maryland
health services
cost review commission

Payment Model Work Group

January 22,2021

Important Spring Dates for Payment Model & Update Factor Season

- **March 5 Workgroup Meeting**
  - Update Factor Table with available draft inputs
- **March 30 Workgroup Meeting**
  - Update Factor Table with available draft inputs
  - Estimated Position on Medicare Target using FYGBR projections
  - MPA Framework and Difference Statistic
  - GSP Impact
- **April 27 Workgroup Meeting**
  - Review of Draft Recommendation
  - Q1 Book for 2022 update inflation
- **May 12 Commission Meeting**
  - Draft Recommendation Presentation to the Commission
- **May 25 Workgroup Meeting**
  - Review of Comment Letters and Final Recommendation
- **June 9 Commission Meeting**
  - Final Recommendation Presentation to the Commission

Update Factor Overview

Balanced Update Model for RY 2022

Components of Revenue Change Link to Hosptial Cost Drivers /Performance

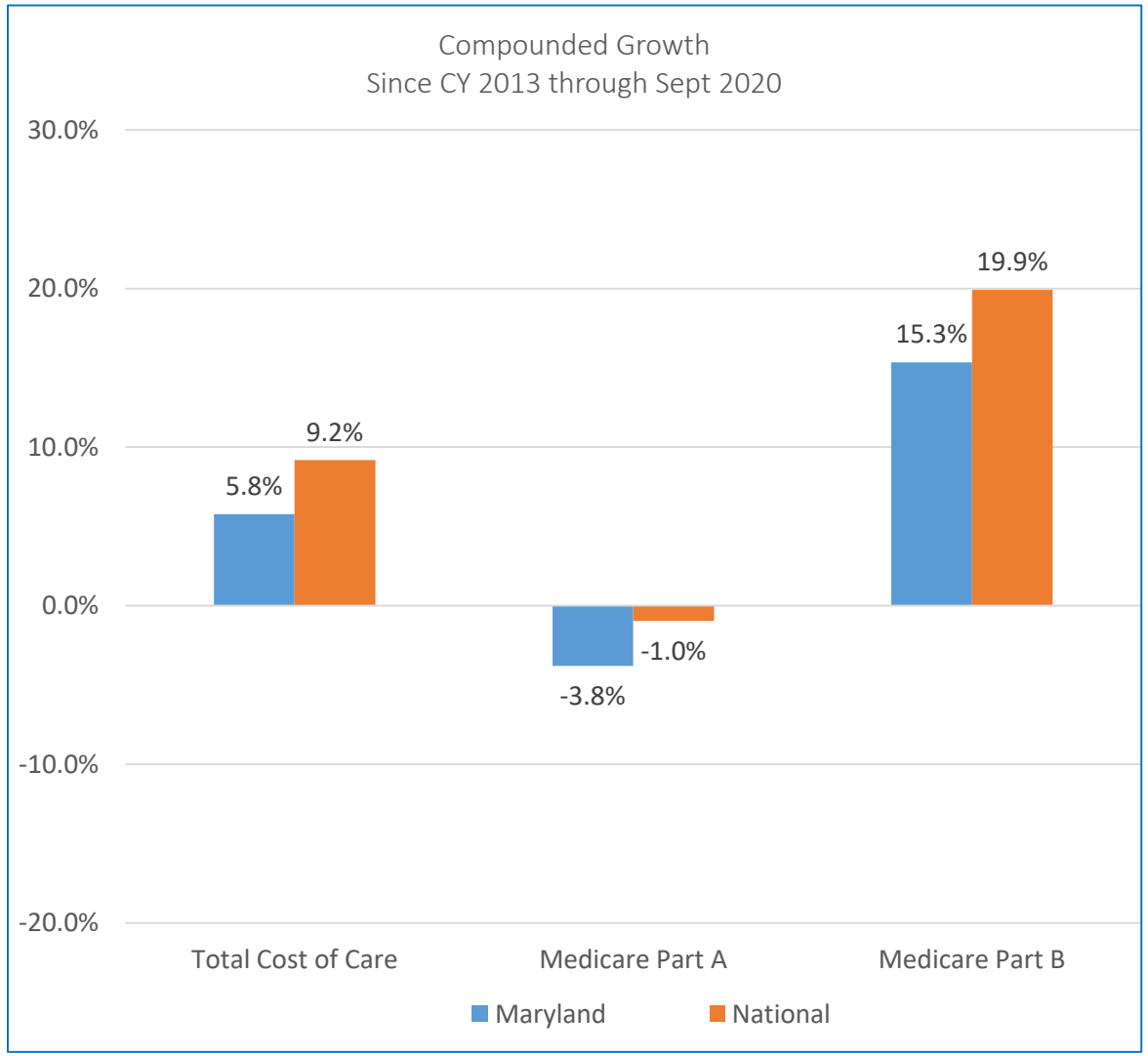
			Weighted Allowance
Adjustment for Inflation			0.00%
- Rising Cost of Outpatient Oncology Drugs			0.00%
Gross Inflation Allowance	**A**		**0.00%**
Care Coordination/Population Health			
- Regional Partnership Grant			
Total Care Coordination/Population Health	**B**		**0.00%**
Adjustment for Volume			
-Demographic /Population			
-Transfers			
-Drug Population/Utilization			
Total Adjustment for Volume	**C**		**0.00%**
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments	D		
- Low Efficiency Outliers	E		0.00%
- Capital Funding	F		0.00%
- Complexity & Innovation	G		0.00%
-Reversal of one-time adjustments for drugs	H		0.00%
Net Other Adjustments	**I=**	**Sum of D thru H**	**0.00%**
Quality and PAU Savings			
-PAU Savings	J		0.00%
-Reversal of prior year quality incentives	K		0.00%
-QBR, MHAC, Readmissions			
-Current Year Quality Incentives	L		0.00%
Net Quality and PAU Savings	**M =**	**Sum of J thru L**	**0.00%**
Total Update First Half of Rate Year 22			
Net increase attributable to hospitals	**N =**	Sum of A + B + C + I + M	**0.00%**
Per Capita First Half of Rate Year (July - December)	**O =**	(1+N)/(1+VOL%)	**0.00%**
Adjustments in Second Half of Rate Year 22			
-Oncology Drug Adjustment	P		0.00%
-QBR	Q		0.00%
Total Adjustments in Second Half of Rate Year 22	**R =**	P + Q	**0.00%**
Total Update Full Fiscal Year 22			
Net increase attributable to hospital for Rate Year	**S =**	N + R	**0.00%**
Per Capita Fiscal Year	**T =**	(1+S)/(1+VOL%)	**0.00%**
Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements			
-Uncompensated care, net of differential	U		0.00%
-Deficit Assessment	V		0.00%
Net decreases	**W =**	U + V	**0.00%**
Total Update First Half of Rate Year 22			
Revenue growth, net of offsets	**X =**	N + W	**0.00%**
Per Capita Revenue Growth First Half of Rate Year	**Y =**	(1+X)/(1+VOL%)	**0.00%**
Total Update Full Rate Year 22			
Revenue growth, net of offsets	**Z =**	S + W	**0.00%**
Per Capita Fiscal Year	**AA =**	(1+Z)/(1+VOL%)	**0.00%**

