maryland
health services
cost review commission

592nd Meeting of the Health Services Cost Review Commission
February 9, 2022

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

EXECUTIVE SESSION
11:30 am

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

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

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

PUBLIC MEETING
1:00 pm

1. Review of Minutes from the Public and Closed Meetings on January 12, 2022

2. Docket Status – Cases Closed
   2569N – Greater Baltimore Medical Center
   2578A – University of Maryland Medical Center
   2579A – John Hopkins Health System

3. Docket Status – Cases Open
   2580R – Brook Lane Hospital
   2581A – John Hopkins Health System

4. Policy Update and Discussion

   a. Model Monitoring
   b. Legislative Update
   c. Workgroup Update
   d. Outcomes-Based Credit Update

5. Hearing and Meeting Schedule

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF January 31, 2022

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials
2580R	Brook Lane Hospital	12/7/2021	1/6/2022	5/6/2022	FULL	JS/AP
2581A	Johns Hopkins Health System	1/26/2021	N/A	N/A	ARM	DNP

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

None

File Status
OPEN
OPEN

IN RE: THE FULL RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF	*	COST REVIEW COMMISSION
BROOK LANE HEALTH	*	DOCKET: 2021
SERVICES - HAGERSTOWN	*	FOLIO: 2390
HAGERSTOWN, MARYLAND.	*	PROCEEDING: 2580R

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STAFF RECOMMENDATION

February 9, 2022

List of Abbreviations

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

Key Methodology Concepts and Definitions

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

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

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

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

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

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

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

Overview

Brook Lane Health Services - Hagerstown ("Brook Lane," or "the Hospital") submitted a full rate application on December 7, 2021, requesting an increase to its permanent revenue totaling $2.1 million, an 8.7 percent increase over Brook Lane's approved revenue base that was effective for the one-year period from July 1, 2021 through June 30, 2022. The statute requires that the effective date of the newly proposed rates be no sooner than 30 days from the filing of the full rate application. However, in this instance both staff and hospital have been working on this application since July 2021. Given the special nature of this hospital, the staff requests that the Commission waive the 30-day requirement and allow for an effective date of December 1, 2021.

The rate application requested increase (8.7 percent) is related to the efficiency of the Hospital's costs relative to Maryland peers, a methodology established during the full rate determination for Sheppard Pratt Hospital. The requested revenue increases are exclusive of HSCRC-approved adjustments, including: the update factor, productivity adjustments, market shift adjustments, demographic adjustments, quality adjustments, population health, and other routine adjustments.

HSCRC staff docketed Brook Lane's full rate application on December 7, 2021.

Request for General Revenue Increase

Brook Lane justifies the requested $2.1 million in additional operating revenue based on its objective to achieve a viable and sustainable operating margin, which decreased from 1.5 percent in Fiscal Year 2014 to -3.7 percent in Fiscal Year 2019.[1] Several cost increases over and above inflation provided in the annual Update Factor contribute to the need for additional revenue:

1. Additional staffing related to increased patient acuity --$2.2 million
2. Increased Depreciation and Interest Costs – $702 thousand
3. Increased Insurance Expenditures (other than malpractice) -- $58 thousand

Additional requests included in the Brook Lane application that are inclusive of the $2.1 million in additional operating revenue are as follows:

1) Brook Lane requested that the rate increase become effective December 1, 2021.

2) Brook Lane requested that the rate application be effectuated in the same manner as the Sheppard Pratt rate application, which accounted for:

[1] Regulated margin was -2.8 percent in Fiscal Year 2020, but due to the COVID Public Health Emergency analyses were restricted to Fiscal Year 2019 and prior years.

a) Inflation for Fiscal Year 2020 and 2021 since the Maryland cost comparison model utilized Fiscal Year 2019 costs to remove the confounding elements of the COVID public health emergency; and

b) A markup[2] to rates to recognize that the effective rate increase will not be equal to the rate determination made by the Commission since Medicare does not pay HSCRC-approved rates at the Hospital.

