings, and generates Model savings if hospital GBRs are appropriately adjusted.

Mr. Konsowski noted that deregulation of inpatient services also reduces the chances of infectious disease and frees up hospital capacity. Mr. Konsowski stated that analysis has determined that there are no differences in quality in or out of the hospital.

Savings from the deregulation of services can be generated in two ways:

1. Direct Adjustment of the Deregulating Hospital Global Budget Revenue (GBR): This approach directly addresses individual hospital revenues and potentially generates TCOC savings but potentially rewards hospitals that fail to deregulate appropriately.

2. Minimization of Update Factors: This approach holds all hospitals accountable for delivering savings under the Model and empowers hospitals to determine their path to clinical redesign within their fundamental responsibility to provide care in the community.

Currently, HSCRC Staff utilizes a balanced approach for generating deregulation savings. Staff maintains the incentive to move patients appropriately down the continuum of care by removing the associated, immediate variable cost. This process allows hospitals to remove fixed costs over time.
so that they can be redeployed for population health investments.

Staff review to determine hospital regulated versus unregulated space is as follows:

- Hospitals should notify staff at least 30 days prior to any shift of service and update their annual GBR appendices to disclose a shift that occurred in prior fiscal year.

- HSCRC staff will make an appropriate volume and revenue adjustment to account for any shifts.

    a. These adjustments typically occur based on a 50% variable cost factor(VCF), as if it were shifted to another hospital.
    b. VCF may be higher if reduction shifts to Medicare or the markup related to cost varies significantly (in the case of drug deregulations)
    c. Staff make permanent and one-time adjustments based on timing of disclosure.

- There are no contractual penalties associated with lack of disclosure. However, staff utilize several tools and analyses to help ascertain if a shift occurred without notification:

    a. Monthly Compliance Monitoring - reviewed to monitor compliance and review trends of

volume loss in a specific rate center, it would trigger an investigation into why volume loss is occurring.

b. Trends File/Market Shift - aggregated view of the all-payer case mix data that allows users to drill down to certain criteria including Equivalent Case mix Adjusted Discharge (ECMAD) declines. This tool can be used to verify already reported shifts or to explore shifts that haven't been disclosed.
c. Regular market shift files were reviewed to determine if any declines were already accounted for.
d. Unrecognized market utilization files were reviewed to determine if there were additional volume declines not accounted for in the regular market shift. Unrecognized volume growth (trend file data) was recently included in the market shift file to review volume changes in addition to market shift. Please note that market shift is revenue neutral, the unrecognized shift is not.
e. Multi-Payer Claims Analytic Tool (MCAT) (recently deployed) - this allows staff to review Medicare FFS ECMAD trends over time including ECMAD declines. This tool can be used to verify already reported shifts or to explore shifts that haven't been disclosed. This data is still in the review stage while we are deploying it, so some additional review by staff is necessary.

Mr. Konsowski noted adjustment for deregulation typically occurs with the mid-year rate order. This allows Staff to perform analysis of data for shifts disclosed by the hospital in their annual GBR appendices to ensure the appropriate adjustment is made. This also allows for Staff and the hospital to discuss declines noted in market shift data (unrecognized ECMADS, noted declines in ECMAD Trends file).

Adjustments for deregulation can also be made in July rate orders when hospitals disclose service closures/shifts prior to the end of the current fiscal year.

ITEM VI
POLICY UPDATE

Public Payer Differential

Ms. Katie Wunderlich stated that the Centers for Medicare & Medicaid Services approved Staff's request to increase the Public Payer Differential from 7.7% to 8.7% from April 1, 2023, to June 30,2024.

Legislative Update

Mr. Paul Katz, Analyst, External Affairs presented the Legislative Update (see "Legislative Update" available on the HSCRC website).

Ms. Katz noted that Staff are monitoring the following bills:

- HB 420/SB 234 - Health Services Cost Review Commission- Hospital Rates- All-Payer Model

Contract

- HB 333/SB404 - Health Services Cost Review Commission- Medical Debt and Financial Reimbursement Process
- HB 200/SB 181- Budget Bill for FY2024 (The Governor's Budget)
- HB 202/SB 183- Budget Reconciliation and Financing Act of 2023
- HB 214/SB 281- Commission on Public Health- Establishment
- HB 271/S 3 – 9-8-8 Trust Fund- Funding
- HB 274/SB 387- Task Force on Reducing Emergency Department Wait Times
- HB 333/SB 404- Hospitals- Financial Assistance- Medical Bill Reimbursement Process
- SB 493/HB 675- Commission to Study Trauma Center Funding in Maryland
- SB 626 – Health Services Cost Review Commission- Members Appointment

A bill was introduced at the last legislative session concerning Medicare Advantage Plan State Funding for $130M.

Model Monitoring

Ms. Deon Joyce, Chief, Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 11 months ending November 2022. Maryland's Medicare Hospital spending per capita growth was favorable when compared to the nation. Ms. Joyce noted that Medicare Nonhospital spending per-capita was trending close to the nation. Ms. Joyce noted that Medicare Total Cost of Care (TCOC) spending per-capita was trending close to the nation. Ms. Joyce noted that the Medicare TCOC guardrail position is 1.62% above the nation through November. Ms. Joyce noted that Maryland Medicare hospital and non-hospital growth through November shows a run rate erosion of $171,843,000.

ITEM VII
HEARING AND MEETING SCHEDULE

April 12, 2023,	Times to be determined- 4160 Patterson Ave HSCRC Conference Room
May 10, 2023,	Times to be determined- 4160 Patterson Ave. HSCRC Conference Room

There being no further business, the meeting was adjourned at 1:57 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission

March 8, 2022

Upon motion made in public session, Chairman Kane called for adjournment into closed session to discuss the following items:

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, a.3-103 and §3-104

3. Update on Commission Response to the COVID-19 Pandemic – Authority General Provisions Article, §3-103 and §3-104

The Closed Session was called to order at 11:39 a.m.

In attendance in addition to Chairman Kane were Commissioners Antos, Bayless, Elliott, and Joshi. Commissioner Malhotra participated via conference call.

In attendance representing Staff were Katie Wunderlich, Jerry Schmith, Allan Pack, William Henderson, Geoff Dougherty, Will Daniel, Claudine Williams, Alyson Schuster, Ph.D., Megan Renfrew, Erin Schurmann, Bob Gallion, and Dennis Phelps.

Also attending were:
Eric Lindemann, Commission Consultant, and Stan Lustman and Ari Elbaum Commission Counsel.