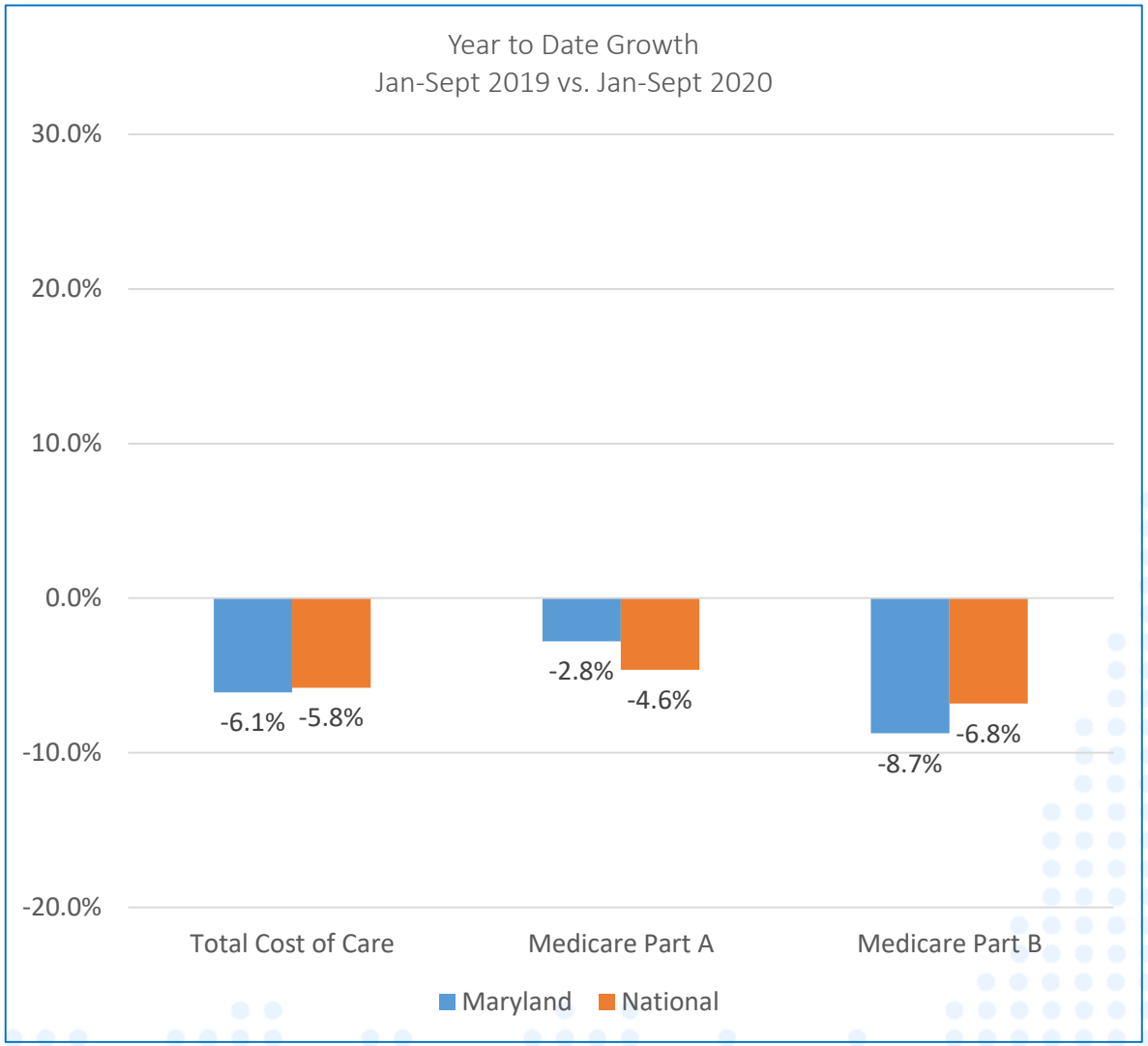
Update on Medicare FFS Data & Analysis

Data through September 2020, Claims paid through November 2020

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.

