NOTICE OF WRITTEN COMMENT PERIOD

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

1) Maximum Revenue Guardrail for Maryland Hospital Quality Programs for Rate Year 2020

WRITTEN COMMMENTS ON THE AFOREMENTIONED STAFF DRAFT RECOMMENDATION ARE DUE IN THE COMMISSION'S OFFICES ON OR BEFORE SEPTEMBER 19, 2018.

State of Maryland
Department of Health

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Vice-Chairman

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554th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
September 12, 2018

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

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

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

3. **Implementation Protocol for Meritus Pharmacy - Authority General Provisions Article, §3-103 and §3-104**

4. **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 11, 2018 and Executive Session call on August 23, 2018.**

2. **New Model Monitoring**

3. **Docket Status – Cases Closed**

4. **Docket Status – Cases Open**

   Greater Baltimore Medical Center – 2442N
   Johns Hopkins Health System – 2443A
   Johns Hopkins Health System – 2444A
   Johns Hopkins Health System – 2445A
   Adventist HealthCare – 2446R
   MedStar Health – 2447A
   MedStar Health – 2448A
   Fort Washington Medical Center – 2449N
   University of Maryland Capital Regional Health – 2450R
   Greater Baltimore Medical Center – 2451R

5. **Draft Recommendation on Maximum Revenue Guardrail for Quality Programs for RY 2020**

6. **Policy Update and Discussion**

   a. **Annual Update Factor**

b. **MDPCP Update**
c. **Workgroup Update**

7. **Hearing and Meeting Schedule**

New Model Monitoring Report

The Report will be distributed during the Commission Meeting

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF SEPTEMBER XX, 2018

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2442R	Greater Baltimore Medical Center	7/24/2018	8/23/2018	12/21/2018	OTH	WH	OPEN
2443A	Johns Hopkins Health System	7/26/2018	N/A	N/A	ARM	DNP	OPEN
2444A	Johns Hopkins Health System	7/26/2018	N/A	N/A	ARM	DNP	OPEN
2445A	Johns Hopkins Health System	7/26/2018	N/A	N/A	ARM	DNP	OPEN
2446R	Adventist HealthCare	7/31/2018	9/12/2018	12/28/2018	PARTIAL	GS	OPEN
2447A	MedStar Health	6/21/2018	N/A	N/A	ARM	DNP	OPEN
2448A	MedStar Health	6/21/2018	N/A	N/A	ARM	DNP	OPEN
2449N	Fort Washington Medical Center	8/2/2018	9/12/2018	12/31/2018	IRC	WH	OPEN
2450R	University of Maryland Capital Regional Health	8/9/2018	9/12/2018	1/7/2019	CHRONIC/REHAB	gs	open
2451R	Greater Baltimore Medical Center	8/9/2018	9/12/2018	1/7/2019	DEF/MGS	WH	open

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

IN RE: THE PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*****	**COST REVIEW COMMISSION**
GREATER BALTIMORE	*****	**DOCKET: 2018**
MEDICAL CENTER	*****	**FOLIO: 2252**
BALTIMORE, MARYLAND	*****	**PROCEEDING: 2442N**

Staff Recommendation

September 12, 2018

Introduction

On July 31, 2018, Greater Baltimore Medical Center ("the "Hospital"), submitted a request to the Commission to establish a new Occupational Therapy ("OTH") rate. The Hospital requests that the rate be set at the statewide median per RVU and be effective October 1, 2018.

Staff Evaluation

To determine if the Hospital's OTH rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all projected cost and statistical data for OTH services for FY 2018. Based on information received, it was determined that the OTH rate based on the Hospital's projected data would be $10.99 per RVU, while the statewide median rate for OTH services is $9.74 per RVU.

Recommendation

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

1. That an OTH rate of $9.74 per RVU be approved effective October 1, 2018;
2. That the OTH rate center not be rate realigned until a full year of cost data has been reported to the Commission; and
3. That no change be made to the Hospital's Global Revenue for OTH services.

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IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2018**
SYSTEM	*	**FOLIO:**	**2253**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2443A**

Staff Recommendation

September 12, 2018

I. INTRODUCTION

Johns Hopkins Health System (System) filed an application with the HSCRC on July 26, 2018 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 an amended global rate arrangement for solid organ transplant, bone marrow transplant, and cardiovascular services with Global Excel Management, formerly Olympus Managed Health for a period of one year beginning September 1, 2018.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
JOHNS HOPKINS HEALTH	*****	**DOCKET:**	**2018**
SYSTEM	*****	**FOLIO:**	**2254**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2444A**

Staff Recommendation

September 12, 2018

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on July 26, 2018 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, 2018.

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

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
JOHNS HOPKINS HEALTH	*****	**DOCKET:**	**2018**
SYSTEM	*****	**FOLIO:**	**2255**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2445A**

Staff Recommendation

September 12, 2018

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on July 26, 2018 on behalf of Johns Hopkins Hospital and its affiliated hospitals ("the Hospitals") for renewal of a revised 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 global rate arrangement for hospital, physician services and certain non-medical services for patients who are not residents or citizens of the United States for a period of one year beginning September 1, 2018.

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II. OVERVIEW OF APPLICATION

The contract will be continue to be held and administered by Johns Hopkins International ("JHI), which is a subsidiary of the System. JHI 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 at the Hospitals. The remainder of the global rate is comprised of physician service costs and the cost of certain non-medical services, i.e., coordination of care, interpreters, hotel and travel arrangements, etc.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff believes that the Hospitals can continue to achieve favorable performance under this revised arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for the provision of hospital, physician and certain non-medical services to patients who are not residents or citizens of the United States for a one year period commencing September 1, 2018. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, and 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 PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**
APPLICATION OF ADVENTIST	*****	**COST REVIEW COMMISSION**
BEHAVIORAL HEALTH	*****	**DOCKET: 2018**
AND WELLNESS SERVICES	*****	**FOLIO: 2256**
CONSOLIDATION WITH SHADY	*****	**PROCEEDING: 2456R**
GROVE MEDICAL CENTER	*****	
ROCKVILLE, MARYLAND	*****	

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Staff Recommendation

September 12, 2018

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Overview and Hospital Request

Adventist Behavioral Health and Wellness Services (ABHWS) submitted a partial rate application on July 31, 2018 requesting to consolidate ABHWS' current HSCRC approved revenue into Shady Grove Medical Center's (SGMC's) permanent Global Budget Revenue (GBR) effective August 1, 2018. ABHWS received approval from the Maryland Health Care Commission (MHCC) to consolidate its services under SGMC's license on May 17, 2018. ABHWS is requesting that its approved revenue at budgeted volumes, $47,011,466 for CY18, be incorporated into SGMC's current approved GBR revenue of $410,104,275, effective for the year ending June 30, 2019.

SGMC is requesting that after the consolidation, new approved rates and budgeted volumes for inpatient psychiatric services and outpatient psychiatric day care services, based on ABHWS' current rate order, be added as new services to SGMC's approved rate order. SGMC also requests that all other budgeted departmental volumes and revenues at ABHWS combine with SGMC's current departmental budgeted volumes and approved revenue.