Item One

Eric Lindemann updated the Commission and the Commission discussed Maryland Medicare Fee-For-Service TCOC versus the nation.

Item Two

William Henderson, Principal Deputy Director, Medical Economics and Data Analytics, presented to the Commission the historical COVID Surge Funding Policy and the need for an updated approach.

Item Three

Mr. Henderson also presented and the Commission discussed analyses of hospital Annual Audited Financial Statements, Monthly Unaudited Statements, and Hospital Systems Financial Data.

Item Four

Ms. Wunderlich updated the Commission on workgroup and staff activities.

Item Five

Ms. Wunderlich updated the Commission on consultations with CMMI concerning a multi-state model.

The Closed Session was adjourned at 1:06 p.m.

MINUTES OF THE
605TH MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
MARCH 20, 2023

Chairman Adam Kane called the public meeting to order at 9:33 a.m. Commissioners Joseph Antos, PhD, Victoria Bayless, James Elliott, M.D., and Maulik Joshi, DrPH, participated virtually.

ITEM 1
HOLY CROSS GERMANTOWN HOSPITAL TEMPORARY RATE APPLICATION

Mr. Jerry Schmith, Principal Deputy Director, Revenue and Compliance, presented the Staff's recommendation concerning Holy Cross Hospital temporary rate application.

On March 7, 2023, Holy Cross Health (HCH), on behalf of the Holy Cross Germantown Hospital ("HCGH," or "the Hospital"), applied to the Health Services Cost Review Commission ("HSCRC," or "the Commission") for a temporary emergency change in rates pursuant to Section 10.37.10.05 of the Code of Maryland Regulations ("COMAR"). The Hospital requests funding of $9.3 million effective March 7, 2023. The temporary funding is to be reconciled in a full rate application to be filed as soon as the full rate review moratorium expires.

In response to the Temporary Rate Change request filed by the Hospital on March 7, 2023, Staff makes the following recommendations:

- Based on the thresholds outlined in COMAR 10.37.10.05, Staff finds that the Hospital has met the requirements for filing a temporary rate application, while demonstrating relative efficiency under the TCOC Model.
- That it is consistent with COMAR 10.37.10.05F that the Commission provide HCGH with a temporary increase of $960,000 effective March 1, 2023, based on the actual audited regulated losses for FY2022, and subject to the results of a full review following the filing of a regular rate application by the Hospital.

Dr. Van Coots, President and CEO, Holy Cross Health, and Anne Gillis, Chief Financial Officer presented a rebuttal to Staff's recommendations.

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

ITEM II

REVIEW OF THE MINUTES FRPM THE MARCH 8, 2023, CLOSED SESSION MEETING

The Commission voted unanimously to approve the March 8, 2022, Closed Session Meeting minutes.

The Public Meeting was adjourned at 10:46 a.m.

H.S.C.R.C's CURRENT LEGAL DOCKET STATUS (OPEN)

AS OF APRIL 3, 2023

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Purpose	Analyst's Initials	File Status
2603R	Luminis Anne Arundel Medical Center	7/22/2022	FULL	KW	OPEN
2608R	Shady Grove Adventist Medical Center	7/18/2022	CAPITAL	GS	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

Title 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 01 Uniform Accounting and Reporting System for Hospitals and Related Institutions

Authority: Health-General Article, §§19-207 and 19-215, Annotated Code of Maryland

Notice of Final Action

[22-352-P-I]

On April 12, 2023, the Health Services Cost Review Commission adopted amendments to Regulation **.02** under **COMAR 10.37.01 Uniform Accounting and Reporting System for Hospitals and Related Institutions.** This action, which was proposed for adoption in 50:02 Md. R. 67-68 (January 27, 2023), has been adopted as proposed.

Effective Date: May 1, 2023

Title 10

MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207 and 19-219, 19-220 and 19-222 Annotated Code of Maryland

Notice of Final Action

[22-294-P]

On April 12, 2023, the Health Services Cost Review Commission adopted amendments to Regulations **.03, .04, and .05** under **COMAR 10.37.10 Rate Application and Approval Procedures.** This action, which was proposed for adoption in 50:03 Md. R. 97 (February 10, 2023), has been adopted as proposed.

Effective Date: May 1, 2023

Maryland
Hospital Association

March 13, 2023

Dennis Phelps
Principal Deputy Director – Audit & Compliance
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Phelps:

On behalf of Maryland's 60 hospitals and health systems, MHA offers its comments on proposed changes to COMAR 10.37.10.05(F)– Rate Applications and Approval Procedures.

MHA requests HSCRC strike the second proposed sentence, *"A temporary rate approved by the Commission may not result in regulated revenue exceeding regulated expenses in the most recently completed fiscal year."*

As written, the sentence limits all temporary HSCRC action to only regulated operating losses, when an operating loss from both regulated and unregulated services may be justified. HSCRC has wide latitude to exercise its judgment on an appropriate temporary increase and need not limit itself to this provision. Hospitals cannot simply ask for a temporary rate increase without consequences because a permanent rate application must follow.

By statute, HSCRC regulates prices and revenues, not margins. The proposed language presupposes a margin. If HSCRC wants to both set a limit and replace the reference to a dated methodology, a methodology-based limit should be proposed in a working group for stakeholder review and comment.

We look forward to commenting on this matter at an upcoming public meeting. If you have any questions or concerns about the concern raised in this letter, please do not hesitate to contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: Katie Wunderlich, Executive Director

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Legislative Update

HSCRC April 2023 Commission Meeting

April 12, 2023

Health Services Cost Review Commission - Hospital Rates - All-Payer Model Contract

Bill #	Description	Status
HB 420 SB 234	**Health Services Cost Review Commission - Hospital Rates - All-Payer Model Contract**	Passed

- HSCRC requested this bill to add a reference to the Total Cost of Care Model to our hospital rate setting statute. The statute already requires the Commission to take the TCOC model into account in other aspects of the rate setting process. This amendment will conform with those other references to the model in law. This bill will not change how HSCRC staff review hospital rates, but rather will ensure our statute aligns with those contractual requirements.

Health Services Cost Review Commission - Members - Appointment

Bill #	Description	Status
SB 626	**Health Services Cost Review Commission - Members - Appointment**	Passed

- This bill requires that the members of the Health Services Cost Review Commission be appointed with the advice and consent of the Senate of Maryland.