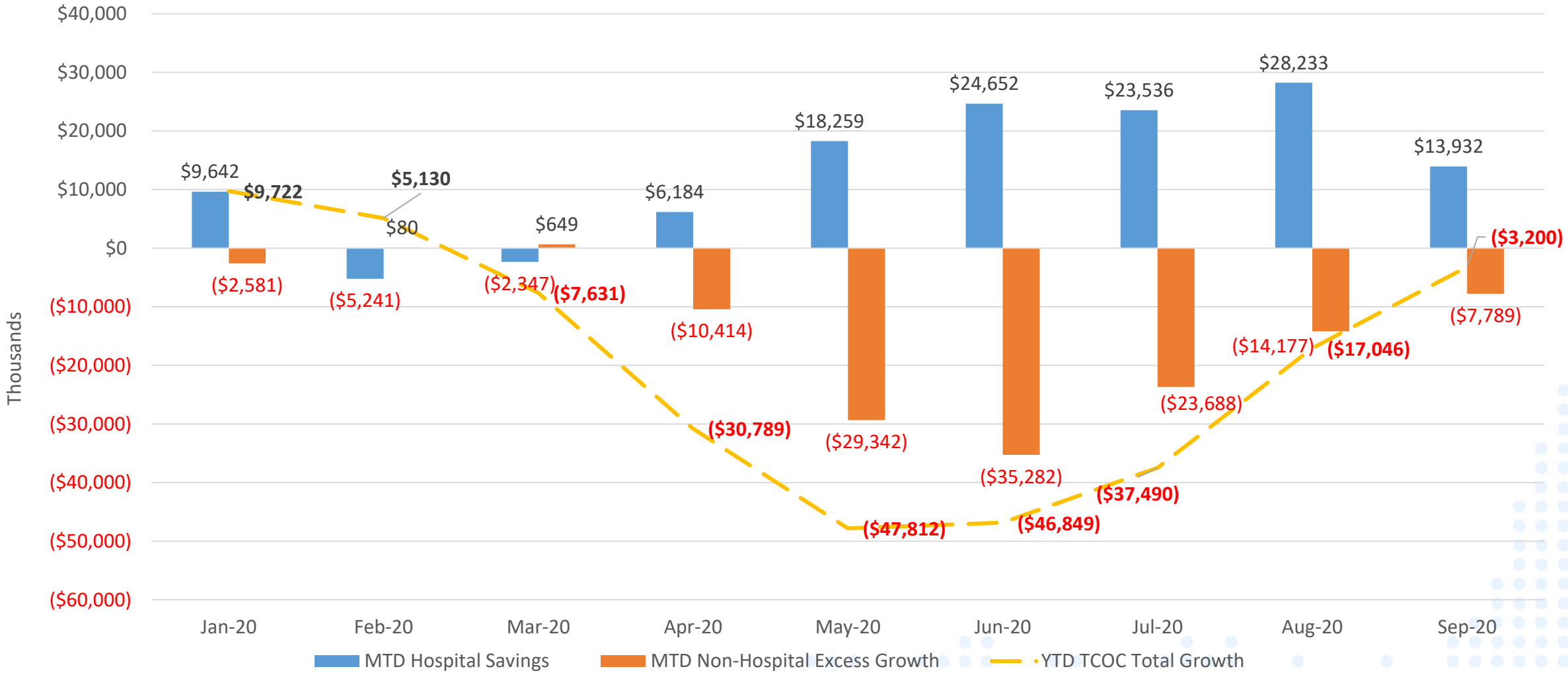
Medicare Total Cost of Care Payments per Capita





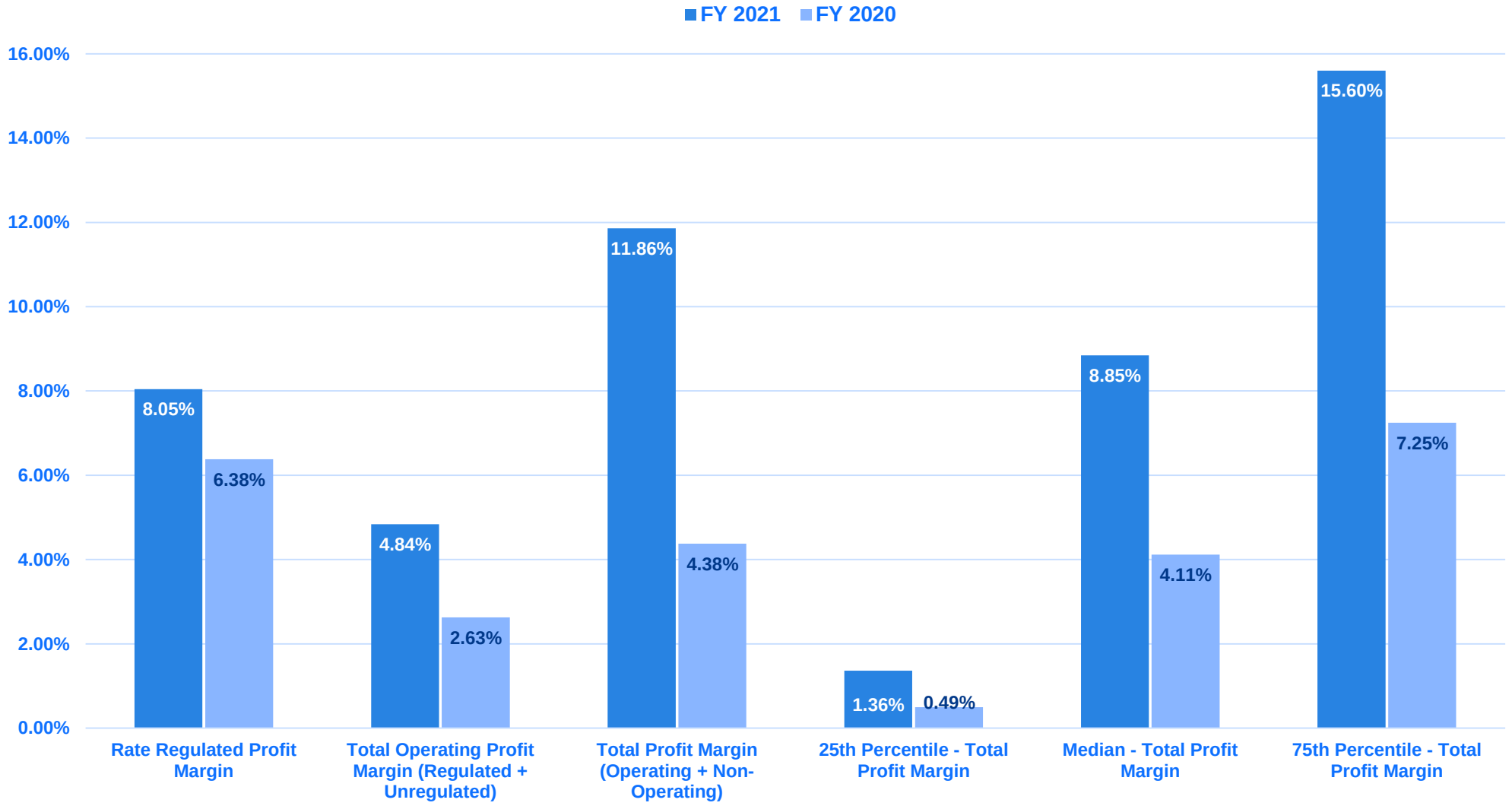
Maryland Medicare Hospital & Non-Hospital Growth

