maryland
health services
cost review commission

**604th Meeting of the Health Services Cost Review Commission**
**March 8, 2023**

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

**EXECUTIVE SESSION**
**11:30 am**

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

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

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

**PUBLIC MEETING**
**1:00 pm**

1. Review of Minutes from the Public and Closed Meetings on February 8, 2023

2. Docket Status – Cases Closed

3. Docket Status – Cases Open
   - 2614A Johns Hopkins Health System
   - 2615A Johns Hopkins Health System
   - 2616A Johns Hopkins Health System
   - 2617A Johns Hopkins Health System
   - 2618A Johns Hopkins Health System

4. Confidential Data Requests

5. Overview of Deregulation Process

6. Policy Update

   a. CRISP Learning Collaborative Maryland Model Analytics Reports
   b. Legislative Update
   c. Model Monitoring

7. Hearing and Meeting Schedule

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# MINUTES OF THE 603rd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION February 8, 2023

Chairman Adam Kane called the public meeting to order at 11:07 am. In addition to Chairman Kane, in attendance were Commissioners Joseph Antos, PhD, Victoria Bayless, James Elliott, M.D., Maulik Joshi. Commissioner Sam Malhotra participated virtually. Upon motion made by Vice Chairman Antos and seconded by Commissioner Elliott, the meeting was moved to Closed Session. Chairman Kane reconvened the public meeting at 1:31p.m.

## REPORT OF FEBRUARY 8, 2023, CLOSED SESSION

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

## TIDALHEALTH PETITION FOR DECLARATORY RULING

TidalHealth filed a petition for declaratory ruling on January 3rd. The Commission has 60 days to rule if TidalHealth petition will be granted or denied. The Commission has considered the hospital's request and has consulted with Counsel.

Commissioner Antos made a motion to deny TidalHealth's petition for declaratory ruling.

The Commissioners voted unanimously to deny TidalHealth's petition for declaratory ruling.

## ITEM I
## REVIEW OF THE MINUTES FROM THE JANUARY 11, 2023, CLOSED SESSION, AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the January 11, 2023, Public Meeting and Closed Session.

## ITEM II
## CLOSED CASES

2611A- Johns Hopkins Health System
2612A- Johns Hopkins Health System
2613A- Johns Hopkins Health System

## ITEM III
## OPEN CASES

2603R- Luminis Anne Arundel Medical Center
2608R- Shady Grove Adventist Medical Center

## ITEM IV
## TRADITIONAL MPA- CY 2023 PERFORMANCE- FINAL RECOMMENDATION

Mr. Willem Daniel, Deputy Director, Payment Reform, presented Staff's draft recommendation on the Medicare Performance Adjustment for CY 2023 (see "Final Recommendation for CY 2023 Medicare Performance Adjustment (MPA)" available on the HSCRC website)

The MPA is a required element for the Total Cost of Care Model ("TCOC") and is designed to increase the hospital's individual accountability for 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 its service area. In recognition of large risk borne by the hospitals collectively through the GBR, the MPA has a relatively low amount of revenue at risk (1 percent of Medicare fee-for-service revenue).

The MPA includes two "components":

- Traditional Component, which holds hospitals accountable for the Medicare TCOC of an attributed patient population, and an
- Efficiency Component, which rewards hospitals for the care redesign interventions.

These two components are added together and applied to the amount that Medicare pays each respective hospital. The MPA is applied as a discount to the amount that Medicare pays on each claim submitted by the hospital.

Currently, the HSCRC assigns patients to hospitals based on their geographic residence. In CY22, the Commission assigned patients to hospitals based on the hospital's Primary Service Areas ("PSAs") as designated in the original hospital GBR agreements. However, based on industry feedback, staff proposed to move towards a geographic algorithmic PSA Definition. For CY 2023, Staff recommends using the revised geographic attribution algorithm as follows:

- Hospitals are attributed the costs and beneficiaries in zip codes that comprise 60% of their volume. Beneficiaries in zip codes claimed by more than one hospital are allocated according to the hospital's share on equivalent case-mix adjusted discharges (ECMADs) for inpatient and outpatient discharges among hospitals claiming that zip code. ECMADs are calculated from Medicare Fee For Service claims for Calendar Year 2019. ECMADs are also used in calculating the volumes in the 60% test.

- Zip codes not assigned to any hospital under step 1 are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed a 30-minute drive-time from the hospital's PSA.
- Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.
- An alternative attribution approach for the AMCs will be used, consistent with that approved for CY2022, where beneficiaries with a CMI of greater than 1.5 and who receive services from the AMC are attributed to the AMC as well as the hospital under the standard attribution.

Staff received public comments on the draft CY 2023 MPA proposal from the Maryland Hospital Association (MHA), MedStar Health, Luminis Health, and TidalHealth. MHA, MedStar Health, and Luminis Health were supportive of removing the MDPCP Supplemental Adjustment and generally supportive of using the geographic attribution in the MPA for CY 23, although all three indicated that geographic attribution was not a perfect attribution algorithm and suggested that staff and the industry continue to investigate potential improvements in the attribution algorithm. Staff agree that geographic attribution is not perfect; however, Staff believe that the attribution algorithm is the best of the algorithms investigated by the TCOC Workgroup. Namely, the geographic attribution has three major advantages: it is simple, it is predictable, and it is consistent. Staff will continue to investigate alternative attribution algorithms but expect to maintain the geographic attribution for the foreseeable future. MHA, MedStar Health, Luminis Health, each indicated support for deferring the inclusion of the population health measures for future years and have suggested alternatives to the proposed ED Diabetes Screening Measure. Staff note that CMMI have approved the MPA without the inclusion of the population health measure in CY 23 but have expressed their expectation that the State include these measures in CY 24. Staff anticipate using the remainder of CY 23 to finalize the population health measures prior to CY 24.

TidalHealth expressed a concern regarding the TCOC benchmarking methodology that is used in the MPA and other HSCRC policies. First, TidalHealth believes that the TCOC benchmarks are flawed because they do not incorporate the CMS hospital wage index that is used to set IPPS rates nationally; second, TidalHealth believes that the benchmarks are flawed because they do not incorporate an adjustment for health outcomes. Staff do not agree with either objection. Regarding the first concern, the CMS hospital wage index is widely acknowledged to be inaccurate for Maryland hospitals. Matching inaccurate Maryland numbers to accurate national numbers would produce inaccurate results. Instead, Staff used median income to measure a hospital's labor costs, which addresses the concern raised by TidalHealth without the data integrity issues of the CMS hospital wage index. Staff also tested other measures of wage costs and did not find a material difference . Regarding the second concern, the benchmarks were designed to measure the relative level of costs in Maryland and demographically similar regions in the rest of the country. The benchmarks were not designed to determine the level of spending necessary to achieve a certain level of health outcomes. While the latter question is academically interesting and may be pertinent to other HSCRC policy goals, the State is required to meet the savings target in the Maryland TCOC Model Agreement, which is accomplished in part through the MPA. The MPA uses the benchmarks to determine factually which Maryland hospitals have relatively high per capita spending and thus most need to reduce costs in order to meet the statewide savings target in a manner proportional to their opportunity. The implementation of the differential targets is gradual and limited by the 1% revenue at risk and therefore does not result in a substantially greater hardship for hospitals with high per capita TCOC. The HSCRC has other policies (Potentially Avoidable Utilization,

Maryland Hospital Acquire Conditions, Readmission Reduction Incentive Program) that financially support hospitals which improve quality.

Staff recommends three changes to the MPA for CY2023:

- Formalize the revision of the geographic attribution algorithm.
- Eliminate the Supplemental Maryland Primary Care Program (MDPCP) adjustment; and
- Increase the amount of revenue at risk by increasing the weight of the MPA quality adjustment.

Staff recommends maintaining the MPA for CY2023 and CY 2024, in order to create as much stability for hospitals as possible.

Laura Russell on behalf of MHA stated that MHA and their member hospitals generally support the Staff recommendation.

Ms. Russell specifically stated support for the following:

- Removing the MDPCP supplemental adjustment. MDPCP Track 3 features downside risk for both physician practices and hospital Care Transformation Organizations beginning in CY 2023
- HSCRC plans to use a different attribution methodology for academic medical centers since the geographic approach does not reflect tertiary care service use patterns.
- Using a formula to assign beneficiaries to hospitals under the geographic attribution. However, we remain concerned that strict geographic attribution does not capture hospital initiatives to transform care delivery.
- HSCRC staff and Centers for Medicare and Medicaid Services (CMS) for not implementing a CY 2023 population health measure because a workable measure is not final. The population health measure should be.

Steven Leonard, President/CEO, TidalHealth expressed concern with the role the TCOC benchmark has in the MPA methodology. Mr. Leonard stated that TCOC benchmarks fail to establish equitable outcomes for the state's rural communities by imposing Maryland financial standards that reflect the poor financial performance of rural hospitals nationally. He noted that the benchmarks ignore the consistently poor health outcomes in the counties used to construct these standards.

Commissioner unanimously voted in favor of Staff's recommendation.

## ITEM V
## EMERGENCY DEPARTMENT CHALLENGES AND STRATEGIES

Ms. Katie Wunderlich, Executive Director, presented a history of Emergency Room (ED) wait times in Maryland (see "Emergency Department Challenges and Strategies" available on the HSCRC website).