Background

Prior to the consolidation, ABHWS was a 117-bed free-standing psychiatric hospital located on the same campus as SGMC in Rockville, Maryland. Of the 117 beds at ABHWS, 30 are allocated to children and adolescents and 87 are allocated to adults. SGMC was licensed for a total of 266 beds. ABHWS and SGMC are unincorporated divisions of Adventist Health Care (AHC) and represent one legal entity. There will be no physical changes to any services at either ABHWS or SGMC to effectuate the consolidation.

As a freestanding psychiatric hospital, the HSCRC approved all payer rates for ABHWS. However, Medicare did not pay ABHWS based on charges; instead, they reimbursed ABHWS under a prospective payment system that is applicable to all freestanding psychiatric hospitals nationally. Historically, ABHWS Medicare reimbursement under the national prospective system ranged from 70 percent to 75 percent of charges, according to ABHWS analyses. After the consolidation, all payers will reimburse HSCRC approved rates and Medicare will no longer use the prospective payment system to reimburse ABHWS.

AHC decided to consolidate ABHWS and SGMC for several reasons. As ABHWS expanded community services and increased care coordination, lengths of stay and reimbursements fell and the facility's financial viability began to decline. ABHWS needs to better coordinate and integrate physical and behavioral health services; consolidation with SGMC will help to facilitate these efforts. Additionally, the facility is concerned that future reimbursement could be impacted for Medicaid beneficiaries aged 21-64. The federal government currently limits federal matching dollars for these beneficiaries if the free-standing psychiatric facility exceeds fifteen licensed beds. A CMS waiver previously enabled Maryland's Medicaid program to receive matching funds for these beneficiaries at ABHWS; however, the waiver expired in 2006 and was fully phased out by 2008. Now, ABHWS and the State of Maryland have taken financial responsibility for treating the Medicaid beneficiaries aged 21-64 treated at the facility.

ABHWS has not previously operated under the GBR program, instead receiving approved unit rate increases annually. Once ABHWS is consolidated under SGMC's GBR, any changes to ABHWS' future volumes will be accounted for under the normal GBR methodology. SGMC will now have the incentive to reduce utilization and avoidable volumes for the ABHWS patients.

Analyses

ABHWS met with HSCRC staff to discuss its concerns regarding the rates and financial viability of its psychiatric programs. As mentioned above, ABHWS reduced its inpatient length-of-stay through increased physician and community services and care management supports. The results of providing better community care meant the facility's inpatient revenues declined, thereby challenging its financial viability. Falling reimbursements also limited funds available for further investments in care integration and community based services; at the same time, unfunded physician and care coordination costs increased.

The HSCRC staff reviewed ABHWS' charges, financial trends, and volume trends. Summaries of these analyses follow:

ABHWS Charge Per Admission History

The table below compares the average charge per admission by year for the fiscal years ending from December 31, 2015 through 2017 and the six-month period ending June 30, 2018:

Table 1. Comparison of ABHWS Average Charge Per Admission, January 1, 2015 through June 30, 2018

Fiscal Year	Inpatient Revenue (in 000's)	Admissions	Average Charge Per Admission	Average Length of Stay
2015	$30,467	2,627	$11,598	9.93 days
2016	$34,474	3,151	$10,940	9.24 days
2017	$36,861	3,750	$9,830	8.57 days
Percent Change 2015-17	21.0 %	42.7 %	(15.2 %)	(12.9 %)

Source: ABHWS HSCRC Annual Reports – Schedule RE for 2015-17 and HSCRC Monthly Experience Reports for 2018.

Although admissions increased by 42.7 percent between FYs 2015 and 2017, inpatient revenue increased by only 21.0 percent resulting in a 15.2 percent reduction in average charges per admission between FYs 2015 and 2017. The decrease in average charge per admission was driven primarily by the reduction in the average length of stay.

Operating Margins

Table 2 below shows ABHWS' regulated, unregulated, and total operating margins reported to the HSCRC for last three ABWHS fiscal years, ending on December 31:

Table 2. ABHWS Regulated and Unregulated Annual Profit Margins-For the 3 fiscal years ended December 31, 2017

	2015 (in 000's)	2016 (in 000's)	2017 (in 000's)
Regulated Profit (in 000's)	$3,568	$5,414	$265
Regulated Profit Margin	14.2 %	19.7 %	.8 %
Unregulated Profit (Loss) (in 000's)	($625)	($3,244)	($3,183)
Unregulated Profit Margin	(6.1 %)	(25.4 %)	(21.4 %)

Total Profit (Loss) (in 000's)	$2,943	$2,170	($2,918)
Total Profit Margin	8.3 %	5.4 %	(5.9 %)

Source: ABHWS HSCRC Annual Reports – Schedule RE.

ABHWS' regulated profit margin has declined from 14.2 percent for FY/CY2015 to 0.8 percent for FY/CY2017. For all services, ABHWS profit margin has declined from 8.3 percent for FY/CY2015 to (5.9 percent) for FY/CY2017.

For the six months ending June 30, 2018, ABHWS reported an unaudited profit for all services of $398,648 compared to a loss from all services for the six months ended June 30, 2017 of ($1,072,494). Therefore, it appears that ABHWS has improved its overall profitability in FY 2018 compared to FY 2017. It is staff's understanding that ABHWS has recently divested itself of a residential treatment center and other unregulated services that were previously generating unregulated losses for ABHWS.

Unit Rate Comparisons

Presently, ABHWS has four separate room and board rates for inpatient psychiatric services, which are: Psychiatric-Acute, Psychiatric-Child/Adolescent, Psychiatric-Geriatric, and Psychiatric-ICU. HSCRC staff requested that ABHWS combine its four separate psychiatric inpatient unit rates into one overall rate to be consistent with acute care hospital psychiatric units in Maryland with only one approved rate for inpatient psychiatric services. In response, ABHWS combined its four individual inpatient psychiatric rates into one overall psychiatric rate of $1,211.37 per patient day. HSCRC staff calculated the simple average psychiatric inpatient rate, excluding ancillary services, for all Maryland acute care hospitals charged for the year ended June 30, 2018 which equaled $1,270.81 per patient day statewide.

Historically, ABHWS charged for outpatient psychiatric services using Clinic RVUs. HSCRC staff requested that ABHWS develop a Psychiatric Day Care (PDC) visit rate to conform to the approach used for other general acute hospitals. ABHWS calculated a PDC rate of $691.93 per visit using existing visits and charge levels. HSCRC staff calculated the actual average PDC rate per visit for all acute care Maryland hospitals for FY2018, which equaled $564.72. HSCRC staff recognizes that there can be service level differences among facilities for these therapies. The difference in ABWHS's PDC revenue from the state average represents approximately $700,000 in total revenues. In spite of this somewhat higher revenue figure for outpatient visits, staff recommends incorporating the outpatient services into the GBR at current rate and revenue levels.

