

**617th Meeting of the Health Services Cost Review Commission**

**February 14, 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. 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

**PUBLIC MEETING**

**1:00 pm**

**Informational**

1. Review of Minutes from the Public and Closed Meetings on January 10, 2024

**Specific Matters**

2. Docket Status – Cases Closed

2640A University of Maryland Medical Center  
2641R UM Upper Chesapeake Behavioral Health Pavilion

3. Docket Status – Cases Open

2642N University of Maryland Medical Center  
2643N Brook Lane Hospital  
2630R UM Shore Medical Center at Easton

4. University of Maryland Rehabilitation and Orthopaedic Institute (UMROI) Recommendation

**Subjects of General Applicability**

5. Final Recommendation on Maryland Hospital Acquired Conditions Program (MHAC)
6. Final Recommendation on Multi-Visit Patients (MVPs)
7. Draft Recommendation on Readmission Reduction Incentive Program (RRIP) - RY 2026

8. Presentation on FY 2023 Audited and System Results

9. Policy Update and Discussion

- a. AHEAD Model Update
- b. Model Monitoring
- c. EDDIE Update
- d. Legislative Update
- e. Workgroup Processes Update
- f. Policy Calendar Update
- g. EQIP Primary Care Subgroup Meeting

10. Hearing and Meeting Schedule

**MINUTES OF THE**  
**615th MEETING OF THE**  
**HEALTH SERVICES COST REVIEW COMMISSION**  
**January 10, 2024**

Chairman Joshua Sharfstein called the public meeting to order at 11:35 a.m. In addition to Chairman Sharfstein, in attendance were Commissioners Joseph Antos, PhD, James Elliott, M.D., Adam Kane, Ricardo Johnson, Maulik Joshi, and Nicki McCann. Upon motion made by Commissioner Kane and seconded by Commissioner Joshi, the Commissioners voted unanimously to go into Closed Session. The Public Meeting reconvened at 1:07 p.m.

**REPORT OF JANUARY 10, 2024, CLOSED SESSION**

Dennis Phelps, Deputy Director, Audit & Compliance, summarized the items discussed at of the January 10, 2024, Closed Session.

**ITEM I**  
**REVIEW OF THE MINUTES FROM THE DECEMBER 6, 2023, PUBLIC**  
**MEETING AND THE DECEMBER 13, 2023, PUBLIC MEETING, AND**  
**CLOSED SESSION**

The Commission voted unanimously to approve the minutes of the December 6, 2023, Public Meeting and December 13, 2023, Public Meeting and Closed Session and to unseal the Closed Session minutes.

**ITEM II**  
**ASSISTANCE IN COMMUNITY INTEGRATION SERVICES PILOT**

Kevin Lindamood, President & CEO, Health Care for the Homeless, Dr. Redonda Miller, President, The Johns Hopkins Hospital, and Christopher Thomaskutty, Senior Vice President, Physician Enterprise, Mercy Health Services presented an overview of the Assistance in Community Integration Services (ACIS) Pilot Program (see “Presentation on Assistance in Community Integration Services Pilot” available on the Health Services Cost Review Commission (HSCRC) website).

Beginning in 2017, the Maryland Department of Health (MDH) received approval by the Centers for Medicare and Medicaid Services (CMS) to administer a pilot program aimed to address health related social needs, specifically related to housing. This pilot, under the authority of Maryland’s §1115 HealthChoice Waiver, delivers housing and tenancy-based services to qualifying individuals experiencing housing insecurity. Currently this pilot operates only within Baltimore City, Cecil County, Montgomery County, and Prince George’s County. The ACIS pilot is effective through December 31, 2026.

**Joshua Sharfstein, MD**  
Chairman

**Joseph Antos, PhD**  
Vice-Chairman

**James N. Elliott, MD**

**Ricardo R. Johnson**

**Maulik Joshi, DrPH**

**Adam Kane, Esq**

**Nicki McCann, JD**

**Jonathan Kromm, PhD**  
Executive Director

**William Henderson**  
Director  
Medical Economics & Data Analytics

**Allan Pack**  
Director  
Population-Based Methodologies

**Gerard J. Schmith**  
Director  
Revenue & Regulation Compliance

**Claudine Williams**  
Director  
Healthcare Data Management & Integrity

As of June 2023, Maryland has allocated 620 of the 900 ACIS participant spaces to local governmental agencies, known as Lead Entities.

- Baltimore City Mayor’s Office of Homeless Services- 300 spaces
- Cecil County Health Department- 15 spaces
- Montgomery County Health and Human Services- 230 spaces
- Prince George’s County Health Department- 75 spaces

To be eligible for this program, a Medicaid participant must meet the needs-based criteria as specified below:

1. Health criteria (at least one)
  1. Repeated incidents of emergency department (ED) use (defined as more than four visits per year) or hospital admissions; or
  2. Two or more chronic conditions as defined in §1945(h)(2) of the Social Security Act
2. Housing Criteria (at least one)
  1. Individuals who will experience homelessness upon release from the settings defined in 24 CFR 578.3; or
  2. Those at imminent risk of institutional placement

Eligible enrollees within the program can receive housing and tenancy-based services, reimbursed on a bundled payment basis. The rates are determined and negotiated as part of an annual process during a fixed budget review.

Hilltop Institute statistics show for the period of CY 2018 to CY 2021 a significant decline in the average number of ED visits, avoidable ED visits and inpatient admissions for ACIS participants in the year following enrollment in the program.

Hilltop statistics also showed participants with four or more ED visits in the previous ACIS year versus post ACIS year declined 36.8%.

### **ITEM III**

#### **OVERVIEW OF DATA VALIDATION ACTIVITIES**

Claudine Williams, Director, Healthcare Data Management & Integrity (HDMI), Christopher O’Brien, Associate Director, Audit, and Integrity and, Oscar Ibarra, Chief, Clinical Data Administration, presented an overview of HDMI validation activities (See “HSCRC Data Validation Activities” available on the HSCRC website).

**ITEM IV**  
**CLOSED CASES**

2631N Tidal Health Peninsula

**ITEM V**  
**OPEN CASES**

**2641R UM UPPER CHESAPEAKE BEHAVIORAL HEALTH PAVILION AT ABERDEEN**

On October 26, 2023, Upper Chesapeake Health System (“UCHS”) submitted a full rate application to the HSCRC to establish a permanent rate structure for UM Upper Chesapeake Behavioral Health Pavilion at Aberdeen (“BHP”) to be effective February 6, 2024. BHP is a new 33-bed psychiatric hospital located in Aberdeen, Maryland.

On April 16, 2020, the Maryland Health Care Commission (“MHCC”) approved a CON authorizing UCHS to establish a 33-bed specialty psychiatric hospital in Aberdeen, Maryland. The new specialty psychiatric hospital, BHP, is part of UCHS’ plan to restructure its health care services and modernize its delivery system, which will consolidate services and realize cost savings and efficiencies. UM Harford Memorial Hospital (“HMH”) will be converting to a freestanding medical facility (“FMF”) and, while maintaining psychiatric services in Harford County, will be establishing a psychiatric specialty hospital in the same building as the FMF. UCHS is constructing a new two-story building five miles from the HMH campus, which will house both the FMF and BHP. The opening is targeted for February 6, 2024. The first floor will house the FMF, and the second floor will include thirty-three inpatient psychiatric beds. Outpatient services including a partial hospitalization program and an outpatient psychiatric clinic will be in the medical office building adjacent to the FMF/BHP building and connected via a skywalk. HMH operates the only acute care adult psychiatric hospital program in Harford County. The establishment of the specialty psychiatric hospital ensures that access to psychiatric services remains in Harford County. As outlined in the CON, UCHS demonstrated that Harford County has a need for thirty-three inpatient psychiatric beds, and the proposed plan complies with the applicable State Health Plan standards.

The Staff recommendation provides BHP with reasonable revenue to cover costs associated with the projections cited in the full rate application. Staff recommends that the HSCRC approve the recommended revenue and unit as noted below, effective February 6th, 2024, for the UM Upper Chesapeake Behavioral Health Pavilion at Aberdeen. Staff also recommends the following:

- That the recommended revenue and unit rates be considered a stub period to account for the five months of the fiscal year that the Hospital will be open.
  - These rates are being recommended for commercial payers. Rates for Governmental payers will be based on Medicare and Medicaid reimbursement schedules and the Hospital will not be subject to a Global Budget.
- That the Commission provides full inflation for BHP for Fiscal Years 2025 and 2026 without an offset for efficiency.

- That if the Hospital does not achieve the anticipated level of savings revenue will be removed from UM Upper Chesapeake to ensure previously agreed upon savings levels are met.

<b><u>HEALTH SERVICES COST REVIEW COMMISSION</u></b>				
New Approved Revenue and Unit Rates for <b>UM Upper Chesapeake Behavioral Health Pavilion at Aberdeen</b>				
Effective February 6, 2024				
<b>Revenue Center</b>	<b>Service Unit</b>	<b>Unit Rates</b>	<b>Budgeted Volume</b>	<b>Budgeted Annual Revenues</b>
Psych Adult	Patient Days	\$1,731.7800	3,268	\$5,659,465
Psychiatric - Geriatric Admissions	Patient Days	\$1,545.6400	918	\$1,419,413
Clinic Services	Admission	\$761.4100	508	\$386,969
Psychiatric Day/Night	RVU'S	\$15.3900	8,767	\$134,930
Laboratory	Visits	\$726.4000	1,625	\$1,180,400
Electrocardiography	MD RVU'S	\$7.6500	182,172	\$1,393,617
Electroencephalography	MD RVU'S	\$16.0000	2,162	\$34,593
Radiology-Diagnostic	74 CAL RVU'S	\$3.7100	929	\$3,448
CT Scanner (R)	HSCRC RVU'S	\$59.4300	1,124	\$66,784
MRI Scanner (R)	RVU'S	\$5.5800	1,954	\$10,903
Physical Therapy	RVU'S	\$39.8200	467	\$18,589
Respiratory Therapy	MD RVU'S	\$35.7400	512	\$18,297
Occupational Therapy	MD RVU'S	\$4.8800	7,141	\$34,849
Speech Therapy	RVU'S	\$24.6400	396	\$9,768
	RVU'S	\$12.4600	60	\$748
(R) Rebundled Rate	<b>TOTAL</b>			<b><u>\$10,372,772</u></b>
<b><u>CHARGES for MEDICAL SUPPLIES and DRUGS SOLD</u></b>				
		<b><u>Mark up</u></b>		<b><u>Maximum Annual Overhead</u></b>
Med/Surg Supplies	Invoice Cost plus Markup of	1.26750	, plus Overhead of	\$1,276
Drugs	Invoice Cost plus Markup of	1.26750	, plus Overhead of	\$565,328

This facility is expected to open in February 2024, therefore, the rate order shown above represents a stub period of 5 months of the rate year.

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

**ITEM VI**  
**UNIVERSITY OF MARYLAND REHABILITATION AND ORTHOPAEDIC INSTITUTE**

Ron Cummings, Senior Vice President and CEO, University of Maryland Medical Center (UMMC ) and Alicia Cunningham, Senior Vice President Reimbursement and Revenue Advisory Services, University of Maryland Medical System (UMMS), presented UMMS redesign proposal for UM Rehabilitation & Orthopaedic Institute (“ROI”) ( see ”UM Rehabilitation & Orthopaedic Institute Redesign Proposal” available on the HSCRC website).

The goals for the ROI redesign proposal are as follows:

- Enhance Inpatient Trauma Rehab by relocating to the University of Maryland Medical Center downtown campus (Stoler Center for Advanced Medicine).
- Relocate Inpatient Complex Medical Rehab and Stroke/Neuro Rehab to new Inpatient Rehabilitation Facility (IRF).
- Contribute funding to support UMMS’ robust community health infrastructure in Baltimore City.
- Create savings by reducing footprint for acute hospital-based services. Consolidate into UMMC’s Midtown and Downtown campuses.

Outline of Anticipated Clinical Program Distribution (\$148M total GBR)

- Inpatient Rehabilitation-
  - Stoler Center - Traumatic Brain Injury, Spinal Cord Injury, and Comprehensive Medical (30%) (GBR 40M).
  - Freestanding IRF- Stroke/Neuro, and Comprehensive Medical (70%) (GBR 37M).
- Acute Hospital Services-
  - Services moving into UMMC Midtown or Downtown- Faculty Programs- Most Ortho Surgery (74%), Other Surgery, and OP dental surgery and clinic, OP Pain, most OP Therapies (68%),and OP Clinics (GBR 46M) .
  - Dissipate to another Acute provider non-faculty surgeries, some faculty ortho surgery (26%), and some OP therapies (GBR \$25M).

ROI Redesign Program aligns with the Model goals as follows:

- Maintains access to needed inpatient rehabilitation level of care.
- Enhanced care delivery for service lines that rely on rehab services as an integral function.
- Needed recapitalization funded entirely within existing resources.
- Eliminates acute capacity. More efficient acute footprint
  - Consolidation of ORs, MDGA beds, Ancillary services, and physician coverage
- Estimated \$29 M revenue beyond ongoing costs of project (operating and capital) entirely dedicated to system savings or community health infrastructure.
  - \$21.5 to system savings
  - \$7.33M to support community health efforts

**ITEM VII**  
**DRAFT RECOMMENDATION ON MARYLAND HOSPITAL ACQUIRED CONDITIONS PROGRAM**

Alyson Shuster, Deputy Director, Quality Methodologies, and Diane Feeney, Associate Director presented staff's draft recommendation on the Maryland Hospital Acquired Conditions Policy for RY 2026 (see "Draft Recommendation for The Maryland's Hospital Acquired Conditions Policy for Rate Year 2026" available on the HSCRC website).

The quality programs operated by the HSCRC, including the Maryland Hospital Acquired Conditions program (MHAC), are intended to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance.

The MHAC program is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time.

The MHAC policy currently holds 2 percent of inpatient hospital revenue at-risk for complications that may occur during a hospital stay because of treatment rather than the underlying progression of disease. Examples of the types of hospital acquired conditions included in the current payment program are respiratory failure, pulmonary embolisms, and surgical-site infections.

This policy affects a hospital's overall GBR and so affects the rates paid by payers at that hospital. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.

Historically the MHAC policy included the better of improvement and attainment, which incentivized hospitals to improve poor clinical outcomes that are often emblematic of disparities. The protection of improvement has since been phased out to ensure that poor clinical outcomes and the associated health disparities are not made permanent, which is especially important for a measure that is limited to in-hospital complications. In the future, the MHAC policy may provide direct hospital incentives for reducing disparities, like the approved readmission disparity gap improvement policy. Also for future consideration is inclusion of electronic Clinical Quality Measures to address areas such as maternal complications, which disproportionately impact lower income, minority patients.

The MHAC policy was redesigned in Rate Year (RY) 2021 to modernize the program for the new Total Cost of Care Model. This RY 2026 draft recommendation, in general, maintains the measures and methodology that were developed and approved for RYs 2022 through 2025.

These are the draft recommendations for the RY 2026 Maryland Hospital Acquired Conditions (MHAC) program:



1. Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.
  - a. Maintain a focused list of PPCs in the payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
  - b. Assess monitoring PPCs based on clinical recommendations, statistical characteristics, and recent trends to prioritize those for future consideration for updating the measures in the payment program.
  - c. Engage hospitals on specific PPC increases as indicated/appropriate to understand trends and discuss potential quality concerns.
2. Use more than one year of performance data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs). The performance period for small hospitals will be CYs 2023 and 2024.
3. Continue to assess hospital performance on attainment only, with adjustment to performance standards for increased stability.
4. Continue to weigh the PPCs in the payment program by 3M cost weights as a proxy for patient harm.
5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent and continuous linear scaling with a hold harmless zone between 60 and 70 percent.
6. Future Considerations:
  - a. Assess options for streamlining (or simplifying) the quality programs overall, or for the hospital acquired complication measures that are currently included in both the QBR Safety Domain and the MHAC program.
  - b. Assess digitally specified quality measures such as electronic Clinical Quality Measures (eCQMs) for future inclusion in quality programs.

No Commission action is necessary as this is a draft recommendation.

**ITEM VIII**  
**EMERGENCY DEPARTMENT DRAMATIC EFFORT (EDDIE) UPDATE**

Dr. Shuster and Jason Mazique, Population Health Project Manager, Quality and Population-Based Methodologies, presented the monthly update on the Emergency Department Dramatic Improvement Performance for December (see “Emergency Department Dramatic Improvement Effort” available on the HSCRC website).

Dr. Schuster stated that Staff received December data from all the hospitals. She noted when the December data was compared to the June data there were three hospitals that had more than a 10% decrease in their length of stay, however, about 50% of the hospitals reported more than a 10% increase. Dr. Schuster noted that seasonality may be the reason for the fluctuation.

Mr. Mazique presented the hospital's EDDIE data for December. Data shows a handful of hospitals falling into a worse (longer wait time) category and none improving.

Dr. Schuster reviewed the QBR ED LOS Measure Development Plan. The Plan is based on the work of two subgroups.

- Subgroup 1-Develop a mechanism to collect ED length of stay data for patients admitted to the hospital. This subgroup will start at the end of January.
- Subgroup 2- Develop ED LOS measure and incentive methodology for RY 2026 QBR. This subgroup will start at the end of March.

Dr. Shuster stated that the next steps are as follows:

- Start QBR ED LOS Workgroup
- Finalize workplan for additional subgroup on Best Practices (1percent idea)
- Continue monthly data collection from hospitals and MIEMSS.
  - Address reporting questions and concerns with hospitals.
  - Present results at monthly Commission meeting.
  - Add visualizations suggested by Commissioners and other stakeholders.
- Collect and present progress on hospital improvement goals from MHA at the monthly Commission meeting. MHA will present an update in January.
- Collaborate with MHA on legislative request and EDDIE quality improvement initiative.

Erin Davis, Director, Quality & Health Improvement, MHA provided an update on the MHA Hospital Throughput Performance Improvement (see "MHA Hospital Throughput Performance Improvement Update" available on the HSCRC website).

The timeline for the MHA ED Improvement Plan is as follows:

#### Emergency Department (ED) Crowding Collaborative

- May - July 2023
- Weekly meetings bringing together multidisciplinary experts to present on and discuss macro and micro solutions to whole system throughput.
- Facilitated by MHA and Dr. Amy Boutwell
- Lessons learned:
  - Many Maryland hospitals have already implemented strategies discussed.
  - Hospitals are diverse and need individual intervention.
  - Scalability and funding can be challenging.

- To make a meaningful impact, hospitals and communities must address interventions upstream and downstream.

### Hospital Throughput Collaborative

- Initiated August 2023 in support of the Emergency Department Dramatic Improvement Effort (EDDIE)
- Facilitated by MHA and Rhonda Wyskiel, RN, MSN
- Four geographic cohorts meet monthly to discuss progress, collaborate and support each other in rapid cycle improvement.
- Guided topical discussion.
- Distribution and review EDDIE data
- On-site hospital visits - 2 completed.

### Aim Statements

- Collected by MHA and submitted to HSCRC in September 2023
- Global vs specific aim statements:
  - Global Aim: Includes a clinical outcome that can be influenced by many factors.
  - Specific aim or “SMART” aim: Progresses towards the Global AIM. The specific or “SMART” aim relates to the global aim via a unifying theory.
- Hospitals were encouraged to submit a specific aim to foster conversation at the process level during meetings.
- Although only 1-3 aim statements were submitted by an individual hospital, hospitals have many improvement projects occurring simultaneously to improve hospital and ED throughput.

### Key Takeaways

- Hospitals are engaging in process improvement activities to improve throughput within the areas they have influence.
- We need help from other partners to address external contributors, including factors that delay hospital discharges and lead to individuals using the ED as a source of primary care.
- We all need to work together to improve the experience for patients in this complex health care system.

### Next Steps

- Continue monthly meetings through July 2024
- Continue to evaluate how MHA can support hospitals and health systems in performance improvement initiatives.
- Evaluate the benefits and resources needed to collect additional data.

**ITEM IX**  
**POLICY UPDATE AND DISCUSSION**

**Model Monitoring**

Deon Joyce Chief of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 9 months ending September 2023. The data showed that Maryland’s Medicare Hospital spending per capita growth was favorable when compared to the nation. Ms. Joyce stated that Medicare Nonhospital spending per-capita was favorable when compared to the nation. Ms. Joyce noted that Medicare Total Cost of Care (TCOC) spending per-capita was favorable compared to the nation. Ms. Joyce noted that the Medicare TCOC guardrail position is 2.84% below the nation through September and that Maryland Medicare hospital and non-hospital growth through September shows a savings of \$244,774,000.

**Hospital Reimbursement Law Stakeholder Engagement**

Megan Renfrew, Deputy Director, External Affairs and Policy, presented an overview of the implementation of the Hospital Free Care Reimbursement Law (see “Hospital Free Care Reimbursement Law Implementation” available on the HSCRC website).

The Fall 2023 Commission retreat included a discussion of Commission workgroups and stakeholder engagement. The purpose of this agenda item is to provide an update on the stakeholder engagement process for the implementation of Health General §19-214.4, which requires general acute care and chronic care hospitals to provide refunds to eligible patients who paid more than \$25 for hospital services received in any year between 2017 and 2021 and who were eligible, at the time of service, for free care from the hospital under Maryland’s hospital financial assistance law. The patients who are eligible for free care have family incomes under 200% of the federal poverty level or are enrolled in the Supplemental Nutrition Assistance Program, the Maryland Energy Assistance Program, the Women and Infant Children’s Program patients, or the free and reduced lunch program.

Under the 2023 amendments to the law, HSCRC is required to work with the Maryland Department of Health, the Department of Human Services, the Office of the Comptroller, the Maryland State Department of Education, the Health Education and Advocacy Unit of the Office of the Attorney General, and the Maryland Hospital Association to develop a process to use tax data and data from the Supplemental Nutrition Assistance Program, the Maryland Energy Assistance Program, and the Women and Infant Children’s Program to identify potentially eligible hospital patients.

HSCRC has been working to develop the necessary policies and procedures to implement the amended law through three subject-specific workgroups:

1. Policy & Legal - Purpose: advise HSCRC on the content of contractual documents and other policy and legal issues to support the implementation of the law. This workgroup has met 3 times.
2. Data Management - Purpose: to advise HSCRC on the creation rules related to data management, secure data transfer, matching methodology, and similar topics. This workgroup has met 5 times.

3. Consumer Support and Communications - Purpose: to advise HSCRC on the development of policies, plans, and documents related to consumer support and consumer communications. This workgroup has met 3 times.

Ms. Renfrew stated that Staff provides periodic updates on the implementation of this law to the sponsor of the legislation, the relevant HGO subcommittee chair, and to the consumer advocates. A legislative report is due October 1, 2024.

Staff also provided an overview of the law to all hospital CFOs at an MHA Technical Workgroup meeting in July.

A draft of the memorandum of understanding and data sharing and nondisclosure agreement was sent to hospital CEOs, CFOs, state agencies, and consumer advocates in December for review and comment. The draft is also posted on HSCRC's website, and feedback is due by February 7, 2024.

### **Process Updates**

Erin Schurmann, Chief, Provider Alignment and Special Projects, presented an update on the HSCRC policy development and workgroup process (see "Policy Development & Workgroup Process Updates" available on the HSCRC website).

### **ITEM X** **HEARING AND MEETING SCHEDULE**

February 14, 2024,	Times to be determined- 4160 Patterson Ave HSCRC Conference Room
March 13, 2024,	Times to be determined- 4160 Patterson Ave. HSCRC Conference Room

There being no further business, the meeting was adjourned at 3.39 p.m.

**Closed Session Minutes  
of the  
Health Services Cost Review Commission**

**January 10, 2023**

Upon motion made in public session, Chairman Sharfstein 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, §3-103 and §3-104
3. Update on Commission Response to the COVID-19 Pandemic – Authority General Provisions Article, §3-103 and §3-104
4. Consultation with Legal Counsel-Authority General Provisions Article, Section §3-305

The Closed Session was called to order by motion at 11:35 a.m.

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

In attendance representing Staff were Jon Kromm, Jerry Schmith, Allan Pack, William Henderson, Claudine Williams, Alyson Schuster, Cait Cooksey, Megan Renfrew, Erin Schurmann, Christa Speicher, Fred Katz, and Dennis Phelps. Attending via conference call was Cait Cooksey.

Also attending was Ari Elbaum Commission Counsel. Attending via conference call was Stan Lustman Commission Counsel.

**Item One**

Jon Kromm, Executive Director, updated the Commission on the progress of the AHEAD Model.

## **Item Two**

William Henderson, Director, Medical Economics & Data Analytics, updated the Commission and the Commission discussed Maryland Medicare Fee-For-Service TCOC versus the nation.

## **Item Three**

Mr. Henderson briefly updated the Commission on the hospitals' unaudited financial performance through November 2023.

The Closed Session was adjourned at 12:30 p.m.



maryland  
**health services**  
cost review commission

---

## Open Cases Overview

February 14, 2024



# Open Cases

- 2642N: University of Maryland Medical Center - Partial Rate Application for Ambulance Services as a rebundled service - **Requires Commission Vote**
- 2643N: Brook Lane Hospital - Partial Rate Application to collapse therapies into room and board and daily visit rate centers - **Requires Commission Vote**
- 2630R: UM Shore Medical Center at Easton - Full Rate Application - *No action required at this time*



maryland  
**health services**  
cost review commission

---

## Partial Rate Application Staff Recommendation

Proceeding 2642N

# Proceeding 2642N University of Maryland Medical Center

On December 14, 2023, University of Maryland Medical Center (“UMMC,” or “the Hospital”) submitted a partial rate application to the Commission requesting the creation of a new rebundled rate for Ambulance - Rebundled (AMR) services effective March 1, 2024. A rebundled rate is approved by the Commission when a hospital provides certain non-physician services through a third-party contractor off-site. By approving a rebundled rate, the Commission makes it possible for a hospital to bill for the services provided off-site, as required by Medicare. The Hospital requests that the rebundled AMR rate be set at the state-wide median. This request is revenue neutral and will not result in any additional revenue for the Hospital.

<u>Service</u>	<u>Service Unit</u>	<u>Unit Rate</u>	<u>Projected Volumes</u>	<u>Approved Revenue</u>
Ambulance Services – Rebundled	RVUs	\$6.24	1	\$6

## Recommendation

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

1. That a rate of \$6.24 be approved effective March 1, 2024 for AMR services;
2. That no change be made to the Hospital’s Global Budget Revenue for the AMR services.
3. That AMR as a rebundled service is exempt from rate realignment.

**IN RE: THE PARTIAL RATE**

\* **BEFORE THE HEALTH  
SERVICES**

**APPLICATION OF THE**

\* **COST REVIEW COMMISSION**

**UNIVERSITY OF MARYLAND**

\* **DOCKET: 2023**

**MEDICAL CENTER**

\* **FOLIO: 2452**

**BALTIMORE, MARYLAND**

\* **PROCEEDING: 2642N**

**Staff Recommendation  
February 14, 2024**

## **Introduction**

On December 14, 2023, University of Maryland Medical Center (“UMMC,” or “the Hospital”) submitted a partial-rate application requesting the creation of a new rebundled rate for Ambulance – Rebundled (AMR) services. A rebundled rate is approved by the Commission when a hospital provides certain non-physician services through a third-party contractor off-site. By approving a rebundled rate, the Commission makes it possible for a hospital to bill for the services provided off-site, as required by Medicare. The Hospital requests that the rebundled AMR rate be set at the state-wide median and be effective March 1, 2024.

## **Staff Evaluation**

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital’s projections. As this service will be provided by a third-party contractor as a rebundled service, no cost finding is necessary. The state-wide median for AMR services is \$6.24 per RVU.

<b><u>Service</u></b>	<b><u>Service Unit</u></b>	<b><u>Unit Rate</u></b>	<b><u>Projected Volumes</u></b>	<b><u>Approved Revenue</u></b>
Ambulance Services – Rebundled	RVUs	\$6.24	1	\$6

## **Recommendation**

After reviewing the Hospital’s application, the staff recommends:

1. That a rate of \$6.24 be approved effective March 1, 2024 for AMR services;
2. That no change be made to the Hospital’s Global Budget Revenue for the AMR services.
3. That AMR as a rebundled service is exempt from rate realignment.



maryland  
**health services**  
cost review commission

---

## Partial Rate Application Staff Recommendation

Proceeding 2643N

Teneshia J. Richards-Brooks  
Analyst, Rate Setting  
Revenue & Regulation Compliance  
Email Address: [Teneshia.Richards-Brooks@maryland.gov](mailto:Teneshia.Richards-Brooks@maryland.gov)

# Staff Recommendation:

## Introduction

On January 11, 2024, Brook Lane Health Services (“the Hospital”) submitted a partial rate application to the Commission requesting to bundle therapy revenue from Individual Therapy (ITH) and Group Therapy (GTH) into the room charge Psychiatric Adult (PAD) and Psychiatric Child and Adolescent (PCD) for Inpatient services and into the daily charge for Psychiatric Day/Night (PDC) to be effective January 1, 2024. These services were previously billed separately.

# Staff Recommendation

## Staff Evaluation

This request is revenue neutral and will not result in any additional revenue for the Hospital. The consolidation of these therapies will bring the Hospital in line with other Psychiatric Hospitals. Staff evaluated the reasonableness of this request by comparing the rates Brook Lane Hospital requested to the rates of Sheppard Pratt. The table below illustrates the analysis that staff completed which compares the net revenue at Sheppard Pratt and Brook Lane. The net revenue generated at Brook Lane using their requested rates is lower than the net revenue at Sheppard Pratt, which staff believe to be reasonable.

	a	b	c	d = b/c	e=d*a	f	g	h=f/g	i=h*a
	Brook Lane Budgeted Volume	Sheppard Pratt Rate	Sheppard Pratt MarkUp	Net Reimbursment	Net Revenue	Brook Lane Requested Rate	Brook Lane Markup	Net Reimbursement	Net Revenue
PAD	6248	\$ 1,634	1.1453	\$ 1,426	\$ 8,911,127	\$ 1,363	1.1667	\$ 1,168	\$ 7,300,466
PCD	11459	\$ 1,565	1.1453	\$ 1,366	\$ 15,656,349	\$ 1,392	1.1667	\$ 1,193	\$ 13,675,594
PDC	3699	\$ 328	1.1453	\$ 287	\$ 1,059,944	\$ 580	1.1667	\$ 497	\$ 1,839,983
				Total Net Rev	\$ 25,627,420			Total Net Rev	\$ 22,816,043



## Staff Recommendation:

The Hospital's new proposed rate are as follows:

	Budgeted Volumes	Approved Revenue	Recommended Unit Rate
Psychiatric Adult (PAD)	6,248	\$8,517,559	\$1,363.23
Psychiatric Child and Adolescent (PCD)	11,459	\$15,955,211	\$1,392.38
Psychiatric Day/Night (PDC)	3,699	\$2,146,708	\$580.35

# Staff Recommendation

## Recommendation

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

1. That the Hospital be allowed to collapse Individual Therapy (ITH) and Group Therapy (GTH) into the Psychiatric Adult (PAD) and Psychiatric Child and Adolescent (PCD), and Psychiatric Day/Night (PDC) rate centers;
2. That rates outlined for Psychiatric Adult (PAD) and Psychiatric Child and Adolescent (PCD), and Psychiatric Day/Night (PDC) be approved effective January 1, 2024; and
3. That the rates approved herein be revenue neutral.

<b>IN RE: THE PARTIAL RATE</b>	*	<b>BEFORE THE HEALTH SERVICES</b>
<b>APPLICATION OF</b>	*	<b>COST REVIEW COMMISSION</b>
<b>BROOK LANE</b>	*	<b>DOCKET: 2023</b>
<b>HEALTH SERVICES</b>	*	<b>FOLIO: 2453</b>
<b>HAGERSTOWN, MARYLAND</b>	*	<b>PROCEEDING: 2463N</b>

**Staff Recommendation**  
**February 14, 2024**

**Introduction**

On January 11, 2024, Brook Lane Health Services (“the Hospital”) submitted a partial rate application to the Health Services Cost Review Commission requesting to bundle therapy revenue from Individual Therapy (ITH) and Group Therapy (GTH) into the room charge Psychiatric Adult (PAD) and Psychiatric Child and Adolescent (PCD) for Inpatient services and into the daily charge for PsychiatricDay/Night (PDC) to be effective January 1, 2024. These services were previously billed separately.

**Staff Evaluation**

This request is revenue neutral and will not result in any additional revenue for the Hospital. The consolidation of these therapies will bring the Hospital in line with other Psychiatric Hospitals. Staff evaluated the reasonableness of this request by comparing the rates Brook Lane Hospital requested to the rates of Sheppard Pratt. The table below illustrates the analysis that staff completed, which compares the net revenue at Sheppard Pratt and Brook Lane. The net revenue generated at Brook Lane using their requested rates is lower than the net revenue at Sheppard Pratt, which staff believes to be reasonable.

	a	b	c	d = b/c	e=d*a	f	g	h=f/g	i=h*a
	Brook Lane Budgeted Volume	Sheppard Pratt Rate	Sheppard Pratt Markup	Net Reimbursement	Net Revenue	Brook Lane Requested Rate	Brook Lane Markup	Net Reimbursement	Net Revenue
PAD	6248	\$ 1,634	1.1453	\$ 1,426	\$ 8,911,127	\$ 1,363	1.1667	\$ 1,168	\$ 7,300,466
PCD	11459	\$ 1,565	1.1453	\$ 1,366	\$ 15,656,349	\$ 1,392	1.1667	\$ 1,193	\$ 13,675,594
PDC	3699	\$ 328	1.1453	\$ 287	\$ 1,059,944	\$ 580	1.1667	\$ 497	\$ 1,839,983
				Total Net Rev	\$ 25,627,420			Total Net Rev	\$ 22,816,043

The Hospital’s new proposed rates are as follows:

	Budgeted Volumes	Approved Revenue	Recommended Unit Rate
<b>Psychiatric Adult (PAD)</b>	6,248	\$8,517,559	\$1,363.23
<b>Psychiatric Child and Adolescent (PCD)</b>	11,459	\$15,955,211	\$1,392.38
<b>Psychiatric Day/Night (PDC)</b>	3,699	\$2,146,708	\$580.35

## **Recommendation**

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

1. That the Hospital be allowed to collapse Individual Therapy (ITH) and Group Therapy (GTH) into the Psychiatric Adult (PAD) and Psychiatric Child and Adolescent (PCD), and Psychiatric Day/Night (PDC) rate centers;
2. That rates outlined for Psychiatric Adult (PAD) and Psychiatric Child and Adolescent (PCD), and Psychiatric Day/Night (PDC) be approved effective January 1, 2024; and
3. That the rates approved herein be revenue neutral.



maryland  
**health services**  
cost review commission

---

# University of Maryland Rehabilitation and Orthopedic Institute Trauma Reunification Project

Staff Recommendation

February 14, 2024

# Background & Overview

On November 15, 2023, as part of its “Trauma Reunification Project,” the University of Maryland Medical System (UMMS) provided a Letter of Intent to

- Transfer rehab beds from University of Maryland Rehabilitation and Orthopedic Institute (UMROI) to University of Maryland Medical Center (UMMC) - 27% of GBR (Component 1)
  - 25 acute inpatient rehab traumatic brain injury beds
  - 18 acute inpatient rehab spinal cord injury beds
  - 5 chronic care beds, and
  - 10 dually licensed acute inpatient rehab and chronic beds
- Allow medical and surgical volumes to be absorbed by existing operating room capacity, primarily within the UMMS system, at which time UMROI plans to close its four acute care hospital beds - 48% of GBR (Component 2 and 3)
  - UMROI’s pediatric dental surgical volumes will be relocated to the UMMC downtown campus
  - UMMS intends to relocate UMROI’s outpatient clinic services, including dental clinic volumes, to UMMC Midtown.
- Deregulate non-trauma acute inpatient rehabilitation care, inclusive of neurology and stroke - 25% of GBR (Component 4)
  - Eventually will relocate 60 beds to a more modern setting
  - See Appendix A for current and future beds

Service	Revenue	Trauma Reunification Project Action
Spinal Cord Injury (SCI) -- Acute	\$14,597,507	Shift to UMMC; FMF Analogous (Component 1)
Traumatic Brain Injury (TBI) -- Acute	\$12,933,003	Shift to UMMC; FMF Analogous (Component 1)
Comprehensive Rehab (CMR) -- Acute (30%)	\$5,246,268	Shift to UMMC; FMF Analogous (Component 1)
Traumatic Brain Injury (TBI) -- Chronic	\$5,903,230	Shift to UMMC; FMF Analogous (Component 1)
Spinal Cord Injury (SCI) -- Chronic	\$1,750,141	Shift to UMMC; FMF Analogous (Component 1)
OP Orthopedic Surgery - Faculty (74%)	\$18,716,635	Absorb into UMMC DTC or Midtown (Component 2)
OP Dental Surgery	\$7,161,790	Absorb into UMMC DTC or Midtown (Component 2)
OP Pain Clinic	\$7,001,036	Absorb into UMMC DTC or Midtown (Component 2)
OP Clinics	\$4,442,966	Absorb into UMMC DTC or Midtown (Component 2)
IP Surgery - Faculty	\$3,363,523	Absorb into UMMC DTC or Midtown (Component 2)
OP therapy (68%)	\$3,350,170	Absorb into UMMC DTC or Midtown (Component 2)
OP Dental Clinics	\$1,259,385	Absorb into UMMC DTC or Midtown (Component 2)
OP Surgery - Non-Ortho	\$177,150	Absorb into UMMC DTC or Midtown (Component 2)
OP Orthopedic Surgery - Non-Faculty	\$12,577,903	Dissipate to other acute provider (Component 3)
OP Orthopedic Surgery - Faculty (26%)	\$6,684,513	Dissipate to other acute provider (Component 3)
IP Surgery - Non-Faculty	\$2,751,973	Dissipate to other acute provider (Component 3)
OP Therapy (32%)	\$1,546,232	Dissipate to other acute provider (Component 3)
OP Surgery -- Other	\$1,099,688	Dissipate to other acute provider (Component 3)
All Other	\$153,769	Dissipate to other acute provider (Component 3)
Stroke (CVA) -- Acute	\$14,876,576	Deregulate (Component 4)
Comprehensive Rehab (CMR) -- Acute (70%)	\$12,241,292	Deregulate (Component 4)
Stroke (CVA) -- Chronic	\$5,036,843	Deregulate (Component 4)
Comprehensive Rehab (CMR) -- Chronic	\$4,483,401	Deregulate (Component 4)
<b>Total</b>	<b>\$147,354,995</b>	

# Hospital Request

- To effectuate this transition of services, UMMS has submitted a Request for Exemption from Certificate of Need from MHCC in order to construct four additional floors on top of the planned Stoler Center for Advanced Medicine and will renovate certain existing space in UMMC's North Hospital.
  - The relocated rehab and chronic care beds from UMROI will occupy two of these floors
- The hospital is requesting of the HSCRC the following:
  - Retention of 75 percent of UMROI's global budget revenue for volume that remains at UMMS regulated facilities,
  - 50 percent of UMROI's global budget revenue related to volume that shifts to non-UMMS hospitals or to any unregulated facilities, and
  - Exemption of UMROI from the Commission's Integrated Efficiency policy until such time as the Project is completed.

Will yield system savings of \$21.5 million (14.6%)

	1) Trauma Rehab/Chronic to Stoler Center (Build at DTC)	2) Acute Relocated to DTC/MTC	3) Acute Care Shifted to Other Providers	4) Shift to Freestanding	Total	% of Current GBR
UM Rehab GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	
Proposed Retention	75%	75%	50%	50%		
<b>Retained GBR @ UMMS</b>	<b>\$30,323</b>	<b>\$34,104</b>	<b>\$12,407</b>	<b>\$18,319</b>	<b>\$95,153</b>	<b>65%</b>
<b>Redistribution of UM Rehab GBR</b>						
Retained at UMMS	\$30,323	\$34,104	\$12,407	\$18,319	\$95,153	65%
Shift to Other Providers	-	-	12,407	18,319	30,726	21%
System Savings	10,108	11,368	-	-	21,476	15%
UM Rehab FY 2023 GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	100%



## Guiding Principles

- The Commission does not yet have a facility conversion policy, so the following principles were adhered to when evaluating the hospital request
  - Ensure that adequate funding is provided to cover the cost of services
  - Ensure that access is not compromised by the conversion
  - Whenever possible, use available policies or prior practice to avoid arbitrary and capricious treatment
  - Ensure a reasonable level of savings is achieved
  - Consider using additional savings to fund population health investments

# Staff Analysis - Variable Cost Factors (VCF)

- Staff determined that there are 4 components to the Trauma Reunification Project that warrant distinct VCF's
  - Component 1** - shifting at a 100% VCF high acuity rehab services wholesale to UMMC where no current service exists- analogous to prior Freestanding Medical Facility (FMF) conversions
  - Component 2** - shifting at a 65% VCF medical and surgical volumes to other UMMS hospitals because these services exist and UMROI will cease to be regulated as an inpatient facility (analogous to other FMF conversions of 65%)
  - Component 3** - shifting medical and surgical volumes at 50% VCF to non-UMMS hospitals - in line with the marketshift policy
  - Component 4** - shifting the remaining volumes at UMROI to a deregulated environment - an entirely new action and demanding of a much a lower VCF
- With the exception of Component 4, all of the proposed variable cost factors are based off of policy or prior practice
  - Component 4 has no readily available anchor because the Commission has not yet experienced a case where the remaining facility will have no regulated services
  - Staff advanced a 15% variable cost factor because a) there is a need for overhead services to still be supported and b) an evaluation of statewide overhead expenses indicated they were 14% of total costs

	HSCRC					
	1) Trauma Rehab/Chronic to Stoler Center (Build at DTC)	2) Acute Relocated to DTC/MTC	3) Acute Care Shifted to Other Providers	4) Shift to Freestanding	Total	% of Current GBR
UM Rehab GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	
Proposed Retention	100%	65%	50%	15%		
<b>Retained GBR @ UMMS</b>	<b>\$40,430</b>	<b>\$29,557</b>	<b>\$12,407</b>	<b>\$5,496</b>	<b>\$87,890</b>	<b>60%</b>
<b>Redistribution of UM Rehab GBR</b>						
Retained at UMMS	\$40,430	\$29,557	\$12,407	\$5,496	\$87,890	60%
Shift to Other Providers	-	-	12,407	18,319	30,726	21%
System Savings	-	15,915	-	12,823	28,739	19.5%
UM Rehab FY 2023 GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	100%

Will yield system savings of \$28.7 million (19.5%)

# Reasonable Savings

- For this guiding principle staff reviewed prior conversions, potential savings from rehab site neutrality and the full rate application methodology
  - Prior conversions yielded savings of 5-15%
    - 13% for Dorchester Hospital
    - 12% for Harford Memorial
    - 7% for Bon Secours/Grace
    - 7% for McCready Hospital
    - 3% for Laurel Medical Center
  - Site neutrality estimates indicated there could be \$55 million in savings; however, given the need for highly specialized spine and TBI rehab, the more relevant savings is \$21.2M
  - The Full Rate Application analysis indicated that rebasing the hospital to the statewide average cost per case plus the historical statewide average regulated profit of 8 percent, would yield a revenue reduction of 22.10%
- Thus, savings of \$28.7M (19.5%) seems reasonable

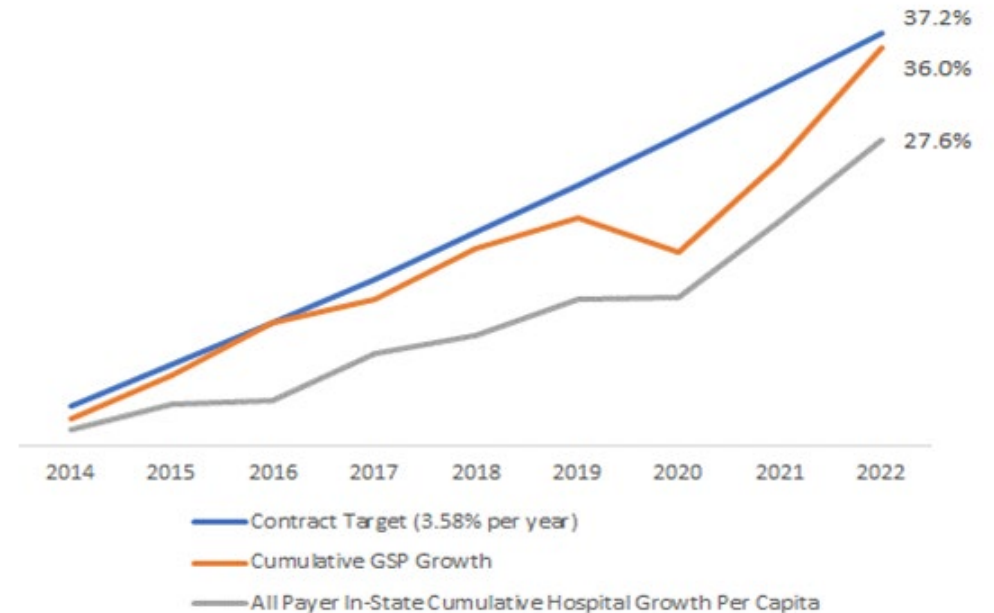
Potential  
Solution for  
Facility  
Conversion  
Policy

# Additional Considerations #1

- Exemption from Integrated Efficiency
  - In RY 2024, UMROI incurred an inflation offset of \$2.3 million through the Integrated Efficiency Policy, which they are currently trying to “buyout” from through the Revenue for Reform policy.
  - To achieve the system savings identified in this recommendation, UMROI would presumably have to incur Integrated Efficiency reductions for 10 years
  - UMROI is requesting that system savings be scored when the project goes live in 2027 and in return the hospital be exempt from future Integrated Efficiency inflation offsets until the project is completed
- Integrated Efficiency policy is achieving one of its intended aims to compel hospitals to transform its care delivery model
- If the proposed savings amount is sufficient, staff believe this approach is a benefit to the system because savings and associated transformation occur at a faster rate.

## Additional Considerations #2

- Consider using additional savings to fund population health investments
  - Staff's recommendation increases the expected savings by \$7.3M, from \$21.5M to \$28.7M
- While staff believes the proposed \$21.5M should be counted as system savings, staff does believe the Commission should consider earmarking the additional \$7.3M to population health investments, specifically through the Revenue for Reform policy
- Staff's rationale is threefold:
  - a) the intention of the Model is to use healthcare dollars for genuine care delivery transformation, not to simply generate savings as other models, e.g., the Inpatient Prospective Payment System, are for more effective at the latter
  - b) the Model currently does not require additional Medicare total cost of care savings to comply with contractual savings targets and
  - c) the main lever to achieve savings in the Model for all-payers continues to be the annual Update Factor, which to date has been quite successful at bending the cost curve relative to statewide economic growth



# Additional Considerations #3

- Ensure access is not comprised
- Staff recommends that funding agreements are contingent on actual volume changes being equivalent to projected volumes.
  - If UMMS reduces the extent of unregulated rehab services, the \$5.5 million associated with a 15% VCF in Component 4 will be clawed back
- Staff also concluded that if unregulated rehab services are not provided, the hospital would decrease its profitability by \$11.6M through “inherent risk.”
- Staff also recommend that UMMS and the HSCRC enter into a contractual agreement, subsequent to the approval of this recommendation, that will codify service level agreements that UMMS must meet.

	Data Inputs	
Total "Bucket 4" cases (All payor cases * 80% from UMMS)	684	<i>80% of UMROI cases are from UMMC, UM Midtown</i>
Excess acute days per case if no IRF (and patient must go to SNF)	5	
Total excess acute days if no IRF (and patient must go to SNF) -- assumed to be at UMMC DTC	3,420	<i>UMMS Cases * Excess Acute Days</i>
UMMC Med/Surg day rate	2,347	<i>UMMC DTC 4/1/2023 approved MSGA rate + 20%</i>
UMMC DTC charges related to excess days (gross) -- in thousands	\$8,030	
	Cost of Excess Days	
95% denial of excess days (gross)	\$7,630	<i>95% assumption per UMMS revenue cycle</i>
Opportunity cost of not backfilling volume (@ 50% VCF)	4,015	<i>50% VCF assumption</i>
<b>Inherent Risk - UMMC DTC financial risk of not doing the case in IRF</b>	<b>\$11,645</b>	<i>Inherent Risk</i>
	Total Risk	
<b>Actual Risk - Retained Revenue for Component 4</b>	<b>\$5,496</b>	<i>\$36M Deregulated Services * 15% VCF</i>
<b>Total Risk - Actual Risk + Inherent Risk</b>	<b>\$17,141</b>	

# Executive Summary

- The facility consolidation of UMROI and UMMC will have significant clinical benefit and will reduce excess capacity in Baltimore
- Payer savings of 14.6% will be the largest amount of savings from a facility conversion under the Model
- An additional 5% will be directed to population health investments under the Revenue for Reform policy, bringing total acute care savings to 19.5%
- HSCRC will ensure that access to services are not compromised by this facility conversion
  - \$5.5M will be at risk
  - \$11.6M is inherently at risk if UMMS fails to create a step down clinical pathway for medically complex rehab patients
  - A contract with HSCRC and UMMS will codify service level agreements that UMMS must meet.

# Staff Recommendation

1. Utilize a 100 percent variable cost factor to realign services rehabilitation and chronic care services from University of Maryland Rehabilitation and Orthopedic Institute to University of Maryland Medical Center
2. Utilize a 65 percent variable factor to realign acute care services from University of Maryland Rehabilitation and Orthopedic Institute to University of Maryland Medical Center Downtown and Midtown Campus'
3. Utilize a 50 percent variable cost factor to realign acute care services from University of Maryland Rehabilitation and Orthopedic Institute to non-University of Maryland Medical System facilities
4. Utilize a 15 percent variable cost factor to realign other rehabilitation services from University of Maryland Rehabilitation and Orthopedic Institute to a unregulated freestanding rehabilitation facility
5. Funding agreements for each realignment outlined in recommendations 1-4 are contingent on actual volume changes being equivalent to projected volumes. If volumes deviate from projected shifts, staff will adjust accordingly.
6. Exempt University of Maryland Rehabilitation and Orthopedic Institute from the Integrated Efficiency Policy in RY 2025 and each year until the Trauma Reunification Project is completed
7. Earmark \$7.3 million from the proposed system savings for population health investments to be approved each year through the Revenue for Reform policy
8. Direct staff to enter into a contractual agreement with University of Maryland Medical System to codify service level agreements that the system must satisfy as part of this facility conversion.
9. Direct staff to develop a facility conversion policy in CY 2024 that will be used for all future care delivery realignments.



# Appendices

# Appendix A

## UM Rehabilitation and Orthopaedic Institute

### Estimated Bed Capacity in Future State

	Bed Need to Accommodate Current ADC <sup>[1]</sup> (FY 2024 Dec YTD)				Estimated Future State		
	A	B	C = A+B	D = C/80% Bed Need (Actual ADC at 80% Occupancy) <sup>[2]</sup>	E	F	G = E+F
	Acute Rehab	Chronic	Total		UMMC DTC	Estimated Unregulated Rehab Facility	Total
TBI	23.8	4.5	28.3	36.0	25.0		25.0
Spine	16.6	2.7	19.3	25.0	18.0		18.0
CMR	17.8	3.8	21.6	28.0		25.0	25.0
Stroke	17.5	4.6	22.1	28.0		25.0	25.0
Stroke					15.0	10.0	25.0
Stroke	75.7	15.6	91.3	117.0	58.0	60.0	118.0

Note:

[1] ADC represents actual FY 2024 Dec YTD

[2] 80% occupancy assumption consistent with CON methodology for calculating bed need

[3] These are estimates based on FY 2024 Dec YTD actual numbers, and subject to change in official CON filings

**University of Maryland Rehabilitation and Orthopedic Institute**

**Trauma Reunification Project**

**Staff Recommendation**

**February 14, 2024**

## **Overview and Hospital Request**

On November 15, 2023, the University of Maryland Medical System (UMMS) provided a Letter of Intent (LOI) on behalf of UM Downtown Baltimore hospitals - University of Maryland Rehabilitation and Orthopedic Institute (UMROI), University of Maryland Medical Center (UMMC) and University of Maryland Medical Center Midtown Campus (UMMC Midtown) - requesting to move global budget revenue in future years from UMROI to UMMC and UMMC Midtown with no intended reduction in net services. Specifically, the LOI outlined that UMMS, as part of its “Trauma Reunification Project,” will transfer from UMROI, as early as the second quarter of 2027, 25 acute inpatient rehab traumatic brain injury beds, 18 acute inpatient rehab spinal cord injury beds, and 5 chronic care beds to UMMC, as well as 10 dually licensed acute inpatient rehab and chronic beds to UMMC.<sup>1</sup> Together, these system realignments constitute 27 percent of UMROI’s global budget. Concurrent with the relocation of beds to UMMC, UMROI’s medical and surgical acute care volumes, approximately 48 percent of UMROI’s global budget, will be absorbed by existing operating room capacity and acute hospital facilities, primarily those within the UMMS system, at which time UMROI plans to close its four acute care hospital beds. UMROI’s pediatric dental surgical volumes will be relocated to the UMMC downtown campus and UMMS intends to relocate UMROI’s dental clinic volumes to UMMC Midtown. UMMS also intends to shift UMROI’s outpatient clinic services to other UMMS campuses including the UMMC Midtown Campus. Finally, for the remainder of UMROI’s care delivery (25 percent of revenue) UMMS is investigating new locations for the construction of a freestanding facility to provide non-trauma acute inpatient rehabilitation care, inclusive of neurology and stroke, in a modern setting. Until a site is identified, which UMROI envisions will be approximately 60 beds, the hospital will continue to provide these services and chronic care at its existing campus. UMROI intends to pursue an exemption from rate regulation from the HSCRC for the special acute inpatient rehabilitation and chronic care hospital that will remain at its existing campus.<sup>2</sup>

---

<sup>1</sup> While Rehabilitation and Chronic beds are similar, there are some distinct differences that can be best captured by the patient characteristics and services: Rehab - a) Regular, direct individual contact by a physiatrist or physician of equivalent training and/or experience in rehabilitation who serves as their lead provider; 1 COMAR 10.24.09, p.4. (b) Daily rehabilitation nursing for multiple and/or complex needs; (c) A minimum of three hours of physical or occupational therapy per day, at least five days per week, in addition to therapies or services from a psychologist, a social worker, a speech-language pathologist, and a therapeutic recreation specialist, as determined by their individual needs; and (d) Based on their individual needs, other services provided in a healthcare facility that is licensed as a hospital . Chronic - a) Requires frequent physician intervention (on average, three visits per patient per week) b) Requires continuous intensive professional nursing services and intervention from a registered nurse. Examples include, but are not limited to, frequent deep tracheal suctioning (more frequently than six times daily), total parenteral nutrition, serious wound (such as, multiple stage III or stage IV decubiti) care, and management of acute medical exacerbations appropriate to the resources of the chronic hospital. c) Has a medical condition that is sufficiently complex to require continuous monitoring, and requires an intensity of resources that is not available in alternative non-acute hospital settings.

