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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 September 9, 2021 Public Meeting:

1. Draft Recommendation on the Medicare Performance Adjustment

WRITTEN COMMMENTS ON THE AFOREMENTIONED STAFF DRAFT RECOMMENDATIONS ARE DUE IN THE COMMISSION'S OFFICES ON OR BEFORE SEPTEMBER 17, 2021, UNLESS OTHERWISE SPECIFIED IN THE RECOMMENDATION.

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587th Meeting of the Health Services Cost Review Commission
September 9, 2021

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

EXECUTIVE SESSION
11:30 am

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

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

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on July 14, 2021 and the Public Meetings on August 26 & 27, 2021

2. Docket Status – Cases Closed

   2558N – Adventist HealthCare Rehabilitation - Rockville Campus
   2559N – Adventist HealthCare Rehabilitation – White Oak Campus
   2560N – Johns Hopkins Bayview Medical Center
   2561N – Sheppard and Enoch Pratt Hospital

3. Docket Status – Cases Open

   2555N - UM Shore Medical Center at Easton
   2562R – Sheppard and Enoch Pratt Hospital
   2563A – Johns Hopkins Health System
   2564N – UM Capital Regional Health Bowie Health Center
   2565A - University of Maryland Medical System
   2566A – University of Maryland Medical System
   2567A – Johns Hopkins Health System
   2568A – Johns Hopkins Health System

4. Draft Recommendation on Traditional Medicare Performance Adjustment

5. Policy Update and Discussion

a. Commission Retreat Update
b. Maryland Commercial Health Insurance Market Data Report

6. Legal Update

7. Hearing and Meeting Schedule

Cases Closed

The closed cases from last month are listed in the agenda

Introduction

On April 27, 2021, UM Shore Medical Center at Easton ("the Hospital" or "SMCE") submitted a partial rate application to obtain a new Psychiatric Acute (PSY) rate. SMCE is redesigning its healthcare delivery on the Eastern Shore as a result of the transition of UM Shore Medical Center at Dorchester (SMCD) to a new freestanding medical facility. Patients requiring Psychiatric Acute inpatient services have been admitted to SMCD. With the conversion of SMCD to a freestanding medical facility as of July 2021, inpatient Psychiatric services will be relocated to SMCE. Establishing Psychiatric Acute services at SMCE will allow patient care to continue uninterrupted during SMCD transition. The Hospital requests to establish a unit rate for Psychiatric Acute services effective August 1, 2021.

Staff Evaluation

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. Based on the information received, the Hospital requested a rate for PSY service of $1,397.98 per patient days, while the statewide median rate for PSY service is $1,412.42 per patient days.

Service	Service Unit	Unit Rate	Projected Volumes	Approved Revenue
Psychiatric Acute	Patient Days	$1,397.98	3,711	$5,187,921

Recommendation

After reviewing the Hospital's application, the staff recommends:

1. That the PSY rate of $1,397.98 per patient days be approved effective August 1, 2021;

2. That the PSY rate center not be rate realigned until a full year of cost data has been reported to the Commission;

3. That no change be made to the Hospital's Global Budget Revenue for the PSY Services; and

4. That the Hospital's actual Global Budget Revenue will be determined at a later date.

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

AS OF SEPTEMBER 1, 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
2555N	University of Maryland Shore Medical Center at Easton	4/27/2021	5/27/2021	9/14/2021	I/P PSYCH SERVICES	WH	OPEN
2562R	Sheppard and Enoch Pratt Hospital	6/28/2021	7/28/2021	11/25/2021	FULL	JS	OPEN
2563A	Johns Hopkins Health System	7/21/2021	N/A	N/A	ARM	DNP	OPEN
2564N	UM Capital Regional Health Bowie Health Center	7/30/2021	8/29/2021	12/27/2021	RESP. THERAPY	WH/WM	OPEN
2565A	University of Maryland Medical System	8/26/2021	N/A	N/A	ARM	DNP	OPEN
2566A	University of Maryland Medical System	8/26/2021	N/A	N/A	ARM	DNP	OPEN
2567A	Johns Hopkins Health System	8/31/2021	N/A	N/A	ARM	DNP	OPEN
2568A	Johns Hopkins Health System	9/1/2021	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

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IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF THE	*	**COST REVIEW COMMISSION**	
UM SHORE MEDICAL	*	**DOCKET:**	**2021**
CENTER AT EASTON	*	**FOLIO:**	**2365**
EASTON, MARYLAND	*	**PROCEEDING:**	**2555N**

Staff Recommendation
September 9, 2021

Introduction

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1. That the PSY rate of $1,397.98 per patient days be approved effective August 1, 2021;

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4. That the Hospital's actual Global Budget Revenue will be determined at a later date.

IN RE: THE FULL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
SHEPPARD AND ENOCH	*	DOCKET: 2021
PRATT HOSPITAL	*	FOLIO: 2472
TOWSON, MARYLAND.	*	PROCEEDING: 2562R

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STAFF RECOMMENDATION

September 9, 2021

List of Abbreviations

CON	Certificate of Need
ECMAD	Equivalent Case-Mix Adjusted Discharge
EIPA	Equivalent Inpatient Admission
EIPD	Equivalent Inpatient Day
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commissions
ICC	Interhospital Cost Comparison
MHCC	Maryland Health Care Commission
PAU	Potentially Avoidable Utilization
TCOC	Total Cost of Care

Key Methodology Concepts and Definitions

Certificate of Need (CON): With certain exceptions, a CON is required to build, develop, or establish a new healthcare facility, move an existing facility to another site, change the bed capacity of a healthcare facility, change the type or scope of any health care service offered by a healthcare facility, or make a healthcare facility capital expenditure that exceeds a threshold established in Maryland statue. The Maryland CON program is intended to ensure that new healthcare facilities and services are developed in Maryland only as needed and that, if determined to be needed, that they are: the most cost-effective approach to meeting identified needs; of high quality; geographically and financially accessible; financially viable; and will not have a significant negative impact on the cost, quality, or viability of other health care facilities and services.

Equivalent Case-mix Adjusted Discharges (ECMADS): Often referred to as case-mix, ECMADS are a hospital volume statistic that account for the relative costliness of different services and treatments, as not all admissions or visits require the same level of care and resources.

Interhospital Cost Comparison (ICC) Standard: Each hospital's ICC revenue base is built up from a peer group standard cost, with adjustments for various social goods (e.g., trauma costs, residency costs, uncompensated care mark-up) and costs beyond a hospital's control (e.g., differential labor market costs) that are not included in the peer group standard. The revenue base calculated through the ICC does not include profits. Average costs are reduced by a productivity factor ranging from 0 percent to 4.5 percent depending on the peer group. The term "Relative efficiency" is the difference between a hospital's actual revenue base and the ICC calculated cost base.

Payer Differential: The HSCRC has employed a differential, whereby public payers (Medicare and Medicaid) pay 7.7 percent (previously 6 percent, prior to July 1, 2019) less than other payers. Commercial payers also pay approximately 2 percent less than billed charges for prompt pay practices.

Potentially Avoidable Utilization (PAU): PAU is the measurement of hospital care that is unplanned and may be prevented through improved care, care coordination, or effective community-based care. PAU includes readmissions and hospital admissions for ambulatory-care sensitive conditions as defined by the Agency for Healthcare Research and Quality's Prevention Quality Indicators (PQIs) measurement approach. PAU may be expressed as a percent of hospital revenue received from PAU events at that hospital or the rate of PAU events for a hospital's attributed population.

Total Cost of Care (TCOC) Model: The agreement between the State of Maryland and the federal government, which obligates the State to obtain certain levels of health care savings to the federal Medicare program (along with other requirements) through State flexibility provided

through the agreement. For example, Medicare participates in the State's system for all-payer hospital global budgets.

Overview

Sheppard and Enoch Pratt Hospital ("Sheppard Pratt," or "the Hospital") submitted a full rate application on June 25, 2021, requesting an increase to its permanent revenue totaling $21.9 million, a 13.3 percent increase over Sheppard Pratt's approved revenue base that was effective for the one-year period from July 1, 2020 through June 30, 2021. Statute requires that the effective date of the newly proposed rates be no sooner than 30 days from the filing of the full rate application. However, in this instance both staff and hospital have been working on this application since February 2021. Given the special nature of this hospital, the staff requests that the Commission waive the 30-day requirement and allow for an effective date of July1, 2021.

A portion of the requested increase (8.55 percent) is related to the efficiency of the Hospital's costs relative to Maryland peers; a second portion (1 percent) is related to the hospital's additional request to provide funding in rates for population health infrastructure; and the remainder is related to the hospital's request to increase markup to account for the fact that Medicare will not increase its rates in line with any rate determination made by the Commission.[1] No capital rate support was requested, but Sheppard Pratt did note further expected deterioration in operating margin related to the opening of its new Elkridge facility on June 17, 2021. The requested revenue increases are exclusive of HSCRC-approved adjustments, including: the update factor, productivity adjustments, market shift adjustments, demographic adjustments, quality adjustments, population health, and other routine adjustments.

Following the submission of additional required information not included with its original submission, HSCRC staff accepted Sheppard Pratt's full rate application and considered it complete on June 28, 2021.

Request for General Revenue Increase

Sheppard Pratt justifies the requested $21.9 million in additional operating revenue based on its objective to improve its regulated solvency, which decreased from 6.6 percent in Fiscal Year 2014 to -2.2 percent in Fiscal Year 2019.[2] The Hospital states that several recent cost increases as well as anticipated cost increases and Commission productivity adjustments in the annual Update Factor contribute to the need for additional revenue:

1. Greater malpractice exposure --$6 million
2. Additional staffing related to increased patient acuity --$10 million
3. Additional Operating Costs for New Elkridge Facility -- $7 million

[1] Sheppard Pratt is reimbursed for Medicare services according to the Inpatient Prospective Payment System and Outpatient Prospective Payment System.

[2] Regulated margin was -1.3 percent in Fiscal Year 2020, but due to the COVID Public Health Emergency analyses were restricted to Fiscal Year 2019 and prior years.

4. Annual Update Factor Productivity Adjustment - $4.8 million[3]

Additional requests included in the Sheppard Pratt application that are inclusive of the $21.9 million in additional operating revenue are as follows:

1) Sheppard Pratt requested for the rate increase to become effective July 1, 2021.

2) Sheppard Pratt requested applying Fiscal Year 2020 and 2021 inflation to cost base determined by the Maryland cost comparison model because the cost analysis utilized Fiscal Year 2019 costs to remove the confounding elements of the COVID public health emergency;

3) Sheppard Pratt requested an increase in its markup[4] to recognize that the effective rate increase will not be equal to the rate determination made by the Commission, since the HSCRC has no rate setting authority over Medicare reimbursement at the Hospital and;

4) Sheppard Pratt requested an additional 1 percent irrespective of its efficiency analysis for purposes of population health investments.

