NOTICE OF WRITTEN COMMENT PERIOD

Notice is hereby given that the public and interested parties are invited to submit written comments to the Commission on the staff draft recommendation that will be presented at the December 12, 2018 Public Meeting:

1) Draft Recommendation on the Readmission Reduction Incentive Program for RY 2021

2) Draft Recommendation on Medicare Advantage Sequestration Adjustment

WRITTEN COMMMENTS ON THE AFOREMENTIONED STAFF DRAFT RECOMMENDATIONS ARE DUE IN THE COMMISSION'S OFFICES ON OR BEFORE DECEMBER 20, 2018, UNLESS OTHERWISE SPECIFIED IN THE RECOMMENDATION.

State of Maryland
Department of Health

Nelson J. Sabatini
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

John M. Colmers

James N. Elliott, M.D.

Adam Kane

Jack C. Keane

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Katie Wunderlich
Executive Director

Allan Pack, Director
Population Based
Methodologies

Chris Peterson, Director
Clinical & Financial
Information

Gerard J. Schmith, Director
Revenue & Regulation
Compliance

557th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
December 12, 2018

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

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

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

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on November 14, 2018**

2. **New Model Monitoring**

3. **Docket Status – Cases Closed**
   2460A – University of Maryland Medical Center **2461A – University of Maryland Medical Center**

4. **Docket Status – Cases Open**

   2452A – Johns Hopkins Health System **2453A – MedStar Health**
   2458A – University of Maryland Medical Center **2459A – Maryland Physicians Care**
   2462A – University of Maryland Medical Center **2463A – University of Maryland Medical Center**
   2464A – Johns Hopkins Health System **2465A – Johns Hopkins Health System**
   2466A – Johns Hopkins Health System **2467A – Johns Hopkins Health System**
   2468A – Johns Hopkins Health System **2469A – Johns Hopkins Health System**

5. **Final Recommendation on Adjustment to the Payer Differential**

6. **Final Recommendation on Updates to the Quality-Based Reimbursement (QBR) Policy for RY 2021**

7. **Draft Recommendation on Updates to the Readmission Reduction Incentive Program Policy for RY 2021**

8. **Draft Recommendation on Medicare Advantage Sequestration**

9. **Report on FY 2017 and 2018 Transformation Grants Activities**

10. Policy Update and Discussion

- **a. Update from Executive Director**
- **b. MDPCP Update**
- **c. Commissioner Discussion of Potentially Avoidable Utilization**

11. Hearing and Meeting Schedule

New Model Monitoring Report

The Report will be distributed during the Commission Meeting

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 DECEMBER 3, 2018

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2452A	Johns Hopkins Health System	9/6/2018	N/A	N/A	ARM	AP	OPEN
2453A	MedStar Health	9/6/2018	N/A	N/A	ARM	AP	OPEN
2458A	University of Maryland Medical Center	10/1/2018	N/A	N/A	ARM	DNP	OPEN
2459A	Maryland Physicians Care	10/1/2018	N/A	N/A	ARM	AP	OPEN
2462A	University of Maryland Medical System	10/15/2018	N/A	N/A	ARM	DNP	OPEN
2463A	University of Maryland Medical System	10/15/2018	N/A	N/A	ARM	AP	OPEN
2464A	Johns Hopkins Health System	10/29/2018	N/A	N/A	ARM	DNP	OPEN
2465A	Johns Hopkins Health System	11/20/2018	N/A	N/A	ARM	DNP	OPEN
2466A	Johns Hopkins Health System	11/27/2018	N/A	N/A	ARM	DNP	OPEN
2467A	Johns Hopkins Health System	11/27/2018	N/A	N/A	ARM	DNP	OPEN
2468A	Johns Hopkins Health System	11/27/2018	N/A	N/A	ARM	DNP	OPEN
2469A	Johns Hopkins Health System	11/30/2018	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
THE JOHNS HOPKINS HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2018**
	*	**FOLIO:**	**2262**
BALTIMORE, MARYLAND	*	**PROCEEDING**	**2452A**

Final Recommendation

December 12, 2018

I. Introduction

On September 6, 2018 Johns Hopkins Health System ("JHHS," or the "System") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Suburban Hospital, and Howard County General Hospital ("the Hospitals"). The System seeks renewal for the continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. Priority Partners, Inc. is the entity that assumes the risk under the contract. The Commission most recently approved this contract under proceeding 2353A for the period from January 1, 2018 through December 31, 2018. The Hospitals are requesting to renew this contract for a one-year period beginning January 1, 2019.

II. Background

Under the Medicaid Health Choice Program, Priority Partners, a provider-sponsored Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. Priority Partners was created in 1996 as a joint venture between Johns Hopkins Health Care (JHHC) and the Maryland Community Health System (MCHS) to operate an MCO under the Health Choice Program. Johns Hopkins Health Care operates as the administrative arm of Priority Partners and receives a percentage of premiums to provide services such as claim adjudication and utilization management. MCHS oversees a network of Federally Qualified Health Clinics and provides member expertise in the provision of primary care services and assistance in the development of provider networks.

The application requests approval for the Hospitals to continue to provide inpatient and

outpatient hospital services, as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. Priority Partners pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. The Hospitals supplied information on their most recent experience as well as their preliminary projected revenues and expenditures for the upcoming year based on the initially revised Medicaid capitation rates.

Priority Partners is a major participant in the Medicaid Health Choice program, providing managed care services to 25.5% of the State's MCO population.

III. Staff Review

This contract has been operating under the HSCRC's initial approval in proceeding 2353A. Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2017, 2018, and 2019. The statements provided by Priority Partners to staff represent both a "stand-alone" and "consolidated" view of Priority's operations. The consolidated picture reflects certain administrative revenues and expenses of Johns Hopkins Health Care. When other provider-based MCOs are evaluated for financial stability, their administrative costs relative to their MCO business are included as well; however, they are all included under the one entity of the MCO.

The consolidated financial performance of Priority Partners was favorable in CY 2017. Priority Partners is projecting to have unfavorable performance in CY 2018 and an unfavorable performance in CY 2019; however, the CY19 unfavorable performance is mainly due to the positing of a large premium deficiency reserve that may not be necessary given recent actions taken by the Maryland Department of Health to increase rates for childless adult population.

IV. Recommendation

Based on this three year analysis, HSCRC has concerns about whether this arrangement could be deemed a loss contract from an MCO ARM perspective.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2019; however, staff is placing Priority Partners on a watch list as described in item (2) below.

(2) Since sustained losses, such as those currently being experienced by Priority Partners may be construed as a loss contract necessitating termination of this arrangement, staff is recommending the following actions:

- **a. On the earlier of July 1, 2019 or if/when Medicaid applies a mid-year adjustment, Priority Partners shall report to HSCRC staff on the impact that any such adjustment is expected to have on CY 2019 financial performance.**
- **b. HSCRC staff shall be cognizant of the MCO's financial performance and the potential for a loss contract in considering any requested adjustments to rates or global budgets of the associated hospitals during FYs 2019 and 2020.**
- **c. In addition to the report provided in (2)(a), Priority Partners shall report to Commission staff (on or before the September 2019 meeting of the**

Commission) on the actual CY 2018 experience and preliminary CY 2019 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2020 using a prescribed template that the HSCRC will provide.

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the 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 also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*****	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*****	**SERVICES COST REVIEW**	
MEDSTAR HEALTH	*****	**COMMISSION**	
SYSTEM	*****	**DOCKET:**	**2018**
	*****	**FOLIO:**	**2263**
COLUMBIA, MARYLAND	*****	**PROCEEDING:**	**2453A**

Final Recommendation

December 12, 2018

I. Introduction

On September 6, 2018, MedStar Health filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of the MedStar Hospitals ("the Hospitals"). MedStar Health seeks renewal for the continued participation of MedStar Family Choice ("MFC") in the Medicaid Health Choice Program. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2358A for the period from January 1, 2018 through December 31, 2018. The Hospitals are requesting to renew this contract for one year beginning January 1, 2019.

II. Background

Under the Medicaid Health Choice Program, MedStar Family Choice, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services, as well as certain non-hospital services, while MFC receives a State-determined capitation payment. MFC pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. As of June 2018, MFC provided services to 7.8% of the total number of MCO enrollees in Maryland.

The Hospitals supplied information on their most recent experience as well as their preliminary projected revenues and expenditures for the upcoming year based on the Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (proceeding 2353A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2017, 2018, and 2019. Over this three year period, Medstar has sustained slightly favorable performance.

IV. Recommendation

Based on past and projected performance, staff believes that the proposed renewal arrangement for Medstar is acceptable.

Therefore:

1) **Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2019.**
2) **Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance in CY 2018, and the MCOs expected financial status into CY 2019. Therefore, staff recommends that Medstar report to Commission staff (on or before the September 2019 meeting of the Commission) on the actual CY 2018 experience, and preliminary CY 2019 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2020 using a prescribed template that the HSCRC will provide.**

3) **Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the 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 also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.**

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2018**
MEDICAL CENTER	*****	**FOLIO:**	**2268**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2458A**

Staff Recommendation

December 12, 2018

I. INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on October 1, 2018 requesting approval to continue its participation in a global rate arrangement with BlueCross and BlueShield Association Blue Distinction Centers for solid organ and blood and bone marrow transplant services for a period of one year beginning November 1, 2018.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an

alternative method of rate determination for blood and bone marrow transplant services, for a one year period commencing November 1, 2018. The Hospital will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
SAINT AGNES HEALTH	*	**COMMISSION**	
WESTERN MARYLAND HEALTH SYSTEM	*	**DOCKET:**	**2018**
MERITUS HEALTH	*	**FOLIO:**	**2269**
HOLY CROSS HEALTH	*	**PROCEEDING:**	**2459A**

Final Recommendation

December 12, 2018

I. Introduction

October 1, 2018 Saint Agnes Health System, Western Maryland Health System, Holy Cross Health, and Meritus Health ("the Hospitals") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06. The Hospitals seek renewal for the continued participation of Maryland Physicians Care ("MPC") in the Medicaid Health Choice Program. MPC is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2356A for the period January 1, 2018 through December 31, 2018. The Hospitals are requesting to renew this contract for one year beginning January 1, 2019.

II. Background

Under the Medicaid Health Choice Program, MPC, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. MPC pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. MPC is a major participant in the Medicaid Health Choice program, and provides services to 18.5% of the total number of MCO enrollees in Maryland.

The Hospitals supplied information on their most recent experience as well as their preliminary projected revenues and expenditures for the upcoming year based on the revised Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (Proceeding 2356A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2017, 2018, and 2019. In CY 2017 MPC had favorable performance and is projecting marginal favorable performance in CY 2018; however, the MCO is projecting marginal unfavorable performance in CY 2019.

IV. Recommendation

Based on past and projected performance, staff believes that the proposed renewal arrangement for MPC is acceptable.

Therefore:

1) **Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2019.**
2) **Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance in CY 2018, and the MCOs expected financial status into CY 2019. Therefore, staff recommends that MPC report to Commission staff (on or before the September 2019 meeting of the Commission) on the actual CY 2018 experience, and preliminary CY 2019 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2020 using a prescribed template that the HSCRC will provide.**

Consistent with its policy paper outlining a structure for review and evaluation of

applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the 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 also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*****	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*****	**SERVICES COST REVIEW**	
UNIVERSITY OF MARYLAND	*****	**COMMISSION**	
MEDICAL SYSTEM	*****	**DOCKET:**	**2018**
	*****	**FOLIO:**	**2272**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2462A**

Staff Recommendation

December 12, 2018

I. Introduction

On October 15, 2018, the University of Maryland Medical System (UMMS) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of its constituent hospitals (the "Hospitals"). UMMS seeks approval for University of Maryland Health Advantage, Inc. ("UMHA") to continue to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. UMHA is the UMMS entity that assumes the risk under this contract. UMHA is requesting an approval for one year beginning January 1, 2019.

II. Background

On September 1, 2015, CMS granted UMHA approval to operate a Medicare Advantage Plan to provide coverage to Maryland eligible residents in Anne Arundel, Baltimore, Caroline, Cecil, Carroll, Dorchester, Harford, Howard, Kent, Montgomery, Queen Anne's, Talbot counties and Baltimore City. UMHA currently offers two products - - UMHA Complete, which is a general enrollment Medicare Advantage Plan that includes Medicare Part D prescription drug coverage, and UMHA Duel Special Needs Plan that limits membership to people with special needs that are eligible for both Medicare and Medicaid. For economic reasons UMHA plans to stop offering the UMHA Complete Plan and to provide only the UMHA Duel Special Needs Plan (in CY 2019. The application requests approval for UMHA to provide for inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a CMS-determined capitation payment. UMHA will pay the Hospitals HSCRC-approved rates for hospital services used by its enrollees. UMHA supplied staff with a copy of its contract with CMS.

III. Staff Review

Staff reviewed the reviewed the financial projections for CY 2019, as well as UMHA's experience and projections for CY 2018. The information reflected the anticipated negative financial results associated with the start-up of a Medicare Advantage Plan. According to UMHA its concentration on the Duel Special Needs market and its exit from the general enrollment market will result in a more favorable experience in CY 2019.

IV. Recommendation

Based on the financial projections, staff believes that the proposed arrangement for UMHA is acceptable under Commission policy. Therefore, staff recommends that the Commission approve the Hospitals' request to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2018. UMHA must meet with HSCRC staff prior to August 31, 2019 to review its financial projections for CY 2020. In addition, UMHA must submit to the Commission a copy of its quarterly and annual National Association of Insurance Commissioners' (NAIC's) reports within 30 days of submission to the NAIC.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment

of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*****	**BEFORE THE HEALTH**
RATE APPLICATION OF	*****	**SERVICES COST REVIEW**
UNIVERSITY OF MARYLAND MEDICAL	*****	**COMMISSION**
SYSTEM CORPORATION		
	*****	**DOCKET: 2018**
	*****	**FOLIO: 2273**
	*****	**PROCEEDING: 2463A**

Final Recommendation

December 12, 2018

I. Introduction

On October 15, 2018 University of Maryland Health Partners, Inc. (UMHP), a Medicaid Managed Care Organization ("MCO"), on behalf of The University of Maryland Medical System Corporation ("the Hospitals"), filed an application for an Alternative Method of Rate Determination ("ARM") pursuant to COMAR 10.37.10.06. UMHP and the Hospitals seek approval for the MCO to continue to participate in the Medicaid Health Choice Program. UMHP is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2410A for the period from January 1, 2018 through December 31, 2018. The former MCO known as Riverside was purchased by University of Maryland Medical System Corporation in August 2015. UMHP and the Hospitals are requesting to implement this new contract for one year beginning January 1, 2019.

II. Background

Under the Medicaid Health Choice Program, UMHP, an MCO owned by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. UMHP pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. UMHP is a relatively small MCO providing services to 3.9% of the total number of MCO enrollees in the HealthChoice Program.

UMHP supplied information on its most recent financial experience as well as its preliminary projected revenues and expenditures for the upcoming year based on the revised Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (proceeding 2410A). Staff reviewed the operating financial performance under the contract. Staff reviewed available final financial information and projections for CYs 2017, 2018, and 2019. UMHP reported marginal favorable financial performance for CY 2017. Initial projections for CYs 2018 and 2019 are unfavorable; however, it should be noted that for CY 2019 UMHP has amended its projection to favorable because of implementing performance improvement options, including eliminating primary care practices with poor cost efficiency performance.

IV. Recommendation

UMHP has only been in operations as a MCO for five years and has only had breakeven years and years of profitability. Nevertheless, staff does have concerns that UMHP's low market share and limited rate increases will make it difficult for them to not operate as a loss leader in CY 2018 and CY 2019.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2018; however, staff is placing UMHP on a watch list as described in item (2) below.

(2) Since sustained losses, such as those currently being experienced by UMHP, may be construed as a loss contract necessitating termination of this arrangement, staff is recommending the following actions:

a. On the earlier of July 1, 2019 or if/when Medicaid applies a mid-year adjustment, UMHP shall report to HSCRC staff on the impact that any

such adjustment is expected to have on CY 2019 financial performance.

b. HSCRC staff shall be cognizant of the MCO's financial performance and the potential for a loss contract in considering any requested adjustments to rates or global budgets of the associated hospitals during FYs 2019 and 2020 using a prescribed template that the HSCRC will provide.

c. In addition to the report provided in (2)(a), UMHP shall report to Commission staff (on or before the September 2019 meeting of the Commission) on the actual CY 2018 experience, preliminary CY 2019 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2020.

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the 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 also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: **THE APPLICATION FOR**	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2018**
SYSTEM	*	**FOLIO:**	**2274**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2464A**

Staff Recommendation

December 12, 2018

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on October 29, 2018 on behalf of its member Hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to participate in a new global rate arrangement for cardiovascular and joint replacement services with Health Design Plus, Inc. for a period of one year beginning December 1, 2018.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving similar joint replacement at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

This new arrangement combines and replaces two prior arrangements approved by the Commission. The experience under the prior arrangements were favorable over the last year.

Therefore, staff recommends approval of the Hospitals' request.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular and joint replacement services for a one year period commencing December 1, 2018. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*****	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*****	**SERVICES COST REVIEW**	
JOHNS HOPKINS HEALTH	*****	**COMMISSION**	
SYSTEM	*****	**DOCKET:**	**2018**
	*****	**FOLIO:**	**2275**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2465A**

Staff Recommendation

December 12, 2018

I. Introduction

On November 20, 2018, the Johns Hopkins Health System (JHHS) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of its constituent hospitals (the "Hospitals"). JHHS seeks approval for Hopkins Health Advantage. Inc. ("HHA") to continue to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. HHA is the JHHS entity that assumes the risk under this contract. JHHS is requesting approval for one year beginning January 1, 2019.

II. Background

On September 1, 2015, CMS granted HHA approval to operate a Medicare Advantage Plan to provide coverage to Maryland eligible residents in Anne Arundel, Baltimore, Calvert, Carroll, Howard, Montgomery, Somerset, Washington, Wicomico, Worcester counties and Baltimore City. HHA is jointly controlled by Johns Hopkins HealthCare, LLC, Advanced Health Collaborative II, LLC (consisting of Adventist Healthcare, Inc., Frederick Regional Health System, Inc., Lifebridge Health, Inc., and Peninsula Regional Health System, Inc.), Anne Arundel Medical Center, and Mercy Health Services, Inc. The application requests approval for HHA to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a CMS-determined capitation payment. HHA will pay the Hospitals HSCRC-approved rates for hospital services used by its enrollees. HHA has supplied the HSCRCV staff with a copy of its contract with CMS.

III. Staff Review

Staff reviewed the reviewed the financial projections for CY 2019, as well as HHA's

experience and projections for CY 2018. The information reflected the anticipated negative financial results associated with the start-up of a Medicare Advantage Plan.

IV. Recommendation

Based on the financial projections, staff believes that the proposed arrangement for HHA is acceptable under Commission policy.Therefore, staff recommends that the Commission approve the Hospitals' request to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2019. The Hospitals must file a renewal application annually for continued participation. In addition, HHA must meet with HSCRC staff prior to August 31, 2019 to review its financial projections for CY 2020. In addition, HHA must submit a copy of its quarterly and annual National Association of Insurance Commissioner's (NAIC's) reports within 30 days of submission to the NAIC.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2018**
SYSTEM	*	**FOLIO:**	**2277**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2467A**

Staff Recommendation

December 12, 2018

INTRODUCTION

Johns Hopkins Health System (System) filed a renewal application with the HSCRC on November 28, 2018 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for continued participation in a capitation arrangement serving persons with mental health needs under the program title, Creative Alternatives. The arrangement is between the Johns Hopkins Health System and the Baltimore Mental Health Systems, Inc., with the services coordinated through the Hospital. The requested approval is for a period of one year beginning January 1, 2019.

II. OVERVIEW OF APPLICATION

The parties to the contract include the System and the Baltimore Mental Health Systems, Inc. Creative Alternatives provides a range of support services for persons diagnosed with mental illness and covers medical services delivered through the Hospital. The System will assume the risk under the agreement, and all Maryland hospital services will be paid based on HSCRC rates.

III. STAFF FINDINGS

Staff found that the experience under this arrangement for FY 2017 was favorable. Staff believes that the Hospital can continue to achieve a favorable performance under this arrangement.

IV. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's renewal application for an alternative method of rate determination for a one year period commencing January 1, 2019.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other

issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
JOHNS HOPKINS HEALTH	*****	**DOCKET:**	**2018**
SYSTEM	*****	**FOLIO:**	**2278**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2468A**

Staff Recommendation

December 12, 2018

I. INTRODUCTION

Johns Hopkins Health System (the System) filed a renewal application with the HSCRC on November 28, 2018 on behalf of its member hospitals, the Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for continued participation in a capitation arrangement serving persons insured with Tricare. The arrangement involves the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare as providers for Tricare patients. The requested approval is for a period of one year beginning January 1, 2019.

II. OVERVIEW OF APPLICATION

The parties to the contract include the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare, a subsidiary of the System. The program provides a range of health care services for persons insured under Tricare including inpatient and outpatient hospital services. Johns Hopkins Health Care will assume the risk under the agreement, and the Hospitals will be paid based on their approved HSCRC rates.

III. STAFF EVALUATION

Staff found the experience under this arrangement to be favorable for the last year. Staff believes that the Hospitals can continue to achieve favorable performance under this arrangement.

V. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' renewal application for an alternative method of rate determination for a one year period beginning January 1, 2019. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract.

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

IN RE: **THE APPLICATION FOR**	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2018**
SYSTEM	*	**FOLIO:**	**2279**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2469A**

Staff Recommendation

December 12, 2018

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on November 30, 2018 on behalf of its member Hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to participate in a new global rate arrangement for joint replacement and joint replacement consult services with Carrum Health, Inc. for a period of one year beginning January 1, 2019.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving similar joint replacement services at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

This new arrangement is similar to several other successful arrangements approved by the

Commission.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular and joint replacement services for a one year period commencing January 1, 2019. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Final Staff Recommendation for Adjustment to the Payer Differential

December 12, 2018

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

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FINAL RECOMMENDATION

Staff is presenting this final recommendation to increase the public-payer differential from 6.0 percent to 7.7 percent, effective July 1, 2019. Given recent trends of increasing bad-debt write-offs in commercial coverage, it is most equitable that the differential be increased 1.7 percentage points (from the current 6.0 percent to 7.7 percent) to ensure that these costs are not shifted to Medicare and Medicaid. This change accounts for the changes in business practices of private Maryland payers that have resulted in higher bad debt costs.

The State of Maryland has employed a differential since the 1970s whereby public payers (Medicare and Medicaid) pay less than other payers (primarily commercial payers) due to business practices that avert bad debt in hospitals and keep Maryland's hospital costs low. Hospital charges are adjusted via a markup to ensure that the differential's reduction in charges to public payers does not result in a decline in hospitals' total revenue.

This report presents analyses and the staff recommendation to adjust the public-payer differential in order to correct for excess bad-debt write-offs from commercial coverage, which is shifting costs onto Medicare and Medicaid. This adjustment will result in a more equitable distribution of uncompensated care costs and adjust the differential for payers who are averting more bad debt. The HSCRC staff is recommending an effective date of July 1, 2019 to allow for implementation by the Medicare intermediary and other payers. This differential change is not intended to supplant the work of providers to generate savings to Medicare under the All-Payer and Total Cost of Care Model Agreements with CMS, but rather to more accurately and fairly adjust for current trends in uncompensated care resulting from plan design changes of private payers.

This report also summarize comments received form stakeholders and Commissioners on this topic. Responses and additional analysis is included as appropriate with regards to the comments received.

BACKGROUND AND HISTORY

The Maryland Health Services Cost Review Commission ("HSCRC," or "Commission") is a state agency with unique regulatory authority. Legally, the HSCRC is authorized to set the rates that Maryland hospitals may charge. These rates form the basis for which all payers in Maryland pay for the provision of hospital services. The federal government granted Maryland the authority to set hospital payment rates for Medicare as part of its all-payer hospital rate-setting system administered by the HSCRC. This all-payer rate-setting approach, which has been in place since 1977, eliminates cost-shifting among payers, while also appropriately accounting for certain differences among payers.

At the inception of the first Medicare waiver in 1977, a payer differential was established based on business practices of payers that helped to avert bad debt to hospitals such as prompt payment and insuring high-risk individuals. It is referred to as a differential rather than a discount, because the differential in payments is built into hospitals' rate structures.

Initially, the HSCRC allowed some private carriers to pay Maryland hospitals four percent less than a hospital's approved rates, with an additional reduction available contingent upon compliance with HSCRC prompt pay regulations. This four percent reduction program, known as Substantial, Available and Affordable Coverage (SAAC), encouraged the provision of health care coverage to high-risk individuals, thereby averting bad debt and reducing uncompensated care at Maryland hospitals. The HSCRC adopted specific requirements for a non-governmental payer to be eligible for the SAAC program. For example, in order to obtain the SAAC discount, a payer was required to provide annually, at a minimum, an open enrollment period of 60 days, comprised of two 30-day periods at least five months apart. Such open enrollment, required to be advertised to the public, would allow for individuals or families to purchase health insurance coverage, without a medical exam or medical screening (referred to as medical underwriting), at a standard, affordable price. The SAAC program and the provision of health insurance to those that may not otherwise have afforded health insurance helped to avert bad debt or non-payment to hospitals.

In 1999, however, the HSCRC decided to examine whether the SAAC policy was achieving its intended purposes in light of numerous complaints regarding changing payer practices. Among the complaints, it was reported that the coverage provided under these SAAC plans was not substantial. For example, many of the policies offered lacked substantial, or any, prescription drug coverage. There were also complaints about availability indicating the gradual shortening of open enrollment timeframes. Furthermore, the employer market became increasingly self-insured, and the SAAC differential was being passed on to the self-insured employers as an administrative benefit, rather than being used to lower the cost of coverage to high-risk individuals. Upon examination, the HSCRC determined that the cost of the SAAC discount greatly outweighed the hospital savings generated by the open enrollment program and the provision of health insurance afforded to high risk individuals. In 2001, recognizing shortcomings of the SAAC program, the legislature required SAAC providers to contribute 37.5

percent of the value of the differential to a Short-Term Prescription Drug Subsidy Plan. The SAAC program was finally discontinued in 2003.

The SAAC program was eventually replaced by the Maryland Health Insurance Program (MHIP), a program that subsidized high-risk individuals who could not obtain medically underwritten coverage or had to pay higher rates to obtain coverage. MHIP was funded through an assessment of the aggregate value of the SAAC discount, or 0.08128 of Net Patient Revenue. In FY 2009 the assessment on hospital rates was increased to one percent of Net Patient Revenue. The MHIP program was discontinued in 2014 after the implementation of the Affordable Care Act which increased availability of coverage for high-risk individuals and expanded Medicaid eligibility. The assessment to pay for the program was also rescinded and savings were generated to all payers in the system.

All payers were still allowed to pay Maryland hospitals two percent less than the hospitals' approved rates if the HSCRC requirements for prompt payment were met, and 2.25 percent less if they provided current financing equivalent to payment upon admission. The two percent reduction is currently made available to all payers other than Medicare.

ASSESSMENT OF CHANGING BUSINESS PRACTICES

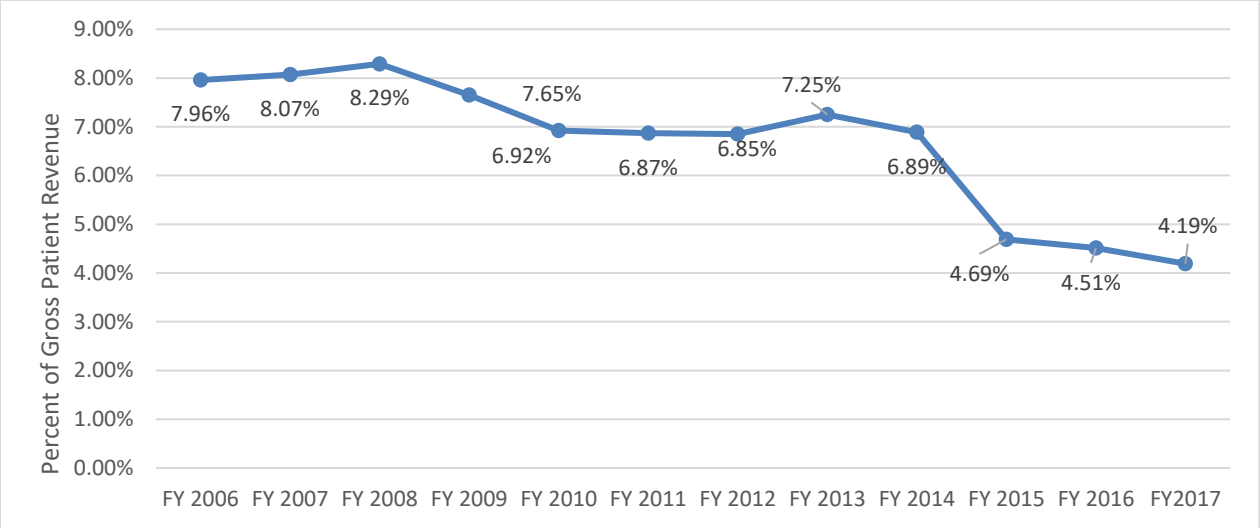
While expansion of coverage under the Affordable Care Act has contributed to a large increase in averted bad debt at hospitals and a subsequent decline in uncompensated care, rising deductibles and coinsurance have resulted in increased levels of uncompensated care for privately covered beneficiaries. The following section provides information on uncompensated care trends, health care coverage, and more detailed information on plan design trends for private payers in Maryland.

Uncompensated Care Trends

The share of hospital revenues attributed to uncompensated care has been declining in Maryland. This decline aligns with the increase in insurance coverage due to the 2007 Maryland Medicaid expansion and the expansion of Medicaid in 2014 under the Affordable Care Act (ACA). Uncompensated care, as a percentage of total patient revenue, has been reduced from 7.25 percent in 2013 (pre-ACA Medicaid Expansion) to 4.19 percent in 2017, a 3.06 percentage point reduction or a 42.2 percent decrease in uncompensated care. The HSCRC adjusts hospital rates overall to reflect state-wide levels of uncompensated care, based on state-wide averages derived from hospitals' most recent annual reports filed with the Commission. When the ACA provided a significant expansion of Medicaid in CY 2014, the HSCRC began reducing hospitals' rates on July 1, 2014 and July 1, 2015, before information was available from annual reports. While there was a lag in removing uncompensated care from rates, at the same time, there was an increase in Medicaid utilization resulting from the expansion. As a result, hospitals were overfunded for uncompensated care, but underfunded for utilization resulting from the expansion. This was resolved through a hospital specific adjustment for Medicaid expansion and a return to using annual reports and the source of uncompensated care for making the state-wide

uncompensated care adjustment beginning July 1, 2016. All payers received the benefit of the 3.06 percentage point reduction in uncompensated care through hospital revenue reductions.

