Health Services Cost Review Commission
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545th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
November 13, 2017

EXECUTIVE SESSION
10:00 a.m.
(The Commission will begin in public session at 10:00 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 Contract and Modeling of the All-payer Model vis-a-vis the All-Payer Model Contract – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-103 and §3-104**

3. **Personnel Matters – Authority General Provisions Article, §3-305 (b) (1)**

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on September 13, 2017**

2. **Executive Director's Report**

   a. **Mid-Year Update Factor Discussion**

3. **Final Recommendation on Updates to the Inter-hospital Cost Comparison Methodology**

4. **Final Recommendation on the Medicare Performance Adjustment**

5. **New Model Monitoring**

6. **Docket Status – Cases Closed**

   2400A – University of Maryland Medical Center 2401A - MedStar Health
   2404A – Johns Hopkins Health System

7. **Docket Status – Cases Open**

   2398N – University of Maryland Midtown Campus 2399A – Priority Partners
   2402A – MedStar Medicare Choice 2403A – MedStar Family Choice
   2405A – Atlantic General Hospital 2406A – Maryland Physicians Care
   2407A – Johns Hopkins Health System 2408A – University of Maryland Health
   2409A – University of Maryland Health Partners, Inc. Advantage, Inc.

2410A – University of Maryland Medical System

8. **Presentation by Anne Arundel Medical Center**
9. **Draft Recommendation on Updates to the QBR Policy for RY 2020**
10. **Hearing and Meeting Schedule**

Executive Director's Report

November 13, 2017

Considerations Regarding RY 2018 Update

The Commission asked the staff to report back at the November 2017 meeting regarding the rate year (RY) 2018 update. There were concerns that the current update could lead to excess growth in total cost of care, especially for Medicare, if utilization did not fall as it did in 2016.

The staff will discuss this topic with the Commission today. Key considerations are:

- The reduction in the final federal updates from preliminary updates. (-0.6%)
- Medicare utilization reductions
- Medicare Total Cost of Care growth
- Annual savings in Total Cost of Care relative to the 2013 base year
- Changes in the Medicare data set and the "audit" underway
- CY 2018 growth guardrail

Update on the Status of the Enhanced Total Cost of Care Model

The CMS review is ongoing. The review process is proceeding according to the agreed timeline. The Secretary of the Maryland Department of Health will initiate an Innovations work group in the near term, to support the process needed to create and scale the change needed.

EMS Systems (MIEMSS) Report on Mobile Integrated Health Programs

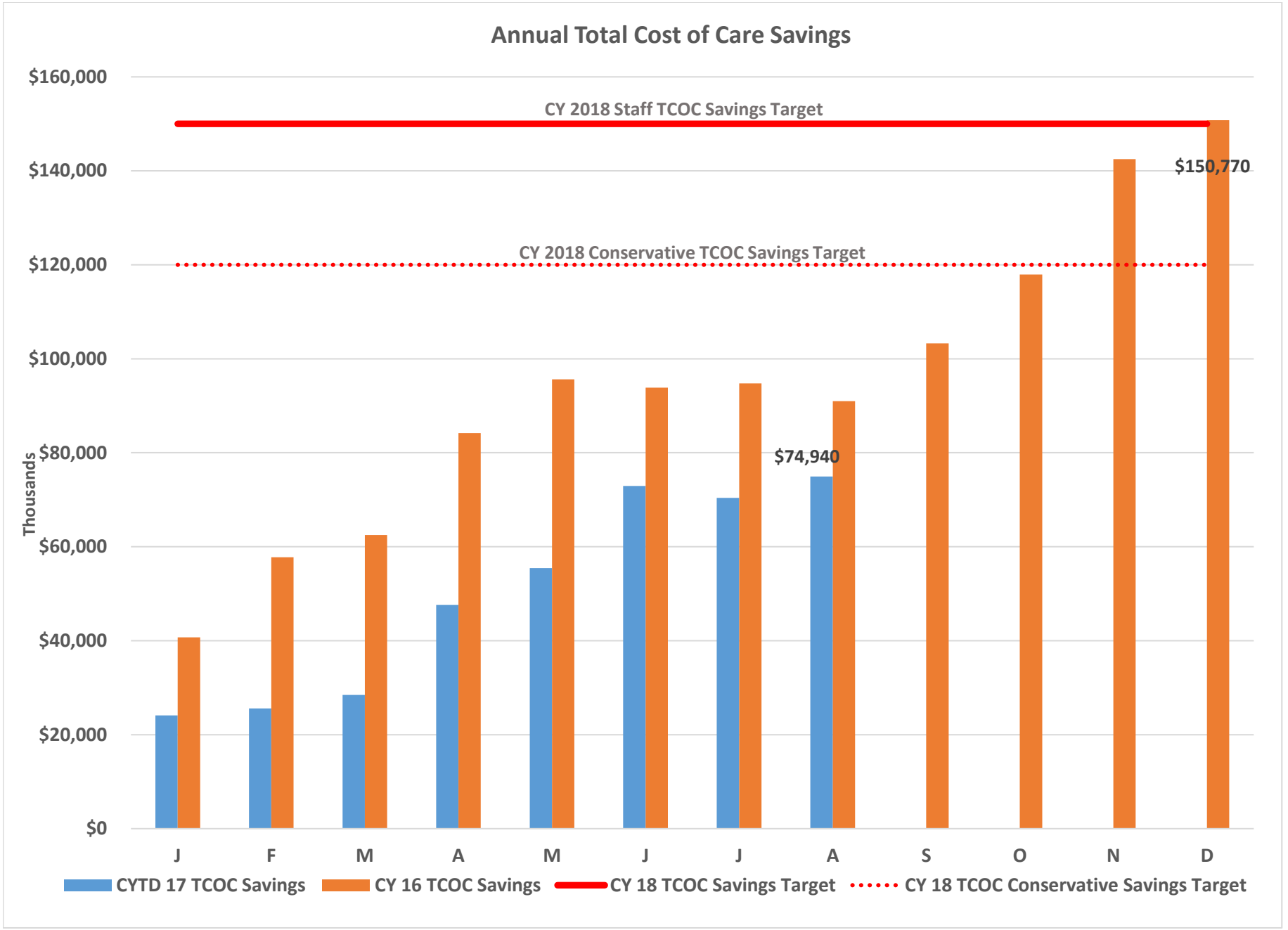
Statewide EMS Case Distribution, by Priority

FY2017	Priority 1	Priority 2	Priority 3	Priority 4	Total
Medical	21,822	170,723	306,959	14,189	513,693
Injury	3,285	26,516	89,519	2,318	121,638
Total	25,107	197,239	396,478	16,507	

Priority 1: — Critically ill or injured person requiring immediate attention; unstable patients with life-threatening injury or illness.
Priority 2: Less serious condition yet potentially life-threatening injury or illness, requiring emergency medical attention but not immediately endangering the patient's life.
Priority 3: Non-emergent condition, requiring medical attention but not on an emergency basis.
Priority 4: Does not require medical attention.

Source: eMEDS Data via Maryland Institute for EMS Systems (MIEMSS) Report on Mobile Integrated Health Programs, 2017

Study of emergency transport cases shows the majority of cases did not need an ER visit. It will be important to have MIEMSS as part of the innovation and transformation planning for the Enhanced Total Cost of Care Model.


Annual Total Cost of Care Savings
$160,000
$140,000
$120,000
$100,000
$80,000
$60,000
$40,000
$20,000
$0
Thousands
CY 2018 Staff TCOC Savings Target
CY 2018 Conservative TCOC Savings Target
$150,770
$74,940
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CYTD 17 TCOC Savings
CY 16 TCOC Savings
CY 18 TCOC Savings Target
CY 18 TCOC Conservative Savings Target

FINAL Recommendations for Updates to the Inter-hospital Cost Comparison Tool Program

November 13, 2017

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LIST OF ABBREVIATIONS

ACA	Affordable Care Act
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis-Related Group
APR-DRG	All Patients Refined-Diagnostic Related Groups
FY	Fiscal Year
FFY	Federal Fiscal Year
HSCRC	Health Services Cost Review Commission
QBR	Quality-Based Reimbursement
RY	Maryland HSCRC Rate Year
VBP	Value-Based Purchasing
ROC	Reasonableness of Charge
ICC	Inter-hospital Cost Comparison
GBR	Global Budget Revenue
MACRA	Medicare Access and Chip and Reauthorization Act
ROC	Reasonableness of Charges
EAPGs	Enhanced Ambulatory Patient Groupings
ECMADs	Equivalent Case-Mix Adjusted Discharges

PROPOSED COMMISSION ACTION

This final policy asks Commissioners to approve staff recommendations to conduct full rate reviews in accordance with the all payer model requirements and to initiate a review process in conjunction with a technical workgroup to review proposed changes to the ICC.

Recommendations

In light of the change in the All-Payer Model from the historic cost-per-case focus to a per capita system with demonstrable care delivery and outcomes improvement requirements, the HSCRC staff makes the following recommendations for consideration:

1. Hospitals filing full rate reviews should demonstrate efficiency in both price and utilization, and the evaluation should consider the total hospital cost of care subject to the Commission's rate setting authority.
    a. Price efficiency (i.e., the cost of performing cases or episodes) should take into account ICC comparison results, supplemented with unit cost or other efficiency analysis of those "cycle billed" services excluded from the ICC. The rate setting process should also continue to consider other information and analysis supplied by the hospital or performed by HSCRC staff regarding efficiency.
    b. For evaluation of utilization efficiency, hospitals should be required to demonstrate that they are making substantial and ongoing progress in achieving more appropriate levels of care, reducing avoidable utilization, eliminating unnecessary care, and improving efficiency in the use of health care resources. They should also be expected to demonstrate that they are making substantial and specific efforts and investments to improve care and to reduce unnecessary care and potentially avoidable care. Additionally, the staff should be directed to consider reducing the allowed global budget of hospitals that have high levels of avoidable utilization and requiring them to achieve additional utilization efficiency over time.
    c. The evaluation should through this process take into account efficiency in both price and utilization of inpatient and outpatient regulated services.

2. The HSCRC staff should seek review from a technical workgroup on its proposed modifications to the Inter-hospital Cost Comparison. This group may provide input, similar to the Total Cost of Care Advisory Group, recognizing, however, that rate setting is a regulatory tool and does not lend itself to consensus-based input.

3. The HSCRC staff should evaluate an expansion of claims data submissions from hospitals for outpatient hospital claims that are "cycle billed claims" to allow for more accurate construction of ECMADs and benchmarks for the outpatient visits and episodes that are now excluded from the ICC.

INTRODUCTION

The State of Maryland is leading an effort to transform its health care system by increasing the emphasis on patient-centered care, improving population health, and lowering health care costs. To achieve these goals, the State of Maryland worked closely with hospitals, payers, other providers, consumers and the Center for Medicare & Medicaid Innovation (CMMI) at the federal Centers for Medicare and Medicaid Services (CMS) to develop the new Maryland All-Payer Model, which was implemented in 2014. The new Model moved away from a volume based payment system and limitation on growth in charge-per-case to a system that limits growth in total hospital spending per capita and increasingly focuses on outcomes. Prior to the implementation of the new Model, the HSCRC had begun to transform the payment system away from charge-per-case; with ten rural hospitals on global hospital payment models initiated in 2010, and most other hospitals with readmissions incorporated into a charge-per-episode system.

In November 2015, full rate reviews were suspended to allow development of tools and methodologies consistent with the new Model. Regulations were introduced at the September 2017 Commission meeting that updated filing requirements for full rate reviews. These updated filing requirements are intended to collect information that will support a more robust review of cost and efficiency, going beyond the cost-per-case or per visit efficiency previously embodied in the review. Cost-per-case and per visit continue to be an important part of the efficiency consideration. This report provides staff analysis and proposed updates to the Inter-hospital Cost Comparison (ICC) methodology, a tool that HSCRC staff proposes to continue using in evaluating hospitals' cost-per-case or per visit efficiency as a key element of full rate reviews. It also provides policy recommendations that go beyond the historical per-case/visit efficiency construct to address the need of evaluating efficiency in the context of a per capita system that also considers levels of utilization.

BACKGROUND

To encourage efficiency and to limit the growth in charge per case prior to 2011, hospital charges per case were compared to a peer group average. This comparison, referred to as Reasonableness of Charges or "ROC" was used to "scale" hospitals' approved charge-per case/visit, gradually giving hospitals with lower charges an incremental per-case increase and gradually lowering the approved charge-per-case for those hospitals with higher charges. In 2011, the ROC was suspended to encourage hospitals to reduce unnecessary utilization because it worked against the incentives to reduce unnecessary and avoidable volumes that might result in higher cost per case. Since 2011, hospitals have not faced efficiency scaling per the ROC, allowing hospitals to adjust to their focus on per capita efficiency and to invest in new models of delivery.

While the ROC was suspended in 2011, a derivative methodology, referred to as Inter-hospital Cost Comparison or "ICC" continued to be used for full rate reviews and partial rate applications for capital. In November 2015, the HSCRC suspended full rate reviews to allow for evolution of the review methodologies, while retaining several avenues to adjust hospitals' global budgets through Global Budget Revenue (GBR) Agreements, emergency adjustments, and partial rate applications for large capital projects.

In September 2017, the Commission introduced revisions to its regulations, updating filing requirements for full rate reviews, and laying out a review construct that considers both cost-per-case/visit and utilization, which will continue to evolve. The revisions require the filing of information regarding a hospital's full financial requirements associated with regulated costs and services, volumes of services, and avoidable and unnecessary utilization. The revisions continue the use of an Inter-hospital Cost Comparison as part of conducting a full review. This report presents staff's proposed approach to updating the ICC methodologies, which will be used in conjunction with other review components when evaluating possible increases or decreases to global budgets in the context of a full rate review. It also lays out policy recommendations regarding the expansion of the scope of the review to encompass efficiency and effectiveness in the context of the All-Payer Model demonstration that was implemented under the Agreement with CMS in 2014.

ASSESSMENT

Efficiency in the Context of Per Capita Costs

Affordability

Healthcare costs have reached a state of crisis in affordability, with ever increasing proportions of household income spent on healthcare services. Reductions in real wage growth and disposable income that can be attributed to healthcare cost increases, have had an increasing impact on consumers and their affordability of coverage. With increased proportions of costs borne by government, rising healthcare costs have also placed an increasing burden on federal and state budgets. If Medicare and Medicaid costs continue to rise faster than GDP, more than ever, Americans will be faced with paying more in taxes for healthcare as a share of economic output as well as the need to further curtail expenditures on non-health outlays.

Several statistics from the National Institute for Healthcare Management (NICHM) Foundation substantiate these statements: (Source: https://www.nihcm.org/topics/cost-quality/the-burden-of-rising-health-spending)

- Per capita healthcare spending increased by nearly 40 percent over the decade 2006 through 2015.

- Healthcare spending now accounts for 28 percent of median personal income, based on 2015 figures.
- Hospital care contributed to 43 percent of the cost increase from 2006 through 2015.
- Out of pocket spending plus premiums for employer-based PPO coverage rose 73 percent during the decade from $15,609 for a family of four in 2008 to $26,944 for a family of four in 2017, with employees bearing an increasing proportion of costs directly through a combination of employee contribution to premium and out-of-pocket spending.
- Medicare spending has risen 58 percent and Medicaid spending has risen 72 percent for the decade ended in 2015.

Maryland's per capita healthcare spending is no exception. Hospital and total personal health care spending per capita ranked 20th and 13th respectively when adjusted for age, and compared by state for 2014, based on figures recently released by CMS' Office of the Actuary and presented at the July 2017 Commission meeting.

Context of Rate Setting in a Per Capita System

Under the historic charge-per-case system construct of Maryland's Medicare waiver in place from 1977 through 2013, the focus of the regulatory system and therefore the related full rate review was in constraining the growth and ensuring the reasonableness of cost per case or per visit. Congress, through the bi-partisan MACRA legislation as well as the ACA, has focused on high value care as efficient delivery of high-quality, evidence-based, patient-centered care. The Maryland All-Payer Model Agreement approved by CMS in 2014 under federal demonstration authority, relies on this same definition of efficiency and value. The HSCRC's statute requires it to approve rates that are sufficient to allow hospitals to provide "efficient and effective" care. Potentially avoidable care (i.e., care that results from healthcare acquired conditions, from poor coordination, from inadequate condition management) as well as unnecessary care (i.e., care that is rarely useful; care that is sometimes useful and needed but often overused; care that is needed and effective but could be provided in lower cost settings and; care that can be avoided with better community interventions) does not meet the standard of efficiency and effectiveness. Higher cost and cost variation per case, per visit, or per episode continue to be important factors in excessive spending which the HSCRC will need to continue focusing its efficiency efforts on: For ease of understanding, this analysis will refer to this as price efficiency. The Inter-hospital Cost Comparison (ICC) is a construct HSCRC has historically used to evaluate price efficiency. HSCRC staff proposes that the Commission continue to use this tool as part of evaluating efficiency in the context of a full rate review. Staff is also proposing updates to the ICC methodology for review with this recommendation.

While higher cost per service and episode contribute to excessive spending, clinical waste also contributes to inefficient costs and poor outcomes. Clinical "waste" consists of care that could be eliminated without reducing quality or outcomes. Staff intend for this to encompass both potentially avoidable care and unnecessary care. Many estimates (e.g., from the Institute of Medicine) place waste at approximately 30% of American healthcare expenditures. The

Maryland hospital system is unique in that it operates under a unique demonstration and waiver arrangement with the federal government. This waiver has permitted the establishment of "fixed budget" agreements, giving hospitals the ability to eliminate unnecessary care without incurring financial harm. The success of the Maryland demonstration under the All-Payer Model is highly dependent on the progress that is made by hospitals in controlling volumes—specifically, efforts to curb volume increases and to eliminate potentially avoidable and unnecessary care. Failure to address the problem of potentially avoidable and unnecessary care will endanger the affordability of health care for individuals, companies and government; it will undermine the profitability and financial status of hospitals if rate updates are tightly controlled; it will limit the funds available for innovation; and it will potentially threaten the long term continuation of the waivered All-Payer Model system.

- It is clear that there are many opportunities to improve value and efficiency in the healthcare system. Reductions in treatments that go beyond the levels determined to be efficacious by widely accepted clinical guidelines are a key potential source of value and efficiency improvements. Reductions in potentially avoidable utilization that can be achieved through reductions in healthcare acquired conditions, poor coordination of care, and ineffective management of chronic and complex conditions are another key potential source of value and efficiency.
- These opportunities exist throughout the health care system, to a greater or lesser degree, but are substantial in virtually all cases across all hospitals and health systems.
- Hospitals and their medical staffs, in concert with other health care providers and consumer representatives, are positioned to work with other providers, health departments and consumers to determine which areas of medical care offer the greatest opportunities for value improvement in their communities.
- The HSCRC has provided infrastructure funding to support efforts at value improvement. The fiscal stability of Maryland hospitals and the viability of the federally-waivered All-Payer Model and the proposed enhanced Total Cost of Care Model depend on the implementation of effective actions to address the overuse problem and provide resources to address areas of underuse such as primary care.
- The HSCRC should allow Maryland hospitals significant latitude to devise the ways in which they will work with physicians, other providers, and their communities to identify the greatest opportunities for value improvement in their service areas.

In addition to providing evidence of price per service efficiency, when hospitals file a full rate application seeking higher global revenue budgets, they should be expected to demonstrate substantial ongoing progress in achieving more appropriate levels of care, evidence of eliminating potentially avoidable and unnecessary care, and evidence of improving efficiency in the use of health care resources. Hospitals should also be expected to demonstrate substantial and specific efforts geared towards improving care outcomes and reducing unnecessary care in key areas shown by health services literature to be particularly problematic.

INTER-HOSPITAL COST COMPARISON METHODOLOGY UPDATE

Background

For decades, the Commission has utilized an Inter-hospital Cost Comparison (ICC) approach to evaluate the reasonableness of hospital costs and to determine the relative efficiency of a particular hospital in comparison to similar institutions. In the earliest years of the Commission, the ICC used cost per unit comparisons. When Diagnosis Related Groups (DRGs) were developed in the late 1970s and early 1980s, the Commission adopted a charge-per-case approach for inpatient cost comparisons while maintaining unit based comparisons for outpatient services. On June 1, 2005, the Commission moved to 3Ms All Patient Refined DRGs (APR-DRGs) which offered major advancements in severity level classifications, allowing for better cost comparisons as well as quality and outcomes comparisons. Upon moving to the APR-DRG system, the Commission found that hospital coding enhancements resulted in excess revenue growth. Hence, the Commission suspended full rate reviews for three years and instituted case-mix governors to limit the impact of coding changes.

In the last decade, as outpatient services grew as a proportion of hospital costs, to allow for more comprehensive cost comparisons in the outpatient setting, the Commission focused on moving outpatient service comparisons to a cost-per-visit approach using 3M's Enhanced Ambulatory Grouping System (EAPGs). The ICC approach evolved to incorporate some outpatient hospital services into a charge-per-case construct, while continuing to maintain selected services on a cost per unit basis. Instances where the HSCRC was and still is unable to develop charge-per-visit comparisons are for cycle-billed services—services billed for on a monthly basis rather than for each visit. Principal services that continue with this billing condition are clinics, physical therapy services, and oncology services. The HSCRC does not collect all of the line item billing elements for these cases which would allow them to be parsed into visits, thus, inhibiting analysis. Staff will revisit this issue later in this recommendation. However, given the improvements in computing software, the decreasing costs of hardware, and the advent of cloud computing, Staff might now consider collecting this data.

As discussed above, the objective of a cost-per-case/cost-per-visit comparison is to allow HSCRC to assess the relative costs of hospitals compared to other hospitals or potentially to other providers offering similar services. The HSCRC has developed a construct to combine these analyses for inpatient and outpatient services, which we refer to as Equivalent Case-Mix Adjusted Discharges or "ECMADs." In the following paragraphs, staff will use the term ECMADs to denote the combination of included inpatient and outpatient cases and visits, while noting that staff is excluding ECMAD data for cycle billed visits at this time—clinics, infusions and related drugs, radiation therapy, physical therapy services, and outpatient psychiatric visits.

The HSCRC staff has evaluated needed updates to the ICC approach and has completed preliminary calculations using the proposed revised approach for those services that would be incorporated into a charge-per-case or charge-per-visit construct. As discussed below, staff is in need of final rate year-end 2017 data (July 1, 2016 through June 30, 2017) to complete the

calculations; this should be forthcoming in the near term. Also, as with all data analyses and technical calculations, our work is subject to technical review prior to finalization.

The following paragraphs will explain staff proposed changes to the ICC methodology at a high level, as well as the process used to reach the comparisons in the ICC. A companion detailed technical document and calculations will be made available at future Commission meetings, once updated data is obtained, documentation is complete, and technical review and input have been considered.

Overview of Calculation

The general steps used by staff, consistent with prior practices, are as follows:

1. Calculate approved permanent revenue for included ECMADs. This excludes the hospital revenues for one-time temporary adjustments and assessments for funding Medicaid expansion and deficits as well as Commission and other user fees.

2. Permanent revenues are adjusted for social goods (e.g., medical education costs) and for costs that take into consideration factors beyond a hospital's control (e.g., labor market areas as well as markup on costs to cover uncompensated care and payer differential).

3. Hospitals are divided into peer groups for comparison, recognizing that the adjustments may not fully account for cost differences. The adjusted revenue per ECMAD is compared to other hospitals within the peer group to assess relative adjusted charge levels. The peer groups are:

    - Peer Group 1 (Non-Urban Teaching)
    - Peer Group 2 (Suburban/Rural Non-Teaching)
    - Peer Group 3 (Urban Hospitals)
    - Peer Group 4 (Academic Medical Center Virtual, which overlaps with peer group 3)

4. For full rate reviews there are two additional steps to convert revenues to cost. The first additional adjustment is to remove from the adjusted revenues, profits from regulated services. The second is to make a productivity adjustment to the costs. These two adjustments are made to allow for consideration of efficient costs for purposes of rate setting.

5. In a full rate review process, an analysis of efficiency is performed with the ICC, while also taking into account other information put forward by the hospital or staff, and incorporating further analysis and consideration of the services (i.e., cycle-billed services) that are not included in the base ICC analysis. Once the process of review is complete, the process of rebuilding back from an adjusted peer group standard to approved revenue is completed by reversing steps one and two.

Proposed Changes to ICC Methodology

The staff will now discuss its considerations in proposing changes to the ICC relative to the methodology in effect in 2011.

We have focused on the approach to adjust revenues for social goods and for factors that are partially beyond a hospital's control (step 2), as well as for the productivity adjustment discussed in step 4. At this time, the staff has not reformulated peer groups (step 3) and has proposed one substantive change to the calculation of permanent revenues (step 1).

Step 1- Calculate Permanent Revenue

Outpatient Drug Overhead Adjustment-

As previously discussed, outpatient cases that are subject to cycle billing are excluded from the cost-per case/visit comparisons and handled separately. Staff proposes to exclude only the cost of outpatient drugs for the cycle billed cases (primarily cancer drugs and biological drugs) and not the charges/cost for overhead. In the HSCRC rate setting calculations, a significant portion of costs continue to be allocated based on "accumulated costs." This process is allocating too much overhead to outpatient biological drugs, and staff has concluded that this allocation distorts cost comparisons. Medicare adds five percent to average sales price to pay for physician administered drugs that are not bundled into a visit cost, while non-governmental payers use a somewhat higher overhead figure when using average sales price in their payment formulation. It is likely that HSCRC will need to change its overhead allocation and rate setting formulation for these biological and cancer drugs in the near term as costs continue to escalate. In the meantime, staff recommends leaving the overhead costs in the revenues and costs subject to charge-per case/visit comparisons.