<https://msa.maryland.gov/megafile/msa/speccol/sc5300/sc5339/000113/001000/001816/unrestricted/20061831e-0007.pdf>

<sup>2</sup> See Appendix A for Bed Categorization Schedule

For a complete itemization of UMROI’s Trauma Reunification Project, please see exhibit 1 below:

**Exhibit 1: UMMS Itemized Proposed Global Budget Adjustments for UMROI**

Service	Revenue	Trauma Reunification Project Action
Spinal Cord Injury (SCI) – Acute	\$14,597,507	Shift to UMMC; FMF Analagous (Component 1)
Traumatic Brian Injury (TBI) – Acute	\$12,933,003	Shift to UMMC; FMF Analagous (Component 1)
Comprehensive Rehab (CMR) – Acute (30%)	\$5,246,268	Shift to UMMC; FMF Analagous (Component 1)
Traumatic Brian Injury (TBI) – Chronic	\$5,903,230	Shift to UMMC; FMF Analagous (Component 1)
Spinal Cord Injury (SCI) – Chronic	\$1,750,141	Shift to UMMC; FMF Analagous (Component 1)
OP Orthopedic Surgery - Faculty (74%)	\$18,716,635	Absorb into UMMC DTC or Midtown (Component 2)
OP Dental Surgery	\$7,161,790	Absorb into UMMC DTC or Midtown (Component 2)
OP Pain Clinic	\$7,001,036	Absorb into UMMC DTC or Midtown (Component 2)
OP Clinics	\$4,442,966	Absorb into UMMC DTC or Midtown (Component 2)
IP Surgery - Faculty	\$3,363,523	Absorb into UMMC DTC or Midtown (Component 2)
OP therapy (68%)	\$3,350,170	Absorb into UMMC DTC or Midtown (Component 2)
OP Dental Clinics	\$1,259,385	Absorb into UMMC DTC or Midtown (Component 2)
OP Surgery - Non-Ortho	\$177,150	Absorb into UMMC DTC or Midtown (Component 2)
OP Orthopedic Surgery - Non-Faculty	\$12,577,903	Dissipate to other acute provider (Component 3)
OP Orthopedic Surgery - Faculty (26%)	\$6,684,513	Dissipate to other acute provider (Component 3)
IP Surgery - Non-Faculty	\$2,751,973	Dissipate to other acute provider (Component 3)
OP Therapy (32%)	\$1,546,232	Dissipate to other acute provider (Component 3)
OP Surgery – Other	\$1,099,688	Dissipate to other acute provider (Component 3)
All Other	\$153,769	Dissipate to other acute provider (Component 3)
Stroke (CVA) – Acute	\$14,876,576	Deregulate (Component 4)
Comprehensive Rehab (CMR) – Acute (70%)	\$12,241,292	Deregulate (Component 4)
Stroke (CVA) – Chronic	\$5,036,843	Deregulate (Component 4)
Comprehensive Rehab (CMR) – Chronic	\$4,483,401	Deregulate (Component 4)
Total	\$147,354,995	

To effectuate this transition of services, UMMS submitted a Request for Exemption from Certificate of Need Review to the Maryland Health Care Commission, pursuant to which they will seek approval to relocate UMROI’s traumatic brain injury (“TBI”) and spinal cord injury (“SCI”) acute inpatient rehabilitation service lines, along with associated chronic care beds, to UMMC. UMMC will construct four additional floors on top of the planned Stoler Center for Advanced Medicine and will renovate certain existing space in UMMC’s North Hospital. The relocated rehab and chronic care beds from UMROI will occupy two of these floors, as well as a portion of existing space in the North Hospital, which UMMC will renovate to accommodate rehab services.

UMMS’ request of the HSCRC is to allow the health system, whose aim is to consolidate physical capacity without reducing access, to retain 75 percent of UMROI’s global budget revenue for volume that remains at UMMS regulated facilities, 50 percent of UMROI’s global budget revenue related to volume that shifts to non-UMMS hospitals or to any unregulated facilities, and

exemption of UMROI from the Commission’s Integrated Efficiency policy until such time as the Project is completed. This proposal will yield approximately \$21.5 million in system savings (14.6 percent of UMROI’s global budget revenue).

### **Background**

UMROI is licensed as an acute care, specialty rehabilitation, and specialty chronic hospital in the Forest Park/Gwynns Falls community in southwest Baltimore City with 2 licensed medical/surgical/gynecological/addictions beds, 102 licensed rehabilitation beds, and 40 licensed chronic hospital beds, including 16 dually licensed chronic/rehabilitation beds. UMROI is a provider of orthopedic surgery, the largest state provider of outpatient pediatric dental services, and the largest inpatient rehabilitation hospital and provider of rehabilitation services in the state of Maryland. The Hospital’s total approved revenue cap for Fiscal Year 2024 is \$148,915,470. In CY 2022, which is a fairly representative year, approximately 23 percent of its revenues came from Baltimore city residents, 20 percent came from Baltimore county residents, 13 percent came from Anne Arundel county residents, 9 percent from Howard county residents, 8 percent came from Carroll and Harford county residents, 6 percent came from Prince George’s county residents, 4 percent came from out-of-state residents, and the remaining 17 percent was derived from all other counties in Maryland.

From Fiscal Years 2014 through 2022, UMROI had an average regulated operating margin of 5.5 percent based on its annual filing Schedule RE reporting. Average total operating margin for the same period, inclusive of unregulated losses, most notably physician subsidies, was 3.3 percent. From 2014 through 2022, the operating cash flow margin, which removes depreciation and amortization and better represents the ongoing cash generation of the organization’s operation, was 4.1 percent, yielding cash generation of \$41 million.

### **Analyses**

The HSCRC staff reviewed the Letter of Intent for consistency with existing policies (e.g., marketshift, deregulation) as well as prior facility conversions. Additionally, because the Commission does not have a formalized facility conversion policy, staff assessed savings from the UMROI conversion relative to the values outlined in the HSCRC Full Rate Application methodology, prior facility conversions, and site neutral rates for services that do not need to be performed in a regulated facility. In effect, staff have acquired additional statistics that help validate the reasonableness of system savings from this transformation.

#### **A: Variable Cost Factors**

UMMS’ proposal for global budget adjustments is composed of four components that are detailed in exhibit 1 and highlighted in exhibit 2 below:

## Exhibit 2: UMMS Proposed Global Budget Adjustments for UMROI<sup>3</sup>

	1) Trauma Rehab/Chronic to Stoler Center (Build at DTC)	2) Acute Relocated to DTC/MTC	3) Acute Care Shifted to Other Providers	4) Shift to Freestanding	Total	% of Current GBR
UM Rehab GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	
Proposed Retention	75%	75%	50%	50%		
<b>Retained GBR @ UMMS</b>	<b>\$30,323</b>	<b>\$34,104</b>	<b>\$12,407</b>	<b>\$18,319</b>	<b>\$95,153</b>	<b>65%</b>
<b>Redistribution of UM Rehab GBR</b>						
Retained at UMMS	\$30,323	\$34,104	\$12,407	\$18,319	\$95,153	65%
Shift to Other Providers	-	-	12,407	18,319	30,726	21%
System Savings	10,108	11,368	-	-	21,476	15%
UM Rehab FY 2023 GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	100%

Each component must be considered individually against existing Commission policies and prior facility conversion practices. In the absence of a planned transition, components 1 and 2 - the movement of services to another UMMS facility - would typically be handled through the Commission marketshift policy and would utilize a 50 percent variable cost factor to recognize the variable cost per unit that would be incurred by the facility providing new services, e.g., increased drugs, supplies, and hourly labor. UMMS has proposed a 75 percent variable cost factor to recognize some level of fixed costs that is necessary to provide these services ( e.g., depreciation and interest, new base salaries), and to ensure the UMROI transformation results in system savings (14.6 percent) that is fairly similar to other facility conversions. Prior UMMS free-standing medical facility conversions resulted in savings of 13 percent for Dorchester Hospital, 12 percent for Harford Memorial, and 3 percent for Laurel Medical Center.<sup>4</sup>

Prior practice indicates that the Commission has allowed a 100 percent variable cost factor if the services are being transitioned to a facility substitute, e.g., a hospital converted to a free standing medical facility, and a 65 percent factor if the service is being transitioned to another facility within the health system.<sup>5</sup> The current UMMS proposal is not a facility substitute per se because the services are being transitioned to UMMC. However, the movement of rehab and chronic care beds will require the wholesale transition of salaried employees from UMROI as well as additional capital improvements (for which UMMS is not seeking additional rate support), because these services are highly specialized and UMMC currently does not have licensed rehab or chronic beds. Thus, for Component 1, a higher variable cost factor than is allotted by the marketshift policy is a valid request, and staff believe the prior practice of allowing 100 percent revenue retention is most appropriate given the transition is analogous to a facility substitute. Conversely, given the additional acute care bed capacity at UMMC and UMMC Midtown, which

<sup>3</sup> Source: UMMS/Berkeley Research Group; See Appendix B for Variations of Model

<sup>4</sup> Savings generated from Laurel transitioning to an FMF were used to finance additional debt associated with building a new hospital for Capital Region Medical Center. The savings were used to finance the remaining portion of the capital project that was not covered by the State or County

<sup>5</sup> Ex: The conversion of Dorchester Hospital utilized a 100 percent variable cost factor for services that were still provided by the Dorchester FreeStanding Medical Facility and 65 percent variable cost factor for services that were transitioned to Easton Hospital.

obviates the need for significant fixed cost investments, using a 100 percent variable cost factor makes less sense for acute care services (Component 2). However, staff do recognize that there will be additional fixed patient care and general overhead costs that will need to transition to UMMC because they cannot be absorbed by existing overhead, e.g., dietary services, medical records, and patient accounts, among others. Given an analysis of UMROI's costs indicate that these are approximately 24 percent of costs and staff anticipates some economies of scale, a 15 percent increase to the typical 50 percent variable cost factor seems reasonable.

Based on review of UMMS proposals, existing policy parameters, prior practice and analysis of estimated cost savings from the Full Rate Application and site neutral estimates (see next section), staff recommend that a 100 percent variable cost factor be utilized for trauma and chronic services (Component 1) and a 65 percent variable cost factor for acute care services in line with other conversions.(Component 2).

Staff are in agreement that a 50 percent variable cost factor is appropriate for Component 3 (Acute Care Shifted to Other Providers), as this approach is in line with the marketshift policy. However, staff do not agree that a 50 percent variable cost factor should be utilized for Component 4 (Shift to Freestanding), because although deregulation policy typically uses a 50 percent variable cost factor, it does so because the facility with dissipation to an unregulated space remains regulated by HSCRC global budget methodologies, i.e., a regulated fixed cost component still exists that requires funding support. In this case, UMMS is envisioning that a future freestanding facility will be exempt from HSCRC rate setting and thus each unit of service reimbursement will presumably reflect both variable and fixed costs, albeit at a significantly reduced rate, i.e., 43.1 percent of the current regulated rate. Again though, some level of fixed general overhead costs currently at the UMROI facility will be necessary to support the delivery of services in an unregulated setting, e.g., patient accounts, medical records, and general accounting, among other things. Given an analysis of UMROI's costs, which indicate that these are approximately 14 percent of costs, a 15 percent variable cost factor seems reasonable. To ensure that the deregulated services are not rationed in a future state, staff recommend that the retained revenue associated with the 15 percent variable cost factor (\$5.5 million) be contingent on UMMS continuing to provide the projected volumes in a freestanding facility

The table below outlines staff's recommendation for each component of UMMS Trauma Reunification Project.



**Exhibit 3: Potential Variable Cost Factors for UMROI Services Relocated to UMMS Facilities**

	HSCRC					
	1) Trauma Rehab/Chronic to Stoler Center (Build at DTC)	2) Acute Relocated to DTC/MTC	3) Acute Care Shifted to Other Providers	4) Shift to Freestanding	Total	% of Current GBR
UM Rehab GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	
Proposed Retention	100%	65%	50%	15%		
Retained GBR @ UMMS	\$40,430	\$29,557	\$12,407	\$5,496	\$87,890	60%
<b>Redistribution of UM Rehab GBR</b>						
Retained at UMMS	\$40,430	\$29,557	\$12,407	\$5,496	\$87,890	60%
Shift to Other Providers	-	-	12,407	18,319	30,726	21%
System Savings	-	15,915	-	12,823	28,739	19.5%
UM Rehab FY 2023 GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	100%

**B: Corroborating Statistics**

As noted above, the Commission does not have a formalized facility conversion policy, which would dictate expected savings and appropriate variable cost factors, among other things (e.g., required maintenance of effort for access to care). While the Commission does have experience with several facility conversions and thus reasonable expectations of savings, relying on past practice alone is not sufficient because staff believe a future conversion policy would scale expected savings by current efficiency performance, i.e., a facility with excessive fixed costs will be expected to generate greater savings than a facility with limited excess capacity. This dynamic is particularly salient because UMROI is a relatively inefficient provider that was identified as such in the RY 2024 Integrated Efficiency policy. Therefore, staff have assessed two additional statistics to validate the reasonableness of the savings being put forward by the HSCRC Proposal delineated in Exhibit 3 (\$28.7M, 19.5 percent).

The first statistic staff considered was the value outlined under the Full Rate Application policy. Under the Inter-hospital Cost Comparison methodology that is used to assess hospital cost efficiency per case, UMROI would incur a reduction of 27.11 percent.<sup>6</sup> While this value exceeds the UMMS proposed savings of 14.6 percent and HSCRC’s proposal of 19.5 percent, staff notes that in a future facility conversion policy, rebasing hospitals to the statewide average cost per case with no allotment for profit to subsidize physician coverage and future recapitalization, as is the norm, would likely not incentivize any hospital to reduce excess capacity. Thus, staff would like to propose a strawman for future policy consideration that could also be used to assess the reasonableness of the Trauma Reunification Project. Specifically, staff propose that a future facility incentive conversion policy consider rebasing hospitals to the statewide average cost per case plus the historical statewide average regulated profit of 8 percent, which if implemented in this case, would yield a revenue reduction of 22.10 percent, excluding any negative scaling related to total cost of performance. This approach does not entirely align with HSCRC’s savings proposal of 19.5 percent, but it is reasonably related and staff believe strongly that a future facility incentive conversion policy must a) recognize that acute care rates have historically cross subsidized low physician

<sup>6</sup> Under the complete Full Rate Application methodology, which further incorporates total cost of care performance, UMROI would incur a reduction of 30.16 percent, a increased reduction of \$4.1 million relative to the ICC, because UMROI’s attributed Medicare population is higher than its national benchmark average and the population has exceeded statewide total cost of care growth by 9.51 percent. However, given the proposed savings of at least \$20.8 million would completely eliminate the TCOC scaling component of the Full Rate Application, staff have elected to eliminate TCOC consideration in this recommendation.

reimbursement rates in the State of Maryland; and b) create a reasonable incentive appealing enough to compel hospitals to remove excess capacity while also generating system savings.

The second statistic staff considered was the savings that would accrue to the public if rehabilitation and chronic services were deregulated and reimbursed at rates similar to other national freestanding rehabilitation facilities. Using MedPAR<sup>7</sup> data and limiting the analysis to national claims with a length of stay greater than 0 and less than 91, UMMS was able to demonstrate that UMROI’s rehabilitation and chronic services would result in a rate that was 23.5 percent of the Spine and Traumatic Brain Injury regulated rates and 43.1 percent for Comprehensive Medical Rehabilitation.<sup>8</sup> As outlined below, this suggests that the potential savings opportunity for moving to a “site neutral rate” would be \$50.7 million; however, a portion of these services, specifically the spine and traumatic brain injury rehabilitation, is significantly more resource-intensive and requires an intermediate step down setting before admission to a rehabilitation specialty hospital, skilled nursing facility, or home.<sup>9</sup> As such, the following table quantifies potential site neutral savings with and without the spine and traumatic brain injury rehabilitation, \$50.7 million and \$21.2 million respectively. Given the need for these specialized acute care services, staff recommend that the relevant statistic to determine the reasonableness of the savings from the Trauma Reunification Project is without the spine and traumatic brain injury rehabilitation, i.e. \$21.2 million, which is in line with the proposed savings put forth by UMMS (\$21.5 million) but less than the savings put forth by HSCRC staff (\$28.7 million).

---

<sup>7</sup> MedPAR data contains information about inpatient (IP) hospital and skilled nursing facility (SNF) stays that were covered by Medicare. MedPAR records are created by rolling up information for a single stay from individual IP and SNF claims. The data on these claims was originally submitted on the CMS 1450 or UB04.

<https://www.cms.gov/data-research/statistics-trends-and-reports/medicare-fee-for-service-parts-a-b/medpar>

<sup>8</sup> Rehabilitation and Chronic Services Deregulation Analysis Notes:

[1] Source: Maryland non-confidential data grouped under APR-DRG v38, Inpatient cases only, Separated by Daily Service code (8=Rehab, 9=Chronic, 1=Acute IP)

[2] Modeled CMS payments utilizing average CMS+coins/deductibles CY2022 MedPar LDS data - applied based on MS-DRG and LOS range, inflated for one quarter of CY23

[3] Limited to claims with payments >0, LOS <91, claims at freestanding rehab hospitals with an admit and discharge date in the data, excluded hospital-based rehab units

[4] Type of care categories (stroke, ortho, brain, etc) based on Rehab Impairment group assignment

[5] Assumption: Medicaid pays 88% of Medicare Fee Schedule, Medicare pays 100%, Commercial Pays 120% of Medicare Fee Schedule.

<sup>9</sup> For patients who cannot return home safely after post-acute care, transfer to a care setting that provides interdisciplinary comprehensive inpatient rehabilitation is most beneficial (DaVanzo et al., 2014; Nehra et al. 2016). For some patients with complex medical needs, an intermediate stepdown setting may be required before admission to comprehensive rehabilitation. For example, the setting may provide care through a Commission on Accreditation of Rehabilitation Facilities (CARF)-accredited brain injury specialty program designed to meet the complex needs of the patient with TBI. Medicare patients with medical necessity who can tolerate 3 hours of therapy per day or 15 hours per week are eligible for admission for an inpatient rehabilitation case.

Source: NIH National Library of Medicine – Rehabilitation and Long-Term Care Needs after Traumatic Brain Injury. <https://www.ncbi.nlm.nih.gov/books/NBK580075/>

### Exhibit 4: Potential Deregulation Savings from Rehabilitation and Chronic Services

Services with an Applicable Unregulated Rate Schedule			
	Revenue	Site-Neutral Savings Opportunity	Algebra
Spinal Cord Injury (SCI) -- Acute	14,597,507	11,167,093	Rev. X (1-.235) for Spine & TBI
Traumatic Brian Injury (TBI) -- Acute	12,933,003	9,893,747	Rev. X (1-.235) for Spine & TBI
Comprehensive Rehab (CMR) -- Acute (30%)	5,246,268	2,985,126	Rev X (1-.431) for CMR
Traumatic Brian Injury (TBI) -- Chronic	5,903,230	4,515,971	Rev. X (1-.235) for Spine & TBI
Spinal Cord Injury (SCI) -- Chronic	1,750,141	1,338,858	Rev. X (1-.235) for Spine & TBI
Stroke (CVA) -- Acute	14,876,576	8,464,772	Rev X (1-.431) for CMR
Comprehensive Rehab (CMR) -- Acute (70%)	12,241,292	6,965,295	Rev X (1-.431) for CMR
Stroke (CVA) -- Chronic	5,036,843	2,865,964	Rev X (1-.431) for CMR
Comprehensive Rehab (CMR) -- Chronic	4,483,401	2,551,055	Rev X (1-.431) for CMR
Total Potential Site Neutral Savings Opportunity	77,068,261	50,747,882	A = sum of rev X (1-unregulated reimbursement rate)
Services that Cannot be Deregulated			
	Revenue	Site-Neutral Savings Opportunity	Algebra
Spinal Cord Injury (SCI) - Acute Regulated	14,597,507	11,167,093	Rev. X (1-.235) for Spine & TBI
Traumatic Brian Injury (TBI) - Acute Regulated	12,933,003	9,893,747	Rev. X (1-.235) for Spine & TBI
Spinal Cord Injury (SCI) - Chronic Regulated	5,246,268	4,013,395	Rev. X (1-.235) for Spine & TBI
Traumatic Brian Injury (TBI) - Chronic Regulated	5,903,230	4,515,971	Rev. X (1-.235) for Spine & TBI
Non-applicable Site Neutral Savings Opportunity	38,680,008	29,590,206	B = sum of rev X (1-unregulated reimbursement rate)
Realizable Savings from Deregulated Pricing Model		21,157,675	C=A-B

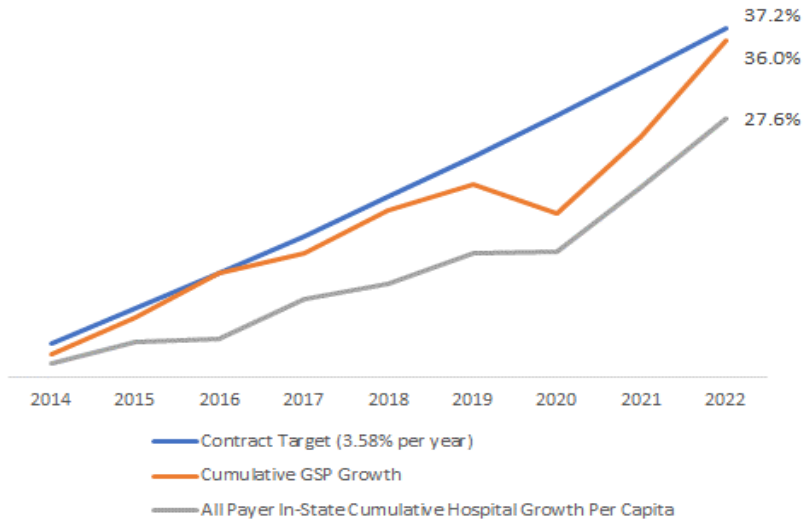
### C: Additional Considerations

There are three additional considerations to examine in the proposed Trauma Reunification Project, namely 1) exemption from Commission’s Integrated Efficiency Policy; 2) the degree to which system savings should be redirected to population health investments in line with goals of the Model and the Revenue for Reform Policy; and 3) accountability to ensure access to rehabilitation services is not compromised.

- 1) In RY 2024, UMROI incurred an inflation offset of \$2.3 million through the Integrated Efficiency Policy, which they are currently trying to “buyout” from through the Revenue for Reform policy. In lieu of participating in this dynamic each year, which will presumably take 10 years to recoup the funding, UMMS has proposed as system savings (\$21.5 million), UMROI is putting forward that system savings be scored when the project goes live in 2027 and in return the hospital be exempt from future Integrated Efficiency inflation offsets in RY 2025 and each year thereafter until the project is completed. In effect, the Integrated Efficiency policy is achieving one of its intended aims to compel hospitals to transform its care delivery model, but in this case in a more expedited manner. If the proposed savings amount is sufficient relative to the potential opportunity as outlined by the Full Rate Application methodology, staff believe this approach is a benefit to the system because savings and associated transformation occur at a faster rate. As such, staff strongly endorse this proposal and the idea generally that hospitals that come forward with a reasonable savings proposal be exempted from the Integrated Efficiency policy.
- 2) The second consideration is if the Commission should consider redirecting a portion of the Trauma Reunification Project savings to population health investments. Staff believe at a minimum that the \$21.5 million (14.6 percent) put forward by UMMS as system savings should be returned to payers and the public writ large, as it aligns with prior practice that facility conversions generate 10-15 percent system savings. However, staff believe the additional savings that were identified in its

proposal (\$28.7 million, a variance of \$7.3 million from UMMS proposal) should be earmarked for population investments, and similar to other hospitals participating in the RY 2024 Integrated Efficiency policy be approved through the Revenue for Reform application process, which will be repeated each year as long as the funding is not redirected to system savings. Staff's rationale on this is threefold: a) the intention of the Model is to use healthcare dollars for genuine care delivery transformation, not to simply generate savings as other models, e.g., the Inpatient Prospective Payment System, are for more effective at the latter; b) the Model currently does not require additional Medicare total cost of care savings to comply with contractual savings targets; and c) the main lever to achieve savings in the Model for all-payers continues to be the annual Update Factor, which to date has been quite successful at bending the cost curve relative to statewide economic growth - see exhibit 5:

**Exhibit 5: Affordability Scorecard**



- Staff are concerned that rehabilitation services to be provided in an unregulated setting (Component 4) are not guaranteed, as is the case with regulated services, i.e., for hospitals to recoup their entire global budget, at least 95 percent of budgeted volumes must be provided in accordance with the Commission's corridor policies. When volumes are no longer under HSCRC purview, it is conceivable that a provider could reduce its service delivery to far less than 95 percent of anticipated services, which is particularly problematic because of the concerns about post-acute availability in Maryland and because the proposal allows UMMS to retain approximately \$17.9 million (Component 3 and 4), which otherwise would not occur since UMMS is transitioning UMROI to an unregulated facility.

For these reasons, staff assessed both actual risk if UMMS discontinues non-trauma rehabilitation services and inherent risk, i.e., the extent to which UMMS would create dissavings for its other regulated entities (UMMC and UMMC Midtown). Actual risk is rather straightforward: if UMMS reduces non-trauma rehabilitation services beyond an agreed upon level (to be defined by a future contractual agreement), the HSCRC will remove \$5.5 million of retained GBR from the system that it

is retaining under Component 4 (see exhibit 3). Inherent risk is less straightforward because it requires quantifying lost variable cost savings from not transitioning patients from an acute care setting to a post-acute setting and reductions to net patient revenue, as extended length of stay in an acute care is often deemed medically unnecessary and thus results in payer denials. For an accounting of the inherent risk, see exhibit 6:

**Exhibit 6: Risk Summary**

	Data Inputs	
Total "Bucket 4" cases (All payor cases * 80% from UMMS)	684	<i>80% of UMROI cases are from UMMC, UM Midtown</i>
Excess acute days per case if no IRF (and patient must go to SNF)	5	
Total excess acute days if no IRF (and patient must go to SNF) -- assumed to be at UMMC DTC	3,420	<i>UMMS Cases * Excess Acute Days</i>
UMMC Med/Surg day rate	2,347	<i>UMMC DTC 4/1/2023 approved MSGA rate + 20%</i>
UMMC DTC charges related to excess days (gross) -- in thousands	\$8,030	
	Cost of Excess Days	
95% denial of excess days (gross)	\$7,630	<i>95% assumption per UMMS revenue cycle</i>
Opportunity cost of not backfilling volume (@ 50% VCF)	4,015	<i>50% VCF assumption</i>
<b>Inherent Risk - UMMC DTC financial risk of not doing the case in IRF</b>	<b>\$11,645</b>	<i>Inherent Risk</i>
	Total Risk	
<b>Actual Risk - Retained Revenue for Component 4</b>	<b>\$5,496</b>	<i>\$36M Deregulated Services * 15% VCF</i>
<b>Total Risk - Actual Risk + Inherent Risk</b>	<b>\$17,141</b>	

Because the associated risk of this transition (\$17.1 million) is reasonably similar to the retained revenue provided under Component 3 and 4 (\$17.9 million), which are the only volume shifts that deviate from preexisting policy or practice, staff are confident that UMMS will maintain the projected non-trauma rehabilitation services in an unregulated setting. However, to further ensure that maintenance of current rehabilitation services, staff recommend that UMMS and the HSCRC enter into a contractual agreement, subsequent to the approval of this recommendation, that will codify service level agreements that UMMS must meet.

## **Recommendations**

The HSCRC staff make the following recommendations:

1. Utilize a 100 percent variable cost factor to realign services rehabilitation and chronic care services from University of Maryland Rehabilitation and Orthopedic Institute to University of Maryland Medical Center
2. Utilize a 65 percent variable factor to realign acute care services from University of Maryland Rehabilitation and Orthopedic Institute to University of Maryland Medical Center Downtown and Midtown Campus'
3. Utilize a 50 percent variable cost factor to realign acute care services from University of Maryland Rehabilitation and Orthopedic Institute to non-University of Maryland Medical System facilities
4. Utilize a 15 percent variable cost factor to realign other rehabilitation services from University of Maryland Rehabilitation and Orthopedic Institute to an unregulated freestanding rehabilitation facility
5. Funding agreements for each realignment outlined in recommendations 1-4 are contingent on actual volume changes being equivalent to projected volumes. If volumes deviate from projected shifts, staff will adjust accordingly.
6. Exempt University of Maryland Rehabilitation and Orthopedic Institute from the Integrated Efficiency Policy in RY 2025 and each year thereafter until the Trauma Reunification Project is completed
7. Earmark \$7.3 million from the proposed system savings for population health investments to be approved each year through the Revenue for Reform policy
8. Direct staff to enter into a contractual agreement with University of Maryland Medical System to codify service level agreements that the system must satisfy as part of this facility conversion.
9. Direct staff to develop a facility conversion policy in CY 2024 that will be used for all future care delivery realignments.

## APPENDIX A: Bed Categorization Schedule

### UM Rehabilitation and Orthopaedic Institute

Estimated Bed Capacity in Future State

	Bed Need to Accommodate Current ADC <sup>[1]</sup> (FY 2024 Dec YTD)				Estimated Future State		
	A	B	C = A+B	D = C/80%	E	F	G = E+F
	Acute Rehab	Chronic	Total	Bed Need (Actual ADC at 80% Occupancy) <sup>[2]</sup>	UMMC DTC	Estimated Unregulated Rehab Facility	Total
TBI	23.8	4.5	28.3	36.0	25.0		25.0
Spine	16.6	2.7	19.3	25.0	18.0		18.0
CMR	17.8	3.8	21.6	28.0		25.0	25.0
Stroke	17.5	4.6	22.1	28.0		25.0	25.0
Stroke					15.0	10.0	25.0
Stroke	<u>75.7</u>	<u>15.6</u>	<u>91.3</u>	<u>117.0</u>	<u>58.0</u>	<u>60.0</u>	<u>118.0</u>

Note:

[1] ADC represents actual FY 2024 Dec YTD

[2] 80% occupancy assumption consistent with CON methodology for calculating bed need

[3] These are estimates based on FY 2024 Dec YTD actual numbers, and subject to change in official CON filings

## APPENDIX 1B: Potential Variable Cost Factors for UMROI Services Relocated to UMMS Facilities (100% Variable Cost Factor)

	100% Variable Cost Factor				Total	% of Current GBR
	Trauma Rehab/Chronic to Stoler Center (Build at DTC)	Acute Relocated to DTC/MTC	Acute Care Shifted to Other			
			Providers	Shift to Freestanding		
UM Rehab GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	
Proposed Retention	100%	100%	100%	100%		
<b>Retained GBR @ UMMS</b>	<b>\$40,430</b>	<b>\$45,473</b>	<b>\$24,814</b>	<b>\$36,638</b>	<b>\$147,355</b>	<b>100%</b>
<b>Redistribution of UM Rehab GBR</b>						
Retained at UMMS	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	100%
Shift to Other Providers	-	-	24,814	15,754	40,568	28%
System Savings	-	-	(24,814)	(15,754)	(40,568)	-27.5%
UM Rehab FY 2023 GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	100%

## APPENDIX 2B: Potential Variable Cost Factors for UMROI Services Relocated to UMMS Facilities (75% Variable Cost Factor)

	75% Variable Cost Factor				Total	% of Current GBR
	Trauma Rehab/Chronic to Stoler Center (Build at DTC)	Acute Relocated to DTC/MTC	Acute Care Shifted to Other			
			Providers	Shift to Freestanding		
UM Rehab GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	
Proposed Retention	75%	75%	75%	75%		
<b>Retained GBR @ UMMS</b>	<b>\$30,323</b>	<b>\$34,104</b>	<b>\$18,611</b>	<b>\$27,479</b>	<b>\$110,516</b>	<b>75%</b>
<b>Redistribution of UM Rehab GBR</b>						
Retained at UMMS	\$30,323	\$34,104	\$18,611	\$27,479	\$110,516	75%
Shift to Other Providers	-	-	18,611	15,754	34,365	23%
System Savings	10,108	11,368	(12,407)	(6,595)	(2,474)	1.7%
UM Rehab FY 2023 GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	100%



## APPENDIX 2C: Potential Variable Cost Factors for UMROI Services Relocated to UMMS Facilities (65% Variable Cost Factor)

	65% Variable Cost Factor				Total	% of Current GBR
	Trauma Rehab/Chronic to Stoler Center (Build at DTC)	Acute Relocated to DTC/MTC	Acute Care Shifted to Other Providers			
			Providers	Shift to Freestanding		
UM Rehab GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	
Proposed Retention	65%	65%	65%	65%		
<b>Retained GBR @ UMMS</b>	<b>\$26,280</b>	<b>\$29,557</b>	<b>\$16,129</b>	<b>\$23,815</b>	<b>\$95,781</b>	<b>65%</b>
<b>Redistribution of UM Rehab GBR</b>						
Retained at UMMS	\$26,280	\$29,557	\$16,129	\$23,815	\$95,781	65%
Shift to Other Providers	-	-	16,129	15,754	31,884	22%
System Savings	14,151	15,915	(7,444)	(2,931)	19,691	13.4%
UM Rehab FY 2023 GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	100%

## APPENDIX 2D: Potential Variable Cost Factors for UMROI Services Relocated to UMMS Facilities (50% Variable Cost Factor)

	50% Variable Cost Factor				Total	% of Current GBR
	Trauma Rehab/Chronic to Stoler Center (Build at DTC)	Acute Relocated to DTC/MTC	Acute Care Shifted to Other Providers			
			Providers	Shift to Freestanding		
UM Rehab GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	
Proposed Retention	50%	50%	50%	50%		
<b>Retained GBR @ UMMS</b>	<b>\$20,215</b>	<b>\$22,736</b>	<b>\$12,407</b>	<b>\$18,319</b>	<b>\$73,677</b>	<b>50%</b>
<b>Redistribution of UM Rehab GBR</b>						
Retained at UMMS	\$20,215	\$22,736	\$12,407	\$18,319	\$73,677	50%
Shift to Other Providers	-	-	12,407	15,754	28,161	19%
System Savings	20,215	22,736	-	2,565	45,516	30.9%
UM Rehab FY 2023 GBR	\$40,430	\$45,473	\$24,814	\$36,638	\$147,355	100%

# R.Y. 2026 Final Policy for the Maryland Hospital Acquired Conditions (MHAC) Program

# Stakeholder Feedback

- Staff received one comment letter from Maryland Hospital Association
  - Supportive of averaging the 20 percent of O/E ratios of the worst and best performing hospitals' results to establish the performance standards, which results in similar benchmark and threshold values but is less sensitive to the influence of outliers than using a single percentile.
  - Supportive of other components as they're unchanged from the RY2025 policy

# MHAC RY 2026 Final Recommendations

1. Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.
  - a. Maintain a focused list of PPCs in the payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
  - b. Assess monitoring PPCs based on clinical recommendations, statistical characteristics, and recent trends to prioritize those for future consideration for updating the measures in the payment program.
  - c. Engage hospitals on specific PPC increases as indicated/appropriate to understand trends and discuss potential quality concerns.
2. Use more than one year of performance data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs). The performance period for small hospitals will be CYs 2023 and 2024.
3. Continue to assess hospital performance on attainment only, with adjustment to performance standards for increased stability.
4. Continue to weight the PPCs in the payment program by 3M cost weights as a proxy for patient harm.
5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent and continuous linear scaling with a hold harmless zone between 60 and 70 percent.
6. Future Considerations:
  1. Assess options for streamlining (or simplifying) the quality programs overall, or for the hospital acquired complication measures that are currently included in both the QBR Safety Domain and the MHAC program.
  2. Assess digitally specified quality measures such as electronic Clinical Quality Measures (eCQMs) for future inclusion in quality programs.



maryland  
**health services**  
cost review commission

# **Final Recommendation for the Maryland Hospital Acquired Conditions Program for Rate Year 2026**

February 14, 2024

This document contains staff final recommendations for the RY 2026 Maryland Hospital Acquired Conditions Program.

## Table of Contents

List of Abbreviations	2
Key Methodology Concepts and Definitions	3
Recommendations	5
Introduction	6
Background	7
Exemption from Federal Hospital-Acquired Condition Programs	7
Overview of the MHAC Policy	8
MHAC Methodology	8
Assessment	9
Statewide PPC Performance Trends	10
Complications Included in Payment Program	10
Monitored Complications	13
Calculating PPC Performance Standards	15
Small Hospital Criteria	16
PPC Clinical Concerns	17
Hospital Scores and Revenue Adjustments	18
Health Equity	20
Stakeholder Feedback and Responses	20
Recommendations	20
Appendix I. Background on Federal Complication Programs	22
Appendix II: RY 2025 MHAC Program Methodology	24
RY 2025 Update: Small Hospital Methodology	28
Appendix III: Monitoring PPCs	30
Appendix IV: Calculating Performance Standards	32
Appendix V: Disparities in PPCs	34

## List of Abbreviations

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

## Key Methodology Concepts and Definitions

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

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

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

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

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

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

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

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

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

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



## Policy Overview

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

## Recommendations

The MHAC policy was redesigned in Rate Year (RY) 2021 to modernize the program for the new Total Cost of Care Model. This RY 2026 final recommendation, in general, maintains the measures and methodology that were developed and approved for RYs 2022 through 2025.<sup>1</sup>

These are the final recommendations for the RY 2026 Maryland Hospital Acquired Conditions (MHAC) program:

1. Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.
  - a. Maintain a focused list of PPCs in the payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
  - b. Assess monitoring PPCs based on clinical recommendations, statistical characteristics, and recent trends to prioritize those for future consideration for updating the measures in the payment program.
  - c. Engage hospitals on specific PPC increases as indicated/appropriate to understand trends and discuss potential quality concerns.
2. Use more than one year of performance data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs). The performance period for small hospitals will be CYs 2023 and 2024.
3. Continue to assess hospital performance on attainment only, with adjustment to performance standards for increased stability.
4. Continue to weight the PPCs in the payment program by 3M cost weights as a proxy for patient harm.
5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent and continuous linear scaling with a hold harmless zone between 60 and 70 percent.
6. Future Considerations:
  1. Assess options for streamlining (or simplifying) the quality programs overall, or for the hospital acquired complication measures that are currently included in both the QBR Safety Domain and the MHAC program.
  2. Assess digitally specified quality measures such as electronic Clinical Quality Measures (eCQMs) for future inclusion in quality programs.

---

<sup>1</sup> See the [RY 2021 policy](#) for detailed discussion of the MHAC redesign, rationale for decisions, and approved recommendations.

## Introduction

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

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

For MHAC, as well as the other State hospital quality programs, annual updates are vetted with stakeholders and approved by the Commission to ensure the programs remain aggressive and progressive with results that meet or surpass those of the national CMS analogous programs (from which Maryland must receive annual exemptions). For purposes of the RY 2026 MHAC final Policy, staff vetted the updated proposed recommendations in December with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies.

Additionally, with the onset of the Total Cost of Care Model Agreement, each program was overhauled to ensure they support the goals of the Model. For the MHAC policy, the overhaul was completed during

2018, which entailed an extensive stakeholder engagement effort. The major accomplishments of the MHAC program redesign were focusing the payment incentives on a narrower list of clinically significant complications, moving to an attainment only system given Maryland's sustained improvement on complications, adjusting the scoring methodology to better differentiate hospital performance, and weighting complications by their associated cost weights as a proxy for patient harm. The redesign also assessed how hospital performance is converted to revenue adjustments, and ultimately recommended maintaining the use of a linear revenue adjustment scale with a hold harmless zone.

Following the MHAC program redesign, this RY 2026 MHAC policy final proposes minimal changes to the program. The assessment section also includes an evaluation of PPCs in "Monitoring" status consistent with the approved recommendations for RY 2021 going forward, which includes identifying PPCs that should be considered for inclusion back into the MHAC payment program due to worsening performance. Based on this analysis and consideration of stakeholder input, the RY 2026 final recommendation does not propose to move any complications from monitoring to payment.

## **Background**

### **Exemption from Federal Hospital-Acquired Condition Programs**

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

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

are maintained throughout the TCOC model. Based on performance to date, CMS has granted Maryland exemptions from the federal pay-for-performance programs (including the HAC Reduction Program) each year through FFY 2024.

## Overview of the MHAC Policy

The MHAC program, which was first implemented for RY 2011, is based on a system developed by 3M Health Information Systems (3M) to identify potentially preventable complications (PPCs) using the present-on-admission variable for eligible secondary diagnosis codes available in claims data. 3M originally developed specifications for 65 PPCs,<sup>2</sup> which are defined as harmful events that develop after the patient is admitted to the hospital and may result from processes of care and treatment rather than from the natural progression of the underlying illness. For example, the program holds hospitals accountable for venous thrombosis and sepsis that occur during inpatient stays. These complications can lead to 1) poor patient outcomes, including longer hospital stays, permanent harm, and death; and 2) increased costs. Thus, the MHAC program is designed to provide incentives to improve patient care by adjusting hospital budgets based on PPC performance.

## MHAC Methodology

Figure 1 provides an overview of the three steps in the RY 2025 MHAC methodology (also see Appendix II) that converts hospital performance to standardized scores, and then payment adjustments, as outlined below:

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

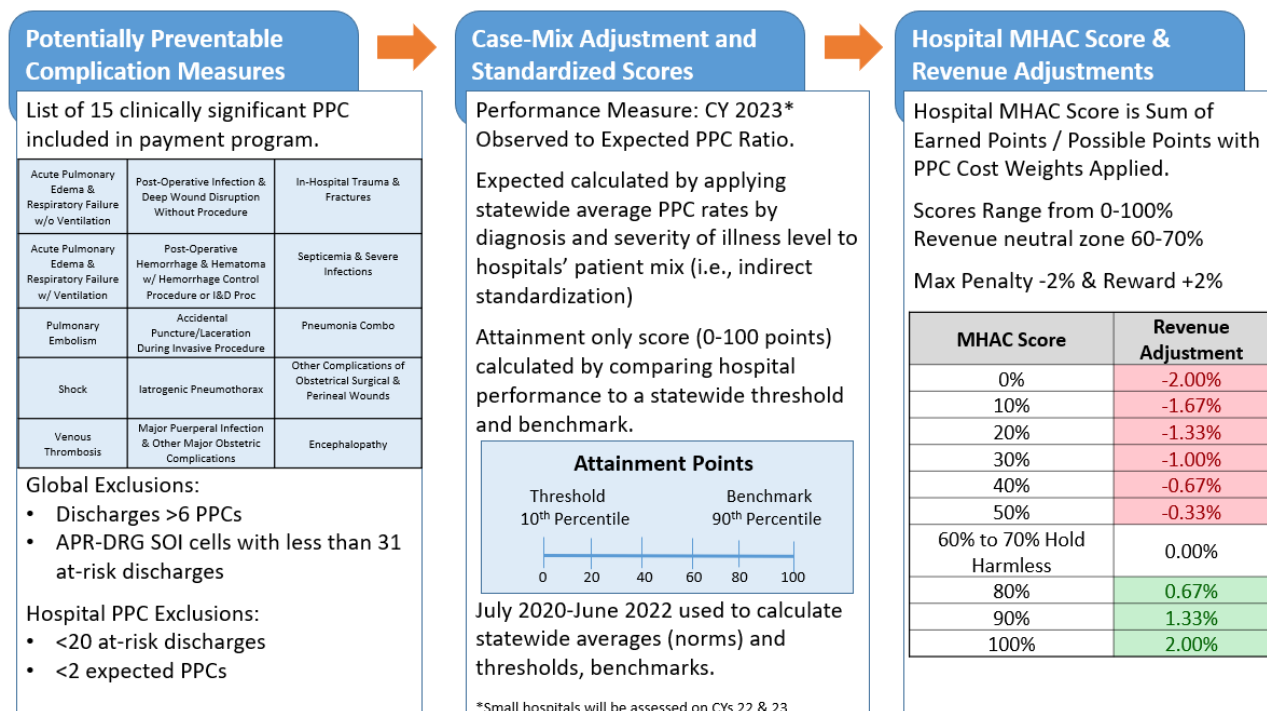
**Step 2.** Case-mix adjustment is used to calculate observed to expected ratios that are then converted to a standardized point based score (0-100 points) based on each hospital's attainment levels using a similar scoring methodology that is used for CMS Value-Based Purchasing and Maryland QBR program.

---

<sup>2</sup> In RY 2020, there were 45 PPCs or PPC combinations included in the program, from an initial 65 PPCs in the software, as 3M had discontinued some PPCs and others were deemed not suitable for a pay-for-performance program.

**Step 3.** Overall hospital scores are then calculated by taking the points for each PPC and multiplying by the 3M PPC cost weights, then summing numerator (points scored) and denominator (possible points) across the PPCs to calculate a percent score. A linear point scale set prospectively is then used to calculate the revenue adjustment percent. This prospective scaling approach differs from national programs that relatively rank hospitals after the performance period. Additionally, the HACRP differs in that it provides no opportunity for rewards and reduces payments by 1 percent for hospitals in the worst-performing quartile.

**Figure 1. Overview Rate Year 2025 MHAC Methodology**



## Assessment

In order to develop the RY 2026 MHAC policy, staff solicited input from the PMWG and other stakeholders. In general, stakeholders support the staff's recommendation to not make major changes to the RY 2026 MHAC program. This section of the report provides an overview of the statewide PPC trends—for those used for payment, under monitoring, and overall—and updates related to 3M clinical logic and MHAC methodology.

## Statewide PPC Performance Trends

### Complications Included in Payment Program

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

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

Under the TCOC Model, Maryland must maintain these improvements by not exceeding the CY 2018 PPC rates for complications included in the payment program. Figure 2 below shows the statewide observed to expected (O/E) ratio from 2018 through June CY 2023.<sup>3</sup> The O/E ratio presents the count of observed PPCs divided by the calculated number of expected PPCs (which is generated using statewide normative values applied to the case-mix of discharges a hospital experiences). An O/E Ratio of greater than 1 indicates that a hospital experienced more PPCs than expected, and conversely, an O/E Ratio less than one indicates that a hospital experienced fewer PPCs than expected. Figure 2 below also indicates how Maryland is performing relative to CY 2018, which is the time period that will be used to assess any backsliding on performance.<sup>4</sup> Specifically, there has been a 27.5 percent decrease in the ratio based on the most recent data available (CY 2018 YTD O/E ratio = 1.09 and CY 2023 YTD O/E ratio = 0.79).

PPCs in the MHAC payment program include:

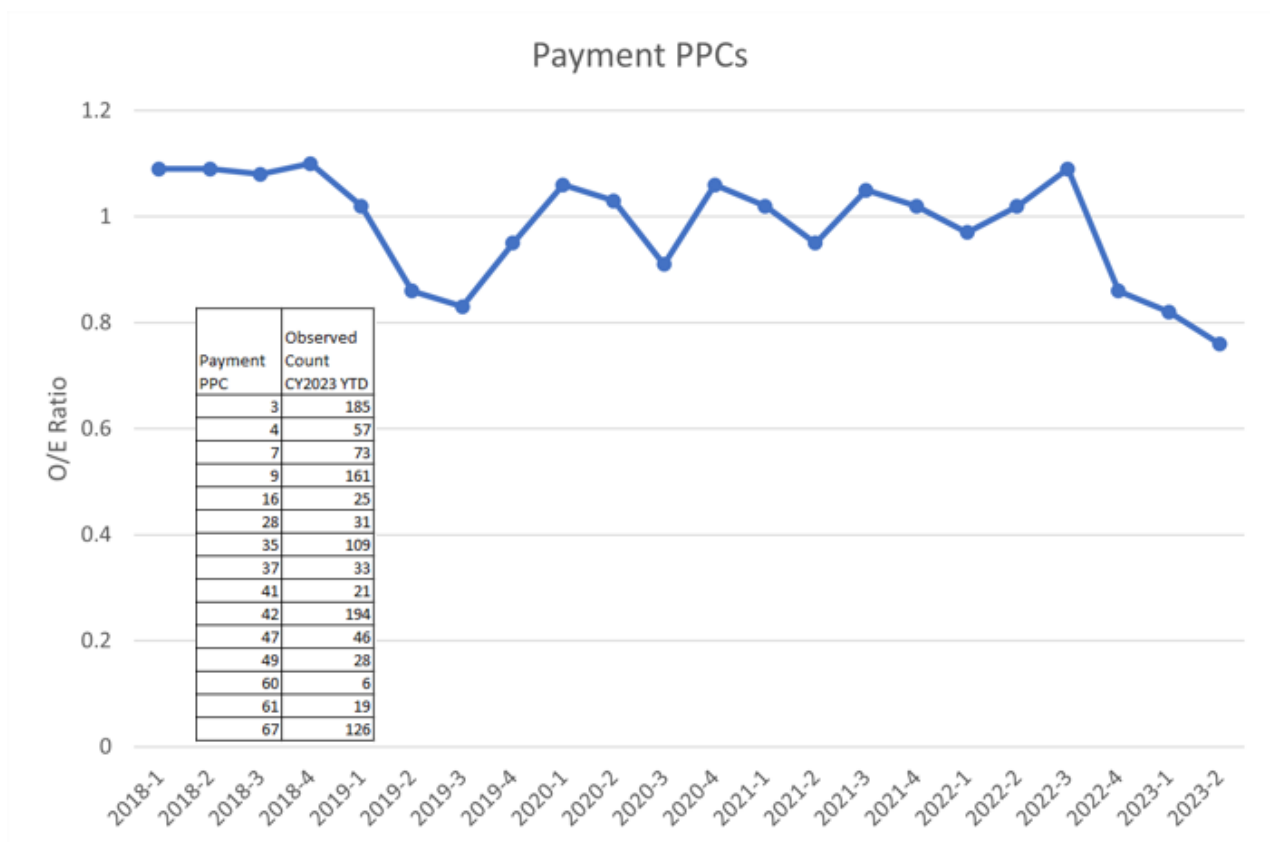
- 3 Acute Pulmonary Edema and Resp Failure w/o Ventilation
- 4 Acute Pulmonary Edema, Resp Failure w/ventilation
- 7 Pulmonary Embolism
- 9 Shock
- 16 Venous Thrombosis
- 28 In-Hospital Trauma and Fractures
- 35 Septicemia & Severe Infections
- 37 Post-Operative Infection & Deep Wound Disruption Without Procedure
- 41 Peri-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D
- 42 Accidental Puncture/ Laceration During Invasive Procedure
- 47 Encephalopathy

<sup>3</sup> Staff notes that, consistent with federal policies during the COVID Public Health Emergency, PPC data from January-June 2020 will not be used for assessing quality of care.

<sup>4</sup>Beginning in v38 of the 3M PPC grouper, COVID exclusions vary by PPC.

- 49 Iatrogenic Pneumothorax
- 60 Major Puerperal Infection and Other Major Obstetric Complications
- 61 Other Complications of Obstetrical Surgical & Perineal Wounds
- 67 Pneumonia Combo (with and without aspiration)

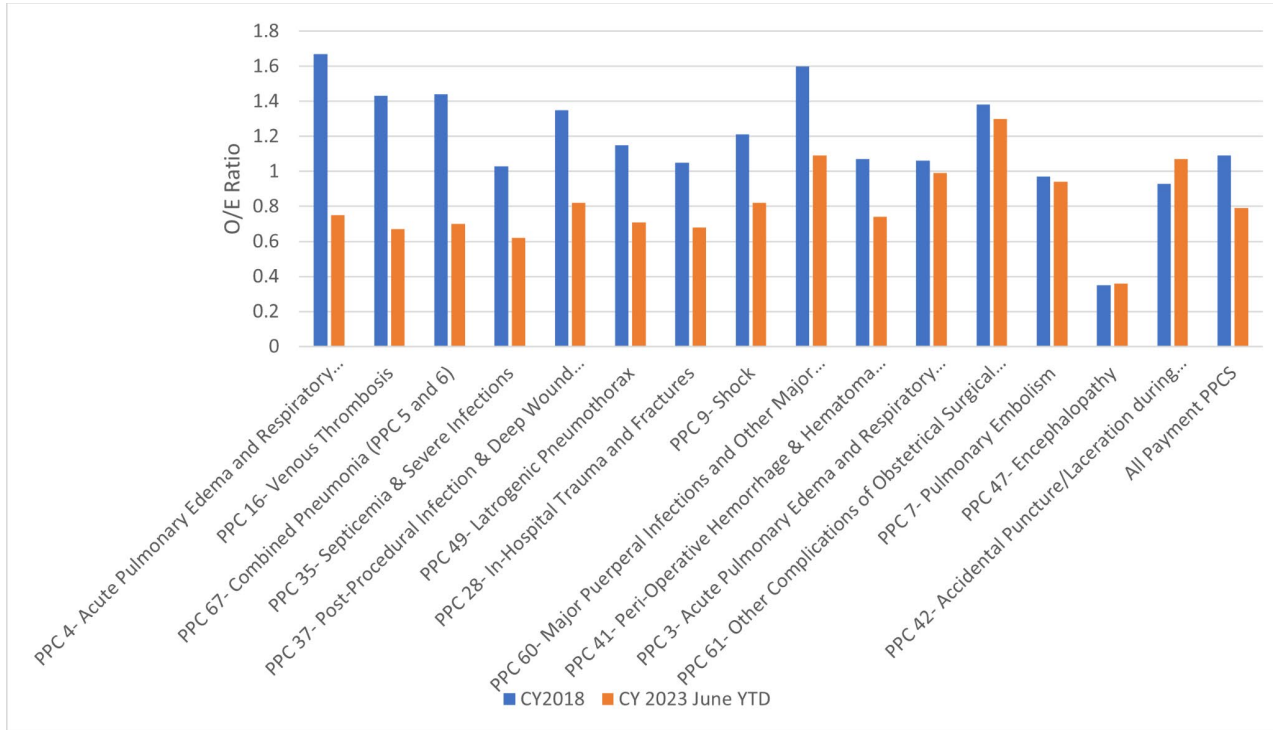
**Figure 2. Payment Program PPCs Observed to Expected Ratios by Quarter CY 2018 to CY 2023 YTD Through June**



In terms of specific improvements among the 15 payment PPCs, Figure 3 shows the O/E ratios for CY 2018 and CY 2023 YTD, sorted from greatest percent decrease (on the left) to greatest percent increase (on the right). The two PPCs that worsened during this time period include PPC 47- Encephalopathy and PPC 42- Accidental Puncture/ Laceration During Invasive Procedure. The three PPCs with the greatest decreases (improvements) include PPC 4- Acute Pulmonary Edema and Respiratory Failure with Ventilation, PPC16- Venous Thrombosis, and PPC 67- Combined Pneumonia.

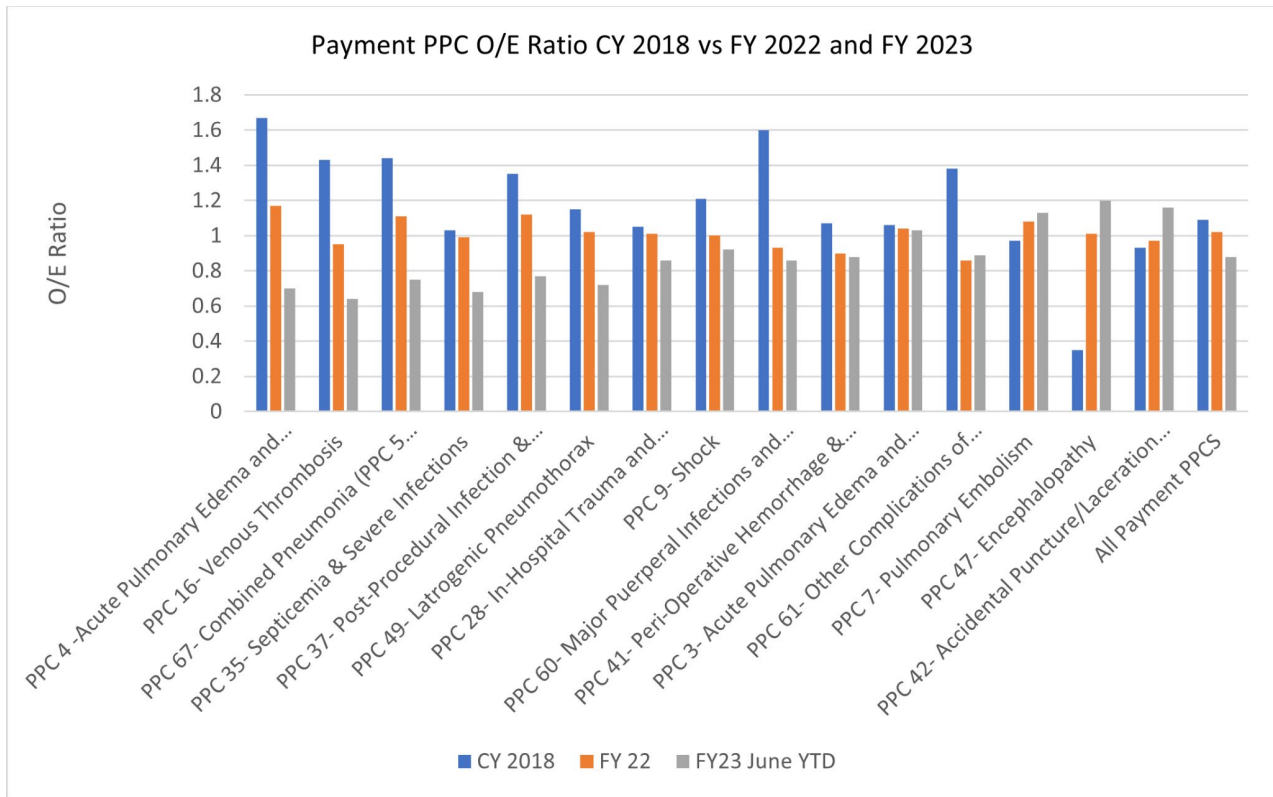


**Figure 3. Payment Program PPC Observed to Expected Ratios CY 2018 and CY 2023 June YTD**



Staff also analyzed payment PPC changes for FYs 2022 and 2023 compared to the base period of 2018 as illustrated in Figure 4 below. The overall PPC O/E ratios show a steadily declining trend across the three time period; from FY2022 to FY2023 there were 11 PPCs that showed a decrease in the O/E ratios (improvement), and 4 PPCs that showed a slight increase (worsening).

