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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 May 12, 2021 Public Meeting:

1. Draft Recommendation on the Update Factor for FY 2022
2. Draft Recommendation on Ongoing Support of CRISP in FY 2022
3. Draft Recommendation on the Maryland Patient Safety Center for FY 2022
4. Draft Recommendation on Community Benefits Reporting Guidelines

WRITTEN COMMMENTS ON THE AFOREMENTIONED STAFF DRAFT RECOMMENDATIONS ARE DUE IN THE COMMISSION'S OFFICES ON OR BEFORE MAY 19, 2021, UNLESS OTHERWISE SPECIFIED IN THE RECOMMENDATION.

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**584th Meeting of the Health Services Cost Review Commission**
**May 12, 2020**

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

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

1. Discussion on Planning for Model Progression – Authority General Provisions Article, §3-103 and §3-104
2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104
3. Update on Commission Response to COVID-19 Pandemic - Authority General Provisions Article, §3-103 and §3-104

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

1. Review of Minutes from the Public and Closed Meetings on April 14, 2020
2. Docket Status – Cases Closed
3. Docket Status – Cases Open

   2553A - Johns Hopkins Health System
   2554A - Johns Hopkins Health System
   2555N - University of Maryland Shore Medical Center at Easton
   2556A – University of Maryland Medical System
4. Final Recommendation on Maternal and Child Health Funding Program
5. Final Recommendation on the Nurse Support Program II for FY 2022
6. Draft Recommendation on the Update Factor for FY 2022
7. Draft Recommendation on Ongoing Support of CRISP in FY 2022
8. Draft Recommendation on the Maryland Patient Safety Center for FY 2022
9. Draft Recommendation on Community Benefits Reporting Guidelines
10. FY 2020 Hospital Financial Condition Report Presentation

11. Policy Update and Discussion
    a. Model Monitoring

12. Hearing and Meeting Schedule

# Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF APRIL 21, 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 |
|---|---|---|---|---|---|---|---|
| 2553A | Johns Hopkins Health System | 4/21/2021 | N/A | N/A | ARM | DNP | OPEN |
| 2554A | Johns Hopkins Health System | 4/21/2021 | N/A | N/A | ARM | DNP | OPEN |
| 2555N | University of maryland Shore Medical Center at Easton | 4/27/2021 | 5/27/2021 | 9/14/2021 | I/P PSYCH SERVICES | WH | OPEN |
| 2556A | University of Maryland Medical System | 5/3/2021 | N/A | N/A | ARM | DNP | OPEN |

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

| | | | |
|---|---|---|---|
| **IN RE: THE APPLICATION FOR** | * | **BEFORE THE MARYLAND HEALTH** | |
| **ALTERNATIVE METHOD OF RATE** | * | **SERVICES COST REVIEW** | |
| **DETERMINATION** | * | **COMMISSION** | |
| **JOHNS HOPKINS HEALTH** | * | **DOCKET:** | **2021** |
| **SYSTEM** | * | **FOLIO:** | **2363** |
| **BALTIMORE, MARYLAND** | * | **PROCEEDING:** | **2553A** |

**Staff Recommendation**

**May 14, 2021**

## I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on April 21, 2021 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital ("the Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) and Johns Hopkins Employer Health Programs, Inc. for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to continue to participate in a global rate arrangement for Executive Health Services with Under Armor, Inc. for a period of one year beginning May 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.

## 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

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

## VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Executive Health Services for a one-year period commencing May 21, 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:** | **2364** |
| **BALTIMORE, MARYLAND** | * | **PROCEEDING:** | **2554A** |

**Staff Recommendation**

**May 14, 2021**

## I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on April 21, 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 revised global rate arrangement with the Priority Partners Managed Care Organization. Inc., the Johns Hopkins Employer Health Programs, Inc., and the Johns Hopkins Uniformed Services Family Health Plan for Spine and Bariatric surgery services. The System requests approval of the arrangement for a period of one year beginning May 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

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

## VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Bariatric and Spine Surgery Procedures for a one year period commencing May 21, 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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# Final Recommendation on Use of Maternal and Child Health Funding

May 2021

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

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# Table of Contents

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# Policy Overview

| Policy Objective | Policy Solution | Effect on Hospitals | Effect on Payers/Consumers | Effect on Health Equity |
|---|---|---|---|---|
| This final recommendation seeks to direct the reserved $10 million from the Regional Partnership Catalyst Program to fund investments in the third SIHIS population health priority area: maternal and child health. | Direct $10 million annually (FY22-2025) to Medicaid and the Prevention and Health Promotion Administration under the Maryland Department of Health to support statewide expansions of evidence-based and promising practices to promote maternal and child health. | HSCRC would issue a uniform, broad-based assessment on all hospitals. Hospitals would transfer funds received through rates to the Maternal and Child Health Population Health Improvement Fund which sunsets in 2025. | Funding for this initiative is already included in rates, so there is no rate increase for this recommendation. Consumers may benefit from additional community programs focused on maternal and child health. | These funds will support interventions that will build critical healthcare infrastructure to assist in improving access to services that address severe maternal morbidity and childhood asthma which disproportionately affect minority communities. |

# Overview

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

improvements, but also reduce significant healthcare disparities in maternal and child health. If this recommendation is approved, staff would execute an MOU with MDH and the funding would be directed to Medicaid and PHPA to fund specific maternal and child health initiatives beginning July 1, 2021 for four years. The MOU would also clearly articulate the conditions of funding including:

- The limited duration of the agreement
- Maintenance of effort requirements for interventions covered in this recommendation
- A framework for operating a workgroup to engage hospitals, MCOs, and other partners to support the funded programs
- Impact measure approach that aligns with SIHIS goals and focuses on health disparities
- Continuation of funding linked to achievement of SIHIS goals for targeted populations; and
- Specifications for annual reporting requirements to the HSCRC.

# Final Staff Recommendation

Staff makes the following recommendations:

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

# Stakeholder Feedback Summary

To ensure stakeholder feedback was considered in the approval of this funding, HSCRC staff accepted public comments on the draft recommendation. Staff received three comment letters from stakeholders in response to the draft recommendation. The respondents were:

1. Maryland Hospital Association
2. CareFirst BlueCross BlueShield
3. Johns Hopkins Health System

We thank the stakeholders for their comment letters about the proposed funding. Copies of the letters received by HSCRC are attached to this final recommendation. The comment letters were generally supportive of new maternal and child health investments, but raised some concerns and offered suggestions for staff to consider in the final recommendation. Stakeholder letters shared some common themes:

- Hospital Engagement
- Use of the Rate Setting System
- Focus of Programs
- Health Equity
- Measurement Alignment

**Stakeholder Comment 1: Hospitals and the private sector need to be engaged more proactively.**

Staff Response: Staff agrees that hospitals are important partners in the spectrum of care for pregnant women and children. Staff has identified opportunities where hospitals, MCOs, and community partners can collaborate to maximize the success of these programs and improve care for the target population which is discussed later in this recommendation. Additionally, MCOs that are hospital-owned are eligible for funding.

Staff have identified four key areas where hospitals can actively engage to support the programs proposed for funding in this recommendation.

1. *Identification and Referrals:* Hospitals can support early identification of pregnancy for MCOs and provide referrals for care which will promote prenatal care earlier in pregnancy. Timely engagement in prenatal care is one of the keys to preventing severe maternal morbidity. Historically, reliance on administrative data (i.e. claims and encounters) to identify pregnancy was too late for payers and other entities to encourage prenatal care early in pregnancy. In 2017, Mercy Medical Center, CRISP, Amerigroup and the Baltimore City Health Department sought to connect pregnant women into the City's care coordination system through an electronic referral. CRISP identifies eligible patients using the lab feed, filters for all positive pregnancy tests (urine hCGs) and matches the MCO panel to the lab feed to send to Baltimore's Administrative Care Coordination Unit (ACCU) at HealthCare Access Maryland. With MCO panel submission now universal and current across MCOs, the Department would like to expand these alerts to all hospitals and labs in the state, with alerts going directly to MCOs, in addition to the local ACCUs.

In addition to early identification of pregnancy, hospitals can identify children with moderate to severe asthma and refer to the State's home-visiting program and community-based programs to address childhood asthma.

2. *Infrastructure and Policy Support:* Hospitals also have opportunities to promote innovative policies and provide needed infrastructure for the programs recommended for funding. For example, hospitals can ensure doulas are permitted at their hospitals to support new, innovative models of non-traditional, non-physician-centered care. Additionally, Centering Pregnancy and HealthySteps require classrooms and office space. Hospitals can identify and offer space for these programs, bringing these innovative programs into their communities and campuses.
3. *Implementation Workgroup:* The State will form a workgroup to support the implementation of the programs and initiatives recommended for funding. The workgroup would include representatives from hospitals, MCOs, and key partners engaged in these programs.
4. *Community-Based Interventions:* Community-based organizations implementing PHPA initiatives must collaborate with local hospitals and health systems.

**Stakeholder Comment 2: Hospital rate setting dollars should not be used to supplant state funding.**

Staff Response: Staff agrees that this recommendation should not be used to justify supplanting State funds. Staff believes that this recommendation and the language in the 2021 BRFA have created very narrow parameters for use of these funds. These funds are intended to be supplemental dollars only. This year, the State made a significant $17 million investment to support maternal health. The legislature passed SB 777[1] which increases funding for prenatal care, as well as SB 923[2] which extends post-partum Medicaid coverage for one year following the end of a woman's pregnancy for those who would have otherwise lost coverage at two months postpartum.

**Stakeholder Comment 3: HSCRC and MDH should include maintenance of effort language in the MOU they develop.**

Staff Response: HSCRC staff plan to include maintenance of effort language in the MOU with MDH to support programs and interventions described in the recommendation. Staff will include language in the MOU on the following provisions:

- Duration of the agreement.
- Maintenance of effort for interventions covered in this recommendation.

[1] SB 777.
Public Health - Maryland Prenatal and Infant Care Grant Program Fund.
https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0777
[2] SB 923. Maryland Medical Assistance Program – Eligibility.
https://mgaleg.maryland.gov/mgawebsite/Legislation/Details/sb0923

- A framework for operating a workgroup to engage hospitals, MCOs, and other partners to support the funded programs.
- Impact measure framework that aligns with SIHIS goals and focuses on health disparities.
- Continuation of funding linked to achievement of SIHIS goals for targeted populations.

**Stakeholder Comment 4: The recommendation should narrow the focus of the programs.**

Staff Response: Staff recommend funding the programs as proposed. The evidence-based programs and promising practices put forth for funding were selected because they have demonstrated positive health outcomes for patients and are narrowly focused to support the MCH goals under SIHIS.

**Stakeholder Comment 5: Funded programs should include an intentional focus on diversity, equity and inclusion.**

Staff Response: Staff agrees that funded programs should be culturally competent to optimize care for the target populations. Additionally, the programs proposed were intentionally selected to support State efforts to reduce healthcare disparities for each of the SIHIS MCH goals.

**Stakeholder Comment 6: Impact measures should align with other programs, where possible.**

Staff Response: Staff agrees that increased alignment will support ongoing efforts to build shared goals and focus stakeholder attention on SIHIS population health goals. As part of the MOU, staff will include language to align impact measures with SIHIS goals and address health disparities. HSCRC and MDH staff will look to align impact measures with other programs, where possible.

# Background

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

While the State identified diabetes and opioid use as key population health priority areas over a year ago, the third priority area was not selected until later in 2020. In fall of 2020, the State formally selected maternal and child health as the third population health priority under SIHIS. Consistent with the State's guiding principle to select goals, measures, and targets that are all-payer in nature, maternal and child

health was deliberately considered as a priority area even though it is not Medicare focused. The selection of maternal and child health as a priority area reflects its importance in the State, and acknowledges both the longstanding history of disparities, as well as the large potential for improvement.

The U.S. faces higher maternal and infant mortality rates compared to other industrialized countries, with large racial/ethnic disparities for each outcome; Maryland's maternal mortality rate from 2013 to 2017 (24.8 maternal deaths per 100,000 live births) ranks 22nd among states, with the rate for African Americans almost four times that of Whites (44.7 maternal deaths vs. 11.3 per 100,000 live births).[3],[4]

In addition, pediatric asthma contributes to increased healthcare utilization and spending, missed school days, and sub-optimal overall health and well-being in Maryland children. Pediatric asthma also has a significant impact on parental productivity. In Maryland, approximately 9.7 percent of children have asthma.[5]

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

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

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

*Table 1. SIHIS Goal: Maternal Health*

| Goal: Reduce severe maternal morbidity rate | |
|---|---|
| **Measure** | Severe Maternal Morbidity Rate per 10,000 delivery hospitalizations |
| **2018 Baseline** | 242.5 SMM Rate per 10,000 delivery hospitalizations |
| **2021 Year 3 Milestone** | Re-launch the Perinatal Quality Collaborative.<br><br>Pilot a Severe Maternal Morbidity Review Process with eight Birthing hospitals<br><br>Complete Maryland Maternal Strategic Plan. |

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

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

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

| | |
|---|---|
| | Launch Regional Partnership Catalyst Grant for MCH, if funding is available. |
| **2023 Year 5 Target** | 219.3 SMM Rate per 10,000 delivery hospitalizations |
| **2026 Year 8 Final Target** | 197.1 SMM Rate per 10,000 delivery hospitalizations |

*Table 2. SIHIS Goal: Child Health*

| **Goal: Decrease asthma-related emergency department visit rates for ages 2-17** | |
|---|---|
| **Measure** | Annual ED visit rate per 1,000 for ages 2-17 |
| **2018 Baseline** | 9.2 ED visit rate per 1,000 for ages 2-17 |
| **2021 Year 3 Milestone** | Obtain Population Projections.<br><br>Development of Asthma Dashboard.<br><br>Launch Regional Partnership Catalyst Grant for MCH, if funding available.<br><br>Asthma-related ED visit is a Title V State Performance Measure and shift some of the Title V funds for Asthma-related interventions. |
| **2023 Year 5 Target** | Achieve a rate reduction from 2018 baseline to 7.2 in 2023 for ages 2-17 |
| **2026 Year 8 Final Target** | Achieve a rate reduction from the 2018 baseline to 5.3 in 2026 for ages 2-17 |

# Funding

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

Staff recommends issuing the remaining 20 percent allocated to the third population health funding stream for maternal and child health investments. While HSCRC staff developed a competitive bid process for the diabetes and behavioral health funding streams under the Regional Partnership Catalyst Program, staff recommends directing the third funding stream to investments led by Medicaid and PHPA, in conjunction

with the Medicaid HealthChoice MCOs. This funding will scale existing statewide evidence-based programs and promising practices and support the expansion of new services for mothers and children. Additionally, using the funding in this manner would also create an opportunity for the State to receive federal match funding to nearly double the investment. Funds would be added to hospital annual rates as temporary adjustments through a uniform, broad-based assessment for four years.

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

Hospitals would transfer funds to the Maternal and Child Health Population Health Improvement Fund. The Maternal and Child Health Population Health Improvement Fund, created through the 2021 Budget Reconciliation and Financing Act (BRFA), may receive funding from hospital rates to invest in maternal and child health initiatives, as approved by Commissioners. The Fund would sunset in 2025. HSCRC staff would establish a Memorandum of Understanding (MOU) with MDH to establish terms and conditions for the administration of the Maternal and Child Health Population Health Improvement Fund.

# Programs and Interventions

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

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

*Table 3. Proposed Medicaid and PHPA Programs and Interventions*

| | Program/Initiative | Annual Funding Distribution |
|---|---|---|
| Medicaid | Home Visiting Services Pilot Expansion | $8 Million |
| | Reimbursement for Doula Services | |
| | CenteringPregnancy | |

| | | |
|---|---|---|
| | HealthySteps | |
| | Maternal Opioid Misuse (MOM) Model Expansion | |
| PHPA | Asthma Home Visiting Program | $1.25 Million |
| | Eliminating Disparities in Maternal Health Initiatives | $750,000 |
| | **Total** | **$10 Million** |

## Medicaid Innovation for Improving Maternal and Child Health

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

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

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

### Home Visiting Services (HVS) Pilot Expansion

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

funding sources. Expanding existing HFA or NFP programs would allow more high-risk pregnant individuals to get access to both health and social support during the prenatal to three year period through home visiting services.

Formal evaluation results will not be available until the summative HealthChoice evaluation in 2023. However, selected annual service utilization data for CY2018 to CY2019 reflects that 100 percent of children in both pilots received at least one well-care visit, 52 percent had at least one ED visit, and only 3.8 percent had at least one ED visit due to injury. Eighty-six (86) percent of children did not receive NICU services, 96 percent had no inpatient admission, and over 70 percent of mothers were screened for depression. Based on existing qualitative reports received through the pilot period from the LEs, families have and continue to benefit from these high touch home visiting services offered prenatally and through the postpartum period, and from the improved care coordination with other needed health and social services and supports. In addition, coordination and communication between the lead entities and MCO case management has greatly improved as a result of the HVS pilot program.

*Sustainability:* State Plan Amendment

*Monitoring and Impact Measures:*

- Process Measures: Increased number of evidence-based home visiting programs participating in Medicaid-funded home visiting pilot programs; number of Medicaid participants
- Outcome Measures: Increased prenatal and postpartum care attendance; increased child vaccination rate and well-child visit attendance
- Expected Impact: Cost savings due to reductions of low birth weight babies, birth complications and C-sections, maternal morbidity and mortality

## Reimbursement for Doula Services

Doulas are trained to provide continuous physical, emotional and informational support to a mother before, during and shortly after childbirth.[6] Key to a doula's function are the provision of emotional support and a constant presence during labor; encouraging laboring individuals and their families; and communicating between mothers and medical professionals. Potential benefits of working with a doula include reductions in C-sections, instrumental vaginal births and the need for oxytocin augmentation, in addition to shortened

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

durations of labor.[7] Doula care has demonstrated a stronger impact for individuals who are socially-disadvantaged, low-income, unmarried, primiparous, giving birth in a hospital without a companion or had experienced language or cultural barriers.[8]

*Sustainability*: State Plan Amendment

*Monitoring and Impact Measures:*

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

## CenteringPregnancy

CenteringPregnancy is an evidence-based group prenatal care model for low-risk pregnancies. Facilitators support a cohort of eight to ten individuals of similar gestational age through a curriculum of ten 90- to 120-minute interactive group prenatal care visits that largely consist of discussion sessions covering medical and non-medical aspects of pregnancy, including nutrition, common discomforts, stress management, labor and birth, breastfeeding and infant care.[9] While Centering groups are comprised of participants of different ages, races and socio-economic backgrounds, this program has been shown to improve outcomes and reduce preterm birth, particularly for Black participants.[10] Evidence suggests CenteringPregnancy reduces costs, improves outcomes and leads to high satisfaction, with one study showing a reduction in risk of premature birth by 36 percent, with an average cost savings of $22,667, in the rate of low birthweight by 44 percent (average savings of $29,627) and NICU stays (average savings of $27,249). There are currently

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

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

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

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

eight CenteringPregnancy sites in Maryland—four in the Baltimore metro area, two in the DC metro area, one on the Eastern Shore and one in Western Maryland.

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

*Monitoring and Impact Measures:*

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

## HealthySteps

HealthySteps, a program of ZERO TO THREE, is a pediatric primary care model that promotes positive parenting and healthy development for babies and toddlers. Under the model, all children ages zero to three and their families are screened and placed into a tiered model of services of risk-stratified supports, including care coordination and on-site intervention.[11] The HealthySteps Specialist, a child development expert, joins the pediatric primary care team to ensure universal screening, provide successful interventions, referrals and follow-up to the whole family.[12] HealthySteps has demonstrated a 204 percent average annual return on investment.[13] Healthy Steps has two existing locations in Maryland: University of Maryland School of Medicine Department of Family & Community Medicine and University of Maryland Pediatrics – Midtown, both located in Baltimore.

*Sustainability*: Inclusion in MCO capitation rates; opening code for preventive medicine counseling (99401); attaching reimbursement for z-code diagnosis

*Monitoring and Impact Measures:*

- Process Measures: Number of sites (existing and new); number of participating MCOs; number of Medicaid participants

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

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

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

- Outcome Measures: Increased prenatal and postpartum care attendance; decreased postpartum depression rate; increased child vaccination rate and well-child visit attendance
- Expected Impact: Cost savings due to reductions in ED utilization for ambulatory-sensitive conditions

## Maternal Opioid Misuse (MOM) Model/Enhanced Case Management for High-Risk Pregnancies

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

The Medicaid program would also invest in an intensive case management protocol for high-risk pregnancies not eligible for the MOM model.

*Sustainability*: §1115 waiver

*Monitoring and Impact Measures:*

- Process Measures: Number of Maryland jurisdictions where services are covered; number of MOM model participants
- Outcome Measures: Increased prenatal and postpartum care attendance; increased utilization of medication for OUD; increased screenings for maternal anxiety, depression and social determinants of health; increased well-child visit attendance
- Expected Impact: Cost savings due to reductions in potentially-avoidable ED utilization and NICU lengths of stay

# PHPA Initiatives for Improving Maternal and Child Health

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

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

## Asthma Home Visiting Program

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

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

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

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

*Monitoring and Impact Measures*

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

### Eliminating Disparities in Maternal Health Initiative

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

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

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

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

# Recommendations

Staff makes the following recommendations:

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

- Healthy Steps, a clinic-based intensive prenatal and postpartum case management framework; and
- Maternal Opioid Misuse (MOM) model expansion/intensive case management for high-risk pregnancies.

5. Approve the use of $2 million annually by PHPA to support the following initiatives and programs:
    - Asthma Home Visiting Program
    - Eliminating Disparities in Maternal Health Initiative
6. Require an annual report from MDH on the use of funds, engagement with hospitals, and progress towards SIHIS goals.

# Appendix 1 – Medicaid Programs – Expansion Estimates

*Table 4. Medicaid Programs - Expansion Estimates*

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

# Appendix 2 – PHPA Programs - Expansion Estimates

*Table 5. Capacity for CHIP-SPA Asthma Home Visiting*

| Current Areas | Estimated Eligible Children (FY 2018) | # of Children w Asthma ED Visits[14] (CY 2018) | # of Child Asthma ED Visits[15] (CY 2018) | Current Enroll-ment Capacity[16] | Expanded Enrollment Capacity[17] | Capacity Growth |
|---|---|---|---|---|---|---|
| Baltimore City [expanded] | 8,897 | 2,482 | 3,419 | 232 | 416 | 79% |
| Baltimore County [Expanded] | 4,020 | 1,391 | 1,849 | 232 | 263 | 13% |
| Charles | 527 | 199 | 243 | 166 | 180 | 8% |
| Dorchester | 339 | 73 | 93 | 99 | 97 | -2% |
| Frederick | 433 | 291 | 373 | 166 | 180 | 8% |
| Harford | 534 | 290 | 353 | 166 | 180 | 8% |
| Prince George's | 3057 | 690 | 771 | 232 | 263 | 13% |
| St. Mary's | 386 | 136 | 167 | 166 | 180 | 8% |
| Wicomico | 453 | 181 | 241 | 166 | 180 | 8% |
| Montgomery [New] | 2,439 | 922 | 1,104 | | 263 | |
| **Total in Jurisdictions** | **21,085** | **6,655** | **8,613** | **1625** | **2202** | **36%** |

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

| Program | Estimated Eligible Population (Annual)[18] | Current Enrollment (Annual) | Expanded Enrollment (Annual) |
|---|---|---|---|
| Centering Pregnancy | 56728 | 600[19] | 1200[20] |
| Maternal and Infant Home Visiting | 56728 | 2747 | 2947[21] |

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

**Maria Harris Tildon**
Executive Vice President
Public Policy & Government Affairs

**CareFirst BlueCross BlueShield**
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Tel. 410-605-2591
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April 21, 2021

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

Dear Chairman Kane:

We have reviewed the HSCRC Staff's recommendation on Use of Maternal and Child Health Funding and appreciate the opportunity to provide our comments. Generally, we enthusiastically support the recommendation as it is tied directly to population health outcomes goals outlined in the Statewide Integrated Health Improvement Strategy (SIHIS). We are grateful to see a heightened focus on population health outcomes and appreciative of dedicating funding and focus to a non-Medicare health matter.

While we are excited about and enthusiastically support this recommendation, below are a few key points of emphasis on particular programs selected.

- **Home Visiting Services Pilot Expansion** – Since this pilot program exists, are you able to share some initial results? If Staff is proposing its expansion, we assume it has been successful, but assessing results would allow us to appropriately set expectations for expansion.

- **Reimbursement for Doula Services** – We strongly support building the infrastructure to meaningfully compensate doulas for their care. We believe this touches on both quality and equity, as evidence demonstrates benefits in prenatal outcomes and reduced health disparities. We recommend an element of this program incorporate an intentional commitment to diversity, equity, and inclusion as the targeted patient population will gravitate toward providers who are familiar to them.

- **CenteringPregnancy** – We believe it is critical for quality-of-care stewards like the National Committee for Quality Assurance (NCQA) to accept non-traditional, non-physician-centered vehicles of care for prenatal care, especially among populations that experience health disparities. While unconventional, we believe their value is overlooked and understated, especially in some populations. In order to improve the outcome measures associated with this program, we recommend tracking the program's success in connecting mothers to a primary care physician.

- **Asthma Home Visiting Program** – The scope of this program is unclear in the recommendation, but we suggest a focus on remediation of environmental factors, such as air filtration systems and replacement of fabric covered furniture with non-allergenic materials, where possible.

We would also like to add a word of caution based on historical rate support for Medicaid. Staff recommends that 80% of the hospital rate derived funding be managed by Medicaid during the four years of the program. Like the Medicaid Deficit Assessment, rates paid by all payers are redirected to one payer. The Medicaid Deficit Assessment was intended to be "temporary" when it started at a very small amount more than 10 years ago. It has now grown to $294.8 million. Hospitals pay the first $56 million while all payers pay the remainder. While the current recommendation is also intended to result in a temporary program, it is important that the concept not be used in the future as a source of general revenue that is shifted from all payers to one payer.

Again, we thank you for this opportunity to share our thoughts regarding the Use of Maternal and Child Health Funding. We look forward to continued collaboration and involvement as the State works toward goals set forth in the SIHIS around the critical issue of maternal and child health.

Sincerely,

Maria Harris Tildon

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

Maryland
Hospital Association

April 22, 2021

Erin Schurmann
Chief, Provider Alignment and Special Projects
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Schurmann,

As the advocate for Maryland's hospitals, MHA appreciates the opportunity to comment on the draft *Recommendation on the Use of Maternal and Child Health Funding*. We support using the remaining Regional Partnership Catalyst Grant set aside of $10 million in each of fiscal years 2022-2025 to further maternal and child health goals in the Statewide Integrated Health Improvement Strategy.

We would note, however, the recommendation misses the mark in its goal of fostering hospitals' relationships with community partners. It is vital that this funding, which is derived from payments for hospitals services, be used to support and further hospitals' partnerships within the community. Better connections before and after pregnancy engender trust and communication that is critical for good maternal outcomes. Hospitals should have a role as it is crucial that they are not viewed just as the point of care during delivery or when serious complications arise.

Furthermore, nearly all the funding is directed to Medicaid for efforts that are already in practice or are in the planning stages. Such interventions are important to reduce longstanding disparities in maternal and child health, yet when they are implemented by the Medicaid program they should be funded directly by the State.

We appreciate the opportunity to comment on this worthwhile grant funding program.

Sincerely,

Traci LaValle
Senior Vice President, Quality & Health Improvement

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

April 21, 2021

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

Dear Chairman Kane,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the draft recommendation on the use of Maternal and Child Health Funding, which would direct $10M annually over four years to Medicaid and the Prevention and Health Promotion Administration to support statewide expansion of evidence-based programs to promote maternal and child health. JHHS is supportive of a new approach to invest directly in public health and is in support of maternal and child health measures. JHHS does have additional recommendations as HSCRC staff considers the reach and sustainability of this work.

