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627th Meeting of the Health Services Cost Review Commission

January 8, 2025

(The Commission will begin in public session at 12:00 pm for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 pm)

CLOSED SESSION
12:00 pm

1. Update on Administration of Model - 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 December 11, 2024 and December 19, 2024

Informational Subjects

2. Presentation by Johns Hopkins on Implementation of a Comprehensive Hospital-Based Addiction Program

Specific Matters

For the purpose of public notice, here is the docket status.

Docket Status – Cases Closed

2662A Johns Hopkins Health System
2663A Johns Hopkins Health System
2664A Johns Hopkins Health System
2665A Johns Hopkins Health System
2666A University of Maryland Medical Center
2634A University of Maryland ARM with Cigna - Extension Request

3. Docket Status – Cases Open

2667A University Of Maryland Medical Center
2668R Johns Hopkins Howard County Medical Center

Subjects of General Applicability

4. Report from the Executive Director

a. Model Monitoring
b. Discussion of Opportunity for Public Comment on HSCRC Volume Policies

5. Final Recommendation: High Cost Drug Funding Approach

6. Draft Recommendation: ED Best Practices Incentive Policy & ED Wait Times Activities

7. Hearing and Meeting Schedule

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Application for an Alternative Method of Rate Determination

University of Maryland Medical Center

January 8, 2025

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IN RE: THE APPLICATION FOR AN	*	BEFORE THE MARYLAND HEALTH	
ALTERNATIVE METHOD OF RATE	*	SERVICES COST REVIEW	
DETERMINATION	*	COMMISSION	
UNIVERSITY OF MARYLAND MEDICAL	*	DOCKET:	2024
CENTER	*	FOLIO:	2477
BALTIMORE, MARYLAND	*	PROCEEDING:	2667A

I. INTRODUCTION

On December 23, 2024, University of Maryland Medical Center ("Hospital") filed a renewal application for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital is requesting approval to continue to participate in a global price arrangement with OptumHealth Care Solutions, Inc. for solid organ transplant and blood and bone marrow transplants. The Hospital requests that the Commission approve the arrangement for one year beginning January 1, 2025.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

V. STAFF EVALUATION

Staff found that the experience under the arrangement for the last year has been unfavorable. According to the Hospital, the losses under this arrangement can attributed to several extraordinary outlier cases. Staff believes that absent these cases, the Hospital can again achieve favorable experience under this arrangement. However, if the experience under the arrangement during the next year continues to be unfavorable, staff will not recommend further approval.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination with OptumHealth Care Solutions, Inc. for solid organ transplant and blood and bone marrow transplants for one-year beginning January 1, 2025. The Hospital must file a renewal application annually for continued participation.

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

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Proposed Revisions to Outpatient High-Cost Drug Funding Policy

Final Recommendation

January 8th, 2025

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

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List of Abbreviations

340B	340B Drug Pricing Program[1]
AHEAD	States Advancing All-Payer Health Equity Approaches and Development Model
ASP	Average Sales Price[2]
Casemix	Patient-level discharge data submitted by hospitals to the HSCRC
CDS-A Drugs	Cost of Drugs Sold - Audit[3]
CMS	Centers for Medicare & Medicaid Services
GBR	Global Budget Revenue
NDCs	National Drug Codes
TCOC	Total Cost of Care Model

[1] The 340B Program requires pharmaceutical companies participating in Medicaid to provide outpatient drugs to clinics that serve certain low-income patients at significantly reduced prices.
[2] Medicare pays for certain Part B drugs through Average Sales Price (ASP) methodology. Most separately payable drugs and biologics are paid at a rate of ASP plus 6% according to CMS
[3] CDS-A stands for Costs of Drugs Sold – Audit and refers to the statewide list of high-cost physician-administered outpatient drugs meeting certain defined inclusion criteria, these criteria are listed in Appendix A. These drugs are subject to an annual audit to validate reported amounts and ensure appropriate funding.

Policy Overview

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/Consumers	Effect on Health Equity
Simplify the current policy to ensure high-cost drugs are adequately funded by making the policy more directly volume variable and reducing complexity in the decision-making process	Adjust volume funding to 100% of measured cost change from the audit and introduce a new annual evaluation report and penalties to maintain hospital incentives for cost efficiency	Hospitals would be 100% reimbursed for changes in high-cost drug volumes. Hospitals would be subject to an annual report to monitor the use of Part B drugs and potential penalties for inefficient cost management.	Annual report would allow HSCRC to monitor hospitals and ensure Part B drugs are efficiently managed to maximize value to payers and consumers	Shifting to 100% volume-based funding will help ensure the availability of life saving treatments regardless of insurance status, location or other demographic characteristics

Summary of the Recommendation

Currently, certain high-cost physician-administered drugs, known as “CDS-A drugs”, are financed via a special funding provision outside of the Global Budget Revenue (GBR) process that is 50% inflation-based and 50% volume-based. HSCRC Staff propose shifting the current CDS-A drug funding policy to 100% volume-based funding in order to simplify the policy and make funding more representative of actual costs at a hospital level. A new report would be instituted to monitor the impact of the changes on the cost of these drugs in Maryland.

Comment letters received were generally supportive of the major change anticipated by this policy. Based on the specific feedback, Staff have made some clarifying revisions to the policy which are outlined in the next section. The Recommendation section has been revised to reflect these changes. The Background and other informational portions of this recommendation are unchanged from the draft policy.

Summary of Comment Letters and Resulting Changes to the Proposed Policy

Overview

Comment letters were received from the Maryland Hospital Association, University of Maryland Medical System (UMMS), Johns Hopkins Health System (JHHS), Tidal Health and MedStar Health. The letters were all generally supportive of the proposed policy but raised a number of concerns about the implementation:

- MHA, TidalHealth, UMMS, JHHS and MedStar asked for clarification around the proposed future penalties and the process for assessing and applying them. UMMS raises concerns that the approach may not have been fully vetted with industry.
- MHA asked for clarification of the process for reviewing drug tiering noted in item 7 of the recommendation. UMMS suggested a more comprehensive review of how overhead is applied to drugs.
- MHA did not support a suggestion made during the draft recommendation discussion for the Commission to implement proactive review of drug efficacy and value. MHA felt hospitals were in the best position to complete this review.
- MHA asked for clarification on how the policy will be implemented operationally, at a rate center level.
- MedStar raised concerns about the time and effort involved in adding NDC to the casemix data but were supportive of the concept.
- TidalHealth raised concerns that the focus on volume changes could underfund price inflation on drugs and suggested a hospital should receive the higher of inflation or CDS-A adjustment in their drug funding.
- UMMS believes the Commission should give consideration to hospitals who are negatively impacted by the change in methodology and ensure that any negative adjustments for FY 2024 do not underfund growing expenses that hospitals may be experiencing in FY 2025.

- MHA, JHHS and UMMS supported the implementation of an additional optional rate adjustment, beyond the standard January 1 and July 1 adjustments, as discussed during the presentation of the draft recommendation. They suggested the use of a % rather than dollar threshold to be eligible for this adjustment.

Staff appreciate the commenters' general support for the proposed changes, the sections below discuss the comments received. Items where Staff are proposing a change to the policy are discussed first and then Staff's responses to other comments.

Clarification Regarding the 20% Penalty

As discussed in the Commission presentation and during the workgroup, shifting to a cost-based reimbursement system (which is the effect of this proposal) always raises the risk that cost control will no longer be prioritized by the funded organization. Staff included the 20% penalty as they felt it was important to create an "order-of-magnitude"-type reference point for potential penalties as the Commission enters this new territory.

Staff continue to believe this consideration is important but agree with commenters that (1) there was some inconsistency in description of the penalties in the original recommendation and (2) there is a lack of specificity around exactly how this will be implemented. In response to item 1, Staff clarified this final recommendation to more clearly state that the 20% is a percent of relevant CDS-A drug costs. On item 2, Staff purposely provided little specificity on the implementation as the report process has not yet been defined and it is unclear how targeted the reporting will be or what issues will be discovered. Therefore, Staff does not believe it is feasible to lay out greater detail at this time. Instead, Staff have revised this recommendation to specify that Staff will submit a revised recommendation to the Commission with greater detail on penalty parameters prior to the implementation of any penalties.

Staff also note that the report proposed in this recommendation was intended to address both the risk of poor cost control as well as the risk of lagging drug adoption. The language has been revised to clarify that penalties could be applied in either case.

Additional Voluntary Adjustment Date

At the request of the industry, during the presentation of the draft recommendation, Staff proposed an additional provision which would provide an accelerated update to drug funding for hospitals on March 1st of each year, in addition to those outlined in the draft recommendation, which follow the current July 1st and January 1st standard. A number of commenters were supportive of this recommendation.

Therefore, Staff have revised the recommendations in this policy to provide an option for hospitals to prepare and submit to Staff a projection of CDS-A drug costs for the current year and receive an update to funding, based on their projection, effective March 1st of that year. To be eligible for this funding adjustment the projection must show a cost increase above a minimum threshold established by staff and be subject to staff review and approval. Any funding received under this approach will be deducted from the future standard adjustments received under the base policy. Staff will work with industry to develop the specific process for the adjustment.

This approach will not change the amount of total funding received, because all changes to drug funding are made retrospective to their effective date, but it would accelerate the funding of some of current year cost growth from the next fiscal year to March 1 to June 30 of the current fiscal year.

Staff note this change adds complexity to the system. While HSCRC gives weight to operational simplicity in policy development, this change was recommended by industry stakeholders as important to the management of their finances. Also, because the adjustment is voluntary, only increases will be funded, whereas all other elements of the policy are simultaneously implemented whether positive or negative.

As noted above, the change does not have any impact on the total funding received by hospitals but does allow them to (1) reduce the impact on cash reserves of the gap between the time drug costs are incurred and funded and (2) better match the expense and income related between periods. Staff does not believe either of these

criteria have a strong policy impact as most Maryland hospitals are allowed to carry cash and investment balances many times greater than the drug costs increases they face. Further, the periods in which income and losses are recorded by not-for-profit institutions has less significance for public reporting requirements. Staff do believe that in the future, if the timing of income recognition is to be a significant element in policy evaluation, the Commission should also consider including hospital investment income as an element in policy development–particularly if the accommodation adds administrative complexity

Staff Response on Other Comments

Drug Rate Tiering: The expectation for hospitals to follow this practice has been well established, however, Staff recognize it has not been a subject to review of late. Staff are completing some initial analysis and intend to work with industry starting in the spring to review this topic. The initial work will focus on understanding current policy and practice and working with industry to refine and implement the existing guidance, no punitive action is expected in the near term. As part of the review of the Annual Filing Staff are also reviewing the overhead assignment process.