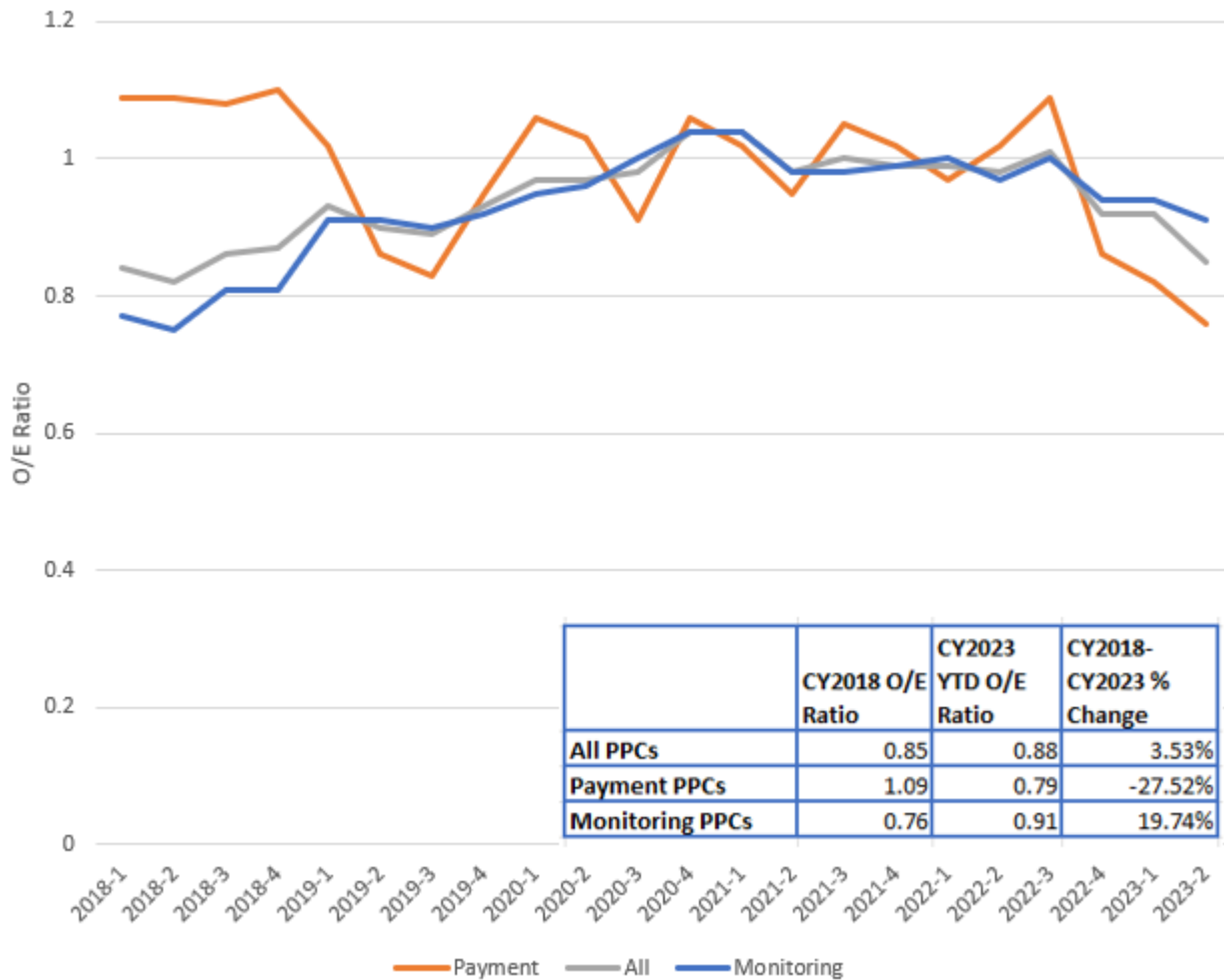
**Figure 4. Payment Program PPC Observed to Expected Ratio Trends; CY 2018, FY 2022, and FY 2023**



## Monitored Complications

In addition to focusing on a narrowed list of PPCs for payment, as stated previously, the RY 2021 MHAC policy following the program redesign included a recommendation to monitor the remaining PPCs. Staff fulfills this recommendation by monitoring all PPCs that are still considered clinically valid by 3M, and distinguishing between “Monitoring” and “Payment” PPCs. The overall PPC trend across all 56 (payment and monitored) PPCs shows that there has been an increase in the overall statewide O/E ratio from 0.85 in CY 2018 to 0.88 in CY 2023 YTD through June; the worsening performance is driven primarily by increases in PPCs under monitoring status, and not increases in the payment program PPCs, as illustrated in Figure 5 below. As also illustrated, the monitored PPC trends have increased from 0.76 as of June YTD 2018 to 0.91 in YTD 2023 with the highest O/E ratios experienced from Q3 2020 to Q1 2021 during the COVID peak period.

**Figure 5. PPC O/E Ratio Trends CY 2018 Qtr 1 Through CY 2023 Qtr 2**



To provide additional context, the MHAC redesign process assessed which PPCs should be included in the pay-for-performance program based on criteria developed by the Clinical Adverse Events Measures (CAEM) subgroup. To support determining the monitored PPCs that are the best candidates for re-adopting into the payment program, staff and stakeholders are using the previously established criteria that include:

- PPC Data Analysis/Statistics
  - Greater than 50% increase in O/E ratio comparing 2022 to 2018
  - Rate per 1,000 generally 0.5 or above
  - Volume of observed events 100 or above (over two years)

- Significant variation across hospitals O/E ratios less than .85 and greater than 1.15
- At least half of the hospitals are eligible for the PPC
- Additional Considerations
  - PSI overlap
  - Clinical significance
  - Potential influence of coding practices/changes
  - Opportunity for improvement/actionability
  - All-payer

The monitored PPCs with the most significant increases in O/E ratios over time included the PPCs listed below. Staff notes, however, that these PPCs were identified as having limited actionability based on input from stakeholders during the program redesign process; therefore, staff is not recommending that these PPCs be moved into the payment program.

- PPC 8: Other Pulmonary Complications
- PPC 15: Peripheral Vascular Complications except Venous Thrombosis
- PPC 53: Infection, Inflammation and Clotting Complication of Peripheral Vascular and Infusions

Appendix III provides the statewide percentage changes in the O/E ratios for the monitored PPCs from 2018 to 2023 YTD through June sorted by the observed PPCs with the largest increases.

## Calculating PPC Performance Standards

Since the RY2021 MHAC Redesign, the performance standards have been the O/E ratio at the 90th (threshold = start to earn points) and 10th (benchmark = full points) percentiles. However, staff are proposing for RY 2026 to modify the methodology slightly to make the performance standards less sensitive to potential outliers by averaging the worst and best performing hospitals (as opposed to taking a single value at a given percentile). This methodology is more in line with the CMS VBP program approach to setting the benchmark. Staff explored a couple of options and suggests averaging the 20 percent of O/E ratios of the worst and best performing hospitals results, which results in similar benchmark and threshold values as compared to the current method but avoids the cliff effects of using a single percentile. See

Appendix IV for additional explanation using the older version of the PPC Grouper and one year of data. Figure 6 shows the results under the current method and potential method using V41 of the PPC Grouper.<sup>5</sup>

**Figure 6. Performance Standards Comparisons by Calculation Method**

Base FY22 and FY23		Current Method		Proposed Method	
		P90	P10	Avg P80	Avg P20
PPC Number	PPC Description	Threshold	Benchmark	Threshold	Benchmark
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	1.4858	0.4248	1.9458	0.3844
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	1.4756	0.1441	2.0135	0.1378
7	Pulmonary Embolism	1.3432	0.1342	1.4736	0.2431
9	Shock	1.874	0.2989	1.8793	0.2747
16	Venous Thrombosis	1.8446	0.2157	1.9665	0.1621
28	In-Hospital Trauma and Fractures	1.6451	0.3822	1.6225	0.3183
35	Septicemia & Severe Infections	1.4583	0.3376	1.6904	0.3397
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	1.4446	0.3896	1.4635	0.3125
41	Peri-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc	2.0363	0	2.2026	0.084
42	Accidental Puncture/Laceration During Invasive Procedure	1.6377	0.2539	1.6748	0.2746
47	Encephalopathy	1.9126	0.2282	1.9165	0.2327
49	Iatrogenic Pneumothrax	1.8791	0.4935	1.8856	0.397
60	Major Puerperal Infection and Other Major Obstetric Complications	1.4697	0.3485	1.4697	0.3485
61	Other Complications of Obstetrical Surgical & Perineal Wounds	1.8459	0	1.911	0.0784
67	Combined Pneumonia (PPC 5 and 6)	1.4979	0.1878	1.6807	0.191

### Small Hospital Criteria

The current MHAC program handles small hospitals in two ways: 1) Hospitals are excluded from being assessed on a PPC if they do not meet the minimum criteria of 2 expected PPCs and 20 admissions at-risk for a PPC; and 2) Hospital performance is assessed using two years of data if across all 15 payment PPCs the hospital has less than 21,500 at-risk or 22 expected PPCs. For the sepsis PPC, one hospital raised a concern about Criteria 1 that requires a minimum of 2 expected PPCs for the hospital to be assessed on the PPC; this is described more fully in the section just below. Staff is not proposing any global changes to the small hospital criteria.

<sup>5</sup> These results were updated since the December Performance Measurement Workgroup to V41 of the PPC grouper and two years of “base” data.

## PPC Clinical Concerns

Over this past calendar year, hospitals have raised concerns about the small hospital PPC inclusion criteria with regard to the sepsis PPC as well as specific clinical concerns regarding some other PPCs on which they have provided input to 3M for consideration in the annual PPC Grouper updating process.

### ***PPC 35 Septicemia & Severe Infections***

One hospital expressed their concerns that they had in previous years been eligible for PPC 35 but had this past year seen their expected rate drop below 2, rendering them ineligible for inclusion of this PPC in their MHAC score. They noted further that the PPC was serious and highly amenable to interventions which they had identified and implemented; however, with the minimum expected criteria of 2, their performance is not counted or recognized in their score. Staff has vetted with the PMWG a proposal that the minimum criteria be waived for PPC 35 Sepsis in light of its seriousness and preventability. While staff are open to stakeholder input on this issue, our initial opinion is that PPCs with small numbers should be removed from the payment program for stability of measurement and that the hospitals still benefit from preventing these complications under the global budget. Stakeholder input on this issue will be summarized in the final policy.

### ***PPC 42: Accidental Puncture or Laceration***

Two clinical scenarios of concern were raised for this PPC during RY 2025. For patients with cerebral and spinal dural tissue tears during a surgical procedure when adhesions are present, hospitals provided input that cases with a code indicating adhesions are present should be excluded for this PPC. 3M has agreed with this input and added the code to the exclusion list for this PPC in the Grouper version 41 just released this October. Similarly, hospitals provided input that this PPC should be excluded for patients with abdominal adhesions that have abdominal surgical procedures. 3M is now considering this input and will make a determination to be addressed in Grouper version 42 scheduled for release in October 2024. Staff proposes to address the changes and remove the PPC42 cases of concern retrospectively for RYs 2025 and 2026 by rerunning the PPC data using Grouper version 41 for RY 2025 for PPC 42, and version 42 for RY 2026 if needed. Hospitals will then be given the better of the score for PPC 42 to reflect a clinical issue recognized by 3M during the performance period while not penalizing hospitals retrospectively.

### ***PPC 07- Pulmonary Embolism***

For this PPC, hospitals raised concerns that patients with codes indicating a deep vein thrombosis is present should be excluded from being assigned this PPC. 3M has agreed and has updated the exclusion code list for PPC 7 in Grouper version 41. Staff again proposes to address the changes retrospectively and remove the cases of concern from PPC 7 assignment for RY 2025 by rerunning the PPC data using Grouper version 41 and using the better of the scores for each hospital that qualifies for the PPC.

The MHAC final recommendation will provide preliminary analyses on the impact of using v41 of the Grouper for PPC 7 and PPC 42 for RY 2025.

## **Stability of Case-Mix Adjusted PPC Rates**

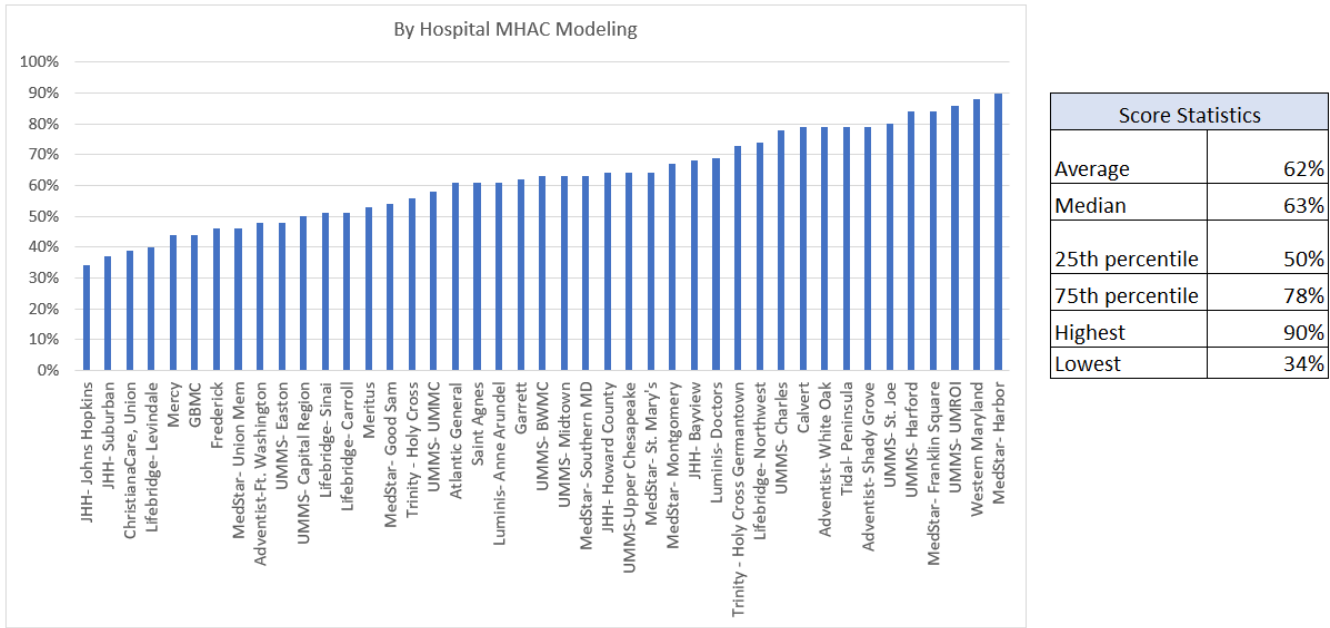
As Maryland hospitals continue to improve on payment PPCs, staff plan to pursue statistical methods that will better address small cell size issues and statistical reliability and validity. Thus, during CY 2023, staff has begun working with our contractor MPR to explore whether changes are needed to the program. The methods that will be considered are similar to methods used by CMS for the same concerns (i.e., Bayesian smoothing) and modeling has been initially presented to the PMWG during the RY 2026 policy development process. Initial concerns raised by stakeholders have included potential smoothing impact on small hospitals where rates would be driven more by statewide average than the hospitals performance. The HSCRC is exploring different options to address these concerns with our contractor MPR. Staff will continue to develop and model hospital scores with select options for smoothing and vet results with the PMWG during CY 2024 with potential for adoption for the RY 2027 MHAC policy.

## **Hospital Scores and Revenue Adjustments**

The hospital scores are calculated across all payment PPCs and then converted to revenue adjustments using a prospectively determined revenue adjustment scale, which allows hospitals to track their progress throughout the performance period. Since the program redesign, the scale has remained the same—that is it ranges from 0 to 100 percent with a hold-harmless zone between 60 and 70 percent. Despite historical concerns regarding the lack of a continuous scale from some stakeholders, staff still believes that the hold harmless zone is reasonable given the lack of national benchmarks for establishing a cut-point. Using data under v41 of the PPC grouper, staff modeled scores for hospitals using the two methods of setting

performance standards. Overall the change in the approach for determining the performance standards results in equal or higher scores for all but one hospital (i.e., Garrett hospitals score went down by 1 percentage point), with the median increase in scores of 3 percentage points (range -1 to +7 percent). Figure 7 shows the distribution of hospital scores and statistics indicating, for example, that the median score was 63 percent. However, using the current RY 2025 scale, 17 hospitals would receive a penalty, 13 hospitals would be held harmless (i.e., no penalty or reward), and 13 hospitals would receive a reward. Given the average scores are within the hold harmless zone, staff does not recommend changing the current revenue adjustments scale for RY 2026.

**Figure 7. Modeled MHAC Scores, SFYs 22-23 Base Period, CY 2023 YTD Through November Performance**



## Health Equity

Over the past two years, staff began to analyze the quality programs and measures for racial and sociodemographic disparities. Specifically for the MHAC program, the results for the payment PPCs were stratified by race, payer and area deprivation index (ADI) and risk-adjusted for age, sex, Admit-DRG, and Severity of Illness level. Results of this analysis, displayed in Appendix V suggested that there are



statistically insignificant differences between racial categories; however, there were statistically significant differences between payers and ADI categories. While statistically significant differences were found between payers and ADI categories, the odds ratios are relatively low and are, therefore, not an area of large concern for staff compared to the disparities uncovered in other quality measures, for example, Timely Follow-Up. Staff remains committed to addressing health equity, but at this time does not recommend including additional incentives for reducing disparities in PPC performance because of the overall low rates in PPCs and the relatively low odds ratios between payer and ADI categories. Over the next year, Staff will continue to monitor disparities in the quality programs' measures and develop disparity measure(s) and incentives that will drive improvement in disparities.

## Stakeholder Feedback and Responses

One comment letter was received from the Maryland Hospital Association stating its support for the draft recommendation. Staff thanks stakeholders, in particular the PMWG members and interested parties, for their engagement and support to update the MHAC policy.

## Recommendations

These are the final recommendations for the RY 2026 Maryland Hospital Acquired Conditions (MHAC) program:

1. Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.
  - a. Maintain a focused list of PPCs in the payment program that are clinically recommended and that generally have higher statewide rates and variation across hospitals.
  - b. Assess monitoring PPCs based on clinical recommendations, statistical characteristics, and recent trends to prioritize those for future consideration for updating the measures in the payment program.
  - c. Engage hospitals on specific PPC increases as indicated/appropriate to understand trends and discuss potential quality concerns.
2. Use more than one year of performance data for small hospitals (i.e., less than 21,500 at-risk discharges and/or 22 expected PPCs). The performance period for small hospitals will be CYs 2023 and 2024.

3. Continue to assess hospital performance on attainment only, with adjustment to performance standards for increased stability.
4. Continue to weight the PPCs in the payment program by 3M cost weights as a proxy for patient harm.
5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent and continuous linear scaling with a hold harmless zone between 60 and 70 percent.
6. Future Considerations:
  1. Assess options for streamlining (or simplifying) the quality programs overall, or for the hospital acquired complication measures that are currently included in both the QBR Safety Domain and the MHAC program.
  2. Assess digitally specified quality measures such as electronic Clinical Quality Measures (eCQMs) for future inclusion in quality programs.

## Appendix I. Background on Federal Complication Programs

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

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

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

### Hospital-Acquired Condition Reduction Program

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

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

<p>Recalibrated Patient Safety Indicator (PSI) measure:<sup>^</sup></p> <ul style="list-style-type: none"> <li>● PSI 03 – Pressure Ulcer Rate</li> <li>● PSI 06 – Iatrogenic Pneumothorax Rate</li> <li>● PSI 08 – In-Hospital Fall with Hip Fracture Rate</li> <li>● PSI 09 – Perioperative Hemorrhage or Hematoma Rate</li> <li>● PSI 10 – Postoperative Acute Kidney Injury Requiring Dialysis Rate</li> <li>● PSI 11 – Postoperative Respiratory Failure Rate</li> <li>● PSI 12 – Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate</li> <li>● PSI 13 – Postoperative Sepsis Rate</li> <li>● PSI 14 – Postoperative Wound Dehiscence Rate</li> <li>● PSI 15 – Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate</li> </ul>
Central Line-Associated Bloodstream Infection (CLABSI) <sup>^*</sup>
Catheter-Associated Urinary Tract Infection (CAUTI) <sup>^*</sup>
Surgical Site Infection (SSI) – colon and hysterectomy <sup>^*</sup>
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia <sup>^*</sup>
Clostridium Difficile Infection (CDI) <sup>^*</sup>

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

For more information on the DRA HAC program POA Indicator, please refer to:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index>

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

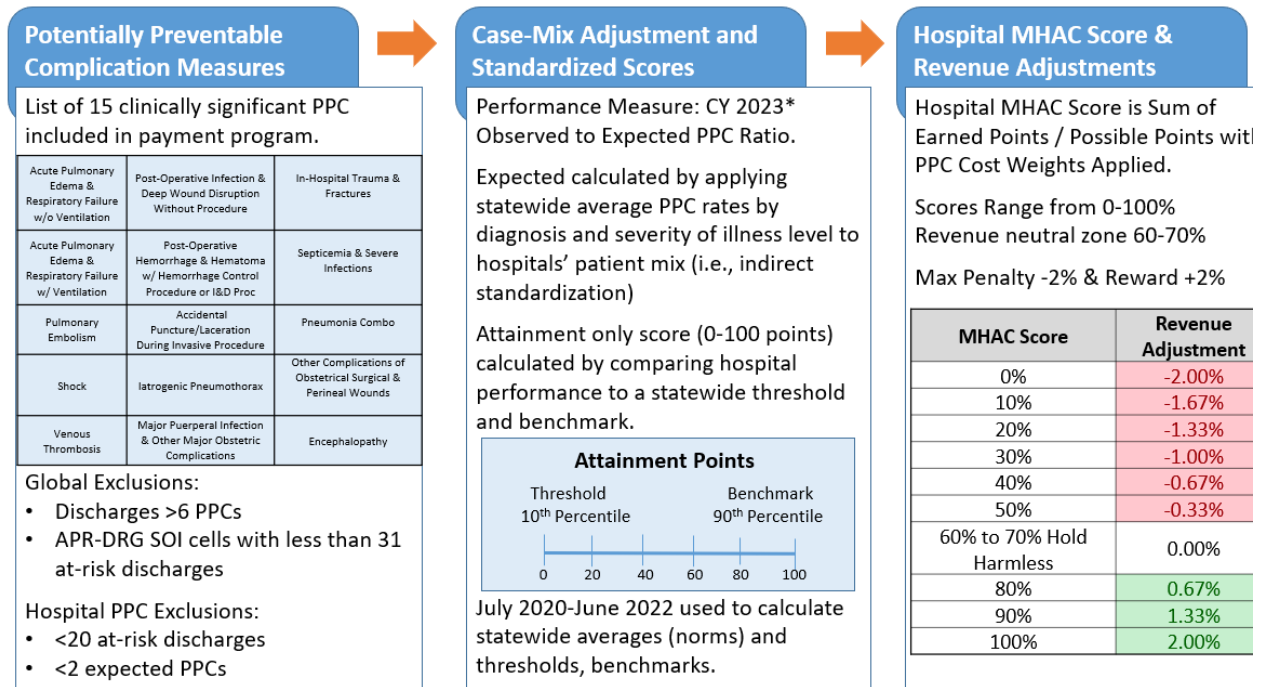
For more information on the HAC Reduction program, please refer to:

<https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program>

## Appendix II: RY 2025 MHAC Program Methodology

Figure 1 below provides a summary overview of the approved RY 2025 MHAC methodology.

Figure 1. Overview of RY 2025 Approved MHAC Methodology



### Performance Metric

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

### Observed and Expected PPC Values

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

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

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

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

Let:

N = norm

P = Number of discharges with one or more PPCs

D = Number of “at-risk” discharges

i = A diagnosis category and severity level

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

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

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

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

Figure 2. Expected Value Computation Example for one Diagnosis Category

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

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

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

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

## **PPC Exclusions**

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

For each hospital, discharges will be removed if:

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

For each hospital, PPCs will be removed if during July 2020 to December 2021:

- The number of cases at-risk is less than 15; and
- The expected number of PPCs is less than 1.5.

The PPCs for which a hospital will be assessed are determined using the July 2020 to December 2021 data and not reassessed during the performance period. This is done so that scores can be reliably calculated during the performance period from a pre-determined set of PPCs. The MHAC summary workbooks provide the excluded PPCs for each hospital.

## **Combination PPCs**

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

## **Hospital Exclusions**

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

## **Benchmarks and Thresholds**



For each PPC, a threshold and benchmark value are calculated using the determined base period data. In previous rate years when improvement was also assessed, the threshold was set at the statewide median of 1 and the benchmark was the O/E ratio for the top performing hospitals that accounted for 25% of discharges. For RY 2021 under an attainment only methodology, staff adapted the MHAC points system to allow for greater performance differentiation by moving the threshold to the value of the observed to expected ratio at the 10th percentile of hospital performance, moving the benchmark to the value of the observed to expected ratio at the 90th percentile of hospital performance, and assigning 0 to 100 points for each PPC between these two percentile values.

### **Attainment Points (possible points 0-100)**

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

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

If the PPC ratio is between the threshold and benchmark, the hospital scores partial points for attainment.

The formula to calculate the Attainment points is as follows:

- $\text{Attainment Points} = [99 * ((\text{Hospital's performance period score} - \text{Threshold}) / (\text{Benchmark} - \text{Threshold}))] + 0.5$

### **Calculation of Hospital Overall MHAC Score**

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

### **RY 2025 Update: Small Hospital Methodology**

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

“Establish small hospital criteria for assessing performance under the MHAC policy based on the number of at-risk discharges and expected PPCs (i.e., small hospitals are those with less than 21,500 at-risk discharges and/or 22 expected PPCs across all payment program PPCs) as opposed to the number of PPC measure types, and for hospitals that meet small hospital criteria, increase reliability of score by using two years of performance data to assess hospital performance (i.e., for RY 2025 use CY 2022 and 2023). “

## Appendix III: Monitoring PPCs

The table below shows the monitored PPCs' O/E ratios for CY 22 YTD (through June) and the percent changes in the observed-to-expected ratio from CY 2018.

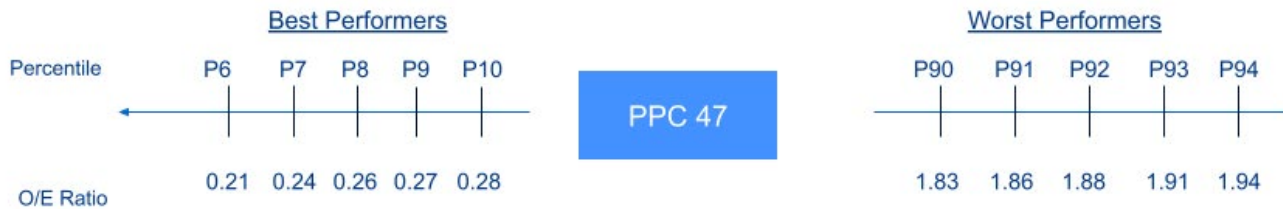
Monitoring PPC	2018 O/E	2023 YTD O/E	2018-2023 % Change
25: Renal Failure with Dialysis	1.02	0.31	-69.43%
2: Extreme CNS Complications	1.29	0.47	-63.92
21: Clostridium Difficile Colitis	1.2	0.64	-47.03%
10: Congestive Heart Failure	0.68	0.55	-18.65%
39: Reopening Surgical Site	1	0.88	-11.93%
65: Urinary Tract Infection without Catheter	1.12	0.98	-12.53%
38: Post-Operative Wound Infection & Deep Wound Disruption with Procedure	0.32	0.29	-7.81%
14: Ventricular Fibrillation/Cardiac Arrest	0.74	0.71	-3.51%
11: Acute Myocardial Infarction	0.88	0.85	-2.58%
33: Cellulitis	0.89	0.95	6.08%
40: Peri-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D Proc	0.8	0.89	11.65%
24: Renal Failure without Dialysis	0.78	0.94	21.09%
34: Moderate Infections	0.58	0.72	24.28%
19: Major Liver Complications	0.64	0.84	30.47%
66: Catheter-Related Urinary Tract Infection	0.99	1.3	31.50%
20: Other Gastrointestinal Complications without Transfusion or Significant Bleeding	0.65	0.86	32.06%
1: Stroke & Intracranial Hemorrhage	0.67	0.92	38.54%
27: Post-Hemorrhagic & Other Acute Anemia with Transfusion	0.74	1.08	45.23%
8: Other Pulmonary Complications	0.85	1.25	46.36%
48: Other Complications of Medical Care	0.6	0.88	46.79%
45: Post-Procedure Foreign Bodies	1.12	1.74	55.70%
52: Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection	0.7	1.13	60.65%
17: Major Gastrointestinal Complications without Transfusion or Significant Bleeding	0.62	1.01	63.86%
50: Mechanical Complication of Device, Implant & Graft	0.55	0.9	64.49%
26: Diabetic Ketoacidosis & Coma	0.48	0.8	67.05%
29: Poisonings due to Anesthesia	0.82	1.37	67.91%
18: Major Gastrointestinal Complication with Transfusion or Significant Bleeding	0.5	0.84	68.51%
13: Other Cardiac Complications	0.13	0.87	71.54%

Monitoring PPC	2018 O/E	2023 YTD O/E	2018-2023 % Change
<b>59: Medical &amp; Anesthesia Obstetric Complications</b>	<b>0.46</b>	<b>0.82</b>	<b>78.40%</b>
<b>23: GU Complications Except UTI</b>	<b>0.55</b>	<b>0.99</b>	<b>82.26%</b>
<b>54: Infections due to Central Venous Catheters</b>	<b>0.6</b>	<b>1.1</b>	<b>82.59%</b>
<b>53: Infection, Inflammation &amp; Clotting Complications of Peripheral Vascular Catheters &amp; Infusions</b>	<b>0.6</b>	<b>1.1</b>	<b>83.08%</b>
<b>44: Other Surgical Complication- Mod</b>	<b>0.49</b>	<b>0.92</b>	<b>88.42%</b>
<b>15: Peripheral Vascular Complications Except Venous Thrombosis</b>	<b>0.46</b>	<b>0.92</b>	<b>99.92%</b>
<b>51: Gastrointestinal Ostomy Complications</b>	<b>0.47</b>	<b>0.95</b>	<b>102.52%</b>
<b>64: Other In-Hospital Adverse Events</b>	<b>0.49</b>	<b>1.02</b>	<b>106.91%</b>
<b>31: Decubitus Ulcer</b>	<b>0.3</b>	<b>0.81</b>	<b>172.70%</b>
30: Poisonings due to Anesthesia	0 observed	0 Observed	
32: Transfusion Incompatibility Reaction	0 observed	0 Observed	

## Appendix IV: Calculating Performance Standards

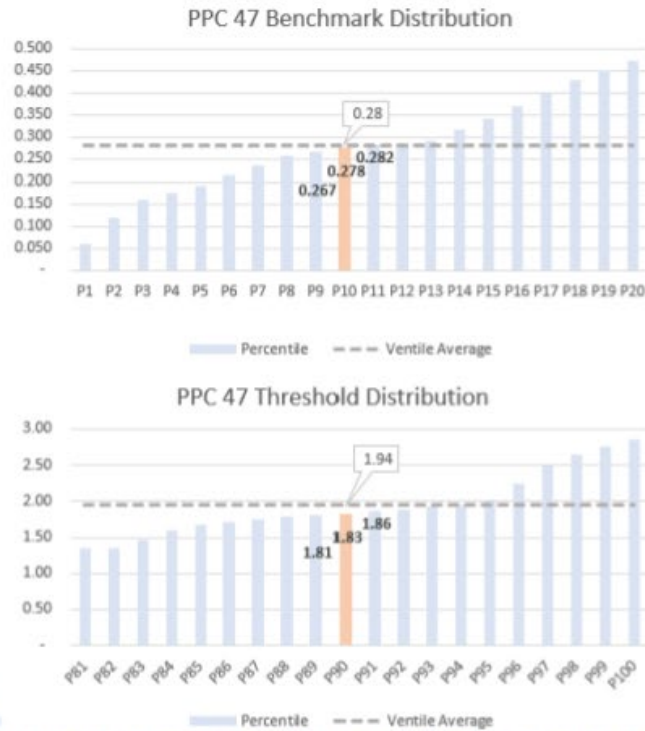
### PPC Variation in Performance

- To understand if there's a need to move to an average approach, staff wanted to understand the variation around the cut points for rewards and penalties
  - Large variation would warrant moving to an average approach



Note: Staff calculations vary from SAS calculations due to rounding differences between SAS and Excel

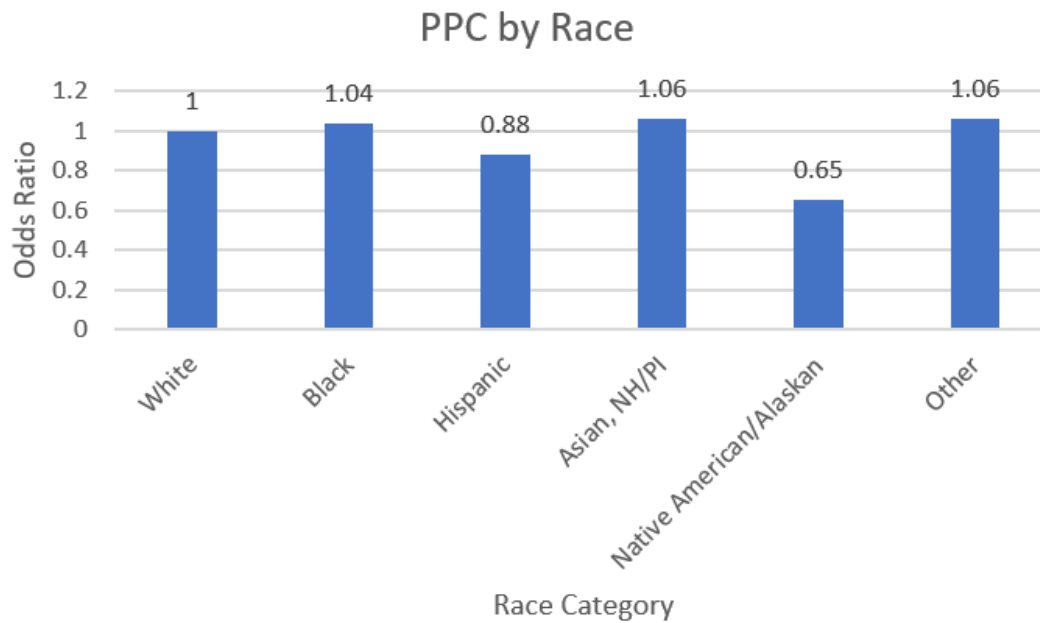
## EX: PPC 47 Variation in Performance



- 10th percentile for benchmark determination appears reasonable
  - Delta between 9th, 10th, and 11th percentile is limited
  - Range between 1st percentile and 20th percentile is limited (~0.4)
  - Average of best ventile is similar to 10th percentile
- 90th percentile for threshold determination appears less reasonable
  - Delta between 89th, 90th, and 91st percentile is more significant
  - Range between 81st percentile and 100th percentile is substantial (~1.5)
  - Average of worst ventile is less similar to 90th percentile

## Appendix V: Disparities in PPCs

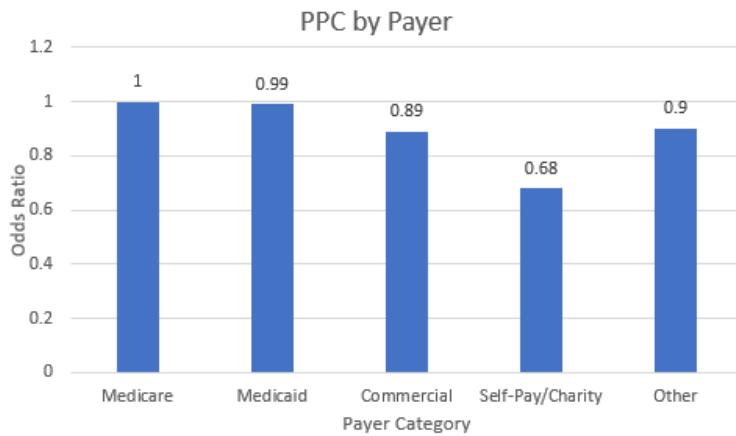
Below slides are presented by race, payer, and ADI categories that show the odds ratio of experiencing a PPC as well as tables that present the odds ratio, the p-value, and the confidence intervals by category.



PPCs	Odds Ratio Coefficient	P-Value	Confidence Intervals
White (reference)			
Black	1.04	0.113	.9913536 - 1.085907
<b>Hispanic</b>	<b>.88</b>	<b>0.027</b>	<b>.7901786 .9856565</b>
Asian	1.06	0.425	.924325 1.205196
Native Am.	.65	0.151	.3552198 1.173473
Other	1.06	0.341	.9408 1.193
Non-White	1.02	0.312	.9797004 1.066333



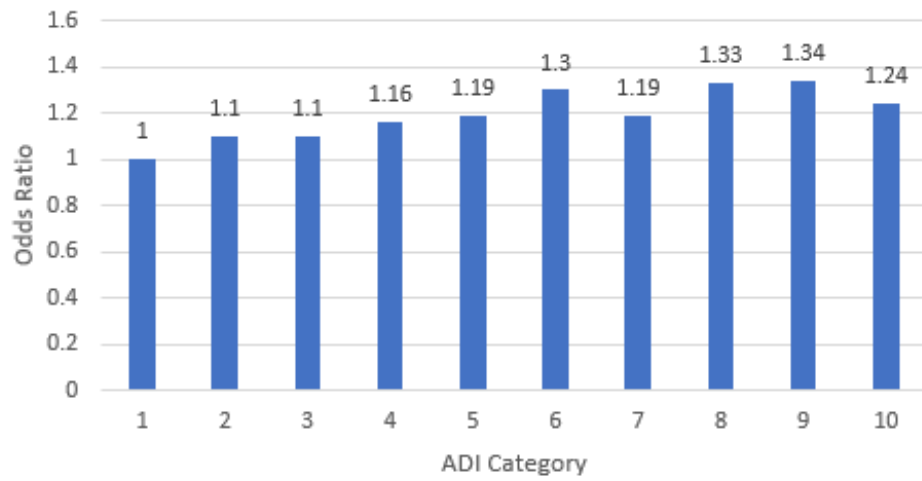
Black	1.04	0.123	.9903417	1.084905
Non-Black vs Black (Non-Black reference)	1.04	0.066	.9973128	1.089417



PPCs	Coefficient	P-Value	CI
Medicare (reference)			

PPCs	Coefficient	P-Value	CI
Medicaid	.99	0.836	.916711 1.07284
<b>Commercial</b>	<b>.89</b>	<b>0.000</b>	<b>.8295058 .9482376</b>
<b>Self-Pay/Charity</b>	<b>.68</b>	<b>0.000</b>	<b>.5441243 .8426922</b>
Other	.90	0.117	.7809703 1.027758

### PPC by ADI Decile



PPCs	Coefficient	P-Value	CI
1 (reference)			
2	1.10	0.041	1.004006 1.209946
3	1.10	0.053	.9987985 1.2043
4	1.16	0.002	1.054725 1.270863
5	1.19	0.001	1.078814 1.313731
6	1.30	0.000	1.170513 1.449902
7	1.19	0.003	1.063426 1.335627
8	1.33	0.000	1.176754 1.498999

<b>9</b>	<b>1.34</b>	<b>0.000</b>	<b>1.182045 1.520293</b>
<b>10</b>	<b>1.24</b>	<b>0.001</b>	<b>1.088737 1.419777</b>



Maryland  
Hospital Association

January 17, 2024

Alyson Schuster, Ph.D.  
Deputy Director, Quality Methodologies  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Dr. Schuster:

On behalf of the Maryland Hospital Association's (MHA) 62 member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) *Draft Recommendations for the Maryland Hospital Acquired Conditions (MHAC) Program for Rate Year (RY) 2026*. We support the staff's recommendations, which are largely unchanged from the existing RY2025 policy.

MHA supports HSCRC's staff recommendation to retain the existing Potentially Preventable Complications (PPCs) in the payment policy and continue to monitor other clinically significant PPCs. Hospitals have significantly decreased the observed-over-expected (O/E) ratio for payment PPCs by more than 27% since 2018. Though, O/E ratios for monitored PPCs rose almost 20% from 2018 through 2023, this represents an improvement of roughly 50 basis points over the last year. Given these findings, MHA supports using the average of the top and bottom 20% O/E ratio results to avoid the cliff effect of using a single percentile for monitoring PPCs. Furthermore, we support the recommendation to use more than one year of performance data for small hospitals.

MHA looks forward to continuing our collaboration with the Commission on this and future policies.

Sincerely,

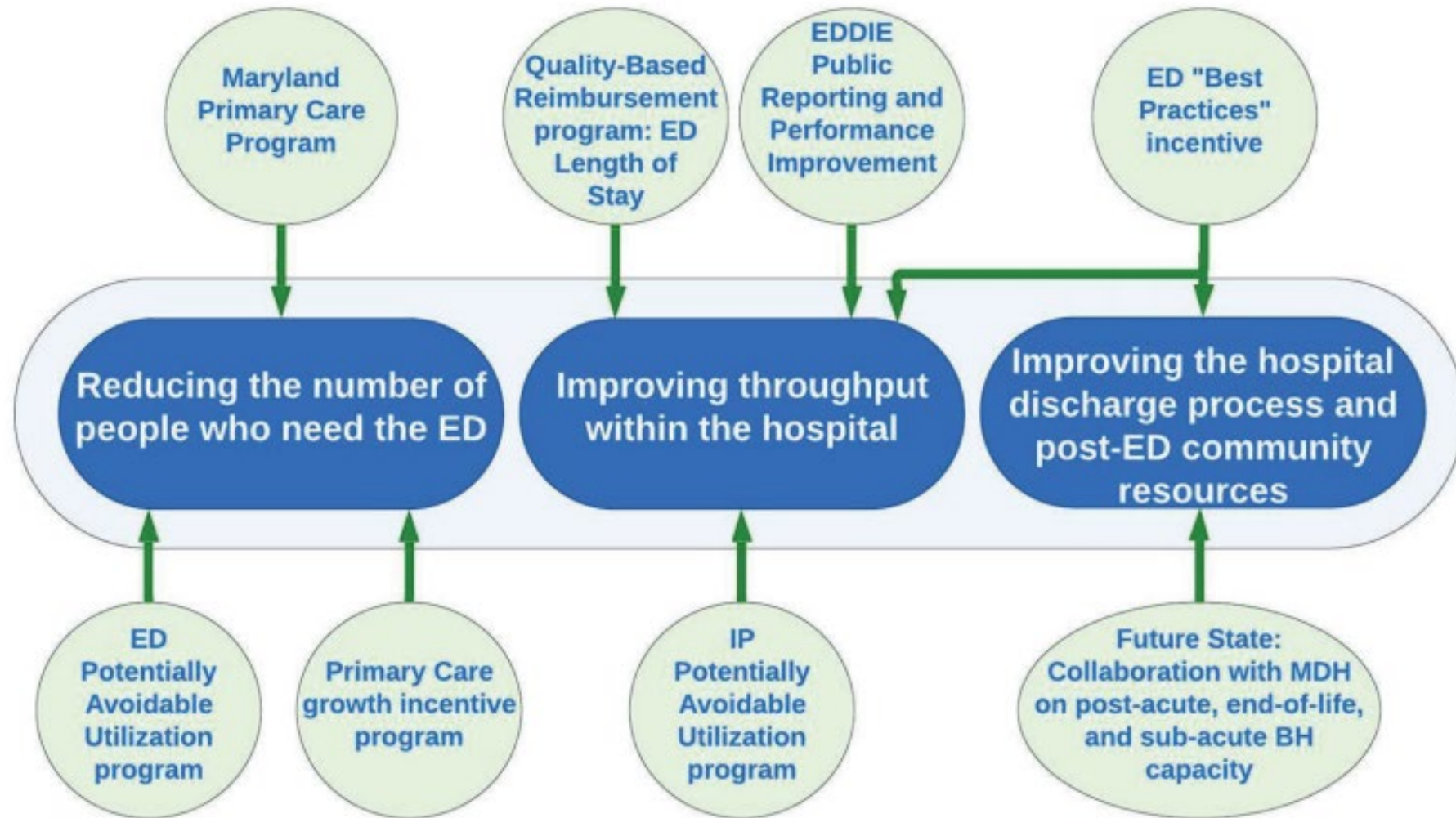
Brian Sims  
Vice President, Quality & Equity

cc: Joshua Sharfstein, M.D., Chairman  
Joseph Antos, Ph.D., Vice Chairman  
James N. Elliott, M.D.  
Ricardo. R. Johnson

Maulik Joshi, DrPH  
Adam Kane, Esq.  
Nicki McCann, JD  
Jonathan Kromm, Ph.D., Executive Director

# Final Recommendations for Establishing the Emergency Department Potentially Avoidable Utilization Program for Rate Year 2026 - Stakeholder Comments

# HSCRC Programs Impacting Emergency Departments





# Stakeholder Comment Letters

- Received from:
  - a. Maryland Hospital Association (MHA)
  - b. Johns Hopkins Health System (JHHS)
  - c. MedStar Health
  - d. Meritus Health
- MedStar and JHHS support the overall policy and recommended modifications.
- MHA opposed the policy but supports a voluntary program with infrastructure funding that incentivizes meaningful regional partnerships and sustainable health care programs.
- Meritus Health expressed concern that the program could result into the unintended consequence of incentivizing hospitals to reduce access to care for the most vulnerable patients.

# Stakeholder Concern: Policy Scope

- The recommendation is singularly focused on hospitals without any intention to engage payers, state and local governments. (JHHS)
- The policy should be more intentionally focused on a single disease that truly represents avoidable care. (JHHS)
- The ED PAU program alone will not address the other factors external to the hospital which have been proven to be the drivers of high MVPs (MHA).
- The policy will unfairly hold hospitals accountable for systematic issues outside of their control. (MHA)

**Staff Response:** Hospitals have a critical role to play in identifying more effective care pathways for MVPs. Thus the policy is appropriately focused on hospitals. The HSCRC will engage with others in the health sector to explore ways to make progress on this issue, and encourages hospitals and the MHA to do the same. Restricting the program to a single diagnosis would limit the impact of the program on ED length of stay and Total Cost of Care Model performance, while also preventing hospitals from developing programs that would be most beneficial to the populations they serve.

There are numerous examples in the peer-reviewed literature of hospital-based programs that have been successful in addressing MVPs, so failing to incentivize hospitals to implement such programs would be a missed opportunity.

## Stakeholder Concern: Ceiling Effect

- When financial incentives for reducing PAU are applied, it will be difficult to keep making incremental progress as PAU percentages decline.
- Similarly, hospitals with high percentages of PAU will be provided more opportunity to achieve financial reward than hospitals who have already achieved low levels of ED PAU (MedStar).
- The policy rewards all volume reduction and views all ED volume as addressable even though there is ED MVP utilization that is appropriate and medically necessary (JHHS and Meritus).

**Staff Response:** Staff acknowledge that even the best-performing EDs will have some MVPs. Given that most hospitals have not implemented programs aimed at identifying more effective care pathways for MVPs, it is likely that there is significant room for improvement before this becomes an issue. Development of an attainment policy component could occur at that point.

Attainment incentives would also provide benefits to hospitals that have already invested in addressing the MVP issue. Staff will explore approaches to provide equitable opportunity under the policy for hospitals that significantly reduced MVP volume prior to the implementation of the policy.

## Stakeholder Concern: Unintended Consequences

- The policy recommendation incentivizes a reduction in care options for marginalized groups (MHA).
- Within the current model, hospitals that reduce or entirely eliminate services are rewarded, while hospitals that provide medically necessary care – or take on volume that was shed by other hospitals, are penalized (JHHS).

**Staff Response:** The intent of the policy is to incentivize hospitals to develop more effective care pathways for MVPs and by extension for marginalized groups. Staff will develop and monitor access to care metrics to ensure the policy has the intended effect. The Market Shift policy ensures that appropriate financial accommodation is made when shifts in patient volume occur across facilities.

# Additional Stakeholder Suggestions

- The focus in the ED should be on improving ED wait times and throughput. (Meritus Health)
  - The MVP policy is one component of the State's response to the ED performance issue. While improving ED throughput and securing additional inpatient resources for ED patients are important, reducing the number of patients visiting the ED remains a key part of the solution.
- Hospital analyses have shown that some MVPs travel farther to seek care at specific hospitals, while others do not have the option to seek care elsewhere. (JHHS)
  - The policy's improvement methodology minimizes the impact of this and other differences in patient populations between hospitals.
- Instead of MVP, HSCRC should create a voluntary program with infrastructure funding that incentivizes meaningful regional partnerships and sustainable programs to address the needs of patients. (MHA)
  - A voluntary program will be insufficient to address the current magnitude of the ED performance challenge in the state, and is not responsive to the Commission's original request to staff

## Additional Stakeholder Suggestions 2

- In order to maximize the effectiveness of the ED PAU Policy, CRISP data will need to be made available in an easy to understand and user-friendly report so hospitals can track MVPs across hospitals in Maryland (MedStar).
  - HSCRC will work with CRISP and hospitals on this.
- Commitment from HSCRC staff this policy is not intended to include downside financial risk (MedStar)
  - Per HSCRC policy, staff do not make commitments on the future structure of financial programs. If significant improvement is observed under the reward-only approach, there would be little justification for changing the policy.

# Staff Recommendation

1. Implement a Rate Year 2026 pay-for-performance policy incentivizing reduction in MVP visits on a reward-only and improvement-only basis
2. Set Calendar Year 2023 as the base year.
3. Establish the threshold for performance reward at 5% improvement.
4. Reward hospitals for improvement as follows:
  - a. Calendar Year 2024 improvement of 5-20%: 0.125% of total revenue
  - b. Calendar Year 2024 improvement of >20%: 0.25% of total revenue
5. Require hospitals to prospectively register interventions and updates to existing programs addressing MVP to be eligible for rewards
6. Develop reporting to assess health disparities

**Final Recommendations for Establishing  
the Emergency Department Potentially Avoidable  
Utilization Program for  
Rate Year 2026**

February 2, 2024

Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215  
(410) 764-2605  
FAX: (410) 358-6217

This document contains the draft staff recommendations for establishing a pay-for-performance incentive for the Emergency Department Potentially Avoidable Utilization Measure for RY 2026. Comments on the draft policy may be submitted by email to [hsrc.quality@maryland.gov](mailto:hsrc.quality@maryland.gov) and are due by 5:00 pm, December 20, 2023.



## EXECUTIVE SUMMARY

This document puts forth a draft recommendation for a new Emergency Department Potentially Avoidable Utilization policy, focused on providing all-payer incentives for hospitals to develop alternative care pathways for the most frequent emergency department (ED) visitors.

### Draft Recommendations for Rate Year 2026 Emergency Department Potentially Avoidable Utilization Program

1. Implement a Rate Year 2026 pay-for-performance policy incentivizing reduction in ED visits by multi-visit patients (MVPs) on a reward-only and improvement-only basis
2. Set Calendar Year 2023 as the base year.
3. Establish the threshold for performance reward at 5% improvement.
4. Reward hospitals for improvement as follows:
  - a. Calendar Year 2024 improvement of 5-20%: 0.125% of total revenue
  - b. Calendar Year 2024 improvement of >20%: 0.25% of total revenue
5. Require hospitals to prospectively register MVP interventions with the Commission
6. Evaluate reporting to assess health disparities and other unintended consequences

## INTRODUCTION

In Calendar Year 2021, the Commission asked staff to begin development of a policy providing hospital payment incentives for reduction of avoidable ED utilization. The rationale for addressing ED utilization includes concerns about cost, volume, and impact on emergency department patient experience. Nationally, avoidable ED visits are estimated to account for 19.6% of ED encounters and \$64.4 billion in costs.<sup>1</sup> ED volume is also recognized as a driver of extended ED length of stay,<sup>2</sup> which is an important consideration given that Maryland hospitals have some of the longest ED length of stay averages in the nation.

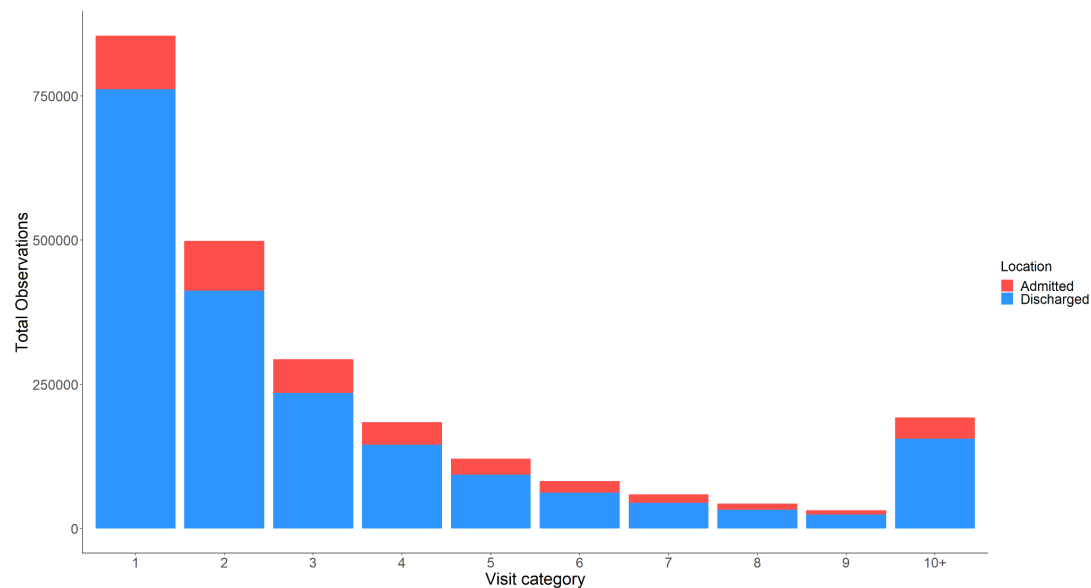
In Calendar Year 2022, staff convened a work group composed of emergency medicine clinicians, hospital representatives and other stakeholders to consider policy options. The group considered a wide variety of policies before concluding that focusing on multi-visit patients would provide hospitals with a well-defined patient population that, due to their frequent presence in the hospital, could be readily targeted with programs offering more effective alternatives to ED care. Participants also took note of several studies detailing successful interventions on multi-visit patients.<sup>3-5</sup>

## BACKGROUND

To understand the visit volume and cost related to MVPs, staff analyzed inpatient and outpatient casemix data across several years. MVPs were defined as those patients with four or more ED visits in a calendar year. This definition, which has been used commonly in the health services research literature, includes both visits that result in an inpatient admission and those that result in a discharge from the ED.

The analysis found that in 2019 MVPs accounted for 30% of all ED visits, and 32% of ED charges. MVP utilization in 2019 totaled \$326 million. The majority of MVP visits resulted in discharge from the ED, which is consistent with the pattern seen in visits by patients who are not MVPs.

