State of Maryland
Department of Health

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543rd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
September 13, 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. **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**

2. **Discussion on Planning for Model Progression – 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 July 12, 2017**

2. **Executive Director's Report**

3. **New Model Monitoring**

4. **Docket Status – Cases Closed**
   2390R – McCready Memorial Hospital
   2393A - Johns Hopkins Health System
   2394A – Johns Hopkins Health System

5. **Docket Status – Cases Open**
   2395A – Johns Hopkins Health System
   2396A – Johns Hopkins Health System
   2397A – Johns Hopkins Health System
   2398N – University of Maryland Midtown Campus
   2399A – Priority Partners

6. **Presentation by Kaiser Permanente**

7. **Confidential Data Request**

8. **Planning for TCOC All-Payer Model Progression (**Please Note: Written comments due 9/27/17**)**

   a. **Overall Timeline for Policy Development**

b. **Discussion of Future Direction for RY 2020 and Enhanced Model Quality Programs**
    i. **HAC Policy**
    ii. **Readmissions Policy**
    iii. **Other Directional Changes**

c. **Discussion of Medicare Performance Adjustment**

9. **Presentation on the MHCC Rural Workgroup**

10. **Report on Hospital Costs Associated with Physicians**

11. **Legal Report**

    a. **Promulgation of Regulation to Amend Full Rate Review Process**

12. **Hearing and Meeting Schedule**

Executive Director's Report

The Executive Director's Report will be distributed during the Commission Meeting

New Model Monitoring Report

The Report will be distributed during the Commission Meeting

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF SEPTEMBER 5, 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
2395A	Johns Hopkins Health Care	7/12/2017	N/A	N/A	ARM	DNP	OPEN
2396A	Johns Hopkins Health Care	7/27/2017	N/A	N/A	ARM	DNP	OPEN
2397A	Johns Hopkins Health Care	7/27/2017	N/A	N/A	ARM	DNP	OPEN
2398N	Univeristy of Maryland Midtown Campus	8/7/2017	9/8/2017	1/5/2018	Defniitive Observation	CK	OPEN
2399A	Priority Partners	8/28/2017	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**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2017**
SYSTEM	*	**FOLIO:**	**2205**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2395A**

Staff Recommendation

September 13, 2017

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on July 12, 2017 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center ("the Hospitals") for renewal of a renegotiated alternative method of rate determination arrangement, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in the revised global rate arrangement for solid organ and bone marrow transplant services with Blue Cross Blue Shield Blue Distinction Centers for Transplants for a period of one year beginning September 1, 2017.

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II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed utilizing historical charges for patients receiving solid organ and bone marrow transplants at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services for a one year period commencing September 1, 2017. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2017**
SYSTEM	*	**FOLIO:**	**2206**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2396A**

Staff Recommendation

September 13, 2017

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on July 27, 2017 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for joint replacement and cardiovascular services with Health Design Plus, Inc. for clients other than those of Pacific Business Group on Health clients for a period of one year beginning September 1, 2017.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for joint replacement and cardiovascular services for a one year period commencing September 1, 2017. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2017**
SYSTEM	*	**FOLIO:**	**2207**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2397A**

Staff Recommendation

September 13, 2017

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on July 27, 2017 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to participate in a global rate arrangement for joint replacement services with Health Design Plus, Inc. for Pacific Business Group on Health clients for a period of one year beginning September 1, 2017.

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V. STAFF EVALUATION

Staff found that the experience under this arrangement over the last year has been

favorable. Therefore, staff recommends approval of the Hospitals' request.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for joint replacement services for a one year period commencing September 1, 2017. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Kaiser Permanente Presentation

Representatives from Kaiser Permanente will present materials at the Commission meeting.

Final Staff Recommendation on the

University of Maryland, Baltimore School of Medicine

Request to Access HSCRC Confidential Patient Level Data

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

September 13, 2017

This is a final recommendation for Commission consideration at the September 13, 2017 Public Commission Meeting.

SUMMARY STATEMENT

The University of Maryland, Baltimore (UMB) School of Medicine is requesting to use 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.

OBJECTIVE

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 (PDTree) 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 (IRB) 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.

REQUEST FOR ACCESS TO THE CONFIDENTIAL PATIENT LEVEL DATA

All requests for Confidential Data are reviewed by the Health Services Cost Review Commission Confidential Data Review Committee. The role of the Review Committee is to review applications and make recommendations to the Commission at its monthly public meeting. Applicants requesting access to the confidential data must demonstrate:

1. The proposed study/ research is in the public interest;
2. The study/ research design is sound from a technical perspective;
3. The organization is credible;
4. The organization is in full compliance with HIPAA, the Privacy Act, Freedom Act, and all other state and federal laws and regulations, including Medicare regulations;
5. There are adequate data security procedures to ensure protection of patient confidentiality.

The independent Confidential Data Review Committee, comprised of representatives from HSCRC staff, the Maryland Department of Health ("MDH"), The Hilltop Institute at the University of Maryland Baltimore County (UMBC) and the Department of Health and Human Services (HHS) Biomedical Advanced Research and Development Authority (BARDA), reviewed the application to ensure it meets the above minimum requirements as outlined in the application form.

The Confidential Review Committee unanimously agreed to recommend access to the confidential limited data set. As a final step in the evaluation process, the applicant will be required to file annual progress reports to the Commission, detailing any changes in goals or design of project, any changes in data handling procedures, work progress, and unanticipated events related to the confidentiality of the data. Additionally, the requester will submit to HSCRC a copy of the final report for review prior to public release.

STAFF RECOMMENDATIONS

1. 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.

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

Planning for Total Cost of Care All-Payer Model Progress

September 13, 2017

HSCRC
Health Services Cost Review Commission

Key Policy Development

Ongoing HSCRC Authority

- Full Rate Reviews (2017)
- Quality Programs, specifically MHAC (2017)
- Update Factor (2018)
- Capital Policy (2018)

Enhanced All-Payer Model

- Medicare Performance Adjustment (2017)
- Medicare Discount, Use of Differential (2018)

Measuring Hospital Quality to Achieve Better Value in Maryland

Performance Measurement in Current and Enhanced All-Payer Models

HSCRC
Health Services Cost Review Commission

Goal of Presentation

Review the policy decisions under consideration and solicit feedback from Commissioners on policy priorities for RY 2020 and Enhanced All-Payer Model. Will not require a formal vote.

- 9/13/2017 – Provide context to Commissioners for upcoming policy decisions in Quality programs
- 9/29/2017 – Solicit feedback from stakeholders
- 10/11/2017 – Summarize stakeholder input at Commission meeting and allow stakeholders to present public testimony

Commissioner Input: Commissioner feedback will help staff set the workplan for Performance Measurement Work Group and HSCRC Contractors

Stakeholder Input: Stakeholders may submit letters to the Commission by Sept. 29, 2017, and may sign up to give public testimony at Oct Commission Meeting.

Timeline for Performance Measurement Work Group and Commission Recommendations

Performance Measurement Work Group:

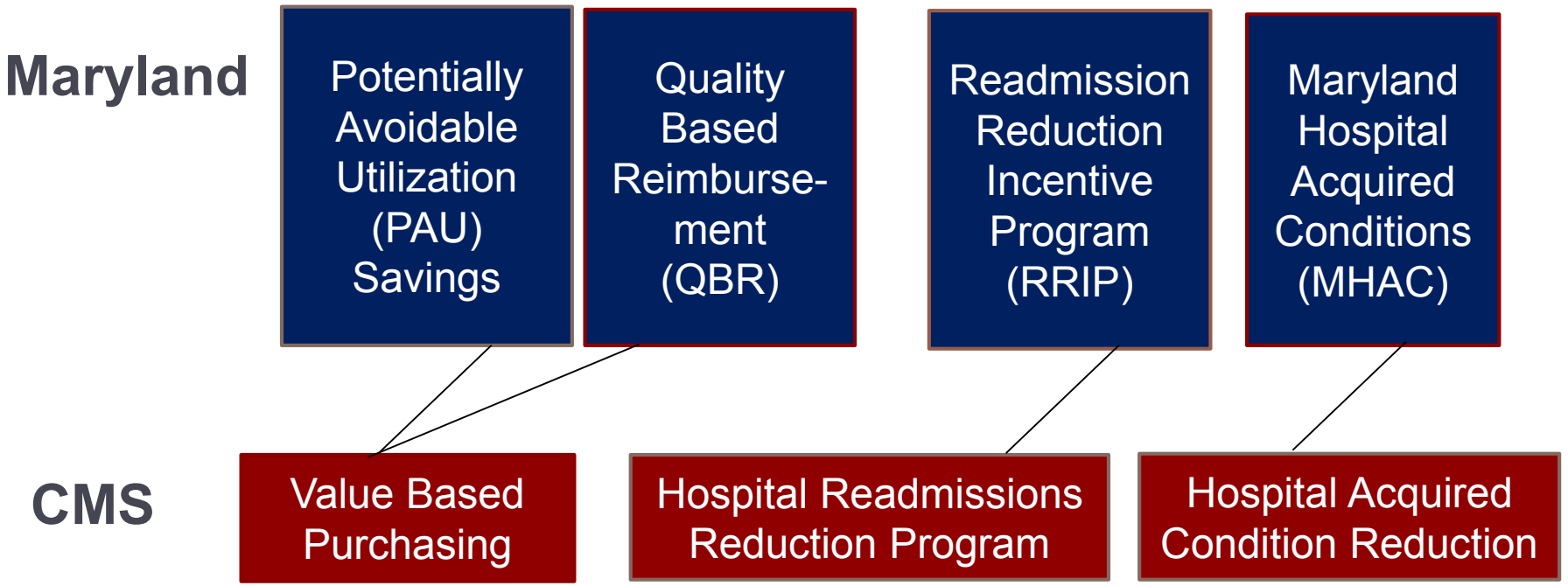
- Meets 3rd Wednesday of Month
- Composed of hospitals, consumers, physicians, payers, other state agencies
- Tentative schedule for Draft and Final Recommendations:

Program	Draft Recommendation	Final Recommendation
QBR	November 2017	December 2017
MHAC	December 2017	January 2018
RRIP	January 2018	February 2018
PAU	April 2018	May 2018

Current Performance-Based Payment Programs

Programs must be: comparable to Federal programs, have aggressive and progressive annual targets, meet annual potential and realized at risk targets, and meet contractually obligated targets, if specified, by end of 2018:

- Reduce Medicare readmissions to at or below the national average
- Reduce Potentially Preventable Complications by 30%.



General Principles for Quality Direction

RY 2020: Meet Goals of Current Model; Refine Quality Programs Only When Necessary

- **Update annual targets** to ensure the State meets Quality goals and ensure continuous quality improvement
- **Maintain** current quality programs through CY 2018 (RY 2020) to meet model tests
- Consider **Performance Measurement Work Group Feedback** and **HSCRC staff capacity** in modifying quality programs

RY 2021 and Beyond: Develop Measures and Goals of Quality Programs for the Enhanced Model

- Currently no specific quality targets but Commission must set annual performance targets that are **"aggressive and progressive"**
- Ensure **measure alignment** among all HSCRC programs and other initiatives
- Develop programs/goals with revenue at risk **comparable to Federal programs**
- Consider need to improve Maryland hospital rankings relative to national hospitals
- Develop population health improvement goals and incorporate aligned measures into quality programs
- Consider **staff bandwidth**, and ensure adequate time to include feedback from Stakeholders (HSCRC workgroups) in preparing for the Enhanced Model

The Enhanced Model terms provide the Commission greater latitude to determine goals for programs, select and revise measures, and remove measures with limited value.

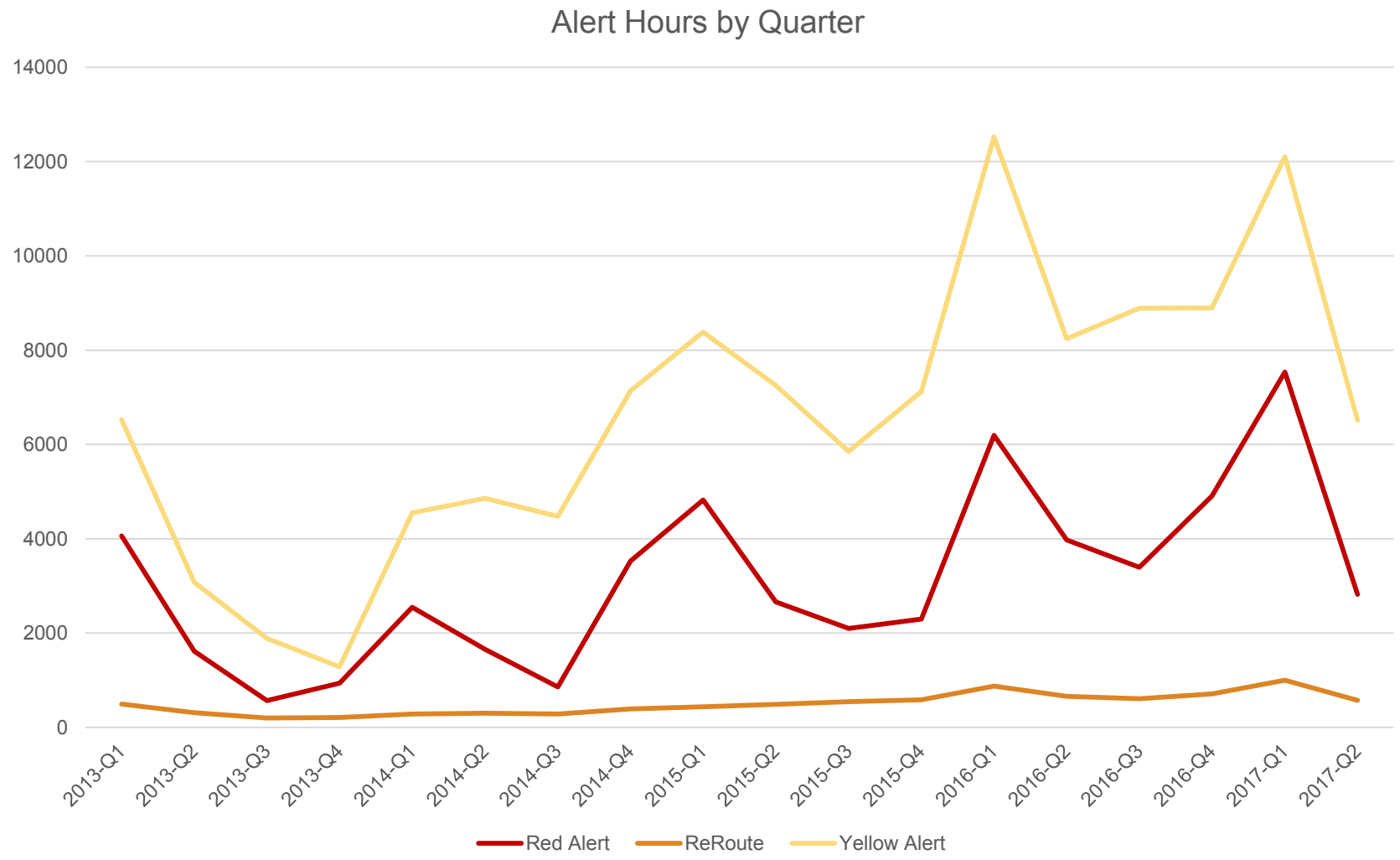
Policy Discussions for HSCRC Quality Programs

	RY 2020	Enhanced Model
QBR	- Consider adding ED wait times to QBR program - Discuss continued lack of HCAHPS improvement	- Remodel based on direction of MHAC program
RRIP	- Develop an appropriate, aggressive, and progressive annual target	- Develop a new appropriate, aggressive and progressive 5-year model target - Consider implementing readmission measure for freestanding psych hospitals - Consider socioeconomic risk-adjustment
PAU	-Modify risk-adjustment/protection -Consider extending to 90-day readmissions	- Consider phasing out PAU Protection - Consider further expanding PAU categories/definition
Population Health	- Develop a methodology for evaluating population health that might be used as a credit to the Enhanced Model's Total Cost of Care test.	- Develop a plan for incorporating population health measures into value-based hospital payments.
MHAC	- Move certain PPCs to monitoring-only status	- Consider different measurements of complications (PPCs vs HACRP) using one of five staff options
Service Line Approach	- Consider developing and testing a service line approach	- Consider utilizing based on Commissioner feedback and remodeling of other quality programs

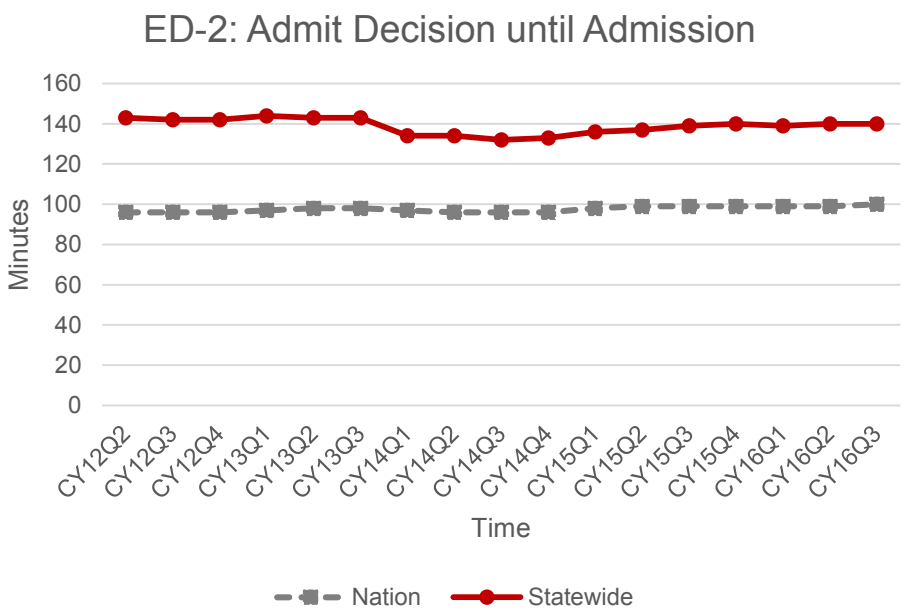
Quality-Based Reimbursement (QBR)

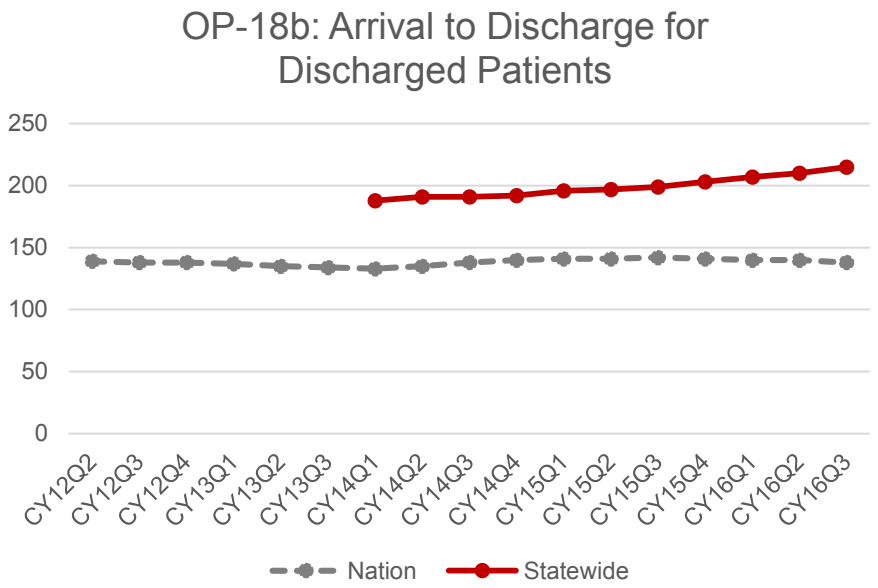
ED Wait Times and HCAHPS Improvement

Stakeholder Concern: Latest Emergency Department Diversion Data



Stakeholder Concern: Latest ED wait time data





- ED-2b – Admit Decision until Admission
- OP-18b – Arrival to Discharge for Discharged Patients

Data Source: CMS Hospital Compare

ED Wait Times - Key Policy Questions

Key Questions:

1) What are we trying to accomplish? What are we trying to measure?
2) Should MD prioritize improving ED wait times, as compared to the Nation?
3) Do hospitals require a payment policy to improve ED wait times?

