maryland
health services
cost review commission

NOTICE OF WRITTEN COMMENT PERIOD

Notice is hereby given that the public and interested parties are invited to submit written comments to the Commission on the staff draft recommendations and updates that will be presented at the April 14, 2021 Public Meeting:

1. Draft Recommendation on the Integrated Efficiency Policy

WRITTEN COMMMENTS ON THE AFOREMENTIONED STAFF DRAFT RECOMMENDATION IS DUE IN THE COMMISSION'S OFFICES ON OR BEFORE MAY 5, 2021, UNLESS OTHERWISE SPECIFIED IN THE RECOMMENDATION.

2. Draft Recommendation on Maternal and Child Health Funding

WRITTEN COMMMENTS ON THE AFOREMENTIONED STAFF DRAFT RECOMMENDATION IS DUE IN THE COMMISSION'S OFFICES ON OR BEFORE APRIL 21, 2021, UNLESS OTHERWISE SPECIFIED IN THE RECOMMENDATION.

maryland
health services
cost review commission

583rd Meeting of the Health Services Cost Review Commission
April 14, 2020

(The Commission will begin 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 March 10, 2021 and March 24, 2021.

2. Docket Status – Cases Closed

3. Docket Status – Cases Open

4. Presentation on COVID-19 Long-Term Care Partnership Funding Program Activities
    a. Holy Cross
    b. Luminis Health

5. Final Recommendation on Medicare Advantage Payer Differential

6. Draft Recommendation on Revised Integrated Efficiency Policy

7. Draft Recommendation on Maternal and Child Health Funding Program

8. Policy Update and Discussion
    a. Model Monitoring
    b. Update on FY 2020 GBR Compliance Recommendation
    c. Update on Reliability of Race Data
    d. CMMI Updates
    e. Legislative Update

9. Hearing and Meeting Schedule

maryland
health services
cost review commission

Final Recommendation on Payer Differential for Medicare Advantage

April 14, 2021

This document contains the final recommendation to change the Medicare Advantage payer differential, contingent on federal approval.

maryland
health services
cost review commission

Table of Contents

Policy Overview 1

Overview 1

Past Funding 3

Grant Program Impact Areas 3

1) Star Rating Measure Improvement 4
2) Increase in Annual Wellness Visits 4
3) Expansion of Coverage 4
4) High Cost Beneficiary Penetration 4

Proposal to Change Payer Differential for Medicare Advantage 5

Stakeholder Feedback 6

Recommendation 7

Appendix A 8

maryland
health services
cost review commission

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/ Consumers	Effect on Health Equity
This recommendation seeks ways to increase access and options for seniors and dual eligible individuals through Medicare Advantage. The State is committed to finding ways to improve access to care, enhance quality and care transformation, improve health outcomes, and ultimately lower the cost of care for all Marylanders.	A payer differential specific to Medicare Advantage has the potential to better align the State's all-payer hospital rate setting system with the Medicare Advantage rate setting methodology. This change to the payer differential is subject to CMS approval.	This recommendation is revenue neutral to hospitals.	This recommendation would change the allocation of charges across payers and would result in lower charges for Medicare Advantage patients and higher charges for other payers (Medicaid, Medicare FFS, Commercial, self-pay).	By strengthening the Medicare Advantage market and increasing options for seniors and dual eligible individuals, this recommendation affords the opportunity to increase access to care and support services for Marylanders.

Overview

Since 2014, Maryland has worked with the Center for Medicare and Medicaid Innovation (CMMI) to reduce cost of care in Maryland and improve quality and health outcomes. The partnership has been successful thus far in implementing payment and system delivery reforms, resulting in over $1.4 billion dollars of hospital savings and improved hospital quality. The initiatives benefit not only Medicare fee-for-service (FFS) beneficiaries living in Maryland, but also all other patients under our all-payer rate setting system. While the Total Cost of Care (TCOC) Model agreement focuses primarily on Medicare FFS targets, the HSCRC must also maintain its historic hospital all-payer rate setting system that seeks to provide access, equity, and contain costs across all payers. Under this unique system, Maryland is able to fulfill its obligations of the TCOC Agreement while at the same time continue its equally important obligation to regulate the remaining 60 percent of the market that includes consumers enrolled in payers other than Medicare FFS.

As an all-payer system, we work to align our State programs across all payers, including commercial insurers, Medicaid, Medicare FFS and Medicare Advantage, to improve access to care, enhance quality and care transformation, improve health outcomes, and ultimately lower the cost of care for all Marylanders. The following recommendation seeks to align the goals and infrastructure of the Medicare Advantage market under the terms of the all-payer hospital rate setting authority consistent with the Maryland Total

Cost of Care Model. Specifically, the Maryland Health Services Cost Review Commission (HSCRC), proposes to temporarily adjust the public payer differential for Medicare Advantage (MA) plans under the TCOC Model in order to improve access to MA for seniors and dual eligibles in Maryland. The MA market is significantly underperforming in Maryland due in part to interactions between the Maryland rate setting model and the MA rate setting methodology. This under-performance leaves consumers with few or no options for MA plans, including plans for dual eligibles, in a significant portion of the State.

This recommendation would align MA with the TCOC Model by adjusting the public payer differential, pending approval by the Centers for Medicare & Medicaid Services (CMS). The proposal would effectively adjust MA rates to what they would be but for the impact of the hospital rate setting component of the TCOC Model, while ensuring that the State would still meet all required savings targets under the terms of the agreement with CMS. The recommendation does not undermine any of the goals or expectations of the TCOC Agreement, nor does it, harm hospitals, other providers, or beneficiaries.

Since the early years of Maryland's All-Payer system, government payers have been afforded a differential from rates paid by private payers. Currently, government payers (Medicare and Medicaid) pay 92.3 percent of HSCRC-approved hospital charges. All payers are required to pay HSCRC approved rates, less any payer class adjustment that has been implemented through Commission law and policy. The majority of the rate differences among payers have been effectuated through the payer differential program. Approving a differential for a particular class of payer is consistent with the Commission's mandate of setting rates equitably among all purchasers or classes of purchasers without undue discrimination or preference. Under the TCOC Model Agreement, the HSCRC has the ability to adjust the public payer differential with CMS approval. CMS most recently approved a public payer differential change that took effect in July 2019[1], which resulted in a 1.17 percent rate increase for commercial payers and a savings of $46 million to Medicare.

This recommendation proposes to increase the public payer differential for MA plans from the current 7.7 percent to about 16.88 percent. This will result in an approximately 0.5 percent rate increase for other payers and annual savings of $75 million to MA plans. Contingent upon CMS approval, the resulting differential for MA would be in effect from January 1, 2022 to December 31, 2024.

The aim of this proposal is to adjust MA hospital costs to where the rates would be absent the State's all-payer rate setting. We believe that this adjustment will attract more MA investment in the State and accomplish significant complementary goals, including strengthening infrastructure to coordinate care for Medicare beneficiaries, assuring Maryland beneficiaries the same choice of coverage and benefits as

[1] Differential Increase effective July 1, 2019. Memorandum to Hospital CFOs. Available at: https://hscrc.maryland.gov/Documents/pdr/PolicyClarification/2019/DifferentialMemo061019.pdf

beneficiaries in other states, creating a competitive MA marketplace, and supporting federal and state policy goals under the TCOC Model. In CY 2024, HSCRC would evaluate the proposal's effects and determine a path forward to potentially include MA-enrolled beneficiaries in the TCOC Model and examine other ways to expand the MA-like benefits to other Maryland beneficiaries. While this differential will increase charges for Medicare FFS, the TCOC Model sets stringent annual savings goals that the State will continue to meet. The State is committed to lowering costs for Medicare total cost of care and to transforming the care delivery system. This proposal will better align the Maryland TCOC Model and the Medicare Advantage market to provide expanded services and lower total costs while not harming the hospitals or any other component of the TCOC demonstration.

Past Funding

In February 2020, the Commission approved a grant program to support MA through Maryland hospitals. This was intended to be an interim step to increase support for Medicare Advantage access throughout the State. The Medicare Advantage Partnership Grant Program was designed to achieve the following:

- Encourage partnerships and strategies that result in long term health improvement of Medicare Advantage Partnership beneficiaries
- Improve Medicare Advantage penetration and/or improved services to high cost and high risk populations
- Preserve and/or expand access to the number of 4+ Star Rating Medicare Advantage plans in the State to promote competition and access for seniors
- Develop strategies that improve care coordination and quality of services offered in Medicare Advantage Plans
- Extend healthcare transformation efforts to the Medicare Advantage market.

The Medicare Advantage Partnership Grant was authorized as a temporary funding mechanism for Fiscal Years 2020 and 2021. Hospitals were able to apply for participation in the grant program by partnering with an MA organization to submit a proposed list of activities that would result in increased quality and expanded access.

Grant Program Impact Areas

The Medicare Advantage Partnership Grants were narrowly focused to foster increased stability for Medicare Advantage organizations, expand access, and create more robust plan designs for beneficiaries, and/or improved quality ratings. Hospitals agreed to spend grant funds on activities to focus on impacting one or more of the following four areas:

1) Star Rating Measure Improvement

Medicare Advantage contracts are rated on up to 45 unique quality and performance measures. Grant funds should be used to design and implement strategies that will result in improvement in the Part C/Part D measures established by CMS for the Medicare Advantage Program. The MAP Grant Program was designed to leverage hospital expertise on quality in an effort to improve star rating measures of Medicare Advantage plans. By doing this, the Medicare Advantage Plans will be eligible for higher reimbursement from CMS. This additional funding can then be returned to enrollees in the form of enhanced benefits and reduced cost-sharing.

2) Increase in Annual Wellness Visits

The Annual Wellness Visit provides an annual opportunity for Medicare Advantage beneficiaries to work with their providers to create or update their personalized prevention plan. This visit can be particularly important for beneficiaries who are high cost or who have high healthcare needs. The Annual Wellness Visit creates an opportunity to proactively assess changes in beneficiary health by performing a health risk assessment at 12 month intervals. Grant funds are being used to design and implement strategies that result in an increase in the number of annual wellness visits per year.

3) Expansion of Coverage

Maryland's current Medicare Advantage Plan penetration and distribution of services do not provide adequate coverage and choice for all eligible Marylanders. Plans are concentrated in urban counties while rural counties have far fewer choices without the extra benefits Medicare Advantage plans can provide, such as vision and dental services. Grant funds are being used to design and implement strategies that result in the expansion of coverage and access to these services.

4) High Cost Beneficiary Penetration

It has been well documented that a small portion of Medicare patients account for more than half the program's spending in any given year. This is true of Medicare Advantage Plans as well. According to a 2019 study by the Commonwealth Fund, "37 percent of Medicare Advantage enrollees have chronic conditions and functional limitations requiring a range of medical and social services; many also contend with low income, low education, and isolation." Because of this, the grant program was designed to encourage hospitals to collaborate with Medicare Advantage Plans to identify and address the high cost/high need beneficiaries. Grant funds are being used to design and implement outreach, education, enrollment, prevention, and management strategies that identify and target these beneficiaries with appropriate coverage and services.

Across these four impact measurement areas, hospitals and their Medicare Advantage Plan partners were required to define areas they intend to address and then start working to make progress in these areas. While the grant program was intended to be an interim step to increase quality among MA plans, it is not a sustainable long-term solution. To address and mitigate payment inconsistencies, HSCRC believes that a change to the underlying MA payment is necessary. Thus, this recommendation represents an additional adjustment that could be made to mitigate the disadvantage that MA plans face in Maryland.

Proposal to Change Payer Differential for Medicare Advantage

The HSCRC believes that care transformation and delivery system reform can be best achieved when all stakeholders, including hospitals, providers, post-acute providers, and payers are engaged. While the TCOC Model is a hospital-based model targeting Medicare FFS cost and quality improvements, staff believes that the proposed change to the differential for MA can benefit Marylanders by providing an additional support for care coordination, wrap-around services, and non-hospital care alignment for high and rising risk Marylanders. All Marylanders should have access to choice, enhanced benefit offerings, and competition that could be offered through a robust MA market. **The recommendation would temporarily increase the public payer differential from 7.7 percent to 16.88 percent for MA from January 1, 2022 until December 31, 2024.** While this recommendation is revenue neutral to hospitals, it does change the allocation of charges across payers as the table below depicts.

			Payer Differential			Estimated Net Revenue			
	FY2019 Revenue (in 000s)	Payer Mix	Current	Proposed	Projected Rate Increase	Current (in 000s)	Proposed (in 000s)	Change (in 000s)	% Change
Medicare Revenue	$6,516,300	37.20%	7.70%	7.70%	0.50%	$6,014,545	$6,044,469	$29,924	0.50%
Medicaid Revenue	788,244	4.50%	7.70%	7.70%	0.50%	727,549	731,169	3,620	0.50%
Blue Cross Revenue IP	1,087,915	6.21%	2.25%	2.25%	0.50%	1,063,437	1,068,728	5,291	0.50%
Blue Cross Revenue OP	1,195,576	6.83%	2.00%	2.00%	0.50%	1,171,664	1,177,494	5,829	0.50%
Medicare MCO	852,318	4.87%	7.70%	16.88%	0.50%	786,690	711,990	(74,700)	-9.50%
Medicaid MCO	2,715,718	15.50%	7.70%	7.70%	0.50%	2,506,807	2,519,078	12,471	0.50%
Medicare Deductibles paid by Medicaid	114,617	0.65%	2.00%	2.00%	0.50%	112,325	112,884	559	0.50%
Uncompensated Care	758,319	4.33%	100.00%	100.00%	0.50%	-	-	-	
Other Payors	3,488,009	19.91%	2.00%	2.00%	0.50%	3,418,249	3,435,255	17,007	0.50%
Total	$ 17,517,016	100.00%				$15,801,066	$15,801,066	($0)	0.00%

The HSCRC projects that, absent the effects of the TCOC waiver, the average MA benchmark in Maryland would be 100.8 percent of fee-for-service spending (4.9 percent above the current level). The proposed increase in the payer differential reflects the additional discount necessary to reduce MA costs by the amount of revenue lost due to the 4.9 percent gap.

The 100.8 percent benchmark was calculated by looking at the average benchmark among the national peer counties identified for each Maryland county and blending to a Maryland average based on MA enrollment. Given a national average of 103.6 percent, the HSCRC believes using the lower benchmark of 100.8 percent appropriately reflects that, even in the absence of the TCOC model, Maryland would be unlikely to fall into the quartiles for the lowest cost counties (107.5 or 115 percent of FFS).

At current enrollment levels, the differential change would reduce hospital expenditures for MA plans by $75 million. This increased differential for MA would not apply to other public payers (Medicare FFS and Medicaid). To maintain revenue neutrality for hospitals, hospital rates would need to increase by 0.5 percent for other payers resulting in cost increases of $30 million for Medicare FFS, $16 million for Medicaid and $29 million for other payers. The amount of rate increase required varies depending on the Medicare Advantage enrollment; therefore, should the State be successful in increasing enrollment, the rate offset would also increase proportionally. For example, doubling the enrollment would double the increase to 1.0 percent. The initial analysis in this recommendation was performed on FY 2019 revenue and enrollment. Should this recommendation be accepted by the Commission and CMS, a revised analysis would be performed with the most recent revenue and enrollment data.

This proposal is budget neutral and would not change the savings target for the TCOC Model and would not require any other Model changes. The current demonstration requires $300 million in savings by CY 2023 compared to the CY 2013. The HSCRC projects that the Model would still achieve annual savings that reach or exceed $300 million in CY 2023 under this proposal.

In CY 2024, Maryland is scheduled to begin working on the next iteration of the TCOC Model. Before that time, staff should complete an analysis of the Medicare Advantage market to determine the best path forward, including potentially incorporating MA enrolled beneficiaries into the TCOC Model.

Including MA in the TCOC Model has the potential to strengthen infrastructure to coordinate care for Medicare beneficiaries, assure Maryland beneficiaries the same choice of coverage and benefits as beneficiaries in other states, create a competitive MA marketplace, and support federal and state policy goals under the TCOC Model.

Stakeholder Feedback

Comment letters were received by the Commission through March 25, 2021 by the following organizations: Johns Hopkins Health System (JHHS), University of Maryland Medical Systems (UMMS), CareFirst, United HealthCare(UHC), Kaiser Permanente, Coalition on Improving Access to Medicare Advantage in Maryland (Maryland +Coalition), and Healthcare Affiliates, Inc. Appendix A includes a copy of all letters received.

Six of the organizations (JHHS, UMMS, CareFirst, UHC. Kaiser Permanente, and Maryland +Coalition) expressed general support for the staff recommendation to increase the differential for MA plans to mitigate the disadvantage to MA plans, including an analysis of the impact of the change on the MA market in Maryland. The following specific considerations were mentioned in comment letters:

- UHC requested that the differential take effect January 1, 2023 “to allow health plans adequate time to incorporate the impact of the change in product offerings across Medicare, Medicaid, and

commercial lines of business." Further, providing a full year advance notice to MA plans would allow the opportunity to understand and respond to the policy with a full bid cycle.

- CareFirst suggested a higher differential increase for Dual Eligible Special Needs Plans (D-SNP), up to 24.4%. CareFirst also advocated for a permanent long-term solution for MA rate setting to be incorporated with the next phase of the Waiver, which could take effect as early as January 1, 2025. Additionally, they continue to cite the need for rate integrity and examination of the overhead and costs distributed between inpatient and outpatient rate centers.
- JHHS and UMMS expressed support for the proposed change in order to expand the unique benefits offered by MA plans, while still delivering total cost of care savings to Medicare FFS per the requirements of the TCOC contract.

Healthcare Affiliates, Inc. expressed opposition to the staff recommendation without further proof that MA plans would adhere to all Medicare regulations and guidelines and improved compliance with the Medicare Encounter Database to submit data in a timely manner.

Staff response: Staff believes that the differential should be allowed to take effect as early as January 1, 2022 in order to give plans three full years to utilize a higher differential to increase options to more beneficiaries in as many counties as possible. This will provide the State an opportunity to examine the effect of the change before negotiations on the next phase of the Model. While the State understands the need to improve access to D-SNP plans in Maryland, staff ultimately recommended a single differential for Medicare Advantage plans. In the analysis of the change after three years, staff will consider how D-SNP plans fared compared to other MA plans and will include that nuance in the recommendation.

Recommendation

Pending federal approval of the differential change, the recommendation would do the following:

1. Temporarily increase the public payer differential from 7.7 percent to 16.88 percent for MA from January 1, 2022 until December 31, 2024.
2. Prepare a report to be submitted to the Commission in July 2024 that compares penetration levels across the State, by county, to assess the effectiveness of the differential change on access and options to MA plans in Maryland, including a separate analysis of D-SNP plan access and penetration.
3. Nothing in this recommendation shall change the State's commitment to achieve TCOC savings under the terms of the contract with CMS.

maryland
health services
cost review commission

Appendix A

Comment letters enclosed.

Healthcare Affiliates, Inc.

1 Vale Road, Suite 200 Bel Air, Maryland 21014
Phone: (410) 879-3264 Fax: (410) 879-3266

Date 3/30/21 **Time:** _____

To: HSCRC

Company: PAYOR DIFFERENTIAL COMMENTS

Fax Number: (410) 358 6217 REVISED

From: Mike Malpezzi Number of pages incl. cover : 3

__ For your information ___Per your request ___Per our conversation ___See Attached

Revised for TYPO's
Thanks

Healthcare Affiliates, Inc.

Health Services Cost Review Commission
4160 Patterson Ave.
Baltimore, MD 21215

March 25, 2021

Dear Sirs,

I am writing today not as a representative of any Maryland hospital but as a private but well-informed citizen on this matter. To give you a sense of my credibility, I note the following:

-I have been in the industry for more than 46 years
-Involved in HSCRC rate settings since 1975
-Did the initial review of the Payer Differential formula when it was first conceived and compile by GBMC CFO- Bob Ginn
-Worked at almost all Maryland hospitals as either an auditor, consultant or employee
-Have served over 400 clients nationally in over 40 states, including chains such as HCA, Tenet, Universal, etc. via Healthcare Affiliates (HAI, a nationally recognized consulting firm I started)
-Represented MHA before Maryland Legislative body for state-wide hospital financial issues
-CFO of 3 Maryland hospitals, most recently St. Joseph Regional Med. Ctr. (1985-92)
-CFO of HMO during development phase
-Unlocked the "mystery" of the black-box calculations for the original waiver tests
-Broadened the waiver cushion from 2001 to the new waiver implementation, through negotiations with CMS's Office of the Actuary-by uncovering errors or other problems within CMS's data and formulas-worked with Bob Murray and Bill Mooney

For the record, I have not been paid by a Maryland hospital for 4 years and therefore I can speak freely as a concerned citizen and Medicare beneficiary.

My experience in the other 39 states where I have worked for hospitals has been nothing but negative as it relates to Medicare Advantage/Managed Care Organizations (MCOs). These organizations demand concessions during "negotiations" by threatening to move their volumes to a competing hospital. Hospitals cannot band together for fear of restraint of trade accusations. Once "negotiations" are finalized the MCOs do the minimum as it relates to compliance with the contract and the maximum as it relates to delays and non-cooperation.

I have not seen the detail of the agreement to receive the heightened discount, but it should include more protections for the hospitals and more compulsion to adhere to all Medicare regs

1 Vale Road, Suite 200 • Bel Air, MD 21014 • 410-879-3264 • Fax: 410-879-3266
www.healthcareaffiliates.com

and guidelines. Such as, the ability to adjust claims up to 4 years as opposed to the typical MCO approach of 12 months. It should also include mandatory compliance with the Medicare Encounter Data Base so that the industry and Medicare have the ability to review data and react accordingly.

The argument for this to be a catalyst for MCO growth in Maryland due to the State's low MCO penetration is not well founded. The penetration level is low because the MCOs can't throw their weight around here as much as they can in other states forcing a never ending spiral of discounts for the MCOs and premiums/increases for others.

The total story of the efficacy of the MCO approach is very hard to determine for a number of reasons not the least of which is the non-compliance of the MCOs nationally to submit data timely or at all to the Medicare Encounter Data base or access to data showing the need for the larger discount. That is, are they efficient and effective providers of Medicare coverage? A test that hospitals had to meet when requesting rate adjustments. Are they financially unstable and need this discount level? If so why? Why should their costs and revenues not be regulated like ours (hospitals') side of the equation? You can't regulate one player in a game—taxis vs Uber and be fair.

Bottom line, hospitals and charge paying entities have absorbed the bulk of the negative impact of 'bright ideas' or experiments or squeaking wheels. This is not a time to inflict one more of those on the hospitals.

I would be willing to answer any questions or fill in any detail that you may have at your convenience.

Sincerely,

Michael Matejevich
President

Maria Harris Tildon
Executive Vice President
Public Policy & Government Affairs

CareFirst BlueCross BlueShield
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
Tel. 410-605-2591
Fax 410-505-2855

March 24, 2021

Adam Kane, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Kane:

We have reviewed the HSCRC Staff's recommendation on the Medicare Advantage (MA) Payer Differential carefully and appreciate the opportunity to provide our comments.

We submitted a letter to you and the MA Coalition dated August 25, 2020 outlining our position on HSCRC's and others' efforts to improve MA options for seniors in Maryland. Our position today remains consistent – we are still supportive of solving this matter "in a way that is equitable and sustainable for the market as a whole, and that prioritizes the needs of the most vulnerable residents in the State." At that time, we also articulated that we sought not to disproportionately impact businesses and households in Maryland through a substantial differential shift, as we have historically opposed differential shifts of any kind, but that under specific circumstances, we could support addressing the MA payment issue in this manner.

We appreciate the HSCRC's consideration of our outlined parameters, which included:

- **Dual Eligible Special Needs Plans (D-SNP)** would be assigned a 24.4% differential, beginning January 1, 2022, and all payers, including governmental, would absorb that impact.
- **Other MA Plans** would be assigned a 16% differential, beginning January 1, 2022, and all payers, including governmental, would absorb that impact.
- HSCRC should commit to unwinding the 25% temporary room and board cost shift to other rate centers.

The Staff's recommendation does not differentiate between D-SNP and MA plans and recommends a 16.88% differential for both. Staff also recommends an effective date of January 1, 2022 with an end date of December 31, 2024. Staff did not address the temporary room and board cost shift in their recommendation.

We understand that seniors in Maryland deserve access to supplemental benefits and zero-premium plans that are offered more broadly in other states by high quality MA plans. We also agree that the Medicare FFS' high payment rates across Maryland make it difficult for MA plans to flourish and temporary intervention is needed. We believe long-term, permanent solutions should be seriously pursued with CMS to acknowledge the impact of Maryland's All-Payer system. In the meantime, we are supportive of this modest adjustment to the payer differential, so long as it is approved with adequate time to be incorporated in MA plan bids.

We urge the HSCRC to pursue long-term, permanent solutions that would take effect with the next phase of the Waiver, which would take effect January 1, 2025. By then, a new set of terms will have been agreed upon with CMS and the goal should be to have a permanent solution to MA incorporated therein.

Finally, also in the interest of rate integrity, we request a detailed plan from HSCRC on how the 25% room and board cost shift that has increased outpatient hospital rates for eight years will be addressed.

Again, we thank you for this opportunity to share our thoughts regarding the MA Payment Differential. We look forward to continued collaboration as this evolves.

Sincerely,

Maria Harris Tildon

Attachment

Cc: Joseph Antos, Ph.D., Vice Chairman
Victoria Bayless
Stacia Cohen, R.N.
John Colmers
James N. Elliott, M.D.
Sam Malhotra
Katie Wunderlich, Executive Director

March 24, 2021

Adam Kane, Esq.
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Kane,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the draft recommendation on the payer differential for Medicare Advantage. JHHS supports the recommendation proposed by the Health Services Cost Review Commission (HSCRC), which would increase the public payer differential for Medicare Advantage (MA) plans in Maryland from January 1, 2022 until December 31, 2024. In doing so, the State would better align the MA rate-setting methodology with Maryland's all-payer hospital rate-setting system, and would increase both access and options for seniors and dual eligible individuals.

Johns Hopkins HealthCare (JHHC) was established in 1995 as the managed care and health services business of Johns Hopkins Medicine. JHHC is now a $3 billion business serving over 700,000 lives, including 330,000 Medicaid and 21,000 Medicare Advantage beneficiaries in the state of Maryland. JHHS appreciates the efforts of the HSCRC to design a solution that is both budget neutral and improves access to care for high-risk Marylanders through Medicare Advantage. As the HSCRC has highlighted, this recommendation would likely attract more MA investment in the State, creating more affordable and coordinated care for beneficiaries. JHHS would like to note the following in support of this proposal:

The Affordable Care Act (ACA) mandated revisions to the MA methodology that did not account for the unique differences in Maryland's rate-setting, and MA plans face a disadvantage in the market as a result. Due to these challenges, seniors and dual-eligible Marylanders disproportionately lack access to MA plans and affordable care.
As JHHS frequently notes, the foundation and uniqueness of the Maryland model is its All-Payor nature. When the ACA methodology was implemented in 2017, there was no adjustment for the misalignment between how MA benchmarks are set and how Maryland rates are set. Nationally, MA options are becoming an increasingly popular and affordable option, with nearly a 40% penetration rate. However, at only 13%, Maryland's MA penetration rate is the third lowest in the country. As several MA plans have either exited the market or reduced their product offerings, twelve Maryland

counties find themselves with only one or no MA options for beneficiaries. Without intervention, JHHS is concerned that these trends towards decreased access and MA options will continue.

Recognizing the challenges that Maryland MA plans face, the HSCRC has implemented short-term solutions through grants made available to hospitals in partnership with MA plans. While this is an important step in the right direction, there is a need for a more sustainable, longer-term solution.

Beginning in March 2020, the HSCRC began the two-year Medicare Advantage Partnership (MAP) Grant Program to provide $100 million over FY20 and FY21. Hospitals and MA plans partnered to apply for funding and create activities to maintain and improve access and quality in the MA market. While the MAP grant was hugely important as an interim strategy, JHHS believes a more sustainable solution that considers the methodology misalignment and payment inconsistencies is necessary.

This proposal would allow for greater access to care for high-risk populations while remaining budget-neutral and allowing the State to remain on track to maintain or exceed the TCOC savings target.

JHHS values the HSCRC's continued efforts and active collaboration as the State strives to meet or exceed savings of $300 million in CY 2023 under the TCOC model. The HSCRC's projections demonstrate that under this proposal, the Model would still achieve these savings, and because the recommendation is budget-neutral, the proposal would not change the savings target. As mentioned above, a longer-term solution is needed as more MA plans exit the market and access for seniors and dual-eligibles decreases; this proposal would allow the State to examine the results of this approach and determine whether this might be a sustainable solution in the next phase of the TCOC model beginning in 2024.

The HSCRC should be applauded for their diligent work to create this proposal that ultimately supports the overall goals of the TCOC Model by limiting cost, improving population health, and providing greater access and choice to beneficiaries in Maryland. JHHS strongly supports this recommendation, and hopes that this proposal can be quickly approved to allow plans enough time for benefit design and MA bids. We look forward to continued engagement and collaboration on this important issue.