Step 2- Adjustments to revenue

Each key adjustment to revenue along with changes to the approach proposed by staff follow:

Medical Education Costs-

Consistent with past practices, direct medical education costs, including nurse and other training as well as graduate medical education (GME) costs, are stripped from the permanent revenues using amounts reported in hospitals' annual cost filings. HSCRC policies limited recognition of growth in residencies beginning in 2002, unless increases in residencies were approved through a full rate review. This is consistent with Medicare policies that also limit recognition of growth in residencies. For the proposed ICC formulation, the staff is limiting the counts and costs used in the GME calculations based on the number of residents and interns that were included in the 2011 regression.

Over the years, Maryland has struggled with the calculation of indirect medical education ("IME") costs. In 2011, HSCRC reached a calculation after much debate of an IME allowance per resident of $230,746. Staff believes this figure may be too high for those hospitals that are

not academic medical centers. Staff proposes to use the 2011 figure and inflate it to current dollar figures, building on the significant work and resource investment that resulted in this formulation in 2011. The most significant concern with reformulation of the allowance is the fact that the calculation results are unstable and are driven primarily by variations in the charges of Maryland's two academic medical centers. Staff is undertaking analyses of national cost data to determine if it is possible to create a more empirically justified calculation, however, this will take some time and may not be ready for use prior to RY 2019.

Labor Market Adjustment-

In the prior ICC, the labor market adjustment was constructed using an HSCRC wage and salary survey which was based on two weeks of pay and included fringe benefits and contract labor. Each hospital was provided with a unique labor market adjustor. Staff has suspended the wage and salary survey submission for 2017 and intends to replace this survey data with CMS's nationally reported data. Although this national CMS data is available historically, HSCRC staff has not had the opportunity to audit the data which may contain reporting errors. Staff and MHA have stressed the importance of accurate data in the 2017 reports to Medicare which are due this year.

While staff will continue to use the HSCRC wage and salary survey in its formulation of the ICC until the new Medicare survey is available, it proposes to eliminate hospital specific adjustments for most hospitals. Specifically, staff proposes to use two sets of hospital groupings, with the first set of grouping for Prince George's County and Montgomery County where wages are higher than Maryland's average and a second grouping of all other hospitals, excluding various border hospitals located in isolated or rural areas.

Capital Cost Adjustment-

Previously, there was a capital cost adjustment for differences in capital costs that were being phased out over time. The time has elapsed and there is no longer an adjustment for capital cost differences.

Disproportionate Share Hospital (DSH) Adjustment-

In the 2011 analysis, staff made an adjustment to charges for patients considered to be poor, in consideration of the cost burden that those patients may place on hospitals with higher levels of poor patients. Prior calculations utilized the percentage of Medicaid, charity pay and self-pay to determine this cost burden.

Medicaid expansion has dramatically increased the number of individuals with coverage. First, the expansion was extended to children, then was extended to childless adults and those with higher incomes through the ACA expansion, rendering the prior definitions of limited use. Additionally, with increased payments available to physicians for hospital and community based services and reductions in hospitals' uncompensated care, the financial reasons for potentially continuing this policy are more limited. To evaluate the need for this adjustment, HSCRC compared the case-mix adjusted inpatient charges of potentially poor patients at each hospital

(Medicaid, a new category of dually-eligible for Medicare and Medicaid, and self-pay and charity) to the case-mix adjusted charges of all other patients. A weighted comparison using the more sensitive severity adjusted APR-DRG's showed a small higher adjusted charge-per-case for Medicaid and dually-eligible persons, and a lower charge-per-case for charity and self-pay patients. This leads staff to conclude that this adjustment is no longer needed. Staff however, do believe that the retention of peer groups helps to adjust for other costs that might not otherwise be well accounted for, such as security costs in inner city settings.

While Medicare has retained a DSH adjustment, it has been split into two parts. One part is for uncompensated care, which the HSCRC addresses through the uncompensated care pool. The other part of the adjustment may help Medicare continue to address a concentration of governmental payers, as Medicare and Medicaid typically reimburse hospitals at a reduced rate. Given Maryland's unique All-Payer Model, which eliminates the cross subsidization between governmental payers and private payers as seen in other states, there appears to be a limited need for a DSH adjustment and the charge comparisons do not support it.

Step 4- Productivity and Cost Adjustments

Staff has retained the same adjustment used to remove profits from the ICC costs that has been used historically. Consistent with the statutory authority of HSCRC, the Commission does not regulate professional physician services. The adjustment removes profits for regulated services and does not incorporate subsidies or losses for professional physician services.

Staff recommends however, an alternative approach to calculate the productivity adjustment. In 2011, the methodology used a productivity adjustment of two percent that was applied across the board to all hospitals in all peer groups. Staff is recommending consideration of an excess capacity adjustment, which it has formulated based on the declines in patient days (including observation cases >23 hours) from 2010 through 2017 in each peer group. This adjustment will vary by peer group. Alternative formulations could consider adjustments for unnecessary and potentially avoidable utilization.

Other ICC Considerations and Issues

The Commission considers other information in making full rate reviews and establishing revenue budgets. For example, staff has paid attention to the needs of rural hospitals. Rural hospitals were among the first hospitals in the state to move to a global budget beginning in 2011, referred to as a Total Patient Revenue (TPR) budget. Hospitals (except for Garrett Regional Medical Center which was already on TPR in 2011) were provided substantial revenue allowances to support the conversion and transition to population based systems, and were able to invest funds in alternative services when inpatient days declined. The Maryland Health Care Commission (MHCC) is in the process of completing a report on rural healthcare delivery and its challenges in Maryland. The HSCRC staff will need to continue to pay close attention to the needs of rural hospitals, including possible residencies and resident rotations so as to address critical physician shortages where they exist.

Another concern is the limitation of comparisons to other hospitals. Some of the services provided by hospitals can be performed in community settings and those cost comparisons should incorporate community payment levels. This is a topic for future consideration.

The ICC is currently constructed using cases and visits. Future iterations could extend to episodes, per capita benchmarks, and regional comparisons: However, this will be a more complex analysis requiring more data. Evaluating hospital utilization per capita benchmarks using the ICC will require data beyond hospitals in order to adjust for differences in sites of service and population based risk adjustments so as to account for patient characteristics. Tools for these type of analyses have not yet been developed.

As in the past, certain costs are excluded from the ICC cost per case analysis, these include cycle billed services, Shock Trauma cases at University of Maryland Medical Center, and chronic hospital cases. Staff proposes to incorporate excluded cycle-billed drug costs based on approved utilization and average sales price or the 340B price. Staff will also review the cost and utilization of other services that are outside of the ICC. Since clinic services provided vary widely among hospitals, staff will review submitted costs in reference to comparable size programs and services. Other programs, such as radiation therapy, may lend themselves to comparisons against the medians, since the units for these services have been conformed to RBRVS (Medicare relative value units). Staff will review each of these scenarios with the technical workgroup and with the Commission.

COMMENTS RECEIVED

In addition to the comments and questions raised at the Commission meeting, staff has received several comment letters on the ICC and our proposed recommendations.

Commissioner Comments from the October 2017 Public Meeting—

1. Commissioner Colmers noted potential concerns about eliminating the disproportionate share adjustment (DSH) and the impending expiration of the policy partially recognizing differences in capital costs in the ICC.

   He also asked about the selection of 2010 as a base year for calculating the capacity adjustment proposed for the productivity adjustment. Staff noted that the DSH adjustment and method for calculating excess capacity or other productivity adjustments could be vetted with a technical workgroup and with the Commission. Relative to the partial recognition of differences in capital costs, the elimination of this adjustment over time had previously been approved by the Commission. In light of the focus on reducing avoidable and unnecessary utilization, particularly in hospitals, and of developing excess capacity, staff supports the elimination of this ICC adjustment.

2. Commissioners asked about other factors to be taken into account in the full rate review. For example, the review of the hospital's financial and operational performance over time, transfers of fund balances, related party transactions, system-wide performance, transfers among system entities, whether the direct costs of high priced drugs would be factored in or out of the ICC comparison, losses on the professional services of physicians, volume growth unrelated to population growth, volume reductions unrelated to hospital programs geared towards reducing avoidable utilization, per-capita cost growth in the hospital's service area, the review of estimates provided for avoidable and unnecessary utilization in the hospital and its service area, and the hospital's programs to reduce avoidable and unnecessary utilization.

   Staff indicated that its recommendation was intended on bringing forward the ICC methodology for more comprehensive review. Nevertheless, it is very important to place the ICC in a context. The ICC focuses on cost per case, while the All-Payer Model has moved away from a singular focus on cost per case to total cost of hospital care on a per capita basis, with quality requirements. As indicated above, the staff intends to bring forward additional analysis and discussion on these topics for Commission and stakeholder review. The staff acknowledges that the ICC is not a complete measure of efficiency; the ICC is just one part of the measurement. Hospitals must address efficiency in utilization, and staff must evaluate the full financial requirements of a hospital in the context of the services regulated by the Commission.

Stakeholder Letters

1. Anne Arundel Medical Center (AAMC) and Johns Hopkins Health System (JHHS) both contended that the ICC policy recommendation did not attempt to further define potentially avoidable and unnecessary care, or excess utilization, nor did the policy recommendation propose a method for assessing a hospital's efficiency relative to excess utilization. As such staff is proposing an "ad hoc" evaluation of excess utilization devoid of clear clinical evidence. AAMC and JHHS also raised concerns about the policy recommendation's focus on the single metric for evaluating hospital efficiency, i.e., the cost per case evaluation tool outlined in the policy recommendation versus evaluating per capita performance and excess utilization.

   While staff acknowledges that it did not propose a new definition of excess utilization, e.g., a redefinition of the Potentially Avoidable Utilization (PAU) methodology currently employed by the HSCRC, staff asserts that numerous analyses in widely accepted health policy literature attest to the fact that excess utilization comprises up to 30% of healthcare expenditures.[1] PAUs, which incorporate unplanned readmissions and Prevention Quality Indicators (PQIs), represent part of avoidable utilization. Clearly, there is more work to

[1] For example, see: http://www.nationalacademies.org/hmd/~/media/Files/Report%20Files/2012/Best-Care/BestCareReportBrief.pdf http://www.healthaffairs.org/do/10.1377/hblog20140425.038647/full/, http://www.healthaffairs.org/do/10.1377/hpb20121213.959735/full/

be done on unnecessary utilization, and hospitals are well positioned to work with their medical staff to identify and prioritize efforts to reduce unnecessary and avoidable utilization.

Staff acknowledges the need to evaluate both cost per case and cost per capita performance, as well as utilization and quality performance in the context of the new Model. JHHS and other commenters have raised the idea of using a matrix to evaluate performance, whereby a hospital would be ranked on both cost per case and cost per capita in four quadrants. This matrix analysis could be used for efficiency measures in the context of ongoing hospital revenue adjustments and also in full rate reviews. Staff supports further development of this concept.

Staff recognizes that the ICC by itself does not measure excess utilization. However, it is universally recognized that a large portion of health care utilization is excessive, and it is up to the hospitals to show that they are offering the most effective and efficient services. Unnecessary and avoidable utilization cannot be considered efficient. AHRQ and the medical community will continue to define unnecessary and avoidable care. HSCRC will need to continue to develop measures of per capita performance and excess utilization. Presently, staff proposes to use the proposed ICC charge per case tool, which will be refined through engagement with a technical workgroup, and at the same time incorporate analyses of excess utilization and per capita performance as well as other evaluations of performance during "Phase II" of a full rate review. In the past, hospitals were able to address unique circumstances to the Commission, after the initial evaluation of cost per case performance. The staff has laid out a process in the proposed regulations that will address utilization and other evaluations of performance during this process.

2. AAMC, JHHS, and University of Maryland Medical System (UMMS) also expressed strong support for establishing a technical workgroup to vet the proposed modifications to the ICC as well as longer standing issues that have arisen due to the introduction of the new ICC methodology, most notably cycle billing and Equivalent Case Mix Adjusted Discharges (EMCADs).

   Staff intends to have multiple workgroup meetings over the next 90 days, or as needed, to refine the ICC methodology, particularly the proposed modifications and the data selected for inclusion in the ICC methodology. A detailed technical write-up and an ICC tool have been developed and will be shared with the technical workgroup prior to the first meeting. Subsequent workgroup meetings will focus on evaluation of proposed modifications and discussions of underlying policies. The ICC is a regulatory tool, and the staff will discuss the policies with the Commission, including potential modifications that arise through the technical workgroup.

   Specific ICC approaches and modifications that have been raised by stakeholders and Commissioners as necessary for review are: the discontinuation of the Disproportionate Share (DSH) adjustment, discontinuation of the capital adjustment, the proposal to use excess capacity in lieu of a state-wide productivity adjustment, the grouping and

weighted average calculation of labor market adjustments, and the trending forward of an Indirect Medical Education (IME) coefficient/adjustment, among others. Staff will review these policies and underlying calculations with the technical workgroup along with underlying data used in the ICC tool. Staff will also review issues arising from the use of ECMADs and evaluate the opportunity to obtain data to better address services that are cycle-billed.

FINAL RECOMMENDATIONS

In light of the change in the All-Payer Model from the historic cost-per-case focus to a per capita system with demonstrable care delivery and outcomes improvement requirements, the HSCRC staff makes the following recommendations for consideration:

1. Hospitals filing full rate reviews should demonstrate efficiency in both price and utilization, and the evaluation should consider the total hospital cost of care subject to the Commission's rate setting authority.

    a. Price efficiency (i.e., the cost of performing cases or episodes) should take into account ICC comparison results, supplemented with unit cost or other efficiency analysis of those "cycle billed" services excluded from the ICC. The rate setting process should also continue to consider other information and analysis supplied by the hospital or performed by HSCRC staff regarding efficiency.

    b. For evaluation of utilization efficiency, hospitals should be required to demonstrate that they are making substantial and ongoing progress in achieving more appropriate levels of care, reducing avoidable utilization, eliminating unnecessary care, and improving efficiency in the use of health care resources. They should also be expected to demonstrate that they are making substantial and specific efforts and investments to improve care and to reduce unnecessary care and potentially avoidable care. Additionally, the staff should be directed to consider reducing the allowed global budget of hospitals that have high levels of avoidable utilization and requiring them to achieve additional utilization efficiency over time.

    c. The evaluation should through this process take into account efficiency in both price and utilization of inpatient and outpatient regulated services.

2. The HSCRC staff should seek review from a technical workgroup on its proposed modifications to the Inter-hospital Cost Comparison. This group may provide input, similar to the Total Cost of Care Advisory Group, recognizing, however, that rate setting is a regulatory tool and does not lend itself to consensus-based input.

3. The HSCRC staff should evaluate an expansion of claims data submissions from hospitals for outpatient hospital claims that are “cycle billed claims” to allow for more accurate construction of ECMADs and benchmarks for the outpatient visits and episodes that are now excluded from the ICC.

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October 30, 2017

Allan Pack, Director
Population-Based Methodologies
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Pack:

The purpose of this letter is to provide our comments to the staff's draft paper titled "Recommendations for Updates to the Inter-hospital Cost Comparison Tool Program," from October 11, 2017. We appreciate the opportunity to present comments on behalf of Anne Arundel Medical Center (AAMC).

Excess Utilization

The staff paper states the following:

> In addition to providing evidence of price per service efficiency, hospitals, especially when they file a full rate application seeking higher global revenue budgets, should be expected to demonstrate that they are making substantial and demonstrable ongoing progress in achieving more appropriate levels of care, eliminating potentially avoidable and unnecessary care and improving efficiency in the use of health care resources. They should also be expected to demonstrate that they are making substantial and specific efforts to improve care and to reduce unnecessary care in key areas that have been shown by the health services literature to be particularly problematic (p. 5).

The overuse of services, the use of clinically ineffective services, and the lack of care coordination are all legitimate issues for consideration in the delivery of services within the healthcare system. To the degree that they occur within the scope of a hospital's control, they are legitimate criteria for consideration in assessing a hospital's rate base. However, the ICC policy is not designed to solve the problems of the healthcare system at large but to assess the efficiency and effectiveness of a specific facility. That should be done within the context of a prospectively established methodology for establishing a standard that will be applied within the context of such a review.

The ICC methodology described in the document does not attempt to further define this potentially avoidable care beyond the definitions already used for other staff policies around PAUs. Nor is there any method for assessing a hospital's relative efficiency around this excess utilization beyond comparisons to peer hospitals.

Any policy around excess utilization should be vetted among stakeholders with clear definitions of what is considered excess utilization, based on clear clinical evidence that is broadly accepted by the clinical community and with clear methods for establishing standards by which an applicant hospital will be compared. This should not be an ad hoc discussion based on staff judgment and negotiation aside from the data-based standard developed through the ICC model.

Productivity Adjustment and Per Capita Costs

As a historical part of the ICC methodology, the Commission has required a productivity adjustment for a hospital to qualify for a rate increase under the methodology. The logic has been that to demonstrate efficiency, the applicant hospital should have costs below the average structure of similar hospitals — recognizing that the average falls below the most inefficient hospitals but above the most efficient facilities. The productivity standard is then designed to develop a standard that requires hospitals to display efficient use of resources to qualify for an increase in rates under the full review methodology.

The staff recommendation applies a different logic. It correctly recognizes that excess capacity has developed in the hospital system under the GBR methodology — hospitals have been provided incentives to reduce volume without financial penalty, so facilities with declining volume have retained revenue. The staff argues that these hospital peer group comparisons therefore do not constitute an efficient standard without further adjustment. Undoubtedly, this is true, but it raises two important issues.

First is the issue of calculation of the efficiency standard itself. The staff paper proposes an excess capacity measure based on volume growth from 2010 through 2017 including observation cases greater than 23 hours. However, HSCRC policy included an 85 percent variable cost factor until 2014 and then shifted to a 50 variable cost factor as part of the market shift calculation under the GBR policy. Any consideration of excess capacity should account for the shift in policy regime over that time. Furthermore, we believe that **only the GBR era (the period from 2014 forward) should be used for the calculation given that was the time period of focus on population health and reducing unnecessary utilization**. And finally, **including only the observation cases over 23 hours ignores the fact that observation cases under 23 hours use hospital bed capacity, inappropriately counting that utilization as excess**. After all, these beds are occupied even if the patient stays less than the threshold.

Second is the issue of equitable treatment of hospitals within the system under the GBR model. The HSCRC has historically sought to tie hospital rates to a facility's underlying costs for efficient and effective care. While that definition has evolved over the years with the advent of new data

collection and enhanced quality measures, the link between cost and rates has been a fundamental concept for sustainability of the system.

In moving to the use of global budgets, the HSCRC has recognized that a proper consideration of efficient care is to consider the total cost of care for a patient and that traditional fee-for-service medicine provided incentives that do not align with coordinated care to achieve total cost of care efficiency. While this broader consideration is valid and in line with the HSCRC's attempt to achieve the triple aim, the GBR policy has not been designed for long-run efficiency. Under the current model, the revenue that is retained by facilities with declining volume resides there indefinitely, with only a market shift policy to reallocate revenue between facilities. And this policy has proven to be insensitive generally, reallocating only $0.25 to $0.30 per dollar of revenue shifted between hospitals. Over time, revenue continues to reside with hospitals that are no longer providing patient services. If these reductions are truly for avoidable utilization, this might be understandable. However, it is not clear that reductions in utilization are unnecessary utilization only. Good volume shifting to other facilities is therefore not funded at a reasonable level (or even at the designed 50%) to pay for the necessary care.

This retention of revenue in the short run may provide the desired incentives to break the economic link between volume and revenue, but **without some mechanism to ultimately tie revenue to the underlying costs of care, the system risks limiting access to care at some facilities and endangers the financial sustainability of hospitals taking up the slack for patients seeking care elsewhere**. This decoupling of revenue from volume entirely violates the principle that revenue should follow the patient and results in a system with an irrational reward distribution of revenue, leading potentially to the de-funding and rationing of necessary care.

While the GBR provides strong incentives as a short run approach to shifting economic incentives away from a volume-driven system, **the Commission needs a system to realign revenue with the costs of care in the long run**. Otherwise, the system will not be sustainable. Hence, there should be consideration of both charge per case (CPC) as the staff is proposing in the revised ICC methodology and hospital revenue per capita: two dimensions for evaluating hospital efficiency instead of a single metric. This could be done in terms of an analysis of per-capita hospital spending in the primary service area (or even the extended primary service area) along with an analysis of adjusted CPC. Hospitals that are high in both per-capita spending and CPC are clear candidates for revenue rebasing reductions. Hospitals with low CPC and low per-capita spending are clear candidates to consider for potential rate relief.

Labor Market

The labor market adjustor in the Reasonableness of Charges (ROC) methodology and the ICC was developed through extensive analysis by industry representatives along with the HSCRC staff and was adopted as policy by the Commission. While there are potentially good reasons to shift from the existing methodology to a labor market adjustor based on data reported to CMS, the staff report provides no analysis of any data or any empirical justification for the choice of

only two labor market groups across the state. Unanswered are questions about differences between the Eastern Shore versus Western Maryland and how Baltimore City compares with the rest of the state. **To the degree that the data indicate that these labor markets are homogeneous, this policy would be appropriate. However, no methodology has been described and no data have been presented to demonstrate that result**. These results should be presented to the Technical Review Group and made available publically for comment prior to a Commission vote.

Other Issues

Cycle Billing

The difficulties to the system from cycle-billed accounts are well known, and the staff's proposed approach recognized the need to consistently evaluate hospitals in the ICC – which cannot be done under the existing inconsistencies with cycle-bill reporting. Before the proposed approach is adopted, however, a clear methodology needs to be articulated on how this revenue will be defined and excluded from the ICC methodology. For the overhead revenue that is proposed to be left in the calculation, there needs to be a clear articulation of the methodology and modeling of the results to understand the impact. The staff should provide a clear statement of why the overhead in these centers is not accurate as well – and what should be done going forward to correct this misalignment.

ECMAD

The basic volume statistic for the full review methodology is the equivalent case mix adjusted discharge, a method for converting outpatient revenue to its inpatient equivalent to develop an overall volume measure. However, ECMADs have shown different trends than in system volume growth than growth measured by units in the past. The staff has spent time to understand this issue, and while cycle-billed accounts account for part of the problem, they do not appear to be the entire source of the discrepancy. Many hospital experts have contended for years that the methodology also does not adequately give credit/weighting for observation patients who often require as much resource provision as do inpatient admissions. **Because a correct volume statistic is vital to an accurate assessment under the ICC, the ECMAD approach should be assessed to be sure that volumes are appropriately measured**.

Technical Review Group

The staff paper calls for a Technical Review Group to vet the proposed ICC methodology changes:

> The HSCRC staff should seek review from a Technical Review Group on its proposed modifications to the Inter-hospital Cost Comparison. This group may provide input, similar to the Total Cost of Care Advisory Group, but rate setting is a regulatory tool and does not lend itself to consensus-based input (p. 11).

Good ideas can come from an open, public discussion of stakeholders. While the Commission and its staff have the responsibility for a consistent, integrated, and equitable policy for hospital regulation, that policy may be developed through a number of approaches. By seeking input, alternative approaches can be considered and weighed appropriately. The Commission may not achieve consensus, but stakeholders will better understand the thought process in the development of methodologies along with the details of the methodology and its application along with an understanding of the underlying data and principles used in its development. While that process will never achieve complete consensus, it will bolster confidence in the integrity and fairness of the regulatory process. Policies developed in the black box or a regulatory vacuum rarely achieve either result.

Further Comments

The process for establishing the standard for rates needs to be clearly specified under the Commission's policy. Crucial to the determination of the standard are issues such as

- What data are to be used?
- How is permanent revenue defined?
- What volume numbers are used in this calculation?

Technical details of this nature may be addressed by the Technical Review Group to be assembled by the staff, but these issues need to be understood more generally and documented for all stakeholders.

Thank you again for the opportunity to provide comments. We look forward to continuing to work with you and the HSCRC staff. Please let me know how we can be of further assistance to you.

Sincerely,

Maulik Joshi, DrPH
Executive Vice President of Integrated Care Delivery &
Chief Operating Officer

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Chief Financial Officer

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JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

October 31, 2017

Allan Pack
Principal Deputy Director for
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Pack:

The purpose of this letter is to provide our comments to the staff's draft paper titled "Recommendations for Updates to the Inter-hospital Cost Comparison Tool Program," from October 11, 2017. We appreciate the opportunity to present comments on behalf of the Johns Hopkins Health System.

Excess Utilization

The staff paper states the following:

> In addition to providing evidence of price per service efficiency, hospitals, especially when they file a full rate application seeking higher global revenue budgets, should be expected to demonstrate that they are making substantial and demonstrable ongoing progress in achieving more appropriate levels of care, eliminating potentially avoidable and unnecessary care and improving efficiency in the use of health care resources. They should also be expected to demonstrate that they are making substantial and specific efforts to improve care and to reduce unnecessary care in key areas that have been shown by the health services literature to be particularly problematic (p. 5).

The overuse of services, the use of clinically ineffective services, and the lack of care coordination are all legitimate issues for consideration in the delivery of services within the healthcare system. To the degree that they occur within the scope of a hospital's control, they are legitimate criteria for consideration in assessing a hospital's rate base. However, the ICC policy is not designed to solve the problems of the healthcare system at large but to assess the efficiency and effectiveness of a specific facility. That should be done within the context of a prospectively established methodology for establishing a standard that will be applied within the context of such a review.

