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618th Meeting of the Health Services Cost Review Commission

March 13, 2024

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

CLOSED SESSION
12:00pm

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

PUBLIC MEETING
1:00 pm

Informational

1. Review of Minutes from the Public and Closed Meetings on February 14, 2024
2. Presentation from Advanced Research Projects Agency for Health (ARPA-H)

Specific Matters

3. Docket Status – Cases Closed

   2642N University of Maryland Medical Center
   2643N Brook Lane Hospital

4. Docket Status – Cases Open

   2630R UM Shore Medical Center at Easton
   2644A Johns Hopkins Health System

Subjects of General Applicability

5. Confidential Data Requests

   - Commissioners will vote on one confidential data request.

6. Final Recommendation on Traditional Medicare Performance Adjustment (MPA)

   - Commissioners will vote on the final recommendation.

7. Update Factor Discussion

    - Staff will present on progress developing the FY 2025 Update Factor.

8. ED Best Practices Incentive Policy - Development Plan & EDDIE Update

    - Staff will present the development plan for the ED Best Practices Incentive Policy and ED wait times.

9. Out Of State & Deregulation Volume Policy - Development Plan

    - Staff will present the development plan for OOS and deregulation volume policies.

10. Policy Update and Discussion

    a. AHEAD Model Update

        - Staff will present an update on the AHEAD Model.

    b. Model Monitoring

        - Staff will present an update on TCOC performance.

    c. Legislative Update

        - Staff will present an update on legislative priorities during the Maryland General Assembly.

    d. Community Benefits Workgroup

        - Staff will present on updates to the Community Benefits Workgroup.

11. Hearing and Meeting Schedule

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2024**
SYSTEM	*	**FOLIO:**	**2454**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2644A**

Staff Recommendation

March 13, 2024

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on February 28, 2024, on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for heart failure services and solid organ and bone marrow transplants with Optum Health, a division of United HealthCare Services, for a period of one year beginning April 1, 2024.

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 AND ASSESSMENT OF RISK

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

maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

The staff found the experience for this arrangement last year to be favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for heart failure, solid organ, and bone marrow transplant services for a one-year period commencing April 1, 2024. 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 Staff Recommendation for the Release of HSCRC Confidential Patient Level Data to

The University of Maryland School of Medicine (UMSOM) Shock Trauma and Anesthesiology Research Center, and the National Study Center for Trauma and EMS (NSC)

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

March 13, 2024

This is a final recommendation for Commission consideration at the March 13, 2024, Public Commission Meeting.

SUMMARY STATEMENT

The University of Maryland School of Medicine (UMSOM), and the National Study Center (NSC) for Trauma and EMS, is requesting access to the Health Services Cost Review Commission (HSCRC) Inpatient and Outpatient Hospital Data, that includes limited confidential information ("the Data") for the Injury Outcome Data Evaluation System (IODES). The Commision last approved access to the Data for this project on January 11, 2023.

OBJECTIVE

The IODES project is designed to make data related to injury available for analysis. The Data will be used for analysis of injuries to persons treated at Maryland hospitals. To fulfill a key component of the IODES effort, the Data will be linked (where possible) to police crash reports, EMS run sheets, and other datasets as required for further analysis. The NSC has been working with the Maryland Department of Transportation, Maryland Highway Safety Office (MDOT MDHSO) and other partners on the Crash Outcome Data Evaluation Systems (CODES) project for more than a decade.

Investigators received approval from the Maryland Department of Health (MDH) IRB on February 7, 2024, and the MDH Strategic Data Initiative (SDI) office on January 12, 2024. The Data will not be used to identify individual hospitals or patients. This project is designed as an umbrella project that will continue to address individual approved projects and tasks to improve the public health of Marylanders with injuries, and has no end date. However, the Project Principal Investigator will notify the HSCRC if the project were terminated, and at that time, the Data will be destroyed, and a Certification of Destruction will be submitted to the HSCRC.

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for the Data are reviewed by the HSCRC Confidential Data Review Committee ("the Review Committee"). The Review Committee is composed of representatives from HSCRC and the MDH Environmental Health Bureau. The role of the Review Committee is to determine whether the study meets the minimum requirements described below and to make recommendations for approval to the HSCRC at its monthly public meeting.