**Figure 1: ED visit volume by count of visits by patient in CY 2019**

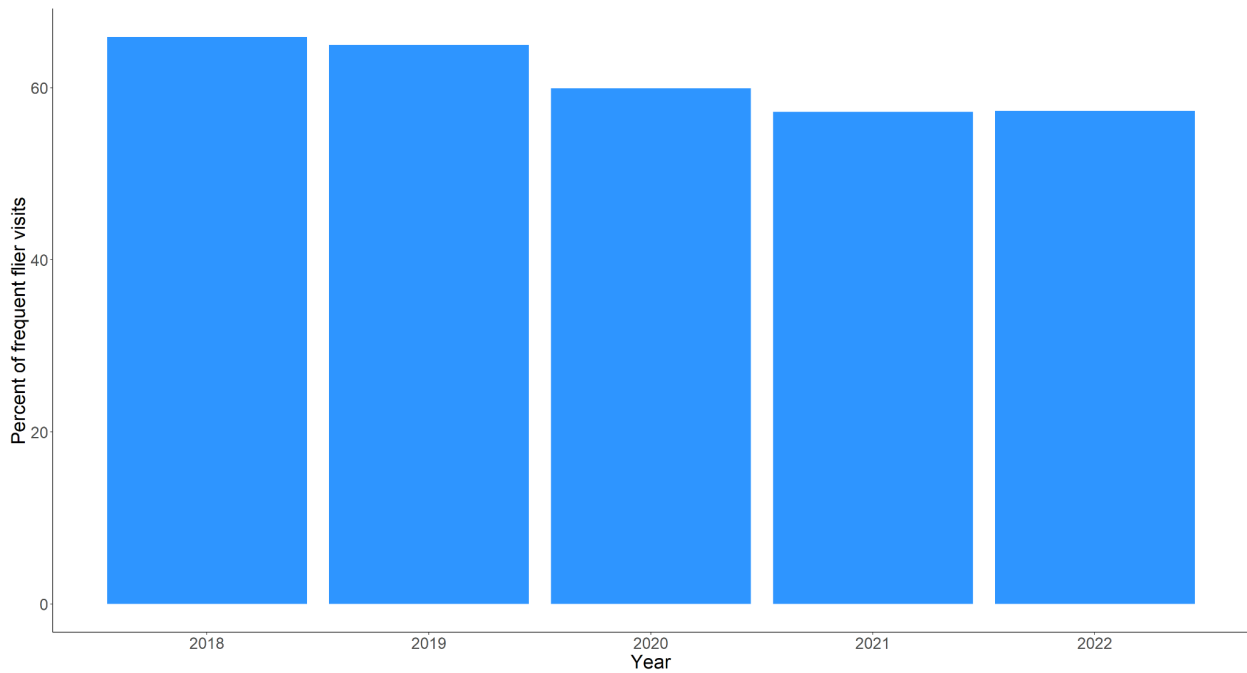


The analysis found that more than 45% of MVPs in 2019 received all of their ED care from a single hospital. The vast majority of MVPs visited one or two hospitals during the year for all of their ED care. When those visits involved multiple hospitals, those hospitals tended to be within the same healthcare system.

Additionally, the analysis found that 67% of MVP visits involved patients with at least one behavioral diagnosis. Behavioral issues also represented the leading principal diagnosis. Other

common principal diagnoses include low-acuity conditions such as back pain, sprains and strains, and other minor injuries. This point is further illustrated by a staff analysis of outpatient MVP visits that found most were assigned triage values indicating lower acuity conditions (Figure 2).

**Figure 2: Outpatient ED visit volume with lower acuity (ESI 3,4,5) triage status by year**



Finally, the analysis indicated that there is minimal overlap between visits addressed by the current Potentially Avoidable Utilization (PAU) program and the proposed Emergency Department Potentially Avoidable Utilization (ED-PAU) program, both of which include in part and whole, respectively, Prevention Quality Indicators (PQI) that are administered by the Agency for Healthcare Research and Quality (AHRQ). The PAU incentive applies to inpatient stays, and thus excludes roughly four out of five ED visits, because those patients are discharged from the ED without admission. Of the MVPs admitted to the hospital, slightly more than a third meet the PQI specifications in the PAU program. Thus, the Commission can be confident that addressing MVPs will not create incentives that duplicate or compete with those in the existing PAU program.

## MEASUREMENT

The goal of the MVP policy is to reduce avoidable ED volume by encouraging hospitals to provide MVPs with more appropriate care pathways, including those focused on behavioral health, end of life care and social needs.

The measurement approach used by the monitoring program used the following definitions.

- **Denominator:** ED claims at a given hospital with a discharge date occurring during the measurement period.
- **Numerator:** Claims in the denominator associated with a patient who has four or more such claims, at any hospital, in the measurement period.

Staff considered an alternate measure definition that would focus on the number of MVPs, rather than the number of visits by MVPs, at a given hospital. However, this would incentivize programs that focus on moving patients across the threshold from four visits to three, leaving significant unmet need among the patients with the highest number of visits. Structuring the policy to focus on visits, rather than patients, encourages hospitals to build programs that target all patients in the MVP population.

Staff also considered whether the MVP criteria should include only visits at the hospital under measurement, or visits across all hospitals. Some hospitals indicated that it would be challenging to identify MVPs other than those who exclusively visit their facility. However, analysis completed by staff suggest that MVPs who visit more than one hospital typically visit other hospitals in the same healthcare system. Thus, system-wide EHR systems can identify patients who are at risk of being included in the MVP measure and flag them for intervention even when they visit multiple hospitals. Leveraging CRISP data can identify such patients when some visits occur outside a given healthcare system. Given these data-sharing features, structuring the policy to focus only on MVPs within a single hospital would needlessly limit the impact of the incentive.

## PAYMENT DETAILS

Because the MVP program represents quality measurement in a new domain, and because constraining ED utilization poses the risk of unintended consequences, staff proposes beginning the program with an improvement-only, reward-only payment approach. This will allow staff to

monitor the program for unintended consequences, evaluate improvement under the initial payment structure in conjunction with assessment of other ED programs, and propose changes as necessary at the end of CY 2024.

Staff also considered the relationship between ED-PAU and the Marketshift and Efficiency policies. Performance under the current PAU program is intentionally excluded from the Marketshift methodology in order to ensure that the incentives do not work at cross purposes. If PAU volume was included in Marketshift, hospitals could potentially see funding shifted to another hospital if PAU increased at that facility but decreased at their own, thus offsetting any reward under the MVP program. To avoid this dynamic, staff recommend carving out of the Marketshift methodology ED services associated with MVPs.

The Efficiency policy has a variety of interactions with the existing PAU methodology. Staff will further explore how to incorporate ED PAU into Efficiency in future workgroup discussions.

## **REPORTING REQUIREMENTS**

**In order to be eligible for rewards, hospitals will be required to prospectively register their MVP interventions with the Commission, using a form that will be developed by Commission staff. Data collected will be used to assess the effectiveness of various types of interventions.**

## **FUTURE UPDATES**

Staff will produce monitoring reports stratifying MVP status and performance at the hospital level by race, payer, gender, Area Deprivation Index, and age group in an effort to prevent the MVP program from furthering existing healthcare disparities.

## **STAKEHOLDER FEEDBACK**

**Stakeholder Comment Letters were received from:**

- Maryland Hospital Association (MHA)
- Johns Hopkins Health System (JHHS)

- MedStar Health
- Meritus Health
- MedStar and JHHS support the overall policy and recommended modifications.
- MHA opposed the policy but supports a voluntary program with infrastructure funding that incentivizes meaningful regional partnerships and sustainable health care programs.
- Meritus Health expressed concern that the program could result into the unintended consequence of incentivizing hospitals to reduce access to care for the most vulnerable patients

### **Stakeholder Concern: Policy Scope**

- The recommendation is singularly focused on hospitals without any intention to engage payers, state and local governments. (JHHS)
- The policy should be more intentionally focused on a single disease that truly represents avoidable care. (JHHS)
- The ED PAU program alone will not address the other factors external to the hospital which have been proven to be the drivers of high MVPs (MHA).
- The policy will unfairly hold hospitals accountable for systematic issues outside of their control. (MHA)

Staff Response: The HSCRC's mandate is to regulate hospitals. Stakeholders are welcome to engage other actors in the health sector to improve performance on the MVP measure.

Restricting the program to a single diagnosis would limit the impact of the program on ED length of stay and Total Cost of Care Model performance, while also preventing hospitals from developing programs that would be most beneficial to the populations they serve.

There are numerous examples in the peer-reviewed literature of hospital-based programs that have been successful in addressing MVPs, so failing to incentivize hospitals to implement such programs would be a missed opportunity.

### **Stakeholder Concern: Ceiling Effect**

- When financial incentives for reducing PAU are applied, it will be difficult to keep making incremental progress as PAU percentages decline.

- Similarly, hospitals with high percentages of PAU will be provided more opportunity to achieve financial reward than hospitals who have already achieved low levels of ED PAU (MedStar).
- The policy rewards all volume reduction and views all ED volume as addressable even though there is ED MVP utilization that is appropriate and medically necessary (JHHS and Meritus).

Staff Response: Staff acknowledge that even the best-performing EDs will have some MVPs. Given that most hospitals have not implemented programs aimed at identifying more effective care pathways for MVPs, it is likely that there is significant room for improvement before this becomes an issue. Staff will monitor policy results. Development of an attainment policy component could occur at that point. Attainment incentives would also provide benefits to hospitals that have already invested in addressing the MVP issue. Staff will explore approaches to provide equitable opportunity under the policy for hospitals that significantly reduced MVP volume prior to the implementation of the policy.

#### **Stakeholder Concern: Unintended Consequences**

- The policy recommendation incentivizes a reduction in care options for marginalized groups (MHA).
- Within the current model, hospitals that reduce or entirely eliminate services are rewarded, while hospitals that provide medically necessary care – or take on volume that was shed by other hospitals, are penalized (JHHS).

Staff Response: The intent of the policy is to incentivize hospitals to develop more effective care pathways for MVPs and by extension for marginalized groups. Staff will develop and monitor access to care metrics to ensure the policy has the intended effect. The Market Shift policy ensures that appropriate financial accommodation is made when shifts in patient volume occur across facilities. Moreover, there are several policy mechanisms in addition to the Market Shift policy that the Commission currently employs to ensure that hospitals are not rewarded for rationing care: a capped corridor policy that doesn't allow hospitals to recoup the entire global budget unless 95 percent of volumes are provided; a deregulation policy that removes funding from hospitals if volumes are relocated to a unregulated setting; and the Integrated Efficiency policy that negatively scales inflation for hospitals that have relatively poor performance in

hospital cost per case assessments and total cost of care, which can be largely driven by excess retained revenue.

### **Stakeholder Suggestions and Staff Comments**

- The focus in the ED should be on improving ED wait times and throughput. (Meritus Health)
  - The MVP policy is one component of the State's response to the ED performance issue. While improving ED throughput and securing additional inpatient resources for ED patients are important, reducing the number of patients visiting the ED remains a key part of the solution.
- Hospital analyses have shown that some MVPs travel farther to seek care at specific hospitals, while others do not have the option to seek care elsewhere. (JHHS)
  - The policy's improvement methodology minimizes the impact of this and other differences in patient populations between hospitals.
- Instead of MVP, HSCRC should create a voluntary program with infrastructure funding that incentivizes meaningful regional partnerships and sustainable programs to address the needs of patients. (MHA)
  - A voluntary program will be insufficient to address the current magnitude of the ED performance challenge in the state, and is not responsive to the Commission's original request to staff
- In order to maximize the effectiveness of the ED PAU Policy, CRISP data will need to be made available in an easy to understand and user-friendly report so hospitals can track MVPs across hospitals in Maryland (MedStar).
  - HSCRC will work with CRISP and hospitals on this.
- Commitment from HSCRC staff this policy is not intended to include downside financial risk (MedStar)



- Per HSCRC policy, staff do not make commitments on the future structure of financial programs. If significant improvement is observed under the reward-only approach, there would be little justification for changing the policy.

## **Final Recommendations for Rate Year 2025 Emergency Department Potentially Avoidable Utilization Program**

1. Implement a Rate Year 2026 pay-for-performance policy incentivizing reduction in MVP visits on a reward-only and improvement-only basis
2. Set Calendar Year 2023 as the base year.
3. Establish the threshold for performance reward at 5% improvement.
4. Reward hospitals for improvement as follows:
  - a. Calendar Year 2024 improvement of 5-20%: 0.125% of total revenue
  - b. Calendar Year 2024 improvement of >20%: 0.25% of total revenue
5. Require hospitals to prospectively report initiation of programs addressing MVP to be eligible for rewards
6. Develop reporting to assess health disparities

## Appendix I: References

1. Galarraga, J. E. & Pines, J. M. Costs of ED episodes of care in the United States. *Am. J. Emerg. Med.* **34**, 357–365 (2016).
2. Morley, C., Unwin, M., Peterson, G. M., Stankovich, J. & Kinsman, L. Emergency department crowding: A systematic review of causes, consequences and solutions. *PLoS One* **13**, e0203316 (2018).
3. Althaus, F. *et al.* Effectiveness of interventions targeting frequent users of emergency departments: a systematic review. *Ann. Emerg. Med.* **58**, 41–52.e42 (2011).
4. Soril, L. J. J., Leggett, L. E., Lorenzetti, D. L., Noseworthy, T. W. & Clement, F. M. Reducing frequent visits to the emergency department: a systematic review of interventions. *PLoS One* **10**, e0123660 (2015).
5. Tsai, M.-H. *et al.* Reducing High-Users' Visits to the Emergency Department by a Primary Care Intervention for the Uninsured: A Retrospective Study. *Inquiry* **55**, 46958018763917 (2018).
6. Ma Z.B., Khatri, R.P., Buehler, G., Boutwell, A., Tseng, K. (2023). Transforming Care Delivery and Outcomes for Multivisit Patients. *NEJM* 4(7)
7. Althaus F., Paroz S., Hugli O., Ghali W.A., Daeppen J., Peytremann-Bridevaux I., Bodenmann P. (2011). Effectiveness of Interventions targeting frequent users of Emergency Departments: a systematic review. *Ann Emerg Med.* Jul;58(1):41-52.e42



**Meritus Health**  
11116 Medical Campus Rd  
Hagerstown, MD 21742  
301.790.8000

January 3, 2024

Jon Kromm, Ph.D.  
Executive Director  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

**Subject: Meritus Health comments on the ED Multi-Visit Patient measure recommended for RY 2026**

Dear Dr. Kromm:

Thank you to the HSCRC for the focus on quality and efficiency in Maryland. Specific to the measure and the rewards-only approach for the multi-visit patients (MVP), we have some concerns noted below and have a suggested option. The focus on the emergency department (ED) is critical and we need to find better ways to address patient needs in a setting other than the ED when able. Our thoughts are as follows:

1. The focus in the ED should be on improving ED wait times and throughput. Based on feedback we receive, our patients and community care about the ED wait times primarily – the time from when you arrive to the ED and are discharged home or admitted to the hospital. This view on improving ED wait times is a statewide theme. Reducing multi-visit patients is intended to reduce ED volume and, thus ED wait times. We appreciate this direction, however, would suggest that we focus only on ED wait times as a payment-related measure since it is our primary outcome of interest.
2. Based upon our Meritus data from the last twelve months ending 11/30/23 (This represents over 70,000 emergency room visits):
  - a. MVP patients are more likely to have Medicaid (30% for MVP patients compared to 23% for non-MVP patients),
  - b. MVP patients present to the ED with a higher acuity (31.0% MVP patient visits with an ESI 1 or 2 – emergent or urgent, compared to 26.3% for non-MVP patient visits)
  - c. MVP patients are more likely to be admitted (31.5% for MVP patients compared to 21.4% for non-MVP patients).

This indicates that our MVP patients may be the patients that are in most need of these acute services. We caution the unintended consequence of incentivizing hospitals to reduce the access to ED care for these patients, our most vulnerable patients. We certainly recognize the need to develop more robust access in other care settings, such as primary care and urgent care, however, these are not new strategies for us, or other hospitals. The reality is that expanding primary and urgent care is a challenge with a growing physician shortage, especially in

underserved areas. We would be happy to share our data in depth if it assists in further analysis statewide.

3. Some options for your consideration:

- a. Track this measure, be transparent with the outcomes, and re-evaluate after year one. Depending on the findings from year one and the state-wide performance on ED wait time improvement, then consider the establishment of this measure as a reward-based program. Or,
- b. Use the ED wait time measure as a trigger measure for the reward. If the hospital's ED wait time is not decreased, then there should be no reward if there is an MVP reduction.

We appreciate the HSCRC's consideration of our thoughts and look forward to continuing to work with you toward better health and quality outcomes for our patients.

Sincerely,

A handwritten signature in black ink, appearing to read "Carrie Adams". The signature is fluid and cursive, with a large initial "C" and "A".

Carrie Adams, PharmD  
Chief Operating Officer



January 5, 2024

Geoff Dougherty  
Deputy Director, Population Health  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Mr. Dougherty,

On behalf the Johns Hopkins Health System (JHHS) and its four Maryland hospitals, thank you for the opportunity to provide input on the Emergency Department Potentially Avoidable Utilization (ED PAU) policy. JHHS supports the concept of developing strategies and accountability for multi-visit patients (MVPs), and encourages the development of policies that align with the intent of the Maryland Model. JHHS's comments and concerns regarding the ED PAU recommendation are detailed below.

JHHS agrees that hospitals should be actively engaged in addressing the needs of multi-visit patients. However, JHHS is also concerned that the current recommendation is singularly focused on hospitals without any effort or intention to engage state and local government as well as Medicaid fee-for-service and Managed Care Organizations and insurers, who are paid to manage the care of the members they serve. Commercial insurers remain the biggest benefactors of the Maryland Model, and their contribution to issues such as ED PAU should be required and measured. Collaboration and accountability for MVPs should extend beyond hospitals alone to generate meaningful change and improvement for Marylanders. As noted by the HSCRC and Maryland Department of Health in the 2016 Population Health paper submitted to CMMI, socio-economic factors such as housing, employment and education account for 40% of health care cost and utilization. Hospitals alone cannot address the lack of focus and investment in these socio-economic factors.

Though the current recommendation is reward-only, it is also crucial to note that the policy as written may have unintended consequences that are similar to other distortions that exist under the Maryland Model. As JHHS has previously noted, the model currently rewards any and all volume reduction, and views all ED volume as addressable. However, there is and will continue to be some ED MVP utilization that is appropriate and medically necessary. Within the current model, hospitals that reduce or entirely eliminate services are rewarded, while hospitals that provide medically necessary care – or take on volume that was shed by other hospitals – are penalized. This approach does not align with the goals of the model, and could be further exacerbated by the ED PAU policy, as the proposed policy could potentially reward hospitals that limit access to care. Further, the policy does not recognize

patient preference and experience. JHHS's analyses reflect that some MVPs travel farther to seek care at specific hospitals, while others do not have the option to seek care elsewhere. JHHS urges staff to account for these additional distortions and considerations when revising the current ED PAU recommendation.

JHHS recommends that staff initiate an ED PAU policy that is limited and more intentionally focused on a single disease that truly represents avoidable care. This policy should require collaboration across multiple stakeholders, including hospitals, state and local government, commercial insurers, and MCOs. Additionally, hospitals should report on their strategies to address MVP utilization to ensure hospitals who may perform well under the policy are not achieving positive results by limiting access in order to decrease volumes. If the policy is more intentionally focused on addressable ED MVP volume, the HSCRC and the industry can then use lessons learned from the initial policy to address additional diseases or conditions in future years. While behavioral health represents the greatest opportunity to improve care for MVPs, it is important to note that the MCOs and hospitals have limited opportunity to improve care for this population under Maryland's existing Medicaid financing for behavioral health. Behavioral health is carved out of MCOs and generally "unmanaged" for the Medicaid population, which accounts for 40% of ED MVPs. Strategies to improve behavioral health care for MVPs should include a fully integrated Medicaid program.

JHHS appreciates the efforts and partnership of the HSCRC staff as the Commission and industry seek to develop intentional strategies to support the needs of multi-visit patients. While supportive of the intent of the policy, JHHS encourages a thoughtful approach to ensure new policy methodologies align with the goals of the Maryland Model, and looks forward to further discussion and collaboration on this policy.

Sincerely,



**Peter Hill, MD**

Senior Vice President - Medical Affairs  
Johns Hopkins Health System

cc: Joshua Sharfstein, MD, Chairman  
Joseph Antos, PhD  
Nicki McCann, JD  
Ricardo Johnson, JD

Maulik Joshi, DrPH  
James Elliott, MD  
Adam Kane, Esq.,



Maryland  
Hospital Association

January 5, 2024

Geoff Dougherty  
Deputy Director, Population-Based Methodologies, Analytics, and Modeling  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, Maryland 21215

Dear Mr. Dougherty:

On behalf of the Maryland Hospital Association's (MHA) 62 member hospitals and health systems, we appreciate the opportunity to comment in opposition to the Health Services Cost Review Commission's (HSCRC) *Draft Recommendations for the Emergency Department Potentially Avoidable Utilization Program for Rate Year (RY) 2026*.

Over the last several months, we have valued the opportunity to collaborate with stakeholders including the HSCRC staff to bring light and focus on the critically important issue of emergency department (ED) utilization and overcrowding. It has allowed all partners to discuss and agreed that this issue is multi-faceted and a symptom of a larger issue in the health care continuum including lack of primary care and behavioral health access, hospital throughput, post-acute availability and services, and state and payer administrative policies and procedures that overcrowd our state's emergency departments. As we work with the Legislative Workgroup for final recommendations for systematic change, hospitals continue to do the performance improvement work to address the hospital specific issues we can control through the EDDIE project.

Unfortunately, the current draft recommendations for the emergency department potentially avoidable utilization program do not help to achieve the aims of addressing the problems of emergency department overcrowding. Specifically,

- It is well-established that patterns of repeated ED utilization are often a function of deficiencies within a public health system and compromised access to alternative sites of care. A policy that focuses solely on hospitals, even if it is reward only, cannot and will not address the services lacking in the community.
- HSCRC data shows a disproportionate number of individuals identified as a multi-visit patient (MVP) are members of marginalized groups. Until we can adequately meet the primary care and social needs of these groups outside of the hospital setting, we oppose a payment policy that incentivizes a reduction in care options for marginalized groups.
- The draft policy sets a precedent of holding hospitals accountable for systematic issues outside of the hospitals' control. Without a comprehensive and coordinated approach that brings all stakeholders together, using hospital rate-setting sets an unfair expectation for hospitals.

Geoff Dougherty

Jan. 5, 2024

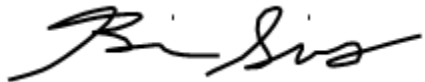
Page 2

We believe a more holistic approach to addressing multi-visit patients would be to create a grant program similar to the Regional Partnership Catalyst Program to provide resources and incentives for hospitals to continue and expand their work with community-based organizations, state agencies, and payers to help Marylanders access more appropriate pathways for care and/or other upstream solutions. Through public/private partnerships, all the stakeholders can work collaboratively to address the goals outlined in the staff recommendations and the complex needs of individuals who frequently return to hospital emergency rooms. A grant program can allow for accountability to be appropriately shared and evaluated, refined, and scaled as needed over time.

Therefore, we oppose the current policy as written and support a voluntary program with infrastructure funding that incentivizes meaningful regional partnerships and sustainable programs to address the needs of our patients.

We look forward to collaborating with staff and partners statewide to improve care for all Marylanders.

Sincerely,

A handwritten signature in black ink, appearing to read "Brian Sims". The signature is fluid and cursive, with the first name "Brian" and last name "Sims" clearly distinguishable.

Brian Sims  
Vice President, Quality & Equity

cc: Joshua Sharfstein, M.D., Chair  
Joseph Antos, Ph.D., Vice Chair  
James N. Elliott, M.D.  
Ricardo. R. Johnson

Maulik Joshi, DrPH  
Adam Kane, Esq.  
Nicki McCann, JD  
Jonathan Kromm, Ph.D., Executive Director



From: **White, David H** <[David.H.White@medstar.net](mailto:David.H.White@medstar.net)>

Date: Fri, Jan 5, 2024 at 5:12 PM

Geoff,

The key points that will be reflected in MedStar's comment letter on behalf of our seven Maryland hospitals on the ED PAU Reduction Policy for RY2026 are as follows:

MedStar is supportive of the policy overall and agrees with the development of new financial incentives to drive improvement in ED wait times as the issue has been of central focus since the pandemic. In alignment with staff's conclusions, MedStar agrees that this patient population (MVPs) poses an opportunity to significantly impact ED throughput and patient wait times through directing these patients to a more appropriate care setting outside the ED. Realizing that these patients are who needs to be the focus when reducing ED PAU, MedStar has already implemented a number of programs designed to devote increased care management resources to these patients and treat them in the appropriate setting and has been successful in reducing the number of MVPs frequenting our EDs.

- 1.
2. MedStar does not believe that financial rewards should be determined on an improvement only basis vs the 2023 calendar year base period. When financial incentives for reducing PAU for first implemented in Maryland hospitals were able to achieve significant success early on once resources were intentionally devoted to the efforts and then as PAU percentages declined found it more difficult to keep making incremental progress. (Hospitals were able to get the low hanging fruit so to speak and then it became for challenging). Similarly, with ED PAU hospitals who have high percentages of avoidable utilization will be provided more opportunity to achieve financial reward than hospitals who have already achieved low levels of ED PAU. The incremental reduction in PAU is much harder to achieve at hospitals who have already implemented strategies and whose EDs run efficiently. MedStar wants a policy that incentivizes in the strongest way possible reductions in ED PAU as well as rewards those hospitals who have historically been effective in treating MVPs in more appropriate settings. Actions taken by MedStar to achieve low levels of ED PAU have benefited patients by reducing wait times and improving care outcomes and have helped limit Total Cost of Care Growth. Any policy financially incentivizing ED PAU reductions should reward these efforts and successes.
3. Data Sharing – to maximize the effectiveness of the ED PAU Policy, CRISP data will need to be made available in an easy to understand and user-friendly report so hospitals can track MVPs across hospitals in Maryland. While we can track them within our system, frequently they do not only seek care at one health systems hospitals.
4. Commitment from HSCRC staff this policy is not intended to include downside financial risk.

All the best,  
Dave White  
Director, Reimbursement Strategy & Methodologies  
MedStar Health



maryland  
**health services**  
cost review commission

---

# Draft RY 2026 Readmission Reduction Incentive Program Policy

HSCRC Quality Team

# RRIP RY 2026 Policy Intent and Considerations

The RRIP program is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and guard against unintended consequences of a global budget system.

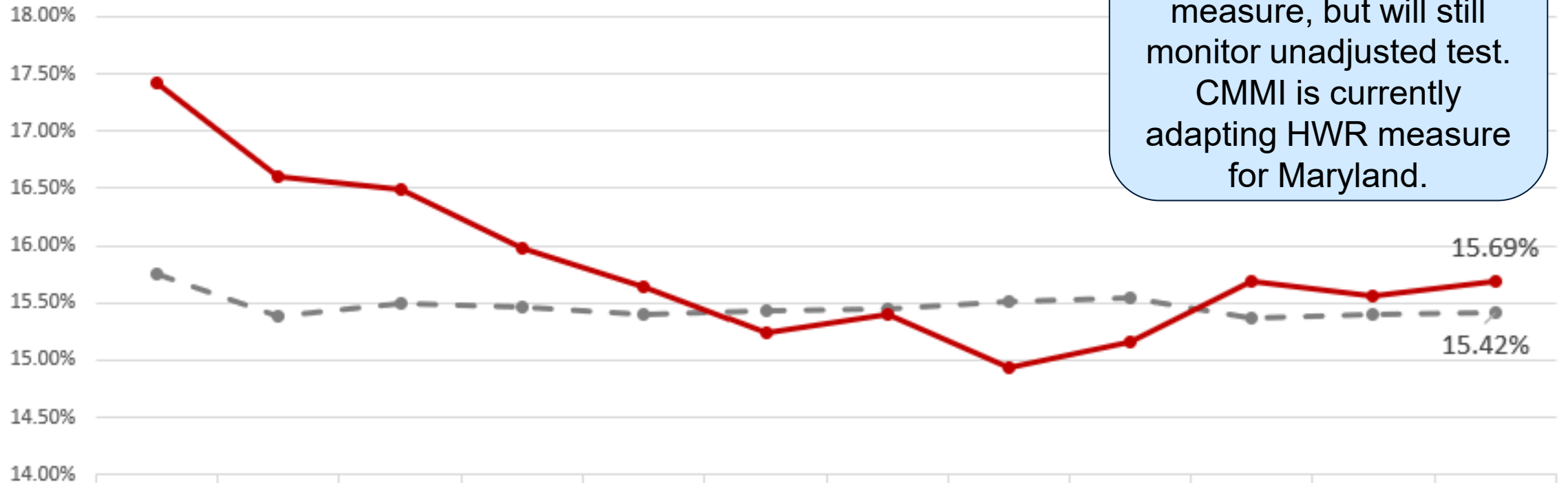
## Today's Presentation:

- Evaluation of performance to date
- RY 2026 Policy Considerations:
  - Improvement target
  - Attainment target
  - Within hospital disparities measure and incentive
  - Impact of revisits/observation and Excess days in acute care measure
- Draft Recommendations

# Current Test: Unadjusted Readmission Rates, MD vs Nation

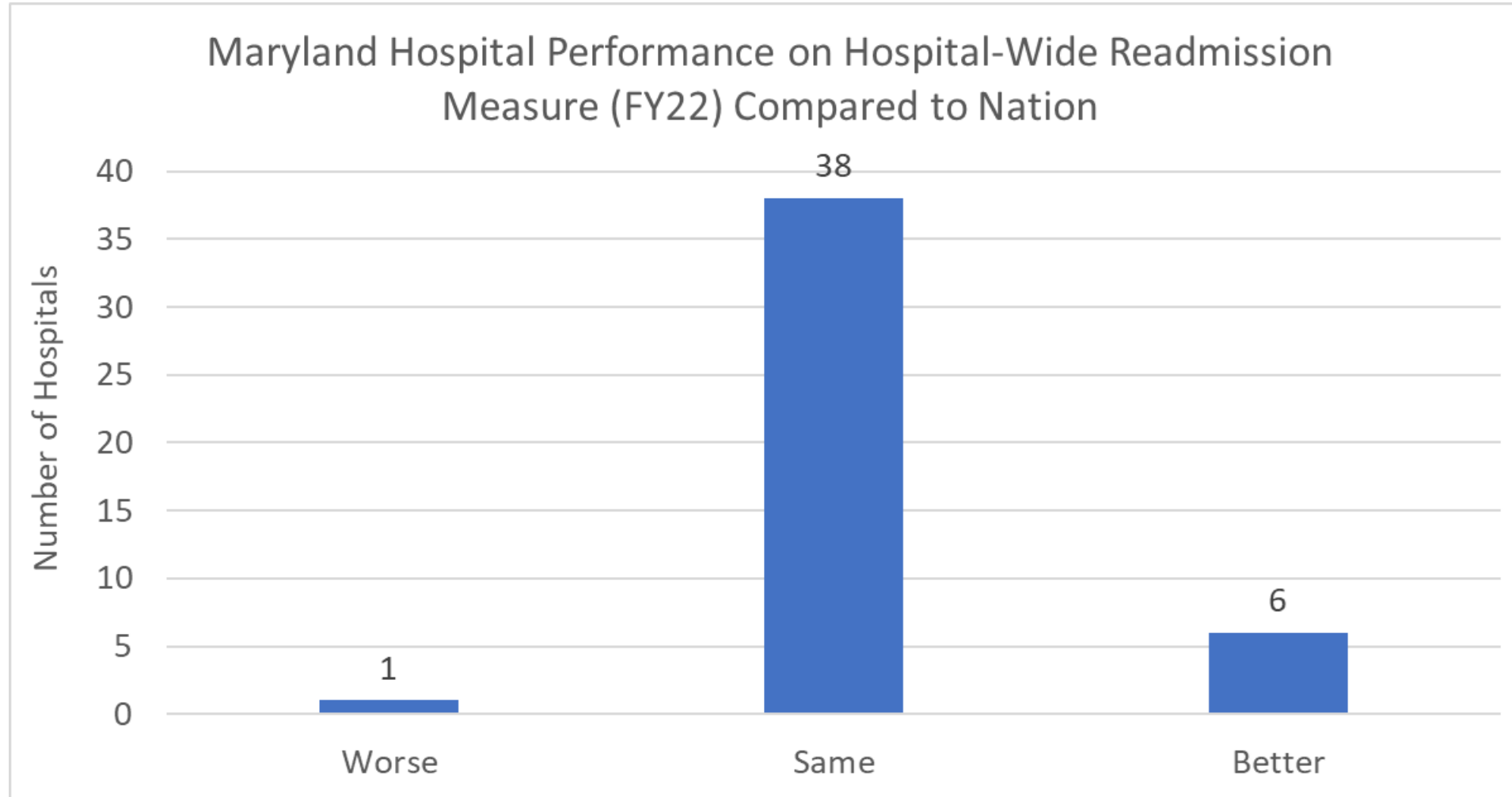
Readmissions - Rolling 12M through August 2023

CMMI has agreed to move to a risk-adjusted measure, but will still monitor unadjusted test. CMMI is currently adapting HWR measure for Maryland.



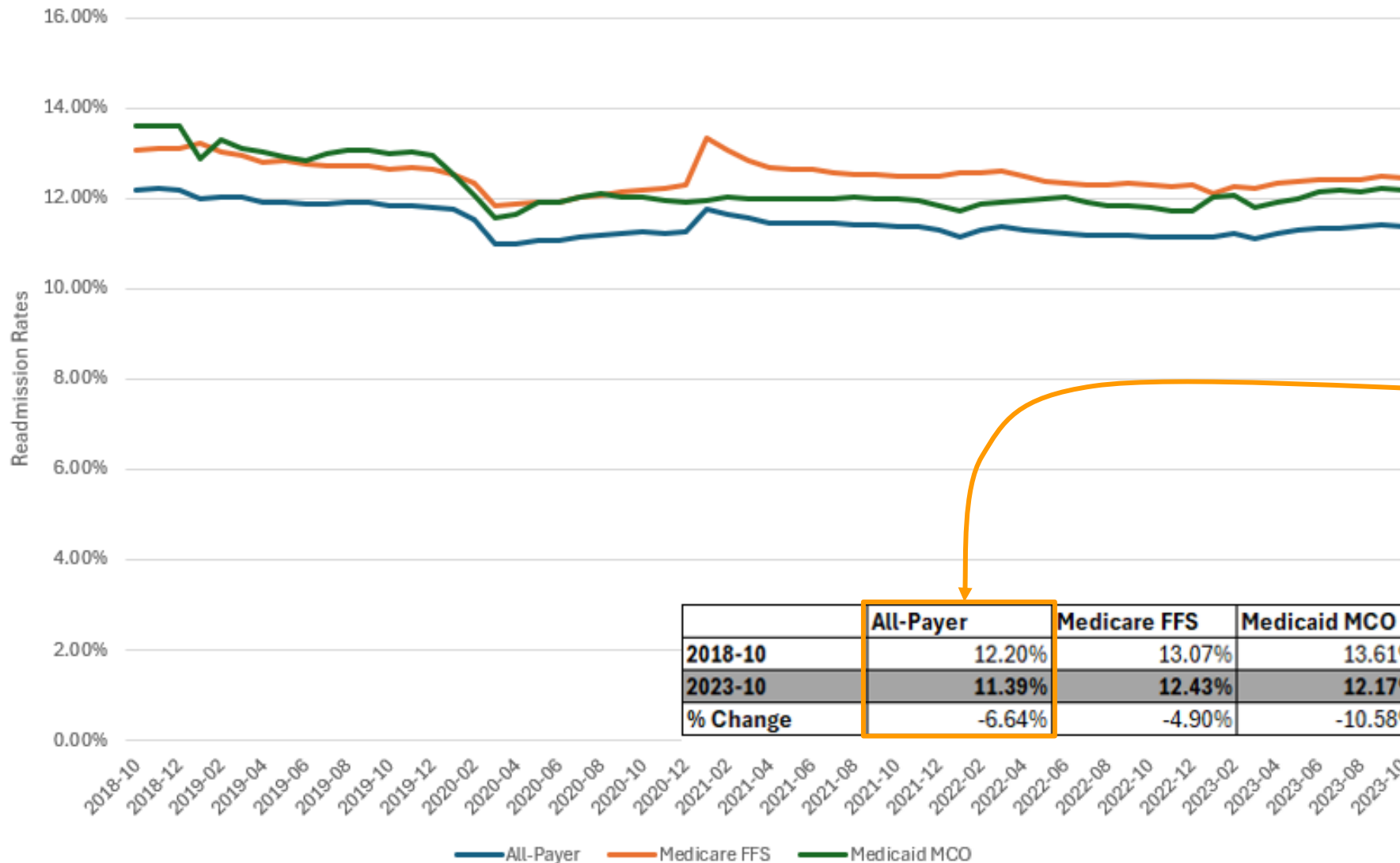
	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018	CY 2019	CY 2020	CY 2021	CY 2022	Rolling 12 Months CY 2023
—●— National	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.45%	15.52%	15.55%	15.37%	15.40%	15.42%
—●— Maryland	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.40%	14.94%	15.17%	15.68%	15.56%	15.69%

# Potential New Test: Medicare Risk-Adjusted Hospital-Wide Readmission Measure



# Case-Mix Adjusted Readmission Rates

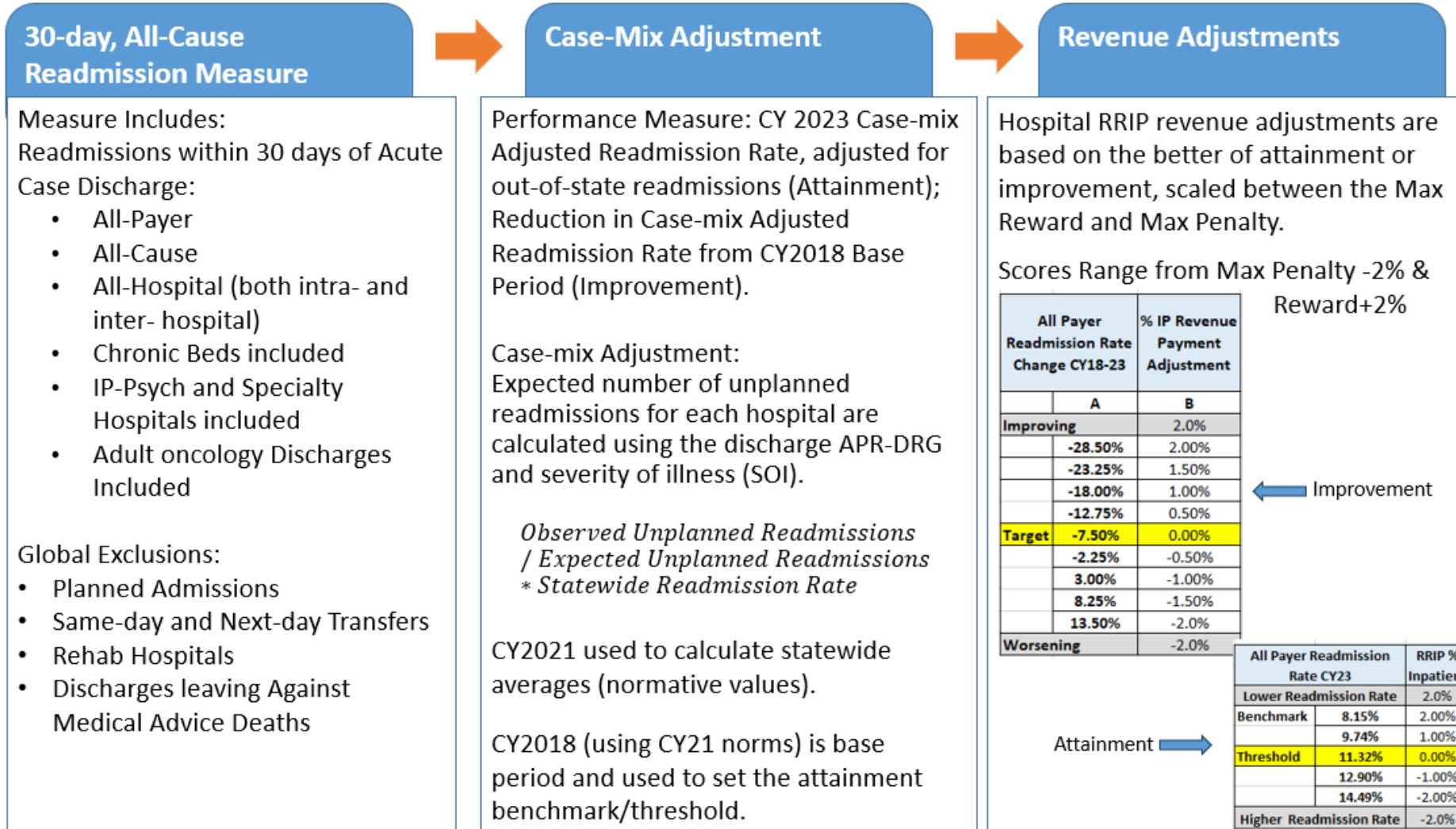
Monthly Case-Mix Adjusted Readmission Rates through Oct 2023



All-payer improvement is close to the goal set in 2019 of a 7.5 percent improvement from 2018 through 2023

# Updates to Methodology: Improvement and Attainment Targets

# RRIP Overview: Improvement and Attainment



At this time, staff is not proposing any changes to the all-payer, case-mix adjusted readmission measure.

However, new improvement target needs to be proposed for CY 2024 and beyond. And the attainment target should be evaluated.



# General Improvement Target Considerations

- RRIP Redesign set 5 year improvement goal (2018-2023) of 7.5 percent
  - Should policy still provide incentives for improvement? If so, over what time period (e.g., 2023-2026)?
  - SDOH adjustment is less critical with improvement incentives
  - Case-mix adjustment using statewide normative values acknowledge changes in case-mix index over time
  - An optimal readmission rate will always be non-zero; some readmissions are unavoidable and hospitals should not be unduly pressured to reach zero readmission rate
    - Should trend in improvement be lower than during last 5 years?

# RY2022 RRIP Redesign

- During the prior redesign, staff developed several estimates to provide a reasonable range of expected improvement
- Based on these estimates, the Commission approved a 5-year, 7.5 percent improvement target (5 years 2018-2023)

Figure 7. Improvement Target Estimates

Estimating Method	Percent Improvement	Resulting Readmission Rate (2023)*
1 Actual Compounded Improvement, 2013-2018	-14.94%	9.73%
2 Actual Improvement 2016-2018, Annualized to 5 Years	-11.48%	10.13%
3 All Hospitals to 2018 Median	-6.5%	10.70%
4 Benchmarking - Peer County/MSA to 75th Percentile	-4.63% to -6.20%	10.73% to 10.91%
5 Reduction in Readmission-PQIs	-9.36%	10.19%
6 Reduction in Disparities	-4.2%	10.96%

\* Assuming a constant CY 2018 readmission rate of 11.44 percent (under RY 2021 logic with specialty hospitals included)

# Updated All-Payer Improvement Estimates

Figure 5. Improvement Target Estimates

Estimating Method	Percent Improvement	Resulting Readmission Rate (2026)*
1 Actual Compounded Improvement, 2018-2022	-8.61%	10.19%
2 Actual Improvement 2021-2022, Annualized to Four Years	-5.54%	10.53%
3 All Hospitals to 2018 Median	-4.1%	10.69%
4a Medicare Benchmarking - Peer County/MSA to 75th Percentile**	-4.75% to -5.45%	TBD
4b Commercial Benchmarking - Peer County/MSA to 75th Percentile**	TBD	TBD
5 Reduction in Readmission-PQIs	TBD	TBD
6 Reduction in Disparities	TBD	TBD

- Staff replicated the prior methods for improvement estimates
- There appears to be better agreement with methods 2-4, and staff are concerned that use of improvement trends confounded by COVID may be problematic
- Based on these estimates, draft policy proposes 5.5 percent improvement target from 2022-2026

# Attainment Target

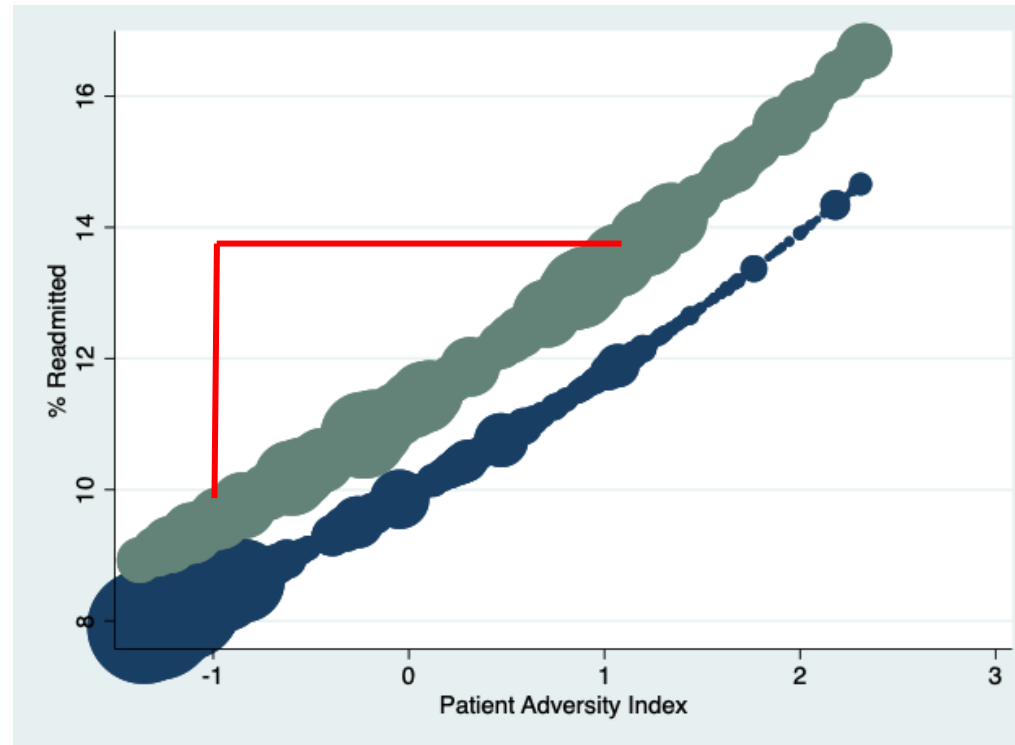
- Hospitals are assessed also on attainment, and get better of the revenue adjustment
  - RY25 hospitals at or better than the 65th percentile of performance receive scaled rewards
  - The 65th percentile was chosen because the base period by hospital performance had the 65th percentile close to the statewide rate with the 7.5 percent improvement goal
  - No adjustment for SDOH because improvement is also assessed
- For RY24, 17 out of 44 (~39%) hospitals performed better under attainment

# RRIP-Disparity Gap Updates

# Policy Overview and History

- Commission approved addition of a disparities component to the RRIP in March 2020
- Incentivizes within-hospital reductions in readmission disparities based on the Patient Adversity Index (PAI)
  - PAI is the predicted readmission risk based on race, medicaid status, and Area Deprivation Index
- We believe Maryland is the first state in the country to provide hospitals with all-payer financial incentives to reduce socioeconomic disparities in quality of care
  - Incentive is reward-only and linked to statewide SIHIS goal
  - Hospitals can earn scaled rewards up to 0.5 percent of inpatient revenue for improvements

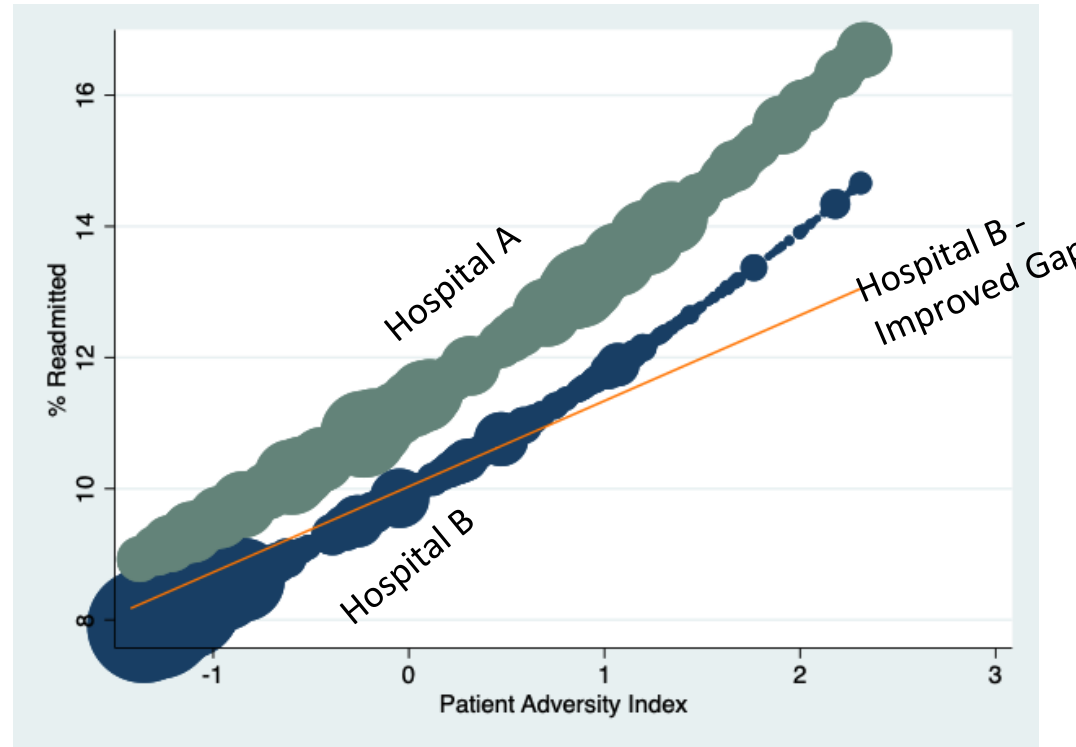
# Understanding the Disparity Measure



Flat horizontal line would indicate no disparity in readmissions with increasing PAI

The multilevel model estimates the slope of the line connecting readmission rates at various levels of PAI within a hospital. A steeper slope means there is a larger disparity between rates for higher-PAI patients and rates for lower-PAI patients.

# Improving the Disparity Gap



Hospital B can still reduce disparity and qualify for reward by reducing readmissions for the patients with higher PAI relative to the rest of its population



# Disparity Gap Reduction Goals

- In CY 2024, to begin receiving rewards, a hospital must reduce their readmission disparity gap by 35.16% when compared to 2018

Disparity Gap Improvement Scaling			
RY	2026	2027	2028
50% improvement (start of rewards)	-35.16%	-40.54%	-45.47%
75% improvement (full reward)	-57.96%	-64.64%	-70.27%

- RY 2024 RRIP-Disparity Gap Program (CY 2022 performance)
  - 11 hospitals rewarded
  - Range: (-29.74%, -61.54%)

# Monitoring of ED Revisits and Observation Stays

# Monitoring of ED Revisits and Observation Stays

- Current policy only looks at inpatient stays as a readmission
- Staff proposes to monitor and assess impact of ED revisits and observation stays
  - Compare statewide and by hospital, readmission rates with and without including ED revisits and/or observation stays on rates and improvement trends
- Given concern about ED volume, should future RRIP policy monitor or include in payment revisits?
  - Concerns on impact to ED of avoiding admission
  - Potentially way to game readmission rates
  - How would inclusion impact access?
- Excess Days in Acute Care is another way to monitor revisits

# Draft Recommendations

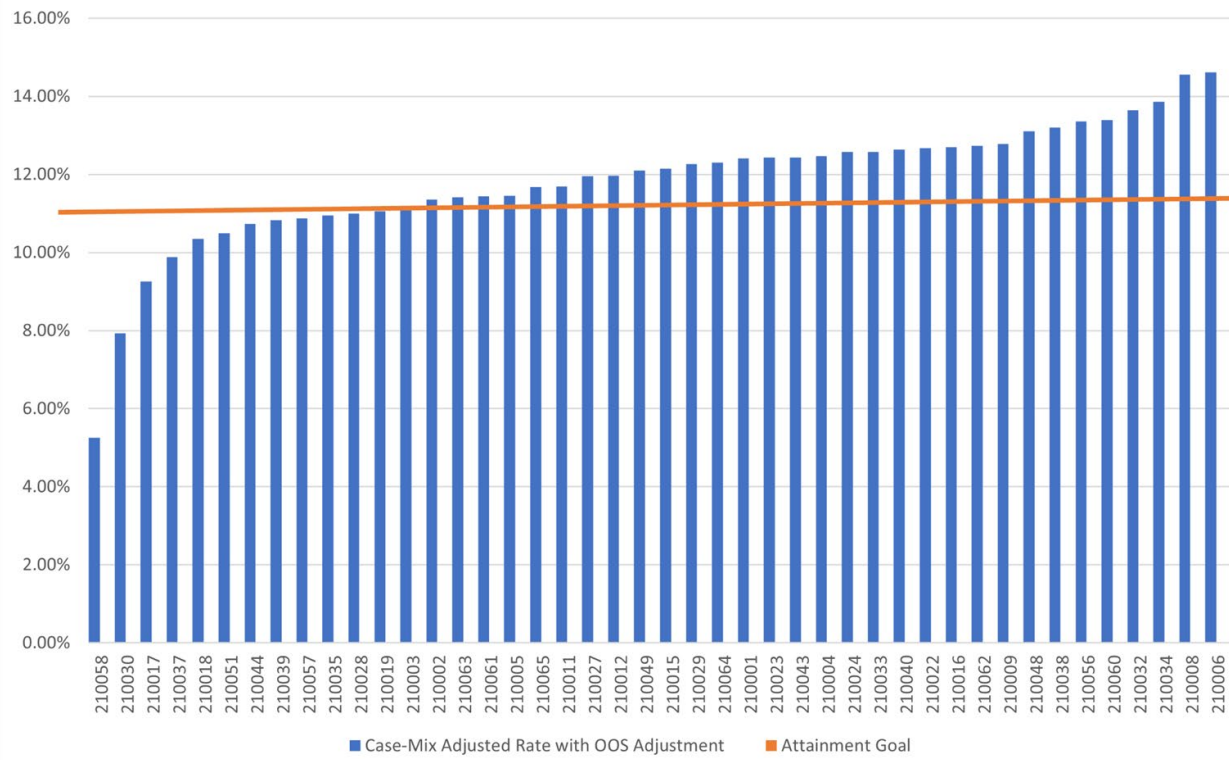
# RY2026 Draft RRIP Recommendations

1. Maintain the 30-day, all-cause readmission measure.
2. Improvement Target - Set statewide 4-year improvement target of -5.5 percent from 2022 base period through 2026.
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
4. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards beginning at 0.25 percent of IP revenue for hospitals on track for 50 percent reduction in disparity gap measure over 8 years, capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
6. Monitor emergency department and observation revisits by adjusting readmission measure and through all-payer Excess Days in Acute Care measure. Consider future inclusion of revisits of EDAC in RRIP program.

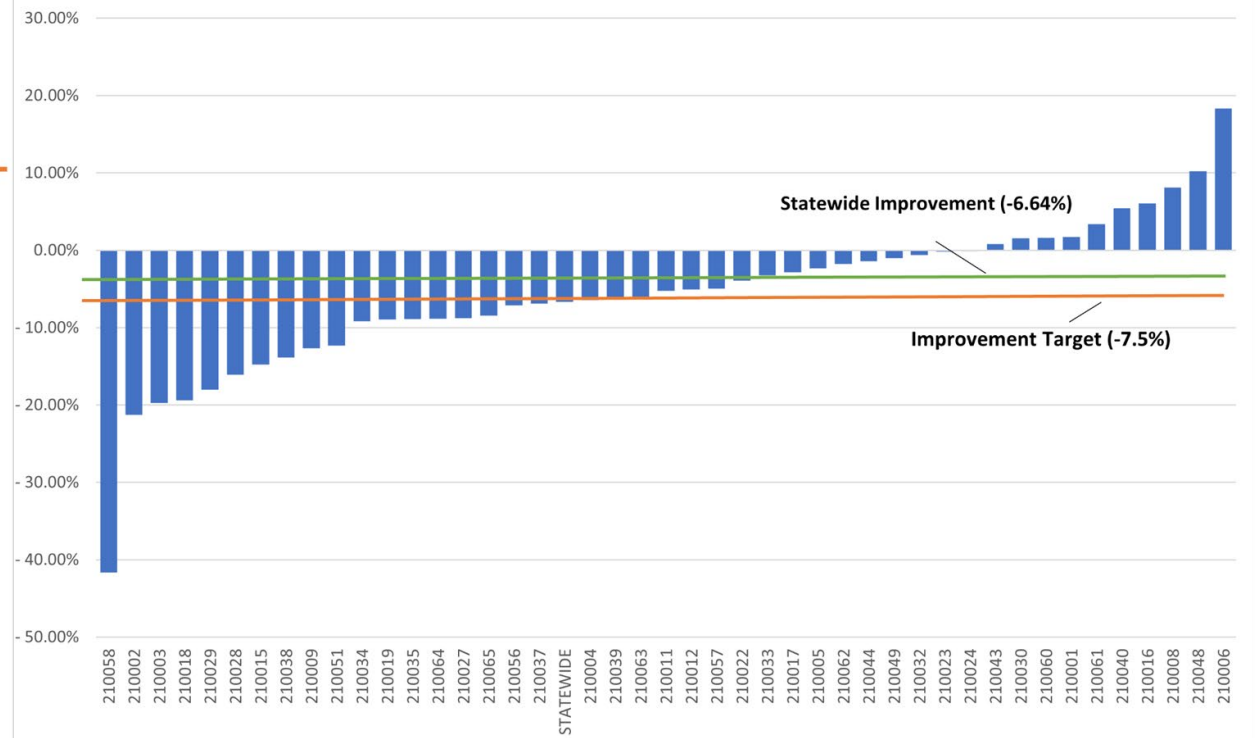
# Appendix

# RX2025 YTD By Hospital Case-Mix Adjusted Readmission Rates

By Hospital Case-Mix Adjusted Readmission Rates, CY2025 YTD Through October



Change in All-Payer Case Mix Adjusted Readmission Rate by Hospital from 2018 to October 2023





maryland  
**health services**  
cost review commission

# Draft Recommendation for the Readmission Reduction Incentive Program for Rate Year 2026

February 14, 2024

This document contains staff draft recommendations for the RY 2026 Readmission Reduction Incentive Program; comments are due by COB Wednesday, February 21, 2024 and may be submitted to [hscrc.quality@maryland.gov](mailto:hscrc.quality@maryland.gov).