Calculation of the Global Budget Add-On for ABHWS

After continued discussions, HSCRC staff and Adventist Health Care representatives agreed that the best approach would be to incorporate the mental health services under the Shady Grove Medical Center's global revenue cap. Bringing the program under Shady Grove's global revenue cap furthers the opportunity to increase care coordination, treat adult Medicaid patients (as the hospital has done in the past), and increase outpatient and community services. These activities will further integrate services, reduce length-of-stay, and decrease the need for inpatient psychiatric care. The HSCRC staff contacted Medicaid representatives to review the consolidation of these services under Shady Grove Medical Center, and they were supportive of this approach.

HSCRC staff set out to calculate an increment to the global budget of Shady Grove Adventist to incorporate ABHWS services. In doing so, it used the state average charge per case for psychiatric services provided in specialized beds in acute general hospitals. One of the reasons CMS discontinued the Medicaid waiver for freestanding psychiatric hospitals was a concern over higher lengths-of-stay in these facilities. By using the average charge per case in acute facilities to calculate the global revenue cap add-on, concerns that the longer length of stay would result in higher charges per case were mitigated.

This approach also credited ABHWS for reductions in length-of-stay. The resulting charge per case used by staff for CY2018 was $10,457, which is 1.5 percent higher than the 2018 year-to-date charge per case, but 9.8 percent lower than the CY2015 charge per case figure. Staff added historical levels of outpatient revenues to the calculated inpatient revenues to arrive at a total global revenue figure of $47,011,466 FY/CY2018.

Shady Grove Medical Center and Adventist Behavioral Health have taken the steps with licensure to consolidate the services under Shady Grove Medical Center.

Increase in Medicare Total Cost of Care

Once ABHWS revenue is consolidated with SGMC, Medicare will reimburse ABHWS' patients at 94 percent of charges as Medicare does for all psychiatric patients in acute care hospitals in Maryland. SGMC will have new approved rates and budgeted volumes for inpatient psychiatric services and outpatient psychiatric day care services. All other projected departmental volumes and revenues at ABHWS will be added to SGMC's current departmental budgeted volumes and approved revenue.

HSCRC staff and ABHWS have estimated that Medicare payments for ABHWS patients will increase by $2.6 million after the consolidation with SGMC, versus current Medicare payments prior to the consolidation. As noted above, under the Medicare reimbursement methodology for free-standing psychiatric hospitals, ABHWS has received on average 70 to 75 percent of charges compared to the 94 percent of charges under the Medicare Waiver agreement for the acute care hospitals in Maryland.

Summary of Findings

The staff has reviewed the financial performance of ABHWS from FY 2015 through June 30, 2018. ABHWS' average lengths of stay and average charge per admission have decreased significantly over the last three years. Although ABHWS' financial situation has improved recently, the hospital is generating an overall profit margin of only 1.6 percent through the first six months of 2018, based on unaudited financial statements submitted by ABHWS and after an overall negative profit margin of (6.3 percent) in FY2017. The global budget add-on was calculated using a statewide average charge per case for hospitals with distinct psychiatric units and adding in actual outpatient revenues. This provides a 1.5 percent increase in charge per case over the current level and locks in a savings of nearly 10 percent relative to historic charge-per-case levels. Staff and ABHWS have projected that Medicare will increase reimbursement for ABHWS' Medicare patients by approximately $2.6 million after consolidating services.

Consolidating ABHWS services into the SGMC's global revenue budget will support further investments in care coordination, care integration, and community based services and will help alleviate the problems posed by the discontinuation of the Medicaid waiver. For these reasons, staff is recommending approval of two new rate centers to incorporate psychiatric care into the SGMC rate order and an addition to SGMC's global revenue cap of $47,011,466, to incorporate the psychiatric facility revenues. SGMC quality programs and market shift figures will need to be adjusted for the inclusion of these services under the SGMC.

Recommendation

The HSCRC staff makes the following recommendations:

- Increase the Shady Grove Medical Center global revenue cap by $47,011,466 to incorporate the services of ABHWS into SGMC GBR;
- Establish two new rate centers at SGMC for psychiatric services using the current blended rate levels for those services;
- Adjust the SGMC quality programs and market shift calculations to incorporate the ABHWS services that have been consolidated;
- Set the rate order volumes for the psychiatric services at the levels used by HSCRC staff to calculate the global revenue add-on and incorporate other ancillary services based on the most recent twelve months of actual volumes.

Staff is also recommending that the regulatory requirement that rate applications be submitted no later than 60 days prior to the operational opening of a new service be waived. Staff recommends an effective date of August 1, 2018.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
MEDSTAR HEALTH	*	**DOCKET: 2018**
	*	**FOLIO: 2257**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2447A**

Staff Recommendation

September 12, 2018

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on June 21, 2018 on behalf of Union Memorial Hospital (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for cardiovascular services with the Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. for one year beginning August 1, 2018.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was renegotiated in 2007. The remainder of the global rate is comprised of physician service costs. Also in 2007, additional per diem payments were negotiated for cases that exceed the outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff reviewed the results of last year's experience under this arrangement and found that it was slightly unfavorable. However, staff believes that the Hospital can still achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's request for continued participation in the alternative method of rate determination for cardiovascular services for a one year period commencing August 1, 2018. The Hospital will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
MEDSTAR HEALTH	*	**DOCKET: 2018**
	*	**FOLIO: 2258**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2448A**

Staff Recommendation

September 12, 2018

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on June 21, 2018 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for joint replacement services with MAMSI for a one year period beginning September 1, 2018.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for continued participation in the alternative method of rate determination for orthopedic services, for a one year period, commencing September 1, 2018. The Hospitals will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document will formalize the understanding between the Commission and the Hospitals, and will 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, and 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 PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**
APPLICATION OF	*****	**COST REVIEW COMMISSION**
FORT WASHIINGTON	*****	**DOCKET: 2018**
MEDICAL CENTER	*****	**FOLIO: 2219**
FT. WASHINGTON, MARYLAND	*****	**PROCEEDING: 2449N**

Staff Recommendation

September 12, 2018

Introduction

On August 2, 2018, Fort Washington Medical Center ("the "Hospital") submitted a partial rate application to the Commission for a new Interventional Cardiology (IRC) rate. The Hospital requests the new rate as several CPT codes are being reallocated from the Radiology- Diagnostic to the IRC rate center, and the Hospital does not have an IRC center rate. The Hospital requests that the IRC rate be effective October 1, 2018.

Staff Evaluation

Based on Staff's review, the IRC rate based on the Hospital's projected data would be $61.43 per minute, while the statewide median to provide IRC services is $61.26 per minute.

Recommendation

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

1. That an IRC rate of $61.26 per minute be approved effective October 1, 2018;
2. That the IRC rate center not be rate realigned until a full year of cost data has been reported to the Commission; and
3. That no change be made to the Hospital's Global Budget Revenue for IRC services.

