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 December 8, 2021 Public Meeting:

1. Draft Recommendation on Maryland Hospital Acquired Conditions (MHAC) Policy for RY 2024

WRITTEN COMMMENTS ON THE AFOREMENTIONED STAFF DRAFT RECOMMENDATIONS ARE DUE IN THE COMMISSION'S OFFICES ON OR BEFORE DECEMBER 15, 2021, UNLESS OTHERWISE SPECIFIED IN THE RECOMMENDATION.

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590th Meeting of the Health Services Cost Review Commission
December 8, 2021

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

EXECUTIVE SESSION
11:30 am

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

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

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on November 10, 2021

2. Docket Status – Cases Closed
   2572A – University of Maryland Medical System

3. Docket Status – Cases Open
   2569N – Greater Baltimore Medical Center
   2573A – University of Maryland Medical System
   2574A – Johns Hopkins Health System
   2575A - Johns Hopkins Health System
   2576A - Johns Hopkins Health System
   2577A - Johns Hopkins Health System

4. Presentation on COVID-19 Community Vaccination Program
   a. Johns Hopkins Health System
   b. Meritus Health

5. Report on Community Benefit Activities for FY 2020

6. Final Recommendation on Medicare Performance Adjustment for CY 2022

7. Draft Recommendation on Maryland Hospital Acquired Conditions (MHAC) for RY 2024

8. Policy Update and Discussion

   a. Model Monitoring
   b. Undercharge Update

9. Hearing and Meeting Schedule

Closed Session Minutes
of the
Health Services Cost Review Commission

November 10, 2021

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

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

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

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

The Closed Session was called to order at 11:33 a.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

In attendance via conference call in addition to Chairman Kane were Commissioners Antos, Bayless, Cohen, Elliott, Joshi and Malhotra.
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In attendance via conference call representing Staff were Katie Wunderlich, Allan Pack, William Henderson, Jerry Schmith, Geoff Daugherty, Will Daniel, Alyson Schuster, Claudine Williams, Megan Renfrew, Xavier Colo, Amanda Vaughn, Bob Gallion, and Dennis Phelps.

Also attending via conference call were Eric Lindemann, Commission Consultant, and Stan Lustman and Tom Werthman, Commission Counsel.

Item One

Katie Wunderlich, Executive Director, and Adam Kane, Chairman, updated the Commission and the Commission discussed efforts to create additional innovations and strategies to make the Model more uniquely successful and recognized as such by the federal government.

Item Two

Eric Lindemann, Commission Consultant, updated the Commission on Maryland Medicare Fee-For-Service TCOC versus the nation.

Item Three

Stan Lustman, Commission Counsel, summarized and the Commission discussed proposed amended regulations on Telehealth services.

The Closed Session was adjourned at 1:12 p.m.

MINUTES OF THE 589th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION November 10, 2021

Chairman Adam Kane called the public meeting to order at 11:33 a.m. Commissioners Joseph Antos, PhD, Victoria Bayless, Stacia Cohen, James Elliott, M.D., Maulik Joshi, DrPH, and Sam Malhotra were also in attendance. Upon motion made by Commissioner Antos and seconded by Commissioner Elliott, the meeting was moved to Closed Session. Chairman Kane reconvened the public meeting at 1:24 p.m.

STAFF UPDATE

Ms. Katie Wunderlich, Executive Director, announced that Tom Werthman, Assistant Attorney General, will be leaving the Commission. Ms. Wunderlich thanked Mr. Werthman for all his dedicated work at the Commission serving the citizens of Maryland.

Ms. Wunderlich also introduced two new Staff employees. Adam Pittman has been hired as the Chief, Population Based Methodologies. Also, Matisia Jones has been hired as an Administrative Officer.

REPORT OF NOVEMBER 10, 2021 CLOSED SESSION

Mr. Dennis Phelps, Deputy Director, Audit & Compliance, summarized the minutes of the November 10, 2021 Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM THE OCTOBER 13, 2021 CLOSED SESSION AND PUBLIC MEETING

The Commissioners voted unanimously to approve the minutes of the October 13, 2021 Public meeting and Closed Session.

ITEM II
CASES CLOSED

2570N – UM Rehabilitation & Orthopedic Institute
2571A – Johns Hopkins Hospitals

ITEM III
OPEN CASES

2569N- Greater Baltimore Medical Center 2572A- University of Maryland Medical Center

ITEM IV
FINAL RECOMMENDATION ON QUALITY-BASED REIMBURSEMENT PROGRAM FOR RY 2024

Ms. Diane Feeney, Associate Director, Quality Initiatives, presented staff's final recommendation on the Quality-Based Reimbursement Program for RY 2024 (see "Final Recommendation for Updating the Quality-Based Reimbursement Program (QBR) for Rate Year 2024" available on the HSCRC website).

The QBR Program, implemented in 2010, includes potential scaled penalties or rewards of up to two percent of inpatient revenue. In addition, the program assesses hospital performance against national standards for Safety domain and Person and Community Engagement.

The QBR Program assesses hospital performance based on the national threshold (50th percentile) and benchmark (mean of the top decile) values for all measures, except the HSCRC calculated in-hospital mortality rate (which uses state data to calculate performance standards).

The QBR Redesign Subgroup is comprised of key stakeholders from the Performance Measures Work Group and the broader Maryland healthcare system community. Members of the subgroup were appointed based on their expertise and potential contribution to the defined scope of work. The subgroup considered options for overhauling the QBR Program to meet or exceed the cost and quality outcomes of the national VBP Program, to explore opportunities for innovation in the hospital quality arena; and to ensure the state achieves the goals of the Total Cost of Care (TCOC) Model

The subgroup established goals to help ensure success under the TCOC Model. The goals focused on: (1) quality and safety areas where Maryland underperforms, relative to the Hospital Value-Based Purchasing (VBP) Program or to national or historic performance in other measurement areas, and (2) opportunities for innovation in hospital measurement and improvement. The goals are as follows:

- Review and suggest options for updating measures in the QBR Program
- Review and suggest options for measurement data sources
- Review and suggest options for updating scoring and incentives.

Stakeholder Feedback and Staff Response

MHA raised concerns that the cut-point of 41% at which hospitals earn reward or receive penalties may be too aggressive since it was determined in large part on 2019 pre-COVID quality data from CMS, and updated data has not become available.

Staff agreed and will retrospectively evaluate the cut-point as part of the work to make retrospective adjustments to the methodology because of the COVID pandemic.

Many hospitals indicated that they would not request a CMS up-front loan since global budgets already provide incentives to improve Hospital Consumer Assessment of Healthcare Providers and System (HCAHPS).

Staff agreed that expending CMS funding without using other hospital resources is inefficient and has removed this option from their final recommendation.

Many stakeholders supported adding HCAHPS linear scores to the Person and Community Engagement (PCE) domain. However, hospital and Commissioners voiced concerns about including the "responsiveness of hospital staff" measure in the set of linear measures and suggested instead the use of the "overall rating of care" measure.

Staff continues to support the "responsiveness" measure in the linear score calculation as this measure is meaningful to patients while they are receiving care and potentially is not as linked to an institutional reputation as the "overall" rating may be. Furthermore, nationally there is high correlation between responsiveness and the overall hospital rating for both top-box and linear scores. Therefore, the recommendation continues to include responsiveness as a linear measure of performance. Furthermore, to address CMS concerns, the Staff proposes that the addition of linear scores be thought of as a pilot that can be phased out in coming years if improvements are not realized.

Stakeholders expressed concern that including requiring Emergency Department (ED) wait times would cause additional, unnecessary hospital expenses in third-party vendor costs. They also noted that ED wait times hold hospitals accountable for an outside infrastructure they cannot control and, therefore, are not appropriate to use a pay-for-performance program.

Staff responded that Maryland is a significant outlier on every measure of ED wait times and that Staff will work with hospitals to establish performance standards and submission timeframes.

Stakeholders agreed that timely follow-up after acute exacerbations of chronic conditions improves patient outcomes; however, they also expressed concerns about the lack of available timely and accurate data and urged suspension of the measure from QBR or limiting it to Medicare-only.

Staff acknowledged that timely and valid hospital data has been difficult to obtain and pointed out that hospitals have had access to their Medicare data to calculate the measure. In addition, Staff observed that hospitals were aware of these conditions before the measurement period and supported the inclusion of behavioral health and Medicaid patients.

Chairman Kane questioned why Maryland seems to have a problem with ED wait times compared to the rest of the nation.

Ms. Feeney noted that elements of the TCOC Model create incentives to retain patients in the ED for longer than is medically necessary to prevent readmissions. However, Ms. Feeney added that this does not fully explain Maryland's performance since Maryland has struggled with ED wait times well before implementing the TCOC Model.

Commissioner Bayless asked if CMS intends to add ED wait times back into its evaluation criteria.

Ms. Feeney stated that CMS has signaled that they may take ED wait times out of its criteria but haven't done so yet. Ms. Feeney noted that Staff views ED wait times as a significant measure to include in Maryland QBR regardless of their inclusion in CMS criteria.

Commissioner Elliott asked Staff to identify exclusions within the 30-day mortality measure.

Ms. Feeney stated that the Staff would explicitly highlight these exclusions in communicating the final approved policy to hospitals

Final Recommendations for RY 2024 QBR Program:

1. Continue Domain Weighting to determine hospitals' overall performance scores as follows: PCE - 50 percent, Safety (National Healthcare Safety Network (NHSN) and Agency for Healthcare Research and Quality (AHRQ) Patient Safety Index composite) - 35 percent, Clinical Care - 15 percent.

    - Within the PCE domain, include four linear measures weighted at 10% of QBR score; remove associated revenue at risk from top box.
    - Within the PCE domain, continue to include timely follow-up after acute exacerbation of a chronic condition weighted at 5% of score; currently, Medicare only measure.

2. Collaborate with partners to implement statewide HCAHPS improvements initiative, which can focus on root causes of HCAHPS performance and the sharing of best practices for improvement.

3. Develop monitoring reports for measures to expand the scope of the policy and that align with the goals of the TCOC Model that will be considered for adoption in RY 2025:
    - 30-day all-payer, all-cause mortality;
    - Follow-up for acute exacerbation of chronic conditions for Medicaid; and
    - Follow-up after hospitalization for mental illness.

4. Collaborate with the Chesapeake Regional Information System for our Patients to develop infrastructure for collection of hospital electronic clinical quality measures (e-CQMs) and core clinical data elements:

    - Require hospitals to submit the CY 2022 ED-2 eCQM and consider for re-adoption in future rate years; and

- Explore development of hospital eCQM for inpatient/outpatient all-payer THA-TKA complications.

5. Maintain the pre-set scale (0-80 percent with cut-point at 41 percent), and continue to hold 2 percent of inpatient revenue at-risk (rewards and penalties) for the QBR program.

6. Adjust retrospectively the RY 2024 QBR pay-for-performance program methodology as needed due to COVID-19 Public Health Emergency and report any changes to Commissioners.

Commissioners voted unanimously in favor of Staff's recommendation.

ITEM V
DRAFT RECOMMENDATION ON REVENUE FOR REFORM

Mr. Willem Daniel, Deputy Director, Payment Reform, and Stakeholder Alignment, presented Staff's draft recommendation on Revenue for Reform (see "Revenue for Reform") available on the HSCRC website.

Since the beginning of the All-Payer Model in 2014, the State has been successful at meeting its financial obligations to CMS as a result of the Global Budget Revenue (GBR) system for hospital payment. The GBR provides hospitals with a revenue target that is relatively inverse to hospital utilization. This reimbursement system rewards hospitals for reducing unnecessary utilization because the revenue that had been associated with that utilization is retained by the hospital under the GBR.

Hospital retained revenues have two purposes under the GBR system. First, retained revenues are used to support hospital financial stability, since per capita revenue is taken out of the system. The TCOC Model commits the State to reducing utilization by $300 million by 2023. If overall utilization remained constant, then the reductions in per capita revenues would necessitate reductions in the price per case. In turn, this would put pressure on hospitals' margins. Under the GBR system, a hospital's retained revenues from reduced utilization are used to 'cushion' hospital finances from overall per capita revenue reductions. In this regard, the GBR system has been remarkably successful. Per capita Medicare costs have declined by nearly $300 million relative to the nation, but per capita utilization has declined significantly and consequently hospital margins have been relatively stable.

The second purpose of retained revenues is to invest in the health of Marylanders. The fee-for-service system is a 'sick-care system' meaning that the majority of spending is directed to treating patients after they become sick. Under the GBR, hospitals have an incentive to invest in the care that keeps patients healthy. Under the GBR, retained revenues are not linked to a particular hospitalization episode and can therefore be reinvested in interventions that keep patients healthy and out of the hospital.

The extent to which hospitals' retained revenues have been used for this purpose is unknown. The HSCRC has not made a systematic attempt to catalogue the monies spent by hospitals on population health. While some laudable initiatives have been well-publicized by hospitals and the media, the total amount of population health spending remains unknown.

Staff estimates that GBRs includes approximately $655M in retained revenue for RY 2021.

Assessing the extent to which retained revenues are used for population health is critical to the long-term success of the Maryland Model. Not only is it critical to sustain utilization reductions under the GBR, but the HSCRC's assessment of hospitals cost-efficiency currently does not incorporate the amount of population health spending. This creates a tension between the Integrated Efficiency policy, which aims to correct any maldistribution in the Model, and the purposes of the GBR. Resolving this tension is necessary to ensure that hospitals are equitably reimbursed while at the same time ensuring that hospitals are able to succeed under the GBR.

Under current policy, the Inter-Hospital Cost Comparison (ICC) compares a hospital's charge per case to its Approved Revenue. Since retained revenue generally results in higher regulated profits, retained revenue will make a hospital appear inefficient. This inefficiency occurs even if the hospital deploys that retained revenue to productive population health investments that are in line with the purpose of the TCOC Model. Therefore, Staff recommends that the Commission consider the hospital's population health investments in the hospital's approved revenue for the ICC evaluation.

Staff recommends the following revisions to the Integrated Efficiency policy:

1. A hospital's qualifying population health investments should be added to their approved revenue for the purposes of the ICC evaluation in the Integrated Efficiency policy. Qualifying population health investments should also not be subject to inflationary reductions, as outlined in the Integrated Efficiency policy.

2. Qualifying population health investments should be limited to the following:

    - Community spending in the hospital's primary service area, net of revenue generated for those services, (e.g.. outside of the hospital's regulated space).
    - Non-physician costs (except as described below).
    - Spending that meets one of three following criteria:

        i. An initiative that is intended to address an unmet health need identified on either the hospital's Community Health Needs Assessment or the Centers for Disease Control and Prevention's Health People 2030 Initiative; or
        ii. Spending on primary care, mental health, or dental providers that are located in a Medically Underserved Area; or
        iii. Initiatives that have a clear population target, an outcomes measure, and an improvement goal within a reasonable time frame.

3. Beginning in Rate Year 2025, hospitals will be spent down to a certain ratio of charges to ICC Approved Revenue, to be determined before RY 2024. Staff recommends that the Commission use the interim period to:

- Work with industry to determine the appropriate threshold based on capital replacement, physician costs, and other factors.
- Provide hospitals and Staff with time to evaluate and approve qualifying population health investments in the hospital's ICC Approved Revenue.

Commissioner Bayless questioned the criteria to be used to discern qualified population health costs under Revenue for Reform.

Mr. Daniel explained that Staff intends to use Community Health Needs Assessments definitions of population health costs. By doing this, Staff will not need to explicitly determine what is or isn't a legitimate cost.

Chairman Kane asked how Staff calculated retained revenue and actual margin by the hospital.

Mr. Daniel responded that FY 2013 unit rates (adjusted for inflation) times current Equivalent Case Mix Adjusted Discharges less actual approved GBR would approximately equal current retained revenue. Mr. Daniel clarified that this differs from the regulated margin. Staff doesn't expect hospitals to reinvest the margin fully. However, if hospitals have become more efficient since FY 2013, they will see better margins regardless of retained revenue.

Commissioner Cohen asked for additional clarification on the timeline to implement this policy change.

Mr. Daniel stated that the safe harboring of population health costs in the ICC component of the Integrated Efficiency policy would occur beginning in RY 2023. Next, the systematic spend-down of hospitals would take effect in RY 2025. Mr. Daniel highlighted that the policy changes would create immediate pressure for hospitals with higher retained revenue and lower efficiency to invest in population health.

Commissioner Elliott asked if there was a downside to limiting population health spending to Statewide Integrated Health Improvement Strategy (SIHIS) criteria.

Mr. Daniel responded that the SIHIS goals are not an exhaustive list of population health goals for Maryland to focus on.

Commissioner Elliot further questioned if this lack of boundaries would dilute the effect of efforts specific to the SIHIS goals.

Mr. Daniel explained that while limiting the spending to initiatives supporting the goals of SIHIS would be more likely to achieve SIHIS goals, hospitals could achieve a more significant impact on overall population health if Staff does not limit the spending on SIHIS related initiatives.

As this is a draft recommendation, no Commission action is required.

ITEM VI
POLICY UPDATE AND DISCUSSION

Model Monitoring

Ms. Caitlin Cooksey, Deputy Director of Hospital Rate Regulation, reported on the Medicare Fee for Service data for the 7 months ending July 2021. Maryland's Medicare Hospital spending per capita growth was trending close to the nation, with the past several months being favorable. Ms. Cooksey noted that Medicare Nonhospital spending per-capita was trending unfavorably for both Part A and Part B when compared to the nation. Nonhospital spending per-capita in Maryland is trending unfavorable by approximately 6.4 % when compared to the nation thru July. Ms. Cooksey noted that Medicare TCOC spending per-capita was unfavorable with the past several months trending close when compared to the nation. Ms. Cooksey noted that the Medicare TCOC guardrail position is 1.47% above the nation thru July. Ms. Cooksey noted that Maryland Medicare Hospital and non-hospital growth thru May shows a run rate erosion of $94,511,000.

Inflation Factors Review

Mr. Jerry Schmith, Director, Revenue & Regulation Compliance, presented an update on the inflation issues that hospitals are dealing with (see "Inflation Pressures on Financial Position of Hospitals") available on the HSCRC website.

Mr. Schmith stated that hospitals have experienced increased cost pressures since the COVID-19 pandemic relating to supply chain disruptions and labor premiums. As a result, Staff added an additional .20% to the hospitals RY 2022 update factor to help hospital respond to the inflationary pressures.

Other than looking at operating margin, Staff currently has no additional data available to assist Staff in its review of hospital salaries. Salary information will not be available until 10/22.

Mr. Schmith stated that hospital margins have been stable through the pandemic because under GBR, Maryland hospital are assured of adequate revenue.

Mr. Schmith noted that hospitals have had favorable operating margins over the past two fiscal years. This would suggest that hospitals have increased liquidity to address transitory inflation in RY 2022.

Mr. Schmith stated that the hospitals' June 30, 2020, audited financial statements (which include 3 months of pandemic volume drops) shows that hospitals remained in a strong cash position with more than 100 days of cash on hand.

Mr. Schmith noted that the RY 2022 Update Factor inflation was 2.57%. When compared to the actual inflation of 2.74, this represents a difference of (.17%) for RY 2022.

ITEM VII
LEGAL UPDATE

Regulations

Final Action

Rate Application and Approval Procedures 10.37.10.03A (2)

The purpose of this action is to amend COMAR 10.37.10.03A (2) in order to extend the period of time for which a hospital that has obtained permanent rates through the issuance of a Commission rate order following a regular (i.e., full) rate application is eligible to file a regular rate application with the Commission from 90 days to 365 days. The proposal was approved for publication in the Maryland Register by the Commission on July 14, 2021. It appeared in the September 10th issue of the Maryland Register with opportunity for public comment.

The Commission voted unanimously to adopt the proposed regulation, which is currently scheduled to be effective on December 13, 2021.

Final Action

Rate Application and Approval Procedures 10.37.10.07-1

The purpose of this action is to amend COMAR 10.37.10.07-1 in order to maintain in place the policy first implemented by the Commission relative to telehealth services in response to the pandemic. This proposal was also approved by the Commission on July 14th for publication, and it appeared in the September 10th issue of the Maryland Register, with opportunity for public comment. As originally drafted the proposal noted:

- A hospital may not bill a separate hospital facility fee when a health care provider who provided telehealth services is authorized to bill independently for the professional services rendered; and
- The delivery of telehealth services where the health care provider or the patient is physically located at the hospital constitutes outpatient services provided at the hospital and, therefore, subject to the Commission's rate setting jurisdiction.
- The originally drafted language is being amended as a non-substantive change in order to clarify that either the provider or the patient needs to be at the hospital when the telehealth service is being provided in order to be considered an outpatient hospital service subject to the HSCRC rate setting jurisdiction.

The Commission voted unanimously to adopt the proposed regulation with the non-substantive change, currently scheduled to be effective on December 13, 2021.

ITEM VIII
HEARING AND MEETING SCHEDULE

December 8, 2021 Times to be determined - Go to Webinar

January 12, 2021 Times to be determined – Go to Webinar

There being no further business, the meeting was adjourned at 3:36 pm.

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF NOVEMBER 30, 2021

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2569N	Greater Baltimore Medical Center	9/8/2021	10/8/2021	3/8/2021	CAPITAL	JS/AP	OPEN
2573A	University of Maryland Medical System	10/28/2021	N/A	N/A	ARM	DNP	OPEN
2574A	Johns Hopkins Health System	11/17/2021	N/A	N/A	ARM	DNP	OPEN
2575A	Johns Hopkins Health System	11/23/2021	N/A	N/A	ARM	DNP	OPEN
2576A	Johns Hopkins Health System	11/23/2021	N/A	N/A	ARM	DNP	OPEN
2577A	Johns Hopkins Health System	11/30/2021	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2021**
MEDICAL CENTER	*	**FOLIO:**	**2383**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2573A**

Staff Recommendation

December 8, 2021

I. INTRODUCTION

University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on October 28,2021 for an alternative method of rate determination under COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for continued participation in global rates for solid organ transplant and blood and bone marrow transplants for nine months with Aetna Health Inc. beginning November 1, 2021.

II. OVERVIEW OF THE APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to UPI for all contracted and covered services. UPI is responsible for billing the payer, collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The Hospital contends that the arrangement between UPI and the Hospital holds the Hospital harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

Staff reviewed the experience under this arrangement for the last year and found it to be unfavorable. This is the second year that the experience under this arrangement has been unfavorable. The Hospital has again renegotiated the arrangement. Staff recommends approval of this arrangement for nine months. However, if the experience under the renegotiated

arrangement during the nine-month period continues to be unfavorable, staff will not recommend further approval.

VI. STAFF RECOMMENDATION

Based on the Hospital's favorable performance, staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ transplant, and blood and bone marrow transplant services, for nine-months beginning November 1, 2021. The Hospital will need to file a renewal application to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2021
SYSTEM	*	FOLIO:	2384
BALTIMORE, MARYLAND	*	PROCEEDING:	2574A

Staff Recommendation

December 8, 2021

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on November 17, 2021 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to participate in a new global rate arrangement with for cardiovascular services, kidney transplant services, and spine surgery with Global Medical Management Inc. for a period of one year beginning January 1, 2022.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff found that the experience under this arrangement over the last year was favorable. Staff believes that the hospitals can continue to achieve a favorable outcome under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services, kidney transplant services, and spine surgery for a one year period commencing January 1, 2022. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
JOHNS HOPKINS HEALTH	*	DOCKET:	2021
SYSTEM	*	FOLIO:	2385
BALTIMORE, MARYLAND	*	PROCEEDING:	2575A

Staff Recommendation

December 8, 2021

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on November 23, 2021 on behalf of its member Hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for cardiovascular, joint replacement services and oncology evaluation services with Health Design Plus, Inc. The Hospitals request approval for a period of one year beginning January 1, 2022.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff found that the actual experience under this arrangement for the last year has

been favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular, joint replacement, and oncology evaluation services for a one year period commencing January 1, 2022. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2021**
SYSTEM	*	**FOLIO:**	**2386**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2576A**

Staff Recommendation

December 8, 2021

I. INTRODUCTION

Johns Hopkins Health System ("System') filed an application with the HSCRC on November 23, 2021 on behalf of its member hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global arrangement to provide solid organ and bone marrow transplants services with Cigna Health Corporation. The System requests approval of the arrangement for a period of one year beginning January 1, 2022.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for participation in an alternative method of rate determination for bone marrow and solid organ transplant services, for a one-year period commencing January 1, 2022, and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU"). The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2021**
SYSTEM	*	**FOLIO:**	**2387**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2577A**

Staff Recommendation

December 8, 2021

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on November 30, 2021 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to continue to participate in a global rate arrangement for bariatric surgery, bladder cancer surgery, anal and rectal cancer surgery, cardiovascular services, joint replacement surgery, pancreatic cancer surgery, spine surgery, and thyroid and parathyroid surgery with BridgeHealth Medical, Inc. for a period of one year beginning January 1, 2022.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

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

V. STAFF EVALUATION

Staff found that there was no experience under this arrangement for the last year. However, Staff believes that the Hospitals can achieve favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for bariatric surgery, bladder cancer surgery, anal and rectal cancer surgery, cardiovascular services, joint replacement surgery, pancreatic cancer surgery, spine surgery, and thyroid and parathyroid surgery for a one year period commencing January 1, 2022. The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

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COVID-19 Community Vaccination Program

Mid-Year Program Update

COVID-19 Community Vaccination Program

- To support the State's effort to increase vaccination rates, the Commission approved the "COVID-19 Community Vaccination Program" that began May 2021 and will run through the end of FY2022.
- The program was designed to help increase the statewide COVID-19 vaccination rate, particularly for underserved and vulnerable populations.
- Despite an unprecedented statewide effort to vaccinate all Marylanders, key challenges persist and threaten our ability to achieve community immunity.
  - Mass Vaccination Sites scaled back operations and were inaccessible for many in the State.
  - While vaccine supply has increased, consumer demand for initial doses has declined.
  - Emergence of delta variant prompted a renewed urgency to reach still-unvaccinated patients and administer booster doses to eligible patients.
  - Large numbers of children now eligible for vaccination, requiring huge outreach effort.
- The COVID-19 Community Vaccination Program provides short-term funding to hospitals in order to allow for the optimization/expansion of their community-based vaccine dissemination strategies in areas with vaccine rates lower than the State average.
- Hospitals volunteered for over 200 zip codes that were identified by the Vaccination Equity Task Force (VETF) or in collaboration with Local Health Departments using CRISP data as disadvantaged, underserved, vulnerable, and/or hard-to-reach areas.

Awardees

- The HSCRC awarded $12 million to 12 hospital systems in Maryland to expand hospitals' existing mobile and community-based vaccination programs and improve existing programs.
  - Atlantic General Hospital
  - Frederick Health
  - Greater Baltimore Medical Center
  - Holy Cross Hospital
  - Johns Hopkins Health System
  - LifeBridge Health and Ascension St. Agnes
  - Luminis Health
  - MedStar Health - Baltimore
  - MedStar Southern Maryland
  - Meritus Medical Center
  - University of Maryland Medical System

Performance Summary

Vaccination Rate in Targeted ZIPs*

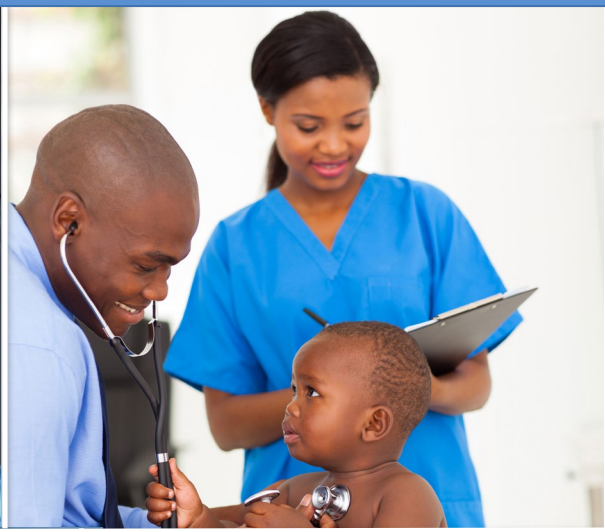
Baseline Vaccination Rate (Dec 2020-April 2021)	Current Vaccination Rate (as of December 1, 2021)
34.60%	65.61%

Doses Administered and Events Funded through Program**

Month	Doses Administered	Community Events & Homebound Efforts
May	12,429	142
June	13,654	294
July	6,506	309
August	11,182	401
September	6,231 (1st/2nd) 863 (Booster)	325
October	3991 (1st/2nd) 2622 (Booster)	279
TOTAL (as of 10/31/21)	**57,478**	**1471**

*Based on Maryland Department of Health ImmuNet Data through CRISP. Rates are not specific to activities conducted solely under the Community Vaccination Program.
**Based on hospital self-reporting. November 2021 reporting, which will include data on pediatric doses administered through this program, will be available later in December.

Meritus Health



HSCRC Mobile Vaccination Clinic

Allen L. Twigg, LCPC, FACHE and David White

December 8, 2021

Meritus Health

Award amount $453,333

Initial dose projection 7,500 fully vaccinated persons
(7,500 – 15,000 total doses)

Doses administered

- 1st & 2nd doses 2,763
- Boosters 1,679
- Pediatrics (ages 5-11) 122

Total doses 4,564 (through 11/30/21)

Meritus Health

Approximately $50 per dose administered

Community Partners

22+ organizations: including **convenience stores**, churches, public and private business, YMCA, Goodwill, Children in Need, shelters, medical practices, schools

Support

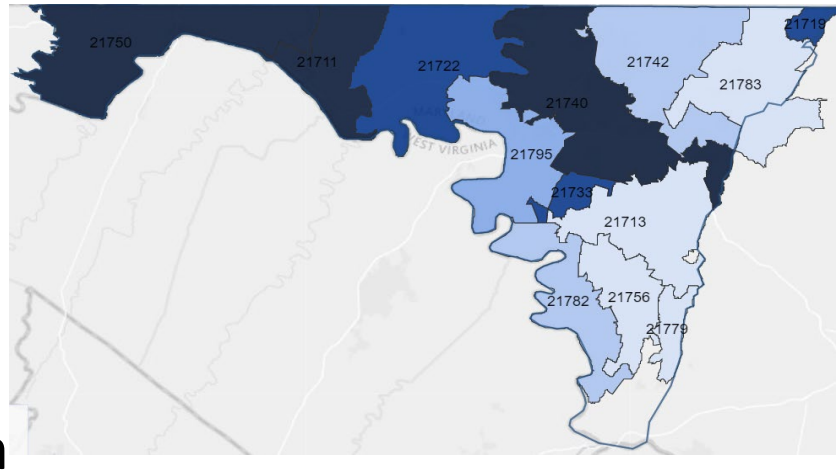
- Space
- Pre-event surveys
- Opportunity to provide education & address vaccine hesitancy
- Promotion; messages, flyers, billboards
- Collaboration and coordination on clinic days
- Police presence upon request for safety

Meritus Health

Target Population

The most vulnerable and underserved persons:

- Seniors
- Latinx
- Black/African American
- Migrant farm workers
- Homebound
- Behavioral health
- Persons without transportation
- Unhoused Populations
- Children



Targeted 15 zip codes with greatest disparities

Reached all 15 zip codes at 90 different locations

Meritus Health

Activities to Date

of community events **14**

# of mobile community clinics **226**

Strategies

- Identified geographic needs (CRISP, CDC Social Vulnerability Index)
- Listened and learned about reasons for hesitancy
- Provided education
- Gained community partners
- Targeted locations (senior living, minority neighborhoods, churches, schools, businesses, **convenience stores**)
- **Enlisted trusted messengers**
- Expanded vaccine options
- Scheduled evening hours and weekends

Meritus Health

Successes & Accomplishments

15 zip codes 90 locations

- Increased access to vaccine
- Experienced team hired (CRNP, RN, Community Health Worker)
- Mobile documentation in EHR
- Offer all three vaccines
- Agile adjustments to changing CDC guidelines
- Overcoming hesitancy
- Building trust
- Offering pediatric vaccination
- Identified as a top mobile clinic for booster administration
- Washington Co. is top county for fully vaccinated in the Tri-State area +51% (north 39.9%, 27.7%, south 33.2%, 32.9%, west 49%)

Meritus Health

Challenges

Vaccine hesitancy

- Meritus Residency collaboration
- Vaccine education materials (print, video, social media)
- Pre-event Q&A sessions
- “Town Halls” with key community leaders
- Trusted messengers
- “Ask a Doc” during clinics

Advertising ahead of event

Weather

Supplies saline solution shortage

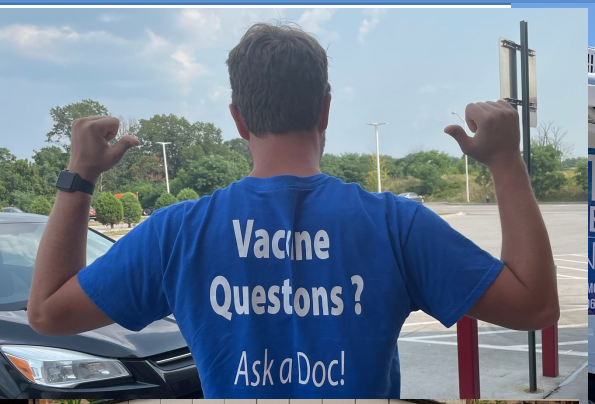
Meritus Health

Planned Work

- Anticipate increase in pediatric and booster needs
- New pediatric clinics beginning Dec. 1
- Increase outreach to Hispanic community; churches, markets, employers
- Coordinating with Maryland Physicians Care to reach unvaccinated members
- Shelters and unhoused population during cold weather
- Friends and family plan
- Continue with convenience store locations

Meritus Health

Questions?



Meritus Health

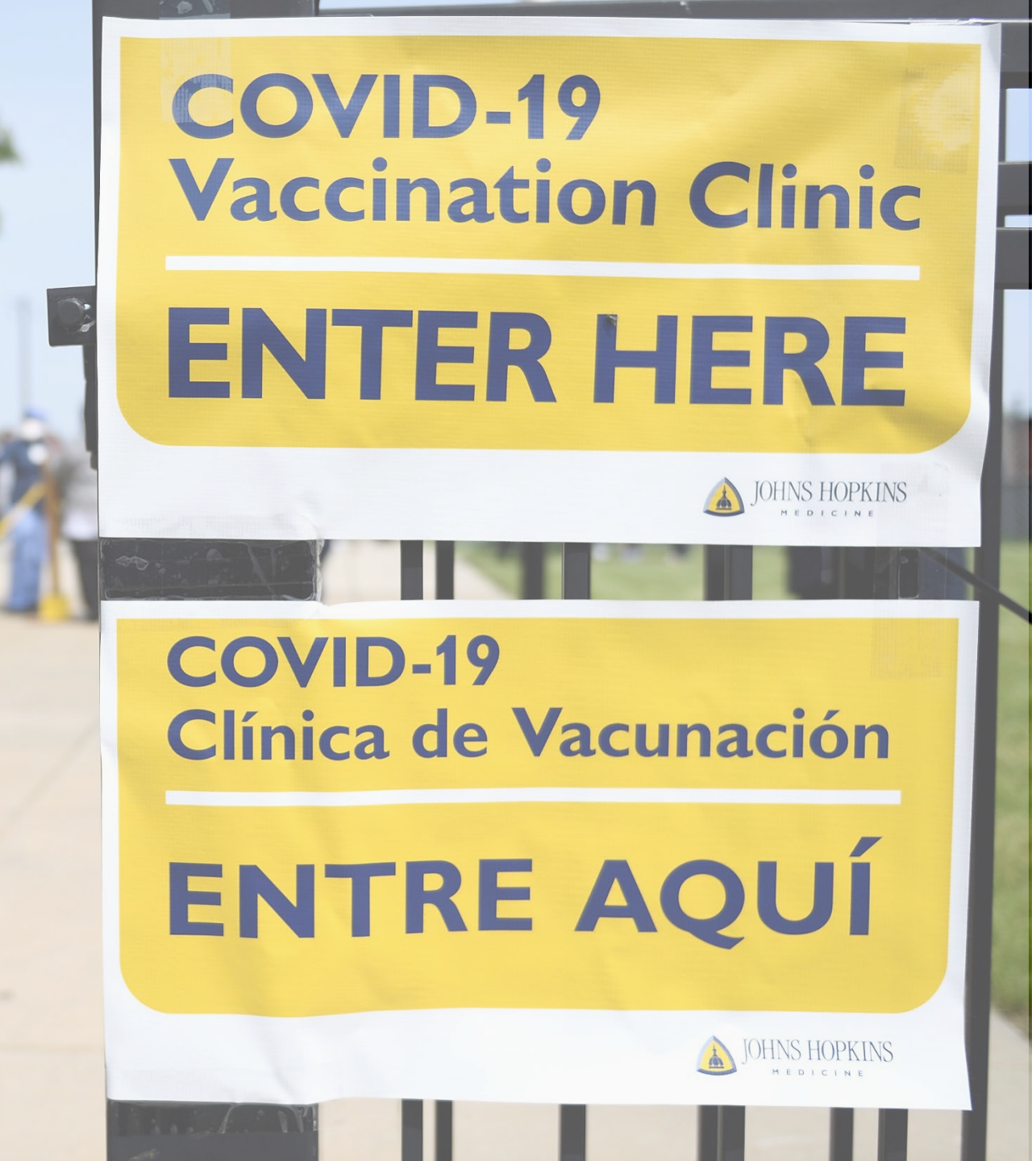
HSCRC COVID-19 Community Vaccination Program

Prepared for The Health Services Cost Review Commission

Presented by:

Ben Bigelow, Director COVID-19 Mobile Vaccine Clinics, JHHS

December 08, 2021



- Johns Hopkins Health System (JHHS) received **$1.653 million** in funding through from the HSCRC to operate a community vaccination program for its four Maryland Hospital
  - Johns Hopkins Hospital
  - Bayview Medical Center
  - Howard County General Hospital
  - Suburban Hospital

- JHHS initial dose projection was **19,800 doses** of the vaccine administered by the end of June 2022.

- As of November 30, 2021, JHHS has administered **20,273 doses**

Community Partners

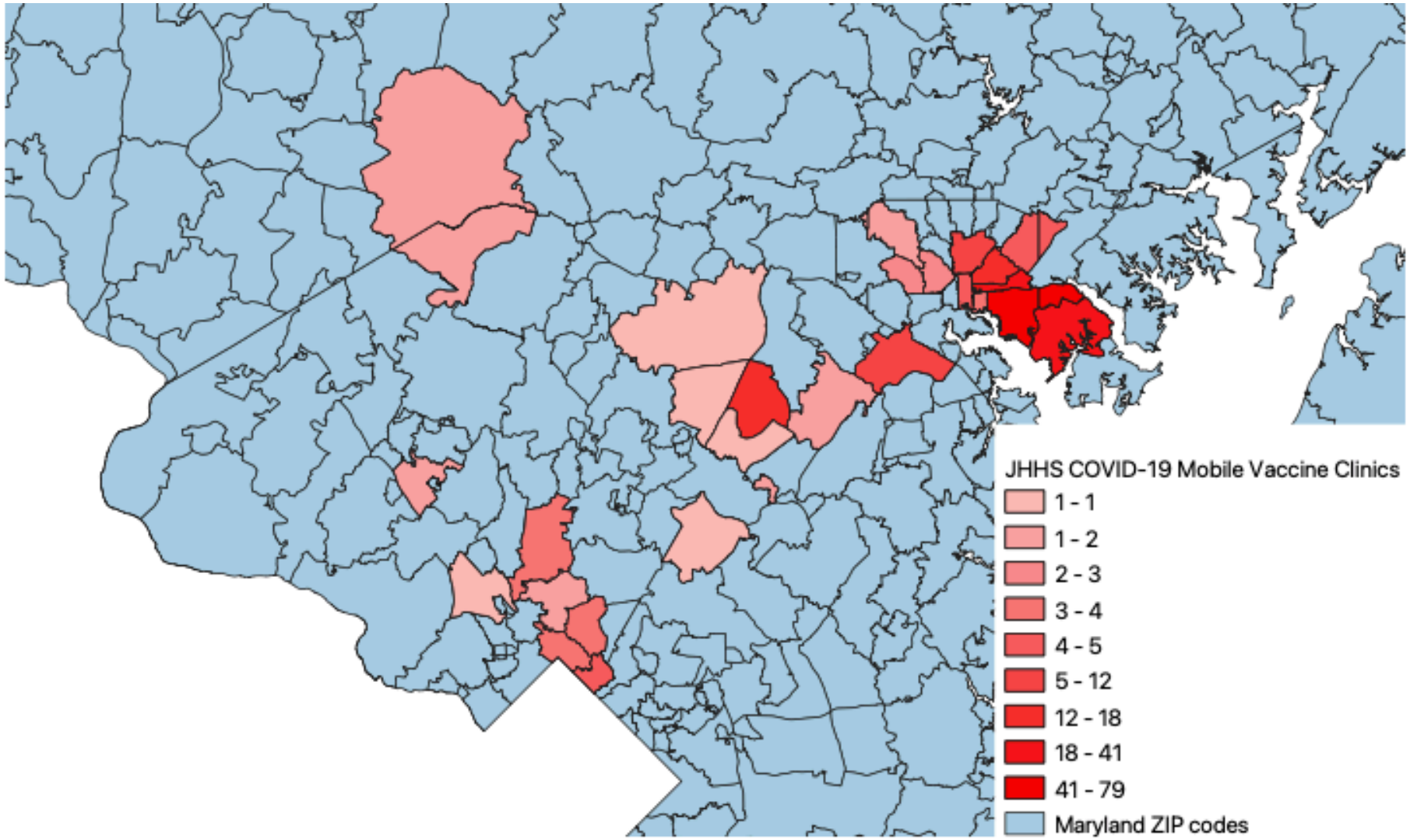
- **JHHS has worked with over 40 community partners to host clinics at their locations.** In addition, we rely on a network of 100+ partners to share information about our events.
  - Partners Include:
    - Sacred Heart Church, Baltimore
    - Henderson Hopkins School, Baltimore
    - Megamart Supermarket, Takoma Park & Baltimore
    - St. Johns Baptist Church, Columbia
    - Salud Y Bienestar, Montgomery County

- These community partners assist by providing outreach to the community, acting as ambassadors for vaccine uptake, and hosting events and informational sessions.