Figure 1. Actual Uncompensated Care Percentage of Gross Patient Revenue FY2006-FY2017

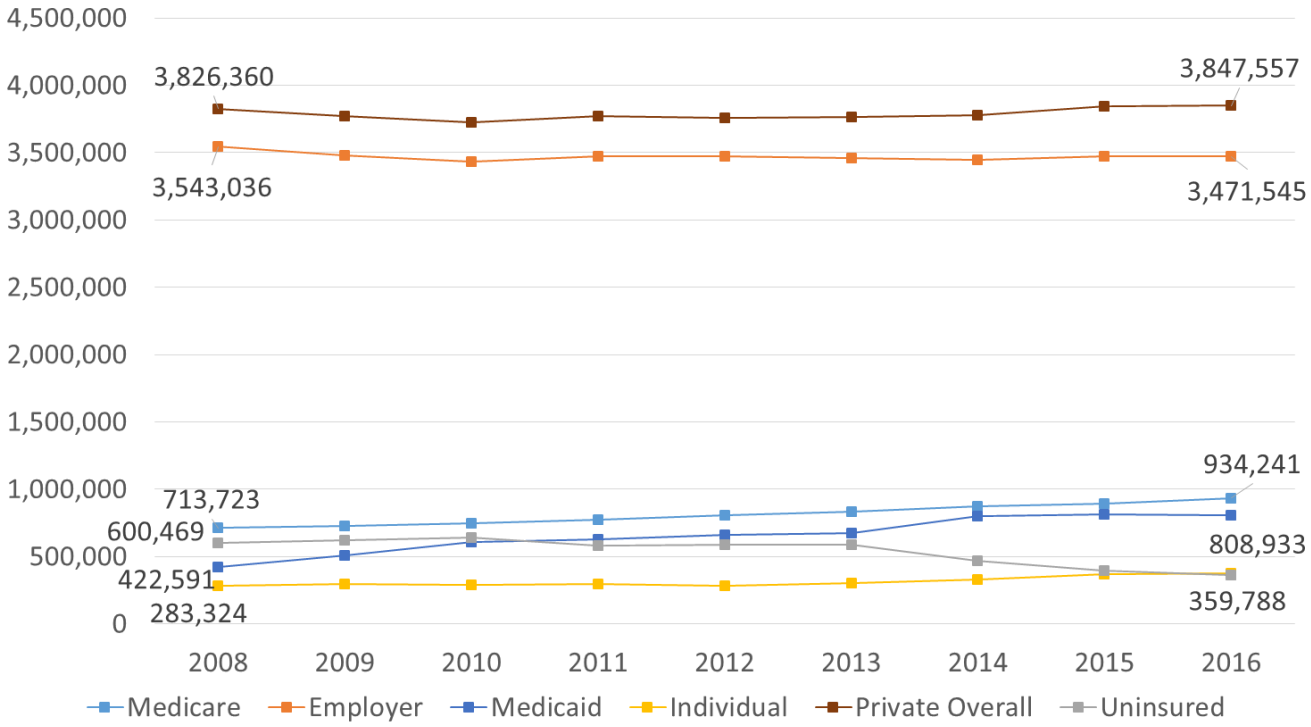


Source: HSCRC Historical Financial Data

Changes in Payer Enrollment

The uncompensated care reduction resulted from an overall increase in health insurance coverage, mainly from the ACA Medicaid expansion. Figure 2 shows the trend of enrollment for Medicaid, individual insurance, employer-sponsored insurance, and aggregate private insurance (aggregate of individual, small group, and large group enrollees), as well as the trend for uninsured individuals, between 2008 and 2016.

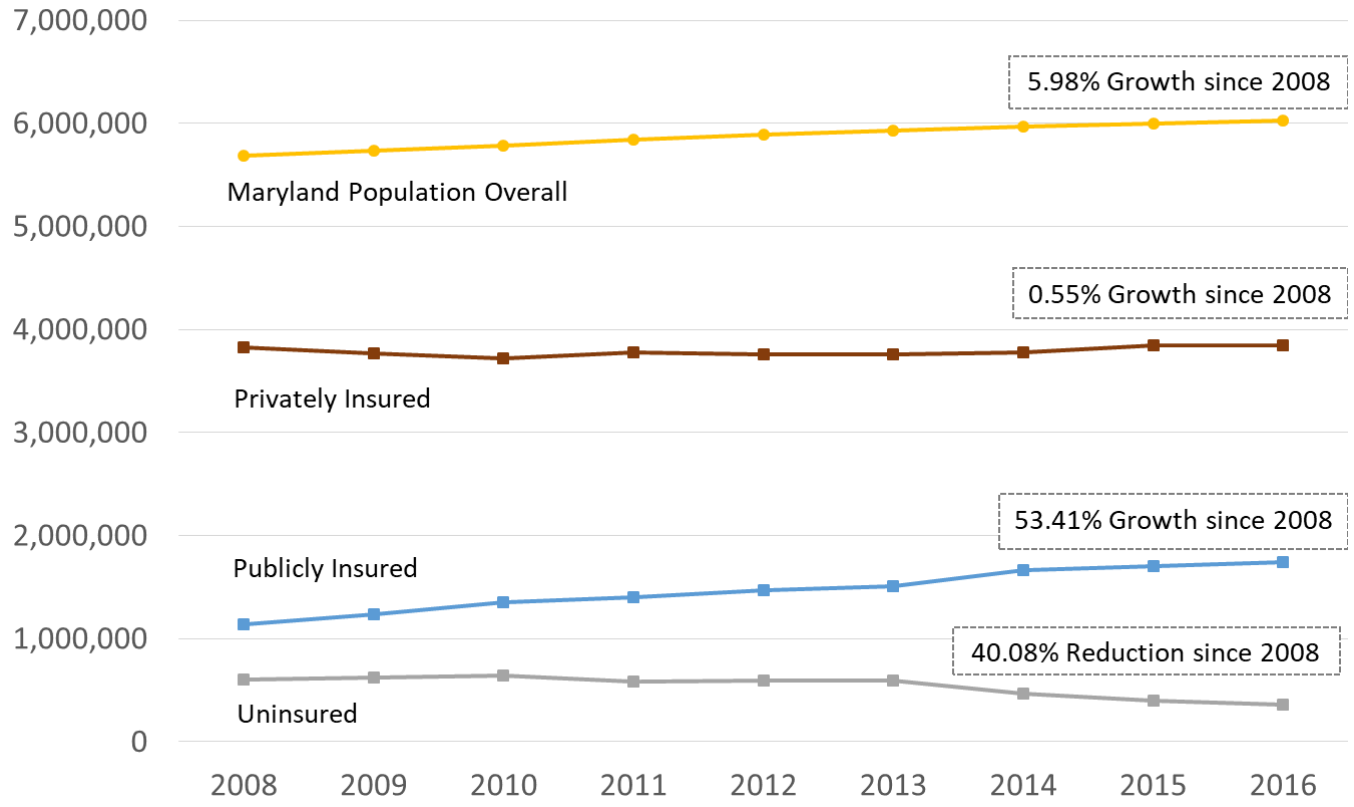
Figure 2. Maryland Health Insurance Coverage by Payer type and Uninsured, CY2008-CY2016.



Source: SHADAC Analysis of the American Community Survey (ACS). http://statehealthcompare.shadac.org/trend/11/health-insurance-coverage-type-by-total#0/1/5/1,2,3,4,5,6,7,8,15/21 and Maryland Department of Health, Office of Healthcare Financing, Accessed June 2018.

While there is little increase overall in privately insured beneficiaries (small and large employers and individual combined), there was an increase of 92,688 people (32.7 percent) enrolled in the individual market. Employer coverage has decreased by 71,491 people, or 2.0 percent. Since 2008, Medicaid enrollment has increased by 386,342 people (91.4 percent overall), with a sharp uptick in Maryland's Medicaid enrollment in 2014 as Maryland Medicaid expanded eligibility under the ACA. As a result of the ACA, the uninsured population has decreased by 240,681 people, or 40.1 percent. Over the same time period, aggregated private health coverage (individual and employer) has only increased by 21,197 people (0.6 percent), significantly less than the population growth rate (0.66 percent average and 5.98 percent growth since 2008) and the 606,860 people newly enrolled in public coverage from Medicare and Medicaid, a 53.4 percent increase. (Figure 3).

Figure 3. Maryland Population Growth and Health Care Coverage, CY2008-CY2016



Private Insurance through the Maryland Health Benefit Exchange

While the uninsured rate in Maryland dropped precipitously between 2012 and 2015 (during the ACA expansion), it appears that this decrease can be attributed more closely to increases in Medicaid enrollment than a large uptake on the individual exchanges. CY2016 estimates of Maryland's marketplace enrollment among potential enrollees show that only 35 percent of eligible enrollees have signed up.[1] A Department of Legislative Services report from 2017 notes that the largest drops in the uninsured rate were for Marylanders at 0-138 percent and 139-200 percent brackets of the federal poverty guidelines (FPG); higher income Marylanders (201-400 percent FPG), who could enroll in private insurance on the exchanges, did not have the same magnitude decrease in their uninsured rates.[1]

Although Maryland already had a subsidized high risk product available to individuals prior to the ACA expansion with the Maryland Health Insurance Plan ("MHIP"), many other existing

[1]Maryland Department of Legislative Services. Assessing the Impact of Health Care Reform In Maryland. January 2017. http://mgaleg.maryland.gov/pubs/legislegal/2017-impact-health-care-reform.pdf

individual policies offered by private carriers were required to expand their benefits under the ACA. CareFirst and Kaiser Permanente provided most of the new individual policies. These policies resulted in losses due to low risk individuals enrolling at a level less than projected, and federal subsidies and premiums not adequately covering costs. During the 2018 legislative session, the State legislature passed legislation to provide relief for insurers providing these products. As a result, a reinsurance program will be established to provide stability in the individual markets and cover some of the losses from the adverse selection noted above.

Private Insurance Offered by Employers

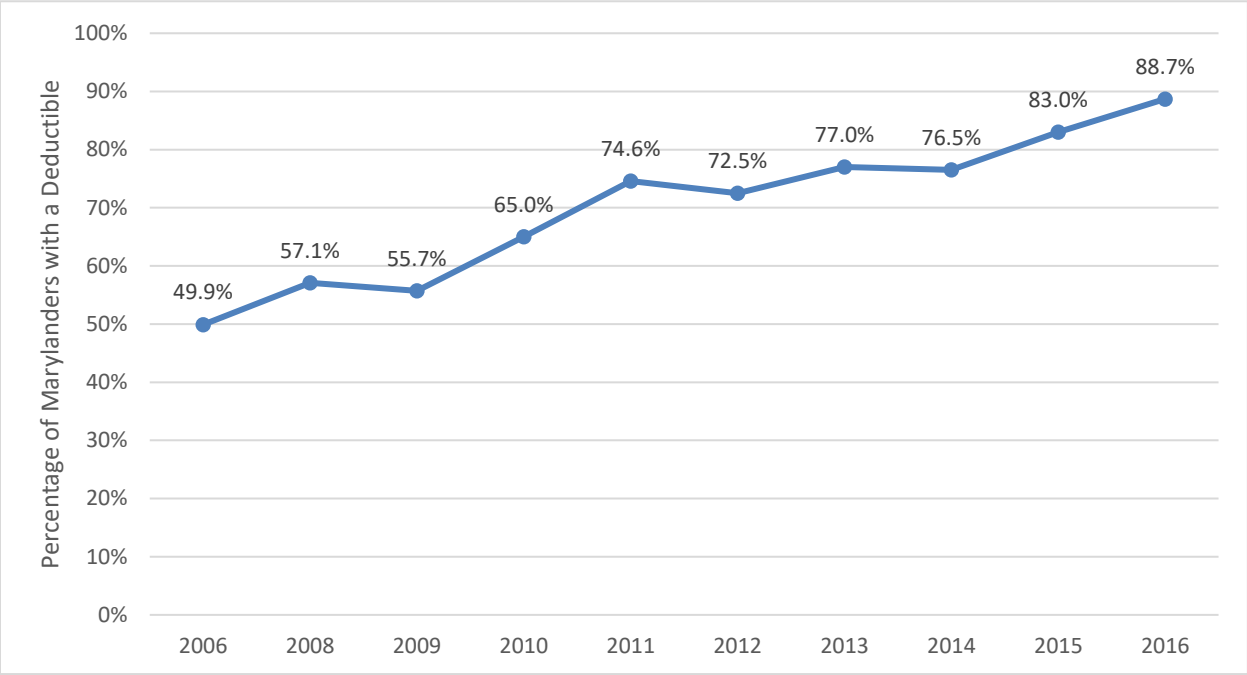
Overall, uptake of employer-sponsored health insurance plans has also dropped in Maryland. Between 2012 and 2015, employee uptake with small group insurance dropped from 72.4 percent to 64.8 percent, and dropped from 78.0 percent to 74.0 percent for large group employers.[1] Medicaid expansion and individual market options may be contributing to this decline.

Commercial Insurance Plan Design Changes

In recent years, private payers have changed plan benefit design to help address growing healthcare costs, as well as address the plan design requirements for individual policies offered under the ACA guidelines. Plans in Maryland, and nationally, are increasingly reliant on beneficiaries to cover larger portions of their care. The share of privately insured Marylanders with a deductible has increased from 49.9 percent in 2006 to 88.7 percent as of 2016. Enrollment in high-deductible health plans has also increased: 44 percent of privately insured Marylanders are now enrolled in a plan with deductibles of at least $1,300 for an individual and $2,600 for a family.[2] Furthermore, average deductibles in Maryland have increased at a rate far outpacing the Consumer Price Index (CPI) for both urban consumers (CPI-U) and medical care (CPI-MC).

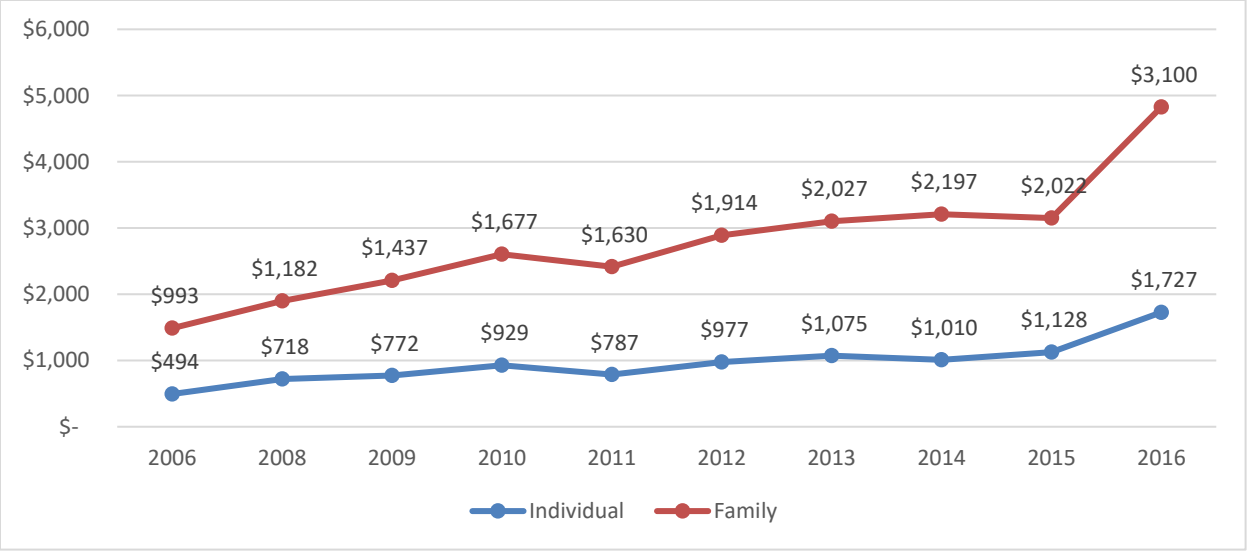
[2] Medical Expenditure Panel Survey (MEPS) Insurance Component, Accessed June 23, 2017 https://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp

Figure 4. Percent of Maryland private-sector employees enrolled in a health insurance plan with deductible (CY2002-CY2016)



Source: Medical Expenditure Panel Survey (MEPS) Insurance Component, Accessed June 23, 2017.
https://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp

Figure 5. Maryland Average Deductibles for Private Insurance, Unadjusted (CY2002-CY2016)



Source: Medical Expenditure Panel Survey (MEPS) Insurance Component, Accessed June 23, 2017.
https://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp

While the plan design changes are aimed at encouraging individual attention to cost levels, the HSCRC staff does not believe it is equitable to have the related uncompensated care allocated to

all payers. Deductibles have increased three-fold since 2006, and twice as many Marylanders are exposed to the rapidly increasing cost burden imposed by deductibles, thereby increasing the level of private payer uncompensated care at hospitals.

Hospital Bad Debt Share by Payer

As a result of the trends noted above, HSCRC staff is concerned that public payers are unduly burdened with the bad debts of private payers. Until recently, HSCRC did not have reliable data to evaluate the impact of increased bad debts for these changing plan designs. The HSCRC used a regression adjustment to estimate predicted bad debt levels for hospitals. Medicaid payer percentages were used to estimate expected charity levels, but with the expansion of Medicaid under the ACA, the relationships used in the regression were no longer valid. Since 2015, HSCRC collected actual write-offs at the account level and matched the write-offs to the case-mix data. Upon collection of this data, HSCRC was able to create new and more accurate estimates of predicted uncompensated care. Staff also evaluated differences in write-offs of patient balances for insured patients. The HSCRC has now collected and analyzed several years of actual write-off data. The data below show a consistent pattern: commercial payer write-off rates are significantly higher than Medicare and Medicaid write-off rates.

Table 1. Maryland Bad Debt to Hospitals, by Payer (FY2015-CY2017)

	Medicare and Medicaid	Commercial	Difference
FY 2015	2.2%	3.6%	1.4%
FY 2016	2.1%	3.8%	1.7%
FY 2017	1.8%	3.6%	1.9%
Change	**-0.5%**	**0.0%**	

According to FY 2017 write-off data, commercial payers' bad-debt write-off rate (3.6 percent) is much higher than the combined rate for Medicare and Medicaid (1.8 percent). If these percentages were applied to FY 2019 revenues, they would translate to approximately $100 million more in write-offs for commercial payers than for Medicare and Medicaid. Of this $100 million, approximately $67 million would be allocated to Medicare and Medicaid through uncompensated care payments funded through hospital rates.

Proposed Change in the Differential

The HSCRC staff believes that this allocation should be corrected through an increase in the differential by 1.7 percentage points in CY 2019. This increase would result in:

- A lower cost to Medicare of approximately $40 million;
- A lower cost to Medicaid of approximately $27 million; and
- An increase in overall commercial payer costs of $67 million, or 0.4 percent, assuming commercial costs reflect approximately one-third of total hospital costs.

The adjustment in the differential is being made to change the allocation of uncompensated care to Medicaid and Medicare. When it is implemented, it will have a revenue neutral effect on hospitals, providing neither more nor less net revenue for each hospital through the formulaic adjustment that is made each year to the mark up for uncompensated care and payer differential. Private payers will see an increase in hospital payments of approximately 1.2 percent (which represents an overall increase of approximately 0.4 percent), while Medicare and Medicaid will see a corresponding decrease in their net payments of 0.7 percent as a result of the higher differential afforded.

This adjustment will ensure more equitable cost allocation going forward, consistent with the HSCRC's statutory mandate.

COMMENTS

After staff presented its draft recommendation at the November Commission meeting, one Commissioner provided written comments that staff has considered and included in this document. Staff also received a number of written comments from stakeholders including CareFirst, the Johns Hopkins Health System (JHHS), the Maryland Hospital Association (MHA), the Maryland Medical Assistance Program (Maryland Medicaid), MedChi, Mercy Health Services and the University of Maryland Medical System (UMMS). Below are the staff responses to Commissioner and stakeholder comments. The responses have been consolidated where practical.

Hospital, MedChi and Medicaid Comments

A majority of the comments supported the proposed differential change. JHHS, MHA, Maryland Medicaid, MedChi, Mercy Health Services and UMMS all expressed their support for changing the public payer differential to account for uncompensated care costs that have been shifted onto public payers from the private payers' changing business practices. Maryland Medicaid also noted the significant expenditures increase from the expansion investment ($8.79 billion total, $1.23 billion to hospitals), and that despite this influx into the system, a significant difference in write-offs between public and private payers remains. MedChi also noted this change was especially important as the system enters into the Total Cost of Care Model in 2019, and that failing to correct for the imbalance would serve as an "injustice" that, in its view, "would disadvantage Maryland's senior citizens and poorer residents as they would subsidize consumers who were fortunate enough to have private health insurance."

Hospital comments (JHHS and UMMS) as well as MHA included a request to change the proposed implementation of the differential change to January 1, 2019, as opposed to July 1, 2019. While staff understands these concerns, CMS has communicated that the change to the differential could not be effective January 1, but suggested a July 1 effective date instead. Staff also notes that the differential change will now naturally align with FY2020 for hospitals, thereby simplifying markup calculations.

Finally, JHHS commented that this differential change should not be excluded from the $300 million total cost of care savings requirement included in the TCOC Agreement. Staff oppose this concept for a number of reasons. This proposed differential change is to correct for a system imbalance and changing business practices of commercial insurers. Additionally, the TCOC Agreement was signed to encourage health system transformation that works to improve outcomes and efficiency to achieve savings. The health care delivery system needs to be accountable for the savings amount the State has committed to the federal government and, therefore, staff included its recommendation that the savings resulting from this change be excluded from TCOC savings and update factor considerations. MHA and UMMS are in agreement with the staff recommendation to exclude the differential shift from TCOC savings performance.

Rationale for Differential

Commissioner Keane's written comments suggest that the staff's logic regarding the rationale for recommending a change in the differential is flawed, as the original differential was not predicated on the basis of different relative write-offs and that Exchange enrollees may be a primary cause of the difference in uncompensated care.

Response:

Staff respectfully disagrees with the assertion that it is necessary to demonstrate that the original differential was based on differences in write-offs. In fact, staff has shown that the original differential was based on Medicare business and prompt pay practices. This was evidenced in the July 20, 1976 contract negotiated with the Social Security Administration to add Skilled Nursing Facilities to the HSCRC prospective hospital payment methodology approved by the federal government ("the 1976 Contract" - Contract number: 600-76-0140) and reiterated in the 2014 All-Payer Model Agreement with CMS.[3] The 1976 contract states, "The minimum total differential (including working capital discount) which will be allowed to Medicare for their business practices and prompt payment practices to the nearest whole percent will be 6 percent. It should be emphasized that this 6 percent is the minimum differential that will be given to Medicare." The 6 percent differential was in effect for the duration of the initial waiver agreement with the federal government.

In contrast, staff's analysis shows that private payers have taken steps in recent years that have uniquely contributed to higher private payer uncompensated care levels through the introduction of more and higher deductibles and coinsurances. Evidence that this has contributed to higher hospital uncompensated care is reported in numerous articles and publications, such as a recent Moody's release.[4] Relative to the past decade in Maryland specifically, staff presented data from the Medical Expenditure Panel Survey (MEPS) demonstrating an increase in deductibles

[3] Ultimately, chronic care beds were included in the Waiver via this methodology.

[4] Moody's: Preliminary medians for not-for-profit hospitals show expenses growing faster than revenues, April 2014 https://www.moodys.com/research/Moodys-Preliminary-medians-for-not-for-profit-hospitals-show-expenses--PR_297735

for private insurance plans in the small and large group markets, which is contributing to higher uncompensated care levels for private payers.

Prior to 2014, staff did not collect information that would allow it to quantify the uncompensated care attributable to privately insured patients, or the difference relative to publicly insured patients. In 2014, HSCRC began collecting individual patient account write-offs to improve the approach to fund uncompensated care and help determine specific sources for uncompensated care. This recent data collection of account-specific uncompensated care along with the documented recent changes in private coverage provided HSCRC staff with the evidence that business practices of private payers have changed. With this new data, staff was able to quantify the difference in the uncompensated care levels between public and private payers. This change in business practices and the excess cost difference attributable to private payers justify the increase in the public payer differential.

The original public payer differential effective 1977 was consistent with a 1976 Maryland Court of Appeals decision that determined a differential can be applied for underlying practices that result in a cost difference among payers. The decision in *Blue Cross of Maryland, Inc. v. Franklin Square Hospital* upheld a payer differential using the same logic from which staff now approaches its analysis and recommendations. The court determined that rates must be set as the statute provided, that is, "equitably among all purchasers or classes of purchasers of services without undue discrimination or preference."[5] The court further stated that "[i]f it can be demonstrated, for example, that any class of purchasers directly cause actual savings or additional expense to any particular hospital, then that class of purchasers may be accorded rates which reflect the actual savings or expenses."[2] The court explained that if Blue Cross could prove that its business practices saved hospitals money, then the Commission could modify rates to a seemingly discriminatory point in Blue Cross's favor, but this would not be considered "undue" discrimination to other payers because of the cost savings that Blue Cross provided.

The court's reasoning in 1976 clarifies that the differential is permissible if the rates are set equitably among all purchasers or classes without "undue discrimination." Staff asserts that if this recommended differential change is viewed as discriminatory, then it is "due" discrimination towards private payers because of their changing business practices and increased bad debt exposure to hospitals, which staff has demonstrated result in higher uncompensated care costs attributable to private payers when compared to public payers. The court's reasoning in 1976 applied as well in 1977 when the first waiver agreement was in effect. Again, Medicare was originally afforded a 6 percent differential for "business practices and prompt payment practices," and the existing 2014 contract with the federal government specifically refers to Medicare's "business practices and prompt payment practices" as the basis for the differential.[6]

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[5] *Blue Cross of Md., Inc. v. Franklin Square Hosp.*, 277 Md. 93, 109 (1976) (quoting Md. Code, Art. 43 § 568U(a) (1957, 1971 Repl. Vol., 1975 Supp.), currently codified in Md. Code Ann., Health-Gen. § 19-219(a)(3) (2015)).
[6] 2014 All-Payer Model Agreement with CMS, Section 7.b.Federal Payment Waiver Agreement, p. 2, HEW Contract No. 600-76-0140, p. 2 (July 20, 1976); Maryland All-Payer Model Agreement § 7(b)(ii), p. 6 (Feb. 11, 2014).

Impact of Individual Plan Exchanges on Bad Debt/Out-of-Pocket Spending

Several commenters questioned whether high deductibles for individual policies offered through the individual Exchanges implemented through the Affordable Care Act were major drivers of the rising out-of-pocket costs and increased uncompensated care associated with privately insured individuals.

Response:

Staff analysis shows that the likely impact of Exchange policies on uncompensated care costs for privately insured individuals is not a material driver of rising uncompensated care costs.

First, as noted above, staff presented data from 2008 that shows the growth in out-of-pocket costs for privately insured individuals preceded the implementation of the ACA and offering of Exchange policies. Staff has shown ten years of data in order to demonstrate that the increase in out-of-pocket costs has occurred over the last decade. As noted, until now, staff did not have the data to track the source of bad debt to hospitals and explore how these trends impacted hospitals.

Staff also wants to emphasize that the data it presented is for employer coverage in the private sector. All of the growth in out-of-pocket costs presented in the tables from MEPS are derived from the U.S. Census Bureau payroll reporting and, therefore, represent members covered through employer-sponsored coverage. These figures do not include individual coverage through the Exchange.

However, several commenters still felt that the Exchange policies may be a major driver of uncompensated care and bad debt for the privately insured. While commenters assumed that most Exchange enrollees choose a bronze level plan, data from the National Academy for State Health Policy (NASHP) suggest otherwise. According to a NASHP report published in 2018 only 22.5 percent of 153,584 individuals enrolling through Maryland's state-based exchange chose a bronze policy in 2018. In fact, a majority (55.3 percent) chose a silver policy, while 19.1 percent chose a gold policy, both of which have lower out-of-pocket costs. The silver plans are eligible for cost sharing reductions.[7,8] From the NASHP data of the total enrollment, 121,629 or 79.2 percent of the individuals enrolled had federally subsidized policies, some of which have cost sharing reductions applied.[6] The data also shows that those subsidized individuals with lower income levels had a slightly lower proportion of bronze policies. In total, a very small proportion of policyholders, 34,529 Marylanders, were enrolled in bronze level Exchange policies in 2018. This constitutes less than one percent of the privately insured population of nearly four million Marylanders, making the impact of these plans and their excess uncompensated care contributions minimal, if any.[9]

[7] https://nashp.org/how-elimination-of-cost-sharing-reduction-payments-changed-consumer-enrollment-in-state-based-marketplaces/
[8] https://nashp.org/wp-content/uploads/2018/03/CSR-Blog_metal-enrollment-chart.pdf
[9] Ibid.

Individuals enrolling through the Exchange whose premiums are subsidized by the federal government are eligible for cost sharing subsidies if they enroll in a 'silver' level plan. HSCRC sought additional information from the Maryland Health Benefit Exchange (MHBE) regarding cost sharing subsidies. The Exchange provided information on its policies for 2018. Currently, CareFirst offers HMO and PPO plans in addition to Kaiser Permanente Exchange products. According to MHBE, 87.9 percent of plans sold on the Exchange were eligible for cost sharing subsidies in 2018.

Staff analyzed the CareFirst HMO enrollment (61,301 beneficiaries) as a representative sample of about half of the exchange enrollment. MHBE staff indicated that enrollment behavior was similar across all three products offered on the Exchange. In Maryland, CareFirst's HMO product on the Exchange had an enrollment of 8,908 beneficiaries with no federal assistance and 52,393 with assistance. Out of the 52,393 with assistance, 11,397 policies were bronze, which have a deductible and out-of-pocket maximum of $6,550. Gold policies, which encompassed 17,260 enrollees, have a deductible of $1,000 and a maximum out-of-pocket of $6,550. Silver polices totaled 23,736 enrollees and are eligible for cost sharing subsidies. Eighty-nine percent of silver enrollees had cost sharing subsidies. Seventy-seven percent of silver plan enrollees (18,231) had *no deductible* and maximum-out-of-pocket of $1,300 to $2,250, and another 2,902 enrollees had a deductible of $3,000 and a maximum-out-of-pocket of $5,850. Finally, 2,603 individuals had no cost sharing subsidies and faced deductibles of $3,500 and maximum out-of-pocket expenses of $7,350.

Through enrollment in silver and gold level plans many lower income Exchange enrollees were protected from high levels of cost sharing.

In conclusion, staff has documented the rise in out-of-pocket costs for employer sponsored coverage over the last decade. Employer-sponsored coverage represents over 90 percent of total private coverage, while bronze policies offered through the individual Exchange represent only 0.9 percent of total private coverage. Of subsidized low income individuals, the majority have selected plans that shield them from higher levels of cost sharing and many have cost sharing reductions applied beyond the standard plan levels. Therefore, staff concludes that the rise in out-of-pocket costs and excess uncompensated care for the privately insured population is broad-based and not primarily driven by bronze policies offered through the individual Exchange that was initiated through the ACA.

Equitable Funding of Uncompensated Care

Commissioner Keane's Memorandum asserts that uncompensated care is disproportionately funded by commercial payers.

Response:

This would suggest that uncompensated care is not funded uniformly in rates and that the funding of uncompensated care is not commensurate with a payer's share of the market. Staff

respectfully disagrees with this assertion. Appendix 1 shows the staff calculation of uncompensated care by payer to show that it is uniformly funded by payers.

The funding of uncompensated care has historically been uniform and equitable under the Maryland All-Payer System, as Former Executive Director, Harold Cohen, PhD, described in the following excerpt:

> *"In Maryland, because of the All-Payor system (which prevents this type of "cost-shifting"), all payers pay the HSCRC established rates for hospital services. These rates reflect a mark-up of approximately 18 percent. This mark-up has been **uniform** and steady over the life of the Rate Setting System. It includes a provision for financing of uncompensated care in the system. Thus, all payers are contributing **equitably** to the financing of care to the uninsured. There is no cost-shifting in Maryland. Patients and payors pay for the care they receive and also their fair share of social costs in the system".*[10]

The computations in the Memorandum and CareFirst's comment letter are inconsistent with these notions of uniform and equitable financing because they suggest uncompensated care funding is not consistent, i.e., that the funding is not a fixed percentage of charges. Currently, actual uncompensated care is 4.18 percent of the hospital market and is funded uniformly by payers as 4.18 percent of charges, although the level of uncompensated care has been as high as 8.0 percent historically.[11]

Moreover, the computation in the Memorandum also suggests that uncompensated care is not funded equitably, which is to say funded commensurate with a payer's share of the market. In effect, the analysis confounds governmental payers' enhanced differential discount with uncompensated care funding. Staff has examined the calculations submitted in the Memorandum, which show the same markup over cost for private payers as public payers. Staff believes this is a flawed calculation because the differential creates a four percent difference in the mark up over costs. Staff has replicated the analysis without this flaw and has determined that the distribution of uncompensated care funding is equitable, as reported in Dr. Cohen's explanation of Maryland's all-payer system.

The submitted comments from both Commissioner Keane and CareFirst also include historical uncompensated care funding trends that are calculated using the same assumptions. For the same concerns expressed above, staff does not believe these historical values are accurate. Staff does not agree with the claim that after the large reduction in uncompensated care under the ACA, funded primarily by the federal government through the expansion of Medicaid, that private payers' contribution to uncompensated care was proportionally increased. In fact, the Medicaid expansion under the ACA was the primary contributor to the large decrease in uncompensated care of more than three percent, which resulted in hospital cost savings that was

[10] http://www.hscrc.state.md.us/Documents/pdr/GeneralInformation/MarylandAll-PayorHospitalSystem.pdf
[11] HSCRC Data. Accessed October 2018.

equitably allocated to all payers in Maryland, including private payers, through hospital rate reductions.