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION FOR	*	**COST REVIEW COMMISSION**
LAUREL REGIONAL	*	**DOCKET: 2018**
HOSPITAL	*	**FOLIO: 2260**
AND PRINCE GEORGES	*	**PROCEEDING: 2450R**
HOSPITAL CENTER	*	

*** ***

Staff Recommendation

September 12, 2018

Overview and Hospital Request

On August 2, 2018, the University of Maryland Medical System filed a partial rate application on behalf of UM Capital Regional Health hospitals (Prince Georges Hospital Center and Laurel Regional Hospital) requesting moving certain rate centers from Laurel Regional Hospital to Prince Georges Hospital Center and combining the hospitals' global budgets into one single global budget. These changes are necessary to implement the plan to convert Laurel Regional Hospital to a Freestanding Medical Center, discontinue inpatient services on the Laurel campus and move services from Laurel Hospital to Prince Georges Hospital.

The hospitals request that the Commission approve a final recommendation to establish a rehabilitation and chronic rate for Prince Georges Hospital. The request also asks the Commission to approve combining the global budgets for Prince Georges Hospital and Laurel Regional Hospital to effectuate an orderly conversion of the Laurel Regional Hospital to a Freestanding Medical Center.

Definitions

Freestanding Medical Center is an outpatient facility, which includes, at a minimum, a freestanding emergency room and may include other outpatient services approved by the Health Services Cost Review Commission (HSCRC) and Maryland Health Care Commission (MHCC). The facility is regulated by the HSCRC through its provider-based status as a component of a hospital, in accordance with the requirements of the Center for Medicare & Medicaid Services.

Background

UM Capital Regional Health hospitals (formerly the Dimensions Health System) is undertaking a comprehensive modernization plan that includes construction of a new replacement facility for the Prince Georges Hospital and replacement of the Laurel Regional Hospital with a new modern Freestanding Medical Center. The new Freestanding Medical Center will consist of Emergency and Observation services in addition to Outpatient Surgery, Outpatient Psychiatric Services, Wound Care and supporting ancillary services. The Dimensions Health System affiliated with the University of Maryland Medical System on September 1, 2017.

The HSCRC Staff and the Commissioners reviewed the projections utilized for this modernization and replacement plan as part of the Certificate of Need (CON) proceedings for replacement of the Prince Georges Hospital. In conjunction with this review, staff appraised a Comfort Order request to the Commission concerning the issuance of bonds to fund a portion of the capital costs of the plan. As part of the reconfiguration of Laurel Regional Hospital to a Freestanding Medical Center, the remaining inpatient services will be transitioned to the Prince Georges Hospital campus. The analyses assumed that the UM Capital Regional Health (the System) would retain all of the revenues for services moved to the Prince Georges Hospital Campus and retain approximately fifty percent of the GBR revenues when services shift to non-system hospitals or unregulated settings. Through this retention, in addition to substantial capital funding from the State of Maryland and Prince Georges County, the hospitals projected that they would be able to undertake these major construction and reconfiguration plans without requesting an increase in the GBR revenues for the System.

In July, 2018, the HSCRC staff met to discuss the approach to implement the reconfiguration and conversion of the Laurel Regional Hospital to a Freestanding Medical Center. On, or about, October 1, 2018, Inpatient Rehabilitation services and Inpatient Chronic services will be relocated to the Prince Georges Campus. The application requests that the current approved rates for these services be moved from the rate order of Laurel Regional Hospital to the Prince Georges Hospital. On, or about, January 1, 2019, the remaining Inpatient Medical Surgical, Intensive Care and Psychiatric services will also be relocated. Since both facilities have rates for these services, the Prince Georges Hospital will not need a new rate center, but Prince Georges Hospital will need to adjust its rates to blend these and supporting ancillary services into its facility rates, while maintaining compliance with the overall global revenue limits.

Upon completion of the service relocation, Laurel Regional Hospital will become a Freestanding Medical Center. At that point in time, its services will be billed as a part of the Prince Georges Hospital, under the Prince Georges Hospital's provider number.

To facilitate this reconfiguration, the HSCRC staff and the System discussed the combination of the two facilities under one GBR, but continuing to maintain two rate orders under the GBR. This will facilitate the service combination and compliance without multiple rate order adjustments.

Analyses

The HSCRC staff reviewed the partial rate application for consistency with the plans previously submitted to the Commission and approach to revenue and rate management under the GBR previously discussed with HSCRC Staff. Staff believe the approach discussed above will provide the smoothest rate and revenue transition.

Recommendations

The HSCRC staff makes the following recommendations:

1. That the GBRs of Prince Georges Hospital and Laurel Regional Hospital be combined into a single GBR for calculation of compliance with the global revenue budget;
2. Rates for Inpatient Chronic and Rehabilitative Services be established in the Prince Georges Hospital rate order at the same level as the rates of Laurel Regional Hospital until rate realignment occurs in conjunction with the RY 2020 update;
3. Rate orders be maintained for each of the two locations, with compliance calculated in the aggregate for the two hospitals using the combined GBR.

IN RE: THE PARTIAL RATE	*****	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*****	**COST REVIEW COMMISSION**
GREATER BALTIMORE	*****	**DOCKET: 2018**
MEDICAL CENTER	*****	**FOLIO: 2261**
GLEN BURNIE, MARYLAND	*****	**PROCEEDING: 2451R**

Staff Recommendation

September 12, 2018

Introduction

On August 8, 2018, Greater Baltimore Medical Center ("the Hospital"), submitted a partial rate application to the Commission requesting that its July 1, 2018 Medical Surgical Acute (MSG) and Definitive Observation (DEF) approved rates be combined effective October 1, 2018.

Staff Evaluation

This rate request is revenue neutral and will not result in any additional revenue for the Hospital. The Hospital wishes to combine these two centers, because the patients in both units are cared for in the same area and have similar nursing to patient staffing ratios. The Hospital's currently approved rates and the new proposed rate are as follows:

	Current Rate	Budgeted Volume	Approved Revenue
Medical Surgical Acute	$1,148.38	35,008	$40,202,426
Definitive Observation	$1,454.92	12,059	$17,545,562
Combined Rate	$1,226.93	47,067	$57,747,988

Recommendation

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

1. That the Hospital be allowed to collapse its DEF rate into its MSG rate;
2. That a MSG rate of $1,226.93 per day be approved effective October 1, 2018; and
3. That no change be made to the Hospital's Global Budget Revenue for MSG services.

Draft Recommendation for the Maximum Revenue Guardrail for Maryland Hospital Quality Programs for Rate Year 2020

September 12, 2018

Health Services Cost Review Commission
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This document contains the draft staff recommendations for updating the Maximum Guardrail Policy for RY 2020. Please submit comments on this draft to the Commission by Friday, September 19, 2018, via email to hscrc.quality@maryland.gov.