# Table of Contents

<b>List of Abbreviations</b>	<b>2</b>
<b>Key Methodology Concepts and Definitions</b>	<b>3</b>
<b>Policy Overview</b>	<b>4</b>
<b>Recommendations</b>	<b>5</b>
<b>Introduction</b>	<b>6</b>
<b>Background</b>	<b>7</b>
Brief History of RRIP program	7
RRIP Methodology	8
<b>Assessment</b>	<b>9</b>
Current Statewide Year To Date Performance	10
Medicare FFS performance	10
All-Payer Readmission Performance	11
Updating the Performance Targets Under the TCOC Model	14
Improvement	14
Attainment	17
Revisits to Emergency Department and Observation Stays	18
Excess Days in Acute Care (EDAC)	18
Digital Measures/Electronic Clinical Quality Measure (eCQM)	19
Reducing Disparities in Readmissions	20
<b>Recommendations</b>	<b>23</b>
<b>Appendix I. RRIP Readmission Measure and Revenue Adjustment Methodology</b>	<b>1</b>
<b>Appendix II. Analyses of Medicare Readmissions</b>	<b>9</b>

## List of Abbreviations

ADI	Area Deprivation Index
AMA	Against Medical Advice
APR-DRG	All-patient refined diagnosis-related group
CMS	Centers for Medicare & Medicaid Services
CMMI	Center for Medicare and Medicaid Innovation
CRISP	Chesapeake Regional Information System for Our Patients
CY	Calendar year
eCQM	Electronic Clinical Quality Measure
EDAC	Excess Days in Acute Care
FFS	Fee-for-service
HCC	Hierarchical Condition Category
HRRP	Hospital Readmissions Reduction Program
HSCRC	Health Services Cost Review Commission
HWR	Hospital-Wide Readmission Measure
MCDB	Medical Claims Database
MPR	Mathematica Policy Research
MSA	Metropolitan Statistical Area
NQF	National Quality Forum
PAI	Patient Adversity Index
PMWG	Performance Measurement Workgroup
PQI	Prevention Quality Indicators
RRIP	Readmissions Reduction Incentive Program
RY	Rate Year
SIHIS	Statewide Integrated Healthcare Improvement Strategy
SOI	Severity of illness
TCOC	Total Cost of Care
YTD	Year-to-date

## Key Methodology Concepts and Definitions

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

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

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

**APR-DRG SOI:** Combination of diagnosis-related groups with severity of illness levels, such that each admission can be classified into an APR-DRG SOI "cell" along with other admissions that have the same diagnosis-related group and severity of illness level.

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

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

**Prevention Quality Indicator (PQI):** a set of measures that can be used with hospital inpatient discharge data to identify quality of care for "ambulatory care sensitive conditions." These are conditions for which good outpatient care can potentially prevent the need for hospitalization or for which early intervention can prevent complications or more severe disease.

**Area Deprivation Index (ADI):** A measure of neighborhood deprivation that is based on the American Community Survey and includes factors for the theoretical domains of income, education, employment, and housing quality.

**Patient Adversity Index (PAI):** HSCRC-developed composite measure of social risk incorporating information on patient race, Medicaid status, and the Area Deprivation Index.

**Excess Days in Acute Care (EDAC):** Capture excess days that a hospital's patients spent in acute care within 30 days after discharge. The measures incorporate the full range of post-discharge use of care (emergency department visits, observation stays, and unplanned readmissions).

## Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
<p>The quality programs operated by the Health Services Cost Review Commission, including the Readmission Reduction Incentive Program (RRIP), are intended to ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Total Cost of Care Model, while guarding against unintended consequences and penalizing poor performance.</p>	<p>The RRIP policy is one of several pay-for-performance quality initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time.</p>	<p>The RRIP policy currently holds up to 2 percent of hospital revenue at-risk for performance relative to predetermined attainment or improvement goals on readmissions occurring within 30-days of discharge, applicable to all payers and all conditions and causes. Specific criteria for inclusion (oncology discharges) and exclusion (discharges leaving Against Medical Advice, Planned Admissions) are detailed in Appendix I.</p>	<p>This policy affects a hospital's overall GBR and so affects the rates paid by payers at that particular hospital. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.</p>	<p>Currently, the RRIP policy measures within-hospital disparities in readmission rates, using an HSCRC-generated Patient Adversity Index (PAI), and provides rewards for hospitals that meet specified disparity gap reduction goals. The broader RRIP policy continues to reward or penalize hospitals on the better of improvement and attainment, which incentivizes hospitals to improve poor clinical outcomes that may be correlated with health disparities. It is important that persistent health disparities are not made permanent.</p>

## Recommendations

These are the draft recommendation for the Maryland Rate Year (RY) 2026 Readmission Reduction Incentives Program (RRIP):

1. Maintain the 30-day, all-cause readmission measure.
2. Improvement Target - Set statewide 4-year improvement target of -5.5 percent from 2022 base period through 2026.
3. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
4. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
5. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards:
  - a. beginning at 0.25 percent of IP revenue for hospitals on pace for 50 percent reduction in disparity gap measure over 8 years, and;
  - b. capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
6. Monitor emergency department and observation revisits by adjusting readmission measure and through all-payer Excess Days in Acute Care measure. Consider future inclusion of revisits of EDAC in the RRIP program.

## Introduction

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

The Readmissions Reduction Incentive Program (RRIP) is one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve patient care and value over time that targets unplanned readmissions. While some hospital readmissions are unavoidable, other hospital readmissions within 30 days result from ineffective initial treatment, poor discharge planning, or inadequate post-acute care and result in poor patient outcomes and financially straining healthcare institutions.<sup>1</sup> The RRIP currently holds up to 2 percent of hospital revenue at-risk in penalties and rewards based on achievement of improvement or attainment targets in 30-day case-mix adjusted readmission rates.

For RRIP, as well as the other State hospital quality programs, updates are vetted with stakeholders and approved by the Commission to ensure the programs remain aggressive and

---

<sup>1</sup> Rammohan R, Joy M, Magam S, et al. (May 15, 2023) The Path to Sustainable Healthcare: Implementing Care Transition Teams to Mitigate Hospital Readmissions and Improve Patient Outcomes. *Cureus* 15(5): e39022. doi:10.7759/cureus.39022

progressive with results that meet or surpass those of the national CMS analogous programs (from which Maryland must receive annual exemptions). For purposes of the RY 2026 RRIP Draft Policy, staff vetted the updated proposed recommendations in January with the Performance Measurement Workgroup (PMWG), the standing advisory group that meets monthly to discuss Quality policies.

Additionally, with the onset of the Total Cost of Care Model Agreement, each program was overhauled to ensure they support the goals of the Model. For the RRIP policy, the overhaul was completed during 2019, which entailed an extensive stakeholder engagement effort. The major accomplishments of the RRIP redesign were modifications to the inclusion and exclusion criteria for the readmission measure, development of a 5-year (2018-2023) improvement target, adjustment of the attainment target, and the addition of an incentive to reduce within hospital disparities in readmissions. See Appendix I for additional information on the Readmission Redesign Subgroup activities.

This draft policy recommends a new four-year improvement target (CY2022 to CY2026), assesses the current attainment target, discusses the issue of revisits to the emergency department/observation following an inpatient admission, and continues the incentive for reductions in within-hospital disparities. The draft policy does not recommend any changes to the current case-mix adjustment readmission measure, and minimal updates to the disparity gap measurement. Given the multi-year nature of this policy, staff may extend this policy for multiple years unless changes are warranted.

## **Background**

### **Brief History of RRIP program**

Maryland made incremental progress each year throughout the All-Payer Model (2014-2018), ultimately achieving the Model goal for the Maryland Medicare FFS readmission rate to be at or below the unadjusted national Medicare readmission rate by the end of Calendar Year (CY) 2018. Maryland had historically performed poorly compared to the nation on readmissions; it ranked

50th among all states in a study examining Medicare data from 2003-2004.<sup>2</sup> In order to meet the All-Payer Model requirements, the Commission approved the inaugural RRIP program in April 2014 to further bolster the incentives to reduce unnecessary readmissions beyond the incentives already inherent in the global budget system.

As recommended by the Performance Measurement Work Group (PMWG), the RRIP is more comprehensive than its federal counterpart, the Medicare Hospital Readmission Reduction Program (HRRP), as it is an all-cause, all-condition measure that includes all eligible discharges regardless of payer.<sup>3</sup> Furthermore, it assesses both improvement and attainment and provides an incentive to focus on disparities.

## RRIP Methodology

Figure 1 provides an overview of the current RRIP methodology (also see Appendix I) that converts hospital performance to payment adjustments. In Maryland, the RRIP methodology evaluates all-payer, all-cause inpatient readmissions using the CRISP unique patient identifier to track patients across Maryland hospitals. The readmission measure excludes certain types of discharges (pediatric oncology, patients who leave against medical advice, rare diagnosis groups) from consideration, due to data issues and clinical concerns. Readmission rates are adjusted for case-mix using all-patient refined diagnosis-related group (APR-DRG) severity of illness (SOI), and the policy determines a hospital's score and revenue adjustment by the better of improvement or attainment.<sup>4</sup> The disparity gap methodology is separate and provides hospitals with the opportunity to earn rewards (no penalties) based on improvement.

---

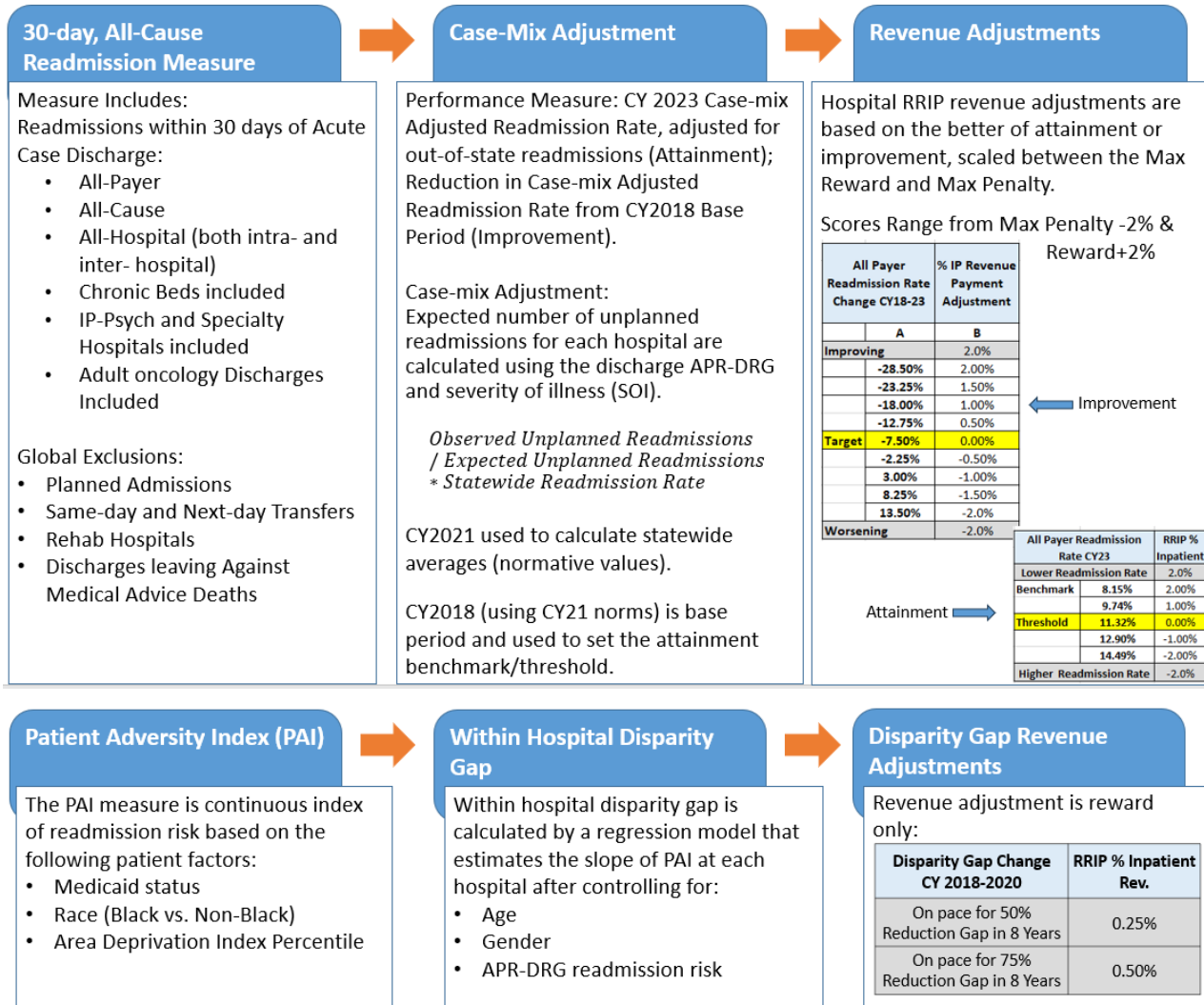
<sup>2</sup> Jencks, S. F. et al., "Hospitalizations among Patients in the Medicare Fee-for-Service Program," *New England Journal of Medicine* Vol. 360, No. 14: 1418-1428, 2009.

<sup>3</sup> For more information on the HRRP, please see: <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program>

<sup>4</sup> See Appendix I for details of on the current RRIP methodology.



Figure 1. RRIP Methodology RY25



## Assessment

For RY 2026, the main policy decision is to develop a new improvement target, since the original TCOC model goal was set through CY 2023. In order to set a new improvement goal, this section assesses readmissions performance and provides improvement scenarios for consideration. While there are no proposed changes to the readmission measure, staff are recommending that additional analytics be conducted over the coming year to assess hospital revisits to the emergency department and/or observation, which staff believes will complement some of the other workstreams the Commission currently

is engaging in to improve emergency room length of stay. Finally, staff provides performance on the disparity gap measure and recommends to continue this targeted focus on high adversity patients.

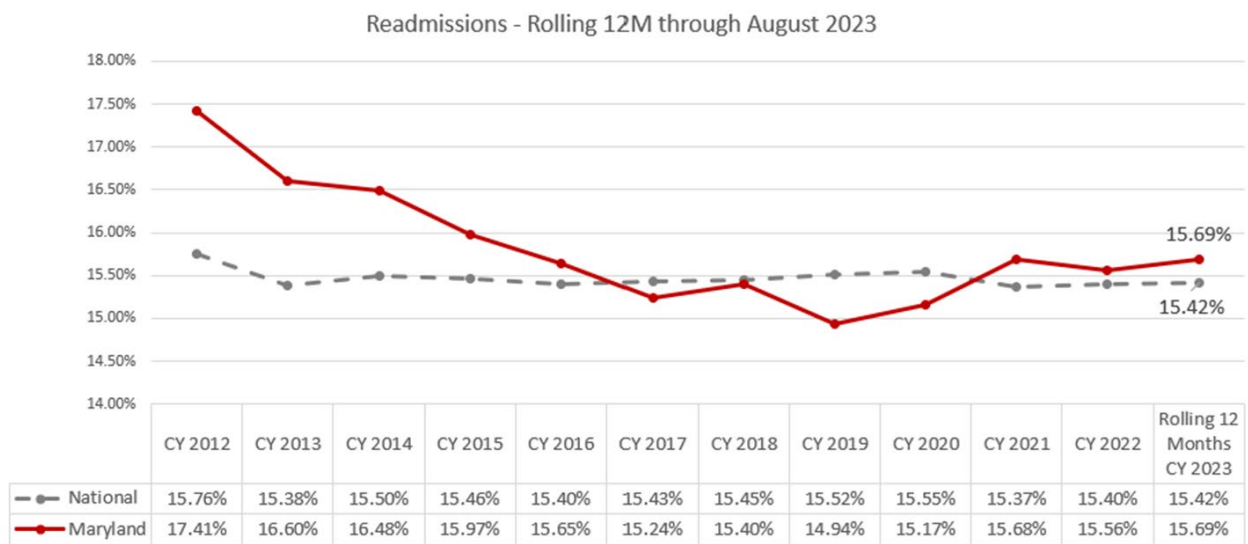
## **Current Statewide Year To Date Performance**

Readmission performance is assessed in several ways. First, we present data on the unadjusted, all-cause Medicare Readmission Rate (the “Waiver Test”), which shows that Maryland currently has a slightly higher unadjusted readmission rate than the nation. Second, we present the all-payer, case mix adjusted readmission results used for the RRIP.

### **Medicare FFS performance**

At the end of 2018, Maryland had an unadjusted FFS Medicare readmission rate of 15.40 percent, which was below the national rate of 15.45 percent. This is the measure that CMMI used to assess Maryland’s successful performance on readmissions under the All-payer Model. Under the TCOC model, Maryland is required to maintain a Medicare FFS readmission rate that is below the nation. However, since CY 2021, Maryland’s FFS Medicare unadjusted readmission rate has hovered slightly above that of the nation. The most recent readmission data, in Figure 2, show Maryland’s readmission rate at 15.69 percent with the nation at 15.42 percent. However, as discussed in Appendix II, staff and CMMI have agreed to move to a risk-adjusted readmission measure that takes into account the case-mix differences between Maryland and the Nation. Overall, when taking case-mix into account, Maryland Medicare FFS patients have a lower readmission rate than National beneficiaries.

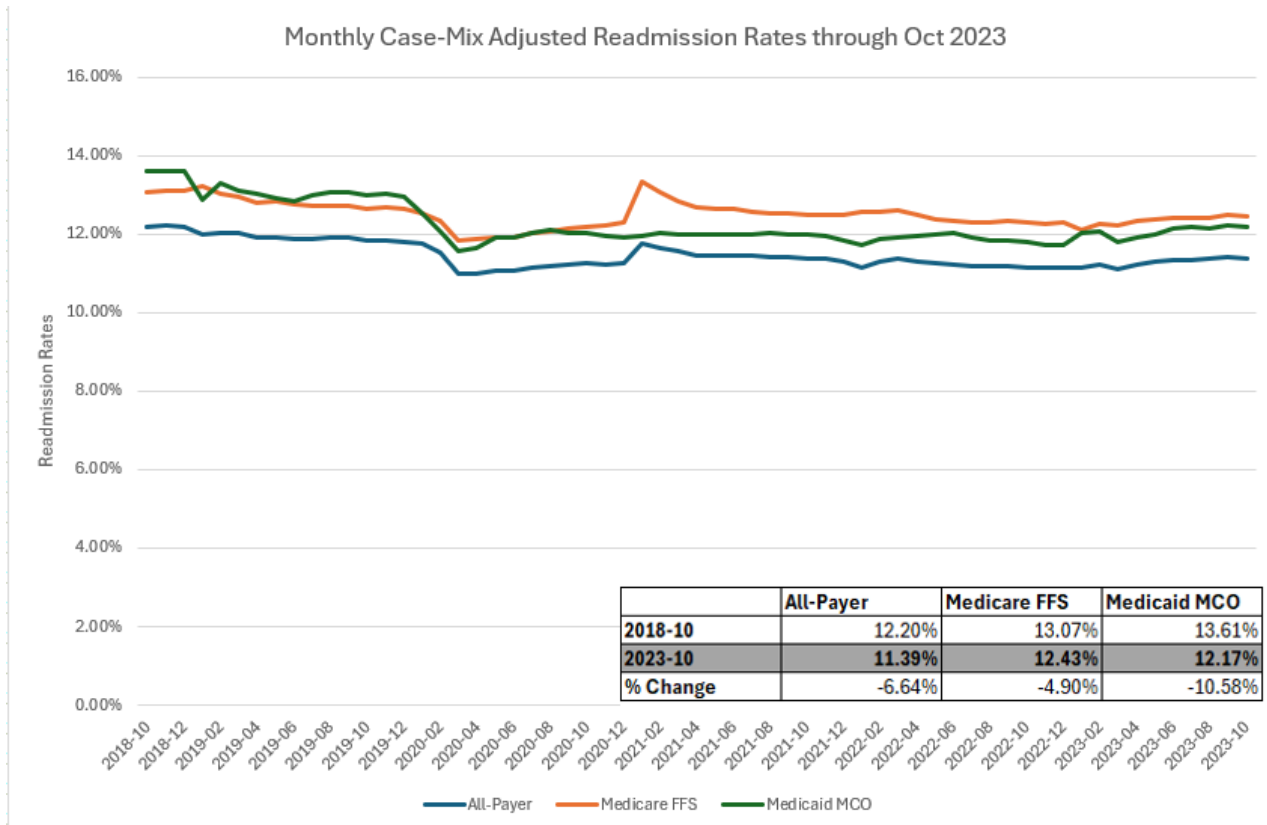
Figure 2. Maryland and National Medicare FFS Unadjusted Readmission Rates



### All-Payer Readmission Performance

Maryland has also performed well statewide over time on RRIP performance standards as shown in Figure 3, with All-payer, Medicare FFS, and Medicaid MCO readmission reductions of 6.64 percent, 4.90 percent and 10.58 percent from 2018 respectively. The all-payer reduction is in line with the 5-year improvement goal, which was set as part of the RRIP redesign, of a 7.5 percent improvement from CY2018 through CY2023.

Figure 3. Statewide Improvement in Case-Mix Adjusted Readmission Rates by Payer, 2018 through 2023 YTD



Most hospitals continue to perform well under the RY 2025 RRIP program, which is based on CY 2023 performance (current results are YTD through October). As illustrated in Figure 4 below, 16 hospitals are on target to reach the improvement goal of 7.5 percent, and as shown in Figure 5, 13 hospitals are on target to have a readmission rate below the benchmark of 11.32 percent. Hospitals performing well on both improvement and attainment will receive the better revenue adjustment (i.e., the higher reward or lower penalty). Overall there are 22 unique hospitals on track to receive a scaled reward for CY 2023 performance, which staff believe is reasonable given the continued improvements and that on a risk-adjusted basis the state is meeting the CMMI target.

Figure 4. By-Hospital Change in All-Payer Case Mix Adjusted Readmission Rates, 2018-YTD 2023

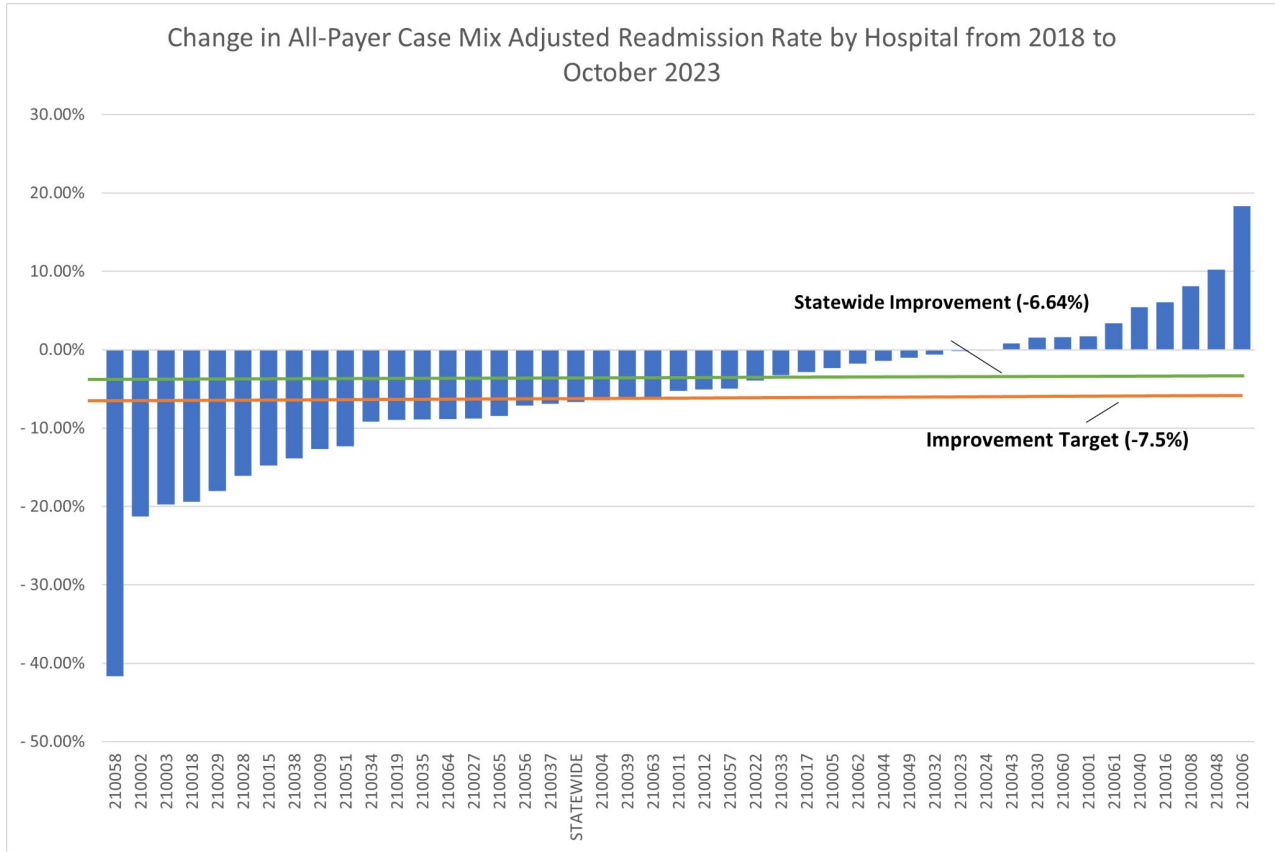
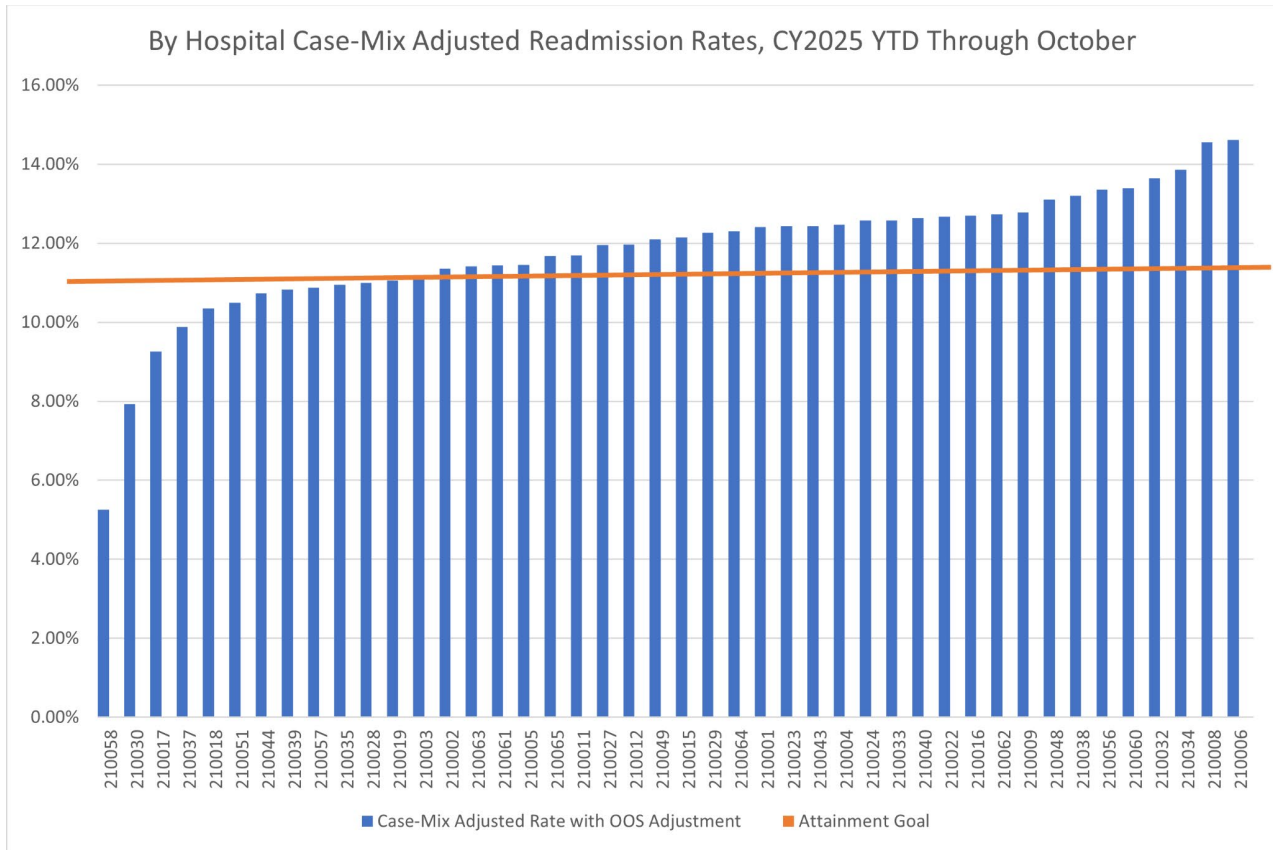


Figure 4. By-Hospital Change Case Mix Adjusted Readmission Rates, YTD 2023



## Updating the Performance Targets Under the TCOC Model

### Improvement

Maryland hospitals achieved the contractual test for Medicare readmissions to be at or below the nation by 2018. Analyses conducted as part of the RRIP redesign suggested that further improvements of 7.5 percent could be achieved. This draft policy repeats the analyses conducted in 2019 to determine whether additional improvement should be expected over the last few years of the TCOC model, and a reasonable improvement goal for earning rewards.

Staff believe that further reductions in readmissions are possible, but recommend a more modest improvement target from CY 2022 through CY2026 in recognition of the sustained and substantial

improvement under the All-Payer Model and the first five years under the TCOC Model. As the literature does not provide an optimal all-payer readmission rate, staff have generated a range of potential improvement scenarios. While the final policy will contain additional benchmarking and may update some of the analyses below, Figure 5 provides the initial analyses completed by staff. These analyses yield readmission rate reductions of approximately 4-9 percent from existing CY 2022 levels.

Figure 5. Improvement Target Estimates

Estimating Method	Percent Improvement	Resulting Readmission Rate (2026)*
1 Actual Compounded Improvement, 2018-2022	-8.61%	10.19%
2 Actual Improvement 2021-2022, Annualized to Four Years	-5.54%	10.53%
3 All Hospitals to 2018 Median	-4.1%	10.69%
4a Medicare Benchmarking - Peer County/MSA to 75th Percentile**	-4.75% to -5.45%	TBD
4b Commercial Benchmarking - Peer County/MSA to 75th Percentile**	TBD	TBD
5 Reduction in Readmission-PQIs	TBD	TBD
6 Reduction in Disparities	TBD	TBD

\* Assuming a constant CY 2022 readmission rate of 11.38 percent (under RY 2024 logic with specialty hospitals included)

\*\*Appendix IV details the Commercial and Medicare benchmarking work done throughout 2019 to inform the readmission improvement and attainment target setting.

For the first estimating method (Row 1), staff analyzed the improvement achieved under the first four years of the TCOC model and assumed that similar improvements could be repeated during

the last four years under the TCOC Model. This ~9 percent reduction represents the higher end of the improvement estimates. The second method (Row 2) uses the (slightly slower) improvement achieved between 2021 and 2022 and annualizes this one-year improvement to four years, resulting in a slightly less aggressive improvement target of ~5.5 percent.

The third and fourth estimating methods derive targets by assuming that hospitals currently performing worse than the statewide median or other peer geographies could improve to these rates. The third method (Row 3) calculates the statewide improvement if all hospitals are reduced to the CY 2022 median readmission rate. This method provides the lowest improvement goal currently calculated. The fourth estimating method (Row 4) uses national benchmarks of like geographies to generate improvement targets for Maryland hospitals to reduce to the 75th percentile of similar geographies. Currently, this benchmarking data is only available for Medicare; however, staff anticipate adding data on commercial benchmarking for the final policy. Based on 2022 data, Maryland Medicare FFS readmission rates would need to improve by 4.75 percent to reach the Peer county 75th best percentile (15.23 percent to 14.96 percent), or 5.75 percent to ensure that all Maryland counties were at or below the 75th percentile (15.23 percent to 14.40 percent).<sup>5</sup> Currently staff are working to finalize the commercial benchmarking analysis to include in the final policy.

The fifth method will estimate what the readmission rate would be if a certain percent of readmissions that are also PQIs (i.e., avoidable admissions for conditions such as diabetes, COPD, and hypertension) are prevented. The last method on the chart will estimate what the readmission rate would be if hospitals in the state with higher than average disparities reduced their readmission disparity gap to the statewide average. Again these analyses will be presented in the final policy and may change the currently proposed improvement goal.

These scenarios identify a range of potential targets but do not determine a specific, optimal readmission rate.. Staff and stakeholders agree generally with the range of potential improvement targets and support the generation of a four-year target rather than annual targets. Stakeholders

---

<sup>5</sup> The second scenario is lower as there are Maryland counties already better than the 75th percentile.



also continue to support including both improvement and attainment in building a revenue adjustment. Reviewing the range of potential targets, the improvement from CY 2018 experienced to-date in CY 2022, and the additional information from the benchmarking, staff feels comfortable to recommend an improvement target of 5.5 percent reduction from 2022 levels across four years, but will follow up in the final policy recommendation with an assessment of what a 5.5 percent improvement will mean for the State's Medicare casemix adjusted readmission rate relative to national comparators. Staff also reserves the right to revisit and revise this target should it prove too aggressive or too lenient such that the state creates unintended consequences or risks not meeting the continued goal of remaining at or below that national Medicare rate.

### **Attainment**

Prior to the RRIP Redesign for the TCOC model, the HSCRC has used the 75th percentile of best performers as the threshold to begin receiving rewards for attainment. In RY 2021, this was amended to the 65th percentile to allow hospitals in the top-third of Maryland performance to earn financial rewards for attainment, which acknowledged that Maryland (historically a poor performer on readmissions) had accomplished substantial improvement during the All-Payer Model. Staff analyzed the historical policy of the 65th percentile and compared this to the improvement targets suggested by the MEDA Center Peer Group national benchmarking analysis and the various opportunity analyses. Ultimately, staff calculated the statewide CY 2018 casemix-adjusted rate inclusive of 7.5% improvement and compared individual hospital CY 2018 readmission rates to this figure. Staff determined that at the 65th percentile of current performance, hospitals have rates equivalent to the targeted statewide readmission rate. Once the improvement modeling is finished, staff will repeat this analysis using the statewide CY 2022 readmission rates plus the improvement target and compare that rate to the 65th percentile of hospital performance in CY 2022. Depending on the results, staff will make a final decision on the attainment target; however, for now in this draft policy we are keeping the 65th percentile as the goal and in general believe that rewarding the top third of hospital performance is reasonable.

## Revisits to Emergency Department and Observation Stays

Improvement in readmission rates under the model should result in better patient experience. However, the current readmission measures only count a readmission if the patient returns to the hospital and is admitted into an inpatient bed. Thus, revisits to the emergency department or for an observation stay after an initial inpatient admission are not considered. This potentially has an impact on hospital throughput and ED boarding as anecdotally ED hospital staff have said that they are doing more testing and diagnostics in the ED that previously may have been done during the inpatient admission to determine whether an admission is really necessary. While this might be appropriate clinically, if these revisits represent quality of care or care coordination concerns, these are not being identified for payment incentives at this time (only exception is PAU includes observation stays  $\geq 24$  hours as inpatient stays). When staff have looked at this previously for just observation stays, we found that while readmission rates increased when observation stays were included, the correlation between the readmission rates with and without observation stays was 0.986 in 2018. This analysis, and the fact that the national program does not include observation stays, led the staff at that time to recommend that the RRIP readmission measure remain an inpatient only measure. However, staff are recommending in this draft policy, and are looking for Commissioner input/support, to repeat these analyses with both ED and observation stays included to assess the extent of revisits, types of revisits, and differential impacts of revisits on readmission performance by hospital (i.e., does the rank order of hospitals change with inclusion of revisits). While PMWG members have told us that revisits do reflect quality of care or other concerns such as medication access, they do remain concerned about lack of benchmarking for a broader measure.

## Excess Days in Acute Care (EDAC)

As discussed above, stakeholders remain concerned about emergency department and observation revisits, especially given the global budget incentives to avoid admissions. Another approach for addressing this issue would be to adopt the Excess Days in Acute Care measure into payment. The EDAC measure captures the number of days that a patient spends in the hospital within 30 days of discharge, and includes emergency department and observation stays by assigning ED visits a half-day length of stay and assigning observation hours rounded up to half-day units.<sup>6</sup> Staff have worked with our methodological contractor to adapt the Medicare

---

<sup>6</sup> Additional information on the EDAC measures and methodology can be found here: <https://www.qualitynet.org/inpatient/measures/edac/methodology>

Excess Days in Acute Care (EDAC) condition-specific measures to an all-cause, all-payer measure for potential program adoption in future years. This work was completed and monitoring reports for this measure are posted on the CRISP portal on a monthly basis for hospital monitoring and input. Over the coming year if staff is directed to assess revisits, the EDAC measure may be one option for consideration rather than adapting the actual readmission measure. However, the EDAC measure has been criticized by some PMWG members because of the time element associated with the readmission. Specifically, the concern is that longer readmissions (which would represent worse performance) may indicate a less preventable readmission. While staff will consider this concern, it could also be countered that a longer readmission represents a more serious quality of care issue from the initial admission.

### **Digital Measures/Electronic Clinical Quality Measure (eCQM)**

Under the Inpatient Quality Reporting program, CMS transitioned from the claims-based 30-day Hospital Wide Readmission (HWR) measure to the digital Hybrid HWR measure with the July, 1 2023-June 30, 2024 mandatory reporting of the hybrid measure for Medicare patients for FFY 2026 payment year. The HWR 30-day readmission hybrid measure merges electronic health record data elements with a set of 13 Core Clinical Data Elements (CCDE) consisting of six vital signs and seven laboratory test results; hospitals must map these 13 CCDE to the patient electronic health record (EHR). The claims and CCDE data are then submitted and used to calculate measure results. For the initial mandatory year beginning July 1, 2023, HSCRC also requires hospitals to submit the hybrid HWR measure data to the State for Medicare patients. Additionally, staff has formally communicated to hospitals the State's intent to expand the measure to all-payers and to patients aged 18 and above beginning with July 1, 2024 discharges. To prepare for this update, CRISP and Medisolv (CRISP digital measure subcontractor) have indicated they are updating the data collection infrastructure and will be ready to receive data on the expanded measure with the first submission scheduled to begin in January 2025. However, in a digital measures stakeholder subgroup staff convened in August 2023, and in subsequent communication with staff, hospital and EHR vendor representatives have raised significant concerns about the feasibility of expanding the measure beyond Medicare patients. Among the specific concerns from hospitals are, in some cases, their EHR vendors are telling them there are additional costs and significant effort to set up and implement the expanded measure; in other

cases, hospitals are noting their EHR vendor is telling them they are unable to do the work to expand and implement the measure. HSCRC staff will continue to investigate the issues voiced by hospitals and identify strategies to progress on expansion of the Hybrid measure, and will also consider options for augmenting the RRIP all-payer measure with EHR data elements in the future.

## Reducing Disparities in Readmissions

Racial and socioeconomic differences in readmission rates are well documented<sup>7,8</sup> and have been a source of significant concern among healthcare providers and regulators for years. In Maryland, the 2018 readmission rate for blacks was 2.6 percentage points higher than for whites, and the rate for Medicaid enrollees was 3.4 points higher than for other patients. A 2019 *Annals of Internal Medicine* paper co-authored by HSCRC staff<sup>9</sup> reported a 1.6 percent higher readmission rate for patients living in neighborhoods with increased deprivation. Maryland hospitals, as well as CMS and the Maryland Hospital Association, identify reduction in disparities as a key priority over the near term. Thus, staff developed and the Commission approved adding a within-hospital disparity gap improvement goal to the RRIP in RY2021.

Specifically, the RRIP within hospital disparity methodology assesses patient-level socioeconomic exposure using the Patient Adversity Index (PAI), a continuous measure that reflects exposure to poverty, structural racism, and neighborhood deprivation. As shown in Figure 6, the relationship between PAI and readmissions is then assessed for each hospital for the base and performance period, and improvements in the slope of the line or in the difference in readmission rates at two points on the line (e.g., PAI = 1 vs PAI = 0) are compared for the base and performance period to calculate improvement. Hospitals that improve on the within hospital disparity gap and improve on overall readmissions, are eligible for a scaled reward up to 0.50 percent of inpatient revenue.

---

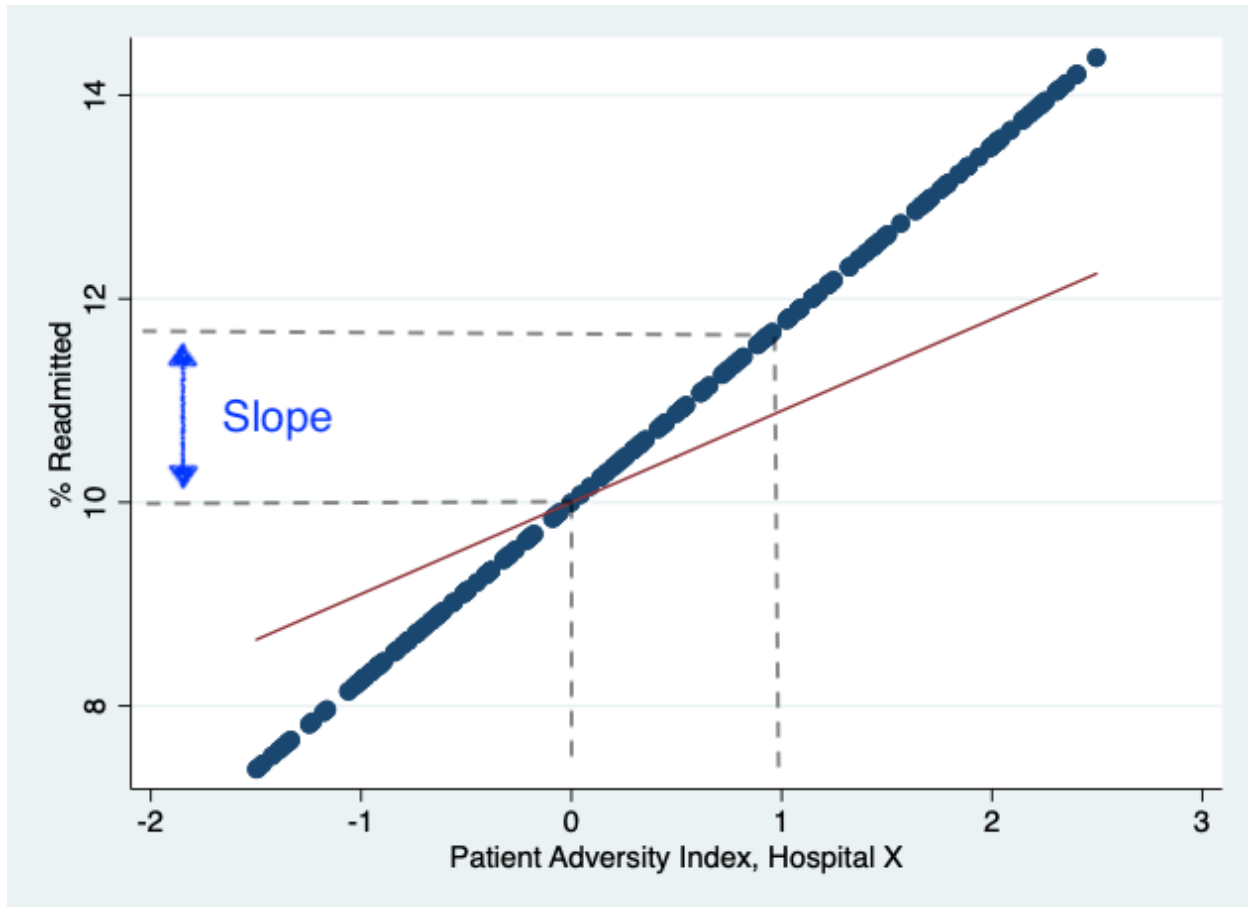
<sup>7</sup> Tsai TC, Orav EJ, Joynt KE. Disparities in surgical 30-day readmission rates for Medicare beneficiaries by race and site of care. *Ann Surg*. 2014;259(6):1086–1090. doi:10.1097/SLA.0000000000000326;

<sup>8</sup> Calvillo–King, Linda, et al. "Impact of social factors on risk of readmission or mortality in pneumonia and heart failure: systematic review." *Journal of general internal medicine* 28.2 (2013): 269-282.

<sup>9</sup> Jencks, Stephen F., et al. "Safety-Net hospitals, neighborhood disadvantage, and readmissions under Maryland's all-payer program: an observational study." *Annals of internal medicine* 171.2 (2019): 91-98.

Additional information on the development of the within-hospital disparity metric can be found in the RY 2021 RRIP policy.<sup>10</sup>

Figure 6. Hypothetical Example of Relationship between PAI and Readmission Rates



The RRIP disparity gap improvement goal was set through the end of the TCOC model (CY2026) and aligns with one of the goals in the Statewide Integrated Improvement Strategy. The SIHIS goal is to have half of eligible hospitals achieve a 50 percent reduction in readmission disparities. CY 2022 data shows that 32 hospitals saw a reduction in their within-hospital disparities in readmissions, ranging from a 0.18% reduction to a 61.54% reduction. Through the RY2024 RRIP-Disparity Gap Program (CY 2022 performance), scaled rewards were provided to 11 of these

<sup>10</sup> ADD FOOTNOTE WITH LINK TO POLICY

hospitals for reducing their disparities in readmissions by the required minimum of 22.89 percent while simultaneously reducing their overall readmission rate; the range of revenue adjustments was 0.26 percent to 0.5 percent for a statewide total of about \$7.8 million in rewards. To meet the CY 2023 SIHIS Target, the State needs at least 22 hospitals to reduce their within-hospital disparities in readmissions by 25 percent. The State remains committed to ensuring hospitals are advancing health equity by continuing to financially incentivize reductions in disparities through the Readmissions Reduction Incentive Program (RRIP) policy and other policies. The ability to set hospital payment incentives specifically for advancing health equity is an important hallmark of the TCOC Model and exemptions from national quality programs. In the RY 2026 Quality Based Reimbursement program, this disparity gap methodology was adapted to the Timely Follow-Up post hospitalization measure and the Commission approved financial incentives for reductions in disparities in follow up for Medicare patients.

Post-COVID there have been some updates to the disparity gap methodology for readmissions. First, HSCRC staff updated the measure to use post-COVID CY 2021 norms that are applied to both the historical CY 2018 data, as well as to the performance periods. However, in doing this, staff decided that in order to fully measure improvement, all of the regression model coefficients used for risk-adjustment such as diagnosis-severity of illness, age, and sex (not just the PAI coefficient) should be “locked in” or not recalculated for each time period. This technical change ensures any improvement over time is fully captured, rather than only capturing improvement above the state average improvement (which would make the SIHIS goal challenging). Staff are working to lock model coefficients from the CY 2021 base period to be applied to the performance period, but initial analyses show this has only a minor impact on results. These updates to the RRIP-Disparity Gap methodology, however, are important for stakeholder engagement.

For RY 2026, the RRIP disparity gap draft recommendation uses the previously calculated improvement targets pushed forward to CY 2024 performance. Staff continue to work with hospitals to help them understand this methodology and are planning to conduct a learning session on the methodology in March. This learning session will review the methodology and model scenarios to show how certain interventions that focus on high adversity patients to reduce readmissions impacts the measure.

## Recommendations

These are the draft recommendation for the Maryland Rate Year (RY) 2026 Readmission Reduction Incentives Program (RRIP):

7. Maintain the 30-day, all-cause readmission measure.
8. Improvement Target - Set statewide 4-year improvement target of -5.5 percent from 2022 base period through 2026.
9. Attainment Target - Maintain the attainment target whereby hospitals at or better than the 65th percentile of statewide performance receive scaled rewards for maintaining low readmission rates.
10. Maintain maximum rewards and penalties at 2 percent of inpatient revenue.
11. Provide additional payment incentive (up to 0.50 percent of inpatient revenue) for reductions in within-hospital readmission disparities. Scale rewards:
  - a. beginning at 0.25 percent of IP revenue for hospitals on pace for 50 percent reduction in disparity gap measure over 8 years, and;
  - b. capped at 0.50 percent of IP revenue for hospitals on pace for 75 percent or larger reduction in disparity gap measure over 8 years.
12. Monitor emergency department and observation revisits by adjusting readmission measure and through all-payer Excess Days in Acute Care measure. Consider future inclusion of revisits of EDAC in the RRIP program.

# Appendix I. RRIP Readmission Measure and Revenue Adjustment Methodology

## Introduction: RRIP Redesign Subgroup

As part of the ongoing evolution of the All-Payer Model's pay-for-performance programs to further bring them into alignment under the Total Cost of Care Model, HSCRC convened a work group to evaluate the Readmission Reduction Incentive Program (RRIP). The work group consisted of stakeholders, subject matter experts, and consumers, and met six times between February and September 2019. The work group focused on the following six topics, with the general conclusions summarized below:

1. Analysis of Case-mix Adjustment and trends in Eligible Discharges over time to address concern of limited room for additional improvement;
  - Case-mix adjustment acknowledges increased severity of illness over time
  - Standard Deviation analysis of Eligible Discharges suggests that further reduction in readmission rates is possible
2. National Benchmarking of similar geographies using Medicare and Commercial data;
  - Maryland Medicare and Commercial readmission rates and readmissions per capita are on par with the nation
3. Updates to the existing All-Cause Readmission Measure;
  - Remove Eligible Discharges that left against medical advice (~7,500 discharges)
  - Include Oncology Discharges with more nuanced exclusion logic
  - Analyze out-of-state ratios for other payers as data become available
4. Statewide Improvement and Attainment Targets under the TCOC Model;
  - 7.5 percent Improvement over 5 years (2018-2023)
  - Ongoing evaluation of the attainment threshold at 65th percentile
5. Social Determinants of Health and Readmission Rates; and
  - Methodology developed to assess within-hospital readmission disparities
6. Alternative Measures of Readmissions
  - Further analysis of per capita readmissions as broader trend; not germane to the RRIP policy because focus of evaluation is clinical performance and care management post-discharge
  - Observation trends under the All-Payer Model to better understand performance given variations in hospital observation use; future development will focus on incorporation of Excess Days in Acute Care (EDAC) measure in lieu of including observations in RRIP policy
  - Electronic Clinical Quality Measure (eCQM) may be considered in future to improve risk adjustment

## Methodology Steps



## 1) Performance Metric

The methodology for the Readmissions Reduction Incentive Program (RRIP) measures performance using the 30-day all-payer all hospital (both intra- and inter-hospital) readmission rate with adjustments for patient severity (based upon discharge all-patient refined diagnosis-related group severity of illness [APR-DRG SOI]) and planned admissions.<sup>11</sup> Unique patient identifiers from CRISP are used to be able to track patients across hospitals for readmissions.

The measure is similar to the readmission rate that is calculated by CMMI to track Maryland performance versus the nation, with some exceptions. The most notable exceptions are that the HSCRC measure includes psychiatric patients in acute care hospitals, and readmissions that occur at specialty hospitals. In comparing Maryland's Medicare readmission rate to the national readmission rate, the Centers for Medicare & Medicaid Services (CMS) will calculate an unadjusted readmission rate for Medicare beneficiaries. Since the Health Services Cost Review Commission (HSCRC) measure is for hospital-specific payment purposes, an additional adjustment is made to account for differences in case-mix. See below for details on the readmission calculation for the RRIP program.

## 2) Inclusions and Exclusions in Readmission Measurement

- Planned readmissions are excluded from the numerator based upon the CMS Planned Readmission Algorithm V. 4.0. The HSCRC has also added all vaginal and C-section deliveries and rehabilitation as planned using the APR-DRGs, rather than principal diagnosis.<sup>12</sup> Planned admissions are counted as eligible discharges in the denominator, because they could have an unplanned readmission.
- Discharges for newborn APR-DRG are removed.<sup>13</sup>
- Exclude bone marrow transplants and liquid tumor patients by making these discharges not eligible to have an unplanned readmission or count as an unplanned readmission.<sup>14</sup>
- Exclude patients with a discharge disposition of Left Against Medical Advice (PAT\_DISP = 71, 72, or 73 through FY 2018; 07 FY 2019 onward)
- Rehabilitation cases as identified by APR-860 (which are coded under ICD-10 based on type of daily service) are marked as planned admissions and made ineligible for readmission after readmission logic is run.
- Admissions with ungroupable APR-DRGs (955, 956) are not eligible for a readmission, but can be a readmission for a previous admission.
- APR-DRG-SOI categories with less than two discharges statewide are removed.
- A hospitalization within 30 days of a hospital discharge where a patient dies is counted as a readmission; however, the readmission is removed from the denominator because the case is

---

<sup>11</sup> Planned admissions defined under [CMS Planned Admission Logic version 4 – updated March 2018].

<sup>12</sup> **Rehab DRGs:** 540, 541, 542, 560, and 860; **OB Deliveries and Associated DRGs:** 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.

<sup>13</sup> **Newborn APR-DRGs:** 580, 581, 583, 588, 589, 591, 593, 602, 603, 607, 608, 609, 611, 612, 613, 614, 621, 622, 623, 625, 626, 630, 631, 633, 634, 636, 639, 640, and 863.

<sup>14</sup> **Bone Marrow Transplant:** Diagnosis code Z94.81 or CCS Procedure code 64; **Liquid Tumor:** Diagnosis codes C81.00-C96.0. See section below for additional details on the oncology logic.

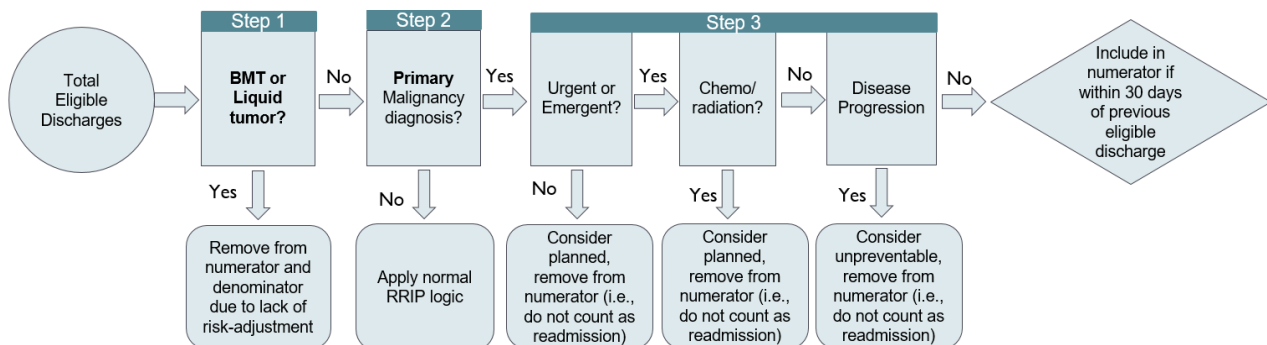
not eligible for a subsequent readmission.

