Health Services Cost Review Commission
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544th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
October 11, 2017

EXECUTIVE SESSION
9:30 a.m.
(The Commission will begin in public session at 9:30 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 Contract and Modeling of the All-payer Model vis-a-vis the All-Payer Model Contract – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-103 and §3-104**

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

PUBLIC SESSION
1:00 p.m.

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

2. **Executive Director's Report**

3. **New Model Monitoring**

4. **Docket Status – Cases Closed**
   2395A – Johns Hopkins Health System
   2396A – Johns Hopkins Health System
   2397A – Johns Hopkins Health System

5. **Docket Status – Cases Open**
   2398N – University of Maryland Midtown Campus
   2399A – Priority Partners
   2400A – University of Maryland Medical Center
   2401A – MedStar Health
   2402A – MedStar Medicare Choice
   2403A – MedStar Family Choice
   2404A – Johns Hopkins Health System

6. **Presentation by Johns Hopkins Hospital**

7. **Draft Recommendation on Updates to the Inter-hospital Cost Comparison Methodology**

8. **Draft Recommendation on the Medicare Performance Adjustment**

9. **Update on Future Direction for RY 2020 and Enhanced Model Quality Programs**

10. Hearing and Meeting Schedule

Closed Session Minutes
Of the
Health Services Cost Review Commission

September 13, 2017

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

1. Discussion on Planning and Administering the Enhanced All-Payer Model – Authority General Provisions Article, §3-103 and §3-104

2. Update on Contract and Modeling of the All-Payer Model vis-a-vis the All-Payer Model Contract – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-103 and §3-104

3. Update on the progress of the Enhanced All-Payer Model Progression term sheet - Authority General Provisions Article, §3-103 and §3-104

The Closed Session was called to order at 9:40 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, Bone, Colmers, Kane and Keane.

In attendance representing Staff were Donna Kinzer, Katie Wunderlich, Chris Peterson, Allan Pack, Jerry Schmith, Alyson Schuster, Claudine Williams, Amanda Vaughn, Madeline Jackson, Erin Schurmann, and Dennis Phelps.

Also attending were Stu Gutterman, Deborah Gracey, and Eric Lindeman, Commission Consultant, and Stan Lustman and Adam Malizio Commission Counsel.

Item One

Ms. Kinzer and the Commission discussed the planning and administering of the Enhanced All-Payer Model.

Item Two

Ms. Kinzer updated the Commission on Medicare data and analysis vis-a-vis the All-Payer Model Agreement.

Item Three

Ms. Kinzer updated the Commission on the revisions to the Enhanced All-Payer Model term sheet.

The Closed Session was adjourned at 1:15 p.m.

MINUTES OF THE
543rd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
September 13, 2017

Chairman Nelson Sabatini called the public meeting to order at 9:40 a.m. Commissioners Joseph Antos Ph.D., Victoria Bayless, George H. Bone, M.D., John Colmers, Adam Kane, and Jack C. 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 1:21 p.m.

REPORT OF THE SEPTEMBER 13, 2017 EXECUTIVE SESSION

Mr. Dennis Phelps, Associate Director, Audit & Compliance, summarized the minutes of the September 12, 2017 Executive Session.

REVIEW OF THE MINUTES FROM THE JULY 12, 2017 EXECUTIVE SESSION AND PUBLIC MEETING

The Commissioners voted unanimously to approve the minutes of the July 12, 2017 Public Meeting as well as the minutes of the July 12, 2017 Executive Session.

ITEM II
PRESENTATION BY KAISER PERMANENTE

Dr. Bernadette Loftus, Associate Executive Director, Kaiser Permanente Mid-Atlantic States (KPMAS), provided an overview of KPMAS operations with a focus on their population health initiatives.

Dr. Loftus noted that since 2008 KPMAS has grown membership in Maryland by 39%. Dr. Loftus noted that KPMAS operates in all lines of business, Commercial, Commercial Exchange, Medicare, Medicaid, and a small Charitable Care program.

Dr. Loftus also noted that KPMAS has managed to lower total cost of care spending per member. This has been made possible through the KPMAS Hub Model of Care and Pillars of the Care Redesign Program, this program includes:

- Adequate primary care physician coverage connected with 24/7 multispecialty backup support
- Extensive urgent care offerings connected to Mid-Atlantic Permanente Medical Group primary and specialty care, fully engaged in KPMAS population health initiatives
- Focus on population health in every other specialty, as well, with extremely high levels of achievement
- Tight coordination between inpatient and outpatient services; less than 30% of admissions are from the Emergency Room, majority are direct admit after ambulatory evaluation

- Extensive data collection and analytics accompanied by data transparency to individual physician level.

KPMAS Hub Model of Care, which is a primary care medical home model, has attributed achieved success in managing care for beneficiaries. KPMAS currently operates five hubs, which offer primary care, radiology, lab, diagnostics, pharmacy as well as Ambulatory Surgery and Urgent Care/Clinical Decision Units.

Dr. Loftus noted that since implementing the model, KPMAS has observed that there has been:

- 20% reduction in hospital days
- 12% reduction in admits per 1,000 members
- 13% reduction in ED Visits per 1,000 members.

Commissioner Bayless inquired about KPMAS' projections for membership growth.

Dr. Loftus indicated that the 2018 membership forecast is expected to increase in the Washington DC and Baltimore areas, and decrease in Virginia. KPMAS is expecting a larger commercial growth in Maryland next year, as CareFirst has left the exchange business with a total increase of about 50,000.

Commissioner Keane asked if having full range of imaging services readily available in the Hub model has increased imaging utilization as it is more readily available. Dr. Loftus indicated that she thought the imaging use rate was lower than average.

Donna Kinzer, Executive Director, asked when in this eight year journey did KPMAS started to see a reduction in utilization.

Dr. Loftus stated results were noticed within a year of implementing the model. Their results were driven by increasing the number of primary care physicians and surrounding them with sufficient specialty panels.

ITEM III
EXECUTIVE DIRECTOR'S REPORT

Ms. Kinzer noted that Staff will be proposing at today's meeting the promulgation of regulations aimed at updating the rate review process to reflect the changes brought about by the All-Payer Model. The regulations establish the framework for hospital submission requirements for full rate applications. The new All- Payer Model focuses on total cost of care, whereas the prior rate setting system focused on cost/charge per case. The new Model is dependent on reductions in unnecessary and avoidable utilization and quality improvements. Staff will continue to use the Inter-hospital Cost Comparison (ICC) tool as part of the review process for hospitals filing a full rate application. At the October Commission meeting, Staff will present the draft revised ICC methodology including changes brought about by the New All-Payer Model. Ms. Kinzer noted that the ICC methodology is not intended to replace the ROC. It is a tool to be used to evaluate efficiency in full rate reviews. Staff recognizes that this is just the beginning of the development

of efficiency policies.

Ms. Kinzer stated that, as it did prior to the initiation of the original All-Payer Model, the Commission will focus on implementation planning for the next phase of the Model. When the preliminary implementation planning is completed, it will be brought to the public meeting for stakeholder input and comment.

Ms. Kinzer observed that today staff will be seeking input from the Commissioner on policy development for the next phase of the Model. In addition, staff invites comments and input from the stakeholders on the Commissioners' comments and suggestions, as well as policy priorities.

Ms. Kinzer introduced two new members to the HSCRC staff. Mr. Adam Malizio has joined the legal team supporting the HSCRC. Mr. Malizio most recently served as an Assistant Attorney General with the Health Occupations Prosecution and Litigation Division. In addition, Ms Prudence Akindo has joined Staff's Population Based Methodologies unit as a Health Policy Analyst. Ms. Akindo has recently served as an Administrative Resident with the Dimension Health Care System.

ITEM IV
NEW MODEL MONITORING

Ms. Amanda Vaughan, Associate Director, Financial Data Administration, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of July 31, 2017 focuses on the fiscal year (July 1, 2017 through July 31, 2017) as well as calendar year results.

Ms. Vaughan reported that for the seven months of the calendar year ended July 31, 2017, All-Payer total gross revenue increased by 5.37% over the same period in CY 2016. All-Payer total gross revenue for Maryland residents increased by 5.33%. All-Payer gross revenue for non-Maryland residents increased by 5.87%.

Ms. Vaughan reported that for the seven months of the calendar year ended July31, 2017, Medicare Fee-For-Service gross revenue increased by 4.66% over the same period in CY 2016. Medicare Fee-For-Service gross revenue for Maryland residents increased by 4.31%. Maryland Fee-For-Service gross revenue for non-residents increased by 8.77%.

Ms. Vaughan reported on hospital revenue per capita growth for the seven months of the calendar year ended July 31, 2017 over the same period in CY 2016:

- All Payer in State capita was 5.01%.
- Medicare Fee for Service in State was 3.40%.

Ms. Andrea Zumbrum, Chief, Quality Analysis and Reporting, presented a report on the current trends in hospital readmissions (through June 2017).

Readmissions

- The All-Payer risk adjusted readmission rate was 11.50% for June 2017 YTD. This is a decrease of 12.94% from the June 2013 risk adjusted readmission rate.
- The Medicare Fee for Service risk adjusted readmission rate was 12.00% for April 2017 YTD. This is a decrease of 14.75% from the June 2013 YTD risk adjusted readmission rate.
- Based on the New Model, hospitals must reduce Maryland's readmission rate to or below the national Medicare readmission rate by 2018. The Readmission Reduction incentive program has set goals for hospitals to reduce their adjusted readmission rate by 14.5% during CY 2017 compared to CY 2016. Currently, 19 out of 46 hospitals have reduced their risk adjusted readmission rate by more than 14.5%. An additional 5 hospitals are on track for achieving the attainment goal.

Ms. Laura Mandel, HSCRC Analyst, presented the current trends for potentially avoidable utilization.

Potential Avoidable Utilization – Readmissions and Prevention Quality Indicators (PQIs) revenue as a percentage of hospital revenue:

- All-Payer readmission revenue declined from 7.5% in CY 2013 to 6.8% in CY 2016 as a percentage of all-payer hospital revenue. This is a decrease of 8.3%.
- All- Payer readmission revenue June 2017 YTD has declined by 1.7% over the all-payer readmission revenue for the same period in 2016.
- All-Payer PQI revenue has been constant over the period from CY 2013 to CY 2016 between 4.2% and 4.4% of all-payer hospital revenue.
- Medicare Fee for Service readmission revenue has declined from 10.8% in CY 2013 to 9.9% in CY 2016 as a percentage of Medicare Fee for Service revenue. This is a decrease of 10.7%.
- Medicare Fee for Service readmission revenue June 2017 YTD has declined by 3.5% over the Medicare Fee for Service revenue for the same period in 2016.
- Medicare Fee for Service PQI revenue has been constant over the period from CY 2013 to CY 2016, between 6.6% and 7.0% of Medicare Fee for Service hospital revenue.

ITEM V
DOCKET STATUS- CLOSED CASES

2390R- McCready Health
2393A- Johns Hopkins Health Care
2394A- Johns Hopkins Health Care

ITEM VI
DOCKET STATUS- OPEN CASES

2395A- Johns Hopkins Health System

On July 12, 2017, 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 solid organ and bone marrow transplant services with Blue Cross Blue Shield Blue Distinction Centers for Transplants. The Hospitals request that the Commission approve the arrangement for one year effective September 1, 2017.

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for one year beginning September 1, 2017, and that this approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve Staff's recommendation. Commissioner Colmers recused himself from the discussion and vote.

2396A- Johns Hopkins Health System

On July 27, 2017, 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 joint replacement and cardiovascular services with Health Design Plus Inc. for clients other than those of Pacific Business Group on Health clients. The Hospitals request that the Commission approve the arrangement for one year effective September 1, 2017.

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for joint replacement and cardiovascular services for one year beginning September 1, 2017, and that this approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve Staff's recommendation. Commissioner Colmers recused himself from the discussion and vote.

2397A- Johns Hopkins Health System

On July 27, 2017, 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 joint replacement and cardiovascular services with Health Design Plus, Inc. for Pacific Business Group on Health clients The Hospitals request that the Commission approve the arrangement for one year effective September 1, 2017.

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for joint replacement and cardiovascular services for one year beginning September 1, 2017, and that this approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve Staff's recommendation. Commissioner Colmers recused himself from the discussion and vote.

ITEM VII
CONFIDENTIAL DATA REQUEST

Ms. Claudine Williams, Associate Director of Policy Analysis, presented the Staff's final recommendation for the University of Maryland Baltimore School of Medicine (UMB) confidential patient data request (see Final Staff Recommendation on the University of Maryland, Baltimore School of Medicine Request to Access HSCRC Confidential Patient Level Data" on the HSCRC website).

The University of Maryland, Baltimore (UMB) School of Medicine is requesting use of a limited confidential dataset for ongoing research related to the prehospital triage of pediatric patients and their subsequent admissions to the hospital or transfer to tertiary care centers.

The primary purpose of this research is to understand the burden of secondary transport for Maryland children. Findings from this research will be used to pilot test pediatric decision tree to optimize correct triage for primary transport to a center that can provide children definitive care. The limited dataset will include confidential variables such as dates of service and age. Investigators received approval from UMB Institutional Review Board on January 26, 2017. These data will not be used to identify individual hospitals or patients. The data will be retained by UMB until January 31, 2020; at that time, the files will be destroyed and a Certification of Destruction will be submitted to the HSCRC.

Staff's final recommendation is as follows:

- HSCRC staff recommends that the request for the limited inpatient and outpatient confidential data files for Fiscal Year 2012 through Fiscal Year 2015 be approved.

- This access will be limited to identifiable data for subjects enrolled in the research study.

The Commission voted unanimously to approve Staff's recommendation.

ITEM VIII
PLANNING FOR TOTAL COST OF CARE ALL-PAYER MODEL PROGRESSION

Mr. Allan Pack, Director, Population Based Methodologies, presented the staff recommendation concerning the planning for total cost of care for the All-Payer Model Progression (see Measuring Hospital Quality to Achieve Better Value in Maryland" on the HSCRC website).

During the July 2017 Commission meeting, Chairman Sabatini suggested that Commissioners should be more involved and proactive in policy development. As a result, Staff prepared background information on upcoming key policy considerations for maintenance of the current system, and for the next phase of the All-Payer model. The intent is to provide Commissioner guidance prior to commencing workgroups for development of policies to be effective in FY

2020 and beyond.

Quality Based Reimbursement (QBR) Policy Considerations

Mr. Pack presented data and trends on Maryland Emergency Department (ED) performance including measures ED-2: Admit Decision until Admission and OP-18b: Arrival to Discharge for Discharged Patients. In both of these measures, Maryland hospitals are being outperformed by the nation. Mr. Pack stated that CMS has pointed out this relatively poor ED performance to the Commission in the past. Mr. Pack also presented recent Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) scores, which also remain below national averages despite the emphasis placed on these measures in recent years by the Commission. Accordingly, Staff proposed the following questions for Commissioner consideration:

- Should ED wait time(s) measures be included in the QBR program in RY2020?
- Should there be additional incentives for HCAHPS improvement?

Commissioner Antos asked if ED wait time measures would fall into the quality or patient satisfaction domains within the QBR program. Mr. Pack responded that there is a correlation between increased ED wait times and mortality, and there are patient satisfaction implications as well, so it could be considered either.

Commissioner Bone asked if ED diversion increases the cost of care. Commissioner Bone also asked if there was a method for identifying or stratifying patient mix where patients use the ED as their source of primary care.

Ms. Kinzer stated that these issues will require a great deal of Staff time to gather this information, and there are other more pressing issues to tackle such as the next phase of the All Payer Model and the full rate application process.

Chairman Sabatini agreed with Commissioner Bone that the Commission needs more information about the individuals that are using the hospital ED as their primary care. Mr. Sabatini indicated he would like to know if Maryland has a similar patient mix as the nation. He also stated he was not convinced that poor ED performance is solely the result of hospital operations, but rather a lack of access to behavioral health and substance abuse services in Maryland.

Commissioner Colmers noted that this is a complex issue and acknowledged that it would take substantial time for the Staff to incorporate ED measures into the QBR program. Mr. Colmers suggested that perhaps the Staff time would be better devoted to focusing on the full rate application process. Commissioner Antos agreed with Commissioner Colmers.

Commissioner Bayless noted that this is clearly a quality and patient satisfaction issue in the State of Maryland. She also indicated she doesn't believe that Maryland is far behind the nation in terms of behavioral health access; however, this is an issue that should be addressed.

Commissioner Keane agreed that the ED measures should be incorporated into the QBR program

given Maryland hospitals' poor performance. Commissioner Keane stated that this has been an issue for a long time that the Commission has monitored, but for which at has taken no action.

Readmission Policy Considerations:

Mr. Pack presented recent readmission results, which indicate that Maryland has met its goal of achieving the national average Medicare admission rate; however, Staff has several readmission policy considerations for Commissioner Input:

- Whether to use a forecasting model that is more aggressive than the national average. Potential changes in the model include different peer groups, national quartile or benchmarks.
- Whether to expand the readmission window to 90 days including observation and ED visits, and whether to include readmissions to and from freestanding psychiatric facilities.
- Whether additional risk adjustments including socio-demographic adjustment should be added.

Commissioner Keane noted that he sees the value in a socio-economic risk adjustment -- that it would be more difficult to manage a patient with low socio-economic status. He also indicated he opposed the dual scale that measures attainment and improvement.

Staff indicated they were not in favor of risk adjusting and setting different readmission targets for different populations, because it would create a low standard of expectation for disparate patient populations.

Commissioner Colmers questioned expanding the readmission to 90 days from 30 days, because it will conflict with the Medicare Performance Adjustment (MPA). Mr. Colmers recommended keeping the readmission definition at 30 days.

Maryland Hospital Acquired Condition (MHAC) Policy Considerations:

Mr. Pack presented several topics for consideration.

- Keep MHAC program, but narrow down the use of PPCs to only those valued as important by Staff and industry.
- Remove MHAC (complications) program all together
- Revise MHAC Program to use Patient Safety Indicators (PSI) measures (more than just those in composite) in lieu of PPCs.

Commissioner Kane asked if the industry was currently tracking CMS defined HACs.

Staff indicated hospitals are currently required to track HACs for the Medicare star rating program, and that the industry wants to focus their attention on one set of complications.

Chairman Sabatini questioned what the impact on overall quality would be if we moved from the MHAC to the HAC program or discontinued the program all together.

Staff stated that complications have decreased dramatically since the MHAC program's inception, and complications may begin to increase again if the MHAC program is discontinued.

Commissioner Keane stated he didn't believe the decrease in complications was an actual decrease, but just a matter of coding.

Service Line Approach:

Mr. Pack noted that the bundling outcomes by service line (e.g., surgical, Medical, OB) is an alternative approach that is more provider and patient-centric.

Benefits of Service Line Approach

- Better measures performance among hospitals that provide similar services;
- Can set benchmarks by service line, which addresses the issue of small hospitals driving Benchmarks;
- Focuses on differences that are of interest to patients;
- May provide more action data for hospital quality improvements;
- Could be applied to the claims based measures from MHAC, RRIP, and QBR programs, and some service lines specific to non-claims based measures.

Medicare Performance Adjustment (MPA) Policy Considerations

Mr. Chris Peterson, Director of Clinical and Financial Information, presented an overview and various topics for consideration by the Commission related to the MPA program including:

- Appropriate capture of hospital spending and total spending across the State
- Consistency with All Payer Model goals and conceptually sensible for hospitals
- Measure stability over time
- Sharing of service areas and/or beneficiaries amongst hospitals
- How should the MPA interact with existing revenue at-risk for quality
- How should the MPA reflect statewide Medicare TCOC performance

Commissioner Keane questioned the efficiency of the attribution methodology and its 87% beneficiary retention rate year over year. He indicated that he expected that there would be less churn (i.e. turnover) year over year. Mr. Keane expressed concern that high beneficiary churn will make it difficult to set total spending targets and hold hospitals accountable. He also stated that he is not convinced that the MPA is technically feasible.

Ms. Kinzer stated that the Commission is currently using a prospective beneficiary attribution methodology, similar to the Next Generation Accountable Care Organization model. This allows hospitals to know who they are responsible for prior to the measurement period. She also noted that the MPA is an important tool for accelerating alignment with physicians, as it will allow them to qualify as Advanced Alternative Payment qualifying physicians under MACRA.

ITEM IX
LEGAL REPORT
REGULATIONS

Regulations

Proposed and Emergency

Rate Application and Approved Procedures 10.37.10.03

The purposes of this action are to: set forth the process for filing a full rate application with the Commission; identify the methodologies to be used in approving permanent rates; describe the annual update factor vis-à-vis the All-Payer Model Agreement, including corrective action if necessary to maintain compliance with the All-Payer Model Agreement; and provide options to hospitals for Commission review of a full rate application.

The Commissioner voted unanimously to forward the proposed revised regulations to the AELR Committee for review and publication in the Maryland Register both as proposed and as emergency.

ITEM X
PRESENTATION ON THE MHCC RURAL WORKGROUP

Mr. Ben Steffen, Executive Director, Maryland Health Care Commission (MHCC) provided an overview of the MHCC Rural Health Workgroup and its activities (See Rural Health Workgroup and Study" on the HSCRC website).

Mr. Steffen noted that the workgroup consists of members of the Maryland General Assembly, the Secretary of the Maryland Department of Health, Chief Financial Officers of rural hospitals.

Mr. Steffen stated that the purpose of the workgroup was to:

- Examine special challenges for delivering health care in the five county Mid-Eastern Shore
- Review policy options developed under the study
- Make recommendations to the General Assembly on approaches for effectively meeting health care needs.

Mr. Steffen noted the following draft recommendations from the workgroup:

- The Rural Community Health Complexes

    a) Create a center for health care delivery in a rural community;
    b) Better integration/coordination of existing services (clinical, governmental and social);

c) Decrease transportation barriers
d) Create a community of wellness
e) Respond to the public's desire to access care close to home.
f) Engage communities in governance.

- Types of Rural Community Health Complexes

    a) Essential Care- Full or part time primary care site;
    b) Advanced primary care- Federally Qualified Health Centers (FQHC), or primary care practice sites;
    c) Advanced Ambulatory Care/ with or without a free standing medical facility
    d) Special Rural Community Hospital.

- Patient Centered Support Care and Technology Hub enables

    a) Coordination between providers;
    b) Assistance in getting needed social, governmental, and behavioral health services;
    c) Education and counseling to help manage chronic conditions.

- Special Rural Hospital Designation/Rural Hospital Program

    a) Create a program under HSCRC's broad authority to facilitate rural hospitals in meeting the goals of the new model contract and enhancing population health;
    b) Hospitals must specify concrete goals and plans for implementation;
    c) Hospitals would describe how it would work with other health care providers and facilities to serve the population in the hospital's service area;
    d) Hospital must meet certain criteria to qualify;
    e) Program would last a specific time and would be renewable through agreement of HSCRC and the hospital.

- Rural Healthcare Workforce:

    a) Establish a Rural Health Scholarship Program;
    b) Create incentive programs for students and residents to practice in rural communities;
    c) Streamline and expand the Maryland Loan Assistance Repayment Program;
    d) Realign Prioritization of the J-1 visa program;
    e) Develop and fund additional nurse practitioner and physician assistant programs in rural colleges and universities;
    f) Enhance behavioral health and substance abuse services.

ITEM XI
REPORT ON HOSPITAL COSTS ASSOCIATED WITH PHYSICIANS

Mr. Dennis Phelps provided an overview on hospital costs associated with physicians (see ”Physician Costs Incurred by Hospitals FY 2016” on the HSCRC website).

Mr. Phelps noted that physician losses continue to be a major issue confronting the hospital industry. In FY2016, the total costs incurred by hospitals for physicians providing services other than Part B professional services were $340M. The total net costs associated with physician Part B services in FY2016 were $535M. This includes net losses associated with hospital based physician services, and net losses associated with non-hospital based physician services. Staff will continue to gather data on costs associated with Part B professional services.

ITEM XII
HEARING AND MEETING SCHEDULE

October 11, 2017	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
November 13, 2017	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 5:45 p.m.

Executive Director's Report

October 11, 2017

Full Rate Applications – Process and Methodology

The regulations proposed last month regarding full rate reviews, including the associated filing requirements, are proceeding through the promulgation process. The Commission received comment letters from the Maryland Hospital Association, Johns Hopkins Medicine, and CareFirst. MHA's major concern was that the hospital comparison methodology was not yet in place. MHA stressed the need for open communication and fair consideration of feedback from the hospitals. Johns Hopkins contended that the proposed changes were too vague, excessively burdensome, and without a clear methodology. CareFirst noted its support for the regulations as proposed. After considering the comments received, staff believes the Commission should stay the course on the promulgation process at this time. An additional comment period will be afforded stakeholders and the public before proposed regulations are permanently adopted.

In addition, the hospital comparison methodology is in the process of final development. A first draft of that methodology will be presented by staff today. Also, staff will be convening a Technical Advisory Group in order to help assure the technical validity of the methodology including its various associated calculations.

MHCC Wear the Cost Initiative

On October 19, 2017, Maryland Health Care Commission will begin its "Wear the Cost" initiative to increase transparency and public engagement on health care costs and quality

We all know the cost of health care is too high. While there isn't a silver bullet to lowering costs, well-considered efforts on many fronts can make a difference. One of those fronts is transparency, or making information on the cost and quality of health care more open and accessible to consumers. This concept is at the center of a new initiative known as "Wear the Cost."

The Maryland Health Care Commission will hold a press conference on October 19, 2017, at MHCC offices at 11:00 am as they explain how a new website and public awareness campaign will make the cost of care at hospitals across the state available to consumers.

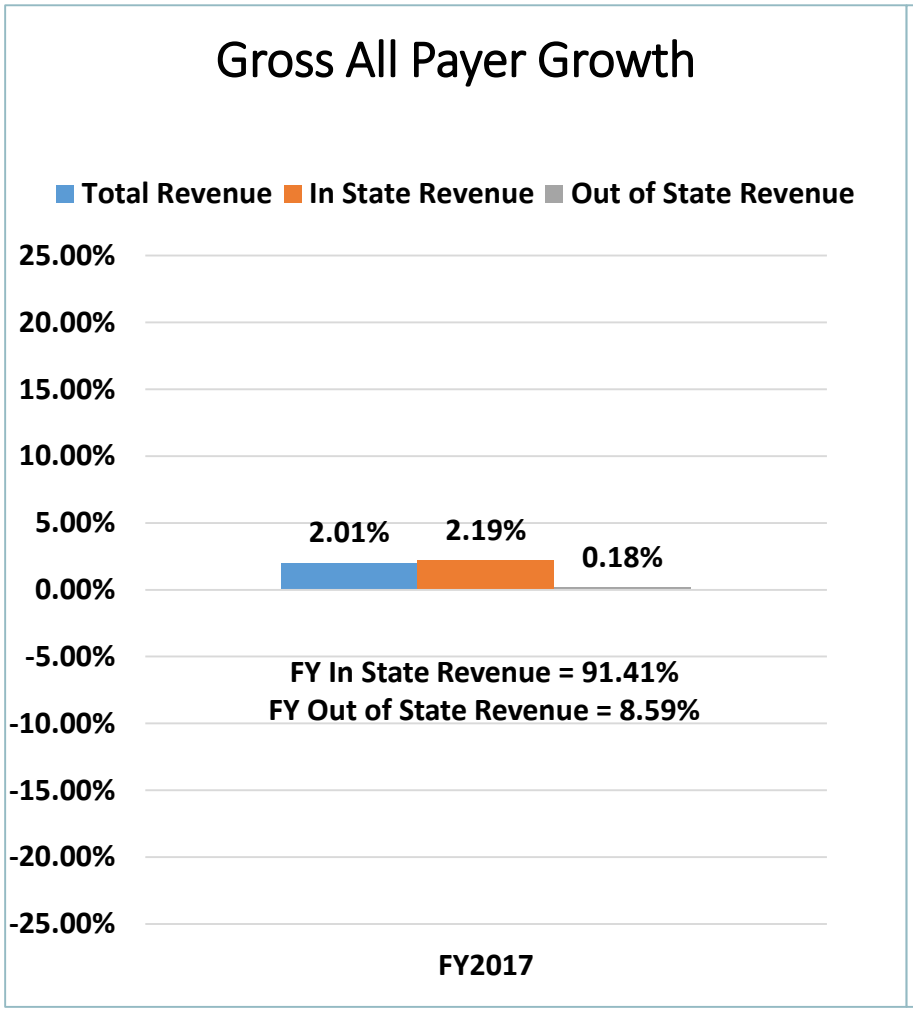
Speakers include MHCC Chairman Robert Emmet Moffit, former Chairman Marilyn Moon, and Executive Director Ben Steffen.

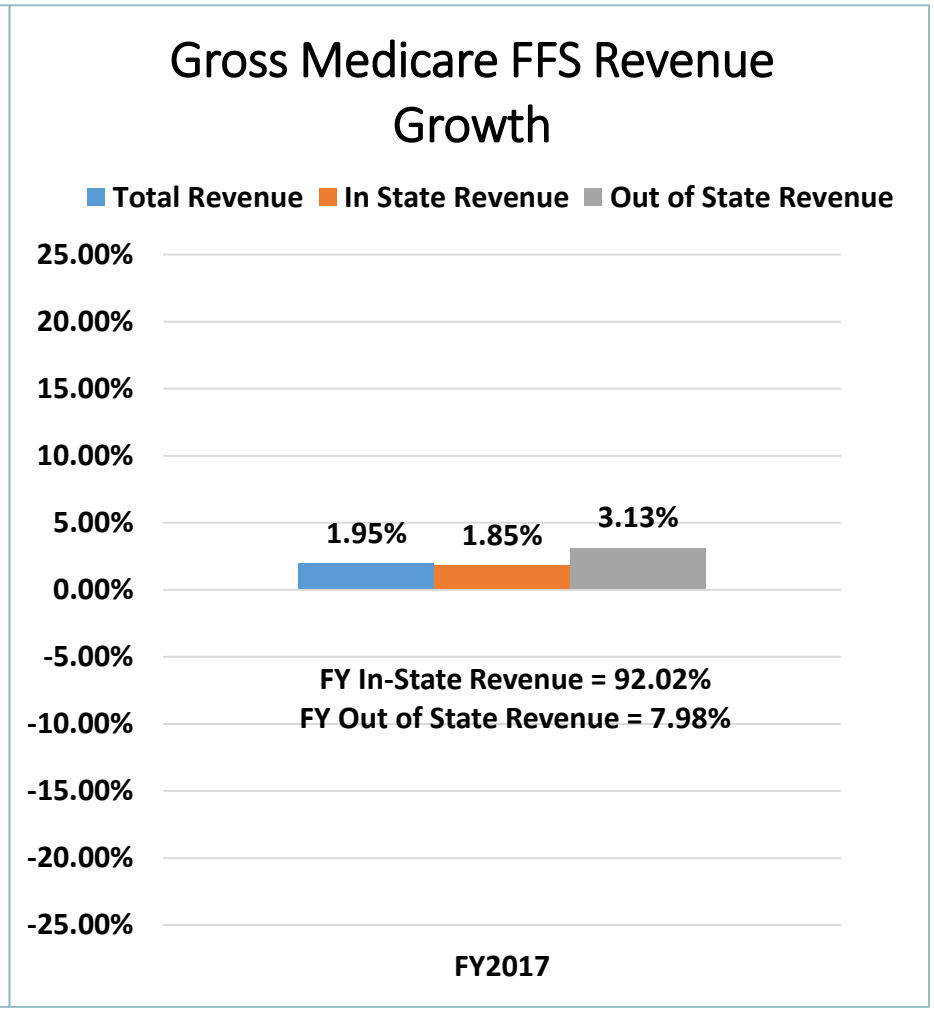
Monitoring Maryland Performance
Financial Data

Year End through June 2017 with Experience Corrections

Source: Hospital Monthly Volume and Revenue and Financial Statement Data
Run: September 27, 2017

Gross All Payer and Medicare Fee for Service Revenue Growth FYE 2017 (FY 2017-Jul 2016-June 2017 over Jul 2015-June 2016)



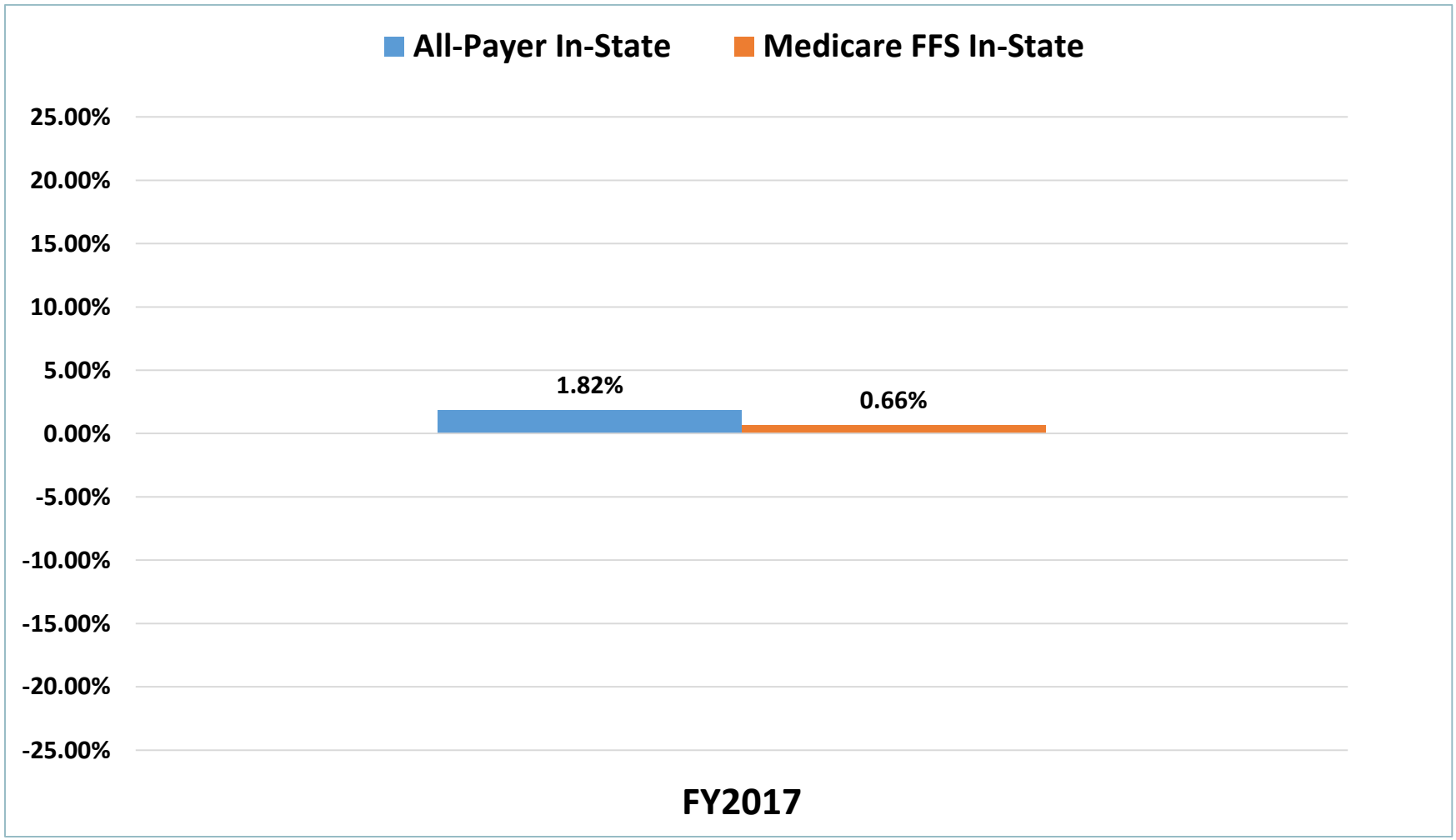


The State's Fiscal Year begins July 1

HSCRC
Health Services Cost Review Commission

Hospital Revenue Per Capita Growth Rates

FYE 2017 (Jul 2016 – June 2017 over Jul 2015 – June 2016)

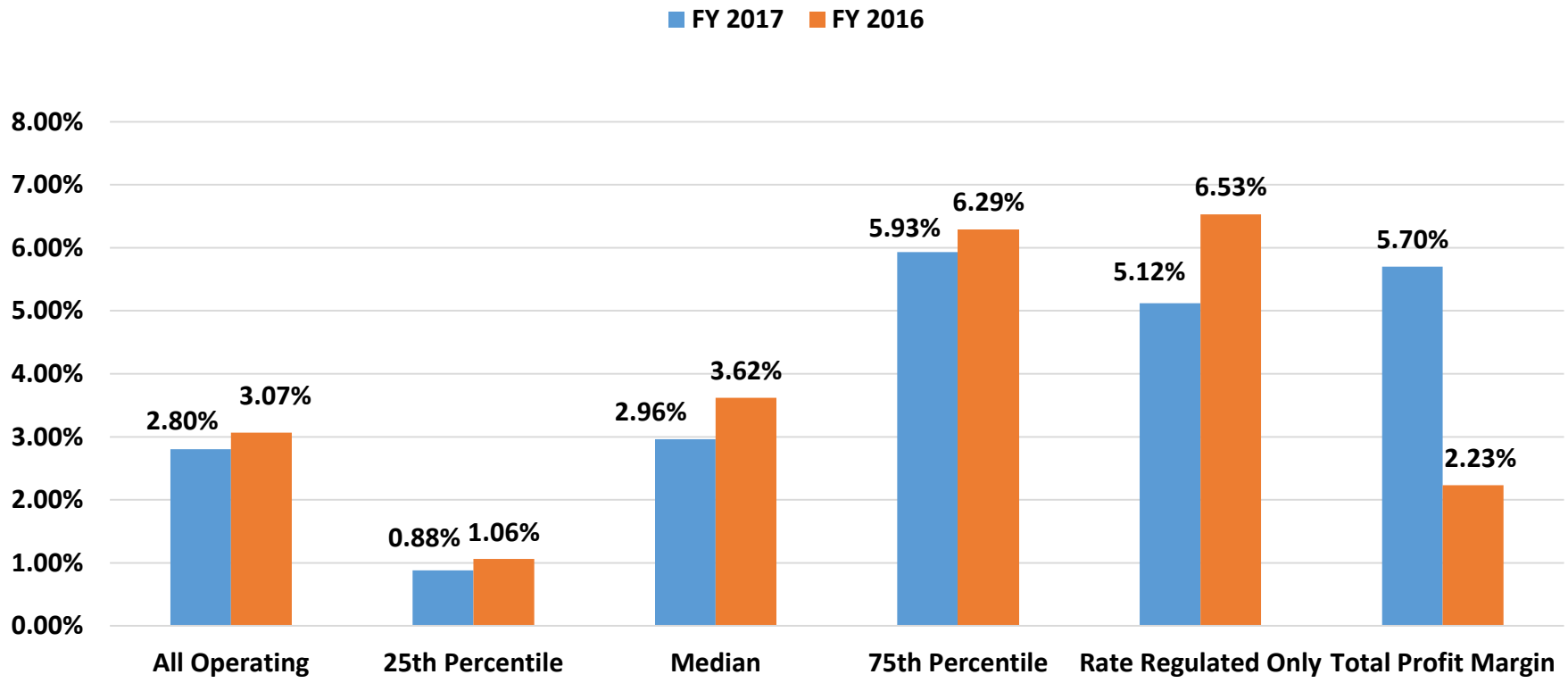


The State's Fiscal Year begins July 1

HSCRC
Health Services Cost Review Commission

Operating and Total Profits

Fiscal Year 2017 (Jul 2016-June 2017) Compared to Same Period in Fiscal Year 2016 (Jul 2015 - June 2016)



FY 2017 unaudited hospital operating profits to date show a decrease of .27 percentage point in total profits compared to the same period in FY 2016. Rate regulated profits for FY 2017 have decreased by 1.41 percentage points compared to the same period in FY 2016.