Prospective Review of Drug Selection: Staff agree with the commenter that primary responsibility for selecting the appropriate drugs should lie with the hospital. Staff are also concerned that they do not have sufficient bandwidth or expertise to support hospitals on a prospective basis. Staff will work with the selected report consultant to accelerate the timeliness of any recommendations so that hospitals can focus quickly on any areas of concern.

Policy Operationalization: Staff recognize industry concerns about the details of policy implementation (e.g. addition of NDC to Casemix). Staff will work with industry on the various operational considerations raised and believe established processes are sufficient to address these concerns.

Inflation Funding: Staff believe drug price inflation is sufficiently addressed through three elements of proposed and existing policies: (1) Inflation based on non-CDS-A drugs is covered in the update factor, (2) same-drug price inflation based on CDS-A

drugs will be covered under the update factor in accordance with this policy[4], (3) a significant portion of drug price inflation is actually switching to new drugs, as this is considered a volume change under the policy and volume changes are always funded at the most recent price, this inflation is covered under the volume elements of this policy. As a result, staff do not believe providing funding at the higher of CDS-A or inflation is needed.

Consideration to Hospitals Who are Negatively Impacted: The proposed policy provides funding at 100% of drug cost effective with Fiscal Year 2024, Staff do not believe any hospitals are negatively impacted by this change in a way unrelated to their drug cost experience but as noted above will work with the industry on operational details.

Background

In HSCRC's rate setting process, certain high-cost drugs paid under the medical benefit, also known as Medicare Part B drugs, are subject to special funding provisions outside of the Global Budget Revenue process. These drugs are referred to as "CDS-A drugs" and include high cost, physician-administered, outpatient, oncology and infusion drugs as well as biologics. CDS-A drugs are determined annually based on a set of criteria established by staff in consultation with industry stakeholders. The current criteria can be found in Appendix A. Currently hospitals are funded for CDS-A Drug cost changes via two pathways: 50% of funding comes from volume adjustments and the other 50% comes from the prospective price inflation factor, which is applied to CDS-A Drugs during the update factor. The current CDS-A approach was implemented in 2016 to recognize high Part B drug trends. The high-cost drug trends decreased later in the decade but began to accelerate again in Fiscal Year 2023 - the Staff expects this acceleration will continue into Fiscal Year 2024. Implementing this policy was necessary as these disproportionate trends were not being addressed by standard GBR policies. The policy was intended to provide extra funding for hospitals experiencing high-cost drug trends while still controlling spending on these drugs. In addition to clinical benefits for patients,

[4] Staff track same-drug price trends as part of the CDS-A policy evaluation and it is typically very limited, most inflation results from the adoption of new drugs.

high-cost drugs should reduce the need for acute hospitalization and other expensive services and therefore their adoption is strongly aligned with the goals of the Maryland Model.

Current Policy

Overview

Hospitals currently receive funding for CDS-A drugs via a 50/50 blend of specific volume-based funding and across the board inflation funding. Volume-based funding is provided either at Medicare's "Average Sales Price" (ASP) or 340B pricing, depending on whether a hospital qualifies for the 340B program. Volume adjustments are based on Casemix reporting and validated by staff via an audit process to ensure hospitals' volumes are appropriately reported.

Inflation funding is included in the annual Update Factor. Amounts are estimated by staff based on historical data and applied to each hospital's CDS-A drug spending. Since the inflation factor is prospective, it is estimated using data from two years prior, so funding tends to lag behind the actual inflation trends under the current policy.

The intention behind this two-lever policy was to incentivize hospitals to manage the high cost of administering these drugs:

- Hospitals that move to lower cost drugs benefit by retaining 50% of the drug cost in their GBR.
- Hospitals can also benefit by "beating" the average prospective inflation by negotiating prices with suppliers. However, 340B prices generally start lower and these participating hospitals may have less opportunity to negotiate.
- Hospitals absorb 50% of volume increases; therefore, a hospital that fails under the prior bullets will lose money under the policy.

The current approach operates under the assumptions that every hospital will have an equal opportunity of success under this policy and that the impact of new high-cost drugs would be evenly distributed because the inflation factor is set on a statewide basis.

Even though HSCRC has provided different inflation factors for academic hospitals[5], it would not be operationally feasible to accurately estimate hospital specific inflation factors for every hospital; therefore, differential inflation experience will never be fully captured under the current policy.

The funding described in this section pertains only to the direct costs of acquiring the covered drugs. It does not impact the funding provided for the administration of drugs or hospital overhead (i.e. a $10,000 increase in funding under this policy increases total funding by only $10,000, there are no additional overhead loads). An important component of current policy is that hospitals are expected to "tier" their charges so that the loads applied to high-cost drugs are less than those applied to lower cost drugs, in percentage terms, as the cost of administration and overhead does not increase proportionally with the drug cost. Staff intend to continue this expectation and increase oversight to ensure it is applied.

Policy Impact

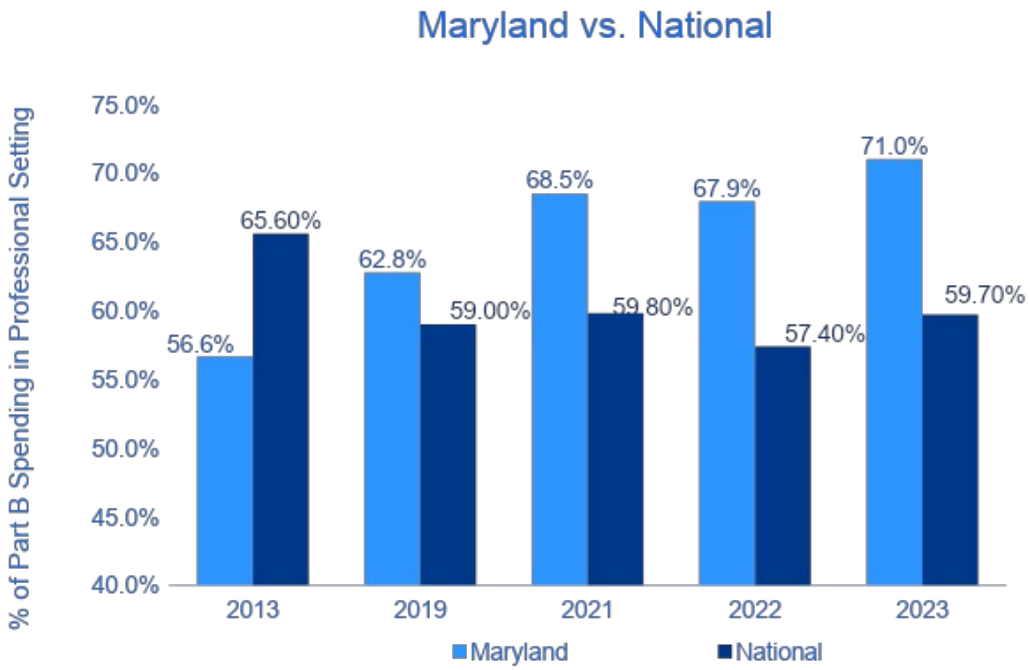
In FY23, HSCRC estimated that the average hospital was overfunded by 0.4% of total GBR based on the two-pathway drug funding approach, with the median hospital being overfunded by an estimated 0.24%.

Maryland has been successful in shifting administration of Part-B drugs to the professional setting rather than the hospital. In 2023, 71.0% of Part-B spending was in the non-hospital setting (that is drugs were billed as professional rather than facility claims), compared to 59.7% for the nation as a whole, which effectively reversed the site of care shares that existed prior to global budgets in 2013 (see Figure 1). Staff estimate that the Part B place of service changes generated Medicare run rate savings of ~$180 million dollars since 2013 under the Total Cost of Care Model (TCOC Model)[6].

[5] In 2024, HSCRC provided a separate inflation factor for academic hospitals due to differing inflation trends. This had not been done previously

[6] *CDS-A Drugs are billed under Medicare Part B and therefore are part of the model savings test. See July 2025 TCOC workgroup materials for further information on model savings. (https://hscrc.maryland.gov/Pages/hscrc-tcoc.aspx)*

Figure 1: Maryland Model Impact on Part B Drugs



Issues with current funding approach

Both the inflation and the volume lever cause challenges for providing accurate funding. While the current approach does vary based on volume, the combination of prospective inflation and 50% volume funding do not reliably match the actual hospital experience. Even if funding is accurate at the statewide level, variation in cost and volume at the hospital level will result in over/underfunding for individual hospitals. Hospitals facing the highest cost pressures are the most likely to be underfunded.

The prospective inflation factor is unlikely to be accurate given the rapidly changing nature of the CDS-A drug market and the two-year data lag. This volatility in the market creates a funding stream at the statewide level that lags the actual needs of hospitals, causing overfunding in times of slow drug cost growth, and under funding in times of high drug cost growth.

Additionally, changes in drug mix receive overlapping funding, as they are considered in both the volume and inflation adjustments. The complexity of this two-track funding policy creates confusion and results in suboptimal decision making, and shifting to a one-track approach would give stakeholders a clearer understanding of the funding approach.

Case for Changes to Cost Reimbursement

Staff believe that now is an appropriate time to change this policy. Currently, hospitals are appropriately funded for CDS-A drugs through FY2023, which means that this policy can be modified without requiring adjustment to current funding levels. The current two-tiered structure makes it difficult to project how these two funding streams will interact in any given situation. This complexity makes it difficult for the HSCRC to administer, hospitals to operationalize, and also risks creating confusion at hospitals about how drug costs will be reimbursed which could adversely impact appropriate adoption of new drugs. Additionally, there are indications that cost growth is shifting primarily towards a small volume of high-cost drugs administered at select hospitals, which the current approach is poorly equipped to handle.

The CDS-A approach is already a volume variable component in GBRs as scored under the TCOC Model[7]. Therefore, making changes to it does not impact that test. However, the current policy has been effective in generating total cost of care savings, which HSCRC should strive to maintain under any proposed policy change.

Staff Recommendation

To simplify the CDS-A policy, HSCRC Staff propose to make it more directly volume variable. This policy will consist of the following components:

[7] Under the TCOC Model Maryland is required to "ensure that 95 percent of all 17 Regulated Revenue for Maryland residents is paid according to a Population-Based Payment methodology". The CDS-A drug funding policy does not meet this standard and is therefore scored against the 5% exception under this provision. It accounts for approximately 2% of total charges.

