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Department of Health and Mental Hygiene

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523rd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
October 14, 2015

EXECUTIVE SESSION
12:00 p.m.
(The Commission will begin in public session at 12:00 p.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1PM.)

1. **Update on Contract and Modeling of the All-payer Model vis-a-vis the All-Payer Model Contract – Authority General Provisions Article, §3-104**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
1:00 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on September 9, 2015**

2. **Executive Director's Report**

3. **New Model Monitoring**

4. **Docket Status – Cases Closed**
   2306A- University of Maryland Medical Center

5. **Docket Status – Cases Open**

   2300R – Washington Adventist Hospital
   2304N – UM St. Joseph Medical Center
   2307A – Maryland Physician Care
   2308A – Priority Partners
   2309A - University of Maryland Medical Center
   2310A – MedStar Family Choice
   2311A – MedStar Family Choice
   2312A - University of Maryland Medical Center
   2313A - University of Maryland Medical Center
   2314A – Riverside Health of Maryland

6. **Final Recommendations on Revisions to the Quality Based Reimbursement Program for Rate Year 2018**

7. **Legal Report**

8. **Hearing and Meeting Schedule**

Closed Session Minutes
Of the
Health Services Cost Review Commission

September 9, 2015

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

1. Update on Contract and Modeling of the All-Payer Model vis-à-vis the All-Payer Model Contract;

The Closed Session was called to order at 12:07 p.m. and held under authority of - §§ 3-104 of the General Provisions Article.

In attendance, in addition to Chairman Colmers, were Commissioners Bone, Jencks, Keane, Loftus, Mullen and Wong.

In attendance representing Staff were Donna Kinzer, David Romans, Steve Ports, Sule Gerovich, Ellen Englert, Jessica Lee, and Dennis Phelps.

Also attending were Deborah Garcey of Health Management Associates, consultant to the HSCRC, and Leslie Schulman and Stan Lustman, Commission Counsel.

Item One

David Romans, Director-Payment Reform and Innovation, presented and the Commission discussed an updated analysis of Medicare per beneficiary data.

Item Two

Ms. Kinzer presented and the Commission discussed an overview of the Maryland All-Payer Model alignment and integration, as well as planning for Phase II of the model agreement.

The Closed Session was adjourned at 12:59 p.m.

Closed Session Minutes
Of the
Health Services Cost Review Commission

October 1, 2015

Upon motion made by Commissioner Mullen and seconded by Commissioner Wong, Chairman Colmers called the closed session to order, prior notice of which was given, to discuss the following item:

1. Planning for Phase II of the All-Payer Model agreement;

The Closed Session was called to order at 11:34 a.m. and held under authority of - §§ 3-103 and 3-104 of the General Provisions Article.

In attendance by telephone, in addition to Chairman Colmers, were Commissioners Jencks, Keane, Loftus, Mullen and Wong.

In attendance representing Staff were Donna Kinzer, David Romans, Steve Ports, Jerry Schmith, Sule Gerovich, Ellen Englert, Jessica Lee, Erin Schurmann, and Dennis Phelps.

Also attending was Stan Lustman, Commission Counsel.

Item One

Ms. Kinzer lead a discussion with the Commissioners and staff on the development of a total cost of care vision for Phase II of the All-Payer Model by the end of the year, as requested by the Center for Medicare and Medicaid Innovation.

The Closed Session was adjourned at 12:38 p.m.

MINUTES OF THE
522nd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

September 9, 2015

Chairman John Colmers called the public meeting to order at 12:07 pm. Commissioners George H. Bone, M.D., Stephen F. Jencks, M.D., MPH, Jack C. Keane, Bernadette C. Loftus, M.D., Thomas Mullen, and Herbert S. Wong, Ph.D. were also in attendance. Upon motion made by Commissioner Jencks and seconded by Commissioner Bone, the meeting was moved to Executive Session. Chairman Colmers reconvened the public meeting at 1:05 pm.

REPORT OF THE SEPTEMBER 9, 2015 EXECUTIVE SESSION

Mr. Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the September 9, 2015 Executive Session.

ITEM I
REVIEW OF THE MINUTES FROM AUGUST 12, 2015 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the August 12, 2015 Executive Session and Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, reported that Staff has released the Request for Proposal (RFP) for Competitive Implementation Plans that the Commission approved for FY2016. The Plans will result in the addition of .25% of approved revenue to rates based on a review of applications to be submitted. The competitive transformation implementation awards are intended to support investments and activities related to partnerships, strategies, vision for care coordination, and provider alignment in the State. Competitive transformation implementation awards will be available to any Maryland acute care or specialty hospital that submits a successful bid.

Ms. Kinzer stated that Staff also released to hospitals and stakeholders the reporting requirements for the Strategic Hospital Transformation Plans that are due on December 7, 2015. These plans will describe each hospital's short-term and long-term strategy to support the goals of the All-Payer Model, particularly as they relate to care coordination, care transitions, and alignment.

Ms. Kinzer expressed her thanks to Steve Ports for his tremendous efforts in working with the transformation support process and bringing the RFP to completion.

Ms. Kinzer noted that Staff, CRISP, the St. Paul Group, and Social & Scientific Systems (SSS), HSCRC's Medicare data vendor, have been working together to develop and execute strategies to make analytic information more available for care coordination and monitoring.

- CRISP has been working on patient level reporting, including the production of analytic data with flags of Potentially Avoidable Utilization (PAU). These data should be available in a trial format to providers in October.
- St. Paul will develop preliminary and final quarterly reports of market shift. These reports will be provided to all hospitals. Staff will release a timeline for the process in the near term.
- Staff has been working on utilization trend analysis that combines data from hospitals' case mix data, and includes analytic information added to the case mix data by CRISP, The St. Paul Group, and Staff. Staff will be presenting some of these data to the Commission today.
- Staff and SSS has been working on reconciling the Medicare claims and enrollment data used to support the Medicare savings calculation requirement under the All-Payer Model. Ms. Kinzer noted that the reconciliation process is complete. Staff expect that the Centers for Medicare and Medicaid Innovation (CMMI) will be able to release the results in the near term.

Ms. Kinzer thanked the Staff as well as stakeholders who were involved in advancing analytics efforts to support implementation of the Model. Ms. Kinzer especially thanked Sule Gerovich and David Romans for their efforts in moving this process forward. It is now Staff's intention to focus analytic efforts on the Total Cost of Care, Cost and Utilization Per Capita, episode costs, advancing outcomes, performance and efficiency measures, and improving current models.

Ms. Kinzer noted that Staff is preparing to work with stakeholders on evaluation and development of performance measures. These will include HSCRC's quality programs, risk adjustment approaches for attainment measures for readmissions and other PAUs, and appropriate efficiency and productivity measures for the new All-Payer Model.

HSCRC has awarded a multi-year contract for professional services support for these efforts. The organization process for this work has begun, and Staff is in the process of fleshing out a work plan for this effort.

Ms. Kinzer stated that ICD-10 implementation is due to take place beginning October 1, 2015. Hospitals and payers have been busily preparing for implementation. Staff has interacted with the Maryland Hospital Association (MHA) work groups and has discussed implementation readiness with the Maryland Insurance Administration (MIA). While hospitals and payers have made strides in readiness, there is a concern that physicians are not uniformly well prepared for implementation. Staff will stay in close contact with MHA and MIA during implementation. If Staff becomes aware of situations where claims are not being processed, Staff will take appropriate steps in conjunction with the MIA.

Ms. Kinzer noted that Staff and CRISP have included addenda to their Memorandum of Understanding that detailed the initial 90-day planning process for state level Integrated Care Network (ICN) infrastructure and support. Staff will continue to work with CRISP to help in the development of the products of deliverables, timelines, benchmarks, and dashboards for continued transparency and accountability related to the ICN infrastructure and support, initially budgeted at $6.2 million.

Ms. Kinzer noted that Staff is currently focused on the following activities:

- Completing the rate orders for rate year 2016. Many rate orders have been issued. All hospitals have received files with draft revenue and rate calculations. Several rate orders have not been issued because staff is still waiting on some adjustments that require data from the hospitals.
- Reviewing radiation therapy, infusion and chemotherapy market shift adjustments with stakeholders.
- Continuing the focus on waivers, alignment models, and state level, regional and hospital transformation planning and implementation.
- Reviewing Certificate of Need (CON) and rate applications that have been filed.
- Moving forward on updates to value-based performance measures, including efficiency measures.
- Turning the focus on per capita costs and total cost of care, for purposes of monitoring, and also to progress toward a focus on outcomes and cost across the health care system.
- Staff will release an RFP for support of the Phase 2 development and application process with CMMI, which will focus on transitioning the All-Payer Model to a greater focus on the total cost of care.

INTERIM REPORTS SUMMARY REGIONAL PARTNERSHIPS FOR TRANSFORMATION

Ms. Nancy Kamp and Ms. Deborah Gracey of Health Management Associates summarized the interim report of the regional transformation planning grants (See "Interim Reports Summary Regional Partnerships for Transformation"- on the HSCRC website).

Ms. Kamp and Ms. Gracey discussed the planning process, organization involvement, data, and considerations identified during the regional transformation planning process.

ITEM III
NEW MODEL MONITORING

Mr. David Romans, Director Payment Reform and Innovation, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of July will focus on fiscal year (July 1 through June 30) as well as calendar year results.

Mr. Romans reported that for the one month period ended July 31, 2015, All-Payer total gross revenue increased by 3.40% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 3.71%; this translates to a per capita growth of 3.13%. All-Payer gross revenue for non-Maryland residents increased by 0.31%.

Mr. Romans reported that for the seven months of the calendar year ended July 31, 2015, All-Payer total gross revenue increased by 2.44% over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 2.85%; this translates to a per capita growth of 2.28%. All-Payer gross revenue for non-Maryland residents decreased by 1.70%.

According to Mr. Romans, for the one month of the fiscal year ended July 31, 2015, unaudited average operating profit for acute hospitals was 4.44%. The median hospital profit was 4.94%, with a distribution of 1.39% in the 25th percentile and 7.35% in the 75th percentile. Rate Regulated profits were 8.21%.

According to Mr. Romans, there are no Medicare Fee for Service data for July 2015 as several hospitals had difficulty with reporting the information and will resubmit the information.

MONITORING MARYLAND PERFORMANCE PRELIMINARY UTILIZATION ANALYTICS FY 2013 –FY2015

Dr. Sule Gerovich Ph.D, Deputy Director Research and Methodology, presented the Staff's preliminary report concerning monitoring Maryland performance in regards to utilization analytics (see "Monitoring Maryland Performance Preliminary Utilization Analytics" on the HSCRC website).

Dr. Gerovich reported preliminary utilization analytics for fiscal year 2013 through fiscal year 2015. All-payer equivalent case mix adjusted discharges (ECMADs), a combined inpatient and outpatient utilization measure, declined 0.99 percent from FY 2013 to FY2014 and increased by 0.46 percent from FY2014 to FY2015. Medicare ECMADs remained unchanged from FY 2013 to FY 2014 and increased by 1.73 percent from FY 2014 to FY2015. The reported changes in utilization were not measured on a per capita or per beneficiary basis.

ITEM IV
OVERVIEW OF THE HEALTH EMPLOYMENT PROGRAM PROPOSAL

Mr. Ron Peterson, President of the Johns Hopkins Hospital and Health System and Executive Vice President of Johns Hopkins Medicine, presented the draft proposal of the Health Employment Program (see "Health Jobs Opportunity Program" on the HSCRC website).

According to Mr. Peterson, the All-Payer Model brings unprecedented employment challenges to Maryland hospitals. Maryland hospitals have committed to improving the overall health of the patients they serve beyond the four walls of the hospital. A shift in focus from care delivered within the hospital setting to community based care requires a broader hospital employment base such as community health workers, health care enrollment specialists, and peer support

specialists. Currently, this employment base needs to be fostered and expanded, and there are few resources available to support the long-term development of this workforce.

Recent civil unrest and rioting demonstrated the urgent need to address the issues of social inequality in Baltimore City. According to Mr. Peterson, a contributing factor to social inequality in the city is the lack of stable entry level employment with opportunities for career advancement.

In addition, Baltimore City also faces extreme poverty levels. The most recent U.S. Census Bureau data indicate that that as of 2013, 23.8% of Baltimore City residents live at or below the poverty level, compared to the statewide amount of 9.8%. The median household income for Baltimore City is $41,385 compared to $73,538 statewide. Some zip codes within Baltimore City have a median income as low as $25,500. Nearly 40% of Baltimore City residents are Medicaid eligible, with enrollment topping 242,000.

Mr. Peterson requested on behalf of the panel that the HSCRC establish a Health Employment Program effective January 1, 2016 to provide up to $40 million per year for the purpose of funding a program that will allow for the expansion of up to 1,000 hospital employed positions to be hired from low income, high unemployment areas for the purpose of:

- Improving the overall socioeconomic determinants of health community by providing entry level stable employment with advancement opportunities and
- Expanding the community health workforce to assist hospitals in improving population health.

All hospitals will be eligible to submit application proposals. Hospital specific applications must:

- Demonstrate that additional positions are needed and are incremental;
- Detail a plan to recruit employees from designated high poverty and unemployment zip codes;
- Include proposed competitive wages, benefits, and education and enrichment opportunities;
- Describe existing or planned programs for employees to improve work skills;
- Describe the role new positions will play in meeting goals of the waiver;
- Detail job readiness and skills training necessary to prepare individuals for successful employment;
- Detail employee retention strategies; and
- Other requirements to be developed by HSCRC staff.

The proposal envisions that the funding will be capped at .25% of approved revenue. HSCRC will keep track of amounts funded to assure that no more than $40 million is funded. Awarded funds will be collected by hospitals through permanent rate increases.

ITEM V
DOCKET STATUS CASES CLOSED

2298A- MedStar Heath
2299A- MedStar Health
2301R- Holy Cross Hospital
2302A- University of Maryland Medical Center
2305A- University of Maryland Medical Center

ITEM VI
DOCKET STATUS- OPEN CASES

2306A- University of Maryland Medical Center

The University of Maryland Medical Center (the "Hospital) filed an application on August 28, 2015 requesting approval to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with Aetna Health, Inc. for one year beginning October 1, 2015.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for one year beginning October 1, 2015, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
SUMMARY OF THE CERTIFICATE OF NEED RELATED CAPITAL ADJUSTMENT PROCESS

Mr. Jerry Schmith, Deputy Director of Hospital Rate Setting, reviewed the HSCRC's current partial rate application process for major capital projects (see "Partial Rate Application for Capital" on the HSCRC website).

Mr. Schmith stated that eligible projects require a Certificate of Need (CON) filing and the project cost must be at least 50 percent of a hospital's approved revenue. Mr. Schmith reviewed the HSCRC's Reasonableness of Charges (ROC) and Interhospital Cost Comparison (ICC) methodologies, historically used to measure hospital efficiency. Under the current process, hospitals are eligible to receive a portion of incremental depreciation and interest expenses associated with major projects, subject to this efficiency measure.

Because this methodology was developed prior to implementing the new All-payer Model, Mr. Schmith noted that several issues will need to be addressed in the future. These include: amounts

provided for volume growth, other avenues for project financing, and efficiency of prices in the context of quality, per capita, and potentially avoidable utilization measures.

ITEM VIII
DRAFT RECOMMENDATIONS ON REVISIONS TO THE QUALITY BASED REIMBURSEMENT PROGRAM FOR RATE YEAR 2018

Ms. Dianne Feeney, Associate Director Quality Initiative, presented Staff's draft recommendation on updating the Quality Based Reimbursement (QBR) Program for FY2018 (See "Draft Recommendation for Updating the Quality Based Reimbursement Program for FY 2018" on the HSCRC website).

HSCRC quality based measurement initiatives, including the scaling methodologies and magnitudes of revenue "at risk" for those programs, are important tools for providing strong incentives for hospitals to improve their quality performance over time. HSCRC implemented the first hospital adjustments for the QBR Program performance in July 2009. Current Commission policy calls for measurement of hospital performance scores across clinical processes of care, outcome and patient experience of care domains, and scaling of hospital performance results in allocating rewards and penalties based on performance.

"Scaling" for QBR refers to the differential allocation of a pre-determined portion of base regulated hospital inpatient revenue based on assessment of the quality of hospital performance. The rewards (positive scale amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year; these scaled amounts are applied on a "one-time" basis and are not considered permanent revenue.

For FY 2018, HSCRC staff draft recommendations include adjusting the weights and updating the measurement domains to be consistent as possible with the Centers for Medicare and Medicaid Services (CMS) Value Based Purchasing Program. They also include holding steady the amount of total hospital revenue at risk for scaling for the QBR Program

The proposed draft recommendations for the QBR Program are as follows:

- Continue to allocate 2 percent of hospital approved inpatient revenue for QBR performance in FY 2018 to be finalized by the Aggregate Revenue "at risk" recommendation.
- Adjust measurement domain weights to include: 50 percent for Patient Experience Care Transition, 35 percent for Safety, and 15 percent for Clinical Care.

No Commission action is necessary as this is a draft recommendation.

ITEM IX
MARKET SHIFT UPDATE

Dr. Gerovich presented an update to the Commission concerning the Market Shift adjustment (see "Market Sift Adjustment Update" on the HSCRC website).