FY 2017 hospital total profit margin (includes income from investments) to date shows an increase of 3.47 percentage points.

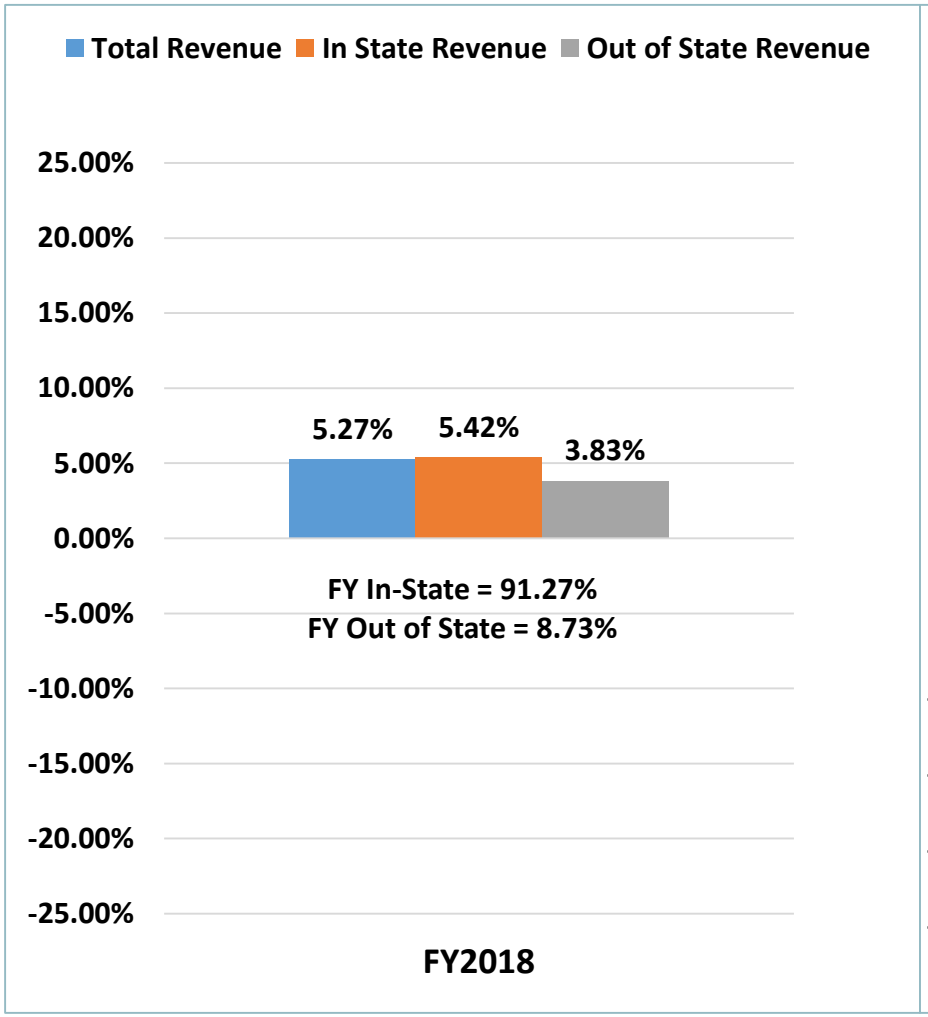
Monitoring Maryland Performance
Financial Data

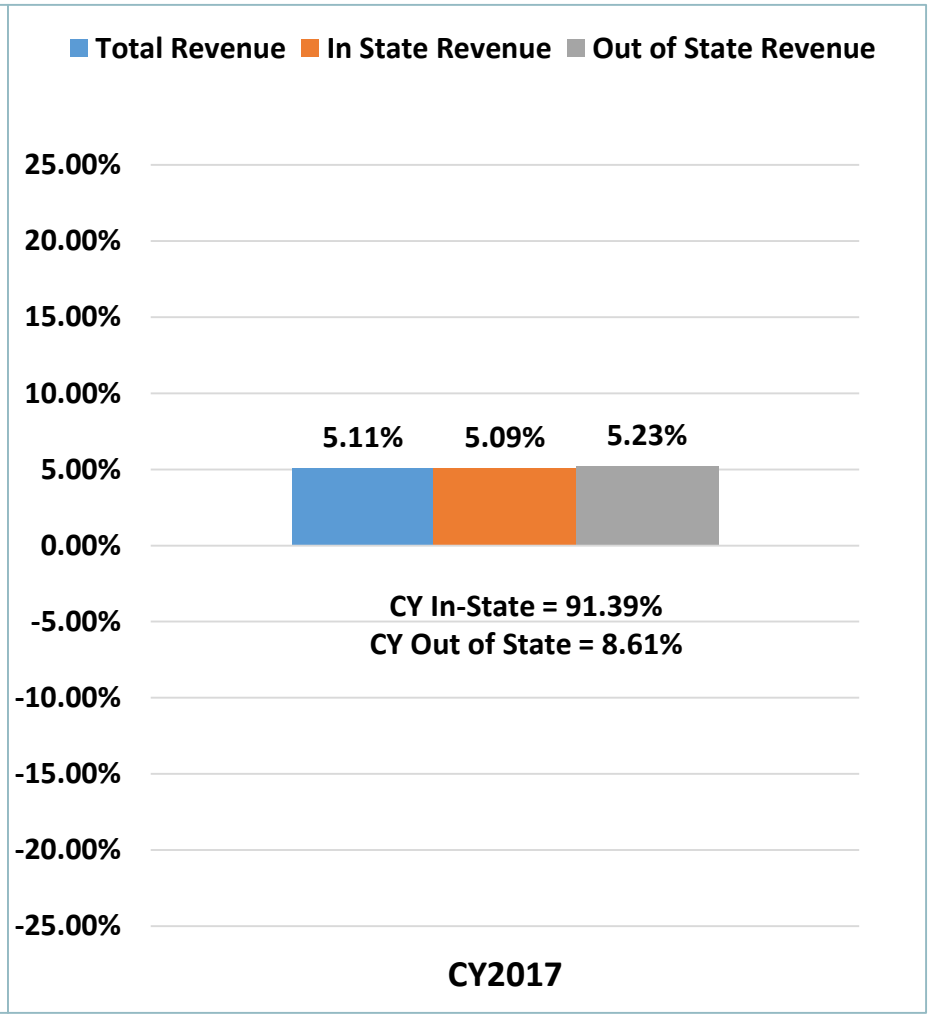
Year to Date through August 2017

Source: Hospital Monthly Volume and Revenue and Financial Statement Data
Run: October 2017

Gross All Payer Revenue Growth

FY 2018 (July - August 2017 over July - August 2016) and CY 2017 (Jan-August 2017 over Jan-August 2016)





The State's Fiscal Year begins August 1

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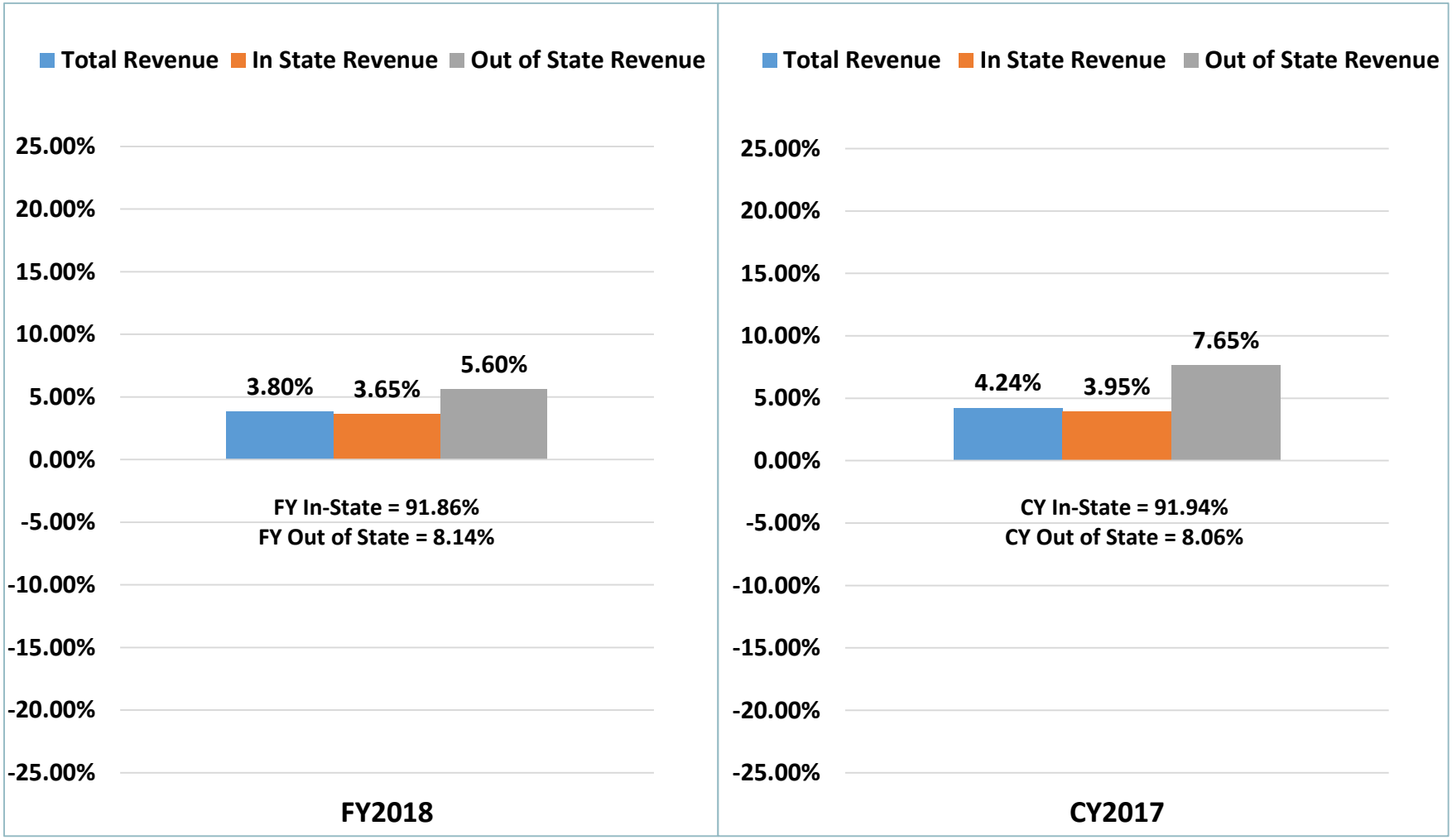
Gross Medicare Fee for Service Revenue Growth

FY 2018 (July - August 2017 over July - August 2016) and CY 2017 (Jan-August 2017 over Jan-August 2016)



The State's Fiscal Year begins August 1

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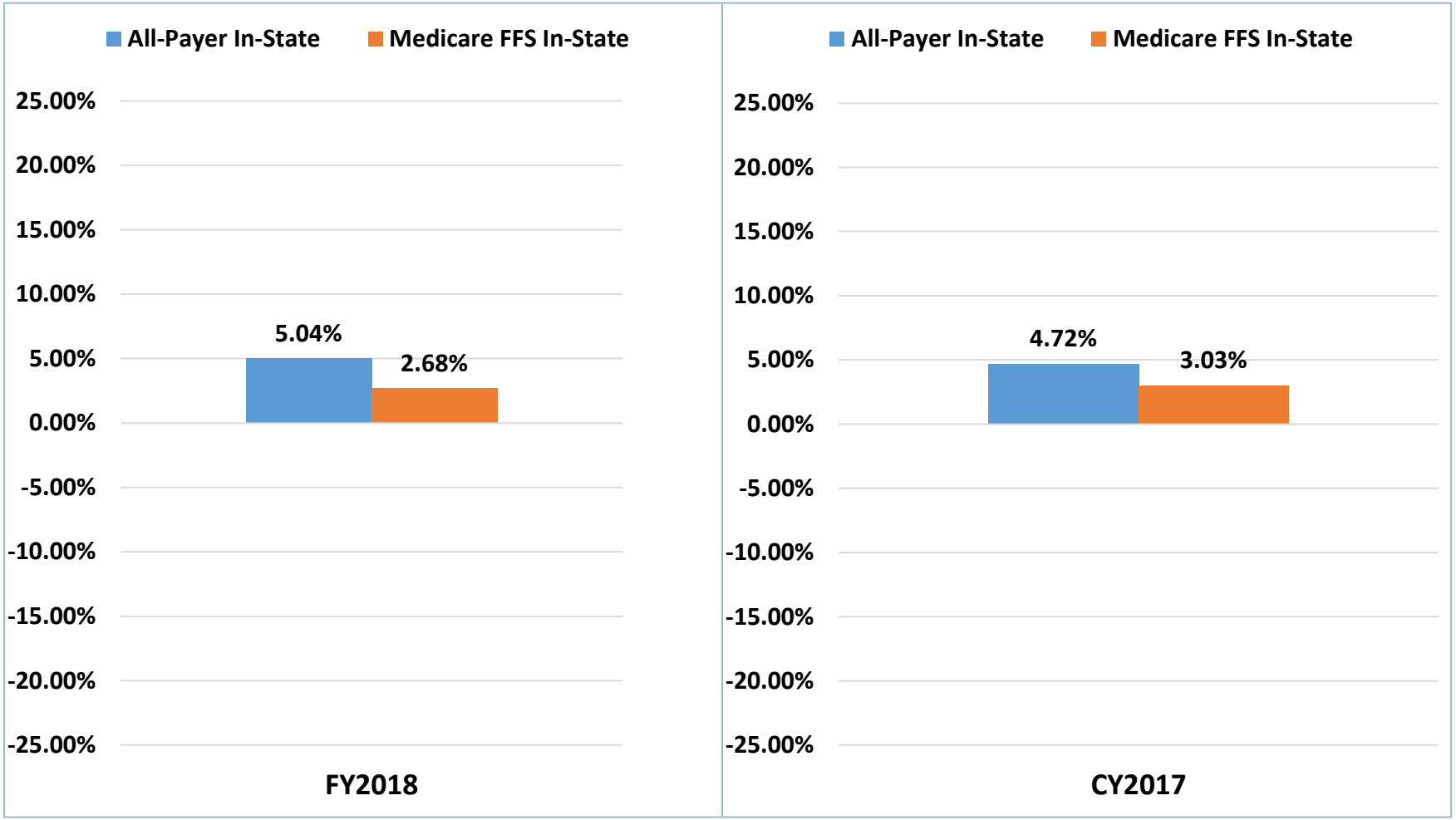
Hospital Revenue Per Capita Growth Rates

FY 2018 (July-August 2017 over July-August 2016) and CY 2017 (Jan-August 2017 over Jan-August 2016)



The State's Fiscal Year begins August 1

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Monitoring Maryland Performance
Financial Data

Year to Date through August 2017

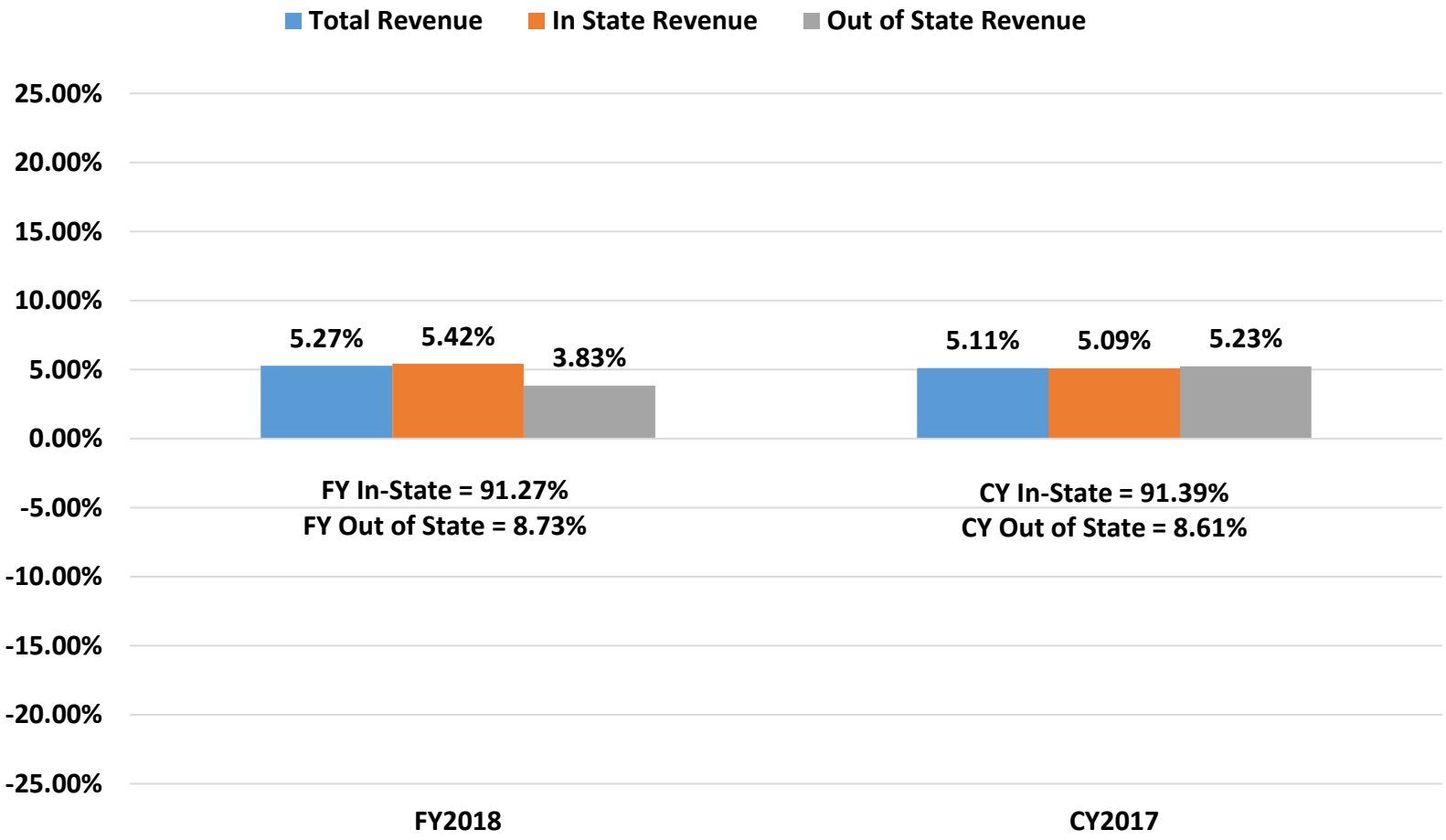
Source: Hospital Monthly Volume and Revenue and Financial Statement Data
Run: October 2017

The per capita growth data pertaining to the Medicare FFS beneficiary counts beginning January 1, 2013 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.

Note for FY18 and CY17: During the first six months of FY17 (August – December 2016), Hospitals undercharged their Global Budget Revenue mid-year targets by approximately 1% ($25M dollars). Slide 4 (Gross All Payer Revenue Growth Adjusted) and slide 6 (Gross Medicare Fee For Service Revenue Growth Adjusted) have been adjusted to 'add back' the undercharge for FY 2017 data. An adjustment to counter the addition to revenue in FY 2017 data has been made to the June 2017 data under CY 2017.

Gross All Payer Revenue Growth

FY 2018 (July - August 2017 over July - August 2016) and CY 2017 (Jan-August 2017 over Jan-August 2016)



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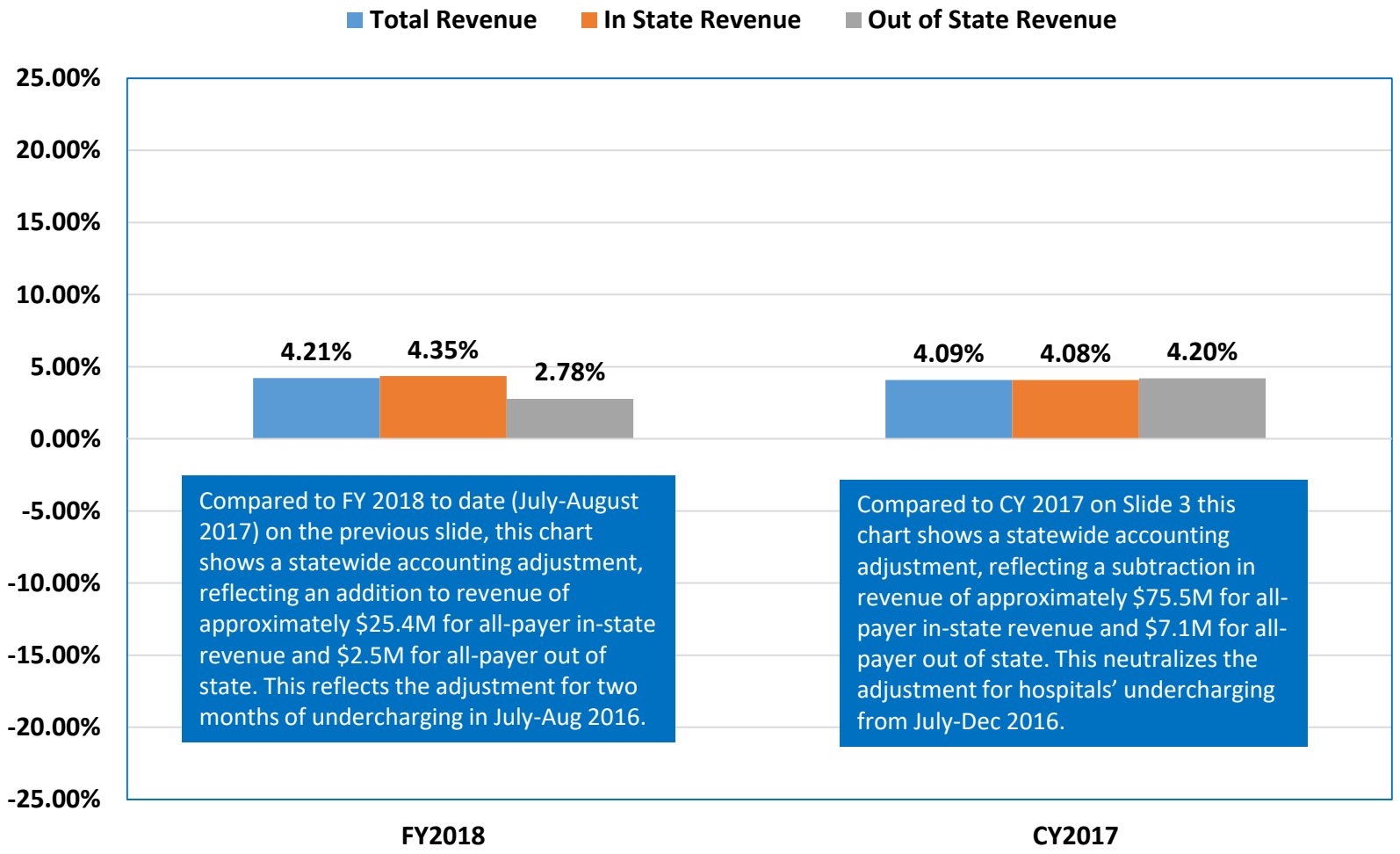
Gross All Payer Revenue Growth

Adjusted for August - December 2016 Undercharge

FY 2018 (July - August 2017 over July - August 2016) and CY 2017 (Jan-August 2017 over Jan-August 2016)

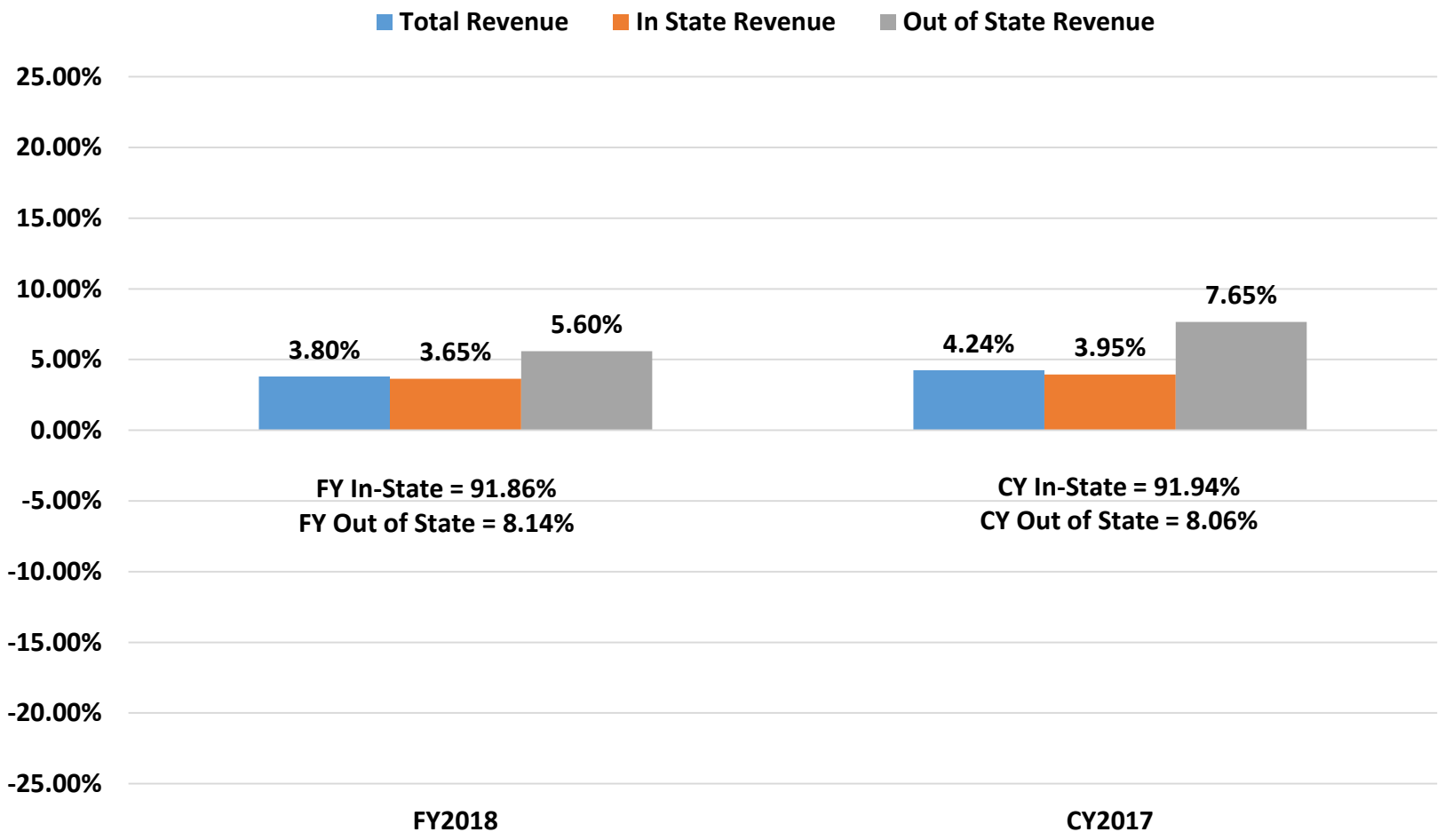


Compared to FY 2018 to date (July-August 2017) on the previous slide, this chart shows a statewide accounting adjustment, reflecting an addition to revenue of approximately $25.4M for all-payer in-state revenue and $2.5M for all-payer out of state. This reflects the adjustment for two months of undercharging in July-Aug 2016.

Compared to CY 2017 on Slide 3 this chart shows a statewide accounting adjustment, reflecting a subtraction in revenue of approximately $75.5M for all-payer in-state revenue and $7.1M for all-payer out of state. This neutralizes the adjustment for hospitals' undercharging from July-Dec 2016.

Gross Medicare Fee for Service Revenue Growth

FY 2018 (July - August 2017 over July - August 2016) and CY 2017 (Jan-August 2017 over Jan-August 2016)



The State's Fiscal Year begins August 1

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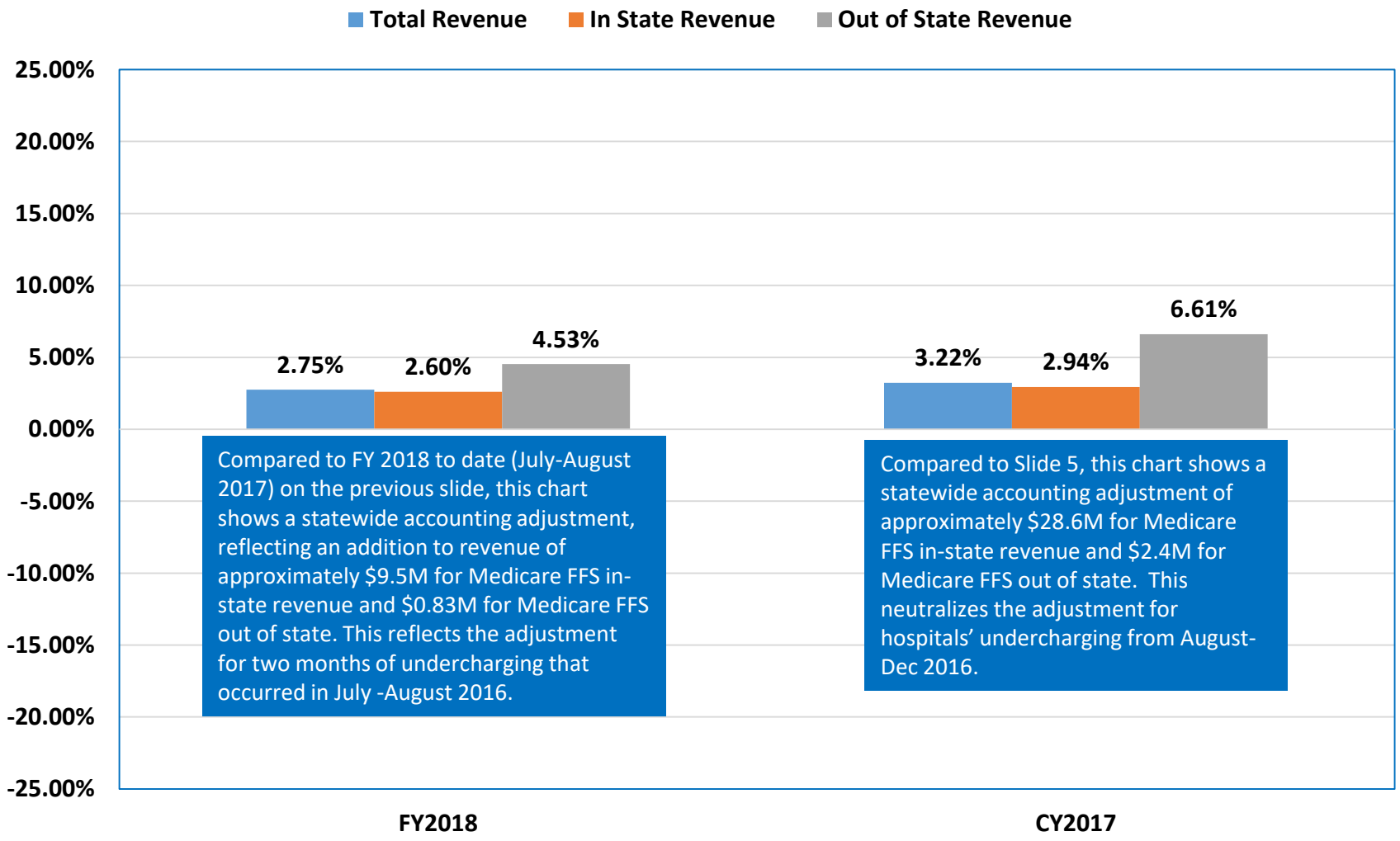
Gross Medicare Fee for Service Revenue Growth

Adjusted for August – December 2016 Undercharge

FY 2018 (July-August 2017 over July-August 2016) and CY 2017 (Jan-August 2017 over Jan-August 2016)



Compared to FY 2018 to date (July-August 2017) on the previous slide, this chart shows a statewide accounting adjustment, reflecting an addition to revenue of approximately $9.5M for Medicare FFS in-state revenue and $0.83M for Medicare FFS out of state. This reflects the adjustment for two months of undercharging that occurred in July -August 2016.

Compared to Slide 5, this chart shows a statewide accounting adjustment of approximately $28.6M for Medicare FFS in-state revenue and $2.4M for Medicare FFS out of state. This neutralizes the adjustment for hospitals' undercharging from August-Dec 2016.

