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616th Meeting of the Health Services Cost Review Commission
January 10, 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. Presentation on Assistance in Community Integration Services (ACIS) Pilot in Baltimore City - Kevin Lindamood, Redonda Miller, Christopher Thomaskutty
2. Overview of Data Validation Activities

Specific Matters

3. Docket Status – Cases Closed

   2631N Tidal Health Peninsula

4. Docket Status – Cases Open

   2640A University of Maryland Medical Center
   2641R UM Upper Chesapeake Behavioral Health Pavilion
   2642N University of Maryland Medical Center

5. Presentation from University of Maryland Rehabilitation and Orthopaedic Institute

Subjects of General Applicability

6. Review of Minutes from the Public and Closed Meetings on December 6 and December 13, 2023
7. Draft Recommendation on Maryland Hospital Acquired Conditions Program (MHAC)

8. Emergency Department Dramatic Improvement Effort (EDDIE) Update
9. Policy Update and Discussion
    a. Model Monitoring
    b. Hospital Reimbursement Law Stakeholder Engagement
    c. Processes Update
10. Hearing and Meeting Schedule

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Presentation on Assistance in Community Integration Services (ACIS) Pilot

Assistance in Community Integration Services (ACIS) Medicaid Supportive Housing Waiver

Baltimore City Pilot, Outcomes, Lessons Learned

Kevin Lindamood, MSW, President & CEO, Health Care for the Homeless
Redonda Miller, MD, MBA, President, The Johns Hopkins Hospital
Christopher Thomaskutty, Senior VP, Physician Enterprise, Mercy Health Services

Why did Baltimore hospitals invest in Permanent Supportive Housing?

- **Meetings of Baltimore City Hospital Presidents** about Social Determinants of Health in 2017; collaborate on Community Health Needs Assessment findings
- **Universal challenge**: Housing Instability/homelessness
  - More than 2,000 residents are experiencing homelessness in the City on any given day
  - Data suggested these patients were being seen at multiple hospitals on a frequent basis
- **HCH and the City approached hospitals** seeking a match to leverage federal funds; HCH was viewed as a trusted, experienced partner
- **Relevance to Maryland Model**: Specific opportunity to reduce avoidable hospital and ED utilization for a defined population through community partnership
- **Steering Committee:** With Hospital support, steering committee worked through details and complicated funding process

Place Matters

- Housing is a key social determinant of health
- Homelessness and health are inextricably linked

Having a home means you'll live much longer.

82 years
Wealthiest Maryland counties

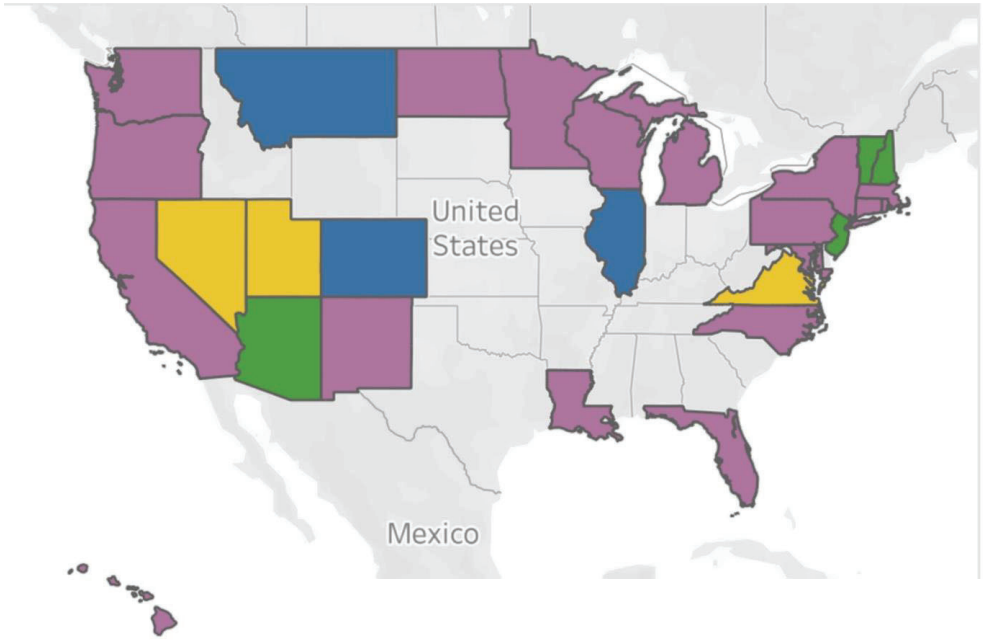
68 years
Segregated Baltimore City neighborhoods

48 years
Homeless

"For the first time in 51 years, my name is on the lease. This is my castle. It's small, but it's mine."

- Charles Himple passed away in 2021, having recovered loving bonds with his family and a home of his own.

Medicaid Tenancy Support Waivers



- 17 Active Programs/Pilots
- 3 Negotiating with CMS
- 3 Planning Stages
- 4 Planning Post-CMS

Corporation for Supportive Housing, www.csh.org
(Updated April 2023)

Assistance in Community Integration Services

- 2017 pilot - §1115 HealthChoice waiver authority
- Supportive services only (must be matched with housing)
- Funds flow through inter-governmental transfer (complicated)
- Initial pilot – 300 statewide; expanded to 600
- Renewed: 900 (620, 6/23) spaces for “lead entities”
  - ✓ 300 - Baltimore City MOHS
  - ✓ 15 - Cecil County Health Department
  - ✓ 230 - Montgomery County HHS
  - ✓ 75 - Prince George’s County Health Department

ACIS Criteria & Eligibility

Health Criteria

Repeated incidents of emergency department (ED) use (defined as more than four visits per year) or hospital admissions; or

Two or more chronic conditions as defined in §1945(h)(2) of the Social Security Act

Housing Criteria

Individuals who will experience homelessness upon release from the settings defined in 24 CFR 578.3; or

Those at imminent risk of institutional placement

Early Baltimore Outcomes

- 52% reduction in hospital visits
- 18% reduction in number of individuals with visits

- 60% decrease in emergency department visits
- 53% decrease in inpatient admissions*
- 77% decrease in hospital readmissions*
- 41% reduction in charges

*Small n; not statistically significant

Health Care for the Homeless, CRISP data, 2022
107 people – 12 months before & after housing placement

Assistance in Community Integration Services Program Assessment, CY 2018 to CY 2021

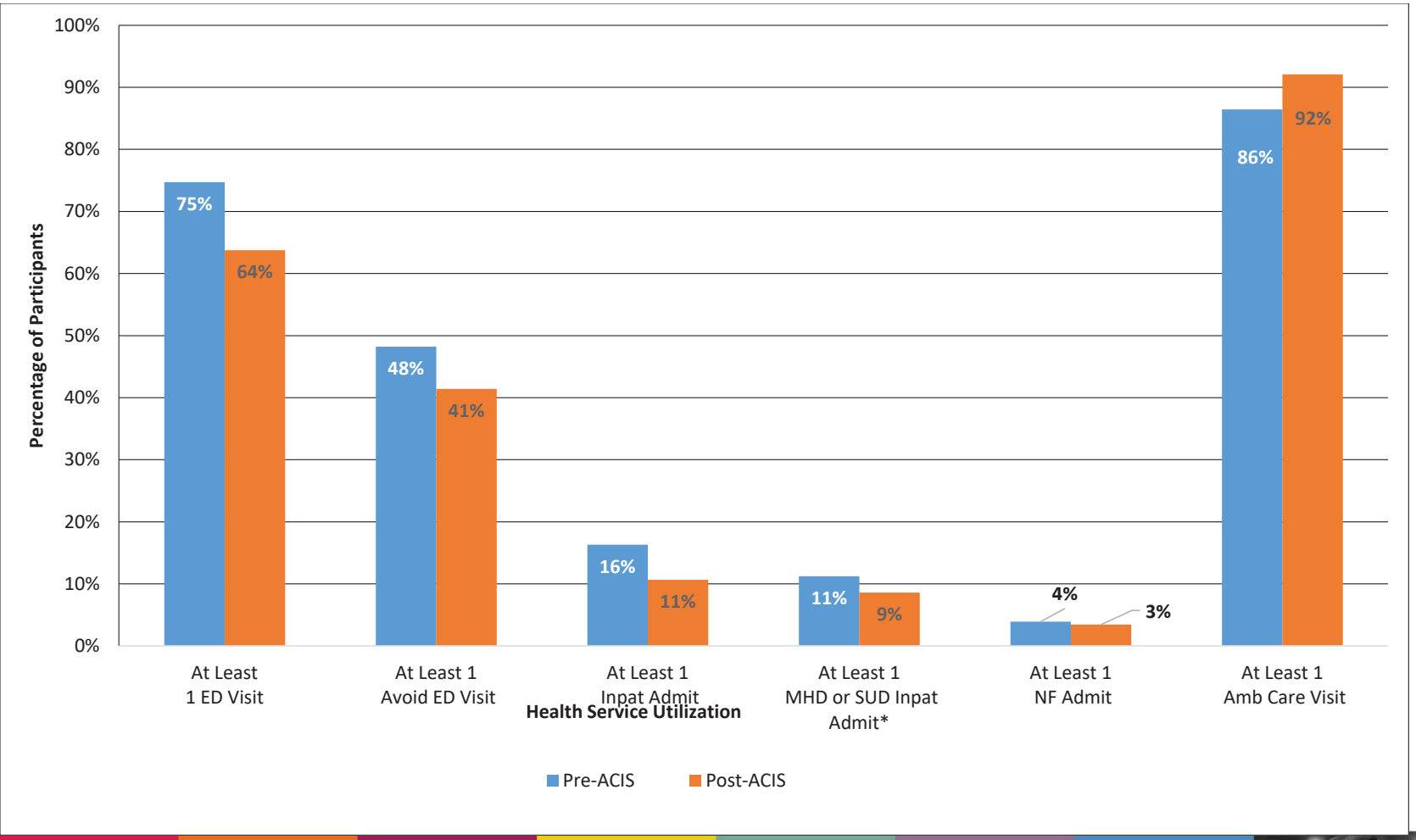
- "Statistically significant decline in the average number of ED visits, avoidable ED visits, and inpatient admissions for ACIS participants in the year following enrollment in the program."

- "Participants with four or more ED visits in the pre- versus post-ACIS year declined 36.8%."

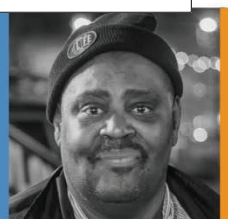
615 Enrolled in ACIS
n=467 (76%) enrolled in Medicaid one year prior to ACIS enrollment

The Hilltop Institute

Pre- and Post-ACIS Health Service Utilization of ACIS Participants



* MDH, Hilltop Institute, 2023



Lessons for Maryland Model

- **Housing status, health, and health equity are closely related**
- **Collective action (hospitals, gov't, HCH) achieved key aims of the Maryland model**
  - Population health, reduction in unnecessary utilization, and cost savings
- **Underlying infrastructure is needed to ensure success**
- **Full participation from Baltimore City hospitals was critical to early success**
- **Prioritization is critical; too many "asks" minimize impact of collective action**
- **State support needed to stabilize and grow ACIS program**
  - Need far outweighs waiver slots; more affordable housing needed
  - Successful pilot; opportunity for expansion & simplification if State covers Medicaid match
  - Supportive services AND housing of equal importance

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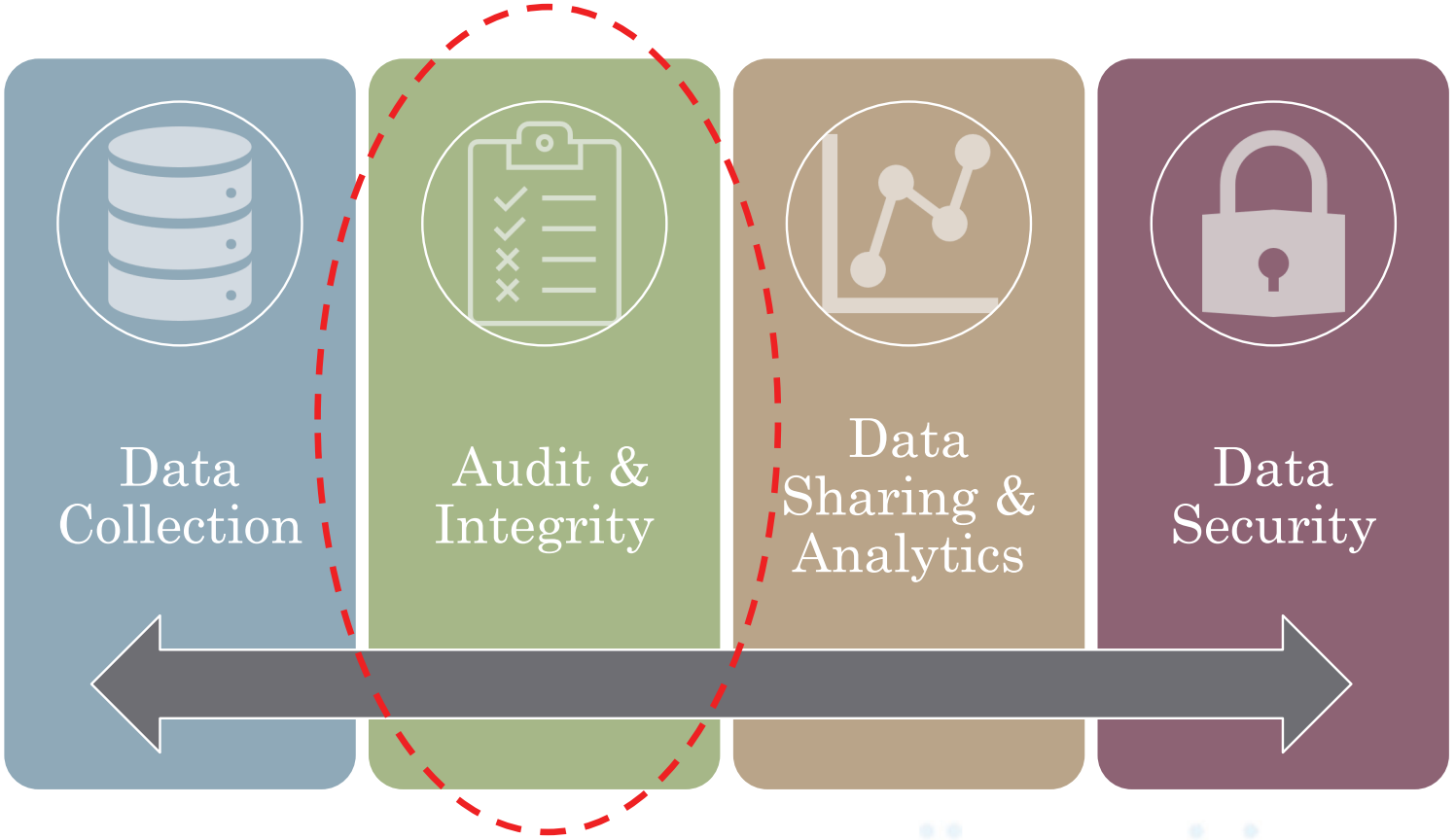
HSCRC Data Validation Activities

Claudine Williams, Director, Healthcare Data Management and Integrity (HDMI)
Oscar Ibarra, Chief, Clinical Data Administration, HDMI
Chris O'Brien, Associate Director, Audit and Integrity, HDMI

January 10,2024

Center for Healthcare Data Management & Integrity (HDMI)



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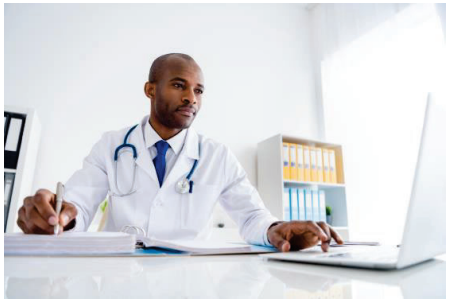
Data is the Life Blood of the Commission

- Hospital data submissions allow the HSCRC to validate Commission policies and ensure hospital compliance, as well as monitor broader industry trends.



- HSCRC collects and audits clinical and financial data from hospitals, which contributes to one of the most robust hospital data sources in the country.
- This data is essential to developing accurate, valid policies.

HSCRC receives a wide variety of data from different sources which allows for validation on an ongoing basis

Monthly

- Inpatient & outpatient volumes and revenue by rate center
- Unaudited Financial Statements
- Price Variance Letter to HSCRC listing rate centers that have rates charged outside of allowed corridors
- Preliminary Inpatient, Outpatient, and IP Psychiatric Case Mix Data
- Medicare claims from CMS (CCLF & CCW)
- Medicaid Eligibility and Claims data

Quarterly

- Bad Debt, Charity, and Denials patient account data
- Denied Charges by payer
- Inpatient hospice patient data
- Reconciliation of Case Mix Data to Monthly Financial Data
- Final Inpatient, Outpatient, and IP Psychiatric Case Mix Data
- All Payer Claims Data (APCD)

Annually

- Annual Filings of volumes expenses and financials
- Audited Financial Statements
- Outpatient Service Survey – list all hospital-owned and unregulated outpatient services and their location
- Trustee Disclosures
- Credit and Collection Policy & Debt Collection Policy
- Special Audit Reports
- Community Benefit Reports
- Federal IRS Form 990
- Listing of interns and residents that rotated at the hospital during the fiscal year
- Population estimates from Maryland Department of Planning and Claritas
- Medicare claims from CMS (CCLF & CCW)
- Population Health Report

Making Sure the Data is Correct at Every Stage

Data	Processing	Reporting	Auditing
Case Mix	Data edits look at: • missing, invalid or mismatched information • Most up to date codes • ungroupable data • % unknown above a threshold for race and ethnicity	• Trends across hospitals, service lines and time • Policy-specific reports (i.e., CDS-A) that provide hospitals with information on accuracy of data submitted	• Case Mix Audits compare what is being reported to the HSCRC with what is recorded in the medical record. • Targeted audits provides a glimpse into potential systematic errors in coding and documentation
Financial	Data edits look at • mismatching, missing, or duplicate information • erroneous time periods • hospital has rate for rate centers being reported • totals match sum across variables	• Reconciliations between case mix and financial data • Monthly unit rate compliance reports that provide hospitals with information on accuracy of information submitted • Experience reports are validated and approved by the hospital annually	• Special audit procedures • CDM audits • Program/Grant-specific audits

Routine Validation Ensures Data Quality and Integrity

Case Mix Audits

Purpose	• To verify what was reported in the case mix data versus what is coded in the medical record • To evaluate the level of accuracy of the hospital discharge submitted to the Commission upon which hospital payment rates and performance-based payments are based.
Process	• 10 hospitals per year; with additional focus reviews as needed • Vendor compares a sample of hospital discharges and visits with the documentation in the medical records, internal hospital policies, and HSCRC Accounting and Budget Manual to identify variances. • Hospitals with accuracy rates below the Performance Benchmark (PB) of 95 percent may be required to submit a corrective actions plan.

Case Mix Audit Results Showed Notable Improvements (FY 2018 – 2022)

- Overall, the weighted average performance scores across IP and OP improved over the five years
- Hospitals that were re-reviewed (due to substantial issues in a prior audit) tended to show performance improvements.
- Reviews of system hospitals showed marginal increase in performance for the certain IP and OP variables.
  - Hospital systems tended to learn from the errors found in hospitals performance reviews and diffuse that learning throughout their systems.
- Despite overall improvement, there were still issues for certain fields that are utilized in payment or performance models, such as discharge disposition.
  - We continued to monitor hospital performance for these fields.

Special Audit (Agreed-Upon Procedures)

Purpose	• To confirm the accuracy of data submitted by hospitals; • To ensure compliance with the regulations approved by the Maryland legislature
Process	• Hospitals hire an independent CPA firms to prepare their Special Audit Report (SAR) annually. • CPA firms will complete the SAR to ensure that the compliance testing contained in the SAR is completed properly. • Once the SAR reports are completed, staff will review for possible errors (exceptions). • When staff identifies an error (exception) in the SARs, staff will contact the hospital to determine how and when it will be rectified. • Annually, the collective results of the SARs and any future changes to the Agreed-Upon Procedures are communicated to MHA and all hospitals.

Significant Improvements in Compliance with the Agreed-Upon Procedures: FY 2022 Highlights

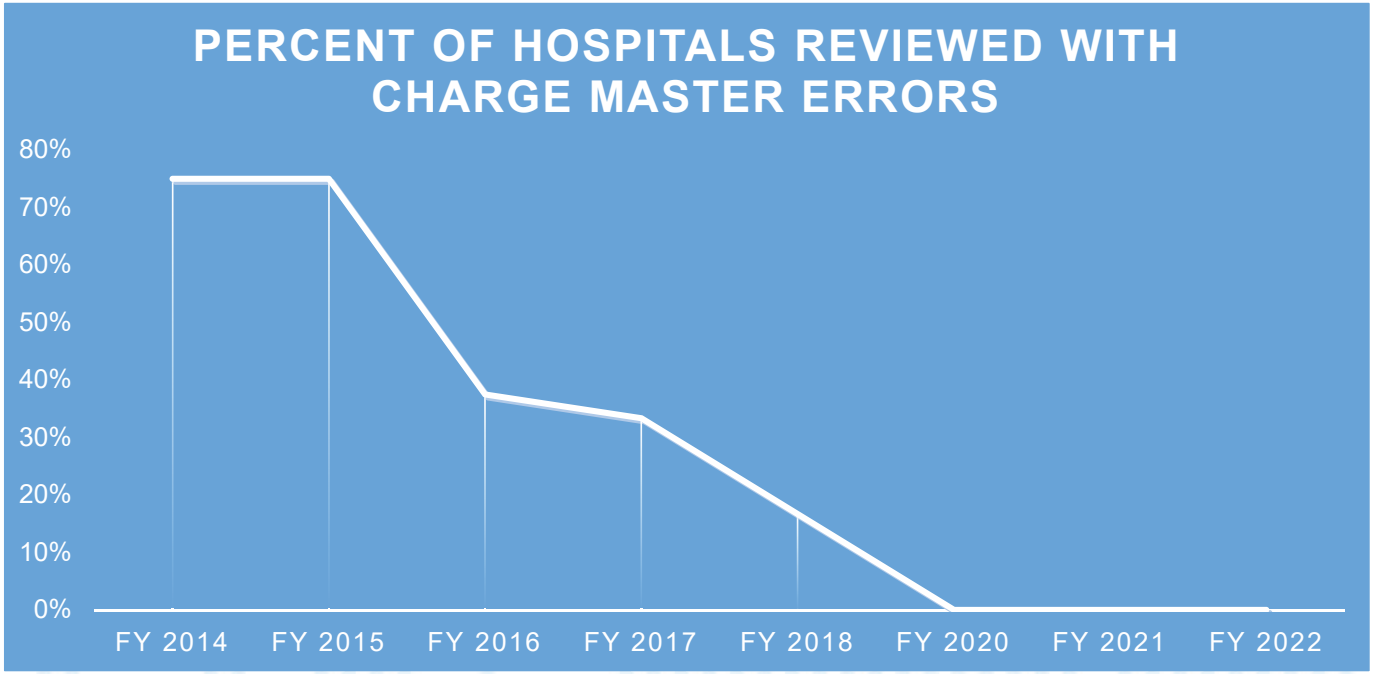
Audit Procedures	Description	Results	Reason
Financial Assistance	Adherence to procedures enumerated in the financial assistance policy	Exceptions reduced by 65%	Hospitals communicated better with their internal processes with their Independent Audit team
Screening Patients	Document the process used to screen patients before they are sent to collections	Exceptions reduced by 81%	Hospitals needed additional time to established new internal processes
Debt Collection / Financial Assistance Reporting	Report the amount of financial assistance received by patients in each ethnic / racial group	Exceptions reduced by 89%	HSCRC clarified reporting instructions

Charge Master Audits

Purpose	• Reconcile Hospital's Chargemaster Report (CDM) to the Monthly Hospital Volume/Revenue submitted to HSCRC • Ensure that the Hospital's Rate Center's RVUs used to calculate the patient charge reconciles to the HSCRC Accounting and Budget Manual (Appendix D) Note: The rate used per rate center is also reviewed by the HSCRC rate staff during their monthly compliance testing
Process	• Staff will randomly choose 6-8 hospitals for testing • From the chosen hospitals, Audit staff will choose 5 ancillary cost centers for testing • Audit staff will request the CDM per each rate Center chosen for testing • CDM data is compared to the hospital volumes and revenue report (Experience Report) for the same period

Chargemaster Audit Results Show Significant Improvements in Reporting

Over the past several years, no material errors have been found as hospitals are doing a better job ensuring their chargemasters are correct.



Race Data Validation

KMPG (on behalf of MHA) analyzed case mix data to understand the quality of the race data and found that all **Race, Ethnicity and Language (REaL) data fields are > 99% complete** and consistent relative to most recent census

Data processing vendor (hMetrix) analyzed case mix data across settings (IP/OP) and hospital and found Between 2016 and 2021, **93% of Unique patients maintained the same race** values across visits.

Significant efforts have been made to ensure completeness of race and ethnicity data. The average percent of records coded as “Unknown” (Race or Ethnicity) is approx. 0.5% percent of total discharges.

Race data have been incorporated into several public reporting dashboards - an important tool in shining a light on health disparities.