1. The proposed study or research is in the public interest;
2. The study or research design is sound from a technical perspective;
3. The organization is credible;
4. The organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations; and
5. The organization has adequate data security procedures in place to ensure protection of patient confidentiality.

The Review Committee unanimously agreed to recommend that UMSOM be given access to the Data. As a condition for approval, the applicant will be required to file annual progress reports to the HSCRC, detailing any changes in goals, design, or duration of the project; data handling procedures; or unanticipated events related to the confidentiality of the data. Additionally, the applicant will submit a copy of the final report to the HSCRC for review prior to public release.

STAFF RECOMMENDATION

1. HSCRC staff recommends that the request by UMSOM for the Data for Calendar Years 2021 through 2026 be approved.

2. This access will include limited confidential information for subjects meeting the criteria for the research.

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Medicare Performance Adjustment Calendar Year 2024

Final Recommendation

February 2024

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Table of Contents

This document contains the staff final recommendations for the Medicare Performance Adjustment for Calendar Year 2024.

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Recommendations For CY 2024 MPA Policy

This recommendation is identical to the recommendation staff shared with the Commission in December 2023 but reflects the removal of the CTI buyout provisions as this was not approved by CMS. Staff recommend the following incremental revisions to the Medicare Performance Adjustment (MPA) policy for calendar year 2024 (CY2024) to align with State and federal policy directives:

1. Increase the maximum at risk under the traditional MPA to 2%
2. Implement the population health quality measure adopted by the Commission into the MPA quality score as outlined in last year's final MPA recommendation.

In 2021, Staff completed a major policy review of the MPA. As a result of the review, the Commission revised the attribution algorithm and the methodology for calculating the rewards / penalties under the MPA. During the review, stakeholders emphasized that the MPA policy had changed numerous times and stressed the need for consistency in the future. Correspondingly, Staff recommend keeping the majority of the MPA unchanged. However, Staff are recommending the limited changes described above to keep the MPA aligned with other State and federal policymaking. The following discussion provides rationale and detail on each of these recommendations.

In addition, Staff recommend the following revision to the Medicare Performance Adjustment Framework (MPA Framework) approved by the Commission in October 2019:

1. Cap the downside risk of a hospital under the CTI program to 2.5% of total Medicare Payments and redistribute additional risk across all hospitals to maintain the overall savings neutrality in the program.

The following discussion provides rationale for this recommendation.

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
The Total Cost of Care (TCOC) Model Agreement requires the State of Maryland to implement a Medicare Performance Adjustment (MPA) for Maryland hospitals each year. The State is required to (1)	This MPA recommendation fulfills the requirements to determine an MPA policy for CY 2024 and makes incremental improvements to the current policy	The MPA policy serves to hold hospitals accountable for Medicare total cost of care performance. As such, hospital Medicare payments are adjusted according to their performance on total cost of care.	This policy does not affect the rates paid by payers. The MPA policy incentivizes the hospital to make investments that improve health outcomes for Marylanders in their service area.	This policy holds hospitals accountable for cost and quality of Medicare beneficiaries in the hospital's service area. Focusing resources to improve total cost

Attribute 95 percent of all Maryland Medicare beneficiaries to some Maryland hospital; (2) Compare the TCOC of attributed Medicare beneficiaries to some benchmark; and (3) Determine a payment adjustment based on the difference between the hospitals actual attributed TCOC and the benchmark.	and to the related MPA Framework.	Improving the policy improves the alignment between hospital efforts and financial rewards. These adjustments are a discount on the amount paid by CMS and not on the amount charged by the hospital. In other words, this policy does not change the GBR or any other rate-setting policy that the HSCRC employs and – uniquely – is applied only on a Medicare basis.		of care provides the opportunity to focus the hospital on addressing community health needs, which can lower total cost of care.

Introduction to MPA Policies

The Medicare Performance Adjustment (MPA) is a required element for the Total Cost of Care Model and is designed to increase the hospital's individual accountability for total cost of care (TCOC) in Maryland. Under the Model, hospitals bear substantial TCOC risk in the aggregate. However, for the most part, the TCOC is managed on a statewide basis by the HSCRC through its GBR policies. The MPA was intended to increase a hospital's individual accountability for the TCOC of Marylanders in their service area.