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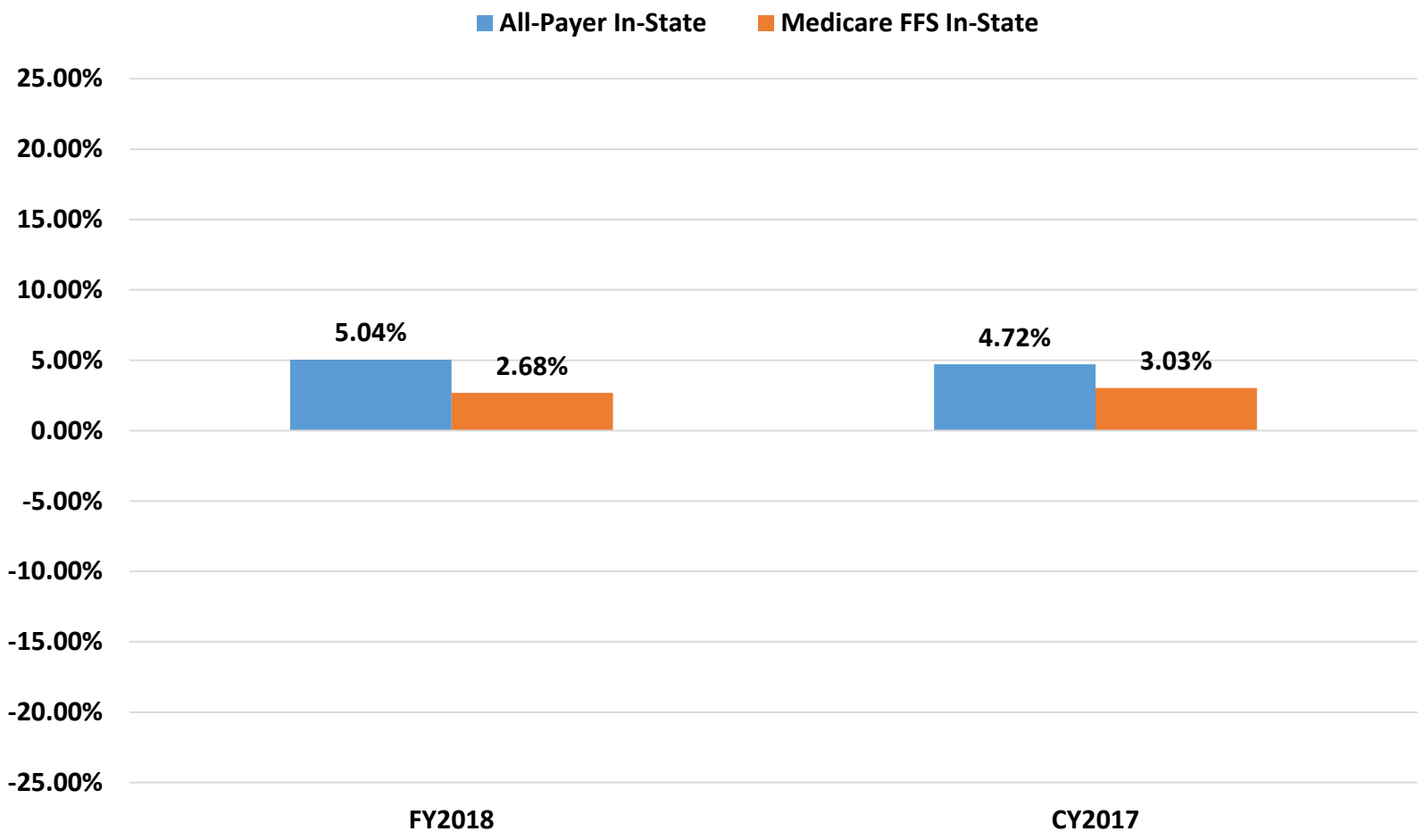
Hospital Revenue Per Capita Growth Rates

FY 2018 (July-August 2017 over July-August 2016) and CY 2017 (Jan-August 2017 over Jan-August 2016)



The State's Fiscal Year begins August 1

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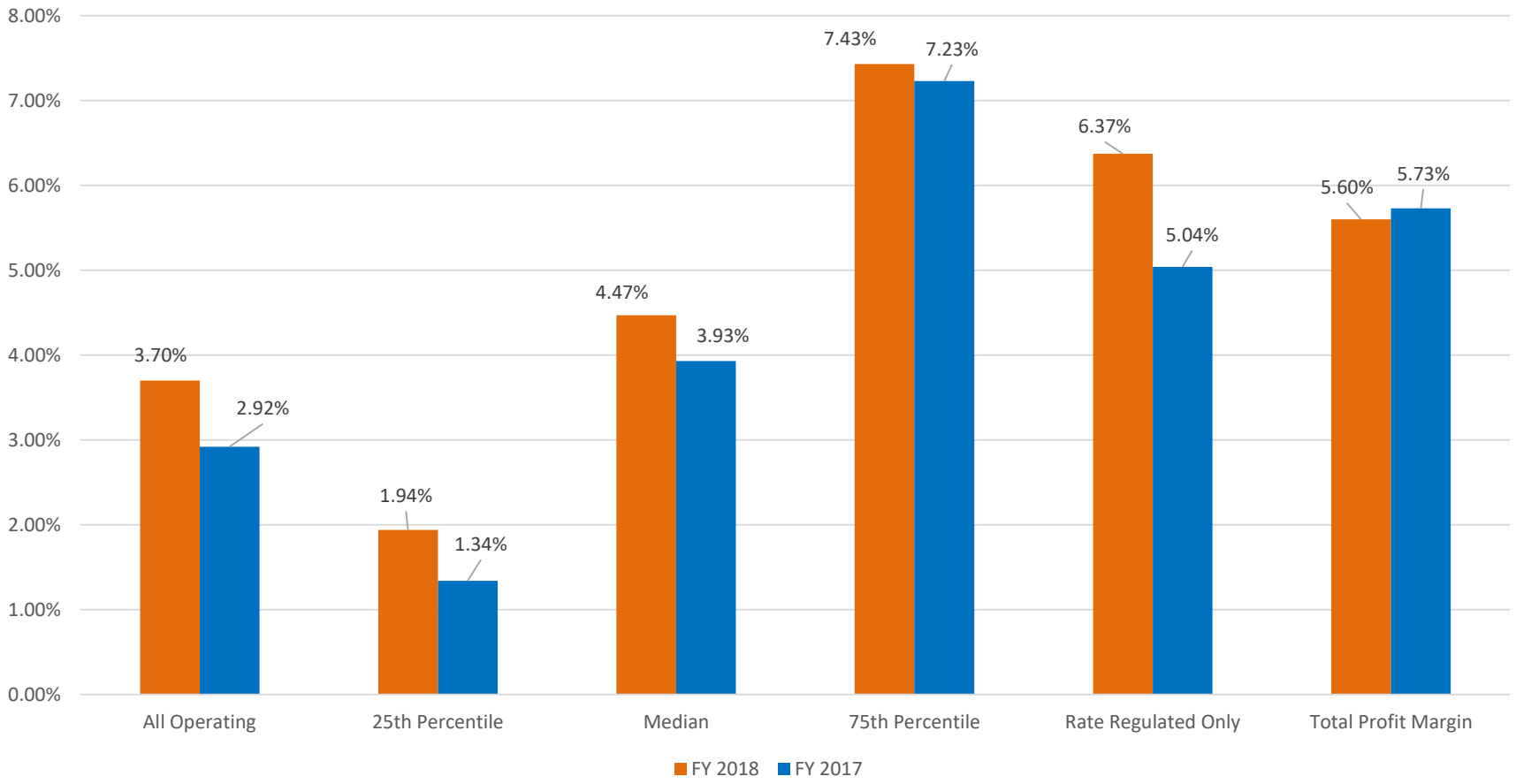
Operating and Total Profits

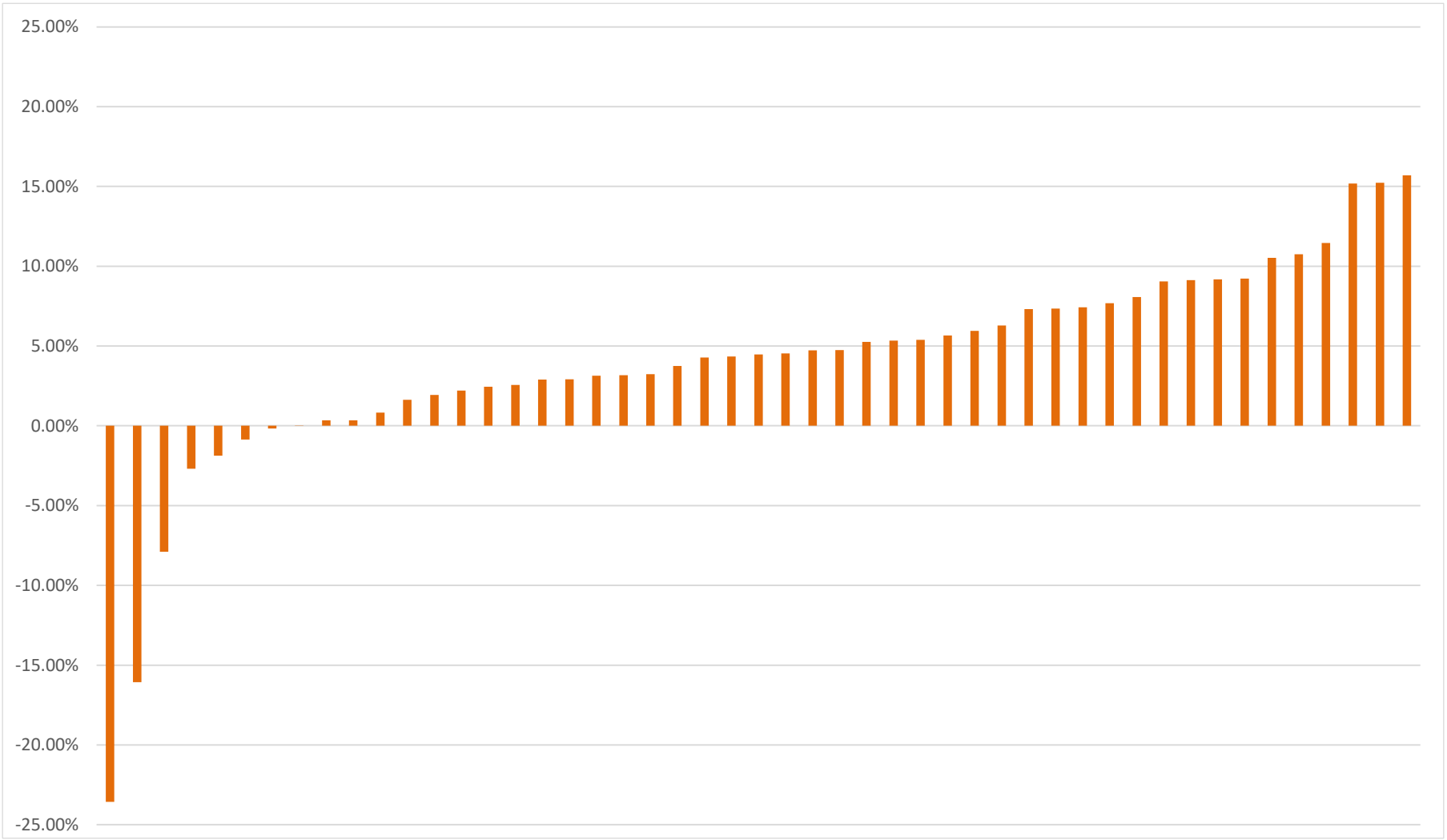
Fiscal Year 2018 (July - August 2017) Compared to Same Period in Fiscal Year 2017 (July - August 2016)



FY 2018 unaudited hospital operating profits to date show an increase of .78 percentage points in total operating profits compared to the same period in FY 2017. Rate regulated profits for FY 2018 have increased by 1.33 percentage points compared to the same period in FY 2017.

Total Operating Profits by Hospital

Fiscal Year 2018 (July - August 2017)



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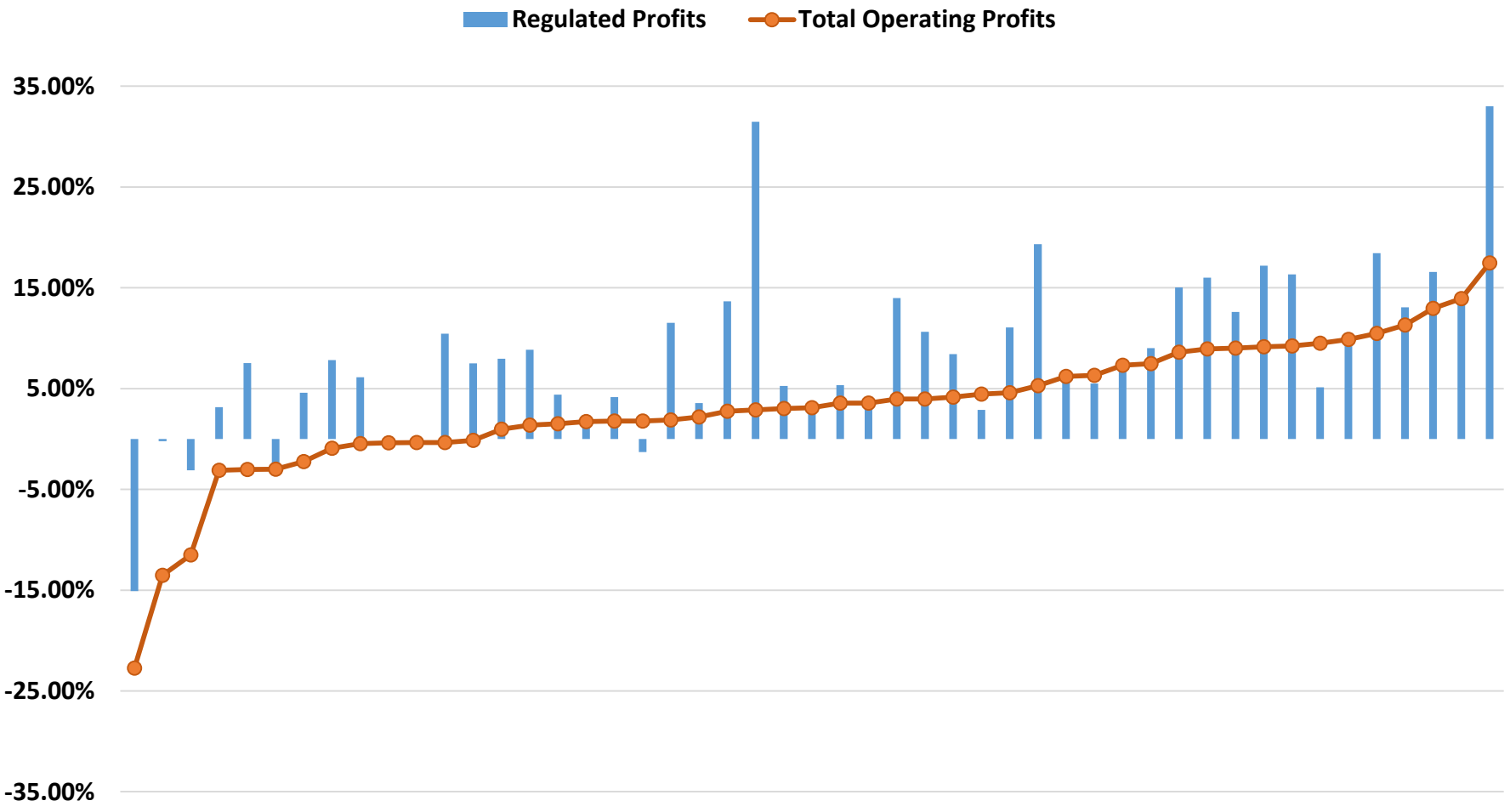
Regulated and Total Operating Profits

Fiscal Year 2018 (July - August 2017)



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Monitoring Maryland Performance Financial/Utilization Data

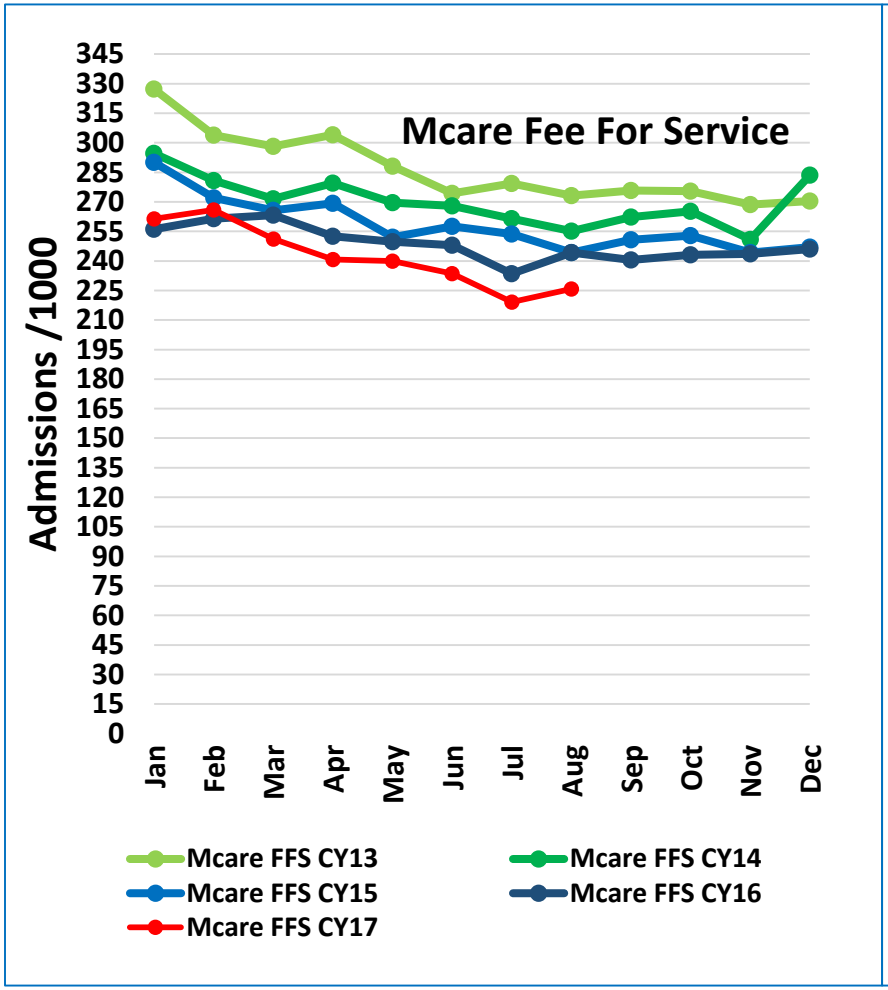
Calendar Year to Date through August 2017

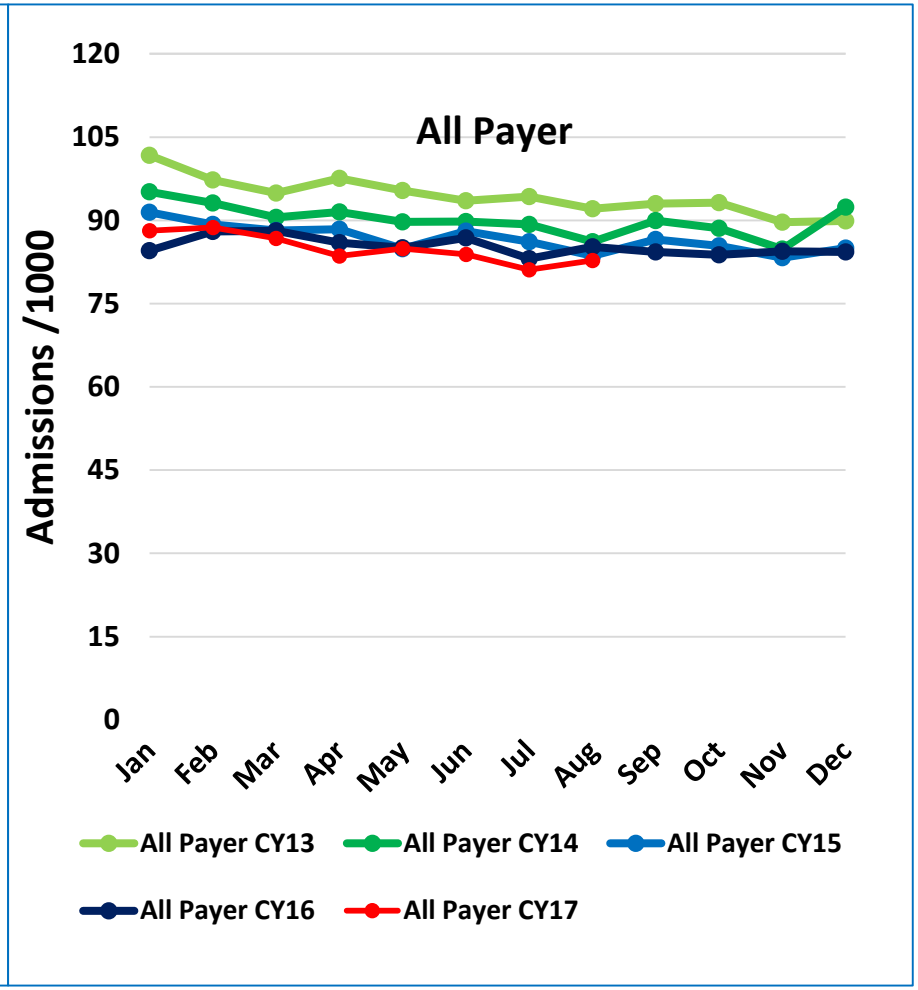
Source: Hospital Monthly Volume and Revenue Data

The per capita growth data pertaining to the Medicare FFS beneficiary counts beginning January 1, 2013 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.

Annual Trends for ADK Annualized

Medicare Fee For Service and All Payer (CY 2013 through CY 2017 August)

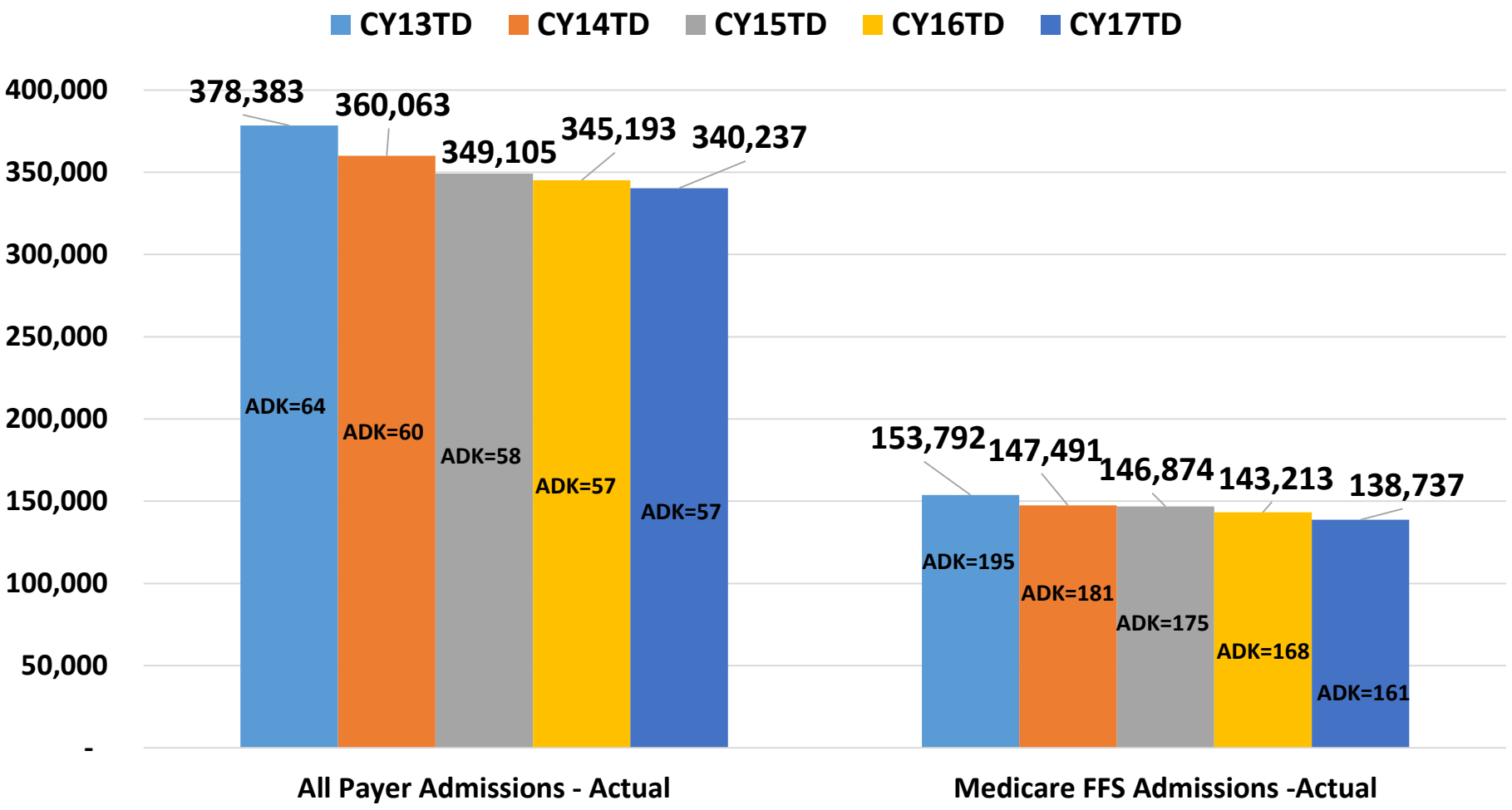




Note - The admissions do not include out of state migration or specialty psych and rehab hospitals.

Actual Admissions by Calendar YTD August

(CY 2013 through CY 2017)



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

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Change in Admissions by Calendar YTD August

(CY 2013 through CY 2017)

Change in All Payer Admissions CYTD13 vs. CYTD14 = -4.84%
Change in All Payer Admissions CYTD14 vs. CYTD15 = -3.04%
Change in All Payer Admissions CYTD15 vs. CYTD16 = -1.12%
Change in All Payer Admissions CYTD16 vs. CYTD17 = -1.44%

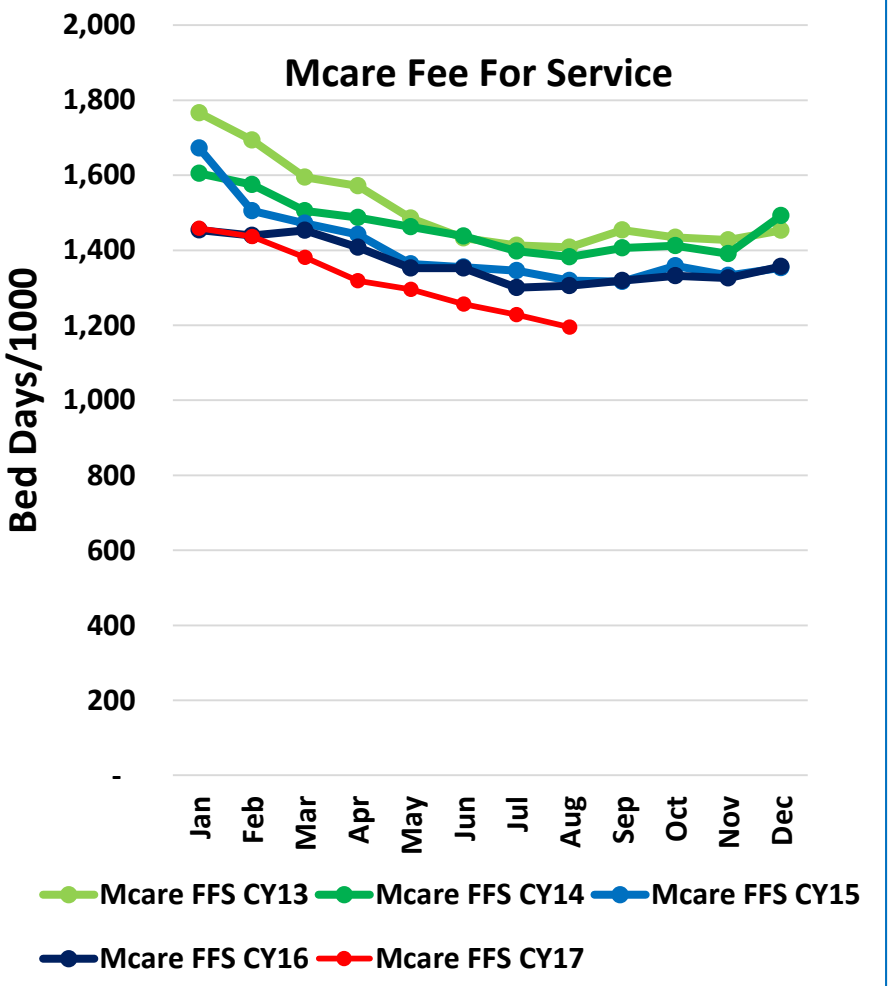
Change in ADK CYTD 13 vs. CYTD 14 = -5.42%
Change in ADK CYTD 14 vs. CYTD 15 = -3.49%
Change in ADK CYTD 15 vs. CYTD 16 = -1.47%
Change in ADK CYTD 16 vs. CYTD 17 = -1.44%

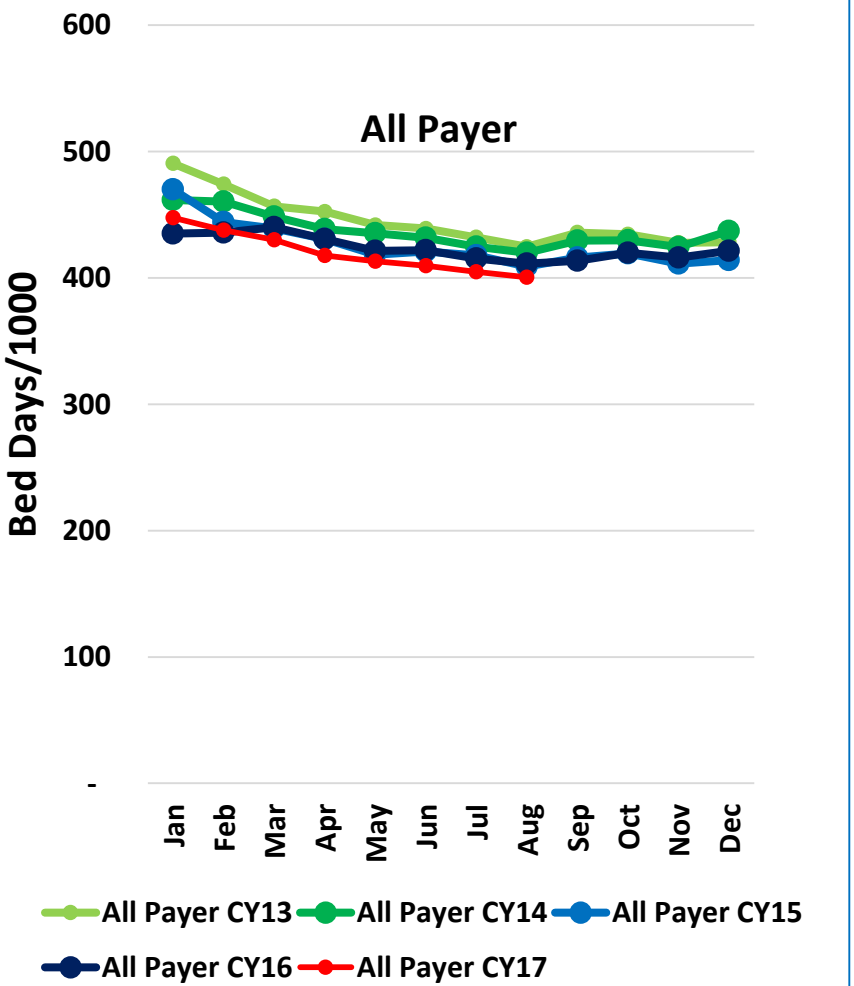
Change in Medicare FFS Admissions CYTD13 vs. CYTD14 = -4.10%
Change in Medicare FFS Admissions CYTD14 vs. CYTD15 = -0.42%
Change in Medicare FFS Admissions CYTD15 vs. CYTD16 = -2.49%
Change in Medicare FFS Admissions CYTD16 vs. CYTD17 = -3.13%

Change in Medicare FFS ADK CYTD 13 vs. CYTD 14 = -7.14%
Change in Medicare FFS ADK CYTD 14 vs. CYTD 15 = -3.50%
Change in Medicare FFS ADK CYTD 15 vs. CYTD 16 = -4.13%
Change in Medicare FFS ADK CYTD 16 vs. CYTD 17 = -4.01%

Annual Trends for BDK Annualized

Medicare Fee For Service and All Payer (CY 2013 through CY 2017 August)





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

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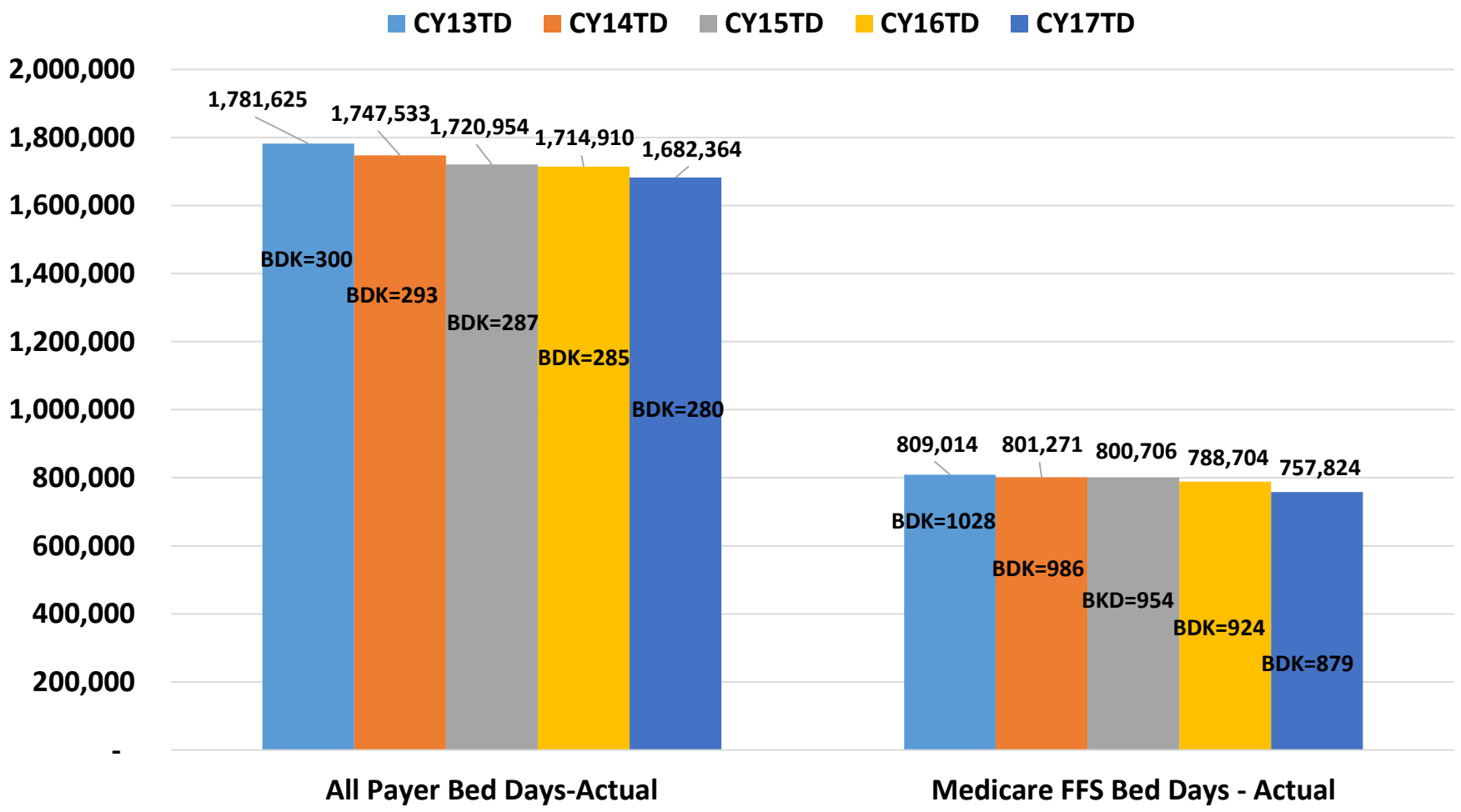
Actual Bed Days by Calendar YTD August

(CY 2013 through CY 2017)



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

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Change in Bed Days by Calendar YTD August

(CY 2013 through CY 2017)

Change in All Payer Bed Days CYTD13 vs. CYTD14 = -1.91%
Change in All Payer Bed Days CYTD14 vs. CYTD15 = -1.52%
Change in All Payer Bed Days CYTD15 vs. CYTD16 = -0.35%
Change in All Payer Bed Days CYTD16 vs. CYTD17 = -1.90%

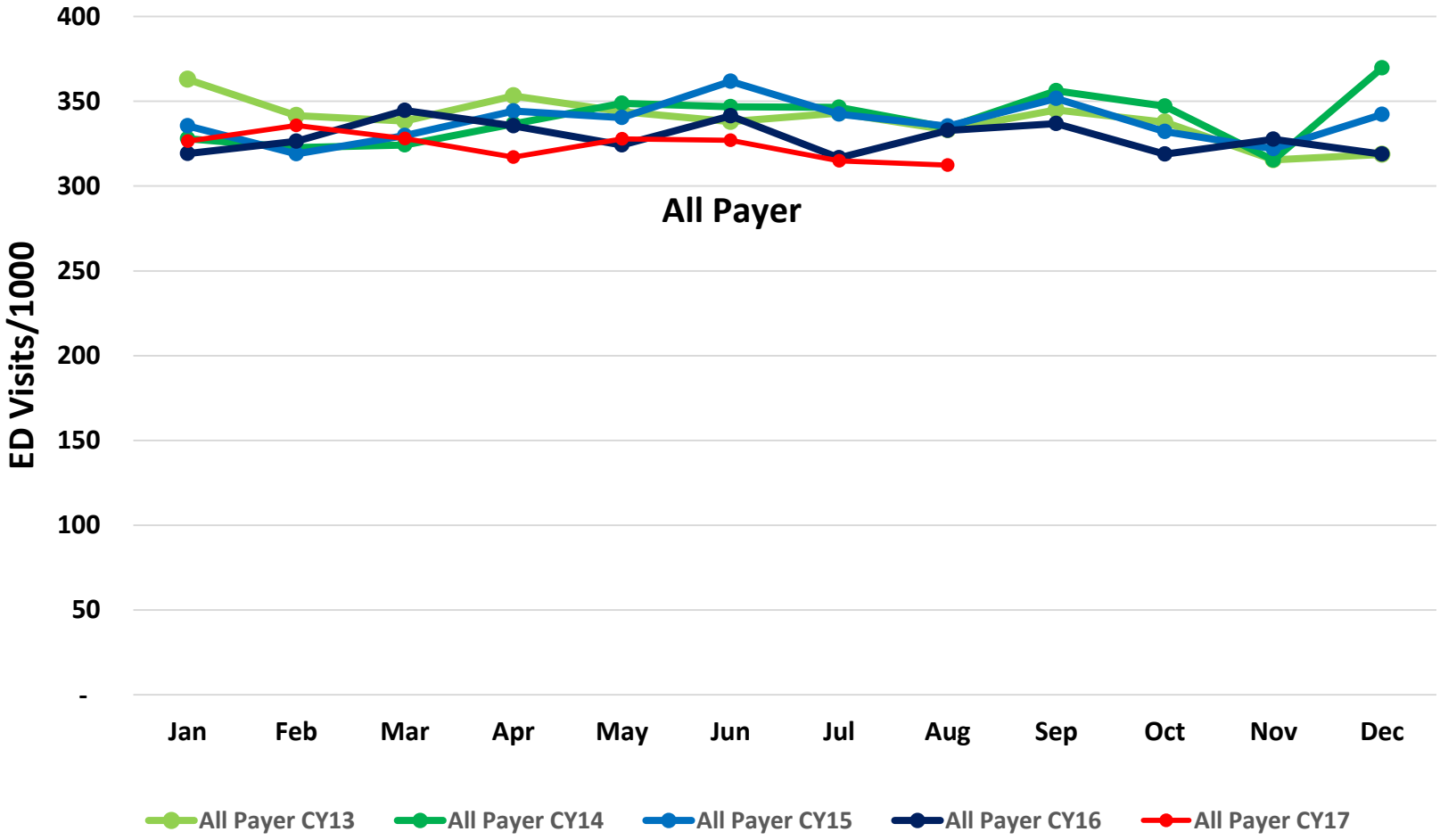
Change in BDK CYTD 13 vs. CYTD 14 = -2.51%
Change in BDK CYTD 14 vs. CYTD 15 = -1.98%
Change in BDK CYTD 15 vs. CYTD 16 = -0.71%
Change in BDK CYTD 16 vs. CYTD 17 = -1.90%

Change in Medicare FFS Bed Days CYTD13 vs. CYTD14 = -0.96%
Change in Medicare FFS Bed Days CYTD14 vs. CYTD15 = 0.07%
Change in Medicare FFS Bed Days CYTD15 vs. CYTD16 = -1.50%
Change in Medicare FFS Bed Days CYTD16 vs. CYTD17 = -3.92%

Change in Medicare FFS BDK CYTD 13 vs. CYTD 14 = -4.11%
Change in Medicare FFS BDK CYTD 14 vs. CYTD 15 = -3.16%
Change in Medicare FFS BDK CYTD 15 vs. CYTD 16 = -3.16%
Change in Medicare FFS BDK CYTD 16 vs. CYTD 17 = -4.93%

Annual Trends for EDK Annualized

All Payer (CY 2013 through CY2017 August)



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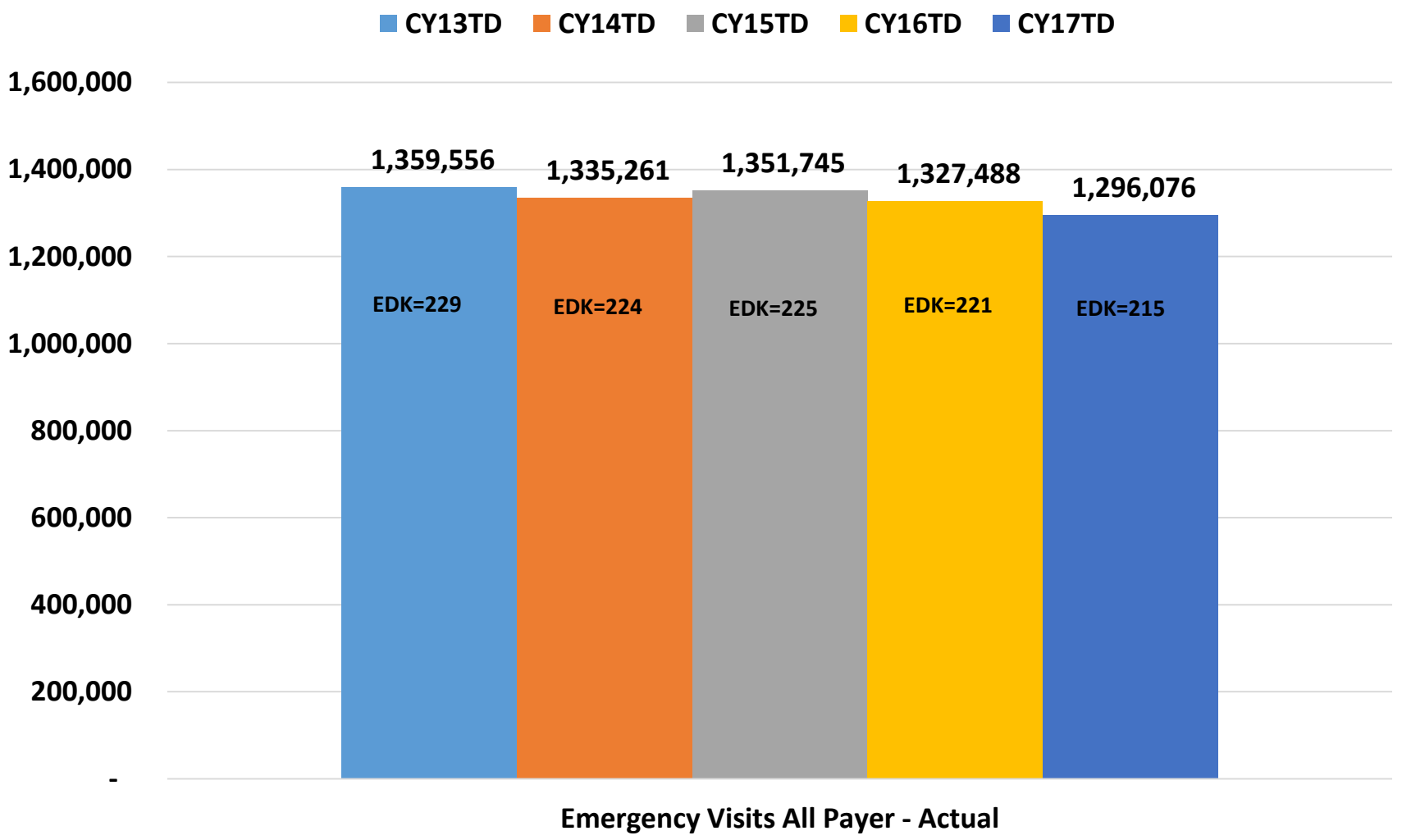
Actual Emergency Department Visits by Calendar YTD August (CY 2013 through CY 2017)



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

Change in ED Visits by Calendar YTD August

(CY 2013 through CY 2017)

Change in ED Visits CYTD 13 vs. CYTD 14 = -1.79%

Change in ED Visits CYTD 14 vs. CYTD 15 = 1.23%

Change in ED Visits CYTD 15 vs. CYTD 16 = -1.79%

Change in ED Visits CYTD 16 vs. CYTD 17 = -2.37%

Change in EDK CYTD 13 vs. CYTD 14 = -2.38%

Change in EDK CYTD 14 vs. CYTD 15 = 0.77%

Change in EDK CYTD 15 vs. CYTD 16 = -2.14%

Change in EDK CYTD 16 vs. CYTD 17 = -2.37%

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 August be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This August 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 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.