Ms. Wunderlich stated that ED wait times in Maryland have been consistently higher than the nation since before the start of the All-Payer model. Ms. Wunderlich noted that Inpatient ED wait times data have been added to Quality Based Reimbursement program in RY 2020 (CY 2018 performance).

Ms. Wunderlich stated that from CY2014 to CY 2022 Outpatient ED wait times in Maryland are also higher than the nation. She noted CMS continues to collect outpatient ED wait times and that outpatient ED wait times are correlated wi th IP wait times

Despite multiple actions by the Commission, ED wait times continue to be worse than the nation. Staff needs to develop strategic policies to improve patient experience and outcomes. Multipronged strategy to address ED wait times is needed, including initiatives to address ED overcrowding

Multi-pronged approach must consider aspects of the delivery system

- Increase access points outside of the hospitals for patients to manage care before the need for an ED visit (Primary Care Physician, Federal Qualified Health Center, Urgent Care Clinics, Mobile Integrated Health, ED Diversion strategies).
- Continue to invest in behavioral health crisis services and other access points to address critical behavioral health patient needs.
- Increase accountability for hospitals to improve throughput and reduce ED overcrowding and wait times.

Mr. Adam Pittman, Chief, Population Health and Analytics, stated that in CY2021, the Commissioners asked Staff to evaluate expansion of PAU to ED utilization. Staff did an analysis of 2.4 million ED observations containing triage. Staff identified Ear Pain and Dental problems that are high volume and low acuity. Staff initial policy focused on incentivizing in reduced volmes in Ear Pain and Dental issues

Mr. Pittman noted that stakeholders concerns are as follows:

- Unclear what the opportunity/intervention is for hospitals.
- Low acuity categories may contain some patients who need emergent care.

Based on worked performed and stakeholders' feedback it was decided to look at high utilizers. Stakeholders stated the following reasons to look at high utilizers:

- Stakeholders suggested focusing on frequent ED visitors
- Easier to intervene on patients with pre-existing relationship with a hospital
- Addresses low-acuity visits and those preventable with better primary care
- Several studies have focused on programs that reduce ED utilization by intervening on frequent visitors
- Interventions include case management, improving primary care access
- Case management may reduce ED use

Staff testing sought to understand volume and cost related to patients that frequented the Emergency Department, as well as overlap with PAU, payer and demographic patterns, and variability across hospitals. Staff analyzed IP/OP data across several years to understand frequent flier patterns. Due to COVID concerns, Staff results are primarily based on CY 2019 O/P casemix data. Mr. Pittman stated that Staff categorized individuals with 4+ visits in a year as high utilizers.

Mr. Pittman stated that based on testing, frequent fliers accounted for 30% of all ED visits in CY2019. He also stated that:

- the bulk of the frequent fliers are discharged from the ED
- lower acuity problems are common in frequent flier populations and
- there was limited overlap with PAU as it focuses mainly with I/P.

Other results from Staff testing:

- O/P visits by high utilizers for low acuity principal diagnoses (lower level of urgency) is 62%.
- High utilizers accounted for 32% of discharged ED costs ($326 million) in CY2019.
- Over 45% of high Utilizers went to the same ED.
- High utilizers' visit percentage is higher for hospitals in inner Baltimore.

Mr. Pittman identified the characteristics of high utilizers based on CY 2019 data as follows:

- 40% are covered by Medicaid
- 37% involve patients in the top quartile of Area Deprivation Index
- 41% involve Black patients
- 1% involve homeless patients
- 38% (of admitted visits) are also flagged as PQI's

## ITEM VI
## ANALYSIS Of UTILIZATION TRENDS UNDER THE TCOC MODEL

Mr. Daniel review Staff's analysis of utilization trends under the TCOC Model (see "Utilization Opportunity Analysis" available on the HSCRC website).

Based on Staff's analysis the following is noted:

- There has been a long-term decline in inpatient utilization. When comparing 2019 volumes as a percent of 2013 volumes the results is an inpatient utilization decline of 11%. Prior to 2019 Maryland has been reducing inpatient utilization about twice as fast when compared to the nation.
- Maryland PAU volumes declined by 19.6% in 2019 over 2013 and declined by 21.3% in FY2021 over FY2019.
- Maryland utilization per thousand is average when compared to nation.
- From 2013 to 2019 outpatient utilization increased as volumes shifted from inpatient.
- Maryland outpatient volumes decreased when compared to the nation due to lower acuity services.
- When comparing outpatient utilization from 2019 to 2021 the results is that outpatient utilization is approximately 60-70% of 2019 volumes.

Mr. Daniel noted the following scenarios due to the fluctuation of IP/OP utilization:

- If the Nation does bounce back, Maryland will be in a strong position to:
  - Generate savings by retaining new utilization strategies and monetizing savings.
  - Generate new utilization advantages while the nation struggles with a return to traditional Fee For Service behavior.
- If the Nation does NOT bounce back, Maryland will need to
  - Convert utilization declines into savings more rapidly in order to meet model goals.
  - Find new utilization reduction opportunities.

- The future of utilization in the nation remains unclear.
  - There is little evidence in the data of a bounce back at this point.
  - National utilization levels can be seen as just accelerated timing of the historic rate of reduction which would suggest a bounce back is unlikely
  - National providers may be limited in their ability due to staffing and labor challenges in the near term
  - However, the underlying forces that drive utilization growth in a fee-for-service environment remain unchanged

## ITEM VII
## Policy Update and Discussion

### Model Monitoring

Ms. Deon Joyce, Chief, Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 10 months ending October 2022. Maryland's Medicare Hospital spending per capita growth was unfavorable when compared to the nation. Ms. Joyce noted that Medicare Nonhospital spending per-capita was trending closer to the nation. Ms. Joyce noted that Medicare Total Cost of Care (TCOC) spending per-capita was trending close to the nation. Ms. Joyce noted that the Medicare TCOC guardrail position is 2.54% above the nation through October. Ms. Joyce noted that Maryland Medicare hospital and non-hospital growth through October shows a run rate erosion of $202,161,000.

### Legislative Update

Ms. Megan Renfrew, Associate Director of External Affairs presented the Legislative Update (see "Legislative Update" available on the HSCRC website).

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

- HB 420/SB 234 Health Services Cost Review Commission- Hospital Rates- All-Payer Model Contract
- HB TBD- Health Services Cost Review Commission- Medical Debt and Financial Assistance
- HB 200/SB 181- Budget Bill for FY2024 (The Governor's Budget)
- HB 202/SB 183- Budget Reconciliation and Financing Act of 2023

- HB 214/SB 281- Commission on Public Health- Establishment
- HB 271/S 3 – 9-8-8 Trust Fund- Funding
- HB 274/SB 387- Task Force on Reducing Emergency Department Wait Times
- HB 333/SB 404- Hospitals- Financial Assistance- Medical Bill Reimbursement Process
- SB 493/HB 675- Commission to Study Trauma Center Funding in Maryland

**Analysis of Hospital Funding in Rural and High Poverty Area**

Ms. Wunderlich presented an analysis of hospital funding in rural and high poverty area in regards to the TCOC Model (see Analysis of Rural Funding and High Poverty Areas" available on the HSCRC website).

The Total Cost of Care Model provides a significant advantage to hospitals in rural and low-income areas compared to peer hospitals in other states.

- In Maryland, all-payers pay the same hospital rates. Hospital rates for public payers (Medicare and Medicaid) are higher than rates at peer hospitals.
- Hospitals in rural and low-income areas have the highest share of public payers, resulting in strong funding for these hospitals compared to peer hospitals.
- Maryland hospitals in disadvantaged areas receive higher total public payer reimbursement per person than peer hospitals in other states, even on a risk-adjusted basis.

    - For rural counties, these hospitals they receive$238 million more annually in reimbursement for hospital services delivered to Medicare and Medicaid enrollees when compared to national hospitals in similar rural areas on a risk adjusted basis ($650 per enrollee, rural counties defined as Allegany, Caroline, Dorchester, Garrett, Kent, Somerset, St. Mary's, Talbot, Washington, Wicomico, and Worcester).

    - For counties with higher levels of deep poverty hospitals receive $781 million more annually in reimbursement for hospital services delivered to Medicare and Medicaid enrollees when compared to national hospitals with areas of similar levels of deep poverty on a risk adjusted basis ($1,392 per enrollee, defined to include counites with greater than 6% deep poverty, includes Allegany, Baltimore City, Caroline, Dorchester, Kent, Somerset, and Wicomico).

**ITEM VIII**
**HEARING AND MEETING SCHEDULE**

March 8, 2023, Times to be determined- 4160 Patterson Ave
HSCRC Conference Room
April 12, 2023, Times to be determined- 4160 Patterson Ave.
HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:00 pm.

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

**February 8, 2022**

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

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

2. Update on Administration of Model - Authority General Provisions Article, §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. Discussion of Tidal Health Petition for Declaratory Ruling – Authority General Provisions Article, §3-305(7)(8)

The Closed Session was called to order at 11:07 a.m.

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

In attendance representing Staff were Katie Wunderlich, Jerry Schmith, William Henderson, Geoff Dougherty, Alyson Schuster, Ph.D., Megan Renfrew, and Dennis Phelps.