Future Activities

Case Mix Audits	• Procuring new vendor • Increasing the number of touch points with hospitals (12 annual plus 6 focused audits) to ensure improvements in accuracy • Including Psych and Freestanding Medical Facilities
Ethnicity	• Investigating the accuracy of ethnicity data
Special Audit Procedures	• Focus on medical debt procedures and financial assistance reporting
Charge Master Audit	• Increasing the number of annual reviews • Aligned with/informed by case mix and special audit results
Additional Audits	• Utilize in-house tools (i.e., Tableau) to look across data sources to investigate data anomalies through focused reviews/audits

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Open Cases Overview

January 10, 2024

Open Cases

- 2640A: University of Maryland Medical Center - OptumHealth Care Solutions, Inc. - *Solid Organ and Bone Marrow Transplants* **- Approved for One Year**
- 2641R**:** UM Upper Chesapeake Behavioral Health Pavilion - Full Rate Application to establish rates for new psychiatric hospital - **Requires Commissioner Vote**
- 2642N: University of Maryland Medical Center - Partial Rate Application for Ambulance Services as a rebundled service - February Staff Recommendation

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2023**
MEDICAL CENTER	*	**FOLIO:**	**2450**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2640A**

Staff Recommendation

January 10, 2024

I. INTRODUCTION

The University of Maryland Medical Center (the "Hospital") filed a renewal application with the HSCRC on November 30, 2023, for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with OptumHealth Care Solutions, Inc. for a one-year period, effective January 1, 2024.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University of Maryland Faculty Physicians, Inc. (FPI), which is a subsidiary of the University of Maryland Medical System. FPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to FPI for all contracted and covered services. FPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between FPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract. FPI maintains that it has been active in similar types of fixed fee contracts for several years, and that FPI is adequately capitalized to the bear risk of potential losses.

V. STAFF EVALUATION

The staff found that the Hospital's experience under this arrangement for the previous year was favorable. Staff believes that the Hospital can continue to achieve a favorable performance.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one-year period beginning January 1, 2024.

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

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Full Rate Application Staff Recommendation

UM Upper Chesapeake Behavioral Health Pavilion at Aberdeen

2023

Background & Overview

- 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.
- UM Upper Chesapeake Behavioral Health Pavilion at Aberdeen ("BHP") is part of UCHS' plan to restructure its health care services and modernize its delivery system, consolidating services for cost savings and efficiency.
- UM Harford Memorial Hospital ("HMH") will convert to a freestanding medical facility, and BHP will be a new 33-bed psychiatric hospital opening on February 6, 2024.
  - UM Harford Memorial Hospital operates the only acute care adult psychiatric hospital program in Harford County.
- BHP expands access to psychiatric services in Harford County, meeting the need for 33 inpatient psychiatric beds and additional outpatient psychiatric services.

Hospital Request

- BHP is requesting a new set of rates for its opening on February 6, 2024.
- Revenue is based on HMH utilization patterns and unit rates, serving the same patient population as HMH with additional gero-psych patients and expanded outpatient psych services.
- The payer mix at BHP includes a significantly higher share of Medicare patients (49 percent) compared to Sheppard Pratt Hospital's ("SPH") 17 percent.

Upper Chesapeake Behavorial Health
Requested Rates
FY2024

Rate Center	Description	Unit of Measure	Upper		Total Psych	Total Psych
PAD	Psychiatric Acute	Patient Days	$1,731.78	1	7,843	$13,582,678
PSG	Psych Geriatric	Patient Days	1,545.64	1	2,204	3,406,581
ADM	Admissions	Admission	761.41	1	1,220	928,726
CL	Clinic Services	RVU	15.39	1	21,042	323,737
PDC	Psychiatric Day/Night	Visits	726.40	1	3,900	2,832,964
LAB	Laboratory	RVU	7.65	1	437,213	3,345,744
EKG	Electrocardiography	RVU	16.00	1	5,189	83,018
EEG	Electroencephalography	RVU	3.71	1	2,231	8,275
RAD	Radiology-Diagnostic[3]	RVU	59.43	1	2,697	160,271
CAT	CT Scanner[3]	RVU	5.58	1	4,689	26,161
MRI	MRI Scanner[3]	RVU	39.82	1	1,120	44,616
PTH	Physical Therapy	RVU	35.74	2	1,229	43,915
RES	Respiratory Therapy	RVU	4.88	2	17,139	83,723
OTH	Occupational Therapy	RVU	24.64	2	951	23,444
STH	Speech Therapy	RVU	12.46	2	144	1,794
MSS	Med./Surg. Supplies	Invoice Cost	1.92	2	4,693	9,008
CDS	Drugs	Invoice Cost	4.10	1	479,007	1,963,082
					Total	$26,867,736

Note 1: Based on RY2024 Sheppard Pratt approved rates adjusted for Upper Chesapeake Behavioral Health mark-up
Note 2: Sheppard Pratt does not have this rate therefore UM Harford Memorial's RY2024 approved rate was utilized
Note 3: Reflects a rebundled rate

Table 1. Requested Rates

Projected System Savings

	Current at RY2024 HMH rates					Psych Specialty Hospital		
Payer	Payer Mix	Charges	Payer Discount	Net Revenue		Charges	Payer Discount	Net Revenue
Medicare	49.3%	$12,513,571	7.7%	$11,550,026		$13,245,794	54.7% 1	$6,004,900
IP Medicaid	25.9%	6,574,067	7.7%	6,067,863		6,958,744	6.0%	6,541,219
OP Medicaid	6.6%	1,675,245	7.7%	1,546,251		1,773,271	10.0%	1,595,944
IP Blue Cross	5.0%	1,269,125	2.3%	1,240,570		1,343,387	2.3%	1,313,161
OP Blue Cross	4.7%	1,192,977	2.0%	1,169,118		1,262,784	2.0%	1,237,528
Provision for Uncollectable Accounts:	3.8%	964,535	100.0%	-		1,020,974	100.0%	-
Provision for Other Payors:	4.7%	1,192,977	2.0%	1,169,118		1,262,784	2.0%	1,237,528
Total	100.0%	$25,382,497		$22,742,945	b	$26,867,736		$17,930,279
Change in Net Reimbursement							c	($4,812,666)
Change in Gross Charges							d = c / (b/a)	($5,371,225)

Table 2. Projected System Savings

	Current at RY2024 HMH rates				Psych Specialty Hospital		
Payer	Payer Mix	Charges	Payer Discount	Net Revenue	Charges	Payer Discount	Net Revenue
Medicare	49.3%	$12,513,571	7.7%	$11,550,026	$13,245,794	43.0% 1	$7,550,103
IP Medicaid	25.9%	6,574,067	7.7%	6,067,863	6,958,744	6.0%	6,541,219
OP Medicaid	6.6%	1,675,245	7.7%	1,546,251	1,773,271	10.0%	1,595,944
IP Blue Cross	5.0%	1,269,125	2.3%	1,240,570	1,343,387	2.3%	1,313,161
OP Blue Cross	4.7%	1,192,977	2.0%	1,169,118	1,262,784	2.0%	1,237,528
Provision for Uncollectable Account	3.8%	964,535	100.0%	-	1,020,974	100.0%	-
Provision for Other Payors:	4.7%	1,192,977	2.0%	1,169,118	1,262,784	2.0%	1,237,528
Total	100.0%	$25,382,497		$22,742,945	$26,867,736		$19,475,482
Change in Net Reimbursement						c	($3,267,464)
Change in Gross Charges						d = c / (b/a)	($3,646,686)

Table 3. Estimated Staff Projections of Gross Savings

- The Hospital projects $5.4 million in system savings related to the opening of BHP. This savings is part of total savings of approximately $15m, previously pledged.
- Staff estimates the highest value of gross savings at $3.6 million if the payer discount is actually 43%.

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Staff Analysis

- Staff recommendation is the result of a thorough analysis of the BHP CON application, approval process, and market conditions.

- Evaluation of requested rates and revenue at projected volume in comparison to the RY 2024 rates for Sheppard Pratt, Harford Memorial, and the statewide median.
  - Requested rate structure was 10.7 percent higher than Sheppard Pratt, 10 percent higher than the statewide median, and 6 percent higher than Harford Memorial.

- Requested rates for BHP are based on Sheppard Pratt's approved rates for RY 2024, Harford Memorial's approved rates for RY 2024 (for rate centers not offered at SP) and adjusted for a BHP specific markup.

Staff Recommendation

- Staff recommends Commission approval of the revenue and unit rates in Table 4, effective February 6th, 2024, for UM Upper Chesapeake Behavioral Health Pavilion at Aberdeen.
- Full inflation for BHP for FY 2025 and 2026 without an offset for productivity.
- If the Hospital does not achieve the anticipated level of savings set forth in table 2, revenue will be removed from UM Upper Chesapeake to ensure previously agreed upon savings levels are met.

HEALTH SERVICES COST REVIEW COMMISSION

New Approved Revenue and Unit Rates
for
UM Upper Chesapeake Behavioral Health Pavilion at Aberdeen

Effective
February 6, 2024

Revenue Center		Service Unit	Unit Rates	Budgeted Volume	Budgeted Annual Revenues
Psych Adult		Patient Days	$1,731.7800	3,268	$5,659,465
Psychiatric - Geriatric		Patient Days	$1,545.6400	918	$1,419,413
Admissions		Admission	$761.4100	508	$386,969
Clinic Services		RVU'S	$15.3900	8,767	$134,930
Psychiatric Day/Night		Visits	$726.4000	1,625	$1,180,400
Laboratory		MD RVU'S	$7.6500	182,172	$1,393,617
Electrocardiography		MD RVU'S	$16.0000	2,162	$34,593
Electroencephalography		74 CAL RVU'S	$3.7100	929	$3,448
Radiology-Diagnostic	R	HSCRC RVU'S	$59.4300	1,124	$66,784
CT Scanner	R	RVU'S	$5.5800	1,954	$10,903
MRI Scanner	R	RVU'S	$39.8200	467	$18,589
Physical Therapy		MD RVU'S	$35.7400	512	$18,297
Respiratory Therapy		MD RVU'S	$4.8800	7,141	$34,849
Occupational Therapy		RVU'S	$24.6400	396	$9,768
Speech Therapy		RVU'S	$12.4600	60	$748
(R) Rebundled Rate		TOTAL			$10,372,772

CHARGES for MEDICAL SUPPLIES and DRUGS SOLD

		Mark up		Maximum Annual Overhead
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

Table 4. Recommended Unit Rates

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IN RE: THE PERMANENT RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
UM UPPER CHESAPEAKE	*	DOCKET: 2023
BEHAVIORAL HEALTH PAVILION	*	FOLIO: 2450
AT ABERDEEN	*	PROCEEDING: 2641R
ABERDEEN, MARYLAND		

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STAFF RECOMMENDATION

January 10, 2023

I. INTRODUCTION

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

II. BACKGROUND

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.

III. THE HOSPITAL REQUEST AND JUSTIFICATION

BHP is expected to begin operations on February 6, 2024, and, therefore, is requesting a new set of rates for its opening. In the CON application, revenue was based on HMH utilization patterns and unit rates. It is expected that BHP will serve the same patient population currently treated at HMH, as well as additional gero-psych patients and expanded outpatient psych services (primarily partial hospitalization). The gero-psych patients will include dually diagnosed

med/surg acute patients, the likely result of which is expected to increase with the aging of the population.

As an adult only unit that includes the additional gero-psych beds, BHP's payer mix includes a significantly higher share of Medicare patients (49 percent) compared to Sheppard Pratt Hospital's ("SPH's") 17 percent. This difference in payer mix results in a mark-up at BHP approximately 10.7 percent higher than SPH. This is due to lower Medicare and Medicaid reimbursement for specialty psychiatric hospitals in Maryland, which is based on the CMS' prospective payment system for Medicare patients and State of Maryland Department of Health for Medicaid patients, not HSCRC approved rates. Historically, Medicare payments have been approximately 30 percent lower than HSCRC approved rates and Medicaid outpatient rates have been 10 percent lower than HSCRC approved outpatient rates.

Table 1

Requested Rates

Upper Chesapeake Behavorial Health
Requested Rates
FY2024

Rate Center	Description	Unit of Measure	Upper		Total Psych	Total Psych
PAD	Psychiatric Acute	Patient Days	$1,731.78	1	7,843	$13,582,678
PSG	Psych Geriatric	Patient Days	1,545.64	1	2,204	3,406,581
ADM	Admissions	Admission	761.41	1	1,220	928,726
CL	Clinic Services	RVU	15.39	1	21,042	323,737
PDC	Psychiatric Day/Night	Visits	726.40	1	3,900	2,832,964
LAB	Laboratory	RVU	7.65	1	437,213	3,345,744
EKG	Electrocardiography	RVU	16.00	1	5,189	83,018
EEG	Electroencephalography	RVU	3.71	1	2,231	8,275
RAD	Radiology-Diagnostic[3]	RVU	59.43	1	2,697	160,271
CAT	CT Scanner[3]	RVU	5.58	1	4,689	26,161
MRI	MRI Scanner[3]	RVU	39.82	1	1,120	44,616
PTH	Physical Therapy	RVU	35.74	2	1,229	43,915
RES	Respiratory Therapy	RVU	4.88	2	17,139	83,723
OTH	Occupational Therapy	RVU	24.64	2	951	23,444
STH	Speech Therapy	RVU	12.46	2	144	1,794
MSS	Med./Surg. Supplies	Invoice Cost	1.92	2	4,693	9,008
CDS	Drugs	Invoice Cost	4.10	1	479,007	1,963,082
					Total	$26,867,736

Note 1: Based on RY2024 Sheppard Pratt approved rates adjusted for Upper Chesapeake Behavioral Health mark-up
Note 2: Sheppard Pratt does not have this rate therefore UM Harford Memorial's RY2024 approved rate was utilized
Note 3: Reflects a rebundled rate

It is the position of BHP that these requested rates are reasonable because:

1. Rates are consistent with SPH's current rate structure adjusted for BHP's payer mix.
2. Due to lower Medicare payment rates, the requested rates would result in System savings compared to if the services remained in an acute care hospital.

IV. HOSPITAL RATE HISTORY

As noted above, BHP is expected to commence operations on February 6, 2024, and therefore, there is no rate history.

V. PROJECTED SYSTEM SAVINGS

The Hospital projects that it will generate $5.4 million in system savings related to the opening of this facility. The change in net reimbursement is based on projected BHP Medicare net reimbursement compared to HMH approved rates for a similar volume of services. This amount of projected gross savings is illustrated in table 2 below.

Table 2

	Current at RY2024 HMH rates				Psych Specialty Hospital		
Payer	Payer Mix	Charges	Payer Discount	Net Revenue	Charges	Payer Discount	Net Revenue
Medicare	49.3%	$12,513,571	7.7%	$11,550,026	$13,245,794	54.7% 1	$6,004,900
IP Medicaid	25.9%	6,574,067	7.7%	6,067,863	6,958,744	6.0%	6,541,219
OP Medicaid	6.6%	1,675,245	7.7%	1,546,251	1,773,271	10.0%	1,595,944
IP Blue Cross	5.0%	1,269,125	2.3%	1,240,570	1,343,387	2.3%	1,313,161
OP Blue Cross	4.7%	1,192,977	2.0%	1,169,118	1,262,784	2.0%	1,237,528
Provision for Uncollectable Accounts:	3.8%	964,535	100.0%	-	1,020,974	100.0%	-
Provision for Other Payors:	4.7%	1,192,977	2.0%	1,169,118	1,262,784	2.0%	1,237,528
Total	100.0%	$25,382,497 a		$22,742,945 b	$26,867,736		$17,930,279
Change in Net Reimbursement						c	($4,812,666)
Change in Gross Charges						d = c / (b/a)	($5,371,225)

Staff is seriously concerned over the calculation of these projected savings. A 30 percent markup has been built into rates at SPH. This amount has not been updated in their mark-up calculation over concerns that an even higher discount to Medicare would shift even more costs to other payers. Staff reviewed inpatient claims data for Medicare patients using data available in the chronic conditions warehouse ("CCW"). A review of CCW data revealed that the actual Medicare discount or reimbursement for psychiatric facilities in the State averaged approximately 43 percent. Given that the details in table 2 were calculated on a series of assumptions, with the patient discount being the most concerning to staff, staff has updated the

table and savings amount with a more accurate estimate for the Medicare discount that utilizes the statewide average for psychiatric facilities.

Table 3

Estimated Staff Projections of System Savings

	Current at RY2024 HMH rates				Psych Specialty Hospital		
Payer	Payer Mix	Charges	Payer Discount	Net Revenue	Charges	Payer Discount	Net Revenue
Medicare	49.3%	$12,513,571	7.7%	$11,550,026	$13,245,794	43.0% 1	$7,550,103
IP Medicaid	25.9%	6,574,067	7.7%	6,067,863	6,958,744	6.0%	6,541,219
OP Medicaid	6.6%	1,675,245	7.7%	1,546,251	1,773,271	10.0%	1,595,944
IP Blue Cross	5.0%	1,269,125	2.3%	1,240,570	1,343,387	2.3%	1,313,161
OP Blue Cross	4.7%	1,192,977	2.0%	1,169,118	1,262,784	2.0%	1,237,528
Provision for Uncollectable Account	3.8%	964,535	100.0%	-	1,020,974	100.0%	-
Provision for Other Payors:	4.7%	1,192,977	2.0%	1,169,118	1,262,784	2.0%	1,237,528
Total	100.0%	$25,382,497 a		$22,742,945 b	$26,867,736		$19,475,482
Change in Net Reimbursement						c	($3,267,464)
Change in Gross Charges						d = c / (b/a)	($3,646,686)

As seen in table 3 above, staff estimates that the highest value of gross savings that will be achieved at the psychiatric facility is $3.6 million, if reimbursement is actually 43 percent.

VI. STAFF ANALYSIS

This staff recommendation is the culmination of significant analysis and consideration of the BHP CON application, the process that resulted in CON approval, and analysis of the assumptions included in the CON compared to current market conditions. In addition, significant consideration was given to the implications of funding BHP relative to the Total Cost of Care. Additionally, staff evaluated the rate structure and approved rates for both Sheppard Pratt Hospital and UM Harford Memorial Hospital.

The requested rates for BHP were based on Sheppard Pratt's approved rates for RY 2024. There are several rate centers that will be at BHP that Sheppard Pratt does not use. For those rate centers, the requested rates were based on Harford Memorial's approved rates for RY 2024. The requested rates were then marked up based on the projected payer mix of patients receiving care at BHP.

Staff compared the requested rates and revenue at projected volume to the RY 2024 rates for Sheppard Pratt, Harford Memorial, and the statewide median. The requested rate structure

was 10.7 percent higher than Sheppard Pratt, 10 percent higher than the statewide median, and six percent higher than Harford Memorial.

As noted, in section III of this document, BHP will be an adult only unit, which establishes two clinically distinct programs: a non-geriatric adult psychiatric program and a geriatric program. There is no age restriction on patients who will be treated for psychiatric disorders within the geriatric program; however, these patients are projected to be in the 65 and older cohort. As a result of the large volume of patients projected to be older than 65, the payer mix is expected to be inclusive of an increased proportion of Medicare patients. The expected payer mix at BHP is the driver for the increased rate structure when compared to target hospitals. It is important to note that the payer mix gets updated each rate year but not the differential. To the extent that this expected payer mix changes, the change in mark-up will be incorporated into rates the following year. Medicare does not reimburse private psychiatric hospitals in Maryland based on Commission approved rates. Instead, private psychiatric hospitals are reimbursed based on Medicare's own reimbursement schedule. These payments had previously resulted in a difference of approximately 30 percent less than Commission approved rates at Sheppard Pratt. Private psychiatric hospitals do not operate under a global budget agreement. These hospitals were not included under the previous waiver or the current waiver.

In addition, staff notes that after a full year of rate history has been developed at the Hospital, it is possible for hospitals to be exempted from Maryland rate setting based on a payer mix that is at least 66-2/3 percent governmental payers.

VII. Staff Recommendation

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 Commission approve the recommended revenue and unit rates set forth in table 4 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 set forth in table 2, revenue will be removed from UM Upper Chesapeake to ensure previously agreed upon savings levels are met.

Table 4

Recommended Unit Rates

HEALTH SERVICES COST REVIEW COMMISSION

New Approved Revenue and Unit Rates
for
UM Upper Chesapeake Behavioral Health Pavilion at Aberdeen

Effective
February 6, 2024

Revenue Center		Service Unit	Unit Rates	Budgeted Volume	Budgeted Annual Revenues
Psych Adult		Patient Days	$1,731.7800	3,268	$5,659,465
Psychiatric - Geriatric		Patient Days	$1,545.6400	918	$1,419,413
Admissions		Admission	$761.4100	508	$386,969
Clinic Services		RVU'S	$15.3900	8,767	$134,930
Psychiatric Day/Night		Visits	$726.4000	1,625	$1,180,400
Laboratory		MD RVU'S	$7.6500	182,172	$1,393,617
Electrocardiography		MD RVU'S	$16.0000	2,162	$34,593
Electroencephalography		74 CAL RVU'S	$3.7100	929	$3,448
Radiology-Diagnostic	R	HSCRC RVU'S	$59.4300	1,124	$66,784
CT Scanner	R	RVU'S	$5.5800	1,954	$10,903
MRI Scanner	R	RVU'S	$39.8200	467	$18,589
Physical Therapy		MD RVU'S	$35.7400	512	$18,297
Respiratory Therapy		MD RVU'S	$4.8800	7,141	$34,849
Occupational Therapy		RVU'S	$24.6400	396	$9,768
Speech Therapy		RVU'S	$12.4600	60	$748
(R) Rebundled Rate		TOTAL			**$10,372,772**

CHARGES for MEDICAL SUPPLIES and DRUGS SOLD

		Mark up		Maximum Annual Overhead
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 in table 4 represents a stub period of 5 months of the fiscal year.

UM Rehabilitation & Orthopaedic Institute Redesign Proposal

HSCRC Public Session

January 10, 2024

compassion | discovery | excellence | diversity | integrity

Our Goals: Enhance Clinical Services, Reduce Excess Capacity, Generate Savings

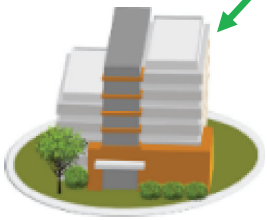
Maintain/Enhance Needed Services

- **Enhance** UMMC's vital Shock Trauma Program
- **Assure** continued access to needed inpatient rehabilitation services

Redesign → Transformation

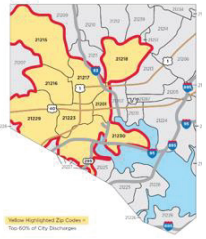
- **Redeploy** funds toward community health efforts
- **Generate Savings** as efficiencies are achieved

Enhance Inpatient Trauma Rehab by relocating to UMMC Downtown Campus (Stoler Center for Advanced Medicine)



Relocate Inpatient Complex Medical Rehab and Stroke/Neuro Rehab to New Inpatient Rehabilitation Facility (IRF)

Community Engagement Focus Area



Contribute funding to support UMMS' robust community health infrastructure in Baltimore City (focusing on W. Balt)

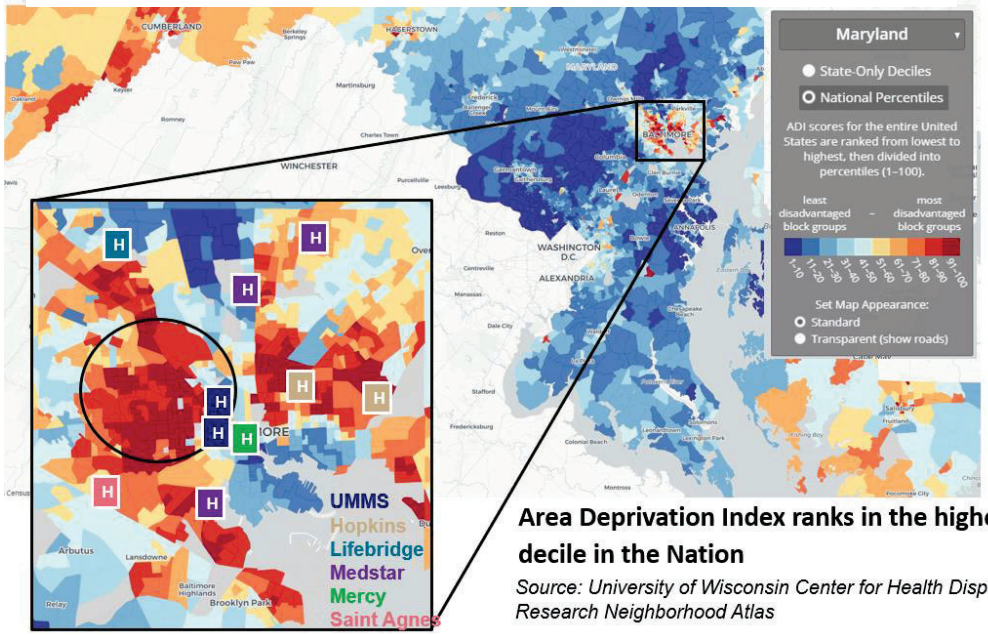
Create savings by reducing footprint for acute hospital-based services (consolidate into UMMC's Midtown and Downtown Campuses)

Outline of Anticipated Clinical Program Distribution

	Stoler Center (@ UMMC)	Freestanding Inpatient Rehabilitation Hospital	Absorb into UMMC Midtown or Downtown Hospital	Dissipate to another acute provider
Inpatient Rehabilitation	-Traumatic Brain Injury -Spinal Cord Injury -Comprehensive Medical (30%)	-Stroke/Neuro -Comprehensive Medical (70%)		
Acute hospital services			<u>Faculty programs</u> -Most Ortho surgery (74%) -Other surgery -OP dental surgery and clinics -OP Pain -Most OP Therapies (68%) -OP Clinics	-Non-faculty surgeries -Some Faculty ortho surgery (26%) -Some OP therapies (32%)
$148M total GBR:	**$40M**	**$37M**	**$46M**	**$25M**

The Proposed Redesign Establishes a Needed Source of Funding to Ensure Sustainability for Enhanced Community Health Efforts in West Baltimore

West Baltimore Community is Among the Most Disadvantaged in the Country



Area Deprivation Index ranks in the highest decile in the Nation

Source: University of Wisconsin Center for Health Disparities Research Neighborhood Atlas

Health Needs	Social/Environmental Factors
Heart Disease/Blood Pressure	Neighborhood Safety/Violence
Diabetes/High Blood Sugar	Poverty
Alcohol/Drug Addiction	Lack of Job Opportunities
Mental Health (Depression/Anxiety)	Racial/Ethnicity Discrimination
Overweight/Obesity	Housing/ Homelessness

Source: UMMC Midtown/Downtown 2021 Community Health Needs Assessment and Implementation Plan (2022-2024)

Value Proposition That Aligns with Model Goals

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/deduplicates acute capacity → more efficient acute footprint

- Consolidation of ORs, MSGA beds, ancillary, support services, and physician coverage

Estimated $29M revenue beyond ongoing costs of project (operating and capital) entirely dedicated to system savings or community health infrastructure

- $21.5M to system savings
- $7.3M restricted to support community health efforts

maryland
health services
cost review commission

MINUTES OF THE
614th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
December 6, 2023

Chairman Josh Sharfstein called the public meeting to order at 8:35 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 Nickki McCann, J.D.