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Budget and BRFA

Bill #	Description	Status
HB 200 SB 181	**Budget Bill for FY 2024 (The Governor's Budget)**	
HB 202 SB 183	**Budget Reconciliation and Financing Act of 2023**	Passed

- Funds HSCRC's Operating Budget.
- Reduces the Medicaid Deficit Assessment by $50M for FY 24 only.
- Includes additional funding for trauma costs ($9.5 million for all trauma hospitals from the Dedicated Purpose Fund and additional support for MEMSOF).

Capital Budget

Bill #	Description	Status
HB 201	**Creation of a State Debt – Maryland Consolidated Capital Bond Loan of 2023, and the Maryland Consolidated Capital Bond Loans of 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, and 2022**	Passed

- Funding for more than 20 hospitals, amounts ranging from $25K to $20M
- Largest funding amounts for UMMS Shore Regional, UMMS Capital Regional, Shock Trauma, & Luminis

Hospitals - Financial Assistance - Medical Bill Reimbursement Process

Bill #	Description	Status
HB 333 SB 404	**Hospitals - Financial Assistance - Medical Bill Reimbursement Process**	Passed

- This bill makes changes to the law requiring that hospitals provide refunds to certain patients who paid bills but were eligible for financial assistance in 2017-2021 (this law passed last year). State data will be used to identify the patients that qualify for refunds. HSCRC is required to create the process to implement this law. HSCRC data is not used for this process.

Commission to Study Trauma Center Funding in Maryland

Bill #	Description	Status
SB 493 HB 675	**Commission to Study Trauma Center Funding in Maryland**	Passed

- Establishes the Commission to Study Trauma Center Funding in Maryland to study the adequacy of trauma center funding across the State for operating, capital, and workforce costs.

Task Force on Reducing Emergency Department Wait Times

Bill #	Description	Status
HB 274 SB 387	**Task Force on Reducing Emergency Department Wait Times**	**Did not pass**

- This bill sought to establish a Task Force to study the root causes of wait times in emergency departments in the State, including health system capacity, health care workforce supply, the availability of inpatient beds and post–hospitalization care options. The task force would also review regulatory and reimbursement policies and make recommendations regarding best practices for reducing emergency department wait times that should be implemented in the State.
- HSCRC submitted a letter supporting the bill with an amendment to add HSCRC, MIEMSS, and MHCC to the task force.

Possible Interim Activities Resulting from 2023 Session

- Reports
  - JCR – **MDPCP Evaluation Report**
- Task Forces & Studies that HSCRC Staff will be participating in-
  - **Behavioral Health Care – Treatment and Access**
  - **Commission to Study Trauma Center Funding**
  - **Commission on Public Health**
- Other Tasks
  - **HB 333 / SB 404 - Hospitals - Financial Assistance - Medical Bill Reimbursement Process:** Clarify process and oversight
  - Consideration of **OR Pricing Pilot** at the request of the Health and Government Operations Committee Chair.

Questions?

Megan Renfrew

Associate Director of External Affairs

megan.renfrew1@maryland.gov

Paul Katz

Analyst

paul.katz@maryland.gov

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Update on Medicare FFS Data & Analysis