Status of CON Review and Approval

Sheppard Pratt received initial CON approval by MHCC for its new Elkridge Facility on September 20, 2016. Additionally, MHCC approved project changes after CON approval on March 18, 2021, and again on June 17, 2021.

Sheppard Pratt did not submit a funding request for additional capital dollars related to the approved CON for its new Elkridge Facility. The reason a request was not made was because any additional capital costs recognized in the Commission's Capital Financing Policy would be accounted for in a full rate review, which the Hospital has also pursued. Thus, to avoid the complexity of applying two methodologies that would result in the same net rate determination as applying a full rate review methodology, Sheppard Pratt elected to submit a full rate application for operating support only.

[3] Starting in Fiscal Year 2013, the Commission started applying productivity adjustments to the annual inflation provided to non-waiver hospitals with the expectation that hospitals that maintain an incentive to increase utilization will become more efficient in the delivery of care as volumes grow. During this time period $4 million of the Update Factor Productivity Adjustment was offset by volume growth since 2015 funded at a 100 percent variable cost factor.

[4] Markup in rates is a historical rate setting mechanism that supports the funding of uncompensated care as well as the discounts individual payers are afforded for promptly paying and for avoiding bad debts.

Background

Full Rate Applications

In January 2018, the Commission updated its regulations for full rate applications to incorporate new requirements for efficiency. In January of 2021, the Commission approved a policy to evaluate full rate applications. The revised methodology utilizes updated but historical evaluations of hospital cost-per-case efficiency and incorporates new measures of efficiency based on the move from volume-based payments under the charge-per-case system, employed prior to 2014, to a per-capita system with value-based requirements.

Due to the unique nature of Sheppard Pratt, which is the single largest psychiatric facility in the State and is not part of Global Budget Revenue methodologies, the evaluation contained in this recommendation addresses cost per unit.[5] Staff believes the cost-per-case efficiency methodology is an effective tool for assessing general acute care facilities, but is concerned that the requisite casemix methodology is not sufficient to determine varying levels of acuity for facilities, such as Sheppard Pratt, that serve patients exclusively with behavioral health needs.[6]

Background on Sheppard Pratt

Sheppard Pratt is a psychiatric teaching hospital with 414 licensed acute care beds and an average daily census of 282 comprising 4,429 adult admissions, and 2,123 adolescent and child admissions. The Hospital also provides care for over 20 thousand partial hospitalizations and 7 thousand outpatient visits. The Hospital's total approved revenue for Fiscal Year 2021 was $164,821,768. Approximately 14 percent of its revenues came from Baltimore City residents in FY 2019, while 26 percent came from Baltimore County, 26 percent came from other central Maryland counties, 13 percent came from out-of-state residents, and the remaining 21 percent was derived from all other counties in Maryland.[7] The Hospital recently relocated a portion of its operations to Elkridge, Maryland.

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[5] The units used in the analysis include admissions, equivalent inpatient discharge, equivalent inpatient admission, patient days, hours, relative value units, gross square feet, patient meals, pounds of laundry, and hours worked.

[6] Sheppard Pratt's volume is not included in the development of equivalent casemix adjusted discharges or ECMADS, the Commission's casemix methodology, because the Hospital is not affected by financial methodologies that utilize ECMADS. Thus, applying casemix weights from this methodology would be inappropriate, especially given the differential overhead levels at general acute care facilities and psychiatric facilities. Moreover, of the $453 million in statewide inpatient psych services used in casemix weight development, of which there are 60 APR-DRG SOI cell combination, $4.8 million are in APR-DRG SOI cells that have fewer than 30 cases, $1.6 million are in cells that required use of national weights due to small cell size, $13.8 million are in cells defined as teaching dominance where academic medical centers constitute more than 70 percent of cases, $33.9 million are in cells that had highly variable charge per case statistics defined by a coefficient of variation greater than 0.90, and $20.1 million are deemed outlier charges and not included in weight development (not all mutually exclusive).

[7] Source: HSCRC hospital discharge data, Fiscal Year 2019

From Fiscal Years 2014 through 2019, Sheppard Pratt had an average operating margin of 3.2 percent based upon its annual filing of schedule RE, which includes both regulated and unregulated operations, specifically the combined operating margins measured: $10.8 million (5.3%) in FY 2014; $10.1 million (4.8%) in FY 2015; $11.6 million (5.3%) in FY 2016; $8.8 million (3.9%) in FY 2017; $1.1 million (0.5%) in FY 2018; and -$1.6 million (-0.7%) in FY 2019.[8]

As part of the Elkridge project CON, Sheppard Pratt provided projected financial statements for the project's operations for Fiscal Year 2022 through 2026. Such projections included a placeholder estimate of $1,080,000 for an assumed increase in its permanent revenue effective Fiscal Year 2022. Furthermore, the assumption for award value was inflated by 2.89 percent each year, which was derived from reference to the average increase for the most recent 5-year history of the hospital's rate order file. The P&L projections for Sheppard Pratt's Elkridge project reflect a positive operating margin in four of the five years presented, and a cumulative operating margin of $3.1 million over the 5-year projection (averaging 1.4 percent of operating revenues. The fifth and final year presented (Fiscal Year 2026) reflects a $358 thousand positive margin (0.7 percent of operating revenues). If one were to remove the assumption for the award, it would imply that the project would not generate a cumulative positive margin in its first 5 years, but rather it may lose $2.6 million. The projections were built so as to afford planned FTE staffing and planned increases to salaries and benefits packages, and should the award be omitted, then the expense plans would need to be amended.

Staff Analyses

HSCRC staff has reviewed costs, financial trends, system financial statements, unregulated losses, volume trends, and quality performance. Recently, HSCRC staff collaborated with Sheppard Pratt and its consultants to assess Fiscal Year 2019 cost per unit relative to Maryland hospital peers. While the basis for staff's recommendation is the assessment of cost per unit relative to Maryland hospital peers, staff also conducted a separate cost analysis of Sheppard Pratt's costs relative to national psychiatric facility peers based on the Fiscal Year 2019 Medicare cost report to support the rate recommendation described herein.

Financial Background and Performance

Hospital Rate History

Sheppard Pratt is not a hospital that has entered into a GBR agreement. The HSCRC regulates the rates of Sheppard Pratt because two thirds of its revenue are not from public payer

[8] The combined operating margin for FY 2020 was -$6.2 million (-2.8 %)

reimbursements.[9] Since Fiscal Year 2014 Sheppard Pratt has received the following adjustments:

Table 1. Sheppard Adjustments, July 1, 2014-2020

	Year Beginning July 1,						
Component:	2014	2015	2016	2017	2018	2019	2020
Update Factor Inflation	1.80%	2.70%	2.70%	2.80%	2.68%	2.57%	2.96%
Productivity/ACA		-0.70%	-0.80%	-0.75%	-0.40%	-0.80%	-0.50%
Infrastructure		0.30%	0.30%				
PAU	NA	NA	NA	NA	NA	NA	NA
Net Permanent Adjustment	**1.80%**	**2.30%**	**2.20%**	**2.05%**	**2.28%**	**1.77%**	**2.46%**
Net Quality Adjustments	NA	NA	NA	NA	NA	NA	NA
Uncompensated Care Funding	7.17%	4.62%	4.32%	4.69%	4.05%	3.75%	3.39%
Mark Up Change	1.03%	-2.60%	-0.21%	0.41%	-0.72%	-0.03%	-0.45%

The mark up reductions resulted from changes in uncompensated care that occurred primarily as a result of Medicaid expansion under the Affordable Care Act (ACA). As uncompensated care was reduced, the HSCRC removed the uncompensated care from hospitals' rates. These adjustments generally reduce hospital rates, but hospital expenses are reduced at the same time.

HSCRC staff has worked with Sheppard Pratt during the COVID Public Health Emergency to provide temporary enhanced rates in order to provide financial stability.

Revenue Growth & Cost Growth

Sheppard Pratt's gross revenue has increased by $20 million or 14 percent from Fiscal Year 2014 to Fiscal Year 2019. During this same period, the State offset the annual update factor amount for non-GBR hospitals by a productivity adjustment. Non-GBR hospitals are under a 100 percent variable cost factor system because unlike GBR hospitals there is no incentive to reduce volume; therefore, the Hospital should become more efficient and profitable as volumes increase and reimbursement is not scaled for covered fixed costs. In addition, Sheppard Pratt is not included in some of the volume incentives GBR hospitals were held to, which was the rationale for the productivity offset. The annual compounded impact of these adjustments amount to a reduction of approximately $4.8 million in permanent revenue since 2014. During this same time period, however, inpatient days grew by 7 percent, which offset the productivity adjustment by a

[9] Md. HEALTH-GENERAL Code Ann. § 19-220, http://www.dsd.state.md.us/comar/comarhtml/10/10.37.03.10.htm

decrease of 3.5 percent.[10] This increase in inpatient days was despite the fact that admissions fell 12 percent from 9,139 to 7,958, due in large part to better care coordination and care moving to the most appropriate setting. It also suggests that acuity of patients at Sheppard Pratt has increased since 2014.

Table 2. Sheppard Pratt Update Factor Impact FY 14-FY 20

Fiscal Year	Gross Update Factor	Offset	Population Health Infrastructure	Net Update	Total Net Revenue (in thousands)	Compounded Impact of Offset (in thousands)
2019	2.57%	-0.80%	0.00%	1.77%	138,997	4,861
2018	2.68%	-0.40%	0.00%	2.28%	135,552	3,627
2017	2.80%	-0.75%	0.00%	2.05%	131,591	2,983
2016	2.70%	-0.80%	0.30%	2.20%	125,532	1,890
2015	2.70%	-0.70%	0.30%	2.30%	120,800	846
2014	1.80%	0.00%	0.00%	1.80%	117,894	-

According to operating margin data submitted by Sheppard Pratt, the hospital has seen significant margin erosion since 2014. Overall margin at Sheppard Pratt decreased from 6.6 percent in 2015 (compared to prior year) to -2.2 percent in 2019. This amounts to a $10.8 million dollar margin deterioration since 2014. 2020 is not accounted for in this comparison due to the confounding factors associated with the COVID-19 pandemic.

[10] The Update Factor Offsets total -3.45 percent from FY2014-FY2019 as shown in Table 2.