The MPA includes three "components": (a) a Traditional Component, which holds hospitals accountable for the Medicare total cost of care (TCOC) of an attributed patient population, (b) a Reconciliation Component, which rewards hospitals for the care redesign interventions and (c) a Savings Component that allows the Commission to adjust hospital rates to achieve the Medicare Total Cost of Care Model (the Model) savings targets.

The Traditional Component is governed via annual updates to the MPA policy adopted by the Commission. This document represents the update for Calendar Year 2024 (also known as MPA Year 6). The Efficiency and Savings Component are governed via the MPA Framework. The recommendation to cap CTI risk at 2.5% is a change to the Reconciliation Component and is the first change in the MPA Framework related to the Reconciliation Component since it was adopted. This policy does not relate to the Savings

Component. These three components are added together and applied to the amount that Medicare pays each respective hospital. The MPA is applied as a discount to inflator to the amount that Medicare pays on each claim submitted by the hospital.

Recommendations Related to the MPA Traditional Component

Recap of Current Program

The following recaps the traditional MPA as it was implemented for Calendar Year 2023, it is included as a reference. The approaches described were adopted incrementally in the Calendar Year 2021, 2022 and 2023 MPA polices, and those policies remain in effect except where changes are specifically denoted in the next section.

The first step in the process is to attribute beneficiaries to hospitals. The Model requires 95% of beneficiaries be attributed to hospitals under the MPA. The current attribution is as follows:

1. Hospitals, except Academic Medical Centers (AMCs) are attributed the costs and beneficiaries in zip codes that comprise 60% of their volume. AMCs are assigned all zip codes for Baltimore City for their geographic attribution. Beneficiaries in zip codes claimed by more than one hospital are allocated according to the hospital's share of equivalent case-mix adjusted discharges (ECMADs) for inpatient and outpatient discharges among hospitals claiming that zip code. ECMADs are calculated from Medicare FFS claims for Calendar Year 2019. ECMADs are also used in calculating the volumes in the 60% test.
2. Zip codes not assigned to any hospital under step 1 are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed a 30-minute drive-time from the hospital's PSA.
3. Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.
4. A second layer is added for AMCs. AMCs are also attributed where beneficiaries with a CMI of greater than 1.5 and who receive services from the AMC are attributed to the AMC as well as to the hospital under the standard attribution. The AMC outcome becomes a blend of this approach and the standard geographic approach.

The MPA then penalizes or rewards hospitals based on their attributed TCOC. Hospitals are rewarded if the TCOC growth of their attributed population is less than national growth. Beginning in 2021, the HSCRC scaled the growth rate target for hospitals based on how expensive that hospital's service area is during the baseline period relative to other geographic areas elsewhere in the nation. This policy is intended to ensure that hospitals which are expensive relative to their peers bear the burden of meeting the Medicare savings

targets, while hospitals that are already efficient relative to their peers bear proportionally less of the burden. The TCOC growth rate adjustments are shown in Table 1 below.

Table 1: Scaled Growth Rate Adjustment

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

Historically, hospitals were required to beat the national TCOC growth rate each year. But in 2021, the HSCRC changed the way that the TCOC is calculated for hospitals. The HSCRC will trend the hospital's baseline TCOC forward based on the national growth rate and the TCOC adjustment factors. This was intended to create more predictability for hospitals. A hospital can now predict what their target will be two or three years out. An example of the methodology to calculate the TCOC targets is shown in Table 2 below. This example covers 2019 to 2021, for each additional year another year of trend similar to item C in Table 2 is added. Each additional year is also adjusted for the Growth Adjustment Factor (item D in Table 2).

Table 2: Calculation of the MPA Targets

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

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

The hospital is rewarded or penalized based on how their actual TCOC compares with their TCOC target. Through last year the rewards and penalties were scaled such that the maximum reward or penalty was 1% which will be achieved at a 3% performance level (the recommendation advanced later in this proposal is to increase this to 2% and 6%). Essentially, each percentage point by which the hospital exceeds its TCOC benchmark results in a reward or penalty equal to one-third of the percentage. An example of the hospital's rewards/penalties is shown in the table below.