Also attending were:
Stan Lustman and Ari Elbaum Commission Counsel, and Dr. Theodore Delbridge, Executive Director and Dr. Timothy Chizmar, Medical Director of the Maryland Institute for Emergency Medical Services System.

## Item One

Dr. Delbridge, Dr. Chizmar, and the Commission discussed hospital Emergency Department performance and its effect on Emergency Medical Services providers.

## Item Two

The Commission discussed TidalHealth's Petition for a Declaratory Ruling. Commission Counsel provided legal advice. William Henderson, Principal Deputy Director, Medical Economics and Data Analytics briefly described the benchmarking methodology in the context of the TidalHealth petition.

## Item Three

Megan Renfrew, Associate Director, External Affairs, updated the Commission on legislation of interest to the Commission.

The Closed Session was adjourned at 1:25 p.m.

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

AS OF FEBRUARY 27, 2023

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

| Docket Number | Hospital Name | Date Docketed | Purpose | Analyst's Initials | File Status |
|---|---|---|---|---|---|
| 2603R | Luminis Anne Arundel Medical Center | 7/22/2022 | FULL | KW | OPEN |
| 2608R | Shady Grove Adventist Medical Center | 7/18/2022 | CAPITAL | GS | OPEN |
| 2614A | Johns Hopkins Health System | 2/8/2023 | ARM | DNP | OPEN |
| 2615A | Johns Hopkins Health System | 2/8/2023 | ARM | DNP | OPEN |
| 2616A | Johns Hopkins Health System | 2/24/2023 | ARM | DNP | OPEN |
| 2617A | Johns Hopkins Health System | 2/24/2023 | ARM | DNP | OPEN |
| 2618A | Johns Hopkins Health System | 3/1/2023 | ARM | DNP | OPEN |

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

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| IN RE: **THE APPLICATION FOR** | * | **BEFORE THE MARYLAND HEALTH** | |
| **ALTERNATIVE METHOD OF RATE** | * | **SERVICES COST REVIEW** | |
| **DETERMINATION** | * | **COMMISSION** | |
| **JOHNS HOPKINS HEALTH** | * | **DOCKET:** | **2023** |
| **SYSTEM** | * | **FOLIO:** | **2424** |
| **BALTIMORE, MARYLAND** | * | **PROCEEDING:** | **2614A** |

**Staff Recommendation**

**March 8, 2023**

## I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on February 8, 2023, on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to participate in a new global rate arrangement with for cardiovascular services, kidney transplant services, and spine surgery with Global Medical Management Inc. for a period of one year beginning April 1, 2023.

## II. OVERVIEW OF APPLICATION

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

## III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving similar procedures at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

## IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

## V. STAFF EVALUATION

Staff found that the experience under this arrangement over the last year was slightly unfavorable. The prices under this arrangement have been renegotiated. Staff believes that the hospitals can continue to achieve a favorable outcome under this revised arrangement.

## VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services, kidney transplant services, and spine surgery for a one-year period commencing April 1, 2023. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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| **IN RE: THE APPLICATION FOR** | ***** | **BEFORE THE MARYLAND HEALTH** | |
| **ALTERNATIVE METHOD OF RATE** | ***** | **SERVICES COST REVIEW** | |
| **DETERMINATION** | ***** | **COMMISSION** | |
| **JOHNS HOPKINS HEALTH** | ***** | **DOCKET:** | **2023** |
| **SYSTEM** | ***** | **FOLIO:** | **2425** |
| **BALTIMORE, MARYLAND** | ***** | **PROCEEDING:** | **2615A** |

**Staff Recommendation**

**March 8, 2023**

## I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on February 8, 2023, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to continue to participate in a global rate arrangement for bariatric surgery, bladder cancer surgery, anal and rectal cancer surgery, cardiovascular services, joint replacement surgery, pancreatic cancer surgery, spine surgery, and thyroid and parathyroid surgery with BridgeHealth Medical, Inc. for a period of one year beginning April 1, 2023.

## II. OVERVIEW OF APPLICATION

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

## III. FEE DEVELOPMENT

The hospital portion 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.

## IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

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

## V. STAFF EVALUATION

Staff found that the experience under this arrangement for the last year was slightly unfavorable. The prices under this arrangement were renegotiated. Staff believes that the Hospitals can achieve favorable experience under this revised arrangement.

## VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for bariatric surgery, bladder cancer surgery, anal and rectal cancer surgery, cardiovascular services, joint replacement surgery, pancreatic cancer surgery, spine surgery, and thyroid and parathyroid surgery for a one-year period commencing April 1, 2023. The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

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| **IN RE: THE APPLICATION FOR** | ***** | **BEFORE THE MARYLAND HEALTH** | |
| **ALTERNATIVE METHOD OF RATE** | ***** | **SERVICES COST REVIEW** | |
| **DETERMINATION** | ***** | **COMMISSION** | |
| **JOHNS HOPKINS HEALTH** | ***** | **DOCKET:** | **2023** |
| **SYSTEM** | ***** | **FOLIO:** | **2426** |
| **BALTIMORE, MARYLAND** | ***** | **PROCEEDING:** | **2616A** |

**Staff Recommendation**

**March 8, 2023**

## I. INTRODUCTION

On February 24, 2023, Johns Hopkins Health System ("System") filed an application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval to continue to participate in a global price arrangement with One Team Health, an international TPA, for cardiovascular services and for the new service of Spine Surgery. The Hospitals request that the Commission approve the arrangement for one year beginning April 1, 2023.

## II. OVERVIEW OF APPLICATION

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

## III. FEE DEVELOPMENT

The hospital portion of the global rates, which was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid, has been adjusted to reflect recent hospital rate increases. The remainder of the global rate is comprised of physician service costs. Additional per diem payments, calculated for cases that exceeded a specific length of stay outlier threshold, were similarly adjusted.

## IV. IDENTIFICATION AND ASSESSMENT RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payers, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC

maintains that it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

## V. STAFF EVALUATION

Staff found that the experience for the prior year under this arrangement was favorable. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

## VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services for the period beginning April 1, 2023. The Hospitals must file a renewal application annually for continued participation.

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

| | | | |
|---|---|---|---|
| IN RE: **THE APPLICATION FOR** | * | **BEFORE THE MARYLAND HEALTH** | |
| **ALTERNATIVE METHOD OF RATE** | * | **SERVICES COST REVIEW** | |
| **DETERMINATION** | * | **COMMISSION** | |
| **JOHNS HOPKINS HEALTH** | * | **DOCKET:** | **2023** |
| **SYSTEM** | * | **FOLIO:** | **2427** |
| **BALTIMORE, MARYLAND** | * | **PROCEEDING:** | **2617A** |

**Staff Recommendation**

**March 8, 2023**

## INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on February 24, 2023, on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to add outpatient joint replacement services to the global rate arrangement approved for bariatric surgery, bladder surgery, anal rectal surgery, cardiovascular services, joint replacement surgery, pancreas surgery, spine surgery, thyroid surgery, parathyroid surgery, solid organ and bone marrow transplants, and Executive Health services, eating disorder, gender affirming surgery, and gall bladder surgery with Assured Partners. The Hospitals request that the approval be for the period for one year beginning April 1, 2023

## II. OVERVIEW OF APPLICATION

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

## III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving similar procedures at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

## IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians continues to hold the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that

JHHC is adequately capitalized to bear the risk of potential losses.

## V. STAFF EVALUATION

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

## VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination to add outpatient joint replacement services to bariatric surgery, bladder surgery, anal rectal surgery, cardiovascular services, joint replacement surgery, pancreas surgery, spine surgery, thyroid surgery, parathyroid surgery, solid organ and bone marrow transplants, and Executive Health services, eating disorder, gender affirming surgery, and gall bladder surgery approved effective April 1, 2023. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

| | | | |
|---|---|---|---|
| **IN RE: THE APPLICATION FOR** | ***** | **BEFORE THE MARYLAND HEALTH** | |
| **ALTERNATIVE METHOD OF RATE** | ***** | **SERVICES COST REVIEW** | |
| **DETERMINATION** | ***** | **COMMISSION** | |
| **JOHNS HOPKINS HEALTH** | ***** | **DOCKET:** | **2023** |
| **SYSTEM** | ***** | **FOLIO:** | **2386** |
| **BALTIMORE, MARYLAND** | ***** | **PROCEEDING:** | **2618A** |

**Staff Recommendation**

**March 8, 2023**

## I. INTRODUCTION

Johns Hopkins Health System (“System’) filed an application with the HSCRC on March 1, 2023, on behalf of its member hospitals (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global arrangement to provide solid organ and bone marrow transplants services with Cigna Health Corporation. The System requests approval of the arrangement for a period of one year beginning April 1, 2023.

## II. OVERVIEW OF APPLICATION

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

## III. FEE DEVELOPMENT

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

## IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

## V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been favorable.

## VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for participation in an alternative method of rate determination for bone marrow and solid organ transplant services, for a one-year period commencing April 1, 2023, and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU"). The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

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# Final Staff Recommendation for the Release of HSCRC Confidential Patient Level Data to Oregon Health & Science University (OHSU)/ University of Utah Center for Policy Research in Emergency Medicine (CPR-EM)

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

March 8, 2023

This is a final recommendation for Commission consideration at the March 8, 2023, Public Commission Meeting.