- Admissions that result in transfers, defined as cases where the discharge date of the admission is on the same or next day as the admission date of the subsequent admission, are removed from the denominator. Thus, only one admission is counted in the denominator, and that is the admission to the transfer hospital (unless otherwise ineligible, i.e., died). It is the second discharge date from the admission to the transfer hospital that is used to calculate the 30-day readmission window.
- Beginning in RY 2019, HSCRC started discharges from chronic beds within acute care hospitals.
- In addition, the following data cleaning edits are applied:
  - Cases with null or missing CRISP unique patient identifiers (EIDs) are removed.
  - Duplicates are removed.
  - Negative interval days are removed.

HSCRC staff is revising case-mix data edits to prevent submission of duplicates and negative intervals, which are very rare. In addition, CRISP EID matching benchmarks are closely monitored. Currently, hospitals are required to make sure 99.5 percent of inpatient discharges have a CRISP EID.

### Additional Details on Oncology Logic:

Flow Chart for Revised Oncology Logic



\*Items that are **bolded** are adaptations from NQF measure

This updated logic replaces the RY 2021 measure logic that removes all oncology DRGs from the dataset, such that an admission with an oncology DRG cannot count as a readmission or be eligible to have a readmission.

**Step 1:** Exclude discharges where patients have a bone marrow transplant procedure, bone marrow transplant related diagnosis code, or liquid tumor diagnosis. This logic varies from the NQF cancer hospital measure that risk-adjusts for bone marrow transplant and liquid tumors. HSCRC

staff recommended removing these discharges (similar to current DRG exclusion) because the current indirect standardization approach did not allow for additional risk-adjustment but based on conversations with clinicians staff agreed these cases were significantly more complicated and at-risk for an unpreventable readmission.

**Step 2:** Flag discharges with a primary malignancy diagnosis to apply cancer specific logic for determining readmissions. This varies from the NQF cancer hospital measure that flags patients with primary or secondary malignancy diagnosis being treated in a cancer specific hospital. Staff think we should only flag those with a primary diagnosis since in a general acute care hospital there may be differences in the types of patients with a secondary malignancy diagnosis. Further, we remove the bone marrow and liquid tumor discharges regardless of malignancy diagnosis, thus ensuring the most severe cases are removed. Last, our initial analyses did not show a large impact on overall hospital rates when primary vs primary and secondary malignancies were flagged. It should be noted however that the current modeling in this policy uses readmission rates where both primary and secondary are flagged.

**Step 3:** Flag planned admissions using additional criteria beyond the CMS planned admission logic:

- a) Nature of admission of urgent or emergent considered unplanned, all other nature of admission statuses are planned
- b) Any admission with primary diagnosis of chemotherapy or radiation is considered planned
- c) Any admission with primary diagnosis of metastatic cancer is not considered preventable, and thus gets excluded from being a readmission

In step 3, admissions are deemed not eligible to be a readmission but they are eligible to have a subsequent unplanned readmission.

### 3) Details on the Calculation of Case-Mix Adjusted Readmission Rate

#### Data Source:

To calculate readmission rates for RRIP, inpatient abstract/case-mix data with CRISP EIDs (so that patients can be tracked across hospitals) are used for the measurement period, with an additional 30 day runout. To calculate the case-mix adjusted readmission rate for CY 2018 base period and CY 2023 performance period, data from January 1 through December 31, plus 30 days in January of the next year are used. CY 2021 data are used to calculate the normative values, which are used to determine a hospital's expected readmissions, as detailed below, as well as the estimated CY 2018 readmission rates.

Please note that, the base year readmission rates are not "locked in", and may change if there are CRISP EID or other data updates. The HSCRC does not anticipate changing the base period data, and does not

anticipate that any EID updates will change the base period data significantly; however, the HSCRC has decided the most up-to-date data should be used to measure improvement. For the performance period, the CRISP EIDs are updated throughout the year, and thus, month-to-month results may change based on changes in EIDs.

**SOFTWARE:** APR-DRG Version 41 for CY 2018-CY 2024.

**Calculation:**

$$\text{Case-Mix Adjusted Readmission Rate} = \frac{\text{(Observed Readmissions) Readmission Rate}}{\text{(Expected Readmissions) Readmission Rate}} * \text{Statewide Base Year}$$

**Numerator:** Number of observed hospital-specific unplanned readmissions.

**Denominator:** Number of expected hospital specific unplanned readmissions based upon discharge APR-DRG and Severity of Illness. See below for how to calculate expected readmissions, adjusted for APR-DRG SOI.

**Risk Adjustment Calculation:**

Calculate the Statewide Readmission Rate without Planned Readmissions.

- o Statewide Readmission Rate = Total number of readmissions with exclusions removed / Total number of hospital discharges with exclusions removed.

For each hospital, enumerate the number of observed, unplanned readmissions.

For each hospital, calculate the number of expected unplanned readmissions at the APR-DRG SOI level (see Expected Values for description). For each hospital, cases are removed if the discharge APR-DRG and SOI cells have less than two total cases in the base period data.

Calculate at the hospital level the ratio of observed (O) readmissions over expected (E) readmissions. A ratio of > 1 means that there were more observed readmissions than expected, based upon a hospital's case-mix. A ratio of < 1 means that there were fewer observed readmissions than expected based upon a hospital's case-mix.

Multiply the O/E ratio by the base year statewide rate, which is used to get the case-mix adjusted readmission rate by hospital. Multiplying the O/E ratio by the base year state rate converts it into a readmission rate that can be compared to unadjusted rates and case-mix adjusted rates over time.

**Expected Values:**

The expected value of readmissions is the number of readmissions a hospital would have experienced had its rate of readmissions been identical to that experienced by a reference or normative set of hospitals, given its mix of patients as defined by discharge APR-DRG category and SOI level. Currently, HSCRC is using state average rates as the benchmark.

The technique by which the expected number of readmissions is calculated is called indirect standardization. For illustrative purposes, assume that every discharge can meet the criteria for having a readmission, a condition called being “eligible” for a readmission. All discharges will either have zero readmissions or will have one readmission. The readmission rate is the proportion or percentage of admissions that have a readmission.

The rates of readmissions in the normative database are calculated for each APR-DRG category and its SOI levels by dividing the observed number of readmissions by the total number of eligible discharges. The readmission norm for a single APR-DRG SOI level is calculated as follows:

Let:

N = norm

P = Number of discharges with a readmission

D = Number of eligible discharges

i = An APR DRG category and a single SOI level

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

For this example, the expected rate is displayed as readmissions per discharge to facilitate the calculations in the example. Most reports will display the expected rate as a rate per one thousand.

Once a set of norms has been calculated, the norms are applied to each hospital's DRG and SOI distribution. In the example below, the computation presents expected readmission rates for a single diagnosis category and its four severity levels. This computation could be expanded to include multiple diagnosis categories, by simply expanding the summations.

Consider the following example for a single diagnosis category.

**Expected Value Computation Example – Individual APR-DRG**

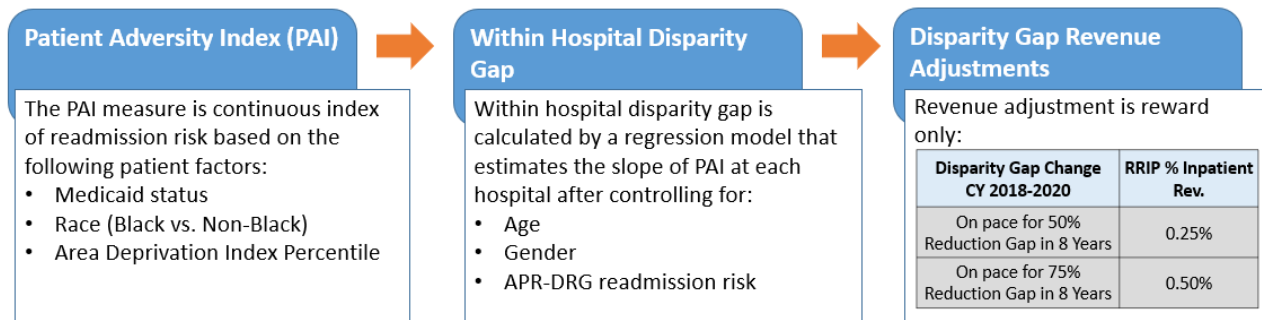
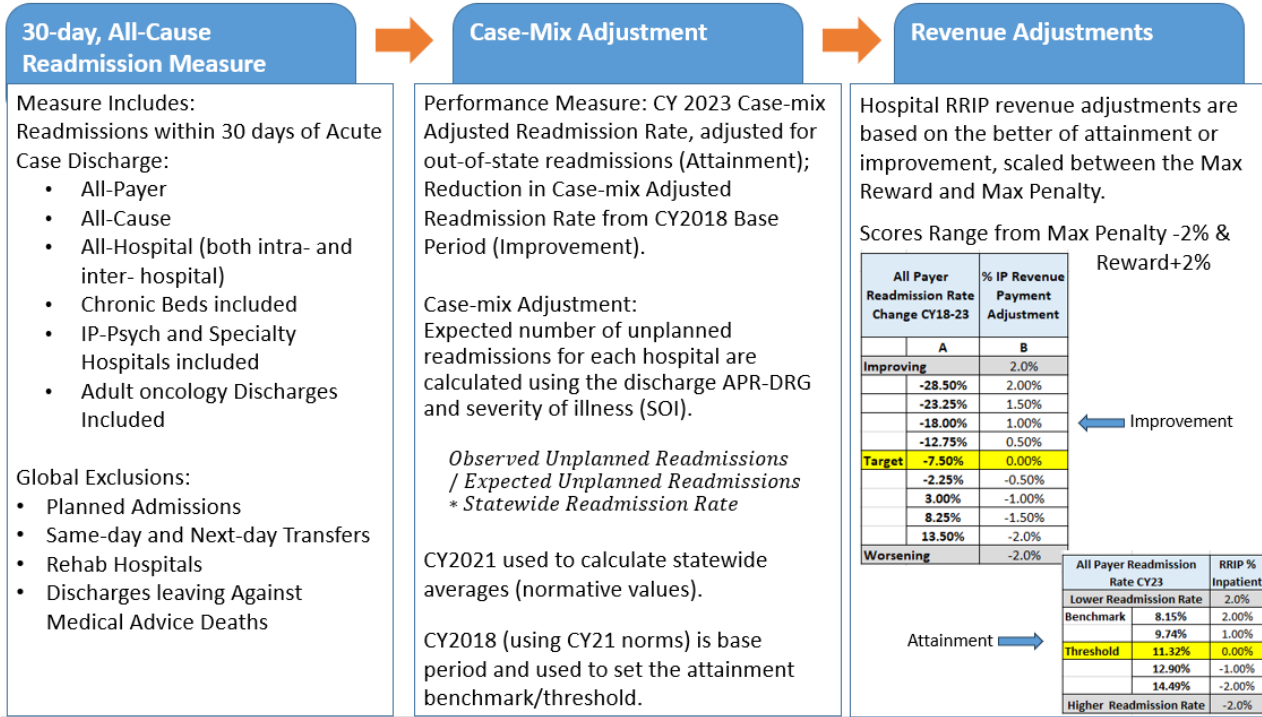
<b>A</b> Severity of Illness Level	<b>B</b> Eligible Discharges	<b>C</b> Discharges with Readmission	<b>D</b> Readmissions per Discharge (C/B)	<b>E</b> Normative Readmissions per Discharge	<b>F</b> Expected # of Readmissions (A*E)
1	200	10	.05	.07	14.0
2	150	15	.10	.10	15.0
3	100	10	.10	.15	15.0
4	50	10	.20	.25	12.5
<b>Total</b>	<b>500</b>	<b>45</b>	<b>.09</b>		<b>56.5</b>

For the diagnosis category, the number of discharges with a readmission is 45, which is the sum of discharges with readmissions (column C). The overall rate of readmissions per discharge, 0.09, is calculated by dividing the total number of eligible discharges with a readmission (sum of column C) by the total number of discharges at risk for readmission (sum of column B), i.e.,  $0.09 = 45/500$ . From the normative population, the proportion of discharges with readmissions for each severity level for that diagnosis category is displayed in column E. The expected number of readmissions for each severity level shown in column F is calculated by multiplying the number of eligible discharges (column B) by the normative readmissions per discharge rate (column E). The total number of readmissions expected for this diagnosis category is the sum of the expected numbers of readmissions for the 4 severity levels.

In this example, the expected number of readmissions for this diagnosis category is 56.5, compared to the actual number of discharges with readmissions of 45. Thus, the hospital had 11.5 fewer actual discharges with readmissions than were expected for this diagnosis category. This difference can also be expressed as a percentage or the O/E ratio.

#### **4) Revenue Adjustment Methodology**

The RRIP assesses improvement in readmission rates from base period, and attainment rates for the performance period with an adjustment for out-of-state readmissions. The policy then determines a hospital's revenue adjustment for improvement and attainment and takes the better of the two revenue adjustments, with scaled rewards of up to 2 percent of inpatient revenue and scaled penalties of up to 2 percent of inpatient revenue. The figure below provides a high level overview of the RY 2025 RRIP methodology for reference.



## Appendix II. Analyses of Medicare Readmissions

Based on analyses, HSCRC staff believe that patients admitted in Maryland have gotten sicker since 2018 (i.e., higher rate of comorbidities) and that this increase in case mix acuity is greater in Maryland than the increase seen nationally. These analyses support what hospitals have reported anecdotally. To examine the change in patient case mix over time from 2018 through 2022, HSCRC staff first used the CCW data to estimate readmission risk in 2018. Then, the annual predicted readmission risk was calculated for CYs 2019 through 2022 by applying the 2018 coefficients for each comorbidity. Changes in the predicted readmission rates indicate that there are differences in the population at-risk for readmissions. Specifically, increases in the predicted readmission rate would indicate that the at-risk population was composed of patients with comorbidities or other risk factors with a higher risk of readmission. Decreases in the predicted readmission rate would indicate the at-risk population was composed of patients with lower risk for readmission than in 2018. Furthermore, differences between the predicted and actual readmission rates reflect how well Maryland performed relative to what was expected based on 2018. We specified two models: One adjusting for age groups, race, sex, dual eligibility status, and the 38 Elixhauser comorbidity flags, and another with just the Elixhauser comorbidity flags. While the results are similar, this report includes the simpler model that only contained the Elixhauser comorbidity flags so that it could focus on changes in health status over time. In addition, the analysis was run for all ages combined, and then for those under 65 versus those 65 and older; given the similarities in results, we have focused on the 65+ model since it is majority of the at-risk population for Medicare and this aligns with the national readmissions measures that restrict to those 65 and older.

The Figure 1 below shows the predicted readmission rate nationally and for Maryland increased by 2.95 and 4.74 percent respectively. The increase in the predicted readmission rate in Maryland indicates that the patients admitted to Maryland hospitals in 2022 were sicker than the patients admitted in 2018, and the increase in case mix index was higher in Maryland than it was nationally.

### Figure 1. Predicted and Actual Maryland and National Readmissions



CCW Analysis		HSCRC Readmission Predictions for 65+ Yrs (CY Dec - Nov)				
Provider	Index Stay Year	Actual Admissions	Actual Readmissions	Predicted Readmission Rate	Actual Readmission Rate	Readmission Rate Difference
National	2018	6,866,364	976,561	14.22%	14.22%	0.00%
National	2019	6,786,204	967,802	14.40%	14.26%	-0.14%
National	2020	5,602,629	789,957	14.62%	14.10%	-0.52%
National	2021	5,354,330	758,226	14.62%	14.16%	-0.46%
National	2022	5,282,350	747,517	14.64%	14.15%	-0.49%
<b>Change from 2018 to 2022</b>				<b>2.95%</b>	<b>-0.49%</b>	
Maryland	2018	149,748	21,229	14.55%	14.18%	-0.38%
Maryland	2019	146,970	20,177	14.72%	13.73%	-0.99%
Maryland	2020	121,924	16,767	15.00%	13.75%	-1.25%
Maryland	2021	122,250	17,495	15.10%	14.31%	-0.79%
Maryland	2022	121,574	17,226	15.24%	14.17%	-1.07%
<b>Change from 2018 to 2022</b>				<b>4.74%</b>	<b>-0.07%</b>	
Prediction using 2018 national data as baseline						
Model is adjusted for 38 Elixhauser comorbidity flags (ICD-10 version)						

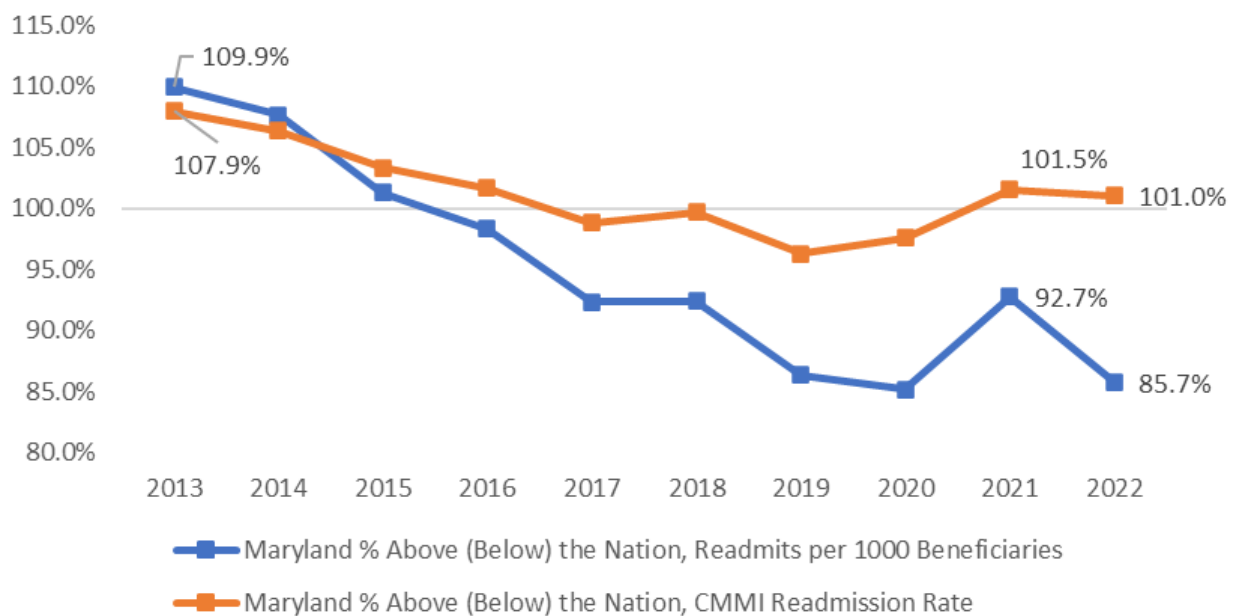
Figure 1 also shows the difference between the predicted and observed readmission rates. In CY 2022, Maryland had an actual readmission rate that was 1.07 percent lower than the predicted readmission rate, and this was more than twice as much as the gap between predicted and actual seen nationally (0.49 percent lower). Overall, staff contend that these analyses support the assertion that Maryland patients are sicker in 2022 than in 2018 and this increase in case mix severity is higher than what was seen nationally.

### 1) Per Capita Readmissions

Another approach to controlling for different admitting populations is to examine the number of readmissions per beneficiary rather than the readmission rate. This removes changes in the nature of the admitted population (the denominator in the traditional readmission rate) and focuses on just the number of readmissions across the entire population. Figure 2 compares Maryland's performance versus the Nation using readmissions per 1000 and the unadjusted CMMI readmission rate. Performance shows that in 2013 both the unadjusted and per capita readmission rates for Maryland were higher than the Nation by 7.9 percent and 9.9 percent, respectively. Starting in 2016 and 2017, the per capita and the unadjusted readmission rate dropped to below the national rate until 2021 where the unadjusted rate again is higher than the Nation but the per capita rate is below the Nation. And while there was erosion in 2021 Maryland,

in CY 2022 the per capita rate drops to 14.3 percent lower than the nation. This means that fewer Medicare beneficiaries are readmitted in Maryland than nationally and it aligns with the idea that those who are admitted in Maryland have a higher case mix acuity than the Nation and thus a higher unadjusted readmission rate.

**Figure 2: Maryland’s Performance Versus the Nation Under Unadjusted Readmission Rate and Readmissions per 1000<sup>15</sup>**



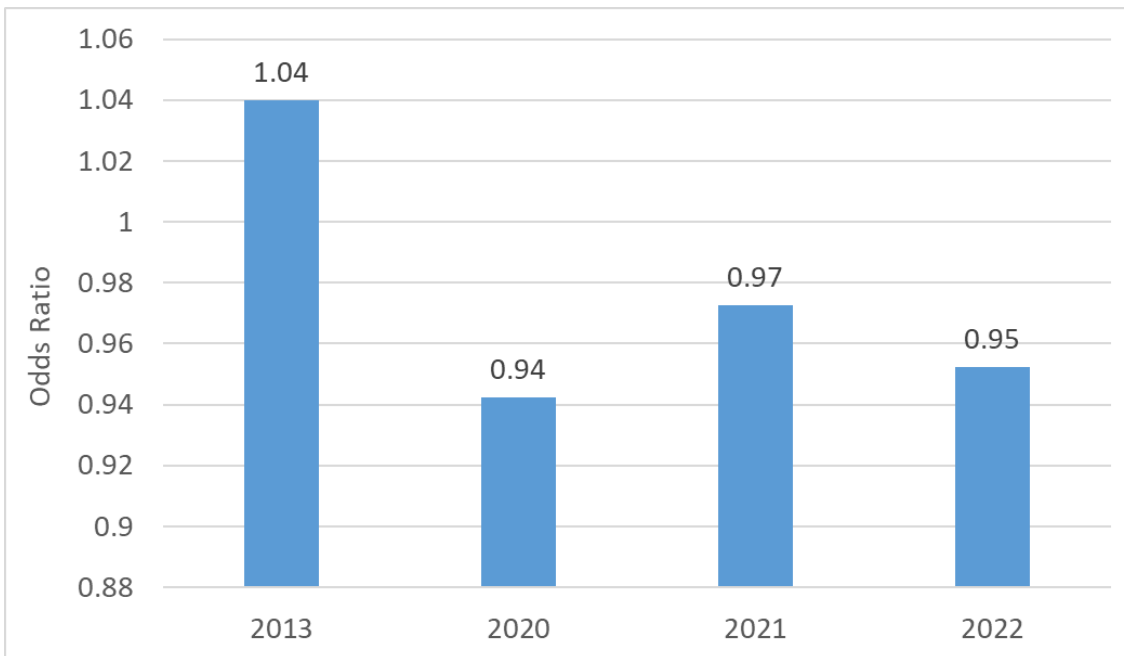
## 2) Risk-Adjusted Medicare Readmission Rates

As discussed in the previous exemption request and above, reductions in inpatient utilization and differential COVID impacts, have increased the case mix index for patients admitted to the hospital in Maryland compared to the nation. Thus the staff continue to advocate for a risk-adjusted readmission measure and appreciate the CMMI team's agreement to collaborate with Maryland to develop a risk-adjusted readmission measure for consideration. By moving to a risk-adjusted measure, Maryland’s performance on readmissions can be more fully evaluated since differences in the admitted population are removed. Currently, HSCRC staff has run regression models for Medicare beneficiaries who were 65 and older using the CCW data for 2013, 2020, 2021, and 2022 controlling for age, sex, COVID-19 status (for post-2020

<sup>15</sup> HSCRC calculation based on 100% Maryland and National Hospital Claim files received annually.

models), Major Diagnostic Category (MDC) and the Elixhauser Comorbidity Index<sup>16</sup>. The results of these models show that in 2021 and 2022, despite higher unadjusted readmissions, Maryland patients had statistically significantly lower odds of being readmitted (2021 OR 0.97, CI 0.956-0.989; 2022 OR 0.95, CI 0.936-0.969). Figure 3 shows the odds ratios for each year. For CY 2022, the odds ratio of 0.95 means that Maryland Medicare FFS patients had a 5 percent lower odds of being readmitted than national patients. We then tested removing the Elixhauser Comorbidity Index for CY 2020, CY 2021, and CY 2022; for CY 2020 the OR increased to 0.972 but Maryland still performed statistically better than the Nation (CI 0.952-0.993) but for CY 2021 and CY 2022 the OR increased and there no longer was a statistically significant difference between MD and the nation. We believe this shows that during CY 2021 and again in CY 2022, MD admissions had higher comorbidities than national admissions (or 2020 admissions), which accounts for the higher unadjusted readmission rate. Again the HSCRC staff appreciate the collaboration with CMMI on developing a risk-adjusted readmission rate for comparing Maryland to the nation.

**Figure 3: Odds Ratio for Risk-Adjusted Readmission Rates for Maryland vs. Nation**



<sup>16</sup> The Elixhauser Comorbidity Index has ICD-9 and ICD-10 versions with different comorbidity flags. Staff tested using the actual version that corresponded with the time period and using the comorbidity flags that were common across both versions. The results did not meaningfully differ, so the results presented here use the common flags.



maryland  
**health services**  
cost review commission

---

## Update on Hospital Financial Condition for FY23

February 2024

# Background

## Sources

- Hospital Financial Statements
  - HSCRC receives annual audited system-level financial information
- HSCRC Annual Cost Report
  - HSCRC receives annual hospital level information.
  - This information is reconciled to the system level financials and is subject to certain special audit procedures although it is not itself audited, and there may be some fluidity in terms of how costs are allocated between entities.

## Entity Terminology

- + Hospital Regulated Business
- + Hospital Unregulated Business
- = Hospital Regulated Entity Results
  
- + Non-Regulated Business
- = Health System Results<sup>1</sup>

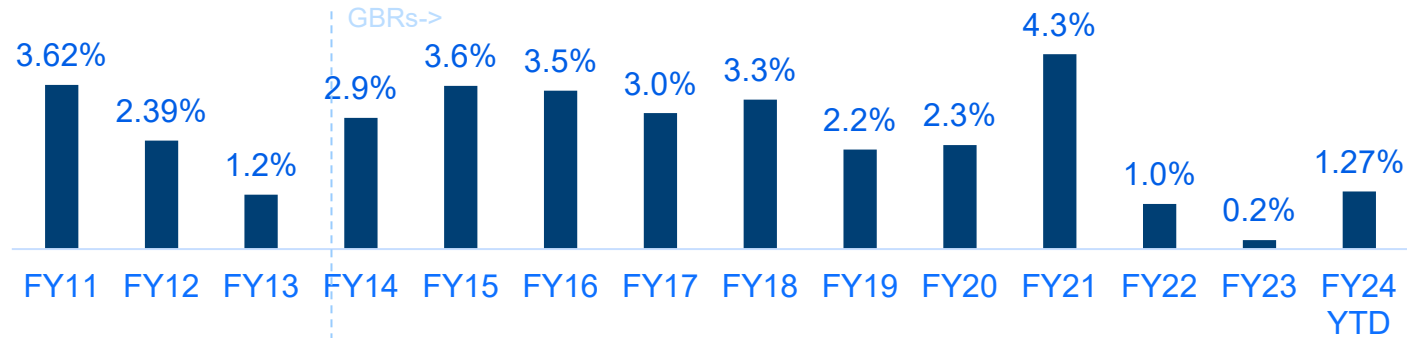
1. Because for some systems results include material non-Maryland entities that swamp the significance of the Maryland entity, system reporting in most HSCRC presentations focuses on systems that are primarily domiciled in Maryland.

# FY23 Hospital Regulated Entity Results

# Hospital Margins FY2014 to FY2024

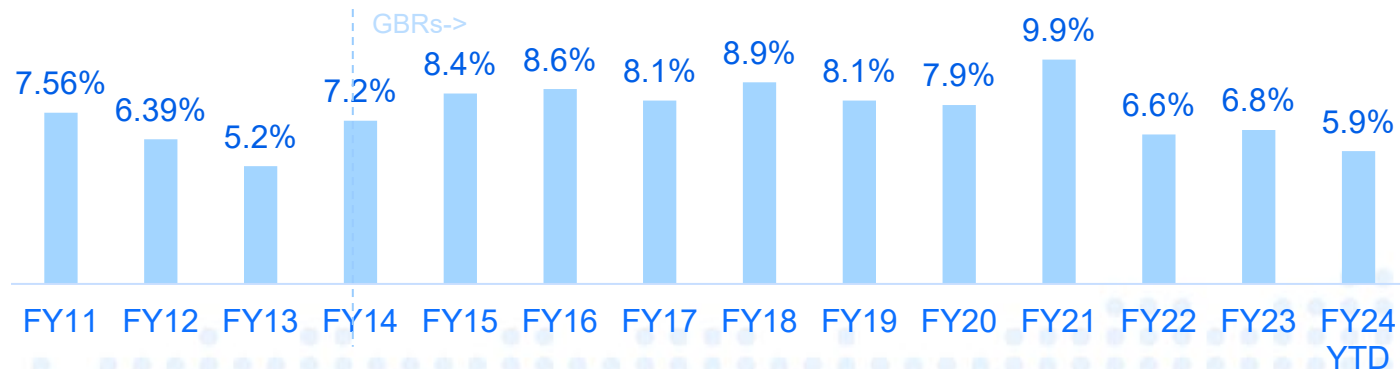
## Total Operating Margin

(Represents margin on the entities regulated by HSCRC, also includes unregulated business that is organized as part of the regulated entities)



## Regulated Operating Margin

(Represents margin on services regulated by HSCRC)



- FY23 margins are the worst of any year. FY21 was the best year. FY24 YTD unaudited margins are stronger compared to the same period in FY23
- Margins for HSCRC regulated business are strong in all periods
- Unregulated costs, particularly physician costs, pull total margins down.
- Even in the weakest years total margins have remained positive.

Source: All years except FY24 per Hospital Annual Filings. FY24YTD from unaudited monthly reports through December 2023. Data for Adventist, Garrett, and Western MD from prior year

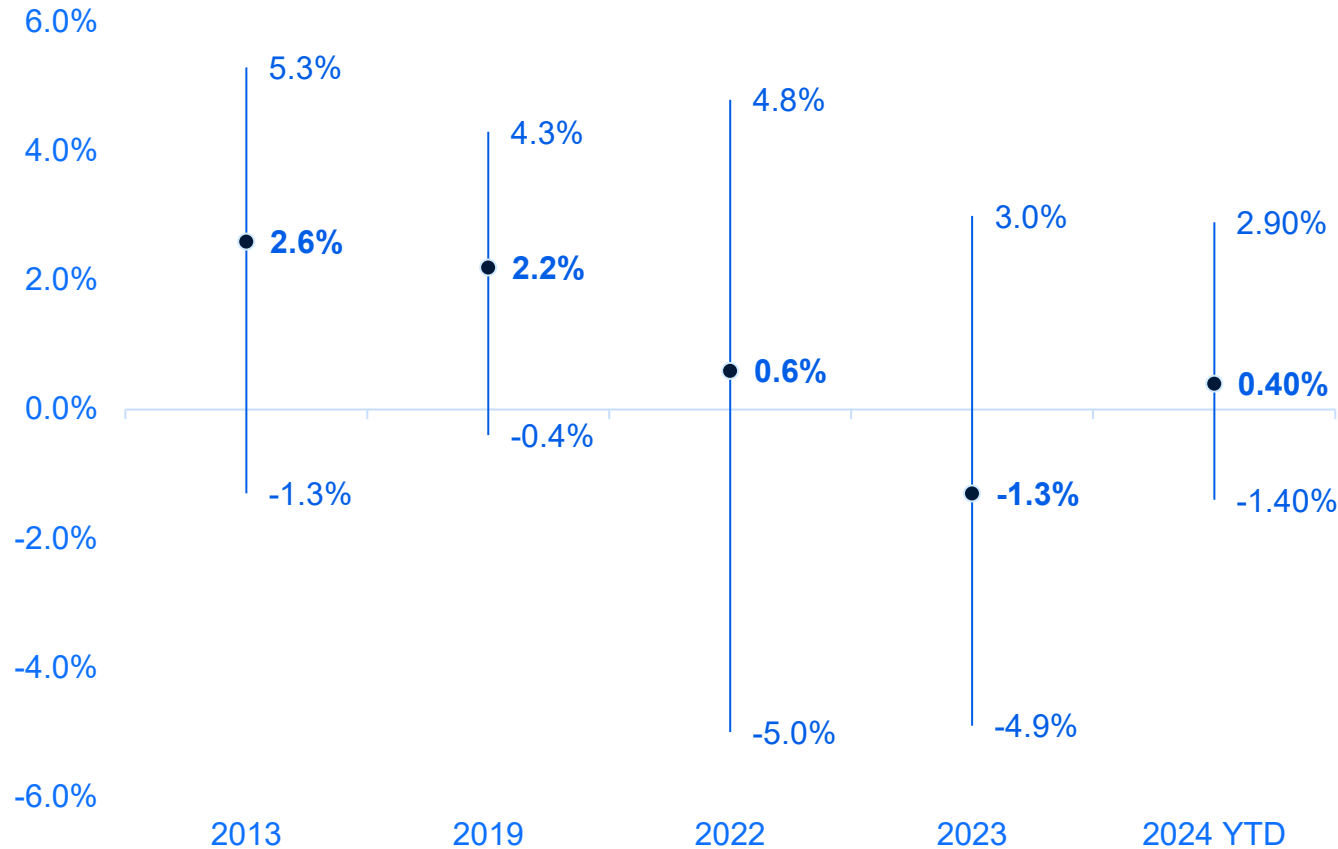
## GBRs contribute to stable hospital finances

	Total Operating Margin	Regulated Operating Margin
Last 2.5 Years	0.7%	6.5%
Last 4.5 Years	1.8%	7.6%
Under GBRs	2.5%	7.9%

- In the most recent period, with the weakest regulated and total margins, average margins remain positive.
- The Model is intended to generate long-term stability.
- Hospital margins have been stable under GBRs.
- FY22 and FY23 margins were weak. HSCRC is seeing some recovery in the first half of FY24.



# Distribution of Hospital Margins (Total Operating Margin)



- Graph shows median (circle) and 25<sup>th</sup> to 75<sup>th</sup> percentile (line) margin % by hospital for selected years.
- Only hospitals at or below the 25<sup>th</sup> percentile were losing money both in 2013 (pre-GBR) and 2019.
- In the most recent years a significant group of hospitals are losing money although the overall median remains around break even.
- Hospitals have several avenues to pursue with the HSCRC if losses become unsustainable.

# FY23 Audited Health System Financial Results (Maryland Domiciled Systems)

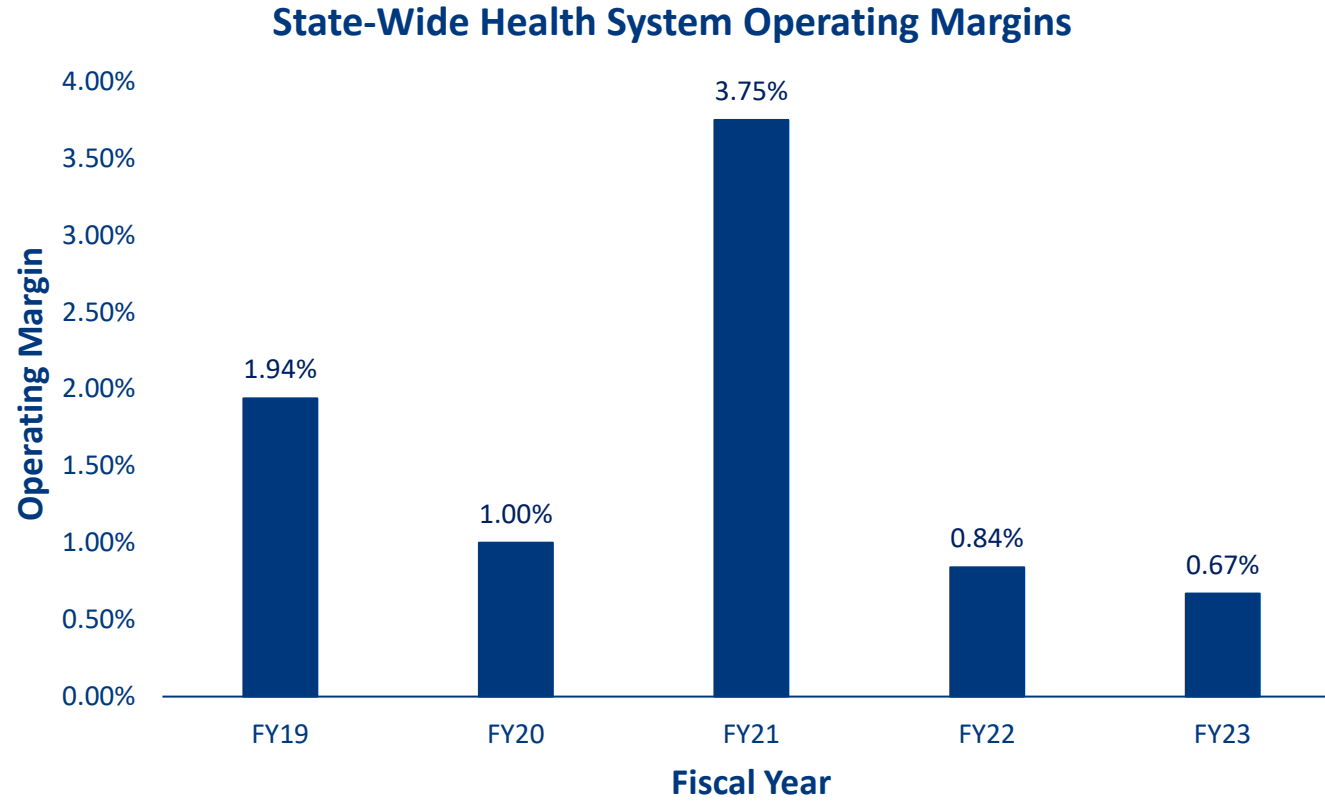
# FY23 System Profits

Health Systems	Total Operating Revenue	Total Operating Expenses	Operating Income	Operating Margin	Non-Operating Revenue	Total Margin
Adventist HealthCare, Inc. and Controlled Entities	\$ 1,151,582,000	\$ 1,150,316,000	\$ 1,266,000	0.11%	\$ (14,823,000)	-1.19%
Atlantic General Hospital Corporation	\$ 156,736,619	\$ 166,422,837	\$ (9,686,218)	-6.18%	\$ 5,662,150	-2.48%
Calvert Health System, Inc. and Subsidiaries	\$ 173,402,861	\$ 187,128,272	\$ (13,725,411)	-7.92%	\$ 9,857,105	-2.11%
Frederick Regional Health System, Inc.	\$ 492,539,000	\$ 522,902,000	\$ (30,363,000)	-6.16%	\$ 22,884,000	-1.45%
GMBC Healthcare, Inc. and Subsidiaries	\$ 680,178,000	\$ 724,236,000	\$ (44,058,000)	-6.48%	\$ 20,693,000	-3.33%
Johns Hopkins Health System Corporation and Affiliates	\$ 8,572,732,000	\$ 8,395,905,000	\$ 176,827,000	2.06%	\$ 307,976,000	5.46%
LifeBridge Health, Inc. and Subsidiaries	\$ 1,981,634,000	\$ 2,003,717,000	\$ (22,083,000)	-1.11%	\$ 78,342,000	2.73%
Luminis Health, Inc. and Subsidiaries	\$ 1,107,955,000	\$ 1,160,963,000	\$ (53,008,000)	-4.78%	\$ 49,110,000	-0.34%
Medstar Health, Inc.	\$ 7,737,000,000	\$ 7,590,200,000	\$ 146,800,000	1.90%	\$ 186,100,000	4.20%
Mercy Health Services, Inc. and Subsidiaries	\$ 937,275,000	\$ 890,511,000	\$ 46,764,000	4.99%	\$ 31,918,000	8.12%
Meritus Medical Center, Inc. and Subsidiaries	\$ 555,495,000	\$ 520,936,000	\$ 34,559,000	6.22%	\$ 24,914,000	10.25%
TidalHealth, Inc.	\$ 795,570,000	\$ 848,882,000	\$ (53,312,000)	-6.70%	\$ 42,062,000	-1.34%
University of Maryland Medical System Corporation and Subsidiaries	\$ 5,068,600,000	\$ 5,050,786,000	\$ 17,814,000	0.35%	\$ 143,479,000	3.09%
<b>2023 Totals</b>	<b>\$ 29,410,699,480</b>	<b>\$ 29,212,905,109</b>	<b>\$ 197,794,371</b>	<b>0.67%</b>	<b>\$ 908,174,255</b>	<b>3.65%</b>
<b>2022 Totals</b>	<b>\$ 28,208,464,083</b>	<b>\$ 27,972,248,891</b>	<b>\$ 236,215,192</b>	<b>0.84%</b>	<b>\$ (711,317,420)</b>	<b>-1.73%</b>

\*Trinity, Ascension, Garrett, Christiana Union, and Western Maryland have been excluded as system level financials are not primarily reflective of Maryland institutions

Adventist data is FY22

# Operating Margins



# FY23 System and Regulated Business Margins

## FY23 Health System Margins

## FY23 Regulated Entity Margins

Health Systems	Total Operating Revenue	Operating Income	Operating Margin	Regulated Entity Total Operating Revenue	Regulated Entity Operating Income	Regulated Entity Operating Margin	% of Regulated Business	System Non-Regulated Operating Margin
Adventist HealthCare, Inc. and Controlled Entities	\$ 1,151,582,000	\$ 1,266,000	0.11%	\$ 844,413,000	\$ 50,554,000	6.0%	73.33%	-16.05%
Atlantic General Hospital Corporation	\$ 156,736,619	\$ (9,686,218)	-6.18%	\$ 156,736,619	\$ (9,686,218)	-6.2%	100.00%	0.00%
Calvert Health System, Inc. and Subsidiaries	\$ 173,402,861	\$ (13,725,411)	-7.92%	\$ 153,952,602	\$ (7,406,989)	-4.8%	88.78%	-32.49%
Frederick Regional Health System, Inc.	\$ 492,539,000	\$ (30,363,000)	-6.16%	\$ 403,863,000	\$ (8,014,000)	-2.0%	82.00%	-25.20%
GBMC Healthcare, Inc. and Subsidiaries	\$ 680,178,000	\$ (44,058,000)	-6.48%	\$ 582,304,000	\$ (16,926,000)	-2.9%	85.61%	-27.72%
Johns Hopkins Health System Corporation and Affiliates	\$ 8,572,732,000	\$ 176,827,000	2.06%	\$ 4,603,074,000	\$ 53,504,000	1.2%	53.69%	3.11%
Lifebridge Health, Inc. and Subsidiaries	\$ 1,981,634,000	\$ (22,083,000)	-1.11%	\$ 1,660,216,000	\$ (431,000)	0.0%	83.78%	-6.74%
Luminis Health System, Inc. and Subsidiaries	\$ 1,107,955,000	\$ (53,008,000)	-4.78%	\$ 863,377,000	\$ (20,188,000)	-2.3%	77.93%	-13.42%
Medstar Health, Inc.	\$ 7,737,000,000	\$ 146,800,000	1.90%	\$ 2,147,800,000	\$ (60,600,000)	-2.8%	27.76%	3.71%
Mercy Health Services, Inc. and Subsidiaries	\$ 937,275,000	\$ 46,764,000	4.99%	\$ 602,479,000	\$ 37,139,000	6.2%	64.28%	2.87%
Meritus Medical Center, Inc. and Subsidiaries	\$ 555,495,000	\$ 34,559,000	6.22%	\$ 449,545,000	\$ 59,473,000	13.2%	80.93%	-23.51%
TidalHealth, Inc.	\$ 795,570,000	\$ (53,312,000)	-6.70%	\$ 500,360,000	\$ 10,905,000	2.2%	62.89%	-21.75%
University of Maryland Medical System Corporation and Subsidiaries	\$ 5,068,600,000	\$ 17,814,000	0.35%	\$ 4,668,131,000	\$ 18,244,000	0.4%	92.10%	-0.11%
<b>2023 Totals</b>	<b>\$ 29,410,699,480</b>	<b>\$ 197,794,371</b>	<b>0.67%</b>	<b>\$ 17,636,251,221</b>	<b>\$ 106,566,793</b>	<b>0.60%</b>	<b>59.97%</b>	<b>0.77%</b>
<b>2022 Totals</b>	<b>\$ 28,208,464,083</b>	<b>\$ 236,215,192</b>	<b>0.84%</b>	<b>\$ 17,190,427,422</b>	<b>\$ 184,631,212</b>	<b>1.07%</b>	<b>60.94%</b>	<b>0.47%</b>

\*Trinity, Ascension, Garrett, Christiana Union, and Western Maryland have been excluded as system level financials are not primarily reflective of Maryland institutions

Adventist data is FY22

# Health System Cash and Investment Holdings

Health Systems	2022	2023
Adventist HealthCare, Inc.**	\$ 291,755,000	\$ 312,131,000
Atlantic General Hospital Corporation	\$ 36,706,309	\$ 36,306,826
Calvert Health System, Inc. and Subsidiaries	\$ 137,541,063	\$ 128,310,556
Frederick Regional Health System, Inc.	\$ 204,079,000	\$ 208,434,000
GBMC Healthcare, Inc. and Subsidiaries	\$ 426,404,000	\$ 378,502,000
Johns Hopkins Health System Corporation and Affiliates	\$ 4,761,469,000	\$ 5,287,752,000
LifEBridge Health, Inc. and Subsidiaries	\$ 1,202,422,000	\$ 1,163,986,000
Luminis Health System, Inc. and Subsidiaries	\$ 475,189,000	\$ 479,476,000
Medstar Health, Inc.	\$ 2,555,000,000	\$ 2,793,800,000
Mercy Health Services, Inc. and Subsidiaries	\$ 477,669,000	\$ 553,673,000
Meritus Medical Center, Inc. and Subsidiaries	\$ 365,216,000	\$ 403,785,000
TitalHealth, Inc.	\$ 459,837,000	\$ 453,671,000
University of Maryland Medical System Corporation and Subsidiaries	\$ 1,622,629,000	\$ 1,795,683,000
<b>Available Cash and Investments</b>	<b>\$13,015,916,372</b>	<b>\$13,995,510,382</b>
<b>Cash held under advanced payment and other programs</b>	<b>\$ 806,675,327</b>	<b>\$ 0</b>
<b>Totals</b>	<b>\$13,822,591,699</b>	<b>\$13,995,510,382</b>
<b>Days Cash on Hand</b>	<b>177</b>	<b>182</b>

- June 2022 and June 2023 balances shown.
- Investments include board-designated funds but exclude other restricted investments.

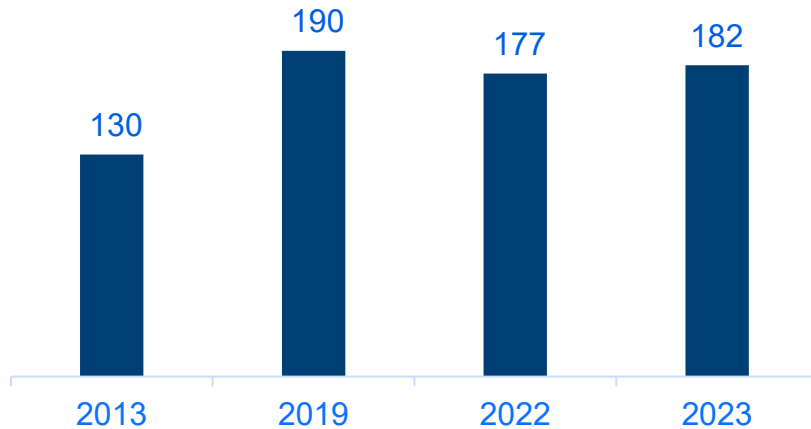
\*Trinity, Ascension, Garrett, ChristianaCare Union of Cecil and Western Maryland have been excluded as system level financials are not primarily reflective of Maryland institutions

\*\*Adventist balances are as of December 2022 and December 2021.

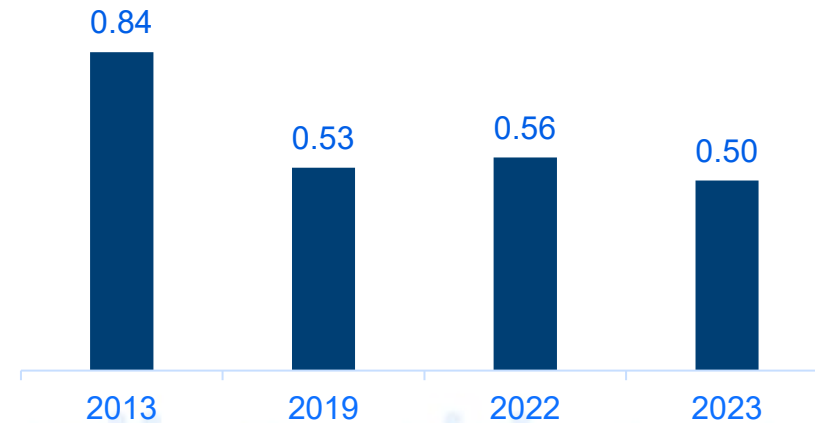
# Balance Sheet Ratios, GBR Period

- Days Cash on Hand have increased by 41% under GBRs despite recent challenges. Days cash on hand is, by definition, an inflation adjusted measure.
- Days Cash on Hand are still below their 2019 peak but have begun increasing again. Declines from 2019 were due to cost pressures during 2022. Federal and State funding eliminated any negative effects from the COVID pandemic through June 2021.
- While strengthening their cash positions, hospitals have also been able to pay down debt under GBRs resulting in lower debt ratios.
- Debt ratios have dropped below 2019 levels and remain 40% below June 2013 levels.

Days Cash on Hand



Debt to Unrestricted Net Assets



Source: Metrics are shown as of June 2013 (pre-GBR), June 2019 (pre-pandemic), June 2022 (post-pandemic), and June 2023 (most recent period available) and are based on Hospital Audited Financial Statements. Amounts are system-level not regulated entity balances, and generally reflect cash, and short and long-term investments, excluding Medicare advances and investments with donor or other restrictions but including board-designated funds. Excludes primarily non-Maryland domiciled systems: WMHS, Garrett ChristianaCare Union, Ascension and Trinity. Adventist data is as of December 31, 2022.



# Appendix

---



# Days Cash on Hand by System, Maryland Domiciled Systems

	<u>2013</u>	<u>2019</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2023 vs 2013</u>	<u>2023 vs 2019</u>	<u>2023 vs 2022</u>
Mercy Health Services, Inc.	137	173	247	215	239	74.4%	37.6%	11.2%
Calvert Health System, Inc.	258	314	351	314	265	2.7%	-15.5%	-15.5%
Meritus Medical Center, Inc.	138	242	331	294	300	116.8%	23.9%	2.1%
Peninsula Regional Health System	226	319	305	217	205	-9.6%	-35.8%	-5.8%
Atlantic General Hospital Corporation	90	60	88	92	84	-6.7%	39.5%	-8.9%
Johns Hopkins Health System Corporation	109	247	272	226	238	117.9%	-3.5%	5.3%
Lifebridge Health, Inc.	179	245	289	247	223	24.6%	-8.9%	-9.8%
Medstar Health, Inc.	128	146	174	134	138	8.2%	-4.9%	3.6%
University of Maryland Medical System Corporat	118	129	143	128	137	16.6%	6.2%	7.3%
Frederick Regional Health System, Inc.	165	197	202	153	148	-10.5%	-24.9%	-3.3%
Luminis Health System, Inc.	155	182	209	151	156	0.4%	-14.2%	3.0%
GBMC healthcare, Inc.	143	245	302	236	201	40.2%	-18.2%	-15.0%
Adventist HealthCare, Inc. (1)	97	115	123	97	105	8.4%	-9.0%	7.5%
Statewide	130	190	217	177	182	40.6%	-4.3%	2.7%
Median	138	197	247	215	201	45.1%	2.1%	-6.4%
Total Cash (in billions)	\$5.9	\$11.3	\$14.6	\$13.0	\$14.0			

- Total cash and investments is up to \$14.0 B versus pre-GBR value of \$5.9 B.
- Average is a 41% increase in days-cash-on-hand since 2013. Median is 45%.
- While System days on hand is down since 2019 only 2 hospitals are in a materially worse position than in 2013, most are significantly better off.
- Some declines should be expected during a period of challenging operations or else there would be no need to accumulate reserve funds.

Source: Metrics are shown as of June 2013 (pre-GBR), June 2019 (pre-pandemic) June 2022 (post-pandemic), and June 2023 (most recent period available) and come from Hospital Audited Financial Statements. Amounts are system-level not regulated entity balances, and generally reflect cash, and short and long-term investments, excluding Medicare advances and investments with donor or other restrictions but including board-designated funds. Excludes primarily non-Maryland domiciled systems: WMHS, ChristianaCare Union, Garrett, Ascension and Trinity. Adventist data is as of December 31, 2022.

## Debt to Unrestricted Net Asset Ratios, Maryland Domiciled Systems

	<u>2013</u>	<u>2019</u>	<u>2021</u>	<u>2022</u>	<u>2023</u>	<u>2023 vs 2013</u>	<u>2023 vs 2019</u>	<u>2023 vs 2022</u>
Mercy Health Services, Inc.	1.51	0.89	0.67	0.65	0.55	-63.4%	-38.1%	-14.6%
Calvert Health System, Inc.	0.52	0.37	0.26	0.27	0.26	-49.6%	-27.7%	-0.8%
Meritus Medical Center, Inc.	1.18	0.90	0.62	0.82	0.69	-41.5%	-23.0%	-15.8%
Peninsula Regional Health System	0.38	0.26	0.32	0.37	0.37	-4.9%	41.9%	-2.3%
Atlantic General Hospital Corporation	0.79	0.74	0.67	0.63	0.64	-18.5%	-13.7%	1.9%
Johns Hopkins Health System Corporation	0.48	0.52	0.37	0.36	0.30	-36.1%	-40.9%	-16.5%
Lifebridge Health, Inc.	0.76	0.46	0.42	0.49	0.44	-42.7%	-6.2%	-10.3%
Medstar Health, Inc.	1.24	0.90	0.67	0.67	0.57	-53.9%	-36.9%	-15.4%
University of Maryland Medical System Corporat	1.25	0.94	0.69	0.66	0.61	-50.9%	-35.1%	-7.7%
Frederick Regional Health System, Inc.	1.01	0.69	0.65	0.69	0.84	-16.9%	21.3%	20.6%
Luminis Health System, Inc.	1.37	0.77	0.72	0.78	0.74	-46.2%	-3.7%	-5.6%
GBMC healthcare, Inc.	0.50	0.29	0.21	0.41	0.42	-15.4%	43.5%	3.2%
Adventist HealthCare, Inc. (1)	0.85	1.31	1.10	1.37	1.42	67.4%	8.7%	4.0%
Statewide	0.84	0.68	0.53	0.56	0.50	-40.1%	-26.4%	-10.4%
Median	0.85	0.74	0.65	0.65	0.57	-33.0%	-23.3%	-11.9%

- Statewide ratio has improved by 40% and median by 33% since 2013 and 26% and 23% since 2019.
- All systems but 1 are in a stronger position than in 2013. Most by a significant percentage.

Source: Metrics are shown as of June 2013 (pre-GBR), June 2019 (pre-pandemic), June 2022 (pre-pandemic) and June 2023 (most recent period available) and come from Hospital Audited Financial Statements. Amounts are system-level not regulated entity balances. Excludes primarily non-Maryland domiciled systems: WMHS, Garrett, ChristianaCare Union, Ascension and Trinity. Adventist data is as of December 31, 2022.



maryland  
**health services**  
cost review commission

---

## AHEAD Model Update

February 14, 2024

## Progress Update

- The State submitted a Letter of Intent (LOI) on February 2, 2024 to participate in Cohort 1 of AHEAD.
- The State has formed three advisory committees to provide advice on the State's application.
  - Each advisory committee has met once and will meet a second time before the AHEAD application is submitted.
  - All meetings are open to the public.
  - Materials and recordings for each have been posted on the [HSCRC website](#).
- The State plans to submit an application to AHEAD on March 18, 2024.