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

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

Example MPA Performance Calculations

Hospital	MPA Target	MPA Performance	% Difference	Reward (Penalty)
Hospital A	$12,359	$12,235	-1.00%	0.30%
Hospital B	$11,846	$11,941	0.80%	-0.30%

Hospital C	$11,792	$11,556	-2.00%	0.70%
Hospital D	$11,800	$12,154	3.00%	-1.00%
Hospital E	$11,294	$11,859	5.00%	-1.00%

In addition, the agreement with CMS requires that a quality adjustment be applied that reflects hospital quality outcomes, this is in addition to the revenue-at-risk for Total Cost of Care. These quality adjustments are derived from those in the Commission's all-payor Readmission Reductions Incentive Program (RRIP) and Maryland Hospital Acquired Conditions (MHAC) program. Revisions to the quality adjustment for CY2024 are outlined below.

Recommended Revisions to the traditional MPA

Increase Maximum Revenue-at-Risk

Staff recommends increasing the amount of revenue-at-risk for Total Cost of Care performance under the Traditional MPA to ±2%. Increasing the revenue at risk under the MPA has been a stated goal of the Center for Medicare and Medicaid Services (CMS) for the last two years. In their approval of the current year MPA dated January 18, 2023, CMS noted "As stated in the MPA PY 2022 CMS response letter issued October 10, 2021, CMS expects the State to increase the revenue-at-risk (± 1%) under the traditional MPA in 2024".

The increase to 2% is consistent with this directive from CMS to increase the revenue-at-risk. Staff are recommending setting the new level at ±2% based on further input from CMS and discussions with stakeholders about the reasonable level of increase. The translation between actual results and the revenue-at-risk would not be changed from the current 3:1 ratio. Therefore, the revenue-at-risk would be reached at ±6%.

Add Population Health Measure

In last year's final recommendation, the Commission approved adding a population health metric to the quality adjustment included in the Traditional MPA once a measure had been identified. This expected addition was also noted by CMS in their January 18, 2023, approval letter. The Commission is now considering a population health measure, Staff recommend including that measure, once finalized, in the Calendar Year 2024 MPA adjustment according to the formula approved last year (adjusted for 2% revenue-at-risk):

TCOC results x 1/3 (capped at 2% of Medicare revenue) x (1 + 2 x (RRIP + MHAC Reward/Penalty + Population Health Quality Measure) where the Population Health Quality Measure is scaled to generate a result of ±4%.

This formula will result in total revenue-at-risk of ±2.32% of Medicare payments.

Recommendations Related to the MPA Framework Reconciliation Component

Recap of Current Program

In the MPA Framework recommendation Staff noted that under GBRs hospitals do not capture utilization savings that occur outside their GBR and therefore any successes they achieve help the State meet the TCOC Model savings target but do not help the hospitals. The Commission adopted the MPA Framework recommendation and implemented the CTI program as a response to this disconnect. The recommendation noted the following principles in order to strengthen hospital incentives:

- Hospitals should keep the savings from their CTIs up to 100% to the extent feasible.
- Incentives should be structured to reward participation in CTIs and penalize non-participation.
- New and Existing CTIs that transform care across the entire delivery system should be supported.

The Framework also included the use of the MPA-RC to pay incentives earned under CTIs and to offset those incentives by reducing Medicare Fee-for-service payments to all hospitals to create a net zero adjustment (the Offset). This approach was adopted as per the Staff's October 2019 Final MPA Framework Recommendation, "First, it mitigates the possibility that these care transformation payments will result in a net increase in the TCOC run rate. Second, when a hospital captures the savings from their CTIs, the resulting increased costs will be spread as an offset across all hospitals resulting in non-participating hospitals being 4 penalized for their non-participation."

The CTI program has just completed its second performance year (on June 30, 2023) and the third performance year is underway. Staff shared results from the first performance year with the Commission in October 2023. These results reflected significant participation with 107 total CTIs, $130 Million of gross scored savings and revenue redistribution from unsuccessful to successful hospitals of $56 Million. In Year 3 the number of CTIs increased to 249.