Key Considerations if Commission decides to include ED wait times in payment policy:

1) What measures should be used?
2) What domain should ED wait times be included with? Patient experience? Safety?
3) What should the benchmark (highest performance) be for evaluating MD hospitals?
4) To what extent should ED wait times influence the overall QBR score?

Tentative Staff Recommendation:

Use Admit Decision Time to ED Departure Time for Admitted Patients (ED_2b) Measure in RY 2020 QBR Program

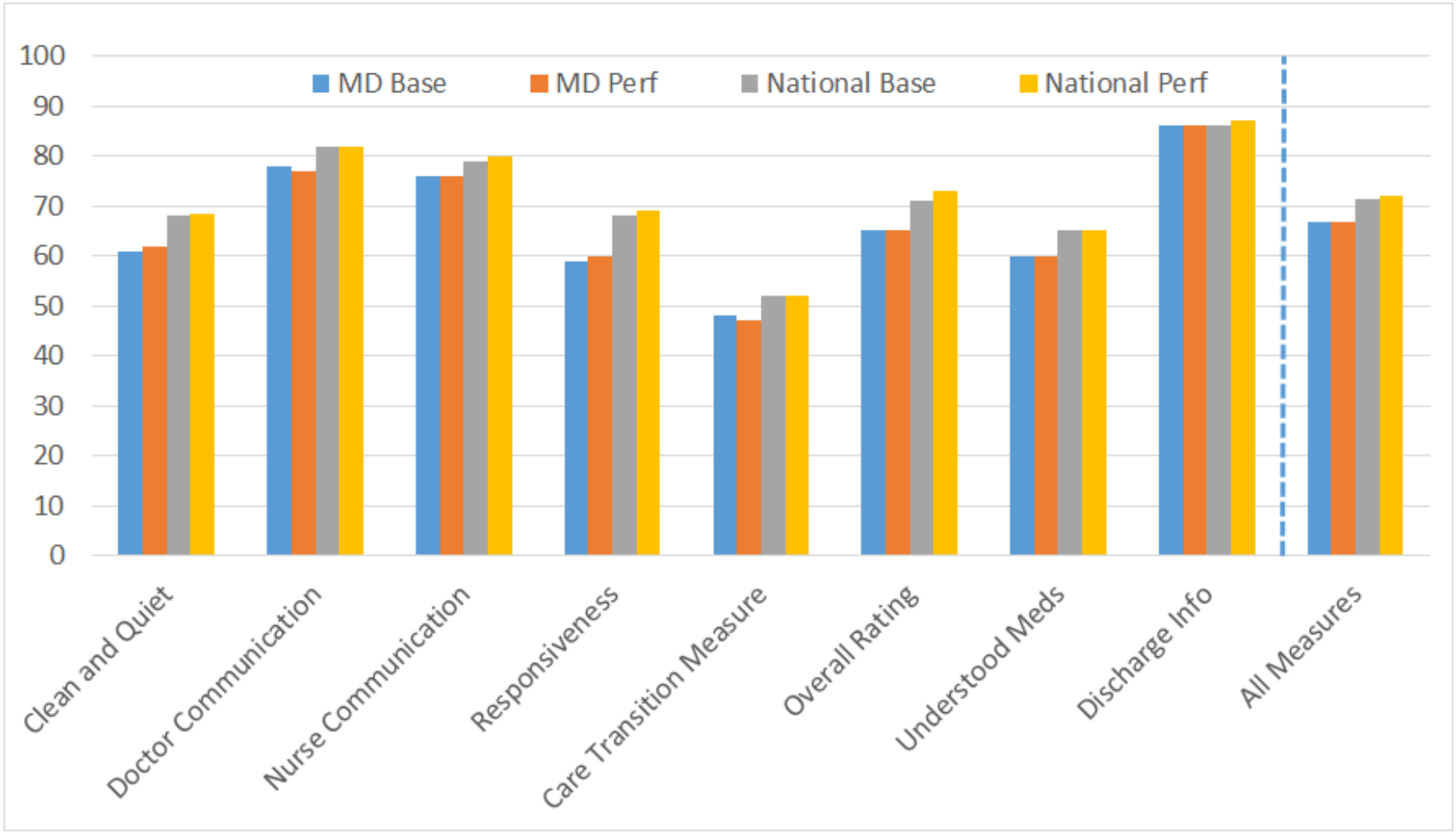
- The ED-2b Measure is under consideration for the QBR program because:
  - National Quality Forum (NQF) endorsed (NQF #0497)
  - ED_2b and other ED wait time measures are part of the National Hospital Star Ratings under the timeliness of care domain
  - There is room for improvement relative to the nation across all hospital sizes

Hospital ED Volume	MD # of Minutes	National # of Minutes
Low (0 – 19,999)	79	58
Medium (20,000 – 39,999)	161	89
High (40,000 – 59,999)	146	118
Very High (60,000 +)	185	136

- Improved ED throughput could increase patient experience (HCAHPS) more immediately for those waiting in the ED to be admitted, and for all other patients waiting in the ED who may benefit from increased ED Efficiency.

MD HCAHPS scores Compared to Nation

Time period CY 2014 (Base) 10/2015 to 9/2016 (Performance)



Commissioner Guidance/Feedback: QBR

- Inclusion of ED Wait Times Measure(s) in RY 2020?
- Incentivizing HCAHPS Improvement

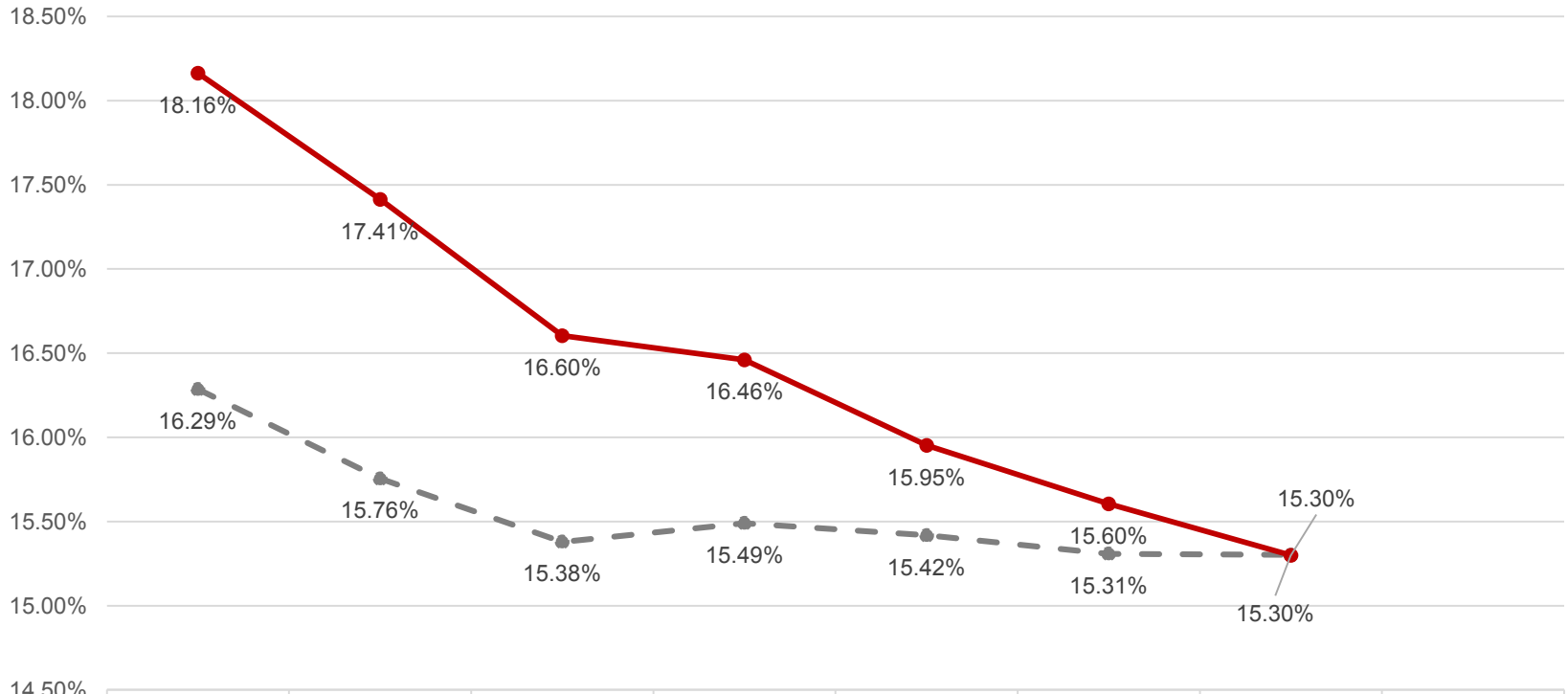
Readmissions

Annual Targets, Expansion of Readmission Definitions, and Socioeconomic Adjustments

MARYLAND

Medicare Test: At or below National Medicare Readmission Rate by end of CY 2018

Maryland is reducing readmission rate faster than the nation. With preliminary data for four months in CY 2017, Maryland is meeting the current hospital model's goal.



	CY2011	CY2012	CY2013	CY2014	CY 2015	CY 2016	CY 2017 YTD Apr	CY 2018
National	16.29%	15.76%	15.38%	15.49%	15.42%	15.31%	15.30%	??
Maryland	18.16%	17.41%	16.60%	16.46%	15.95%	15.60%	15.30%	??
Gap	-1.88%	-1.66%	-1.22%	-0.97%	-0.53%	-0.30%	0.00%	0.00%

* Readmissions through April 2017. Data subject to change due to claims runout.

Reliability of Readmissions Forecasting

- No methodology thus far can predict the national readmission rate with 100% accuracy.

- **Staff plans on recommending using a forecasting model that is more aggressive than the National average**
  - If MD performance is worse than National Average when goal is set, staff will propose a small “cushion” to ensure waiver test is met (e.g. 0.1%)
  - If MD performance is equal or better than National Average, staff will propose alternative benchmarks

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Considerations for Readmissions in Enhanced Model

- **How should HSCRC set a Readmissions Target Rate under Enhanced Model?**
  - Enhanced Model requires **"aggressive and progressive"** quality metrics
  - Would the State want to improve beyond the national median?
    - Possible options: **top national quartile** or select **a new comparison group**, perhaps similar peer states

Staff recommendation: **Additional data and analysis is required to determine a reasonable benchmark.**

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Considerations for Readmissions in Enhanced Model – Cont.

- **Expand definition of Readmissions/Revisits:**
  - Consider expanding readmission window to 90 days
    - Better incentivize care management, especially for high needs patients?
    - CRISP has care alerts for 3100+ high risk-patients in June 2017, growing from ~400 in October 2016. Is this sufficient?
  - Consider including OBS and/or ED visits in readmission meas.
    - Addresses concerns of revisits in general and avoids gaming of incentives
  - Include readmissions to and from free-standing psychiatric facilities
    - Important for accurately accounting for readmissions between acute hospital psych beds and freestanding
    - Moves freestanding psych hospitals into MD payment programs
- **Incorporate additional risk-adjustment, sociodemographic adjustment?**

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Commissioner Guidance/Feedback: Readmissions

- Setting Improvement Target for RY 2020
- Setting Readmissions Targets under Enhanced Model
- Expanded Definition of Readmissions
  - Expanding to 90 days from 30 days
  - Including Observation and/or ED visits
  - Including readmissions into free standing psychiatric facilities
- Socioeconomic risk-adjustment

Maryland Hospital Acquired Conditions (MHAC)

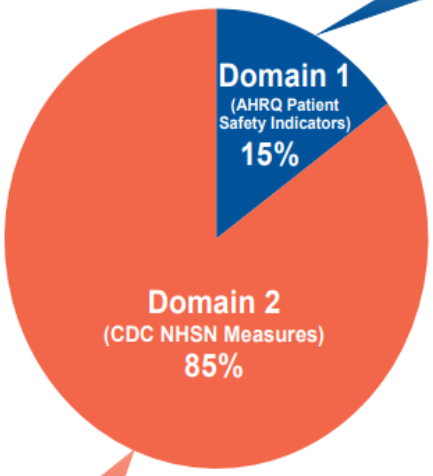
Measure Selection for Hospital Complications

Does Industry Want CMS HAC Methodology or Measures?

Methodology:

- No comparison to base period
- Time period of measurement and length of performance period differ
- Z-scores result in continuous scores
- NHSN measure scores are averaged
- Hospitals ranked and lowest performing 25% are penalized full 1%

FY 2019 HAC Reduction Program Domain Weighting and Measures
(Payment adjustment effective for discharges from October 1, 2018 –September 30, 2019)



DOMAIN 1	
	Performance Period: October 1, 2015 – June 30, 2017
AHRQ* Modified PSI 90 Measure**	Winsorized Z-Score
PSI 03 Pressure ulcer rate	
PSI 06 Iatrogenic pneumothorax rate	
PSI 08 In-hospital fall with hip fracture rate	
PSI 09 Perioperative hemorrhage or hematoma rate	
PSI 10 Postoperative acute kidney injury requiring dialysis rate	
PSI 11 Postoperative respiratory failure rate	
PSI 12 Perioperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT)	
PSI 13 Postoperative sepsis rate	
PSI 14 Postoperative wound dehiscence rate	
PSI 15 Unrecognized abdominopelvic accidental puncture/laceration rate	

*The Agency for Healthcare Research and Quality
** Modified PSI 90: Patient Safety and Adverse Events Composite. The weighting is based not only on volume of each, but also on harms associated with events.

DOMAIN 2	
	Performance Period: January 1, 2016 – December 31, 2017
CDC NHSN* Measures	Average of Winsorized Z-Score of each measure
CLABSI SIR rate	
CAUTI SIR rate	
SSI Colon† Abdominal Hysterectomy†	
MRSA Bacteremia	
CDI	

*Centers for Disease Control and Prevention National Healthcare Safety Network

†There will be one SSI measure score that will be a weighted average based on predicted infections for both procedures.

CMS HAC Reduction (All Measures) & QBR (All Safety & Complications Measures)

CMS HAC Reduction	QBR
NHSN HAI1 CLABSI	NHSN HAI1 CLABSI
NHSN HAI2 CAUTI	NHSN HAI2 CAUTI
NHSN HAI3 SSI Hysterectomy	NHSN HAI3 SSI Hysterectomy
NHSN HAI4 SSI Colon	NHSN HAI4 SSI Colon
NHSN HAI5 MRSA	NHSN HAI5 MRSA
NHSN HAI6 CDIFF	NHSN HAI6 CDIFF
PSI-90 (discontinued in 2019) Replace with Patient Safety & Adverse Events Composite (2023)	PSI-90 (discontinued in 2019) Replace with Patient Safety & Adverse Events Composite (2020?)*
	INPATIENT ALL CAUSE MORTALITY

* Due to our own regulatory authority, we could introduce revised PSI-90 at an earlier date than federal government

Considerations of PPCs versus CMS HAC

Category	MHAC	CMS HAC
Coverage of complications	- Per previous audit, PPCs capture complications not flagged by HAC logic. - Although surgically biased, all but 6 PPCs apply to both medical and surgical cases.	- Many PSI HACs include only surgical cases in the denominator. (see Measure Overlap)
Ability to refine clinical logic	- Hospitals have ability to refine PPC logic in direct collaboration with 3M	- Hospitals limited in providing input except through public comment.
Measure overlap	- Overlap but not duplicative of QBR measures (reference MHCC cross-validation with NHSN)	- Measures are already in QBR program and may identify fewer complications - Aligns with measures in the hospital star ratings
	Ex: Sepsis PPC in MHAC program is medical and surgical, while sepsis PSI in the CMS programs is surgical only; among surgical patients, PSI identifies 50% fewer complications than PPCs	
Applicability	- Limited to $200 million exposure in a $17 billion industry, thus quality improvements may not merit the investment	- Nationally used - Measures targeted to Medicare patients
Service Line approach	-Wider range of complications that more easily lends itself to service line approach	- NHSN measures (except SSI measures) cannot be done by service line - PSI could be done by service line. - Could consider additional PSI measures that are not part of PSI-90 composite

Commissioner Guidance/Feedback: MHAC

Options for Measuring Complications in Enhanced Model

1. Keep MHAC Program, but narrow down use of PPCs to only those valued as most important by staff and industry.
   a. Could reduce PPCs from 49 currently used to 10-20 most important (66 possible PPCs in total)
   b. Could consider moving some PPCs to monitoring only in RY 2020 prior to decision on MHAC program in Enhanced Model.

2. Remove MHAC (Complications) Program altogether.
   a. Double the at-risk value of QBR program, given strong similarities to measures in HAC Reduction Program, OR:
   b. Divide QBR into two programs – one for complications and clinical care, and one for patient experience (HCAHPS) – while ensuring that the aggregate at-risk for a new QBR(s) is equal to current QBR and MHAC

3. Revise MHAC Program to use PSI measures (more than just those in composite) in lieu of PPCs
   a. Use current MHAC program's case-mix adjustment and scoring methodology

Commissioner Guidance/Feedback: MHAC

Options for Measuring Complications in Enhanced Model – Cont.