The ICC methodology described in this document does not attempt to further define this potentially avoidable care beyond the definitions already used for other staff policies around PAUs. Nor is there any

method for assessing a hospital's relative efficiency around this excess utilization beyond comparisons to peer hospitals.

Any policy around excess utilization should be vetted among stakeholders with clear definitions of what is considered excess utilization, based on clear clinical evidence that is broadly accepted by the clinical community and with clear methods for establishing standards by which an applicant hospital will be compared. This should not be an ad hoc discussion based on staff judgment and negotiation aside from the data-based standard developed through the ICC model.

Productivity Adjustment

As a historical part of the ICC methodology, the Commission has required a productivity adjustment for a hospital to qualify for a rate increase under the methodology. The logic has been that to demonstrate efficiency, the applicant hospital should have costs below the average structure of similar hospitals — recognizing that the average falls below the most inefficient hospitals but above the most efficient facilities. The productivity standard is then designed to develop a standard that requires hospitals to display efficient use of resources to quality for an increase in rates under the full review methodology.

The staff recommendation applies a different logic. It correctly recognizes that excess capacity has developed in the hospital system under the GBR methodology — hospitals have been provided incentives to reduce volume without financial penalty, so facilities with declining volume have retained revenue. The staff argues that these hospital peer group comparisons therefore do not constitute an efficient standard without further adjustment. Undoubtedly, this is true, but it raises two important issues.

First is the issue of calculating the efficiency standard itself. The staff paper proposes an excess capacity measure based on volume growth from 2010 through 2017 including observation cases greater than 23 hours. However, HSCRC policy included an 85 percent variable cost factor until 2014 and then shifted to a 50 percent variable cost factor as part of the market shift calculation under the GBR policy. Any consideration of excess capacity should account for the shift in policy regime over that time. Further, including only the observation cases over 23 hours ignores the fact that observation cases under 23 hours use hospital bed capacity, inappropriately counting that utilization as excess. After all, these beds are occupied even if the patient stays less than the threshold.

Second is the issue of equitable treatment of hospitals within the system under the GBR model. The HSCRC has historically sought to tie hospital rates to a facility's underlying costs for efficient and effective care. While that definition has evolved other the years with the advent of new data collection and enhanced quality measures, the link between cost and rates has been a fundamental concept for sustainability of the system.

In moving to the use of global budgets, the HSCRC has recognized that a proper consideration of efficient care is to consider the total cost of care for a patient and that traditional fee-for-service medicine provided incentives that do not align with coordinated care to achieve total cost of care efficiency. While this broader consideration is valid and in line with the HSCRC's attempt to achieve the triple aim, the GBR policy has not been designed for long-run efficiency. Under the current model, the revenue that is retained by facilities with declining volume resides there indefinitely, with only a market shift policy to reallocate revenue between facilities. And this policy has proven to be insensitive generally, reallocating on $0.25 to $0.30 per dollar of revenue shifted between hospitals.

Over time, revenue continues to reside with hospitals that are no longer providing patient services – an explicit reward for reduced utilization. If these reductions are truly for avoidable utilization, this might be understandable. However, it is not clear that reductions in utilization are just unnecessary utilization. GBR provides incentives to reduce utilization, so the low rates of partial funding for volumes that are shifting to other facilities may not pay for necessary care.

This retention of revenue in the short run may provide the desired incentives to break the economic link between volume and revenue, but without some mechanism to ultimately tie revenue to the underlying costs of care, the system risks limiting access to care at some facilities and endangers the financial sustainability of hospitals taking up the slack for patients seeking care elsewhere. This decoupling of revenue from volume entirely violates the principle that revenue should follow the patient and results in a system with an irrational distribution of revenue.

While the GBR provides strong incentives as a short run approach to shifting economic incentives away from a volume-driven system, the Commission needs a system to realign revenue with the costs of care in the long run. Otherwise, the system will not be sustainable. Hence, there should be consideration of both charge per case (CPC) as the staff is proposing in the revised ICC methodology and hospital revenue per capita: two dimensions for evaluating hospital efficiency instead of a single metric. This could be done in terms of an analysis of per-capita hospital spending in the primary service area (or even the extended primary service area) along with an analysis of adjusted CPC. Hospitals that are high in both per-capita spending and CPC are clear candidates for revenue rebasing. Hospitals with low CPC and low per-capita spending are clear candidates to consider for potential rate relief. When a hospital is high on one count and low on the other, their case for rate relief is less clear and should depend on the specific circumstances of any request being made.

DSH in Efficiency Measurement

As the HSCRC staff has revised the Commission's efficiency methodology, it has reconsidered the adjustments made to charges that recognize social costs lying outside the hospital's control. Adjustments have typically included markups in rates for uncompensated care, direct medical education costs, the hospital's case mix, capital costs, and an empirical adjustment for indirect medical education (IME) and disproportionate share costs (DSH).

The staff has proposed several revisions to the efficiency methodology (formerly the Reasonableness of Charges analysis and before that the screens), including changes to the IME-DSH methodology. The staff has argued that the DSH adjustment should be eliminated because the substantial expansion of Medicaid expansion in the State has mitigated the need for adjustments for low income populations, following the national policy initiatives advocated by MedPAC and CMS. The staff's argument in the proposed ICC policy misinterprets the purpose of the DSH measure, however. In national policy, the term *disproportionate share* is a financial adjustment that recognizes the large amount of uncompensated care borne by hospitals when they serve large populations of poor patients. In the Maryland All Payer System, an uncompensated care policy is designed to build reasonable levels of uncompensated care into rates through the rate-setting process.

In the HSCRC efficiency models, the *disproportionate share* measure is a recognition of higher costs associated with treating poor populations. These costs include security costs for patients, staff, and their families. They also include longer hospital stays when clinicians do not discharge patients into

environments without social support. Finally, these patients may have higher acuity associated with lack of access to care prior to their Medicaid coverage under the ACA expansion and social determinants of health that are largely unchanged with the acquisition of healthcare coverage. The financial measure from national policy is clearly related to the efficiency measure incorporated into the previous models for comparing relative hospital rates, but the two measures are distinct. Access to expanded Medicaid may reduce the financial needs for hospitals, but the Medicaid expansion is unlikely to solve social issues that create inefficiency in treating these populations. Hence, these social costs still need to be addressed as a cost outside the hospital's direct control in treating poor populations. While the draft policy states that these differences are no longer observed empirically, no analysis or empirical evidence is provided to document those results. These results should be assessed by the Technical Review Group and made available for public comment prior to a Commission vote.

Labor Market

The labor market adjustor in the Reasonableness of Charges (ROC) methodology and the ICC was developed through extensive analysis by industry representatives along with the HSCRC staff and was adopted as policy by the Commission. While there are potentially good reasons to shift from the existing methodology to a labor market adjustor based on data reported to CMS, the staff report provides no analysis of any data or any empirical justification for the choice of only two labor market groups across the state. Unanswered are questions about differences between the Eastern Shore versus Western Maryland and how Baltimore City compares with the rest of the state. To the degree that the data indicate that these labor markets are homogeneous, this policy would be appropriate. However, no methodology has been described and no data have been presented to demonstrate that result. These results should be presented to the Technical Review Group and made available publically for comment prior to a Commission vote.

Capital Costs

The staff paper correctly states that HSCRC policy calls for the phase out of the capital cost adjustment to allow for some consideration of hospital-specific costs. However the phase-out was approved under the charge per case payment methodology at a time when the Reasonableness of Charges (ROC) was still in effect. With the shift to GBR and the discontinued use of the ROC in payment methodologies the HSCRC should evaluate whether the phase-out is still appropriate under the GBR methodology.

Indirect Medical Education

While the staff paper relies on the last published ROC in FY2011 and its underlying methodology as the basis for the IME adjustment discussed in the staff recommendation, the last actual ROC used in Commission policy was in 2014 for the Commission's comments on the Washington Adventist CON application. There is no explanation for the process arrived at choosing which estimate should form the basis of the staff calculation.

In addition the coefficient produced by the regression is dependent on all of the other variables used in the calculation. The IME policy should be evaluated by the staff and Technical Review Group once the other factors outlined in this comment letter have been appropriately addressed.

Technical Review Group

The staff paper calls for a Technical Review Group to vet the proposed ICC methodology changes:

> The HSCRC staff should seek review from a Technical Review Group on its proposed modifications to the Inter-hospital Cost Comparison. This group may provide input, similar to the Total Cost of Care Advisory Group, but rate setting is a regulatory tool and does not lend itself to consensus-based input (p. 11).

We welcome the input from a Technical Review Group but challenge the dismissive comment that the policy does not lend itself to consensus-based input. Commission policies should be developed within the context of an open, public discussion. While it is true that policies cannot be developed with complete consensus, the staff paper misses the point of public discussion of these methodologies. First, the Commission and its staff need to understand the viewpoint of stakeholders in the system. The HSCRC staff is filled with talented and committed professionals, but few of them have clinical or administrative experience with either a hospital, provider, or payer. The reality of healthcare can seem quite different from the practitioner's perspective than the health policy perspective. There are institutional details that matter in the delivery of services that may not seem important from the high-level perspective of healthcare policy but matter to patients and practitioners for the quality of care, patient satisfaction, providers' job satisfaction, and financial sustainability of the hospital. These viewpoints need to be considered.

Good ideas can come from many quarters. While the Commission and its staff have the responsibility for a consistent, integrated, and equitable policy for hospital regulation, that policy may be developed through a number of approaches. By seeking input, alternative approaches can be considered and weighed appropriately. The Commission may not achieve consensus, but stakeholders will better understand the thought process in the development of methodologies along with the details of the methodology and its application along with an understanding of the underlying data and principles used in its development. While that process will never achieve complete consensus, it will bolster confidence in the integrity and fairness of the regulatory process. Policies developed in the black box or a regulatory vacuum rarely achieve either result.

Cycle Billing

The difficulties to the system from cycle-billed accounts are well known, and the staff's proposed approach recognized the need to consistently evaluate hospitals in the ICC – which cannot be done under the existing inconsistencies with cycle-bill reporting. Before the proposed approach is adopted, however, a clear methodology needs to be articulated on how this revenue will be defined and excluded from the ICC methodology. For the overhead revenue that is proposed to be left in the calculation, there needs to be a clear articulation of the methodology and modeling of the results to understand the impact. The staff should provide a clear statement of why the overhead in these centers is not accurate as well – and what should be done going forward to correct this misalignment.

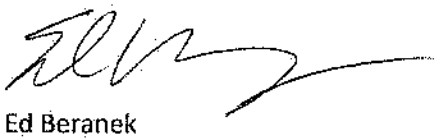
ECMAD

The basic volume statistic for the full review methodology is the equivalent case mix adjusted discharge, a method for converting outpatient revenue to its inpatient equivalent to develop an overall volume

measure. However, ECMADs have shown different trends than in system volume growth that growth measured by units in the past. The staff has spent time on to understand this issue, and while cycle-billed accounts account for part of the problem, they do not appear to be the entire source of the discrepancy. Because a correct volume statistic is vital to an accurate assessment under the ICC, the ECMAD approach should be assessed to be sure that volumes are appropriately measured.

We appreciate the opportunity to comment on this proposed policy. If you have any questions, please contact me at (443) 997-0631.

Sincerely,



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Vice President of Revenue Management and Reimbursement
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CORPORATE OFFICE

October 31, 2017

Allan Pack
Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Pack:

The purpose of this letter is to provide comments on COMAR 10.37.10 and the staff recommendation on Updates to the Inter-Hospital Cost Comparison Tool Program on behalf of the University of Maryland Medical System. These proposed regulatory changes are designed to update the HSCRC's requirements for hospital's seeking full rate reviews, making the approach compatible with the All Payer Model adopted in 2014. These changes create a necessary alignment between the model and the Commission's administrative responsibility to review the adequacy of a hospital's rate structure under Maryland law.

There are three components of the proposed regulations our letter addresses:

1) The amount of hospital specific information requested and the open-ended requirements not explicitly defined;
2) The intent of the requirement for health system information
   and
3) Technical adjustments included in the proposed ICC methodology

Hospital Specific Information Requirements

UMMS supports the general revisions to the regulations and understands the need to collect a broad range of information to provide a complete financial picture for the Commission to understand a petitioning hospital's financial

needs. However, these requirements should not be so burdensome that it is impractical for hospitals to file and have a rate review docketed for the Commission's consideration. The extensive and open-ended list of requirements in the proposed regulations seemed designed as a barrier to filing more than a reasonable list of information for assessing a hospital's financial needs. Much of the information is duplicative of information already reported to the Commission, and the requirement to provide multiple years of data already available to the Commission simply increases the time required to construct the application and raises the cost to approach the Commission for administrative relief. This is ironic for an administrative review that stresses hospital efficiency.

The regulations should lay out clear requirements for what a hospital needs to submit for an application to be docketed for Commission consideration. The proposed regulations call for any information that the staff deems necessary to assess the hospital's request. While it may be necessary for Commission staff to request additional information after it reviews an application, it should not be able to withhold consideration while probing endlessly for additional information that may or may not be central to understanding a hospital's rate request. From the current proposed regulations, the path for a hospital to get its application docketed is not clear and cannot be clarified as long as non-specific, open-ended requirements remain as part of the language for *filing* the application for a full review.

Intent of Health System Information

Further, UMMS is concerned about the requirements for system information for a hospital that is part of a system. The review should not be a full review of the hospital's system but of the specific facility's needs. While there are legitimate elements of system membership to consider due to the joint costs for services allocated to the specific facility, the consideration of system membership should be limited. The full review process is a consideration of a hospital's rates, not the entire system's performance. The information for understanding the system relationship to the facility should be limited to those purposes and not an unlimited exploration of the system's information.

Technical Updates to the Inter-hospital Cost Comparison Tool Program

ECMADs- The staff paper proposes to utilize the current ECMAD methodology as the basis for counting volume while excluding ECMAD data for cycle billed visits. While UMMS agrees that cycle billed accounts are problematic, several options exist for correcting visit counts for these patients. A modification to the ECMAD calculation should be evaluated to include these case types instead of excluding them. In the event that an alternative calculation is not viable, UMMS believes that ALL case types identified in the staff recommendation (clinics, infusions and related drugs, radiation therapy, physical therapy, and outpatient psychiatry visits) be excluded for ALL hospitals to maintain consistency when comparing hospitals to their peers. In addition to the cycle billed visits, other discrepancies in volume measurement between ECMADs and hospital units exist that suggest the ECMAD methodology does not adequately reflect appropriate changes in volume or intensity (i.e., secondary procedures in the operating room or Emergency Room visit intensity). We believe that these issues should be reconciled and resolved to ensure appropriate measurement of volume prior to using ECMADs as the volume standard in an ICC methodology.

Outpatient Drug Overhead Adjustment - The staff paper proposes to include all outpatient drug overhead while excluding cycle billed cases, including infusion and chemotherapy patients. We agree that allocating overhead to the cycle-billed patients is problematic when using cost as the basis, but retaining the entire overhead amount in the ICC comparison causes a mismatch between cost and volume. This mismatch will cause the drug overhead associated with cycle billed patients to be treated as excess cost. An alternative approach to allocating overhead should be vetted through the Technical Review Group in lieu of no adjustment.

Indirect Medical Education - The staff paper proposes to use the average cost per resident from 2011, inflated forward. This IME amount was calculated under the previous ICC methodology, when adjustments for DSH and a detailed Labor Market Adjustment were also made. The IME has historically been the last adjustment in the ROC/ICC methodology and it has long since been understood that any costs which are not adequately captured via other adjustments are captured within the IME adjustment itself. By choosing and IME amount from a prior period and eliminating or minimizing other adjustments that were made during that same period, the ICC will now treat costs associated with Disproportionate Share and Labor Market as unexplained variations in cost.

Labor Market Adjustment - The staff paper proposes that the Labor Market Adjustment be modified to include two sets of hospital groupings until the CMS labor market data for 2017 is available. While UMMS agrees that the transition to CMS's national methodology makes sense, the use of only two groupings does not adequately adjust for variations in wages across the state. Historically, the labor market adjustment showed variations in wage indices of over 10%. By transitioning to a two grouping adjustment, the adjustment becomes inadequate and variations in labor cost will now be treated as unexplained.

Capital Cost Adjustment- The staff paper states that HSCRC policy calls for the phase out of the capital cost adjustment to allow for some consideration of hospital-specific costs. However, it states that the ten-year phase out has elapsed. The policy was adopted on June 9, 2010 when the Commission adopted the staff recommendation "Final Recommendation for Revisions to the Reasonableness of Charges (ROC) Methodology for FY2011, and therefore the phase out should continue under current policy through FY2020.

Disproportionate Share Adjustment (DSH) - The staff paper proposes to eliminate the DSH adjustment in the proposed ICC methodology. In the HSCRC efficiency models, the disproportionate share measure is a recognition of higher costs associated with treating poor populations. These costs include security costs for patients, staff, and their families. They also include longer hospital stays when clinicians do not discharge patients into environments without social support. Additionally, these patients may have higher acuity associated with lack of access to care prior to their Medicaid coverage under the ACA expansion and social determinants of health that are largely unchanged with the acquisition of healthcare coverage. Access to expanded Medicaid may reduce the financial needs for hospitals, but the Medicaid expansion is unlikely to solve social issues that create inefficiency in treating these populations. Hence, these social costs still need to be addressed as a cost outside the hospital's direct control in treating poor populations.

Excess Capacity & Productivity Adjustment - The staff paper proposes an excess capacity measure based on volume growth from 2010 through 2017 including observation cases greater than 23 hours. The HSCRC policy included an 85 percent variable cost factor until 2014 and then shifted to a 50 variable cost factor as part of the market shift calculation under the GBR policy. Any consideration of excess capacity should account for the shift in policy regime over that time. Further, including only the observation cases over 23 hours ignores the fact that observation cases under 23 hours use hospital bed capacity, inappropriately counting that utilization as excess.

UMMS appreciates the opportunity to comment on these regulations. While revisions are necessary to modernize the regulations to align with the All Payer Model, they should be clarified to require the information necessary to support a hospital's rate request in an efficient manner with clear guidelines for providing an application that will be docketed by the staff. In addition, technical calculations and modifications should be vetted with industry representatives to allow for thorough evaluation of all options. We look forward to participating on the Technical Review Group to further discuss these important and complicated issues. Please contact me if you have any questions.

Sincerely,

Alicia Cunningham

Senior Vice President, Reimbursement & Revenue Advisory Services

Cc: Donna Kinzer, Jerry Schmith, Hank Franey

COMAR 10.37.10
Rate Application and Approval Procedures

Submitted Comments

Anne Arundel Medical Center
2001 Medical Parkway
Annapolis, Md. 21401
443-481-1000
askAAMC.org

October 30, 2017

Diana Kemp, Regulations Coordinator
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Kemp:

The purpose of this letter is to provide comments on COMAR 10.37.10 on behalf of Anne Arundel Medical Center (AAMC). We understand that the intent of the proposed regulatory changes is to update the HSCRC's requirements for hospitals seeking full rate reviews, making the approach compatible with the All Payer Model adopted in 2014.

Data Submission Requirements

We understand the need to collect a broad range of information to provide a complete financial picture for the Commission to understand a petitioning hospital's financial needs. However, the extensive and open-ended list of requirements in the proposed regulations seem designed to be a barrier to filing rather than a reasonable list of information for assessing a hospital's financial needs.

The newly proposed data submission requirements are excessively burdensome and redundant – requiring submission of multiple years of information that the Commission already collects, expansions of existing required reporting, and the inclusion of reports that are no longer required for general reporting purposes by the Commission (such as the detailed reporting regarding hospitals' use of population health infrastructure money included in rates.) While the Commission may require additional information of applicant hospitals to understand and test the need for additional funding in rates, the level of detail specified here is excessive.

The regulations should also provide clear requirements for what a hospital needs to submit for an application to be docketed for Commission consideration along with the standards by which the hospital will be evaluated. The proposed regulations allow staff to request any information deemed necessary to assess the hospital's request. While it may be necessary for Commission staff to request additional information after it reviews an application, staff should not be allowed to halt processing the application while seeking supplemental information. As currently proposed regulations are worded, the path for a hospital to get its application docketed is not clear and remains open to interpretation because non-specific, open-ended requirements remain as part of the language for *filing* the application for a full review.

Data Comparability and Context

The information to be collected under these regulations has limited value in the context of a full rate review because it allows the Commission to see only the applicant's activities without any context for comparison with other hospitals' activities. For some limited activities, this may have value, but without appropriate context, this review approach could lead to inappropriate, inaccurate subjective interpretation. Detailed, hospital-specific data requests would best be left to answer specific questions in the course of the full review, and not as a requirement for initially docketing every hospital's application whether the information is applicable or not.

Departure from the Foundational Tenets of the HSCRC

Expanded information can provide a more complete picture of a health system's activities, but the detailed information required here goes beyond gaining an understanding of the hospital's activities and toward the Commission's managing the facility, which is inappropriate. The Commission's historic philosophy for rate regulation has been to provide revenue sufficient for efficient and effective hospitals, using a data-driven standard supplemented by consideration of special circumstances for unique factors outside the hospital's control. The rate review process was meant to be an assessment of a hospital's rates based on comparisons to peer hospitals, neither an assessment of a hospital's management nor a determination of the adequacy of a hospital's profits.

These new regulations appear to signal a departure from that approach. In discussing these regulations and the ICC methodology in public meetings, the staff has indicated that the ICC is not the end all and be all of a full review process, and that it is just one tool. This viewpoint is clearly borne out by the data submissions required under the proposed regulations. However, the full rate review process should not be a subjective determination but rather a formal process with coherent, transparent policy to guide it. Otherwise, the Commission risks shifting standards, and compromising equity and consistency in the application of its methodologies across hospitals, thus fostering a mistrustful relationship shrouded in non-transparent processes.

Policy Clarity and Transparency

Applicant hospitals should have a clear understanding of how they will be evaluated prior to the filing of an application, either through the regulations or through supporting policies that have been subject to the input of system stakeholders. The proposed regulations refer to a methodology for evaluating the adequacy of hospital's rate structure, but no clear methodology exists in these regulations being proposed. Under current regulations, the HSCRC is required to have a new methodology approved by the expiration of the moratorium on full rate reviews on October 31, 2017 (COMAR 10.37.10.03A). Aside from a staff paper that outlines a general approach for the full review, however, there has been no public vetting of a methodology to date, and no details of the approach have been presented so that the approach can be modeled with any specificity.

And finally, the proposed regulations should be clarified to require the information necessary to support a hospital's rate request in an efficient manner with clear guidelines for providing an application that will be docketed by the staff. The regulations or supporting Commission policies should clarify the specific method(s) for evaluating applicant hospitals so that the standards of review are clear in advance of applications.

Thank you again for the opportunity to provide comments. We look forward to continuing to work with you and the HSCRC staff. Please let me know how we can be of further assistance to you.

Sincerely,

Maulik Joshi, DrPH
Executive Vice President of Integrated Care Delivery &
Chief Operating Officer

Bob Reilly
Chief Financial Officer

Cc: Victoria Bayless, President & Chief Executive Officer, AAMC
Nelson J. Sabatini, Chairman, HSCRC
Donna Kinzer, Executive Director, HSCRC

MedStar Health

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October 31, 2017

Diana Kemp
Regulations Coordinator
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Kemp:

On behalf of MedStar Health Member Hospitals, we support the Maryland Hospital Association's letter and recommendations related to COMAR 10.37.03 Types and Classes of Charges Which Cannot Be Changed Without Prior Commission Approval. We also believe there is a need to align this regulation with related Health Services Cost Review Commission (HSCRC) policies, Global Budget Revenue (GBR) agreements, and informal HSCRC staff guidance and we want to emphasize a few key areas that need to be addressed.

We believe MHA's proposal, along with setting rates based on the most current volumes, will decrease the operational challenges and administrative burden placed on the Hospitals as well as the HSCRC as it will appropriately align unit rates with the GBR target. It will also help address the misalignment that currently exists between rates charged and rate orders, which raises questions with other regulatory bodies and payors, including the CMS subcontractor RTI. Without this resetting of unit rates, imposing standard price compliance corridors in a policy will not be achievable.

Also, before any interim unit price corridor policy is recommended, we would hope there would be additional conversations with stakeholders to ensure that the policy can be operationalized and that the recommendation would address the identified issues/problems and not create additional challenges. For example, given the fluctuation in unit rate volumes , creating monthly compliance corridors will not be achievable. Additionally, constraining corridors for supplies and drugs and basing corridors on revenue and not utilization creates significant challenges to meet unit rate compliance and the GBR target.

This is an area that we believe has become overly complex over the last several years and we have substantial opportunity to simplify and achieve the outcomes anticipated. As we continue to work on all the other programs/changes to transform the delivery system in Maryland, this would be a positive step in eliminating operational challenges and align regulations with written policies. We appreciate the opportunity to provide input and look forward to continuing to work with you during this time of significant change.

Sincerely,

Kathy Talbot

Kathy Talbot
Vice President of Reimbursement
MedStar Health, Inc.