CYTD through September 2020



Profits & GSP

Profit Margins from Monthly Financial Statements July – November FY21 vs July – November FY20



Gross State Product

Measure	Growth %
5 Year GSP	2.89%
5 Year Growth in Annualized Charges	1.49%
3 Year GSP	2.62%
3 Year Growth in Annualized Charges	1.47%
All-Payer Growth Limit	3.58%

- 5 year growth in annualized charges are 1.40 percentage points below the 5 year GSP
- 3 year growth in annualized charges are 1.15 percentage points below the 3 year GSP
- GSP Figures will be updated when final CY20 data is available

*3 & 5 year growth figures use Q3 GSP data and annualized charges for 2020

**GSP growth 2020 vs. 2019 shows decline of .17 percent

CARES Funding

Analysis of Annual Filing Data for COVID Impact on Costs

- HSCRC is in process of compiling FY2020 Annual Filing Data
- Analysis of COVID expenses will be done in the context of the annual filing because:
  - Creating COVID-specific expense report would create additional reporting burden and is unlikely to result in credible, comparable data across systems.
  - Staff believes incremental COVID-related expenses need to be evaluated in the context of other changes in cost.
- Goal will be to develop a generalizable approach to quantifying the impact of COVID on Hospital Costs. Towards this goal:
  - Staff will be reviewing the change in reported costs in total and per unit at both a summary and cost center.
  - Cost trend will be compared to historic trends.
  - Outlier cost center and hospitals will be evaluated.
  - COVID volumes as reported in casemix will also be considered.
- If hospitals wish to submit supplemental analyses on COVID expenses, Staff will also review this material. Any analysis submitted should focus on FY2020.

Proposed Final Settlement of FY20 and FY21 GBR

Approved Revenue	
Total FY20 and First Six Months of FY21 Charges inclusive of Approved Expanded Corridors	A
FY 20 Undercharge + FY 21 Undercharge for First Six Months	B
Impact of COVID on FY20 Expenses (1)	C
Impact of COVID on FY21 Expenses (1,2)	D
FY21 Funding Under Current COVID Surge Policy - if any (3)	E
Total Approved Revenue	F = A + B + C + D + E
Actual Revenue	
Actual Charges for FY20 and First Six Months of FY21	G
Regulated Portion of CARES funding (4)	H
Total Actual Revenue	I = G + H
Net Under (Over) Funding	J = F - I

- If analysis shows a net under funding hospital will be allowed to bill revenue in subsequent periods. If a net over funding hospitals will be required to reduce future charges to eliminate the over funding - earliest effective date is July 1, 2021
- If material CARES act monies are subsequently recaptured by the Federal Government the Commission will work with hospital to recover these funds through additional charges in subsequent rate years.

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(1) Expenses will be assessed through aggregated annual filing analysis; will not calculate individual COVID related cost increases
(2) As these amounts will not be known until early FY22, final adjustment will likely be in the FY23 rate order.
(3) Calculated based on monthly assessments
(4) HSCRC will use amounts reported in Federal Reporting on the HHS Provider Relief Fund multiplied by the % of regulated revenue reported by the hospital entity in FY19. Hospital should submit separate reporting if that amount is not appropriate. HSCRC will also compare this amount to revenue reported in the annual filing.

CARES Funding Status 12/31/21

	FY20 Revenue Position				FY21 Revenue Position					Net Position			
System	FY 2020 Revenue Targets	FY 2020 Actual Revenue	FYE 2020 Variance	FYE 2020 Variance	FY 2021 Five Month Revenue Target	FY 2021 Five Month Actual Revenue	FY 2021 Five Month Variance	FY 2021 Variance	Net Over (Under) Charge	Cares Funding	Net Position 17 Months Ended 11/20	Regulated Margin 17 Months Ended 11/20	Total Margin 17 Months Ended 11/20
Luminis Health	$951	$897	($54)	-6.1%	$412	$398	($14)	-3.6%	($69)	$78	$9	$80	$28
Adventist Health Care	$866	$835	($31)	-3.7%	$370	$389	$19	5.0%	($12)	$92	$80	$66	$50
Holy Cross - Trinity Health	$656	$632	($23)	-3.7%	$282	$278	($4)	-1.6%	($28)	$72	$44	$31	$106
Johns Hopkins Health	$4,027	$3,759	($268)	-7.1%	$1,732	$1,732	$0	0.0%	($268)	$244	-$24	-$289	$177
LifeBridge	$1,525	$1,458	($67)	-4.6%	$650	$628	($22)	-3.6%	($89)	$88	-$1	$154	$211
MedStar	$2,164	$2,140	($24)	-1.1%	$933	$958	$25	2.6%	$1	$169	$170	$312	$87
Tidal Health	$494	$471	($23)	-4.8%	$215	$214	($1)	-0.5%	($24)	$30	$6	$61	$97
UM	$4,513	$4,246	($267)	-6.3%	$1,939	$1,900	($39)	-2.0%	($306)	$297	-$9	$469	$317
Non-System	$3,177	$2,989	($188)	-6.3%	$1,359	$1,357	($2)	-0.2%	($190)	$156	-$34	$386	$226
Total	$18,373	$17,427	($946)	-5.4%	$7,892	$7,854	($39)	-0.5%	($985)	$1,227	$242	$1,271	$1,299
												5.8%	5.1%
											With Reversal	$1,028	$1,057
												4.7%	4.2%

- Slide does not acknowledge any amounts due under COVID surge policy re-established effective November 1, 2020.
- Slide does not acknowledge any COVID related expenses.