Target Populations

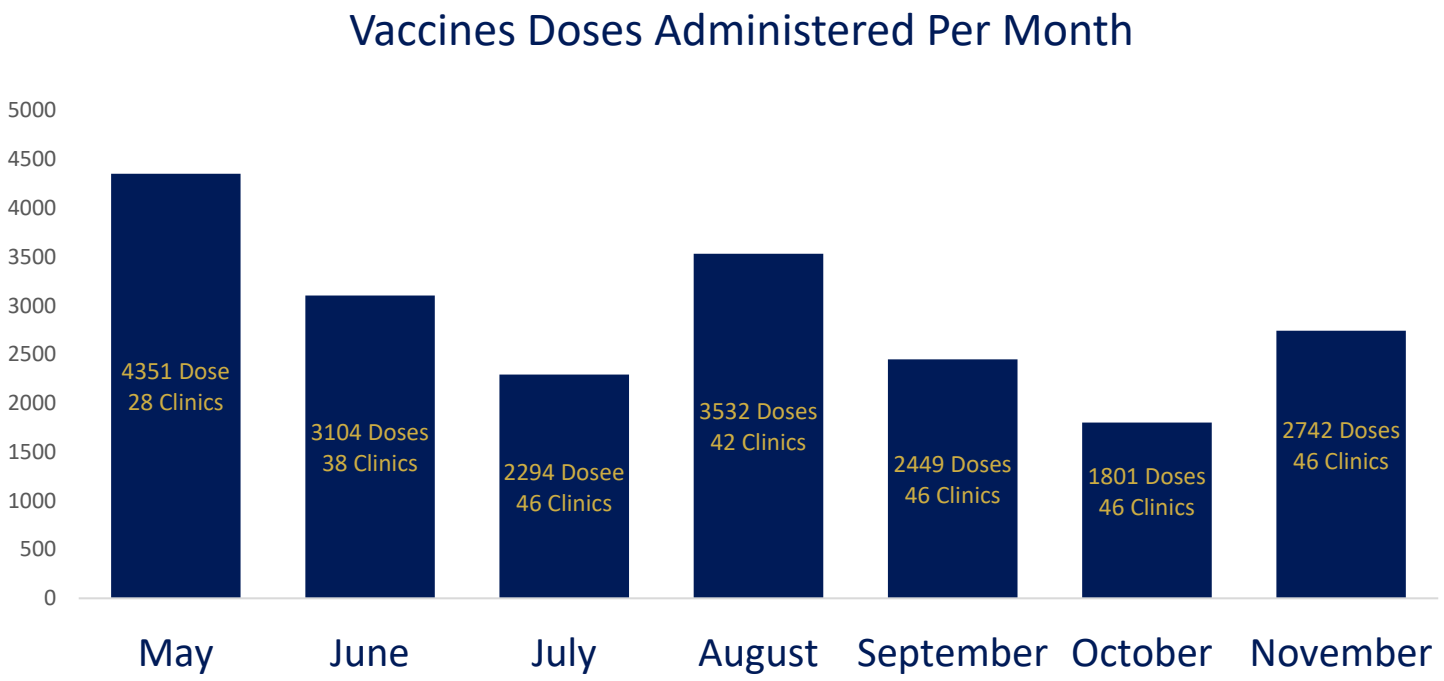
- JHHS has targeted a number of populations including:
  - Latinx—JHHS has **vaccinated over 5,000 Latinx individuals** who reported having limited English proficiency.
  - East Baltimore Residents—Through a partnership with BCHD over **800 doses have been administered in non-traditional locations** such as markets, strip malls, and community events.
  - Longshoremen and Seafarers—**Over 1,000 doses provided in the Port of Baltimore.**

Zip codes Targeted



Timeline of Program

JOHNS HOPKINS MEDICINE



HSCRC COVID-19 Community Vaccination Program Approach to Outreach

Close Collaboration with Local Health Departments

- We work closely with the local health departments to identify areas to host clinics, particularly those with low vaccine uptake.
- Promote events through use of online media, door-to-door canvassing, and education during the clinic.
- Call all patients to ensure they return for their 2nd dose or help them find a different clinic date if they missed their appointment.

Community Partners

- We have long term partnerships with several key community groups that allow us to be a trusted source with the community.
- We also continuously look for new partners that will allow us to reach new pockets of unvaccinated individuals.
- Partner with faith groups, schools, businesses, etc.

Utilizing Community Health Workers

- Leverage the expertise of our Community Health Workers (CHW). This includes understanding the community and where to advertise and/or host events.
- Our CHW's provide feedback on what they are hearing from patients including common misconceptions or barriers to getting a vaccine.

Continuing Challenges

- Despite the amazing work that is being done across Maryland there are still many individuals that are vaccine hesitant.
  - **Meet People Where They Are:** Using tools such as the mobile vaccine truck we can hold clinics in high traffic areas and naturally engage people in conversations about the vaccine and their concerns. This often takes several interactions, but have proved successful time and again
  - **Address Mistrust of Medical System:** We partner with trusted community groups in order to build relationships. Educate members of these organizations to canvass for events and empower them to be vaccine ambassadors.
  - **Provide Language Congruent Care:** JHHS has focused on hiring bilingual staff such CHW's, registration staff, pharmacists, and nurses. The importance of providing care in someone's own language is key to building trust.

The Next 6 Months

- As we move forward, we will continue to focus on getting more individuals vaccinated with their 1st and 2nd dose as well as providing booster doses.
    - Increase education activity: We plan to increase our educational sessions with community members who are vaccinated teaching them about COVID-19 and the vaccine. The goal is to **empower them to talk to family and friends that are vaccine hesitant**.
    - While hosting booster clinics encourage individuals to bring family and friends that are unvaccinated, take opportunities to talk to parents about the importance of their children being vaccinated. **Encourage multi-generational protection.**

Thank you!

- Stephen Sisson
- Nicki McCann
- Jeanne Hitchcock
- Michael Preston
- Chrystal Green
- Kathleen Page
- Celia Proctor
- Lisa Broadhead
- Tracy Novak
- Monique Sanfuentes
- Mobile Vaccine Team

- And many more!

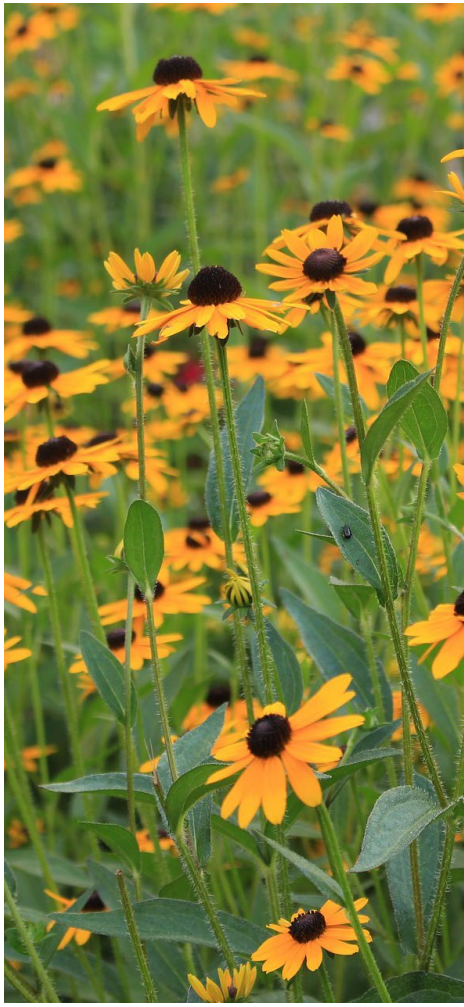
90%

of individuals vaccinated at mobile clinics identify as minorities or people of color.

The Hilltop Institute

FY 2020 Hospital Community Benefit Report

Laura Spicer
Maryland Health Services Cost Review Commission
December 8, 2021



UMBC

Upcoming Changes

Presented by
Will Daniel

Introduction

- The HSCRC is required to collect hospital community benefit(CB) information and compile into a statewide, publicly available report
- Two components:
  - Financial Report
  - Narrative Report
- FY 2020 marks the 17th year of reporting

Maryland-Recent Legislation

- HB1169/SB0774 of the 2020 Legislative Session updated §19-303 of the Health General Article
- It updated CB reporting requirements:
  - Updates the definition of CB
  - More closely ties initiatives back to the community health needs assessment (CHNA)
  - Requires listing of tax exemptions the hospital claimed during the preceding year

Working Groups

- To implement these new requirements, the HSCRC convened the Consumer Standing Advisory Community and a Technical Subgroup in the summer and fall of 2020
- Submitted a legislative report with recommendations in December 2020
- Some changes will be optional for FY 2021 reporting; all changes will be required for FY 2022

Key Changes: Financial Reporting

- The financial reporting will be split into three sections:
  1. HCB summary spreadsheet
  2. Itemized HCB expenditures that address CHNA priority areas
  3. Itemized physician subsidy expenditures
- Clearer reporting of rate support as off-setting revenue
- Allowing for separate indirect cost ratios for hospital- v. community-based services
- Forthcoming – additional guidance on mission-driven services/physician subsidies

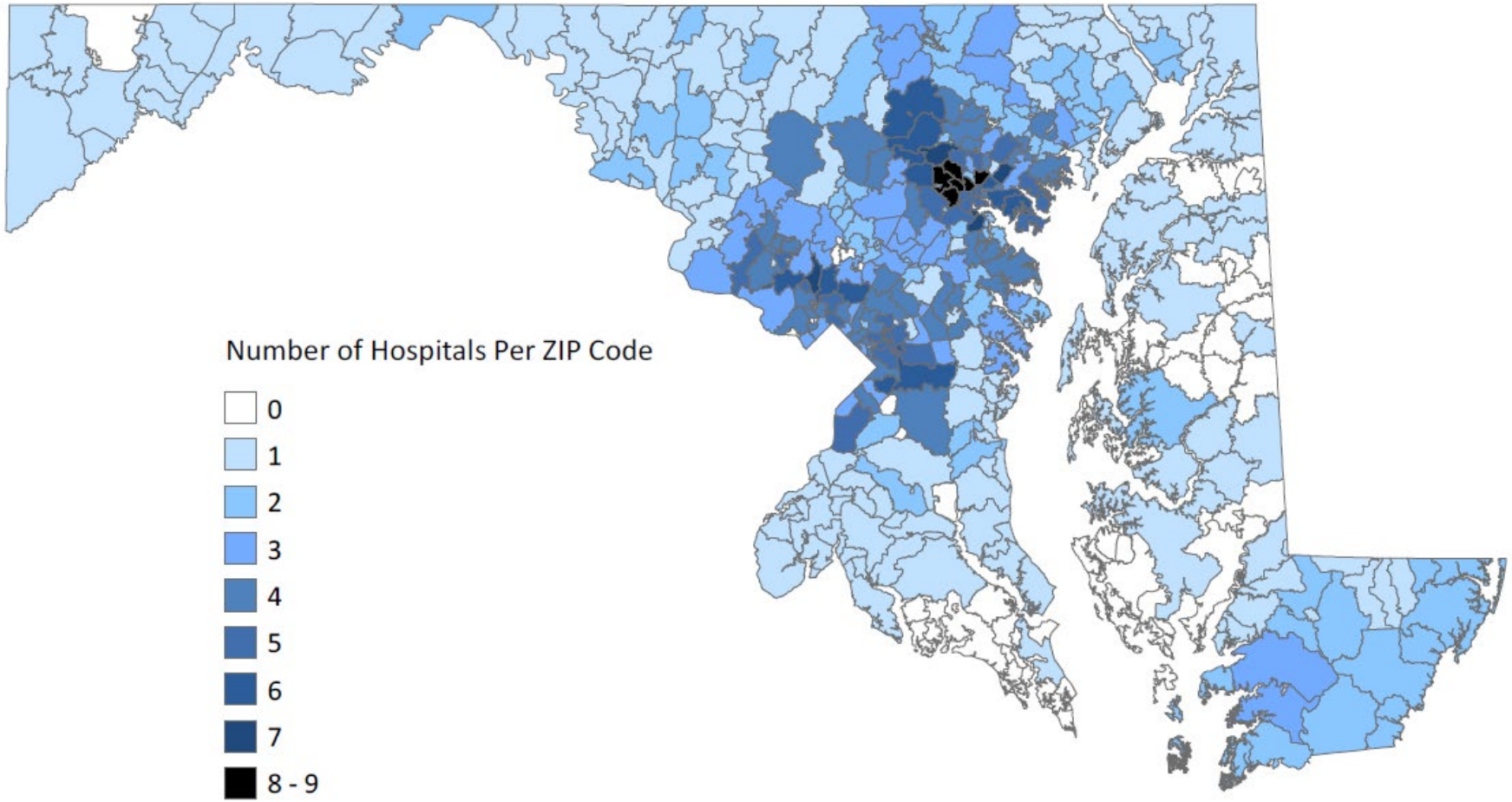
Key Changes to the Narrative Report

- Self assessment of community engagement in the CHNA process
- Engagement in CHNA recommended practices, as identified by the Maryland Hospital Association
- Clearer guidance on reporting justifications for physician subsidies
  - For each line-item physician subsidy listed in the financial report, provide detail on why each subsidy was needed
- Indicating initiatives that address State Integrated Health Improvement Strategy (SIHIS) goals
- Listing of tax exemptions
  - State/Local
  - Federal

FY 2020 Report Highlights

Presented by
Laura Spicer

Community Benefit Service Areas Cover all but 91 Maryland ZIP Codes



FY 2020 Financial Report Highlights

- 50 hospitals submitted
- $1.94 billion in community benefit expenditures, compared to $1.89 billion in FY 2019
  - Represents 11.3% of statewide hospital operating expenses compared to 11.2% in FY 2019
  - Ranges from 2.8% to 32.8%
- After accounting for rate support, community benefit expenses totaled $1.2 billion, the same as in FY 2019
  - Represents 7.2% of statewide hospital operating expenses, compared to 7.4% in FY 2019
  - Ranges from 1.2% to 31.4%

FY 2020 Hospital Community Benefit Expenditures by Category

Community Benefit Category	Number of Staff Hours	Number of Encounters	Net Community Benefit Expense	Percent of Total CB Expenditures	Net Community Benefit Expense Less: Rate Support	Percent of Total CB Expenditures w/o Rate Support
Unreimbursed Medicaid Cost	0	0	$56,475,884	2.91%	$56,475,884	4.57%
Community Health Services	934,443	4,453,676	$128,725,778	6.63%	$128,725,778	10.41%
Health Professions Education *	6,968,311	191,808	$609,639,789	31.38%	$236,125,334	19.09%
Mission Driven Health Services	4,153,090	1,785,749	$717,069,936	36.91%	$717,069,936	57.98%
Research	115,676	21,284	$15,459,334	0.80%	$15,459,334	1.25%
Financial Contributions	25,710	144,373	$14,821,576	0.76%	$14,821,576	1.20%
Community Building	379,825	68,848	$37,626,055	1.94%	$37,626,055	3.04%
Community Benefit Operations	99,211	94,153	$12,928,699	0.67%	$12,928,699	1.05%
Foundation	3,452	11,163	$1,165,182	0.06%	$1,165,182	0.09%
Charity Care*	0	0	$348,683,332	17.95%	$16,455,798	1.33%
Total	**12,679,719**	**6,771,054**	**$1,942,595,565**	**100%**	**$1,236,853,576**	**100%**

Mission-Driven Services and Off-Setting Revenue

- Hospitals report off-setting revenue for each CB category
- Mission-driven services (56.6%) and the Medicaid deficit assessment (39.5%) account for 96.1% of all off-setting revenue
- Mission-driven services, however, are intended to be services provided to the community that are not expected to result in revenue
  - 13 hospitals reported no offsetting revenue for mission-driven services
  - 7 hospitals reported off-setting revenue for over 50% of their mission-driven expenditures

Physician Subsidies

- A subcategory of mission-driven services
- Include:
  - Hospital-based physicians
  - Non-resident house staff and hospitalists
  - ED call
  - Physician provision of financial assistance
  - Physician recruitment
  - Other subsidies
- Inconsistencies and ambiguity in reporting – difficult to analyze

Narrative Report Highlights

- Top community health needs addressed by initiatives:
  - Educational and Community-Based Programs
  - Diabetes
  - Oral Health
  - Health-Related Quality of Life & Well-Being
  - Behavioral Health
  - Other Social Determinants of Health
  - Nutrition and Weight Status
  - Heart Disease and Stroke
  - Physical Activity
  - Older Adults
- 96% of hospitals address at least one State Health Improvement Process goal in their initiatives

Narrative Report Highlights

- 96% of hospitals employ population health directors/staff
- 87% of hospitals employ staff dedicated to community benefit
- 94% of hospitals incorporate community benefit investments in their strategic transformation plans

Questions??

About Hilltop

The Hilltop Institute is a nonpartisan research organization at the University of Maryland, Baltimore County (UMBC) dedicated to improving the health and wellbeing of people and communities. We conduct cutting-edge data analytics and translational research on behalf of government agencies, foundations, and nonprofit organizations to inform public policy at the national, state, and local levels.

www.hilltopinstitute.org

Contact

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Maryland Hospital Community Benefit Report: FY 2020

December 8, 2021

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List of Abbreviations

ACA	Affordable Care Act
CBR	Community Benefit Report
CBSA	Community Benefit Service Area
CHNA	Community Health Needs Assessment
DME	Direct Medical Education
ED	Emergency Department
FPL	Federal Poverty Level
FY	Fiscal Year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
IRS	Internal Revenue Service
LHIC	Local Health Improvement Collaboratives
NSPI	Nurse Support Program I
PSA	Primary Service Area
SHIP	State Health Improvement Process
UCC	Uncompensated Care

Introduction

The term community benefit refers to initiatives, activities, and investments undertaken by tax-exempt hospitals to improve the health of the communities they serve. Maryland law defines community benefit as a planned, organized, and measured activity that is intended to meet identified community health needs within a service area.[1] Examples of community benefit activities can include the following:

- Community health services
- Health professional education
- Research
- Financial contributions
- Community–building activity, including partnerships with community–based organizations
- Charity care
- Mission-driven health services

In 2001, the Maryland General Assembly passed House Bill 15,[2] which required the Maryland Health Services Cost Review Commission (HSCRC or Commission) to collect community benefit information from individual hospitals and compile it into a statewide, publicly available Community Benefit Report (CBR). In response to this legislative mandate, the HSCRC initiated a community benefit reporting system for Maryland's nonprofit hospitals that included two components. The first component, the *Community Benefit Collection Tool*, is a spreadsheet that inventories community benefit expenses in specific categories defined by the HSCRC's *Community Benefit Reporting Guidelines and Standard Definitions*. These categories are similar—but not identical—to the federal community benefit reporting categories found in Part I of the Internal Revenue Service (IRS) Form 990, Schedule H.[3] The second component of Maryland's reporting system is the CBR narrative report.

In 2020, the Maryland General Assembly passed HB 1169/SB 774 which required the HSCRC to update the community benefit reporting guidelines to address the growing interest in understanding the types and scope of community benefit activities conducted by Maryland's nonprofit hospitals in relation to community health needs assessments (CHNAs).[4] This bill required the HSCRC to establish a Community Benefit Reporting Workgroup and adopt regulations recommended by the Workgroup regarding community benefit reporting. The bill also modified the definition of community benefit and expanded the list of items that hospitals must include in their CBRs.

[1] MD. CODE. ANN., Health-Gen. § 19-303(a)(3).
[2] H.D. 15, 2001 Gen. Assem., 415th Sess. (Md. 2001).
[3] https://www.irs.gov/pub/irs-pdf/f990sh.pdf
[4] S. 774, 2020 Leg., 441st Sess. (Md. 2020).

This summary report provides background information on hospital community benefits and the history of CBRs in Maryland, summarizes the community benefit narrative and financial reports for fiscal year (FY) 2020, and concludes with a summary of data reports from the past 10 years.

Background

Federal Requirements

The Internal Revenue Code defines tax-exempt organizations as those that are organized and operated exclusively for specific religious, charitable, scientific, and educational purposes.[5] Nonprofit hospitals are generally exempt from federal income and unemployment taxes, as well as state and local income, property, and sales taxes. In addition, nonprofit hospitals may raise funds through tax-deductible donations and tax-exempt bond financing.

Originally, the IRS considered hospitals to be "charitable" if they provided charity care to the extent that they were financially able to do so.[6] However, in 1969, the IRS issued Revenue Ruling 69-545, which modified the "charitable" standard to focus on "community benefits" rather than "charity care."[7] Under this IRS ruling, nonprofit hospitals must provide benefits to the community in order to be considered charitable. This ruling created the "community benefit standard," which is necessary for hospitals to qualify for tax-exemption.

The Affordable Care Act (ACA) created additional requirements for hospitals to maintain tax-exempt status. Every §501(c)(3) hospital—whether independent or part of a hospital system—must conduct a CHNA at least once every three years to maintain its tax-exempt status and avoid an annual penalty of up to $50,000.[8] A CHNA is a written document developed for a hospital facility that includes a description of the community served, the process used to conduct the assessment, identification of any persons with whom the hospital collaborated on the assessment, and the health needs identified through the assessment process. CHNAs must incorporate input from individuals who represent the broad interests of the communities served, and hospitals must make them widely available to the public.[9] CHNAs must include an implementation strategy that describes how the hospital plans to meet the community's health needs, as well as a description of what the hospital has historically done to address its community's needs.[10] Further, the hospital must identify any needs that have not been met and explain why they were not addressed. Tax-exempt hospitals must report this information on Schedule H of IRS Form 990.

[5] 26 U.S.C. § 501(c)(3).
[6] Rev. Ruling 56-185, 1956-1 C.B. 202.
[7] Rev. Ruling 69-545, 1969-2 C.B. 117.
[8] 26 U.S.C. § 501(r)(3); 26 U.S.C. § 4959.
[9] 26 U.S.C. § 501(r)(3)(B).
[10] 26 U.S.C. § 501(r)(3)(A).

Maryland Requirements

The Maryland General Assembly adopted the Maryland CBR process in 2001,[11] and the first data collection period was FY 2004. Maryland law requires hospitals to include the following information in their CBRs:

- The hospital's mission statement
- A list of the hospital's activities to address the identified community health needs
- The costs of each community benefit activity
- A description of how each of the listed activities addresses the community health needs of the hospital's community
- A description of efforts taken to evaluate the effectiveness of each community benefit activity
- A description of gaps in the availability of providers to serve the community
- A description of the hospital's efforts to track and reduce health disparities in the community
- A list of the unmet community health needs identified in the most recent community health needs assessment
- A list of tax exemptions the hospital claimed during the immediately preceding taxable year[12]

This FY 2020 report represents the HSCRC's 17th year of reporting on Maryland hospital community benefit data.

Updates to Maryland's Reporting Instructions

In response to HB 1169/SB 774 passed during the 2020 legislative session, the HSCRC made changes to reporting instructions. Among other items, hospitals will be required to:

1. Report all initiatives that tie to the CHNA
2. Within the financial report, separately itemize all physician subsidies claimed by type and specialty
3. List the types of tax exemptions claimed
4. Self-assess the level of community engagement in the CHNA process

Understanding that hospitals needed enough lead time to implement these changes, items 1 and 4 above were made optional for FY 2021 reporting, but will be mandatory for FY 2022.

[11] MD. CODE. ANN., Health-Gen. § 19-303.
[12] MD. CODE. ANN., Health-Gen. § 19-303(c)(4).

Narrative Reports

This section of the document summarizes the findings of the FY 2020 narrative reports by major report section.

Hospitals Submitting Reports

The HSCRC received 47 CBR narratives from all 50 hospitals in FY 2020. This is because the University of Maryland Medical System submits a single CBR for three of its hospitals on the Eastern Shore and another CBR for two of its hospitals in Harford County. Table 1 summarizes the hospitals submitting CBRs by hospital system.

Table 1. Maryland Hospitals that Submitted CBRs in FY 2020, by System

Adventist HealthCare	**Luminis Health**
Adventist HealthCare Fort Washington Medical Center	Anne Arundel Medical Center
Adventist HealthCare Rehabilitation	Doctors Community Hospital
Adventist HealthCare Shady Grove Medical Center	**MedStar Health**
Adventist HealthCare White Oak Medical Center	MedStar Franklin Square Medical Center
Ascension	MedStar Good Samaritan Hospital
Saint Agnes Hospital	MedStar Harbor Hospital
Christiana Care Health Services, Inc.	MedStar Montgomery Medical Center
Christiana Care, Union Hospital	MedStar Southern Maryland Hospital Center
Independent Hospitals	MedStar St. Mary's Hospital
Atlantic General Hospital	MedStar Union Memorial Hospital
CalvertHealth Medical Center	**TidalHealth**
Frederick Health Hospital	TidalHealth McCready Pavilion
Greater Baltimore Medical Center	TidalHealth Peninsula Regional
Mercy Medical Center	**Trinity Health**
Meritus Medical Center	Holy Cross Germantown Hospital
Sheppard Pratt	Holy Cross Hospital
Johns Hopkins Heath System	**University of Maryland Medical System**
Howard County General Hospital	UM Baltimore Washington Medical Center
Johns Hopkins Bayview Medical Center	UM Capital Region Health
Suburban Hospital	UM Charles Regional Medical Center
The Johns Hopkins Hospital	UM Rehabilitation & Orthopaedic Institute
Jointly Owned Hospitals	UM Shore Regional Health
Mt. Washington Pediatric Hospital*	UM St. Joseph Medical Center
LifeBridge Health	UM Upper Chesapeake Health
Carroll Hospital Center	UMMC Midtown Campus
Grace Medical Center	University of Maryland Medical Center
Levindale Hebrew Geriatric Center and Hospital	**UPMC**
Northwest Hospital Center, Inc.	UPMC Western Maryland
Sinai Hospital of Baltimore, Inc.	**WVU Medical System**
	Garrett Regional Medical Center

*Mt. Washington Pediatric is jointly owned by the University of Maryland Medical System and Johns Hopkins

Section I. General Hospital Demographics and Characteristics

Section I of the report collects demographic and other characteristics of the hospital and its service area.

Hospital-Specific Demographics

The first section of the CBR narrative collects information on hospital demographic and utilization statistics (Table 2). Overall, there were 10,052 beds and 545,514 inpatient admissions. The percentage of admissions by insurance status ranged from 0.3 to 8.4 percent for charity care/self-pay, 2.5 to 80.1 percent for Medicaid, and 14.0 to 90.8 percent for Medicare-among hospitals accepting Medicare clients. These percentages were largely similar to those for FY 2019.

Table 2. Hospital Bed Designation, Inpatient Admissions, and Patient Insurance Status, FY 2020

Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Admissions Charity Care/Self-Pay	Percentage of Admissions Medicaid	Percentage of Admissions Medicare
Adventist HealthCare					
Adventist HealthCare Fort Washington Medical Center	28	1,538	4.4	13.9	54.1
Adventist HealthCare Rehabilitation	87	316	0.6	13.9	53.8
Adventist HealthCare Shady Grove Medical Center	329	22,248	4.4	21.9	25.5
Adventist HealthCare White Oak Medical Center	178	11,096	1.6	48.3	34.8
Ascension					
Saint Agnes Hospital	247	13,327	2.2	30.8	43.6
Christiana Care Health Services, Inc.					
Christiana Care, Union Hospital	75	4,846	1.7	32.5	43.6
Independent Hospitals					
Atlantic General Hospital	40	2,652	1.7	9.6	68.1
CalvertHealth Medical Center	73	6,128	0.8	19.0	45.1
Frederick Health Hospital	269	16,669	2.3	9.7	38.7
Greater Baltimore Medical Center	257	19,988	0.8	16.3	31.7
Mercy Medical Center	182	14,470	5.8	33.2	28.5
Meritus Medical Center	237	15,813	2.4	23.2	44.4
Sheppard Pratt	414	7,357	2.7	22.8	14.0
Johns Hopkins Health System					

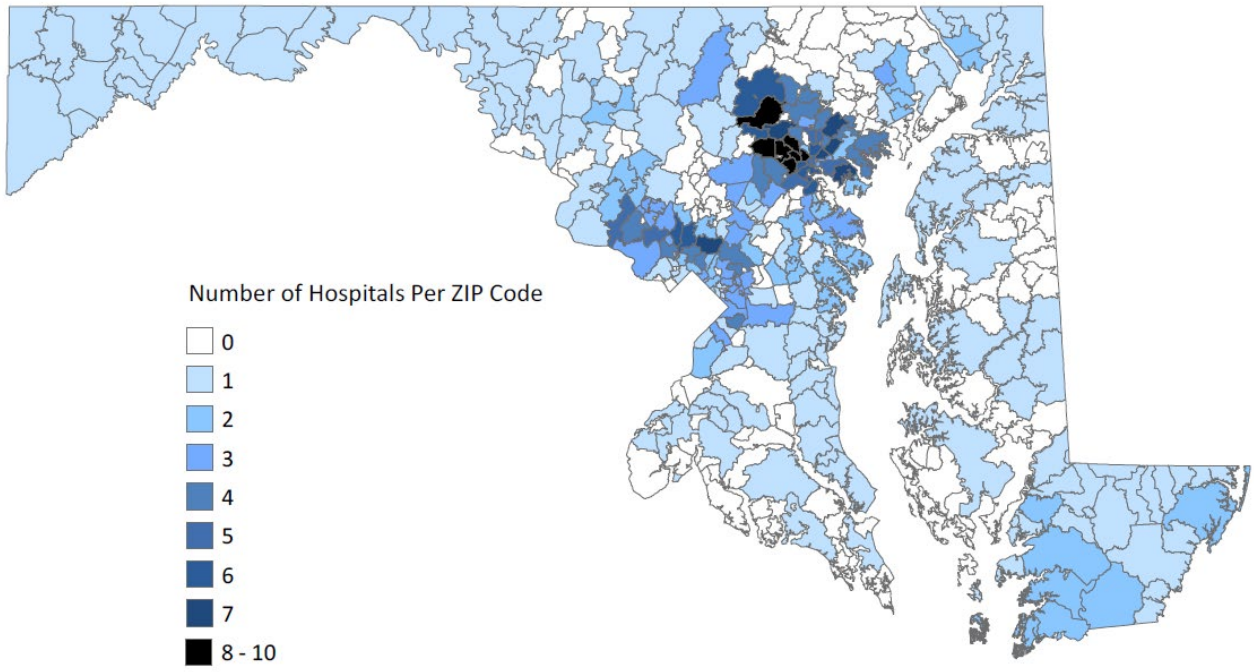
Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Admissions Charity Care/Self-Pay	Percentage of Admissions Medicaid	Percentage of Admissions Medicare
Howard County General Hospital	225	17,039	0.9	14.7	36.5
Johns Hopkins Bayview Medical Center	349	19,049	2.8	34.1	39.6
Suburban Hospital	228	11,858	2.1	10.1	58.0
The Johns Hopkins Hospital	1,095	41,445	1.1	28.8	27.6
Jointly Owned Hospitals					
Mt. Washington Pediatric Hospital	16	513	-	80.1	-
LifeBridge Health					
Carroll Hospital	161	10,335	0.5	16.1	49.5
Grace Medical Center	71	1,720	0.6	48.0	27.6
Levindale Hebrew Geriatric Center and Hospital of Baltimore, Inc.	100	1,060	1.4	2.5	90.8
Northwest Hospital, Inc.	190	7,752	0.5	26.3	54.4
Sinai Hospital of Baltimore, Inc.	347	16,993	0.5	30.1	41.9
Luminis Health					
Anne Arundel Medical Center	349	28,216	1.1	14.6	36.7
Doctors Community Hospital	206	10,340	2.8	17.9	50.6
MedStar Health					
MedStar Franklin Square Medical Center	338	20,049	1.3	34.1	40.8
Medstar Good Samaritan Hospital	143	7,753	1.5	21.9	60.9
Medstar Harbor Hospital	131	8,014	1.0	48.6	29.5
MedStar Montgomery Medical Center	104	5,978	0.7	19.3	51.5
MedStar Southern Maryland Hospital Center	182	10,907	1.8	27.6	38.6
MedStar St. Mary's Hospital	93	7,802	1.9	22.6	37.4
MedStar Union Memorial Hospital	185	9,361	1.0	21.0	58.2
TidalHealth					
TidalHealth McCready Pavilion	3	97	1.0	12.4	78.4
TidalHealth Peninsula Regional	266	16,152	0.8	24.1	46.5
Trinity Health					
Holy Cross Germantown Hospital	70	6,346	3.3	24.9	29.0
Holy Cross Hospital	377	33,050	4.2	31.6	20.2
University of Maryland					
UM Baltimore Washington Medical Center	285	18,691	0.7	24.2	44.3
UM Capital Region Health	297	11,861	8.4	35.6	31.9

Hospital Name	Bed Designation	Inpatient Admissions	Percentage of Admissions Charity Care/Self-Pay	Percentage of Admissions Medicaid	Percentage of Admissions Medicare
UM Charles Regional Medical Center	98	6,536	1.1	19.5	52.0
UM Rehabilitation & Orthopaedic Institute	2	1,977	0.4	22.5	46.9
UM Shore Regional Health – Easton	97	6,684	0.3	29.8	46.7
UM Shore Regional Health – Dorchester	34	1,046	0.5	34.0	50.4
UM Shore Regional Health – Chester River	12	579	0.9	14.9	72.7
UM St. Joseph Medical Center	219	14,722	1.0	16.9	42.1
UM Upper Chesapeake Health – Harford Memorial Hospital	81	3,745	0.5	23.1	49.6
UM Upper Chesapeake Health – Upper Chesapeake Medical Center	159	11,826	0.3	16.9	49.3
UMMC Midtown Campus	100	4,677	0.9	49.1	39.3
University of Maryland Medical Center	806	22,460	0.4	38.1	32.0
UPMC					
UPMC Western Maryland	191	10,810	1.4	19.3	53.2
WVU Medical System					
Garrett Regional Medical Center	26	1,623	1.9	21.3	44.2
Total	**10,052**	**545,514**	**1.9**	**25.4**	**38.6**

Primary Service Area

Each hospital has a primary service area (PSA), as defined in its global budget revenue (GBR) agreement.[13] Figure 1 displays a map of Maryland's ZIP codes. Each ZIP code has a color indicating how many hospitals claim that area in their PSAs.

Figure 1. Number of Hospitals Claiming the ZIP Code in Their PSAs, FY 2020



Community Benefit Service Area

The CBR also collects the ZIP codes included in each hospital's community benefit service area (CBSA). Each hospital defines its own CBSA and must disclose the methodology behind this definition in both their CBRs and federally mandated CHNAs.[14] Table 3 summarizes the methods reported by Maryland hospitals. The most common method was based on patterns of service utilization, such as percentages of hospital discharges and emergency department (ED) visits. In general, the other methods that hospitals reported were based on proximity to the facility, social

[13] The exception is the specialty hospitals that do not have GBRs. For these hospitals, the ZIP codes that account for 60 percent of discharges are reported.
[14] 26 CFR § 1.501(r)-3(b).

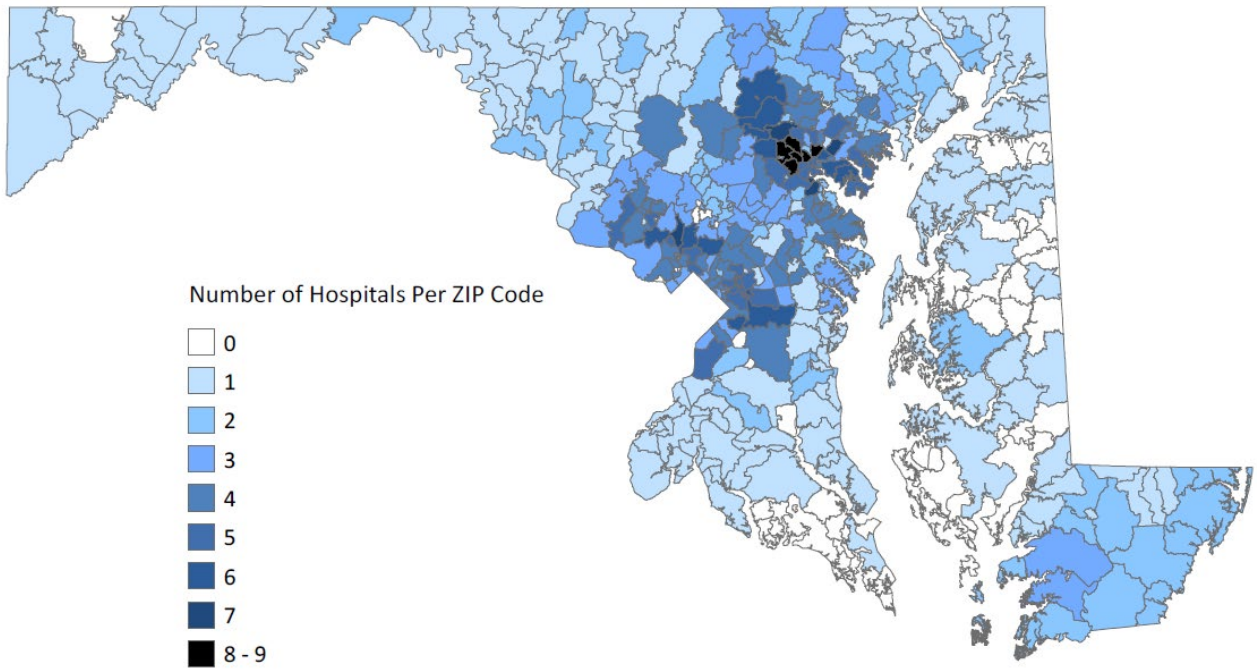
determinants of health indicators, and the proportion of residents who were medically underserved or uninsured/underinsured. Ten hospitals based their CBSAs on the PSAs described above.

Table 3. Methods Used by Hospitals to Identify their CBSAs, FY 2020

CBSA Identification Method	Number of Hospitals
Based on ZIP Codes in Financial Assistance Policy	8
Based on ZIP Codes in their PSA	10
Based on Patterns of Utilization	25
Other Method	27

Figure 2 displays the number of hospitals claiming each ZIP code in their CBSAs. A total of 91 ZIP codes—those that appear white on the map—are not a part of any hospital's CBSA. This is a slight increase over FY 2019, which identified 89 ZIP codes that were not covered. Six ZIP codes in Baltimore City/County—those that appear black on the map—are part of eight or more hospitals' CBSAs. Although hospital CBSAs and PSAs overlap to some degree, there are differences in the footprint of the CBSAs and PSAs. Please note that there is no requirement for CBSAs and PSAs to overlap. Please also note that hospitals may include out-of-state ZIP codes in their CBSA, but these are not displayed below.

Figure 2. Number of Hospitals Claiming the ZIP Code in Their CBSAs, FY 2020



Other Demographic Characteristics of Service Areas

Hospitals report details about the communities located in their CBSAs. Because most of the required measures in this section of the report are not available at the ZIP code level, they are reported at the county level. Table 4 displays examples of the county-level demographic measures required in the CBR. Because hospitals vary in their approaches to describing their service areas, the data in Table 4 were retrieved independently. See Appendix A for other community health data sources reported by hospitals.

The following measures were derived from the five-year (2015-2019) average estimates of the U.S. Census Bureau's American Community Survey: median household income, percentage of families below the federal poverty level (FPL), percentage uninsured, percentage with public health insurance, mean travel time to work, percentage that speak a language other than English at home, percentage by racial categories, and percentage by ethnicity categories. The life expectancy three-year average (2017-2019) and the crude death rate (2019) measures were derived from the Maryland Department of Health's Vital Statistics Administration.

maryland health services cost review commission

Table 4. Community Statistics by County

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race: % White	Race: % Black	Ethnicity: % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Maryland		**84,805**	**6.1**	**6.1**	**32.3**	**23.6**	**33.2**	**19.0**	**58.3**	**31.8**	**10.1**	**79.2**	**841.5**
Allegany	1	45,893	10.5	4.8	46.8	31.6	21.8	4.0	90.3	9.7	1.8	76.7	1,298.0
Anne Arundel	7	100,798	3.9	4.4	27.8	17.0	31.4	11.4	76.4	18.9	7.8	79.3	784.3
Baltimore	12	76,866	5.8	5.2	33.1	25.0	29.8	14.8	62.9	30.5	5.4	78.1	1,030.5
Baltimore City	17	50,379	16.0	6.6	46.0	43.6	31.4	9.9	32.3	64.0	5.3	72.8	1,119.5
Calvert	1	109,313	3.1	3.9	26.4	16.0	42.5	4.2	85.3	14.2	4.0	79.4	843.0
Caroline	1	58,638	9.4	5.6	45.7	36.4	32.7	8.3	82.3	15.8	7.3	76.8	942.9
Carroll	3	96,769	3.2	2.9	27.7	14.1	36.2	5.0	93.3	4.7	3.5	78.6	981.9
Cecil	2	76,887	6.4	4.1	36.0	25.9	29.9	5.5	90.4	8.5	4.4	75.7	1,067.5
Charles	1	100,003	4.7	3.8	27.9	20.4	45.0	8.2	48.1	50.1	5.8	78.6	751.6
Dorchester	1	52,917	10.7	5.4	51.1	41.1	27.6	6.3	69.5	30.1	5.6	75.6	1,299.8
Frederick	4	97,730	4.1	4.5	26.4	16.6	35.4	14.6	83.5	11.4	9.6	80.5	753.6
Garrett	1	52,617	6.8	7.0	42.6	29.7	24.8	3.1	98.3	1.4	1.1	78.3	1,244.2
Harford	2	89,147	4.7	3.4	29.9	18.3	32.0	7.4	81.5	15.6	4.6	79.0	864.8
Howard	4	121,160	3.6	3.9	23.4	14.5	31.2	25.4	60.7	21.2	6.9	83.2	559.1
Kent	1	58,598	6.4	5.2	44.3	25.9	27.2	6.2	83.0	15.9	4.4	79.0	1,349.0
Montgomery	8	108,820	4.7	7.1	26.8	18.2	34.7	41.2	56.5	20.3	19.5	85.1	589.2
Prince George's	9	84,920	5.8	10.1	31.9	25.6	37.3	27.3	18.6	64.8	18.4	79.1	709.3
Queen Anne's	2	97,034	3.1	4.8	31.7	16.9	37.3	5.6	90.8	7.7	3.9	79.8	940.8
Saint Mary's	1	89,845	6.2	5.1	28.1	20.3	31.5	7.3	81.7	16.4	5.2	78.5	767.3
Somerset	3	37,803	17.0	5.8	49.5	35.0	24.4	5.9	55.1	44.4	3.6	75.5	1,034.5

County	# of Hospitals w/ CBSAs in that County	Median Household Income	% Below FPL	% Uninsured	% Public Health Insurance	% Medicaid	Mean Travel Time to Work (mins)	% Speak Language Other than English at Home	Race: % White	Race: % Black	Ethnicity: % Hispanic or Latino	Life Expectancy	Crude Death Rate (per 100,000)
Talbot	2	73,547	5.6	4.3	43.7	23.0	28.1	7.8	86.5	13.8	6.8	80.4	1,385.1
Washington	1	60,860	9.1	5.7	40.6	30.0	30.1	7.5	85.8	13.6	5.1	76.8	1,120.8
Wicomico	2	56,956	8.6	6.6	43.2	34.1	21.9	11.2	68.9	28.1	5.2	76.6	1,023.1
Worcester	2	63,499	6.3	4.9	46.4	25.6	24.8	5.5	85.2	14.2	3.5	79.6	1,203.2
Source	[15]	[16]	[17]	[18]	[19]	[20]	[21]	[22]	[23]	[24]	[25]	[26]	[27]

[15] As reported by hospitals in their FY 2020 Community Benefit Narrative Reports.
[16] American Community Survey 5-Year Estimates 2015 – 2019, Selected Economic Characteristics, Median Household Income (Dollars), https://data.census.gov/cedsci/.
[17] American Community Survey 5-Year Estimates 2015 – 2019, Selected Economic Characteristics, Percentage of Families and People Whose Income in the Past 12 Months is Below the Federal Poverty Level – All Families.
[18] American Community Survey 5-Year Estimates 2015 – 2019, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – No Health Insurance Coverage.
[19] American Community Survey 5-Year Estimates 2015 – 2019, Selected Economic Characteristics, Health Insurance Coverage (Civilian Noninstitutionalized Population) – With Public Coverage.
[20] American Community Survey 1-Year Estimate, 2019 (denominator) and The Hilltop Institute (numerator).
[21] American Community Survey 5-Year Estimates 2015 – 2019, Selected Economic Characteristics, Commuting to Work – Mean Travel Time to Work (Minutes).
[22] American Community Survey 5-Year Estimates 2015 – 2019, Language Spoken at Home, Population 5 Years and Over, Speak a Language Other Than English.
[23] American Community Survey 5-Year Estimates 2015 – 2019, ACS Demographic and Housing Estimates, Race - Race alone or in combination with one or more other races - Total Population – White.
[24] American Community Survey 5-Year Estimates 2015 – 2019, ACS Demographic and Housing Estimates, Race - Race alone or in combination with one or more other races - Total Population – Black or African American.
[25] American Community Survey 5-Year Estimates 2015 – 2019, ACS Demographic and Housing Estimates, Hispanic or Latino and race - Total Population - Hispanic or Latino (of any race).
[26] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2019, Table 7. Life Expectancy at Birth by Race, Region, and Political Subdivision, Maryland, 2017 – 2019.
[27] Maryland Department of Health and Mental Hygiene Vital Statistics Report: 2019, Table 39A. Crude Death Rates by Race, Hispanic Origin of Mother, Region, and Political Subdivision, Maryland, 2019.