ITEM X
REPORT OF THE CONSUMER ENGAGEMENT GROUP

Ms. Leni Preston, Maryland Women's Coalition for Health Care Reform and Ms. Hillery Tsumba, Primary Care Coalition of Montgomery County, presented a final update to the Commission on the activities of the HSCRC Consumer Engagement Taskforce (CETF) (See "Consumer Engagement Taskforce: Final Report" on the HSCRC website).

Ms. Tsumba outlined the goals of the CETF. They are as follows:

- Establish a consumer centered health care delivery system with an ongoing role for consumers to participate in the design and implementation of policies and procedures at all levels.
- Engage, educate, and activate people who use or who are potential users of health services for their own health care to promote efficient and effective use of the health care system.

Ms. Tsumba also reviewed the communications strategy of the CETF and the development of materials for implementation from a consumer centered approach.

CETF Recommendations are as follows:

- Allow for meaningful, ongoing role for consumers at the HSCRC through continued representation of Commissioner(s) with primary consumer interest, and through a new created standing advisory committee with diverse representation.
- In collaboration with key stakeholders, develop a statewide public education campaign specific to the new All-Payer Model which is part of a broader campaign to promote health and wellness.
- Convene an interagency task force, with consumer representation to oversee the public education campaign including the development of related consumer-oriented information.
- Provide options and opportunities that support regular, longitudinal, and effective consumer engagement in the development of policies, procedures, and programs by hospitals, health care providers, health care payers, and government.
- In coordination with the Standing Advisory Committee, the MHCC and other key stakeholders, consider development of a Consumer Gold Star system for hospitals based upon consumer engagement standards.
- Define Community Benefit dollars to include consumer engagement initiatives and promote these dollars for this use, particularly for those supporting vulnerable

populations.

- Continue to encourage and incentivize independent and collaborative approaches to support people who are at risk of becoming high utilizers.
- Encourage hospitals to provide current, consistent, and transparent information on average procedure costs using the data made readily available by the Maryland Health Care Commission (www.marylandqmdc.org), and to make new pricing transparency tools available on new All-Payer Model and/or other appropriate website(s).
- Include discussions about patient and family decision making and preferences about advanced directives in the context of consumer engagement and education.

ITEM XI
REPORT OF THE CONSUMER OUTREACH TASK FORCE

Mr. Vincent DeMarco, Chairman Consumer Outreach and Education Task Force, presented a final update on the Consumer Outreach and Education Task Force (See "Update from Consumer Outreach and Education Task Force" on the HCRC website).

As the leader of the HSCRC Consumer Outreach Task Force (COTF), over the past seven months, the Maryland Citizens' Health Initiative Education Fund, Inc. has collaborated with the Local Health Improvement Coalitions, health departments, hospitals, local community, faith leadership and the Maryland Hospital Association to hold eleven public forums all across the State on the subject of health system transformation.

Over 800 Marylanders representing over 300 community, health, faith, business, government, union, and policy organizations have heard the message that local hospitals, healthcare providers, and community based organizations are working together to help Marylanders be as healthy as possible. Feedback shows that Marylanders are unaware of the state's unique and long standing status as an all-payer state or the new state/federal agreement that is further transforming the health system in Maryland. Once informed, however, consumers are eager to be engaged. They want a clear call to action and follow up steps for ongoing collaboration.

COTF recommendations to the Commission for continued outreach to consumers are as follows:

- Periodically convene stakeholders and consumers to provide updates on the progress of health system transformation.
- Continue to give consumers a voice in the transformation of Maryland's health system.
- Encourage local leaders to develop and join a dynamic Faith Community Health Network
- Collaborate to educate primary care providers on and engage them in health system transformation.
- Maximize communications with consumers via traditional and new media.

ITEM XII
SUMMARY OF FY 2014 COMMUNITY BENEFITS REPORT

Steve Ports, Principal Deputy Director-Policy and Operations, provided background and

summarized the FY 2014 Maryland Hospital Community Benefits Report (CBR) (see "Maryland Hospital Community Benefits Report FY 2014" on the HSCRC's website).

Each year, the HSCRC collects community benefit information from individual hospitals to compile into a publicly available statewide (CBR). Current year and previous CBRs submitted by hospitals are available on the HSCRC website.

According to Mr. Ports, the FY CBR indicated that hospitals: 1) reported a total of $1.5 billion in community benefits for FY 2014 (FY 2013 amount was also approximately $1.5 billion); 2) provided an average of 10.47% of total operating expenses in community benefits (compared to 11.12% in FY 2012); 3) provided net charity care of $19.9 million; and 4) provided net community care of $724.7 million or 5.14% of hospitals' net operating expenses (up from $712.4 million and 5.2% of hospitals' net operating expenses in FY 2013).

ITEM XIII
HEARING AND MEETING SCHEDULE

October 14, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
November 18, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 4:11 pm.

Executive Director's Report

Health Services Cost Review Commission

October 14, 2015

Health Job Opportunity Program Proposal

At the Commission's September 9, 2015 public meeting, Ronald R. Peterson, President of the Johns Hopkins Hospital and Health System, on behalf of a panel of several hospital representatives and the Maryland Hospital Association, proposed that the HSCRC provide up to $40 million through hospital rates to establish about 1,000 entry level health care jobs in areas of extreme poverty and unemployment. This proposal came about as a result of the unrest in Baltimore City and the belief that employment is an important element needed to change the current situation. Hospitals are among the largest employers in Baltimore City as well as in other areas of the State that have pockets of extreme poverty and unemployment. The Health Job Opportunity Program Proposal (the Proposal) seeks to create community-based jobs that can contribute to improved community health as well as hospital jobs that create employment opportunities in economically challenged areas.

The Payment Models Workgroup held a meeting to discuss this and other topics on October 5, 2015. Program description materials and a series of questions were sent out in advance of the meeting and posted to the website. Comments were also accepted from other individuals attending the meeting.

The work group members and other commenters expressed their appreciation for the leadership in bringing forward this proposal. There were many letters of support as well. (The Proposal and comment letters received to date are attached to this report.)

Following is a general summary of comments:

- Several commenters expressed the view that if the Commission were to take on a program of this nature, it would be very important to define success. Success would need to be framed not only in creating jobs, but also in the context of the New All Payer Model and Triple Aim of improving care, improving health, and lowering costs.
    - A program that could not meet those requirements might be better implemented outside of the rate system.

    - Proposers of the Program indicated that evaluative criteria should be developed and that if the Program was not meeting those criteria, that it should be discontinued.
    - Because the jobs are entry level and for untrained workers, there was an indication that it might take some time to evaluate the impact on health and costs. Whether the jobs could be filled and the workers maintained could be determined much sooner.
- Several commenters felt that it would be important to focus on jobs outside of hospitals, such as Community Health Workers. The concern was expressed that the reduction of avoidable utilization in hospitals might reduce the need for some of the hospital jobs that were referred to in the Proposal.
    - One of the Academic Medical Centers felt that its utilization would not decrease with potentially avoidable utilization, but would encounter a backfill as out of state volumes increased or other referrals could be served.
    - One commenter expressed concern about the need for training of Community Health Workers, making sure they were prepared to be in the community working with frail and severely ill patients. (Note that there was a work group that recently produced a set of recommendations regarding Community Health Workers.) More design and structure would need to be in place.
- Several commenters felt that infrastructure adjustments already provided to hospitals, or the additional amount that is slated for award in January 2016, were already focused on similar activities, and that this effort would be duplicative.
    - Proposers responded that the infrastructure funds were already committed in their budgets for other purposes, and that a new source of funding is needed for rapid deployment of additional jobs.
    - Commenters indicated that a Return on Investment should be expected, similar to the recent infrastructure increases approved by the Commission.
- It was also suggested that other funding sources be considered for Program implementation.
    - The proposers indicated that this might slow the process down, or detract from the level of possible implementation and impact.
- Several commenters indicated that if the Proposal were to move forward, much more detailed design work needs to take place.
    - One suggestion was to ask the hospitals to organize an effort with other stakeholders and experts to further develop potential design criteria
    - Another commenter indicated that the Commission staff might take this on and organize a work group to develop the program

- One commenter expressed concerns about accountability to payers, including the need for a return on investment

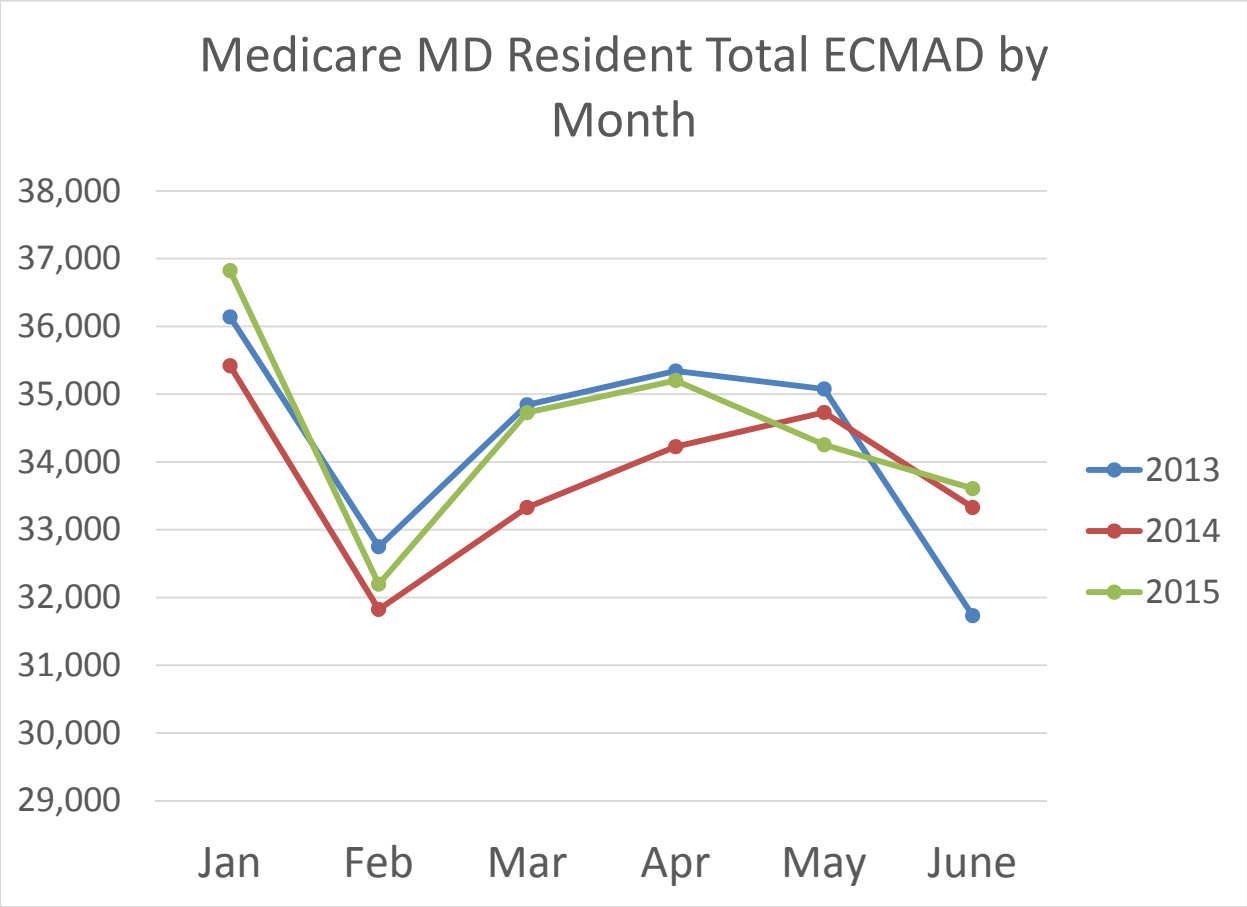
Staff is currently considering all oral and written comments received to date and will report back to the Commission at the November meeting.

Medicare Volume Increases

The HSCRC staff has been paying attention to Medicare growth in charges and utilization. There has been an uptick in Medicare volumes, and this is likely to affect Medicare savings. The Commission will need to monitor the situation closely and consider whether any special actions or changes in policies are warranted. From fiscal year 2013 to 2014, there were increases in orthopedic surgery and oncology service lines for Medicare patients, but these increases were more than offset by decreases in avoidable utilization such as readmissions and PQI admissions, with a net reduction in Equivalent Case Mix Adjusted Discharges (ECMADs). (ECMADs account for both inpatient and outpatient volumes of services using an assigned weight for each case). From FY 2014 to FY 2015, there were larger increases in orthopedic surgery and oncology for Medicare patients, and there was a modest reduction in readmissions. However, there was an increase in PQI admissions as well as other medical admissions. The result was an increase of 2.09% in ECMADs for FY 2015. The rate adjustments provided by the Commission on July 1, 2014 and July 1, 2015 are based on the assumption that Medicare per capita growth will be lower than the All Payer growth by about 2%. However, the uptick in Medicare volumes has narrowed the differential. The calendar year per capita growth per resident in All Payer revenue through August 2016 versus the same period in 2015 was 2.5%. The Medicare growth for the same period was 1.71%, with the gap at .79% rather than the projected 2%. The chart below shows the monthly trend in utilization for January through June of each of the preceding three calendar years. (This chart is not adjusted for the growth in Medicare beneficiaries, which is approximately 3% per year.) 2015 ECMADs were higher than 2014 in all but one month and were higher than the 2013 figures in 2 months.

The success of the model is dependent on reducing avoidable utilization. Hospitals will need to accelerate their efforts to reduce avoidable utilization in order to achieve the volume levels that support the savings requirements for Medicare. HSCRC staff notes that a number of planning efforts are underway, and some hospitals have implemented significant interventions. However, there is significant work to scale the efforts necessary to reduce avoidable utilization, including working more closely with primary care physicians to coordinate care and address chronic conditions more effectively, implementing comprehensive care coordination for high needs and complex patients, and working with post-acute and long term care facilities to reduce avoidable hospitalizations.

HSCRC staff is evaluating our ECMAD data closely together with preliminary national data we receive from CMMI. At the same time Medicare hospital utilization increased, we are also noting an increase in payments to SNF providers. HSCRC staff will investigate these two trends and consider the implications.



Value Based Purchasing Exemption

CMS has granted Maryland an exemption from the national Medicare Value Based Purchasing Program for FY 2016. CMS notes that Maryland significantly lags national performance in patient experience of care in the Hospital Consumer Assessment of Healthcare Providers and Systems surveys. As a result of this lagging performance, HSCRC has assigned a higher proportion of the weighting to this domain and increased the amount of revenue at risk for this program.

Staff Focus

HSCRC staff is currently focused on the following activities:

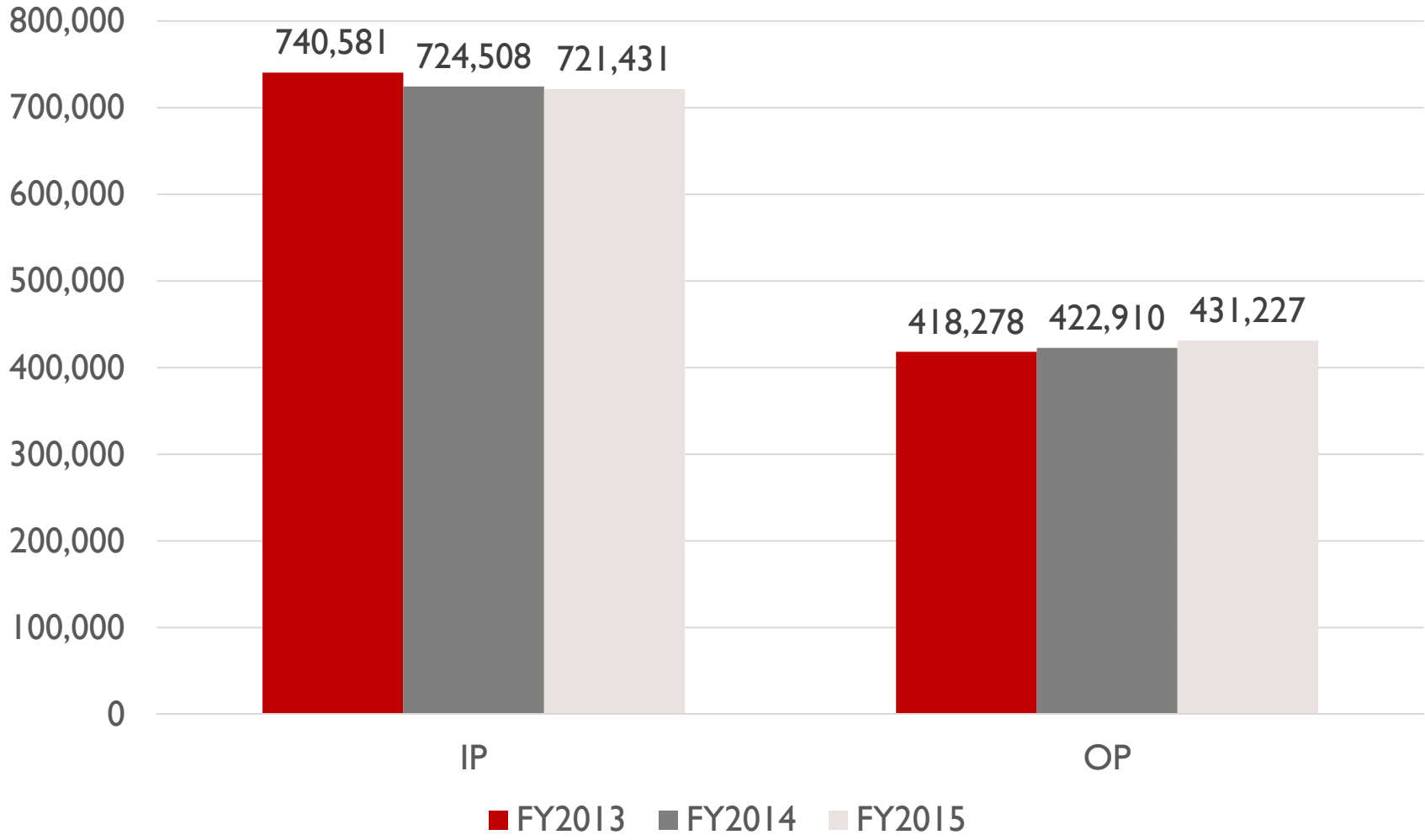
- Issuing amended rate orders that adjust for final reconciliation of GBR/TPR and rate compliance and QBR performance.
- Reviewing radiation therapy, infusion and chemotherapy market shift adjustments with stakeholders. It appears that we are reaching resolution for the 2016 adjustment, although the stakeholders and HSCRC will focus on refinements for rate year 2017.
- Reviewing Certificate of Need (CON) applications that have been filed.
- Moving forward on updates to value-based performance measures, including efficiency measures.
- Turning to focus on per capita costs and total cost of care, for purposes of monitoring and also to progress toward a focus on outcomes and cost across the health care system.
- Preparing to finalize and implement a stakeholder process that will be executed together with DHMH and other agencies, focused on developing a vision for Phase 2 of the All Payer Model and developing interim approaches that will provide progression toward Phase 2. Medicaid is evaluating formation of an ACO-like model for dual eligible enrollees (beneficiaries with both Medicare and Medicaid coverage). This process will be combined with the stakeholder process for progressing of the All Payer Model.
- Staff is evaluating proposals received for support of the Phase 2 application development and application process with CMMI, together with other state agencies.