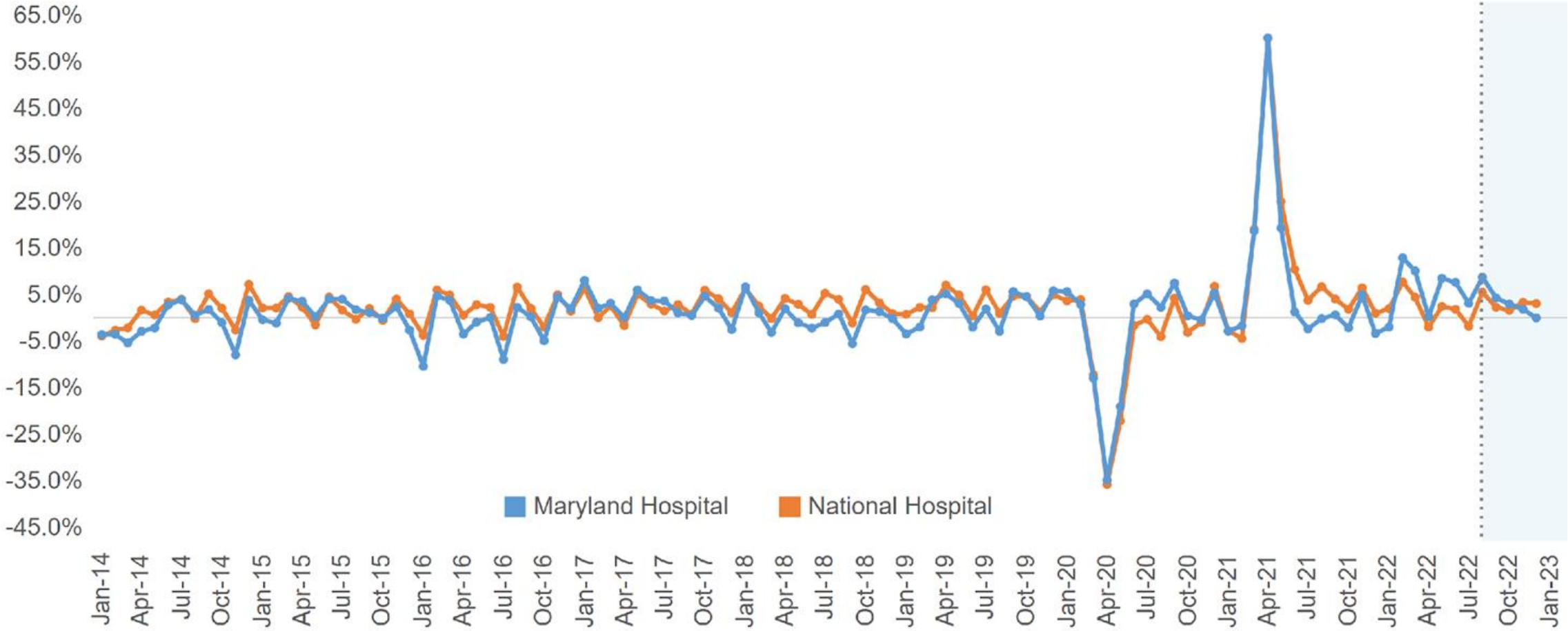
April 2023 Update

Data through December 2022, Claims paid through February 2023

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

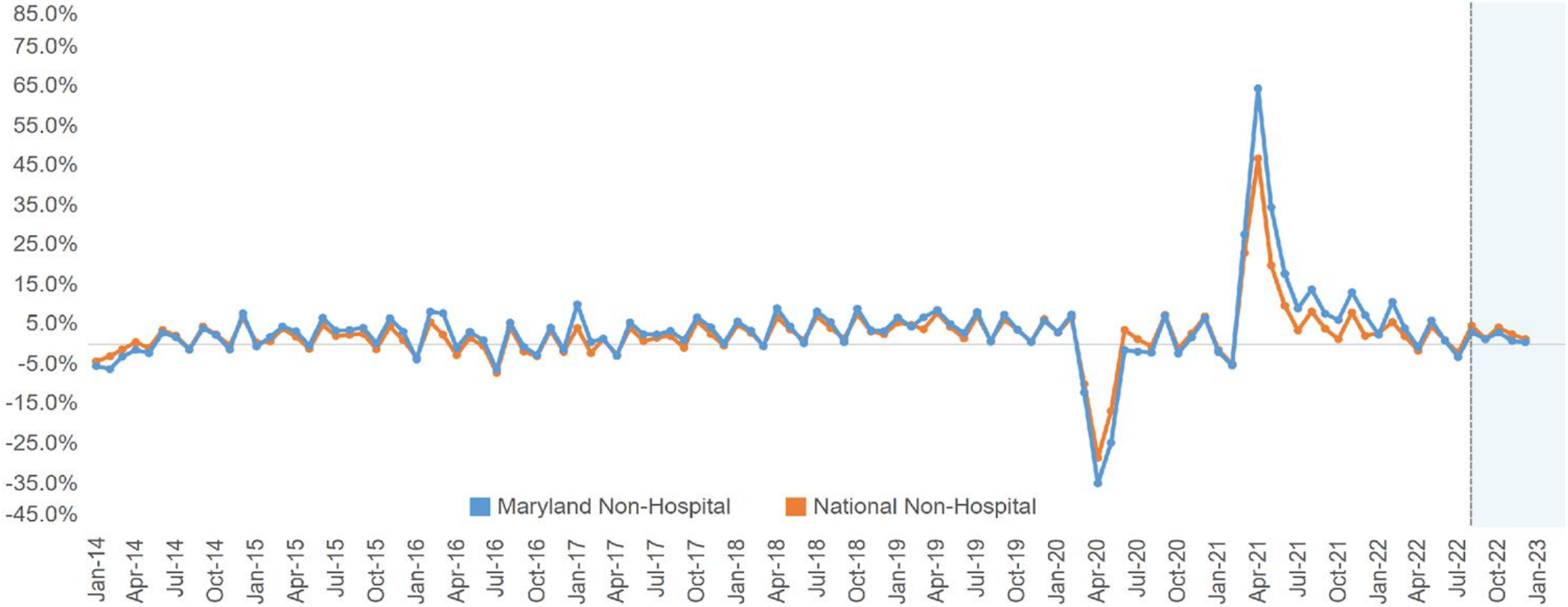
Actual Growth Trend (CY month vs. Prior CY month)



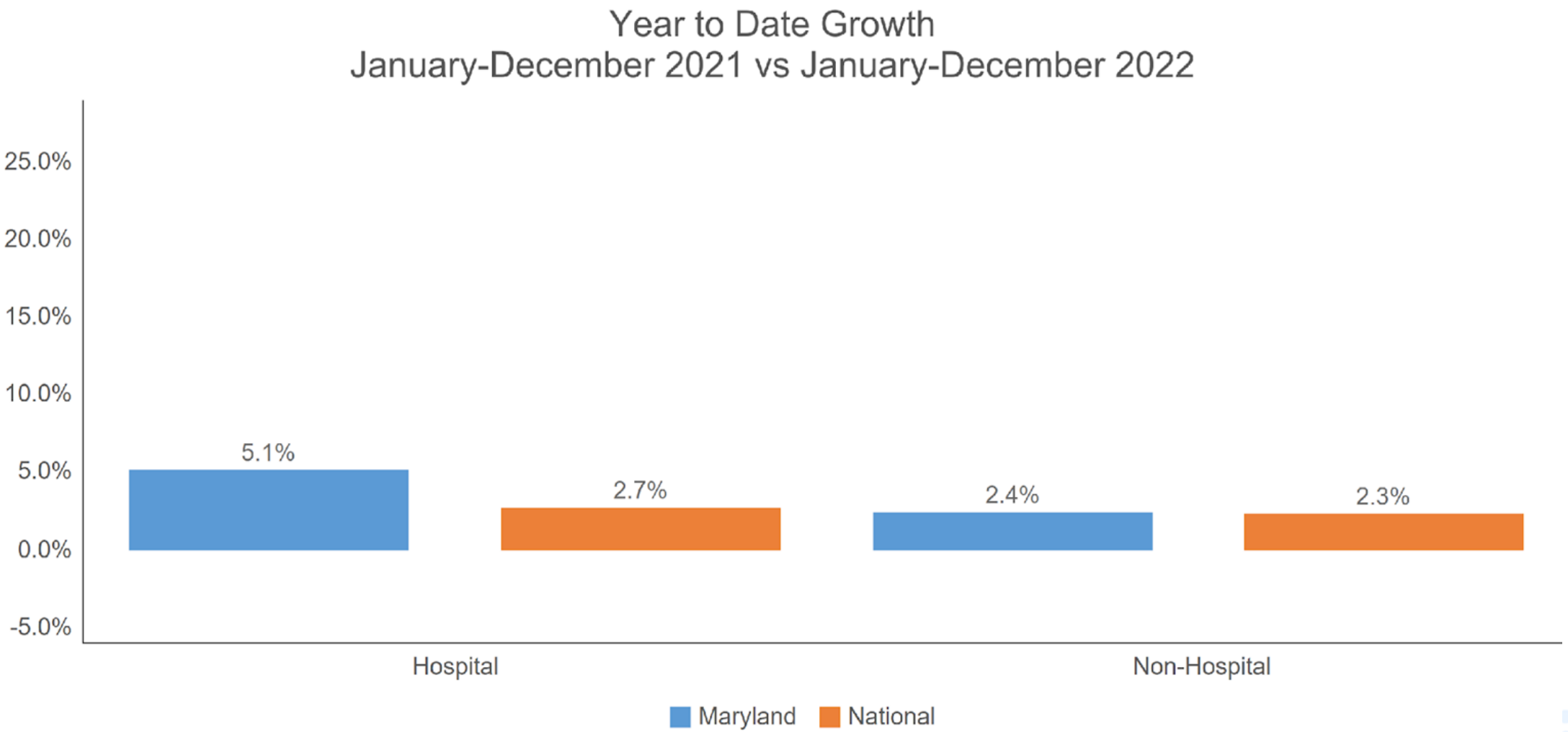
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