CareFirst's Comments

CareFirst commented that it disagrees with the conclusion that uncompensated care (UCC) costs have been shifted from commercial to government payers and disputes the factual basis of the analysis presented by staff to justify a differential change. CareFirst presented data in its comment letter claiming that since Rate Year 2013, as hospital UCC percentages have declined, the HSCRC's rate setting system has shifted the funding of UCC from government payers to commercial payers. CareFirst claims that as a result, commercial payers now fund approximately 58 percent of hospital UCC even though such payers account for only 33 percent of hospital charges – shifting $65 million from governmental to commercial payers since the beginning of the Maryland Model Demonstration. The comment letter goes on further to state that while CareFirst believes a change in the differential level is unwarranted, it recognizes that staff intends to proceed with a one-time change to the differential and urges the Commission to ensure this one-time action does not result in future modification of the differential. CareFirst also mentioned that this change would result in additional cost shift to individuals, small and large businesses, county and municipal governments, and other groups already struggling with the high cost of purchasing or funding private health benefit coverage. CareFirst has voiced these concerns to staff and through industry workgroups and a number of meetings have been held with staff for specific discussion. HSCRC staff has agreed to include language in the Recommendation to address CareFirst's concerns.

Response:

Staff appreciates that CareFirst's comment letter recognized that staff has worked with CareFirst to address concerns that the differential change would be used to alleviate the Total Cost of Care performance requirements, and that the differential would be subject to ongoing changes. Over the course of the last three months, staff has worked to address the concerns raised by CareFirst such that appropriate conditions would be placed on the final recommendation.

Staff disagrees with CareFirst's analysis that the differential is used to pay for actual uncompensated care. As stated earlier in this document, uncompensated care is adjusted each year through changes to hospitals' rates and is shared equitably by payers. The initial waiver contract indicated that the differential was for business practices and prompt pay practices, not to shift payment for actual uncompensated care onto private payers.

Staff has provided a more detailed analysis in response to comments regarding equitable uncompensated care funding in Appendix 1 of this recommendation.

RECOMMENDATION

Based on the assessment above, staff recommends the following, effective July 1, 2019:

1) Increase the differential by 1.7 percentage points (from the current 6.0 percent to 7.7 percent) to more equitably allocate higher uncompensated care costs incurred by commercially insured patients. This adjustment will be made through the hospital mark-up adjustment, which will provide a net revenue neutral result for hospitals.
2) To assure that the savings from the differential adjustment is not used to justify an increase to rates in a future rate year, the staff recommends that the cost reduction to Medicare as a result of the change in the differential be removed from the Total Cost of Care performance evaluation when establishing future annual updates. Furthermore, the savings associated with the increased differential should not supplant hospital savings needed to meet the annual savings goals required by the TCOC contract.
3) Similarly, the savings to Medicare resulting from the differential adjustment should not be included in the trend factor used to calculate a hospital's performance under the Medicare Total Cost of Care algorithm.
4) The Commission should develop and adopt policies that prioritize the use of the All-Payer rate reductions and the Medicare Performance Adjustment as a means to account for costs and savings to the system. The success of the TCOC Model is dependent on improving care and health, reducing avoidable utilization, and providing efficient and effective quality health care services. To this end, the Commission should not use changes to the differential to meet Medicare total cost of care performance requirements.
5) It is the intent of the Commission to make this a one-time adjustment at the beginning of the TCOC Model, as permitted by the contract, to correct for cost inequities and to avoid future changes to the public-payer differential to assure stability of the system and to preserve the all-payer nature of the Maryland Model.

APPENDIX 1

The Commissioner Keane Memorandum and CareFirst Comment letter assert that uncompensated care is disproportionately funded by commercial payers. This would suggest that uncompensated care is not funded uniformly in rates and that the funding of uncompensated care is not commensurate with a payer's share of the market. Staff does not agree with the computations that lead to this conclusion, because they use a statewide markup and ignore the differential when preparing a payer specific cost analysis. As a result, the calculation draws the inaccurate conclusion that private payers fund a disproportionate share of uncompensated care. Staff explains below the differences in the two conclusions.

Table One below was extracted from Section B of the Keane Memorandum. Table One shows the difference between charges (Line 1) and net revenues (Line 5) after removing any payments for uncompensated care (UCC) and removing the discounts for the payer differential that are afforded to each payer. Staff agrees with the calculations through Line 5.[12] The problems with the calculation presented in Table One begin with Line 7. In Line 8, the same mark up of 1.0939 (from Line 7) is removed from each payer's gross charges to estimate each payer's allowable costs. Staff disagrees with the use of a statewide markup value when narrowing the analysis to payer types because it fails to recognize the differential in costs. The differential accorded to governmental payers for cost differences attributable to business practices and prompt pay is 6 percent. The prompt pay discount is 2 percent for both governmental and private payers. Therefore there is a net difference (6 percent minus 2 percent) in the estimated underlying costs allocable to the government payers for their business practices. As a result, the mark down from gross charges to estimate payer specific costs must differ by approximately 4 percent. In Table Two below, staff has corrected the calculation shown in the Keane Memorandum to show the payer specific markup, which reflects the proper differential, to reduce gross charges to net revenue. The correct mark up to reduce charges to cost for governmental payers is approximately 11 percent, and the correct markup for private payers is approximately 7 percent, with the expected 4 percent differential.

The calculation in Table One applies all of the differential toward the payment of uncompensated care and draws the conclusion that private payers are shouldering a higher proportion of the burden. When the correct markup figures are used in Table Two reflecting the differential, the calculation shows that uncompensated care is equitably funded by all payers.

[12] In Table One, it is important to note that the calculation assumes that the difference between net revenue, i.e., the funding a hospital will be reimbursed, and allowable costs is equivalent to the funding of uncompensated care. While the actual difference between net revenue and allowable cost has typically exceeded 18 percent, the assumption that the only difference is uncompensated care can be used for illustrative purposes. The actual markup over cost accounts for additional items, including hospital assessments, regulated profits, and other financial considerations.

Table One:

Jack Keane Memorandum Calculations--Allowed Charges, Payments, UCC, Allowed Costs, Margins and Related Comparisons

		GOVT PAYERS	COMM PAYERS	UCC	TOTAL
L1	Estimated Charges: RY 2017	$10,934,432,000	$5,908,305,000	$735,272,000	$17,578,009,000
L2	Share of Estimated Charges	0.6221	0.3361	0.0418	
L3	Differential or Discount	0.06	0.02	1.00	
L4	Payment Rate	0.94	0.98	0.00	
L5	Estimated Total Payments (i.e. Net Revenue)	$10,278,366,080	$5,790,138,900	$0	$16,068,504,980
L6	Share of Total Payments	0.6397	0.3603	0.0000	
L7	Markup	1.0939	1.0939	1.0939	
L8	Estimated Allowable Cost	$9,995,442,353	$5,400,931,848	$672,130,833	$16,068,505,035
L9	Margin of Payments Over Allowable Cost (= Estimated Net Revenue Minus Allowable Cost in $)	$282,923,727	$389,207,052	-$672,130,833	
L10	Margin Proportion Rel to Allowable Cost (= Estimated Net Revenue/Allowable Cost)	0.0283	0.0721		0.0000
L11	Margin Rel to Charges	0.0259	0.0659		0.0000
L12	Prop Allocation of UCC by Payer (= Share of Estimated Payments x UCC Cost)	$429,934,631	$242,196,202		$672,130,833
L13	Payment Margin Minus Allocated UCC Allocation of UCC	-$147,010,904	$147,010,849		
L14	Payment Margin/Allocated UCC	**0.6581**	**1.6070**		
L15	Share of UCC Being Paid by the Government and Commercial Payers	**0.4209**	**0.5791**		

The calculations in Table Two are consistent with the equitable financing of uncompensated care that has been in place over time. (See quote from Dr. Cohen, above.)

The computations in the Keane Memorandum are inconsistent with the notions of uniform and equitable financing because they suggest uncompensated care funding is not uniform, i.e. that the funding is not a fixed percentage of charges. In effect, the analysis confounds governmental payers' enhanced differential discount with uncompensated care funding. The calculations in the Memorandum assumes that the differential funds actual bad debt, so that as bad debt increases, the private payers shoulder a lower proportion of the burden and as it goes down, they shoulder a greater portion of the burden. This leads to the incorrect conclusion that after the federal government funded Medicaid expansion and exchange policies under the ACA that private payers were shouldering more of the uncompensated care burden.

Table Two:

HSCRC Staff Calculations Reflecting the Four Percent Differential between Government and Private (Commercial) Payers to Calculate Allowed Cost and UCC Funding[13]

	Inputs		Government Payers	Commercial Payers	UCC	Total
L1	RY 2017 Payer Mix		62.21%	33.61%	4.18%	100%
L2	EST RY19 Allowable Charges		$10,934,432	$5,908,305	$735,272	$17,578,009
L3	Differential Discount		6.00%	2.00%	0%	
L4	Statewide Markup (rounded)		1.11	1.07	1.04	
	Calculations					
L5	Magnitude of Differential	L2*L3	$656,066	$118,166	$0	
L6	Net Revenue from Payer (after Differential is applied)	L2-L5	$10,278,366	$5,790,139	$0	$16,068,505
L7	Allowable Cost (after Statewide Markup for Differential)	L2/L4	$9,820,989	$5,543,000	$704,516	$16,068,505
L8	UCC Funding	L6-L7	$457,377	$247,139		$704,516
L9	Share of Total UCC Funding	L8/(Total L8)	64.92%	35.08%	0%	100%
L10	UCC Funding in Rates	L8/L2	4.18%	4.18%		

As noted above, the key flawed assumption in the Memorandum is the use of a statewide markup as opposed to a payer specific markup when reducing payer specific gross charges to payer specific "allowed cost." It is important, therefore, to demonstrate how staff derived a payer specific markup. In Tables Three and Four, staff will illustrate how to calculate a statewide markup and a governmental payer markup:

[13] Please note that final governmental and commercial shares of uncompensated care are slightly higher than their proportion of the market to account for their removal of the uncompensated care payer type as a viable payer. As an example, the calculation for governmental payers proportion of uncompensated care funding is derived as follows:

Governmental Payer Share / Governmental Payer Share + Commerical Payer Share	=	Governmental Uncompensated Care Payer Share
62.21% / 62.21%+33.61%	=	64.92%

Table Three:

Statewide Markup Calculation

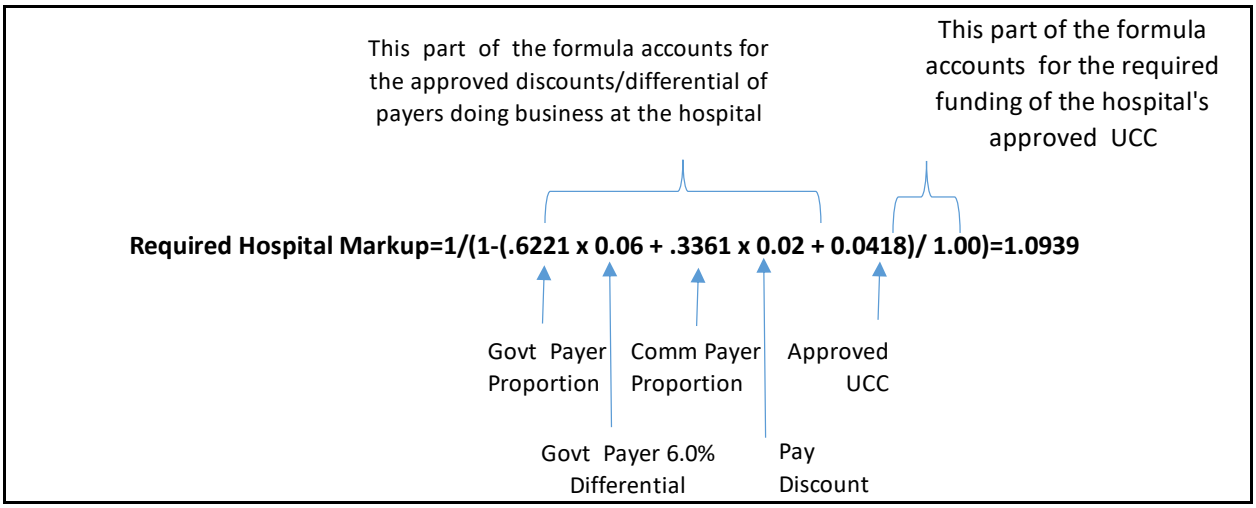
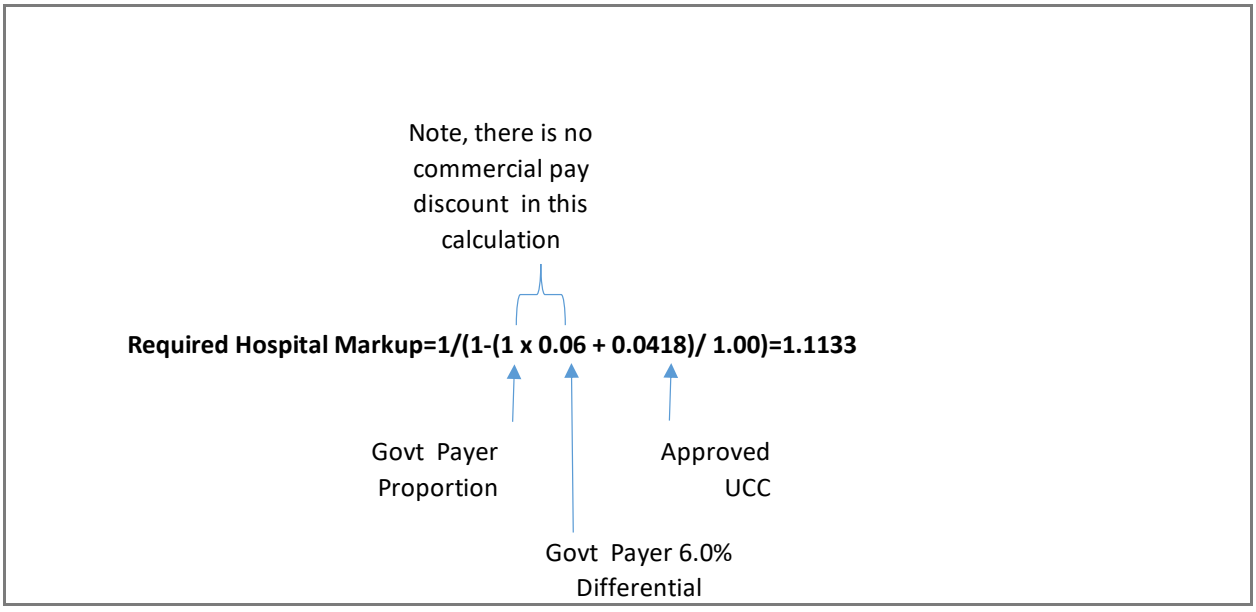


Table Four:

Governmental Payer Markup Calculation



In section C of the Memorandum, historical uncompensated care funding is calculated using the same statewide markup assumption. For the same concerns expressed above, staff does not believe these historical values or the conclusions derived from the calculations are accurate.

UNIVERSITY of MARYLAND MEDICAL SYSTEM

900 Elkridge Landing Road
4th Floor East
Linthicum Heights, Maryland 21090
www.umms.org

Finance Shared Services

November 21, 2018

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

Dear Ms. Wunderlich:

On behalf of the University of Maryland Medical System (UMMS), representing 15 acute care hospitals and health care facilities, we are submitting comments in response to the Health Services Cost Review Commission's (HSCRC) draft policy recommendation for an increase to the Medicare payer differential. We strongly support the proposed recommendation, and we look forward to working with the HSCRC on its implementation.

We agree with the HSCRC's staff analysis that reveals an increase in hospital bad debts over the last few years. UMMS conducted a similar analysis for its member hospitals and the results are similar to those for the state. Commercial payer write-off rates are more than double the write-off rate for Medicare and Medicaid. In Fiscal Year 2017 (FY17) the Commercial bad debt write-off rate was 4.4% compared to 2.0% for Medicare and Medicaid. The write-off rate for Commercial payers increased by 0.5% between FY15 and FY17, while Medicare and Medicaid write-off rates declined by 0.5% during the same period. The portion of hospital total bad debts associated with Commercial payers also significantly increased over the past several years (17.9% in FY15 up to 22.4% in FY17) while the portion of bad debt write-offs associated with all other payers declined (82.1% in FY15 down to 78.6% in FY17). The 0.5% increase in Commercial uncompensated care rate is equivalent to an increase in annual bad debts totaling $6 million for our organization.

We believe the proposed differential change should take effect January 1, 2019 with the start of the TCOC model, rather than next July. While we understand operational adjustments are needed and those modifications require time, we do not feel that these minor changes warrant an eight month delay. We urge the HSCRC to make this change effective January 1 and to work with CMS to make it a higher priority for the earlier implementation date.

We support the removal of the differential adjustment from the trend factor used to calculate hospital-specific performance under the Medicare TCOC algorithm. We feel that the treatment of this adjustment is consistent with the final 2019 Medicare Performance Adjustment policy (approved at the November 14, 2018 Commission meeting) to remove MDPCP Care Management Fees and Performance-Based Incentives from the TCOC trend factor.

We look forward to the final staff recommendation at the December 2018 Commission meeting. If you have any questions, please do not hesitate to contact me.

Sincerely,

Alicia Cunningham

Senior Vice President, Corporate Finance & Revenue Advisory Services

Cc: Chairman Sabatini
HSCRC Commissioners
Robert Chrencik, UMMS CEO
Henry Franey, UMMS CFO

Maryland
Hospital Association

November 9, 2018

Nelson J. Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Sabatini:

On behalf of the Maryland Hospital Association's (MHA) 63 member hospitals and health systems, we are submitting comments in response to the updated draft policy recommendation for a small adjustment to the public payer differential, from 6 percent to 7.7 percent. With the exception of the proposed effective date, we *strongly support the proposed recommendation*, and we look forward to working with the commission on its speedy implementation.

We agree with the Health Services Cost Review Commission's (HSCRC) staff analysis that reveals a significant increase in hospital bad debts over the last few years due to high-deductible and other large cost-sharing plans. This added burden on Maryland's nearly 3 million commercially insured consumers has unfairly shifted uncompensated care costs to Medicare and Medicaid. This shift occurred at the same time that commercial payers disproportionately benefitted from the expansion of Medicaid coverage under the Affordable Care Act, which reduced uncompensated care in hospitals' rates – from over 7 percent to just 4.16 percent – in the latest global budget update approved by the HSCRC.

Staff estimate a modest increase in private payer premiums of no more than 0.4 percent as a result of this action *if, and only if, payers shift all of the impact of this proposal to the paying public.* That is a small price to pay as our state moves forward on the implementation of the Total Cost of Care (TCOC) model, which will require contribution from all stakeholders to ensure its success.

We believe the proposed differential change can take effect January 1—the start of the TCOC model—rather than next July as we were told the Centers for Medicare & Medicaid Services (CMS) asked. We would simply note that when the Medicare sequester was put into effect several years ago, there was virtually no delay in its implementation. We urge the HSCRC to make this change effective January 1 and to work with CMS to make it a higher priority for the earlier implementation date.

We also agree that the impact of the differential should be removed from consideration of the annual hospital payment update. This is similar to the action taken last June, in which the HSCRC voted to remove the impact of the costs of the Maryland Primary Care Program (MDPCP) from consideration during the annual update process. *Moreover, it would be helpful for the commission to remind stakeholders of the action it took in June regarding the MDPCP costs and the update*.

Similarly, the condition to remove the differential from the trend factor used to calculate hospital-specific performance under the Medicare TCOC algorithm should be consistent with the recommendation in the final Medicare Performance Adjustment policy proposal to remove MDPCP Care Management Fees and Performance-Based Incentives from the TCOC trend factor calculated for 2019.

We look forward to discussing this proposed recommendation at the December meeting. If you have any questions, please do not hesitate to contact me.

Sincerely,

Michael B. Robbins
Senior Vice President

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
James N. Elliott, M.D
Adam Kane
Jack Keane
Katie Wunderlich, Executive Director

Brian D. Pieninck
President and Chief Executive Officer

CareFirst BlueCross BlueShield
1501 S. Clinton Street, 17th Floor
Baltimore, MD 21224-5744
Tel: 410-998-5320
Fax: 410-781-7606
brian.pieninck@carefirst.com

November 20, 2018

Nelson J. Sabatini, Chairman
Katie Wunderlich, Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Sabatini and Ms. Wunderlich:

Thank you for the opportunity to comment on the HSCRC staff's Draft Recommendation to increase the Public Payer Differential (Differential). CareFirst has been a strong supporter of Maryland's Medicare Waiver since its inception in 1977. The waiver has greatly benefitted Marylanders, hospitals, payers and the state's entire health care system. The reliability of the differential has been a cornerstone in the waiver design and has ensured equitable funding of hospitals costs, including uncompensated care (UCC), by all-payers.

The staff's recommendation is based on the idea that increased bad-debt write-offs resulting from coverage and benefit changes in private health insurance plans are being disproportionately funded by government payers. Staff is proposing to increase the Differential by 1.7 percentage points – from 6.0% to 7.7% -- in order to "correct for excess bad-debt write-offs from commercial coverage, which is shifting costs onto Medicare and Medicaid."

As previously communicated, CareFirst disagrees with the conclusion that UCC costs have been shifted from commercial to government payers and disputes the factual basis of the analysis presented by staff to justify a Differential change. CareFirst has presented data demonstrating that since Rate Year 2013, as hospital UCC percentages have declined, the HSCRC's rate setting system has shifted the funding of UCC from government payers to commercial payers. As a result, commercial payers now fund approximately 58% of hospital UCC even though such payers account for only 33% of hospital charges – shifting $65 million from governmental to commercial payers since the beginning of the Maryland Model Demonstration. Our analysis was based on the unit cost rate setting methodology that aggregates payers' differentials into a single hospital mark-up but allocates payer specific discounts that results in actual payer funding proportions.[1] Accordingly, CareFirst believes there is no factual basis for the current staff Recommendation.

The 6% Differential was a negotiated number and was not based on a quantification of the amount of hospital bad debts "averted" by the presence of the governmental insurance programs or based on the distribution of UCC between government and commercial payers over time. UCC levels have changed over the life of the rate setting system due to coverage cutbacks and

[1] A further description of this cost-based rate setting approach and the actual funding of approved hospital UCC approach now and over the past 41 years of the All-Payer system is provided in an attachment to this letter.

expansions by government and commercial payers, with no change in the Differential.[2] This is because UCC has always been viewed as a general cost of hospital business in a community without universal health insurance coverage. Any changes to the Differential would have caused increased instability and uncertainty to the rate setting system.

CareFirst has voiced these concerns to staff and through industry workgroups. In response, the staff has agreed to include language in the Recommendation to address our issues. While this language is clear and appreciated, if the Commission approves this recommendation, we request that the HSCRC emphasize:

1) this adjustment will be one-time only and it is not the intention of the Commission to adjust the Differential again during the life of the waiver model;
2) staff will factor out the impact of the Differential change from the annual TCOC Medicare savings performance targets;
3) staff will also factor out the impact of the Differential change from future annual hospital rate Updates; and
4) the staff and the Commission will rely exclusively on all-payer rate reductions and incentive-based mechanisms to moderate hospital volume growth to control hospital costs.

In conclusion, based on our analysis of stakeholder funding of UCC, a change in Differential levels is unwarranted. We recognize that staff intends to proceed with this one-time change to the Differential and urge the Commission to ensure this one-time action does not result in future modification of the Differential. Any such change would result in additional cost shift to individuals, small and large businesses, county and municipal governments, and other groups already struggling with the high cost of purchasing or funding private health benefit coverage.

Should the HSCRC enact future cost-shifts to meet the Medicare TCOC tests, we believe it will undermine the reputation of the Maryland Model as a credible, non-discriminatory and viable "all-payer" demonstration of cost control. CareFirst remains vigilant in its efforts to assist the Commission in ensuring that the State meets its required savings targets through actual cost control and reduction, to benefit the individuals, businesses, accounts, and communities that we mutually serve.

Sincerely,

Brian D. Pieninck
President and Chief Executive Officer

[2] An example of a change in the practice of Governmental payers that contributed to large increases in hospital UCC were: 1) the imposition of day limits in the late 1980s and 2) the elimination of the Medicaid State-Only Program in the 1990s. These two changes contributed significantly to increases in hospital UCC and yet there was no change in the Differential.

Attachment I – Description of the HSCRC Cost-Based Rate Setting System and An Illustration of how Hospital UCC is Funded

- The HSCRC rate setting methodology has always been characterized as a "cost-based rate setting system" which is designed to set hospital unit rates at levels to provide Maryland hospitals with net payments sufficient to fund two categories of approved hospital costs: 1) the unit costs of patient services provided by Maryland hospitals to each payer's beneficiaries; and 2) the Uncompensated Care Costs (UCC) that the Commission determined to be "reasonable."

- The establishment of hospital rates must also account for the HSCRC approved deductions from charges (e.g., the Prompt Pay discount and the Public Payer Differential). The establishment of rate levels and accounting for approved deductions is achieved through the use of a hospital-specific Mark Up formula, that takes into consideration each hospital's payer mix and level of approved UCC.

- The Hospital Mark Up, increases (or "marks up") rates above a hospital's Allowable Costs to provide hospitals with net payments (net patient revenue) sufficient to fund patient care costs and an additional and readily identifiable "margin" to fund approved UCC.

- Given this methodology, one can easily quantify both Net Payments and Allowable costs for any payer or any class of payer (i.e., Governmental payers and Commercial payers) at either a hospital specific level or in aggregate as shown in Table 1 below. The data in Table 1 is taken from the staff's presentation of charges and net payments by payer class for the Rate Year (RY) 2017. Because the Mark Up is calculated to establish charge levels sufficient to fund both Allowable costs and UCC, while accounting for the approved discounts and the Differential, Allowable costs can be determined by dividing gross revenue by one plus the Mark Up (1.09394 in the staff's example). Hospital Allowable Costs are shown on line 7 of Table 1.

- Net Payments to hospitals for each payer class are determined based on HSCRC approved charge levels less the applicable deductions from charges for each payer class (i.e., Government payers are eligible for the 6% Differential and pay 94% of charges and Commercial payers are eligible for the 2% prompt pay discount and pay 98% of charges). These net payments are shown on line 5 below.

- The amounts provided hospitals in their rates to fund UCC is merely the difference their net payments and their allowable costs (L5 – L7). Table 1 shows that based on RY 2017 data, Commercial payers funded 57.9% of approved levels of UCC while Government payers funded 42.1% of UCC (shown on L9 below).

Table 1
Funding of UCC by Payer Class
Based on the 2017 Payer Mix (Dollars in $000)

	Current Situation	Government Payers	Commercial Payers	UCC	Total
L1	RY 2017 Payer Mix	62.21%	33.61%	4.18%	100.00%
L2	Est RY 19 Allowable Charges	$10,934,432	$5,908,305	$735,272	$17,578,009
L3	Differential/Discount	6.0%	2.0%	100.0%	100.0%
L4	Magnitude	$656,066	$118,166		
L5	Net Revenue from Payer	$10,278,366	$5,790,139	$0	
L6	Statewide Markup 1.09394				
L7	Allowable Cost	$9,995,442	$5,400,932	$672,131	$16,068,505
L8	Available to Fund UCC	$282,924	$389,207		$672,131
L9	% Total UCC Funding	42.1%	57.9%		

- A key conclusion of our analysis is that each payer's contribution to the funding of hospital UCC is not a function of its proportion of a hospital charges that it accounts for in the system, as is presumed by staff. This is crucial error in the staff's analysis that renders the staff's conclusions completely erroneous.

- Rather, under the cost-based rate setting approach of the HSCRC, the amount of excess funding (over and above the cost of care provided to a payer's patients) available to fund hospital UCC can be precisely quantified by individual payer or payer class as shown above.

- Because the Hospital Mark Up formula depends on the level of approved UCC in the system, the Mark Up varies from year to year as the percentage of UCC changes. Table 2 shows that since RY 2013, UCC percentages have declined from 7.25% to 4.18% resulting in the Hospital Mark Up declining from 1.10 to 1.09394 as hospital UCC has been reduced. The mathematics of the Hospital Mark Up formula has then reallocated the funding of hospital UCC from nearly equal proportions in RY 2013, to the current 42.1% Government payer and 57.9% Commercial payer spilt.

Table 2
Funding of UCC by Payer Class
Rate Years 2013-2017 (Dollars in $000)

		Government Payers	Commercial Payers	UCC	UCC %
FY 2013	UCC Funding	$584,634	$544,970	$1,129,604	7.25%
	UCC Funding Proportion	51.8%	48.2%		
FY 2014	UCC Funding	$547,224	$524,755	$1,071,979	6.88%
	UCC Funding Proportion	51.0%	49.0%		
FY 2015	UCC Funding	$325,795	$405,109	$730,904	4.69%
	UCC Funding Proportion	44.6%	55.4%		
FY 2016	UCC Funding	$307,595	$395,275	$702,870	4.51%
	UCC Funding Proportion	43.8%	56.2%		
FY 2017	UCC Funding	$282,924	$389,207	$672,131	4.18%
	UCC Funding Proportion	42.1%	57.9%		

- Moreover, since the beginning of the Model Demonstration given these changes in the hospital Mark Up, we calculate that there has been approximately $65 million in additional UCC funding shifted from Government payers to Commercial payers. Based on our analysis, we also have determined that because Commercial payers are funding 57.9% of all hospital UCC, these payers are actually funding more than the total amount of Write-offs attributed to them by the HSCRC's write-off data. This result is shown in Table 3.

Table 3
Write-offs and Actual UCC Funding by Payer Class

		A	B	C	D	E	F
	Payer Class	Total Charges	Write-Offs	Pct. Subtotal	Proportion of UCC Funding by Payer Class	Actual Funding of Write-Offs	Actual UCC Funding less Actual Write-offs
L1	Government	$10,266,623,257	$181,017,034	47.4%	42.1%	$160,847,779	-$20,169,255
L2	Commercial	$5,534,497,764	$201,044,199	52.6%	57.9%	$221,213,454	$20,169,255
L3	Total Govt + Commercial	$15,801,121,021	$382,061,233	100.0%	100.0%	$382,061,233	

- As shown in Table 3, staff quantified Commercial write-offs as $201 million and Government write-offs as $181 million in RY 2017 (a total of $382 m in aggregate write offs for both payer classes). Per our analysis, the Commercial payers are funding 57.9% of these aggregate write-offs ($221 million as shown on L2, column E) or $20.2 million (see L1, Column F) more than the incremental write-off amounts attributed to them by the staff's analysis ($201 million in incremental write-offs attributed to them).

MARYLAND
Department of Health

Larry Hogan, Governor · Boyd K. Rutherford, Lt. Governor · Robert R. Neall, Secretary

November 19, 2018

Nelson Sabatini
Chair
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Sabatini,

On behalf of the Maryland Medicaid program, I would like to thank you for the opportunity to provide comments on the draft recommendation for increasing the public payer differential from 6.0 percent to 7.7 percent. The Maryland Medicaid program has followed the conversation surrounding this change and is in support of the recommendation.

Historically, Medicaid payer percentages were used to estimate expected charity levels; this methodology was altered after Maryland expanded Medicaid under the Patient Protection and Affordable Care Act (ACA) in 2014. Since the enactment of the Medicaid expansion, expenditures for the expansion population have totaled over $8.79 billion—including $1.23 billion in hospital expenditures in 2017 alone. Recent analysis has demonstrated that write-offs for commercial coverage are much higher than for public payers, with the difference equating to approximately $100 million. The proposed differential increase will reallocate a portion of that difference to Medicare ($40 million) and Medicaid ($27 million). This will become increasingly important as the State assumes a greater share of Medicaid expansion expenditures in the coming years.

If you have any questions, please do not hesitate to contact me.

