Health Services Cost Review Commission
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556th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
November 14, 2018

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

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

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

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on October 10, 2018**

2. **New Model Monitoring**

3. **Docket Status – Cases Closed**
   2454A – MedStar Health
   2455A – Johns Hopkins Health System
   2456A – University of Maryland Medical Center
   2457A – Johns Hopkins Health System

4. **Docket Status – Cases Open**

   2452A – Johns Hopkins Health System
   2453A – MedStar Health
   2458A – University of Maryland Medical Center
   2459A – Maryland Physicians Care
   2460A – University of Maryland Medical Center
   2461A – University of Maryland Medical Center
   2462A – University of Maryland Medical Center
   2463A – University of Maryland Medical System

5. **Final Recommendation on the Medicare Performance Adjustment for RY 2021**

6. **Presentation by Baltimore Population Health Workforce Collaborative**

7. **Draft Recommendation and FY 2017 & 2018 Report on Population Health Workforce Support for Disadvantaged Areas Program**

8. **Draft Recommendation for Adjustment to the Payer Differential**

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

10. **Presentation on Recalibrating Funding under Population-Based Revenue Model**

a. **Funds Associated with Shifts of Services from Regulated to Unregulated Settings**
b. **High-Cost Outlier Hospital Spenddowns – University of Maryland Midtown**

11. Policy Update and Discussion

a. Update from Executive Director
b. Medicare Advantage Sequestration
c. Commissioner Discussion of Capital Funding Considerations under the TCOC Model

12. Legal Report – Proposed Regulation Amendment COMAR 10.37.10.26

13. Hearing and Meeting Schedule

Closed Session Minutes
Of the
Health Services Cost Review Commission

October 10, 2018

Upon motion made in public session, Chairman Sabatini called for adjournment into closed session to discuss the following items:

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

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

The Closed Session was called to order at 11:38 a.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

In attendance in addition to Chairman Sabatini were Commissioners Antos, Bayless, Colmers, Elliott, Kane, and Keane.

In attendance representing Staff were Katie Wunderlich, Chris Peterson, Allan Pack, Jerry Schmith, Alyson Schuster, Geoff Dougherty, Amanda Vaughan, Joe Delenick, and Dennis Phelps.

Also attending were Eric Lindeman, Commission Consultant, Stan Lustman and Adam Malizio, Commission Counsel, Will Daniel, representing CRISP, and Tyler Dunn, Administrative Resident, Johns Hopkins Health System.

Item One

Katie Wunderlich, Executive Director, Alyson Schuster, Associate Director, Jerry Schmith and Allan Pack, Directors, updated the Commission on current staff activities. Also, the Commission was updated on the Critical Action Timeline.

Item Two

Executive Director Wonderlich updated the Commission on the status of discussions with University of Maryland Mid-Town Campus regarding efficiency.

In addition, Ms. Wonderlich updated the Commission and the Commission discussed Medicare Total Cost of Care (TCOC).

The Commission was also informed of plans to convene regular CEO/Commission meetings.

Item Three

Mr. Lindeman updated the Commission on Medicare Fee-for-Service data and analyses. Included in the update was Maryland TCOC per capita versus the nation.

Item Four

The Executive Director advised the Commission on the status of Medicare Advantage Plans and sequestration.

The Closed Session was adjourned at 1:02 p.m.

MINUTES OF THE
555th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
October 10, 2018

Chairman Nelson Sabatini called the public meeting to order at 11:38 a.m. Commissioners Joseph Antos, Victoria Bayless, John Colmers, James Elliott, M.D., Adam Kane and Jack Keane were also in attendance. Upon motion made by Commissioner Colmers and seconded by Commissioner Antos, the meeting was moved to Executive Session. Chairman Sabatini reconvened the public meeting at 1:09 p.m.

REPORT OF OCTOBER 10, 2018 EXECUTIVE SESSION

Mr. Dennis Phelps, Associate Director, Audit & Compliance, summarized the minutes of the October 10, 2018 Executive Session.

ITEM I
REVIEW OF THE MINUTES FROM SEPTEMBER 12, 2018 EXECUTIVE SESSION AND PUBLIC MEETING

The Commissioners voted unanimously to approve the minutes of the September 12, 2018 Public Meeting and Executive Session.

ITEM II
NEW MODEL MONITORING

Ms. Caitlin Cooksey, Assistant Chief, Hospital Rate Regulation, reported for the six months ending June 2018 that Maryland's Medicare Hospital spending per capita growth was trending favorably. Ms. Cooksey noted that Medicare Non-Hospital spending per capita growth was trending unfavorably for the same period. This results in Medicare Hospital and Non-Hospital savings of $44,187,000.

Ms. Amanda Vaughan stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of August 2018 focuses on the calendar year (January 1 through December 31).

Ms. Vaughan reported that for the eight months of the calendar year ended August 31, 2018, All-Payer total gross revenue increased by 1.20% over the same period in CY 2017. All-Payer total gross revenue for Maryland residents increased by 1.55%; this translates to a per capita increase of 1.08%. All-Payer gross revenue for non-Maryland residents decreased by 2.47%.

Ms. Vaughan reported for the eight months of calendar year ended August 31, 2018, that

Medicare Hospital Fee-For-Service gross revenue increased by 1.22 % over the same period in CY 2017. Medicare Hospital Fee-For-Service gross revenue for Maryland residents increased by 1.60%; this translates to a per capita increase of 0.24%. Medicare Hospital Fee-For-Service gross revenue for non-residents decreased by 3.12%.

Ms. Vaughan reported that for the two months of the fiscal year ended August 31, 2018 over the same period in CY 2017:

- All Payer in State per capita hospital revenue growth was 1.03%.
- Medicare Fee for Service hospital per revenue capita growth in the State was a decreased by 0.38%.

According to Ms. Vaughan, for the fiscal year ended June 30, 2018, unaudited average operating profit for acute hospitals was 3.55%. The median hospital profit was 4.10%, with a distribution of 1.36% in the 25th percentile and 7.25% in the 75th percentile. Rate Regulated profits were 7.70%.

ITEM III
DOCKET STATUS- CASES CLOSED

2442N- Greater Baltimore Medical Center
2443A-Johns Hopkins Health System
2444A- Johns Hopkins Health System
2445A- Johns Hopkins Health System
2446R – Adventist HealthCare
2447A- MedStar Health
2448A- MedStar Health
2449A- Fort Washington Medical Center
2450R- Laurel Regional Hospital and Prince Georges Hospital Center
2451R- Greater Baltimore Medical Center

ITEM IV
DOCKET STATUS –OPEN CASES

2454A-MedStar Health

MedStar Health filed an application with the HSCRC on September 11, 2018 on behalf of Union Memorial Hospital (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. MedStar requests approval from the HSCRC to continue to participate in a global arrangement for joint replacements with the National Orthopedic & Spine Alliance for a one year period beginning November 1, 2018.

The staff recommends that the Commission approve the Hospital's request for participation in the alternative method of rate determination for joint replacement services, for a one year period, commencing November 1, 2018. The Hospital will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this

approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract.

Commissioners voted unanimously in favor of Staff's recommendation.

2455A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed an application with the HSCRC on September 25, 2018 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) and Johns Hopkins Employer Health Programs, Inc. The purpose of the application is to add additional services to its existing global rate arrangement with Accarent for bariatric surgery, bladder surgery, anal rectal surgery, cardiovascular services, joint replacement surgery, pancreas surgery, spine surgery, parathyroid surgery, solid organ and bone marrow transplants, and Executive Health services approved February 14, 2018. The System would like to add services related to Eating Disorders and Gall Bladder Surgery to the arrangement effective November 1, 2018.

The staff recommends that the Commission approve the Hospital's' application to add services related to Eating Disorders and Gall Bladder Surgery to its existing arrangement for an alternative method of rate determination for bariatric surgery, bladder surgery, anal rectal surgery, cardiovascular services, joint replacement surgery, pancreas surgery, spine surgery, parathyroid surgery, solid organ and bone marrow transplants, and Executive Health services with an effective date for the new services of November 1, 2018. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract.

Commissioners voted unanimously in favor of Staff's recommendation. Commissioner Colmers recused himself from the discussion and vote.

2456A-University of Maryland Medical Center

The University of Maryland Medical Center (the "Hospital") filed a renewal application with the HSCRC on September 25, 2018 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with OptumHealth Care Solutions, Inc. for a one-year period, effective November 1, 2018.

Staff recommends that the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone

marrow transplant services for a one year period beginning November 1, 2018. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract.

Commissioners voted unanimously in favor of Staff's recommendation.

2457A- Johns Hopkins Health System

On September 25, 2018, the Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") requesting approval from the HSCRC to continue to participate in a global rate arrangement for cardiovascular, pancreas, bariatric surgery and joint procedures with Quality Health Management. The Hospitals request that the Commission approve the arrangement for one year effective November 1, 2018.

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular, joint, pancreas, and bariatric surgery procedures for one year beginning November 1, 2018. The Hospitals must file a renewal application annually for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract.

Commissioners voted unanimously in favor of Staff's recommendation. Commissioner Colmers recused himself from the discussion and vote.

ITEM V
FINAL RECOMMENDATION ON MAXIMUM REVENUE GUARDRAIL FOR QUALITY PROGRAMS FOR RY 2020

Alyson Schuster, Ph.D., Associate Director Performance Measurement, presented the Staff's final recommendation on maximum revenue guardrail for quality programs (See "Final Recommendation for the Maximum Revenue Guardrail for Maryland Hospital Quality program for Rate Year 2020" on the HSCRC website).

HSCRC's performance-based payment methodologies are important policy tools that provide strong incentives for hospitals to improve their quality performance over time. These performance-based payment programs hold amounts of hospital revenue at-risk directly related to specified performance benchmarks. Because of its long-standing Medicare waiver for its all-payer hospital rate-setting system, special considerations were given to Maryland, including exemption from the federal Medicare quality-based programs. Instead, the HSCRC implements various Maryland-specific quality-based payment programs, which are discussed in further detail in the background section of this report.

Maryland entered into an All-Payer Model Agreement with the Centers for Medicare & Medicaid Services (CMS) on January 1, 2014 and will enter into a Total Cost of Care Model Agreement on January 1, 2019. One of the requirements under both agreements is that the proportion of hospital revenue that is held at-risk under Maryland's quality-based payment programs must be greater than or equal to the proportion that is held at-risk under national Medicare quality programs. Given that Maryland's programs are fundamentally different from the nation in how revenue adjustments are determined (e.g., most programs have prospective incremental revenue adjustment scales with both rewards and penalties), the at-risk is measured both as potential risk (i.e., highest maximum penalty per program) and realized risk (absolute average of adjustments per program).

The purpose of this recommendation is to recommend the maximum amount one hospital can be penalized for RY 2020, otherwise known as the maximum revenue guardrail. The recommendations for the maximum penalties and rewards for each quality program are set forth in the individual policies rather than in an aggregate at-risk policy.

Staff's final recommendation is to set the maximum penalty guardrail for RY 2020 at 3.40% of total hospital revenue.

Commissioners voted unanimously to approve Staff's recommendation.

ITEM VI
PRESENTATION ON CARE REDESIGN PROGRAMS

Chris Peterson, Director Clinical & Financial Information, Jo Surpin, President, Applied Medical Software Inc., Craig Behm, Maryland Program Director, CRISP, and Nicole Stallings, Senior Vice President of Government Affairs, MHA, presented an overview of the Care Redesign Program (see "Care Redesign Program- Overview and Update" on the HSCRC website).

Mr. Peterson noted that the Care Redesign Programs (CRP) were developed to support the Total Cost of Care Model. CRP is made up of the Complex and Chronic Care Improvement Program (CCIP), Hospital Care Improvement Program (HCIP), and the Episodic Care Improvement Program (ECIP).

Mr. Peterson provided an overview of CCIP program which provides incentives to primary care physicians for reducing potentially preventable hospitalization of high and rising risk beneficiaries. Mr. Peterson indicated hospital and provider participation has slowed due to the implementation of the Maryland Primary Care Program (MDPCP), which is similar in design.

Ms. Surpin provided an overview of the HCIP which provides incentives to physicians to reduce utilization in the hospital. Ms. Surpin noted that there is growing participation in the HCIP program, and results have varied for initial program participants.

Mr. Behm provided an overview of the ECIP which focuses on improving post-acute care to generate Total Cost of Care (TCOC) savings. The ECIP has had 35 nonbinding letters of intent for the January 1, 2019 start.

Commissioner James Elliot, M.D., asked if there has been any clinical improvement in patient outcomes related to participation in any of the programs. Ms. Surpin stated that it was too early to tell with the HCIP, but they are seeing some "operationalization" of the CRP protocols in hospitals.

Commissioner Kane asked what savings, if any, have been realized as the result of the CRP programs. He wanted to understand if there were controls in place to identify and calculate program savings. Commissioner Kane encouraged stakeholders to demonstrate savings to the Commission from the CRP programs before hospitals invest in these programs.

Chairman Sabatini agreed with Commissioner Kane and questioned whether any savings have been identified to date.

Ms. Surpin responded that it is highly unusual to realize savings in the first performance year of these types of programs due to the long ramp-up period. Ms. Surpin suggested that savings should increase in the 2nd and 3rd performance periods. Mrs. Stallings added that the stakeholders are continually working to determine program inefficiencies and are encouraging collaboration among the programs.

Commissioner Colmers stated the necessity to convey to providers that they are responsible for carrying out the objectives of the TCOC model. He also agreed with Commissioner Kane that the Commission must monitor savings generated from the programs and discontinue those that do not realize savings.

ITEM VII
DRAFT RECOMMENDATION ON THE MEDICARE PERFORMANCE ADJUSTMENT FOR RY 2021

Mr. Peterson, Director Clinical & Financial Information, presented the Staff's draft recommendation on the Medicare Performance Adjustment (See "Draft Recommendation for the Medicare Performance Adjustment Policy for Rate Year 2021" on the HSCRC website).

The State implemented a value-based payment adjustment, referred to as the Medicare Performance Adjustment (MPA) with performance beginning in Calendar Year (CY) 2018. The MPA increases the responsibility on providers by placing hospitals' federal Medicare payments at risk, based on the total cost of care for Medicare fee-for-service (FFS) beneficiaries attributed to a hospital.

Since 2014, the State and CMS have operated Maryland's unique all-payer rate-setting system for hospital services to adopt new and innovative policies aimed at reducing per capita hospital expenditures and TCOC spending, while improving health care quality, patient outcomes, and population health. Under this initiative, hospital-level global budgets are 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, and 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.

The MPA provides a mechanism to further support aligned efforts of hospitals with other providers. This includes the opportunity for physicians who partner with hospitals under Maryland's Care Redesign Programs (i.e., HCIP, CCIP, and ECIP) to be eligible for bonuses and increased payment rates under the federal MACRA law.

Although outside the scope of the MPA attribution algorithm and other aspects described in this document, the State also has the flexibility to apply an MPA Efficiency Adjustment to adjust hospitals' Medicare payments for other purposes. There are two primary use cases for the MPA Efficiency Adjustment. First, the MPA Efficiency Adjustment can permit the flow of Medicare funds to hospitals based on their performance in other programs. For example, Medicare payments to qualifying hospitals under ECIP will occur through an MPA Efficiency Adjustment separate from the MPA's adjustment based on the hospital's performance on its attribution population. In addition, the MPA Efficiency Adjustment may also be used to reduce hospital payments if necessary to meet Medicare financial targets that are not approved on an all-payer basis.

Based on the assessment above, staff recommends the following for RY 2021 (with details as described above).

1. Measure Medicare TCOC by attributing Medicare fee-for-service beneficiaries to providers, primarily based on use of primary care services, and then linking providers to hospitals based on existing relationships.

    - Use a hierarchy of MDPCP-actual, Accountable Care Organization (ACO)-like, PCP-like, and Primary Service Area-Plus (PSAP) attribution for beneficiary-to-provider attribution

    - Use existing provider-hospital relationships to link providers to hospitals based on a hierarchy of hospital-affiliated Care Transformation Organizations (CTOs), hospital affiliated ACOs, hospital employment, and provider referral patterns

    - Implement official algorithm result review period

2. Set the maximum penalty at 1.0% and the maximum reward at 1.0% of federal Medicare revenue with maximum performance threshold of ±3%.

3. Set the TCOC benchmark at each hospital's risk-adjusted (demographics only) TCOC from 2018, updated with a Trend Factor of 0.33% below the national Medicare FFS growth rate for CY 2019.

4. Continue to assess performance on each hospital's own improvement in its attributed population's per capita TCOC

    - Adjust for year-over-year changes in the demographic characteristics of the hospital's attributed population

    - For future years, continue to explore incorporating attainment and further risk adjustment into the MPA's performance assessment

5. Include the MPA as part of the aggregate revenue at risk under HSCRC quality programs.

6. Continue to evaluate the MPA throughout the year and consider enhancements for future MPA policies, 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. Continue to 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.

Commissioner Colmers observed that it was important to make clear that the MPA is not insurance risk. He emphasized that the MPA was a relatively small adjustment to hospital rates based on the hospital's Medicare Total Cost of Care performance. He stated that the Commission was not asking the hospitals to bear the full cost of care for attributed populations.
As this is a draft recommendation, no Commission action is necessary.

ITEM VIII
POLICY UPDATE AND DISCUSSION

Katie Wunderlich, Executive Director, and Allan Pack, Director, Population Based Methodologies provided an update on the Maryland Primary Care Program (MDPCP), Volume Based Methodology and workgroup activities.

Ms. Wunderlich provided an update on the status of the enrollment in the MDPCP. She noted that there was higher than expected physician interest in the program. Due to the interest, the MDPCP Program Management Office in the Maryland Department of Health has increased from six to 12 the number of practice coaches to assist with implementation.

Ms. Wunderlich also presented a brief update on current workgroup activities. The Performance Measurement workgroup met to discuss the RY 2021 quality based program policies. The TCOC workgroup continues to focus its efforts on changes to the MPA policy. The Payment Models workgroup is pursuing activities related to rate setting policies (e.g., rate realignment, payer differential, etc.).

Mr. Pack discussed Staff's efforts to review and assess hospital volume based policies over the next five to six months. Chairman Sabatini expressed concerns about the time line to complete these tasks. He encouraged a more rapid and active response due to the concerns already brought to the Commission about current volume based policies. Commissioner Colmers and Commissioner Keane reminded the Commission about their previous recommendations regarding volume based policies and in particular the market shift policy. Commissioner Colmers emphasized the need for hospitals to be able to project how their revenue will be impacted based on changes in volume. Commissioner Colmers expressed his view that the current market shift policy today is not transparent and suggested that it be revaluated. Commissioner Bayless supported Commissioner Colmers and noted that it was important to ensure that whatever path is taken, volume growth should not be encouraged.

ITEM IX
HEARING AND MEETING SCHEDULE

November 14, 2018	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
December 12, 2018	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 2:29 p.m.

Monitoring Maryland Performance
Financial Data

Year to Date through September 2018

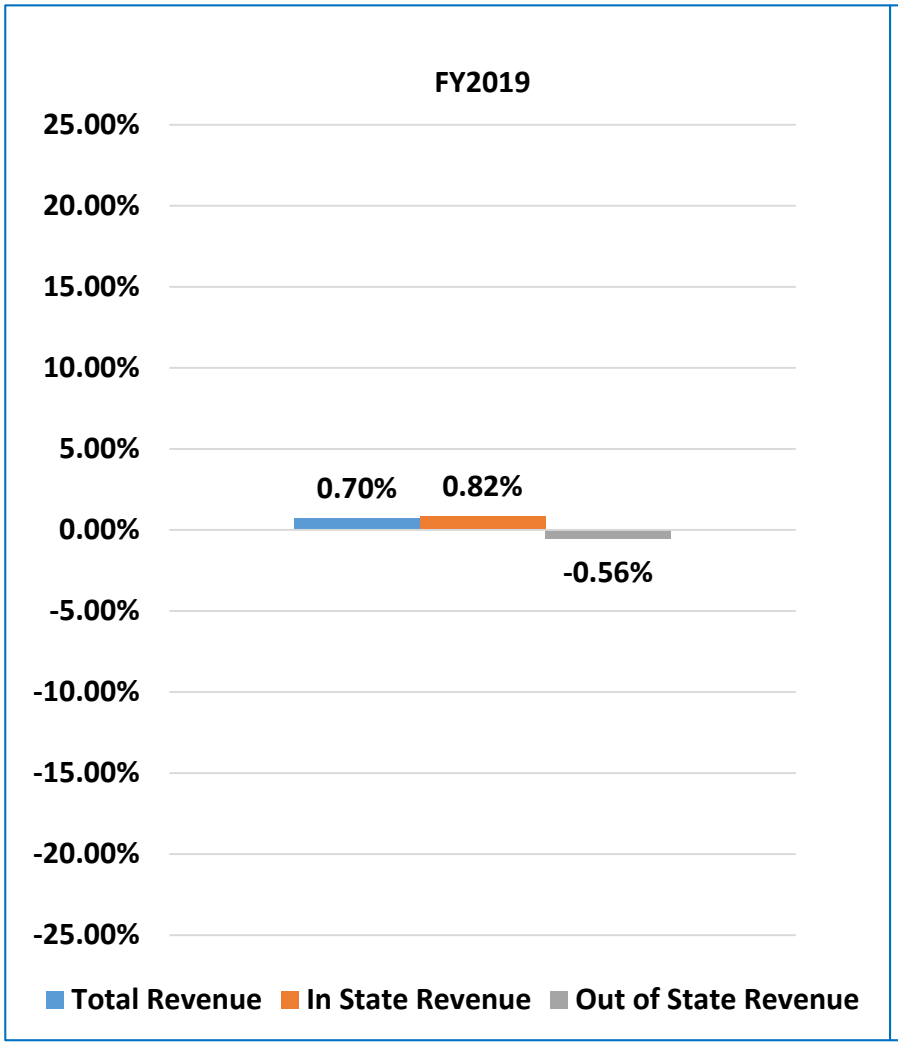
Source: Hospital Monthly Volume and Revenue
Run: November 9, 2018

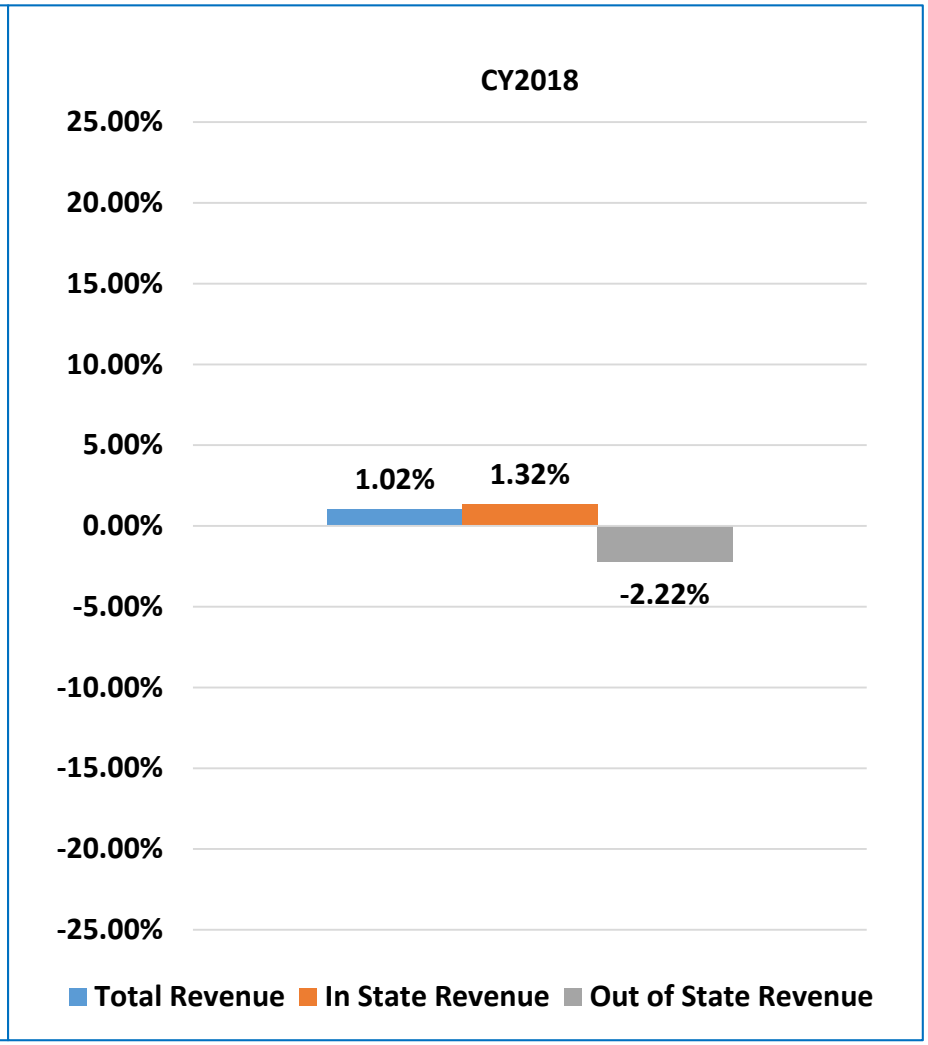
The per capita growth data pertaining to the Medicare FFS beneficiary counts beginning January 1, 2017 have been revised. CMS has changed the enrollment source for the Chronic Condition Data Warehouse (CCW) from the Enrollment Database (EDB) to the Common Medicare Environment (CME) database. Part A changed very slightly and Part B is more noticeably changed.

The Population Estimates from the Maryland Department of Planning have been revised in December, 2017. The new FY 18 Population growth number is 0.46%.

Gross All Payer Hospital Revenue Growth

FY 2019 (July 18 – Sept 18 over July 17 – Sept 17) and CY 2018 (Jan - Sept 18 over Jan – Sept 17)



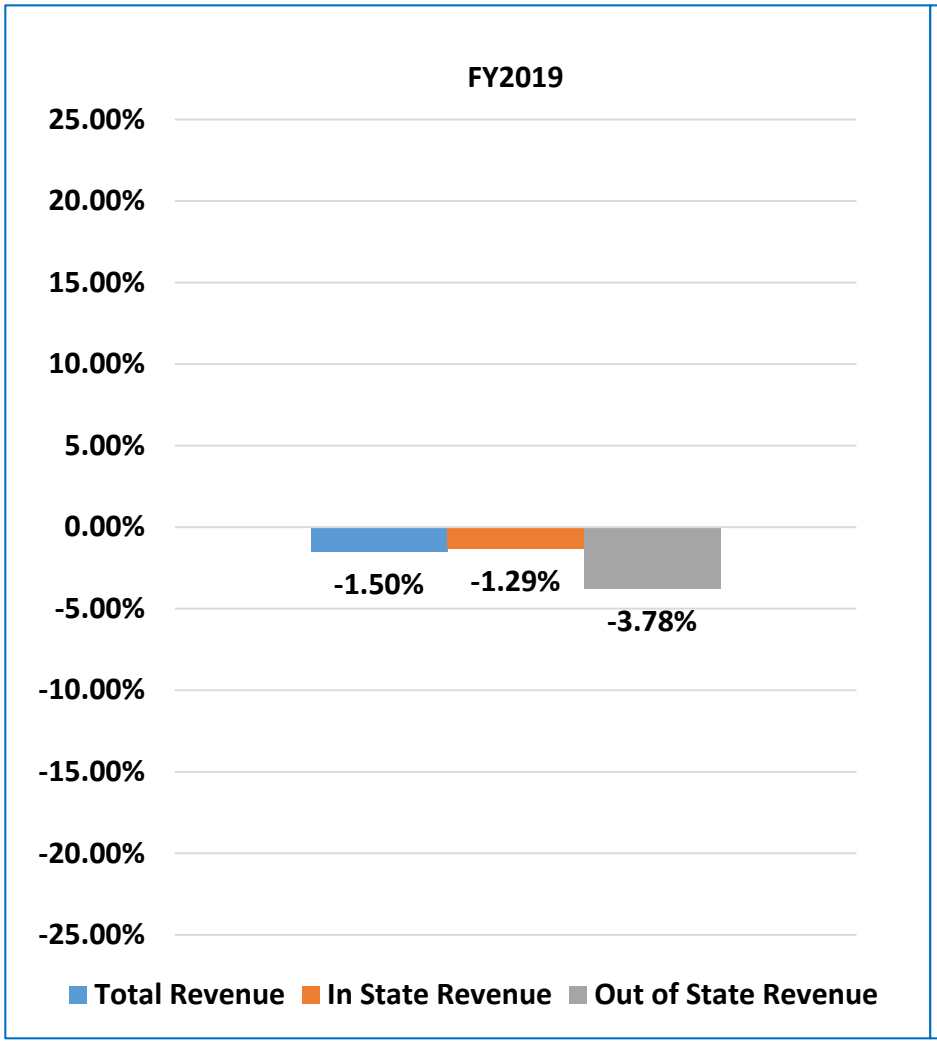


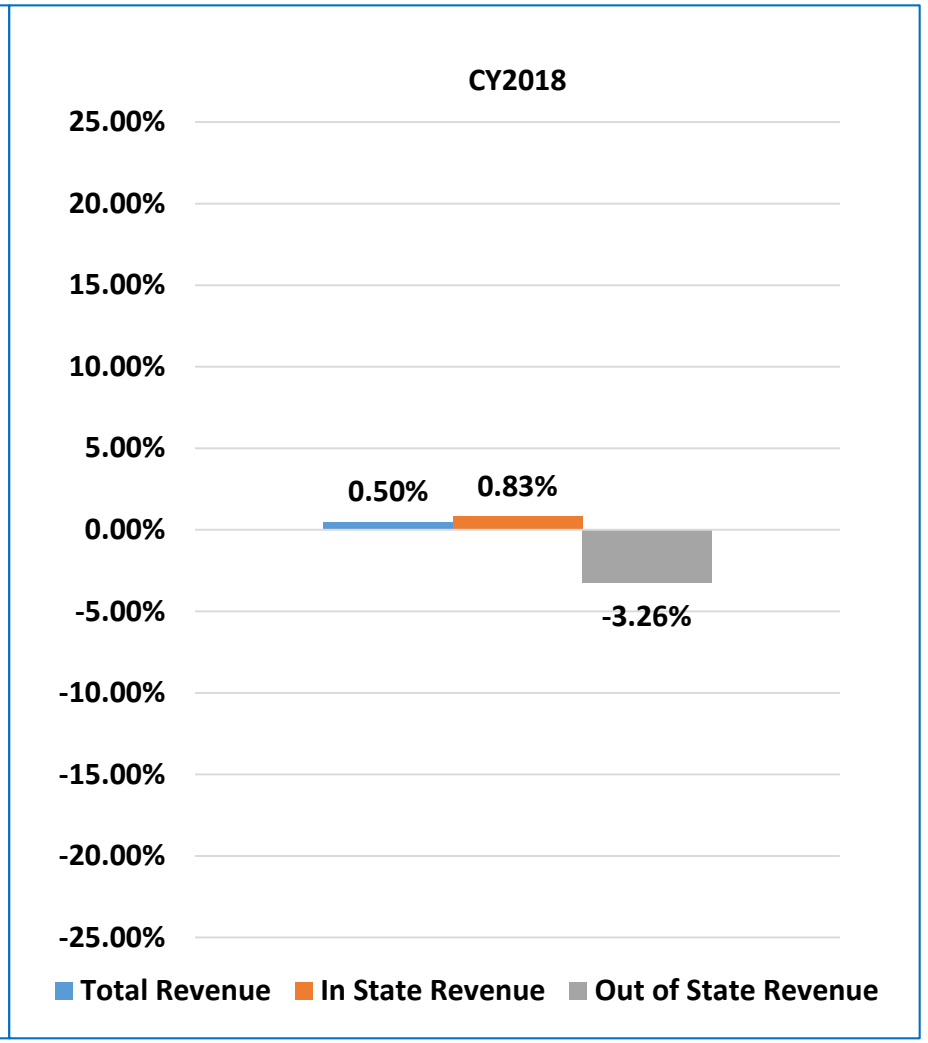
The State's Fiscal Year begins July 1

HSCRC
Health Services Cost Review Commission

Gross Medicare Fee for Service Hospital Revenue Growth

FY 2019 (July 18 – Sept 18 over July 17 – Sept 17) and CY 2018 (Jan - Sept 18 over Jan - Sept 17)



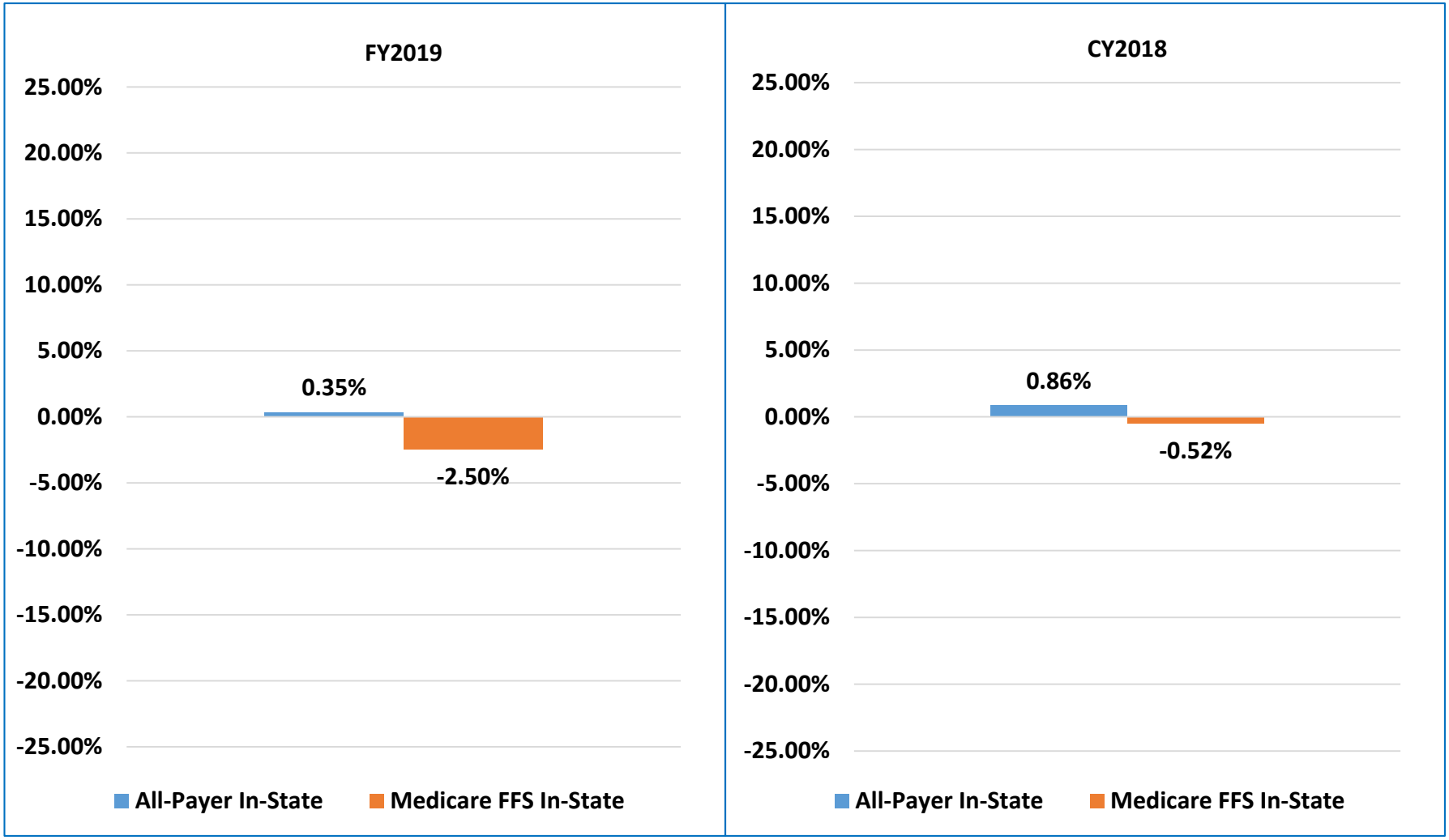


The State's Fiscal Year begins July 1

HSCRC
Health Services Cost Review Commission

Hospital Revenue Per Capita Growth Rates

FY 2019 (July 18 – Sept 18 over July 17 – Sept 17) and CY 2018 (Jan - Sept 18 over Jan - Sept 17)

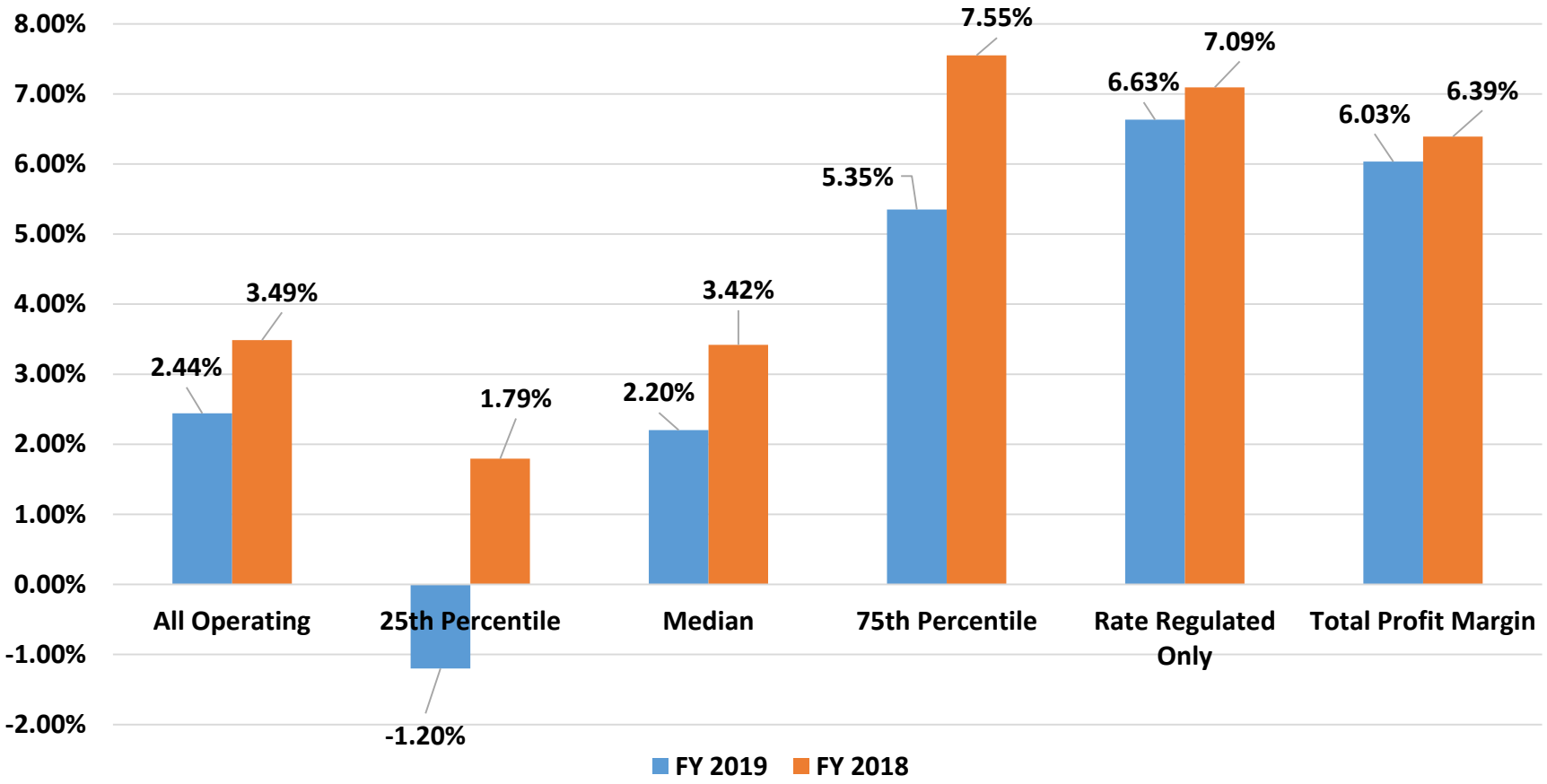


The State's Fiscal Year begins July 1

HSCRC
Health Services Cost Review Commission

Hospital Operating, Regulated and Total Profits

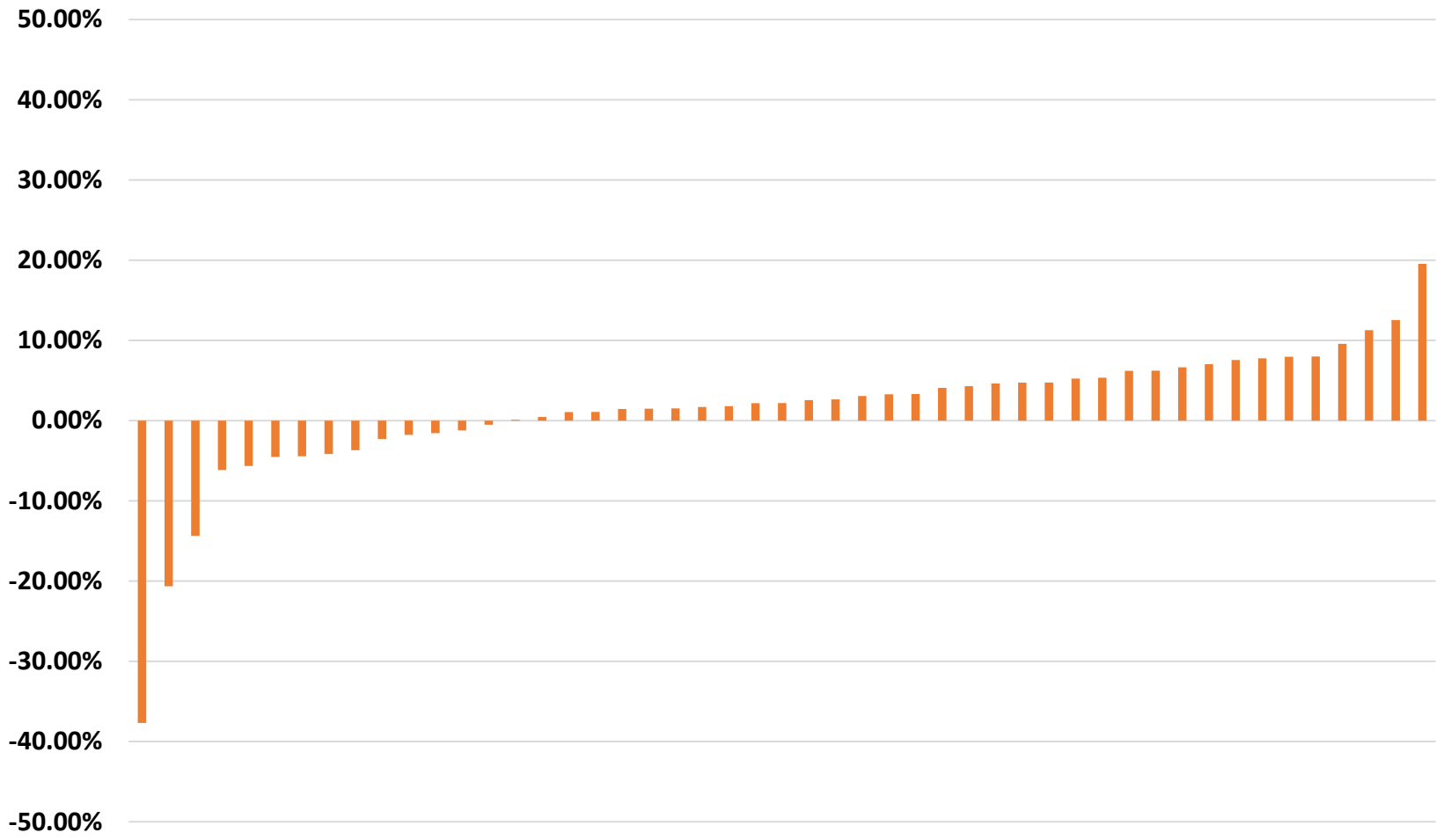
Fiscal Year 2019 (July 2018 – September 2018) Compared to Fiscal Year 2018 (July 2017 – September 2017)



FY 2019 unaudited hospital operating profits show a decline of 1.05 percentage points in total operating profits compared to FY 2018. Rate regulated profits for FY 2019 have declined .46 percentage points compared to FY 2018.