Table 3. Sheppard Pratt Margin Decline FY 2014 compared to FY 2019

FY 2014 Operating Margin		7,777.6	6.6%
FY 2019 Operating Margin		(3,000.5)	-2.2%
Change		(10,778.1)	
Impact of Inflation			
Infrastructure Funding	835.4		
Productivity Adjustment	(5,591.7)	(4,756.3)	
Impact of Volume Change			
Incremental Net Revenue (@100%)	8,091.3		
Incremental Expense (@50% VCF)	(4,045.7)	4,045.7	
Net Impact of Inflation & Volume Change		(710.6)	6.6%
Growth in Malpractice Costs		(1,920.7)	17.8%
Staffing mix changes		(8,806.4)	81.7%
Other		659.7	-6.1%
Total Change		(10,778.1)	100.0%

In addition to inflation not being adequate due to Commission-approved productivity adjustments as well as marginal deterioration in profit due to changes in markup, cost pressures that contributed to margin erosion include: greater malpractice exposure and, clinical and direct care staffing cost increases due to increased patient acuity.

Malpractice insurance costs for excess liability coverage have steadily increased in recent years in line with state and national trends. Sheppard Pratt has also experienced an increase in pre-trial claim payouts within the self-insured trust, which has led to an increase in reserve requirements to maintain the trust. As a result, the increase in malpractice costs over the most recent 12 month period have increased by $6 million since 2019, while excess liability coverage has increased to $1.4 million from $647 thousand. Since 2014, malpractice cost pressures have contributed to 17.8 percent of the Hospital's margin deterioration ($1.9 million).

The most significant cost pressure experienced by Sheppard Pratt has been acuity related labor premiums. Specifically, the Hospital has had to increase FTEs as a direct response to growing increases in patient acuity, which has led to a margin deterioration since 2014 of 81.7 percent

($8.8 million). Annual filing data from the C & D schedules shows FTEs increased 166.88 from 2014 to 2019, which is an increase of 15.7 percent. During this same time, using Equivalent Inpatient Day data divided by Equivalent Inpatient Admission data, days per admission rose by 22.8 percent, which suggests Sheppard Pratt did indeed experience higher intensity cases.

Table 4. Sheppard Pratt's FTE Increase and Acuity Increase 2014-2019

	2014	2015	2016	2017	2018	2019
FTEs	1,062.9	1,113.4	1,138.1	1,195.9	1,218.5	1,229.8
YOY Increase		4.8%	2.2%	5.0%	2.0%	0.9%
Cumulative Increase		4.8%	7.1%	12.4%	14.6%	**15.7%**
EIPD/EIPA	11.13	11.30	11.55	12.20	12.95	13.67
YOY Increase		1.6%	2.2%	5.6%	6.2%	5.5%
Cumulative Increase		1.6%	3.8%	9.7%	16.4%	**22.8%**

Sheppard Pratt anticipates further margin deterioration due its continued investment in infrastructure. Sheppard Pratt has recently opened a new facility in Elkridge to replace the Ellicott City leased location. The new location is larger in square footage, which requires additional staffing needs and is anticipated to cause an increase in utilities and maintenance costs. While this facility will be larger, licensed beds are not increasing. As a result, volume increase is not expected to be a driver of efficiency gains and increased margin position.

Staff worked with Sheppard Pratt to develop a model reflecting projected Profit & Loss operating performance for a 5-year period beginning with Fiscal Year 2022. The model included and separately presented three (3) components of service: the regulated hospital operations; the unregulated hospital operations as reported to the HSCRC on schedules RE (Statement of Revenue and Expense) and RE-R (Reconciliation of the Audited Financials to Schedule RE) which are not part of the hospital proper; and the unregulated costs for the labor component from the professional association for those professionals who directly service the hospital's patients. The model projected growth in gross patient service revenues at the rate of 2.89 percent annually, assuming no change in the current occupancy rate of 87.4 percent on 334 beds. Contra revenues that account for contractual disallowances, bad debts and charity write-offs were

projected at a flat 14.5 percent which is in line with recent history. The projections on operating expenses assumed the opening of the Elkridge facility in Fiscal Year 2022; staffing and compensation packages consistent with the intention to get back to market rates (>20 percent raises) and mitigated turnover, which is consistent with the planning projections included in the Elkridge CON; the acquisition and implementation of electronic medical records systems to be in place by Fiscal Year 2023; and other operating expenses set at 2 percent annual inflation except for interest and depreciation.

When no award for revenue through the full rate application ($0) is applied, the model reflects an average regulated operating margin of -9.7 percent (-$15.2 million) over the 5-year period. When the HSCRC proposed award to increase revenue ($14.1 million) is applied and effective beginning July 1, 2022 and rolls though the 5-year projections, the effect is to drive an average regulated operating margin of -1.8 percent (-$3.1 million) over the 5-year period. When coupled with the labor element found in the professional association the projected operating loss following the HSCRC proposed award grows to an average combined operating margin of -5.6 percent (-$10.9 million) over the 5-year period. Given that losses persist even after applying rate relief afforded by current regulatory methodologies, it is evident that Sheppard Pratt must supplement the award with operational efficiencies, philanthropy, and some level of compromise on their planned spending.

The combination of low revenue growth due to low updates, increased cost pressures since 2014, and anticipated cost growth due to the new Elkridge facility have led to Sheppard Pratt's financial issues. The following sections of this report detail the steps HSCRC staff and the Hospital took to analyze an appropriate funding level based on peer group comparisons and proven efficiency.

Maryland Cost Comparison Model

HSCRC staff, in conjunction with Sheppard Pratt, developed an alternative cost model to the standard Inter-Hospital Comparison methodology. The Maryland cost comparison model that was developed first established a criteria for Maryland peers. Specifically, to be considered comparable to Sheppard Pratt, general acute care facilities had to have at least 20 percent of its inpatient revenue related to acute inpatient psychiatric services, as defined by the service line IP psych in the market shift methodology. Secondly, additional exclusions were applied: a) hospitals deemed high tech, i.e. 5 percent or more of its charges were attributable to cardiothoracic surgery, invasive cardiology, and cardiology service lines, were excluded; b) hospitals with higher supply costs, i.e. 25 percent or more of hospital charges were attributable to surgical service lines, were excluded ; and c) hospitals with high drug costs, i.e. hospitals that had 5 percent or more of their charges attributable to the oncology drug service line in the market shift methodology, were excluded. This exercise resulted in 6 hospitals selected as Sheppard Pratt peers:

Table 5. List of Maryland Peer Hospitals

Adventist HealthCare Shady Grove Medical Center	MedStar Harbor Hospital Center
Northwest Hospital	UM Harford Memorial Hospital
UM Midtown	UM Shore Dorchester

While these hospitals did provide better comparability to Sheppard Pratt by eliminating unique costs that Sheppard Pratt does not incur (e.g. supply costs for transaortic valve replacements), HSCRC staff also worked with the Hospital to adjust for the higher overhead costs incurred at general acute care facilities. Specifically, the Maryland cost comparison model discounted all overhead cost centers for Sheppard Pratt's Maryland peers by the differential overhead these hospitals incur for medical/surgical inpatient discharges versus psychiatric inpatient discharges. In effect, the costs for the patient related overhead (e.g. dietary services, laundry) for Sheppard Pratt's selected peers was reduced by 34.1 percent, and other overhead costs (e.g. general accounting, medical records) were reduced by 48 percent. Without this adjustment, the Maryland cost comparison model would have indicated Sheppard Pratt's costs were 455 percent more efficient than otherwise determined.

The final component of the Maryland cost comparison model was calculating the average cost per unit for the selected peers (inclusive of the overhead discount described above) and applying that to Sheppard Pratt's units. Then, this established cost base was compared to Sheppard Pratt's actual costs to determine the efficiency of the Hospital. For a summary schedule of this analysis, see the table below:

Table 6. Summary of Maryland Cost Comparison Model

Sheppard Pratt
Cost Comparison: Sheppard Pratt vs. Psychiatry Hospitals
Fiscal Year 2019

	Peer Group Comparison Cost				Sheppard Pratt Cost	Variance	
		Adjustment Factor for Psych Cost Intensity					
Description	FY 2019 C&D Comparison: Results	%	$	Adjusted Peer Group Comparison Costs	FY 2019 C&D Comparison: Results	Sheppard Pratt Favorable/ (Unfavorable)	% Favorable / (Unfavorable)
Plant Operations	$21,228,882	34.1%	($7,229,928)	$13,998,954	$7,626,278	$6,372,676	83.6%
Dietary Services	5,933,259	34.1%	(2,020,692)	3,912,567	3,773,004	139,563	3.7%
Purchasing and Stores	2,123,945	34.1%	(723,353)	1,400,592	227,859	1,172,733	514.7%
Pharmacy	2,264,659	34.1%	(771,276)	1,493,384	2,649,604	(1,156,221)	(43.6%)
Laundry and Linen	308,048	34.1%	(104,912)	203,136	372,674	(169,538)	(45.5%)
Social Services	904,294	34.1%	(307,976)	596,318	2,110,568	(1,514,250)	(71.7%)
Patient Care Overhead Total	$32,763,087		($11,158,136)	$21,604,951	$16,759,988	$4,844,963	28.9%
Hospital Administration	$27,977,507	48.0%	($13,416,749)	$14,560,758	$11,327,705	$3,233,053	28.5%
Depreciation & Amortization	16,899,444	48.0%	(8,104,210)	8,795,234	10,339,498	(1,544,264)	(14.9%)
Long Term Interest	3,751,536	48.0%	(1,799,067)	1,952,469	2,036,941	(84,472)	(4.1%)
Housekeeping	10,119,844	48.0%	(4,853,020)	5,266,824	3,323,669	1,943,154	58.5%
Malpractice Insurance	3,577,466	48.0%	(1,715,591)	1,861,875	2,363,712	(501,837)	(21.2%)
Patient Accounts	7,079,535	48.0%	(3,395,025)	3,684,510	4,700,622	(1,016,112)	(21.6%)
General Accounting	3,943,724	48.0%	(1,891,232)	2,052,492	1,247,023	805,469	64.6%
Medical Staff Administration	2,280,266	48.0%	(1,093,513)	1,186,753	506,756	679,997	134.2%
Leases and Rentals	2,669,879	48.0%	(1,280,353)	1,389,526	2,136,195	(746,670)	(35.0%)
Medical Care Review	3,322,566	48.0%	(1,593,353)	1,729,214	1,896,400	(167,186)	(8.8%)
Medical Records	1,678,531	48.0%	(804,948)	873,583	950,289	(76,705)	(8.1%)
Other Insurance	425,454	48.0%	(204,029)	221,426	755,465	(534,040)	(70.7%)
Nursing Administration	8,618,737	48.0%	(4,133,157)	4,485,580	6,974,788	(2,489,208)	(35.7%)
Other Overhead Total	$92,344,489		($44,284,247)	$48,060,242	$48,559,063	($498,821)	(1.0%)
Overhead Total	$125,107,576		($55,442,383)	$69,665,194	$65,319,052	$4,346,142	6.7%
Adult Psychiatry	$37,653,198	0.0%	$0	$37,653,198	$35,010,865	$2,642,333	7.5%
Child Psychiatry	19,536,753	0.0%	0	19,536,753	15,969,931	3,566,822	22.3%
Geriatric Psychiatry	6,791,981	0.0%	0	6,791,981	6,158,357	633,624	10.3%
Observation	432	0.0%	0	432	1,500	(1,068)	(71.2%)
Adolescent Neuropsychiatry	2,680,013	(76.8%)	2,059,056	4,739,069	4,008,898	730,171	18.2%
IP, Nursing, Obv Total	$66,662,378		$2,059,056	$68,721,434	$61,149,551	$7,571,883	12.4%
Clinic Services	$1,302,525	0.0%	$0	$1,302,525	$500,538	$801,987	160.2%
Electroencephalography	60,692	0.0%	0	60,692	23,045	37,647	163.4%
Magnetic Resonance Imaging	15,357	0.0%	0	15,357	68,200	(52,843)	(77.5%)
Radiology - Diagnostic	79,468	0.0%	0	79,468	154,200	(74,732)	(48.5%)
Electrocardiography	19,225	0.0%	0	19,225	136,850	(117,625)	(86.0%)
Laboratory Services	1,303,353	0.0%	0	1,303,353	1,855,100	(551,747)	(29.7%)
Psych. Day and Night Care	8,180,998	0.0%	0	8,180,998	7,981,919	199,079	2.5%
Electroconvulsive Therapy	726,928	0.0%	0	726,928	726,928	0	0.0%
Ancillary Total	$11,688,546		$0	$11,688,546	$11,446,780	$241,765	2.1%
Total Direct Patient Care	$78,350,923		$2,059,056	$80,409,979	$72,596,331	$7,813,648	10.8%
Total Excluding Supplies and Drugs	$203,458,499		($53,383,327)	$150,075,173	$137,915,383	$12,159,790	8.8%