Sincerely,
Nicki Sandusky McCann, Esq
Vice President, Provider/Payer Transformation
Johns Hopkins Health System

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
Katie Wunderlich, Executive Director
John M. Colmers
James Elliott, MD
Sam Maholtra

Adam Kane, Esq.
Response to Payer Differential for Medicare Advantage
March 24, 2021

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20852

March 24, 2021

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
750 E. Pratt Street
Baltimore, MD 21202

Submitted electronically via latonya.hamilton@maryland.gov

RE: Draft Recommendation on Payer Differential for Medicare Advantage

Dear Ms. Wunderlich:

Kaiser Permanente appreciates the opportunity to comment on the HSCRC's draft recommendation on a payer differential for Medicare Advantage.

Kaiser Permanente is the largest private integrated health care delivery system in the United States, delivering health care to over 12 million members in eight states and the District of Columbia.[1] Kaiser Permanente of the Mid-Atlantic States, which operates in Maryland, provides and coordinates complete health care services for approximately 775,000 members. In Maryland, we deliver care to over 450,000 members. KP's Mid-Atlantic Medicare Advantage plan, which serves over 46,000 Maryland residents in 11 counties, has a 5-star rating and was one of 21 plans (out of 818 nationwide) that received CMS' High Performing Indicator for 2021.[2]

Kaiser Permanente agrees that a payer differential specific to Medicare Advantage has the potential to better align the State's all-payer hospital rate setting system with the Medicare Advantage rate setting methodology. Eligible Marylanders may benefit from possible enhancements in the market such as access to choice, enhanced benefit offerings, and competition that could be created through a more robust MA market. However, we are cognizant that the proposal shifts costs to other parts of the market and want to ensure that any proposal does not materially impact the ability of Marylanders with other health care coverage to receive high quality, affordable care.

The draft recommendation notes that in CY 2024, Maryland is scheduled to begin working on the next iteration of the Total Cost of Care Model, and before that time, HSCRC staff should complete an analysis of the Medicare Advantage market to

[1] Kaiser Permanente comprises Kaiser Foundation Health Plan, Inc., the nation's largest not-for-profit health plan, and its health plan subsidiaries outside California and Hawaii; the not-for-profit Kaiser Foundation Hospitals, which operates 39 hospitals and over 650 other clinical facilities; and the Permanente Medical Groups, self-governed physician group practices that exclusively contract with Kaiser Foundation Health Plan and its health plan subsidiaries to meet the health needs of Kaiser Permanente's members.
[2] CMS Star Ratings Fact Sheet, https://www.cms.gov/files/document/2021starratingsfactsheet-10-13-2020.pdf

consider potentially incorporating MA-enrolled beneficiaries into the TCOC Model. Kaiser Permanente supports exploring this option and would appreciate the opportunity to work with the HSCRC on the analysis.

Thank you for the opportunity to comment. Please feel free to contact Allison Taylor at Allison.W.Taylor@kp.org or (202) 924-7496 with questions.

Sincerely,

Ruth Williams-Brinkley
Regional President
Kaiser Foundation Health Plan of Mid-Atlantic States, Inc.

March 23, 2021

Katie Wunderlich, Executive Director
Health Services Cost Review Commission (HSCRC)
The State of Maryland
4160 Patterson Avenue
Baltimore, Maryland 21215

cc: John M. Colmers, Chairman, HSCRC
Chris Konsowski, Chief, Hospital Rate Regulation, HSCRC

Dear Director Wunderlich:

UnitedHealth Group is a highly diversified health and well-being company dedicated to helping people live healthier lives and helping make the health system work better for everyone. In Maryland, UnitedHealth Group employs more than 3,200 people and serves over 810,000 members across our Medicare Advantage, Medicare Supplement, Part D, Medicaid and individual and group commercial insurance products. We support HSCRC's interest in adjusting the payer differential for Medicare Advantage (MA) plans from 7.7% to 16.88% to promote increased access to MA plans for Medicare-eligible Marylanders. We also suggest a January 1, 2023 implementation date for the proposed change, to allow health plans adequate time to incorporate the impact of the change in product offerings across Medicare, Medicaid and commercial lines of business.

Medicare Advantage provides beneficiaries with high-quality care, financial savings and security, and more robust benefits than traditional Medicare fee-for-service (FFS). Nationally, MA members had a 40% lower rate of avoidable hospitalizations for chronic conditions than FFS beneficiaries due to the engagement of members in tailored disease management programs, service coordination, and increased in-home resources. Across the industry, MA has a 10% higher preventive screening rate than FFS Medicare for health conditions like depression, breast cancer, prostate cancer, and fall risk.

As the HSCRC is aware, nationally, 41% of Medicare beneficiaries choose MA plans for their coverage. In Maryland, only 15% of total Medicare-eligible individuals participate in MA. Historically, the Maryland hospital rate setting model combined with CMS' MA pricing methodology, have stalled development of a strong MA marketplace. By expanding the differential between commercial and MA plans from 7.7% to 16.88%, MA plans would have greater opportunity to serve the market and offer Maryland Medicare beneficiaries a more robust set of benefits and services.

While we are very supportive of the HSCRC's proposed policy change to increase Medicare Advantage competition and participation in Maryland, we recommend that HSCRC consider delaying implementation until January 1, 2023. Currently, MA plans are in the process of filing bids to CMS for the 2022 plan year. The HSCRC's policy change will likely not be finalized before the MA deadline to submit bids to CMS. This proposal, while welcome, would impact plans' bid strategies, and the benefits available to beneficiaries, introducing uncertainty in the market in 2022. The HSCRC will realize the full benefit of this policy change if they allow plans the opportunity to understand and respond to the policy with a full bid cycle. This is particularly important given that HSCRC has proposed that differential increase will only be in effect for a three-year period.

This proposal is not without impact to commercial and Medicaid plans. The HSCRC calculates this proposal would increase commercial and Medicaid rates by 0.5%. As a participant in the commercial market across group and individual products in Maryland, our request delaying implementation to January 1, 2023 will allow for planning for the increased differential in our business strategy.

UnitedHealthcare is also a participant in the HealthChoice program. Delaying implementation to January 1, 2023 will allow for planning in collaboration with the Maryland Department of Health to assure that the increased differential will be incorporated in the Medicaid MCO capitation rate setting process to ensure actuarial soundness and support sustainability and stability of the HealthChoice Program.

We welcome opportunity for additional dialogue with you to encourage a more robust Medicare Advantage marketplace for Marylanders. Thank you for the opportunity to provide feedback to this proposal.

Sincerely,

Kathlyn Wee
CEO, UnitedHealthcare
Community Plan of Maryland

Joseph Ochipinti
CEO, UnitedHealthcare of the Mid-Atlantic

March 24, 2021

VIA ELECTRONIC SUBMISSION

Adam Kane
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Kane:

On behalf of the Coalition on Improving Access to Medicare Advantage in Maryland (Maryland +Coalition), we support the Health Services Cost Review Commission (HSCRC) proposal to increase the public payer differential for Medicare Advantage (MA). The proposal would address unintended interactions between Maryland's unique Total Cost of Care (TCOC) Model and the national MA benchmark-setting methodology. We encourage the HSCRC to approve the proposal during the April 14, 2021 meeting.

The Maryland+Coalition represents Maryland-based MA plans, including provider-sponsored plans offered by John Hopkins. The HSCRC has identified concerns based on Maryland's low MA penetration rate relative to other states. Hovering around 16 percent, Maryland's MA penetration rate is the fifth lowest in the country and lags far behind the nearly 40 percent average national penetration rate.[1] Nationally, more Medicare beneficiaries are choosing MA plans, whereas several MA plans in Maryland have exited the market or reduced product offerings. Lack of access to MA options in Maryland cuts seniors off from high-value coverage choices that are increasingly popular in other states as seniors seek out affordable care.

Low-income Marylanders are also disadvantaged. Based on projections conducted by the Maryland+Coalition, if MA penetration in Maryland increases to 22 percent – approximately half of the national average – dual eligible MA enrollment would increase from 12 to 31 percent. This represents over 16,000 dual eligible individuals moving from traditional Medicare FFS to MA in Maryland, allowing more vulnerable, low-income seniors to have access to valuable extra benefits and lower costs. Our projections also show this shift would provide $11 million in additional savings for the TCOC Model. Further, only eight percent of individuals in Maryland are enrolled in zero premium MA plans, whereas approximately 53 percent of individuals are enrolled in zero premium plans across the country.

The decline in MA and in beneficiary coverage choice is largely due to the phase in of MA payment methodology changes mandated by the Affordable Care Act (ACA), completed in 2017, which did not account for the unique circumstances created by Maryland's TCOC Model. The ACA required

[1] Meredith Freed, Anthony Damico, and Tricia Neuman. A Dozen Facts About Medicare Advantage in 2020. January 13, 2021. Accessible here: https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/#:~:text=In%202020%2C%20nearly%20four%20in,time%20since%20the%20early%202000s.

MA benchmarks to be calculated as a variable percentage of Medicare fee-for-service (FFS) spending such that plans are incentivized to negotiate lower prices where FFS spending is relatively high, including in Maryland. Under the TCOC Model, however, plans are unable to negotiate for savings with hospitals because the HSCRC sets payment rates for all payers, including Medicare FFS and MA. This unique situation makes it difficult to operate an MA plan in Maryland.

The HSCRC's proposal leverages existing tools under the TCOC Model to improve access to MA coverage. The TCOC Model allows government payers to be afforded a lower payment rate. HSCRC's proposal would increase the public payer differential for MA plans, which would result in $75 million in annual savings to MA plans, funded by all other payers. The MA differential under HSCRC's proposal would be approximately 16.88 percent (increased from the current 7.7 percent) from January 1, 2022 to December 31, 2024. This would effectively adjust MA rates to what they would be but for the effect of the hospital rates set under the TCOC Model (as opposed to Medicare FFS rates outside of the model). Importantly, this proposal would maintain the TCOC spending targets under the State's agreement with the Centers for Medicare & Medicaid Services (CMS). It also provides a bridge for the state to identify a more elegant solution to this issue in the context of the next phase of the waiver.

In addition to expanding coverage choices for seniors, we believe an increased MA presence would drive efficiencies into the state's health care system. By delivering care through a capitated payment system, MA plans are incentivized to provide the highest quality care while maintaining low costs. Greater managed care penetration can improve care coordination, provide wrap around services, and align care for high-risk seniors throughout health care systems. Increased Medicare managed care penetration has also been shown to drive down hospital utilization costs.[2]

In 2024, Maryland and CMS are scheduled to begin working on the newest iteration of the TCOC Model. Increasing the MA differential during 2022-2024 as proposed will create the opportunity for data collection on the effects of improved access to MA, which will inform Maryland's work with CMS to determine the best path forward to incorporate MA into the TCOC Model permanently.

We hope the HSCRC Commissioners and CMS will approve the proposal in order to allow Maryland MA plans to account for the new proposal in decision making for the 2022 MA plan year. Our member companies are currently working on developing plans for 2022 and need adequate time to account for the differential change before filing MA bids in early June.

Thank you for the opportunity to provide comments for the HSCRC's proposal. It leverages the tools provided under the TCOC Model to increase MA options that will benefit Maryland seniors and the dual eligible population without threatening TCOC Model savings targets. We appreciate the HSCRC's work and offer any assistance we can provide to the HSCRC Commissioners.

---

[2] Katherine Baicker, Michael Chernew, Jacob Robbins. The Spillover Effects of Medicare Managed Care: Medicare Advantage and Hospital Utilization. May 2013. Available at https://www.nber.org/system/files/working_papers/w19070/w19070.pdf

Sincerely,

Tom Kowalczyk
Cigna HealthSpring

Michelle Lee
University of Maryland Medical System

James P. Holland
Johns Hopkins HealthCare

Maria Harris Tildon
CareFirst BlueCross BlueShield

UNIVERSITY of MARYLAND MEDICAL SYSTEM

900 Elkridge Landing Road
4th Floor East
Linthicum Heights, Maryland 21090
www.umms.org

Finance Shared Services

March 24, 2021

RE: Staff Recommendation on Payer Differential for Medicare Advantage

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Katie:

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, we are submitting comments in response to the Health Services Cost Review Commission's ("HSCRC") Draft Recommendation on Payer Differential for Medicare Advantage.

UMMS agrees with the draft recommendation to increase the payer differential for Medicare Advantage payers from 7.7% to 16.88%. We believe Medicare Advantage plans offer unique benefits and it is important for the citizens of Maryland to have the same access to these benefits as do the citizens of other states. In addition, we believe Maryland's unique system should not be a hindrance but instead, should encourage the growth of these plans in the state.

UMMS believes it will be important to monitor and understand the impact of this change in the payer differential in order to assess the success of this initiative as we move forward into the next iteration of the Total Cost of Care (TCOC) model. UMMS, therefore, agrees with the staff's plan to analyze the Medicare market toward the end of this initiative in order to determine the best path forward from that point.

We appreciate the HSCRC's work and thank you for the opportunity to provide feedback.

Sincerely,

Alicia Cunningham
Senior Vice President, Corporate Finance & Revenue Advisory Services

cc:
Adam Kane, Chairman
Joseph Antos, PhD, Commissioner
Victoria Bayless, Commissioner
James Elliott, MD, Commissioner
John Colmers, Commissioner
Stacia Cohen, RN, MBA, Commissioner
Sam Malhotra, Commissioner
Mohan Suntha, MD, UMMS CEO
Michelle Lee, UMMS CFO

maryland
health services
cost review commission

Draft Recommendation on Integrated Efficiency Policy for RY 2022: Withholding Inflation for Relative Efficiency Outliers and Potential Global Budget Revenue Enhancements

Aril 14, 2021

This document contains the second draft staff recommendation for creating an Integrated Efficiency Policy for the purposes of withholding inflation for inefficient hospitals and awarding Global Budget Revenue enhancements for high performing hospitals. The Final Recommendation for this policy will be introduced at the June Commission Meeting. Since this represents the second iteration of this draft recommendation, staff did already address previously submitted comments in this report. In the Final Recommendation, staff will provide responses to previously submitted comments and any additional comments provided subsequent to this draft. Additional comments related to the second iteration of this draft policy are due by May 5, 2021.

maryland
health services
cost review commission

Table of Contents

Key Methodology Concepts and Definitions 1

Policy Overview 2

Recommendations 2

Introduction 4

Background 6

Efficiency Tools 6

Efficiency Implementation 7

Overview of Efficiency Calculations 9

Overview of ICC Calculation 9

Overview of Medicare Total Cost of Care Calculations 24

Efficiency Assessment 29

ICC Results 29

TCOC Results 33

Implementation of Efficiency Results 35

Stakeholder Comments and Staff Response 41

Future Policy Considerations 51

Recommendations 52

Appendix 1: Revised Casemix Methodology Discussion 53

Appendix 2. Outpatient Casemix Methodology Steps 57

A. Group and Assign Outpatient Records a Principal EAPG Type & APG High Type 57

B. Merge all datasets and Calculate expected charges to outpatient categories 58

C. Calculate ECMAD 60

Appendix 3: Rehab Casemix Mapping and Reliability Results 61

61

Appendix 5a. Efficiency Matrix with Existing ICC Peer Groups 62

Appendix 5b. Efficiency Matrix with Alternative Proposal to Adjust for Indigent Care 63

maryland
health services
cost review commission

Key Methodology Concepts and Definitions

1. Equivalent Casemix Adjusted Discharges (ECMADS) – ECMADS are a volume statistic that account for the relative costliness of different services and treatments, as not all admissions or visits require the same level of care and resources.

2. Inter-hospital Cost Comparison (ICC) Standard – Each hospital's ICC revenue base is built up from a peer group standard cost, with adjustments for various social goods (e.g., trauma costs, residency costs, uncompensated care mark-up) and costs beyond a hospitals control (e.g. differential labor market costs) that are not included in the peer group standard. The revenue base calculated through the ICC does not include profits. Average costs are reduced by a productivity factor of 2 percent. The term "Relative efficiency" is the difference between a hospital's actual revenue base and the ICC calculated cost base.

3. Volume Adjusted Inter-hospital Cost Comparison (ICC) - A version of the ICC that incorporates hospitals' reduction in potentially avoidable utilization, as defined by the Potentially Avoidable Utilization Shared Savings Program and additional proxies for avoidable utilization. Volumes from this analysis, both negative and positive, amend a hospital's final ICC calculated cost base – not the peer group cost standard - as well as the hospital's position relative to the ICC Cost Standard.

4. Efficiency Matrix – A combined ranking of a hospital's performance in the Inter-hospital Cost Comparison and Total Cost Care. Total Cost of care is measured by comparing the per capita cost of care in a hospital's service area to matched national Medicare and Commercial benchmarks on a risk-adjusted basis. Both measures are weighting equally and hospitals are arrayed into quartiles to determine overall efficiency.

maryland
health services
cost review commission

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The GBR approach explicitly rewards hospitals by allowing them to retain revenue as volume declines. While this incentive remains fundamental to the model, it has the potential side effect of masking hospitals that operate inefficiently.	This policy penalizes significantly inefficient hospitals and rewards significantly efficient ones by evaluating them on a normalized cost per case basis. To avoid penalizing hospitals that are effectively reinvesting savings from lower utilization in improving population health, the cost per case measure is balanced with a measure of total cost of care.	Hospitals that run efficiently and effectively manage total cost of care in their service areas will be entitled to additional revenue. Those that are inefficient and are not effectively managing total cost of care will lose revenue. Only clear outliers will be impacted, most hospitals will not be affected.	By incenting both efficiency and effective total cost of care management, this policy will control unit level cost inflation faced by the direct healthcare consumer while also improving the effectiveness of the healthcare delivery for all residents.	Through this policy, hospitals are evaluated, in part, on total cost of care, thereby incentivizing hospitals to improve care coordination and non-hospital investments in their service area. An increased focus on total cost of care can help to improve access and quality of care for residents in the hospital's service area. Although this does not directly affect health equity, the investments that are made in the community can indirectly improve health disparities.

Recommendations

Since 2018, staff has been working with Commissioners and stakeholders to develop a formulaic and transparent methodology that identifies and addresses relative efficiency performance in order to bring hospitals closer to peer average standards over time. The purpose of this exercise is to update the HSCRC's efficiency measures to be in line with the incentives of Maryland's Total Cost of Care (TCOC) Model, so that objective standards are in place when the Commission adjusts hospitals' permanent rate structure and to address and correct maldistribution of global revenues.

In July 2019, a staff draft recommendation was brought before the Commission. During the course of review following the publication of the July draft recommendation, a number of concerns were identified by staff, Commissioners, and stakeholders regarding: a) the casemix adjustment for rehabilitation cases; b) use of a growth calculation in lieu of a benchmark attainment analysis for

total cost of care performance; c) the appropriateness of current peer groups in the hospital cost per case efficiency assessment and d) general concerns that the policy should identify larger amounts of inappropriately retained revenue.

Commissioners at the October and November 2020 Commission meetings also expressed concern that the designation of hospitals as outliers based on a one standard deviation hospital pricing rule created an undesirable cliff effect, especially when the penalty was not scaled to reflect gradations in hospital performance. Commissioners also noted a desire to expedite the use of staff's proposed Revenue for Reform concept that allows hospitals to have safe harbors for hospital revenue, i.e., revenue that is used for specific care transformation efforts at the hospital that could be excluded from efficiency analyses. Finally, staff also noted that an additional risk adjustment for hospitals deemed similar to critical access hospitals would be included in future iterations of the Integrated Efficiency Policy.

In light of all of these issues, staff has: a) implemented a change to its casemix adjustment that reduces the variability of rehabilitation case groupings; b) incorporated total cost of care benchmark performance into efficiency evaluations; c) reviewed the effectiveness of ICC peer groups and recommended an alternative approach; d) arrayed hospitals into quartiles instead of quintiles and incorporated Commercial benchmark performance to expand the extent of revenue redistributed through this policy; e) proposed a scaling approach in the newest revrehabised recommendation that penalizes all hospitals in the worst quartile but on a sliding scale basis; f) reflected a pilot Revenue for Reform safe harbor; and g) proposed a critical access hospital adjustment. As such, staff is presenting the following recommendations for Commission approval:

1) Formally adopt policies to
    a. Determine hospitals that are relatively inefficient;
    b. Evaluate Global Budget Revenue enhancement requests using the criteria identified above;
2) Use the Inter-Hospital Cost Comparison, including its supporting methodologies to compare relative cost-per-case for the above evaluations;
    a. Adopt a risk adjustment for indigent care cost variation that will be applied to all efficiency policies
3) Use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance for the above evaluations;

4) Withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals based on criteria described herein; and
5) Use set aside outlined in the Annual Update Factor and funding secured from withhold from outlier hospitals to fund potential Global Budget Revenue enhancement requests.

Introduction

In response to Commissioner directives to incorporate per capita efficiency measures into overall efficiency analyses in line with the TCOC Model, staff developed an integrated efficiency methodology that uses and equally weights Volume Adjusted Interhospital Cost Comparisons (ICC) and Total Cost of Care benchmark performance, together referred to as the Efficiency Matrix. Incorporating the traditional cost-per-case analysis with total cost of care performance ensures that the HSCRC still adheres to its statutory mandate to ensure that total costs are reasonable and that aggregate charges are reasonably related to aggregate costs, while at the same time incorporating new population based measures of reasonable cost in line with the per capita goals of the TCOC Model.

While much work has been done to improve the Commission's efficiency methodologies, staff has not yet deployed them in an integrated and formulaic fashion across all hospitals. To date, the HSCRC has addressed efficiency concerns that excess revenues were being inappropriately retained by hospitals by making over $80 million in adjustments for services that shifted to unregulated settings, including adjustments for oncology and infusion drugs shifted to unregulated settings. This figure also includes the first year of a negotiated revenue reduction plan for one outlier hospital, whose cost performance had been affected by service discontinuation and deregulation. Staff will continue to make adjustments for shifts to deregulated settings based on hospital disclosures and annual reviews. However, in order to expedite the process of adjusting revenues for high cost hospitals, the HSCRC staff proposes a more formulaic approach to reduce excessive revenue by limiting rate updates provided in the Annual Update Factor Policy.

To implement formulaic revenue reductions, staff proposes to withhold, on a sliding scale basis, the Medicare and Commercial portion of the RY 2022 Update Factor effective July 1, 2021 using Volume Adjusted ICC cost-per-case results and Medicare and Commercial Total Cost of Care benchmark performance, as evaluated through the Efficiency Matrix. It should be noted that only

Medicare fee-for-service and Commercial data was used in this evaluation as equivalent total cost of care data is not currently available for Medicaid. In acknowledgement of this limitation, staff proposes that any impact from this policy should be limited to the Medicare and Commercial portion of a hospital's revenue update (~73% statewide), but the modification to a hospital's global revenue will be shared among all payers.

To limit the extent of this policy to a select group of inefficient hospitals, staff proposes to only identify hospitals in the worst quartile of performance on these three metrics and to scale the inflation withhold based on a hospital's points distance from the 3rd quartile, thereby reducing cliff effects and better recognizing gradations in hospital performance in the worst quartile.

In response to concerns about requests for GBR modifications, staff also proposes in the policy to outline the metrics by which GBR enhancement requests will be evaluated. Staff proposes to similarly utilize the Efficiency Matrix to identify hospitals that perform the best in a combined evaluation of cost-per-case and Medicare and Commercial total cost of care benchmark performance. Specifically, staff proposes that hospitals will only be deemed eligible for potential GBR enhancements if they are in the best quartile of performance in the Efficiency Matrix and they perform better than one standard deviation from average Volume Adjusted ICC performance (1.05 times the ICC Standard), the latter of which is an indication of cost efficiency and potential hospital insolvency. In this capacity, the HSCRC will create a policy that clearly and prospectively outlines the standards by which hospitals may potentially receive additional funding outside of a full rate review so that efficient and effective hospitals can operate on a solvent basis.

This report outlines the ICC and TCOC methodology to be used in Integrated Efficiency Policy and the proposed approach to implement formulaic revenue reductions for inefficient hospitals as well as to identify hospitals eligible for potential GBR enhancements. This report also outlines the results of these methodologies that are to be considered for implementation in RY 2022. Due to concerns over existing peer groups in the ICC, staff has provided the results both with current peer groups and with an alternative approach that consolidates peer groups and directly risk adjusts for the added costs associated with serving lower socioeconomic patient populations, heretofore referred to as indigent care. Staff is requesting that Commissioners provide direction on what approach to use for addressing indigent care and would also ask that Commissioners adopt this

approach across all efficiency policies – Capital Financing Policy and Full Rate Application Policy.

As is consistent with other Commission policies, future work may present opportunities to further refine this policy, most notably incorporation of national inpatient analyses for academic medical center efficiency evaluations and potential changes to allowed medical residents costs, both of which may have an effect on hospitals' efficiency rankings.

Background

Efficiency Tools

While staff has utilized the ICC and various total cost of care analyses to support Commission proposals to modify hospitals' global revenues outside of a full rate application,[1] thereby implicitly approving these efficiency tools through adjudication, no formal policies that address scaling of inflation or global budget modifications are currently in place. It is important that formal policies reflective of all methodology enhancements are approved by the Commission to provide greater clarity to the industry and to allow for the Commission's methodologies to be more formulaic and uniform in their application.

In terms of the ICC, staff did not materially change the methodology from what was presented to the Commission in November of 2017. The ICC still currently places hospitals into peer groups based on socioeconomic factors and teaching status and then develops a peer group cost average, devoid of unique hospital cost drivers (e.g., labor market, casemix) and various social goods (e.g., residency programs), to ultimately build up hospital revenue for each hospital based on the calculated peer group cost average. The difference between a hospital's evaluated revenue and its revenue calculated from the ICC cost standard is the measure of a hospital's relative cost-per-case efficiency. As aforementioned, staff has also included in this report a slightly different ICC assessment that removes peer groups and directly risk adjusts for indigent care.

Additional modifications to the November 2017 ICC include modifying the casemix methodology that governs the singular volume statistic used in the ICC, creating a differential cost estimate for

[1] Anne Arundel Medical Center, Garret Regional Medical Center, UMMC Midtown Hospital, Bayview Hospital

indirect medical education costs of major academic medical centers versus other residency programs, limiting the resident and intern cost strip to the State average cost per resident, updating the input values to reflect RY 2020 revenue and RY 2019 casemix volume, and adjusting the ICC for changes in Volume, all of which will be discussed in greater detail in the *ICC Calculation* section below. As discussed in the *Introduction* section, consistent with the historical practice of continuing to refine methodologies, staff plans to potentially update the ICC further, including replacing the academic medical center inpatient evaluation with a national cost-per-case efficiency analysis and establishing a statewide physician supply and demand analysis that will would allow hospitals to request updates to allowed medical residents.

As for Medicare total cost of care, staff originally had two established tools for analysis: total cost of care growth relative to 2013 (the base year for the All-Payer Model) based on a strictly geographic attribution; and total cost of care growth relative to 2015 based on the attribution in the Medicare Performance Adjustment (MPA), which incorporates patient and physician matching. Although both of these approaches yield similar results when the performance period is the same, both have limitations in determining absolute efficiency because both are dependent upon the date by which growth is evaluated, i.e., the base year, and typically growth calculations are not as reliable year over year as attainment analyses. For these reasons, staff has developed total cost of care "attainment" benchmark calculations into the final efficiency determinations, inclusive of Commercial performance, that will be discussed in the Overview of the *Total Cost of Care Calculation* section.

Efficiency Implementation

Withholding Inflation from Outlier Hospitals

In prior applications of the HSCRC efficiency methodologies, hospitals' revenues were reduced under spend-down agreements if they were deemed to have cost-per-case beyond a set level. In another application of efficiency measures, hospitals with favorable hospital cost-per-case positions were given higher annual updates than those hospitals with poor relative cost-per-case. However, all of these prior iterations of efficiency analyses were based on fee-for-service mechanisms and did not have to account for relative cost efficiency in a per capita system. In a per

capita system, a hospital aligned with the TCOC Model will reduce utilization by improving the health of the population, retain a portion of the revenue associated with the reduced utilization, and potentially appear to be less cost efficient in a cost-per-case analysis. Moreover, hospitals can confound this analysis in the global revenue era by reducing utilization through shifting services to non-hospital providers (referred to as deregulation), eliminating services outright, or by simply continuing to pursue additional volume growth beyond population and demographic driven changes. Despite these complexities, the HSCRC must still establish charges that are reasonably related to costs, which in turn should be reasonable themselves, while also properly incentivizing hospitals to reduce unnecessary utilization and total cost of care.

For these reasons, staff cannot evaluate hospital cost-per-case or total cost of care analyses independently, and any combination of tools will not precisely identify hospitals' efficiency ranking, especially near the mid-range of performance. Thus, staff will focus this policy on the worst quartile and recommend that hospitals in this quartile have a portion of their Annual Update Factor withheld, based on a 50/50 weighting of a Volume adjusted cost-per-case and geographic Medicare and Commercial total cost of care attainment calculations.