4. Partially incorporate HAC measures in Complications program, per stakeholder request.
   a. Include PSI measures into MHAC program, and remove from QBR.
   b. Do not include NHSN measures in MHAC program; leave these in QBR.
5. Test service line approach using:
   a. PPCs only
   b. PSI measures only
   c. PSI measures and additional PPCs (if there are important clinical areas to measure that are missed by PSI measures)

Service Line Approach

Service Line Specific Approach

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 actionable data for hospital quality improvement
- Could be applied to the claims-based measures from the MHAC, RRIP, and QBR programs, and some service line specific non-claims based measures (i.e., early elective delivery, NHSN surgical site infection measures)

Considerations for Development of Service Line Approach

Define service lines using the following key principles:

- **Scope.** Service lines should apply to a minimum threshold number of hospitals (determined based on discussions with HSCRC and stakeholders), so it is possible to produce most measures for most hospitals.
- **Transparency.** Service lines should be clearly defined so stakeholders can understand each service line and compare hospitals by service line.
- **Clinical coherence.** Service lines should form groups that reflect similar technical requirements or patient needs.
- **Coverage (case size).** Each measure and service line should have enough cases (stays, procedures, etc.) or hospitals to establish statistical reliability in assessing hospital performance.

Determine level of aggregation:

- Program scores specific to each service line (i.e., multiple scores for each program by service line for MHAC, RRIP, and QBR)
- Program-specific aggregate scores (i.e., one score per Quality program)
- Service line-specific aggregate scores across programs (i.e., one score per service line)
- Overall hospital score that aggregates across all measures and service lines.

Commissioner Guidance/Feedback: Service Line Approach

- Continue to Explore Developing a Service Line Approach?

Summary

Summary of Policy Discussions for HSCRC Quality Programs

	RY 2020	Enhanced Model
Overall	- Meet goals of current model - Refine quality programs only when necessary	-Establish goals in conjunction with stakeholders given that goals are not prescribed in the term sheet -Align measures across quality programs and ensure programs are comparable to federal programs.
QBR	- Consider adding ED wait times to QBR program - Discuss continued lack of HCAHPS improvement	-Remodel based on direction of MHAC program
RRIP	- Develop an appropriate, aggressive, and progressive annual target	- Develop a new appropriate,aggressive and progressive 5 year model target - Consider implementing readmission measure for freestanding psych hospitals -Consider socioeconomic risk-adjustment
PAU	-Modify risk-adjustment/protection -Consider extending to 90-day readmissions	- Consider phasing out PAU Protection - Consider further expanding PAU categories/definition
Population Health	- Develop the methodology for evaluating population health that might be used as a credit to the Enhanced Model's Total Cost of Care test.	-Develop plan for incorporating population health measures into value-based hospital payments.
MHAC	-Move certain PPCs to monitoring-only status	- Consider different measurements of complications (PPCs vs HACRP) with of one five staff options
Service Line	-Consider developing and testing a service line approach	-Consider utilizing based on Commissioner feedback and remodeling of other quality programs

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Appendix

What is the QBR Program?

QBR Consists of 3 Domains:

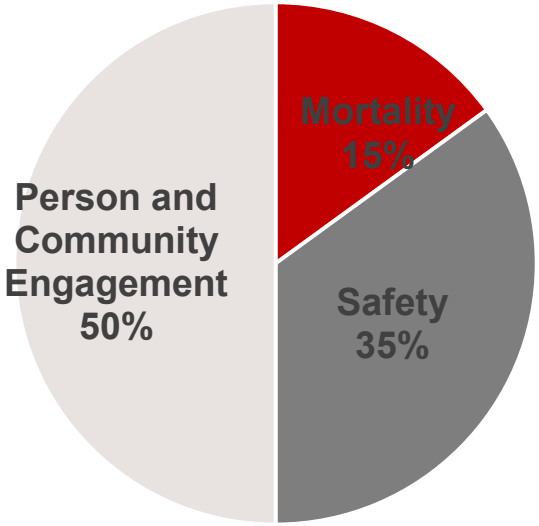
- **Person and Community Engagement (HCAHPS) -** 8 measures;
- **Mortality -** 1 measure of in-patient mortality;*
- **Safety -** 6 measures of in-patient Safety (infections, early elective delivery)

QBR is MD-specific answer to federal Value-Based Purchasing Program

Up to 2% Reward or Penalty under QBR

Preset scale of 0-80 with cut point of 45

QBR Domain Weights



What is the Readmissions Reduction Incentive Program (RRIP)?

- **Measures readmissions** across hospitals in Maryland to incentivize readmission reductions for Medicare and All-Payers.
  - Adjusts All-Payer readmission rates for patient case-mix and severity of illness
  - Excludes planned admissions from the program using CMS logic with Maryland-specific adjustments (i.e., all deliveries are considered planned)
    - Also excludes: transfers, rehabilitation hospitals, oncology, deaths

- Measures **hospital performance on an All-Payer basis** as the better of attainment or improvement to determine payment adjustments
  - Adjusts attainment scores to account for readmissions occurring at non-Maryland hospitals.
  - Scales rewards and penalties for attainment based on relative performance to statewide attainment benchmark and for improvement based on relative performance to statewide minimum improvement target.
  - Sets Max Penalty in RY2019 at 2% and Max Reward at 1%.

What is the Maryland Hospital Acquired Condition (MHAC) Program?

- Uses list of 65 Potentially Preventable Complications (PPCs) developed by 3M.
- PPCs are post-admission (in-hospital) complications that may result from hospital care and treatment, rather than underlying disease progression
  - Examples: Accidental puncture/laceration during an invasive procedure or hospital acquired pneumonia
- Goal for first model was to reduce complications by 30%. To date, the State has exceeded this goal by reducing complications by over 45%
- Relies on Present on Admission (POA) Indicators
- Links hospital payment to hospital performance by comparing the observed number of PPCs to the expected number of PPCs.
- Measure hospital performance as the better of attainment or improvement to determine payment adjustments.
  - Max Penalty in RY2019 is 2% and Max Reward is 1%.

Measure Overlap with CMS Star Ratings

The Star Ratings system provides and overall national ranking (1 to 5 stars) based on 57 quality measures in seven domains (Mortality, Safety of Care, Readmission, Patient Experience, Effectiveness of Care, Timeliness of Care, and Effective Use of Medical Imaging).

Complications Related Quality Programs	# of Star Measures that Overlap with Complications Related Quality Programs
MHAC	0
QBR	16
CMS VBP	19
CMS HAC Reduction*	6
CMS DRA HAC	0

* CMS HAC Reduction has 7 Star Measures but one of them (PSI-90) was discontinued in 2019 and will not be used again in the federal program until 2023.

High Level Categorization of RY 2019 Measures (Data Sources)*

	Total Measures	Claims Data	Survey Data	Clinical Chart Data	% Service Line Applicable
MHAC	45	45	0	0	100%
QBR	15	1	8	6	20%
RRIP	1	1	0	0	100%
PAU	2	2	0	0	100%
CMS VBP	19	5	8	6	21%
CMS HAC Reduction	7	1	0	6	43%

Strategic Performance Measurement Goals: Align with CMS Quality Strategy?

- Goal 1: Make Care Safer by Reducing Harm Caused in the Delivery of Care
  - Strategic Result: Healthcare-related harms are reduced.
- Goal 2: Strengthen Person and Family Engagement as Partners in Their Care
  - Strategic Result: Persons and families are engaged as informed, empowered partners in care.
- Goal 3: Promote Effective Communication and Coordination of Care
  - Strategic Result: Communication, care coordination, and satisfaction with care are improved.
- Goal 4: Promote Effective Prevention and Treatment of Chronic Disease
  - Strategic Result: Leading causes of mortality are reduced and prevented.
- Goal 5: Work with Communities to Promote Best Practices of Healthy Living
  - Strategic Result: Best practices are promoted, disseminated, and used in communities.
- Goal 6: Make Care Affordable
  - Strategic Result: Quality care is affordable for individuals, families, employers, and governments.

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Update on the Medicare Performance Adjustment (MPA)

September 13, 2017

HSCRC
Health Services Cost Review Commission

Purposes of MPA

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**
  - Allows 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)
  - Provides a vehicle that links non-hospital costs to the All-Payer Model, potentially allowing clinicians participating in a Care Redesign Program to be eligible for bonuses under MACRA

MPA: Design Process

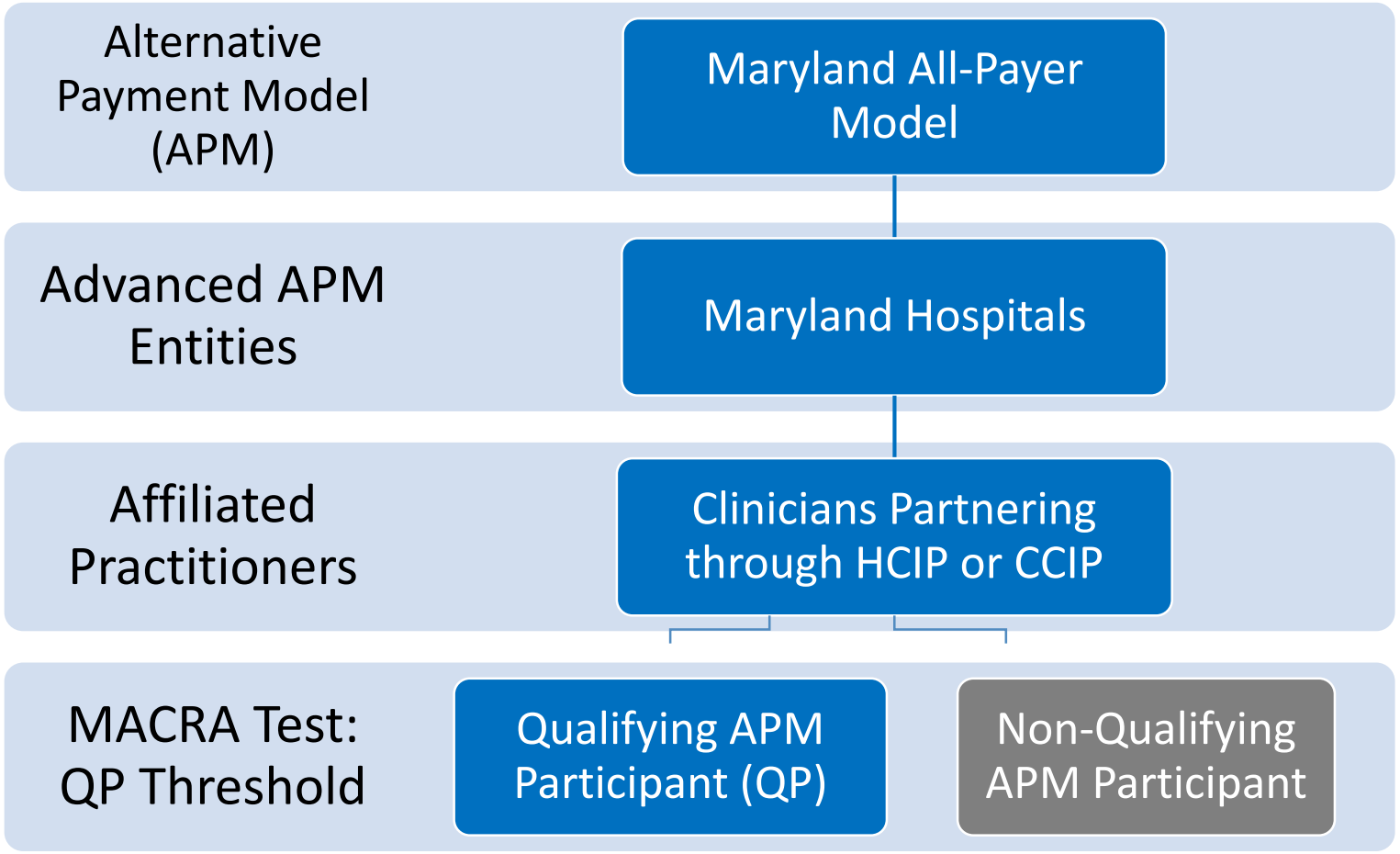
- **Initial staff and stakeholder discussions** (including Advisory Council)
  - Discussed high-level concept
- **Progression Plan** – Key Element
  - Summarized discussions to date under "Key Element 1b: Implement local accountability for population health and Medicare TCOC through the geographic value-based incentive"
- **TCOC Workgroup**
  - Considering MPA options since December 2016
- **Other ongoing discussions** with staff, stakeholders, and experts

Proposed MACRA Framework for Care Redesign Programs

MPA and Potential MACRA Opportunity

- Under federal MACRA law, clinicians who are linked to an Advanced Alternative Payment Model (APM) Entity and meet other requirements may be Qualifying APM Participants (QPs), qualifying them for:
  - 5% bonus on QPs' Medicare payments for Performance Years through 2022, with payments made two years later (Payment Years through 2024)
  - Annual updates of Medicare Physician Fee Schedule of 0.75% rather than 0.25% for Payment Years 2026+
- Maryland is seeking CMS determination that:
  - Maryland hospitals are Advanced APM Entities; and
  - Clinicians participating in Care Redesign Programs (HCIP, CCIP, et seq.) are eligible to be QPs based on % of Medicare beneficiaries or revenue from residents of Maryland or of out-of-state PSAs
- Other pathways to QP status include participation in a risk-bearing ACO, potentially MDPCP, etc.

Proposed MACRA framework for Maryland's Care Redesign Programs

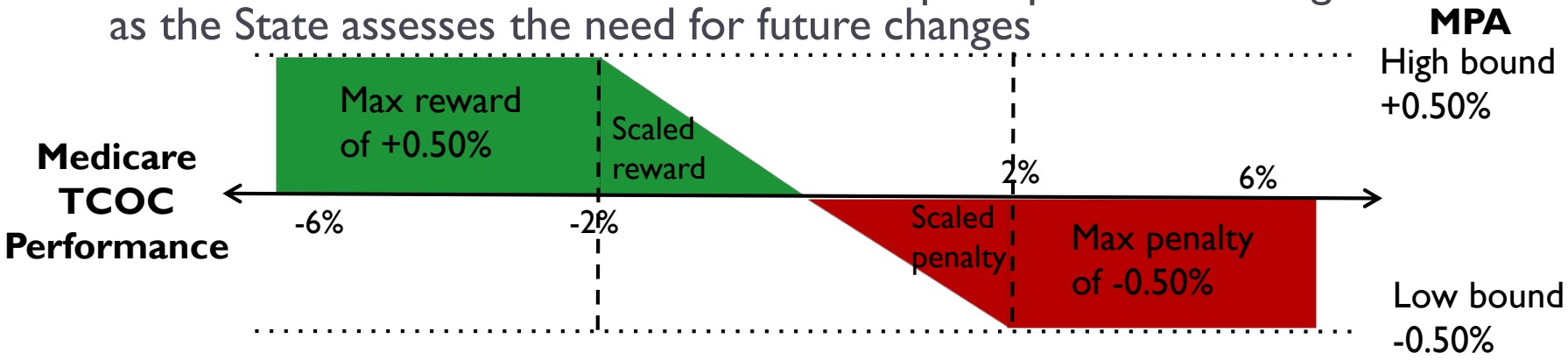


Eligible clinicians for 2017 defined as physicians, nurse practitioners, physician assistants, certified nurse specialists, and CRNA

Proposed MPA Structure

MPA: Current Design Concept

- 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
  - Be a part of the revenue at-risk for quality programs; redistribution of amounts at-risk may be necessary
  - NOTE: Not an insurance model
- Scaling approach includes a narrow band to minimize volatility risk
- MPA will be applied to Medicare hospital spending, starting at a maximum MPA of 0.5% of federal Medicare hospital payments
  - First payment adjustment in July 2019
  - Increase to 1.0% Medicare revenue at-risk, perhaps more moving forward, as the State assesses the need for future changes



Federal Medicare Payments (CY 2016) by Hospital, and 0.5% of Those Payments

Hospital	CY 16 Medicare claims	
A	B	C = B * 0.5%
STATE TOTAL	**$4,399,243,240**	**$21,996,216**
Anne Arundel	163,651,329	818,257
Atlantic General	30,132,666	150,663
BWMC	137,164,897	685,824
Bon Secours	22,793,980	113,970
Calvert	45,304,339	226,522
Carroll County	85,655,790	428,279
Charles Regional	46,839,127	234,196
Chestertown	23,104,009	115,520
Doctors Community	71,932,763	359,664
Easton	105,796,229	528,981
Franklin Square	152,733,233	763,666
Frederick Memorial	107,572,532	537,863
Ft. Washington	12,404,606	62,023
GBMC	109,329,016	546,645
Garrett County	12,485,063	62,425
Good Samaritan	111,439,737	557,199
Harbor	49,811,070	249,055
Harford	32,986,577	164,933
Holy Cross	84,757,140	423,786
Holy Cross Germantown	17,709,263	88,546
Hopkins Bayview	166,936,445	834,682
Howard County	74,364,089	371,820
Johns Hopkins	385,219,507	1,926,098

Hospital	CY 16 Medicare claims	
A	B	D = B * 0.5%
Laurel Regional	$28,395,414	$141,977
Levindale	37,853,194	189,266
McCready	5,281,208	26,406
Mercy	123,251,053	616,255
Meritus	93,863,687	469,318
Montgomery General	58,955,109	294,776
Northwest	87,214,773	436,074
Peninsula Regional	129,202,314	646,012
Prince George	60,059,396	300,297
Rehab & Ortho	26,772,477	133,862
Shady Grove	92,559,096	462,795
Sinai	231,161,132	1,155,806
Southern Maryland	77,940,994	389,705
St. Agnes	122,910,533	614,553
St. Mary	53,984,389	269,922
Suburban	89,000,075	445,000
UM St. Joseph	135,505,261	677,526
UMMC Midtown	61,852,594	309,263
Union Of Cecil	47,233,811	236,169
Union Memorial	141,726,131	708,631
University Of Maryland	365,949,340	1,829,747
Upper Chesapeake Health	107,984,715	539,924
Washington Adventist	69,512,752	347,564
Western Maryland	100,950,387	504,752

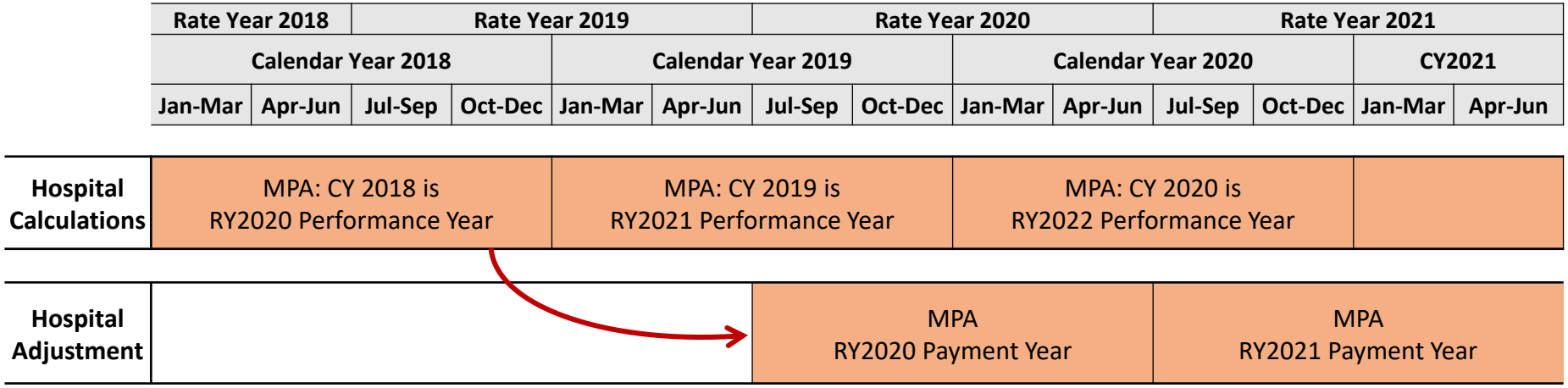
Source: HSCRC analysis of data from CMMI