Cc: Nelson Sabatini, Chairman, Health Services Cost Review Commission
Donna Kinzer, Executive Director, Health Services Cost Review Commission
Susan Nelson, EVP, Chief Financial Officer, MedStar Health

Maryland
Hospital Association

October 27, 2017

Diana Kemp
Regulations Coordinator
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Kemp:

On behalf of Maryland's 47 acute care hospitals, we appreciate the opportunity to submit comments as part of the mandatory Regulatory Review for years 2012-2020, concerning Subtitle 37 Health Services Cost Review Commission. We have attached specific comments on the following chapters:

10.37.02	Standards of Rate Review
10.37.03	Types and Classes of Charges Which Cannot Be Charged Without Prior Commission Approval
10.37.08	Conduct of Public Meetings
10.37.09	Fee Assessment for Financing Hospital Uncompensated Care
10.37.10	Rate Application and Approval Procedures
10.37.11	Rules of Procedure; Related Institutions

Last month, MHA submitted written comments on Chapter 10.37.10, Rate Application and Approval Procedures; we have attached an additional copy of that comment letter with this submission.

As a general rule, our comments on each of these regulations are designed to update them in a manner consistent with Maryland's all-payer model, or in recognition of the many years that have passed since the regulations were established. We submit these comments in the spirit of collaboration that has been the hallmark of the commission's work to improve the rate-setting process.

We look forward to further dialogue with the commission about the comments on the attached regulations. As always, if you have any questions, please contact me at 443-561-2030.

Sincerely,

Michael B. Robbins

Michael B. Robbins
Senior Vice President

Maryland
Hospital Association

October 27, 2017

Diana Kemp
Regulations Coordinator
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Kemp:

Comments Regarding 10.37.02 Standards of Rate Review

Under Sub-Section (.02) (C) (2), regarding merged or consolidated hospitals, we recommend that the last sentence be deleted. The regulation, as written, applies the variable cost factor to the number of inpatient admissions at the closed hospital, as "applied to the *average cost of hospitals in the screening group* of the closed hospital (adjusted for wage differences as appropriate) (my emphasis)." To our knowledge, no such screening group average cost exists, nor would we recommend the development of such an average cost *per admission* under the incentives of Maryland's global budget system. We recommend that a separate approach be developed for this alternative costing mechanism, perhaps derived from the Inter-hospital Cost Comparison (ICC) methodology to be developed under Chapter 10.37.10. We would be willing to work with commission staff on alternatives to the current approach contained in 10.37.02 (02) (C) (2).

Sincerely,

Michael B. Robbins

Michael B. Robbins
Senior Vice President

Maryland
Hospital Association

October 27, 2017

Diana Kemp
Regulations Coordinator
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Kemp:

Comments Regarding 10.37.03 Types and Classes of Charges Which Cannot Be Changed Without Prior Commission Approval

On behalf of the Maryland Hospital Association's 64 member hospitals and health systems, are submitting our comment letter on COMAR 10.37.03 – Types and Classes of Charges Which Cannot be Changed Without Prior Commission Approval. We believe that there is a need to align this regulation with related Health Services Cost Review Commission (HSCRC) policies, Global Budget Revenue (GBR) agreements, and informal HSCRC staff guidance.

Background
Historically, the HSCRC established charge compliance rules in COMAR through the authority in its enabling statutes. Health General 19-219 provides broad authority for the HSCRC to set rates based on reasonable costs.

> Health General 19-219
> (b) Power to approve rate or amount of revenue. --
> (1) To carry out its powers under subsection (a) of this section, the Commission may review and approve or disapprove the reasonableness of any rate or amount of revenue that a facility sets or requests.
> (2) A facility shall:
> (i) Charge for services only at a rate set in accordance with this subtitle

The HSCRC implements hospital charging standards, corridors and penalties in COMAR 10.37.03.

> 10.37.03.01 – Change in Rates: A hospital may not increase any existing rate or charge of any class or type or impose any new rate or charge of any class or type without the approval of the Commission, except for those changes specifically excepted by regulation or order of the Commission.

10.37.03.05 – Overcharges and Undercharges:

A. For purposes of this regulation, the following definitions apply:

(1) "Overcharge" means any charge for a hospital service under the jurisdiction of the Commission that is in excess of its approved rate.

(2) "Undercharge" means any charge for a hospital service under the jurisdiction of the Commission that is less than its approved rate.

B. When any hospital overcharges by more than the allowed corridors, as defined in §G of this regulation, that overcharge shall be recovered in prospective rates at 140 percent plus appropriate interest factors.

C. When any hospital overcharges less than the allowed corridor, as defined in §G of this regulation, that overcharge shall be reduced from prospectively approved rates at the actual amount of overcharge plus appropriate interest.

D. When any hospital undercharges more than 2 percent in obstetrics, nursery, labor and delivery, clinic, emergency room, pediatrics, or intensive care units, that undercharge may not be recovered in prospective periods.

E. When any hospital undercharges less than 2 percent in the patient service centers listed in §D of this regulation, that undercharge shall be added to prospectively approved rates at the actual amount of undercharges.

F. When a hospital undercharges beyond the allowed corridors, as defined in this section, the amount of undercharge in excess of the corridors less 40 percent shall be added to prospectively approved rates. These allowed undercharge corridors are defined as follows:

(1) Patient care areas, when the unit of service is a patient day, not listed in §D of this regulation ----- 3 percent;

(2) Admissions center ---------- 3 percent;

(3) Ancillary service areas and ambulatory service areas not listed in §D of this regulation ---------- 5 percent.

G. Overcharge Corridors and Pricing for Medical/Surgical Supplies and Drugs.

(1) The allowed overcharge corridors are defined as follows:

(a) Daily patient care areas, ambulatory service areas, and admissions center ---------- 2 percent;

(b) Labor and delivery room ---------- 3 percent;

(c) Renal dialysis ---------- 5 percent;

(d) Ancillary service areas other than labor and delivery room and renal dialysis ---------- 3 percent.

(2) There are no price corridors for medical/surgical supplies and drugs.

H. Notwithstanding this regulation, if any hospital's net overcharges are more than 1 percent of the hospital's total approved revenue, that overcharge shall be recovered in prospective rates at 140 percent plus appropriate interest factors.

I. In cases when a flagrant disregard of approved rates is found, the Commission may require direct repayment of overcharges and penalties to those patients who were overcharged.

J. The Commission may assess penalties as described in this regulation, for rates approved effective July 1, 1978.

As reflected in 10.37.03, this regulation is outdated and should be modernized. In addition to conflicting with unit rate compliance language in the GBR agreement and informal HSCRC staff guidance, this regulation does not reflect the GBR target compliance corridors, the GBR interim (six month) compliance requirements and the applicable penalties for non-compliance with the GBR target.

Historically, HSCRC staff measured unit rate compliance both at year end, and on an interim or "rolling" basis for a specific period. For interim compliance, hospitals could be penalized if they were outside of the allowable corridors for more than three consecutive months. (Prior to three months, interim compliance was measured on a six month basis.) HSCRC *monitored* unit rate compliance on a monthly basis, but did not impose penalties unless the hospital was out of compliance for more than three consecutive months.

All-Payer Demonstration Model

Since implementing global budgets, including Total Patient Revenue (TPR), Maryland's hospitals have been required to comply with an overall GBR "cap" by adjusting unit prices relative to underlying service use. The fundamental incentive of a global budget is to establish a predetermined revenue cap to encourage hospitals to reduce unnecessary or avoidable service use.

Under the current All-Payer Demonstration Model (Waiver), several statutes grant the HSCRC specific authority to implement global budgets and underlying charge structures to support global budgets.

Health General 19-207(b)(9) grants HSCRC the authority to enact global budgets.

> Health General 19-207
> (b) General duties. -- In addition to the duties set forth elsewhere in this subtitle, the Commission shall:
>> (9) Beginning October 1, 2014, and, subject to item (10)(ii) of this subsection, every 6 months thereafter, submit to the Governor, the Secretary, and, subject to § 2-1246 of the State Government Article, the General Assembly an update on the status of the State's compliance with the provisions of Maryland's all-payer model contract, including:
>>> (iii) Actions approved and considered by the Commission to promote alternative methods of rate determination and payment of an experimental nature, as authorized under § 19-219(c)(2) of this subtitle.

Beyond establishing the HSCRC's broad rate setting authority, Health General 19-219 authorizes compliance with the terms and conditions of Maryland's all-payer model, and establishes alternate methods of rate determination, including global budgets.

> Health General 19-219
> (b) Power to approve rate or amount of revenue.

> (1) To carry out its powers under subsection (a) of this section, the Commission may review and approve or disapprove the reasonableness of any rate or amount of revenue that a facility sets or requests.
> (2) A facility shall:
> > (i) Charge for services only at a rate set in accordance with this subtitle; and (c) Consistent with Maryland's all-payer model contract approved by the federal Center for Medicare and Medicaid Innovation, and notwithstanding any other provision of this subtitle, the Commission may:
> > > (1) Establish hospital rate levels and rate increases in the aggregate or on a hospital-specific basis; and
> > > (2) Promote and approve alternative methods of rate determination and payment of an experimental nature for the duration of the all-payer model contract.

Health General 19-212 specifies establishing global budgets and associated limits.

> Health General 19-212
> (6) Develop guidelines for the establishment of global budgets for each facility under Maryland's all-payer model contract, including guidelines to prevent facilities from taking actions to meet a budget that the Commission determines would have adverse consequences for recipients or purchasers of services;
> (7) Receive confirmation from Commission staff that facility global budget agreements, as they are developed, are consistent with the guidelines; and
> (8) After review by the Commission for compliance with the guidelines, post each executed global budget agreement on the Commission's Web site

To implement appropriate unit rate charge compliance, the HSCRC included language in its GBR agreement and subsequent addendums.

> GBR agreement and addendums
> V. Compliance
> > B. Unit Rate Flexibility
> > The hospital be expected to monitor and its unit charges on an ongoing basis to ensure that it operates within the Annual Regulated Revenue that is approved by the HSCRC under the GBR model… The HSCRC will relax the unit rate compliance corridors that is general applies to hospitals. *(Presumably from COMAR regulations?)* Specifically, the Hospital will be permitted to charge at a level up to five percent (5 percent) above (or below) the approved individual unit rates without penalty. This limit may be extended to ten percent (10 percent) at the discretion of the HSCRC staff if the Hospital presents satisfactory evidence that it would not otherwise be able to achieve its approved total revenue for the Rate Year. Charges beyond the corridors shall be subject to penalties as specified in HSCRC regulations in COMAR 10.37.03.05.

On March 20, 2015, HSCRC staff sent a memorandum on unit rate compliance to hospital Chief Financial Officers.

The memorandum clarified that:

- Supporting documentation should be supplied for any request to expand unit rate corridors to +/- 10 percent.
- Interim penalties for three consecutive months' unit rate non-compliance, sometimes referred to as the rolling month penalties, *are not being imposed*
- Unit rate compliance will be measured for the full rate year. However, compliance is measured by staff monthly, and any large shifts among centers will be addressed.

Recent Interpretation, Considerations and Recommendations
As reflected above, while the statutes provide the HSCRC authority to implement global budgets and appropriate limits, COMAR, GBR agreements and staff policies are inconsistent. The GBR agreement refers to penalties under COMAR 10.37.03.05. However, the enabling statues appear to give deference to the GBR agreements to measure unit rate compliance and impose penalties for non-compliance.

There are several considerations that we believe require clear guidance and alignment between COMAR, the GBR addendum and HSCRC staff policy. Recent Commission rate setting practices and the calculation of underlying unit rates are included in these considerations.

1) **Use of most current period volume to set unit rates** – Historically, HSCRC staff used the most recent prior period rate center units to set underlying unit rates. For example, July 1 unit rates were calculated using actual, unadjusted 12 months of rate center volume for the period ending June 30. Since the inception of GBR, HSCRC staff use rate year 2013 units, adjusted for market shift and other across the board volume changes. The 2013 volumes are realigned, but not updated, using the most recent period actual data. Using the 2013 volumes disconnects the GBR cap and actual unit rate charging from unit rate compliance. As volumes increase or decrease, hospitals adjust prices to achieve the GBR cap. In many hospitals, unit rate volumes have changed significantly from 2013 to the most recent period, beyond the price corridors. Using older volumes – even with adjustments and realigned on new experience – will result in an unofficial spenddown if hospitals cannot recover their allowed global budget.

   HSCRC staff stated that use of the 2013 GBR base period unit rate volume would remain in place until an efficiency measure is developed. HSCRC recently proposed its Inter-hospital Cost Comparison (ICC) methodology, therefore it is time to "rebase" unit rate volumes to the appropriate current period, and continue to rebase in each annual rate order. Rebasing unit rate volume will create less pressure on unit rate compliance corridors as unit rates will be much closer to actual charging practices. This step alone may mitigate the need for several recommendations because hospital rates will agree to the GBR, causing most hospitals to be within the current allowable corridors.

2) **Consecutive month rate compliance** – The March 20, 2015 addendum specifies that interim or "rolling" compliance penalties are not being imposed. At MHA's August 10 Financial Technical Work Group, HSCRC staff informed the field that interim compliance penalties may be imposed if a hospital beyond its approved corridor in *any* single month. This seems to contrast with the March 20, 2015 guidance. The GBR addendum states that charges beyond the corridors may be subject to penalties, but the addendum does not specify what time period will be used for measurement.

3) **Supply and drug price compliance** – Under GBR, HSCRC staff measure supply and drug price compliance on a *revenue* basis, not a unit rate basis. Charging for supplies and drugs is very different than charging a typically unit rate. For a typical unit rate, the hospital can "fix" the price of the unit and charge accordingly. Unit pricing can be "fixed" in the face of seasonality or change in service mix. Hospitals use hundreds and thousands of supplies every day, many with different prices, making it difficult to charge within +/- 5 percent, or even +/- 10 percent of approved revenue on a monthly basis. Increases or decreases in supply and drug use will lead to hospitals needing to change mark-ups to meet a fixed revenue target. This can be the result of seasonality, or, a change in the mix of surgical and non-surgical cases, etc.

4) **Unit rate corridors to achieve GBR compliance** – As reflected in GBR agreements, hospitals may vary unit rate charge up to +/- 5 percent without permission, and may vary unit rate charges up to +/- 10 percent with HSCRC staff permission.

   An increase to +/- 10 percent is only valid for a specified period and must be accompanied by an "acceptable" explanation and supporting documentation. Hospital staff and HSCRC staff may engage in a lengthy exchange of correspondence before an agreement is reached, challenging the ability to achieve compliance on a timely basis. This practice also places a heavy administrative burden on HSCRC staff and on Maryland's hospitals, diverting resources that could be used to transform care delivery under the All-Payer Model.

   There is no standard process, documentation or explanation that HSCRC staff prescribes to grant corridor increases. Therefore, it is difficult to predict what information the HSCRC staff will want to support the request.

   A global budget system has one true incentive – the hospital receives a fixed level of revenue, even when it reduces avoidable utilization. Artificially limiting unit rate corridors stifles the incentive to reduce avoidable utilization beyond a certain point. We are aware that other factors, market shift, etc., may cause changes in hospital volume and may require a corresponding adjustment to the GBR cap. These other factors should complement, not supersede, the ability to raise and lower rates to achieve GBR compliance.

In certain cases, the HSCRC requires, recommends or otherwise allows hospitals to tier certain unit rates. For example, in a January 18, 2012 memorandum, the HSCRC mandated that hospitals established a tiered charging structure for supplies and drugs. Informally, it is recommended that hospitals tier the Same Day Surgery (SDS) rate to differentiate charges for the amount of post-surgical recovery time required, and tier the Clinic (CL) rate to differentiate the resources used by different types of clinics. Hospitals are also allowed to tier their 100 percent inpatient "room and board" rates to reflect utilization differences during the stay. Tiering of these rates, supplies and drugs in particular, require corresponding compliance flexibility as long as the hospital maintains annual, unit rate price compliance, and overall GBR compliance.

5) **Unit rate compliance early in the rate year** – The hospital field appreciates the HSCRC's best efforts to issue rate orders in a timely manner, and hospitals attempt to project the subsequent year's rates for compliance. However, until a final rate order is received, hospitals are supposed to comply with the most recently issued rate order, which may be the prior year's order. If hospitals must comply with the prior year's order to achieve "monthly" compliance, then a final rate order is issued a month or two into the new rate year, unit rate compliance problems may arise because rates are realigned and rate factors are updated. This also challenges the ability to increase or decrease rates in tandem since realignment may affect individual rates differently.

   For a variety of reasons, several rate orders may be issued until a rate order is final. If hospitals are expected to comply with the final rate order for the month of July, unit rate corridor increases may need to be approved on a retroactive basis. Hospitals also have difficulty moving all rates in tandem if the final rate order varies from the preliminary rate orders.

6) **Mid-year rate adjustments and December 31 GBR compliance** – In recent years, HSCRC staff have implemented rate January 1 rate adjustments, in the middle of the rate year. In several cases, these mid-year adjustments were effective for the entire rate year, requiring hospitals to increase or reduce charges in the compressed period from January through June. Though both GBR and unit rates are adjusted, the compressed period can make it more difficult for hospitals to effectively raise or lower prices to achieve compliance.

   HSCRC staff have also required hospitals to comply with a six-month GBR target for the period July 1 through December 31. In order to achieve GBR compliance with the six month target, hospitals may need to raise or lower unit rates in this compressed period. To do so, hospitals often submit urgent requests to expand corridors, increasing the administrative burden on hospitals and HSCRC staff.

On behalf of the hospital field, MHA respectfully requests that HSCRC staff consider the following actions:

1) Update COMAR 10.37.03 to repeal sections D through F
2) Update COMAR 10.37.03 to include the following subsections:
    a. "Annual rate orders shall reflect the actual, unadjusted unit rate volume for the preceding twelve month period ending June 30 to set unit rates."
    b. "Unit rate compliance shall be measured on an annual, rate year basis for the purpose of enforcing unit rate penalties. An annual price corridor, the amount a hospital may charge above or below the established rate without penalty, shall be proposed by HSCRC staff and approved by the Commission. The annual price corridor may be changed with Commission approval. The current staff policy shall be reflected in the hospital's GBR agreement with the Commission. The price corridors shall be consistently applied across all hospitals."
    c. "GBR cap compliance shall be measured on an annual, rate year basis for the purpose of enforcing penalties. An annual price corridor, the amount a hospital may charge above or below the established rate without penalty, shall be proposed by HSCRC staff and approved by the Commission. The annual price corridor may be changed with Commission approval. The current staff policy shall be reflected in the hospital's GBR agreement with the Commission. The price corridors shall be consistently applied across all hospital."
        i. "Should Maryland's performance under the All-Payer Model be measured on a period different than the HSCRC rate year, HSCRC staff may impose interim GBR compliance targets and penalties, upon HSCRC staff recommendation and Commission approval."
    d. "HSCRC staff shall monitor unit rate compliance on an interim basis. Price corridors and penalties for non-compliance may be established by the Commission on an interim basis, if approved by the Commission."
3) The HSCRC staff should recommend a rate compliance policy to enforce the principles established in regulation. The policy should be reviewed and approved by the Commission in a public meeting, with the opportunity for public comment. Maryland's hospital's recommend the following be included in this proposed rate compliance policy:
    a. The existing GBR price corridors, penalties and compliance methodology, established by the HSCRC in GBR agreements, should be reflected in the proposed policy.
    b. The *annual* price compliance corridors for unit rate centers, except supplies and drugs, shall be +/- 5 percent, with the opportunity to request a +/- 10 percent *annual* corridor. HSCRC policies should be appropriately flexible to achieve GBR compliance. Maryland's hospitals should provide HSCRC staff sufficient lead time when requesting annual corridor changes, and the HSCRC staff should respond to the requests in a timely manner. Improving timeliness will allow appropriate management of corridors during the year and reduce potential price fluctuations.

c. If the HSCRC chooses to establish interim, unit rate price compliance corridors, the interim unit rate price corridors shall be *twice* the allowable annual corridors. The allowable annual corridors include approval by the commission to increase the corridor from +/- 5 percent to +/- 10 percent, and thus the interim corridors would reflect two times the annual, from +/- 10 percent to +/- 20 percent.
d. Should the HSCRC choose to establish price corridors on an interim basis, HSCRC staff should specify which rate order the hospital should comply with during the early part of the rate year. HSCRC staff should have flexibility to allow the hospital to charge to a projected set of unit rates, rather than the prior year rate order, if agreed to by the hospital and HSCRC.
e. Supply and drug revenue compliance *should not be measured on an interim basis* since the current measure is based on monthly revenue, subject to seasonality and sudden price changes. Measuring supply and drug revenue compliance on an interim basis often results in significant and sharp changes in supply and drug charges because of the underlying utilization. Supply and drug revenue compliance should be measured annually, with price corridors established at +/- 20 percent, allowing for greater flexibility needed for these unique charge structures. HSCRC staff and hospitals should evaluate alternative methods of supply and drug compliance, and, supply and drug revenue realignment as part of the annual rate order process.

4) Hospital should only prove the need to achieve GBR compliance as the reason to approve price corridor changes. The lone exception should be hospital disclosure of a moving a service or services unregulated setting. Hospital members have been asked to prove that unit price adjustments to achieve GBR compliance did not result from temporary market shifts or other matters that ultimately affect the GBR. This should not be required because the HSCRC has a market shift policy and other policies in place to adjust GBR revenues appropriately. Though the market shift adjustments reflect a six month lag, hospital GBR revenues will ultimately be adjusted appropriately by the HSCRC's methodology.
5) Mid-year rate adjustments should be limited to changes from Commission actions that occur during the year. Routine policy adjustments should be placed in rates July 1. The HSCRC's market shift adjustment is the lone exception as it is applied bi-annually to reflect changing market conditions.
6) HSCRC staff and hospitals should review rate realignment, including supplies and drugs, in the annual rate as certain rate centers have not been realigned in several years. The rate realignment methodology review should include how overhead costs are assigned to rate centers and how these costs are currently adjusted.
7) Changes to rate compliance regulations and Commission rate compliance policies should be clearly communicated to the Centers for Medicare and Medicaid Services (CMS) and their representatives responsible for analyzing the Maryland model.
8) HSCRC staff should provide clear, written guidance on rate compliance during the current fiscal year, fiscal year 2018, including a formal position on interim, unit rate compliance.

Thank you for your consideration of these important matters. MHA and Maryland's hospitals look forward to working with HSCRC staff to address these considerations. Should you have any questions, please call (410) 540-5060, or email bmccone@mhaonline.org. We are happy to discuss these issues in more detail at MHA's Technical Work Group or at a meeting of the HSCRC staff's request.

Sincerely,

Brett McCone
Vice President

Maryland
Hospital Association

October 27, 2017

Diana Kemp
Regulations Coordinator
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Kemp:

Comments Regarding 10.37.08 Conduct of Public Meetings

In order to improve the openness and transparency of the commission policy-making process, we recommend that Sub-section (.04) (Agenda) be substantially re-written. In developing the agenda for each public meeting, the executive director should be required to have *all* materials for *any* item on the agenda available for public review at least one (1) week prior to the public meeting, to allow for sufficient review by commissioners and the public before those items are discussed. In addition, to facilitate broad-based stakeholder input, public comment should be allowed on any item on the agenda, including those which may be included for information only by commission staff or other stakeholders. Finally, for the past few years, the commission has followed a process of having staff present policy recommendations in draft form in one month, followed by final action on a final staff policy recommendation at a subsequent meeting. We support this approach, and would recommend codifying that practice in this section of the regulation.

Under Sub-Section (.05) (Records), we recommend that, in addition to making meeting minutes available for public inspection at its offices, the commission should make minutes available on its website after they have been approved at a public meeting.

Finally, under Sub-section (.06) (Voting), we recommend deleting sub-section (D). It is our view that any commission vote should take place in a public meeting, so allowing each commissioner one vote on matters submitted for vote "between public meetings" would be inappropriate.

Sincerely,

Michael B. Robbins

Michael B. Robbins
Senior Vice President

Maryland
Hospital Association

October 27, 2017

Diana Kemp
Regulations Coordinator
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Kemp:

Comments Regarding 10.37.09 Fee Assessment for Financing Hospital Uncompensated Care

Under Sub-section (03) (A), we recommend deleting the words "By January 1, 2009," at the beginning of the first sentence.

Sincerely,

Michael B. Robbins

Michael B. Robbins
Senior Vice President

Maryland
Hospital Association

September 27, 2017

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 64 member hospitals and health systems, I am writing to comment on Health Services Cost Review Commission (HSCRC) regulation 10.37.10 – Rate Application and Approval Procedures. The commission approved emergency promulgation of this regulation at its September public meeting.

Background
A regular or "full" rate application is a structured administrative proceeding that allows Maryland's hospitals to seek rate relief from the commission. It is hospitals' only recourse to question rates and revenues they believe are unreasonable. A full rate application allows for the complete, open and transparent review of hospital rates and revenues by the commission, which means more than changing the global budget revenue cap. The process begins with application filing and HSCRC staff review, commission action, and if necessary, allows for a public hearing and judicial appeal. Maryland's hospitals have been prohibited from filing a full rate application since December 2015, even though the full rate application is a critical administrative proceeding under HSCRC regulation.

A rate efficiency methodology has not been proposed by HSCRC staff
Our most serious concern with adopting the regulation on an emergency basis is that the hospital comparison methodology is not yet complete. The moratorium on rate applications was to last until the commission adopted a rate efficiency, or Inter-hospital Cost Comparison measure, consistent with the All-Payer Model. The rate efficiency measure was originally scheduled to be in place on or about July 1, 2016, with the deadline further extended until October 31, 2017.

We appreciate HSCRC's efforts to meet the moratorium deadline, but are concerned about advancing regulations supported by a critical methodology that is not yet in place. Commission staff stated that the cost comparison methodology will be proposed at the October public meeting, just 22 days before the end of the moratorium. Following its proposal, HSCRC staff should immediately convene a work group to discuss the proposed methodology. Open communication and fair consideration of feedback from Maryland's hospitals will be crucial to creating an effective comparison methodology.