# Technical Advisory Group Charges & Next Mtgs

- The **Healthcare Transformation Advisory Committee (H-TAC)** provides advice on all-payer cost targets, hospital quality improvement, and continued transformation of Maryland's healthcare delivery system.
  - Friday, February 16, 2024 – 1:00pm-3:00pm
- The **Population Health Transformation Advisory Committee (P-TAC)** provides advice to MDH and HSCRC to transform the state's approach to equity-centered population health improvement.
  - Monday, March 4, 2024 – 1:00pm-3:00pm
- The **Primary Care Program Transformation Advisory Committee (PCP-TAC)** provides advice on primary care spending targets and the future of a multi-payer aligned primary care program.
  - Friday, February 23, 2024 – 8:30am-10:30am



maryland  
**health services**  
cost review commission

---

# Update on Medicare FFS Data & Analysis

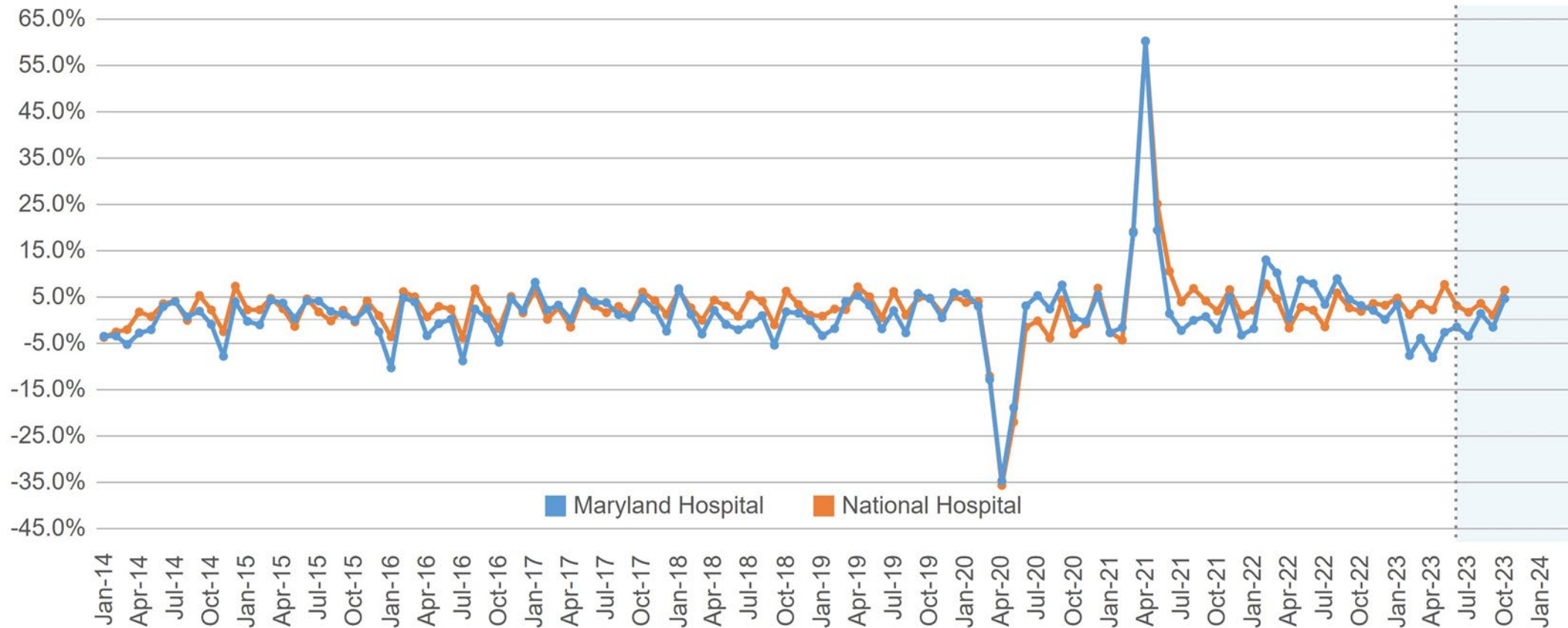
## February 2024 Update

Data through October 2023, Claims paid through December 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

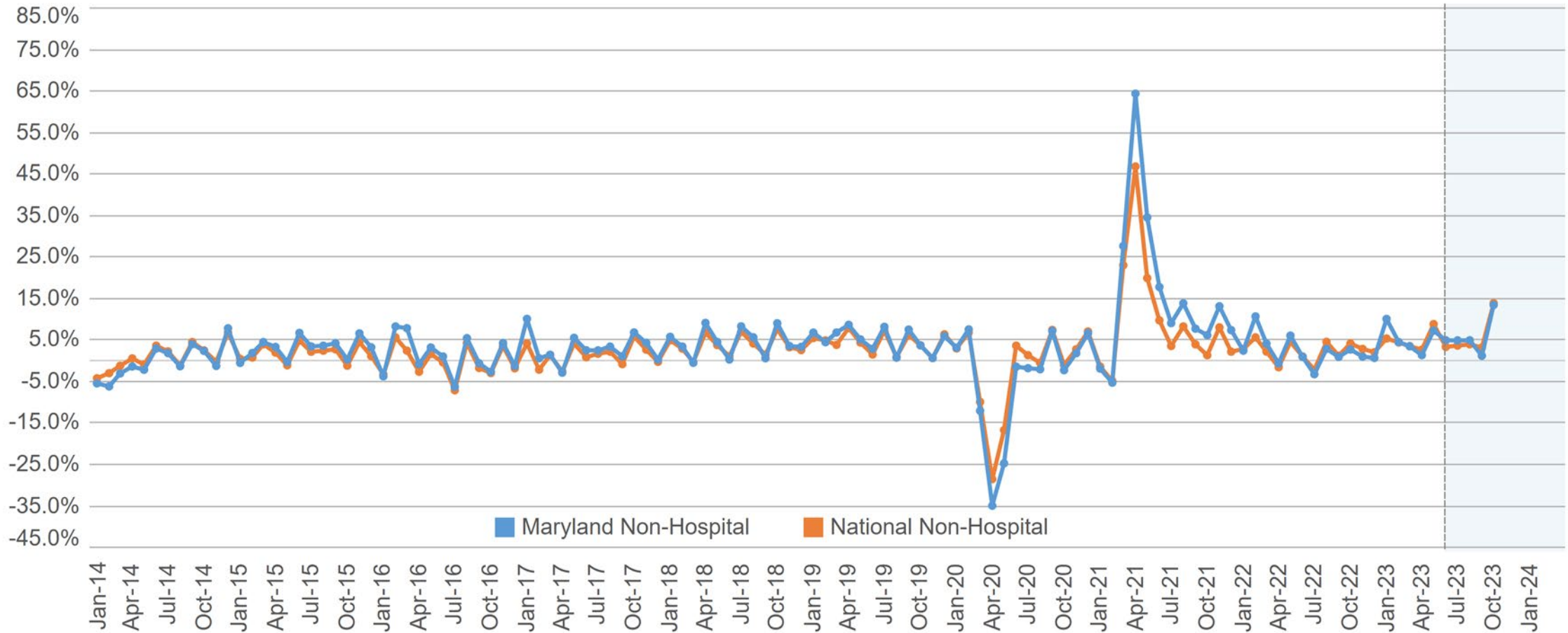
## Actual Growth Trend (CY month vs. Prior CY month)



CY16 has been adjusted for the undercharge.

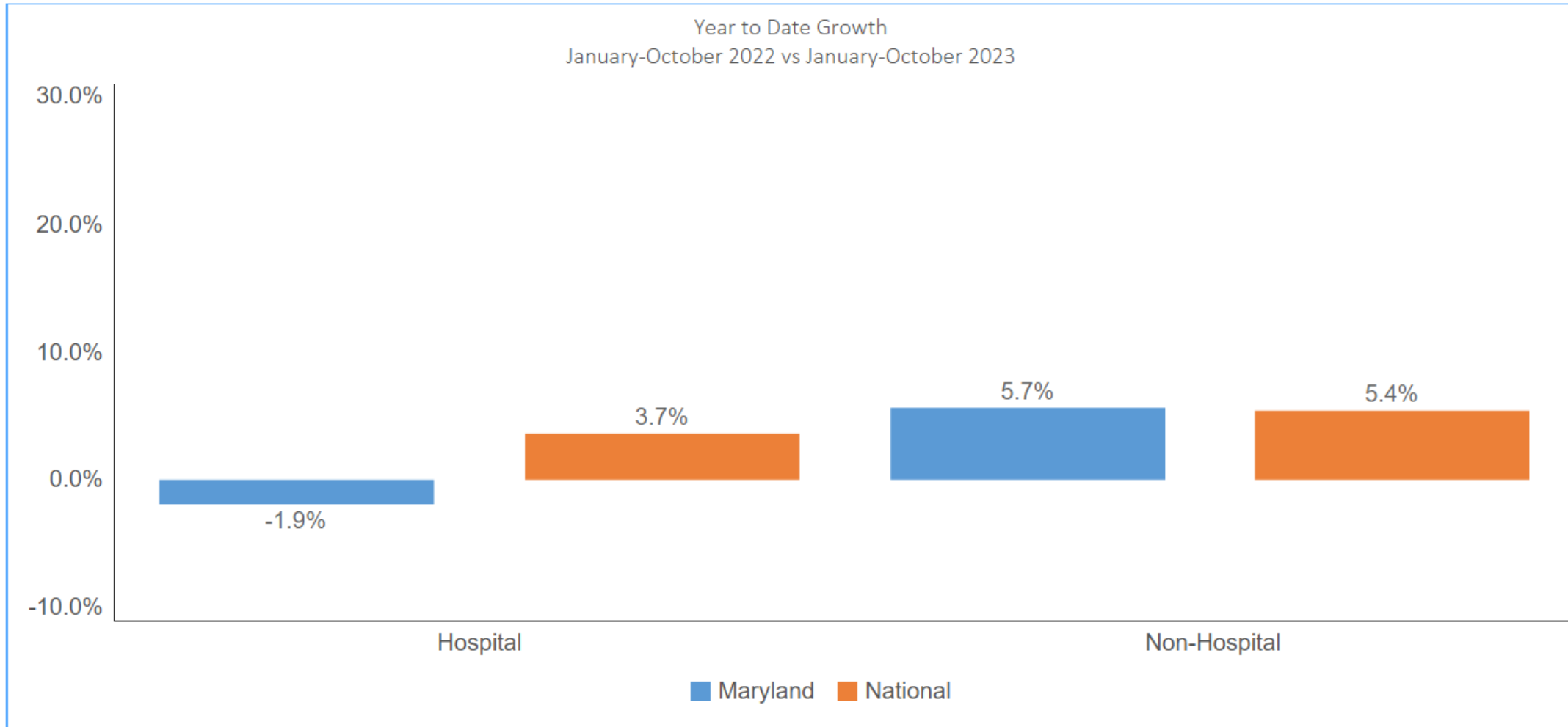
# Medicare Non-Hospital Spending per Capita

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



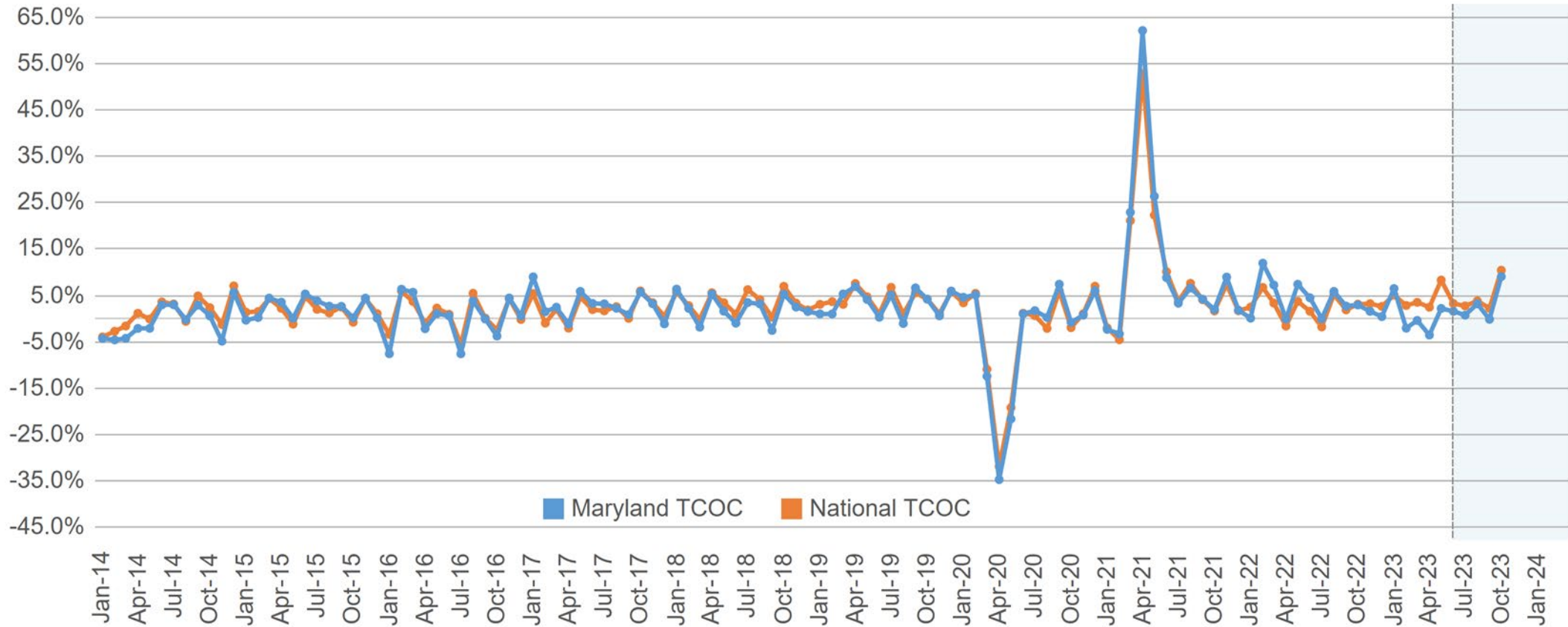


# Medicare Hospital and Non-Hospital Payments per Capita



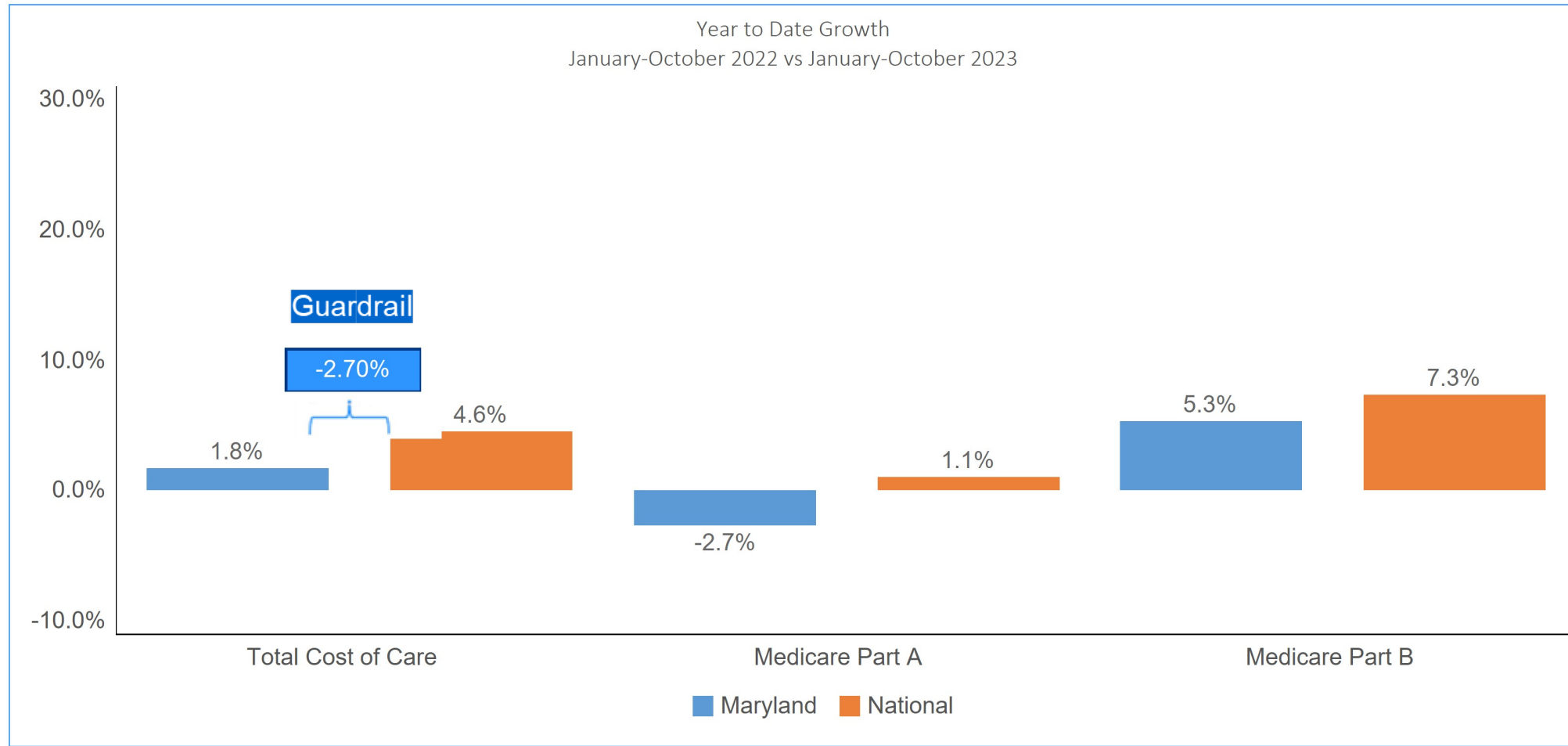
# Medicare Total Cost of Care Spending per Capita

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



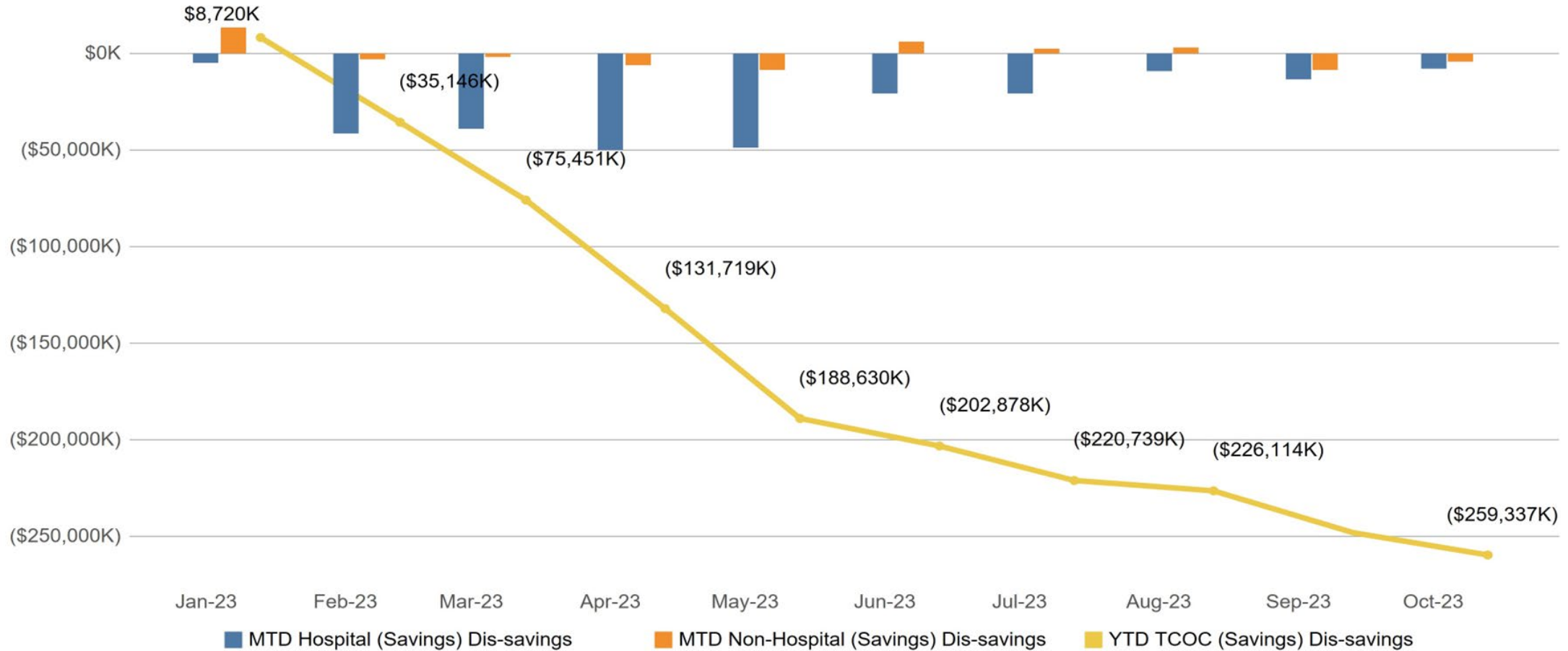
CY16 has been adjusted for the undercharge

# Medicare Total Cost of Care Payments per Capita



# Maryland Medicare Hospital & Non-Hospital Growth

## CYTD through October 2023





maryland  
**health services**  
cost review commission

---

Emergency Department Dramatic Improvement Effort (EDDIE)

February Commission Meeting

# ED Length of Stay and EMS Turnaround Data

- Monthly, unaudited data on ED length of stay for January 2024 was received from all hospitals
  - No distinct trends
  - Three hospitals show more than a 10 percent decrease in December compared to June, while 50 percent of hospitals that reported had greater than 10 percent increase in December compared to June.
    - Could reflect seasonality
- EMS turnaround time data shows minimal movement of hospitals across categories for January 2024, with three hospitals improving in performance and two hospitals declining in performance

See data in Appendix for graphs and data for all measures

# Staff Accomplishments

## QBR ED-1 Measure

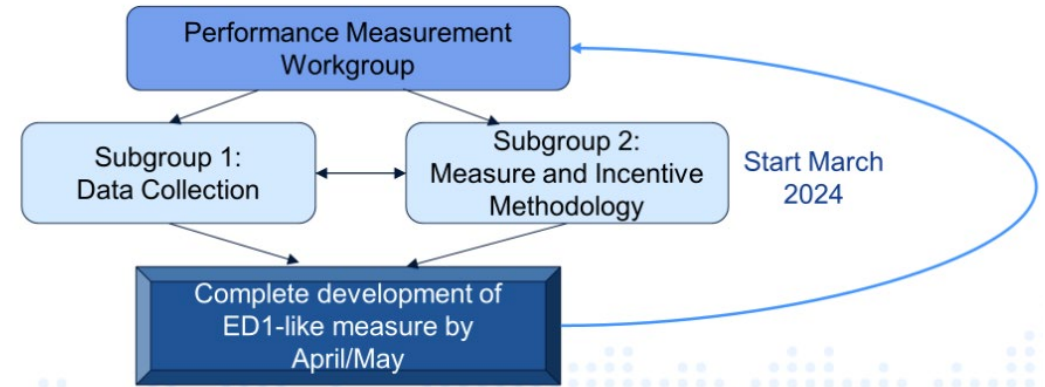
- Finalized membership and meeting schedule for subgroups
- Convened 1st subgroup on 2/1

Developed draft work plan for best practices subgroup (see next slide)

Presented on ED length of stay at Maryland's Health Finance and Management Association meeting

Finalized ED PAU MVP policy for Commission consideration

Reviewing legislation to address ED LOS concerns



# ED Best Practices Incentive Policy Development

Draft Work Plan  
Goals for  
Discussion/Feedback

## Objective:

- Develop a series of process, structural, and/or outcome measures that will address systematically longer ED length of stay (LOS) in the State.
- Will incentivize hospital best practices, alignment with EDDIE, and value based arrangements with non-hospital providers that will improve hospital throughput and by extension ED LOS.

## Description:

- Subgroup will advise on the development of 3-5 measures that will constitute a 1% revenue at risk program for CY 2025 performance.
- Workgroup will need to include those who are familiar with quality measurement, emergency department/hospital operations, non-hospital operations/policy (including home health, behavioral health, and skilled nursing facilities), and pay-for-performance/value-based payments.
- Will convene starting in March/April and should complete the task within 4-5 monthly subgroups.
- Monthly updates on progress will be provided to Commissioners as part of EDDIE presentations.



# Appendix

# EDDIE Overview

- Maryland has underperformed most other states on ED throughput measures since before the start of the All-Payer model
- EDDIE is a Commission-developed quality improvement initiative that began in June 2023 with two components:

## EDDIE: Improved ED Experience for Patients

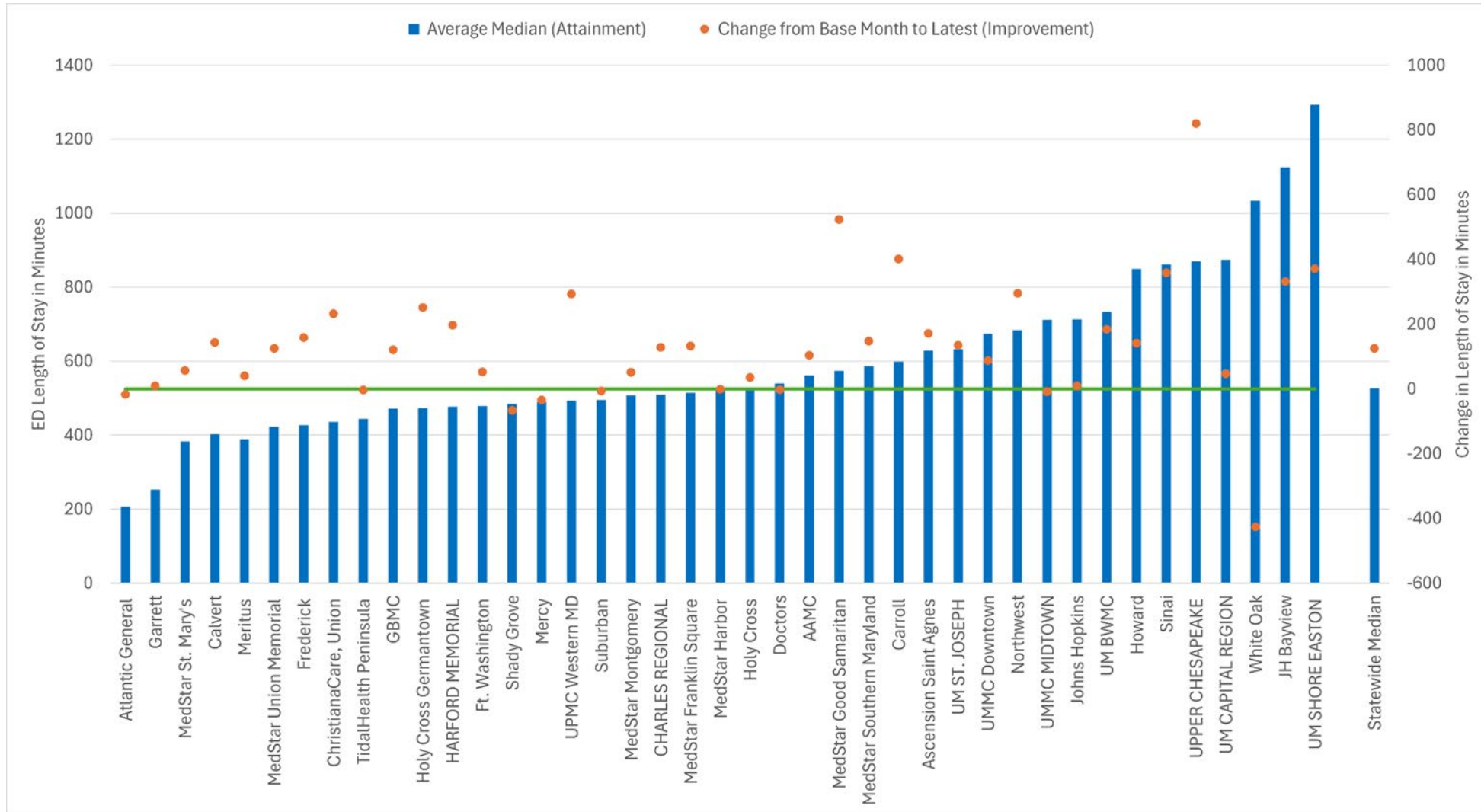
### Quality Improvement

- Rapid cycle QI initiatives to meet hospital set goals related to ED throughput/length of stay
- Learning collaborative
- Convened by MHA

### Commission Reporting

- Public reporting of monthly data for three measures
- Led by HSCRC and MIEMSS

# ED 1a: ED Arrival to Inpatient Admission



# January 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

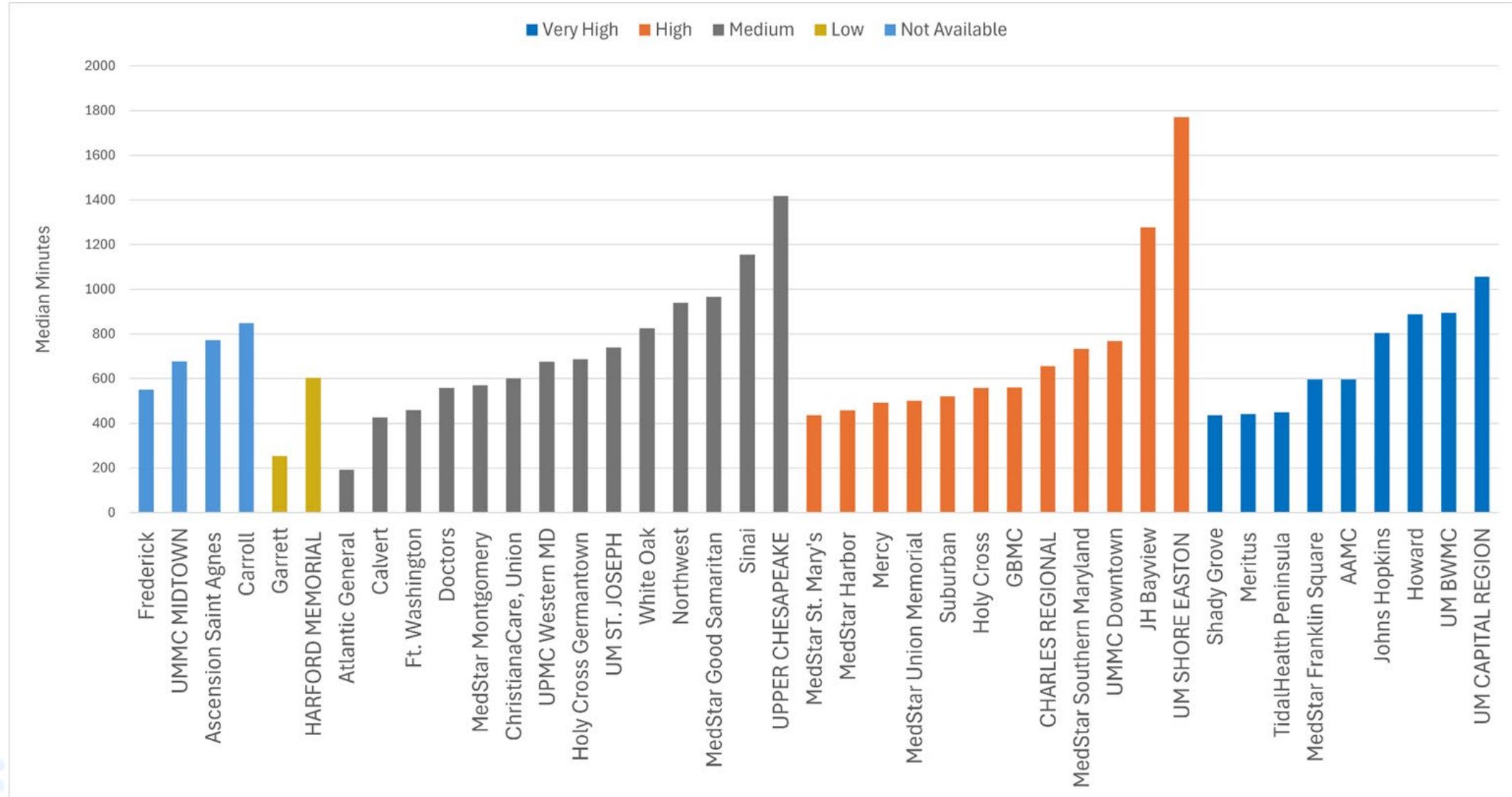
## January data received for all hospitals

- 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
- One health system asked for reporting extension

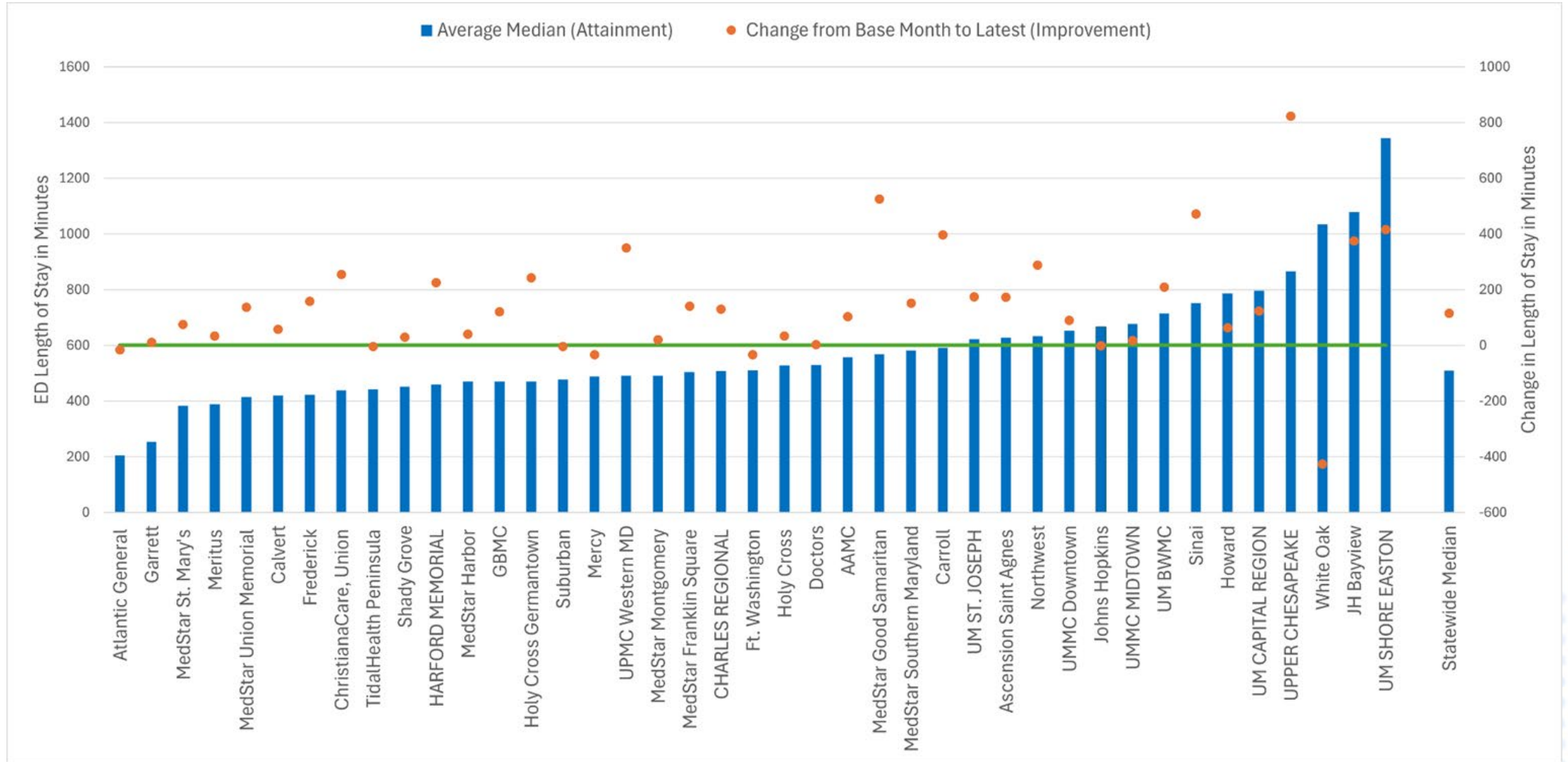
## Graphs:

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

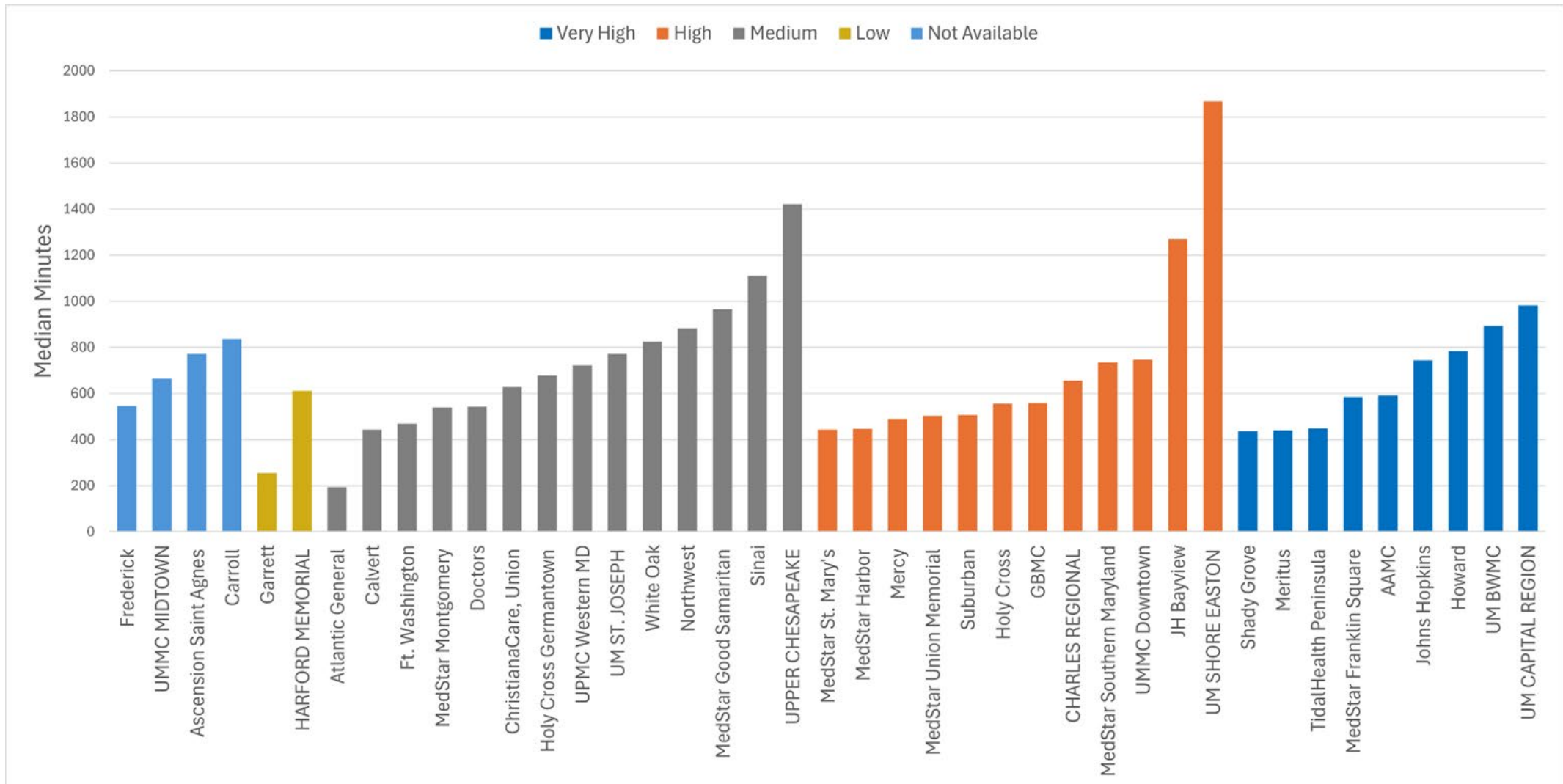
# ED 1a: ED Arrival to Inpatient Admission Time Latest Month Median By Volume--Latest Month



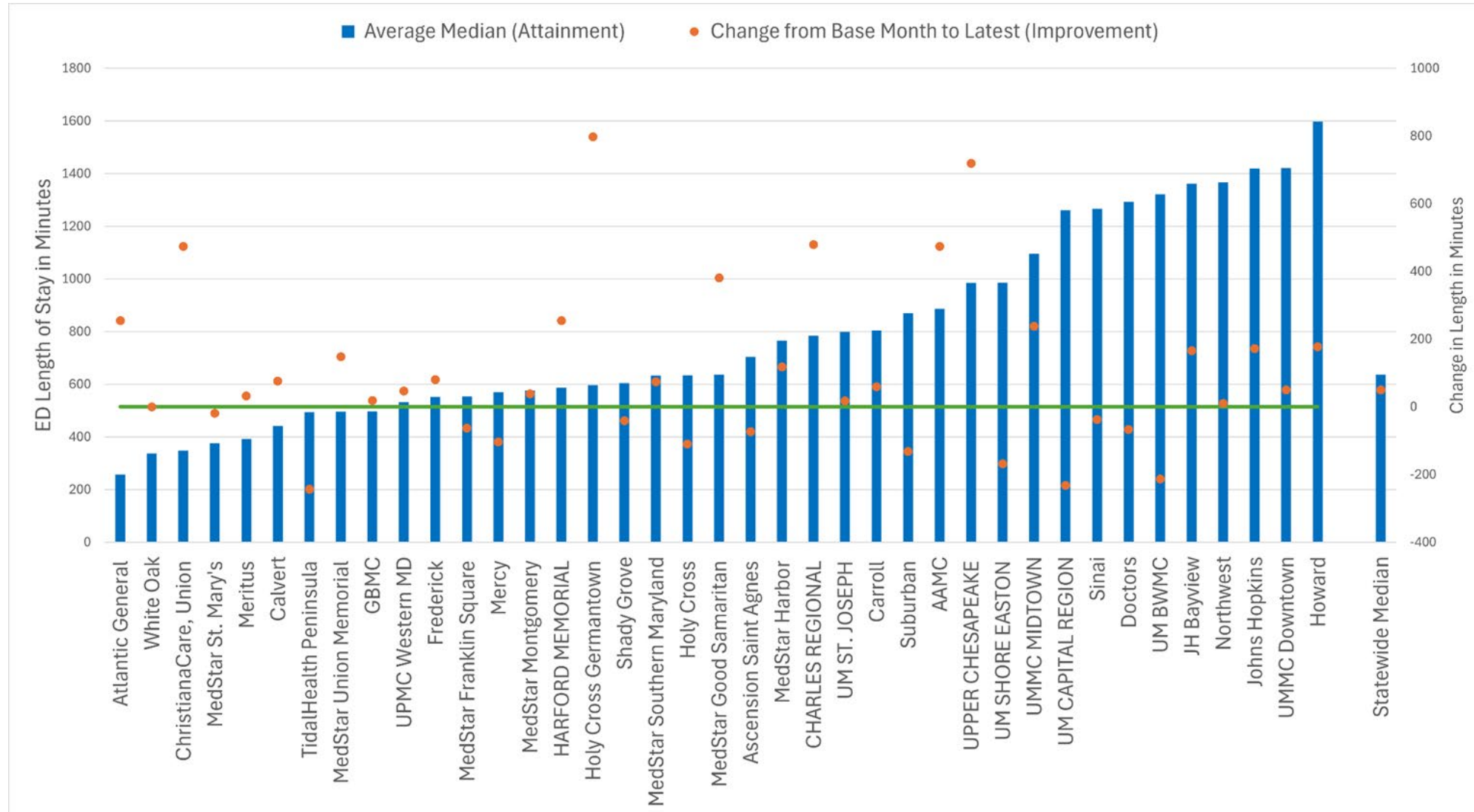
# ED 1b: ED Arrival to Inpatient Admission Time - Non-Psychiatric



# ED 1b: ED Arrival to Inpatient Admission Time by Volume Non-Psychiatric ED Visits

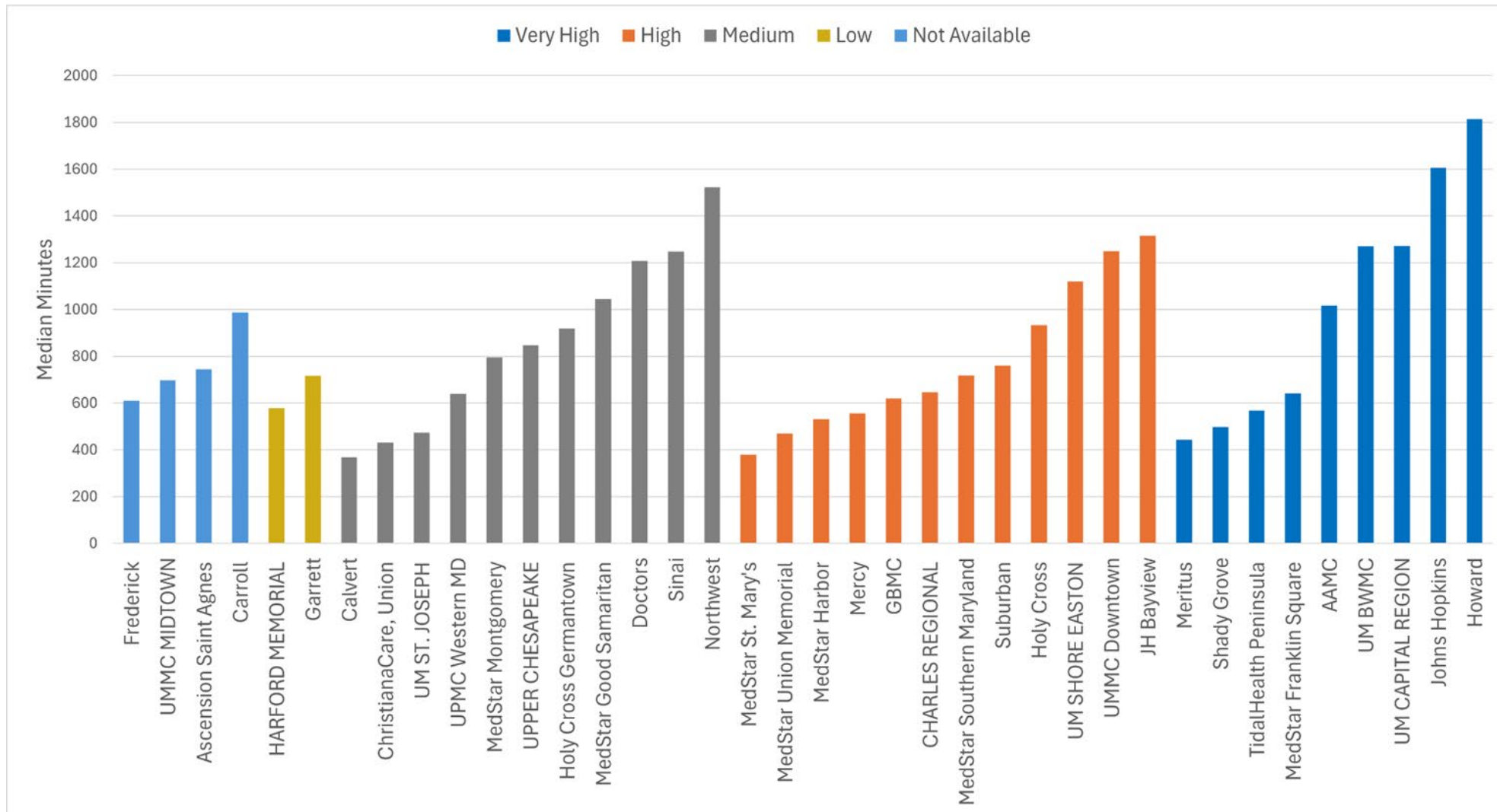


# ED 1c: ED Arrival to Inpatient Admission Time - Psychiatric

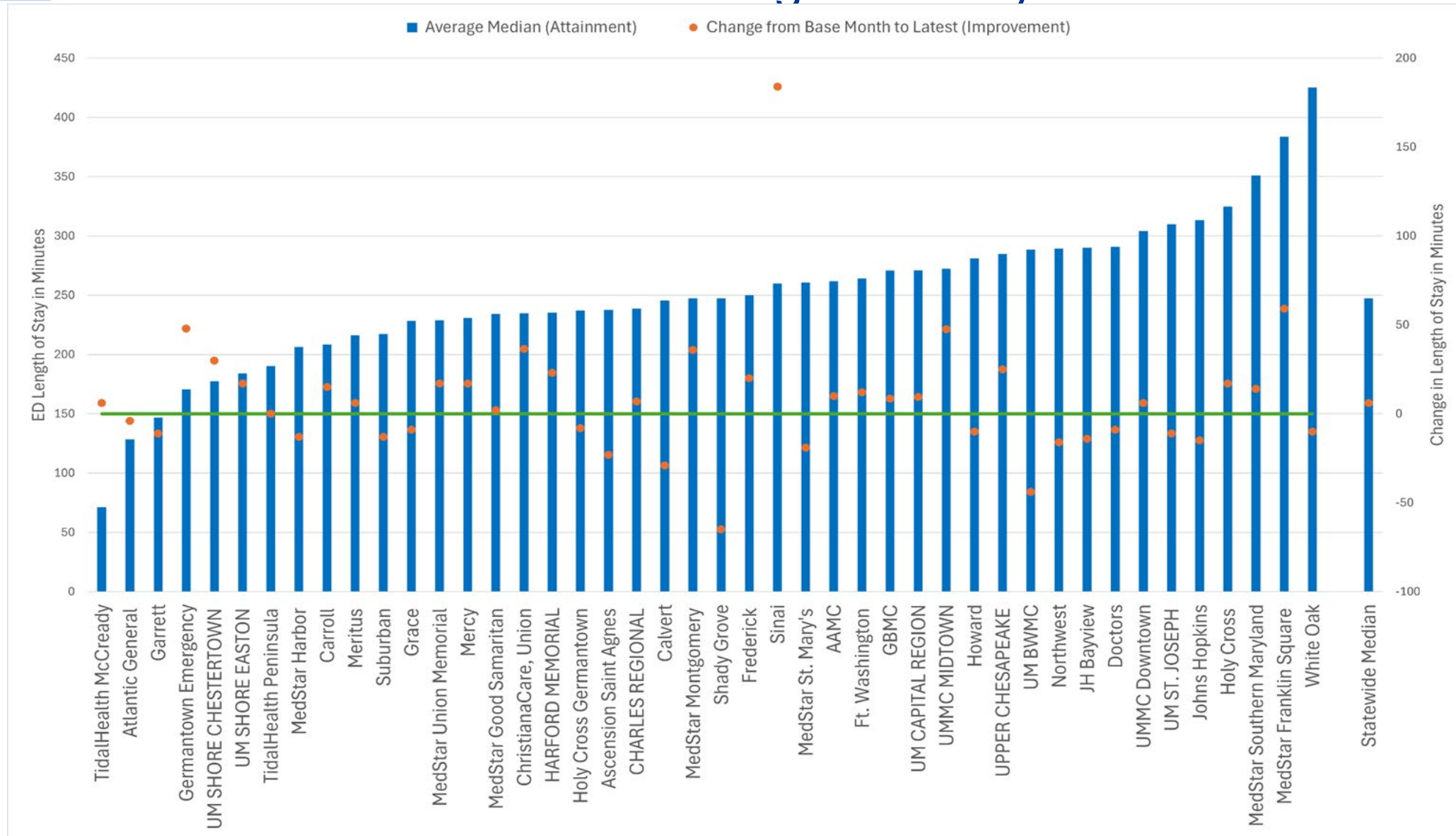




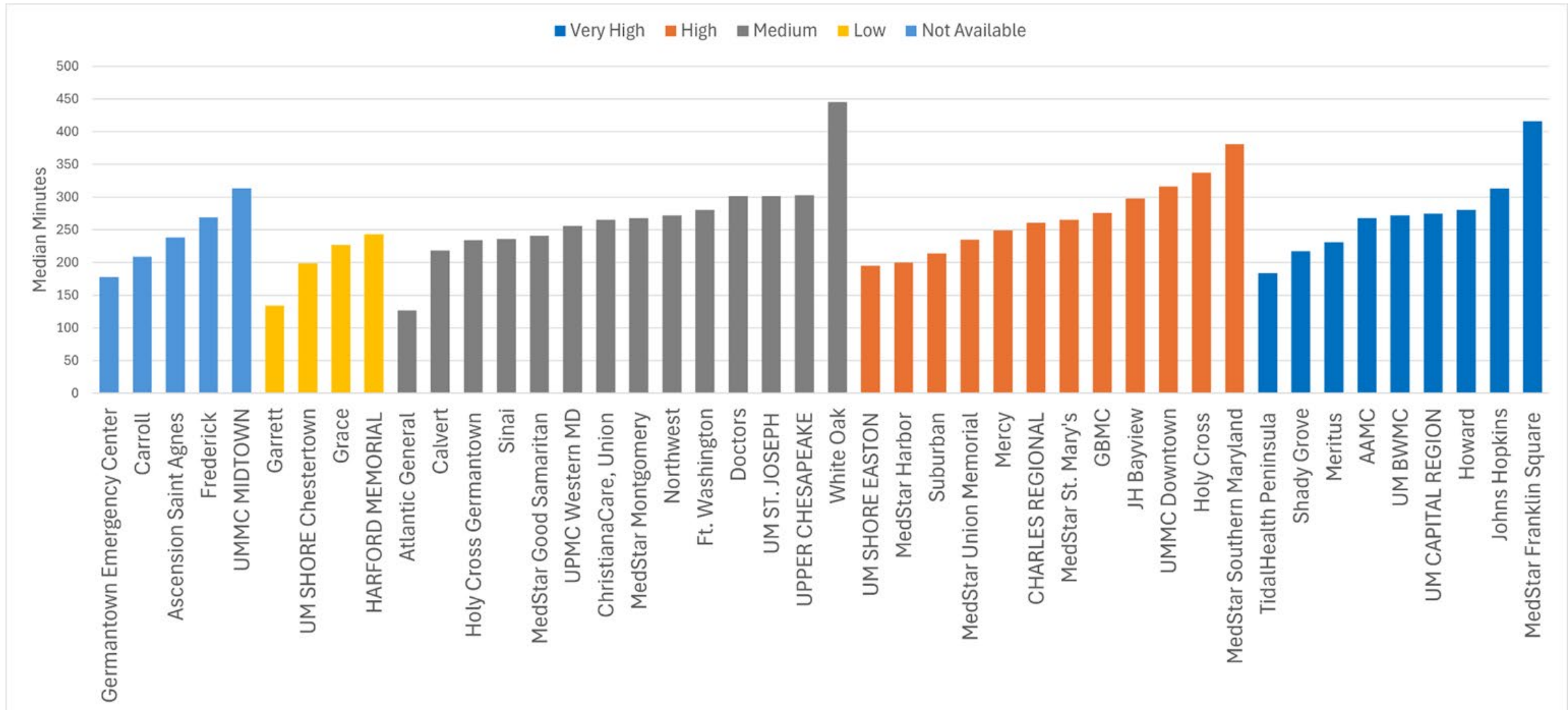
# ED 1c: ED Arrival to Inpatient Admission Time by Volume Psychiatric ED Visits