High-level Issues to be Addressed in Year 1 MPA Policy

- Algorithm for attributing Medicare beneficiaries (those with Part A and Part B) to hospitals, to create a TCOC per capita
- Assess performance
  - Base year TCOC per capita (e.g., CY 2017 for Y1)
    - Apply TCOC Trend Factor (e.g., national Medicare FFS growth minus X%) to create a TCOC Benchmark
  - Performance year TCOC per capita (CY 2018 for Y1)
  - Compare performance to TCOC Benchmark (improvement only for Y1)
- Calculate MPA (i.e., percentage adjustment on hospital's federal Medicare payments – applying in RY 2020 for Y1)
  - Maximum Revenue at Risk (0.5% for Y1): Upper limit on MPA
  - Maximum Performance Threshold (2% for Y1): Percentage above/below TCOC Benchmark where Maximum Revenue at Risk is reached, with scaling in between

Tentative MPA Timeline

Date	Topic/Action
Ongoing	TCOC Work Group meetings, transitioning to technical revisions of potential MPA policy with stakeholders
October 2017	Staff drafts RY 2020 MPA Policy
November 2017	Draft RY 2020 MPA Policy presented to Commission
December 2017	Commission votes on Final RY 2020 MPA Policy
Jan 1, 2018	Performance Period for RY 2020 MPA begins



Considerations in Developing Attribution Algorithm for Hospital-specific Medicare TCOC

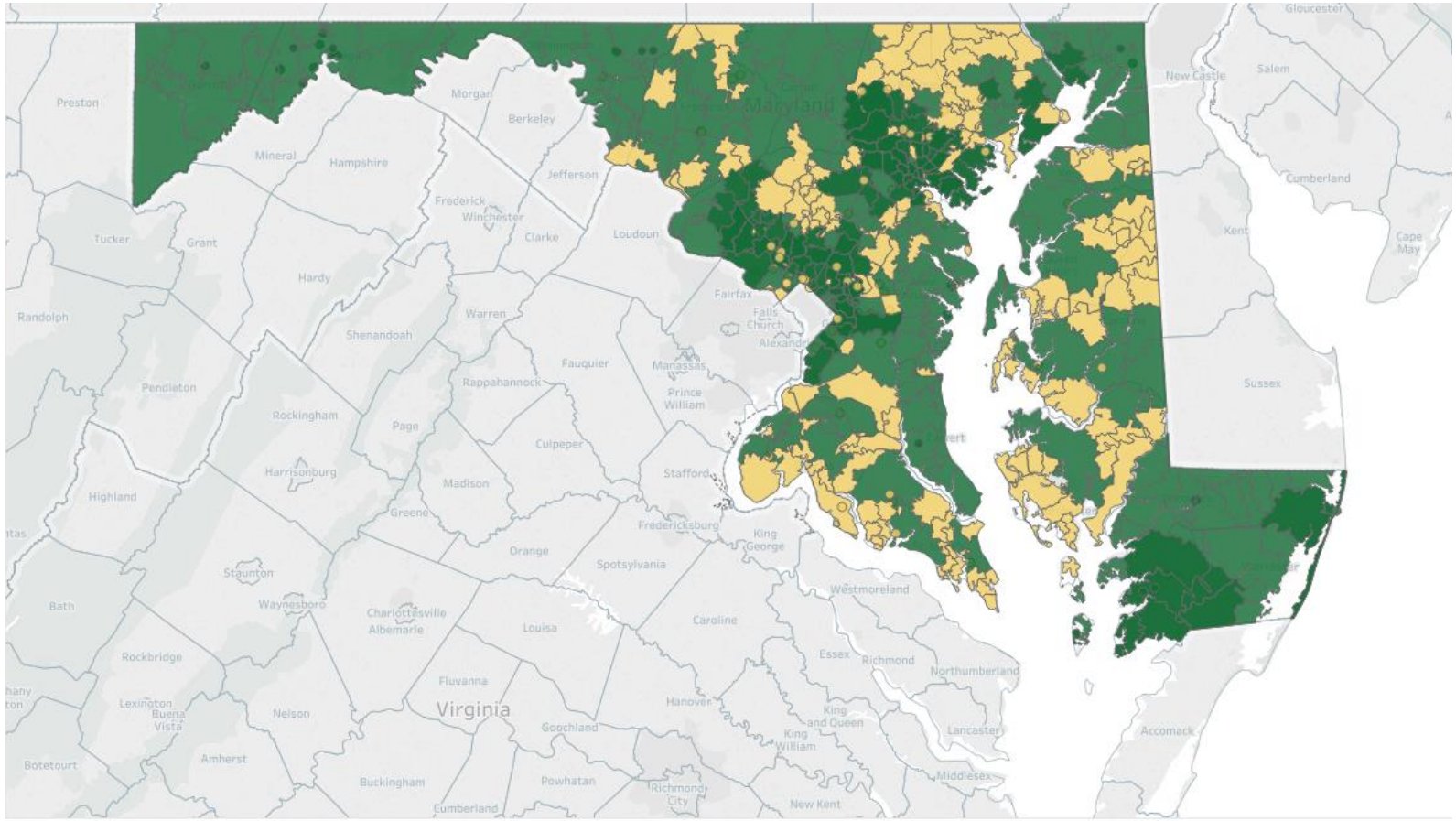
- Appropriate capture of hospital spending and total spending across the state
- Consistent with Model goals and conceptually sensible for hospitals
  - Are further reductions in avoidable utilization incentivized?
  - Can hospitals intervene on assigned beneficiaries and costs?
  - Does measure build upon existing investments and efforts to reduce TCOC?
- Measure stability over time
- Sharing service areas and/or beneficiaries
  - How does the method affect hospitals with overlapping geography?
  - How does the method deal with hospital care received outside of a beneficiary's residential geography?

Example: 3-Step Attribution Algorithm Under Consideration

Medicare beneficiary attribution could be based on hierarchy:

- ACO-like
  - Attribution of beneficiaries to ACO doctors based on primary care use
  - Linking of ACO doctors to Maryland hospitals in that ACO
- 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
- 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

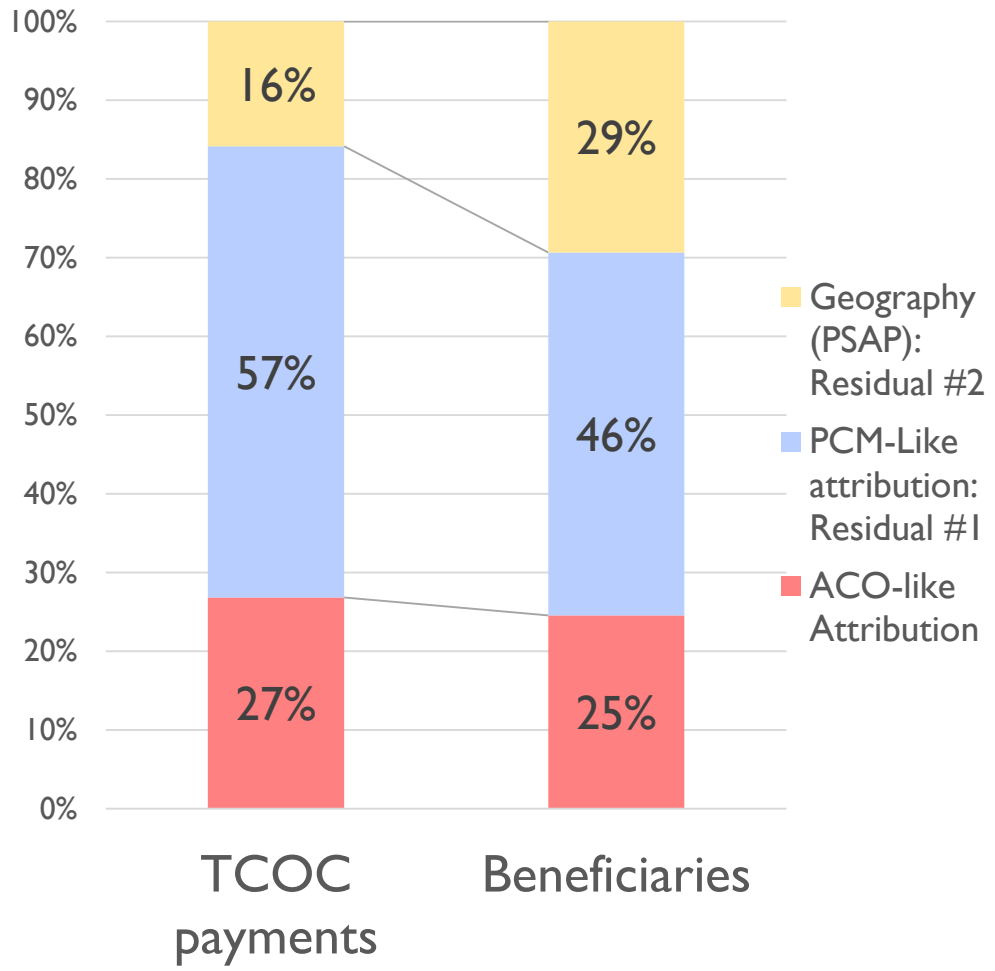
Zip Codes: In Current PSAs (green) vs. Not



Map based on Longitude (generated) and Latitude (generated). Color shows sum of PSA. Details are shown for Bene Zip and Hospname. The view is filtered on Hospname, which keeps 47 of 47 members.

0 1

Example: 3-Step Attribution Algorithm with Hospital-based ACO / PCM-Like / Geography



- Attribution occurs prospectively, based on utilization in prior 2 years
  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
- 87% retention of attributed beneficiaries to same hospital/system (excluding deaths and new Medicare enrollees)

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

If MPA Had Been In Effect on CY2016 Data with Hospital-based ACO / PCM-Like / Geography …

- Statewide net payout by Medicare to hospitals of $3.6 million
  - 15 hospitals at maximum positive 0.5% MPA
  - 9 hospitals with positive MPA less than maximum of 0.5%
  - 18 hospitals with negative MPA less than maximum of 0.5%
  - 4 hospitals at maximum negative 0.5% MPA
- Out of $22.0 potential at-risk, $13.8 million realized (positive and negative)
- Other attribution methods yielded net payouts of $1.1-$3.1 million, vs. $3.6 million

Medicare TCOC Measure Methodology: Year 2 Considerations

- Assessing for possible refinements
  - Beneficiary and cost consistency over time
  - Additional ways to sensibly link doctors to hospitals (e.g., Care Redesign, Clinically Integrated Networks, etc.)
  - Refinements on geography and impact of geography changes over time
- Increased Maximum Revenue at Risk under MPA (+/- 1%)
  - Appropriate Maximum Performance Threshold still 2%?
- Steps toward Attainment?
  - Adjusting for demographics/risk?
- Effects on other programs/unintended consequences

MPA: Strategic Design Questions

- How should the MPA interact with existing revenue at-risk for quality?

Maximum Quality Penalties or Rewards for Maryland and The Nation

MD All-Payer	Max Penalty %	Max Reward %	National Medicare	Max Penalty %	Max Reward %
RY 2019			FFY 2019		
MHAC	2.0%	1.0%	HAC	1.0%	N/A
RRIP	2.0%	1.0%	HRRP	3.0%	N/A
QBR	2.0%	2.0%	VBP	2.0%	2.0%

- How should the MPA reflect statewide Medicare TCOC performance? Possible options:
  - In future years, split MPA into two parts: (a) hospital-specific TCOC performance and (b) statewide TCOC performance?
  - Adjust trend factor for benchmarking by statewide TCOC performance?

Rural Health Workgroup and Study

Ben Steffen

Executive Director, MHCC

September 13th, 2017

MARYLAND HEALTH CARE COMMISSION

SB 707 Freestanding Medical Facilities- Certificate of Need, Rates and Definitions

- Requires MHCC to establish regulations for freestanding medical facility conversions.
- Regulations must address a public notification process.
- Regulations adopted in 2017
  - University of Maryland Upper Chesapeake submitted an exemption request to convert Harford Memorial to an FMF at Bulle Rock.
  - University of Maryland Shore Health has notified MHCC and HSCRC of plans to convert Dorchester General to an FMF.
  - University of Maryland Capital Region Health is working on plans for Laurel Regional Hospital.

SB 707 - Rural Health Workgroup

- Members
  - General Assembly Members
  - Secretary of MDH
  - CEOs of several rural hospitals
  - Providers, consumers, local government, businesses, labor
- Purpose
  - 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.

SB 707- Rural Health Study

- Examine challenges in health care delivery in the five county region of the Mid-Eastern Shore.
- Examine the economic impact of hospital closure or conversion.
- Identify opportunities created by telehealth and the Maryland all-payer model.
- Develop policy options for addressing the health care needs and delivery system in the five county region.
- Identify approaches for applying policy options to other rural areas of Maryland.

Rural Health Delivery Study

- Examine challenges to the delivery of health care in the Mid Shore area, including:
  - the limited availability of health care providers and services;
  - the special needs of vulnerable populations;
  - transportation barriers; and
  - the economic impact of the closure, partial closure, or conversion of a health care facility;
- Identify opportunities created by telehealth, the current Maryland all–payer model, and the future TCOC model, for restructuring the delivery of health care services.
- Develop policy options for addressing the health care needs of residents of, and improving the health care delivery system in, the Mid-Shore.
- Use the five county Mid Shore area as a model for other rural Maryland regions.

Process and Progress

- Workgroup
  - Met 6 times beginning in August 2016 and the final meeting is September 28, 2017
  - Established four advisory groups (each met ~4 times)
    - Workforce
    - Economic Development
    - Transportation
    - Vulnerable Populations
  - Held Public Hearings in each of the 5 Jurisdictions
- Study – UMCP School of Public Health & Walsh Center at NORC
  - Quantitative Research
  - Qualitative Research
    - Focus Groups
    - Stakeholder Interviews

Key Draft Recommendations

- The Rural Community Health Complex
  - Goals:
    - Create a center for health care delivery in a rural community
    - Better integration/coordination of existing services (clinical, governmental and social)
    - Decrease transportation barriers
    - Create a community of wellness
  - Responds to the public's desire to access care close to home
  - Engages communities in governance

Key Draft Recommendations

- Rural Community Health Complex
  - Types/Components of Complexes
    - Essential Care - full or part-time primary care site;
    - Advanced Primary Care – FQHC, or primary care practice site;
    - Advanced Ambulatory Care/ with or without an FMF;
    - Special Rural Community Hospital.
  - Patient-Centered Support Care and Technology Hub enables
    - Coordination between providers;
    - Assistance in getting needed social, governmental and behavioral health services;
    - Education and counseling to help manage chronic conditions;
    - Use of existing supports such as CRISP and the proposed MDPCP.
  - Acute general hospitals and regional medical centers would be important links to the local complexes.

Key Draft Recommendations

- Special Rural Hospital Designation/Rural Hospital Program
  - 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.
  - Hospitals must specify concrete goals and plans for implementing those goals to include:
    - Improving quality of care;
    - Establishing expanded access to advanced primary care;
    - Decreasing admissions, readmissions and transfers.
  - Hospital would describe how it would work with other health care providers and facilities to serve the population in the hospital's service area and explain how any enhancements provided through the additional GBR would contribute to the population's health.
  - Hospital must meet certain criteria to qualify.
  - Program would last a specific time (5 years) and would be renewable through agreement of HSCRC and the Hospital.

Key Draft Recommendations

- Workforce
  - Establish a Rural Health Scholarship Program for medical students and students in other health professions willing to practice in rural Maryland.
  - Create incentives and programs for students and residents to practice in rural communities by:
    - Identifying sustainable funding for a primary care track program;
    - Establishing a primary care residency program or a primary care rotation;
    - Establish specialty rotation programs outside of the Baltimore metro region.
  - Streamline and expand the Maryland Loan Assistance Repayment Program.
  - Realign the prioritization of the J-1 visa program and encourage/assist communities where J-1 visa recipients are placed.
  - Develop and fund additional nurse practitioner and physician assistant programs in rural colleges and universities.
  - Enhance behavioral health and substance abuse services in the community.
  - Revisit several Recommendations of the Workgroup on Workforce Development for Community Health Workers.

Next steps

- September 28th - Workgroup will consider Draft Recommendations and Report
  - Finalize recommendations into 3 broad buckets which align with the goals of the workgroup:
    - Fostering participation in Statewide Models and Programs in Rural Communities;
    - Bringing Care to the Patient;
    - Building Coalitions to promote healthy communities.
  - Establish implementation phases
- October 19th – MHCC considers Report and Recommendations
- November 2017 – Final Report to Governor and Legislative Committees

Physician Costs Incurred by Hospitals

FY 2016

Physician Costs Incurred by Hospitals

There are two categories of physician costs incurred by hospitals:

- Costs associated with physicians providing non-Part B professional services in the regulated hospital
- Costs associated with the losses incurred by the provision of physician professional services by hospital employed physicians and by physician practices owned at least 50% by the hospital

Non-Part B Services Provided by Physicians

These services provided by physicians to hospitals include:

- Administration and supervision
- Chief of Medical Staff
- Medical Care Review
- Research
- Graduate Medical Education

In FY 2016 the total costs incurred by hospitals for physicians providing services other than Part B professional services were $339,969,710 (Exhibit A).

Physicians Part B Professional Services

Costs incurred by hospitals associated with the provision of physician Part B professional services include:

- Physicians employed by the hospital
- Net Losses associated with physician practices in which the hospital owns at least 50% of the practice

It should be noted that the data presented today does not include physician costs associated with physicians employed by or practices owned by Hospital Systems.

Physician Part B Professional Services

Prior to FY 2016 hospitals only reported the expenses and revenues associated with physician Part B professional services in the aggregate. However, beginning with FY 2016, hospitals were required to report by physician specialty and by whether or not the physician is hospital-based.

This enables physician profit and losses to be categorized by hospital based and non-hospital based physicians by hospital and by specialty.