Section 10.37.10.04-1 describes using a rate efficiency methodology "with the appropriate adjustments to reflect changes in the hospital volume since the beginning of the new All-Payer Model agreement and the inception of (global budget revenue) agreements." We note that section 10.37.10.04-2(A) changes "reasonable rates" to "reasonable revenues." Though subtle, this change implies that revenue levels are affected by both price (rates), and service use (volume). The All-Payer Model reflects per capita revenue incentives. Maryland's hospitals will work with HSCRC staff to ensure that a new efficiency measure will align with the All-Payer Model's incentives.

Proposal Increases information required to submit application
Section 10.37.03.B reflects the information required to submit a full rate application, including many items already submitted by hospitals to HSCRC. These include Medicare's Interns and Residents Information System report files, lists of expensive outpatient drugs, and transactions with related entities. The proposed regulations require resubmitting the reconciliations of HSCRC abstract volumes to the monthly departmental revenues and statistics *for the last three years*. This level of detail is not necessary because commission staff can review the prior hospital submissions as needed.

Rate applications by hospitals in a system
Section 10.37.10.04-1.C proposes that the commission may take into account the financial situation of other Maryland hospitals if they are part of the same health system as the requesting hospital. Each Maryland hospital is allowed reasonable rates to provide efficient and effective services. Economies of scale and cost saving efforts lead to resource sharing among hospitals in a system. Should HSCRC staff and the commission choose to consider volumes and costs within a system, HSCRC staff and the commission should consider granting explicit, greater flexibility to share global budget revenue limits among the same hospitals.

References to global budget revenue methodology
We support the proposed updates to outdated references to charge-per-case target methodology. Many of the references in this regulation have been outdated since adoption of the All-Payer Model in 2014.

Alternative to evidentiary hearing
Section 10.37.10.11 proposes that the commission may allow written submissions to support an application in lieu of a public hearing. A hospital that chooses this process therefore waives its right to a hearing, though it retains its right to a judicial review of a final commission decision. A hospital may also choose to enter into a binding arbitration process as prescribed by the commission. These appear to be reasonable alternatives to a public hearing, giving each hospital the flexibility to appropriately address its issues.

Thank you for your consideration of these important matters. MHA and Maryland's hospitals look forward to working with HSCRC staff on the proposed regulations, and on a collaborative process to implement the new hospital comparison methodology in a timely fashion. Should you have any questions, please call (410) 540 5060, or email bmccone@mhaonline.org.

Sincerely,

Brett McCone
Vice President

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Adam Kane
Jack C. Keane
Donna Kinzer, Executive Director
Allan Pack, Director, Population Based Methodologies
Jerry Schmith, Director, Revenue and Compliance

Maryland
Hospital Association

October 27, 2017

Diana Kemp
Regulations Coordinator
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Kemp:

Comments Regarding 10.37.11 Rules of Procedure: Related Institutions

More than 40 years have passed since Sub-section (.02) was promulgated. There are a number of references in sections (.02) (B) – (G) that we believe are out of date and not consistent with current commission practice, particularly with regard to the Medicaid per diem, submission of Medicaid charge information, and updates to the Medicaid rate of increase in Sub-sections (B), (E), and (F).

Also, we recommend that Sub-section (D) should be amended to apply to all patients, not just non-Medicaid, and that consideration be given to allowing hospitals less than the current advance notice of thirty (30) days before rate changes are implemented, given the need for close adherence to commission rate compliance requirements under Chapter 10.37.03.

Finally, we ask the commission consider the applicability of Sub-sections (G) and (H) in light of the modernized all-payer model.

Sincerely,

Michael B. Robbins
Senior Vice President

Final Recommendation for the Medicare Performance Adjustment (MPA) for Rate Year 2020

November 13, 2017

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

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PROPOSED COMMISSION ACTION

Staff will be asking the Commission to vote on the final MPA recommendation for RY 2020. The final recommendation differs from the draft recommendation in two important ways. First, while the draft recommendation left open for discussion the possibility of using either a pre-set scale or a prospectively set methodology, the final recommendation from staff is to set the TCOC Trend Factor for RY 2020 at 0.33% below the national Medicare growth rate. Second, the final recommendation places greater emphasis of the importance of monitoring the MPA and sharing information with hospitals for RY 2020, and of assessing potential changes to the MPA for the RY2021 policy.

Final Recommendations for RY 2020 MPA Policy

1) Implement the Medicare Performance Adjustment, based on HSCRC calculations.
2) Measure TCOC using the hierarchical algorithm of ACO-Like, MDPCP-Like, and PSAP attribution.
3) Set the maximum penalty at 0.5% and the maximum reward at 0.5% of federal Medicare revenue with maximum performance thresholds of ±2%.
4) Include the MPA as part of the aggregate revenue at-risk under HSCRC quality programs.
5) Set the TCOC benchmark as each hospital's TCOC from 2017, updated with a Trend Factor of 0.33% below the national Medicare growth rate for CY 2018.
6) Continue to evaluate the MPA throughout the year and consider enhancements for a Year 2 MPA policy, obtaining input through continued meetings of the TCOC Workgroup.
7) Provide national Medicare growth rate estimates relative to Maryland throughout the year to help hospitals monitor their progress.
8) Work with CMS and CRISP to provide information to hospitals so they can more effectively engage in care coordination and quality improvement activities, assess their performance, and better manage the TCOC by working in alignment with both independent and affiliated providers whose beneficiaries they serve.

LIST OF ABBREVIATIONS

AAPM	Advanced Alternative Payment Model
ACO	Accountable Care Organization
CMS	Centers for Medicare & Medicaid Services
CY	Calendar Year
E&M	Evaluation and Management Codes
ECMAD	Equivalent case-mix adjusted discharge
FFS	Medicare Fee-For-Service
FFY	Federal Fiscal Year
FY	Fiscal Year
GBR	Global Budget Revenue
HSCRC	Health Services Cost Review Commission
MACRA	Medicare Access and CHIP Reauthorization Act of 2015
MHAC	Maryland Hospital-Acquired Conditions Program
MPA	Medicare Performance Adjustment
MDPCP	Maryland Primary Care Program
NPI	National Provider Identification
PCP	Primary Care Provider
PSA	Primary Service Area
RRIP	Readmission Reduction Incentive Program
RY	Rate Year
TCOC	Medicare Total Cost of Care

INTRODUCTION

The State of Maryland is leading an effort to transform its health care system by increasing the emphasis on patient-centered care, improving population health, and lowering health care costs. To achieve these goals, the State of Maryland worked closely with hospitals and the Center for Medicare & Medicaid Innovation (CMMI) at the federal Centers for Medicare & Medicaid Services (CMS) to develop the Maryland All-Payer Model, which was implemented in 2014. The State, in partnership with providers, payers, and consumers, has made significant progress in this statewide modernization effort. Under the State's existing All-Payer Model, Maryland hospitals participate in a global hospital payment system with both individual and shared responsibility for limiting cost growth, including Medicare's total cost of care (TCOC).

This document outlines how Maryland hospitals would assume increasing responsibility for limiting the growth in TCOC for Medicare Fee-for-Service (FFS) beneficiaries, working together with other providers, over time, beginning with performance in Calendar Year (CY) 2018. To incorporate this additional responsibility, Maryland will utilize a value-based payment adjustment, referred to as a Medicare Performance Adjustment (MPA). The MPA will place hospitals' federal Medicare payments at risk, based on the total cost of care for Medicare beneficiaries attributed to a hospital.

BACKGROUND

The Maryland Health Services Cost Review Commission (HSCRC) is a State agency with unique regulatory authority: for all acute-care hospitals in Maryland, HSCRC sets the amount that each hospital will be reimbursed by all payers. The federal government has granted Maryland the authority for HSCRC to set hospital payment rates for Medicare as part of its all-payer hospital rate-setting system. This all-payer rate-setting approach, which has been in place since 1977, eliminates cost-shifting among payers.

Beginning in 2014, the State and CMS entered into a new initiative to modernize Maryland's unique all-payer rate-setting system for hospital services. This initiative allows Maryland to adopt new and innovative policies aimed at reducing per capita hospital expenditures and improving patient health outcomes. Under this new initiative, hospital-level global budgets were established, so that each hospital's total annual revenue is known at the beginning of each fiscal year. Annual revenue is determined from a historical base period that is adjusted to account for inflation updates, infrastructure requirements, population-driven volume increases, performance in quality-based or efficiency-based programs, changes in payer mix, and changes in levels of uncompensated care. Annual revenue may also be modified for changes in services levels, market share shifts, or shifts of services to unregulated settings.

In December 2016, Maryland submitted a "Progression Plan" to CMS describing its goals and plans for an Enhanced TCOC All-Payer Model, under which the State will expand the Model's focus to incorporate the entire continuum of care. As part of this progression, the MPA is based on a TCOC measure, constructed by attributing all Maryland Medicare beneficiaries with Part A

and Part B FFS coverage to one or more hospitals. Their Medicare TCOC will include costs in both hospital and non-hospital settings. To incentivize increased focus on TCOC growth, the MPA would make a percentage adjustment to hospitals' federal Medicare payments. For its initial year (Performance Year 2018, affecting hospital payments from Medicare in Rate Year (RY) 2020), the MPA will be based on per capita TCOC spending for the beneficiaries attributed to a given hospital. (In future years, the MPA may also be formulated so that hospitals would share in statewide Medicare TCOC performance.)

To calculate the MPA percentage adjustment to each hospital's federal Medicare payments (limited in the first year to a positive or negative adjustment of no more than 0.5%), the policy must determine the following:

- An algorithm for attributing Maryland Medicare beneficiaries and their TCOC to one or more hospitals;
- A methodology for assessing hospitals' TCOC performance based on the beneficiaries and TCOC attributed to them; and
- A methodology for determining a hospital's MPA based on its TCOC performance.

The remainder of this document describes the recommendation for calculating the MPA for RY 2020, based on extensive feedback from the industry and other stakeholders through the Total Cost of Care Work Group and other meetings.

As with all of Maryland's value-based payment programs, HSCRC may modify this approach over time, based on experience, ongoing analyses, and input from stakeholders. The State's intent is to gradually increase the Maryland health care delivery system's responsibility for TCOC.

The key objective of the MPA for Year 1 is to further Maryland's progression toward developing the systems and mechanisms to control TCOC, by increasing hospital-specific responsibility for Medicare TCOC (Part A and B) over time — not only in terms of increased financial accountability, but also increased accountability for care, outcomes and population health.

To provide a mechanism to support aligned efforts by physicians/clinicians practicing at the hospital as well as those working in community settings, we are seeking to allow physicians/clinicians participating in Care Redesign Programs (e.g., HCIP and CCIP) to be eligible for bonuses and increased rates under the federal MACRA law.

ASSESSMENT

The HSCRC worked extensively with a stakeholder group, the Total Cost of Care Work Group, on the technical specifications to determine a hospital-specific measure of Medicare FFS TCOC. This recommendation reflects valuable insights provided by the work group—which has held regular public meetings over the past year—as well as analyses by HSCRC contractors LD

Consulting and Mathematica Policy Research (MPR) and other communications and meetings with health system stakeholders.

Based on the State's experience with performance-based payment adjustments, as well as guiding principles for quality payment programs from the HSCRC Performance Measurement Work Group, the TCOC Work Group discussed the following principles for the development of the Medicare Performance Adjustment (MPA):

1. **The hospital-specific measure for Medicare TCOC should have a broad scope**
   1.1. The TCOC measure should, in aggregate, cover all or nearly all Maryland FFS Medicare beneficiaries and their Medicare Part A and B costs.

2. **The measure should provide clear focus, goals, and incentives for transformation**
   2.1. Promote efficient, high quality and patient-centered delivery of care.
   2.2. Emphasize value.
   2.3. Promote new investments in care coordination.
   2.4. Encourage appropriate utilization and delivery of high quality care.
   2.5. The measure should be based on prospective or predictable populations that are "known" to hospitals.

3. **The measure should build on existing transformation efforts, including on current and future provider relationships already managed by hospitals or their partners.**

4. **Performance on the measure should reflect hospital and provider efforts to improve TCOC**
   4.1. Monitor and minimize fluctuation over time.
   4.2. Hospitals should have the ability to track their progress during the performance period and implement initiatives that affect their performance.
   4.3. The TCOC measure should reward hospitals for reductions in potentially avoidable utilization (e.g., preventable admissions), as well as for efficient, high-quality care episodes (e.g., 30- to 90-day episodes of care).
   4.4. Hospitals recognize the patients attributed to them and their influence on those patients' costs and outcomes

5. **Payment adjustments should provide calibrated levels of responsibility and should increase responsibility over time**
   5.1. Prospectively determine methodology for determining financial impact and targets.
   5.2. Payment adjustments should provide levels of responsibility calibrated to hospitals' roles and adaptability and revenue at-risk that can increase over time, similar to other quality and value-based performance programs.

Total Cost of Care Attribution Algorithm

Based on the Total Cost of Care Work Group's input and discussion, the staff developed a multi-step prospective attribution method. The method will assign beneficiaries and their costs to Maryland hospitals based primarily on beneficiaries' treatment relationship with a primary care provider (PCP) and that PCP's relationship to a hospital, based on a formal Accountable Care Organization (ACO) relationship or through the PCPs' hospital referral patterns. (See Appendix I for estimated timeline of algorithm assignment and ACO list submission.)

The TCOC Attribution Algorithm uses the following hierarchy (each method of attribution is explained more fully below): (1) ACO-like attribution; (2) Maryland Primary Care Program (MDPCP)-like attribution; and (3) Geographic attribution. This approach is intended to recognize that hospitals can identify and influence most easily the quality and costs of patients who use them and their affiliated providers, while ensuring that responsibility for other beneficiaries is equitably assigned. The State's objective is to focus hospitals and physicians/clinicians who practice at hospitals to work effectively with physicians/clinicians who work in the community to coordinate the care and the transitions of care, provide effective and efficient care, and to focus on high-needs beneficiaries in alignment. Through aligned efforts with both independent and affiliated physicians/clinicians, Maryland aims to provide better care while limiting the growth in total cost of care.

The total costs for a hospital's beneficiaries attributed through the ACO-like method, MDPCP-like method, and Geographic method will be summed and divided by the total number of beneficiaries attributed to the hospital through those methods to result in a single total cost of care per capita number.

$$Hospital\ Medicare\ TCOC\ per\ Capita = \frac{TCOC_{ACOlike} + TCOC_{MDPCPlike} + TCOC_{Geo}}{Benes_{ACOlike} + Benes_{MDPCPlike} + Benes_{Geo}}$$

ACO-like attribution

The ACO-like attribution enables hospitals that have already agreed to be accountable for beneficiaries in their ACO to build on those relationships. This step in the attribution is relevant for Maryland hospitals participating in the Medicare Shared Savings Program or Medicare Next Generation ACO Program. Assignment is based on elements of ACO attribution logic, which assigns beneficiaries to ACOs according to their PCP use, then specialist use if a PCP cannot be identified. Beneficiaries are assigned to ACOs according to their use of participating providers (Appendix II). Beneficiaries affiliated with the ACO are then attributed to hospitals affiliated with that ACO. (If an ACO does not have a Maryland hospital as a participant, it is not included in the algorithm.) Based on 2016 Medicare spending of beneficiaries modeled in the attribution algorithm, beneficiaries attributed through the ACO-like portion of the algorithm account for 29% of Maryland Medicare beneficiaries and 31% of the statewide Medicare TCOC.

HSCRC will rely on CMS-provided lists of ACO providers in November of each year to determine ACO participation for that Base Year and the upcoming Performance Year (Appendix I). Any changes to ACO provider lists throughout the year will not be included until the following Performance Year.

For ACOs with more than one hospital participating, the beneficiaries and their TCOC will be distributed in one of two ways. As outlined in the draft recommendation, the default approach is that beneficiaries will be distributed proportionally according to each participating hospital's Medicare market share (as measured by Equivalent Case-Mix Adjusted Discharges (ECMADs)) in the beneficiaries' place of residence. However, if the ACO's participating hospitals elect to designate their ACO PCPs to specific ACO hospitals, beneficiaries attributed to those PCPs will be attributed to the specific ACO hospital connected with that PCP, if approved by HSCRC.

Maryland Primary Care Program-like Attribution

Beneficiaries not assigned to hospitals through the ACO-like method will then be considered for attribution to hospitals based on beneficiaries' use of primary care providers and those providers' treatment relationships with hospitals. Beneficiaries' relationships with primary care providers are determined through their use of PCP services, as proposed in the MDPCP. Each provider is assigned to the hospital from which that provider's patients receive the plurality of their care. Primary care providers are defined by unique NPIs, regardless of practice location, and are not aggregated or attributed through practice group or TIN (Appendix II).

The method is similar to that by which beneficiaries are assigned to ACO providers; however, as with the ACO-like attribution, the MDPCP-like attribution can differ from the program on which it is based, if doing so more successfully aligns with the MPA principles laid out above. For example, although CMS ultimately decided that the MDPCP could not include any specialists, it was the general consensus of staff, TCOC WG members, and industry to permit the inclusion of certain specialists (if no other PCP was flagged and other criteria were met) in the MDPCP-like part of the MPA attribution algorithm (Appendix II). Based on 2016 Medicare spending of beneficiaries modeled in the attribution algorithm, beneficiaries attributed through the MDPCP-like portion of the algorithm account for 42% of Maryland Medicare beneficiaries and 52% of the statewide Medicare TCOC.

Geographic Attribution

The remaining beneficiaries and their TCOC — or the "residual of the residual" — will be assigned to hospitals based on geography. The Geographic methodology assigns zip codes to hospitals based on hospital primary service areas (PSAs) listed in hospitals' Global Budget Revenue (GBR) agreements. Zip codes not contained in a hospital's PSA are assigned to the hospital with the greatest share of hospital use in that zip code, or, if that hospital is not sufficiently nearby, to the nearest hospital. This approach is also referred to as PSA-Plus or PSAP (Appendix II). Based on 2016 Medicare spending of beneficiaries modeled in the attribution algorithm, beneficiaries attributed through the Geographic portion of the algorithm account for 29% of Maryland Medicare beneficiaries and 16% of the statewide Medicare TCOC.

Assessment Methods

Multiple options for assigning beneficiaries and their costs to hospitals were explored with the TCOC Work Group over the past several months. In developing this staff recommendation, HSCRC staff evaluated the methods selected for attribution based on the degree to which they conform to the principles laid out above. In particular, the following metrics were used to assess each option. Results for the final selected attribution algorithm are included below each metric.

Scope: Measured by the share of Medicare TCOC and beneficiaries attributed statewide.

- 100% of Maryland Medicare beneficiaries are attributed under the recommended approach.

Incentives: Measured by the share of Medicare TCOC and beneficiaries uniquely attributed to hospitals, in total and by hospital

- 75% of beneficiaries, with 92% of TCOC, are uniquely attributed to a system/hospital under the recommended approach. Beneficiaries are assigned to multiple systems/hospitals only if multiple systems/hospitals have claimed the same PSA.

Relation to existing efforts: Promoted by adopting existing ACO and primary-care arrangements, and measured by the extent to which these arrangements are reflected in the attribution.

- Combined, ACO-like and PCM-like yield attribution to hospitals of 71% of beneficiaries and 83% of TCOC under the recommended approach.

Hospital efforts reflected: The stability of attribution resulting from proposed methods to ensure that hospital efforts are reflected, measured as the share attributed to the same provider, hospital, and system (as applicable) in consecutive years.

- 87% of beneficiaries attributed to same system/hospital between 2015 and 2016 under the recommended approach (excluding beneficiaries who during those two years were newly enrolled, died, or otherwise were not in both years of data, with whose inclusion this number would be 82%).

Calibrated responsibility: Measured as the association of hospitals' Medicare revenue with the Medicare TCOC to which they were assigned responsibility, and the impact of current and proposed future payment adjustments on hospitals' revenues.

- 0.5% maximum revenue at risk for Y1 under the recommended approach.

These numbers reflect specific design choices, reflected in this recommendation, purposely designed to optimize the algorithm's first-year performance under the above measures. For example, 87% of beneficiaries were attributed to same system/hospital between 2015 and 2016 under the recommended approach for several reasons, including:

- Annual attribution is based on two years of data;
- Attribution is fixed prospectively, with changes during the Performance Year in physicians'/clinicians' participation in ACOs or beneficiaries' intrastate moves, for

example, not altering attribution; and

- The combination of all three components of the algorithm (i.e., ACO-like, MDPCP-like and Geography) ensures greater year-over-year consistency than any one component.

Performance Assessment

For Rate Year 2020, which is the MPA's first year of implementation, hospital performance on Medicare TCOC per capita in the performance year (CY 2018) will be compared against the TCOC Benchmark. The TCOC Benchmark will be the hospital's prior (CY 2017) TCOC per capita, updated by a TCOC Trend Factor determined by the Commission, as described in greater detail below. Thus, for Rate Year 2020, performance will be assessed based on each hospital's own improvement.

The attribution of Medicare beneficiaries to hospitals will be performed prospectively. Specifically, beneficiaries' connection to hospitals is determined based on the two Federal fiscal years preceding the performance year, so that hospitals can know in advance the beneficiaries for whom they will be assuming responsibility in the coming performance year. For attribution for Performance Year 2018, data for the two years ending September 30, 2017 will be used. For attribution for Base Year 2017, data for the two years ending September 30, 2016 will be used.

TCOC Trend Factor

The Final TCOC Trend Factor must be approved and determined by the Commission and approved by CMS before the MPA is applied, beginning July 1, 2019. Final TCOC data for the State and the nation are available in the May following the end of a calendar rear. For RY 2020, this means that CY 2018 performance data will be available in May 2019, and the MPA would be applied in July 2019.

HSCRC staff proposed that the TCOC Trend Factor should be set in reference to national Medicare FFS growth. However, some stakeholders expressed interest in fixing a pre-set Trend Factor prior to the start of the performance period. While this would give hospitals the appearance of greater certainty regarding the targets, a pre-set Trend Factor could result in problems if, for example, the Trend Factor was not set aggressively enough. If actual national Medicare growth was substantially lower than the projections on which the pre-set factor was based, hospitals could receive a reward even if the State had an unfavorable year compared to the nation. Such a scenario could cause concerns with model performance requirements, compelling the Commission to adjust the pre-set Trend Factor after the performance period, resulting in dissatisfaction due to changing expectations.

Although staff is concerned about balancing the needs for a prospective and predictable target, staff is recommending to prospectively set the methodology for the TCOC Trend Factor, but not to pre-set the specific target for the first performance year. The Final Recommendation is to set the TCOC Trend Factor for RY 2020 at 0.33% below the national growth rate, which is what is

currently calculated as necessary to attain the required Medicare TCOC savings by 2023 under the Enhanced TCOC Model.

Staff understands hospital concerns with this approach and will provide periodic updates and national projections to aid hospitals in their progress. The Commission may consider revisiting the use of a pre-set target in future years of the MPA as the Commission becomes more comfortable with performance under the Model.

Medicare Performance Adjustment Methodology

For each hospital, its TCOC Performance compared to the TCOC Benchmark, as well as an adjustment for quality, will be used to determine the MPA's scaled rewards and penalties. For RY 2020, the agreement with CMS requires the maximum penalty be set at 0.5% and the maximum reward at 0.5% of hospital federal Medicare revenue. The expectation is that the potential penalties and rewards will increase over time, as hospitals adapt to the new policy and desirable modifications are indicated, developed, and implemented.

The draft agreement with CMS also requires that the Maximum Performance Threshold (that is, the percentage above or below the TCOC Benchmark at which the Maximum Revenue at Risk is attained) be set at 2% for RY 2020. Before reaching the RY 2020 Maximum Revenue at Risk of ±0.5%, the Maximum Performance Threshold results in a scaled result — a reward or penalty equal to one-quarter of the percentage by which the hospital's TCOC differs from its TCOC target.

In addition, the draft agreement with CMS requires that a quality adjustment be applied. For RY 2020, the staff proposes to use the existing measures in the HSCRC's Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Infections (MHAC) to determine these quality adjustments; however, staff recognizes that the Commission may choose to revise the programs used for the quality adjustments over time, to increase the alignment between hospitals and other providers to improve coordination, transitions, and effective and efficient care. Both quality programs have maximum penalties of 2% and maximum rewards of 1%. The sum of the hospital's quality adjustments will be multiplied by the scaled adjustment (Appendix II). Regardless of the quality adjustment, the maximum reward and penalty of ±0.5% will not be exceeded.

With the maximum ±0.5% adjustment, staff recommends that the MPA be included in the HSCRC's portfolio of value-based programs and be counted as part of the aggregate revenue at-risk for HSCRC quality programs. Staff will examine the impact of including the MPA in aggregate revenue-at-risk from both Medicare and All-Payer perspectives.

MPA Implementation

Based on the hospital-specific MPA percentages calculated by HSCRC for Performance Year 2018, CMS can implement the MPA as an adjustment to hospitals' federal Medicare payments in Rate Year 2020. CMS continues to affirm its ability to implement the MPA based on its application of similar Medicare payment adjustments in other models (e.g., Next Generation ACOs, Comprehensive Primary Care Plus (CPC+)).