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

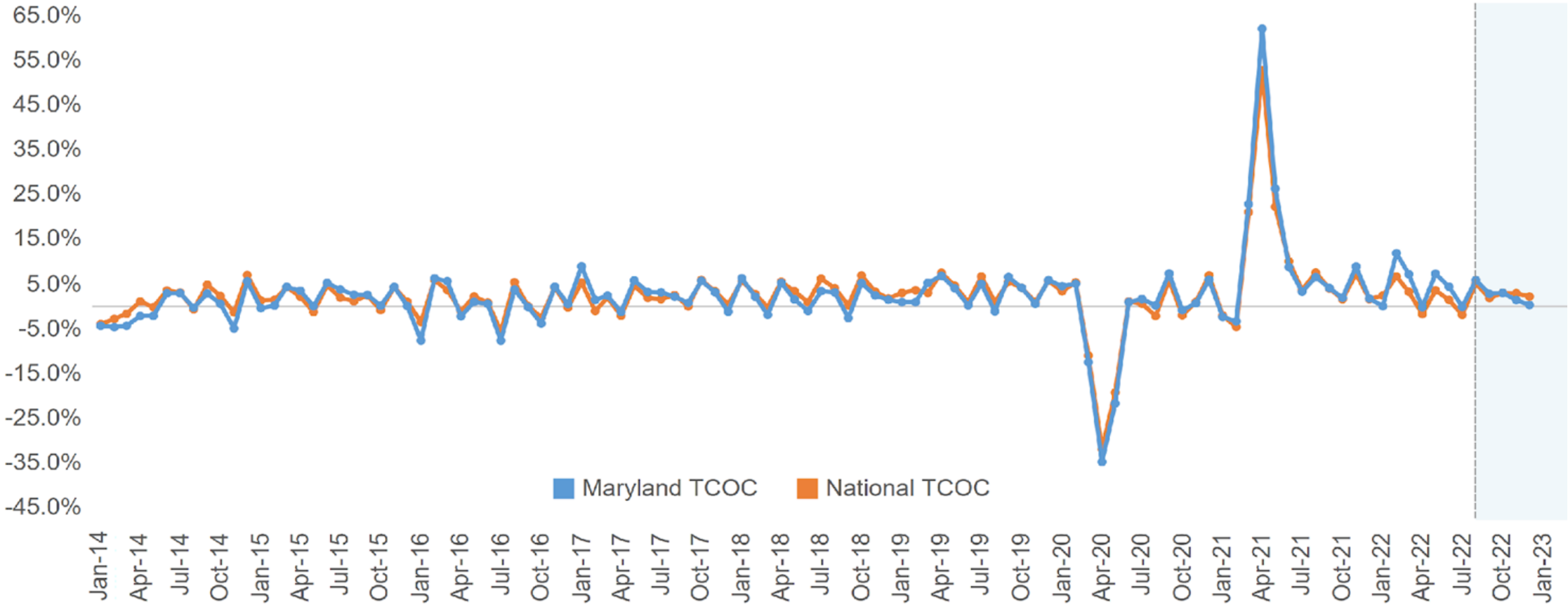


Medicare Hospital and Non-Hospital Payments per Capita



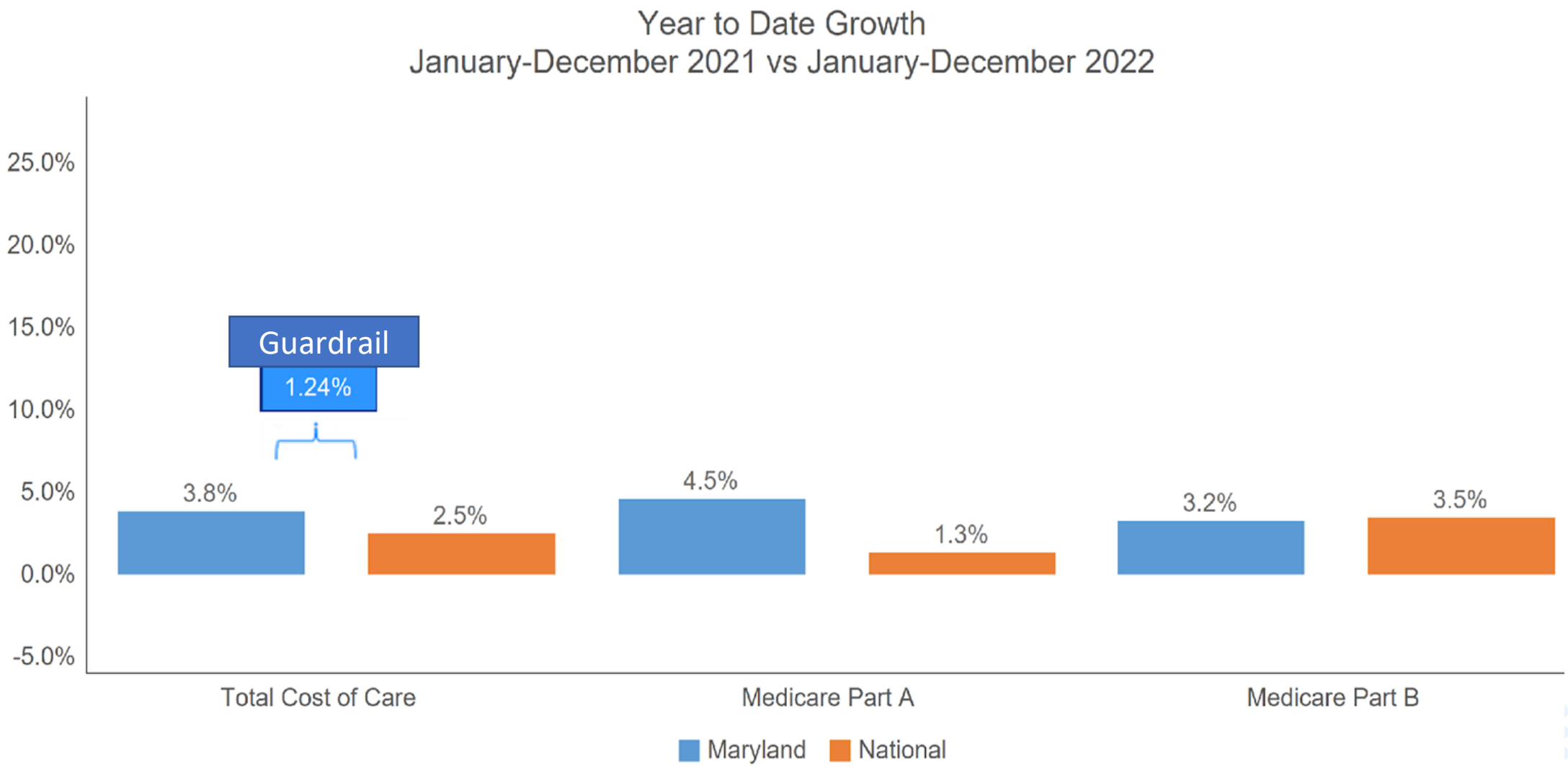
Medicare Total Cost of Care Spending per Capita