Background

Full Rate Applications

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

Due to the unique nature of Brook Lane, which is a psychiatric facility in the State and is not part of Global Budget Revenue methodologies, the evaluation contained in this recommendation addresses cost per unit.[3] Staff believes the cost-per-case efficiency methodology is an effective tool for assessing general acute care facilities, but is concerned that the requisite casemix methodology is not sufficient to determine varying levels of acuity for facilities, such as Brook Lane or Sheppard Pratt Hospitals that serve patients exclusively with behavioral health needs.[4]

Background on Brook Lane

Brook Lane is a private mental health inpatient facility with 57 beds located in Hagerstown,

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

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

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

Maryland. Over 50 percent of the inpatient services provided are in the Child and Adolescent Units at the Hospital. Brook Lane also works with various Partial Hospital Programs that are associated with schools. The Hospital's total approved revenue for Fiscal Year 2021 was $23,278,579. In FY 2019, approximately 1 percent of its revenues came from Baltimore City; 1 percent came from Baltimore County; 5 percent came from central Maryland Counties; 16 percent came from out-of-state residents; and the remaining 77 percent was derived from all other counties in Maryland, suggesting Brook Lane is a statewide resource.[5]

From Fiscal Years 2014 through 2019, Brook Lane had an average total operating margin of 1.7 percent based upon its annual filing of schedule RE, which includes both regulated and unregulated operations, specifically the combined operating margins measured: $352 thousand (1.5%) in FY 2014; $867 thousand (3.3%) in FY 2015; $1.6 million (5.1%) in FY 2016; $1.2 million (3.6%) in FY 2017; $116 thousand (0.5%) in FY 2018; and -$773 thousand (-3.7%) in FY 2019.

Staff Analyses

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

Financial Background and Performance

Hospital Rate History

Brook Lane is not a GBR hospital. The HSCRC regulates the rates of Brook Lane because it is a Maryland licensed hospital and because two thirds of its revenue are not from public payer reimbursements.[6] Since Fiscal Year 2014 Brook Lane has received the following adjustments:

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

[6] Md. Health-General Code Ann., Sections 19-211 and 19-220, http://www.dsd.state.md.us/comar/comarhtml/10/10.37.03.10.htm

Table 1. Brook Lane Adjustments, July 1, 2014-2020

	Year Beginning July 1,						
Component:	2014	2015	2016	2017	2018	2019	2020
Update Factor Inflation	1.80%	2.70%	2.70%	2.80%	2.68%	2.57%	2.96%
Productivity/ACA		-0.70%	-0.80%	-0.75%	-0.40%	-0.80%	-0.50%
Infrastructure		0.30%	0.30%				
PAU	NA	NA	NA	NA	NA	NA	NA
Net Permanent Adjustment	**1.80%**	**2.30%**	**2.20%**	**2.05%**	**2.28%**	**1.77%**	**2.46%**
Net Quality Adjustments	NA	NA	NA	NA	NA	NA	NA
Uncompensated Care Funding	3.25%	3.47%	4.24%	4.64%	5.27%	4.53%	4.22%
Mark Up Change	-0.81%	3.55%	1.03%	1.74%	-3.27%	3.88%	-0.45%

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

Revenue Growth & Cost Growth

Brook Lane's regulated gross revenue has increased by $8 million or 55 percent from Fiscal Year 2014 to Fiscal Year 2019. During this same period, the State offset the annual update factor amount for non-GBR hospitals by a productivity adjustment. Non-GBR hospitals are under a 100 percent variable cost factor system because unlike GBR hospitals, there is no incentive to reduce volume; therefore, the Hospital should become more efficient and profitable as volumes increase and reimbursement is not scaled for covered fixed costs. In addition, Brook Lane is not included in some of the volume incentives GBR hospitals were held to, which was the rationale for the productivity offset. The 2019 annual compounded impact (from 2014 through 2019) of these adjustments was a reduction in 2019's revenue of approximately $789 thousand in permanent revenue. During this same time, however, inpatient days grew by 37 percent, which offset the productivity adjustment by a decrease of 3.5 percent.[7] This increase in inpatient days occurred even though admissions grew by just 4 percent from 1,677 to 1,746, due in large part to better care coordination and care moving to the most appropriate setting. It also suggests that acuity of patients at Brook Lane has increased since 2014.