Data Caveats cont.

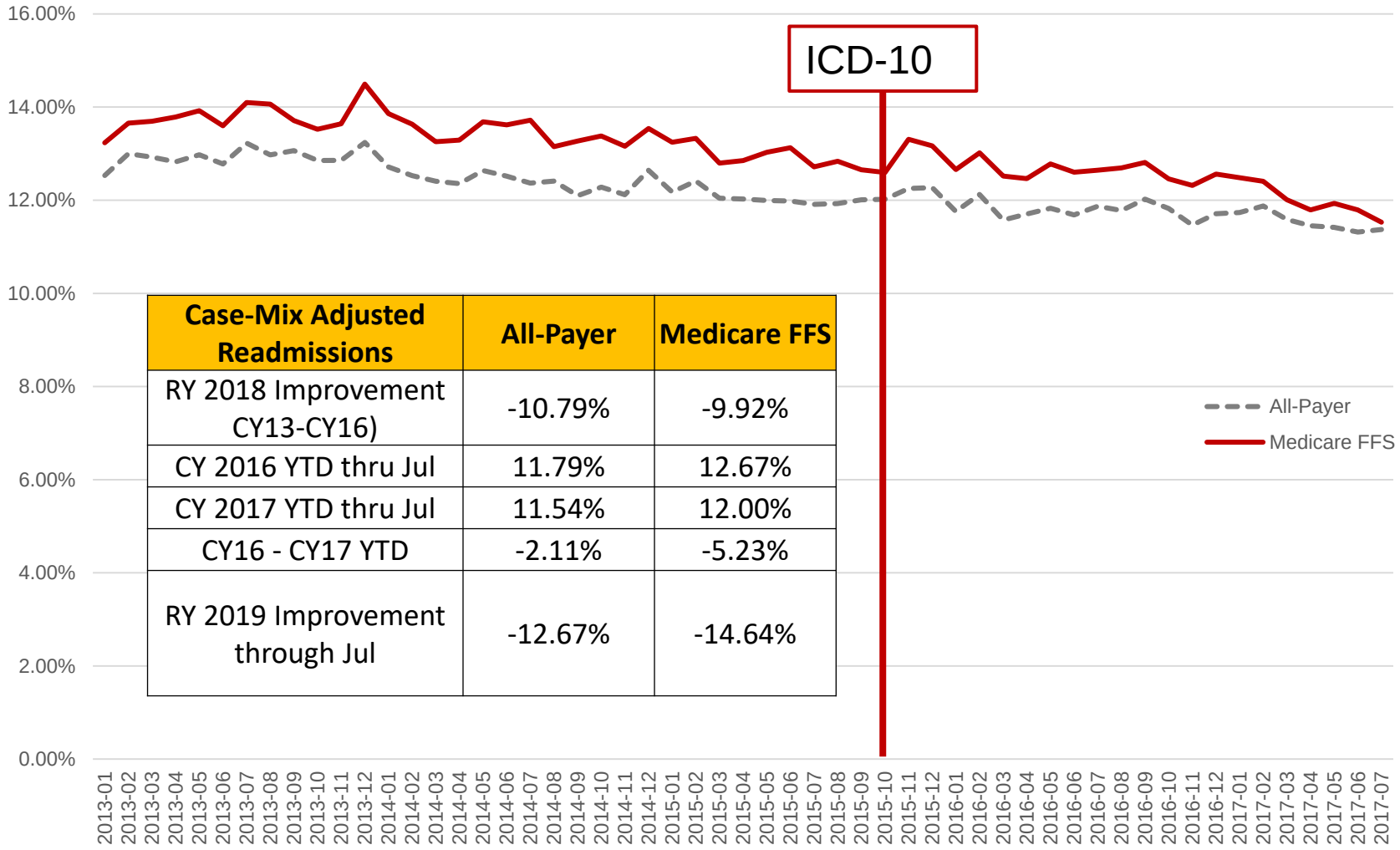
- The source data is the monthly volume and revenue statistics.
- ADK – Calculated using the admissions multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- BDK – Calculated using the bed days multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- EDK – Calculated using the ED visits multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- All admission and bed days calculations exclude births and nursery center.
- Admissions, bed days, and ED visits do not include out of state migration or specialty psych and rehab hospitals.

Monitoring Maryland Performance
Quality Data

October 2017 Commission Meeting Update

Readmission Reduction Analysis

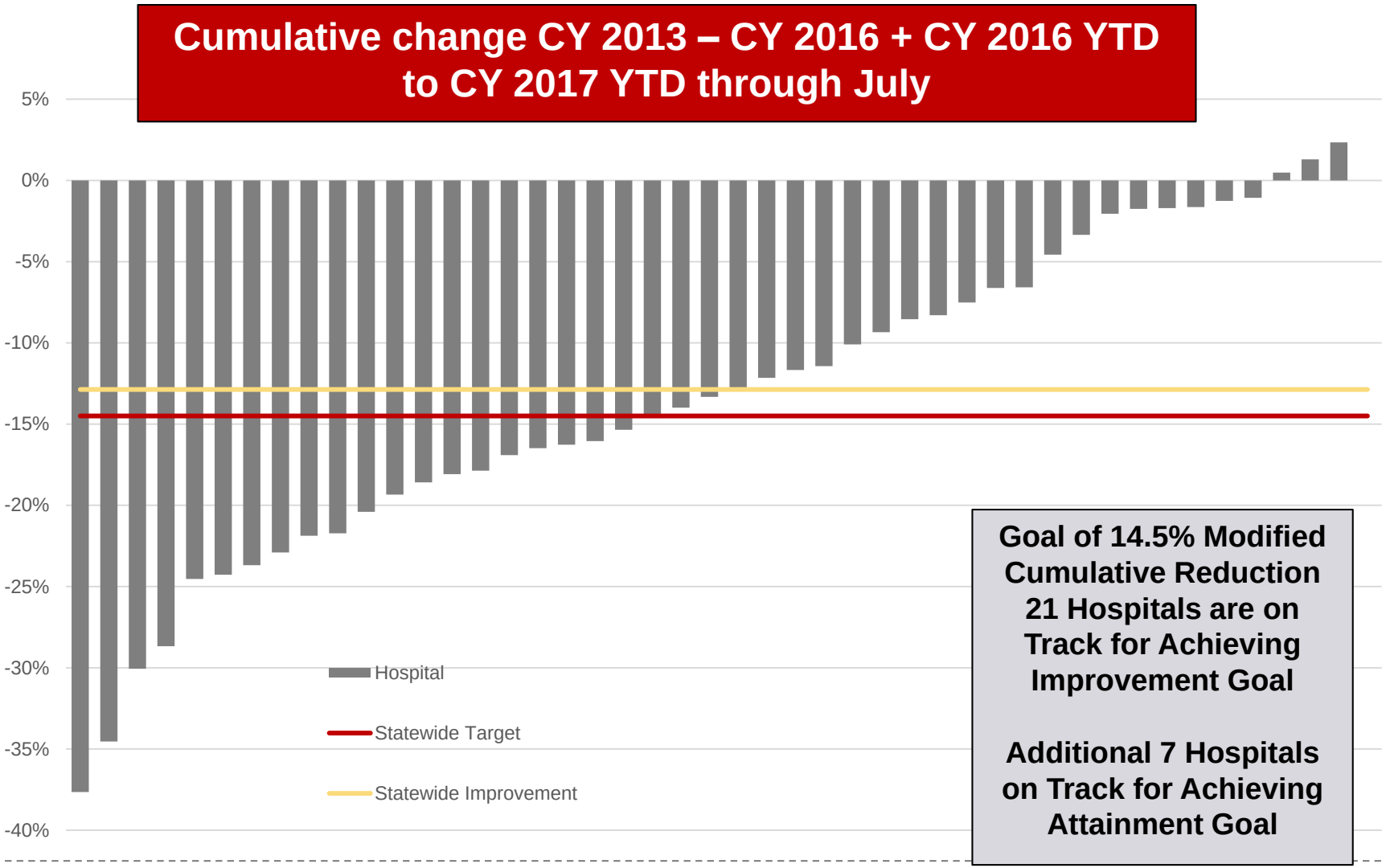
Monthly Case-Mix Adjusted Readmission Rates



Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
RY 2018 Improvement CY13-CY16)	-10.79%	-9.92%
CY 2016 YTD thru Jul	11.79%	12.67%
CY 2017 YTD thru Jul	11.54%	12.00%
CY16 - CY17 YTD	-2.11%	-5.23%
RY 2019 Improvement through Jul	-12.67%	-14.64%

Note: Based on final data for January 2012 – Jun 2017; Preliminary Data for Jul-Aug 2017. Statewide improvement to-date is compounded with complete RY 2018 and RY 2019 YTD improvement.

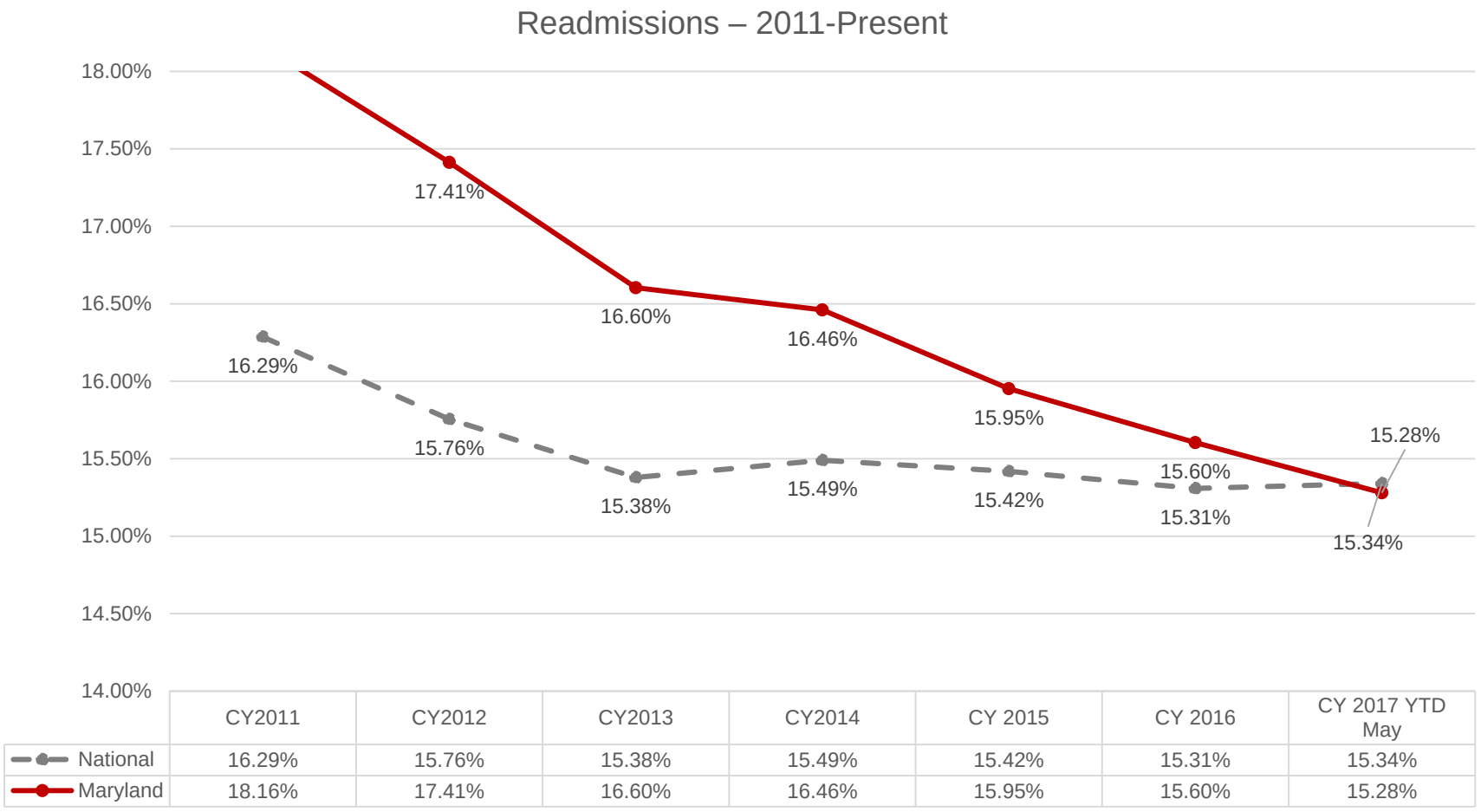
Change in All-Payer Case-Mix Adjusted Readmission Rates by Hospital



Note: Based on final data for January 2013-June 2017, Preliminary through August 2017.

Medicare Readmission Model Test

Medicare Readmissions – 2011-Present



	CY2011	CY2012	CY2013	CY2014	CY 2015	CY 2016	CY 2017 YTD May
National	16.29%	15.76%	15.38%	15.49%	15.42%	15.31%	15.34%
Maryland	18.16%	17.41%	16.60%	16.46%	15.95%	15.60%	15.28%

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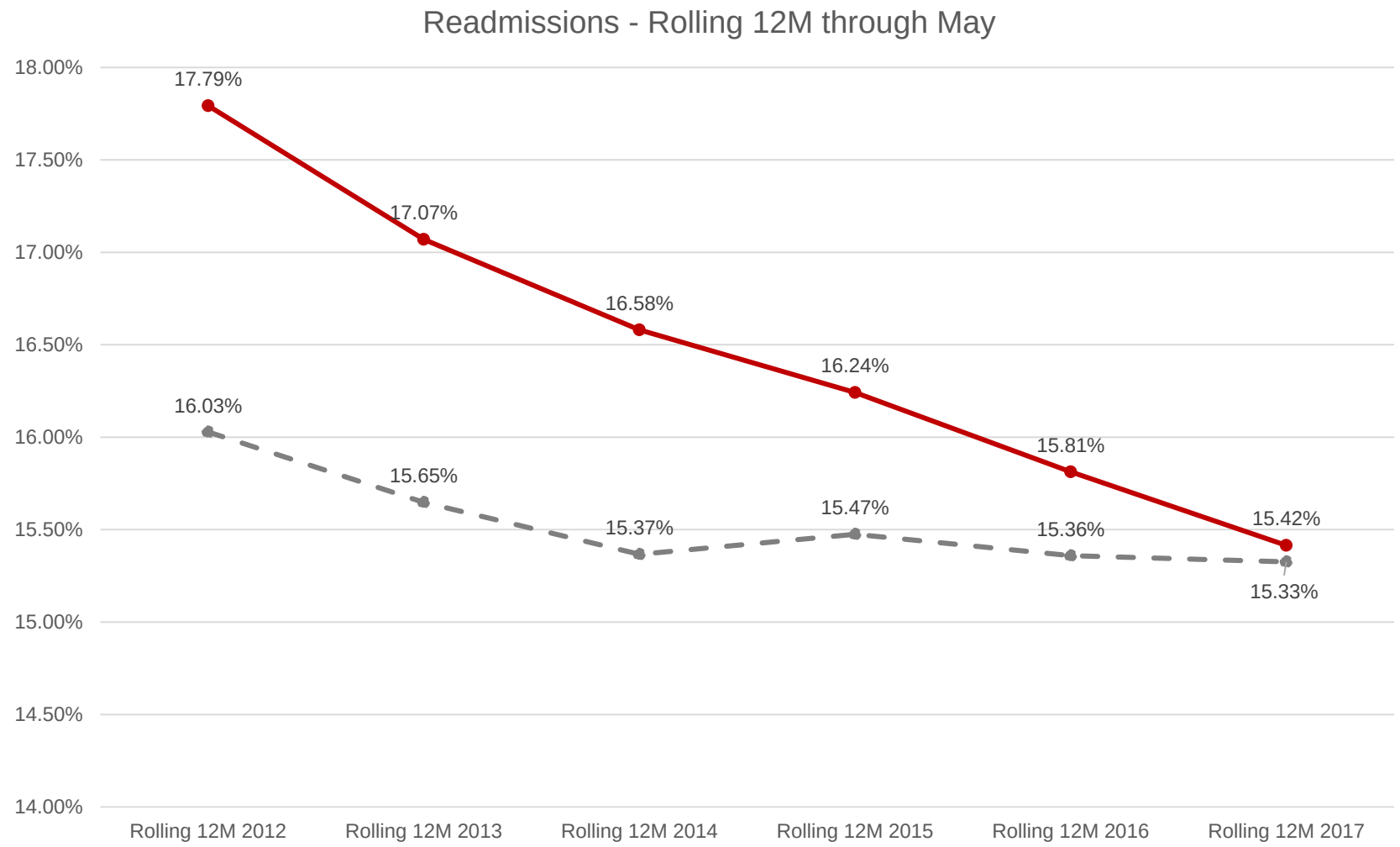
Medicare Readmissions – Rolling 12 Months Trend



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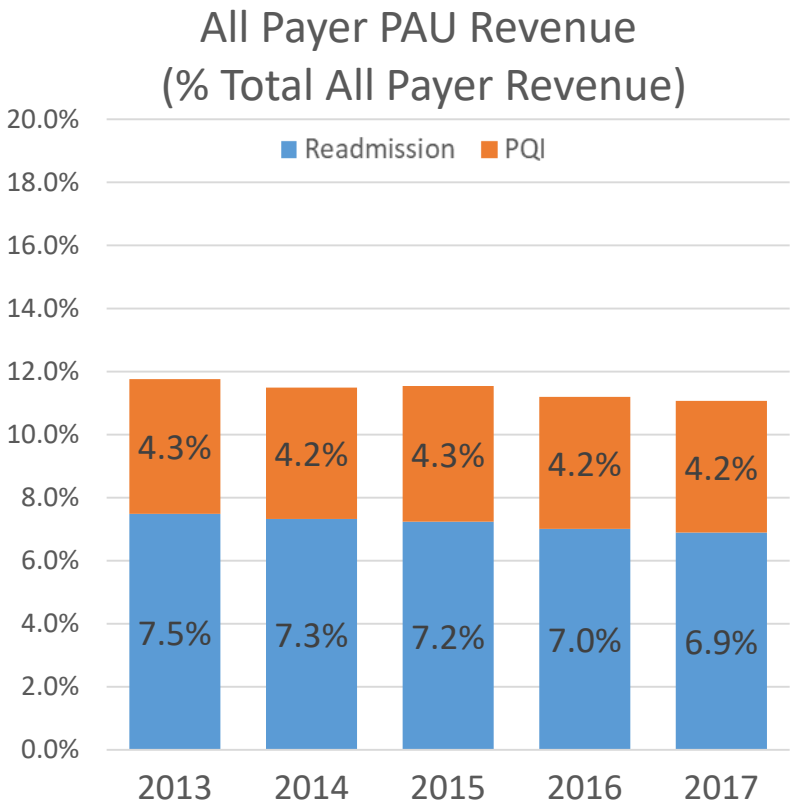
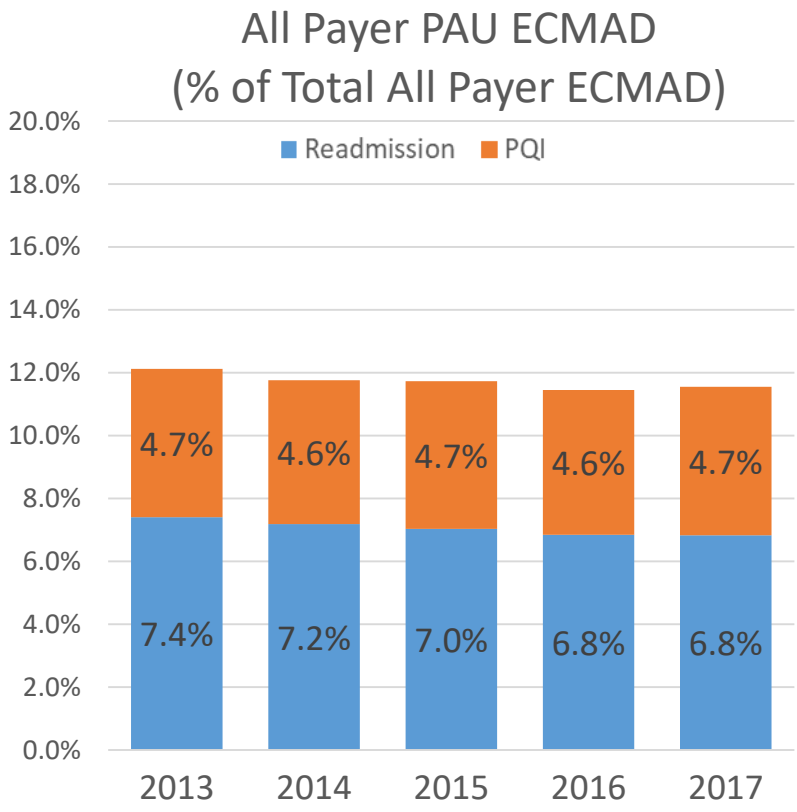
Potentially Avoidable Utilization (PAU) Monitoring

Statewide CYTD (Jan-Aug) All Payer PAU





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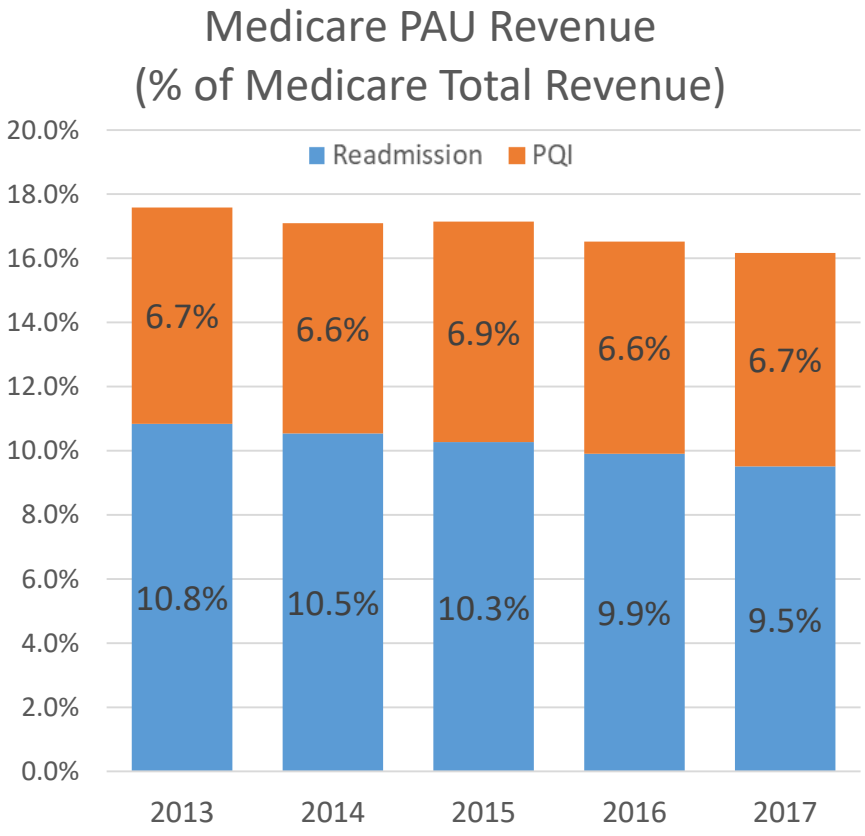
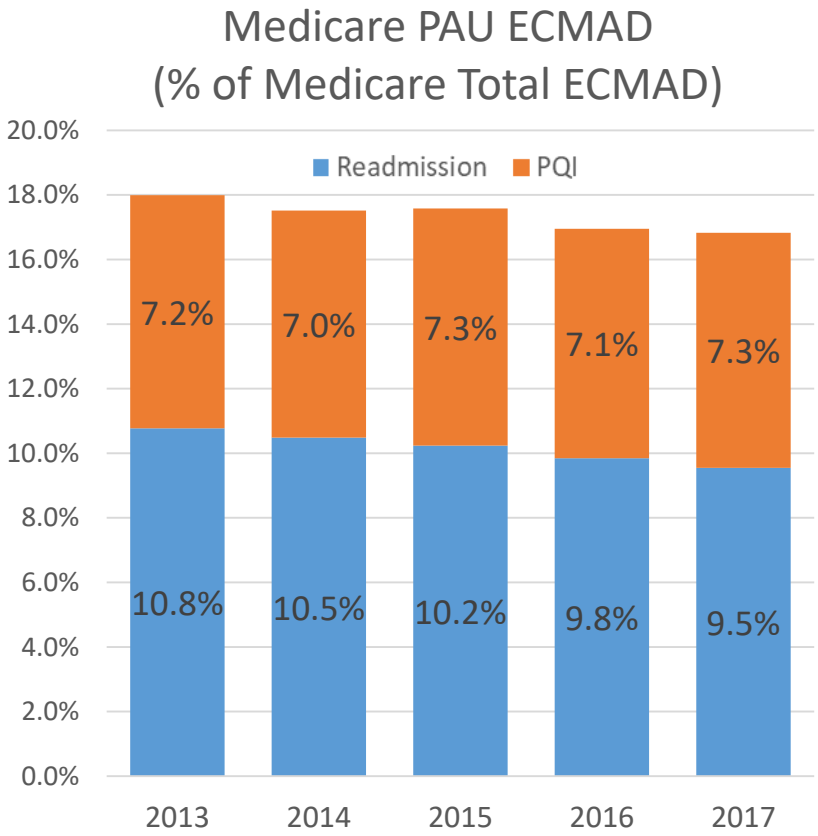
Statewide CYTD (Jan-Aug) Medicare PAU





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Emergency Department Efficiency Measures - By-Hospital
(Sorted by ED-2b Measure)

Lower values indicate greater efficiency.	ED-1b (in minutes)	ED-2b (in minutes)	OP-18b (in minutes)	Yellow Alert Diversion (in hours)
Hospital	Oct15-Sep16	Oct15-Sep16	Oct15-Sep16	Oct16-Sep17
LOW Annual ED Visit Volume (Less than 20,000)				
National Median for Low Volume Hospitals	**216**	**60**	**116**	**N/A**
EDWARD MCCREADY MEMORIAL HOSPITAL	215	45	75	15.0
GARRETT COUNTY MEMORIAL HOSPITAL	206	60	97	1.9
UNIVERSITY OF MD SHORE MEDICAL CTR AT CHESTERTOWN	352	98	134	109.1
MEDIUM (Less than 40,000)				
National Median for Medium Volume Hospitals	**259**	**88**	**140**	**N/A**
ATLANTIC GENERAL HOSPITAL	222	74	92	-
UNION HOSPITAL OF CECIL COUNTY	323	90	183	37.4
UNIVERSITY OF MARYLAND HARFORD MEMORIAL HOSPITAL	335	112	175	33.9
UNIVERSITY OF MD SHORE MEDICAL CENTER AT DORCHESTER	359	120	120	24.3
UNIVERSITY OF MD SHORE MEDICAL CENTER AT EASTON	359	120	120	112.3
MEDSTAR MONTGOMERY MEDICAL CENTER	332	157	171	1,002.5
UNIVERSITY OF MD MEDICAL CENTER MIDTOWN CAMPUS	445	161	224	540.8
BON SECOURS HOSPITAL	366	169	140	125.5
LAUREL REGIONAL MEDICAL CENTER	499	252	217	213.4
HIGH (Less than 60,000)				
National Median for High Volume Hospitals	**295**	**111**	**161**	**N/A**
FORT WASHINGTON HOSPITAL	278	86	146	231.5
WESTERN MARYLAND REGIONAL MEDICAL CENTER	309	98	192	0.0
NORTHWEST HOSPITAL CENTER	362	110	254	794.1
UNIVERSITY OF MARYLAND ST JOSEPH MEDICAL CENTER	396	129	212	1,648.3
GREATER BALTIMORE MEDICAL CENTER	368	134	229	1,462.6
MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER	379	140	252	1,023.9
MEDSTAR GOOD SAMARITAN HOSPITAL	397	141	188	1,224.0
MEDSTAR HARBOR HOSPITAL	357	151	139	376.4
CARROLL HOSPITAL CENTER	353	158	198	929.2
CALVERT MEMORIAL HOSPITAL	413	175	170	216.2
DOCTORS' COMMUNITY HOSPITAL	410	176	218	683.8
SUBURBAN HOSPITAL	353	182	178	700.6
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	486	197	271	2,412.4
MEDSTAR SAINT MARY'S HOSPITAL	448	210	187	76.5
ADVENTIST HEALTHCARE WASHINGTON ADVENTIST HOSPITAL	434	226	173	526.6
PRINCE GEORGES HOSPITAL CENTER	587	303	181	148.9

Red highlighted cells denote ED Wait Times greater than the volume stratified national median (see table above)
Hospitals with greater than 1,000 Yellow Alert Hours in last 12 months are highlighted.

Emergency Department Efficiency Measures - By-Hospital
(Sorted by ED-2b Measure)

Lower values indicate greater efficiency.	ED-1b (in minutes)	ED-2b (in minutes)	OP-18b (in minutes)	Yellow Alert Diversion (in hours)
Hospital	Oct15-Sep16	Oct15-Sep16	Oct15-Sep16	Oct16-Sep17
VERY HIGH (Greater than 60,000)				
National Median for High Volume Hospitals	**332**	**130**	**172**	**N/A**
UNIVERSITY OF MD CHARLES REGIONAL MEDICAL CENTER	327	91	194	841.3
FREDERICK MEMORIAL HOSPITAL	335	108	Not Available	335.5
UNIVERSITY OF M D UPPER CHESAPEAKE MEDICAL CENTER	341	114	204	589.4
SAINT AGNES HOSPITAL	370	128	190	1,327.1
MERCY MEDICAL CENTER INC	362	130	152	1,107.7
PENINSULA REGIONAL MEDICAL CENTER	310	152	136	-
MEDSTAR UNION MEMORIAL HOSPITAL	368	154	187	1,098.7
ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER	380	166	170	1,020.0
MEDSTAR FRANKLIN SQUARE MEDICAL CENTER	463	175	262	957.5
MERITUS MEDICAL CENTER	374	185	207	677.7
UNIVERSITY OF MD BALTO WASHINGTON MEDICAL CENTER	431	202	244	728.8
HOWARD COUNTY GENERAL HOSPITAL	462	205	236	653.9
HOLY CROSS HOSPITAL	463	210	243	1,571.8
SINAI HOSPITAL OF BALTIMORE	610	239	287	1,530.8
JOHNS HOPKINS HOSPITAL, THE*	554	243	259	2,960.0
ANNE ARUNDEL MEDICAL CENTER	525	298	201	533.9
UNIVERSITY OF MARYLAND MEDICAL CENTER	662	326	226	2,192.3
UNCLASSIFIED				
HOLY CROSS GERMANTOWN HOSPITAL	448	218	186	364.1
LEVINDALE HEBREW GERIATRIC CENTER AND HOSPITAL	Not Available	Not Available	Not Available	-

National ED Wait Times by Volume	MD Hospitals Over National Median	MD Hospitals Over National Median	MD Hospitals Over National Median
Low	33.33%	33.33%	33.33%
Medium	88.89%	88.89%	55.56%
High	93.75%	81.25%	87.50%
Very High	88.24%	70.59%	82.35%

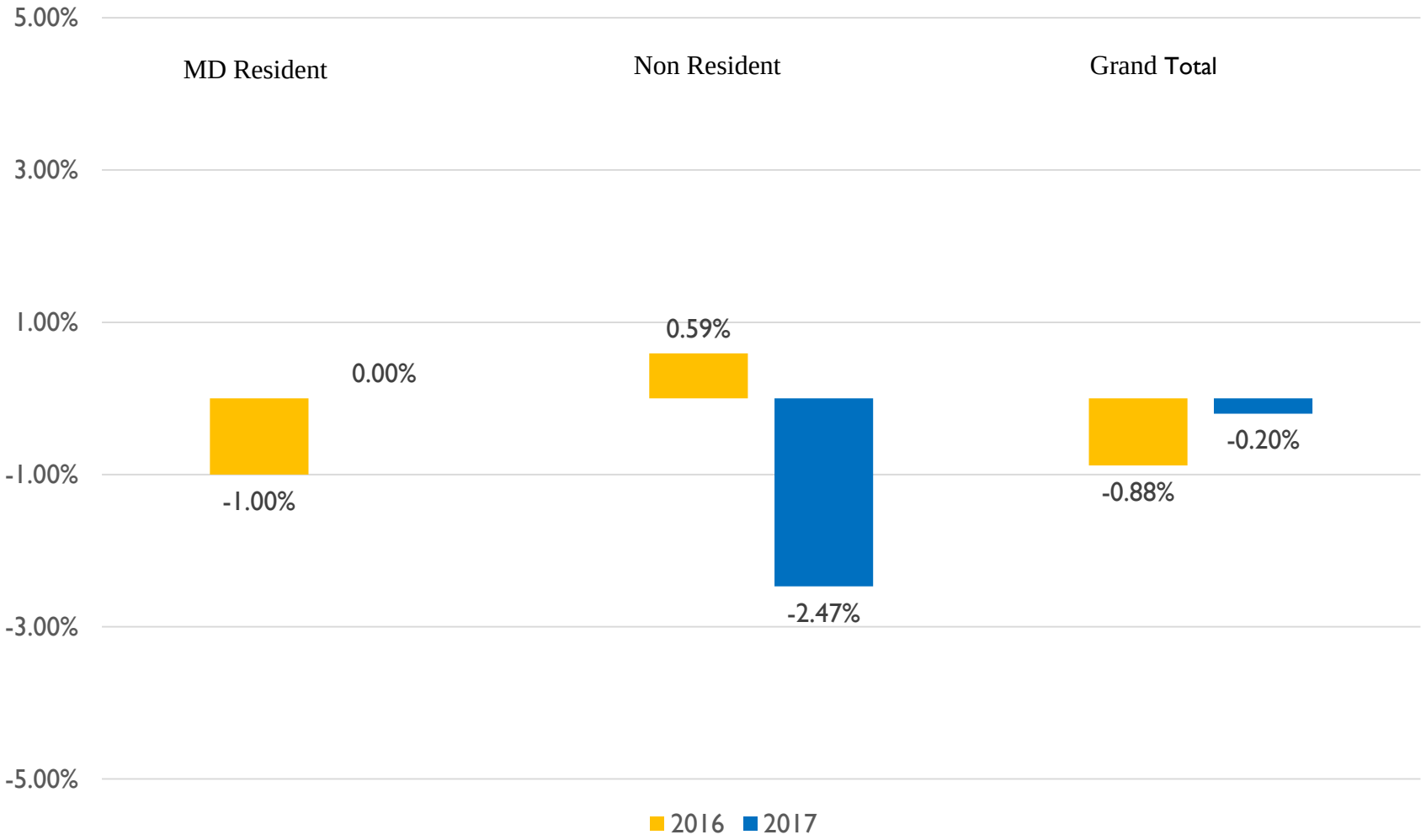
Red highlighted cells denote ED Wait Times greater than the volume stratified national median (see table above)
Hospitals with greater than 1,000 Yellow Alert Hours in last 12 months are highlighted.