*Engagement of All Stakeholders*

JHHS believes there is value in directly funding public health initiatives, but without proper constraints and incentives to engage all stakeholders, we are concerned that this process could ultimately become a mechanism consistently used to fund public health initiatives that have historically been the responsibility of the State and local government. The purpose of the Statewide Integrated Health Improvement Strategy (SIHIS) is to bring public and private stakeholders together around eliminating health disparities and improving population health throughout Maryland. The current approach simply diverts rate dollars to the state budget. JHHS recommends the HSCRC explore an alternative approach to ensure engagement from all stakeholders in determining how these funds are spent, where they are directed, and include an accountability framework with respect to performance, outcomes and sustainability.

*Importance of Memorandum of Understanding (MoU) between Maryland Department of Health (MDH) and HSCRC*

The recommendation notes that if approved, HSCRC staff will establish a MoU with MDH to establish terms and conditions for the administration of the Maternal and Child Health Population Health Improvement Fund. JHHS believes that this MoU must articulate the State's commitment to maintain and continue to increase investments in maternal and child health, as no progress will be made if simply replacing state dollars with hospital dollars. This additional funding should continue to augment efforts both in place and planned. Additionally, given staffing and infrastructure timeline constraints that may exist, the State must ensure that any regulatory and operational challenges are rapidly addressed so programs may be launched and expanded with ease.

SIHIS is the result of an agreement between the State and CMMI, presenting both a responsibility and opportunity for State agencies and policy makers to be more engaged in ensuring the success of the Maryland Model. This Maternal and Child Health MoU should maximize the State's ability to influence improvement in these critical areas. Through the MoU, the State should consider aligning the SIHIS goals with the HealthChoice Value Based Purchasing program and HEDIS measures. We appreciate that some alignment already exists, however strengthening efforts to bring greater alignment between managed care organizations and providers will support and focus the efforts of all stakeholders on the three population health measures identified in the Statewide Integrated Health Improvement Strategy.

*Validity of Identified Programs and Interventions*

Staff have identified a number of proposed programs and initiatives that would receive support under this recommendation. JHHS recommends a narrower focus on a few select programs to ensure meaningful improvement in targeted areas, particularly given the importance of concentrated investment in areas of need and in disparities reduction. A narrow focus will also allow for a more conclusive analysis of what interventions are successful and should be expanded. A set of criteria should be developed to determine which of these suggested programs and interventions have the most promise and will meaningfully impact the identified health outcomes. Additional evidence-based programs to consider using these developed criteria include Building Better Beginnings (3B), National Committee for Quality Assurance Multicultural Health Designation, asthma public school collaborations, and others.

*Additional Concern*

While this recommendation will bring meaningful funding to the identified maternal and child health programs and interventions, the expansion estimates for this funding are significantly smaller than the total eligible population. Though Medicaid and PHPA's reach is meaningful, some funding should be dedicated to enhancing care and outcomes of populations who are currently ineligible for or lack access to health insurance and other populations that face barriers to engaging in healthcare and accessing maternal child health services.

We appreciate the continued efforts of the HSCRC staff on this important proposal, and we look forward to our continued collaboration. Thank you for the opportunity to provide feedback.

Sincerely,

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

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

maryland
health services
cost review commission

# Nurse Support Program II Competitive Institutional Grants Program Review Panel and Faculty Workgroup Statewide Initiatives Recommendations for FY 2022

Final Recommendation

May 2021

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

maryland
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# Table of Contents

# Introduction

This report presents recommendations for the Nurse Support Program II (NSP II) Competitive Institutional Grants Review Panel for Fiscal Year (FY) 2022. As part of the NSP II Program Evaluation recommendations approved in the December 11, 2019 report, the Faculty Workgroup and Nurse Support Program I (NSP I) and NSP II Advisory Group met regularly to improve the NSP II faculty-focused programs and advance the mutual goals of NSP I and NSP II. This report and the recommendations are jointly submitted by the staff of the Maryland Higher Education Commission (MHEC) and the Maryland Health Services Cost Review Commission (HSCRC or Commission). The FY 2022 NSP II recommendations align with the NSP I and NSP II overarching goals of excellence in nursing practice and education.

# Background

The HSCRC has funded programs to address the cyclical nursing workforce shortages since 1986. In July 2001, the HSCRC implemented the hospital based NSP I to address the nursing shortage impacting Maryland hospitals. Since that time, the NSP I completed three five-year program evaluation cycles. The most recent renewal was approved on July 12, 2017 to extend the funding until June 30, 2022.

The HSCRC established the NSP II on May 4, 2005, to increase Maryland's academic capacity to educate nurses. The Annotated Code of Maryland, Education Article § 11-405 Nurse Support Program Assistance Fund [2006, chs. 221, 222] was revised in 2016 to delete "bedside" to allow for the necessary nurse skill mix. Provisions are included for a continuing, non-lapsing fund, with a portion of the competitive and statewide grants be used to attract and retain minorities in nursing and nurse faculty careers in Maryland. The Commission approved funding of up to 0.1 percent of regulated gross hospital revenue to increase nursing graduates and mitigate barriers to nursing education through institutional and faculty-focused initiatives. MHEC was selected by the HSCRC to administer the NSP II programs as the coordinating board of higher education.

In 2012, the NSP II program was modified to include support for greater development of new and existing nursing faculty through doctoral education grants. Additionally, there were revisions to the Graduate Nurse Faculty Scholarship including, renaming the nurse educator scholarship in honor of Dr. Hal Cohen and his wife Jo, and sunsetting the living expense grant component. At the conclusion of the first ten years of funding in 2015, the HSCRC renewed funding through June 30, 2020, and for another five-year cycle through June 30, 2025, in December 2019.

# New Transition to Nurse Residency Program

During the COVID-19 pandemic, the Maryland Organization of Nurse Leaders, Maryland Nurse Residency Collaborative (MNRC) formed a task force of Maryland hospital and academic leaders to develop onboarding strategies for new nurses transitioning into practice during this period. In March 2020, the pandemic's strain on hospital resources and the concern for the safety of students, hospital staff, faculty and patients caused leaders to cease on-site student clinical experiences. Adjusting quickly, nurse educators moved student learning to the clinical simulation and virtual simulation delivery options to compensate for the loss of on-site clinical experiences.

Even with established guidelines for students to return to clinical at the hospitals, there were still barriers to students gaining clinical experience. Limited clinical sites and personal protective equipment (PPE), and reductions in the number of students permitted on clinical units resulted in students graduating without hands-on clinical practice opportunities and experiences, especially in specialty areas like labor and delivery, pediatrics, and behavioral health. Many entered the workforce feeling unprepared and lacked confidence.

Hospital and academic leaders formed a statewide task force to find a solution to address concerns about the clinical and emotional preparedness of new-to-practice nurses entering the workforce during the pandemic. The Transition to Nurse Residency Program (TNRP) was developed as an innovative two-week long or 80-hour curriculum to help hospitals fill the education-practice gap of new nurses entering the workforce during the COVID-19 pandemic. The goal of the TNRP is to build the new-to-practice nurses' skills and competencies to the same level of their pre-pandemic counterparts. The purpose is to assess and develop specific skills and competencies that pre-licensure nursing students could not demonstrate or experience due to the reduction or cancelation of in-person clinical education. The TNRP does not duplicate nor replace the 12-month Vizient/AACN Nurse Residency Program (NRP) which supports new nurse retention (Table 1). Instead, the TNRP program is a time-limited precursor to the NRP offered at onboarding and before the new-to-practice nurses assume patient assignments. Currently, 15 hospitals plan to implement the program using a toolkit that was developed to guide hospital nursing leaders with the program implementation.

*Table 1. MNRC Data on Retention of New Nurse Graduates*

| | 2017 | 2018 | 2019 | 2020 |
|---|---|---|---|---|
| **Number of Residents Hired** | 1,564 | 1,503 | 1,903 | 2,060 |
| **Percent of Residents Terminated** | 7% | 10% | 10% | 9% |
| **Retention Rate** | 93% | 90% | 90% | 91% |

*Source: MNRC, TNRP Toolkit, 2021*

# Progress on "80 Percent BSN by 2025" Goal

In 2021, the proportion of BSN or higher prepared nurses increased to 67.1 percent (RWJF, 2021), with continued steady progress on the 80 percent BSN by 2025. At present, Maryland ranks fourth in the percent of BSN or higher prepared nurses; following North Dakota (76.8 percent), District of Columbia (73.1 percent) and Vermont (71.1 percent) and lead our neighboring states by 10 to 15 percent (Table 2). Working closely with all 15 community colleges and their university partners in Associate-to-Bachelor's degree dual enrollment partnerships has dual benefits; saves money and completion time for the nurses while affording hospitals new nurse hires that are closer to completing their BSN.

*Table 2. Comparison of Geographic Neighbors in Percent Bachelor of Science in Nursing*

| State | 2010 | 2018 | Percent Increase |
|---|---|---|---|
| **Maryland** | 55.4% | **67.1%** | 11.7% |
| **Virginia** | 51.1% | 51.7% | 8.3% |
| **West Virginia** | 37.4% | 51.3% | 13.8% |
| **Delaware** | 42.1% | 54.6% | 12.5% |
| **Pennsylvania** | 45.9% | 57.4% | 11.5% |
| **US** | 48.8% | **57%** | 8.2% |

*Source: RWJF/AARP Future of Nursing Campaign for Action Education Map, 2021*

Despite the change to virtual delivery, programs for nurses in practice and academia continued with institutional technology support. Overall, nursing education adapted and continued the steady progression of nursing students and nurses seeking higher degrees, however, some studies have shown conflicting data. On one hand, there was an influx of new students interested in the career of nursing, while other studies have shown increases in the number of nurses considering leaving the field due to the stress of the pandemic, overtime, and the acuity level of the patients.

# Statewide Initiatives: Faculty-Focused Programs

The NSP II staff meet regularly with the Maryland Deans and Directors of Nursing Programs (MDDNP) and faculty leaders serving as project directors for the NSP II Competitive Institutional Grants to receive guidance, feedback and engagement on workgroups and subcommittees, including the NSP I and NSP II Advisory Group and Faculty Workgroup.

The NSP II Faculty Workgroup made several recommendations to revise and align all faculty-focused programs, including increased funding for the New Nurse Faculty Fellowship (NNFF) and the Nurse Educator Doctoral Grants for Practice and Dissertation Research (NEDG) in FY 2020. The NNFF is a multi-year award for nurse educators who have already been hired and committed to a faculty career path. Awardees from prior fiscal years were grandfathered into the revised programs. The Maryland

Deans and Directors of Nursing Programs (MDDNP) recommended revisions to the Nurse Faculty Annual Recognition (NFAR) award to include criteria related to faculty development to recognize the excellence of awardees in mentoring new faculty hires.

The NSP II Faculty Workgroup also noted that the Cohen Scholars (CS) program for potential future faculty was not aligned with similar NSP II initiatives and recommended several actions to realign all NSP II scholarship initiatives and ensure a consistent and simple process for service time. The revised guidelines for the CS program included transitioning to a competitive scholarship, with required educational plans of study and incorporated core coursework in nursing education delivery, curriculum development, and teaching practicums, as well as 1:1 personal faculty mentoring and structured guidance in preparation for their future roles. The Scholars' mentor will assist in job placement and follow-up communications to ensure a good fit in nursing education. Scholars will also have access to the Maryland Educator Career Portal (www.leadnursingforward.org), which provides information on the nurse educator career, educational requirements, as well as job openings for full-time educators, adjunct faculty, clinical instructors and other nursing positions at MD hospitals or schools. For scholars who decide to choose a field other than education after graduation, NSP II staff will complete the required repayment process to promptly remit the scholarship funding if the accepted terms are not met.

Going forward, MHEC staff will ensure that there is consistent, equitable, and clear 1:1 service obligation repayment across all NSP II initiatives for all nurses currently teaching in Maryland nursing programs or hospital education departments. Any participants in the program prior to this modification will be grandfathered into the standard tuition to service obligation. In addition, MHEC (in consultation with HSCRC staff) recommends expanding opportunities for nurses to complete their teaching service to all NSP I and NSP II hospitals, health systems and their affiliates, to reduce any barriers in complying with this requirement. With oversight from an active CS Coalition faculty mentoring team, the guidance and expectations for all scholarship participants in every graduate degree program will be the same.

Additionally, all NSP II faculty award programs will use an evaluation survey that was endorsed by the Faculty Workgroup in collaboration with the National League of Nursing (NLN) that is founded on the nurse educator competencies, including data to identify areas of funding utilization and career progression. The results of the survey will inform future program evaluations with additional benchmarks beyond the positive outcome of 93 percent retention at 3 years of employment. In-state surveys continue to reflect over half of the experienced educators plan to retire in the next 10 years. Funding for each program is outlined in Table 3.

*Table 3. Statewide Initiatives: Faculty-Focused Programs*

| Program | FY 2020 | | FY 2021 | |
|---|---|---|---|---|
| | Number Awarded | Amount Awarded | Number Awarded | Amount Awarded |
| **New Nurse Faculty Fellowship** | 52 | $920,000 | 51 | $1,320,000 |
| **Nurse Educator Doctoral Grants** | 6 | $180,000 | 36 | $1,470,000 |
| **Academic Nurse Educator Certification** | 29 | $145,000 | 39 | $195,000 |
| **Nurse Faculty Annual Recognition** | 0 | $0 | 13 | $130,000 |
| **Total** | **87** | **$1,245,000** | **139** | **$3,115,000** |

*Source: NSP II Faculty-Focused Program Awards, FY 2020-2021*

# Certified Nurse Educator Workshops

Four NLN Certified Nurse Educator (CNE) Workshops were held virtually for 136 nurse educators between July 2020 and April 2021 to prepare nurse faculty and Cohen Scholars entering the educator workforce. The Academic Nurse Educator Certification (ANEC) award included 39 newly certified and re-certified faculty in April 2021. Maryland's CNE pass rate exceeds the nation, 87.5 percent compared to the national pass rate of 72 percent (NLN, March 30, 2020). There have been 13 community colleges and 11 universities with nominees for the award since it was instituted in FY 2019, with 24-27 schools participating each year. In order to renew the credential every 5 years, faculty must demonstrate continued excellence in the specialty practice of nursing education. This is a mark of distinction and demonstrates the NSP II focus on meeting the highest standards for educators charged with teaching all levels of nursing students. Maryland is leading the way in the increased proportion of nurse faculty who hold the CNE credential.

At the recommendation of the NSP I and II Advisory Group, all faculty-focused nomination forms were revised to include ethnicity, race and gender to measure outcomes on increasing diversity and underrepresented groups in nursing. In FY 2021, 58 percent of CNE Workshop faculty participants were minorities (Table 4). Staff will continue to report on the race and ethnicity of program participants as data becomes available.

*Table 4. Number of Faculty Nursing Participants at CNE Workshops, by Race/Ethnicity*

| FY 2021 CNE Workshops | Total Faculty Attending | Caucasian | | African American | | Hispanic | | Asian | |
|---|---|---|---|---|---|---|---|---|---|
| | | Number | Percent | Number | Percent | Number | Percent | Number | Percent |
| **April 2021** | 29 | 12 | 41.3% | 12 | 41.3% | 3 | 10.3% | 2 | 6.8% |
| **January 2021** | 37 | 14 | 37.8% | 22 | 59.4% | 0 | 0.0% | 1 | 2.7% |
| **October 2020** | 31 | 12 | 38.7% | 16 | 55.1% | 0 | 0.0% | 3 | 9.6% |
| **July 2020** | 39 | 19 | 48.7% | 18 | 46.1% | 0 | 0.0% | 2 | 5.1% |
| **Total** | **136** | **57** | **41.9%** | **68** | **50.0%** | **3** | **2.2%** | **8** | **5.8%** |

# Maryland Nursing Workforce Center

In August 2019, the National Council of State Boards of Nursing (NCSBN) announced that the NCLEX nursing examination would be revised and updated to evaluate clinical judgement among new graduate nurses. The Next Generation (NGN) NCLEX is projected to be implemented with the Spring 2023 nursing graduates. In January 2020, the Maryland Nursing Workforce Center hosted an introductory Next Generation NCLEX-RN workshop with strong statewide participation. As a state, all nursing programs will be provided the tools and support to prepare students and faculty for the NGN. Dr. Rebecca Wiseman, director of the Maryland Nursing Workforce Center (MNWC), in collaboration with Dr. Diane Billings, a nationally recognized expert, and a group of faculty are developing a series of workshops to assist nursing leaders and faculty across all state programs to determine if the current clinical judgement model is implemented across the curriculum and aligned with the NGN testing strategies. The observed outcomes of critical thinking and decision-making processes in clinical judgement are using nursing knowledge to observe and assess presenting situations, prioritize patient concerns and generate the best possible evidence-based solutions to deliver safe patient care. The goal is to be proactive in supporting faculty as they help students develop clinical judgement and achieve NGN NCLEX-RN success. The Next Generation Summit to kick off the year-long series of free workshops for Maryland nursing programs is planned for September 9, 2021 and funded through the NSP II and MNWC.

# Nursing Workforce and Entry-Level Nurses

The registered nurse (RN) workforce is the single largest group of health professionals, with more than three million nationally and an estimated 53,150 employed in the State of Maryland (DLLR, 2020). The Health Resources and Services Administration (HRSA) continues to explore systematic differences in state-based administrative data and analyze how each model handles entry-to-practice output. All researchers agree that “co-monitoring changes in RN entry is the single most important factor that affects each model and hence accuracy of its projections” (Auerbach, et al., 2017, pg. 294). Researchers are encouraging caution when using forecast models for policy and decision-making, as nursing shortages are highly sensitive to multiple variables and difficult to pinpoint beyond regional trends.

With this guidance, NSP II is monitoring the state-level data closely and will report on these points each year. Data on the number of newly licensed nurses entering the profession is available through the Maryland Board of Nursing (MBON). MBON collects the number of first-time successful National Council Licensure Examination – Registered Nurse (NCLEX-RN) testers. Since RN entry-to-practice is the most important factor affecting projections of the nursing workforce supply, this may be a better reflection of the number of new nurses in Maryland. Due to several program changes, the number of MBON first-time NCLEX-RN testers had trended down over the past five years, but in FY 2021, Maryland rallied to the highest number of first-time testers becoming new nurses since FY 2016 (Table 5).

*Table 5. Maryland's First Time NCLEX-RN Candidates FY 2015- FY 2020*

| Fiscal Year | Maryland BSN Programs | | Maryland ADN Programs | | Maryland MS Entry Programs | | Total All Maryland Programs | | Passing Rates | |
|---|---|---|---|---|---|---|---|---|---|---|
| | No. Tested | No. Passed | No. Tested | No. Passed | No. Tested | No. Passed | No. Tested | No. Passed | MD | US |
| **FY 2015** | 1,207 | 930 | 1,658 | 1,355 | 70 | 64 | 2,935 | 2,349 | 80.03% | 82.53% |
| **FY 2016** | 1,158 | 957 | 1,557 | 1,291 | 44 | 37 | 2,759 | 2,285 | 82.82% | 83.94% |
| **FY 2017** | 961 | 806 | 1,457 | 1,252 | 163 | 150 | 2,581 | 2,208 | 85.55% | 86.22% |
| **FY 2018** | 773 | 676 | 1,316 | 1,145 | 261 | 240 | 2,350 | 2,061 | 87.70% | 87.81% |
| **FY 2019** | 867 | 743 | 1,375 | 1,245 | 305 | 275 | 2,339 | 2,071 | 88.54% | 88.36% |
| **FY 2020** | 775 | 650 | 1,467 | 1,299 | 304 | 286 | 2,546 | 2,235 | 87.78% | 87.93% |

*Source: Maryland Board of Nursing. National Council State Boards of Nursing, and Pearson Vue. All Maryland RN 1st time candidates who graduated from a Maryland nursing program and tested in any U.S. jurisdiction.*

Candidates for licensing as a new nurse may be graduates of an Associate Degree in Nursing (ADN), Bachelor of Science in Nursing (BSN), second-degree BSN, or entry-level Master of Science (MS) in Nursing program.

# Rapid Adjustments in Nursing Education for 2020-2021

The Deans and Directors of pre-licensure programs were surveyed on the changes in clinical hours, clinical learning, use of clinical simulation or virtual learning and online delivery during the last year in response to the pandemic. They completed the survey on adjustments made from March 15, 2020 to March 15, 2021. The majority of programs became 100 percent virtual or moved to clinical simulation formats with video conferenced case studies facilitated by clinical instructors during the Spring 2020 semester. Learning packets were developed for each simulation to guide students in meeting specific learning outcomes. By the Summer 2020 semester, some schools cancelled a few classes to focus on the preparations for Fall entry students, while a few other schools were able to return to hospital-based clinical experiences. However, by the Fall 2020 semester, most nursing programs had returned to their usual on-site clinical experiences at hospitals.

The silver lining for the Maryland nursing programs was the ability to deliver clinical simulation education to faculty in a Train the Trainer model at Maryland Clinical Simulation Resource Consortium at Montgomery College School of Nursing since 2015. Approximately 400 Simulation Education Leaders were prepared and ready to step in. The majority reported utilizing the Interprofessional Education modules and learning materials from The Johns Hopkins University School of Nursing (funded from 2013-2020) and the Psychiatric and Leadership Toolkits and video modules from Salisbury University (funded since 2015). All survey respondents reported utilizing the Simulation Video library, developed over the

past 6 years and freely accessible to all in-state programs. In addition, 70 percent of respondents had accessed the NSP II website for free COVID-19 resources for students and faculty. All materials funded through NSP II are hosted at www.nursesupport.org. The statewide resources are intended to serve all schools.

Most of the survey respondents participated in developing the Maryland Nurse Residency Collaborative's Transition to Nurse Residency program. One key focus of the survey was to evaluate the impact of the disruption of traditional clinical practice hour delivery due to the pandemic on entry level competency. The faculty concluded that it would be important to analyze the student outcomes and determine the best mix of simulation to face-face clinical experiences. The cost for clinical experiences, regardless of delivery method (simulation or face-face), is increased due to the need for more clinical faculty per student. Many hospitals have reduced the size of the clinical groups they will accept, from 6-8 students to 4-6 students. Program leaders agreed that the combination of reduced access to clinical practice sites and size restrictions of clinical groups, coupled with the increase in the number of clinical instructors needed, has significantly impacted their program.

When asked if they expected the 2021 nursing graduates to have any difficulty with the NCLEX-RN licensure examination, there was unanimous agreement that the programs had adjusted in response to the changes and their students would perform well with no change in the program's licensure pass rates. Additionally, a few programs provided early exit opportunities for students to join the nursing workforce as soon as possible to relieve the frontline nursing staff at the hospitals. There were approximately 200 BSN and 60 Masters Entry graduates who were eligible and volunteered to enter the nursing workforce during the time of special need.

The Maryland Board of Nursing (MBON) does not require any specific number of clinical hours nor determines what percentage can be delivered safely in clinical simulation. National research has outlined up to 50 percent of clinical hours could be delivered through simulation with no change in the outcomes. Each nursing program develops curriculum and the corresponding clinical requirements. The number of clinical hours for nursing students in Maryland varies from 510 hours to 890 hours, depending on the program. The MBON provided guidance in implementing the Governor's Executive Orders prompted by the pandemic.

In Spring 2020, NSP II funded the implementation of the R3 – Renewal, Resilience and Retention program – at The Johns Hopkins University for nurses, nurse residents, educators, and faculty. Four universities, nine community colleges and six hospital partners participated including, Anne Arundel Medical Center, The Johns Hopkins Hospital, University of Maryland Medical Center, Peninsula Regional Medical Center and Atlantic General Hospital. This program could not have come at a better time for the well-being of nurses in Maryland.

# Competitive Institutional Grants Program

The Competitive Institutional Grants Program builds educational capacity and increases the number of nurse educators to adequately supply hospitals and health systems with well-prepared nurses. The FY 2022 NSP II Review Panel was composed of nine members with backgrounds in healthcare, regulation, nursing education, and hospital administration, and included former NSP II project directors and NSP I and NSP II staff members.

# Staff Recommendations

***Staff Recommendation #1:*** Funding recommended NSP II programs

HSCRC and MHEC staff recommend the following seven proposals presented in Table 6 for the FY 2022 NSP II Competitive Institutional Grants Program for a total of $6.6 million. This final recommendation describes the panel's recommendations for Commission approval.

*Table 6. FY 2022 Recommendations for Funded Proposals*

| Proposal # | School | Title | Total Funding |
|---|---|---|---|
| **NSP II-22-101** | Community College of Baltimore County | First Semester Experience and Mentorship Program- Increasing Enrollments and Graduation | $656,907 |
| **NSP II-22-102** | Coppin State University | Implementation of Doctoral Education Advancement (IDEA) through the BSN-DNP | $983,146 |
| **NSP II-22-106** | Salisbury University | Fast Track to a BSN: Expanded Opportunities for 1st and 2nd degree students | $986,344 |
| **NSP II-22-107** | Stevenson University | Enhancing Clinical Education Through Partnerships | $587,359 |
| **NSP II-22-111** | University of Maryland School of Nursing | Preparing Clinical Faculty | $700,000 |
| **NSP II-22-117** | University of Maryland School of Nursing | Academic-Practice: Pilot DEU Model | $282,124 |
| **NSP II 22-201** | University of Maryland School of Nursing | Academic-Practice Partnership-Clinical Nurses competing higher degrees- RN-BSN-MSN | $2,471,019 |
| **TOTAL** | | | **$6,666,899** |

These highly recommended proposals include:

- Expanding enrollments to graduate an additional 96 pre-licensure nursing students in the Fast Track to a 1st or 2nd degree Bachelor of Science in Nursing at Salisbury University.

- Developing 3 new models for clinical education at Stevenson University with 20 additional clinical supervisor equivalents from five partner hospitals: Greater Baltimore Medical Center, Lifebridge Northwest Hospital Center, MedStar Union Memorial Hospital, Medstar Good Samaritan Hospital and Medstar Franklin Square Hospital.
- Implementing the Bachelor of Science in Nursing to Doctor of Nursing Practice (DNP) Nurse Practitioner degree program at Coppin State University that will graduate 20 additional DNPs. It one of only five HBCUs with DNP programs in the nation and one of only two HBCUs with a BSN-DNP program.
- Continuing the successful Academic Practice Partnership for 200 clinical nurses to graduate with higher degrees at University of Maryland School of Nursing and 10 partner hospitals: Anne Arundel Medical Center, University of Maryland (UM) Medical Center, UM Baltimore-Washington Medical Center, MedStar Franklin Square Medical Center, Frederick Health, UM Harford Memorial Hospital, Holy Cross Hospital, UMMC Midtown Campus, UM Prince George's Hospital Center and UM Saint Joseph Medical Center.
- Preparing 600 clinical faculty through three annual Institute for Educator's Clinical Faculty Workshops and providing NSP II CNE-cl awards to up to 80 newly credentialed participants.
- Piloting a dedicated education unit that incorporates senior practicum students as peer tutors in the Spring of 2022. This program is a partnership between University of Maryland School of Nursing at the Universities at Shady Grove and Adventist White Oak Medical Center
- Increasing enrollments to produce 36 additional graduates by increasing the number of first semester students at The Community College of Baltimore County. The program is providing a new emphasis on guiding first semester student experience and providing faculty level mentoring.

***Staff Recommendation #2:*** Include all NSP I and II hospitals, health systems, and affiliated facilities as approved service agreement sites and grandfather all nurse educators into 1:1 service.