Physician Part B Specialties with the Greatest Cost to Hospitals

Hospital Based		Non-Hospital Based	
Internal Medicine	$62 million	Internal Medicine	$44 million
Critical Care Medicine	$31 million	General Surgery	$42 million
Anesthesiology	$30 million	Cardiology	$29 million
General Practice	$20 million	Orthopedic Surgery	$29 million
Obstetrics/Gyn.	$18 million	Obstetrics/Gyn.	$15 million

Physician Part B Specialties with the Greatest Cost to Hospitals

	Total
Internal Medicine	$106 million
General Surgery	$47 million
Anesthesiology	$36 million
Critical Care Medicine	$34 million
Obstetrics/Gyn.	$34 million

Physician Part B Professional Services

- The total net costs associated with physician Part B professional services in FY 2016 were $534,990,120 (By Hospital Exhibit B & By Specialty Exhibit C)
- The net losses associated hospital based physician Part B professional services in FY 2016 were $207,268,700 (By Hospital Exhibit D & By Specialty Exhibit E)
- The net losses associated with non-hospital based physician Part B professional services were 337,721,420 (By Hospital Exhibit F & By Specialty Exhibit G)

TOTAL PHYSICIAN COSTS FY 2016

- The total physician costs incurred by hospitals in FY 2016 for both Part B professional services and Non-Part B services were $874,959,830 (EXHIBIT H).

9/5/2017

EXHIBIT H

Hospital Number	Hospital	NON-PART B PHYSICIAN SERVICES COSTS: Chief of Medical Staff	Medical Care Review	Part A Administration & Supervision*	Education	Research	Total	PART B - UNREGULATED PHYSICIAN PROFESSIONAL SERVICES COSTS: Hospital Based Physician (Profit)/Loss	Non-Hospital Based Physician (Profit)/Loss	Total (Profit)/Loss	Total Physician Cost to Hospital
210001	Meritus	$ -	$ -	$ 5,606,000	$ -	$ -	$ 5,606,000	$ 4,572,600	$ 2,074,000	$ 6,646,600	$ 12,252,600
210002	UMMC	$ -	$ -	$ 12,492,650	$ 65,586,420	$ -	$ 78,079,070	$ -	$ 15,450,200	$ 15,450,200	$ 93,529,270
210003	PG Hospital	$ -	$ -	$ 3,768,640	$ 898,000	$ -	$ 4,666,640	$ 17,663,282	$ 12,960,048	$ 30,623,330	$ 35,289,970
210004	Holy Cross	$ -	$ -	$ 1,772,180	$ 204,560	$ -	$ 1,976,740	$ 6,040,100	$ -	$ 6,040,100	$ 8,016,840
210005	Frederick	$ -	$ -	$ 1,644,210	$ -	$ -	$ 1,644,210	$ 1,345,400	$ 8,993,200	$ 10,338,600	$ 11,982,810
210006	UM-Harford	$ -	$ -	$ 1,142,000	$ -	$ -	$ 1,142,000	$ -	$ 1,989,200	$ 1,989,200	$ 3,131,200
210008	Mercy	$ -	$ -	$ 7,735,070	$ 354,780	$ -	$ 8,089,850	$ 4,274,552	$ 1,143,753	$ 5,418,305	$ 13,508,155
210009	Johns Hopkins	$ -	$ 2,393,770	$ 12,947,250	$ 52,319,850	$ -	$ 67,660,870	$ 10,106,751	$ 1,490,349	$ 11,597,100	$ 79,257,970
210010	UM-Dorchester	$ -	$ -	$ 2,233,000	$ -	$ -	$ 2,233,000	$ -	$ -	$ -	$ 2,233,000
210011	St. Agnes	$ -	$ -	$ 4,778,600	$ 2,455,000	$ -	$ 7,233,600	$ 11,527,700	$ 24,383,700	$ 35,911,400	$ 43,145,000
210012	Sinai	$ -	$ 2,338,900	$ 16,103,700	$ 4,700,600	$ 610,500	$ 23,753,700	$ 9,099,900	$ 28,191,100	$ 37,291,000	$ 61,044,700
210013	Bon Secours	$ -	$ -	$ 1,112,840	$ -	$ -	$ 1,112,840	$ 8,480,100	$ 695,800	$ 9,175,900	$ 10,288,740
210015	MedStar Fr Square	$ -	$ 717,980	$ 6,858,200	$ 4,362,670	$ -	$ 11,938,850	$ 14,469,100	$ 9,355,200	$ 23,824,300	$ 35,763,150
210016	Washington Adventist	$ -	$ -	$ 362,000	$ -	$ -	$ 362,000	$ 6,537,500	$ 3,683,600	$ 10,221,100	$ 10,583,100
210017	Garrett	$ -	$ -	$ 16,000	$ -	$ -	$ 16,000	$ 382,420	$ 657,200	$ 1,039,620	$ 1,055,620
210018	MedStar Montgomery	$ -	$ 122,350	$ 697,270	$ -	$ -	$ 819,620	$ 3,925,600	$ 4,255,900	$ 8,181,500	$ 9,001,120
210019	Peninsula	$ -	$ -	$ 1,073,500	$ -	$ -	$ 1,073,500	$ 15,927,500	$ 13,198,400	$ 29,125,900	$ 30,199,400
210022	Suburban	$ -	$ -	$ 2,082,760	$ 21,680	$ -	$ 2,104,440	$ 2,134,000	$ 3,606,800	$ 5,740,800	$ 7,845,240
210023	Anne Arundel	$ -	$ -	$ 4,480,200	$ -	$ -	$ 4,480,200	$ 10,151,700	$ 12,725,300	$ 22,877,000	$ 27,357,200
210024	MedStar Union Memorial	$ -	$ 404,110	$ 3,857,900	$ 8,142,270	$ -	$ 12,404,280	$ 8,318,400	$ 22,927,600	$ 31,246,000	$ 43,650,280
210027	Western Maryland	$ -	$ -	$ 1,977,400	$ -	$ -	$ 1,977,400	$ -	$ 20,262,600	$ 20,262,600	$ 22,240,000
210028	MedStar St. Mary's	$ -	$ 30,160	$ 94,560	$ -	$ -	$ 124,720	$ 3,041,200	$ 3,626,600	$ 6,667,800	$ 6,792,520
210029	JH Bayview	$ -	$ 327,400	$ 20,856,200	$ 11,273,300	$ -	$ 32,456,900	$ 4,549,675	$ 1,927,600	$ 6,477,275	$ 38,934,175
210030	UM-Chestertown	$ -	$ -	$ 725,000	$ -	$ -	$ 725,000	$ (791,200)	$ 1,975,700	$ 1,184,500	$ 1,909,500
210032	Union of Cecil	$ -	$ -	$ 426,800	$ -	$ -	$ 426,800	$ 654,300	$ 8,964,200	$ 9,618,500	$ 10,045,300
210033	Carroll	$ 49,800	$ -	$ 1,259,990	$ -	$ -	$ 1,309,790	$ 5,264,100	$ 4,704,100	$ 9,968,200	$ 11,277,990
210034	MedStar Harbor	$ -	$ 430,910	$ 826,760	$ 1,449,110	$ -	$ 2,706,780	$ 555,100	$ 4,895,600	$ 5,450,700	$ 8,157,480
210035	UM-Charles Regional	$ -	$ -	$ 878,420	$ -	$ -	$ 878,420	$ -	$ 3,032,000	$ 3,032,000	$ 3,910,420
210037	UM-Easton	$ -	$ -	$ 5,200,300	$ -	$ -	$ 5,200,300	$ -	$ -	$ -	$ 5,200,300
210038	UMMC Midtown	$ -	$ 371,710	$ 2,587,820	$ 1,147,860	$ -	$ 4,107,390	$ -	$ 18,936,400	$ 18,936,400	$ 23,043,790
210039	Calvert	$ -	$ -	$ 551,190	$ -	$ -	$ 551,190	$ -	$ 4,081,600	$ 4,081,600	$ 4,632,790
210040	Northwest	$ 120,850	$ 31,240	$ 698,310	$ -	$ -	$ 850,400	$ 6,560,200	$ 5,477,500	$ 12,037,700	$ 12,888,100
210043	UM-BWMC	$ -	$ -	$ 1,861,410	$ -	$ -	$ 1,861,410	$ -	$ 5,728,400	$ 5,728,400	$ 7,589,810
210044	GBMC	$ -	$ -	$ 5,820,400	$ 1,030,500	$ 75,200	$ 6,926,100	$ 18,262,400	$ 3,016,800	$ 21,279,200	$ 28,205,300
210045	McCready	$ -	$ -	$ 829,860	$ -	$ -	$ 829,860	$ 63,600	$ (551,500)	$ (487,900)	$ 341,960
210048	Howard County	$ -	$ -	$ 4,141,810	$ -	$ -	$ 4,141,810	$ 6,591,000	$ -	$ 6,591,000	$ 10,732,810
210049	UM-Upper Chesapeake	$ -	$ -	$ 3,349,850	$ -	$ -	$ 3,349,850	$ -	$ 8,144,200	$ 8,144,200	$ 11,494,050
210051	Doctors	$ -	$ -	$ 833,410	$ -	$ -	$ 833,410	$ 3,587,300	$ 2,926,700	$ 6,514,000	$ 7,347,410
210055	Laurel Regional	$ -	$ 29,490	$ 316,730	$ -	$ -	$ 346,220	$ 6,090,100	$ 2,269,900	$ 8,360,000	$ 8,706,220
210056	MedStar Good Samaritan	$ -	$ 2,192,850	$ 2,339,510	$ 1,732,330	$ -	$ 6,264,690	$ 1,886,200	$ 15,764,000	$ 17,650,200	$ 23,914,890
210057	Shady Grove	$ -	$ -	$ 431,610	$ -	$ -	$ 431,610	$ 4,205,100	$ 3,622,600	$ 7,827,700	$ 8,259,310
210058	UMROI	$ -	$ -	$ 6,348,900	$ 2,852,410	$ -	$ 9,201,310	$ -	$ -	$ -	$ 9,201,310
210060	Ft. Washington	$ -	$ -	$ 1,520,280	$ -	$ -	$ 1,520,280	$ -	$ 366,850	$ 366,850	$ 1,887,130
210061	Atlantic General	$ -	$ -	$ 892,380	$ -	$ -	$ 892,380	$ 3,898,621	$ 7,035,119	$ 10,933,740	$ 11,826,120
210062	MedStar Southern MD	$ 370,000	$ -	$ -	$ -	$ -	$ 370,000	$ 1,741,600	$ 16,721,600	$ 18,463,200	$ 18,833,200
210063	UM-St. Joe	$ -	$ -	$ 1,888,330	$ -	$ -	$ 1,888,330	$ -	$ 16,342,100	$ 16,342,100	$ 18,230,430
210064	Levindale	$ 186,000	$ -	$ -	$ -	$ -	$ 186,000	$ 277,000	$ 198,700	$ 475,700	$ 661,700
210065	HC-Germantown	$ -	$ -	$ 99,190	$ -	$ -	$ 99,190	$ 5,875,800	$ -	$ 5,875,800	$ 5,974,990
210088	UM-Queen Anne's ED	$ -	$ -	$ 895,690	$ -	$ -	$ 895,690	$ -	$ -	$ -	$ 895,690
210333	Bowie ED	$ -	$ -	$ 106,860	$ -	$ -	$ 106,860	$ -	$ 470,700	$ 470,700	$ 577,560
218992	UM-Shock Trauma	$ -	$ -	$ 1,937,950	$ 10,174,260	$ -	$ 12,112,210	$ -	$ -	$ -	$ 12,112,210
		$ 726,650	$ 9,390,870	$ 160,460,890	$ 168,705,600	$ 685,700	$ 339,969,710	$ 207,268,701	$ 327,721,419	$ 534,990,120	$ 874,959,830

8/2/2017

NON-PART B PHYSICIAN SERVICES COSTS

EXHIBIT A

Hospital Number	Hospital	Chief of Medical Staff	Medical Care Review	Part A Administration & Supervision*	Education	Research	Total
210001	Meritus	$ -	$ -	$ 5,606,000	$ -	$ -	$ 5,606,000
210002	UMMC	$ -	$ -	$ 12,492,650	$ 65,586,420	$ -	$ 78,079,070
210003	PG Hospital	$ -	$ -	$ 3,768,640	$ 898,000	$ -	$ 4,666,640
210004	Holy Cross	$ -	$ -	$ 1,772,180	$ 204,560	$ -	$ 1,976,740
210005	Frederick	$ -	$ -	$ 1,644,210	$ -	$ -	$ 1,644,210
210006	UM-Harford	$ -	$ -	$ 1,142,000	$ -	$ -	$ 1,142,000
210008	Mercy	$ -	$ -	$ 7,735,070	$ 354,780	$ -	$ 8,089,850
210009	Johns Hopkins	$ -	$ 2,393,770	$ 12,947,250	$ 52,319,850	$ -	$ 67,660,870
210010	UM-Dorchester	$ -	$ -	$ 2,233,000	$ -	$ -	$ 2,233,000
210011	St. Agnes	$ -	$ -	$ 4,778,600	$ 2,455,000	$ -	$ 7,233,600
210012	Sinai	$ -	$ 2,338,900	$ 16,103,700	$ 4,700,600	$ 610,500	$ 23,753,700
210013	Bon Secours	$ -	$ -	$ 1,112,840	$ -	$ -	$ 1,112,840
210015	MedStar Fr Square	$ -	$ 717,980	$ 6,858,200	$ 4,362,670	$ -	$ 11,938,850
210016	Washington Adventist	$ -	$ -	$ 362,000	$ -	$ -	$ 362,000
210017	Garrett	$ -	$ -	$ 16,000	$ -	$ -	$ 16,000
210018	MedStar Montgomery	$ -	$ 122,350	$ 697,270	$ -	$ -	$ 819,620
210019	Peninsula	$ -	$ -	$ 1,073,500	$ -	$ -	$ 1,073,500
210022	Suburban	$ -	$ -	$ 2,082,760	$ 21,680	$ -	$ 2,104,440
210023	Anne Arundel	$ -	$ -	$ 4,480,200	$ -	$ -	$ 4,480,200
210024	MedStar Union Memorial	$ -	$ 404,110	$ 3,857,900	$ 8,142,270	$ -	$ 12,404,280
210027	Western Maryland	$ -	$ -	$ 1,977,400	$ -	$ -	$ 1,977,400
210028	MedStar St. Mary's	$ -	$ 30,160	$ 94,560	$ -	$ -	$ 124,720
210029	JH Bayview	$ -	$ 327,400	$ 20,856,200	$ 11,273,300	$ -	$ 32,456,900
210030	UM-Chestertown	$ -	$ -	$ 725,000	$ -	$ -	$ 725,000
210032	Union of Cecil	$ -	$ -	$ 426,800	$ -	$ -	$ 426,800
210033	Carroll	$ 49,800	$ -	$ 1,259,990	$ -	$ -	$ 1,309,790
210034	MedStar Harbor	$ -	$ 430,910	$ 826,760	$ 1,449,110	$ -	$ 2,706,780
210035	UM-Charles Regional	$ -	$ -	$ 878,420	$ -	$ -	$ 878,420
210037	UM-Easton	$ -	$ -	$ 5,200,300	$ -	$ -	$ 5,200,300
210038	UMMC Midtown	$ -	$ 371,710	$ 2,587,820	$ 1,147,860	$ -	$ 4,107,390
210039	Calvert	$ -	$ -	$ 551,190	$ -	$ -	$ 551,190
210040	Northwest	$ 120,850	$ 31,240	$ 698,310	$ -	$ -	$ 850,400
210043	UM-BWMC	$ -	$ -	$ 1,861,410	$ -	$ -	$ 1,861,410
210044	GBMC	$ -	$ -	$ 5,820,400	$ 1,030,500	$ 75,200	$ 6,926,100
210045	McCready	$ -	$ -	$ 829,860	$ -	$ -	$ 829,860
210048	Howard County	$ -	$ -	$ 4,141,810	$ -	$ -	$ 4,141,810
210049	UM-Upper Chesapeake	$ -	$ -	$ 3,349,850	$ -	$ -	$ 3,349,850
210051	Doctors	$ -	$ -	$ 833,410	$ -	$ -	$ 833,410
210055	Laurel Regional	$ -	$ 29,490	$ 316,730	$ -	$ -	$ 346,220
210056	MedStar Good Samaritan	$ -	$ 2,192,850	$ 2,339,510	$ 1,732,330	$ -	$ 6,264,690
210057	Shady Grove	$ -	$ -	$ 431,610	$ -	$ -	$ 431,610
210058	UMROI	$ -	$ -	$ 6,348,900	$ 2,852,410	$ -	$ 9,201,310
210060	Ft. Washington	$ -	$ -	$ 1,520,280	$ -	$ -	$ 1,520,280
210061	Atlantic General	$ -	$ -	$ 892,380	$ -	$ -	$ 892,380
210062	MedStar Southern MD	$ 370,000	$ -	$ -	$ -	$ -	$ 370,000
210063	UM-St. Joe	$ -	$ -	$ 1,888,330	$ -	$ -	$ 1,888,330
210064	Levindale	$ 186,000	$ -	$ -	$ -	$ -	$ 186,000
210065	HC-Germantown	$ -	$ -	$ 99,190	$ -	$ -	$ 99,190
210088	UM-Queen Anne's ED	$ -	$ -	$ 895,690	$ -	$ -	$ 895,690
210333	Bowie ED	$ -	$ -	$ 106,860	$ -	$ -	$ 106,860
218992	UM-Shock Trauma	$ -	$ -	$ 1,937,950	$ 10,174,260	$ -	$ 12,112,210
	Totals	$ 726,650	$ 9,390,870	$ 160,460,890	$ 168,705,600	$ 685,700	$ 339,969,710