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

Table 2. Brook Lane Update Factor Impact FY 14-FY 20

Fiscal Year	Gross Update Factor	Offset	Population Health Infrastructure	Net Update	Total Net Revenue (in thousands)	Compounded Impact of Offset (in thousands)
2019	2.57%	-0.80%	0.00%	1.77%	22,563	789
2018	2.68%	-0.40%	0.00%	2.28%	22,853	612
2017	2.80%	-0.75%	0.00%	2.05%	21,984	498
2016	2.70%	-0.80%	0.30%	2.20%	20,804	313
2015	2.70%	-0.70%	0.30%	2.30%	17,202	120
2014	1.80%	0.00%	0.00%	1.80%	14,513	-

According to operating margin data submitted by Brook Lane, the Hospital has seen significant margin erosion since 2014. Overall margin at Brook Lane (combined regulated and unregulated) decreased from 1.5 percent in 2014 to -3.7 percent in 2019. This amounts to a $1.1 million dollar margin deterioration since 2014. 2020 is not accounted for in this comparison due to the confounding factors associated with the COVID-19 pandemic

As reflected in Table 2, the cumulative loss in revenues from 2014 through 2019 attributable to the offset to the annual update factor totals $2.332 million. As per review of the audited financial statements, the balance sheet reflects a decline in current assets between 2014 and 2019 of $1.290 million. Although cash and other current assets are highly liquid and subject to material changes, it is reasonable to attribute part of the measured decline in current assets to the effects of the repeated annual offset.

Brook Lane has experienced growth in operating cost beyond that anticipated by the provision of the annual update factor.

Table 3. Brook Lane Cost Escalation Exceeds Update Factor Expectation ($ Thousands)

Regulated Operating Expenses 2014	$14,386.7
Cumulative Update Factor 2015 – 2019	1.1419
Regulated Operating Expenses 2014 stated in 2019 $s	$16,429.8
Regulated Operating Expenses 2019	$19,934.8
Cost Escalation beyond Update Factor Expectation	$ 3,505.0

Breakdown of Material Costs Escalations:

	2014 Exp.	As Updated	2019 Exp.	Beyond
Payroll/Benefits/Agency RNs	$10,529.6	$12,024.1	$14,272.6	$2,248.5
Depreciation & Amortization	$ 531.5	$ 606.9	$ 1,130.3	$ 523.4
Interest Expense	$ 91.4	$ 104.4	$ 282.8	$ 178.4
Insurance (other than malpractice)	$ 42.2	$ 48.2	$ 106.4	$ 58.2
Other				$ 496.5
Total Cost Escalations beyond Update Factor Expectation				$3,505.0

The most significant cost pressure experienced by Brook Lane has been acuity-related labor premiums. Annual filing data from the C & D schedules shows FTEs increased by 31 from 2014 to 2019, which is an increase of 20.9 percent. During this same time, using Equivalent Inpatient Day data divided by Equivalent Inpatient Admission data as a measure of acuity, days per admission rose by 31.4 percent, which suggests Brook Lane did indeed experience higher intensity cases.

Table 4. Brook Lane's FTE Increase and Acuity Increase 2014-2019.

	2014	**2015**	**2016**	**2017**	**2018**	**2019**
FTEs	148	152	182	169	181	179
YOY Increase		2.7%	19.7%	-7.1%	7.1%	-1.1%
Cumulative Increase		2.7%	22.9%	14.2%	22.3%	**20.9%**
EIPD/EIPA	7.41	8.03	8.20	8.45	8.97	9.74
YOY Increase		8.4%	2.1%	3.0%	6.2%	8.6%
Cumulative Increase		8.4%	10.7%	14.0%	21.1%	**31.4%**