Operating Profits by Hospital

Fiscal Year 2019 (July 2018 – September 2018)



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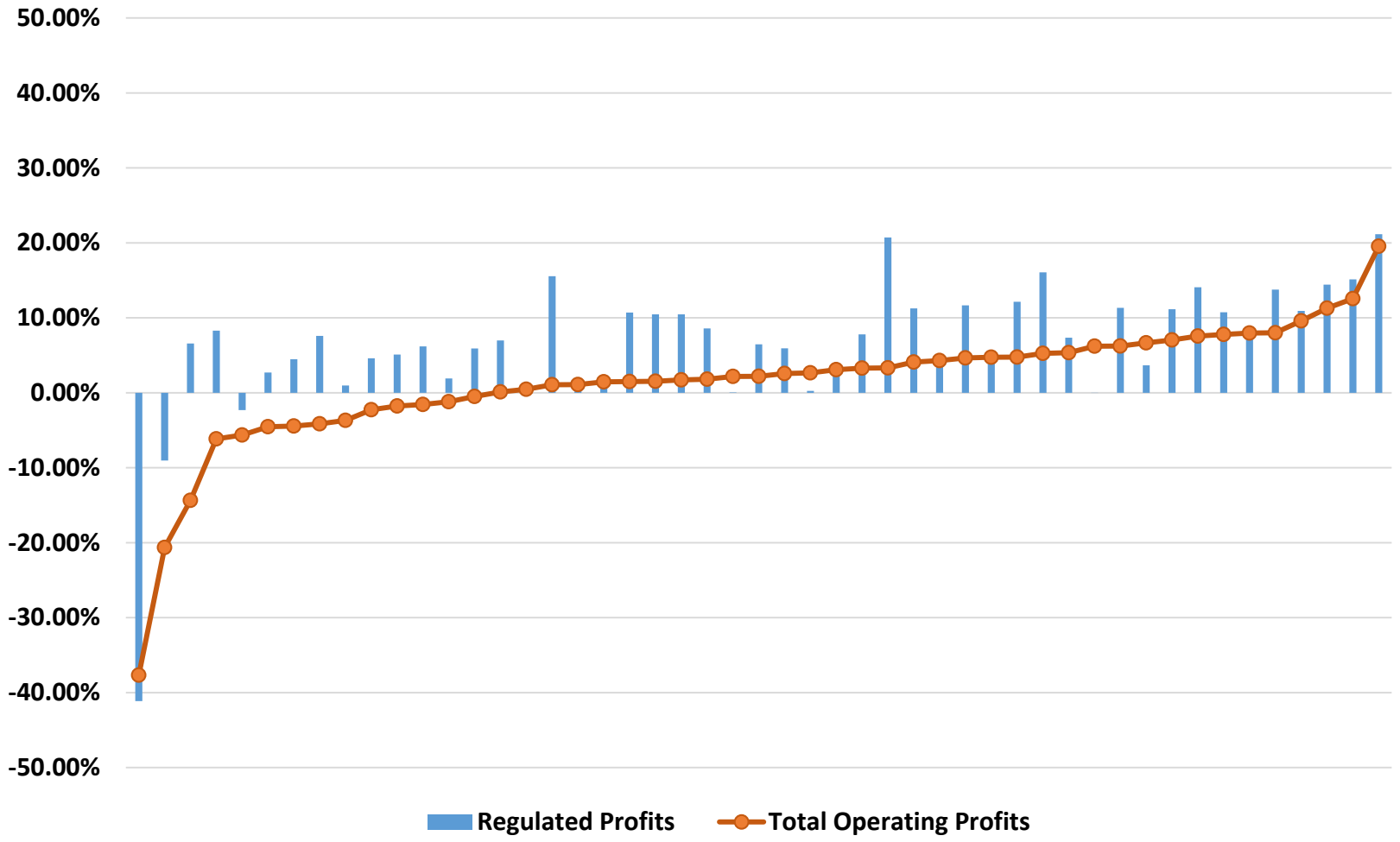
Health Services Cost Review Commission

Operating and Regulated Profits by Hospital

Fiscal Year 2019 (July 2018 – September 2018)



HSCRC
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Monitoring Maryland Performance
Financial/Utilization Data

Calendar Year to Date through September 2018

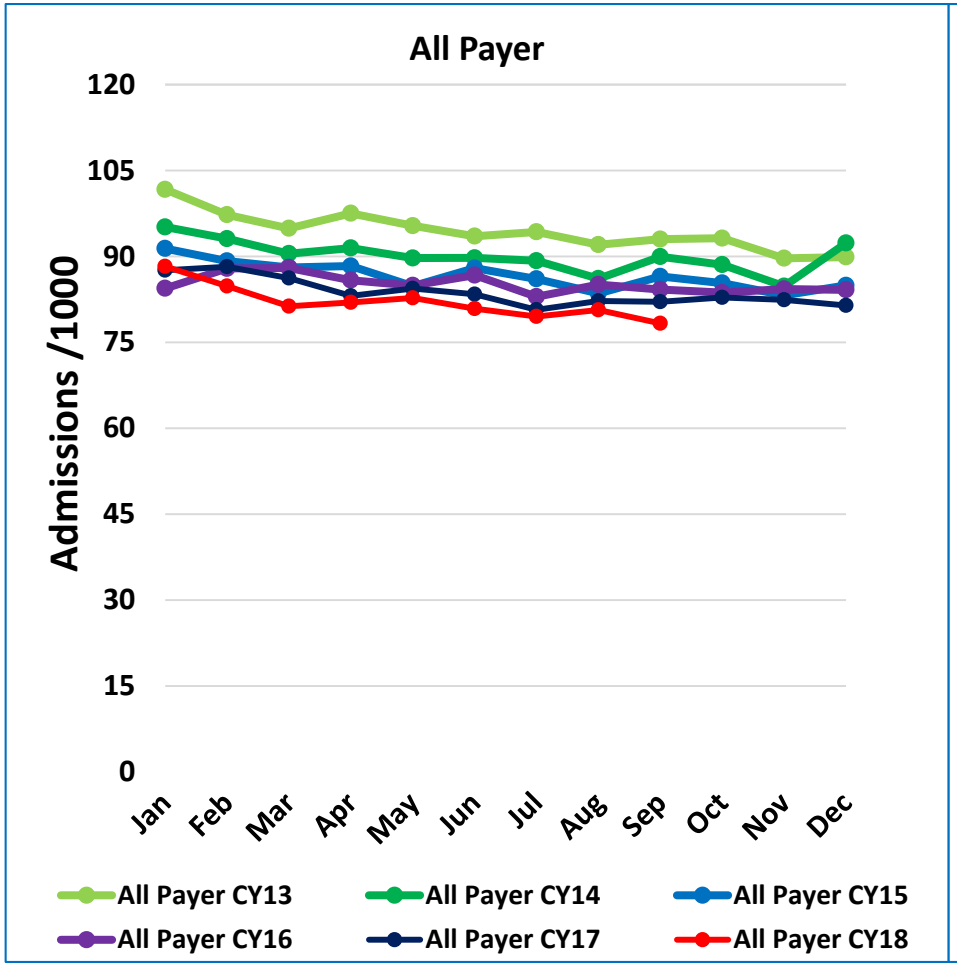
Source: Hospital Monthly Volume and Revenue Data

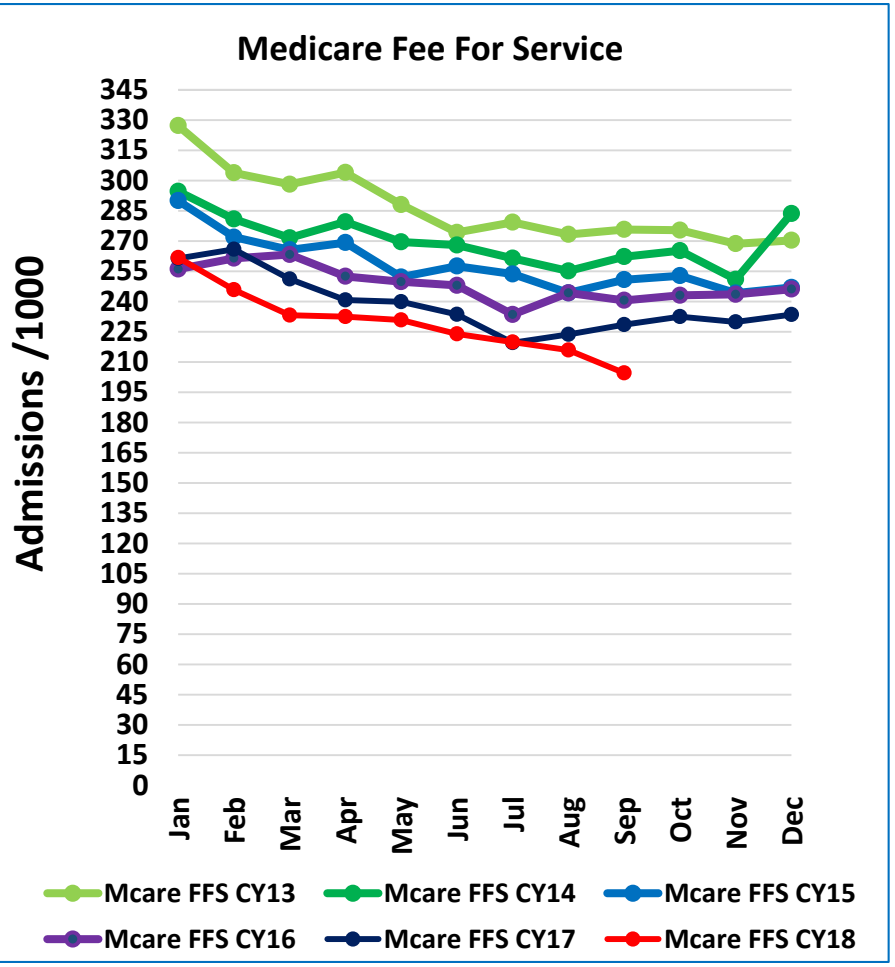
The per capita growth data pertaining to the Medicare FFS beneficiary counts beginning January 1, 2017 have been revised. CMS has changed the enrollment source for the Chronic Condition Data Warehouse (CCW) from the Enrollment Database (EDB) to the Common Medicare Environment (CME) database. Part A changed very slightly and Part B is more noticeably changed.

The Maryland Department of Planning released new population estimates in December 2017. The population numbers used to calculate the ADK, BDK and EDK have been revised accordingly.

Annual Trends for ADK Annualized

All Payer and Medicare Fee For Service (CY 2013 through CY 2018 September)

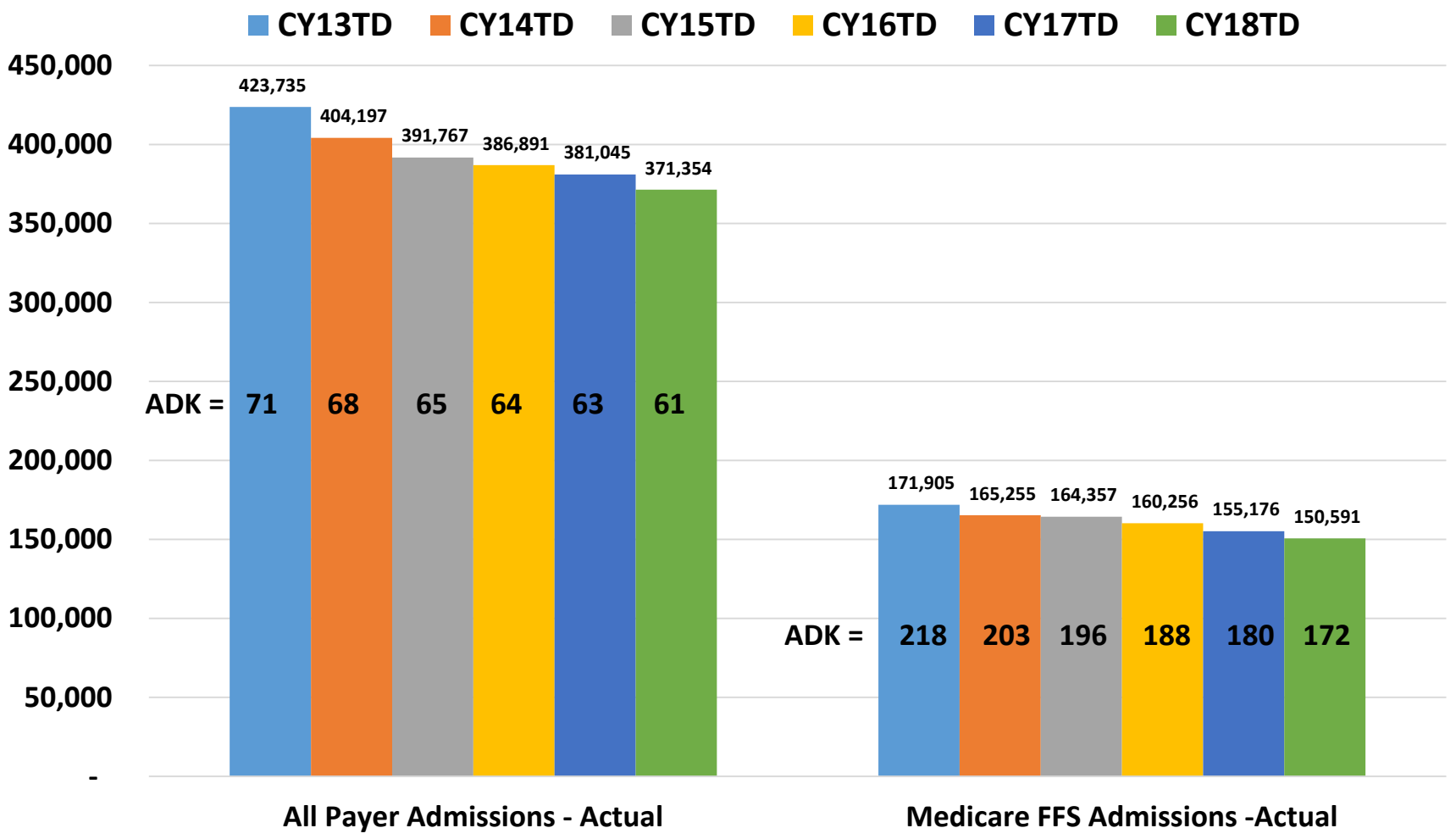




Note - The admissions do not include out of state migration or specialty psych and rehab hospitals.

Actual Admissions by Calendar YTD - September

(CY 2013 through CY 2018)



Note - The admissions do not include out of state migration or specialty psych and rehab hospitals.

Change in Admissions by Calendar YTD August

(CY 2013 through CY 2018)

Change in All Payer Admissions CYTD13 vs. CYTD14 = -4.61%
Change in All Payer Admissions CYTD14 vs. CYTD15 = -3.08%
Change in All Payer Admissions CYTD15 vs. CYTD16 = -1.24%
Change in All Payer Admissions CYTD16 vs. CYTD17 = -1.51%
Change in All Payer Admissions CYTD17 vs. CYTD18 = -2.54%

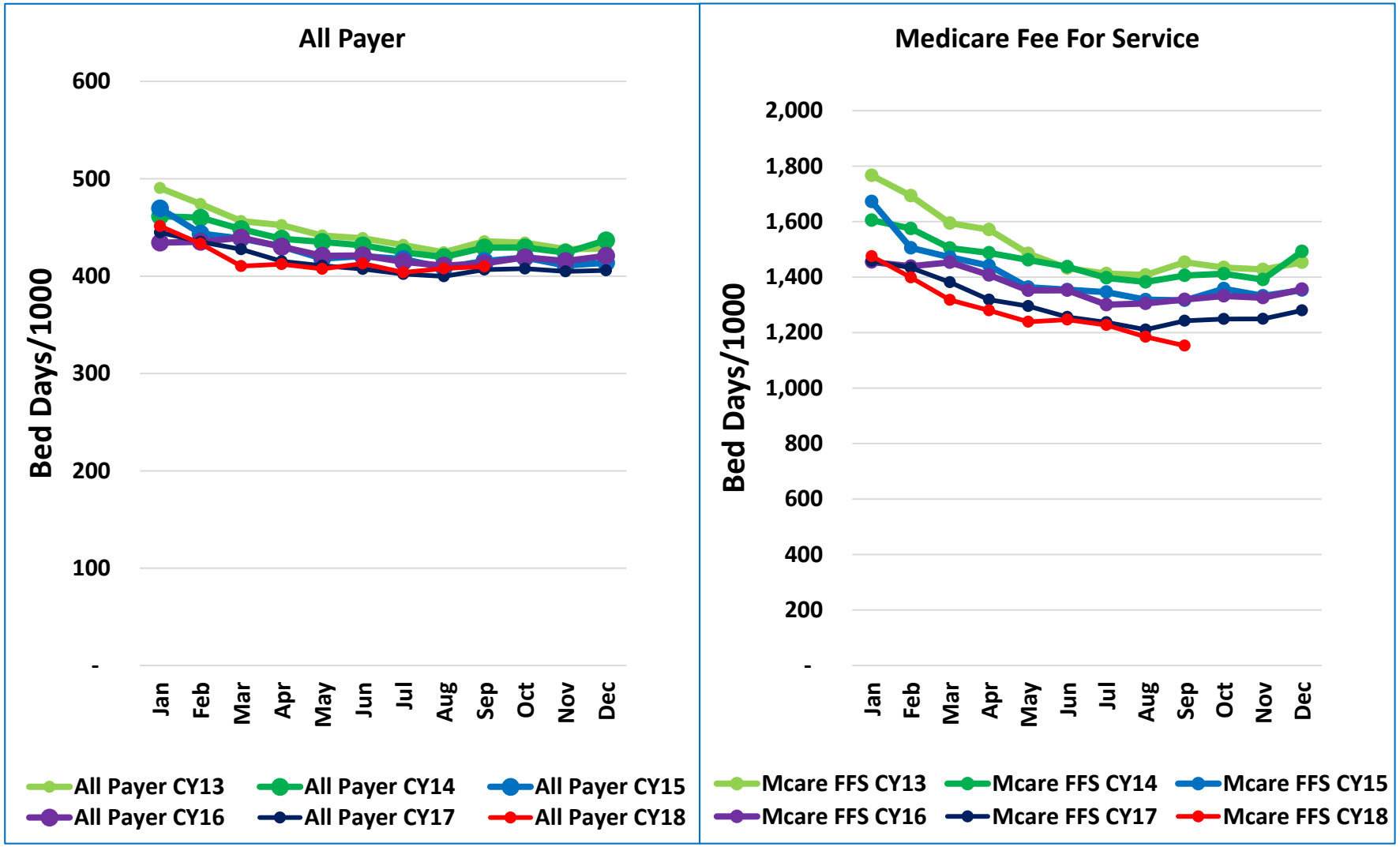
Change in ADK CYTD 13 vs. CYTD 14 = -5.21%
Change in ADK CYTD 14 vs. CYTD 15 = -3.56%
Change in ADK CYTD 15 vs. CYTD 16 = -1.64%
Change in ADK CYTD 16 vs. CYTD 17 = -1.96%
Change in ADK CYTD 17 vs. CYTD 18 = -2.54%

Change in Medicare FFS Admissions CYTD13 vs. CYTD14 = -3.87%
Change in Medicare FFS Admissions CYTD14 vs. CYTD15 = -0.54%
Change in Medicare FFS Admissions CYTD15 vs. CYTD16 = -2.50%
Change in Medicare FFS Admissions CYTD16 vs. CYTD17 = -3.17%
Change in Medicare FFS Admissions CYTD17 vs. CYTD18 = -2.95%

Change in Medicare FFS ADK CYTD 13 vs. CYTD 14 = -6.91%
Change in Medicare FFS ADK CYTD 14 vs. CYTD 15 = -3.59%
Change in Medicare FFS ADK CYTD 15 vs. CYTD 16 = -4.13%
Change in Medicare FFS ADK CYTD 16 vs. CYTD 17 = -4.19%
Change in Medicare FFS ADK CYTD 17 vs. CYTD 18 = -4.38%

Annual Trends for BDK Annualized

All Payer and Medicare Fee For Service (CY 2013 through CY 2018 September)

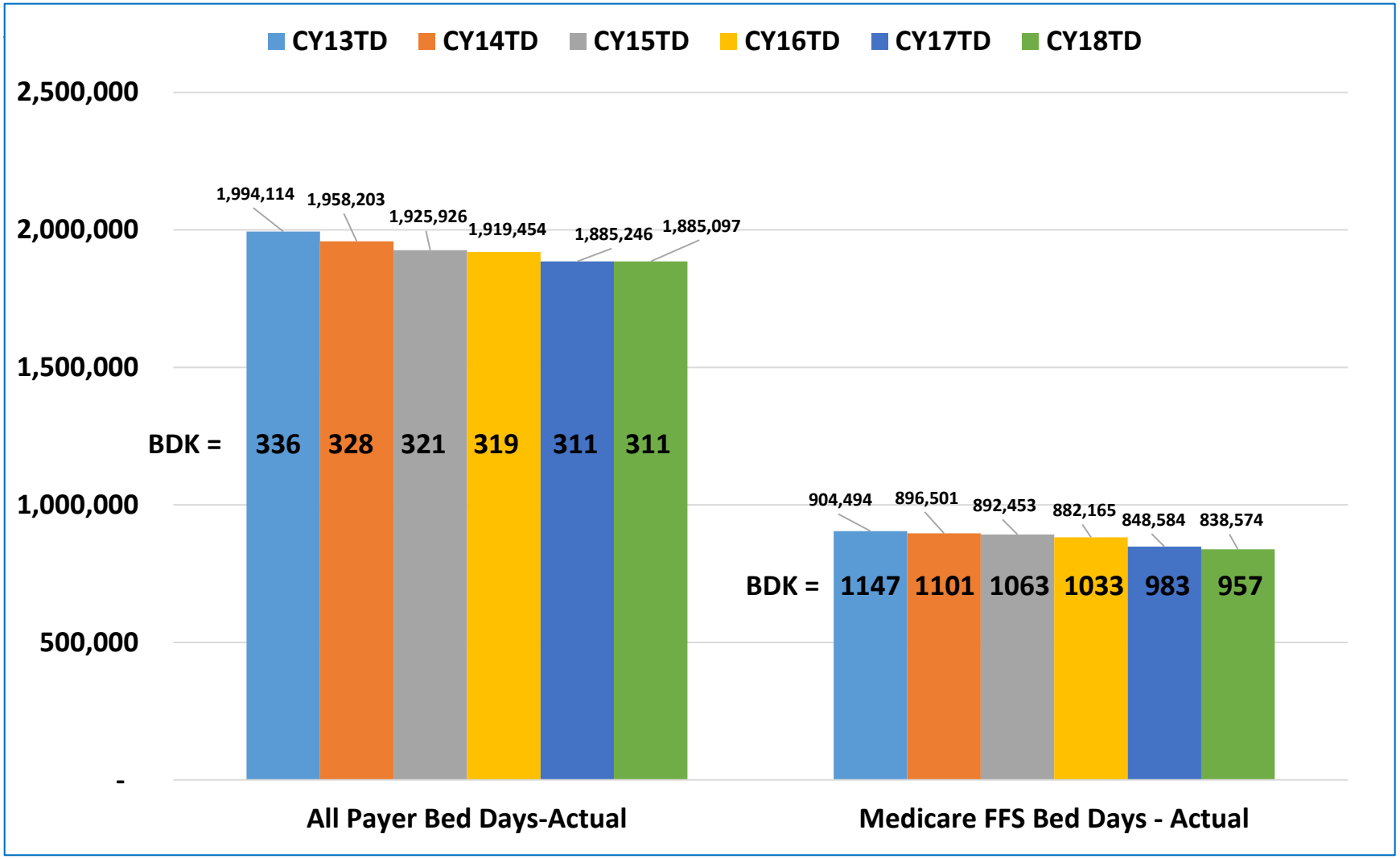


Note - The bed days do not include out of state migration or specialty psych and rehab hospitals.

HSCRC
Health Services Cost Review Commission

Actual Bed Days by Calendar YTD September

(CY 2013 through CY 2018)



Note - The bed days do not include out of state migration or specialty psych and rehab hospitals.

HSCRC
Health Services Cost Review Commission

Change in Bed Days by Calendar YTD August

(CY 2013 through CY 2018)

Change in All Payer Bed Days CYTD13 vs. CYTD14 = -1.80%
Change in All Payer Bed Days CYTD14 vs. CYTD15 = -1.65%
Change in All Payer Bed Days CYTD15 vs. CYTD16 = -0.34%
Change in All Payer Bed Days CYTD16 vs. CYTD17 = -1.78%
Change in All Payer Bed Days CYTD17 vs. CYTD18 = -0.01%

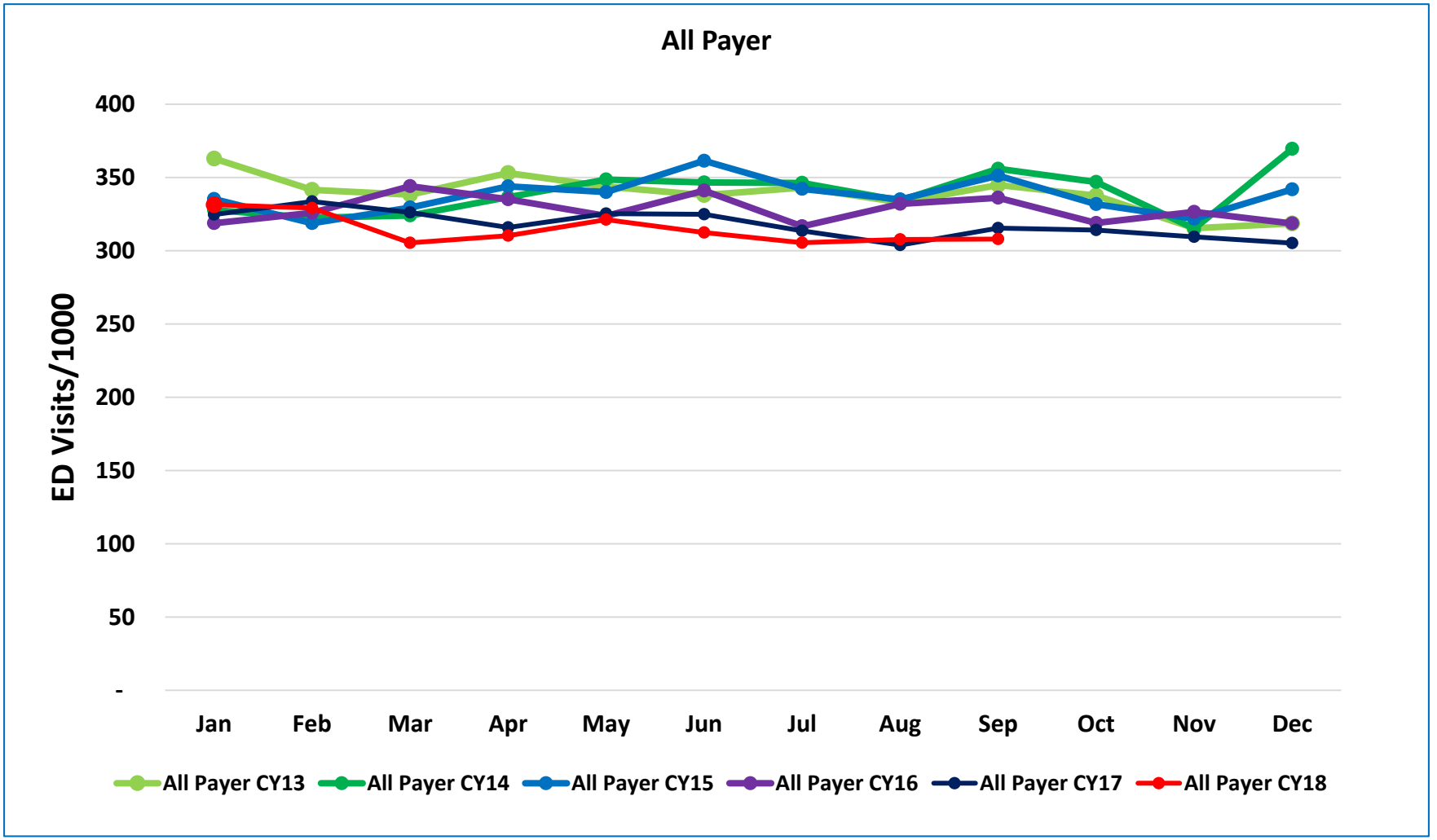
Change in BDK CYTD 13 vs. CYTD 14 = -2.42%
Change in BDK CYTD 14 vs. CYTD 15 = -2.15%
Change in BDK CYTD 15 vs. CYTD 16 = -0.74%
Change in BDK CYTD 16 vs. CYTD 17 = -2.23%
Change in BDK CYTD 17 vs. CYTD 18 = -0.01%

Change in Medicare FFS Bed Days CYTD13 vs. CYTD14 = -0.88%
Change in Medicare FFS Bed Days CYTD14 vs. CYTD15 = -0.45%
Change in Medicare FFS Bed Days CYTD15 vs. CYTD16 = -1.15%
Change in Medicare FFS Bed Days CYTD16 vs. CYTD17 = -3.81%
Change in Medicare FFS Bed Days CYTD17 vs. CYTD18 = -1.18%

Change in Medicare FFS BDK CYTD 13 vs. CYTD 14 = -4.02%
Change in Medicare FFS BDK CYTD 14 vs. CYTD 15 = -3.49%
Change in Medicare FFS BDK CYTD 15 vs. CYTD 16 = -2.82%
Change in Medicare FFS BDK CYTD 16 vs. CYTD 17 = -4.83%
Change in Medicare FFS BDK CYTD 17 vs. CYTD 18 = -2.63%

Annual Trends for EDK Annualized

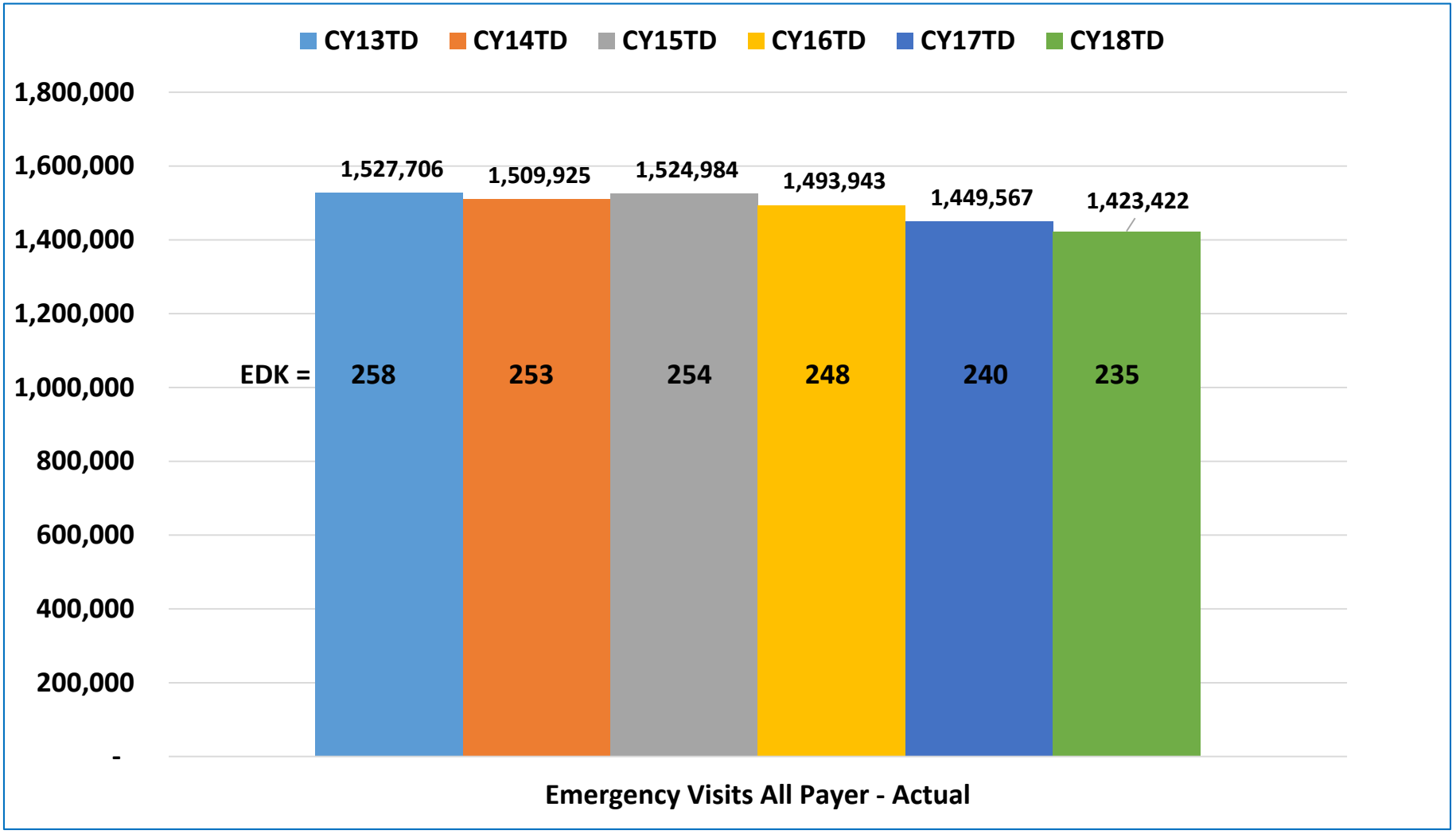
All Payer (CY 2013 through CY2018 September)



Note - The ED Visits do not include out of state migration or specialty psych and rehab hospitals.