1. Continue to identify high-cost drugs for volume-based funding based on criteria set by Staff in consultation with industry stakeholders (see Appendix A for current criteria)
2. Continue to conduct an audit of reported volumes to ensure volume-based reimbursement is fairly stated
3. Change volume funding to 100% of measured cost change, per the annual audit, effective 1/1 each year.
4. Implement two provisional adjustments for each year, one on March 1st and one on July 1st, to smooth the impact of the increased adjustment size:
    a. The March 1st adjustment will be voluntary and based on a projection of current year spending prepared by the hospital. To be eligible for this funding adjustment the projection must show a cost increase above a minimum threshold established by staff and be subject to staff review and approval.
    b. The July 1st adjustment will be automatic and based on the first 6 months of data from the prior fiscal year. The adjustment will be directly calculated by staff using Casemix data, excluding drugs with outlier dosage counts. No manual adjustments will be made to this adjustment. The impact of any adjustment made in the prior March 1st adjustment will be deducted.
    c. Provisional adjustments will be temporary only, final adjustment derived from the audit will supersede the provisional adjustment and all amounts will be trued up to the final audit.
5. Set the drug component of inflation in the update factor to only reflect any price inflation not captured during the volume adjustment;[8] inflation on drugs will primarily be provided through the volume adjustment
6. Implement a new annual report, produced by a consultant, to identify hospital effectiveness in managing CDS-A drugs and assess penalties of 20% of

[8] If the price of a drug changes and there is no volume change, the volume adjustment will not capture that inflation; therefore, a small allowance is needed in the Update Factor for this impact.

relevant CDS-A drug costs, to hospitals that are not meeting target goals. Prior to the implementation of any penalties a revised version of this policy will be developed, with stakeholder input, that specifies in greater detail the approach for any penalties assessed. Further details are outlined below.

7. Hospitals will continue to be expected to "tier" charges for drugs. Staff will periodically evaluate hospital tiering of drug prices to ensure high-cost drugs are not being loaded with proportionate overhead, resulting in unfair costs to consumers.
8. Continue to audit data reported in Casemix to validate amounts reported and gather appropriate ASP and 340B price data.

Staff recommend implementing the revised policy retrospectively for FY2024, effective 1/1/2025. As volume adjustments under this policy were always implemented retrospectively, HSCRC Staff believe it is appropriate to implement in FY25 for FY24. Policy timelines can be found in Appendix B.

New Reporting Requirements

In order to maintain incentives to appropriately control cost growth of CDS-A drugs under this new policy, HSCRC proposed additional reporting requirements via an annual report. 100% volume-based cost reimbursement does not provide the same incentives to manage costs effectively as the current policy. Therefore, the HSCRC will contract for an annual report to monitor the State's use of Part B drugs both in terms of cost management and adoption of effective new drugs. If this report finds an erosion in the appropriateness of Maryland spend, GBR reductions equal to 20% of relevant CDS-A drug costs will be assessed on a statewide, regional, or hospital basis, depending on the extent of the concern. However, prior to the implementation of any penalties a revised version of this policy will be developed, with stakeholder input, that specifies in greater detail the approach for any penalties assessed. This annual report would become the basis for these and any future policy changes.

The annual report will be compiled by a consultant with a background in Pharmaeconomics and other relevant topics. HSCRC has enlisted the Prescription Drug Affordability Board (PDAB) to aid us by managing this report. The report will focus on the following factors regarding high-cost drugs:

- Place of service use rates
- Generic and biosimilar use rates
- Adoption rate of new drugs
- Acquisition pricing

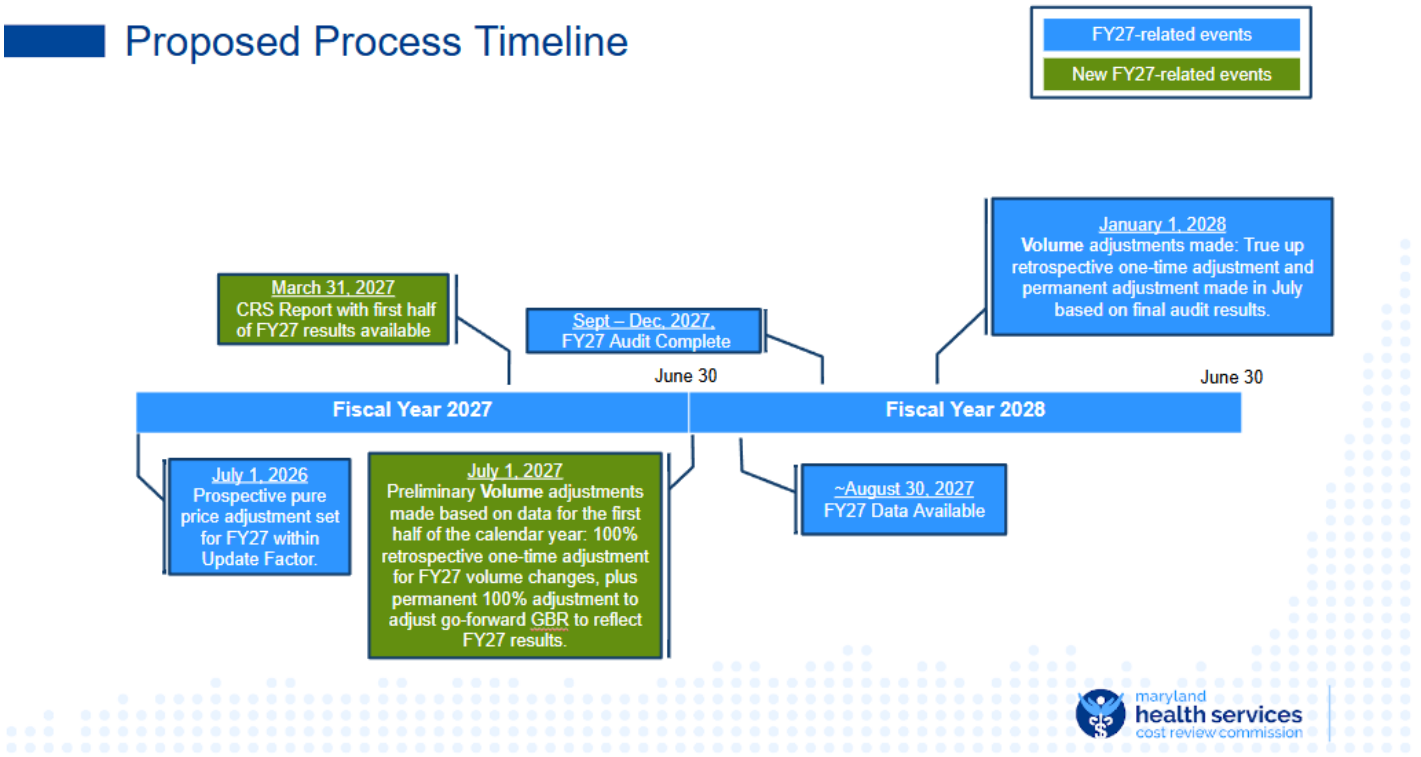
This report will allow the HSCRC to effectively evaluate whether the policy change is impacting the efficiency of high-cost drug utilization in Maryland and examine additional opportunities for improved utilization efficiency and effectiveness. In the new report, Staff will require NDCs to be collected as part of Casemix data. HSCRC expects that the first report will be released in late CY2025 based on FY25 data to assess the baseline metrics and initial impacts of this policy change. The report would be released annually thereafter.

Appendix A: Criteria for Drugs to be Treated under CDS-A Policy

The state-wide list is composed of Billed High-Cost Physician-Administered Outpatient Infusion, Chemotherapy, & Biological Oncology Drugs meeting all the following criteria:

- 3M's EAPG Class Code of VII or higher in either of the past two fiscal years (to reference relatively high cost per patient visit), and
- State-wide case-mix charges in either of the past two fiscal years of $2 million or greater (to reference relatively high-cost utilization), and
- Market share by point of service of less than 90% at physicians' offices (to minimize inclusion of drugs best served outside of a hospital setting), and
- An Ambulatory Payment Classification - OPPS Payment Status Indicator of G or K, Paid under OPPS/Separate APC payment (to preclude drugs packaged under other charge codes), and
- Inclusion of alternate codes for same listed drug (so to capture brand, generic, biologic, biosimilar, replacement, discontinued and temporary codes)

Appendix B: Policy Timeline



Note: Graphic does not reflect March 1st voluntary adjustment.

MedStar Health

8094 Sandpiper Circle
Suite G
Nottingham, MD 21236

MedStarHealth.org

November 27, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Executive Director Kromm,

On behalf of MedStar Health System (MedStar) and its seven Maryland hospitals, I write in support of the proposed changes to the Health Services Cost Review Commission (HSCRC)'s high-cost drug funding policy, known as CDS-A, presented during the November 13, 2024 HSCRC public session. HSCRC staff's recommendation to change the CDS-A policy to provide 100% cost reimbursement for the direct cost of the drugs covered under it eliminates some of the complexity associated with funding hospitals for these high-cost but critical drugs and is a prudent action to take as Maryland prepares for the start of the AHEAD model in 2026.

While overall supportive of HSCRC staff's recommendation, MedStar does however have concerns regarding the proposed annual report to monitor the State's use of Medicare Part B drugs. As described in the staff's recommendation, this report is intended to highlight any erosion in the efficiency of Maryland spending compared to 2023 levels. HSCRC staff is proposing to use this report to reduce hospital GBRs by up to 20% of CDS-A spending if there is a determination that erosion has occurred, and additionally, use the report for future policy changes. While MedStar agrees that changing the CDS-A policy to fund 100% of drug cost does not maintain the same incentives for hospitals to manage costs effectively, we are concerned about the vague definition of 'efficiency' as it relates to the utilization of these drugs. Given the magnitude of a 20% GBR adjustment for hospital revenue, MedStar suggests that HSCRC staff more clearly define how efficiency will be measured and who they intend to contract with to ensure the report is completed by an organization with the appropriate expertise. Additionally, the requirement that NDCs be collected as part of hospital case mix data will require hospitals and health systems to devote a significant amount of time to revising data submission systems and processes. While we understand the importance of collecting this data, MedStar encourages staff to establish deadlines for this requirement that are in line with the effort required.

MedStar looks forward to the final Staff Recommendation at the December 2024 Commission meeting. If you would like to discuss this matter further or have any questions, please do not hesitate to contact me.