ITEM I
REVIEW OF SELECT HSCRC PROCESSES

The Commission and staff discussed potential changes to HSCRC work processes.

Staff reviewed the existing process for managing workgroups, the current structure of the HSCRC standing workgroups (Payment Models, Performance Measurement, and Total Cost of Care Workgroups), the use of technical subgroups, and the role of workgroups to serve as advisory bodies to staff.

Commissioners and staff discussed establishing a formal policy for workgroups that incorporated the current approach of hosting all meetings publicly and posting all meeting webinar links and materials to the HSCRC website. Commissioners and staff discussed the significance of building diverse memberships, so multiple perspectives are heard in the policy development process. Staff were charged with considering approaches to updating membership rosters to ensure robust participation, and that key stakeholders are represented. Commissioners and staff also discussed additional topics for the policy, including obtaining formal feedback from workgroup membership and providing regular updates to the Commissioners on workgroup activities. Commissioners and staff agreed to develop a policy on workgroups that could be released for public comment before being finalized.

Staff and commissioners next discussed existing processes for reviewing and developing new policies and programs and potential refinements to the policymaking process. Staff discussed the current approach to policy development, which includes analytics and modeling, stakeholder engagement, and presenting draft and final policies to Commissioners. Commissioners and staff discussed developing a formal policy that would include a step of bringing a plan early to the Commission before workgroup engagement and full policy development. The Commission will review and approve such an approach to policy development at a future Commission meeting.

Commissioners and staff also discussed using a similar approach for initial policy development when promulgating regulations. Staff would potentially bring an initial plan to Commissioners at the beginning

of the process and highlight critical elements for Commissioner consideration. Based on this discussion, the staff will bring an approach for regulation development to a future Commission meeting for adoption.

ITEM II
REVIEW OF HSCRC WORK ITEMS

The Commission and staff discussed prioritization of key staff activities over the next 18 months. No decisions on priorities were made, and Director Kromm indicated that an 18-month policy calendar will be reviewed by the Commission at a future meeting.

These topics included:

High cost drug funding. Staff indicated that the Commission will consider modifications to policy, given recent changes in clinical care.

Revenue for reform. Staff also discussed bringing back an update on Revenue for Reform applications in the spring and making further policy changes to align with Maryland Department of Health (MDH) population health priorities later in the year.

Capital policy. Staff discussed the capital policy and the interrelationship with market shift and volume policies. Future considerations to the capital policy included limiting the eligible size of projects, reassessing the excess capacity adjustment, and the influence of efficiency on potential funding. Staff noted that many hospitals have been able to make capital improvements independent of HSCRC policy.

Market shift adjustments. Staff highlighted some considerations related to consolidation of defined markets, reassessing the appropriateness of a 50 percent variable cost factor, and evaluating current and potential exclusions.

Volume policies. Staff discussed the idea of codifying the existing policies to improve transparency, as well as convening a technical subgroup to obtain feedback on key questions There was discussion about the challenge of reviewing the capital, market shift, and volume policies in isolation, given their interactions.

Quality and equity measures. Staff noted that as surgeries move to outpatient facilities, the HSCRC loses the ability to directly monitor quality. Commissioners and staff discussed the challenges for HSCRC to become more involved in monitoring quality outside of hospitals. Staff also discussed current activities to build new equity measures around timely follow-up and monitoring CMMI health equity requirements.

Financial protections. Staff discussed consumer financial protections related to financial assistance, facility fee notices, and medical debt collection regulations. Staff highlighted that consumer financial

protections have been a legislative priority, and that the Commission should address these policies proactively. Staff discussed future work related to refining law, regulations, and documents to strengthen consumer protections. Staff also discussed the need to strengthen technical assistance to hospitals, as hospitals have cited operational challenges and implementation challenges associated with cost and complexity. Staff also discussed improving data collection, reporting, oversight, and compliance.

Hospital financial performance. Staff discussed whether it made sense to prioritize a hospital financial performance assessment that hospitals requested and was approved by Commissioners in the FY 2024 update factor recommendation. Staff indicated that staff already shares financial data publicly and with the Commission, and that staff assess financial data on an ad-hoc basis in addressing specific issues. The staff and commissioners noted the challenges in conducting a full assessment, which would involve close examination of hospital spending outside of regulated areas.

ITEM III
NEW OPPORTUNITIES

The Commission and staff discussed "blue sky" ideas for consideration over the next two years. Executive Director Kromm indicated that "blue sky" opportunities are intended to explore relatively new areas of policy development as opposed to refinement of current policy. These are early-stage thoughts of Commissioners and staff and not yet formed into proposed policy approaches. Prior to any of these ideas becoming policy, there would be discussion at a Commission meeting and public engagement. In addition, it was noted that some or all of these ideas could be considered by the State of Maryland through the development of the AHEAD model.

Here are the "blue sky" ideas discussed:

Megan Renfrew discussed opportunities to improve community benefits accountability and alignment. She noted that there is no required minimum amount of community benefit spending, and that spending could be coordinated with population health goals and other aligned programs.

Erin Schurmann discussed the significance of developing a broad, wide-reaching approach to addressing population health and health equity that engages partners beyond MDH/HSCRC and traditional healthcare providers and experts. She highlighted the significance of addressing social determinants of health to achieve population health and health equity improvements The idea included a social determinants of health (SDOH) special funding program that would aim to leverage aligned funding sources from cross-sector partners around a single program framework to support community health programming and investments.

Allan Pack discussed the need for a Freestanding Medical Facility (FMF) policy as more hospitals consider converting to FMFs. The policy would create standards for any major facility conversion, outline a process for hospitals to follow when considering conversion, and establish expected savings, maintenance of effort for various types of access to care, and allow retained revenue for population health investments and/or recapitalization.

Commissioner Joshi presented an idea for the Commission to support graduate medical education (GME) program expansion in underserved areas. Commissioner Joshi discussed a need to review current investment in GME, growing primary care-oriented residencies, and how to grow residency programs. Staff highlighted the difficulty in unraveling GME funds from hospital rates.

Commissioner Joshi discussed opportunities around statewide quality improvement efforts, similar to the current EDDIE emergency wait time project. Commissioner Joshi suggested identifying areas in need of significant improvement or areas in which the State would like to be a national leader. Commissioner Joshi suggested leveraging HSCRC policy levels (e.g., payment) to hold hospitals accountable for performance improvement and the significance of best practice sharing. Staff and Commissioners discussed the important role that the Maryland Hospital Association (MHA) and Maryland QIO could play in ongoing hospital quality improvement.

Chairman Sharfstein discussed the potential development of an Innovation Fund which would support opportunities to improve health outcomes, patient experience, and equity and lower costs when there is promising evidence that certain interventions can be successful. The Commission could develop a fund that would co-invest with health systems individually or collectively in the implementation of innovative approaches.

Commissioner McCann and Commissioner Elliott discussed exploring Hospital at Home as a future program under the Model. Staff indicated that this was a program that was explored in prior years and that they would circulate a previously published staff report on Hospital at Home to Commissioners after the meeting.

Commissioner McCann discussed an idea to support the development of community health collaboratives to address health disparities. The collaboratives would bring multiple stakeholders together to address unmet healthcare needs and large SDOH issues. The program would use retained revenue, along with other public and philanthropic funding to support the collaboratives.

Commissioner McCann raised the idea of revisiting volume policies which had been discussed in the prior agenda item. It was noted again that review of volume policies could be included in a policy calendar.

Commissioner McCann discussed evaluating capacity and forming a BRAC-like commission to evaluate existing healthcare capacity across the state as well as future need.

Commissioner Kane discussed the need to further align hospital and non-hospital providers under the Model. Commissioner Kane discussed the need for potential new programs beyond existing frameworks to support provider collaboration.

Commissioner Johnson discussed a recommendation to align healthcare resources with community needs, specifically around capacity with hospital beds, urgent care, ASCs, and SNFs. Commissioner Johnson discussed the need to determine the appropriate supply regionally and to develop economic incentives to drive investment in disinvested areas and limit investment in oversupplied areas.

Commissioner Johnson discussed establishing rate integrity for clinic, surgical, and hospital prices. Commissioner Johnson discussed eliminating clinic rate centers and redistributing revenue across remaining rate centers. Commissioners and staff discussed concerns about the negative impact this could potentially have on access to care, particularly for Medicaid beneficiaries.

ITEM IV
CLOSING REMARKS AND NEXT STEPS

Chairman Sharfstein and Executive Director Kromm thanked all participating staff and Commissioners for their participation.

ITEM V
HEARING AND MEETING SCHEDULE

December 13, 2023, Times to be determined- 4160 Patterson Ave
HSCRC Conference Room

January 10, 2023, Times to be determined- 4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:18 p.m.

MINUTES OF THE
615th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
December 13, 2023

Chairman Joshua Sharfstein called the public meeting to order at 11:28 a.m. In addition to Chairman Kane, 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 Johnson and seconded by Vice Chairman Antos, the Commissioners voted unanimously to go into Closed Session. The Public Meeting reconvened at 1:00 p.m.

Dr. Kedar Mate

Dr. Kedar Mate, President & CEO, Institute for Healthcare Improvement, discussed the current struggles for healthcare systems/hospitals to maintain quality based measures.

Dr Mate stated that healthcare systems suffer from three essential problems.

The first problem is scale. With the number of pilot activities on going, many small projects can't be scaled to the level of a whole system.

The second problem deals with sustainability. With leadership or team turnover, health systems lose the gains made by former leadership/team.

The third problem "breaking down silos". Dr. Mate noted health systems struggle with silos as patient safety work is happening in one corner of the system, while workflow, value and equity work is happening in another.

Dr. Mate stated that the above problems are really the same true lack of structure in healthcare quality work.

Dr. Mate stated that for healthcare systems to succeed they need to build operating systems for quality. Dr. Mate stated that healthcare systems must imbed quality functions into their daily management activities of frontline care teams when they build quality operating systems.

Jon Kromm, Executive Director, asked Dr Mate for his opinion on how to improve the hospital's ED length of stay.

Dr. Mate recommended both to incentivize the ED process and outcome measures, but also to develop an observable set of structural changes.

STAFF UPDATE

Mr. Kromm introduced Christa Speicher, Oseizame Emaseula, and Jason Mazique as new members of the Staff. Ms. Speicher will be the Deputy Director Payment Reform, Medical Economics and Data Analytics, and Mr. Emaseula and Mr. Mazique positions will be Population Health Project Manager, Quality and Population Based Methodologies.

Mr. Kromm stated that Eric Lindeman will be transitioning as the lead consultant on the HSCRC Model Monitoring analytics at the end of the year. Mr. Kromm noted that Mr. Lindeman has been a key member of the HSCRC team since 2015.

Mr. Kromm also stated that Adam Fillhaber will be leaving CMMI at the end of the month. Mr. Fillhaber has served as the Maryland Model co-lead for four years.

REPORT OF DECEMBER 13, 2023, CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the items discussed at of the December 13, 2023, Closed Session.

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

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

ITEM II
ANNUAL FILING MODERNIZATION PROJECT OVERVIEW

Karen Teague, Associate Director, Data Analytics, and Wayne Nelms, Assistant Chief, Audit, and Integrity, presented an overview of the Staff's Annual Filing Modernization Project (see "Annual Filing Modernization Project Overview" available on the HSCRC website).

Ms. Teague noted that the Annual Filing Modernization Project (AFM) is a 3-year project. AFM goals are as follows:

- Modernize policies and templates used for gathering data on provider costs and population health resources.
- Modernize policies and templates used for gathering data on various cost centers.
- Revise the cost allocation framework to enable centralized application of consistent allocation algorithms across all Maryland hospitals.
- Assemble a comprehensive web-based tool for Maryland hospitals to utilize in completing and submitting their future Annual Filings

- Perform a complete review and update of the Accounting and Budget Manual to reflect current policy and practice and achieve greater user.

The critical elements of the AFM are the participation from Maryland Hospital and other stakeholders. In addition to the support from i3 Healthcare Consulting LLC, Mathematica and SB and Company.

The AFM is made up as follows:

Subgroup 1-

Modernize policies and data gathering in key areas of hospital operations.

a. Provider costs (physicians and extenders) and related revenues for which the hospital is responsible.
b. Population Health operating costs and revenues
c. Administrative and overhead costs

Update the overhead cost allocation framework.

a. Ensure consistent allocation of overhead costs across all Maryland hospitals – Categories of cost & metrics used to determine allocation.

Subgroup 2- Data Management

Assemble a comprehensive web-based tool for Maryland hospitals to utilize in completing and submitting their future Annual Filings.

Subgroup 3- Manual Revisions

Create an Accounting and Budgeting Manual that reflects current policy and delivers it online in a user-friendly format.

The manual revision will be done in two phases.

Phase 1

- Remove outdated content.
- Update to current policy
- Seek Regulatory approval.

Phase 2

- Revise to reflect upcoming policy changes, data collection and use.
- Seek Regulatory approval.

Once approved the revised Accounting and Budget Manual will be published. It is anticipated that the revised manual will be published by April 2025.

. **ITEM III**

HOSPITAL AND REGIONAL FACTORS ASSOCIATED WITH EMERGENCY DEPARTMENT LENGTH OF STAY

Geoff Dougherty, Deputy Director, Population Based Methodologies, Analytics, and Modeling presented an update on hospital and regional factors associated Emergency Department (ED) length of stay (see "Hospital and Regional Factors Associated with ED Length of Stay" on the HSCRC website posted with the post-meeting materials for December 2023.

After the presentation, Chairman Sharfstein asked Staff to clarify the statement that Medicare patients receiving annual wellness visits see a significantly lower ED LOS.

Dr. Dougherty explained that this was the case when other variables were controlled. He stated this was not empirical evidence, but visits with PCPs influence patient acuity.
.

Staff's draft recommendation is as follows:

Recommendations for ongoing measurement and engagement

- EDDIE - Continue to steward rapid cycle improvement in ED performance.
- Other Efforts Coordinated with Maryland Hospital Association

Recommendations for payment policy

- Quality-Based Reimbursement (QBR) policy – Staff proposal provides new incentive for improvement on CMS ED-1 measure.
- Multi-Visit Patient policy – Financial reward for reduction in percentage of ED visits accounted for by patients with 4 or more visits per year.
- Workgroup to monitor impact of policies on ED performance, propose payment policy changes and provide periodic reporting to General Assembly
    - Potentially establish a stand-alone pay-for-performance program weighted at 1% of inpatient revenue that incents improvements in ED LOS root causes and continued improvement in EDDIE.

ED Wait Times Update

Alyson Shuster, Deputy Director, Quality Methodologies, and Geoff Dougherty, Deputy Director, Population-Based Methodologies, Analytics, and Modeling presented the monthly update on the Emergency Department Dramatic Improvement performance for November (see "Emergency Department Dramatic Improvement Effort" available on the HSCRC website).

At the June Public Meeting, Staff stated that the state legislature requested that Staff and MHA convene a workgroup to identify solutions to improve hospital Emergency Department (ED) performance.

Maryland has underperformed on ED measures since well before the start of the All-Payor model.

The workgroup task will address:

- ED challenges due to significant lack of statewide Emergency Medical Services units.
- Developing payment policies for ED wait times and avoidable ED for CY 24
- Identifying short-term policies that could spur rapid city improvement.

To help improve ED performance the workgroup developed the Emergency Department Dramatic Improvement Effort (EDDIE) project.

Staff implemented the EDDIE project in August.

EDDIE is a short-term reporting project that will be used for conversation and input. The components to be addressed are as follows:

The first component of EDDIE is a rapid cycle Quality Initiative (QI) that will be led by MHA. MHA has hired a contractor to lead 4 hospital group discussions on how to address ED length of stay.

All hospitals submitted an initial aim statement to MHA as part of the rapid-cycle QI initiative.

- Submitting initial aim statements represents an important first step.
- The intent for the EDDIE Project is to engage in a multi-cycle improvement process to bring Maryland ED length of stay (i.e., wait times) towards the national average within an agreed upon time frame**.**
- Ongoing monthly progress updates will be critical for executing the intended multi-cycle improvement process.

When reviewing these aim statements, Staff determines if the statements were specific, measurable, achievable, realistic, and timely. Staff believe that the hospitals may need to clarify their aim statements so that they are specific enough to be monitored.

The staff has determined that the next step is to decide on statewide long-term goals and a timeframe for achievement. They will also monitor progress on QI sprints to ensure achievement of long-term goals.

The second component of EDDIE is the monthly, public reporting of three measures:

- ED1 Inpatient arrival to admission time
- OP18 Outpatient ED arrival to discharge time.
- EMS turnaround time (data from Maryland Institute for Emergency Systems)

Dr. Schuster stated that Staff received November data from all of the hospitals. She noted that this data is preliminary and has not been audited.

Dr. Dougerty presented the hospital's EMS Turnaround EDDIE data for November. Dr Dougherty noted t Suburban, Good Samaritan, St. Josephs and Grace Memorial moved up into the highest performing category. CalvertHealth fell to the middle category.

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

- Provide Commissioners with draft recommendation for inclusion of ED related measures in RY26 (CY24) Quality Based Reimbursement.
- 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.
- Determine statewide long-term goals and timeframe for achievement.
- Invite high and low performing hospitals or other speakers to a future Commission meeting.

ITEM IV
FINAL RECOMMENDATION ON QUALITY-BASED REIMBURSEMENT PROGRAM FOR RY 2026

Dr. Schuster and Dianne Feeney, Associate Director, Quality Initiatives, presented Staff's final recommendation on the Quality-Based Program for RY 2026 (see "Final Quality-Based Reimbursement Program for Rate Year 2026" available on the HSCRC website).

The quality programs operated by the HSCRC, including the Quality Based Reimbursement (QBR) 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.

The QBR 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 within a global budget framework.

The QBR policy currently holds 2 percent of hospital inpatient revenue at-risk for Person and Community Engagement, Safety, and Clinical Care outcomes.

This policy ensures that the quality of care provided to consumers is reflected in the rate structure of a hospital's overall global budget. The HSCRC quality programs are all payer in nature and so improve quality for all patients that receive care at the hospital.

Quality programs that reward hospitals for the better of attainment or improvement (QBR and RRIP) better allow the policies to target improvements in hospitals that serve a high proportion of under-resourced patients. The Health Equity Workgroup (HEW) analyzed the Medicare Timely Follow-Up (TFU) measure and found disparities by race, dual-status, and Area Deprivation, and thus is proposing an addition of a disparity gap improvement metric for TFU. Going forward, HSCRC staff will continue to analyze disparities and propose incentives for reducing them in the program.
Staff received comments from Commissioners, Hospitals, PMWG members, and stakeholders. Based on comments received Staff will revise their final recommendation to include the following:

- Domain Weighting
    - Increase Safety from 25% to 30%
    - Decrease Clinical Care from 15% to 10%
    - To add ED wait time measure weighted at 10%.
    - Remove THA-TKA measure and reduce which results in Clinical Care weight being reduced by 5%.
- To adjust the RY2024 QBR cut point from 41% to 32% due to pre-COVID performance standards.

Based on comments, Staff's final recommendations for RY 2026 QBR Program are as follows:

1. Modify Domain Weighting as follows for determining hospitals' overall performance scores: Person and Community Engagement (PCE) - 60 percent (+10% from RY2025), Safety (NHSN measures) - 30 percent (5% from RY 2025), Clinical Care - 10 percent (-5% from RY 2025).
    - Within the PCE domain:
        a) Increase domain weight to 60 percent to accommodate new measures.
        b) Decrease the weight on HCAHPS top box: maintain weight on consistency linear measures.
        c) Continue to include Medicare and Medicaid Timely Follow-Up (TFU) rates and add TFU Disparity Gap measure weighted at 10%
        d) Add an ED wait time measure weighted at 10%.
    - Within the Safety domain:
        a) Reduce overall domain weight from 35 to 30 percent to be closer the CMS VBP program weighted at 25%
    - Within the Clinical Care domain:
        a) Continue to include the inpatient mortality measure in the program.
        b) Remove THA-TKA measure and reduce domain weight by 5%

c) Add the all-payer, all-cause 30-Day Mortality measure.
d) Split the domain weight between the two mortality measures.

2. Develop the following monitoring reports to track hospital performance:

    - Timely Follow-Up for Behavioral Health
    - Sepsis Dashboard: Sepsis mortality, Sep-1 measure–Early Management Bundle, Severe Sepsis/Septic Shock

3. Continue implementing the HCAHPS improvement framework with key stakeholders.

    - Explore statewide adoption of added question(s) to the survey linked to best practice with evidence that implementation improves HCAHPS scores.
    - Address emergency department length of stay/hospital throughput issues as strategy to improve HCAHPS.

4. Continue collaboration with CRISP and other partners on infrastructure to collect hospital electronic clinical quality measures and core clinical data elements for hybrid measures;
5. Maintain the pre-set scale (0-80 percent with cut-point at 41 percent) and continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) for the QBR program.

    - Retrospectively evaluate 41 percent cut point using more recent data to calculate national average score for RY25 and RY26.
    - Based on more analyses on the impact of pre-COVID performance standards on national hospital performance, adjust the RY24 QBR cut point to 32%.

Representatives from Johns Hopkins Health System, Adventist Health System, and Maryland Hospital Association voiced their concerns with various components of the Staff's final recommendation. For example, the representative from Johns Hopkins Health System cited the difficulty hospitals have in discharging certain patients to explain why it could be unfair to penalize hospitals for high ED wait times. The representative from Adventist Health System said it would be unfair to treat all hospitals the same under an ED wait time policy, since the circumstances, such as the number of patients coming to the ED, vary between hospitals.

Arin Foreman, representing CareFirst stated that the revenue at risk under this program should be increased from 10% to 11% and that the ED wait time measure should be weighted at 1/3 of QBR due to the need for more financial accountability.

Commissioner Johnson added that payers should collaborate with hospitals to incentivize patients to go elsewhere for care rather than the ED.

Commissioner McCann explained the importance of making sure the program is implemented fairly.

Dr. Schuster clarified that the process measure of 10 percent does not need to be the "end all be all," meaning that it can be adjusted over time.

Commissioner McCann added that ED wait times is a system failure problem, and this recommendation should not be passed, as it may give the false impression of solving a complex problem that is not actually being solved. She noted that this program cannot be applied the same across all hospitals.

Chairman Sharfstein requested that the Commissioners vote on the ED wait time measure separately from the Staff final recommendation. The Commissioners agreed.

Commissioners unanimously voted in favor of Staff's recommendation (the ED wait time measure not included).

Commissioners voted 4-2 in favor of including the 10% ER wait time measure in the Staff's QBR recommendation. Commissioners Elliott and McCann voted against the recommendation.

ITEM V
DRAFT RECOMMENDATIONS FOR ESTABLISHING THE EMERGENCY DEPARTMENT POTENTIALLY AVOIDABLE UTILIZATION PROGRAM FOR RATE YEAR 2026

Geoff Doughtery, Deputy Director, Population Based Methodologies, Analytics, and Modeling presented Staff's draft recommendation for establishing the Emergency Department Avoidable Utilization Program for RY 2026 (see "Draft Recommendation for Establishing the Emergency Department Potentially Avoidable Utilization Program for Rate Year 2026" available on the HSCRC website).

In CY 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. ED volume is also recognized as a driver of extended ED length of stay, which is an important consideration given that Maryland hospitals have some of the longest ED length of stay averages in the nation.

To understand the visit volume and cost related to multi-visit patients (MVPs), staff analyzed inpatient and outpatient case mix 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.

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.

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.

Draft 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. Develop reporting to assess health disparities.

Commissioner McCann asked what impact payer class and geography have.

Dr. Dougherty explained that geography is a factor and only data on Medicare patients exists.

Commissioner McCann requested more information on how access to PCPs is correlated to ED wait times and what that data would show on a map.

Chairman Sharfstein stated that payers have a role in supporting multi-visit patients, and that the Commission could ask payers whether they are working with this population and consider this a quality improvement issue from their perspective.

Commissioner McCann added that getting more information from payers would be beneficial.

Vice Chairman Antos stated that this is not a hospital problem, and there is a need to get other state agencies involved because so many factors are outside the hospitals' control.