Sincerely,

Robert R. Neall
Secretary

JOHNS HOPKINS
MEDICINE

Kevin W. Sowers, MSN, RN, FAAN

President
Johns Hopkins Health System

Executive Vice President
Johns Hopkins Medicine

November 21, 2018

Nelson Sabatini
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the proposed Adjustment to the Payer Differential. JHHS strongly supports the staff recommendation to increase the differential from 6.0 to 7.7% and commends the thoughtful analysis of staff to support the modest increase in the differential. JHHS does, however, have concerns with some of the conditions outlined in the staff recommendation and offer suggested clarification.

The recent availability of reliable data analyzed by the HSCRC demonstrates a shift in uncompensated care. Due to commercial payer practices, public payers have inappropriately and unreasonably assumed more of the uncompensated care costs. At JHHS, we have witnessed the growing increase of uncompensated care as a result of rising deductibles and coinsurance as more and more of our patients are unable to meet the financial demands established under their insurance policies. The Johns Hopkins Hospital experienced a 12% shift in charity care for insured patients from 2013 to 2018, with charity care for insured patients increasing and self-pay decreasing. This increase in patient financial responsibility for co-pays and deductibles comes at a time when rising drug costs and high cost innovative therapies only widen the gap between what patients can afford to pay and what is covered by insurance. The practical impact has been an increase in hospital uncompensated care associated with private insurance. Across the Maryland hospitals within JHHS, there was a 10.6% increase in uncompensated care for the insured from 2017 to 2018.

Any concerns that an increase in the payer differential would result in an increase in premiums should be tempered by the reality that the increase would be small in comparison to the substantial benefit payers and consumers have received over the years as a result of the all payer system. Additionally, for the small portion of the commercial market included in the exchange market, the

733 North Broadway, MRB 104, Baltimore, Maryland 21205, 410-955-9540 phone, 410-955-0856 fax, ksowers4@jhmi.edu

impact is likely to be mitigated by the recent market stabilization efforts of the Hogan Administration and Maryland General Assembly during the 2018 legislative session. In addition to establishing a reinsurance program, lawmakers made over $360 million available to decrease private insurer losses. Considering the recent influx of financial support to private insurers and the potential minimal impact of 0.4% to overall commercial payer costs, it seems highly unlikely that a $67 million reallocation of uncompensated care through a 1.7% increase in the payer differential would result in a greater cost burden to the consumer.

While JHHS strongly supports the staff recommendation to increase the payer differential, we are concerned that it is premature to recommend that the Commission should not use changes to the differential to meet Medicare total cost of care performance requirements or that savings associated with the increased differential should not supplant hospital savings needed to meet the annual goals required by the Maryland Total Cost of Care Model State Agreement (Agreement). There is strong consensus that the differential should not be used as a mechanism to shift focus from the work already established by hospitals to reduce unnecessary care and costs; however, considering the uncertainty of the impact of Maryland Primary Care Program in potentially increasing Total Cost of Care (TCOC), all resources should remain available as potential options to help the state and hospitals meet the TCOC targets. The future use of the differential to meet savings targets is permissible under the Agreement. As stated in section 8.b.ii.1 of the Agreement, a request to change the differential "To enable the State to meet the Annual Savings Target" would be considered by CMS.

Additionally, JHHS has concerns with the intent of the Commission "to make this a one-time adjustment" or to "avoid future changes to the differential." As noted above, outlined in the Agreement both the state and CMS anticipate the potential use of the differential to ensure success of the TCOC Model. The Agreement details an annual process by which changes to the differential may be requested in order to meet annual savings targets or "that may be necessary to adjust, recalibrate, or modernize Maryland's rate-setting structure…" Any changes to the differential should be deliberate, justified, and thoughtful, but the Commission should not unilaterally remove any future change from consideration. This is the first time the differential has materially changed in decades, and any subsequent change would have to meet the scrutiny of both the Commission and CMS. Considering the commitment of state and federal governments, hospitals, insurers, and all Marylanders to the continuation of all-payer model, we believe that the differential should not be eliminated as a resource to help meet the targets of the Model when it is otherwise justifiable.

JHHS also supports the recommendation of our hospital colleagues to implement the change to differential January 1, 2019, instead of July 1, 2019. If a January 1 implementation date is not achievable for Medicare, considering the substantial savings to the state Medicaid program, we recommend proceeding with January 1 for Medicaid.

Thank you for the efforts of the HSCRC commissioners and staff who have demonstrated their willingness to ensure that all stakeholders contribute to the future success of the Total Cost of Care

Model. This fair and balanced approach fosters ongoing engagement in and enthusiasm for the new model. We look forward to continued collaboration in our mutual efforts to support the Total Cost of Care Model.

Sincerely,

Kevin W. Sowers, M.S.N., R.N., F.A.A.N
President, Johns Hopkins Health System
Executive Vice President, Johns Hopkins Medicine

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
Katie Wunderlich
James Elliott, MD
Adam Kane
Jack C. Keane

Memorandum

To: Nelson Sabatini
HSCRC Chairman
From: Jack Keane
Subj: Proposed Change in Medicare/Medicaid Differential
cc: J. Antos; V. Bayless; J. Colmers; J. Elliott, MD; A. Kane; K. Wunderlich; and S. Lustman
Date: 11/14/2018

The agenda for the Public Session of 11/14/2018 includes a "Draft Staff Recommendation for Adjustment to the Payer Differential." I believe the technical and conceptual bases for this proposed change in the Differential from 6.0% (where it has stood for approximately forty years despite myriad changes in the financing and delivery of health care services) to 7.7% are deeply flawed for the reasons which are presented below.

Accordingly, I would appreciate it if you would include this Memorandum in the post-meeting documents that are published on the HSCRC web site and direct the HSCRC staff to address the concerns raised below, and report back to the Commission in writing regarding them, prior to our upcoming December meeting when a vote is scheduled to be taken on the proposed modification of the Differential.

A. Basis for the Proposed Change in the Differential

The Staff argues that the Differential should be increased from 6.0% to 7.7% because the write-off percentage associated with the Commercial payers (i.e., 3.63%) exceeds the write-off percentage associated with the Government payers (i.e., 1.76%) by 1.87% (i.e., 3.63% - 1.76% = 1.87%) and that this difference has the effect of unfairly charging the Government payers for an excessive level of Uncompensated Care Costs (UCC).

This logic is flawed for several reasons. First, the Differential of 6% that was given to Medicare and Medicaid (the Government payers) at the outset of the HSCRC's waiver was not predicated on the relative write-off percentages of the Government and Commercial payers. Second, to my knowledge, there is no reliable information extant regarding the relative level of write-offs at the outset of the waivered system. The Staff recommendation proposes to change the existing Differential based on a calculation of the relative write-offs of the Government and Commercial payers in RY 2017 projected to RY 2019. It seems reasonable to expect, under these circumstances, that this argument would be supported by at least two factual pillars: (1) documentation that the existing 6.0% Differential was created based on relative write-offs; and (2) evidence that the write-offs have changed from those that existed when the Differential was established. The proposed recommendation lacks both of these foundations.

Moreover, if the Commercial payers are to be required to pay higher hospital bills, as a result of the proposed change in the Differential, and the change in the Differential is to be justified by the higher level of write-offs associated with the Commercials, relative to the Government payers, it is important to consider the reasons underlying the level of Commercial write-offs and the policy implications of the proposed change.

As noted above, no evidence is available regarding the original relationship between Government and Commercial write-offs, or the changes in that relationship that undoubtedly occurred over the last forty years, but we do know that one factor that has recently increased Commercial write-offs, at least for Kaiser Permanente (KP) and CareFirst, is their participation in the ACA Exchange. Most persons who enroll in the Exchange choose a "bronze" level plan because they are typically strapped in their efforts to afford health insurance, even with the help of subsidies. The bronze plans carry with them substantial member cost-sharing obligations. The persons who are covered by KP and CareFirst through their Exchange products are, on average, less financially capable of affording health insurance than their non-Exchange members, and they very likely generate higher levels of bad debts and free care because their coverage is less comprehensive than the coverage enjoyed by other KP and/or CareFirst members. Consequently, the commitment by KP and CareFirst to offer products through the Exchanges can reasonably be assumed to have driven up the level of write-offs associated with their members.

Given these dynamics, it is reasonable to ask this question: "Why would the HSCRC elect to raise the Differential, and increase the costs incurred by Commercial plans (on the grounds that they have higher write-off percentages), when the higher write-offs have resulted, to at least some degree, from their participation in the Exchange products, especially when their participation has resulted in the socially beneficial effect of decreasing the level of Uncompensated Care Costs (and Averted Bad Debts)? The proposed increase in the Differential punishes the participation of the Commercials in the Exchanges and undermines the broadly endorsed goal of extending affordable health insurance coverage to as many Marylanders as feasible.

B. The Current Funding of Uncompensated Care Costs (UCC) Already Allocates a Disproportionately High Share of UCC to the Commercial Payers

The hallmark characteristic of the HSCRC system that has distinguished it from other hospital payment systems throughout its existence is the funding of UCC. Under the HSCRC system, the costs of persons who cannot afford to pay for hospital care, or default on their bills, are funded by the other payers. If it is timely to examine the Differential, which gives the Government payers a 6% reduction in their payment obligations, relative to the 2% reduction that generally applies to the Commercial payers, it is reasonable to examine the current levels of UCC funding that are provided by the Government and Commercial payers.

Table One provides information for the Government and Commercial payers that has been drawn or derived from the information provided by the HSCRC Staff in its formulations of the proposed Differential change from 6.0% to 7.7%. In particular, Table One shows the Allowed Charges, Differentials/Discounts, Payment Rates, Payment Amounts and Allowed Costs for the Government payers, the Commercial payers and the Total system in RY 2017. It also shows the relative proportion of Payments, the overall level of UCC in the system and the absolute and proportional amounts of UCC that are reasonably allocated to the Government and Commercial payers.

As shown in Table One, the Government payers accounted for $10,278,366,080, or 64% (0.6397) of Total Payments, and the Commercials accounted for $5,790,138,900, or 36% (0.3603) of Total Payments, in RY 2017. Total UCC amounted to $672,130,833. If we follow the principle that the costs of UCC are to be allocated fairly across the Government and Commercial payers, we would assign UCC costs based on the share of Total Payments accounted for, respectively, by the Government and Commercial payers. This allocation would assign UCC costs of $429,934,631 to the Government payers (i.e., 64% x $672,130,833 = $429,934,631) and UCC costs of $242,196,202 (i.e., 36% x 672,130,833 =

$242,196,202) to the Commercial payers. A reasonable case for changing the current Differential of 6% might be made if the amount of funding provided by the Government and Commercial payers, respectively, diverged substantially from their allocated UCC shares.

In order to pursue the question of whether the current funding of UCC is inequitable, and should be changed, it is necessary to compare the Total Payments made by the Government payers and the Commercial payers to their levels of Allowed Costs and their allocated shares of UCC. The Total Payments made by the payers are computed by applying their associated Differentials/Discounts to the Allowed Charges which they were billed by the hospitals for the services consumed by their members. The Total Payments attributable to the Government and Commercial payers are shown in Line 5 in Table One—specifically, they were $10,278,366,080 by the Government payers and $5,790,138,900 by the Commercial payers. The Allowed Costs attributable to the payers are easily derived by dividing their Allowed Charges by the Mark Up. The overall Mark Up for the Maryland hospital industry, as calculated by the HSCRC Staff, was 1.09394 in RY 2017. As shown in Table One, on Line 5, the Allowed Costs of the Government payers amounted to $9,995,442,353 (i.e., Allowable Charges of $10,934,432,000/1.09394 = $9,995,442,353) and the Allowed Costs of the Commercial payers amounted to $5,400,931,848 (i.e., Allowable Charges of $5,908,305,000/1.09394 = $5,400,931,848).

Table One:
Allowed Charges, Payments, UCC, Allowed Costs, Margins and Related Comparisons

		GOVT PAYERS	COMM PAYERS	UCC	TOTAL
L1	Estimated Charges: RY 2017	$10,934,432,000	$5,908,305,000	$735,272,000	$17,578,009,000
L2	Share of Estimated Charges	0.6221	0.3361	0.0418	
L3	Differential or Discount	0.06	0.02	1.00	
L4	Payment Rate	0.94	0.98	0.00	
L5	Estimated Total Payments (i.e. Net Revenue)	$10,278,366,080	$5,790,138,900	$0	$16,068,504,980
L6	Share of Total Payments	0.6397	0.3603	0.0000	
L7	Markup	1.0939	1.0939	1.0939	
L8	Estimated Allowable Cost	$9,995,442,353	$5,400,931,848	$672,130,833	$16,068,505,035
L9	Margin of Payments Over Allowable Cost (= Estimated Net Revenue Minus Allowable Cost in $)	$282,923,727	$389,207,052	-$672,130,833	
L10	Margin Proportion Rel to Allowable Cost (= Estimated Net Revenue/Allowable Cost)	0.0283	0.0721		0.0000
L11	Margin Rel to Charges	0.0259	0.0659		0.0000
L12	Prop Allocation of UCC by Payer (= Share of Estimated Payments x UCC Cost)	$429,934,631	$242,196,202		$672,130,833
L13	Payment Margin Minus Allocated UCC Allocation of UCC	-$147,010,904	$147,010,849		
L14	Payment Margin/Allocated UCC	**0.6581**	**1.6070**		
L15	Share of UCC Being Paid by the Government and Commercial Payers	**0.4209**	**0.5791**		

The Margin of Total Payments over Allowable Costs, which is shown on Line 9 in Table One, is the amount of money provided by the payers that is available to cover UCC expenses. In RY 2017, the Margin provided by the Government payers was $282,923,727 and the Margin provided by the Commercial payers was $389,207,052. The UCC costs allocated to these payers—by multiplying Total UCC of $672.1 million by their share of Total Payments—are shown in Line 12: $429,934,631 for the Government payers and $242,196,202 for the Commercial payers. As shown on Line 14, the Margin provided by the Government payers over Allowed Cost amounted to only 65.8% of the amount of UCC

allocated to the Government payers whereas the Margin provided by the Commercial payers over Allowed Cost amounted to 161.7% of the amount of UCC allocated to them. As shown on Line 15, the Government payers provided 42.1% of the overall funding for Total UCC costs while the Commercial payers provided 57.9% of the funding for Total UCC costs.

In summary, the Government payers accounted for 62.2% of Allowed Charges, and 64.0% of Total Payments, but provided only 42.1% of the funding for UCC whereas the Commercial payers accounted for 33.6% of Allowed Charges, and 36.0% of Total Payments, and provided 57.9% of the funding for UCC. This distribution indicates that the Government payers are not shouldering an inequitably high share of UCC ; instead, they are paying for only 65.8% of the UCC costs that are reasonably allocated to them. If a change in the Differential is needed, the Differential should be reduced, not increased, to address the fact that the Commercials are paying 161.7% of the UCC costs that are reasonably attributed to them.

C. Changes in the Share of UCC Funded by the Government and Commercial Payers: RY 2011 to RY 2017

Table Two:
Changes in the Share of UCC Funding by Payer: FY 2011 to RY 2017

		Government Payers	Commercial Payers	UCC	UCC %	
FY 2011	UCC Funding	$547,668	$524,995	$1,072,663	6.87%	
	UCC Funding Proportion	51.1%	48.9%			
FY 2012	UCC Funding	$545,123	$523,621	$1,068,744	6.85%	
	UCC Funding Proportion	51.0%	49.0%			
FY 2013	UCC Funding	$584,634	$544,970	$1,129,604	7.25%	
	UCC Funding Proportion	51.8%	48.2%			
FY 2014	UCC Funding	$547,224	$524,755	$1,071,979	6.88%	
	UCC Funding Proportion	51.0%	49.0%			
FY 2015	UCC Funding	$325,795	$405,109	$730,904	4.69%	
	UCC Funding Proportion	44.6%	55.4%			
FY 2016	UCC Funding	$307,595	$395,275	$702,870	4.51%	
	UCC Funding Proportion	43.8%	56.2%			
FY 2017	UCC Funding	$282,924	$389,207	$672,131	4.18%	Original
	UCC Funding Proportion	42.1%	57.9%			Case

As shown in Table Two, the share of UCC funding provided by the Government payers was 51.1%, and the share provided by the Commercial payers was 48.9%, in RY 2011. The relative shares of UCC funding stayed relatively constant from RY 2011 through RY 2014. In RY 2015, the relative shares diverged substantially—specifically, the Government share dropped to 44.6% and the Commercial share rose to 55.4%. The decline in the Government share continued after RY 2014 and reached 42.1% in RY 2017 while the increase in the Commercial share continued and reached 57.9% in RY 2017.

Table Two shows that UCC funding has shifted away from the Government payers, and toward the Commercial payers, since RY 2011. This pattern undermines the Staff argument that the Differential should be increased from 6.0% to 7.7% to achieve a more equitable funding of UCC.

Finally, it is important to observe that the decline in the Government share of UCC funding occurred during the period when UCC was declining sharply because of the Medicaid expansion and the coverage provided by the ACA Exchange. As UCC declines, the Differential should be decreased to prevent inequitable shifts of UCC funding away from the Government payers to the Commercial payers. This relationship is clearly illustrated by the fact that a decline of UCC from its current levels to 2.0% would bring the Mark Up down to approximately 1.06. With a 1.06 Mark Up, and an unchanged Differential of 6.0%, the Government payers would pay nothing to cover the costs of UCC—at that point, all of the UCC costs would be borne by the Commercial payers.

* * * * * * *

Note: Some amounts in the Tables above do not perfectly tie out because of rounding and other factors.

OFFICE OF SENIOR VICE PRESIDENT & CFO

Mercy
HEALTH SERVICES

A University Affiliated Center Conducted by the Sisters of Mercy

November 12, 2018

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

Dear Ms. Wunderlich:

Mercy Health Services supports the HSCRC Staff Recommendation to adjust the public payer differential from 6 percent to 7.7 percent.

The Mercy Health Services team appreciates the hard work and efforts of the Commission and its staff to continue to evaluate and make recommendations to the Total Cost of Care Model.

Sincerely,

Justin C. Deibel
Sr. Vice President/CFO

cc Mike Robbins, MHA

301 ST. PAUL PLACE BALTIMORE, MD 21202-2102 (410) 659-2905 FAX (410) 951-1711
TTY (410) 332-9888

MedChi
The Maryland State Medical Society

Your Advocate.
Your Resource.
Your Profession.

The Honorable Nelson J. Sabatini
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
Sent Via Email to katie.wunderlich@maryland.gov

Dear Chairman Sabatini:

On behalf of MedChi, The Maryland State Medical Society, who represents thousands of Maryland physicians and their patients, we are writing today to strongly support the proposed draft policy recommendation for a small adjustment to the public payer differential from 6 percent to 7.7 percent.

MedChi believes it is both logical and fair to make this adjustment since we are entering into a new contract with CMMI. We would further suggest that the Commission consider adopting a formal policy to review the differential each time the contract is updated with an analysis and study as completed by the staff this year. MedChi supports the Commission's staff analysis that reveals a significant increase in hospital bad debts over the last few years due to high-deductible and other large cost-sharing plans.

Failing to fix this inequity for nearly 3 million commercially-insured consumers in Maryland who have subsidized, uncompensated healthcare costs for Medicare and Medicaid would be an injustice. It is important that we monitor and judicially manage this issue this year and beyond. A failure to act would disadvantage Maryland's senior citizens and poorer residents as they would subsidize consumers who were fortunate enough to have private health insurance.

MedChi appreciates the efforts of the Commission and looks forward to continuing their leadership role as Maryland works to implement the new All Payer contract and the directly-related Maryland Primary Care Program.

Please feel free to reach out to me if you have any questions.

Sincerely,

Gene M Ransom III

Gene M. Ransom, III
Chief Executive Officer

cc: Members of the HSCRC

1211 Cathedral Street • Baltimore, MD 21201-5516 • 410.539.0872 • Fax: 410.547.0915 • 1.800.492.1056 • www.medchi.org

Final Recommendations for Updating the Quality-Based Reimbursement Program for Rate Year 2021

December 12, 2018

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

This document contains the final staff recommendations for updating the Quality Based Reimbursement Program for RY 2021.

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LIST OF ABBREVIATIONS

CDC	Centers for Disease Control & Prevention
CAUTI	Catheter-associated urinary tract infection
CDIFF	Clostridium Difficile infection
CLABSI	Central line-associated blood stream infections
CMS	Centers for Medicare &e Medicaid Services
DRG	Diagnosis-related group
ED	Emergency department
FFY	Federal fiscal year
HCAHPS	Hospital Consumer Assessment of Healthcare Providers and Systems
HSCRC	Health Services Cost Review Commission
MRSA	Methicillin-resistant staphylococcus aureus
NHSN	National Health Safety Network
PQI	Prevention quality indicators
QBR	Quality-Based Reimbursement
RY	Maryland HSCRC Rate Year
SIR	Standardized infection ratio
SSI	Surgical site infection
THA/TKA	Total hip and knee arthroplasty risk standardized complication rate
VBP	Value-Based Purchasing

EXECUTIVE SUMMARY

This document puts forth RY 2021 Quality-Based Reimbursement (QBR) final policy recommendations that include maintaining the RY 2020 quality domains, scoring approach, and pre-set revenue adjustment scale. This final recommendation also proposes minimal changes to the program measures, as outlined below.

Final Recommendations for RY 2021 QBR Program

1. Implement the following **measure updates**:
    A. **Add the Total Hip Arthroplasty/Total Knee Arthroplasty Risk-Standardized Complication Rate measure** to the Clinical Care Domain, and weight the measure at 5% to align with the National VBP program**;**
    B. **Remove the PC-01 and ED-1b measures** commensurate with their removal from the CMS VBP and IQR programs respectively.
2. Continue **Domain Weighting** as follows for determining hospitals' overall performance scores: Person and Community Engagement - 50%, Safety (NHSN measures) - 35%, Clinical Care - 15%.
3. Maintain the **pre-set scale** (0-80% with cut-point at 45%), and continue to hold 2% of inpatient revenue at-risk (rewards and penalties) for the QBR program.

INTRODUCTION

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) Quality Based Reimbursement (QBR) program is one of several pay for performance initiatives that provide incentives for hospitals to improve patient care and value over time. Under the current five-year All-Payer Model Agreement between Maryland and the Centers for Medicare & Medicaid Services (CMS), effective through December 2018, there are specific quality performance requirements, including reducing Medicare readmissions to below the national average and reducing hospital complications by 30% over 5 years. Maryland is on target to meet or exceed both of these targets. The QBR program had no stated performance requirements in the All-Payer Model. However, the Commission has prioritized aligning the QBR program with the federal Value Based Purchasing (VBP) program and has attempted to encourage improvement in areas where Maryland has exhibited poor performance relative to the nation. As Maryland enters into a new Total Cost of Care (TCOC) Model Agreement with CMS on January 1, 2019, performance standards and targets in HSCRC's portfolio of quality and value-based payment programs will be updated. In the first year of the TCOC Model, staff will seek to revise two of the Commission's Quality programs, the Maryland Hospital Acquired Complications program and the Potentially Avoidable Utilization program, per directives from HSCRC Commissioners.[1] The QBR program will include new measures but will largely remain similar to prior iterations of the policy.

A central tenet of the healthcare reform in Maryland since 2014 is that hospitals are funded under Population Based Revenue, a fixed annual revenue cap that is adjusted for inflation, quality performance, reductions in potentially avoidable utilization, market shifts, and demographic growth. Under the Population Based Revenue system, hospitals are incentivized to transition services across the continuum of care and may keep savings that they achieve via improved quality of care (e.g., reduced avoidable utilization, readmissions, hospital acquired infections). On the other hand, constraining hospital resources can have unintended consequences, including declining quality of care. Thus, HSCRC Quality programs must reward quality improvements and reinforce the incentives of the Population Based Revenue system, as well as penalize poor performance and potential unintended consequences.

Maryland's exemptions from national quality programs are essential because the Population Based Revenue system benefits from having autonomous, quality-based measurement and payment initiatives that set consistent all-payer quality incentives. Furthermore, these exemptions afford Maryland the flexibility to select performance measures and targets in areas where improvement is needed, and allow Maryland to develop programs with greater potential for system transformation. For example, unlike the national VBP program, QBR does not

[1] In the fall of 2017, HSCRC Commissioners with staff support conducted several strategic planning sessions to outline priorities and guiding principles for the upcoming Total Cost of Care Model. Based on these sessions, the HSCRC developed a Critical Action Plan that delineates timelines for review and possible revisions of financial and quality methodologies, as well as other staff operations.

relatively rank hospitals, but instead provides all hospitals the opportunity to earn rewards, which are determined using a prospective revenue adjustment scale. Under the TCOC Model, the State will receive exemptions from the CMS Hospital Acquired Conditions (HAC) program, Hospital Readmission Reduction program (HRRP), and Value-Based Purchasing (VBP) program based on annual reports to CMS that demonstrate that Maryland's program results continue to be aggressive and progressive, meeting or surpassing those of the nation.

The QBR program measures and domains are similar to those of the VBP program, but there are a few differences. Most notably, QBR does not include an Efficiency domain, and HSCRC has put higher weight on the Person and Community Engagement and Safety domains to encourage improvement. Staff recommends retaining this approach for the final RY 2021policy. The HSCRC staff plans to expand the Potentially Avoidable Utilization (PAU) definition to incorporate other categories of unnecessary and avoidable utilization, and to incorporate other measures of efficiency based on per beneficiary measures.[2] In addition, the Medicare Performance Adjustment is also a measure of TCOC Efficiency that can be considered under the aggregate revenue at-risk across quality programs.

The HSCRC incorporates more comprehensive measures relative to the VBP program, most notably an all-cause, Maryland mortality measure versus VBP's condition-specific mortality measures, but generally the Commission tries to align the QBR program to measures of national import. For this reason, staff is recommending to incorporate into the RY 2021 QBR policy complication measures related to elective total hip and knee arthroplasties. Staff will also recommend to discontinue the use of various measures that will no longer have a federal data source (e.g., early elective delivery and emergency room wait time from time of arrival to admission), and staff will not recommend to adopt additional emergency room wait time measures at this time.

This report provides final recommendations for updates to Maryland's QBR program for Rate Year (RY) 2021. The QBR program has potential scaled penalties or rewards of up to 2% of inpatient revenue. Hospital's performance is assessed relative to national standards for its Safety and Person and Community Engagement domains. For the Clinical Care domain, the program uses Maryland-specific standards for the inpatient mortality measure, and proposes to use national standards for the new hip and knee complication measure.

[2] Maryland has implemented an efficiency measure in the Population Based Revenue system, based on a calculation of potentially avoidable utilization (PAU), but it has not made efficiency part of its core quality programs as a domain because the revenue system fundamentally incentivizes improved efficiency. PAU is currently defined as the costs of readmissions, and of admissions measured by the Agency for Healthcare Research and Quality Prevention Quality Indicators (PQIs).

BACKGROUND

The Affordable Care Act established the hospital Medicare Value-Based Purchasing (VBP) program,[3] which requires CMS to reward hospitals with incentive payments for the quality of care provided to Medicare beneficiaries. While the QBR program has many similarities to the federal Medicare VBP program, it differs in some ways as Maryland's unique Model Agreements and autonomous position allow the State to be innovative and progressive. Figure 1 below compares the RY 2020 QBR measures and domain weights to those used in the CMS VBP program.

Figure 1. RY 2020 QBR Measures and Domain Weights Compared with CMS VBP Programs[4]

	Maryland QBR Domain Weights and Measures	CMS VBP Domain Weights and Measures
Clinical Care	15% (1 measure: all cause inpatient Mortality)	25% (4 measures: 3 condition-specific Mortality, THA/TKA measure)
Person and Community Engagement	50% (8 HCAHPS measures, 2 ED wait time measure)	25% (Same HCAHPS measures, no ED wait time measures)
Safety	35% (6 measures: CDC NHSN HAI)	25% (7 measures: 6 CDC NHSN, PSI-90)
Efficiency	N/A	25% (Medicare Spending Per Beneficiary measure)

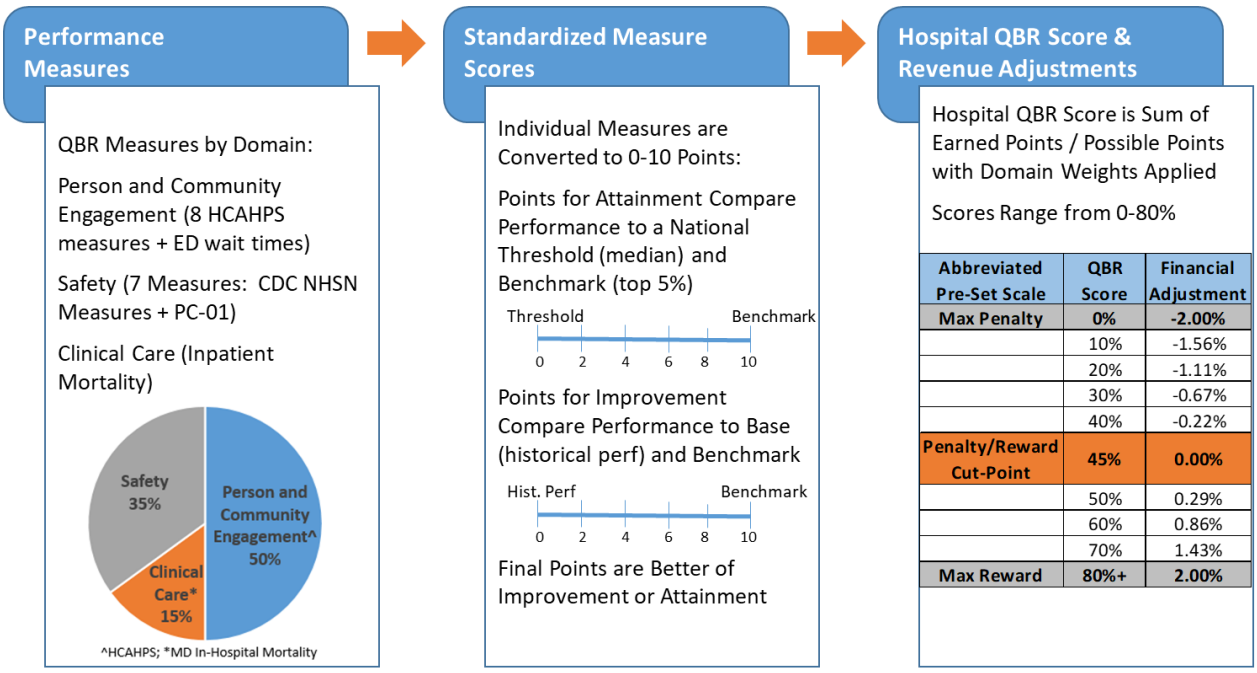
In the RY 2019 QBR recommendation, the Commission also approved moving to a preset scale based on national performance to ensure that QBR revenue adjustments are linked to Maryland hospital performance relative to the nation. Prior to RY 2019, Maryland hospitals were evaluated by national thresholds and benchmarks, but their scores were then scaled in accordance with Maryland performance, i.e., if the top performing hospital had an overall score of 57%, this became the high end of the scale by which all other Maryland hospitals were judged. This policy resulted in Maryland hospitals receiving financial rewards despite falling behind the nation in performance. Consequently, the scale is now 0 to 80% regardless of the highest performing hospital's score, and the cutoff by which a hospital earns rewards is 45%. This reward cutoff was based on an analysis of FFY 2017 data that indicated that the average national score using Maryland domain weights (i.e., without the Efficiency domain) was 41%; thus, the 45% incentivizes performance better than the nation.

[3] For more information on the VBP program, see https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-Value-Based-Purchasing/

[4] Details of CMS VBP measures may be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

The methodology for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019, and involves: 1) assessing performance on each measure in the domain; 2) standardizing measure scores relative to performance standards; 3) calculating the total points a hospital earned divided by the total possible points for each domain; 4) finalizing the total hospital QBR score (0-100%) by weighting the domains based on the overall percentage or importance the Commission has placed on each domain; and 5) converting the total hospital QBR scores into revenue adjustments using the preset scale that ranges from 0 to 80%, as aforementioned. The methodology is illustrated in Figure 2 below.