HSCRC staff intends to work with CMS and CRISP to provide hospitals with information so they can more effectively engage in care coordination and care improvement activities, assess their performance, and better manage TCOC in alignment with physicians/clinicians for beneficiaries attributed to them under the MPA. This information may include, as appropriate and consistent with federal and state privacy laws and requirements:

- List of PCPs whose beneficiaries are attributed to a hospital under the attribution algorithm
- List of beneficiaries attributed to a hospital under the attribution algorithm
- Reports of performance on the TCOC for each hospital relative to the attributed population during the performance year

Comments on Proposed MPA Algorithm and Recommendation

HSCRC staff received comments from the Maryland Hospital Association (MHA), Anne Arundel Medical Center (AAMC), University of Maryland Medical System (UMMS), as well as oral feedback in the last Commission meeting from CareFirst and MHA. While there were concerns raised over the attribution approach, comment letters were generally supportive of the MPA draft recommendation, but raised numerous issues that staff plans to explore with the TCOC Work Group for improving the MPA and its algorithm for RY 2021. Staff recognizes that there are advantages and disadvantages of any attribution approach; however, staff believes it is important to operate the MPA and to make adjustments to the approach based on learning from initial operations. Therefore, staff continues to recommend implementation in alignment with the State's draft agreement with CMS.

Continued support and interest in stakeholder engagement

Stakeholders expressed the importance of the TCOC Work Group in providing a venue for stakeholders to voice concerns, assess options based on analytic work, and suggest improvements. HSCRC staff agrees and will continue the TCOC Work Group. In November and throughout 2018, the work group will focus on implementation of the RY 2020 policy and potential improvements for the RY 2021 policy. Stakeholders must lead the effort of transformation in the State for it to be successful, and staff believes that the TCOC Work Group has provided a valuable forum to obtain input from stakeholders, as reflected in this recommendation. The staff is interested in inviting additional participation in the TCOC Work Group. For example, staff welcomes the expertise that CareFirst brings in focusing on high-needs beneficiaries and serving them and in operating one of the largest PCMH models for commercial beneficiaries in the nation.

Implementation
To be successful in TCOC performance, stakeholders noted the need to identify and engage beneficiaries who are most at risk. To address these concerns, HSCRC is actively working to provide data and reporting to hospitals. Through the Care Redesign Amendment, CMS will make data available for care redesign efforts through the participation agreement, subject to applicable requirements for data use. Hospitals can use this data to focus their efforts in coordination, care management resources, and efficiency. In addition, HSCRC staff have provided hospitals with lists of PCPs with beneficiaries attributed to hospitals under the ACO-like and MDPCP-like portions of the algorithm if the MPA had been in place for Performance Year 2016. These lists, including near term updates to the lists, can help hospitals identify physicians/clinicians with whom they should work to improve coordination and transitions of care. CRISP is working with hospitals and with HSCRC to produce reports that can assist hospitals in monitoring their performance under the MPA. With the TCOC Work Group, staff will also monitor data for any unintended consequences of MPA implementation.

Revenue at Risk
HSCRC staff agrees with the stakeholders that the revenue at risk under the MPA is included as part of the revenue at risk in HSCRC quality programs. The specific effects on the other quality measures will be addressed by the Commission when the broader set of RY 2020 quality policies are considered.

Benchmark/Trend Factor
Stakeholders acknowledged staff concerns about the accuracy of predicting a trend factor ahead of time, but supported the development of a pre-set trend factor prior to the start of the performance period. Based on prior experiences with pre-set factors, as under the Quality-Based Reimbursement (QBR) adjustment, HSCRC staff believes that it is preferable to align the MPA's TCOC Trend Factor with the State's goal of beating national Medicare TCOC growth by a certain percentage. However, staff is willing to consider a pre-set trend factor for future years, subject to Commissioners' review. In the meantime, HSCRC will provide national Medicare growth estimates less a savings requirement and actual growth throughout the year to help hospitals monitor their progress.

Performance assessment
Multiple stakeholders advocated for a policy that recognizes both attainment and improvement, which can address concerns about penalizing hospitals that have reduced total cost of care and explain some variation in spending growth. HSCRC staff recognizes the potential value of adding attainment to the assessment of TCOC under the MPA. However, staff recommends that the TCOC Work Group considers how to introduce attainment for the RY 2021 policy, due to the number of complicated issues to analyze, such as:

- Defining the attainment benchmark(s). (Options for benchmarks could include the lowest adjusted quartile of TCOC among Maryland hospitals, comparisons to best quartile of national benchmarks with peer groupings, among others.)

- When making comparisons across hospitals, adjusting for TCOC differences over which a hospital has little or no control. (Options could include adjustments for the population's health risks, dually-eligible status, demographic factors, as well as adjustments for other factors affecting cross-hospital TCOC comparisons, such as Graduate Medical Education payments and labor market differences.)
- Applying the appropriate blend of attainment versus improvement. (Options could include adjusting the MPA's TCOC Trend Factor based on performance on attainment, taking the better of improvement or attainment, or assigning shares of revenue at risk for attainment versus improvement.)

Other technical suggestions for review in RY 2021

Staff has incorporated some of the technical suggestions for Rate Year 2020, such as allowing ACOs to designate ACO physicians to specific ACO hospitals. The TCOC Work Group will explore the additional suggestions for Rate Year 2021, including attributing providers based on existing physician contractual relationships with hospitals or based on the plurality of weighted utilization measures instead of visits. Other issues raised that the TCOC Workgroup and staff plan to explore next year include modifications to the quality adjustment, a multi-year measurement approach, TCOC exclusions or adjustments based on type of spending, the relationship between actual and attributed TCOC, and the possibility of an all-geographic approach for some areas of the State. Staff looks forward to gaining insights on this issue from hospitals and clinicians for determining a potential RY 2021 policy.

RECOMMENDATIONS

Based on the assessment above, staff recommends the following for RY 2020 (with details as described above). The final recommendation differs from the draft recommendation in two important ways. First, while the draft recommendation left open for discussion the possibility of using either a pre-set scale or a prospectively set methodology, the final recommendation from staff is to set the TCOC Trend Factor for RY 2020 at 0.33% below the national Medicare growth rate. Second, the final recommendation places greater emphasis of the importance of monitoring the MPA and sharing information with hospitals for RY 2020, and of assessing potential changes to the MPA for the RY2021 policy.

1) Implement the Medicare Performance Adjustment, based on HSCRC calculations.
2) Measure TCOC using the hierarchical algorithm of ACO-Like, MDPCP-Like, and PSAP attribution.
3) Set the maximum penalty at 0.5% and the maximum reward at 0.5% of federal Medicare revenue with maximum performance thresholds of ±2%.
4) Include the MPA as part of the aggregate revenue at-risk under HSCRC quality programs.
5) Set the TCOC benchmark as each hospital's TCOC from 2017, updated with a Trend Factor of 0.33% below the national Medicare growth rate for CY 2018.

6) Continue to evaluate the MPA throughout the year and consider enhancements for a Year 2 MPA policy, obtaining input through continued meetings of the TCOC Workgroup.
7) Provide national Medicare growth rate estimates relative to Maryland throughout the year to help hospitals monitor their progress.
8) Work with CMS and CRISP to provide information to hospitals so they can more effectively engage in care coordination and quality improvement activities, assess their performance, and better manage the TCOC by working in alignment with both independent and affiliated providers whose beneficiaries they serve.

APPENDIX I. ESTIMATED ALGORITHM TIMELINE

Estimated Timing	Action
Oct-Nov 2017	CMS* provides HSCRC with ACO Participant List for Performance Year 2018 (also used for Base Year 2017)
Nov-Dec 2017	HSCRC runs attribution algorithm for Base Year 2017 and Performance Year 2018, and provides hospitals and CMS with attribution lists
January 2018	Performance Year begins

*Subject to change, dates as noted in https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/ACO-Participant-List-Agreement.pdf

APPENDIX II. TCOC ATTRIBUTION ALGORITHM

Eligible Population: Maryland Medicare Fee-for-Service beneficiaries, defined as Medicare beneficiaries who have at least one month of Part A and Part B enrollment during the previous two years and no months of HMO enrollment or enrollment in Part A or Part B alone, who resided in Maryland or in an out-of-state PSA claimed by a Maryland hospital.

Hierarchy: Maryland Medicare beneficiaries are first assessed for attribution to a hospital through the ACO-like method. Beneficiaries not attributed under ACO-like attribution (the first residual) are then assessed for attribution through the MDPCP-like attribution. Those not attributed through the MDPCP-like attribution (residual of the residual) are attributed through the Geographic attribution (PSA-Plus). This final step captures all remaining Maryland Medicare beneficiaries, including those with no previous claims experience because they are newly enrolled in Medicare.

Exclusions: Claims associated with categorically excluded conditions are removed prior to episode assignment. Claims in any setting from an episode beginning 3-days before and extending to 90-days after a hospital stay for such a condition are excluded from the TCOC and from the determination of ACO-like and PCM-like affiliation. These conditions are primarily transplants and burns identified by diagnoses, procedure codes and DRGs.

ACO-like Attribution

All beneficiaries are considered eligible for ACO-like attribution, and ACO-like attribution will be attempted for all. However, only ACOs with participating Maryland hospitals in the Medicare Shared Savings Program (MSSP) or Next Generation ACOs will be attributed beneficiaries through this method. Beneficiaries are attached to clinicians through use of professional services, while clinicians are attached to ACOs if their identifier appears on the ACO's participant list. HSCRC will rely on CMS-provided lists of ACO providers in November of each year to determine ACO participation for that Base Year and the upcoming Performance Year. Any changes to ACO provider lists throughout the year will not be included until the following Performance Year. Hospital affiliation is also identified through ACO participation, and only hospitals affiliated with a Maryland ACO are used for attribution.

Beneficiary-to-Provider attribution

Based on the two Federal Fiscal Years preceding the performance period, eligible beneficiaries with at least one visit for a primary care service are attributed to clinicians based on the plurality of allowed charges for primary care services. If the identified clinician is on a list of ACO providers, the beneficiary is attributed to the corresponding ACO. PCPs are identified based on specialty. Primary care services are identified by HCPCS codes and measured by allowed charges. If a beneficiary does not have any PCP visit claims, the same logic is performed for

clinicians of other specialties. PCP and selected specialties and codes for primary care services are presented below.

Provider-to-ACO attribution

Clinicians will be considered ACO providers if their National Provider Identification (NPI) number is included on an ACO list provided by CMMI and a Maryland hospital participates in that ACO.

ACO-to-Hospital attribution

Maryland hospitals participating in an ACO for the purposes of this method will be defined as hospitals listed on the Participant List of an ACO domiciled in Maryland. All beneficiaries and costs for beneficiaries of ACOs with a participating Maryland hospital will be attributed to that hospital. For ACOs with more than one hospital, beneficiaries and their TCOC will be attributed through one of two approaches. The default approach will be to distribute TCOC by Medicare market share to all hospitals in the ACO. However, if an ACO elects to designate ACO PCPs to specific ACO hospitals, beneficiaries attributed to those PCPs will be attributed to the specific ACO hospital connected with that PCP. This designation must occur before the Performance Year and cannot be changed once the current Performance Year has begun.

ACO Specialties

Primary Care Providers are defined as physicians with a primary specialty of Internal Medicine; General Practice; Geriatric Medicine; Family Practice; Pediatric Medicine, or non-physician primary care providers - Nurse Practitioners, Clinical Nurse Specialists, or Physician Assistant. Other specialties include Obstetrics/Gynecology; Osteopathy; Sports Medicine; Physical Medicine and Rehabilitation; Cardiology; Psychiatry; Geriatric Psychiatry; Pulmonary Disease; Hematology; Hematology/Oncology; Preventive Medicine; Neuropsychiatry; Medical or Gynecological Oncology or Nephrology.

ACO Primary Care Codes

Domiciliary, rest home or custodial care

- CPT 99324 – 99337
- CPT 99339 – 99340

Home services

- CPT 99341– 99496

Wellness visits

- CPT G0402, G0438 & G0439

New G code for outpatient hospital claims

- CPT G0463

Domiciliary, rest home or custodial care

- CPT 99324 – 99337
- CPT 99339 – 99340

Home services

- CPT 99341– 99496

Wellness visits

- CPT G0402, G0438 & G0439

New G code for outpatient hospital claims

- CPT G0463

MDPCP-like Attribution

After removing the cost and beneficiaries assigned to hospitals through the ACO-like method, hospitals will be assigned beneficiaries based on beneficiaries' primary care providers (identified based on primary care utilization) and hospitals used by the beneficiaries of those providers over the two Federal fiscal year period preceding the performance period. Assignment of beneficiaries to primary care providers is determined based on the beneficiaries' use of primary care services as originally proposed in the Maryland Primary Care Program (MDPCP) by the Maryland Department of Health (MDH) to CMMI. A PCP for this purpose includes traditional PCPs but also physicians from other selected specialties if the beneficiary has chosen that clinician to provide primary care. Each clinician is assigned to a hospital based on the hospital most used by the clinician's beneficiaries.

Beneficiary-to-Provider attribution

Primary care providers are attributed beneficiaries based on proposed MDPCP logic with minor adjustments. Each Medicare FFS beneficiary with Medicare Part A and Part B is assigned the National Provider Identification (NPI) number of the clinician who billed for the plurality of that beneficiary's office visits during the 24 month period preceding the performance period AND who also billed for a minimum of 25 Total Office Visits by attributed Maryland beneficiaries in the same performance period. If a beneficiary has an equal number of qualifying visits to more than one practice, the provider with the highest cost is used as a tie-breaker. Beneficiaries are

attributed to Traditional Primary Care Providers first and, if that is not possible, then to Specialist Primary Care Providers.

The cost of primary care services must represent 60% of total costs performed by a provider during the most recent 12 months, excluding hospital and emergency department costs. Primary care services are identified by procedure codes from the list appended below. Clinicians enrolled in the Next Generation ACO Model, ACO Investment Model, or Advanced Payment ACO Model; or any other program or model that includes a shared savings opportunity with Medicare FFS initiative are excluded. Primary care providers are defined as unique NPIs regardless of practice location and are not aggregated or attributed through practice group or TIN. (Unlike in the MDPCP, in the methodology used in the MPA attribution, there is no requirement on practice size. The MDPCP requires a practice to have a minimum of 150 Medicare beneficiaries.)

Provider-to-Hospital attribution

A provider and the beneficiaries and costs assigned to that provider's NPI are in turn assigned to a hospital based on the number of inpatient and outpatient hospital visits by the provider's attributed beneficiaries. All of the provider's beneficiaries are attributed to the hospital with the greatest number of visits by beneficiaries assigned to that provider. If a provider's beneficiaries have equal visits to more than one hospital, the provider is attributed to the hospital responsible for the greatest total hospital cost. Practice group and location do not impact provider to hospital attribution, nor does the number of practices or TINs to which the provider is affiliated.

MDPCP Eligible Specialties

Traditional Primary Care Providers are defined as providers with a primary specialty of Internal Medicine; General Practice; Geriatric Medicine; Family practice; Pediatric Medicine; Nurse Practitioner; or Obstetrics/Gynecology. Specialist Primary Care Providers are defined as providers with a primary specialty of Cardiology; Gastroenterology; Psychiatry; Pulmonary Disease; Hematology/Oncology; or Nephrology. These specialties may differ from those used in the MDPCP.

MDPCP Primary Care Codes

- Office/Outpatient Visit E&M (99201-99205 99211-99215);
- Complex Chronic Care Coordination Services (99487-99489);
- Transitional Care Management Services (99495-99496);
- Home Care (99341-99350);
- Welcome to Medicare and Annual Wellness Visits (G0402, G0438, G0439);
- Chronic Care Management Services (99490)
- Office Visits (M1A, M1B); Home Visit (M4A); Nursing Home Visit (M4B) BETOS Codes
- Specialist Visits (M5B, M5D); Consultations (M6) BETOS Codes
- Immunizations/Vaccinations (O1G) BETOS Codes

- Other Testing BETOS Codes (T2A Electrocardiograms, T2B Cardiovascular Stress Tests, T2C EKG Monitoring, T2D Other Tests)

Geographic Attribution

The remaining beneficiaries and their costs will be assigned to hospitals based on Geography, following an algorithm known as PSA-Plus. Geography is determined on the basis of all Medicare TCOC for all Maryland Medicare beneficiaries, not only those left in this step of the attribution. The Geographic methodology assigns zip codes to hospitals through three steps:

1. Costs and beneficiaries in zip codes listed as Primary Service Areas (PSAs) in the hospitals' GBR agreements are assigned to the corresponding hospitals. Costs in zip codes claimed by more than one hospital are allocated according to the hospital's share on equivalent case-mix adjusted discharges (ECMADs) for inpatient and outpatient discharges among hospitals claiming that zip code. ECMAD is calculated from Medicare FFS claims for the two Federal fiscal years preceding the performance period.

2. Zip codes not claimed by any hospital are assigned to the hospital with the plurality of Medicare FFS ECMADs in that zip code, if it does not exceed 30 minutes' drive time from the hospital's PSA. Plurality is identified by the ECMAD of the hospital's inpatient and outpatient discharges during the attribution period.

3. Zip codes still unassigned will be attributed to the nearest hospital based on drive-time.

Beneficiaries not assigned based on ACO-Like or MDPCP-Like affiliation who reside in a zip code attributed to multiple hospitals will be included among attributed beneficiaries of each hospital. However, the per capita TCOC for those beneficiaries will be divided among those hospitals based on market share.

Maryland
Hospital Association

September 20, 2017

Chris L. Peterson
Director, Clinical and Financial Information
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chris:

On behalf of Maryland's 47 acute care hospitals, we appreciate the opportunity to comment on HSCRC's Medicare Performance Adjustment policy. The policy brings accountability for Medicare total cost of care, previously only measured statewide, to the individual hospital. This requires attributing all Maryland beneficiaries to an individual hospital or system. All other providers that have entered into Medicare demonstrations with the federal government have attributed beneficiaries to a physician who has agreed to be part of an Accountable Care Organization (ACO) or other demonstration entity. The Medicare Performance Adjustment is the first policy to base payment on the efficacy of a hospital's care for its entire Medicare population – a policy that goes beyond global budgets and fully aligns an individual hospital's Medicare total cost of care risk with the statewide risk under the enhanced model demonstration. HSCRC is proposing an attribution approach which would first attribute beneficiaries to physicians and then link the physicians to a hospital or system. This approach supports the view, which we share, that physician partnerships are fundamental to managing and controlling total cost of care.

The Medicare total cost of care attribution brings the accountability to individual hospitals and health systems for the statewide Medicare total cost of care. As a result, the attribution approach is a necessary methodology that could be used in other policies, such as: a mechanism to reduce hospital budgets more broadly, if the state was in danger of exceeding a savings target; an "efficiency" component of a full rate review process or determination of eligibility to access capital funds; a "denominator" in a population health measure. Measurement of spending per beneficiary is aligned with the current demonstration and the proposed enhanced model, unlike previous measures of spending per discharge which can create an incentive for volume growth. However, because many details have not been scrutinized or tested, we caution the commission against using the Medicare total cost of care per beneficiary measurement in other policies and placing additional revenue at risk without further discussion of the implications.

While the Medicare Performance Adjustment policy is an important component of Maryland's progress toward the enhanced model and a requirement to qualify Maryland's hospitals as Advanced Alternative Payment Models under the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), it is also important to recognize that the methodology is untested. The development process has been thoughtful and collaborative, but the timing required to implement

in calendar 2018 does not allow for testing and validation before implementation. As such, we recommend that the commission continue to work with the hospital field to refine, test and modify the policy over the coming year.

The method of attributing beneficiaries to individual hospitals or systems should match, as closely as possible, the mechanisms by which hospitals can manage care delivery and influence total cost of care. Hospitals have invested significant resources in arrangements with physicians and other providers to manage Medicare total cost of care, including ACOs, and physician practice ownership and management arrangements. Although participation in those arrangements may change over time, attributing beneficiaries to hospitals based on existing arrangements should be the first step of an attribution methodology. The commission has also proposed a methodology that links a physician and their attributed beneficiaries to a hospital based on where the plurality of the physician's patients are admitted. This model attributes based on actual practice patterns instead of formal agreements to work together. As expected, the two attribution approaches overlap, but are not identical. This approach also has merit, but only if a hospital is provided information on the physicians linked to their hospital and driving their total cost of care. Knowing which physicians are linked to the hospital, whether the physician refers primarily to one hospitals or a handful of hospitals in a region, and the risk profile of their associated beneficiaries, provides the hospital with the opportunity to reinforce regional partnerships and influence care patterns and total cost of care.

We would like to continue working with the commission staff on the following issues, incorporating as many as possible into a calendar 2018 performance year (fiscal 2020 adjustment) policy as possible, and carrying the remaining issues forward to adopt as part of the calendar 2019/fiscal 2021 policy.

1. **Reduce Risk on Other Quality Policies**
   The revenue at risk in the Medicare Performance Adjustment should offset a portion of the risk in the Quality-Based Reimbursement program, as Maryland now has a corollary to the national Medicare spending per beneficiary measure.

2. **Operational Issues**
   Maryland's hospitals are taking on risk for the entire Medicare population in Maryland. Managing therefore requires identification and engagement of beneficiaries who are most at risk. In accordance with federal and state privacy laws and requirements, hospitals and physicians are eligible to receive data on beneficiaries with whom they have existing relationships. It remains unclear how much access hospitals will have to information that allows them to adequately manage the total cost of care and associated financial risk. While this issue is manageable for year one, we look forward to working with the commission to ensure appropriate access to information.

3. **Risk Adjustment**
   The pool of beneficiaries attributed to each hospital will have different risk profiles. Although measuring the annual change in spending per beneficiary mitigates some of the volatility in

using unadjusted data, adjusting for beneficiaries' age, gender and comorbidities will explain some variation in spending growth. Hierarchical Condition Categories are widely used by Medicare for risk adjustment and need to be evaluated along with simpler demographic models.

4. **Methodology Validation**
   - Over the coming year, the hospital field will need to validate the HSCRC methodology, including exclusions, programming, and other details.
   - We would recommend that HSCRC continue the Total Cost of Care Work Group to focus on issues that are unaddressed in the first year, and that may be discovered as the policy is implemented.
   - Consideration may need to be given for hospitals with fewer than 5,000 attributed beneficiaries. Medicare requires a minimum of 5,000 beneficiaries in an ACO's risk pool, and it is not yet clear what impact a smaller risk pool has on certain Maryland hospitals.

5. **Improvement Only or Attainment and Improvement**
   For the first year, the HSCRC is considering an individual hospital's annual change compared to the prior year. However, improvement-only assumes that all hospitals have the same opportunity to reduce spending in their beneficiary pools. Differences in base period spending per beneficiary may impact the relative opportunity in the same way that hospitals with lower base period readmission rates were disadvantaged by an improvement-only methodology. Risk adjustment will help address the differences in opportunity for improvement; however, a policy that recognizes attainment or improvement can address concerns about penalizing hospitals that have reduced total cost of care.

We appreciate the commission's consideration of our feedback and the opportunity to continue working with the HSCRC. Should you have any questions, please call me at 410-540-5087.

Sincerely,

Traci La Valle

Traci La Valle, Vice President

cc: Nelson J. Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
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October 30, 2017

Chris Peterson
Director, Clinical and Financial Information
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Peterson:

On behalf of Anne Arundel Medical Center (AAMC), we appreciate the opportunity to comment on the proposed Medicare Performance Adjustment (MPA) policy. As we transition to Phase II of the Demonstration Model, we recognize the importance of creating local accountability for the total cost of care (TCOC). However, we do have some concerns with the proposed policy, namely:

(1) The current policy compares each hospital to its performance in the prior year. As the MHA and others have pointed out, an improvement-only measure does not acknowledge the substantial gains made to date by certain hospitals. Hospitals have varying degrees of cost reduction opportunity. Therefore, **the policy should recognize both improvement and attainment** so that high performing hospitals are not unjustly penalized for achieving significant TCOC savings prior to the MPA. This is essential and is similar to other existing state and national policy approaches that consider both improvement and attainment.

(2) **The policy should address near-term increases in TCOC due to appropriate and planned utilization meant to prevent avoidable utilization later.** For example, the consequences of implementing the Maryland Primary Care Program (MDPCP) will mean, by design, that Maryland's Medicare FFS population will receive more evidence-based screening and preventative care. And even as the program is designed to also promote reductions in ED and hospital use, MDPCP nevertheless will incentivize the primary care workforce to doggedly ensure screening and preventative care interventions are provided. The *cost* of an increased percentage of the population receiving these beneficial interventions will be reflected in the TCOC for Maryland's Medicare FFS population, whereas the cost *avoidance* will not be experienced for years or decades after the interventions are applied. Further, the eventual ROI in dollars may be less than anticipated. Whereas the per-person cost of this "good utilization," may seem trivial,

multiplying the costs across tens of thousands of individuals will predictably jeopardize our near-term goals in controlling the TCOC. We suggest that clinical judgment be inserted in the analysis of spending trends, and that the costs of appropriate preventative care be differentiated when determining TCOC performance.

(3) The proposed MPA beneficiary attribution hierarchy model incorporates (after ACO assignment) the beneficiaries' hospital utilization patterns to assign beneficiaries to hospitals.. **We applaud the first-tier assignment using ACO attribution yet we suggest the second attribution tier be based on contractual arrangements that primary care practices have with hospitals**. This consideration is paramount in MDPCP because in the currently proposed attribution model, a primary care practice may choose Hospital A's subsidiary as his Care Transformation Organization, yet the practices' beneficiaries may be attributed to Hospital B. This confusion frustrates existing and planned efforts as hospitals navigate with physicians through care redesign programs.. A contractual-based attribution method could continue to include the current policy's use of the ACO (through ACO participation agreements) **and** the MDPCP, but through Care Transformation Organization agreements rather than historic patient traffic volumes to hospitals. **Such an attribution methodology, based on contractual agreements, would allow implementation of coherent strategies as hospitals share data and resources with physician practices.** Regardless of the attribution methodology that is ultimately chosen, we agree with MHA's stance that it is imperative that hospitals receive information on which practices are attributed to them,, what the referral patterns of the practices' physicians are, and what the risk profiles of attributed beneficiaries are.