Section II. Community Health Needs Assessment

Section II of the CBR narrative asks hospitals whether they conducted a CHNA, when they last conducted it, and whether they adopted an implementation strategy. All hospitals reported conducting CHNAs that conform to the IRS definition within the past three fiscal years, and all but two hospitals reported adopting an implementation strategy.[28] See Appendix B for the dates in which hospitals conducted their last CHNAs. These dates ranged from November 2017 to June 2020.

This section also asks the hospitals to report on the internal and external participants involved in the CHNA process, including their corresponding roles. More than half of all hospitals reported collaborating with other hospitals or community/neighborhood organizations to identify priority health needs. Only 12 hospitals did not partner with local health improvement collaboratives (LHICs) in their most recent CHNA efforts. These distributions were similar to what was reported in FY 2019. See Appendix C for more detail on the internal and external participants in development of the hospitals' CHNAs.

Section III. Community Benefit Administration

This section of the narrative CBR requires hospitals to report on the process of determining which needs in the community would be addressed through community benefit activities. Hospitals also must report on the internal and external participants involved in community benefit activities and their corresponding roles. Tables 5 and 6 present some highlights, and Appendix D provides full detail. Of note, around 90 percent of hospitals employed population health staff and staff dedicated to community benefit. Additionally, nearly all hospitals collaborated with local health departments to administer community benefit activities. Large majorities of hospitals worked with other hospitals and behavioral health organizations. These figures have increased greatly since FY 2019.

Table 5. Number of Hospitals Reporting Staff in the Following Categories

Staff Category	Number of Hospitals	% of Hospitals
Population Health Staff	44	94%
Community Benefit Staff	42	89%
CB/Pop Health Director	45	96%

Table 6. Number of Hospitals that Collaborated with Selected Types of External Organizations

Collaborator Type	Number of Hospitals	% of Hospitals
Post-Acute Care Organizations	15	32%
Local Health Departments	44	94%
Other Hospitals	34	72%
Behavioral Health Organizations	30	64%

[28] One hospital changed ownership during the reporting period, making a strategic plan unavailable. The other hospital was creating its strategic plan at the time of reporting.

Internal Audit and Board Review

This part of the report addresses whether the hospital conducted an internal audit of the CBR financial spreadsheet and narrative. Table 7 shows that 46 out of 47 hospitals conducted some kind of audit of the financial spreadsheet. Audits were most frequently performed by hospital or system staff. These figures are slightly higher than what was reported in FY 2019.

Table 7. Hospital Audits of CBR Financial Spreadsheet

	Number of Hospitals	
Audit Type	**Yes**	**No**
Hospital Staff	40	7
System Staff	31	16
Third-Party	7	40
No Audit	1	46
Two or More Audit Types	29	18
Three or More Audit Types	3	44

This section also addresses whether the hospital board reviews and approves the CBR spreadsheet and narrative. Table 8 shows that most hospital boards review and approve the CBR. Of the hospitals that reported that they did not submit their reports for board review, their rationale was largely related to timing issues or because the board had delegated this authority to executive staff. For example, several hospitals reported that their board meets only twice per year and did not have the opportunity to review before the report deadline. These responses were very similar to what was reported in FY 2019.

Table 8. Hospital Board Review of the CBR

	Number of Hospitals	
Board Review	**Yes**	**No**
Spreadsheet	38	9
Narrative	38	9

This section also asks if community benefit investments were incorporated into the major strategies of the Hospital Strategic Transformation Plan. Table 9 shows that nearly all hospitals indicated that community benefit investments were a part of their Strategic Transformation Plan.

Table 9. Community Benefit Investments in Hospital Strategic Transformation Plan

Community Benefit Investments in Strategic Transformation Plan	Number of Hospitals
Yes	44
No	3

Section IV. Hospital Community Benefit Program and Initiatives

The CBR asks hospitals to describe three, ongoing community benefit initiatives undertaken to address needs in the community. Additionally, hospitals must indicate whether the reported initiatives address a CHNA-identified need. Table 10 summarizes the types of initiatives reported. Hospital community benefit initiatives are more likely to target chronic conditions than acute conditions. Of 141 total initiatives reported across all hospitals, 82 addressed the prevention of chronic conditions. Hospitals could report more than one category of intervention for each initiative. This distribution was similar to what was reported in FY 2019.

Table 10. Types of Community Benefit Initiatives

Category	Number of Interventions in Each Category	Percentage of Interventions that Fall within Category
Chronic condition-based intervention: treatment intervention	65	46%
Chronic condition-based intervention: prevention intervention	82	58%
Acute condition-based intervention: treatment intervention	47	33%
Acute condition-based intervention: prevention intervention	48	34%
Condition-agnostic treatment intervention	13	9%
Social determinants of health intervention	75	53%
Community engagement intervention	65	46%
Other	8	6%

Table 11 presents the types of evidence that hospitals used to evaluate the effectiveness of their community benefit initiatives. By far, the most common category of evidence used for this purpose was the count of participants, followed by surveys of participants. Hospitals could report more than one type of evaluative criteria for each initiative.

Table 11. Types of Evidence Used to Evaluate Effectiveness of Initiatives

Evaluation Criteria	Number of Interventions Using each Type of Evaluation Criteria	Percentage of Interventions that Use each Type of Evaluation Criteria
Count of Participants	130	92%
Other Process Measures	42	30%
Surveys of Participants	47	33%
Biophysical Health Indicators	41	29%
Assessment of Environmental Change	2	1%
Impact on Policy Change	5	4%
Effects on Healthcare Utilization or Cost	29	21%
Assessment of Workforce Development	3	2%
Other	32	23%

Table 12 summarizes the top ten community health needs addressed by these initiatives, as identified in the hospitals' CHNAs. Educational/community-based programs were the top community health needs addressed by the selected initiatives. Hospitals could select multiple community health needs per initiative. In FY 2019, the top community health needs were largely the same.

Table 12. Community Health Needs Addressed by Selected Hospital Community Benefit Initiatives, FY 2020

Community Health Needs	Number of Initiatives	Percentage of Initiatives
Educational and Community-Based Programs	61	43%
Diabetes	50	35%
Oral Health	49	35%
Health-Related Quality of Life & Well-Being	48	34%
Behavioral Health, including Mental Health and/or Substance Abuse	46	33%
Other Social Determinants of Health	45	32%
Nutrition and Weight Status	43	30%
Heart Disease and Stroke	42	30%
Physical Activity	37	26%
Older Adults	34	24%

The CBR also asks about community health needs identified through the CHNA process that were not addressed by the hospitals. Overall, 23 hospitals reported that one or more primary community health needs were not addressed, and 24 responded that all needs were addressed. Some hospitals listed the following reasons for not addressing all of the needs identified in their CHNAs: lack of resources, lack of expertise, and the fact that other local organizations, hospitals, or partnerships were addressing the needs.

Community Benefit Operations/Activities Related to State Initiatives

Hospitals were asked how their community benefit operations/activities worked toward the state's initiatives for improvement in population health, as identified by the State Health Improvement Process (SHIP). The SHIP provides a framework for accountability, local action, and public engagement to advance the health of Maryland residents. In the context of the state's Total Cost of Care Model, hospitals are tasked with improving quality, including decreasing readmissions and hospital-acquired conditions. Of the 47 hospitals, 45 reported that their community benefit activities addressed at least one SHIP goal. Table 13 presents the number of hospitals that addressed at least one goal under each SHIP category. Because hospitals targeted their community benefit initiatives to address community health needs identified in their CHNAs, the SHIP goals selected tended to be those that were in alignment with hospital CHNAs.

Table 13. Number of Hospitals with CB Activities Addressing SHIP Goals, by Category, FY 2020

	Number of Hospitals in Alignment
Healthy Beginnings	27
Healthy Living	41
Healthy Communities	39
Access to Health Care	38
Quality Preventive Care	42

Section V. Physician Gaps in Availability

Maryland law requires hospitals to provide a written description of gaps in the availability of specialist providers to serve their uninsured populations.[29] Each hospital uses its own criteria to determine what constitutes a physician gap. Table 14 shows the gaps in availability that were identified by the hospitals and the number of hospitals that reported each gap. The most frequently reported gap was mental health (reported by 34 hospitals), followed by primary care and substance abuse and detoxification. Four hospitals reported no gaps. See the mission-driven services section of the financial report summary for a related discussion.

[29] MD. CODE. ANN., Health-Gen. § 19-303(c)(4)(vi).

Table 14. Gaps in Availability

Physician Specialty Gap	Number of Hospitals
No Gaps	***4***
Mental Health	34
Primary Care	22
Substance abuse/detoxification	22
Neurosurgery/neurology	17
Dental	16
Internal Medicine	16
General Surgery	14
Obstetrics	13
Dermatology	12
Orthopedic Specialties	11
Otolaryngology	10
Other	27

Section VI. Financial Assistance Policies

Finally, the narrative section of the CBR requires hospitals to submit information about their financial assistance policies. Maryland law established the requirements for hospitals to provide free or reduced cost care as part of their financial assistance policies as follows:[30]

- Hospitals must provide free, medically necessary care to patients with family income at or below 200 percent of the FPL.[31] Sixteen hospitals reported a more generous threshold.
- Hospitals must provide reduced-cost, medically necessary care to patients with family income between 200 and 300 percent of the FPL.[32] Thirty-five hospitals reported a more generous threshold.
- Hospitals must provide reduced-cost, medically necessary care to patients with family income below 500 percent of the FPL who have a financial hardship, which is referred to as the financial hardship policy.[33] In order to qualify as having a financial hardship, the medical debt incurred by a family over a 12-month period must exceed 25 percent of the family's income.[34] Five hospitals reported a more generous threshold.

Staff noted variation among the hospitals in the content and format of their financial assistance policy documents.

[30] MD. CODE. ANN., Health-Gen. § 19-214.1; COMAR 10.37.10.26.
[31] MD. CODE. ANN., Health-Gen. § 19-214.1(b)(2)(i); COMAR 10.37.10.26(A-2)(2)(a)(i).
[32] COMAR 10.37.10.26(A-2)(2)(a)(ii).
[33] COMAR 10.37.10.26(A-2)(3).
[34] COMAR 10.37.10.26(A-2)(1)(b)(i).

Financial Reports

The CBR financial reports collect information about staff hours, the number of encounters, and direct and indirect costs of community benefits, categorized by type of community benefit activity. The reporting period for these financial data is July 1, 2019, through June 30, 2020. Hospitals were instructed to use data from audited financial statements to calculate the cost of each of the community benefit categories contained in the CBR financial reports and to limit reporting to only those hospital services reported on the IRS 990 schedule H. Fifty hospitals submitted individual financial reports.

FY 2020 Financial Reporting Highlights

Table 15 presents a statewide summary of community benefit expenditures for FY 2020. Maryland hospitals provided roughly $1.94 billion in total community benefit activities in FY 2020—a total that is slightly higher than FY 2019 ($1.89 billion). The FY 2020 total includes: net community benefit expenses of $717 million in mission-driven health care services (subsidized health services), $610 million in health professions education, $349 million in charity care, $129 million in community health services, $56 million in Medicaid deficit assessment costs, $38 million in community building activities, $15 million in financial contributions, $15 million in research activities, $13 million in community benefit operations, and $1 million in foundation-funded community benefits. These totals include hospital-reported indirect costs, which vary by hospital and by category from a fixed dollar amount to a calculated percentage of the hospital's reported direct costs.

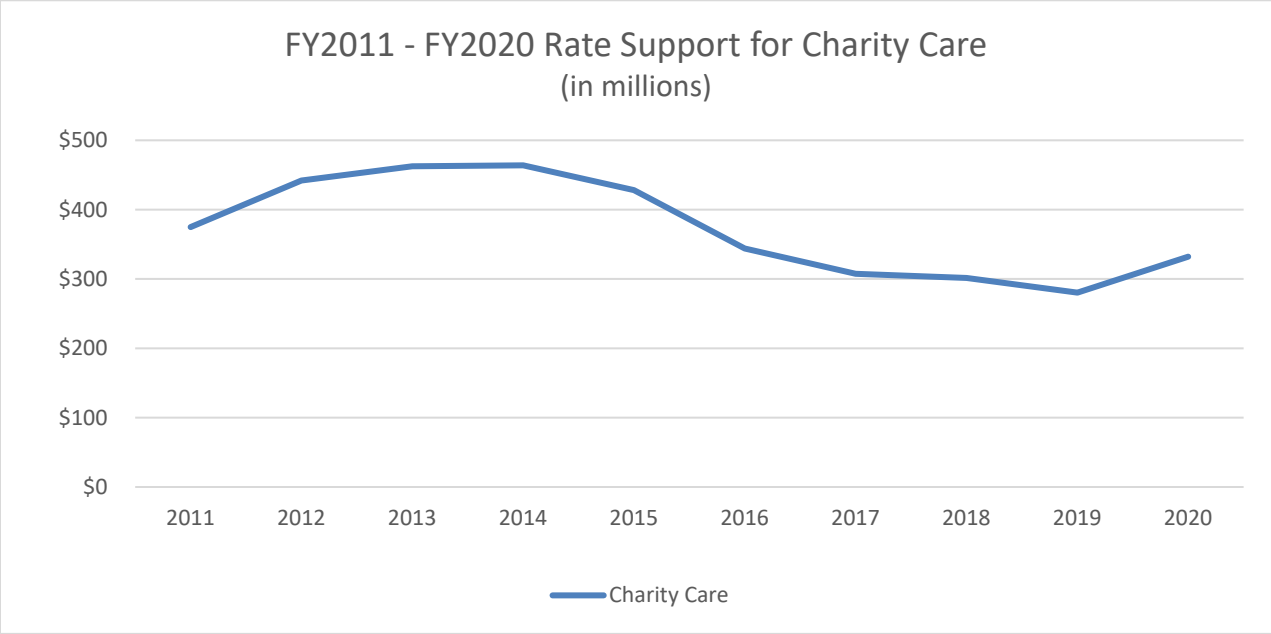
Table 15. Total Community Benefits, FY 2020

Community Benefit Category	Number of Staff Hours	Number of Encounters	Net Community Benefit Expense	Percent of Total CB Expenditures	Net Community Benefit Expense Less: Rate Support	Percent of Total CB Expenditures w/o Rate Support
Unreimbursed Medicaid	0	0	$56,475,884	2.91%	$56,475,884	4.57%
Community Health Services	934,443	4,453,676	$128,725,778	6.63%	$128,725,778	10.41%
Health Professions Education *	6,968,311	191,808	$609,639,789	31.38%	$236,125,334	19.09%
Mission Driven Health Services	4,153,090	1,785,749	$717,069,936	36.91%	$717,069,936	57.98%
Research	115,676	21,284	$15,459,334	0.80%	$15,459,334	1.25%
Financial Contributions	25,710	144,373	$14,821,576	0.76%	$14,821,576	1.20%
Community Building	379,825	68,848	$37,626,055	1.94%	$37,626,055	3.04%
Community Benefit Operations	99,211	94,153	$12,928,699	0.67%	$12,928,699	1.05%
Foundation	3,452	11,163	$1,165,182	0.06%	$1,165,182	0.09%
Charity Care*	0	0	$348,683,332	17.95%	$16,455,798	1.33%
Total	**12,679,719**	**6,771,054**	**$1,942,595,565**	**100%**	**$1,236,853,576**	**100%**

In Maryland, the costs of uncompensated care (including charity care and bad debt) and graduate medical education are built into the rates for which hospitals are reimbursed by all payers. Additionally, the rates include amounts for nurse support programs provided at Maryland hospitals. These costs are essentially "passed through" to the payers of hospital care. To comply with IRS Form 990 and avoid accounting confusion among programs that are not funded by hospital rate setting, the HSCRC requests that hospitals exclude from their reports all revenue that is included in rates as offsetting revenue on the CBR worksheet. Appendix E details the amounts that were included in rates and funded by all payers for charity care, direct graduate medical education, and nurse support programs in FY 2020.

As noted above, the HSCRC includes a provision in hospital rates for uncompensated care—which includes charity care—because it is considered a community benefit. It also includes bad debt, which is not considered a community benefit. Figure 3 shows the rate support for charity care from FY 2011 through FY 2020, which ticked up in 2020 after continuously decreasing in the wake of ACA implementation. See Appendix F for more details on the charity care methodology.

Figure 3. Rate Support for Charity Care, FY 2011-FY 2020



Another social cost funded through Maryland's rate-setting system is the cost of graduate medical education, generally for interns and residents trained in Maryland hospitals. Included in graduate medical education costs are the direct costs (i.e., direct medical education, or DME), which include the residents' and interns' wages and benefits, faculty supervisory expenses, and allocated overhead. The HSCRC's annual cost report quantifies the DME costs of physician training programs at Maryland hospitals. In FY 2020, DME costs totaled $355 million.

The HSCRC's Nurse Support Program I (NSP I) is aimed at addressing the short- and long-term nursing shortage affecting Maryland hospitals. In FY 2020, the HSCRC provided $19 million in hospital rate adjustments for the NSPI. See Appendix E for detailed information about funding provided to specific hospitals.

When the reported community benefit costs for Maryland hospitals were offset by rate support, the net community benefits provided in FY 2020 totaled over $1.2 billion, or 7.8 percent of total hospital operating expenses. This is nearly equivalent to the over $1.2 billion in net benefits provided in FY 2019, which totaled 7.4 percent of hospital operating expenses.

Table 16 presents staff hours, the number of encounters, and expenditures for health professional education by activity. As with prior years, the education of physicians and medical students made up the majority of expenses, totaling $546.6 million. The second highest category was the education of nurses and nursing students, totaling $34.4 million. The education of other health professionals totaled $19.1 million.

Table 16. Health Professions Education Activities and Costs, FY 2020

Health Professions Education	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Physicians and Medical Students	6,112,327	101,768	$546,627,005
Nurses and Nursing Students	543,359	49,027	$34,374,750
Other Health Professionals	248,203	33,811	$19,061,170
Scholarships and Funding for Professional Education	1,233	220	$5,057,990
Other	63,188	6,982	$4,518,874
Total	**6,968,311**	**191,808**	**$609,639,789**

Table 17 presents staff hours, the number of encounters, and expenditures for community health services by activity. As with prior years, health care support services comprised the largest portion of expenses in the category of community health services, totaling $65.3 million. Community health education was the second highest category, totaling $22.7 million, and community-based clinical services were the third highest, totaling $10.9 million. For additional detail, see Appendix G.

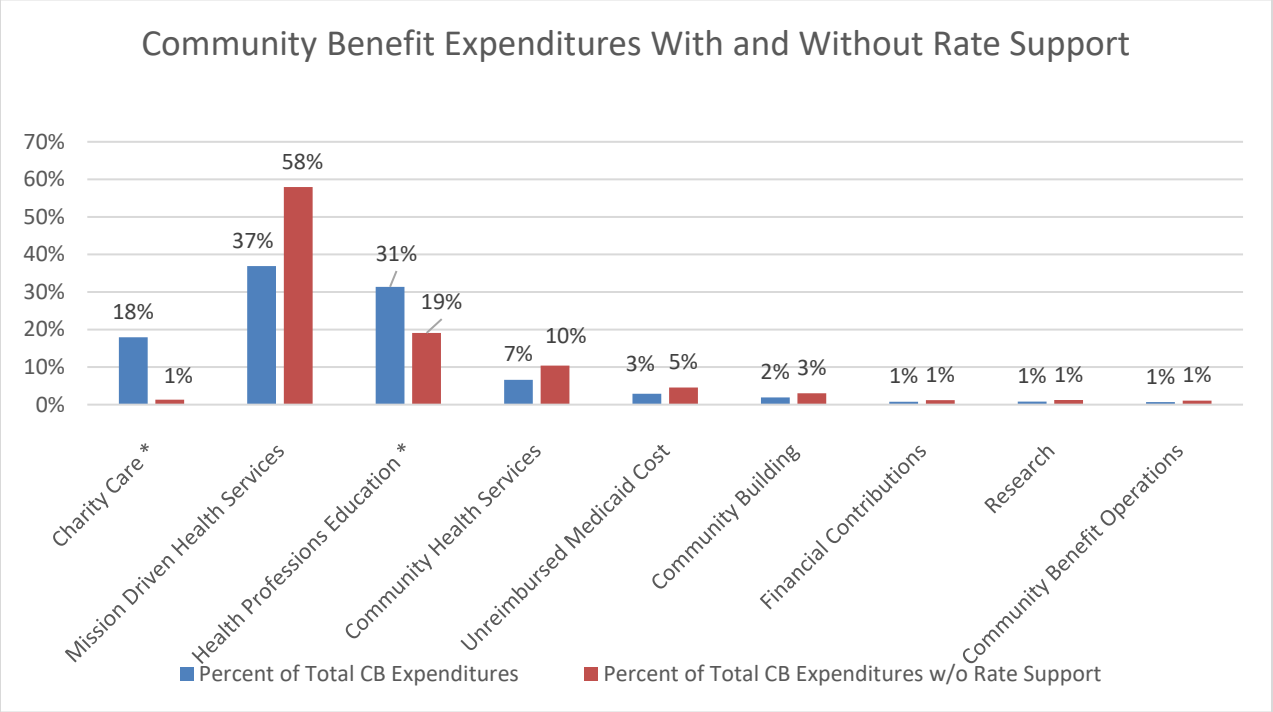
Table 17. Community Health Services Activities and Costs, FY 2020

Community Health Services	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Health Care Support Services	367,620.97	434,912.65	$65,318,211.18
Community Health Education	262,440.67	3,364,056.68	$22,670,380.06
Community-Based Clinical Services	117,778.32	100,541.78	$10,936,430.39
Free Clinics	15,828.50	32,449.00	$9,944,362.28
Screenings	13,856.44	23,684.00	$3,946,919.23

Community Health Services	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Support Groups	36,123.95	215,310.00	$2,932,221.85
Mobile Units	13,020.80	74,871.00	$882,147.03
Self-Help	33,855.30	13,884.00	$746,945.57
One-Time/Occasionally Held Clinics	1,040.00	3,978.00	$186,905.42
Other	72,878.18	189,989.00	$11,161,254.96
Total	**934,443.12**	**4,453,676.10**	**$128,725,777.97**

Accounting for rate support significantly affects the distribution of expenses by category. Figure 4 shows expenditures for each community benefit category as a percentage of total expenditures. Mission-driven health services, health professions education, and charity care represented the majority of the expenses, at 37 percent, 31 percent, and 18 percent, respectively. Figure 4 also shows the percentage of expenditures by category without rate support, which changed the distribution: mission-driven health services remained the category with the highest percentage of expenditures, at 58 percent. Health professions education followed, with 19 percent of expenditures, and community health services accounted for 10 percent of expenditures.

Figure 4. Percentage of Community Benefit Expenditures by Category with and without Rate Support, FY 2020



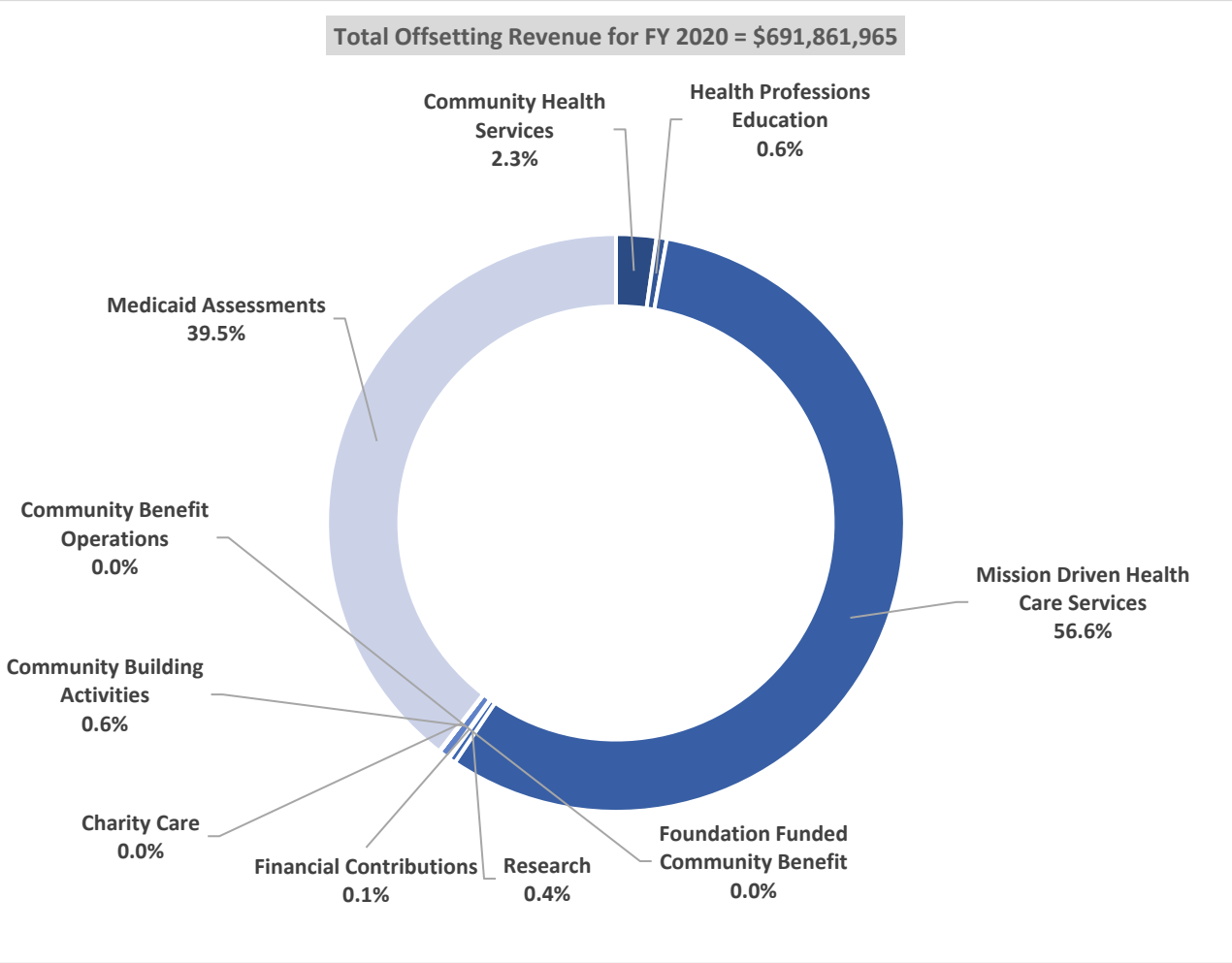
Appendix H compares hospitals in terms of the total amount of community benefits reported, the amount of community benefits recovered through HSCRC-approved rate supports (i.e., charity care, direct medical education, and nurse support) or as revenue from billable services, and the number of staff and staff hours dedicated to community benefit operations. On average, in FY 2020, 1,984 staff hours were dedicated to community benefit operations, lower than FY 2019's figure of 2,220. Three hospitals reported zero staff hours dedicated to community benefit operations, which is the same as FY 2019. The HSCRC continues to encourage hospitals to incorporate community benefit operations into their overall strategic planning.

The total amount of net community benefit expenditures without rate support as a percentage of total operating expenses ranged from 1.21 to 31.38 percent, with an average of 7.84 percent, which was slightly lower than in FY 2019. Eleven hospitals reported providing benefits in excess of 10 percent of their operating expenses, compared with twelve hospitals in FY 2019.

Mission-Driven Services and Offsetting Revenue

The instructions for the financial report require hospitals to report offsetting revenue for their community benefit activities, which is defined as any revenue generated by the activity or program, such as payment for services provided to program patients, restricted grants, or contributions used to provide a community benefit. Figure 5 presents the total FY 2020 offsetting revenue by community benefit category. The largest components of offsetting revenue were mission-driven health care services (56.6 percent) and the Medicaid deficit assessment (39.5 percent). Last year, these two categories accounted for 48.6 percent and 45.6 percent of offsetting revenue, respectively. Other categories had minimal offsetting revenue. Please note that the Medicaid deficit assessment is a broad-based uniform assessment to hospital rates that is set by the Maryland General Assembly. The hospitals pay this assessment, but a portion of it is reimbursed back to the hospital through all-payer rates, which is then reported as offsetting revenue. Therefore, the offsetting revenue reported for the Medicaid deficit assessment is different from the offsetting revenue reported for other community benefit categories.

Figure 5. Sources of Offsetting Revenue for Maryland Hospitals, FY 2020



Excluding the Medicaid deficit assessment, mission-driven health services accounted for the vast majority of offsetting revenues. By definition, mission-driven services are intended to be services provided to the community that are not expected to result in revenue. Rather, hospitals undertake these services as a direct result of their community or mission driven initiatives, or because the services would otherwise not be provided in the community. Table 18 presents offsetting revenue for mission-driven services by hospital. The hospitals are sorted in increasing order of the proportion of reported expenditures offset by revenue. Thirteen hospitals did not report any offsetting revenue from mission-driven health services. Seven hospitals reported offsetting revenue for 50 percent or more of their mission-driven expenditures.

Table 18. Mission-Driven Health Services Expenditure and Offsetting Revenue among Maryland Hospitals, FY 2020

Hospital Name	Total Expenditure	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Net Community Benefit
Garrett Regional Medical Center	$0	$0	-	$0
Adventist Healthcare Rehabilitation	$858,137	$0	0.0%	$858,137
Carroll Hospital	$11,711,013	$0	0.0%	$11,711,013
Doctors Community Hospital	$5,374,267	$0	0.0%	$5,374,267
Holy Cross Germantown	$2,575,182	$0	0.0%	$2,575,182
Howard County General Hospital	$16,100,121	$0	0.0%	$16,100,121
McCready Foundation Hospital	$43,165	$0	0.0%	$43,165
UM Charles Regional Medical Center	$9,487,756	$0	0.0%	$9,487,756
UM Shore Regional Health Chester River	$9,783,568	$0	0.0%	$9,783,568
UM Shore Regional Health Dorchester	$10,457,600	$0	0.0%	$10,457,600
UM Shore Regional Health Easton	$26,058,335	$0	0.0%	$26,058,335
UM St. Joseph Medical Center	$35,068,368	$0	0.0%	$35,068,368
Washington Adventist	$19,214,966	$0	0.0%	$19,214,966
Frederick Memorial Hospital	$17,751,759	$8,527	0.0%	$17,743,232
Shady Grove Medical Center	$17,876,133	$428,117	2.4%	$17,448,016
Johns Hopkins	$23,763,218	$627,183	2.6%	$23,136,035
Mercy Hospital	$22,256,668	$782,885	3.5%	$21,473,784
Suburban Hospital	$14,860,683	$867,526	5.8%	$13,993,157
Anne Arundel Medical Center	$41,021,480	$3,275,356	8.0%	$37,746,124
Levindale Hospital	$666,637	$58,028	8.7%	$608,609
Atlantic General Hospital	$209,718	$19,055	9.1%	$190,663
Sheppard Pratt Health System	$19,629,913	$1,803,931	9.2%	$17,825,981
Johns Hopkins Bayview	$11,764,809	$1,114,078	9.5%	$10,650,731
UM Medical Center Midtown Campus	$20,444,548	$2,656,789	13.0%	$17,787,760
Calvert Memorial Hospital	$15,408,115	$2,061,380	13.4%	$13,346,735
MedStar St. Mary's Hospital	$11,367,520	$1,830,953	16.1%	$9,536,567
Holy Cross Hospital	$8,776,706	$1,679,154	19.1%	$7,097,552
Prince George's Hospital	$49,692,000	$10,414,000	21.0%	$39,278,000
Sinai Hospital	$33,038,115	$8,184,510	24.8%	$24,853,605
MedStar Southern Maryland Hospital	$11,728,652	$3,017,105	25.7%	$8,711,547
UM Harford Memorial	$4,293,053	$1,118,844	26.1%	$3,174,209
Northwest Hospital Center	$11,114,509	$2,945,400	26.5%	$8,169,109
UM Rehabilitation & Orthopedic Institute	$3,304,315	$912,000	27.6%	$2,392,315

Hospital Name	Total Expenditure	Offsetting Revenue	Proportion of Total Expenditure Offset by Revenue	Net Community Benefit
UM Upper Chesapeake Medical Center	$8,998,096	$2,610,635	29.0%	$6,387,461
Mt. Washington Pediatric Hospital	$795,046	$263,890	33.2%	$531,156
University of Maryland Medical Center	$24,433,233	$9,897,507	40.5%	$14,535,726
Bon Secours	$13,060,126	$5,607,915	42.9%	$7,452,211
Union Hospital of Cecil County	$15,697,981	$6,887,031	43.9%	$8,810,950
St Agnes Hospital	$30,550,033	$13,533,465	44.3%	$17,016,568
Meritus Medical Center	$82,349,231	$37,524,481	45.6%	$44,824,750
MedStar Union Memorial Hospital	$6,648,613	$3,067,948	46.1%	$3,580,665
MedStar Harbor Hospital	$16,652,797	$7,801,071	46.8%	$8,851,726
Western Maryland Health System	$87,961,493	$42,389,383	48.2%	$45,572,110
Peninsula Regional Medical Center	$104,657,378	$55,896,290	53.4%	$48,761,088
MedStar Good Samaritan	$6,612,267	$3,589,799	54.3%	$3,022,468
MedStar Franklin Square	$40,723,836	$24,802,331	60.9%	$15,921,505
Greater Baltimore Medical Center	$109,843,505	$67,978,196	61.9%	$41,865,309
MedStar Montgomery Medical Center	$11,160,083	$7,654,608	68.6%	$3,505,475
UM Baltimore Washington Medical Center	$62,525,288	$58,008,335	92.8%	$4,516,953
Fort Washington Medical Center	$274,877	$257,271	93.6%	$17,606
Total	**$1,108,644,913**	**$391,574,977**	**35.3%**	**$717,069,936**

FY 2004 – FY 2020 17-Year Summary

FY 2020 marks the 17th year since the inception of the CBR. In FY 2004, community benefit expenses represented $586.5 million, or 6.9 percent of hospitals' operating expenses. In FY 2020, these expenses represented roughly $1.94 billion, or 11.3 percent of operating expenses. The reporting requirement for revenue offsets and rate support has changed since the inception of the CBR in FY 2004. For consistency purposes, the following figures illustrate community benefit expenses from FY 2011 through FY 2020. Figures 6 and 7 show the trend of community benefit expenses with and without rate support. On average, approximately 50 percent of expenses were reimbursed through the rate-setting system, though that figure fell below 40 percent in FY 2018.

Figure 6. FY 2011 – FY 2020 Community Benefit Expenses with and without Rate Support

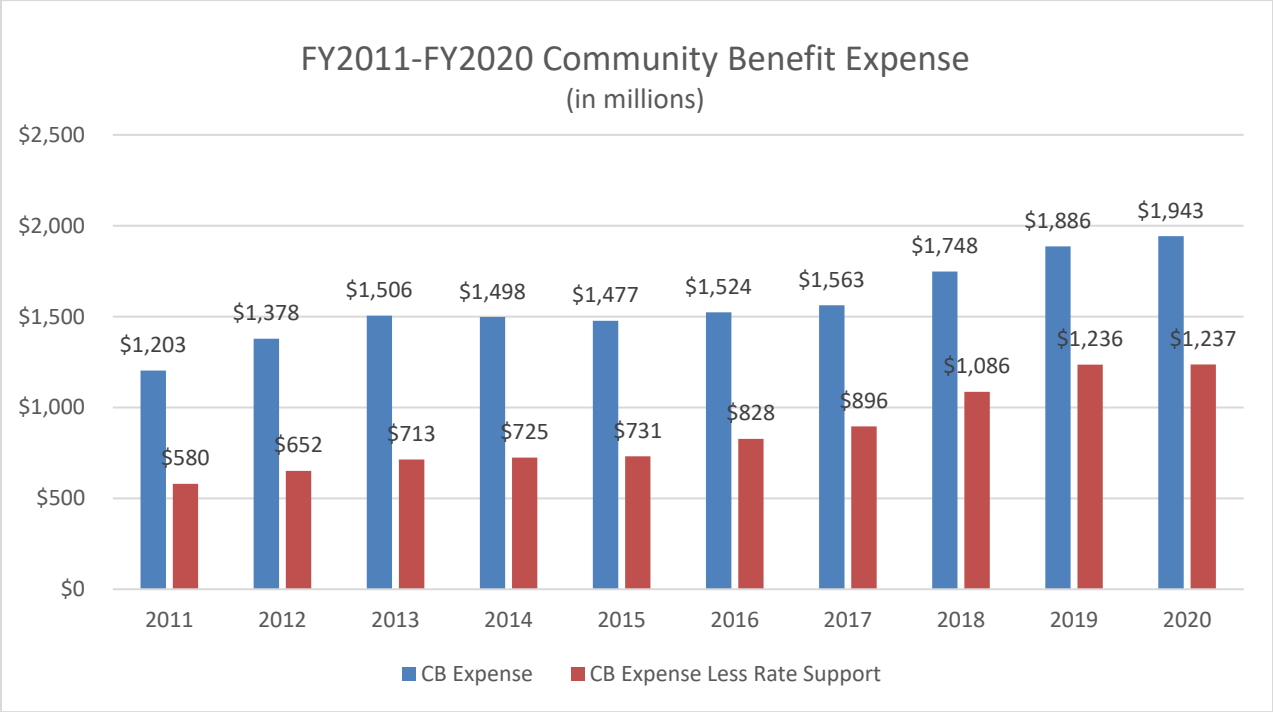
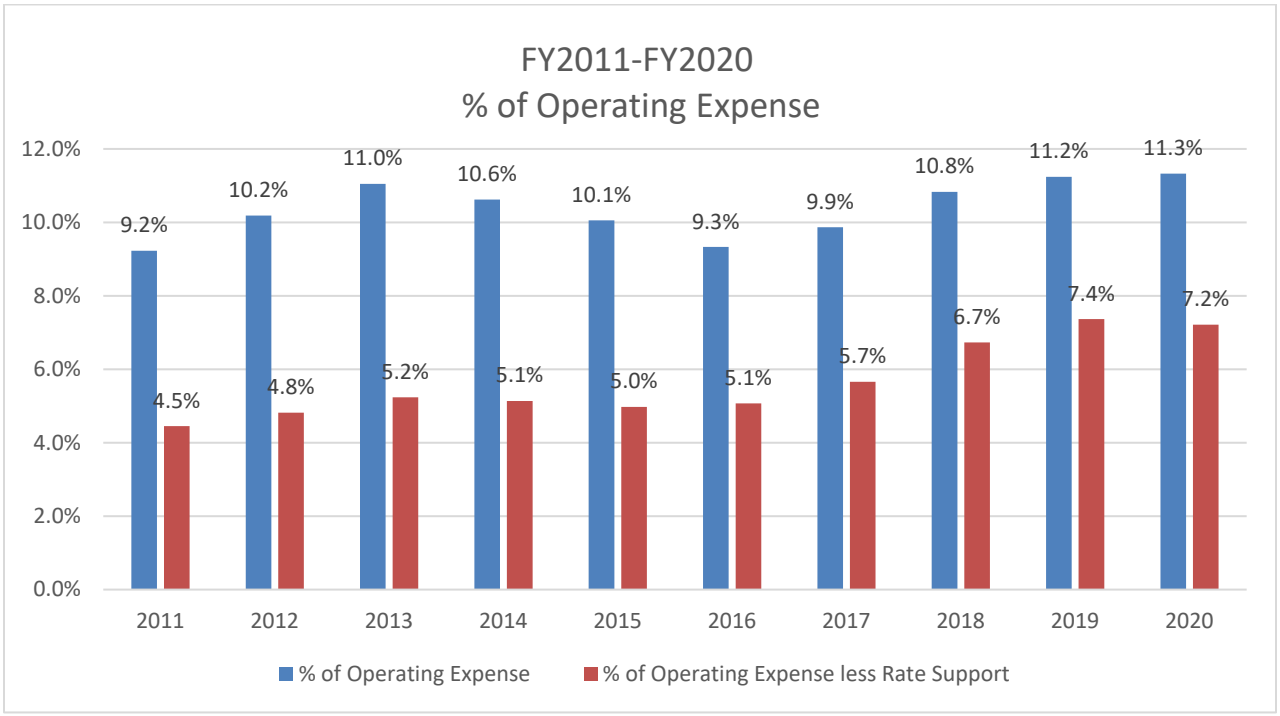


Figure 7. FY 2011 – FY 2020 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support



Conclusion

In summary, all 50 Maryland hospitals submitted FY 2020 CBRs, showing a total of $1.9 billion in community benefit expenditures, approximately the same as in FY 2019. The distribution of expenditures across community benefit categories remained similar to prior years, with mission-driven services accounting for the majority of expenditures. Overall, expenditures as a percentage of operating expenses increased from 11.2 percent to 11.3 percent from FY 2019 to FY 2020. After accounting for rate support, expenditures as a percentage of operating expenses slightly decreased from 7.4 percent to 7.2 percent.

The narrative portion of the CBR provides the HSCRC with richer detail on hospital community benefit and CHNA activities beyond what is included in the financial report. The hospitals continued to be very responsive to using the reporting tool, and all hospitals successfully submitted their reports online. Encouraging findings of the review include a senior-level commitment to community benefit activities and community engagement. For example, 96 percent of hospitals employed a population health director, and most reported that these staff members were involved in selecting the community health needs to target and in developing community benefit initiatives. Eighty-seven percent of hospitals employ staff dedicated to community benefit. Community benefit initiatives frequently targeted diabetes treatment/prevention, which is consistent with needs identified in hospital CHNAs and the goals of the state's new Diabetes Action Plan.

The review also identified the following areas for improvement:

- Staff noted variation in the format and content of the hospitals' financial assistance policy documents. Standardization of these documents could provide greater clarity for consumers.
- Inconsistencies and ambiguity in reporting on physician subsidies makes it difficult to tie these expenditures to needs specifically identified in the CHNA or gaps in physician availability. Revisions to the reporting instructions will provide clarification on what counts as physician subsidy and allow for more precise analyses in subsequent years.
- Hospitals are taking inconsistent approaches to reporting offsetting revenue within mission-driven health services and also including line items that appear inappropriate. In general, mission-driven health services are meant to represent services with no expectation of reimbursement or other revenue; nonetheless, several hospitals have reported multi-million-dollar line items with a significant portion of the total offset by revenue. Given that this category accounts for such a large amount of reported community benefits, priority will be given towards working with hospitals to ensure consistency.