Maryland Cost Comparison Model

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

Table 5. List of Maryland Peer Hospitals

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

While these hospitals did provide better comparability to Brook Lane by eliminating unique costs that Brook Lane does not incur (e.g., supply costs for transaortic valve replacements), HSCRC staff also worked with the Hospital to adjust for the higher overhead costs incurred at general acute care facilities. Specifically, the Maryland cost comparison model discounted all overhead cost centers for Brook Lane's Maryland peers by the differential overhead these hospitals incur for medical/surgical inpatient discharges versus psychiatric inpatient discharges. In effect, the costs for the patient related overhead (e.g., dietary services, laundry) for Brook Lane's selected peers were reduced by 34.1 percent, and other overhead costs (e.g., general accounting, medical records) were reduced by 48 percent. Without this adjustment, the Maryland cost comparison model would have indicated Brook Lane's costs were 412 percent more efficient than otherwise determined.

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

Table 6. Summary of Maryland Cost Comparison Model

Berkeley Research Group
Brook Lane
Cost Comparison: Brook Lane vs. Psychiatry Hospitals
Fiscal Year 2019

	Peer Group Comparison Cost				Brook Lane Cost	Variance	
		Adjustment Factor for Psych Cost Intensity					
Description	FY 2019 C&D Comparison: Results	%	$	Adjusted Peer Group Comparison Costs	FY 2019 C&D Comparison: Results	Brook Land Favorable/ (Unfavorable)	% Favorable / (Unfavorable)
Plant Operations	$2,058,892	34.1%	($701,197)	$1,357,694	$790,000	$567,694	71.9%
Dietary Services	745,885	34.1%	(254,026)	491,859	576,700	(84,841)	(14.7%)
Purchasing and Stores	317,833	34.1%	(108,244)	209,588	0	209,588	0.0%
Pharmacy	475,477	34.1%	(161,933)	313,544	0	313,544	0.0%
Laundry and Linen	59,627	34.1%	(20,307)	39,320	42,300	(2,980)	(7.0%)
Social Services	198,404	34.1%	(67,570)	130,833	0	130,833	0.0%
Patient Care Overhead Total	$3,856,117		($1,313,279)	$2,542,838	$1,409,000	$1,133,838	80.5%
Hospital Administration	$4,186,627	48.0%	($2,007,717)	$2,178,910	$2,347,700	($168,790)	(7.2%)
Depreciation & Amortization	2,528,877	48.0%	(1,212,735)	1,316,142	895,900	420,242	46.9%
Long Term Interest	561,390	48.0%	(269,217)	292,173	282,800	9,373	3.3%
Housekeeping	4,293	48.0%	(2,059)	2,234	395,600	(393,366)	(99.4%)
Malpractice Insurance	535,341	48.0%	(256,726)	278,616	215,400	63,216	29.3%
Patient Accounts	787,426	48.0%	(377,614)	409,812	1,663,700	(1,253,888)	(75.4%)
General Accounting	590,149	48.0%	(283,009)	307,140	929,700	(622,560)	(67.0%)
Medical Staff Administration	341,225	48.0%	(163,636)	177,589	309,400	(131,811)	(42.6%)
Leases and Rentals	399,528	48.0%	(191,595)	207,932	0	207,932	0.0%
Medical Care Review	497,197	48.0%	(238,433)	258,764	298,100	(39,336)	(13.2%)
Medical Records	210,991	48.0%	(101,182)	109,809	392,700	(282,891)	(72.0%)
Other Insurance	63,666	48.0%	(30,531)	33,135	106,400	(73,265)	(68.9%)
Nursing Administration	1,241,765	48.0%	(595,494)	646,271	133,300	512,971	384.8%
Other Overhead Total	$11,948,475		($5,729,949)	$6,218,526	$7,970,700	($1,752,174)	(22.0%)
Overhead Total	$15,804,592		($7,043,228)	$8,761,364	$9,379,700	($618,336)	(6.6%)
Adult Psychiatry	$4,119,003	0.0%	$0	$4,119,003	$2,525,900	$1,593,103	63.1%
Child Psychiatry	6,082,547	(13.7%)	832,482	6,915,029	4,869,500	2,045,529	42.0%
Individual Therapy	0	0.0%	0	0	936,300	(936,300)	(100.0%)
Group Therapies	0	0.0%	0	0	165,600	(165,600)	(100.0%)
IP, Nursing, Obv Total	$10,201,550		$832,482	$11,034,032	$8,497,300	$2,536,732	29.9%
Electroencephalography	183	0.0%	0	183	1,000	(817)	(81.7%)
Radiology - Diagnostic	420	0.0%	0	420	1,700	(1,280)	(75.3%)
Electrocardiography	4,301	0.0%	0	4,301	4,100	201	4.9%
Laboratory Services	7,666	0.0%	0	7,666	134,300	(126,634)	(94.3%)
Psych. Day and Night Care	396,486	0.0%	0	396,486	475,700	(79,214)	(16.7%)
Electroconvulsive Therapy	330,300	0.0%	0	330,300	330,300	0	0.0%
Ancillary Total	$739,356		$0	$739,356	$947,100	($207,744)	(21.9%)
Total Direct Patient Care	$10,940,906		$832,482	$11,773,388	$9,444,400	$2,328,988	24.7%
Total Excluding Supplies and Drugs	$26,745,498		($6,210,746)	$20,534,752	$18,824,100	$1,710,652	9.1%