Monitoring Maryland Performance
Preliminary Utilization Analytics

FY2013-FY2015

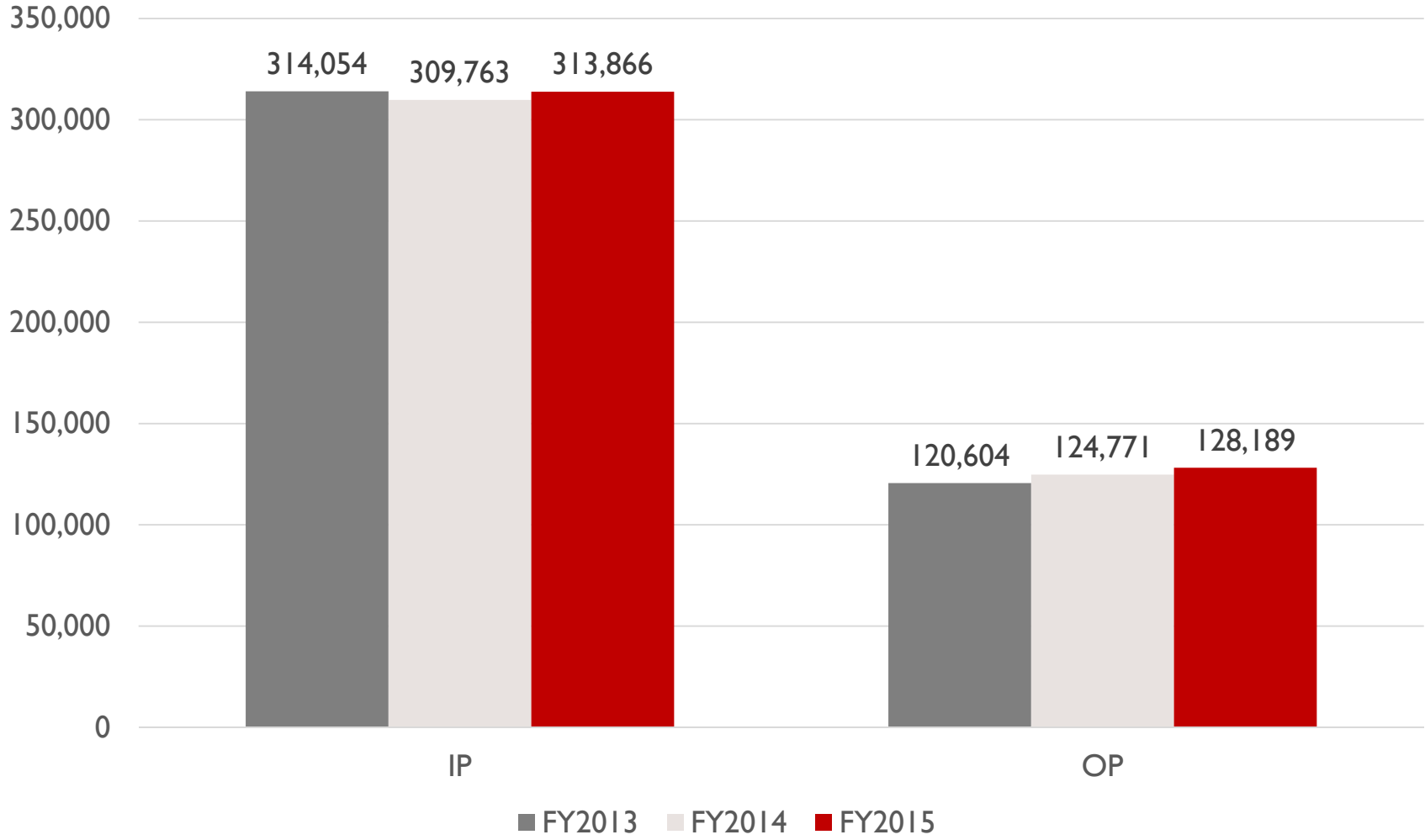
HSCRC
Health Services Cost
Review Commission

All-Payer Inpatient(IP) and Outpatient (OP) ECMAD Trend



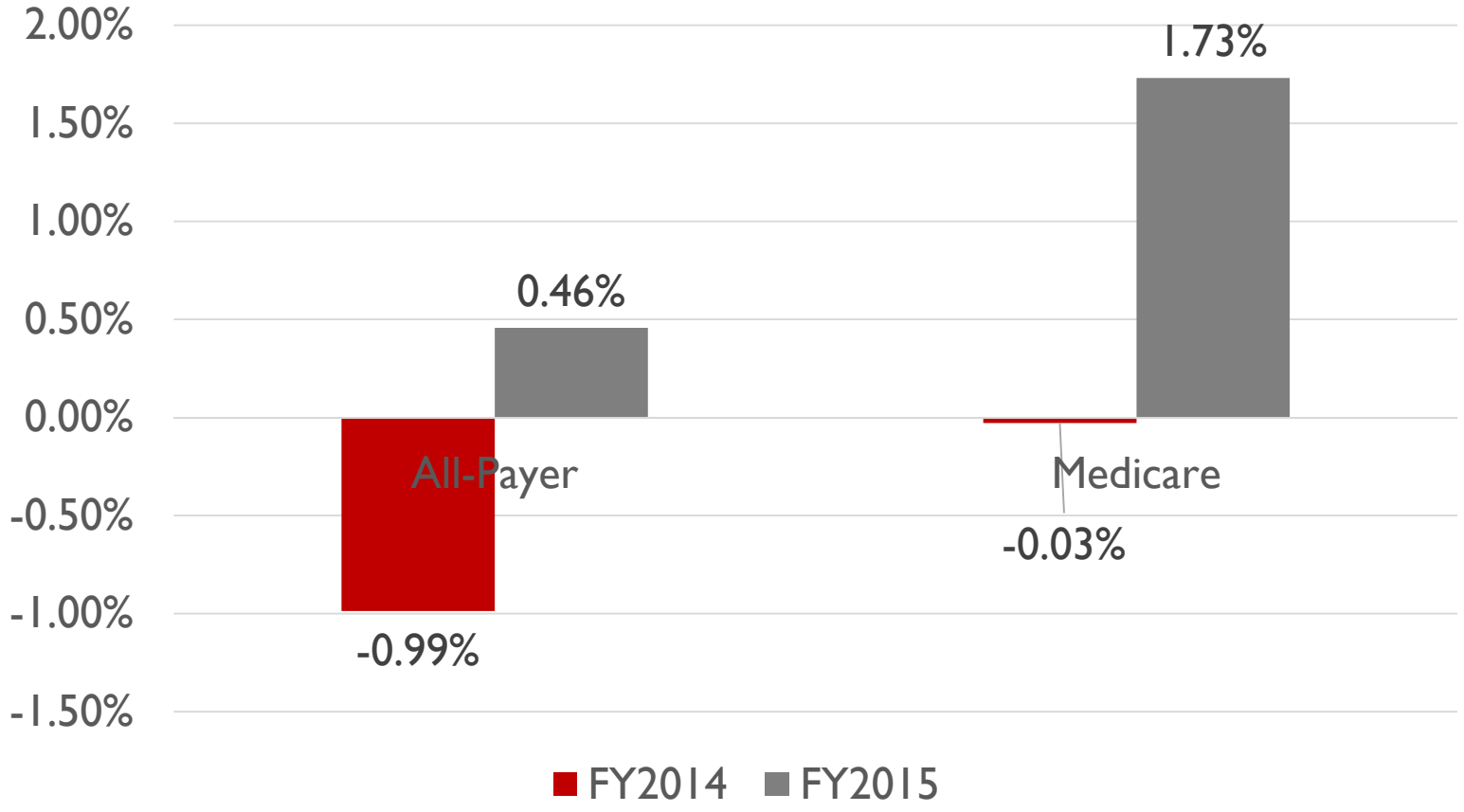
HSCRC
Health Services Cost Review Commission

Medicare All-Payer Inpatient(IP) and Outpatient (OP) ECMAD Trend



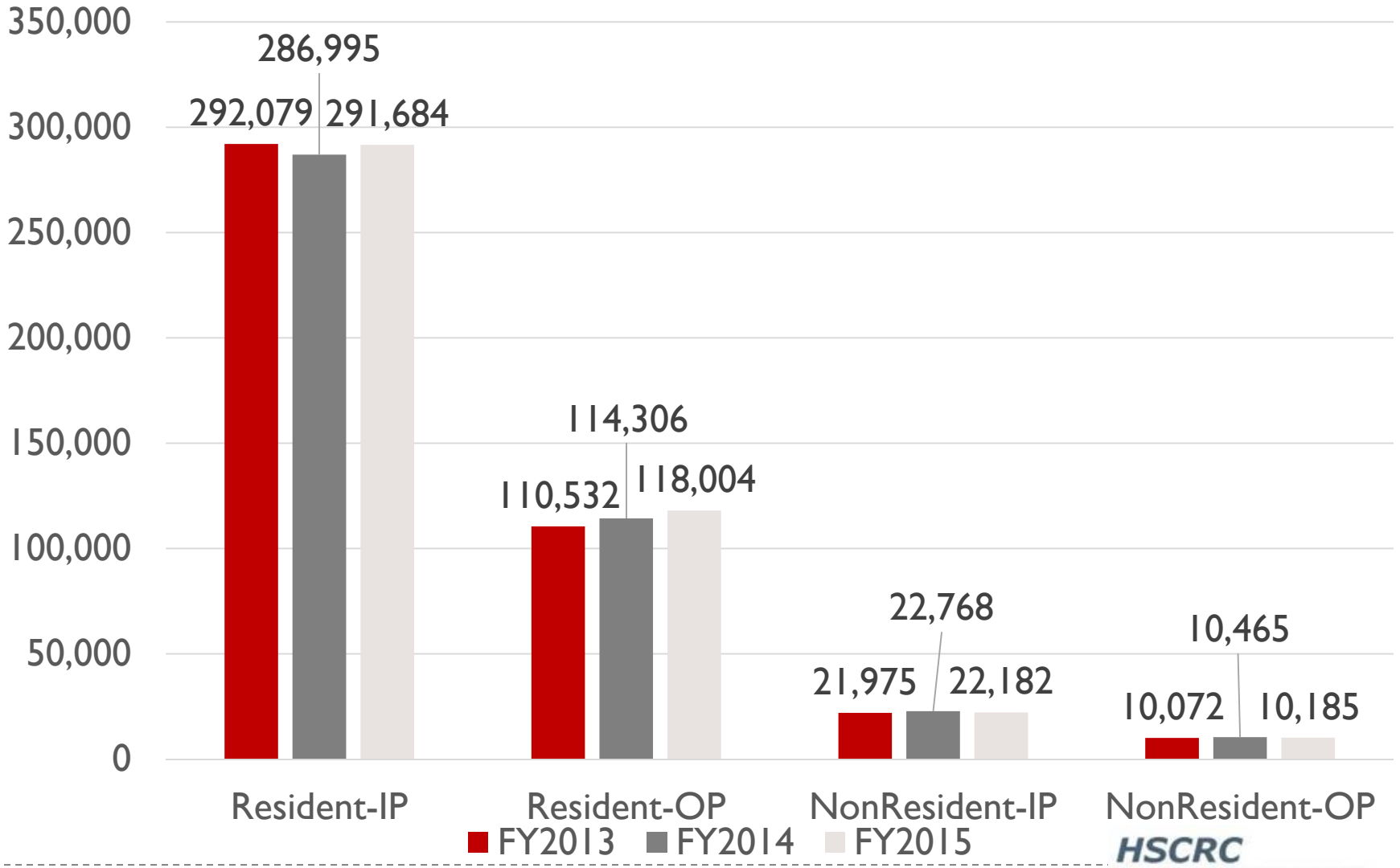
HSCRC
Health Services Cost Review Commission

Annual Percent Growth Rate-Total ECMAD



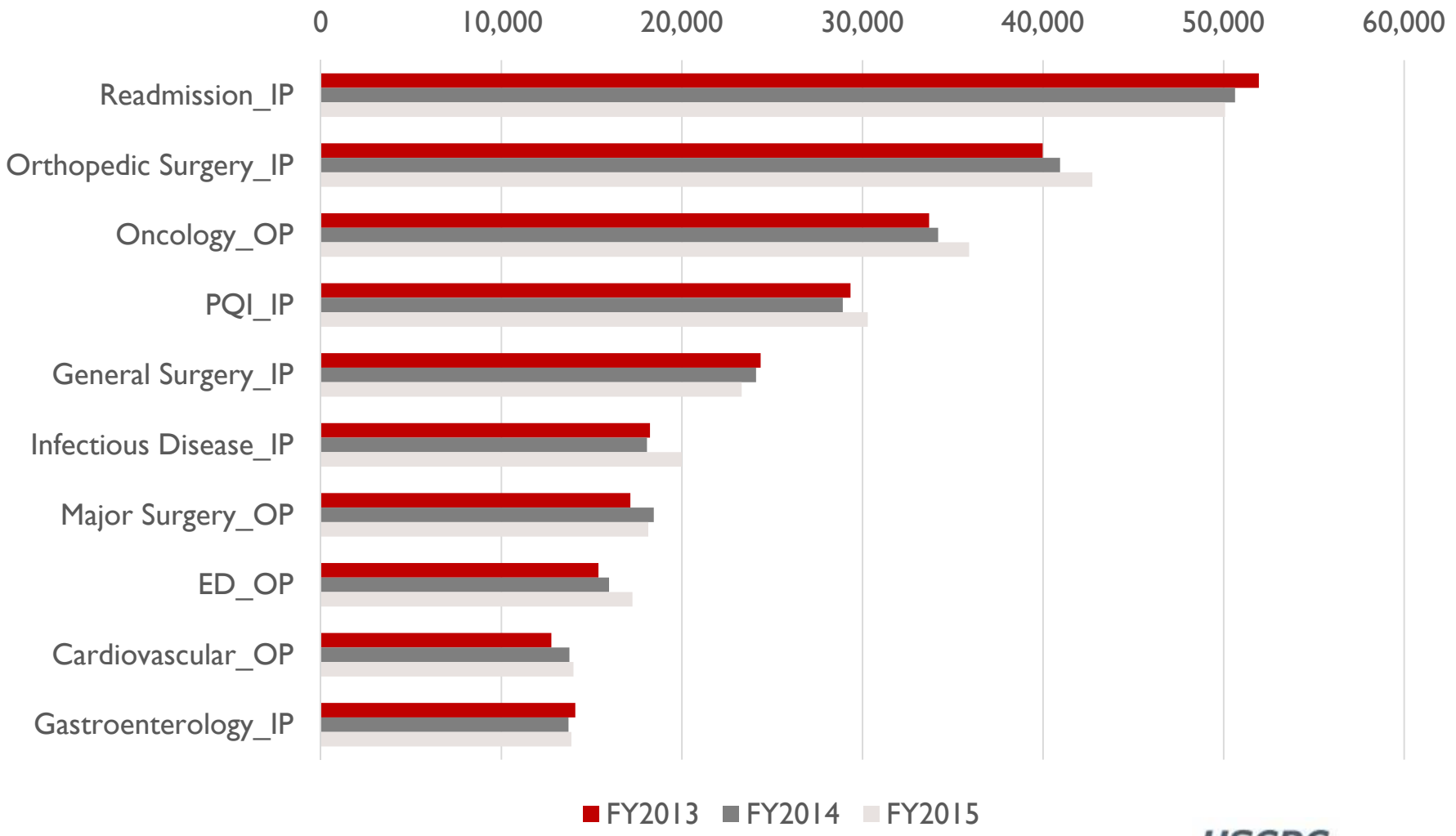
HSCRC
Health Services Cost Review Commission