Actual Emergency Dept. Visits by Calendar YTD September

(CY 2013 through CY 2018)



Note - The ED Visits do not include out of state migration or specialty psych and rehab hospitals.

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Change in ED Visits by Calendar YTD August

(CY 2013 through CY 2018)

Change in ED Visits CYTD 13 vs. CYTD 14 = -1.16%
Change in ED Visits CYTD 14 vs. CYTD 15 = 1.00%
Change in ED Visits CYTD 15 vs. CYTD 16 = -2.04%
Change in ED Visits CYTD 16 vs. CYTD 17 = -2.97%
Change in ED Visits CYTD 17 vs. CYTD 18 = -1.80%

Change in EDK CYTD 13 vs. CYTD 14 = -1.79%
Change in EDK CYTD 14 vs. CYTD 15 = 0.49%
Change in EDK CYTD 15 vs. CYTD 16 = -2.43%
Change in EDK CYTD 16 vs. CYTD 17 = -3.41%
Change in EDK CYTD 17 vs. CYTD 18 = -1.80%

Purpose of Monitoring Maryland Performance

Evaluate Maryland's performance against All-Payer Model requirements:

All-Payer total hospital per capita revenue growth ceiling for Maryland residents tied to long term state economic growth (GSP) per capita

- 3.58% annual growth rate

- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of $330 million in savings over 5 years
- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets

Data Caveats

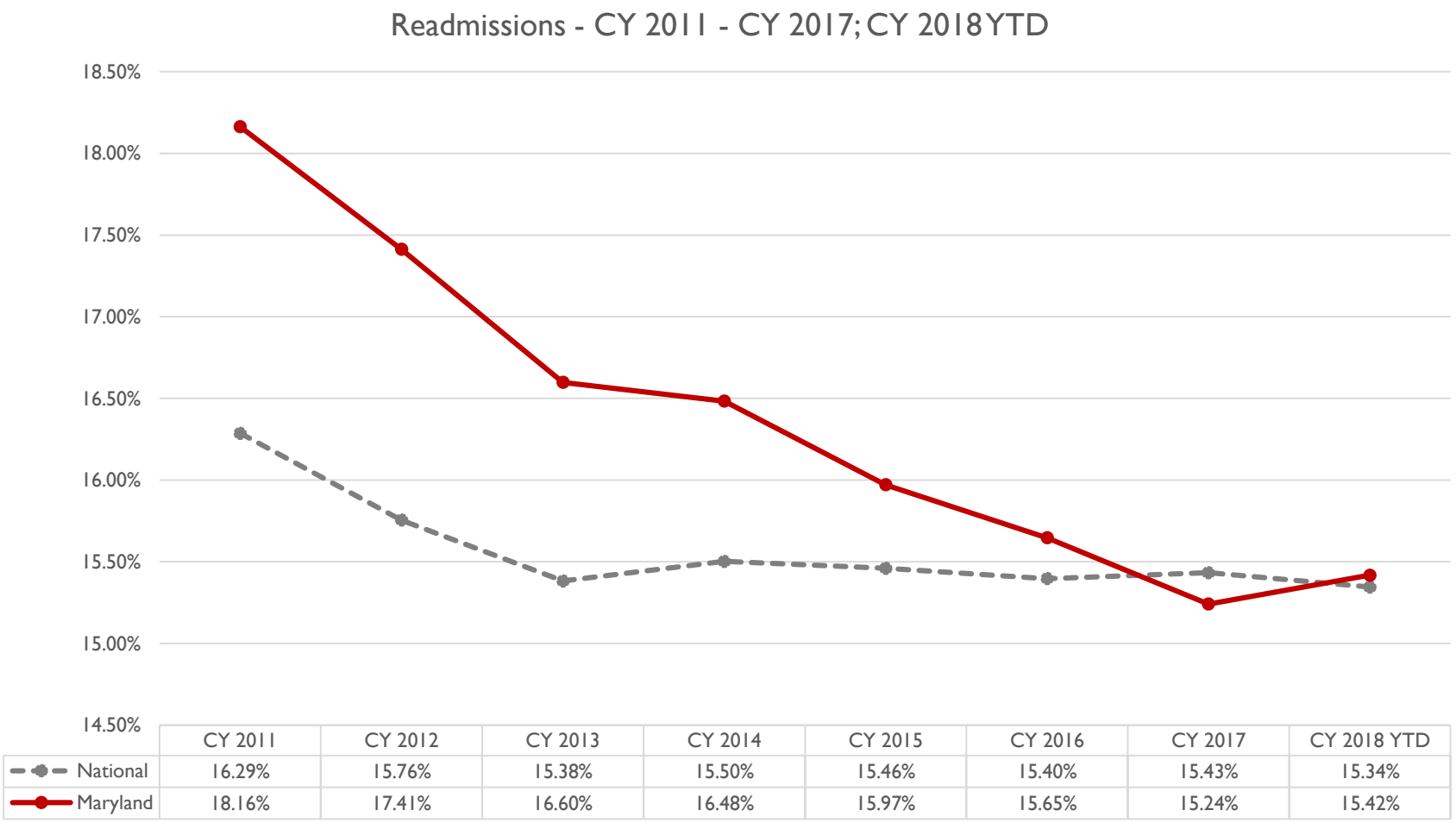
- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2015 CY 2016 and FY 2017 rely on Maryland Department of Planning projections of population growth of .36% for FY18 and FY17, .52% for FY 16, and .52% for CY 15. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

Monitoring Maryland Performance
Quality Data

November 2018 Commission Meeting Update

Medicare Readmission Model Test

Readmissions – 2011-2017; 2018 YTD through Jun



	CY 2011	CY 2012	CY 2013	CY 2014	CY 2015	CY 2016	CY 2017	CY 2018 YTD
National	16.29%	15.76%	15.38%	15.50%	15.46%	15.40%	15.43%	15.34%
Maryland	18.16%	17.41%	16.60%	16.48%	15.97%	15.65%	15.24%	15.42%

HSCRC
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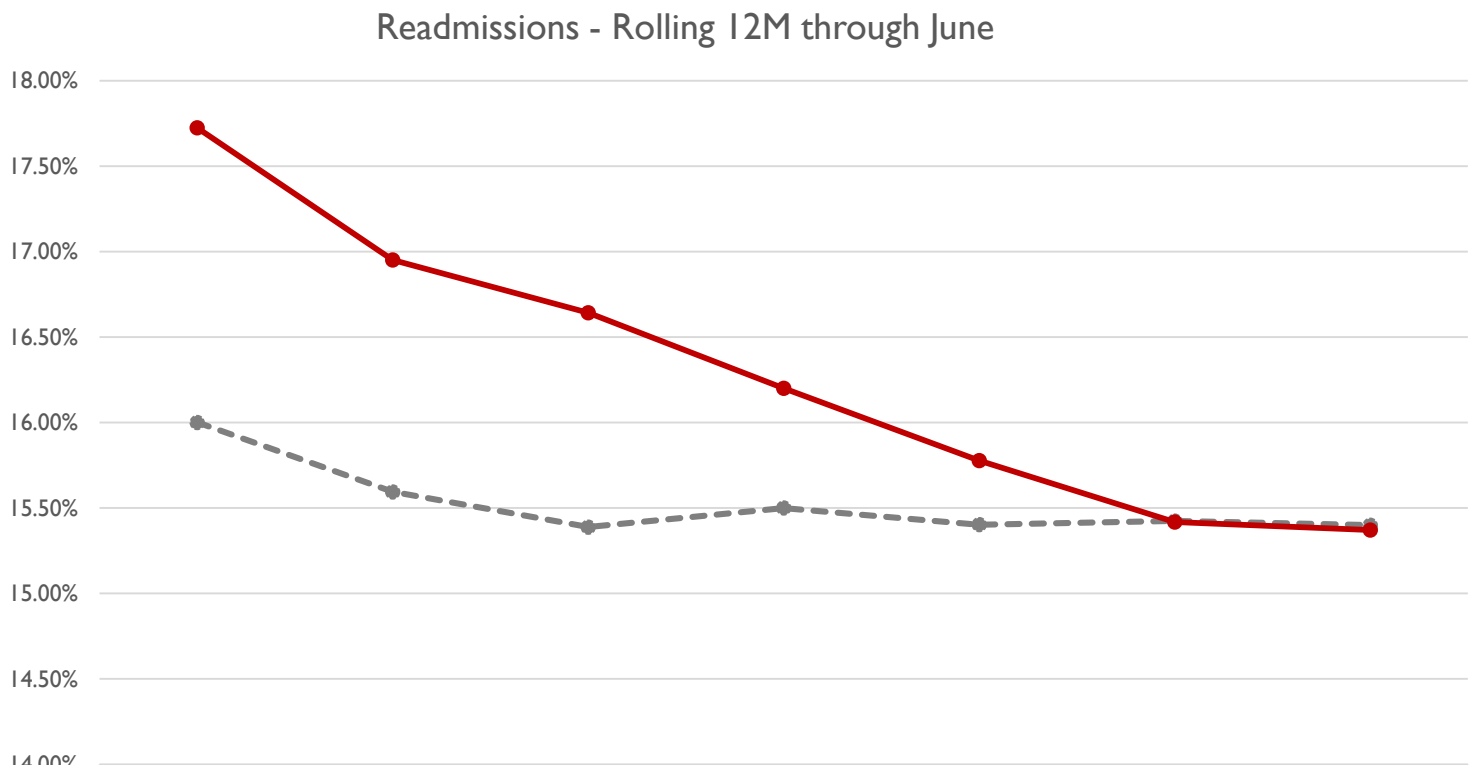
Medicare Readmissions – Rolling 12 Months Trend



	Rolling 12M 2012	Rolling 12M 2013	Rolling 12M 2014	Rolling 12M 2015	Rolling 12M 2016	Rolling 12M 2017	Rolling 12M 2018
National	16.00%	15.59%	15.39%	15.50%	15.40%	15.42%	15.40%
Maryland	17.72%	16.95%	16.64%	16.20%	15.78%	15.42%	15.37%

Data are currently available through June 2018

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 NOVEMBER 5, 2018

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2452A	Johns Hopkins Health System	9/6/2018	N/A	N/A	ARM	AP	OPEN
2453A	MedStar Health	9/6/2018	N/A	N/A	ARM	AP	OPEN
2458A	University of Maryland Medical Center	10/1/2018	N/A	N/A	ARM	DNP	OPEN
2459A	Maryland Physicians Care	10/1/2018	N/A	N/A	ARM	DNP	OPEN
2460A	University of Maryland Medical Center	10/15/2018	N/A	N/A	ARM	DNP	OPEN
2461A	University of Maryland Medical Center	10/15/2018	N/A	N/A	ARM	DNP	OPEN
2462A	University of Maryland Medical System	10/15/2018	N/A	N/A	ARM	DNP	OPEN
2463A	University of Maryland Medical System	10/15/2018	N/A	N/A	ARM	AP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2018**
MEDICAL CENTER	*****	**FOLIO:**	**2270**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2460A**

Staff Recommendation

November 14, 2018

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed a renewal application with the HSCRC on October 15, 2018 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for participation in a new global rate arrangement for solid organ and blood and bone marrow transplant services with Humana for a one-year period, effective December 1, 2018.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

V. STAFF EVALUATION

Although there has been no activity under this arrangement in the last year, staff believes that the

Hospital can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period beginning December 1, 2018.

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

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2018**
MEDICAL CENTER	*****	**FOLIO:**	**2271**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2461A**

Staff Recommendation

November 14, 2018

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed an application with the HSCRC on October 15, 2018 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with INTERLINK for a period of one year, effective December 1, 2018.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. (UPI). UPI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

Hospital can achieve a favorable experience under this arrangement.

V I. STAFF RECOMMENDATION

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

Final Recommendation: RY 2021 (Y2) Medicare Performance Adjustment (MPA)

November 14, 2018

HSCRC
Health Services Cost Review Commission

Medicare Performance Adjustment (MPA)

- **What is it?**
  - A scaled adjustment for each hospital based on its performance relative to a Medicare Total Cost of Care (TCOC) benchmark

- **Objectives**
  - Brings direct accountability to individual hospitals on Medicare TCOC performance
  - Links non-hospital costs and quality measures to the TCOC Model, allowing participating clinicians to be eligible for bonuses under MACRA
  - Additional flexibility to use as Efficiency Adjustment and as a Care Redesign tool

RY 2021 MPA Staff Recommendations

Attribution

- Reorganize algorithm to ensure that all of a provider's attributed beneficiaries are linked with the same hospital
  - 1) Beneficiary Attribution to PCPs
  - 2) Provider-to-Hospital Linkage
- Add MDPCP-actual beneficiaries attributed to PCPs in MDPCP for Step 1
- Hospital-affiliated CTO and voluntary employment for Step 2

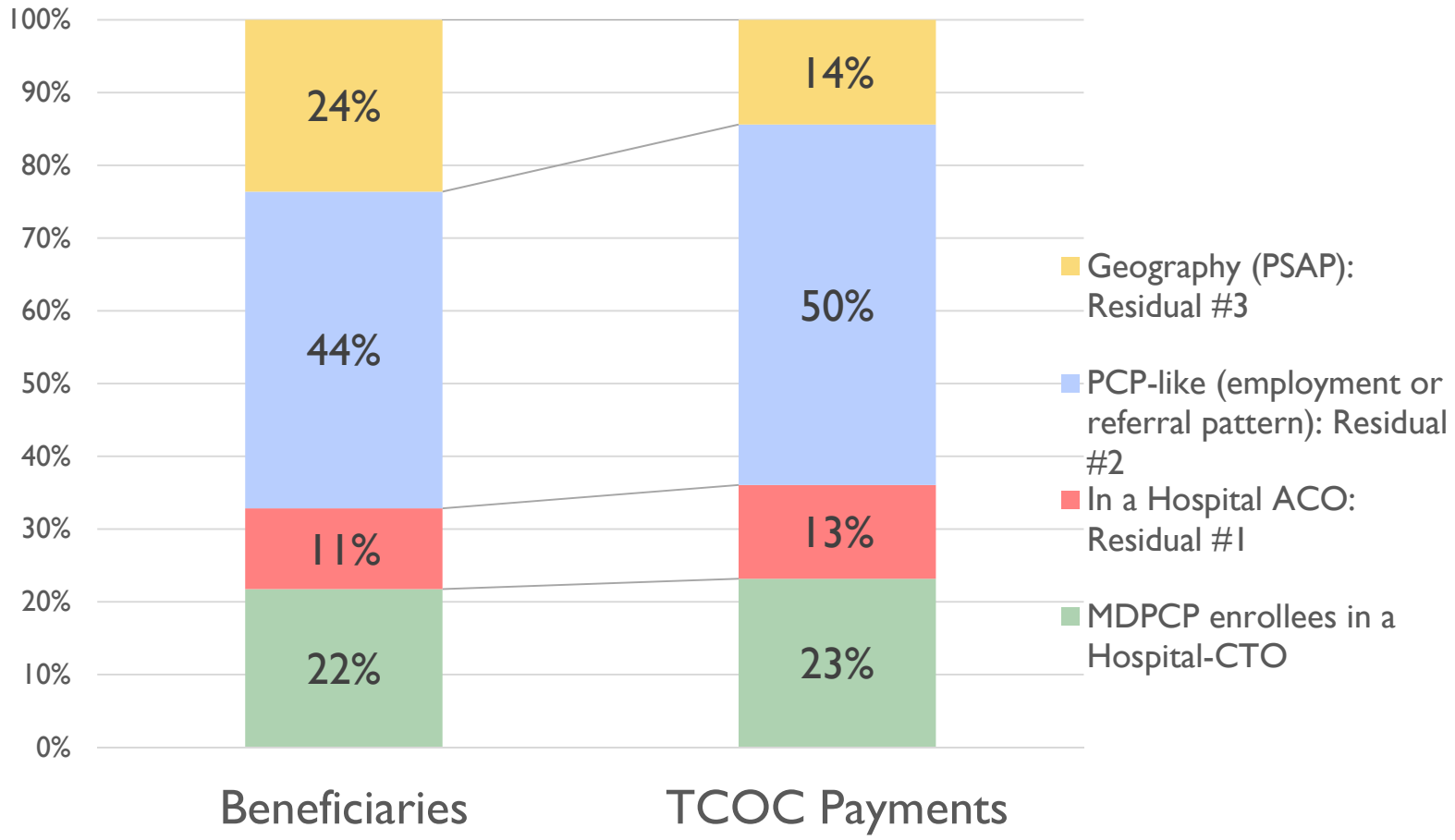
Performance Assessment

- Set each hospital's maximum reward and penalty at 1% of federal Medicare hospital revenue with maximum performance thresholds of ±3%
- Set the TCOC Benchmark as each hospital's CY 2018 TCOC, updated with a Trend Factor of 0.33% below the national Medicare growth rate for CY 2019
- Add New Enrollee Risk Adjustment and continue to work on TCOC benchmarking methodology for attainment

Attribution

- Once beneficiaries are attributed to PCPs, those PCPs are then linked to hospitals.
  - All beneficiaries attributed to a PCP are attributed to the same hospital
- PCPs will be linked to hospitals using the following hierarchy
  1. *New:* Participating with a hospital-affiliated Care Transformation Organization (CTO)
  2. Participating with a hospital-affiliated ACO
  3. *New:* Employed by a hospital entity (voluntary submission)
  4. Provider referral patterns
- PCPs participating together in MDPCP practice will be considered as a single provider throughout the PCP-to-hospital linkage process

Proposed Y2 MPA Provider-to-Hospital Attribution Algorithm



Source: HSCRC analysis based on CY 2017 Medicare (CCW) data

RY 2021 MPA Staff Recommendations, cont.

Accounting for MDPCP Expenditures:

- Staff propose gradually incorporating MDPCP expenditures into the MPA performance assessment.
- Excluding Care Management Fees (CMF) and Performance-based Incentive Payments (PBIP) in CY19 allows hospitals to be held harmless while this additional revenue is incorporated into the base year comparison for future rate years.

		CPCP	CMF	PBIP
RY2021	MPA Base: CY18	✗	✗	✗
	MPA Performance: CY19	✓	✗	✗
	Tentative CMS State Financial Test	✓	✓	✗
RY2022	MPA Base: CY19	✓	✓	✗
	MPA Performance: CY20	✓	✓	✗
	Tentative CMS State Financial Test	✓	✓	Net CY19 PBIP
RY2023	MPA Base: CY20	✓	✓	Net CY19 PBIP
	MPA Performance: CY21	✓	✓	Net CY20 PBIP
	Tentative CMS State Financial Test	✓	✓	Net CY20 PBIP

Types of MDPCP expenses:

1. Comprehensive Primary Care Payments (CPCP) with reduced FFS expenses for Track 2 participants
2. Care Management Fees (CMF)
3. Performance-based Incentive Payments (PBIP)

RY 2021 MPA Staff Recommendations, cont.

Stakeholder Engagement

- Continue to evaluate the MPA throughout the year and consider enhancements for a Year 3 MPA policy, obtaining input through continued meetings of the TCOC Workgroup

Implementation

- Added formal attribution review period to resolve issues and address unique situations
- Provide some financial protection to hospitals by winsorizing extreme values at the 99th percentile (approximately $200,000)
- Continue to 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.

Feedback addressed

Feedback	HSCRC Response
Exclude MDPCP care management fees in MPA performance assessment.	• Addressed in final recommendation. • MDPCP care management fees and performance payments will be excluded from CY19 performance but will be incorporated in future years.
Risk adjustment including diagnoses and social determinants	• Addressed in final recommendation. • Recommend the New Enrollee Risk Adjustment approach, as specified in draft.
Financial protections against extreme cases	• Addressed in final recommendation. • Winsorize extreme cases at 99%.
Attribution Review Process	• Addressed in final recommendation. • Purpose is to review for errors, not revisit attribution algorithm.
Encouraging Equitable Care	• Amended final recommendation to include equitable as a subcomponent of the MPA guiding principles (Principle 2.1).
Strengthen Consumer Engagement and Feedback	• HSCRC is developing TCOC Model communications plan, and plans to leverage the Consumer-Standing Advisory Committee for input.

Looking Forward on MPA Policy

- Impact to RY 2021 maximum revenue guardrail for quality programs
- Continue to monitor MPA performance, tools, and possible changes with TCOC Work Group
- Attainment adjustment makes sense conceptually
  - But need appropriate benchmarks/comparisons
  - Benchmarking work has begun
  - Additional risk adjustment merited when including attainment?

Final Recommendation for the Medicare Performance Adjustment (MPA) Policy for Rate Year 2021

November 14, 2018

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

Table of Contents

PROPOSED COMMISSION ACTION

Staff will be asking the Commission to vote on the final MPA recommendation for RY 2021. The final recommendation remains largely unchanged compared to the draft, with the exception of specifying that Maryland Primary Care Program (MDPCP) care management fees will be excluded from the MPA assessment of total cost of care in the RY2021 policy.

FINAL RECOMMENDATIONS FOR RY 2021 MPA POLICY

1) Measure Medicare Total Cost of Care (TCOC) by attributing Medicare fee-for-service beneficiaries to non-hospital providers, primarily based on use of primary care services, and then linking providers to hospitals based on existing relationships.
    a) Use a hierarchy of Maryland Primary Care Program (MDPCP)-actual, Accountable Care Organization (ACO)-like, PCP-like, and Geographic attribution for beneficiary-to-provider attribution
    b) Use existing provider-hospital relationships to link providers to hospitals based on a hierarchy of hospital-affiliated Care Transformation Organizations (CTOs), hospital-affiliated ACOs, hospital employment, and provider referral patterns
    c) Implement official algorithm result review period
2) Set the maximum penalty at 1.0% and the maximum reward at 1.0% of federal Medicare revenue with maximum performance threshold of ±3%.
3) Set the TCOC benchmark as each hospital's risk-adjusted (demographics only) TCOC from 2018, updated with a Trend Factor of 0.33% below the national Medicare FFS growth rate for CY 2019. In CY 2019, exclude MDPCP Care Management Fees and Performance-based Incentive Payments, but include Comprehensive Primary Care Payments for Track 2 practices.
4) Continue to assess performance on each hospital's own improvement in its attributed population's per capita TCOC
    a) Adjust for year-over-year changes in the demographic characteristics of the hospital's attributed population
    b) For future years, continue to explore incorporating attainment and further risk adjustment into the MPA's performance assessment
5) Include the MPA as part of the aggregate revenue at risk under HSCRC quality programs.
6) Continue to evaluate the MPA throughout the year and consider enhancements for future MPA policies, obtaining input through continued meetings of the TCOC Work Group.
7) Provide national Medicare growth rate estimates relative to Maryland throughout the year to help hospitals monitor their progress.
8) Continue to 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.

INTRODUCTION

The State implemented a value-based payment adjustment, referred to as the Medicare Performance Adjustment (MPA), with performance beginning in Calendar Year (CY) 2018. The MPA brings direct financial accountability to individual hospitals based on the total cost of care (TCOC) of Medicare fee-for-service (FFS) beneficiaries attributed to them.

MEDICARE PERFORMANCE ADJUSTMENT MECHANICS

To calculate the MPA percentage adjustment to each hospital's federal Medicare payments (limited in the second year, RY 2021, to a positive or negative adjustment of no more than 1.0%), the policy must determine the following: an algorithm for attributing Maryland Medicare beneficiaries and their TCOC to one or more hospitals without double-counting; 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 HSCRC explored potential changes to the MPA based on extensive feedback from the industry and other stakeholders via its Total Cost of Care Workgroup and other meetings. This recommendation reflects valuable insights provided by the work group—which has held regular public meetings over the past two years—as well as analyses by HSCRC contractors LD Consulting and Mathematica Policy Research (MPR), and other communications and meetings with stakeholders.

The key objective of the MPA for Year 2 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.

Total Cost of Care Attribution Algorithm

For Year 1 of the MPA, a multi-step prospective attribution method assigned 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 the Total Cost of Care Work Group's input and discussion, as well as initial Year 1 experience, HSCRC staff recommends keeping the main elements of the existing algorithm, but with some reorganization and a few key new elements. This recommendation focuses on explaining the new or changed components. The appendices provide additional detail.

General algorithm organization and provider-to-hospital consistency

In response to Maryland Hospital Association comments, staff has reorganized the structure of the algorithm for the RY 2021 policy to first attribute beneficiaries to providers and then link

providers with hospitals, rather than performing the steps simultaneously. This change ensures that each PCP with attributed beneficiaries will be linked with only one hospital, regardless of how a beneficiary is attributed to that PCP. These beneficiaries are attributed to providers based on their use of primary care services. Beneficiaries that cannot be attributed to a provider through MDPCP-actual, ACO-like or PCP-like are attributed directly to a hospital based on geography (that is, where the beneficiary resides). Providers with attributed beneficiaries are linked to hospitals based on existing provider-hospital relationships.

Beneficiary attribution algorithm changes

Addition of Maryland Primary Care Program (MDPCP)-actual beneficiary attribution. With the launch of Maryland Primary Care Program (MDPCP) in January 2019, the TCOC Work Group generally supports alignment between the MPA and MDPCP to further align accountability, improve care, and strengthen physician engagement in controlling Medicare TCOC. To align to this important initiative, staff recommends that beneficiaries are first attributed to PCPs in MDPCP-actual. Beneficiaries' relationships with primary care providers are determined through their use of PCP services, as determined in the MDPCP. Beneficiaries not attributed under MDPCP-actual are then assessed for attribution under the ACO-like and, if necessary, PCP-like, and Geographic attribution based on the beneficiary's zip code of residence compared to each hospital's Primary Service Area-Plus (PSAP).

ACO-like beneficiary attribution. Staff recommends no change to the Accountable Care Organization (ACO)-like beneficiary attribution. Under ACO-like, beneficiaries are attributed based on primary care use of clinicians in a hospital-based ACO. Assignment is based on elements of CMS's ACO attribution logic, which assigns beneficiaries to ACOs according to their PCP use, then use of certain specialists if a traditional PCP cannot be identified.

PCP-like beneficiary attribution. Staff recommends changing the name of the "MDPCP-like" portion of the algorithm to "PCP-like," but otherwise recommends no changes to this component. Beneficiaries not assigned to providers through the MDPCP-actual or ACO-like methods will then be considered for attribution to providers based on their use of PCP services, as approved in the Y1 MPA policy.

Geographic attribution. Staff recommends no changes to this component**.** Any beneficiaries not attributed through MDPCP-actual, ACO-like, or PCP-like components are attributed using the primary service areas listed in each hospital's global budget revenue agreement, and as well as additional zip codes not claimed in any hospital's primary service area (PSA) based on plurality of hospital utilization and drive time. This approach is also referred to as Medicare PSA-Plus or PSAP.

Provider-to-hospital relationships

Year 1 of the MPA included recognizing relationships between ACO providers and hospital-affiliated ACOs, as well as a provider's referral patterns. However, many hospitals expressed strong interest in the MPA accounting for additional relationships. For Year 2 of the MPA,

eligible provider-to-hospital relationships begin with MDPCP provider participation with a hospital-affiliated Care Transformation Organization (CTO), followed by ACO provider participation with an ACO-affiliated hospital. If the provider does not participate with a hospital in these programs, providers may be linked with hospitals based on employment. All remaining providers with attributed beneficiaries will be linked to hospitals based on the referral patterns of their attributed beneficiaries, as described below and in the appendices. Throughout the linkage steps, providers participating in an MDPCP practice will be considered together for the purposes of linkage between providers and hospitals. This ensures that all providers in an MDPCP practice are linked with the same hospital, regardless of the method of linking.

Addition of linkage of MDPCP provider to CTO hospital. Many hospitals are participating in MDPCP as Care Transformation Organizations that help practices provide high-quality care for their beneficiaries. Because of these significant financial investments, staff recommends adding the relationship between MDPCP practices and hospital-affiliated CTOs as the first linkage under the MPA between providers and hospitals. MDPCP practices participating with a hospital-affiliated care transformation organization will be linked with the corresponding hospital, and all attributed beneficiaries for that practice will be attributed to that hospital. All remaining providers and practices will be assessed for linkage through an ACO.

Linkage of ACO provider to ACO hospital. Staff recommends no changes. Remaining providers with attributed beneficiaries not linked under the MDPCP-CTO linkage will be assessed for ACO linkage. Providers participating in an MDPCP practice with a non-hospital affiliated CTO or no CTO will be assessed together as a practice group under this ACO approach. ACO providers participating with a hospital-affiliated ACO will be linked with the corresponding hospital, and all attributed beneficiaries for that provider (regardless of beneficiary attribution method) will be attributed to a hospital. As in the Y1 policy, ACOs with multiple hospitals may designate ACO PCPs to specific ACO hospitals, which will ensure that beneficiaries attributed to those PCPs are attributed to a single hospital; otherwise TCOC will be distributed by Medicare market share (based on federal Medicare FFS hospital payments) of the hospitals in the ACO. All remaining providers and practices will be assessed for linkage based on employment.

Employment linkage. Throughout the past year, some hospital stakeholders have expressed that employment represents one of the strongest links between hospitals and providers. HSCRC staff agree that employment allows for easier coordination and sharing of resources, and therefore should be included in the algorithm, but also believe it is crucial to continue encouraging participation in official payment structures with CMS oversight, such as MDPCP or ACOs. In addition, there is no consistent definition of employment agreed to by all hospitals, and HSCRC will have to rely on voluntary submission of hospital lists that cannot be easily validated. To balance these considerations, HSCRC recommends using employment as a voluntary link between providers and hospitals after the MDPCP and ACO-like linkages. Any providers not linked to hospitals through the CTO or ACO linkages may be linked to hospitals based on voluntary hospital-submitted employment lists. HSCRC will accept the Maryland Hospital Association definition of employment as the eligible providers who will receive a W-2 from the hospital or its parent or subsidiary organization for the calendar year preceding the performance

period with full time status. These lists must be submitted to HSCRC by a specified date and represent full-time, fully employed providers with a single hospital/hospital system. Remaining providers participating in an MDPCP practice not linked with hospital-affiliated CTO or ACO will be assessed together as a practice group based on employment.

Referral pattern linkage. Remaining providers will be assigned to the hospital from which that provider's attributed beneficiaries receive the plurality of their care, as in the Y1 MPA policy. Remaining providers participating in an MDPCP practice not linked with hospital-affiliated CTO, ACO, or employment will be assessed together as a practice group based on referral pattern.

Review period

While staff has worked to address some concerns of the TCOC Work Group, no attribution method is perfect. Therefore, staff recommends the implementation of an official algorithm review period. Following the initial running of the attribution algorithm for Year 2, hospitals will have the opportunity to raise concerns about the attribution algorithm output. This period is intended to ensure the attribution algorithm is performing as expected, not as an opportunity to revisit the core elements of the algorithm.

The review period is intended to serve two purposes: (1) identify and correct mechanical errors (e.g., incorrect data submissions); and (2) address specific cases of unintended and misaligned linkages that do not reflect the intent of the MPA policy. For example, in some scenarios, a provider may have significant relationships with more than one hospital. In this case, the hospitals involved may propose to have joint accountability for the total cost of care. In practice, this could result in a portion of the total cost of care attributed to one hospital and the other portion to another hospital. In evaluating any such proposals, HSCRC staff will consider whether the request is reasonable based on the situation and can be implemented into MPA monitoring reports without significant burden. HSCRC staff will work with the TCOC Work Group to determine guidelines associated with review period proposals.

Opportunities for improving linkages/attribution

Consistent with the Commission's Year 1 MPA final recommendation, HSCRC staff have been working with the TCOC Work Group, the Maryland Hospital Association, and other stakeholders to explore merited changes to the attribution, including attributing providers based on existing physician contractual relationships with hospitals or grouping providers in a practice together. With the start of MDPCP, HSCRC is able to group participating providers in MDPCP practices together throughout the linkage process and ensure providers in an MDPCP practice are linked with the same hospital. Data is limited on extending these approaches outside of MDPCP and analyses performed to date have not revealed a consistent approach that can be consistently applied across hospitals. Staff remain committed to exploring these options with the TCOC Work Group and stakeholders.

Performance Assessment

For Rate Year 2021, which is the MPA's second year of implementation, hospital performance on Medicare TCOC per capita in the performance year (CY 2019) will be compared against the TCOC Benchmark. The TCOC Benchmark will be the hospital's prior (CY 2018) TCOC per capita, updated by a TCOC Trend Factor determined by the Commission, as described in greater detail below. This approach is a year-over-year comparison, based on each hospital's own improvement. In the case that external events impact hospitals' Medicare TCOC (e.g., changes to the differential or reductions to hospital rates), the HSCRC reserves the right to adjust base year performance to capture those changes and better reflect a hospital's 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 providers for whom they will be assuming responsibility in the coming performance year. For attribution for Performance Year 2019, data for the two years ending September 30, 2018 will be used. For attribution for Base Year 2018, data for the two years ending September 30, 2017 will be used.[1]

In response to work group concerns around changes in hospital-attributed populations over time, staff is recommending to add risk adjustment to the year-over-year comparison. This risk adjustment will use Medicare New Enrollee Demographic Risk Score.

The total cost of care for a hospital's beneficiaries attributed through all methods 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. The State's objective is to incentivize hospitals and hospital-based physicians/clinicians to work effectively with community-based physicians/clinicians in order to coordinate care and care transitions, provide effective and efficient care, and focus on high-needs beneficiaries.

This policy for RY2021 represents a continuation of an improvement-only methodology. HSCRC staff is not recommending adopting an attainment policy at this time. An attainment policy for the MPA requires consideration of a number of complex issues, such as an appropriate attainment benchmark, intrinsic differences between hospital payment rates (such as labor market differences, Graduate Medical Education payments, etc.), and an appropriate risk adjustment methodology. In addition, staff is concerned about alignment and performance on the State's Medicare TCOC financial tests with the federal government, which are improvement-only, if an attainment policy is adopted. Staff acknowledge stakeholder support for an attainment policy that may help mitigate concerns about penalizing hospitals that have reduced total cost of

[1] For Base Year 2018 and Performance Year 2019, the algorithm will rely on 2019 ACO lists, MDPCP lists, and employment lists. As a result, each hospital's TCOC performance as assessed for 2018 as the base year will differ from that calculated for 2018 as the performance year, which is based on 2018 ACO lists.

care and explain some variation in spending growth. However, staff believe further discussion and analyses are necessary to implement a responsible and fair attainment policy. HSCRC staff are actively pursuing new options and methodologies for developing benchmarks and are hopeful these efforts will aid in developing an attainment policy. The Total Cost of Care Work Group will continue to discuss attainment as part of its work plan.

TCOC Trend Factor

The MPA for Rate Year 2021, which begins July 2020, will be based on hospital performance on Medicare TCOC per capita in the performance year (CY 2019) compared to its TCOC Benchmark. The TCOC Benchmark will be the hospital's prior (CY 2018) TCOC per capita, updated by the TCOC Trend Factor. Final Medicare TCOC data for the State and the nation for calculating the MPA will be available in May 2020.

Consistent with the RY 2020 policy, HSCRC staff proposes that the TCOC Trend Factor for RY 2021 remains set at 0.33% below the national Medicare FFS growth rate. This is the growth rate calculated as necessary to attain the required Medicare TCOC savings by 2023 under the TCOC Model Agreement with the federal government. Even after being approved by the Commission and CMS, however, the TCOC Trend Factor may be adjusted by the Commission and CMS if necessary to meet Medicare financial tests.

Staff recognizes that some stakeholders have 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.

Accounting for Maryland Primary Care Model (MDPCP) Expenditures

The Maryland Primary Care Model is designed to provide additional funding and flexibility to primary care practices to invest in care management, population health, and other high value services. Staff propose gradually incorporating MDPCP expenditures into the MPA performance assessment. For CY19 expenditures included in the RY 2021 policy, staff propose the following:

- Exclude Care Management Fees (CMF) and Performance-based Incentive Payments (PBIP).
- Include Comprehensive Primary Care Payments (CPCP) paid quarterly to Track 2 MDPCP practices (approximately 10% of practices that applied), along with the sum of their reduced fee-for-service revenue

Beginning with the RY 2022 policy, staff intend to include CMF in both the base year and the performance year. Beginning with the RY 2023 policy, staff intend to include PBIP in both the base year and the performance year. Excluding CMF and PBIP payments in CY19 allows hospitals to be held harmless while this new spending is incorporated into the base year comparison for future rate years.

Special Approaches to Increasing Hospital Accountability

The University of Maryland Rehabilitation and Orthopedic Institute (UMROI) provides specialized stroke rehabilitation services along with other rehabilitation services to patients from across Maryland. Recognizing UMROI as a unique state resource and the challenges with operationalizing the MPA for UMROI, the HSCRC recommends piloting an episode-based approach to increase the financial and quality accountability for Medicare beneficiaries receiving services at UMROI.

Hospitals also have the opportunity to collectively address TCOC (e.g., leverage regional partnerships or other regional accountability) by opting to have multiple hospitals treated as a single hospital for MPA purposes. This opportunity was formally shared with hospital CFOs in an HSCRC memo dated March 14, 2018, for the RY 2020 policy. The opportunity is also available for RY 2021. Such a combination of hospitals must be agreed to by all the hospitals, must include a regional component, and serve a purpose that is enhanced by the combination. For example, a small system hospital with a very small attributed TCOC may enter a combination with a large, nearby system hospital. In this case, the combination creates a more stable pool for the small system hospital and acknowledges the hospitals' shared service areas and resources. Another possible scenario is a number of hospitals in a particular county joining in a combination option, where they already share resources and infrastructure. (System affiliation without a geographic area will not be accepted as a combination rationale.) Hospitals should submit their request before the Performance Year and cannot be changed once the current Performance Year has begun, except as agreed to by HSCRC.

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 2021, the agreement with CMS requires the maximum penalty be set at 1.0% and the maximum reward at 1.0% of hospital federal Medicare revenue.

The 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 3% for RY 2021. Before reaching the RY 2021 Maximum Revenue at Risk of ±1.0%, the Maximum Performance Threshold results in a scaled result — a reward or penalty equal to one-third of the percentage by which the hospital's TCOC differs from its TCOC target.