Due to the concern related to accurately assessing the efficiency of costs within the pharmacy rate center, which may reflect unique discounts not available to all hospitals, these costs were excluded from the Maryland cost comparison model and passed through without qualification

($856 thousand or 4 percent of Brook Lane's Fiscal Year 2019 cost base). This effectively reduced Brook Lane's favorable cost position from 9.1 percent efficient relative to Maryland peers to 8.7 percent.

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

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

	Cost Assessed	Cost Change ($)	Approved Cost	Cost Change (%)
Maryland Cost Comparison Model	$18,824,100	$1,710,652	$20,534,752	9.1%
Pharmacy Rate Center	$856,600	$0	$856,600	0%
Total	**$19,680,700**	**$1,710,652**	**$21,391,352**	**$8.7%**

National Cost Comparison Model

Given the concerns about making a rate determination based on a comparison between Maryland general acute care facilities and a specialized psychiatric facility, HSCRC staff also collaborated with Brook Lane to assess the Hospital's efficiency to similar stand-alone psychiatric facilities across the country. Specifically, the national cost comparison model used Fiscal Year 2019 Medicare cost reports[8] and evaluated Brook Lane's costs per equivalent patient days (EIPDs)[9] relative to 11 psychiatric facilities from 8 different states. The final assessment determined that Brook Lane t was 5.6 percent efficient relative to its selected national peers - within a reasonable range of the 8.7 percent determined by the Maryland cost comparison model. Below, staff will outline the peer selection process and the underlying methodology for the national cost comparison model.

To select national peers, HSCRC staff and Brook Lane settled on the following criteria, which when applied resulted in no Medicare cost report variables demonstrating a statistically significant relationship with efficiency assessments:

- Comparable licensed beds (at least 35)
- Average length of stay greater than 6 days and less than 15 days

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

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

- Average daily census greater than 20 and less than 70
- Medicare days between 6 and 25 percent of total hospital days
- Medicaid days between 10 and 45 percent of total hospital days
- Provides pediatric services
- Provides both inpatient and outpatient services

Once peer facilities were selected, staff did not use volumes derived from the Medicare Severity-Diagnosis Related Group (MS-DRG), because MS-DRGs do not adequately measure patient acuity in this context, which is evidenced by the fact that CMS pays a per diem amount under the Psych inpatient prospective payment system (IPPS) with adjustments for age, specific diagnoses, and length of stay. As such, staff utilized EIPDs, as discussed above. For a summary of the national cost comparison model, see table 8 below:

Table 8. Cost Comparison to National Peer Group Hospitals

ProvNo	Name	EIPDs	Licensed Beds	Average Daily Census	Average Length of Stay	% Medicare Day	% Medicaid Day	Total Reimb Costs per EIPDs	% of over/ under Average
214003	**Brook Lane**	**18,186**	**65**	**47**	**10**	**12.2%**	**41.7%**	**$1,021**	**(5.6%)**
264032	CenterPointe Hospital of Columbia	8,073	72	22	8	20.3%	27.7%	$1,153	**6.6%**
454134	Haven Behavioral Hospital of Frisco	13,335	70	35	7	19.1%	20.0%	$1,047	**(3.2%)**
054131	John Muir Behavioral Health Center	21,006	73	42	6	10.9%	26.0%	$1,713	**58.4%**
454124	Mesa Springs	38,767	72	60	7	6.8%	21.6%	$622	**(42.5%)**
204006	Northern Light Acadia Hospital	35,047	68	66	14	17.4%	35.9%	$1,303	**20.5%**
154057	Options Behavioral Health System	16,371	70	44	7	18.7%	21.7%	$609	**(43.6%)**
054096	Sutter Center for Psychiatry	29,968	73	53	7	13.1%	14.4%	$1,242	**14.8%**
144029	The Pavilion Behavioral Health System	25,320	72	62	7	7.6%	24.4%	$554	**(48.8%)**
374026	Tulsa Center for Behavioral Health	17,216	56	46	11	10.2%	10.4%	$558	**(48.4%)**
454131	Westpark Springs	23,640	72	51	8	14.5%	28.5%	$734	**(32.1%)**
524041	Willow Creek Behavioral Health	16,781	72	42	7	8.9%	15.2%	$813	**(24.8%)**
							Weighted Average	**$1,081**	

Cost Model Selection and Implementation

HSCRC staff supports Brook Lane's request to make a rate determination based on the Maryland cost comparison model because the analysis, which assesses cost for each hospital rate center using the relevant unit of measurement, is more thorough and less prone to acuity mismeasurement than the national cost comparison model that assesses total costs per EIPD. However, the full rate recommendation also outlined two additional requests that need to be considered:

1) Brook Lane requested that the rate increase become effective December 1, 2021;

2) Brook Lane requested that the rate application be effectuated in the same manner as the Sheppard Pratt rate application, which accounted for:

a) Inflation for Fiscal Year 2020 and 2021 since the Maryland cost comparison model utilized Fiscal Year 2019 costs to remove the confounding elements of the COVID public health emergency; and

b) A markup[10] to rates to recognize that the effective rate increase will not be equal to the rate determination made by the Commission since Medicare does not pay HSCRC-approved rates at the Hospital.

HSCRC staff agrees with the first consideration to implement a rate increase effective December 1, 2021, as staff has been working with Brook Lane since July to apply an alternative efficiency evaluation, and staff believes that the Hospital has demonstrated an immediate need for rate support due to its recent negative operating margins and efficient cost base.

HSCRC staff also agrees with the second consideration that any cost assessment based on a prior year needs to be inflated to current year costs and supports the request to have a markup to rates that recognizes the historical revenue increases that have been built into rates to account for Medicare's lower reimbursement levels. As such, HSCRC staff recommends applying the 8.7 percent favorable cost performance to the Hospital's Fiscal Year 2022 permanent revenue base of $23,984,920. This would yield an increase of $2,084,838, of which $1,530,380 would be collected, since Medicare does not pay Commission-approved rates at Brook Lane; therefore, the effective revenue increase would be 7.4 percent. This effective revenue increase is also more closely aligned with the favorable cost performance of 5.6 performance outlined in the national cost comparison model above.

For a summary of Brook Lane's effective revenue increase and the HSCRC staff recommendation, see the table below:

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

Table 9. Summary of Brook Lane's Effective Revenue Increase Per HSCRC Recommendation