Due to the concern related to accurately assessing the efficiency of costs for interns and residents as well as the costs included within the pharmacy rate center, which may reflect unique discounts not available to all hospitals, these costs were excluded from the Maryland cost comparison model and passed through without qualification ($4.3 million or 3 percent of Sheppard Pratt's Fiscal Year 2019 cost base). This effectively reduced Sheppard Pratt's favorable cost position from 8.8 percent efficient relative to Maryland peers to 8.55 percent.

The table below describes the results of the Maryland cost comparison model and the costs that were evaluated without qualification.

Table 7. Summary of Components of ICC Recommended Revenue for Sheppard Pratt Hospital

	Cost Assessed	Cost Change ($)	Approved Cost	Cost Change (%)
Maryland Cost Comparison Model	$137,915,383	$12,159,790	$150,075,173	8.82%
Residents and Interns	$2,692,100	$0	$2,692,100	0%
Pharmacy Rate Center	$1,622,417	$0	$1,622,417	0%
Total	$142,229,900	$12,159,790	$154,389,690	$8.55%

National Cost Comparison Model

Given the concerns about making a rate determination based on a comparison between Maryland general acute care facilities and a specialized psychiatric facility, HSCRC staff also collaborated with Sheppard Pratt to assess the Hospital's efficiency to similar stand-alone psychiatric facilities across the country. Specifically, the national cost comparison model used Fiscal Year 2019 Medicare cost reports[11] and evaluated Sheppard Pratt's costs per equivalent patient days (EIPDs)[12] relative to 11 psychiatric facilities from 9 different states. The final assessment determined that Sheppard Pratt was 6.8 percent efficient relative to its selected national peers - within a reasonable range of the 8.55 percent determined by the Maryland cost comparison model. Below, staff will outline the peer selection process and the underlying methodology for the national cost comparison model.

[11] CMS maintains the cost report data in the Healthcare Provider Cost Reporting Information System (HCRIS) https://www.cms.gov/Research-Statistics-Data-and-Systems/Downloadable-Public-Use-Files/Cost-Reports

[12] EIPDs are a long established measure that attempts to standardize inpatient and outpatient volume into a singular metric by multiplying the ratio of total revenue to inpatient revenue by a hospital's inpatient days.

To select national peers, HSCRC staff and Sheppard Pratt settled on the following criteria:

- Comparable licensed beds (at least 150)
- Average length of stay less than 25 days
- Provides both inpatient and outpatient services

Once peer facilities were selected, staff did not use volumes derived from the Medicare Severity-Diagnosis Related Group (MS-DRG), because MS-DRGs do not adequately measure patient acuity in this context, which is evidenced by the fact that CMS pays a per diem amount under the Psych inpatient prospective payment system (IPPS) with adjustments for age, specific diagnoses, and length of stay. As such, staff utilized EIPDs, as discussed above, and further accounted for acuity by applying to the average reimbursable cost[13] per EIPD a 'Medicare Payment Factor.'[14] For a summary of the national cost comparison model, see table 4 below:

Table 8. Cost Comparison to National Peer Group Hospitals

Provider Name	EIPDs	Total Reimburseable Costs	Non-Reimbursable	Total Costs	Overhead Allocated to Reimb CC	Overhead % of Reimb CC	Total Reimb Costs per EIPDs	Medicare per Day Payment Factor	Total Reimb Costs per EIPDs Adj by Pymt Factor	% of over/under Average
SHEPPARD & ENOCH PRATT HOSPITAL	**121,510**	**$120,792,701**	**$134,405,575**	**$255,198,276**	**$60,569,321**	**50.1%**	**$994**	**1.06**	**$934**	**(6.8%)**
ROGERS MEMORIAL HOSPITAL INC.	74,688	139,156,257	714,144	139,870,401	73,623,045	52.9%	1,863	0.95	1,955	**95.2%**
MCLEAN HOSPITAL	94,484	121,446,547	80,196,002	201,642,549	67,780,399	55.8%	1,285	1.11	1,162	**16.0%**
LAKESIDE HOSPITAL	99,069	41,966,697	3,609,499	45,576,196	23,402,260	55.8%	424	0.99	427	**(57.4%)**
BELMONT BEHAVIORAL HEALTHCARE	78,724	52,091,309	1,210,974	53,302,283	31,800,415	61.0%	662	1.02	650	**(35.1%)**
HOLLY HILLS HOSPITAL	84,433	33,132,772	62,547	33,195,319	18,650,480	56.3%	392	0.96	407	**(59.3%)**
SOUTHERN NEVADA ADULT MENTAL HEALTH	34,025	70,681,006	12,773,861	83,454,867	14,019,503	19.8%	2,077	0.92	2,251	**124.8%**
SOUTH OAKS HOSPITAL	66,252	87,925,494	3,808,447	91,733,941	49,007,323	55.7%	1,327	1.01	1,318	**31.6%**
SHARP MESA VISTA HOSPITAL	68,609	75,974,455	13,436,882	89,411,337	36,179,999	47.6%	1,107	1.01	1,093	**9.2%**
COLLEGE HOSPITAL INC	75,669	54,519,623	4,115,383	58,635,006	19,996,916	36.7%	720	0.96	749	**(25.2%)**
RIVEREDGE HOSPITAL	46,509	27,160,592	1,027,544	28,188,136	15,384,532	56.6%	584	0.96	606	**(39.5%)**
BRENTWOOD BEHAVIORAL-SHREVEPORT	62,085	23,883,827	1,553,995	25,437,822	12,449,339	52.1%	385	0.96	399	**(60.2%)**
Average	71,322	66,176,294	11,137,207	77,313,442	32,935,837	50.0%	984	0.99	$1,002	**0.0%**

Cost Model Selection and Implementation

HSCRC staff supports Sheppard Pratt's request to make a rate determination based on the Maryland cost comparison model because the analysis, which assesses cost for each hospital rate center using the relevant unit of measurement, is more thorough and less prone to acuity mismeasurement than the national cost comparison model that assesses total costs per EIPD.

[13] Reimbursable costs were pulled from the CMS HCRIS dataset for cost reports for the FY18/19 fiscal years (the latest available) and include overhead allocations but excludes services and programs that CMS does not cover under the Medicare program.

[14] The Medicare Payment Factor was calculated from the CMS limited data set inpatient file for Calendar Year 2018 and represents the total Medicare payments plus coinsurance and deductibles at a wage index of one divided by the number of covered Medicare days where Medicare was the primary payer for the final claim.

However, the full rate recommendation also outlined four additional requests that need to be considered:

1) Sheppard Pratt requested for the rate increase to become effective July 1, 2021;

2) Sheppard Pratt requested applying Fiscal Year 2020 and 2021 inflation to cost base determined by the Maryland cost comparison model because the cost analysis utilized Fiscal Year 2019 costs to remove the confounding elements of the COVID public health emergency;

3) Sheppard Pratt requested an increase in its markup[15] to recognize that the effective rate increase will not be equal to the rate determination made by the Commission since the HSCRC has no rate setting authority over Medicare reimbursement at the Hospital and;

4) Sheppard Pratt requested an additional 1 percent irrespective of its efficiency analysis for purposes of population health investments.

HSCRC staff agrees with the first consideration to implement a rate increase effective July 1, 2021, as staff has been working with Sheppard Pratt since February to develop an alternative efficiency evaluation in light of Sheppard Pratt's unique service mix, and staff believe that the Hospital has demonstrated an immediate need for rate support due to its recent negative operating margins and efficient cost base.

HSCRC staff agrees with the second consideration that any cost assessment based on a prior year needs to be inflated to current year costs. However, staff does not concur with the method in which Sheppard Pratt recommended accounting for inflation. Specifically, the Hospital requested inflating the costs determined in the Maryland cost comparison model by the statewide inflation rate less the productivity adjustment provided in the last two years (2.46 percent and 2.77 percent for fiscal year 2020 and fiscal year 2021, respectively). HSCRC staff disagrees with this approach because it adds complexity and because, in prior rate determinations for Sheppard Pratt, staff increased the markup to charges to account for the fact that Medicare would not reimburse Commission established rates. This increased revenue related to higher markup is built into the permanent revenue base, which staff would like to maintain by applying the 8.55 percent favorable cost performance to the Hospital's Fiscal Year 2021 permanent revenue base of $164,821,768. This would yield an increase of $14,091,257, of which $11,752,108 would be collected due to the Commission not having rate setting authority over Medicare, i.e. the effective revenue increase would be 7.13 percent. This effective revenue increase is also much more closely aligned with the favorable cost performance of 6.8 performance outlined in the national cost comparison model above.