Appendix A. Community Health Measures Reported by Hospitals

In addition to the measures reported in Table 4 of the main body of this report, hospitals reported using a number of other sources of community health data, including the following:

- 2019 Cigarette Restitution Fund Program's Cancer in Maryland Report
- Baltimore Neighborhood Indicators Alliance
- CDC National Center for Health Statistics
- CDC National Center on Birth Defects and Developmental Disabilities
- CDC National Center for Chronic Disease Prevention and Health Promotion
- Conduent - Healthy Communities Institute
- Chesapeake Regional Information System for our Patients (CRISP)
- Healthy People 2020
- Johns Hopkins Bloomberg School of Public Health - Healthy Food Priorities Map
- Local Health Departments' Community Health Statistics
- Maryland Behavioral Risk Factor Surveillance System
- Maryland Department of Planning
- Maryland Physician Workforce Study
- Maryland Sexually Transmitted Infections Program
- Maryland State Health Improvement Plan (SHIP)
- Maryland Vital Statistics
- Maryland Youth Risk Behavior Survey
- National Cancer Institute
- Nielsen/Claritas
- Robert Wood Johnson Foundation – City Health Dashboard
- Robert Wood Johnson Foundation – County Health Rankings
- Substance Abuse and Mental Health Services Administration (SAMHSA) – National Survey on Drug Use and Health (NSDUH)
- Truven/IBM Market Expert
- U.S. Census Bureau - American Community Survey
- United Way – United for ALICE (Asset-Limited, Income Constrained, Employed)
- University of Wisconsin School of Medicine and Public Health – Neighborhood Atlas

Appendix B. CHNA Schedules

Hospital	Date Most Recent CHNA was Completed
CalvertHealth Medical Center	Nov-17
TidalHealth McCready Pavilion	Dec-17
Lifebridge Levindale	Mar-18
Lifebridge Northwest	Mar-18
Lifebridge Sinai	Mar-18
Lifebridge Carroll Hospital Center	May-18
Johns Hopkins Bayview	May-18
UM Upper Chesapeake	May-18
UM Rehab & Ortho	May-18
Mt. Washington Pediatric	Jun-18
UMMC	Jun-18
UMMC Midtown	Jun-18
Mercy Medical Center	Jun-18
Johns Hopkins Hospital	Jun-18
St. Agnes Hospital	Jun-18
MedStar Harbor	Jun-18
MedStar Good Samaritan	Jun-18
UM Charles Regional	Jun-18
MedStar Franklin Square	Jun-18
MedStar Union Memorial	Jun-18
MedStar St. Mary's	Jun-18
MedStar Southern Maryland	Jun-18
MedStar Montgomery	Jun-18
Anne Arundel Medical Center	Feb-19
Doctors Community Hospital	Apr-19
Frederick Health Hospital	May-19
Sheppard Pratt	May-19
Meritus Medical Center	May-19
Atlantic General	May-19
Adventist Ft Washington	May-19
UM Shore Regional	May-19
GBMC	Jun-19
UM Capitol Region	Jun-19
TidalHealth Peninsula Regional	Jun-19
UM BWMC	Jun-19

Hospital	Date Most Recent CHNA was Completed
Suburban	Jun-19
UM St. Joseph	Jun-19
ChristianaCare Union Hospital	Jun-19
Howard County General	Jun-19
Grace Medical Center	Jul-19
Holy Cross Germantown	Oct-19
Holy Cross Hospital	Oct-19
Adventist HealthCare Rehabilitation	Dec-19
Adventist HealthCare Shady Grove	Dec-19
Adventist White Oak	Dec-19
Garrett Regional	Jan-20
UPMC Western Maryland	Jun-20

*Data Source: As reported by hospitals on their FY 2020 CBRs.

maryland health services cost review commission

Appendix C. CHNA Internal and External Participants and Their Roles

CHNA Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Member of CHNA Committee	Participated in the Development of the CHNA Process	Advised on CHNA Best Practices	Participated in Primary Data Collection	Participated in Identifying Priority Health Needs	Participated in Identifying Community Resources to Meet Health Needs	Provided Secondary Health Data	Other
Internal Participants										
CB/ Community Health/Population Health Director (facility level)	4	9	33	31	31	28	34	34	18	6
CB/ Community Health/ Population Health Director (system level)	12	7	18	23	21	18	23	22	16	5
Senior Executives (CEO, CFO, VP, etc.) (facility level)	2	1	35	30	17	15	31	23	2	8
Senior Executives (CEO, CFO, VP, etc.) (system level)	5	5	19	25	17	6	22	10	1	7
Board of Directors or Board Committee (facility level)	10	3	16	15	14	5	22	16	3	13
Board of Directors or Board Committee (system level)	14	5	5	10	14	1	11	6	1	10
Clinical Leadership (facility level)	3	0	33	27	27	19	40	33	10	2
Clinical Leadership (system level)	15	5	20	19	17	5	23	18	6	3
Population Health Staff (facility level)	3	10	29	25	21	21	33	33	21	2
Population Health Staff (system level)	15	6	19	21	17	17	22	18	13	4
Community Benefit staff (facility level)	0	13	31	31	31	28	32	30	26	2
Community Benefit staff (system level)	10	9	18	19	23	17	19	18	12	5
Physician(s)	5	0	23	21	16	20	38	26	4	1
Nurse(s)	6	0	28	26	20	21	39	34	12	1
Social Workers	11	1	21	16	14	16	32	32	8	1
Community Benefit Task Force	6	13	23	21	20	23	25	23	9	5

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CHNA Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Member of CHNA Committee	Participated in the Development of the CHNA Process	Advised on CHNA Best Practices	Participated in Primary Data Collection	Participated in Identifying Priority Health Needs	Participated in Identifying Community Resources to Meet Health Needs	Provided Secondary Health Data	Other
Hospital Advisory Board	6	22	10	12	11	8	19	16	3	0
Other (specify)	3	1	2	1	2	6	4	3	1	1
External Participants										
Other Hospitals	17		14	0	18	23	24	20	13	3
Local Health Department	0		26	0	33	43	40	39	35	7
Local Health Improvement Coalition	12		18	0	19	27	30	29	17	3
Maryland Department of Health	19		3	0	6	7	5	8	20	2
Maryland Department of Human Resources	43		0	0	0	1	0	1	2	0
Maryland Department of Natural Resources	45		0	0	0	0	0	0	2	0
Maryland Department of the Environment	40		0	0	0	1	1	0	7	0
Maryland Department of Transportation	39		1	0	0	1	1	1	7	0
Maryland Department of Education	36		1	0	0	1	1	1	9	0
Area Agency on Aging	15		9	0	6	17	19	17	12	2
Local Govt. Organizations	16		9	0	9	17	24	21	10	3
Faith-Based Organizations	6		10	0	3	21	33	32	3	1
School - K-12	14		9	0	6	16	22	24	11	1
School - Colleges and/or Universities	20		9	0	11	16	24	23	8	1
School of Public Health	35		2	0	2	8	8	6	4	1
School - Medical School	40		0	0	1	5	5	6	5	0
School - Nursing School	35		1	0	3	7	8	9	4	0
School - Dental School	46		0	0	0	0	0	1	0	0
School - Pharmacy School	45		0	0	0	0	1	2	0	0
Behavioral Health Organizations	12		13	0	11	16	29	29	10	0

CHNA Participant Category	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Member of CHNA Committee	Participated in the Development of the CHNA Process	Advised on CHNA Best Practices	Participated in Primary Data Collection	Participated in Identifying Priority Health Needs	Participated in Identifying Community Resources to Meet Health Needs	Provided Secondary Health Data	Other
Social Service Organizations	12		9	0	8	20	31	31	7	1
Post-Acute Care Facilities	31		1	0	1	7	9	12	4	1
Community/Neighborhood Organizations	13		11	0	4	18	31	27	5	3
Consumer/Public Advocacy Organizations	20		10	0	5	16	24	23	7	0
Other	6		7	0	5	20	28	24	5	3

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Appendix D. Community Benefit Internal and External Participants and Their Roles

	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing Funding for CB Activities	Allocating budgets for individual initiatives	Delivering CB Initiatives	Evaluating the Outcome of CB Initiatives	Other (explain)
Internal Participants										
CB/ Community Health/Population Health Director (facility level)	1	8	38	38	37	29	34	37	34	3
CB/ Community Health/ Population Health Director (system level)	9	10	24	23	25	14	17	18	18	4
Senior Executives (CEO, CFO, VP, etc.) (facility level)	2	0	37	37	25	34	36	9	21	1
Senior Executives (CEO, CFO, VP, etc.) (system level)	6	6	25	24	17	20	19	5	18	4
Board of Directors or Board Committee (facility level)	7	2	24	19	12	7	6	2	16	5
Board of Directors or Board Committee (system level)	19	6	18	9	7	5	0	0	6	2
Clinical Leadership (facility level)	3	0	35	32	27	7	16	29	25	1
Clinical Leadership (system level)	18	8	18	16	12	5	9	6	12	0
Population Health Staff (facility level)	0	9	31	28	29	13	15	30	32	0
Population Health Staff (system level)	13	8	20	20	18	6	11	19	21	2
Community Benefit staff (facility level)	2	12	27	27	30	11	14	28	29	1
Community Benefit staff (system level)	6	14	19	18	21	4	4	17	20	5
Physician(s)	4	0	29	28	16	2	5	32	19	3
Nurse(s)	3	1	25	25	20	6	9	38	23	1
Social Workers	13	0	20	22	18	3	5	32	18	1
Community Benefit Task Force	6	13	25	22	24	2	4	13	24	2

	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing Funding for CB Activities	Allocating budgets for individual initiatives	Delivering CB Initiatives	Evaluating the Outcome of CB Initiatives	Other (explain)
Hospital Advisory Board	15	17	12	9	5	1	2	2	10	1
Other (specify)	5	2	3	4	4	2	2	4	4	1
External Participants										
Other Hospitals	13		18	15	19	10	11	22	19	5
Local Health Department	3		26	23	27	14	12	32	25	6
Local Health Improvement Coalition	10		27	18	19	2	4	19	20	2
Maryland Department of Health	27		6	10	6	8	2	4	5	2
Maryland Department of Human Resources	45		0	0	0	1	0	1	0	0
Maryland Department of Natural Resources	45		0	0	0	0	0	1	0	1
Maryland Department of the Environment	46		0	0	0	0	0	0	0	1
Maryland Department of Transportation	45		0	0	0	0	0	0	0	2
Maryland Department of Education	41		1	2	2	1	0	3	1	2
Area Agency on Aging	19		12	11	12	4	4	21	13	2
Local Govt. Organizations	20		9	10	5	6	2	17	3	4
Faith-Based Organizations	11		13	9	4	0	0	26	5	8
School - K-12	15		9	8	5	1	1	24	8	5
School - Colleges and/or Universities	22		5	6	4	2	1	18	5	4
School of Public Health	38		2	1	2	0	0	8	3	0
School - Medical School	36		2	0	2	2	2	8	2	1
School - Nursing School	32		2	3	4	1	0	12	4	1
School - Dental School	46		1	0	0	0	0	0	0	0
School - Pharmacy School	42		1	0	0	0	0	3	0	0
Behavioral Health Organizations	17		11	10	7	0	1	26	14	2
Social Service Organizations	18		13	13	8	5	3	21	13	2

	N/A - Person or Organization was not Involved	N/A - Position or Department Does Not Exist	Selecting health needs that will be targeted	Selecting the initiatives that will be supported	Determining how to evaluate the impact of initiatives	Providing Funding for CB Activities	Allocating budgets for individual initiatives	Delivering CB Initiatives	Evaluating the Outcome of CB Initiatives	Other (explain)
Post-Acute Care Facilities	32		8	5	5	3	0	10	7	2
Community/Neighborhood Organizations	15		17	13	8	3	1	24	14	3
Consumer/Public Advocacy Organizations	25		9	8	4	0	0	15	9	0
Other	20		9	9	4	4	1	15	12	2

Appendix E. FY 2020 Funding for Nurse Support Program I, Direct Medical Education, and Charity Care

Hospital Name	DME	NSP I	Charity Care	Total Rate Support
Adventist Rehabilitation	$0	$0	$0	$0
Anne Arundel General Hospital	$1,295,673	$696,466	$4,665,000	$6,657,140
Atlantic General Hospital	$0	$48,776	$2,080,700	$2,129,476
Bon Secours Hospital	$0	$123,744	$213,345	$337,089
Calvert Memorial Hospital	$0	$165,427	$2,092,026	$2,257,453
Carroll County General Hospital	$0	$260,680	$503,782	$764,462
Doctors Community Hospital	$0	$274,648	$9,425,649	$9,700,297
Fort Washington Medical Center	$0	$48,776	$400,374	$449,150
Frederick Memorial Hospital	$0	$393,815	$5,822,311	$6,216,126
Garrett County Memorial Hospital	$0	$64,222	$3,088,077	$3,152,299
Greater Baltimore Medical Center	$7,731,237	$510,520	$2,193,000	$10,434,757
Holy Cross	$2,300,163	$568,651	$25,216,478	$28,085,292
Holy Cross German Town	$0	$457,635	$4,804,910	$5,262,545
Howard County General Hospital	$0	$344,313	$4,679,000	$5,023,313
Johns Hopkins	$119,235,430	$2,657,027	$35,066,500	$156,958,957
Johns Hopkins Bayview Med. Center	$25,126,324	$745,887	$21,680,000	$47,552,211
Levindale	$0	$67,583	$936,020	$1,003,603
McCready Foundation, Inc.	$0	$19,140	$0	$19,140
MedStar Franklin Square Hospital	$8,779,317	$596,421	$12,318,684	$21,694,422
MedStar Good Samaritan Hospital	$4,725,287	$0	$7,178,703	$11,903,990
MedStar Harbor Hospital Center	$3,866,851	$217,001	$5,448,214	$9,532,066
MedStar Montgomery General Hospital	$0	$202,905	$3,193,638	$3,396,544
MedStar Southern Maryland Hospital	$0	$293,107	$5,442,147	$5,735,253
MedStar St. Mary's Hospital	$0	$217,835	$4,539,656	$4,757,491
MedStar Union Memorial Hospital	$13,134,515	$489,843	$9,977,661	$23,602,019
Mercy Medical Center, Inc.	$5,222,206	$594,951	$17,767,062	$23,584,219
Meritus Medical Center	$0	$371,947	$5,280,200	$5,652,147
Mt. Washington Peds	$0	$67,837	$43,123	$110,960
Northwest Hospital Center, Inc.	$0	$296,207	$1,929,688	$2,225,895
Peninsula Regional Medical Center	$0	$501,914	$13,045,900	$13,547,814
Shady Grove Adventist Hospital	$0	$67,583	$11,221,259	$11,288,842
Sheppard Pratt	$2,692,100	$167,184	$4,391,731	$7,251,015
Sinai Hospital	$17,345,063	$870,729	$5,349,000	$23,564,792
St. Agnes Hospital	$8,822,979	$488,207	$12,957,524	$22,268,710
Suburban Hospital Association, Inc	$598,256	$363,619	$4,768,896	$5,730,772

Hospital Name	DME	NSP I	Charity Care	Total Rate Support
UM Capital Region	$4,654,172	$440,819	$10,373,355	$15,468,345
UMROI	$4,059,878	$0	$1,382,000	$5,441,878
Union Hospital of Cecil County	$0	$184,880	$1,429,900	$1,614,780
UM BWMC	$650,488	$474,915	$6,375,000	$7,500,403
UM Charles Regional	$0	$172,930	$1,088,000	$1,260,930
UM Harford	$0	$117,515	$1,819,000	$1,936,515
Univ. of Maryland Medical Center	$119,732,582	$1,876,955	$21,239,000	$142,848,537
UM Midtown Campus	$4,875,719	$265,141	$3,763,000	$8,903,860
UM Shore Chestertown	$0	$66,388	$624,742	$691,129
UM Shore Dorchester	$0	$57,159	$425,237	$482,396
UM Shore Easton	$0	$235,287	$2,913,105	$3,148,392
UM St. Josephs	$0	$457,635	$7,456,792	$7,914,427
UM Upper Chesapeake	$0	$379,634	$3,918,000	$4,297,634
Washington Adventist Hospital	$0	$311,221	$9,248,445	$9,559,667
Western Maryland Hospital	$0	$371,134	$12,451,700	$12,822,834
Total	**$354,848,240**	**$18,666,216**	**$332,227,534**	**$705,741,989**

Appendix F. Charity Care Methodology

The purpose of this appendix is to explain why the charity care amounts reported by hospitals in their community benefit reports may not match the charity care amounts applied in their global budgets for the same year. The charity care amounts in rates are part of the HSCRC's uncompensated care (UCC) policy, which is a prospective policy applied at the beginning of the rate year. In contrast, the amounts reported by hospitals in their community benefit report retrospective.

The HSCRC applies the following procedures to calculate the charity care dollar amount to subtract from total dollars provided by hospitals in the statewide Community Benefit Report.

Step 1

Determine the amount of uncompensated care that was projected for each hospital for the fiscal year being reported (in this case, the FY 2020 Community Benefit Report) based on the policy approved by the Commission for the beginning of the rate year (also FY 2020).

- The HSCRC uses a logistic regression to predict actual hospital uncompensated care costs in a given year (FY 2020).
- The uncompensated care logistic regression model predicts a patient's likelihood of having UCC based on payer type, the location of service (i.e., inpatient, ED, and other outpatient), and the Area Deprivation Index.[35]
  - An expected UCC dollar amount is calculated for every patient encounter.
  - These UCC dollars are then summarized at the hospital level.
  - These summarized UCC dollars are then divided by the hospital's total charges to estimate the hospital's UCC level.
- The hospital's most current fiscal year financially audited UCC levels (FY 2020) are averaged with the hospital's estimated UCC levels from the prior FY (FY 2019) to determine hospital-specific adjustments. These are predicted amounts provided to hospitals to fund the next year's UCC.

Step 2

Retrospectively, determine the actual ratio of charity care to total UCC from the hospital's audited financial statements to determine the rate of charity expense to apply to the predicted UCC amount from the rate year 2020 policy. The resulting charity care amount is the estimated amount provided in rates that will be subtracted from the hospital's community benefit.

Example Johns Hopkins Hospital:

[35] The Area Deprivation Index represents a geographic area-based measure of the socioeconomic deprivation experienced by a neighborhood.

Predicted Value from FY 2016 Estimated UCC Levels	3.60%
FY 2017 Audited Financial UCC Level	2.25%
Predicted 50/50 Average	3.02%

Split between Bad Debt and Charity Care Amounts – FY 2017 Audited Financials

Regulated Gross Patient Revenue	**Regulated Total UCC**	**Regulated Bad Debt**	**Regulated Charity**	**Bad Debt**	**Charity Chare**
$2,352,718,900	$61,819,012	$40,121,239	$21,697,773	64.90%	35.10%

Estimate amount of UCC $ provided in rates at the beginning of FY 2017:

FY17 Regulated Gross Patient Revenue ($2,352,718,900) * 3.02% (3.02192482223646%) = $ 71,097,396

Estimate of Charity $ provided in rates at the beginning of FY 2017:

35.10% (35.0988673193289%) * $71,097,396 = $24,954,381.

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APPENDIX G. FY 2020 Community Benefit Analysis

Hospital Name	Number of Employees	Total Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2020 Amount in Rates for Charity Care, DME, and NSPI*	Total Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
Adventist Rehabilitation	476	392	$50,824,294	$3,005,220	5.91%	$0	$3,005,220	5.91%	$551,776
Anne Arundel	4,926	875	$585,311,000	$61,575,726	10.52%	$6,657,140	$54,918,587	9.38%	$4,665,050
Atlantic General	985	84	$134,967,041	$3,764,790	2.79%	$2,129,476	$1,635,314	1.21%	$2,158,110
Grace	567	0	$66,479,100	$8,777,659	13.20%	$337,089	$8,440,570	12.70%	$213,345
Calvert Hospital	0	2,520	$137,396,210	$17,969,884	13.08%	$2,257,453	$15,712,431	11.44%	$2,087,095
Carroll	1,875	2,080	$201,484,375	$17,714,787	8.79%	$764,462	$16,950,325	8.41%	$503,783
Doctors Community	1,577	1,540	$215,413,138	$18,108,642	8.41%	$9,700,297	$8,408,346	3.90%	$9,528,010
Fort Washington	375	88	$46,221,264	$1,314,343	2.84%	$449,150	$865,193	1.87%	$981,260
Frederick	2,390	192	$356,515,000	$30,593,551	8.58%	$6,216,126	$24,377,425	6.84%	$7,159,000
Garrett County	508	127	$49,847,123	$4,100,015	8.23%	$3,152,299	$947,716	1.90%	$3,074,822
GBMC	2,617	4,560	$514,005,000	$54,792,557	10.66%	$10,434,757	$44,357,799	8.63%	$2,329,000
Holy Cross	3,333	6,259	$453,889,368	$46,698,333	10.29%	$28,085,292	$18,613,041	4.10%	$30,178,692
Holy Cross German Town	735	353	$108,611,245	$8,115,922	7.47%	$5,262,545	$2,853,376	2.63%	$4,811,636
Howard County General	1,747	2,955	$262,623,000	$29,341,719	11.17%	$5,023,313	$24,318,406	9.26%	$4,678,771
Johns Hopkins	0	6,334	$2,658,945,000	$311,170,744	11.70%	$156,958,957	$154,211,786	5.80%	$35,067,000
Johns Hopkins Bayview	3,410	538	$671,878,000	$93,408,687	13.90%	$47,552,211	$45,856,476	6.83%	$21,680,000
Levindale	816	815	$80,197,000	$2,795,618	3.49%	$1,003,603	$1,792,015	2.23%	$1,597,300
McCready	263	0	$10,283,006	$308,083	3.00%	$19,140	$288,942	2.81%	$198,594

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Hospital Name	Number of Employees	Total Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2020 Amount in Rates for Charity Care, DME, and NSPI*	Total Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
MedStar Franklin Square	2,905	2,636	$549,838,800	$48,273,948	8.78%	$21,694,422	$26,579,526	4.83%	$12,318,684
MedStar Good Samaritan	1,710	1,148	$263,976,142	$23,374,331	8.85%	$11,903,990	$11,470,341	4.35%	$7,178,703
MedStar Harbor	1,127	3,054	$191,182,619	$23,766,596	12.43%	$9,532,066	$14,234,531	7.45%	$5,448,214
MedStar Montgomery	1,016	0	$171,486,283	$8,727,049	5.09%	$3,396,544	$5,330,505	3.11%	$3,193,638
MedStar Southern Maryland	1,149	1,360	$240,415,418	$17,056,467	7.09%	$5,735,253	$11,321,214	4.71%	$5,442,147
MedStar St. Mary's	1,184	5,053	$162,834,942	$18,390,288	11.29%	$4,757,491	$13,632,797	8.37%	$4,735,612
MedStar Union Memorial	2,113	1,413	$430,645,261	$45,660,746	10.60%	$23,602,019	$22,058,727	5.12%	$9,977,661
Mercy	3,539	2,723	$492,374,189	$71,666,597	14.56%	$23,584,219	$48,082,378	9.77%	$17,767,062
Meritus	2,826	319	$399,338,982	$57,109,549	14.30%	$5,652,147	$51,457,401	12.89%	$5,453,564
Mt. Washington	752	2,658	$62,631,697	$1,861,658	2.97%	$110,960	$1,750,697	2.80%	$65,146
Northwest Hospital	1,623	4,687	$249,673,000	$15,601,890	6.25%	$2,225,895	$13,375,995	5.36%	$1,929,700
Peninsula Regional	2,895	430	$493,289,357	$70,601,728	14.31%	$13,547,814	$57,053,914	11.57%	$14,451,000
Shady Grove Adventist	2,556	879	$395,307,320	$39,045,441	9.88%	$11,288,842	$27,756,599	7.02%	$9,670,999
Sheppard Pratt	2,500	378	$232,824,428	$26,672,620	11.46%	$7,251,015	$19,421,605	8.34%	$4,443,367
Sinai Hospital	5,258	14,877	$791,568,000	$73,675,916	9.31%	$23,564,792	$50,111,125	6.33%	$6,345,767
St. Agnes Hospital	2,450	0	$460,174,000	$45,328,937	9.85%	$22,268,710	$23,060,227	5.01%	$16,137,703
Suburban Hospital	1,896	1,652	$311,199,000	$30,311,893	9.74%	$5,730,772	$24,581,121	7.90%	$4,769,000
UM Capital Region	2,500	4,160	$322,178,000	$54,771,320	17.00%	$15,468,345	$39,302,974	12.20%	$9,170,000
UMROI	624	750	$108,289,000	$11,885,649	10.98%	$5,441,878	$6,443,771	5.95%	$1,382,000
Union of Cecil	1,185	893	$159,947,807	$11,110,606	6.95%	$1,614,780	$9,495,825	5.94%	$1,432,729
UM BWMC	3,215	4,576	$398,520,000	$14,436,003	3.62%	$7,500,403	$6,935,600	1.74%	$6,375,000

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Hospital Name	Number of Employees	Total Staff Hours for CB Operations	Total Hospital Operating Expense	Total Community Benefit Expense	Total CB as % of Total Operating Expense	FY 2020 Amount in Rates for Charity Care, DME, and NSPI*	Total Net CB minus Charity Care, DME, NSPI in Rates	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
UM Charles Regional	872	1,249	$133,537,960	$12,815,037	9.60%	$1,260,930	$11,554,108	8.65%	$1,088,212
UM Harford	787	930	$88,580,314	$9,172,043	10.35%	$1,936,515	$7,235,529	8.17%	$1,818,538
UMMC	9,010	2,749	$1,692,179,000	$235,720,079	13.93%	$142,848,537	$92,871,542	5.49%	$21,239,000
UM Midtown Campus	1456	738	$232,223,000	$29,646,890	12.77%	$8,903,860	$20,743,030	8.93%	$3,763,000
UM Shore Chestertown	185	1,460	$43,821,000	$10,778,269	24.60%	$691,129	$10,087,140	23.02%	$635,000
UM Shore Dorchester	269	2,160	$34,558,000	$11,326,735	32.78%	$482,396	$10,844,339	31.38%	$501,000
UM Shore Easton	1,316	2,000	$218,075,000	$32,081,030	14.71%	$3,148,392	$28,932,637	13.27%	$3,090,000
UM St. Josephs	2,041	529	$340,304,000	$48,903,007	14.37%	$7,914,427	$40,988,581	12.04%	$7,921,000
UM Upper Chesapeake	2,477	2,170	$272,962,267	$24,344,308	8.92%	$4,297,634	$20,046,674	7.34%	$3,917,727
Washington Adventist	1,273	1,553	$265,481,640	$37,330,187	14.06%	$9,559,667	$27,770,520	10.46%	$9,664,081
Western Maryland	2,096	316	$333,791,774	$67,592,470	20.25%	$12,822,834	$54,769,636	16.41%	$15,894,834
All Hospitals	**85,022**	**99,211**	**$17,148,098,364**	**$1,942,595,565**	**11.33%**	**$705,741,989**	**$1,236,853,576**	**7.21%**	**$348,683,332**

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APPENDIX H. FY 2020 HOSPITAL COMMUNITY BENEFIT AGGREGATE DATA

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
Unreimbursed Medicaid Costs								
T99	**Medicaid Assessments**			**$329,825,000**	-	**$273,349,116**	**$56,475,884**	**$56,475,884**
Community Health Services								
A10	Community Health Education	262,441	3,364,057	$15,467,367	$8,630,185	$1,427,171	$22,670,380	$14,040,195
A11	Support Groups	13,856	23,684	$2,337,396	$1,641,442	$31,919	$3,946,919	$2,305,477
A12	Self-Help	13,021	74,871	$664,095	$380,052	$162,000	$882,147	$502,095
A20	Community-Based Clinical Services	117,778	100,542	$8,798,168	$5,526,513	$3,388,250	$10,936,430	$5,409,918
A21	Screenings	36,124	215,310	$2,170,372	$1,471,826	$709,976	$2,932,222	$1,460,396
A22	One-Time/Occasionally Held Clinics	1,040	3,978	$124,701	$62,760	$556	$186,905	$124,145
A23	Free Clinics	15,829	32,449	$6,675,902	$3,282,319	$13,859	$9,944,362	$6,662,043
A24	Mobile Units	33,855	13,884	$1,649,695	$816,513	$1,719,262	$746,946	$(69,568)
A30	Health Care Support Services	367,621	434,913	$48,321,472	$21,701,489	$4,704,749	$65,318,211	$43,616,723
A40	Other	72,878	189,989	$10,910,692	$3,667,751	$3,417,189	$11,161,255	$7,493,504
A99	**Total**	**934,443**	**4,453,676**	**$97,119,859**	**$47,180,850**	**$15,574,931**	**$128,725,778**	**$81,544,928**
Health Professions Education								
B1	Physicians/Medical Students	6,112,327	101,768	$368,029,289	$181,563,634	$2,965,918	$546,627,005	$365,063,371
B2	Nurses/Nursing Students	543,359	49,027	$23,281,121	$11,094,930	$1,301	$34,374,750	$23,279,820
B3	Other Health Professionals	248,203	33,811	$13,247,968	$5,980,056	$166,854	$19,061,170	$13,081,114

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
B4	Scholarships/Funding for Professional Education	1,233	220	$3,423,624	$1,680,448	$46,082	$5,057,990	$3,377,542
B50	Other	63,188	6,982	$3,329,596	$1,972,651	$783,373	$4,518,874	$2,546,223
B99	**Total**	**6,968,311**	**191,808**	**$411,311,598**	**$202,291,719**	**$3,963,528**	**$609,639,789**	**$407,348,070**
	Mission-Driven Health Services							
	Mission-Driven Health Services Total	**4,153,090**	**1,785,749**	**$965,405,337**	**$143,239,576**	**$391,574,977**	**$717,069,936**	**$573,830,360**
	Research							
D1	Clinical Research	75,839	19,452	$9,941,889	$3,274,828	$2,632,353	$10,584,364	$7,309,536
D2	Community Health Research	39,837	1,832	$2,791,247	$1,468,733	$0	$4,259,980	$2,791,247
D3	Other	0	0	$378,247	$261,018	$24,276	$614,989	$353,971
D99	**Total**	**115,676**	**21,284**	**$13,111,383**	**$5,004,580**	**$2,656,629**	**$15,459,334**	**$10,454,754**
	Financial Contributions							
E1	Cash Donations	3,108	27,163	$7,640,728	$303,167	$119,574	$7,824,320	$7,521,154
E2	Grants	2,690	307	$501,141	$41,270	$40,505	$501,905	$460,636
E3	In-Kind Donations	19,599	116,140	$3,541,343	$140,655	$187,434	$3,494,563	$3,353,909
E4	Cost of Fund Raising for Community Programs	313	763	$2,872,058	$128,729	$0	$3,000,787	$2,872,058
E99	**Total**	**25,710**	**144,373**	**$14,555,269**	**$613,820**	**$347,513**	**$14,821,576**	**$14,207,756**
	Community-Building Activities							
F1	Physical Improvements/Housing	3,590	19,956	$1,284,478	$405,089	$69,227	$1,620,341	$1,215,251
F2	Economic Development	4,555	3,323	$1,335,029	$516,190	$162,307	$1,688,912	$1,172,722

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	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
F3	Support System Enhancements	263,382	17,865	$14,306,947	$8,632,115	$2,562,800	$20,376,262	$11,744,147
F4	Environmental Improvements	5,140	20	$616,615	$216,731	$0	$833,346	$616,615
F5	Leadership Development/Training for Community Members	7,470	721	$332,217	$241,386	$25,000	$548,603	$307,217
F6	Coalition Building	19,964	6,794	$3,190,771	$2,054,114	$1,017,691	$4,227,194	$2,173,080
F7	Community Health Improvement Advocacy	10,355	3,211	$1,249,101	$556,955	$0	$1,806,056	$1,249,101
F8	Workforce Enhancement	63,438	15,728	$4,016,449	$2,519,256	$284,952	$6,250,753	$3,731,497
F9	Other	1,932	1,230	$192,993	$81,595	$0	$274,588	$192,993
	Total	**379,825**	**68,848**	**$26,524,600**	**$15,223,432**	**$4,121,977**	**$37,626,055**	**$22,402,623**
Community Benefit Operations								
G1	Dedicated Staff	78,831	1,334	$5,553,313	$3,151,687	$23,010	$8,681,990	$5,530,303
G2	Community health/health assets assessments	19,486	92,769	$1,181,525	$862,246	$13,575	$2,030,196	$1,167,950
G3	Other Resources	894	50	$1,749,289	$467,225	$0	$2,216,514	$1,749,289
G99	**Total**	**99,211**	**94,153**	**$8,484,127**	**$4,481,157**	**$36,585**	**$12,928,699**	**$8,447,542**
Charity Care								
	Total Charity Care	**$348,683,332**						
Foundation-Funded Community Benefits								
J1	Community Services	3,397	10,570	$494,134	$122,857	$105,099	$511,892	$389,035
J2	Community Building	55	593	$378,849	$406,052	$131,610	$653,291	$247,239
J3	Other	0	0	$0	$0	$0	$0	$0

	Type of Activity	Number of Staff Hours	Number of Encounters	Direct Cost	Indirect Cost	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
J99	**Total**	**3,452**	**11,163**	**$872,982**	**$528,909**	**$236,709**	**$1,165,182**	**$636,273**
Total Hospital Community Benefits								
A	Community Health Services	934,443	4,453,676	$97,119,859	$47,180,850	$15,574,931	$128,725,778	$81,544,928
B	Health Professions Education	6,968,311	191,808	$411,311,598	$202,291,719	$3,963,528	$609,639,789	$407,348,070
C	Mission Driven Health Care Services	4,153,090	1,785,749	$965,405,337	$143,239,576	$391,574,977	$717,069,936	$573,830,360
D	Research	115,676	21,284	$13,111,383	$5,004,580	$2,656,629	$15,459,334	$10,454,754
E	Financial Contributions	25,710	144,373	$14,555,269	$613,820	$347,513	$14,821,576	$14,207,756
F	Community Building Activities	379,825	68,848	$26,524,600	$15,223,432	$4,121,977	$37,626,055	$22,402,623
G	Community Benefit Operations	99,211	94,153	$8,484,127	$4,481,157	$36,585	$12,928,699	$8,447,542
H	Charity Care	0	0	$348,683,332	$0	$0	$348,683,332	$348,683,332
J	Foundation Funded Community Benefit	3,452	11,163	$872,982	$528,909	$236,709	$1,165,182	$636,273
T99	Medicaid Assessments	0	0	$329,825,000	$0	$273,349,116	$56,475,884	$56,475,884
K99	**Total Hospital Community Benefit**	**12,679,719**	**6,771,054**	**$2,215,893,488**	**$418,564,042**	**$691,861,965**	**$1,942,595,565**	**$1,524,031,523**

	Total Operating Expenses	**$17,148,098,364**
	% Operating Expenses w/ Indirect Costs	**11.33%**
	% Operating Expenses w/ o Indirect Costs	**8.89%**

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Final Recommendation on the CY 2022 Medicare Performance Adjustment (MPA)

December 2021

Final CY22 MPA Recommendation

The HSCRC is required to submit a proposal to CMS on the Medicare Performance Adjustment (MPA). Staff recommend revising the MPA attribution algorithm but otherwise maintaining the existing MPA policy, except for minor updates.

Staff recommend changing the MPA attribution algorithm because:

1. Staff believe that the current MPA attribution is overly complex and reduces the validity of the TCOC measurement.
   - There is substantial churn in the attributed beneficiaries from one year to the next.
   - The hospital's MPA results can be driven by changes in the attribution, rather than in actual improvement in TCOC management.
2. Additionally, the MPA attribution algorithm is operationally complex (multiple NPI lists / CFO Attestations).
   - Hospitals are required to submit lists of NPIs for their employment, MDPCP, and ACO relationships so that HSCRC can attribute beneficiaries to the hospital.
   - Hospitals also must submit lists of NPIs that have a 'care coordination relationship' with the hospital for the purpose sharing PHI data.
   - Using geographic approach will allow staff to build a PHI access methodology that is as efficient and complete as possible for that purpose (could be expanded to non-primary care relationships)
3. Staff believe moving to geographic attribution would be more stable and simpler.

Revised Attribution Methodology for CY22

Staff recommend revising the attribution algorithm for CY 22 in two respects:

- All Medicare beneficiaries that reside within the hospital's PSAP service area will be attributed to the hospital.
  - Beneficiary duplication will be allowed for zip codes that are shared between hospitals will be attributed to both hospitals.
  - Any zip code that is not in any one hospital's PSAP will be assigned to a hospital by the HSCRC.
- Academic Medical Centers will have an alternative attribution.
  - The PSAP attribution results in "too few" dollars being attributed to the AMCs.
  - As an alternative, HSCRC intends to work with the AMCs to create an alternative attribution for the two AMCs.
  - The AMC attribution will be based on a hospital "touch" attribution for beneficiaries with CMI above 1.5.

CTI Buyout Recommendation

In the draft MPA Proposal, HSCRC recommended a “CTI Buyout” for the MPA.

- Under the CTI Buyout, any MPA penalty will be scaled based on the ratio of attributed TCOC dollars to CTI dollars.
- For example, if the hospital’s CTI is equal to 50% of the hospital’s attributed TCOC under the MPA, then any MPA penalty will be reduced by 50%.

CMS approved the CTI Buyout for CY21 only. CMS expressed concern about the CTI Buyout reducing the hospital’s accountability for TCOC management.

- Staff continue to believe that the CTI is a better tool than the traditional MPA.
- The magnitude at risk under the CTI is larger than the MPA and the CTI are better targeted.

CMMI Responses to the State's MPA Proposal

Component	Original Proposal	Updated Proposal
CTI Buyout	Continue temporary 6-month CTI buyout policy into CY2022	CTI buyout will be terminated starting December 31, 2021.
Quality Adjustment	Both quality programs have maximum penalties of 2%. The Quality Adjustment Score is the sum of each hospital's RRIP and MHAC quality adjustment.	Staff will work with HSCRC stakeholders to increase quality adjustment weights under both CTI and MPA mechanisms.
Revenue at Risk	The MPA's Maximum Revenue at Risk is set at ±1.0% for Y4. The Y4 Maximum Performance Threshold is set at ±3%. Before reaching the Maximum Revenue at Risk of ±1.0%, the Maximum Performance Threshold results in a scaled result — a reward or penalty equal to one-third of the percentage by which the hospital's TCOC differs from its TCOC target.	In addition to the increase in quality adjustment score weights, Staff will discuss the revenue at risk under the MPA with CMMI and the industry.

CMMI Response to the MPA Proposal

- CMS approved moving to geographic attribution for the MPA. However, CMS rejected the proposal for the CTI Buyout.
  - CMMI believes that the traditional MPA remains important because it holds hospitals directly accountable for the TCOC of all Maryland beneficiaries.
  - Staff are disappointed that CMS did not approve the CTI buyout and continue to believe that the traditional MPA is not the most effective tool for holding hospitals accountable.
- CMS also requested that the HSCRC revise the quality component of the MPA in future years.
  - Currently the MPA uses the same adjustment as the hospital quality programs. The magnitude of the quality adjustment is also limited.
  - Staff believes that quality programs should be all-payer. Therefore, staff intends to work on an additional quality programs that would hold hospitals accountable for improving on the SIHIS measures but would develop the program as an all-payer program.
- CMS requested that the State increase the revenue at risk under the MPA.
  - Currently the revenue at risk is limited to 1% of hospitals revenues.
  - Staff believe that hospitals have sufficient risk under the MPA given the history volatility in the MPA outcomes and attribution.
  - Staff will work with CMMI and the industry to assess the level of revenue at risk under existing hospital quality programs and the most appropriate level of revenue at risk under the MPA.

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Medicare Performance Adjustment

Final Recommendation

December 2021

This document contains the final staff recommendations for the CY 2022 Medicare Performance Adjustment.

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Final Recommendations For CY 2022 MPA Policy

Staff recommend the following revisions to the MPA policy for calendar year 2022 (CY2022):

1. Replace the existing multi-step MPA attribution with geographic attribution, with an additional attribution layer for Academic Medical Centers for calendar year 2022.

2. Maintain the other aspects of the MPA with the following exceptions:

    a. Modify the Supplemental MPA attribution to be based on HSCRC's MDPCP-like attribution;

    b. Add additional attribution for beneficiaries participating in the Episode Quality Improvement Program (EQIP)

Staff recommend revising the existing MPA attribution in order to align beneficiaries with hospitals based on their geographic service area, rather than on the hierarchical, multi-step attribution method that has been used in the past based on primary care networks in MDPCP and other programs. In addition to the complexity, the multi-step attribution algorithm is volatile and unpredictable, meaning that a significant number of beneficiaries are attributed to different hospitals in successive years. This inhibits a hospital's ability to target interventions at the beneficiaries who will remain attributed to that hospital and are located in their service area.

Staff believe a change to the attribution based on geography will simplify the MPA and allow hospitals to focus on CTI and other programs that better match the hospital's clinical strategies. This will also ensure that hospital resources are deployed and invested in the hospital's immediate geographic area. With the exception of the attribution algorithm, Staff recommend maintaining the majority of the MPA policy, as finalized by the Commission in December of 2020. The MPA policy has changed frequently, resulting in uncertainty about future MPA rewards, targets, and expectations. Staff recommend maintaining the existing structure of the MPA, with the changes recommended here, for CY2022 and CY2023 – barring any changes required by CMMI. Finally, in line with the Commission and CMMI's focus on increasing the importance of health equity, population health, and quality measures within all programs, during 2022 Staff will work with stakeholders to assess the measures and share of risk related to quality under the MPA and implement agreed upon changes in an update to this policy for CY2023. Any modification to the quality measures included will leverage measures being utilized in other programs, including SIHIS.

The following discussion provides rationale and detail or each of these recommendations.

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Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The Total Cost of Care (TCOC) Model Agreement requires the State of Maryland to implement a Medicare Performance Adjustment (MPA) for Maryland hospitals each year. The State is required to (1) Attribute 95 percent of all Maryland Medicare Beneficiaries to some Maryland hospital; (2) Compare the TCOC of attributed Medicare beneficiaries to some benchmark; and (3) Determine a payment adjustment based on the difference between the hospitals actual attributed TCOC and the benchmark.	This MPA recommendation fulfills the requirements to determine an MPA policy for CY 2022 and makes important improvements to the reward calculation methodology, and adds additional hospital flexibility through Care Transformation Initiatives.	The MPA policy serves to hold hospitals accountable for Medicare total cost of care performance. As such, hospital Medicare payments are adjusted according to their performance on total cost of care. Improving the policy improves the alignment between hospital efforts and financial rewards. These adjustments are a discount on the amount paid by the CMS and not on the amount charged by the hospital. In other words, this policy does not change the GBR or any other rate-setting policy that the HSCRC employs and – uniquely – is applied only on a Medicare basis.	This policy does not affect the rates paid by payers. The MPA policy incentivizes the hospital to make investments that improve health outcomes for Marylanders in their service area.	This policy holds hospitals accountable for cost and quality of Medicare beneficiaries in the hospital's service area. Focusing resources to improve total cost of care provides the opportunity to focus the hospital on addressing community health needs, which can lower total cost of care.

Overview of the MPA Policy

The Medicare Performance Adjustment (MPA) is a required element for the Total Cost of Care Model and is designed to increase the hospital's individual accountability for total cost of care (TCOC) in Maryland. Under the Model, hospitals bear substantial TCOC risk in the aggregate. However, for the most part, the TCOC is managed on a statewide basis by the HSCRC through its GBR policies. The MPA was intended to increase a hospital's individual accountability for the TCOC of Marylanders in their service area. In recognition of large risk borne by the hospitals collectively through the GBR, the MPA has a relatively low amount of revenue at risk (i.e. 1 percent of Medicare fee-for-service revenue).

The MPA includes two "components": a Traditional Component, which holds hospitals accountable for the Medicare total cost of care (TCOC) of an attributed patient population, and an Efficiency Component, which rewards hospitals for the care redesign interventions. These two components are added together and applied to the amount that Medicare pays the hospitals. The MPA is applied as a discount to the amount that Medicare pays on each claim submitted by the hospital.

Traditional Component

Currently, the HSCRC assigns patients to hospitals using a hierarchical algorithm. First, beneficiaries are attributed based on participation in the Maryland Primary Care Program (MDPCP). Second, beneficiaries are attributed under an ACO-like attribution where HSCRC replicates CMS's attribution for the Medicare Shared Savings Program (SSP) ACOs and physicians voluntarily identified by hospitals as employed by their system. Third, any beneficiary not attributed based on the prior two attribution approaches could be attributed under a referral relationship where HSCRC assigned physicians to hospitals based on where the plurality of their patients' hospitalizations occurred and then attributed any beneficiary who received a plurality of their primary care services from the physician to that hospital. Finally, any beneficiary not attributed under the previous approaches would be attributed to a hospital based on the hospital's geographic service area.

The MPA then penalized or rewarded hospitals based on their attributed TCOC. Hospitals are rewarded if the TCOC growth of their attributed population is less than national. Beginning in 2021, the HSCRC has scaled the growth rate target for hospitals based on how expensive that hospital's service area is relative to other geographics elsewhere in the national. This policy is intended to ensure that hospitals which are expensive relative to their peers bear the burden of meeting the Medicare savings targets while hospitals that are already efficient relative to their peers bear proportionally less of the burden. The TCOC growth rate adjustments are shown in Table 1 below.