(4) The current policy **has not identified a clear TCOC trend factor**. While there are advantages and disadvantages to both a prospective and retrospective trend factor, we support the development of a pre-set trend factor prior to the start of the performance period. Without an estimated target, it is difficult to motivate stakeholders and create clear expectations. We understand the Staff's concerns about accurately predicting a pre-set trend factor; however, the hazards of proposing a prospective trend factor can be mitigated if the hospital field is (a) informed on the level of volatility inherent with a pre-set trend factor and (b) regularly updated on changing trend lines that may require an adjustment of the pre-set trend factor.

(5) We understand the time-sensitive nature of establishing the MPA to allow Maryland physicians to be deemed Qualifying Participants under an Advanced Alternative Payment Model (AAPM) (a status we are eager to help our physicians achieve). However, we are concerned about the rushed nature of such a critical policy. While we are willing to support the adoption of the MPA in 2018, we need assurances that the

HSCRC will be receptive to the concerns and findings from the hospital field and will work in collaboration with the hospital field to make necessary changes. **The TCOC Workgroup will be vital in voicing hospital concerns and making changes during the first implementation year.**

Thank you again for the opportunity to provide comments. We look forward to continuing to work with you and the HSCRC Staff. Please let me know how we can be of further assistance to you.

Sincerely,

Maulik Joshi, DrPH
Executive Vice President of Integrated Care Delivery &
Chief Operating Officer

Bob Reilly
Chief Financial Officer

Cc: Victoria Bayless, President & Chief Executive Officer, AAMC
Pat Czapp, M.D., Chair of Clinical Integration, AAMC
Nelson J. Sabatini, Chairman, HSCRC
Donna Kinzer, Executive Director, HSCRC

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CORPORATE OFFICE

October 27, 2017

Chris L. Peterson
Director, Clinical and Financial Information
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Peterson:

The purpose of this letter to provide our comments to the "Draft Recommendations for the Medicare Performance Adjustment (MPA) for Rate Year 2020," presented at the October 11, 2017 HSCRC Public Session. We appreciate the opportunity to present comments on behalf of the University of Maryland Medical System (UMMS).

Total Cost of Care Attribution Algorithm

The staff paper describes a multi-step prospective attribution method that assigns beneficiaries and their costs to Maryland hospitals according to a hierarchical attribution algorithm: 1) ACO-like attribution, 2) Maryland Primary Care Program (MDPCP)-like attribution, and 3) geographic attribution. In concept, UMMS is supportive of this attribution methodology for several reasons:

1. Linking beneficiaries who utilize hospital-based ACO physicians directly to the hospital that owns the ACO as a first step reinforces the existing investments and management arrangements that hospitals have made through the ACOs.

2. As a second step, linking beneficiaries to physicians and, subsequently, physicians to hospitals based on practice patterns provides hospitals with incentives to make investments and establish partnerships with physicians to manage a distinct, predictable population.

3. After steps 1 and 2, the remaining population is low cost with minimal utilization of physicians and hospitals. UMMS expects that the utilization captured in steps 1 and 2 of the hierarchy will represent the significant drivers of total cost of care and provide hospitals the most opportunity to impact performance. To the extent that 100% attribution is the goal, a geographic attribution methodology for this remaining population is a reasonable approach.

In regards to the attribution methodology proposed by HSCRC staff, UMMS appreciates the opportunity to provide the following comments and considerations:

Utilization measure used in establishment of pluralities

HSCRC staff is utilizing visit counts to measure beneficiary utilization in the establishment of pluralities for MDPCP-like attribution (Step 2 of hierarchy). This logic does not consider differences among visits in utilization or complexity. Under this logic, all hospital visits (tertiary inpatient cases, surgeries, low severity inpatient medical cases, ED visits, outpatient clinic visits, etc.) are assigned equal weight, regardless of actual utilization. HSCRC staff should consider a utilization metric that more accurately represents actual utilization, such as Medicare FFS payments or Equivalent Case Mix Adjusted Discharges (ECMADs).

ACO-to-hospital attribution

For system ACOs with more than one linked hospital, the draft methodology distributes ACO cost and beneficiaries proportionally across hospitals based on Medicare market share. This distribution logic does not provide a rational, direct linkage of ACO physicians to hospitals. Rather, the proposed methodology provides an equal spreading of ACO total cost of care performance across the hospital system. A more direct linkage of ACO physicians to hospitals within the system would better align with the incentives and management arrangements that systems have put into place through their ACOs. Per our previous emails, UMMS would welcome the opportunity to continue to work with HSCRC staff to develop an attribution logic for ACO physicians in a way that best aligns with the ACO's population health goals.

MDPCP-like attribution of physicians with existing hospital relationships

Following the draft attribution methodology, employed physicians who are not members of a system's ACO will be attributed according to the MDPCP-like logic. In some cases, this attribution may result in attribution of employed physicians to hospitals other than the employing hospital. It is worth considering how this dynamic reconciles with the attribution logic's goal of providing opportunities to establish direct partnerships between physicians and hospitals. In this case, the attribution complicates the linkage between physician and hospital. One potential solution to this issue is to give hospitals the opportunity to review attributed physicians and request 100% responsibility for specific physicians who would not otherwise attribute to the hospital.

Medicare Performance Adjustment Performance Assessment

While the staff paper puts forward a draft recommendation for performance assessment under the MPA, the focus of the Total Cost of Care Workgroup to this point has been the attribution logic. Staff has proposed the idea of continuing the Total Cost of Care Workgroup to continue discussion/evaluation of the MPA. UMMS welcomes the opportunity to evaluate this methodology over the first year of implementation. We put forward the following considerations regarding the proposed performance assessment methodology:

MPA Exclusions

The draft methodology excludes claims in any setting from an episode beginning 3 days before an extending to 90 days after a case that is identified as a categorical exclusion. In addition to categorical cases, staff should consider excluding the following:

- **High charge outliers** – Similar to categorical exclusions, high charge outliers vary year to year and are largely uncontrollable by the hospital. This volume should be excluded from both the attribution logic and the performance assessment.

- **Rate adjustments related to quality and population health** – The MPA should neutralize for changes to rate capacity related to quality performance and population health. Examples include, but are not limited to, annual quality adjustments, population health infrastructure adjustments, and population health grants. If these rate adjustments are not excluded, they will flow through the MPA as an erosion in TCOC performance. A hospital should not be penalized for receiving funds related to its good work in quality or population health management.

Establishment of benchmark

The draft methodology proposes a benchmark based on actual national growth rate during the performance year (less a TCOC trend factor that is established annually by the Commission). Due to availability of national data, this benchmark would not be finalized until 5-6 months *after* the performance period. While some preliminary data may be available during the performance year, a large enough sample to be reliable would not be available until 6-9 months into the performance year. We believe strongly, hospitals require a predictable target to achieve success under the MPA. With a stable, predictable target that is established prior to the performance period, hospitals will be better positioned to set targets, monitor performance throughout the year, and take corrective action when necessary.

Scaled Reward/Penalty

The goal of the attribution logic is to link hospitals to physicians and geographies. A hospital's attributed TCOC is determined by physician practice patterns and location; not necessarily the Medicare FFS utilization that occurs at the hospital. As a result, a hospital's attributed TCOC may be much different from its Medicare FFS utilization in both size and makeup. For example, University of Maryland Medical Center (UMMC) provides more than $365 million in Medicare FFS hospital care, but preliminary modeling of the MPA attributes less than $200 million to UMMC. Conversely, while UM Charles Regional Medical Center provides less than $50 million in Medicare FFS hospital care, preliminary modeling of the MPA attributes more than $140

million. By tying MPA scaling to something other than attributed TCOC (0.5% of hospital Medicare FFS payments in this case), the draft MPA risks providing rewards/penalties that are disproportionate to at-risk revenue. In UMMC's case, the reward/penalty is linked to a revenue amount that is nearly twice the size of the attributed revenue; while in UM CRMC's case, the reward/penalty revenue amount is nearly one-third the size of the attributed revenue. A scaling amount that is linked directly to attributed TCOC would link rewards/penalties proportionally to performance.

Attainment vs. Improvement

An improvement only logic assumes that all hospitals have the same opportunity to reduce TCOC and penalizes hospitals who have low historical TCOC. While UMMS acknowledges the difficulties in measurement (for example, the need for risk adjustment), HSCRC staff should investigate options for addition of an attainment logic to the MPA methodology. The Commission has acknowledged the need for an attainment logic in other quality programs such as the Readmissions Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Conditions (MHAC) program.

Adjustment for Quality

UMMS believes that the adjustment to scaling for quality performance has insignificant impact and adds unnecessary complexity to the calculation.

Measurement over multiple years

Several aspects of the long-term measurement and administration of this methodology to consider:

1. Considering the performance threshold of +/- 2%, will there be any multi-year smoothing of results? For example, a hospital with annual performance of 4% *favorable* Year 1 and 2% *unfavorable* Year 2 would receive 0.5% + (0.5%) = no adjustment over the two years (even as cumulative growth is 2% *favorable*).

2. The mechanics of payment of multiple years of rewards/penalties through the Medicare FFS discount factor.

Operational Considerations

Data needs

Successful management of these populations requires availability of a significant amount of data. More discussion of specifics regarding the data that will be available to hospitals and whether that is sufficient to allow hospitals be successful is necessary. Sufficient data availability is critical to appropriately allocate resources in the most cost effective fashion.

Communication with attributed beneficiaries and providers

UMMS welcomes the opportunity to have a necessary discussion with HSCRC staff regarding how these changes in relationship impact communication. How does this change a hospital's relationship with attributed physicians where there was previously no relationship? Will attributed beneficiaries be notified of their participation?

We appreciate the opportunity to comment on this proposed policy. If you have any questions, please contact me at 410-328-1380.

Sincerely,

Alicia Cunningham
Senior Vice President Corporate Finance
& Revenue Advisory Services
University of Maryland Medical System

cc: Donna Kinzer, Executive Director, HSCRC
Jerry Schmith, Director, HSCRC
Hank Franey, Chief Financial Officer, UMMS

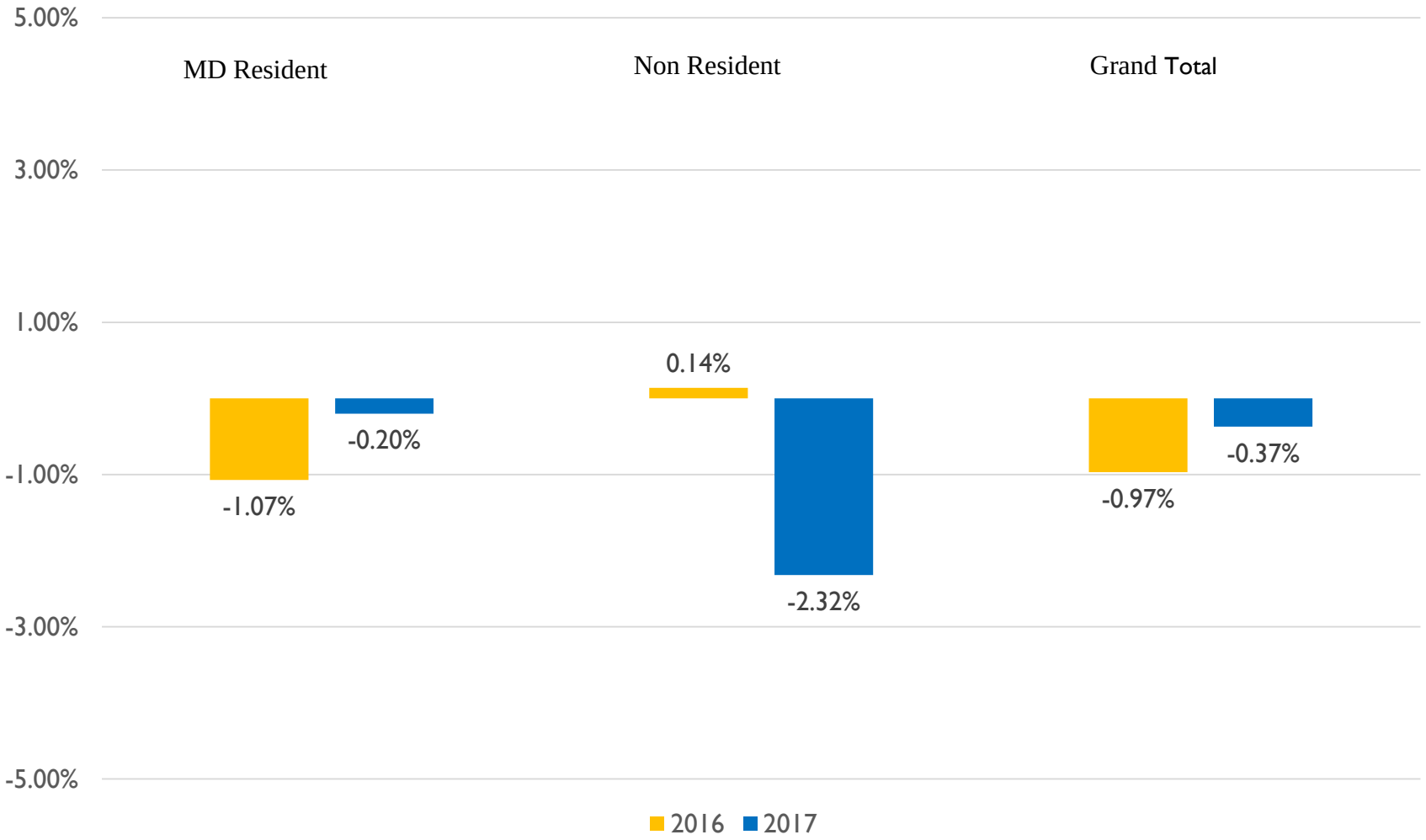
New Model Monitoring Report

The Report will be distributed during the Commission Meeting

Monitoring Maryland Performance
Preliminary Utilization Trends

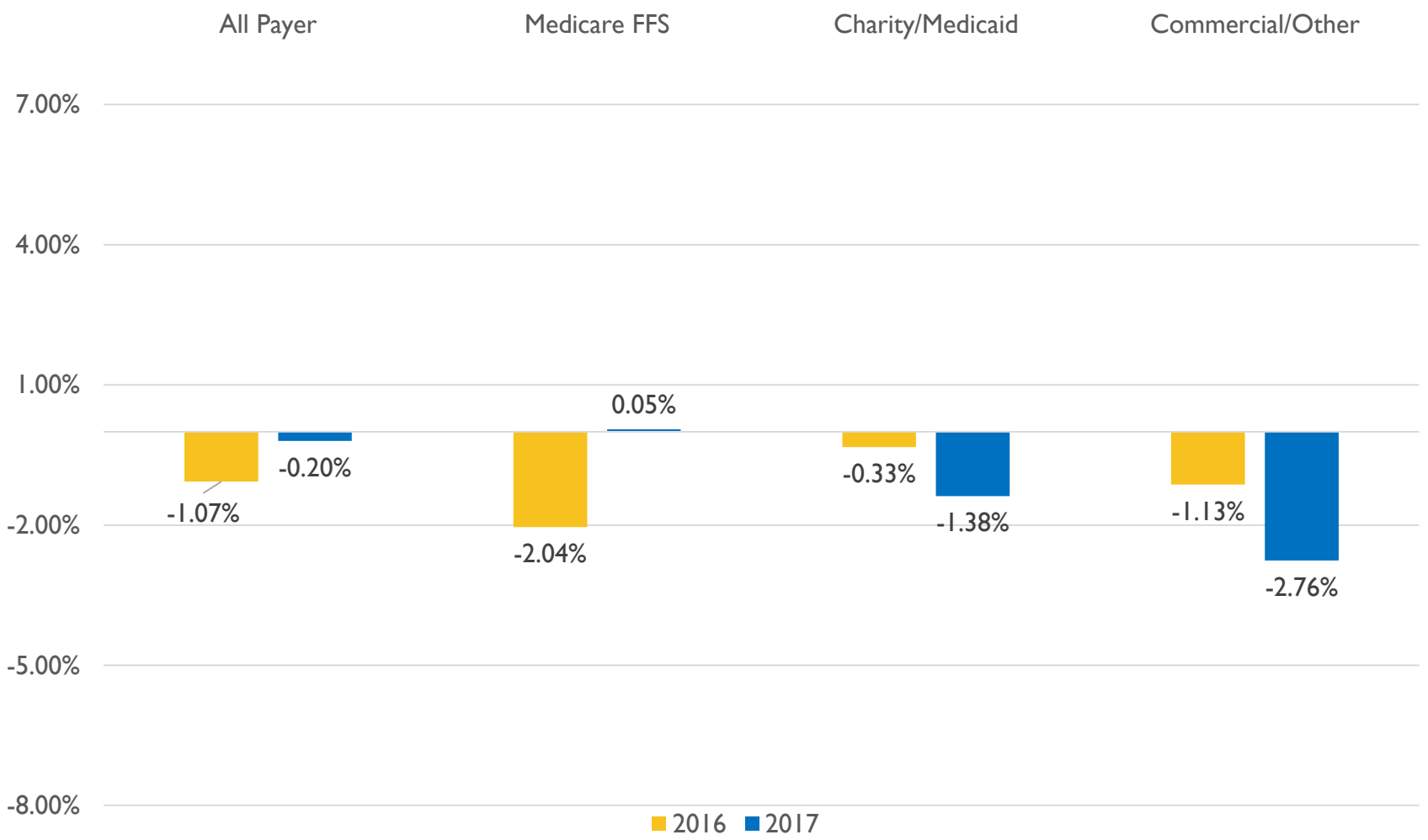
2017 vs 2016
(January to September)