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## SUMMARY STATEMENT

The Oregon Health & Science University (OHSU) Center for Policy and Research in Emergency Medicine (CPR-EM)/University of Utah- National Emergency Medical Services Information System (NEMSIS) Technical Assistance Center (T.A.C.) is requesting access to Health Services Cost Review Commission (HSCRC) Inpatient and Outpatient Hospital data ("the Data"), for the following projects:

1. An evaluation of pediatric firearm injury risk prediction in children using emergency services in the US;
2. An evaluation of the National Pediatric Readiness Project (NPRP); and
3. Identifying ways to further improve pediatric outcomes and quality of care, and to examine the associated costs, all with national health policy implications.

## OBJECTIVE

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

## REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee is composed of representatives from HSCRC, the MDH Environmental Health Bureau, and the Behavioral Health Administration. The role of the Review Committee is to determine whether the study meets the minimum requirements described below and to make recommendations for approval to the HSCRC at its monthly public meeting.

1. The proposed study or research is in the public interest;
2. The study or research design is sound from a technical perspective;
3. The organization is credible;
4. The organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations; and
5. The organization has adequate data security procedures in place to ensure protection of patient confidentiality.

The Review Committee unanimously agreed to recommend that OHSU be given access to the Data. As a condition for approval, the applicant will be required to file annual progress reports to the HSCRC, detailing any changes in goals, design, or duration of the project; data handling procedures; or unanticipated events related to the confidentiality of the data. Additionally, the applicant will submit a copy of the final report to the HSCRC for review prior to public release.

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## STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by OHSU for the Data for Calendar Years 2018 through 2021, data be approved. Additionally, Staff recommends approval of OHSU's continued use of Calendar Years 2012 through 2017, previously approved at the HSCRC Public meeting on March 13, 2019.

2. This access will include limited confidential information for subjects meeting the criteria for the research.

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# Deregulation Overview

# What is Deregulation?

- Deregulation is the movement of a hospital service from a hospital regulated space to an unregulated space (most often outpatient services but also chronic and rehab).
  - A  service is presumed to be regulated if it is performed in a building on the campus of a hospital
  - Criteria outlined in COMAR are considered for determination of unregulated services, which need to be approved by the Commission

- Deregulation is a desirable outcome of the Model because
  - It moves services to less costly settings for patients.
  - If properly adjusted for, it reduces TCOC - Savings in outpatient hospital have been the biggest driver of savings under the Model as the incentives for hospitals to deregulate are stronger than in the rest of the nation.
  - Moving services outside of acute care settings reduces the chance of infectious disease complications for patients, especially during the pandemic.
  - It frees up hospital capacity, e.g. it reduces the burden on emergency rooms.
  - Currently, there are no discernable differences in quality in or out of the hospital, although this should be further explored.

- HSCRC policy should balance that continued incentive to move services to less costly settings, while also recognizing and appropriately reducing GBR for services that are moved to non-hospital settings.

# What is Deregulation? (cont'd)

- Deregulation savings can be achieved through:
  - (a) direct adjustment of the deregulating hospital and/or
  - (b) by minimizing update factors.
  - While the former tool directly addresses hospital retained revenue that may generate TCOC dissavings, it also rewards hospitals who fail to deregulate appropriately by shielding them from delivering savings under the Model.
  - The latter tool holds all hospitals accountable for delivering savings under the Model and empowers hospitals to determine their own path to clinical redesign within their fundamental responsibility to provide care in their community.

- The balanced approach to deregulation is to:
  - Maintain the incentive to move patients appropriately down the continuum of care by removing the associated, immediate variable cost; allow hospitals to remove fixed costs over time that, with retained revenue, can improve the financial health of the hospital and/or create opportunities for community investment.

- Service movement can be initiated by:
  - Payers, Ex: Remicade, Immunoglobulin, Endoscopies and Ultrasounds;
  - Hospital, Ex: Frederick Oncology, Johns Hopkins Ambulatory Surgery;
  - Physician Practices, Ex: Easton and Dorchester Endoscopy;
  - Service Discontinuation, Ex: Union Memorial Eye Services; Sleep Services at multiple locations;
  - Cross Border Movement, Ex: MedStar Inpatient Surgery & Cardiology into D.C.

# Global Budget Agreement Provisions related to Shifts to Unregulated

Section IV.B.3a of the Global Budget Agreement states the following: *The HSCRC and the Hospital recognize that some services may be offered more effectively in an unregulated setting. When services covered by the GBR model are moved to an unregulated setting, the HSCRC staff will calculate and apply a reduction to the Hospitals' Approved Regulated Revenue. At a minimum, the reduction will ensure that the shift provides a savings to the public and Medicare after taking into consideration the payment amounts likely to be made for the same services in an unregulated setting*.

VI.3 of the Global Budget Agreement states the following: *Significant changes in the healthcare delivery system in the Hospital's Primary and Secondary Service Areas could influence the appropriateness of the Approved Regulated Revenue established for the Hospital under this Agreement. Therefore, the Hospital agrees to declare and describe, in Appendix G, any financial interest (or control) it hold in other hospitals or entities that provide services, including non-hospital services, in the Hospital's Primary and Secondary Service Areas, as of the Effective Date of this Agreement. In addition, the Hospital agrees to inform the HSCRC at least thirty (30) days in advance, in writing, or at the earliest practicable time thereafter, of any acquisitions or divestitures which it undertakes regarding such interests. The HSCRC may request data from the Hospital, on periodic or ongoing basis, regarding the utilization of the services provided by such related entities, to ensure that the Hospital complies with the GBR constraint through better management of its existing regulated services and not by moving services from the HSCRC – regulated sector to unregulated sectors of the hospital or non-hospital environment in ways that do not comport with the objectives of the GBR model, the Three Part Aim and the final contract between CMMI and the State of Maryland.*

# Staff Review

- Hospitals should notify staff at least 30 day prior to any shift AND update their annual GBR appendices to disclose a shift that occurred in prior fiscal year.
- HSCRC staff will make an appropriate volume AND revenue adjustment to account for any shifts
  - These adjustments typically occur based on a 50% variable cost factor(VCF), as if it were shifted to another hospital
  - VCF may be higher if reduction shifts to Medicare or the markup related to cost varies significantly (in the case of drug deregulations)
  - Staff take permanent and one-time adjustments based on timing of disclosure
- There are no contractual penalties associated with lack of disclosure. However, staff utilize several tools and analyses to help ascertain if a shift occurred without notification:
  - Monthly Compliance Monitoring - reviewed to monitor compliance and review trends of volume loss in a specific rate center, it would trigger an investigation into why volume loss is occuring.
  - Trends File/Market Shift - aggregated view of the all payer casemix data that allows users to drill down to certain criteria including ECMAD declines. This tool can be used to verify already reported shifts or to explore shifts that haven't been disclosed.
  - Regular market shift files were reviewed to determine if any declines were already accounted for.
  - Unrecognized market utilization files were reviewed to determine if there were additional volume declines not accounted for in regular market shift. Unrecognized volume growth (trend file data) was recently included in the market shift file to review volume changes in addition to market shift. Please note that market shift is revenue neutral, the unrecognized shift is not.
  - **Multi-Payer Claims Analytic Tool** (MCAT) (recently deployed) - this allows staff to review Medicare FFS ECMAD trends over time including ECMAD declines. This tool can be used to verify already reported shifts or to explore shifts that haven't been disclosed. This data is still in the review stage while we are deploying it, so some additional review by staff is necessary.

# Staff Review (cont'd)

- Deriving information about deregulation from data can be challenging as volumes change organically over time and given changes at a hospital could represent secular volume changes, marketshift or deregulation. And furthermore, changes may be indicative of short term volatility or long-term shifts.
  - This is particularly true for the last 3 years due to the significant disruption from COVID.
  - As a result changes identified through Staff review will likely require significant discussion with the hospital involved to confirm the accuracy and size of any adjustment.

# Timeline For Deregulation Adjustments/Next Steps

- Adjustment for deregulation typically occurs with the mid-year rate order. This allows Staff to perform analysis of data for shifts disclosed by the hospital in their annual GBR appendices to ensure the appropriate adjustment is made. This also allows for Staff and the hospital to discuss declines noted in marketshift data (e.g. Unrecognized ECMADS, noted declines in ECMAD Trends file).
- Adjustments for deregulation made in July rate orders when hospitals disclose service closures/shifts prior to the end of the current fiscal year.
- MCAT Deregulation Tool Next Steps
  - Brand new tool; will go “live” in April.
  - Provide training to Staff on use of the tool
  - Data uploaded from the Chronic Conditions Warehouse (CCW) quarterly. This allows Staff to review for declines in Hospital PSA ECMADs (including increases in non-hospital volumes) to determine if a previous noted decline has continued and/or if the decline is offset in the unregulated space.
  - Deregulation adjustments to be made in July rate orders.
  - Potential pitfalls include CCW data is Medicare claims only and does not provide a full picture of hospital activity (if this proves useful we are considering including Medicaid and commercial payer data).