HSCRC and MHEC staff recommend the inclusion of all NSP I and NSP II hospitals, health systems and their affiliates as approved NSP II service agreement sites for nurse educators prepared through the Cohen Scholars. The staff developed a master listing of participant hospitals and affiliates to guide service requirements. Any current recipient who is in the service period and not working in an eligible position will be advised of other opportunities and given a reasonable amount of time to enter one of the eligible educator positions. This will assist the MNRC and the TNRP programs in meeting educator needs.

In addition, the staff recommend approving the NSP II Faculty Workgroup recommendations for all past Hal and Jo Cohen Graduate Nurse Faculty Scholars to be grandfathered into the current 1:1 service

agreement, for equitable, clear, and consistent guidance and administration of the Cohen Scholars program.

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# Draft Recommendation for the Update Factors for Rate Year 2022

May 12, 2021

Please submit stakeholder comments to

hscrc.payment@maryland.gov by COB May 19, 2021

# Table of Contents

# List of Abbreviations

| | |
|---|---|
| ACA | Affordable Care Act |
| CMS | Centers for Medicare & Medicaid Services |
| CY | Calendar year |
| FFS | Fee-for-service |
| FFY | Federal fiscal year, refers to the period of October 1 through September 30 |
| FY | Fiscal year |
| GBR | Global Budget Revenue |
| HSCRC | Health Services Cost Review Commission |
| MHAC | Maryland Hospital Acquired Conditions |
| MPA | Medicare Performance Adjustment |
| PAU | Potentially avoidable utilization |
| QBR | Quality Based Reimbursement |
| RRIP | Readmission Reduction Incentive Program |
| RY | Rate year, which is July1 through June 30 of each year |
| TCOC | Total Cost of Care |
| UCC | Uncompensated care |

# Summary

The following report includes a draft recommendation for the Update Factor for Rate Year (RY) 2022. This update is designed to provide hospitals with reasonable inflation to maintain operational readiness, both during and after the COVID-19 response, and to keep healthcare affordable in the State of Maryland.

This update factor generally follows approaches established in prior years for setting the update factors. Staff recognizes that the COVID-19 crisis continues to create significant uncertainty and will likely drive large short and long-term changes in the healthcare industry. This policy recommendation takes into account CARES funding that hospitals received from the Federal government. Staff plans to continue to work with all stakeholders to develop and adapt existing policies in specific ways to address the COVID-19 crisis and its lingering effects on healthcare in the State of Maryland.

At this time, the staff requests that Commissioners consider the following draft recommendations:

For Global Revenues:

a) Provide an overall increase of 2.23 percent for revenue (net of uncompensated care offset) and 2.07 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

b) Allocate 0.23 percent of the total 2.37 percent inflation allowance based on each hospital's proportion of oncology and other high cost drugs to the total drug cost in order to more equitably adjust hospitals' revenue for increases in high-cost drugs.

c) Adjust rates effective July 1, 2021, over a 6 month window, to implement the reconciliation of CARES Provider Relief Funds (PRF) and HSCRC support for Rate Year 2020 as described in this recommendation. The general impact of this proposal is that:

- For hospitals where the sum of actual charges and PRF Funding is less than their fiscal year 2020 approved Global Budget Revenue the adjustment would add the shortfall, net of any preliminary amount already provided in the January 1st, 2021 rate order, to their July 1, 2021 rate order.
- For hospitals where the sum of actual charges and PRF Funding is greater than their fiscal year 2020 approved Global Budget Revenue the adjustment would subtract the lessor of the excess or the COVID corridor relief provided by the Commission (as defined in the body of this recommendation) from their July 1, 2021 rate order.
- Staff recommends that the Commission guarantee RY 2021 Global Budget Revenues for hospitals and implement a similar reconciliation policy as outlined

above to maintain financial stability for hospitals, given that the COVID pandemic continues to have an impact on health care delivery in RY 2021.

For Non-Global Revenues hospitals, including psychiatric hospitals and Mt. Washington Pediatric Hospital:

a) Provide an overall update of 2.37 percent for inflation.

b) Withhold implementation of the productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

# Introduction & Background

The Maryland Health Services Cost Review Commission (HSCRC or Commission) updates hospitals' rates and approved revenues on July 1 of each year to account for factors such as inflation, policy-related adjustments, other adjustments related to performance, and settlements from the prior year. For this upcoming fiscal year, the HSCRC is considering the extraordinary circumstances of the COVID-19 response in the development of the update factor.

In July 2018, CMS approved a new 10-year Total Cost of Care (TCOC) Model Agreement for Maryland, which began January 1, 2019. Under the new TCOC Model, the State committed to continue to limit the growth in hospital costs in line with economic growth, reach an annual Medicare total cost of care savings rate of $300 million by 2023 ("the Medicare TCOC Savings Requirement"), continue quality improvements, and improve the health of the population. It is worth mentioning that Maryland has already met the 5 year total cost of care savings requirement under the Total Cost of Care Agreement, but this progress must be sustained through 2023 as the savings requirement is not a cumulative test.

To meet the ongoing requirements of the Model, HSCRC will need to continue to ensure after the COVID-19 crisis abates that state-wide hospital revenue growth is in line with the growth of the economy. The HSCRC will also need to continue to ensure that the Medicare TCOC Savings Requirement is met. The approach to develop the RY 2022 annual update is outlined in this report, as well as staff's estimates on calendar year Model tests.

## Hospital Revenue Types Included in this Recommendation

There are two categories of hospital revenue:

1. Hospitals under Global Budget Revenues, which are under the HSCRC's full rate-setting authority. The proposed update factor for hospitals under Global Budget Revenues is a revenue update. A revenue update incorporates both price and volume adjustments for hospital revenue under Global Budget Revenues. The proposed update should be compared to per capita growth rates, rather than unit rate changes.

2. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland and, thus, Medicare does not pay based on those rates. This includes freestanding psychiatric hospitals and Mount

Washington Pediatric Hospital. The proposed update factor for these hospitals is strictly related to price, not volume.

This recommendation proposes Rate Year (RY) 2022 update factors for both Global Budget Revenue hospitals and HSCRC regulated hospitals with non-global budgets.

## Overview of Draft Update Factors Recommendations

For RY 2022, HSCRC staff is proposing an update of 2.07 percent per capita for global budget revenues and an update of 2.37 percent for non-global budget revenues. These figures are described in more detail below.

## Calculation of the Inflation/Trend Adjustment

For hospitals under both revenue types described above, the inflation allowance is central to HSCRC's calculation of the update adjustment. The inflation calculation blends the weighted Global Insight's Fourth Quarter 2020 market basket growth estimate with a capital growth estimate. For RY 2022, HSCRC staff combined 91.20 percent of Global Insight's Fourth Quarter 2020 market basket growth of 2.50 percent with 8.80 percent of the capital growth estimate of 1.00 percent, calculating the gross blended amount as a 2.37 percent inflation adjustment. The First Quarter 2021 market basket is updated and remains consistent with Fourth Quarter 2020 market basket growth.

## Update Factor Recommendation for Non-Global Budget Revenue Hospitals

For non-global budget hospitals (psychiatric hospitals and Mt. Washington Pediatric Hospital), HSCRC staff proposes applying the inflation adjustment of 2.37 percent. The pandemic's effect on hospitals resulted in historically low volumes. For this reason, HSCRC staff propose to withhold the productivity adjustment from this year's gross blended inflation amount. It is important to note that these hospitals receive an adjustment based on their actual volume change, rather than a population adjustment. HSCRC staff continues to include these non-global budget hospitals in readmission calculations for global budget hospitals and may implement quality measures for these hospitals in future rate years

Table 1

| | Global Revenues | Psych & Mt. Washington |
|---|---|---|
| Proposed Base Update (Gross Inflation) | 2.37% | 2.37% |
| Productivity Adjustment | | -0.20% |
| Proposed Update | 2.37% | 2.37% |

Productivity Adjustment SUSPENDED for Psych & Mt. Washington

## Update Factor Recommendation for Global Budget Revenue Hospitals

In considering the system-wide update for the hospitals with global revenue budgets under the All-Payer Model, HSCRC staff sought to achieve balance among the following conditions:

- Meeting the requirements of the Total Cost of Care Model agreement;
- Providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes;
- Ensuring that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the Total Cost of Care Model;
- Incorporating quality performance programs; and
- Ensuring that healthcare remains affordable for all Marylanders.

As shown in Table 2, after accounting for all known changes to hospital revenues, HSCRC staff estimates net revenue growth (before accounting for changes in uncompensated care and assessments) of 2.15 percent and per capita growth of 1.99 percent for RY 2022. After accounting for changes in uncompensated care and assessments, the HSCRC estimates net revenue growth at 2.23 percent with a corresponding per capita growth of 2.07 percent for RY 2022.

In order to measure the proposed update against financial tests, which are performed on Calendar Year results, staff needs to split the annual Rate Year revenue into six-month targets. Staff intends to apply 49.73 percent of the Total Approved Revenue to determine the mid-year target for the calendar year calculation, with the full amount of RY 2022 estimated revenue used to evaluate the Rate Year year-end target. HSCRC staff will adjust the revenue split to accommodate their normal seasonality for hospitals that do not align with the traditional seasonality described above.

## Net Impact of Adjustments

Table 2 summarizes the net impact of the HSCRC staff's draft recommendation for inflation, volume, Potentially Avoidable Utilization (PAU) savings, uncompensated care, and other adjustments to global revenues. Descriptions of each step and the associated policy considerations are explained in the text following the table.

## Table 2

| Balanced Update Model for RY 2022 | | | |
|---|---|---|---|
| Components of Revenue Change Link to Hosptial Cost Drivers /Performance | | | |
| | | | Weighted Allowance |
| Adjustment for Inflation (this includes 1.45% for wage & compensation) | | | 2.14% |
| - Outpatient Oncology Drugs | | | 0.23% |
| **Gross Inflation Allowance** | **A** | | **2.37%** |
| **Care Coordination/Population Health** | | | |
| - Reversal of One-Time Grants | | | -0.33% |
| - Regional Partnership Grant Funding RY22 | | | 0.14% |
| **Total Care Coordination/Population Health** | **B** | | **-0.19%** |
| **Adjustment for Volume** | | | |
| -Demographic /Population | | | 0.16% |
| -Transfers | | | |
| -Drug Population/Utilization | | | |
| **Total Adjustment for Volume** | **C** | | **0.16%** |
| **Other adjustments (positive and negative)** | | | |
| - Set Aside for Unknown Adjustments | D | | 0.10% |
| - Low Efficiency Outliers | E | | -0.10% |
| - Complexity & Innovation | G | | 0.10% |
| -Reversal of one-time adjustments for drugs | H | | -0.04% |
| **Net Other Adjustments** | **I=** | **Sum of D thru H** | **0.06%** |
| **Quality and PAU Savings** | | | |
| -PAU Savings | J | | -0.24% |
| -Reversal of prior year quality incentives | K | | -0.11% |
| -QBR, MHAC, Readmissions | | | |
| -Current Year Quality Incentives | L | | 0.11% |
| **Net Quality and PAU Savings** | **M =** | **Sum of J thru L** | **-0.24%** |
| **Total Update First Half of Rate Year 22** | | | |
| Net increase attributable to hospitals | **N =** | Sum of A + B + C + I + M | **2.15%** |
| Per Capita First Half of Rate Year (July - December) | **O =** | (1+N)/(1+0.16%) | **1.99%** |
| **Adjustments in Second Half of Rate Year 22** | | | |
| -Oncology Drug Adjustment | P | | 0.00% |
| -Future Adjustment | Q | | 0.00% |
| **Total Adjustments in Second Half of Rate Year 22** | **R =** | P + Q | **0.00%** |
| **Total Update Full Fiscal Year 22** | | | |
| Net increase attributable to hospital for Rate Year | **S =** | N + R | **2.15%** |
| Per Capita Fiscal Year | **T =** | (1+S)/(1+0.16%) | **1.99%** |
| Components of Revenue Offsets with Neutral Impact on Hospital Finanical Statements | | | |
| -Uncompensated care, net of differential | U | | 0.08% |
| -Deficit Assessment | V | | 0.00% |
| Net decreases | **W =** | U + V | **0.08%** |
| **Total Update First Half of Rate Year 22** | | | |
| Revenue growth, net of offsets | **X =** | N + W | **2.23%** |
| Per Capita Revenue Growth First Half of Rate Year | **Y =** | (1+X)/(1+0.16%) | **2.07%** |
| **Total Update Full Rate Year 22** | | | |
| Revenue growth, net of offsets | **Z =** | S + W | **2.23%** |
| Per Capita Fiscal Year | **AA =** | (1+Z)/(1+0.16%) | **2.07%** |

## Central Components of Revenue Change Linked to Hospital Cost Drivers/Performance

HSCRC staff accounted for a number of factors that are central provisions to the update process and are linked to hospital costs and performance. These include:

- **Adjustment for Inflation:** As described above, the inflation factor uses the gross blended statistic of 2.37 percent. The gross inflation allowance is calculated using 91.2 percent of Global Insight's Fourth Quarter 2020 market basket growth of 2.50 percent with 8.80 percent of the capital growth index change of 1.00 percent. The adjustment for inflation includes 1.45 percent for wage compensation. A portion of the 2.37 inflation allowance (0.23 percent) will be allocated to hospitals in order to more accurately provide revenues for increases in outpatient oncology and infusion drugs. This drug cost adjustment is further discussed below.

- **Outpatient Oncology and Infusion Drugs:** The rising cost of drugs, particularly of new physician-administered oncology and infusion drugs in the outpatient setting led to the creation of separate inflation and volume adjustment for these drugs. Not all hospitals provide these services and some hospitals have a much larger proportion of costs allocated. To address this situation, in Rate Year 2016, staff began allocating a specific part of the inflation adjustment to funding increases in the cost of drugs, based on the portion of each hospital's total costs that comprised these types of drug.

  In addition to the drug inflation allowance the HSCRC provides a utilization adjustment for these drugs. Half of the estimated cost changes due to usage or volume changes are recognized as a one-time adjustment and half are recognized as a permanent adjustment. This process is implemented separately from this Update Factor so only the inflation portion is addressed herein.

  Starting in Rate Year 2021, staff began using a standard list of drugs based on criteria established with the industry in evaluating high-cost drug utilization and inflation. This list was used to calculate the inflation allowance as well as the drug utilization adjustment component of funding for these high-cost drugs. Rate Year 2022 continues this practice.

  While volume continues to grow for these drugs, staff analysis shows that the price per drug of the drugs covered has stabilized and the need for a higher inflation rate on this component of spending has been mitigated. This trend was recognized in Rate Year 2021 through a lowering of the drug inflation factor from 10 percent to 6 percent. Data from the most recent period support a continued reduction in price trend, however, 2020 trends are likely distorted due to the COVID crisis so at this time staff is recommending no further reduction and continued use of a 6 percent trend for Rate Year 2022.

- **Care Coordination / Population Health:** There were several grant programs aimed at Care Coordination and Population Health in RY 2021 hospital revenues. These programs include: Long Term Care Grants, Medicare Advantage Program Grant Funding, Regional Partnership Funding for

Behavioral Health, Regional Partnership Funding for Diabetes Prevention and Management. These funds were provided to hospitals on a one-time basis. For this reason you will see a line in table 2 reversing out grant funding in RY 2021 of -0.33 percent. Regional Partnership funding for Behavioral Health and Diabetes Prevention and Management is part of a 5 year program. Included in this adjustment is funding for the proposed Maternal Child Health initiatives, pending Commission approval at the May 2021 Commission meeting. RY 2022 funding is expected to be approximately 0.14 percent.

- **Adjustments for Volume:** The Maryland Department of Planning's estimate of population growth for CY 2020 was 0.16 percent. The estimate for CY 2021 has not yet been released; staff expect the estimate to be publicly available by the second week of May. For RY 2022, the staff is proposing recognizing the full value of the Department of Planning CY 2021 growth estimate for the Demographic Adjustment in keeping with prior year norms, but given the data delay staff will use the CY 2020 estimate of 0.16 percent as a temporary proxy in the Draft Recommendation.

- **Low-Efficiency Outliers:** The Integrated Efficiency policy outlines a methodology for determining inefficient hospitals in the TCOC Model. This policy will utilize the Inter-Hospital cost comparisons to compare relative cost-per case efficiency. This policy will also use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance relative to national benchmarks for each service area in the State. The above evaluations are then used to withhold the Medicare and Commercial portion of the Annual Update Factor for relatively inefficient hospitals, which will be available for redistribution to relatively efficient hospitals. The amount under review for RY22 as determined by the Integrated Efficiency policy is approximately $19.9 million or a -0.10 percent reduction from the update. This withhold is subject to revisions based on updated data and Commission approval.

- **Set-Aside for Unforeseen Adjustments:** The set-aside for RY22 will be 0.10 percent. This amount was determined by the 0.10 percent reduction outlined in the Integrated Efficiency policy. The intention of the set-aside is to use these funds for potential Global Budget Revenue enhancements and other potentially unforeseen requests that may occur at hospitals.

- **Complexity and Innovation (formerly Categorical Cases):** The prior definition of categorical cases included transplants, burn cases, cancer research cases, as well as Car-T cancer cases, and Spinraza cases. However, the definition, which was based on a preset list, did not keep up with emerging technologies and excluded various types of cases that represent greater complexity and innovation, such as extracorporeal membrane oxygenation cases and ventricular assist device cases. Thus, the HSCRC staff developed an approach to provide a higher variable cost factor (100% for drugs and supplies, 50% for all other charges) to in-state, inpatient cases when a hospital exhibits dominance in an ICD-10 procedure codes and the case has a casemix index of 1.5 or higher. Staff used this approach to determine the historical average growth rate of cases deemed eligible for the complexity and innovation policy and evaluated the adequacy of funding of these cases relative to prospective adjustments provided to Johns Hopkins Hospital and University of Maryland Medical Center in RY 2017, 2018, 2019, and 2020. Based on this analysis, staff concluded that the historical average growth rate was .39 percent, which equates to a combined state impact of .10 percent for the RY 2022 Update Factor.

- **PAU Savings Reduction:** The statewide RY 2022 PAU savings adjustment is calculated based on update factor inflation and demographic adjustment applied to CY 2019 PAU revenue. RY 2022 PAU savings adjustment represents the change between RY 2021 and RY 2022. Previous years of PAU savings adjustments are not reversed out.

- **Quality Scaling Adjustments:** HSCRC staff and hospital stakeholders expressed concerns about using CY 2020 data for the RY 2022 hospital quality pay-for-performance programs due to the COVID-19 public health emergency and data reliability and validity concerns. These pay-for-performance programs include: Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Quality Based Reimbursement program (QBR). HSCRC staff proposed to CMMI that the State should be allowed to re-use RY 2021 revenue adjustments and apply these adjustments for RY 2022. This request was approved by CMMI. For this reason you will see the reversal and new inputs for RY 2022 quality programs net to 0 in Table 2.

  Staff note that the recently released proposed rule for the Hospital Inpatient Prospective Payment System (IPPS) outlines that various components of the federal value-based purchasing program will not be included in the federal RY 2022 payment program due to data validity concerns. Since this program is the analog to the QBR program, staff may revise its recommendation to align with federal guidance. Any modifications to Quality revenue adjustments will be effectuated in January rate orders, as the final IPPS rule will not be promulgated until after the start of the State fiscal year. Similarly, the IPPS rule outlined measure suppression policies for the Hospital-Acquired Condition Reduction Program (HACRP) and the Hospital Readmissions Reduction Program (HRRP), which are the analogs for the MHAC and RRIP, respectively. As such, staff will potentially modify revenue adjustments for MHAC and RRIP in the January rate orders to align with the final IPPS rule.

## Central Components of Revenue Offsets with Neutral Impact on Hospital Financial Statements

In addition to the central provisions that are linked to hospital costs and performance, HSCRC staff also considered revenue offsets with a neutral impact on hospital financial statements. These include:

- **Uncompensated Care (UCC):** The proposed uncompensated care adjustment for RY 2022 will be 0.08 percent. The amount in rates was 4.41 percent in RY 2021, and the proposed amount for RY 2022 is 4.49 percent, an increase of 0.08 percent.
- **Deficit Assessment:** The legislature did not propose a further reduction to the Deficit Assessment in RY 2022, and as a result, this line item is 0.00 percent.

## Additional Revenue Variables

In addition to these central provisions, there are additional variables that the HSCRC considers. These additional variables include one-time adjustments, revenue and rate compliance adjustments and price

leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

## PAU Savings Updated Methodology

The PAU Savings Policy prospectively reduces hospital global budget revenues in anticipation of volume reductions due to care transformation efforts. Starting in RY2020, the calculation of the statewide value of the PAU Savings was included in the Update Factor Recommendation; however, a PAU measurement report was presented separately to the Commission in March of 2019.

For RY 2022, the incremental amount of statewide PAU Savings reductions is determined formulaically using inflation and demographic adjustment applied to the amount of PAU revenue (see Table 3). This will result in a RY 2022 PAU savings reduction of -0.24 percent statewide, or $42,379,302. Hospital performance on avoidable admissions per capita and sending readmissions estimated revenue determines each hospital's share of the statewide reduction.

**Table 3**

| **Statewide PAU Reduction** | **Formula** | **Value** |
|---|---|---|
| RY 2020 Total Estimated Permanent Revenue* | A | $17,648,042,368 |
| RY 2022 Inflation Factor (preliminary)** | B | 2.3% |
| CY 2019 Total Experienced PAU $ | C | $1,844,766,206 |
| RY 2022 Proposed Revenue Adjustment $ | D = B*C | -$42,429,623 |
| RY 2022 Proposed Revenue Adjustment % | E = D/A | -0.24028% |
| RY 2022 Adjusted Proposed Revenue Adjustment % | F = ROUND(E) | **-0.24%** |
| RY 2022 Adjusted Proposed Revenue Adjustment $ | G = F*A | **-$42,379,302** |
| Total PAU % | H | 10.43% |
| Total PAU $ | I = A*H | $1,842,058,805 |
| Required Percent Reduction PAU | J = G/I | -2.3% |

*Does not include revenue from Grace, UM-Laurel, or freestanding EDs.
** Inflation factor is subject to revisions related to updated data Commission approval and updated information on the RY 2022 Demographic Adjustment.

## Consideration of Total Cost of Care Model Agreement Requirements & National Cost Figures

As described above, the staff proposal increases the resources available to hospitals to account for rising inflation, population changes, and other factors, while providing adjustments for performance under quality programs. Staff's considerations in regards to the TCOC Model agreement requirements are described in detail below.

## Medicare Financial Test

This test requires the Model to generate $300 million in annual Medicare fee-for-service (FFS) savings in total cost of care expenditures (Parts A and B) by 2023. The TCOC Model Medicare Savings Requirement is different from the previous All-Payer Model Medicare savings requirement in several ways. First, as previously discussed, Maryland's Total Cost of Care Model Agreement progresses to setting savings targets based on total costs of care, which includes non-hospital cost increases, as opposed to the hospital only requirements of the All-Payer Model. This shift ensures that spending increases outside of the hospital setting do not undermine the Medicare hospital savings resulting from Model implementation. Additionally, the change to the total cost of care focuses hospital efforts and initiatives across the spectrum of care and creates incentives for hospitals to coordinate care and to collaborate outside of their traditional sphere for better patient care.

Secondly, the All-Payer Model Savings Requirement was a *cumulative* savings test, where the savings for each year relative to the base period were added up to determine the total *hospital* savings. The TCOC Model requires that the State reach *annual* total cost of care savings of $300 million relative to the national growth rate by 2023, relative to a 2013 base year. Thus, there must be sustained improved performance overtime to meet the new TCOC Medicare Savings Requirements. The new TCOC Model contains specific annual Medicare Savings Requirements for each year. Based on the CY 2020 estimated performance, staff calculates that Maryland hospitals have exceeded the TCOC Model's annual Savings Requirement of $156 million for performance year two (CY 2020). Final CY 2020 data is in the process of being reconciled and approved with CMS and will be released at a later date. Similar to the All-Payer Model, there are TCOC growth guardrails. Maryland's Medicare TCOC growth may not exceed the national Medicare TCOC growth rate in any two successive years and Maryland may not exceed the national growth rate by more than one percent in any year. Corrective actions are required if these limits are exceeded.

## Meeting Medicare Savings Requirements and Total Cost of Care Guardrails

In past years, staff compared Medicare growth estimates to the all-payer spending limits, to estimate that Model savings and guardrails were being met. Due to the ongoing COVID-19 pandemic and the uncertainty and volatility of the current landscape, staff created an alternative approach to measure projected savings and compliance with the Total Cost of Care guardrails. Actual revenue resulting from RY 2021 updates affect the CY 2021 results. As a result, staff must convert the recommended RY 2022 update to a calendar year growth estimate. Table 4 below shows the current revenue projections for CY 2021 to assist in estimating the impact of the recommended update factor together with the projected RY 2021 results. The overall increase from the bottom of this table is used in Table 5.

**Table 4**

| Estimated Position on Medicare Test | | |
|---|---|---|
| | | **Scenario A: Based on Last Year Acutal** |
| Actual Revenue CY 2020 | | 17,663,547,233 |
| **Step 1:** | | |
| Approved GBR RY 2021 | | 19,091,716,940 |
| Actual Revenue 7/1/20-12/31/20 | | 9,337,804,834 |
| Approved Revenue 1/1/21-6/30/21 | **A** | **9,753,912,106** |
| **Step 2:** | | |
| Approved GBR RY 2021 | | 19,091,716,940 |
| Reverse One Time Extrodinary Adjustments: | | |
| Extraordinary Price Variance in RY2021 | | (96,867,601) |
| Adjusted GBR RY 2021 | | 18,994,849,339 |
| Projected Approved GBR RY 2022 | | 19,419,129,675 |
| Permanent Update RY 2022 | | 2.23% |
| Adjusted Change from GBR RY 2021 | | 1.71% |
| **Step 3:** | | |
| Estimated Revenue 7/1/21-12/31/21 (after 49.73% & seasonality) | | 9,657,133,188 |
| Reconciliation of PRF and HSCRC-Support | | (51,000,000) |
| Estimated FY21 Undercharge in First Half of CY21 | | (200,000,000) |
| Projected Revenue 7/1/21-12/30/21 | **B** | **9,406,133,188** |
| **Step 4:** | | |
| **Estimated Revenue CY 2021** | **A+B** | **19,160,045,294** |
| Increase over CY 2020 Revenue | | 8.47% |
| Growth Used in Alternative Guardrail Scenario | | |
| Increase over CY2020 Revenue w/o pop growth | | 8.38% |

Steps to explain Table 4 are described as below:

The table begins with actual revenue for CY 2020.

Step 1: The table uses global revenue for RY 2021 and actual revenue for the last six months for CY 2020 to calculate the projected revenue for the first six months of CY 2021 (i.e. the last six months of RY 2021).

Step 2: This step begins with the approved revenue for RY 2021 and reverses out the price variance from RY 2021 that was a result of the RY 2020 undercharge from the COVID-19 pandemic. The result is an adjusted RY 2021 GBR. The proposed update of 2.23 percent, as shown in Table 2, is then applied to the adjusted RY 2021 GBR amount to calculate the projected revenue for RY 2022.

Step 3: For this step, to determine the calendar year revenues, staff estimate the revenue for the first half of RY 2022 by applying the recommended mid-year split percentage of 49.73 percent to the estimated approved revenue for RY 2022. Additionally, staff applied the reconciliation of CARES PRF and HSCRC-support accrued in RY 2020 (as described in this report), as well as the estimated RY21 undercharge from the first half of CY 2021.