Medicare ECMAD Trends by Resident Status



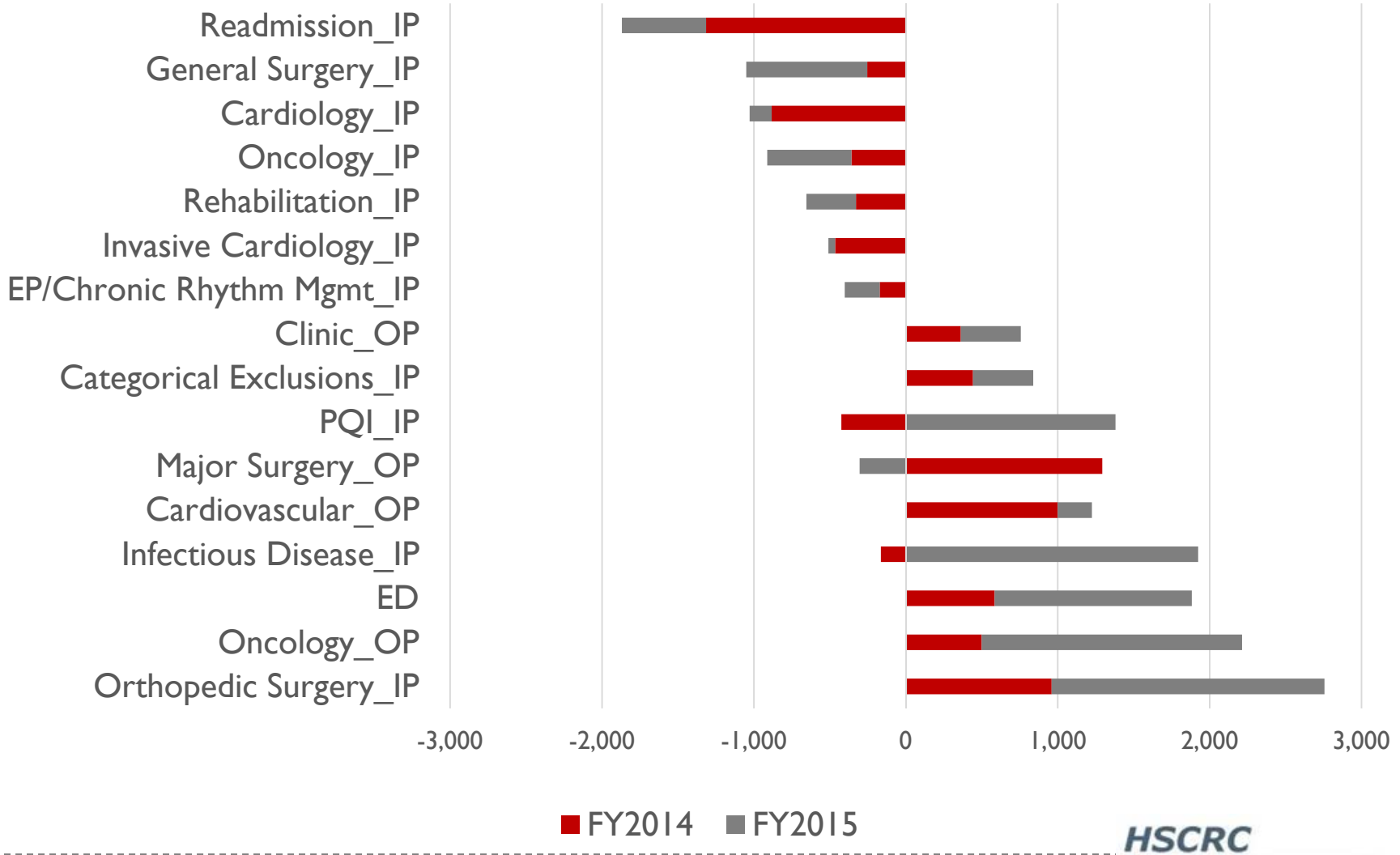
HSCRC
Health Services Cost Review Commission

Medicare MD Resident Largest 10 Service Line Trends

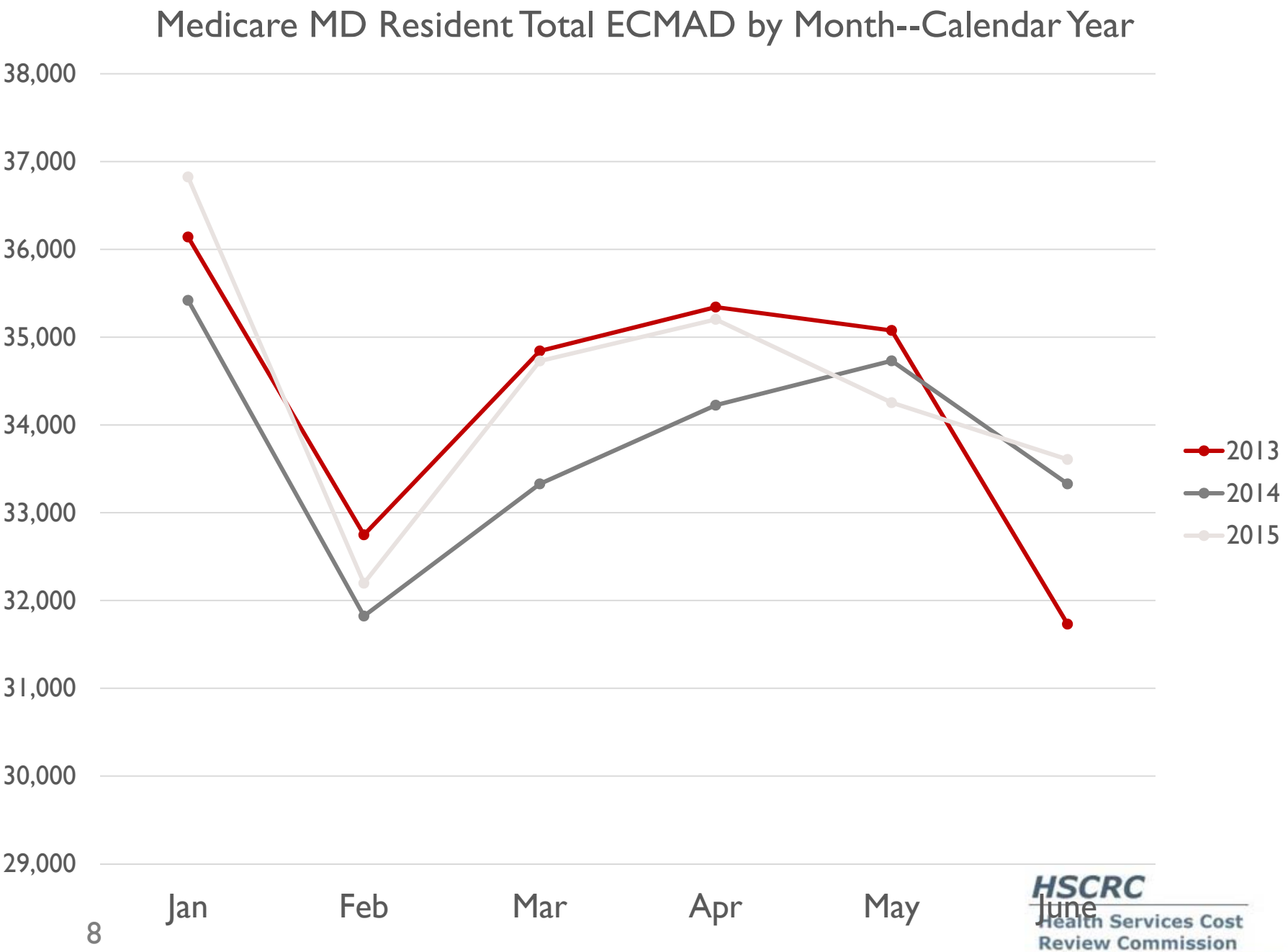


HSCRC
Health Services Cost Review Commission

Medicare MD Resident Service Lines with Largest Net Changes FY15 vs FY13



HSCRC
Health Services Cost Review Commission



HSCRC
Health Services Cost Review Commission

Utilization Analytics

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

Service Line Definitions

- Inpatient service lines:
  - APR DRG to service line mapping
  - Readmissions and PQIs are top level service lines (include different service lines)
- Outpatient service lines:
  - Highest EAPG to service line mapping
  - Hierarchical classifications (ED, major surgery etc)
- Market Shift technical documentation

BARBARA A. MIKULSKI
MARYLAND

COMMITTEES:

APPROPRIATIONS

HEALTH, EDUCATION, LABOR, AND PENSIONS

United States Senate

WASHINGTON, DC 20510–2003

IN REPLY PLEASE REFER TO OFFICE INDICATED:

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BALTIMORE, MD 21231
(410) 962–4510
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ANNAPOLIS, MD 21401–2448
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BALTIMORE: (410) 269–1650

☐ 6404 IVY LANE, SUITE 406
GREENBELT, MD 20770–1407
(301) 345–5517

☐ 32 WEST WASHINGTON STREET
ROOM 203
HAGERSTOWN, MD 21740–4804
(301) 797–2826

☐ THE PLAZA GALLERY BUILDING
212 MAIN STREET, SUITE 200
SALISBURY, MD 21801–2403
(410) 546–7711

September 1, 2015

Mr. John M. Colmers
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215-2254

Dear Mr. Colmers:

Your office will soon be receiving a proposal from Maryland's hospitals to create a hospital-led employment program that hires from communities with high rates of poverty and unemployment. I am writing to express my strong support for the proposal and to urge you to give it every favorable consideration.

As outlined in the proposal, poverty is a contributing factor to poor health. A hospital employment program that targets impoverished communities not only improves the economic stability of the communities, this effort will also have a positive impact on the overall health of these communities. Because Maryland's All-Payer Model Agreement shifts hospital care towards a population health approach we believe this program is consistent with the Model Agreement.

I strongly support this collaborative and innovative approach toward population based health. Thank you for your consideration.

Sincerely,

Barbara A. Mikulski

Barbara A. Mikulski
United States Senator

BAM:wbk

ELIJAH E. CUMMINGS
7TH DISTRICT, MARYLAND

RANKING MEMBER, COMMITTEE ON
OVERSIGHT AND GOVERNMENT REFORM

RANKING MEMBER,
SELECT COMMITTEE ON BENGHAZI

COMMITTEE ON
TRANSPORTATION AND INFRASTRUCTURE
SUBCOMMITTEE ON COAST
GUARD AND MARITIME TRANSPORTATION
SUBCOMMITTEE ON
RAILROADS, PIPELINES, AND HAZARDOUS
MATERIALS

JOINT ECONOMIC COMMITTEE

Congress of the United States
House of Representatives
Washington, DC 20515

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FAX: (202) 225–3178

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FAX: (410) 455–0110

☐ 8267 MAIN STREET
ROOM 102
ELLICOTT CITY, MD 21043–9903
(410) 465–8259
FAX: (410) 465–8740

www.house.gov/cummings

August 27, 2015

John M. Colmers
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Chairman Colmers:

I am writing to express support for the proposal from Maryland's hospitals to create a hospital-led employment program that hires from communities with high rates of poverty and unemployment.

As outlined in the proposal, poverty is a contributing factor to poor health. A hospital employment program that targets impoverished communities would not only improve economic stability, it would also have a positive impact on community health. Because Maryland's All-Payer Model Agreement shifts hospital care toward a population health approach, I believe this program is consistent with the Model Agreement.

I hope that you will give this proposal every reasonable consideration.

Sincerely,

Elijah E. Cummings
Member of Congress

DONNA F. EDWARDS
4TH DISTRICT, MARYLAND

HOUSE COMMITTEE ON
SCIENCE, SPACE, AND TECHNOLOGY
SUBCOMMITTEE ON THE ENVIRONMENT
SUBCOMMITTEE ON SPACE, RANKING MEMBER

HOUSE COMMITTEE ON
TRANSPORTATION AND INFRASTRUCTURE
SUBCOMMITTEE ON ECONOMIC DEVELOPMENT,
PUBLIC BUILDINGS, AND EMERGENCY MANAGEMENT
SUBCOMMITTEE ON HIGHWAYS AND TRANSIT
SUBCOMMITTEE ON WATER RESOURCES
AND ENVIRONMENT

Congress of the United States
House of Representatives
Washington, DC 20515–2004

September 2, 2015

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

Dear Chairman Colmers:

I am writing to express support for the proposal from Maryland's hospitals to create a hospital-led employment program that hires from communities with high rates of poverty and unemployment. Maryland may be one of the wealthiest states in the nation, but we continue to experience health disparities associated with low income. Further, empirical evidence has shown that the inability to obtain employment with growth opportunities consistently contributes to the cycle of poverty.

A hospital employment program that targets impoverished communities not only improves the economic stability of those communities, but also will have a positive impact on the overall physical health of these communities.

As you know, hospitals are some of the largest employers in many of Maryland's diverse communities, and I support a program that will hire thousands of Marylanders from low-income, high-unemployment zip codes. Because Maryland's All-Payer Model Agreement shifts hospital care towards a population health approach, I believe this program is consistent with the Model Agreement.

I strongly support this collaborative and innovative approach toward population based health care.

Sincerely,

Donna F. Edwards
Member of Congress

5001 SILVER HILL ROAD
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SUITLAND, MARYLAND 20746
TELEPHONE: (301) 516–7601
FAX: (301) 516–7608

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RITCHIE COURT OFFICE BUILDING
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SEVERNA PARK, MD 21146
TELEPHONE: (410) 421–8061
FAX: (410) 421–8065

DONNA F. EDWARDS
4TH DISTRICT, MARYLAND

HOUSE COMMITTEE ON
SCIENCE, SPACE, AND TECHNOLOGY
SUBCOMMITTEE ON THE ENVIRONMENT
SUBCOMMITTEE ON SPACE, RANKING MEMBER

HOUSE COMMITTEE ON
TRANSPORTATION AND INFRASTRUCTURE
SUBCOMMITTEE ON ECONOMIC DEVELOPMENT,
PUBLIC BUILDINGS, AND EMERGENCY MANAGEMENT
SUBCOMMITTEE ON HIGHWAYS AND TRANSIT
SUBCOMMITTEE ON WATER RESOURCES
AND ENVIRONMENT

Congress of the United States
House of Representatives
Washington, DC 20515–2004

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

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FAX: (202) 225–8714

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FAX: (410) 421–8065

http://donnaedwards.house.gov

C.A. DUTCH RUPPERSBERGER
2ND DISTRICT, MARYLAND

REPLY TO:

☐ 2416 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-3061
FAX: (202) 225-3094

☐ 375 WEST PADONIA ROAD, SUITE 200
TIMONIUM, MD 21093
(410) 628-2701
FAX: (410) 628-2708

www.dutch.house.gov

PERMANENT SELECT COMMITTEE
ON INTELLIGENCE
RANKING MEMBER

Congress of the United States
House of Representatives
Washington, DC 20515–2002

August 31, 2015

Mr. John Colmers
Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Colmers:

I am writing to express my support for Johns Hopkins' proposal to create a hospital-led employment program that hires from communities with high rates of poverty and unemployment. This program was modeled on Maryland's Nursing Support Program, which alleviated a severe nursing shortage and saved the state over $100 million by reducing hospitals' dependence on contract nurses. Johns Hopkins' current proposal aims to create 1,000 jobs with a budget of less than $40 million per year using a portion of the "cushion" from Maryland's All-Payer Model Agreement.

The correlation between poverty and poor health is widely recognized. As some of the state's largest employers and community anchors, hospitals are uniquely positioned to address both of these issues. A hospital employment program that targets impoverished communities will improve not only the economic stability but also the overall health of these communities. As hospitals shift their focus to providing holistic, community-based care, this employment program will address the underlying causes of poverty and provide resources to expand the community health workforce.

I strongly support this collaborative and innovative approach toward population-based health care and I hope you will give this proposal serious consideration. Thank you very much for your attention to this matter.

Sincerely,

C.A. Dutch Ruppersberger

C.A. Dutch Ruppersberger
Member of Congress

CADR:ng

JOHN P. SARBANES
3RD DISTRICT, MARYLAND

COMMITTEE ON
ENERGY AND COMMERCE

2444 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-4016
FAX: (202) 225-9219

Congress of the United States
House of Representatives
Washington, DC 20515–2003

www.sarbanes.house.gov

September 1, 2015

Mr. John Colmers
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215-2254

Dear Mr. Colmers:

I am writing to express my strong support for the proposal submitted to the Health Services Cost Review Commission (HSCRC) by Maryland's hospitals. The proposal will create a health employment program which will utilize funds to hire healthcare professionals from communities with high rates of poverty and unemployment within Baltimore City.