Table 1: Scaled Growth Rate Adjustment

Hospital Performance vs. Benchmark	TCOC Growth Rate Adjustment
1st Quintile (-15% to + 1% Relative to Benchmark)	0.00%
2nd Quintile (+1% to +10% Relative to Benchmark)	-0.25%
3rd Quintile (+10% to +15% Relative to Benchmark)	-0.50%
4th Quintile (+15% to +21% Relative to Benchmark)	-0.75%
5th Quintile (+21% to +28% Relative to Benchmark)	-1.00%

Historically, hospitals were required to beat the national TCOC growth rate each year. But in 2021, the HSCRC changed the way that the TCOC is calculated for hospitals. The HSCRC will trend the hospital's baseline TCOC forward based on the national growth rate and the TCOC adjustment factors. This was intended to create more predictability for hospitals. A hospital can now predict what their target will be two or three years out. An example of the methodology to calculate the TCOC targets is shown in Table 2 below.

Table 2: Calculation of the MPA Targets

Variable	Source
A = 2019 TCOC	Calculation from attributed beneficiaries
B = 2020 National TCOC Growth	Input from national data
C = 2021 National TCOC Growth	Input from national data (assumed to be 3% in example below)
D = Growth Rate Adjustment Factor	From Growth Rate Table (applies to 2021 and all subsequent years)
E = MPA TCOC Target	A x (1 + B) x (1 + C - D)

Example Calculation of MPA Targets

Hospital	Quintile	Target Growth Rate	2019 TCOC	2020 MPA Target	2021 MPA Target
Hospital A	1	3% - 0.00% = 3.00%	$11,650	$12,000	$12,359
Hospital B	2	3% - 0.25% = 2.75%	$11,193	$11,529	$11,846
Hospital C	3	3% - 0.50% = 2.50%	$11,169	$11,504	$11,792
Hospital D	4	3% - 0.75% = 2.25%	$11,204	$11,540	$11,800
Hospital E	5	3% - 1.00% = 2.00%	$10,750	$11,073	$11,294

The hospital is rewarded or penalized based on how their actual TCOC compares with their TCOC target. the rewards and penalties will be scaled such that the maximum reward or penalty is 1% which will be achieved at a 3% performance level. Essentially, each percentage point by which the hospital exceeds its TCOC benchmark results in a reward or penalty equal to one-third of the percentage. The amount of revenue at risk under the MPA policy is capped at 1% of the hospital's Medicare revenue. An example of the hospital's rewards/penalties is shown in the table below.

Table 3: Example of MPA Reward & Penalty Calculations (excluding quality adjustments)

Variable	Input
E = MPA Target	See previous section
F = 2021 MPA Performance	Calculation
G = Percent Difference from Target	(E - F) / E
H = MPA Reward or Penalty	(G / 3%) x 1%
I = Revenue at Risk Cap	Greater / lesser of H and + / - 1%

Example MPA Performance Calculations				
Hospital	**MPA Target**	**MPA Performance**	**% Difference**	**Reward (Penalty)**
Hospital A	$12,359	$12,235	-1.00%	0.30%
Hospital B	$11,846	$11,941	0.80%	-0.30%
Hospital C	$11,792	$11,556	-2.00%	0.70%
Hospital D	$11,800	$12,154	3.00%	-1.00%
Hospital E	$11,294	$11,859	5.00%	-1.00%

In addition, the agreement with CMS requires that a quality adjustment be applied that includes the measures in the HSCRC's Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Conditions (MHAC). Staff recommends continuing the current policy of using the RRIP and MHAC all-payer revenue adjustments to determine these quality adjustments. Under the existing approach the reward or penalty before the quality adjustment is multiplied by 1 + the quality adjustment. Regardless of the quality adjustment, the maximum reward and penalty of ±1.0% will not be exceeded.

In line with the Commission and CMMI's focus on increasing the importance of health equity, population health, and quality measures within all programs, during 2022 Staff will work with stakeholders to assess the measures and share of risk related to quality under the MPA and implement agreed upon changes in an update to this policy for CY2023. Any modification to the quality measures included in the MPA adjustment will use measures being utilized in other programs, including SIHIS.

Efficiency Component

The MPA includes additional rewards and penalties for hospitals that reduce the TCOC through care redesign program, include the Episode Care Improvement Program (ECIP), the Care Transformation Initiatives (CTI), and the Maryland Primary Care Program (MDPCP). The HSCRC increases the MPA reward or penalty based on the success of these programs. The HSCRC developed the Efficiency Component because the Traditional MPA was not targeted well enough to reward a hospital for a specific target population. A hospital would only be rewarded for a successful care redesign effort under the Traditional Component of the MPA, if every beneficiary included in the effort was attributed to the hospital and if the impact of the program was not washed out by the impact on other beneficiaries who were also attributed to the hospital. Historically, the Traditional MPA has not been well aligned with individual hospital care redesign efforts which necessitated the development of the Efficiency Component.

Attribution Issues

In November 2019, the Commission directed staff to explore potential changes to the MPA based on feedback from the industry and other stakeholders via its Total Cost of Care Workgroup and other meetings. Based on this review, Staff concluded that the multi-step attribution method has both strengths and weaknesses. Attribution based on primary care visits aligns with clinical relationships that, presumably, have significant influence over the TCOC of the attributed beneficiaries. However, the multi-step attribution method is complex. Hospitals and staff spend a significant amount of time and energy analyzing the MPA attribution and its complexity has led to questions about whether a hospital's performance is due to the hospital's efforts or due to the eccentricities of the attribution algorithm.

Staff compared the current attribution algorithm with simpler attribution methods, namely those based solely on geographic relationships. Geographic attribution performed just as well on a variety of measures as the current attribution algorithm, except for Academic Medical Centers (AMCs). Based on this analysis, Staff recommended modifying the MPA attribution to use a purely geographic attribution with an adjustment for AMCs. However, the industry's comments to the Draft Recommendation emphasized that geographic attribution would lose an important clinical link between the patients seen by the hospital's physician networks and the patients attributed to the hospitals. During the workgroup process, numerous hospitals recommended that HSCRC analyze whether moving to geographic attribution would result in a more tenuous relationship between the hospital and its attributed patients. Staff analyzed the number of attributed beneficiaries that receive services from the hospital that they are attributed to and found that a similar proportion of beneficiaries received services from the hospital under both the existing attribution and the geographic attribution.

Staff analyzed the impact of moving to the geographic attribution by measuring the percentage of beneficiaries who are attributed to the hospital and who also receive services from that hospital. Under the existing attribution 12.8 percent of attributed beneficiaries receive a service from the hospital that they are attributed too. Under the geographic attribution, 14.2 percent of attributed beneficiaries receive a service from the hospital they are attributed to. This indicates that the geographic attribution captures the clinical relationship between the hospitals and their attributed beneficiaries.

While staff recognize the importance of a clinical relationship between the hospitals and their attributed beneficiaries, staff does not believe that the Traditional MPA component accurately encompass hospital's clinical relationships for two reasons: 1) the MPA attribution is required to attribute 95 percent of all Maryland beneficiaries to some hospital and therefore each hospital will receive a significant number of non-clinically attributed beneficiaries; and 2) the MPA is a one-size fits all attribution that does not allow for the specifics of individual hospital's clinical strategies. Therefore, while a portion of the hospital's MPA performance represents the impact of the hospital's clinical networks on the total cost of care and a

portion of the hospital's MPA results are driven by the MPA attribution algorithm. Untangling the two effects is difficult and takes significant time and effort.

The HSCRC developed the CTI policy in order better capture the impact of hospitals' clinical strategies on the total cost of care. Hospitals may tailor the CTI to their own clinical programs and thus can more precisely target the attribution logic to their own clinical strategies. Additionally, the CTI measures the impact of the hospital's interventions at the programmatic level and does not have the confounding impact of other beneficiaries attributed to the hospital to ensure that 95 percent of all Medicare beneficiaries are attributed to some hospitals. Staff therefore believe that the CTI will more accurately attribute beneficiaries and be a more valid measure of the direct clinical impact that hospitals have on the total cost of care.

MPA Final Recommendations

Staff recommend three changes to the MPA for CY2022: 1) revise the attribution algorithm to be aligned with the hospital's service area, with an adjustment for AMCs; 2) revise the attribution approach in the MDPCP supplemental adjustment; and 3) add an efficiency component for the EQIP program. Once those changes are made, Staff recommends maintaining the MPA for CY2022 and CY2023 in order to create as much stability for hospitals as possible.

Revised Attribution

Staff recommend replacing the current 'tiered attribution' approach to the MPA with a purely geographic approach. The geographic attribution algorithm will be unchanged from the geographic tier in the current MPA algorithm. Under this approach beneficiaries and their costs will be assigned to hospitals based on their residency. Zip codes are assigned to hospitals based on hospital primary service areas (PSAs) listed in hospitals' Global Budget Revenue (GBR) agreements. Zip codes not contained in a hospital's PSA are assigned to the hospital with the greatest share of hospital use in that zip code, or, if that hospital is not sufficiently nearby, to the nearest hospital. Specifically, each zip code is assigned to hospitals through three steps:

1. Costs and beneficiaries in zip codes listed as a hospital's Primary Service Areas (PSAs). Staff will work with industry to rationalize the existing definition of PSAs over the next 6 months so that during 2022 the PSAs will reflect a systematic approach to defining service areas. Costs 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. ECMAD is calculated from Medicare FFS claims for the two Federal fiscal years preceding the performance period.

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 it 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.

4. Using an alternative attribution approach for the AMCs, where beneficiaries with a CMI of greater than 1.5 and who receive services from the AMC are attributed to the AMC as well as the hospital under the standard attribution. AMCs will also have a geographic based attribution.

Some zip codes are included in multiple hospitals' PSA. Beneficiaries that reside in those zip codes will be attributed to each hospital; however, the TCOC for those beneficiaries will be divided among those hospitals based the hospitals' market share within those zip codes.

Supplemental MDPCP Accountability

In 2021, the Commission directed staff to increase the accountability for managing the TCOC in the MDPCP. Therefore, HSCRC added a supplemental MPA adjustment for hospitals that are affiliated with practices that are participating in MDPCP. Staff recommended measuring the hospital's performance based on the beneficiaries attributed to the hospital by CMMI. The purpose of this policy was to hold hospitals accountable for the beneficiaries included the MDPCP program.

However, hospitals joined the MDPCP program at different times. Since a hospital is not attributed any beneficiaries until they join the program, there is no consistent baseline of attributed beneficiaries for hospitals in MDPCP. Consequently, it is impossible to compare hospitals relative performance. Therefore, Staff recommend using the HSCRC's MDPCP-like attribution to create a consistent baseline of beneficiaries in order to determine the hospitals relative performance. This change would also apply to the CY21 calculation.

Efficiency Component for the EQIP Program

Currently, the Maryland TCOC Model holds hospitals accountable for managing the total cost of care even though they are not responsible for nonhospital costs. In order to increase the accountability held by nonhospital providers, Staff developed EQIP – an episode-based program – that pays nonhospital providers for reducing the cost of episodes of care that they provide. EQIP providers are paid a share of the savings that they create. In order to pay the providers, the savings for the program first have to be paid to a hospital through the MPA. The HSCRC will increase the MPA for the administering hospital and then that hospital will pay the providers through the EQIP program.

The University of Maryland Medical Center (UMMC) volunteered to be the administering entity for the EQIP program. Therefore, Staff recommend increasing the UMMC's MPA adjustment by an amount equal to the savings earned by the EQIP providers. Furthermore, the EQIP beneficiaries will be attributed to UMMC. This will ensure that the EQIP providers meet the threshold for being a Qualified Practitioner

under Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). These beneficiaries will not be considered in calculating the Traditional MPA.

Stakeholder Responses and Feedback

Comment letters were submitted by the Maryland Hospital Association (MHA), the Johns Hopkins Health System (JHHS), the University of Maryland Health System (UMMS), and Medstar Health.

JHHS and UMMS were supportive of the move towards geographic attribution. Both noted that geographic attribution is not perfect, particularly in rural areas. However, they recognized that geographic attribution would reduce beneficiaries churn and other undesirable characteristics of the MPA and therefore supported moving to geographic attribution. Both JHHS and UMMS were supportive of the alternative attribution for the Academic Medical Centers. Medstar Health was not supportive of using geographic attribution because hospitals would be attributed beneficiaries with whom they do not have an established clinical relationship. Staff do not agree with the Medstar comment because hospitals are currently attributed beneficiaries with whom they have no clinical relationship under the geographic tier of the existing algorithm; moving to a purely geographic algorithm will not substantially change the number of beneficiaries with whom the hospital does not have a clinical relationship. Therefore, Staff continue to believe that simplifying the attribution algorithm will result in a more stable and understandable policy.

Medstar Health also recommended that the State limit delay the application for new CTIs so that hospitals can better understand their financial risk under the CTI. Staff intend to allow hospitals to apply for new CTIs that begin in July of 2022 and annually thereafter. Staff believe that hospitals should be allowed to modify and create new CTI on an annual basis, since the purpose of that program is to give hospitals flexibility to tailor their Medicare attributed population to their clinical interventions.

Staff submitted the State's MPA proposal to CMMI in November of 2021. CMMI approved the move to geographic attribution and other aspects of the proposal but did not approve the 'CTI Buyout', which would lower the traditional MPA penalty based on the number of CTI attributed beneficiaries the hospital receives. CMMI believes that the traditional MPA is an important policy for holding hospitals accountable for managing the total cost of care of Maryland beneficiaries. Staff do not agree with CMMI and continue to believe that the CTI is a better policy for holding hospitals accountable for managing the total cost of care. However, the magnitude of the traditional MPA penalties have been relatively limited and therefore Staff believe that the impact of eliminating the CTI buyout is relatively limited.

CMMI also encouraged the State to develop additional quality measures for the MPA. Staff believe that hospitals can do more to manage population health in line with the State's Integrated Health Improvement Strategy (SIHIS) and plan to develop additional quality measures over the upcoming year. However, Staff believes that quality measures should be all-payer in nature and therefore Staff recommend incorporating

those measures into existing quality programs or develop a new population health quality program, rather than developing new measures specifically for the MPA. Staff will work to convince CMMI that quality measures should be all-payer in nature and not developed specifically for the Medicare population.

The MHA agreed with Staff's disappointment that CMMI did not approve the CTI Buyout. Additionally, the MHA agreed that quality measures should be developed on an all-payer basis. The MHA did suggest that Staff conduct and assessment of the revenue at risk under the Commission' various quality programs. Staff will work with stakeholders to assess the different quality programs over the next several workgroup meetings.

Maryland
Hospital Association

November 30, 2021

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

Dear Ms. Wunderlich:

On behalf of the Maryland Hospital Association's (MHA) 60 member hospitals and health systems, we appreciate the opportunity to comment on the Commission's proposed Medicare Performance Adjustment (MPA) policy for 2022. Our comments focus on the Center for Medicare & Medicaid Innovation's (CMMI) response to the state's proposal, shared by HSCRC staff at the Nov. 17 Total Cost of Care Work Group meeting.

Like HSCRC staff, MHA was disappointed that CMMI does not support the Care Transformation Initiative (CTI) buyout methodology. We agree with HSCRC staff that CTIs allow appropriate flexibility for hospitals to tailor care transformation solutions to their communities, and the results can be directly tied to hospital action.

CMMI wants more revenue at risk under the MPA. Hospitals already face significant financial risk for performance, including total cost of care, through CTIs, MPA (with and without a CTI buyout), quality measures, the annual payment update, and the global budget itself. Because HSCRC may boost revenue adjustments under revenue for reform at the same time CMMI recommends we raise MPA risk, **we ask HSCRC staff to please summarize the financial risk of all HSCRC policies** and to show CMMI and other stakeholders how much risk hospitals really bear. Moreover, we ask the Commission to consider the total amount hospitals have at risk when contemplating new policies or refining existing policies.

CMMI also recommended HSCRC strengthen the quality adjustments in the MPA. MHA believes HSCRC's approach of applying quality adjustments on an all-payer payer basis is a better financial incentive to improve quality.

Thank you for considering our comments. If you have any questions, please do not hesitate to contact me.

Sincerely,

Brett McCone
Senior Vice President, Health Care Payment

cc: Adam Kane, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
James N. Elliott, M.D.
Maulik Joshi, Dr.P.H.
Willem Daniel, Deputy Director, Payment Reform and Stakeholder Alignment

UNIVERSITY of MARYLAND MEDICAL SYSTEM
Corporate Finance
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Linthicum Heights, MD 21090

September 17, 2021

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

RE: UMMS Comment Letter for Medicare Performance Adjustment Draft Recommendation

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 Medicare Performance Adjustment (MPA) Policy.

As always, we do appreciate the HSCRC leading industry workgroups and providing analyses to evaluate new and existing methodologies. UMMS appreciates the opportunity to provide comments and offers the following points regarding the MPA Methodology.

MPA Attribution should be changed to a geographic attribution

The current tiered MPA attribution logic was carefully vetted by hospitals and relevant stakeholders for several years. It considered the physician relationship and population health investments to better manage patients regardless of hospital touch. Our experience with this attribution logic has shown that often forces outside the control of the hospital have had more of an effect on performance in the MPA policy than those within the hospital's sphere of influence. Attribution is marred by significant churn each year. Many of the population health programs at the hospitals take time to produce positive impacts on Total Cost of Care. Significant efforts are made by our hospitals to enroll patients in care management programs only to discover that many are not attributed in a subsequent year. Additionally, while hospitals may have influence over the care delivered by employed physicians, the portion of the MPA population that is attributed by other means is still large and is often a driving factor in the hospital's overall MPA results.

We agree with the commission staff that CTIs are more effective in measuring the impact of hospital programs on the populations they serve. These programs are designed by nature to focus on patients who have received care at the hospital and are participating in hospital-based programs. The option of using CTIs to 'buy-out' negative MPA geographic performance protects hospitals from the 'free rider' issue, whereby hospitals can be negatively impacted by others who are not doing their 'fair share' to reduce total cost of care.

Given all of these factors, we believe that the geographic approach proposed by the Commission staff represents a more simplistic approach to attributing TCOC. Further, it allows hospitals the time and resources to focus on CTIs in lieu of continually working to understand performance fluctuations driven by attribution.

An Alternative methodology should be implemented for AMCs and UM Rehab

As discussed in the TCOC workgroups, given that AMCs serve as safety net hospitals for the entire state, the geographic methodology does not produce a reasonable attribution. Therefore, an alternative methodology should be utilized for both University of MD and Johns Hopkins. In addition, UM Rehab is a highly specialized hospital that also receives patients from across the state and has developed an alternative MPA methodology that has been in place for 2 years. This alternative approach should be retained for UM Rehab as the state considers a move to a geographic attribution methodology.

Primary Service Areas should be uniformly defined and revised

Current Primary Service Area (PSA) definitions are derived from Global Budget Agreements that were established in 2013. At that time, PSA was not uniformly defined and hospitals were left to use their own methodology to determine what zip codes to include. In addition to a lack of a standardized definition, the services and service areas served by hospitals has changed significantly over the past 8 years. While these changes may only create a marginal impact across the state, they can have significant impact on hospitals where there are multiple hospitals within a service area. We therefore support the HSCRC's proposal to work with the industry over the next several months to develop a standard definition of PSA.

TCOC Benchmark should continue to be vetted and evaluated

The HSCRC staff has worked on the benchmark methodology and corresponding policy for substantial periods of time and has been transparent with the industry by publishing several whitepapers. Given that this methodology is rather lengthy and complex, we feel that commission staff should continue to work with the industry in vetting and evaluating this methodology for future performance years.

EQIP funding and attribution are appropriate

We support the Commission staff's proposal to modify MPA payments for UMMC to fund the anticipated EQIP incentive amounts. We will work closely with Commission staff to ensure that these additional funds to not adversely impact UMMC in any methodology.

We appreciate the HSCRC's goal to continually evaluate and improve methodologies and hope to have the opportunity to provide additional input into the MPA methodology. 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, Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
John M. Colmers
James N. Elliott, MD
Sam Malhotra
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JOHNS HOPKINS MEDICINE
JOHNS HOPKINS HEALTH SYSTEM

September 17, 2021

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, we appreciate the opportunity to comment on the Commission's proposed Medicare Performance Adjustment (MPA) Policy for 2022.

JHHS believes that there is no ideal attribution methodology that fits all hospitals equally. A pure geographic approach may work better in areas where there is not a lot of overlap of providers/hospitals, but in more urban/populous areas it may not work as well. For this reason, we still have some concerns with a move to a fully geographic attribution methodology. However, HSCRC staff have made valid points in support of moving towards a geographic model. JHHS is willing to support this transition to geographic attribution knowing that the HSCRC will continue to monitor the methodology to ensure it is fair and actionable.

JHHS agrees that the CTI buyout should remain in place. These programs are designed to focus on patients who have received care at the hospital and are participating in hospital-based programs. The CTI program aims not only to reward hospitals for successful initiatives, but also mitigates risk under the MPA where there is population overlap. For these reasons, we support the CTI buyout.

If the geographic model is approved, JHHS believes that the CTI buyout option needs to be part of that approval.

As mentioned in previous comment letters, JHHS is also committed to working with UMMS and HSCRC staff to develop an attribution model for Academic Medical Centers (AMC). AMC's provide tertiary and quaternary care, as well as specialty services statewide. This care model is not reflected in the existing hierarchical and proposed geographic attribution methods.

JHHS also believes that there should be a consistent methodology used to establish the Primary Service Areas (PSA) for each hospital. When the PSAs were established in the original GBR agreements they were not established consistently across all hospitals and may not accurately reflect current market share. We would urge the staff to work with hospitals to define PSAs using standard criteria.

Thank you for your consideration of our comments. If you have any questions, please do not hesitate to contact me.

Sincerely,

Ed Beranek

Ed Beranek
Vice President, Revenue Management and Reimbursement
Johns Hopkins Health System

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September 17, 2021

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

Dear Ms. Wunderlich:

We are writing to memorialize our comments regarding the HSCRC staff recommendation on the MPA policy. There are two areas which concern us:

(1) Geographic attribution
While we understand no attribution methodology is perfect, we have significant concerns about moving to a geographic attribution, especially when applied to high density, overlapping hospital service areas common in metropolitan Baltimore. If the expectation is for Hospitals to be "accountable" for the attributed population they are given, it is essential that the Hospital has some relationship with that attributed population. The recent data provided showing hospital-specific beneficiary retention under the current vs. the proposed geographic methodology reveals very high percentages of beneficiaries with no care relationship at all with the Hospital to which they are attributed in metropolitan areas. This data substantiates our concern that geographic attribution is not appropriate in most situations, and it is only in rural, one-hospital markets where this geographic methodology makes sense. Given that patient data is only available if a clinical relationship has been historically established, it is as if hospitals will be accountable for beneficiaries without any insight into their clinical needs. Nevertheless, if the HSCRC adopts such a geographic methodology, then we do not believe GBR zip codes are appropriate as they were specific to the GBR policy and not appropriate for MPA methodology purposes.

(2) CTI Buyout
With CMMI not approving the CTO Buyout in its current form, we would request the following:
(1) Delay timeline for submission of any new CTI's until HSCRC obtain approval from CMMI and HSCRC can make any necessary changes to the program to meet CMMI's requirements. We believe it is important for Hospitals to understand the potential financial risk before they decide to participate in new CTI's; and
(2) That no changes are made that impact financial risk mid-year. We believe it would be better to delay than to create changes in the first year mid-stream.

We would be happy to discuss with you further.

Have a good weekend.

Sincerely,

Kathy Talbot

Kathy Talbot
Vice President, Rates and Reimbursement
MedStar Health, Inc.

Debi Kuchka-Craig

Debi Kuchka-Craig
Senior Vice President, Managed Care
MedStar Health, Inc.

Cc: Willem Daniel, Deputy Director, Provider Alignment and Payment Reform, HSCRC
Adam Kane, HSCRC Chairman
Joseph Antos, Ph.D., HSCRC Vice Chairman
James N. Elliott, M.D., HSCRC Commissioner
Victoria W. Bayles, HSCRC Commissioner
Sam Malhorta, HSCRC Commissioner
Stacia Cohen, RN, HSCRC Commissioner
Maulik Joshi, Dr.P.H., HSCRC Commissioner

RY 2024 Draft Recommendation for the Maryland Hospital Acquired Conditions (MHAC) Program

maryland health services cost review commission

Maryland Hospital Acquired Conditions (MHAC) Program: Overview

Purpose: Improve patient care and hospital decision-making by adjusting GBR based on 14 identified potentially preventable complications (PPCs), complications acquired during a hospital stay that were not present on admission

Examples of PPCs: An accidental laceration during a procedure, hospital acquired venous thrombosis, hospital-acquired pneumonia

PPC Significance: These complications can lead to poor patient outcomes, including longer hospital stays, permanent harm, and death, and they also lead to increased costs.

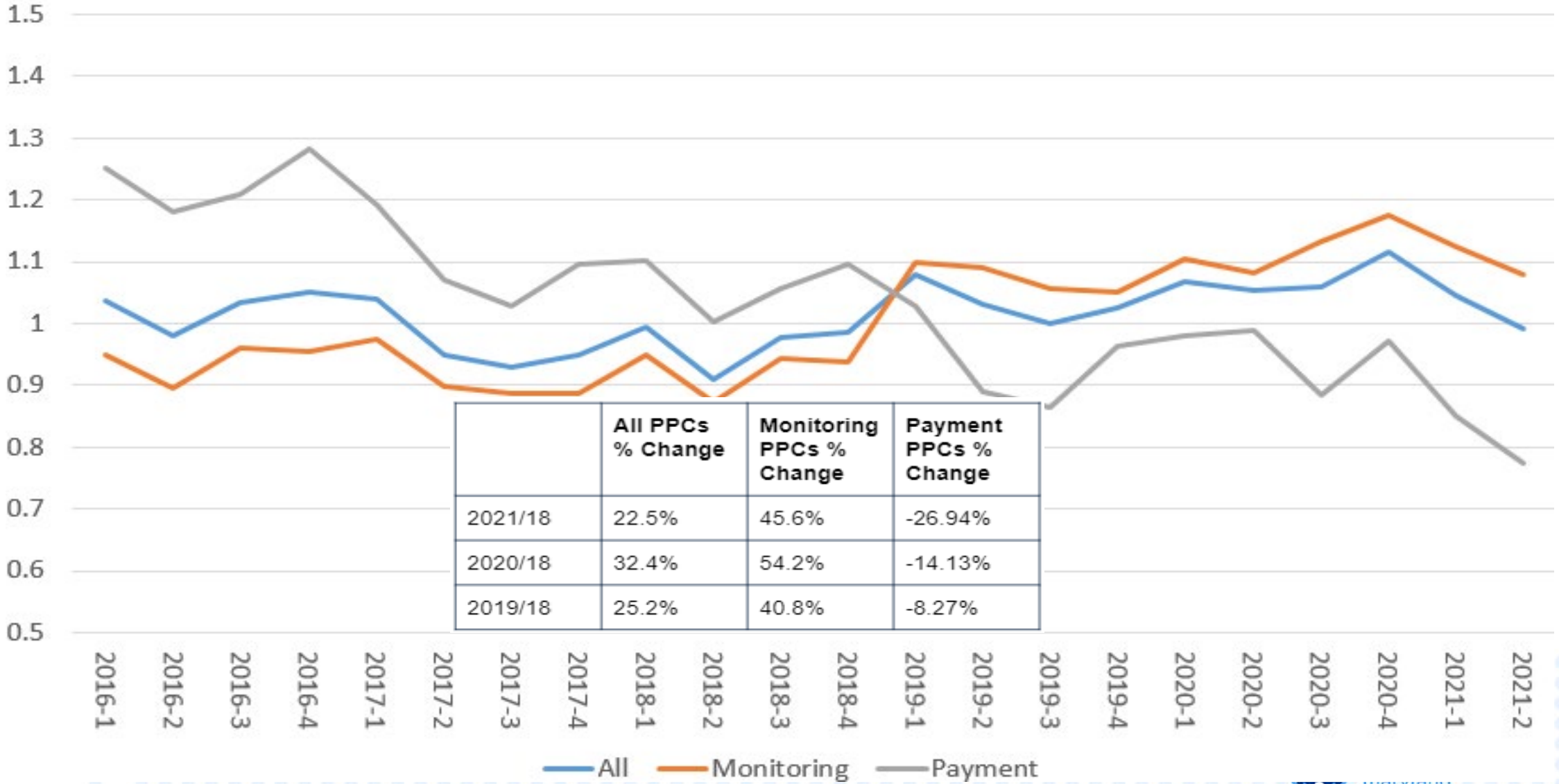
Similar to the federal Medicare HAC program

Maryland's program uses a different and targeted list of PPC measures, and does not relatively rank hospitals in assigning financial rewards and penalties.

MHAC RY 2024 Updates for Consideration

- Staff proposes minimal changes for RY 2024:
  - Consider adopting subset of monitored PPCs with increasing rates based on previously established PPC selection criteria
  - Exclude palliative care cases due to coding guidance updates
  - Grouper Version: APR-DRG and PPC Version 39
  - Use most recent cost weights available
  - Determine COVID-19 updates, to be implemented retrospectively
  - Explore future updates to the program that account for patient race and ethnicity, social determinants of health, socioeconomic status, and neighborhood factors to support hospitals in the State of Maryland working to address disparities in health outcomes.

Performance: PPC Observed/Expected Rates for Payment, Monitoring, and Overall



	All PPCs % Change	Monitoring PPCs % Change	Payment PPCs % Change
2021/18	22.5%	45.6%	-26.94%
2020/18	32.4%	54.2%	-14.13%
2019/18	25.2%	40.8%	-8.27%

*Note: This analysis excludes COVID-19 patients. The percent change table is only a reflection of the first and second quarters of the specified years.

PPC Assignment for COVID-19 Patients for RYs 2023-2024

- Update to most current PPC Grouper version to ensure updated logic for COVID cases
- Exclude Jan-June 2020 data from base period
- Determine the longer performance period for small hospitals
- Retrospectively evaluate inclusion of COVID-19 patients in policy and/or in on case-mix adjustment:

Models Under Consideration	Model 1 *original baseline period*	Model 2a *concurrent norms with COVID-19 cases*	Model 2b *concurrent norms without COVID-19 cases*
Description	original base period norms	concurrent norms including COVID-19 cases	concurrent norms excluding COVID-19 cases from normative values and performance period calculations

RY 2024 Draft Recommendations

1. Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.
   a. Monitor all PPCs and provide reports for hospitals and other stakeholders.
   b. Update PPC measures for inclusion in the payment program based on clinical recommendations, statistical characteristics, and recent trends.
2. Use more than one year of performance data for small hospitals (i.e., less than 20,000 at-risk discharges and/or 20 expected PPCs). The performance period for small hospitals will be CY 2021 and 2022.
3. Continue to assess hospital performance on attainment only.
4. Continue to weigh the PPCs in the payment program by 3M cost weights as a proxy for patient harm.
5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent and continuous linear scaling with a hold harmless zone between 60 and 70 percent.
6. Adjust retrospectively the RY 2024 MHAC pay-for-performance program methodology as needed due to COVID-19 Public Health Emergency and report any changes to Commissioners.

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Draft Recommendation for the Maryland Hospital Acquired Conditions Program for Rate Year 2024

December 8, 2021

This document contains the draft staff recommendations for the Maryland Hospital Acquired Conditions Program for RY 2024; comments on the draft may be submitted to hscrc.quality@maryland.gov and are due Wednesday, December 15, 2021.

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List of Abbreviations

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

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Key Methodology Concepts and Definitions

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

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

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

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

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

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

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

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

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

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

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Policy Overview

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

Recommendations

The MHAC policy was redesigned in Rate Year (RY) 2021 to modernize the program for the new Total Cost of Care Model. This RY 2024 draft recommendation, in general, maintains the measures and methodology that were developed and approved for RYs 2022 and 2023.[1]

These are the draft recommendations for the RY 2024 Maryland Hospital Acquired Conditions (MHAC) program:

1. Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.
    a. Monitor all PPCs and provide reports for hospitals and other stakeholders.
    b. Update PPC measures for inclusion in the payment program based on clinical recommendations, statistical characteristics, and recent trends.
2. Use more than one year of performance data for small hospitals (i.e., less than 20,000 at-risk discharges and/or 20 expected PPCs). The performance period for small hospitals will be CY 2021 and 2022.
3. Continue to assess hospital performance on attainment only.
4. Continue to weigh the PPCs in the payment program by 3M cost weights as a proxy for patient harm.
5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent and continuous linear scaling with a hold harmless zone between 60 and 70 percent.
6. Adjust retrospectively the RY 2024 MHAC pay-for-performance program methodology as needed due to COVID-19 Public Health Emergency and report any changes to Commissioners.

[1] See the RY 2022 policy for detailed discussion of the MHAC redesign, rationale for decisions, and approved recommendations.

Introduction

Maryland hospitals have been funded under a population-based revenue system with a fixed annual revenue cap under the All-Payer Model agreement with the Centers for Medicare & Medicaid Services (CMS) beginning in 2014, and continuing under the current Total Cost of Care (TCOC) Model agreement, which took effect in 2019. Under the global budget system, hospitals are incentivized to transition services to the most appropriate setting of care, and may keep savings that they achieve via improved health care delivery and hospital quality (e.g., reduced avoidable utilization, readmissions, hospital-acquired infections). It is important that the Commission ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) quality programs reward quality improvements and achievements that reinforce the incentives of the global budget system, while guarding against unintended consequences and penalizing poor performance.

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

For MHAC, as well as the other State hospital quality programs, annual updates are vetted with stakeholders and approved by the Commission to ensure the programs remain aggressive and progressive with results that meet or surpass those of the national CMS analogous programs (from which Maryland must receive annual exemptions). Additionally, with the onset of the Total Cost of Care Model Agreement with CMS on January 1, 2019, each program was overhauled to ensure they support the goals of the Model. For the MHAC policy, the overhaul was completed during 2018. The major accomplishments of the MHAC program redesign were focusing the payment incentives on a narrower list of clinically significant complications, moving to an attainment only system given Maryland's sustained improvement on complications, adjusting the scoring methodology to better differentiate hospital performance, and weighing complications by their associated cost weights as a proxy for patient harm. The redesign also assessed how hospital performance is converted to revenue adjustments, and ultimately recommended maintaining the use of a linear revenue adjustment scale with a hold harmless zone.

In light of the recent MHAC program redesign, and the ongoing COVID-19 Public Health Emergency (PHE), this RY 2024 draft MHAC policy proposes minimal changes to the program. The assessment section does, however, include an evaluation of PPCs in "Monitoring" status because the approved recommendations for

RY 2021 and future rate years included identifying PPCs that due to worsening performance should be included back into the MHAC program. Furthermore, the assessment section outlines necessary timeline changes and the current plan to assess the impact of COVID-19 for both the RYs 2023 and 2024 policy; as with the RY 2023 this policy includes a recommendation to retrospectively adjust the program as needed to provide the fairest assessment of hospital quality.

Background

Exemption from Federal Hospital-Acquired Condition Programs

The Federal Government operates two hospital complications payment programs, the Deficit Reduction Act Hospital Acquired Condition program (DRA-HAC), which reduces reimbursement for hospitalizations with inpatient complications, and the HAC Reduction Program (HACRP), which penalizes hospitals with high rates of complications. Detailed information, including HACRP complication measures, may be found in Appendix I.

Because of the State's unique all-payer hospital model and its global budget system, Maryland does not directly participate in the federal pay-for-performance programs. Instead, the State administers the Maryland Hospital Acquired Conditions (MHAC) program, which relies on quality indicators validated for use with an all-payer inpatient population. However, the State must submit an annual report to CMS demonstrating that Maryland's MHAC program targets and results continue to be aggressive and progressive, i.e. that Maryland's performance meets or surpasses that of the nation. Specifically, the State must ensure that the improvements in complication rates observed under the All-Payer Model through 2018 are maintained throughout the TCOC model. Based on the 2020 PPC results, CMS granted Maryland exemption from the federal pay-for-performance programs (including the HAC Reduction Program) for Federal Fiscal Year 2022 on October 29, 2020.

Overview of the MHAC Policy

The MHAC program, which was first implemented for RY 2011, is based on a system developed by 3M Health Information Systems (3M) to identify potentially preventable complications (PPCs) using present-on-admission for eligible secondary diagnosis codes available in claims data. 3M originally developed specifications for 65 PPCs[2], which are defined as harmful events that develop after the patient is admitted to the hospital and may result from processes of care and treatment rather than from the natural

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

progression of the underlying illness. For example, the program holds hospitals accountable for venous thrombosis and sepsis that occur during inpatient stays. These complications can lead to 1) poor patient outcomes, including longer hospital stays, permanent harm, and death; and 2) increased costs. Thus, the MHAC program is designed to provide incentives to improve patient care by adjusting hospital budgets based on PPC performance.

MHAC Methodology

Figure 1 provides an overview of the three steps in the RY 2023 MHAC methodology[3] that converts hospital performance to standardized scores, and then payment adjustments, as outlined below:

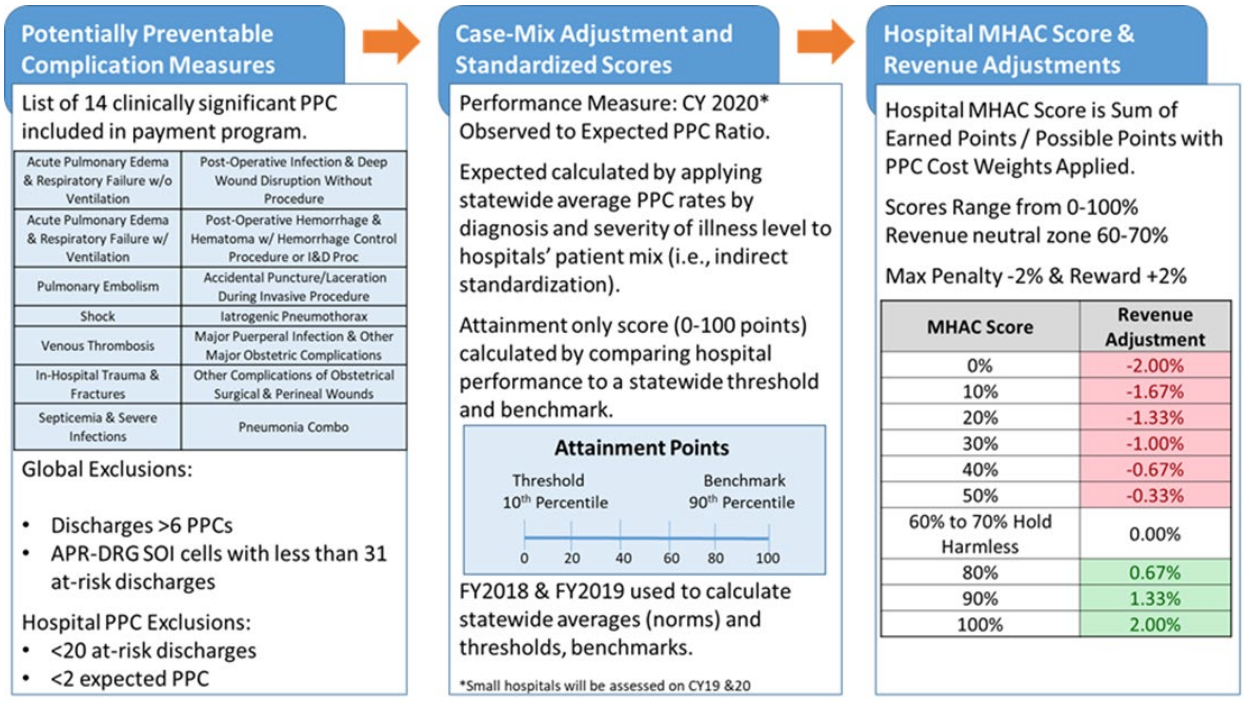
Step 1. For the PPCs identified for payment, clinically-determined global and PPC-specific exclusions, as well as volume based hospital-level exclusions are identified to ensure fairness in assignment of complications.

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

Step 3. Overall hospital scores are then calculated by taking the points for each PPC and multiplying by the 3M PPC cost weights, then summing numerator (points scored) and denominator (possible points) across the PPCs to calculate a percent score. A linear point scale set prospectively is then used to calculate the revenue adjustment percent. This prospective scaling approach differs from national programs that relatively rank hospitals after the performance period.

Because of the ongoing COVID PHE, staff working with PMWG and other stakeholders is currently considering retrospective adjustments to the approved RY 2023 methodology outlined above and illustrated in Figure 1 below. Among the changes being considered are inclusion versus exclusion of COVID patients, updates to the base and performance periods, and updates to the performance standards. Additional information on the current MHAC policy for RY 2023 can be found in Appendix II.

[3] Due to COVID-19 PHE, this methodology will need to be retrospectively adjusted, pending future CMS guidance, assessment of performance standards, and to address any future surge in COVID cases.



Assessment

In order to develop the RY 2024 MHAC policy, staff solicited input from the PMWG and other stakeholders. In general, stakeholders support the staff's recommendation to not make major changes to the RY 2024 MHAC program. Staff is still soliciting input on selecting monitoring PPCs with increasing rate trends to include back in the program. This section of the report provides an overview of the data and issues discussed by the PMWG, including analysis of statewide PPC trends—for those used for payment, under monitoring, and overall—and discussion of COVID-19 related changes and analyses that need to be done to fairly assess hospital performance.

Statewide PPC Performance Trends

Complications Included in Payment Program

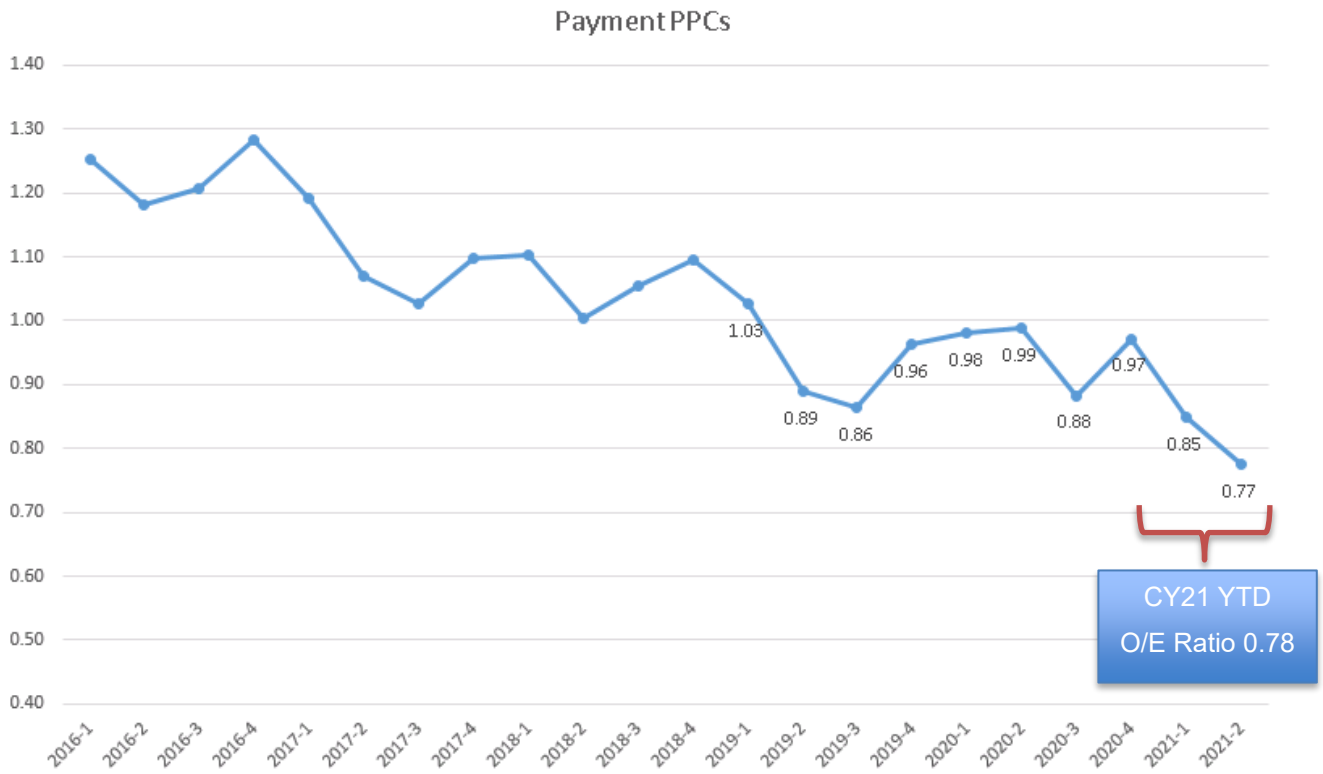
Under the All-Payer Model, Maryland hospitals saw a dramatic decline in complications and, as a State, well exceeded the requirement of a 30 percent reduction by the end of CY 2018. These reductions were achieved through clinical quality improvement, as well as improvements in documentation and coding.