	FY2022 Permanent Revenue				Projected Net Patient Revenue			Variance	
Payer Mix	Payer Mix[1]	Charges	Payer Discount	Net Revenue	Charges	Payer Discount	Net Revenue	Charges	Net Revenue
Ratio of Medicare Charges	16.1%	$3,859,174	30.0%	$2,701,422	$4,194,614	35.6%	$2,701,422	$335,440	$0
Ratio of Medicaid I/P Charges	43.6%	10,457,425	6.0%	9,829,980	11,366,387	6.0%	10,684,404	908,962	854,425
Ratio of Medicaid O/P Charges	2.6%	621,209	46.0%	335,453	675,205	50.3%	335,453	53,996	-
Ratio of Blue Cross I/P Charges	17.6%	4,218,947	2.3%	4,124,021	4,585,659	2.3%	4,482,482	366,712	358,461
Ratio of Blue Cross O/P Charges	1.7%	407,744	2.0%	399,589	443,185	2.0%	434,321	35,441	34,732
Ratio of HMO Charges to Total	0.0%	-	6.0%	-	-	6.0%	-	-	-
Deductibles Paid by Medicaid & Blue Cross	0.0%	-	2.0%	-	-	2.0%	-	-	-
Provision for Uncollectable Accounts:	4.6%	1,101,627	100.0%	-	1,197,381	100.0%	-	95,754	-
Provision for Other Payors:	13.8%	3,319,513	2.0%	3,253,123	3,608,046	2.0%	3,535,885	288,533	282,762
Total	100.0%	$23,984,920		$20,643,587	$26,069,696		$22,173,967	$2,084,838	$1,530,380
								8.7%	*7.4%*

Total Cost of Care Performance

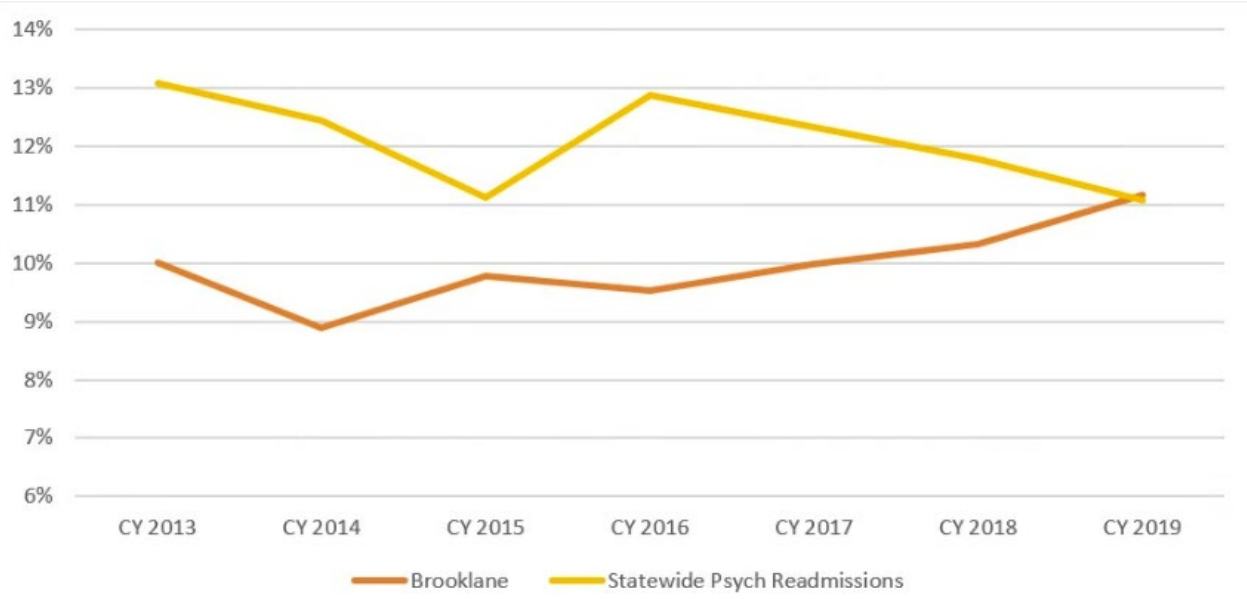
Under a per-capita model, a hospital's efficiency may not be adequately measured by cost-per-case measures. In order to consider how the cost per-capita performance might alter the results from a hospital cost efficiency analysis, the HSCRC also evaluates Total Cost of Care (TCOC) performance. Exceptional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

In the case of Brook Lane, HSCRC staff did not attempt to assess its TCOC performance because it is not a hospital that participates in the population-based methodologies that underpin the TCOC Model, e.g., Global Budget Revenue, Demographic Adjustment, Market Shift, Potentially Avoidable Utilization Shared Savings, and the Medicare Performance Adjustment. Nor will the impact of this rate determination affect Medicare TCOC because Medicare does not pay HSCRC-approved rates at the Hospital.