Tens of thousands of manufacturing jobs in the Baltimore metropolitan area have been lost over the last 40 years. This loss has resulted in a critical need of new entry level employment with opportunities for career advancement. This employment program will allow for the expansion of up to 1,000 hospital employed positions to be hired from low income, high unemployment areas. A hospital employment program that targets impoverished communities will improve the economic stability of the entire city.

The proposed employment program is consistent with the Maryland All-Payer Model Agreement that shifts hospital care towards a population health approach. Hospitals in Maryland are uniquely positioned to help in this process. While the program is intended to address the immediate issues facing Baltimore City, this endeavor will create a model that can be applied to any community in need of employment opportunities.

I ask that you give all appropriate consideration to the health employment program proposal to HSCRC.

Sincerely,

John P. Sarbanes
Member of Congress

JPS/jl

600 BALTIMORE AVENUE
SUITE 303
TOWSON, MD 21204
(410) 832-8890
FAX: (410) 832-8898

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FAX: (410) 295-1682

3901 NATIONAL DRIVE
SUITE 220
BURTONSVILLE, MD 20866
(301) 421-4078
FAX: (301) 421-4079

CHRIS VAN HOLLEN
8TH DISTRICT, MARYLAND

COMMITTEE ON THE BUDGET

Congress of the United States
House of Representatives
Washington, DC 20515

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WASHINGTON, DC 20515
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ROCKVILLE, MD 20850
(301) 424-3501

205 CENTER STREET
SUITE 206
MOUNT AIRY, MD 21771
(301) 829-2181

www.vanhollen.house.gov

August 26, 2015

Mr. John M. Colmers
Chairman
Maryland Health Services Cost Review Commission
4160 Patterson Ave.
Baltimore, MD 21215

Dear Chairman Colmers:

I am writing to express my strong support for the efforts of Johns Hopkins University Hospital and other Maryland hospitals to create a hospital-led employment program that hires residents of communities with high rates of poverty and unemployment.

Funding for this proposal will enable this collaborative hospital employment program to develop career pathways to jobs in the high growth healthcare industry for un- and under-employed Maryland residents of communities experiencing high rates of poverty. Hospitals provide a variety of entry-level positions that offer competitive salaries and benefits. Not only will this employment program improve the economic stability of the communities, but it will also have a positive impact on the overall health of these communities.

The proposed program is a collaborative and innovative approach toward population-based health care. I urge you to give it your most serious consideration.

Sincerely,

Chris Van Hollen
Member of Congress

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

THOMAS V. MIKE MILLER, JR.
PRESIDENT OF THE SENATE

MICHAEL E. BUSCH
SPEAKER OF THE HOUSE

THE MARYLAND GENERAL ASSEMBLY
STATE HOUSE
ANNAPOLIS, MARYLAND 21401-1991

September 9, 2015

John M. Colmers
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Colmers:

As the presiding officers of the Maryland General Assembly, we offer our full support of the Hospital Employment Program.

The success of Maryland's unique hospital rate setting system is not only a source of pride for the State, it is also a platform for innovations that improve the health of Maryland's residents. We believe the Hospital Employment program represents a broad based collaboration that addresses the social and economic conditions that contribute to poor health. Creating an employment path for Maryland's most economically disadvantaged communities will not only bring stability and improved health to those communities but it will also improve the overall quality of living for all Marylanders.

We applaud all those involved in this innovative approach to population health. Thank you for your time and consideration.

Sincerely,

Thomas V. Mike Miller, Jr.
Senate President

Michael E. Busch
Speaker of the House

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

PETER A. HAMMEN
46th Legislative District
Baltimore City

Chair
Health and Government
Operations Committee

Annapolis Office
The Maryland House of Delegates
6 Bladen Street, Room 241
Annapolis, Maryland 21401
410-841-3770
800-492-7122 *Ext.* 3770

District Office
821 S. Grundy Street
Baltimore, Maryland 21224
410-342-3142

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

September 9, 2015

John M. Colmers
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Colmers:

I am writing to express my strong support of the Hospital Employment Program. As Chairman of the House Health and Government Operations Committee, I work with committee members to shape health policy for our state. As we work to meet the goals of Maryland's All-Payer Model Agreement, we must look to new sources of partnership and innovation. The Hospital Employment Program aligns with the new All-Payer Model Agreement's focus on population health by creating community-based jobs targeting overall population health. This program utilizes our unique waiver system to improve economic and health outcomes for the pockets of Maryland that need stability most. As a representative of Baltimore City I welcome the opportunity to support a program poised to provide significant support to City residents. Additionally, this targeted employment program, focused on the State's most disadvantaged communities, has the potential to produce savings from improved overall community health.

The Maryland All-Payer Model Agreement provides Maryland with the unique opportunity for innovation. The Hospital Employment Program is a strong example of the type of collaboration we need to be successful under the new agreement. I strongly support this innovative approach to population health.

Sincerely,

Peter A. Hammen

Peter A. Hammen

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

MAGGIE MCINTOSH
Legislative District 43
Baltimore City

Chair
Appropriations Committee

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Maggie.McIntosh@house.state.md.us

The Maryland House of Delegates
ANNAPOLIS, MARYLAND 21401

September 9, 2015

John M. Colmers
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Colmers:

As Chair of the Maryland General Assembly House Committee on Appropriations, I am writing to express my support of the Hospital Employment Program. This program aims to improve the health, economy and stability of some of the state's most disadvantaged communities through a targeted employment program that offers hospital-based jobs to those who need them most.

The success of Maryland's unique hospital rate setting system is not only a source of pride for the State, it is also a platform for innovations that improve the health of Maryland's residents. I believe the Hospital Employment program represents a broad based collaboration that addresses the social and economic conditions that contribute to poor health. Creating an employment path for Maryland's most economically disadvantaged communities will not only bring stability and improved health to those communities but it will also improve the overall quality of living for all Marylanders. I applaud all those involved for this innovative approach to population health.

Sincerely,

Maggie L. McIntosh

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

STEPHANIE RAWLINGS-BLAKE
MAYOR

100 Holliday Street, Room 250
Baltimore, Maryland 21202

September 9, 2015

Mr. John M. Colmers
Chairman, Health Services Cost Review Commission
3910 Keswick Road
Suite N-2200
Baltimore, Maryland 21211

Dear Chairman Colmers:

I am writing to express my enthusiastic support of the Hospital Employment Program. This program represents the widespread collaboration between the City, the State, Maryland's hospitals, business leaders and insurers to address health and income disparities within the most disadvantaged communities. Given the number of qualifying zip codes that meet the criteria of the program, these efforts will make a substantial difference in improving the quality of life for may Baltimore City residents.

If you have any questions, please contact Kaliope Parthemos on (410) 396-4876 or Kaliope.parthemos@baltimoremorecity.gov .

Sincerely,

Stephanie Rawlings-Blake
Mayor
City of Baltimore

Cc: Kaliope Parthemos, Chief of Staff
Dr. Leana Wen, Baltimore City Health Commissioner
Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

Larry Hogan, Governor - Boyd Rutherford, Lt. Governor - Van Mitchell, Secretary

September 8, 2015

John M. Colmers
Chairman
The Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Colmers:

The Department has reviewed the Health Employment Program document prepared by the Maryland Hospital Association. In short, the proposal will build into hospital rates $40 million in additional funds to hire about 1,000 workers. The types of workers include community health workers, Medicaid and Health Benefit Exchange enrollment assistors, peer support specialists, as well as more traditional hospital employees, including environmental services, dietary staff, nursing assistants, escorts, and security personnel. We are writing to express our concern about the Health Employment Program and urge the HSCRC to conduct a comprehensive review of the hospital proposal before moving forward.

A Mechanism Already Exists for Funding this Initiative

The HSCRC has already made infrastructure adjustments to the hospitals rates totaling almost $200 million. These adjustments are not one-time adjustments; rather, they have been built permanently into hospital global budgets. Hospitals will receive these infrastructure monies every year unless the Commission takes action to end it.

The HSCRC built a 0.325 percent infrastructure adjustment into global budgets for FY 2014 and FY 2015, for a cumulative amount of roughly $100 million. Another 0.4 percent infrastructure adjustment was built into FY 2016 rates, and the hospitals have the potential to receive another 0.25 percent adjustment starting January 1, 2016. The additional 0.25 percent will be competitive, meaning that a hospital's ability to receive the additional 0.25 percent will depend on the quality of the hospital proposal or plan submitted on December 1, 2015. Nothing precludes the hospitals from submitting a proposal that includes a Health Employment Program. The estimated impact on the FY 2016 infrastructure adjustment is $100 million, meaning that in FY 2016 and every year thereafter, hospitals will receive $200 million in additional infrastructure monies.

Costs Will Not Be Offset Without Return on Investment from Hospital Global Budgets

We disagree that the savings will be largely offset from fewer people utilizing public programs such as Medicaid. Under federal eligibility requirements, and depending a number

of factors, including the income, cost of other coverage offered and household size of the individuals participating, they or their family members could remain eligible for Medicaid.

Additionally, during our Community Health Workers workgroup sessions, many participants questioned whether additional Community Health Workers would have the opposite effect on the Medicaid budget—that is, create more opportunities to enroll individuals on Medicaid. In the past, the Department has seen the utilization of Community Health Workers as a way to better coordinate care for our high cost populations more effectively. We believe, notwithstanding the potential outreach impact that additional Community Health Workers could result in additional savings to the overall program. A large component of those savings would come from hospital services. The proposal does not mention any of these savings being passed onto payers through a reduction in future hospital global budget revenues. Without a formula in place for payers to realize a return on investment accrued by the savings achieved by hospitals, there will be no offsetting of costs.

Applicants for the competitive 0.25 infrastructure rate increase are required to submit a calculation for the expected return on investment for their proposed interventions; should a separate Hospital Employment Program be created, it is the Department's position that a similar costing exercise should be produced.

Proposal Lacks Accountability to the Payers

The proposal outlines that hospitals receiving monies through the Health Employment Program will be required to submit biannual reports to HSCRC detailing the incremental employees hired and the costs associated with these hires. The proposal does not include a process where payers can provide feedback and recommendations on the new positions or the program in general. Medicaid pays for roughly 20 percent of hospital charges in Maryland. In other words, Medicaid will pay roughly $8 million of the $40 million proposal annually. The Department wants to ensure that an equal portion of any monies is devoted to employees who benefit the Medicaid population. The current proposal lacks this feedback mechanism or any measures to evaluate the program's impact.

The Department looks forward to working with the HSCRC on his important initiative. Please contact Shannon McMahon, Deputy Secretary of Health Care Financing at 410-767-5807 should you have any questions.

Sincerely,

Van T. Mitchell
Secretary

Monitoring Maryland Performance

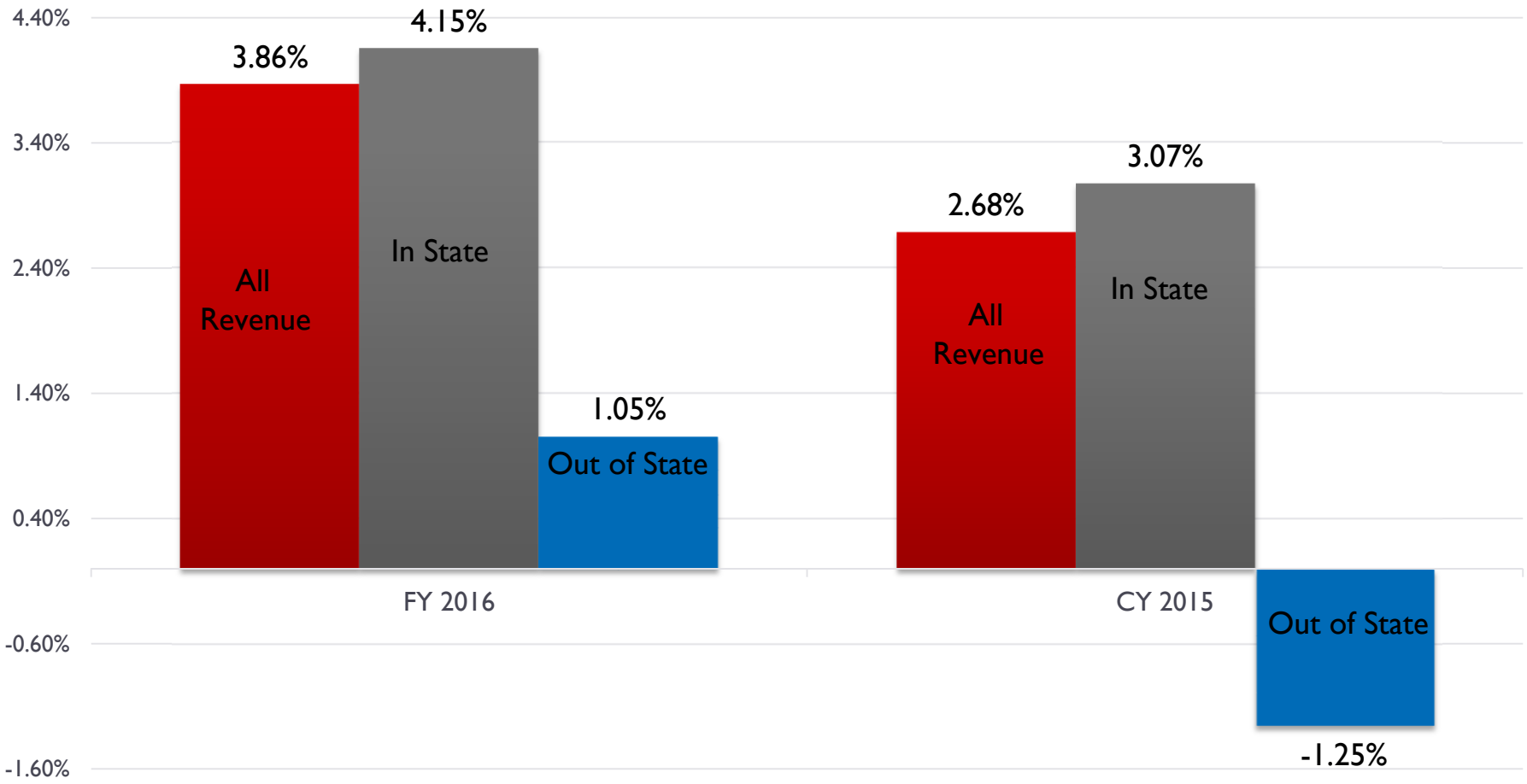
Financial Data

Year to Date thru August 2015

HSCRC
Health Services Cost Review Commission

Gross All Payer Revenue Growth

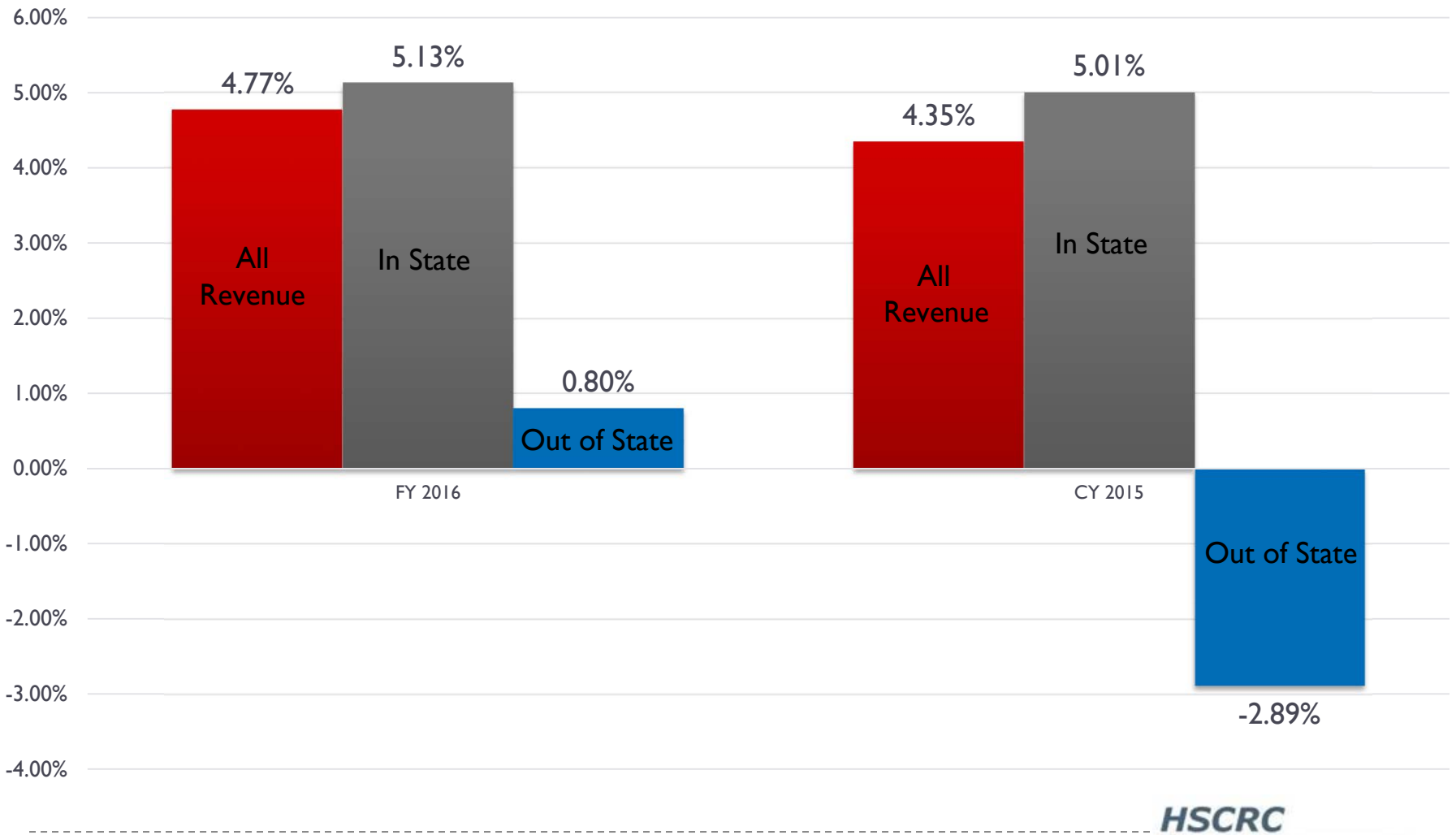
Year to Date (thru August 2015) Compared to Same Period in Prior Year