The third consideration Sheppard Pratt put forward was for the Commission to increase its markup from 1.076 to 1.1367. HSCRC staff does not recommend approving the Hospital's request because the increase in markup is based on assuming Medicare is afforded a 30 percent discount to HSCRC-established rates that other payers should subsidize. This assumption does

[15] Markup in rates is a historical rate setting mechanism that supports the funding of uncompensated care as well as the discounts individual payers are afforded for promptly paying and for avoiding bad debts.

not recognize the historical adjustment the Commission has made to account for lower Medicare reimbursement, as described above. Moreover, this requested increase nearly doubles the markup that would otherwise be provided in rates, thereby yielding an effective revenue increase of 11.06 percent, which is an increase of 251 basis points relative to the 8.55 percent favorable cost performance that will be borne by all non-Medicare payers.

The fourth consideration put forward by Sheppard Pratt was to provide a 1 percent increase in rates for population health infrastructure. This increase would be analogous to the 1.05 percent built into rates for GBR hospitals and would recognize the protection not afforded to a volume variable hospital that makes investments in population health improvement activities that have the potential to reduce volume. While HSCRC staff is sympathetic to the Hospital's concerns that any population health investments may reduce volume and therefore imperil its revenue base, staff does not recommend approving the request for the following reasons: a) since Fiscal Year 2014 Sheppard Pratt has received .60 percent in rates for infrastructure funding; b) GBR hospitals received infrastructure funding in concert with annual reductions in inflation related to Potentially Avoidable Utilization Shared Savings Program, in which Sheppard Pratt does not participate; c) it is unclear if Sheppard Pratt, which serves as a statewide resource for behavioral healthcare, should be subsidized to reduce utilization; and d) HSCRC does not believe it is appropriate to opine on requests to increase a hospital's rate structure if there are not underling efficiency evaluations to support the revenue increase. Moving forward, HSCRC staff believes it is reasonable to allow Sheppard Pratt to apply for population health grants as a direct applicant, such as the regional partnerships, which previously the Hospital was precluded from participating in as a primary recipient.

For a side-by-side comparison of Sheppard Pratt's effective revenue increase and the HSCRC staff recommendation, see the table below:

Table 9. Comparison of Sheppard Pratt Rate Request and HSCRC Recommendation

	Sheppard Pratt Rate Request		HSCRC Recommendation
Proxy ICC	**Sheppard Pratt Health System**	**Maryland Peer Group**	
Regulated Costs	**137,915,383**	**150,075,173**	
Add: SPH Interns and Residents	2,692,100	2,692,100	
Add: Other	1,622,417	1,622,417	
Total Regulated Costs	142,229,900	154,389,690	8.55%
Inflation 2020 and 2021		5.3%	
Costs Inflated to 2021		162,569,475	
Hospital Specific Mark-up		1.13691	
ICC Result		184,826,837	
Population Health Infrastructure 1%		1,848,268	
Adjusted ICC Result		186,675,105	
FY2021 Approved Permanent Revenue		164,821,768	164,821,768
Requested Rate Adjustment		**21,853,337**	
Percent Change		**13.26%**	
Recommenmded Rate Adjustment			**14,091,257**
Percent Change			**8.55%**
Medicare Payermix %		16.60%	16.60%
Non-Medicare Payermix %		83.40%	83.40%
Requested Effective Revenue Increase ($)		**18,225,683**	
Requested Effective Percent Increase (%)		**11.06%**	
Recommended Effective Revenue Increase			**11,752,108**
Recommended Effective Percent Increase			**7.13%**

Total Cost of Care Performance

Under a per-capita model, a hospital's efficiency may not be adequately measured by cost-per-case measures. In order to consider how the cost per-capita performance might alter the results from a hospital cost efficiency analysis, the HSCRC also evaluates Total Cost of Care (TCOC) performance. Exceptional TCOC performance might allow for a revenue increase in the results from a hospital cost efficiency analysis, while poor results might suggest reductions from a hospital cost efficiency analysis.

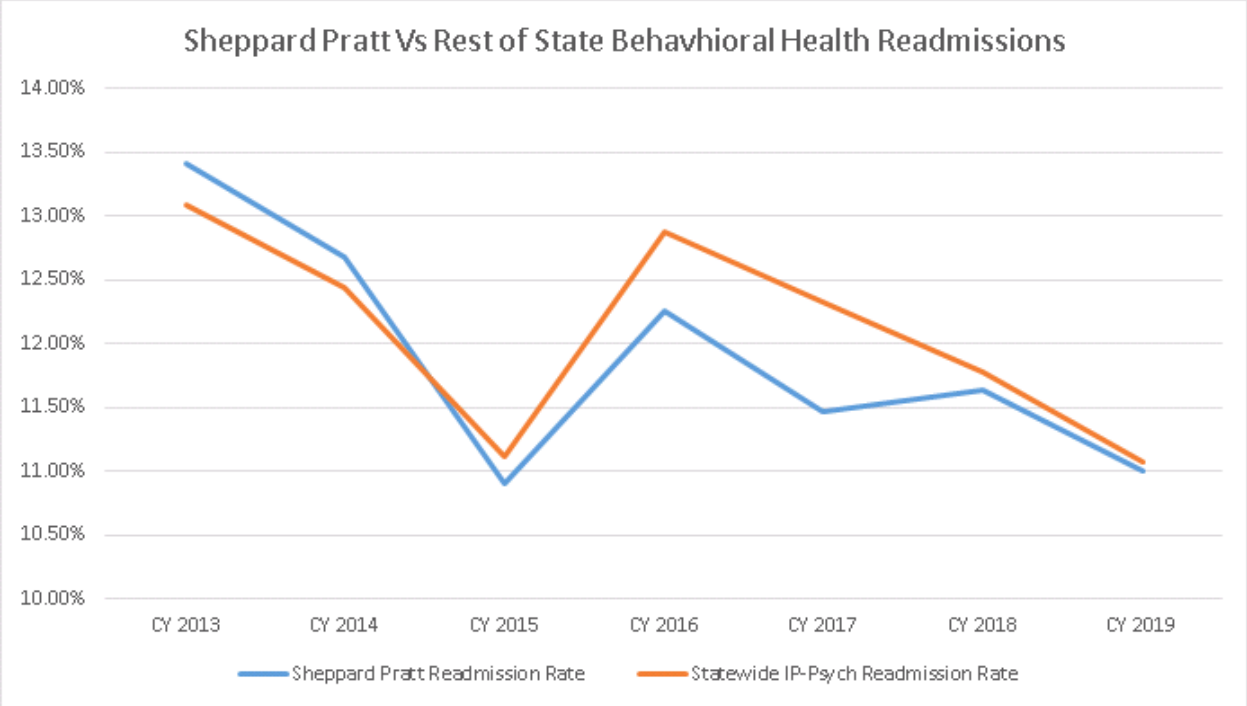
In the case of Sheppard Pratt, HSCRC staff did not make an effort to assess its TCOC performance because it is not a hospital that participates in the population-based methodologies that underpin the TCOC Model, e.g. Global Budget Revenue, Demographic Adjustment, Market Shift, Potentially Avoidable Utilization Shared Savings, and the Medicare Performance Adjustment. Nor will the impact of this rate determination affect Medicare TCOC because HSCRC does not have rate setting authority over Medicare reimbursement at the Hospital.

Quality Performance

Similar to TCOC performance, the HSCRC staff cannot fully evaluate quality performance, as Sheppard Pratt does not participate in the Commission's pay for performance quality programs under its unique service delivery model. However, the Hospital did note in several instances in the rate application that it was providing a benefit to the TCOC model because "...Sheppard Pratt has already been successful in reducing readmissions Statewide and in Central Maryland since the inception of GBR related to behavioral health services… [and] Sheppard Pratt believes there is an opportunity to [further] reduce the number of behavioral health 30-day readmissions in Maryland through a special focus on those patients." The Hospital further asserts that "If readmissions within thirty days were reduced by 25%, savings to the State of Maryland would be approximately $8.1 million."

HSCRC staff tested the assertion that Sheppard Pratt was successful in reducing readmissions, despite not participating in the Readmissions Reduction Incentive Program (RRIP), and further how the hospital fared against hospitals that did participate in RRIP. Staff concluded that Sheppard Pratt did indeed reduce readmissions for behavioral health admissions and actually outperformed acute care facilities in the state in improvement since the start of the All-Payer Model. Moreover, since 2015 Sheppard Pratt has maintained a lower readmission rate relative to the rest of the State despite the acuity increases the Hospital experienced, as documented in Table 4 above:

Table 10. Sheppard Pratt Behavioral Health Readmissions



Recommendation

HSCRC staff recommends that the Commission:

1) Approve a general revenue increase request of $14,091,257 effective July 1, 2021, because the hospital has demonstrated cost efficiency and a revenue structure that is insufficient to support the underlying cost base. Since Medicare does not pay HSCRC-approved rates, the expected net amount of this increase is estimated to be approximately $11,752,108 million.

2) Allow Sheppard Pratt to apply for population health grants, such as the regional partnerships, which previously the Hospital was precluded from participating in.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTHCARE, LLC	*	**DOCKET:**	**20121**
	*	**FOLIO:**	**2373**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2563A**

Staff Recommendation

September 9, 2021

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on July 21, 2021, on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (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 solid organ and bone marrow transplants services with 6 Degrees Health, Inc. The System requests approval for a period of one year beginning November 1, 2021.

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 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. 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 and 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

Although there has been no activity under this arrangement, staff believes that the

Hospitals can achieve a favorable experience under this arrangement.

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VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one-year period commencing November 1, 2021

. 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.

maryland
health services
cost review commission

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF THE	*	**COST REVIEW COMMISSION**	
UM CAPITAL REGIONAL HEALTH	*	**DOCKET:**	**2021**
BOWIE HEALTH CENTER	*	**FOLIO:**	**2374**
BOWIE, MARYLAND	*	**PROCEEDING:**	**2564N**

Staff Recommendation
September 9, 2021

Introduction

On July 30, 2021, UM Bowie Health Center ("BHC" or "the Hospital"), submitted a partial rate application requesting a new rate for Respiratory Therapy (RES) services. Currently at BHC, patient requiring respiratory therapy services are done either by nurses, and included in clinical care time, or by respiratory therapists. The Hospital would like to establish a separate RES rate to bill appropriately for respiratory therapy services. The Hospital requested to establish a unit rate for Respiratory Therapy effective October 1, 2021.

Staff Evaluation

HSCRC policy is to set the rates for new services at the lower of the statewide median or at a rate based on a hospital's projections. Based on the information received, the Hospital requested a rate for RES service of $2.29 per RVU, the statewide median rate.