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LIST OF ABBREVIATIONS

CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFY	Federal fiscal year
FY	State fiscal year
HSCRC	Health Services Cost Review Commission
MHAC	Maryland Hospital-Acquired Conditions Program
PAU	Potentially avoidable utilization
PQI	Prevention quality indicator
QBR	Quality-based reimbursement
RRIP	Readmissions Reduction Incentive Program
RY	State rate year
VBP	Value-based purchasing

INTRODUCTION

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

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

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

BACKGROUND

1. Federal Quality Programs

In developing the recommendation for the maximum revenue guardrail, the staff first analyzed the aggregate revenue at-risk for Maryland's quality-based payment programs compared to the amount at-risk for the following national Medicare quality programs:

- The Medicare Hospital Readmissions Reduction Program (HRRP), which reduces payments to inpatient prospective payment system hospitals with excess readmissions.[1]

[1] For more information on the Medicare Hospital Readmissions Reduction Program, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.

- The Medicare Hospital-Acquired Condition Reduction Program (HACRP), which ranks hospitals according to performance on a list of hospital-acquired condition quality measures and reduces Medicare payments to the hospitals in the lowest performing quartile.[2]
- The Medicare Value Based Purchasing (VBP) Program, which adjusts hospitals' payments based on their performance on the following four hospital quality domains: clinical care, patient experience of care, safety, and efficiency.[3]

2. Maryland's Quality-Based Programs

As discussed in the introduction section of this report, Maryland is exempt from the federal Medicare hospital quality programs. Instead, Maryland implements the following quality-based payment programs:

- The Quality Based Reimbursement (QBR) program employs measures in several domains, including clinical care, patient experience, and safety. Starting in FY 2019, the QBR program revenue adjustments were linked to a preset scale instead of relatively ranking hospitals, which was designed to provide hospitals with more predictable revenue adjustments. Furthermore, the Commission approved a modified full scaling approach to ensure that rewards would only be given out to hospitals that perform well compared to the nation. For additional discussion on the QBR scale, please refer to the RY 2020 QBR policy posted to the HSCRC website.
- The Maryland Hospital Acquired Conditions (MHAC) program measures hospital performance using 3M's potentially preventable complications. HSCRC calculates observed-to-expected ratios for each complication and compares them with statewide benchmarks and thresholds. As with the QBR program, the MHAC program uses a pre-set scale to provide hospitals with the ability to prospectively estimate revenue adjustments. For additional discussion on the MHAC scale, please refer to the RY 2020 policy posted to the HSCRC website.
- The Readmission Reduction Incentive Program (RRIP) establishes a readmissions reduction target, an attainment target, and a scale for rewards/penalties for hospitals. The statewide minimum improvement target is established to eliminate the gap between the national Medicare readmission rate and the Maryland Medicare readmission rate. For additional discussion on the improvement target, please refer to the RY 2020 policy posted to the HSCRC website.

[2] For more information on the Medicare Hospital-Acquired Condition Reduction program, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html.
[3] For information on the Medicare VBP program, see https://www.medicare.gov/hospitalcompare/Data/hospital-vbp.html.

- In addition to the three programs described above, two additional performance-based payment adjustments are implemented to hospital revenues prospectively as part of the annual update factor. The Potentially Avoidable Utilization (PAU) Savings Program reduces each hospital's approved revenues prospectively based on revenue associated with avoidable admissions and readmissions. The demographic PAU efficiency adjustment reductions are applied to global budgets to reduce allowed volume growth based on the percentage of revenue associated with PAU for each hospital.

Figure 1 below provides the maximum penalties or rewards for the three CMS and Maryland quality programs for RY/FFY 2019 and RY/FFY 2020. In general, CMS programs relatively rank hospital performance when determining penalties or rewards, whereas Maryland's quality programs use prospectively determined preset scales. For RY 2019 and RY 2020 staff believe that the Maryland quality programs have met or exceeded the national potential risk. Furthermore, staff estimate that through RY 2018 the State has also met or exceeded the national realized risk (FFY 2019 revenue adjustments not yet available). These estimates use the methodology that HSCRC and CMMI agreed upon, but final numbers are pending CMMI review. See Appendix A for additional details on the aggregate at-risk test.

Figure 1. 2018 Maximum Quality Penalties or Rewards for Maryland and The Nation

MD All-Payer	Max Penalty %	Max Reward %	National Medicare	Max Penalty %	Max Reward %
RY/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%	1.0%	VBP	2.0%	2.0%
RY/FFY 2020					
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%

ASSESSMENT

In order to develop the maximum revenue at-risk guardrail for RY 2020 quality programs, HSCRC staff considered CMS relevant policies, conducted analyses, and solicited input from the Performance Measurement Workgroup.[4] During its February meeting, the Performance Measurement Workgroup reviewed data comparing the amount of revenue at-risk in Maryland with the national Medicare programs. Again the RY 2020 aggregate at-risk amounts were

[4] For more information on the Performance Measurement Workgroup, see https://hscrc.maryland.gov/Pages/hscrc-workgroup-performance-measurement.aspx

approved as part of the actual quality program policies, and this report only presents a recommendation for the maximum revenue guardrail.

Maximum Revenue at-risk Hospital Guardrail

As the HSCRC increases the maximum revenue adjustments statewide, the potential for a particular hospital to receive significant revenue reductions has raised concerns that such penalties may generate unmanageable financial risk. Similar to the risk corridors in other VBP programs, a maximum penalty guardrail may be necessary to mitigate the detrimental financial impact of unforeseen large adjustments in Maryland programs. Given the increases in risk levels in other programs, a hospital-specific guardrail will provide better protection than a statewide limit. In RY 2017, RY2018, and RY 2019, the hospital maximum penalty guardrail was set at 3.50 percent of total hospital revenue. Staff used the inpatient Medicare aggregate amount at-risk total as the benchmark to calculate the hospital maximum penalty guardrail (e.g. 6 percent * 58 percent revenue attributable to inpatient services). For RY 2020, staff recommend updating the percent of inpatient revenue (dropped from 58 to 57 percent) for calculating the maximum guardrail, which results in a slightly reduced maximum revenue guardrail of 3.40 percent. This maximum revenue guardrail applies to QBR, MHAC, RRIP, and net PAU Savings. Historically, no hospital penalties have reached the maximum revenue guardrail. For reference, in RY 2019 the highest revenue adjustment was a 2.05 percent total revenue reduction (which corresponds to 2.74 percent revenue reduction for inpatient revenue).

RECOMMENDATION

For RY 2020, the maximum penalty guardrail should be set at 3.40 percent of total hospital revenue.

APPENDIX A. COMPARISON OF AGGREGATE REVENUE AT-RISK FOR MARYLAND QUALITY-BASED PAYMENT PROGRAMS COMPARED TO MEDICARE PROGRAMS

After discussions with CMS, HSCRC staff performed analyses of both "potential" and "realized" revenue at-risk. Potential revenue at-risk refers to the maximum amount of revenue that is at-risk in the measurement year. Realized risk refers to the actual amounts imposed by the programs. The comparison with the national amounts is calculated on a cumulative basis. Exhibit 1 compares the potential amount of revenue at-risk in Maryland with the amount at-risk in the national programs. The difference between the national Medicare and Maryland all-payer annual amounts are summed after each year's experience to compare the annual difference.