HSCRC
Health Services Cost Review Commission

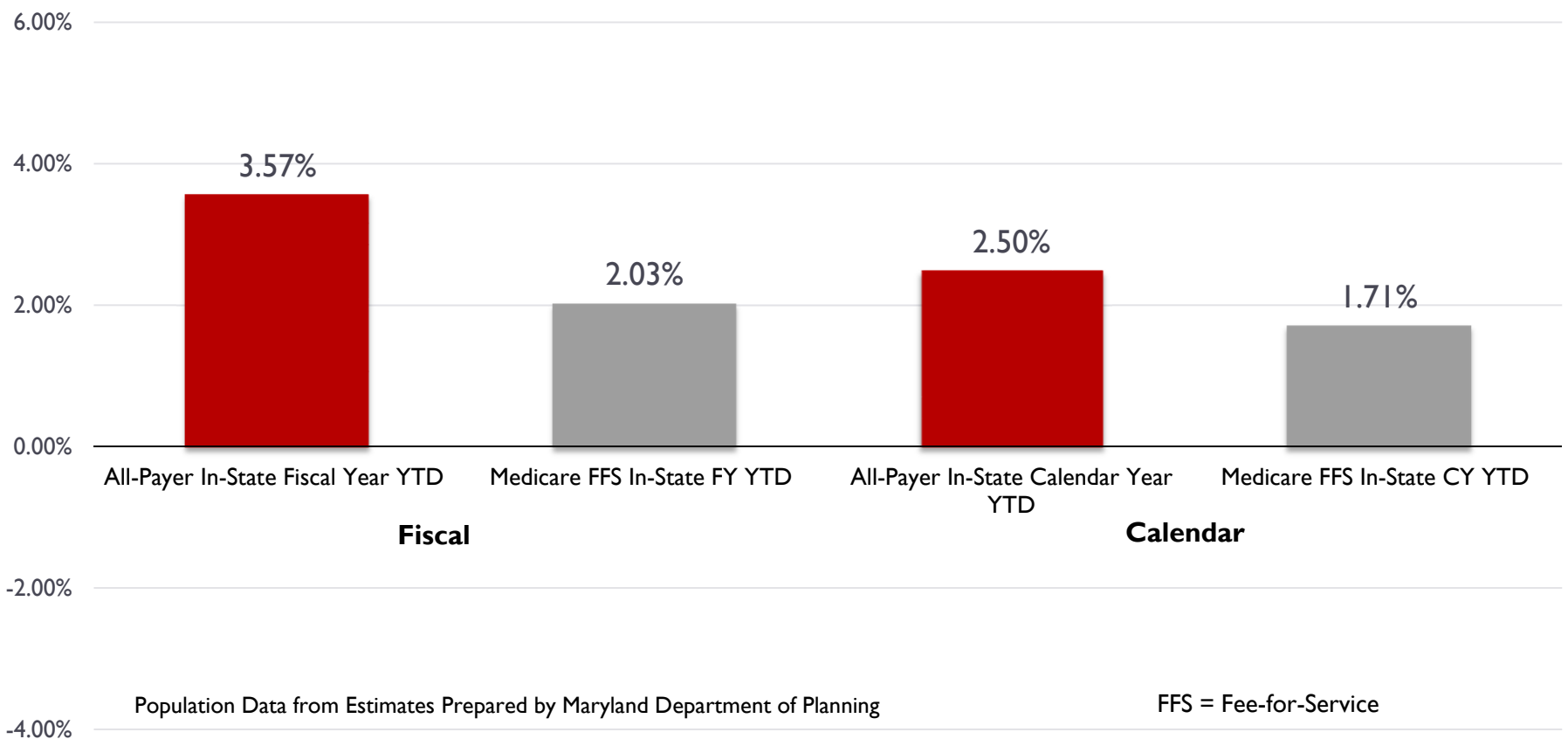
Gross Medicare Fee-for-Service Revenue Growth

Year to Date (thru August 2015) Compared to Same Period in Prior Year



HSCRC
Health Services Cost Review Commission

Per Capita Growth Rates
Fiscal Year 2016 and Calendar Year 2015



Population Data from Estimates Prepared by Maryland Department of Planning

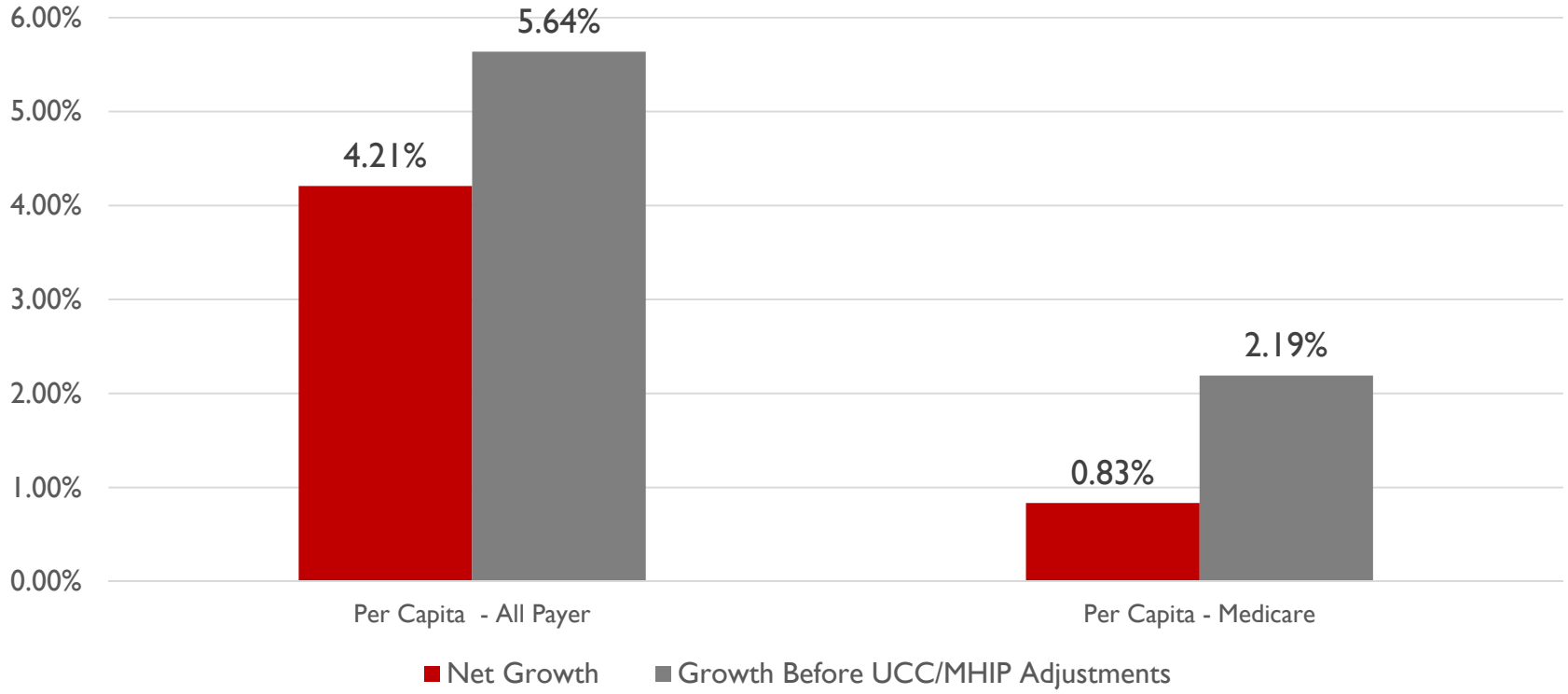
FFS = Fee-for-Service

- **Calendar and Fiscal Year trends to date are below All-Payer Model Guardrail for per capita growth.**

HSCRC
Health Services Cost Review Commission

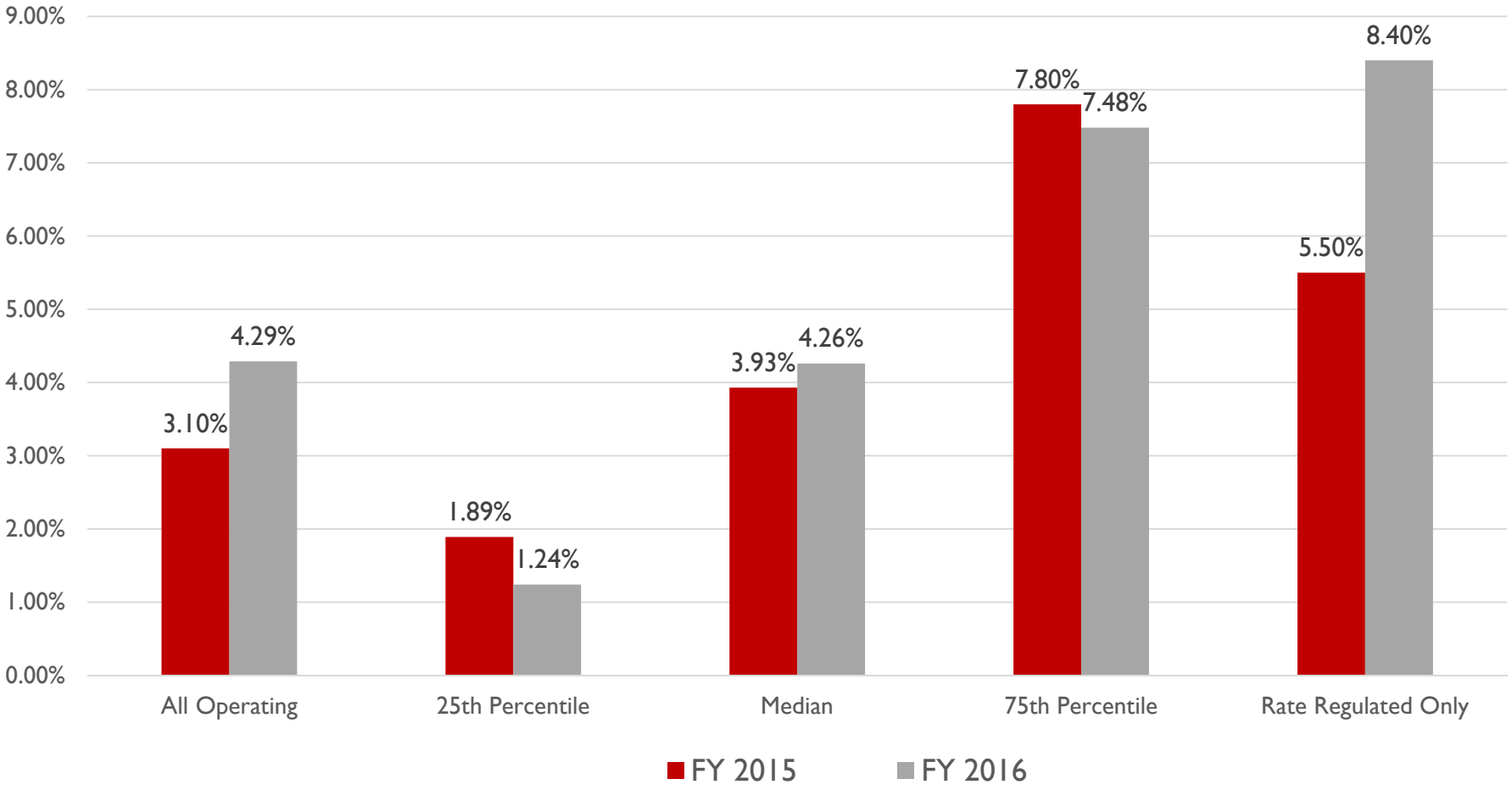
Per Capita Growth – Actual and Underlying Growth

CY 2015 Year to Date Compared to Same Period in Base Year (2013)



- Two year per capita growth rate is well below maximum allowable growth rate of 7.29% (growth of 3.58% per year)
- Underlying growth reflects adjustment for FY 15 & FY 16 revenue decreases that were budget neutral for hospitals. 1.09% decrease from MHIP assessment and hospital bad debts in FY 15. Additional 1.41% adjustment in FY 16 due to further reductions to hospital bad debts and elimination of MHIP assessment.

Operating Profits: Fiscal 2016 Year to Date (July-August) Compared to Same Period in FY 2015



- Year to date FY 2016 unaudited hospital operating profits improved compared to the same period in FY 2015.

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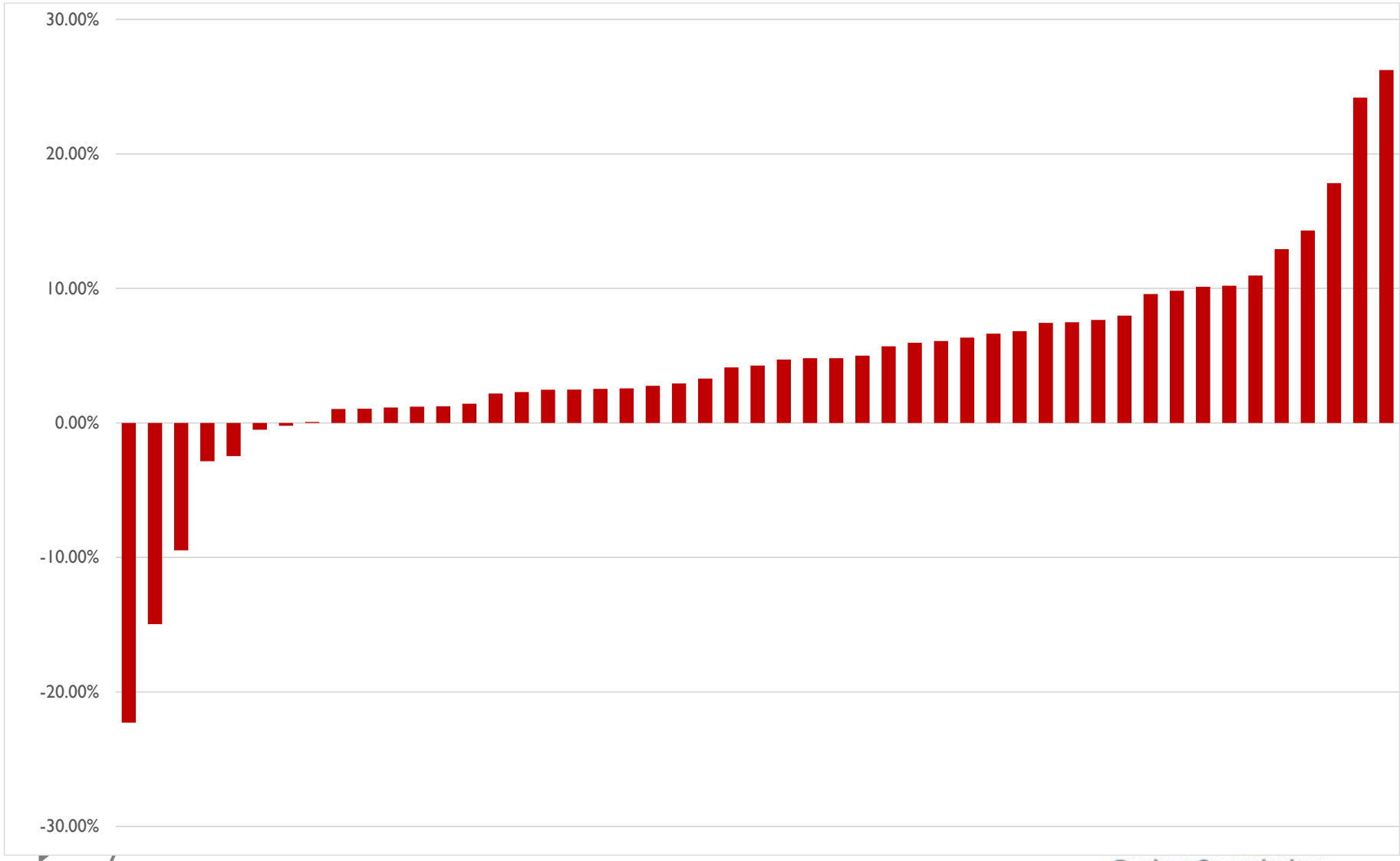
Health Services Cost Review Commission