8/2/2017

TOTAL - PART B PHYSICIAN PROFESSIONAL COSTS

EXHIBIT B

Hospital Number	Hospital	Wage, Salaries & Fringe Benefits	Other Expenses	Total Expenses	Revenue	Profit/Loss
210001	Meritus	$ 4,756,800	$ 5,231,700	$ 9,988,500	$ 3,341,900	$ (6,646,600)
210002	UMMC	$ -	$ 15,450,200	$ 15,450,200	$ -	$ (15,450,200)
210003	PG Hospital	$ 6,556,916	$ 33,020,446	$ 39,577,362	$ 8,954,032	$ (30,623,330)
210004	Holy Cross	$ 2,562,600	$ 6,163,600	$ 8,726,200	$ 2,686,100	$ (6,040,100)
210005	Frederick	$ 360,000	$ 9,994,700	$ 10,354,700	$ 16,100	$ (10,338,600)
210006	UM-Harford	$ -	$ 1,989,200	$ 1,989,200	$ -	$ (1,989,200)
210008	Mercy	$ 13,185,101	$ 793,455	$ 13,978,556	$ 8,560,251	$ (5,418,305)
210009	Johns Hopkins	$ -	$ 11,597,100	$ 11,597,100	$ -	$ (11,597,100)
210010	UM-Dorchester	$ -	$ -	$ -	$ -	$ -
210011	St. Agnes	$ 81,877,900	$ 18,187,000	$ 100,064,900	$ 64,153,500	$ (35,911,400)
210012	Sinai	$ 65,571,600	$ 26,298,800	$ 91,870,400	$ 54,579,400	$ (37,291,000)
210013	Bon Secours	$ 3,341,300	$ 10,640,100	$ 13,981,400	$ 4,805,500	$ (9,175,900)
210015	MedStar Fr Square	$ 74,250,400	$ 28,847,300	$ 103,097,700	$ 79,273,400	$ (23,824,300)
210016	Washington Adventist	$ 108,300	$ 10,720,300	$ 10,828,600	$ 607,500	$ (10,221,100)
210017	Garrett	$ 2,127,500	$ 952,800	$ 3,080,300	$ 2,040,680	$ (1,039,620)
210018	MedStar Montgomery	$ 7,268,900	$ 5,935,400	$ 13,204,300	$ 5,022,800	$ (8,181,500)
210019	Peninsula	$ 34,241,900	$ 8,616,000	$ 42,857,900	$ 13,732,000	$ (29,125,900)
210022	Suburban	$ -	$ 6,556,100	$ 6,556,100	$ 815,300	$ (5,740,800)
210023	Anne Arundel	$ 954,900	$ 22,144,400	$ 23,099,300	$ 222,300	$ (22,877,000)
210024	MedStar Union Memorial	$ 45,706,400	$ 34,705,800	$ 80,412,200	$ 49,166,200	$ (31,246,000)
210027	Western Maryland	$ 13,180,600	$ 15,085,200	$ 28,265,800	$ 8,003,200	$ (20,262,600)
210028	MedStar St. Mary's	$ 3,733,400	$ 5,794,600	$ 9,528,000	$ 2,860,200	$ (6,667,800)
210029	JH Bayview	$ -	$ 7,509,175	$ 7,509,175	$ 1,031,900	$ (6,477,275)
210030	UM-Chestertown	$ 3,004,000	$ 391,300	$ 3,395,300	$ 2,210,800	$ (1,184,500)
210032	Union of Cecil	$ 9,965,100	$ 12,012,200	$ 21,977,300	$ 12,358,800	$ (9,618,500)
210033	Carroll	$ 2,677,300	$ 8,699,200	$ 11,376,500	$ 1,408,300	$ (9,968,200)
210034	MedStar Harbor	$ 9,043,600	$ 9,557,100	$ 18,600,700	$ 13,150,000	$ (5,450,700)
210035	UM-Charles Regional	$ 62,000	$ 3,276,300	$ 3,338,300	$ 306,300	$ (3,032,000)
210037	UM-Easton	$ -	$ -	$ -	$ -	$ -
210038	UMMC Midtown	$ 22,515,200	$ 1,155,500	$ 23,670,700	$ 4,734,300	$ (18,936,400)
210039	Calvert	$ 381,800	$ 3,685,100	$ 4,066,900	$ (14,700)	$ (4,081,600)
210040	Northwest	$ 16,785,500	$ 5,199,300	$ 21,984,800	$ 9,947,100	$ (12,037,700)
210043	UM-BWMC	$ 299,200	$ 7,091,800	$ 7,391,000	$ 1,662,600	$ (5,728,400)
210044	GBMC	$ 28,895,800	$ 7,433,600	$ 36,329,400	$ 15,050,200	$ (21,279,200)
210045	McCready	$ 276,200	$ 537,000	$ 813,200	$ 1,301,100	$ 487,900
210048	Howard County	$ -	$ 6,591,000	$ 6,591,000	$ -	$ (6,591,000)
210049	UM-Upper Chesapeake	$ -	$ 8,144,200	$ 8,144,200	$ -	$ (8,144,200)
210051	Doctors	$ 5,904,600	$ 2,975,100	$ 8,879,700	$ 2,365,700	$ (6,514,000)
210055	Laurel Regional	$ 1,215,600	$ 8,572,400	$ 9,788,000	$ 1,428,000	$ (8,360,000)
210056	MedStar Good Samaritan	$ 23,414,900	$ 18,735,800	$ 42,150,700	$ 24,500,500	$ (17,650,200)
210057	Shady Grove	$ 62,600	$ 7,765,100	$ 7,827,700	$ -	$ (7,827,700)
210058	UMROI	$ -	$ -	$ -	$ -	$ -
210060	Ft. Washington	$ 348,008	$ 800,702	$ 1,148,710	$ 781,860	$ (366,850)
210061	Atlantic General	$ 19,676,061	$ 8,049,788	$ 27,725,849	$ 16,792,109	$ (10,933,740)
210062	MedStar Southern MD	$ 4,789,200	$ 20,162,700	$ 24,951,900	$ 6,488,700	$ (18,463,200)
210063	UM-St. Joe	$ 1,187,200	$ 15,154,900	$ 16,342,100	$ -	$ (16,342,100)
210064	Levindale	$ 558,300	$ 143,400	$ 701,700	$ 226,000	$ (475,700)
210065	HC-Germantown	$ 59,400	$ 6,421,400	$ 6,480,800	$ 605,000	$ (5,875,800)
210088	UM-Queen Anne's ED	$ -	$ -	$ -	$ -	$ -
210333	Bowie ED	$ 70,000	$ 400,700	$ 470,700	$ -	$ 400,700
218992	UM-Shock Trauma	$ -	$ -	$ -	$ -	$ -
		$ 510,976,086	$ 449,188,966	$ 960,165,052	$ 425,174,932	$ (534,990,120)

8/2/2017

TOTAL - PART B PHYSICIAN PROFESSIONAL SERVICES COSTS

EXHIBIT C

Code	Physician Description	Wage, Salaries & Fringe Benefits	Other Expenses	Total Expenses	Revenue	Profit/(Loss)
1	GENERAL PRACTICE	$ 30,167,421	$ 15,773,920	$ 45,941,340	$ 17,287,693	$ (28,653,648)
2	GENERAL SURGERY	$ 39,601,743	$ 28,473,912	$ 68,075,654	$ 20,939,159	$ (47,136,496)
4	OTOLARYNGOLOGY	$ 3,101,403	$ 2,093,500	$ 5,194,903	$ 2,639,800	$ (2,555,103)
5	ANESTHESIOLOGY	$ 8,868,764	$ 36,098,576	$ 44,967,340	$ 8,835,427	$ (36,131,913)
6	CARDIOLOGY	$ 20,959,238	$ 27,062,232	$ 48,021,470	$ 18,883,528	$ (29,137,942)
7	DERMATOLOGY	$ 2,022,451	$ 2,542,872	$ 4,565,323	$ 3,204,049	$ (1,361,274)
8	FAMILY PRACTICE	$ 30,167,936	$ 18,107,790	$ 48,275,727	$ 31,299,071	$ (16,976,656)
9	INTERVENTIONAL PAIN MANAGEMENT	$ 10,000	$ 500	$ 10,500	$ 600	$ (9,900)
10	GASTROENTEROLOGY	$ 10,013,453	$ 5,483,767	$ 15,497,220	$ 10,517,545	$ (4,979,675)
11	INTERNAL MEDICINE	$ 74,885,770	$ 80,367,728	$ 155,253,498	$ 49,064,324	$ (106,189,174)
12	OSTEOPATHIC MANIPULATIVE MEDICINE	$ 458,400	$ 348,100	$ 806,500	$ 292,200	$ (514,300)
13	NEUROLOGY	$ 15,006,621	$ 7,061,231	$ 22,067,852	$ 10,989,231	$ (11,078,621)
14	NEUROSURGERY	$ 7,589,963	$ 3,980,700	$ 11,570,663	$ 6,156,400	$ (5,414,263)
16	OBSTETRICS & GYNECOLOGY	$ 37,588,330	$ 36,859,077	$ 74,447,407	$ 40,818,452	$ (33,628,955)
17	HOSPICE & PALLIAATIVE CARE	$ 226,700	$ 699,900	$ 926,600	$ 13,700	$ (912,900)
18	OPHTHALMOLOGY	$ 5,167,100	$ 3,466,600	$ 8,633,700	$ 7,019,200	$ (1,614,500)
19	ORAL SURGERY	$ 57,070	$ 949,045	$ 1,006,115	$ 23,282	$ (982,833)
20	ORTHOPEDIC SURGERY	$ 47,903,421	$ 34,831,914	$ 82,735,335	$ 54,128,272	$ (28,607,063)
22	PATHOLOGY	$ 4,465,330	$ 2,392,117	$ 6,857,447	$ 5,838,865	$ (1,018,582)
23	SPORTS MEDICINE	$ 1,999,200	$ 1,352,600	$ 3,351,800	$ 2,024,700	$ (1,327,100)
24	PLASTIC & RECONSTRUCTIVE SURGERY	$ 4,912,599	$ 2,771,039	$ 7,683,638	$ 3,603,330	$ (4,080,308)
25	PHYSICAL MEDICINE & REHABILITATION	$ 4,357,840	$ 2,080,282	$ 6,438,122	$ 4,194,042	$ (2,244,080)
26	PSYCHIATRY	$ 13,397,181	$ 11,649,631	$ 25,046,812	$ 8,724,637	$ (16,322,175)
29	PULMONARY DISEASE	$ 11,699,608	$ 4,522,577	$ 16,222,186	$ 4,543,669	$ (11,678,517)
30	DIAGNOSTIC RADIOLOGY	$ 5,716,264	$ 11,132,717	$ 16,848,981	$ 8,774,614	$ (8,074,367)
33	THORACIC SURGERY	$ 5,471,000	$ 2,875,800	$ 8,346,800	$ 3,716,700	$ (4,630,100)
34	UROLOGY	$ 2,821,144	$ 3,180,536	$ 6,001,680	$ 2,107,075	$ (3,894,605)
37	PEDIATRIC MEDICINE	$ 19,610,898	$ 11,821,624	$ 31,432,522	$ 18,378,892	$ (13,053,630)
38	GERIATRIC MEDICINE	$ 963,900	$ 644,367	$ 1,608,267	$ 922,513	$ (685,754)
39	NEPPHROLOGY	$ 192,700	$ 543,200	$ 735,900	$ 87,300	$ (648,600)
40	HAND SURGERY	$ 79,400	$ 187,000	$ 266,400	$ 39,500	$ (226,900)
44	INFECTIOUS DISEASE	$ 2,277,800	$ 741,200	$ 3,019,000	$ 1,444,900	$ (1,574,100)
46	ENDOCRINOLOGY	$ 10,947,158	$ 5,630,225	$ 16,577,383	$ 8,989,166	$ (7,588,217)
48	PODIATRY	$ 1,200	$ 44,600	$ 45,800	$ 28,200	$ (17,600)
66	RHEUMATOLOGY	$ 820,169	$ 512,550	$ 1,332,719	$ 461,065	$ (871,654)
72	PAIN MANAGEMENT	$ 2,022,058	$ 365,114	$ 2,387,173	$ 1,168,013	$ (1,219,160)
77	VASCULAR SURGERY	$ 5,695,200	$ 3,653,200	$ 9,348,400	$ 7,696,700	$ (1,651,700)
78	CARDIAC SURGERY	$ 2,893,100	$ 7,259,000	$ 10,152,100	$ 2,758,400	$ (7,393,700)
79	ADDICTION MEDICINE	$ 5,324,900	$ 323,900	$ 5,648,800	$ 1,255,200	$ (4,393,600)
81	CRITICAL CARE MEDICINE	$ 23,401,541	$ 24,011,077	$ 47,412,618	$ 13,073,658	$ (34,338,960)
82	HEMATOLOGY	$ 4,300	$ 565,000	$ 569,300	$ -	$ (569,300)
83	HEMATOLOGY - ONCOLOGY	$ 5,363,951	$ 2,756,517	$ 8,120,468	$ 8,836,530	$ 716,062
84	PREVENTIVE MEDICINE	$ 349,000	$ 279,300	$ 628,300	$ 404,400	$ (223,900)
85	MAXILLOFACIAL SURGERY	$ -	$ 82,000	$ 82,000	$ -	$ (82,000)
86	NEUROPSYCHIATRY	$ -	$ 71,800	$ 71,800	$ -	$ (71,800)
90	MEDICAL ONCOLOGY	$ 14,637,797	$ 9,949,211	$ 24,587,008	$ 6,876,219	$ (17,710,788)
91	SURGICAL ONCOLOGY	$ 2,980,392	$ 1,791,367	$ 4,771,759	$ 2,707,204	$ (2,064,555)
92	RADIATION ONCOLOGY	$ 4,739,900	$ 4,480,500	$ 9,220,400	$ 3,301,000	$ (5,919,400)
93	EMERGENCY MEDICINE	$ 14,389,219	$ 22,825,478	$ 37,214,697	$ 16,307,533	$ (20,907,164)
94	INTERVENTIONAL RADIOLOGY	$ 1,867,571	$ 1,636,400	$ 3,503,971	$ 776,000	$ (2,727,971)
98	GYNECOLOGICAL ONCOLOGY	$ 2,093,481	$ 554,178	$ 2,647,659	$ 2,126,829	$ (520,830)
C3	INTERVENTIONAL CARDIOLOGY	$ 1,680,400	$ 2,227,900	$ 3,908,300	$ 1,849,700	$ (2,058,600)
CO	SLEEP MEDICINE	$ 4,100	$ 73,595	$ 77,695	$ 46,445	$ (31,250)
		$ 510,976,086	$ 449,188,966	$ 960,165,051	$ 425,174,932	$ 534,990,120

9/1/2017

HOSPITAL BASED - PART B PHYSICIAN PROFESSIONAL SERVICES COSTS

EXHIBIT D

Hospital Number	Hospital	Wage, Salaries & Fringe Benefits	Other Expenses	Total Expenses	Revenue	Profit/Loss
210001	Meritus	$ 214,900	$ 4,371,400	$ 4,586,300	$ 13,700	$ (4,572,600)
210002	UMMC	$ -	$ -	$ -	$ -	$ -
210003	PG Hospital	$ 6,287,016	$ 18,746,985	$ 25,034,001	$ 7,370,719	$ (17,663,282)
210004	Holy Cross	$ 2,562,600	$ 6,163,600	$ 8,726,200	$ 2,686,100	$ (6,040,100)
210005	Frederick	$ 133,900	$ 1,211,500	$ 1,345,400	$ -	$ (1,345,400)
210006	UM-Harford	$ -	$ -	$ -	$ -	$ -
210008	Mercy	$ 8,697,305	$ 398,586	$ 9,095,891	$ 4,821,339	$ (4,274,552)
210009	Johns Hopkins	$ -	$ 10,106,751	$ 10,106,751	$ -	$ (10,106,751)
210010	UM-Dorchester	$ -	$ -	$ -		$ -
210011	St. Agnes	$ 26,312,600	$ 1,594,000	$ 27,906,600	$ 16,378,900	$ (11,527,700)
210012	Sinai	$ 9,077,400	$ 6,234,400	$ 15,311,800	$ 6,211,900	$ (9,099,900)
210013	Bon Secours	$ 2,526,300	$ 10,177,600	$ 12,703,900	$ 4,223,800	$ (8,480,100)
210015	MedStar Fr Square	$ 25,665,300	$ 9,971,200	$ 35,636,500	$ 21,167,400	$ (14,469,100)
210016	Washington Adventist	$ 50,900	$ 6,486,600	$ 6,537,500	$ -	$ (6,537,500)
210017	Garrett	$ 1,743,000	$ 423,800	$ 2,166,800	$ 1,784,380	$ (382,420)
210018	MedStar Montgomery	$ 3,487,700	$ 2,847,900	$ 6,335,600	$ 2,410,000	$ (3,925,600)
210019	Peninsula	$ 11,158,000	$ 6,580,500	$ 17,738,500	$ 1,811,000	$ (15,927,500)
210022	Suburban	$ -	$ 2,308,200	$ 2,308,200	$ 174,200	$ (2,134,000)
210023	Anne Arundel	$ 419,700	$ 9,732,000	$ 10,151,700	$ -	$ (10,151,700)
210024	MedStar Union Memorial	$ 9,672,900	$ 7,344,900	$ 17,017,800	$ 8,699,400	$ (8,318,400)
210027	Western Maryland	$ -	$ -	$ -	$ -	$ -
210028	MedStar St. Mary's	$ 1,831,200	$ 2,842,200	$ 4,673,400	$ 1,632,200	$ (3,041,200)
210029	JH Bayview	$ -	$ 4,793,375	$ 4,793,375	$ 243,700	$ (4,549,675)
210030	UM-Chestertown	$ 977,000	$ 105,400	$ 1,082,400	$ 1,873,600	$ 791,200
210032	Union of Cecil	$ -	$ 3,233,000	$ 3,233,000	$ 2,578,700	$ (654,300)
210033	Carroll	$ 173,000	$ 5,091,100	$ 5,264,100	$ -	$ (5,264,100)
210034	MedStar Harbor	$ 2,590,200	$ 2,737,300	$ 5,327,500	$ 4,772,400	$ (555,100)
210035	UM-Charles Regional	$ -	$ -	$ -	$ -	$ -
210037	UM-Easton	$ -	$ -	$ -	$ -	$ -
210038	UMMC Midtown	$ -	$ -	$ -	$ -	$ -
210039	Calvert	$ -	$ -	$ -	$ -	$ -
210040	Northwest	$ 8,129,100	$ 2,414,800	$ 10,543,900	$ 3,983,700	$ (6,560,200)
210043	UM-BWMC	$ -	$ -	$ -	$ -	$ -
210044	GBMC	$ 24,799,100	$ 6,379,700	$ 31,178,800	$ 12,916,400	$ (18,262,400)
210045	McCready	$ -	$ 261,400	$ 261,400	$ 197,800	$ (63,600)
210048	Howard County	$ -	$ 6,591,000	$ 6,591,000	$ -	$ (6,591,000)
210049	UM-Upper Chesapeake	$ -	$ -	$ -	$ -	$ -
210051	Doctors	$ 5,473,500	$ 15,500	$ 5,489,000	$ 1,901,700	$ (3,587,300)
210055	Laurel Regional	$ 381,200	$ 5,929,400	$ 6,310,600	$ 220,500	$ (6,090,100)
210056	MedStar Good Samaritan	$ 2,044,400	$ 1,635,900	$ 3,680,300	$ 1,794,100	$ (1,886,200)
210057	Shady Grove	$ 34,100	$ 4,171,000	$ 4,205,100	$ -	$ (4,205,100)
210058	UMROI	$ -	$ -	$ -	$ -	$ -
210060	Ft. Washington	$ -	$ -	$ -	$ -	$ -
210061	Atlantic General	$ 6,216,213	$ 1,623,914	$ 7,840,127	$ 3,941,507	$ (3,898,620)
210062	MedStar Southern MD	$ 451,800	$ 1,901,900	$ 2,353,700	$ 612,100	$ (1,741,600)
210063	UM-St. Joe	$ -	$ -	$ -	$ -	$ -
210064	Levindale	$ 503,000	$ -	$ 503,000	$ 226,000	$ (277,000)
210065	Holy Cross Germantown	$ 59,400	$ 6,421,400	$ 6,480,800	$ 605,000	$ (5,875,800)
210088	UM-Queen Anne's ED	$ -	$ -	$ -	$ -	$ -
210333	Bowie ED	$ -	$ -	$ -	$ -	$ -
218992	UM-Shock Trauma	$ -	$ -	$ -	$ -	$ -
		$ 161,672,734	$ 160,848,211	$ 322,520,945	$ 115,252,245	$ (207,268,700)