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

Under the TCOC Model, Maryland must maintain these improvements by not exceeding the CY 2018 PPC rates. Figure 2 below shows the statewide observed to expected (O/E) ratio from 2016 through June CY 2021.[4] The O/E ratio presents the count of observed PPCs divided by the calculated number of expected PPCs (which is generated using normative values applied to the case-mix of discharges a hospital experiences). An O/E Ratio of greater than 1 indicates that a hospital experienced more PPCs than expected, and conversely, an O/E Ratio less than one indicates that a hospital experienced fewer PPCs than expected. The Figure 2 below also indicates how Maryland is performing relative to CY 2018, which is the time period that will be used to assess any backsliding on performance.[5] Specifically, there has been a 26% decrease in the ratio based on the most recent data available (CY 2018 O/E ratio = 1.06 and CY 2021 YTD O/E ratio = 0.78).

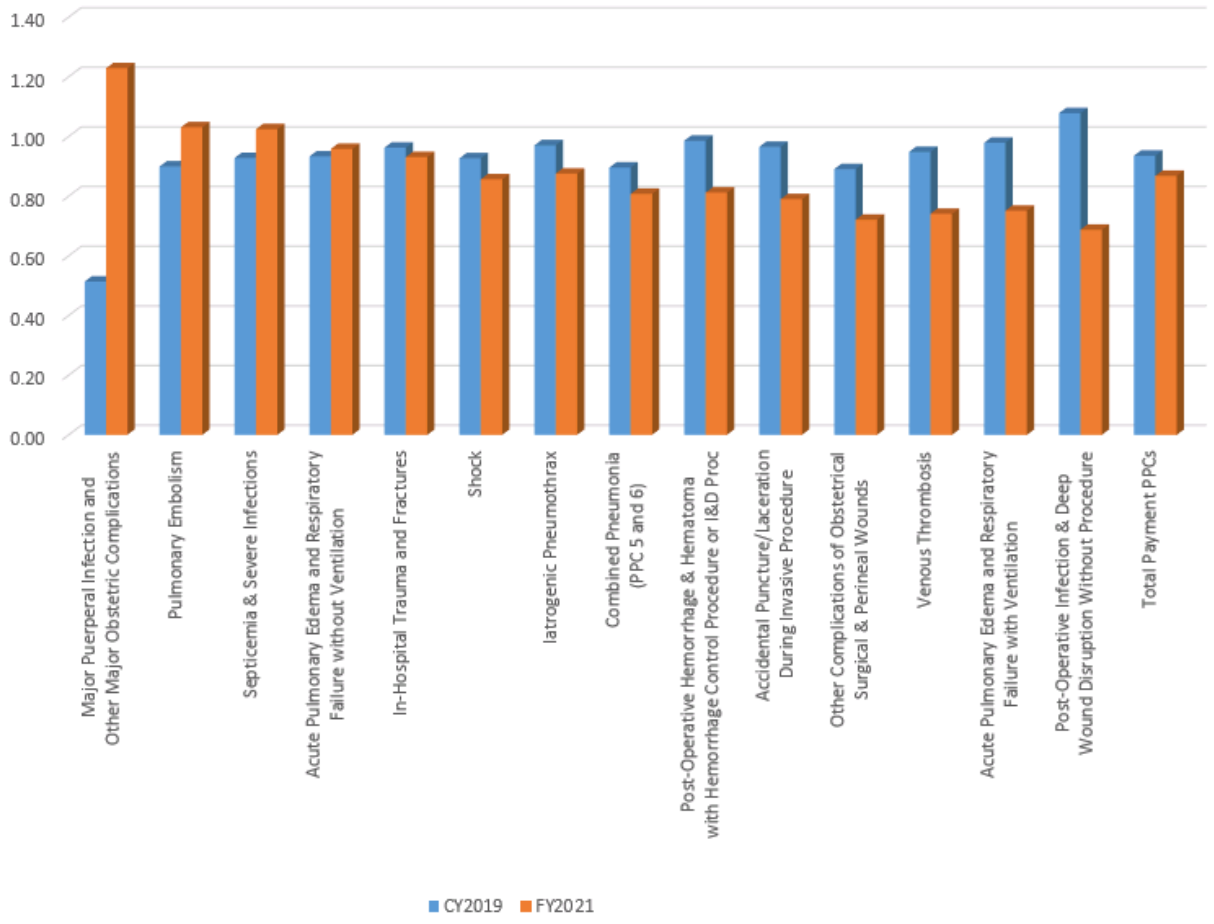
[4] Staff notes that, consistent with federal policies during the COVID Public Health Emergency, PPC data from January-June 2020 will not be used for assessing quality of care.
[5] The O/E ratios presented here are calculated with COVID-19 discharges removed; a final decision on whether to include or exclude COVID-19 discharges has not yet been made for RYs 2023 and 2024.

Figure 2. Payment Program PPCs Quarterly Observed to Expected Ratios CY 2016 to CY 2021 June



In terms of specific improvements among the 14 payment PPCs, Figure 3 shows the O/E ratios for CY 2019 and CY 2021 YTD, sorted from greatest percent increase (on the left) to greatest decrease (on the right). The four PPCs that worsened during this time period include PPC 3- Acute Pulmonary Edema and Respiratory Failure without Ventilation, PPC 60- Major Puerperal Infection and Other Major Obstetric Complication, PPC 7- Pulmonary Embolism, and PPC 35- Septicemia and Severe Infections. The three PPCs with the greatest decreases include PPC 42- Accidental Puncture/Laceration During Invasive Procedure, PPC 37- Post- Operative Infection and Deep Wound Disruption Without Procedure, and PPC 16- Venous Thrombosis.

Figure 3. Payment Program PPC Observed to Expected Ratios CY 2019 and FY 2021

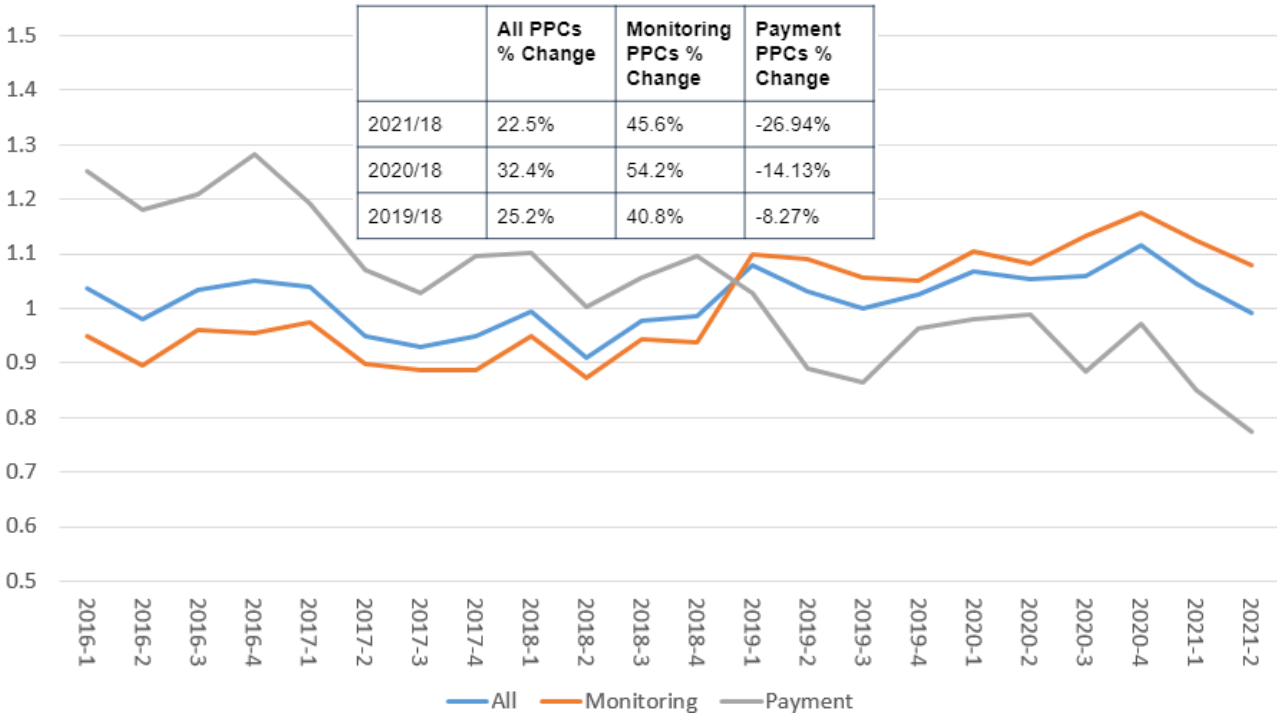


Monitored Complications

In addition to focusing on a narrowed list of PPCs for payment, as stated previously, the RY 2021 MHAC policy included a recommendation to monitor the remaining PPCs. Staff fulfills this recommendation by monitoring all PPCs that are still considered clinically valid by 3M, and distinguishing between “Monitoring” and “Payment” PPCs. The overall PPC trend across all 54 PPCs shows that there has been a slight increase in the overall statewide O/E ratio from 0.98 in CY 2018 to 1.01 in CY 2021 YTD; the slight worsening in performance is driven primarily by increases in PPCs under monitoring status, and not increases in the payment program PPCs, as illustrated in Figure 4. As discussed in the RY 2023 policy, staff had reached out to hospitals with increases in monitoring PPCs and had been given several reasons for the increase unrelated to declining quality. Furthermore, last year staff had planned to analyze data for CY 2019 and through June 2020 to determine whether any monitored PPCs needed to be placed back into

the payment program. Due to the lack of valid and reliable data during the COVID-19 PHE for January-June 2020, staff did not recommend any PPCs be moved back into the payment program for RY 2023, but maintained the recommendation to monitor and possibly move PPCs back into the payment program in the future. Appendix III provides the statewide changes in observed, expected, and the O/E ratios for the monitoring PPCs sorted by the observed PPCs that accounted for the largest proportion of the increase from 2018 to 2021 YTD through June.

Figure 4. PPC O/E Ratio Trends CY 2016 Through CY 2021 Qtr 2



*Note: This analysis excludes COVID-19 patients. The percent change table is only a reflection of the first and second quarters of the specified years.

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

- PPC Data Analysis/Statistics
  - Greater than 50% increase in O/E ratio comparing 2021 to 2018
  - Rate per 1,000 generally 0.5 or above
  - Volume of observed events 100 or above (over two years)

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

Based on staff assessment to date of monitored PPC trends and the criteria above, staff is vetting the PPCs listed below with PMWG stakeholders. In addition to adjusting the expected rates at each hospital by their APR-DRG Severity of Illness (SOI) patient mix, staff has noted that the MHAC program also relies on the work of 3M to review the PPC clinical logic and perform PPC Grouper updates annually. Staff has encouraged stakeholders, particularly clinicians, to review 3M updated global exclusion logic and PPC-specific assignment and exclusion logic and to weigh in on the monitored PPCs they believe are best to include in the payment program. Staff has established two tiers of PPCs currently monitored to consider for use in the payment program.

- Strongly Consider
    - 31: Decubitus Ulcer
    - 51: Gastrointestinal Ostomy Complications
    - 47: Encephalopathy
    - 26: Diabetic Ketoacidosis & Coma
    - 50: Mechanical Complication of Device, Implant & Graft
    - 45: Post Procedure Foreign Body
- Consider
    - 15: Peripheral Vascular Complication except Venous Thrombosis
    - 23: Genitourinary Complications except UTI
    - 34: Moderate Infections
    - 18: Major GI Complications w/ Transfusion or Significant Bleeding
    - 13: Other Cardiac Complications
    - 17: Major GI Complications w/o Transfusion or Significant Bleeding (Possibly combine with PPC #18)

Again, as stated above, staff is committed to ensuring that the additional monitored complication measures, if any, that are areas of concern and are deemed appropriate for a pay-for-performance program are proposed for re-inclusion. Staff welcomes stakeholder comments on the monitored PPC's listed for potential

inclusion, particularly those indicated as “Strongly Consider.” The final RY 2024 MHAC policy, which will take into consideration stakeholder comments on this subject, will provide any additional PPCs that will be added and/or a process for a public workgroup to determine inclusion based on the outlined criteria and any additional clinical feedback from stakeholders.

COVID-19 Program Adjustments

RY 2024 Changes to Timelines

Staff notes that, on September 2, 2020, CMS published an Interim Final Rule (IFR) in response to the COVID-19 PHE. In this IFR, they announced that CMS will not use CY Q1 or CY Q2 of 2020 quality data even if submitted by hospitals. Thus, the two-year base period for establishing performance standards (normative values, and the benchmarks/thresholds) needs to be modified for RY 2024 to exclude this 6 month period. The proposed base period for RY 2024 will be July 2020 through CY 2021 (see below for discussion of concurrent performance standards). This change shortens the base period by 6 months and will delay the availability of normative values and the benchmarks/thresholds until final data for all of CY 2021 is received. While this change does violate the guiding principles of our programs to be prospective and to allow hospital track performance during the performance period, these adjustments as well as potentially retrospective adjustments discussed below are necessitated by the unprecedented COVID PHE.

Assessing Performance During COVID

For both RY 2023 and RY 2024, retrospective changes may be needed to more fairly assess hospital performance. In the RY 2023 policy staff proposed to include COVID-19 related discharges to ensure quality of care was being monitored for all patients. However, staff recognize that the normative values for calculating expected complications during the performance period and the benchmarks/thresholds for scoring hospital performance are using a pre-COVID base period. Thus, for RY 2023 the staff is currently working with Mathematica Policy Research (MPR) to evaluate the impact of COVID on hospital performance. Specifically, as shown in Figure 5, MPR is going to assess the impact of concurrent norms (i.e., using the performance period to develop performance standards as opposed to a historical time period) with and without COVID-19 discharges on hospitals scores, model fit, reliability and validity, hospital rankings relative to COVID volumes, impact on specific DRGS (e.g., Major Respiratory infections and inflammations, sepsis), and equity considerations. The PMWG has reviewed this analysis plan and staff will be bringing results to PMWG over the next few months. The staff anticipates proposing any updates for RY 2023 by March 2022. These decisions may then be carried over or reassessed for RY 2024. As discussed in PMWG, the changes needed due to COVID will continue to impact the Maryland quality programs for the

foreseeable future. As always the staff appreciate the input of stakeholders and the patience of the hospital industry as we work to ensure the fairest approach for quality assessment.

Figure 5. MHAC Program COVID Analytics Models

Models Under Consideration	Model 1 *original baseline period*	Model 2a *concurrent norms with COVID-19 cases*	Model 2b *concurrent norms without COVID-19 cases*
Description	original base period norms	concurrent norms including COVID-19 cases	concurrent norms excluding COVID-19 cases from normative values and performance period calculations

Palliative Care Update

Last year for RY 2023, the MHAC program adjusted its methodology to not exclude palliative care cases because there was data on whether palliative care cases were present-on-admission. The 3M PPC grouper then could assign PPCs to discharges where palliative care was not present-on-admission. This addressed a long-standing concern among HSCRC staff that complications were being missed that caused a patient to go into palliative care during the hospitalization. Unfortunately, starting in October 2021 the palliative care diagnosis is again exempt from POA coding. While 3M plans to assess and update the PPC grouper in future years to clinically determine which complications should be assigned to all patients with a palliative care diagnosis, in the meantime the HSCRC staff will remove discharges with palliative care from October-December 2021 and for all of CY 2022. The RY 2025 policy will re-evaluate palliative care Coding Clinic updates, PPC trend results with/without palliative care, and clinical updates to the PPC grouper v.40 to determine if the palliative care exclusion can be removed.

Hospital Scores and Revenue Adjustments

This draft policy does not present modeling of the RY 2024 methodology and proposes no changes to the current revenue adjustment scale. For the final policy modeling or RY 2023 YTD data may be included. However, since there are likely to be retrospective changes (e.g., use of concurrent norms) to the

methodology due to COVID, staff is proposing at this time to keep the current revenue adjustment scale and re-evaluate it as part of the retrospective changes needed due to COVID.

The scale recommended in this policy ranges from 0 to 100 percent, with a hold harmless zone between 60 and 70 percent. The revenue adjustment scale is normally determined by looking at the distribution of scores from modeling. Despite historical concerns regarding the lack of a continuous scale from some stakeholders, staff still believe that the hold harmless zone is reasonable given the lack of national benchmarks for establishing a cut-point. Based on this scale, the RY 2021 MHAC program had net revenue adjustments of about $39M ($3M penalties, $42M rewards). These revenue adjustments reflect the continued improvement on complications during the TCOC model.

Additional Future Considerations

Staff continue to believe that it is important to seek national comparison data to evaluate relative Maryland PPC performance. The AHRQ HCUP data, containing all-payer claims data from ~40 states, may provide such an opportunity; however, staff notes that the data lag is two years and the COVID-19 PHE emergency has made this type of benchmarking much more difficult. In the meantime, staff will be assessing hospital performance on the all-payer Patient Safety Indicators, which includes some complications that are similar to the payment and monitoring PPCs but may be able to provide a national comparison.

As Maryland hospitals continue to improve on payment PPCs, staff are wanting to pursue statistical methods that will better address small cell size issues and statistical reliability and validity. Thus, over the coming years, staff will work with our contractor MPR to explore whether changes are needed to the program. The methods that will be considered are similar to methods used by CMS for the same concerns.

As mentioned throughout this document, the impact of COVID-19 is still a factor for our quality programs. As COVID-19 prevalence declines and/or becomes endemic, the Maryland quality programs will need to include these patients in assessments of quality. Staff believes that the analytic plan using concurrent norms may allow us to include COVID-19 discharges. However, in future years when we have a base period that is after the most acute phases of the pandemic, staff will want to use that data to set performance standards so that we can not be making retrospective changes to the program.

Finally, staff notes that patient race and ethnicity, social determinants of health, socioeconomic status, and neighborhood factors need to be considered, as hospitals and the State of Maryland work to address disparities in health outcomes. Staff plans to analyze the complication measures data to understand disparities on these measures and other quality outcomes. During the upcoming year staff plans to convene a subgroup that assesses areas of focus for the Commission’s equity work.

Recommendations

The MHAC policy was redesigned in Rate Year (RY) 2021 to modernize the program for the new Total Cost of Care Model. This RY 2024 draft recommendation, in general, maintains the measures and methodology that were developed and approved for RY 2023.[6]

These are the draft recommendations for the RY 2024 Maryland Hospital Acquired Conditions (MHAC) program:

1. Continue to use 3M Potentially Preventable Complications (PPCs) to assess hospital acquired complications.
    a. Monitor all PPCs and provide reports for hospitals and other stakeholders.
    b. Update PPC measures for inclusion in the payment program based on clinical recommendations, statistical characteristics, and recent trends.
2. Use more than one year of performance data for small hospitals (i.e., less than 20,000 at-risk discharges and/or 20 expected PPCs). The performance period for small hospitals will be CY 2021 and 2022.
3. Continue to assess hospital performance on attainment only.
4. Continue to weigh the PPCs in the payment program by 3M cost weights as a proxy for patient harm.
5. Maintain a prospective revenue adjustment scale with a maximum penalty at 2 percent and maximum reward at 2 percent and continuous linear scaling with a hold harmless zone between 60 and 70 percent.
6. Adjust retrospectively the RY 2024 MHAC pay-for-performance program methodology as needed due to COVID-19 Public Health Emergency and report any changes to Commissioners.

[6] See the RY 2023 policy for detailed discussion of the MHAC redesign, rationale for decisions, and approved recommendations

Appendix I. Background on Federal Complication Programs

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

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

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

Hospital-Acquired Condition Reduction Program

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

Figure 1. CMS Hospital-Acquired Condition Reduction Program (HACRP) FFY 2020 Measures

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

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

For more information on the DRA HAC program POA Indicator, please refer to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/index

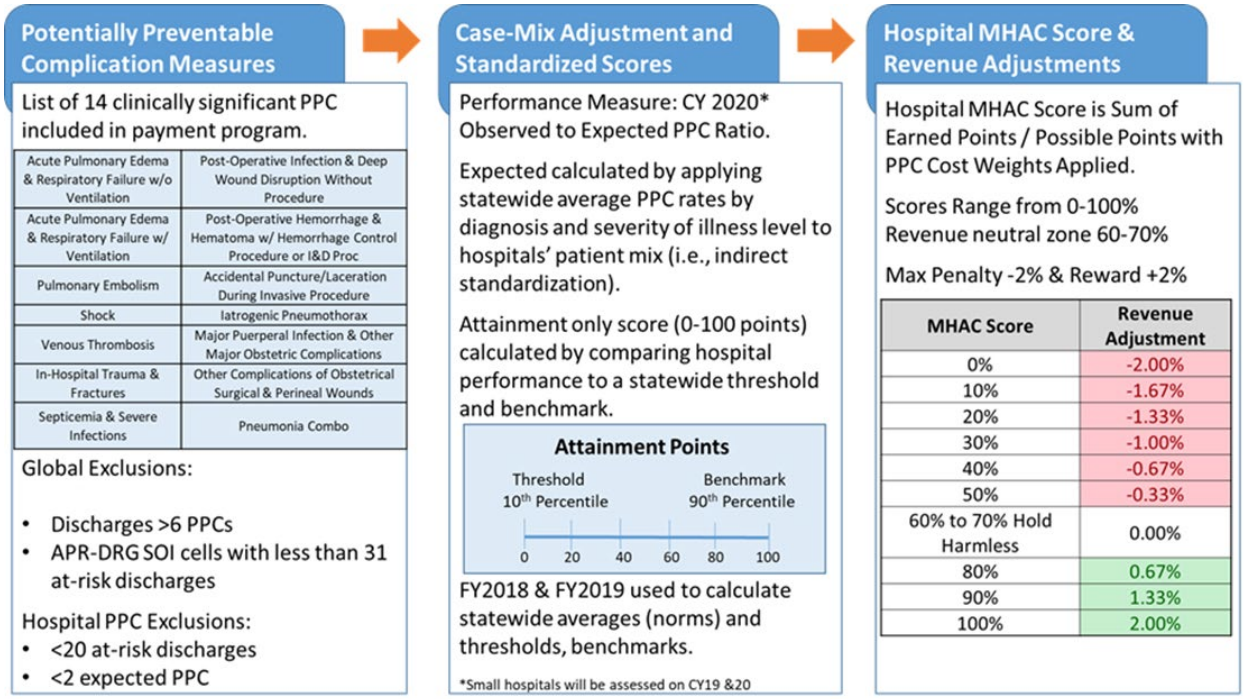
For more information on the DRA HAC program, please refer to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalAcqCond/Downloads/FAQ-DRA-HAC-PSI.pdf

For more information on the HAC Reduction program, please refer to: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program

Appendix II: RY 2023 MHAC Program Methodology

Figure 1 below provides a summary overview of the approved RY 2023 MHAC methodology.

Figure 1. Overview of RY 2023 Approved MHAC Methodology



Performance Metric

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

Observed and Expected PPC Values

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

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

The expected number of PPCs is calculated using a technique called indirect standardization. For illustrative purposes, assume that every hospital discharge is considered "at-risk" for a PPC, meaning that all discharges would meet the criteria for inclusion in the MHAC program. All discharges will either have no

PPCs, or will have one or more PPCs. In this example, each discharge either has at least one PPC, or does not have a PPC. The unadjusted PPC rate is the percent of discharges that have at least one PPC.

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

Let:

N = norm

P = Number of discharges with one or more PPCs

D = Number of “at-risk” discharges

i = A diagnosis category and severity level

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

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

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

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

Figure 2. Expected Value Computation Example for one Diagnosis Category

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

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

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

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

PPC Exclusions

Consistent with prior MHAC policies, the number of at-risk discharges is determined prior to the calculation of the normative values (hospitals with <10 at-risk discharges are excluded for a particular PPC) and the

normative values are then re-calculated after removing PPCs with <2 complication expected. The following exclusions will also be applied:

For each hospital, discharges will be removed if:

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

For each hospital, PPCs will be removed if during FY 2018 and FY 2019:

- The number of cases at-risk is less than 20; and
- The expected number of PPCs is less than 2.

The PPCs for which a hospital will be assessed are determined using the FY 2018 and FY 2019 data and not reassessed during the performance period. This is done so that scores can be reliably calculated during the performance period from a pre-determined set of PPCs. The MHAC summary workbooks provide the excluded PPCs for each hospital.

Combination PPCs

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

Hospital Exclusions

Acute care hospitals that do not have sufficient volume to have at least 20 at-risk and 2 expected for any payment program PPC are excluded from the MHAC policy.

Benchmarks and Thresholds

For each PPC, a threshold and benchmark value are calculated using the determined base period data. In previous rate years when improvement was also assessed, the threshold was set at the statewide median of 1 and the benchmark was the O/E ratio for the top performing hospitals that accounted for 25% of

discharges. For RY 2021 under an attainment only methodology, staff adapted the MHAC points system to allow for greater performance differentiation by moving the threshold to the value of the observed to expected ratio at the 10th percentile of hospital performance, moving the benchmark to the value of the observed to expected ratio at the 90th percentile of hospital performance, and assigning 0 to 100 points for each PPC between these two percentile values.

Attainment Points (possible points 0-100)

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

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

If the PPC ratio is between the threshold and benchmark, the hospital scores partial points for attainment. The formula to calculate the Attainment points is as follows:

- Attainment Points = [99 * ((Hospital's performance period score - Threshold)/ (Benchmark – Threshold))] + 0.5

Calculation of Hospital Overall MHAC Score

To calculate the final score for each hospital, the attainment points earned by the hospital and the potential points (i.e., 100) for each PPC are multiplied by the 3M cost weights. Hospital scores across PPCs are calculated by summing the total weighted points earned by a hospital, divided by the total possible weighted points (100 per PPC * 3M cost weight). Figure 5 provides a hypothetical example of the points based scoring approach with the 3M cost weights.

RY 2023 Update: Small Hospital Methodology

Hospital-specific PPC inclusion requirements were maintained in the RY 2023 policy, i.e., all hospitals are required to have at least 20 at-risk discharges and 2 expected PPCs in order for a particular PPC to be included in the payment program. Because of the volatility in performance scores for smaller hospitals, the Commission also approved the following policy updates in RY 2022:

> "Establish small hospital criteria for assessing performance under the MHAC policy based on the number of at-risk discharges and expected PPCs (i.e., small hospitals are those with less than 20,000 at-risk discharges and/or 20 expected PPCs across all payment program PPCs) as opposed

to the number of PPC measure types, and for hospitals that meet small hospital criteria, increase reliability of score by using two years of performance data to assess hospital performance (i.e., for RY 2022 use CY 2019 and 2020). “

Because of the COVID PHE, the above proposal was not implemented for RY 2022 but instead, the MHAC scores and revenue adjustments for RY 2021 were repeated in RY 2022.

For RY 2023, staff proposed to maintain the small hospital criteria and expected to utilize CY 2020 and CY2021 for the assessment of small hospitals. However, staff will need to reconsider this approach due to the COVID related suspension of data use for January to June of 2020. Thus, in the RY 2023 recommendations, staff proposed that for small hospitals more than one year of data be used, and that the performance period will be CY 2021 plus yet to be determined performance period. For example, if the Commission decides to use July to December 2020 data, then small hospitals could be assessed on data from July 2020 through December 2020 and January to December 2021

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Appendix III: Monitoring PPCs

The table below shows the monitored PPCs O/E ratios for CY 21 YTD (through June) and the changes in the ratio from CY 2018. The PPCs highlighted in green represent those PPCs that staff believes should be "strongly considered," and those highlighted in yellow are those that should be "considered." In addition, the following statistical information is provided:

- The CY 2021 and 2019 rates per thousand
- The observed counts for CYs 2019 and 2020 combined
- The 3M cost weights: these are based upon cost variation correlated with individual PPCs. The cost measurement provides an estimate of the incremental cost of the average PPC over the cost of the typical case at admission. Cost estimates are converted into relative weights on a similar scale to those of other admissions to provide context.
- Reliability and validity statistics for CY 18-19
- Variations among hospitals' O/E ratios with percent of hospitals below 0.85 or above 1.15 O/E
- Number of hospitals in the state eligible for the PPC (20 or more cases at risk for the PPCs and 2 or more expected PPCs) for those staff is recommending be strongly considered or considered.

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Monitoring PPCs Strongly Recommended
Monitoring PPCs Recommended
Monitoring PPCs Not Recommended

	PPC Description	O/E Ratio 2021	21/18 % change	21 rate per 1000 (obs/atrisk *1000)	19 rate per 1000 (obs/atrisk *1000)	obs counts 19&20	3M cost weights	Reliability CY 18-19	Spearman's Predictive Validity CY18-19	Pearson's Predictive Validity CY18-19	Hospital Variation CY 18-19 O/E	Qualifying Hospitals CY18-19
31	Decubitis Ulcer	2.072532252	177.75%	1.1979359	0.65542465	159	2.732754	Strong	Very Weak	Very Weak	82.61	46
51	Gastrointestinal Ostomy Complications	1.718597992	143.68%	0.7390512	0.430243656	363	1.536037	Moderate	Weak	Moderate	80	40
47	Encephalopathy	1.564997708	95.30%	1.0876954	0.711396182	428	0.73486	Strong	Moderate	Moderate	86.62	39
26	Diabetic Ketoacidosis & Coma	1.241225227	90.48%	0.1579474	0.144046556	71	0.529726	Low	N/A	N/A	94.74	19
50	Mechanical Complication of Device, Implant & Graft	1.469228381	83.29%	1.0828006	0.859003256	669	1.16229	Strong	Weak	Moderate	72.5	40
45	Post Procedure Foreign Body	1.590764476	68.36%	0.0290641	0.019134827	22	0.599007	Very Low	Very Weak	Very Weak	95.65	46
15	Peripheral Vascular Complications except Venous Thrombosis	1.536704471	104.91%	0.5493201	0.377287304	261	1.509014	Moderate	Very Weak	Weak	68.97	29
23	GU Complications Except UTI	1.413699187	85.21%	0.4168621	0.329810917	241	0.59266	Low	Weak	Very Weak	81.82	33
34	Moderate Infectious	1.592439017	77.22%	1.3389441	0.813836638	233	1.319832	Strong	Strong	Very Strong	78.79	33
18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding	1.359434475	70.32%	0.6059707	0.450138595	340	1.532197	Moderate	Weak	Moderate	78.95	38
13	Other Cardiac Complications	1.175128606	51.50%	0.3970074	0.36516392	252	0.370811	Strong	Moderate	Moderate	88.57	35
17	Major Gastrointestinal Complications without Transfusion or Significant Bleeding	1.255369369	48.50%	0.6737902	0.547433419	397	1.243755	Strong	Weak	Weak	89.74	39
29	Poisonings except from Anesthesia	1.144385284	48.25%	0.1542033	0.156751835	88	0.135078	Moderate	Very Strong	Very Strong		
52	Inflammation & Other Complications of Devices,Implants or Gr	1.084425214	36.36%	1.2117467	1.177818333	836	1.114926	Strong	Moderate	Moderate		
20	Other Gastrointestinal Complications without Transfusion or Si	1.294820046	34.31%	1.1186044	0.801833667	641	1.084788	Moderate	Very Weak	Very Weak		
40	Post-Operative Hemorrhage & Hematoma withoutHemorrhage	1.120816644	27.35%	4.8969488	4.477363636	1150	0.726008	Strong	Very Weak	Very Weak		
66	Catheter-Related Urinary Tract Infection	1.593794825	25.92%	0.1702901	0.046158462	9	0.800112	Strong	N/A	N/A		
1	Stroke & Intracranial Hemorrhage	1.118901984	24.41%	1.4162018	1.1961753	919	0.903899	Moderate	Weak	Weak		
19	Major Liver Complications	1.136822422	23.16%	0.6633808	0.515488787	413	0.726922	Strong	Very Weak	Weak		
27	Post-Hemorrhagic & Other Acute Anemia withTransfusion	1.05087275	11.70%	1.0401768	0.896475793	518	0.976265	Strong	Moderate	Moderate		
10	Congestive Heart Failure	0.96501292	11.70%	0.1710669	0.185425552	94	0.421532	Strong	N/A	N/A		
8	Other Pulmonary Complications	0.837757869	7.52%	0.6607423	0.904226378	373	0.844686	Strong	Moderate	Moderate		
25	Renal Failure with Dialysis	1.025418548	7.31%	0.2468878	0.215890282	107	2.904097	Moderate	N/A	N/A		
39	Reopening Surgical Site	1.055902787	6.91%	2.8355142	2.207216287	446	1.678212	Moderate	Weak	Weak		
11	Acute Myocardial Infarction	0.932359935	5.26%	1.1045771	1.180943012	840	0.407992	Strong	Moderate	Moderate		
33	Cellulitis	0.890671509	-4.43%	0.6884197	0.749318391	465	0.912768	Strong	Moderate	Moderate		
21	Clostridium Difficile Colitis	0.856196362	-14.80%	4.7207173	5.333759647	667	1.3374	Strong	Moderate	Weak		
65	Urinary Tract Infection without Catheter	0.919584705	-15.57%	4.0051524	3.515917693	2406	0.677804	Strong	Moderate	Moderate		
6	Aspiration Pneumonia	0.832606481	-20.70%	0.9345935	0.942210085	617	0.926432	Strong	Moderate	Moderate		
2	Extreme CNS Complications	0.513988392	-44.27%	0.3701015	0.660879402	411	0.463291	Strong	Moderate	Strong		
5	Pneumonia & Other Lung Infections	0.624438177	-45.88%	1.3265499	1.683720491	534	1.296954	Strong	Very Weak	Very Weak		
63	Postoperative Respiratory Failure with Tracheostomy	0	-100.00%	0	31.25	4	7.572636	#N/A	#N/A	#N/A		
38	Post-Operative Wound Infection & Deep WoundDisruption with	1.236654438	140.38%	0.4604052	0.529836413	11	2.464263	Very Low	#N/A	#N/A	100	3
59	Medical & Anesthesia Obstetric Complications	1.550394274	122.98%	3.7068818	3.022534498	400	0.125938	Strong	Very Weak	Very Weak	87.1	31
44	Other Surgical Complication - Mod	1.882049283	102.00%	0.8025682	0.38502916	104	1.08229	Low	N/A	N/A	90	20
54	Infections due to Central Venous Catheters	1.708700704	84.83%	0.2510166	0.142946606	44	2.964553	Moderate	N/A	N/A	90	10
53	Infection, Inflammation & Clotting Complicationsof Peripheral \	1.582724561	84.35%	0.2333961	0.155606161	105	0.52856	Strong	N/A	N/A	80.77	26
64	Other In-Hospital Adverse Events	1.284914723	80.18%	0.4154651	0.390416411	296	0	Strong	Very Weak	Very Weak	86.84	38
48	Other Complications of Medical Care	1.190529596	59.08%	0.4286806	0.408025869	285	1.074701	Moderate	Very Weak	Very Weak	86.11	36
14	Ventricular Fibrillation/Cardiac Arrest.	1.240931756	32.75%	4.2005757	3.057108823	2020	0.510352	Strong	Weak	Moderate	67.39	46

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Update on Medicare FFS Data & Analysis

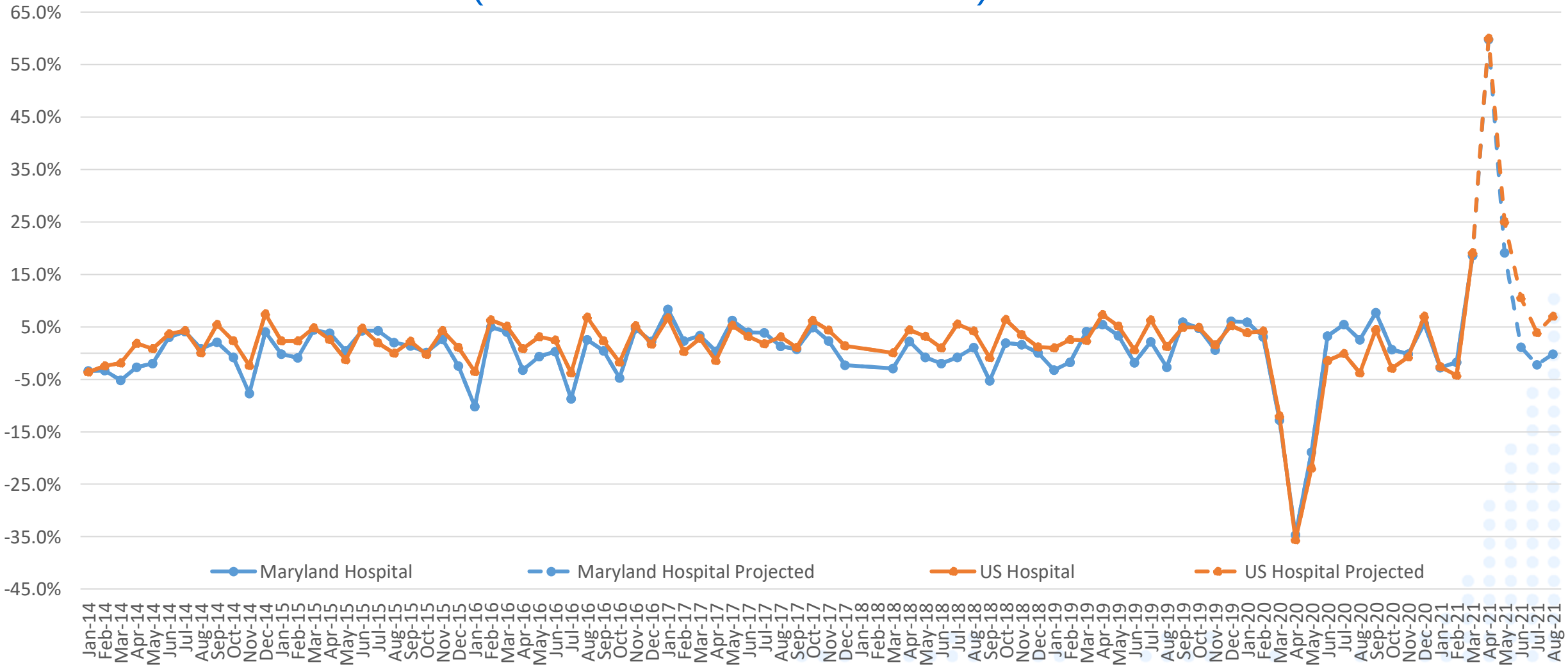
December 2021 Update

Data through August 2021, Claims paid through October 2021

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

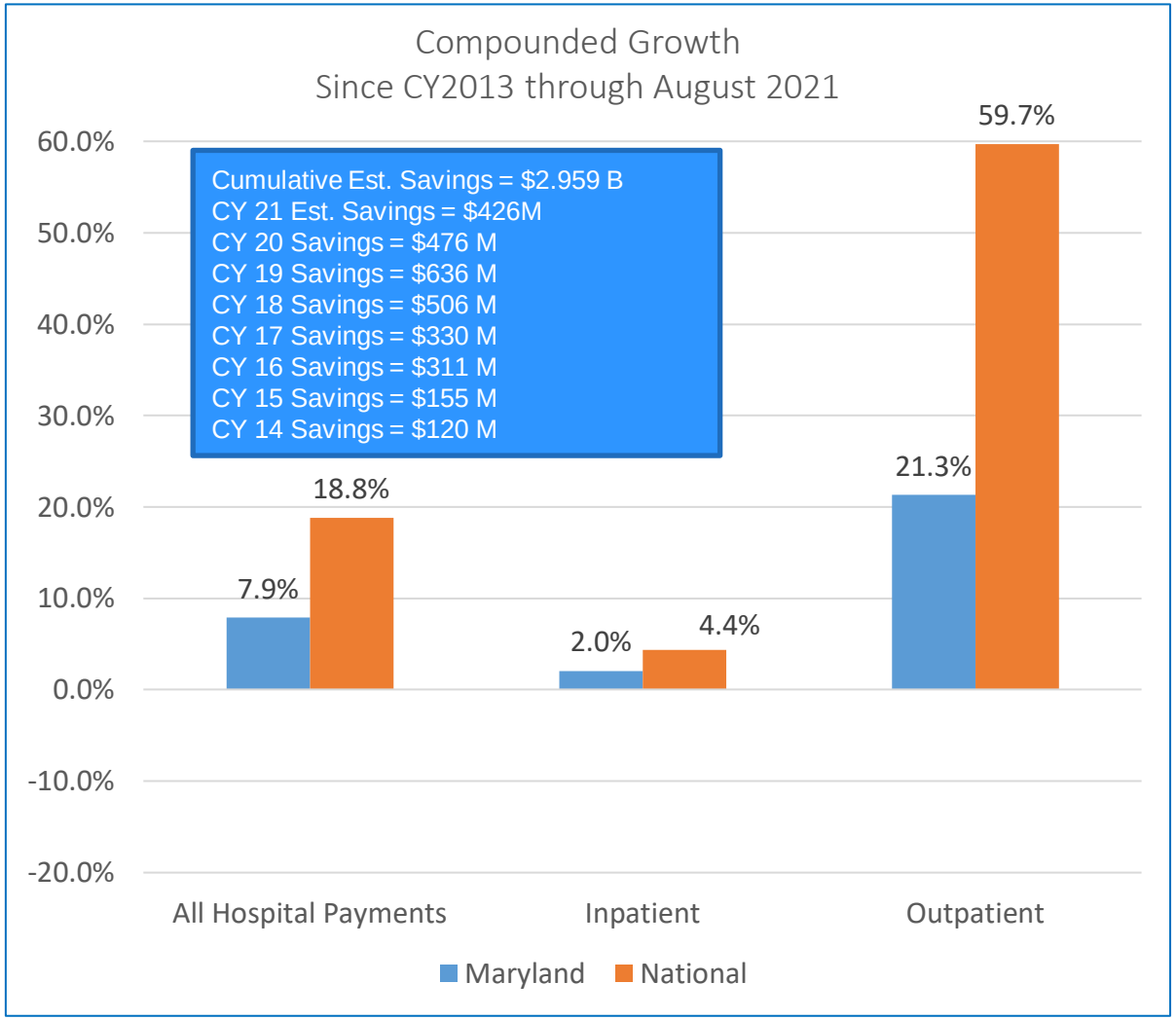
Medicare Hospital Spending per Capita

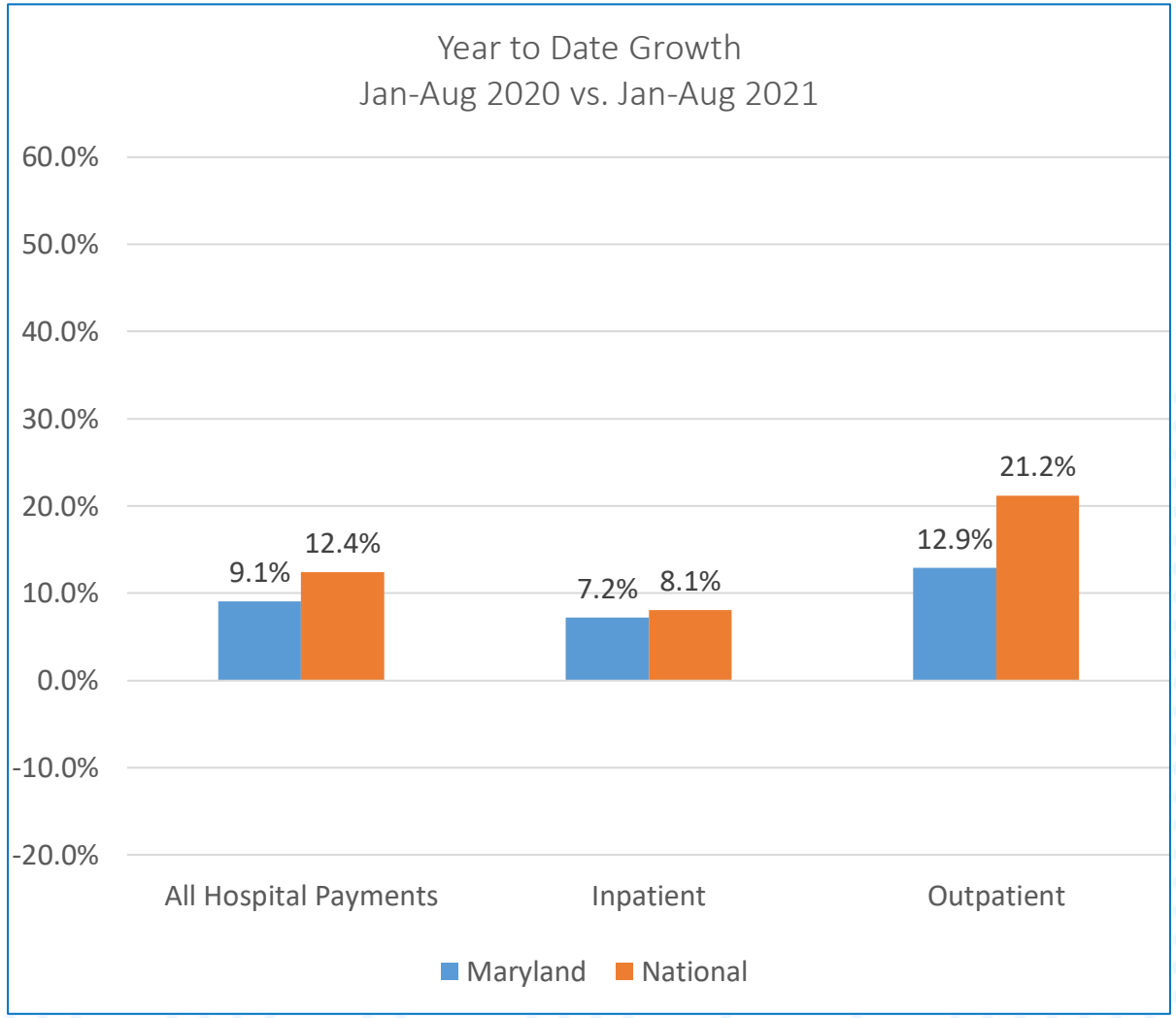
Actual Growth Trend (CY month vs. Prior CY month)



CY16 has been adjusted for the undercharge.