Yellow Alerts By-Hospital Q317 compared to Q316				
Hospital	Q316	Q317	Simple Difference	%Change
MEDSTAR FRANKLIN SQUARE MEDICAL CENTER	906.41	18.69	-887.72	-97.9%
MEDSTAR UNION MEMORIAL HOSPITAL	505.47	169.9	-335.57	-66.4%
FREDERICK MEMORIAL HOSPITAL	383.97	52.05	-331.92	-86.4%
MEDSTAR GOOD SAMARITAN HOSPITAL	428.64	224.41	-204.23	-47.6%
ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER	338.17	181.17	-157	-46.4%
UNIVERSITY OF MD CHARLES REGIONAL MEDICAL CENTER	242.61	87.21	-155.4	-64.1%
ANNE ARUNDEL MEDICAL CENTER	175.92	22.08	-153.84	-87.4%
MERCY MEDICAL CENTER INC	368.58	225.22	-143.36	-38.9%
HOWARD COUNTY GENERAL HOSPITAL	214.91	74.51	-140.4	-65.3%
GREATER BALTIMORE MEDICAL CENTER	268.85	148.96	-119.89	-44.6%
ADVENTIST HEALTHCARE WASHINGTON ADVENTIST HOSPITAL	159.86	42.57	-117.29	-73.4%
MEDSTAR SAINT MARY'S HOSPITAL	122.4	5.31	-117.09	-95.7%
HOLY CROSS GERMANTOWN HOSPITAL	164.4	53	-111.4	-67.8%
LAUREL REGIONAL MEDICAL CENTER	115.81	20.95	-94.86	-81.9%
MEDSTAR HARBOR HOSPITAL	111.95	19.79	-92.16	-82.3%
UNIVERSITY OF MD BALTO WASHINGTON MEDICAL CENTER	160.14	70.06	-90.08	-56.3%
NORTHWEST HOSPITAL CENTER	183.14	110.78	-72.36	-39.5%
HOLY CROSS HOSPITAL	363.71	292.53	-71.18	-19.6%
JOHNS HOPKINS BAYVIEW MEDICAL CENTER	601.35	536.48	-64.87	-10.8%
BON SECOURS HOSPITAL	58.11	13.13	-44.98	-77.4%
MERITUS MEDICAL CENTER	56.57	27.72	-28.85	-51.0%
SUBURBAN HOSPITAL	108.08	80.22	-27.86	-25.8%
CALVERT MEMORIAL HOSPITAL	26.77	3.2	-23.57	-88.0%
PRINCE GEORGES HOSPITAL CENTER	29.84	11.58	-18.26	-61.2%
MEDSTAR MONTGOMERY MEDICAL CENTER	212.47	200.27	-12.2	-5.7%
UNIVERSITY OF MD SHORE MEDICAL CENTER AT DORCHESTER	9.97	3.51	-6.46	-64.8%
UNIVERSITY OF MD SHORE MEDICAL CTR AT CHESTERTOWN	25.56	21.61	-3.95	-15.5%
UNION HOSPITAL OF CECIL COUNTY	4.76	4.63	-0.13	-2.7%
GARRETT COUNTY MEMORIAL HOSPITAL	0	1.86	1.86	
FORT WASHINGTON HOSPITAL	21.36	23.89	2.53	11.8%
UNIVERSITY OF MD SHORE MEDICAL CENTER AT EASTON	34.02	37.7	3.68	10.8%
UNIVERSITY OF MARYLAND HARFORD MEMORIAL HOSPITAL	8.34	12.19	3.85	46.2%
UNIVERSITY OF M D UPPER CHESAPEAKE MEDICAL CENTER	77.71	82.1	4.39	5.6%
UNIVERSITY OF MD MEDICAL CENTER MIDTOWN CAMPUS	144.32	158.59	14.27	9.9%
SINAI HOSPITAL OF BALTIMORE	254.59	282.91	28.32	11.1%
CARROLL HOSPITAL CENTER	58.57	97.66	39.09	66.7%
DOCTORS' COMMUNITY HOSPITAL	65.47	114.25	48.78	74.5%
JOHNS HOPKINS HOSPITAL, THE	736.05	800.32	64.27	8.7%
MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER	150.76	218.07	67.31	44.6%
UNIVERSITY OF MARYLAND ST JOSEPH MEDICAL CENTER	193.8	269.45	75.65	39.0%
SAINT AGNES HOSPITAL	198.59	292.69	94.1	47.4%
UNIVERSITY OF MARYLAND MEDICAL CENTER	571.08	722.05	150.97	26.4%

Monitoring Maryland Performance
Preliminary Utilization Trends

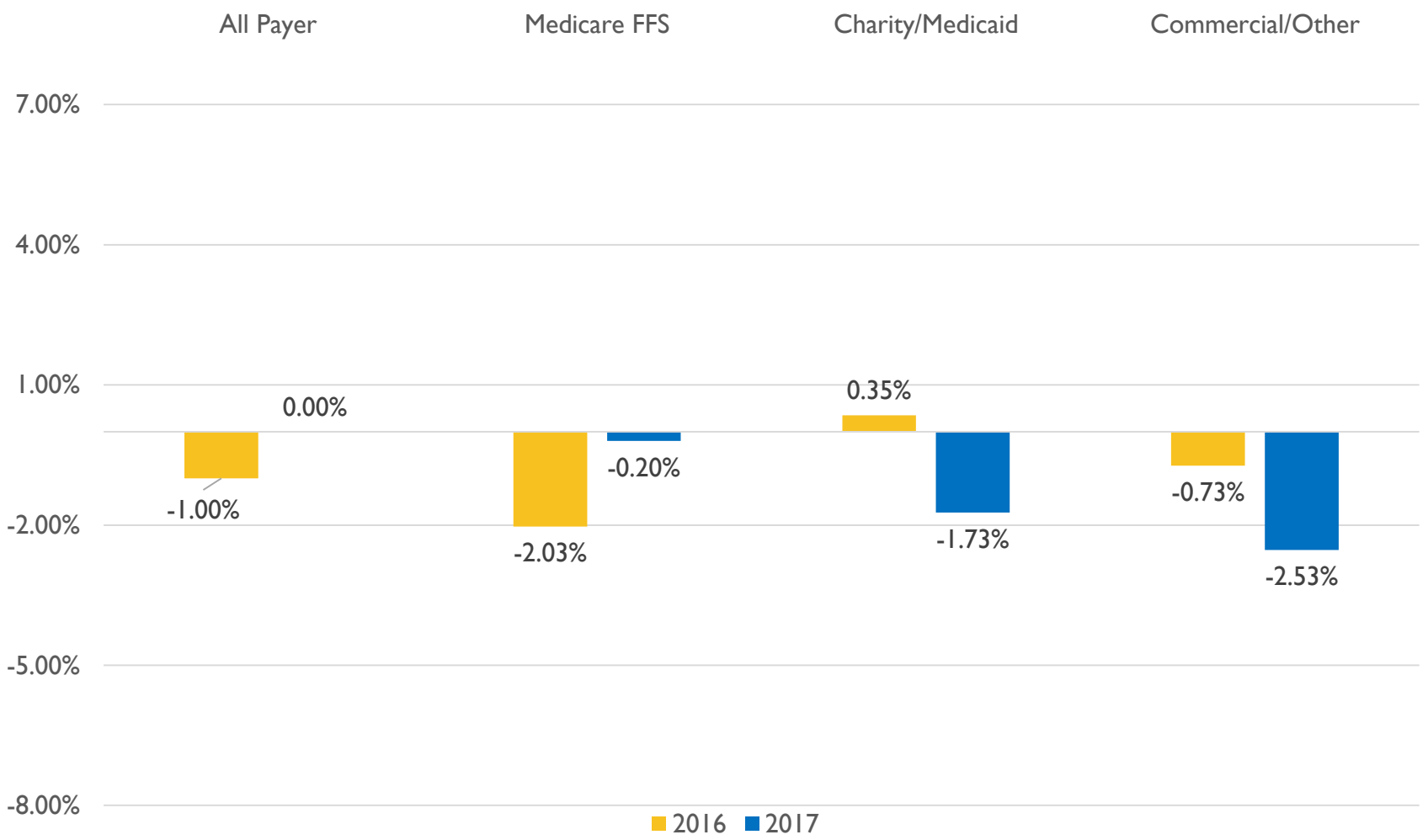
2017 vs 2016
(January to August)

All Payer ECMAD CYTD Annual Growth

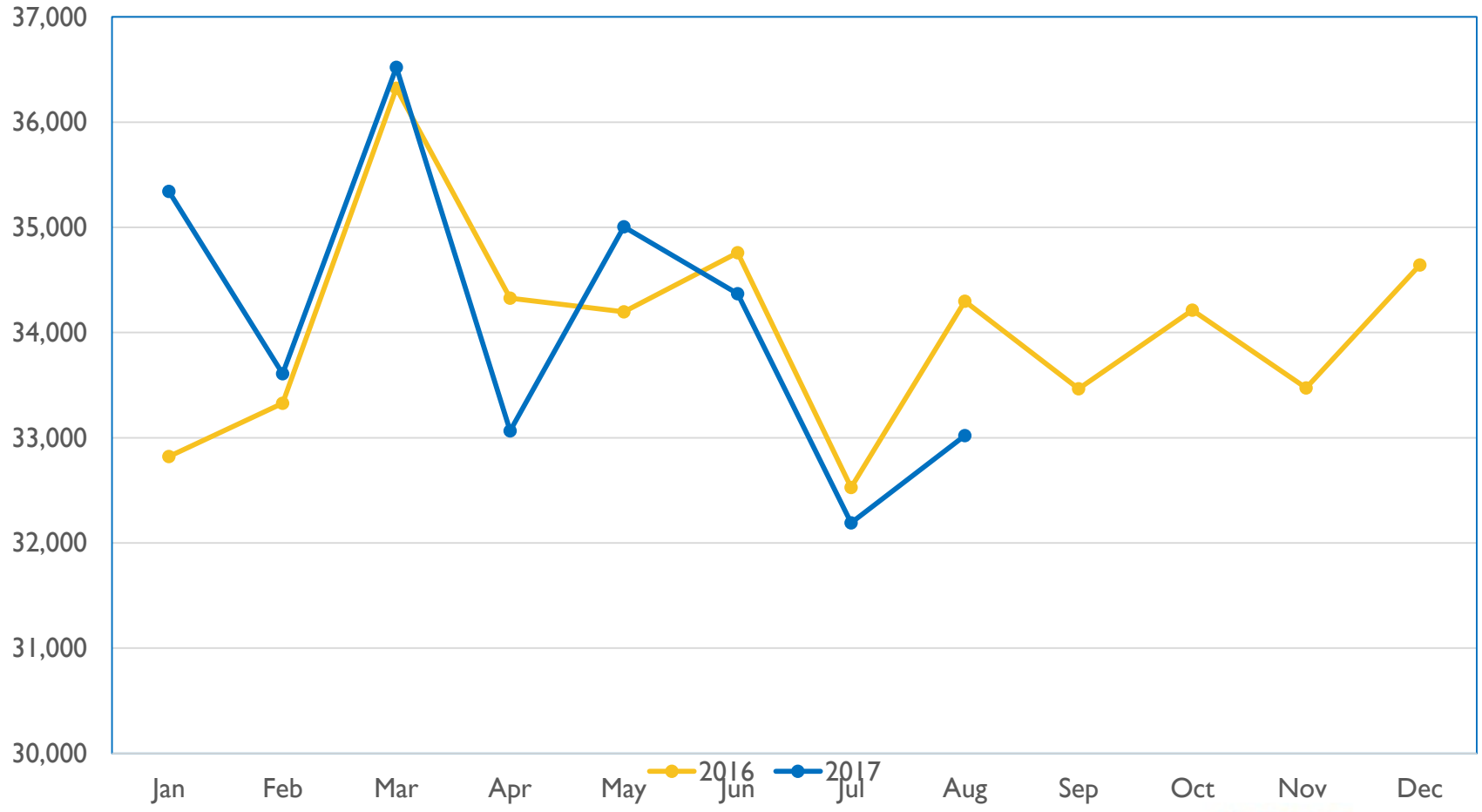


HSCRC
Health Services Cost Review Commission

MD Resident ECMAD CYTD Annual Growth

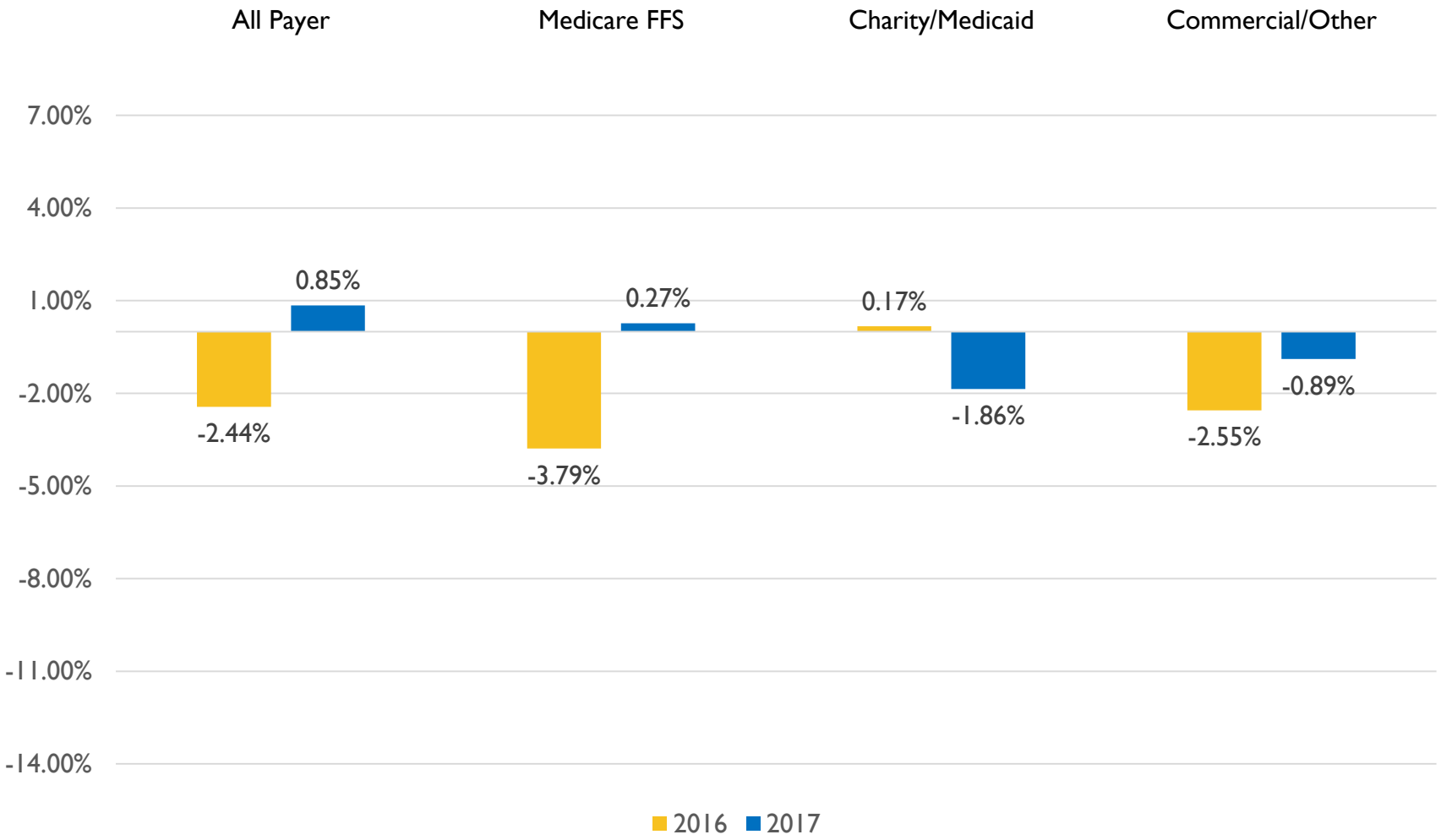


Medicare MD Resident ECMAD Annual Growth by Month



HSCRC
Health Services Cost Review Commission

MD Resident Inpatient ECMAD CYTD Annual Growth



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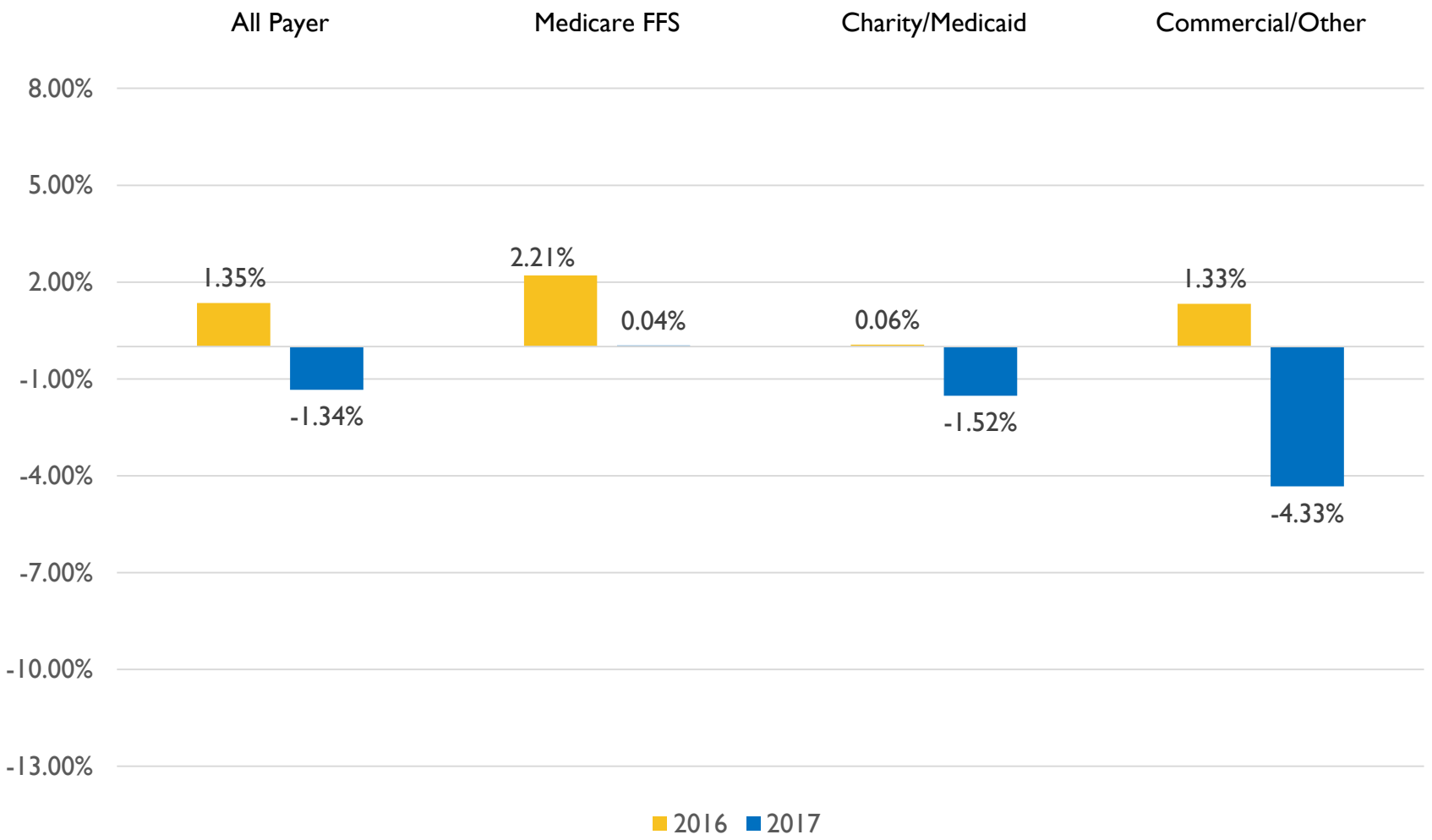
HSCRC
Health Services Cost Review Commission

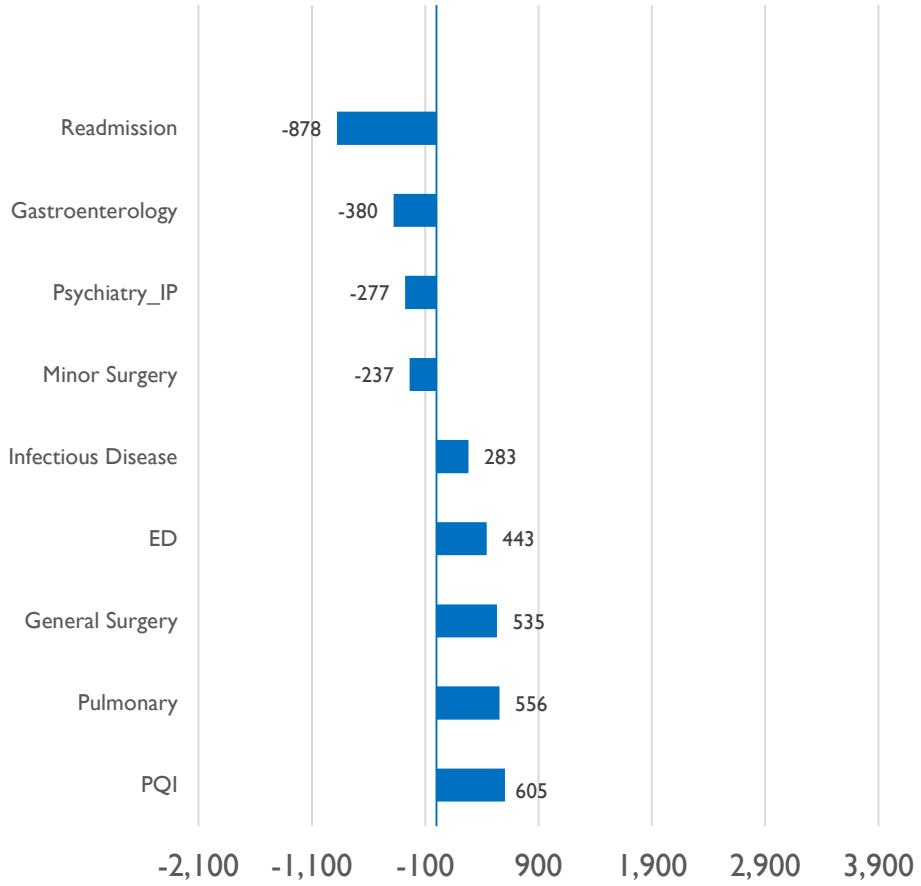
MD Resident Outpatient ECMAD CYTD Annual Growth

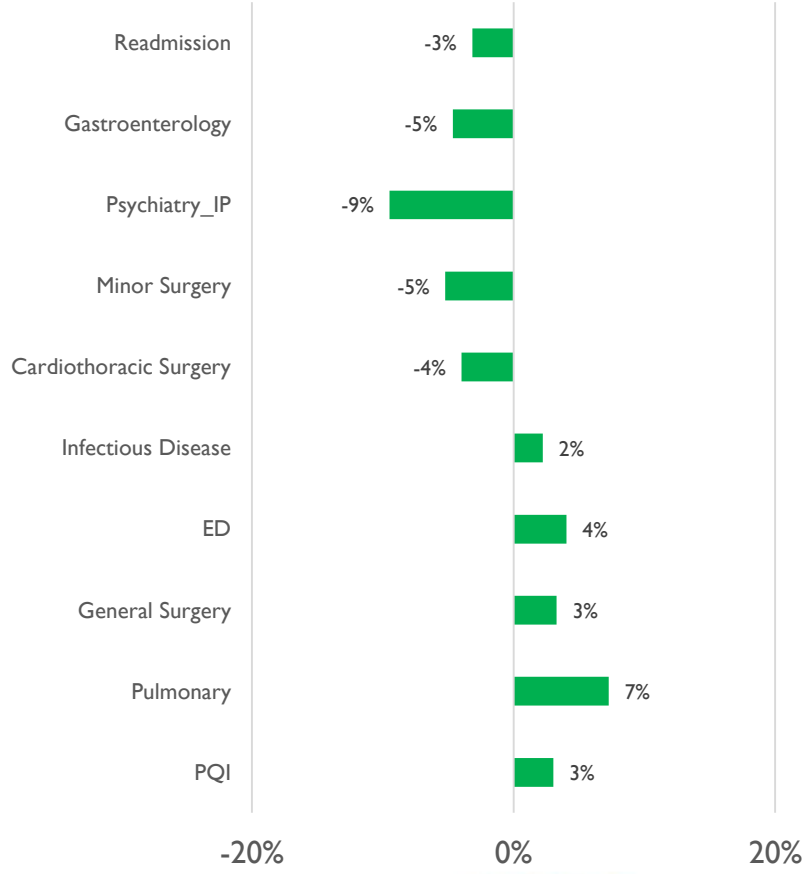


6

HSCRC
Health Services Cost Review Commission

Medicare MD Resident Top 5 Service Line Changes (Total ECMAD Increase = 540





HSCRC
Health Services Cost Review Commission

Utilization Analytics – Data Notes

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

Service Line Definitions

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

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF SEPTEMBER 28, 2017

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2398N	Univeristy of Maryland Midtown Campus	8/7/2017	10/11/2017	1/5/2018	Defniitive Observation	CK	OPEN
2399A	Priority Partners	8/28/2017	N/A	N/A	ARM	DNP	OPEN
2400A	University of Maryland Medical Center	9/15/2017	N/A	N/A	ARM	DNP	OPEN
2401A	MedStar Health	9/15/2017	N/A	N/A	ARM	DNP	OPEN
2402A	MedStar Medicare Choice	9/15/2017	N/A	N/A	ARM	DNP	OPEN
2403A	MedStar Family Choice	9/15/2017	N/A	N/A	ARM	DNP	OPEN
2404A	Hohns Hopkins Health System	9/28/2017	N/A	N/A	ARM	DNP	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:**	**2017**
MEDICAL CENTER	*****	**FOLIO:**	**2210**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2400A**

Staff Recommendation

October 11, 2017

I. INTRODUCTION

The University of Maryland Medical Center (the "Hospital") filed a renewal application with the HSCRC on September 15, 2017 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, 2017.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. (UPI), which is a subsidiary of the University of Maryland Medical System. UPI will 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

The staff found that the actual experience under this arrangement for the prior year has

been favorable.

VI. 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 for a one year period beginning November 1, 2017.

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**	
MEDSTAR HEALTH	*	**DOCKET:**	**2017**
	*	**FOLIO:**	**2211**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2401A**

Staff Recommendation

October 11, 2017

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on September 15, 2017 on behalf of Union Memorial Hospital (the "Hospital") to participate once again in an alternative method of rate determination, pursuant to COMAR 10.37.10.06 with the National Orthopedic & Spine Alliance. This same global rate arrangement for orthopedic and spinal services with the National Orthopedic & Spine Alliance arrangement was approved by the Commission at its February 10, 2016 public meeting for one year effective February 6, 2016 and was not renewed. MedStar Health now requests that the arrangement with National Orthopedic & Spine Alliance be approved for a one year period beginning November 1, 2017.

II. OVERVIEW OF APPLICATION

The contract will be held and administered by Helix Resources Management, Inc. ("HRMI"). HRMI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating the 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 submit bills to HRMI for all contracted and covered services. HRMI 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 HRMI and the Hospital holds the Hospital harmless from any shortfalls in payment from the

global price contract.

V. STAFF EVALUATION

There was no activity under this arrangement during its prior approval; however, staff still believes that the Hospital can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's request for participation in the alternative method of rate determination for orthopedic and spine services, for a one year period, commencing November 1, 2017. The Hospital will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
JOHNS HOPKINS HEALTH	*****	**DOCKET:**	**2017**
SYSTEM	*****	**FOLIO:**	**2214**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2404**

Staff Recommendation

October 11, 2017

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on September 28, 2017 on behalf of its member hospitals (the Hospitals), requesting approval to continue to participate in a global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplant services. The Hospitals request that the Commission approve the arrangement for one year beginning November 1, 2017.

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II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the 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 calculated for cases that exceed a specific length of stay outlier threshold were similarly adjusted.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

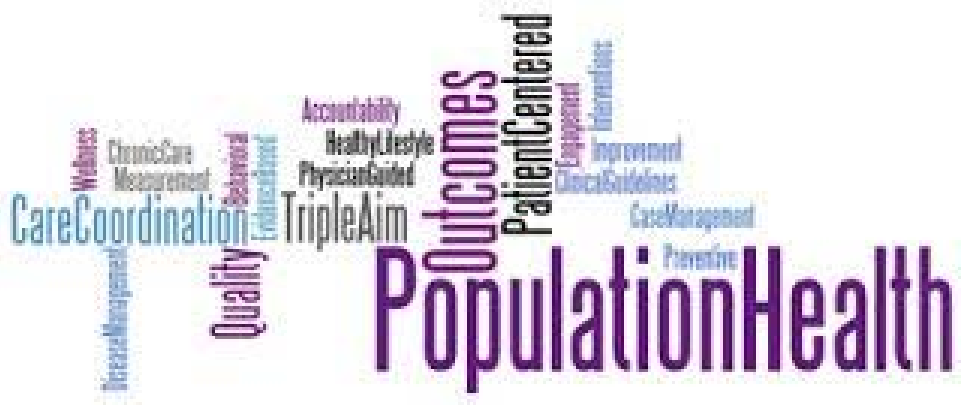
The staff found that the actual experience under this arrangement for the last year has

been favorable.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one year period beginning November 1, 2017. The Hospitals must file a renewal application annually for continued participation.

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



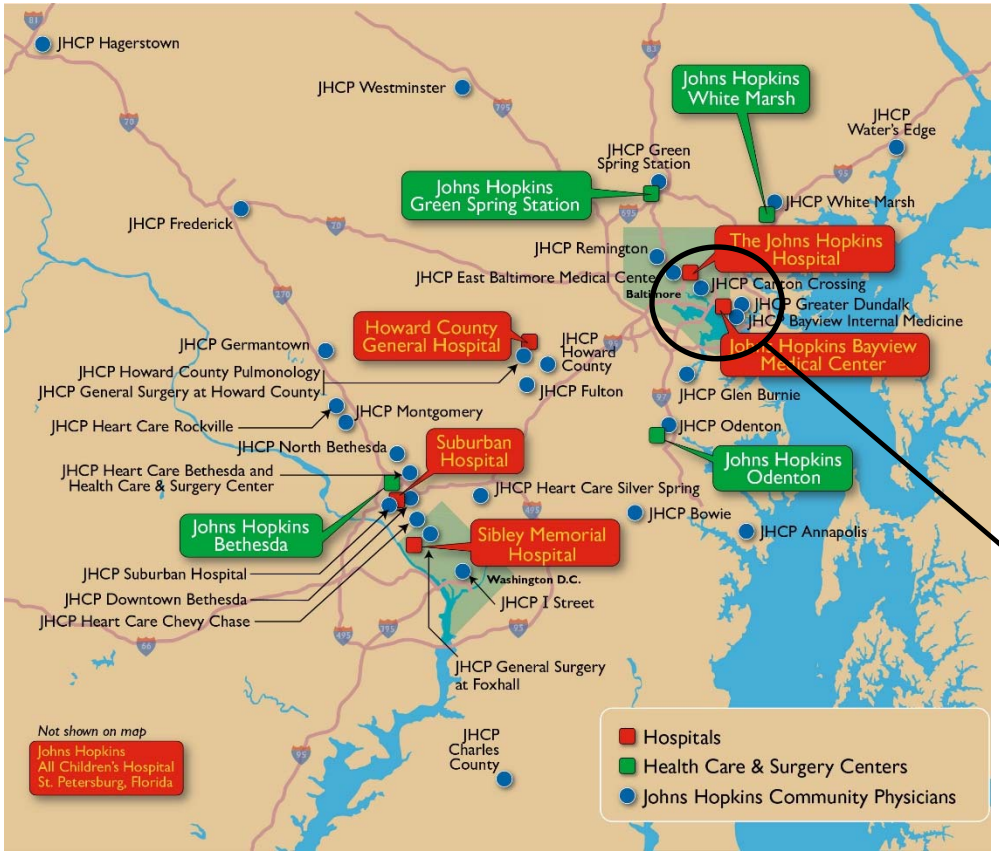
JOHNS HOPKINS
MEDICINE

Presentation to the HSCRC

From Episodic Acute Care to Population Health

Redonda Miller, M.D.
President, The Johns Hopkins Hospital

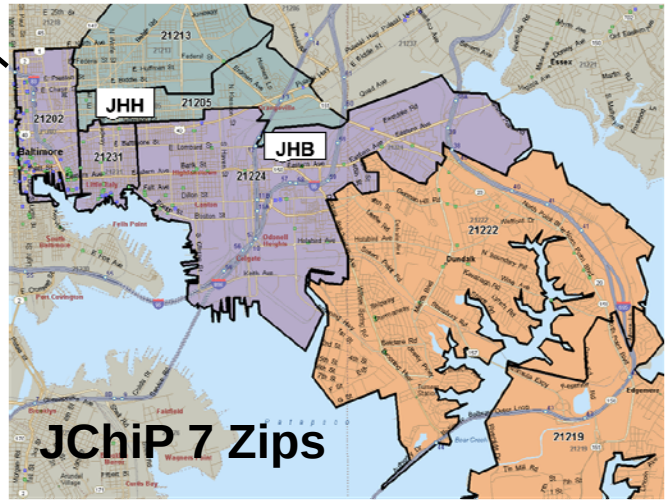
JHM: Who We Are and the Community We Serve



The Johns Hopkins Hospital

We are two hospitals:

- The Academic Medical Center that serves the state, the nation and the world; and
- The Community Hospital that serves East Baltimore



The Timeline for Change: *Care Delivery Redesign*

JOHNS HOPKINS MEDICINE

2009

Planning and Early Implementation of Care Coordination Bundle
(Pilot and Evaluation)

2012–2015

Expansion of Strategies
(CMMI Supplemental Funding)
JCHiP

2015–Present

Evolution to Population Health and Continuum of Care
(Supplemented by HSCRC (Investments)

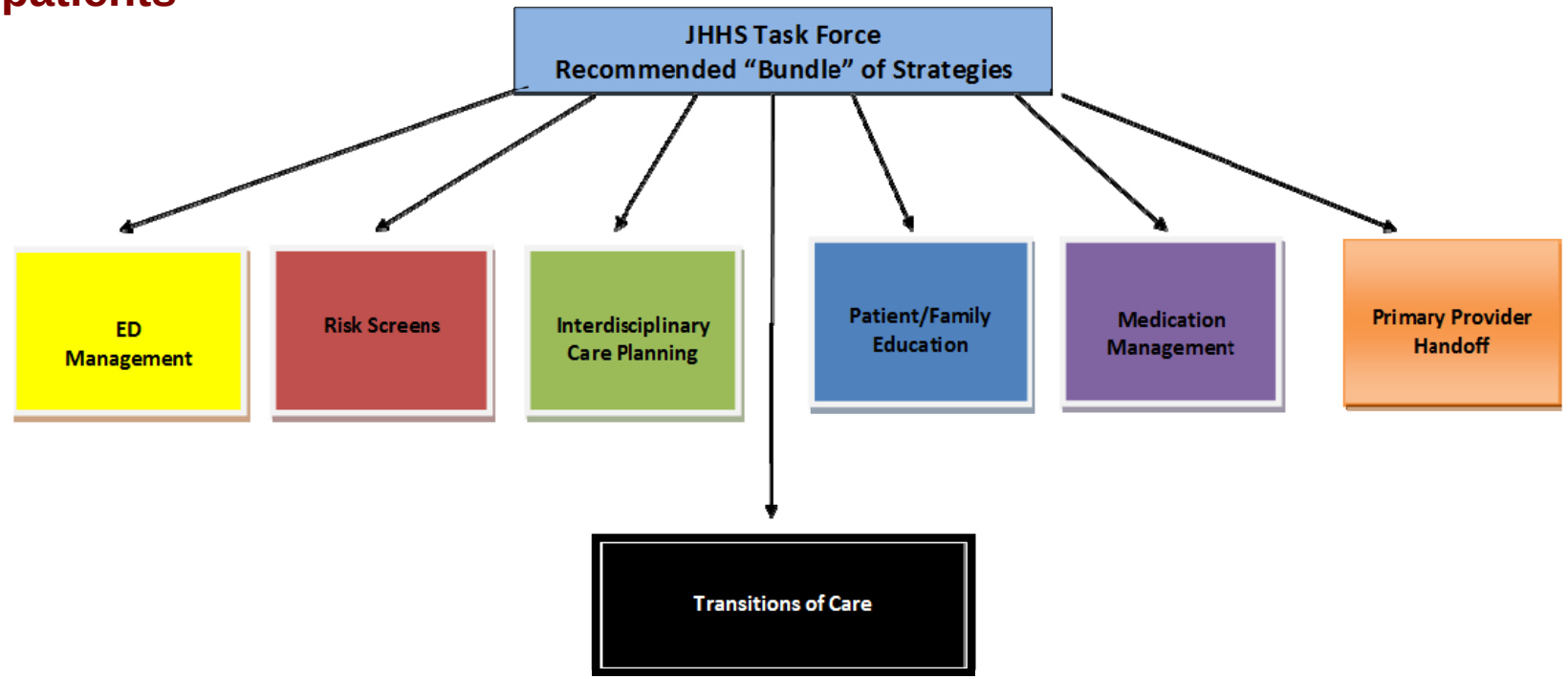



2009

Transforming JHHS Care Delivery: An Evidenced Based Model for Care Coordination

JOHNS HOPKINS MEDICINE

A *Trans-disciplinary* Care Coordination Model for ALL Hospitalized patients



Care Coordination Outcomes: Avoidable Hospitalization, Optimized Utilization, Patient Engagement, Clinical Outcomes