Service	Service Unit	Unit Rate	Projected Volumes	Approved Revenue
Respiratory Therapy	RVUs	$2.29	37,629	$86,170.41

Recommendation

After reviewing the Hospital's application, the staff recommends:

1. That an RES rate of $2.29 per RVU be approved effective October 1, 2021 for RES services provided by respiratory therapists or other RES clinicians whose costs are in the RES rate center. RES services provided by bedside nurses are included in the patient room & board rate;

2. That the RES rate center not be rate realigned until a full year of cost data has been reported to the Commission; and

3. That no change be made to the Hospital's Global Budget Revenue for the RES services.

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:**	**2375**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2565A**

Staff Recommendation

September 9, 2021

I. INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on August 26, 2021 requesting approval to continue its participation in a global rate arrangement with BlueCross and BlueShield Association Blue Distinction Centers for solid organ and blood and bone marrow transplant services for a period of one year beginning October 1, 2021.

II. OVERVIEW OF 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 continue to 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 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

The staff found that the experience under this arrangement for the prior year has been favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for blood and bone marrow transplant services, for a

one year period commencing October 1, 2021. The Hospital 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 Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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:**	**2376**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2566A**

Staff Recommendation

September 9, 2021

I. INTRODUCTION

University of Maryland Medical Center (the Hospital) filed an application with the HSCRC on August 26, 2021 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for heart, liver, kidney, lung, and pancreas transplants, SPK services, blood and bone marrow transplants and VAD services for a period of one year with Cigna Health Corporation beginning October 1, 2021.

II. OVERVIEW OF APPLICATION

The contract will continue 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 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 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

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for heart, liver, kidney, lung, and pancreas transplants, SPK services, blood and bone marrow transplants and VAD services, for a one year period commencing October 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, 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:**	**2377**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2567A**

Staff Recommendation

September 9, 2021

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on August 31, 2021, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (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 heart failure services and solid organ and bone marrow transplants with Optum Health, a division of United HealthCare Services, for a period of one year beginning October 1, 2021.

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. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION ANDASSESSMENT 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

The staff found the experience for this arrangement last year to be slightly unfavorable. The Hospitals have adjusted the prices in the arrangement to eliminate the under recovery. Staff believes that the Hospitals will be able to achieve a favorable outcome under the revised arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for heart failure, solid organ, and bone marrow transplant services for a one-year period commencing October 1, 2021. 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:**	**2378**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2568A**

Staff Recommendation

September 9, 2021

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on September 1, 2021 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center ("the Hospitals") for approval to add kidney transplant services to the global rate arrangement for solid organ and bone marrow transplant services with Blue Cross Blue Shield Blue Distinction Centers approved at the December 9, 2021 public meeting. The System requests that the approval to add kidney transplant services be effective October 2, 2021 through November 30, 2021.

II. STAFF EVALUATION

The Hospitals have successfully provided like services successfully in prior global arrangements and staff believes that the Hospitals can achieve favorable performance for kidney transplant services under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application to add kidney transplant services beginning October 2, 2021. 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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Medicare Performance Adjustment

Draft Recommendation

September 2021

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

Comments for this policy are due by September 17, 2021 to hscrc.tcoc@maryland.gov.

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

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Draft 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 changed 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 Draft Recommendations

Staff recommend four 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) continue the CTI buyout policy; 3) revise the attribution approach in the MDPCP supplemental adjustment; and 4) 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.

Weighting for CTI Participation

In 2021, the HSCRC began to weight the hospital's Traditional MPA results based on their participation in the CTI program. If a hospital covered an equivalent amount of TCOC under the CTI as they were attributed under the CTI, then the hospital would be exempt from the Traditional MPA penalties. If they covered only a portion of the attributed costs, then the Traditional MPA penalties would be scaled by that amount. CMMI approved the CTI buyout policy for 2021 but indicated that they would review it in future years. CMMI indicated the need for maintaining the hospital's accountability for all Maryland Medicare beneficiaries.

Staff recommend continuing the CTI buyout policy in the MPA proposal submitted to CMMI. As discussed previously, the MPA is a one-size-fits-all approach that is unlikely to ever capture the full nuance of the hospital's clinical interventions; on the other hand, the CTIs are designed by the hospitals themselves in order to capture the impact of their clinical interventions. Therefore, staff consider the CTI a more precise measure of the hospital's efforts to reduce the TCOC that should be recognized as attainment is introduced into the target setting. Staff believes that the CTI weighting policy is an important complement to a purely geographic MPA attribution. However, Staff believe that the advantages of geographic attribution outweigh costs, even if the CMMI does not approve the CTI buyout.

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.

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MEMORANDUM

To: Commissioners

From: William Henderson, Principal Deputy Director
Medical Economics and Data Analytics

Date: September 2, 2021

Re: Introduction to Milliman Report on Maryland Commercial Health Market Insurance Data

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The HSCRC continues to be focused on how the benefits of the Maryland Model reach the healthcare consumer. One aspect of this is considering how healthcare costs savings under the model translate into commercial health premiums.

An advantage of the all-payer system is that each payer shares equitably in the cost of care. As a result, under Maryland's all-payer rate setting system, hospital costs paid by Medicare are higher than in other states while hospital costs paid by commercial payers are lower than other states. This commercial hospital cost advantage translates into lower overall costs for commercial healthcare payers. A number of published studies have supported Maryland's commercial cost advantage including the HSCRC's recent benchmarking analysis which showed a significant per capita total cost of care advantage for Maryland's commercial payers.

However, analyses of Maryland premiums (that is the rate paid by commercially insured employers and individuals) have shown mixed results, with premiums typically being around national average[1]. To frame this issue and begin to understand the gap between costs and premiums, the HSCRC contracted with Milliman, a nationally recognized healthcare consulting firm, to compile public data on Maryland premiums and costs in comparison to the nation. The attached report documents Milliman's findings. This report was intended to provide a framework for discussing the differences and provide fundamental relevant statistics on a reasonably comparable basis, This report was not intended to be a comprehensive analysis of the differences in healthcare claims costs and premiums between Maryland and the nation. Table 1 contains a recap of key metrics extracted from the report by HSCRC Staff. Based on a review of the report, Staff note that:

1. Maryland premiums and costs are significantly cheaper in the Small Group market[2]. Premiums are 14.0% lower than the national average and healthcare claims costs are 15.7% below the national average. The

[1]See, for example, the table accompanying this report: https://www.commonwealthfund.org/publications/issue-briefs/2020/nov/state-trends-employer-premiums-deductibles-2010-2019

[2] Small group typically equals less than 50 employees, although four states have expanded the definition to include employers with between 1 – 100 employees

advantage over the Mid-Atlantic (defined to include Maryland border states) and the Northeast regions are greater. The 15.7% advantage in costs is consistent with the findings of Staff's claims on benchmarking.

2. While the portion of premiums retained by insurers for administration and margin in the Small Group market is slightly higher in Maryland, nearly all of healthcare cost savings are being passed on to the premium payer.
3. While the statistics in the Small Group market are consistent with Maryland having a cost advantage, the Large Group results are not. Maryland is 15.0% higher on costs and 13.2% higher on premiums versus the nation in the Large Group market. Results versus the Mid-Atlantic are similar while Maryland has a small advantage versus the Northeast.
4. While the healthcare cost advantage is not appearing in these results, the premium retained by the insurers is not driving the issue. Maryland insurer's share of premium is below the national average in the Large Group Market.
5. This report does show a Maryland advantage in the Small Group market, and it does not show excess retention by Maryland insurers (which given the premiums are regulated by the Maryland Insurance Agency, would be unlikely). However, there remains a significant gap in the Large Group market – Maryland costs and resulting premiums do not appear to be below the nation although the existence of a cost advantage is well documented elsewhere. Some potential reasons include:
    a. Insurance reporting is based on the location of the insurance contract not on the location of the employee. Therefore, in a state like Maryland where major population centers are adjacent to other States, there may be substantial crossover in insurance reporting, particularly for large group employers with big employee bases. As a result, Maryland reported premiums could include significant out-of-state experience which would dilute the findings.
    b. Data on healthcare claims costs is available at an individual level, this allows for robust normalization for population differences. Premium data is not available at this level therefore comparisons may not be as accurate as it would be for claims costs. The contrasting results between small and large groups illustrate the sensitivity of outcomes to population selection. There are a number of reasons why the comparisons shown in this report may be skewed: (1) Maryland populations may be higher risk (Maryland has a higher percentage of people over 65 in the workforce than the national average), (2) Maryland insurers may provide richer benefit packages resulting in higher premiums and costs, (3) the large group sector in this report reflects only fully-insured plans, which are a minority of all large group plans, these plans may not be comparable or representative of the full sector and the mix may vary across states.
    c. Retail drugs are a significant portion of the premiums shown, Maryland may have a high retail pharmacy spend which would offset the medical advantage.

See Table 1 on the next page.

Table 1: Summary of Key Statistics[3]

	Small Group				Large Group (fully-insured)			
	Maryland	National	Mid-Atlantic	Northeast	Maryland	National	Mid-Atlantic	Northeast
Per Capita:								
Premiums	$415.53	$483.29	$541.42	$549.25	$490.86	$433.73	$438.16	$507.32
Healthcare Claims Costs	$340.97	$404.56	$445.12	$468.57	$443.74	$386.01	$392.31	$447.43
Maryland % Above (Below) Comparison:								
Premiums per Capita		-14.0%	-23.3%	-24.3%		13.2%	12.0%	-3.2%
Healthcare Claims Costs per Capita		-15.7%	-23.4%	-27.2%		15.0%	13.1%	-0.8%
Adminstrative Loss + Underwriting Ratio	17.9%	16.3%	17.8%	14.7%	9.6%	11.0%	10.5%	11.8%
Maryland Above (Below) in % Pts		1.6%	0.1%	3.2%		-1.4%	-0.9%	-2.2%

[3] Individual market data is in the report but not shown here as individual market comparability is heavily impacted by state-level regulations. Administrative Loss + Underwriting Ratio represents the portion of the premium retained by the insurer for administrative costs and margin.

MILLIMAN REPORT

Maryland Health Services Cost Review Commission

Maryland Commercial Health Insurance Market Data

June 2021

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Contents

I. Introduction and Background

The Maryland Health Services Cost Review Commission (HSCRC) is responsible for regulating the State's hospital industry, including the all-payer hospital rate setting system, and leads the State's Total Cost of Care (TCOC) Model contract. Under the TCOC model, introduced in January 2019, HSCRC is moving to a system where hospitals and other providers are responsible for the total cost of care of beneficiaries.[i] HSCRC seeks to establish affordability standards for the hospital costs and approaches to evaluate the total cost of care under the new model. HSCRC requested Milliman perform an assessment of commercial insurance health premiums, medical and administrative costs, and underwriting gains or losses in the Maryland insurance markets, compared to regional and composite national data as one component of assessing how the total cost of care should be evaluated. This report provides a summary of our market assessment, commercial market data, and related considerations.