Notes

1. Profit and actual revenue amounts reflect unaudited monthly reports.
2. CARES funding is as of Federal reporting on January 6th, 2021 and will continue to be updated.
3. Freestanding EDs are excluded.

Full Rate Methodology
For Informational Purposes Only

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Disparities in Healthcare
Per statute, the Commission is required to establish rates for a hospital that are reasonably related to reasonable costs. These determinations are to be done within 150 days of hospitals filing of full rate application and in the TCOC Model should assess a hospitals performance in TCOC.	This policy develops objective standards for determining a rate structure in line with hospital's current service delivery and hospital's bearing on TCOC for its surrounding region.	Staff envisions that this policy will only be utilized to provide revenue commensurate with reasonable cost levels to hospitals that file a full rate application.	By establishing objective standards by which hospitals may quality for additional revenue in a full rate application, this policy ensures that rate enhancements are not provided arbitrarily or needlessly and therefore, along with other Commission efficiency policies, protects consumers from excessive charge levels.	Staff does not anticipate this policy to have any demonstrable effect on disparities in healthcare and notes that many of the risk adjustments in the policy normalize the difference between serving an affluent population and a more impoverished population, e.g. risk adjustments for higher levels of uncompensated care and governmental payer mix in the ICC and risk adjustments for deep poverty and purchasing power parity in the TCOC benchmark analyses.

Full Rate Application: Historical Overview

Full Rate Applications Overview

- Historically, the HSCRC has had a full rate application methodology to review a hospital's entire regulated rate structure and was employed:
  - When a hospital submitted a full rate application for an increased rate structure; or
  - When HSCRC staff identified a hospital with high cost inefficiency in order to reduce the hospital's rate structure.
- Cost per case efficiency assessments have historically been based on a hospital's cost per case efficiency relative to a peer group standard (average cost per case PLUS a productivity adjustment)
  - This analysis has always been attainment only, i.e. there are no additional modifications related to improvement or lack thereof.

Full Rate Applications Overview cont.

- Due to the incentives of the TCOC Model and broader cost accountability, Commissioners directed staff to develop total cost of care metrics that would:
  - Complement the Commission's cost review methodology in a TCOC Model, and yet
  - Still adhere to the statutory mandate, per Maryland HEALTH-GENERAL Article, An. Code Ann. § 19-219(a), to assure each purchaser of hospital services that:
    - (1) The total costs of all hospital services offered by or through a facility are reasonable;
    - (2) The aggregate rates of the facility are related reasonably to the aggregate costs of the facility; and
    - (3) The rates are set equitably among all purchasers or classes of purchasers without undue discrimination or preference.

Full Rate Application: Use of TCOC Benchmarks & Growth

TCOC Accountability vs Responsibility

- While hospitals are held accountable for total cost of care through the Update Factor, they are not currently directly responsible for all TCOC
  - Hospital Services for all Maryland Medicare FFS beneficiaries represents 54% of total cost of care spend
  - Hospital Services for all Maryland Commercial Enrollees represents 30% of total cost of care spend

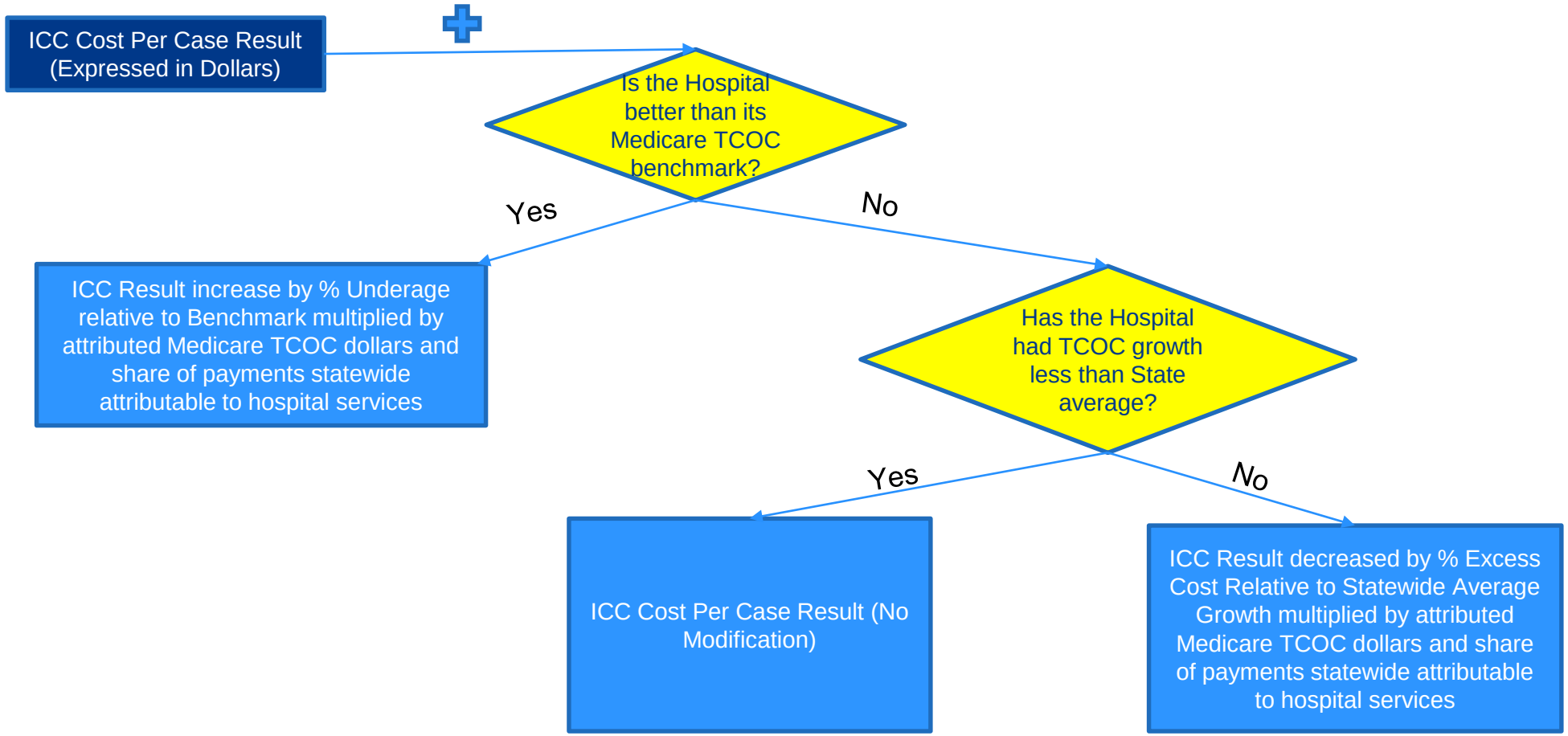
- In the future through a potential hospital centered capitated model, whereby all lives in a given region are attributed to a hospital to determine its global budget revenue, hospitals could be directly responsible for all TCOC
  - Could lead to 100% accountability