Figure 2. Process for Calculating RY 2020 QBR Scores



Abbreviated Pre-Set Scale	QBR Score	Financial Adjustment
Max Penalty	**0%**	**-2.00%**
	10%	-1.56%
	20%	-1.11%
	30%	-0.67%
	40%	-0.22%
Penalty/Reward Cut-Point	**45%**	**0.00%**
	50%	0.29%
	60%	0.86%
	70%	1.43%
Max Reward	**80%+**	**2.00%**

Appendix I contains further background and technical details about the QBR and VBP programs.

ASSESSMENT

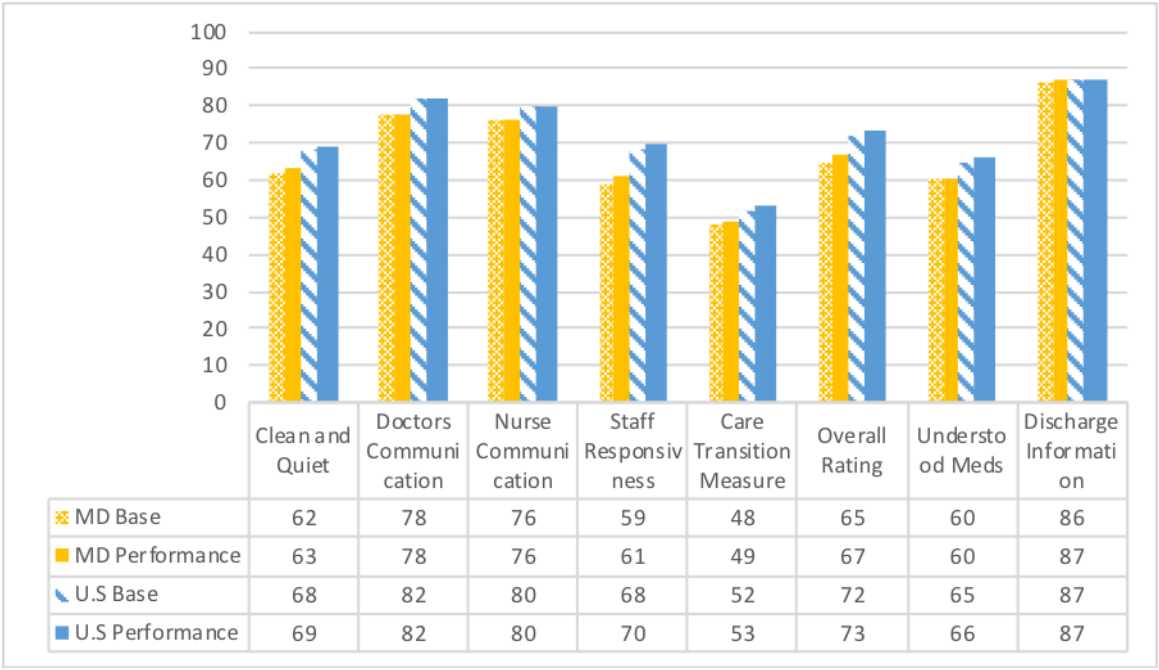
The purpose of this section is to assess Maryland's performance on current and potential QBR measures within each domain that, together with the deliberations of the Performance Measurement Workgroup (PMWG), serve as the basis for the recommendations for the RY 2021 QBR program. In addition, the staff have modeled the QBR revenue adjustments with the recommended changes.

Maryland Performance by QBR Domain

The **Person and Community Engagement** domain measures performance using the HCAHPS patient survey, as well as two emergency department wait time measures for admitted patients. The addition of the emergency department wait time measures is an example of Maryland's quality programs differing from the nation to target an area of concern.

Figure 3 provides the HCAHPS measure results for the RY2019 base and performance periods for Maryland and the Nation. It shows that Maryland improved by 1-3% on 5 out of 8 of the measures; however, the nation also improved on five of the measures. In summary, the gap between Maryland and the nation was reduced by approximately 1% for the "discharge information" measure and the "overall rating" measure; the gap between Maryland and nation for "understood medication" widened by 1% because Maryland's score remained constant and the nation improved; and for all other measures, the gap remained the same.

Figure 3. HCAHPS Results: Maryland Compared to the nationfor RY 2019



	Clean and Quiet	Doctors Communication	Nurse Communication	Staff Responsiveness	Care Transition Measure	Overall Rating	Understood Meds	Discharge Information
MD Base	62	78	76	59	48	65	60	86
MD Performance	63	78	76	61	49	67	60	87
U.S Base	68	82	80	68	52	72	65	87
U.S Performance	69	82	80	70	53	73	66	87

***Time period Calendar Year 2015 (Base); 10/2016 to 9/2017 (Performance)**

While the statewide data suggests that Maryland continues to lag behind the nation on HCAHPS measures, there is variability in performance across individual hospitals, with some performing better than the national average on each measure. Furthermore, while the statewide improvements were modest, there were individual hospitals with significant improvements on each measure (Appendix II).

It should be noted that hospital stakeholders have raised concerns about HCAHPS patient mix adjustment changes between the base and performance periods. CMS has advised staff that these changes occur on an ongoing basis, and that the most recent changes are not considered

materially significant for the VBP program. Further, staff believes that the changes in any given year may slightly benefit or disadvantage each hospital on their respective QBR scores, but recognize the use of the prospective preset scale may make this issue more of a concern in Maryland. Therefore, staff will evaluate the impact of the patient mix adjustment changes for RY 2019 and RY 2020, but does not support retrospective QBR revenue adjustments. Staff may re-visit this position with the Commission should analysis determine the patient mix adjustment changes are materially significant. For RY2021 it is unknown whether there will be any patient mix adjustment changes, but staff will assess any changes that occur.

Emergency department wait time measures have been publicly reported nationally on Hospital Compare since 2012 for patients admitted (ED-1b and ED-2b), and since 2014 for patients treated and released (OP-18b). Based upon Maryland's sustained poor performance on these ED throughput measures, the Commission voted to include the two ED Wait Time measures for admitted patients as part of the QBR program for RY 2020.[5] However, staff notes that the impact of adding the measures to the QBR program cannot be assessed at this time, since the data are lagged by 9 months and will not be available for the complete RY 2020 performance period until the fall of 2019. As the Hospital Compare quarterly data is released, staff will assess any emerging changes in the trends. The measure definitions are provided below in Figure 4.

Figure 4. CMS ED Wait Time Measures

Measure ID	Measure Title
ED-1b	Median time from emergency department arrival to emergency department departure for admitted emergency department patients
ED-2b	Admit decision time to emergency department departure time for admitted patient
OP-18*	Emergency department arrival time to departure time for discharged patients.

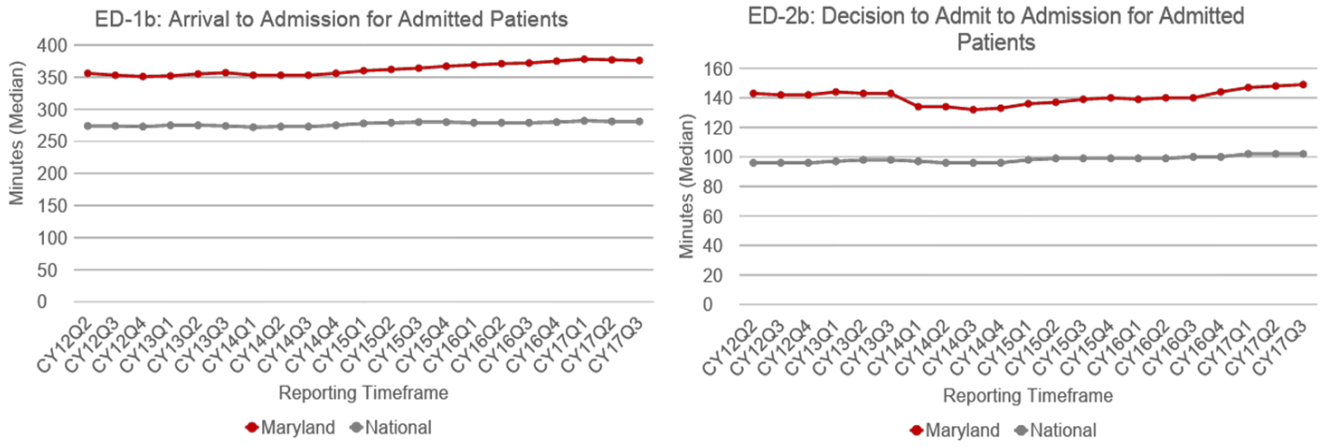
*OP-18 is not recommended to be a measure in the RY 2021 Program. OP-18b strata includes non-psychiatric patients and OP-18c strata includes psychiatric patients.

Based on the most current data available, Maryland continues to perform poorly on the ED wait time measures compared to the nation, as illustrated in Figure 4 below. At the hospital level, the most recent data show approximately 85% of Maryland hospitals perform worse than the national median in ED wait times.[6]

[5] Staff believes that poor ED wait times may also be contributing to less favorable hospital HCAHPS scores, based on analysis of statistical correlation done last year when the RY 2020 policy was adopted.

[6] 93% of Maryland hospitals perform worse than the nation in ED-1b, 78% perform worse than the nation in ED-2b, and 82% perform worse on OB-18b. The median wait times are adjusted based upon ED volume. These results are similar to the 80% reported in RY2020 policy.

Figure 5. Maryland Statewide ED Wait Time Trends for Admitted Patients Compared to the Nation, Q2 2012 to Q32017.



For RY 2021, staff recommends that the QBR program include only the ED-2b measure, as CMS has discontinued mandatory data collection for ED-1b after CY 2018. In the latest final rule, CMS removed or de-duplicated 39 measures from the hospital Inpatient Quality Reporting program to focus measurement on the most critical quality issues with the least burden for clinicians and providers. While ED-1b was removed from CMS reporting, it should be noted that the Joint commission has retained the measure and given statewide performance this is a more critical quality issue for Maryland than the nation.

Based on stakeholder interest last year and the removal of ED-1b, staff and the PMWG reconsidered whether to propose inclusion of OP-18 (non-admitted patients) for RY 2021. Maryland currently performs poorly on the wait time for non-admitted/discharged patients for both the non-psychiatric patients "b" strata measure, and the psychiatric patients "c" strata measure (OP-18c is newly added to Hospital Compare in latest public reporting release), as illustrated in Figure 6. Some stakeholders voiced support for inclusion of the OP-18b measure but others suggested the measure is at odds with hospitals' efforts to reduce inpatient admissions through ED care coordination.

Figure 6. Maryland Performance and National Benchmarks for ED Wait Times 10-1-2016 to 9-30-2017

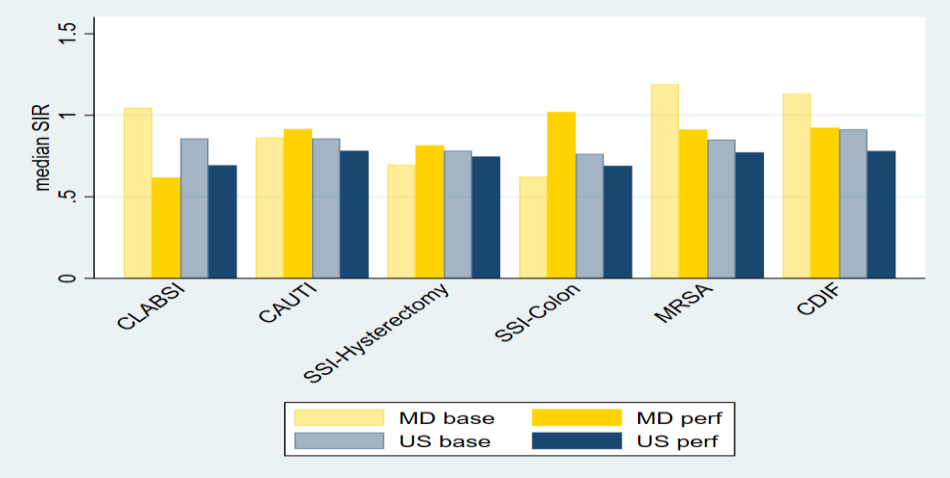
OP-18b (non-psychiatric patients)	MD	National
Low Volume	131	111
Moderate Volume	182	142
High Volume	190	161
Very High Volume	213	171
OP-18c (psychiatric patients)	**MD**	**National**
Low Volume	194	245
Moderate Volume	349	164
High Volume	324	218
Very High Volume	359	279

Based on this feedback, staff intends to actively monitor performance on the OP-18 measure (both OP-18b and OP-18c) over the next program year. Staff acknowledges that there are difficulties with the behavioral health system in the State, such as aging behavioral health system infrastructure and labor shortages, which exacerbate emergency department throughput problems. However these issues are not unique to Maryland. Furthermore, staff believes that continuing to include the measure of admit decision time to emergency department departure time for admitted patients will have spillover effects on outpatient emergency department wait times. However, if improvements are not seen in outpatient ED wait times, staff will reconsider a proposed recommendation for inclusion of OP-18b next year. Staff will pay particular attention to this issue in light of the fact that Maryland's higher wait times are paired with declining statewide ED visits.

Based on the analysis of the Person and Community Engagement domain, HSCRC staff recommends continuing to weight this domain at 50% of the QBR score, and retaining the ED-2b measure along with HCAHPS in the domain.

The **Safety** domain consists of six CDC National Health Safety Network (NHSN) healthcare associated infection (HAI) measures, and one measure of perinatal care (PC-01 Early Elective Delivery). Staff does not recommend any changes to this domain in RY 2021 beyond discontinuance of the PC-01 measure, which is being removed from the VBP program for FY 2021 due to relatively high performance of all hospitals. As illustrated in Figure 7 below, Maryland's performance on the NHSN measures has been mixed (lower scores are better). While median hospital standardized infection ratios (SIR) for all six HAI categories declined nationally during the performance period, Maryland hospitals experienced higher SIRs in three out of six of the infection categories. However, for the three infections in which Maryland hospitals also experienced declining standardized rates in the base period, the declines in Maryland were larger than national peers.

Figure 7. Maryland vs. National Median Hospital SIRs on NHSN HAI Safety Measures (Base period Calendar Year 2015, Performance period October 1, 2016 to September 30, 2017)

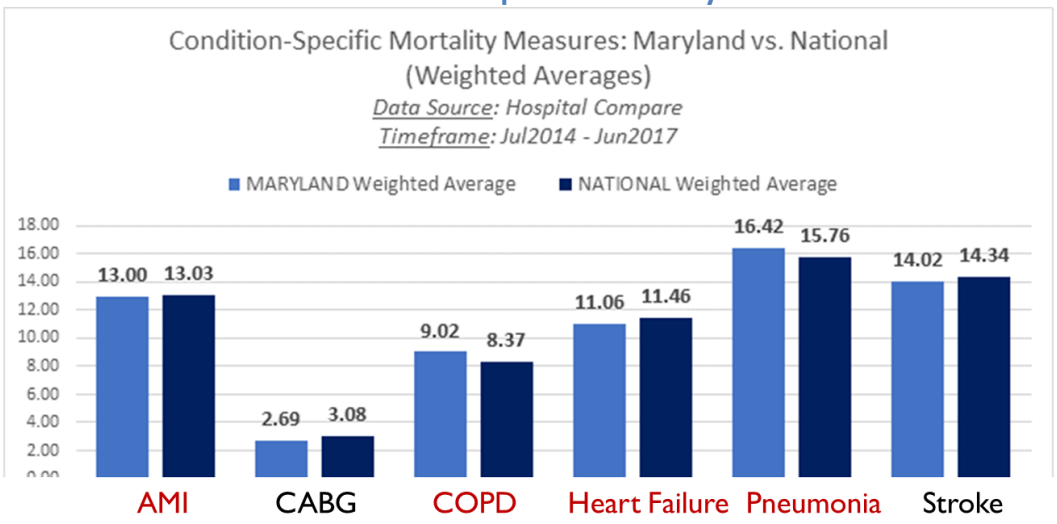


The QBR **Safety** domain does not include the Patient Safety Index Composite (PSI-90) measure that is included in VBP. Currently, the Agency for Healthcare Research and Quality (AHRQ) has yet to release a PSI-90 risk-adjustment methodology under ICD-10 for all payers. The HSCRC plans to consider options for re-adopting the PSI-90 composite measure on an all-payer basis as soon as the risk-adjustment is available. To this end, staff intends to vet with stakeholders the PSI composite measure in context of the QBR and MHAC complications programs as we consider its use under the TCOC Model starting in RY 2022.

Staff recommends continuing to weight the Safety domain at 35% of the total QBR score.

The QBR **Clinical Care** domain consists of one all-payer, all-cause inpatient mortality measure in the QBR program, while the federal Medicare VBP program measures four 30-day condition-specific Mortality measures (Heart Attack, Heart Failure, Pneumonia and COPD), as well as a Total Hip and Knee Arthroplasty (THA/TKA) complication measure on patients with elective primary procedures. Medicare also monitors two additional mortality measures for Coronary Artery Bypass Graft and Stroke, but does not include these measures in VBP. Based on the data obtained from Health Quality Innovators, Maryland performs similarly to the nation for all condition-specific measures of 30-day mortality (Figure 9).

Figure 9. Maryland Hospital Performance Compared with the nationon CMS Condition-Specific Mortality Measures

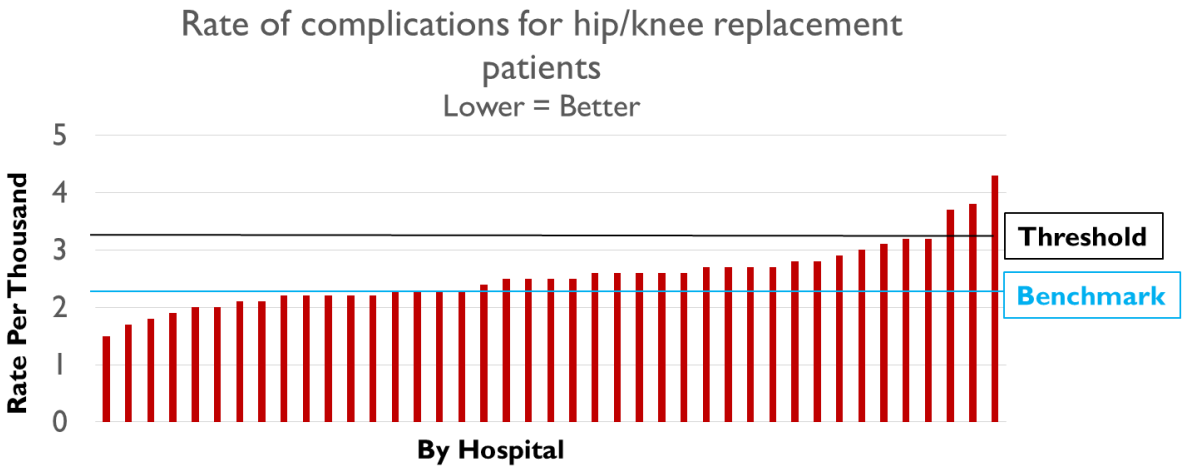


Source: Health Quality Innovators (HQI). Red are conditions included in VBP.

In terms of performance on the QBR inpatient mortality measure, 25 hospitals have shown a decrease in their risk-adjusted inpatient mortality rate through June 2018 compared to the RY2020 base period. An additional 7 hospitals have mortality rates that are better than the 95th percentile of state performance in the base period (i.e., they have exceeded the statewide benchmark and would earn full 10 points if performance continued through end of 2018). Finally, 8 hospitals that did not improve earned at least one attainment point for performance greater than the statewide average (i.e., threshold) during the base period.

For the hip and knee complication measure, Figure 10 illustrates that of the hospitals that qualify for the measure, all but 3 hospitals perform better than the current VBP threshold, and close to half of the hospitals perform better than the benchmark, but variation in performance remains. To qualify for the hip and knee complication measure a hospital must perform a minimum of 25 elective primary procedures.

Figure 10. Maryland THA/TKA Measure Performance Compared to VBP Standards, Base Period April 2011-March 2014, Performance Period April 2016-March 2019



Staff notes that adding the hip and knee complication measure to the QBR program is consistent with the goals of the TCOC model, namely expanding beyond the initial hospital stay since complications measured may occur up to 90 days postoperatively.

Staff recommends including the hip and knee replacement measure in the Clinical Care domain consistent with the VBP program, and continuing to weight the Clinical Care domain at 15%[7].

Appendix III details the available published performance standards (for VBP measures) for each measure by domain for RY2021; staff will calculate and disseminate the inpatient mortality standards within the next two months when v. 36 of the APR DRG grouper is implemented.

The Assessment section outlines Maryland's performance for available measures, and highlights those proposed for RY 2021. Appendix IV contains additional discussion of the QBR program and potential future changes under the Maryland Total Cost of Care Model.

Revenue Adjustment Modeling

HSCRC staff modeled hospital QBR scores and revenue adjustments consistent with the preset scaling approach approved for RY 2020. With the exception of the HSCRC-derived measures, the thresholds and benchmarks for the QBR scoring methodology are based on the national average (threshold) and the top performance (benchmark) values for all measures. A score of 0% means that performance on all measures are below the national average or not improved, while a score of 100% means all measures are at or better than the top 5% best performing rates. The

[7] If a hospital does not qualify for THA/TKA measure, then mortality will remain weighted at 15%.

Commission moved to a preset scale that reflects a full distribution of potential scores and raised the reward potential to 2% of inpatient revenue for RY 2019. Given Maryland's mixed performance relative to the nation, staff believes that the more aggressive scaling is warranted and proposes to continue this scale for RY 2021 QBR program.

This preset scale uses a modified full score distribution ranging from 0% to 80%, and sets the reward/penalty cut-point at 45%. The 45% cutoff was originally established by estimating the national average VBP scores for FFY2017 without the efficiency domain and with RY 2017 Maryland QBR-specific weights applied, which was 41%. Therefore, HSCRC staff recommended 45% as the cut-point for RY 2019 in order to establish an aggressive bar for receiving rewards. This analysis was updated for FFY 2016 through FFY 2018 (FFY 2019 data not yet publicly available) using the proposed RY2021 QBR domain weights, and the average national scores were relatively consistent at 42% for FFY16, 40% FFY17, and 42% FFY18. Staff plan to analyze FFY2019 results when publicly available to assess national average scores and may use this as basis to decide whether the HCAHPS patient mix adjustment changes are significant.

Staff modeled hospital scores for RY 2021 QBR using the aforementioned preset scale with a cutoff point of 45% and RY 2019 data using the base period of calendar year 2015, and the performance period of Q4 2016-Q3 2017. In order to assess the impact of removed measures and the addition of THA/TKA, the results of the following two models are provided:

- Model 1: Removal of PC-01 and Removal of ED-1b
- Model 2: Same as above, and addition of THA/TKA measure

Hospital-specific domain scores and total QBR scores for both models are included in Appendix V. The modeled hospital-specific and statewide revenue impacts are found in Appendix VI. With ED-1b and PC-01 excluded, 4 hospitals receive rewards of approximately $427 thousand and the remaining hospitals receive penalties of approximately $69 million. With the THA/THA included, 4 hospitals receive rewards of approximately $485 thousand, and the remaining hospitals receive penalties of approximately $64 million.

STAKEHOLDER COMMENTS AND RESPONSES

HSCRC Commissioners as well as hospital industry, payer and physician stakeholders have given verbal and written comments to HSCRC staff regarding the RY 2021 QBR program, applicable both in the short term, and as it evolves under the new TCOC Model. Staff summarizes the comments and responses below and the comment letters are included in Appendix VII.

OVERALL CONCERNS

The letter from MHA states that the **QBR policy is generally flawed** because the data on performance is delayed (9 month lag after performance period before data is available), the patient experience HCAHPS measures are difficult to improve upon, the infection measures are

volatile because of the low volume of events, and national concerns have been raised about the adequacy of the risk adjustment and measure data validation.

Staff Response:

Staff notes that the concerns raised about the QBR policy are all issues that impact the national VBP program and have been debated in previous QBR policies. Stakeholders must keep in mind that Maryland must meet or exceed performance levels in quality and cost under our Model agreement with CMS. Specifically, each year Maryland must submit to CMS our outcomes on VBP and other quality measures to receive an annual exemption from the CMS VBP program. While Maryland could maintain the all-payer rate setting system without this exemption, Maryland hospitals could be required to participate in the national VBP program. Under the VBP program, all US hospitals are held accountable to performance levels on the HCAHPS and NHSN measures.

Additionally, in response to specific concerns raised in this year's letter from MHA, staff notes that while the data is delayed for public posting on Hospital Compare, hospitals have access on a timelier basis to the data they submit to CMS as well as the data associated with the inpatient mortality measure that is calculated by the HSCRC. Thus, there is data during the performance period that can be used for quality improvement. Next, while the HCAHPS measures at a statewide level have shown only small improvements, there have been significant improvements at select hospitals. Appendix II shows hospital changes for RY 2019.

MEASURE UPDATES

During the November Commission meeting, some Commissioners raised concerns at the continued excessive **ED Wait Times** in Maryland compared to the Nation. Their concern centered on the ability to put the appropriate incentives in place, especially with the removal of the ED 1-b measure (wait time from arrival to admission) from the QBR program[8]. The OP 18-b measure (wait time from arrival to departure for patients not admitted) was also discussed as a possible consideration for use in the QBR program. Commissioners also inquired about the status of the Efficiency Improvement Action Plans that certain hospitals with the longest wait times were requested to submit earlier this year. The Maryland Chapter of the American College of Emergency Physicians (MD ACEP) continues to support the inclusion of the ED 2-b measure in light of extended wait times, but voiced concern in their letter regarding the addition of OP 18-b in the payment program because of time needed for care coordination to avoid admissions. As expressed last year, Johns Hopkins Hospital continues to raise concerns regarding inclusion of the one remaining ED 2-b measure (wait time from decision to admit to admission) due to occupancy rate impacts at their hospital, and behavioral health systems concerns.

[8] Data for the ED 1-b measure will no longer be available from Hospital Compare after CY 2018 because of the measure's discontinuance in the hospital Inpatient Quality Reporting program.

Staff Response:

Staff notes that, due to the data lag, the impact of adding the ED 1-b and 2-b measures to the RY 2020 QBR program, and potential spillover impacts on OP 18-b, are not yet known. Staff conducted preliminary analysis of one quarter of data from the RY 2020 QBR performance period after the draft policy was released, which reveals there may be marginal improvements on the measures for about half of the hospitals but cautions that one quarter of data is insufficient for evaluating performance trends. Moreover, the RY 2020 QBR program was not approved by Commissioners until December 2017, 2 months after the start of the performance period, so it would be difficult to suggest that the first three months of the performance period were impacted by the Commission decision to include ED wait time measures.

Regarding the hospital high occupancy rate and behavioral health system impact concerns raised at the November Commission meeting and by JHH in their letter, staff notes that the bar is not aggressive for this measure as hospitals receive full credit for the measure if they reach the national median. Additionally, there are protections to ensure that as long as the hospital improves on ED wait times, they are not hurt by the measure's inclusion in the policy. Staff notes that the literature demonstrates that decreases in hospital wait times for admitted patients is achievable, as is a decrease in the rate of patients that leave without being seen, when hospitals improve their inpatient efficiency and throughput.[9] In addition, staff believes that the stratification of hospital wait time measures by ED volume will further mitigate some of these concerns.

Regarding the addition of OP 18-b, staff supports monitoring of the measure but does not recommend adding the measure to the QBR program in light of hospitals' continued efforts to prevent avoidable admissions and employ care coordination activities in the ED. However if OP-18b does not improve over time as care coordination becomes more efficient, the staff may recommend inclusion of this measures in the RY 2022 QBR program.

Regarding the Efficiency Improvement Action Plans, 13 hospitals submitted Plans that described a wide variety of approaches, including efforts to change care processes, enhance facilities, and improve staffing. For example:

- **Union Hospital of Cecil County in 2016 sought to move low-acuity patients more quickly through the ED by including a provider in the triage process.**

[9]Artenstein, Andrew, MD, et al., Decreasing Emergency Department Walkout Rate and Boarding Hours by Improving Inpatient Length of Stay, West J Emerg Med. 2017 Oct; 18(6): 982–992., Last accessed: December 4, 2018.

Additionally, UHCC developed a marketing plan to encourage non-emergent patients to use affiliated urgent care centers rather than the ED, and organized a workgroup to address delays in diagnostic imaging.

- **University of Maryland Medical Center (UMMC) stationed a medical admitting officer in the ED 16 hours per day, and staffs an RN flow coordinator position to work with physicians on improving patient flow. The hospital has also partnered with the UM School of Nursing on an urgent care strategy, and opened an urgent care center across the street from the ED to handle low-acuity patients.**
- **Medstar Harbor instituted the ED FlexCare program, which routes non-emergent patients to primary care treatment options. The hospital also developed a "vertical care" track within the ED, in which intermediate-acuity patients remain seated for the duration of their stay, freeing ED beds for higher-acuity patients.**

Since the Plans were qualitative in nature, staff is determining the best way going forward to evaluate such information, and will again analyze ED wait time trends as the data becomes available.

Staff continues to support the use of ED 2-b in QBR program with its focus on hospital efficiencies to move patients to inpatient beds once the decision is made for admission.

The **addition of the hip and knee arthroplasty complication measure** to align with the CMS VBP program was generally supported by the hospitals and insurers. A concern was raised by Johns Hopkins Hospital related to deliberate actions to move uncomplicated hip and knee replacement surgeries to community hospitals within their system so the hospital does not have sufficient volume to qualify for the measure. As specified in the draft policy, JHH notes that hospitals that do not qualify for the hip and knee measure will have the inpatient mortality measure weighted at the full 15% of the Clinical Care domain. JHH recommended that the Commission consider attributing other system hospitals' scores to them for the QBR program. JHH also recommended that the Commission **consider in future years adopting the Medicare 30 day condition-specific mortality measures** in lieu of the all-payer, all condition inpatient mortality measure currently used in the QBR measure. Furthermore, JHH raises concerns regarding the inclusion of palliative care cases in the inpatient mortality measure and the inadequacy of the risk-adjustment.

Staff Response:

Staff continues to support general alignment with the national VBP program by adopting the hip/knee complication measure. With regard to the concern raised by Johns Hopkins, staff does not support giving credit for other system hospitals' performance, as this does not align with the measurement approach of the national program. Staff notes that at 5%, the measure is not heavily weighted; staff also does not believe the re-weighting of the inpatient mortality measure to the full 15%

of the Clinical Care domain justifies departing from the national measurement approach by attributing other system hospitals' scores to the academic facility with insufficient case volume. Staff adds that the Clinical Care domain is weighted at 15%, which is 10% less than the national VBP program.

Regarding the use of the Medicare 30 day condition-specific measures in lieu of the all payer measure in the future, staff notes that the Commission is working with contractors to develop a 30 day all-payer all condition mortality measure and will consider the Medicare mortality measures for future use as well.

In terms of the JHH concerns regarding the inclusion of palliative care cases, the staff remind the Commission that this was done to more accurately assess improvement as the use of palliative care was increasing. However, when assessing attainment the staff recognized the need to risk-adjust for palliative care status. In terms of the inadequacy of the risk-adjustment, staff is unclear as to the issues with the current risk adjustment but would be willing to discuss concerns and how they could be addressed in future years. Options for consideration include a) going back to the hybrid approach from RY 2019 that assessed improvement with palliative care included and attainment without palliative care, b) moving to an attainment only model with an exclusion for palliative care, or c) revising the risk adjustment. Finally, despite these concerns staff also notes that one hospital did report that including palliative care patients in the measure has incentivized them to work with nursing homes to provide better care within the nursing home for patients receiving end of life care.

SCORING AND REVENUE ADJUSTMENTS

Various hospital stakeholders (MHA, Medstar, UMMS) indicated they believe that the **aggressive payment scale is overly punitive** and that this is **amplified by the domain weights** we use for QBR. Specifically, hospital stakeholders point out that the **reward/penalty cut point** is too aggressive at 45% and resulted in RY 2019 with all but two hospitals receiving penalties. Thus, stakeholder input recommends that the QBR program should align the payment scale with the national VBP (Medstar, MHA, UMMS). Based on the most recently available data, the national average score, and hence the cut point, would be 41% with Maryland measurement domains weights applied, and 37% with national domain weights applied (Medstar).