Step 4: This step shows the resulting estimated revenue for CY 2021 and then calculates the increase over actual CY 2020 Revenue. There are two increases shown in this section. The first one, 8.47 percent, is the estimated increase over CY 2020 revenue using the update of 2.23 percent. The second increase of 8.39 percent is the estimated increase over CY 2020 revenue using an update of 2.07 percent, which is the update without a volume adjustment included. The 8.39 percent is used to estimate CY 2021 hospital spending per capita for Maryland in our guardrail calculation, which is explained later in this policy.

Previous updates utilized Medicare fee-for-service growth estimates from the CMS Office of the Actuary. Due to the variability in the estimates from actual performance, staff moved to using actual national Medicare fee-for-service total cost of care growth from the previous calendar year in the RY 2020 update factor policy. Total Cost of Care growth for the nation showed a significant decline in CY 2020, due to the COVID-19 pandemic. Staff did not feel that using a negative growth rate to measure our guardrail was an appropriate proxy to predict future trends. As a result, staff created an alternative guardrail approach to be used in the RY 2022 update factor policy to determine and project Maryland's CY 2021 guardrail position. Of note, staff does intend to revisit using actual national total cost of care growth from the previous year in future policy decisions.

Staff's approach to project the CY 2021 guardrail position utilized Medicare fee-for-service per capita data for Maryland and the nation. To project CY 2021 growth in the nation, staff calculated the average trend from 2017 to 2019 and trended 2019 data forward two years so as to remove the confounding of COVID-19 pandemic in CY 2020.. This was calculated in four buckets (hospital part A, hospital part B, non-hospital part A, and non-hospital part B) and added together to calculate a total per capita estimate. Staff used the same approach to estimate non-hospital part A and B for Maryland. To estimate CY 2021 hospital growth, staff applied the CY 2020 growth of 8.38 percent, shown in Table 4, to CY 2020 growth because global budget revenues are a known data element. The Maryland hospital growth estimate takes into account available hospital specific factors and the estimated RY 2021 undercharge settlement. Table 5 below shows the results of this analysis. Using this approach, Maryland is projected to be below the nation by 0.10 percent. This analysis assumes that Medicare growth equals All-Payer growth and does not include any prediction for pent-up demand or change in healthcare utilization patterns that may occur due the COVID-19 pandemic.

**Table 5**

| MARYLAND | Hospital | | Non-Hospital | | |
|---|---|---|---|---|---|
| | Part A | Part B | Part A | Part B | Total |
| 2017 Actual | | | $1,344 | $4,074 | $11,727 |
| 2019 Actual | | | $1,308 | $4,625 | $12,376 |
| | | | -1.3% | 6.6% | |
| 2020 Actual | $4,198 | $2,080 | | | $11,916 |
| 2021 Projected | $4,550 | $2,254 | $1,274 | $5,252 | $13,331 |
| | | | | | 11.87% |

| US | Hospital | | Non-Hospital | | |
|---|---|---|---|---|---|
| | Part A | Part B | Part A | Part B | Total |
| 2017 Actual | $3,400 | $1,545 | $1,526 | $3,700 | $10,172 |
| 2019 Actual | $3,512 | $1,770 | $1,548 | $4,154 | $10,984 |
| | 1.6% | 7.0% | 0.7% | 6.0% | |
| 2020 Actual | | | | | $10,618 |
| 2021 Projected | $3,628 | $2,028 | $1,570 | $4,664 | $11,889 |
| | | | | | 11.97% |

Update Factor - CY 2020 Revenue Growth

8.38% Applied to CY 2020 Actual Hospital Spending (Taken from Table 4)

Staff also modeled the growth and compared it to economic growth in Maryland as measured by the Gross State Product. The purpose of this modeling is to ensure that healthcare remains affordable in the State. Staff calculated the compounded annual growth rate (CAGR) for three years using the most updated State GSP numbers available (CY17-CY20). The 3-year CAGR calculation shows a per capita amount of 3.17 percent. Staff then compared that number to the 3 year CAGR for Hospital Acute Charges using (CY18-CY21). Staff was able to estimate CY 2021 charges using the proposed RY 2022 update factor. The CAGR for hospital charge growth equated to 3.29 percent. Staff believes using a 3-year comparison of GSP to hospital charges provides more accurate assessment of affordability. The chart below shows this comparison.

**Table 6**

| 3 Year CAGR | | | | |
|---|---|---|---|---|
| | | Maryland Hospital | | |
| | GSP | Charges | | Variance |
| 2017-2020 | 3.17% | 3.29% | 2018-2021 | 0.12% |

## Medicare's Proposed National Rate Update for FFY 2022

CMS released its proposed rule for the change to the Inpatient Prospective Payment System's (IPPS) payment rate on April 27, 2021. In the proposed rule, CMS would increase rates by approximately 2.80 percent which includes a market basket increase of 2.50 percent, a productivity reduction of -0.20 percent, and a legislative increase of 0.50 percent. This proposed increase will not be finalized until August 2021 and will not go into effect until October 1, 2021. This also does not take into account volume changes.

# Reconciliation of CARES Provider Relief Fund and HSCRC-support

During the COVID crisis, hospitals have faced unprecedented challenges both in meeting the acute needs of COVID patients and in handling significant volume declines due to economic shutdowns and other ramification of the COVID crisis.

In fulfilling its mandate to ensure adequate funding to Maryland hospitals, the Health Services Cost Review Commission (HSCRC) made a number of policy accommodations to ensure hospitals remained financially stable during the crisis. Subsequent to HSCRC actions, the Federal Government also provided significant funding to all healthcare providers nationwide and hospitals were a major beneficiary of this funding. As the HSCRC has noted previously, it will take federal funding into account when setting a hospital's Global Budget Revenue (GBR) for FY 2022.

The simultaneous provision of these dual sources of funding requires the HSCRC to set a hospital's GBR appropriately so as to avoid an overlap that would result in payers paying twice. For the current year, the resolution of an overlap is a key component in evaluating Maryland's ability to comply with the total cost of care guardrails under the Maryland Total Cost of Care Model. At this point it appears that Medicare spending growth in Maryland for CY 2021 may exceed that of the nation. Therefore, staff is incorporating this policy within this Update Factor Recommendation, which is the primary vehicle for monitoring and helping assure compliance with these federal tests.

## Background & Timeline

On March 19, 2020 the HSCRC issued a notice to hospitals that leveraged Maryland's unique rate setting model to provide two financial accommodations in relation to the crisis. Specifically, the memo stated:

1. "The HSCRC will permit hospitals to increase rate corridors up to the 10 percent threshold or by an additional 5 percentage points from their current charging position, whichever is greater"
2. "To further accommodate any GBR revenue that may not be able to be billed in FY 2020 due to fluctuating volumes over the final quarter, HSCRC staff will suspend undercharge penalties and allow hospitals to recoup those undercharges over the 12 months of FY 2021 as a one-time adjustment."

The first of these provisions provided immediate practical relief, to the extent feasible, given a desire to avoid excess charge increases to patients and providers and the second guaranteed hospitals 100% of their GBR over the long term, consistent with the revenue stability that is intended under a fixed revenue model.

On April 10, 2020 the Federal Government passed the CARES Act, which established the Provider Relief Fund which appropriated $178 billion for hospitals and other healthcare providers nationwide. This money was distributed over the next 9 months on various bases. Based on reporting received from the Federal Government the HSCRC believes Maryland regulated hospitals have received $1.262 Billion from all allocations made by the Federal Government through December 31, 2020.

Recognizing that the State and Federal funding commitments were likely to overlap, on April 23rd the HSCRC issued notice to hospitals that "We will consider all available funding from these federal programs before determining eligibility for additional GBR funding to cover preparedness costs and lost revenue/undercharges". This guidance was reinforced in a memo dated July 28th, 2020 that noted undercharges would be recovered net of CARES PRF Funds.

On April 30, 2020, the Commission approved the Final Recommendation on COVID Surge Funding (the COVID Surge Policy, available here Final Recommendation on COVID Surge Funding). Under the policy, hospitals were eligible for additional funding to the extent COVID cases caused hospital volumes to exceed those established in a hospital's GBR. This policy was effective March 1, 2020 until it was suspended by the Commission effective June 30, 2020 as COVID cases declined. No payments were due under this policy for this period. It was then re-instituted as of November 1, 2021 and is currently in effect. Amounts due to hospitals are calculated over the entire period the policy is active and therefore will not be available until the Commission elects to suspend the policy.

On May 8, 2020 the Commission issued a memo expanding the corridor relief for inpatient only, patient care rate centers to 20 percent. This expansion was considered at the request of hospitals and is consistent with, but more generous than, Medicare's policy under the Inpatient Prospective Patient System which included a 20 percent increase in reimbursement for entire Medicare inpatient COVID cases.

As of June 30, 2020, for the completed fiscal year, actual hospital charges were $17,432 Billion versus an FY2020 final statewide GBR of $18.373 Billion - an undercharge of $941 Million. The HSCRC estimates that had the two COVID corridor expansions not been provided, the undercharge would have been $285 Million larger for FY 2020 (i.e. payers paid an additional $285 Million in Q4 of 2020 than they would have had to if a fee-for-service system had been in place).

Effective January 1, 2021, the HSCRC provided approximately $97 Million of funding to selected hospitals who had an undercharge, after considering PRF funds, for FY 2020 consistent with the Commission's original commitment to fund the FY 2020 undercharges. This amount was added such that recovery will occur in the first 6 months of the calendar year. These amounts were intended as preliminary relief to hospitals with an undercharge and will be revised based on this recommendation in July 1, 2021 rate orders.

## Considerations not Addressed in this Approach

In order to simplify the issues involved in this recommendation, the HSCRC is choosing not to consider two items:

1. Undercharge amounts are all calculated based on charges without consideration to the differential adjustments received by most payers, which reduce the amount actually paid to hospitals. This is appropriate when considering policy-related amounts within the Maryland system as any recovery of undercharges in future periods would also be subject to the same differential. However, when considering undercharges versus external funding such as PRF funding it creates a slight mismatch as a hospital loses only approximately $0.95 cents per $1.00 of charges, but a hospital receives

100% of relevant PRF funds. Staff elected not to adjust this phenomenon in order to simplify the calculations, but would note that it means hospitals' financial positions are likely slightly more favorable than discussed in this recommendation and exhibits.

2. The only COVID-specific funding source staff considered in this recommendation is the PRF funding. Hospitals are able to receive temporary and permanent funding support through a number of other programs such as FEMA and the Medicare Advanced Payment Program. Staff did not consider these programs because the amounts are uncertain, relatively immaterial, and, in some cases, require repayment (i.e. only provide liquidity support).

## Draft Recommendation and Public Comment

In the February 2021 Commission meeting, staff recommended that the Commission resolve the overlap between PRF Funds and HSCRC rate relief for the 18 months ended December 31, 2020, by counting the PRF funds towards a hospital's GBR and then adjusting, effective July 1, 2021, any resulting over or under charge (the Draft Recommendation). Further detail on this proposal can be found in the Commission materials for the February 10th meeting.

Nine Public Comment letters were received and are appended to the end of this recommendation. Four letters were supportive of the draft recommendation (Johns Hopkins Health System, JLMcGee Consulting, CareFirst, and Leni Preston). Four letters (MedStar, Holy Cross Health, Tidal Health, and Adventist HealthCare) argued that the Commission delay any action and raised a number of other technical issues with the Draft Recommendation which will be addressed throughout this document and one letter (University of Maryland Medical System) supported an alternative approach described in the February Commission meeting, discussed further below, as well as argued that any settlement should be done at a hospital rather than system level. The Draft Recommendation and the alternative approach were both described as being settled at a system level, i.e. combining the results of all hospitals in a system before determining the outcome.

# Definition of Allocated PRF Funds

## Draft Recommendation Allocation Approach and Comment Letters

HHS distributed PRF payments to providers over the course of Calendar Year 2020 in multiple phases and on multiple bases with different organizations eligible for different distributions (a full timeline can be found here: PRF Timeline). Hospitals were not the only recipient of funds, and other organizations such as physician practices received funding; however, the HSCRC is only responsible for setting rates for Maryland's regulated hospitals. Therefore, to reconcile GBR funding and PRF funding, it is necessary to determine how much PRF funding is relevant to the regulated hospital.

In the Draft Recommendation, staff proposed the following process to identify the relevant funding.

(1) Capture the funding provided to the regulated hospital entity under the PRF[1]
(2) Allocate that funding between regulated and unregulated portions of the regulated entity based on the revenue reported in the 2019 Annual Filing for the hospital
(3) Count only the regulated allocation in assessing overlap with GBR Funding

The process after this allocation only considers funding provided to the regulated hospital entity; the unregulated portion of PRF is excluded from further calculation. Staff notes this process excludes any funding received by the unregulated providers within the regulated entity. In other words within the regulated entity, funding provided to the regulated provider is allocated to unregulated providers but the reverse is not true. This approach, which likely understates the regulated allocation, is necessary because the HSCRC has no way to identify the providers within the unregulated reporting.

The industry raised a number of issues in regard to this approach:

1. Varying methods of reporting result in the revenue reported for unregulated business in the annual filing being significantly depressed for some hospitals.
2. Varying corporate structures between hospitals impact the degree to which their unregulated business is reported in the HSCRC Annual Filing or within a corporate entity not subject to annual filing requirements.
3. Federal guidance permits entities to move PRF funds between entities which commenters interpreted to mean that the allocation of funds used in this settlement should be at the total discretion of the hospital.
4. That only accounting for PRF funds and only allocating from regulated to unregulated results in an overly favorably outcome to hospitals.

The HSCRC has limited reporting on entities outside the regulated entity and it is not feasible to use that reporting to allocate PRF funds. However, to be responsive to this issue, and the issue raised in item 1 above, staff is recommending a revised allocation approach as described below under.

The logical extension of item 3 is that the HSCRC can not consider any PRF Funds for a hospital system because the hospital system could choose to allocate all the funds to another entity. Under such an approach, Maryland rate payers would be 100% responsible for shortfalls under the GBR. Moreover, this policy presents equity concerns for small, independent Maryland hospitals who do not have out-of-state sister entities or extensive unregulated operations to potentially "shelter" PRF funds.

Further staff does not believe that this was the intent of the Federal guidelines. The HSCRC's authority allows the Commission to consider all sources of funding in assessing the viability of the regulated entities.

[1] Staff is now working with CMS and have obtained an authoritative list of funding under item (1) and expect to be able to maintain that data with CMS as additional funding is received or funding is returned. This report will be used in determining any settlements and is reflected in the data in Appendix A. To date no Maryland hospital has returned funding to the Federal Government.

Finally, the HSCRC is using the allocation approach outlined below to estimate the amount of PRF Funds relevant to setting regulated Maryland rates, it does not preclude the health system from using the PRF funds amongst its other entities.

## Definition of Allocated PRF Funds

Allocated PRF Funds shall be calculated as follows:

(1) Capture the funding provided to the regulated hospital entity under the PRF as reported to the HSCRC by CMS.
(2) Allocate that funding between regulated and unregulated portions of the regulated entity based on (1) the percentage of revenue reported in the 2019 Annual Filing for the hospital and (2) the percentage of statewide revenue for the same period.
(3) Use only the smaller of the two regulated allocations in the step above in assessing overlap with GBR funding.

Staff believes that using the more favorable hospital-specific and Statewide regulated/unregulated split is a reasonable and equitable way to address the first two industry concerns noted in the prior section. The Allocated PRF Funds would be recalculated should a hospital return PRF Funding to the Federal Government in the future, but the imputed percentage that allocated funds are based on would remain the same.

Staff acknowledges the commenters' concerns that the original and the revised approach to this allocation will tend to result in a favorable allocation for hospitals. However, staff believes a bias towards more generous funding to hospitals is appropriate in the crisis given the lack of information to allow a more rigorous calculation.

# Settlement Period

## Current Recommendation

Industry raised a number of concerns about the 18-month settlement period proposed in the Draft Recommendation, specifically:

1. GBRs are typically settled on a fiscal year basis and the HSCRC expressly waived the interim target for FY21, thus calculating that settlement through this window would be technically problematic.
2. The COVID crisis is ongoing
3. The PRF allowed for spending and lost revenue through June 30, 2021.

In recognition of these concerns, this final recommendation addresses only FY20. In the approach outlined below, staff considers all Allocated PRF Funds in assessing FY20 outcomes. However, since the new approach does not offset Allocated PRF funds beyond those needed for FY20 relief, it does not preclude the use of these funds in FY21 and therefore is not in conflict with the Federal program timing.

# Recommended Settlement Approach

## Overall Approach

For hospitals where Allocated PRF Funds do not cover the hospitals' actual GBR undercharge, this Recommendation has not changed. The hospital will still be permitted to recover the undercharge and any incremental net COVID expenses and funding under the COVID surge policy.

Given industry concerns over the HSCRC recovering PRF dollars that could be used by a health system for another entity, staff has revised the recommended approach for hospitals whose Allocated PRF Funds exceed their FY20 undercharge. Whereas previously, the HSCRC would reduce on a one-time basis FY21 GBRs equivalent to how much a hospital's FY20 GBR was exceeded by hospital charges and Allocated PRF Funds, the proposed revision limits recoveries to the lessor of the relief provided by the Commission or the amount of extra funding. Staff believes this is consistent with the HSCRC mandate which is to consider all sources of funding in assessing hospital financial conditions.

In addition, the staff is recommending that the calculation would be resolved at a hospital level, although a system may choose to make any resulting adjustments across the system, at their discretion, subject to staff approval.

The specific calculation would be as follows:

1. If the sum of FY20 Actual Charges and Allocated PRF Funds exceed the FY20 GBR, remove from the hospital's future rates the lessor of:
    a. The amount of COVID Relief Provided provided by the Commission
    b. The amount by which actual FY20 Actual Charges + Allocated PRF Funds exceed FY20 GBR
2. If the sum of FY20 Actual Charges and Allocated PRF Funds is less than the FY20 GBR, add to the rates the amount of such shortfall.

For this calculation:

- COVID Relief Provided by the Commission is defined as the greater of zero and the sum of the following:
    I. Actual Q4 FY2020 (which coincides with the start of the pandemic) charges less FY2020 rate order rates X Actual Q4 2020 Volumes X 1 plus Corridor relief percentage granted prior to COVID.
    II. COVID Surge Funding, for any period where the Surge Policy was in effect, which has been completed at the time the settlement is determined.
    III. Net incremental COVID expenses for FY20 as defined by staff.
- Actual Charges are the charges reported by the hospital in their financial reports.
- FY20 GBR is the final GBR as of June 30, 2020. FY20 rates are the rates calculated from that GBR.

This approach is the same as the alternative approach described in the February 2020 Commission meeting except that (a) it is limited to FY20, (b) it is at a hospital level, (c) the Allocated PRF Funds calculation has been revised as described above and (d) the COVID Surge Funding and Net Excess COVID expenses are included as COVID relief. Staff changed the handling of the items (d) because they believe that the

Commission should not provide extra funding for these items to the extent that the System has remaining PRF Funding.

Appendix A contains a calculation by a hospital of the amounts due to or from each hospital under this recommendation based on currently available data and before consideration of the COVID Surge Policy or net incremental COVID expense. This estimate shows a net statewide increase of $46 million in rates to be applied on July 1, 2021. However, since $97 million of preliminary relief was granted on January 1, 2021 rate orders the actual year over year impact will be $51 million of recovery, which will be implemented over the last 6 months of the calendar year (as shown in Table 4). Note the amounts referenced above and in Appendix A are included for informational purposes and are not intended to reflect final settlement amounts which will be updated for the yet-to-be-determined information.

## Timing

The rate adjustments described above would be calculated based on the available information and applied in the July 1, 2021 rate orders for recovery during the first 6 months of FY21. To the extent that the amounts subsequently change because, for example, the hospital returns PRF Funding to the Federal Government or additional expense information becomes available, additional adjustments will be made in future rate orders.

## Other considerations

Staff believes this Draft Recommendation addresses most of the comments raised in the comment letters received. Comments not addressed include:

**The pandemic crisis is ongoing and funds should not be removed now:** Funds are being removed effective July 1, 2021, staff is assuming that the crisis will be substantially mitigated at this point. If this is not the case the Commission could delay these adjustments.

**Statute and GBR Agreements do not allow the HSCRC to treat PRF payments as revenue for hospital services as with other sources such as fundraising, state and local grants:** Staff believe the statute allows consideration of all revenue sources in evaluating financial condition.

**Burden of COVID in a specific service area was extreme and conflicting guidance and lack of recognition for the burden of treatment will force reassessment of resources dedicated to care transformation under the TCOC model:** While staff acknowledges the burden of treatment and the enormous efforts hospitals have made, staff also notes that almost all care transformation requirements on hospitals have been delayed and that, given the large amount of funding available, Maryland hospitals both individually and collectively are in no weaker financial position now than they were before the crisis. Therefore, Staff sees no reason for the industry to change its approach to the long-term crisis of keeping healthcare affordable for all Marylanders.

**Staff should follow the HHS approach of quantifying and funding incremental expenses at a detail level and considering the entire system rather than relying on net impact on the annual filings:** Based on a preliminary review of Annual Filings, staff believes that hospitals realized cost savings due to reduced volumes that generally offset incremental expenses. While staff does not have access to system-level costs at the same level of detail, the assumption is that the same dynamic is true. Staff does not believe that Maryland rate payers should reimburse hospitals for added COVID expenses without realizing the benefit of lower costs in other areas, given that the hospital's revenue base is guaranteed regardless of volume. Staff will be reviewing hospitals individually and allowing for expense recovery for hospitals that bore an expense burden disproportionate to their cost reductions.

**Future rate offsets should not be implemented because (1) such future reductions may not be counted for the purpose of justifying CARES funding and (2) that the HHS terms that hospitals sign to receive CARES money referencing lost revenues and expenses "other sources are obligated to reimburse" prevent the HSCRC from revising rates beyond any COVID specific corridor expansions:** Given the cap on HSCRC recoveries in this final recommendation is limited to COVID relief provided by the Commission, staff believes the scenario described in 1 is no longer relevant. In addition, staff notes, under this Recommendation, should the Federal Government recover funds from a hospital the hospital's calculated settlement would be adjusted and the hospital would be entitled to recover funds through the HSCRC based on the adjusted settlement. Staff does not believe the "other sources are obligated to reimburse" clause in HHS guidance refers to the HSCRC since the HSCRC is not a payer and does not reimburse any provider. To the contrary in Maryland, the HSCRC determines what payers are obligated to reimburse, and therefore it is impossible for the HSCRC to be in conflict with this clause.

# Stakeholder Comments

HSCRC staff worked with the Payment Models Workgroup to review and provide input on the proposed RY 2022 update. HSCRC staff will update this section when the official stakeholder comment period has closed.

# Recommendations

Based on the currently available data and the staff's analyses to date, the HSCRC staff provides the following draft recommendations for the RY 2022 update factors.

For Global Revenues:

a) Provide an overall increase of 2.23 percent for revenue (net of uncompensated care offset) and 2.07 percent per capita for hospitals under Global Budgets, as shown in Table 2. In addition, the staff is proposing to split the approved revenue into two targets, a mid-year target, and a year-end target. Staff will apply 49.73 percent of the Total Approved Revenue to determine the mid-year target and the remainder of revenue will be applied to the year-end target. Staff is aware that there are a few hospitals that do not follow this pattern of seasonality and will adjust the split accordingly.

b) Allocate 0.23 percent of the total inflation allowance based on each hospital's proportion of drug cost to the total cost to more equitably adjust hospitals' revenue budgets for increases in drug prices and high-cost drugs.

c) Adjust rates effective July 1, 2021, over a 6 month window, to implement the reconciliation of CARES Provider Relief Funds (PRF) and HSCRC support for Rate Year 2020 as described in this recommendation. The general impact of this proposal is that:

- For hospitals where the sum of actual charges and PRF Funding is less than their fiscal year 2020 approved Global Budget Revenue the adjustment would add the shortfall, net of any preliminary amount already provided in the January 1st, 2021 rate order, to their July 1, 2021 rate order.
- For hospitals where the sum of actual charges and PRF Funding is greater than their fiscal year 2020 approved Global Budget Revenue the adjustment would subtract from the lessor of the excess or the COVID corridor relief provided by the Commission (as defined in the body of this recommendation) from their July 1, 2021 rate order.
- Staff recommends that the Commission guarantee RY 2021 Global Budget Revenues for hospitals and implement a similar reconciliation policy as outlined above to maintain financial stability for hospitals, given that the COVID pandemic continues to have an impact on health care delivery in RY 2021.

For Non-Global Revenues including psychiatric hospitals and Mt. Washington Pediatric Hospital:

a) Provide an overall update of 2.37 percent for inflation.

b) Withhold implementation of productivity adjustment due to the low volumes hospitals are experiencing as the result of the COVID-19 pandemic.