II. Methodology

We conducted this engagement using a multi-step process. The steps included: 1) Compile financial and administrative data, 2) Synthesize findings and observations, and 3) Complete a summary of findings. Our approach to completing each of these tasks follows below.

TASK 1: COMPILE FINANCIAL AND ADMINISTRATIVE DATA

Task 1 involved a sequence of several steps. First, we collected and compiled financial and administrative data for commercial plans from the publicly available National Association of Insurance Commissioners (NAIC) annual filings Supplemental Health Care Exhibit (SHCE) for calendar year (CY) 2019 using S&P Global Market Intelligence which includes organizations filing health, life, and property and casualty NAIC forms. We used the compiled data in our assessment. Next, we created comparison groups by geographic region.

- Comparisons to Maryland were conducted comparing Geographic Regions (Mid-Atlantic (excluding MD), Northeast, Southeast, Midwest, Southwest, and West) and Composite (without MD). All 50 states and the District of Columbia were included in the comparison.
- Commercial product categories for comprehensive health coverage, as defined by NAIC SHCE, are Individual, Small Group Employer, and Large Group Employer.

The Geographic Regions, as defined in the S&P Global Market Intelligence data, were used with the exception of an intentional region reassignment of 3 states. We reassigned New Jersey and New York from the Mid-Atlantic Region to the Northeast Region and Virginia from the Southeast Region to the Mid-Atlantic Region to create a region (the Mid-Atlantic) comprised of the states that border Maryland: Delaware, District of Columbia, Pennsylvania, and Virginia.

Based on discussion with the HSCRC, our comparison financial data was limited to insurers with a significant concentration of business in the commercial market. Certain insurers were excluded from our comparison data if any of the following criteria were met (based on analysis of CY 2019 NAIC statutory statements): 1) all insurance companies that had more than 80 percent of health premiums generated from non-commercial business (Medicare Advantage, Medicaid, Medicare Supplement, etc.), 2) Dental, Vision, Other Health or Other Non-Health categories, 3) Consumer Oriented and Operated Plans (CO-OP), Multiple Employer Welfare Arrangements (MEWA), and short-term disability or life insurance plans, and 4) plans that had less than 1,000 members or approximately $6 million in annual health premiums. Note that Statement of Statutory Accounting Principles (SSAP) #47[ii] specifically states that self-funded business covered by administrative services only (ASO) contracts is to be excluded from reported membership, revenue, and expense, thus we could not develop comparisons of self-funded business.

The final sample of health plans was comprised of 243 companies, included health insurers that operate in multiple states; thus, the total health plan count used in this assessment was 543 insurers, with an average of approximately 10 plans per state. Collectively, these organizations represent approximately 50 million members and annual health premiums of nearly $278 billion across all 50 states and the District of Columbia. We reviewed the sample for reasonableness and noted that a limitation to the data is that several California based-health insurers file with the state's Department of Managed Care, rather than the NAIC, and therefore do not complete the NAIC SHCE.

The NAIC SHCE provides a breakdown of the commercial market into Individual, Small Group Employer (Small Group) and Large Group Employer (Large Group). The combination of these three markets comprises 'Comprehensive Health Coverage'. The markets are defined using the NAIC definitions in the NAIC Annual Statement Instructions for Health companies.

The **Individual market** is defined as a policy covering individuals and their dependents, including policies sold on or off the Federally Qualified Health Insurance Marketplace or other State Exchanges.

The **Small Group market** is defined as any health policy offered in the small group market, as defined in each state. The majority of states define small groups as "an employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year."[iii] California, Colorado, New York, and Vermont have expanded the definition of small groups to employers who have between 1 and 100 employees in the preceding year.[iv]

The **Large Group market** is defined as policies issued to large group employers. A large employer is defined as "an employer who employed an average of at least 51 employees on business days during the preceding calendar year."[v] The four states noted above define large employers as employers that have an average of at least 101 employees in the preceding year.

We calculated an underwriting (UW) gain or loss ratio, medical loss ratio (MLR), and administrative loss ratio (ALR) using the following for each plan/state combination as reported in NAIC filings:

TABLE 1: SOURCE DATA

Report Name	Source Name	Line Number
Member Months	Member Months	SHCE Part 1
Health Premiums Earned	Net Adjusted Premiums Earned after Reinsurance	SCHE Part 1 Line 1.12
Total Incurred Claims	Net Incurred Claims after Reinsurance	SCHE Part 1 Line 5.7
Administrative Expense	Healthcare Quality Improvement Expenses (HCQI)	SCHE Part 1 Line 6.6
Administrative Expense	Claims Adjustment Expense	SCHE Part 1 Line 8.3
Administrative Expense	General Administrative Expense	SCHE Part 1 Line 10.5
Underwriting Gain/(Loss)	Underwriting Gain/(Loss)	SCHE Part 1 Line 11

TABLE 2: FORMULA CALCULATIONS FOR MARYLAND, EACH REGION, AND IN COMPOSITE, BY MARKET AND IN AGGREGATE

Calculation	Formula
Total Administrative Expense	HCQI + Claims Adjustment Expense + General Administrative Expense
Medical Loss Ratio (MLR)*	Net Incurred Claims after Reinsurance / Net Adjusted Premiums Earned after Reinsurance
Administrative Loss Ratio (ALR)	Total Administrative Expense / Net Adjusted Premiums Earned after Reinsurance
Underwriting Gain/Loss Ratio (UW%)	Underwriting Gain/(Loss) / Net Adjusted Premiums Earned after Reinsurance

*Note that the NAIC MLR definition is not the same as the ACA MLR definition which includes Healthcare Quality Improvement Costs in the numerator.

In the Small Group and Large Group market, Health Premiums Earned includes employer paid premium and any member contribution to premium. In the individual market, Health Premiums Earned includes member paid premium and also includes subsidies from the federal government also referred to as "Advance Premium Tax Credit" or "APTC". The Health Premiums Earned and the Total Incurred Claims do not reflect member payments to providers as a result of plan cost sharing, e.g., out-of-pocket and deductible amount.

TASK 2: SYNTHESIZE FINDINGS AND OBSERVATIONS

We reviewed and synthesized all inputs to produce and validate summary tables, comparing premiums earned, incurred claims, administrative expense, and MLR, by commercial market, for Maryland, the regions, and in composite. Included in each table is a total count of health plans in each region, by market. We also present a comparison of Maryland to the composite average and the 25th and 75th percentile values (excluding Maryland), by market. We compared Maryland data to data stratified by organization size rather than by geography but did not find useful observations in this comparison.

TASK 3: COMPLETE A SUMMARY OF FINDINGS

As the final step in our process, we developed a summary report.

Note that the findings presented in this report represent a review of calendar year 2019, a single year of data. Financial results can vary from year to year. A study which included more than one year of data could change the results of this analysis, possibly significantly.

Additionally, the results of this analysis are presented as averages by market and region. Results presented by insurer in each region and market could vary materially from the averages presented.

The NAIC statements are filed using Statutory Accounting Standards[vi] which are designed for regulatory use and are developed with the concepts of consistency, recognition, and conservatism in mind. These statements are based on an accrual accounting method which recognizes transactions when they are known, can be estimated, and are likely to occur. Actual results could differ significantly from those estimates.

The premiums and experience included in this analysis segment membership by insurer and state. In the individual market, members are likely to reside and receive the majority of health care services in the state in which they purchase coverage. In the small and large group markets, it is possible that employers have employees (health plan members) in multiple states; however, this membership is all reported in the state where the company purchases health benefits. For instance, if a company's corporate office is located in New York, but employs people from New Jersey and California, the members would be included in the New York market filing and in the New York state data for this analysis.

III. Commercial Market Benchmark Summary

Maryland's commercial market is made up of 11 health plans that meet the criteria described in Section II. Collectively, these 11 health plans cover approximately 1.5 million members. Approximately 68% of those members are enrolled in large group plans, approximately 17% in small group, and approximately 15% in individual plans. The Mid-Atlantic region demonstrates a similar membership distribution. Tables 3 through 8 provide a summary of our assessment comparing Maryland's commercial health insurance, by market and in aggregate, to regional and composite averages. The data contained in these tables are based on NAIC SHCE filings for calendar year 2019.

TABLE 3: CY 2019 COMPARISON OF MARYLAND TO COMPOSITE – TOTAL COMPREHENSIVE

	Maryland PMPM	Composite* PMPM	Mid-Atlantic* PMPM	Northeast PMPM	Southeast PMPM	Midwest PMPM	Southwest PMPM	West PMPM
Count of Plans	11	532	53	77	82	161	65	94
Health Premium Earned	$ 473.39	$ 463.75	$ 476.72	$ 520.59	$ 476.00	$ 444.97	$ 448.95	$ 425.76
Total Incurred Claims**	409.92	402.00	412.86	454.65	407.16	384.90	392.50	370.76
Total Administrative Expense	51.70	47.47	44.93	58.36	49.06	44.29	44.79	43.42
Underwriting Gain/Loss	$ 11.77	$ 14.28	$ 18.93	$ 7.58	$ 19.78	$ 15.78	$ 11.66	$ 11.58
Medical Loss Ratio	86.6%	86.7%	86.6%	87.3%	85.5%	86.5%	87.4%	87.1%
Administrative Loss Ratio	10.9%	10.2%	9.4%	11.2%	10.3%	10.0%	10.0%	10.2%
Underwriting Ratio	2.5%	3.1%	4.0%	1.5%	4.2%	3.5%	2.6%	2.7%

*Composite and Mid-Atlantic do not include Maryland
**Includes medical, pharmacy, behavioral health, etc.

TABLE 4: CY 2019 COMPARISON OF MARYLAND TO COMPOSITE AND REGIONS – TOTAL INDIVIDUAL (15% OF TOTAL COMPREHENSIVE)

	Maryland PMPM	Composite* PMPM	Mid-Atlantic* PMPM	Northeast PMPM	Southeast PMPM	Midwest PMPM	Southwest PMPM	West PMPM
Count of Plans	7	315	32	49	51	94	39	50
Health Premium Earned	$ 459.95	$ 555.04	$ 594.87	$ 530.43	$ 579.82	$ 531.28	$ 570.76	$ 511.02
Total Incurred Claims**	332.82	459.92	478.79	464.06	468.72	441.45	488.56	421.99
Total Administrative Expense	61.77	56.66	58.33	62.51	59.81	51.77	56.72	51.13
Underwriting Gain/Loss	$ 65.36	$ 38.46	$ 57.75	$ 3.86	$ 51.29	$ 38.06	$ 25.48	$ 37.90
Medical Loss Ratio	72.4%	82.9%	80.5%	87.5%	80.8%	83.1%	85.6%	82.6%
Administrative Loss Ratio	13.4%	10.2%	9.8%	11.8%	10.3%	9.7%	9.9%	10.0%
Underwriting Ratio	14.2%	6.9%	9.7%	0.7%	8.8%	7.2%	4.5%	7.4%

*Composite and Mid-Atlantic do not include Maryland
**Includes medical, pharmacy, behavioral health, etc.