Commenters had varying perspectives on the measurement domain weights that should be used in the QBR program. The MHA letter and others also state that the higher weight on HCAHPS has not resulted in improvement relative to the nation. Payer stakeholders (CareFirst) support keeping the domain weights as focus on needed improvement areas in Maryland, while hospital stakeholders (MHA, Medstar and UMMS) support re-weighting the measurement domains to align with the VBP program. Regarding the **amount of revenue at risk for performance**, MHA raises concerns that the amount is substantially larger in Maryland programs compared to the national programs and supports lowering the amount to levels more comparable to the

national programs, with consideration for the Medicare Performance Adjustment (MPA) in addition to the other quality adjustments.

Staff Response:

Staff believes that to compare scores you must adjust the domain weighting to be consistent across Maryland and the nation. As such, staff reweighted the national scores for FFY 2016 through FFY 2018 and found the average score range was 40%-42%. Staff does not believe that the 37% average score for the Nation (derived using national domains and weights) is an appropriate comparison since Maryland does not have the efficiency domain, which in FFY 2018 was the domain with the worst average scores and thus lowers the overall VBP average score. Regardless, even if the 37% cut point were to be used, FFY 2019 performance data from CMMI on the VBP measures for Maryland hospitals indicates that 34 hospitals would be penalized.

Staff believes under a prospective system an improvement factor should be added to the cut point but recognizes that the 45% cut point is aggressive and penalizes more hospitals than the VBP program. However, the number of hospitals penalized does not reflect the size of potential penalties Maryland hospitals could receive under the VBP program. As a reminder the VBP program uses a linear scale to assign rewards or penalties up to 2% by relatively ranking hospitals. Staff notes that of the 34 hospitals that would be estimated to receive VBP penalties, approximately half of them have scores in the lowest quartile of national performance and as such could receive significant penalties.

Next, staff agrees with Carefirst that the domain weights should emphasize areas of needed improvement in Maryland, most notably HCAHPS, and does not support the industry's recommendation to weight the domains equally. Staff has recently been informed about and is encouraged by hospital pilots that have been newly established for improving HCAHPS. Staff believes, therefore, that a long-term consistent policy is needed to emphasize the importance of these measures and to incentivize further investments. Moreover, reducing the weight on HCAHPS now would send the incorrect message to Maryland hospitals, especially hospitals that are engaging in pilot programs to improve their HCAHPS performance, and would be difficult to justify to CMS when requesting a waiver from CMS VBP.

Staff acknowledge the need for a more comprehensive analysis and comparison between Maryland's aggregate at-risk for performance based payments and the nation's aggregate at-risk. Staff looks forward to working with consumers, payers, and hospitals to help balance hospital concerns of high revenue at-risk on Medicare with the importance of continued quality improvement and revenue at-risk for all other consumers and payers. As part of this conversation, supplemental analyses may consider looking at how payers in other states implement their own revenue at-risk policies that are not included in the national Medicare numbers. The

Commission may consider revisiting the revenue at-risk in the RY 2021 policies in light of these conversations.

In addition, staff notes that the Maryland aggregate at-risk test is not the same as the MHA provided analysis. HSCRC is responsible for ensuring Maryland meets the current all-payer inpatient revenue aggregate at-risk tests agreed to by CMS. The numbers staff have currently calculated, illustrated below in Figure XX, are based on the percent of inpatient revenue potentially at-risk and the absolute dollar value exchanged based on quality. This differs from MHA's calculations that present the percent of total hospital charges, although staff does not believe this is the only difference between our estimates and MHA's, and will continue to work to identify other discrepancies. As a reminder, the all-payer nature of the Maryland quality programs is critical as it enables the state to receive waivers from the national quality programs, allowing for state innovations such as preset scaling and opportunities for rewards.

Figure 11. HSCRC Estimate of Maryland Compared to Medicare Potential and Realized Revenue at Risk for Quality Programs

CURRENT TEST	Maryland All-Payer Inpatient Revenue (State Fiscal Year 2019)		National Medicare Inpatient Revenue (Federal Fiscal Year 2018)	
	Maximum adjustment (potential risk)[1]	Actual adjustment (realized risk)[2]	Maximum adjustment (potential risk)[1]	Actual adjustment (realized risk)[2]
QBR/VBP, Complications, readmissions	6%	1.47%	6%	1.33%
PAU savings (cumulative)	5.81%	3.57%	N/A	N/A
MPA (begins in FY2020)[3]	N/A	N/A	N/A	N/A
Total	11.81%	5.04%%	6%	1.33%

[1] Maximum revenue at-risk (aka potential) is the absolute value of the largest penalty or reward a hospital could receive in a specific fiscal year for a program. Commission sets these values for the three core quality programs and the MPA, but not PAU savings, which is defined as the largest non-outlier adjustment received by a hospital.
[2] Actual adjustments (Realized at-risk) are calculated as the average of the absolute value of all inpatient adjustments for that program.
[3] As noted in the MHA table, the MPA adjustments do not begin until FY 2020, so the MPA is not included in the potential risk for RY 2019

As part of HSCRC negotiations to agree on aggregate at-risk calculations for the Total Care of Cost Model, CMMI has indicated concern with the use of cumulative PAU savings numbers instead of net PAU savings numbers. While this calculation is still under discussion, preliminary staff analyses indicate that it will be difficult to justify continuing to use the cumulative PAU savings numbers every year, as the cumulative amount does not represent additional annual revenue at-risk based on quality. Figure 12 below illustrates the same data as the previous table but with net PAU savings instead of cumulative savings. In the updated table, Maryland potential and realized risk is still above the national numbers.

Figure 12. HSCRC Estimate of Maryland Compared to Medicare Revenue at Risk for Quality Programs, with Net PAU Savings

POTENTIAL FUTURE TEST USING RY19	Maryland All-Payer Inpatient Revenue (State Fiscal Year 2019)		National Medicare Inpatient Revenue (Federal Fiscal Year 2018)	
	Maximum adjustment (potential risk)[1]	Actual adjustment (realized risk)[2]	Maximum adjustment (potential risk)[1]	Actual adjustment (realized risk)[2]
QBR/VBP, Complications, readmissions	6%	1.47%	6%	1.33%
PAU savings (net)	2%	0.61%	N/A	N/A
MPA (begins in FY2020)[3]	N/A	N/A	N/A	N/A
Total	8%	2.08%	6%	1.33%

[1] Maximum revenue at-risk (aka potential) is the absolute value of the largest penalty or reward a hospital could receive in a specific fiscal year for a program. Commission sets these values for the three core quality programs and the MPA, but not PAU savings, which is defined as the largest non-outlier adjustment received by a hospital.
[2] Actual adjustments (Realized at-risk) are calculated as the average of the absolute value of all inpatient adjustments for that program.
[3] As noted in the MHA table, the MPA adjustments do not begin until FY2020, so the MPA is not included in the potential risk for RY2019

FINAL RECOMMENDATIONS FOR RY 2021 QBR PROGRAM

Based on the staff assessment and stakeholder deliberations to date, staff proposes that the Commission consider the final recommendations below.

1. Implement the following m**easure updates**:
    A. **Add the Total Hip Arthroplasty/Total Knee Arthroplasty (THA/TKA) Risk-Standardized Complication Rate measure** to the Clinical Care Domain, and weight the measure at 5% to align with National VBP program;
    B. **Remove the PC-01 and ED-1b measures** commensurate with their removal from the CMS VBP and IQR programs respectively;
2. Continue **Domain Weighting** as follows for determining hospitals' overall performance scores: Person and Community Engagement - 50%, Safety (NHSN measures) - 35%, Clinical Care - 15%.
3. Maintain the **pre-set scale** (0-80% with cut-point at 45%), and continue to hold 2% of inpatient revenue at-risk (rewards and penalties) for the QBR program.

APPENDIX I. HSCRC QBR PROGRAM BACKGROUND

The Affordable Care Act established the hospital Medicare Value-Based Purchasing (VBP) program,[10] which requires CMS to reward hospitals with incentive payments for the quality of care provided to Medicare beneficiaries. The program assesses hospital performance on a set of measures in Clinical Care, Person and Community Engagement, Safety, and Efficiency domains. The incentive payments are funded by reducing the base operating diagnosis-related group (DRG) amounts that determine the Medicare payment for each hospital inpatient discharge.[11] The Affordable Care Act set the maximum penalty and reward at 2% for federal fiscal year (FFY) 2017 and beyond.[12]

Maryland's Quality-Based Reimbursement (QBR) program, in place since July 2009, employs measures that are similar to those in the federal Medicare VBP program, under which all other states have operated since October 2012. Similar to the VBP program, the QBR program currently measures performance in Clinical Care, Safety, and Person and Community Engagement domains, which comprise 15%, 35%, and 50% of a hospital's total QBR score, respectively. For the Safety and Person and Community Engagement domains, which constitute the largest share of a hospital's overall QBR score (85%), performance standards are the same as those established in the national VBP program. The Clinical Care Domain, in contrast, uses a Maryland-specific mortality measure and benchmarks. In effect, Maryland's QBR program, despite not having a prescribed national goal, reflects Maryland's rankings relative to the nation by using national VBP benchmarks for the majority of the overall QBR score.

In addition to structuring two of the three domains of the QBR program to correspond to the federal VBP program, the Commission has increasingly emphasized performance relative to the nation through benchmarking, domain weighting, and scaling decisions. For example, beginning in RY 2015, the QBR program began utilizing national benchmarks to assess performance for the Person and Community Engagement and Safety domains. Subsequently, the RY 2017 QBR policy increased the weighting of the Person and Community Engagement domain, which is measured by the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey instrument to 50%[13]. The weighting was increased in order to raise incentives for HCAHPS improvement, as Maryland has consistently scored in the lowest decile nationally on these measures.

While the QBR program has many similarities to the federal Medicare VBP program, it does differ because Maryland's unique Model Agreements and autonomous position allow the State to

[10] For more information on the VBP program, see https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-Value-Based-Purchasing/
[11] 42 USC § 1395ww(o)(7).
[12] 42 USC § 1395ww(o)(7)(C).
[13] The HCAHPS increase reduced the Clinical Care domain from 20% to 15%.

be innovative and progressive. Figure 13 below compares the RY 2020 QBR measures and domain weights to those used in the CMS VBP program.

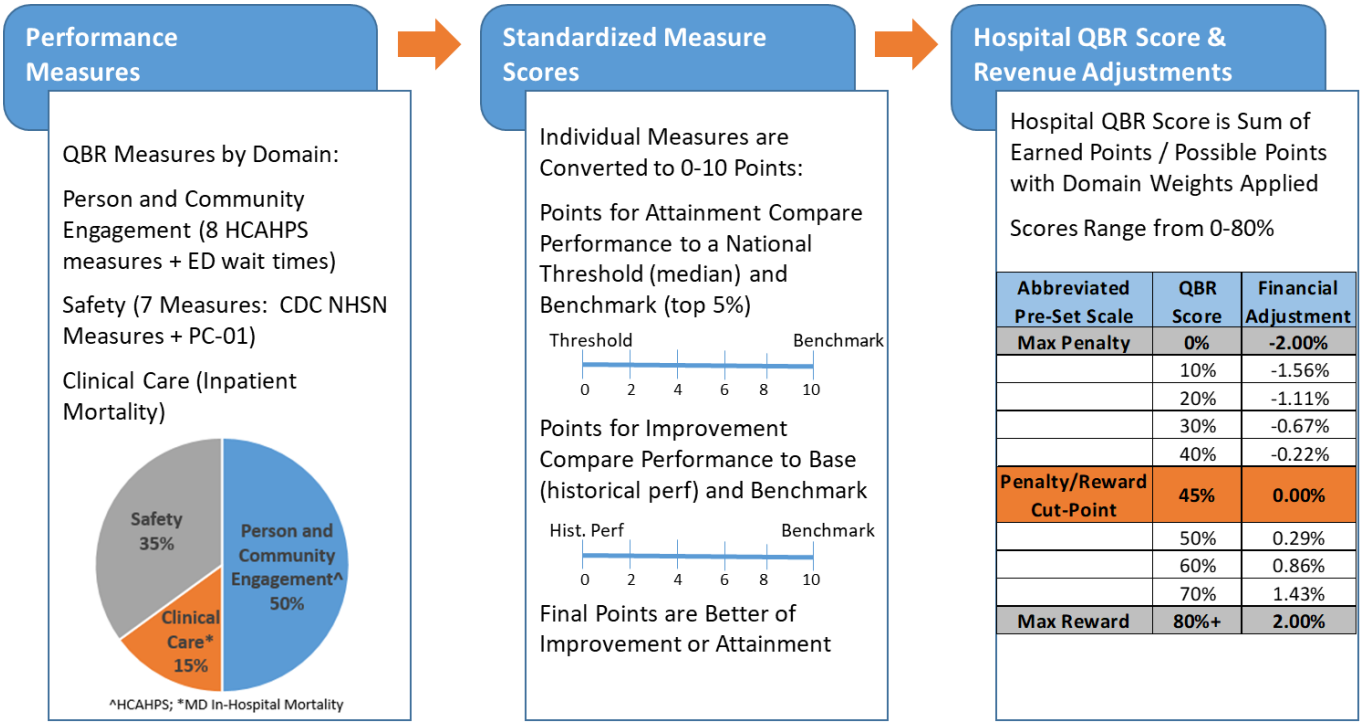
Figure 13. RY 2020 QBR Measures and Domain Weights Compared with CMS VBP Program[14]

	Maryland QBR Domains and Measures	CMS VBP Domain Weights and Measure Differences
Clinical Care	15% (1 measure: all cause inpatient Mortality)	25% (4 measures: condition-specific Mortality, THA/TKA Complication)
Person and Community Engagement	50% (8 HCAHPS measures, 2 ED wait time measures)	25% Same HCAHPS measures, no ED wait time measures
Safety	35% (7 measures: CDC NHSN, PC-01)	25% (8 measures: CDC NHSN, PC-01, PSI-90)
Efficiency	N/A	25% (Medicare Spending Per Beneficiary measure)

The methodology for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019, and involves: 1) assessing performance on each measure in the domain; 2) standardizing measure scores relative to performance standards; 3) calculating the total points a hospital earned divided by the total possible points for each domain; 4) finalizing the total hospital QBR score (0-100%) by weighting the domains based on the overall percentage or importance the Commission has placed on each domain; and 5) converting the total hospital QBR scores into revenue adjustments using the preset scale that ranges from 0 to 80%, as aforementioned. The methodology for RY 2020 is illustrated in Figure 14 below.

[14] Details of CMS VBP measures may be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html.

Figure 14. Process for Calculating RY 2020 QBR Scores



Domain Weights and Revenue At Risk

As illustrated in the body of the report, for the RY 2021 QBR program, the HSCRC proposed to weight the clinical care domain at 15 % of the final score, the Safety domain at 35 %, and the Person and Community Engagement domain at 50 %. The measures by domain are listed with their data sources in the table below (Figure 15).

Figure 15. Proposed RY 2021 QBR Domains, Measures and Data Sources

	Clinical Care	Person and Community Engagement	Safety
Proposed QBR RY 2021	15% 2 measures ▸ Inpatient Mortality (HSCRC case mix data) ▸ THA TKA (CMS Hospital Compare, Medicare claims data)	50% 9 measures ▸ 8 HCAHPS domains (CMS Hospital Compare patient survey) ▸ 1 ED wait time (CMS Hospital Compare chart abstracted)	35% 6 measures ▸ 6 CDC NHSN HAI measures (CMS Hospital Compare chart abstracted)

The HSCRC sets aside a percentage of hospital inpatient revenue to be held “at risk” based on each hospital’s QBR program performance. Hospital performance scores are translated into

rewards and penalties in a process that is referred to as scaling.[15] Rewards (referred to as positive scaled amounts) or penalties (referred to as negative scaled amounts) are then applied to each hospital's update factor for the rate year. The rewards or penalties are applied on a one-time basis and are not considered permanent revenue. The Commission previously approved scaling a maximum reward of 1% and a penalty of 2% of total approved base inpatient revenue across all hospitals for RY 2019.

HSCRC staff has worked with stakeholders over the last several years to align the QBR measures, thresholds, benchmark values, time lag periods, and amount of revenue at risk with those used by the CMS VBP program where feasible,[16] allowing the HSCRC to use data submitted directly to CMS.[17] As mentioned above, Maryland implemented an efficiency measure in relation to population based revenue budgets based on potentially avoidable utilization outside of the QBR program. The potentially avoidable utilization (PAU) savings adjustment to hospital rates is based on costs related to potentially avoidable admissions, as measured by the Agency for Healthcare Research and Quality Prevention Quality Indicators (PQIs) and avoidable readmissions. HSCRC staff will continue to work with key stakeholders to complete development of an efficiency measure that incorporates population-based cost outcomes.

QBR Proposed Measures Update: THA/TKA

In addition to the measure details provided above, the detail of the newly proposed THA/TKA measure already in use by the CMS VBP program is outlined below.

- The measure applies to patients **aged 65 or older** with **elective** primary **THA/TKA** procedure enrolled in Medicare fee-for-service.
- The **risk-standardized complication rate** (RSCR) is calculated as the ratio of the number of "predicted" to the number of "expected" admissions with a complication, multiplied by the national unadjusted complication rate. The numerator of the ratio is the number of admissions with a complication predicted on the basis of the hospital's performance with its observed case-mix.
- During the index hospital admission or within **seven days** from the date of index admission, the following complications acute myocardial infarction (AMI), pneumonia, and sepsis/septicemia/shock are measured;
- During the index hospital admission or within **30 days** of admission, death, surgical site bleeding, and pulmonary embolism are measured.

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[15] Scaling refers to the differential allocation of a pre-determined portion of base-regulated hospital inpatient revenue based on assessment of the quality of hospital performance.

[16] HSCRC has used data for some of the QBR measures (e.g., CMS core measures, CDC NHSN CLABSI, CAUTI) submitted to the Maryland Health Care Commission (MHCC) and applied state-based benchmarks and thresholds for these measures to calculate hospitals' QBR scores up to the period used for RY 2017.

[17] VBP measure specifications may be found at: www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html

- During the index hospital admission or within **90 days** of admission, mechanical complications and periprosthetic joint infection/wound infection are measured.
- Complications are counted only if they occur during the index hospital admission or during a readmission.

QBR Score Calculation

QBR Scores are evaluated by comparing a hospital's performance rate to its base period rate, as well as the threshold (which is the median, or 50th percentile, of all hospitals' performance during the baseline period), and the benchmark, (which is the mean of the top decile, or approximately the 95th percentile, during the baseline period).[18]

Attainment Points: During the performance period, attainment points are awarded by comparing an individual hospital's rates with the threshold and the benchmark. With the exception of the MD Mortality measure applied to all payers, the benchmarks and thresholds are the same as those used by CMS for the VBP program measures.[19] For each measure, a hospital that has a rate at or above benchmark receives 10 attainment points. A hospital that has a rate below the attainment threshold receives 0 attainment points. A hospital that has a rate at or above the attainment threshold and below the benchmark receives 1-9 attainment points

Improvement Points: The improvement points are awarded by comparing a hospital's rates during the performance period to the hospital's rates from the baseline period. A hospital that has a rate at or above the attainment benchmark receives 9 improvement points. A hospital that has a rate at or below baseline period rate receives 0 improvement points. A hospital that has a rate between the baseline period rate and the attainment benchmark receives 0-9 improvement points.

Consistency Points: The consistency points relate only to the experience of care domain. The purpose of these points is to reward hospitals that have scores above the national 50th percentile in all of the eight HCAHPS dimensions. If they do, they receive the full 20 points. If they do not, the dimension for which the hospital received the lowest score is compared to the range between the national 0 percentile (floor) and the 50th percentile (threshold) and is awarded points proportionately.

Domain Denominator Adjustments: In particular instances, QBR measures will be excluded from the QBR program for individual hospitals. In the Person and Community Engagement domain, ED wait time measures (if included in the RY 2020 program) will be excluded for protected hospitals. As described in the body of the report, a hospital may exclude one or both of the ED wait time measures if it has earned at least one improvement point and if its improvement

[18] The ED wait time measures do not have a benchmark; the methodology calculates hospital improvement relative to the national threshold, which is the national median for each respective ED volume category.
[19] For the ED wait time measures, attainment points are not calculated; instead full 10 points are awarded to hospitals at or below (more efficient) than the national medians for their respective volume categories in the performance period.

score would reduce its overall QBR score. If a measure is excluded, the Person and Community Engagement domain will reduce from 120 total points to 110 points.

Similarly, hospitals are exempt from measurement for any of the NHSN Safety measures for which there is less than 1 predicted case in the performance period. If a hospital is exempt from an NHSN measure, its Safety domain score denominator reduces from 60 to 50 points. If it is exempt from two measures, the Safety domain score denominator would be 40 total possible points. Hospitals must have at least 3 of 6 Safety measures in order to be included in the Safety domain.

Domain Scores: Composite scores are then calculated for each domain by adding up all of the measure scores in a given domain divided by the total possible points x 100. The better of attainment and improvement for experience of care scores is also added together to arrive at the experience of care base points. Base points and the consistency score are added together to determine the experience of care domain score.

Total Performance Score*:* The total Performance Score is computed by multiplying the domain scores by their specified weights, then adding those totals and dividing them by the highest total possible score. The Total Performance Score is then translated into a reward/ penalty that is applied to hospital revenue.

RY 2021 Proposed Timeline (Base and Performance Periods; Financial Impact)

Rate Year (Maryland Fiscal Year)	Q3-16	Q4-16	Q1-17	Q2-17	Q3-17	Q4-17	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19	Q3-19	Q4-19	Q1-20	Q2-20	Q3-20	Q4-20	Q1-21	Q2-21	Q3-21	Q4-21
Calendar Year	Q1-16	Q2-16	Q3-16	Q4-16	Q1-17	Q2-17	Q3-17	Q4-17	Q1-18	Q2-18	Q3-18	Q4-18	Q1-19	Q2-19	Q3-19	Q4-19	Q1-20	Q2-20	Q3-20	Q4-20	Q1-21	Q2-21
Rate Year 2021																						
QBR					Hospital Compare Base Period (HCAHPS measures, ED-2b; All NHSN Measures)														Rate Year Impacted by QBR Results			
												Hospital Compare Performance Period (HCAHPS measures, ED-2b, All NHSN measures)										
							QBR Maryland Mortality Base Period															
													QBR Maryland Mortality Performance Period								
		POTENTIAL NEW MEASURE: Hospital Compare THA/TKA Performance Period**																				

**Hospital Compare THA /TKA Base Period April 1, 2011-March 31, 2014

APPENDIX II. RY 2019 PATIENT EXPERIENCE MEASURE RESULTS BY HOSPITAL

HCAHPS Measures		Care Transitions		Clean/Quiet		Understood Meds		Doctor Communication		Nurse Communication		Discharge Info		Overall Rating		Staff Responsive-ness	
Hospital ID	Hospital Name	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base
210001	Meritus	46%	1%	63%	1%	59%	-1%	75%	-1%	77%	2%	88%	-1%	67%	3%	59%	0%
210002	UMMC	54%	-1%	55%	-4%	62%	-4%	79%	-1%	79%	1%	88%	1%	70%	1%	58%	-3%
210003	PG Hospital	39%	2%	53%	-2%	49%	0%	74%	1%	63%	1%	78%	0%	47%	3%	43%	2%
210004	Holy Cross	44%	-1%	65%	10%	55%	2%	74%	-1%	71%	-1%	80%	0%	64%	5%	55%	-1%
210005	Frederick	50%	-2%	70%	2%	62%	-2%	78%	-1%	80%	1%	89%	2%	70%	3%	59%	-2%
210006	UM-Harford	45%	-9%	57%	-3%	58%	-14%	75%	-6%	77%	-5%	81%	-3%	65%	0%	61%	3%
210008	Mercy	55%	-1%	71%	-1%	70%	5%	82%	-2%	81%	-1%	89%	0%	79%	1%	68%	6%
210009	Johns Hopkins	59%	0%	68%	1%	64%	0%	80%	0%	81%	0%	88%	-1%	81%	-1%	60%	-2%
210010	UM-Dorchester	48%	-2%	66%	4%	63%	2%	80%	-2%	81%	1%	86%	0%	66%	2%	68%	1%
210011	St. Agnes	48%	1%	60%	2%	61%	3%	78%	0%	75%	1%	86%	2%	66%	4%	59%	5%
210012	Sinai	48%	-2%	65%	-3%	63%	1%	78%	0%	79%	1%	88%	3%	69%	-1%	61%	1%
210013	Bon Secours	44%	11%	64%	3%	59%	-4%	80%	7%	73%	10%	87%	-1%	54%	4%	59%	15%
210015	MedStar Fr Square	46%	4%	56%	0%	61%	-3%	78%	0%	75%	-5%	87%	0%	68%	0%	56%	-3%
210016	Washington Adventist	43%	-2%	61%	-1%	58%	-1%	76%	-1%	73%	-1%	85%	-1%	67%	-1%	58%	1%
210017	Garrett	49%	-3%	64%	2%	67%	-1%	82%	-1%	79%	0%	91%	4%	69%	2%	69%	3%

HCAHPS Measures		Care Transitions		Clean/Quiet		Understood Meds		Doctor Communication		Nurse Communication		Discharge Info		Overall Rating		Staff Responsive-ness	
Hospital ID	Hospital Name	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base
210018	MedStar Montgomery	43%	2%	63%	4%	54%	-5%	75%	-3%	72%	1%	87%	-1%	62%	1%	54%	-3%
210019	Peninsula	50%	-2%	62%	-3%	62%	1%	76%	-4%	79%	1%	89%	2%	69%	1%	61%	-4%
210022	Suburban	51%	0%	67%	3%	58%	-3%	80%	-2%	77%	-3%	84%	0%	70%	-2%	64%	-3%
210023	Anne Arundel	54%	-1%	67%	5%	62%	1%	81%	2%	81%	4%	85%	-2%	78%	5%	70%	6%
210024	MedStar Union Mem	50%	-4%	69%	3%	63%	2%	83%	1%	79%	0%	88%	-2%	74%	-2%	63%	1%
210027	Western Maryland	52%	1%	67%	3%	68%	4%	79%	1%	80%	1%	92%	0%	70%	3%	63%	2%
210028	MedStar St. Mary's	51%	-3%	66%	-3%	59%	-8%	79%	-3%	79%	-4%	90%	-1%	67%	-5%	62%	-5%
210029	JH Bayview	54%	1%	59%	3%	62%	3%	78%	1%	76%	1%	87%	2%	68%	0%	62%	4%
210030	UM-Chestertown	47%	5%	61%	5%	57%	3%	80%	6%	79%	10%	86%	4%	62%	10%	69%	9%
210032	Union of Cecil	47%	-3%	62%	4%	62%	0%	75%	-1%	76%	-2%	86%	-4%	65%	-1%	60%	-1%
210033	Carroll	48%	-1%	66%	3%	60%	-3%	75%	-1%	79%	-1%	87%	1%	67%	-5%	65%	1%
210034	MedStar Harbor	46%	1%	65%	3%	62%	2%	80%	-1%	76%	-1%	85%	-2%	67%	1%	62%	1%
210035	UM-Charles Regional	50%	2%	61%	-5%	63%	2%	73%	-2%	78%	3%	86%	-2%	65%	3%	65%	9%

HCAHPS Measures		Care Transitions		Clean/Quiet		Understood Meds		Doctor Communication		Nurse Communication		Discharge Info		Overall Rating		Staff Responsive-ness	
Hospital ID	Hospital Name	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base
210037	UM-Easton	48%	-2%	66%	4%	63%	2%	80%	-2%	81%	1%	86%	0%	66%	2%	68%	1%
210038	UMMC Midtown	47%	6%	65%	1%	62%	7%	77%	1%	75%	6%	86%	9%	61%	4%	64%	12%
210039	Calvert	48%	-4%	65%	4%	62%	2%	75%	-3%	79%	2%	88%	1%	65%	0%	62%	1%
210040	Northwest	49%	1%	64%	-3%	61%	-2%	77%	1%	77%	0%	88%	4%	68%	0%	67%	1%
210043	UM-BWMC	47%	-1%	61%	0%	58%	-3%	76%	1%	75%	-2%	85%	1%	65%	-5%	56%	-4%
210044	GBMC	52%	-5%	58%	-5%	58%	-10%	81%	-5%	77%	-4%	90%	5%	72%	-6%	64%	-5%
210048	Howard County	50%	4%	64%	2%	58%	-3%	78%	0%	78%	1%	86%	1%	71%	3%	60%	-4%
210049	UM-Upper Chesapeake	51%	2%	64%	3%	64%	1%	78%	3%	79%	3%	86%	2%	70%	3%	64%	8%
210051	Doctors	44%	0%	60%	-3%	60%	8%	75%	0%	73%	1%	86%	0%	66%	3%	56%	7%
210055	Laurel Regional	39%	-1%	54%	-5%	50%	-1%	71%	-4%	62%	-6%	80%	1%	50%	-5%	53%	1%
210056	MedStar Good Sam	47%	-1%	62%	1%	64%	5%	75%	-7%	77%	-1%	90%	2%	67%	-1%	61%	6%
210057	Shady Grove	49%	3%	61%	4%	59%	6%	79%	0%	77%	3%	86%	-1%	70%	6%	59%	7%
210060	Ft. Washington	38%	-8%	59%	-4%	54%	-4%	77%	-2%	72%	-1%	86%	2%	60%	2%	63%	5%
210061	Atlantic	53%	2%	59%	2%	65%	5%	79%	-2%	78%	-1%	90%	1%	67%	-3%	66%	0%

HCAHPS Measures		Care Transitions		Clean/Quiet		Understood Meds		Doctor Communication		Nurse Communication		Discharge Info		Overall Rating		Staff Responsive-ness	
Hospital ID	Hospital Name	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base
	General																
210062	MedStar Southern MD	42%	5%	57%	1%	57%	4%	75%	-2%	70%	0%	82%	0%	54%	4%	53%	0%
210063	UM-St. Joe	55%	0%	67%	1%	61%	-3%	82%	2%	82%	3%	88%	0%	78%	3%	68%	2%
210065	HC-Germantown	47%	2%	66%	2%	56%	6%	77%	4%	68%	-2%	82%	0%	68%	1%	50%	-2%

APPENDIX III. RY 2021 QBR PERFORMANCE STANDARDS

Person and Community Engagement Domain*

Dimension	Benchmark	Achievement Threshold	Floor
Communication with Nurses	87.36%	79.06%	42.06
Communication with Doctors	88.10%	79.91%	41.99
Responsiveness of Hospital Staff	81.00%	65.77%	33.89%
Communication about Medicines	74.75%	63.83%	33.19%
Cleanliness and Quietness of Hospital Environment	79.58%	65.61%	30.60%
Discharge Information	92.17%	87.38%	66.94%
3-Item Care Transition	63.32%	51.87%	6.53%
Overall Rating of Hospital	85.67%	71.80%	34.70%

*The Person and Community Engagement performance standards displayed in this table were calculated using four quarters of calendar year 2017 data, and published in the CMS Inpatient Prospective Payment System FFY 19 Final Rule.

Safety Domain*

Measure Short ID	Measure Description	Benchmark	Achievement Threshold
CAUTI	Catheter-Associated Urinary Tract Infection	0	0.774
CDI	Clostridium *difficile* Infection	0.067	0.748
CLABSI	Central Line-Associated Blood Stream Infection	0	0.687
MRSA	Methicillin-Resistant Staphylococcus *aureus*	0	0.763
SSI	SSI - Abdominal Hysterectomy	0	0.726
	SSI - Colon Surgery	0	0.754

*The Safety Domain performance standards were published in the CMS Inpatient Prospective Payment System FFY 19 Final Rule.

Clinical Care Domain			
Measure Short ID	**Measure Description**	**Benchmark**	**Achievement Threshold**
Mortality	All Condition Inpatient Mortality	TBD*	TBD*
THA/TKA RSCR**	Total Hip/Knee Arthroplasty Risk Standardized Complication Rate	0.022418	0.031157

*Mortality standards will be calculated and disseminated with implementation of v. 36 of the APR DRG grouper.
**THA/TKA standards were published in the CMS Inpatient Prospective Payment System FFY 19 Final Rule.