# Appendix A:

Note: Amounts do not reflect rate relief granted January 1, 2021, so actual July 1, 2021 adjustment will be net of that relief

| Hospital Name | FY20 Final GBR (Under) Over Charge | Allocated PRF Funds | (Under) Over Charge Position with Allocated PRF Funds | Q4 Charges w Pre-COVID Corridor | Actual Q4 Charges | Commission Granted COVID Relief - Revenue Shortfall | Other Commission Granted Relief (1) | Total Commission Granted Relief | Rate (Incr) Decr Implemented July 1, 2021 |
|---|---|---|---|---|---|---|---|---|---|
| | A | B | C = A + B | D | E | F = E - D | G | H = G + F | Min of (Max(H or $0) or C) |
| Meritus Medical Center | ($33,436,603) | $8,355,099 | ($25,081,504) | $73,851,370 | $78,753,600 | $4,902,230 | TBD | $4,902,230 | ($25,081,504) |
| UMMC | ($80,031,647) | $97,006,111 | $16,974,464 | $395,521,529 | $424,077,896 | $28,556,367 | TBD | $28,556,367 | $16,974,464 |
| Prince George | ($10,810,766) | $68,969,587 | $58,158,821 | $83,328,719 | $80,215,622 | ($3,113,098) | TBD | ($3,113,098) | $0 |
| Holy Cross | ($23,017,050) | $51,133,098 | $28,116,048 | $114,189,306 | $117,988,836 | $3,799,530 | TBD | $3,799,530 | $3,799,530 |
| Frederick Memorial | ($17,354,453) | $17,395,122 | $40,669 | $73,710,515 | $78,375,833 | $4,665,318 | TBD | $4,665,318 | $40,669 |
| UM Harford Memorial | ($12,587,225) | $2,433,790 | ($10,153,435) | $19,447,784 | $18,518,473 | ($929,312) | TBD | ($929,312) | ($10,153,435) |
| Mercy | ($39,411,366) | $9,314,239 | ($30,097,126) | $110,806,440 | $123,258,229 | $12,451,789 | TBD | $12,451,789 | ($30,097,126) |
| Johns Hopkins | ($160,141,265) | $116,728,681 | ($43,412,584) | $514,860,904 | $545,472,395 | $30,611,491 | TBD | $30,611,491 | ($43,412,584) |
| UM Shore Medical Dorchester | ($9,325,434) | $15,423,184 | $6,097,750 | $6,904,722 | $7,318,969 | $414,246 | TBD | $414,246 | $414,246 |
| St. Agnes | ($30,562,445) | $34,580,325 | $4,017,880 | $82,473,795 | $89,101,985 | $6,628,190 | TBD | $6,628,190 | $4,017,880 |
| Sinai | ($32,916,550) | $29,965,351 | ($2,951,199) | $171,384,858 | $194,385,139 | $23,000,281 | TBD | $23,000,281 | ($2,951,199) |
| Bon Secours | ($2,626,367) | $10,312,859 | $7,686,492 | $7,915,008 | $10,061,487 | $2,146,478 | TBD | $2,146,478 | $2,146,478 |
| MedStar Franklin Square Medica | ($331,551) | $24,494,340 | $24,162,789 | $129,610,920 | $151,967,561 | $22,356,641 | TBD | $22,356,641 | $22,356,641 |
| Washington Adventist | ($4,126,333) | $59,063,362 | $54,937,030 | $80,389,189 | $76,278,484 | ($4,110,705) | TBD | ($4,110,705) | $0 |
| Garrett County Memorial | ($4,776,096) | $9,543,311 | $4,767,215 | $13,422,904 | $12,101,658 | ($1,321,246) | TBD | ($1,321,246) | $0 |
| MedStar Montgomery Medical Cen | $362,566 | $21,193,888 | $21,556,454 | $38,445,260 | $42,614,628 | $4,169,368 | TBD | $4,169,368 | $4,169,368 |
| Peninsula Regional Med Cen | ($21,666,823) | $26,319,555 | $4,652,732 | $101,422,841 | $106,402,444 | $4,979,603 | TBD | $4,979,603 | $4,652,732 |
| Suburban | ($28,351,528) | $31,095,740 | $2,744,212 | $61,378,548 | $66,873,028 | $5,494,480 | TBD | $5,494,480 | $2,744,212 |
| Anne Arundel Med Cen | ($38,452,368) | $42,551,034 | $4,098,666 | $129,374,389 | $139,182,105 | $9,807,716 | TBD | $9,807,716 | $4,098,666 |
| MedStar Union Mem Hospital | ($1,598,073) | $24,946,521 | $23,348,448 | $76,082,221 | $107,704,432 | $31,622,211 | TBD | $31,622,211 | $23,348,448 |
| Western Maryland Regional Medi | ($8,586,321) | $14,158,753 | $5,572,432 | $78,302,942 | $81,555,744 | $3,252,803 | TBD | $3,252,803 | $3,252,803 |
| MedStar St. Mary | $482,675 | $10,097,457 | $10,580,132 | $42,924,295 | $49,747,037 | $6,822,742 | TBD | $6,822,742 | $6,822,742 |
| Hopkins BayviewMedical | ($59,743,931) | $52,384,438 | ($7,359,493) | $125,956,648 | $134,837,910 | $8,881,263 | TBD | $8,881,263 | ($7,359,493) |
| UM Shore Medical Chestertown | ($13,168,085) | $6,021,315 | ($7,146,771) | $8,025,810 | $8,295,531 | $269,721 | TBD | $269,721 | ($7,146,771) |
| Union Hospital Cecil County | ($10,521,647) | $7,276,337 | ($3,245,309) | $33,959,857 | $37,786,245 | $3,826,388 | TBD | $3,826,388 | ($3,245,309) |
| Carroll Hospital Center | ($11,410,909) | $11,595,391 | $184,482 | $47,652,464 | $51,084,737 | $3,432,273 | TBD | $3,432,273 | $184,482 |
| MedStar Harbor Hospital | ($10,384,160) | $19,543,543 | $9,159,383 | $35,340,556 | $38,599,086 | $3,258,530 | TBD | $3,258,530 | $3,258,530 |
| UM Charles Regional | ($10,060,006) | $12,201,627 | $2,141,622 | $35,865,408 | $32,963,785 | ($2,901,623) | TBD | ($2,901,623) | $0 |
| UM Shore Medical Easton | $626,210 | $0 | $626,210 | $47,840,408 | $50,210,549 | $2,370,141 | TBD | $2,370,141 | $626,210 |
| UMMC Midtown Campus | ($15,405,321) | $21,038,797 | $5,633,477 | $44,550,287 | $46,351,086 | $1,800,799 | TBD | $1,800,799 | $1,800,799 |
| Calvert Health | ($2,294,938) | $7,241,356 | $4,946,418 | $38,249,519 | $39,635,767 | $1,386,248 | TBD | $1,386,248 | $1,386,248 |
| Northwest | ($16,789,476) | $20,474,502 | $3,685,026 | $54,206,526 | $61,368,989 | $7,162,463 | TBD | $7,162,463 | $3,685,026 |
| UM BWMC | ($30,926,741) | $28,137,939 | ($2,788,802) | $83,575,572 | $95,413,477 | $11,837,905 | TBD | $11,837,905 | ($2,788,802) |
| G.B.M.C. | ($28,502,629) | $15,383,066 | ($13,119,563) | $96,837,840 | $106,343,289 | $9,505,450 | TBD | $9,505,450 | ($13,119,563) |
| McCready | ($374,572) | $0 | ($374,572) | $989,509 | $938,421 | ($51,088) | TBD | ($51,088) | ($374,572) |
| Howard County General | ($19,993,336) | $25,166,150 | $5,172,814 | $62,978,539 | $69,665,693 | $6,687,154 | TBD | $6,687,154 | $5,172,814 |
| UM Upper Chesapeake | ($26,179,241) | $26,025,879 | ($153,362) | $66,933,329 | $65,877,501 | ($1,055,828) | TBD | ($1,055,828) | ($153,362) |
| Doctors Community Hosp | ($15,946,682) | $28,097,966 | $12,151,284 | $49,042,184 | $58,851,158 | $9,808,974 | TBD | $9,808,974 | $9,808,974 |
| Laurel Regional | ($2,955,247) | $0 | ($2,955,247) | $4,876,506 | $4,336,559 | ($539,947) | TBD | ($539,947) | ($2,955,247) |
| Ft. Washington | ($2,858,785) | $5,518,096 | $2,659,311 | $11,432,974 | $11,375,237 | ($57,737) | TBD | ($57,737) | $0 |
| Atlantic General | ($9,605,883) | $8,684,566 | ($921,317) | $21,840,286 | $21,661,783 | ($178,503) | TBD | ($178,503) | ($921,317) |
| Medstar Southern Maryland Hosp | ($6,796,561) | $34,276,660 | $27,480,098 | $55,206,999 | $65,068,799 | $9,861,800 | TBD | $9,861,800 | $9,861,800 |
| UM St. Joseph Medical Center | ($34,712,587) | $17,576,410 | ($17,136,177) | $70,028,786 | $73,750,063 | $3,721,277 | TBD | $3,721,277 | ($17,136,177) |
| Holy Cross Germantown Hospital | ($405,000) | $0 | ($405,000) | $28,057,747 | $28,339,724 | $281,977 | TBD | $281,977 | ($405,000) |
| Germantown Emergency Center | ($1,588,210) | $0 | ($1,588,210) | $2,223,063 | $2,434,335 | $211,272 | TBD | $211,272 | ($1,588,210) |
| Queen Anne Emergency Ctr | ($374,616) | $0 | ($374,616) | $2,052,700 | $1,955,383 | ($97,317) | TBD | ($97,317) | ($374,616) |
| Bowie Emergency Center | ($2,306,134) | $0 | ($2,306,134) | $3,271,252 | $3,125,556 | ($145,696) | TBD | ($145,696) | ($2,306,134) |
| UM Rehab Ortho Inst | ($15,895,008) | $2,163,142 | ($13,731,866) | $18,925,234 | $21,653,905 | $2,728,671 | TBD | $2,728,671 | ($13,731,866) |
| MedStar Good Samaritan Hospita | ($6,954,734) | $25,435,925 | $18,481,190 | $55,075,079 | $62,185,451 | $7,110,372 | TBD | $7,110,372 | $7,110,372 |
| Levindale | ($3,206,520) | $2,930,138 | ($276,381) | $13,090,688 | $14,333,766 | $1,243,078 | TBD | $1,243,078 | ($276,381) |
| Shady Grove Adventist | ($23,290,976) | $20,328,796 | ($2,962,180) | $105,303,291 | $102,533,975 | ($2,769,316) | TBD | ($2,769,316) | ($2,962,180) |
| Total | ($941,290,744) | $1,122,583,446 | $181,292,701 | $3,629,137,521 | $3,912,933,346 | $283,795,825 | | $283,795,825 | ($46,806,714) |

1. Includes (1) incremental net FY20 COVID-related expenses to be assessed by Staff and (2) COVID Surge Funding, for any period where the Surge Policy was in effect, which has been completed at the time the settlement is determined.

# Appendix B: Public Comment Letters Re: Reconciliation of CARES Provider Relief Fund and HSCRC-support

JLMcGee Consulting

Leni Preston, Independent Consumer Voice on Health Policy

Adventist HealthCare

University of Maryland Medical System

Holy Cross Health

CareFirst

Johns Hopkins Health System

MedStar Health

Tidal Health

**JLMcGee Consulting**

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Adam Kane, Esq., Chairman
Health Services Cost Review Commission
4160 Patterson Ave.
Baltimore, MD 21215

February 24, 2021

RE: CARES Funding Policy Update

Dear Chairman Kane:

Thank you for allowing me this opportunity to offer comments on the draft CARES Funding Policy update. I am recently retired as the Executive Director of the Transit Employees Health & Welfare Fund and the newly formed Transit Employees Retiree Health Plan. However, I am still engaged for some limited consulting. The funds are governed by boards of trustees representing the management of the Washington Metropolitan Area Transit Authority and ATU Local 689.

At the June 2020 Commission meeting I submitted comments on the update factor. Much of this letter will echo those comments which seem sadly prescient in hindsight. In that letter I wrote:

> "I would like to see a clear plan that anticipates the possibility that the combination of hospital revenue from payers and additional federal and/or state COVID-19 relief funds might exceed hospital expenses. If so, how will that additional revenue flow back to private payers?"

These are still perilous times; and not just for the hospital industry and their fearless employees who have worked tirelessly to keep themselves and the public alive and safe. Over 1,000 Metro employees have lost time due to contracting COVID. Four have died. Many have those hospitals and those employees to thank for their continued health and even their lives.

During the past year, we have seen workplaces altered and far too many shuttered. Our economy, perhaps even our way of life, may be permanently altered. Throughout this, the unique hospital rate setting experiment in Maryland has allowed Maryland hospitals a degree of stability that is surely the envy of hospitals throughout the country.

But something that makes any crisis more tolerable is the idea of shared sacrifice. That is not a phrase that has been associated with this pandemic, but it is a value that is part of the Maryland rate setting experiment. I feel that the staff proposal on CARES funding is fair to the hospitals and to the publics they serve and shares our sacrifice equitably.

I urge the Commissioners to accept the staff CARES funding policy update.

Sincerely

James L. McGee, CEBS

**JLMcGee Consulting**

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Adam Kane, Esq., Chairman
Health Services Cost Review Commission
4160 Patterson Ave.
Baltimore, MD 21215

February 24, 2021

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I urge the Commissioners to accept the staff CARES funding policy update.

Sincerely

James L. McGee, CEBS

**Leni Preston**
**Independent Consumer Voice on Health Policy**
**Email: lenipreston@verizon.net  Cell: 301.351.9381**

24 February 2021

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

RE: CARES funding policy option

Dear Chairman Kane:

I appreciate the opportunity to comment on the draft CARES funding policy option.  I do so as the former chair of the Board of Directors of Consumer Health First and as a current and former member of several HSCRC workgroups, including the Consumer-Standing Advisory Committee.

I wish to echo the points made in the comments submitted by Jim McGee and reinforce his emphasis on the need for "shared sacrifice."  To achieve that, with funding from the CARES Act, it is important that those dollars be factored into the reconciliation process with hospital rate setting.

Therefore, I urge you to accept the recommendation of the HSCRC staff.  This is the only fair and equitable approach that will ensure that, in the end, consumers do not end up paying more than their fair share.

Thank you for taking these comments into consideration as you deliberate this important issue.

Sincerely,

Leni Preston

Adventist HealthCare

March 11, 2021

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

Dear Chairman Kane,

On behalf of Adventist HealthCare, thank you for the opportunity to provide comments on the HSCRC's CARES Funding Policy Update presented at the February 10, 2020 meeting of the Health Services Cost Review Commission.

Timing:

In the February 10, 2021 presentation, the staff states the "intent is to provide ***final*** guidance for the 18 months ended 12/31/20 shortly so hospitals can have certainty moving forward." We believe that it is premature to issue final guidance as the pandemic, our response as well as the distribution and justification of use of the Provider Relief Funds is still on-going. To date, we estimate that HHS has allocated just under $130B of the $178B of available funding including amounts for Phase 3 General Distributions which began in mid-December of 2020 and will continue into the first months of 2021. This leaves an additional $48B that may be allocated to providers between now and June 30, 2021. Additionally, in a 10/28/2020 FAQ, HHS states that "Providers do not need to be able to prove, at the time they accept a Provider Relief Fund payment that prior and/or future lost revenues and increased expenses attributable to COVID-19 (excluding those covered by other sources of reimbursement) meet or exceed their Provider Relief Fund payment. Instead, HHS expects that providers will only use Provider Relief Fund payments for permissible purposes and if on June 30, 2021, providers have leftover Provider Relief Fund money that they cannot expend on permissible expenses or losses, then they will return this money to HHS. HHS will provide directions in the future about how to return unused funds. HHS reserves the right to audit Provider Relief Fund recipients in the future and collect any Relief Fund amounts that were used inappropriately." Even with receipts thus far which are not complete, providers have through June 30, 2021 to demonstrate the use of these funds consistent with U.S. Department of Health and Human Services (HHS) Terms and Conditions.

Due to the incomplete financial picture that is currently available which will be complicated by ultimately crossing multiple rate years, we believe it would be difficult for the HSCRC staff to develop a fully informed final policy proposal at this time.

In addition to the timing considerations, we believe that there are inconsistencies between the proposed HSCRC policy and HHS application of CARES funds that may lead to unintended negative financial consequences for Maryland Hospitals.

Revenue and Expense considerations:

The HHS guidelines clearly state that the "Provider Relief Fund and the Terms and Conditions require that recipients be able to demonstrate that lost revenues and increased expenses attributable to COVID-19, excluding expenses and losses that have been reimbursed from other sources or that other sources are obligated to reimburse, exceed total payments from the Relief Fund." While we recognize there is information the HSCRC staff has not yet had the opportunity to collect and analyze, we are concerned that the Policy update presented on February 10, 2020 meeting, may not have represented a full picture to the Commissioners that hospitals and health systems are experiencing related to both revenue ***and*** expense. We feel that it is important to make the Commissioners aware that there are significant COVID related expenses that were not presented and looking at undercharges compared to the amount of CARES Act money received alone does not present a full picture of the financial impact of COVID on an organization. It is critical to understand hospitals and health systems which have experienced higher COVID related volumes may have received more CARES funding, while not experiencing as much of an undercharge as other organizations, but those organizations are also likely experiencing greater expenses related to COVID which were not presented in the policy update.

Organizational Structure and Use of Funds:

While we understand the HSCRC only has jurisdiction over hospital rate setting, the pandemic has impacted all areas of the care delivery system and health systems have experienced lost revenues and expenses beyond Acute Care hospitals, while also needing to quickly deploy resources in unprecedented ways. HHS and Congress have recognized the need for health systems to have flexibility in allocating both the General Distribution and Targeted funds received. As such, the Consolidated Appropriations Act, 2021, permits that "For any reimbursement by the Secretary from the Provider Relief Fund to an eligible health care provider that is a subsidiary of a parent organization, the parent organization may, allocate (through transfers or otherwise) all or any portion of such reimbursement among the subsidiary eligible health care providers of the parent organization, including reimbursements referred to by the Secretary as 'Targeted Distribution'' payments, among subsidiary eligible health care providers of the parent organization…."

The HSCRC staff propose the use of the FY 2019 RE Schedules to determine a regulated apportionment to use in a calculation to determine "Net Over/(Under) Funding." We believe this could be potentially flawed for a couple of reasons. First the HSCRC's Annual Filing may not represent an organization or health system in its entirety. Most, if not all, health systems have patient care related subsidiaries that are not reflected on one of its Annual Filings. Because of the flexibility that HHS

allows health systems in the allocation for use of funds, we believe that this inconsistency could create a situation where the funds have been used and reported to HHS differently than how the HSCRC is evaluating the funds for application in rate setting and inadvertently disadvantage Maryland hospitals. It is important to note that providers are required by HHS to provide detailed reporting justifying the use of the funds and that reporting is subject to a Single Audit conducted under 45 CFR Part 75. We recommend the HSCRC use the reports and the organization's reported use and allocation of funds as submitted to HHS, which are already subject to audit and significant anti-fraud monitoring.

Offsets to Future Rates:

In its Funding policy update, the HSCRC Staff indicate amounts of HHS funds received in excess of its GBR undercharge (FY 2020 plus the first 6 months of FY 2021) plus the impact of COVID on expenses for the same period, be treated as "over-funding" and therefore be subject to a future rate reduction. We believe this view is flawed for a couple of important reasons:

First, it would be inappropriate to assume the 18-month period is complete. As mentioned earlier, the funds have not been fully distributed by HHS and the period for which a provider can justify the use of funds has not been completed, regardless of when the funds were received during the pandemic. Providers are recognizing HHS funds as revenue as they can demonstrate lost revenues or COVID expenses consistent with HHS guidelines, which may mean many organizations have a portion of total receipts recorded as a liability on their balance sheets. If a provider does not have lost revenues or expenses to justify the use of those funds, it will be required to return those funds to HHS. If between December 31, 2020 and June 30, 2021, the provider experiences further lost revenues and/or COVID related expenses, additional funds may be released into income to cover those amounts. The HSCRC staff's proposal does not appear to take into consideration the amounts received are intended by HHS to go through June 30, 2021 nor does it acknowledge providers will be required to return funds not used consistent with HHS guidelines.

Second, we believe an approach which offsets future rates would unduly harm Maryland hospitals and may violate HHS terms and conditions. HHS guidelines "require that recipients be able to demonstrate lost revenues and increased expenses attributable to COVID-19, excluding expenses and losses that have been reimbursed from other sources *or that other sources are obligated to reimburse*, exceed total payments from the Relief Fund." It is our interpretation that by reducing future rates to offset the "over-funding" as determined by the HSCRC, beyond any extraordinary corridor expansions granted in order to retain HHS funds as additional "lost revenue" would violate this requirement by reducing the amount that "other sources are obligated to reimburse." We believe reducing rates for a reason and amount which is outside of normal policy would in effect be reducing the payers, both governmental and commercial, obligation to reimburse. Additionally, we strongly believe that even if rate reductions were permissible to justify lost revenue, reducing future rates beyond the June 30, 2021 time frame

would preclude hospitals from claiming that lost revenue as the current guidelines stipulate in the notice of reporting requirements on the Provider Relief Fund website, funds must be expended no later than June 30, 2021. For these reasons, we do not believe the HSCRC is able to consider CARES Act receipts in excess of lost revenues and increased expenses as reported to HHS as an "overcharge" and subsequently reduce future rates.

We appreciate the opportunity to provide comment and we fully support the need for a well thought out policy on the use of Provider Relief Funds within the context of the Maryland system. The impacts of the pandemic are still on-going and extremely fluid and there are still outstanding and complex factors which need to be considered in the HSCRC's CARES Funding Policy. For the reasons outlined above, we respectfully request the HSCRC staff delay its final policy decision until further clarification and analysis can be conducted to ensure the HSCRC policy is consistent with HHS requirements and guidance, and we welcome further discussion with Commissioners and Commission staff regarding the complexities of the HHS terms and conditions for receipt and use of the Provider Relief Funds.

Sincerely,

Kristen Pulio
SVP, Chief Revenue Officer
Adventist HealthCare, Inc.

cc: Terry Forde, President & CEO, Adventist HealthCare, Inc.
James Lee, EVP & CFO, Adventist HealthCare, Inc.
Katie Wunderlich, HSCRC Executive Director
Joseph Antos, Ph.D, HSCRC Vice Chairman
Victoria W. Bayless, HSCRC Commissioner
Stacia Cohen, RN, HSCRC Commissioner
John M. Colmers, HSCRC Commissioner
James Elliott, M.D. HSCRC Commissioner
Sam Malhorta, HSCRC Commissioner

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**Mohan Suntha, MD, MBA**
**President and Chief Executive Officer**

March 11, 2021

**RE: Fiscal Year 2020 and 2021 HSCRC Undercharge Settlement Approach**
Katie Wunderlich
Executive Director, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Katie:

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, we are submitting comments in response to the Health Services Cost Review Commission's ("HSCRC") proposed action related to the Department of Health and Human Services ("HHS") CARES Act Funding.

Since the pandemic began, the HSCRC has assisted Maryland hospitals in their response to this unique emergency. As an academic medical system, UMMS has been duly focused on providing care in our local communities as well as supporting the State in its efforts to respond on statewide level. We appreciate working closely with the HSCRC throughout the pandemic to develop solutions to issues never before contemplated.

UMMS agrees that the proposed action to include CARES Act funding in the settlement process is a necessary component in reconciling the financial impact of the pandemic to Maryland hospitals and UMMS supports the general framework of the settlement calculation which also considers Global Budget Revenue (GBR) undercharges, operating expenses and recognition of physician losses.

UMMS would like to offer the following specific comments on certain aspects of this proposed action.

**Settlement and Identification of HSCRC's View of "Overfunding"**
UMMS is concerned with the overlapping nature of the Staff's approach to identifying "overfunding" versus HHS requirements to attest to and reconcile CARES Act funding. The HHS attestation and reconciliation process will also evaluate potential overfunding but will use a different approach to identifying COVID expense. This difference in methodologies will likely create disparities between the HSCRC and the HHS conclusions.

At the onset of the pandemic, the HSCRC provided a critically important stabilizing mechanism by allowing hospitals to expand rate corridors beyond the normal five percent. With the benefit of the support received through the CARES Act, it is possible that some of that funding was

ultimately not required by every hospital. To the extent that such charging support was ultimately not needed, we believe the HSCRC should take back those specific funds provided by the Commission to support hospitals to respond to COVID such as the revenue generated by the expanded corridors and that the principles and policies that govern GBR should remain in place.

**Multi-Year Approach to Reconciling**

The current proposed action aims at considering regulated revenues, operating expenses and CARES Act funding through the 24 month period ending June 30, 2021. We agree with this multi-year approach and we support a preliminary reconciliation through April 2021 for July 1, 2021 implementation.

**Settlement Approach - System vs. Individual Hospital**

HSCRC Staff intends to calculate the reconciliation at a health system level. All Maryland hospitals have unique GBRs and corresponding unit rates established on the basis of individual hospital cost structures. We believe this to be an important and key principle of our rate setting system. As such, we are concerned that deviating from a hospital-specific approach in this reconciliation will potentially set an unintended precedent for future commingling of GBR within a system. For consistency and equity, whether a stand-alone hospital or a hospital within a health system, we believe the reconciliation should be done on a hospital-specific basis.

**Method to Allocate CARES Act Funding to Unregulated Services**

The Staff's recognition of the need to support physician losses when considering the utilization of CARES Act funding is a welcome addition to the settlement process. We appreciate the Staff evaluating modified approaches to using the Schedule RE as presented at the March 5 HSCRC Payment Models work group and we are supportive of an approach that considers the potential differences in hospital reporting as well as recognizing hospital specific issues. Alternative 2 appears to be a more equitable option, but we emphasize the need for the HSCRC to continue to provide hospitals the opportunity to bring forth hospital specific issues.

Thank you for the opportunity to provide feedback. We appreciate the HSCRC's ongoing recognition of the significant financial implications COVID has created for hospitals. If you have any questions, please do not hesitate to contact me.

Sincerely,

Mohan Suntha, MD
University of Maryland Medical System
President and Chief Financial Officer

cc: Adam Kane, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
Stacia Cohen, RN
John M. Colmers
James N. Elliott, MD
Sam Malhotra
Katie Wunderlich, Executive Director
William Henderson, Principal Deputy Director
Jerry Schmith, Principal Deputy Director
Michelle Lee, UMMS Chief Financial Officer
Alicia Cunningham, UMMS SVP Finance

HOLY CROSS HEALTH

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HolyCrossHealth.org

March 11, 2021

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

Dear Mr. Kane,

On behalf of Holy Cross Health, we appreciate the opportunity to comment on the CARES funding policy presented at the HSCRC's February 10, 2021 public meeting.

The COVID-19 pandemic has placed unprecedented challenges upon our healthcare delivery system and has required significant investment in critical resources to meet the care demands of our community. While our Global Budget System provided the essential backstop that allowed Maryland hospitals to sustain a revenue base despite dramatic patient volume fluctuations, it was the addition of federal Provider Relief Funds which kept Holy Cross Health financially stable while we worked to support, expand and reinforce our front line facilities, access points, and care teams in meeting the overwhelming demands generated by the pandemic. The essential funding allowed us to recruit additional front-line care givers, many of whom were agency labor and came at a premium cost throughout the pandemic, in some cases amounting to almost double the standard full-time staffing rates, while uplifting and retaining our front-line teams. It also allowed us to provide essential PPE, obtain critical resources and supplies, pivot to new methods of care and communication when families and visitors were unable to be present, and provide new and essential care for our at risk community member who are uninsured and underinsured.

In accepting Provider Relief Funds, Holy Cross Health is now obligated to meet the specific terms and conditions as outlined in the Post-Payment Notice of Reporting Requirements issued by HHS, dated January 15, 2021. This guidance describes how funds are expected to be used and states *"funding will reimburse the recipient for only health care related expenses or lost revenue attributable to Coronavirus and will not reimburse expenses or losses that have been reimbursed from other sources or that other sources are obligated to reimburse"*. With this condition of acceptance, it is important the HSCRC's approach consider and incorporate essential elements of the HHS guidance in forming its recommended policy. The HSCRC's current proposal references the use of Provider Relief Funds to cover only lost revenue (GBR undercharges) but does not consider the incredible cost burden experienced by those hospitals who managed significant levels of COVID-19 surge cases. Our service area of Montgomery and Prince Georges Counties were the first hit by the pandemic and Holy Cross was the first in the region to respond. Additionally, as you know, our region was hardest hit by the pandemic and includes 1/3 of the State's uninsured and underinsured population, many of whom reside in the hardest hit zip codes. Holy Cross' immediate action to respond and expanded our resources to meet the needs came at a very high cost. Conflicting polices/guidance on how funds can be utilized and the lack of recognition for the tremendous costs burden fails to recognize these efforts and hospitals that have given so much will be forced to reassess and, potentially scale back, vital resources and investments made to support the transformation of care delivery under the Total Cost of Care model.

In addition, each Provider Relief Fund recipient is required to comply with specific reporting requirements as specified by HHS. If recipients are unable to sufficiently substantiate the use of the funds and document their utilization through prescribed reporting requirements, then the recipient is obligated to pay back any unjustified

funding to HHS. Hospitals were also permitted to redistribute Provider Relief Funds amongst their affiliated facilities to offset COVID-19 costs and lost revenue not otherwise covered by Provider Relief Funds or other sources. Neither of these unique elements have been considered in the current proposed HSCRC policy. The Hospitals' reporting requirements to HHS should be the basis upon which the HSCRC validates costs associated with COVID-19 and allow for the distribution of funding amongst their affiliated facilities. If any residual Provider Relief Funds remain, then the Hospital is obligated to send that funding back to HHS.

It will also be important to consider the timing in recognizing Provider Relief funding as we are still incurring costs to support the fight against COVID-19. With the burnout experienced by our exhausted caregivers, the impact of the pandemic is still being felt across our hospitals' cost structures. Provider Relief Funds were intended to support costs incurred throughout the pandemic and HHS has stated that if recipients do not expend Provider Relief Funds in full by the end of the calendar year 2020, they will have an additional six months in which to use the remaining amounts. Adjusting for these federal funds in advance of this time period is premature and ongoing costs incurred to address our community's needs must also be considered in the policy development. The full impact of the pandemic is still evolving and must be considered when developing this policy.

This is a complex issue and one that requires distinction between our GBR system and federal funding. We urge the Commission to carefully consider all aspects when finalizing their approach and distributing ongoing guidance.

Thank you for this opportunity to offer our comments on this policy and welcome the opportunity to participate in further discussion in its development.