TABLE 5: CY 2019 COMPARISON OF MARYLAND TO COMPOSITE AND REGIONS – TOTAL SMALL GROUP (17% OF TOTAL COMPREHENSIVE)

	Maryland PMPM	Composite* PMPM	Mid-Atlantic* PMPM	Northeast PMPM	Southeast PMPM	Midwest PMPM	Southwest PMPM	West PMPM
Count of Plans	9	375	39	58	57	111	45	65
Health Premium Earned	$ 415.53	$ 483.29	$ 541.42	$ 549.25	$ 444.55	$ 473.03	$ 463.62	$ 431.63
Total Incurred Claims**	340.97	404.56	445.12	468.57	366.40	390.27	391.41	365.22
Total Administrative Expense	76.94	59.94	60.90	70.63	59.65	55.45	58.62	53.21
Underwriting Gain/Loss	$ (2.38)	$ 18.79	$ 35.40	$ 10.05	$ 18.50	$ 27.31	$ 13.59	$ 13.20
Medical Loss Ratio	82.1%	83.7%	82.2%	85.3%	82.4%	82.5%	84.4%	84.6%
Administrative Loss Ratio	18.5%	12.4%	11.2%	12.9%	13.4%	11.7%	12.6%	12.3%
Underwriting Ratio	(0.6%)	3.9%	6.5%	1.8%	4.2%	5.8%	2.9%	3.1%

*Composite and Mid-Atlantic do not include Maryland
**Includes medical, pharmacy, behavioral health, etc.

TABLE 6: CY 2019 COMPARISON OF MARYLAND TO COMPOSITE AND REGIONS – TOTAL LARGE GROUP (68% OF TOTAL COMPREHENSIVE)

	Maryland PMPM	Composite* PMPM	Mid-Atlantic* PMPM	Northeast PMPM	Southeast PMPM	Midwest PMPM	Southwest PMPM	West PMPM
Count of Plans	10	473	47	70	72	141	57	86
Health Premium Earned	$ 490.86	$ 433.73	$ 438.16	$ 507.32	$ 430.78	$ 419.54	$ 408.53	$ 405.11
Total Incurred Claims**	443.74	386.01	392.31	447.43	386.41	371.99	365.32	360.84
Total Administrative Expense	43.18	41.20	38.39	52.70	40.58	39.57	36.24	39.02
Underwriting Gain/Loss	$ 3.94	$ 6.52	$ 7.46	$ 7.19	$ 3.79	$ 7.98	$ 6.97	$ 5.25
Medical Loss Ratio	90.4%	89.0%	89.5%	88.2%	89.7%	88.7%	89.4%	89.1%
Administrative Loss Ratio	8.8%	9.5%	8.8%	10.4%	9.4%	9.4%	8.9%	9.6%
Underwriting Ratio	0.8%	1.5%	1.7%	1.4%	0.9%	1.9%	1.7%	1.3%

*Composite and Mid-Atlantic do not include Maryland
**Includes medical, pharmacy, behavioral health, etc.

We created a comparison by market segment of the average Maryland MLR, the Composite Median MLR, and the Composite 25th and 75th percentiles, as shown in Table 7. Compared to the average MLRs, the 25th percentile (i.e., lower MLR) is lower whereas the 75th percentile is higher.

TABLE 7: CY 2019 COMPARISON OF MARYLAND MLR TO COMPOSITE MEDIAN MLR, 25TH PERCENTILE AND 75TH PERCENTILE MLR

Market Segment	Maryland MLR	Composite* 25th Percentile MLR	Composite* Median MLR	Composite* 75% Percentile MLR
Comprehensive	86.6%	81.4%	86.0%	90.8%
Individual	72.4%	73.4%	83.4%	112.8%
Small Group	82.1%	75.5%	81.9%	89.9%
Large Group	90.4%	83.5%	87.9%	92.7%

*Composite does not include Maryland
Market percentiles are calculated using MLRs based on each insurer and state combination. For example, the median percentile would be the insurer/state combination with an equal number of insurer/state data points above and below it.

The Maryland MLR for the total or "comprehensive" business reviewed is slightly higher than the composite median MLR. Individual market MLR is slightly lower than the composite 25th percentile MLR, Small Group MLR is comparable to the composite median MLR, and Large Group MLR is between the composite median MLR and the composite 75th percentile MLR.

We also created a comparison by market segment of the average Maryland ALR, the Composite Median ALR, and the Composite 25th and 75th percentiles, as shown in Table 8. As in the MLR comparison, the 25th percentile (i.e., lower ALR) is lower than the average ALR, whereas the 75th percentile is higher than the average ALR.

TABLE 8: CY 2019 COMPARISON OF MARYLAND ALR TO COMPOSITE MEDIAN ALR, 25TH PERCENTILE AND 75TH PERCENTILE ALR

Market Segment	Maryland ALR	Composite* 25th Percentile ALR	Composite* Median ALR	Composite* 75% Percentile ALR
Comprehensive	10.9%	9.2%	11.4%	15.2%
Individual	13.4%	6.8%	11.1%	15.7%
Small Group	18.5%	10.5%	12.9%	15.7%
Large Group	8.8%	8.4%	10.4%	13.1%

*Composite does not include Maryland
Market percentiles are calculated using ALRs based on each insurer and state combination. For example, the median percentile would be the insurer/state combination with an equal number of insurer/state data points above and below it.

The Maryland ALR for the total or "comprehensive" business reviewed is slightly lower than the composite median ALR. Individual market ALR is between the composite median and the composite 75th percentile ALR, Small Group ALR is 3% higher than the composite 75th percentile ALR, and Large Group ALR is comparable to the composite 25th percentile ALR.

IV. Observations and Considerations

This assessment of commercial insurance health premiums, medical and administrative costs, and UW gains or losses compares Maryland to regional and composite data. Related observations are described below.

TOTAL COMPREHENSIVE MARKET

The total Comprehensive market UW gain/loss ratio of 2.5% for Maryland is slightly less than the composite average of 3.1% and the Mid-Atlantic regional average of 4.0%. The MLR of 86.6% is comparable to both the composite and Mid-Atlantic region averages. PMPM health premiums earned and PMPM total incurred claims are both approximately 2.0% higher than the composite average and 0.7% lower than the Mid-Atlantic region averages. Total ALR is higher relative to the composite and Mid-Atlantic region by 0.7% and 1.5%, respectively. Higher administrative expenses are driving the lower UW ratio in Maryland compared to the composite and Mid-Atlantic regional averages.

INDIVIDUAL MARKET

Maryland's individual market health premiums earned PMPM are approximately 17.1% lower than the composite PMPM and 22.7% lower than the Mid-Atlantic PMPM. Additionally, Maryland's total incurred claims PMPM is 27.6% and 30.5% lower than the composite and Mid-Atlantic market averages, respectively. This variance is primarily attributable to Maryland's state-based reinsurance program for the individual market. In 2019, Maryland was one of seven states operating a state-based reinsurance program under a Section 1332 waiver.[vii] Maryland's ALR is 3.2% higher than the composite average and 3.6% higher than the Mid-Atlantic ALRs. In combination, these variances are driving the UW ratio of 14.2%, which is approximately twice the composite UW ratio of 6.9% and nearly 50% greater than the Mid-Atlantic UW ratio. The state's reinsurance program is contributing to the variances total incurred claims and UW gain/loss ratios.

SMALL GROUP MARKET

Maryland premiums in the Small Group markets are approximately 14.0% lower than the composite average and 23.3% lower than the Mid-Atlantic average. Additionally, Maryland's ALR is approximately 6.1% and 7.3% higher than the composite average and Mid-Atlantic ALRs, respectively. Maryland's Small Group MLR is comparable to the composite MLR of 83.7% and Mid-Atlantic MLR of 82.2%.

LARGE GROUP

Maryland's earned premiums and incurred claims are approximately 13.2% and 15.0% higher than the composite, respectively, and 12.0% and 13.1% higher than the Mid-Atlantic, respectively. Likewise, the total ALR is approximately 0.7% lower than the composite and equal to the Mid-Atlantic ALR. Maryland's UW ratio of 0.8% is slightly lower than the composite and Mid-Atlantic region benchmarks. Conversely, Maryland's MLR of 90.4% is slightly higher than the composite and Mid-Atlantic region benchmarks.

Caveats and Limitations

The project described herein, and this deliverable are subject to the contract terms and conditions between the Maryland Health Services Cost Review Commission (HSCRC) and Milliman, Inc. (Milliman) effective November 12, 2020. This report has been prepared solely for the internal use of and is only to be relied upon by the HSCRC. No portion of this report may be provided to any other party without Milliman's prior written consent. Milliman does not intend to benefit or create a legal duty to any third-party recipient of its work. If such consent is granted, this document must be released in its entirety.

In performing this work, Milliman relied on information provided by the HSCRC and information from the National Association of Insurance Commissioners (NAIC) Supplemental Health Care Exhibit (SHCE) annual statement filings and from publicly available sources. We have not audited or verified this information, but a limited review was performed for reasonableness and consistency. If the underlying information is inaccurate or incomplete, the results of our assessment may likewise be inaccurate or incomplete.

Milliman recommends that the user of this information possess or be advised by professionals with expertise in health care operations so as not to misinterpret the information contained herein.

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[i] https://hscrc.maryland.gov/pages/tcocmodel.aspx
[ii] https://content.naic.org/sites/default/files/inline-files/047_q.pdf
[iii] https://www.law.cornell.edu/cfr/text/45/155.20
[iv] https://www.kff.org/other/state-indicator/small-group-market-rating-reforms/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D
[v] https://www.law.cornell.edu/cfr/text/45/155.20
[vi] https://content.naic.org/cipr_topics/topic_statutory_accounting_principles.htm
[vii] https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_State_Innovation_Waivers-

Milliman is among the world's largest providers of actuarial and related products and services. The firm has consulting practices in life insurance and financial services, property & casualty insurance, healthcare, and employee benefits. Founded in 1947, Milliman is an independent firm with offices in major cities around the globe.

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maryland
health services
cost review commission

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: September 9, 2021

RE: Hearing and Meeting Schedule

October 13, 2021 To be determined - GoTo Webinar

November 10, 2021 To be determined - GoTo Webinar

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

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