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



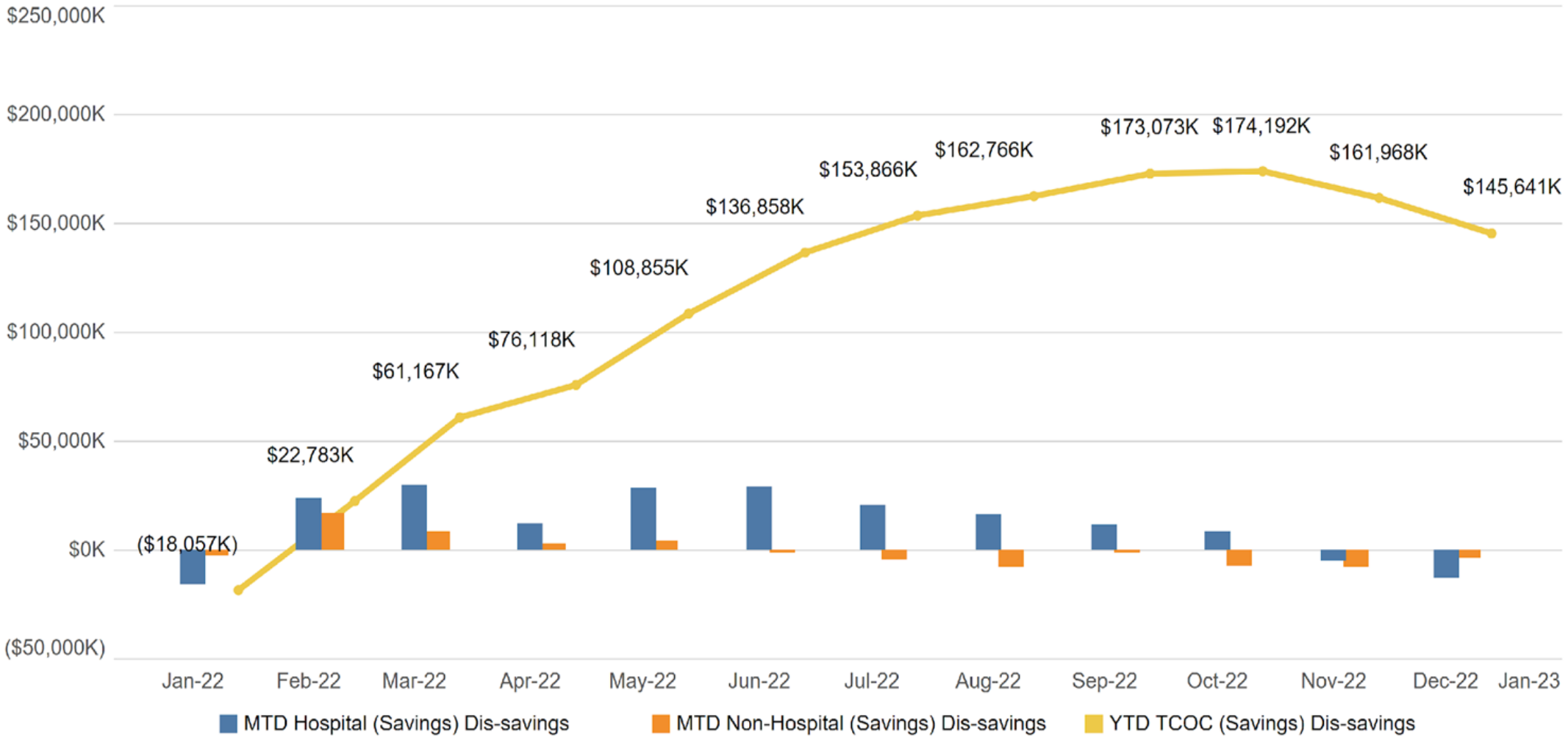
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through December 2022



A positive number represents dissavings/excess growth

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Workgroup Updates

April 12, 2023

Efficiency Workgroup Update

Efficiency Policy Suite and Potential Modifications

- Staff have developed 3 efficiency policies over the last five years to ensure hospitals have adequate resources to be successful under the TCOC Model
  - Full Rate Application Methodology
  - Integrated Efficiency Policy
  - Capital Financing Methodology
- Under the ethos of constantly evolving methodologies to improve them and to address unintended consequences, staff discussed the following in 2 workgroups meetings:
  - 1) “Unsticking” hospitals in the current TCOC benchmarking assessment by moving to a MPA approach for Medicare and Commercial TCOC, which would be applied to:
    - Integrated Efficiency
    - Capital Financing Methodology
  - 2) Targeting TCOC rewards in the Full Rate Application Methodology to growth that is slower than the statewide average when hospitals are less expensive than national benchmarking peers
  - 3) Proposing a Revenue for Reform provision in the Integrated Efficiency policy to redirect excess revenue to population health and community health investments.