9/1/2017

HOSPITAL BASED - PART B PHYSICIAN PROFESSIONAL SERVICES

EXHIBIT E

Code	Physician Description	Wage, Salaries & Fringe Benefits	Other Expenses	Total Expenses	Revenue	Profit/(Loss)
1	GENERAL PRACTICE	$ 22,628,700	$ 10,153,000	$ 32,781,700	$ 12,289,300	$ (20,492,400)
2	GENERAL SURGERY	$ 1,609,676	$ 4,717,288	$ 6,326,964	$ 1,146,373	$ (5,180,591)
5	ANESTHESIOLOGY	$ 8,063,964	$ 29,927,376	$ 37,991,340	$ 8,313,927	$ (29,677,413)
8	FAMILY PRACTICE	$ 6,917,100	$ 3,123,800	$ 10,040,900	$ 6,864,400	$ (3,176,500)
11	INTERNAL MEDICINE	$ 57,765,906	$ 41,429,634	$ 99,195,540	$ 36,538,615	$ (62,656,925)
16	OBSTETRICS & GYNECOLOGY	$ 6,106,941	$ 18,469,315	$ 24,576,256	$ 6,108,972	$ (18,467,284)
17	HOSPICE & PALLIAATIVE CARE	$ 214,900	$ 243,500	$ 458,400	$ 13,700	$ (444,700)
22	PATHOLOGY	$ 4,215,530	$ 2,026,717	$ 6,242,247	$ 5,394,065	$ (848,182)
26	PSYCHIATRY	$ 2,408,881	$ 2,733,643	$ 5,142,524	$ 917,200	$ (4,225,324)
30	DIAGNOSTIC RADIOLOGY	$ 4,688,164	$ 5,891,501	$ 10,579,665	$ 6,850,956	$ (3,728,709)
37	PEDIATRIC MEDICINE	$ 7,890,761	$ 3,560,372	$ 11,451,133	$ 3,669,200	$ (7,781,933)
81	CRITICAL CARE MEDICINE	$ 23,298,341	$ 20,336,077	$ 43,634,418	$ 13,073,658	$ (30,560,760)
90	MEDICAL ONCOLOGY	$ 5,344,500	$ 2,729,988	$ 8,074,488	$ 3,087,900	$ (4,986,588)
93	EMERGENCY MEDICINE	$ 8,651,800	$ 13,869,600	$ 22,521,400	$ 10,207,980	$ (12,313,420)
94	INTERVENTIONAL RADIOLOGY	$ 1,867,571	$ 1,636,400	$ 3,503,971	$ 776,000	$ (2,727,971)
		$ 161,672,735	$ 160,848,211	$ 322,520,946	$ 115,252,246	$ (207,268,700)

9/5/2017

NON-HOSPITAL BASED - PART B PHYSICIAN PROFESSIONAL COSTS

EXHIBIT F

Hospital Number	Hospital	Wage, Salaries & Fringe Benefits	Other Expenses	Total Expenses	Revenue	Profit/Loss
210001	Meritus	$ 4,541,900	$ 860,300	$ 5,402,200	$ 3,328,200	$ (2,074,000)
210002	UMMC	$ -	$ 15,450,200	$ 15,450,200	$ -	$ (15,450,200)
210003	PG Hospital	$ 269,900	$ 14,273,461	$ 14,543,361	$ 1,583,313	$ (12,960,048)
210004	Holy Cross	$ -	$ -	$ -	$ -	$ -
210005	Frederick	$ 226,100	$ 8,783,200	$ 9,009,300	$ 16,100	$ (8,993,200)
210006	UM-Harford	$ -	$ 1,989,200	$ 1,989,200	$ -	$ (1,989,200)
210008	Mercy	$ 4,487,796	$ 394,869	$ 4,882,665	$ 3,738,912	$ (1,143,753)
210009	Johns Hopkins	$ -	$ 1,490,349	$ 1,490,349	$ -	$ (1,490,349)
210010	UM-Dorchester	$ -	$ -	$ -	$ -	$ -
210011	St. Agnes	$ 55,565,300	$ 16,593,000	$ 72,158,300	$ 47,774,600	$ (24,383,700)
210012	Sinai	$ 56,494,200	$ 20,064,400	$ 76,558,600	$ 48,367,500	$ (28,191,100)
210013	Bon Secours	$ 815,000	$ 462,500	$ 1,277,500	$ 581,700	$ (695,800)
210015	MedStar Fr Square	$ 48,585,100	$ 18,876,100	$ 67,461,200	$ 58,106,000	$ (9,355,200)
210016	Washington Adventist	$ 57,400	$ 4,233,700	$ 4,291,100	$ 607,500	$ (3,683,600)
210017	Garrett	$ 384,500	$ 529,000	$ 913,500	$ 256,300	$ (657,200)
210018	MedStar Montgomery	$ 3,781,200	$ 3,087,500	$ 6,868,700	$ 2,612,800	$ (4,255,900)
210019	Peninsula	$ 23,083,900	$ 2,035,500	$ 25,119,400	$ 11,921,000	$ (13,198,400)
210022	Suburban	$ -	$ 4,247,900	$ 4,247,900	$ 641,100	$ (3,606,800)
210023	Anne Arundel	$ 535,200	$ 12,412,400	$ 12,947,600	$ 222,300	$ (12,725,300)
210024	MedStar Union Memorial	$ 36,033,500	$ 27,360,900	$ 63,394,400	$ 40,466,800	$ (22,927,600)
210027	Western Maryland	$ 13,180,600	$ 15,085,200	$ 28,265,800	$ 8,003,200	$ (20,262,600)
210028	MedStar St. Mary's	$ 1,902,200	$ 2,952,400	$ 4,854,600	$ 1,228,000	$ (3,626,600)
210029	JH Bayview	$ -	$ 2,715,800	$ 2,715,800	$ 788,200	$ (1,927,600)
210030	UM-Chestertown	$ 2,027,000	$ 285,900	$ 2,312,900	$ 337,200	$ (1,975,700)
210032	Union of Cecil	$ 9,965,100	$ 8,779,200	$ 18,744,300	$ 9,780,100	$ (8,964,200)
210033	Carroll	$ 2,504,300	$ 3,608,100	$ 6,112,400	$ 1,408,300	$ (4,704,100)
210034	MedStar Harbor	$ 6,453,400	$ 6,819,800	$ 13,273,200	$ 8,377,600	$ (4,895,600)
210035	UM-Charles Regional	$ 62,000	$ 3,276,300	$ 3,338,300	$ 306,300	$ (3,032,000)
210037	UM-Easton	$ -	$ -	$ -	$ -	$ -
210038	UMMC Midtown	$ 22,515,200	$ 1,155,500	$ 23,670,700	$ 4,734,300	$ (18,936,400)
210039	Calvert	$ 381,800	$ 3,685,100	$ 4,066,900	$ (14,700)	$ (4,081,600)
210040	Northwest	$ 8,656,400	$ 2,784,500	$ 11,440,900	$ 5,963,400	$ (5,477,500)
210043	UM-BWMC	$ 299,200	$ 7,091,800	$ 7,391,000	$ 1,662,600	$ (5,728,400)
210044	GBMC	$ 4,096,700	$ 1,053,900	$ 5,150,600	$ 2,133,800	$ (3,016,800)
210045	McCready	$ 276,200	$ 275,600	$ 551,800	$ 1,103,300	$ 551,500
210048	Howard County	$ -	$ -	$ -	$ -	$ -
210049	UM-Upper Chesapeake	$ -	$ 8,144,200	$ 8,144,200	$ -	$ (8,144,200)
210051	Doctors	$ 431,100	$ 2,959,600	$ 3,390,700	$ 464,000	$ (2,926,700)
210055	Laurel Regional	$ 834,400	$ 2,643,000	$ 3,477,400	$ 1,207,500	$ (2,269,900)
210056	MedStar Good Samaritan	$ 21,370,500	$ 17,099,900	$ 38,470,400	$ 22,706,400	$ (15,764,000)
210057	Shady Grove	$ 28,500	$ 3,594,100	$ 3,622,600	$ -	$ (3,622,600)
210058	UMROI	$ -	$ -	$ -	$ -	$ -
210060	Ft. Washington	$ 348,008	$ 800,702	$ 1,148,710	$ 781,860	$ (366,850)
210061	Atlantic General	$ 13,459,848	$ 6,425,874	$ 19,885,722	$ 12,850,602	$ (7,035,120)
210062	MedStar Southern MD	$ 4,337,400	$ 18,260,800	$ 22,598,200	$ 5,876,600	$ (16,721,600)
210063	UM-St. Joe	$ 1,187,200	$ 15,154,900	$ 16,342,100	$ -	$ (16,342,100)
210064	Levindale	$ 55,300	$ 143,400	$ 198,700	$ -	$ (198,700)
210065	Holy Cross Germantown	$ -	$ -	$ -	$ -	$ -
210088	UM-Queen Anne's ED	$ -	$ -	$ -	$ -	$ -
210333	Bowie ED	$ 70,000	$ 400,700	$ 470,700	$ -	$ (470,700)
218992	UM-Shock Trauma	$ -	$ -	$ -	$ -	$ -
		$ 349,303,352	$ 288,340,755	$ 637,644,107	$ 309,922,687	$ (327,721,420)

9/5/2017

NON-HOSPITAL BASED - PART B PHYSICIAN PROFESSIONAL SERVICES COSTS

EXHIBIT G

Code	Physician Description	Wage, Salaries & Fringe Benefits	Other Expenses	Total Expenses	Revenue	Profit/(Loss)
1	GENERAL PRACTICE	$ 7,538,721	$ 5,620,920	$ 13,159,641	$ 4,998,393	$ (8,161,248)
2	GENERAL SURGERY	$ 37,992,067	$ 23,756,624	$ 61,748,691	$ 19,792,786	$ (41,955,905)
4	OTOLARYNGOLOGY	$ 3,101,403	$ 2,093,500	$ 5,194,903	$ 2,639,800	$ (2,555,103)
5	ANESTHESIOLOGY	$ 804,800	$ 6,171,200	$ 6,976,000	$ 521,500	$ (6,454,500)
6	CARDIOLOGY	$ 20,959,238	$ 27,062,232	$ 48,021,470	$ 18,883,528	$ (29,137,942)
7	DERMATOLOGY	$ 2,022,451	$ 2,542,872	$ 4,565,323	$ 3,204,049	$ (1,361,274)
8	FAMILY PRACTICE	$ 23,250,836	$ 14,983,990	$ 38,234,827	$ 24,434,671	$ (13,800,156)
9	INTERVENTIONAL PAIN MANAGEMENT	$ 10,000	$ 500	$ 10,500	$ 600	$ (9,900)
10	GASTROENTEROLOGY	$ 10,013,453	$ 5,483,767	$ 15,497,220	$ 10,517,545	$ (4,979,675)
11	INTERNAL MEDICINE	$ 17,119,864	$ 38,938,094	$ 56,057,958	$ 12,525,709	$ (43,532,249)
12	OSTEOPATHIC MANIPULATIVE MEDICINE	$ 458,400	$ 348,100	$ 806,500	$ 292,200	$ (514,300)
13	NEUROLOGY	$ 15,006,621	$ 7,061,231	$ 22,067,852	$ 10,989,231	$ (11,078,621)
14	NEUROSURGERY	$ 7,589,963	$ 3,980,700	$ 11,570,663	$ 6,156,400	$ (5,414,263)
16	OBSTETRICS & GYNECOLOGY	$ 31,481,389	$ 18,389,762	$ 49,871,151	$ 34,709,480	$ (15,161,671)
17	HOSPICE & PALLIAATIVE CARE	$ 11,800	$ 456,400	$ 468,200	$ -	$ (468,200)
18	OPHTHALMOLOGY	$ 5,167,100	$ 3,466,600	$ 8,633,700	$ 7,019,200	$ (1,614,500)
19	ORAL SURGERY	$ 57,070	$ 949,045	$ 1,006,115	$ 23,282	$ (982,833)
20	ORTHOPEDIC SURGERY	$ 47,903,421	$ 34,831,914	$ 82,735,335	$ 54,128,272	$ (28,607,063)
22	PATHOLOGY	$ 249,800	$ 365,400	$ 615,200	$ 444,800	$ (170,400)
23	SPORTS MEDICINE	$ 1,999,200	$ 1,352,600	$ 3,351,800	$ 2,024,700	$ (1,327,100)
24	PLASTIC & RECONSTRUCTIVE SURGERY	$ 4,912,599	$ 2,771,039	$ 7,683,638	$ 3,603,330	$ (4,080,308)
25	PHYSICAL MEDICINE & REHABILITATION	$ 4,357,840	$ 2,080,282	$ 6,438,122	$ 4,194,042	$ (2,244,080)
26	PSYCHIATRY	$ 10,988,300	$ 8,915,988	$ 19,904,288	$ 7,807,437	$ (12,096,851)
29	PULMONARY DISEASE	$ 11,699,608	$ 4,522,577	$ 16,222,186	$ 4,543,669	$ (11,678,517)
30	DIAGNOSTIC RADIOLOGY	$ 1,028,100	$ 5,241,216	$ 6,269,316	$ 1,923,658	$ (4,345,658)
33	THORACIC SURGERY	$ 5,471,000	$ 2,875,800	$ 8,346,800	$ 3,716,700	$ (4,630,100)
34	UROLOGY	$ 2,821,144	$ 3,180,536	$ 6,001,680	$ 2,107,075	$ (3,894,605)
37	PEDIATRIC MEDICINE	$ 11,720,137	$ 8,261,252	$ 19,981,389	$ 14,709,692	$ (5,271,697)
38	GERIATRIC MEDICINE	$ 963,900	$ 644,367	$ 1,608,267	$ 922,513	$ (685,754)
39	NEPPHROLOGY	$ 192,700	$ 543,200	$ 735,900	$ 87,300	$ (648,600)
40	HAND SURGERY	$ 79,400	$ 187,000	$ 266,400	$ 39,500	$ (226,900)
44	INFECTIOUS DISEASE	$ 2,277,800	$ 741,200	$ 3,019,000	$ 1,444,900	$ (1,574,100)
46	ENDOCRINOLOGY	$ 10,947,158	$ 5,630,225	$ 16,577,383	$ 8,989,166	$ (7,588,217)
48	PODIATRY	$ 1,200	$ 44,600	$ 45,800	$ 28,200	$ (17,600)
66	RHEUMATOLOGY	$ 820,169	$ 512,550	$ 1,332,719	$ 461,065	$ (871,654)
72	PAIN MANAGEMENT	$ 2,022,058	$ 365,114	$ 2,387,173	$ 1,168,013	$ (1,219,160)
77	VASCULAR SURGERY	$ 5,695,200	$ 3,653,200	$ 9,348,400	$ 7,696,700	$ (1,651,700)
78	CARDIAC SURGERY	$ 2,893,100	$ 7,259,000	$ 10,152,100	$ 2,758,400	$ (7,393,700)
79	ADDICTION MEDICINE	$ 5,324,900	$ 323,900	$ 5,648,800	$ 1,255,200	$ (4,393,600)
81	CRITICAL CARE MEDICINE	$ 103,200	$ 3,675,000	$ 3,778,200	$ -	$ (3,778,200)
82	HEMATOLOGY	$ 4,300	$ 565,000	$ 569,300	$ -	$ (569,300)
83	HEMATOLOGY - ONCOLOGY	$ 5,363,951	$ 2,756,517	$ 8,120,468	$ 8,836,530	$ 716,062
84	PREVENTIVE MEDICINE	$ 349,000	$ 279,300	$ 628,300	$ 404,400	$ (223,900)
85	MAXILLOFACIAL SURGERY	$ -	$ 82,000	$ 82,000	$ -	$ (82,000)
86	NEUROPSYCHIATRY	$ -	$ 71,800	$ 71,800	$ -	$ (71,800)
90	MEDICAL ONCOLOGY	$ 9,293,297	$ 7,219,223	$ 16,512,520	$ 3,788,319	$ (12,724,200)
91	SURGICAL ONCOLOGY	$ 2,980,392	$ 1,791,367	$ 4,771,759	$ 2,707,204	$ (2,064,555)
92	RADIATION ONCOLOGY	$ 4,739,900	$ 4,480,500	$ 9,220,400	$ 3,301,000	$ (5,919,400)
93	EMERGENCY MEDICINE	$ 5,737,419	$ 8,955,878	$ 14,693,297	$ 6,099,553	$ (8,593,744)
94	INTERVENTIONAL RADIOLOGY	$ -	$ -	$ -	$ -	$ -
98	GYNECOLOGICAL ONCOLOGY	$ 2,093,480	$ 554,178	$ 2,647,658	$ 2,126,829	$ (520,829)
C3	INTERVENTIONAL CARDIOLOGY	$ 1,680,400	$ 2,227,900	$ 3,908,300	$ 1,849,700	$ (2,058,600)
CO	SLEEP MEDICINE	$ 4,100	$ 73,595	$ 77,695	$ 46,445	$ (31,250)
		$ 349,303,351	$ 288,340,755	$ 637,644,106	$ 309,922,686	$ (327,721,420)

Title 10 MARYLAND DEPARTMENT OF HEALTH

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-207, 19-212, 19-216, 19-218, 19-219, 19-220, and, 19-222 Annotated Code of Maryland

NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulations .03 under COMAR 10.37.10 Rate Application and Approval Procedures. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on September 13, 2017, notice of which was given pursuant to General Provisions Article, § 3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about January 15, 2018.

Statement of Purpose

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.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has an economic impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or (410) 764-2576, or fax to (410) 358-6217, or email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed amendments until November 13, 2017. A hearing may be held at the discretion of the Commission.

.03 Regular Rate Applications.

A. A hospital may [not] file a regular *(i.e., or "full")* rate application with the Commission [until rate efficiency measures are adopted by the Commission which are consistent with the all-payer model contract approved by the Centers for Medicare & Medicaid Services (CMS). During this interim period of time, a hospital may seek a rate adjustment under any other administrative remedy available to it under existing Commission, law, regulation, or policy. The rate efficiency

measures shall be adopted by the Commission no later than October 31, 2017. Once the moratorium is lifted, a hospital may file a regular rate application with the Commission] at any time if:

(1) – (2) (text unchanged)

B. Full Rate Application.

(1) (text unchanged)

(2) In order for a full rate application to be docketed, it shall comply with a template for such applications as prescribed by the Commission *staff* and shall:

(a) (text unchanged)

(b) Be accompanied by appropriate supporting documents[;] *including:*

1. The Annual Report of Revenues, Expenses, and Volumes projected and explained (e.g., how much of the requested increase relates to inflation, volumes, and other factors) for the period for which the hospital requests new rates.