Sincerely,

Mike Wood
Vice President, Revenue Management & Reimbursement
MedStar Health

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi

Maryland
Hospital Association

Dec. 6, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm,

On behalf of the Maryland Hospital Association (MHA) and its member hospitals and health systems, I am writing to comment on the Health Services Cost Review Commission (HSCRC) draft recommendation to shift the current CDS-A drug funding policy to a 100% volume-based funding model.

MHA supports the proposed policy change, which aims to more accurately reflect actual acquisition costs for high-cost drugs. We support the proposed alternative option that would allow hospitals to access an interim update in the current fiscal year, on March 1, based on projected spending. This approach supports financial stability by aligning cost increases with the corresponding revenue within the same fiscal year. HSCRC should consider whether a percentage-based threshold, rather than a dollar amount threshold, would be more appropriate for determining access to an earlier interim update for smaller hospitals.

Before finalizing the policy, MHA asks that HSCRC address the following proposed policy elements to ensure it is effective and implementable.

- **Penalties for Not Meeting Target Goals**. Clarification is needed regarding the drug cost target goals and assessment of penalties if hospitals do not meet the target based on findings in a new annual report. The proposal suggests that an erosion in the efficiency of Maryland spending from 2023 levels would be the basis for assessing a penalty. Under the proposal, global budget revenue (GBR) reductions "equal to 20% of CDS-A spending" would be assessed on a statewide, regional, or hospital basis. The proposal also states that penalties would be assessed to hospitals not meeting target goals "up to 20% of drug cost." As proposed, there is uncertainty about whether the penalty would be calculated as up to 20% of the specific drug cost that is off target or as a reduction in the GBR equal to 20% of all CDS-A spending. Additionally, we request more details on how these penalties will be assessed, including whether they will apply to specific drugs or drug classes and how they will be allocated at the statewide, regional, or hospital level, and urge the HSCRC to outline the specific metrics and criteria a consultant will use to evaluate utilization efficiency under the new reporting requirement for CDS-A drugs.

- **Drug Charge Tiering Oversight.** During the November HSCRC public meeting, the need for drug tiering oversight was discussed. We ask for clarification on the

requirements for tiering drug overhead costs and how tiering expectations will align with current drug charges and cost requirements. Tiering requirements must be clear before implementing any evaluation or other oversight measure.

- **Proactive Drug Review.** A suggestion was made to implement a proactive drug review process to assess the clinical efficacy and value of high-cost drugs before approving them for funding under the policy for CDS-A drugs during the November HSCRC meeting. Hospitals are in the best position to perform this type of evaluation through pharmacy and therapeutics committees and other processes already in place to ensure high-value drugs.

- **Operational Considerations.** MHA encourages HSCRC to consider practical operational implications to ensure smooth implementation of this policy. Specifically, we request clarification on how rate center adjustments will be made under the new policy.

In conclusion, we support the transition to a 100% volume-based funding approach for CDS-A drugs. We look forward to working with HSCRC to ensure that the policy appropriately funds and provides access to high-cost drugs in a manner that can be easily operationalized.

We appreciate the opportunity to provide feedback on this important matter. Should you have any questions, please feel free to reach out to me.

Sincerely,

Patrick D. Carlson

Patrick D. Carlson
Vice President, Health Care Payment

cc: Dr. Laura Herrera-Scott, Secretary, Maryland Department of Health
Dr. Joshua Sharfstein, Chair
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi

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

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

December 9, 2024

Dr. Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Dr. Kromm,

Thank you for the opportunity for Johns Hopkins Health System (JHHS) to provide comments to the Health Services Cost Review Commission (HSCRC) on the Draft Recommendation for Proposed Revisions to the Outpatient High-Cost Drug Funding Policy.

JHHS appreciates the HSCRC's willingness to continue to review and better align polices under the current model as the industry evolves and innovates. We are generally very supportive of the staff recommendation, specifically:

- We support 100% funding for high-cost drugs, especially as the cost of many of these drugs continues to increase. It is important that hospitals receive adequate funding for these lifesaving drugs.

- We support a provisional adjustment period but believe funding should flow into hospital rates in the year that the increase in expense is occurring. Many high-cost drugs are increasingly used to treat various conditions, and some are now curative for patients who previously would have suffered from chronic conditions, in turn significantly increasing the expense of delivering these treatments. Given this expense increase, we strongly believe that it is important for the revenues to match expenses in the same fiscal period.

- We are also supportive of implementing this change with the 1/1/25 rate order as this is consistent with the way the policy is currently applied.

The recommendation also lays out new reporting requirements and possible associated penalties. We believe that more information is required to ensure hospitals fully understand these new requirements and assure that they are reasonably aligned with good patient care as well as the

intent of the model. We are also concerned about the intent of the penalties being considered since we are talking about only covering the actual cost of the drug.

JHHS appreciates the opportunity to comment on the Outpatient High-Cost Drug Funding Policy. We look forward to working with staff to continue to review polices to better align them under the current system.

Sincerely,

Ed Beranek

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

cc: Dr. Joshua Sharfstein, Chairman
Dr. James Elliott
Ricardo Johnson
Dr. Maulik Joshi
Adam Kane
Nicki McCann
Dr. Farzaneh Sabi
William Henderson

TidalHealth™

Peninsula Regional

100 East Carroll Street
Salisbury, MD 21801

(410) 546-6400

December 9, 2024

Jon Kromm, PhD
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215 re

Dear Dr. Kromm,

We are writing to submit several comments on the recommended changes to the CDS-A Drug Funding Policy. We are in support of enhanced funding for high-cost drugs shifting from 50% to 100% volume-based funding with the following considerations:

(1) Making sure that future update factors still appropriately fund all hospitals pharmacy inflation by making sure certain hospitals are not penalized by redirecting funding to only high-cost drugs with volume changes. This could be done by providing the higher of drug inflation or the CDS-A formula.

(2) We do believe and agree that monitoring growth in funding will be important as to ensure that the new policy addresses inadequate level of drug funding but does not have other unintended consequences. We do not agree that a penalty should be put in place without clarity on what specifically would drive a penalty application.

(3) While this policy is being refined and other policies are being reviewed to provide enhanced funding for areas that drive significant cost growth (i.e. capital and volume), we continue to support and champion the need for a GME Policy for Rural Communities as it will be a significant cost pr4ssure but is needed to provide the gaps in physician coverage. The AHEAD Model reduces the amount of dollars required under the Global Budget and consideration/funding outside of the GBR should be given to address unique issues facing rural communities that cause access barriers and equitable care.

We appreciate the opportunity to submit our comments.

Sincerely,

Kathy Talbot

Kathy Talbot
Associate Vice President of Finance

Cc:
Joshua Sharfstein, Chair HSCRC
Dr. James Elliott, Commissioner
Richardo Johnson, Commissioner
Dr. Maulik Joshi, Commissioner
Adam Kane, Commissioner
Nicki McCann, Commissioner
Dr. Farzaneh Sabi, Commissioner
William Henderson

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

250 W. Pratt Street
24th Floor
Baltimore, MD 21201-6829
www.umms.org

CORPORATE OFFICE

December 9, 2024

Jon Kromm
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: UMMS Comment Letter Regarding Proposed Revisions to Outpatient High-Cost Drug Funding Policy

Dear Jon:

On behalf of the University of Maryland Medical System (UMMS) and its member hospitals, we are writing today in response to the Commission's Proposed Revisions to Outpatient High-Cost Drug Funding Policy. UMMS supports the Commission's proposal to fully fund the expense associated with high-cost outpatient drugs. As an industry, we are seeing an acceleration in the development and use of high-cost drugs, biologics and cell therapies and the commission's proposal provides much needed funding to support the delivery of new technology and advanced care to the citizens of Maryland. While we are generally supportive of the proposed funding approach, we would also like to address some areas of concern in the policy as written.

FY 2024 Implementation

Given the rising costs of emerging high-cost drugs and biologics, UMMS supports implementing changes to the CDS-A policy in a timely manner. The Commission should give consideration to hospitals who are negatively impacted by the change in methodology and ensure that any negative adjustments for FY 2024 do not underfund growing expenses that hospitals may be experiencing in FY 2025.

Timing of Mid-Year Adjustments

UMMS supports the continuation of a July 1 mid-year CDS-A funding adjustment with an additional provision that additional funding may be given in March should a hospital's actual experience exceed a certain threshold. We agree with MHA that this threshold should be set as a percentage of cost rather than a specific dollar amount. This is especially important as the average cost and number of new biologics and cell therapies coming into the market are on the rise, causing significant strains on hospital margins.

Part B Drug Use Monitoring

UMMS has concerns regarding the application of penalties on hospitals for shifts in the site of service for infusions. The Commission should vet new policies or methodologies which have implications on hospital revenue with the industry prior to putting the policy forward for approval. Hospitals were not afforded the

opportunity to comment on this new addition and are uncomfortable supporting this undefined portion of the CDS-A drug funding policy without industry vetting of the methodology.

Drug Pricing

Given the concerns raised related to markups on high-cost drugs, UMMS suggests the Commission convene an industry workgroup to develop a more reasonable and consistent approach to establishing overhead amounts for supplies and drugs. Disproportionate overhead amounts contribute to the higher markups required to maintain unit rate compliance.

We appreciate the opportunity to provide feedback on the Proposed Revisions to Outpatient High-Cost Drug Funding Policy. Please let us know if you have any additional questions.

Sincerely,

Alicia Cunningham
SVP, Reimbursement & Revenue Advisory Services
University of Maryland Medical System

cc: Joshua Sharfstein, MD Chairman
James Elliott, MD, Vice Chairman
Adam Kane
Maulik Joshi, DrPH
Ricardo R. Johnson
Nicki McCann, JD
Farzaneh (Fazi) Sabi, MD
William Henderson, Principal Deputy Director

maryland
health services
cost review commission

Draft Recommendations on Hospital Best Practice Policy for Rate Year 2027

January 8, 2025

This document contains the staff draft recommendations for RY 2027. Comments are due by noon 1/17/2025 and may be submitted to hscrc.quality@maryland.gov.