Sincerely,

Norvell "Van" Coots, M.D.
President and CEO

Anne D. Gillis
Chief Financial Officer

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

**Maria Harris Tildon**
Executive Vice President
Public Policy & Government Affairs

**CareFirst BlueCross BlueShield**
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February 24, 2021

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

Dear Chairman Kane:

CareFirst appreciates the opportunity to comment on the "CARES Funding Policy Update." We recognize that hospitals and other providers continue to go above and beyond to take care of the community and we applaud actions by the HSCRC to support them in doing so. We support the Draft Recommendation as proposed.

HSCRC has been clear from the beginning that it is their intent for hospitals to utilize accountable federal support before rate dollars, and we understand that in order to maintain rate integrity, settle-ups should occur as close as possible to the Fiscal Years in which federal CARES support was provided. Therefore, we believe that staff's approach to begin the reconciliation now and make appropriate adjustments as more information and data are available is prudent.

We understand the policy's attempt to reconcile funding provided to hospitals for COVID-related expenses and lost revenue. Staff is required to consider all sources of revenue and is looking to avoid double payment by considering the expanded rate corridors utilized as well as CARES funding from the federal government. While the Staff's proposal could have been more conservative by considering other non-rate support received by hospitals, we understand Staff's decision to focus on CARES federal funding as it is both the largest and most trackable portion of non-rate support.

While this is a complex topic, it is clear Staff has heard the desire from the industry to simplify its policy approaches. Not only did Staff narrow its efforts to a scope of just COVID rate corridor expansion and CARES federal funding, Staff also proposed a standardized, logical approach to identifying regulated CARES funding. We understand hospitals and health systems were provided funding from the federal government to cover both regulated and unregulated operations and there was no assignment of those dollars upfront. Since it would require sophisticated, consistent cost accounting across the industry to identify all COVID-related expenses as either regulated or unregulated, Staff took an understandably simple approach that can be replicated in future reconciliations without added administrative burden on hospitals. We support Staff's use of historical revenue splits between regulated and unregulated as a means for determining the regulated portion of CARES funding.

During a period in which many hospitals across the country struggled financially, as patient volume plummeted, Maryland's hospitals were fortunate to have the flexibility and stability of the rate-setting system to ensure their financial statements remained healthy. Rather than waiting for the federal government to intervene, HSCRC acted quickly and expanded rate corridors early

on, leading to little interruption in either hospital's top-line revenue or cash position. Appropriately, this policy attempts to settle-up the few instances where HSCRC and the federal government's combined support overestimated the actual impact COVID-19 had on hospitals during the 18-month period ending December 31, 2020.

It is important to remember that hospitals' revenues represent expenses to the community. Many other businesses and individuals struggled financially during 2020. We have seen firsthand the impact COVID has had on our members and accounts and made many accommodations for our members and communities, including lengthened grace periods for premium payments, premium credits, waived co-payments for COVID-19 testing and treatment, waived co-payments for telehealth during the initial months of the pandemic, procurement of PPE for community providers, and extensive community support, to name just a few. It is important to ensure that duplicative rate dollars for CARES Act support are quickly reconciled, in order to prevent any further burden on businesses, individuals, municipalities, and others who are paying the bills for hospital services in the State.

The policy proposed by Staff removes the estimated $284 million overfunding from rates and appropriately shares the savings with the public. In addition to the fully insured members we serve, more than half of CareFirst's members are under administrative services only plans, meaning that CareFirst administers the benefits, but the account holds the risk and pays the bill. Therefore, reduced hospital rates would directly benefit employers that have suffered economic pressures brought on by the pandemic.

Again, we thank you for this opportunity to share our support and thoughts regarding the "CARES Funding Policy Update." We understand there will still be industry participation in the discussion around identification of COVID-related expenditures and which hospitals were disproportionately affected. We look forward to continued collaboration as this evolves.

Sincerely,

Maria Harris Tildon

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

JOHNS HOPKINS
MEDICINE

**Kevin W. Sowers, MSN, RN, FAAN**

*President*
**Johns Hopkins Health System**

*Executive Vice President*
**Johns Hopkins Medicine**

March 10, 2021

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

Dear Ms. Wunderlich,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the HSCRC CARES Funding Policy. JHHS generally supports the staff's position for the treatment of the CARES Funds within the HSCRC Rate Setting System. The policy has been thoughtfully developed and provides a fair and reasonable approach to the treatment of the funds. Developing a policy around the CARES Funding is critical in protecting the Maryland Model.

JHHS supports the principle that any hospital undercharges that the HSCRC allowed to flow from FY 20 into FY 21 rates should be offset for CARES Funds received from the Federal Government (HHS). This is consistent with the HSCRC position articulated in March 2020. While the HHS distribution of the CARES Funds and the HSCRCs treatment of those funds are related, they are two separate issues. We believe that the HSCRC has the authority to adjust hospital rates in a fair and equitable manner and also has the authority to consider other sources of funding that a hospital may receive. During these unprecedented times, the HSCRC adjusted their charging policies to allow hospitals to recover incremental revenues in FY 20, without penalty, to help assure adequate cash flow at the beginning of the pandemic. The flexibility that the HSCRC allowed in the rate setting system allowed for a higher level of financial stability than other hospitals across the country experienced. It is also important to acknowledge that these are one-time funds and will not impact a hospitals permanent rate structure moving forward.

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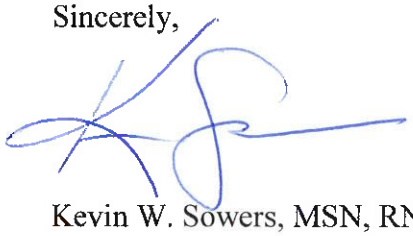
Katie Wunderlich
CARES Funds Policy
March 10, 2021

JHHS does believe that the adjustments made to rates should be done at the individual hospital level as that is how the CARES Funds were distributed. The GBR system operates at an individual hospital level and making adjustment at the system level could set a precedent for allowing movements of GBR dollars across hospitals within a system for other reasons. We believe that assuring that the rates a hospital charges are reasonably related to the underlying cost structures of that hospital are an important tenant of the HSCRC rate setting system.

We also realize that the settlement of the CARES Funds within the rate setting system will be a multi-year issue. As we are still in the midst of the Public Health Emergency, we understand that there could be additional funds distributed by HHS and that COVID expenses at the hospitals will also need to be considered. We appreciate the staff's consideration of these factors in the development and final settlement of any CARES Funds within the rate setting system.

JHHS appreciates the opportunity to comment on the CARES Funding Policy. We also commend the staff for their thoughtful work on developing a policy that balances the individual hospital impact with the overall performance of the state while taking into consideration the goals of the All-Payer Model and the Total Cost of Care Model.

Sincerely,



Kevin W. Sowers, MSN, RN, FAAN
President, Johns Hopkins Health System
EVP, Johns Hopkins Medicine

MedStar Health

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Susan K. Nelson
Executive Vice President and
Chief Financial Officer

February 24, 2021

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

Dear Chairman Kane:

On behalf of MedStar Health, Inc. and our subsidiary Maryland hospitals, we are providing comments on the CARES Funding Policy Update Presentation presented by the Health Services Cost Review Commission (HSCRC) Staff on February 10, 2021. We understand at this time this is not a draft policy to be voted on by HSCRC Commissioners and that it is stated in the presentation that the expectation is "to finalize approach in the March Meeting." We feel it is imperative to provide MedStar's position on the approach presented.

The presentation's approach is flawed for the following reasons:

1. **It is premature to evaluate Provider Relief Fund (PRF) payments received by hospitals and health systems before the U.S. Department of Health & Human Services (HHS) has finalized guidance on use of PRF payments and health systems have determined how to use the funds and whether they will need to return payments to HHS.** The pandemic is ongoing, and it is too early to draw conclusions on the status of PRF funding received by the health systems. Current HHS guidance indicates that PRF recipients must use their payments by June 30, 2021, and recipients must return to HHS any unused payments as of that date, although it is possible this deadline could be extended. Importantly, HHS expects health systems to allocate PRF payments across different care providers within the same system in order to coordinate its COVID-19 response, and many health systems have not yet made final decisions as to how payments will be allocated. Therefore, the proposed HSCRC approach is backwards - the HSCRC should wait <u>until after</u>, not before, any final determination of how those federal funds are allocated and used. Also troubling is that the proposed approach relies on incomplete funding data that is in flux and will continue to be updated. Most critically, every Maryland hospital is continuing to deal with the effects of the ongoing pandemic, including the high costs of labor and supplies, additional testing supplies, costs necessary to maintain the additional bed capacity, and the establishment of vaccination clinics. Given that the financial impact of the pandemic on hospitals and health systems is continuing, it would not be appropriate to take away financial resources needed to continue pandemic response efforts.

2. **The proposed approach would thwart the purpose of the PRF and take away the federal benefit that Congress and HHS intended for hospitals and health systems.** Congress and HHS intended for PRF payments to provide hospitals and health care providers with extraordinary relief to respond to an unprecedented, global public health

emergency. PRF payments are intended to reimburse health care related costs attributable to COVID-19 and/or to be a backstop against lost revenues due to the COVID-19 pandemic. The federal government has recognized that this will be a multi-year effort that will require accountability in complying with federal requirements but also flexibility with the changing nature of the pandemic. Therefore, the HSCRC should not make its own policy of characterizing PRF funding in a way that is inconsistent with the purposes for which PRF funds have been allocated under federal law. The HSCRC proposed approach would effectively take away financial resources from hospitals and health systems, essentially undoing the federal relief afforded by Congress.

3. **HSCRC does not have authority to treat PRF payments as revenue for hospital services that is subject to the GBR Agreements.** The HSCRC authorizing statutes and regulations, as well as the GBR Agreements, do not support the inclusion of the extraordinary federal relief provided under PRF as part of regulated revenue. To do so would suggest that other types of funding, including FEMA grants, state and local grants, research grants and even fundraising dollars, should also be considered part of revenues subject to HSCRC regulation. Consistent with its proper regulatory authority, the HSCRC cannot include these funding sources as part of revenue for inpatient and outpatient hospital services.

We would welcome a chance to discuss these points with you and other Commissioners given both the significance and complexity surrounding this topic.

Sincerely,

Susan K. Nelson
Executive Vice President &
Chief Financial Officer
MedStar Health, Inc.

cc: Kenneth A. Samet, FACHE, President & CEO, MedStar Health, Inc.
Katie Wunderlich, HSCRC Executive Director
Joseph Antos, Ph.D., HSCRC Vice Chairman
James N. Elliott, M.D., HSCRC Commissioner
Victoria W. Bayless, HSCRC Commissioner
Sam Malhorta, HSCRC Commissioner
Stacia Cohen, RN, HSCRC Commissioner
John M. Colmers, HSCRC Commissioner

TidalHealth™

Executive Office

100 East Carroll Street
Salisbury, MD 21801

410-543-7111

March 12, 2021

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

Dear Chairman Kane:

On behalf of TidalHealth we appreciate the opportunity to comment on Health Care Services Cost Review Commission (HSCRC) proposed action on U.S. Department of Health and Human Services (HHS) CARES Act funding and, specifically, the Provider Relief Fund (PRF) Payments.

**1) HSCRC should not supersede HHS guidance and allowable uses.**

HHS is the CARES funding grantor, and hospitals must follow HHS rules, terms, and conditions. The HSCRC proposal considers how hospitals *received* funding from HHS. However, HHS allows health systems to *use* funding broadly among their entities to coordinate their COVID response. This includes use of alternative sites and expanded outpatient and virtual access to health services. HSCRC should not ignore HHS guidance for these necessary and allowable uses.

The authority of the HSCRC is in question when considering granted funds outside of established regulation. It is alarming to consider where this action may lead to when considering alternative sources of funds such as investment income, state funding, grants, and foundation donations, etc. We have witnessed firsthand HSCRC staff indicate a willingness to consider or be influenced by these types of revenue streams and implement policy changes outside the purview of established regulation. The pace and direction of change is causing greater and greater concern and should be evaluated.

**2) It is premature to determine the course of action.**

The pandemic has not ended. Hospital volumes and COVID-related expenses are volatile and may not settle to normal until the end of calendar year 2022, if not later. Any hospital revenue adjustments should reflect the complete and full impact when the pandemic has passed. A $1.9T package was recently approved and may likely convolute the picture even further for rural hospitals. We should be maximizing federal support as these funds are not counted in the total cost of care calculations.

Maryland's hospitals appreciate the Total Cost of Care Model ("Model") guardrails and the need to manage the system within those borders. Projecting total state Medicare spending growth relative to the nation is not feasible with any degree of accuracy.

Given the unknown effect of financial support, service use, and ongoing COVID impact, we would suggest that the HSCRC work with the Centers for Medicare & Medicaid Services (CMS) to evaluate Maryland's performance during the pandemic over a multi-year period. The funding adjustments made by HSCRC and HHS are non-recurring, while the Model is designed to demonstrate savings over a longer period.

**3) HSCRC rate action should be limited to the support HSCRC provided.**

HSCRC supported hospitals in several ways, including guaranteeing global budget undercharge carry-forward, price corridor expansion, surge funding, and yet to be determined, expenses. If the HSCRC is compelled to adjust already distributed funds, future HSCRC rate adjustments should not exceed amounts placed in rates.

*****

Thank you again for allowing comments to contribute to this determination. If you have any questions, please feel free to contact me.

Sincerely,

Steven Leonard, PhD, MBA, FACHE
CEO/President

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

maryland
health services
cost review commission

# Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: FY 2022 Funding to Support HIE Operations and CRISP Reporting Services

## Draft Recommendation

May 12, 2021

Comments on the draft policy may be submitted by email to william.henderson@maryland.gov and are due by May 19, 2021.

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

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# Table of Contents

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# List of Abbreviations

| | |
|---|---|
| BRFA | Budget Reconciliation and Financing Act |
| CMS | Centers for Medicare & Medicaid Services |
| CRISP | Chesapeake Regional Information System for Our Patients |
| CRP | Care Redesign Program |
| CRS | CRISP Reporting Services |
| EHR | Electronic Health Record |
| FY | Fiscal year |
| HIE | Health information exchange |
| HITECH | Health Information Technology for Economic and Clinical Health Act |
| HSCRC | Health Services Cost Review Commission |
| IAPD | Implementation Advanced Planning Document |
| MDH | Maryland Department of Health |
| MHCC | Maryland Health Care Commission |
| MHIP | Maryland Health Insurance Plan |
| MES | Medicaid Enterprise System |
| PDMP | Prescription Drug Monitoring Program |

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# Policy Overview

| Policy Objective | Policy Solution | Effect on Hospitals | Effect on Payers/Consumers | Effect on Health Equity |
|---|---|---|---|---|
| To fund Maryland's Health Information Exchange, CRISP, for activities related to the HSCRC and the Total Cost of Care Model. | Add an assessment to hospital rates that is then used to fund CRISP. | Hospitals benefit from CRISP programs and pay a separate user fee. This assessment is a pass through and has no impact on hospitals. | CRISP provides vital coordination and reporting that allow hospitals and other Maryland providers to enhance the quality and cost effectiveness of the care provided. | Provider reporting supported by CRISP will collect data on social determinants of health and disparities in health outcomes. |

# Summary of the Recommendation

In accordance with its statutory authority to approve alternative methods of rate determination consistent with the Total Cost of Care Model and the public interest,[1] this draft recommendation identifies the following amounts of State-supported funding for fiscal year (FY) 2022 to the Chesapeake Regional Information System for our Patients (CRISP):

- Direct funding and matching funds under Medicaid Enterprise System (MES) Federal Programs for Health Information Exchange (HIE) operations and infrastructure ($2,500,000)
- Direct funding and Medicaid Enterprise System (MES) matching funds for reporting and program administration related to population health, the Total Cost of Care Model, and hospital regulatory initiatives ($6,740,000)

Therefore, the staff recommends the HSCRC provide funding to CRISP totaling $9,240.000, an increase of $4,070,000 (79 percent) from FY 2020. This amount represents approximately 31 percent of CRISP's Maryland funding, compared to 24 percent in FY 2021. The remainder of CRISP's Maryland funding is derived from user fees, Federal matching funds and the Maryland Department of Health (MDH).

The significant increase in the funding level is driven by 3 factors: (1) the roll-out of new programs under the Total Cost of Care Model, (2) the switch from a 10 percent State match to earn Federal funds to a 25 percent State match, as funding moves from the HITECH IAPD to MES (as described in last year's recommendation), and most significantly (3) a change in Federal matching rules that allocates Federal

[1] MD. CODE ANN., Health-Gen §19-219(c).

responsibility based on the number of beneficiaries rather than the number of providers participating in Medicaid programs.

The $4,070,000 increase in HSCRC funding correlates to only a 7-percentage point increase in the HSCRC's share of funding (from 24 to 31 percent) because, simultaneously, CRISP has experienced a significant expansion in its MDH-funded public health related work. In order to minimize the funding required, CRISP has reduced the proposed FY 2022 budget by approximately 18 percent from projected FY 2021 levels.

# Background – Past Funding

Over the past ten years, the Commission has approved funding to support the general operations of the CRISP HIE and reporting services through hospital rates as shown in Table 1.

*Table 1. HSCRC Funding for CRISP HIE and Reporting Services, Last 10 Years*

| CRISP Budget: HSCRC Funds Received | |
|---|---|
| **FY 2012** | $2,869,967 |
| **FY 2013** | $1,313,755 |
| **FY 2014** | $1,166,278 |
| **FY 2015** | $1,650,000 |
| **FY 2016** | $3,250,000 |
| **FY 2017** | $2,360,000 |
| **FY 2018** | $2,360,000 |
| **FY 2019** | $2,500,000 |
| **FY 2020** | $5,390,000 |
| **FY 2021** | $5,170,000 |

In December 2013, the Commission authorized staff to provide continued funding support for CRISP for FYs 2015 through 2019 without further Commission approval if the amount did not exceed $2.5 million in any year. Since FY 2020, when Maryland Health Insurance Plan (MHIP) funding terminated, requests have exceeded that amount and require Commission approval.

# Funding Through Hospital Rates

Beginning in FY 2020, when MHIP funding was no longer available, HSCRC assumed full responsibility for managing the CRISP assessment where it was previously shared with MHCC. CRISP-related hospital rate assessments are paid into an HSCRC fund, and the HSCRC reviews the invoices for approval of appropriate payments to CRISP. This process – which includes bi-weekly update meetings, monthly written reports, and auditing of the expenditures – has created transparency and accountability.

# Funding Through Federal Matching

HSCRC funding has been used to obtain Federal Matching Funds throughout the history of the program. Federal Match is obtained through two programs outlined below. Beginning with the Federal fiscal year starting October 1, 2021, the rules for obtaining these matches has changed from provider to beneficiary based. As a far higher percentage of providers participate in Medicaid than do State healthcare utilizers, this has reduced available Federal funding by approximately $10,000,000 on an annual basis. In addition, the HITECH IAPD program terminates September 30, 2021, moving more of the match into the MES program where the match required for ongoing programs is 25 percent versus the 10 percent from IAPD.

The two factors referenced in the prior paragraph drive the increase in the required HSCRC funding. The increase reflects the new share of programs run by the HSCRC under the Total Cost of Care models. The lost match on general HIE operations will be funded by MDH, as these programs relate primarily to provider connectivity and other general public health initiatives.

## Implementation Advanced Planning Document (IAPD) Matching Funds

In addition to its role in HIE among providers, CRISP is also involved in health care transformation activities related to HSCRC, MHCC, and MDH. In its collaboration with the Medicaid program, uniform and broad-based funding through hospital rates can also be used to leverage federal financial participation under the Health Information Technology for Economic and Clinical Health (HITECH) Act, known as IAPD funding. Under the HITECH Act, the Centers for Medicare & Medicaid Services (CMS) may approve states for Medicaid Electronic Health Record Incentive Program funding, and states receive a 90 percent federal financial participation match for expanding HIE through September 2021. This request will enable CRISP (working with MDH) to obtain federal funding. IAPD funding allows CRISP (working with MDH) to qualify for funding to implement HIE use cases.

Activities enabled through IAPD that enhance the point of care delivery include encounter notification services, practice-level advanced-implementation support, ambulatory integration, hospital integration, and image exchange. Common infrastructure activities include data routing and consent management, technical infrastructure and operations expense, and data architecture. Finally, there are a number of public health reporting initiatives as well, including public health use case management, electronic lab reporting, MDH interface development and validation, and CMS Clinical Quality Measures reporting.

As discussed above, this funding source will end after September 30, 2021 and CRISP anticipates moving this funding to the MES funding described below.

## Medicaid Enterprise System (MES) Matching Funds

MES is a Federal program designed to promote effective care for Medicaid beneficiaries through investments in information technology infrastructure. Medicaid benefits from CRISP's data sharing and reporting initiatives through the care management and cost control initiatives facilitated for all Medicaid patients under CRISP all-payer activities and for dual-eligible patients under CRISP's Medicare activities.

Activities funded under this element of the assessment include point-of-care and other provider data sharing initiatives, and CRISP reporting tools utilizing the Medicare claims and the HSCRC's hospital case mix data set. CRISP reporting from these datasets is used by hospitals, the HSCRC and other stakeholders to manage and track progress under a number of HSCRC programs and enable hospitals to identify and pursue care efficiency initiatives.

In FY 2021, CRISP was able to obtain funding under MES to a greater degree than anticipated in the assessment request. In addition, the implementation of certain reporting initiatives was delayed because of the COVID crisis and other program changes. As a result of these two factors, there was a funding balance remaining from FY 2021, which will be retained by the HSCRC and disbursed to CRISP as relevant projects are completed.

Under MES, state funds are eligible for either a 90 percent match for new reporting initiatives or a 75 percent match for ongoing reporting. The assessment funding will provide the State's portion of this match.

# Description of Activities Funded

Activities funded directly by this assessment and from Federal Match dollars earned fall into two categories described below. The descriptions below are intended to describe, in general terms, the programs for which funds will be used. Staff will direct funding to specific programs within the general parameters described.

## HIE Operations Funding and Infrastructure

The value of an HIE rests in the premise that more efficient and effective access to health information will improve care delivery while reducing administrative health care costs. The General Assembly charged the MHCC and HSCRC with the designation of a statewide HIE.[2] In the summer of 2009, MHCC conducted a competitive selection process which resulted in awarding state designation to CRISP, and HSCRC approved up to $10 million in startup funding over a four-year period through Maryland's unique all-payer hospital rate setting system. CRISP maintained designation through multiple renewal processes, with the most recent occurring in 2019. HSCRC's annual funding for CRISP is illustrated in Table 1 above.

[2] MD. CODE ANN., Health-Gen §19-143(a).

The use of HIEs is a key component of health care transformation, enabling clinical data sharing among appropriately authorized and authenticated users. The ability to exchange health information electronically in a standardized format is critical to improving health care quality and safety.

Many states, along with federal policy makers, look to Maryland as a leader in HIE implementation. CRISP continues to build the infrastructure necessary to support existing and future use cases and to assist HSCRC in administering per-capita and population-based payment structures under the Total Cost of Care Model. A return on the State's investment is demonstrated through implementation of a robust technical platform that supports innovative use cases to improve care delivery, increase efficiencies in health care, and reduce health care costs. MDH made extensive use of CRISP's capabilities during the COVID crisis.

The total amount of funding recommended by staff for FY 2021 for the HIE function is $2,500,000.

## Reporting and Program Administration Related to Population Health, the Total Cost of Care Model, and Hospital Regulatory Initiatives

These initiatives were designed to reduce health care expenditures and improve outcomes for all Marylanders. Many of these programs focus on unmanaged high-needs Medicare patients and patients dually eligible for Medicaid and Medicare, consistent with the goals of Maryland's All-Payer Model. These initiatives encourage collaboration between and among providers, provide a platform for provider and patient engagement, and allows for confidential sharing of information among providers. To succeed under the new Total Cost of Care Model, providers will need a variety of tools to manage high-needs and complex patients that CRISP is currently working to develop and deploy.

Based on broad program participation, including non-hospital providers, and the ability to secure federal match funds, these programs will be funded through a combination of assessments and federal matching funds. This recommendation covers three components:

(1) Funding for population health and cost and quality management reporting in support of HSCRC regulations and the Total Cost of Care Model

(2) Funding for program administration related to programs under the Total Cost of Care Model

(3) Funding for innovative reporting initiatives such as enhanced data on social determinants of health and the integration of electronic health record data into statewide hospital quality measurement

The total amount of funding recommended by staff for FY 2021 for the activities described above is $6,740,000.

In FY 2021, CRISP offered hospitals a discount on user fees in return for meeting defined standards for submission of data to CRISP. A total of 37 hospitals participated in the program and successfully improved their data feeds, thereby driving significant value to the healthcare system. Staff recommend that, in the

future, the Commission consider assessing non-compliance penalties under the Commission's regulatory authority because even limited non-compliance erodes the value of the data collected and the investment made by the rest of the system.

# Staff Recommendation

Staff is recommending the Commission approve a total of $9,240,000 in funding through hospital rates in FY 2022 to support the HIE and continue the investments made in the Total Cost of Care Model initiatives through both direct funding and obtaining Federal MES matching funds.

Table 2 shows the funding through hospital rates and the Federal match that will be generated from the IAPD and MES funding as well as the user fee and MDH funding.

*Table 2. FY 2021 Recommended Rate Support for CRISP as a share of estimated total Maryland Funding*

| FY 2021 Project Name | Hospital Rates | Federal Budgeted Funding | User Fees | MDH | Total |
|---|---|---|---|---|---|
| HIE Operations | $2,500,000 | $2,580,000 | $4,400,000 | $2,920,000 | $12,400,000 |
| Reporting and Program Administration | $6,740,000 | $1,836,000 | $0 | $324,000 | $8,900,000 |
| Other non-HSCRC programs | $0 | $2,340,000 | $275,000 | $5,760,000 | $8,375,000 |
| **Total Funding** | **$9,240,000** | **$6,756,000** | **$4,675,000** | **$9,004,000** | **$29,675,000** |
| **% of Total** | **31%** | **23%** | **16%** | **30%** | **100%** |

maryland
health services
cost review commission

# Draft Recommendation on Continued Financial Support for the Maryland Patient Safety Center for FY 2022

May 12, 2021

This is the draft staff recommendation; written comments should be submitted to hscrc.quality@maryland.gov no later than May 19, 2021.