2. Any audited financial statements over the most recent five years not yet filed with the Commission, plus the most recent unaudited financial statements for the current period, which are available at the time of the filing of the full rate application;

3. An Excel file listing and summarizing balance sheets, statements of operations and changes in net assets, and statements of cash flow for the last five years per the audited financial statements along with a narrative explaining any major changes;

4. An Excel file listing the information contained within the Annual Report RE schedules for the last five years breaking out regulated and unregulated revenues and expenses by category and in total;

5. A detailed history of HSCRC-approved revenue and actual revenue for the hospital for the last two calendar years;

6. A detailed history for the most recent four Rate Years of HSCRC-approved GBR revenue and actual revenue and volumes, in addition to any approved and actual revenue and volumes available at the date of the filing of the full rate application. The history of approved and actual revenue changes should detail the basis of the changes in approved and actual revenue including allowed inflation and all other factors;

7. An identification of related organizations (i.e., an organization related to the hospital through some type of control or ownership), including subsidiaries of the hospital as well as hospitals that are part of the same hospital system as the applicant hospital. For applicant hospitals that are part of a system, the hospital may be required to submit financial and other information related to the system hospitals, including any system transactions among the system hospitals, which may affect the financial condition of the applicant hospital;

8. A listing of any services provided by related organizations including the amount charged to the applicant hospital for the services;

9. A listing of any transfers of funds to or from a related organization including an explanation of such transfers;

10. Copies of the two most recent Medicare Cost Reports, including any home office cost report files – the Interns and Resident Information System report (IRIS) files, and the wage and occupational mix files, along with any adjustments and corrections;

11. Reconciliations of inpatient and outpatient volumes and revenue submitted in the HSCRC abstract data to the departmental revenue and statistics submitted monthly for the last three years;

12. In Excel, listing of Outpatient drugs accounting for at least 80 percent of the Hospital's total outpatient drug expenses, with applicable HCPCS codes for last three years, including frequency of charges, amount of charges and units billed, Average Sales Price at the end of each year and applicable 340B discounts and an estimate of billed charges for unlisted drugs;

13. For profits or losses associated with the support of physician practices, the applicant hospital may be required to provide a detailed accounting of those profits or losses over time. Additional information regarding compensation, subsidies and other forms of financial support provided to physicians may be required following staff's initial review to the extent that these profits or losses have a material impact on the financial condition of the applicant hospital;

14. A supporting document, in Excel, that compares the requested departmental rates of the applicant hospital to that hospital's current departmental rates. The supporting document should also compare these current and requested departmental rates to those of other HSCRC-regulated hospitals located in the Primary Service Area (PSA) of the applicant hospital. If no other regulated hospitals are located in the applicant hospital's PSA, then the comparison should be made to statewide median departmental rates.

15. An accounting of the amounts reported by the applicant hospital to the HSCRC regarding its uses of population health infrastructure money included in rates.

(c) Include a [complete] description [of what is] *of the rate adjustments that are being* requested *in the full rate application*; and

(d) Include specific detail and substantiation of any circumstances the applicant hospital cites as unique to its facility, [that] *which* would require revenue in excess of the amount [resulting from use of the ICC methodology set forth in Regulation .04-1 of this chapter] *currently provided in its approved regulated revenue;*

(e) Describe in detail what the applicant hospital has specifically done consistent with the All-Payer Model to reduce or eliminate unnecessary or potentially avoidable utilization. For purposes of this regulation, unnecessary or potentially avoidable utilization means the utilization of health care items and services, including care furnished to treat complications during a hospital admission, that may be avoided through improved efficiency, care coordination, or effective community-based care, or that is not medically necessary or evidence-based care. The Staff may request additional information as needed;

(f) Provide estimates for the next five years of reductions in utilization that will be accomplished through care redesign initiatives;

(g) Provide a history of denials for the most recent three years, including any year-to-date figures;

(h) The Staff may request additional information that bears directly on the hospital's request for rate relief and its financial condition.

[(3) Requests for special consideration of a full rate application shall be accompanied by supporting documentation in the format of applicable reports under COMAR 10.37.01.03H.]

(*3*) The provisions of §B(2) [and (3)] of this regulation may be waived by staff if the application applies only to:

(a) A request filed [as a requirement of COMAR 10.37.03.06 (Hospital-based physician compensation source)] *for a change in the applicant hospital's uncompensated care allowance*;

(b) A request for [a change in the applicant's uncompensated care allowance] *rates to cover government-mandated or similar action affecting more than one previously approved rate for which the staff believes the provisions of §B(2)* [and (3)] *of this regulation are not necessary*; *or*

(c) A request for rates [to cover government-mandated or similar action affecting more than one previously approved rate for which the staff believes the provisions of §B(2) and (3) of this regulation are not necessary] *associated with a Certificate of Need-approved capital project, which request may be considered to be a "partial rate application" by staff.*[; or

(d) A request for rates associated with a Certificate of Need — approved capital project.]

C. (text unchanged)

[D. Uncompensated Care Policy—Medicaid Day Limits.

(1) A hospital may request a change in its approved provision of uncompensated care by means of a partial rate application in response to action taken by the Secretary of Health to establish hospital day limits under the Medical Assistance Program.

(2) In evaluating such a request, the Commission shall consider the following factors before deciding whether to approve, deny, or modify the hospital's request:

(a) The hospital's actual uncompensated care and estimated uncompensated care from the Commission's most recent uncompensated care regression analysis;

(b) The hospital's cash position, operating margin, and net margin as shown on its latest audited financial statements and its most recent unaudited FS Schedules submitted to the Commission;

(c) Any other financial considerations that are presented to the Commission with the partial rate application;

(d) The hospital's position on the Commission's most recent Reasonableness of Charges analysis;

(e) Whether changing a hospital's approved provision of uncompensated care in response to the establishment of hospital day limits places the Medicare waiver in potential jeopardy; and

(f) Whether implementing such a change to a hospital's approved provision of uncompensated care is in the public interest.

(3) The review of a hospital's request for additional revenue in its approved provision of uncompensated care related to Medicaid's day limits shall be completed by the Commission as soon as practicable.

(4) Any action taken by the Commission on such a request may not be considered a final decision in a contested case under the Administrative Procedure Act, and a hospital retains the right to file a full rate application in accordance with Commission law and regulation.

(5) Any additional revenue approved by the Commission under such a request shall be removed from approved rates prospectively upon the expiration of the hospital day limits established by the Medical Assistance Program.]

.03-1 Partial Rate Application.

A. The provisions of Regulation .03B(2) [and (3)] of this chapter may be waived by staff in the review of a partial rate application.

B.-D. (text unchanged)

.04 Commission Review of Established Rates.

A.-B. (text unchanged)

.04-1 [ICC] *Rate Efficiency* Methodology.

A. In evaluating the reasonableness of a hospital's permanent rate structure, the Commission *shall* [may] use [its] *an Inter-hospital* Cost Comparison (ICC) methodology*, which compares the costs of the hospital to those costs, including adjustments for reasonableness and efficiency, of its peer hospitals, with appropriate adjustments to reflect changes in the hospital's volume since the beginning of the new All-Payer Model Agreement and the inception of the hospital's revenue agreement, as the foundation of its review of the full rate application. The staff shall make modifications to the ICC which are needed to properly reflect any additional factors that are relevant to the determination of a reasonable cost level that should be reflected in the hospital's approved regulated revenue. The ICC analysis does not constitute a strict, unalterable or absolute methodology. It shall be modified as needed to give proper attention to the particular circumstances of the hospital, and the staff shall give due consideration to information provided by the hospital in determining the appropriate rate levels and rate structure for the hospital. The ICC shall take into account, in the establishment of appropriate rate levels, those factors for which the hospital will not be held accountable such as special grants from the Commission, assessments, uncompensated care levels, and characteristics of the population in the hospital's primary service area.* [as a benchmark for reasonableness. Thus, the results of an ICC analysis do not constitute an absolute rule, and the Commission shall consider the individual circumstances of the subject hospital in determining the appropriate rate structure. The ICC methodology begins by establishing costs for the target hospital and its peer group. Under the methodology, costs are determined by calculating the hospitals' charges and then removing markup and profits. The methodology then compares the subject hospital's costs to the average costs of its peer group after adjusting for factors for which the hospital is not held accountable. These factors include, but need not be limited to, case mix, labor market cost differences, reasonable medical education costs, and special grants awarded by the Commission.]

B. [The Commission] *Factors considered in the ICC methodology may evolve during the course of full rate reviews. The Commission shall take into account the specific circumstances of the applicant hospital, and staff shall make the key contents, analytic steps and findings of such reviews available to all hospitals and the public.* [shall fully describe and publicly disseminate the technical provisions of the methodology used to evaluate a hospital's permanent rate structure. Any Commission approved updates or changes to these provisions shall similarly be described and disseminated.]

C. *When reviewing a full rate application filed by a hospital that is owned or controlled by a hospital system that also owns other hospitals located in Maryland, the Commission may take into account the financial situation of the other hospitals in the system including their profitability and any shifts of services, volume, revenues or assets between the hospital and the other hospitals or related organizations of the system.* [The final rates that are approved by the Commission for a nonprofit hospital's permanent rate structure shall allow the hospital to charge reasonable rates that will permit it to provide, on a solvent basis, effective and efficient service that is in the public interest.]

D. The final rates that are approved by the Commission for a *nonprofit hospital's permanent rate structure shall allow the hospital to charge reasonable rates that will permit it to provide, on a solvent basis, effective and efficient service that is in the public interest.* [proprietary profit-making hospital's permanent rate structure shall allow the hospital to charge reasonable rates that will permit it to provide effective and efficient service that is in the public interest and include enough allowance for and provide a fair return to the owner of the hospital.]

E. The final rates that are approved by the Commission for a proprietary profit-making hospital's permanent rate structure shall allow the hospital to charge reasonable rates that will permit it to provide effective and efficient service that is in the public interest and include enough allowance for and provide a fair return to the owner of the hospital.

F. The Commission shall set rates for the applicant hospital consistent with the All-Payer Model approved by the federal Center for Medicare and Medicaid Innovation.

.04-2 [Case Target] *Global Budget Revenue* Methodology.

A. [Effective July 1, 2000, the Commission shall implement its case target methodology (CTM)] *The Global Budget Revenue (GBR) methodology implemented by the Commission effective January 1, 2014, establishes* [for the purpose of establishing] reasonable [rates] *revenue levels* for Maryland's general acute hospitals*, which will enable them to improve quality and efficiency on a solvent basis within the constraints imposed by the All-Payer Model*. [Effective July 1, 2008, the Commission shall expand its case target methodology to include outpatient services. This methodology is prospective in nature and designates a charge-per-admission target and a charge-per-visit target for each hospital.]

B. In setting [individual targets] *reasonable revenue levels*, the Commission shall take into account *a number of* [the following] factors*. These may include, but are not limited to the following:*

(1) The casemix severity *and reasonable utilization* of the *hospital's* patients;

(2) – (3) (text unchanged)

(4) The *hospital's* [payor] payer mix;

(5) The reasonable uncompensated care *requirements* of the hospital;

(6) *The reasonable* Graduate [m]Medical [e]Education *(GME) costs of the hospital as determined by the Commission*;

(*7*) Appropriate adjustments, if any, associated with exceptional or outlier cases as defined by the Commission;

(8) Wage levels at the hospital and at other hospitals in the geographic area of the hospital and elsewhere in Maryland;

(9) Adjustments for quality improvement and value-based payment programs applicable to the hospital;

(10) Reasonable infrastructure funding for care management and care coordination for hospital patients;

[(9)]*(11)* The annual update factor;

[(10)] *(12) The proportion of unnecessary care, including Potentially Avoidable Utilization (PAU) at the hospital; and* [Appropriate adjustments associated with the hospital's relative adjusted charge per case.]

(13) The performance of the State as a whole under the All-Payer Model.

C. The [CTM] *GBR* shall be implemented through a[n] *written* agreement entered into by the Commission and each individual general acute hospital. This agreement *and any addenda thereto*, which shall be annual *and renewed automatically*, shall set forth all relevant provisions *governing the GBR including, but not limited to, performance corridors; interim rate adjustments; the exclusion or special treatment of certain cases; the treatment of volume changes, including those involving residents of Maryland and other patients; the penalties associated with failure to comply with the terms of the GBR agreement; interim revenue limits; care redesign requirements; and other changes to the agreement that may be needed from time to time. A hospital that enters into a GBR agreement shall submit a signed copy of the agreement to the Commission's offices within sixty (60) days after it is initially approved by the Commission. A hospital that is party to the addendum shall submit a signed copy of the addendum to the Commission's offices within sixty (60) days from the issuance of the addendum. Failure to submit the signed GBR agreement or the signed addendum in a timely manner, absent an extension granted by staff, may subject the hospital to penalties under COMAR 10.37.01.03R. Thereafter, on an annual basis, the hospital shall receive an updated rate order.* [for achieving

the charge-per-case target established, including, but not limited to, performance corridors, interim rate adjustments, the exclusion of certain cases, and the penalties associated with failure to comply with the terms of the agreement. A hospital that is a party to this agreement shall submit a signed copy of the agreement to the Commission's offices within 60 days of the issuance of the annual unit rate and charge-per-case target update rate order. Following the receipt of its inpatient charge-per-case agreement, a hospital will receive an addendum to the agreement that establishes the charge-per-visit target. The addendum, which shall be annual, shall set forth all relevant provisions for achieving the charge-per-visit target established, including, but not limited to, interim rate adjustments, the exclusion of certain cases, and the penalties associated with failure to comply with the agreement. A hospital that is a party to the addendum shall submit a signed copy of the addendum to the Commission's offices within 60 days of the issuance of the charge-per-visit target addendum. Failure to submit either the signed agreement or the signed addendum in a timely manner may subject the hospital to penalties under COMAR 10.37.01.03N.] A hospital that disagrees with a proposed [target] *GBR* may file a full rate application with the Commission in accordance with Regulation .03 of this chapter.

[D. In lieu of a [CTM] *GBR* agreement, a hospital may request that it be permitted to enter into a total patient revenue (TPR) agreement with the Commission. A TPR agreement establishes a revenue cap for qualifying hospitals. A qualifying hospital is one that typically is located in a rural area and has a well-defined catchment area with a stable population.]

.04-3 [Case Target Update] Global Budget Revenue Mechanism.

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

(1) (text unchanged)

(2) "[Hospital update] *Demographic Adjustment*" means the [amount] *percentage* [by which an individual hospital's charge per admission may increase in a rate year (that is, July 1—June 30)] *increase in allowed revenue related to changes in population and the age/sex mix of the population residing in the hospital's primary service area, net of any reductions*.

(3) "[National growth allowance] *Market Shift Adjustment*" means [one-half of the amount, if any, by which national growth in net revenue per adjusted admission exceeds factor cost inflation growth in any rate year] *the rate adjustment applied by the Commission, which increases or decreases the approved GBR revenue of a hospital to reflect changes in volume at the hospital for which there was a corresponding change in volume at another Maryland hospital or other provider*.

(4) "[National growth reduction] *Hospital Update*" means the amount[, if any, by which factor cost inflation growth exceeds the growth in national net revenue per adjusted admission in any rate year] *by which an individual hospital's approved GBR revenue changes in a particular rate year (i.e., July 1 – June 30)*.

(5) (text unchanged)

B. Annual Update Factor.

(1) On or before [April] *July* 1 of each year, the Commission shall establish an annual update factor for the purpose of adjusting the [rates] *GBR revenue* of each individual hospital. The annual update factor shall be *designed to reflect projected factor cost inflation, an allowance for certain volume adjustments, productivity adjustments, the revenue constraints included in the All-Payer Model Agreement and other relevant factors, demographic adjustments, market shift adjustments, and other appropriate adjustments* [calculated on the basis of projected factor cost inflation adjusted by any national growth allowance or national growth reduction] .

(2) If *after approving an update factor for a given year, a hospital or hospitals collectively exceed their approved revenue,* [Maryland hospitals exceed the annual update factor established by the Commission for a given year,] the annual update factor [shall] *may* be reduced in future years to recoup the excess revenue growth. Similarly, if *a* Maryland hospital *or hospital*s *collectively* fall below *their approved revenue for a given year,* [the annual update factor for a given year,] the annual update factor [shall] *may* be adjusted accordingly in future years.

(3) (text unchanged)

C. (text unchanged)

D. Corrective Action. If, at any time, the Commission estimates that the *financial constraints or other terms imposed by the All-Payer Model Agreement are at risk of being violated (based on modelling using the CMS actuary's most recent projections and Health Services Cost Review Commission analysis of Medicare payments data), the Commission may take immediate and appropriate corrective action as it deems necessary and proper to meet the Medicare savings requirements and limits on growth in Medicare payments and prevent any further deterioration in compliance with the Model Agreement. The Commission shall provide sufficient notice and opportunity for comment before taking corrective action. This comment opportunity does not constitute a contested case within the meaning of the Administrative Procedure Act.* [relative Medicare waiver test cushion is established to be 5 percent or less (based on modeling using the Health Care Financing Administration actuary's most recent projections and Health Services Cost Review Commission casemix data adjusted for the historical relationship between charges and payments), the Commission may take immediate corrective action, as it deems necessary and proper, to restore the minimum waiver cushion and to reverse any further deterioration. The Commission shall provide sufficient notice and opportunity for comment before taking corrective action. This comment opportunity does not constitute a contested case within the meaning of the Administrative Procedure Act. Any reductions implemented to preserve the waiver are not subject to the limitation requiring the annual update factor to be at least 1 percent].

E. The provisions of this regulation apply to all Maryland's general acute care hospitals from July 1, [2000] *2014*, and [after that] *thereafter*.

F. Compliance and Penalties. [CTM] *GBR* compliance shall be monitored during the agreement period. Penalties shall be assessed prospectively at the beginning of the next period. Penalties shall be based on the corridors specified in the *GBR* Agreement.

.04 – 10 (text unchanged)

.11 Recommendations of the Commission's Staff to the Commission, *Options for Commission Review*.

A.-F. (text unchanged)

G. The Commission may prescribe a process for its consideration of a full rate application, which allows for written submissions in support of an application in lieu of an evidentiary hearing. A hospital that chooses this process for a Commission decision on its full rate application shall be afforded the right to submit to the Commission rebuttal information following any written response to the full rate application filed by Commission staff or designated interested parties. A hospital that chooses this written submission process waives its right to an evidentiary hearing. A hospital that chooses this written submission process does not waive its right to judicial review of a final Commission decision under the Administrative Procedure Act. As an additional alternative to an evidentiary hearing, a hospital may choose to enter into a binding arbitration process as prescribed by the Commission.

NELSON SABATINI
Chairman
Health Services Cost Review Commission

State of Maryland
Department of Health

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TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **September 13, 2017**

RE: **Hearing and Meeting Schedule**

October 11, 2017	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
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

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.