Chairman Sharfstein noted that it is important to remember that Eds' needs are not being met, and many issues involved are out of the scope of hospitals, but providing more resources for solutions is vital.

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

ITEM VI
DRAFT RECOMMENDATION ON TRADITIONAL MEDICARE PERFORMANCE ADJUSTMENT- CY 2024 PERFORMANCE

Willaim Henderson, Principal Deputy Director, Medical Economics and Data Analytics, presented Staff's draft recommendation on the Medicare Performance Adjustment for CY 2024 (see "Medicare Performance Adjustment Calendar Year 2024" on the HSCRC website).

The Medicare Performance Adjustment (MPA) is a required element for the Total Cost of Care Model and is designed to increase the hospital's individual accountability for Total Cost of Care (TCOC) in Maryland. Under the Model, hospitals bear substantial TCOC risk in the aggregate. However, for the most part, the TCOC is managed on a statewide basis by the HSCRC through its GBR policies. The MPA was intended to increase a hospital's individual accountability for the TCOC of Marylanders in their service area.

The MPA includes three "components":

- Traditional Component, which holds hospitals accountable for the Medicare total cost of TCOC of an attributed patient population,
- Reconciliation Component, which rewards hospitals for the care redesign interventions and
- Savings Component that allows the Commission to adjust hospital rates to achieve the Medicare Total Cost of Care Model (the Model) savings targets.

The Traditional Component is governed via annual updates to the MPA policy adopted by the Commission. This document represents the update for Calendar Year 2024 (also known as MPA Year 6). The Efficiency and Savings Component are governed via the MPA Framework. The recommendation to cap CTI risk at 2.5% is a change to the Reconciliation Component and is the first change in the MPA Framework related to the Reconciliation Component since it was adopted. This policy does not relate to the Savings Component. These three components are added together and applied to the amount that Medicare pays each respective hospital. The MPA is applied as a discount to inflator to the amount that Medicare pays on each claim submitted by the hospital.

Staff recommends the following incremental revisions to the MPA policy for calendar year 2024 (CY2024) to align with State and federal policy directives:

1. Increase the maximum at risk under the traditional MPA to 2%
2. Implement the population health quality measure (weight of 4% bonus/penalty) adopted by the Commission into the MPA quality score as outlined in last year's final MPA recommendation.

3. Institute a "CTI Buy-out" that allows hospitals to eliminate the downside risk on the traditional MPA, effective with the second program year (Fiscal Year 2023) based on the ratio of the unique beneficiaries covered by their CTIs to the beneficiaries attributed to the hospital under the Traditional MPA.

In addition, Staff recommends the following revision to the Medicare Performance Adjustment Framework (MPA Framework) approved by the Commission in October 2019:

1. Cap the downside risk of a hospital under the Care Transformation Initiative (CTI) program to 2.5% of total Medicare Payments and redistribute additional risk across all hospitals to maintain the overall savings neutrality in the program.

Commissioner McCann clarified that even if an organization administers the CTI that generates savings, they may still end up paying into the CTI program if other CTIs generate higher levels of savings since the CTI program is revenue neutral statewide.

Mr. Henderson explained that this is correct and added that the Staff's recommendation would cap CTI downside risk at 2.5 percent of total Medicare payments for all hospitals.

Chairman Sharfstein agreed that a cap on CTI downside risk is necessary and asked Staff to evaluate the appropriateness of 2.5 percent as the threshold once the CTI program is more mature.

Mr. Henderson agreed that the 2.5 percent cap is only for RY2024 and will be reevaluated annually.

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

ITEM VII
POLICY UPDATE AND DISCUSSION

Model Monitoring

Ms. Deon Joyce Chief of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 8 months ending August 2023. Maryland's Medicare Hospital spending per capita growth was favorable when compared to the nation. Ms. Joyce noted that Medicare Nonhospital spending per-capita was unfavorable 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 2.42% below the nation through August. Ms. Joyce noted that Maryland Medicare hospital and non-hospital growth through June shows a savings of $190,117,000.

ITEM VIII
CLOSED CASES

2627A- Johns Hopkins Health System 2628A- Johns Hopkins Health System
2629A- Johns Hopkins Health System 2637A- Johns Hopkins Health System
2638A- Johns Hopkins Health System 2639A- Johns Hopkins Health System

ITEM IX
OPEN CASES

2631N- Tidal Health Peninsula

On August 28, 2023, Tidal Health Peninsula Regional ("THPR" or "The Hospital") submitted a partial rate application requesting a new rate for Inpatient Child and Adolescent Acute Psychiatric (PCD) services. The Hospital received approval on May 16, 2019, from the Maryland Health Care Commission (MHCC) for the establishment of a 15-bed inpatient psychiatric unit for treatment of children and adolescents to address the needs of the residents of the lower Eastern Shore and neighboring communities for these acute care hospital services. These services are expected to open on January 1, 2024. Currently, there are no pediatric inpatient psychiatric resources available on Maryland's Eastern Shore.

These beds were approved by MHCC as child and adolescent beds and subsequently licensed as child and adolescent beds by the Office of Healthcare Quality. 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. There are currently no acute care hospitals in the state that have a rate for PCD.

For fiscal year 2024, THPR has a PSY rate of $1,838.55 and the median rate per patient day which is 1,845.67. The 12.6 percent cost differential was applied to THPR's current FY 2024 PSY rate of $1,838.55 to calculate a recommended rate of $2,071.21 for PCD services.

After reviewing the Tidal Health application, the staff recommends:

1. That the PCD rate of $2,070.21 per patient day be approved effective January 1, 2024; and
2. That the PCD rate center is not rate realigned until one full year of cost data has reported to the Commission; and
3. That the Hospital's Global Budget be adjusted outside of this recommendation for the incremental volume consistent with the FY2022 GBR Modification agreement.

Commission unanimously voted in favor of Staff's recommendation.

ITEM X
HEARING AND MEETING SCHEDULE

January 10, 2024, Times to be determined- 4160 Patterson Ave
HSCRC Conference Room
February 14, 2024, Times to be determined- 4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:40 p.m.

Closed Session Minutes
of the
Health Services Cost Review Commission

December 13, 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 11:28 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, Deb Rivkin, Geoff Dougherty, Alyson Schuster, Cait Cooksey, Megan Renfrew, Erin Schurmann, Bob Gallion, Christa Speicher, and Dennis Phelps. Attending via conference call was Cait Cooksey.

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

Item One

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

Item Two

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

Item Three

William Henderson, Director, Medical Economics & Data Analytics, updated the Commission on the hospitals' unaudited financial performance through October 2023.

Item Four

Erin Schurmann, Chief, Provider Alignment& Special Projects, updated the Commission and the Commission discussed the performance and contractual requirements of the diabetes Regional Partnership Program.

The Closed Session was adjourned at 12:58 p.m.

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Draft RY 2026
Maryland Hospital Acquired Conditions Policy

January 10, 2024

HSCRC Quality Team

MHAC RY 2026 Policy Intent and Considerations

- The 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 guard against unintended consequences of a global budget system.
- Evaluation of performance to date
  - Overall performance
  - Payment PPC performance
  - Monitored PPC performance
  - Staff recommends no changes to measures in the Program
- Methodology updates
  - Update to determining norms
- Draft Recommendations

MHAC-CMS HACRP Comparison

	CMS HACRP	MHAC Program
Measures	-5 CDC NHSN HAI measures -AHRQ PSI 90 composite*	15 Potentially Preventable Complications (3M HIS)
Payments applied to	Medicare Revenue	All-Payer Revenue
Financial impact	1% revenue penalty for hospitals in worst performing quartile	Max 2% revenue reward or penalty based on attainment

E.g., respiratory failure, pulmonary embolisms, and surgical-site infections not present on admission

*Maryand QBR Program includes NHSN and PSI 90 measures in the Safety Domain.

Payment PPC Selection Criteria

- PPC Data Analysis/Statistics
  - High rates: Rate per 1,000 generally 0.5 or above
  - High Volume: Volume of observed events 100 or above (over two years)
  - Significant variation across hospitals
  - At least half of the hospitals are eligible for the PPC

- Additional Considerations
  - Clinical significance
  - Potential influence of coding practices/changes
  - Opportunity for improvement/actionability
  - PSI overlap
  - All-payer

Performance To Date

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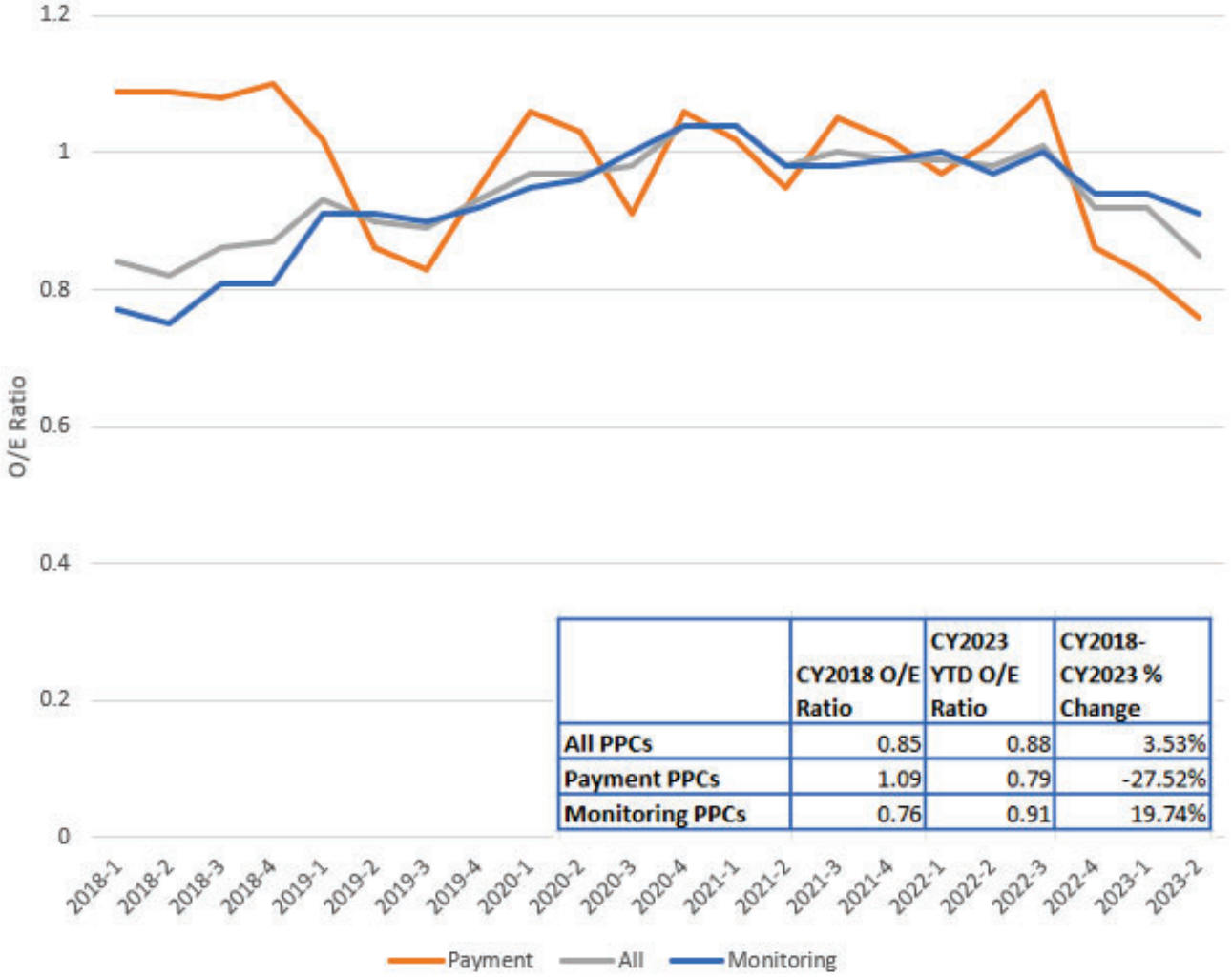
Overall Statewide PPC Performance Trends 2018 through 2023 Q2



	CY2018 O/E Ratio	CY2023 YTD O/E Ratio	CY2018-CY2023 % Change
All PPCs	0.85	0.88	3.53%
Payment PPCs	1.09	0.79	-27.52%
Monitoring PPCs	0.76	0.91	19.74%

- Overall PPC trends show statewide worsening from 2018.
- Payment PPC trends have improved.
- Monitored PPCs similar to overall trends (primary driver of overall worsening)

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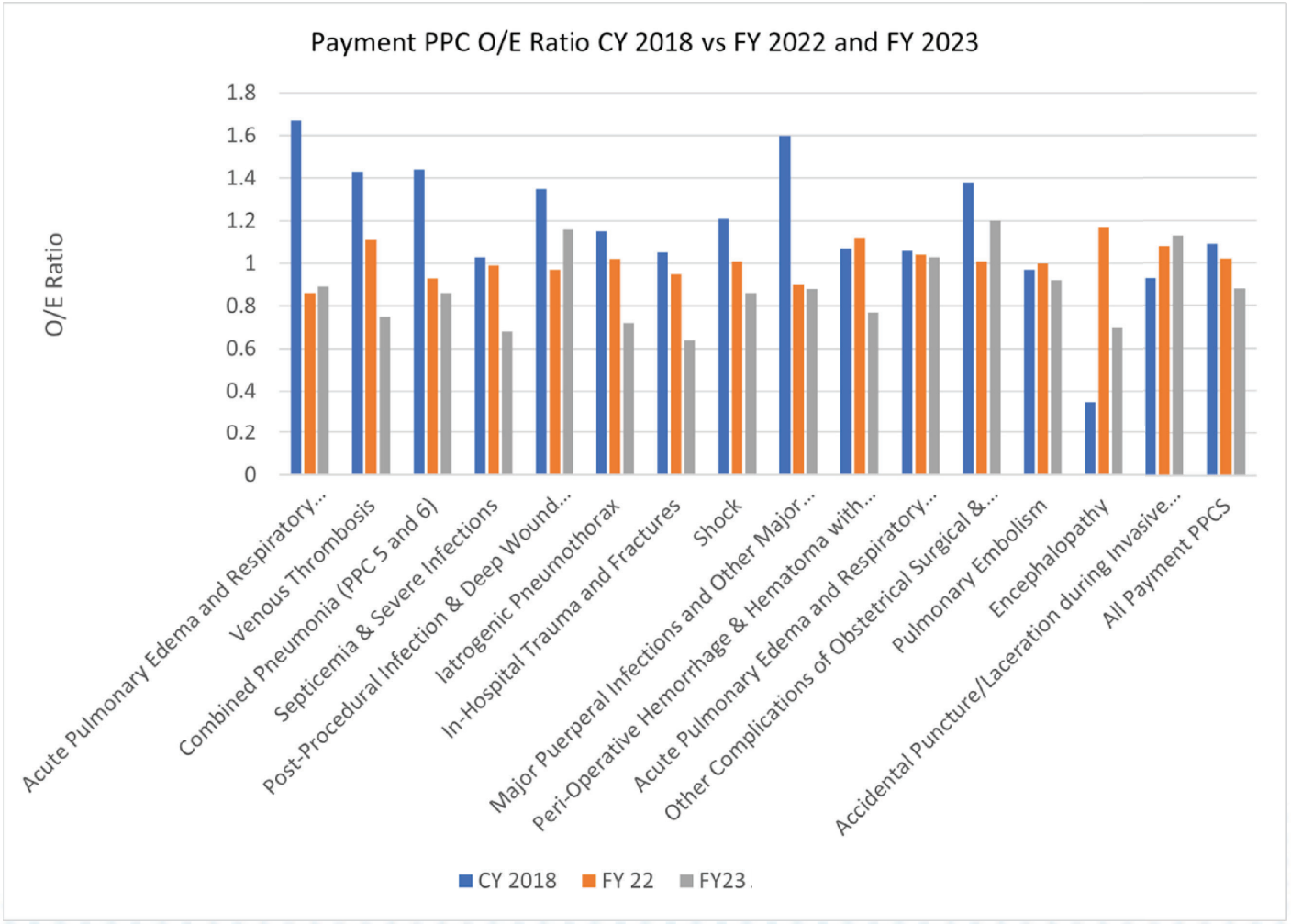
Performance on 15 Payment PPCs 2018 vs FY 22 and FY 23



- Since 2018 all PPCs improved w/ exception of accidental puncture or laceration during procedure and encephalopathy (added to payment last year due to increases)
- While majority of PPCs had annual reductions between FY22 and FY23, four PPCs showed increases.

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Methodology Updates

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MHAC Program Methodology Overview, RY 2025

Potentially Preventable Complication Measures

List of 15 clinically significant PPC included in payment program.

Acute Pulmonary Edema & Respiratory Failure w/o Ventilation	Post-Operative Infection & Deep Wound Disruption Without Procedure	In-Hospital Trauma & Fractures
Acute Pulmonary Edema & Respiratory Failure w/ Ventilation	Post-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D Proc	Septicemia & Severe Infections
Pulmonary Embolism	Accidental Puncture/Laceration During Invasive Procedure	Pneumonia Combo
Shock	Iatrogenic Pneumothorax	Other Complications of Obstetrical Surgical & Perineal Wounds
Venous Thrombosis	Major Puerperal Infection & Other Major Obstetric Complications	Encephalopathy

Global Exclusions:

- Discharges >6 PPCs
- APR-DRG SOI cells with less than 31 at-risk discharges

Hospital PPC Exclusions:

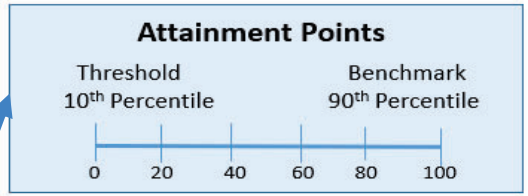
- <20 at-risk discharges
- <2 expected PPCs

Case-Mix Adjustment and Standardized Scores

Performance Measure: CY 2023* Observed to Expected PPC Ratio.

Expected calculated by applying statewide average PPC rates by diagnosis and severity of illness level to hospitals' patient mix (i.e., indirect standardization)

Attainment only score (0-100 points) calculated by comparing hospital performance to a statewide threshold and benchmark.



July 2020-June 2022 used to calculate statewide averages (norms) and thresholds, benchmarks.

*Small hospitals will be assessed on CYs 22 & 23

Hospital MHAC Score & Revenue Adjustments

Hospital MHAC Score is Sum of Earned Points / Possible Points with PPC Cost Weights Applied.

Scores Range from 0-100%
Revenue neutral zone 60-70%

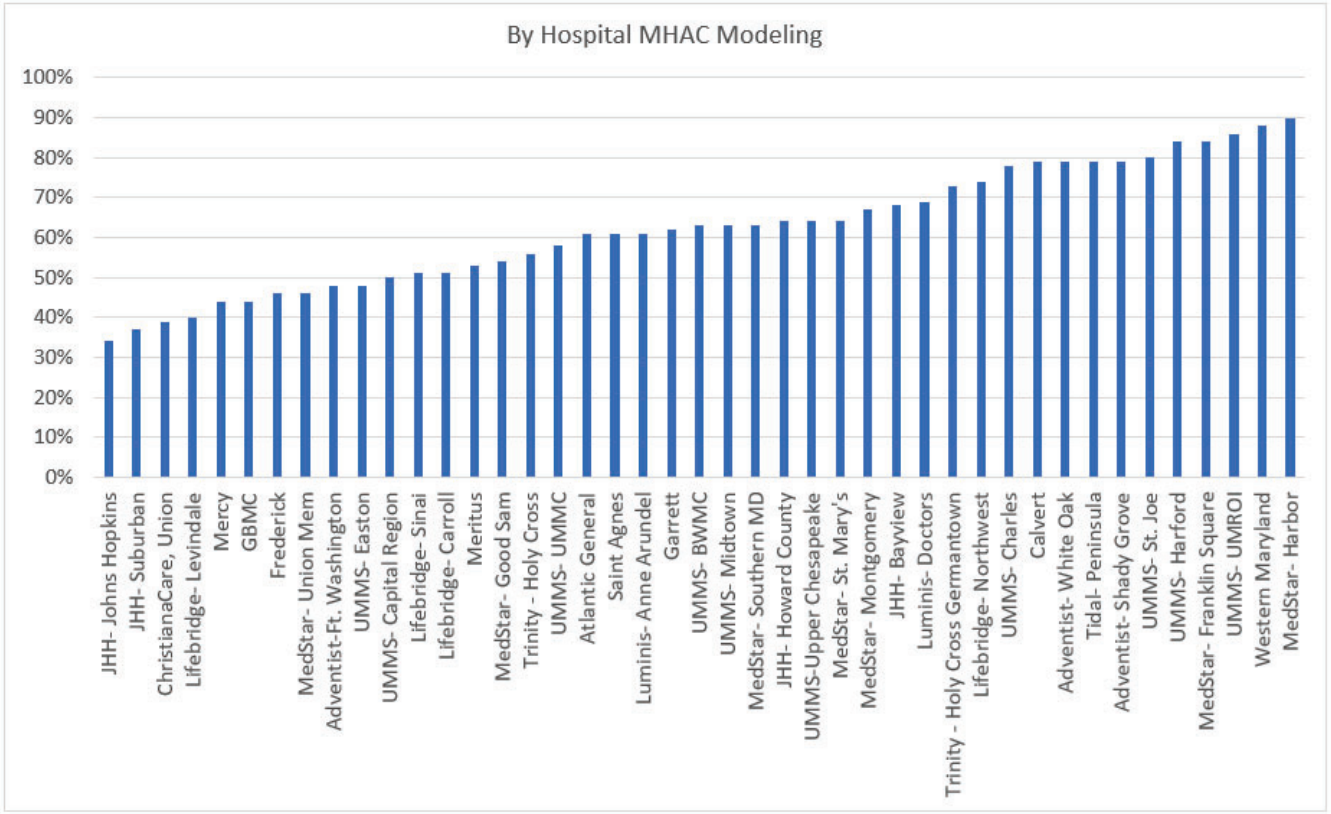
Max Penalty -2% & Reward +2%

MHAC Score	Revenue Adjustment
0%	-2.00%
10%	-1.67%
20%	-1.33%
30%	-1.00%
40%	-0.67%
50%	-0.33%
60% to 70% Hold Harmless	0.00%
80%	0.67%
90%	1.33%
100%	2.00%

RY 2026: Use average of the top and bottom 20 percent of O/E ratio results for threshold and benchmark to avoid cliff effects of using a single percentile.

RY 2026: Use CYs 2023 and 2024 to assess small hospitals. No other changes to address small hospitals.

By-Hospital Modeled Scores, SFYs 22-23 Base Period, CY 2023 YTD Through November



Score Statistics	
Average	62%
Median	63%
25th percentile	50%
75th percentile	78%
Highest	90%
Lowest	34%

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Draft Recommendations

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RY 2026 Draft Recommendations for 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.

RY 2026 Draft Recommendations for MHAC Program

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

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Payment PPCs List

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 Post-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D
42 Accidental Puncture/ Laceration During Invasive Procedure
47 Encephalopathy
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)

Payment PPC	Observed Count CY2023 YTD
3	185
4	57
7	73
9	161
16	25
28	31
35	109
37	33
41	21
42	194
47	46
49	28
60	6
61	19
67	126

Proposed Change to Modifying Standards Calculation

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
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41	Post-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

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Draft Recommendation for the Maryland Hospital Acquired Conditions Program for Rate Year 2026

January 10, 2024

This document contains staff draft recommendations for the RY 2026 Maryland Hospital Acquired Conditions Program; comments are due by COB Wednesday, January 17, 2024 and may be submitted to hscrc.quality@maryland.gov.

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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

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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
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.	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 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.	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.	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.

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 draft recommendation, in general, maintains the measures and methodology that were developed and approved for RYs 2022 through 2025.[1]

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.
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[1] 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 Draft 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 draft 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 draft 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,[2] 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:

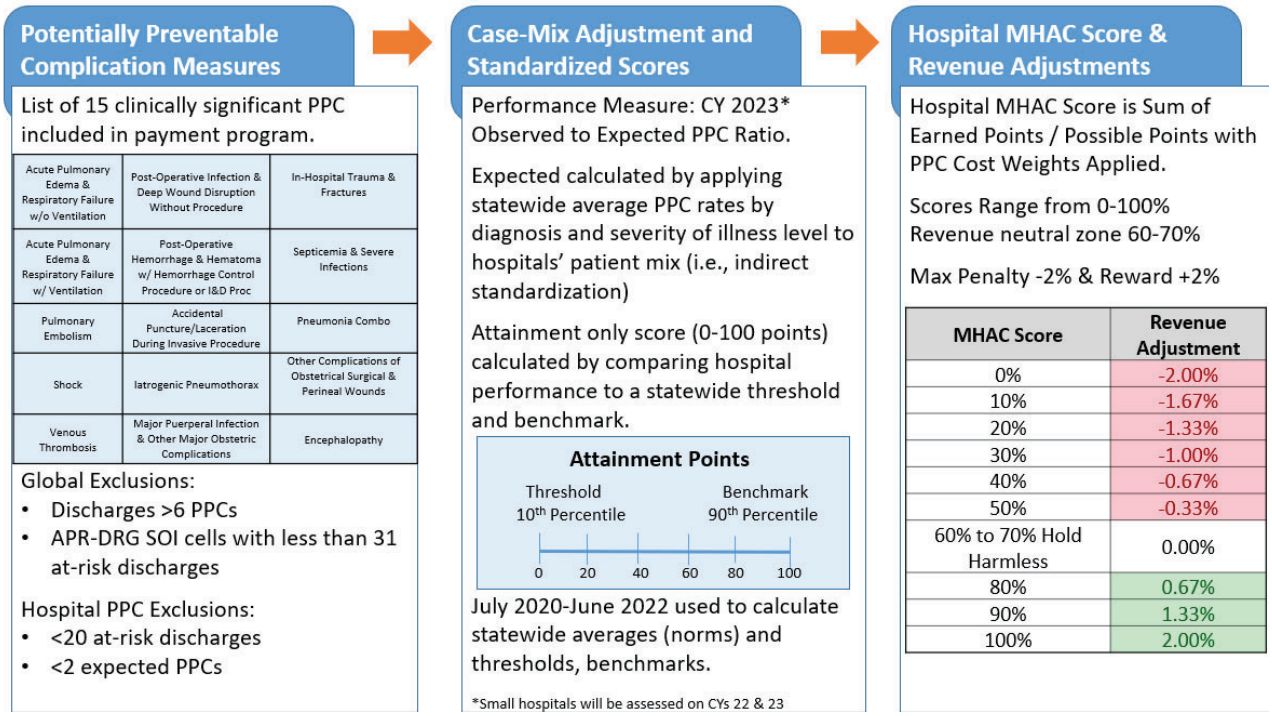
Step 1. For the PPCs identified for payment, clinically-determined global and PPC-specific exclusions, as well as volume based hospital-level exclusions are identified to ensure fairness in assignment of complications.