- In the interim staff had to wrestle with incorporating TCOC performance to reflect hospital's accountability but not broad scale responsibility.
  - Staff proposes to strike this balance by using TCOC attainment and growth standards in a multi-step algorithm that only rewards and/or penalizes when standards have been clearly met.
    - Expressed in terms of absolute attributed TCOC dollars and weighted by a hospital's statewide share of TCOC responsibility by payer (54% for Medicare and 30% for Commercial)
    - Output of this algorithm is then used to **modify** a hospital's ICC cost-per-case efficiency assessed revenue

TCOC Influences on Rate Applications

TCOC Performance	Reward/Penalty Modification to ICC
Better than Medicare Benchmark	Reward
Better than Medicare Benchmark AND Average of Top Half of Commercial Performance	Additional Reward
Worse than Medicare Benchmark but better than average State TCOC growth	No action
Worse than Medicare benchmark and worse than average State TCOC growth	Penalty
Worse than Commercial Benchmark	Additional Penalty
All Rewards Capped so that a Hospital Does not Exceed Medicare Benchmark	

Visual Representation of Efficiency Algorithm (Phase 1 - Medicare)



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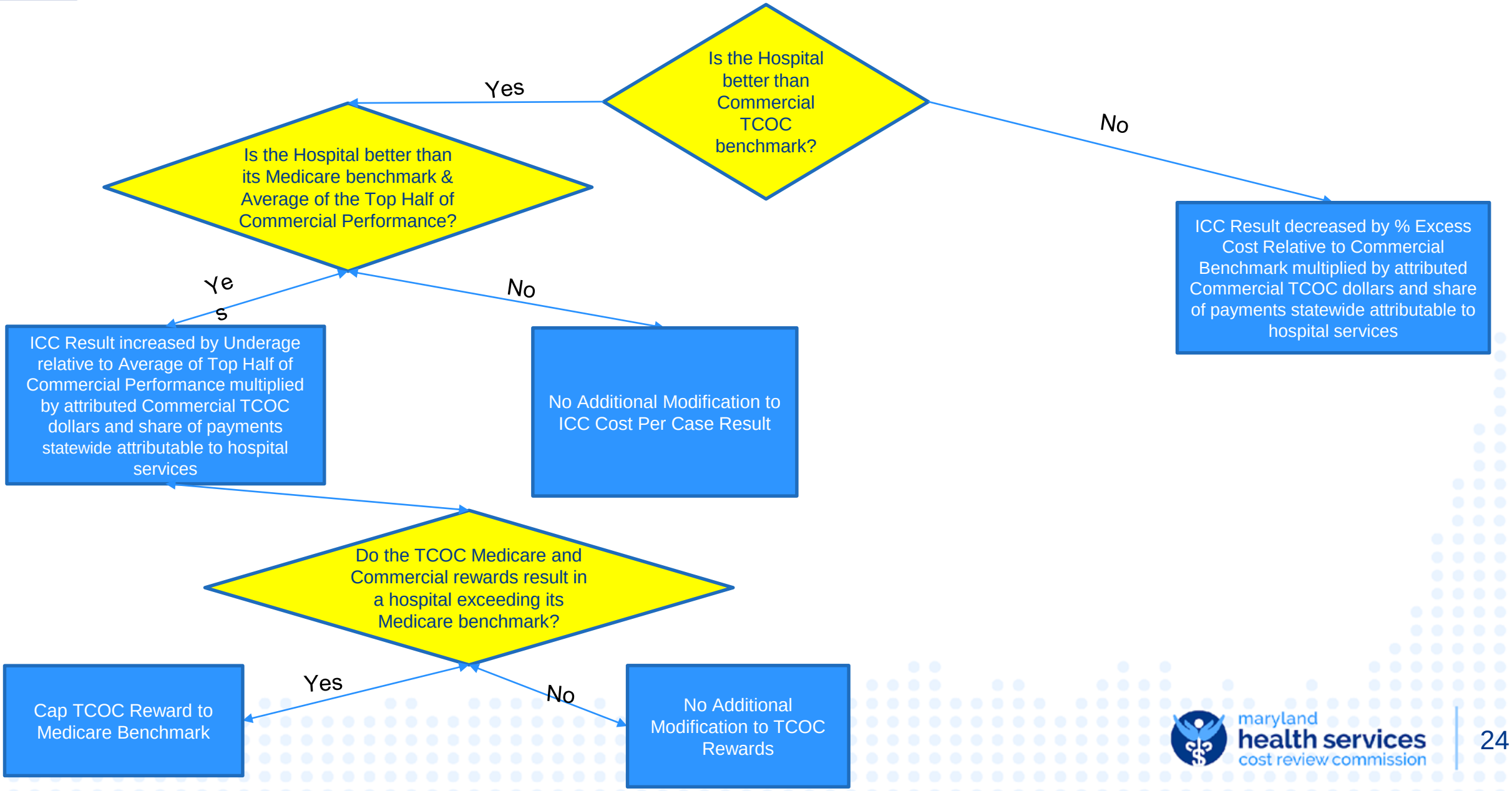
Visual Representation of Efficiency Algorithm (Phase 2 - Commercial)