Staff notes that this policy would be the first broad scale, incremental step towards creating a formulaic use of efficiency methodologies in the per capita and global revenue era. Over time this policy will bring hospitals more in line with average cost-per-case and total cost of care performance.

Global Budget Revenue Enhancements

Staff's original efficiency proposals limited the application of the policy to poor performing outlier hospitals. Positive revenue adjustments would be addressed through an additional policy on the evaluation of rate applications once total cost of care benchmarks were developed. However, concerns regarding GBR enhancement requests have prompted staff to also outline a methodology for evaluating excellent performing hospitals and describe a process by which additional revenue may be requested outside of a full rate application.

Specifically, staff proposed that all GBR revenue enhancements outside of a full rate application be limited to hospitals that are among the best performers in cost-per-case, as measured by a

Volume Adjusted ICC, and Medicare and Commercial total cost of care, using a geographic benchmark attainment analysis. This evaluation mirrors the analysis performed for determining poor performing outliers. For hospitals to receive a GBR enhancement outside of a full rate review, they must be in the best quartile of performance as evaluated in the Efficiency Matrix and must be better than one standard deviation from average Volume Adjusted ICC performance (1.05 times the ICC standard), which indicates potential insolvency. Further, a hospital that qualifies for a GBR enhancement must submit a formal request to the HSCRC that outlines either: a) how a previous methodology disadvantaged the hospital; or b) a spending proposal that aligns with the aims of the Total Cost of Care (TCOC) Model. Total revenue enhancements will be capped by the funding made available by the set aside in the Annual Update Factor approved by the Commission each year (.25% or ~$45 million in RY 2021) and the funding derived from withholding inflation from hospitals in the worst quartile.

This process and proposed budget cap does not restrict hospitals from submitting a formal rate application request.

Overview of Efficiency Calculations

Overview of ICC Calculation

The general steps for the ICC calculation, consistent with prior practices, are as follows:

1. Calculate approved permanent revenue for included volume as measured by Equivalent Case Mix Adjusted Discharges (ECMADs) that will be evaluated in the ICC methodology. This excludes the hospital revenues for one-time temporary adjustments and assessments for funding Medicaid expansion, Medicaid deficits and user fees, such as fees that support the operations of the HSCRC.

2. Permanent revenues are adjusted for social goods (e.g., medical education costs) and for costs that take into consideration factors beyond a hospital's control (e.g., labor market areas as well as markup on costs to cover uncompensated care and payer differential).

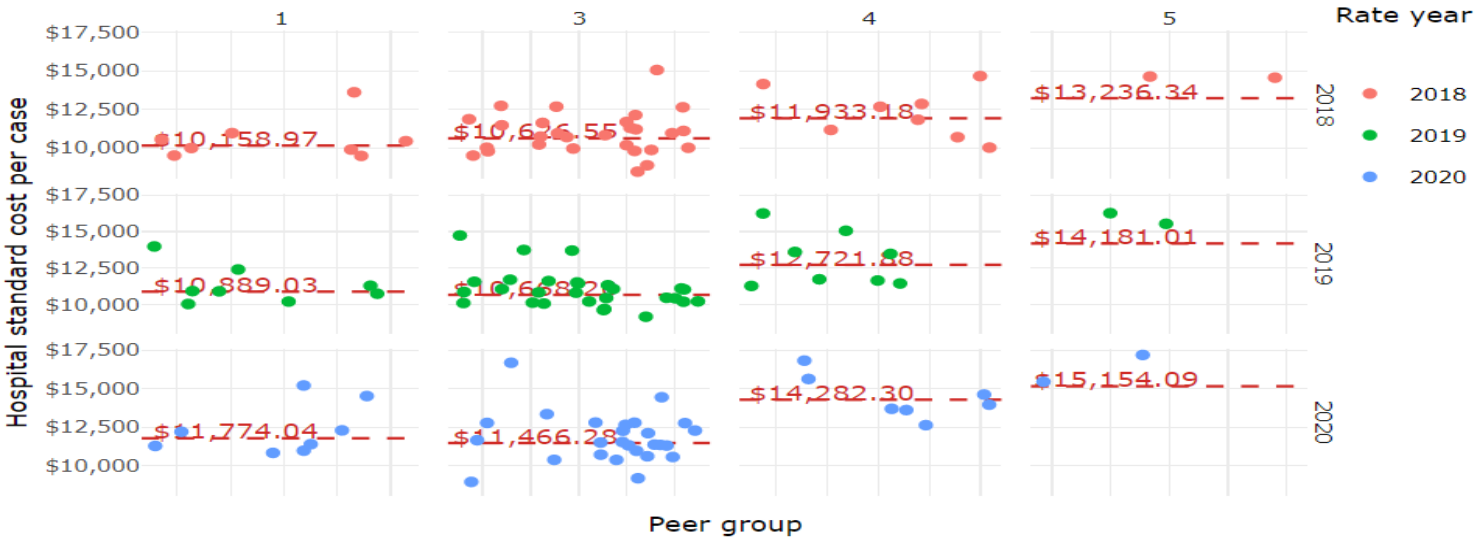
3. Hospitals are divided into peer groups for comparison, recognizing that specific adjustments may not fully account for cost differences. The adjusted revenue per ECMAD is compared to other hospitals within the peer group to assess relative adjusted charge levels. The peer groups are:

- Peer Group 1 (Non-Urban Teaching)
- Peer Group 3 (Suburban/Rural Non-Teaching)
- Peer Group 4 (Urban Hospitals)
- Peer Group 5 (Academic Medical Center Virtual, which overlaps with peer group 4)

Staff have also developed an alternative approach, whereby all peer groups, save Peer Group 5, are eliminated and instead direct adjustments are made through a regression to account for the intended purposes of the peer groups, most notably added costs related to teaching and to a greater extent serving a lower socioeconomic population or indigent care.

Staff arrived at this alternative approach due to many industry requests to assess the validity of the peer groups and because analysis of the peer groups indicated that there was greater variation in terms of cost per case within the peer group than across peer groups, which is not ideal for an adjustment that aims to align hospitals with similar characteristics and therefore similar cost profiles. This is best demonstrated graphically in Table 1 below, which shows that: a) hospital cost per case variation is greater in the smaller peer groups (Peer Group 1and Peer Group 4); b) cost per case performance in many cases tends to be more similar across peer groups than within peer groups; and c) variation with the peer groups is growing larger over time, which is another imprecision associated with peer groups since they do not automatically update, and yet there are ongoing changes in the patient population and market.

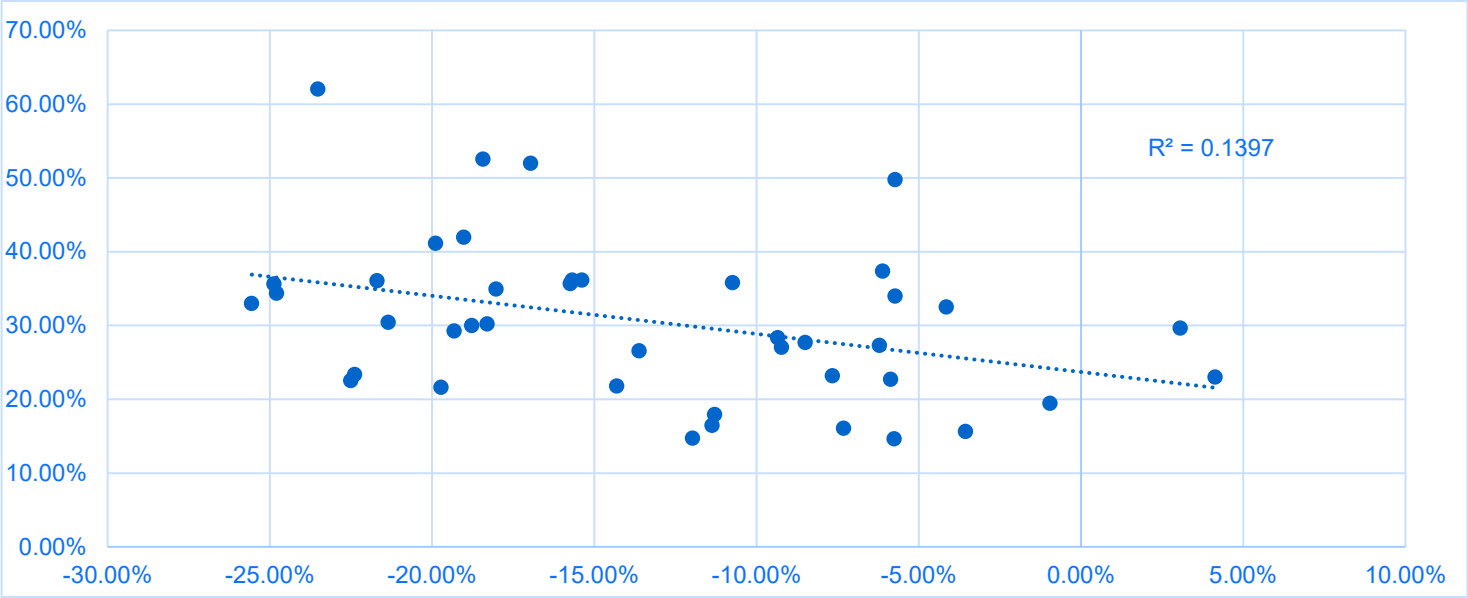
Table 1: Hospital Cost Per Case Variation (RY 2018 ICC – RY 2020 ICC)



The second concern about the current peer group design was that there remained a statistically significant relationship between levels of indigent care and ICC performance after application of the peer groups, indicating the peer groups had not fully addressed the residual cost variation for which they were intended. Specifically, staff noted that poor share (the percent of hospital revenue attributable to Medicaid, dual eligibles, and charity care) as well as the percent of revenue attributable to dual eligibles by itself had a small but not insignificant bearing on ICC performance when the historical peer groups were retained and indigent care was not adjusted for directly, as evidenced by a R2 of 0.1397 and a p value less than .05.[2]

[2] R2 denotes the extent to which a given set of variables in a regression explains variation in results or outcomes; the larger the R2 the higher the percentage of variation is explained. The complementary measures of p value indicate the extent to which the variables in the regression are not random. Typically p values less than .1 indicate the independent variables in the regression are not random and exert meaningful influence on the outcome.

Table 2: Correlation between Integrated Efficiency ICC Performance & Poor Share Percentage



Conversely, the alternative approach of consolidating Peer Groups 1, 3 and 4 and directly risk adjusting for indigent care resulted in an elimination of the statistically significant relationship between indigent care and ICC performance, which will be discussed in greater detail in subsection *D. Disproportionate Share Hospital (DSH) Adjustment.*

4. There are two additional steps to convert revenues to cost. The first additional adjustment is to remove profits from regulated services from the adjusted revenues (profit strip henceforth). The second is to make a productivity adjustment to the costs. These two adjustments are made to allow for consideration of efficient costs for purposes of rate setting.

5. After applying the calculated peer group cost average to each hospital, all costs that were removed in Step 2 (social goods and factors beyond a hospital's control) are added back to each hospital to build revenue up to the ICC calculated value. The profit strip and productivity adjustment outlined in Step 4 are not added back to a hospital's revenue. The difference between the ICC calculated value and the revenue included in the ICC evaluation, as described in Step 1, is the measure of a hospital's relative efficiency in relation to the ICC Cost Standard.

For a graphic outline of this process(not inclusive of staff's alternative approach outlined in Table 7 to directly risk adjust for indigent care in lieu of using peer groups), please see Tables 3a and 3b.

Table 3a: Overview of ICC Cost Comparison Calculation Determining Peer Group Cost-per-case (Stripping Down)

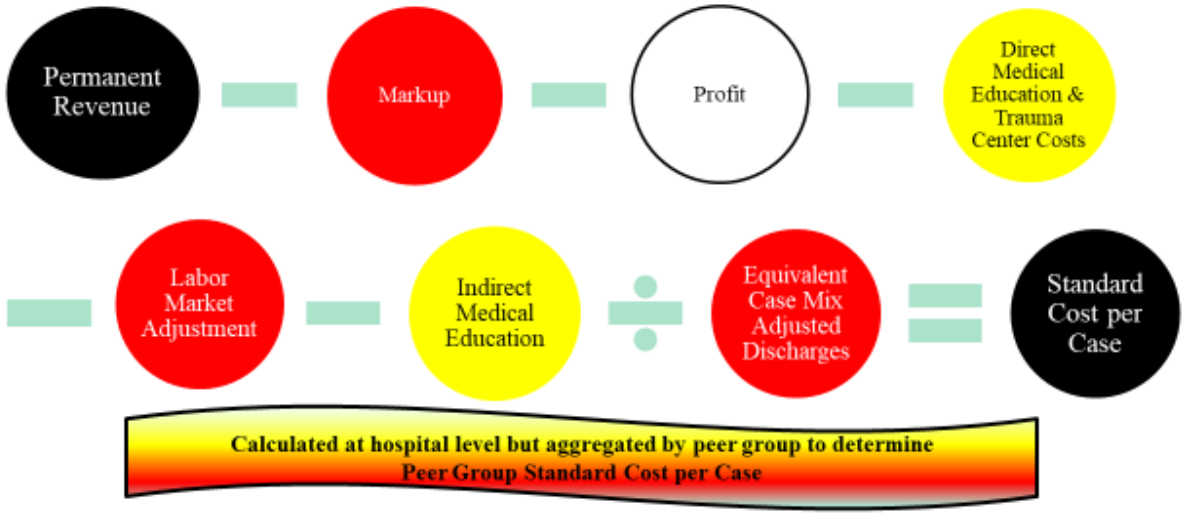
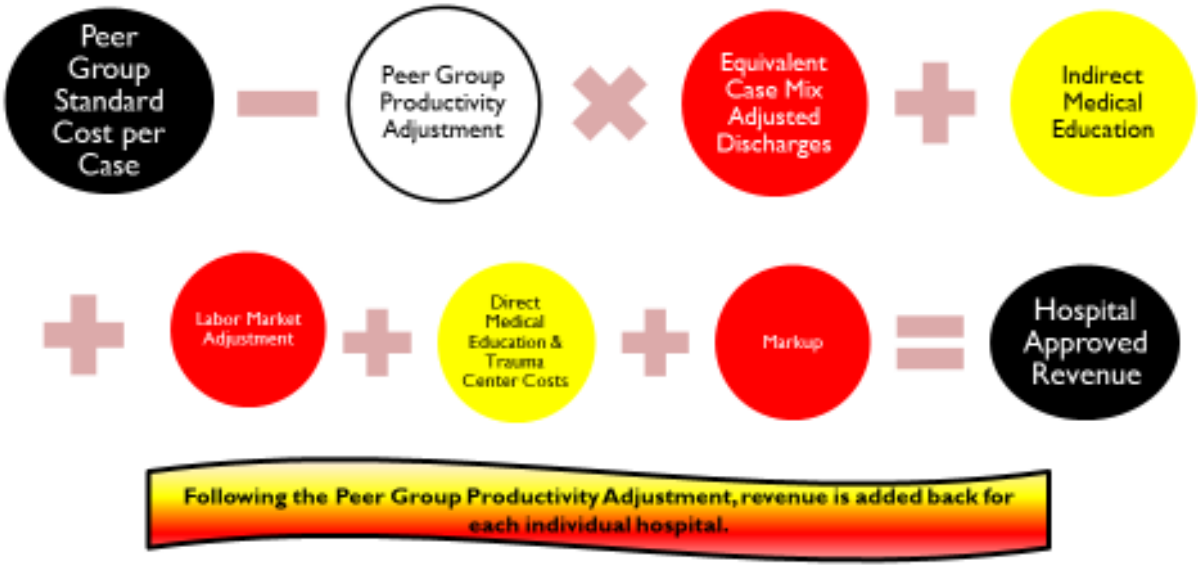


Table 3b: Overview of ICC Cost Comparison Calculation Determining Total Revenue (Building Back Up)



Proposed Changes to ICC Methodology

The following section outlines the proposed changes to the ICC relative to the methodology in effect in 2011.

Step 1- Calculate Permanent Revenue

A. Outpatient Drug Overhead Adjustment

As described in Appendix 1, staff has concluded its work in developing weights on outpatient cases, particularly cases that are subject to cycle billing and are ubiquitous across multiple outpatient settings. Staff did not develop usable weights for oncology and infusion drugs because these costs are highly variable by hospital due to various discounts that only certain hospitals receive, e.g., 340b discounts, and therefore do not offer a reliable efficiency comparison. As such, staff excluded oncology drugs from the cost-per-case/visit comparisons but retained the charges/cost constituting drug overhead, especially since the magnitude of drug overhead allocations are not uniform across hospitals. In the HSCRC rate setting calculations, a significant portion of costs continues to be allocated based on "accumulated costs." This process is allocating too much overhead to outpatient biological drugs, and staff has concluded that this allocation distorts cost comparisons.[3]

B. Revenue for Reform Safe Harbor

In response to Commissioner requests to expedite the use of staff's proposed Revenue for Reform concept, whereby hospital revenue is placed into safe harbors, i.e., it is not assessed in efficiency analyses if the revenue subsidizes care transformation, staff has put into the modelling for this iteration of the Integrated Efficiency Policy a pilot safe harbor for Chestertown Hospital. Specifically, a portion of revenue has been removed from the ICC and any potential scaling

[3] Medicare adds six percent to average sales price to pay for overhead on physician administered drugs that are not bundled into a visit cost, while non-governmental payers use a somewhat higher overhead figure on top of average sales price in their payment formulation. It is likely that HSCRC will need to change its overhead allocation and rate setting formulation for these biological and cancer drugs in the near term as costs continue to escalate. In the meantime, staff recommends retaining the overhead related revenues/costs in revenues evaluated under ICC charge-per case/visit comparisons.

adjustments in the Efficiency Matrix in recognition of Chestertown's intent to divert inpatient hospital revenue to rural health transformation, including an Aging and Wellness Center.

Staff does not recommend including any additional safe harbors until the Revenue for Reform Policy is officially promulgated, at which point a reporting and auditing function for safe harbors will be outlined.

Step 2- Adjustments to Revenue

Adjustments to revenue along with changes to each adjustment methodology are proposed by staff below:

A. Medical Education Costs

Consistent with past practices, direct medical education costs, including nurse and other training as well as graduate medical education (GME) costs, are stripped from the permanent revenues using amounts reported in hospitals' annual cost filings. HSCRC policies limited recognition of growth in residencies beginning in 2002, unless increases in residencies were approved through a rate setting process, consistent with Medicare policies that also limit recognition of growth in residencies. For the proposed ICC formulation, the staff is limiting the counts and costs used in the GME calculations based on the number of residents and interns that were included in the 2011 regression. Moreover, staff is capping direct medical education costs for hospitals to no more than the average direct cost per resident statewide, which in the RY 2019 annual filing was $132,803.

Over the years, the calculation of indirect medical education ("IME") costs has been difficult. In 2011, the HSCRC reached a calculation after much debate of an IME allowance per resident of $230,746. Staff believed this figure was too high for those hospitals that are not major academic medical centers with high ratios of residents per bed. As such, staff worked with a contractor to create a nationally calibrated two-peer-group model to determine major academic indirect medical education costs versus the IME costs per resident of other teaching hospitals.[4] The criteria staff used for defining these two peer groups were as follows:

[4] Several studies also show that major teaching hospitals (sometimes, though not always, defined as academic medical centers or AMCs) have higher IME costs than non-major teaching hospitals. In its 2007 Report to Congress,

Table 4 Criteria used to define teaching intensity hospital peer groups

Teaching intensity	Major AMC	Number of beds	IRB ratio
High	Yes	500 or more	0.60 or higher
Moderate to Low	No	Fewer than 500	0.03 to 0.60

Source: AAMC website and HCRIS, 2013-2015.
AAMC = American Association of Medical Colleges; AMC = academic medical center; HCRIS = Hospital Cost Reporting Information System

IRB ratio=Number of Interns and Residents/beds

Using the most recent three years of national hospital data (2013–2015) from the Hospital Cost Reporting Information System[5] and a regression that controlled for the other factors commonly associated with costs, such as hospitals' average patient severity and indigent care burden[6], it was determined that IME costs among high-teaching intensity hospitals are $302,887 and $110,875 for low- and moderate-teaching intensity hospitals combined. These values were inflated from the 2015 analysis to be equivalent to RY 2020 dollars.

Future development work may result in different allowed resident counts, but the methodologies for determining the cost per resident for direct and indirect medical education will remain the same.

Table 5 Estimated IME costs, by hospital peer group, 2013–2015

Teaching intensity	IME coefficient ($)	Standard error	P-value	95 percent confidence interval	
All	230,675***	11,753	0.000	207,639	253,711

MedPAC (2007) reported separate IME cost estimates for AMCs and other teaching hospitals. The results showed a stronger relationship to cost in AMCs than in other teaching hospitals. The IME cost estimate for major AMCs (2.6 percent) was nearly double the estimate for other teaching hospitals (1.5 percent). Nguyen and Sheingold (2011) also reported that the impact of teaching intensity on costs was higher among large urban hospitals than other hospitals. They found that costs per case for large urban hospitals increased 1.4 percent for every 10 percent increase in the ratio of residents to beds, compared with a 1.1 percent increase over all teaching hospitals.

[5] All Medicare-certified institutional providers are required to submit an annual cost report to a Medicare administrative contractor, which serves as the basis for the Hospital Cost Reporting Information System database. The cost report contains provider information such as facility characteristics, utilization data, cost and charges by cost center, in total and for Medicare.

[6] Several variables (including hospitals' case-mix index, wage index, census region, and urban or rural designation) were derived from the IPPS Impact File, which CMS uses to estimate payment impacts of various policy changes in the IPPS proposed and final rules.

High[a]	192,012***	41,873	0.000	109,942	274,082
Moderate and low (omitted group)	110,875***	17,216	0.000	77,132	144,619

Sources: HCRIS, 2013–2015; IPPS Impact File, 2013–2015.

Notes: The results are based on 124 hospitals in the high-teaching intensity group, 510 hospitals in the moderate-teaching intensity group, and 1,006 hospitals in the low-teaching intensity group.

[a] To calculate the marginal effect for these groups, add the estimated IME coefficient with the estimated IME coefficient for the omitted group within a given model. Estimated IME costs for high-teaching intensity hospitals in the two-peer group model are $302,887.

***Significantly different from zero at the .01 level, two-tailed t-test.

HCRIS = Hospital Cost Reporting Information System; IPPS = inpatient prospective payment system.

B. Labor Market Adjustment

In the prior ICC, the labor market adjustment was constructed using an HSCRC wage and salary survey that was based on two weeks of pay and included fringe benefits and contract labor. Each hospital was provided with a unique labor market adjustor that was more indicative of a hospital's ability or decision to pay salaries as opposed to the cost pressures hospitals face in various labor markets, and there were concerns about the consistency and accuracy of reported benefit levels and their impact on the measured wage levels. Staff suspended the wage and salary survey submission for 2017 and intends to replace this survey data with data that better accounts for labor costs hospitals cannot control. One potential solution is to utilize CMS's nationally reported data. Although this national CMS data is available historically, HSCRC staff has not had the opportunity to audit the data, and there may be reporting errors. Staff and MHA have stressed the importance of accurate data in the 2017 reports to Medicare.

While staff will continue to use the HSCRC wage and salary survey in its formulation of the ICC until a new labor data source is available, it proposed in the 2018 ICC formulation to eliminate hospital specific adjustments for most hospitals. Specifically, the ICC will use two sets of hospital groupings, with the first set of grouping for Prince George's County and Montgomery County where wages are higher than Maryland's average, and a second grouping of all other hospitals.

C. Capital Cost Adjustment

Previously, there was a capital cost adjustment for differences in capital costs, which was being phased out over time. The time has elapsed, and there is no longer an adjustment for capital cost differences.

D. Disproportionate Share Hospital (DSH) Adjustment

In the 2011 analysis, staff made an adjustment to charges for patients considered to be poor, in consideration of the cost burden that those patients may place on hospitals with higher levels of indigent care. Prior calculations utilized the percentage of Medicaid, charity pay, and self-pay, referred to as poor share, as an independent variable in a multi-variate regression to determine this cost burden.

Staff discontinued this adjustment and instead retained peer groups, most notably Peer Group 4 (the urban peer group), because the peer group design and direct risk adjustment for indigent care were duplicative and disadvantaged hospitals, not part of the urban peer group, with similar levels of indigent care. Since this discontinuation, stakeholders have continued to raise concerns that while the peer group assignments and indigent care are duplicative, there is variation in patient populations outside of the urban peer group that are not adequately addressed with the current ICC evaluation.

As such, staff engaged Mathematica Policy Research in developing a new DSH adjustment once it was determined that the peer groups in their current configuration (and in many other configurations based on cluster analyses) did not adequately address residual cost variation related to indigent care. The alternative approach built off the discontinued regression that utilized poor share as an independent variable because it demonstrated the greatest influence on ICC performance once peer groups were removed. Staff further added to the regression by controlling for Baltimore city hospitals, as staff was concerned that indigent care, as the last remaining adjustment in the ICC, was capturing other cost variation, likely due to actual inefficiency, e.g. excess capacity. Finally, staff identified slight volatility in the regression's annual coefficients and thus advanced the idea of using a regression that calculated indigent care cost per 1% of poor share over a three year ICC assessment, thereby smoothing out any instability in the DSH adjustment.

Table 6 DSH Adjustment Based on 3 Year ICC Assessment Poor

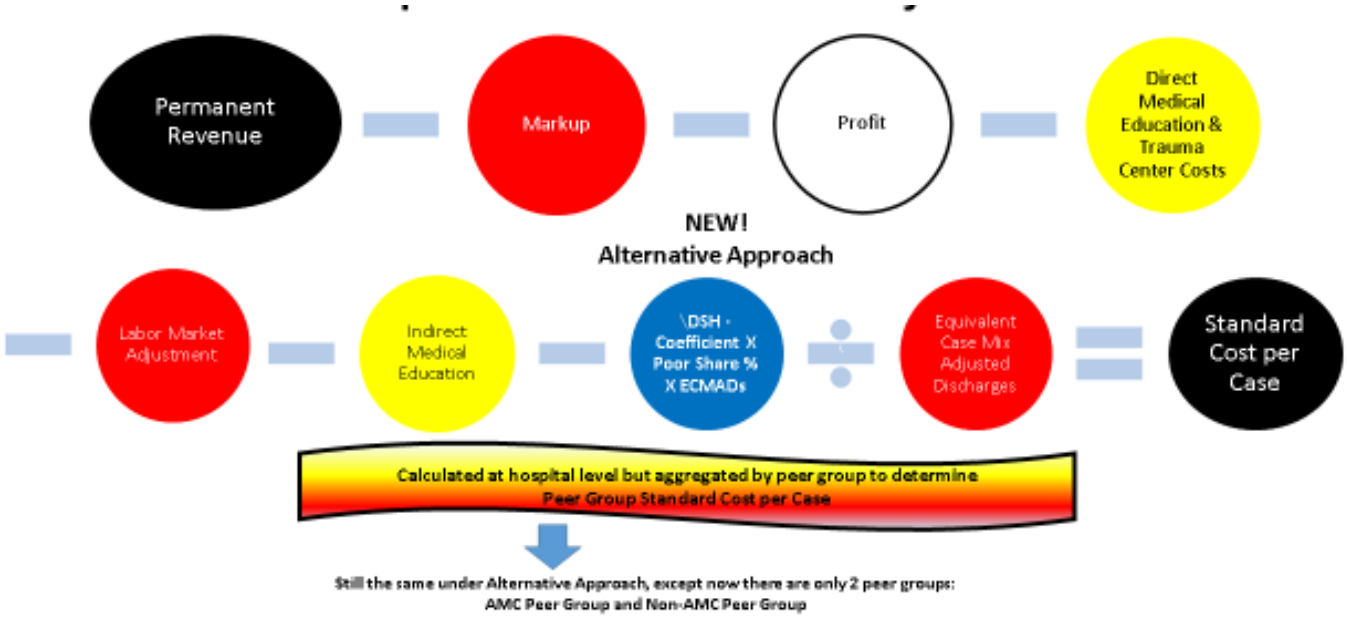
	RY18-RY20
Poor Share (DSH Adjustment)	6,914.33***
Metropolitan Indicator	1,070.08**
Constant	9,067.09***
Observations	41
R2	0.52

After calculating the poor share coefficient of $6,914, staff incorporated it directly into the ICC by multiplying it by a hospital's poor share percentage and its ECMADS when developing the peer

Note: *p<0.1; **p<0.05; ***p<0.01

group cost per case, which is a statewide peer group, save the academic medical centers, in the alternative approach. For a graphical demonstration of this see table 7 below:

Table 7: Overview of ICC Cost Comparison Calculation Determining Peer Group Cost-per-case with DSH Cost Strip (Stripping Down)



Similar to other cost strips (e.g., labor market, indirect medical education), the DSH adjustment is built back into a hospital's revenue base once the standard cost per case is developed.