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.

[2] 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.[3] 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.[4] 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).

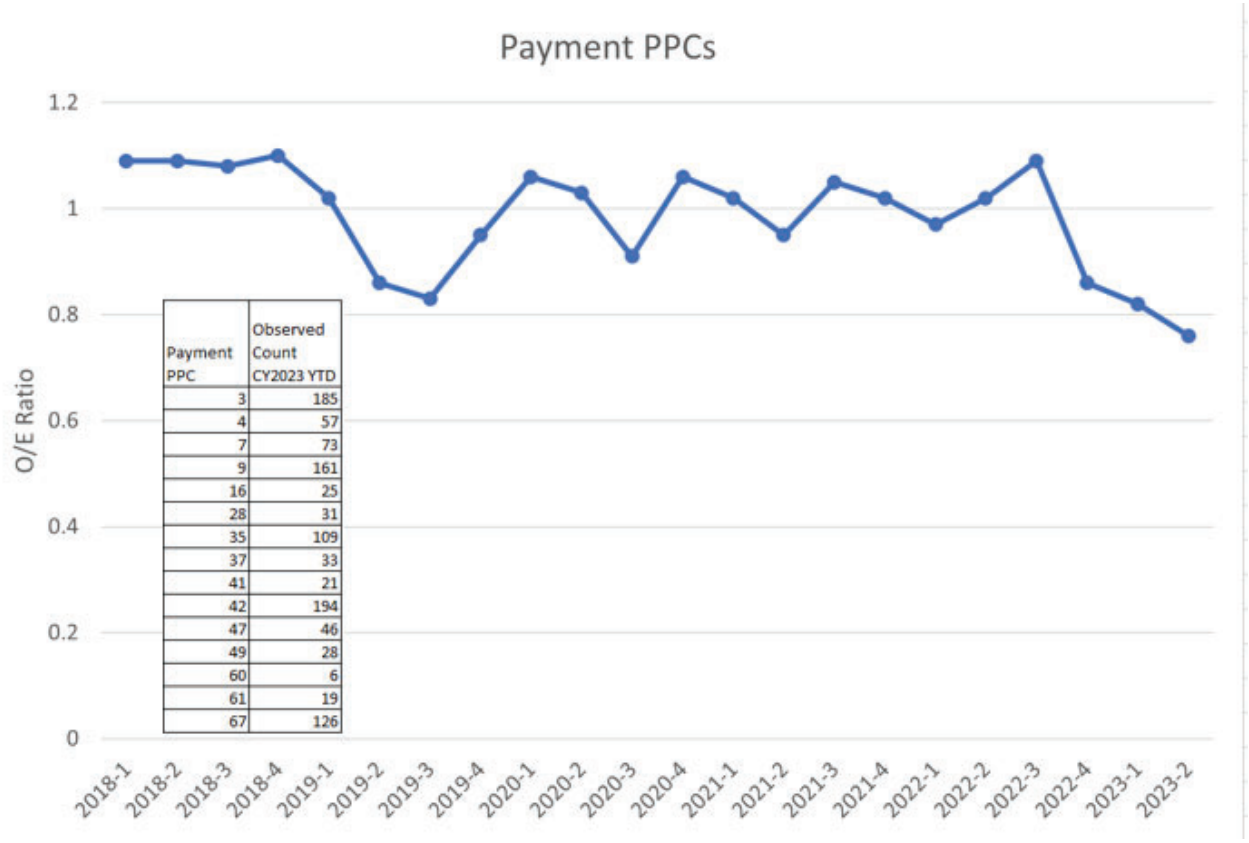
PPCs in the MHAC payment program include:

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 Post-Operative Hemorrhage & Hematoma w/ Hemorrhage Control Procedure or I&D
42 Accidental Puncture/ Laceration During Invasive Procedure
47 Encephalopathy

[3] 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.
[4] 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)

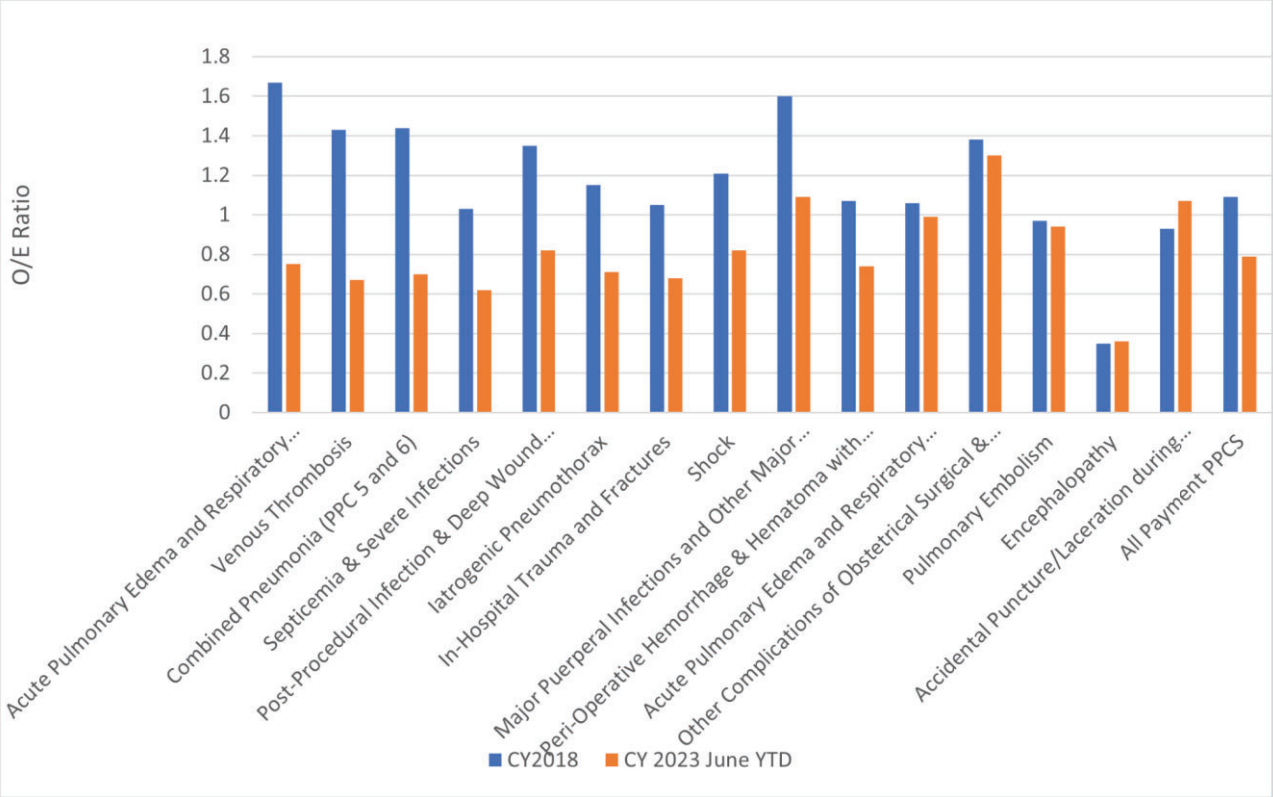
Figure 2. Payment Program PPCs Observed to Expected Ratios by Quarter CY 2018 to CY 2023 YTD Through June



Payment PPC	Observed Count CY2023 YTD
3	185
4	57
7	73
9	161
16	25
28	31
35	109
37	33
41	21
42	194
47	46
49	28
60	6
61	19
67	126

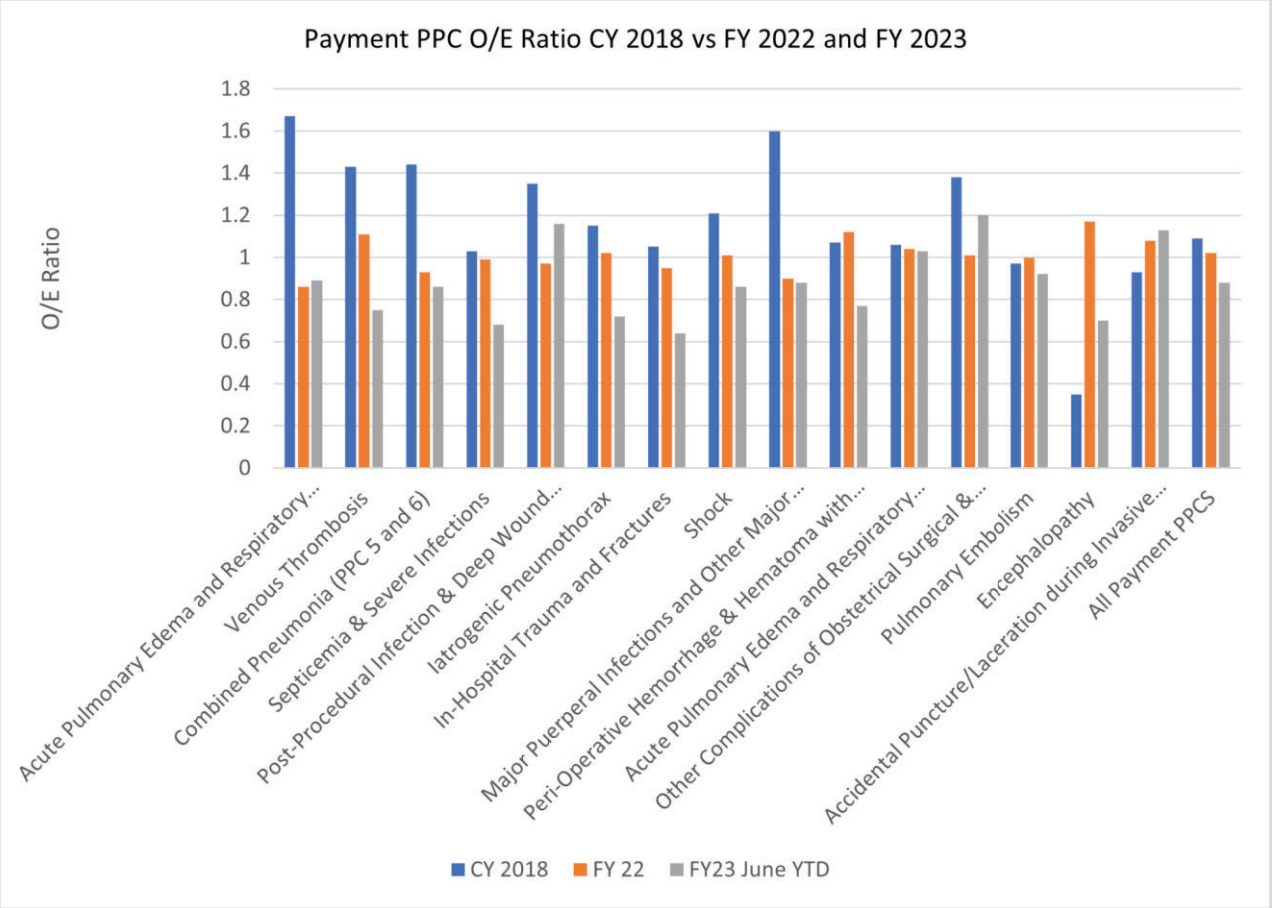
In terms of specific improvements among the 15 payment PPCs, Figure 3 shows the O/E ratios for CY 2018 and CY 2023 YTD, sorted from greatest percent decrease (on the left) to greatest percent increase (on the right). The two PPCs that worsened during this time period include PPC 47- Encephalopathy and 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

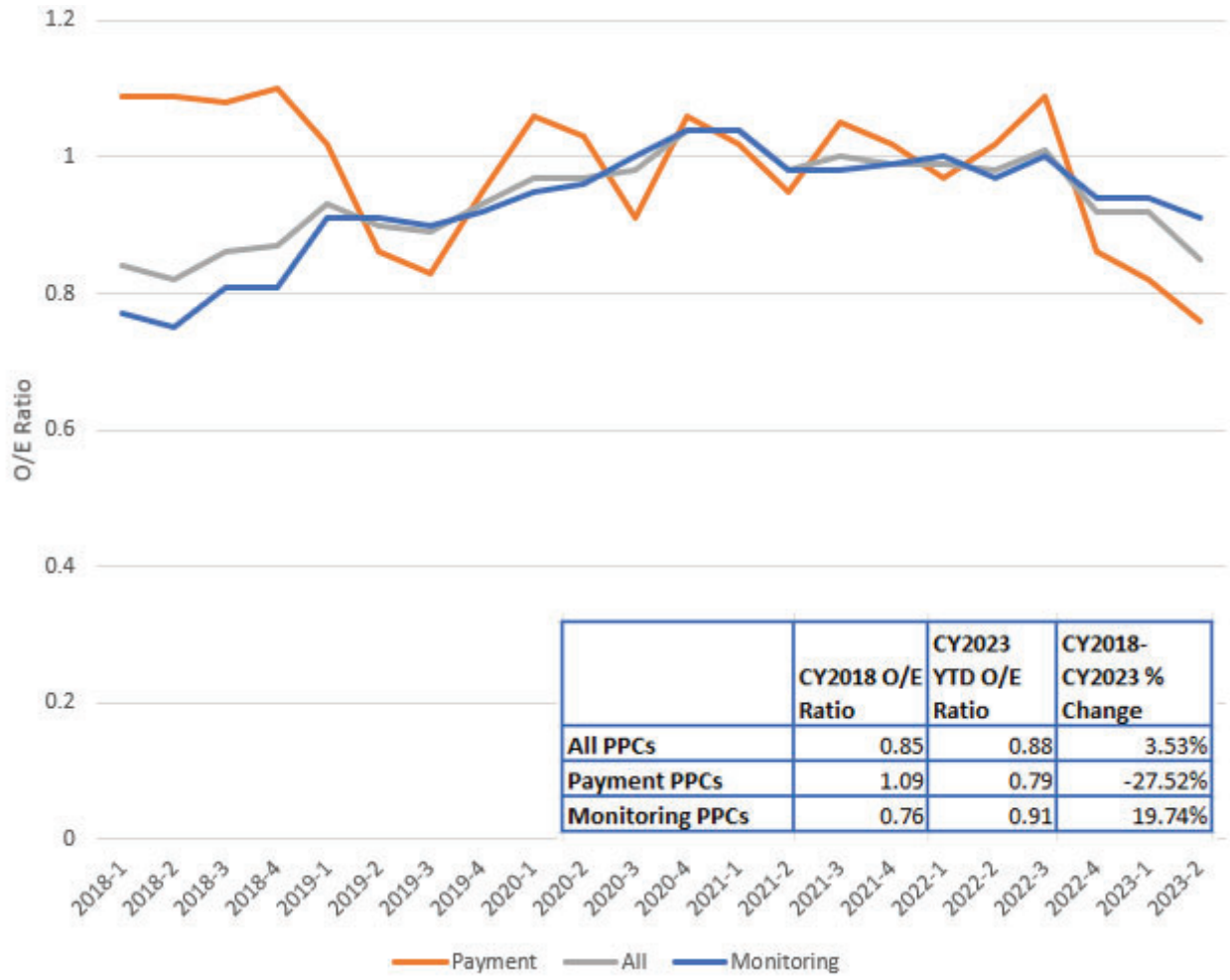


Monitored Complications

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 RatioTrends CY 2018 Qtr 1 Through CY 2023 Qtr 2



	CY2018 O/E Ratio	CY2023 YTD O/E Ratio	CY2018-CY2023 % Change
All PPCs	0.85	0.88	3.53%
Payment PPCs	1.09	0.79	-27.52%
Monitoring PPCs	0.76	0.91	19.74%

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.[5]

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
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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

[5] These results were updated since the December Performance Measurement Workgroup to V41 of the PPC grouper and two years of "base" data.

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.

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

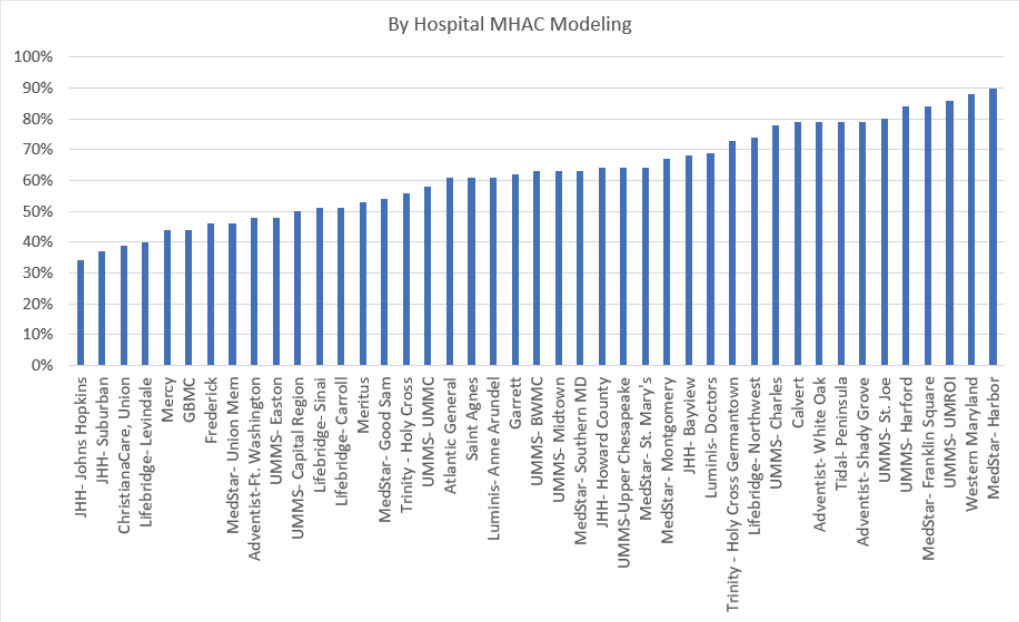
As Maryland hospitals continue to improve on payment PPCs, staff plan to pursue statistical methods that will better address small cell size issues and statistical reliability and validity. Thus, during CY 2023, staff has begun working with our contractor MPR to explore whether changes are needed to 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



Score Statistics	
Average	62%
Median	63%
25th percentile	50%
75th percentile	78%
Highest	90%
Lowest	34%

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.

Recommendations

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 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

Recalibrated Patient Safety Indicator (PSI) measure:^ ● PSI 03 – Pressure Ulcer Rate ● PSI 06 – Iatrogenic Pneumothorax Rate ● PSI 08 – In-Hospital Fall with Hip Fracture Rate ● PSI 09 – Perioperative Hemorrhage or Hematoma Rate ● PSI 10 – Postoperative Acute Kidney Injury Requiring Dialysis Rate ● PSI 11 – Postoperative Respiratory Failure Rate ● PSI 12 – Perioperative Pulmonary Embolism or Deep Vein Thrombosis Rate ● PSI 13 – Postoperative Sepsis Rate ● PSI 14 – Postoperative Wound Dehiscence Rate ● PSI 15 – Unrecognized Abdominopelvic Accidental Puncture/Laceration Rate
Central Line-Associated Bloodstream Infection (CLABSI)^*
Catheter-Associated Urinary Tract Infection (CAUTI)^*
Surgical Site Infection (SSI) – colon and hysterectomy^*
Methicillin-resistant Staphylococcus aureus (MRSA) Bacteremia^*
Clostridium Difficile Infection (CDI)^*

^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

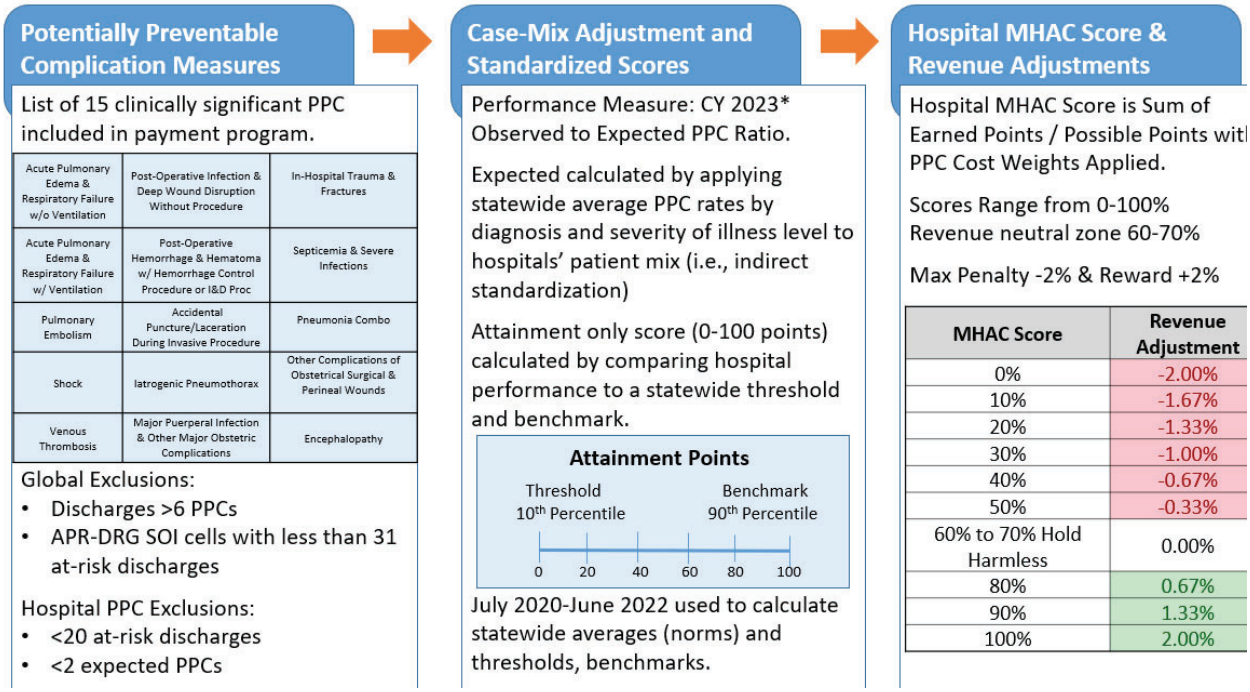
For more information on the DRA HAC program, please refer to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/FAQ-DRA-HAC-PSI.pdf

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
Total	**500**	**45**	**.09**		**56.5**	**0.7965**

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:

- Attainment Points = [99 * ((Hospital's performance period score - Threshold)/ (Benchmark – 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). "

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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: Post-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%

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

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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

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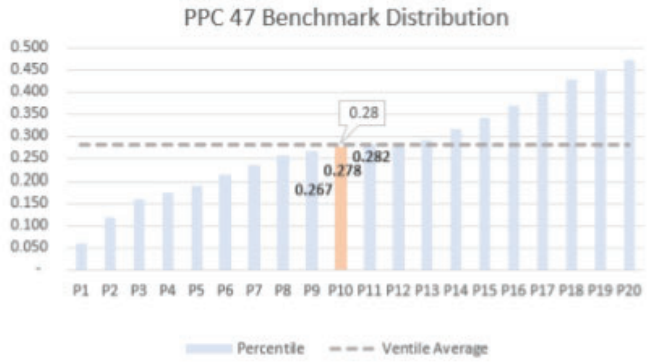
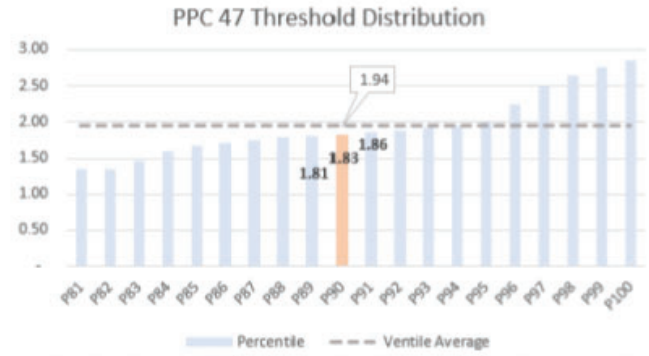
EX: PPC 47 Variation in Performance





- 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

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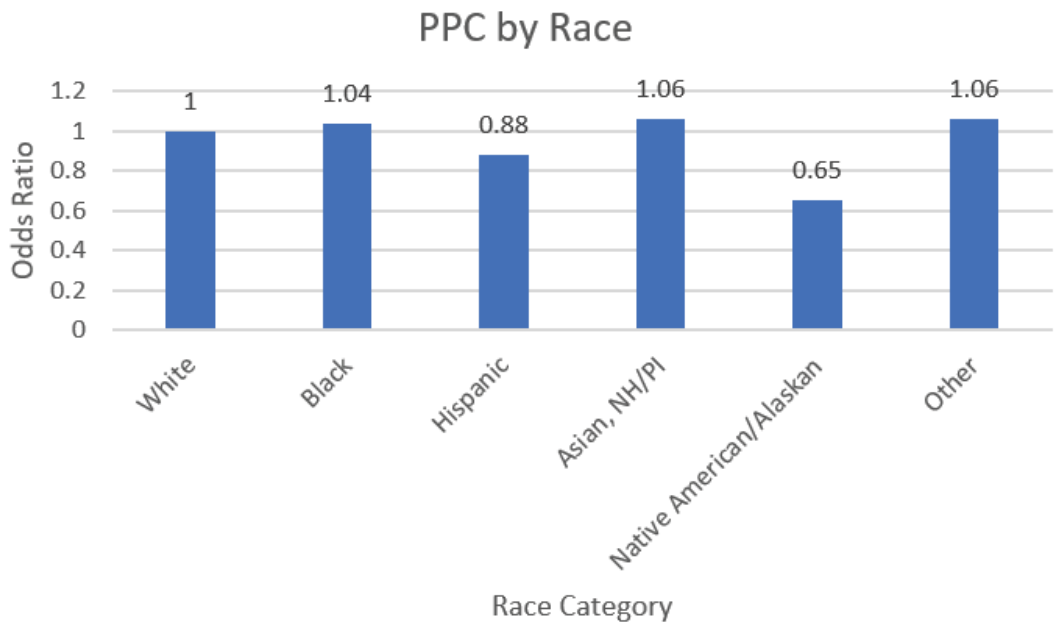
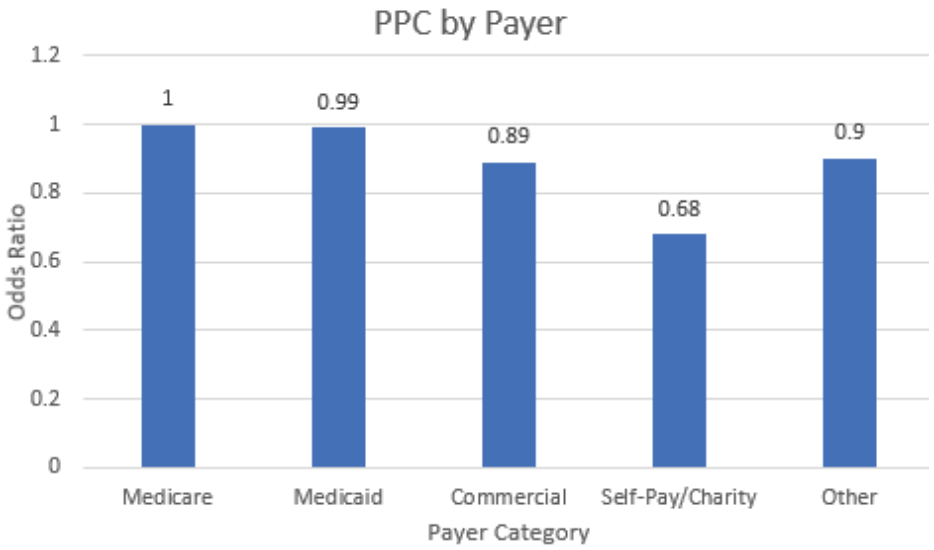
Appendix V: Disparities in PPCs

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.