In addition, the agreement with CMS requires that a quality adjustment be applied that includes the measures in the HSCRC's Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Infections (MHAC). For RY 2021, staff proposes to continue to use the existing RRIP and MHAC all-payer revenue adjustments to determine these quality adjustments; however, staff recognizes that the Commission may choose to add to 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 MHAC and RRIP 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. Regardless of the quality adjustment, the maximum reward and penalty of ±1.0% will not be exceeded. The MPA reward or penalty will be incorporated in the following year through adjusted Medicare hospital payments on Maryland Medicare FFS beneficiaries.

With the maximum ±1.0% Medicare FFS hospital 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.

Comments on Draft RY2021 MPA Recommendation

HSCRC staff received comments from the Maryland Hospital Association (MHA), Consumer Health First (CHF), MedStar Health, University of Maryland Medical System (UMMS), Johns Hopkins Health System (JHHS), and combined comments from JHHS, UMMS, and MedStar Health.

While there were concerns raised over the risk adjustment approach and requests for additional clarity around MDPCP expenditures, comment letters were generally supportive of the MPA draft recommendation and appreciative of changes made to the attribution algorithm.

Additional Considerations for the Attribution Algorithm

Stakeholders expressed broad appreciation for the enhancements to the attribution algorithm. Staff received a few comments from stakeholder recommending small changes to the attribution algorithm (e.g., using ACO-actual provider attribution instead of ACO-like, and moving employment to be the first step in the provider linkage step of the algorithm). Given the different attribution approaches across ACO models, staff recommends retaining ACO-like as it is, which has broader inclusion of additional provider types and allows attribution to remain prospective. At this time, staff recommends monitoring the performance of the attribution algorithm and will continue to consider changes to the attribution algorithm in future MPA design discussions. Staff also recommends having actual MDPCP attribution precede employment relationships, since MDPCP is focused on improving quality and reducing Medicare TCOC, while employment relationships between physicians and hospitals may not reflect the goals of the model.

Increase Robustness of Risk Adjustment

Both provider and consumer stakeholders expressed a desire for more robust risk adjustment in calculating TCOC performance. The HSCRC agrees that some level of risk adjustment in the

MPA is appropriate, but must be balanced against additional administrative burden and unintended consequences. Differences may be better controlled for in an attainment approach by use of peer groups rather than risk adjustment, for future MPA performance assessment. The HSCRC staff remain concerned about risk adjusting based on a beneficiary's full diagnositic profile in risk adjustment. Including the full diagnosticprofile could lead to increased incentives to intensify coding documentation (potentially with differing levels of execution) and overstate the disease burden of the population and adding administrative burden. The State continues to evaluate approaches to incorporate social determinants of health into the MPA policy in a way that incentivizes hospitals to reduce disparities and improve equity. Approaches may include variables such as racial/ethnic identity and the resources available in a patient's community (e.g., area deprivation index (ADI)). Staff plans on adding additional reporting and analytics to monitor trends in health equity and disparities throughout HSCRC programs. To reflect our commitment to equity, staff updated the guiding principles used to inform the design of the MPA to include equity (Appendix 2, Principle 2.1). Staff welcomes additional thoughts from stakeholders on how to incorporate social determinants in a way that fairly holds hospitals accountable for health care outcomes while incentivizing hospitals to improve equity across their populations.

Continued Support of Developing an Attainment Approach

Stakeholders remain very interested in an attainment approach for rewarding performance under the MPA. The HSCRC is currently working with its contractors to develop a statistical approach to construct national hospital peer groups, which is the first step in developing an attainment benchmark. Staff plans on working with the TCOC Work Group to review these results and help develop an overarching attainment approach over the next year.

Other technical suggestions for review in RY 2021

Staff incorporated some additional technical suggestions for Rate Year 2021, such as building in additional financial protections for extremely costly patients. The HSCRC plans to winsorize extreme values at the 99th percentile to provide some insulation to hospitals from expensive but medically necessary cases.

Looking forward: 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 2019, the work group will focus on implementation of the RY 2021 policy and potential improvements for the RY 2022 policy. The TCOC Work Group has provided a valuable forum to obtain input from stakeholders and co-create policies that will lead to our collective success.

FINAL RECOMMENDATIONS FOR RY 2021 MPA POLICY

Based on the assessment above, staff recommends the following for RY 2021 (with details as described above).

1) Measure Medicare Total Cost of Care (TCOC) by attributing Medicare fee-for-service beneficiaries to providers, primarily based on use of primary care services, and then linking providers to hospitals based on existing relationships.
   a) Use a hierarchy of Maryland Primary Care Program (MDPCP)-actual, Accountable Care Organization (ACO)-like, PCP-like, and Primary Service Area-Plus (PSAP) attribution for beneficiary-to-provider attribution
   b) Use existing provider-hospital relationships to link providers to hospitals based on a hierarchy of hospital-affiliated Care Transformation Organizations (CTOs), hospital-affiliated ACOs, hospital employment, and provider referral patterns
   c) Implement official algorithm result review period
2) Set the maximum penalty at 1.0% and the maximum reward at 1.0% of federal Medicare revenue with maximum performance threshold of ±3%.
3) Set the TCOC benchmark as each hospital's risk-adjusted (demographics only) TCOC from 2018, updated with a Trend Factor of 0.33% below the national Medicare FFS growth rate for CY 2019. In CY 2019, exclude MDPCP Care Management Fees and Performance-based Incentive Payments, but include Comprehensive Primary Care Payments for Track 2 practices.
4) Continue to assess performance on each hospital's own improvement in its attributed population's per capita TCOC
   a) Adjust for year-over-year changes in the demographic characteristics of the hospital's attributed population
   b) For future years, continue to explore incorporating attainment and further risk adjustment into the MPA's performance assessment
5) Include the MPA as part of the aggregate revenue at risk under HSCRC quality programs.
6) Continue to evaluate the MPA throughout the year and consider enhancements for future MPA policies, 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) Continue to 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
CMF	Care Management Fees
CMS	Centers for Medicare & Medicaid Services
CPCP	Comprehensive Primary Care Payments
CTO	Care Transformation Organization
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
PBIP	Performance-based Incentive Payments
PCP	Primary Care Provider
PSA	Primary Service Area
RRIP	Readmission Reduction Incentive Program

RY	Rate Year
TCOC	Medicare Total Cost of Care
TIN	Tax Identification Number

APPENDIX I. 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.

Since 2014, the State and CMS have operated Maryland's unique all-payer rate-setting system for hospital services to adopt new and innovative policies aimed at reducing per capita hospital expenditures and TCOC spending, while improving health care quality, patient outcomes, and population health. Under this initiative, hospital-level global budgets are 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.

The MPA provides a mechanism to further support aligned efforts of hospitals with other providers. This includes the opportunity for physicians who partner with hospitals under Maryland's Care Redesign Programs (i.e., Hospital Care Improvement Program (HCIP), Complex and Chronic Care Improvement Program (CCIP), and Episode Care Improvement Program (ECIP)) to be eligible for bonuses and increased payment rates under the federal MACRA law.

Although outside the scope of the MPA attribution algorithm and other aspects described in this document, the State also has the flexibility to apply an MPA Efficiency Adjustment to adjust hospitals' Medicare payments for other purposes. There are two primary use cases for the MPA Efficiency Adjustment. First, the MPA Efficiency Adjustment can permit the flow of Medicare funds to hospitals based on their performance in other programs. For example, Medicare payments to qualifying hospitals under ECIP will occur through an MPA Efficiency Adjustment separate from the MPA's adjustment based on the hospital's performance on its attributed population. In addition, the MPA Efficiency Adjustment may also be used to reduce hospital payments if necessary to meet Medicare financial targets that are not approved on an all-payer basis.

APPENDIX II. ASSESSMENT PRINCIPLES

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 equitable, 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.

APPENDIX III. ESTIMATED TIMELINE AND HOSPITAL SUBMISSION

Estimated Timing	Action
December 2018	• *Required for ACOs:* Hospitals provide HSCRC with ACO Participant List for Performance Year 2019 (also used for Base Year 2018) • *Voluntary*: Hospitals participating in multi-hospital ACOs designate which ACO providers should be linked with which ACO hospital. • *Voluntary:* Hospitals provide HSCRC with a list of full-time, fully employed providers • *Voluntary:* Hospitals wanting to be treated as a combination under the MPA submit a joint request to HSCRC
January 2019	• Performance year begins • HSCRC combines hospital lists and identifies potential overlaps • HSCRC runs attribution algorithm for Base Year 2018 and Performance Year 2019, and provides hospitals with preliminary provider-attribution lists
February 2019	• Official review period for hospitals of 2 weeks following preliminary provider-attribution lists. • HSCRC reruns attribution algorithm for implementation

APPENDIX IV. BENEFICIARY 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 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 MDPCP-actual method. Beneficiaries not attributed under MDPCP-actual attribution are then assessed for attribution through the ACO-like attribution. Beneficiaries not attributed under ACO-like attribution are then assessed for attribution through the PCP-like attribution. Those not attributed through the PCP-like attribution 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 attribution assignment. These claims in any setting trigger an episode beginning three days before and extending to 90 days after a hospital stay for such a condition and are excluded from the TCOC as well as from the determination of ACO-like and PCP-like attribution. These conditions are primarily transplants and burns identified by diagnoses, procedure codes and DRGs.

MDPCP-actual beneficiary attribution

The Medicare Performance Adjustment will use the actual attribution used in MDPCP. HSCRC will rely on the actual beneficiaries attributed to MDPCP practices participating in MDPCP as of January of the performance year. Beneficiary attribution in MDPCP is based on primary care services with clinicians participating in MDPCP.

ACO-like beneficiary attribution

After removing the cost and beneficiaries assigned to practices through the MDPCP-actual method, remaining beneficiaries are considered eligible for ACO-like attribution, and ACO-like attribution will be attempted for all remaining. Beneficiaries are attributed to ACOs based on the use of professional services with ACO clinicians, while clinicians are attached to ACOs if their identifier appears on the ACO's participant list. HSCRC will work with Maryland hospitals and the Maryland Hospital Association to receive lists of ACO providers in the winter 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. The hospital-provided ACO lists should be the same list that is submitted to CMS for ACO participation. Hospital affiliation is also identified through ACO participation, and only hospitals affiliated with a Maryland ACO are used for attribution.

Based on the two Federal Fiscal Years preceding the performance period, the logic determines the plurality of allowed charges for primary care services for eligible beneficiaries with at least one visit for a primary care service. If the plurality of charges are to a set of clinicians that are on

a list of ACO providers, the beneficiary is attributed to the corresponding ACO, as is done in the CMS ACO logic. If the plurality of charges are to clinicians that are not on an ACO list, the beneficiary is not attributed to an 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. All beneficiaries that see a specific clinician may not necessarily be attributed to the same ACO or system. Because the ACO-like attribution methodology uses multiple clinicians to determine whether a beneficiary is attributed to an ACO, an additional step is required to determine the specific ACO beneficiary and ACO provider link. The ACO provider with the plurality of services is attributed the ACO beneficiary.

ACO Specialties

Primary Care Providers' specialty codes are sourced from the Medicare Shared Savings Program Guidance, defined as:[2]

- physicians with a primary specialty of Internal Medicine, General Practice, Geriatric Medicine, Family Practice, or Pediatric Medicine; or
- non-physician primary care providers (Nurse Practitioners, Clinical Nurse Specialists, or Physician Assistants).

Other specialties include Obstetrics/Gynecology, Osteopathy, Sports Medicine, Physical Medicine and Rehabilitation, Cardiology, Psychiatry, Geriatric Psychiatry, Pulmonary Disease, Hematology, Hematology/Oncology, Preventive Medicine, Neuropsychiatry, Neurology, Medical or Gynecological Oncology or Nephrology.

ACO Primary Care Codes

Primary care codes are sourced from the Medicare Shared Savings Program Guidance.[3] The codes include new or established patient visits for office or other outpatient services; initial nursing facility care; subsequent nursing facility care; nursing facility discharge services; other nursing facility services; domiciliary, rest home or custodial care; home services; wellness visits; new G code for outpatient hospital claims.

PCP-like beneficiary attribution

After removing the cost and beneficiaries assigned to hospitals through either the MDPCP-actual or the ACO-like method, providers will be attributed beneficiaries based on beneficiary primary care utilization. Assignment of beneficiaries to primary care providers is determined based on the

[2] https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/Shared-Savings-Losses-Assignment-Spec-V6.pdf
[3] See previous.

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 and adopted in the Y1 MPA policy. A PCP for this purpose includes traditional PCPs but also physicians from other selected specialties.

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. Primary care providers are defined as unique NPIs regardless of practice location and are not aggregated or attributed through practice group or tax identification number (TIN).

PCP-like 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 and ACO-like.

PCP-like 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 beneficiary attribution

The remaining beneficiaries and their costs will be assigned to hospitals based on Geography, following an algorithm known as PSA-Plus. The Geographic methodology assigns zip codes to hospitals through three steps:

1. 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 2014 and 2015.

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 for all beneficiaries in that zip code.

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

Beneficiaries not assigned based on MDPCP-actual, ACO-like, or PCP-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.

APPENDIX V. PROVIDER-TO-HOSPITAL LINKAGE

MDPCP Provider to CTO Hospital Attribution

MDPCP providers will be assessed as a practice for participation with a hospital-affiliated Care Transformation Organization (CTO). All attributed beneficiaries for that practice will be attributed to the affiliated hospital. Maryland hospitals participating with a CTO for the purposes of this method will be determined by the Maryland Department of Health. Any providers not participating with MDPCP are assessed for linkage under ACO approach. Providers participating in an MDPCP practice with a non-hospital affiliated CTO or no CTO will be assessed together as a practice under subsequent steps.

ACO Provider to ACO Hospital Attribution

Remaining providers not linked to a hospital under the MDPCP-CTO linkage will be assessed for ACO linkage. Providers participating with a hospital-affiliated ACO will be linked with the corresponding hospital/system, and all attributed beneficiaries for that provider will be attributed to that hospital/system. ACOs with multiple hospitals (e.g., systems) may designate ACO PCPs to specific ACO hospitals, which will ensure that beneficiaries attributed to those PCPs are attributed to that hospital, if approved by HSCRC. This designation must occur before the Performance Year and cannot be changed once the current Performance Year has begun, except as agreed to by HSCRC. If ACOs with multiple hospitals do not elect to designate ACO PCP and ACO hospital linkages, TCOC will be distributed by Medicare market share (based on federal Medicare FFS hospital payments) of the hospitals in the ACO. MDPCP practices that are not linked to a hospital under CTO linkage will be assessed together as a group for ACO linkage.

Employed Provider to Hospital Attribution

Any providers not linked to hospitals through the MDPCP or ACO linkages may be linked to hospitals based on voluntary hospital-submitted employment lists. These lists must be submitted to HSCRC by a specified date and represent full-time, fully employed providers with a single hospital/hospital system. MDPCP practices that are not linked to a hospital under CTO or ACO linkage will be assessed together as a group for employment linkage.

Referral Patterns Provider to Hospital Attribution

Under PCP-like, if the provider is not linked to a hospital through MDPCP, ACO, or employment, 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. MDPCP practices that are not linked to a hospital under CTO, ACO, or employment linkage will be assessed together as a group for referral pattern linkage. Aside from MDPCP practices, 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. All beneficiaries attributed to a specific clinician through the PCP-like method will be attributed to a single hospital.

Maryland
Hospital Association

October 17, 2018

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

Dear Chris:

On behalf of Maryland's 63 hospital and health system members, we appreciate the opportunity to comment on the Health Services Cost Review Commission's (HSCRC) *Medicare Performance Adjustment (MPA) policy for Rate Year 2021*. We support the draft recommendation. Most importantly, the modifications proposed align the policy with care management relationships hospitals already have with physicians. Hospitals have invested in ACOs, employment models, and Care Transformation Organizations. Partnering with physicians in these vehicles is key to moving the needle on total cost of care (TCOC).

We are pleased that the policy will adjust for a person's age, sex, disability status, and living situation (home or long-term care facility). In future years, beneficiaries' health status must be factored in as well. A specific spending level, or attainment target, is not included in the calendar 2019 policy. We appreciate that the commission plans a significant effort to understand the factors that contribute to differences in baseline amounts of TCOC per beneficiary. Hospitals with lower baseline TCOC per beneficiary may not have the same opportunity to reduce spending as hospitals that start higher.

Under the Maryland Primary Care Program, the Centers for Medicare & Medicaid Services will pay certain fees to participating physicians as incentives to manage care in new ways. Most of the payments will be made to practices or Care Transformation Organizations, not individual physicians. Further, most of the payments will be made outside the claims process. The draft MPA policy did not address whether these payments would be included in a hospital's MPA calculation, and if so, how the fees would be attributed to hospitals.

Hopefully, the additional incentives for physicians ultimately support better care and TCOC reductions. To better understand the impact of the Maryland Primary Care Program, the state should track the associated payments by physician, beneficiary, and Care Transformation Organization.

We appreciate the opportunity to comment and look forward to continue working with you to test and improve the policy over the coming year.

Sincerely,

Traci La Valle
Vice President

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

Consumer Health First

Access ▪ Quality ▪ Equity

5 October 2018

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

Dear Chris:

Thank you for the opportunity to provide comments on the Discussion Draft for the Medicare Performance Adjustment (MPA) Policy for Rate Year 2021. As a predicate for my comments, I would note that MDH Secretary Neall stated at the signing of the Total Cost of Care (TCOC) contract, "This comprehensive approach ensures the patient is at the center of decision making and their needs are being met with greater transparency and accountability." Therefore, I have three primary recommendations as regards the draft policy:

- The revised TCOC **attribution algorithm** relies upon data from the new Primary Care Program (PCP). This is a sensible approach toward securing timely and accurate attributions and I appreciate the staff's emphasis on a **review period** (page 5). However, given Secretary Neall's statement I believe it is important to add a third purpose for the review. This would entail measuring and evaluating the impact on the patients who are being attributed through their provider to a hospital. If, in fact, they are at the "center of decision making" then it is only rational that a review include the impact on them and that any negative effects related to the algorithm be corrected going forward.

  Addressing such an evaluation will require that there are **effective communications** with these individuals and that they are made aware of their rights and protections as this new model is being implemented. As I noted in my memo of July 5, 2018, communications with consumers remains a key weakness in the implementation of the TCOC and it is critical component of the Secretary's promise of **"transparency and accountability."** This is an area where the Consumer-Standing Advisory Committee could prove useful.

- As regards the addition of a **risk adjustment** for the year over year comparison, this is reasonable goal to "provide effective and efficient care and focus on high-needs beneficiaries." However, I have two specific r**ecommendations** that I believe will, again, better address the patient-centered goal, add: **(1**) **"equitable"** to the sentence above to read. "... equitable, effective and efficient..."; and **(2) race** to the risk score data of age and gender.

  While this was supported by other Workgroup members, staff cited the lack of CMS **data** on race as the reason not to include it. I believe this is an insufficient reason given that such data is, as I understand it, retrievable through CRISP. And, while hospital data may vary I think that rather than saying "we can't do this," Maryland's policy makers should be using this opportunity to establish standards that will inform all aspects of delivery system reform.

- In regard to the issues raised above, I believe there is an opportunity to **improve the assessment** principles so that, in future, they would better inform a broader goal of health equity that should be integral to all of Maryland's transformation initiatives. I believe this could be done in one of two ways under the second principle - "The measure should provide clear focus, goals, and incentives for transformation." (1) Restate 2.1 to read "promote equitable, efficient, high quality and patient-centered delivery of care." or (2) add a new 2.6 "Reduce health inequities."

I would also like to take this opportunity to raise another issue of concern to advocates that may not fall under the TCOC Workgroup, but which I believe is important to raise. Consumer advocates have long been concerned regarding the efficacy of **measurements that could illustrate <u>both</u> under-utilization vs. over-utilization.** The latter appears to be a higher priority for HSCRC whereas it is under-utilization that could adversely impact vulnerable populations who are our highest concern. A related issue is the potentially perverse incentives to ration post-acute care. Therefore, we would appreciate, through the C-SAC or other workgroups, to gain a better understanding of what the measures are in these areas, what the analysis shows, and what steps are being taken to address those.

Once again, thank you for the opportunity to comment on the MPA Policy. I am happy to discuss the recommendations or any other issues as you would find that helpful.

Sincerely,

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MedStar Health

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Kathy Talbot
Vice President

Rates and Reimbursement

October 17, 2018

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

Dear Chris:

On behalf of MedStar Health, Inc and our member hospitals, we are submitting comments on the Health Services Cost Review Commission's (HSCRC) Medicare Performance Adjustment (MPA) Policy for Rate Year 2021.

We appreciate all the work you and your team has done to-date to update the methodology to better align the attribution with existing care coordination relationships. We also are very supportive of the process to review the attribution in detail to identify any unintended consequences and thank you for adding that as part of the upfront process.

Below are several other recommendations we hope will be considered:

(1) While the Care Transformation Organization (CTO) might make sense in the future, we are concerned utilizing the CTO as first step in the attribution given the newness of the CTO and the Maryland Primary Care Program (MDPCP) and not having data to understand how it might impact or influence the MPA. We recommend that employment be the first attribution criteria as it is the most direct link to a hospital provider.
(2) We would recommend that beside the attribution review process, that a more formal HSCRC process that would allow hospitals to request changes based on unique circumstances throughout the Calendar Year.
(3) We continue to support a risk adjustment methodology as outlined in the June 6 letter to HSCRC by UMMS, Johns Hopkins, and MedStar.

We appreciate the opportunity to comment and look forward to continued collaboration to improve this important Policy.

Sincerely,

Kathy Talbot

Kathy Talbot
Vice President
Rates and Reimbursement

Cc: Katie Wunderlich, HSCRC Executive Director
Dr. Stephen Evans, Executive Vice President, Medical Affairs and Chief Medical Officer

JOHNS HOPKINS
MEDICINE

Kevin W. Sowers, MSN, RN, FAAN

President
Johns Hopkins Health System

Executive Vice President
Johns Hopkins Medicine

October 17, 2018

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

Dear Ms. Wunderlich,

On behalf of the Johns Hopkins Health System (JHHS), thank you for the opportunity to provide input on the proposed Medicare Performance Adjustment (MPA) Policy for Rate Year 2021. JHHS appreciates the HSCRC's goal and efforts to revise the MPA to better reflect existing and future transformation efforts between hospitals and providers. We believe the staff recommendation presented on October 10, 2018 makes significant improvements regarding the alignment between hospitals, providers and patients through changes to the attribution algorithm, however additional modifications to the risk adjustment methodology would better account for the cost associated with medically necessary care. We also believe additional clarification is needed regarding the intersection of the MDPCP and hospital specific Total Cost of Care (TCOC).

Attribution and Review Period

The proposed MPA reflects input from stakeholders regarding the attribution methodology. Specifically, the proposed MPA accounts for requests from stakeholders for greater hospital attribution alignment with the Maryland Primary Care Program (MDPCP) as well as with hospital or health-system employed physicians. However, we believe that it may be preferable to employ the actual ACO attribution methodology, rather than the current "ACO-like" methodology. Additionally, the proposed MPA includes an official review period that will help ensure that the attribution algorithm is functioning as expected. We greatly appreciate the HSCRC's inclusion of these changes and believe they will help ensure an attribution process that is fair and stable.

Risk Adjustment and Attainment

Several stakeholders also requested the inclusion of a comprehensive risk adjustment methodology; however the proposed MPA recommends using the Medicare New Enrollee Demographic Risk Score. Noticeably absent from this risk adjustment is any consideration of chronic conditions or

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socioeconomic conditions. The Hierarchal Condition Category could better serve as a risk adjustment scale that captures Medicare beneficiaries' comorbidities, and the Area Deprivation Index could better capture social determinates of health. Robust risk adjustment better reflects the resources needed to deliver quality care to high risk beneficiaries. Please refer to the attached comment letter submitted to the HSCRC on June 6 on behalf of JHHS, MedStar and UMMS for additional information regarding the JHHS position on an appropriate risk adjustment methodology.

An additional action that could help mitigate the potential for a disproportionate impact on hospitals related to high cost beneficiaries would be the adoption of a policy similar to the CMS ACO expenditure methodology. Under this methodology, CMS truncates a beneficiary's annualized expenditure so it does not exceed a specified dollar threshold equal to the 99th percentile of annualized expenditures of the national assignable FFS population. This is done to reduce the impact of catastrophically high expenditures for some beneficiaries. HSCRC's current MPA methodology includes categorical exclusions for burn and transplant, but other high cost treatments such as expensive infusion Part B drugs, prolonged ICU stays and medical complexity are currently not recognized within the MPA methodology. Although this is late for consideration, this approach would allow the Commission to remove from all hospitals, high cost outliers from the MPA calculation using an approach that is already employed by CMS in the MSSP program. Removing such a small portion of the cost using the 99th percentile would not diminish the goal of the MPA to link hospitals to the performance under TCOC, yet it would not expose hospitals to significant outlier costs, particularly when treatment is unavoidable and medically necessary. JHHS recommends consideration of a policy similar to CMS's policy to truncate outlier expenditures in the current year and consideration of other risk adjustment approaches in upcoming years.

The proposed MPA policy recommends continuation of an improvement-only methodology, with a commitment to ongoing consideration of an attainment policy. JHHS supports this approach, recognizing that attainment benchmarks are not appropriate without adequate risk adjustment and stable attribution.

MDPCP

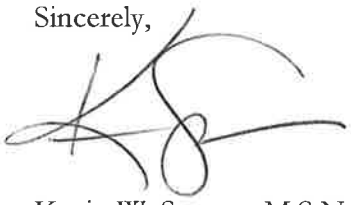
JHHS believes that MPA policy requires additional clarification regarding the impact of the MDPCP on individual hospital performance on TCOC Targets. The hospital industry greatly appreciates the June 13, 2018 Commission Resolution recognizing that "hospitals should not be held financially liable for the cost of the MDPCP Care Management Fees." While we understand that the annual update factor will not be impacted as a result of the increased Medicare costs associated with the MDCPC Care Management Fee expenses, there has been no indication that individual hospitals will be afforded the same considerations under the Commission Resolution. Considering the increased alignment between hospitals and the MDPCP under the proposed MPA policy, hospitals can expect to see increases in their individual TCOC through the addition of the MDPCP Care Management Fees. JHHS recognizes that the MDPCP program is considered a key element in the new TCOC Model, with the expectation that advanced primary care will ultimately result in increased quality and

lower costs. However, it is important to note that the national Comprehensive Primary Care Model, which serves as the foundation for MDPCP, has yet to result in savings.[1] If the Commission were to recognize and account for the increase in hospital specific TCOC under the MDPCP it would further cement the state's commitment to not to hold hospitals accountable for changes in these Care Management Fees. While we appreciate that the impact at 1% of Medicare revenue is modest, it is critical that the MPA function as intended; to reflect hospital and provider efforts to improve TCOC. This would be particularly true as CY2019 data is introduced and compared to a baseline when such costs were not included.

The proposed MPA notes that "penalties and rewards will increase over time." JHHS hopes that the MPA will not increase beyond the current maximum penalty and reward of 1% of federal Medicare revenue until the MPA attribution has proven to be stable and predictable and proper guardrails are implemented to guard against outlier expenses. As we learned in the first year, time, experience and evaluation are needed to validate the success of the MPA in both attributing beneficiaries and controlling TCOC. Hospitals have already assumed significant risk through the adoption of Phase 2 of the demonstration model; any additional risk should be directly linked to each hospital's ability to influence costs and outcomes of patients who have an established relationship with the hospital. We commend the HSCRC for the significant changes and improvements that have been made to improve the attribution methodology and appreciate the collaborative process by which these changes were incorporated into the second year of the MPA; the third year will likely yield significant recommendations for change as well.

Thank you to the efforts of the HSCRC staff who have been thoughtful and transparent in their efforts around this complex issue. We look forward to continued collaboration in our mutual efforts to reduce Total Cost of Care.

Sincerely,



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

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[1] Peikes, D. et al. "Fourth Annual Report." *Mathmatica Policy Research Evaluation of the Comprehensive Primary Care Program,* May 2018.

Peter Hill, M.D., M.S., F.A.C.E.P.
Senior Vice President, Medical Affairs, Johns Hopkins Health System
Associate Professor of Emergency Medicine

cc: Nelson J. Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
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September 26, 2018

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

Dear Katie,

On behalf of the University of Maryland Medical System (UMMS), I am submitting recommendations regarding the Health Services Cost Review Commission's (HSCRC) Medicare Performance Adjustment (MPA) Policy for Rate Year (RY) 2021. UMMS appreciates HSCRC's efforts to update the policy to better align the attribution methodology with existing care coordination relationships between hospitals and non-hospital providers.

UMMS recommends additional changes to the methodology, focused on three key areas:

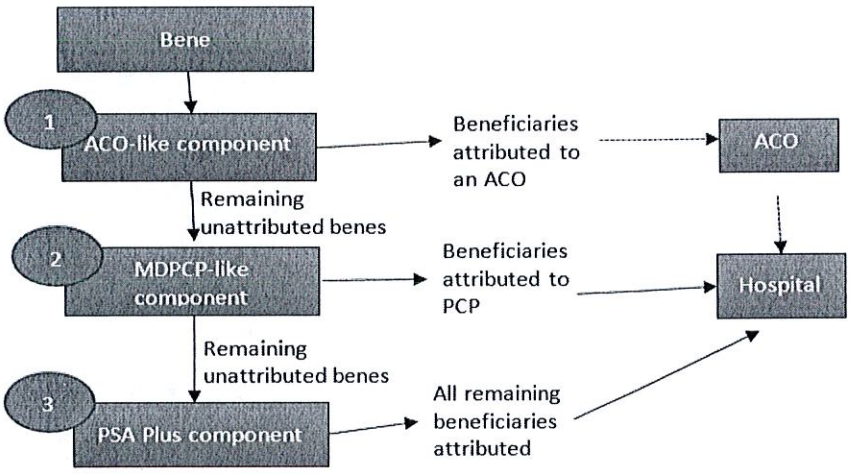
- An adjustment to the attribution hierarchy that is inclusive of additional hospital-provider relationships and minimizes the potential for providers to be attributed to multiple hospitals;
- Include a post-attribution review process to account for unique relationships that may arise and not be accounted for under the methodology; and,
- Include a risk adjustment and an attainment option.

The premise of the MPA is to incentivize care coordination between hospital and non-hospital settings by making adjustments to hospitals' Medicare payments. Considering hospitals assume responsibility for total cost of care (TCOC), the attribution methodology should be modelled and targeted to align with the following goals to allow for reasonable performance adjustment:

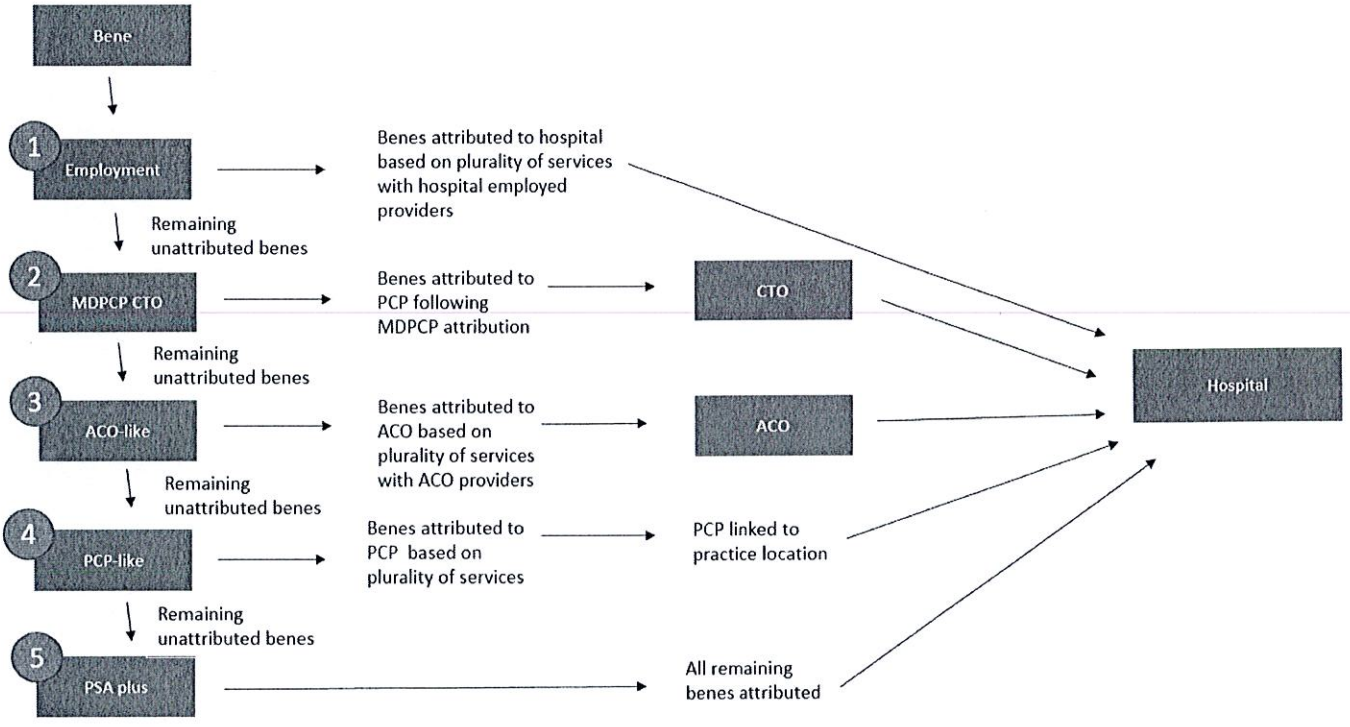
- Align attribution where resources are already being expended to manage the Medicare Fee for Service population;
- Align attribution where there is an existing provider to hospital relationship; and,
- Attribute providers at a practice location level, preventing the attribution of providers at a single location from being attributed to multiple hospitals

The following outlines the current MPA attribution methodology and recommended RY 2021 methodology:

Current RY 2020 Methodology



Recommended RY 2021 Methodology



Step 1 – Employment

Employment is the most direct linkage of providers to hospitals for purposes of the MPA. In order to accomplish this initial step:

- Hospitals may voluntarily submit a list of employed providers to the HSCRC by a pre-determined date for consideration in the MPA.
- If a provider is included on more than one hospital employment list, the attribution will automatically move to subsequent steps.
- Beneficiaries will be attributed to employed providers using the same attribution process as the current ACO- like attribution, which attributes beneficiaries to an ACO based on their plurality of services with ACO providers.[1]

Step 2 – Maryland Primary Care Program (MDPCP) Care Transformation Organization (CTO)

Inclusion of hospital-provider linkages through the MDPCP is critical for RY 2021, as the program enhances care coordination between hospitals and non-hospital providers. For this step:

- Only providers participating in the MDPCP and partnered with a hospital owned CTO will be considered under this step.
- Those providers participating in MDPCP but not partnered with a hospital CTO will not be attributed by this step and will be subject to subsequent steps.
- Beneficiaries will be attributed to providers using the MDPCP attribution process.[2]

Steps 3-5

Two changes are recommended for these steps:

- Change the name of the "MDPCP-like" to "PCP-like" to avoid confusion with the actual MDPCP.
- For the PCP-like step, providers will be linked to a single practice site location to minimize providers from being attributed to multiple hospitals.

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[1] Health Services Cost Review Commission. (2018) *Final Recommendation for Medicare Performance Adjustment (MPA) for Rate Year 2020.* Retrieved from: http://www.hscrc.state.md.us/Documents/Work%20Group%20Uploads/Total%20Cost%20of%20Care%20(TCOC)/2017.11.29/MPA%20Recommendation%2020171114%20finalized.pdf

[2] Centers for Medicare & Medicaid Services. (2018) *Maryland Primary Care Program Request for Applications.* Retrieved from: https://innovation.cms.gov/Files/x/mdtcocm-rfa.pdf

Post-Attribution Review Process

It is recommended that hospitals have the ability to review and mutually agree to adjust the linkage of providers to hospitals, as unique situations may arise that are unaccounted for under the MPA methodology. This would be accomplished by establishing a process with the following characteristics:

- Hospitals submit an adjustment request through a simple online form or standard email box.
- The following information would be required:
  - Hospital names
  - Hospital representatives' contact information
  - NPI numbers to be considered for a hospital linkage adjustment
  - Attestation from both parties
- Established criteria by the HSCRC for adjustment requests.
- Timeline for HSCRC to receive and process the requests.

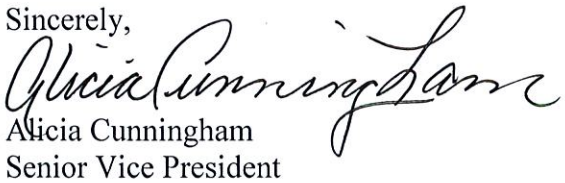
Risk Adjustment and Attainment

UMMS supports expanding the MPA measurement to "better of improvement or attainment" as is the norm with the quality pay for performance programs. We also support a risk adjustment as it will have the positive effect of better capturing the true acuity of Medicare enrollees and more accurately aligning the resources to manage them. This will result in a more fair assessment amongst hospitals and prevent early performers from being inappropriately penalized. Please refer to the comment letter submitted to the HSCRC by UMMS, Johns Hopkins and MedStar Health on June 6 for more information.

We appreciate the opportunity to comment on the RY 2021 MPA attribution policy, and look forward to your consideration. We also would like to acknowledge our appreciation for you considering an alternative episodic methodology for measuring total cost of care for University of Maryland Rehabilitation and Orthopedic Institute.

We look forward to the HSCRC's response regarding the above recommendations. If you have any questions regarding our recommendations, please do not hesitate to contact me.

Sincerely,



Alicia Cunningham
Senior Vice President
Corporate Finance & Revenue Advisory Services

cc: Chris Peterson, HSCRC
Hank Franey, UMMS
Patrick Dooley, UMMC

June 6, 2018

Donna Kinzer
Executive Director, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Donna,

We appreciate the ongoing efforts of the Total Cost of Care Workgroup (Workgroup) to engage stakeholders to make recommendations regarding risk adjustment methodologies and calculations as it relates to the Medicare Performance Adjustment (MPA). Over the past several months, the Workgroup has proposed using a risk adjustment methodology to measure hospital year over year improvement for MPA. The University of Maryland Medical System, Johns Hopkins Health System, and MedStar Health are supportive of the inclusion of a risk adjustment methodology, however, we would like to share our concerns regarding the two methodologies currently under consideration and offer a solution that will result in a fairer measurement among hospitals.

The Health Services Cost Review Commission (HSCRC) has consistently recognized the importance of risk adjustment in many of its incentive programs and payment policies. For example, the Complex and Chronic Care Improvement Program uses the Centers for Medicare and Medicaid Services (CMS) Hierarchical Condition Category (HCC) coding to scale incentives for physicians with pools of higher risk patients, and the Quality Based Programs (QBR, MHAC, & RRIP) incorporate risk adjustment so hospitals are not unfairly penalized for higher acuity patients. Risk adjustment is also being considered for calculating Potentially Avoidable Utilization (PAU) for the PAU Program in Revenue Year 2020.
In recent months, the Workgroup has proposed two risk adjustment options for year over year improvement based on demographic factors. One utilizes the Medicare Advantage New Enrollee Risk Adjustment, and the other was developed by HSCRC as a more "Maryland-specific" option.