TCOC Modelling Options for Integrated Efficiency

- Staff provided industry with 8 modelling options.
  - Model 1: No change to current methodology
  - Model 2: Adopt Medicare to MPA only, no change to Commercial
  - Model 3: Leave Medicare and adopt Commercial Option 1 (MPA Analog)
  - Model 4: Adopt Medicare to MPA and adopt Commercial Option 1 (MPA Analog)
  - Model 5: Leave Medicare and adopt Commercial Option 2
  - Model 6: Adopt Medicare to MPA and adopt Commercial Option 2
  - Model 7: Leave Medicare and adopt Commercial Option 3
  - Model 8: Adopt Medicare to MPA and adopt Commercial Option 3

Consensus was reached to abandon Models 5-8 due to minimization of commercial performance

- Staff used a variety of time periods in modeling these options as 2021 CO benchmarks are not yet available.
- Ultimately for RY 2024 Staff expects to update to most appropriate time period for the selected method

Findings

- There was fairly strong consistency in the 8 models
  - Rank correlation relative to the current methodology was consistently over .70; average of correlation statistics was .84
  - Statewide $ reduction averaged $36M and deviated only $6M in either direction ($42M in Model 1, $30M in Models 4 and 5)
- MPA and Commercial Analog Approach did a better job of capturing
  - Hospitals that were relatively near average benchmarks performance in 2019 and have diverged in TCOC growth
  - Hospitals that had significant improvements in the MPA and/or the Commercial MPA Analog but still fared relatively poorly in attainment only analyses

									# of Models (X=Penalty, $=Potential Reward, Blank=No Action)		
Hospital ID	Model 1	Model 2	Model 3	Model 4	Model 5	Model 6	Model 7	Model 8	Penalized	Rewarded	No Action
210048	$	$	$	$	$	$	$	$	0	8	0
210065	$	$	$	$	$	$	$	$	0	8	0
210015		$		$	$	$	$	$	0	6	2
210017	$		$	$	$		$	$	0	6	2
210028	$		$	$	$	$	$		0	6	2
210043	$	$	$	$	$		$		0	6	2
210001			$	$	$		$		0	4	4
210003									0	0	8
210004									0	0	8
210006									0	0	8
210009									0	0	8
210011									0	0	8
210016									0	0	8
210019									0	0	8
210022									0	0	8
210023									0	0	8
210027									0	0	8
210029									0	0	8
210034									0	0	8
210035									0	0	8
210039									0	0	8
210044									0	0	8
210049									0	0	8
210051									0	0	8
210056									0	0	8
210061									0	0	8
210062									0	0	8
210002			X	X					2	0	6
210018				X		X		X	3	0	5
210024	X	X	X						3	0	5
210033	X				X		X		3	0	5
210057				X		X		X	3	0	5
210008	X	X	X	X					4	0	4
210038	X		X		X		X		4	0	4
210040	X		X		X		X		4	0	4
210060		X	X	X		X		X	5	0	3
210063		X			X	X	X	X	5	0	3
210032	X	X			X	X	X	X	6	0	2
210037	X	X			X	X	X	X	6	0	2
210005		X	X	X	X	X	X	X	7	0	1
210012	X	X	X	X	X	X	X	X	8	0	0
210030	X	X	X	X	X	X	X	X	8	0	0
210058	X	X	X	X	X	X	X	X	8	0	0

Interim Conclusions

- Staff share workgroup concern that Models 5-8 minimize variation in commercial performance and thus do not support them as modifications to the Integrated Efficiency policy
- There are various hospitals that always get identified in the Integrated Efficiency matrix as outliers in the ICC and multiple variations of TCOC effectiveness, and these hospitals should be addressed in a future Integrated Efficiency policy.
- The MPA and Commercial MPA analog are preferable to strictly relying on the current benchmarking performance assessment, especially in the outyears, because they blend attainment and improvement into one evaluation and are more sensitive to deviations in performance, especially around the statewide median
  - Staff originally steered away from TCOC improvement metrics due to Year over Year instability but the passage of time allows measurement of growth versus a fixed base, which alleviates this concern (particularly as more time elapses)
- In the 3rd and final workgroup meeting, stakeholders will present proposals on preferred TCOC scaling

FRA TCOC Scaling Methodology

TCOC Performance	Reward/Penalty Modification to ICC
Better than Medicare Benchmark **and better than average State TCOC growth (NEW!)**	Reward
Better than Medicare Benchmark AND Average of Top Half of Commercial Performance **and better than average State Commercial TCOC growth (NEW!)**	Additional Reward
Better than Medicare Benchmark and worse than average State TCOC growth (NEW!)	No action
Better than Medicare Benchmark AND Average of Top Half of Commercial Performance and worse than average State Commercial TCOC growth (NEW!)	No action
Worse than Medicare Benchmark but better than average State TCOC growth	No action
Worse than Medicare benchmark and worse than average State TCOC growth	Penalty
Worse than Commercial Benchmark regardless of growth	Penalty

All Rewards Capped so that a Hospital Does not Exceed Medicare Benchmark

Findings and Interim Conclusions

- As expected the change to the TCOC scaling approach in the FRA reduces the extent of TCOC rewards in the methodology; there is no effect on penalties.
  - This is consistent with the review of TCOC benchmarking in February of 2022 that noted that due to the "sensitivity of absolute results [in benchmarking]..." staff should move away from "...rate enhancements based solely on performance relative to Medicare and commercial TCOC benchmarks."

Effect	Current Methodology	Proposed Methodology
Penalties	-$83,258,344	-$83,258,344
Rewards	$206,356,481	$32,710,347

- This is due to the fact that the rewards are capped at the lesser of positive TCOC growth (relative to the statewide average) and a hospitals 2021 benchmark average
  - Under the current Methodology, 9 hospitals would have received rewards equivalent to 100% of the variance between current Medicare attributed TCOC and the benchmark average ($204.9M); 2 hospitals would have received approximately 50% ($1.5M)
  - Under the proposed Methodology, 1 hospital would receive rewards equivalent to 100% of the variance between current Medicare attributed TCOC and the benchmark average ($680k); 6 other hospitals would receive rewards ranging from 12% to 95% ($32.0M)
- Given the proposed TCOC scaling better reflects actions taken during the Model to improve TCOC effectiveness (and gradations in effectiveness) staff propose moving to the proposed methodology, thereby aligning with the downside TCOC scaling approach
- In the 3rd and final workgroup meeting, stakeholders will provide suggestions on modified scaling approach

Revenue 4 Reform - Demonstrating Investments in Community Health

- In a TCOC Model that aims to improve population health and support community health, there should be an explicit directive to redeploy excess revenue toward community investments.
- Staff are proposing to add community investment directive to the Integrated Efficiency Policy.
- Options include:
  - Application process for hospitals to apply for Revenue for Reform safeharbor; OR
  - Integrated Efficiency Policy would simply withhold inflation from hospitals in order to support future Primary Care and Behavioral Health Collaborative to create new access points in underserved areas

Qualifying Population Health Investments

- Any spending, net of offsetting revenue for that activity, that meets qualifying criteria, will reduce the hospital's integrated efficiency penalty.
- All community health investments should meet the following three criteria:
  - 1) The investment must take place outside of the hospital (i.e. services are provided to beneficiaries off the hospital's campus, even if the intervention is deployed from the hospital
  - 2) The investment must be on a non-physician cost (except for the physician safe harbor)
  - 3) The investment must be primarily serving people who live within the hospital's primary service area
- Various stakeholders have raised concerns about restricting r4r to unregulated costs because certain items like care management are indicative of community health investments
  - Staff will address this in the 3rd and final workgroup meeting
  - Initial concerns are that it would render the ICC to be potentially superfluous, community investments is typically defined as non-clinical approaches for improving health, and there is limited variation in categories like regulated care management

Other Improvements to Efficiency Policies

Major Improvements Contemplated:

1. Address TCOC benchmark applications to streamline across efficiency policies
2. Add explicit directive to fund community health investments through Revenue for Reform in Integrated Efficiency Policy
3. Other suggested improvements?