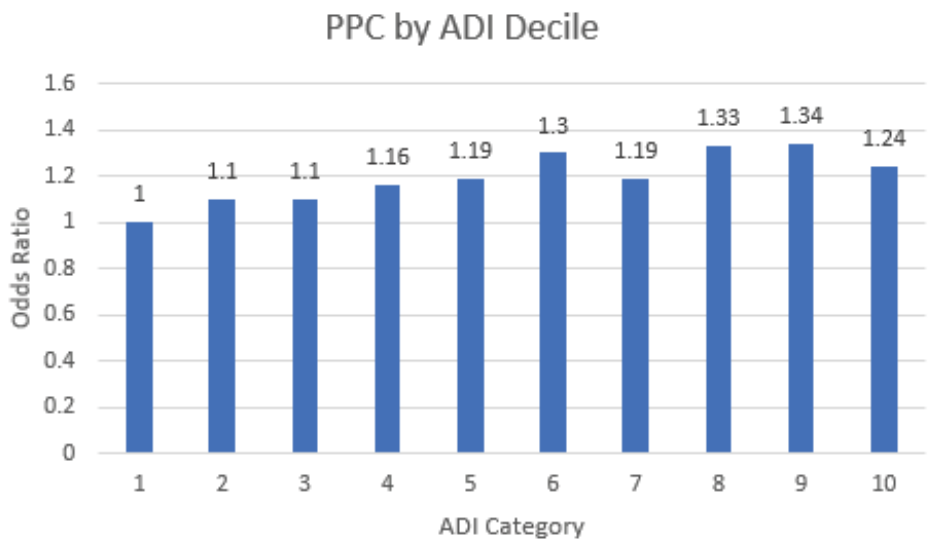


PPCs	Odds Ratio Coefficient	P-Value	Confidence Intervals
White (reference)			
Black	1.04	0.113	.9913536 - 1.085907
Hispanic	**.88**	**0.027**	**.7901786 .9856565**

PPCs	Odds Ratio Coefficient	P-Value	Confidence Intervals
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)			
Medicaid	.99	0.836	.916711 1.07284
Commercial	**.89**	**0.000**	**.8295058 .9482376**
Self-Pay/Charity	**.68**	**0.000**	**.5441243 .8426922**
Other	.90	0.117	.7809703 1.027758



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**
9	**1.34**	**0.000**	**1.182045 1.520293**
10	**1.24**	**0.001**	**1.088737 1.419777**

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Emergency Department Dramatic Improvement Effort (EDDIE)

January Commission Meeting

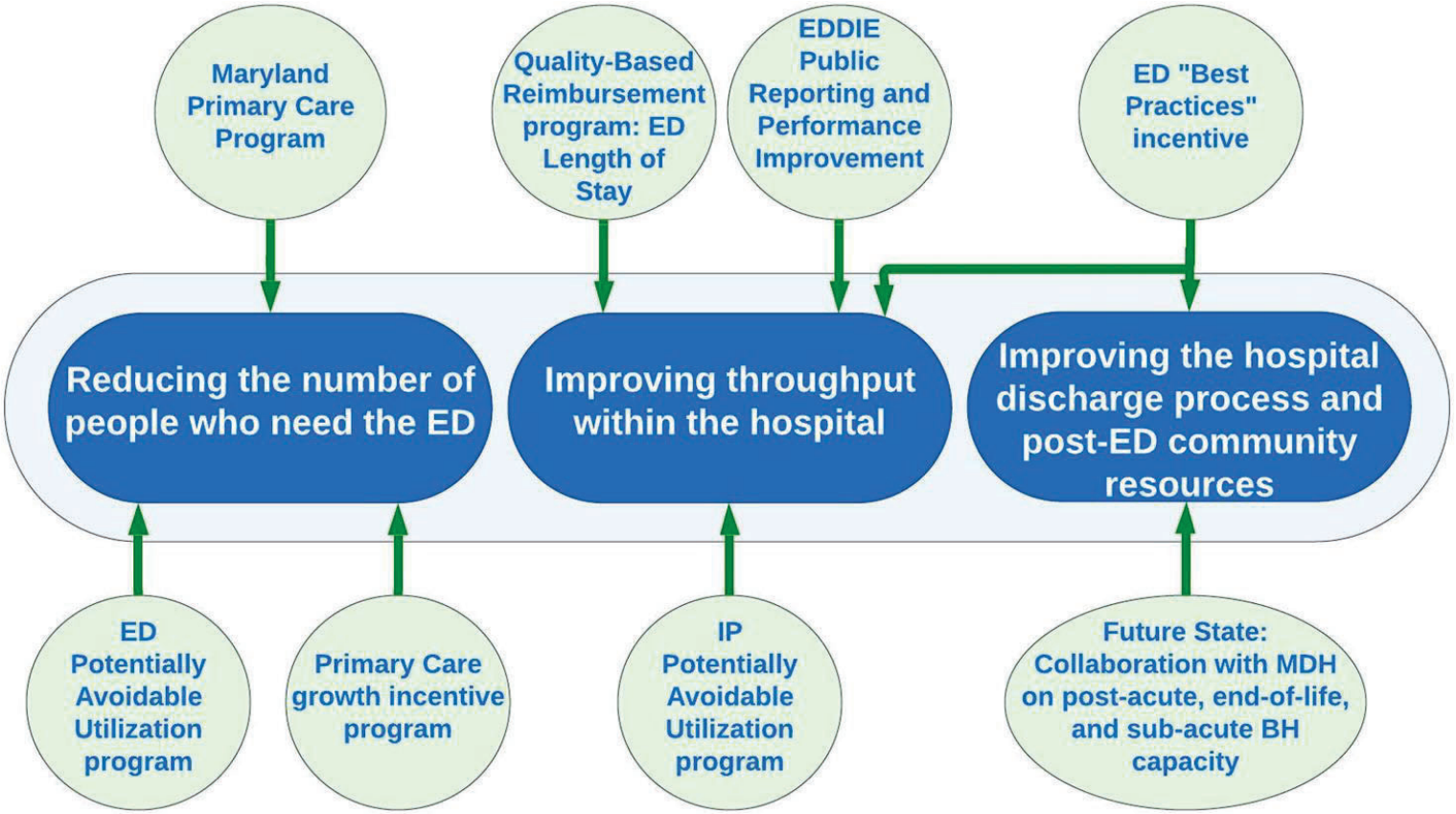
Geoff Dougherty and Alyson Schuster

ED Length of Stay and EMS Turnaround Data

- Monthly, unaudited data on ED length of stay for December 2023 was received from most 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 a handful of hospitals falling into a worse (longer wait time) category and none improving

See data in Appendix for additional details and graphs
Only Strata A (all patients) is presented for ED1 and OP18 this month

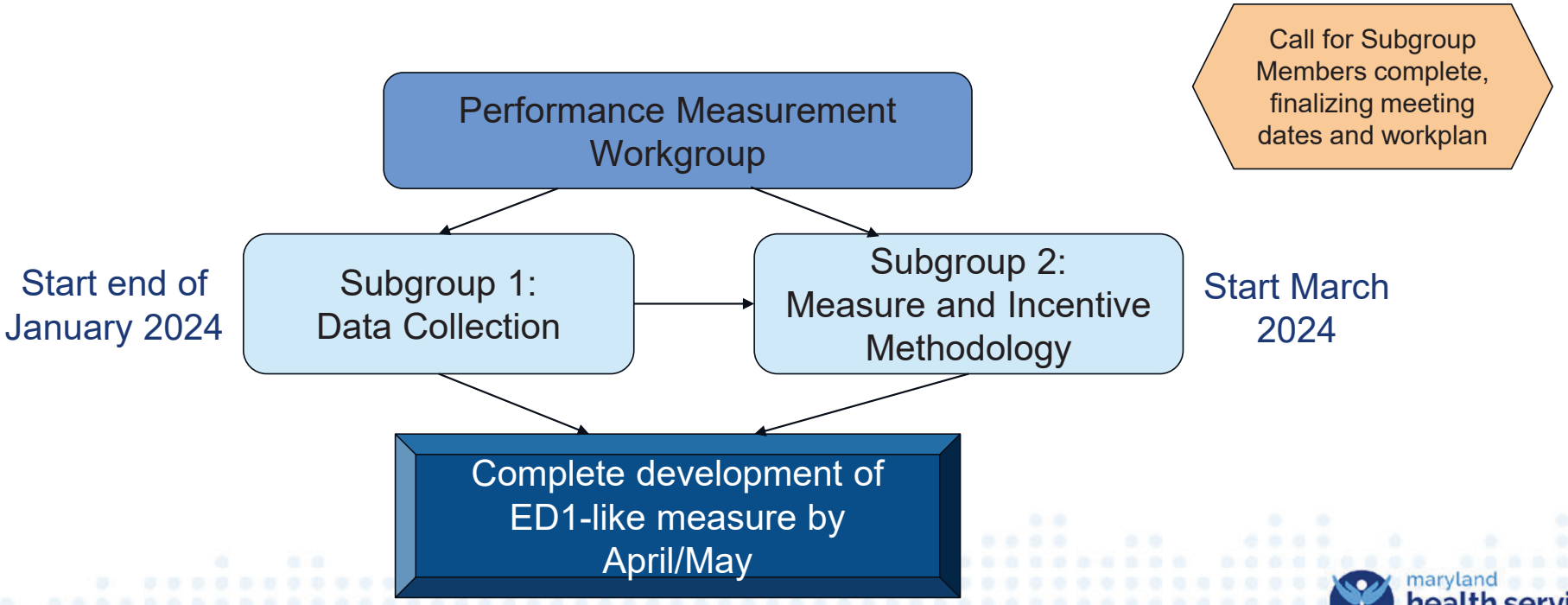
Incentives for Improving ED Length of Stay



QBR: ED LOS Measure Development Plan

Objective:

- Subgroup 1: Develop mechanism to collect ED length of stay for patients admitted to the hospital
- Subgroup 2: Develop ED LOS measure and incentive methodology for RY 2026 QBR



maryland health services cost review commission

Staff Next Steps

- Start QBR ED LOS subgroups
- Finalize workplan for additional subgroup on Best Practices (1 percent idea)
- Continue monthly data collection from hospitals and MIEMSS
  - Address reporting questions and concerns with hospitals
  - Provide results at monthly Commission meeting
  - Add visualizations suggested by Commissioners and other stakeholders
- Collaborate with MHA on legislative request and EDDIE quality improvement initiative

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

December Data 2023 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

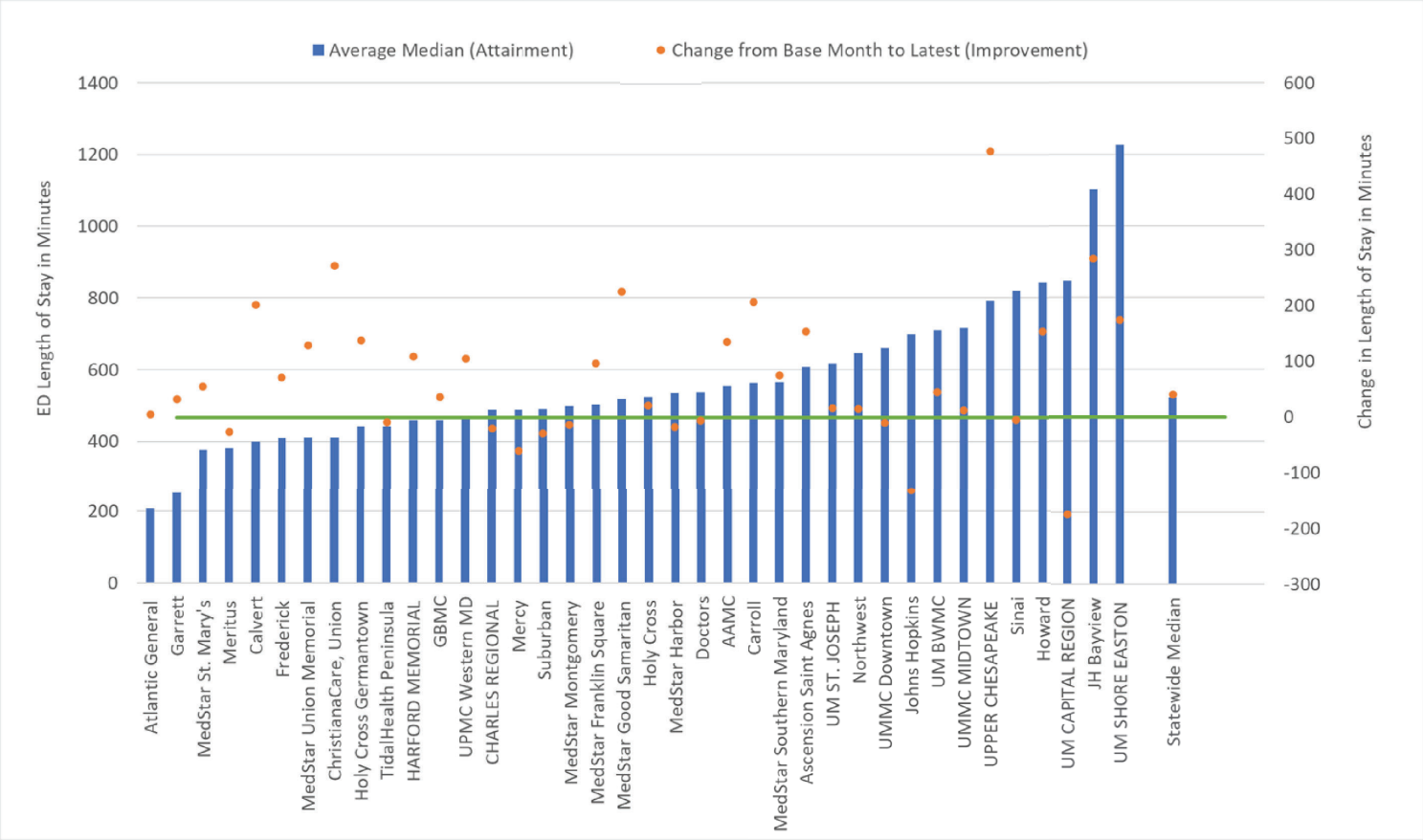
December data received for most hospitals

- 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

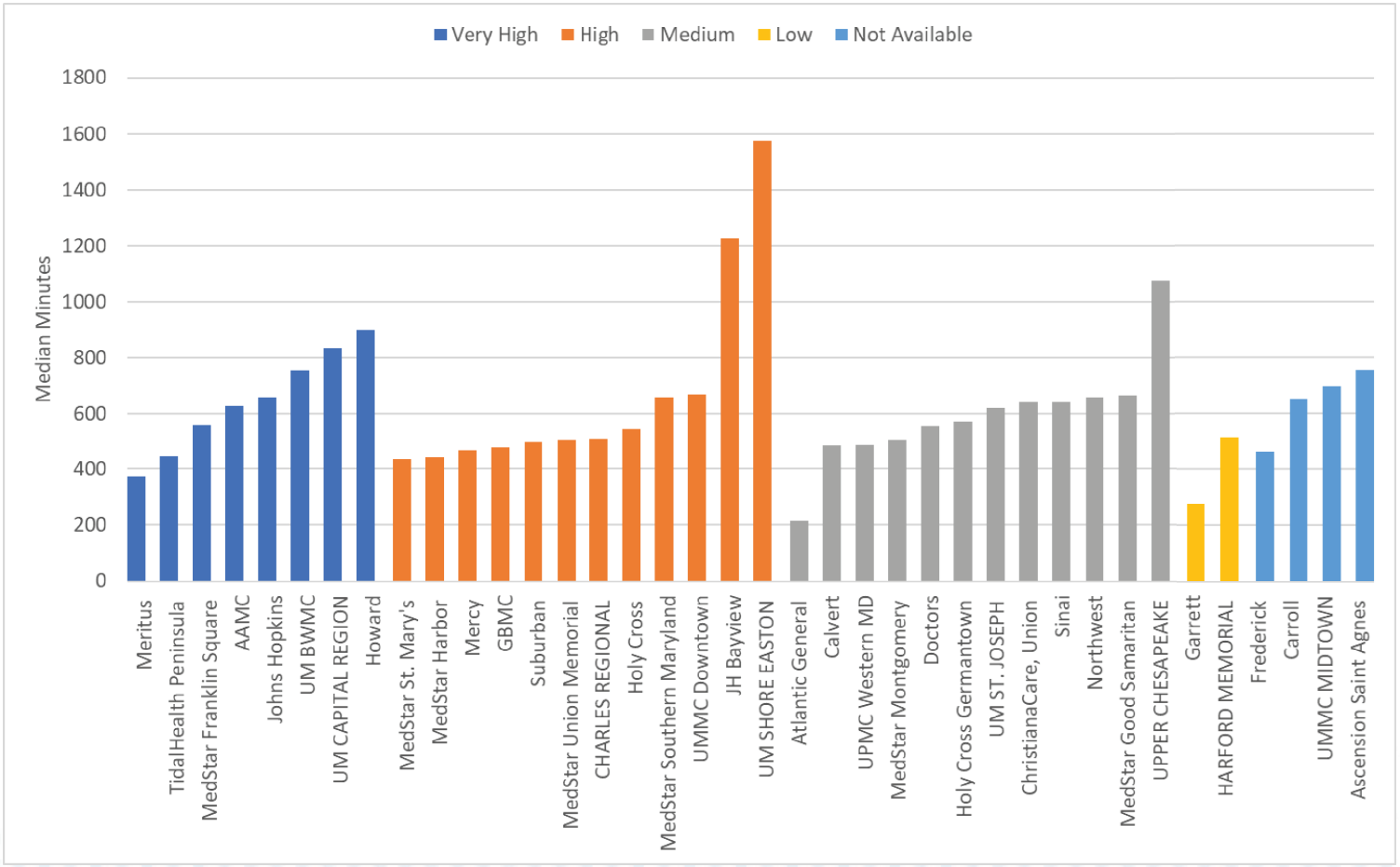
Graphs for ED1a and OP18a

- Graphs for non-psych and psych patients were skipped this month
- 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

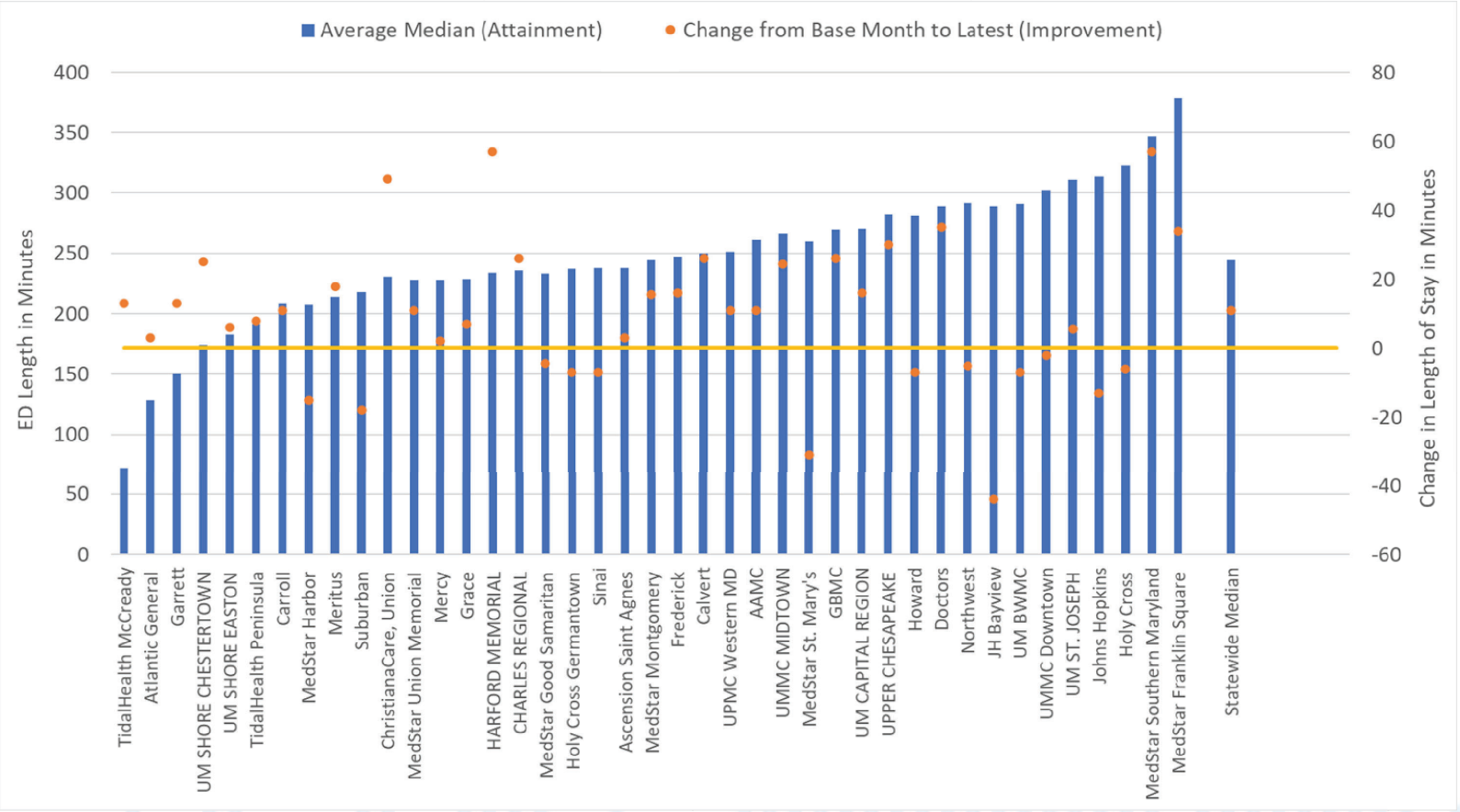
ED 1a: ED Arrival to Inpatient Admission