Operating Profits by Hospital

Fiscal Year to Date (July – August)



Review Commission

Purpose of Monitoring Maryland Performance

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

- **All-Payer total hospital per capita revenue growth ceiling** for Maryland residents tied to long term state economic growth (GSP) per capita
  - 3.58% annual growth rate
- **Medicare payment savings** for Maryland beneficiaries compared to dynamic national trend. Minimum of $330 million in savings over 5 years
- **Patient and population centered-measures** and targets to promote population health improvement
  - Medicare readmission reductions to national average
  - 30% reduction in preventable conditions under Maryland's Hospital Acquired Condition program (MHAC) over a 5 year period
  - Many other quality improvement targets

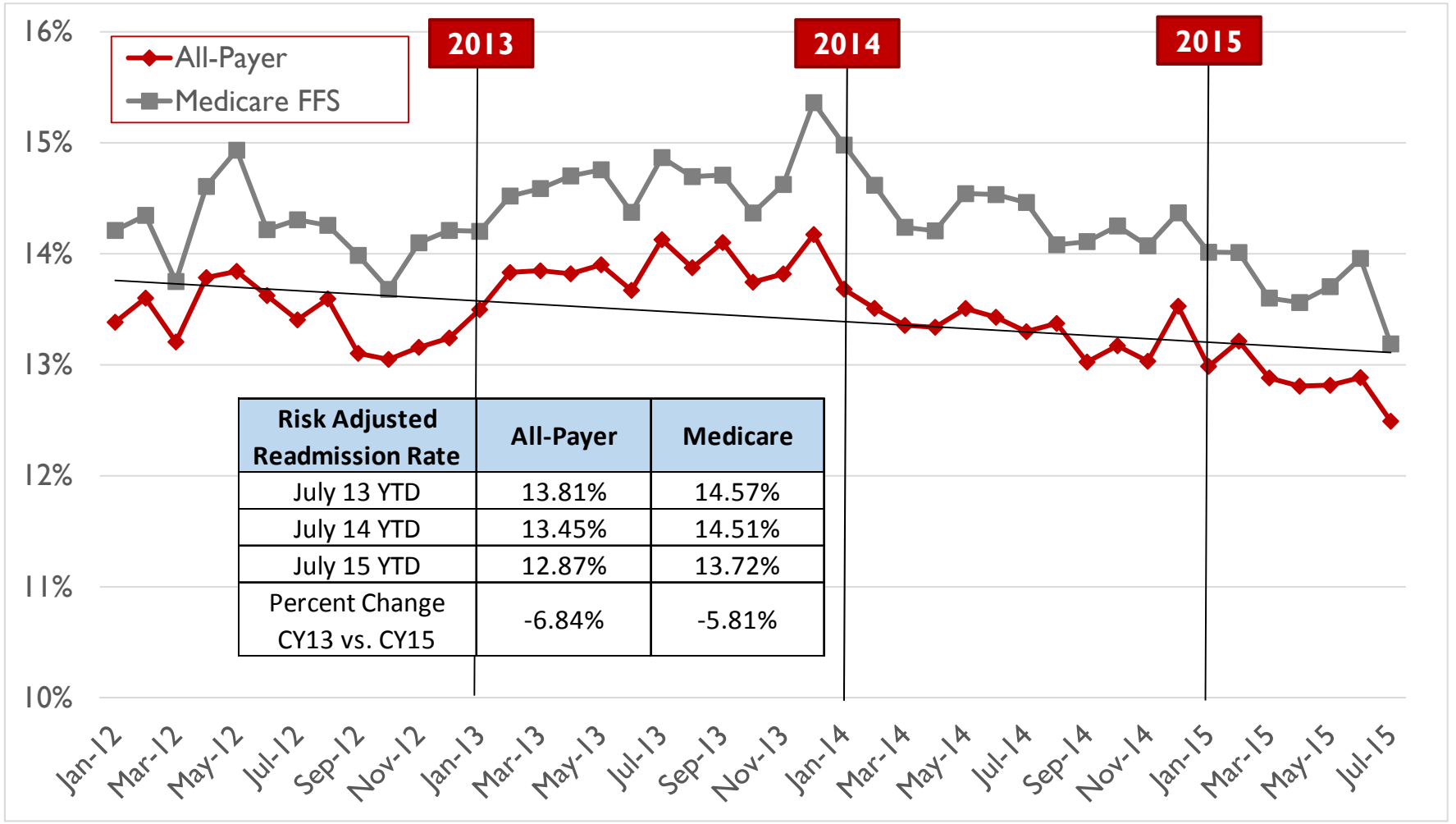
Data Caveats

- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2015 and Fiscal 2016 rely on Maryland Department of Planning projections of population growth of .56% for FY 16 and .56% for CY 15. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

Monitoring Maryland Performance
Quality Data

October 2015 Commission Meeting Update

Monthly Risk-Adjusted Readmission Rates

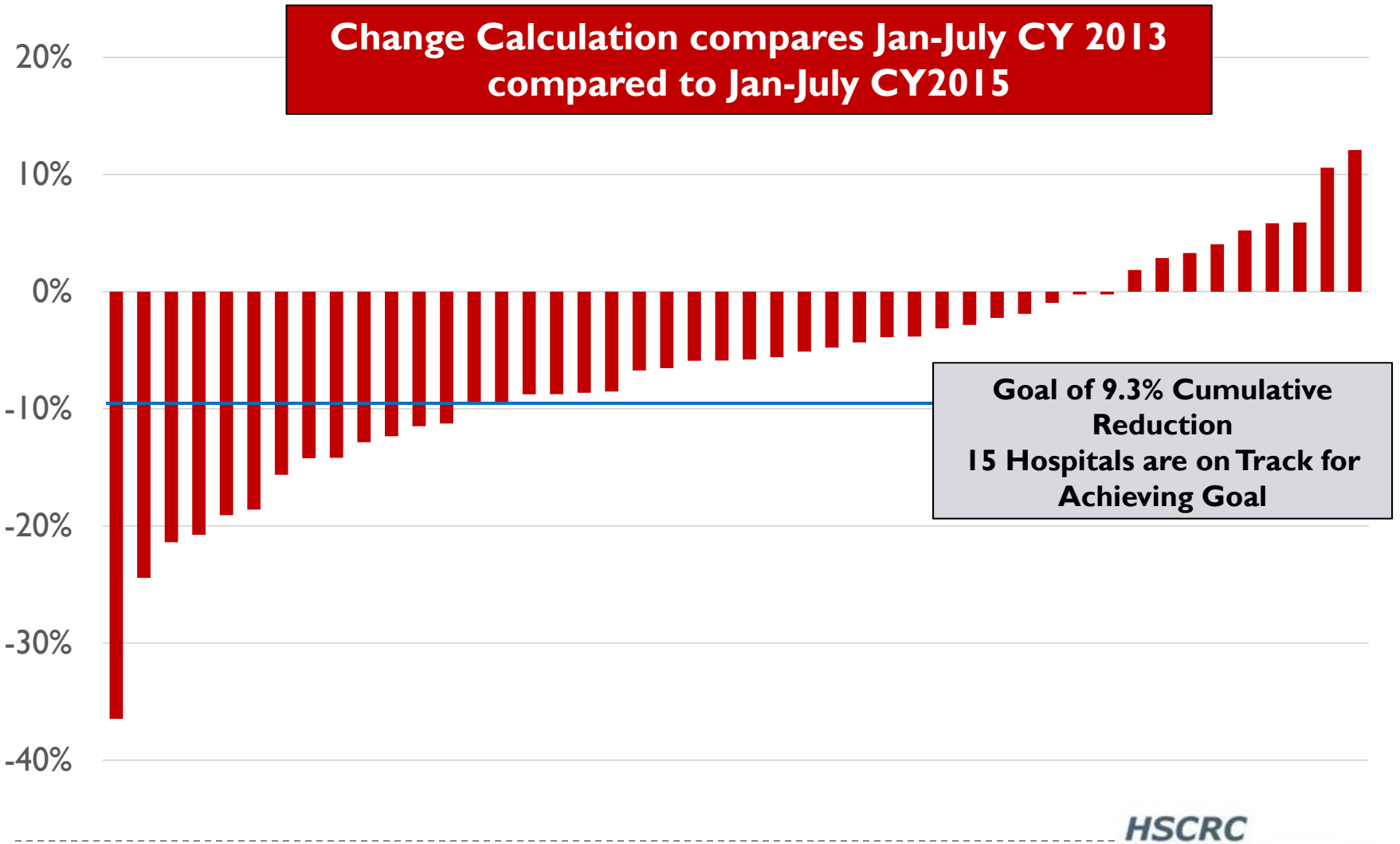


Risk Adjusted Readmission Rate	All-Payer	Medicare
July 13 YTD	13.81%	14.57%
July 14 YTD	13.45%	14.51%
July 15 YTD	12.87%	13.72%
Percent Change CY13 vs. CY15	-6.84%	-5.81%

Note: Based on final data for January 2012 – June 2015, and preliminary data through August 2015.

HSCRC
Health Services Cost Review Commission

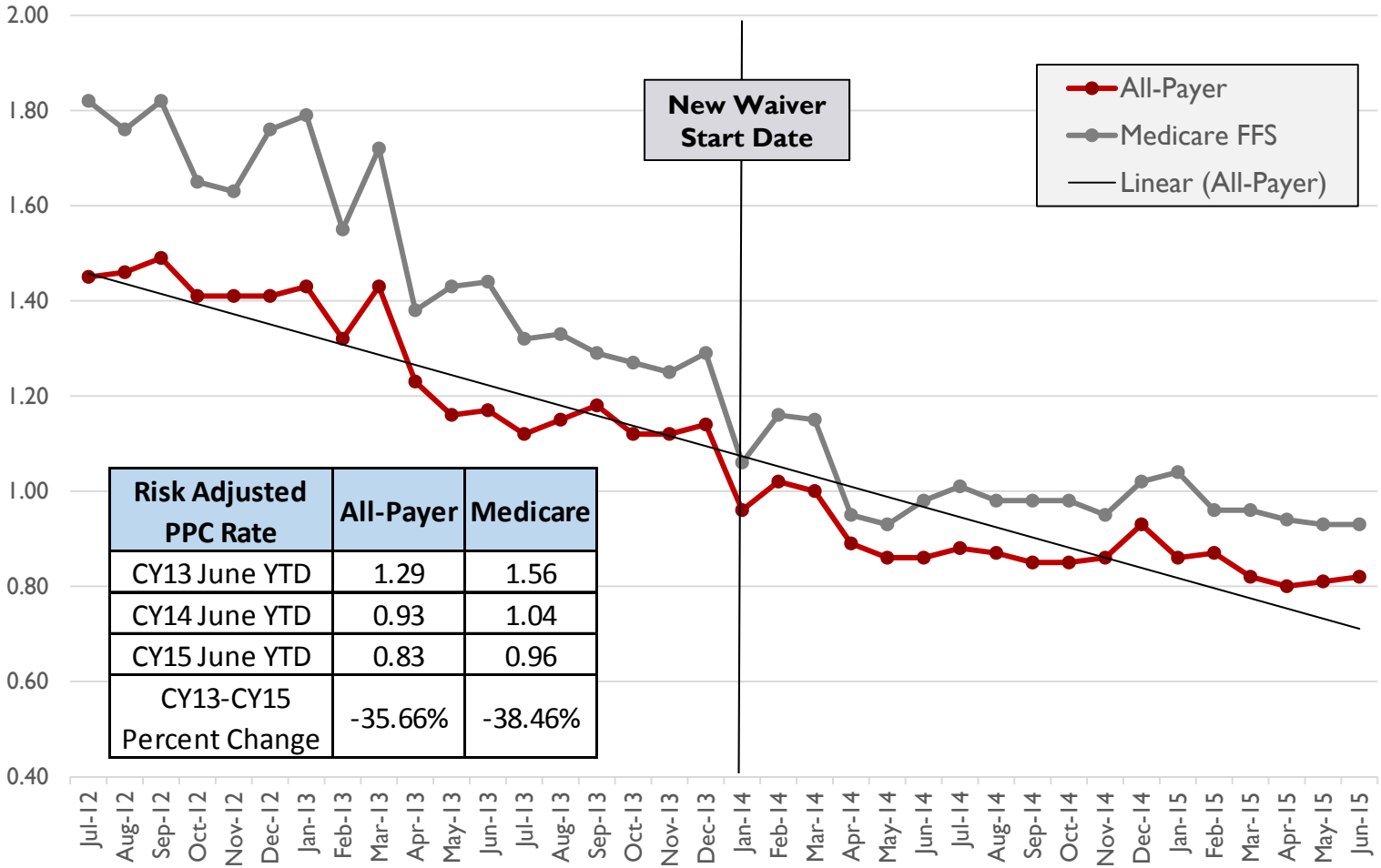
Change in All-Payer Risk-Adjusted Readmission Rates by Hospital



Note: Based on final data for January 2012 – June 2015, and preliminary data through August 2015.

HSCRC
Health Services Cost Review Commission

Monthly Risk-Adjusted PPC Rates

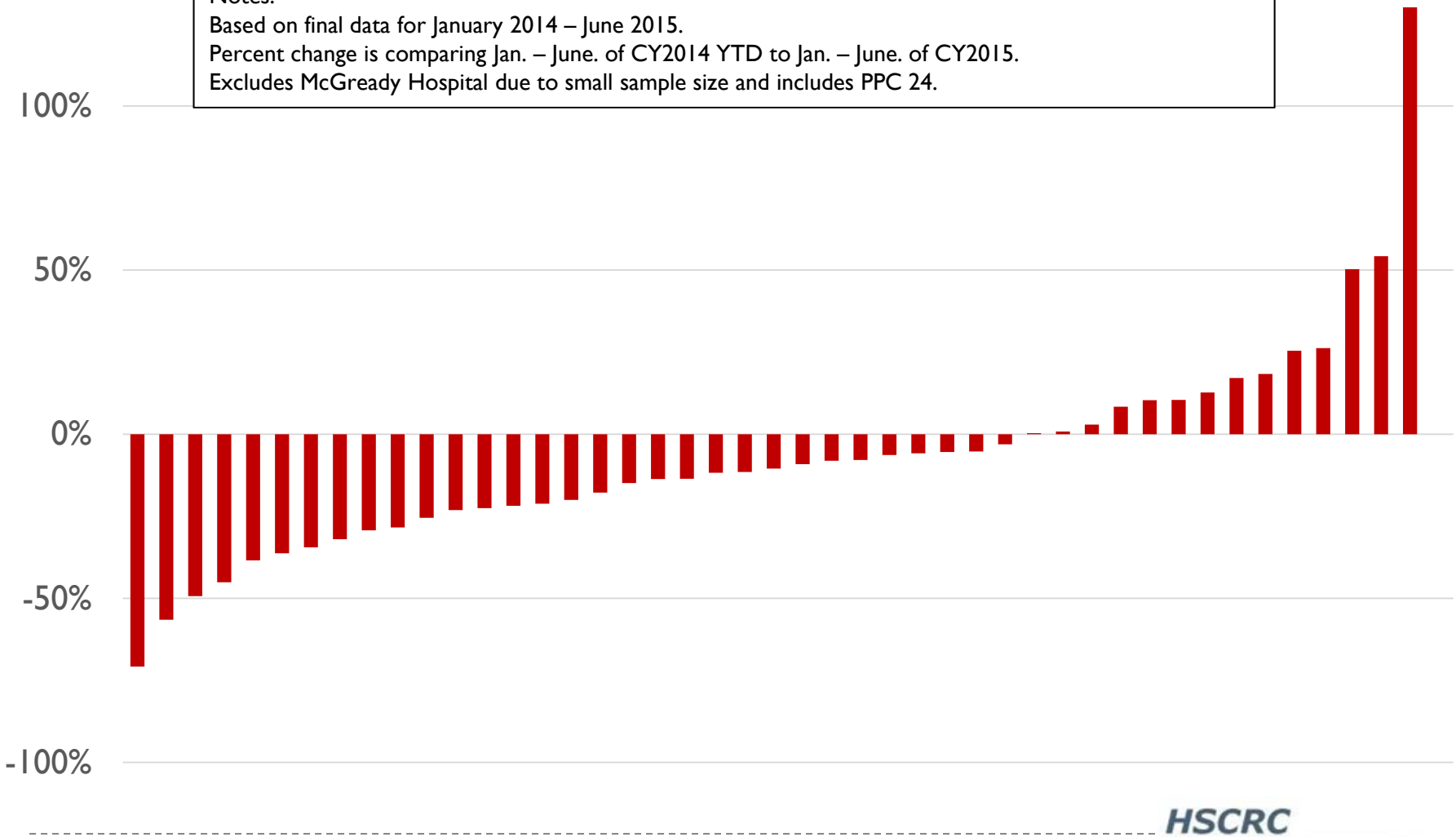


Risk Adjusted PPC Rate	All-Payer	Medicare
CY13 June YTD	1.29	1.56
CY14 June YTD	0.93	1.04
CY15 June YTD	0.83	0.96
CY13-CY15 Percent Change	-35.66%	-38.46%

Note: Reported as of 9/30/2015, based on final data through June 2015. Includes PPC24.