The two methodologies currently being proposed by the HSCRC do not adequately account for the evolving acuity of the population nor do they account for the influence of chronic conditions, which greatly impacts costs related to the management and treatment of patients served. They also do not accurately measure the specific risk of an individual as risk adjustment solely based on demographic or other information does not account the specific comorbidities of an individual.

We recommend using a methodology that factors in chronic conditions, such as the CMS HCC risk adjustment that is used to calculate payments to Medicare Advantage plans. Similar to the two options proposed by the HSCRC, the HCC methodology adjusts risk scores based on demographic information, such as age-sex pairs, disease-disabled status and Medicaid eligibility. However, the methodology also considers long-term conditions likely to affect health expenditures, including chronic disease burden, disease interactions and diagnostic resources.

We are proposing the HCC methodology as it has several advantages:

1. HCC is a methodology that has already been approved by CMS and is both industry and government adopted. There is no need to create an alternative risk adjustment methodology when one is already in place and widely used for this specific population.

2. HCC forms the basis for risk adjustment for Medicare Advantages plans. Given the lack of Medicare Advantage penetration in the state historically, the acuity of the current enrollees is potentially under documented, thereby reducing the revenue available to the plans to provide services to enrollees.

3. CMS utilizes HCC for risk adjusting the attributed population in the Medicare Shared Savings Program Accountable Care Organizations (ACO) when establishing an ACO's benchmark. By more appropriately risk adjusting the attributed populations, ACOs are able to receive a more accurate benchmark in line with necessary medical expenditures, thereby increasing the opportunity to earn shared savings by better managing care.

4. The Maryland Primary Care Program (MDPCP) is proposing to provide care management fees to providers based on the HCC of their attributed patients. Better risk adjustment will lead to greater care management fees. Under the MDPCP, these care management fees are required to be spent on care coordination and other activities, with the goals of increasing quality and reducing unnecessary utilization.

5. HCC as a risk adjustment tool is thoroughly audited by CMS to prevent fraud and abuse. This is an important balance that allows for appropriate coding and documentation of the population while not allowing inaccurate coding for the sole purpose of increasing revenue.

6. HCC is patient centric, a key goal of the State's innovative payment delivery models, as it appropriately captures the specific conditions of an individual.

Better aligning the above CMS-approved programs to the risk adjustment methodology under the MPA will provide greater alignment between the hospitals and community providers, a central tenet of the All-Payer Waiver and MPA. It will have the positive effect of better capturing the true acuity of Medicare enrollees and more accurately aligning the resources to manage them. We would encourage the HSCRC to work collaboratively with the hospital industry to model an alternative risk adjustment model that incorporates the ideas that have been outlined.

Thank you for your consideration. We look forward to future discussions and encourage HSCRC staff to contact us regarding any questions or concerns.

Sincerely,

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

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

Kathy Talbot
Vice President, Reimbursement Services
Medstar Health

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September 26, 2018

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

Dear Katie,

On behalf of the University of Maryland Medical System (UMMS), I am submitting recommendations regarding the Health Services Cost Review Commission's (HSCRC) Medicare Performance Adjustment (MPA) Policy for Rate Year (RY) 2021. UMMS appreciates HSCRC's efforts to update the policy to better align the attribution methodology with existing care coordination relationships between hospitals and non-hospital providers.

UMMS recommends additional changes to the methodology, focused on three key areas:

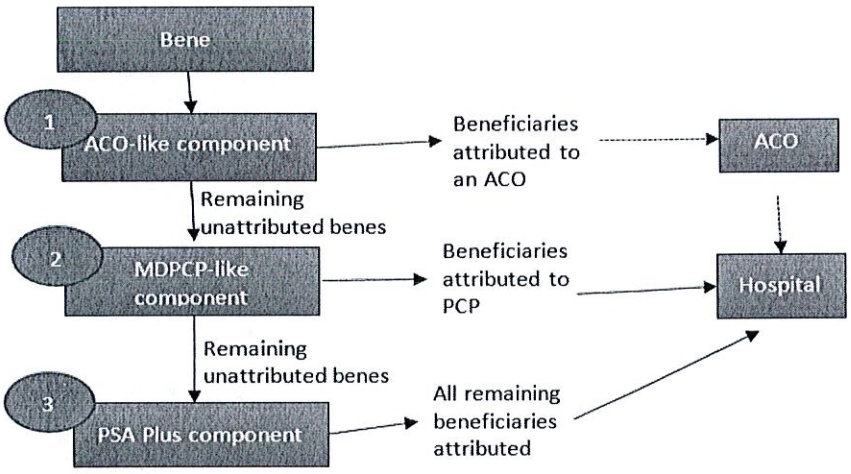
- An adjustment to the attribution hierarchy that is inclusive of additional hospital-provider relationships and minimizes the potential for providers to be attributed to multiple hospitals;
- Include a post-attribution review process to account for unique relationships that may arise and not be accounted for under the methodology; and,
- Include a risk adjustment and an attainment option.

The premise of the MPA is to incentivize care coordination between hospital and non-hospital settings by making adjustments to hospitals' Medicare payments. Considering hospitals assume responsibility for total cost of care (TCOC), the attribution methodology should be modelled and targeted to align with the following goals to allow for reasonable performance adjustment:

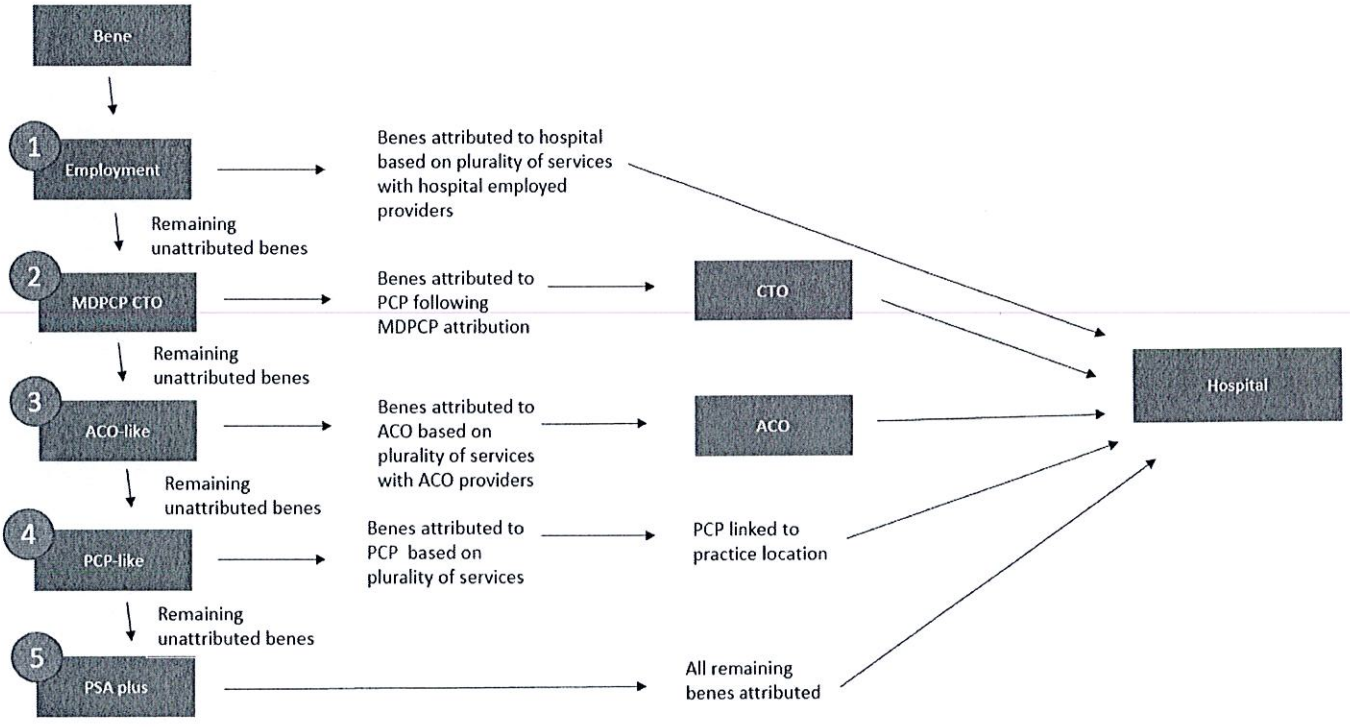
- Align attribution where resources are already being expended to manage the Medicare Fee for Service population;
- Align attribution where there is an existing provider to hospital relationship; and,
- Attribute providers at a practice location level, preventing the attribution of providers at a single location from being attributed to multiple hospitals

The following outlines the current MPA attribution methodology and recommended RY 2021 methodology:

Current RY 2020 Methodology



Recommended RY 2021 Methodology



Step 1 – Employment

Employment is the most direct linkage of providers to hospitals for purposes of the MPA. In order to accomplish this initial step:

- Hospitals may voluntarily submit a list of employed providers to the HSCRC by a pre-determined date for consideration in the MPA.
- If a provider is included on more than one hospital employment list, the attribution will automatically move to subsequent steps.
- Beneficiaries will be attributed to employed providers using the same attribution process as the current ACO- like attribution, which attributes beneficiaries to an ACO based on their plurality of services with ACO providers.[1]

Step 2 – Maryland Primary Care Program (MDPCP) Care Transformation Organization (CTO)

Inclusion of hospital-provider linkages through the MDPCP is critical for RY 2021, as the program enhances care coordination between hospitals and non-hospital providers. For this step:

- Only providers participating in the MDPCP and partnered with a hospital owned CTO will be considered under this step.
- Those providers participating in MDPCP but not partnered with a hospital CTO will not be attributed by this step and will be subject to subsequent steps.
- Beneficiaries will be attributed to providers using the MDPCP attribution process.[2]

Steps 3-5

Two changes are recommended for these steps:

- Change the name of the "MDPCP-like" to "PCP-like" to avoid confusion with the actual MDPCP.
- For the PCP-like step, providers will be linked to a single practice site location to minimize providers from being attributed to multiple hospitals.

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[1] Health Services Cost Review Commission. (2018) *Final Recommendation for Medicare Performance Adjustment (MPA) for Rate Year 2020.* Retrieved from: http://www.hscrc.state.md.us/Documents/Work%20Group%20Uploads/Total%20Cost%20of%20Care%20(TCOC)/2017.11.29/MPA%20Recommendation%2020171114%20finalized.pdf

[2] Centers for Medicare & Medicaid Services. (2018) *Maryland Primary Care Program Request for Applications.* Retrieved from: https://innovation.cms.gov/Files/x/mdtcocm-rfa.pdf

Post-Attribution Review Process

It is recommended that hospitals have the ability to review and mutually agree to adjust the linkage of providers to hospitals, as unique situations may arise that are unaccounted for under the MPA methodology. This would be accomplished by establishing a process with the following characteristics:

- Hospitals submit an adjustment request through a simple online form or standard email box.
- The following information would be required:
  - Hospital names
  - Hospital representatives' contact information
  - NPI numbers to be considered for a hospital linkage adjustment
  - Attestation from both parties
- Established criteria by the HSCRC for adjustment requests.
- Timeline for HSCRC to receive and process the requests.

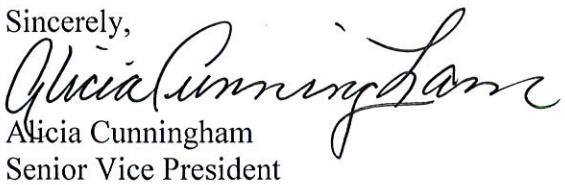
Risk Adjustment and Attainment

UMMS supports expanding the MPA measurement to "better of improvement or attainment" as is the norm with the quality pay for performance programs. We also support a risk adjustment as it will have the positive effect of better capturing the true acuity of Medicare enrollees and more accurately aligning the resources to manage them. This will result in a more fair assessment amongst hospitals and prevent early performers from being inappropriately penalized. Please refer to the comment letter submitted to the HSCRC by UMMS, Johns Hopkins and MedStar Health on June 6 for more information.

We appreciate the opportunity to comment on the RY 2021 MPA attribution policy, and look forward to your consideration. We also would like to acknowledge our appreciation for you considering an alternative episodic methodology for measuring total cost of care for University of Maryland Rehabilitation and Orthopedic Institute.

We look forward to the HSCRC's response regarding the above recommendations. If you have any questions regarding our recommendations, please do not hesitate to contact me.

Sincerely,



Alicia Cunningham
Senior Vice President
Corporate Finance & Revenue Advisory Services

cc: Chris Peterson, HSCRC
Hank Franey, UMMS
Patrick Dooley, UMMC

Baltimore Population Health Workforce Collaborative

Population Health Workforce Support for Disadvantaged Areas

Program Partners

- Collaborative Members
  - Johns Hopkins Bayview Medical Center
  - Johns Hopkins Hospital
  - LifeBridge Sinai Hospital
  - MedStar Franklin Square Medical Center
  - MedStar Good Samaritan Hospital
  - MedStar Harbor Hospital
  - MedStar Union Memorial Hospital
  - University of Maryland Medical Center – Downtown Campus
  - University of Maryland Medical Center – Midtown Campus

Program Partners

- Intermediary
  - BACH (Baltimore Alliance for Careers in Healthcare)
- Essential Skills
  - Turnaround Tuesday
- Technical Skills
  - BAHEC (Baltimore Area Health Education Council)
  - CCBC (Community College of Baltimore Count)
  - JPRT (Jordan Peer Recovery Training)

Program Goals

- **The goal of BPHWC is to concomitantly improve the socio-economic status of disadvantaged communities and promote population health in the Baltimore region.**
- This is being achieved by improving the continuity of healthcare in the communities where CHWs, PRSs, and home care CNAs work and providing income through jobs that impact the health and well-being of the workers. Targeted neighborhoods are those in hospital Community Benefit Service Areas that have higher poverty and unemployment rates than Baltimore City overall.

Target Workforce Population

- The primary target workforce populations to be trained and recruited are:
  - Unemployed/underemployed residents living in high poverty communities
  - Those who have little or no work history
  - Have no more than a HS diploma or GED equivalent
  - May possess a criminal record
  - Persons in long-term recovery from substance use disorders (SUD) and/or mental health issues

Program Process

- Recruitment, Screening, Intake, Barrier Removal, Essential Skills
- Technical Skills, Job Preparation
- Career Coaching *(Ongoing throughout process)*
- Hiring Process
- Onboarding and Deployment
- Continued Support and Development

Training Tracks and Associated Jobs

- **Community Health Workers**
  - CHWs help promote healthy behaviors and are connectors with the health care system to increase access to care to reduce health disparities and identify/navigate patients with unmet social needs to appropriate health care. CHWs are most effective when they serve the communities from which they come and thus provide continuity between healthcare systems and the community.
- **Peer Recovery Specialists**
  - PRSs have experienced substance use disorder or mental illness and recovery and can help persons with behavioral health issues by serving as a link between the clinical setting and the community to enhance access to and participation in treatment services to prevent relapse.
- **Home Care CNA/GNAs**
  - CNA/GNAs in the program expand the current homes support reach in the community. They also help reduce readmission by serving hospital discharged patients who need personal care at home, but otherwise could not afford or access such preventative care.

Technical Training Through June 2018

Track	Started	Completed
CNA/GNA	8	5
Community Health Worker	143	134
Peer Recovery Specialist	56	44
Total Technical Trainees	207	183

Workers Hired through June 2018

Hospital	CHW Hired	PRS Hired	CNA Hired	Total Hired Y1-Y2
JHHS + JH SOM	20	2	14	36
JHBMC	8	2		10
Lifebridge Sinai	6	0		6
MedStar HH	3	3		6
MedStar GS	4	4		8
MedStar FS	6	1	*N/A*	7
MedStar UM	5	2		7
UMMC	14	8		22
UMMC Midtown	7	5		12
COLLABORATIVE	**73**	**27**	**14**	**114**

Worker Impact on Quality Measures

- Workers support a variety of new and existing initiatives as part of comprehensive population and community health programs, making it difficult to attribute differences in readmission and ED utilization rates to individual workers.
- Worker activity metrics and anecdotal evidence suggest that workers are having the intended effects on improving engagement and health outcomes for patients and communities.

- **Worker Activity** *(Program Inception through June 2018)*
  - **16,311 Interventions**
    Direct, Remote, and Community Based
  - **10,422 Referrals**
    Connections to Medical or Social Services Based on Needs Assessments

Turnaround Tuesday

- A Second Chance Jobs Movement
  - MISSION: To prepare “returning”, unemployed, and under employed citizens to reenter the workforce and take an active role in transforming their communities.
- PWSDA Role
  - Recruitment
  - Eligibility Screening
  - Barrier Removal
  - Essential Skills Training
  - Long-term Wraparound Services

Population Health Workforce Support for Disadvantaged Areas Program Recommendation and Report on FY 2017 and FY 2018 Activities

HSCRC
Health Services Cost Review Commission

Overview of PWSDA

- In December 2015, Commission authorized $10 million in rate increases for hospitals to train and hire workers from areas of high economic disparities and unemployment
- Hospitals must match rate increases at 50%
- Hospitals must train, hire, and support workers to fill new positions designed to improve population health and further the goals of the Total Cost of Care Model
- University of Maryland School of Medicine has served as evaluators of the program

Awardees (FY 2017-FY 2019)

- Garrett Regional Medical Center
  - Includes Garrett County and West Virginia communities
  - Rate increase of $221,485 across three years
  - Train and hire five community health workers (CHWs)
    - 50% must be Maryland residents
- Baltimore Population Health Workforce Collaborative (Baltimore Collaborative)
  - Four systems – Nine hospitals
    - Hopkins (Johns Hopkins Hospital, Bayview)
    - Medstar (Franklin Square, Union Memorial, Good Samaritan, Harbor)
    - Lifebridge Sinai
    - University of Maryland (University of Maryland Medical Center, Midtown)
  - Rate increase of $6,675,666 across three years
  - Train and hire 208 community health workers, peer recovery specialists, and certified nursing assistants

Training Outcomes

Baltimore Collaborative

- 207 individuals began training
- 183 individuals completed training
- 114 individuals hired

Position	Worker Count as of 6/30/18
Community Health Worker	73
Peer Recovery Specialist	27
Certified/Geriatric Nursing Assistant	14
Worker Totals	114

- Training and hiring continues in FY 2019

GRMC

- Six individuals began training
- Five individuals completed training
- All five were hired as CHWs
- Four work full-time, one works part-time
- Three are MD residents, two are WV residents
- Additional hires made in FY 2019

Patient Care Activities

Baltimore Collaborative

- Diverse patient population with a focus on high-utilizer and high-risk Medicare patients
- Key Activities include:
  - Care Coordination
  - Health Education and Health System Navigation
  - Companion Care and Patient Escort
  - Transitional Care for Home Health
  - Peer Recovery Support
  - Linking to Community Services

GRMC

- Focus on high-utilizers and patients with chronic conditions
- Key Activities include:
  - Disease management assistance
  - Follow-up phone calls and visits after hospital discharge
  - Working with community services to better coordinate care and prevent duplication of services

Recommendations

- Extend the PWSDA program for three years through FY 2022 to the Baltimore Collaborative to maintain current progress and reach and sustain intended employment goals.
- Make adjustments to rates to remove unspent PWSDA funds from population-based budgets from FY 2017-FY 2019; Estimated to be approximately $3.5 million from FY 2017 and FY 2018, pending staff audit conclusions.
- Provide $5,875,804 in rates to the Baltimore Collaborative across FY 2020-FY 2022 with hospitals matching at least 50 percent of rate funding.

Recommendation and Report on Population Health Workforce Support for Disadvantaged Areas (PWSDA) Activities for Fiscal Years 2017 and 2018

November 14, 2018

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

This recommendation was approved by the Commission in draft form. Questions may be submitted to erin.schurmann@maryland.gov.

Table of Contents

OVERVIEW

This report summarizes fiscal year (FY) 2017[1] and 2018 activities for the Population Health Workforce Support for Disadvantaged Areas and provides a recommendation to extend the program for three years (FY 2020 – FY 2022) for the Baltimore Population Health Workforce Collaborative (Baltimore Collaborative), one of the two original grantees. In December 2015, the Commission authorized up to $10 million in hospital rates for hospitals that committed to train and hire workers from geographic areas of high economic disparities and unemployment. Workers will fill new positions to support care coordination, population health, consumer engagement, and related positions. The PWSDA was developed in an effort to support job opportunities for individuals who reside in neighborhoods with a high area deprivation index (ADI), and thus enable low-income urban, suburban, and rural communities to improve their socioeconomic status while working to improve population health. The overall objective is to address the social determinants of health and assist hospitals in bolstering population health and meeting the goals of the All-Payer Model and the new Total Cost of Care Model.

When approved in 2015, the PWSDA program limited the award total to $10 million in hospital rates over a three-year period, with the condition that hospitals provide matching funds of at least 50 percent of the amount included in their rates. The HSCRC awarded rate increases to two applicants: the Baltimore Collaborative and Garrett Regional Medical Center. The applicants were required to explain how they will use the increase in rates to support the training and hiring of individuals consistent with the goals of the program.

Hospitals report on three areas: training and hiring activities, patient care activities, and spending. Evaluators at the University of Maryland School of Medicine collect, review, and summarize these reports on behalf of the HSCRC. This report provides a summary of worker training and hiring counts, key areas of patient care provided by PWSDA workers, and a summary of spending from January 1, 2017 through June 30, 2018. Staff recommendations are outlined below.

RECOMMENDATIONS

Staff is proposing a three year extension of the program for the Baltimore Collaborative. Due to the delayed start of the program in FY 2017 and a slower than anticipated ramp up, the Baltimore Collaborative is still working to meet the aggressive training and hiring counts articulated in their 2016 proposal. Staff proposes an extension through FY 2022 to the Baltimore Collaborative to maintain current training and hiring progress and reach intended employment goals.

Based on staff findings from the last two years of reporting, staff recommend the following:

[1] Hospital activities for FY 2017 activities and spending began in January 2017 and ran through June 30, 2017, a 6-month period.

- Extend the PWSDA program for three years through FY 2022.

- Make adjustments to rates to remove unspent PWSDA funds from population-based budgets from FY 2017-FY 2019; Estimated to be approximately $3.5 million from FY 2017 and FY 2018, pending staff audit conclusions.

- Provide $5,875,804 in rates to the Baltimore Collaborative across FY 2020-FY 2022 with hospitals matching at least 50 percent of rate funding.

BALTIMORE POPULATION HEALTH WORKFORCE COLLABORATIVE

Background

The Baltimore Population Health Workforce Collaborative is a consortium of four major health systems that includes nine hospitals in the Baltimore Metropolitan Area:

- Johns Hopkins Hospital
- Johns Hopkins - Bayview
- Sinai Hospital
- Medstar – Good Samaritan
- Medstar – Harbor Hospital
- Medstar – Union Memorial
- Medstar – Franklin Square
- University of Maryland Medical Center
- University of Maryland – Midtown

In 2016, the Baltimore Collaborative submitted a proposal to hire individuals from high poverty communities to fill positions such as community health workers (CHWs), peer recovery specialists (PRSs), certified nursing/geriatric nursing assistants (CNAs/GNAs), and other positions serving patients in the community. The Commission authorized $6,675,666 across FY 2017 – FY 2019 to provide essential skills training to 444 individuals, provide technical skills training to 263 individuals, and employ 208 individuals by the third year of the project. The Collaborative has partnered with the Baltimore Alliance for Careers in Healthcare (BACH) to implement and manage the recruiting and training process.

Hiring and Training Activities

The Baltimore Collaborative has focused most heavily on recruiting, training, and hiring community health workers to provide a variety of services including education, outreach, care coordination, and patient navigation. Select hospitals have also engaged peer recovery specialists to bolster their services to persons with substance use disorders and certified nursing assistants/geriatric nursing assistants to provide in-home care. Hiring and training activities started later in FY 2017 than originally anticipated so training and hiring numbers have been lower than projected in the initial proposal.

BACH has assisted the Baltimore Collaborative by coordinating training activities and other program administration efforts. Key community partners assisting in the recruiting and training process include TurnAround Tuesday, Center for Urban Families, Penn-North Community Resource Center, and others. Technical training was provided by the Baltimore Area Health Education Center, Community College of Baltimore County, and Mission Peer Recovery Training. Hiring by hospitals continues to increase as the recruitment and training process continues.

Over the 18 months of the program, 207 individuals began technical training, 183 of whom completed the program. Of those individuals who completed technical training, 114 individuals were hired by hospitals. Hired positions included CHWs, PRSs, and CNAs/GNAs. Hiring and training has continued since June 2018.

Baltimore Collaborative Hired Workers

Position	Worker Count as of 6/30/18
Community Health Worker	73
Peer Recovery Specialist	27
Certified/Geriatric Nursing Assistant	14
Worker Totals	**114**

Worker Activities and Patients Served

Workers provided a wide range of patient care to a demographically diverse patient population, with a particular focus on high-utilizer and high-risk patients on Medicare. Key patient care activities included care coordination, health education and health system navigation, transitional care for home health, and community/home care. Additionally, peer recovery specialists provided support for inpatient behavioral unit patients with substance use disorders, ED patients, and those with substance use disorders; PRSs connected patients with community services after discharge, or referred them to therapy after screening and brief intervention. Over the 18 months of the program, PWSDA workers completed 16,311 interventions and provided 10,422 referrals to patients.

Patient Care Activity	Patient Population Served
Care Coordination	○ High needs patients with few comorbidities ○ Follow up discharged patients from hospital or ED ○ Frequent ED visitors ○ High risk patients with difficulty adhering to treatment

Health Education	○ Diabetic and pre-diabetic patients ○ Patients with sickle cell anemia ○ Palliative care patients ○ IV drug users in the ED for hepatitis C and HIV screening ○ Sex workers and homeless
Health System Navigation	○ OB-GYN & pediatric patients with social determinant-related barriers ○ Frequent ED users
Transitional Care for Home Health and Linkage to Social Services	○ High-risk Medicare patients ○ High healthcare utilizers with COPD, congestive heart failure, hypertension, HIV, and diabetes
Peer Recovery Support	○ Inpatient behavioral unit patients ○ Chemical detox unit ○ Overdose survivors outreach program ○ ED patients Screening, Brief intervention and Referral to Treatment (SBIRT) ○ High-Risk Substance Users
Community / Home Care	○ Convalescent patients who need support with ADL ○ Adult patients with chronic conditions ○ Women with perinatal depression ○ Frequent ED visitors ○ OB-GYN and pediatrics patients

Because of the short duration of the program, no significant quality outcome measures are available at this time. Additionally, many workers have been incorporated into existing hospital programs which makes identifying the direct impact of PWSDA workers on quality indicators and population health difficult.

Budget

Total expenditures for this reporting period were $672,527 in FY 2017 and $4,074,572 in FY 2018. HSCRC staff are currently conducting an audit of FY 2017 and FY 2018 spending to confirm actual spending against reported amounts. Staff will adjust rates at the end of the program to remove any unspent funds from hospital global budgets at the end of FY 2019.

FY 2017 Budget and Spending

Expenditure	Budgeted	Actual
Training	$505,959	$328,783
Salaries & Benefits	$2,001,402	$305,040
Consultant (BACH)	$269,196	-
Other Costs	$106,250	$38,704
Totals	**$2,882,807**	**$672,527**

FY 2018 Budget & Spending

Expenditure	Budgeted	Actual
Training	$314,070	$292,003
Salaries & Benefits	$8,357,658	$3,247,972
Consultant (BACH)	$343,565	$256,352
Other Costs	$218,875	$278,245
Totals	**$9,234,168**	**$4,074,572**

GARRETT REGIONAL MEDICAL CENTER

Background

Garrett Regional Medical Center (GRMC) submitted a proposal to hire five individuals to provide health education and care coordination for high utilizers of inpatient care, in particular patients enrolled the Well Patient Program which is managed by a social worker and nurse navigator. Potential workers would be selected for training and employment from the same Well Patient Program under the premise that individuals struggling with chronic conditions may be best equipped to educate and assist other patients with similar health conditions.

The Commission authorized a total of $221,485 in hospital rates to Garrett Regional Medical Center across three years. Additionally, due to GRMC's overlapping service areas with West Virginia, the Commission required that 50% of hired workers be from Maryland.

Hiring and Training Activities

Workers hired by GRMC under the PWSDA are actively managing chronic conditions. Consequently, workers are afforded more flexibility in the training phase and their employment can be on a full-time or part-time basis as needed. Over the course of the program, GRMC found that hiring community health workers with personal experience managing chronic conditions was a strength of the program. The CHWs meet with patients who have been admitted to the hospital or visited the emergency department and assist them with post-discharge needs.

GRMC recruited six individuals during FY 2017 and FY 2018. Five of the six enrollees completed the training and all were hired as CHWs at the hospital. Three workers are from Maryland and two workers are from West Virginia, which fulfills the Commission requirement that 50% of hires must be Maryland residents. An additional hire was made in July 2018.

Worker Activities and Patients Served

PWSDA workers provided support for programs already conducted by GRMC. Community health workers supporting the Well Patient Program assisted the nurse navigator and social workers to provide disease management support for high-utilizers and patients with chronic conditions. Under the Care Coordination Program, CHWs assisted patients with high LACE scores through follow-up phones calls and visits after hospital discharges. Through the Community Care Collaboration Project, CHWs are expected to meet with other agencies that provide support services to patients in order to better coordinate care and prevent duplication of services.

Over the 18 month period, GRMC reported that the number of patients served in the Well-Patient Program increased from 20 individuals to 125. For the 852 patients in the Care Coordination Program, the program observed 94 hospitals admissions and 235 emergency department visits which was smaller than their targets of 100 and 288, respectively.

Because of the short duration of the program, no significant quality outcome measures are available at this time. Because these workers have been incorporated into existing hospital programs, identifying the direct impact of PWSDA workers on quality indicators and population health difficult.

Budget

Total expenditures for the reporting period were $45,198 for FY 2017 and $92,918 for FY 2018.

FY 2017 Budget & Spending

Expenditure	Budgeted	Actual
Training	$10,480	$3,800
Salaries & Benefits	$113,537	$41,148
Other Costs	$3,500	$250
Totals	**$127,517**	**$45,198**

FY 2018 Budget & Spending

Expenditure	Budgeted	Actual
Training	$8,016	$3,300
Salaries & Benefits	$164,523	$74,798
Other Costs	$2,000	$14,820
Totals	**$174,539**	**$92,918**

CONCLUSION

The PWSDA program as initially approved concludes at the end of FY 2019. The HSCRC will continue to collect information on awardee training and hiring activities, worker activities and patient care, and any associated quality metrics. HSCRC staff is currently conducting an audit of hospital spending for Year 1 and 2 of the program and will make appropriate adjustments to hospital rates at the conclusion of the first three years of the program to remove any unspent funds from population-based budgets.

As articulated earlier in this report, staff recommends an extension through FY 2022 to the Baltimore Collaborative to maintain current training and hiring progress and reach intended goals of the program. The Commission reserves the right to terminate or rescind an award at any time for material lack of performance or for not meeting the letter or intent of the program.

JOHNS HOPKINS

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443-287-9900 / Fax 443-287-9898

October 23, 2018

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

Dear Ms. Wunderlich,

On behalf of the Johns Hopkins Health System, thank you for the opportunity to voice my support for the Baltimore Population Health Workforce Collaborative (BPHWC). BPHWC has been an outstanding example of hospitals and the state working together to address the population health needs of Baltimore City. Even the early data is showing positive results – we have heard and collected numerous individual examples of how this program significantly changed the lives of the recipients of these population health based jobs, as well as the lives of patients who have been touched by our Peer Recovery Specialists and Community Health Workers.

The Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center were early advocates of this program, and we are encouraged by its success. Johns Hopkins and our other partners in this program recognize that there were unexpected barriers in the initial launch of the program, however we fully expect the BPHWC to meet its hiring targets and goals. We appreciate the interest of the HSCRC to see this program reach its full potential, and we believe the that continuation of Population Health Workforce Support for Disadvantaged Areas program is an essential tool in addressing the population health needs of Baltimore City and the patients we serve.

Sincerely,

Mary E. Clapsaddle
Director, State Affairs

cc: Nelson J. Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
James Elliott, MD
Adam Kane
Jack C. Keane

UNIVERSITY of MARYLAND
MEDICAL CENTER

Mohan Suntha, MD, MBA
President and Chief Executive Officer

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November 5, 2018

Ms. Katie Wunderlich
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21201

Dear. Ms. Wunderlich,

I am writing on behalf of the University of Maryland Medical Center (UMMC) to strongly advocate for extending support for the Baltimore Population Health Workforce Collaborative (BPHWC). This program is an excellent example of how Baltimore City hospitals and the State can work together creatively to begin to address the many complex challenges facing our most vulnerable patients. It has proven to be an enormous success both for our patients and for the community members who have participated in the program by becoming community health workers and peer recovery counselors. As you will see from our collective impact report, we were able to achieve many of the goals set forth, achieved high retention rates from the participants, and fully expect to complete our hiring and programmatic goals.

Through the resources provided by the BPHWC, UMMC was able to hire 21 community health workers and 13 peer recovery specialists during the first 2 years of the program. These individuals have become an integral and important part of our care management teams and are making a significant impact on the patients we serve. One of our community health workers was appointed by Governor Hogan to be a member of the State of Maryland's Community Health Worker Advisory Committee for a five-year term. This is an example of the outstanding talent that our partners, such as Turnaround Tuesday, are pipelining to our collaborative efforts.

As you know, our Midtown Campus (formerly Maryland General Hospital) has been a resource for the community for the past 136 years. As an anchor institution in West Baltimore, UMMC is intricately connected to the community, and is working diligently to develop strategies and tactics to address population health as we prepare to move into the new Total Cost of Care model. Our commitment continues to be stronger than ever.

We are grateful to the HSCRC for supporting this important initiative and believe that the continued funding of this program is essential to meeting the goals of the Phase II Medicare Waiver Program and making a collective impact in the communities we serve.

Sincerely,

Mohan Suntha, MD, MBA
President and Chief Executive Officer

Cc: Nelson J. Sabatini, Chairman
Joseph Hoffman
Dana Farrakhan

MedStar Health

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medstarhealth.org

October 26, 2018

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

Dear Chairman Sabatini:

On behalf of MedStar Health and our four Baltimore region hospitals (MedStar Franklin Square Medical Center, MedStar Good Samaritan Hospital, MedStar Harbor Hospital, and MedStar Unioun Memorial Hospital), we are writing to express our strong support to extend the Baltimore Population Health Workforce Collaborative to allow each hospital to reach and sustain the original training and hiring goals. As you know, while training and hiring processes were slow to be fine-tuned, those issues have been resolved, and the impact has clearly been demonstrated to benefit the patients we serve.

Thus far, MedStar's four Baltimore hospitals have hired 26 community health workers and retained 20 of them against a goal of 27. We have hired 15 peer recovery counselors and have retained 11 against a target of 16. Our retention rate for both roles is 81 percent against our goal of 90 percent.

Beyond the numbers, this program has proved to be such an overwhelming success both for our patients, the participants, and our clinicians. These individuals are connecting with our patients in ways we have never done before. There are many barriers in our patients' lives that negatively impact their health, including transportation challenges, access to healthy food, utility assistance and stable housing. Community health workers and peer recovery counselors are identifying and connecting patients to local services to address these issues, and, in many ways, they are solving the problems that medicine will never be able to address. Our Community Health workers had 683 patient encounters resulting in nearly 4,000 interventions. The Outpatient Peer Recovery team worked with 281 clients and provided 262 referrals to substance abuse resources. The emergency department SBIRT team contributed more than 1,400 linkages to substance abuse treatment. As a result, we have seen improved patient engagement and motivation to improve health.

Our clinicians have truly embraced this additional resource, as well. Clinicians become frustrated when discharging a patient knowing patients are likely to return based on the totality of their social needs. In addition to going to the patient's home, community health workers participate with our interdisciplinary model of care teams to help ensure the patient's care transition is successful. These new teams are integrated within each hospital's care and case management teams, CHAs and PRCs participate in patient huddles and post-discharge care

more-

planning. The teams are seen as a critical part of providing comprehensive patient care, and treating the whole person as part of care delivery. They have identified resources in the community we did not know existed. They are often the front line volunteers at various health fairs and have learned to conduct many health screenings.

Lastly, this program has allowed the participants to gain confidence about their employment journey. For some, this is their first job in a professional medical setting and it can be intimidating. We have watched them grow and learn in their jobs and their commitment to helping our patients is inspiring. In fact, several participants are taking additional classes, including professional degree programs, to continue growing their skills.

As implementation of the Total Cost of Care rolls out, these individuals will play a critical role in the success of that initiative. For that reason, in addition to extending the original program, we would ask that you consider increasing the funding available for this purpose.

Thank you for the opportunity comment on this important and successful program.

Sincerely,

Bradley S. Chambers
President, MedStar Union Memorial Hospital & MedStar Good Samaritan Hospital & Senior Vice President, MedStar Health

Stuart M. Levine, MD
President & Chief Medical Officer, MedStar Harbor Hospital & Senior Vice President, MedStar Health

Samuel E. Moskowitz, FACHE
President, MedStar Franklin Square Medical Center & Senior Vice President, MedStar Health

SINAI HOSPITAL
A LifeBridge Health Center

October 22, 2018

Baltimore Alliance for Careers in Healthcare
Magdalena Nowosadko, HSCRC Project Manager
1500 Union Avenue, Suite 1400
Baltimore, Maryland 21211

Letter of Support to BACH for Continuation of the HSCRC Jobs Project

Dear Magdalena,

Confirmation of support for application: HSCRC Jobs Project

This letter is to confirm that LifeBridge Health wishes to continue its participation in the proposed continuation of the HSCRC Jobs Project led by The Baltimore Alliance for Careers in Healthcare.

The Baltimore Alliance for Careers in Healthcare (BACH) is providing comprehensive training for Community Health Worker (CHW) candidates. By providing this training, we integrate them into our care teams to help us to better understand our patients and get a total picture of the person, knowing more about their life "outside" of the hospital's walls.
These CHWs provide an invaluable extension of care deep into our communities. They are effective care team members as they often come from the communities that their clients live, and they are dedicated to helping them live healthier lives through navigation of the health system, sharing resources, advocacy, education and support.

We are committed to continuing to match the financial support necessary to support this important work.

Please do not hesitate to contact me if you need any further information.