"Isolated interventions may have small effects… Bundled interventions may realize an additive effect or additional value through organizational or culture changes." ***"Interventions to Reduce 30-Day Rehospitalization: A Systematic Review:" (Annals of Internal Medicine, 10/2011)***

Care Coordination "Bundle"

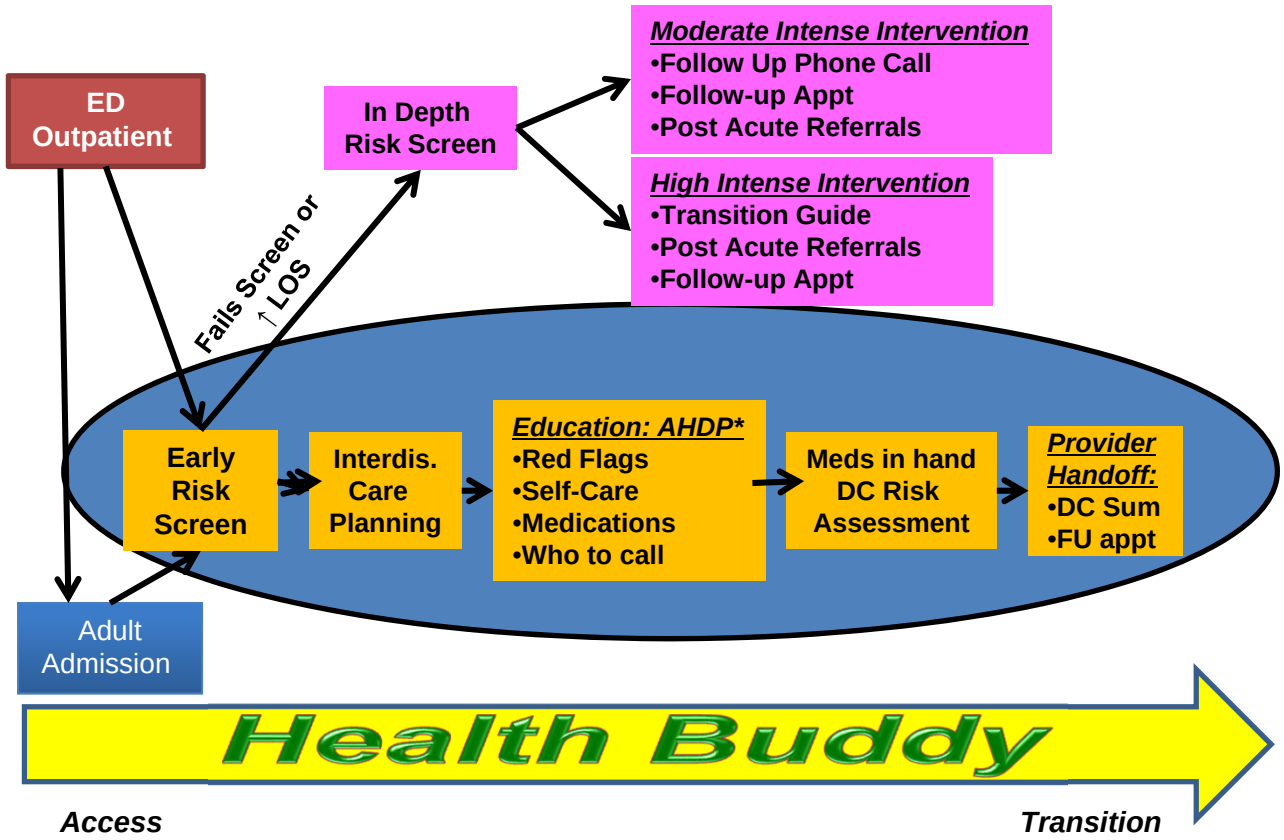
JOHNS HOPKINS MEDICINE

- ***ED Care Management***
  - ED Care Protocols
  - Increased obs services
  - 7day/week CM/SW care coordination
  - CHWs
- ***Risk screening—Early and periodic***
  - All adults—ESDP on Hospitalization
  - AMP: Functional Assessment
- ***Interdisciplinary care planning***
  - Multidisciplinary team-based rounds: every day, every patient
  - Mobility initiative
  - Projected discharge date on every patient
  - Quarterly readmissions review
- ***Patient family education***
  - JHM strategy for context specific education across continuum
  - Multiple technologies
  - After Hospital Discharge Plan: Focus on "pillars" *self-care management, medications, disease, and red flags*.
  - "Teach-back" competencies
  - Health literacy assessments
- ***Medication Management***
  - "Medications in hand" before discharge (high risk and new meds)
  - Medication reconciliation.
  - Pharmacist to Patient Education.
- ***Provider handoffs***
  - ***Provider communication on admission and DC***
  - Discharge summary within 5 days.
  - PCP follow-up within 7-14 days.
- ***Transitions of Care***
  - ***Appropriate post-acute referrals based on risk***
  - ***PAL***--Post Discharge phone calls.
  - Home visits (Transition Guides/Pharmacy).
  - "Bridge to Home" Health Buddy
  - Community Social Work
  - Follow up appointments prior to DC
  - ***After Care Clinic***

"Isolated interventions may have small effects… Bundled interventions may realize an additive effect or additional value through organizational or culture changes." ***"Interventions to Reduce 30-Day Rehospitalization: A Systematic Review:" (Annals of Internal Medicine, 10/2011)***

JHHS Model for Care Coordination

Implementing the Bundle:
Every Patient Every Day



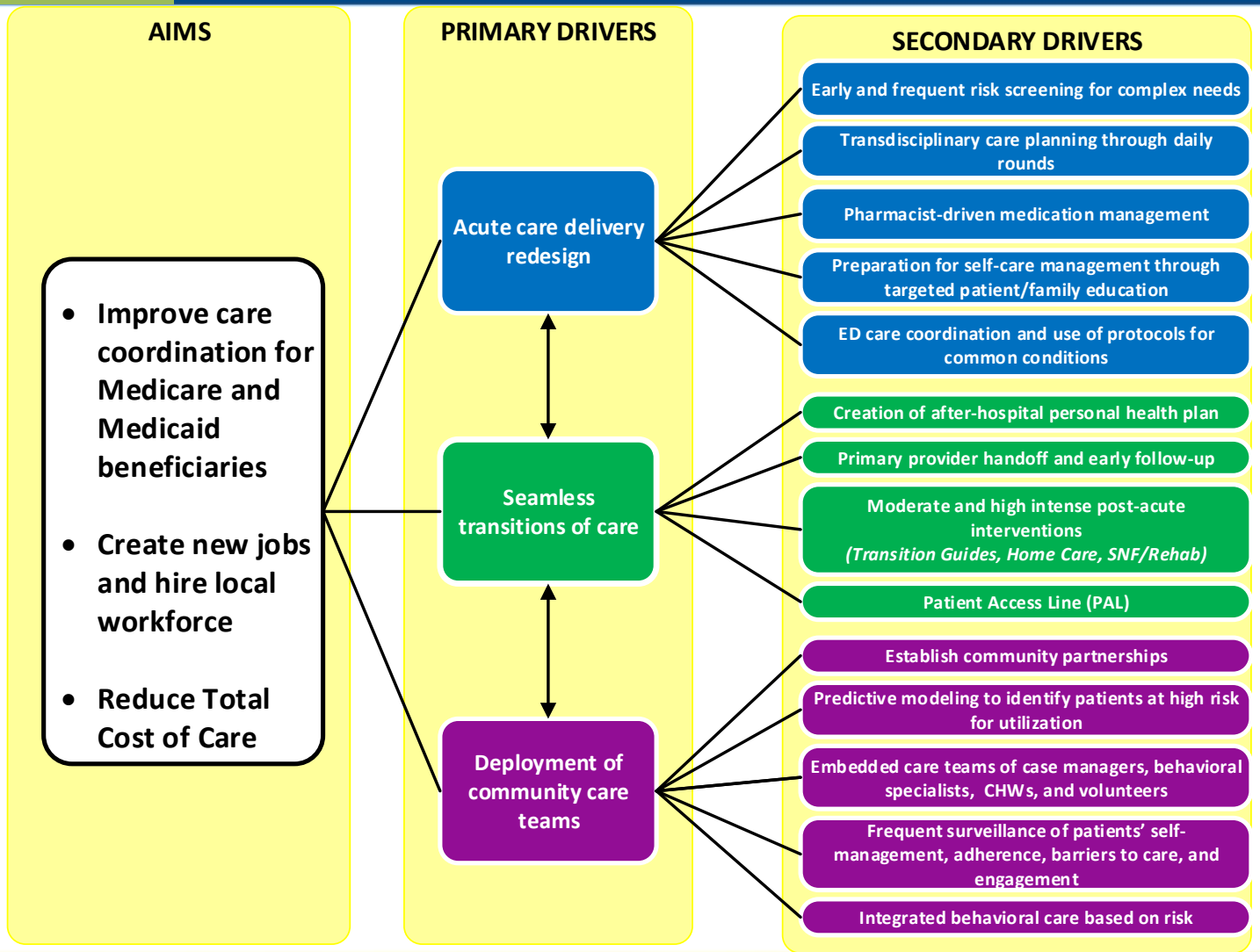
Of 27,208 Adult Inpatient Discharges:

- **72%** identified for complex discharge planning through screening
  - **81%** of patients require continued complex discharge planning
  - **77%** received targeted post-acute interventions

*After Hospital Discharge Plan

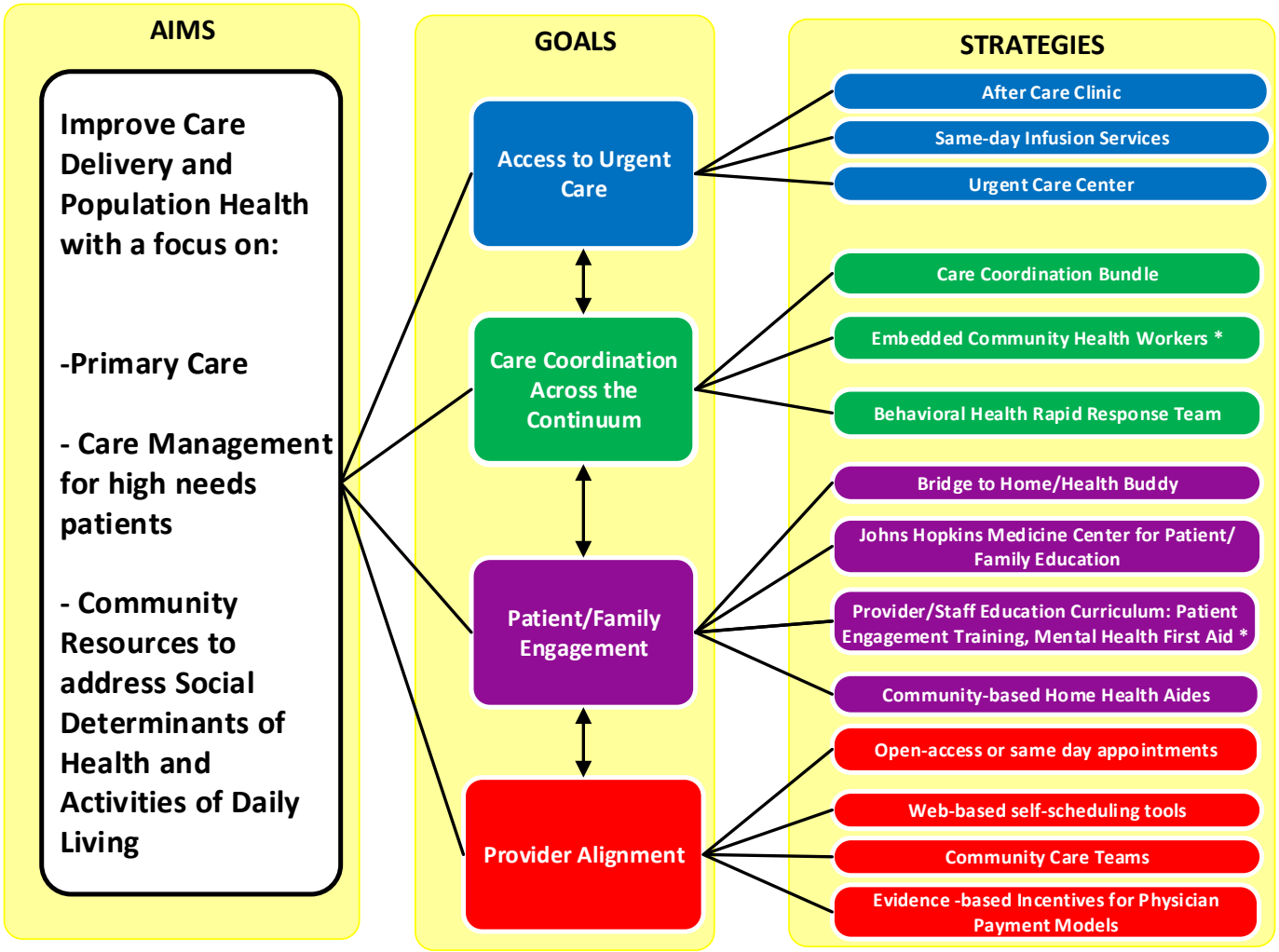
July 2012
to June 2015

CMMI: J-CHiP



July 2015
to present

HSCRC: Expanding the Bundle Through Strategic Plans and Investments



* Johns Hopkins Regional Partnership Initiative

Evolution to Population Health

Planning and Early Implementation of Care Coordination Bundle (Pilot and Evaluation)

2009

Acute/Post Acute
- Multi-D Rounds
- Screen for Complex DC Planning
- Unit based Pharm-Ds, Care Coordinators
- Ed Protocols
- Provider to Provider Communication
- Teachback Competencies

Community Based Care
- Nurse Transition Guides
- Health Community Partnership (Partnerships between faith communities and providers)

Expansion of Strategies (CMMI Supplemental Funding) JCHiP

2012--2015

Acute/Post Acute
- Multi-D Rounds Expansion
- Screen for Complex DC Planning all Adults
- Unit based Pharm-Ds
- New Unit Based Care Coordination Model (CMs/SWs)
- Interactive Pt/Family ED across continuum
- PAL—Post DC phone Calls
- DC Coordinators—Follow up appts
- Meds to home
- PET Training

Community Based Care
- Nurse Transition Guides Expansion
- SNF Initiatives
- Embedded Case Managers
- CHWs/Neighborhood Navigators
- Community Social Work
- Called to Care-Support to CareGivers
- Centro Sol—Healthcare equity for SE Latino community
- BREATHE—90 day transition program for COPD patients

Evolution to Population Health and Continuum of Care (Supplemented by HSCRC (Investments)

2015--Present

Acute/Post Acute
- Multi-D Rounds Expansion
- Screen for Complex DC Planning all Adults
- ED Protocol Expansion
- Unit based Pharm-Ds, CMS, SWs
- Evolution for JHM Strategy for Pt/Family ED across continuum
- PAL—Post DC phone Calls
- DC Coordinators
- Meds to home
- Nurse Transition Guides
- After Care Clinic
- Behavioral Health Intervention Teams
- HF NP in ED
- Infusion Expansion and New Center

Community Based Care
- Nurse Transition Guides Expansion
- JHHS SNF Collaborative
- Embedded Case Managers
- CHWs/Neighborhood Navigators
- Community Social Work
- Project Capable
- Jobs Program Implementation (CNA/GNA, CHWs, PRSs)
- ED/Acute screening and intervention for patients with addiction
- Telemedicine

*New Strategies Introduced

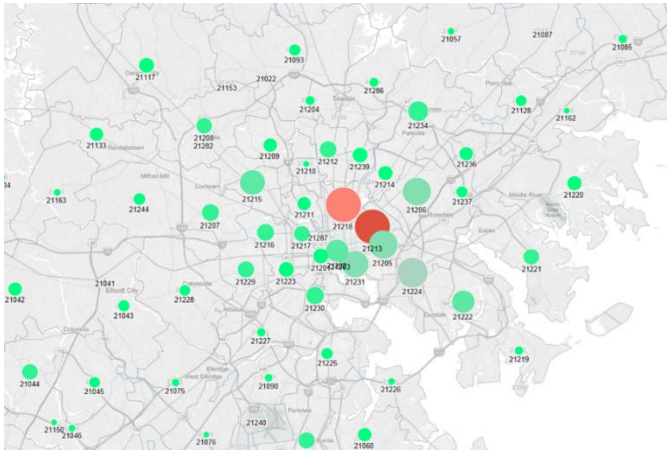
Program Evaluation: ***Everything We Do is Data Driven***

JOHNS HOPKINS MEDICINE

Effect of Comorbidities on Expected Readmission Rates

	Unadjusted Analysis		Adjusted Analysis	
CmbVars	OR (95% CI)	P value	OR ((95% CI)	P value
Valve Disease	1.58 (1.50-1.66)	<0.001	1.07 (1.01-1.13)	0.02
Pulm Circ Disease	2.04 (1.95-2.15)	<0.001	1.13 (1.07-1.19)	<0.001
PVD	1.65 (1.56-1.74)	<0.001	1.15 (1.08-1.22)	<0.001
HTN	1.62 (1.58-1.67)	<0.001	1.12 (1.08-1.16)	<0.001
Paralysis	1.37 (1.27-1.48)	<0.001	1.05 (0.96-1.14)	0.27
Other Neuro	1.34 (1.28-1.40)	<0.001	1.10 (1.05-1.16)	<0.001
Chronic Pulm Disease	1.49 (1.44-1.55)	<0.001	1.14 (1.10-1.19)	<0.001
Diabetes W/O CC	1.57 (1.51-1.63)	<0.001	1.21 (1.16-1.26)	<0.001
Diabetes W CC	2.10 (1.99-2.22)	<0.001	1.33 (1.25-1.40)	<0.001
Hypothyroid	1.41 (1.34-1.48)	<0.001	1.18 (1.12-1.24)	<0.001
Renal Failure	2.29 (2.20-2.38)	<0.001	1.31 (1.26-1.37)	<0.001
Liver Disease	2.13 (2.02-2.24)	<0.001	1.30 (1.23-1.37)	<0.001
PUD w/ Bleed	1.38 (0.62-2.76)	0.39	0.96 (0.43-1.96)	0.92
AIDs	2.39 (2.17-2.62)	<0.001	1.11 (1.00-1.23)	0.04
Cancer (Combined)	1.24 (1.19-1.30)	<0.001	1.16 (1.11-1.21)	<0.001
Rheum/CTD	1.35 (1.24-1.47)	<0.001	1.05 (0.97-1.15)	0.24
Coagulopathy	1.63 (1.54-1.73)	<0.001	0.99 (0.93-1.05)	0.78
Obesity	1.11 (1.06-1.16)	<0.001	1.09 (1.04-1.15)	<0.001
Wgt Loss	1.61 (1.49-1.74)	<0.001	1.02 (0.94-1.10)	0.70
Fluid/Electrolyte Disorder	1.85 (1.80-1.91)	<0.001	1.06 (1.03-1.10)	<0.001
Chronic Blood Loss Anemia	0.68 (0.61-0.77)	<0.001	0.99 (0.88-1.12)	0.93
Deficiency Anemia	1.90 (1.84-1.97)	<0.001	1.25 (1.21-1.30)	<0.001
ETOH/DU	1.50 (1.45-1.56)	<0.001	1.32 (1.26-1.38)	<0.001
Psych/Depr	1.49 (1.44-1.54)	<0.001	1.33 (1.28-1.38)	<0.001

Medicare Readmissions by Zip code

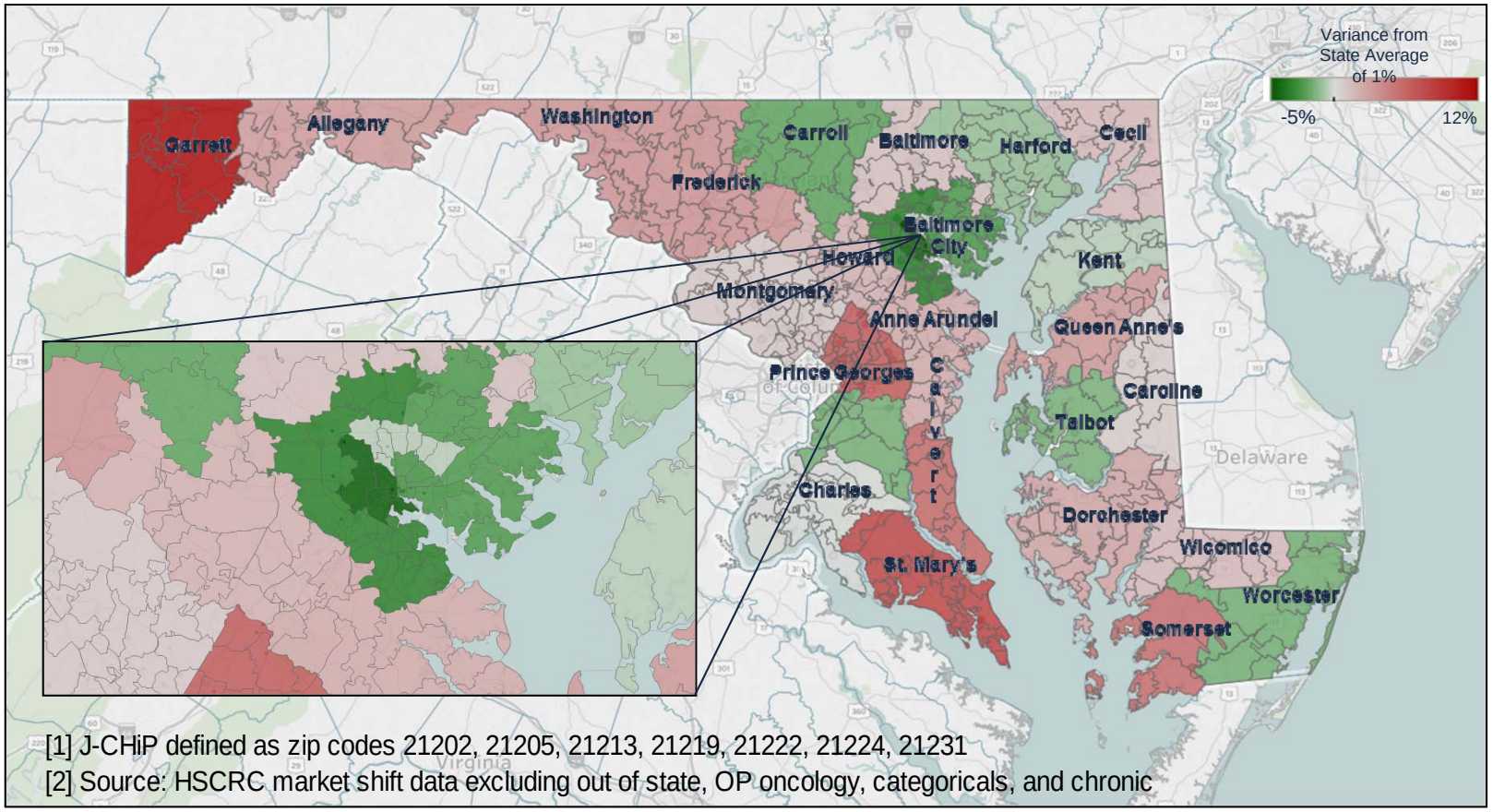


High Utilizers Identified--TABLEAU

RESULTS

Statewide Utilization Change and JCHiP Zip Codes: *FY2014 to CY2016*

Since GBR (FY2014), hospital utilization in the J-CHiP area has declined by **2.15%** compared to statewide growth of **0.89%**



[1] J-CHiP defined as zip codes 21202, 21205, 21213, 21219, 21222, 21224, 21231

[2] Source: HSCRC market shift data excluding out of state, OP oncology, categoricals, and chronic

JCHiP Total Cost of Care Savings by CMMI Awardee: NORC Evaluation

JCHiP Hospital Intervention

Total: $89,000,000

- Highest aggregate cost savings for Medicaid and Medicare compared to all awardees with statistically significant findings

JCHiP Community Intervention

Total: $29,000,000

- 3rd highest savings in Medicaid (after JCHiP Hospital)

Outcome Measure	Medicaid Beneficiaries (N=13,921)	Medicare Beneficiaries (N=26,144)
Total Cost of Care Savings	**$59.8M Saved** **$4,295 Saved per Hospitalization**	**$29.2M Saved** **$1,115 Saved per Hospitalization**

Exhibit ES.5: Aggregate Total Cost of Care for Awardees with Statistically Significant Findings, by Awardee

NOTES: Aggregate cost savings for J-CHiP Hospital Medicare not shown to scale.

JHH: Other Global Outcomes of Care Coordination

Readmissions:

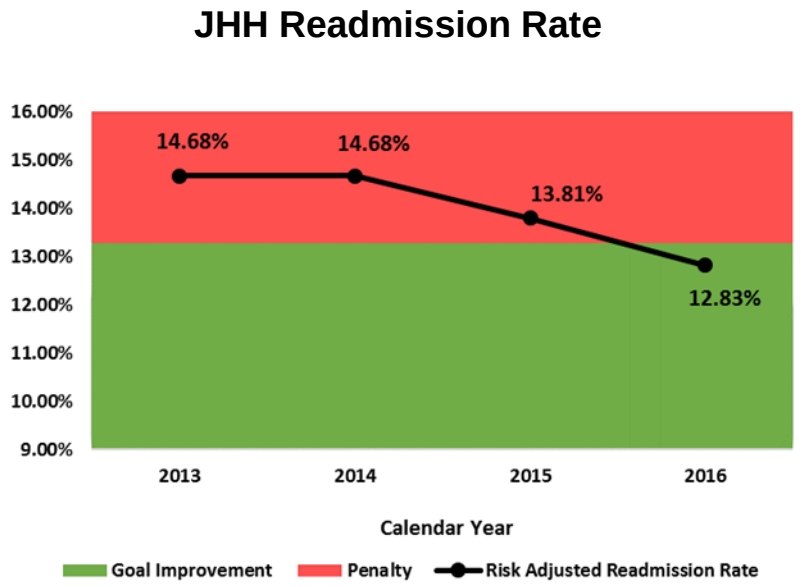
- **JHH 12.66 % Reduction** (exceeded target of 9.5%)

PAU % Cost Reduction

- **JHH -5.54%**
  (compared to state -2.94%)

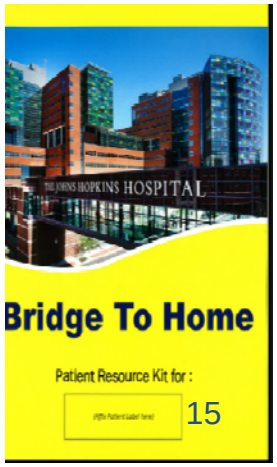
HCAHPS: *Patient Satisfaction*

- **Care Transitions Measure**: **Top box 64%** (compared to national mean of 51%)
- **Discharge Information**: **Top box 91%** (compared to national mean of 87%)



Our Experience: Interventions with Promise

- PAL (Patient Access Line)
- Transitions Guides
- After Care Clinic
- Mobility Initiative
- Medications for Home
- Bridge to Home: Health Buddy
- JHM Center for Education
- Behavioral Health Intervention Teams
- Timely Discharge Instructions
- Project Capable
- Oncology Urgent Care
- Ambulatory Infusion



Interventions with Promise: Outcomes Evaluation

Patient Access Line (PAL) Post DC phone calls to reinforce self-care management and post acute referrals	**N=20,500** over 3 years. Those who did not get connected with PAL had a 45% increased odds of readmission. **29.7% relative reduction** in readmissions
Transitions Guides Assist patients/caregivers in the home with post discharge self-care management	**N=8,300** over 3 years. Those who did not get converted for TG services had a 91% increased odds of readmission. **41.4%** relative reduction in readmissions
After Care Clinic Safety net for patients discharged from Hospital or ED who need rapid follow-up but cannot secure timely appointments	**N=3,700** over 2 years. Reduced ED visits and hospitalizations. **Avoided 87 potential hospitalizations and 491 ED visits**
Activity Mobility Promotion Interventions to increase functional status through early assessment and mobility	Patients ambulating increased from **43%-70%.** LOS decreases by 1.1 days in patients with ELOS >7 days. Decreased inappropriate PT/OT referrals
Meds for Home Expedited authorizations for discharge medications and provision of bedside delivery of filled prescriptions	**N=14,430** patients served. 18% provided medication vouchers to lower costs to patients
Urgent Care: Ambulatory Infusion/Sickle Cell Broadened ambulatory infusion operations to accommodate patients requiring same-day urgent and after hours appointments	New infusion center opened May 2017. **Increased volumes for urgent, same day treatments by 46%**. **Sickle Cell:** Largest volume **(550 adults)** in state (**increased by 34%, 2459 visits**). Decreased ED visits, admissions and readmissions compared to nation.
Behavioral Health Intervention Team Early screen and proactive intervention for all Medicine admissions.	**N= 3,812** patients served. Expanded access to consult services to medical patients and **lowered LOS by 1.24** days compared to traditional psych consult service. Linked to community resources.

JHH: Academic Innovation for Better Health, Better Care, Lower Cost

- **Clinical Communities**
  - JHM clinical teams focused on clinical effectiveness, variance analysis, and care standardization (25 Communities)

- **Agile MD Software**
  - Decision support tool to facilitate evidenced based evaluation and treatment in the ED
- **Johns Hopkins "in Health"**
  - Individualized health through ***precision medicine*** approaches resulting in quicker diagnoses, improved treatment and better outcomes.
- **High Value Practice: Academic Alliance**
  - "Choosing Wisely"--Value improvement strategies to reduce wasteful practice (unnecessary diagnostics, transfusions, meds, and procedures, etc.)
- **Telemedicine**
  - 32 initiatives from remote clinic visits to in home consultation all embedded in our EHR
- **"Apps" to support patient/family engagement**
  - Development of decision support and self-care management tools for patients and families.

Care Coordination: Advancing The Science

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- Hoyer EH, Brotman DJ, Apfel A, Leung C, Boonyasai RT, Richardson M, Lepley D, Deutschendorf A. **Improving Outcomes after Hospitalization: A Prospective Observational Multi-Center Evaluation of Care-Coordination Strategies on 30-day Readmissions to Maryland Hospitals.** *Journal of General Internal Medicine*. 2017 (in press)
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- Hoyer, E. H., Needham, D. M., Miller, J., Deutschendorf, A., Friedman, M., & Brotman, D. J. (2013). **Functional status impairment is associated with unplanned readmissions.** *Archives of Physical Medicine and Rehabilitation*.
- Hoyer, E. H., Odonkor, C. A., Bhatia, S. N., Leung, C., Deutschendorf, A., & Brotman, D. J. (2016). **Association between days to complete inpatient discharge summaries with all-payer hospital readmissions in Maryland.** *Journal of Hospital Medicine*.
- Oduyebo, I., Lehmann, C. U., Pollack, C. E., Durkin, N., Miller, J. D., Mandell, S., … Brotman, D. J. (2013). **Association of self-reported hospital discharge handoffs with 30-day readmissions.** *JAMA Internal Medicine*.
- Pherson, E. C., Shermock, K. M., Efird, L. E., Gilmore, V. T., Nesbit, T., Leblanc, Y., … Swarthout, M. D. (2014). **Development and implementation of a postdischarge home-based medication management service.** *American Journal of Health-System Pharmacy*.
- Wilbur, M. B., Mannschreck, D. B., Angarita, A. M., Matsuno, R. K., Tanner, E. J., Stone, R. L., … Fader, A. N. (2016). **Unplanned 30-day hospital readmission as a quality measure in gynecologic oncology**. *Gynecologic Oncology*.

And Wait…

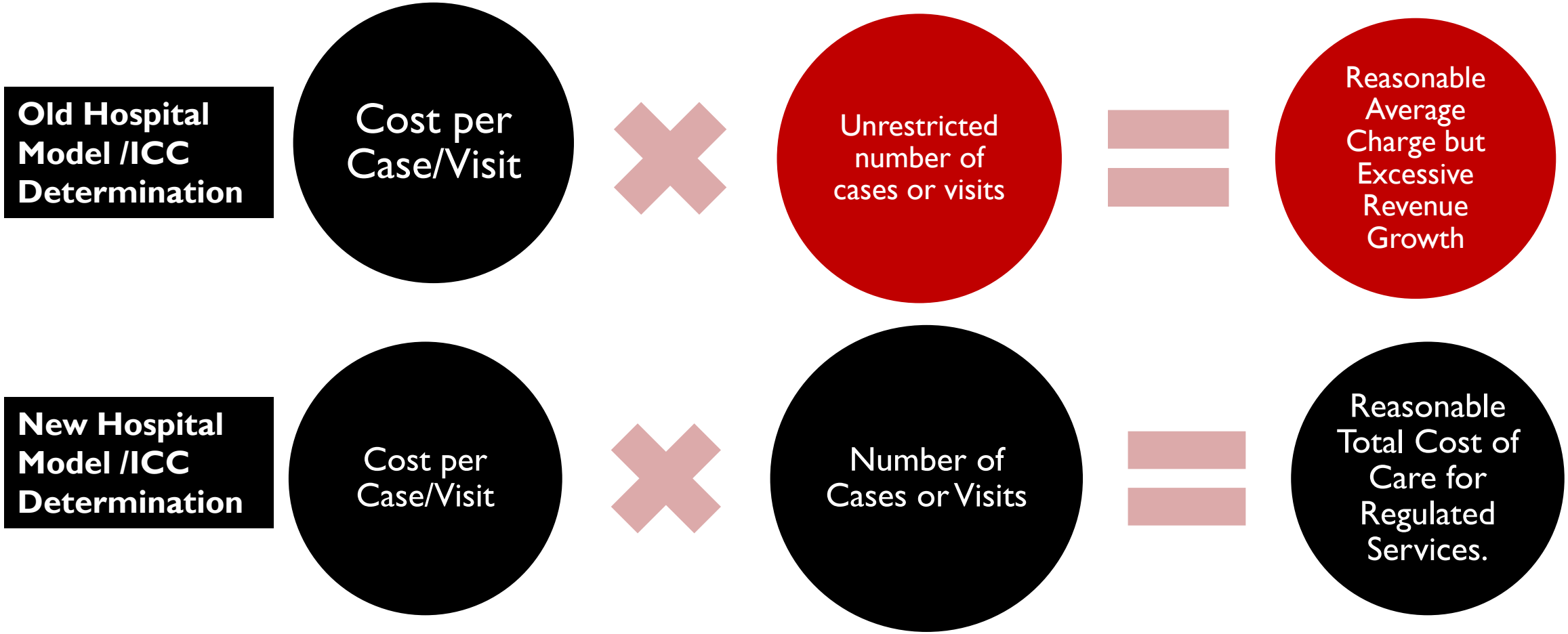
- There's more:
  - Johns Hopkins Medicine Alliance for Patients (JMAP): Our ACO
  - JHM SNF Collaborative
  - Community Health Partnership of Maryland (Regional Partnership)

Draft Update to the Inter-hospital Cost Comparison

October 11, 2017

Concept

- An updated evaluation of efficient and effective care must consider cost per case as well as appropriate level of volume.



HSCRC
Health Services Cost Review Commission

Introduction

- Historical rate review methodologies focused on cost per case in keeping with the Medicare waiver requirements to constrain growth in inpatient payments per case
  - Reasonableness of Charges (ROC)
  - Interhospital Cost Comparison (ICC)

- In January 2014, Maryland implemented a new All-Payer Model that focused on total hospital spending per capita
  - Total hospital revenue per capita vs. charges per case

- Draft policy recommendation updates the full rate review process consistent with the new Model
  - Inter-hospital Cost Comparison (ICC) methodology (charge-per-case/visit efficiency)
  - Utilization efficiency and effectiveness
  - Total regulated hospital cost of care and efficiency

Background

- In 2011, the Reasonableness of Charges (ROC) methodology, which was used to "scale" hospitals' approved charge-per-case, was suspended.
  - Commission wanted to encourage hospitals to reduce unnecessary utilization
- Inter-hospital Cost Comparison (ICC), a derivative methodology of the ROC, continued to be used for:
  - Full rate reviews
  - Partial rate applications for capital
- In November 2015, the HSCRC suspended full rate reviews to allow for evolution of rate review methodologies
  - Moratorium expires October 31, 2017

What is the ICC?

- The ICC is a comparison of hospital costs per case/visit to peer hospitals.

- The ICC has been used for decades to evaluate:
  - Reasonableness of hospital costs
  - Hospital efficiency relative to peer hospitals

- Evolution over time
  - Per unit
  - Per inpatient case
  - Per hospital case/visit
  - NOW part of the picture for total cost of hospital care per capita

Avoidable and unnecessary utilization

- Avoidable and unnecessary care
  - Care that could eliminated without reducing quality or outcomes
  - Care that could be avoided through improved quality, care coordination, and chronic care management

- Approximately 30% of healthcare expenditures according to many estimates, including the Institute of Medicine
  - HSCRC captures some of these expenditures with MHAC, Readmissions, and PQIs
  - But there is more unnecessary and avoidable care not captured by these measures

- Failure to address avoidable utilization will result in:
  - Increasing healthcare costs for individuals, companies and government
  - Reduced profitability for hospitals in a per capita/global system
  - Reduced funding for new innovation (e.g. less money for new drugs/interventions/prevention)
  - Possible loss of the MD All-Payer demonstration

Overview of ICC Cost Comparison Approach

- The ICC has five principal steps:

1) Calculate approved permanent revenue for included cases.
    1) Excludes the hospital revenues for one-time temporary adjustments and assessments and certain "cycle-billed" cases.