Quality Performance

Similar to TCOC performance, the HSCRC staff cannot fully evaluate quality performance, as Brook Lane does not participate in the Commission's pay for performance quality programs under its unique service delivery model. However, in our all-payer Readmission Reduction Incentive Program (RRIP), we include psychiatric hospitals to account for any readmissions from an acute hospital to a psychiatric hospital. Thus, we can evaluate Brook Lane's case-mix adjusted readmission rate. As shown in Table 10, staff concluded that Brook Lane outperformed the State on psychiatric readmissions from 2013 to 2018. In 2019, Brook Lane performed on par

with the statewide readmission rate due to statewide reductions and even though the Hospital has no financial incentive to reduce readmissions. Moreover, since 2013, Brook Lane has maintained a lower readmission rate relative to the rest of the State despite the acuity increases the Hospital experienced, as documented in Table 4 above:



Recommendation

HSCRC staff recommends that the Commission:

1) Approve a general revenue increase request of $2,084,838 effective December 1, 2021, because the Hospital has demonstrated cost efficiency and a revenue structure that is insufficient to support the underlying cost base. Since Medicare does not pay HSCRC-approved rates at Brook Lane, the expected net amount of this increase is estimated to be approximately $1,530,380.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2022**
SYSTEM	*	**FOLIO:**	**2391**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2581A**

Staff Recommendation

February 9, 2022

I. INTRODUCTION

On January 26, 2022, Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval to continue to participate in a revised global price arrangement with Life Trac (a subsidiary of Allianz Insurance Company of North America) for solid organ and bone marrow transplants and cardiovascular services. The Hospitals request that the Commission approve the arrangement for one year beginning March 1, 2022.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payers, 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 that it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

The staff found that the experience under the arrangement has been favorable for the last year. Staff believes that the Hospitals can continue to achieve a favorable performance under the arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services and cardiovascular services for the period beginning March 1, 2022. The Hospitals 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 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.

RECOMMENDATION TO GRANT AN EXTENSION OF APPROVAL OF THE ALTERNATIVE METHOD OF RATE DETERMINATION (ARM) ARRANGEMENT BETWEEN JOHNS HOPKINS HEALTH SYSTEM AND THE BLUE DISTINCTION CENTERS FOR TRANSPLANTS

February 9, 2022

Background

Effective December 9, 2020, a one-year approval was granted for the renewal of an alternative rate arrangement (ARM) between the Johns Hopkins Health System (JHHS) and Blue Distinction Center for Transplants for the provision of solid organ and blood and bone marrow services.

In October of 2021, JHHS requested and was granted a three-month extension of the approval for the ARM arrangement with Blue Distinction Center for Transplants to provide time to complete renegotiation of the arrangement.

Request

On January 26, 2022, JHHS requested an additional one-month extension, to March 31, 2022, to finalize negotiations on the ARM arrangement with Blue Distinction Center for Transplants.

Findings

Staff found that the experience for ARM arrangement between the JHHS and Blue Distinction Center for Transplants has been favorable for the last twelve months.

Recommendation

Since the authority granted to staff to extend Commission approval on ARM arrangements is limited to three months, staff recommends that the Commission approve JHHS's request for an additional one-month extension, to March 31, 2022, of Commission approval for the ARM arrangement between the JHHS and Blue Distinction Center for Transplants.

maryland
health services
cost review commission

TO: HSCRC Commissioners

FROM: HSCRC Staff

DATE: February 9, 2022

RE: Hearing and Meeting Schedule

March 9, 2022 To be determined - GoTo Webinar

April 13, 2022 To be determined - GoTo Webinar

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

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