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

Table of Contents

List of Abbreviations

AHEAD	State's Advancing All-Payer Health Equity Approaches and Development Model
APR DRG	All Patient Refined Diagnosis Related Group
CDC	Centers for Disease Control & Prevention
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis-Related Group
eCQM	Electronic Clinical Quality Measure
ED	Emergency Department
ED-1 Measure	Emergency Department Arrival to Departure for Admitted Patients
ED-2 Measure	Time of Order to Admit until Time of Admission for ED Patients
EDDIE	Emergency Department Dramatic Improvement Effort
FFY	Federal Fiscal Year
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HSCRC	Health Services Cost Review Commission
LOS	Length of Stay
MIEMSS	Maryland Institute for Emergency Medical Services Systems
NHSN	National Health Safety Network
PQI	Prevention Quality Indicators
QBR	Quality-Based Reimbursement
RY	Maryland HSCRC Rate Year (Coincides with State Fiscal Year (SFY) July-Jun; signifies the timeframe in which the rewards and/or penalties would be assessed)
VBP	Value-Based Purchasing

POLICY OVERVIEW

Policy Objective	Policy Solution	Effect on Hospitals	Effect on Payers/ Consumers	Effect on Health Equity
The quality programs operated by the Health Services Cost Review Commission, including the Best Practices policy, are intended to promote quality improvement and ensure that any incentives to constrain hospital expenditures under the Total Cost of Care Model and subsequent AHEAD model (Maryland Model), do not result in declining quality of care. Thus, HSCRC's quality programs reward quality improvements and achievements that reinforce the incentives of the Maryland Model while guarding against unintended consequences and penalizing poor performance. The objective of implementing a Hospital Best Practice Policy is to track and incentivize hospitals to implement and strengthen operational structures and processes, which are designed to provide high quality, evidence-based care to all patients, at all times.	The Best Practice policy is a newly proposed pay-for-performance quality initiative that provides incentives for hospitals to improve and maintain high-quality patient care and value within a global budget framework. For Year 1, RY 2027, we propose to focus on best practices related to hospital throughput, that should ultimately reduce ED LOS. Specifically, during Year 1, HSCRC staff will collaborate with hospitals to finalize the best practices and tiers, develop infrastructure for data collection, and disseminate statewide monitoring reports to track performance. Hospitals will be expected to participate in the implementation of best practices and submission of data for tracking by an agreed upon deadline to avoid an "accountability" penalty of 0.1 percent of all-payer, Inpatient revenue. This penalty will be applicable to any hospital that does not implement and report on the selected best practices. This approach will allow sufficient time to establish workflows, report development, and validate data collection mechanisms. This Best Practice policy will initially focus on ED-Hospital Throughput Best Practices but is written with the intention of developing and standardizing best practices for various clinical processes and operations as appropriate.	For program Year 1, RY 27, hospitals will be required to implement or strengthen best practices designed to improve patient care and throughput and report data to the HSCRC to track intensity and fidelity to the best practices. For Year 1, there is no revenue at risk associated with performance. There will be an accountability penalty for not reporting on best practice measures. This penalty will be 0.1% of all-payer, inpatient revenue, to be assessed in the January 2026 rate update. We will follow our extraordinary circumstances exception policy to address any unforeseen events (i.e. cyberattack, natural disaster, etc.). For program Year 2, RY 28, we recommend 0.25% inpatient revenue at risk associated with performance on designated best practice measures. This will be reassessed at the end of Year 1 after evaluating the impact of the best practices	This policy ensures that the quality of care provided to consumers is evidence-based and patient-centered. by incentivizing specific types of best practices to address areas of concern. Hospitals that do not participate in implementation and data tracking of best practices, will be penalized through their Global budget. The HSCRC quality programs are all-payer in nature and so improve quality for all patients that receive care at the hospital.	There is currently not a health equity measure in the Best Practice policy, but we can stratify data collected to evaluate for health disparities. Health equity incentives could be integrated in a subsequent rate year. Standardization of Best Practices across all patients should better ensure that all patients receive the same evidence-based interventions. By focusing on structures and processes, this program will allow all hospitals the potential to earn rewards regardless of the types of patients served or other barriers that hospitals may face that may also impact outcomes such as ED LOS. Going forward, HSCRC staff will continue to analyze disparities and propose incentives for reducing them in the program.

Draft Recommendations

This document puts forth for consideration the RY 2027 (CY 2025 performance period) draft policy recommendations on hospital best practices:

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).
    a. For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2027.
    a. Failure to implement and report data to the Commission by October 2025 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2026.
3. We propose that subsequent rate years will have 0.25 percent inpatient hospital revenue at risk tied to performance on these best practice metrics but intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

INTRODUCTION

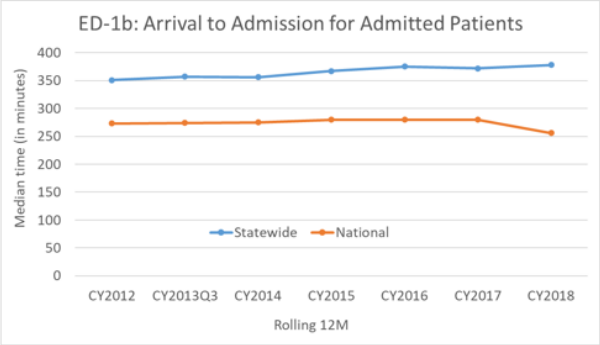
Maryland hospitals are funded under a population-based revenue system with a fixed annual revenue cap set by the Maryland Health Services Cost Review Commission (HSCRC or Commission) under the All-Payer Model agreement with the Centers for Medicare & Medicaid Services (CMS) beginning in 2014, and continuing under the current Total Cost of Care (TCOC) Model agreement, which took effect in 2019 and will transition to the AHEAD Model in 2026. Under the global budget system, hospitals are incentivized to shift services to the most appropriate care setting and simultaneously have revenue at risk under Maryland's unique, all-payer, pay-for-performance quality programs; this allows hospitals to keep any savings they earn via better patient experiences, reduced hospital-acquired infections, improved emergency department length of stay, or other improvements in care. Maryland systematically revises its quality and value-based payment programs to better achieve the state's overarching goals: more efficient, higher quality care, and improved population health. It is important that the Commission ensure that any incentives to constrain hospital expenditures do not result in declining quality of care. Thus, the Commission's quality programs reward quality improvements and achievements that reinforce the incentives of the global budget system, while guarding against unintended consequences and penalizing poor performance.

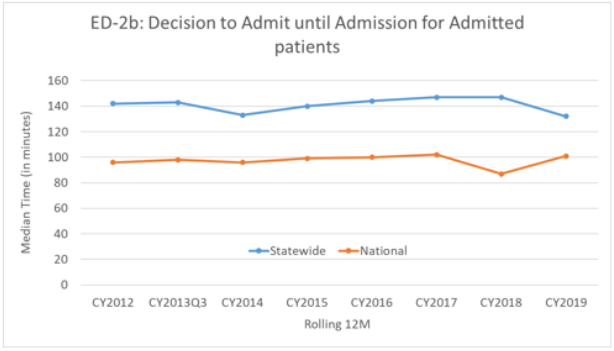
The Hospital Best Practice Policy is a new program that is being proposed for Commissioner consideration. The Best Practice Policy would be one of several quality pay-for-performance initiatives that provide incentives for hospitals to improve and maintain high-quality patient care and value over time. However, unlike other quality policies that primarily focus on outcomes of care, the Best Practice policy would specifically provide incentives tied to the structure and process of care delivery in Maryland hospitals. During this initial year, the policy will incentivize hospitals to improve upon ED and hospital throughput to address the long ED LOS experienced by patients in Maryland. Specifically, the commission will refine a set of up to six best practices for RY 2027 and require hospitals to select and report data on two best practices by the latter part of CY 2025. If data is not submitted by hospitals in Year 1, an accountability penalty will be implemented. After the initial year focused on development, implementation and reporting, the program will have a designated percentage of inpatient hospital revenue at-risk based on performance on best practice measures. In addition to this Best Practice policy, the RY 2027 Quality-Based Reimbursement Policy, which was approved at the December 2024 Commission meeting, has a financial incentive tied ED LOS. The ED-Hospital Throughput best practice measures are process and structural measures aligned to support the outcome measure, ED LOS, in the QBR program.

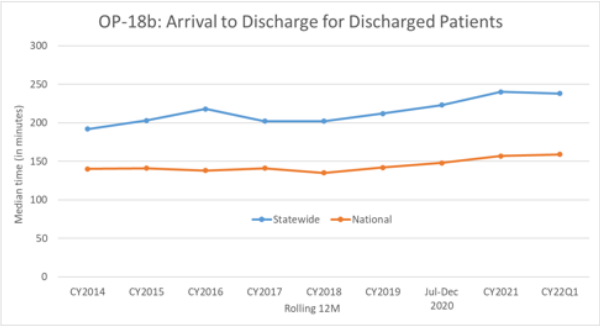
BACKGROUND

ED length of stay (LOS)--i.e., wait times–has been a significant concern in Maryland, predating Maryland's adoption of hospital global budgets instituted in 2014,[1] with multiple underlying causes and potential negative impacts (e.g., poorer patient experience, quality, care outcomes). Thus, the Commission approved the addition of an ED wait time or length of stay (LOS) measure in the RY 2026 QBR program and voted to continue its inclusion in RY 2027. Previously published and available data on CMS Care Compare reveals Maryland's poor performance compared to the Nation on both inpatient and outpatient ED measures (i.e., higher wait times for both those admitted to the inpatient hospital and those discharged home), as shown in Figure 1.

Figure 1. Emergency Department Performance on CMS ED Wait Time Measures





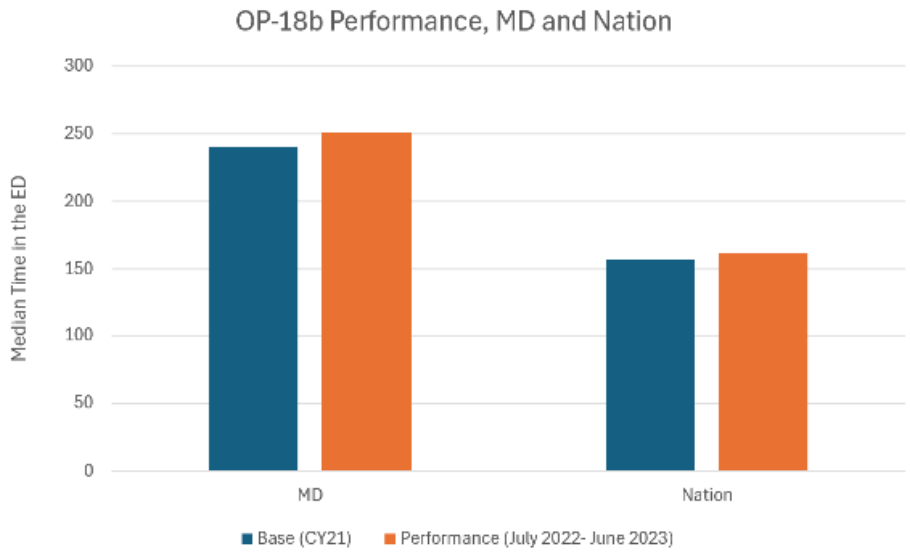


Measure ID	Measure Definition
ED-1	Median time from ED arrival to departure for admitted patients
ED-2	Median admit decision time to ED departure time for admitted patients
OP-18	Median time of ED arrival to departure for discharged patients

As illustrated in Figure 2 below, based on the most current data available, the OP-18b wait time for discharged patients has increased slightly for both Maryland and the Nation from the base to the performance year, and Maryland wait times continue to be significantly above those of the Nation for both the base and performance years.