Demographic Adjustment Update

Demographic Adjustment

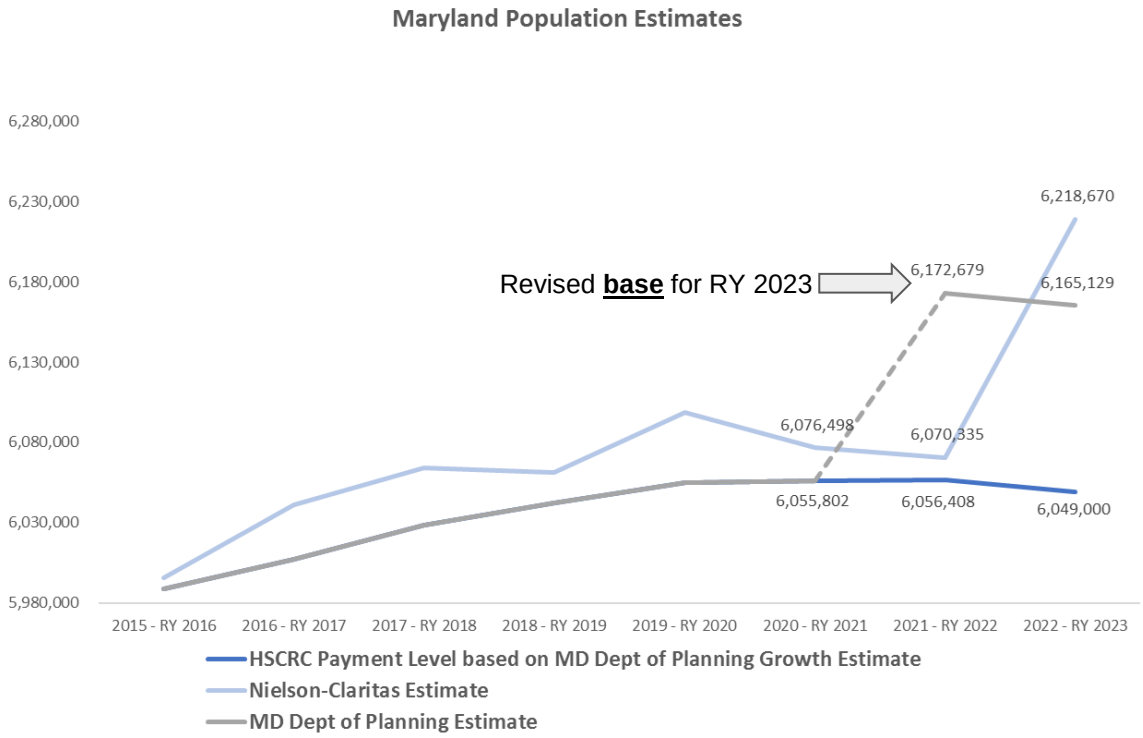
- The Demographic Adjustment is provided each year to hospitals to recognize utilization growth related to
  - Population Growth and
  - Aging of the Population

Age group	Per Capita Revenue	Age Cost Weights
0 to 4	$1,825	0.64
5 to 14	$397	0.14
15 to 44	$1,714	0.60
45 to 54	$2,583	0.91
55 to 64	$4,162	1.46
65 to 74	$5,940	2.09
75 to 84	$8,045	2.83
85+	$8,121	2.85
Total	$2,845	1.00

- When first implemented, the Commission elected to use Claritas to estimate population growth by eight age cohorts at the zip code level, which is then age adjusted based on the cohorts' per capita hospital revenue spend relative to the statewide average
  - Allocation of the population growth is done by assessing a hospital's casemix adjusted market share in a given zip code

- The Commission further elected to scale statewide age adjusted growth so that it was equivalent to the annual population estimates published by the Maryland Department of Planning

Alternate Approaches to 10 Year Forecasting Error



- The July 2021 estimate from Department of Planning that was used as the RY 2023 Demographic Adjustment was -0.12%
  - It did not reflect census catch up of 2.01%
- Claritas' estimate of CY 2022, which was used for RY 2023 DA, was 2.44%
  - Variance was due to alternate approaches to addressing 10 year forecasting error
- The diverging methods to account for the forecasting error underscored one of the underlying issues with the Demographic Adjustment, i.e. potential redistribution
  - 27 hospitals with Claritas projected age adjusted growth received a negative Demographic Adjustment in RY 2023

Staff Demographic Adjustment Proposal

1. Do not implement Department of Planning negative population growth estimate of -0.16% (April 2021 - July 2022) in RY 2024.
   a. Continue to use Claritas estimates to determine age adjusted growth.
   b. Scale statewide age adjusted growth statistic back to 0%, not -0.16%

2. Consider reversing RY 2023 adjustments related to Department of Planning scaling factor
   a. Some measure of scaling is appropriate because we do not fund age adjusted growth at a statewide level and Planning miss was 2.01% from 2010 to 2020 (1.93% from revised RY 2023 base) AND population based methodologies did not exist for the entirety of the last decade
   b. Focus initial efforts on hospitals that had a net negative adjustment in RY 2023 because the policy effectively funded population growth in some parts of the State by removing funding from other parts of the State. Eliminating all negative adjustments (~$80M), would result in a net add to the UF of ~0.40%
   c. The State's position on the savings tests both this year and last do not permit a larger catch up adjustment

3. Convene workgroup with industry and stakeholders to correct RY 2023 Demographic Adjustment
   a. Will need to consider how much of the 10 year forecasting error is attributable to time period when State had Global Budgets, i.e., 2014 to 2020.
   b. Must establish how quickly this correction should be made
   c. Will likely use the reversal of future negative growth estimates from Department of Planning as corrective tool

maryland
health services
cost review commission

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: April 12, 2023

RE: Hearing and Meeting Schedule

May 10, 2023 To be determined - GoTo Webinar

June 14, 2023 To be determined - GoTo 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.