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

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# LIST OF ABBREVIATIONS

| | |
|---|---|
| Delmarva | Delmarva Foundation for Medical Care |
| FY | Fiscal Year |
| HQI | Hospital Quality Initiative |
| HSCRC | Health Services Cost Review Commission |
| LTC | Long Term Care |
| MAPSO | Mid-Atlantic Patient Safety Organization |
| MDH | Maryland Department of Health |
| MHA | Maryland Hospital Association |
| MHCC | Maryland Health Care Commission |
| MPSC | Maryland Patient Safety Center |
| NAS | Neonatal Abstinence Syndrome |
| OHCQ | Office of Health Care Quality |
| PFAC | Patient Family Advisory Committee |
| RALI | Rx Abuse Leadership Initiative |
| RFP | Request for Proposals |
| TCOC | Total Cost of Care |

# POLICY OVERVIEW

| Policy Objective | Policy Solution | Effect on Hospitals | Effect on Payers/ Consumers | Effect on Health Equity |
|---|---|---|---|---|
| The draft MPSC Recommendation seeks to continue funding the successful patient safety initiatives demonstrated in FY 2021. | The MPSC is part of the State's multi-pronged strategy to assess, target and improve Patient Safety. Interventions MPSC employs include learning on safety improvement methods, and collaborations among hospitals and other providers to improve safety. | The MPSC portfolio of initiatives involves working directly with hospitals on quality improvement training, collaboratives to implement best practices, caring for the caregiver, and convening hospitals with LTC partners to reduce infections and related outcomes such as readmissions to the hospital. | The MPSC funding supports continued work to engage patients and families and elected officials representing consumers in defining areas of concern where MPSC should work, and implementing Patient Family Advisory Committees, among other areas. | The MPSC work targets important areas for improving health equity that include such issues as improving COVID vaccine hesitancy among Black and Brown people and training perinatal providers on implicit bias and its negative effects, directly aligning with the SIHIS goal on reducing SMM outcomes. |

# RECOMMENDATIONS

HSCRC staff provides the following draft recommendations for the MPSC funding policy for FY 2022:

1. Consistent with prior Commission recommendations, the HSCRC should reduce the amount of **unrestricted** funding support for the MPSC in FY 2022 by 75 percent from the FY 2019 HSCRC unrestricted grant amount of $492,075. The result is an adjustment to hospital rates in the amount of $123,028.
2. In order to receive funding from the hospital rate setting system, the MPSC should continue to report annually at a minimum on data that it has collected from hospitals and other facilities that participate in its quality and safety initiatives and should demonstrate, to the extent possible, the ways in which MPSC initiatives are producing measurable gains in quality and safety at participating facilities.
3. MPSC requests additional funding from HSCRC that will be **restricted for targeted projects** that align with the statewide TCOC Model's quality and safety goals, and which the Commission can consider on a case-by-case basis.
    a. For FY 2022, staff recommends that the HSCRC fund an additional $125,000 for the 18-month Clean Collaborative Phase III for Long-Term Care project completion, which began and was funded in FY 2021.
4. The MPSC should continue to pursue strategies to achieve long-term sustainability through other sources of revenue, including identifying other provider groups that benefit from MPSC programs, as FY 2022 will be the final year of unrestricted funding from the HSCRC.

# INTRODUCTION

In 2004, the Maryland Health Services Cost Review Commission (HSCRC or Commission) adopted recommendations to provide seed funding for the Maryland Patient Safety Center (MPSC) through hospital rates, with the initial recommendations funding 50 percent of the budgeted costs of the MPSC. In FY 2021, HSCRC funds accounted for 13 percent of MPSC's total budget. FY 2022 represents the last year of unrestricted funding for MPSC, as it will transition to a self-sustaining resource moving forward.

Under the Total Cost of Care Model (TCOC Model), it is increasingly important that patient safety and quality of care improve across all care settings. The key stakeholders that are involved with the MPSC include hospitals, patients and families, physicians, long-term care and post-acute providers, ambulatory care providers, and pharmacy – all groups that are critical to the success of the TCOC Model. To achieve mutual healthcare goals for these stakeholders, MPSC prioritizes the Center's collaborations with Maryland's key health policy agencies including the Maryland Department of Health (MDH), the Maryland Health Care Commission (MHCC), the HSCRC and the Office of Health Care Quality (OHCQ). The MPSC is in a unique position in the State to develop and share best practices among these key stakeholders, avoiding duplicative efforts and reducing costs. MPSC is also favorably positioned to act as a convener for hospital and non-hospital providers in Maryland to support provider sharing of best practices and disseminate data that will help them succeed under the TCOC Model. It is imperative that MPSC partner closely with those private sector providers, including hospitals, nursing homes, and skilled nursing facilities, in order to continue this important work once the HSCRC funding has ended. Indeed, as evidenced by this report, MPSC has positioned itself as a resource to hospitals and LTC providers and as such have been awarded additional partnership funds directly by hospitals.

Key current MPSC hospital and non-hospital projects that particularly align with the TCOC model goals include:

- **HRSA Maryland Maternal Health Innovation Grant (known as MDMOM)[1]—** MPSC has recruited all 32 birthing hospitals in the State into their program, which provides implicit bias trainings to care providers at these hospitals. This training program is critical to improving maternal mortality and morbidity and reducing health disparities in particular. ***This work directly aligns with the State Integrated Healthcare Improvement Strategy (SIHIS) goal of reducing disparities in severe maternal morbidity (SMM).***
- **Clean Collaborative Phase III for Long Term Care—** Last year, due to the devastation nursing homes faced during the COVID PHE, the Commission voted to provide restricted funding to MPSC to initiate an 18-month collaborative for ten LTCs across the state. Among the goals were to reduce Emergency Department visits and hospital readmissions. Following recruitment and ramp-up, data collection began in October 2020. Early results are provided later in this report, but trends are demonstrating a reduction in infection related ED visits and hospital admissions, and therefore the total cost of care.
- **Clean Collaborative Phase IV: HSCRC Hospital Partnership Grants with Long Term Care—** Recognizing the value of Phases I and II of the MPSC Clean Collaborative, three hospital systems have partnered with MPSC and are currently working with fourteen LTC partners under the HSCRC Partnership Grants. While it is very early in the data collection process which began in December 2020, early results look promising in reducing infection related ED visits and hospital admissions as well as impacting the reduction of COVID -19 positivity rates in residents and staff at the participating LTC facilities.

The HSCRC collaborates with MPSC on projects as appropriate and reviews an annual briefing on the progress of the MPSC in meeting its goals, as well as an estimate of expected expenditures and revenues for the upcoming fiscal year. Based on both the FY 2021 project outcomes and the projected FY 2022 budget, staff makes recommendations to the Commission regarding the continued financial support of the MPSC. In 2019, the Commission approved a recommendation to decrease the funding by 25% each subsequent year from the 2019 levels such that HSCRC funding would

[1] MPSC is a sub-awardee in the Johns Hopkins Bloomberg School of Public Health $10.3 million five-year HRSA grant to improve maternal health in Maryland.

conclude after FY 2022. In May 2021, the HSCRC received the MPSC program plan update for FY 2022. The MPSC is requesting a total of $123,028 in unrestricted funding, a 75 percent decrease over the FY 2019 budget, representing 7 percent of the total MPSC 2022 budget, consistent with the Commission's intent to reduce State funds over time and encourage a sustainable business model for the MPSC.

In addition to the $123,028, MPSC is proposing that the Commission consider two options: the first is a request for restricted funding to complete the Clean Collaborative PHASE III with LTC that HSCRC funded in FY 2021, in the amount of $125K; the second is funding to convene an additional LTC Clean Collaborative with a new cohort of ten LTC facilities in the amount of $275K. The restricted funding request for FY 2022 ranges from $125K-$400K from the HSCRC and is detailed in the Budget sub-section under the Assessment section. At this time, staff is not recommending funding for the Phase V LTC Clean Collaborative. Instead, MPSC should pursue direct funding with hospitals and LTC facilities to disseminate best practices around infection control that can lead to better health outcomes and lower ED utilization.

# BACKGROUND

The 2001 General Assembly passed the Patients' Safety Act of 2001,[2] charging the Maryland Health Care Commission (MHCC)—in consultation with the Maryland Department of Health (MDH)—with studying the feasibility of developing a system for reducing the number of preventable adverse medical events in Maryland, including a system of reporting such incidences. The MHCC subsequently recommended the establishment of the MPSC to improve patient safety in Maryland.

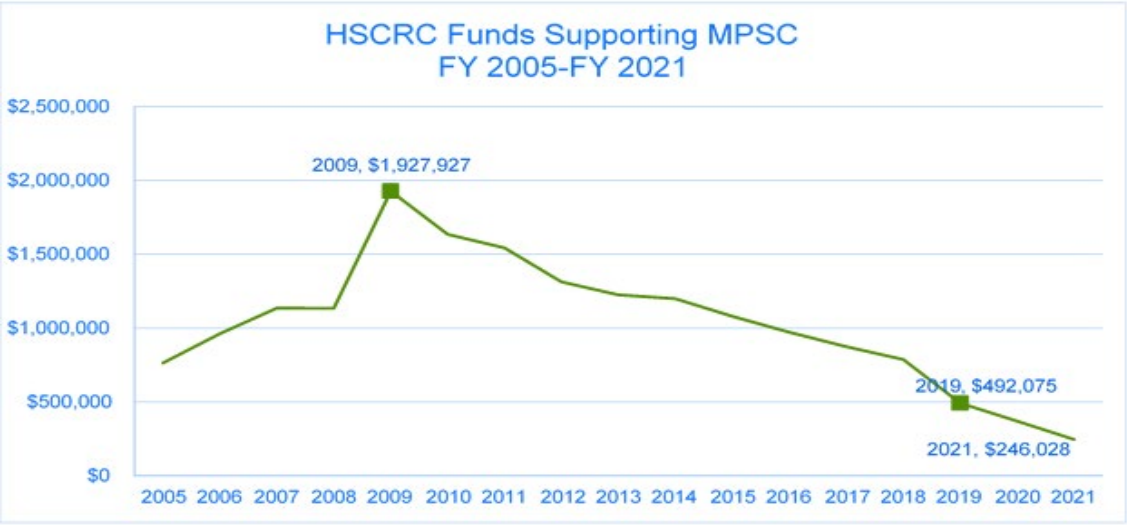
In 2003, the General Assembly endorsed this concept by including a provision in legislation to allow the MPSC to have medical review committee status, thereby making the proceedings, records, and files of the MPSC confidential and not discoverable or admissible as evidence in any civil action.[3]

[2] Chapter 318, 2001 Md. Laws.
[3] MD. **CODE**. ANN., Health-Gen. § 1-401(b)(14);(d)(1).

The MHCC selected the Maryland Hospital Association (MHA) and the Delmarva Foundation for Medical Care (Delmarva) through the State's Request for Proposals (RFP) procurement process to establish and operate the MPSC in 2004, with an agreement that the two organizations would collaborate in their efforts. MHA and Delmarva jointly operated the MPSC from 2004 to 2009. The MPSC was then reorganized as an independent entity and was re-designated by the MHCC as the State's patient safety center starting in 2010 for two additional five-year periods with an expiration in April 2020, following an extension from the December 2019 date. An RFP process was conducted by MHCC in the first quarter of 2020, and MHCC again selected and re-designated MPSC as the State's patient safety center for a five-year period through 2025.

Over the past 17 years, the HSCRC included an adjustment to the rates of eight Maryland hospitals to provide funding to cover the costs of the MPSC. Funds are transferred biannually. Although funding increased between FY 2005 and FY 2009, the level of HSCRC support has declined each year since FY 2009, consistent with the original intent to scale back State-funded support. In FY 2019, the Commission approved a recommendation to decrease the funding by 25% each subsequent year from the 2019 levels such that HSCRC funding would conclude after FY 2022. **Figure 1** below shows the HSCRC's funding level in support of the MPSC over time.

Figure 1. HSCRC Unrestricted Funds Supporting MPSC FY 2005-FY 2021



# ASSESSMENT

## Strategic Priorities and Partnerships

The MPSC's mission is **Keeping Maryland health care safe**. Its vision is to be a model of patient safety innovation and implementation, convening providers, patients and families across the healthcare continuum to prevent avoidable harm and provide safe and equitable health care to all.

The MPSC's goals are to:

- Achieve zero preventable harm across all levels of health care;
- Foster a shared culture of safety, compassion, and respect among all providers;
- Enhance patient experience by involving patients and families in all aspects of their care; and
- Support caregivers to ensure resiliency and prevent burnout.

To accomplish its mission, vision, and goals, the MPSC established and continues to build upon its strategic partnerships with an array of key private and public organizations.

### MPSC Members and Partnerships

As of FY 2021, MPSC has 50 paid member facilities (increased from 45 from last year), including 45 hospitals, two rehabilitation hospitals, one long-term care facility one ambulatory center, and one addiction recovery center. Additionally, MPSC provided 24 complimentary FY 2021 memberships to all Phase III and Phase IV Clean Collaborative long term care participants. Membership fees provide the largest portion of MPSC's FY21 annual revenue. Paid membership provides member organizations with unlimited staff participation at education sessions and conferences free of charge or at a significantly reduced rate (Six Sigma, Lean for Healthcare, and TeamSTEPPS® Master Trainer).

MPSC actively seeks patient and family participation in MPSC leadership and initiatives. Their perspective is included on a majority of collaboratives and projects. Patients and families are represented by two board members. In addition, the Maryland legislature is represented by two members of the board and the MHCC is represented by one board member.

With regard to expanding membership to non-hospital entities, MPSC notes that they actively seek membership from non-hospital organizations by offering in-person educational programs and webinars free of charge. MPSC has recently begun negotiating with Federally Qualified Health Centers regarding potential membership. Through their efforts to engage non-hospital members, MPSC notes that:

- Non-hospital budgets are limited for participation in quality and patient safety programs.
- Financial incentives are different for non-hospital organizations, presenting additional challenges in engaging participation.

The **Mid-Atlantic Patient Safety Organization (MAPSO)**, a component of the MPSC, includes **43 members** representing hospitals and long-term care facilities. **Membership is separate from MPSC and is voluntary.** The primary activities of the MAPSO are to improve patient safety and healthcare quality by collecting adverse event reports and holding Safe Tables for members. Safe Tables are a forum conducted under the federal law establishing Patient Safety Organizations (PSOs), such as MAPSO, at which healthcare professionals convene and have open dialogues about patient safety and quality issues. Frank and transparent discussions are encouraged in these legally and privileged settings held for MAPSO member organizations only. MAPSO held the last Safe Table in October 2019, and due to the pandemic has cancelled them since. AHRQ has provided guidance for virtual Safe Tables to assure confidentiality; a survey of members is currently underway to explore this option. MAPSO has collected, analyzed and trended over 96,000 adverse events from 13 facilities, with 15,000 in the last 12 months.

The MPSC identifies 15 strategic partners in FY 2021:

- **Qlarant** – Maryland QIO
- **Health Facilities Association of Maryland -** A leader and advocate for Maryland's long-term care provider community
- **Maryland Healthcare Education Institute** – The educational affiliate of the Maryland Hospital Association

- **Maryland Hospital Association** - The advocate for Maryland's hospitals, health systems, communities, and patients before legislative and regulatory bodies
- **MD MOM –** HRSA-funded Maryland Maternal Innovation Grant
- **MedChi -** Statewide professional association for licensed physicians
- **CRISP -** Regional health information exchange (HIE) serving Maryland and the District of Columbia
- **Society to Improve Diagnosis in Medicine -** National non-profit that catalyzes and leads change to improve diagnosis and eliminate harm
- **Maryland Ambulatory Surgical Association -** The state membership association that represents ambulatory surgery centers (ASCs) and provides advocacy and resources to assist ASCs in delivering high quality, cost-effective ambulatory surgery to the patients they serve
- **Johns Hopkins School of Medicine / The Armstrong Institute for Patient Safety and Quality** – The patient safety center within Johns Hopkins Medicine
- **MedStar Health**
- **MD RxALI**
- **Johns Hopkins Bloomberg School of Public Health**
- **Lifespan**
- **State entities -** HSCRC, MHCC, MDH, OHCQ

## FY 2021 Maryland Patient Safety Center Activities and Accomplishments

MPSC initiatives have engaged providers in hospitals, long-term care facilities, and ambulatory care facilities, as well as patients and consumers. MPSC uses a collaborative model to bring together providers from across the care spectrum to learn best practices to improve care and outcomes. MPSC uses the Berkley Research Group to verify and analyze data collected from hospitals and other providers participating in MPSC initiatives, as well as to provide return on investment figures. Highlights from FY 2021 are provided below in the sections that follow

## Collaboratives

**Clean Collaborative Phase III for Long Term Care:** In consideration of SARS-CoV-2 challenges surrounding the high rates of infection and death in LTC facilities, MPSC used designated funding from HSCRC to initiate an 18-month collaborative for ten LTCs across the State. Nineteen LTC facilities applied, and the project had capacity for ten to participate. The collaborative provides the facilities with tools to establish cleaning and disinfection procedures, as well as access to technologies to substantiate validation of cleanliness. Using a collaborative model, the facilities share best practices, participate in educational webinars and collaborative calls. Data collection began in October 2020 and will be completed in March 2022, should the funding be approved to conclude the eighteen-month collaborative.

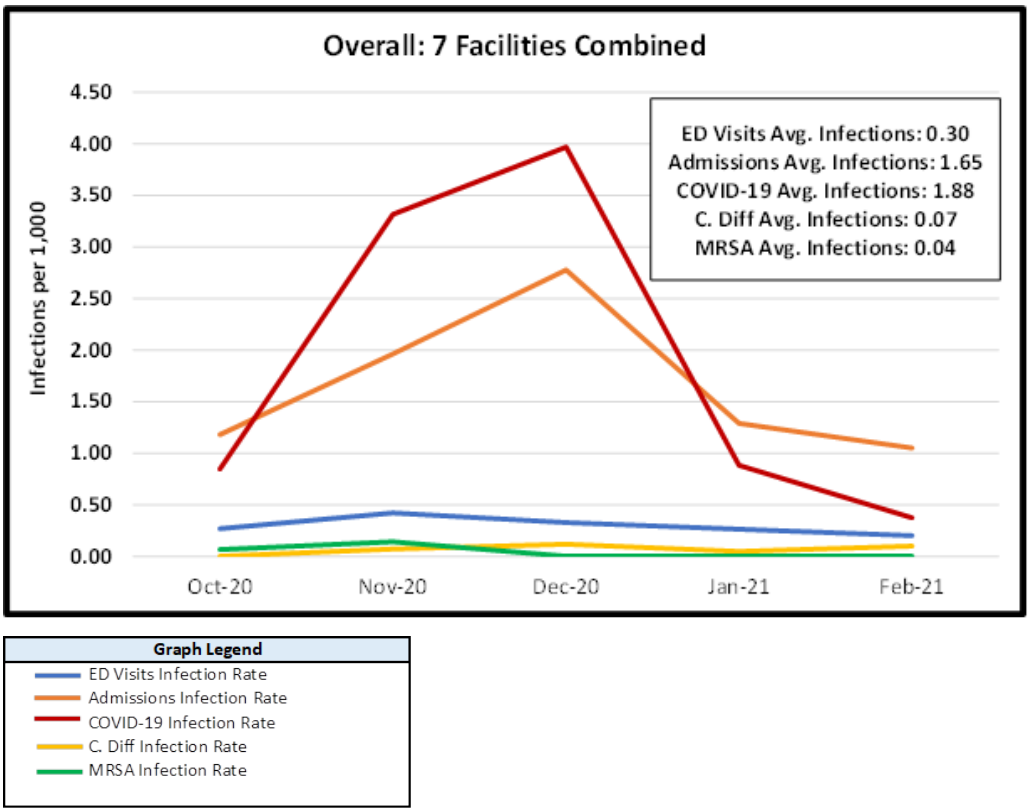
The goals of the collaborative are to:

1. Reduce the collaborative average relative light units (measure of cleanliness) of specified surfaces sampled.
2. Reduce emergency department visits for infection-related diagnoses.
3. Reduce hospital admissions for infection-related diagnoses.
4. Reduce facility acquired cases of COVID-19, MRSA and C-Difficile

Results to date:

The Clean Collaborative Phase III outcome data is early in the collection process, but as illustrated in Figure 2 below, data from seven of the ten facilities shows promising trends in infection related ED visits and hospital admissions from October 2020 to February 2021. We expect CRISP to provide us with Medicare claims data for the ten participating facilities to compare this trend in June 2021.

**Figure 2: Clean Collaborative Phase III-LTC Infection related data N= 7 of 10**




**Clean Collaborative Phase IV: Hospital partnership grants with Long Term Care**

Three hospitals, recognizing the value and effectiveness of Phase I and II of the Clean Collaborative, partnered with MPSC to work with them on their applications and awards of HSCRC Hospital Partnership grants. Phase IV of the Clean Collaborative is the result of those partnerships. Frederick Health System (with 10 long-term care partnership facilities), Luminis Doctors Hospital (with one long-term care partner facility), and Luminis Anne Arundel Medical Center (with three LTC partners) have included MPSC's Clean Collaborative as a sub-awardee in their approved partnership grants. These facilities kicked off the project in November 2020 and began data collection for a one-year period in December 2020. Early data for these partnerships is also promising with the data we have from December 2020 to February 2021, but we do not yet have enough data to report.

## Additional FY 2021 Initiatives and Activities

In addition to the above collaboratives, MPSC engaged in the following activities and initiatives in FY 2021:

**Caring for the Caregiver: Implementing Resilience in Stressful Events (RISE) Program**– MPSC continues to grow participation in the program, a partnership with the Johns Hopkins Armstrong Institute. To date, domestic and international participants include 68 different hospitals, four provider groups, and one School of Nursing. The program provides training that assists in establishing a peer responder program to provide immediate, confidential, "psychological first aid" and emotional support to "second victims" following work-related traumatic events. MPSC closed FY 2020 with $431,000 in gross sales, of which MPSC will receive $172,400, and total gross sales for FY 2021 are projected around $300,000.

An economic evaluation of the cost benefit of the *Caring for the Caregiver: Implementing RISE* program was conducted by the Johns Hopkins Armstrong Institute for Patient Safety and Quality, MPSC's partner and subject matter experts for this program. The study found a net monetary benefit savings of $22,500 per nurse who initiated a peer support encounter through the program at a 1,000-bed hospital. These savings were determined to be 99.9% consistent on the basis of a probability sensitivity analysis with an impact that revealed a 1,000- bed hospital could save $1.81 million each year in personnel costs because of the program. Twenty-two Maryland hospitals have implemented Caring for the Caregiver. Based on the cited study, and averaging across the twenty-two hospitals participating in Maryland, a cost savings of approximately $10 million can be estimated for the state per year.[4]

While this study was specific to utilization by nurses, it is important to recognize that the *Caring for the Caregiver* program is not discipline specific. A 2018 article from the American Medical Association stated that the organizational cost of physician burnout can range from $500,000 to more than $1 million per doctor.[5] This estimate includes recruitment, sign-on bonuses, lost billings and onboarding costs for replacement physicians. Providing programmatic peer support to physicians and other healthcare

[4] Dane Moran, MPH,*† Albert W. Wu, MD,*† Cheryl Connors, MS,‡ Meera R. Chappidi, MPH,*†,Sushama K. Sreedhara, MBBS,† Jessica H. Selter, MD,* and William V. Padula, PhD. "Cost-Benefit Analysis of a Support Program for Nursing Staff", Journal of Patient Safety, Volume 00, Number 00, Month 2017

[5] Source: https://www.ama-assn.org/practice-management/physician-health/how-much-physician-burnout-costing-your-organization ; last accessed 5/1/2021.

staff will generate additional attrition-related monetary benefit while also improving clinical effectiveness and reducing avoidable patient harm.

The rapid growth of this program has created unique opportunities to evolve. MPSC is in the process of developing an online *Caring for the Caregiver: Implementing RISE* training program through the internationally known Siemens Healthineers, and recently added a training partner from Denver Health to assist with expansion efforts in the Mountain Region and the West Coast.

**HRSA Maryland Maternal Health Innovation Grant—** MPSC was named as a sub-awardee in the Johns Hopkins Bloomberg School of Public Health $10.3 million five-year HRSA grant to improve maternal health in Maryland. The project is known as MDMOM (www.mdmom.org). MPSC, through its strong relationships with the Maryland birthing hospitals, will facilitate implicit bias training, training on stigma associated with opioid use disorder in pregnancy, and provide quality improvement training for hospital maternal units. In FY 2020 MPSC conducted a needs assessment survey with a 100% return rate from the birthing hospitals related to implicit bias and stigma. Eight hospitals began the training in February 2021. Phase IIA kicked off in April and Phase IIB will kick off in June.

**Opioid Education for Consumers—**In FY 2020 MPSC joined with the Rx Abuse Leadership Initiative (RALI) of Maryland, an alliance of more than 20 local, state and national organizations committed to finding solutions to end the opioid crisis in Maryland. MPSC continues to provide complimentary consumer education through our e-Learning platform.

**Diagnostic Errors:** MPSC served as a consultant to MedStar, which was awarded an AHRQ grant to develop a new TeamSTEPPS® module to improve communication among the healthcare team in ambulatory settings to improve diagnosis. This consultative invitation is a result of Maryland's long history of provision of TeamSTEPPS® training and early work convening experts in improving diagnosis. In addition, MPSC was one of the earliest organizational members of the Society to Improve Diagnosis in Medicine (SIDM).

**Patient Safety Officer Forums and PSO list serv—** MPSC convenes quarterly forums for patient safety officers, quality improvement staff, risk managers, and others interested in patient safety across the State. The one-hour fora have been offered virtually every other month this year. These fora provide the opportunity for topic-driven exchange of ideas pertaining to issues of interest to this group. The MPSC manages a PSO list serv that supports this group and is an active means for quick exchange of best practices, ideas, and concerns across the State. Participants are from acute care, long term care, specialty hospitals, and State entities such as OHCQ.

**Patient Safety Certification and Organization Specific Education**– MPSC offers Patient Safety Certification and Education to healthcare organizations with facility specific consultation. Most recently (in 2020) **UM Capital Region Health** was certified for increasing near-miss reporting by 44%, decreasing serious adverse events by 80%, and reducing Hospital Acquired Infections (HAIs) by 67%.

**Patient and Family Advisory Councils for Quality and Safety (PFACQS®)** – The PFACQS® Program, a partnership between MPSC and MedStar Health, was designed to help organizations take their patient and family engagement strategies to the next level with a focus on improving outcomes, reducing costs, promoting transparency and reinforcing staff joy and meaning in healthcare work. While many healthcare systems have invested in patient and family advisory councils to ensure patient-centered care and patient satisfaction, very few have recognized the full potential of these councils to improve core quality and safety measures as well as operational and financial performance.

## Activities initiated or Adapted in Response to COVID-19 Pandemic

In an effort to provide the healthcare community with support and resources related to the COVID-19 pandemic MPSC has initiated or adapted its initiatives as outlined below.

**Caring for the Caregiver: Implementing RISE**– MPSC shared a series of interventions on social media specific targeting COVID-19. Additionally, MPSC provided

a FREE training manual with tips for effective and efficient peer support to organizations upon request; distributing over 130 copies worldwide.

**PFACQS® --**MPSC recognizes that as a result of COVID-19 some patients are anxious, ill, and possibly facing death while separated from their loved ones. This has resulted in healthcare providers engaging in tough conversations with families in untraditional ways. Strategies for successful decision-making, communication, and patient experience have been challenged. MPSC in collaboration with the MedStar Institute for Quality and Safety (MIQS) presented, "Patient and Family Engagement During COVID-19: What can we do? How can we help?" a complimentary one-hour live webinar discussion on ideas and resources to effectively engage patients, families and the patient and family advisory council during these difficult times. There were just over 330 registrants and the recorded session and resource guide remains available on the MPSC website.

MPSC and MIQS will offer another complimentary webinar on May 6, 2021 titled, "Exploring the Role of PFACs in a COVID-Shaped World". An innovative panel of experts will discuss deploying Patient and Family Advisory Councils to address the post-COVID transformation of care including the needs of the long-haul COVID patient, the shift to Tele-health, visitations policies, behavioral healthcare needs exacerbated by the pandemic, and delayed diagnosis with reluctance to seek care.

**Vaccine Acceptance Among Communities of Color Series**—MPSC, in partnership with the Maryland Hospital Association, offered a complimentary series of webinars featuring nationally recognized, local pediatrician and expert in patient advocacy and healthcare inequities, Nicole Rochester, MD. Dr. Rochester focused on addressing the systemic racism and the healthcare disparities that have led to a current state of medical mistrust among minority communities and a hesitancy to accept the COVID-19 vaccine. She presented thoughtful and practical methods for building vaccine acceptance among Black and Brown communities—both in the public and among healthcare providers-- and introduced local healthcare-community partnerships as successful models for improvements.

The series received over 650 unique registrants representing more than 170 different organizations and the recordings of all three sessions remain available for viewing on the MPSC website along with attendant resource guides.