Examples of TCOC Influence on Rate Application

ICC and TCOC Scenario	ICC Performance Relative to Standard	2018 Share of Medicare TCOC Spend Attributable to Hospital Services Statewide	2018 Medicare FFS Attributed Dollars (Part A and Part B)	2018 Medicare TCOC Relative to Benchmark	Medicare TCOC Attainment Credit	2013-2018 Medicare TCOC Growth (State Avg = 7.31%)	Excess Medicare TCOC Growth Penalty	2018 Share of Commercial TCOC Spend Attributable to Hospital Services Statewide	2018 Commercial Attributed Dollars	2018 Commercial TCOC Relative to Benchmark	Commercial TCOC Attainment Penalty	2018 Commercial Average of Top Half	Commercial TCOC Attainment Credit	Total TCOC Credit / Penalty	Full Rate Application Recommendation
A	B	C	D	E	F=C*D*E*-1	G	H=(G-7.31%)*C*D*-1	I	J	K	L=I*J*K*-1	M	N=I*J*M*-1	O = Lessor of (F+H+L+N) and E	P($)=B($)+O
Did not meet ICC Standard but better on Medicare & Commercial Benchmark	-4.92% (Reduction of $16.9 M)	53.82%	$379.6 M	-10.14% ($38.5 M under benchmark)	$20.7 M	12.37%	NA	29.90%	$608 M	-36.06%	NA	-29.72%	$54 million	$38.5 M	6.30% (Increase of $21.6 M resulting in $364.8 M)
Met ICC Standard but excess Medicare TCOC growth	4.23% (Increase of $23.7 M)	53.82%	$189.9 M	17.56% ($33.4 M over benchmark)	NA	9.23%	-$1.9 M	29.90%	$180.2 M	-19.96%	NA	-14.15%	NA	-$1.9 M	3.88% (Increase of $21.7 M resulting in $581 M)
Met ICC Standard but excess Medicare TCOC Growth and Poor Commercial TCOC Performance	7.08% (Increase of $4.4 M)	53.82%	$49.8 M	7.79% ($3.8 M over benchmark)	NA	19.96%	-$3.4 M	29.90%	$56.1 M	3.01%	-$0.5 M	13.62%	NA	-$3.9 M	0.87% (Increase of of $0.5 M resulting in $63.3 M)

Logic of TCOC Rules

- Multiplying all TCOC performance metrics by share of payments attributable to hospital services ensures hospitals are not rewarded or penalized for spend outside the scope of their direct **responsibility.**

- Using absolute TCOC dollars attributed to a hospital instead of relatively ranking hospitals based on a 50/50 weighting of cost per case and TCOC efficiency ensures that the more care for which a hospital is accountable, the **greater the size of the reward** they can earn.

- Rewarding hospitals that are better than Medicare benchmark performance, regardless of TCOC growth, ensures that hospitals are **rewarded for a level of efficiency that is extremely difficult to achieve** in Maryland's hospital all payer rate structure

- Holding harmless hospitals that are not worse than the Medicare benchmark recognizes that the **Commission expects hospitals to have TCOC greater than national peers** given the hospital all-payer rate structure

Logic of TCOC Rules cont.

- Penalizing hospitals that are worse than Medicare benchmark AND have exceeded statewide average TCOC growth underscores that while hospitals may be excused for performing worse than the benchmark at this time, they **must reduce TCOC growth over time if this Model is to succeed.**

- Penalizing hospitals that are worse the Commercial benchmark and only rewarding hospitals that are better than the average of the top half of Commercial performers recognizes **the Commission expects hospitals to have low Commercial costs** given the hospital all-payer rate structure.

- Capping hospital TCOC rewards to Medicare benchmarks ensures that hospitals, despite Maryland's hospital all payer structure, **do not excessively exceed the total cost of care associated with other regions of the country that are reimbursed through IPPS/OPPS:**
  - The Federal government's alternative to the Maryland TCOC model AND
  - Not a desirable outcome in a TCOC Model that seeks to retain higher governmental hospital reimbursement in exchange for better TCOC performance
    - Important to note that hospitals that qualify for a rate enhancement under the ICC will not have their rate application capped by Medicare TCOC performance.