The top half of Exhibit 1 displays the percentage of potential inpatient revenue at-risk in Maryland for all payers for each of Maryland's quality-based payment programs for RYs 2014 through 2020. The bottom half of the figure displays the percentage of potential national Medicare inpatient revenue at-risk for quality-based payment programs for FFYs 2014 through 2020. These potential at-risk numbers are the absolute values of the maximum penalty or reward. Due to efforts to align Maryland's quality-based payment programs with the national programs and the increasing emphasis on value-based payment adjustments, Maryland has exceeded the national aggregate maximum at-risk amounts since RY 2016.

Exhibit 1. Potential Revenue at-risk for Quality-Based Payment Programs, Maryland Compared with the National Medicare Programs, 2014-2020

% of MD All-Payer Inpatient Revenue	RY 2014	RY 2015	RY 2016	RY 2017	RY 2018	RY 2019	RY 2020
MHAC	2.0%	3.0%	4.0%	3.0%	3.0%	2.0%	2.0%
RRIP			0.5%	2.0%	2.0%	2.0%	2.0%
QBR	0.5%	0.5%	1.0%	2.0%	2.0%	2.0%	2.0%
Subtotal	2.5%	3.5%	5.5%	7.0%	7.0%	6.0%	6.0%
PAU Savings*	0.4%	0.9%	1.4%	4.5%	5.9%	5.8%	*5.8%*
Demographic PAU Efficiency Adjustment*	0.5%	0.9%	1.1%	1.3%	0.5%	0.8%	*0.8%*
MD Aggregate Max. At Risk	3.4%	5.2%	8.0%	12.8%	13.4%	12.6%	12.6%
*Italicized numbers subject to change							

% of National Medicare Inpatient Revenue	FFY2014	FFY2015	FFY2016	FFY2017	FFY2018	FFY2019	FFY2020
HAC		1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
Readmissions	2.0%	3.0%	3.0%	3.0%	3.0%	3.0%	3.0%
VBP	1.3%	1.5%	1.8%	2.0%	2.0%	2.0%	2.0%
Medicare Aggregate Max. At Risk	3.3%	5.5%	5.8%	6.0%	6.0%	6.0%	6.0%
Annual MD-US Difference	0.2%	-0.3%	2.2%	6.8%	7.4%	6.6%	6.6%
*Please note that these numbers are rounded in the table to the 10th decimal and results in some discrepancies compared to calculations done with the table numbers.							

As Maryland's programs moved away from revenue neutral rewards and penalties and toward payment adjustments based on preset payment scales, the actual amounts imposed in quality-based programs differ from the maximum amounts established in the policies and none of the hospitals may be subject to the maximum penalty when the payment adjustments are implemented. On the other hand, the national Medicare programs may make payment adjustments only to the lowest performing hospitals, limiting the reach of the performance-based adjustments. CMMI and HSCRC staff worked on a methodology to compare the total actual payment adjustments by summing the absolute average payment adjustments across all programs, namely aggregate realized at-risk. Maryland is expected to meet or exceed both the potential and realized at-risk amounts of the national Medicare programs but final approval is pending CMMI confirmation. Exhibit 2 provides a comparison of the average adjustment amount between Maryland and national programs. Maryland's overall aggregate average adjustments were 5.25 percent of the total inpatient revenue in RY 2019, compared to 1.33 percent in the national Medicare programs in FFY 2018 (FFY 2019 revenue adjustments in table are estimates based on FFY 2018; if available final policy will include actual FFY 2019 adjustments). While the PAU savings revenue adjustments account for a large proportion of Maryland's higher realized risk, Maryland meets the realized risk requirement even without the PAU savings or demographic PAU efficiency adjustment.

Exhibit 2. Realized Revenue at-risk for Quality-Based Payment Programs, Maryland Compared with the National Medicare Programs, 2014-2019

% of MD All-Payer Inpatient Revenue	RY 2014	RY 2015	RY 2016	RY 2017	RY 2018	RY 2019
MHAC	0.22%	0.11%	0.18%	0.40%	0.50%	0.25%
RRIP			0.15%	0.57%	0.61%	0.58%
QBR	0.11%	0.14%	0.30%	0.26%	0.59%	0.64%
Subtotal	0.34%	0.25%	0.63%	1.23%	1.70%	1.47%
PAU Savings	0.29%	0.64%	0.93%	2.55%	3.05%	3.57%
Demographic PAU Efficiency Adjustment	0.28%	0.33%	0.39%	0.35%	0.22%	0.21%
MD Aggregate Max.At Risk	**0.90%**	**1.22%**	**1.95%**	**4.13%**	**4.97%**	**5.25%**
% of National Medicare Inpatient Revenue	**FFY 2014**	**FFY2015**	**FFY2016**	**FFY2017***	**FFY2018***	**FFY2019***
HAC		0.22%	0.23%	0.24%	0.24%	0.24%
Readmits	0.28%	0.52%	0.51%	0.61%	0.56%	0.56%
VBP	0.20%	0.24%	0.40%	0.51%	0.53%	0.53%
Medicare Aggregate Max. At Risk	**0.47%**	**0.97%**	**1.14%**	**1.36%**	**1.33%**	**1.33%**
Annual MD-US Difference	**0.43%**	**0.25%**	**0.81%**	**2.77%**	**3.63%**	**3.92%**

*The CMS realized risk was calculated by the HSCRC and are subject to CMS validation.

In summary, staff estimate that Maryland outperformed the national programs in the potential and realized aggregate payment amounts for RY 2019. Maryland hospitals continued to improve their performance in reducing complications and readmissions. However, further reductions in revenue associated with PAU will be important for financial success under the all-payer and Total Cost of Care model. Finally, as additional performance-based revenue adjustments are implemented, such as the Medicare Performance Adjustment for total cost of care, the potential aggregate at-risk amounts for other programs should be evaluated. Staff will continue to discuss the appropriate amounts for performance-based payment programs with the workgroups and other stakeholders.

See Exhibit 3 for hospital-level results.

Exhibit 3. Consolidated Adjustments for All Quality-Based Payment Programs for Rate Year 2019, by Hospital