2) Adjust permanent revenue for:
    1) Social goods (e.g. medical education costs)
    2) Costs beyond a hospital's control (e.g. labor market areas as well as markup on costs to cover uncompensated care and payer differential).

3) Hospitals are divided into peer groups for comparison
    1) There are 4 peer groups including Non-Urban Teaching, Suburban/Rural Non-Teaching, Urban Hospitals, Academic Medical Centers

4) For full rate reviews there are two additional steps to convert revenues to cost.
    1) Remove profits from regulated services from the adjusted revenues.
    2) Assess a productivity adjustment to the costs.

5) Reverse Steps 1 and 2 and build back revenue from the peer group standard.

How is the ICC different from Earlier Iterations?

- Indirect Medical Education
  - Prior results for RY2011 are trended forward
- Labor Market Adjustment
  - Hospitals are grouped primarily into two regions (Prince George's and Montgomery counties & the Rest of the State), except for some rural/border hospitals

Capital Adjustment
  - Completed phase out

- Disproportionate Share Hospital (DSH) Adjustment
  - Discontinued the use of DSH due to:
    - Not justified by calculations of risk adjusted cost-per-case within hospital
    - Medicaid expansion
    - Uncompensated Care financing through pool
    - All-Payer Model does not pay below cost for Medicaid/Medicare

How is the ICC different from Earlier Iterations? (cont.)

- Outpatient Drug Overhead
  - Include the overhead associated with drug charges not in the ICC
- Productivity Adjustment
  - Excess Capacity as measured by reduction in patient days from 2010 to 2017
    - Prior adjustments were a uniform 2% reduction
- Total Approved Revenue
  - Additional analysis to focus on avoidable and unnecessary use
  - Focus on total cost of care and utilization for regulated services, not just cost-per-case

Recommendations

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

2) Seek input from Technical Review Group of proposed modifications to the Interhospital Cost Comparison.

3) Consider expansion of claims data submissions from hospitals for outpatient hospital claims that are "cycle billing claims."

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

October 11, 2017

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

This document contains the draft staff recommendations for updating the Inter-hospital Cost Comparison Tool for consideration at the October 11, 2017 Commission meeting. Please submit comments on the draft to the Commission by Tuesday, October 31, 2017 via hard copy mail or e-mail to allani.pack@maryland.gov.

Table of Contents

LIST OF ABBREVIATIONS

ACA	Affordable Care Act
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis-related group
FY	Fiscal year
FFY	Federal fiscal year
HSCRC	Health Services Cost Review Commission
QBR	Quality-based reimbursement
RY	Maryland HSCRC Rate Year
VBP	Value-based purchasing

INTRODUCTION

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

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

BACKGROUND

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

While the ROC was suspended in 2011, a derivative methodology, referred to as Inter-hospital Cost Comparison or "ICC", continued to be used for full rate reviews and partial rate

applications for capital. In November 2015, the HSCRC suspended full rate reviews to allow for evolution of the review methodologies, while retaining several avenues to adjust hospitals' global budgets through Global Budget Revenue (GBR) Agreements, emergency adjustments, and partial rate applications for large capital projects.

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

ASSESSMENT

Efficiency in the Context of Per Capita Costs

Affordability

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

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

- Per capita healthcare spending increased by nearly 40 percent over the decade 2006 through 2015.
- Healthcare spending now accounts for 28 percent of median personal income, based on 2015 figures.
- Hospital care contributed to 43 percent of the cost increase from 2006 through 2015.
- Out of pocket spending plus premiums for employer-based PPO coverage rose 73 percent during the decade from $15,609 for a family of four in 2008 to $26,944 for a family of

four in 2017, with employees bearing an increasing proportion of costs directly through a combination of employee contribution to premium and out-of-pocket spending.

- Medicare spending has risen 58 percent and Medicaid spending has risen 72 percent for the decade ended in 2015.

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

Context of Rate Setting in a Per Capita System

Under the historic charge-per-case system construct of Maryland's Medicare waiver in place from 1977 through 2013, the focus of the regulatory system and therefore the related full rate review was in constraining the growth and ensuring the reasonableness of cost per case or per visit. Congress, through the bi-partisan MACRA legislation as well as the ACA, has focused on high value care as efficient delivery of high-quality, evidence-based, patient-centered care. The Maryland All-Payer Model Agreement approved by CMS in 2014 under federal demonstration authority, relies on this definition of efficiency and value. The HSCRC's statute requires it to approve rates that are sufficient to allow hospitals to provide "efficient and effective" care. Potentially avoidable care—i.e., care that results from healthcare acquired conditions, from poor coordination, from inadequate condition management as well as unnecessary care—i.e., care that is rarely useful; care that is sometimes useful and needed but often overused; care that is needed and effective that could be provided in lower cost settings; and care that can be avoided with better community interventions—does not meet the standard of efficiency and effectiveness.

Higher cost and cost variation per case, per visit, or per episode continues to be important factors in excessive spending and the HSCRC will need to continue focusing on efficiency in this context. For ease of understanding, this analysis will refer to this as price efficiency. The Inter-hospital Cost Comparison (ICC) is a construct that HSCRC historically has used to evaluate price efficiency. The HSCRC staff propose that the Commission continue to use this tool as part of evaluating efficiency in the context of a full rate review. The HSCRC staff is proposing updates to the ICC methodology for review with this recommendation.

While higher cost per service and episode contribute to excessive spending, clinical waste also contributes to inefficient costs and poor outcomes. Clinical "waste" consists of care that could be eliminated without reducing quality or outcomes, and staff intend for this to encompass both potentially avoidable care and unnecessary care. Many estimates (e.g., from the Institute of Medicine) place waste at approximately 30% of American healthcare expenditures. The Maryland hospital system is unique in that it operates under a unique demonstration and waiver arrangement with the federal government which has permitted the establishment of "fixed budget" agreements that give hospitals the ability to eliminate unnecessary care without incurring financial harm. The success of the Maryland demonstration under the All-Payer Model is highly dependent on the progress that is made by hospitals in controlling volume levels—

specifically, efforts to curb volume increases and to eliminate potentially avoidable and unnecessary care. Failure to address the problem of potentially avoidable and unnecessary care will endanger the affordability of health care for individuals, companies and government; it will undermine the profitability and financial status of the hospitals if rate updates are tightly controlled; it will limit the funds that are available for innovation; and it will potentially threaten the long term continuation of the waivered All-Payer Model system.

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

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

INTER-HOSPITAL COST COMPARISON METHODOLOGY UPDATE

Background

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

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

The HSCRC staff has evaluated needed updates to the ICC approach and has completed preliminary calculations using the proposed revised approach for those services that would be incorporated into a charge-per-case or charge-per-visit construct. As discussed below, staff needs final rate year-end 2017 data (July 1, 2016 through June 30, 2017) to complete the calculations; which should be forthcoming in the near term. Also, as with all data analyses and technical calculations, the work should be subjected to a technical review prior to its finalization. In the following paragraphs, the staff will explain the changes that are being proposed to the methodology at a high level.

As discussed above, the objective of a cost-per-case/cost-per-visit comparison is to allow HSCRC to assess the relative costs of hospitals compared to other hospitals or potentially to other providers offering similar services. The HSCRC has developed a construct to combine these analyses for inpatient and outpatient services, which we refer to as Equivalent Case-Mix Adjusted Discharges or "ECMADs". In the following paragraphs, staff will use the term

ECMADs to denote the combination of included inpatient and outpatient cases and visits, while noting that staff is excluding ECMAD data for cycle billed visits at this time (clinics, infusions and related drugs, radiation therapy, physical therapy services, and outpatient psychiatric visits).

Staff will describe at a high level the process used to reach the comparisons in the ICC, including a description of proposed changes. A companion detailed technical document and calculations will be made available at future Commission meetings, once updated data is obtained, documentation is complete, and technical review and input are considered.

Overview of Calculation

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

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

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

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

- Peer Group 1 (Non-Urban Teaching)
- Peer Group 3 (Suburban/Rural Non-Teaching)
- Peer Group 4 (Urban Hospitals)
- Peer Group 5 (Academic Medical Center Virtual, which overlaps with peer group 4)

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

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

Proposed Changes to ICC Methodology

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

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

Step 1- Calculate Permanent Revenue

Outpatient Drug Overhead Adjustment-

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

Step 2- Adjustments to revenue

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

Medical Education Costs-

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

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

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

Labor Market Adjustment-

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

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

Capital Cost Adjustment-

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

Disproportionate Share Hospital (DSH) Adjustment-

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

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

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

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

Step 4- Productivity and Cost Adjustments

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

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

Other ICC Considerations and Issues

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

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

The ICC is currently constructed using cases and visits. Future iterations could extend to episodes, per capita benchmarks, and regional comparisons; however there is more data that would be needed for this analysis, which is complex. The ICC could also evaluate hospital utilization per capita benchmarks. However, this requires data beyond hospitals to adjust for differences in site of service and population based risk adjustment to account for patient characteristics. These tools are not yet developed.

RECOMMENDATIONS

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

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

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

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

Maryland
Hospital Association

September 27, 2017

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

Dear Chairman Sabatini:

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

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

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

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

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

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

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

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

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

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

Sincerely,

Brett McCone
Vice President

cc: Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
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September 27, 2017

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

Dear Ms. Kinzer:

The purpose of this letter is to provide comments on COMAR 10.37.10 on behalf of the Johns Hopkins Health System (JHHS).

The proposed regulatory changes are designed to update the HSCRC's requirements for hospitals seeking full rate reviews, making the approach compatible with the All Payer Model adopted in 2014. JHHS agrees that changes are necessary for alignment between the model and the Commission's administrative responsibility to review the adequacy of a hospital's rate structure under Maryland law and supports the need to modify the information collected to provide the Commission with a complete financial picture of a petitioning hospital's needs. However, the proposed changes are too vague for applicants to understand how to successfully submit an application. They are also excessively burdensome with requirements for submission of multiple years of information that the Commission already collects. These new requirements should not be so burdensome that it is impractical for hospitals to file an application and have a rate review docketed for the Commission's consideration. The extensive and open-ended list of requirements in the proposed regulations seem designed to be a barrier to filing more than a reasonable list of information for assessing a hospital's financial needs. The changes as written will significantly increase the time and cost required to construct the application to approach the Commission for administrative relief.

Furthermore, the regulations refer to a methodology for evaluating the adequacy of hospital's rate structure, but no clear methodology exists as these regulations are being proposed. Applicant hospitals should have a clear understanding of how they will be evaluated prior to the filing of an application, either through the regulations or through supporting policies that have been subject to the input of system stakeholders. The regulations should lay out clear requirements for what a hospital needs to submit for an application to be docketed for Commission consideration and for the standards by which the hospital will be evaluated. The proposed regulations call for any information that the staff deems necessary to assess the hospital's request. While it may be necessary for Commission staff to request additional information after it reviews an application,

it should not be able to withhold consideration while probing endlessly for additional information that may or may not be central to understanding a hospital's rate request. From the current proposed regulations, the path for a hospital to get its application docketed is not clear and cannot be clarified as long as non-specific, open-ended requirements remain as part of the language for *filing* the application for a full review.

JHHS is also concerned about the requirements for health system information when a petitioning hospital is part of a system. The review should not be a full review of the hospital's system but of the specific facility's needs. The full review process is a consideration of a hospital's rates, not the entire system's performance. A hospital's rate application should not become an opportunity for an unlimited exploration of the system's data, some of which is proprietary information and may be outside the Commission's regulatory authority.

JHHS appreciates the opportunity to comment on these regulations. While revisions to the current regulations are necessary to modernize and align them with the All Payer Model, the proposed regulations should be clarified to require the information necessary to support a hospital's rate request in an efficient manner with clear guidelines for providing an application that will be docketed by the staff. The regulations should clarify the method for evaluating applicant hospitals so that the standards of review are clear and can be evaluated in advance of applications. Thank you for your consideration of these comments. Please contact us if you have any questions.

Sincerely,

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

Chet Burrell
President and Chief Executive Officer

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September 25, 2017

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

Dear Mr. Sabatini and Ms. Kinzer:

I am writing to express CareFirst's support for the HSCRC's proposed regulations regarding hospitals' full rate reviews. These proposed regulations will enable the HSCRC to (1) properly reflect any factors that are relevant to the determination of a hospital's reasonable cost level; and (2) develop a methodology that is consistent with and supports the policy goals of the current Demonstration. We provide our detailed comments below.

CareFirst supports the proposed requirement that hospitals demonstrate that they have made effective efforts to reduce unnecessary services that go beyond the current definition of PAUs (i.e., excess diagnostic tests, scans and procedures, as well as, care that is needed but that should be performed in a lower-cost setting). A foundation of the current Demonstration is that reductions in unnecessary services will be a key source of financial sustainability of hospitals operating under fixed global budgets.

CareFirst also believes the HSCRC should evaluate the financial status and efficiency of each hospital requesting a rate review after considering overall performance of other hospitals in the same healthcare system. Presumably, hospital systems have been established to achieve system-wide efficiencies, improve quality of care and enhance overall care-coordination. Therefore, it is appropriate for the HSCRC to evaluate an individual hospital's rate request in the context of the overall performance of the hospital system.

Finally, CareFirst supports the proposed evaluation of the profits and losses of physician practices acquired by a hospital seeking a rate review. Data made available by the HSCRC has long demonstrated that most Maryland hospitals are spending considerable sums to attract and support physician practices for strategic purposes. Many hospitals appear to be losing considerable sums of money through the subsidization of physician-related activities. Under its current authority, the HSCRC cannot include Medicare Part B expenditures in establishing rate bases of regulated hospitals. Therefore, we believe that these subsidies should be carefully examined and evaluated in determining the merits of a hospital's rate request.

We look forward to providing testimony at the October Public meeting in support of these regulations.

Sincerely,

Chet Burrell
President & CEO

Cc: Joseph Antos
Victoria Bayless
George Bone
John Colmers
Adam Kane
Jack Keane

JOHNS HOPKINS
MEDICINE

JOHNS HOPKINS
HEALTH SYSTEM

October 10, 2017

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

Dear Ms. Kinzer:

As the All Payer Model continues into its fourth year, a number of operational issues have emerged, even as the model has achieved its stated goals under the contract with CMMI. Enclosed is a white paper that addresses an important issue, especially with the end of the moratorium on full rate reviews. The purpose of this brief paper is to provide the Johns Hopkins Health System's (JHHS) view of potential efficiency measures under the Global Budget Revenue model for rate regulation and how the Commission's previous measures should be modified in light of the system's new goals and economic incentives.

JHHS is contributing this paper to add to an open and transparent discussion of this and other issues that affect the implementation of Maryland's All Payer Model. This issue is one component of several that must be considered for the continued success of the system, and such discussions must be ongoing and iterative due to the interaction of the individual components of the system. JHHS is committed to an open and transparent discussion of goals, issues, and methodologies.

We appreciate the opportunity to express our view to you on this topic, and we request that you share this document with the Commissioners. Please contact us if you have any questions.

Sincerely,

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

Principles for Measuring Efficiency under Maryland's All Payer Model

The Johns Hopkins Health System
October 10, 2017

Introduction

As the hospital rate regulatory agency in Maryland, the Health Services Cost Review Commission (HSCRC or the "Commission") has used measures of relative hospital efficiency to carry out its legislative mandate for establishing rates that provide solvency for efficient and effective hospitals. These measures have changed over time, depending on the Commission's regulatory goals and the data available to measure hospital performance. The purpose of this brief paper is to provide the Johns Hopkins Health System's (JHHS) view of these measures under the Global Budget Revenue model for rate regulation and how the Commission's previous measures should be modified in light of the system's new goals and economic incentives.

JHHS is contributing this paper to add to an open and transparent discussion of this and other issues that affect the implementation of Maryland's All Payer Model. This issue is one component of several that must be considered for the continued success of the system, and such discussions must be ongoing and iterative due to the interaction of the individual components of the system. JHHS is committed to an open and transparent discussion of goals, issues, and methodologies.

Monitoring Rates

The HSCRC has generally measured relative efficiency for two broad purposes: 1) for judging relative performance of hospitals to determine hospitals-specific adjustments to annual update factors; and 2) for assessing the adequacy of rates when Commission staff are involved in negotiations over hospital-specific issues concerning rate-setting methodologies. The first version of this process was referred to as a screen, in which hospital charges were compared to others in the State after a series of adjustments for various factors deemed by the Commission to be reasonable in accounting for differences among hospitals, e.g., case mix, medical education, uncompensated care. The screens were later modified to compare permanent revenue per inpatient discharge instead of actual charges, comparing an applicant hospital to pre-established peer groups – a methodology referred to as the Reasonableness of Charges (ROC) analysis. The ROC underwent further modifications until its last official publication in 2011.

Full Rate Reviews

A more extensive process has been in place when a formal and comprehensive assessment is required. The full rate review process is the HSCRC's administrative process for considering a hospital's request for a review of whether the hospital's rates are sufficient to provide solvency for efficient and effective hospital. Typically this process follows hospital negotiations with the Commission's staff about the sufficiency of existing rates. The full rate review begins with a formal application to the Commission after the staff has declined to offer relief or if the staff believes that it cannot justify further relief under existing policies adopted by the Commission. The full rate review methodology, formally referred to as the Inter-hospital Cost Comparison (ICC), establishes a standard for determining reasonable rates for an efficient and effective hospital with similar characteristics to the applicant.

Principles

In the 2000 redesign of the HSCRC's regulatory process, the Commission accepted a sound principle for the redesign – to align the Commission's measurement tools with the goals upon which hospitals were to be assessed. At that time, the Commission's ICC methodology was based on the unit rate approach initially developed by the HSCRC to set hospital rates in the 1970s. Since that initial model was developed, however, the HSCRC had developed new monitoring methodologies under the Guaranteed Inpatient Revenue model (GIR). Further, the formal Medicare waiver had been established that set legislative limits to Maryland's Medicare growth in inpatient spending per case for Medicare beneficiaries as a condition to keep the State's waiver from Medicare national rate-setting policies under the Inpatient Prospective Payment System (IPPS) and later the Outpatient Prospective Payment System (OPPS). In that redesign process, the Commission decided to use the Inpatient Charge per Case (CPC) as the basis for monitoring relative hospital efficiency on an ongoing basis (the ROC methodology) and developed a revised ICC methodology linked directly to the calculation of the ROC.

This principle was reaffirmed when in 2008, when eight new hospitals were added to two existing hospitals on the Total Patient Revenue (TPR) model which established global budgets for rural hospitals. At this time, the Commission removed all 10 TPR hospitals from the ROC model because the incentives under global budgets no longer aligned with CPC measurement – just the opposite, in fact. If hospitals moved the low acuity cases to settings outside the hospital, the remaining cases were likely to be more expensive on average. If the case mix indeed did not rise commensurately, the hospital would look relatively less efficient compared to other hospitals in the State. Because the incentives did not align, the ROC was no longer an appropriate methodology for assessing relative efficiency for those hospitals.

As the current moratorium on full rate reviews is scheduled to expire on October 31, 2017, there has yet be new methodologies proposed to replace the ROC and ICC approaches developed for the CPC system. Our understanding is that the HSCRC staff is pursuing updates to these methodologies to refresh them with current data and to modify certain concepts to modernize the approach. To the degree that this is true, The Johns Hopkins Health System raises two concerns: (1) a lack of transparency and stakeholder input to the process that has been the case in all other significant changes to rate setting methodologies and (2) a fundamental misalignment of the status quo version of ROC and ICC with the goals and incentives under the current Global Budget Revenue (GBR) model. The second concern is the subject of this paper.

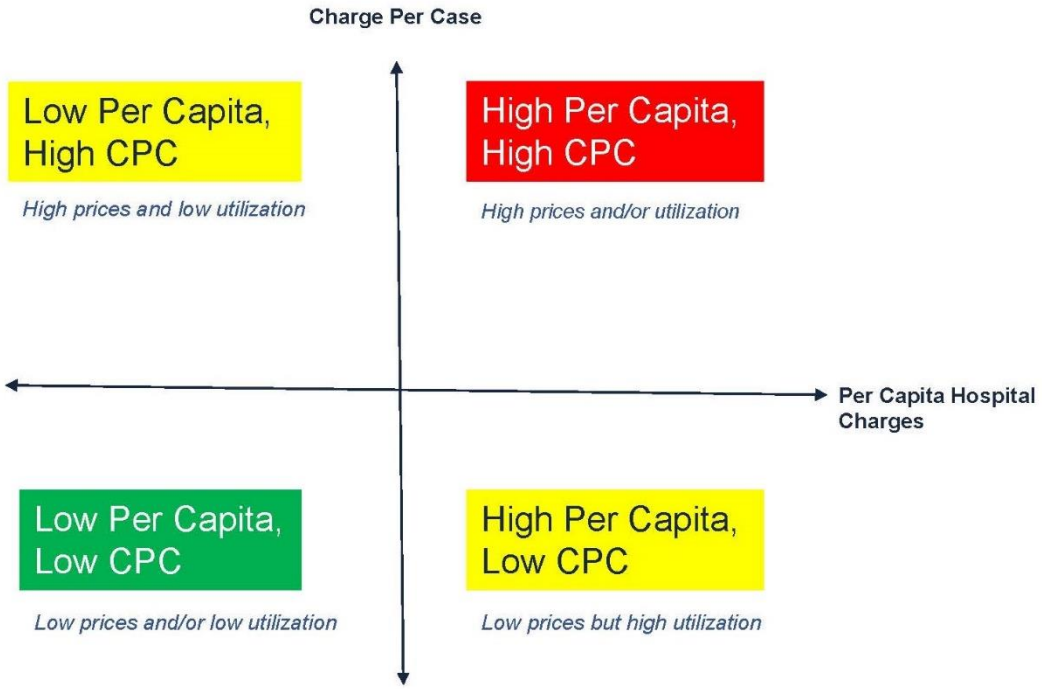
Despite the change to GBR, hospital prices remain relevant, so a ROC methodology can still inform the policy process. Under a global budget approach, however, the ROC alone does not align with the general incentives under population-based payment methods, as the Commission itself understood with TPR hospitals. The Hospital All Payer Model established revenue limits on a per-capita basis and Medicare savings targets on a per-beneficiary basis. Clearly, new incentives are to save overall hospital spending for a given population, which calls for broader efficiency improvements than the per-case savings that are rewarded under the ROC methodology. These incentives are to remove services from the hospital through improved care coordination to prevent unnecessary hospitalizations, improved transitions of care to appropriate settings with greater speed, provide greater attention to chronic patients with high readmissions, and to social determinants that contribute to high emergency department utilization and hospital readmissions.

The Need for New Monitoring and Assessment Tools

The GBR model was designed to provide strong incentives for hospitals to reduce unnecessary volume by sending patients to more appropriate low-acuity settings without financial penalties to the provider. When the GBR approach was adopted, however, it was discussed as a temporary approach to be implemented for a couple of years. Without modification, a strict application of global budgets would not allow revenue to follow patients over the long run. The principle of revenue following the patient is a fundamental requirement for the system's financial sustainability; therefore, the GBR approach would necessarily require modification from its original incarnation. While the staff has implemented a market shift methodology to allow some reallocation of revenue between hospitals who have experienced changes in market share (appropriately excluding potentially avoidable utilization (PAU) from consideration), the marginal shifts in revenue have been small, leaving hospitals with declining market share relatively large revenue bases while inadequately funding hospitals that have seen market share growth under the GBR model.

Under global budgets, hospitals that shed volume are allowed to keep the revenue, but if a hospital continues to shed volume without substantial adjustments for market shifts, its prices will become unreasonable – both in terms of relatively high unit rates and its relative CPC. Hence, there should be consideration of both CPC and hospital revenue per capita: two dimensions for evaluating hospital efficiency instead of a single metric. This could be done in terms of an analysis of per-capita hospital spending in the primary service area (or even the extended primary service area) along with an analysis of adjusted CPC through a ROC-like approach. Hospitals that are high in both per-capita spending and CPC are clear candidates for revenue rebasing. Hospitals with low CPC and low per-capita spending are clear candidates to consider for potential rate relief. When a hospital is high on one count and low on the other, their case for rate relief is less clear and should depend on the specific circumstances of any request they are making.

Graph: An Efficiency Metric along Two Dimensions – Charge Per Case versus Per Capita Hospital Charges Illustration



Representatives of hospitals that have decreased volume are likely to argue that a consideration of CPC flies in the face of the incentives to reduce volume in the first place. The guarantee of fixed revenue as volume declines is the central feature of the GBR system. A shortcoming of the GBR model, however, was to never specify a duration on how long the hospital could keep the revenue. How long is appropriate – a year? For the duration of the five-year model? In perpetuity? An approach that incorporates both per-capita hospital spending and a consideration of relative CPC provides a reasonable policy approach to address those questions directly.

We recognize that there are data and methodology issues to address for an analysis that incorporates per-capita hospital spending. For hospitals sitting near the State's border, patient flows into and out of the State have to be considered for a fair comparison of per capita spending. However, if the Commission's methodology for measuring relative rate efficiency and for considering full rate applications is to align with the goals of the All Payer Model, hospital per-capita spending must be a factor in these methodologies. Because the Medicare population is of specific interest in the All Payer

Model and data are most readily available for this specific population of patients receiving care outside of Maryland, initial per capita analyses may start with this subset of the population.

Conclusion

As the Commission adopts a methodology for assessing relative hospital efficiency and the adequacy of hospital rates under full rate reviews, the Johns Hopkins Health System advocates an approach that considers two dimensions of the cost of care to patients: hospital charge per case and the per capita cost of hospital care. Because the All Payer Model's focus is on population health, per capita measurement would align the goals of the Model with its efficiency metrics, a principle long accepted within the rate-setting system. Even in the absence of perfect measurement, as much evidence as possible should be incorporated and given consideration in acknowledgement of the population health goals to be achieved by the All Payer Model. Applying the same principles in the future under Phase II of the All Payer Model may require the HSCRC to modify efficiency measurement further to consider per capita spending for total costs of care, not just for hospital spending. That will be a topic for further discussion.

Medicare Performance Adjustment RY 2020 Draft Policy

October 11, 2017

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**
  - Allow Maryland to step progressively toward developing the systems and mechanisms to control TCOC, by increasing hospital-specific responsibility for Medicare TCOC (Part A & B) over time (Progression Plan Key Element 1b)
  - Provide a vehicle that links non-hospital costs to the All-Payer Model, allowing participating clinicians to be eligible for bonuses under MACRA

Elements of RY 2020 (Y1) Draft MPA Policy

- Total Cost of Care Attribution algorithm: Attributes beneficiaries and their TCOC to one or more hospitals
- Performance Assessment: Determine how well a hospital performs on its per capita TCOC
- Medicare Performance Adjustment Methodology: Based on the performance, calculate an MPA for each hospital (percentage adjustment to federal Medicare payments)
- Medicare Performance Adjustment Implementation: Roles of HSCRC and CMS

RY 2020 Performance Assessment

- Compare TCOC per capita performance to TCOC Benchmark
  - Create a TCOC per capita benchmark
    - Previous calendar year's TCOC per capita (CY 2017 for Y1)
    - Apply TCOC Trend Factor (e.g., national Medicare FFS growth minus X%)
  - Assess TCOC per capita in performance year (CY 2018 for Y1)
  - Compare performance to TCOC Benchmark (improvement only for Y1)

- Considerations for TCOC Trend Factor
  - Required Medicare TCOC savings under the Enhanced Model
  - Timing of Trend Factor approval – balancing predictability with accuracy

RY 2020 MPA Staff Recommendations

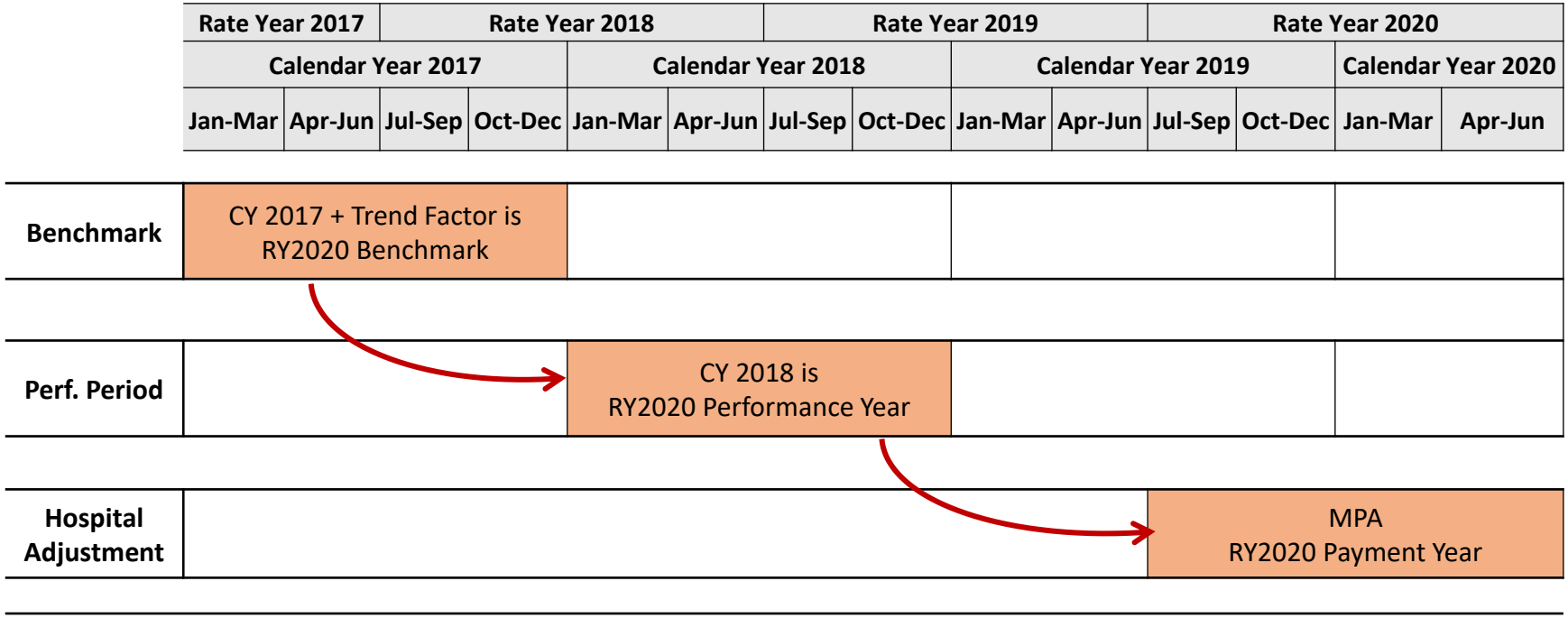
- Ensure implementation of the Medicare Performance Adjustment by CMS based on HSCRC calculations
- Measure TCOC using the hierarchical algorithm of ACO-Like, MDPCP-Like and PSAP attribution
- Set the TCOC benchmark as each hospital's TCOC from the previous year, updated with a Trend Factor decided by the Commission
- Set the maximum penalty at 0.5% and the maximum reward at 0.5% of federal Medicare revenue with maximum performance thresholds of ±2%
- Include the MPA as part of the aggregate revenue at-risk under HSCRC quality programs

RY 2020 MPA Staff Recommendations (con't)

- Continue to evaluate the MPA throughout the year and consider enhancements for a Year 2 MPA policy, obtaining input through continued meetings of the TCOC Workgroup
- Provide information to hospitals so they can more effectively engage in quality improvement activities, assess their performance, and better manage the TCOC based on the PCPs and beneficiaries attributed to them under the MPA

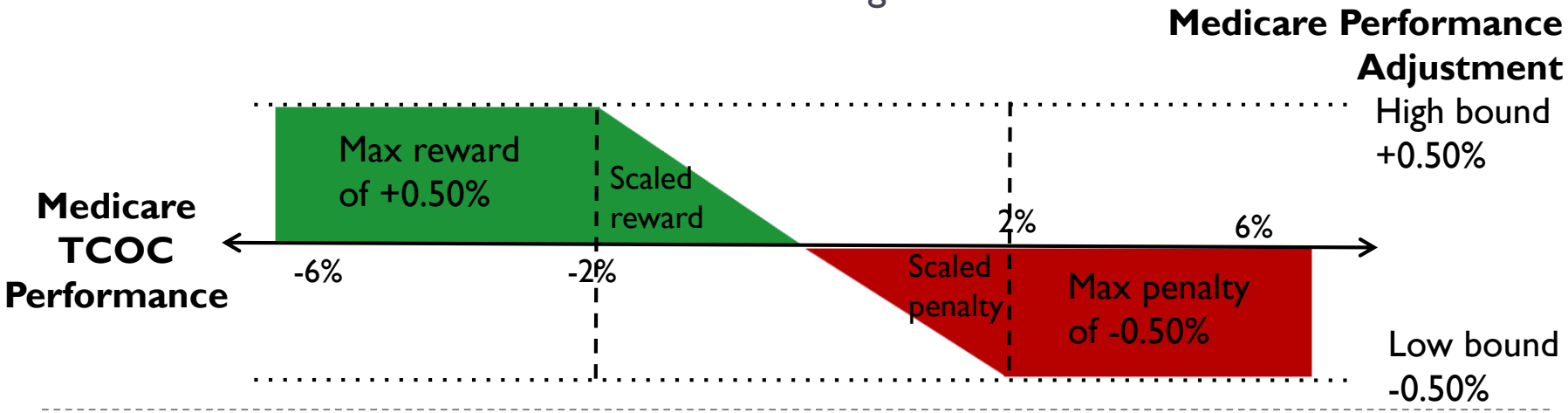
Appendix

RY 2020 MPA Timeline



MPA Calculation

- Based on a hospital's performance on the Medicare TCOC measure, the hospital will receive a scaled bonus or penalty
  - Function similarly to adjustments under the HSCRC's quality programs
- Scaling approach includes a narrow band to share statewide performance and minimize volatility risk
- MPA will be applied to Medicare hospital spending, starting at 0.5% Medicare revenue at-risk (which translates to approx. 0.2% of hospital all-payer spending)
  - First payment adjustment in July 2019
  - Increase to 1.0% Medicare revenue at-risk, perhaps more moving forward, as HSCRC assesses the need for future changes

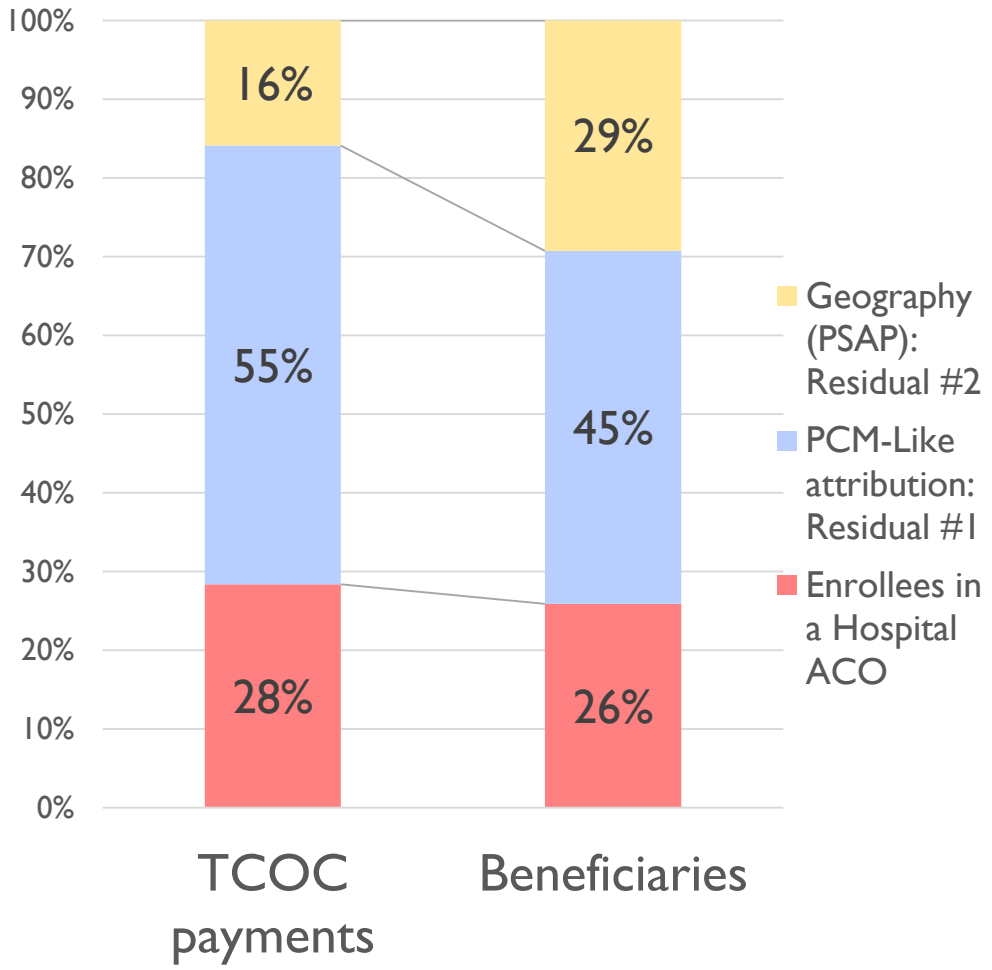


TCOC Attribution Algorithm

Medicare beneficiary attribution based on a hierarchy:

1. ACO-like
   - Attribution of beneficiaries to ACO doctors based on primary care use
   - Linking of ACO doctors to Maryland hospitals in that ACO
2. Primary Care Model (PCM)-like
   - Attribution of beneficiaries to PCPs based on primary care use
   - Linking of doctors to Maryland hospitals based on plurality of hospital utilization by those beneficiaries
3. PSA-Plus (PSAP): Geography (zip code where beneficiary resides)
   - Hospitals' Primary Service Areas (PSAs) under GBR Agreement
   - Additional areas based on plurality of utilization and driving time

Option of hierarchy with prospective attribution: Hospital-based ACO / PCM-Like / Geography



- Attribution occurs prospectively, based on utilization in prior 2 years, but using their current-year TCOC
  1. Beneficiaries attributed first based on link to clinicians in hospital-based ACO
  2. Beneficiaries not attributed through ACO are attributed based on PCM utilization
  3. Finally, beneficiaries still not attributed would be attributed with a Geographic approach
- Performance would be assessed on TCOC spending per capita
- For hospitals not in an ACO, attribution would be PCM Use + Geography, among beneficiaries not in a hospital-based ACO

Source: Draft HSCRC analysis based on CY 2016 Medicare (CCW) data

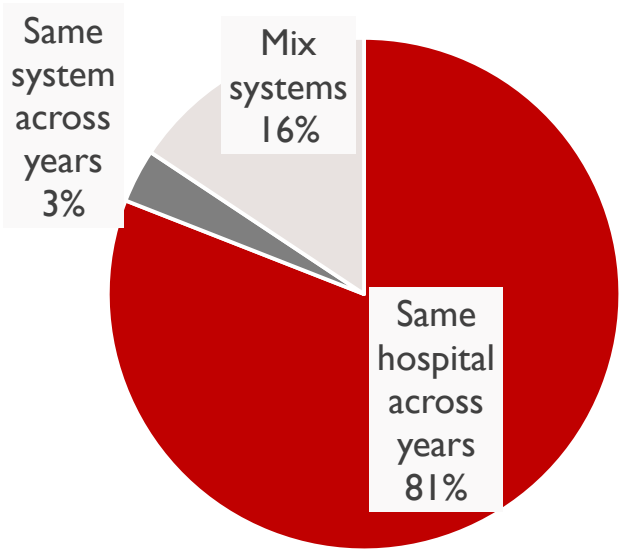
Assessment Methods

- **Scope:** Measured by the share of Medicare TCOC and beneficiaries attributed, statewide and by hospital
  - 100% of beneficiaries attributed
- **Incentives:** Measured by the share of Medicare TCOC and beneficiaries uniquely attributed to hospitals, in total and by hospital
  - 75% of beneficiaries, with 92% of TCOC, are uniquely attributed to a system/hospital
- **Relation to existing efforts:** Promoted by adopting existing ACO and primary-care arrangements, and measured by the extent to which these arrangements are reflected in the attribution.
  - Combined, ACO-like and PCM-like yield attribution to hospitals of 71% of beneficiaries and 83% of TCOC
- **Hospital efforts reflected:** The stability of attribution resulting from proposed methods to ensure that hospital efforts are reflected, measured as the share attributed to the same provider, hospital, and system (as applicable) in consecutive years.
  - 87% of beneficiaries attributed to same system/hospital between 2015 and 2016
- **Calibrated responsibility:** Measured as the association of hospitals' Medicare revenue with the Medicare TCOC to which they were assigned responsibility, and the impact of current and proposed future payment adjustments on hospitals' revenues.
  - 0.5% maximum revenue at risk for Y1

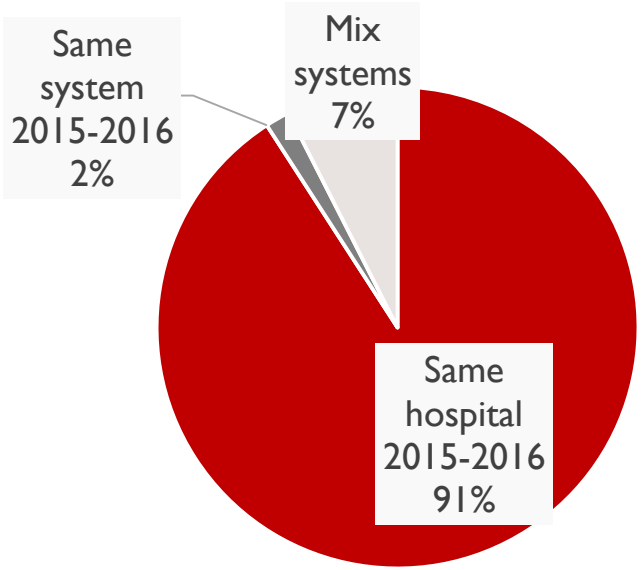
Stability of attribution: PCP-to-hospital

- PCM-like PCP-hospital match is consistent for most PCPs across years
  - PCM-like approach based on the plurality of hospital utilization by attributed beneficiaries
  - 2016 (n = 2803) compared to other years (left) and 2015 (right)

PCP-Hospital link – 2016 compared across other years



PCP-Hospital Link – 2016 compared to 2015



Definitions

- Same hospital = PCPs matched to the same hospital for all years the PCP was in the dataset
- Same system = PCPs matched to the same system for all years the PCP was in the dataset
- Mix system = PCPs matched to more than one system over the years the PCP was in the dataset

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

October 11, 2017

Health Services Cost Review Commission
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Table of Contents

LIST OF ABBREVIATIONS

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

INTRODUCTION

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

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

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. This all-payer rate-setting approach eliminates cost-shifting among 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. Maryland submitted a "Progression Plan" (Plan) to CMS in December 2016, describing its goals and plans for an Enhanced TCOC All-Payer Model. The Plan describes how the State will expand the Model's focus to incorporate the entire continuum of care.