All Payer ECMAD CYTD Annual Growth

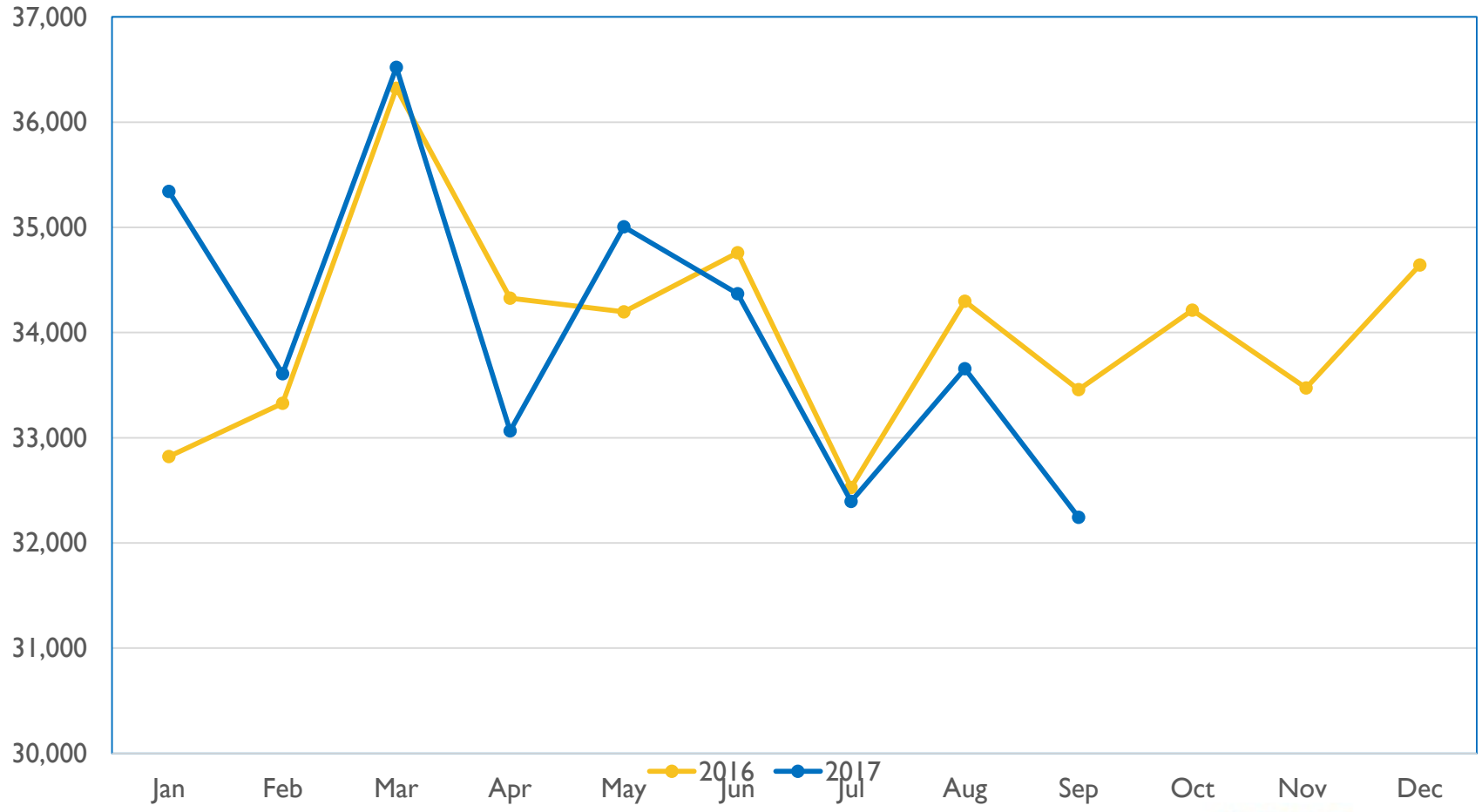


HSCRC
Health Services Cost Review Commission

MD Resident ECMAD CYTD Annual Growth

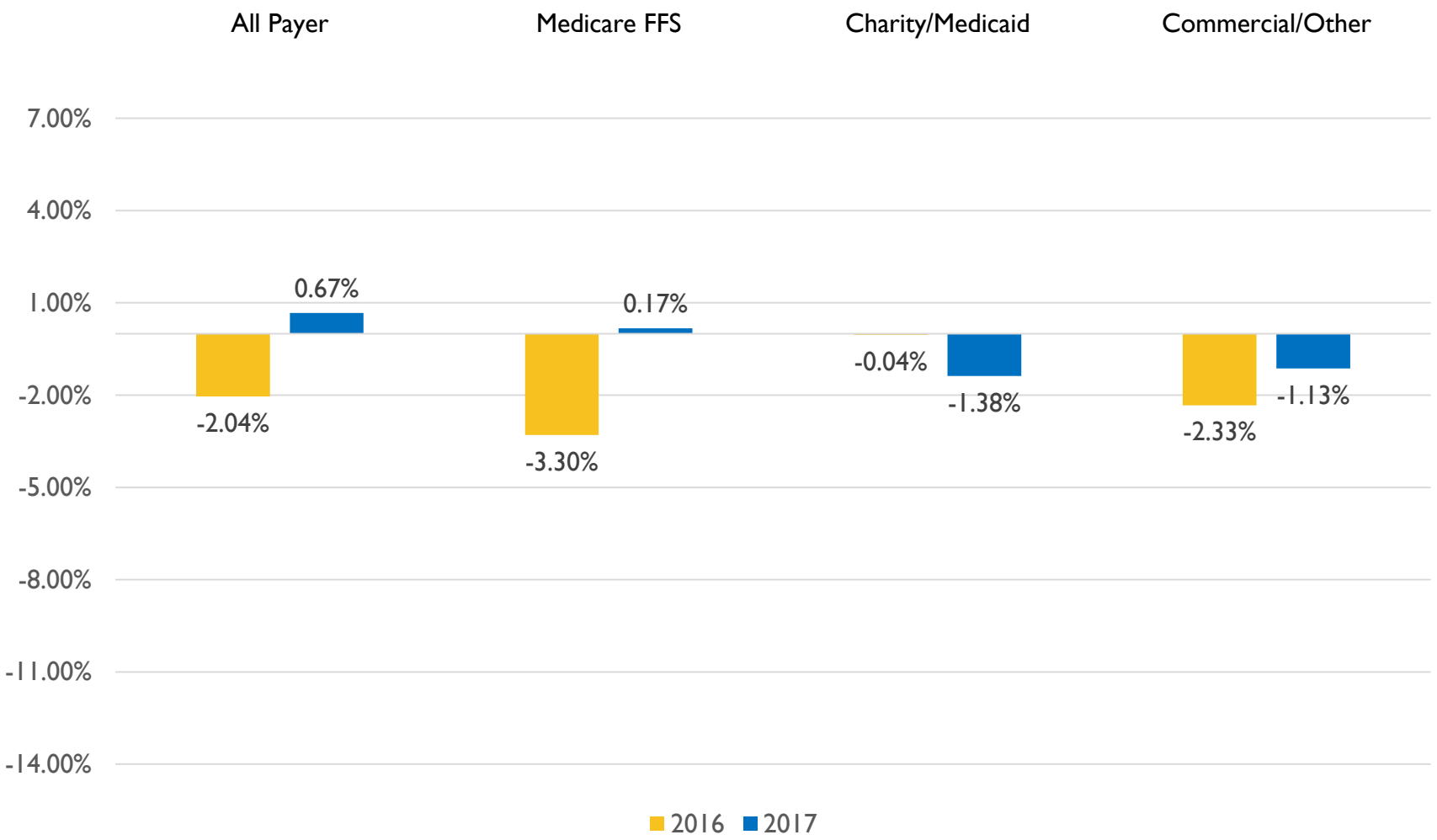


Medicare MD Resident ECMAD Annual Growth by Month



HSCRC
Health Services Cost Review Commission

MD Resident Inpatient ECMAD CYTD Annual Growth



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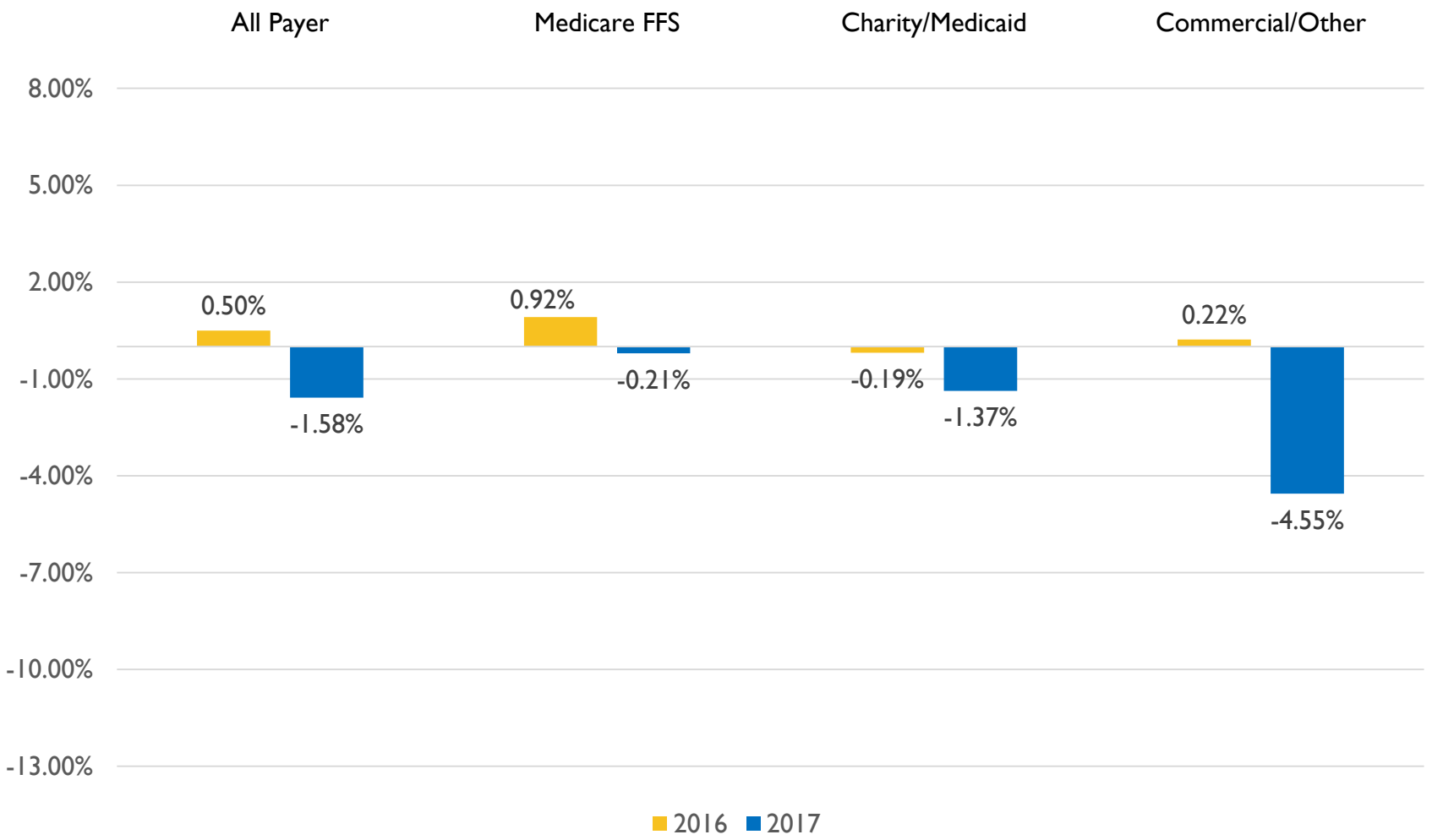
HSCRC
Health Services Cost Review Commission

MD Resident Outpatient ECMAD CYTD Annual Growth



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HSCRC
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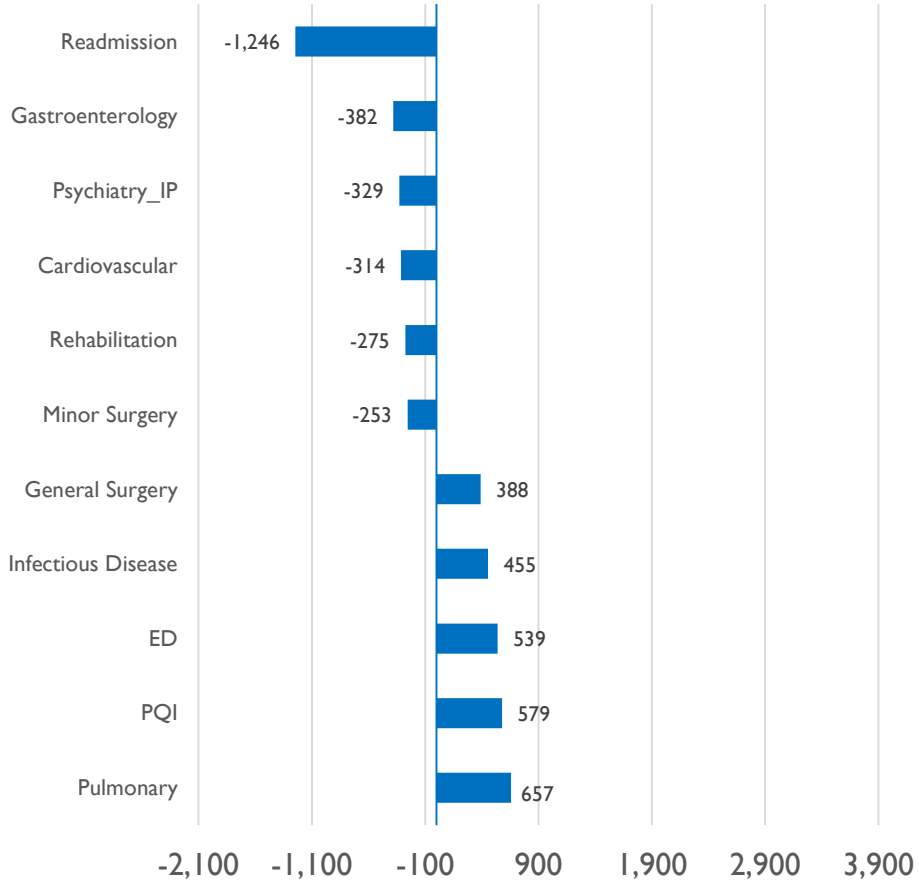
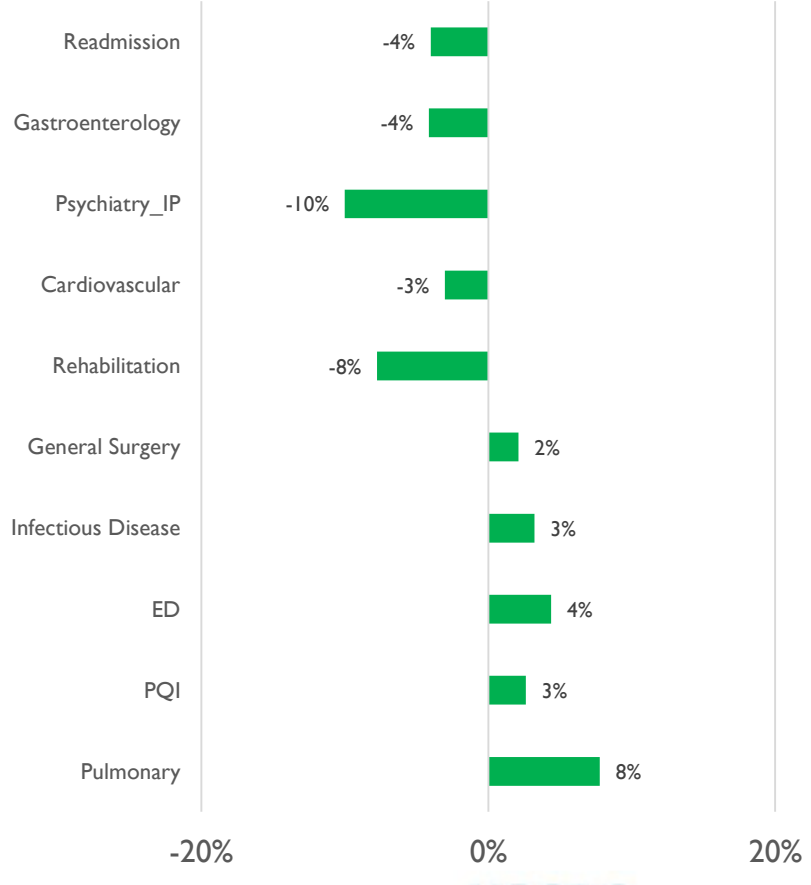
Medicare MD Resident Top 5 Service Line Changes (Total ECMAD Increase = 166)

Medicare Resident Top 5 Service Lines Changes (CYTD 16 vs CYTD 17)



Medicare Resident Top 5 Service Lines % Changes (CYTD 16 vs CYTD 17)



HSCRC
Health Services Cost Review Commission

Utilization Analytics – Data Notes

- Utilization as measured by Equivalent Case-mix Adjusted Discharges (ECMAD)
  - 1 ECMAD Inpatient discharge=1 ECMAD Outpatient Visit
- Observation stays with more than 23 hour are included in the inpatient counts
  - IP=IP + Observation cases >23 hrs.
  - OP=OP - Observation cases >23 hrs.
- Preliminary data, not yet reconciled with financial data
- Careful review of outpatient service line trends is needed

Service Line Definitions

- Inpatient service lines:
  - APR DRG (All Patient Refined Diagnostic Related Groups) to service line mapping
  - Readmissions and PQIs (Prevention Quality Indicators) are top level service lines (include different service lines)
- Outpatient service lines:
  - Highest EAPG (Enhanced Ambulatory Patient Grouping System) to service line mapping
  - Hierarchical classifications (Emergency Department, major surgery etc)
- Market Shift technical documentation

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 OCTOBER 3, 2017

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
2398N	Univeristy of Maryland Midtown Campus	8/7/2017	11/13/2017	1/5/2018	Defniitive Observation	CK	OPEN
2399A	Priority Partners	8/28/2017	N/A	N/A	ARM	AP	OPEN
2400A	University of Maryland Medical Center	9/15/2017	N/A	N/A	ARM	DNP	OPEN
2401A	MedStar Health	9/15/2017	N/A	N/A	ARM	DNP	OPEN
2402A	MedStar Medicare Choice	9/15/2017	N/A	N/A	ARM	DNP	OPEN
2403A	MedStar Family Choice	9/15/2017	N/A	N/A	ARM	AP	OPEN
2404A	Johns Hopkins Health System	9/28/2017	N/A	N/A	ARM	DNP	OPEN
2405N	Atlantic General Hospital	9/28/2017	11/13/2017	2/26/2018	IRC	CK	OPEN
2406A	Maryland Physicians Care	10/16/2017	N/A	N/A	ARM	AP	OPEN
2407A	Johns Hopkins Health System	10/20/2017	N/A	N/A	ARM	DNP	OPEN
2408A	Johns Hopkins Health System	10/26/2017	N/A	N/A	ARM	DNP	OPEN
2409A	University of Maryland Medical System	11/2/2017	N/A	N/A	ARM	DNP	OPEN
2410A	University of Maryland Medical System	11/2/2017	N/A	N/A	ARM	AP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

IN RE: THE PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*****	**COST REVIEW COMMISSION**
UNIVERSITY OF MARYLAND	*****	**DOCKET: 2017**
MIDTOWN CAMPUS	*****	**FOLIO: 2208**
BALTIMORE, MARYLAND	*****	**PROCEEDING: 2398N**

Staff Recommendation

November 13, 2017

Introduction

On August 3, 2017, University of Maryland Midtown Campus (the "Hospital"), a member of the University of Maryland Medical System, submitted a partial rate application to the Commission requesting a new rate for Definitive Observation (DEF). The Hospital requests that the DEF rate be set at the lower of a rate based on its projected costs to provide DEF services or the statewide median and be effective November 1, 2017.

Staff Evaluation

To determine if the Hospital's DEF rates should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all projected cost and statistical data for DEF for FY 2017. Based on information received from the Hospital, the DEF rate would be $2,045.57 per patient day. The statewide median for DEF is $1,167.79 per patient day. Staff noted that the statewide median rate is below the Hospital's Med/Surg. Acute (MSG) rate of $1,788.94 per patient day. As DEF is a step down unit between Med./Surg. Intensive Care (MIS) and MSG, Staff believes it would not be appropriate to assign the statewide median rate for DEF, given that more resources and direct nursing hours are utilized in patient in DEF then in MSG.

This rate request is revenue neutral and will not result in any additional revenue to the Hospital, since it involves carving out DEF services from the current approved revenue for MSG services. The Hospital currently charges DEF as part of its MSG rate. The Hospital wishes to carve these services out to provide a more equitable charging to its patients. The new proposed rates are as follows:

	Current Rate	New Rate	Budgeted Volume	Approved Revenue
Med./Surg. Acute	$1,788.94	$1,770.83	11,782	$20,244,400
Definitive Observation	N/A	$2,045.57	807	$1,650,479

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That a MSG rate of $1,770.83 per patient day be approved effective November 1, 2017;

2. That a DEF rate of $2,045.57 per patient day be approved effective November 1, 2017;
3. That the MSG and DEF rates not be rate realigned until a full year's cost experience data has been reported to the Commission; and
4. That no change be made to the Hospital's Global Budget Revenue.

IN RE: THE ALTERNATIVE	*****	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*****	**SERVICES COST REVIEW**	
THE JOHNS HOPKINS HEALTH	*****	**COMMISSION**	
SYSTEM	*****	**DOCKET:**	**2017**
	*****	**FOLIO:**	**2209**
BALTIMORE, MARYLAND	*****	**PROCEEDING**	**2399A**

Draft Recommendation

November 13, 2017

I. Introduction

On August 28, 2017, 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 2399A for the period from January 1, 2017 through December 31, 2018. The Hospitals are requesting to renew this contract for a one-year period beginning January 1, 2018.

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 25.2% of the State's MCO population, up from 24.5% in CY 2016.

III. Staff Review

This contract has been operating under the HSCRC's initial approval in proceeding 2399A. 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 2016, 2017, and 2018. 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 2016. Priority Partners is projecting to have favorable performance in CY 2017 and an unfavorable performance in CY 2018.

IV. Recommendation

With the exception of CY 2015, Priority Partners has continued to achieve favorable consolidated financial performance in recent years. Based on past and projected performance, staff believes that the proposed renewal arrangement for Priority Partners is acceptable under Commission.

Therefore:

1) **Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2018.**
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 2017, and the MCOs expected financial status into CY 2018. Therefore, staff recommends that Priority Partners report to Commission staff (on or before the September 2018 meeting of the Commission) on the actual CY 2017 experience, and preliminary CY 2018 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2019.**
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:**	**2017**
	*****	**FOLIO:**	**2212**
COLUMBIA, MARYLAND	*****	**PROCEEDING:**	**2402A**

Draft Recommendation

November 13, 2017

I. Introduction

On September 15, 2017, MedStar Health filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of MedStar Franklin Square Hospital, MedStar Good Samaritan Hospital, MedStar Harbor Hospital, MedStar Union Memorial Hospital, MedStar Montgomery Medical Center, MedStar Southern Maryland Hospital Center, and MedStar St. Mary's Hospital (the "Hospitals"). MedStar Health seeks approval for MedStar Family Choice ("MFC") to continue to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Hospitals are requesting an approval for one year beginning January 1, 2018.

II. Background

MFC has been operating a CMS-approved Medicare Advantage Plan under the plan name of MedStar Medicare Choice for five years in the District of Columbia. In 2014, CMS granted MFC permission to expand under the same Medicare Advantage plan number to provide coverage to Maryland eligible residents in Anne Arundel, Baltimore, Calvert, Charles, Harford, Howard, Prince George's, St. Mary's counties and Baltimore City. However, beginning in CY 2018. MFC will reduce its service area to Harford, Howard, and Prince George's counties and Baltimore City. The application requests continued approval for MFC to provide inpatient and outpatient hospital services, as well as certain non-hospital services in its service area, in return for a CMS-determined capitation payment. MFC will continue to pay the Hospitals HSCRC-approved rates for hospital services used by its enrollees.

MFC supplied financial projections for its operations in Maryland for CY 2017 through

CY 2020.

III. Staff Review

Staff reviewed the reviewed the financial projections for CY 2018 through CY 2020, as well as MFC's experience and projections for CY 2017. The information reflected significant negative financial results through CY 2019 and a break-even result for CY 2020. In addition, based on its Medical Loss Ratios, MFC has been covering its medical costs but not its administrative costs. Staff also noted a significant reduction in the number of plan members and revenue associated with the reduction in service area beginning in CY 2018.

IV. Recommendation

Based on its review of the financial projections, staff has concerns with the continued approval of this arrangement:

- Staff does not have information regarding the effect on MFC's financial results of the reduction in service area and the resulting sharp decline in membership beginning in CY 2018.
- This arrangement has had significant negative financial results for three years, CYs 2015, 2016, and 2017.
- MFC is projecting somewhat smaller losses for two more years, CY 2018 and CY 2019 with MFC essentially breaking even in CY 2020. It should be noted that last year MFC projected positive financial results for CY 2017.
- Five years of negative financial is concerning to the staff. Consequently, although staff may recommend continuation under the existing Memorandum of Understanding with the MedStar System, staff believes that this arrangement

requires additional monitoring and oversite.

Therefore, staff recommends conditional approval of the Hospitals' request to continue to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2018. The Hospitals must file a renewal application annually for continued participation. The conditions for approval are:

- MFC must meet with HSCRC staff prior to August 31, 2018 to review its financial projections for CY 2019.
- MFC must submit a copy to the Commission of its quarterly and annual National Association of Insurance Commissioners' (NAIC's) reports within 30 days of submission to the NAIC.
- MFC shall submit on a quarterly basis, 30 days after the end of each calendar quarter in the format provided by staff, a comparison of MFC's budgeted financial data with its actual experience for CY 2018. MFC shall also provide a detailed explanation of any material unfavorable differences between the budget and actual experience.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval also 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**	
MEDSTAR HEALTH	*****	**COMMISSION**	
SYSTEM	*****	**DOCKET:**	**2017**
	*****	**FOLIO:**	**2213**
COLUMBIA, MARYLAND	*****	**PROCEEDING:**	**2403A**

Draft Recommendation

November 13, 2017

I. Introduction

On September 15, 2017, 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 2403A for the period from January 1, 2017 through December 31, 2017. The Hospitals are requesting to renew this contract for one year beginning January 1, 2018.

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. MFC provides services to 7.4% of the total number of MCO enrollees in Maryland, which represents which represents approximately the same market share as CY 2016

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 2403A). 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 2016, 2017, and 2018. Over this three year period, profits, based on Medstar's October projections, have improved from a small loss in CY 2016 to projected profits in CY 2017 and CY 2018; however, it should be noted that Medicaid data from August anticipated a net loss in CY 2017.

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, 2018; however, staff is placing MFC on a watch list as described in item (2) below.

(2) Since sustained losses, such as those currently being experienced by MFC, 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, 2018 or if/when Medicaid applies a mid-year adjustment, MFC shall report to HSCRC staff on the impact that any such adjustment is expected to have on CY 2017 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 2018 and 2019.

c. In addition to the report provided in (2)(a), MFC shall report to Commission staff (on or before the September 2018 meeting of the Commission) on the actual CY 2017 experience and preliminary CY 2018 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2019.

(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 PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*****	**COST REVIEW COMMISSION**
ATLANTIC GENERAL	*****	**DOCKET: 2017**
HOSPITAL	*****	**FOLIO: 2215**
BERLIN, MARYLAND	*****	**PROCEEDING: 2405N**

Staff Recommendation

November 13, 2017

Introduction

On September 21, 2017, Atlantic General Hospital (the "Hospital") submitted a partial rate application to the Commission for a new Interventional Radiology/Cardiovascular (IRC) rate. The Hospital requests the new rate as several CPT codes are being reallocated from the Radiology-Diagnostic to the IRC rate center, and the Hospital has not had an IRC center rate. The Hospital requests that the IRC rate be effective July 1, 2017 as this is the effective date the Commission approved changes to the RVU scale.

Staff Evaluation

Based on Staff's review, the IRC rate based on the Hospital's projected data would be $79.30 per minute, while the statewide median to provide IRC services is $63.27 per minute.

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That an IRC rate of $63.27 per minute be approved effective July 1, 2017;
2. That the IRC rate center not be rate realigned until a full year of cost data has been reported to the Commission; and
3. That no change be made to the Hospital's Global Budget Revenue for IRC services.

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
SAINT AGNES HEALTH	*	**COMMISSION**	
WESTERN MARYLAND HEALTH SYSTEM	*	**DOCKET:**	**2017**
MERITUS HEALTH	*	**FOLIO:**	**2216**
HOLY CROSS HEALTH	*	**PROCEEDING:**	**2406A**

Draft Recommendation

November 13, 2017

I. Introduction

On October 16, 2017, 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 2406A for the period January 1, 2017 through December 31, 2017. The Hospitals are requesting to renew this contract for one year beginning January 1, 2018.

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 18.7% of the total number of MCO enrollees in Maryland, which represents approximately the same market share as CY 2016.

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 2406A). 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 2016, 2017, and 2018. In recent years, the financial performance of MPC overall has been marginally favorable with unfavorable performance in CY 2015 (as with all of the provider-based MCOs), favorable performance in CY 2016 and favorable projections for CYs 2017 and 2018.

IV. Recommendation

With the exception of CY 2015, MPC has generally maintained favorable performance in recent years. However, all of the provider-based MCOs incurred losses in CY 2015. 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, 2018.

(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 for CY 2017 and the MCO's expected financial status into CY 2018. Staff recommends that Maryland Physicians Care report to Commission staff (on or before the September 2018 meeting of the Commission) on the actual CY 2017 experience, preliminary CY 2018 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2019.

(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**	
JOHNS HOPKINS HEALTH	*****	**COMMISSION**	
SYSTEM	*****	**DOCKET:**	**2017**
	*****	**FOLIO:**	**2217**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2407A**

Draft Recommendation

November 13, 2017

I. Introduction

On October 16, 2017, 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 an approval for one year beginning January 1, 2018.

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. 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 supplied a copy of its contract with CMS.

III. Staff Review

Staff reviewed the reviewed the financial projections for CY 2018, as well as HHA's experience and projections for CY 2017. The information reflected the anticipated negative financial results associated with 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, 2018. The Hospitals must file a renewal application annually for continued participation. In addition, HHA must meet with HSCRC staff prior to August 31, 2018 to review its financial projections for CY 2019. 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 SYSTEM	*	**DOCKET:**	**2017**
	*	**FOLIO:**	**2218**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2408A**

Staff Recommendation

November 13, 2017

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on October 31, 2017 on behalf of Johns Hopkins Hospital, Johns Hopkins HealthCare LLC, and Johns Hopkins Employee Health Plans to continue to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for executive health services with Total Wine and More. The System requests approval for a period of one year beginning December 1, 2017.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospital will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer and collecting payments, disbursing payments to the Hospital at its full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospital, and the physicians holds the Hospitas 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

Although there has been no activity under this arrangement in the last year, staff believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for executive health services, for a one year period commencing December 1, 2017. 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 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	*****	**COMMISSION**	
MEDICAL SYSTEM	*****	**DOCKET:**	**201**
	*****	**FOLIO:**	**2219**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2409A**

Draft Recommendation

November 13, 2017

I. Introduction

On November XX, 2017, 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, 2018.

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. 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 2018, as well as UMHA's experience and projections for CY 2017. The information reflected the anticipated negative financial results associated with start-up of a Medicare Advantage Plan.

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, 2018 to review its financial projections for CY 2019. 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: 2017**
	*****	**FOLIO: 2220**
	*****	**PROCEEDING: 2410A**

Draft Recommendation

November 13, 2017

I. Introduction

On November 2, 2017, 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, 2017 through December 31, 2017. 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, 2018.

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 3.5% of the total number of MCO enrollees in the HealthChoice Program, which represents approximately the same market share as CY 2015.

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 2016, 2017, and 2018. UMHP reported breakeven financial performance for CY 2016. Initial projections for CYs 2017 and 2018 are unfavorable; however, it should be noted that for CY 2017 UMHP has amended its projection to favorable because of implementing claims and vendor management initiatives and because of a prior year settlement with the State.

IV. Recommendation

Since Riverside/UMHP has only been in operations as a MCO for four years, one would expect multiple years of losses because of ramp up, but Riverside has 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.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2017; 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, 2018 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 2018 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 2018 and 2019.

c. In addition to the report provided in (2)(a), UMHP shall report to Commission staff (on or before the September 2018 meeting of the Commission) on the actual CY 2017 experience, preliminary CY 2018 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2019.

(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.

Anne Arundel Medical Center Presentation

Representatives from Anne Arundel Medical Center will present materials at the Commission meeting.

State of Maryland
Department of Health

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Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

George H. Bone, MD

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TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **November 13, 2017**

RE: **Hearing and Meeting Schedule**

November 29, 2017	Executive Session - Call
December 13, 2017	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
January 10, 2018	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 10:15 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/commission-meetings-2017.cfm.

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