Finally, to determine the efficacy of the alternative approach, staff ran final correlations to evaluate if the relationship between indigent care and ICC performance was reduced, ideally to a point where it was no longer statistically significant. In this exercise, staff also evaluated other hospital characteristics that stakeholders expressed concern over, most notably charge variance – the degree to which a hospital must change its charges to align the GBR to current service volume and which serves as a measure of TCOC Model incentives. In all cases, the relationship between indigent care and these other statistics of interest weakened under the alternative approach, and in the ICC used in the Integrated Efficiency Methodology the relationship between indigent care and ICC performance was not statistically significant:

Table 9: Residual Variation As Measured by R^2 with Other Metrics

Due to the sensitivity of the peer group risk adjustment, staff has reflected in the *Efficiency Assessment* section results of the Integrated Efficiency Methodology with peer groups and with the alternative approach, and will ask Commissioners to provide direction on what approach to adopt, both in the Integrated Efficiency Policy and all other efficiency policies.

Step 3 Productivity and Cost Adjustments

A. Profits

Staff has retained the same adjustment used to remove profits from the ICC costs, which has been used historically. Consistent with the statutory authority of HSCRC, the Commission does not regulate professional physician services. The adjustment removes profits for regulated services and does not incorporate subsidies or losses for professional physician services.

B. Productivity Adjustment

In prior iterations of this policy, staff recommended using an alternative approach to calculate the productivity adjustment. The excess capacity adjustment, which was formulated based on the

declines in patient days (including observation cases >23 hours) from 2010 through 2018 in each peer group as well as the change in outpatient surgery days with a length of stay greater than 1 from 2013 to 2017, produced varying levels of required increased productivity for each peer group, which staff believed was a methodological improvement to the historical 2 percent productivity adjustment employed across the board. However, given further review based on the final promulgation of the Major Capital Financing policy that also uses this calculation on a hospital specific basis, staff has determined that the excess capacity calculation should not be used to determine a peer group productivity adjustment due to the 85 percent variable cost factor in place from 2010 to 2014, which made the calculation overestimate the level of productivity expected of each peer group. Thus, staff is recommending returning to the historical 2 percent productivity adjustment. This approach varies from the final approved policy for Full Rate Applications, which temporarily discontinued the use of a productivity adjustment, but because the Integrated Efficiency Policy is a relative ranking methodology and all hospitals incur the same productivity adjustment, the retention of a 2 percent productivity adjustment does not affect results.

Step 4- Building Up a Hospital's Permanent Revenue

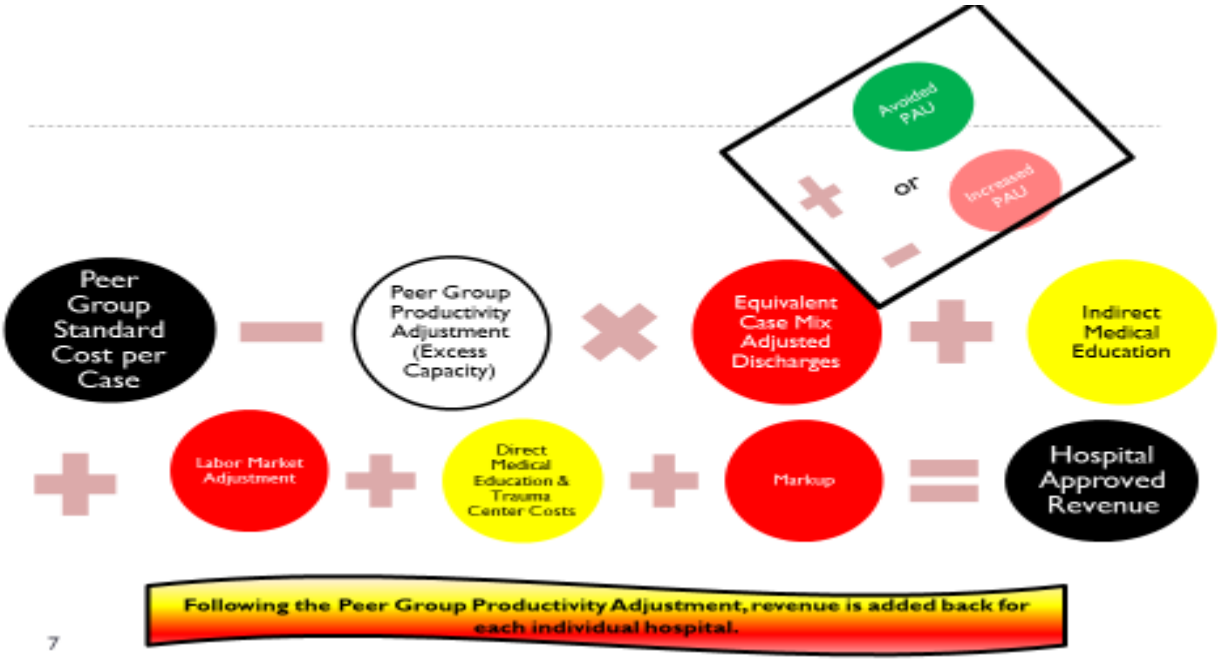
A. Volume Adjustment

In iterations of the ICC that relatively rank hospitals for the purpose of identifying inefficient hospitals, staff proposes to volume adjust the ICC because there exists an inverse correlation of (.53), whereby reductions in potentially avoidable utilization result in worse ICC performance. To correct for this, growth rates for potentially avoidable utilization, as defined by the PAU Shared Savings program,[7] will be assessed from CY 2013 to RY 2019. The inverse of PAU growth rates, both positive and negative, will be multiplied by a hospital's PAU ECMADS, thereby adding or subtracting volume used in the final calculation of a hospital's ICC approved revenue. That is, if a hospital reduced PAU over the course of the All-Payer Model, the volume will be added to its evaluation, thereby making the hospital appear more efficient in a cost-per-case analysis.

[7] In the PAU Shared Savings program, there are two volume measurements: readmissions that are specified as 30-day, all-payer, all-cause readmissions at the receiving hospital with exclusions for planned admissions; and hospitalizations for ambulatory-care sensitive conditions as determined by the Agency for Health Care Research and Quality's Prevention Quality Indicators (PQIs).

Conversely, if a hospital increased PAU, volume will be removed from the ICC evaluation, thereby making the hospital less efficient.

Table 10: Overview of ICC Cost Comparison Calculation Determining Total Revenue (Building Back Up) with Volume Adjustment



This PAU volume adjustment in concert with the alternative approach to ICC peer groups is also what ensures that there is no statistically significant relationship between indigent care and ICC performance, as evidenced by Table 9.

B. Critical Access Hospital (CAH) Adjustment

In recognition of the costs required to provide hospital care in rural areas, HSCRC staff proposes to add an additional risk adjustment for hospitals that would otherwise qualify as critical access hospitals. Based on analyses of hospital size, driving distance to the nearest facility, and low volume with short length of stay, staff has concluded that Chestertown Hospital should be

provided a Critical Access Hospital (CAH) Adjustment, i.e., an adjustment that benchmarks Chestertown Hospital's costs to similar national CAH's.[8] [9]

Following selection of peer hospitals, the CAH adjustment is based on straight average of cost centers from Medicare Cost Reports, excluding cost centers that represent services not provided (e.g., Psych, SNF). Casemix adjusted inpatient and outpatient discharges are then utilized to recognize differences in acuity and to scale the straight average method to the hospital's volume, which effectively weights the comparison. Then to convert the analysis to all-payer, a ratio of non-Medicare casemix index to Medicare casemix index is utilized, all of which will yield a predicted total cost standard based on national CAH benchmarks. Finally, staff adjusted the hospital's approved cost structure at the end of the ICC methodology so as not to affect Maryland peer group cost average, i.e., it functions as a final credit in ICC.

Overview of Medicare Total Cost of Care Calculations

Consistent with the Total Cost of Care (TCOC) Model, the cost used in this evaluation will include all types of medical costs (including both hospital and non-hospital services) with the exception of retail pharmacy.

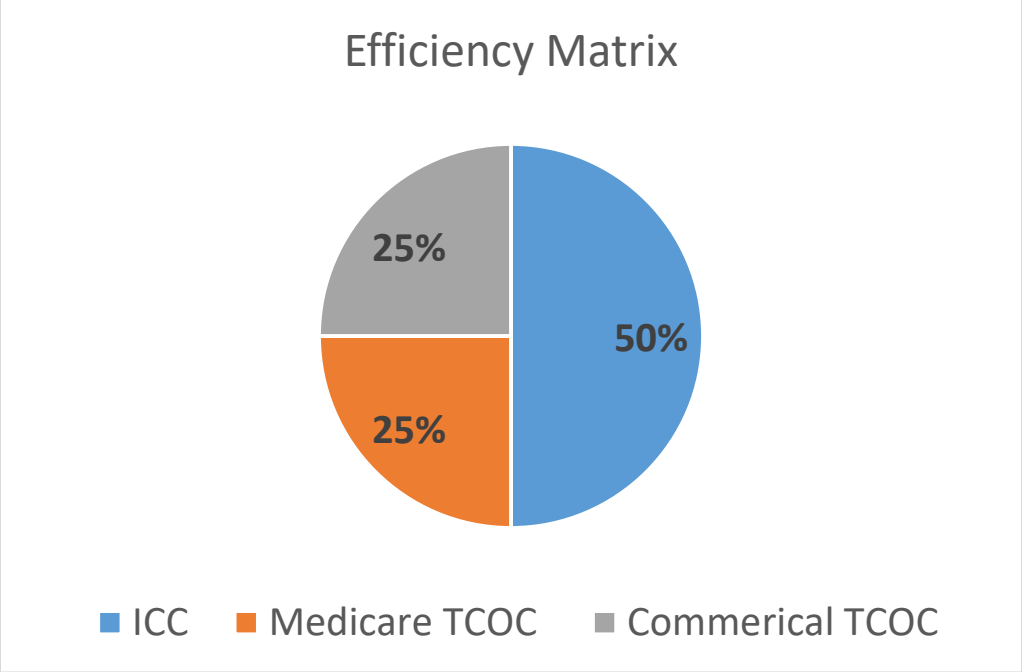
Hospitals' TCOC performance will be ranked by percentage variance from the Medicare benchmark performance (or average of similar demographic national peers), and this same approach will be applied to Commercial performance. The score from this ranking will be added to the ranking from the ICC and will comprise 50% of the evaluation – Medicare and Commercial

[8] Qualification for CAH classification nationally requires: a) Having 25 or fewer acute care inpatient beds; b) Being located more than 35 miles from another hospital; c) Maintaining an annual average length of stay of 96 hours or less for acute care patients; and d) Providing 24/7 emergency care services. Sixty-two percent of rural hospitals are paid as Critical Access Hospitals (CAH), comprising 35% of rural hospital payment for Medicare

[9] The criteria used for choosing peer CAH hospitals were as follows: flagged CAH's in national cost report database (~1,300 hospitals); established selection criteria, including: similar size; high quality; not financially distressed;, private, not for profit hospitals; similar wage levels--wage index of .85 or higher; and heavy Medicare mix--Medicare revenue is 30% or higher (24 hospitals); removed hospitals not available in American Hospital Directory data and hospitals that once swing beds were removed were too small for comparison (15 hospitals).

performance will comprise an even share of the total cost of care evaluation (25% each) as both represent approximately the same share of hospital payments statewide. This statewide weighting approach ensures that total of care is heavily influential to the efficiency analysis and ensures that hospitals with more favorable payer mixes, i.e., more commercial purchasers, are not artificially advantaged.

Table 11: Efficiency Matrix Weighting



Geographic Attribution Approach

For the purpose of this calculation, a hospital's attributed beneficiaries will be determined based on the Primary Service Area-Plus (PSAP) method used for the geographic attribution layer of the Medicare Performance Adjustment attribution approved by the Commission in November 2017. Under this approach, beneficiaries are attributed based on their zip code of residence. Zip codes are attributed to hospitals through three steps:

1. Costs and beneficiaries in zip codes listed as Primary Service Areas (PSAs) in the hospitals' GBR agreements are assigned to the corresponding hospitals. Costs and 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 FFS claims for the federal fiscal years 2014 and 2015.

2. Zip codes not claimed by any hospital are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if such zip code does not exceed 30 minutes' drive time from the hospital's PSA. Plurality is identified by the ECMAD of the hospital's inpatient and outpatient discharges during the attribution period.
3. Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.

Medicare and Commercial Benchmark Methodologies

A Medicare and a Commercial benchmark was calculated for each hospital. Each benchmark was developed in a three step process. Step 1 was to identify benchmark groups for each Maryland geography. Step 2 was to translate the geographic benchmarks into hospital-level benchmarks. Step 3 was to complete the cost comparison adjusting for beneficiary risk and demographics.

Detailed methodologies for each payer and additional data files related to the benchmarking process can be found in the Resources section of the Total Cost of Care Workgroup page on the HSCRC's website. The following is an abbreviated overview of these materials.

Step 1: Identify Benchmark Groups for each Maryland Geography

For Medicare benchmarking the geographic unit was a county. Due to limitations of the commercially available national data, the benchmark geographic unit was a Metropolitan Statistical Area. (MSA) However, in Maryland where more granular data is available through the Maryland Health Care Commission's Medical Claims Database (MCDB), Maryland counties were reorganized into a group of MSA-like cohorts such that all Maryland counties were included and no non-MD counties were included (this is not the case with standard MSAs).

Potential comparison geographies for each Maryland geography were narrowed based on population density and size. Various demographic factors were then calculated for every geographic unit within this narrowed selection. The demographic values used were intended to capture the health needs and economic situation of the geography. Factors related to health

system design like physician supply or provider concentration were explicitly excluded to avoid creating results that were biased by the nature of the delivery system.

A benchmark cohort was then developed for each Maryland geographic units (1 for Medicare and 1 for Commercial). The cohort was established based on selecting the 20 or 50 most statistically similar national geographies for each Maryland geography. The cohort includes 20 members for all Commercial areas and for 5 large Maryland counties for Medicare. (Anne Arundel, Baltimore City, Baltimore County, Montgomery County and Prince George's County). 50 member cohorts were used for Medicare for the remaining Maryland counties.

The cohort sizes were selected to balance the relative similarity of the included national geographies against the need for stable results over time. Medicare and Commercial benchmark cohorts are not identical as the same geographic unit was not used, but there is substantial overlap, and the selection metrics were identical except that payer mix was used in the Commercial selection but not in the Medicare selection.

Step 2: Translate Geographic Benchmarks into Hospital benchmarks

As the policy requires measuring performance at a hospital level, it was necessary to develop a hospital specific benchmark. This was done in three steps:

A. Calculate Maryland per capital total cost of care for each Maryland hospital based on its Primary Service Area Plus (PSAP). The PSAP is the service area selected by the hospital in their GBR agreement with any shared zip codes split based on ECMAD share and any unassigned zip codes assigned to a hospital based on travel distance. With these modifications, the PSAP methodology attributes 100% of Maryland's population to a hospital.

B. Calculate the benchmark by blending the relevant geographic benchmarks based on the distribution of the beneficiaries within the hospital's PSAP. For example, a hospital with 60% of its beneficiaries in geographic unit A and 40% in geographic unit B has a benchmark per capita total cost of care equal to 60% A and 40% B.

C. Adjust the Maryland and benchmark values using the adjustments described in Step 3 below to adjust for differences between the Hospital's PSAP demographics and those in the geographic units in its benchmark.

Step 3: Complete the Cost Comparison adjusting for Beneficiary Risk and Demographics

Per capita total cost of care is calculated for each Maryland hospital and its benchmark. For Medicare the paid amounts are used and for Commercial the allowed amount was used. For Medicare, the paid amount was utilized, as that is the amount for which Maryland is accountable under the Total Cost of Care Model. For Commercial, the allowed amount was utilized to remove the impact of varying cost sharing amounts across different commercial populations. The raw amounts are then adjusted as follows:

A. Medical Education costs were stripped from all values. Medical Education was removed so that Maryland hospitals would not be harmed or helped versus their benchmark cohort based on the level of medical education provided.

B. Risk adjustment is applied. Medicare risk adjustment is applied using Medicare Hierarchical Conditioning Categories (HCCs). Commercial risk adjustment is applied using HHS-HCC Platinum Risk Scores. Both these methodologies are publicly available validated risk adjustment methodologies. Age and sex are incorporated in these methodologies and therefore were not separately addressed.

C. (Commercial Only) Benefit adjustment is applied. While the use of allowed amounts removes the cost impact of member cost shares, it does not remove the utilization impact of varying cost shares. Generally, a plan with richer benefits will result in higher utilization. The benefit adjustment is intended to eliminate this impact from the comparison, so Maryland is not harmed or helped because of its commercial health plans having poorer or richer benefits. The adjustment resulted in a scaled index for each MSA reflecting the relative richness of benefits. This value is then used to remove the impact of benefit differential from the per capita total cost of care.

D. Demographic Adjustment was applied. A demographic adjustment was developed to better standardize for demographic factors beyond the control of the health system that impact cost of care. The adjustment was calculated separately for Medicare and Commercial, but in both cases was based on a regression of the risk and benefit adjusted total per capita cost of care against Median Income and Deep Poverty as reported by zip code in census data. The resulting regression coefficients were used to create a predicted value for each county, and the ratio of the actual value to the predicted value was used to adjust the risk and benefit-adjusted per capita total cost of care.

The values calculated can then be used to compare each hospital's per capita total cost of care to their peer average (or other comparison points derived from the benchmark cohort, e.g. 75th percentile) while removing the impact of medical education, beneficiary risk, benefits and demographics from the comparison.

Efficiency Assessment

Withholding Inflation from Outlier Hospitals

In this section, staff provides the results of the Volume Adjusted ICC for RY 2020 permanent revenue as well as results for 2018 Medicare and Commercial Total Cost of Care benchmark performance. Using these three statistics and weighting them respectively as 50%, 25%, and 25%, hospitals are arrayed into quartiles, such that hospitals in the bottom quartile will be considered to be the most costly relative to hospital peers. Based on this analysis, staff ultimately recommends that the remaining hospitals that are in worst quartile of performance, as outlined above should have a portion of their Medicare and Commercial RY 2022 update factor withheld, effective July 1, 2021.

Global Budget Revenue Enhancements

In this section, the best performing quartile for Volume Adjusted ICC and Medicare Total Cost of Care growth from 2013 to 2018 is also listed. Staff removed hospitals that are not better than one standard deviation from average Volume Adjusted ICC performance or 1.05 times the ICC Cost Standard. The remaining hospitals will be considered favorably when submitting requests for GBR enhancements.

ICC Results

As noted above, the difference between the Volume Adjusted ICC evaluated revenue figure, the revenue that was actually inputted into the ICC methodology, and the Volume Adjusted ICC calculated value is a hospital's measure of efficiency relative to the ICC cost standard. Table 12a (with peer groups) and Table 12b (without peer groups) below demonstrate this measure of efficiency as a percentage variance from the ICC standard. The table is ranked in order of most favorable to least favorable. Please note the results in table 12a have changed slightly because: a) staff has updated RY 2020 permanent revenue figures for hospitals that modifications to their rate structure after February of 2020; b) all revenue at Sinai Hospital associated with the Bon Secours transition was removed from the analysis, as this represented a prospective budget amount with no

associated volume – future years will include this revenue minus the agreed upon safe harbors; and c) staff included a critical access hospital adjustment and a pilot safe harbor for rural care transformation at Chestertown Hospital.

Table 12a: RY 2020 Volume Adjusted ICC Efficiency Rankings (Percentage and Dollar)* Inclusive of Historical ICC Peer Groups

	Relative Efficiency to ICC Standard %		Relative Efficiency to ICC Standard %
Garrett County Memorial Hospital	4.14%	Western Maryland Regional Medical Center	-14.31%
Mercy Medical Center	3.06%	St. Agnes Hospital	-15.38%
Atlantic General Hospital	-0.95%	MedStar Franklin Square Hospital Center	-15.68%
Suburban Hospital	-3.56%	Sinai Hospital	-15.74%
MedStar Union Memorial Hospital	-4.16%	Prince Georges Hospital Center	-16.96%
MedStar Harbor Hospital Center	-5.73%	University of Maryland Shore Medical Center at Chestertown	-18.01%
Fort Washington Medical Center	-5.73%	Shady Grove Adventist Hospital	-18.30%
Anne Arundel Medical Center	-5.76%	University of Maryland Shore Medical Center at Dorchester	-18.43%
Howard County General Hospital	-5.87%	Harford Memorial Hospital	-18.78%
Johns Hopkins Bayview Medical Center	-6.12%	MedStar Good Samaritan Hospital	-19.03%
Johns Hopkins Hospital	-6.22%	Doctors Community Hospital	-19.32%
Holy Cross Hospitals	-6.43%	Carroll Hospital Center	-19.73%
Greater Baltimore Medical Center	-7.32%	Washington Adventist Hospital	-19.89%
Peninsula Regional Medical Center	-7.66%	University of Maryland Shore Medical Center at Easton	-21.35%
University of Maryland Baltimore Washington Medical Cent	-8.50%	Northwest Hospital Center	-21.69%
MedStar St. Mary's Hospital	-9.24%	Calvert Memorial Hospital	-22.39%
Meritus Medical Center	-9.35%	MedStar Montgomery Medical Center	-22.51%
University of Maryland Medical Center	-10.74%	University of Maryland Medical Center Midtown Campus	-23.52%
Upper Chesapeake Medical Center	-11.30%	University of Maryland Rehabilitation & Orthopaedic Institute	-24.80%
University of Maryland St. Joseph Medical Center	-11.37%	Union Hospital of Cecil County	-24.87%
Frederick Memorial Hospital	-11.97%	MedStar Southern Maryland Hospital Center	-25.56%
University of Maryland Charles Regional Medical Center	-13.62%		

*Highlighted values represent hospitals that have an ICC calculated value better than one standard deviation of average performance, which would qualify these hospitals for a global budget revenue enhancement.

Table 12b: RY 2020 Volume Adjusted ICC Efficiency Rankings (Percentage and Dollar)* Inclusive of Alternative Peer Groups Approach

	Relative Efficiency to ICC Standard %		Relative Efficiency to ICC Standard %
Garrett County Memorial Hospital	6.49%	Upper Chesapeake Medical Center	-12.05%
Fort Washington Medical Center	2.75%	Shady Grove Adventist Hospital	-12.85%
Atlantic General Hospital	-0.87%	University of Maryland St. Joseph Medical Center	-12.92%
University of Maryland Shore Medical Center at Dorchester	-1.85%	Western Maryland Regional Medical Center	-13.01%
Holy Cross Hospitals	-2.36%	Harford Memorial Hospital	-13.47%
Howard County General Hospital	-3.91%	Northwest Hospital Center	-13.65%
Meritus Medical Center	-4.39%	Johns Hopkins Bayview Medical Center	-14.15%
MedStar St. Mary's Hospital	-4.94%	Doctors Community Hospital	-14.39%
Peninsula Regional Medical Center	-5.49%	Frederick Memorial Hospital	-14.45%
University of Maryland Baltimore Washington Medical Center	-6.17%	MedStar Union Memorial Hospital	-14.81%
Suburban Hospital	-7.97%	University of Maryland Shore Medical Center at Easton	-16.03%
Johns Hopkins Hospital	-8.03%	Union Hospital of Cecil County	-17.34%
MedStar Harbor Hospital Center	-8.41%	University of Maryland Shore Medical Center at Chestertown	-17.39%
Anne Arundel Medical Center	-8.47%	Prince Georges Hospital Center	-18.42%
Washington Adventist Hospital	-9.15%	Carroll Hospital Center	-18.60%
St. Agnes Hospital	-9.27%	MedStar Southern Maryland Hospital Center	-19.31%
MedStar Franklin Square Hospital Center	-9.50%	University of Maryland Rehabilitation & Orthopaedic Institute	-20.08%
University of Maryland Medical Center	-9.60%	Calvert Memorial Hospital	-20.46%
University of Maryland Charles Regional Medical Center	-9.79%	MedStar Montgomery Medical Center	-20.98%
Mercy Medical Center	-10.11%	University of Maryland Medical Center Midtown Campus	-21.24%
MedStar Good Samaritan Hospital	-10.43%	Sinai Hospital	-23.69%
Greater Baltimore Medical Center	-11.25%		

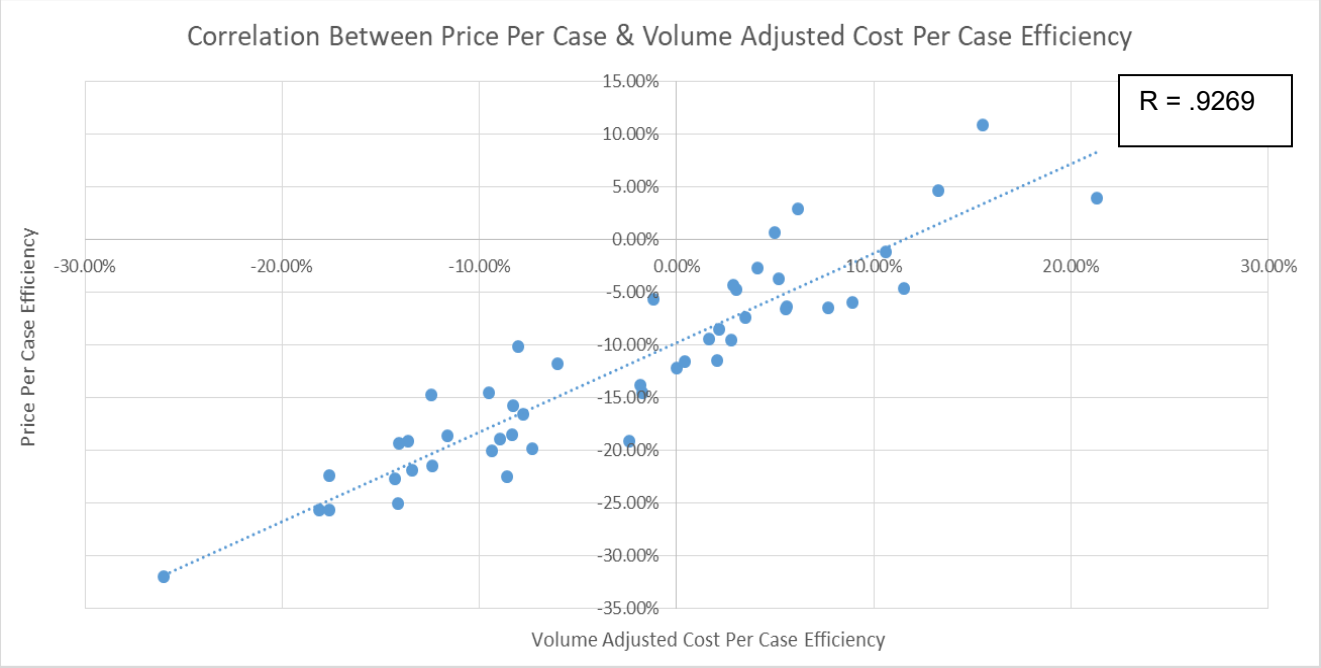
As shown in Table 12a and Table 12b, only two hospitals are deemed more efficient than the ICC cost standard, i.e., have a positive percentage variance, but it is important to note that this is because the ICC standard has become more difficult to attain, since hospital profits have improved under the All-Payer Model and Total Cost of Care Model. It is also important to note that this does not preclude best performing hospitals from qualifying for a GBR enhancement under the Integrated Efficiency Policy, as the standard for qualification based on ICC performance is being better than one standard deviation from average performance – 5 hospitals meet the one standard

deviation ICC rule in the version with peer groups and 7 hospitals meet the standard without peer groups.

While total profit margins are lower because of unregulated losses, most notably physician subsidies, staff has not made adjustments to the profits stripped from hospitals' revenue base to account for these losses. This is consistent with the statutory authority of HSCRC, as the Commission does not regulate professional physician services. Future work outlined in the *Future Policy Considerations* section below does indicate that staff will attempt in subsequent iterations of the ICC to credit unregulated losses that are in line with the incentives of the Total Cost of Care Model, but at this point staff will make no modifications.

Critics of the ICC have noted that not accounting for unregulated losses does not accurately portray the new costs associated with providing care in a population-based per capita model. Staff agrees with this concern but notes that this is why the implementation of the efficiency policy incorporates total cost of care performance and only removes funding from hospitals in the worst quartile. Regardless of any imprecision in the ICC methodology, hospital prices per case grew in the global revenue era as volumes have declined or remained static. This is an expected outcome similar to the rise in per diem payments when length-of-stay initially fell under the DRG system. To ensure that charges do not become unreasonably high, especially given Medicare outpatient coinsurance that is already high due to the all-payer rate setting nature of the system, staff recommends using the combination of cost-per-case analyses and total cost of care. Moreover, staff notes that there is a high degree of correlation between high priced hospitals and high cost hospitals, as determined by the ICC (R=.9269). This suggests that the hospitals identified in the outlier analysis are not just inefficient in costs relative to their peers, but that they are also receiving reimbursement commensurate with their higher costs (see Table 13 below for the correlation analysis).