Medicare Hospital Payments per Capita





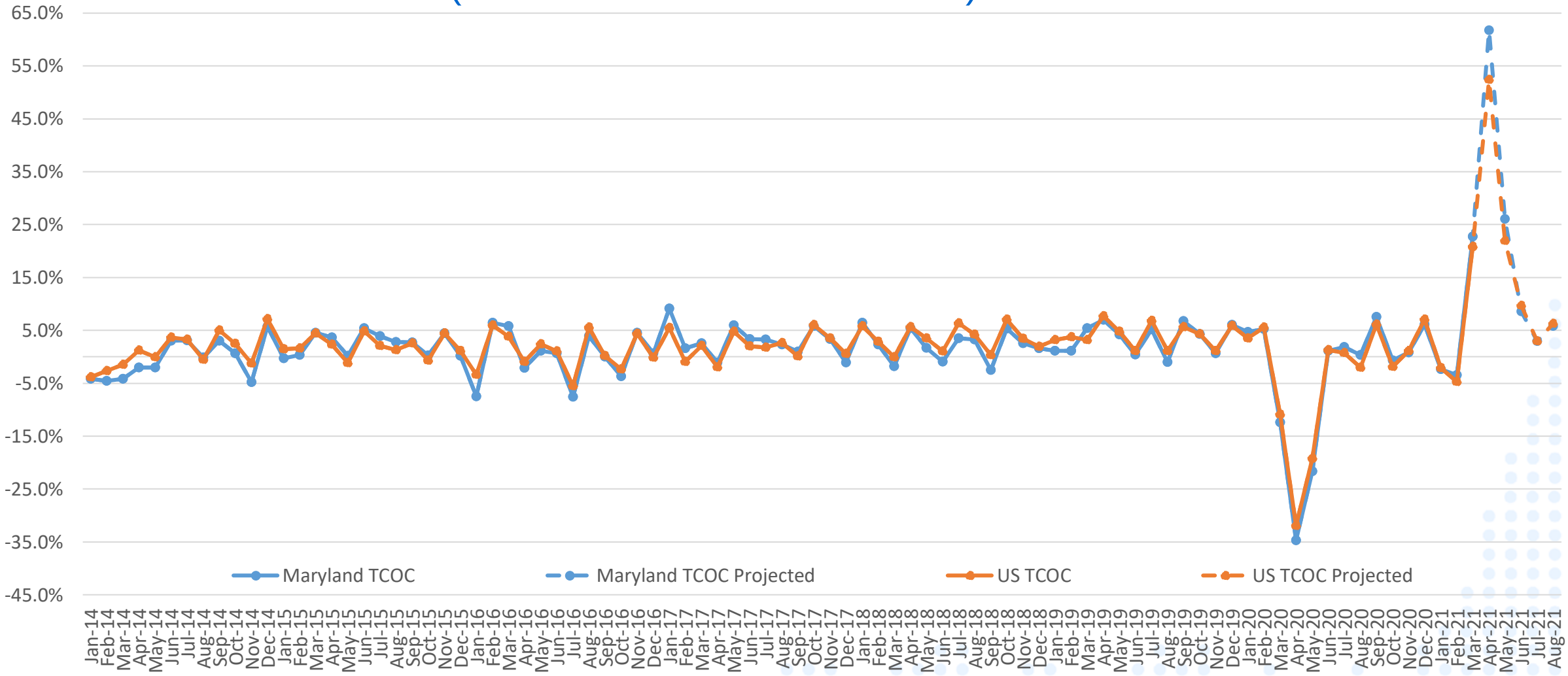
This chart has been adjusted for the undercharge of approximately $25 M for July – Dec 2016.

Medicare Hospital Payments per Capita: Observations

- Since the 2013 base year, Maryland has had a lower per capita growth (10.9 percentage point difference) relative to National Medicare spending through August 2021.
- Year over year (CYTD August 2020 vs. CYTD August 2021), Maryland has had a lower growth rate than the Nation by 3.3 percentage points.

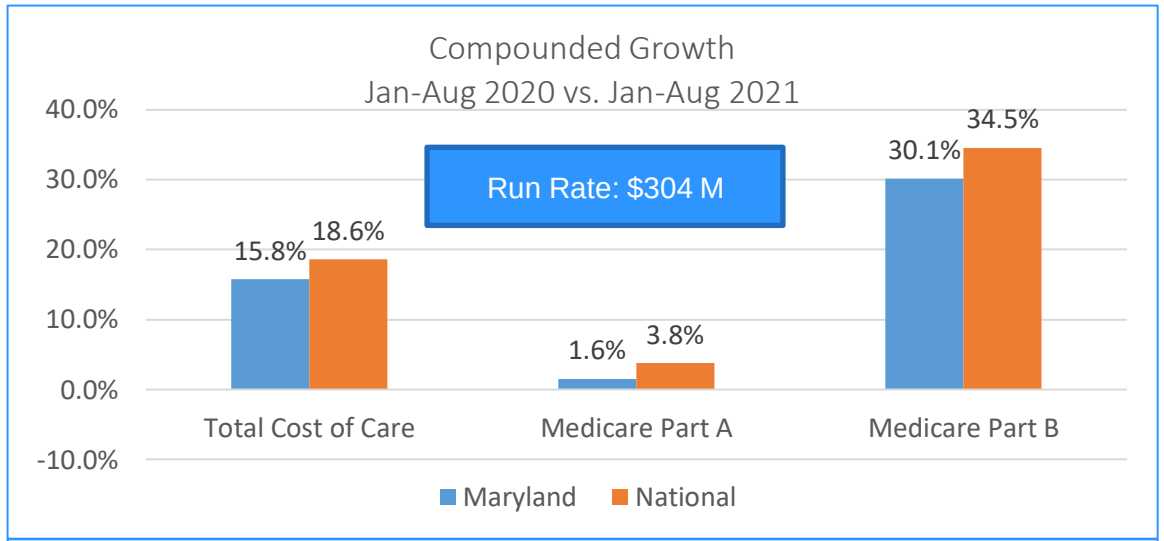
Medicare Total Cost of Care Spending per Capita

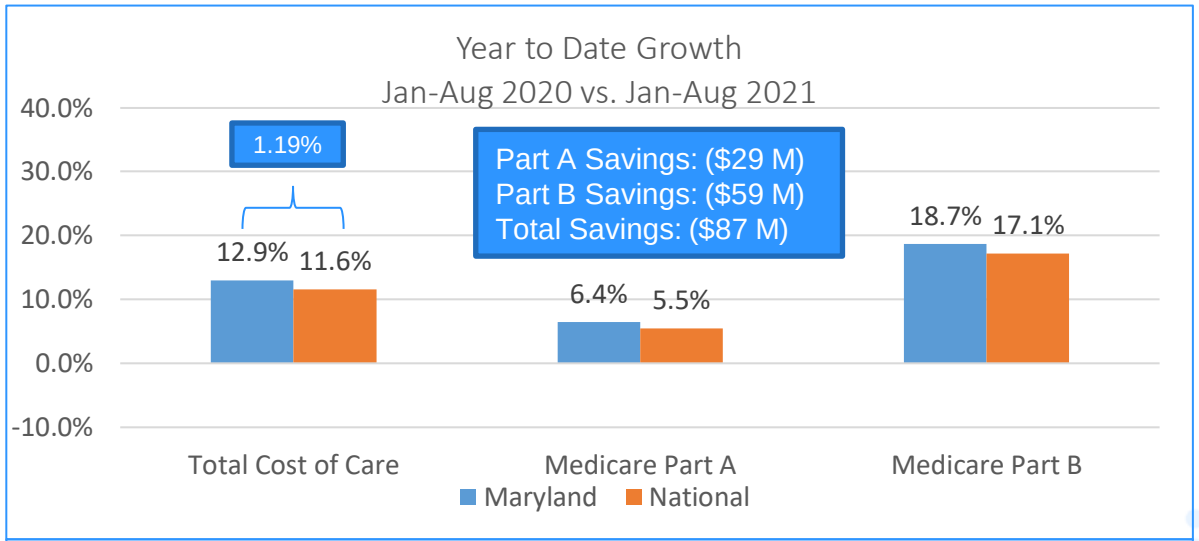
Actual Growth Trend (CY month vs. Prior CY month)

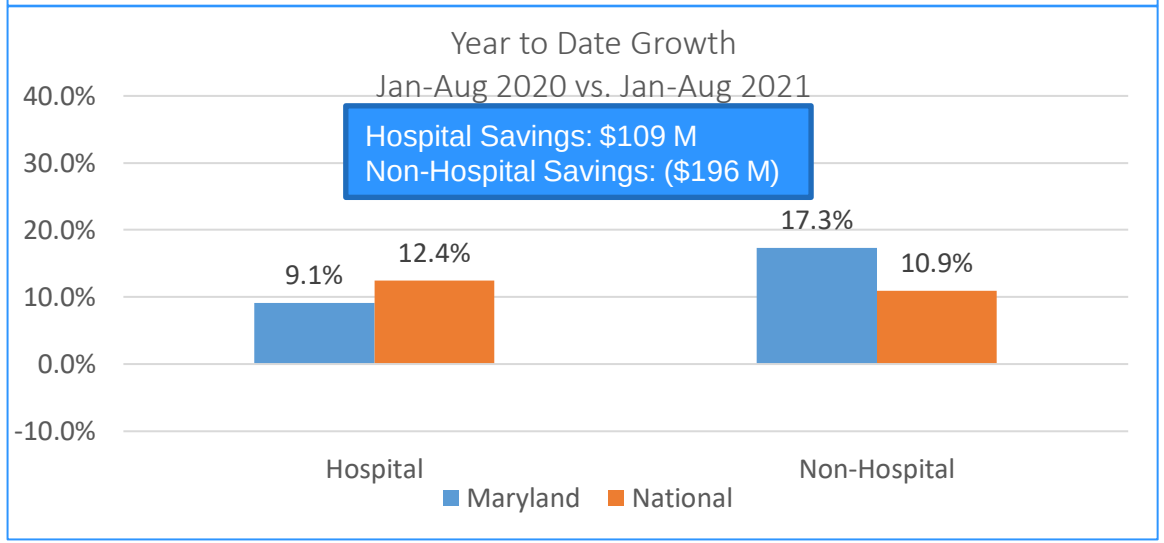


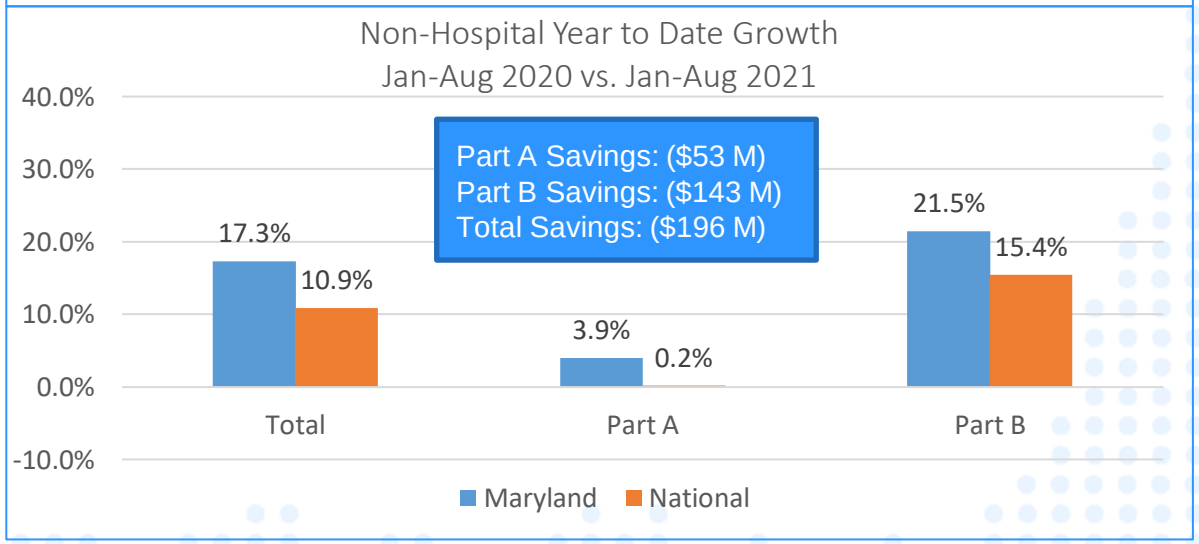
CY16 has been adjusted for the undercharge

Medicare Total Cost of Care Payments per Capita



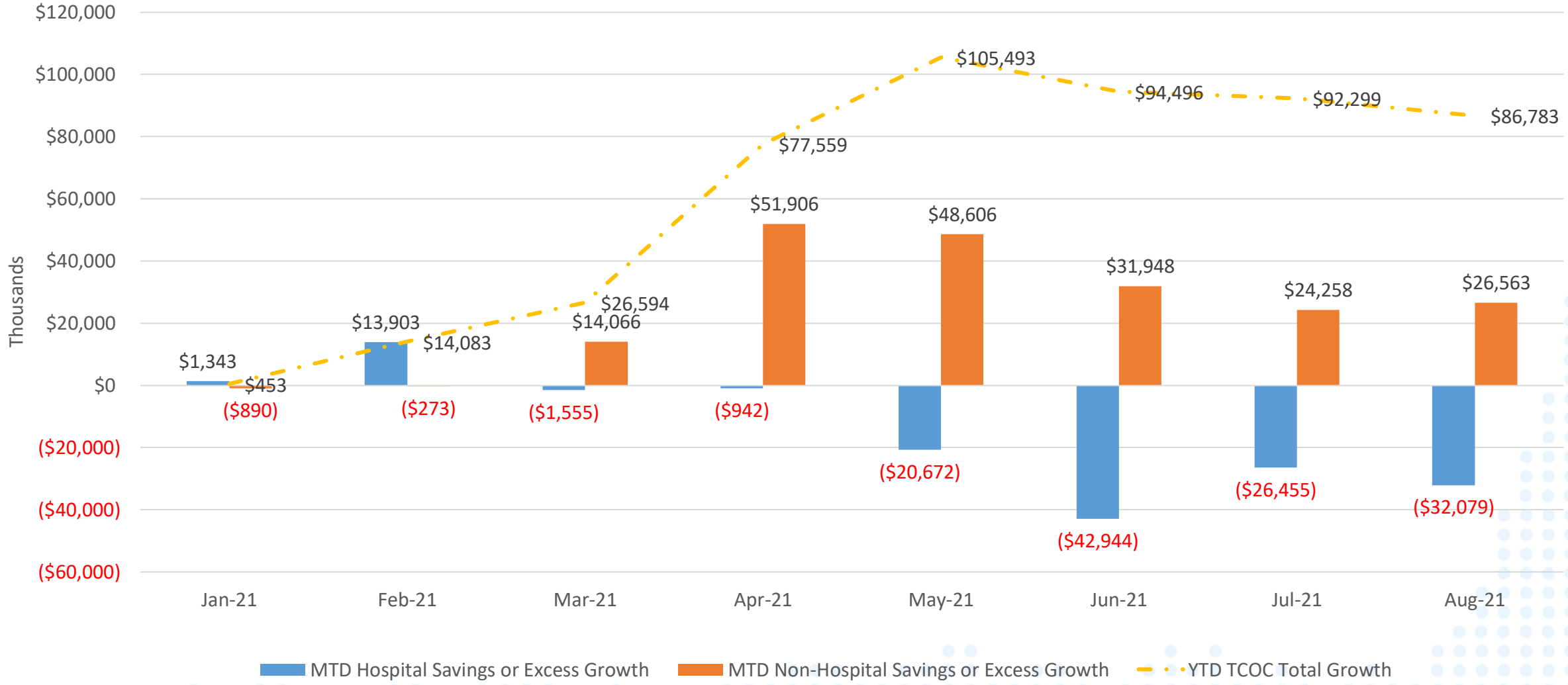






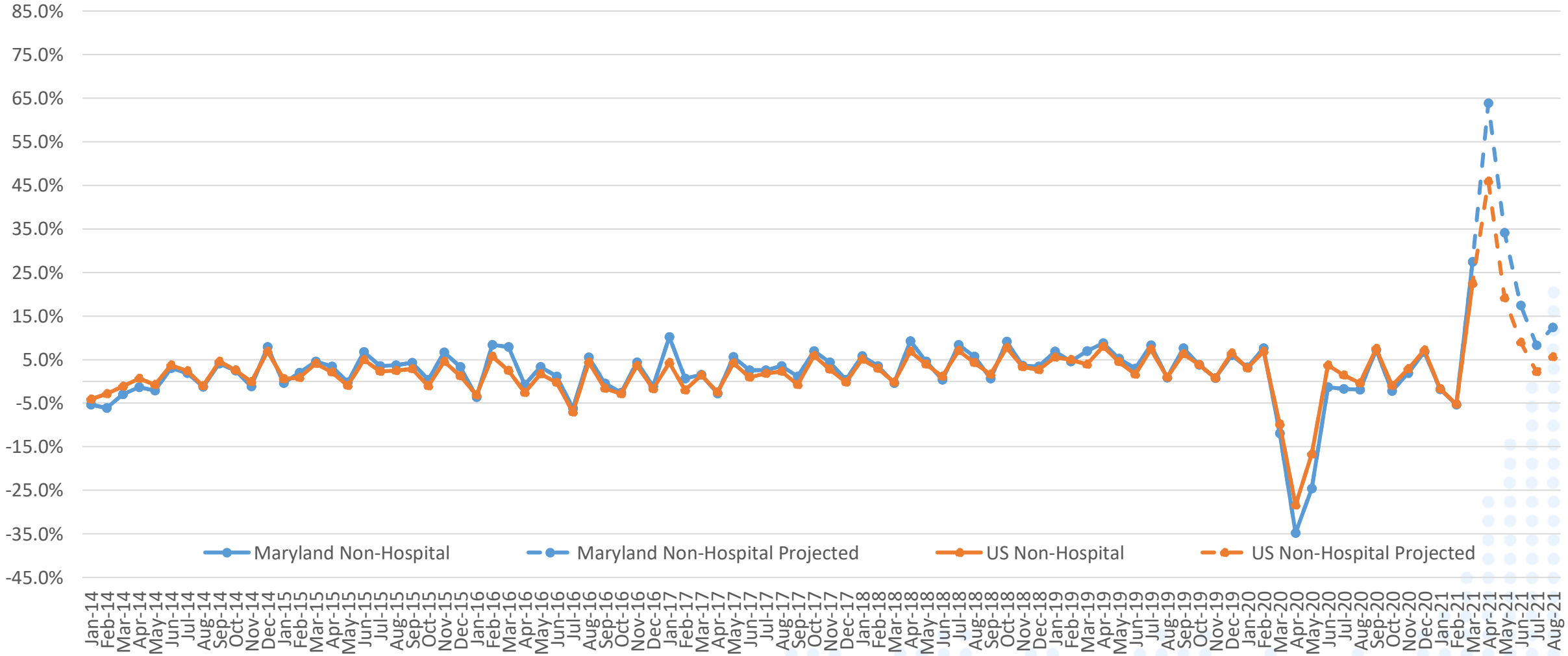
Maryland Medicare Hospital & Non-Hospital Growth

CYTD through August 2021



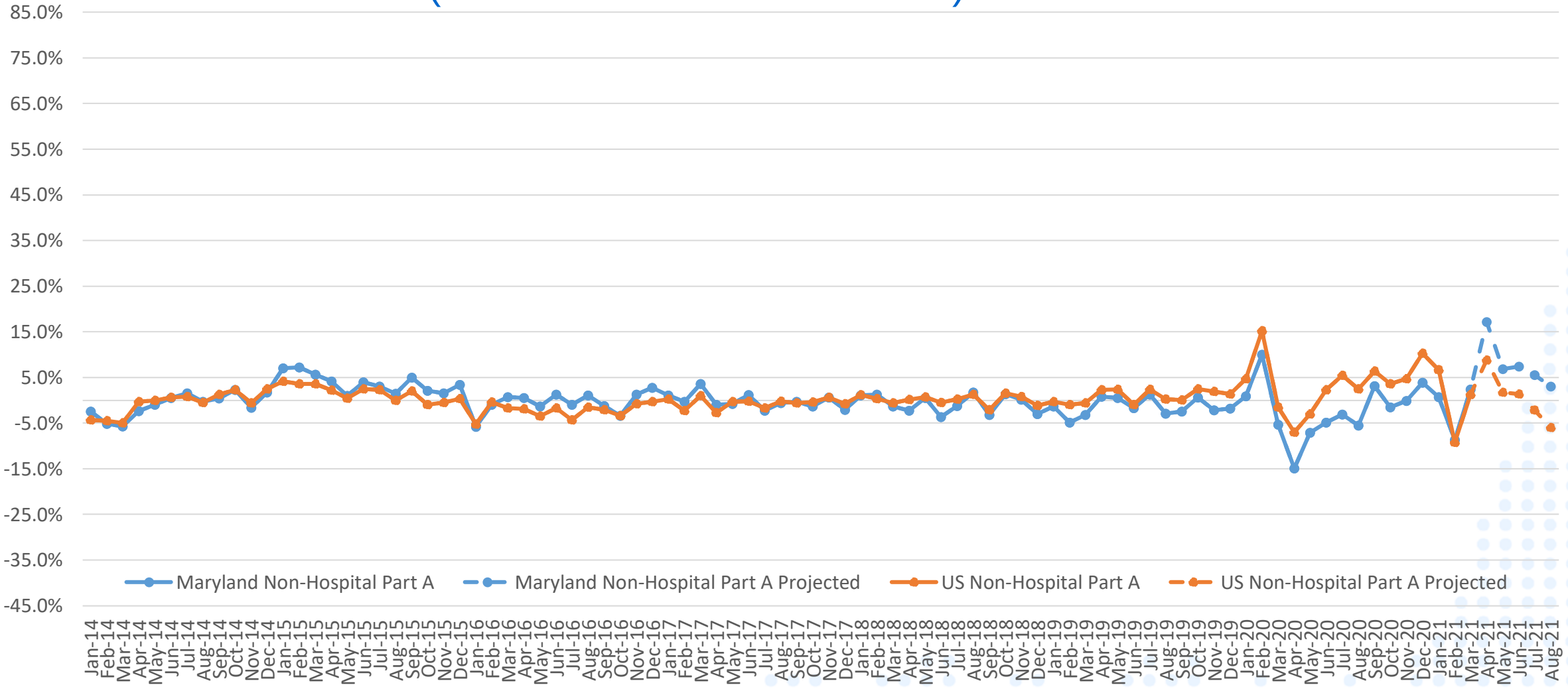
Medicare Non-Hospital Spending per Capita

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



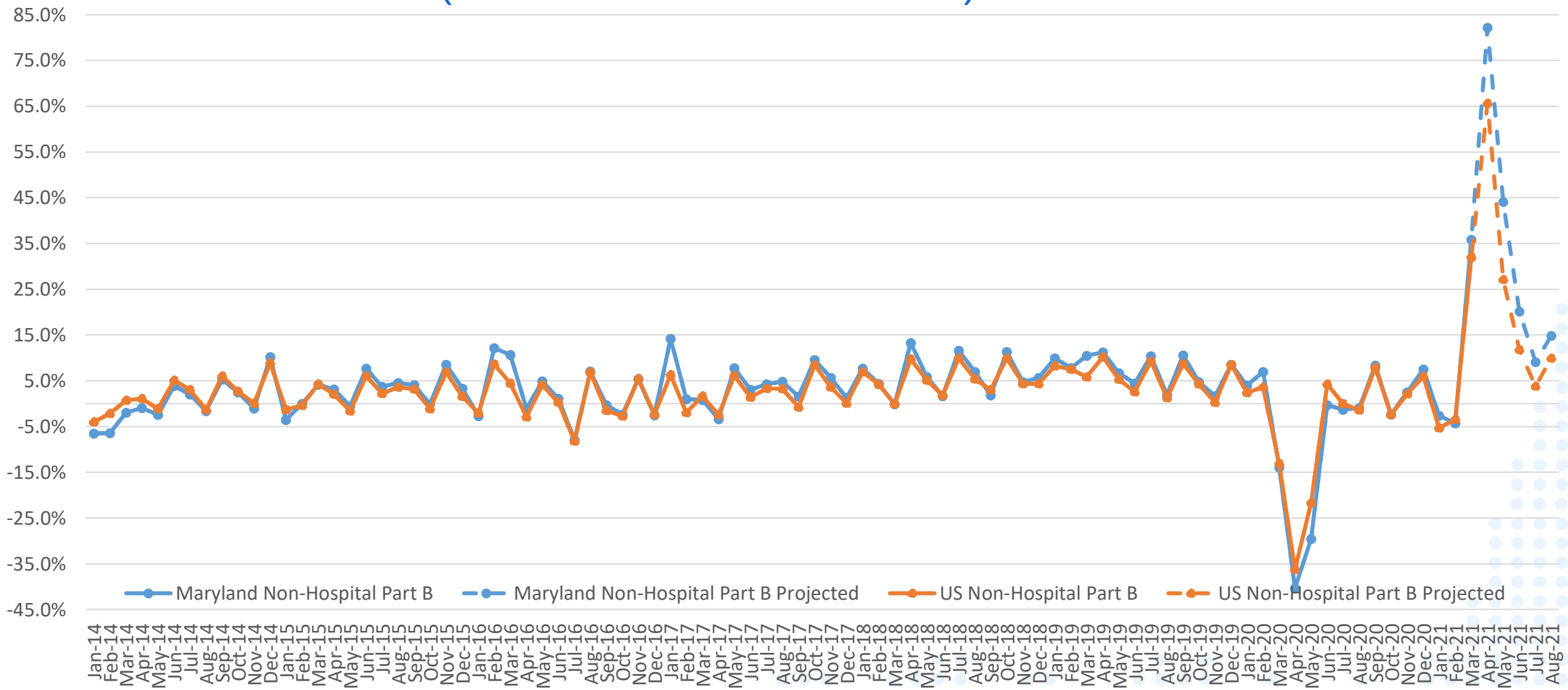
Medicare Non-Hospital Part A Spending per Capita

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



Medicare Non-Hospital Part B Spending per Capita

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

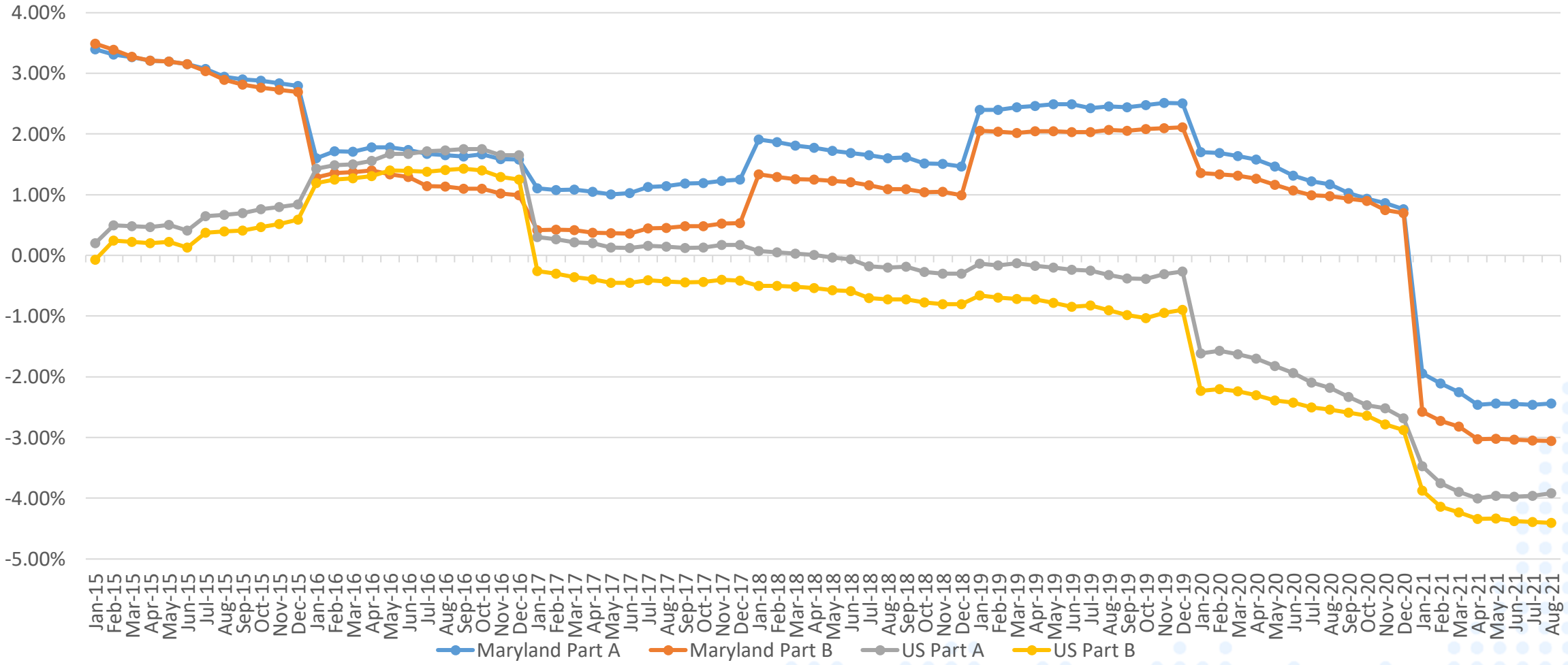


Medicare Total Cost of Care per Capita: Observations

- Compounded Growth:
  - The growth in Maryland spending through August 2021 is about 2.8 percentage points lower than the National growth since 2013.
- Year to Date Growth:
  - The trend in Maryland spending is 1.19 percentage points above the Nation for CYTD 2020 vs. CYTD 2021.
  - Contract guardrails for TCOC are calculated on a year over year basis
- Year to Date Growth by Care Setting:
  - Maryland hospital growth through August 2021 is 9.1%, compared to 12.4% Nationally.
  - Maryland non-hospital growth through August 2021 is 17.3%, compared to 10.9% Nationally.
- Non-Hospital Year to Date Growth:
  - The delta in non-hospital spending growth showed Maryland 6.4 percentage points above the Nation through August 2021.
  - ~$110 M of Care Management Fees have been added to non-hospital Part B payment data through August 2021 vs. ~$78 M through August 2020 in Maryland. ~$543M of Care Management Fees have been added to non-hospital Part B payment data through August 2021 vs. ~$488M through August 2020 Nationally.

Medicare Beneficiary Growth

Calendar Year to Date Cumulative Growth through August 2021



MARYLAND SPENDING PER BENEFICIARY Jan-Sep Paid thru Oct

Provider Type	BETOS	2020 MD Spend	2020 MD Visits	2020 MD Visits per K	2020 MD Spend per Capita	2021 MD Spend	2021 MD Visits	2021 MD Visits per K	2021 MD Spend per Capita	% Util Change 21 vs 20	% Unit Cost Change 21 vs 20	% per Capita Change 21 vs 20	5% NATIONAL % Util Change 21 vs 20	5% NATIONAL % Unit Cost Change 21 vs 20	5%NATIONAL % per Capita Change 21 vs 20	2021 CY Excess Growth 21 vs 20
Inpatient Hospital		**$2,767,528,904**	**841,640**	**921.8**	**$3,031.17**	**$2,886,772,575**	**881,099**	**988.1**	**$3,237.37**	**7.2%**	**-0.4%**	**6.8%**	**3.0%**	**4.5%**	**7.6%**	**($22,124,805)**
SNF		**$439,695,495**	**904,098**	**990.2**	**$481.58**	**$474,099,957**	**944,219**	**1,058.9**	**$531.68**	**6.9%**	**3.2%**	**10.4%**	**-2.4%**	**3.9%**	**1.4%**	**$38,585,153**
Home Health		**$218,787,175**	**153,078**	**167.7**	**$239.63**	**$224,451,878**	**61,247**	**68.7**	**$251.71**			**5.0%**	**-59.5%**		**2.1%**	**$6,300,540**
Hospice		**$177,844,219**	**1,016,304**	**1,113.1**	**$194.79**	**$160,511,929**	**879,824**	**986.7**	**$180.01**	**-11.4%**	**4.3%**	**-7.6%**	**-3.4%**	**3.6%**	**0.1%**	**($13,419,784)**
Total Part A Spend		**$3,603,855,793**	**2,915,120**		**$3,947.17**	**$3,745,836,338**	**2,766,389**		**$4,200.77**			**6.4%**			**5.6%**	**$9,341,104**
Part A Beneficiaries		**913,024**				**891,703**										
Outpatient Hospital		**$1,165,437,479**	**4,945,342**		**$1,497.85**	**$1,253,887,446**	**5,670,041**		**$1,660.25**			**10.8%**			**20.2%**	**($105,864,234)**
	E&M - ER	$89,396,619	231,726	297.8	$114.89	$90,285,314	252,287	334.0	$119.55	12.2%	-7.2%	4.0%	5.8%	6.5%	12.6%	($7,405,906)
	E&M - Other	$114,210,298	339,919	436.9	$146.79	$118,560,561	393,556	521.1	$156.98	19.3%	-10.3%	6.9%	20.3%	5.7%	27.2%	($22,452,106)
	Part B Rx	$241,823,368	690,694	887.7	$310.80	$207,735,121	777,255	1,029.2	$275.06	15.9%	-23.7%	-11.5%	12.4%	-7.6%	3.8%	($35,906,583)
	Lab	$118,016,765	2,377,749	3,055.9	$151.68	$132,535,827	2,639,441	3,494.8	$175.49	14.4%	1.2%	15.7%	15.5%	4.4%	20.6%	($5,560,907)
	Imaging	$108,073,958	508,564	653.6	$138.90	$118,432,352	583,987	773.2	$156.81	18.3%	-4.6%	12.9%	17.7%	0.9%	18.7%	($6,106,799)
	Other Professional	$133,359,066	299,835	385.4	$171.40	$178,707,746	474,361	628.1	$236.62	63.0%	-15.3%	38.1%	61.8%	76.4%	185.5%	($190,898,409)
	Proc-Minor	$69,243,207	242,206	311.3	$88.99	$72,064,945	264,235	349.9	$95.42	12.4%	-4.6%	7.2%	14.4%	5.0%	20.2%	($8,700,230)
	DME	$43,346,767	52,239	67.1	$55.71	$49,914,678	64,669	85.6	$66.09	27.5%	-7.0%	18.6%	22.5%	16.8%	43.2%	($10,332,517)
	Proc-Ambulatory	$34,520,494	30,205	38.8	$44.37	$41,142,140	36,449	48.3	$54.48	24.3%	-1.2%	22.8%	15.4%	-0.3%	15.1%	$2,591,054
	Proc-Major Cardiology	$42,317,964	17,016	21.9	$54.39	$51,035,312	20,897	27.7	$67.58	26.5%	-1.8%	24.2%	15.6%	1.9%	17.8%	$2,648,707
	Proc-Major Other	$34,374,346	22,275	28.6	$44.18	$39,891,556	24,678	32.7	$52.82	14.1%	4.8%	19.6%	16.0%	4.5%	21.2%	($551,768)
	Proc-Eye	$7,683,933	5,561	7.1	$9.88	$9,602,683	7,886	10.4	$12.71	46.1%	-11.9%	28.7%	31.3%	-3.0%	27.3%	$104,556
	Proc-Endocrinology	$32,492,713	33,074	42.5	$41.76	$38,631,830	40,511	53.6	$51.15	26.2%	-2.9%	22.5%	25.3%	0.2%	25.6%	($966,655)
	Proc-Major Orthopaedic	$23,503,931	8,552	11.0	$30.21	$37,383,151	12,246	16.2	$49.50	47.5%	11.1%	63.9%	55.6%	11.5%	73.5%	($2,197,457)
	Proc-Oncology	$72,721,364	85,104	109.4	$93.46	$67,572,613	76,892	101.8	$89.47	-6.9%	2.8%	-4.3%	1.5%	6.4%	8.0%	($8,688,174)
	Proc-Dialysis	$352,687	623	0.8	$0.45	$391,618	691	0.9	$0.52	14.3%	0.1%	14.4%	2.8%	7.4%	10.5%	$13,421
Total Hospital		**$3,932,966,383**			**$4,529.02**	**$4,140,660,020**	**6,551,140**	**988.1**	**$4,897.62**			**8.1%**			**12.0%**	**($127,989,039)**
ESRD		**$178,156,783**	**1,066,954**	**1,371.3**	**$228.97**	**$156,392,372**	**1,053,222**	**1,394.6**	**$207.08**	**1.7%**	**-11.1%**	**-9.6%**	**-4.9%**	**-11.2%**	**-15.6%**	**$10,505,000**
Outpatient Other		**$85,827,834**	**1,586,454**	**2,038.9**	**$110.31**	**$89,931,882**	**1,872,470**	**2,479.3**	**$119.08**	**21.6%**	**-11.2%**	**8.0%**	**10.3%**	**-6.2%**	**3.5%**	**$3,742,394**
Clinic		**$10,364,999**	**174,873**	**224.8**	**$13.32**	**$11,245,777**	**189,952**	**251.5**	**$14.89**	**11.9%**	**-0.1%**	**11.8%**	**2.9%**	**15.0%**	**18.3%**	**($661,064)**
ProfessionalClaims		**$2,129,329,268**	**28,519,427**		**$2,736.66**	**$2,547,218,320**	**32,693,007**		**$3,372.73**			**23.2%**			**17.6%**	**$117,484,089**
	E&M - PCP	$313,930,947	3,489,045	4,484.2	$403.47	$386,150,608	3,750,995	4,966.6	$511.30	10.8%	14.4%	26.7%	4.7%	13.4%	18.8%	$24,261,625
	E&M - Specialist	$383,354,821	5,326,472	6,845.7	$492.70	$478,057,826	5,796,474	7,675.0	$632.99	12.1%	14.6%	28.5%	6.5%	15.5%	23.0%	$20,514,597
	Part B Rx	$399,957,455	1,108,657	1,424.9	$514.03	$421,659,380	906,618	1,200.4	$558.31	-15.8%	28.9%	8.6%	-14.7%	25.8%	7.2%	$5,448,853
	Lab	$185,546,506	8,374,103	10,762.6	$238.47	$242,497,222	9,650,325	12,777.8	$321.09	18.7%	13.4%	34.6%	12.4%	9.3%	22.9%	$21,216,978
	Imaging	$171,038,601	2,419,261	3,109.3	$219.82	$202,927,391	2,740,291	3,628.4	$268.69	16.7%	4.7%	22.2%	12.4%	2.8%	15.4%	$11,260,498
	Other Professional	$101,226,284	1,722,835	2,214.2	$130.10	$155,322,653	2,811,086	3,722.1	$205.66	68.1%	-6.0%	58.1%	42.9%	-4.2%	36.9%	$20,827,528
	Proc-Minor	$112,310,080	2,944,841	3,784.8	$144.34	$137,269,034	3,678,200	4,870.2	$181.76	28.7%	-2.1%	25.9%	26.0%	-1.7%	23.9%	$2,255,241
	DME	$99,606,825	$1,347,376	1,731.7	$128.02	$102,708,477	1,348,484	1,785.5	$135.99	3.1%	3.0%	6.2%	0.0%	5.1%	5.1%	$1,079,231
	ASC	$89,821,142	$264,074	339.4	$115.44	$118,996,287	309,335	409.6	$157.56	20.7%	13.1%	36.5%	16.7%	10.1%	28.5%	$6,936,811
	Proc-Ambulatory	$51,642,460	$740,703	952.0	$66.37	$59,674,386	845,595	1,119.6	$79.01	17.6%	1.2%	19.0%	14.4%	-0.1%	14.3%	$2,389,708
	Proc-Major Cardiology	$56,876,253	$55,957	71.9	$73.10	$56,588,700	61,406	81.3	$74.93	13.1%	-9.3%	2.5%	7.7%	-4.1%	3.3%	($457,967)
	Proc-Major Other	$44,294,890	$127,145	163.4	$56.93	$49,047,559	143,602	190.1	$64.94	16.4%	-2.0%	14.1%	10.7%	-0.4%	10.3%	$1,624,089
	Proc-Eye	$23,980,014	$128,143	164.7	$30.82	$30,452,111	149,181	197.5	$40.32	19.9%	9.1%	30.8%	19.0%	5.7%	25.8%	$1,169,515
	Proc-Endocrinology	$20,494,121	$136,695	175.7	$26.34	$24,969,245	167,359	221.6	$33.06	26.1%	-0.5%	25.5%	19.5%	0.1%	19.6%	$1,179,654
	Proc-Major Orthopaedic	$25,184,066	$45,631	58.6	$32.37	$27,980,051	49,710	65.8	$37.05	12.2%	2.0%	14.5%	8.4%	-0.5%	7.8%	$1,622,858
	Proc-Oncology	$33,864,763	$194,757	250.3	$43.52	$35,360,352	199,915	264.7	$46.82	5.8%	1.7%	7.6%	2.7%	3.9%	6.7%	$290,659
	Proc-Dialysis	$16,200,041	$93,732	120.5	$20.82	$17,557,039	84,431	111.8	$23.25	-7.2%	20.3%	11.7%	-14.1%	18.9%	2.1%	$1,507,755
Total Part B Spend		**$3,569,116,363**			**$4,587.11**	**$4,058,675,796**			**$5,374.03**			**17.2%**			**16.2%**	**$25,206,183**
Part B Beneficiaries		**778,075**				**755,239**										
Total Spend		**$7,172,972,157**			**$8,534.28**	**$7,804,512,135**			**$9,574.80**			**12.2%**			**11.2%**	**$34,547,288**