HOSP ID	Hospital Name	FY 17 Total Permanent Revenue	FY 17 Permanent Inpatient Revenue	MHAC % Inpatient	RRIP % Inpatient	QBR % Inpatient	PAU Savings % Inpatient	PAU Net Impact % Inpatient	PAU Demographic % Inpatient	Total Impact % Inpatient	Total Impact % Total Revenue
210003	UM-PG	$287,707,710	$215,464,625	0.13%	-0.98%	-1.49%	-2.41%	-0.41%	-0.05%	-2.74%	-2.05%
210004	HOLY CROSS	$489,724,686	$340,412,069	0.24%	-1.63%	-1.08%	-2.57%	-0.25%	-0.03%	-2.72%	-1.89%
210001	MERITUS	$321,955,560	$190,799,459	-0.18%	-1.02%	-1.07%	-3.71%	-0.82%	-0.38%	-3.09%	-1.83%
210062	SOUTHERN MD	$271,260,318	$163,844,003	-0.89%	-0.04%	-1.05%	-4.49%	-0.94%	-0.33%	-2.92%	-1.76%
210022	SUBURBAN	$313,631,832	$197,431,392	-0.04%	-1.18%	-1.23%	-2.61%	-0.34%	-0.20%	-2.79%	-1.76%
210015	FRANKLIN SQ	$522,059,009	$300,623,972	-0.22%	-1.19%	-0.85%	-3.14%	-0.67%	-0.04%	-2.93%	-1.69%
210034	HARBOR	$186,978,444	$112,526,840	0.00%	-1.47%	-0.88%	-3.00%	-0.45%	-0.02%	-2.80%	-1.68%
210033	CARROLL	$225,263,359	$132,801,017	-0.62%	-0.35%	-0.56%	-4.56%	-1.29%	-0.36%	-2.83%	-1.67%
210065	HC GERMAN	$102,303,760	$60,632,167	0.38%	-1.56%	-0.51%	-3.54%	-0.82%	-0.22%	-2.51%	-1.49%
210002	UMMC	$1,399,559,924	$919,253,797	-0.31%	-0.36%	-0.83%	-2.12%	-0.65%	-0.04%	-2.16%	-1.42%
210005	FREDERICK	$338,085,918	$220,972,343	0.07%	-0.06%	-0.89%	-3.50%	-1.21%	-0.41%	-2.09%	-1.37%
210032	UNION OF CECIL	$158,683,870	$66,514,320	0.00%	-1.80%	-0.57%	-4.31%	-0.76%	-0.37%	-3.13%	-1.31%
210024	UNION MEMORIAL	$421,547,476	$235,346,415	-0.71%	0.09%	-0.67%	-3.43%	-0.99%	-0.03%	-2.28%	-1.27%
210018	MS MONTGOMERY	$172,101,071	$77,808,657	0.16%	-0.56%	-1.51%	-4.36%	-0.75%	-0.32%	-2.66%	-1.20%
210029	HOPKINS BAYVIEW	$647,476,458	$357,620,585	0.00%	-0.84%	-0.56%	-3.27%	-0.65%	0.00%	-2.05%	-1.13%
210048	HOWARD	$298,460,107	$183,348,539	-0.62%	-0.11%	-0.45%	-3.39%	-0.64%	-0.36%	-1.82%	-1.12%
210056	GOOD SAMARITAN	$264,597,392	$140,674,848	0.09%	0.28%	-1.10%	-5.21%	-1.05%	0.00%	-1.78%	-0.95%
210010	DORCHESTER	$49,226,292	$26,021,222	0.31%	-0.83%	-0.64%	-3.42%	-0.63%	-0.05%	-1.79%	-0.94%
210019	PRMC	$431,713,670	$241,466,813	0.00%	-0.66%	-0.43%	-3.09%	-0.28%	-0.15%	-1.37%	-0.77%
210016	WASHADVENTIST	$265,729,172	$158,337,604	0.13%	0.28%	-1.12%	-3.03%	-0.57%	-0.14%	-1.28%	-0.76%
210055	UM-LAUREL	$99,871,376	$58,931,276	0.44%	0.35%	-1.61%	-2.98%	-0.47%	-0.14%	-1.28%	-0.76%
210009	JOHNS HOPKINS	$2,352,963,223	$1,378,259,901	0.00%	-0.28%	-0.36%	-2.52%	-0.58%	-0.04%	-1.22%	-0.72%
210051	DOCTORS	$239,227,750	$144,686,192	0.22%	-0.05%	-0.31%	-4.67%	-1.00%	-0.37%	-1.14%	-0.69%
210006	HARFORD	$102,314,327	$48,557,781	0.38%	-0.42%	-0.91%	-5.66%	-0.46%	-0.76%	-1.42%	-0.67%
210027	WESTERN MD	$320,642,519	$171,000,183	-0.44%	0.01%	-0.09%	-3.47%	-0.72%	0.00%	-1.24%	-0.66%

HOSP ID	Hospital Name	FY 17 Total Permanent Revenue	FY 17 Permanent Inpatient Revenue	MHAC % Inpatient	RRIP % Inpatient	QBR % Inpatient	PAU Savings % Inpatient	PAU Net Impact % Inpatient	PAU Demographic % Inpatient	Total Impact % Inpatient	Total Impact % Total Revenue
210011	ST. AGNES	$422,820,202	$237,889,236	0.29%	0.12%	-0.70%	-4.24%	-0.85%	-0.05%	-1.14%	-0.64%
210043	UM-BWMC	$409,703,662	$229,151,792	0.13%	0.38%	-0.92%	-4.20%	-0.67%	-0.46%	-1.07%	-0.60%
210038	UMMC MIDTOWN	$234,227,770	$117,217,727	0.40%	-0.29%	-0.62%	-3.61%	-0.67%	0.00%	-1.18%	-0.59%
210061	AGH	$105,151,502	$37,316,219	0.53%	0.07%	-0.96%	-4.26%	-1.10%	-0.28%	-1.45%	-0.52%
210057	SHADY GROVE	$387,674,359	$231,939,525	0.00%	0.01%	-0.20%	-2.88%	-0.66%	-0.17%	-0.85%	-0.51%
210028	MS ST. MARY	$177,161,733	$76,303,058	0.49%	0.18%	-0.75%	-4.63%	-1.04%	-0.51%	-1.13%	-0.48%
210023	AAMC	$609,013,273	$299,264,995	0.33%	-0.02%	-0.64%	-2.93%	-0.63%	-0.21%	-0.96%	-0.47%
210044	G.B.M.C.	$442,204,396	$225,145,722	-0.71%	0.40%	-0.38%	-2.54%	-0.18%	-0.03%	-0.87%	-0.44%
210012	SINAI	$752,409,746	$398,036,508	-0.31%	1.00%	-0.73%	-2.78%	-0.49%	0.00%	-0.53%	-0.28%
210008	MERCY	$516,410,170	$223,932,822	0.00%	0.21%	-0.18%	-2.08%	-0.45%	-0.02%	-0.42%	-0.18%
210060	FT WASHINGTON	$48,244,588	$19,548,527	0.62%	1.00%	-1.42%	-5.82%	-0.65%	-0.34%	-0.44%	-0.18%
210037	EASTON	$202,561,563	$105,222,295	0.31%	-0.27%	-0.31%	-2.93%	0.01%	-0.19%	-0.26%	-0.13%
210017	GARRETT	$54,328,266	$21,075,334	0.00%	1.00%	-0.73%	-3.41%	-0.54%	-0.30%	-0.27%	-0.10%
210013	BON SECOURS	$115,902,722	$65,798,042	0.00%	0.97%	-0.37%	-3.18%	-0.56%	0.00%	0.04%	0.02%
210035	UM-CHARLES	$148,909,451	$75,199,112	0.38%	0.34%	-0.32%	-4.08%	-0.35%	-0.49%	0.04%	0.02%
210064	LEVINDALE	$58,867,710	$56,105,767	-0.62%	0.85%		-1.25%	-0.16%	-0.16%	0.06%	0.06%
210058	UMROI	$120,638,692	$69,966,359	0.00%	0.22%		-0.12%	-0.11%	0.00%	0.11%	0.06%
210045	MCCREADY	$15,618,329	$3,033,907		0.38%		-6.87%	0.00%	-0.40%	0.38%	0.07%
210049	UM-UCH	$334,751,759	$130,150,364	0.18%	1.00%	-0.04%	-4.62%	-0.85%	-0.47%	0.29%	0.11%
210040	NORTHWEST	$255,493,814	$133,828,758	0.18%	0.89%	-0.07%	-4.96%	-0.78%	-0.11%	0.22%	0.11%
210063	UM ST. JOE	$398,711,781	$237,924,618	0.00%	0.32%	0.12%	-2.17%	-0.23%	-0.08%	0.21%	0.12%
210039	CALVERT	$143,263,199	$63,677,722	0.11%	1.00%	-0.02%	-4.17%	-0.65%	-0.59%	0.44%	0.20%
210030	UM-Chester	$55,473,722	$21,139,936	0.00%	0.62%	0.24%	-5.06%	0.23%	-0.45%	1.09%	0.41%
State	**Statewide**	**$16,292,627,632**	**$9,222,204,362**	**-0.06%**	**-0.21%**	**-0.63%**	**-3.09%**	**-0.61%**	**-0.13%**	**-1.52%**	**-0.86%**