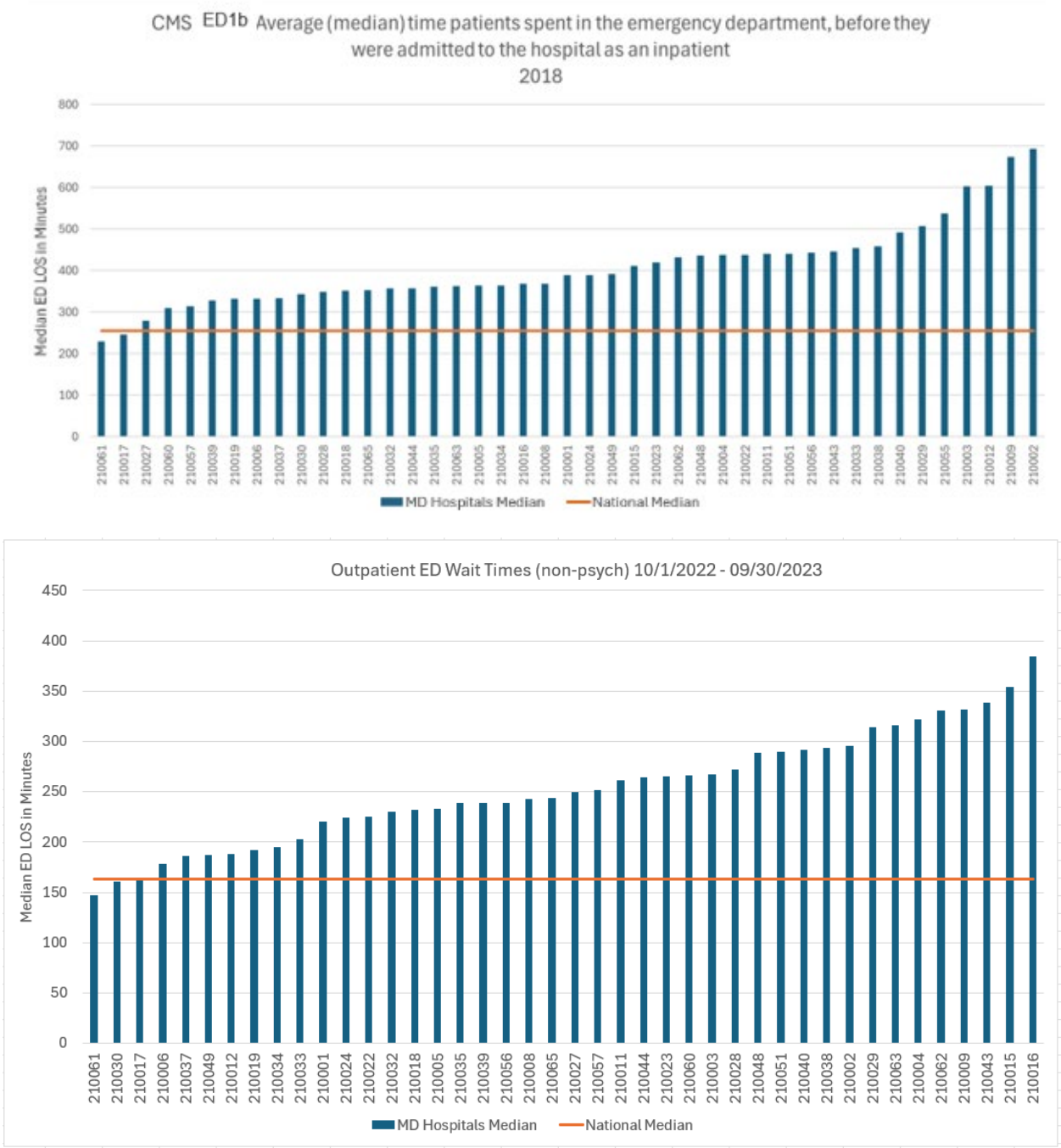
[1] Under alternative payment models, such as hospital global budgets or other hospital capitated models, some stakeholders have voiced concerns that there may be an incentive to reduce resources that lead to ED-hospital throughput issues.

Figure 2. Maryland and National Performance on ED Wait Times for Discharged Patients



Furthermore, all but a couple of hospitals in Maryland perform worse than the national average. Figure 3, shows the ED length of stay for non-psychiatric patients who are admitted (ED1b) for 2018 (last year this was reported) and for those who are discharged home (OP-18b) using the most recently available data.

Figure 3. Maryland by Hospital and National Performance on ED Wait Times



Based on these results, staff believes all hospitals in Maryland have an opportunity to improve ED LOS through incentives on Best Practices and the outcome. Furthermore, there has been increased public scrutiny on Maryland's ED Wait times, which have been consistently higher than all other states for the past decade. Several initiatives have been underway over the last two years to analyze Maryland's ED length of stay and promote improvement (e.g., MHA Legislative Taskforce, EDDIE). In the 2024 Maryland General Assembly Session, a new

ED Wait Time Reduction Commission was established. The ED Commission is co-chaired by the HSCRC Executive Director and staffed by the HSCRC. The ED Commission will work on hospital and wider access issues to improve hospital throughput and will develop a state goal for improvement in ED wait times. The development of Best Practices focused on ED-Hospital Throughput is one of the specific goals outlined by the ED Wait Time Reduction Commission. Appendix A provides additional background on initiatives that the HSCRC and hospitals have undertaken to address this issue.

POLICY DEVELOPMENT AND IMPLEMENTATION

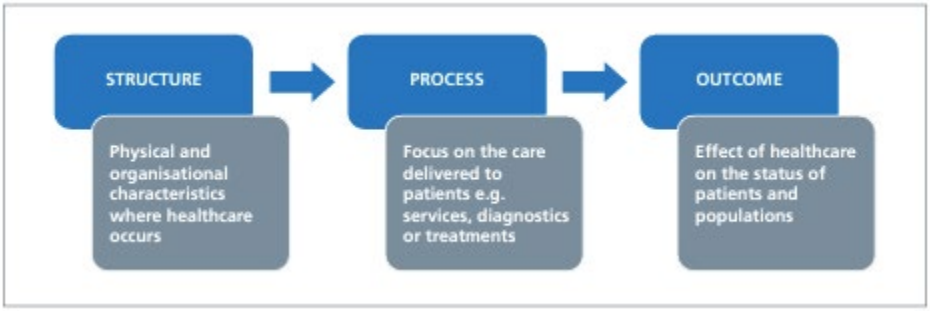
In this section, staff provides an overview of work done during CY 2024 to develop this Best Practice Policy. This includes discussion on why the Commission should develop incentives related to structure and process measures, description of stakeholder engagement, as well as an outline of the six best practices that have been selected and examples of tiers for assessing the intensity and fidelity to the best practices. The section concludes with next steps and draft recommendations for input.

Policy Origins

The Donabedian model of quality of care assesses three components as shown in Figure 4. While most current pay for performance incentives are focused on outcomes (i.e., mortality, complications, readmissions), structure and process measures are important to measure to understand how changes in quality actually occur and are still required for some areas by CMS (e.g., attestation measures for health equity). There are several additional reasons why incentivizing structure and process measures should be considered in the case of ED LOS improvement. First, given that the ED LOS data collection and measure development is still underway, staff are hesitant to put additional revenue at risk on the outcome measure at this time. Second, the changes that can occur within a hospital to impact ED LOS may not be sufficient to improve the State's rankings nationally by themselves. This is because ED and hospital throughput is impacted by access to outpatient primary care, specialty care, behavioral health, and post-acute care. Third, there may be ways to reduce ED LOS to earn an incentive that would not result in better care to patients and these unintended consequences could be avoided by providing incentives to focus hospitals on better care delivery through optimization of known best practices. Hospitals in the State have engaged willingly in this work thus far, and will be held accountable in RY 2027 if they do not submit data showing their commitment to this work. Thus, staff feels that the current revenue at-risk on the outcome through QBR is sufficient at this time, but that more can be done to improve the care received by patients through ensuring best practices such as the ones identified below, are implemented well for all patients, at all times. By developing tiers and measures to assess the intensity and fidelity to these best practices, the State has a unique opportunity to improve more than just ED LOS. Thus, staff believe a mix of incentives on

structure, process, and outcomes is appropriate and could be more impactful than simply adding more revenue to outcomes alone.