***Release of CRISP Learning Collaborative Maryland Model Analytics Reports***
***February 2023***

The Maryland Model Analytics project set out to evaluate specific aspects of the Maryland Total Cost of Care (TCOC) model and care transformation efforts throughout the state. CRISP contracted with multiple vendors to address one or more investigative analysis questions. These vendors worked multiple stakeholders to understand aspects of care redesign, potential best practices, and areas of improvement for future consideration. CRISP recently released the second set of these reports.

**Evaluation of Maryland Medicare Spending on Inpatient Care – Acumen, November 2022**

Maryland has an arrangement with the Centers for Medicare & Medicaid Services (CMS) regarding hospital reimbursement based on a fixed global budget to avoid unnecessary inpatient utilization. These alternative reimbursement strategies have resulted in different patterns of care across several dimensions, particularly inpatient care. This report summarizes the results of the investigation that analyzed Maryland hospitals' performance across different MS-DRGs and compared that performance to hospitals' performance in other states, where this arrangement is not implemented.

As expected, inpatient stays in Maryland are more expensive than inpatient stays in other states when examining allowed amounts. In terms of patterns of care, key findings include that in Maryland Medical MS-DRGs making up a larger share of total volume of inpatient stays than Surgical MS-DRGs, Maryland generally having a higher 30-day post-discharge spending than other states, and Maryland hospitals tend to have a lower share of stays in the higher severity MS-DRG (with complications). The report includes detail data about the prevalence, length of stay and payments by MS-DRGs for 2019.

Report:
https://www.crisphealth.org/wp-content/uploads/2023/02/2022-11-17-crisp-task3-report-v10.pdf
Upcoming Webinar: Fri, Mar 10: 01:00 PM - 02:00 PM

**Evaluation of Maryland Medicare Spending on Chronic Conditions - Acumen, November 2022**

The Maryland Total Cost of Care (TCOC) Model builds on earlier models that achieved cost savings by focusing on reducing inpatient costs. This report summarizes the total costs of care for Medicare Fee-for-Service (FFS) beneficiaries with 25 chronic conditions, comparing the costs between Maryland and other states. The report contains two main sets of analyses, first looking at high-level trends across conditions, such as the mean annual cost per beneficiary and the prevalence of conditions. The second set of analyses looks in detail at the costs per setting by beneficiary, focusing on conditions, including those where there are the largest overall differences in mean annual allowed amount between Maryland and other states. In addition, the Appendix to the report replicates the analysis for the first half of 2022 and compares it to the first half of 2019 to allow an understanding of how the COVID-19 pandemic impacted the delivery of care to patients with Chronic conditions.

Overall, the mean annual allowed amounts tend to be higher for beneficiaries in Maryland than other states with some notable exceptions for neurodegenerative diseases. Maryland's acute hospitalization costs are higher per beneficiary than other states because of the all-payer nature of hospital reimbursement in Maryland, but the utilization rate remains lower. Other key differences in cost and service utilization include Maryland having lower rates of PAC utilization and Maryland's mean DME

costs are lower. Between 2019 and 2022 both Maryland and the nation experienced significant drops in inpatient utilization by those with chronic conditions. The report includes extensive data tables allowing for analysis of care by chronic condition for both Maryland and the Nation for 2019 and 2022.

Report:
https://www.crisphealth.org/wp-content/uploads/2023/02/2023-01-06-crisp-task4-report-v9-FINAL.pdf
Upcoming Webinar: Thu, Mar 16: 01:00 PM - 02:00 PM

**Outcomes and Costs Associated with Evidence-based Treatment of First Episode Psychosis – Acumen, September 2022**

Research shows that expeditious and comprehensive treatment of first episode psychosis (FEP) positively impacts a range of clinical and social outcomes. This descriptive study estimated the prevalence of psychosis among Maryland commercial insurance enrollees ages 15 to 30, examined patterns of behavioral health treatment following a diagnosis of FEP, and explored how demographic characteristics and treatment patterns following an FEP diagnosis related to clinical outcomes in the year following diagnosis (excluding the initial 30-days following the diagnosis).

Overall, the patterns of care by age group appeared inconsistent with the evidence that early, aggressive treatment of a first psychotic episode may mitigate the progression to more severe psychosis and functional impairment. Additional analyses suggests that more complex and higher need beneficiaries drive hospital admissions and that these individuals may be prioritized for hospitalization given the limited availability of inpatient psychiatric services in Maryland, particularly for adolescents.

Final Report:
https://www.crisphealth.org/wp-content/uploads/2023/02/Acumen-MD-Model-Analytics_T7-FEP_Final Report_20220926.pdf
Upcoming Webinar: Wed, Mar 1: 02:00 PM - 03:00 PM

**Health Care Costs in Baltimore Relative to Other Urban Areas in Maryland – ABT Associates, December 2022**

This report explores differences in 2019 per-capita costs of care between counties in the Baltimore area and other urban counties in Maryland, before and after risk adjustment for patient complexity to their peers in other states. Analyses health care costs and utilization for individuals covered by employer-sponsored health insurance in Maryland and also includes a discussion of similar Medicare results. This report also assessed drivers of differences in per-capita costs, including the extent to which differences were by driven by unit cost, versus utilization, and differences in the location and mix of services provided.

Overall, total costs of care for commercial patients were 4% higher in the Baltimore area than in other urban areas in Maryland, relative to their respective benchmarks. This was driven by relatively higher unit costs in the Baltimore area. For employer-sponsored health insurance the Baltimore area had higher total spending than non-Baltimore urban areas of roughly $40 million in inpatient facility spending and $120 million in outpatient facility spending, which was offset by $86 million less in total spending on professional services. The report includes detail spending comparisons between the Baltimore Area and other urban Maryland regions and their benchmarks to allow the reader to understand the relatively contribution of different areas of spending.

Final Report:
https://www.crisphealth.org/wp-content/uploads/2023/02/HSCRC-Benchmarking-Baltimore-Cost-Report-2022-12-15.pdf
Upcoming Webinar: Fri, Mar 24: 10:00 AM - 11:00 AM

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850


CENTER FOR MEDICARE AND MEDICAID INNOVATION

February 17, 2023

Katie Wunderlich
Executive Director, HSCRC
4160 Patterson Avenue
Baltimore, Maryland 21215

**RE: Public Payer Differential Change Beginning April 1, 2023**

The purpose of this letter is to inform the Health Services Cost Review Commission (HSCRC) and the State of Maryland that the HSCRC's proposal to increase the Public Payer Differential submitted to the Centers for Medicare & Medicaid Services on December 22, 2022 has been approved. In accordance with Section 8.b.ii.1.a of the Total Cost of Care State Agreement ("Agreement"), the State may submit to CMS a request to change the Public Payer Differential to enable the State to meet the Annual Saving Target for the subsequent Model Year if hospital expenditures for the current Model Year are less than the All-payer Revenue Limit calculated by the State in alignment with Section 6.f and Appendix B of this Agreement for that Model Year.

In reference to the State-submitted "*Request to Increase the Public Payer Differential*" memo received December 22, 2022, the State is projecting to fall short of the $267M CY 2022 annual Medicare savings target by $187M and is expecting the temporary 1 percent Public Payer Differential (PPD) increase to generate $26M of savings to Medicare. CMS notes that the CY 2022 Total Cost of Care Annual Performance Requirements will not be finalized until May of CY 2023 to account for three months of claims runout. As a result, CMS uses its discretion to approve the State's request before the CY 2022 All-Payer Revenue Limit and other performance result are finalized for two reasons: (1) the State has met the All-Payer Revenue Limit requirement for all Model Years since the start of the Maryland Total Cost of Care Model and (2) the State is expecting to meet the All-Payer Revenue Limit requirement for CY 2022, which for purposes of this request is considered the current Model Year.

CMS expects to implement the State's request to increase the Public Payer Differential by 1 percentage point effective April 1, 2023. The PPD will increase from 7.7% to 8.7%; therefore, from April 1, 2023 ending June 30, 2024 Public Payers will pay 91.3% of billed charges. CMS recognizes that the State's request to increase the PPD is temporary, which may impact the State's ability to meet future financial performance requirements, specifically the Total Cost of Care Growth Guardrail. CMS expects the State to meet all future annual performance requirements of the Model as defined in the Agreement and ensure that this flexibility does not jeopardize future performance results. We appreciate the efforts put forth by the State to proactively correct CY 2022 performance challenges and look forward to our continued partnership.

Sincerely,

Tequila V. Terry -S

Digitally signed by Tequila V. Terry -S
Date: 2023.02.17 07:45:21 -05'00'

Tequila Terry
Director, State Population Health Group
Center for Medicare and Medicaid Innovation

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# MEMORANDUM

To: Chief Financial Officers and Other Stakeholders

From: Katie Wunderlich, Executive Director

Date: March 1, 2023

Re: Adjustment to the Public Payer Differential

To mitigate the excess Medicare TCOC growth in Maryland, the Health Services Cost Review Commission, at its December 14, 2022 public meeting, voted and CMMI subsequently approved increasing the public-payer (Medicare, Medicare Advantage Plans, Medicaid fee-for-service and Medicaid MCOs) differential by 1 percentage point, from 7.7 percent to 8.7 percent, effective April 1, 2023. The increase will be effective for the remainder of FY 2023 and the duration of FY 2024. The adjustment will be made through a hospital mark-up adjustment and will be revenue neutral to hospitals. The payer differential shall apply to claims with discharge dates and outpatient services dates on and after April 1, 2023.