Table 13: Correlation between Hospital ICC Cost Efficiency and ICC Price Efficiency



TCOC Results

Using the geographic attribution described in the *Efficiency: Overview of Total Cost of Care Calculations* section, staff has determined that 7 hospitals perform better than their national geographic peers in Medicare total cost of care; 10 hospitals perform worse than national peers but better than average statewide performance relative to national benchmarks (11.5% statewide unweighted); and 26 hospitals perform worse than average statewide performance relative to national benchmarks. As one would expect due to the all-payer rate setting nature of the Maryland system, the results are quite different relative to national peers for commercial, as 40 hospitals perform better than national benchmarks, but quite interestingly the results on the two total cost of care metrics are correlated but not strongly (R = .5165). Table 14 below shows hospital total cost of care performance relative to national benchmarks, both in terms of percentage variance and statewide ranking based on percentage variance.

maryland
health services
cost review commission

Table 14: Hospital Attributed Total Cost of Care Growth Performance

Hospital Name*	2018 Medicare TCOC Relative to Benchmark	2018 Medicare TCOC Rank	2018 Commercial TCOC Relative to Benchmark	2017 Commercial TCOC Rank
Suburban Hospital	-10.14%	1	-36.06%	1
MedStar Southern Maryland Hospital Center	-6.70%	2	-28.54%	7
Doctors Community Hospital	-4.86%	3	-31.06%	6
Fort Washington Medical Center	-3.80%	4	-21.35%	23
Howard County General Hospital	-2.22%	5	-32.32%	3
Shady Grove Adventist Hospital	-2.05%	6	-31.64%	4
Anne Arundel Medical Center	-1.33%	7	-31.15%	5
Washington Adventist Hospital	2.03%	8	-26.22%	11
MedStar Montgomery Medical Center	2.69%	9	-32.46%	2
Calvert Memorial Hospital	2.86%	10	-26.77%	9
Holy Cross Hospitals	2.89%	11	-28.02%	8
MedStar St. Mary's Hospital	5.28%	12	-13.24%	37
Prince Georges Hospital Center	5.39%	13	-22.23%	20
University of Maryland Charles Regional Medical Center	6.02%	14	-21.83%	22
Garrett County Memorial Hospital	7.79%	15	3.01%	43
University of Maryland Baltimore Washington Medical Center	10.19%	16	-24.27%	15
Frederick Memorial Hospital	10.22%	17	-25.04%	14
University of Maryland Shore Medical Center at Dorchester	11.60%	18	-23.21%	17
University of Maryland Shore Medical Center at Easton	11.60%	18	-12.07%	38
University of Maryland Shore Medical Center at Chestertown	13.29%	20	-12.02%	40
MedStar Union Memorial Hospital	13.87%	21	-13.68%	36
St. Agnes Hospital	14.13%	22	-23.55%	16
Greater Baltimore Medical Center	14.37%	23	-20.28%	26
Johns Hopkins Hospital	14.42%	24	-20.79%	25
Meritus Medical Center	14.45%	25	-16.75%	32
Union Hospital of Cecil County	15.43%	26	-3.56%	42
Carroll Hospital Center	15.88%	27	-21.25%	24
University of Maryland St. Joseph Medical Center	16.58%	28	-18.03%	29
University of Maryland Rehabilitation & Orthopaedic Institute	16.60%	29	-26.77%	9
University of Maryland Medical Center	16.60%	29	-25.70%	12
Johns Hopkins Bayview Medical Center	17.46%	31	-17.82%	30

Mercy Medical Center	17.56%	32	-19.96%	27
University of Maryland Medical Center Midtown Campus	19.01%	33	-23.21%	17
MedStar Franklin Square Hospital Center	19.24%	34	-16.15%	34
Upper Chesapeake Medical Center	19.30%	35	-22.89%	19
MedStar Good Samaritan Hospital	20.32%	36	-9.88%	41
Sinai Hospital	20.99%	37	-14.56%	35
Peninsula Regional Medical Center	21.47%	38	-21.99%	21
Harford Memorial Hospital	21.74%	39	-18.97%	28
Northwest Hospital Center	23.86%	40	-16.30%	33
Western Maryland Regional Medical Center	24.36%	41	-12.05%	39
MedStar Harbor Hospital Center	27.59%	42	-25.13%	13
Atlantic General Hospital	29.41%	43	-17.29%	31

*Dorchester Hospital receives the same TCOC performance as Easton; UMROI receives the same TCOC performance as Midtown Hospital.

Implementation of Efficiency Results

Withholding Inflation from Outlier Hospitals

Staff recognizes that any combination of cost-per-case and total cost of care tools does not precisely identify a hospital's efficiency rank order, especially near the median of performance, and staff believes that implementation of an efficiency policy should align with historical HSCRC policies to focus on the tail ends of the distribution. Moreover, a central limitation in these analyses is that the total cost of care tools are Medicare and Commercial only.

Therefore, staff recommends weighting equally the two rankings from the Volume Adjusted ICC and geographic total cost of care benchmark performance to array hospitals into quartiles, such that hospitals in the bottom quartile will be considered the least efficient and hospitals in the top quartile will be considered the most efficient relative to hospital peers. Finally, staff recommends that the remaining hospitals, deemed inefficient as outlined above, should have the Medicare and Commercial portion of their annual update factor withheld on a sliding scale to recognize gradations in performance.

In reviewing the array of hospitals according to a 50/50 ranking of Volume Adjusted ICC and geographic total cost of care benchmark performance ranking, staff identified eleven hospitals when using an ICC that maintained historical peer groups and ten hospitals when using staff's

proposed alternative approach to adjusting for indigent care that would be subject to an inflation factor reduction[10] See Table 15a and 15b for results:[11]

Table 15a: Inefficient Hospitals as Determined by ICC & Geographic TCOC Rankings (inclusive of existing peer groups) – Efficiency Matrix

Hospital Name	Volume Adjusted ICC Result	ICC Rank (50%)	2018 Medicare TCOC Relative to Benchmark	2018 Medicare TCOC Rank (25%)	2018 Commercial TCOC Relative to Benchmark	2017 Commercial TCOC Rank (25%)	Total Rank Points (Low Score is Better)
MedStar Franklin Square Hospital Center	-15.68%	25	19.24%	34	-16.15%	34	59
Carroll Hospital Center	-19.73%	34	15.88%	27	-21.25%	24	60
University of Maryland Rehabilitation & Orthopedic Institute	-24.80%	41	16.60%	29	-26.77%	9	60
Sinai Hospital	-15.74%	26	20.99%	37	-14.56%	35	62
Western Maryland Regional Medical Center	-14.31%	23	24.36%	41	-12.05%	39	63
University of Maryland Shore Medical Center at Easton	-21.35%	36	11.60%	18	-12.07%	38	64
Harford Memorial Hospital	-18.78%	31	21.74%	39	-18.97%	28	65
University of Maryland Medical Center Midtown Campus	-23.52%	40	19.01%	33	-23.21%	17	65
MedStar Good Samaritan Hospital	-19.03%	32	20.32%	36	-9.88%	41	71
Northwest Hospital Center	-21.69%	37	23.86%	40	-16.30%	33	74
Union Hospital of Cecil County	-24.87%	42	15.43%	26	-3.56%	42	75

Table 15b: Inefficient Hospitals as Determined by ICC & Geographic TCOC Rankings (inclusive of alternative approach for indigent care) – Efficiency Matrix

Hospital Name	Volume Adjusted ICC Result	ICC Rank (50%)	2018 Medicare TCOC	2018 Medicare TCOC	2018 Commercial TCOC	2017 Commercial	Total Rank Points

[10] As is always the case, a hospital has a legal opportunity to contest a rate order through the Full Rate Review process, pursuant to Health-General Article §19-222 and COMAR 10.37.10.03 et seq.

[11] For the complete array of hospitals based on ICC ranking and TCOC ranking, see Appendix 5

			Relative to Benchmark	Rank (25%)	Relative to Benchmark	TCOC Rank (25%)	(Low Score is Better)
Harford Memorial Hospital	**-13.47%**	27	21.74%	39	-18.97%	28	61
MedStar Union Memorial Hospital	**-14.81%**	32	13.87%	21	-13.68%	36	61
University of Maryland Shore Medical Center at Easton	**-16.03%**	33	11.60%	18	-12.07%	38	61
Carroll Hospital Center	**-18.60%**	37	15.88%	27	-21.25%	24	63
Northwest Hospital Center	**-13.65%**	28	23.86%	40	-16.30%	33	65
University of Maryland Shore Medical Center at Chestertown	**-17.39%**	35	13.29%	20	-12.02%	40	65
Western Maryland Regional Medical Center	**-13.01%**	26	24.36%	41	-12.05%	39	66
University of Maryland Medical Center Midtown Campus	**-21.24%**	42	19.01%	33	-23.21%	17	67
Union Hospital of Cecil County	**-17.34%**	34	15.43%	26	-3.56%	42	68
Sinai Hospital	**-23.69%**	43	20.99%	37	-14.56%	35	79

Of these hospitals, one was removed from consideration because it already had a preexisting arrangement with the HSCRC to address its cost inefficiencies: University of Maryland Medical Center Midtown Campus. Also of note, seven of the eleven hospitals in Table 15a are deemed inefficient in Table 15b, suggesting rather strong alignment in the results. In fact, the correlation across all quartiles between both ICC assessments (without and without peer groups) is .70 and stronger still when the efficiency matrix scores inclusive of TCOC assessments are considered (R=.83).

For the remaining hospitals in Tables 15a and 15b, staff calculated a withholding from the RY 2022 Update Factor on a sliding scale basis. The withholding is calculated by multiplying the inflationary factor of 2.30 percent [12] by the statewide share of hospital's revenue attributable to Medicare fee for service and commercial (73 percent) and then prorated by a hospital's point distance from the 3rd quartile. Under the peer group approach this would remove $17.7 million in

[12] Current calculations for RY 2022 Update Factor indicate that general inflation for hospitals will be 2.14% and the Demographic Adjustment will be 0.16%, the latter of which is a placeholder from last year due to anticipated delays in population estimates from the Maryland Department of Planning

inflation funding; the withhold increases slightly to $19.9 million under the alternative approach to adjusting for indigent care in lieu of peer groups.

Staff has included in the tables below a comparison between the new proposed scaling and the old scaling logic that removed the entire update factor for all hospitals in the worst quartile and worse than one standard deviation in the ICC. Please note this is only for illustrative purposes, as the actual dollar amount will change when staff updates the scaling to the approved RY 2022 Update Factor, which will be the first time this policy goes into effect.

Table 16a: RY 2022 Update Factor Withhold for Inefficient Hospitals inclusive of existing Peer Groups – Total Potential Withhold of 1.7% (2.3% Update Factor X 73% of Revenue Attributable to Medicare and Commercial Payer Mix)

Worst Quartile Hospitals	Total Points (Efficiency Matrix)	Prior Scaling Policy (No Sliding Scale & One Standard Deviation Rule)	Prior Policy % Withhold	Prior Policy Withhold as % of RY 2019 Margin	New Scaling Policy (Scaling Entire Worst Quartile with Sliding Scale)	New Policy % Withhold	New Policy Withhold as % of RY 2019 Margin
MedStar Franklin Square Hospital Center	59.0	$0	0.0%	0.0%	$532,458	0.1%	1.0%
Carroll Hospital Center	59.5	$0	0.0%	0.0%	$331,788	0.1%	1.5%
UMROI	60.0	$2,147,007	1.7%	61.4%	$238,556	0.2%	6.8%
Sinai Hospital	62.0	$0	0.0%	0.0%	$3,126,121	0.4%	3.9%
Western Maryland Regional Medical Center	63.0	$0	0.0%	0.0%	$1,579,412	0.5%	4.5%
Easton Hospital	64.0	$3,827,918	1.7%	8.8%	$1,275,973	0.6%	2.9%
Harford Memorial Hospital	64.5	$0	0.0%	0.0%	$658,221	0.6%	8.3%
Midtown Hospital	65.0	$0	0.0%	0.0%	$0	0.0%	0.0%
MedStar Good Samaritan Hospital	70.5	$0	0.0%	0.0%	$3,173,495	1.2%	64.1%
Northwest Hospital Center	73.5	$4,603,593	1.7%	11.3%	$3,964,205	1.4%	9.7%
Union Hospital of Cecil County	76.0	$2,837,422	1.7%	20.5%	$2,837,422	1.7%	20.5%
Total		**$13,415,941**			**$17,717,651**		

Table 16b: RY 2022 Update Factor Withhold for Inefficient Hospitals with Alternative Approach to Peer Groups – Total Potential Withhold of 1.7% (2.3%

Update Factor X 73% of Revenue Attributable to Medicare and Commercial Payer Mix)

Worst Quartile Hospitals	Total Points (Efficiency Matrix)	Prior Scaling Policy (No Sliding Scale & One Standard Deviation Rule)	Prior Policy % Withhold	Prior Policy Withhold as % of RY 2019 Margin	New Scaling Policy (Scaling Entire Worst Quartile with Sliding Scale)	New Policy % Withhold	New Policy Withhold as % of RY 2019 Margin
Harford Memorial Hospital	60.5	$0	0.0%	0.0%	$93,475	0.1%	1.2%
MedStar Union Memorial Hospital	60.5	$0	0.0%	0.0%	$369,458	0.1%	1.6%
Easton Hospital	61.0	$0	0.0%	0.0%	$294,455	0.1%	0.7%
Carroll Hospital Center	62.5	$3,981,459	1.7%	18.0%	$612,532	0.3%	2.8%
Northwest Hospital Center	64.5	$0	0.0%	0.0%	$1,180,409	0.4%	2.9%
Chestertown Hospital	65.0	$0	0.0%	0.0%	$242,269	0.5%	19.6%
Western Maryland Regional Medical Center	66.0	$0	0.0%	0.0%	$1,895,295	0.6%	5.4%
University of Maryland Medical Center Midtown Campus	67.0	$0	0.0%	0.0%	$0	0.0%	0.0%
Union Hospital of Cecil County	68.0	$0	0.0%	0.0%	$1,236,825	0.7%	8.9%
Sinai Hospital	79.0	$14,067,543	1.7%	17.6%	$14,067,543	1.7%	17.6%
Total		**$18,049,001**			**$19,992,261**		

Global Budget Revenue Enhancements

As noted above, this recommendation also outlines the process by which hospitals will be evaluated when GBR enhancement requests are submitted to HSCRC staff. Specifically, for a hospital to receive a GBR enhancement, it must be in the best quartile of performance as evaluated in the Efficiency Matrix; it must be better than one standard deviation from average Volume Adjusted ICC performance (1.05 times the ICC standard); and it must submit a formal request to HSCRC staff that outlines either: a) how a previous methodology disadvantaged the hospital; or b) a spending proposal that aligns with the aims of the Total Cost of Care Model.

Because this recommendation still requires hospitals to submit a formal proposal to successfully receive a GBR enhancement, staff will not outline the exact amounts a hospital may receive under such a policy. However, in Tables 17a and 17b below, staff does identify the hospitals that currently would be eligible for a GBR enhancement:

Table 17a: Hospitals Eligible for a GBR Enhancement in RY 2021 (with existing ICC peer groups)

Hospital Name	Volume Adjusted ICC Result	ICC Rank (50%)	2018 Medicare TCOC Relative to Benchmark	2018 Medicare TCOC Rank (25%)	2018 Commercial TCOC Relative to Benchmark	2017 Commercial TCOC Rank (25%)	Total Rank Points (Low Score is Better)
Suburban Hospital	-3.56%	4	-10.14%	1	-36.06%	1	5
Garrett County Memorial Hospital	4.14%	1	7.79%	15	3.01%	43	30
Mercy Medical Center	3.06%	2	17.56%	32	-19.96%	27	32
MedStar Union Memorial Hospital	-4.16%	5	13.87%	21	-13.68%	36	34

Table 17b: Hospitals Eligible for a GBR Enhancement in RY 2021 (with alternative proposal to adjusting for indigent care)

Hospital Name	Volume Adjusted ICC Result	ICC Rank (50%)	2018 Medicare TCOC Relative to Benchmark	2018 Medicare TCOC Rank (25%)	2018 Commercial TCOC Relative to Benchmark	2017 Commercial TCOC Rank (25%)	Total Rank Points (Low Score is Better)
Howard County General Hospital	-3.91%	6	-2.22%	5	-32.32%	3	10
Holy Cross Hospitals	-2.36%	5	2.89%	11	-28.02%	8	15
Fort Washington Medical Center	2.75%	2	-3.80%	4	-21.35%	23	16
University of Maryland Shore Medical Center at Dorchester	-1.85%	4	11.60%	18	-23.21%	17	22
Garrett County Memorial Hospital	6.49%	1	7.79%	15	3.01%	43	30

maryland
health services
cost review commission

Stakeholder Comments and Staff Response

Staff received comment letters from five stakeholders and several verbal comments from Commissioners. Most comments were focused on the following topics and will be discussed together:

Implementation Timeline	Concern over 50/50 weighting of Medicare and Commercial TCOC
Benchmarking (Appropriate Vetting, Proprietary Information, Winners and Losers – Rural/Urban//Border)	**Benchmarking moving away from All-Payer focus**
Inclusion of Price in Benchmarking may Skew Results	**Revenue Neutrality**
Inclusion of Attainment and Improvement for TCOC Analyses	**Rebasing Global Budget Volumes**
Scaling vs Standard Deviation Approach	**Enhanced Review of Hospital Overhead and TCOC Model Investments**

CareFirst addressed separate topics and will be discussed individually:

- Concern over hospitals potentially being stuck in the penalty zone
- Coding improvements influencing hospital's position in the efficiency analysis

Topic	MHA, UMMS, Luminis, Commissioners	CareFirst
Delay Implementation	- Various hospitals and the Maryland Hospital Association expressed concern over implementing the Integrated Efficiency Policy in January due to the ongoing public health emergency and because stakeholders need additional time to validate the TCOC benchmarking methodology. - MHA also requested delay so that HSCRC staff may continue its work in assessing the validity of peer groups and the allowed medical residents in the ICC methodology. - Commissioners supported a delayed implementation in the November Commission meeting by requesting that staff bring forward another Draft Recommendation for the Integrated Efficiency Policy in December with a planned implementation for July 1, 2021.	CareFirst noted that an efficiency methodology be implemented as soon as possible to ensure that individual hospital costs do not become unreasonable relative to their competitors.

Staff brought forward the Integrated Efficiency policy with an implementation date of January 1, 2021 so that Commissioners had the option to promulgate the policy in RY 2021. In light of the Commissioner's directive to delay implementation to July 1, 2021, staff's Final Recommendation for the Integrated Efficiency Policy will be introduced in April 2021 and will affect inflation for RY 2022 - modelling results will change based on approved RY 2022 inflation.

Delay provides benefits to policy development including: revised scaling approach; future removal of unreliable RY 2020 volume; and additional work on peer group and allowed medical residents in ICC methodology.

Topic	Maryland Hospital Association	Johns Hopkins Health System	University of Maryland Medical System	Luminis Health
Appropriate Vetting	Hospitals support an attainment measure. However, MHA recommends delaying its use. Implementing inflation withholds on or after July 1, 2021 will allow hospitals adequate time to consider the benchmarking methodology.	The benchmarking methodology needs further evaluation by the hospital industry and Commissioners, including the longer-term cost savings target proposed by staff.	Hospitals need more time to evaluate and understand such a complex analysis.	The open and transparent workgroup process has eroded over time as much of the detail for developing and applying methodologies is not publicly documented and requires persistent discussion with the staff to obtain the details of relevant calculations when a hospital wishes to replicate the work
Proprietary Information		The Commercial benchmarks that are being used are based on Milliman data, a proprietary source that cannot be recreated by the hospitals or broader industry to validate without purchasing the data. This is contrary to the transparency of other HSCRC and industry supported methodologies.		Construction of policies based on confidential data so that stakeholders cannot replicate the policies or test the sensitivity of models to methodology choices.
Winners and Losers			Hospitals located in wealthier jurisdictions tend to have better TCOC results while hospitals serving poor rural or urban jurisdictions perform poorly Border hospitals tend to perform better in the Medicare benchmarking due to the number of patients who seek care outside Maryland at lower payment rates	This policy has clear winners (Montgomery, Howard, Anne Arundel County) and losers (Baltimore City/County, Eastern Shore, other rural areas). Hospitals that are primarily compared to counties and MSAs on the East or West coast do relatively well, while hospitals compared to those in the rest of the country fare far worse.

Staff recognized that the release of the final benchmarks was delayed as part of the slowdown due to the COVID crisis. However, the fundamental process has been discussed for almost 2 years, and peer groups and preliminary results were released in late 2019. Peer groups have not changed, and results were similar to those in the final version, which was released August 31st including extensive supporting data.

In the two months since the data release, no specific technical issues have been raised, and HSCRC did not receive any comments on peer groups or the approach used following data shared in late 2019. Moreover, due to the delay in Integrated Efficiency policy, per Commissioners' directive, revenue

adjustments based on this methodology will be made in July of 2021, giving hospitals sufficient time to understand the payment implications of the benchmarking.

In terms of proprietary information, the source of the national commercial TCOC data is Milliman, which is recognized as an industry leader. The hospitals have free access to extensive detail behind the commercial benchmarks and to date staff has received no specific questions.

Finally, staff would note that it agrees that unintentionally punishing poorer areas is not a desirable outcome. However, the benchmarking methodology includes extensive risk/demographic adjustments, and claiming that the risk/demographic adjustment is insufficient because it results in an unfavorable comparison for some urban hospitals is assuming a conclusion with no substantive evidence.

Topic	University of Maryland Medical System	Luminis
Price Inclusion in TCOC Benchmarks	The inclusion of price in the benchmark analysis skews results and tends to place urban and suburban areas at a disadvantage. Utilization performance should be considered as an alternative to measuring performance to eliminate some of the price disparity caused by our all-payer model	The benchmark comparison should be limited to utilization variances since price is addressed through the ICC calculation. Measuring only utilization would eliminate price differences due to the Maryland All Payer model. Limiting price considerations in the benchmarks may also eliminate some of the inequities resulting from the construction of the national peer groups.

Staff does not agree with the Luminis comment that price is addressed through the ICC calculation. While it is true that the ICC measures cost per hospital case and is therefore a good proxy for hospital prices, it does not address pricing variation for total cost of care. Moreover, measuring price in the context of TCOC differentiates between: a) good price inefficiency that lowers TCOC by reinvesting retained revenue in efforts to reduce TCOC; and b) bad price inefficiency, which results from a failure to capture and reinvest costs released by lower volumes. The ICC methodology by itself does not differentiate between the two and risks rewarding the latter behavior.

Topic	University of Maryland Medical System	Johns Hopkins Health System	Luminis
Including Attainment and Improvement	TCOC measure should include both attainment and improvement, similar to the approach taken with the quality policies	Only measuring growth or only measuring attainment could disadvantage hospitals with very low TCOC relative to peers or hospitals that have shown reductions to TCOC but have not yet reached a benchmark.	Any benchmarking methodology needs to provide for both an attainment and improvement measure. This is consistent with the approach of other HSCRC programs such as the Readmissions Reduction Incentive Program

Staff remains concerned about the reliability of TCOC improvement statistics to determine relative efficiency for the following reasons: a) Improvement analysis is inappropriate in a relative efficiency analysis that redistributes revenue among hospitals; b) Hospitals with smaller attributed TCOC dollars have very unstable growth statistics; c) They add additional complexity that may not differentiate hospitals' rank order substantively; and d) Inclusion of TCOC growth would likely require additional, perhaps arbitrary weighting in the Efficiency Matrix.

Staff notes that penalties in this policy are now scaled so a poor attainment hospital receives a penalty that is likely minimal versus its attainment shortfall, and as long as the hospital improves, it will have ample time to avoid the penalty before the impact becomes material.

Finally, staff offers for Commissioner consideration, that in lieu of relative efficiency assessment, improvement could be considered as an exemption from a penalty.

Topic	Maryland Hospital Association	Luminis	CareFirst	Commissioners
Scaling Approach	MHA agrees with HSCRC staff's conclusion that the policy should apply to hospitals that are clearly outliers so as not to counteract utilization management incentives.	A continuous scaling logic (rather than just addressing outliers) may better address the apparent inequity between rural/urban hospitals, may reduce the extent to which this policy penalizes smaller hospitals that operate on thin margins, and more appropriately penalize hospitals with retained revenue that do not look inefficient largely due to geographic location, while also more aggressively addressing the variation in the system.	The approach of quartiles and one standard deviation on the ICC is called into question given the small size of the revenue withheld from hospitals in this policy. While the ICC distribution does represent a normal distribution, that does not imply that costs below the mean plus one standard deviation are reasonable. Therefore, CareFirst recommends that these thresholds continue to be evaluated over time to ensure that they are truly capturing the outlier hospitals.	Commissioners likewise share CareFirst's concerns that the policy does not remove more revenue and believe hospitals are inappropriately incentivized by the policy to maintain cost per case variation up to one standard deviation from average performance. Moreover, Commissioners expressed concerns about the cliff effect of using a one standard deviation rule and withholding the same revenue percentage among all outlier hospitals despite gradations in performance in the worst quartile.

Staff still holds that the policy should focus on outliers and believes that the measure of an effective efficiency policy is not how much revenue is withheld from hospitals. Given concerns over the cliff effect and the lack of recognition of performance variation in the worst quartile, staff has presented in the revised draft recommendation a continuous scaling approach that will withhold revenue for all hospitals in the worst quartile. Staff still notes that there is a cliff effect between the 3rd and 4th quartile in this proposal.

Topic	Johns Hopkins Health System	Luminis
50/50 Weighting of Med/CO TCOC	Not considering the significant payor mix differences in Maryland's hospitals could have an unintended consequence of disadvantaging a hospital based on payor mix	Concerned that the policy assumes a 50/50 attainment measurement mix between Medicare and Commercial payers, not taking into account the significant payer mix differences in Maryland's hospitals.

Staff's weighting of Medicare and Commercial TCOC performance at 50 percent each for the 50 percent TCOC component of the policy (i.e., 25 percent for each TCOC assessment) was purposeful. Given the all-payer nature of Maryland hospital rate setting that advantages commercial payers relative to national peers, and disadvantages Medicare, and the fact that price is not removed from the benchmarks, the 50/50

weighting for all hospitals ensures that no hospital has an advantage due to its unique payer mix in an all-payer state

Specifically, hospitals with larger commercial shares are not artificially advantaged. One potential downside to this approach is that if a hospital has a low, unrepresentative share of an individual payer that then comprises 25% of the efficiency assessment. However, analysis of CY 2019 Hospital Payer Mix indicates that no hospitals fall below 2 standard deviations in Medicare or Commercial payer shares relative to the statewide average, and very low coefficient of variation for Medicare (.28) and Commercial (.16) payer mix corroborate the idea there is limited variation.

Topic	Johns Hopkins Health System	Luminis	Commissioners
Diminished All Payer Focus	The goal of driving Medicare to national benchmarks while preserving Commercial rates that are nearly 25% below the nation is counter to the All Payer Model and reduces the value of the Waiver. Methodologies that would eliminate the difference would preserve the problems of the national Medicare fee-for-service system while constraining hospitals from charging rates to commercial payers in line with the nation.	The benchmarks focus on Medicare and not All Payer targets: The goal of driving Medicare to national benchmarks while preserving Commercial rates that are nearly 25% below the nation is counter to the All Payer Model and eliminates the value of the Waiver. Methodologies that would eliminate the difference would preserve the problems of the Medicare fee-for-service system (inpatient rates barely above breakeven and outpatient rates that do not cover costs) while constraining hospitals from charging rates to commercial payers in line with the nation.	Some Commissioners have noted generally that the all-payer aspect of the Model, which has been a hallmark of the hospital payment system in Maryland for over forty years, must be underscored in all policies.

Staff agrees that the TCOC Model and all its supporting methodologies/policies should reflect an all-payer perspective. Staff notes, however, that comparing hospitals to a TCOC benchmark average and then relatively ranking hospitals based on percentage variation from that benchmark in order to scale inflation does not eliminate the higher governmental reimbursement for hospitals in Maryland.

Future policies that use TCOC benchmark performance as a defined attainment standard will need additional scrutiny to ensure the all-payer tenets of the Model are not compromised. It should also be noted

that currently it is not possible to create an all-payer total cost of care assessment due to the dearth of national Medicaid cost data.

Staff still holds that the policy is not the means by which system savings should be generated. Its purpose

Topic	Maryland Hospital Association	Johns Hopkins Health System	CareFirst	Commissioners
Revenue Neutrality	We agree that if revenues are reduced for high-cost hospitals (as HSCRC defines such), the full sum of this reduction should be available to be redistributed within the system. None should be withheld.	JHHS believes that the efficiency policy should be revenue neutral on a statewide basis. If high cost hospital's revenues are reduced, the full sum of this reduction should be available within the system and no portion should be withheld.	Dollars derived from withholding the update factor from poor performing outlier hospitals should be passed along as savings to purchasers of hospital care who have been paying more for those inefficient services.	Various Commissioners have noted that staff should consider using the efficiency assessments and the associated policy to accrue system savings.

is to correct maldistribution of global budget revenue in the Model, i.e., to redistribute all revenue removed from inefficient hospitals to efficient hospitals. Savings have been realized and should continue to be generated through the Annual Update Factor Policy, which on a statewide basis holds hospitals accountable for Medicare total cost of care and hospital affordability, while not upending the central incentive of the Model to reduce avoidable utilization.