Recommended Revisions – Cap Hospital Downside Risk

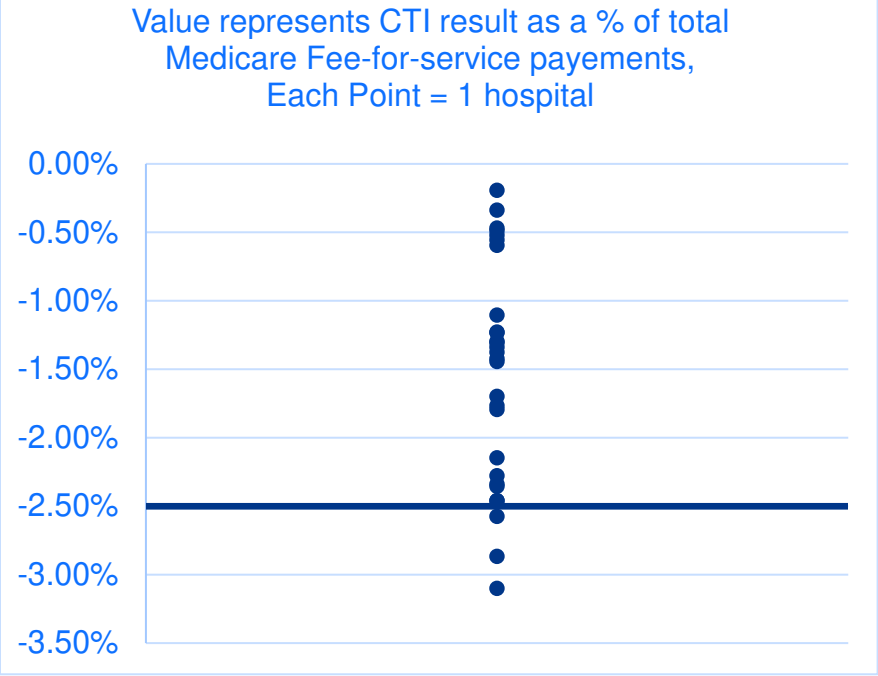
As discussed above one of the principles of CTIs was that "hospitals should keep the savings from their CTIs up to 100% to the extent feasible." One result of that principle is that there can be no cap on downside risk to hospitals in the Offset or else hospitals would not be able to realize their full benefit and maintain overall neutrality. The implication of this approach is that hospitals have theoretically unlimited downside risk and the amount of actual risk is hard to quantify as it depends on the level of success achieved by other hospitals.

For these reasons hospitals have advocated for a cap on downside risk after implementation of the Offset. Staff have been concerned that such a cap would dilute the incentives for hospitals by allowing them to "choose" the downside cap rather than aggressively pursuing care transformation. This concern was particularly acute when there was no insight into the actual level of downside risk in the program.

Now that the first year of CTI performance results are available Staff believes setting a downside cap at the outer edge of actual experience to create greater predictability for hospitals is appropriate. Therefore, Staff recommends the Commission cap the downside risk of a hospital under the CTI program to 2.5% of total Medicare Payments, effective with the second program year (Fiscal Year 2023) and redistribute additional risk across all hospitals to maintain the overall savings neutrality in the program (note the redistribution would include the capped hospitals resulting in an effective cap slightly higher than 2.5%).

The recommendation of a cap equal to 2.5% is based on the actual results from the first year. These results are summarized in Exhibit 1. This level was selected to avoid creating immunity from harm for hospitals while still providing a level of protection that is relevant to the outcomes of the program.

Exhibit 1: Distribution of Loss Values, First CTI Performance Year



Discussions of Comments Received

Background

As with all recommendations this draft recommendation was developed with substantial community input including ideas and commitments resulting from prior recommendations, a series of specific workgroups and ongoing dialog with stakeholders. However, a formal comment period and Staff discussion of those responses is usually held for the final recommendation. Staff departed from this practice for this draft recommendation because this recommendation will be the basis for requesting approval from CMS for the MPA Policy, as required under the TCOC Model Agreement. Should CMS not approve the approach outline herein those changes will be addressed in the Final Recommendation.

In addition to discussion during the workgroups, Staff held two more formal comment submission periods during the workgroup process, one prior to the October 25, 2024, Total Cost of Care Workgroup and a second prior to the submission of this recommendation. The next section recaps these comments along with staff response. Across the two rounds letters were received from MHA, the University of Maryland Medical System. Medstar Health, Johns Hopkins Health System and Adventist Health System in the first round.

Recap of Comments

Major areas of focuses addressed by multiple stakeholders include:

Support for the CTI Buy Out: Industry stakeholders strongly supported the re-introduction of the CTI Buy Out.