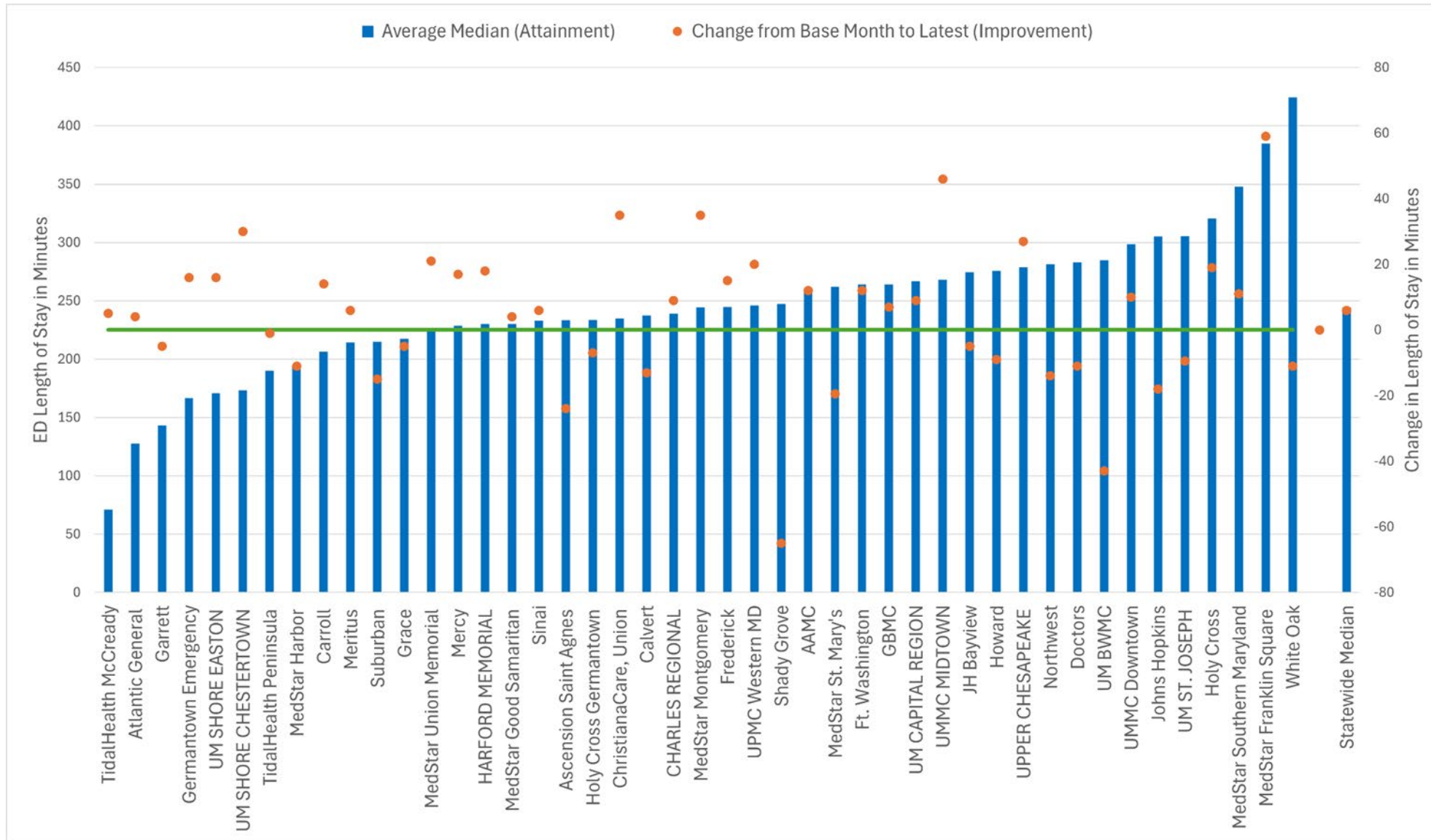
# OP18a: ED Arrival to Discharge Time by Month



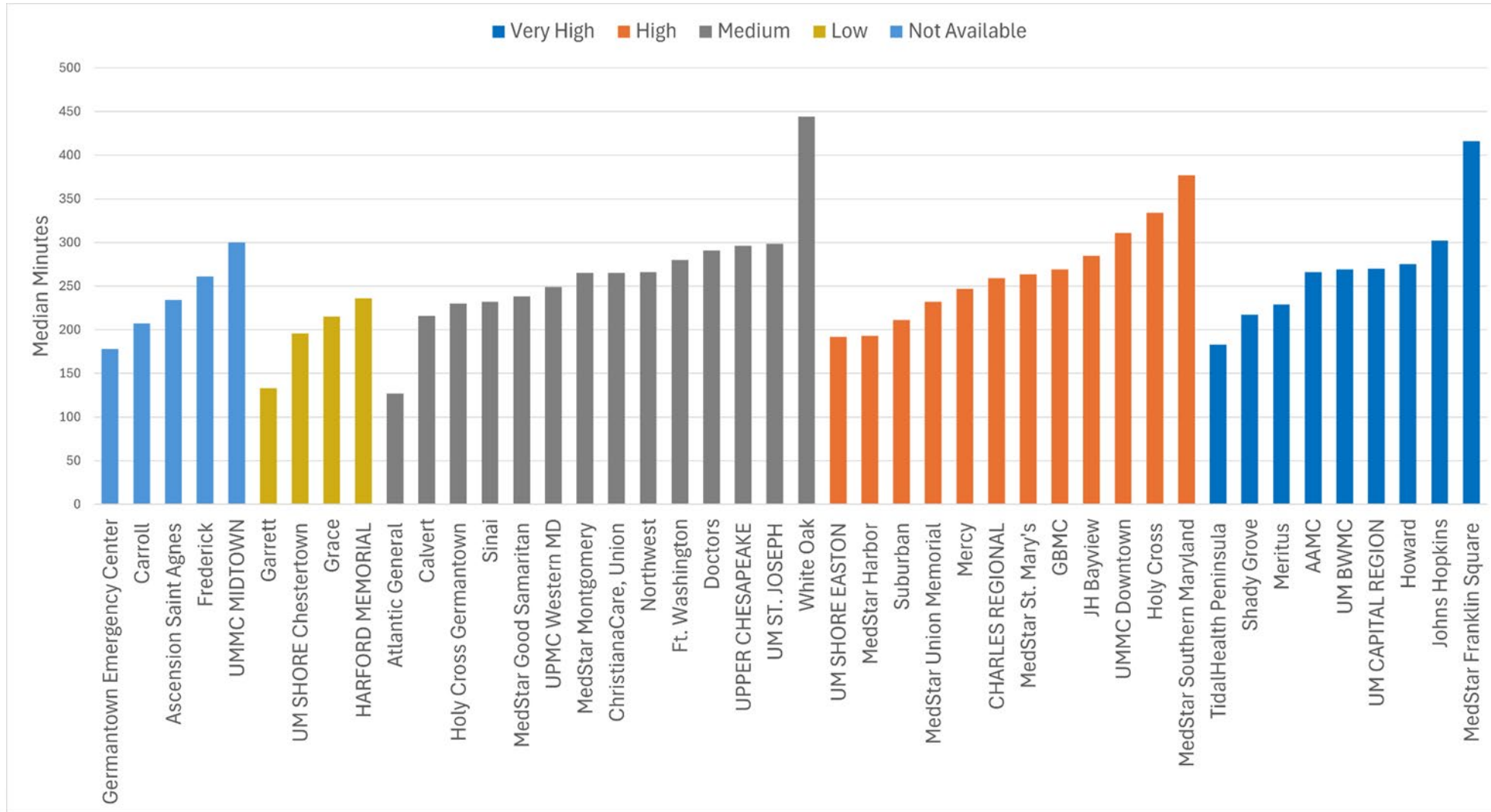
# OP18a: ED Arrival to Discharge Time Latest Month Median By Volume--Latest Month



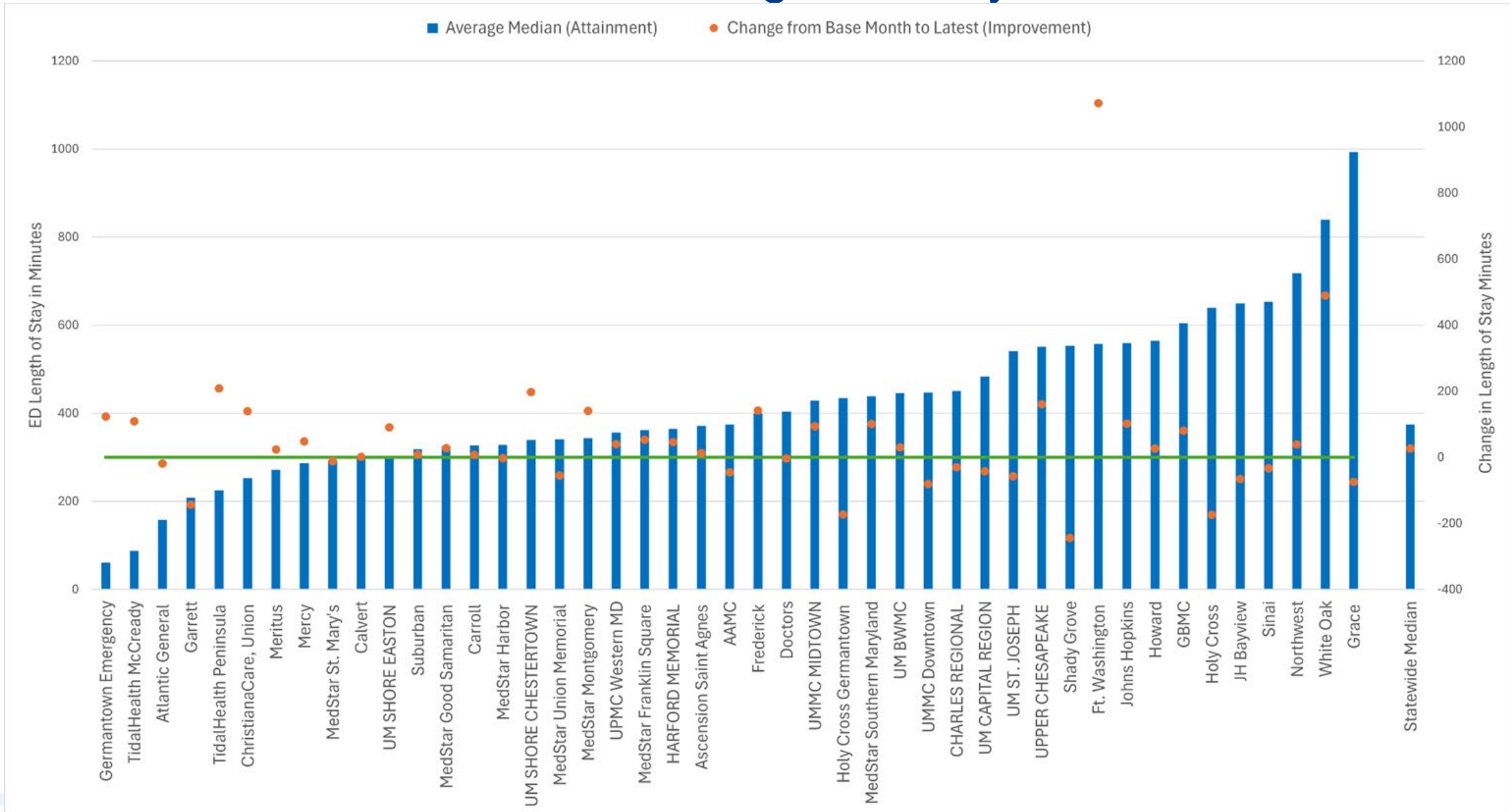
# OP18b: ED Arrival to Discharge Time - Non-Psychiatric



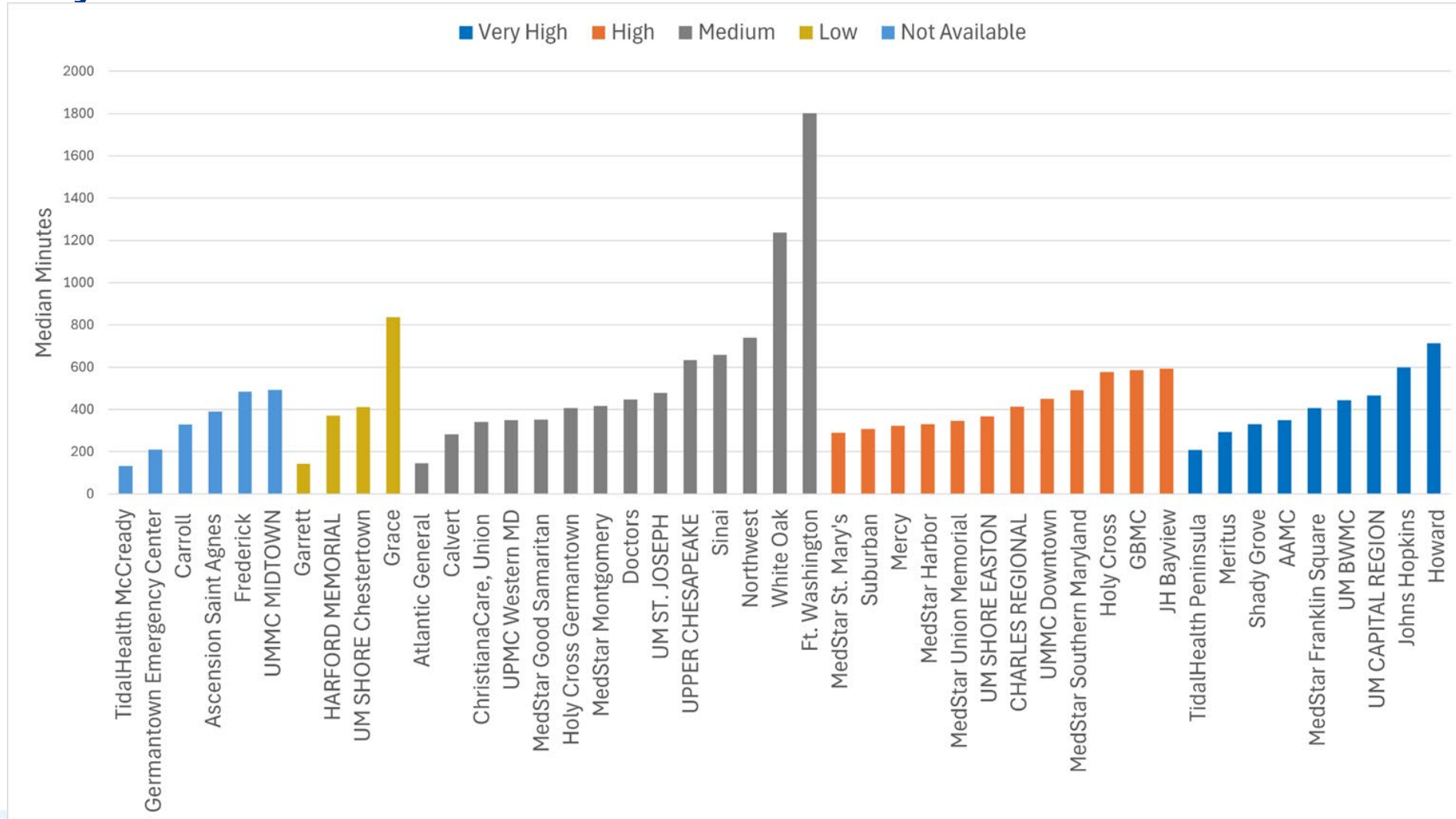
# OP18b: ED Arrival to Discharge Time by Volume Non-Psychiatric ED Visits



# OP18c: ED Arrival to Discharge Time by Month



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



## EMS Turnaround Public Reporting Measure

- Currently, MIEMSS provides weekly data reflecting turnaround time at the 90th percentile by hospital
  - Provides visibility on delays that have most impact on system performance
  - Not all hospitals have elected to receive this data
- MIEMSS provides monthly reporting on 90th percentile turnaround times by hospital for use in HSCRC programs



# EMS Turnaround Times: January Performance

- 21 hospitals reported the 90th percentile of turnaround time was  $\leq 35$  minutes
  - No net change from last month
- 24 hospitals reported the 90th percentile of turnaround time was 35-60 minutes
  - Net increase of 1 Hospital from last month
- 7 hospitals reported the 90th percentile of turnaround time was over 60 minutes
  - Net decrease of 1 Hospital from last month
- Hospitals with improving performance
  - (Average to high performing): Chestertown
  - (Low performing to average): Anne Arundel Medical Center, Upper Chesapeake Medical Center
- Hospitals with declining performance
  - (High performing to average): Cambridge Freestanding ED
  - (Average to low performing) : St. Agnes Hospital

# EMS Turnaround Times: January 2024 Performance

## 90th Percentile: 0-35 Minutes

Atlantic General Hospital  
Chestertown +  
Frederick Health Hospital  
Garrett Regional Medical Center  
Germantown Emergency Center  
Harford Memorial Hospital  
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  
Union Hospital  
Union Memorial Hospital  
Walter Reed National Military Medical Center  
Western Maryland

## >35 Minutes

Anne Arundel Medical Center +  
Baltimore Washington Medical Center  
Bowie Health Center  
CalvertHealth Medical Center  
Cambridge Free-Standing ED -  
Carroll Hospital Center  
Charles Regional  
Easton  
Franklin Square  
Good Samaritan Hospital  
Grace Medical Center  
Greater Baltimore Medical Center  
Harbor Hospital  
Johns Hopkins Bayview  
Johns Hopkins Hospital ADULT  
Laurel Medical Center  
Mercy Medical Center  
Midtown  
Northwest Hospital  
Sinai Hospital  
St. Joseph Medical Center  
Suburban Hospital  
University of Maryland Medical Center  
Upper Chesapeake Medical Center +

## >60 Minutes

Capital Region Medical Center  
Doctors Community Medical Center  
Fort Washington Medical Center  
Howard County Medical Center  
Southern Maryland Hospital  
St. Agnes Hospital -  
White Oak Medical Center

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



maryland  
**health services**  
cost review commission

---

## Legislative Update

HSCRC February 2024 Commission Meeting

February 14, 2024

# MDH Study of Health Commissions and MIA

<p>SB 694 HB 887</p>	<p><b>Maryland Department of Health - Health Commissions and Maryland Insurance Administration - Study</b></p>	<p>Position Support</p>
<p>MDH will hire an independent consultant to study the Health Services Cost Review Commission, the Maryland Health Care Commission, the Maryland Insurance Administration, and the Maryland Community Health Resources Commission. The study shall</p> <ul style="list-style-type: none"> <li>• examine overlap of the statutory and regulatory duties performed by these agencies,</li> <li>• identifying duties that should reside in MDH or another agency, and how agencies could be streamlined to reduce overlap of duties and to improve effectiveness and efficiency.</li> </ul> <p>MDH will report to the legislature by January 1, 2026, and offer recommendations.</p>		<p>Hearings:</p> <ul style="list-style-type: none"> <li>• 2/21 - Finance</li> <li>• 2/21 - Health and Government Operations (HGO)</li> </ul>

# Emergency Department Wait Times

HB 784	<b>Task Force on Reducing Emergency Department Wait Times</b>	Likely seeking amendments
<p>Establishes the Task Force on Reducing Emergency Department Wait Times to monitor, discuss, and make recommendations for reducing emergency department wait times including legislative, regulatory, or other policy initiatives. Requires the Task Force to report its findings and recommendations to the Governor and the General Assembly by January 1, 2026.</p>		2/28 - HGO
HB 1143	<b>Emergency Medical Services - Maryland Emergency Department Wait Time Reduction Commission and Standardized Protocols - Establishment</b>	Likely seeking amendments
<p>Establishes the Maryland Emergency Department Wait Time Reduction Commission in MIEMSS. Requires MIEMMS to develop certain standardized operational protocols and establish a system for monitoring emergency department performance.</p>		2/28 - HGO

# Trauma Funding (1/2)

SB 784 HB 935	<b>Comprehensive Community Safety Funding Act</b>	No Position
<p>This bill creates an excise tax on firearms, accessories, and ammunition.</p> <ul style="list-style-type: none"> <li>• 44% of this new funding will go to the Trauma Fund and 29% will go to Shock Trauma.</li> <li>• The remaining funding will be used for violence prevention and supporting victims.</li> </ul>		2/14 - Budget and Taxation 2/22 - Ways and Means
SB 1092	<b>Vehicle Registration - Emergency Medical System Surcharge - Increase and Distribution of Funds</b>	No Position
<p>Increases the motor vehicle registration emergency medical system surcharge from \$17.00 to \$40.00 per year for certain motor vehicles.</p> <ul style="list-style-type: none"> <li>• \$5 of this increase will go to the Trauma fund and \$9 will go to shock trauma.</li> <li>• The balance will go to the Maryland Emergency Medical System operations fund.</li> </ul>		2/29 - Budget and Taxation

## Trauma Funding (2/2)

HB 1439	<b>Public Health – Funding for Trauma Centers and Services</b>	No Position
<ul style="list-style-type: none"><li>• Changes the Trauma Fund statute to allow funding for other practitioners, in addition to physicians.</li><li>• Increases reimbursement rates and makes other changes to the fund.</li><li>• Adds a requirement that the annual report to the legislature include the amount that HSCRC allowed in hospital rates for trauma costs.</li><li>• Increases the motor vehicle registration surcharge to provide \$7.5 more to the Trauma Fund.</li><li>• Adds a new funding source (fines from DUIs).</li><li>• Provides at least \$10M/year to Shock Trauma.</li></ul>		2/28 – Appropriations

# Financial Assistance and Debt Collection

SB 1006	<b>Medical Debt Collection - Sale of Patient Debt</b>	Likely seeking amendments
<p>Medical debt cannot normally be sold in MD. This bill allows governmental entities to purchase medical debt from hospitals for the sole purpose of absolving individuals of their debt obligations. Requires reporting to the HSCRC to adjust UCC.</p>		3/8 - Finance
HB 328	<b>Hospitals - Financial Assistance Policies - Revisions</b>	Support
<p>This bill removes language that allows hospitals to only provide reduced cost care to patients in their service area. It also prohibits hospitals from using asset tests to determine eligibility for free and reduced-cost care.</p>		2/14 – HGO



# Notice of Outpatient Facility Fees

SB 1103 HB 1149	<b>Hospitals and Related Institutions - Outpatient Facility Fees</b>	No Position
<p>This bill strengthens consumer notice requirements for outpatient facility fees by requiring notices for all outpatient services, not just the clinic rate center. HSCRC is required to do a study to make recommendations for changes to hospital outpatient facility fees on cost, access, and health equity.</p>		<p>Hearings:</p> <ul style="list-style-type: none"><li>• 3/12 - Finance</li><li>• 3/6 - HGO</li></ul>

# Hospital Staffing Committees

<p>SB 1020 HB 1194</p>	<p><b>Hospitals - Clinical Staffing Committees and Plans - Establishment</b></p>	<p>No Position</p>
<p>Requires hospitals to establish staffing committees which will create annual clinical staffing plans indicating</p> <ul style="list-style-type: none"> <li>• how many patients are assigned to each RN and</li> <li>• the number of nurses and ancillary staff present on each unit and shift.</li> </ul> <p>The bill would require HSCRC to:</p> <ul style="list-style-type: none"> <li>• collect staffing plans from hospitals and post the plans on our website;</li> <li>• investigate complaints about failure of a hospital to establish a staffing committee and/or adopt a staffing plan;</li> <li>• publicly post infractions, require corrective action plans, and apply civil penalties,</li> <li>• Hold a workgroup and submit an annual report to the legislature.</li> </ul>		<p>Hearings:</p> <ul style="list-style-type: none"> <li>• 3/14 - Finance</li> <li>• 3/13 - HGO</li> </ul>

## Hospitals - Quality

SB 332 HB 84	<b>Hospitals and Urgent Care Centers - Sepsis Protocol (Lochlin's Law)</b>	Letter of Information
<p>This bill requires each hospital and urgent care center to implement a protocol and periodic training for the early recognition and treatment of a patient with sepsis, severe sepsis, or septic shock.</p>		Hearings: <ul style="list-style-type: none"><li>• 2/15 - Finance</li><li>• 2/15 - HGO</li></ul>

## Access to Insurance

SB 705 HB 728	<b>Health Insurance - Qualified Resident Enrollment Program (Access to Care Act)</b>	Support
Pending approval by CMS, allows Maryland residents who do not qualify for Medicaid, CHIP, or premium tax credits through the Maryland Health Connection to buy qualified health insurance through the Maryland Health Connection with no tax credits.		Hearings: <ul style="list-style-type: none"><li>• 2/21 - Finance</li><li>• 2/8 - HGO</li></ul>

# Budget

SB 360 HB 350	<b>Budget Bill (Fiscal Year 2025)</b>	No Position
<p>Includes HSCRC's operating budget, funding for CRISP, and the uncompensated care fund.</p> <p>HSCRC's budget hearings:</p> <ul style="list-style-type: none"><li>• 2/15 – Health and Social Services Subcommittee of the House Appropriations Committee</li><li>• 2/19 – Health and Social Services Subcommittees of the Senate Budget and Taxation Committee</li></ul>		TBD – Full Committee Hearings on the Budget Bill

# Questions?

Paul Katz

Analyst - External Affairs

[paul.katz@maryland.gov](mailto:paul.katz@maryland.gov)

# Appendix

## Legislative Briefings

HSCRC had two briefings before Legislative Committees in January

- HSCRC Overview of Total Cost of Care Model, AHEAD Model, and Improving ED Wait Times for the House Health Government Operations (HGO) Committee (1/17)
- Improving ED Wait Times Overview for Senate Finance Committee (1/25)



# Reports during Legislative Interim

## HSCRC submitted 4 legislative reports:

- Annual Governors Report, required by Health-General §19-207(b)(9)
- Evaluation of the Maryland Primary Care Program, required by the 2023 JCR
- Summary of UMMS Board of Directors Financial Disclosure, required by Education Article §13- 304(l)(4)
- Maryland Hospital Community Benefit Report: FY 2022, required by Ch. 437, 2020



maryland  
**health services**  
cost review commission

---

## Workgroup Processes Update

February 2024

## Overview

- HSCRC solicited public feedback on proposed workgroup management processes through January 31, 2024.
- Staff considered the feedback and incorporated select recommendations into the final processes.
- The Commission will review workgroup management workflows on a regular basis and revise them as needed.

## Purpose & Staffing

1. The HSCRC will operate three standing workgroups: Payment Models, Performance Measurement, and Total Cost of Care.
2. Standing workgroups will have a written charge.
3. Technical subgroups will have written charges and report back to standing workgroups.
4. Each workgroup meeting will be led by HSCRC staff.
5. Workgroups are meant to support staff in advancing the mission of the HSCRC and are advisory bodies only.

# Communications

1. Each workgroup will have its own webpage and email address.
2. Industry representatives and members of the public can email the dedicated email address to be added to workgroup distribution lists.
3. HSCRC staff will aim to issue workgroup materials in advance of meetings to give members sufficient time to review and prepare.
4. HSCRC will maintain a master calendar of standing workgroup and subgroup meeting dates on the HSCRC website.

# Membership

1. The HSCRC strives toward diversity in expertise, experience, background, geography, and race/ethnicity in its workgroups.
2. Each workgroup will have listed membership which staff will review annually and determine if there is a need to replace any members.
3. Staff will monitor member attendance and consider attendance records during its annual review of membership rosters.
4. Staff will consider developing a dedicated consumer engagement approach.
5. Staff will survey workgroup members annually for feedback.

# Meetings

1. Each meeting will be open to the public.
2. All meetings will be announced and have materials and minutes or recordings posted on the website in a timely manner.
3. Workgroups may set aside time at meetings for public comment.
4. Each meeting will offer closed captioning to ensure meeting content is accessible to all participants and listeners.

## Next Steps

1. Staff has posted the final processes document on the [HSCRC Workgroups](#) page.
2. Staff is building a master calendar of workgroup dates and will post it on the [HSCRC Workgroups](#) page once complete.
3. Staff is updating workgroup charters and will post them on dedicated workgroup pages, along with membership rosters.





maryland  
**health services**  
cost review commission

# Workgroup Management Process

February 2024

## **Table of Contents**

<b>Background</b>	<b>1</b>
<b>Purpose &amp; Staffing</b>	<b>1</b>
<b>Communications</b>	<b>1</b>
<b>Membership</b>	<b>1</b>
<b>Meetings</b>	<b>2</b>

## Background

The HSCRC is formalizing the below processes regarding preparing for workgroup meetings, managing communications and membership, and hosting and facilitating meetings in a public setting. HSCRC solicited public feedback on proposed workgroup management processes through January 31, 2024. Staff considered the feedback and have incorporated select recommendations into the processes outlined below. The Commission will review workgroup management workflows on a regular basis and revise them as needed.

## Purpose & Staffing

1. The HSCRC will operate three standing workgroups: Payment Models, Performance Measurement, and Total Cost of Care.
2. Standing workgroups will have a written charge.
3. Technical subgroups will have written charges and report back to standing workgroups.
4. Each workgroup meeting will be led by HSCRC staff.
5. Workgroups are meant to support staff in advancing the mission of the HSCRC and are advisory bodies only.

## Communications

1. Each workgroup will have its own webpage and email address.
2. Industry representatives and members of the public can email the dedicated email address to be added to workgroup distribution lists.
3. HSCRC staff will aim to issue workgroup materials in advance of meetings to give members sufficient time to review and prepare.
4. HSCRC will maintain a master calendar of standing workgroup and subgroup meeting dates on the HSCRC website.

## Membership

1. The HSCRC strives toward diversity in expertise, experience, background, geography, and race/ethnicity in its workgroups.
2. Each workgroup will have listed membership which staff will review annually and determine if there is a need to replace any members.
3. Staff will monitor member attendance and consider attendance records during its annual review of membership rosters.
4. Staff will consider developing a dedicated consumer engagement approach.

## Meetings

1. Each meeting will be open to the public.
2. All meetings will be announced and have materials and minutes or recordings posted on the website in a timely manner.
3. Workgroups may set aside time at meetings for public comment.
4. Each meeting will offer closed captioning to ensure meeting content is accessible to all participants and listeners.



January 31, 2024

Erin Shurmann  
Chief, Provider Alignment and Special Projects  
Health Services Cost Review Commission  
4160 Patterson Avenue  
Baltimore, MD 21215

Dear Ms. Shurmann,

Adventist HealthCare appreciates the opportunity to comment on the proposed Policy Development & Workgroup Process Updates. We strongly support the proposed changes as they are necessary for informed decision-making and transparency.

### **Workgroup Management**

Adventist strongly supports the proposed changes for workgroup management. It's critical that standing workgroups have a written charge and a balanced membership to ensure diversity of expertise, geography, gender and race/ethnicity. Additional considerations include:

- **Balance of city, suburban and rural hospitals** as they represent diverse perspectives.
- **Representation from Prince George's and Montgomery counties as the two most populous counties in the state.** We have often observed heavy representation of Baltimore City interest on State workgroups. Prince George's and Montgomery counties are experiencing vastly different population challenges than Baltimore City and should have a clear voice at the table representative of their dominant populations.
- **Timely and consistent posting of materials.** Historically, meeting materials have not been consistently posted in advance of meetings or after meetings making it challenging to prepare meaningful feedback for workgroup meetings. Additionally, not all workgroup meeting materials have been posted to HSCRC's website and not all meetings have been recorded. With the large number of workgroup meetings, it's critical to post recordings of these public meetings so that stakeholders can stay up to speed. We look forward to more consistency with the proposed changes.



- **Reliable maintenance of HSCRC distribution lists.** Historically, inconsistent practices have been used to be added to distribution lists for meetings and materials. Multiple requests for addition to workgroup or memo distribution lists sometimes fail. A process should be put in place for stakeholders to sign up for workgroups and maintain key contact lists. Often, critical memos are sent to the wrong leaders. Adventist recognizes the difficult task of maintaining up-to-date contact lists for the State but encourages stronger processes and automation to maintain these critical communication channels.
- **Standing agenda time for public comment.** While several work groups already encourage public comment during meetings, this is not a consistent practice. To effectively engage stakeholders, a forum is needed to raise concerns that may be outside the pre-programmed agenda. Open comment periods to raise relevant concerns should be encouraged. Additionally, Adventist strongly supports the recommendation for stakeholder feedback on workgroups.
- **Adventist strongly supports the proposed 2-month period for draft policy and allowing comments during the presentation of the draft policy.** Often, the compressed time frame to provide feedback results in rushed feedback without the opportunity for thoughtful consideration. Given the impact of HSCRC payment policy on Marylander's access-to-care it's critical that adequate vetting time is allowed to discern potential inequities or inadequacies of a potential policy.
- **Clear posting of final payment policies.** The current HSCRC website is fractured to access final payment policies. Often it is faster to use Google to search for final memos or policies rather than navigate the HSCRC website. There are currently 25+ payment policies; it should be easy to quickly access the most current version. The current website does not facilitate this.
- **HSCRC should consider a master calendar to make it easy to see all scheduled meetings.** Currently, workgroup meetings are buried under individual web pages, and you have to know what to look for in order to find the appropriate meetings. A centralized calendar that lists all public meetings would make it easier for stakeholder to ensure appropriate engagement.

Thank you for considering our perspectives and contributions.



Katie Eckert, CPA  
Vice President, Reimbursement & Strategic Analytics  
Adventist HealthCare





MedStar Health

8094 Sandpiper Circle  
Suite G  
Nottingham, MD 21236

[MedStarHealth.org](http://MedStarHealth.org)

January 31, 2024

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

Dear Chairman Sharfstein,

On behalf of MedStar Health (MedStar) we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) proposed changes to the policy making process. MedStar strongly supports the changes proposed by the HSCRC to increase transparency, stakeholder participation, and public participation in the policy making process. MedStar echoes the points included in the Maryland Hospital Association's comment letter on this subject. Included in this letter are key points that MedStar is strongly in favor of and believes implementation of these changes would be beneficial to all stakeholders.

**Distribute workgroup materials to the public one week prior to meetings and continue maintenance of workgroup information on HSCRC website.**

MedStar applauds the collaborative nature of the HSCRC staff across the various workgroups convened to discuss and develop policy recommendations to be brought forward before the HSCRC. To ensure that stakeholders have adequate time to understand & formulate constructive feedback on policy proposals, MedStar strongly encourages the staff to commit to distributing meeting materials at least one week prior to meeting dates whenever possible. Additionally, maintaining the workgroup information regularly and providing frequent updates to the HSCRC website to ensure meeting materials are available after the fact is crucial to stakeholders being well informed as policies are developed and MedStar encourages that this practice is maintained.

**Allow public comments on draft HSCRC staff recommendations and timely posting of final Commission decisions, inclusive of commissioner votes & adopted amendments.**

To increase stakeholder engagement in the policy making process, MedStar strongly encourages that the HSCRC allow for oral comments to be made on draft staff recommendations brought before the HSCRC.

**It's how we treat people.**

Currently, only allowing oral comments to be made on final staff recommendations limits the ability of commissioners to hear from all interested parties prior to voting on policies. In addition, to provide clarity to the public, MedStar encourages the HSCRC to publish final approved policies on their website, including any approved amendments to staff recommendations, and the final commissioner voting records. This will help avoid any circumstances where the public is not clear on exactly what has been approved by the HSCRC, particularly when amendments are proposed and adopted to final policy recommendations.

Again, MedStar supports HSCRC leadership and staff in this endeavor to promote and increase transparency and stakeholder engagement in the policy making process. We hope that the additional changes suggested in this letter can be implemented to help further the goals of the HSCRC leadership and staff and looks forward to continuing to work in partnership during the development of healthcare payment policies in Maryland.

Sincerely,

A handwritten signature in black ink, appearing to read "Mike Wood". The signature is fluid and cursive, with the first name "Mike" and last name "Wood" clearly distinguishable.

Mike Wood  
Vice President, Revenue Management & Reimbursement  
MedStar Health





Maryland  
Hospital Association

January 31, 2024

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

Dear Mr. Kromm,

On behalf of the Maryland Hospital Association's (MHA) member hospitals and health systems, we appreciate the opportunity to comment on Health Services Cost Review Commission (HSCRC) staff's recommendations on policymaking and work group processes.

We appreciate the Commission engaging stakeholders in the development process for informed decision making, transparency, inclusivity, and continuous evaluation. We look forward to collaborating with Commissioners and staff on the opportunities presented below.

**Policy & Program Development**

The hospital field is in general agreement with the draft policy and program development workflow with additional recommendations:

- Incorporate opportunities for stakeholder engagement and public feedback in the prioritization process. Commission priorities should be open for public comment, so stakeholders can provide feedback on those that are most impactful, operationally feasible, and contribute to Model success. Related to this suggestion, the priorities from the December Commissioner retreat should be presented for public comment at an upcoming meeting.
- Determine the criteria to develop new policies including an evaluation of ability to impact the stated outcomes and goals.
- Embed appropriate checkpoints throughout the policymaking process to ensure stakeholders can give meaningful feedback on methodological and operational considerations before policies are finalized.
- Leverage current best practices like the quality policy development calendar, shared with the Performance Measurement Work Group at each meeting.
- Participate in conversations with the hospital field and HSCRC with CMMI on Model administration to allow the field to offer insights on operational feasibility and how certain elements may be improved.

### **Promulgating Policies & Regulations (COMAR)**

The hospital generally agrees with the draft workflows for promulgating workgroup vetted policies and regulations, particularly implementing longer time periods between presentation of draft policies to the Commission and final vote. We also put forth the following recommendations:

- Strongly encourage the reinstatement of oral comments on draft recommendations to allow commissioners to hear from all interested parties before final recommendations.
- Post final Commission decisions including commissioner votes, proposed, and adopted amendments, and final policies, as done currently for staff recommendations.
- Develop a process for refinement and evaluation of policies, considering the total impact of risk and rewards across policies to ensure incentives are balanced. Sunset unnecessary policies as needed to focus on those producing the most meaningful engagement and results.

### **Work Group Management**

The hospital field is in general agreement with the draft recommendations, particularly identifying the scope and charge of each group. We also request the incorporation of the following:

- Strongly encourage longer time periods for stakeholders to vet policy and methodological recommendations prior to Commissioner vote to allow for evaluation of key issues and barriers, amendments where appropriate, and thoughtful evaluation and monitoring.
- Limit the number of new regulatory policies and methodologies to allow hospitals to develop and finalize methodologies and operationalize changes sequentially. This will limit competing priorities and allow for more meaningful engagement.
- Encourage more transparency in the workgroup management including posting all work group materials at least one week in advance of meetings, reviewing rosters annually, and distributing meeting summaries with clear and actionable next steps. If materials are not sent out with enough time to process (less than a week), we encourage meetings to be delayed for meaningful feedback.

Thank you for engaging stakeholders in the process. We believe our recommendation will further enhance the good work put forth in your draft document. If you want to discuss any of our recommendations in more detail, please contact us.

Sincerely,



Melony G. Griffith  
President & CEO  
Maryland Hospital Association

cc: Joshua Sharfstein, M.D., Chairman  
Joseph Antos, Vice Chairman  
James Elliott, M.D.  
Ricardo Johnson  
Maulik Joshi, DrPH  
Adam Kane  
Nicki McCann, JD



maryland  
**health services**  
cost review commission

---

## Policy Calendar

January 2024 – June 2025

February 14, 2024

# Overview

- Staff developed a policy and activities calendar for January 2024 – June 2025.
- The policy calendar and staff workplan are subject to change based on competing staff demands, policy needs shift, or new policy needs emerge.
- Staff considered current staff capacity and workload, existing contractor resources, state partner support, and future procurement requirements when developing this document.
- Activities do not reflect the workload associated with implementing the AHEAD Model, if Maryland is accepted into Cohort 1.
- New policies and activities may be added to the policy calendar and staff workplan as the year progresses.

# Timing

- The policy calendar outlines when Commissioners will receive presentations on policy development plans and draft policy recommendations and take votes on final policy recommendations.
- Staff will bring policy development plans to Commissioners for consideration quarterly or more frequently if need arises.
- The majority of policies will have a two-month gap between a draft and final recommendation.
- Changes to the policy calendar will be reflected in monthly public meeting agendas and staff policy development plans.
- **March Preview:** Staff will present the final MPA recommendation and the policy development plan on the ED Best Practices Incentive Policy.



maryland  
**health services**  
cost review commission

# Policy Calendar

Calendar Year 2024 through June 2025

Updated February 12, 2024

# Table of Contents

<b>Introduction</b>	<b>1</b>
<b>Impact of AHEAD on HSCRC Activities</b>	<b>1</b>
<b>Anticipated Commission Votes (January 2024 – June 2025)</b>	<b>2</b>
<b>Policy Summaries</b>	<b>6</b>
Quality	6
Rate Setting & Financial Methodologies	7
Healthcare Infrastructure Support	7
<b>New and Ongoing Staff Activities</b>	<b>8</b>
<b>Appendix 1. HSCRC Staff Activities Timeline</b>	<b>8</b>



## Introduction

This document reflects staff and Commissioner discussion on priorities for the HSCRC over 18 months between January 2024 and June 2025. Staff is sharing a policy and activities calendar that staff believes is both ambitious but achievable given the current resources available to the HSCRC. Staff have considered current staff capacity and workload, existing contractor resources, state partner support, and future procurement requirements when developing this document. This document contains two components:

1. A list of HSCRC policies that will receive a Commission vote and a month-by-month outline of all policies that will be considered at each meeting through June 2025.
2. An outline of staff activities required to advance and implement the policies and programs critical to the State's all-payer rate setting system and the Maryland Model.

The activities outlined as part of #2 may be specific to implementing existing policies or programs, critical for hospital rate setting purposes, or required by the Center for Medicare and Medicaid Innovation (CMMI) under the terms of the Total Cost of Care (TCOC) Model State Agreement.

## Impact of AHEAD on HSCRC Activities

The Centers for Medicare & Medicaid Services (CMS) released a Notice of Funding Opportunity (NOFO) for the States Advancing All-Payer Health Equity Approaches and Development (AHEAD) Model in fall 2023. The AHEAD Model is an 11 year, voluntary, state total cost of care model that seeks to drive state and regional health care transformation and multi-payer alignment to accelerate transformation across the entire health system. The AHEAD Model is designed to curb health care cost growth, improve population health, and advance health equity by reducing disparities in health outcomes across all payers including Medicare, Medicaid, and private coverage. AHEAD is the pathway to continue Maryland's all-payer rate setting authority and offers tools for primary care transformation, healthcare cost containment, and population health improvement. AHEAD builds on the Maryland TCOC Model, advancing the vision of equity and excellence in Maryland's healthcare delivery system to improve the health of all.

Maryland anticipates applying to participate in Cohort 1 of AHEAD which would run from CY 2026 through CY 2034. The Model would be preceded by an 18-month pre-implementation period (June 2024-December 2025) wherein the State and CMS would negotiate a State Agreement outlining the terms of Maryland's participation in AHEAD. The activities outlined in this document do not account for the level of effort and resources required of HSCRC staff to implement AHEAD, if Maryland is accepted into the model.

## Anticipated Commission Votes (January 2024 – June 2025)

Based on discussion of existing policy requirements, policy refinement opportunities, and implementation responsibilities, staff have developed the following calendar for updating and developing new policies between CY 2024 and June 2025. Dates are subject to change based on staff capacity, data availability, stakeholder input, and other factors that may delay the policy-making process. Staff aim to have a two-month gap between presenting a draft policy recommendation and a Commission vote on a final policy recommendation (e.g. a draft is presented in March and a final is presented in May) if a policy is being developed for the first time or substantive changes are being made. This revised timeline may not be possible for select policies where data limitations, compliance requirements, and other time-sensitive issues impact the development timeline. In those cases, a final policy recommendation will be presented in the subsequent month following a draft.

In advance of submitting draft recommendations, staff will bring proposed policy development plans to Commissioners for consideration on a quarterly basis. Policy development plans will include goals, a plan for needed data and analytics, a plan for stakeholder engagement, and an anticipated timeline. Staff plan to provide these quarterly updates in the following months:

- April 2024
- July 2024
- October 2024
- January 2025
- April 2025

Staff are providing the below table outlining the policies that the Commission will vote on between January 2024 and June 2025. **The dates listed may change and any changes will be reflected in the monthly Commission meeting agendas posted on the HSCRC website.** Many 2024 policies in development are nearing completion, so staff will begin presenting development plans for fall policies in Spring/Summer 2024.

*Table 1. CY 2024 Policy Votes*

CY 2024 Policy Votes	Development Plan	Draft Policy	Final Policy Vote
Multi-Visit Patient Policy (RY 2026)		December 2023	February 2024

CY 2024 Policy Votes	Development Plan	Draft Policy	Final Policy Vote
Maryland Hospital Acquired Conditions (MHAC) Program (RY 2026)		January 2024	February 2024
Medicare Performance Adjustment (CY 2024 Policy / FY 2026 Payment)		December 2023	March 2024
Readmission Reduction Incentive Program (RRIP – RY 2026)		February 2024	April 2024
Relative Value Unit (RVU) Updates (FY 2025)		April 2024	June 2024
Nurse Support Program II – Competitive Grants (FY 2025)			May 2024
Update Factor (RY 2025)		May 2024	June 2024
CRISP HIE Funding (RY 2025)		May 2024	June 2024
Out-of-State (OOS) and Deregulation Volume Policy	April 2024	July 2024	September 2024
ED Best Practices Incentive Policy	March 2024	October 2024	December 2024
Quality Based Reimbursement (QBR) Program (RY 2027)	July 2024	October 2024	December 2024

Table 2. CY 2025 Policy Votes

CY 2025 Policy Votes	Development Plan	Draft Policy	Final Policy Vote
Maryland Hospital Acquired Condition (MHAC) Program (RY 2027)	July 2024	November 2024	January 2025
Nurse Support Program II – Program Renewal (FY 2026 – 2023)	April 2024	November 2024	January 2025
Medicare Performance Adjustment (CY 2025 Policy / FY 2027 Payment)	October 2024	December 2024	February 2025
Revenue for Reform (RY 2026)	July 2024	December 2024	February 2025

CY 2025 Policy Votes	Development Plan	Draft Policy	Final Policy Vote
Multi-Visit Patient Policy (RY 2027)	July 2024	December 2024	February 2025
Freestanding Medical Facility (FMF) Conversion Policy	July 2024	January 2025	March 2025
Readmission Reduction Incentive Program (RRIP – RY 2027)	July 2024	February 2025	April 2025
Relative Value Unit (RVU) Updates (FY 2026)	January 2025	April 2025	June 2025
Nurse Support Program II – Competitive Grants (FY 2026)	July 2024		May 2025
Update Factor (RY 2026)	January 2025	May 2025	June 2025
CRISP HIE Funding (RY 2026)		May 2025	June 2025

Table 3. CY 2024 Presentations by Month

Month	Policy & Presentation Type
February 2024	<ol style="list-style-type: none"> <li>Final Policy – Multi-Visit Patient Policy (RY 2026)</li> <li>Final Policy – Maryland Hospital Acquired Conditions (MHAC) Program (RY 2026)</li> <li>Draft Policy – Readmission Reduction Incentive Program (RY 2026)</li> </ol>
March 2024	<ol style="list-style-type: none"> <li>Final Policy - Medicare Performance Adjustment (CY 2025 Policy / FY 2027 Payment)</li> <li>Development Plan - ED Best Practices Incentive Policy</li> </ol>
April 2024 (Quarterly Update)	<ol style="list-style-type: none"> <li>Final Policy – Readmission Reduction Incentive Program (RRIP) (RY 2026)</li> <li>Draft Policy - Relative Value Unit Updates (FY 2025)</li> <li>Development Plan – Nurse Support Program II Program Renewal (FY 2026 – 2030)</li> <li>Development Plan – OOS and Deregulation Policy</li> </ol>
May 2024	<ol style="list-style-type: none"> <li>Final Policy – Nurse Support Program II – Competitive Grants (FY 2025)</li> <li>Draft Policy – Update Factor (RY 2025)</li> <li>Draft Policy – CRISP HIE Funding (RY 2025)</li> </ol>

Month	Policy & Presentation Type
<b>June 2024</b>	<ol style="list-style-type: none"> <li>1. Final Policy – Update Factor (RY 2025)</li> <li>2. Final Policy – CRISP HIE Funding (RY 2025)</li> <li>3. Final Policy – Relative Value Unit (RVU) Updates (FY 2025)</li> </ol>
<b>July 2024</b>  (Quarterly Update)	<ol style="list-style-type: none"> <li>1. Draft Policy – OOS and Deregulation Volume Policy</li> <li>2. Development Plan – Quality Program Updates (MHAC, QBR, RRIP) (RY 2027)</li> <li>3. Development Plan – Revenue for Reform Policy Updates (RY 2026)</li> <li>4. Development Plan – Multi-Visit Patient (MVP) Policy Updates (RY 2027)</li> <li>5. Development Plan – Nurse Support Program II Competitive Grants (RY 2026)</li> <li>6. Development Plan – FMF Conversion Incentive Program</li> </ol>
<b>September 2024</b>	<ol style="list-style-type: none"> <li>1. Final Policy – OOS and Deregulation Policy</li> </ol>
<b>October 2024</b>  (Quarterly Update)	<ol style="list-style-type: none"> <li>1. Draft Policy – Quality Based Reimbursement (QBR) Program Updates (RY 2027)</li> <li>2. Draft Policy – ED Best Practices Incentive Policy</li> <li>3. Development Plan – Medicare Performance Adjustment (CY 2025 Policy / FY 2027 Payment)</li> </ol>
<b>November 2024</b>	<ol style="list-style-type: none"> <li>1. Final Policy - Quality Based Reimbursement (QBR) Program Updates (RY 2027)</li> <li>2. Draft Policy – Nurse Support Program II Program Renewal (FY 2026 – 2030)</li> <li>3. Draft Policy - Maryland Hospital Acquired Conditions (MHAC) Program Updates (RY 2027)</li> </ol>
<b>December 2024</b>	<ol style="list-style-type: none"> <li>1. Final Policy - Maryland Hospital Acquired Conditions (MHAC) Program Updates (RY 2027)</li> <li>2. Final Policy – ED Best Practices Incentive Policy</li> <li>3. Draft Policy - Medicare Performance Adjustment (CY 2025 Policy / FY 2027 Payment)</li> <li>4. Draft Policy - Revenue for Reform Policy Updates (RY 2026)</li> <li>5. Draft Policy- Multi-Visit Patient (MVP) Policy Updates (RY 2027)</li> </ol>

*Table 4. CY 2025 Presentations by Month*

Month	Presentation Type
<b>January 2025</b>  (Quarterly Update)	<ol style="list-style-type: none"> <li>1. Final Policy - Nurse Support Program II Program Renewal (FY 2026 – 2030)</li> <li>2. Draft Policy - FMF Conversion Incentive Program</li> <li>3. Development Plan – Relative Value Unit (RVU) Updates (FY 2026)</li> <li>4. Development Plan – Update Factor (RY 2026)</li> </ol>

Month	Presentation Type
February 2025	<ol style="list-style-type: none"> <li>1. Final Policy - Medicare Performance Adjustment (CY 2025 Policy / FY 2027 Payment)</li> <li>2. Final Policy - Revenue for Reform Policy Updates (RY 2026)</li> <li>3. Final Policy- Multi-Visit Patient (MVP) Policy Updates (RY 2027)</li> <li>4. Draft Policy – Readmission Reduction Incentive Program (RRIP) (RY 2027)</li> </ol>
March 2025	<ol style="list-style-type: none"> <li>1. Final Policy - FMF Conversion Incentive Program</li> </ol>
April 2025 (Quarterly Update)	<ol style="list-style-type: none"> <li>1. Final Policy - Readmission Reduction Incentive Program (RRIP) (RY 2027)</li> <li>2. Draft Policy - Relative Value Unit (RVU) Updates (FY 2026)</li> </ol>
May 2025	<ol style="list-style-type: none"> <li>1. Final Policy – Nurse Support Program II Competitive Grants (FY 2026)</li> <li>2. Draft Policy – Update Factor (RY 2026)</li> <li>3. Draft Policy – CRISP HIE Funding (FY 2026)</li> </ol>
June 2025	<ol style="list-style-type: none"> <li>1. Final Policy – Update Factor (RY 2026)</li> <li>2. Final Policy – CRISP HIE Funding (RY 2026)</li> </ol>

## Policy Summaries

Below are high level summaries of the policies that the Commission will consider in CY 2024 and the first half of CY 2025.

### Quality

- Quality-Based Reimbursement Program:** Ensures quality of hospital care across multiple domains; comply with TCOC Model contractual obligation to meet or exceed the quality and cost outcomes of the Medicare Value Based Purchasing (VBP) program, and provide payment incentives to address/support state-specific priorities and goals through innovations in measurement areas and incentive design.
- Maryland Hospital Acquired Conditions (MHAC) Program:** Incentivizes maintaining prior reductions in hospital acquired complications in line with federal contractual obligation that requires the State to not backslide from All-Payer Model performance.
- Readmissions Reduction Incentive Program (RRIP):** Incentivizes reducing all-payer readmissions in line with federal contractual obligation that requires the State to have a Medicare readmission at or below the national average. Advances health equity through disparity gap methodology.

- **Emergency Department (ED) Best Practices Incentive Policy:** Incentivizes hospital best practices, alignment with Emergency Department Dramatic Improvement Initiative (EDDIE), and value-based arrangements with non-hospital providers that will improve hospital throughput and by extension reduce ED length of stay (LOS).
- **Multi-Visit Patient (MVP) Policy:** Provides all-payer incentives for hospitals to develop alternative care pathways for the most frequent emergency department (ED) visitors.

## Rate Setting & Financial Methodologies

- **Update Factor:** Provides hospitals with reasonable changes to rates in order to maintain operational readiness while also seeking to contain the growth of hospital costs in the State. In addition, the policy aims to be fair and reasonable for hospitals and payers. RY 2025 policy will include an update on the high-cost drug policy.
- **Medicare Performance Adjustment (MPA):** Brings direct financial accountability to individual hospitals based on the TCOC of Medicare fee-for-service (FFS) beneficiaries attributed to them.
- **Relative Value Unit (RVU) Updates:** Proposes updates to RVUs, which are values/weights assigned to a specific service based on relative resources used when compared to other services.
- **Revenue for Reform Policy:** Directs inefficient hospitals, which may be a function of retained revenue, to fund community-based population health investments outside of hospital walls.
- **Freestanding Medical Facility (FMF) Conversion Incentive Policy:** Establishes requirements for any major facility conversion (e.g., acute hospital to FMF). Outlines the process that hospitals will need to follow when considering a facility conversion and will establish the expected savings, maintenance of effort for various types of access and potential funding for population health.
- **Out-of-State (OOS) and Deregulation Volume Policy:** Ensure changes in hospital volumes for out-of-state volume growth and deregulation are appropriately captured in hospital global budgets.

## Healthcare Infrastructure Support

- **CRISP Health Information Exchange (HIE) Funding:** Approves the annual assessment in hospital rates to fund and sustain projects and operations for CRISP, the State's HIE.
- **Nurse Support Program (NSP) II:** Administers special funding to advance nursing in higher education settings. The program is administered by the Maryland Higher Education Commission (MHEC). The Commission will vote on both the annual competitive grant awards and a five-year program renewal.

## New and Ongoing Staff Activities

In addition to the policies that will be refined or newly developed over the next 18 months, HSCRC staff will continue to advance and implement the policies and programs critical to the State's all-payer rate setting system and the Maryland Model. The activities outlined may be specific to implementing existing policies or programs, critical for hospital rate setting purposes, or required by the Center for Medicare and Medicaid Innovation (CMMI) under the terms of the Total Cost of Care (TCOC) Model State Agreement.

Staff have grouped work into seven different categories:

- Financial Methodologies & Rate Setting
- Quality
- Population Health
- Care Transformation
- Data Management
- Hospital and Model Performance Monitoring
- State Health Infrastructure

Appendix 1 provides a work breakdown structure and timeline for staff activities through June 2025. A commission vote may or may not be required for staff to carry out the functions associated with the work outlined. Additionally, the list will be modified and updated as the year progresses. **Stakeholders should use these dates as a guide to HSCRC activities but refer to staff leading associated work for exact timelines, deadlines, and detailed workflows.** These timelines are subject to change if new policy needs emerge, staff determine that refinements are needed to existing policies or programs or competing priorities (such as AHEAD) require staff to redirect efforts.

## Appendix 1. HSCRC Staff Activities Timeline



## EQIP Primary Care Subgroup

- Program is to provide incremental funding for primary care in underserved areas.
- Program was approved by the Commission and CMS at the end of last year. Staff is working on implementation targeting a 2025 go-live
  - RFI was completed in January and responses are being compiled
  - Stakeholder sub-group will be hosted by MedChi
    - Initial meeting tentatively schedule at 11 Am on February 28<sup>th</sup>.
    - For more information or to be included on the relevant distribution, email: [hsrcr.tcoc@maryland.gov](mailto:hsrcr.tcoc@maryland.gov)



**TO:** HSCRC Commissioners  
**FROM:** HSCRC Staff  
**DATE:** February 14, 2024  
**RE:** Hearing and Meeting Schedule

---

**Joshua Sharfstein, MD**  
Chairman

**Joseph Antos, PhD**  
Vice-Chairman

**James N. Elliott, MD**

**Ricardo R. Johnson**

**Maulik Joshi, DrPH**

**Adam Kane, Esq**

**Nicki McCann, JD**

March 13, 2024 To be determined - GoTo Webinar

April 10, 2024 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.

**Jonathan Kromm, PhD**  
Executive Director

**William Henderson**  
Director  
Medical Economics & Data Analytics

**Allan Pack**  
Director  
Population-Based Methodologies

**Gerard J. Schmith**  
Director  
Revenue & Regulation Compliance

**Claudine Williams**  
Director  
Healthcare Data Management & Integrity