Staff remains concerned about purchasers paying more for inefficient services but would note that the current cost sharing concern for purchasers is restricted to Medicare Outpatient coinsurance, as that is the only purchaser scenario with cost sharing arrangements resulting in higher required payments relative to national peers. Future policy development should focus on alleviating cost sharing concerns by revising reimbursement methodologies that do not upend the central incentive of the Model to reduce avoidable utilization.

Staff, therefore, strongly recommends maintaining revenue neutrality in this policy. If Commissioners do not concur with staff's recommendation, staff would ask Commissioners to consider savings generated by this policy in the various total cost of care and affordability tests employed in the Annual Update Factor Policy.

Topic	Maryland Hospital Association	Johns Hopkins Health System
Rebasing Global Budget Volumes	MHA asks the HSCRC to set annual unit rates using volumes from the most recent 12-month period preceding the rate order, citing the complexity of measuring monthly rate compliance and adjusting unit rates, as well as the reduced need for maintaining 2013 volumes once the efficiency policy is implemented.	JHHS believes that if the staff recommendation is approved that staff should set annual unit rates using volumes from the most recent 12-month period preceding the rate order. We appreciate the need to hold hospitals accountable to GBR targets, and the efficiency policy will reduce overall GBR revenues for outlier hospitals

Staff is supportive of rebasing global budget volumes should an efficiency policy be implemented for the following reasons:

- Stakeholders are correct about administrative concerns regarding corridor compliance
- Rebasing volumes will increase the incentive to reduce avoidable utilization, especially for hospitals that are at or are approaching corridor limits

Topic	Maryland Hospital Association	CareFirst	Commissioners
Overhead and Investment Review	HSCRC's intent to quantify investments in unregulated settings in order to provide credit to hospitals in the ICC is appropriate. However, hospitals have serious concerns about HSCRC staff judging which hospital investments are worthwhile. As the regulator, the commission should set broad goals and targets that satisfy our Model agreement and meet the triple aim	The rapid growth in unregulated costs and losses over the course of the past five years is unsustainable and continues to be funded by increased regulated profits. Increased reporting requirements and transparency are critical so that HSCRC Staff can ascertain which unregulated operations are contributing to the goals of the model. Hospitals cannot be given credit for the work they are doing in their unregulated operations until the full picture is understood, especially since they are now a major cost driver in the system.	Various Commissioners have expressed concerns that the largest source of unregulated losses, physician subsidies, are necessary to operate a hospital, and the current regulatory authority of the HSCRC has prevented the Commission from appropriately accounting for a key component of hospital operations. Other Commissioners have also expressed a desire to quantify what regulated margins are subsidizing, especially with regards to potential safe harbors in the Revenue for Reform concept. Finally, several Commissioners have urged staff to establish evaluations of appropriate levels of overhead.

Staff remains committed to establishing a reporting and auditing function for quantifying costs intrinsic to a hospital's operations and in line with the TCOC Model (both regulated and unregulated). The degree to

which these costs are deemed appropriate and therefore eligible for credit in an efficiency assessment will need to need to be determined with industry input and with directives from Commissioners.

Initial thinking on this subject suggests staff would work with stakeholders to establish criteria for ICC credit (required hospital physician services, highlighted in a Community Health Needs Assessment, indicative of an evidence-based model, etc.) in lieu of Commission staff evaluating each unregulated investment. Staff believes that while establishing methodologies for capturing appropriate levels of overhead is necessary and important, it cannot be done "…until the full picture is understood."

Topic	CareFirst Comment	Staff Response
Stuck Phenomenon	In the past, similar threshold policies [worst quartile and an outlier on price] created a "stuck hospital" phenomenon where there was little opportunity for hospitals to get to the next level. As part of an ongoing evaluation, Staff should consider whether this phenomenon is occurring under the new policy.	Staff concur that future iterations of the Integrated Efficiency Policy should address the extent to which hospitals can improve such that they are not penalized. In any relative ranking methodology, this is a possible outcome and is partially why staff advocated for an exemption to the policy if a hospital fell below a pricing outlier threshold, i.e. one standard deviation from average performance on the ICC. Given the significant stakeholder support expressed for using both TCOC attainment and improvement in the efficiency assessment (which staff believes is difficult to do in a relative ranking methodology) staff would like to suggest for Commissioner consideration the idea that successful TCOC growth (i.e. improvement) allow a hospital to be exempted from penalties in the Integrated Efficiency Policy threshold to be determined. This would provide a way for a hospital to avoid getting stuck in a penalty zone by virtue of sorting in a relative ranking methodology that assesses attainment only. Staff would note that the tradeoff for this proposal is it will reduce the dollar impact in the policy.
Coding Improvements	Staff should consider whether coding improvement is influencing hospitals' positions in the results of the efficiency outlier methodology.	Staff agree that analyses of coding should occur to establish if efficiency assessments are yielding artificial results. Staff would note though that for the ICC possible coding improvement is restricted to the volume statistic (ECMADS), and this is regularly audited as it has significant impact on other methodologies, most notably Market Shift and the Demographic Adjustment. For TCOC assessments, the analysis is restricted to costs per population and is therefore not manipulable.

Future Policy Considerations

While staff believes the efficiency methodologies and implementation proposal are sound, staff acknowledges that additional work could further refine the ICC and total cost of care analyses. Staff describes below various work streams to improve the efficiency methodologies.

1) Medium term - Staff will work to include national analyses that were completed for inpatient efficiency evaluations of the State's two major academic medical centers. Staff plans to complement these analyses by incorporating them into an outpatient-only ICC that will effectively evaluate the State's two academics both on a national level for inpatient services and on a Maryland peer group level for outpatient services. Completion of this task is contingent upon submission from Johns Hopkins Hospital and University of Maryland Medical Center, per the agreement proposed in the Innovation Policy and prior Update Factor recommendations.
2) Medium term – Staff is also engaging an outside contractor to review the adequacy of current physician supply by specialty by region. This analysis will incorporate out year demand projections, inclusive of Maryland's role as a net exporter of medical professionals, and will be used to determine the allowed residents in the ICC analysis. This task should be completed in January of 2021.
3) Long term - Staff will continue the work to quantify the investments hospitals are making in unregulated settings that are in line with the incentives of the Total Cost of Care Model, thereby providing a path for hospitals to acquire credit in the ICC evaluation when retained revenues are used to improve health outcomes.

In terms of total cost of care, staff will focus on maintaining the total cost of care analyses and updating them each year with new data. Additionally, staff will explore developing Medicaid benchmark analyses, but it should be noted that data nationally on Medicaid total cost of care is far less robust than Medicare and commercial data.

Short and medium term adjustments to the ICC may have effects on hospitals' current efficiency rankings and whether a hospital is eligible for revenue adjustments in the Integrated Efficiency policy, although it should be noted that prior modernization efforts, such as the overhaul of the casemix methodology, did not substantially alter results. Nevertheless, Commissioners should consider this when determining the implementation date for the Integrated Efficiency policy.

Recommendations

1) Formally adopt policies to
    a. Determine hospitals that are relatively inefficient;
    b. Evaluate Global Budget Revenue enhancement requests using the criteria identified above;
2) Use the Inter-Hospital Cost Comparison, including its supporting methodologies to compare relative cost-per-case for the above evaluations;
    b. Adopt a risk adjustment for indigent care cost variation that will be applied to all efficiency policies
3) Use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance for the above evaluations;
4) Withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals based on criteria described herein; and
5) Use set aside outlined in the Annual Update Factor and funding secured from withhold from outlier hospitals to fund potential Global Budget Revenue enhancement requests.

Appendix 1: Revised Casemix Methodology Discussion

Fundamental to a sound efficiency methodology is a reliable volume statistic that accounts for acuity and expected cost differences, as not all services require the same level of care and resources. The HSCRC historically has had a reliable inpatient casemix adjusted volume statistic that outputs relative weights to measure the relative cost or resources needed to treat a mix of patients at a given Maryland hospital using specific APR-DRG/severity of illness levels.[13]

The calculation of relative weights used by Maryland hospitals, which in many respects is just creating ratios based on average charges (adjusted for price differences among hospitals), has been the following since the adoption of the APR-DRG Grouper in 2004 for all hospitals:

1) Use the outlier trim methodology to adjust charges for outlier cases so that the maximum charge equals the trim limit.
2) Calculate an average charge per case in each APR-DRG/severity category.
3) Calculate a statewide average charge per case (CPC).
4) Divide the cell average by the statewide average to generate the cell weight.
5) Calculate hospital-specific relative weights as follows:
    a) For each hospital i, calculate the average charge per case-mix adjusted discharge: C(i).
    b) For the state as a whole, calculate the average charge per case-mix adjusted discharge: C.
    c) For each hospital, calculate a standardizing factor: S(i) = C(i) / C.
    d) For each hospital, adjust its charges to the state level by dividing by S(i).
    e) Recalculate the case-mix weights using the standardized charges.

[13] At a summary level, the case-mix index (CMI), which is the average value of the relative weights for the patients at a given hospital, identifies how resource needs vary across groups of patients and hospitals.

f) Go back to step 6a and repeat until the changes in weights are minimal or non-existent.

7) Calculate the average weight per APR-DRG/severity category.

8) Adjust the weights in low volume cells (cells with less than 30 cases) by blending the average weight per APR-DRG/severity category in step 7 with the 3M National Relative Weights.

9) Adjust the weights to be monotonically increasing by severity of illness.

10) Normalize the weights to a statewide CMI of 1.00.

Despite the general consensus that the inpatient casemix methodology is sufficient, the HSCRC historically has had a less reliable outpatient casemix methodology. The first reason for this is because of cycle billed claims where unique hospital billing practices created inconsistent data for determining relative weights across hospitals. Additionally, procedures that can occur in multiple outpatient settings and are different in service intensity[14] were not separated from one another in weight development, thereby creating weights not indicative of the intensity of resources that must be applied in an emergency room versus a clinic..

These concerns mattered less for the first few years of the All-Payer model because the principal use of outpatient weights in HSCRC methodologies was the Market Shift Adjustment, a methodology that evaluates growth. If the inconsistent measurement were present in both the base and performance period for the Market Shift, the issue was of less concern as long as the billing method did not change at a hospital. However, because efficiency methodologies evaluate a single period of time and inter-hospital comparisons, the concerns over inconsistent and unreliable outpatient weights became more pressing once the moratorium on rate reviews was lifted in November of 2017.

[14] In the past, HSCRC applied special weighting differences on the coded severity levels 1 through 5 of an emergency room visits. However, multiple studies have documented coding variations and upcoding in the emergency room. As a result, HSCRC is using the standard method included in the outpatient grouper, which takes into account diagnoses and other coded information to assign emergency room cases to an EAPG. The EAPG grouper assigns medical cases based on diagnosis. In the most recent casemix iteration, HSCRC has separated emergency room and clinic cases to provide higher weights to emergency room cases given the higher resources that must be provided to patients presenting in the emergency room.

The Commission prioritized the need to develop a sufficient outpatient methodology for purposes of evaluating hospital cost efficiency and evaluating ongoing volume changes. Staff worked with industry and additional stakeholders to create a new outpatient weighting approach that utilized a similar methodology to the inpatients weighting system but also did the following:

(1) All claims, including cycle-billed claims (i.e., accounts where patients are billed monthly) were parsed out into visits, which allows accurate and consistent visit weights to be applied to oncology services, clinics, outpatient psychiatry, and physical therapy;

(2) Emergency room and clinic visits were given different weights, with higher weights allotted to emergency room patients, replacing an approach that used the same weight regardless of hospital site of service;

(3) All coded claims lines (i.e., all claims lines with a CPT or HCPCS code) were used to ensure more accurate weight development, replacing an approach where only 45 claim lines were used in weight development and Enhanced Ambulatory Patient Grouping ("EAPG")[15] assignment – possible because of enhanced computing power;

(4) Outpatient services within 5 days of one another that had similar care profiles were repackaged into visit episodes to ensure that all charges associated with an episode of care (e.g., supply charges for surgery) were not weighted independently of one another.

(5) Oncology and infusion drugs were removed from the oncology services portion of the claim, allowing oncology services to be weighted independent of oncology drugs, thereby allowing oncology services to be evaluated through Market Shift and oncology and infusion drugs to continue be evaluated through the CDS-A process.[16]

During the process of assessing the construct validity of new casemix methodology, the HSCRC employed Mathematica Policy Research (MPR). MPR concluded that improvements to the

[15] EAPGs are a 3M product, which results from the assignment of encounters to clinically meaningful outpatient groupings, similar to inpatient DRG groupings.

[16] The CDS-A accounts for usage changes in high cost oncology and infusion drugs, and provides a hospital specific adjustment based on 50 percent of estimated growth. The remainder of drug cost growth is provided through a targeted inflation adjustment. For additional detail on the new casemix methodology, please see Appendix 2.

casemix methodology resulted in better recognition of clinical severity, as evidenced by improved monotonicity and goodness of fit.

Specifically, to evaluate monotonicity, which means services of increasing complexity are assigned weights of increasing magnitude, MPR employed a clinical expert to conduct a review of the 564 EAPGs. The EAPGs were categorized and combined into 25 different clinically compatible service areas such as general medicine, gastroenterology, general surgery, and oncology. Within each service area, the EAPGs were then ranked by level of clinical complexity on a scale of 1 to 5, where 1 is least complex and 5 is most complex. For example, in the category of general medicine, a level one ranking includes vaccine administration and a level 5 ranking includes the treatment of AIDS. The rankings in each service area were then reviewed by another clinical expert to reach consensus. Then using a fixed effects regression, MPR evaluated the weighting difference from level 5 to level 1. Table A below demonstrates that for each level the weight is significantly higher than the weight in the level below:[17]

Table A. Regression results for association between procedure groups and severity levels of ECMADs on EAPG weight (all ECMADs)

EAPG Weight	Number of EAPGs	Coefficient	Std Err	t	Difference	T of difference
Level 5 (omitted)	79	-	-	-	-	-
Level 4	110	-0.435*	0.133	3.27	-0.435*	3.27
Level 3	149	-0.936*	0.127	7.36	-0.501*	4.09
Level 2	179	-1.506*	0.125	12.02	-0.570*	4.66
Level 1	189	-1.873*	0.123	15.20	-0.367*	3.28

EAPG = enhanced ambulatory patient grouping; ECMAD = equivalent casemix adjusted discharge; Std Err = standard error; T = T-statistic

* Significantly different than 0, p<.05

Finally, to evaluate goodness of fit or the predictive accuracy of the outpatient weights, MPR evaluated Winsorized charges, i.e., removing charges below the 5th percentile and above the 95th

[17] MPR also estimated the proportion of EAPGs with weights within the range predicted by their severity level (1-5). The weight falls in the correct range when the ECMAD for a given EAPG is within the bounds of the predicted severity level. They found that 45.5 percent of EAPG high type combinations were within those bounds. They found that 70.7 percent were within the ECMAD range including EAPGs one level lower and one level higher.

percentile, and determined that the R2 was .726, suggesting that the new weighting system had a very high degree of explanatory power.

Appendix 2. Outpatient Casemix Methodology Steps

A. Group and Assign Outpatient Records a Principal EAPG Type & APG High Type

- ***Step 1: Group Data***
  - Outpatient data grouped using the EAPG grouper version 3.12 (change from the EAPG grouper version 3.8 previously used)
    - An EAPG is identified for every CPT that is coded in the record
    - Medical visits also use ICD-10 diagnosis codes for grouping
    - Each record can contain hundreds of EAPGs

- ***Step 2: Exclude Observation Cases***
  - If the Observation Rate Center units in any outpatient visit record are greater than 23 hours, the entire record is excluded from the outpatient weight assignment calculation.
  - Future consideration may be given to maintaining outpatient visits greater than 23 hours in the outpatient data set when developing weights for purposes of the ICC

- ***Step 3: Assign Principal Record Type***
  - A principal EAPG Type is assigned to all records
    - HSCRC applies a hierarchy based on EAPG Type
      - Each CPT code is linked to an EAPG, and each EAPG is linked to an EAPG Type
  - The records are categorized by APG High Type and assigned in hierarchy as follows:
    - Type 2: Oncology Related Services
    - Type 8: Oncology Drugs
    - Type 5: Rehab and Therapy
    - Type 6: Psychiatric Visits
    - Type 4: ED Visits
    - Type 1: Significant Procedures
    - Type 3: Non-ED Visits

- ☐ Type 7: Other Visits

☐ ***Step 4: Consolidating cases into records - for APG High Type Oncology Related Services (ORS)***

- ☐ All aggregated outpatient records per APG High Type are unbundled and parsed out by service dates
  - ☐ Each identified EAPG within the APG High Type has its own service date
  - ☐ Visits with a length of stay (LOS) 5 days or less are assigned the same service date as their corresponding APG High Type
- ☐ Consolidate into one record all EAPGs associated with ORS occurring on the same service date
- ☐ Determine the EAPG with the highest weight within the record (Previously calculated weights are used as the preliminary weight for assigning the high weight)
- ☐ The high weight EAPG is the High Weight EAPG (HIWTAPG)
- ☐ Consolidate into the record any ancillary EAPGs occurring on the same service date as the EAPG with the highest weight within the ORS
- ☐ Any ancillary EAPGs <u>not</u> occurring within the same service date as the high weight EAPG within the ORS is appended back into the outpatient records

☐ ***Step 5: Calculate the total charge***

- ☐ The sum of all EAPG charges in the ORS record
- ☐ The HIWTAPG assumes all charges associated with that record i.e. the total charge

☐ **Step 6: Apply the Trim Logic to the APG High Type by HIWTAPG (Expected Charge)**

- ☐ Trim logic = (the statewide average expected charge by HIWTAPG * 2) or the (the statewide average expected charge by HIWTAPG + 10,000); whichever is greater
- ☐ The expected charge is usually the total charge except where a trim is applied, then the trim charge becomes the expected charge
- ☐ (Step 1-6 is repeated for each APG High Type)

B. Merge all datasets and Calculate expected charges to outpatient categories

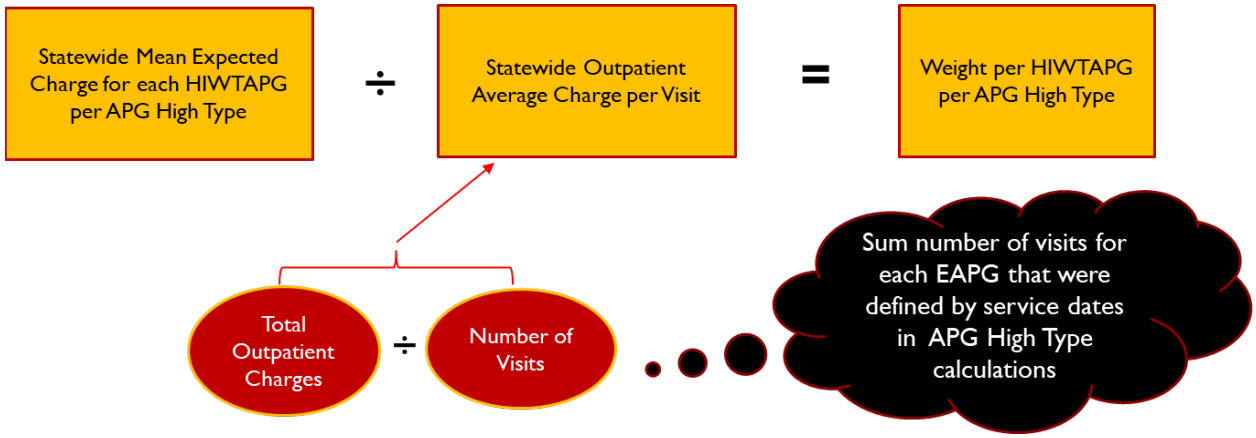
☐ ***Step 7: Merge all eight APG High Types and begin the iterative process of determining weights***

- ☐ **Step a: Calculate the statewide average charge per visit**
  - ☐ The mean of all trimmed charges as determined by the trim logic

- ☐ ***Step b: Calculate the Mean Statewide Expected Charge by APG High Type and HIWTAPG***

- ☐ The mean of expected charges across all hospitals by APG High Type and HIWTAPG

☐ ***Step 8: Calculate initial weights for each APG High Type and HIWTAPG***



☐ ***Step 9: Normalize the Hospital HIWTAPG Expected Charge about the Mean Expected Charge Per Hospital***

- ☐ ***Calculate Hospital Specific Average charge and casemix index (CMI) and hospital specific charge adjustment factor***
  - ***Hospital Specific average charge divided by the hospital specific average CMI = Hospital specific expected charge***
  - ***Hospital specific expected charge divided by the statewide average charge (as determined in step 7a) = Hospital Specific adjustment factor***
  - ***Recalculate the total charge by dividing the initial trim charge by the hospital charge adjustment factor***
- ☐ Perform 31 Iterations as shown above until convergence (hospital specific adjustment factor equals1.00)
- ☐ The final iteration determines the statewide expected charge (as described in step 7b) used for the **final weight calculation** (repeat step 8)

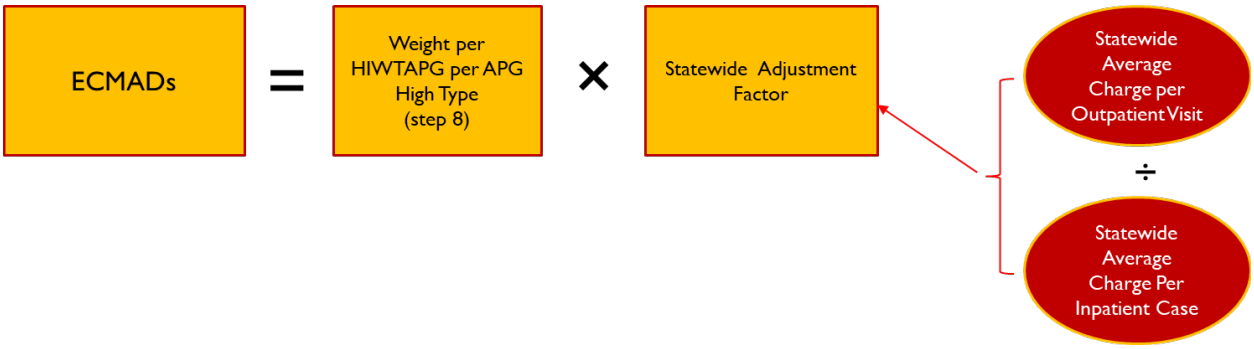
☐ ***Step 10: Assign Principal Record Type by High Weighted EAPG***

- ☐ This overrides step number 3 because in many instances lower acuity services or ancillaries will garner all of the charges associated with that record, most notably within the Significant Procedures High Type.

- ☐ Because weights are reassigned, they have to be checked again for monotonicity and normalized to 1.0.

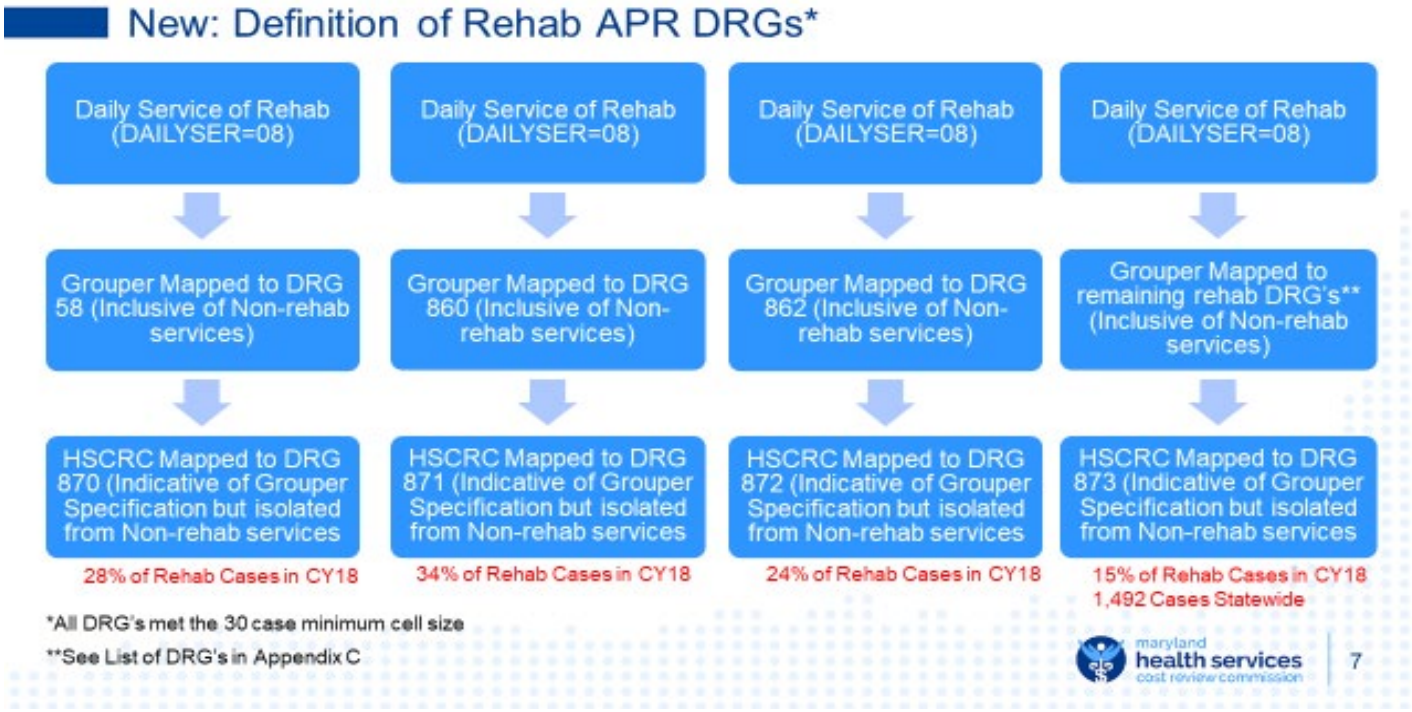
C. Calculate ECMAD

- ☐ ***Step 11: Calculate the Statewide Adjustment Factor*** **= Outpatient Charge per visit divided by Average charge per Inpatient case**
  - ☐ ECMAD is defined as the normalized weight from Step 16 multiplied by the Statewide Charge Ratio Adjustment Factor



maryland
health services
cost review commission

Appendix 3: Rehab Casemix Mapping and Reliability Results



DRG	Severity Level	# of Cases	Average LOS	Average Charge	Coefficient of Variation
58 - OTHER DISORDERS OF NERVOUS SYSTEM	1	354	12	$24,147	0.52
58 - OTHER DISORDERS OF NERVOUS SYSTEM	2	1,331	14	$28,866	0.57
58 - OTHER DISORDERS OF NERVOUS SYSTEM	3	958	17	$35,309	0.61
58 - OTHER DISORDERS OF NERVOUS SYSTEM	4	93	18	$40,232	0.74
860 - REHABILITATION	1	214	8	$18,310	0.51
860 - REHABILITATION	2	1,403	9	$20,070	0.54
860 - REHABILITATION	3	1,376	13	$28,295	0.71
860 - REHABILITATION	4	340	19	$41,478	0.84
862 - OTHER AFTERCARE & CONVALESCENCE	1	404	11	$21,732	0.46
862 - OTHER AFTERCARE & CONVALESCENCE	2	1,197	12	$26,037	0.59
862 - OTHER AFTERCARE & CONVALESCENCE	3	657	13	$30,003	0.71
862 - OTHER AFTERCARE & CONVALESCENCE	4	77	15	$35,958	0.64

maryland
health services
cost review commission

Appendix 5a. Efficiency Matrix with Existing ICC Peer Groups

Hospital Name	Volume Adjused ICC Result	ICC Rank (50%)	2018 Medicare TCOC Relative to Benchmark	2018 Medicare TCOC Rank (25%)	2018 Commercial TCOC Relative to Benchmark	2017 Commercial TCOC Rank (25%)	Total Rank Points (Low Score is Better)
Suburban Hospital	-3.56%	4	-10.14%	1	-36.06%	1	5
Howard County General Hospital	-5.87%	9	-2.22%	5	-32.32%	3	13
Anne Arundel Medical Center	-5.76%	8	-1.33%	7	-31.15%	5	14
Fort Washington Medical Center	-5.73%	7	-3.80%	4	-21.35%	23	21
Holy Cross Hospitals	-6.43%	12	2.89%	11	-28.02%	8	22
Garrett County Memorial Hospital	4.14%	1	7.79%	15	3.01%	43	30
University of Maryland Baltimore Washington Medical Center	-8.50%	15	10.19%	16	-24.27%	15	31
Mercy Medical Center	3.06%	2	17.56%	32	-19.96%	27	32
MedStar Union Memorial Hospital	-4.16%	5	13.87%	21	-13.68%	36	34
MedStar Harbor Hospital Center	-5.73%	6	27.59%	42	-25.13%	13	34
Shady Grove Adventist Hospital	-18.30%	29	-2.05%	6	-31.64%	4	34
Johns Hopkins Hospital	-6.22%	11	14.42%	24	-20.79%	25	36
Frederick Memorial Hospital	-11.97%	21	10.22%	17	-25.04%	14	37
Greater Baltimore Medical Center	-7.32%	13	14.37%	23	-20.28%	26	38
Doctors Community Hospital	-19.32%	33	-4.86%	3	-31.06%	6	38
University of Maryland Medical Center	-10.74%	18	16.60%	29	-25.70%	12	39
Atlantic General Hospital	-0.95%	3	29.41%	43	-17.29%	31	40
University of Maryland Charles Regional Medical Center	-13.62%	22	6.02%	14	-21.83%	22	40
Johns Hopkins Bayview Medical Center	-6.12%	10	17.46%	31	-17.82%	30	41
MedStar St. Mary's Hospital	-9.24%	16	5.28%	12	-13.24%	37	41
St. Agnes Hospital	-15.38%	24	14.13%	22	-23.55%	16	43
Peninsula Regional Medical Center	-7.66%	14	21.47%	38	-21.99%	21	44
Prince Georges Hospital Center	-16.96%	27	5.39%	13	-22.23%	20	44
Washington Adventist Hospital	-19.89%	35	2.03%	8	-26.22%	11	45
MedStar Montgomery Medical Center	-22.51%	39	2.69%	9	-32.46%	2	45
Meritus Medical Center	-9.35%	17	14.45%	25	-16.75%	32	46
Upper Chesapeake Medical Center	-11.30%	19	19.30%	35	-22.89%	19	46
University of Maryland Shore Medical Center at Dorchester	-18.43%	30	11.60%	18	-23.21%	17	48
Calvert Memorial Hospital	-22.39%	38	2.86%	10	-26.77%	9	48
MedStar Southern Maryland Hospital Center	-25.56%	43	-6.70%	2	-28.54%	7	48
University of Maryland St. Joseph Medical Center	-11.37%	20	16.58%	28	-18.03%	29	49
University of Maryland Shore Medical Center at Chestertown	-18.01%	28	13.29%	20	-12.02%	40	58
MedStar Franklin Square Hospital Center	-15.68%	25	19.24%	34	-16.15%	34	59
Carroll Hospital Center	-19.73%	34	15.88%	27	-21.25%	24	60
University of Maryland Rehabilitation & Orthopaedic Institute	-24.80%	41	16.60%	29	-26.77%	9	60
Sinai Hospital	-15.74%	26	20.99%	37	-14.56%	35	62
Western Maryland Regional Medical Center	-14.31%	23	24.36%	41	-12.05%	39	63
University of Maryland Shore Medical Center at Easton	-21.35%	36	11.60%	18	-12.07%	38	64
Harford Memorial Hospital	-18.78%	31	21.74%	39	-18.97%	28	65
University of Maryland Medical Center Midtown Campus	-23.52%	40	19.01%	33	-23.21%	17	65
MedStar Good Samaritan Hospital	-19.03%	32	20.32%	36	-9.88%	41	71
Northwest Hospital Center	-21.69%	37	23.86%	40	-16.30%	33	74
Union Hospital of Cecil County	-24.87%	42	15.43%	26	-3.56%	42	76

maryland
health services
cost review commission

Appendix 5b. Efficiency Matrix with Alternative Proposal to Adjust for Indigent Care