Yours sincerely,

Sharon L McClernan

Sharon L. McClernan, RN, BSN, MBA/MHA
Vice President for Clinical Integration, Carroll Hospital
AVP for Population Health, LifeBridge Health

Briefing Document – HSCRC Staff Analysis for Adjustment to the Payer Differential

November 14, 2018

HSCRC
Health Services Cost Review Commission

Overview

- Private payers are changing business practices and increasing out of pocket costs to consumers, resulting in increasing uncompensated care costs.
- This cost increase negatively impacts public payers since actual Uncompensated Care (UCC) is distributed across all payers through a uniform mark-up.
  - This UCC markup is adjusted annually based on the prior year's actual cost.
- The HSCRC staff has calculated that an increase of 1.7 percentage points in the public payer differential would compensate for this difference and changes in business practices of private Maryland payers.

Background

History--Maryland's Public-Private Payer Differential

- Negotiated at the beginning of the All-Payer system in 1977
  - The differential was designed to respond to payer practices that averted bad debt and accelerated payment of hospital bills, thus generating cost savings to hospitals.
  - This practice was supported by the Maryland Court of Appeals.
- Public payers (Medicare and Medicaid) pay 6 percent less than approved charges.
  - A 1995 contract amendment with the federal government set the Medicare differential at a minimum of 6.0 percent, for business practices and prompt payment practices.
  - The All-Payer Model contract requires that the differential, "be at a minimum 6.0 percent," to account for Medicare's, "business practices and prompt payment practices."
  - The Medicaid differential is 4.0 percent for its business practices and an additional 2.0 percent conditioned on meeting prompt pay requirements. Medicaid MCOs receive the differential.

History--Maryland's Public-Private Payer Differential, cont.

- Some private payers also received a discount, including:
  - A 2.0 percent 'prompt pay' differential to private payers for working capital; and,
  - A 4 percent differential to payers participating in the substantial, available, and affordable coverage program (SAAC carriers) for averted bad debt via high-risk coverage and accepting all eligible individuals without medical screening and underwriting.
- The private payer differential was changed in 2003 to eliminate the SAAC carriers 4 percent differential due to changes in their business practices. The MHIP program replaced coverage for non-group individuals.
- Presently, many private payers in Maryland receive a 2.0 to 2.25 percent differential for prompt payment practices.
  - CareFirst is the only payer which has qualified for the 2.25 percent differential

How the Differential Works

- Hospital charges are increased, or marked up, to ensure that the reduction in payments resulting from applying the differential does not result in decreased revenues to hospitals.
- Maryland's payer differential between public and private payers is significantly less than the rest of the nation where private payers typically pay significantly more than public payers.

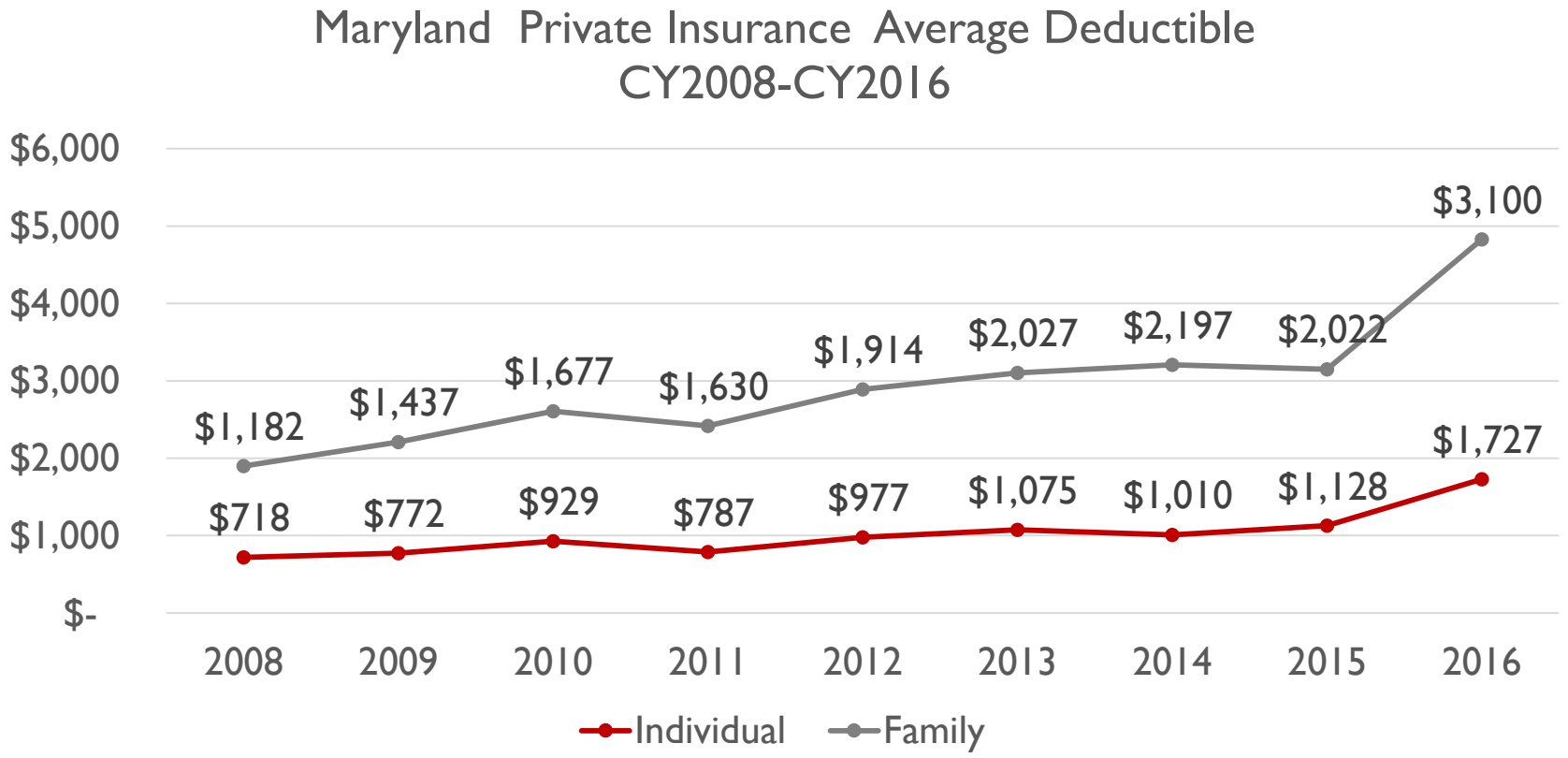
Analysis

Increasing the Public-Private Payer Differential

- Private insurance plan design changes increasingly expose hospitals to bad debt as consumers are responsible for more cost sharing.
  - Out of pocket costs are increasing rapidly and more consumers are exposed to coinsurance and deductibles.
  - Private insurances plans are averting less bad debt than public payers due to these business practices.
- Staff has calculated that a change in the public payer differential of 1.7 percent to address these changes that are increasing hospitals' uncompensated care should be considered.
  - This proposed increase is recommended to respond to increasing bad debt write-offs in private coverage and to prevent cost shifting to Medicare and Medicaid.

Private Insurance Deductibles Costs are Increasing Rapidly

- The share of privately insured Marylanders with a deductible has increased from 57.1 percent in 2008 to 88.7 percent as of 2016.
- Increases in deductibles outpace consumer and medical cost inflation.



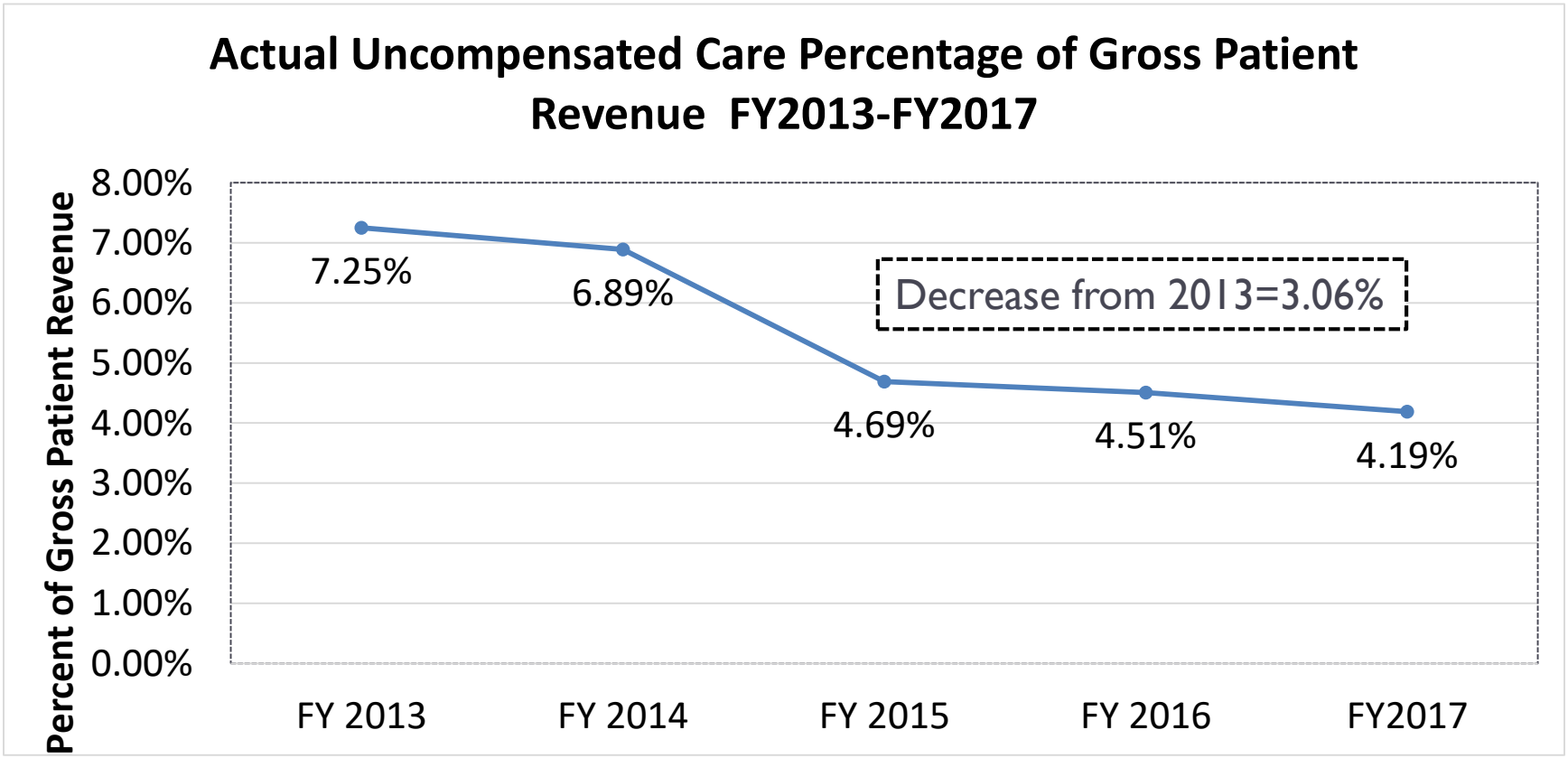
Source: Medical Expenditure Panel Survey (MEPS) Insurance Component, Accessed June 23, 2017.
https://meps.ahrq.gov/mepsweb/data_stats/MEPSnetIC.jsp

Impact of Medicaid Expansion on Payers

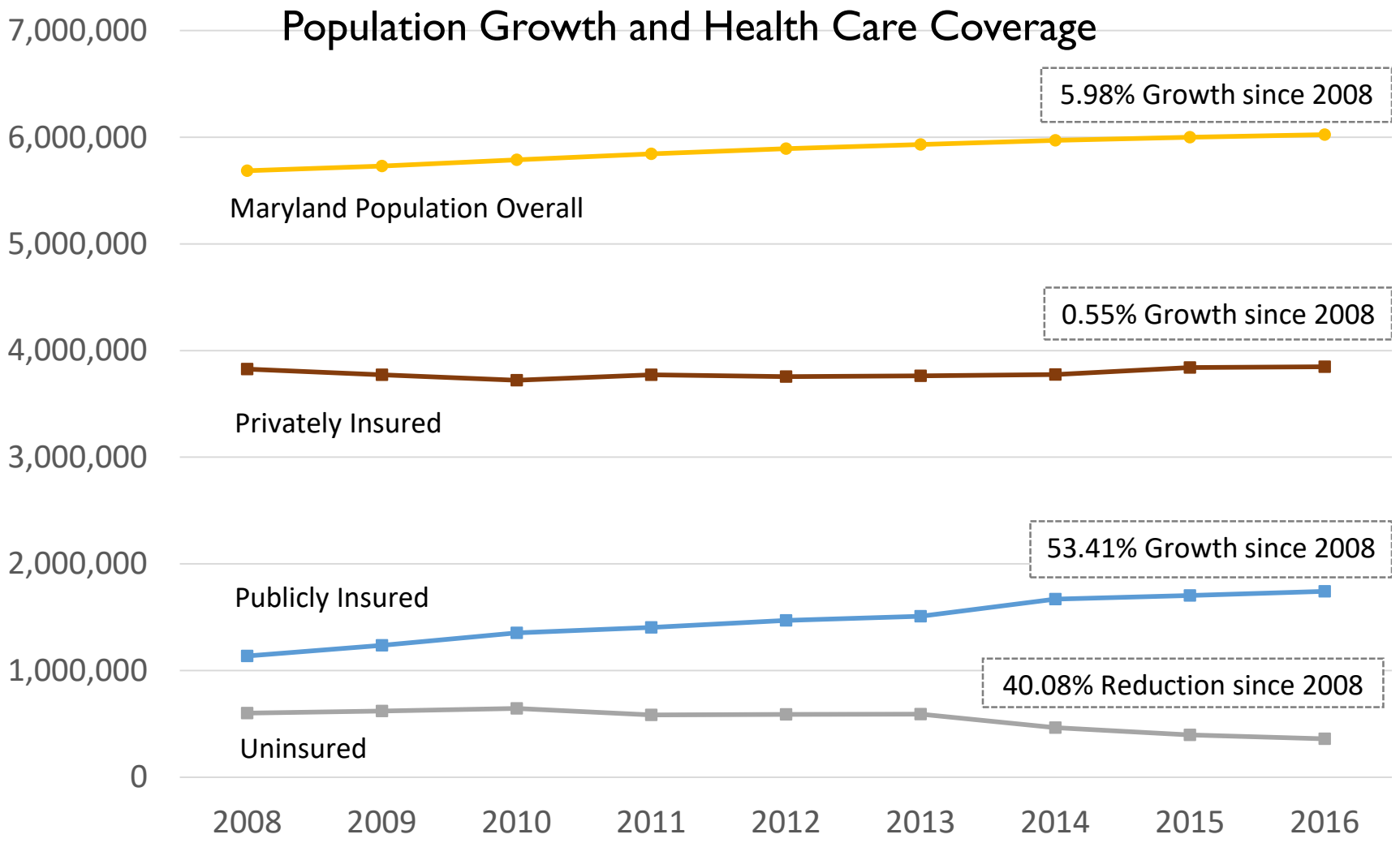
- There have been large reductions in uncompensated care, particularly related to the Medicaid expansion that took place in 2014 under the Affordable Care Act (ACA).
  - For the expansion that took place prior to 2011, the averted uncompensated care attributable to the Medicaid coverage expansion was allocated back to Medicaid through implementation of an all-payer assessment of 1.25 percent, which is paid to Medicaid each year.
  - From 2014 through 2017, there was a reduction in uncompensated care of 3.06 percent, much of which resulted from the expansion of Medicaid. While funded disproportionately by the federal government, the benefit of this reduction was provided to all payers through a hospital revenue decrease in Maryland.
- While private payers were benefitting from public payer investments that averted uncompensated care/bad debt under the ACA, public payers were being adversely impacted by increasing bad debts attributable to changing business practices of private payers.

Uncompensated Care In Maryland has Considerably Reduced

- Since 2013, Maryland has experienced a 42.2 percent decrease in uncompensated care

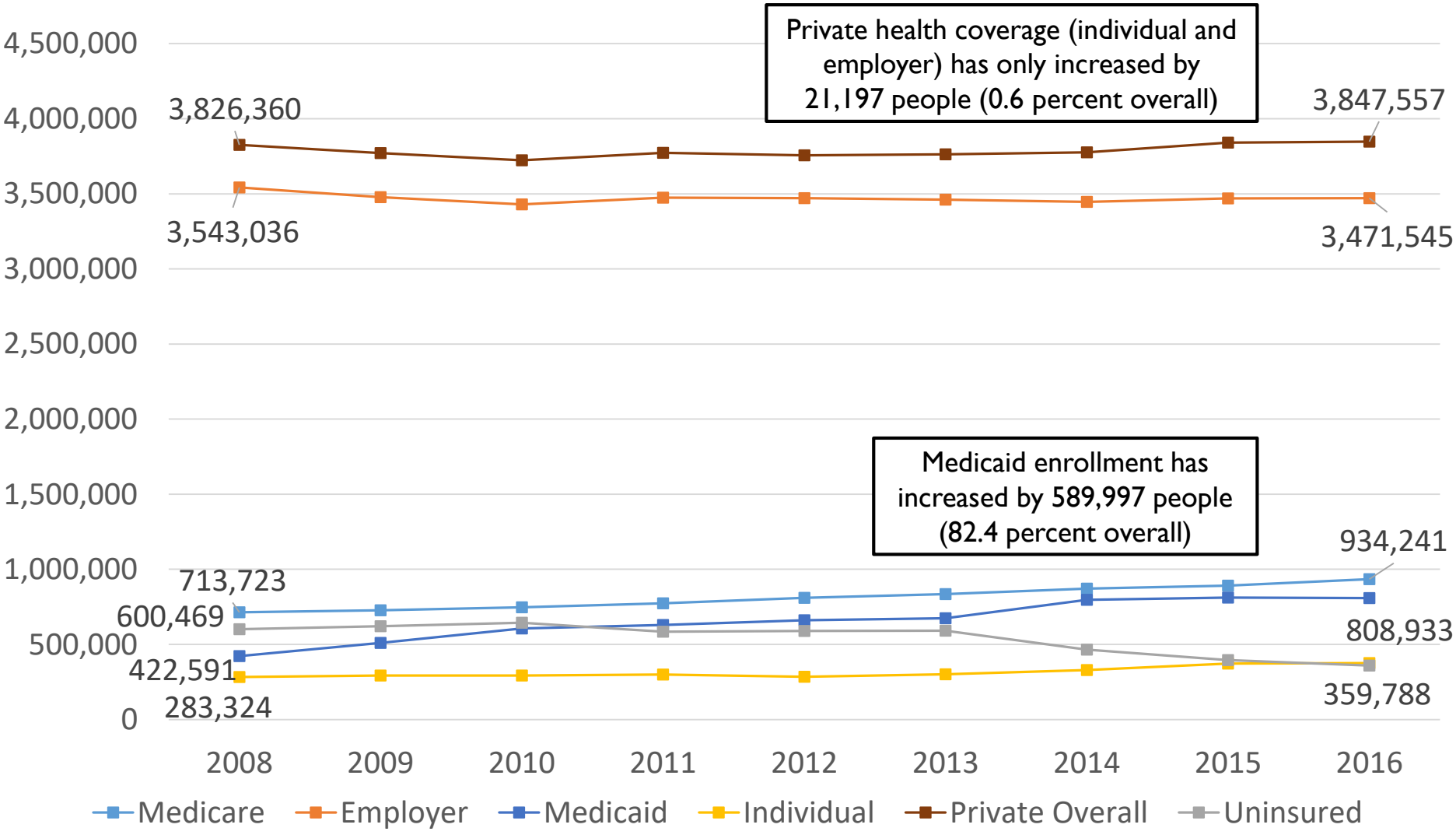


Governmental Payers are Increasingly Providing Coverage for the Population



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

Increases in Medicaid Coverage have Contributed the Largest Reductions in the Uninsured Population



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

Impact of Increasing Differential and Conditions

Calculating the Increased Differential

- HSCRC staff calculated the needed increase in the public differential to compensate for the difference in public/private payer write-off levels resulting from business practice changes.
  - Staff used matched claim level write-off data and case-mix data to quantify the write-offs associated with each payer.
  - The difference in the write-off rates between public and private payers was 1.9 percent in 2017.
  - The differential increase needed to eliminate the portion of this difference that is allocated to public payers is 1.7 percentage points.

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

Increase the Public Payer Differential by 1.7 Percentage Points

- Effective July1, 2019
- Public payer differential moves from 6.0 percent to 7.7 percent
- Charges increase by 1.2 percent to provide a revenue neutral impact to hospitals, consistent with current practice.
- This differential increase would result in:
  - A lower cost to Medicare of approximately $40 million;
  - A lower cost to Medicaid of approximately $27 million; and
  - An increase in overall private payer costs of $67 million, or 0.4 percent, assuming hospital costs comprise approximately one-third of private payer costs.

Conditions

1. The cost reduction to Medicare as a result of the change in the differential be removed from the Total Cost of Care performance evaluation when establishing future annual updates. Savings associated with the increased differential should not supplant hospital savings needed to meet the annual savings goals required by the Total Cost of Care Model contract.
2. Similarly, the savings to Medicare resulting from the differential adjustment should not be included in the trend factor used to calculate a hospital's performance under the Medicare Total Cost of Care algorithm.
3. The Commission should develop and adopt policies regarding the appropriate use of various rate-setting tools to meet Medicare total cost of care performance requirements. The success of the Model is dependent on improving care, reducing avoidable utilization, and providing efficient and effective care. To this end, the Commission should not use changes to the differential to meet TCOC savings performance requirements.
4. It is the intent of the Commission to make a one-time adjustment at the beginning of the TCOC Model, as permitted by the contract to correct for cost inequities within the system and to avoid future changes to the public payer differential to assure the stability of the system and to preserve the all-payer nature of the Maryland Model.

Draft Staff Recommendation for Adjustment to the Payer Differential

November 14, 2018

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

This is a draft recommendation. Comments on the draft policy may be submitted by email to madeline.jackson@maryland.gov and are due by Wednesday, November 21, 2018.

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DRAFT RECOMMENDATION

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

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

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

BACKGROUND AND HISTORY

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

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

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

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

shortcomings of the SAAC program, the legislature required SAAC providers to contribute 37.5 percent of the value of the differential to a Short-Term Prescription Drug Subsidy Plan. The SAAC program was finally discontinued in 2003.

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

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

ASSESSMENT OF CHANGING BUSINESS PRACTICES

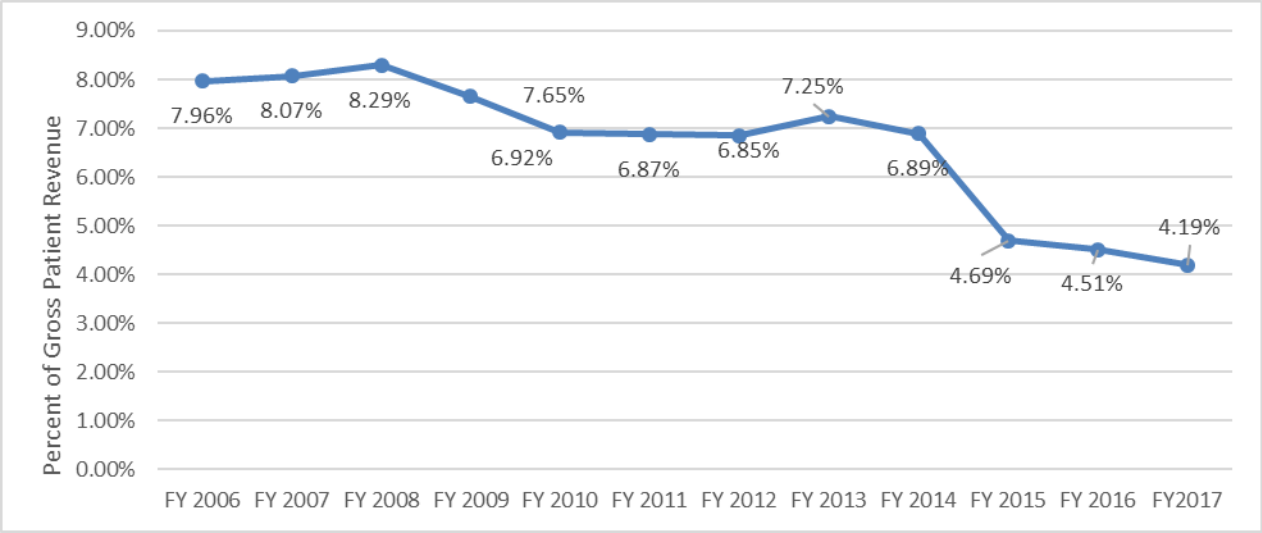
While expansion of coverage under the Affordable Care Act has contributed to a large increase in averted bad debt at hospitals and a subsequent decline in uncompensated care, rising deductibles and coinsurance have resulted in increased levels of uncompensated care for privately covered beneficiaries.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

Uncompensated Care Trends

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

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

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

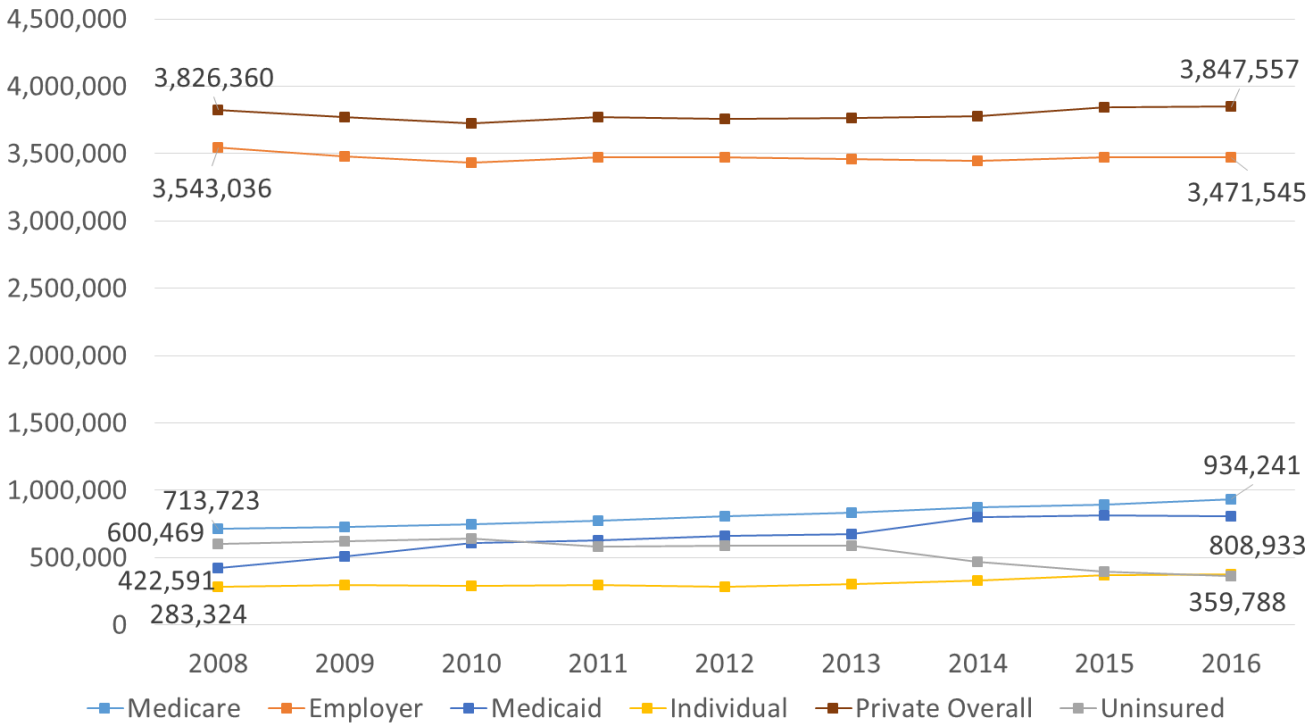


Source: HSCRC Historical Financial Data

Changes in Payer Enrollment

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

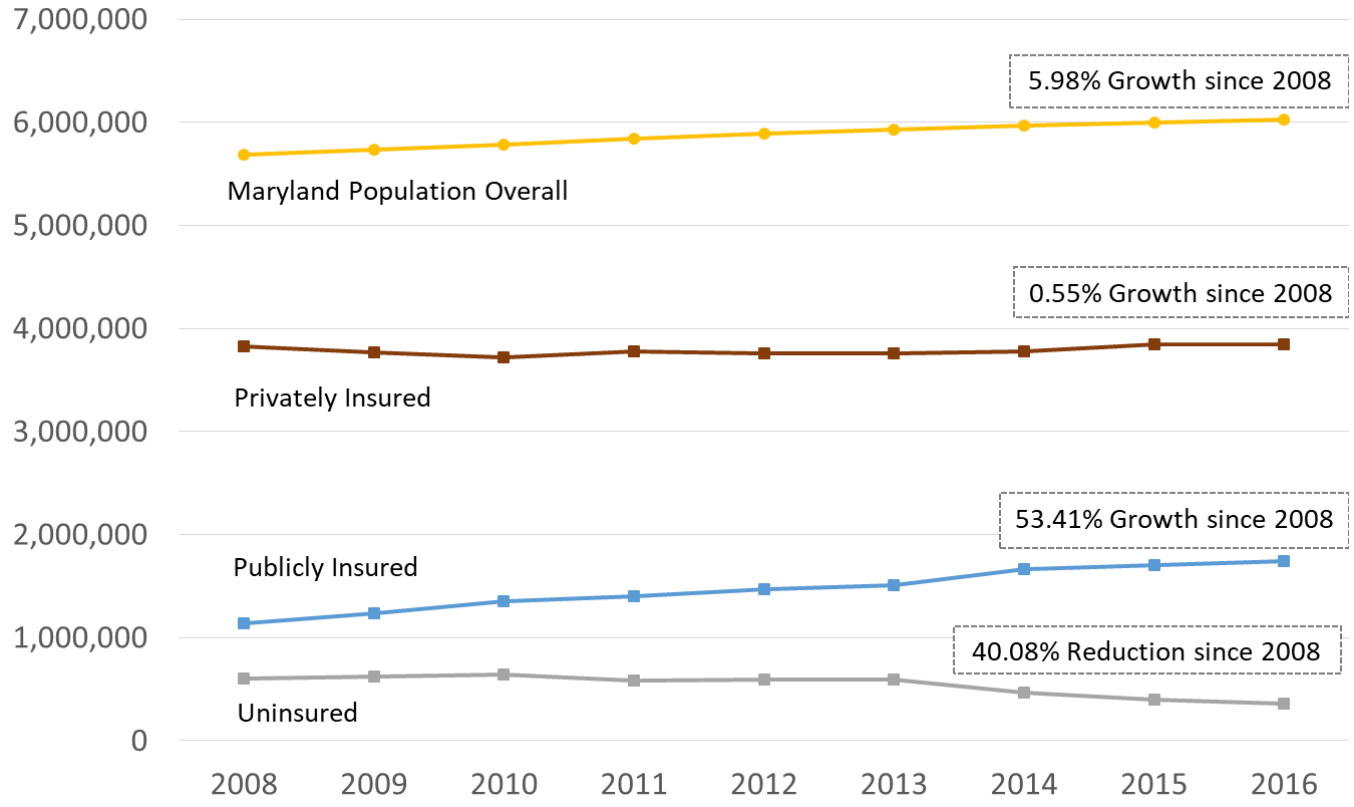
Figure 2. Maryland Health Insurance Coverage by Payer type and Uninsured, CY2008-CY2016.



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

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

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



Private Insurance through the Maryland Health Benefit Exchange

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

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

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

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

Private Insurance Offered by Employers

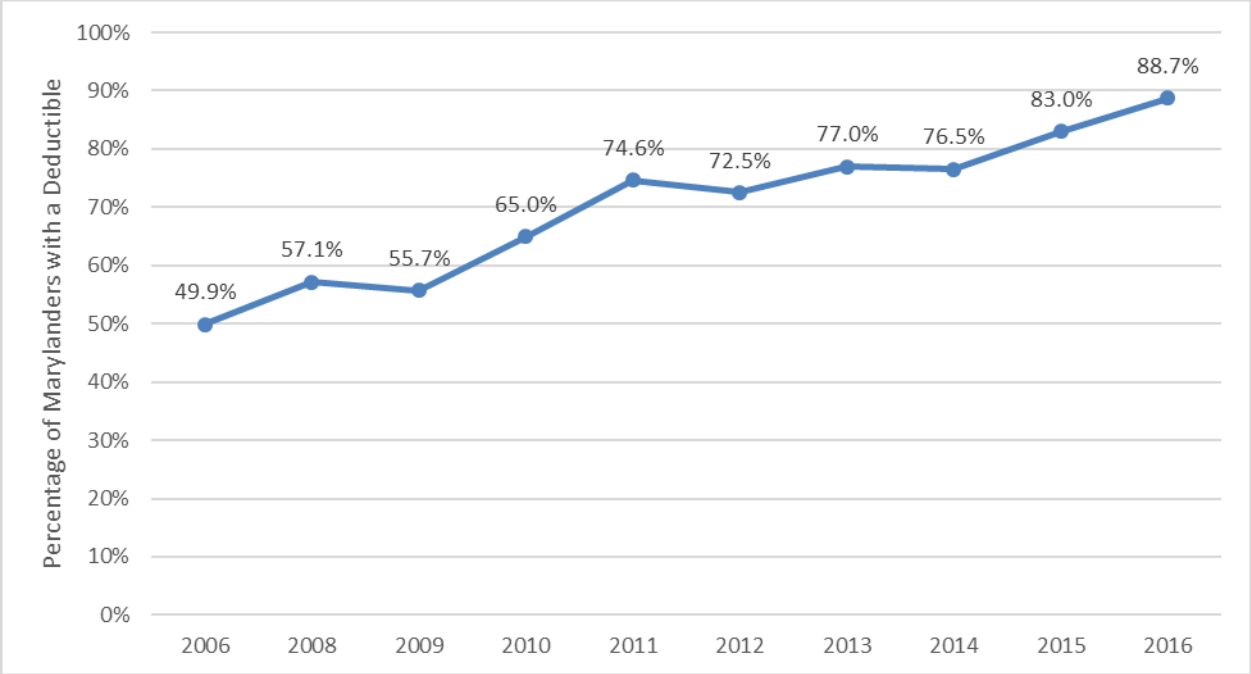
Overall, uptake of employer-sponsored health insurance plans has also dropped in Maryland. Between 2012 and 2015, employee uptake with small group insurance dropped from 72.4 percent to 64.8 percent, and dropped from 78.0 percent to 74.0 percent for large group employers.[1] Medicaid expansion and individual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

Commercial Insurance Plan Design Changes

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

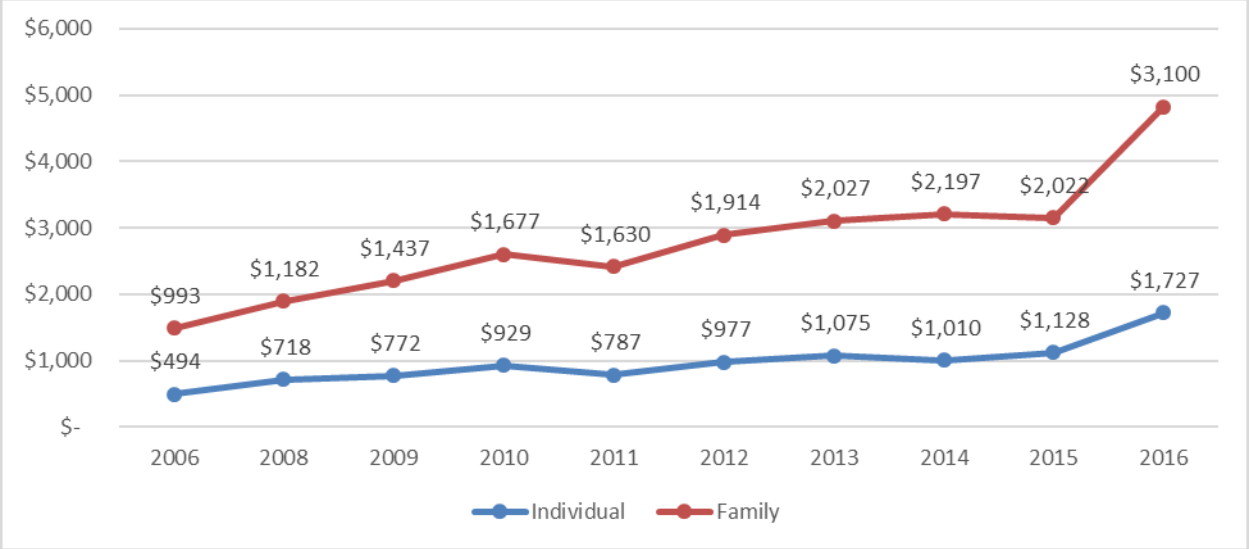
Figure 4. Percent of Maryland private-sector employees enrolled in a health insurance plan with deductible (CY2002-CY2016)

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



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

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



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

While the plan design changes are aimed at encouraging individual attention to cost levels, the HSCRC staff does not believe it is equitable to have the related uncompensated care allocated to all payers. Deductibles have increased three-fold since 2006, and twice as many Marylanders are

exposed to the rapidly increasing cost burden imposed by deductibles, thereby increasing the level of private payer uncompensated care at hospitals.