MARYLAND SPENDING PER BENEFICIARY Jan-Sep Paid thru Oct

Provider Type	BETOS	2013 MD Spend	2013 MD Visits	2013 MD Visits per K	2013 MD Spend per Capita	2021 MD Spend	2021 MD Visits	2021 MD Visits per K	2021 MD Spend per Capita	% Util Change 21 vs 13	% Unit Cost Change 21 vs 13	% per Capita Change 21 vs 13	5% NATIONAL % Util Change 21 vs 13	5% NATIONAL % Unit Cost Change 21 vs 13	5%NATIONAL % per Capita Change 21 vs 13	2021 CY Excess Growth 21 vs 13
Inpatient Hospital		**$2,500,569,206**	**993,388**	**1,259.8**	**$3,171.30**	**$2,886,772,575**	**881,099**	**988.1**	**$3,237.37**	**-21.6%**	**30.2%**	**2.1%**	**-22.9%**	**33.1%**	**2.6%**	**($15,435,814)**
SNF		**$452,688,461**	**1,110,330**	**1,408.2**	**$574.11**	**$474,099,957**	**944,219**	**1,058.9**	**$531.68**	**-24.8%**	**23.2%**	**-7.4%**	**-25.9%**	**33.6%**	**-1.0%**	**($32,785,115)**
Home Health		**$195,420,195**	**136,538**	**173.2**	**$247.84**	**$224,451,878**	**61,247**	**68.7**	**$251.71**			**1.6%**	**-68.0%**		**-13.7%**	**$33,764,033**
Hospice		**$116,505,034**	**685,222**	**869.0**	**$147.76**	**$160,511,929**	**879,824**	**986.7**	**$180.01**	**13.5%**	**7.3%**	**21.8%**	**11.0%**	**9.6%**	**21.7%**	**$130,330**
Total Part A Spend		**$3,265,182,896**	**2,925,478**		**$4,141.01**	**$3,745,836,338**	**2,766,389**		**$4,200.77**			**1.4%**			**1.5%**	**($14,326,565)**
Part A Beneficiaries		**788,499**				**891,703**										
Outpatient Hospital		**$919,456,318**	**5,693,673**		**$1,336.54**	**$1,253,887,446**	**5,670,041**		**$1,660.25**			**24.2%**			**65.3%**	**($537,478,192)**
	E&M - ER	$71,526,971	428,067	622.2	$103.97	$90,285,314	252,287	334.0	$119.55	-46.3%	114.2%	15.0%	-14.9%	115.3%	83.2%	($53,567,500)
	E&M - Other	$101,980,858	476,757	693.0	$148.24	$118,560,561	393,556	521.1	$156.98	-24.8%	40.8%	5.9%	8.9%	25.9%	37.1%	($34,949,164)
	Part B Rx	$128,412,994	448,814	652.4	$186.66	$207,735,121	777,255	1,029.2	$275.06	57.7%	-6.6%	47.4%	40.6%	78.8%	151.4%	($146,671,274)
	Lab	$110,675,682	2,845,780	4,136.7	$160.88	$132,535,827	2,639,441	3,494.8	$175.49	-15.5%	29.1%	9.1%	3.8%	-28.0%	-25.3%	$41,730,199
	Imaging	$106,069,365	622,236	904.5	$154.18	$118,432,352	583,987	773.2	$156.81	-14.5%	19.0%	1.7%	6.2%	19.0%	26.4%	($28,767,485)
	Other Professional	$123,857,241	373,401	542.8	$180.04	$178,707,746	474,361	628.1	$236.62	15.7%	13.6%	31.4%	61.7%	72.8%	179.5%	($201,373,474)
	Proc-Minor	$59,059,913	240,328	349.3	$85.85	$72,064,945	264,235	349.9	$95.42	0.1%	11.0%	11.1%	24.0%	34.8%	67.2%	($36,330,155)
	DME	$18,614,167	41,225	59.9	$27.06	$49,914,678	64,669	85.6	$66.09	42.9%	70.9%	144.3%	44.0%	84.8%	166.1%	($4,457,419)
	Proc-Ambulatory	$39,000,217	46,279	67.3	$56.69	$41,142,140	36,449	48.3	$54.48	-28.3%	33.9%	-3.9%	9.2%	13.3%	23.7%	($11,828,386)
	Proc-Major Cardiology	$41,506,014	22,304	32.4	$60.33	$51,035,312	20,897	27.7	$67.58	-14.7%	31.2%	12.0%	0.5%	33.4%	34.0%	($10,046,585)
	Proc-Major Other	$20,231,524	16,164	23.5	$29.41	$39,891,556	24,678	32.7	$52.82	39.1%	29.1%	79.6%	53.4%	29.3%	98.4%	($4,165,915)
	Proc-Eye	$13,437,719	13,454	19.6	$19.53	$9,602,683	7,886	10.4	$12.71	-46.6%	21.9%	-34.9%	5.8%	2.1%	8.0%	($6,336,013)
	Proc-Endocrinology	$31,623,779	41,529	60.4	$45.97	$38,631,830	40,511	53.6	$51.15	-11.1%	25.2%	11.3%	6.9%	34.4%	43.6%	($11,222,557)
	Proc-Major Orthopaedic	$3,093,543	2,279	3.3	$4.50	$37,383,151	12,246	16.2	$49.50	389.5%	124.9%	1000.7%	302.6%	223.8%	1203.7%	($6,891,600)
	Proc-Oncology	$49,930,871	73,789	107.3	$72.58	$67,572,613	76,892	101.8	$89.47	-5.1%	29.9%	23.3%	47.7%	11.3%	64.5%	($22,605,870)
	Proc-Dialysis	$435,461	1,267	1.8	$0.63	$391,618	691	0.9	$0.52	-50.3%	64.9%	-18.1%	-18.6%	-0.7%	-19.1%	$5,007
Total Hospital		**$3,420,025,524**			**$4,507.84**	**$4,140,660,020**	**6,551,140**	**988.1**	**$4,897.62**			**8.6%**			**19.5%**	**($552,914,006)**
ESRD		**$145,519,331**	**774,871**	**1,126.4**	**$211.53**	**$156,392,372**	**1,053,222**	**1,394.6**	**$207.08**	**23.8%**	**-20.9%**	**-2.1%**	**33.0%**	**-26.8%**	**-2.7%**	**$871,751**
Outpatient Other		**$67,825,007**	**1,566,726**	**2,277.4**	**$98.59**	**$89,931,882**	**1,872,470**	**2,479.3**	**$119.08**	**8.9%**	**10.9%**	**20.8%**	**16.4%**	**35.0%**	**57.1%**	**($27,073,137)**
Clinic		**$6,478,117**	**84,712**	**123.1**	**$9.42**	**$11,245,777**	**189,952**	**251.5**	**$14.89**	**104.3%**	**-22.6%**	**58.1%**	**84.4%**	**-4.2%**	**76.7%**	**($1,318,996)**
ProfessionalClaims		**$1,640,873,898**	**29,394,319**		**$2,385.21**	**$2,547,218,320**	**32,693,007**		**$3,372.73**			**41.4%**			**27.3%**	**$259,694,875**
	E&M - PCP	$210,719,756	3,463,707	5,034.9	$306.31	$386,150,608	3,750,995	4,966.6	$511.30	-1.4%	69.2%	66.9%	-11.0%	32.6%	18.0%	$113,119,056
	E&M - Specialist	$341,495,882	5,819,450	8,459.3	$496.41	$478,057,826	5,796,474	7,675.0	$632.99	-9.3%	40.5%	27.5%	-8.4%	35.6%	24.2%	$12,464,620
	Part B Rx	$168,623,793	934,553	1,358.5	$245.12	$421,659,380	906,618	1,200.4	$558.31	-11.6%	157.8%	127.8%	-14.7%	120.0%	87.7%	$74,278,743
	Lab	$157,225,761	8,940,834	12,996.6	$228.55	$242,497,222	9,650,325	12,777.8	$321.09	-1.7%	42.9%	40.5%	-8.5%	38.1%	26.4%	$24,378,074
	Imaging	$167,377,643	2,619,036	3,807.1	$243.30	$202,927,391	2,740,291	3,628.4	$268.69	-4.7%	15.9%	10.4%	-7.2%	13.0%	4.9%	$10,259,012
	Other Professional	$97,575,180	1,893,828	2,752.9	$141.84	$155,322,653	2,811,086	3,722.1	$205.66	35.2%	7.2%	45.0%	17.0%	4.1%	21.9%	$24,790,552
	Proc-Minor	$91,883,812	2,535,593	3,685.8	$133.56	$137,269,034	3,678,200	4,870.2	$181.76	32.1%	3.0%	36.1%	37.3%	-1.1%	35.8%	$328,953
	DME	$93,022,268	$1,282,615	1,864.4	$135.22	$102,708,477	1,348,484	1,785.5	$135.99	-4.2%	5.0%	0.6%	-5.9%	14.1%	7.3%	($6,891,015)
	ASC	$65,251,582	$433,925	630.8	$94.85	$118,996,287	309,335	409.6	$157.56	-35.1%	155.8%	66.1%	-33.1%	151.5%	68.3%	($1,553,379)
	Proc-Ambulatory	$50,812,381	$747,857	1,087.1	$73.86	$59,674,386	845,595	1,119.6	$79.01	3.0%	3.9%	7.0%	27.4%	-6.5%	19.1%	($6,770,736)
	Proc-Major Cardiology	$41,417,260	$71,691	104.2	$60.21	$56,588,700	61,406	81.3	$74.93	-22.0%	59.5%	24.5%	-18.1%	22.2%	0.1%	$11,074,057
	Proc-Major Other	$34,758,527	$77,120	112.1	$50.53	$49,047,559	143,602	190.1	$64.94	69.6%	-24.2%	28.5%	49.0%	-18.9%	20.8%	$2,942,425
	Proc-Eye	$30,968,312	$111,282	161.8	$45.02	$30,452,111	149,181	197.5	$40.32	22.1%	-26.6%	-10.4%	32.2%	-26.1%	-2.3%	($2,760,374)
	Proc-Endocrinology	$26,809,583	$169,311	246.1	$38.97	$24,969,245	167,359	221.6	$33.06	-10.0%	-5.8%	-15.2%	-3.9%	0.6%	-3.3%	($3,502,730)
	Proc-Major Orthopaedic	$23,132,725	$42,399	61.6	$33.63	$27,980,051	49,710	65.8	$37.05	6.8%	3.2%	10.2%	12.6%	2.2%	15.1%	($1,262,836)
	Proc-Oncology	$25,265,312	$160,408	233.2	$36.73	$35,360,352	199,915	264.7	$46.82	13.5%	12.3%	27.5%	-7.7%	6.3%	-1.8%	$8,132,235
	Proc-Dialysis	$14,534,118	$90,710	131.9	$21.13	$17,557,039	84,431	111.8	$23.25	-15.2%	29.8%	10.0%	-15.4%	25.1%	5.8%	$668,219
Total Part B Spend		**$2,780,152,671**			**$4,041.29**	**$4,058,675,796**			**$5,374.03**			**33.0%**			**37.1%**	**($305,303,699)**
Part B Beneficiaries		**687,937**				**755,239**										
Total Spend		**$6,045,335,567**			**$8,182.30**	**$7,804,512,135**			**$9,574.80**			**17.0%**			**18.5%**	**($319,630,264)**

MARYLAND SPENDING PER BENEFICIARY Jan-Sep Paid thru Oct

Provider Type	BETOS	2019 MD Spend	2019 MD Visits	2019 MD Visits per K	2019 MD Spend per Capita	2021 MD Spend	2021 MD Visits	2021 MD Visits per K	2021 MD Spend per Capita	% Util Change 21 vs 19	% Unit Cost Change 21 vs 19	% per Capita Change 21 vs 19	5% NATIONAL % Util Change 21 vs 19	5% NATIONAL % Unit Cost Change 21 vs 19	5%NATIONAL % per Capita Change 21 vs 19	2021 CY Excess Growth 21 vs 19
Inpatient Hospital		**$2,793,328,055**	**953,006**	**1,058.6**	**$3,102.96**	**$2,886,772,575**	**881,099**	**988.1**	**$3,237.37**	**-6.7%**	**11.8%**	**4.3%**	**-8.4%**	**10.0%**	**0.8%**	**$97,803,841**
SNF		**$453,286,248**	**1,013,509**	**1,125.9**	**$503.53**	**$474,099,957**	**944,219**	**1,058.9**	**$531.68**	**-5.9%**	**12.3%**	**5.6%**	**-5.3%**	**14.2%**	**8.1%**	**($11,402,780)**
Home Health		**$250,435,604**	**0**	**0.0**	**$278.20**	**$224,451,878**	**61,247**	**68.7**	**$251.71**			**-9.5%**			**-9.8%**	**$776,970**
Hospice		**$168,117,225**	**978,280**	**1,086.7**	**$186.75**	**$160,511,929**	**879,824**	**986.7**	**$180.01**	**-9.2%**	**6.2%**	**-3.6%**	**0.6%**	**5.6%**	**6.2%**	**($16,415,448)**
Total Part A Spend		**$3,665,167,133**	**2,944,795**		**$4,071.44**	**$3,745,836,338**	**2,766,389**		**$4,200.77**			**3.2%**			**1.1%**	**$70,762,583**
Part A Beneficiaries		**900,214**				**891,703**										
Outpatient Hospital		**$1,273,665,603**	**6,214,190**		**$1,655.85**	**$1,253,887,446**	**5,670,041**		**$1,660.25**			**0.3%**			**11.4%**	**($139,246,358)**
	E&M - ER	$110,126,015	319,195	415.0	$143.17	$90,285,314	252,287	334.0	$119.55	-19.5%	3.7%	-16.5%	-18.3%	5.5%	-13.8%	($2,955,636)
	E&M - Other	$139,268,231	504,113	655.4	$181.06	$118,560,561	393,556	521.1	$156.98	-20.5%	9.0%	-13.3%	-12.0%	0.0%	-12.0%	($1,785,196)
	Part B Rx	$224,533,134	812,371	1,056.1	$291.91	$207,735,121	777,255	1,029.2	$275.06	-2.6%	-3.3%	-5.8%	0.7%	11.9%	12.8%	($40,853,026)
	Lab	$126,035,325	2,940,968	3,823.5	$163.85	$132,535,827	2,639,441	3,494.8	$175.49	-8.6%	17.2%	7.1%	0.4%	15.4%	15.8%	($10,764,051)
	Imaging	$129,749,666	662,471	861.3	$168.68	$118,432,352	583,987	773.2	$156.81	-10.2%	3.5%	-7.0%	-3.1%	5.4%	2.1%	($11,696,063)
	Other Professional	$146,126,091	357,723	465.1	$189.97	$178,707,746	474,361	628.1	$236.62	35.1%	-7.8%	24.6%	47.6%	87.4%	176.6%	($218,099,457)
	Proc-Minor	$81,924,621	305,125	396.7	$106.51	$72,064,945	264,235	349.9	$95.42	-11.8%	1.6%	-10.4%	-4.8%	10.7%	5.4%	($12,694,592)
	DME	$41,963,354	68,507	89.1	$54.56	$49,914,678	64,669	85.6	$66.09	-3.9%	26.0%	21.1%	9.0%	37.3%	49.6%	($11,743,389)
	Proc-Ambulatory	$40,330,433	41,563	54.0	$52.43	$41,142,140	36,449	48.3	$54.48	-10.7%	16.3%	3.9%	-1.7%	4.8%	3.0%	$340,344
	Proc-Major Cardiology	$49,315,261	21,002	27.3	$64.11	$51,035,312	20,897	27.7	$67.58	1.3%	4.0%	5.4%	0.8%	7.3%	8.1%	($1,325,583)
	Proc-Major Other	$39,611,155	26,605	34.6	$51.50	$39,891,556	24,678	32.7	$52.82	-5.5%	8.6%	2.6%	9.0%	-0.5%	8.4%	($2,262,709)
	Proc-Eye	$11,523,204	9,039	11.8	$14.98	$9,602,683	7,886	10.4	$12.71	-11.1%	-4.5%	-15.1%	-0.2%	-2.3%	-2.5%	($1,432,714)
	Proc-Endocrinology	$41,328,227	46,602	60.6	$53.73	$38,631,830	40,511	53.6	$51.15	-11.5%	7.5%	-4.8%	-3.0%	10.9%	7.6%	($5,042,590)
	Proc-Major Orthopaedic	$18,926,100	7,606	9.9	$24.61	$37,383,151	12,246	16.2	$49.50	64.0%	22.7%	101.2%	84.3%	48.2%	173.1%	($13,374,800)
	Proc-Oncology	$72,393,283	90,274	117.4	$94.12	$67,572,613	76,892	101.8	$89.47	-13.3%	9.6%	-4.9%	4.4%	3.8%	8.4%	($9,446,600)
	Proc-Dialysis	$511,505	1,026	1.3	$0.66	$391,618	691	0.9	$0.52	-31.4%	13.7%	-22.0%	-28.3%	31.1%	-6.0%	($80,614)
Total Hospital		**$4,066,993,658**			**$4,758.81**	**$4,140,660,020**	**6,551,140**	**988.1**	**$4,897.62**			**2.9%**			**4.5%**	**($41,442,517)**
ESRD		**$176,598,092**	**1,019,005**	**1,324.8**	**$229.59**	**$156,392,372**	**1,053,222**	**1,394.6**	**$207.08**	**5.3%**	**-14.3%**	**-9.8%**	**-1.9%**	**-13.6%**	**-15.2%**	**$9,303,545**
Outpatient Other		**$91,881,467**	**1,920,851**	**2,497.2**	**$119.45**	**$89,931,882**	**1,872,470**	**2,479.3**	**$119.08**	**-0.7%**	**0.4%**	**-0.3%**	**-0.8%**	**4.6%**	**3.8%**	**($3,689,947)**
Clinic		**$11,661,168**	**188,266**	**244.8**	**$15.16**	**$11,245,777**	**189,952**	**251.5**	**$14.89**	**2.8%**	**-4.4%**	**-1.8%**	**-0.7%**	**5.4%**	**4.7%**	**($738,109)**
ProfessionalClaims		**$2,294,141,035**	**33,590,191**		**$2,982.54**	**$2,506,057,925**	**32,693,007**		**$3,318.23**			**11.3%**			**8.6%**	**$59,387,931**
	E&M - PCP	$284,303,169	3,788,256	4,925.0	$369.61	$344,990,213	3,750,995	4,966.6	$456.80	0.8%	22.6%	23.6%	-6.0%	14.7%	7.8%	$44,129,908
	E&M - Specialist	$437,963,194	6,526,691	8,485.1	$569.38	$478,057,826	5,796,474	7,675.0	$632.99	-9.5%	22.9%	11.2%	-10.7%	23.0%	9.8%	$5,931,715
	Part B Rx	$366,896,507	1,066,311	1,386.3	$476.99	$421,659,380	906,618	1,200.4	$558.31	-13.4%	35.2%	17.0%	-14.8%	35.2%	15.1%	$6,911,352
	Lab	$212,570,144	9,715,142	12,630.3	$276.36	$242,497,222	9,650,325	12,777.8	$321.09	1.2%	14.8%	16.2%	-1.2%	10.3%	9.0%	$14,976,154
	Imaging	$204,557,209	2,921,388	3,798.0	$265.94	$202,927,391	2,740,291	3,628.4	$268.69	-4.5%	5.8%	1.0%	-5.2%	5.4%	-0.1%	$2,202,597
	Other Professional	$118,151,250	2,171,796	2,823.5	$153.60	$155,322,653	2,811,086	3,722.1	$205.66	31.8%	1.6%	33.9%	19.5%	2.2%	22.1%	$13,631,914
	Proc-Minor	$139,500,488	3,848,832	5,003.7	$181.36	$137,269,034	3,678,200	4,870.2	$181.76	-2.7%	3.0%	0.2%	2.2%	2.0%	4.3%	($5,540,154)
	DME	$105,255,594	$1,368,436	1,779.1	$136.84	$102,708,477	1,348,484	1,785.5	$135.99	0.4%	-1.0%	-0.6%	-0.6%	5.4%	4.8%	($5,568,154)
	ASC	$103,329,126	$380,105	494.2	$134.33	$118,996,287	309,335	409.6	$157.56	-17.1%	41.5%	17.3%	-15.1%	34.9%	14.5%	$2,870,034
	Proc-Ambulatory	$60,143,359	$942,546	1,225.4	$78.19	$59,674,386	845,595	1,119.6	$79.01	-8.6%	10.6%	1.1%	-0.6%	4.7%	4.1%	($1,793,500)
	Proc-Major Cardiology	$68,534,285	$66,039	85.9	$89.10	$56,588,700	61,406	81.3	$74.93	-5.3%	-11.2%	-15.9%	-5.6%	2.6%	-3.1%	($8,597,091)
	Proc-Major Other	$50,995,719	$100,589	130.8	$66.30	$49,047,559	143,602	190.1	$64.94	45.4%	-32.6%	-2.0%	25.4%	-21.4%	-1.4%	($330,626)
	Proc-Eye	$33,788,049	$154,737	201.2	$43.93	$30,452,111	149,181	197.5	$40.32	-1.8%	-6.5%	-8.2%	1.5%	-7.1%	-5.7%	($837,711)
	Proc-Endocrinology	$28,026,301	$189,378	246.2	$36.44	$24,969,245	167,359	221.6	$33.06	-10.0%	0.8%	-9.3%	-5.5%	3.7%	-2.0%	($1,988,420)
	Proc-Major Orthopaedic	$30,269,836	$55,425	72.1	$39.35	$27,980,051	49,710	65.8	$37.05	-8.7%	3.1%	-5.9%	-4.6%	0.4%	-4.2%	($488,459)
	Proc-Oncology	$33,885,151	$196,443	255.4	$44.05	$35,360,352	199,915	264.7	$46.82	3.6%	2.5%	6.3%	-1.0%	7.1%	6.1%	$64,621
	Proc-Dialysis	$15,971,653	$98,077	127.5	$20.76	$17,557,039	84,431	111.8	$23.25	-12.3%	27.7%	12.0%	-16.3%	24.0%	3.8%	$1,284,140
Total Part B Spend		**$3,847,947,366**			**$5,002.59**	**$4,017,515,401**			**$5,319.53**			**6.3%**			**8.1%**	**($74,982,938)**
Part B Beneficiaries		**769,191**				**755,239**										
Total Spend		**$7,513,114,499**			**$9,074.03**	**$7,763,351,740**			**$9,520.30**			**4.9%**			**4.9%**	**($4,220,355)**

MARYLAND SPENDING PER BENEFICIARY Jan-Sep Paid thru Oct

Provider Type	BETOS	2019 MD Spend	2019 MD Visits	2019 MD Visits per K	2019 MD Spend per Capita	2020 MD Spend	2020 MD Visits	2020 MD Visits per K	2020 MD Spend per Capita	% Util Change 21 vs 19	% Unit Cost Change 21 vs 19	% per Capita Change 21 vs 19	5% NATIONAL % Util Change 21 vs 19	5% NATIONAL % Unit Cost Change 21 vs 19	5%NATIONAL % per Capita Change 21 vs 19	2021 CY Excess Growth 21 vs 19
Inpatient Hospital		**$2,492,187,612**	**854,439**	**950.1**	**$2,771.35**	**$2,445,822,635**	**748,458**	**820.2**	**$2,680.33**	**-13.7%**	**12.0%**	**-3.3%**	**-11.7%**	**5.0%**	**-7.3%**	**$100,971,887**
SNF		**$405,534,763**	**905,594**	**1,007.0**	**$450.96**	**$390,064,078**	**805,324**	**882.5**	**$427.46**	**-12.4%**	**8.2%**	**-5.2%**	**-3.2%**	**9.6%**	**6.1%**	**($46,424,073)**
Home Health		**$226,340,175**	**0**	**0.0**	**$251.69**	**$191,578,838**	**150,137**	**164.5**	**$209.95**			**-16.6%**			**-13.3%**	**($7,584,187)**
Hospice		**$150,289,426**	**871,941**	**969.6**	**$167.12**	**$158,612,957**	**904,628**	**991.4**	**$173.82**	**2.2%**	**1.7%**	**4.0%**	**4.8%**	**1.6%**	**6.5%**	**($3,876,304)**
Total Part A Spend		**$3,274,351,976**	**2,631,974**		**$3,641.13**	**$3,186,078,508**	**2,608,547**		**$3,491.56**			**-4.1%**			**-5.1%**	**$43,087,323**
Part A Beneficiaries		**899,269**				**912,508**										
Outpatient Hospital		**$1,127,129,959**	**5,496,560**		**$1,466.97**	**$1,014,701,258**	**4,324,878**		**$1,305.20**			**-11.0%**			**-9.1%**	**($22,414,789)**
	E&M - ER	$97,879,497	283,562	369.1	$127.39	$78,585,496	204,884	263.5	$101.08	-28.6%	11.1%	-20.7%	-21.3%	-3.4%	-24.0%	$3,277,299
	E&M - Other	$123,165,276	447,737	582.7	$160.30	$100,183,677	296,263	381.1	$128.87	-34.6%	22.9%	-19.6%	-26.7%	-7.6%	-32.3%	$15,758,916
	Part B Rx	$197,727,008	715,713	931.5	$257.34	$213,662,243	602,561	775.1	$274.83	-16.8%	28.4%	6.8%	-10.8%	20.4%	7.4%	($1,211,616)
	Lab	$111,435,887	2,600,738	3,384.9	$145.03	$101,769,735	2,080,433	2,676.0	$130.91	-20.9%	14.2%	-9.7%	-13.4%	8.0%	-6.4%	($3,761,025)
	Imaging	$115,497,525	587,792	765.0	$150.32	$93,668,068	444,536	571.8	$120.48	-25.3%	7.2%	-19.8%	-18.3%	3.1%	-15.7%	($4,799,159)
	Other Professional	$129,216,339	316,674	412.2	$168.18	$114,869,398	261,580	336.5	$147.76	-18.4%	7.6%	-12.1%	-9.0%	4.4%	-5.0%	($9,314,226)
	Proc-Minor	$72,226,064	268,075	348.9	$94.00	$60,572,639	212,228	273.0	$77.91	-21.8%	5.9%	-17.1%	-16.4%	2.9%	-13.9%	($2,339,525)
	DME	$37,315,188	60,824	79.2	$48.57	$36,938,028	45,517	58.5	$47.51	-26.0%	32.3%	-2.2%	-12.3%	17.4%	3.0%	($1,940,289)
	Proc-Ambulatory	$35,786,046	36,950	48.1	$46.58	$29,735,569	26,285	33.8	$38.25	-29.7%	16.8%	-17.9%	-15.7%	3.5%	-12.7%	($1,860,774)
	Proc-Major Cardiology	$44,020,741	18,638	24.3	$57.29	$36,138,712	14,609	18.8	$46.48	-22.5%	4.7%	-18.9%	-14.1%	4.3%	-10.4%	($3,769,651)
	Proc-Major Other	$35,212,847	23,456	30.5	$45.83	$29,678,971	19,376	24.9	$38.18	-18.4%	2.0%	-16.7%	-7.6%	-6.2%	-13.3%	($1,202,940)
	Proc-Eye	$10,247,329	8,048	10.5	$13.34	$6,500,320	4,763	6.1	$8.36	-41.5%	7.2%	-37.3%	-25.1%	-1.8%	-26.5%	($1,121,963)
	Proc-Endocrinology	$36,793,299	41,494	54.0	$47.89	$28,044,446	28,485	36.6	$36.07	-32.2%	11.0%	-24.7%	-23.7%	9.8%	-16.2%	($3,141,666)
	Proc-Major Orthopaedic	$16,732,931	6,687	8.7	$21.78	$19,734,389	7,244	9.3	$25.38	7.1%	8.9%	16.6%	15.8%	31.5%	52.3%	($6,056,002)
	Proc-Oncology	$63,435,779	79,282	103.2	$82.56	$64,313,295	75,570	97.2	$82.73	-5.8%	6.4%	0.2%	3.1%	-3.0%	0.0%	$142,562
	Proc-Dialysis	$438,204	890	1.2	$0.57	$306,269	544	0.7	$0.39	-39.6%	14.3%	-30.9%	-30.1%	21.9%	-14.7%	($71,851)
Total Hospital		**$3,619,317,571**			**$4,238.32**	**$3,460,523,893**	**5,073,336**	**820.2**	**$3,985.53**			**-6.0%**			**-7.9%**	**$78,557,098**
ESRD		**$156,301,394**	**900,552**	**1,172.1**	**$203.43**	**$157,811,308**	**943,498**	**1,213.6**	**$202.99**	**3.5%**	**-3.6%**	**-0.2%**	**3.3%**	**-2.3%**	**0.9%**	**($1,732,378)**
Outpatient Other		**$85,715,083**	**1,735,296**	**2,258.5**	**$111.56**	**$74,793,817**	**1,379,928**	**1,775.0**	**$96.21**	**-21.4%**	**9.7%**	**-13.8%**	**-10.9%**	**11.8%**	**-0.4%**	**($11,587,315)**
Clinic		**$10,373,250**	**166,607**	**216.8**	**$13.50**	**$8,855,223**	**150,871**	**194.1**	**$11.39**	**-10.5%**	**-5.7%**	**-15.6%**	**-3.3%**	**-9.9%**	**-12.8%**	**($295,248)**
ProfessionalClaims		**$2,034,132,284**	**29,601,474**		**$2,647.44**	**$1,835,103,313**	**24,561,023**		**$2,360.48**			**-10.8%**			**-9.4%**	**($30,333,228)**
	E&M - PCP	$261,920,324	3,357,349	4,369.6	$340.89	$273,306,077	3,066,199	3,944.0	$351.55	-9.7%	14.3%	3.1%	-11.1%	1.2%	-10.1%	$34,989,180
	E&M - Specialist	$385,165,274	5,798,806	7,547.2	$501.30	$330,229,326	4,654,002	5,986.4	$424.77	-20.7%	6.8%	-15.3%	-17.4%	6.2%	-12.3%	($11,715,752)
	Part B Rx	$319,415,488	770,264	1,002.5	$415.72	$340,651,147	707,508	910.1	$438.18	-9.2%	16.1%	5.4%	-8.8%	15.5%	5.3%	$230,411
	Lab	$187,787,762	8,600,103	11,193.1	$244.41	$158,519,958	7,241,590	9,314.8	$203.90	-16.8%	0.3%	-16.6%	-13.7%	-0.2%	-13.9%	($5,029,404)
	Imaging	$180,860,213	2,590,961	3,372.2	$235.39	$147,196,034	2,105,798	2,708.7	$189.34	-19.7%	0.1%	-19.6%	-16.8%	1.8%	-15.3%	($7,768,097)
	Other Professional	$104,665,516	1,928,614	2,510.1	$136.22	$88,024,619	1,504,329	1,935.0	$113.23	-22.9%	7.8%	-16.9%	-17.5%	6.9%	-11.7%	($5,444,351)
	Proc-Minor	$123,255,596	3,405,958	4,432.9	$160.42	$96,637,867	2,548,510	3,278.1	$124.30	-26.0%	4.8%	-22.5%	-20.5%	3.4%	-17.8%	($5,861,718)
	DME	$93,879,366	$1,208,084	1,572.3	$122.18	$86,997,170	1,180,645	1,518.7	$111.90	-3.4%	-5.2%	-8.4%	-0.9%	-0.7%	-1.6%	($6,470,821)
	ASC	$91,465,082	$340,302	442.9	$119.04	$76,932,809	227,179	292.2	$98.96	-34.0%	26.0%	-16.9%	-29.6%	22.6%	-13.7%	($2,934,056)
	Proc-Ambulatory	$52,974,989	$835,938	1,088.0	$68.95	$44,530,520	642,654	826.6	$57.28	-24.0%	9.3%	-16.9%	-14.7%	4.5%	-10.9%	($3,217,474)
	Proc-Major Cardiology	$61,687,736	$58,921	76.7	$80.29	$50,189,885	49,095	63.2	$64.56	-17.7%	-2.4%	-19.6%	-13.8%	5.7%	-8.9%	($6,682,117)
	Proc-Major Other	$45,098,567	$89,283	116.2	$58.70	$38,055,595	109,597	141.0	$48.95	21.3%	-31.3%	-16.6%	11.0%	-21.2%	-12.5%	($1,876,998)
	Proc-Eye	$30,021,326	$137,519	179.0	$39.07	$20,492,570	111,116	142.9	$26.36	-20.1%	-15.5%	-32.5%	-16.4%	-13.2%	-27.4%	($1,550,975)
	Proc-Endocrinology	$24,846,142	$168,322	219.1	$32.34	$17,574,018	117,887	151.6	$22.61	-30.8%	1.0%	-30.1%	-22.6%	3.1%	-20.2%	($2,487,839)
	Proc-Major Orthopaedic	$26,890,637	$49,195	64.0	$35.00	$21,582,737	39,105	50.3	$27.76	-21.4%	1.0%	-20.7%	-13.4%	0.5%	-12.9%	($2,105,141)
	Proc-Oncology	$30,128,521	$174,809	227.5	$39.21	$29,969,800	172,967	222.5	$38.55	-2.2%	0.5%	-1.7%	-4.3%	3.0%	-1.4%	($93,751)
	Proc-Dialysis	$14,069,746	$87,046	113.3	$18.31	$14,213,180	82,842	106.6	$18.28	-5.9%	6.1%	-0.2%	-2.2%	4.1%	1.8%	($282,960)
Total Part B Spend		**$3,413,651,971**			**$4,442.89**	**$3,091,264,919**			**$3,976.27**			**-10.5%**			**-8.5%**	**($66,362,958)**
Part B Beneficiaries		**768,340**				**777,429**										
Total Spend		**$6,688,003,947**			**$8,084.02**	**$6,277,343,427**			**$7,467.83**			**-7.6%**			**-6.9%**	**($23,275,636)**

Note for CY 2016:

During the last six months of CY 2016 (July – December of 2016), Hospitals undercharged their Global Budget Revenue mid-year targets by approximately 1% ($25M dollars). The following slides have been adjusted to 'add back' the undercharge to the period of July – December 2016 to offset the decline in savings for January – June 2017.

Staff has noted which slides in the following presentation include the adjustment for the undercharge.

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Discussion of HSCRC Rate Relief: FY 21 GBR Undercharge

12/8/2021

HSCRC Rate Relief for COVID-19 Pandemic

HSCRC staff have worked since the beginning of the pandemic to provide stabilization of the industry including:

1. Guaranteed FY20 GBRs, including rollover of all undercharge
2. Allowed hospitals to increase corridors to charge for lost revenue
3. Provided a settle up to industry net of federal funding received

$79 M was put into rates at July 1, 2021 to be accrued between January - December 2021 (CY 2021)

RY 2021 Undercharge

FY21 Undercharge was guaranteed as part of the FY22 Update Factor Recommendation, given the uncertainty of the COVID-19 pandemic.

Our current guardrail performance is unfavorable. For this reason, staff has proposed the following settle up in the January rate files.

- Hospitals who were overcharged in FY21 will pay back the entire overcharge + any associated overcharge penalties
- Hospitals who were undercharged in FY21 will get ⅓ of their net undercharge back in January
  - The remaining ⅔, or $150 million in undercharge, will be released pending further Commission discussion
- All unit rate penalties will be assessed, unless the hospital and HSCRC have an agreement on waiver of penalties.

FY21 Undercharge Summary

		Total Impact	Impact for 1/1/2022 rate orders
FY 2021 Actual Undercharge	A	($259 M)	
Unspent CARES Funding & Commission Granted COVID Relief	B	$35 M	
FY 2021 Net Undercharge [1,2]	C = A+B	($224 M)	($74 M)
FY 2021 Actual Overcharge	D	$47 M	$47 M
FY 2021 Net Actual (Under)/Overcharge	E = C+D	($177 M)	($27 M)
FY 2021 Unit Rate Penalties [3]	F	$28 M	$28 M
FY 2021 GBR Overcharge Penalties	G	$10 M	$10 M
FY 2021 Net (Under)/Overcharge	H = E+F+G	($139 M)	$11 M

[1] The net undercharge reflects an adjustment for CARES PRF funding. The impacted hospitals had remaining CARES PRF funds from FY20 settle ups. As a result, their FY 21 undercharges were added to our model and any remaining COVID relief was offset against their undercharges.

[2] Staff is proposing to provide ⅓ of the undercharge amount in the January rate files, which equates to approximately ($74 M) and recover all of the overcharge. ($150 M) represents remaining ⅔ of undercharge.

[3] This amount may change pending agreements with hospitals

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TO: Chief Financial Officers

FROM: Gerard Schmith, Director - Center for Revenue & Compliance

DATE: November 22, 2021

RE: Treatment of RY21 Undercharge in Hospital Rate Orders

The purpose of this memorandum is to inform the industry on how staff intend to account for the RY 21 undercharge in the January rate updates for RY 22.

As part of the RY 22 Update Factor Recommendation, staff recommended the Commission guarantee RY 21 Global Budget Revenues for hospitals. The net statewide undercharge for RY 21 is ($212) million. This includes an overcharge of $47 million and an undercharge of ($259) million.

Maryland's current CY 21 guardrail performance with data through July is unfavorable by 1.47 percentage points. Our Model tests do not allow us to be above the Nation in Total Cost of Care growth by 1 percent in any year or above the Nation in two consecutive years. While our position is projected to become more favorable by the end of the year, we are still projected to have growth above 1 percent. Based on our current guardrail position, staff intend to provide the following in the January rate updates:

- Hospitals who were overcharged in RY21 will pay back the entire overcharge + any associated penalties
- Hospitals who were undercharged in RY21 will get ⅓ of their net undercharge back in January
- All unit rate penalties will be assessed, unless the hospital and the HSCRC staff have an agreement on waiver of penalties.

Future payback of the remaining ⅔ of the RY 21 undercharge will be released pending further review of waiver results and RY 23 update factor.

Staff request hospitals to review the following documents and provide feedback by December 10, 2021:

1) **FY21 Under/Over Charge Settle Up:** This worksheet shows RY 21 GBR overcharge and overcharge penalties, RY 21 undercharge adjusted for the availability of previously received CARES dollars, and RY 21 unit rate penalties by hospital. Please note that if a hospital is undercharged, the intention is to begin the one-time adjustments to fund one-third of the undercharge in the January 2022 rate orders. Please also note that this worksheet DOES NOT include system adjustments for compliance and may not include any additional hospital specific adjustments.
2) **Federal Funding feedback**: Staff is requesting that hospitals provide an update on additional funding that may be received from the Federal government, specifically Provider Relief Funds (PRF) and FEMA funding. This will not be taken into account on January 1, but may be considered in future policy decision making, as was the case with federal PRF funding received in RY 20 and accounted for in the calculation of undercharges in that year. Please fill out the form on the following page and return to your analyst by December 10th.

Federal Funding: PRF & FEMA
Due: Dec 10, 2021

Hospital Name:_____

Have you requested additional funding through the Provider Relief Fund?

_____Yes _____No

If so, how much?_____

Have you requested money under FEMA, if so how much?

_____Yes _____No

If so, how much?_____

Are you aware of any additional funding you will be receiving?

_____Yes _____No

If so, how much?_____

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FY21 Under/Over Charge Settle Up

Please note that these figures have been calculated at a hospital level. They **DO NOT** include any system level adjustments and may not include any hospital specific adjustments.

		A	B	C	D
HospID	HospitalName	FY21 Net Undercharge*	FY21 Actual Over Charge	FY22 Over Charge Penalties	FY21 Unit Price Penalties
1	Meritus	$ (7,707,831)	$ -	$ -	$ 37,544
2	UMMC & Shock Trauma	$ -	$ 475,916	$ -	$ -
3	UM-Capital Region	$ (3,113,098)	$ -	$ -	$ 20,043
4	Holy Cross	$ -	$ -	$ -	$ 920,460
5	Frederick	$ (2,104,458)	$ -	$ -	$ -
6	UM Harford Memorial	$ (5,430,017)	$ -	$ -	$ 464,077
8	Mercy	$ (7,692,643)	$ -	$ -	$ -
9	Johns Hopkins	$ -	$ 11,213,100	$ -	$ 7,631
10	UM-Dorchester	$ (6,128,385)	$ -	$ -	$ 440,222
11	St. Agnes	$ (30,940,087)	$ -	$ -	$ 95,509
12	Sinai	$ (3,311,344)	$ -	$ -	$ -
13	Grace Medical	$ (6,643,899)	$ -	$ -	$ 1,105,045
15	MedStar Franklin Sq	$ -	$ 420,378	$ -	$ -
16	Adventist White Oak	$ -	$ 14,189,486	$ 5,797,954	$ -
17	Garrett	$ (1,321,246)	$ -	$ -	$ 1,514
18	MedStar Montgomery	$ -	$ 156,084	$ -	$ -
19	Peninsula	$ (443,650)	$ -	$ -	$ -
22	Suburban	$ (4,261,812)	$ -	$ -	$ 112,113
23	Anne Arundel	$ (28,372,101)	$ -	$ -	$ 6,913,678
24	MedStar Union	$ -	$ 383,915	$ -	$ -
27	Western Maryland	$ -	$ 1,305,493	$ -	$ -
28	MedStar St. Marys	$ -	$ 490,619	$ -	$ -
29	Bayview	$ -	$ 2,169,362	$ -	$ 5,084,024
30	UM-Chestertown	$ (13,712,459)	$ -	$ -	$ 528,567
32	ChristianaCare, Union	$ -	$ 77,884	$ -	$ 594,507
33	Carroll	$ (399,955)	$ -	$ -	$ -
34	MedStar Harbor	$ -	$ -	$ -	$ -
35	UM-Charles Regional	$ -	$ 239,666	$ -	$ -
37	UM-Easton	$ -	$ 1,809,315	$ 116,383	$ 1,868,804
38	UMMC Midtown	$ -	$ 120,127	$ -	$ 422,957
39	Calvert	$ -	$ -	$ -	$ 887
40	Northwest	$ (14,935,263)	$ -	$ -	
43	UM-BWMC	$ (12,018,214)	$ -	$ -	$ 38,561
44	GBMC	$ (4,567,457)	$ -	$ -	$ 702,308
45	McCready	$ (594,227)	$ -	$ -	$ 221,003
48	Howard County	$ (7,878,284)	$ -	$ -	$ 89,191
49	UM-Upper Chesapeake	$ (135,617)	$ -	$ -	$ 1,471
51	Doctors	$ (29,250,700)	$ -	$ -	$ 579,490
55	UM-Laurel	$ (8,650,421)	$ -	$ -	$ 83,714
60	Ft. Washington	$ -	$ 7,859,723	$ 3,708,182	$ 156,096
61	Atlantic General	$ (141,474)	$ -	$ -	$ 1,232,678
62	MedStar Southern Maryland	$ -	$ -	$ -	$ 19,218
63	UM-St Joe	$ (766,442)	$ -	$ -	$ 3,028
65	Holy Cross Germantown	$ -	$ 34,522	$ -	$ 4,852,532
87	Germantown ED	$ (3,221,744)	$ -	$ -	$ 8,413
88	UM-Queen Anne's ED	$ -	$ 170,593	$ 52,882	$ 714,570
333	UM-Bowie ED	$ (4,151,250)	$ -	$ -	$ 75,977
2001	UMROI	$ (5,309,389)	$ -	$ -	$ 149,299
2004	MedStar Good Sam	$ -	$ 640,902	$ -	$ -
5033	Levindale	$ (11,297,035)	$ -	$ -	$ 2,183
5050	Shady Grove	$ -	$ 5,273,512	$ 664,320	$ 2,384
	Statewide	$ (224,500,502)	$ 47,030,596	$ 10,339,722	$ 27,549,697

*Statewide Undercharge is ($259 M) - this amount has been adjusted by approximately $35 M to account for unspent CARES funds

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TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: December 8, 2021

RE: Hearing and Meeting Schedule

January 12, 2022 To be determined - GoTo Webinar

February 9, 2022 To be determined - GoTo Webinar

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

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