Hospital Name	Volume Adjused ICC Result	ICC Rank (50%)	2018 Medicare TCOC Relative to Benchmark	2018 Medicare TCOC Rank (25%)	2018 Commercial TCOC Relative to Benchmark	2017 Commercial TCOC Rank (25%)	Total Rank Points (Low Score is Better)
Howard County General Hospital	-3.91%	6	-2.22%	5	-32.32%	3	10
Suburban Hospital	-7.97%	11	-10.14%	1	-36.06%	1	12
Holy Cross Hospitals	-2.36%	5	2.89%	11	-28.02%	8	15
Fort Washington Medical Center	2.75%	2	-3.80%	4	-21.35%	23	16
Anne Arundel Medical Center	-8.47%	14	-1.33%	7	-31.15%	5	20
University of Maryland Shore Medical Center at Dorchester	-1.85%	4	11.60%	18	-23.21%	17	22
Washington Adventist Hospital	-9.15%	15	2.03%	8	-26.22%	11	25
University of Maryland Baltimore Washington Medical Center	-6.17%	10	10.19%	16	-24.27%	15	26
Shady Grove Adventist Hospital	-12.85%	24	-2.05%	6	-31.64%	4	29
Garrett County Memorial Hospital	6.49%	1	7.79%	15	3.01%	43	30
MedStar St. Mary's Hospital	-4.94%	8	5.28%	12	-13.24%	37	33
Doctors Community Hospital	-14.39%	30	-4.86%	3	-31.06%	6	35
St. Agnes Hospital	-9.27%	16	14.13%	22	-23.55%	16	35
Meritus Medical Center	-4.39%	7	14.45%	25	-16.75%	32	36
Johns Hopkins Hospital	-8.03%	12	14.42%	24	-20.79%	25	37
University of Maryland Charles Regional Medical Center	-9.79%	19	6.02%	14	-21.83%	22	37
Peninsula Regional Medical Center	-5.49%	9	21.47%	38	-21.99%	21	39
University of Maryland Medical Center	-9.60%	18	16.60%	29	-25.70%	12	39
Atlantic General Hospital	-0.87%	3	29.41%	43	-17.29%	31	40
MedStar Harbor Hospital Center	-8.41%	13	27.59%	42	-25.13%	13	41
MedStar Southern Maryland Hospital Center	-19.31%	38	-6.70%	2	-28.54%	7	43
Greater Baltimore Medical Center	-11.25%	22	14.37%	23	-20.28%	26	47
Frederick Memorial Hospital	-14.45%	31	10.22%	17	-25.04%	14	47
MedStar Montgomery Medical Center	-20.98%	41	2.69%	9	-32.46%	2	47
Mercy Medical Center	-10.11%	20	17.56%	32	-19.96%	27	50
Calvert Memorial Hospital	-20.46%	40	2.86%	10	-26.77%	9	50
Upper Chesapeake Medical Center	-12.05%	23	19.30%	35	-22.89%	19	50
MedStar Franklin Square Hospital Center	-9.50%	17	19.24%	34	-16.15%	34	51
Prince Georges Hospital Center	-18.42%	36	5.39%	13	-22.23%	20	53
University of Maryland St. Joseph Medical Center	-12.92%	25	16.58%	28	-18.03%	29	54
University of Maryland Rehabilitation & Orthopaedic Institute	-20.08%	39	16.60%	29	-26.77%	9	58
MedStar Good Samaritan Hospital	-10.43%	21	20.32%	36	-9.88%	41	60
Johns Hopkins Bayview Medical Center	-14.15%	29	17.46%	31	-17.82%	30	60
Harford Memorial Hospital	-13.47%	27	21.74%	39	-18.97%	28	61
MedStar Union Memorial Hospital	-14.81%	32	13.87%	21	-13.68%	36	61
University of Maryland Shore Medical Center at Easton	-16.03%	33	11.60%	18	-12.07%	38	61
Carroll Hospital Center	-18.60%	37	15.88%	27	-21.25%	24	63
Northwest Hospital Center	-13.65%	28	23.86%	40	-16.30%	33	65
University of Maryland Shore Medical Center at Chestertown	-17.39%	35	13.29%	20	-12.02%	40	65
Western Maryland Regional Medical Center	-13.01%	26	24.36%	41	-12.05%	39	66
University of Maryland Medical Center Midtown Campus	-21.24%	42	19.01%	33	-23.21%	17	67
Union Hospital of Cecil County	-17.34%	34	15.43%	26	-3.56%	42	68
Sinai Hospital	-23.69%	43	20.99%	37	-14.56%	35	79

Maryland
Hospital Association

November 5, 2020

Adam Kane
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Kane:

On behalf of Maryland's 61 member hospitals and health systems, the Maryland Hospital Association (MHA) appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) proposed integrated efficiency policy.

Inflation withholds should apply on or after July 1, 2021.
We agree with HSCRC staff's conclusion that the policy should apply to hospitals that are clearly outliers so as not to counteract utilization management incentives. We respectfully ask HSCRC to apply inflation withholds no sooner than July 1, 2021. We understand HSCRC postponed its planned July 1, 2020 implementation as a result of COVID-19. Hospitals continue to face significant financial uncertainty due to the pandemic, largely because of anticipated final guidance on federal relief funds, reporting COVID expenses in January 2021, and impact of relief funds and expenses on rates.

In addition to COVID uncertainty, one-half of the efficiency policy is based on HSCRC's proposed benchmarking of commercial and Medicare spending per beneficiary. HSCRC has been creating the methodology for some time. However, the formal release of information did not occur until August, and many hospitals have not had adequate opportunity to give attention to review and validate the information while addressing other financial challenges during the pandemic. Implementing inflation withholds on or after July 1, 2021 will allow hospitals adequate time to consider the benchmarking methodology.

HSCRC also plans to review peer groups, including for Johns Hopkins Hospital and University of Maryland Medical Center, along with resident counts in graduate medical education adjustments. Changes to these factors may alter the results. These tasks are slated to be complete in January 2021. A July 1, 2021 or later implementation date would allow for these changes.

If adopted, HSCRC should set unit rates under global budgets using the most recent volumes.
We respectfully ask HSCRC staff to set annual unit rates using volumes from the most recent 12-month period preceding the rate order. Measuring monthly rate compliance and adjusting unit rates, with the process of requesting adjustments outside certain corridors, imposes a heavy burden on hospital reimbursement staff, with very little net value. We appreciate the need to hold hospitals accountable to revenue targets, and the efficiency policy will lessen allowable revenues for outlier hospitals. Connecting unit rates to GBRs will reduce the burden on HSCRC staff and hospitals.

The efficiency policy should be revenue neutral statewide.
We agree that if revenues are reduced for high-cost hospitals (as HSCRC defines such), the full sum of this reduction should be available to be redistributed within the system. None should be withheld. We appreciate HSCRC staff's consideration that allows low-cost outliers to apply for increases and other proposed uses of savings, including capital funding, etc.

HSCRC's intent to credit investments is appropriate. Judging which hospital investments align with the Total Cost of Care Model is concerning.
One of HSCRC's long term policy considerations is to "quantify investments…in unregulated settings…in line with the incentives of the Total Cost of Care Model." A byproduct would be to credit hospitals in the ICC evaluation for retained revenues. The intent is appropriate because Maryland's Total Cost of Care Model holds the state accountable for more than just hospital spending. HSCRC enforces accountability via the efficiency adjustment and the annual payment update by accounting for total spending growth.

However, hospitals have serious concerns about HSCRC staff judging which hospital investments are worthwhile. As the regulator, the commission should set broad goals and targets that satisfy our Model agreement and meet the triple aim. Hospitals should be accountable to achieve both state and hospital specific targets. Hospitals need latitude to choose and to demonstrate their investments. Some may fail, but that is acceptable within the parameters of the Model.

This policy consideration should be removed from the efficiency policy and become the subject of strategic conversations between HSCRC commissioners and staff and the hospital field, before determining a course of action.

Adjustments may be required if applying the policy in full rate applications.
The efficiency methodology will be used in the full-rate application process. When the methodology is developed, it will likely remain in place for several years. As the full-rate application methodology is proposed, MHA will comment on efficiency policy calculations in a full-rate application and how it may differ from annual inflation adjustments.

Thank you again for your careful consideration of these matters. If you have any questions, please contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
John M. Colmers
James N. Elliott, M.D.
Sam Malhotra
Katie Wunderlich, Executive Director
Allan Pack, Principal Deputy Director

Maria Harris Tildon
Executive Vice President
Marketing & Government Affairs

CareFirst BlueCross BlueShield
1501 S. Clinton Street, Suite 700
Baltimore, MD 21224-5744
Tel. 410-605-2591
Fax 410-505-2855

November 6, 2020

Adam Kane, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Kane:

CareFirst submits the following comments related to the "Draft Recommendation Integrated Efficiency Policy for RY 2021: Withholding Inflation for Relative Efficiency Outliers and Potential Global Budget Revenue (GBR) Enhancements".

CareFirst appreciates the time and effort required to develop this elaborate and thoughtful methodology. Elements of the methodology cross virtually all Centers within the HSCRC, and the outcome reflects a high-level, albeit complex, quantitative approach to re-establishing efficiency fairness within the all-payer system. The former Interhospital Cost Comparison (ICC) approach has been obsolete since the implementation of GBRs and Maryland's All Payer Model in 2014. Therefore, to ensure that individual hospital costs do not become unreasonable relative to their competitors, CareFirst supports implementing an efficiency methodology as soon as possible.

As with any important complex methodology it is essential that stakeholders remain open to refinement over time to ensure that it remains fair and equitable. We agree with several comments made by Commissioners during the October 14 public meeting regarding areas of potential refinement moving forward.

Use of Quartiles and One Standard Deviation as Thresholds

As raised at the public meeting, given the absence of a comprehensive efficiency adjustment for more than six years (and longer for rural hospitals), we too were surprised that the adjustment was not larger. This calls into the question the use of quartiles and whether one standard deviation of average Volume Adjusted ICC performance (or 1.22 times the ICC cost standard) are the right thresholds. We understand that the ICC distribution represents a normal distribution, but that does not imply that costs below the mean plus one standard deviation are reasonable. Therefore, we recommend that these thresholds continue to be evaluated over time to ensure that they are truly capturing the outlier hospitals.

In addition, in the past, similar threshold policies created a "stuck hospital" phenomenon where there was little opportunity for hospitals to get to the next level. As part of an ongoing evaluation, Staff should consider whether this phenomenon is occurring under the new policy.

In addition, Staff should consider whether coding improvement is influencing hospitals' positions in the results of the efficiency outlier methodology.

"Right-Sizing" GBRs

Further commentary at the public meeting related to fixed costs not really being fixed in the long run. While this point can be interpreted to address the need to reevaluate capacity in the system over time, we also think it addresses the issue that current GBRs are all still based on FY2013 utilization and underlying costs may have changed over time. The impact of hospital-driven care transformation necessitates a more comprehensive look at whether the current GBRs are still reasonably reflective of hospital cost, particularly as more services are appropriately moved to lower cost, non-hospital settings under the TCOC model. As such, we see this recommendation as a reasonable first step in a progression to right-sizing GBRs. We understand Staff's position that we don't want to introduce a counterincentive to reducing utilization, but we ought to look at whether the readmission and PAU policies adequately address the risk of increased unnecessary utilization.

Potential for System Savings

There was an interest from a number of commissioners in utilizing the efficiency calculation as a means to accrue system savings, rather than reallocating revenue in a neutral manner. CareFirst believes that this methodology provides such an opportunity with only minor tweaks to its application. We support the Staff recommendation that all revenue enhancement under this policy be capped by a set aside in the Annual Update Factor. However, dollars derived from withholding the update factor from poor performing outlier hospitals should be passed along as savings to purchasers of hospital care who have been paying more for those inefficient services.

Future Policy Enhancements related to Overhead and ICC Profit/Productivity Strips

Staff also discussed the prospect of enhancing data definitions that could allow for the addition of an overhead cap and a potential adjustment to the ICC profit and productivity strips to better reflect creditable costs. Staff has been working diligently to refine definitions and reporting regarding overhead and unregulated costs/losses that could be deemed creditable or not creditable for an overhead policy and potential changes to the profit or productivity strip. The rapid growth in unregulated costs and losses over the course of the past five years is unsustainable and continues to be funded by increased regulated profits. Increased reporting requirements and transparency are critical so that HSCRC Staff can ascertain which unregulated operations are contributing to the goals of the model. Hospitals cannot be given credit for the work they are doing in their unregulated operations until the full picture is understood, especially since they are now a major cost driver in the system. We support these efforts and will continue to be available to assist in that process.

Thank you for this opportunity to share our support of this policy, and to inject our thoughts and comments regarding elements of it. We look forward to working with you on the future development of the efficiency policy.

Sincerely,

Maria Harris Tildon

Cc: Joseph Antos, Ph.D., Vice Chairman
Victoria Bayless
Stacia Cohen, R.N.
John Colmers
James N. Elliott, M.D.
Sam Malhotra
Katie Wunderlich, Executive Director

Luminis Health℠

2001 Medical Parkway
Annapolis, Md. 21401
443-481-1000 | luminishealth.org

November 6, 2020

Mr. Adam Kane
Chairman
Health Services Cost Review Commission

Dear Chairman Kane,

Thank you for the opportunity to provide written comments on the Integrated Efficiency Policy from Health Services Cost Review Commission (HSCRC) staff. While we support aspects of the policy, we remain concerned with certain specific provisions including the process by which they were developed.

TCOC Benchmarking

HSCRC staff has developed a methodology to benchmark geographies in Maryland against national peers for both Medicare and Commercial TCOC per beneficiary. The goal is to use these metrics to introduce a Medicare TCOC attainment as a metric into and the CY2021 Medicare Performance Adjustment (MPA).

Major components of the national benchmarking methodology include setting TCOC benchmarks per beneficiary for a hospital's Primary Service Area against "like populations" nationwide (adjusting for case mix, teaching, and socioeconomic factors). These benchmarks are set differently for the hospital's Medicare and commercial populations. The Medicare calculation is a county-level TCOC per beneficiary calculation based on county-level comparisons. The commercial benchmark is based on metropolitan statistical areas (MSAs).

We have several concerns regarding this benchmarking approach and methodology:

1. The decision to make a long-term goal of the Waiver to be for Medicare expenditures in Maryland to be comparable to the nation is a fundamental shift, requiring further and extensive discussion between CMMI, the State, and hospital stakeholders on the purpose and future of the Waiver.

2. The benchmarks focus on Medicare and not All Payer targets:

    a. The goal of driving Medicare to national benchmarks while preserving Commercial rates that are nearly 25% below the nation is counter to our All Payer Model and eliminates the value of the Waiver.

    b. Methodologies that would eliminate the difference would preserve the problems of the Medicare fee-for-service system (inpatient rates barely above breakeven and outpatient rates that do not cover costs) while constraining hospitals from charging rates to commercial payers in line with the nation.

3. TCOC attainment includes price and utilization:

    a. The benchmark comparison should be limited to utilization variances since price is addressed through the ICC calculation. Measuring only utilization would eliminate price differences due to the Maryland All Payer model.

    b. Limiting price considerations in the benchmarks may also eliminate some of the inequities resulting from the construction of the national peer groups.

        i. It is notable that this policy has clear winners (Montgomery, Howard, Anne Arundel County) and losers (Baltimore City/County, Eastern Shore, other rural areas).
        ii. Hospitals that are primarily compared to counties and MSAs on the East or West coast do relatively well, while hospitals compared to those in the rest of the country fare far worse.

4. Any benchmarking methodology needs to provide for both an attainment and improvement measure. This is consistent with the approach of other HSCRC programs such as the Readmissions Reduction Incentive Program.

Stakeholder Process

The HSCRC has typically not been required to follow the burdensome process of promulgating detailed regulations that required months of prolonged comment periods and regulatory steps to put regulations into COMAR. Instead, the Commission has engaged stakeholders through workgroups that discussed HSCRC policies with public votes by the Commission to adopt the policy. The policy papers and minutes of the Commission meetings served to document what the current state of policy was for many of the detailed methodologies, with only general administrative requirements in regulation.

This open and transparent process has eroded over time as much of the detail for developing and applying methodologies is not publicly documented and requires persistent discussions with the staff to obtain the details of relevant calculations when a hospital wishes to replicate the work. Thoughtful comments from stakeholders is difficult in this process for several reasons:

1. The short timeframe provided for the public to read and attempt to understand complex methodologies.

2. Construction of policies based on confidential data so that stakeholders cannot replicate the policies or test the sensitivity of models to methodology choices.

3. Policy goals are not clearly stated or generally accepted in the policy process.

Without the need to seek Commission approval of a policy, the staff may change the calculations used for adjustments as staff members decide that the results require modification. These changes are not widely discussed or promulgated, but they have consequences for hospital revenue and budgets.

The most recent policies proposed by HSCRC staff have been worked on for substantial periods of time, beginning last year or earlier, but the staff introduced these policies to the industry in a few workgroup meetings in September and immediately requested input on these proposals. The time for stakeholders to consider these issues has been short, and the opportunity for the hospital industry to consider the implications of the policy and to examine potential alternatives has been truncated.

While we greatly appreciate the staff's willingness to meet to discuss the policies and provide clarification, a more robust and transparent stakeholder process needs to be in place.

Integrated Efficiency Policy

The HSCRC staff's Integrated efficiency metric would identify outliers (based on a blend of price efficiency and TCOC performance) for potential rate adjustments. The draft recommendation proposes adjustments to be effective July 1, 2020 but implemented January 1, 2021 (meaning full-year impact would apply in FY2021).

As a general approach, this is not good policy. This approach creates unnecessary instability in hospital revenue with retrospective changes in rates, while hospital budgets were built on expectations of policies in place prior to the beginning of the fiscal year. This retrospective adjustment compounds the instability associated with COVID-19 pandemic. As a general principle, Commission rate setting has been prospective, and it should remain prospective to maximize predictability and stability within the system.

Major Components of this policy:

- Rank hospitals on three metrics
    - 50% price: hospitals ranked based on ICC result
    - 25% Medicare TCOC benchmark attainment
    - 25% Commercial TCOC benchmark attainment
- Select 4-5 inefficient outliers based on the relative performance under the ICC calculation weighted with the Medicare and Commercial TCOC benchmarks; identified hospitals must be
    - A statistical outlier on price and
    - in the bottom quartile on overall hospital ranking
- At risk is the Commercial and Medicare update factor (~2/3 of annual update).
- For the 4-5 efficient outliers identified by the policy, the hospital must be
    - A statistical outlier on price and
    - In the top quartile on overall hospital ranking

As a reward for performance under this methodology, the hospital can request Global Budget Revenue (GBR) enhancements, limited on an annual basis by the combined total of the annual set aside and amounts withheld from inefficient outliers.

Our concerns with the proposed policy include:

- The policy creates an inherent inequity between rural/urban and suburban hospitals
  - Unfairly penalizes smaller hospitals who operate on thin margins and will be crushed by the elimination of the update factor
  - The current methodology allows for the continuation of retained revenue by certain hospitals largely due to geographic location, not relative efficiency
- The policy assumes a 50/50 attainment measurement mix between Medicare and Commercial payers, not taking into account the significant payer mix differences in Maryland's hospitals
- The Commercial benchmarks that are being used are based on Milliman data, a proprietary source that cannot be recreated by the hospitals or broader industry to validate. This is contrary to the transparency of other HSCRC and industry supported methodologies.
- A continuous scaling logic (rather than just addressing outliers) may better address the above issues and more aggressively address the variation in the system
- The revenue should not be removed in FY2021, which would effectively eliminate the FY2021 update factor mid-year in a COVID year

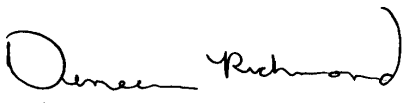
Conclusion

We continue to be supportive of the HSCRC Commissioners' and staffs' efforts to develop financial and quality policies that incentivize care delivery changes while maintaining a reasonable price structure for the populations that we serve. We remain concerned, however, with the process used to develop these most recent policies and some of the specific methodologies as proposed. We would welcome additional discussion regarding ways to improve them as we share the same overall goals.

Thank you for the opportunity to provide comments on this policy.

Sincerely,

Sherry B. Perkins, PhD, RN, FAAN
President, Luminis Health, Anne Arundel Medical Center



Deneen Richmond, MHA, RN
Acting President, Luminis Health, Doctors Community Medical Center

Ed Beranek
Vice President of Revenue Management
and Reimbursement
3910 Keswick Road
South Building / 4th Floor
Suite S-4200D
Baltimore, MD 21211
443-997-0631/FAX 443-997-0622
Jberane1@jhmi.edu

November 6, 2020

Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Wunderlich:

On behalf of the Johns Hopkins Health System (JHHS), we appreciate the opportunity to comment on the commission's Draft Recommendation on Integrated Efficiency Policy for RY 2021.

JHHS supports the proposal to adjust hospital revenues for efficiency. We also believe that it is appropriate to have both a Price Efficiency metric as well as a Total Cost of Care (TCOC) metric included as part of the methodology. Measuring efficiency in a fixed revenue environment is challenging, and we appreciate the HSCRC staff's approach to balance price efficiency with hospital specific, per capita TCOC performance.

JHHS also believes that the efficiency policy should be revenue neutral on a statewide basis. If high cost hospital's revenues are reduced, the full sum of this reduction should be available within the system and no portion should be withheld. We appreciate the HSCRC staff's consideration that allows low cost outliers to apply for increases and other proposed uses of savings. This does not however preclude hospitals from pursuing a full rate application if they feel that the adjustments from the efficiency methodology are not adequate to meet the hospitals financial needs. Nor does it preclude the HSCRC from reviewing a hospital's rate structure and rebasing a hospital's GBR if they feel that too much revenue has been retained by a hospital with large declines in volumes. We believe that both of these important components of the rate setting system need to be maintained and utilized when appropriate.

Benchmarking Methodology

JHHS has some concerns with the benchmarking methodology. The benchmarking methodology needs further evaluation by the hospital industry and Commissioners. The goal of driving Medicare to national benchmarks while preserving Commercial rates that are nearly 25% below the nation is counter to the All Payer Model and reduces the value of the Waiver. Methodologies that would eliminate the difference would preserve the problems of the national Medicare fee-for-service system while constraining hospitals from charging rates to commercial payers in line with the nation.

The recommendation assumes a 50/50 attainment measurement mix between Medicare and Commercial payers, not considering the significant payor mix differences in Maryland's hospitals. This could have

an unintended consequence of disadvantaging a hospital based on payor mix. Additionally, the Commercial benchmarks that are being used are based on Milliman data, a proprietary source that cannot be recreated by the hospitals or broader industry to validate without purchasing the data. This is contrary to the transparency of other HSCRC and industry supported methodologies.

Total Cost of Care

JHHS agrees that TCOC is an important measure in the efficiency policy because the system incentives are population based. However, only measuring growth or only measuring attainment could disadvantage hospitals with very low TCOC relative to peers or hospitals that have shown reductions to TCOC but have not yet reached a benchmark. We believe that it would be appropriate to take both measures into consideration in this efficiency policy.

Establishment of Unit Rates

JHHS believes that if the staff recommendation is approved that staff should set annual unit rates using volumes from the most recent 12-month period preceding the rate order. We appreciate the need to hold hospitals accountable to GBR targets, and the efficiency policy will reduce overall GBR revenues for outlier hospitals. Connecting unit rates to GBRs will reduce the burden on HSCRC staff and hospitals.

Finally, we believe that this and all methodologies need to be reviewed and revisited on a regular basis to assure that the underlying methodologies are keeping in sync with the goals of the new model and to provide refinements where needed.

Thank you again for your consideration and thanks to the HSCRC staff for all of their efforts in crafting a policy on this very complex matter. If you have any questions, please feel free to contact me.

Sincerely,

Ed Beranek

Ed Beranek
Vice President, Revenue Management and Reimbursement

UNIVERSITY of MARYLAND MEDICAL SYSTEM

Corporate Finance
900 Elkridge Landing Road
4th Floor East
Linthicum Heights, Maryland 21090

November 6, 2020

Katie Wunderlich
Executive Director, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: UMMS Comment Letter for the Integrated Efficiency Policy

Dear Katie:

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, we are submitting comments in response to the Health Services Cost Review Commission's (HSCRC) Draft Recommendation for the Integrated Efficiency Policy.

We support the Staff's proposal to implement a standardized approach for evaluating hospital efficiency and adjusting hospital revenue. An efficiency policy is necessary to ensure that hospital costs remain reasonable and that health care is affordable in the state of Maryland. We believe the Inter-hospital Cost Comparison (ICC) and a per capita comparison measure are appropriate measures of efficiency.

The industry understands that this and other methodologies were placed on hold earlier this spring due to the emerging COVD-19 pandemic. UMMS does appreciate the respite from changes in these policies which allowed us to focus on taking care of the residents of Maryland during a time of great crisis. We do have concerns, however, that this pause has now caused an acceleration of the process, which has resulted in the lack of proper vetting of this and other methodologies.

UMMS would like to offer the following specific concerns regarding the Integrated Efficiency Methodology:

The inflation withhold should be delayed until July 1, 2021

We support MHA's position to delay an inflation withhold until July 1, 2021. Hospitals continue to face significant financial uncertainty due to the pandemic. Retracting an update factor amount that was provided at the beginning of the fiscal year will create more financial struggles when those are funds the hospitals have already spent to continue operations.