Hospital Bad Debt Share by Payer

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

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

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

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

Proposed Change in the Differential

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

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

The adjustment in the differential is being made to change the allocation of uncompensated care to Medicaid and Medicare. When it is implemented, it will have a revenue neutral effect on

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

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

RECOMMENDATION

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

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

Memorandum

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

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

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

A. Basis for the Proposed Change in the Differential

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

* * * * * * *

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

Quality Based Reimbursement Program
RY 2021 Draft Recommendations

11/14/2018

HSCRC
Health Services Cost Review Commission

Proposed Commission Action

- This is a draft recommendation

- Staff proposes minimal changes for RY 2021
  - Add hip/knee replacement complication rate measure
  - Remove early elective delivery and ED-1b
  - Maintain RY 2020 QBR scoring and revenue adjustment methodology

QBR Program Background

- Maryland is **required** to submit a report to CMS demonstrating that cost and quality outcomes for QBR are equal to or better to the nation to maintain the exemption from the VBP program
- Maryland's unique all payer model and autonomous position allows the State to be innovative and progressive

RY2020 Domains	Maryland QBR Domain Weights and Measures	CMS VBP Domain Weights and Measures
Clinical Care	**15%** (1 measure: all cause inpatient Mortality)	**25%** (4 measures: 3 condition-specific Mortality, THA/TKA measure)
Person and Community Engagement	**50%** (8 HCAHPS measures, 2 ED wait time measure)	**25%** (Same HCAHPS measures, no ED wait time measures)
Safety	**35%** (6 measures: CDC NHSN HAI)	**25%** (7 measures: 6 CDC NHSN, PSI)
Efficiency	N/A	**25%** (Medicare Spending Per Beneficiary measure)

QBR Methodology

Performance Measures

QBR Measures by Domain:

Person and Community Engagement (8 HCAHPS measures + ED wait times)

Safety (7 Measures: CDC NHSN Measures + PC-01)

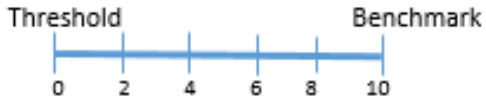
Clinical Care (Inpatient Mortality)

^HCAHPS; *MD In-Hospital Mortality

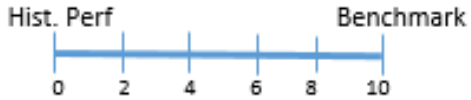
Standardized Measure Scores

Individual Measures are Converted to 0-10 Points:

Points for Attainment Compare Performance to a National Threshold (median) and Benchmark (top 5%)



Points for Improvement Compare Performance to Base (historical perf) and Benchmark



Final Points are Better of Improvement or Attainment

Hospital QBR Score & Revenue Adjustments

Hospital QBR Score is Sum of Earned Points / Possible Points with Domain Weights Applied

Scores Range from 0-100%

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

RY 2019 Maryland Performance Relative to National Performance

- **Person and Community Engagement** domain:
  - Maryland has improved on most HCAHPS measures
  - MD continues to lag behind the nation on all HCAHPS and ED Wait Time Measures
- **Clinical Care** domain:
  - Condition-specific mortality measures: Maryland is comparable to the nation
  - Inpatient Mortality Measure: Maryland hospitals continue to improve
  - THA/TKA hip/knee replacement complication measure: MD hospitals perform relatively well compared to the nation but there is variation in performance.
- **Safety** domain (6 NHSN Infection Measures):
  - Maryland Standardized Infection Ratios (SIRs) are better than the nation in 3 out of 6 measures.
  - MD improvement eclipsed the Nation on 3 of 6 SIRs

Scaling Considerations: Using National Scores to Set the Scale

- Previously – scale established by state standards, allowing rewards not commensurate with performance relative to the nation
- The QBR RY 2019 Recommendation moved to a national pre-set scale ranging from 0 to 80% with a cutoff for reward at 45%
  - Rationale for 45%: Staff estimated the national average VBP scores under QBR logic,
    - Removed the efficiency domain and applied RY 2017 QBR Domain weights

FFY2016	FFY2017	FFY2018
42%	40%	41%

- Staff supports a reward/penalty cutoff of 45% so that rewards are provided for comparably good performance relative to the nation

QBR RY 2020 Draft Recommendations-

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

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

November 14, 2018

Health Services Cost Review Commission
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Baltimore, Maryland 21215
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This document contains the draft staff recommendations for updating the Quality Based Reimbursement Program for RY 2021. Comments on the draft policy may be submitted by email to hscrc.quality@maryland.gov and are due by Tuesday, November 20, 2018.

Table of Contents

LIST OF ABBREVIATIONS

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

EXECUTIVE SUMMARY

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

Draft Recommendations for RY 2021 QBR Program

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

INTRODUCTION

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

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

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

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

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

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

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

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

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

BACKGROUND

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

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

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

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

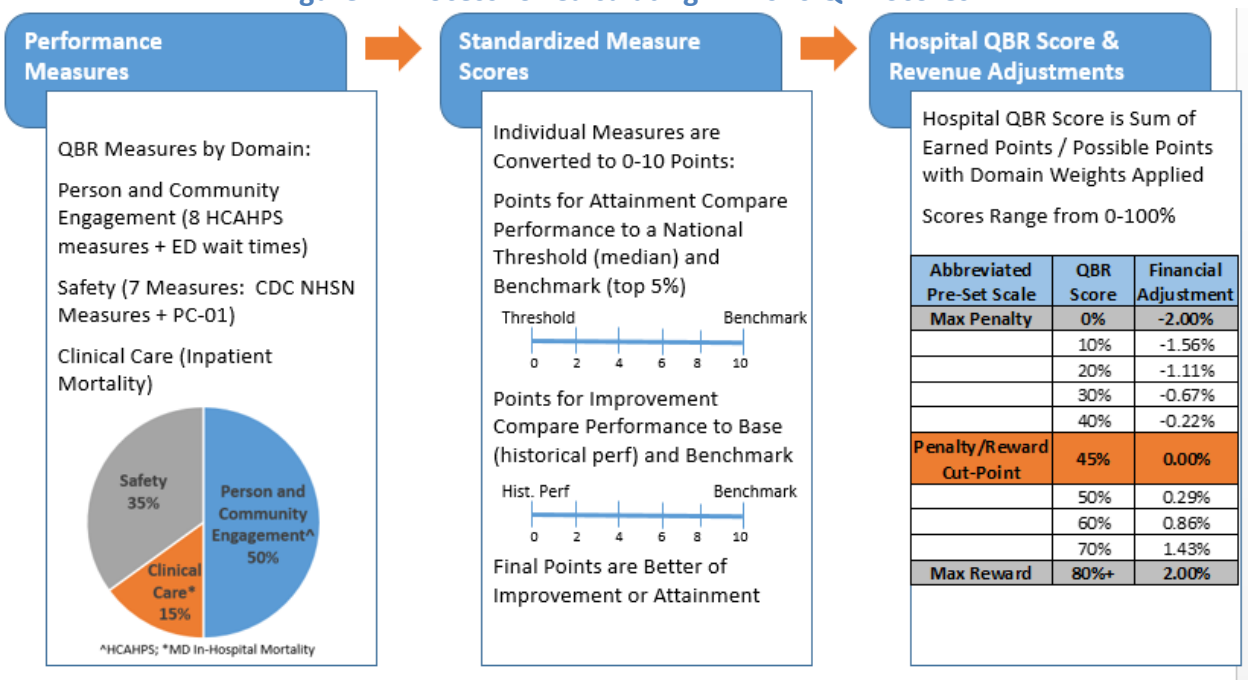
The methodology for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019, and involves: 1) assessing

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

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

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

Figure 2. Process for Calculating RY 2020 QBR Scores



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

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

ASSESSMENT

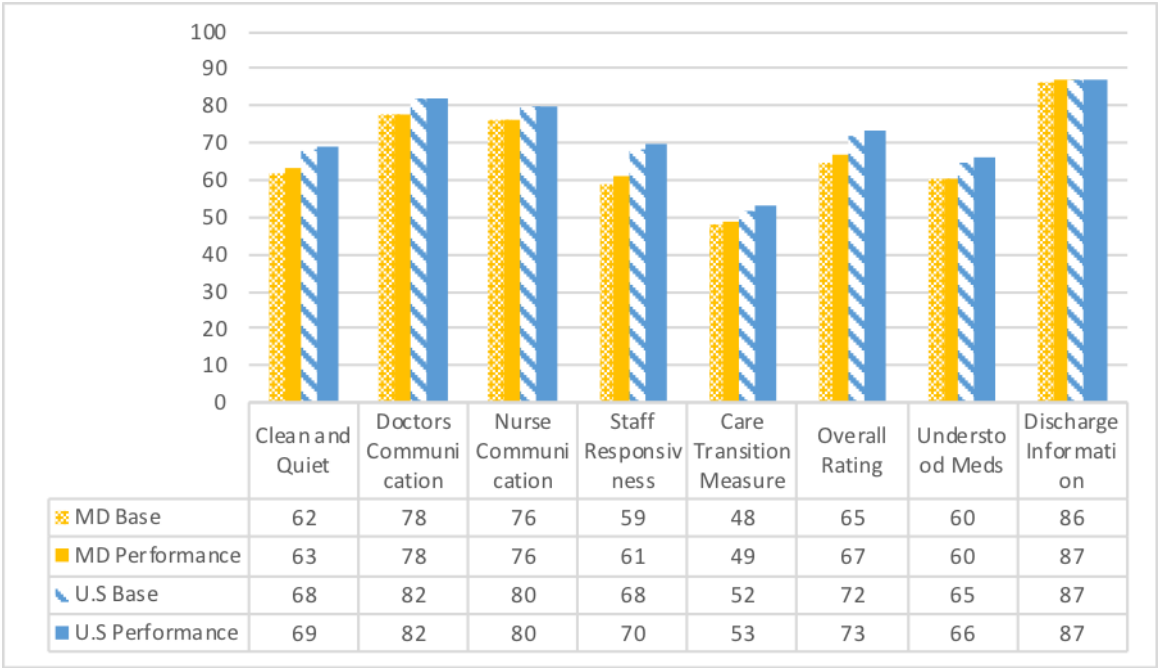
The purpose of this section is to assess Maryland's performance on current and potential QBR measures within each domain that, together with the deliberations of the Performance Measurement Workgroup (PMWG), serve as the basis for the recommendations for the RY 2021 QBR program. In addition, the staff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

Maryland Performance by QBR Domain

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

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

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



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

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

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

It should be noted that hospital stakeholders have raised concerns about HCAHPS patient mix adjustment changes between the base and performance periods. CMS has advised staff that these changes occur on an ongoing basis, and that the most recent changes are not considered materially significant for the VBP program. Further, staff believes that the changes in any given year may slightly benefit or disadvantage each hospital on their respective QBR scores, but recognize the use of the prospective preset scale may make this issue more of a concern in Maryland. Therefore, staff will evaluate the impact of the patient mix adjustment changes for RY 2019 and RY 2020, but does not support retrospective QBR revenue adjustments. Staff may re-visit this position with the Commission should analysis determine the patient mix adjustment

changes are materially significant. For RY2021 it is unknown whether there will be any patient mix adjustment changes, but staff will assess any changes that occur.

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

Figure 4. CMS ED Wait Time Measures

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

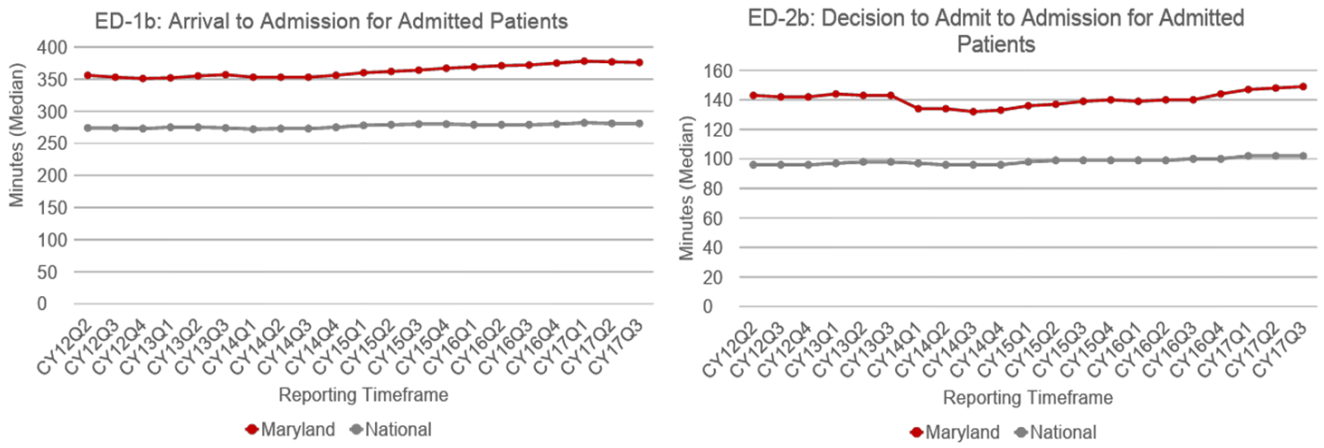
*OP-18 is not recommended to be a measure in the RY 2021 Program. OP-18b strata includes non-psychiatric patients and OP-18c strata includes psychiatric patients.

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

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

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

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



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

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

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

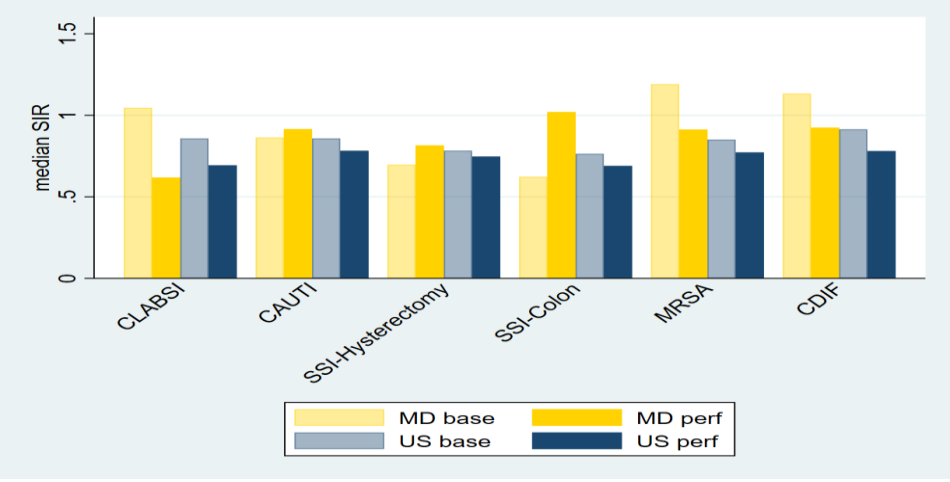
OP-18b (non-psychiatric patients)	**MD**	**National**
Low Volume	131	111
Moderate Volume	182	142
High Volume	190	161
Very High Volume	213	171
OP-18c (psychiatric patients)	**MD**	**National**
Low Volume	194	245
Moderate Volume	349	164
High Volume	324	218
Very High Volume	359	279

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

Based on the analysis of the Person and Community Engagement domain, HSCRC staff recommends continuing to weight this domain at 50% of the QBR score, and retaining the ED-1b measure along with HCAHPS in the domain.

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

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

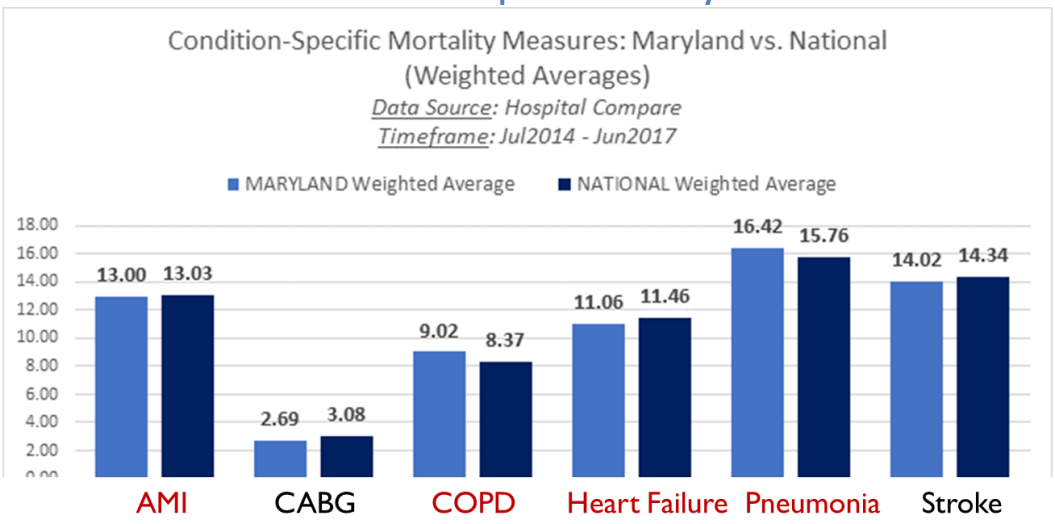


The QBR **Safety** domain does not include the Patient Safety Index Composite (PSI-90) measure that is included in VBP. Currently, the Agency for Healthcare Research and Quality (AHRQ) has yet to release a PSI-90 risk-adjustment methodology under ICD-10 for all payers. The HSCRC plans to consider options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

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

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

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

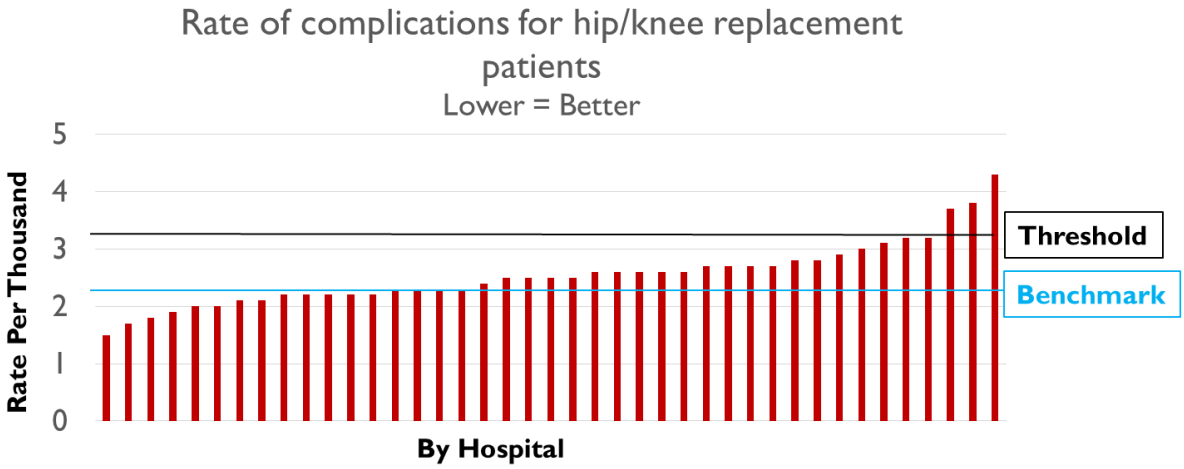


Source: Health Quality Innovators (HQI). Red are conditions included in VBP.

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

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

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



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

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

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

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

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

Revenue Adjustment Modeling

HSCRC staff modeled hospital QBR scores and revenue adjustments consistent with the preset scaling approach approved for RY 2020. With the exception of the HSCRC-derived measures, the thresholds and benchmarks for the QBR scoring methodology are based on the national average (threshold) and the top performance (benchmark) values for all measures. A score of 0% means that performance on all measures are below the national average or not improved, while a score of 100% means all measures are at or better than the top 5% best performing rates. The Commission moved to a preset scale that reflects a full distribution of potential scores and raised the reward potential to 2% of inpatient revenue for RY 2019. Given Maryland's mixed performance relative to the nation, staff believes that the more aggressive scaling is warranted and proposes to continue this scale for RY 2021 QBR program.

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

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

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

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

DRAFT RECOMMENDATIONS FOR RY 2021 QBR PROGRAM

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

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

APPENDIX I. HSCRC QBR PROGRAM BACKGROUND

The Affordable Care Act established the hospital Medicare Value-Based Purchasing (VBP) program,[8] which requires CMS to reward hospitals with incentive payments for the quality of care provided to Medicare beneficiaries. The program assesses hospital performance on a set of measures in Clinical Care, Person and Community Engagement, Safety, and Efficiency domains. The incentive payments are funded by reducing the base operating diagnosis-related group (DRG) amounts that determine the Medicare payment for each hospital inpatient discharge.[9] The Affordable Care Act set the maximum penalty and reward at 2% for federal fiscal year (FFY) 2017 and beyond.[10]

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

In addition to structuring two of the three domains of the QBR program to correspond to the federal VBP program, the Commission has increasingly emphasized performance relative to the nation through benchmarking, domain weighting, and scaling decisions. For example, beginning in RY 2015, the QBR program began utilizing national benchmarks to assess performance for the Person and Community Engagement and Safety domains. Subsequently, the RY 2017 QBR policy increased the weighting of the Person and Community Engagement domain, which is measured by the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey instrument to 50%[11]. The weighting was increased in order to raise incentives for HCAHPS improvement, as Maryland has consistently scored in the lowest decile nationally on these measures.

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

[8] For more information on the VBP program, see https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-Value-Based-Purchasing/
[9] 42 USC § 1395ww(o)(7).
[10] 42 USC § 1395ww(o)(7)(C).
[11] The HCAHPS increase reduced the Clinical Care domain from 20% to 15%.

be innovative and progressive. Figure 11 below compares the RY 2020 QBR measures and domain weights to those used in the CMS VBP program.

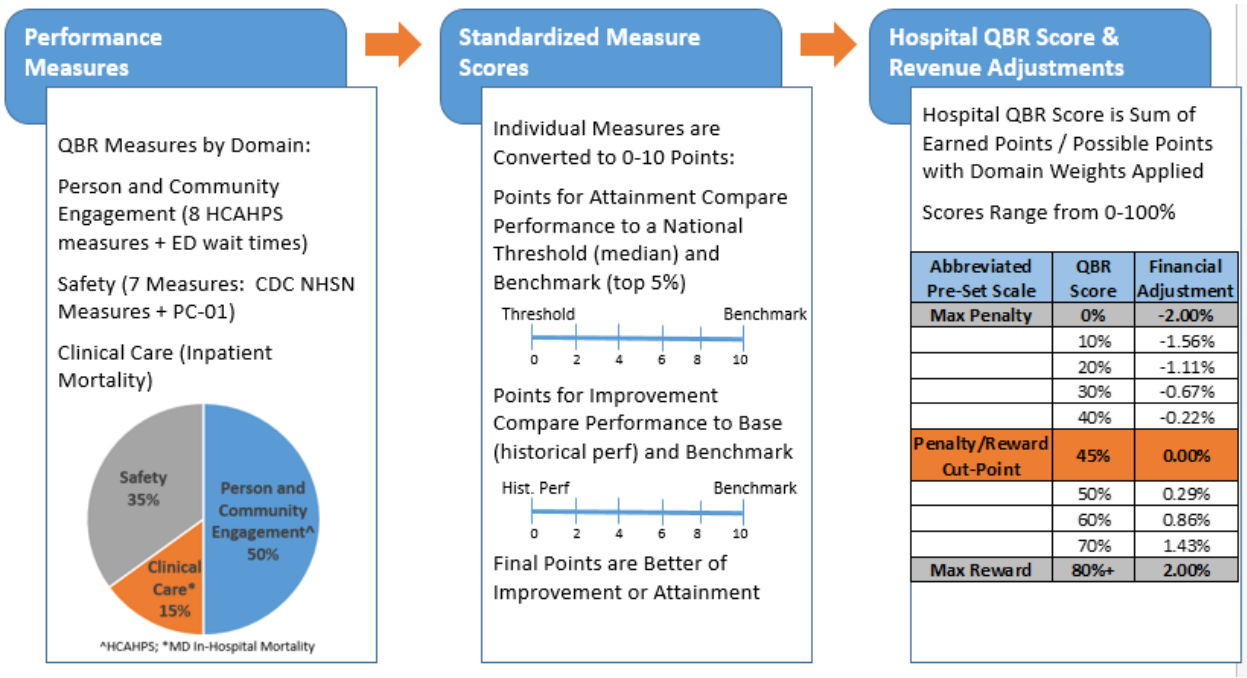
Figure 11. RY 2020 QBR Measures and Domain Weights Compared with CMS VBP Program[12]

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

The methodology for calculating hospital QBR scores and associated inpatient revenue adjustments has remained essentially unchanged since RY 2019, and involves: 1) assessing performance on each measure in the domain; 2) standardizing measure scores relative to performance standards; 3) calculating the total points a hospital earned divided by the total possible points for each domain; 4) finalizing the total hospital QBR score (0-100%) by weighting the domains based on the overall percentage or importance the Commission has placed on each domain; and 5) converting the total hospital QBR scores into revenue adjustments using the preset scale that ranges from 0 to 80%, as aforementioned. The methodology is illustrated in Figure 12 below.

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

Figure 12. Process for Calculating RY 2019 QBR Scores



Domain Weights and Revenue At Risk

As illustrated in the body of the report, for the RY 2021 QBR program, the HSCRC proposed to weight the clinical care domain at 15 % of the final score, the Safety domain at 35 %, and the Person and Community Engagement domain at 50 %. The measures by domain are listed with their data sources in the table below (Figure 18).

Figure 18. Proposed RY 2021 QBR Domains, Measures and Data Sources

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

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

rewards and penalties in a process that is referred to as scaling.[13] Rewards (referred to as positive scaled amounts) or penalties (referred to as negative scaled amounts) are then applied to each hospital's update factor for the rate year. The rewards or penalties are applied on a one-time basis and are not considered permanent revenue. The Commission previously approved scaling a maximum reward of 1% and a penalty of 2% of total approved base inpatient revenue across all hospitals for RY 2019.

HSCRC staff has worked with stakeholders over the last several years to align the QBR measures, thresholds, benchmark values, time lag periods, and amount of revenue at risk with those used by the CMS VBP program where feasible,[14] allowing the HSCRC to use data submitted directly to CMS.[15] As mentioned above, Maryland implemented an efficiency measure in relation to population based revenue budgets based on potentially avoidable utilization outside of the QBR program. The potentially avoidable utilization (PAU) savings adjustment to hospital rates is based on costs related to potentially avoidable admissions, as measured by the Agency for Healthcare Research and Quality Prevention Quality Indicators (PQIs) and avoidable readmissions. HSCRC staff will continue to work with key stakeholders to complete development of an efficiency measure that incorporates population-based cost outcomes.

QBR Proposed Measures Update: THA/TKA

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

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

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

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

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

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

QBR Score Calculation

QBR Scores are evaluated by comparing a hospital's performance rate to its base period rate, as well as the threshold (which is the median, or 50th percentile, of all hospitals' performance during the baseline period), and the benchmark, (which is the mean of the top decile, or approximately the 95th percentile, during the baseline period).[16]

Attainment Points: During the performance period, attainment points are awarded by comparing an individual hospital's rates with the threshold and the benchmark. With the exception of the MD Mortality measure applied to all payers, the benchmarks and thresholds are the same as those used by CMS for the VBP program measures.[17] For each measure, a hospital that has a rate at or above benchmark receives 10 attainment points. A hospital that has a rate below the attainment threshold receives 0 attainment points. A hospital that has a rate at or above the attainment threshold and below the benchmark receives 1-9 attainment points

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

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

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

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

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

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

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

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

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

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

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

APPENDIX II. RY 2019 PATIENT EXPERIENCE MEASURE RESULTS BY HOSPITAL

HCAHPS Measures		Care Transitions		Clean/Quiet		Understood Meds		Doctor Communication		Nurse Communication		Discharge Info		Overall Rating		Staff Responsiveness	
Hospital ID	Hospital Name	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base
210001	Meritus	46%	1%	63%	1%	59%	-1%	75%	-1%	77%	2%	88%	-1%	67%	3%	59%	0%
210002	UMMC	54%	-1%	55%	-4%	62%	-4%	79%	-1%	79%	1%	88%	1%	70%	1%	58%	-3%
210003	PG Hospital	39%	2%	53%	-2%	49%	0%	74%	1%	63%	1%	78%	0%	47%	3%	43%	2%
210004	Holy Cross	44%	-1%	65%	10%	55%	2%	74%	-1%	71%	-1%	80%	0%	64%	5%	55%	-1%
210005	Frederick	50%	-2%	70%	2%	62%	-2%	78%	-1%	80%	1%	89%	2%	70%	3%	59%	-2%
210006	UM-Harford	45%	-9%	57%	-3%	58%	-14%	75%	-6%	77%	-5%	81%	-3%	65%	0%	61%	3%
210008	Mercy	55%	-1%	71%	-1%	70%	5%	82%	-2%	81%	-1%	89%	0%	79%	1%	68%	6%
210009	Johns Hopkins	59%	0%	68%	1%	64%	0%	80%	0%	81%	0%	88%	-1%	81%	-1%	60%	-2%
210010	UM-Dorchester	48%	-2%	66%	4%	63%	2%	80%	-2%	81%	1%	86%	0%	66%	2%	68%	1%
210011	St. Agnes	48%	1%	60%	2%	61%	3%	78%	0%	75%	1%	86%	2%	66%	4%	59%	5%
210012	Sinai	48%	-2%	65%	-3%	63%	1%	78%	0%	79%	1%	88%	3%	69%	-1%	61%	1%
210013	Bon Secours	44%	11%	64%	3%	59%	-4%	80%	7%	73%	10%	87%	-1%	54%	4%	59%	15%
210015	MedStar Fr Square	46%	4%	56%	0%	61%	-3%	78%	0%	75%	-5%	87%	0%	68%	0%	56%	-3%
210016	Washington Adventist	43%	-2%	61%	-1%	58%	-1%	76%	-1%	73%	-1%	85%	-1%	67%	-1%	58%	1%
210017	Garrett	49%	-3%	64%	2%	67%	-1%	82%	-1%	79%	0%	91%	4%	69%	2%	69%	3%
210018	MedStar Montgomery	43%	2%	63%	4%	54%	-5%	75%	-3%	72%	1%	87%	-1%	62%	1%	54%	-3%
210019	Peninsula	50%	-2%	62%	-3%	62%	1%	76%	-4%	79%	1%	89%	2%	69%	1%	61%	-4%
210022	Suburban	51%	0%	67%	3%	58%	-3%	80%	-2%	77%	-3%	84%	0%	70%	-2%	64%	-3%
210023	Anne Arundel	54%	-1%	67%	5%	62%	1%	81%	2%	81%	4%	85%	-2%	78%	5%	70%	6%
210024	MedStar Union Mem	50%	-4%	69%	3%	63%	2%	83%	1%	79%	0%	88%	-2%	74%	-2%	63%	1%
210027	Western Maryland	52%	1%	67%	3%	68%	4%	79%	1%	80%	1%	92%	0%	70%	3%	63%	2%
210028	MedStar St. Mary's	51%	-3%	66%	-3%	59%	-8%	79%	-3%	79%	-4%	90%	-1%	67%	-5%	62%	-5%

HCAHPS Measures		Care Transitions		Clean/Quiet		Understood Meds		Doctor Communication		Nurse Communication		Discharge Info		Overall Rating		Staff Responsiveness	
Hospital ID	Hospital Name	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base	Perf	Change from base
210029	JH Bayview	54%	1%	59%	3%	62%	3%	78%	1%	76%	1%	87%	2%	68%	0%	62%	4%
210030	UM-Chestertown	47%	5%	61%	5%	57%	3%	80%	6%	79%	10%	86%	4%	62%	10%	69%	9%
210032	Union of Cecil	47%	-3%	62%	4%	62%	0%	75%	-1%	76%	-2%	86%	-4%	65%	-1%	60%	-1%
210033	Carroll	48%	-1%	66%	3%	60%	-3%	75%	-1%	79%	-1%	87%	1%	67%	-5%	65%	1%
210034	MedStar Harbor	46%	1%	65%	3%	62%	2%	80%	-1%	76%	-1%	85%	-2%	67%	1%	62%	1%
210035	UM-Charles Regional	50%	2%	61%	-5%	63%	2%	73%	-2%	78%	3%	86%	-2%	65%	3%	65%	9%
210037	UM-Easton	48%	-2%	66%	4%	63%	2%	80%	-2%	81%	1%	86%	0%	66%	2%	68%	1%
210038	UMMC Midtown	47%	6%	65%	1%	62%	7%	77%	1%	75%	6%	86%	9%	61%	4%	64%	12%
210039	Calvert	48%	-4%	65%	4%	62%	2%	75%	-3%	79%	2%	88%	1%	65%	0%	62%	1%
210040	Northwest	49%	1%	64%	-3%	61%	-2%	77%	1%	77%	0%	88%	4%	68%	0%	67%	1%
210043	UM-BWMC	47%	-1%	61%	0%	58%	-3%	76%	1%	75%	-2%	85%	1%	65%	-5%	56%	-4%
210044	GBMC	52%	-5%	58%	-5%	58%	-10%	81%	-5%	77%	-4%	90%	5%	72%	-6%	64%	-5%
210048	Howard County	50%	4%	64%	2%	58%	-3%	78%	0%	78%	1%	86%	1%	71%	3%	60%	-4%
210049	UM-Upper Chesapeake	51%	2%	64%	3%	64%	1%	78%	3%	79%	3%	86%	2%	70%	3%	64%	8%
210051	Doctors	44%	0%	60%	-3%	60%	8%	75%	0%	73%	1%	86%	0%	66%	3%	56%	7%
210055	Laurel Regional	39%	-1%	54%	-5%	50%	-1%	71%	-4%	62%	-6%	80%	1%	50%	-5%	53%	1%
210056	MedStar Good Sam	47%	-1%	62%	1%	64%	5%	75%	-7%	77%	-1%	90%	2%	67%	-1%	61%	6%
210057	Shady Grove	49%	3%	61%	4%	59%	6%	79%	0%	77%	3%	86%	-1%	70%	6%	59%	7%
210060	Ft. Washington	38%	-8%	59%	-4%	54%	-4%	77%	-2%	72%	-1%	86%	2%	60%	2%	63%	5%
210061	Atlantic General	53%	2%	59%	2%	65%	5%	79%	-2%	78%	-1%	90%	1%	67%	-3%	66%	0%
210062	MedStar Southern MD	42%	5%	57%	1%	57%	4%	75%	-2%	70%	0%	82%	0%	54%	4%	53%	0%
210063	UM-St. Joe	55%	0%	67%	1%	61%	-3%	82%	2%	82%	3%	88%	0%	78%	3%	68%	2%
210065	HC-Germantown	47%	2%	66%	2%	56%	6%	77%	4%	68%	-2%	82%	0%	68%	1%	50%	-2%

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

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

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

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

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

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

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

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

Staff has started developing new policy targets and to align measures for success under the TCOC Model. This will entail considering options for bundling outcomes across quality programs, evaluating opportunities for performance standards outside the hospital walls, ensuring that financial incentives under the population-based revenue system are compatible, and developing reporting measures that are more holistic and patient-centered. This longer-term work has begun with the convening a clinical subgroup to evaluate candidate measures of complications that Maryland should include in its pay for performance regimen. In addition, work has begun to evaluate external data sources to determine if the Commission can utilize them to incentivize improvement inside[18] and outside the hospital; revisit financial methodologies and cultivate new ones, such as Inter-Hospital Cost Comparison, to ensure resources are being disseminated in accordance with TCOC Model goals; and consider options for establishing an overarching service line approach to the hospital quality programs so as to break down silos and promulgate a more holistic and patient-centered environment. Staff acknowledges this will require a lot of work in concert with industry and a broad array of other stakeholders—consumers, payers, cross-continuum providers, quality measurement experts, and government agencies (local, state and federal)— as the success of the TCOC Model depends on reducing cost on a per capita basis without compromising quality of care.