Support for capping downside risk on CTIs: Industry stakeholders strongly supported a cap on downside risk on CTIs to create a level of predictability for hospitals. Staff changed the proposed cap from 3.0% to 2.5% based on this feedback.

Concerns about overall level of total cost of care risk: Stakeholders acknowledge the need to raise the revenue-at-risk under MPA to 2%. Industry raised concerns that under the combination of MPA, CTI and Commission Efficiency policy, hospitals have significant revenue at risk related to total cost of care. Staff included in this recommendation a quantification of that total risk exposure and plans to include a similar discussion in the MPA request to CMS. While most comments pertained to the level of risk being potentially too high, one commenter noted that the 3:1 translation of performance in the MPA (i.e. it takes a 6% win/miss to generate a 2% reward/penalty) dilutes the rewards for strong MPA performance and significantly and may be a disincentive to effective management. Staff believes the Commission should consider a change to this approach in the future.

Population Health Measure: There were significant concerns raised about the proposed diabetes-related quality measure to be used in the population health element of the MPA quality adjustment. This recommendation is silent on the specific measure to be used and Staff believe those concerns will be addressed in the relevant recommendation. Staff notes that the inclusion of a population health metric in the MPA has long been a request of CMS and that the Commission needs to identify a meaningful measure for inclusion within this recommendation.

Other CTI Provisions: Stakeholders identified a number of concerns related to specific technical elements of the CTI program and the need for continual education on these programs. Staff continually review the specifics of these programs. Staff working with CRISP have established a Learning Collaborative to provide information to hospitals and other stakeholders on these programs.

Data Analytics: One stakeholder identified areas where the Commission could strengthen analytics related to the various care transformation programs. Staff continually work with CRISP to enhance reporting under these programs.

Benchmarking: One stakeholder suggested the Commission should revisit the benchmarks used to set the MPA targets as performance may have changed since the base year of 2019. Staff are currently planning to refresh the total cost of care benchmarks starting in the summer of 2024 for 2025 implementation.

Continued interest in revising the beneficiary algorithm used in the MPA: Industry commentator acknowledge the challenges with the old primary care-based attribution in the MPA but also continued to raise concerns that the current geographic-based attribution does not properly incent care transformation. Staff believe the combination of the geographic MPA and the hospital-targeted CTI policy is the best available alternative given current constraints and does not believe revisiting this issue is merited in the short-term.

Impact of CTI offset on Academic Institutions: One commenter noted that *"The linkage of these policies [CTI-related policies] to Medicare revenue disproportionately impacts the state's academic medical centers (AMCs) compared to others in the state, because AMCs receive patients from across the state and country due to the regional and national programs they support. This provides less opportunity to engage in and impact longitudinal care or outcomes for some patients who reside outside of the immediate area of the hospital."* Staff understands the concern that the opportunity for AMCs under CTI may be less than their relative revenue under the policy as the offsetting revenue to CTI savings is distributed based on fee-for-service Medicare revenue. However, Staff does not believe a policy change is merited absent quantification of the relative lack of opportunity and an alternative method of distributing the offset that was fair to all parties.

Appendix A: CTI Representation Analysis

Exhibit A1 compares the representations of certain populations in implemented CTIs ("Attributed" column) to their representation were the same set of CTI definitions implemented Statewide for all Medicare Fee-for-service beneficiaries ("Unattributed" column). The results are not consistent with systematic underrepresentation among the underserved populations that we analyzed. There is a slight underrepresentation in implemented CTIs in rural areas and a slight over-representation in Health Professional Shortage areas (see note 2). Both of these are populations with relatively small representation in total and therefore it only takes 1 or 2 CTIs to create this phenomenon. Staff will work with rural hospitals during the next enrollment period to determine if there are any systematic barriers.