This new TCOC measure will be constructed by attributing Maryland Medicare beneficiaries with Part A and Part B FFS coverage to one or more hospitals. Their Medicare TCOC will include costs in both hospital and non-hospital settings. To incentivize increased focus on TCOC growth, HSCRC is proposing to make a percentage adjustment to federal Medicare payments called the Medicare Performance Adjustment (MPA). For its initial year (Performance Year 2018, affecting hospital payments from Medicare in Rate Year (RY) 2020), the MPA will be based on per capita TCOC spending for the beneficiaries attributed to a given hospital. (In future years, the MPA may also be used to share in statewide Medicare TCOC performance.)

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

- An algorithm for attributing Maryland Medicare beneficiaries and their TCOC to one or more hospitals;

- A methodology assessing hospitals' TCOC performance based on the beneficiaries and TCOC attributed; and
- A methodology for determining a hospital's MPA based on its TCOC performance.

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

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

The key objectives of the MPA for Year 1 are 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 increased financial accountability, but also increased accountability on care, outcomes and population health; and

- Provide a vehicle that links non-hospital costs to the All-Payer Model, allowing clinicians participating in Care Redesign Programs (e.g., HCIP and CCIP) to be eligible for bonuses and increased rates under the federal MACRA law.

ASSESSMENT

The HSCRC worked extensively with a stakeholder group, the Total Cost of Care Work Group, on the technical specifications to determine a hospital-specific measure of Medicare FFS TCOC. This recommendation reflects valuable insights provided by the work group over the past several months as well as analyses by HSCRC contractors LD Consulting and Mathematica Policy Research (MPR).

Based on the State's experience with performance-based payment adjustments, as well as well-established guiding principles for quality payment programs from the HSCRC Performance Work Group, the TCOC Work Group discussed the following general 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 cover all or nearly all Maryland FFS Medicare beneficiaries and their Medicare Part A and B costs.

2. **The measure should provide clear focus, goals, and incentives for transformation**
   2.1. Promote efficient, high quality and patient-centered delivery of care.
   2.2. Emphasize value.
   2.3. Promote new investments in care coordination.

2.4. Encourage appropriate utilization and delivery of high quality care.

3. **The measure should build on existing transformation efforts**
   3.1. The measure should build upon existing investments and efforts to reduce TCOC, including on current and future provider relationships already managed by hospitals or their partners.
   3.2. The measure should be based on prospective or predictable populations that are "known" to hospitals.

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.

Assessment Methods

A number of methods for attributing beneficiaries to hospitals were explored with the TCOC Work Group over the past several months. In coming to a staff recommendation, HSCRC staff evaluated the methods selected for attribution based on the degree to which they conform to the principles above. In particular, the following metrics were used to assess each method.

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

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

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

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

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

Total Cost of Care Attribution Algorithm

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

The TCOC Attribution Algorithm uses the following hierarchy (each method of attribution is explained more fully below): 1) ACO-like attribution; 2) Maryland Primary Care Program (MDPCP)-like attribution; and 3) Geographic attribution. This approach is intended to recognize that hospitals can identify and influence most easily the quality and costs of patients who use them and their affiliated providers, while ensuring that responsibility for beneficiaries for whom no hospital use can be equitably assigned.

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

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

ACO-like attribution

The ACO-like attribution enables hospitals that have already agreed to be accountable for beneficiaries in their ACO to build on those relationships. This step in the attribution is relevant for Maryland hospitals participating in the Medicare Shared Savings Program or Medicare Next Generation ACO Program. Assignment is based on MSSP attribution logic, which assigns beneficiaries to ACOs according to their PCP use, then specialist use if a PCP cannot be identified. Beneficiaries are assigned to ACOs according to their use of participating providers

(Appendix). Beneficiaries affiliated with the ACO are then attributed to hospitals affiliated with that ACO. (If an ACO does not have a Maryland hospital as a participant, it is not included in the algorithm.) For ACOs with more than one hospital participating, the beneficiaries and their TCOC will be distributed proportionally according to the participating hospitals' Medicare market share in the beneficiaries' place of residence. (See Appendix for technical details.)

Maryland Primary Care Program-like Attribution

Beneficiaries not assigned to hospitals through the ACO-like method will be assigned to hospitals based on the beneficiary's relationship with primary care providers and those providers' relationships with hospitals. Their relationship with primary care providers is determined through beneficiaries' use of PCP services as detailed in the Maryland Primary Care Program (MDPCP). The method is similar to that by which beneficiaries are assigned to ACO providers.

Each provider is assigned to the hospital from which that provider's patients receive the plurality of their care. Primary care providers are defined by unique NPIs, regardless of practice location, and are not aggregated or attributed through practice group or TIN. (See Appendix for technical details.)

Geographic Attribution

The remaining beneficiaries and their TCOC — or the "residual of the residual" — will be assigned to hospitals based on geography. The Geographic methodology assigns zip codes to hospitals based on hospital primary service areas (PSAs) listed in hospitals' Global Budget Revenue (GBR) agreements. Zip codes not contained in a hospital's PSA are assigned to the hospital with the greatest share of hospital use in that zip code, or, if that hospital is not sufficiently nearby, to the nearest hospital. This approach is also referred to as PSA-Plus or PSAP. (See Appendix for technical details.)

Performance Assessment

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

Attribution is performed prospectively. That is, beneficiaries' connection to hospitals is measured based on the two Federal fiscal years preceding the performance year (for example October 1, 2014 to September 30, 2016 for attribution for performance year 2017). The benchmark value for the purpose of performance measurement would then be trended from the 2016 attribution based on the preceding two Federal fiscal years (October 1, 2013 to September 30, 2015).

TCOC Trend Factor

The Final TCOC Trend Factor must be approved and determined by the Commission and approved by CMS before the MPA is applied, beginning July 1, 2019. Final TCOC data for the State and the Nation are available in the May following the end of a Calendar Year. For Rate Year 2020, this means that Calendar Year 2018 Performance data will be available in May 2019, and the MPA would be applied in July 2019.

The HSCRC staff originally proposed that the TCOC Trend Factor should be set with reference to national Medicare FFS growth. For example, to attain the required Medicare TCOC savings by 2023 under the Enhanced Model, average annual TCOC growth in Maryland must be 0.33% below the national growth rate.

However, some stakeholders have expressed interest in the development of a pre-set Trend Factor prior to the start of the Performance Period. To this end, the Commission may choose to approve an interim or prospective trend factor for the MPA closer to the beginning of the Performance Period. As with any HSCRC program, the Commission may adjust or update this policy if necessary. Any subsequent updates to a pre-set trend factor must receive CMS approval before becoming a Final Trend Factor for implementation. However, staff is concerned about balancing the needs for a prospective and predictable target with accuracy and consistency. If the Commission sets a preset trend factor that is not aggressive enough, hospitals may expect and budget for a reward even if the State has an unfavorable year compared to the Nation. In this case, the Commission may need to adjust the target after the Performance Period, which may be difficult for hospital budgets.

Figure 1. Medicare TCOC Per Capita Growth*

Year	Actual Nation TCOC Per Capita Growth	Nation growth rate less 0.33%	Actual Maryland TCOC Per Capita Growth	MD compared to Nation less 0.33%
2014	0.86%	0.53%	-0.67%	-1.20%
2015	1.61%	1.28%	2.32%	1.04%
2016	0.73%	0.40%	0.04%	-0.36%

*Numbers may differ slightly from MPA TCOC due to adjustments made for the MPA methodology (inclusion of benes with Medicare FFS Part A AND Part B, certain exclusions, etc.)

Medicare Performance Adjustment Methodology

TCOC Performance compared to the TCOC Benchmark, as well as an adjustment for quality, will be used to determine scaled rewards and penalties. For Rate Year 2020, staff proposes to set the maximum penalty at 0.5% and the maximum reward at 0.5% of hospital federal Medicare revenue. The staff also recommends that maximum performance thresholds be set as the percentage above or below the TCOC Benchmark at which the Maximum Revenue at Risk is attained (either maximum reward or penalty) in order to minimize volatility risk. For Rate Year 2020, staff proposes a maximum performance threshold of ±2%.

The scaled result, a reward or penalty equal to 25% of the amount by which the hospital's TCOC differs from its TCOC target, will be multiplied by the sum of the hospital's quality adjustments. For Rate Year 2020, the staff proposes to use the HSCRC's Readmission Reduction Incentive Program (RRIP) and Maryland Hospital-Acquired Infections (MHAC) for the quality adjustments; however, staff recognizes that the Commission may choose revise the programs used for the quality adjustments if necessary. Both programs have maximum penalties of 2% and maximum rewards of 1%. For example, a hospital with TCOC scaled reward equivalent to a 0.3%, MHAC quality adjustment of 1% and RRIP quality adjustment of 0% would receive an MPA adjustment of 0.303%. (See Appendix for technical details.) Regardless of the quality adjustment, the maximum reward and penalty of ±0.5% will not be exceeded.

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

MPA Implementation

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

HSCRC staff intends to provide hospitals with information so they can more effectively engage in quality improvement activities, assess their performance, and better manage TCOC based on the PCPs and beneficiaries attributed to them under the MPA. This information may include, as appropriate and consistent with federal and state privacy laws and requirements:

- List of PCPs attributed to a hospital under the attribution algorithm
- List of beneficiaries attributed to a hospital under the attribution algorithm
- Reports of hospital performance on the TCOC of its attributed population during the performance year

RECOMMENDATIONS

Based on this assessment, staff recommends the following for Rate Year 2020:

1) Ensure implementation of the Medicare Performance Adjustment by CMS based on HSCRC calculations
2) Measure TCOC using the hierarchical algorithm of ACO-Like, MDPCP-Like and PSAP attribution, as specified above
3) Set the TCOC benchmark as each hospital's TCOC from the previous year, updated with a Trend Factor decided by the Commission. The Commission should decide in the final policy

whether to set a prospective Trend Factor target prior to the performance period or to base the Trend Factor on the national experience after the end of the performance period.

4) Set the maximum penalty at 0.5% and the maximum reward at 0.5% of federal Medicare revenue with maximum performance thresholds of ±2%
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 a Year 2 MPA policy, obtaining input through continued meetings of the TCOC Workgroup
7) Provide information to hospitals so they can more effectively engage in quality improvement activities, assess their performance, and better manage the TCOC based on the PCPs and beneficiaries attributed to them under the MPA

APPENDIX. TCOC ATTRIBUTION METHODOLOGIES

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

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

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

ACO-like Attribution

All beneficiaries are considered eligible for ACO-like attribution, and ACO-like attribution will be attempted for all. However, only ACOs with participating Maryland hospitals in the Medicare Shared Savings Program (MSSP) or Next Generation ACOs will be attributed beneficiaries through this method. Beneficiaries are attached to clinicians through use of professional services, while clinicians are attached to ACOs if their identifier appears on the ACO's participant list. Hospital affiliation is also identified through ACO affiliation and only Hospitals affiliated with a Maryland ACO are used for attribution.

Beneficiary-to-Provider attribution

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

Provider-to-ACO attribution

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

ACO-to-Hospital attribution

Maryland hospitals participating in an ACO for the purposes of this method will be defined as hospitals listed on the Participant List of an ACO domiciled in Maryland. All beneficiaries and costs for beneficiaries of ACOs with a participating Maryland hospital will be attributed to that hospital. For ACOs with more than one hospital, TCOC will be distributed by Medicare market share.

ACO Specialties

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

ACO Primary Care Codes

Domiciliary, rest home or custodial care

- CPT 99324 – 99337
- CPT 99339 – 99340

Home services

- CPT 99341– 99496

Wellness visits

- CPT G0402, G0438 & G0439

New G code for outpatient hospital claims

- CPT G0463

Domiciliary, rest home or custodial care

- CPT 99324 – 99337

- CPT 99339 – 99340

Home services

- CPT 99341– 99496

Wellness visits

- CPT G0402, G0438 & G0439

New G code for outpatient hospital claims

- CPT G0463

MDPCP-like Attribution

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

Beneficiary-to-Provider attribution

Primary care providers are attributed beneficiaries based on proposed MDPCP logic with minor adjustments. Each Medicare FFS beneficiary with Medicare Part A and Part B is assigned the National Provider Identification (NPI) number of the clinician who billed for the plurality of that beneficiary's office visits during the 24 month period preceding the performance period AND who also billed for a minimum of 25 Total Office Visits by attributed Maryland beneficiaries in the same performance period. If a beneficiary has an equal number of qualifying visits to more than one practice, the provider with the highest cost is used as a tie-breaker. Beneficiaries are attributed to Traditional Primary Care Providers first and, if that is not possible, then to Specialist Primary Care Providers.

The cost of primary care services must represent 60% of total costs in a practice during the most recent 12 months, excluding hospital and emergency department costs. Primary care services are identified by procedure codes from the list appended below. Clinicians enrolled in the Next Generation ACO Model, ACO Investment Model, or Advanced Payment ACO Model; or any

other program or model that includes a shared savings opportunity with Medicare FFS initiative are excluded. Primary care providers are defined as unique NPIs regardless of practice location and are not aggregated or attributed through practice group or TIN. (Unlike in the MDPCP, in the methodology used in the MPA attribution, there is no requirement on practice size. The MDPCP requires a practice to have a minimum of 150 Medicare beneficiaries.)

Provider-to-Hospital attribution

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

MDPCP Eligible Specialties

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

MDPCP Primary Care Codes

- Office/Outpatient Visit E&M (99201-99205 99211-99215);
- Complex Chronic Care Coordination Services (99487-99489);
- Transitional Care Management Services (99495-99496);
- Home Care (99341-99350);
- Welcome to Medicare and Annual Wellness Visits (G0402, G0438, G0439);
- Chronic Care Management Services (99490)
- Office Visits (M1A, M1B); Home Visit (M4A); Nursing Home Visit (M4B) BETOS Codes
- Specialist Visits (M5B, M5D); Consultations (M6) BETOS Codes
- Immunizations/Vaccinations (O1G) BETOS Codes
- Other Testing BETOS Codes (T2A Electrocardiograms, T2B Cardiovascular Stress Tests, T2C EKG Monitoring, T2D Other Tests)

Geographic Attribution

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

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

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

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

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

Maryland
Hospital Association

September 20, 2017

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

Dear Chris:

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

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

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

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

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

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

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

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

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

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

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

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

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

Sincerely,

Traci La Valle

Traci La Valle, Vice President

cc: Nelson J. Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Adam Kane
Jack C. Keane
Donna Kinzer, Executive Director

Measuring Hospital Quality to Achieve Better Value in Maryland

October 11, 2017

HSCRC
Health Services Cost Review Commission

In this Presentation…

- Commissioners reviewed and provided feedback in Sept 2017 meeting on the following four topics:
  - Quality-Based Reimbursement
  - Readmission Reductions
  - Complications in Maryland Hospitals
  - Service Line Approach
- Stakeholders also submitted written feedback on the same topics, and are invited to give public testimony at this meeting.
- Presentation Goal: Summarize strategic direction feedback
  - Specific questions or concerns raised will be addressed in draft and final policies (for Commissioner Review/Approval).

Quality-Based Reimbursement

- Commissioner and Stakeholder Feedback:
  - Support for continued focus on HCAHPS improvement
  - Mixed support of ED Wait Time measure inclusion
    - Need greater understanding of the drivers and opportunities for improvement
    - ED Wait Times are important patient experience and patient safety issue
    - Explore alternatives for addressing ED efficiency
- HSCRC Next Steps:
  - With Commission agreement, staff plans to include ED measures in RY 2020 QBR draft policy recommendation
    - HSCRC will model improvement for ED measures as part of person and community engagement domain
    - Will continue to work with performance measurement workgroup to refine draft policy recommendation

Readmission Reduction: CY 2018 & Enhanced Model

- Commissioner and Stakeholder Feedback:
  - Encouraged by readmission progress; support targets to incentivize meeting current Model Goal
  - Maryland should not be content to remain at national average
  - Lack of support for changes to readmission measure (i.e., 90 day, observation stays)

- HSCRC Next Steps:
  - Build improvement target for CY 2018 that is more aggressive than national forecast (build target with "cushion")
  - Look at ways to build improvement targets in Enhanced Model
    - "Aggressive and Progressive" Targets
    - Comparable to the Nation
    - Consider distribution of National Readmission Rates

Complications in MD Hospitals: CY 2018 & Enhanced Model

- Commissioner and Stakeholder Feedback:
  - Potentially Preventable Complications (PPCs)
    - Most stakeholders support moving to HAC measures, while some stakeholders support paring down PPCs
    - Concern over clinical coverage gaps and emphasis on surgical complications
- HSCRC Next Steps:
  - Staff plans to create a sub-group of clinical experts to determine if there are important clinical gaps with existing HAC measures.
  - Will analyze how to structure complications and value-based purchasing in the context of moving away from PPCs

Topic: Service Line - Enhanced Model

- Commissioner and Stakeholder Feedback:
  - Interesting concept
  - Does staff have the capacity to work on this?

- HSCRC Next Steps:
  - Staff plans to build timeline for incremental adoption of service line
  - Will consider initial use as analytical tool for monitoring/quality improvement

Priorities for Quality Staff

- Short-term (next 3-4 months)
  - Statewide Population Health measurement and credit
  - Readmissions Targets for CY 2018
  - ED Wait Times
  - Revised PAU protection
  - Standard updates for RY 2020 recommendations
- Longer-term (4+ months)
  - Hospital Population Health Measures
  - Clinical Subgroup on Complications; migration to HAC measures
  - Long Term Readmission Targets
  - Incremental service line analytics
  - PAU expansion

Maryland
Hospital Association

September 28, 2017

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

Dear Allan:

On behalf of the Maryland Hospital Association's 64 member hospitals and health systems, we appreciate the opportunity to comment on the Health Services Cost Review Commission's quality policy priorities, principles and direction. Developing population health metrics, aligning metrics with the national quality programs and creating a readmissions comparison group or benchmark should be top priorities for quality policy over the coming year.

As Maryland approaches performance year 2018, the fifth and final year of the current All-Payer demonstration, we urge commission staff to focus on the measures and policies that are needed to support the upcoming second phase of the model. Since this enhanced model will hold all hospitals individually accountable for population outcomes, equitable performance metrics and policies will bring even greater challenges than those we currently face. In addition, Maryland's performance will be compared to the measures that comprise national payment policies. As a result, we believe the measures used in Maryland's quality policies should align with the nation as closely as possible.

Quality Priorities
Over the next year, commission staff must expend significant resources to prepare for the implementation of the enhanced model. These activities should be prioritized:

- **Develop at least one population health metric.** Although a number of population health metrics are measured by Accountable Care Organizations, primary care practices, medical homes and health plans, no population health measures have been developed for individual hospital use. Identifying a data source and developing a method to assign populations to individual hospitals will be challenging.
- **Align with the national Hospital-Acquired Conditions (HAC) measures.** Maryland is on track to far exceed the 30 percent reduction in Potentially Preventable Conditions (PPCs) required in the current contract; since no other state uses the PPCs, there is no other group with which to compare Maryland's performance. The Maryland Hospital-Acquired Conditions (MHAC) have no national comparison, and moving away from them would allow hospitals to focus on metrics that they consider more meaningful and on the critical work of transforming

care delivery. Commission staff resources would also benefit by leveraging measures and performance standards administered by the Centers for Medicare & Medicaid Services.

- Identify an appropriate readmissions benchmark that considers best practices among hospitals and populations with characteristics similar to Maryland.

Hospital-Acquired Conditions
Transition from MHACs to a policy based on the national HAC measures for performance year 2019. Aligning Maryland's metrics with the national metrics will better position Maryland's hospitals to focus on the complications that national policy makers have determined are most important. In addition, reducing the sheer number of metrics (eliminating the 60+ Potentially Preventable Conditions) allows hospitals to redirect staff to the care delivery transformation activities that are so critical to the success of the model. Recognizing that this would be a significant change in hospital operations, adequate time to prepare for the transition will also be key.

Although the national HAC program is a penalty-only policy, the same metrics are used in the national Value-Based Purchasing (VBP) program that includes the possibility of both rewards and penalties. While leveraging the national VBP program could reduce complexity for hospitals and for commission staff, we need more time to work through the details of how the national program could be adapted to Maryland. We welcome continued dialogue on this issue.

Readmissions
As we anticipate reducing the statewide all-cause 30-day unadjusted Medicare readmissions rate below the national average by the end of the 2018 performance year, we will need to agree on the desired level of readmissions. Some level is appropriate to address serious or potentially life-threatening unanticipated changes in a person's health or new conditions that are unrelated to the initial admission. So far, there is no accepted method to determine the "right" level of readmissions, nor is there an accepted method to account for the social, demographic, and community factors that affect readmissions rates, particularly in an all-payer population. Over the coming year, we should work together to recommend an appropriate benchmark or comparison group of hospitals that provides a safe and achievable performance target.

We do not recommend changing the readmissions metric to include emergency department visits, observation stays or a 90-day window. The current readmissions metric is working well and the number of readmissions that occur after 30 days is small. It is most important to focus on the population health and measure alignment priorities.

Emergency Department Measures
We do not recommend adding emergency department wait time measures to the quality programs. These metrics are not an effective way to address concerns that have been raised about long wait times. Maryland's hospitals have been challenged by relatively long emergency department throughput times and the need to rely on diversions. Recognizing the importance to patient safety and shared responsibility for the Marylanders we touch, hospitals over the last year have been addressing the issue with our hospital clinical leaders and emergency department

physician leaders. Root cause analysis has identified a number of factors contributing to the problem, including: insufficient access to behavioral health treatment; Medicaid expansion and patterns of primary care delivery including non-emergent use of the emergency department; nursing shortages; and care transformation and redesign. Emergency departments are at the center of transformation. Increased screening and use of evidence-based practices to decrease readmissions and unnecessary inpatient stays require hospitals to rebalance the needs of all hospital units. Tracking the number of hours emergency departments are on diversion is a quicker way to show progress than wait times, which have a longer data lag. Yellow diversions have decreased more than 20 percent from second quarter 2017 compared to second quarter 2016.

Service Line
Evaluating performance along service lines may have advantages, such as addressing measurement biases. However, it would tax HSCRC staff resources that are needed to pursue the priorities identified earlier: population health metrics, alignment with national HAC measures and development of a readmissions benchmark. Using an existing model that would still allow Maryland's hospitals to be compared to a national cohort might be a more feasible approach.

Expansion of Potentially Avoidable Utilization
We do not recommend expanding the definition of Potentially Avoidable Utilization – a change that is not immediately needed to support the enhanced all-payer model. In the future, as we implement population health measures and expand hospitals' accountability for populations, it may be worthwhile to re-evaluate the way in which the Prevention Quality Indicators are implemented using hospital discharges as the denominator. The Agency for Healthcare Research and Quality developed the metric to measure how well an entity manages a population by providing necessary care in the ambulatory setting and avoiding hospitalizations. Experience with the Medicare Performance Adjustment and population health measures may provide insight into how to improve the way we use this measure.

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

Sincerely,

Traci La Valle

Traci La Valle, Vice President

cc: Nelson J. Sabatini, Chairman
Joseph Antos, Ph.D., Vice Chairman
Victoria W. Bayless
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September 29, 2017

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

Dear Health Services Cost Review Commission,

Thank you for this opportunity to provide feedback on the policy priorities for Rate Year 2020 and the Enhanced All-Payer Model. I write to you on behalf of Maryland Citizens' Health Initiative Education Fund, a nonprofit group that works to guarantee all Marylanders access to quality, affordable healthcare.

The upcoming shift to the Enhanced All-Payer Model is very good news for consumers looking toward the Triple Aim of better care, improved health, and lower costs. Consumers are excited and ready to engage with hospitals and community partners to see improvement in the health of their communities. To achieve the goals of this enhanced model, we fully support the goal to develop methodology for evaluating population health and incorporating those measures into value-based hospital payments. We understand that the timeline for creating and implementing these measures is ambitious and we support giving this task the significant time and attention it deserves.

Excessive emergency department wait times are a serious concern for patients. For many Marylanders, periodic visits to the emergency department are the only times they interact with hospital personnel in a given year. Longer ED wait times erode patient confidence in the hospital system and are perceived by many as an indicator of poor quality care provision. For that reason, MCHI recommends that the Commission add ED-1b, ED2b, and OP-18b measures for wait times under the QBR program, and more specifically to the patient experience panel. We can and should do better to reduce emergency department wait times for both those eventually being admitted and those being discharged.

MCHI recommends that the Commission work collaboratively with Maryland hospitals to determine high performance benchmarks, overall weighting for these measures, and whether a payment adjustment is needed to help hospitals achieve the goal of reducing wait times. We realize this is a complex issue and appreciate the efforts that Maryland hospitals have already made, including decreasing ED diversion rates. We also appreciate that hospitals are taking extra time to educate patients and connect them with appropriate community resources, and we do not want to discourage hospitals from equipping patients to take care of their health upon discharge. Further, MCHI hopes that the state and community providers can support hospitals in achieving shorter wait-times for those who need to be admitted while still providing robust ED services to everyone who enters the ED. Under the QBR program, we also support having more discussion around improving overall HCAHPS scores as well as how to engage consumers to help support that goal.

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We look forward to discussing how to proceed with the Maryland Hospital Acquired Conditions Program under the Enhanced Model. If Maryland switches to use the CMS HAC model, we would be interested in discussing whether to retain a number of PPC's that meet certain criteria, such as being clinically important, showing variation between hospitals, and having room for improvement.

Under the Potentially Avoidable Utilization program, we are interested in any policy that would incentivize better care coordination and transitions of care and collaboration between providers. Depending on HSCRC staff's available time and resources, we are open to a discussion around extending readmission to 90 days from 30 days, and would also be open to discussing other policies that might achieve these goals.

We are also interested in having a discussion around developing and testing a service line approach. Consumers who seek care from hospitals for a particular service line could potentially benefit from a system that measures how hospitals perform on that service line. From a reporting standpoint, improving consumers' ability to compare hospital performance on individual service lines most relevant to their needs could be a powerful tool.

Thank you for the opportunity to submit this feedback on the upcoming policy priorities for the HSCRC. I look forward to engaging with staff and stakeholders in the Performance Measurement Workgroup on all of these programs over the next year.

Sincerely,

Stephanie Klapper, MSW
Deputy Director, Maryland Citizens' Health Initiative Education Fund

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CORPORATE OFFICE

September 28, 2017

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

Dear Allan:

On behalf of the 14 hospitals of the University of Maryland Medical System (UMMS), we appreciate the opportunity to comment on the policy decisions under consideration by the Commission staff and shared with the Performance Measurement Workgroup on September 20, 2017. We are all invested in providing the best quality of care that drives optimum clinical outcomes for our patients, and our thoughts and recommendations on these issues are centered by this core value. We also believe we have a unique opportunity within the State of Maryland to look at our own past and current experience with our quality pay for performance programs, look at the national quality programs, and improve upon both to build an even better program to drive excellent clinical outcomes at the lowest costs.

A white paper was presented to HSCRC last year outlining a potential approach to measuring quality through the lens of clinical services. UMMS still believes the best approach to look at quality of care is the clinical service approach where we can engage providers, reduce unwarranted variations in care, and realize the best outcomes for those patient populations.

Our comments below will address separately the programs in the final year of this waiver as well as the future programs in years beyond. This letter provides our comments at a high level and we hope to have the opportunity to follow with more detailed program recommendations in the near future.

CY 2018 Performance Period (FY 2020 Financial Impact)
We do understand HSCRC's perspective of keeping the current programs consistent as resources will be focused on future program improvement.

MHAC Program:
We do ask your consideration to make some modifications to the existing MHAC program related to the Norms risk adjustment methodology. In looking at statewide Norms distribution, we have validated actual PPCs occur in only 8% of the total cells included in the pay for performance program, resulting in significant instability of expected values across SOI cells. We can demonstrate this instability becomes more significant for hospitals with higher volumes of

complex patient populations. Knowing there may be more significant changes to the program after performance year 2018, we would like to finalize and bring forward a formal recommendation that will require little change to methodology, but target improvement of higher volume PPCs. It is our intent to have this recommendation for your consideration prior to the October Performance Measurement Workgroup meeting.

QBR Program:
We are aware of the rationale for the proposed addition of Emergency Department measures and agree that continued performance improvement in this area is needed. We do not, however, believe adding this to the pay for performance program is beneficial. Again, we are trying to consider this based on our core value of the best quality of care that drives optimum clinical outcomes for our patients. The first metric proposed was ED 2b, decision to admit to transfer of admitted patient, does have two complicating factors we have considered. One, as we and others have communicated, there is a time stamp issue driving variations in length of stay for this metric. Requiring a consistent point of start time for this metric may improve our national standings and actually have no impact on patient care or experience. The second concern lies with unintended consequences. Pressure to meet expected targets in a pay for performance program could create an unintentional conflict of interest between patient throughput and diversion. I am not suggesting this would be an intentional strategy for improvement, but this needs to be recognized as a potential issue. If in fact the final decision is to include ED-2b in the RY 2020 QBR program, we recommend this be considered a patient experience metric.

The second proposed metric is ED-1b, median time from ED arrival to ED departure for admitted ED patients, we believe is a direct conflict with expectations to reduce avoidable utilization of inpatient services. UMMS asks that this not be included in next year's program. While these patients are eventually admitted, there may be a misperception that these admissions are straight forward decisions and therefore could be expedited. In fact, ED physicians will tell you there is just as much rigor required for many of these patients to find alternative care options other than admission. Evaluation of previous care rendered, determining what support resources mat be available, and the potential improvement of physical condition after ED care and treatment all contribute to extending these times in the ED.

Considerations for the Enhanced Model

UMMS asks for a short extension of time to prepare and present an updated clinical service model to include a comprehensive approach to patient quality and the MHAC, QBR, and RRIP programs. We believe the clinical service line approach strengthens overall the Maryland programs and highlights the best of care that drives optimum clinical outcomes for our patients. Qualities of the program lead to the development of benchmarks driven by top performing clinical services. Strengths to the program include:

- Clinically relevant – trending by patient response to service not by individual metric (i.e. PPC)
- Compares like patient populations
- Top performing hospitals driven by both small and larger hospitals
- Highlights quality issues

Options for Measuring Complications in the Enhanced Model:
It is our hope HSCRC will be able to model the three options provided to better understand the quality impact and financial implications of the programs. Based on our current review of these three options, we believe keeping a modified MHAC program with narrowed use of PPCs to those most impacting our patient populations would best serve our patients and provide a collaborative environment for clinicians to engage in discussing care practices. We do feel it important to keep the number of PPCs within the program meaningful to those clinical services where opportunity for avoidable complications has been demonstrated.

We do not recommend removing the MHAC program altogether. CMS requires our Maryland programs to sustain a 6% at risk revenue match to the national program. Eliminating the MHAC program will result in 4% of at risk revenue to be assigned to one program – QBR. This type of weighting is not consistent with any national program.

A revised MHAC program using PSI measures in lieu of PPCs would be heavily weighted toward surgical services and not be consistent with our intent to improve quality across the general patient population.

UMMS does not support movement to the HAC program. This program essentially duplicates many metrics already within the QBR program and does not meet at least four of the guiding principles established by HSCRC:

- Program should prioritize high volume, high cost, opportunity for improvement and areas of national focus
- Predetermined performance targets and financial impact
- Hospital ability to track progress
- Encourage cooperation and sharing of best practices

Readmissions:
The ability to determine an accepted "target" for readmissions continues to be a great debate across the country. Anticipating Maryland will be below the national average by the end of 2018, there should now be opportunity to look at the clinical service line approach, analyze variations and best practices within like clinical services, and benchmark good practices related to readmissions. This will support a continued structure of improvement and achievement methodology, and encourage cooperation and sharing of best practices.

We do not recommend changing the readmissions metric to include emergency department visits or observation stays as these are appropriate care options to our patients with acute care needs. We do not recommend expansion to a 90 day window as we continue to build the infrastructure to support a robust care delivery system required to manage chronic and noncompliant patients.

On behalf of all of the UMMS hospitals, we appreciate your consideration of our comments and hope we have the opportunity to continue working through the details of these recommendations.

Sincerely,

Patricia Ercolano
Vice President Quality Management
University of Maryland Medical System

cc: Robert A. Chrencik
President and Chief Executive Officer
University of Maryland Medical System

Henry J. Franey
Executive Vice President and Chief Financial Officer
University of Maryland Medical System

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TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **October 11, 2017**

RE: **Hearing and Meeting Schedule**

November 13, 2017	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room ****Please note that this will NOT be held on the second Wednesday of the month and has been moved to the following Monday**
December 13, 2017	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 9:15 a.m.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website at http://hscrc.maryland.gov/commission-meetings-2017.cfm.

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