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

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

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

		Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Difference
Hospital ID	**Hospital Name**	**HCAHPS Final Score**	**HCAHPS Final Score**	**Mortality Final Score**	**Mortality Final Score**	**Safety Final Score**	**Safety Final Score**	**Total Score**	**Total Score**	**Total Score**
210001	Meritus	17%	17%	10%	33%	18%	18%	16.30%	19.80%	3.50%
210002	UMMC	20%	20%	0%	33%	8%	8%	12.80%	17.80%	5.00%
210003	UM-PGHC	5%	5%	10%	10%	14%	14%	9.13%	9.13%	0.00%
210004	Holy Cross	12%	12%	60%	40%	26%	26%	24.10%	21.10%	-3.00%
210005	Frederick	24%	24%	100%	70%	6%	6%	29.10%	24.60%	-4.50%
210006	UM-Harford	27%	27%	20%	47%	40%	40%	30.64%	34.64%	4.00%
210008	Mercy	55%	55%	50%	67%	28%	28%	44.57%	47.07%	2.50%
210009	Johns Hopkins	38%	38%	20%	20%	24%	24%	30.40%	30.40%	0.00%
210010	UM-Dorchester	33%	33%	60%	63%	28%	28%	35.30%	35.80%	0.50%
210011	St. Agnes	17%	17%	20%	40%	0%	0%	11.50%	14.50%	3.00%
210012	Sinai	22%	22%	40%	60%	28%	28%	26.80%	29.80%	3.00%
210013	Bon Secours	35%	35%	60%	60%	40%	40%	40.50%	40.50%	0.00%
210015	MedStar Fr Square	23%	23%	80%	87%	32%	32%	34.56%	35.56%	1.00%
210016	Washington Adventist	15%	15%	50%	60%	28%	28%	24.80%	26.30%	1.50%
210017	Garrett	37%	37%	10%	27%			30.79%	34.79%	4.00%
210018	MedStar Montgomery	12%	12%	10%	33%	14%	14%	12.40%	15.90%	3.50%
210019	Peninsula	23%	23%	100%	100%	36%	36%	39.10%	39.10%	0.00%
210022	Suburban	17%	17%	30%	53%	18%	18%	19.30%	22.80%	3.50%
210023	Anne Arundel	34%	34%	40%	60%	10%	10%	26.32%	29.32%	3.00%
210024	MedStar Union Mem	28%	28%	0%	33%	28%	28%	23.80%	28.80%	5.00%
210027	Western Maryland	42%	42%	20%	47%	36%	36%	36.51%	40.51%	4.00%

		Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Model 1	Model 2	Difference
Hospital ID	**Hospital Name**	**HCAHPS Final Score**	**HCAHPS Final Score**	**Mortality Final Score**	**Mortality Final Score**	**Safety Final Score**	**Safety Final Score**	**Total Score**	**Total Score**	**Total Score**
210028	MedStar St. Mary's	25%	25%	80%	87%	32%	32%	35.93%	36.93%	1.00%
210029	JH Bayview	17%	17%	40%	60%	30%	30%	25.00%	28.00%	3.00%
210030	UM-Chestertown	30%	30%	100%	100%			46.10%	46.10%	0.00%
210032	Union of Cecil	17%	17%	10%	33%	50%	50%	27.50%	31.00%	3.50%
210033	Carroll	22%	22%	90%	93%	32%	32%	35.70%	36.20%	0.50%
210034	MedStar Harbor	20%	20%	90%	70%	30%	30%	34.00%	31.00%	-3.00%
210035	UM-Charles Regional	35%	35%	70%	77%	25%	25%	36.98%	37.98%	1.00%
210037	UM-Easton	33%	33%	50%	57%	28%	28%	33.80%	34.80%	1.00%
210038	UMMC Midtown	24%	24%	100%	90%	10%	10%	30.50%	29.00%	-1.50%
210039	Calvert	26%	26%	100%	93%	67%	67%	51.52%	50.52%	-1.00%
210040	Northwest	28%	28%	100%	93%	48%	48%	45.89%	44.89%	-1.00%
210043	UM-BWMC	13%	13%	90%	77%	24%	24%	28.40%	26.40%	-2.00%
210044	GBMC	24%	24%	90%	77%	58%	58%	45.80%	43.80%	-2.00%
210048	Howard County	17%	17%	40%	30%	36%	36%	27.24%	25.74%	-1.50%
210049	UM-Upper Chesapeake	35%	35%	60%	73%	28%	28%	36.53%	38.53%	2.00%
210051	Doctors	17%	17%	30%	47%	80%	80%	41.00%	43.50%	2.50%
210055	UM-Laurel	10%	10%	20%	47%	13%	13%	12.67%	16.67%	4.00%
210056	MedStar Good Sam	34%	34%	60%	60%	16%	16%	31.60%	31.60%	0.00%
210057	Shady Grove	31%	31%	0%	0%	34%	34%	27.35%	27.35%	0.00%
210060	Ft. Washington	24%	24%	0%	27%			18.20%	24.60%	6.40%
210061	Atlantic General	34%	34%	100%	83%	0%	0%	31.82%	29.32%	-2.50%
210062	MedStar Southern MD	13%	13%	0%	10%	34%	34%	18.40%	19.90%	1.50%
210063	UM-St. Joe	44%	44%	70%	80%	28%	28%	42.12%	43.62%	1.50%
210065	HC-Germantown	15%	15%	80%	80%	50%	50%	36.77%	36.77%	0.00%

APPENDIX VI. MODELING OF QBR PROGRAM REVENUE ADJUSTMENTS

			Model 1: Removed PC-01 and ED-1b			Model 2: Model 1 + THA/TKA Measure		
HOSPID	HOSPITAL NAME	RY18 Permanent Inpatient Revenue	RY 2021 Prelim QBR Points	% Revenue Impact	$ Revenue Impact	RY 2021 Prelim QBR Points	% Revenue Impact	$ Revenue Impact
210001	MERITUS	$190,799,459	16.30%	-1.28%	-$2,442,233	19.80%	-1.12%	-$2,136,954
210002	UNIVERSITY OF MARYLAND	$919,253,797	12.80%	-1.43%	-$13,145,329	17.80%	-1.21%	-$11,122,971
210003	PRINCE GEORGE	$215,464,625	9.13%	-1.59%	-$3,425,888	9.13%	-1.59%	-$3,425,888
210004	HOLY CROSS	$340,412,069	24.10%	-0.93%	-$3,165,832	21.10%	-1.06%	-$3,608,368
210005	FREDERICK MEMORIAL	$220,972,343	29.10%	-0.71%	-$1,568,904	24.60%	-0.91%	-$2,010,848
210006	HARFORD	$48,557,781	30.64%	-0.64%	-$310,770	34.64%	-0.46%	-$223,366
210008	MERCY	$223,932,822	44.57%	-0.02%	-$44,787	47.07%	0.12%	$268,719
210009	JOHNS HOPKINS	$1,378,259,901	30.40%	-0.65%	-$8,958,689	30.40%	-0.65%	-$8,958,689
210010	DORCHESTER	$26,021,222	35.30%	-0.43%	-$111,891	35.80%	-0.41%	-$106,687
210011	ST. AGNES	$237,889,236	11.50%	-1.49%	-$3,544,550	14.50%	-1.36%	-$3,235,294
210012	SINAI	$398,036,508	26.80%	-0.81%	-$3,224,096	29.80%	-0.68%	-$2,706,648
210013	BON SECOURS	$65,798,042	40.50%	-0.20%	-$131,596	40.50%	-0.20%	-$131,596
210015	FRANKLIN SQUARE	$300,623,972	34.56%	-0.46%	-$1,382,870	35.56%	-0.42%	-$1,262,621
210016	WASHINGTON ADVENTIST	$158,337,604	24.80%	-0.90%	-$1,425,038	26.30%	-0.83%	-$1,314,202
210017	GARRETT COUNTY	$21,075,334	30.79%	-0.63%	-$132,775	34.79%	-0.45%	-$94,839
210018	MONTGOMERY GENERAL	$77,808,657	12.40%	-1.45%	-$1,128,226	15.90%	-1.29%	-$1,003,732
210019	PENINSULA REGIONAL	$241,466,813	39.10%	-0.26%	-$627,814	39.10%	-0.26%	-$627,814
210022	SUBURBAN	$197,431,392	19.30%	-1.14%	-$2,250,718	22.80%	-0.99%	-$1,954,571
210023	ANNE ARUNDEL	$299,264,995	26.32%	-0.83%	-$2,483,899	29.32%	-0.70%	-$2,094,855
210024	UNION MEMORIAL	$235,346,415	23.80%	-0.94%	-$2,212,256	28.80%	-0.72%	-$1,694,494
210027	WESTERN MARYLAND	$171,000,183	36.51%	-0.38%	-$649,801	40.51%	-0.20%	-$342,000
210028	ST. MARY	$76,303,058	35.93%	-0.40%	-$305,212	36.93%	-0.36%	-$274,691
210029	HOPKINS BAYVIEW MED CTR	$357,620,585	25.00%	-0.89%	-$3,182,823	28.00%	-0.76%	-$2,717,916
210030	CHESTERTOWN	$21,139,936	46.10%	0.06%	$12,684	46.10%	0.06%	$12,684

			Model 1: Removed PC-01 and ED-1b			Model 2: Model 1 + THA/TKA Measure		
HOSPID	**HOSPITAL NAME**	**RY18 Permanent Inpatient Revenue**	**RY 2021 Prelim QBR Points**	**% Revenue Impact**	**$ Revenue Impact**	**RY 2021 Prelim QBR Points**	**% Revenue Impact**	**$ Revenue Impact**
210032	UNION HOSPITAL OF CECIL	$66,514,320	27.50%	-0.78%	-$518,812	31.00%	-0.62%	-$412,389
210033	CARROLL COUNTY	$132,801,017	35.70%	-0.41%	-$544,484	36.20%	-0.39%	-$517,924
210034	HARBOR	$112,526,840	34.00%	-0.49%	-$551,382	31.00%	-0.62%	-$697,666
210035	CHARLES REGIONAL	$75,199,112	36.98%	-0.36%	-$270,717	37.98%	-0.31%	-$233,117
210037	EASTON	$105,222,295	33.80%	-0.50%	-$526,111	34.80%	-0.45%	-$473,500
210038	UMMC MIDTOWN	$117,217,727	30.50%	-0.64%	-$750,193	29.00%	-0.71%	-$832,246
210039	CALVERT	$63,677,722	51.52%	0.37%	$235,608	50.52%	0.32%	$203,769
210040	NORTHWEST	$133,828,758	45.89%	0.05%	$66,914	44.89%	0.00%	$0
210043	BALTIMORE WASHINGTON	$229,151,792	28.40%	-0.74%	-$1,695,723	26.40%	-0.83%	-$1,901,960
210044	G.B.M.C.	$225,145,722	45.80%	0.05%	$112,573	43.80%	-0.05%	-$112,573
210048	HOWARD COUNTY	$183,348,539	27.24%	-0.79%	-$1,448,453	25.74%	-0.86%	-$1,576,797
210049	UPPER CHESAPEAKE HEALTH	$130,150,364	36.53%	-0.38%	-$494,571	38.53%	-0.29%	-$377,436
210051	DOCTORS COMMUNITY	$144,686,192	41.00%	-0.18%	-$260,435	43.50%	-0.07%	-$101,280
210055	LAUREL REGIONAL	$58,931,276	12.67%	-1.44%	-$848,610	16.67%	-1.26%	-$742,534
210056	GOOD SAMARITAN	$140,674,848	31.60%	-0.60%	-$844,049	31.60%	-0.60%	-$844,049
210057	SHADY GROVE	$231,939,525	27.35%	-0.78%	-$1,809,128	27.35%	-0.78%	-$1,809,128
210060	FT. WASHINGTON	$19,548,527	18.20%	-1.19%	-$232,627	24.60%	-0.91%	-$177,892
210061	ATLANTIC GENERAL	$37,316,219	31.82%	-0.59%	-$220,166	29.32%	-0.70%	-$261,214
210062	SOUTHERN MARYLAND	$163,844,003	18.40%	-1.18%	-$1,933,359	19.90%	-1.12%	-$1,835,053
210063	UM ST. JOSEPH	$237,924,618	42.12%	-0.13%	-$309,302	43.62%	-0.06%	-$142,755
210065	HC-GERMANTOWN	$60,632,167	36.77%	-0.37%	-$224,339	36.77%	-0.37%	-$224,339
	Statewide Total	**$9,093,098,329**			**-$68,910,681**			**-$63,837,724**

Shifting of Hospital Services from Regulated to Unregulated Setting

Health Service Cost Review Commission

November 2018

HSCRC
Health Services Cost Review Commission

Revenue Reductions are Needed When Services Shift to Unregulated Settings

- If services are shifted to deregulated settings, global budgets generally must be reduced to prevent excess billings
- Section IV.B.3a. Of the Global Budget Agreement states the following:
  - *"The HSCRC and the Hospital recognize that some services may be offered more effectively in an unregulated setting. When services covered by the GBR model are moved to an unregulated setting, the HSCRC staff will calculate and apply a reduction to the Hospital's Approved Regulated Revenue. At a minimum, this reduction will ensure that the shift provides a savings to the public and Medicare after taking into consideration the payment amounts likely to be made for the same services in an unregulated setting."*
- Staff is formalizing and strengthening the review process to make more timely reductions
- Staff will be working with the volume and contract subgroups of the Payment Models Workgroup to further refine recommendations

Hospital are Required to Disclose Shifts to Unregulated Settings

- Global Budget Agreement requires each hospital to:
  - Disclose establishment of unregulated services
  - Submit an Appendix F & G annually, within 30 days after the end of the rate year, to disclose which services, if any, were shifted to the unregulated setting or regulated setting of another hospital

Process for Identifying Shifts to Unregulated Settings

- Staff takes the following steps to identify service shifts to unregulated settings:
  - Review deregulation disclosures made by hospitals, including Appendix F & G
  - Review monthly utilization statistics and rate order compliance
    - Large declines in utilization, particularly in the outpatient setting
  - Review unrecognized market shift
    - Declines in cases that are not adjusted for via market shift, particularly outpatient reductions and cases that may be shifted to nursing home settings
    - New focus on shifts of IP joint replacement cases to unregulated outpatient settings
  - Review outpatient case-mix data for declines in volumes year-over-year, trended from 2013
    - Data is organized using 3Ms Enhanced Ambulatory Patient Grouping System
  - Review shifts to out of state and unregulated settings using Medicare claims data, Truven DC Hospital Association IP case mix data
  - Future—use All Payer Claims Data Base (including Medicaid data) to identify and adjust for shifts

Outpatient Oncology and Infusion Shifts

- Once per year, staff audits the supplemental outpatient drug volume submission for high cost oncology and infusion drugs (CDS-A) submitted by hospitals. This audit is used to aid in the determination of any oncology center deregulation, in addition to determining funding adjustments for increases/decreases in high-cost outpatient drug use.
  - Medicare claims data is used to evaluate physician billing in deregulated settings
  - Medicare is the payer for approximately 50% of these drugs, so it's a good source to assess deregulation

Revenue Adjustments Made for RY18 and RY19 to date

- Identified Revenue Adjustments from hospital's global budgets to deregulation*:
  - RY18 & RY19
    - Permanent adjustments: $56,000,000
    - One-time adjustments: $16,000,000 (still reviewing)
    - **Identified Revenue Adjustments in RY18 & RY19** : $72,000,000
  - RY20
    - **Identified Revenue Adjustments in RY20**: $11,400,000
- These figures exclude drug utilization reductions made through the annual drug volume review for high cost oncology and infusion drugs
- Additional adjustments are being reviewed and staff expects to made additional adjustments in January

*These figures are preliminary. Some adjustments are still in discussion and have not been finalized.

Revenue Adjustments Made Prior to Rate Year 2018

- Prior to 2018, there were adjustments for oncology deregulations and shifts of hospitals on global budgets under the Total Patient Revenue system (2011-2014)
  - Carroll Hospital Center, Western Maryland Health System, and UM-Shore Regional Health (3 hospitals) had revenue reductions for shifts to unregulated settings for the period of time they were under a global budget from 2011 through 2014.
  - Frederick Memorial Hospital and Atlantic General Hospital deregulated oncology services in prior periods and their revenues were reduced accordingly.

Revenue Adjustment Levels

- Generally fifty percent of affected revenue
  - May be higher if reduction shifts costs onto Medicare
- Drug deregulation considers the cost of drugs, since markup over cost varies and is tiered

Future Policy and Contract Considerations

- Incremental reductions or fines for hospitals failing to report deregulations
- More specific disclosure requirements regarding estimates of revenue shifts to unregulated settings
- Additional consideration of what constitutes a shift
  - E.g. not presently adjusting for shifts to primary care settings and urgent care
  - Some circumstances may warrant adjustment, but generally supportive of primary care growth outside of hospitals settings
- Improved use of the All Payer Claims Database for this effort
- Improved staff documentation of execution of reviews
- HSCRC staff will be working with the volume and contract subgroups of the Payment Models Workgroup to further refine recommendations

Midtown Rate Structure Recommendation

November 14, 2018

Context

- HSCRC Commissioners, as part of its strategic sessions, directed staff to review high cost and low cost outlier hospitals
- Factors considered for high cost hospitals
  - Interhospital Cost Comparison (ICC) result
  - Total Cost of Care (TCOC) per capita growth rate
  - Potentially Avoidable Utilization (PAU) growth rate and PAU attainment
  - Quality Program Performance - MHAC, RRIP, and QBR performance
- University of Maryland Medical Center Midtown Campus
  - Highest rate of cost per case compared to other Maryland hospitals (32.65% inefficient compared to the peer group average)
  - Top quintile for TCOC growth rate per capita
  - Favorable PAU growth rate, but significantly high PAU attainment
  - Mixed quality outcomes

HSCRC ICC Analysis

Rate Efficiency Model	Cost Efficiency	% Net Change	$ Impact	$ Net Impact
ICC Result (base $237M Permanent Revenue)	-32.65%		-$77,653,780	
REM Result (no profits)	-26.12%	6.53%	-$62,116,569	$15,537,211
Additional Modifications	**Cost Efficiency**	**% Net Change**	**$ Impact**	**$ Net Impact**
100% Pass Through on Unevaluated Revenue ($53.4M)	-20.25%	5.87%	-$48,162,727	$13,953,842
Reduction in RY 2018 Revenue	-19.03%	1.22%	-$45,258,409	$2,904,318
7.0% Allowed Inefficiency	-12.03%	7.00%	-$28,539,176	$16,719,233

HSCRC Next Steps

- HSCRC Recommendation for Spend-down
  - Revenue calculation includes both included and excluded revenue in current ICC methodology
  - Considerations were made for profits, revenue not included in ICC, acknowledgement of RY 18 actual revenue reductions, and allowance for inefficiency due to treating patient population in West Baltimore
    - Given unfavorable TCOC performance, favorable PAU performance (albeit from a high base), no further modification was made to ICC result
  - Spend-down over 5 year period of time
  - Allowance to re-evaluate at the end of year 2 and year 4 once ICC methodology is finalized and hospital has had time to improve cost per efficiency and TCOC performance.

HSRC Recommendation to Reduce Total Revenue

- RY 19: 3% reduction (Guaranteed Reduction)
- RY 20: 3% reduction (Guaranteed Reduction)
- RY 21: 2% reduction (Potential adjustment in RY 21)
- RY 22: 2% reduction
- RY 23: 2% reduction (Potential adjustment in RY 23)

- Spend-down of total revenue is 12% reduction over 5 years.
- Review and reassess at the end of RY 20 and RY 22 to determine if adjustments should be made to reduce total spend-down in subsequent years.

Dollar Impact of Recommendation

Rate Year	Proposed Revenue Reduction (based on 2018 GBR)	$ Impact (2018 denominator locked)	$ Cumulative Impact
2019	3%	-$7,134,794	-$7,134,794
2020	3%	-$7,134,794	-$14,269,588
2021	2%	-$4,756,529	-$19,026,117
2022	2%	-$4,756,529	-$23,782,647
2023	2%	-$4,756,529	-$28,539,176

Performance Evaluation for adjustments in RY 21 and RY 23

- In order to receive credit for ICC efficiency improvement, TCOC performance will also be considered
  - If TCOC growth is higher than statewide growth on 2018 base, there would be no credit for ICC efficiency
  - If TCOC growth is below statewide growth on 2018 base, full ICC efficiency credit
  - If TCOC growth ranking improves relative to 2018 base, but TCOC growth still remains above the statewide growth, Midtown may be eligible for partial ICC efficiency credit
- If ICC efficiency remains the same or deteriorates, no credit unless TCOC growth is below statewide growth on 2018 base
- Additional considerations for credit in RY 21 and 23
  - Quality Metric – If current definition of PAU is reduced more than the peer group average, additional credit could be considered in an amount equal to PAU difference
  - Population Health Metric - Improvement in population health metric related to diabetes prevalence could also be considered

RATE AGREEMENT BETWEEN
THE HEALTH SERVICES COST REVIEW COMMISSION
AND UNIVERSITY OF MARYLAND MEDICAL CENTER'S MIDTOWN HOSPITAL CAMPUS
NOVEMBER 14, 2018

I. OVERVIEW

After four years of the global revenue agreements that were implemented for hospitals under the All-Payer Model and with the suspension of the Reasonableness of Charges evaluation since 2011, the Health Services Cost Review Commission (HSCRC or Commission) requested that staff evaluate high cost outlier hospitals that have retained an excessive amount of revenue causing high charges for patients and payers. The University of Maryland Medical Center's Midtown Hospital Campus ("UMMC-Midtown" or "the Hospital") is one such hospital that was identified as an outlier. This proposed agreement outlines the steps that will be taken to bring the Hospital's approved revenue to reasonable levels.

II. BACKGROUND

Prior to 2011, the HSCRC used an adjusted charge per case comparison, referred to as the Reasonableness of Charges ("ROC") to identify hospitals with high charges per case and to scale annual updates based on performance. In 2011, this tool was suspended for rural hospitals that adopted global budgets under the Total Patient Revenue (TPR) system, recognizing that reductions of avoidable utilization could work against those hospitals in comparing charges per case. Other hospitals went under an episode payment arrangement in 2011 and 2012, which bundled readmissions into an episode payment. Since the ROC could penalize hospitals with readmission declines, the ROC was suspended for the remaining hospitals.

In 2014, all hospitals were moved under global revenue arrangements with the advent of the All-Payer Model Agreement with the Centers for Medicare & Medicaid Services (CMS). Within the construct of these agreements, referred to as global budget revenue (GBR), hospitals are allowed to charge up to a fixed annual revenue amount that is set at the beginning of the year, even as volumes may decline. This structure offers incentives for hospitals to engage in population-based health management and to reduce unnecessary hospital utilization. Annual revenue is determined from an historical base period that is adjusted to account for inflation updates, market shifts, demographic changes, infrastructure requirements, performance in quality-based or efficiency-based programs, changes in payer mix, and changes in levels of UCC. Annual revenue may also be modified for changes in services levels, shifts of services to unregulated settings, or other approved modifications to global revenues.

After suspension of the ROC for more than six years, the Commission prioritized the development of an updated Inter-hospital Cost Comparison (ICC) tool and requested that staff

evaluate high cost outlier hospitals that have retained an excessive amount of revenue causing high charges for patients and payers. The Total Cost of Care Model Agreement with CMS, signed in July 2018 and scheduled to begin on January 1, 2019, will require the State to contain the growth of costs for both hospital and non-hospital services on a per capita basis. With these considerations, staff used a combination of factors to identify high cost outlier hospitals taking into account cost per case efficiency under the ICC, performance on Medicare total cost of care (TCOC) per capita growth, potentially avoidable use (PAU) levels and reductions achieved, and quality indicators such as the Maryland Hospital Acquired Conditions (MHAC), Readmission Reduction Incentive Program (RRIP), and Quality Based Reimbursement (QBR) performance.

During this evaluation, the UMMC-Midtown Hospital was identified by staff as an outlier hospital. Using the ICC for RY 2018 revenue, staff determined that the Hospital has the most unfavorable adjusted cost per case compared to other Maryland hospitals, with an inefficiency of -32.65% compared to the peer group standard. The Hospital is also in the least favorable quintile of hospitals for Medicare TCOC growth rate per capita, with a growth rate of 8.02% from 2013 to 2017, compared to the State average TCOC growth rate of 3.9%. The Hospital has been able to reduce the growth of PAU admissions more rapidly than the State, but still has high levels of PAU (30.8% of eligible revenue as compared to the statewide average of 18.3%), partially as a result of the health disparities of the population it serves. Finally, the Hospital has had mixed quality outcomes. While it ranked in the most favorable quintile for reductions in potentially preventable complications, as measured through the Maryland Hospital Acquired Conditions program, it was in the second least favorable quintile for patient satisfaction surveys, as measured through HCAHPS surveys in the Quality Based Reimbursement program, and the least favorable quintile for casemix adjusted readmissions rates, as measured through the Readmissions Reductions Incentive program.

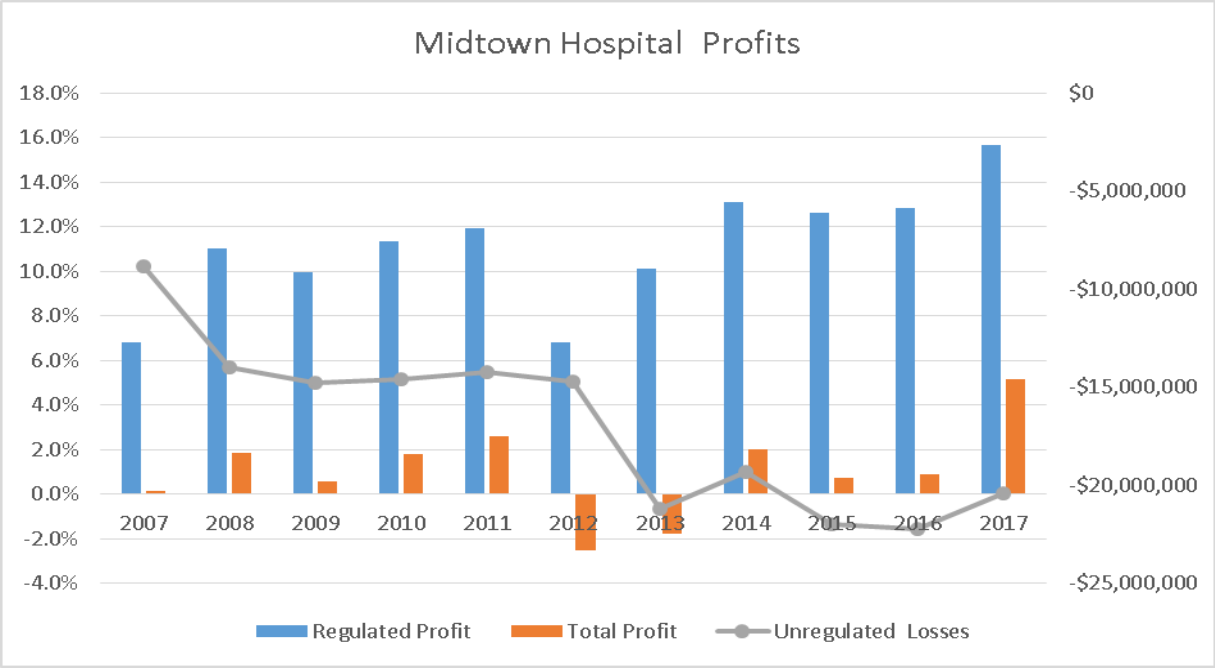
In the fall of 2017, the HSCRC staff notified UMMC-Midtown regarding its outlier status under the ICC. Staff began evaluations regarding the cause of the outlier status and reduced the Hospital's revenues by $6.5 million in the rate year ended June 30, 2018 for shifts of chronic patients to unregulated settings. Since April 2018, the HSCRC staff and representatives of the Hospital have met to discuss the reasons that the Hospital's adjusted charge per case is relatively high and what considerations should be made when determining an appropriate rate structure. Finally, staff and the Hospital had a series of meetings to determine the acceptable terms of a negotiated revenue reduction over time, referred to herein as a "spenddown" agreement.

The staff's proposal for the negotiated spenddown includes considerations made for profits, discounting revenue not included in the ICC calculation, acknowledgement of RY18 revenue reductions already in place, growth and current levels of PAU relative to the State and peers, Medicare TCOC growth per capita compared to the State and peers, and an allowance for health disparities in the patient population that is treated at the Hospital. Additional detail on the considerations are included below:

- In the past, when the Commission initiated spenddowns, it did not remove profits from the revenue target levels. The ICC removes peer group profits to get to a cost level comparison. The staff restored profits to adjust the ICC calculation, which reduced the excess charge per case from 32.65% to 26.12%.
- Certain revenues were excluded from the ICC and these were likewise excluded from spenddown consideration, i.e., these revenues received no spenddown adjustment. This reduced the excess charge per case from 26.12% to 20.25%.
- If a hospital's cost per case was high as a result of higher reductions in avoidable utilization, the HSCRC should avoid revenue reductions that would undermine the incentives of the global revenue system. If charge per case increased but cost per capita remained the same or decreased after accounting for inflation, revenue reductions should be mitigated for achieving the desired improvement. HSCRC staff reviewed the Medicare total cost of care growth for UMMC-Midtown from 2013 to 2017 and found that the Hospital was in the least favorable quintile of state performance, with growth in excess of two times the statewide average. PAU reductions were greater than the state and peer group averages. After reviewing these results, the staff determined that the Hospital was not due relief for its performance in PAU reductions or total cost of care, as the favorable PAU reductions were offset by the unfavorable Medicare total cost of care growth.
- UMMC-Midtown is in the top decile of the State in terms of various measures of poverty such as Medicaid percentages, income per capita, Area Deprivation Index, among others. The staff has incorporated a reduction allowance in the required spenddown to allow the Hospital to continue to invest in interventions that will improve population health and reduce health disparities. This will take time.

Finally, when considering the appropriate time period for a spenddown, the Hospital's regulated profits were considered.

Figure 1. Midtown Profit Analysis



The Hospital's regulated profits and losses for the years ended June 30, 2016 and 2017 were $23.9M and $31.6 – total profit was $1.7M and $11.1M, respectively. The Hospital has also incorporated faculty physicians into the operations of the Hospital, providing hospitalist services and also providing needed clinical expertise for the severe chronic conditions that are prevalent in West Baltimore. This has increased the operating cost structure of the Hospital. In order to meet the challenge of a significant rate revenue reduction plan, a five year time period was agreed to as appropriate.

The Hospital believes that part of its unfavorable charge per case performance has resulted from the reduction of inpatient services at the Hospital, some of which relates to patients being treated in other hospitals or in deregulated settings. The Hospital has introduced important new outpatient services that are focused on the reduction of health disparities, including diabetes clinics, infectious disease clinics, cardiology and pulmonary clinics, and behavioral health clinics, among others. The expanded clinic operations are part of a concerted effort to deal with the many chronic health conditions that challenge the residents of West Baltimore. In addition to the investments to expand clinical capacity and expertise, the population health strategy also includes aspects such as transportation, transitional care, patient education and social support. Significant investments are required to care for the social determinants of health in West Baltimore. The Hospital has demonstrated a commitment to improving the health status of the West Baltimore population as illustrated in the FY 2017 Community Benefits Report. After accounting for funds provided in rates for direct medical education, nurse support, and charity care, UMMC-Midtown compares favorably

to the state average in Community Benefit support and falls within the top decile for Community Benefit contribution.

These new services are important enhancements to the community that aim to address chronic conditions, improve the health of the population, and reduce health disparities in West Baltimore. The staff has proposed spenddown targets that recognize the importance of this effort and the need to continue these investments. The Hospital also expects to work with the University of Maryland Medical Center to relocate additional low intensity services to the UMMC-Midtown campus. This is expected to free up revenue capacity at UMMC for more intense cases as well as to lower the charge-per-case at UMMC-Midtown. The interim review process outlined below will allow for an assessment of the Hospital's progress in execution of its plans.

II. AGREEMENT

After discussions about the reasonable level of efficiency improvement that should be expected, the Hospital and HSCRC staff have agreed to a 12% reduction to the Hospital's RY 2018 GBR, with an opportunity to assess the Hospital's efficiency level at two points during the five-year period as follows:

- RY 19: 3% reduction (Guaranteed Reduction)
- RY 20: 3% reduction (Guaranteed Reduction)
- RY 21: 2% reduction (Performance evaluation)
- RY 22: 2% reduction
- RY 23: 2% reduction (Performance evaluation)

Figure 2. Spenddown Recommendation for Midtown

Rate Year	Proposed Revenue Reduction (based on 2018 GBR)	$ Impact (2018 denominator locked)	$ Cumulative Impact
2019	3%	-$7,134,794	-$7,134,794
2020	3%	-$7,134,794	-$14,269,588
2021	2%	-$4,756,529	-$19,026,117
2022	2%	-$4,756,529	-$23,782,647
2023	2%	-$4,756,529	-$28,539,176

Figure 2 shows the value of the reduction to be included in rates that the spenddown agreement specifies over the 5 year period. The impact of the rate reduction can be mitigated in RYs 21 through 23, if the Hospital demonstrates improved cost efficiency while also constraining the

Medicare Total Cost of Care per capita growth, as detailed in Section 3 of this document. The staff will also consider the annual adjustments made to account for inflation updates, infrastructure requirements, population driven volume increases/decreases or successor policies, market shift, performance in quality-based or efficiency-based programs, changes in payer mix, changes in levels of UCC, and any settlements beyond FY 2017 applicable to all hospitals for charge variation, deregulation, or quality adjustments when determining the Hospital's annual allowed global revenues.

III. PERFORMANCE EVALUATION

The Hospital has the opportunity to mitigate the impact of the revenue reduction before RYs 21 and 23, based on the performance evaluation described in this section. While performance will be evaluated at only two points during the five-year period, any credit for improvement can be applied to RYs 21, 22, or 23, to the extent that the credit exceeds the spenddown total for that year. The agreement allows the Hospital to earn credit for improved cost efficiency as measured by the ICC, as long as the Hospital's Medicare TCOC per capita growth has not deteriorated. Staff can modify the revenue reduction for improved ICC efficiency. It is important to measure the per capita changes in cost to ensure that the Hospital does not improve on the ICC by increasing avoidable utilization or simply growing volumes, as this would undermine the Total Cost of Care Model. Therefore, in reviewing performance, the HSCRC staff proposes to consider the following during its review of performance.

- Full ICC improvement credit if TCOC growth is below statewide growth on 2018 base.
- Partial ICC improvement credit if TCOC growth ranking improves relative to 2018 base, but TCOC growth still remains above the statewide growth.
- No credit for ICC improvement if TCOC growth is higher than statewide growth on 2018 base and the Hospital's ranking on TCOC growth among hospitals also deteriorates.

Also, it is important to retain the incentives for hospitals to reduce avoidable utilization and improve Total Cost of Care performance. Therefore, the staff also proposes to consider better TCOC performance in its evaluation.

- Partial credit if the Hospital's TCOC growth rate is lower than the statewide TCOC growth on 2018 base, even if ICC efficiency remains the same or deteriorates.

Additional considerations will also be made at the HSCRC's discretion for improvement on PAU indicators and population health metrics as follows:

- If current definition of PAU is reduced more than the peer group average, additional credit could be considered in an amount equal to PAU difference.

- Improvement in population health metric related to diabetes prevalence.

IV. OTHER TERMS

The terms of this spenddown agreement will be incorporated in the Hospital's RY 2019 rate order. If the Hospital does not agree to the RY 2019 rate order, it has the right to file a full rate application, in accordance with State law and regulation.

1. By entering into this agreement, the Hospital does not waive any rights with respect to the filing of a rate application under the Commission's statutory law and regulations.

2. By entering into this agreement, it is understood that during the term of this agreement the Hospital will receive industry-wide rate adjustments applicable to hospitals.

3. In the event of merger, consolidation, or transfer of ownership, this agreement is assignable subject to mutual written agreement of the Commission and the surviving parties.

4. If the Hospital defaults on the financial covenant(s) of its bond indebtedness, and the default is not cured within the terms of the bond documents, then the Hospital and the Commission shall meet to discuss options including a potential renegotiation of this agreement.

5. In consideration of the effective date of this agreement, the Commission agrees to waive any and all corridor penalties applicable on July 1, 2019 related to the Hospital's compliance with this agreement so long as the Hospital displays a good faith effort to comply with the provisions of this agreement.

V. TERMINATION PROVISIONS

This agreement will terminate on June 30, 2023 or at any time prior to June 30, 2023 if the Hospital reaches the Target. Also, this agreement may be terminated prior to June 2023 under the following conditions:

1. If the Hospital declares bankruptcy at any time during the term of this agreement.

2. If the State of Maryland dissolves the HSCRC's rate regulatory authority.

3. If the Total Cost of Care Model granted to Maryland is terminated.

4. If the Hospital files a full rate application, this agreement will terminate on the effective date of the new final rate order issued by the Commission.

5. Under such extraordinary circumstances where the Commission believes that termination of this agreement is in the best interests of the public.

HSCRC Capital Funding Policies

November 14, 2018

HSCRC
Health Services Cost Review Commission

Maryland's Current Capital Costs – FY17

- Statewide Capital Costs represented 8.5 percent of total hospital costs.
  - This is including Depreciation and Amortization of $866 million; and,
  - $280 million in Interest.
- Hospitals also reported lease and rental payments of an additional $122 million, 0.9 percent of total hospital cost.

Historical Capital Funding Policy

- Initial rate methodology for Capital Facilities Allowance:
  - Debt service including principal and interest payments on fixed costs;
  - Price-leveled depreciation for purchased and leased major moveable equipment;
  - General equipment replacement allowance for all other equipment; and,
  - Funding of a 20 percent down payment on future replacement of building and fixed equipment.
- During the CON process hospitals had the option of either:
  - Pledge not to request an HSCRC approved rate increase for new capital costs; or,
  - Reserve the right to request an HSCRC approved rate increase in the future to fund the increased capital costs.
- In order to address hospitals' requests for capital cost increases associated with large construction projects without submitting a full rate review, HSCRC staff developed a partial rate application process for capital costs.

Partial Rate Applications for Capital Funding

- The partial rate application process for additional capital funding applied a modified Inter-hospital Cost Comparison (ICC) review.
- If the applicant hospital's combined average inpatient charges per case and outpatient charges per unit of service was less than the peer group average, then the applicant hospital was eligible for a rate increase for capital cost increases.
- The ICC review for capital projects differed from the normal ICC Full Rate Review process and did not include a negative productivity adjustment of two percent.

Example Partial Rate Application for Capital Costs

- Hospital A is 3% under its ICC peer group average for non-capital expenses:
  - ICC Peer Group Percent of Total Costs Devoted to Capital: 7.7%
  - Hospital A's Percent of Total Costs Devoted to Capital (allowed in rates): 7.1%
  - Hospital A's Requested new Capital Costs: 5.5% → 12.6% when combined with current
- Allowed Capital Costs: 10.2%
  - 50% of Hospital A's new Capital Costs (12.6%)
  - 50% of ICC Peer Group's Percent of Total Costs Devoted to Capital (7.7%)
- Approved Rate Increase for Hospital A's Requested New Capital: 3.1%
  - Difference between Hospital A's of Total Costs Devoted to Capital (7.1%) and Allowed Capital Costs (10.2%)
- **Actual Rate Increase for Hospital A's Requested New Capital: 3.0%**
  - Below approved rate increase because Hospital A was only 3% more efficient than its ICC peer group average

Further Development of Capital Funding

- Under the GBR methodology, hospitals have requested rate updates for unusual capital cost increases for new projects.
- Staff are developing an updated ICC methodology that incorporates a new adjustment for excess hospital capacity by region.
- Staff will also incorporate hospital performance reviews as part of the revised partial rate application review for allowing a rate increase in capital costs:
  - TCOC improvements measured on a per capita basis;
  - TCOC attainment measured using primary service area;
  - TCOC per capita versus either statewide or regional TCOC per capita; and
  - Quality of care measured on an improvement basis and attainment basis.

Considerations for Future Capital Funding Policy

- Determine what beds are necessary with MHCC and the appropriate financing mechanism.
- Suggested principles include:
  - The HSCRC should not fund replacement capital beyond needed capacity. Current or projected excess capacity should be removed from any funding provided.
    - Variances in inpatient discharge use rates among hospital primary service areas will be a key statistic in developing future bed needs.
  - The HSCRC should not fund capital costs or provide comfort orders for services that can be provided in lower costs alternative settings.
  - Hospitals should be expected to fund at least a portion of new capital costs with operational efficiencies, fundraising, and retained savings.
  - Should HSCRC fund depreciation and interest **or** principal and interest?
  - Consider cost performance, compared to peers and statewide averages, when assessing capital funding requests.
  - What is the threshold that would allow a hospital to file a partial rate review for additional capital funding?
  - Should social determinants funding be considered/required?

Title 10 MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Applications and Approval Procedures

Authority: Health-General Article, §§ 19-214.1 and 19-214.3, Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulation .26 under COMAR 10.37.10 Rate Applications and Approval Procedures. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on November 14, 2018, notice of which was given pursuant to General Provisions Article, § 3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about March 5, 2019.

Statement of Purpose

The purpose of this action is to require hospitals to better inform patients of facility fees and their right to request and receive a written estimate of the total charges for the non-emergency hospital services, procedures, and supplies that reasonably are expected to be incurred and billed to the patient by the hospital.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has an economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or (410) 764-2576, or fax to (410) 358-6217, or email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed amendments until January 7, 2019. A hearing may be held at the discretion of the Commission.

A. Hospital Information Sheet.

(1) Each hospital shall develop an information sheet that:

(a)- (c) *text unchanged*

(d) Provides contact information for the Maryland Medical Assistance Program; **[**and**]**

(e) Includes a statement that physician charges, to both hospital inpatients and outpatients, are generally not included in the hospital bill and are billed separately*;***[.]**

(f) Informs patients that the hospital is permitted to bill outpatients a fee, commonly referred to as a "facility fee," for their use of hospital facilities, clinics, supplies and equipment, non-physician services, including but not limited to the services of non-physician clinicians, in addition to physician fees billed for professional services provided in the hospital;

(g) Informs patients of their right to request and receive a written estimate of the total charges for the hospital non-emergency services, procedures, and supplies that reasonably are expected to be provided and billed for by the hospital.

(2) The information sheet shall be provided to the patient, the patient's family, or the patient's authorized representative:

(a) Before the patient receives scheduled medical services;

(b) Before discharge;

[(b)**]** *(c)* With the hospital bill; and

[(c)**]** *(d)* On request.

(3)-*(4) text unchanged*

NELSON SABATINI
Chairman
Health Services Cost Review Commission

State of Maryland
Department of Health

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Chairman

Joseph Antos, PhD
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Methodologies

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Clinical & Financial
Information

Gerard J. Schmith, Director
Revenue & Regulation
Compliance

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **November 14, 2018**

RE: **Hearing and Meeting Schedule**

December 12, 2018	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
January 9, 2019	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room

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

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

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