Table A1: Representativeness of Attributed CTI Episodes Relative to Unattributed CTI Episodes

	All Potential CTI Episodes		
Population	**Attributed**	**Unattributed**	**MSD (1)**
N	345,357	16,374,896	-
Black or African American	26.4%	26.5%	-0.001
Hispanic	1.3%	1.3%	-0.001
Asian/Pacific Islander, American Indian/Alaska Native, Other/Unknown	7.4%	7.4%	0.000
Dual Medicaid Eligibility	20.3%	17.7%	0.069
Disabled	19.4%	19.4%	0.000
High-Deprivation Neighborhood	12.6%	13.7%	-0.031
Rural Census Tract	3.4%	7.3%	-0.148
Health Professional Shortage area	3.2%	1.7%	0.117

Notes:

1. MSD: The Mean Standardized Difference is the difference in means between two groups as a fraction of the standard deviation in the measure.
2. An MSD below 0.10 is generally considered ignorable small and many sources consider an MSD less than 0.20 as ignorable.
    a. An MSD > 0 indicates that attributed EQIP episodes have more representation of a given underserved population than in the pool of statewide unattributed episodes.
    b. An MSD < 0 indicates that attributed EQIP episodes have less representation.

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Hospital Community Benefit Reporting Instructions Workgroup Charge

March 2024

Maryland law requires the Maryland Health Services Cost Review Commission (HSCRC) to collect community benefit information from individual hospitals and compile it into a statewide, publicly available annual Community Benefit Report (CBR).[1] HSCRC updated the community benefits reporting requirements for FY 2021, with mandatory reporting on the new data elements beginning for FY 2022. The primary purpose of these reporting changes was to collect more information about the relationship between hospital community benefit activities and community health needs assessments (CHNAs).[2]

After reviewing the results of the FY 2022 community benefits reports from hospitals, two topics were identified as priorities for possible revision of the reporting requirements. HSCRC staff plan to convene a short-term workgroup to review reporting instructions in the following areas:

- Indirect Cost Ratios. There was wide variation between the indirect cost ratios reported by hospitals. Many hospitals reported very high ratios. The workgroup will review the methodology for calculating indirect cost ratios, and make recommendations about possible changes to this methodology, including whether caps on indirect cost ratios are appropriate.
- CHNA-Aligned Spending. There was wide variation between hospitals in the percentage of community benefit expenditures that were reported as being aligned with the hospital's CHNA initiatives. The workgroup will review the criteria hospitals are using to determine whether expenditures are CHNA-related. The workgroup will make

[1] MD. CODE. ANN., Health-Gen. § 19-303. Maryland law defines community benefit as a planned, organized, and measured activity that is intended to meet identified community health needs within a service area.

[2] The changes to reporting included requirements that hospitals 1) report on initiatives that directly address needs identified in the CHNA; 2) self-assess the level of community engagement in the CHNA process; 3) separately itemize all physician subsidies claimed as community benefits by type and specialty; and 4) list the tax exemptions the hospital claimed during the immediately preceding tax year. Reporting of items 1 and 2 by hospitals was optional for fiscal year (FY) 2021 but was mandatory for FY 2022.

recommendations about whether HSCRC's reporting instructions should provide additional guidance to hospitals on this topic.

Timeline

Activity	Timeline
Finalize Workgroup Charge	Early March
Schedule Workgroup Meetings	Early March
Recruit Workgroup Members	Early March
Brief Commissioners	March 13
Meeting 1	Week of April 8
Meeting 2	Week of April 22
Meeting 3	Week of May 6
Final Workgroup Comments on Reporting Instruction Edits	May 28
Release Final FY 2024 Reporting Instructions	July 1, 2024

Proposed Meeting Agendas

Meeting 1

- Introductions
- Brief background/history of Community Benefit reporting in Maryland
- Review workgroup charge and timeline
- Discussion topic: indirect cost ratios
    - Review hospital reporting results showing wide variation
    - Review current reporting instructions, which are tied to the HSCRC Annual Cost Report Schedule M, including consultation with HSCRC staff responsible for the Cost Report
    - Discuss options for revisions to reporting instructions
- Provide an overview of the agenda for next meeting

Meeting 2

- Introductions
- Review any follow-ups from previous meeting on indirect cost ratios
- Discussion topic: reporting CHNA-related expenditures
    - Review hospital reporting results showing wide variation
    - Review current reporting instructions
    - Review best practices identified in FY 22 reports
    - Discuss options for revisions to reporting instructions
- Provide an overview of the agenda for next meeting

Meeting 3

- Introductions
- Review any follow-ups from previous meeting
- Discussion topic: updates to reporting instructions
    - Staff to review draft changes based on discussions in previous meeting
    - Collect comments/feedback
- Summarize next steps for finalizing instructions