Figure 4. The Donabedian model for quality of care



Stakeholder Process and Selected Best Practices

Staff formed an ED Subgroup in February 2024 to develop the ED LOS measure and incentive methodology for the RY 2026 QBR policy. By the fall of 2024, staff transitioned this subgroup to work on the development of ED and Hospital Best Practices to improve throughput and reduce ED LOS. This was also aligned, as mentioned above, with the ED Wait Time Reduction Commission's legislative mandate to focus on the sharing of best practices. Since September 2024, there have been eight subgroup meetings to collect, discuss, and select the proposed best practices. Specifically, the subgroup vetted over thirty best practice suggestions and narrowed down the list to six and proposed that hospitals be expected to implement or improve upon two best practices during CY 2025. While there were several discussions on whether to select two best practices that all hospitals must uniformly implement, hospitals felt strongly that options were needed since certain types of best practices may be more or less effective in different settings; additionally, since hospitals were engaged in the selection of the best practice options, and will be engaged in developing and finalizing the measures and the tiers for each of the options, the staff felt that providing choices would best maintain collaboration and address the variation in hospital settings. However, the selection of the number of best practice options, requirements for implementation, and focus of the best practices can change over time as this policy evolves. Figure 1 provides an overview of the six best practices for ED-Hospital Throughput. In addition, examples of how the best practices could be measured and tiered (i.e., assessed on intensity and fidelity) are provided. The idea would be that in future years hospitals would earn points based on the measures and could earn more points for higher intensity or fidelity to the best practice, as opposed to an all or nothing incentive. ***All measures and tiers listed below are examples. As the subgroup continues to meet and finalize measure and tier development, the table will be updated. Final measures and tiers will be presented in the final policy recommendations.***

Figure 1. ED-Hospital Throughput Best Practices

Best Practice	Measures (EXAMPLE ONLY--Still in development)	Points (0-10 scale)
Interdisciplinary Rounds	• Tier 1: Interdisciplinary Rounds piloted with a target of x% on at least 1 unit • Tier 2; Interdisciplinary Rounds implemented on X additional units AND documentation of discharge planning initiated Day 1 • Tier 3: Leadership involvement in Interdisciplinary Rounds OR Documentation of prior auth for post-acute placement by x timeframe; specialist consults completed within 24 hours of order, etc.	• Tier 1 earns 0-2 points • Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) • Tier 3 earns up to 4 additional points
Bed Capacity Alert System	• Tier 1: Bed capacity Alert triggered at a certain surge level, alert goes to all inpatient and outpatient areas And triggers mandatory leadership huddles • Tier 2: Bed capacity alert includes non-hospital partners (outpatient providers, local post-acute facilities) • Tier 3: Leverage Access centers and CRISP to facilitate most appropriate patient placement; potentially partner with MIEMSS long-term	• Tier 1 earns 0-2 points • Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) • Tier 3 earns up to 4 additional points
Standardized Daily/Shift Huddles	• TBD—tier development and metrics in process, initial discussions focused on integrating ED census, wait time etc. into huddles, as well as linkage to interdisciplinary rounds	• Tier 1 earns 0-2 points • Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) • Tier 3 earns up to 4 additional points

Best Practice	Measures (EXAMPLE ONLY--Still in development)	Points (0-10 scale)
Expedited Care Intervention (Expediting team, expedited care unit)	Proposal 1: select one or more of multiple expediting practices **Nurse expediter** Tier 1: Designated RN for admission/discharge planning/coordination Tier 2: Tier 1 & x% decrease in discharge order to discharge time for D/C to Home pts Tier 3: Tier 1 & 2 plus (x+5% decrease in discharge order time for D/C to Home pts **Discharge Lounge** Tier 1: Designated clinical space & staff to discharge patients from a Discharge lounge Tier 2: Tier 1 & (x%) decrease to discharge order to discharge time Tier 3: Tier 1, 2 & (x+5%) decrease in discharge order to discharge time **Observation Unit** Tier 1: Dedicated clinical space and staffing for short stay patients Tier 2: Tier 1 & Decrease in Total Obs (ED Obs & Hospital Obs) LOS Tier 3: Tier 1 & @ & (x+5%) Decrease in Total Obs LOS Proposal 2: Develop and implement processes and specific metrics, mandatory sharing across hospitals and reporting to HSCRC; no defined targets for CY25 in order to prevent unintended consequences	• Tier 1 earns 0-2 points • Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) • Tier 3 earns up to 4 additional points

Best Practice	Measures (EXAMPLE ONLY--Still in development)	Points (0-10 scale)
Patient Flow Throughput Performance Council	• Tier 1: Established Patient Flow Throughput Performance Council with front-line and leadership representation, meets at least monthly • Tier 2: Council tracks and implements specific interventions targeted at decreasing inpatient LOS • Tier 3: Leadership has strategic goals for each department tied to patient flow throughput	• Tier 1 earns 0-2 points • Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) • Tier 3 earns up to 4 additional points
Clinical Pathways/Observation Management	• TBD: currently focused on evidence-based pathways that facilitate care across the continuum with overarching goal of enhancing and expediting care • Example: Chest pain protocol that leverages nurse driven protocol and/or expedited evaluation in an outpatient setting if clinically appropriate, also expedited protocol for admitted patients.	• Tier 1 earns 0-2 points • Tier 2 earns up to 4 additional points (cumulative tier 1 and 2 has 6 possible points) • Tier 3 earns up to 4 additional points

Staff had originally planned to propose additional revenue at risk for performance on best practices for CY 2025 but the work needed to refine the tiers and develop data collection is substantial. Furthermore, given concerns about the time it took to develop the ED LOS measure and incentive concurrent to its use, staff believe additional time is needed to do this well. In addition, stakeholder engagement has been exceptional during this process and should be commended by providing this additional time for hospitals to develop the data collection needed to measure the tiers. Staff recommends that RY 2027 be focused on refinement and implementation of best practice measures, workflow redesign, and report development and validation. Therefore, staff recommends that RY 2027 efforts be focused on development of the Best Practice tiers and data collection, but that no revenue be tied to performance on the best practice measures for RY2027. Specifically, staff have proposed a 0.1 percent all-payer, IP revenue, accountability penalty tied to best practice implementation and data submission, meaning a penalty would be assessed if a hospital did not report data by October 2025 for its two selected best practices. Staff intends to continue the refinement of the best practices and development of measures to define tiers, as well as address other feedback, between the draft and the final policy.

Draft Recommendations

This document puts forth for consideration the RY 2027 (CY 2025 performance period) draft policy recommendations on hospital best practices:

1. Building upon the ongoing work of staff and key stakeholders, refine the specifications developed by the Best Practice subgroup on a set of up to six Hospital Best Practices that are designed to improve emergency department (ED) and hospital throughput and reduce ED length of stay (LOS).

    a. For each best practice identified, develop three weighted tiers with corresponding measures that reflect the fidelity and intensity of each best practice.
2. Require hospitals to select two Best Practices to implement and report data on for RY 2027.
    a. Failure to implement and report data to the Commission by October 2025 will result in a 0.1 percent penalty on all-payer, inpatient revenue to be assessed in January 2026. We will follow our extraordinary circumstances exception policy to address any unforeseen events (i.e. cyberattack, natural disaster, etc.).
3. We propose that subsequent rate years will have 0.25 percent inpatient hospital revenue at risk tied to performance on these best practice metrics but intend to evaluate the impact of the best practices and make a final recommendation for subsequent rate years after the Year 1 Best Practice program impact is assessed.

APPENDIX A: HSCRC EFFORTS TO ADDRESS ED LENGTH OF STAY

Concerns about unfavorable ED throughput data have been shared by many Maryland stakeholders, including the HSCRC, the MHCC, payers, consumers, emergency department and other physicians, hospitals, the Maryland Institute of Emergency Medical Services Systems, and the Maryland General Assembly, with around a dozen legislatively mandated reports on the topic since 1994, including the Maryland General Assembly Hospital Throughput Work Group Final Report in March 2024.

Historically, the HSCRC has taken several steps to address emergency department length of stay concerns. However, in the past few years, the COVID public health emergency and its effects on inflation and labor have had particularly significant negative impacts on hospitals and other care settings that patients may use after receiving hospital care (e.g., nursing homes), further exacerbating pressures on emergency departments.

Previously, the HSCRC included ED LOS measures in the QBR program for two years. In RY 2020 (CY 2018 measurement period), the QBR Program introduced the use of the two CMS inpatient ED wait time measures (chart abstracted measures: ED-1 and ED-2) as part of the QBR Person and Community Engagement (PCE) domain because of the high correlation between ED wait times and HCAHPS performance (also in the PCE domain and on which the state also performs poorly). CMS retired ED-1 after CY 2018 and ED-2 after CY 2019 necessitating both measures' removal from the QBR program after only two years. Overall, ED LOS improved (i.e., ED LOS time went down) for more than half the hospitals when the measures were in QBR, although some of the improvements were minimal. With the retirement of the chart-abstracted ED LOS measures, the HSCRC continued to work to find a way to collect the data and include the results in QBR.

More recently, staff collaborated with CRISP and their contractor to collect the electronic Clinical Quality Measure (eCQM) ED-2 (Order of admission to admit time) for CYs 2022-2023. However, analyses of the ED-2 eCQM found that there are a significant number of hospitalizations (>50,000 statewide) that are dropped from the ED measure due to an exclusion for stays where the patient spends more than one hour in observation care. Furthermore, CMS discontinued this eCQM measure in CY 2024, rendering it not feasible for hospitals to continue to report the eCQM at this time for use in the QBR program.

To determine the direction for inclusion of an ED throughput measure in the RY 2026 QBR policy that would begin with CY2024 performance, the Commission considered several measurement options proposed by staff as well as other initiatives underway to address this issue going forward.

Ultimately, the Commission approved inclusion of ED 1-like measure in the RY 2026 QBR program to be finalized during CY 2024 and that would not require additional Commission approval. In working with ED Subgroup stakeholders in early 2024, staff selected a measure that mirrors the CMS ED1 measure, with specifications aligned with those of The Joint Commission as much as possible; the initial measure collection and submission is through an ad hoc electronic data pull for all patients that will be submitted on an ongoing basis eventually

through the existing HSCRC case mix data submission process; the initial ad hoc electronic data pull and submission includes data from CY 2023 to serve as the performance baseline period, and from January through March 2024. Hospitals also provided an ad hoc submission in December 2024 that will correct any previously submitted data and provide data from April through September 2024; beginning with data from October 2024 going forward, the ED measure data elements will be included as part of the standard case mix submission process. The ED1 LOS measure captures the time of emergency department arrival to the time of physical departure from the emergency department for patients admitted to the facility. The population is all ED patients (pediatrics and adults) admitted to an inpatient (IP) bed and discharged from the hospital during the reporting period.

Additional Initiatives: Emergency Department Dramatic Improvement Effort (EDDIE)

In June of 2023, Commissioner Joshi convened HSCRC, MIEMSS, MHA, and MDH to propose the EDDIE project with the goal of reducing the time patients spent in the emergency department and pushed the HSCRC staff and MHA to begin this project immediately (i.e., not wait until next policy year) given the importance of this issue. The EDDIE project focuses on short-term, rapid-cycle improvement in ED patient experience by collecting and publicly reporting on ED performance data and fostering a quality improvement process to address those metrics.

Specifically, starting in July 2023, hospitals are submitting data on measures that mirror the CMS ED 1 and OP 18 CMS measures on a monthly basis in accordance with an excel reporting template along with a memo provided by HSCRC staff that contains reporting instructions and high-level specifications. The HSCRC has requested that the measures submitted be stratified by behavioral health based on initial ICD codes. Additionally, the HSCRC has developed a reporting process by which MIEMSS provides monthly reporting on EMS turnaround times by hospital. This will provide hospital accountability for improving efficiency in handoffs by EMS personnel, which will in turn improve EMS unit availability and decrease response times.