Global Budget compliance will be applied on a blended basis for FY 2023.

If you have any questions, you may contact Dennis N. Phelps, Deputy Director, Audit & Compliance at dennis.phelps@maryland.gov or Chris Konsowski, chris.konsowski@maryland.gov.

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# Legislative Update

## HSCRC March 2023 Commission Meeting

March 8, 2023

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

| Bill # | Description | Position |
|---|---|---|
| HB 420<br>SB 234 | **Health Services Cost Review Commission - Hospital Rates - All-Payer Model Contract** | Support |

- HSCRC requested this bill to add a reference to the Total Cost of Care Model to our hospital rate setting statute. The statute already requires the Commission to take the TCOC model into account in other aspects of the rate setting process. This amendment will conform with those other references to the model in law. This bill will not change how HSCRC staff review hospital rates, but rather will ensure our statute aligns with those contractual requirements.
- SB 234 had a hearing in the Senate Finance Committee on 2/2 and HB 420 had a hearing in HGO on 2/21.
  - Katie Wunderlich and Megan Renfrew testified in support of the bill.
- SB 234 passed in the Senate and was referred to HGO. HB 420 was voted favorably out of the HGO committee on 3/3.

# Budget and BRFA

| Bill # | Description | Position |
|---|---|---|
| HB 200<br>SB 181 | **Budget Bill for FY 2024 (The Governor's Budget)** | |
| HB 202<br>SB 183 | **Budget Reconciliation and Financing Act of 2023** | Support |

- Funds HSCRC's Operating Budget.
- Reduces the Medicaid Deficit Assessment by $50M for FY 24 only.
- HSCRC Budget bill hearings:
  - 2/23– Health and Social Services Subcommittee of the Appropriations Committee (House)
  - 3/6 – Health and Social Services Subcommittee of the Budget and Taxation Committee (Senate)
- BRFA hearings
  - 2/28 – Appropriations Committee (House)
  - 3/01 – Budget and Taxation Committee (Senate)

# Hospitals - Financial Assistance - Medical Bill Reimbursement Process

| Bill # | Description | Position |
|---|---|---|
| HB 333<br>SB 404 | **Hospitals - Financial Assistance - Medical Bill Reimbursement Process** | Letter of Information |

- This bill makes changes to the law requiring that hospitals provide refunds to certain patients who paid bills but were eligible for financial assistance in 2017-2021 (this law passed last year). State data will be used to identify the patients that qualify for refunds. HSCRC is required to create the process to implement this law.
- SB 404 had hearing in the Senate Finance Committee on 2/23 and HB 333 had a hearing in HGO on 2/28.

# Health Services Cost Review Commission - Members - Appointment

| Bill # | Description | Position |
|---|---|---|
| SB 626 | **Health Services Cost Review Commission - Members - Appointment** | No position |

- Requiring that the members of the Health Services Cost Review Commission be appointed with the advice and consent of the Senate of Maryland.
- Referred to Executive Nominations on 2/15.
- No hearing date has been scheduled.

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# Task Force on Reducing Emergency Department Wait Times

| Bill # | Description | Position |
|---|---|---|
| HB 274<br>SB 387 | **Task Force on Reducing Emergency Department Wait Times** | Support with amendment |

- Establishes the Task Force on Reducing Emergency Department Wait Times to study best practices for reducing ED wait times; requires the Task Force to report findings/recommendations to the Governor and the General Assembly by January 1, 2024.
- SB 387 had hearing in the Senate Finance Committee on 2/23 and HB 274 had a hearing in HGO on 2/21.
- Requested amendment: To expand the membership of the Task Force from seven to ten members to include key State agencies – HSCRC, MIEMSS, and MHCC.

# Commission on Public Health - Establishment

| Bill # | Description | Position |
|---|---|---|
| HB 214<br>SB 281 | **Commission on Public Health - Establishment** | Support |

- The PH Commission will assess State and local health department ability to provide public health services, with an emphasis on the State's response to COVID-19, overdose deaths, and racial and ethnic disparities in maternal mortality and birth outcomes.
- HSCRC is named in the bill to consult with the Department (amended from being a Commission member).
- HB 214 has passed the House and has been referred to Senate finance. SB 281 had a hearing in the Senate.

# 9-8-8 Trust Fund - Funding

| Bill # | Description | Position |
|---|---|---|
| HB 271<br>SB 3 | **9-8-8 Trust Fund - Funding** | Support |

- Requires the Governor to include $12,000,000 in the annual budget bill for fiscal year 2025 for the 9-8-8 Trust Fund. Designates and maintains 9-8-8 as the universal telephone number for a national suicide prevention and mental health crisis hotline. Develops and implements a statewide initiative for the coordination and delivery of behavioral health crisis response services.
- SB 3 has passed the Senate and has been referred to HGO. HB 271 had a hearing in the House.

# Commission to Study Trauma Center Funding in Maryland

| Bill # | Description | Position |
|---|---|---|
| SB 493<br>HB 675 | **Commission to Study Trauma Center Funding in Maryland** | Support |

- Establishes the Commission to Study Trauma Center Funding in Maryland to study the adequacy of trauma center funding across the State for operating, capital, and workforce costs; and requires the Commission to report its finding and recommendations to the Governor and the General Assembly by December 1, 2023.
- SB 493 has a hearing in the Senate Budget and Taxation Committee on 3/09, and HB 675 has a hearing in HGO on 3/9.

# Questions?


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# Update on Medicare FFS Data & Analysis

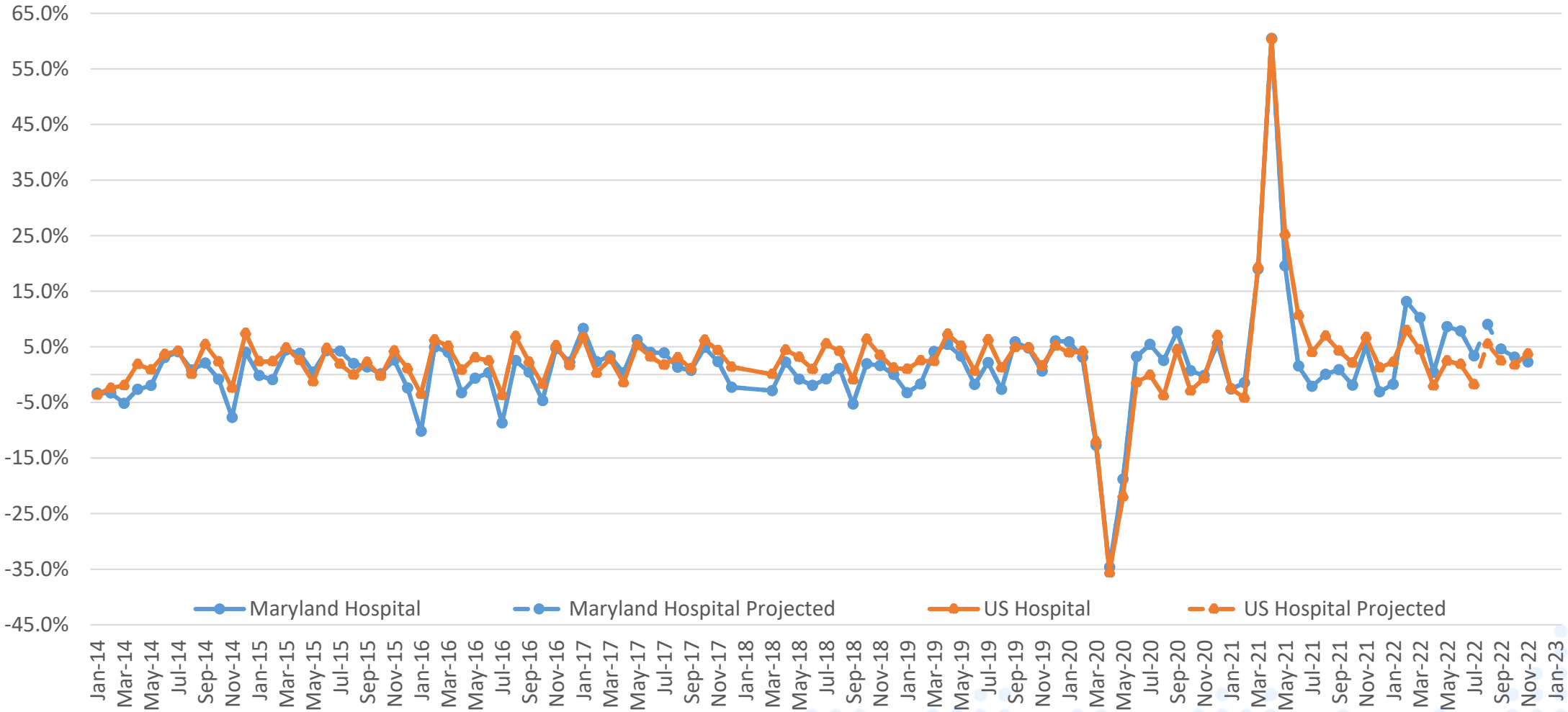
## March 2023 Update

Data through November 2022, Claims paid through January 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.