## Educational Programs and Conferences

### *Safety Tools Education*

Customized educational programs for MPSC members are driven by changing needs of members and the healthcare industry. In FY 2021 the following educational programs were offered virtually, in deference to realities during the COVID-19 pandemic. Educational programs via live webinars included:

- Root Cause Analysis (RCA)
- Failure Modes and Effects Analysis (FMEA)
- TeamSTEPPS® Train the Trainer
- TeamSTEPPS® Master Trainer
- Six Sigma Green Belt Certification
- Lean for Healthcare

Also, as a result of the pandemic, MPSC recognized a need for greater flexibility in learning opportunities and therefore implemented a new enduring education format through our e-Learning website, making the following courses accessible to registrants 24/7 to take when convenient:

- Appreciative Inquiry
- Opioid Education for Consumers
- Performance Improvement Series- 1. Change Management

### *Safety Conferences*

The **Annual Patient Safety Conference** has grown from 1,200 to 1,500 registrants annually.

- Participants from acute care hospitals, long term care, rehabilitation hospitals, ambulatory surgery centers, state agencies, quality improvement organizations
- Continuing education credits are provided for multiple specialties.

- The spring 2020 conference was postponed due to the COVID-19 pandemic and rescheduled to September 9, 2020, therefore two Annual Maryland Patient Safety Conferences were held during FY 2021:
  - September 9, 2020: 16th Annual Maryland Patient Safety Conference
    - "Putting the Patient at the Center of Patient Safety
    - 1645 registrants

  April 29, 2021: 17th Annual Maryland Patient Safety Conference

  "Healing Our Healer: Organizational solutions for safety and wellbeing"

  1140 registrants

The **Medication Safety Conference draws** 200 to 500 registrants annually and is held in the fall. There were 341 registrants for the November 13, 2020 virtual conference – "Facing the Challenges Unmasked by COVID-19".

- Participants include medication safety officers, pharmacists, quality improvement professionals, other disciplines
- Continuing education credits are provided.
- MPSC plans to hold the FY 2022 conference on November 5, 2021

## FY 2022 Projected Budget

MPSC expects to continue the work of the following initiatives, programs, education, and conferences in FY 2022 with the requested $123,028:

- Mid-Atlantic PSO
- Safety Tools Education
- Safety Conferences
- Opioid Education for Consumers
- Diagnostic Errors
- Maryland Maternal Health Innovation program- implicit bias, etc training
- PFACQS
- Patient Safety Officer Forums
- Patient Safety Certification/Education
- Caring for the Caregiver

- Health Equity – Maternal Health Equity and COVID vaccine hesitancy

MPSC anticipates increased revenue from membership and sales of the *Caring for the Caregiver Program*. Program sales for PFACQS® are projected and some grant funding has been obtained. Other grant opportunities will continue to be explored. These amounts are reflected in the FY 2022 proposed budget Version A outlined in Appendix A. Consistent with FY 2021, most of the revenue anticipated in FY 2022 is derived from membership dues and conference revenue. In consideration of the tremendous patient safety needs identified with the COVID-19 pandemic, MPSC is proposing in Version A of the budget that funding in the amount of $125,000 be designated and restricted to complete the 18-month *Clean Collaborative Phase III for Long Term Care*. This work is scheduled to be completed with data collection in March 2022.

Additionally, MPSC is ready and able to conduct projects in FY 2022, particularly on Infection Control and Prevention in LTC facilities throughout the State; these projects are described below in "FY 2022 Additional Budget Requests/Proposals".

Should HSCRC elect not to fund the continuation of the *Clean Collaborative PHASE III for LTC* project, budget B in Appendix A is proposed.

## FY 2022 Additional Budget Requests/Proposals

In addition to the completion of the Clean Collaborative Phase III for LTC as included in Version A of the budget (Appendix A) above, MPSC is also requesting that there be designated funding for ten more LTC facilities- Clean Collaborative Phase V. This Phase will replicate the work of Phase III to: (1) identify best practices for cleaning and disinfecting hard and soft surface areas throughout the facility and (2) to educate and promote best management practices via webinars, collaborative calls, face to face meetings and onsite consultation and evaluation. Through collection of quantitative data on a monthly basis each facility will be able to respond to and evaluate changes in products, frequency and cleaning practices in their facility.

Phase V will also be an 18-month collaborative if it is funded. MPSC will provide subject matter experts and an experienced infection preventionist to consult and evaluate through site visits with participating facilities. Estimated Phase V collaborative cost: $275,000 Year 1 (FY 2022); $125,000 Year 2 (FY 2023).

**Total additional request for FY 2022:**
**Clean Collaborative Phase III completion: $125,000**
**Clean Collaborative Phase V: $275,000**
**Total Restricted Funding requests: $400,000**

Budget Plan C (Appendix A) presents revised revenues and expenses with the optional projects outlined above included. Staff is not recommending HSCRC funding for this project. Instead, MPSC should pursue direct funding with hospitals and LTC facilities to disseminate best practices around infection control that can lead to better health outcomes and lower ED utilization.

# MPSC RETURN ON INVESTMENT

As noted in the last several Commission recommendations, the HSCRC provides funding for the MPSC with the expectation that there will be both short- and long-term reductions in Maryland healthcare costs, particularly related to such outcomes as reduced mortality rates, lengths of stay, patient acuity, and malpractice insurance costs.

**Clean Collaborative Phase III for LTC**

Early data shows that the Clean Collaborative in LTC is reducing infection related ED visits and hospitalizations from our participating LTCs. Although, it is too early to quantify this ROI in dollars, as noted previously the early trend shows a reduction in infection related ED visits and hospital admissions, which impact the total cost of care.

**Clean Collaborative Phase IV: HSCRC Hospital Partnership Grants with Long Term Care**

As noted earlier, there is not enough data available yet, but early results look promising regarding a reduction in ED visits and hospitals admissions.

**Vaccine Hesitancy**

Addressing and acknowledging the underlying issues associated with COVD-19 vaccine hesitancy is an important step in restoring trust as we undertake a statewide vaccination campaign. Although the increases in healthcare workers and communities of color vaccine rates cannot be completely attributed to our educational offerings**, *MPSC work in this area has received overwhelming positive feedback from the 650 unique registrants representing more than 170 different organizations that participated*.**

**Caring for the Caregiver: Implementing RISE**

Johns Hopkins Medicine has shown that their RISE program saves $22,576.05 per nurse who uses the peer support system to handle a stressful event. The budget impact analysis revealed that a hospital could save US $1.81 million each year because of the *Caring for the Caregiver: Implementing RISE* program. (Journal of Patient Safety, 2017)**.**

Additionally, in a 2018 article from the American Medical Association, the organizational cost of physician burnout is quantified between $500,000 to more than $1 million per doctor. This estimate includes recruitment, sign-on bonuses, lost billings and onboarding costs for replacement physicians.

Additional data on all of the MPSC's programs is needed to ensure that the limited dollars available for MPSC funding creates meaningful improvements in quality and outcomes at facilities in Maryland to achieve the goals of the Total Cost of Care Model. The MPSC should continue to report results from its initiatives to HSCRC staff.

# RECOMMENDATIONS

Quality and safety improvements are the primary drivers to achieve the goals of reduced potentially avoidable utilization and reduced complications in acute care settings under the TCOC Model. MPSC has demonstrated value to Maryland hospitals, as demonstrated by the partnerships that they have formed.  Individual hospitals across

the State are experimenting with strategies to improve care coordination, enhance processes for better care, and advance systems and data sharing to maximize the efficiency and effectiveness of care; the MPSC is in a unique position to convene healthcare providers and share best practices that have been identified through multi-provider collaborative testing and change. The key stakeholders that are involved with the MPSC include hospitals, patients, physicians, long-term care and post-acute providers, ambulatory care providers, and pharmacy – all groups that are critical to the success of the Total Cost of Care Model. The MPSC is in a favorable position in the State to develop and share best practices among this group of key stakeholders. The MPSC should consider alignment with the broader statewide plan for patient safety.

HSCRC staff provides the following draft recommendations for the MPSC funding policy for FY 2022:

1. Consistent with prior Commission recommendations, the HSCRC should reduce the amount of **unrestricted** funding support for the MPSC in FY 2022 by 75 percent from the FY 2019 HSCRC unrestricted grant amount of $492,075. The result is an adjustment to hospital rates in the amount of $123,028.
2. As a condition of funding from the hospital rate setting system, the MPSC should continue to report annually on data that it has collected from hospitals and other facilities that participate in its quality and safety initiatives and should demonstrate, to the extent possible, the ways in which MPSC initiatives are producing measurable gains in quality and safety at participating facilities.
3. MPSC requests additional funding from HSCRC that will be **restricted for targeted projects** that align with the statewide TCOC Model's quality and safety goals, and which the Commission can consider on a case-by-case basis.
    a. For FY 2022, staff recommends that the HSCRC fund an additional $125,000 for the Clean Collaborative Phase III for Long-Term Care project completion, which began and was funded in FY 2021.
4. The MPSC should continue to pursue strategies to achieve long-term sustainability through other sources of revenue, including identifying other provider groups that benefit from MPSC programs, as FY 2022 will be the final year of unrestricted

funding from the HSCRC.

# Appendix A

## Maryland Patient Safety Center, Inc.

## Statement of Income and Expenses

**DRAFT**

**04-30-21**

**Working Copy for FY 2021 (Version A)Description**
**Beginning Restricted Fund Balance as of July 1**

| | FY 2021 Budget | FY 2022 Budget |
|---|---|---|
| | 3,575 | **48,300** |
| Restricted Grant Revenue-MDH | - | **-** |
| Restricted Grant Revenue-HRSA | 36,600 | **40,000** |
| Restricted HSCRC Funding-Phase III Clean Collaborative | 275,000 | **125,000** |
| Restricted HSCRC Funding-Phase IV Clean Collaborative | | **-** |
| Restricted HSCRC Funding-Phase V Clean Collaborative | | **-** |
| Net Assets Released from Restriction-MDH | - | **-** |
| Net Assets Released from Restriction-HRSA | ( 36,600 ) | **( 40,000 )** |
| Net Assets Released from Restriction-PH III Clean Collaborative | ( 275,000 ) | **( 125,000 )** |
| Net Assets Released from Restriction-PH IV Clean Collaborative | - | **( 48,300 )** |
| Net Assets Released from Restriction-PH V Clean Collaborative | - | **-** |
| **Change in Restricted Net Assets** | - | **( 48,300 )** |
| **Ending Restricted Fund Balance as of June 30** | 3,575 | **-** |
| **Unrestricted Funds as of July 1** | | |
| Board-Designated Operating Reserve | 174,344 | **-** |
| Unrestricted Net Assets | 1,576,700 | **1,485,859** |
| **Total Unrestricted Funds as of July 1** | 1,751,044 | **1,485,859** |
| **Revenue** | | |
| HSCRC Funding | 246,056 | **123,000** |
| Membership Dues | 503,650 | **518,000** |
| Fundraising Campaign Revenue | - | **4,000** |
| Education Session Revenue | 18,800 | **10,000** |
| Annual Patient Safety Conference Revenue | 175,500 | **115,000** |
| Medsafe Revenue | 24,000 | **7,000** |
| Caring for HC/Rise Program Sales | 392,000 | **275,000** |
| Sales - Team STEPPS | - | **3,000** |
| Other Grants & Contributions | - | **-** |
| Care Alerts Collaborative Revenue | - | **-** |
| Net Assets Released from Restriction | 311,600 | **213,300** |
| **Total Revenue** | 1,671,606 | **1,268,300** |
| **Expenses** | | |
| Administration | 416,980 | **456,720** |
| Education Sessions | 27,400 | **15,000** |
| Patient Safety | 421,800 | **331,800** |
| Medication Safety | 122,200 | **173,375** |
| Caring for HC | 348,979 | **276,300** |
| Certification | 54,000 | **36,500** |
| MidAtlantic PSO | 81,500 | **74,100** |
| PFAQS | 58,733 | **53,400** |
| Diagnosis Errors | 47,900 | **14,800** |
| Maternal Health | 38,900 | **42,900** |
| Opioid Safety | 43,400 | **28,400** |
| HSCRC Funding-Phase III Clean Collaborative | 275,000 | **146,200** |
| HSCRC Funding-Phase IV Clean Collaborative | - | **20,600** |
| HSCRC Funding-Phase V Clean Collaborative | - | **-** |
| **Total Expenses** | 1,936,792 | **1,670,095** |
| **Change in Unrestricted Net Assets** | ( 265,185 ) | **( 401,795 )** |
| **Ending Fund Balances:** | | |
| **Net Assets with Donor Restrictions - June 30** | 3,575 | **-** |
| **Net Assets with Board-Designated Restrictions - June 30** | 174,344 | **-** |
| **Net Assets without Donor or Board-Designated Restrictions - June 30** | 1,311,515 | **1,084,064** |
| **Total Ending Fund Balances** | 1,489,434 | **1,084,064** |

| **Note 1: FY22 Conference expenses of $258,820 have been prepaid. As a result, no additional cash output will be needed to cover these FY22 expenses. Please see the following calculation, reflecting the net unfunded change in net assets.** | |
|---|---|
| Total Budgeted Change in Net Assets without Restrictions | (401,795) |
| Less: Prepaid Conference Expenses | 258,820 |
| FY22 Unfunded Change in Net Assets | (142,975) |

# Maryland Patient Safety Center, Inc.
# Statement of Income and Expenses

**Working Copy for FY 2021 (Version B)**

**DRAFT**

**04-30-21**

| Description | FY 2021 Budget | FY 2022 Budget |
|---|---|---|
| **Beginning Restricted Fund Balance as of July 1** | - | **48,300** |
| Restricted Grant Revenue-MDH | - | **-** |
| Restricted Grant Revenue-HRSA | 36,600 | **40,000** |
| Restricted HSCRC Funding-Phase III Clean Collaborative | 275,000 | **-** |
| Net Assets Released from Restriction-MDH | - | **-** |
| Net Assets Released from Restriction-HRSA | ( 36,600 ) | **( 40,000 )** |
| Net Assets Released from Restriction-PH III Clean Collaborative | ( 275,000 ) | **-** |
| Net Assets Released from Restriction-PH IV Clean Collaborative | - | **( 48,300 )** |
| Net Assets Released from Restriction-PH V Clean Collaborative | - | **-** |
| **Change in Restricted Net Assets** | - | **( 48,300 )** |
| **Ending Restricted Fund Balance as of June 30** | - | **-** |
| **Unrestricted Funds as of July 1** | | |
| Board-Designated Operating Reserve | 174,344 | **-** |
| Unrestricted Net Assets | 1,576,700 | **1,485,858** |
| **Total Unrestricted Funds as of July 1** | 1,751,044 | **1,485,858** |
| **Revenue** | | |
| HSCRC Funding | 246,056 | **123,000** |
| Membership Dues | 503,650 | **518,000** |
| Fundraising Campaign Revenue | - | **4,000** |
| Education Session Revenue | 18,800 | **10,000** |
| Annual Patient Safety Conference Revenue | 175,500 | **115,000** |
| Medsafe Revenue | 24,000 | **7,000** |
| Caring for HC/Rise Program Sales | 392,000 | **275,000** |
| Sales - Team STEPPS | - | **3,000** |
| Other Grants & Contributions | - | **-** |
| Care Alerts Collaborative Revenue | - | **-** |
| Net Assets Released from Restriction | 311,600 | **88,300** |
| **Total Revenue** | 1,671,606 | **1,143,300** |
| **Expenses** | | |
| Administration | 416,980 | **459,920** |
| Education Sessions | 27,400 | **15,000** |
| Patient Safety | 421,800 | **328,700** |
| Medication Safety | 122,200 | **177,875** |
| Caring for HC | 348,979 | **275,500** |
| Certification | 54,000 | **43,500** |
| MidAtlantic PSO | 81,500 | **84,900** |
| PFAQS | 58,733 | **64,500** |
| Diagnosis Errors | 47,900 | **29,000** |
| Maternal Health | 38,900 | **42,900** |
| Opioid Safety | 43,400 | **33,600** |
| HSCRC Funding-Phase III Clean Collaborative | 275,000 | **-** |
| HSCRC Funding-Phase IV Clean Collaborative | - | **21,700** |
| HSCRC Funding-Phase V Clean Collaborative | - | **-** |
| **Total Expenses** | 1,936,792 | **1,577,095** |
| **Change in Unrestricted Net Assets** | ( 265,185 ) | **( 433,795 )** |
| **Ending Fund Balances:** | | |
| **Net Assets with Donor Restrictions - June 30** | - | **-** |
| **Net Assets with Board-Designated Restrictions - June 30** | 174,344 | **-** |
| **Net Assets without Donor or Board-Designated Restrictions - June 30** | 1,311,515 | **1,052,063** |
| **Total Ending Fund Balances** | 1,485,859 | **1,052,063** |

**Note 1: FY22 Conference expenses of $258,820 have been prepaid. As a result, no additional cash output will be needed to cover these FY22 expenses. Please see the following calculation, reflecting the net unfunded change in net assets.**

| | |
|---|---|
| Total Budgeted Change in Net Assets without Restrictions | (433,795) |
| Less: Prepaid Conference Expenses | 258,820 |
| FY22 Unfunded Change in Net Assets | (174,975) |

# Maryland Patient Safety Center, Inc.
# Statement of Income and Expenses

**Working Copy for FY 2021 (Version C)**

**DRAFT**

**04-30-21**

| Description | FY 2021 Budget | FY 2022 Budget |
|---|---|---|
| **Beginning Restricted Fund Balance as of July 1** | - | **48,300** |
| Restricted Grant Revenue-MDH | - | **-** |
| Restricted Grant Revenue-HRSA | 36,600 | **40,000** |
| Restricted HSCRC Funding-Phase III Clean Collaborative | 275,000 | **125,000** |
| Restricted HSCRC Funding-Phase V Clean Collaborative | - | **275,000** |
| Net Assets Released from Restriction-MDH | - | **-** |
| Net Assets Released from Restriction-HRSA | ( 36,600 ) | **( 40,000 )** |
| Net Assets Released from Restriction-PH III Clean Collaborative | ( 275,000 ) | **( 125,000 )** |
| Net Assets Released from Restriction-PH IV Clean Collaborative | - | **( 48,300 )** |
| Net Assets Released from Restriction-PH V Clean Collaborative | - | **( 275,000 )** |
| **Change in Restricted Net Assets** | - | **( 48,300 )** |
| **Ending Restricted Fund Balance as of June 30** | - | **-** |
| **Unrestricted Funds as of July 1** | | |
| Board-Designated Operating Reserve | 174,344 | **-** |
| Unrestricted Net Assets | 1,576,700 | **1,485,858** |
| **Total Unrestricted Funds as of July 1** | 1,751,044 | **1,485,858** |
| **Revenue** | | |
| HSCRC Funding | 246,056 | **123,000** |
| Membership Dues | 503,650 | **518,000** |
| Fundraising Campaign Revenue | - | **4,000** |
| Education Session Revenue | 18,800 | **10,000** |
| Annual Patient Safety Conference Revenue | 175,500 | **115,000** |
| Medsafe Revenue | 24,000 | **7,000** |
| Caring for HC/Rise Program Sales | 392,000 | **275,000** |
| Sales - Team STEPPS | - | **3,000** |
| Other Grants & Contributions | - | **-** |
| Care Alerts Collaborative Revenue | - | **-** |
| Net Assets Released from Restriction | 311,600 | **488,300** |
| **Total Revenue** | 1,671,606 | **1,543,300** |
| **Expenses** | | |
| Administration | 416,980 | **447,020** |
| Education Sessions | 27,400 | **15,000** |
| Patient Safety | 421,800 | **312,800** |
| Medication Safety | 122,200 | **161,275** |
| Caring for HC | 348,979 | **275,000** |
| Certification | 54,000 | **37,100** |
| MidAtlantic PSO | 81,500 | **71,400** |
| PFAQS | 58,733 | **54,300** |
| Diagnosis Errors | 47,900 | **10,600** |
| Maternal Health | 38,900 | **42,900** |
| Opioid Safety | 43,400 | **26,000** |
| HSCRC Funding-Phase III Clean Collaborative | 275,000 | **139,100** |
| HSCRC Funding-Phase IV Clean Collaborative | - | **13,700** |
| HSCRC Funding-Phase V Clean Collaborative | - | **63,900** |
| **Total Expenses** | 1,936,792 | **1,670,095** |
| **Change in Unrestricted Net Assets** | ( 265,185 ) | **( 126,795 )** |
| **Ending Fund Balances:** | | |
| **Net Assets with Donor Restrictions - June 30** | - | **-** |
| **Net Assets with Board-Designated Restrictions - June 30** | 174,344 | **-** |
| **Net Assets without Donor or Board-Designated Restrictions - June 30** | 1,311,515 | **1,359,063** |
| **Total Ending Fund Balances** | 1,485,859 | **1,359,063** |

**Note 1: FY22 Conference expenses of $258,820 have been prepaid. As a result, no additional cash output will be needed to cover these FY22 expenses. Please see the following calculation, reflecting the net unfunded change in net assets.**

| | |
|---|---|
| Total Budgeted Change in Net Assets without Restrictions | (126,795) |
| Less: Prepaid Conference Expenses | 258,820 |
| FY22 Unfunded Change in Net Assets | 132,025 |

maryland
health services
cost review commission

# Draft Recommendation for the Community Benefit Reporting

May 12, 2021

Please submit stakeholder comments to hscrc.cbr@maryland.gov by COB May 19, 2021

# Policy Overview

| Policy Objective | Policy Solution | Effect on Hospitals | Effect on Payers/Consumers | Effect on Health Equity |
|---|---|---|---|---|
| This draft recommendation seeks to improve the community benefit reporting guidelines in order to identify the amount hospitals spend on community health initiatives. | Hospitals will be required to report the amount they spent on initiatives identified on their Community Health Needs Assessment. | There are no rate implications for hospitals with this draft recommendation. | There are no implications for payers or consumers. | The HSCRC and the public will have a better insight into the community health spending and can analyze the impact of their spending on health equity. |

# Executive Summary

Staff recommend updating the community benefits reporting guidelines, pursuant to legislation passed in the 2020 General Assembly session, to include 1) an assessment of public engagement in the CHNA process; 2) a report on the amount the hospital spends to address their community health needs.

# Introduction & Background

Chapter 437 of 2020 (SB774 and HB1169) directed the Health Services Cost Review Commission (HSCRC) to form a Community Benefit Reporting Workgroup (Workgroup) to discuss the Community Benefit reporting process and the inclusion of community partners when conducting the hospital's Community Health Needs Assessment. The workgroup focused on two aspects of the community benefit reporting process:

> (1) a description of each hospital's process for soliciting input in the development of the community health needs assessment for the purpose of §501(r)(3) of the Internal Revenue Code; and
>
> (2) recommendations for the Maryland Department of Health and the local health departments to assess the effectiveness of hospitals' community benefit spending to address the community health needs." (CH 437 of 2020)

Based on the Workgroup's discussions, Staff recommend making the following changes to the community benefit reporting process.

# Recommendations for Community Benefit Reporting

Hospitals are required to conduct an analysis of their community's health needs. This assessment must include members of the community. Staff believe that hospitals generally engage in an extensive community engage process while writing their CHNAs. However, the extensiveness of those efforts may vary. Therefore, Staff recommend updating the reporting guidelines to require hospitals to describe those efforts. Additionally, hospitals do not currently report the portion of the community benefit spending that is directed to CHNA initiatives. Currently, community benefit reporting requirements require the hospitals to report spending in high-level categories, such as "Mission Driven Health Services" or "Charity Care." These categories are not detailed enough to allow the HSCRC, other policymakers, or the public to identify spending that is directed to community health needs. Staff recommends updating the community benefit reporting guidelines to link the hospital's community benefit reports with the hospitals CHNA initiatives.

1. Description of Hospital's Public Engagement Process

   Staff recommend including a description of the community's participation in the hospital's Community Health Needs Assessment. Under existing IRS regulations, hospitals are required to: "Solicit and take into account input received from persons who represent the broad interests of that community, including those with special knowledge of or expertise in public health" (IRS Section 501(r)(3)(B)). Staff worked with the Maryland Hospital Association and members of the Workgroup to identify eight best practices shown in Figure 1 below for hospitals to follow when developing their CHNA.

***Figure 1: Best Practices for Engaging Patients and Communities in the CHNA Process***


Staff recommend including a self-assessment in the community benefits reporting guidelines. Hospitals will be required to report the extent to which they performed these best practices. Hospitals will give themselves a rating on a scale of 1 to 6 based on a typology developed by the International Association for Public Participation (IAP2). The scale ranges from the hospital informing members of their community to the community itself driving the development of the Community Health Needs Assessment.

## 2. Assessing the Effectiveness of Hospitals' Community Benefit Spending to Address Community Health Needs

Staff recommend updating the community benefits reporting requirements to require hospitals to report the amount of their community benefit spending that was directed to addressing needs identified on their community health needs assessment. Under the HSCRC's current reporting guidelines, there is no way to accurately identify spending specifically made in response to a CHNA. Hospitals report aggregate community benefit spending categories that include spending on both local community health needs and other public health priorities. Thus, the HSCRC will update

reporting guidelines to identify community health needs spending among aggregate Community Benefit spending.

Hospitals will be required to disclose each priority area that they are focused on addressing with their community benefit spending. For example, a hospital may report that they are focused on reducing the incidence of diabetes in their local community as a priority area. The hospital will then report the target population and goals for that population. In other words, a hospital could focus on reducing incidence of diabetes by one percent among children aged 15 – 18 within ten years. The hospital will also annually report its progress to date in achieving those goals and other important programmatic information. Under each priority example, the hospital will have multiple initiatives that are expected to contribute to the overall priority area.

The hospitals will be required to report on every initiative created to support their community health needs priority areas and goals. This reporting will include detailed information at a line-item level so that the State can identify the community health initiatives that hospitals are engaged in. Initiatives that have full-time-equivalent (FTE)/staffing allocations or a programmatic budget are considered a 'Community Health Initiative', thus, will be reported as a line item. Finally, hospitals will be required to report the amount that they spent on each Community Health Initiative, as they do with the aggregate Community Benefit financials. Table 2 includes an example of the required information from each hospital's CHNA to be included in the Community Benefit reporting.

# Conclusion

Staff recommend updating the community benefits reporting guidelines to include 1) an assessment of public engagement in the CHNA process; and 2) a report on the amount the hospital spends to address their community health needs.

Chapter 437 also required the HSCRC to make recommendations on how MDH and LHDs can utilize the data collected by the HSCRC to assess the portions of hospitals' community benefit spending deployed to address community health needs. Staff recommend updating the annual Nonprofit Hospital Community Health Benefit Report available to the legislature and members of the public to highlight the amount of spending that is directed towards the community local health needs. MDH and LHDs can use this information to assess the extent to which the hospital's spending aligns with the community's health needs.

Additionally, Chapter 437 also directed hospitals' Community Benefit reporting to include information on: 1) the gaps in provider availability in their community; 2) a description of hospital efforts to track and reduce health disparities; 3) a list of unmet community health needs. Staff believes this is already included in the community benefit report and additional changes are not necessary. Finally, Chapter 437 requires the hospitals to include a list of tax exemptions that the hospital claimed during the preceding tax year.

Updated Community Benefit guidelines will go into effect for FY2021 reporting and finalized prior to the end of the fiscal year. Data from the revised reporting requirements will be available in the fall of 2022 for the FY 2021 fiscal year.

**Policy Update Report and Discussion**

Staff will present materials at the Commission Meeting.

maryland
health services
cost review commission

**TO**: HSCRC Commissioners

**FROM**: HSCRC Staff

**DATE**: May 5, 2021

**RE**: Hearing and Meeting Schedule

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June 9, 2021 To be determined - GoTo Webinar

July 14, 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.