STATUS REPORT ON ANNUAL UPDATE

SEPTEMBER 2018

Overview

At the July Commission meeting, the Commission voted to reduce the proposed update by 0.25 percent for FY 2019 amid concerns that Maryland's Medicare total cost of care was growing beyond initial projections due to higher growth rates in non-hospital settings. This status report provides an update to the Commission on the most recent information relative to the Medicare total cost of care projections for CY 2018. As a reminder, the State must not exceed the national Medicare total cost of care growth rate under the guardrail tests of the All-Payer Model agreement with CMS.[1] Updates to projections and conditions most pertinent to the annual update include:

- Final Medicare inpatient regulations have been issued. There was a **small increase in the federal Medicare inpatient update in excess of the initial estimates**, which would increase national costs. However, the preliminary rules for the Medicare outpatient increase due January 2019 are cause for concern, as they provide **no increase in outpatient rates**. While this will not affect CY 2018, it **raises concerns for CY 2019**.

- As reported in July, the **CMS Office of the Actuary has increased the national hospital and total cost of care projections for CY 2018**, which improve the likelihood of favorable Maryland performance producing cost increases below the national Medicare growth rate.

- **Hospital revenue growth estimates are comparable to the initial growth estimates.** Staff has made adjustments for some shifts to unregulated. The regulation of the Meritus Oncology Center partially offset reductions made for shifts to unregulated. Additional work is underway to evaluate disclosures submitted in July and August and the need for additional adjustments.

- Our most recent estimates of year over year growth for Medicare Total Cost of Care are that Maryland will **grow somewhere between 0.20 percent and 0.40 percent below** the national growth rate for the Calendar Year 2018. However, short term projections are volatile and subject to change.

[1] The All-Payer Model Agreement guardrails stipulate that Maryland's total cost of care growth may not exceed the nation by more than one percent in any given year or any amount in two consecutive years.

Details

CMS Final Rule for FY 2019 (Oct. 1 through Sept. 30) Inpatient Prospective Payment System Update

The final rule had a minor increase in inpatient payments (0.10 percent higher inflation) as compared to the preliminary rule used by staff in evaluating the update factor.

CMS Proposed CY 2019 Medicare Hospital Outpatient Prospective Payment System Update

The proposed update of approximately zero percent, resulting from a proposed spending cut for offsite clinics, is lower than the HSCRC staff estimate utilized in the update recommendation.

- This will not affect CY 2018 performance, but will put pressure on outpatient performance for CY 2019, if finalized as proposed.

- CMS proposed to increase rates by approximately 1.25 percent (market basket, less productivity and ACA offset).This is generally consistent with HSCRC staff assumptions in the annual update.

- CMS proposed to decrease rates 1.2 percent by implementing site-neutral payments for clinic visits provided at off-campus, provider based hospitals. If finalized, this would cut $760 million in Medicare outpatient spending for CY 2019.

  The net of the increase and decrease is near zero percent.

CMS Actuarial Forecast for Hospital and Total Cost of Care Growth for Medicare for CY 2018

As previously reported, the CMS Actuarial forecast for CY 2018 has changed. Hospital growth estimates increased from to 2.1 percent to 2.9 percent annual growth, and the Total Cost of Care growth estimates have risen from 2.0 percent to 3.2 percent.

Revenue Projections

HSCRC staff has developed updated revenue projections based on the rate order files for the FY 2019 timeframe (July 1, 2018 through June 30, 2019). Staff has made several reductions to revenues for deregulation of services, as well as increasing revenues for the regulation of oncology services at Meritus. The new revenue projections are similar to those used in the update calculations.

The new revenue projections show revenues of 1.76 percent, compared to the estimates of revenue of 2.01 percent used in the update for the first half of the fiscal year. The 2.01 percent includes a 0.25 percent set-aside for unknown adjustments. When the set-aside is removed from the initial estimate, current revenue projections are on target with the revenue estimates that were used in the update recommendation. Please note, these revenue projections do not include price settlements or the QBR adjustment, which will be included in mid-year updates.

Revised Update Requirements Based on Latest Actuarial Forecast and Revenue Projections

As stated above, staff received updated actuarial projections showing an increased growth in national Medicare hospital and total cost of care. Staff completed multiple independent analyses to estimate CY 2018 Maryland total cost of care growth relative to national Medicare growth. These estimates used updated actuarial forecasts, historical performance, conservative projections of non-hospital growth, and the most recent revenue projections. After review, the staff's best estimate is a range of 0.2 to 0.4 percent lower growth in Maryland relative to national Medicare growth rates. Since these estimates are based on assumptions, and actual results will likely vary from projections, the variances may be significant.

Update on Total Cost of Care Growth through June 30, 2018

The cumulative savings in total cost of care through June 30, 2018 are estimated at just under $700 million. Please note that these are preliminary figures through four and one-half years of performance. The 2018 portion of these figures is based on claims paid through July, 2018 and is subject to change. While the State is ahead of cumulative performance requirements relative to Medicare hospital costs and total cost of care, there are also annual growth limitations. The State may not have annual year over year total cost of care growth in excess of the national growth for two consecutive years. Since statewide growth in CY 2017 was higher than national growth, following a year of much lower growth in CY 2016, the State will need to ensure that the CY 2018 growth rate is below the national growth rate. Through June 30, 2018, the State was 0.70 percent below the national total cost of care growth year to date, although this figure may fluctuate when actual claims for the period are received.

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TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **September 12, 2018**

RE: **Hearing and Meeting Schedule**

October 10, 2018	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
November 14, 2018	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room

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

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

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