APPENDIX IV: FUTURE OF QBR IN TOTAL COST OF CARE MODEL

To date, Maryland hospitals have met all of the Agreement goals laid out in the current contract with CMS. For the TCOC Model, contract terms do not define specific quality performance targets, but dictate that performance targets must be aggressive and progressive, must align with other HSCRC programs, must be comparable to federal programs, and must consider rankings relative to the nation. Maryland must submit annual reports to CMS demonstrating that our quality programs' design elements, operational impacts, and results meet or exceed those of national Medicare program. The HSCRC, in consultation with staff, industry and other key stakeholders, continues to lay the framework and has begun to the process to determine specific quality performance targets in the TCOC Model.

Staff has started developing new policy targets and to align measures for success under the TCOC Model. This will entail considering options for bundling outcomes across quality programs, evaluating opportunities for performance standards outside the hospital walls, ensuring that financial incentives under the population-based revenue system are compatible, and developing reporting measures that are more holistic and patient-centered. This longer-term work has begun with the convening a clinical subgroup to evaluate candidate measures of complications that Maryland should include in its pay for performance regimen. In addition, work has begun to evaluate external data sources to determine if the Commission can utilize them to incentivize improvement inside[20] and outside the hospital; revisit financial methodologies and cultivate new ones, such as Inter-Hospital Cost Comparison, to ensure resources are being disseminated in accordance with TCOC Model goals; and consider options for establishing an overarching service line approach to the hospital quality programs so as to break down silos and promulgate a more holistic and patient-centered environment. Staff acknowledges this will require a lot of work in concert with industry and a broad array of other stakeholders—consumers, payers, cross-continuum providers, quality measurement experts, and government agencies (local, state and federal)— as the success of the TCOC Model depends on reducing cost on a per capita basis without compromising quality of care.

[20] For example, staff notes that, although ED-1b is retired from CMS Inpatient Hospital Reporting and that PC-01 (early elective delivery) is retired from VBP after CY 2018, these measures continue to be optional for reporting to the Joint Commission. Therefore, staff could explore Joint Commission data for potential use in our quality programs in future years.

APPENDIX V. MODELING OF SCORES BY DOMAIN: RY 2019 QBR DATA WITH RY 2021 MEASURES

This appendix includes modeling of the removal of PC-01 and ED-1b (Model 1) versus these changes plus the addition of THA-TKA measure (Model 2).

		Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Difference
Hospital ID	**Hospital Name**	**HCAHPS Final Score**	**HCAHPS Final Score**	**Mortality Final Score**	**Mortality Final Score**	**Safety Final Score**	**Safety Final Score**	**Total Score**	**Total Score**	**Total Score**
210001	Meritus	17%	17%	10%	33%	18%	18%	16.30%	19.80%	3.50%
210002	UMMC	20%	20%	0%	33%	8%	8%	12.80%	17.80%	5.00%
210003	UM-PGHC	5%	5%	10%	10%	14%	14%	9.13%	9.13%	0.00%
210004	Holy Cross	12%	12%	60%	40%	26%	26%	24.10%	21.10%	-3.00%
210005	Frederick	24%	24%	100%	70%	6%	6%	29.10%	24.60%	-4.50%
210006	UM-Harford	27%	27%	20%	47%	40%	40%	30.64%	34.64%	4.00%
210008	Mercy	55%	55%	50%	67%	28%	28%	44.57%	47.07%	2.50%
210009	Johns Hopkins	38%	38%	20%	20%	24%	24%	30.40%	30.40%	0.00%
210010	UM-Dorchester	33%	33%	60%	63%	28%	28%	35.30%	35.80%	0.50%
210011	St. Agnes	17%	17%	20%	40%	0%	0%	11.50%	14.50%	3.00%
210012	Sinai	22%	22%	40%	60%	28%	28%	26.80%	29.80%	3.00%
210013	Bon Secours	35%	35%	60%	60%	40%	40%	40.50%	40.50%	0.00%
210015	MedStar Fr Square	23%	23%	80%	87%	32%	32%	34.56%	35.56%	1.00%
210016	Washington Adventist	15%	15%	50%	60%	28%	28%	24.80%	26.30%	1.50%
210017	Garrett	37%	37%	10%	27%			30.79%	34.79%	4.00%
210018	MedStar Montgomery	12%	12%	10%	33%	14%	14%	12.40%	15.90%	3.50%

		Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Difference
Hospital ID	**Hospital Name**	**HCAHPS Final Score**	**HCAHPS Final Score**	**Mortality Final Score**	**Mortality Final Score**	**Safety Final Score**	**Safety Final Score**	**Total Score**	**Total Score**	**Total Score**
210019	Peninsula	23%	23%	100%	100%	36%	36%	39.10%	39.10%	0.00%
210022	Suburban	17%	17%	30%	53%	18%	18%	19.30%	22.80%	3.50%
210023	Anne Arundel	34%	34%	40%	60%	10%	10%	26.32%	29.32%	3.00%
210024	MedStar Union Mem	28%	28%	0%	33%	28%	28%	23.80%	28.80%	5.00%
210027	Western Maryland	42%	42%	20%	47%	36%	36%	36.51%	40.51%	4.00%
210028	MedStar St. Mary's	25%	25%	80%	87%	32%	32%	35.93%	36.93%	1.00%
210029	JH Bayview	17%	17%	40%	60%	30%	30%	25.00%	28.00%	3.00%
210030	UM-Chestertown	30%	30%	100%	100%			46.10%	46.10%	0.00%
210032	Union of Cecil	17%	17%	10%	33%	50%	50%	27.50%	31.00%	3.50%
210033	Carroll	22%	22%	90%	93%	32%	32%	35.70%	36.20%	0.50%
210034	MedStar Harbor	20%	20%	90%	70%	30%	30%	34.00%	31.00%	-3.00%
210035	UM-Charles Regional	35%	35%	70%	77%	25%	25%	36.98%	37.98%	1.00%
210037	UM-Easton	33%	33%	50%	57%	28%	28%	33.80%	34.80%	1.00%
210038	UMMC Midtown	24%	24%	100%	90%	10%	10%	30.50%	29.00%	-1.50%
210039	Calvert	26%	26%	100%	93%	67%	67%	51.52%	50.52%	-1.00%
210040	Northwest	28%	28%	100%	93%	48%	48%	45.89%	44.89%	-1.00%
210043	UM-BWMC	13%	13%	90%	77%	24%	24%	28.40%	26.40%	-2.00%
210044	GBMC	24%	24%	90%	77%	58%	58%	45.80%	43.80%	-2.00%

		Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Difference
Hospital ID	**Hospital Name**	**HCAHPS Final Score**	**HCAHPS Final Score**	**Mortality Final Score**	**Mortality Final Score**	**Safety Final Score**	**Safety Final Score**	**Total Score**	**Total Score**	**Total Score**
210048	Howard County	17%	17%	40%	30%	36%	36%	27.24%	25.74%	-1.50%
210049	UM-Upper Chesapeake	35%	35%	60%	73%	28%	28%	36.53%	38.53%	2.00%
210051	Doctors	17%	17%	30%	47%	80%	80%	41.00%	43.50%	2.50%
210055	UM-Laurel	10%	10%	20%	47%	13%	13%	12.67%	16.67%	4.00%
210056	MedStar Good Sam	34%	34%	60%	60%	16%	16%	31.60%	31.60%	0.00%
210057	Shady Grove	31%	31%	0%	0%	34%	34%	27.35%	27.35%	0.00%
210060	Ft. Washington	24%	24%	0%	27%			18.20%	24.60%	6.40%
210061	Atlantic General	34%	34%	100%	83%	0%	0%	31.82%	29.32%	-2.50%
210062	MedStar Southern MD	13%	13%	0%	10%	34%	34%	18.40%	19.90%	1.50%
210063	UM-St. Joe	44%	44%	70%	80%	28%	28%	42.12%	43.62%	1.50%
210065	HC-Germantown	15%	15%	80%	80%	50%	50%	36.77%	36.77%	0.00%

APPENDIX VI. MODELING OF QBR PROGRAM REVENUE ADJUSTMENTS

			Model 1: Removed PC-01 and ED-1b			Model 2: Model 1 + THA/TKA Measure		
HOSPID	**HOSPITAL NAME**	**RY18 Permanent Inpatient Revenue**	**RY 2021 Prelim QBR Points**	**% Revenue Impact**	**$ Revenue Impact**	**RY 2021 Prelim QBR Points**	**% Revenue Impact**	**$ Revenue Impact**
210001	MERITUS	$190,799,459	16.30%	-1.28%	-$2,442,233	19.80%	-1.12%	-$2,136,954
210002	UNIVERSITY OF MARYLAND	$919,253,797	12.80%	-1.43%	-$13,145,329	17.80%	-1.21%	-$11,122,971
210003	PRINCE GEORGE	$215,464,625	9.13%	-1.59%	-$3,425,888	9.13%	-1.59%	-$3,425,888
210004	HOLY CROSS	$340,412,069	24.10%	-0.93%	-$3,165,832	21.10%	-1.06%	-$3,608,368
210005	FREDERICK MEMORIAL	$220,972,343	29.10%	-0.71%	-$1,568,904	24.60%	-0.91%	-$2,010,848
210006	HARFORD	$48,557,781	30.64%	-0.64%	-$310,770	34.64%	-0.46%	-$223,366
210008	MERCY	$223,932,822	44.57%	-0.02%	-$44,787	47.07%	0.12%	$268,719
210009	JOHNS HOPKINS	$1,378,259,901	30.40%	-0.65%	-$8,958,689	30.40%	-0.65%	-$8,958,689
210010	DORCHESTER	$26,021,222	35.30%	-0.43%	-$111,891	35.80%	-0.41%	-$106,687
210011	ST. AGNES	$237,889,236	11.50%	-1.49%	-$3,544,550	14.50%	-1.36%	-$3,235,294
210012	SINAI	$398,036,508	26.80%	-0.81%	-$3,224,096	29.80%	-0.68%	-$2,706,648
210013	BON SECOURS	$65,798,042	40.50%	-0.20%	-$131,596	40.50%	-0.20%	-$131,596
210015	FRANKLIN SQUARE	$300,623,972	34.56%	-0.46%	-$1,382,870	35.56%	-0.42%	-$1,262,621
210016	WASHINGTON ADVENTIST	$158,337,604	24.80%	-0.90%	-$1,425,038	26.30%	-0.83%	-$1,314,202
210017	GARRETT COUNTY	$21,075,334	30.79%	-0.63%	-$132,775	34.79%	-0.45%	-$94,839
210018	MONTGOMERY GENERAL	$77,808,657	12.40%	-1.45%	-$1,128,226	15.90%	-1.29%	-$1,003,732
210019	PENINSULA REGIONAL	$241,466,813	39.10%	-0.26%	-$627,814	39.10%	-0.26%	-$627,814
210022	SUBURBAN	$197,431,392	19.30%	-1.14%	-$2,250,718	22.80%	-0.99%	-$1,954,571
210023	ANNE ARUNDEL	$299,264,995	26.32%	-0.83%	-$2,483,899	29.32%	-0.70%	-$2,094,855

			Model 1: Removed PC-01 and ED-1b			Model 2: Model 1 + THA/TKA Measure		
HOSPID	**HOSPITAL NAME**	**RY18 Permanent Inpatient Revenue**	**RY 2021 Prelim QBR Points**	**% Revenue Impact**	**$ Revenue Impact**	**RY 2021 Prelim QBR Points**	**% Revenue Impact**	**$ Revenue Impact**
210024	UNION MEMORIAL	$235,346,415	23.80%	-0.94%	-$2,212,256	28.80%	-0.72%	-$1,694,494
210027	WESTERN MARYLAND	$171,000,183	36.51%	-0.38%	-$649,801	40.51%	-0.20%	-$342,000
210028	ST. MARY	$76,303,058	35.93%	-0.40%	-$305,212	36.93%	-0.36%	-$274,691
210029	HOPKINS BAYVIEW MED CTR	$357,620,585	25.00%	-0.89%	-$3,182,823	28.00%	-0.76%	-$2,717,916
210030	CHESTERTOWN	$21,139,936	46.10%	0.06%	$12,684	46.10%	0.06%	$12,684
210032	UNION HOSPITAL OF CECIL	$66,514,320	27.50%	-0.78%	-$518,812	31.00%	-0.62%	-$412,389
210033	CARROLL COUNTY	$132,801,017	35.70%	-0.41%	-$544,484	36.20%	-0.39%	-$517,924
210034	HARBOR	$112,526,840	34.00%	-0.49%	-$551,382	31.00%	-0.62%	-$697,666
210035	CHARLES REGIONAL	$75,199,112	36.98%	-0.36%	-$270,717	37.98%	-0.31%	-$233,117
210037	EASTON	$105,222,295	33.80%	-0.50%	-$526,111	34.80%	-0.45%	-$473,500
210038	UMMC MIDTOWN	$117,217,727	30.50%	-0.64%	-$750,193	29.00%	-0.71%	-$832,246
210039	CALVERT	$63,677,722	51.52%	0.37%	$235,608	50.52%	0.32%	$203,769
210040	NORTHWEST	$133,828,758	45.89%	0.05%	$66,914	44.89%	0.00%	$0
210043	BALTIMORE WASHINGTON	$229,151,792	28.40%	-0.74%	-$1,695,723	26.40%	-0.83%	-$1,901,960
210044	G.B.M.C.	$225,145,722	45.80%	0.05%	$112,573	43.80%	-0.05%	-$112,573
210048	HOWARD COUNTY	$183,348,539	27.24%	-0.79%	-$1,448,453	25.74%	-0.86%	-$1,576,797
210049	UPPER CHESAPEAKE HEALTH	$130,150,364	36.53%	-0.38%	-$494,571	38.53%	-0.29%	-$377,436
210051	DOCTORS COMMUNITY	$144,686,192	41.00%	-0.18%	-$260,435	43.50%	-0.07%	-$101,280
210055	LAUREL REGIONAL	$58,931,276	12.67%	-1.44%	-$848,610	16.67%	-1.26%	-$742,534
210056	GOOD SAMARITAN	$140,674,848	31.60%	-0.60%	-$844,049	31.60%	-0.60%	-$844,049

			Model 1: Removed PC-01 and ED-1b			Model 2: Model 1 + THA/TKA Measure		
HOSPID	**HOSPITAL NAME**	**RY18 Permanent Inpatient Revenue**	**RY 2021 Prelim QBR Points**	**% Revenue Impact**	**$ Revenue Impact**	**RY 2021 Prelim QBR Points**	**% Revenue Impact**	**$ Revenue Impact**
210057	SHADY GROVE	$231,939,525	27.35%	-0.78%	-$1,809,128	27.35%	-0.78%	-$1,809,128
210060	FT. WASHINGTON	$19,548,527	18.20%	-1.19%	-$232,627	24.60%	-0.91%	-$177,892
210061	ATLANTIC GENERAL	$37,316,219	31.82%	-0.59%	-$220,166	29.32%	-0.70%	-$261,214
210062	SOUTHERN MARYLAND	$163,844,003	18.40%	-1.18%	-$1,933,359	19.90%	-1.12%	-$1,835,053
210063	UM ST. JOSEPH	$237,924,618	42.12%	-0.13%	-$309,302	43.62%	-0.06%	-$142,755
210065	HC-GERMANTOWN	$60,632,167	36.77%	-0.37%	-$224,339	36.77%	-0.37%	-$224,339
	Statewide Total	**$9,093,098,329**			**-$68,910,681**			**-$63,837,724**

APPENDIX VII. STAKEHOLDER COMMENT LETTERS

Maryland
Hospital Association

November 19, 2018

Dianne Feeney
Associate Director, Quality Initiatives
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dianne:

On behalf of the Maryland Hospital Association's 63 member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC's) *Draft Recommendations for Updating the Quality-Based Reimbursement Program for Rate Year 2021*. The Quality Based Reimbursement (QBR) policy includes measures of in-hospital safety and outcomes such as infections, patient experience of care and mortality. Of all Maryland's value-based policies, this one aligns most closely with national Medicare policies, in this case, the Value Based Purchasing (VBP) program. Two years ago, commissioners approved the staff's recommendation to set an aggressive payment scale for the rate year 2019 QBR policy in order to provide additional incentive for Maryland's hospitals to improve performance relative to the nation. As expected, Maryland's hospitals improved – as did the nation's – and all but two Maryland hospitals are being penalized in fiscal 2019 for a total revenue reduction of 0.36 percent, or over $6 million.

Although the HSCRC's intention was to strengthen incentives to close the performance gap relative to the nation, in this case, it has not produced the hoped-for results. Our view is that attempting to strengthen the incentive through a tougher payment scale and larger penalties did not work because the policy is flawed.

A number of concerns have been raised with the VBP program and those concerns have weakened its ability to drive performance improvement. The program was the first Medicare program to tie performance to payment. The programs implemented since then are simpler and easier to monitor. The concerns plaguing this policy include:

- The lag between performance period, data publication and payment adjustment is long, making it difficult to tie specific interventions and behaviors to outcomes
- Performance improvement on patient experience of care measures moves slowly, making it difficult to notice the impact of new interventions. This measure accounts for half of Maryland's QBR score
- Infections occur infrequently, making measurement of performance volatile. This component accounts for 35 percent of Maryland's score.
- Questions have been raised nationally about whether risk adjustment and validation of the measures are adequate, calling into question the validity of results

Our recommendations

The staff's recommendation to align the measures with national Medicare policies is a step in the right direction, but do not go far enough. We also recommend weighting the domains and payment scale to align with national Medicare policy. Each domain is weighted equally in the national policy, and the score to begin earning rewards tends to be 37 percent to 40 percent. The Maryland scale requires a hospital to score above 45 percent to avoid a penalty and begin earning a reward. Based on the most recent Medicare data, the national average score in the VBP program would be 37 percent. (Details enclosed.)

HSCRC staff has said that the Medicare Performance Adjustment (MPA) will be included in the accounting of Maryland's revenue at risk. The MPA risk should not just be added to the already high risk in Maryland; it should offset some of the risk.

Nearly 8 percent of Maryland's all-payer revenue is tied to performance-based policies – compared to 4 percent of Medicare revenue nationally tied to performance measures. The national risk on an all-payer basis is 1.6 percent (4 percent x an assumption of 40 percent Medicare). Even considering that hospitals may have some performance-based contracts with private payers, Maryland's risk – on these measures alone – is substantially higher than the nation. (Details enclosed.)

As Maryland's hospitals focus on managing total cost of care, working with physician and community partners, and meeting the aims of the total cost of care demonstration, it is important to keep the focus on the measures that matter. Our recommendations noted above will provide that greater focus if implemented.

We appreciate the commission's consideration of our feedback. Should you have any questions, please call me at 410-540-5087.

Sincerely,

Traci La Valle, Vice President

cc: Nelson Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
James N. Elliott, M.D
Adam Kane
Jack Keane
Katie Wunderlich, Executive Director

Enclosure

Almost 8 Percent of Maryland's Hospitals' All-Payer Revenue is Tied to Value Compared to 4 Percent of Medicare Revenue in the Nation

Comparison of Maryland All-Payer and National Medicare Value-Based Risk

	Maryland All-Payer		National Medicare	
	Maximum Penalty Risk	FY 2019 Actual Penalties	Maximum Penalty Risk	FY 2018 Actual Penalties
QBR/VBP, Complications and Readmissions	3.9%	-0.51%	3.9%	-0.46%
MPA (Begins in FY 2020)	0.2%	N/A	-	-
PAU Savings	3.8%	-1.69%	-	-
Total	7.9%	-2.20%	3.9%	-0.46%

To compare the nation's 0.46% Medicare penalty to Maryland's 2.20% all-payer penalty, multiply the 0.46% national penalty x an assumption of 40% Medicare share. The resulting national all-payer penalty is 0.18%. Maryland's hospitals' actual risk is more than 10 times greater than the nation's.

Notes: In Maryland, a total of 6 percent of inpatient all-payer revenue is at risk on QBR, Complications and Readmissions. In CY 2018/FY 2020, 0.5 percent of total Medicare revenue is at risk on the Medicare Performance Adjustment. 5.85 percent of all-payer inpatient is at risk on PAU Savings. In the nation, a total of 6 percent of Medicare inpatient revenue is at risk on VBP, Complications, and Readmissions. Actual penalties are the revenue-weighted statewide and national adjustments and the net of penalties and rewards. Actual amounts are provided for the nation in FY 2018 instead of estimating FY 2019 national Medicare hospital payments.

Percentages of total revenue are based on the national inpatient/outpatient proportion of 65%/35% and the assumption that Medicare payments are 40 percent of all-payer.

MHA Recommendation: FY 2021 Quality Weighting

		CMS FFY 2019 National		Maryland CY 18/FY 2020		MHA Recommendation: CY 2019/FY 2021	
VBP/QBR		Weight	Risk	Weight	Risk	Weight	Risk
	NHSN, PC-01, PSI-90*	25%	0.50%	35%	0.70%	25%	0.50%
	HCAHPS	25%	0.50%	50%	1.00%	25%	0.50%
	Mortality*and THA/TKA Complications	25%	0.50%	15%	0.30%	25%	0.50%
	Efficiency*	25%	0.50%		-	25%	0.50%
	Total	100%	2.00%	100%	2.00%	100%	2.00%
Complications							
	NHSN, PC-01 and PSI-90*		1.00%		-		-
	PPCs				2.00%		1.00%
Readmissions			3.00%		2.00%		1.50%
PAU					1.75%		1.75%
Total			6.00%		7.75%		6.25%

* PC-01 is early elective delivery and PSI-90 is a composite patient safety indicator (PSI-90 is currently on hold). CMS measures 30-day mortality rate for acute myocardial infarction, heart failure, pneumonia, chronic obstructive pulmonary disease and coronary artery bypass graft. Maryland measures all-payer in-hospital mortality. THA and TKA are total hip and knee 90-day complications—not included in Maryland policy. Efficiency in the national program is measured as Medicare spending per beneficiary. In Maryland, the risk on the new Medicare Payment Adjustment policy can be counted as an efficiency measure in QBR.

Maryland's Hospitals Would Still Bear Significantly More Risk than Hospitals Nationally by Adopting MHA Recommendations

Comparison of Maryland All-Payer and National Medicare Value-Based Risk with MHA Recommendations for FY 2021

	Maryland All-Payer		National Medicare	
	Maximum Penalty Risk	FY 2019 Actual Penalties	Maximum Penalty Risk	FY 2018 Actual Penalties
QBR/VBP, Complications and Readmissions	2.6%	-0.51%	3.9%	-0.46%
MPA	0.4%	N/A	-	-
PAU Savings	3.8%	-1.69%	-	-
Total	6.8%	-2.20%	3.9%	-0.46%

Notes: In Maryland, a total of 6 percent of inpatient all-payer revenue is at risk on QBR, Complications and Readmissions. In CY 2018/FY 2020, 0.5 percent of total Medicare revenue is at risk on the Medicare Performance Adjustment. 5.85 percent of all-payer inpatient is at risk on PAU Savings. In the nation, a total of 6 percent of Medicare inpatient revenue is at risk on VBP, Complications, and Readmissions. Actual penalties are the revenue-weighted statewide and national adjustments and the net of penalties and rewards. Actual amounts are provided for the nation in FY 2018 instead of estimating FY 2019 national Medicare hospital payments.

Percentages of total revenue are based on the national inpatient/outpatient proportion of 65%/35% and the assumption that Medicare payments are 40 percent of all-payer.

Brian D. Pieninck
President and Chief Executive Officer

CareFirst BlueCross BlueShield
1501 S. Clinton Street, 17th Floor
Baltimore, MD 21224-5744
Tel: 410-998-5320
Fax: 410-781-7606
brian.pieninck@carefirst.com

November 20, 2018

Nelson J. Sabatini, Chairman
Katie Wunderlich, Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Sabatini and Ms. Wunderlich:

Thank you for this opportunity to provide comments on the HSCRC Staff's Draft Recommendations for the Quality Based Reimbursement (QBR) program for Rate Year (RY) 2020.

We strongly support efforts to improve the HSCRC QBR program by: better aligning it with the federal Value Based Purchasing (VBP) program; encouraging improvement in areas where Maryland hospitals have performed less favorably than hospitals nationally; and to use the flexibility afforded the State to expand and augment the QBR program so that it provides an appropriate balance against any tendency toward reduced quality of care resulting from the unique incentives facing Maryland hospitals under their global budgets.

We also applaud the Commission's decision last year to move to a pre-set scale that more directly compared Maryland hospital performance to national hospital performance. This change allowed for more aggressive scaling of Maryland hospital performance, which was appropriate particularly given the State's relatively poor performance in the Person and Community Engagement Domain.[1]

With regards to this year's Draft set of recommendations, we make the following comments and suggestions:

1) CareFirst supports the continuation of the current Domain weights and the recommendation to add the Total Hip Arthroplasty/Total Knee Arthroplasty complication rates to the Clinical Care Domain at 5% to better align the QBR with the national VBP.

2) We are disappointed that the Staff is not recommending the inclusion of measure OP-18b (time from arrival to departure from the ED for non-admitted patients) to the Person and Community Engagement Domain to augment the focus on improving Maryland's ED wait time performance. Staff indicated during Performance Measurement Work Group

[1] We would note, that Staff characterizes this change as reflecting "the full distribution of hospital scores nationally." However, scale range adopted is not 0-100% as would be expected given this assertion, it is 0-80%. Staff may wish to comment on this apparent contradiction and the rationale for the use of a 0-80% scale instead of the full 0-100% range.

discussions that it was strongly considering the inclusion of OP-18b given that outpatient ED visits account for over 85% of all ED visits, the observation by at least one Maryland hospital that OP-18b was a key indicator of ED efficiency and the strong correlation between high ED wait times and low HCAPHS scores, which remain low relative hospital scores nationally. We also note that data provided by the Maryland Institute for Emergency Medical Services System (MIEMSS) and the HSCRC showed that outpatient ED wait times were continuing to increase in recent years. Although Staff did not provide data on trends in outpatient ED wait times in this Draft Recommendation, we expect that wait times increased once again in the most recent measurement period. The need to include OP-18b in the QBR is also heightened by the recent elimination of the ED-1b measure from QBR in future years.

Despite these circumstances, Staff continues to be concerned that use of the OP-18b measure in the QBR would "be at odds with hospitals' efforts to reduce inpatient admissions through ED care coordination." In contrast, we would suggest that the failure to include this important measure is at odds with the need to balance the resource constraining incentives of the GBR system with the need to protect against unintended declines in hospital quality. "Active monitoring" of what is clearly a deteriorating situation will not address this critical issue. Accordingly, we strongly recommend that the Staff reconsider this strategy and instead recommend inclusion of the OP-18b measure for purposes of calculating RY 2020 QBR hospital performance.

Finally, at a previous public meeting, the Commission Chairman recommended that the staff pursue alternative approaches to incentivize the lowest performing hospitals on ED wait times and either require the submission of "corrective action plans" or make direct negative adjustments to these hospitals' Annual Updates if they failed to improve. We strongly supported this approach but have not seen information about any alternative approaches to date. We also would suggest that this type of more targeted approach could be effective in addressing Maryland's continued poor performance on its HCAPHS scores.

Sincerely,

Brian D. Pieninck
President and Chief Executive Officer

Peter Hill, MD, MsC, FACEP
Senior Vice President Medical Affairs, Johns Hopkins Health System
Vice President Medical Affairs, The Johns Hopkins Hospital
Associate Professor Emergency Medicine, Johns Hopkins School of Medicine

Renee J. Demski, MSW, MBA
Vice President of Quality
The Johns Hopkins Hospital and Johns Hopkins Health System
Armstrong Institute for Patient Safety and Quality
Office (410) 955-4313
Email: rdemski@jhmi.edu

JOHNS HOPKINS
MEDICINE

November 20, 2018

Nelson Sabatini
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the proposed Quality Based Reimbursement (QBR) Program for RY 2021. JHHS strongly supports efforts to improve alignment with national measures as appropriate. We also appreciate the thoughtful analysis by staff to avoid duplication of the same or similar measures in multiple Maryland pay for performance programs. JHHS does have concerns with some of the details outlined in the draft recommendations and proposes some solutions for consideration.

The inclusion of emergency department (ED) wait time measures in a pay for performance program, specifically the Person and Community Engagement domain of QBR, remains a concern. JHHS remains passionately engaged in improving patient experience, and maximizing the capacity and efficiency at each of our EDs. For example, the Johns Hopkins Hospital (JHH) ED team's commitment to improvement reduced wait times down to an average time of four minutes from arrival to triage nurse. Rather than penalizing individual hospitals, we continue to advocate for systemic evaluation of the factors beyond the control of hospitals, such as surges in patients brought in under emergency petition and an ongoing lack of placements for psychiatric patients. Over the past decade, there has been an increasing demand for behavioral health services, while the funding for and availability of state run behavioral health services has decreased dramatically. This has put stress on Maryland EDs as they struggle to find the appropriate placements for patients with complex behavioral health needs, resulting in patients languishing in EDs, often in a medical bed, well beyond what is medically necessary and contributing to overall increases in ED wait times.

Inpatient occupancy also has a major impact on patient flow. ED boarding time and admitted patient throughput is difficult to improve when inpatient occupancy remains high. Occupancy averages 90% at Johns Hopkins Bayview Medical Center (JHBMC), 85% at Howard County General Hospital, and 87% at Suburban Hospital. At JHH, occupancy in the Department of Medicine, where most patients from the ED are admitted, is consistently at 96-98%. The lack of available beds results in extended ED wait times. Our analysis indicates that when the occupancy rate is below 93%, boarding time is more reasonable for patients going to the Department of Medicine. However, once beyond 93% occupancy, boarding time rises rapidly. For these reasons, we recommend that ED wait time measures be closely monitored along with other relevant statewide performance measures, but not included in QBR at this time.

With respect to the Safety domain, we strongly support the continued suspension of PSI-90 until reliable base and performance data is readily available.

In the Clinical Care domain, JHHS has two areas of concern and associated recommendations. First, we support consideration of national mortality measures and would like to collaborate with staff on analysis to determine the accuracy and viability for consideration in future years. Rather than adding the national mortality measures to the current program, with inherent duplication of similar measures, we would like to explore future use of the national measures in lieu of the Maryland-unique mortality measure. We support continuing with the Maryland mortality measure for RY 2021.

The second concern in the Clinical Care domain relates to the addition of the Total Hip and Knee Arthroplasty (THA/TKA) complication measure. Under the proposed policy, if a hospital has insufficient volume and does not qualify for the measure, then the full domain weight will apply to mortality. Overweighting mortality relative to other Maryland hospitals seems inequitable and misses an opportunity to highlight another important initiative. JHHS has taken a thoughtful and deliberate approach regarding the location of our hip and knee surgery program. As these surgeries are becoming more "routine", they are provided in a setting that is both lower cost and closer to a patient's residence. JHH serves as both a specialty hospital serving the nation and the world, and as a community hospital serving East Baltimore. For the past several years, JHH has operated at approximately 95% capacity, with our medical and surgical beds consistently in high demand. In order to meet the needs of patients seeking highly specialized care that is unique to JHH, we must take a system approach in establishing robust programs at our community hospitals for lower intensity care. For years, JHBMC has served as the JHHS primary Baltimore location for hip and knee replacement surgery. Suburban Hospital has become the primary hip and knee joint replacement hospital of JHHS for residents of Montgomery County and the broader National Capital Region. This system approach of expanding hip and knee program at JHBMC and Suburban is overseen and managed by our Johns Hopkins University School of Medicine Faculty, ensuring the same level of expertise, quality and standards of care that would be provided at JHH. Therefore, for purposes of this QBR measure, we request the THA/TKA performance of JHBMC or Suburban Hospital be reflected both for JHH and the respective JHHS Hospital selected. If this is not possible, then we request that palliative care be included for the JHH mortality measure to mitigate the effects of the full domain weighting.