Results of Full Rate Application Methodology

	2% Productivity Adjustment		No Productivity Adjustment	
Hospital Name	Full Rate Application Recommendation ($)	Full Rate Application Recommendation (%)	Full Rate Application Recommendation ($)	Full Rate Application Recommendation (%)
Suburban Hospital	21,976,492	6.40%	28,531,522	8.31%
Mercy Medical Center	13,152,665	2.35%	24,187,879	4.32%
Fort Washington Medical Center	1,168,428	2.23%	2,200,044	4.20%
Garrett County Memorial Hospital	711,755	1.13%	2,066,488	3.29%
Anne Arundel Medical Center	(9,170,536)	-1.42%	2,938,213	0.45%
Howard County General Hospital	(5,269,115)	-1.70%	767,471	0.25%
Atlantic General Hospital	(2,217,411)	-1.97%	(34,345)	-0.03%
Johns Hopkins Hospital	(119,451,299)	-4.68%	(84,031,835)	-3.30%
Holy Cross Hospitals	(29,884,450)	-4.70%	(17,596,402)	-2.76%
Johns Hopkins Bayview Medical Center	(39,405,139)	-5.59%	(27,817,689)	-3.94%
MedStar Union Memorial Hospital	(25,160,227)	-5.88%	(17,267,838)	-4.04%
Greater Baltimore Medical Center	(33,399,984)	-6.89%	(24,957,520)	-5.15%
University of Maryland Baltimore Washington Medical Center	(34,858,317)	-7.68%	(26,372,910)	-5.81%
Peninsula Regional Medical Center	(38,289,258)	-8.32%	(29,792,923)	-6.47%
Meritus Medical Center	(32,527,523)	-8.46%	(25,741,352)	-6.69%
Doctors Community Hospital	(22,090,031)	-8.49%	(17,501,345)	-6.73%
MedStar Harbor Hospital Center	(16,528,213)	-8.58%	(13,043,196)	-6.77%
University of Maryland Medical Center	(163,676,439)	-10.13%	(143,928,596)	-8.91%
MedStar St. Mary's Hospital	(19,703,982)	-10.25%	(16,340,985)	-8.50%
Upper Chesapeake Medical Center	(34,681,540)	-10.75%	(28,731,179)	-8.91%
Frederick Memorial Hospital	(40,998,182)	-11.36%	(34,481,732)	-9.55%
Western Maryland Regional Medical Center	(41,397,715)	-12.26%	(35,730,809)	-10.58%
University of Maryland St. Joseph Medical Center	(50,197,103)	-12.84%	(43,107,860)	-11.03%
Sinai Hospital	(127,293,696)	-15.02%	(115,354,728)	-13.61%
Prince Georges Hospital Center	(54,939,361)	-15.78%	(49,335,358)	-14.17%
MedStar Franklin Square Hospital Center	(90,976,174)	-15.98%	(82,231,335)	-14.45%
University of Maryland Charles Regional Medical Center	(25,974,289)	-16.54%	(23,205,308)	-14.78%
Shady Grove Adventist Hospital	(80,409,975)	-17.16%	(72,694,610)	-15.51%
Carroll Hospital Center	(43,340,017)	-18.33%	(39,378,130)	-16.65%
St. Agnes Hospital	(79,470,128)	-18.54%	(72,819,948)	-16.99%
Calvert Memorial Hospital	(28,334,791)	-18.55%	(25,913,790)	-16.96%
Harford Memorial Hospital	(20,921,342)	-19.33%	(19,139,779)	-17.68%
Washington Adventist Hospital	(59,172,716)	-19.66%	(54,248,865)	-18.02%
MedStar Southern Maryland Hospital Center	(56,211,837)	-20.06%	(52,037,452)	-18.57%
University of Maryland Shore Medical Center at Easton	(48,639,396)	-21.39%	(45,209,411)	-19.89%
University of Maryland Shore Medical Center at Dorchester	(10,003,063)	-21.66%	(9,267,430)	-20.07%
Northwest Hospital Center	(62,383,958)	-22.82%	(58,189,525)	-21.28%
University of Maryland Rehabilitation & Orthopaedic Institute	(29,418,804)	-23.07%	(27,783,412)	-21.79%
MedStar Good Samaritan Hospital	(64,340,168)	-23.71%	(60,194,601)	-22.18%
University of Maryland Medical Center Midtown Campus	(54,737,824)	-24.39%	(51,712,115)	-23.04%
Union Hospital of Cecil County	(42,919,589)	-25.47%	(40,377,887)	-23.96%
MedStar Montgomery Medical Center	(47,110,649)	-26.04%	(44,398,197)	-24.55%
University of Maryland Shore Medical Center at Chestertown	(17,877,317)	-33.72%	(17,183,046)	-32.41%

Full Rate Application: Process for Incorporating Rate Determinations in Global Budgets

Full Rate Application Process Aligning with Intent of Policy

- Unlike the Integrated Efficiency Policy, staff does not believe funding for full rate applications should be capped at the sum of a set aside in the Update Factor and inflation funding not provided to poor performing outliers
  - Meeting an absolute standard, especially a difficult absolute standard, should not be capped by available funding. If a hospital is entitled to $50 million under a full rate application but the set aside and funding from outliers is only $40 million, the rate application should not be capped at $40 million.
- Important statutory and regulatory timeline requirements make it difficult to rely on the Update Factor to account for TCOC implications:
  - Hospitals are allowed to a file for a change in its rate schedule that will be effective based on the date that the rate application notice specifies, which must be at least 30 days after the date on which the notice is filed
  - Commission must review and act on the rate application within 150 days after the notice is filed, unless both parties agree to postpone this deadline
    - If the Commission fails to complete the review of the rate application within 150 days, the change in rate structure will be effective to the date provided on the rate application notice.
  - If the Commission decides to hold a public hearing, the Commission must set a place and time for the hearing within 65 days of the filing notice
    - In the event of a hearing, the Commission may suspend the effective date of any proposed change until 30 days after the hearing.
  - Due to the alacrity with which rate determinations must be made, staff is concerned about the effect rate enhancements may have on TCOC savings tests

Proposed Full Rate Application Process

- All full rate applications processed outside of the Integrated Efficiency Policy will be presented as formal recommendations to Commissioners:
  - With total cost of care implications outlined therein, especially annual guardrail tests.
- If Commissioners approve additional revenue for a hospital through a rate application, Commissioners will have one of four possible options:
  1. Provide revenue increase immediately because there are no potential concerns about total cost of care performance
  2. Provide revenue increase immediately but reduce inflation across the board for all hospitals due to total cost of care performance
  3. Provide portion of revenue increase immediately and provide remaining revenue at semi-annual milestone (Jan or July 1st) when total cost of care can be accounted for in Update Factor Policy
  4. Delay revenue increase to semi-annual milestone (Jan or July 1st) when total cost of care can be accounted for in Update Factor Policy

Full Rate Application Policy Final Recommendations

- 1) Formally adopt policies to assess cost per case efficiency and total cost of care efficiency to determine the rate structure for hospitals* should:
  - a. A hospital request a full rate application; or
  - b. HSCRC open a full rate review on a hospital;
- 2) Use the Inter-Hospital Cost Comparison, including its supporting methodologies to compare cost-per-case for the above evaluations;
- 3) Use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance for the above evaluations;
- 4) Allow staff to include in full rate application recommendations the following:
  - a. Implementation date for global budget enhancement that considers and comports with the State's TCOC savings tests; and
  - b. Hospital specific, mutually agreed upon moratorium on full rate applications that extends beyond the regulatory limits.
    - COMAR 10.37.10.03 allows a hospital to file a full rate application at any time provided there is no pending hospital-instituted case before the Commission or the subject hospital has not obtained permanent rates through the issuance of a Commission rate order within the previous 90 days. **REMOVED**

***Total Cost of Care Assessments relative to attainment and growth standards performed by payer will be used to modify a hospital's cost per case efficiency analysis.**