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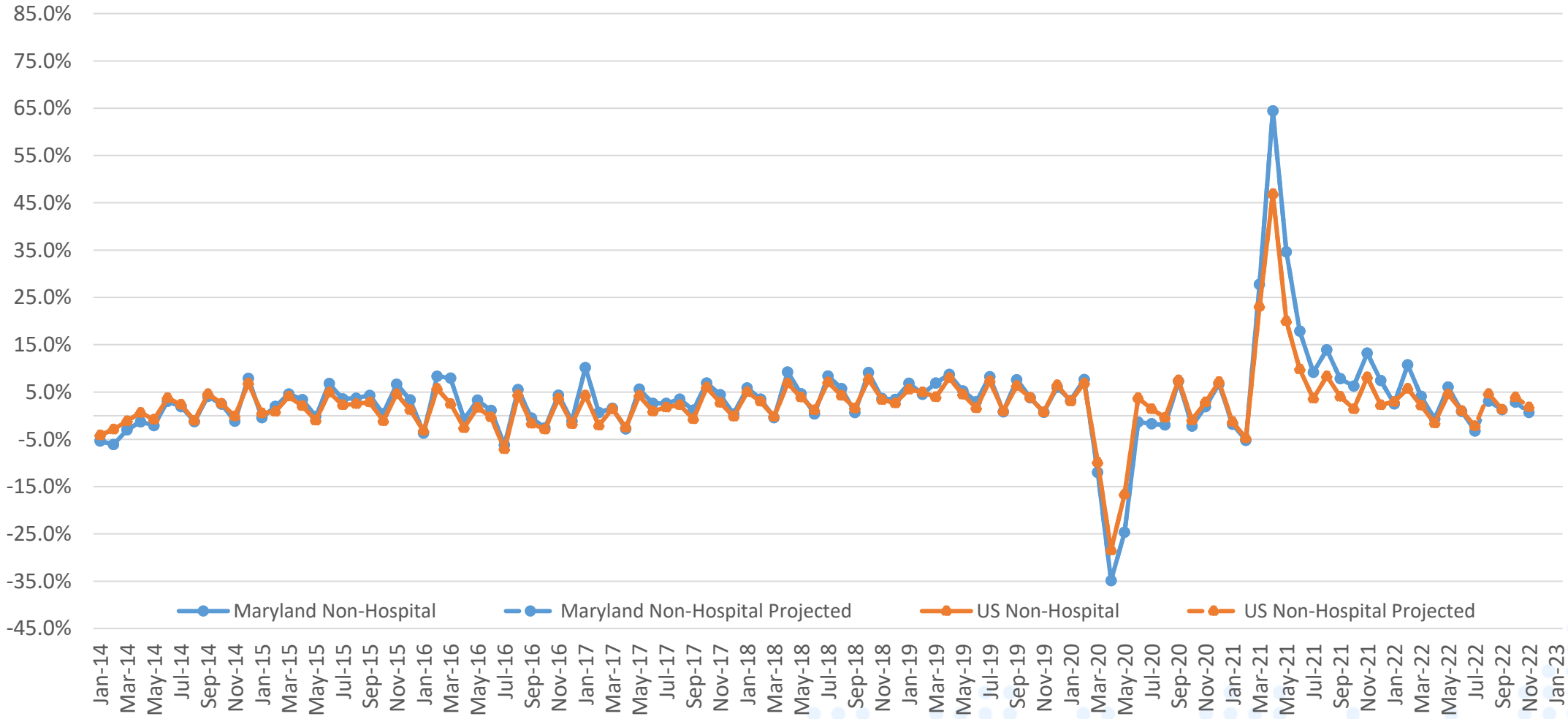
# Medicare Non-Hospital Spending per Capita

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

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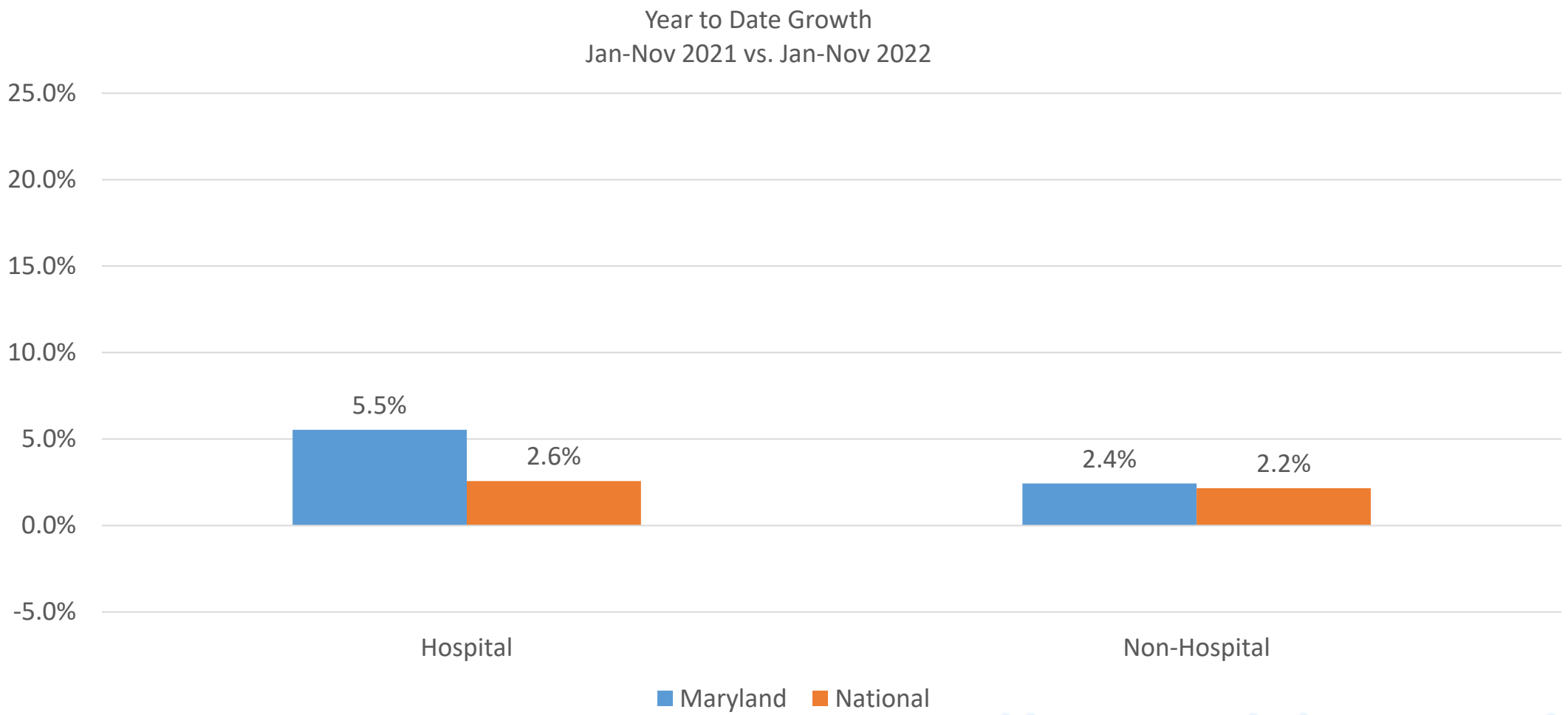
# Medicare Hospital and Non-Hospital Payments per Capita

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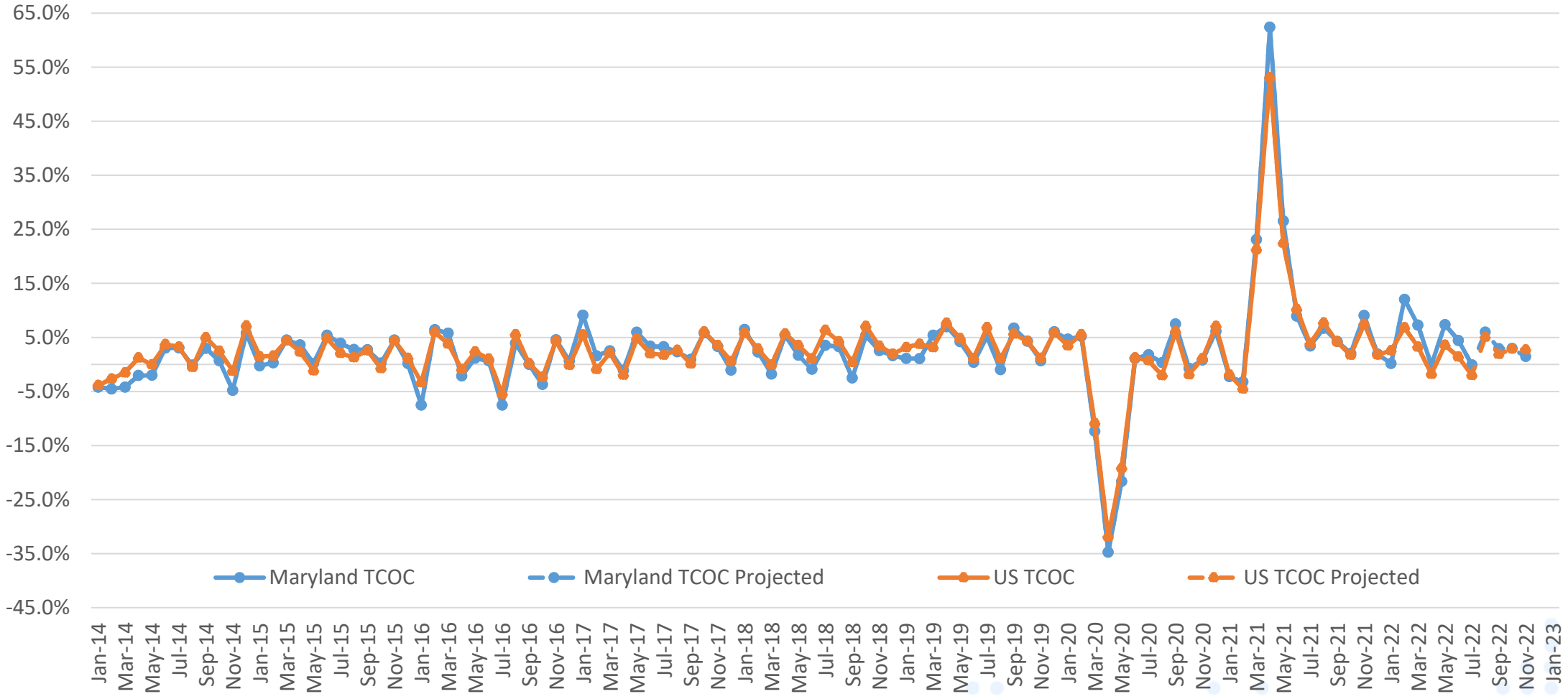
# Medicare Total Cost of Care Spending per Capita