TCOC Benchmark should be further evaluated

As mentioned earlier, the short reprieve to workgroups has placed a tight time constraint on hospital vetting opportunities. The HSCRC staff has worked on the benchmark methodology and corresponding policy for substantial periods of time, beginning last year or earlier, but the staff introduced these policies to the industry in a few workgroup meetings in August and quickly looked for hospital understanding on the proposals. This short time period has not allowed hospitals adequate time to evaluate and understand such a complex analysis and we feel that more time is warranted to vet the methodology. During the course of our high level and quick review of the proposed methodology, UMMS has identified areas of concern and a few suggestions we would like to explore further with the HSCRC Staff:

- Hospitals located in wealthier jurisdictions tend to have better TCOC results while hospitals serving poor rural or urban jurisdictions perform poorly
- The inclusion of price in the benchmark analysis skews results and tends to place urban and suburban areas at a disadvantage
- Utilization performance should be considered as an alternative to measuring performance to eliminate some of the price disparity caused by our all-payer model
- Border hospitals tend to perform better in the Medicare benchmarking due to the number of patients who seek care outside Maryland at lower payment rates
- TCOC measure should include both attainment and improvement, similar to the approach taken with the quality policies

We support the concept of a National Peer Group for the AMCs

UMMS supports the incorporation of an inpatient national peer group for both Maryland academic hospitals. Using a Maryland peer group of non-academic teaching hospitals for the AMCs has not provided the appropriate comparison of costs for these institutions. They are very unique in their cost structure and should be compared to other institutions with the similar costs. While we support the concept of national data for the AMCs, there are still many technical issues to be addressed in the methodology. We are committed to working through those issues with commission staff, but we are unable to do so for the final Staff Recommendation. We will, however, work with Staff to target a July 1, 2021 timeframe.

A disproportionate number of 'outlier' hospitals are small, rural or unique facilities and should be studied further

UMMS is concerned over the large number of unique and smaller facilities (e.g. UM Rehab, Union of Cecil and Chestertown) being identified as outliers. These facilities often face unique challenges due to circumstances such as size, type of services and/or location. Often a 'one size fits all' approach within a methodology is not necessarily appropriate. UMMS feels that the identification of several small and rural hospitals as outliers is not consistent with the intent of the policy. We therefore recommend the HSCRC staff evaluate the circumstances contributing to the outlier status of these small facilities and consider making adjustments to recognize their unique nature and circumstances.

We appreciate the HSCRC's goal to continually evaluate and improve methodologies and hope to have the opportunity to provide additional input into both the MPA as well as the Efficiency Measure methodologies. Thank you for the opportunity to provide feedback.

Sincerely,

Alicia Cunningham
Senior Vice President, Corporate Finance & Revenue Advisory Services

cc: Adam Kane, Chairman
HSCRC Commissioners
Mohan Suntha, MD, UMMS CEO
Michelle Lee, UMMS CFO

maryland
health services
cost review commission

Draft Recommendation on Use of Maternal and Child Health Funding

April 2020

This is a draft recommendation. Written comment letters should be sent to erin.schurmann@maryland.gov by April 21, 2020.

P: 410.764.2605 ● 4160 Patterson Avenue | Baltimore, MD 21215 ● hscrc.maryland.gov

maryland
health services
cost review commission

Table of Contents

Policy Overview 1

Overview 1

Background 2

Funding 4

Programs and Interventions 5

Medicaid Innovation for Improving Maternal and Child Health 6

Home Visiting Services (HVS) Pilot Expansion 6

Reimbursement for Doula Services 7

CenteringPregnancy 7

HealthySteps 8

Maternal Opioid Misuse (MOM) Model 9

PHPA Initiatives for Improving Maternal and Child Health 10

Asthma Home Visiting Program 10

Eliminating Disparities in Maternal Health Initiative 11

Recommendations 11

Appendix 1 – Medicaid Programs – Expansion Estimates 13

Appendix 2 – PHPA Programs - Expansion Estimates 14

maryland
health services
cost review commission

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
This draft recommendation seeks to direct the reserved $10 million from the Regional Partnership Catalyst Program to fund investments the third SIHIS population health priority area: maternal and child health.	Direct $10 million annually (FY22-2025) to Medicaid and the Prevention and Health Promotion Administration under the Maryland Department of Health to support statewide expansions of evidence-based and promising practices to promote maternal and child health.	HSCRC would issue a uniform, broad-based assessment on all hospitals. Hospitals would transfer funds received through rates to the Maternal and Child Health Population Health Improvement Fund.	The funds were included in the calculations for the FY 2021 annual update factor and thus does not increase the overall total cost of care. Consumers will benefit from additional community programs focused on maternal and child health.	These funds will support interventions that will build critical healthcare infrastructure to assist in improving access to services that address severe maternal morbidity and childhood asthma which disproportionately affect minority communities.

Overview

The Maryland Health Services Cost Review Commission ("HSCRC," or "Commission") staff have prepared the following recommendation to authorize the remaining funding under the Regional Partnership Catalyst Program to be directed to fund maternal and child health interventions. The program would fund maternal and child health programs and initiatives led by Medicaid and the Prevention and Health Promotion Administration (PHPA) under the Maryland Department of Health (MDH), in conjunction with the Medicaid HealthChoice MCOs. When the Regional Partnership Catalyst Program was approved in November 2019, 20 percent of the funding ($10 million annually) was set aside for future investment in the then to-be-determined third population health priority area under the Statewide Health Improvement Strategy (SIHIS). In fall of 2020, maternal and child health was formally selected as the State's third population health priority area and submitted as part of the now-approved SIHIS proposal to the Center for Medicare and Medicaid Innovation (CMMI). While HSCRC staff developed a competitive hospital bid process for the diabetes and behavioral health funding streams under the Regional Partnership Catalyst Program, staff recommends directing the third funding stream to Medicaid and PHPA investments in evidence-based programs and promising practices to promote maternal and child health that can be implemented in conjunction with the Medicaid HealthChoice MCOs. Directing these reserved dollars to fund maternal and child health investments would satisfy a key requirement under SIHIS. HSCRC staff believes these expansive investments will help the State achieve not only statewide improvements, but also reduce significant

healthcare disparities in maternal and child health. If this recommendation is approved, staff would execute an MOU with MDH and the funding would be directed to Medicaid and PHPA to fund specific maternal and child health initiatives beginning July 1, 2021 for four years.

Background

In 2019, the State of Maryland collaborated with the Center for Medicare and Medicaid Innovation (CMMI) to establish the domains of healthcare quality and delivery that the State could impact under the Total Cost of Care (TCOC) Model. The collaboration also included an agreed upon process and timeline by which the State would submit proposed goals, measures, milestones, and targets to CMMI. In December 2020, the State submitted its proposal for a Statewide Integrated Health Improvement Strategy (SIHIS) which aligns statewide efforts across three domains: hospital quality, care transformation across the system, and total population health. Under the third domain, total population health, the State identified three key health priority areas for improvement: diabetes, opioid use, and maternal and child health. CMMI approved the State's proposal on March 17, 2021.

While the State identified diabetes and opioid use as key population health priority areas over a year ago, the third priority area was not selected until later in 2020. In fall of 2020, the State formally selected maternal and child health as the third population health priority under SIHIS. Consistent with the State's guiding principle to select goals, measures, and targets that are all-payer in nature, maternal and child health was deliberately considered as a priority area even though it is not Medicare focused. The selection of maternal and child health as a priority area reflects its importance in the State, and acknowledges both the longstanding history of disparities, as well as the large potential for improvement.

The U.S. faces higher maternal and infant mortality rates compared to other industrialized countries, with large racial/ethnic disparities for each outcome; Maryland's maternal mortality rate from 2013 to 2017 (24.8 maternal deaths per 100,000 live births) ranks 22nd among states, with the rate for African Americans almost four times that of Whites (44.7 maternal deaths vs. 11.3 per 100,000 live births).[1],[2]

In addition, pediatric asthma contributes to increased healthcare utilization and spending, missed school days, and sub-optimal overall health and well-being in Maryland children. Pediatric asthma also has a

[1] America's Health Rankings analysis of CDC WONDER Online Database, Mortality files 2017, United Health Foundation, AmericasHealthRankings.org, Accessed February 9, 2020.

[2] Maryland Department of Health. Maryland Maternal Mortality Review 2019 Annual Report. https://phpa.health.maryland.gov/mch/Documents/Health-General%20Article,%20%C2%A713-1207,%20Annotated%20Code%20of%20Maryland%20-%202019%20Annual%20Report%20%E2%80%93%20Maryland%20Maternal%20Mortality%20Review.pdf Accessed May 19, 2020.

significant impact on parental productivity. In Maryland, approximately 9.7 percent of children have asthma.[3]

As part of the SIHIS proposal, the State identified two goals to improve maternal and child health:

- Reduce the severe maternal morbidity rate
- Reduce asthma-related emergency department (ED) visit rates for ages 2-17

Additionally, the State proposed the use of the reserved Regional Partnership Catalyst Program funding for maternal and child health as a 2021 milestone under both SIHIS goals. Directing these reserved dollars to fund maternal and child health investments would satisfy a key requirement under SIHIS.

Table 1. SIHIS Goal: Maternal Health

Goal: Reduce severe maternal morbidity rate	
Measure	Severe Maternal Morbidity Rate per 10,000 delivery hospitalizations
2018 Baseline	242.5 SMM Rate per 10,000 delivery hospitalizations
2021 Year 3 Milestone	Re-launch the Perinatal Quality Collaborative. Pilot a Severe Maternal Morbidity Review Process with eight Birthing hospitals Complete Maryland Maternal Strategic Plan. Launch Regional Partnership Catalyst Grant for MCH, if funding is available.
2023 Year 5 Target	219.3 SMM Rate per 10,000 delivery hospitalizations
2026 Year 8 Final Target	197.1 SMM Rate per 10,000 delivery hospitalizations

Table 2. SIHIS Goal: Child Health

Goal: Decrease asthma-related emergency department visit rates for ages 2-17	
Measure	Annual ED visit rate per 1,000 for ages 2-17
2018 Baseline	9.2 ED visit rate per 1,000 for ages 2-17
2021 Year 3 Milestone	Obtain Population Projections. Development of Asthma Dashboard. Launch Regional Partnership Catalyst Grant for MCH, if funding available.

[3] Children's Environmental Health Advisory Council. 2017 Legislative Report of the Maryland Asthma Control Program. https://phpa.health.maryland.gov/Documents/Maryland-Asthma-Control-Program-2017-Legislative-Report.pdf. Accessed November 15, 2020

	Asthma-related ED visit is a Title V State Performance Measure and shift some of the Title V funds for Asthma-related interventions.
2023 Year 5 Target	Achieve a rate reduction from 2018 baseline to 7.2 in 2023 for ages 2-17
2026 Year 8 Final Target	Achieve a rate reduction from the 2018 baseline to 5.3 in 2026 for ages 2-17

Funding

In November 2019, the Commission approved a five-year investment of 0.25 percent of statewide all-payer hospital revenue (approximately $45 million annually) to support the population health goals of SIHIS through the Regional Partnership Catalyst Program. Eighty percent of this approved amount was allocated to two funding streams dedicated to the State's identified key population health priorities: diabetes and opioid use. The State had not yet selected its third population health priority, so 20 percent ($10 million annually) of the approved funding was set aside for a future funding stream. Given that the State had not yet selected a third population health priority, the first year of funding was re-directed to address the public health emergency through the COVID-19 Long-Term Care (LTC) Partnership Program which ends June 30, 2021.

Staff recommends issuing the remaining 20 percent allocated to the third population health funding stream for maternal and child health investments. While HSCRC staff developed a competitive bid process for the diabetes and behavioral health funding streams under the Regional Partnership Catalyst Program, staff recommends directing the third funding stream to investments led by Medicaid and PHPA, in conjunction with the Medicaid HealthChoice MCOs. This funding will scale existing statewide evidence-based programs and promising practices and support the expansion of new services for mothers and children. Additionally, using the funding in this manner would also create an opportunity for the State to receive federal match funding to nearly double the investment. Funds would be added to hospital annual rates as temporary adjustments through a uniform, broad-based assessment for four years.

- FY 2022 (July 2021 – June 2022)
- FY 2023 (July 2022 – June 2023)
- FY 2024 (July 2023 – June 2024)
- FY 2025 (July 2024 – June 2025)

Hospitals would transfer funds to the Maternal and Child Health Population Health Improvement Fund. The Maternal and Child Health Population Health Improvement Fund, created through the 2021 Budget

Reconciliation and Financing Act (BRFA), may receive funding from hospital rates to invest in maternal and child health initiatives, as approved by Commissioners. The Fund would sunset in 2025. HSCRC staff would establish a Memorandum of Understanding (MOU) with MDH to establish terms and conditions for the administration of the Maternal and Child Health Population Health Improvement Fund.

Programs and Interventions

While identifying the initiatives presented in this recommendation, HSCRC staff prioritized the selection of programs and interventions that could be sustained after the funding expires. For the initiatives listed below, our State partners have identified pathways to sustainable funding for initiatives deemed successful. Additionally, our State partners are developing impact measurement frameworks to ensure accountability in use of funds.

The table below lists the proposed programs and initiatives that would receive support under this recommendation. Staff proposes an 80/20 funding split between Medicaid and PHPA under which $8 million would be issued to Medicaid and $2 million would be issued to PHPA annually.

Table 3. Proposed Medicaid and PHPA Programs and Interventions

	Program/Initiative	**Annual Funding Distribution**
Medicaid	Home Visiting Services Pilot Expansion	$8 Million
	Reimbursement for Doula Services	
	CenteringPregnancy	
	HealthySteps	
	Maternal Opioid Misuse (MOM) Model Expansion	
PHPA	Asthma Home Visiting Program	$1.25 Million
	Eliminating Disparities in Maternal Health Initiatives	$750,000
	Total	**$10 Million**

Medicaid Innovation for Improving Maternal and Child Health

The Medicaid program proposes a suite of evidence-based and promising practices to improve maternal and child health outcomes in partnership with its managed care organizations (MCOs), including:

1. Home Visiting Services pilot expansion
2. Reimbursement for doula services
3. CenteringPregnancy, a clinic-based group prenatal care model;
4. Healthy Steps, a clinic-based intensive prenatal and postpartum case management framework; and
5. Maternal Opioid Misuse (MOM) model expansion.

Appendix 1 shows the impact that additional HSCRC funding would have on enrollment in the proposed programs.

Home Visiting Services (HVS) Pilot Expansion

Medicaid has operated a Home Visiting Services pilot since 2017 through its §1115 waiver, which has enabled an expansion of evidence-based home visiting services to Medicaid eligible high-risk pregnant individuals and children up to age two. The HVS pilot program is aligned with two evidence-based models focused on the health of pregnant individuals. The Nurse Family Partnership (NFP) model is designed to reinforce maternal behaviors that encourage positive parent-child relationships and maternal, child and family accomplishments. The Healthy Families America (HFA) model targets parents facing issues such as single parenthood, low income, childhood history of abuse, substance use disorder, mental health issues or domestic violence. The current financing structure of the HVS pilot, which requires local lead government entities to provide a local match through an intergovernmental transfer, has garnered limited participation from additional lead entities because of the requirement to produce the required match from non-federal funding sources. Expanding existing HFA or NFP programs would allow more high-risk pregnant individuals to get access to both health and social support during the prenatal to three year period through home visiting services.

Sustainability: §1115 waiver

Monitoring and Impact Measures:

- Process Measures: Increased number of evidence-based home visiting programs participating in Medicaid-funded home visiting pilot programs; number of Medicaid participants
- Outcome Measures: Increased prenatal and postpartum care attendance; increased child vaccination rate and well-child visit attendance

- Expected Impact: Cost savings due to reductions of low birth weight babies, birth complications and C-sections, maternal morbidity and mortality

Reimbursement for Doula Services

Doulas are trained to provide continuous physical, emotional and informational support to a mother before, during and shortly after childbirth.[4] Key to a doula's function are the provision of emotional support and a constant presence during labor; encouraging laboring individuals and their families; and communicating between mothers and medical professionals. Potential benefits of working with a doula include reductions in C-sections, instrumental vaginal births and the need for oxytocin augmentation, in addition to shortened durations of labor.[5] Doula care has demonstrated a stronger impact for individuals who are socially-disadvantaged, low-income, unmarried, primiparous, giving birth in a hospital without a companion or had experienced language or cultural barriers.[6]

Sustainability: §1115 waiver; State Plan Amendment under 42 CFR §440.130(c)

Monitoring and Impact Measures:

- Process Measures: Development of infrastructure for Medicaid reimbursement (scope, supervision, payment mechanism, establishment of direct billing process through CMS Preventive Services Rule); number of certified doulas eligible to bill Medicaid; number of Maryland jurisdictions where services are covered; number of Medicaid participants utilizing doula services
- Outcome Measures: Increased prenatal and postpartum care attendance
- Expected Impact: Cost savings due to reductions in low birth weight babies, birth complications and C-sections, maternal morbidity and mortality

CenteringPregnancy

CenteringPregnancy is an evidence-based group prenatal care model for low-risk pregnancies. Facilitators support a cohort of eight to ten individuals of similar gestational age through a curriculum of ten 90- to 120-

[4] https://www.dona.org/what-is-a-doula/

[5] Gruber, K. J., Cupito, S. H., & Dobson, C. F. (2013). Impact of doulas on healthy birth outcomes. *The Journal of perinatal education*, *22*(1), 49–58. https://doi.org/10.1891/1058-1243.22.1.49

[6] Vonderheid S. C., Kishi R., Norr K. F., & Klima C. (2011). Group prenatal care and doula care for pregnant women In Handler A., Kennelly J., & Peacock N. (Eds.), *Reducing racial/ethnic disparities in reproductive and perinatal outcomes: The evidence from population-based interventions* (pp. 369–399). 10.1007/978-1-4419-1499-6_15

minute interactive group prenatal care visits that largely consist of discussion sessions covering medical and non-medical aspects of pregnancy, including nutrition, common discomforts, stress management, labor and birth, breastfeeding and infant care.[7] While Centering groups are comprised of participants of different ages, races and socio-economic backgrounds, this program has been shown to improve outcomes and reduce preterm birth, particularly for Black participants.[8] Evidence suggests CenteringPregnancy reduces costs, improves outcomes and leads to high satisfaction, with one study showing a reduction in risk of premature birth by 36 percent, with an average cost savings of $22,667, in the rate of low birthweight by 44 percent (average savings of $29,627) and NICU stays (average savings of $27,249). There are currently eight CenteringPregnancy sites in Maryland—four in the Baltimore metro area, two in the DC metro area, one on the Eastern Shore and one in Western Maryland.

Sustainability: Explore value-based purchasing arrangements or in-lieu of or §1115 waiver coverage; determine how to include in specifications for prenatal care measures, e.g. HEDIS

Monitoring and Impact Measures:

- Process Measures: Number of sites (existing and new); number of participating MCOs; number of Medicaid participants
- Outcome Measures: Increased prenatal and postpartum care attendance and screenings for STIs and HIV
- Expected Impact: Cost savings due to reductions in preterm births, low birthweight, elective C-sections, infant mortality, NICU stays and ED visits for mothers and babies

HealthySteps

HealthySteps, a program of ZERO TO THREE, is a pediatric primary care model that promotes positive parenting and healthy development for babies and toddlers. Under the model, all children ages zero to three and their families are screened and placed into a tiered model of services of risk-stratified supports, including care coordination and on-site intervention.[9] The HealthySteps Specialist, a child development expert, joins the pediatric primary care team to ensure universal screening, provide successful interventions, referrals and follow-up to the whole family.[10] HealthySteps has demonstrated a 204 percent

[7] https://www.centeringhealthcare.org/uploads/files/PressRelease_BirthEquityIssueBrief_10.2.19.pdf

[8] https://www.centeringhealthcare.org/what-we-do/centering-pregnancy

[9] https://ztt-healthysteps.s3.amazonaws.com/documents/222/attachments/Funding_HealthySteps_Site_System_Snapshots.pdf?1597851037

[10] https://www.healthysteps.org/the-model

average annual return on investment.[11] Healthy Steps has two existing locations in Maryland: University of Maryland School of Medicine Department of Family & Community Medicine and University of Maryland Pediatrics – Midtown, both located in Baltimore.

Sustainability: §1115 waiver; inclusion in MCO capitation rates; opening code for preventive medicine counseling (99401); attaching reimbursement for z-code diagnosis

Monitoring and Impact Measures:

- Process Measures: Number of sites (existing and new); number of participating MCOs; number of Medicaid participants
- Outcome Measures: Increased prenatal and postpartum care attendance; decreased postpartum depression rate; increased child vaccination rate and well-child visit attendance
- Expected Impact: Cost savings due to reductions in ED utilization for ambulatory-sensitive conditions

Maternal Opioid Misuse (MOM) Model

The MOM model focuses on improving care for pregnant and postpartum Medicaid participants diagnosed with opioid use disorder (OUD). With over 21,000 individuals of childbearing age diagnosed with an OUD in Maryland, substance use is a leading cause of maternal death and has a significant impact on the approximately 1,500 infants born to Medicaid beneficiaries with OUD in Maryland per year. Utilizing HealthChoice MCOs as care delivery partners, the MOM model focuses on improving clinical resources and enhancing care coordination to Medicaid beneficiaries with OUD during and after their pregnancies. Under the Maryland MOM model, HealthChoice MCOs will receive a per member, per month payment to provide a set of enhanced case management services, standardized social determinants of health screenings and care coordination, as well as to encourage appropriate somatic and behavioral health care utilization, such as prenatal care and behavioral health counseling. The Maryland MOM model is currently a CMMI-funded demonstration; model services will be provided on a pilot basis in one Maryland jurisdiction (St. Mary's County) when enrollment begins in July 2021.

Sustainability: §1115 waiver

Monitoring and Impact Measures:

- Process Measures: Number of Maryland jurisdictions where services are covered; number of MOM model participants

[11] Internal Presentation: HealthySteps Slides for March 2021 Medicaid Meeting.

- Outcome Measures: Increased prenatal and postpartum care attendance; increased utilization of medication for OUD; increased screenings for maternal anxiety, depression and social determinants of health; increased well-child visit attendance
- Expected Impact: Cost savings due to reductions in potentially-avoidable ED utilization and NICU lengths of stay

PHPA Initiatives for Improving Maternal and Child Health

PHPA proposes directing funding to evidence-based and promising practices to improve maternal and child health outcomes through two main programs and initiatives:

1. Expansion of the State's existing asthma home-visiting program
2. Eliminating Disparities in Maternal Health Initiative

Asthma Home Visiting Program

In 2017, MDH submitted a successful application to the Centers for Medicare and Medicaid Services (CMS) for a Health Services Initiative (HSI) under the Children's Health Insurance Program (CHIP). The new program, approved as a State Plan Amendment (SPA), allowed MDH to create a $3 million home visiting program for children who are enrolled in or eligible for Medicaid (including CHIP), based on diagnosis of either moderate to severe asthma or lead poisoning.

The program operates in nine jurisdictions: Baltimore City and Baltimore, Charles, Dorchester, Frederick, Harford, Prince George's, St. Mary's, and Wicomico Counties. These are sites with some of the highest burden of asthma ED visits. Once they are deemed eligible and enrolled in the program, the children's families are eligible for up to six home visits to receive education and training around home environmental factors that trigger asthma, durable goods that can reduce or eliminate home triggers, and improved care coordination with providers through asthma action plans. The program similarly provides home visiting for eligible children who have been lead poisoned and is one of the first such programs in the country. Appendix 2 shows the impact that additional HSCRC funding would have on home visiting capacity under the program.

While $1 million of the proposed funding would support the Asthma Home Visiting Program describe above, $250,000 would fund community-based interventions, such as mobile asthma treatment, for patients of all payer types.

Sustainability: Continued State funds and Federal match; Public-Private Partnerships

Monitoring and Impact Measures

- Process Measures: Enrollment capacity

- Outcome Measures: Increase in program referrals and enrollment
- Expected Impact: Cost savings due to reductions in asthma-related ED utilization for children, reductions in school absenteeism

Eliminating Disparities in Maternal Health Initiative

PHPA also proposes developing an Eliminating Disparities in Maternal Health initiative which will provide funding opportunities to jurisdictions with elevated severe maternal morbidity rates. PHPA intends to release a Request for Application to support health systems, community-based organizations, Federally Qualified Health Centers (FQHCs), community health centers, and local health departments (LHDs) to develop and implement a CenteringPregnancy Model of Care and expand promising practices in home visiting (e.g. Healthy Start, Maternal and Infant Health Care, and Family Connect).

As described earlier in the recommendation, Medicaid also proposes to support the CenteringPregnancy Model of Care and home visiting. These investments would be mutually reinforcing, with PHPA funding focused on expanding infrastructure for programs and non-Medicaid patients seeking similar services. In addition, PHPA's funding focus on home visiting is focused on promising practices.

Sustainability: Applicants would be required to develop sustainability plans at the end of the funding period. Sustainability plans would vary based on the initiatives being performed.

Monitoring and Impact Measures: PHPA is developing scale targets, similar to those used in the Regional Partnership Catalyst Program, to ensure accountability for funding recipients.

Recommendations

Staff makes the following recommendations:

1. Approve the use of the $10 million in reserved annual Regional Partnership Catalyst Program funding to support the third SIHIS population health priority area, maternal and child health, for four years (FY 2022 – FY 2025).
2. Authorize funding to be applied to annual hospital rates through a broad-based, uniform assessment on hospitals for transfer to the Maternal and Child Health Population Health Improvement Fund which will sunset in 2025.
3. Authorize HSCRC staff to enter a MOU with MDH to establish the terms and conditions of administration of the Maternal and Child Health Population Health Improvement Fund.
4. Approve the use of $8 million annually by Medicaid to support the following initiatives and programs:
    - Home Visiting Services pilot expansion

- Reimbursement for doula services;
- CenteringPregnancy, a clinic-based group prenatal care model;
- Healthy Steps, a clinic-based intensive prenatal and postpartum case management framework; and
- Maternal Opioid Misuse (MOM) model expansion.

5. Approve the use of $2 million annually by PHPA to support the following initiatives and programs:
    - Asthma Home Visiting Program
    - Eliminating Disparities in Maternal Health Initiative

Appendix 1 – Medicaid Programs – Expansion Estimates

Table 4. Medicaid Programs - Expansion Estimates

Program	Estimated Eligible Population (annual)	Current Enrollment (annual)	Expanded Enrollment (annual)
Postpartum Coverage	3,667	0	3,455
Reimbursement for Doula Services	25,037	0	1,502
HVS Pilot Expansion	1,432	45	1387
MOM Model	1,362	30	817

Appendix 2 – PHPA Programs - Expansion Estimates

Table 5. Capacity for CHIP-SPA Asthma Home Visiting

Current Areas	Estimated Eligible Children (FY 2018)	# of Children w Asthma ED Visits[12] (CY 2018)	# of Child Asthma ED Visits[13] (CY 2018)	Current Enroll-ment Capacity[14]	Expanded Enrollment Capacity[15]	Capacity Growth
Baltimore City [expanded]	8,897	2,482	3,419	232	416	79%
Baltimore County [Expanded]	4,020	1,391	1,849	232	263	13%
Charles	527	199	243	166	180	8%
Dorchester	339	73	93	99	97	-2%
Frederick	433	291	373	166	180	8%
Harford	534	290	353	166	180	8%
Prince George's	3057	690	771	232	263	13%
St. Mary's	386	136	167	166	180	8%
Wicomico	453	181	241	166	180	8%
Montgomery [New]	2,439	922	1,104		263	
Total in Jurisdictions	**21,085**	**6,655**	**8,613**	**1625**	**2202**	**36%**

Table 6. Enrollment Capacity for Eliminating Disparities in Maternal Health Initiative

Program	Estimated Eligible Population (Annual)[16]	Current Enrollment (Annual)	Expanded Enrollment (Annual)
Centering Pregnancy	56728	600[17]	1200[18]
Maternal and Infant Home Visiting	56728	2747	2947[19]

[12] With Asthma as the primary diagnosis
[13] With Asthma as the primary diagnosis
[14] Based on staffing
[15] Based on staffing
[16] Eligible population estimate based on number of delivery hospitalizations in the 12 jurisdictions (Anne Arundel, Baltimore City, Baltimore County, Carroll, Charles, Frederick, Harford, Howard, Montgomery, Washington, Prince George's, Wicomico) that account for 90% of the SMM events.
[17] Enrollment calculated based on an additional 6 certified sites
[18] Enrollment based on 6 certified sites at approximately 100 individuals per site per year
[19] Enrollment based on expansion in 5 additional sites at an increase of 40 clients per year for specific Maternal and Infant home visiting site.

maryland
health services
cost review commission

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: March 10, 2020

RE: Hearing and Meeting Schedule

May 12, 2021 To be determined - GoTo Webinar

July 9, 2021 To be determined - GoTo Webinar

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday 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.