The HSCRC and MIEMSS are supporting this work by collecting and publicly reporting hospital ED wait times at monthly Commission meetings. The intent is to provide a mechanism for Commission monitoring of timely ED performance data that brings on-going attention to this issue through public reporting, provides an opportunity for the Commission to recognize and learn from high performers, and to track the hospitals performance improvement efforts relative to their aim statements. Once hospitals have submitted CY 2023 and CY 2024 patient level data, the staff will ask the Commissioners whether EDDIE data submissions are still needed.

Additional Initiatives: ED Potentially Avoidable Utilization

In CY 2021, Commissioners asked staff to evaluate expansion of potentially avoidable utilization (PAU) to emergency department utilization. Staff recommendations initially focused on high volume and low acuity chief complaint encounters (e.g., ear pain, dental problems) based on analysis of 2.4M ED observations with triage ratings. With workgroup/stakeholder vetting, this project was re-focused on multi-visit patients in the ED with >3

ED visits (statewide) in a 12-month period. A hospital monitoring program with reporting through CRISP has been established in CY 2023, with plans to consider a payment policy for CY 2025. A draft ED PAU policy will be presented at the November 2024 commission meeting.

Additional Initiatives: Legislative Workgroup

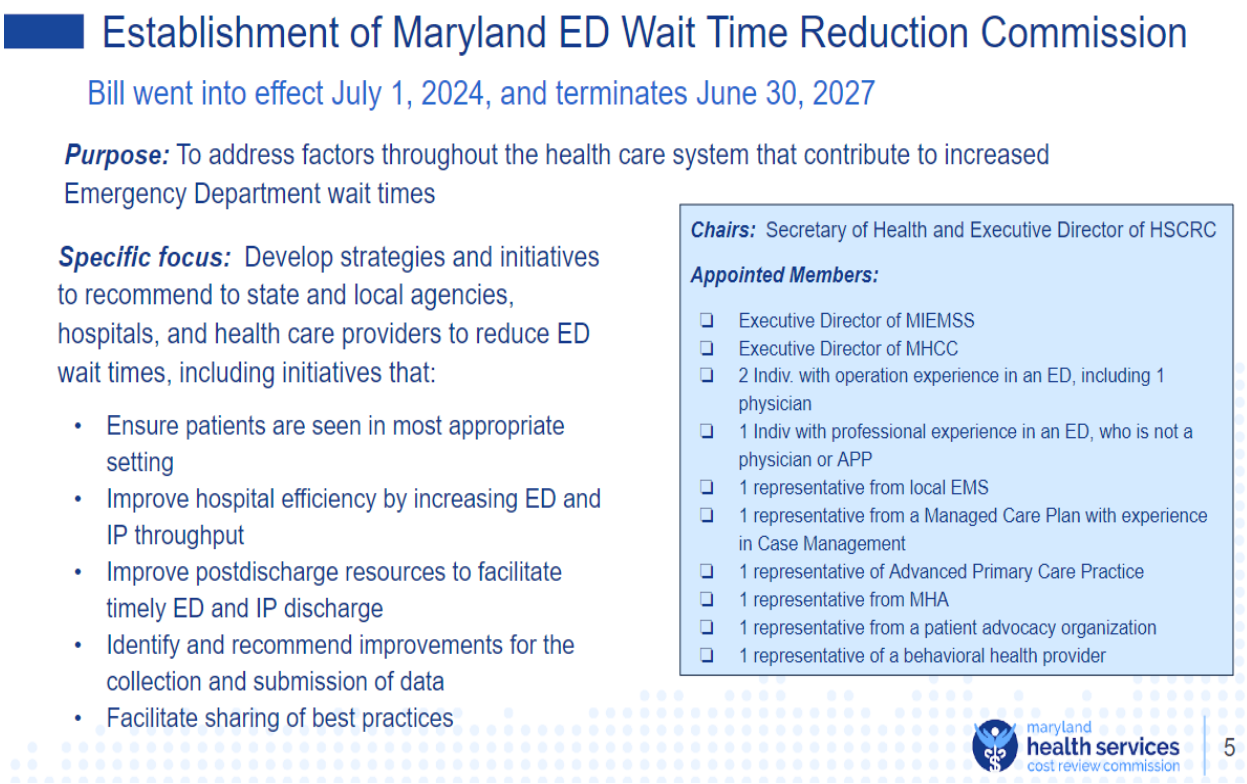
In early 2023, the Maryland General Assembly passed legislation establishing the Task Force on Reducing Emergency Department Wait Times to study best practices for reducing emergency department wait times; and requiring the Task Force to report its findings and recommendations to the Governor and the General Assembly by January 1, 2024. In response, MHA, with co-chair Dr. Ted Delbridge, executive director of Maryland Institute for Emergency Medical Services Systems (MIEMSS), led a multi-stakeholder work group, the Hospital Throughput Work Group, aimed at making recommendations to improve the patient journey in Maryland.

Members included hospital representatives, legislators, the HSCRC, the MHCC, the state Department of Health, patient advocates and emergency department and behavioral health providers. The Task Force was charged with making legislative, regulatory and/or policy recommendations in a report. The Maryland General Assembly Hospital Throughput Work Group Final Report was submitted in March 2024. The HSCRC staff was an active participant in the Task Force and believe that inclusion of an ED length of stay measure in QBR will be consistent with any policy recommendations designed to improve ED length of stay and hospital throughput (i.e., a payment incentive should bolster performance improvement and not hinder other policy recommendations).

New Commission: Maryland Emergency Department Wait Time Reduction Commission

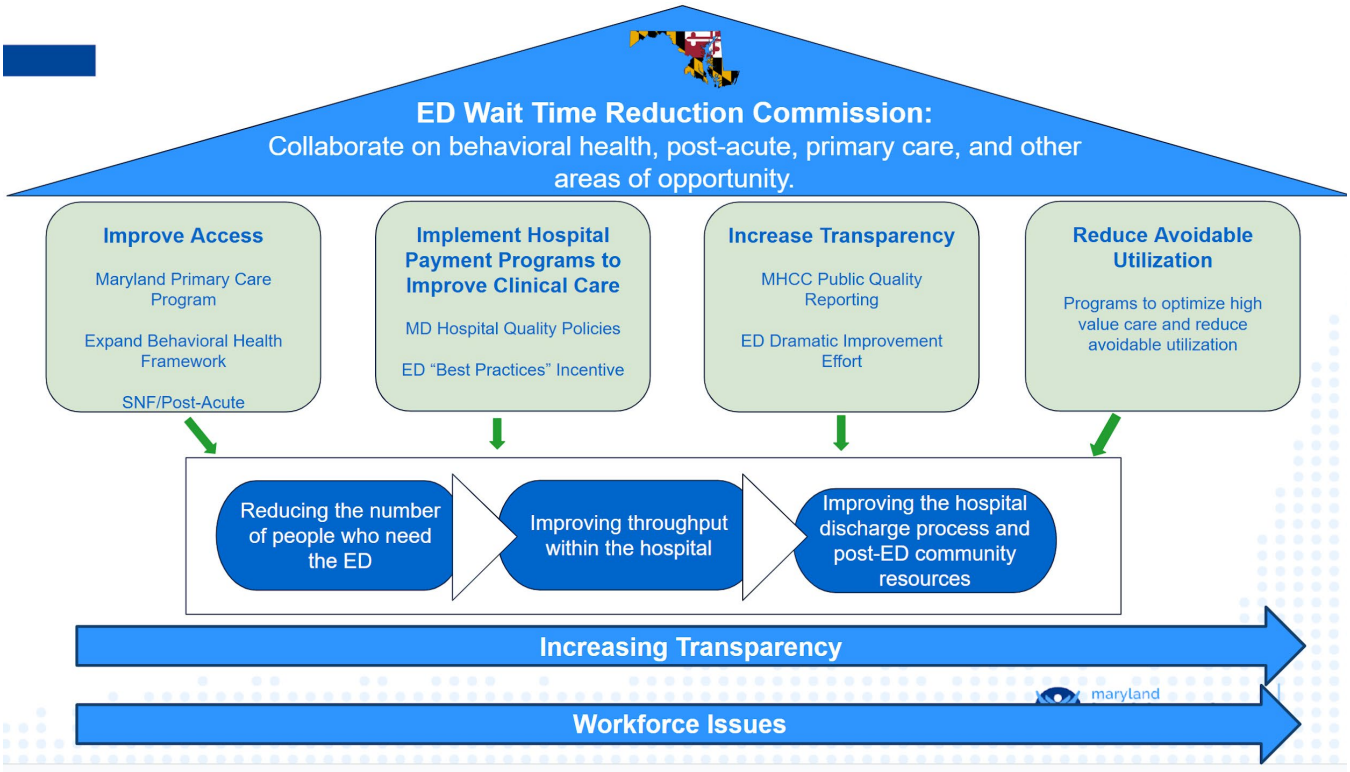
In the 2024 General Assembly session, legislation was passed establishing the ED Wait Times Reduction Commission, which went into effect on July 1, 2024. Figure E1 provides details on the ED Commission purpose, specific tasks, and member representation on the ED Commission.

Figure E1. ED Wait Time Commission Description



The ED Commission's work aligns with many of the current HSCRC policies and those under development. These policies, shown in Figure E2, are designed to address ED and hospital throughput by reducing the number of people who need ED services, improving ED and hospital throughput, and improving the hospital discharge process and community resources. The ED Commission will address state-level opportunities related to access to hospital and community-based services that impact ED wait times, such as access to behavioral health care, post-acute/SNF beds, and primary care. The ED Commission will also support hospital best practices to address ED wait times and throughput across Maryland hospitals. The ED Commission members have been appointed and the first meeting occurred in October 2024. Four subgroups have been established and are reporting up through the ED Wait Time Reduction Commission, including the ED Hospital Throughput Best Practices subgroup, which also reports up through the HSCRC Commission as it relates to hospital policy.

Figure E2. ED Wait Time Commission and Other Initiatives to Reduce ED Wait Times



maryland
health services
cost review commission

TO:
HSCRC Commissioners

FROM:
HSCRC Staff

DATE:
January 8, 2025

RE:
Hearing and Meeting Schedule

February 12, 2025 In person at HSCRC office and Zoom webinar

March 12, 2025 In person at HSCRC office and Zoom webinar

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

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