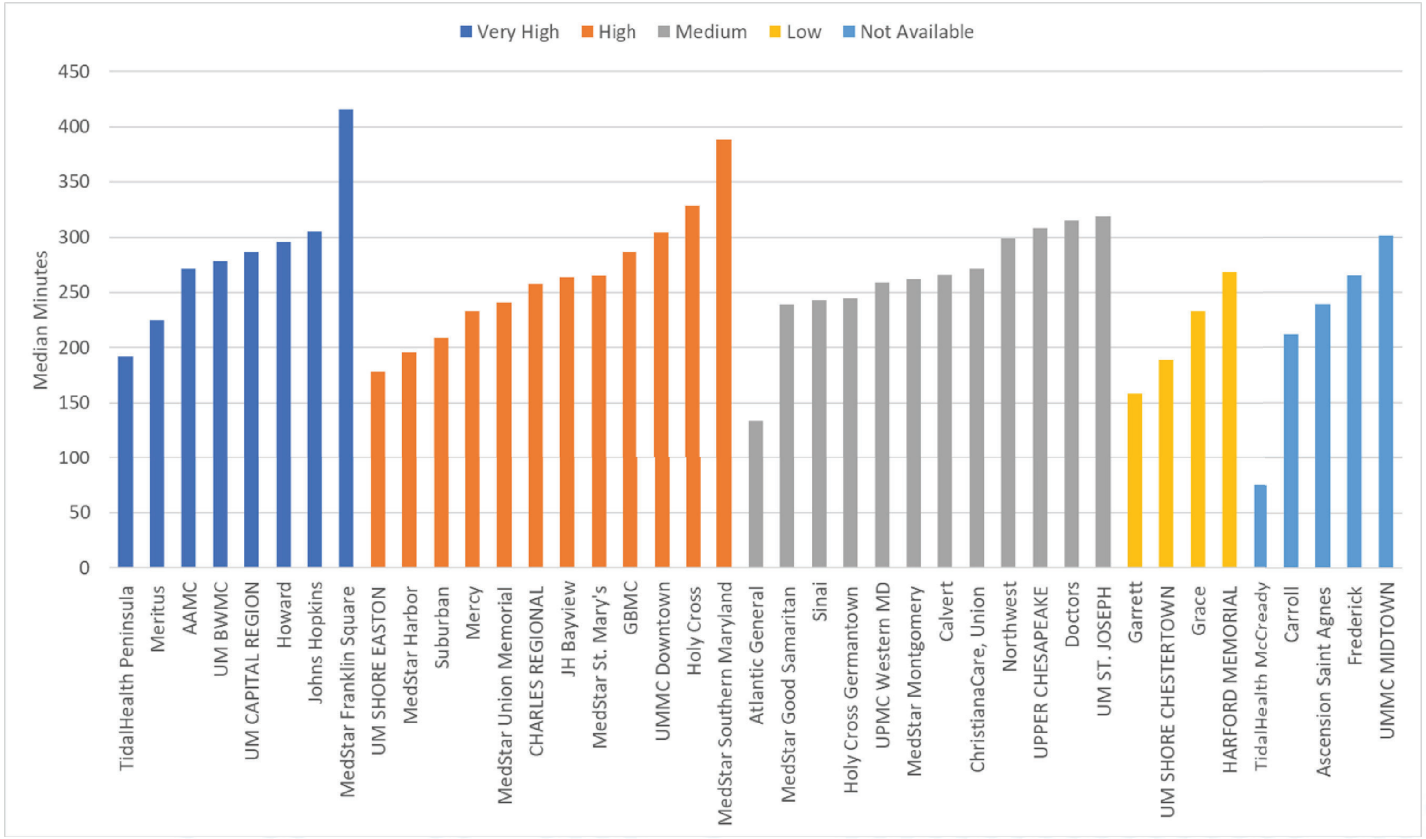
ED 1a: ED Arrival to Inpatient Admission Time Latest Month Median By Volume--Latest Month



OP18a: ED Arrival to Discharge Time by Month



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



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: December Performance

- 21 hospitals reported the 90th percentile of turnaround time was <=35 minutes
  - Decrease of 5 Hospitals from last month
- 23 hospitals reported the 90th percentile of turnaround time was 35-60 minutes
  - Increase of 3 Hospitals from last month
- 8 hospitals reported the 90th percentile of turnaround time was over 60 minutes
  - Increase of 2 Hospitals from last month
- Hospitals with declining performance
  - (High performing to average): Easton, Good Samaritan Hospital, Grace Medical Center, St. Joseph Medical Center, Suburban Hospital
  - (Average to low performing) : Doctors Community Medical Center, Upper Chesapeake Medical Center

EMS Turnaround Times: December Performance

90th Percentile: 0-35 Minutes

Atlantic General Hospital
Cambridge Free-Standing ED
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

Baltimore Washington Medical Center
Bowie Health Center
Calvert Health Medical Center
Carroll Hospital Center
Charles Regional
Chestertown
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. Agnes Hospital
St. Joseph Medical Center -
Suburban Hospital -
University of Maryland Medical Center

>60 Minutes

Anne Arundel Medical Center
Capital Region Medical Center
Doctors Community Medical Center -
Fort Washington Medical Center
Howard County General Hospital
Southern Maryland Hospital
Upper Chesapeake Medical Center -
White Oak Medical Center

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

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MHA HOSPITAL THROUGHPUT PERFORMANCE IMPROVEMENT UPDATE

January 2024

Maryland
Hospital Association

MARYLAND HOSPITAL ASSOCIATION (MHA) TEAM

Brian Sims

Vice President, Quality & Equity

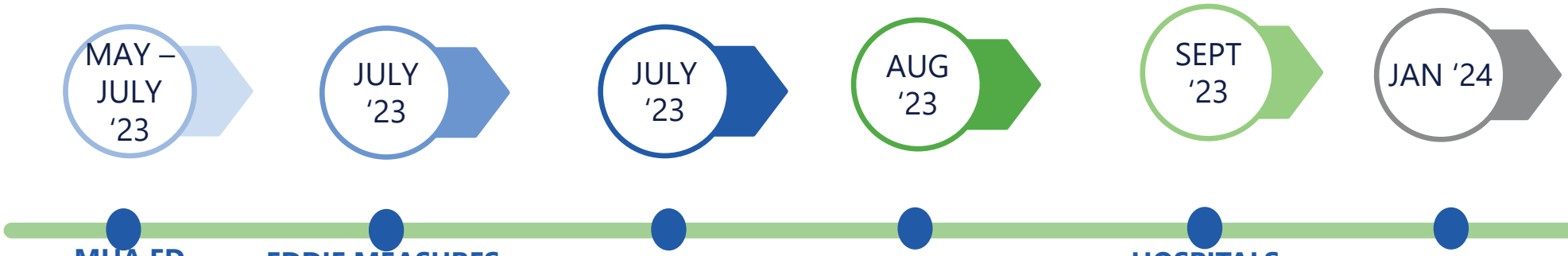
Erin Dorrien

Vice President, Policy

Erin Davis

Director, Quality & Health Improvement

TIMELINE



MHA ED CROWDING COLLABORATIVE

- 10-week sprint

EDDIE MEASURES COLLECTION INITIATED BY HSCRC

- Monthly reporting

ED WAIT TIME TASK FORCE INITIATED

- Monthly
- Multistakeholder
- Output: report to General Assembly

MHA ED THROUGHPUT COLLABORATIVE INITIATED

- Monthly meetings through July 2024

HOSPITALS SUBMIT AIM STATEMENTS

- Aim statements are submitted to HSCRC

ED WAIT TIME TASK FORCE REPORT

- Report submitted to General Assembly

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 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

PRESENTERS

TidalHealth

The University of Kansas Health System

Upstate University Hospital

HarrisHealth System

University of Maryland Medical Center

U Health University of Utah

BayCare

Massachusetts General Hospital
Founding Member, Mass General Brigham

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DISCUSSION TOPICS

- Collaboration between emergency medical services and hospitals
- ED care pathways
- Individualized care plans
- Enhancing early discharge through Medicaid complex care clinics
- Post-acute care collaboration
- Technology assisted throughput operation centers
- Early discharge planning and outflow strategies
- Technology enabled matching for behavioral health patients

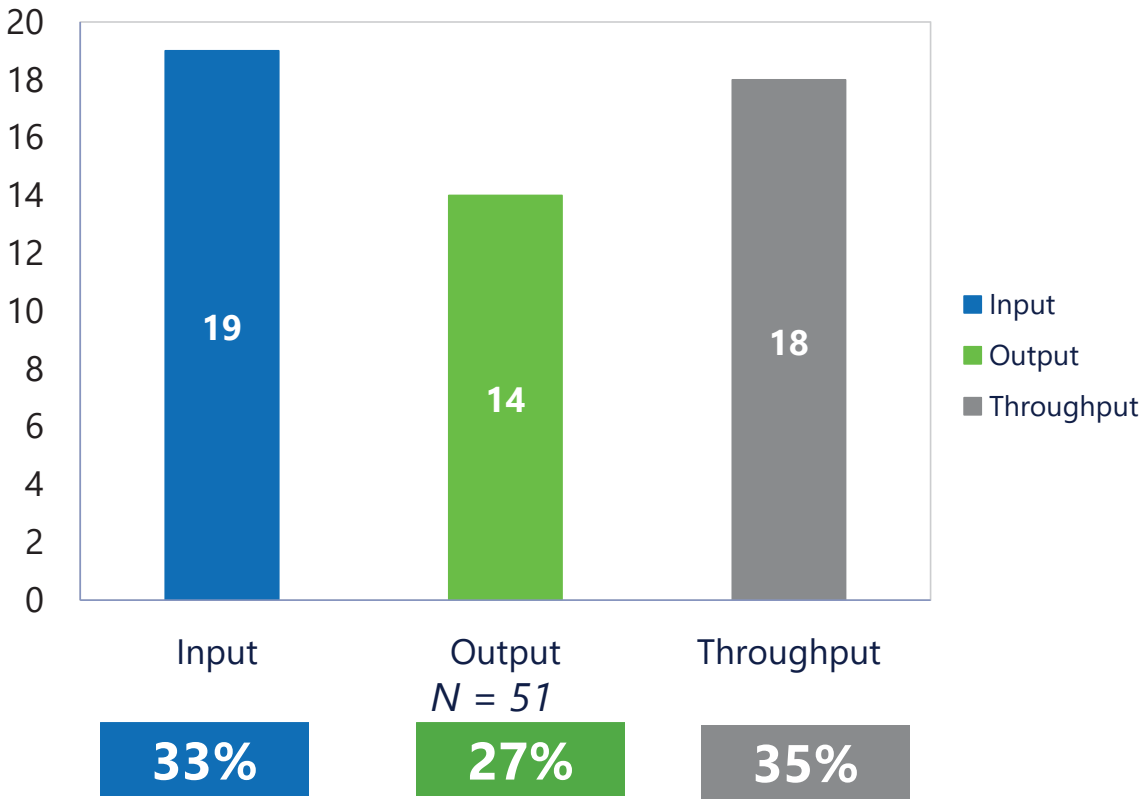
HOSPITAL THROUGHPUT COLLABORATIVE

- 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

SUBMITTED AIM STATEMENTS



1

2

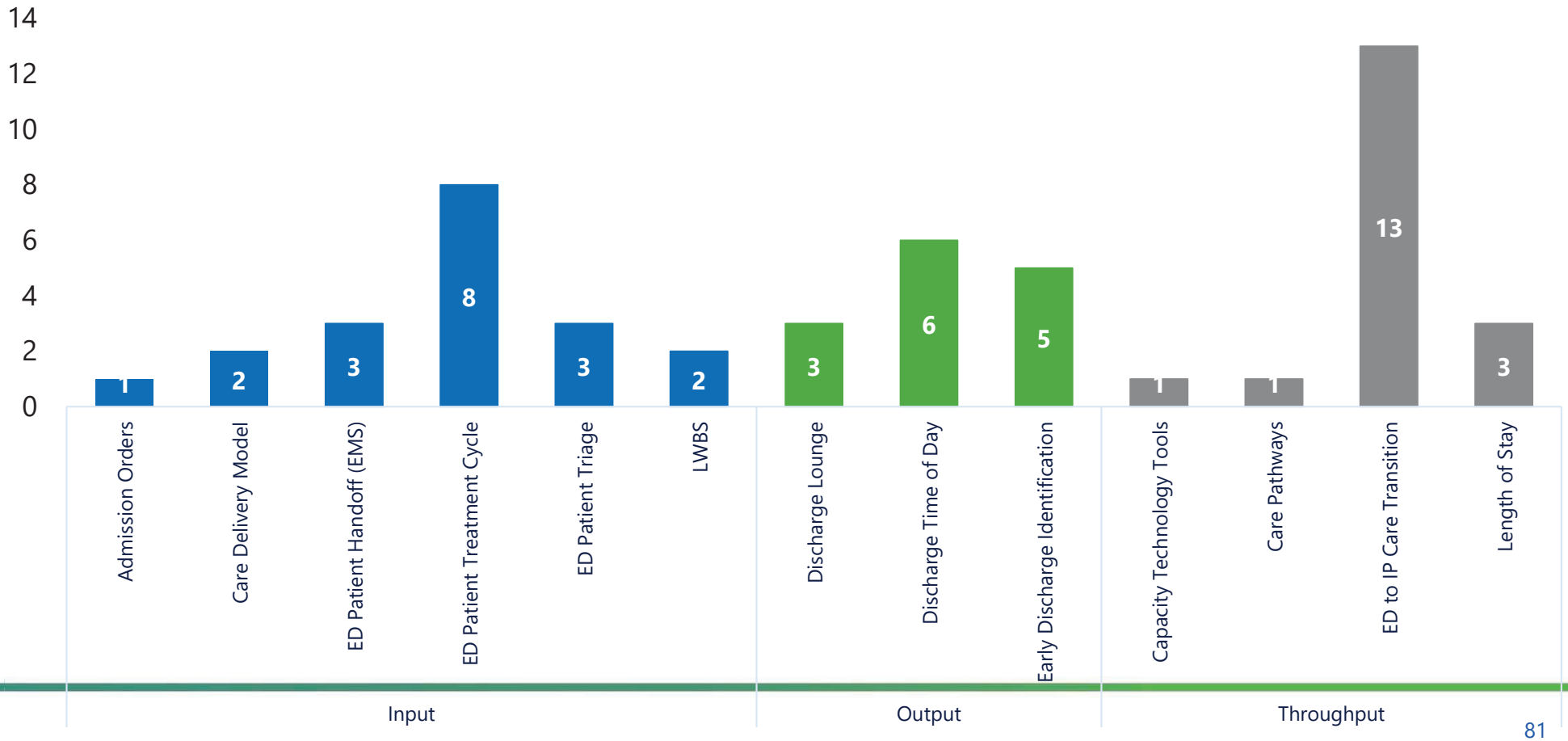
3

Input
Patients entering the hospital care system

Throughput
All processes and systems in the acute hospital care cycle

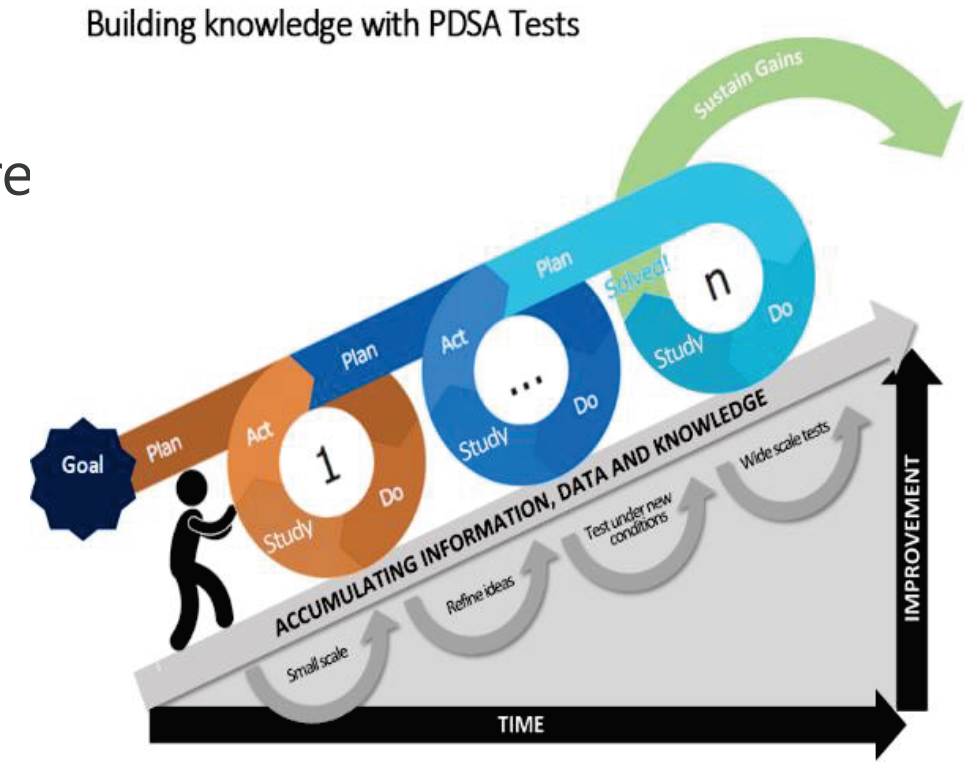
Output
Efforts needed to successfully support transition of care beyond the hospital setting

AIM STATEMENTS CATEGORIES



GUIDED DISCUSSION TOPICS

- Engagement and education
- Outcome and process measure
- Developing hypotheses
- Action planning
- Spheres of influence
- Spanning boundaries



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 benefit and resources needed to collect additional data

APPENDIX

Maryland
Hospital Association

AMY BOUTWELL, MD

Dr. Boutwell is the founder of Collaborative Healthcare Strategies and a nationally recognized thought leader in the field of reducing readmissions and improving care for high utilizers. During her career, she has advised several statewide initiatives on reducing readmissions and improving care for high utilizers.

Dr. Boutwell was the co-designer of the Institute for Healthcare Improvement's State Action on Avoidable Rehospitalizations (STAAR) Initiative and subsequently the co-author of the Agency for Healthcare Research and Quality's "Hospital Guide to Reducing Medicaid Readmissions" (the "ASPIRE" Guide). Dr. Boutwell also co-designed the New York State MAX program.

RHONDA MALONE WYSKIEL, RN, MSN

Ms. Wyskiel is a Principal at Hord Coplan Macht (HCM), an Architecture and Planning firm in Baltimore. In her role at HCM, she engages healthcare clients in the design of clinical space based on her expertise in patient safety and quality improvement, design thinking, and lean principles. She provides clinical consulting services in process improvement and lean process to help organizations improve outcomes. Previously, Ms. Wyskiel was the Senior Director of Performance Improvement & Innovation at Greater Baltimore Medical Center (GBMC), leading a health system transformation toward a Lean Management System. She played a key role in contributing to and leading work which was recognized as innovative and transformative as GBMC achieved the 2020 Malcolm Baldridge National Quality Award, the Nation's highest presidential honor for performance excellence.

Prior to joining GBMC, Ms. Wyskiel served in a leadership role at the Johns Hopkins Hospital and the Armstrong Institute for Patient Safety & Quality where she led design, implementation and evaluation of multi-institutional safety cohort programs both nationally and internationally. Additionally, Ms. Wyskiel has co-led implementation of safety and quality programs in over 1700 intensive care units across the United States leading to a 30 percent reduction in central line infections.

QUESTIONS

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Update on Medicare FFS Data & Analysis

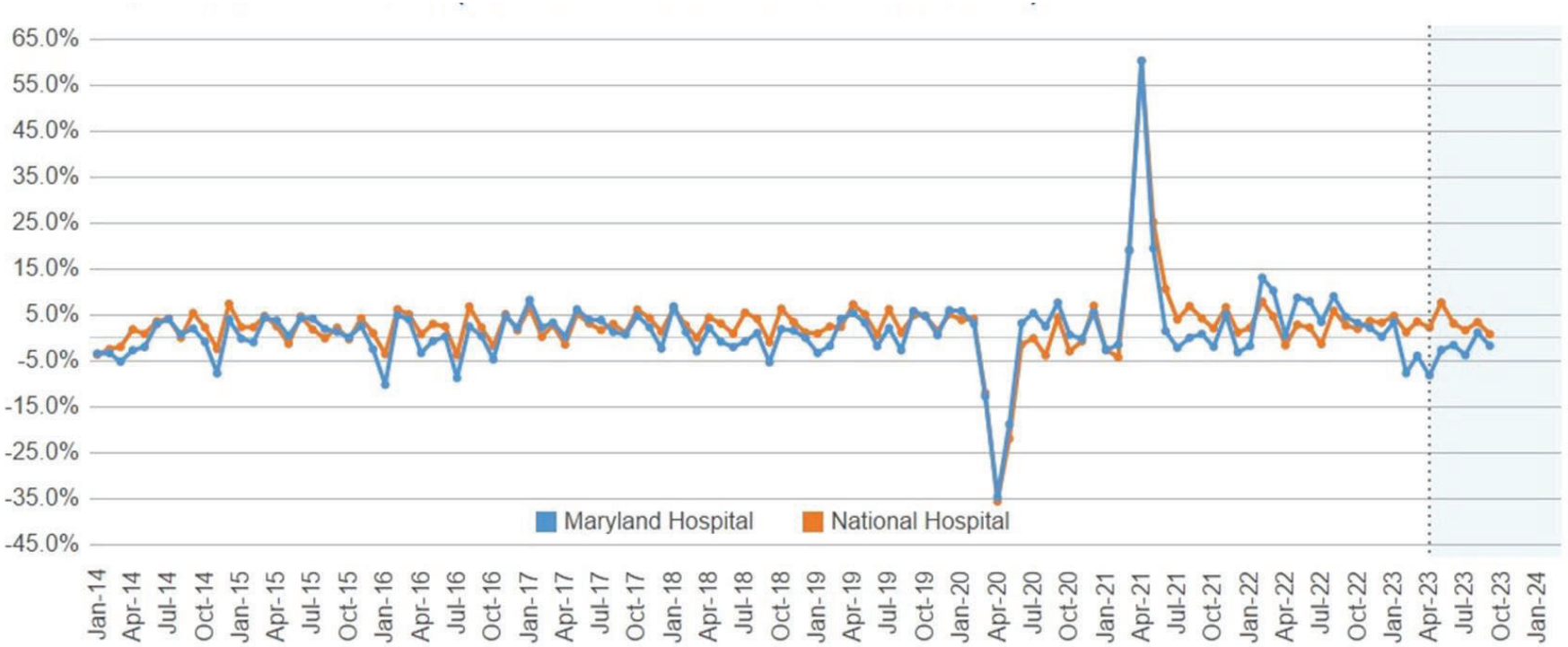
January 2024 Update

Data through September 2023, Claims paid through November 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

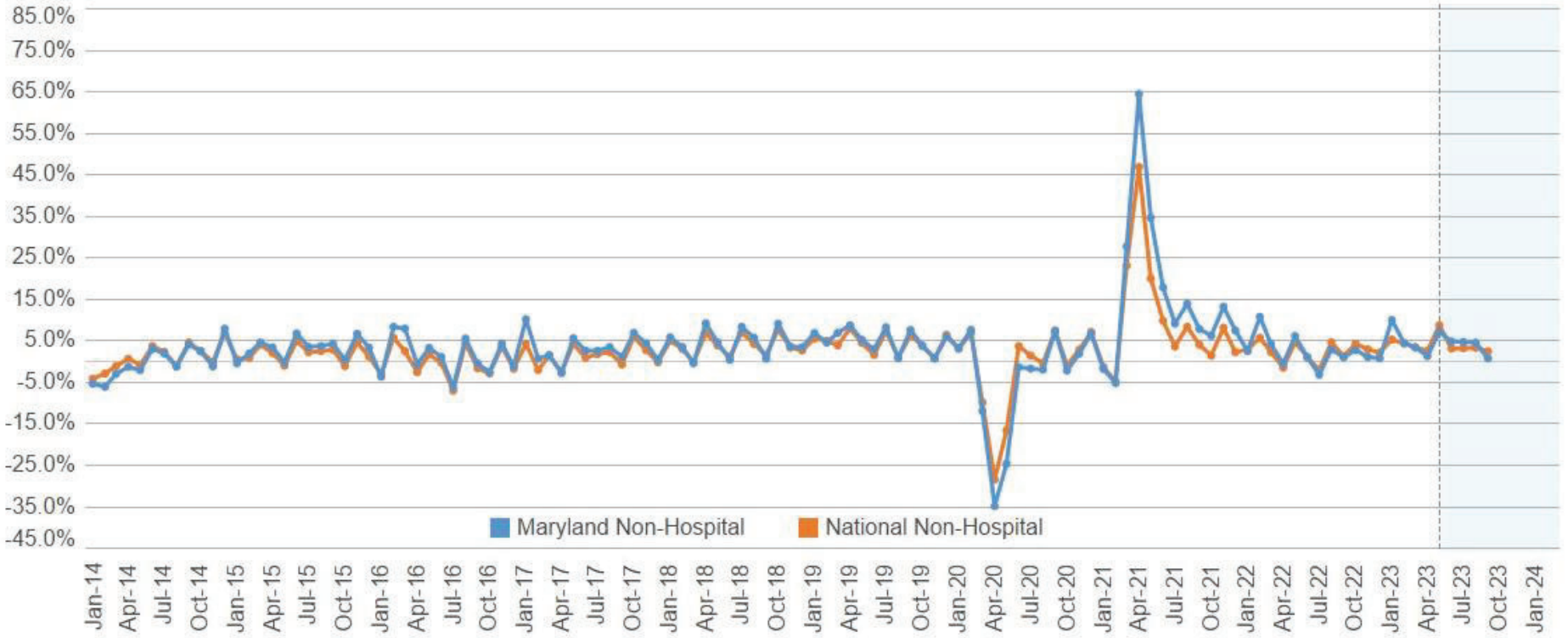
Actual Growth Trend (CY month vs. Prior CY month)



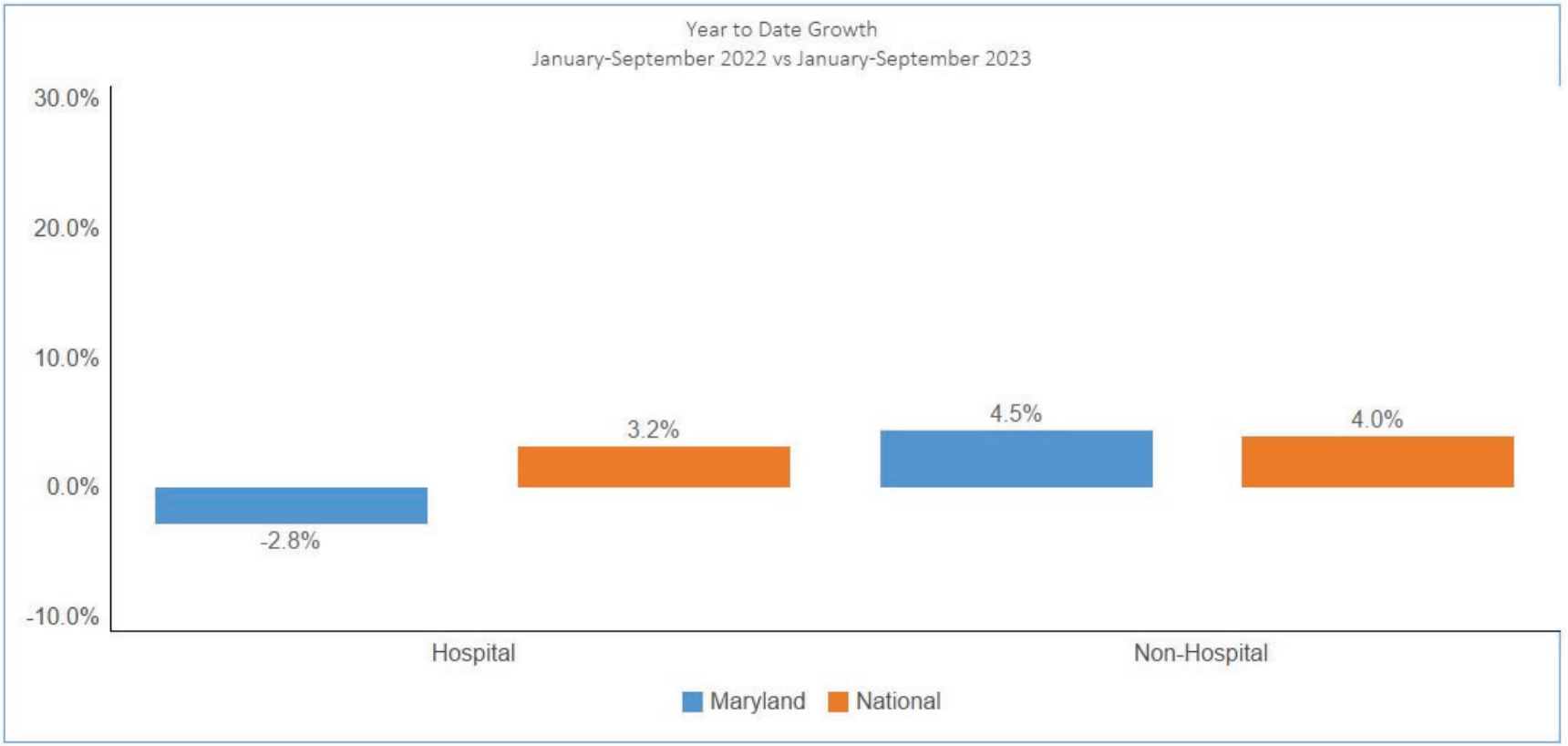
CY16 has been adjusted for the undercharge.