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




CY16 has been adjusted for the undercharge

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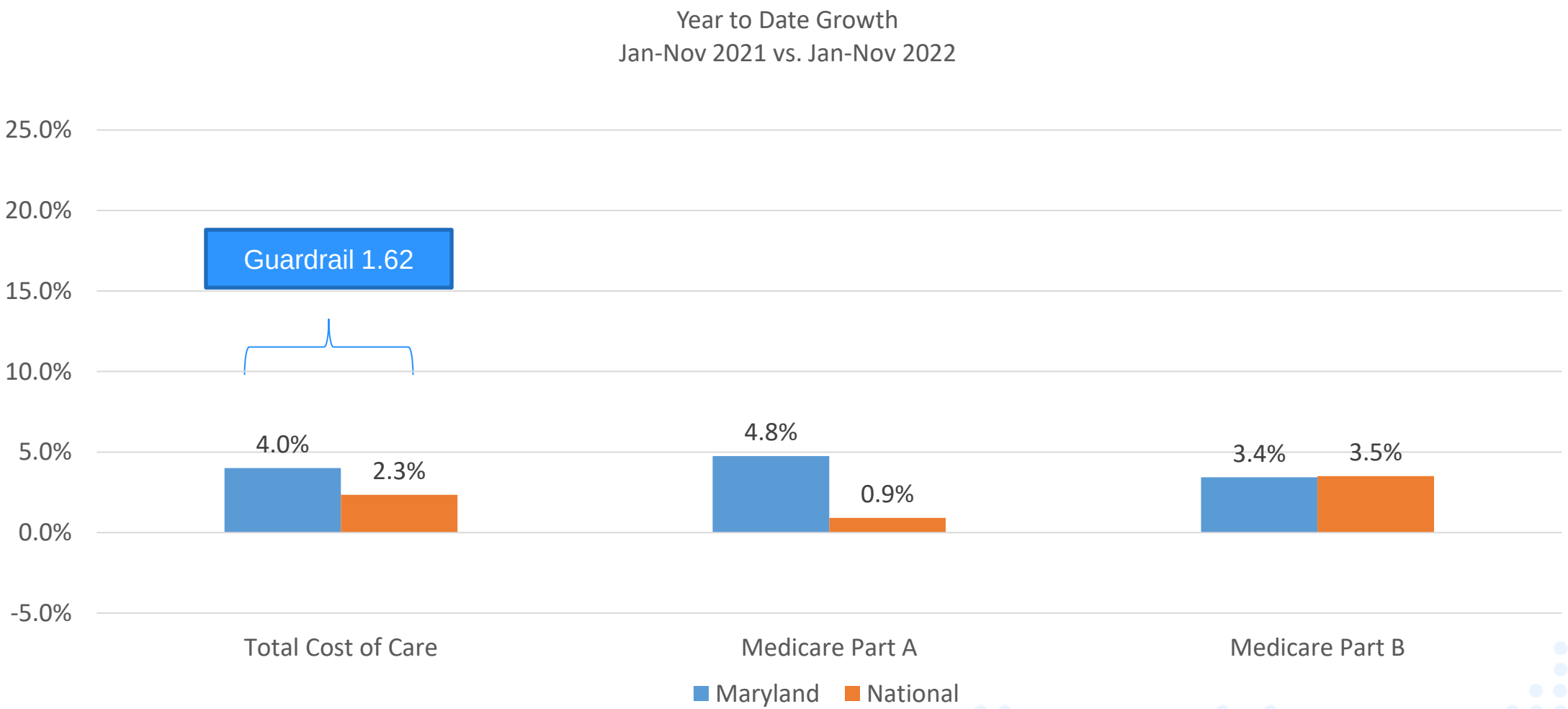
# Medicare Total Cost of Care Payments per Capita

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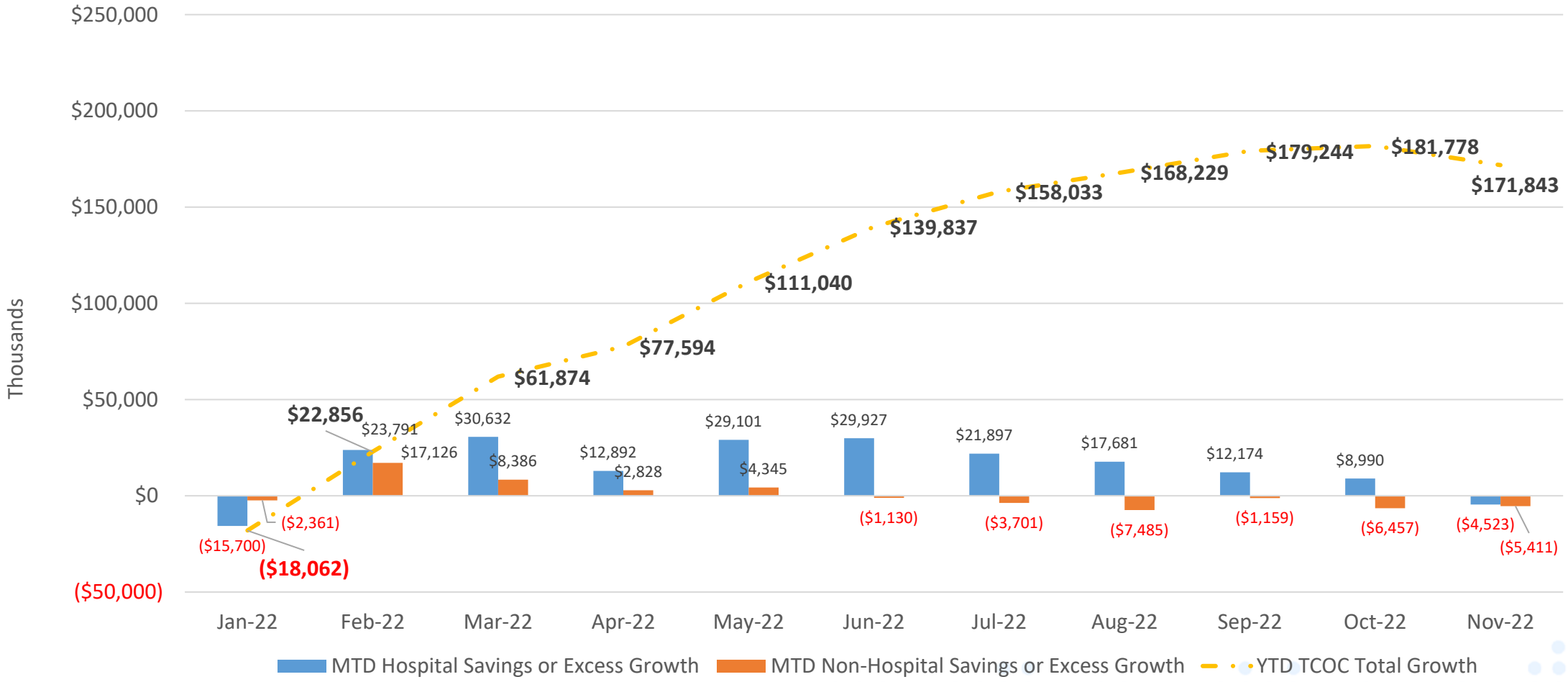
# Maryland Medicare Hospital & Non-Hospital Growth

## CYTD through November 2022

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**TO**: HSCRC Commissioners

**FROM**: HSCRC Staff

**DATE**: March 8, 2023

**RE**: Hearing and Meeting Schedule

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April 12, 2023 To be determined - GoTo Webinar

May 10, 2023 To be determined - GoTo Webinar

The Agenda for the Executive and Public Sessions will be available for your review on the Wednesday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/Pages/commission-meetings.aspx.

Post-meeting documents will be available on the Commission's website following the Commission meeting.