In addition, for the Maryland mortality measure, JHHS remains concerned about the exclusion of palliative care. For the clinical reasons stated in our prior letter on the topic, we recommend reinstatement of the palliative care exclusion. The risk adjustment factor for palliative care is insufficient. Many of our population want to come back into the hospital, for various reasons, even when we have addressed terminal and end of life care choices. Restoration of the palliative care exclusion would help to differentiate care that is helping to save lives from terminal illnesses that are being cared for in a clinically appropriate manner.

Thank you to HSCRC commissioners and staff who have demonstrated their willingness to ensure that all stakeholders contribute the ongoing success of the QBR Program. This collaborative approach fosters ongoing engagement. We look forward to continued collaboration in our mutual efforts to support these critically important performance improvement initiatives.

Sincerely,

Peter Hill, MD

Renee Demski

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
Katie Wunderlich
James Elliott, MD
Adam Kane
Jack C. Keane

1211 Cathedral Street
Baltimore, MD 21201-5585
410-727-2237
e-mail: info@mdacep.org
www.mdacep.org

Maryland Chapter
AMERICAN COLLEGE OF EMERGENCY PHYSICIANS

November 19, 2018

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

RE: Draft Recommendation on Updates to the Quality-Based Reimbursement (QBR) Policy for RY 2021

Dear Ms. Wunderlich:

On behalf of the Maryland Chapter of the American College of Emergency Physicians (MD ACEP), we are writing to express our support for the above-referenced draft recommendation. ACEP fully supported the inclusion of the ED-1b and ED-2b measures as part of the QBR program for RY2020 to address Maryland's continuing poor performance in emergency department wait times. While we are disappointed that the ED-1b measure will be removed from the QBR program for RY2021, we understand that it is a result of CMS removing the measure from its VBP and IQR programs. We maintain our support and are pleased that the Commission staff recommends the continued inclusion of the ED-2b measure for RY2021.

With regards to the OP-18, MD ACEP agrees that this measure should be carefully monitored but that it is premature to include this measure under the QBR program. For this measure, we do believe that there may be several factors in Maryland at odds with this measurement, including hospitals' efforts to reduce inpatient admissions through care coordination programs. Over the next year, MD ACEP would like to work with the Commission staff to monitor the OP-18 measure to determine if its inclusion would be appropriate in later rate years.

Again, MD ACEP is pleased that the Commission staff continues to recommend inclusion of the ED-2b measure in the QBR program and looks forward to continuing to work with the Commission to not only monitor the OP-18 measure but Maryland's overall performance in addressing ED wait times. Thank you.

Sincerely,

Orlee Panitch

Orlee Panitch, MD, FACEP
MD ACEP President

MedStar Health

8010 Suite O Corporate Dr.
Nottingham, MD 21236
410-933-2300 PHONE
medstarhealth.org

November 21, 2018

Dianne Feeney
Associate Director, Quality Initiatives
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dianne:

We support the continued improvement in policies that recognizes and rewards high quality care and MedStar Health appreciates the opportunity to comment on the Health Services Cost Review Commission's (HSCRC's) *Draft Recommendations for Updating the Quality-Based Reimbursement Program (the "Program") for Rate Year 2021.*

We support HSCRC's staffs continued movement to align the Program more closely with Medicare's Value Based Purchasing and agree to the measure changes that have been recommended. However, we are requesting the following areas be reconsidered:

- That the penalty/reward cut-off point does not increase and if anything decreases. The proposal increases the cut-off point from 41% to 45%. Currently, with the 41% cut-off point, 46 Hospitals have penalties and 2 Hospitals have rewards. Increasing the cut-off point will make it more difficult to achieve a reward and most likely will increase the $58m penalty received in Fiscal Year 2019. CMS's Value Based Purchasing Program has a cut-off point of 37%, which is substantially lower than HSCRC's recommendation of 45%. Under CMS's value based purchasing, we believe MedStar Health would be in a reward situation in aggregate, instead of a significant penalty under the QBR program. This better reflects the positive work we are doing and shows we are better performing than the Nation.
- We support MHA's comment letter to reduce the total dollars at risk for performance based policies based on Maryland's percentage of dollars of risk being significantly higher than Medicare. As a first step, we would recommend reducing the QBR dollars at risk to offset the appropriate addition of the Medicare Performance Adjustor and therefore, holding the risk % constant.

Thank you for the opportunity to comment and allowing us to actively participate in these important workgroups to move forward and improve pay for performance policies.

Sincerely,

Stephen R. T. Evans, MD
Executive Vice President, Medical Affairs & Chief Medical Officer
MedStar Health

Cc: Nelson Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
James Elliott, M.D.
Adam Kane
Jack Keane
Katie Wunderlich, Executive Director

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

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

CORPORATE OFFICE

November 20, 2018

Dianne Feeney
Associate Director, Quality Initiatives
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Dianne:

On behalf of the University of Maryland Medical System, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC's) *Draft Recommendations for Updating the Quality-Based Reimbursement Program for Rate Year 2021*. The Quality Based Reimbursement (QBR) policy has been designed specifically to align closely with the national Value Based Purchasing (VBP) program. In recent years we understand the staff recommended an aggressive payment scale in order to provide additional incentive for Maryland hospitals to improve performance relative to the nation. While Maryland hospitals have improved, the result of that aggressive payment scale led to all but two Maryland hospitals being penalized in fiscal 2019 for a total revenue reduction of 0.36 percent, or over $6 million.

We accept underperformance should not be financially rewarded and the intention of the program is to strengthen incentives to close the performance gap. However, we believe the domain weight adjustments have placed significant emphasis on those metrics where performance has been most criticized, specifically in patient experience and hospital acquired infections. National advisors admit performance improvement on patient experience measures moves slowly. Our own experience has demonstrated it is very difficult to sustain top ranking scores from quarter to quarter. This measure accounts for half of Maryland's QBR score.

Maryland hospitals continue to strive for these improvements. With the domain weights distributed to drive incentive, the added aggressive payment scale places undue financial burden on hospitals and penalizes performance that would otherwise be rewarded in the national program. HSCRC staff calculated the comparable payment scale cut off between penalty and reward to be 41%, yet they are recommending the Maryland QBR program cut off to be 45%. While a change of 4% seems minor, the financial impact to Maryland hospitals is significant at approximately $12.2M.

We believe the MHA recommendation to align both domains and payment scale to the national Medicare policy is most appropriate. Minimally we ask the payment scale be aligned with national Medicare policy.

We appreciate the Commission's consideration of our feedback.

Sincerely,

Henry J. Franey
Executive Vice President & Chief Financial Officer
UMMS

cc: Nelson Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
John M. Colmers
James N. Elliott, M.D
Adam Kane
Jack Keane
Katie Wunderlich, Executive Director

Draft Recommendation on Medicare Advantage Sequestration Adjustment

December 12, 2018

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

This is a draft recommendation. Please submit comments on this draft to the Commission by Thursday, December 20, 2018 via email to katie.wunderlich@maryland.gov.

REQUEST

On September 18, 2018, three Maryland Medicare Advantage plans (UM Health Advantage, Hopkins Advantage, and Cigna HealthSpring) requested that HSCRC make a formal determination regarding whether Medicare Advantage plans are permitted to take the two percent sequestration reduction from the final payments issued to Maryland hospitals. The Medicare Advantage Plans contend that the reduction is applicable, and that they should receive the benefit of the reduction in payments due to Maryland hospitals as a result of the Medicare sequestration. This report provides background and HSCRC staff's analysis, along with a draft recommendation that the Commission adopt a formal policy allowing Medicare Advantage plans to take the sequestration reduction on payments to hospitals made after January 1, 2019.

BACKGROUND

On March 1, 2013, the President signed a sequestration order directing a series of across-the-board reductions in federal spending. The sequestration order included a two percent reduction in Medicare fee-for-for-service (FFS) payments, effective April 1, 2013. The Health Services Cost Review Commission voted to make no change in hospital rates in response to the sequestration.

Initially, the HSCRC deferred taking a position as to whether Medicare Advantage Organizations in Maryland were entitled to take the two percent reduction on payments to Maryland hospitals under the Medicare waiver. On April 17, 2014, the CMS Administrator wrote a letter to the American Hospital Association on this topic. The letter indicated that sequestration did not change fee schedules -- only the final payment. The letter indicated that payments to contracted providers are governed by the terms of the contract between the Medicare Advantage plan and the provider. As a result, a Medicare Advantage plan could only alter its contracted payment schedule by mutual agreement with the provider. On May 21, 2014, HSCRC issued a memorandum to hospital CFOs. Following the logic in the letter from the CMS Administrator, the HSCRC memorandum indicated that Medicare Advantage plans in Maryland may not alter their contracted payment schedule (HSCRC approved rates) with a hospital in Maryland in order to pass on the sequestration cuts unless its contract permits such an adjustment.

ANALYSIS

Recently, the Maryland Medicare Advantage plans provided additional documentation to HSCRC regarding the sequestration discount, which included a memorandum dated March 22, 2013, from CMS regarding "Additional Information Regarding the Mandatory Payment Reductions in the Medicare Advantage, Part D, and Other Programs" (Attachment 1). Although dated prior to the CMS letter to the American Hospital Association, HSCRC staff was not aware of this documentation in 2014 when it issued its memorandum to hospital CFOs about this issue. The March 22, 2013 document informed Medicare Advantage plans that they are entitled to take the two percent sequestration reduction on the Medicare payable amount when the plan makes payments to providers not contracted with the plan because, by regulation, a non-contract provider must "accept FFS [fee-for-service] payment amounts as payment in full." The March

22 document was supplemented by a May 1, 2013 memorandum from CMS to Medicare Advantage Organizations (Attachment 2).

Given the differing direction from CMS regarding contracted versus non-contracted providers, HSCRC staff requests that the Commission adopt a formal policy regarding the availability of the two percent sequestration payment reduction for Medicare Advantage plans in Maryland. The health plans have indicated that the two percent reduction is being taken for other provider types (e.g., physicians, nursing homes, etc.) in Maryland, and that plans are applying the sequestration reduction outside of Maryland. Further, as part of CMS's Sequestration policy, premiums for Medicare Advantage plans were reduced by two percent.

Staff researched the status of the sequestration discount in other states. Apparently, the discrepancy between the treatment of contracted and non-contracted providers in other states also led to the need to adopt new policies. For example, a large health plan in North Carolina adopted a new policy that took effect in August 2015 after the discrepancy developed:

> "Because Section 1854(a)(6)(B)(iii) of the Social Security Act puts the contractual arrangements between MAOs [Medicare Advantage Organizations] and their network providers largely beyond CMS's regulatory reach, CMS's Sequestration policy for MAOs did not directly effectuate or implement a 2% adjustment to the payments made by MAOs to their contracted providers for services supplied to members of Medicare Advantage plans administered by the MAOs. As a result, a discrepancy has developed between the reimbursement policies applied by CMS in the original Medicare program (i.e., Part A and Part B) and the reimbursement policies applied by MAOs in the Medicare Advantage program (i.e., Part C). To align the reimbursement policies applicable to provider payments made in connection with [the Health Plan's] Medicare Advantage plans with the Sequestration methodology applied to provider payments made by CMS in connection with Part A and Part B of Medicare, [the Health Plan] will reduce by 2% payments made to participating providers for items and services supplied to members of [the Plan's] Medicare Advantage plans. This policy will apply to payments made by [the Health Plan] for covered items and services supplied to members covered by [the Health Plan's] Medicare Advantage health plans. The Sequestration payment adjustment will be applied at the final payment level after all other edits, rules, and adjustments have been applied."[1]

Similar to the situation that has required clarification and prospective policy adjustment in other states, the Maryland Medicare Advantage plans have called upon the Commission to resolve this matter formally.

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[1]https://www.bluecrossnc.com/sites/default/files/document/attachment/providers/public/pdfs/medicare_sequestration_alignment_policy.pdf

Staff believes it is in the best interest of Maryland's Medicare beneficiaries for the Commission to permit Medicare Advantage Plans to apply the two percent sequestration reduction on payments to Maryland hospitals consistent with the CMS requirement for non-contracted providers to "accept FFS [fee-for-service] payment amounts as payment in full." Because HSCRC sets the rates to be paid by Medicare Advantage plans in Maryland, it is necessary for the Commission to adopt a formal policy. Medicare Advantage policies offer seniors enhanced benefits and services relative to Medicare fee-for-service options, and the approach offered by Medicare Advantage is consistent with the All-Payer and Total Cost of Care Models. Tightly managed patient care serves to reinforce the incentives for improving patient outcomes while controlling the total cost of providing that care. It should also be noted that Commission rate orders explicitly allow the 6 percent differential for both Medicare and Managed Care Organizations that contract with Medicare.

In sum, it is important to have Medicare Advantage plans available for seniors and other Medicare enrollees in Maryland. These plans offer a comprehensive package of services and pharmacy coverage for a low monthly premium. Plans also offer additional customer supports, such as care management supports for critically ill patients and help with managing chronic conditions as well as other supports to help enrollees stay healthier. Additionally, some plans offer supplemental benefits for vision and dental services.

Staff believes, therefore, that the Commission should be proactive in enhancing their presence in Maryland. Affording them the two percent sequestration reduction is consistent with CMS advice and with the goals of the Total Cost of Care Model; it is consistent with what other states do; it is consistent with how the HSCRC sets rates for Medicare recipients; and it is legally authorized under the Commission's authority to set rates equitably among all purchasers of health care hospital services without undue discrimination. Staff recommends that this policy be implemented effective January 1, 2019.

Finally, when Medicare initiated the sequestration adjustment in 2013, the Commission adopted a policy to make no changes to hospital rates as a result of the sequestration. The staff recommends likewise that there be no adjustment to hospital rates as a result of sequestration amounts that would be taken by Medicare Advantage plans under the proposed policy recommendation.

RECOMMENDATION

The HSCRC staff makes the following recommendations for Commission consideration.

1. That the Commission adopt a formal policy effective January 1, 2019, that permits Medicare Advantage plans to take a two percent sequestration reduction on the final payments due to Maryland hospitals for Medicare Advantage beneficiaries, so long as the sequestration continues in effect.

2. That the Medicare Advantage Plans be directed to apply the sequestration payment reduction at the final payment level after all other edits, rules, and adjustments have been applied, consistent with how Medicare applies the reduction.
3. Consistent with the Commission policy regarding the Medicare sequestration, there should be no adjustment to hospital approved rates or revenues as a result of the reduction taken by Medicare Advantage plans for the sequestration.

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard, Mail Stop C1-13-07
Baltimore, Maryland 21244-1850
MEDICARE PLAN PAYMENT GROUP

DATE: March 22, 2013

TO: All Medicare Advantage Organizations, Prescription Drug Plans, Cost Plans, PACE Organizations, and Demonstrations

FROM: Cheri Rice /s/
Director

SUBJECT: **Medicare Advantage Prescription Drug System (MARx) April 2013 Payment – INFORMATION**

This letter provides information about the April payment, which is scheduled for receipt on April 1, 2013, and other payment related items that may require plan action.

Mandatory Payment Reductions in the Medicare Advantage and Part D Programs – "Sequestration"

As required by law, President Obama issued a sequestration order on March 1, 2013 requiring a series of across-the-board reductions in Federal spending. The Administration continues to urge Congress to take prompt action to replace sequestration with balanced deficit reduction.

Beginning April 1, 2013, payments made to Medicare Advantage (MA) plans and Part D sponsors will generally be reduced by two percent in accordance with the Balanced Budget and Emergency Deficit Control Act of 1985, as amended. For the MA and Part D programs, sequestration will be applied to payments associated with enrollment periods beginning on or after April 1, 2013. Certain payments are exempt from sequestration under the law, including the Low Income Premium Subsidy, Low Income Cost Sharing Subsidy, reinsurance, and amounts paid to plans on behalf of beneficiaries for premium amounts withheld from their Social Security checks.

CMS will report sequestration adjustments to plans on the Monthly Plan Payment Report. Adjustments will appear in the Special Adjustments section of the report with an Adjustment Type of "SEQ".

Premium Payment Option not changed from Social Security Administration (SSA) to Direct Bill

CMS processed a data clean-up on the weekend of March 1, 2013 to correct an issue related to the Premium Payment Option (PPO) not changing from SSA withhold to Direct Bill for beneficiaries who elect to have premiums withheld but the election is not executed by SSA

within two months of accepting the CMS request. The premium periods involved in the clean-up are from March 2011 to June 2011. As a result of the clean-up, an affected beneficiary's PPO will be set to Direct Bill and the MARx User Interface will display the appropriate value.

Affected plans received corrected data in their normal Daily Transaction Reply Reports dated March 4 or 5, 2013 (plans would have received a TRC 144: PPO changed to Direct Bill), and should evaluate whether the data should be processed.

SSA Premium Withholding Limit Change
SSA limits the amount of total Part C and D premiums that can be withheld from one benefit check, which may include retroactive amounts that could be due. Previously, that amount was $200. Effective January 2013, SSA has raised the "safety net limit" to $300.

Reconciliation of Plans That Terminated in 2011
CMS conducts final reconciliations for terminated plans to settle amounts that were processed after their termination dates, including the final risk adjustment reconciliation for 2011 that was completed in December 2012, and the Coverage Gap Discount (CGD) reconciliation scheduled to be completed in May 2013. Once the CGD reconciliation is completed, CMS will begin processing final settlements. Plans should begin receiving the results of these settlements in July 2013.

End Stage Renal Disease (ESRD) Payment Discrepancies
CMS has been notified that there has been a change in how ESRD status information is processed. Previously, the renal networks were responsible for inputting the 2728 forms into the ESRD system and CMS used the information to compute payment at the ESRD level. Effective May 2012, the ESRD facilities are responsible for inputting the 2728 forms into the ESRD system. If plans have issues with the ESRD status of their members, they should contact the facilities that are treating their members. Division of Payment Operations (DPO) staff are working with the CMS staff who oversee this process to address the ESRD cases that existed prior to May 2012.

Medicare Secondary Payer – Electronic Correspondence Referral System (ECRS) Changes
The updates listed below have been made to the ECRS Web User Guide effective April 1, 2013.

- Chapter 1 has been added to provide an overview of all significant revisions to the ECRS Web User Guide.
- Chapter 6 (Prescription Drug Inquiry Transactions) was revised. The Insurance Company Name field on the Prescription Coverage page of the Prescription Drug Inquiry transaction is now a required field.
- The Prescription Drug Inquiry (PDI) Layout Detail Record was modified to show that the Insurance Company Name is now required on a PDI transaction.
- The values that are considered invalid Insurance Company Names have been revised. As of April 22, 2013, if the Insurance Company Name is blank or only contains one of the following values, then it is considered an error: ATTORNEY, BC, BCBS, BCBX, BLUE CROSS, BLUE SHIELD, BS, BX, CMS, COB, COBC, COORDINATION OF BENEFITS CONTRAC, HCFA, INSURER, MEDICARE, MISC, MISCELLANEOUS, N/A, NA, NO, NONE, SUPPLEMENT, SUPPLEMENTAL, UNK, XX, or UNKNOWN.

- New Action 'ID' has been added for Common Working File (CWF) Assistance Request records. This Action is to be used when asking the Coordination of Benefits Contractor (COBC) to investigate a possible duplicate Medicare Secondary Payer (MSP) record for deletion from the Common Working File (CWF). Note: Contractors should no longer use Action 'DR' to investigate possible duplicate MSP record for deletion from CWF. Action 'DR' should only be used when asking the COBC to investigate/redevelop a closed or deleted record.
- Action 'ID' cannot be submitted with any other Action codes.
- When Action 'ID' is submitted on a CWF Assistance Request and the COBC determines that a duplicate record exists, the MSP record will be deleted from CWF, and the CWF Assistance Request will be returned with a Status/Reason CM50.
- When Action 'ID' is submitted on a CWF Assistance Request and the COBC determines that a duplicate record does not exist, the CWF Assistance Request will be returned with a Status/Reason CM83. The response will include any relevant comments.
- The MSP Inquiry Additional Information page has been revised to prevent entering Diagnosis Codes when the MSP Type (entered on the MSP Information page) is A (Working Aged), B (ESRD), or G (Disabled).

  The ECRS Web User Guide can be found at: http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Internet-Only-Manuals-IOMs-Items/CMS019017.html.

  If you have any questions about these ECRS changes, please contact: Erica.Watkins@cms.hhs.gov

Please contact the appropriate DPO Representative (list attached) if you have any questions about the information in this letter or need assistance with other payment or premium related issues. Thank you.

cc: DPO Representatives
Director, DPO
MAPD Customer Support

CENTERS FOR MEDICARE
MEDICARE PLAN PAYMENT GROUP
DIVISION OF PAYMENT OPERATIONS (DPO)
REGIONAL REPRESENTATIVES – 2013

Boston and Kansas City	Terry Williams (410) 786-0705 Terry.Williams@cms.hhs.gov
New York, Demos/PACE	William Bucksten (410) 786-7477 William.Bucksten@cms.hhs.gov
Philadelphia	James Krall (410) 786-6999 James.Krall@cms.hhs.gov
Atlanta	Louise Matthews (410) 786-6903 Louise.Matthews@cms.hhs.gov
Chicago	Mary Stojak (410) 786-6939 Mary.Stojak@cms.hhs.gov
Dallas	Michelle Page (410) 786-6937 Michelle.Page@cms.hhs.gov
San Francisco And Denver	Kim Miegel (410) 786-3311 Kim.Miegel@cms.hhs.gov
Seattle	Shawanda Perkins (410) 786-7412 Shawanda.Perkins@cms.hhs.gov
DPO Director	John Scott (410) 786-3636 John.Scott@cms.hhs.gov

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Medicare
7500 Security Boulevard, Mail Stop C1-13-07
Baltimore, Maryland 21244-1850

CENTER FOR MEDICARE

DATE: May 1, 2013

TO: Medicare Advantage Organizations
Medicare Advantage-Prescription Drug Organizations
Sections 1876 and 1833 Cost Contractors
PACE Organizations
Demonstrations
Prescription Drug Plan Sponsors
Employer/Union-Sponsored Group Health Plans
Medicare-Medicaid Plans

FROM: Cheri Rice
Director, Medicare Plan Payment Group

Danielle R. Moon, J.D., M.P.A.
Director, Medicare Drug & Health Plan Contract Administration Group

SUBJECT: Additional Information Regarding the Mandatory Payment Reductions in the Medicare Advantage, Part D, and Other Programs

On March 22, 2013, the Centers for Medicare & Medicaid Services (CMS) released a memorandum notifying Medicare Advantage Organizations (MAOs), Part D plans, and other programs (including Managed Care Organizations) that, beginning April 1, 2013, payments made to MAOs, Part D sponsors, and other programs will generally be reduced by two percent in accordance with the Balanced Budget and Emergency Deficit Control Act of 1985 (BBEDCA), as amended. This process of payment reduction is referred to as sequestration. This memorandum provides additional information about the application of sequestration to the Medicare Advantage (MA) program, Part D, and other specified program payments.

Calculation of Amount Being Sequestered

In its March 22, 2013 memorandum, CMS explained that the two percent sequestration reduction will be applied to MA, Part D, and other program payments associated with enrollment periods beginning on or after April 1, 2013. CMS has received a number of questions asking for more details about how the sequestration applies to the MA, Part D, and other program payments.

Payments to all plans and plan types are subject to sequestration, including MAOs, Prescription Drug Plans, Sections 1876 and 1833 Cost Plans, Health Care Prepayment Plans, PACE plans, and demonstration plans of all types. The two percent reduction is applied to the Net Capitation Payment (NCP) made to plans. All non-exempt capitation payments are included in the NCP. For example, Part C Risk Adjusted payments (after MSP reduction) and MA rebates are included. For Part D, Direct Subsidy payments and Coverage Gap Discount payments are included. Part D payments for Low Income Subsidies and Reinsurance are exempt from sequestration and therefore not reduced.

Beginning April 1, 2013 (and for the duration of the sequestration period), prospective payments in the payment categories identified above are netted against adjustments to capitation payments for enrollment periods beginning or continuing in effect on or after April 1, 2013. The resulting NCP amount, whether positive or negative, is then multiplied by two percent to account for reductions that need to be made, and any reductions that were previously made for payments that are being adjusted (e.g., a retroactive disenrollment adjustment that is being processed for an enrollment payment that was previously reduced due to sequestration).

Only NCPs associated with enrollment periods beginning on or after April 1, 2013 are subject to sequestration. That means, for example, that the April 1, 2013 prospective payment made to a plan for members who were enrolled on April 1, 2013 is subject to the two percent reduction, but any payment adjustments to prospective payments made for those members for periods prior to April 1, 2013 are not subject to sequestration, even if those payment adjustments occur on or after April 1, 2013. Similarly, the 2012 final risk score reconciliation occurring later this year will not be affected by the sequester.

If there are any adjustments for periods that straddle April 1, 2013, the portion of the adjustment for the enrollment period starting on April 1, 2013 will be subject to sequestration. For example, if the State and County Code (SCC) for an enrollee changes for the May 1st payment and the SCC change is retroactive to January 2013, the portion of the adjustment relating to the January, February, and March payments will not be reduced due to the sequester, but the portion of the adjustment related to April payment will be reduced.

Cost Plans: The monthly payments made to Section 1876 and 1833 cost-based Managed Care Organizations (MCOs) are subject to sequestration in the same manner described above for MAOs. In addition, the reduction in payment will apply to the cost reports submitted by Sections 1876 and 1833 cost-based MCOs. The two percent reduction will be prorated based on the portion of the cost reporting period covered by the sequestration order, which became effective for Medicare programs on April 1, 2013. CMS will provide specific cost report preparation instructions at a later date.

Coverage Gap Discount Program (CGDP) Payments: Prospective CGDP payments from CMS to plans are subject to sequestration. Therefore, CMS will reduce the prospective CGDP payments by two percent. However, the actual discounts collected from the pharmaceutical manufacturers are not subject to sequestration. Because CMS is reducing payments associated with enrollment periods beginning April 1, 2013, any offsets that CMS makes for prospective CGDP payments made before April 1, 2013 are not subject to sequestration. CMS will make the

appropriate adjustments to the offset amount to reflect the required reductions, as well as to the prospective CGDP payment, when conducting the CGDP reconciliation for this time period.

Part D Risk Corridor Reconciliation: In accordance with Section 256(d) of BBEDCA, CMS will not take into account any reductions in prospective payment amounts due to sequestration for purposes of computing the Part D risk corridor reconciliation under section 1860D–15(e) of the Social Security Act. In other words, the "Target Amount" will not include any sequester reductions in prospective payments. In addition, Section 256(d)(7) of the BBEDCA exempts payments made under section 1860D-15(e)(2)(B) of the Social Security Act from sequestration. Therefore, any payment resulting from the Part D Reconciliation (i.e., payments made as a result of risk sharing) would not be subject to sequestration.

Electronic Health Records (EHR) Incentive Program Payments: Under section 256(d) of BBEDCA, incentive payments made under the EHR Incentive Program are subject to sequestration. Following the approach of applying sequestration to payments associated with enrollment periods beginning April 1, 2013, CMS will reduce the incentive payments by two percent when the last day of the EHR reporting period is on or after April 1, 2013. Note that the two percent reduction will be applied to the total incentive amount for that reporting period regardless of whether some of the EHR use accounted for in that reporting period occurred prior to April 1, 2013. The MA EHR incentive payments that CMS will make in June 2013 are for the 2012 reporting period and therefore will not be reduced due to sequestration.

Reducing Payments to Contracted Providers

Section 1854(a)(6)(B)(iii) of the Social Security Act prohibits CMS from interfering in the payment arrangements between MAOs and contract providers. The statute specifies that CMS "may not require any MA organization to…require a particular price structure for payment under such a contract…" Thus, whether and how sequestration might affect an MAO's payments to its contracted providers are governed by the terms of the contract between the MAO and the provider. We note that MAOs must follow the prompt pay provisions established in their contracts with providers and to pay providers under the terms of those contracts (see 42 CFR sections 422.520(b)(1) and (2)). Similarly, the question of whether and how sequestration might affect a Part D plan sponsor's payment to its contracted providers is governed by the payment terms of the contract between the plan sponsor and its network pharmacy providers. We note that Part D plan sponsors must follow the prompt pay provisions established in their contracts with network pharmacy providers and to pay the providers under the terms of those contracts (see 42 CFR sections 423.520(b)(1) and (2)).

Beneficiary Liability Under Sequestration

Sequestration does not affect the basic and supplemental benefits offered by the MAO or Part D sponsor, nor does it change the plan's approved premium or cost sharing requirements for CY 2013. As a result, MAOs and Part D sponsors are not permitted to modify the currently-approved benefit or cost sharing structure in any way. This includes increases in premiums or cost sharing, or reductions in benefits in an attempt to offset the lower payments due to sequestration.

Reducing Payments to Non-Contract Providers

Pursuant to the Medicare regulations at 42 CFR § 422.214, a non-contract provider must accept, as payment in full, the amount that it could collect if the beneficiary were enrolled in the Medicare Fee-for-Service program. On March 8, 2013, CMS sent a bulletin titled "Mandatory Payment Reductions in the Medicare Fee-for-Service (FFS) Program – Sequestration" via the Medicare Learning Network. That bulletin provided the following guidance regarding how the reduction applies to payments under the Medicare FFS program (i.e., Part A and Part B):

> In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment. Claims for durable medical equipment (DME), prosthetics, orthotics, and supplies, including claims under the DME Competitive Bidding Program, will be reduced by 2 percent based upon whether the date-of-service or the start date for rental equipment or multi-day supplies is on or after April 1, 2013.
>
> The claims payment adjustment shall be applied to all claims after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments.
>
> Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction.

For example, if a provider bills for a service with a Medicare approved amount of $100.00 and $50.00 is applied to the deductible, a balance of $50.00 remains. Medicare FFS normally would pay 80 percent of the approved amount after the deductible is met, which is $40.00 ($50.00 x 80 percent = $40.00). The patient is responsible for the remaining 20 percent coinsurance amount of $10.00 ($50.00 - $40.00 = $10.00). However, due to the sequestration reduction, 2 percent of the $40.00 calculated payment amount is not paid, resulting in a payment of $39.20 instead of $40.00 ($40.00 x 2 percent = $0.80).

MAOs may apply a similar process to determine the amount owed to a non-contract provider. The MAO should calculate the net payment owed to the non-contract provider by subtracting the member's out-of-network (OON) cost-sharing amount from the total Medicare approved amount under FFS for that particular service. The minimum payment amount due to the non-contract provider would be equal to the net payment amount reduced by 2 percent due to sequestration. As an example, if a non-contract provider bills an MAO for a service with a FFS approved amount of $100.00 and the member has a 20 percent OON cost-sharing obligation, the member would be responsible for paying the $20 coinsurance amount ($100 x 20 percent = $20) and the MAO would normally pay the non-contract provider $80 ($100 x80% = $80). However, due to the sequestration reduction, the $80.00 calculated payment amount would be reduced by 2 percent ($80.00 x 2 percent = $1.60), resulting in a payment of $78.40 instead of $80.00 ($80.00 - $1.60 = $78.40).

We would note, however, that the requirement for a non-contract provider to accept FFS payment amounts as payment in full serves as a floor on MAOs' payments to these providers. As a result, it is at the MAOs' discretion as to whether to impose a reduction due to sequestration for these payments. Additionally, MAOs must continue to meet the prompt payment requirements for paying non-contract providers (see 42 CFR section 422.520(a)(3)).

If you have any questions about the guidance in the memorandum, please contact Jean Stiller at Jean.Stiller@cms.hhs.gov.

Transformation Grants Report

Staff will present materials on FY 2017 and FY 2018 transformation grant activities at the December meeting.

Policy Update Report and Discussion

Staff will present materials at the Commission Meeting.

State of Maryland
Department of Health

Nelson J. Sabatini
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

James N. Elliott, M.D.

John M. Colmers

Adam Kane

Jack C. Keane

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Katie Wunderlich
Executive Director

Allan Pack, Director
Population Based
Methodologies

Chris Peterson, Director
Clinical & Financial
Information

Gerard J. Schmith, Director
Revenue & Regulation
Compliance

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **December 10, 2018**

RE: **Hearing and Meeting Schedule**

January 9, 2019	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
February 13, 2019	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 11:15 a.m.

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

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