Medicare Non-Hospital Spending per Capita

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

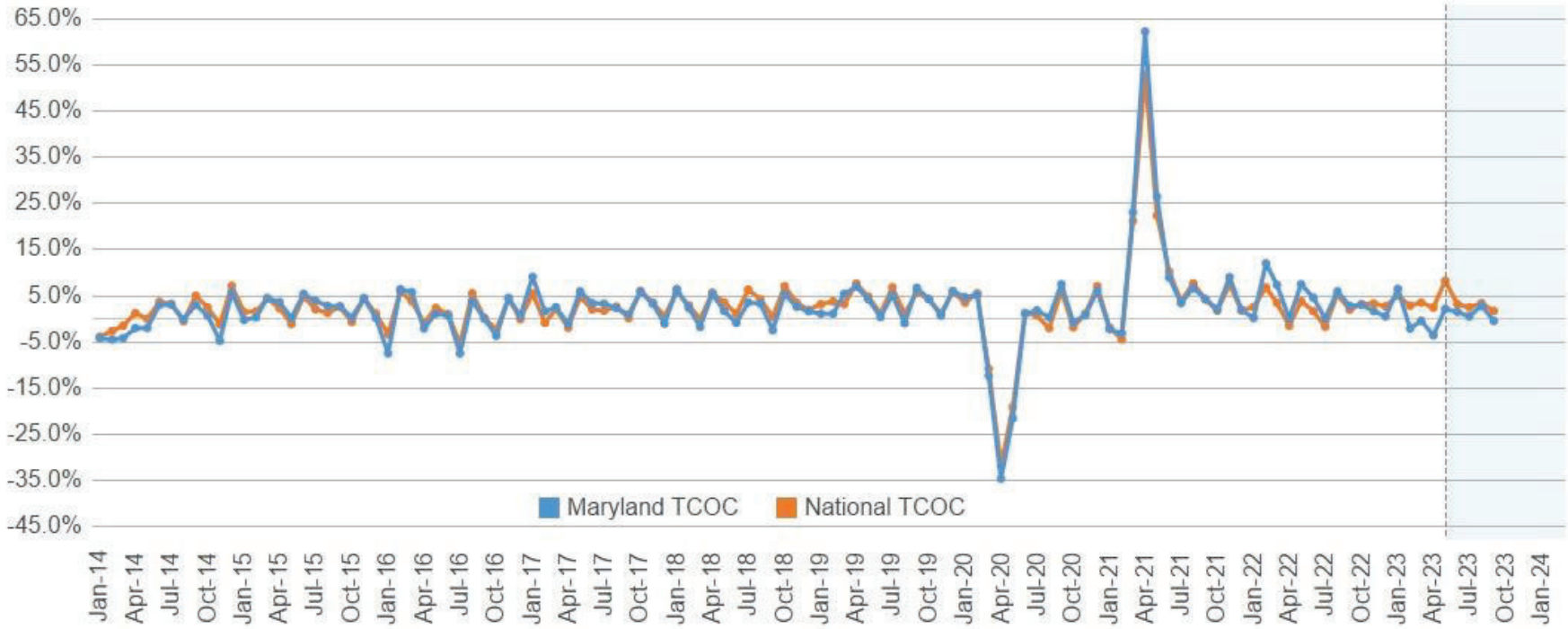


Medicare Hospital and Non-Hospital Payments per Capita



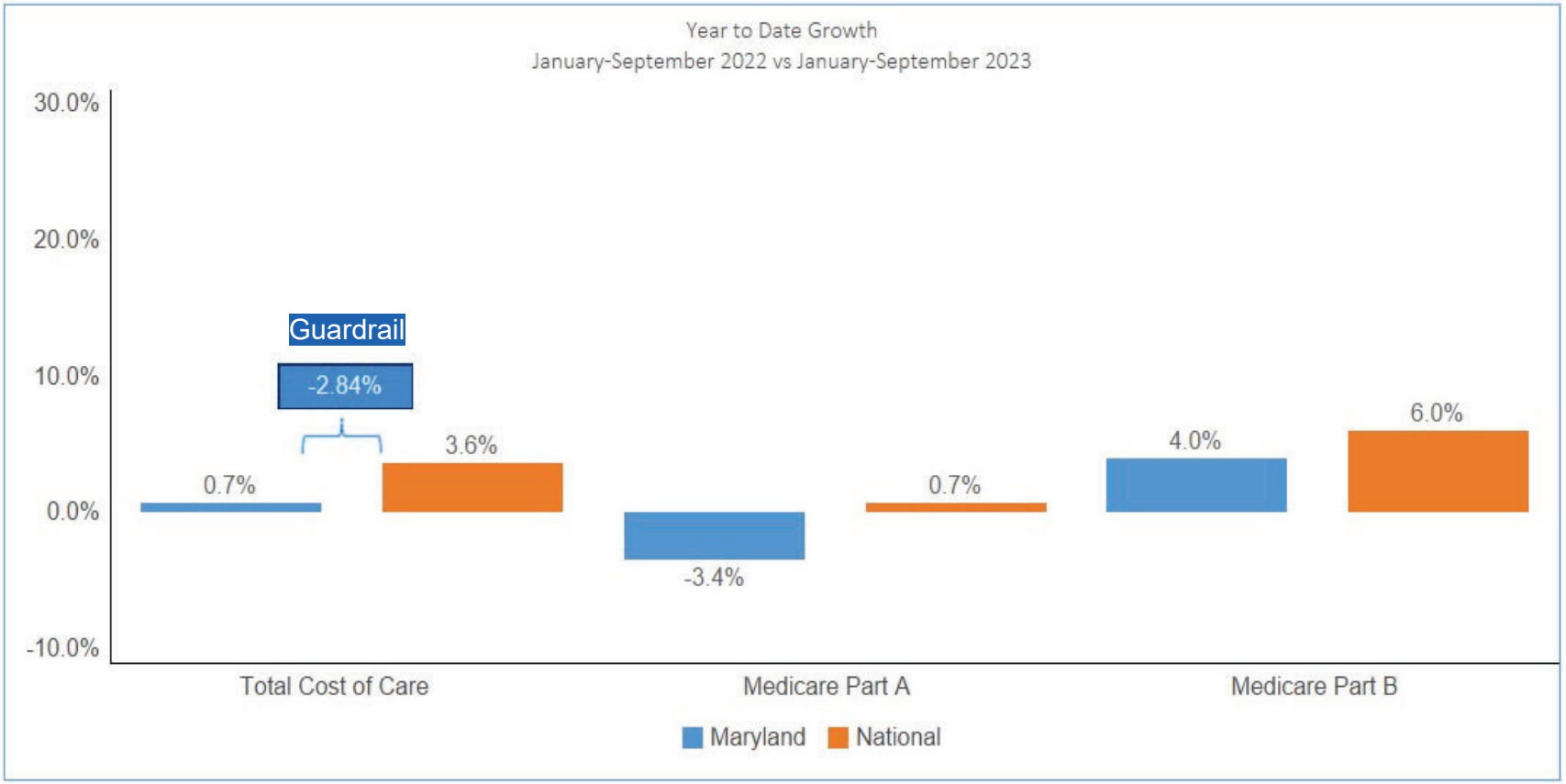
Medicare Total Cost of Care Spending per Capita

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



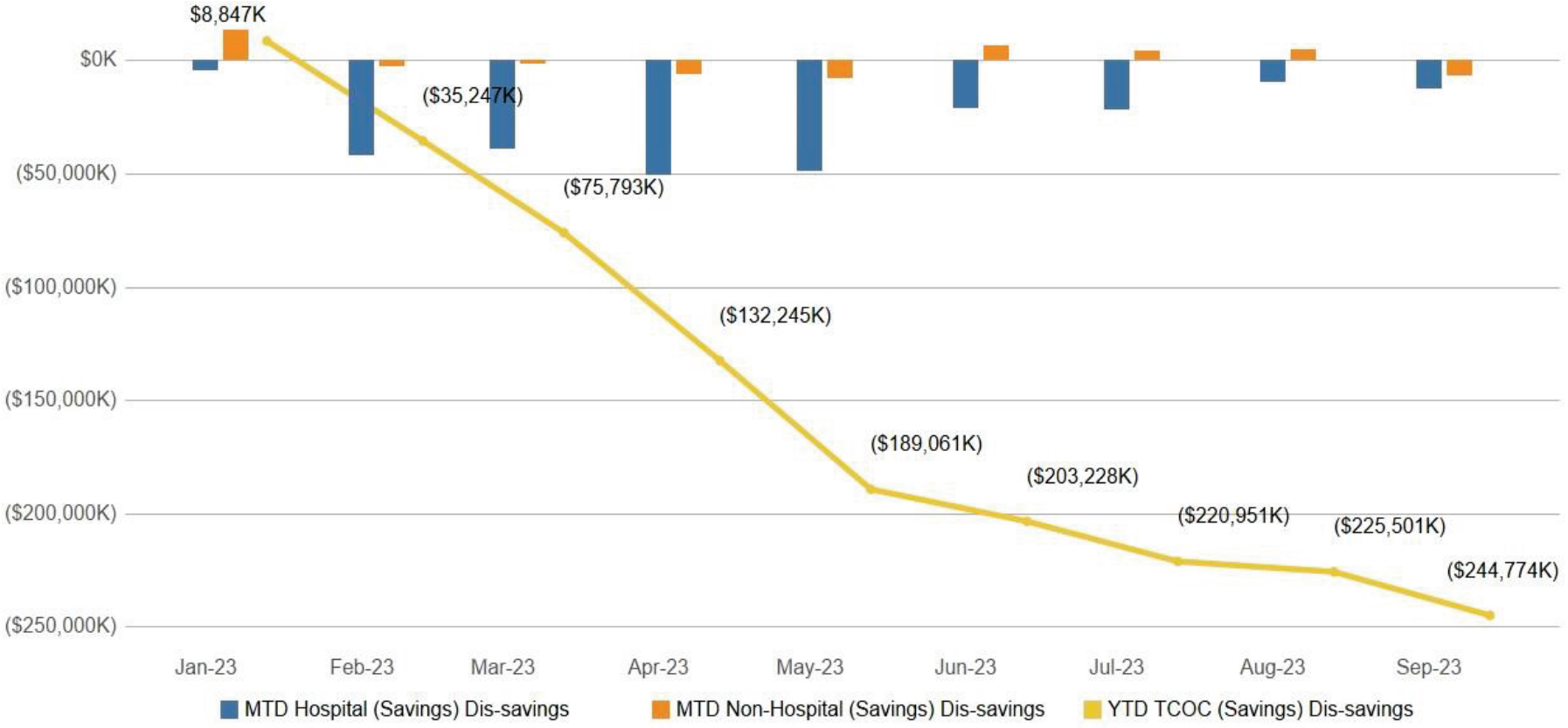
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



Maryland Medicare Hospital & Non-Hospital Growth

CYTD through September 2023



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Hospital Free Care Reimbursement Law Implementation

Overview and Stakeholder Process

Megan Renfrew, Deputy Director

January 10, 2024

Overview of Law

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

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

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

Workgroups

Started in September 2023. These workgroups include State agency staff and hospital representatives. Hospital representatives were recruited by MHA.

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 meet 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.

HSCRC staffs and leads all workgroups.

Legislators, Advocates, and Hospitals

- Staff provide 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 provided an overview of the law to all hospital CFOs at a 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.
  - Feedback is due by February 7, 2024
  - Send feedback to HSCRC.RefundLaw@maryland.gov
- Additional process updates will be provided on this webpage.

Thank you!

- Megan Renfrew, Deputy Director
  - Megan.Renfrew1@Maryland.gov
  - 410-382-3855 (cell)

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Stakeholder Engagement in the implementation of the Hospital Medical Bill Reimbursement Law

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.

This law originally went into effect on July 1, 2022 (Ch 683, 2022). In 2022, the HSCRC worked with the Department of Human Services (DHS), the State Designated Exchange, the Office of the Comptroller, the Maryland Hospital Association (MHA), consumer advocates, hospital revenue cycle experts, and other stakeholders to develop possible processes for implementing the law and identify any barriers to the implementation of the law. The findings from that work are contained in a 2022 report, "Free Hospital Care Refund Process: Required by Health General §19-214.4, MSAR #14289". This report recommended statutory changes to resolve changes related to compliance with federal and State privacy and data security laws. In 2023, the legislature amended the law to address the legal barriers to implementation. The amendments went into effect in July 2023.

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 and Legal, 2) Consumer Support and Communications, and 3) Data Management and Use. These workgroups started in September 2023. These workgroups include State agency staff and hospital representatives. The hospital representatives were recruited by MHA. A recent memo to all hospitals solicited additional hospital members. Each of these workgroups has met at least 3 times since

September. The charter and membership documents for these workgroups are attached to this document.

The workgroups will be maintained for as long as is necessary to support the implementation of this law.

In addition to the workgroups, HSCRC staff provide periodic updates on the implementation of this law to the sponsor of the legislation, the relevant HGO subcommittee chair, and to consumer advocates. Staff also provided an overview of the law to all hospital CFOs at a MHA Technical Workgroup meeting in July.

In December 2023, staff sent a draft of the memorandum of understanding (MOU) and data sharing and nondisclosure agreement to hospital CEOs, CFOs, state agencies, and consumer advocates for review and comment. The draft MOU is also posted on HSCRC's website. Feedback is due by **February 7, 2024.**

HSCRC staff hope that the MOU will be finalized by Spring/Summer 2024 and data exchange to identify eligible patients will begin in the summer. The current expectation is that the first refunds will likely be sent to consumers late in 2024. HSCRC is required to submit a legislative report on the implementation of this law by October 1, 2024. The reimbursement process will continue through the sunset date of the law in mid-2025.

The media has shown interest in this project. HSCRC expects more media coverage when the patient refunds begin.[1]

In addition to refunding patients, hospitals must compensate state agencies for time and resources spent on implementation of the law. HSCRC expects to invoice hospitals for these expenses in the third or fourth quarter of calendar year 2024 and again one year later. This means that the implementation of this law is budget neutral to the state agencies involved.

[1] Articles have appeared in the Baltimore Banner, WTOP, and Becker's CFO Report.

Workgroup Charters and Membership

Consumer Support and Communications Workgroup

Workgroup Charge: The purpose of the consumer support and communications workgroup is to advise HSCRC on the development of policies, plans, and documents related to consumer support and consumer communications to support the requirements of Health General 19-214.4 (Ch. 310, 2023), the hospital medical bill reimbursement process.

Deliverables for review include:

- Content for messages to consumers on refunds
- Rules around methods and frequency of consumer contacts from hospitals
- Content & related rules for hospital webpages on the reimbursements
- Clarity on agency and hospital roles in consumer support in the scope of work document
- Outreach campaign (TBD)

Members

Organization	Name
HEAU	Kim Cammarata
HEAU	Heather Forsyth
MDH	Jennifer Wilson
Comptroller	Justin Hayes
JHHS	Albert Galinn
Frederick Health	Shawn McCardell
GMBC	Anita Petri
GMBC	Greg Shaffer
Meritus	Patrick Teta
ChristianaCare Union Hospital	Jenifer Harris
ChristianaCare Union Hospital	Judy Riesen
ChristianaCare Union Hospital	Tracie Henry
Medstar	Mary Sonier

ChristianaCare Union Hospital	Chantel Moulton

Policy and Legal Workgroup

Workgroup Charge: The purpose of the Policy and Legal workgroup is to advise HSCRC on the content of the MOU, DUA, and SOW and other policy and legal issues to support the implementation of Health General 19-214.4 (Ch. 310, 2023), the hospital medical bill reimbursement process.

Deliverables for review include:

- MOU
- DSNA
- SOW (attachment to MOU)
- Other policy documents (including details not included in the broad SOW)

Members

Organization	**Name**
DHS	Ann Ware
Comptroller	Krista Sermon
HEAU	Kim Cammarata
HEAU	Heather Forsyth
HSCRC	Stan Lustman
HSCRC	Ari Elbaum
MDH	Jennifer Wilson
JHHS	Albert Galinn
Frederick Health	Shawn McCardell
GMBC	Anita Petri
GMBC	Lauren Klemm
ChristianaCare Union Hospital	Sarah Stowens
JHHS	Patricia Douge

ChristianaCare Union Hospital	Judy Riesen
ChristianaCare Union Hospital	Tracie Henry
Medstar	Patrick Wall

Data Workgroup

Workgroup Charge: The purpose of the data workgroup is to advise HSCRC on the creation of rules related to data management, secure transfer, matching methodology, and similar topics to support the requirements of Health General 19-214.4 (Ch. 310, 2023), the hospital medical bill reimbursement process.

Deliverables for review include:

- Data Fields (see data template below)
- Technical Documents
    - Data Template and Instructions
        - Format of data fields
        - Format of file naming convention (the file names may be used to indicate which state agency produced the file)
    - Data Matching Methodology for the Office of the Comptroller, DHS, and WIC/MDH
        - There will be separate methodologies for each agency based on their data availability.
    - How data will be transferred securely
    - Timeline/deadlines for each entity to complete their process steps
    - Data templates for summary data submission

Members

Organization	Name
DHS	Asnake Yeheyis
DHS	Maryann Maher
DHS	Meena Genjendiran
Comptroller	Brandy Richmond
Comptroller	Jeff Hill
HSCRC	Claudine Williams
WIC/MDH	Bryan Thompson
HSCRC	Oscar Ibarra
HSCRC	Kai-Ing Duh

HSCRC	Curtis Willis
JHHS	Albert Galinn
ChristianaCare Union Hospital	Mike Winiarz
Frederick Health	Aaron Clutter
Frederick Health	Shawn McCardell
GMBC	Lauren Klemm
GMBC	Jennifer Hillenbrand
Frederick Health	Prableen Singh
Medstar	Debbie Herron
ChristianaCare Union Hospital	Tracie Henry
ChristianaCare Union Hospital	Chantel Moulton
ChristianaCare Union Hospital	Magen Underwood
ChristianaCare Union Hospital	Kelli Tome
ChristianaCare Union Hospital	Judy Riesen

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Policy Development & Workgroup Process Updates

January 2024

HSCRC is accepting written public comments on the workgroup processes through January 31, 2024.

Email comments to erin.schurmann@maryland.gov.

Building Blocks of Development & Implementing HSCRC Policies

- Commissioners and staff reviewed select processes that are key to developing and implementing HSCRC policy.
  - Workgroup Management
  - Policy & Program Development (New Policies and Standard Updates)
  - Promulgating Regulations
- These materials formally document existing practices and updates intended to best engage Commissioners for policy feedback and enhance stakeholder engagement efforts.
- Through these processes, HSCRC aims to serve as a nimble policymaking body that prioritizes informed decision-making, transparency, inclusivity, and continuous evaluation.
- HSCRC is accepting written public comments on the **workgroup processes** through January 31, 2024. Email comments to erin.schurmann@maryland.gov.

Workgroup Management

- Preparation
  - Standing workgroups will have a written charge. (Payment Models, Performance Measurement, Total Cost of Care)
  - Technical subgroups will report back to standing workgroups.
  - Each workgroup meeting will be led by HSCRC staff.
  - Each workgroup will have its own webpage and email address.
  - Workgroups are meant to support staff in advancing the mission of the HSCRC and are advisory bodies only.
- Membership
  - The HSCRC strives toward diversity in expertise, experience, background, geography, and race/ethnicity in its workgroups.
  - Each workgroup will have listed membership which staff will review annually and determine if there is a need to replace any members.
  - Staff will conduct a roll call each meeting to monitor member attendance.
  - Staff will consider developing a dedicated consumer engagement approach.
- Meetings
  - Each meeting will be open to the public.
  - All meetings will be announced and have materials and minutes or recordings posted on the website.
  - Workgroups may set aside time at meetings for public comment.
- Feedback
  - Standing workgroups will survey workgroup members annually for feedback.
  - At one meeting a year, staff shall review workgroup processes with the Commission to consider updates.

Policy & Program Development Workflow

1. Staff develops a proposed policy plan, that includes goals, plan for needed data and analytics, plan for public engagement and an anticipated timeline.
2. Staff presents a proposed plan to Commissioners for consideration quarterly.
3. Staff proceed with plan, including collecting necessary data, conducting analytics, and engaging with stakeholders (e.g. workgroups, one-on-one outreach).
4. Staff presents Commissioners with draft policy recommendation.
5. Commission advises staff to move forward with draft policy recommendation.
6. After Commissioners give direction to move forward with a draft policy, the draft is considered open for public comment.
7. A final recommendation will be presented two months after the draft recommendation, with some exceptions (e.g. data availability limitations, Model requirement deadlines, etc).
8. Staff generate responses to public comment and update policy recommendation accordingly.
9. Staff present final policy recommendation to Commissioners for a final vote (2 months after draft)
10. Staff implement policy.

Promulgating Regulations (COMAR) Workflow

1. Staff prepare proposed plan for regulations with goals, timelines, and plan for public engagement.
2. Staff present proposed plan to Commission as part of quarterly updates.
3. Staff follow plan to develop draft regulations, including public engagement as proposed.
4. Staff provide an update to Commission on any substantive policy decisions for direction, if appropriate.
5. Staff present draft regulations to Commission.
6. Commission votes to send regulations to Maryland Register for public comment.
7. Public comment period (30 days)
8. Staff consider and respond to public comments.
9. If substantive changes are indicated based on public comment, staff seek Commission approval and re-propose updated regulations.
10. Staff present final regulations for adoption to Commission.
11. Commissioners take final action to implement regulations.
12. Notice of Final Action sent to Maryland Register; effective 10 days after posting.

Next Steps

- HSCRC is accepting public comments on the formal workgroup process.
  - Email comments to erin.schurmann@maryland.gov by January 31, 2024.
- Based on public feedback on the workgroup process, HSCRC will issue updated charters for the standing workgroups and make any necessary updates to the HSCRC website, membership rosters, and meeting management.
- HSCRC will release a policy calendar detailing Commission work priorities for CY 2024 through June 2025 in the coming weeks.

maryland
health services
cost review commission

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: January 10, 2024

RE: Hearing and Meeting Schedule

February 14, 2024 To be determined - GoTo Webinar

March 13, 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.