Change in All-Payer Risk-Adjusted PPC Rates YTD by Hospital

Notes:
Based on final data for January 2014 – June 2015.
Percent change is comparing Jan. – June. of CY2014 YTD to Jan. – June. of CY2015.
Excludes McGready Hospital due to small sample size and includes PPC 24.



HSCRC
Health Services Cost Review Commission

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 30, 2015

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
2300R	Washington Adventist Hospital	6/8/2015	10/14/2015	11/5/2015	Capital	GS	OPEN
2304N	UM St. Joseph Medical Center	7/17/2015	10/14/2015	12/14/2015	CCU/DEF	CK	OPEN
2307A	Maryland Physician Care	8/31/2015	N/A	N/A	ARM	SP	OPEN
2308A	Priority Partners	9/17/2015	N/A	N/A	ARM	SP	OPEN
2309A	University of Maryland Medical Center	9/18/2015	N/A	N/A	ARM	DNP	OPEN
2310A	MedStar Health Family Choice	9/23/2015	N/A	N/A	ARM	SP	OPEN
2311A	MedStar Health Family Choice	9/23/2015	N/A	N/A	ARM	DNP	OPEN
2312A	University of Maryland Medical Center	9/28/2015	N/A	N/A	ARM	DNP	OPEN
2313A	University of Maryland Medical Center	9/28/2015	N/A	N/A	ARM	DNP	OPEN
2314A	Riverside Health of Maryland	9/30/2015	N/A	N/A	ARM	SP	OPEN
2315A	Johns Hopkins Health System	10/2/2015	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE PARTIAL RATE APPLICATION OF	*	BEFORE THE HEALTH SERVICE COST REVIEW COMMISSION
WASHINGTON ADVENTIST	*	DOCKET: 2015
HOSPITAL	*	FOLIO: 2110
TAKOMA PARK, MARYLAND	*	PROCEEDING: 2300R

* * * * * * * * * * * * *

STAFF RECOMMENDATION

October 14, 2015

I. OVERVIEW

Washington Adventist Hospital (WAH, or the Hospital) filed a rate application requesting that its rates be increased in 2019 to help pay for a large capital cost increase associated with the construction of a replacement facility in a new location in Montgomery County. This partial rate application is being filed during the Certificate of Need (CON) review, which is underway at the Maryland Health Care Commission (MHCC). This rate request is being filed in advance of CON approval because WAH represented in its CON application that it will require a rate increase to make its project financially feasible. In order for the Maryland Health Services Cost Review Commission (HSCRC) and MHCC to evaluate the financial feasibility of the proposed project, it is necessary to first determine the amount of funds that would be provided to WAH for the additional capital costs. Once the rate application is acted upon, the HSCRC will need to complete a feasibility evaluation and provide comments to MHCC regarding the feasibility of the project. MHCC will determine whether to grant a CON based on its own review. Finally, WAH will need to seek a Comfort Order from HSCRC since it expects to finance the project through the Maryland Health and Higher Educational Facilities Authority (MHHEFA).

II. BACKGROUND AND REQUEST

WAH filed a partial rate application with the HSCRC on June 8, 2015 for capital related to a CON project to relocate the facility from Takoma Park, Maryland to White Oak, Maryland. WAH filed a CON application with MHCC on November 20, 2013 (as amended on September 29, 2014) to seek approval for the relocation and construction of a replacement facility. MHCC is

currently in the process of reviewing WAH's CON application, including volume projections, and will act on the CON request after its review is completed. HSCRC staff are in the process of reviewing the financial feasibility of the CON project.

The total cost of the proposed project is $330,829,524. WAH proposes to contribute $50,575,175 in cash and $11,000,000 in land toward the project. It will also fundraise an additional $20,000,000, and finance the remainder with the sale of $244,750,000 in bonds and $4,504,349 of related interest earnings.

WAH is owned and operated by Adventist Healthcare Incorporated (AHI). In addition to WAH, AHI owns and operates the following facilities in Maryland: Shady Grove Adventist Hospital, Adventist Behavioral Health Services, and Adventist Rehabilitation Hospital of Maryland. WAH intends to finance the bonds associated with the project through AHI.

WAH is requesting a permanent revenue increase of $19,700,000, or 7.3 percent of its current total approved permanent revenue. WAH is requesting that 50 percent of the revenue increase be effective on January 1, 2019, the anticipated opening date of the new facility in White Oak. WAH is requesting that the remaining 50 percent of the revenue increase be effective on July 1, 2019. The requested revenue increase represents approximately 80 percent of the estimated additional depreciation and interest costs associated with the project.

The project consists of a replacement hospital to be built on approximately 49 acres in White Oak. The new facility will have 427,662 total square feet with seven stories above grade and one story below grade. It will have a full complement of acute care services, including 170

private inpatient rooms, emergency services with 32 treatment bays, 8 general operating rooms, observation services, and other acute care services. WAH will reduce its licensed bed capacity for medical/surgical and obstetrics services from the current 192 beds to the 170 proposed beds once the new facility is opened. The existing Takoma Park facility will continue to house 40 behavioral health beds and non-acute services, including a federally qualified health center, a women's center providing prenatal and other services for the community, and a walk-in primary care clinic.

In its CON application, WAH projects an annual *decrease* in admissions of approximately 1.1 percent from 2014 to 2018. Once the new facility opens in 2019, it projects that admissions will *increase* by 1 percent annually. WAH anticipates a small decrease in market share from 2013 through 2018. Once the new facility opens, WAH anticipates that it will maintain its market share moving forward and that population growth and aging will account for the projected 1 percent annual growth in volume. WAH projects that population growth and aging through 2023 will lead to incremental growth in volumes in its service area, offsetting the loss of volumes due to reductions in potentially avoidable utilization (PAU).

The CON application projects that the Hospital's length of stay will remain constant through 2020 and that emergency department visits will increase by 2 percent annually after the new facility is opened.

WAH projects net profits of $5,465,000 in 2019 and $6,897,000 in 2020, the first two years of operation after the new facility opens. These projected net profits include the assumption that the requested revenue increase of $19,700,000 is approved.

III. HOSPITAL RATE HISTORY

WAH entered into a Global Budget Revenue (GBR) agreement effective July 1, 2013. Under the GBR agreement, WAH received the following adjustments:

Table 1. WAH's GBR Adjustments, 2014 Final and 2015 Preliminary

	July 1, 2014 (in 1,000s) Final	July 1, 2015 (in 1,000s) Preliminary
Initial Approved Revenue	$254,864	$256,326
Update factor for inflation	5,359	5,325
Population/Market Shift		1,965
Change in Mark-up	(1,832)	(1,956)
Infrastructure Adjustment		2,625
Change in One-Time Assessments	(2,065)	(1,376)
Total Approved Revenue	$256,326	$262,909

IV. HOSPITAL FINANCIAL SITUATION

WAH's fiscal year ends on December 31. For the past three years, it has reported the following audited results:

Table 2. WAH's Year-End Audited Financial Results, 2012-2014

Year Ending December 31	Net Operating Revenue (Regulated)	Net Operating Profit (Regulated)	Operating Margin (Regulated)	Net Profits (Loss)
2012	$206,488,551	$3,310,437	1.6%	($7,395,620)
2013	$199,999,850	$969,950	0.5%	($12,230,680)
2014	$211,284,900	$16,639,700	7.9%	$2,625,900

WAH improved its financial situation between 2013 and 2014, primarily as a result of increasing revenue and improving overall expense efficiencies. The table below lists the number of inpatient admissions, equivalent inpatient admissions (EIPAs), and the average regulated expenses per EIPA for the last three audited years:

Table 3. WAH's Inpatient Admissions and EIPAs, 2012-2014

Year Ending December 31	Inpatient Admissions	EIPAs	Regulated Expense Per EIPA
2012	13,111	19,124	$10,624
2013	11,648	18,392	$10,821
2014	11,472	18,043	$10,758

V. STAFF ANALYSIS

In October 2003, the Commission adopted the staff's recommendation for revisions to the HSCRC's Inter-Hospital Cost Comparison (ICC) and Reasonableness of Charges (ROC) methodologies. Specifically, the Commission approved policies regarding full rate reviews and permitted partial rate applications for additional capital costs associated with a CON-approved major project. The ICC standard methodology is based on the average charges of a comparable group of hospitals adjusted to take into account variations among the hospitals for the percentage of mark up, poor patients, labor market differences, capital and teaching commitments, and case mix. In addition, the percentage of profit generated on HSCRC-regulated services is eliminated from the standard, but the ICC standard used for reviewing capital cost increases is not reduced for the 2 percent productivity adjustment that is applied for full rate reviews.

The focus of a partial capital-related rate application review is to allow a hospital that has a large capital cost increase associated with a major project to obtain some level of rate relief to the extent that the hospital's rates are determined to be reasonable under an HSCRC-defined methodology. The Commission's policy is that the ICC standard applied in the case of a partial

rate review for capital be the current ICC analysis (retaining the profit strip) without the 2 percent productivity adjustment. This policy was meant to generate rate relief for a hospital with low charges relative to its peers and is undertaking a major capital project. Under this modified ICC standard, efficient hospitals will be able to generate profits through cost savings related to operational efficiencies.

HSCRC staff are in the process of evaluating methodologies to incorporate additional measures of operational efficiency under the framework introduced by the new All-Payer Model that became effective on January 1, 2014. This may include standards for and reductions in PAU, as well as per capita efficiency measures, among others. While this partial rate application would establish an expected amount of incremental funding for capital costs, it does not affect the application of other HSCRC policies, including any efficiency polices that might be adopted between the time of this staff recommendation and the date in which the new facility becomes operational.

The HSCRC's current methodology allows the subject hospital to estimate capital costs as reflected by the depreciation and interest associated with the CON-approved project and the estimated routine annual capital replacement over the project period. WAH's rate application requests that the HSCRC grant a revenue increase equal to 80 percent of the projected incremental capital costs associated with the project. The CON includes a projected first-year interest costs of $14,685,000, first-year depreciation costs of $9,769,000, and first-year amortization costs of $175,000 for a total of $24,629,000 in incremental capital costs.

As stated above, WAH is requesting that 80 percent of the $24,629,000 in incremental capital costs, or $19,700,000, be placed into rates. WAH is requesting that 50 percent of the costs be added to rates on January 1, 2019, and that the remaining 50 percent be added to rates on July 1, 2019. The January 1, 2019 rate increase coincides with the anticipated opening date of the new hospital. The total rate increases for the two dates equate to approximately 7.3 percent of projected total permanent revenue.

WAH assumed an interest rate of 6.0 percent for the project. The Hospital is proposing to finance the project under the AHI Obligated Group. According to the notes in WAH's December 31, 2014 Audited Financial Statements, AHI issued debt in 2014 with a fixed coupon rate of 3.56 percent. Staff contacted Annette Anselmi, Executive Director of MHHEFA, regarding the use of such a high interest rate in WAH's projections. Ms. Anselmi indicated that, with the uncertainty in the market and indications that interest rates will possibly rise in the near future, the 6 percent interest rate is a reasonable assumption.

Staff believe that the actual interest rate on the debt associated with this project will be less than the 6 percent assumed in the CON. If the actual interest rate for the debt is lower than the assumed interest rate, then the annual interest cost would be reduced. The lower interest costs could reduce the requested rate increase by as much as 2 percent.

WAH was 7.01 percent below the peer group average of a ROC comparison and 0.92% below the average of the modified ICC comparison that was calculated based on 2014 data. Based on the Annual Cost Schedule (ACS) from the Hospital's 2013 Annual Report of Revenue and Expenses, WAH had $2,272,818 in HSCRC-regulated interest expenses, $8,153,219 in

regulated depreciation and amortization expenses, and $869,404 in regulated capital lease expenses, for a total of $11,300,441 in capital expenses. The $11,300,441 represents 5.68 percent of WAH's total 2013 regulated expenses.

As stated above, WAH is projecting $14,685,000 in annual interest expenses and $9,944,000 in annual depreciation and amortization expenses related to the new project in the CON. WAH is also projecting an additional $5,852,000 in depreciation expenses related to assets at the AHI corporate offices that will continue to be allocated to the Hospital after the new facility is opened. Total projected capital costs at that time will be $30,481,000, representing 12.4 percent of WAH's projected 2019 total costs. The difference between WAH's current capital cost of $11,300,441 and the projected $30,481,000 in capital costs after the new facility is opened is $19,180,559, or approximately $500,000 less than the $19,700,000 revenue increase requested.

VI. IMPACT OF GLOBAL BUDGETED REVENUE AND PAU

Under the new All-Payer Model and the associated global budget rate-setting agreements, Maryland hospitals are focused on reducing PAU that can result from care improvements and reductions in unplanned admissions. Revenues are increased for changes in population and in other limited circumstances, but volume growth is not a factor in determining revenue. Further, hospitals can no longer plan on increasing volumes to pay for capital improvement projects.

As part of the HSCRC's annual calculation of allowable rate increases by hospitals, an adjustment is incorporated to account for hospitals' ongoing performance in reducing PAU. In

the latest calculations updating statewide revenues as of July 1, 2015, WAH's PAU was 16.47 percent, compared with a statewide average of 13.65 percent. This comparison of PAU has not yet been adjusted for socioeconomic status or other health disparities. In the most recent ROC calculations WAH had 29.3% of its patients classified as disproportionate share (poor patients) compared to an average of 17.8% for the total hospitals in the comparison group. WAH's significantly higher than the average disproportionate share is likely contributing to the higher than average percentage of PAU.

VII. CALCULATION OF CAPITAL ADJUSTMENT

The HSCRC's current policy on revenue increases related to new capital projects calls for WAH to receive a revenue increase for a portion of the new capital costs offset by the percentage amount that it exceeds the ICC methodology. Since WAH was 0.92 percent below the modified ICC standard, no reduction will be applied.

The 2014 capital costs of the 28 hospitals included in WAH's ICC group represented 10.08 percent of total costs according to the Schedules of Revenues and Expenses submitted by the hospitals. Staff are recommending that WAH receive a rate increase equal to the difference between (1) the average of the ICC group hospitals' 10.08 percent capital costs and WAH's projected capital costs after the new facility is opened and (2) WAH's current capital costs of 5.68 percent. This would result in an approved revenue increase of $15,391,282 to WAH's permanent approved GBR.

VIII. Recommendation

Staff recommend that $15,391,282 be added to WAH's permanent rate base at the time the new facility opens, estimated to be January 1, 2019. This revenue adjustment will be reduced if the actual interest rate incurred is different from the projected 6 percent used in these calculations. Also, the staff's recommended revenue is based on, among other things, the information and representations contained within the Hospital's CON application. Should the information or representations change materially in the view of HSCRC staff, staff reserve the right to bring the matter back to the HSCRC for reevaluation and potential modification to the revenue approved herein.

WAH will continue to be subject to any revenue adjustments related to the GBR or any new rate-setting system developed in response to changes in health care delivery or payment methodologies in Maryland. As noted above, staff are in the process of developing new rate methodologies over the next few years that will account for operational efficiencies and ongoing efforts to reduce PAU.

This staff recommendation should not be construed in any way as staff's rendering any opinion at this time on the financial feasibility of the capital project. Staff's opinion on financial feasibility will follow a thorough analysis and will be provided to the MHCC in writing, consistent with the advisory role that the HSCRC staff have historically played in CON applications. As noted, the final determination of whether or not a CON is to be granted rests within the authority of the MHCC. Rate approval for a facility granted a CON rests within the

authority of the HSCRC. HSCRC staff may ultimately conclude that a project is financially feasible. On the other hand, HSCRC staff may determine otherwise, in which case it may recommend against the issuance of a Comfort Order by the HSCRC.

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
SAINT AGNES HEALTH	*	**COMMISSION**	
WESTERN MARYLAND HEALTH SYSTEM	*	**DOCKET:**	**2015**
MERITUS HEALTH	*	**FOLIO:**	**2117**
HOLY CROSS HEALTH	*	**PROCEEDING:**	**2307A**

Draft Recommendation

October 14, 2015

This is a draft recommendation.

I. Introduction

On August 21, 2015, Saint Agnes Health System, Western Maryland Health System, Holy Cross Health, and Meritus Health ("the Hospitals") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06. The Hospitals seek renewal for the continued participation of Maryland Physicians Care ("MPC") in the Medicaid Health Choice Program. MPC is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2270A for the period January 1, 2015 through December 31, 2015. The Hospitals are requesting to renew this contract for one year beginning January 1, 2016.

II. Background

Under the Medicaid Health Choice Program, MPC, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. MPC pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. MPC is a major participant in the Medicaid Health Choice program, and provides services to 18.2% of the total number of MCO enrollees in Maryland, which represents approximately the same market share as CY 2014.

The Hospitals supplied information on their most recent experience as well as their preliminary projected revenues and expenditures for the upcoming year based on the revised Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (Proceeding 2270A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2014, 2015, and 2016. In recent years, the financial performance of MPC has been favorable. The actual financial experience reported to staff for CY2014 was favorable; however, projections for CY 2015, like all of the provider-based MCOs, are unfavorable. MPC is projecting to resume favorable performance in CY 2016.

IV. Recommendation

With the exception of CY 2013, MPC has generally maintained favorable performance in recent years. However, all of the provider-based MCOs are expecting losses in CY 2015. Based on past and projected performance, staff believes that the proposed renewal arrangement for MPC is acceptable under Commission.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2016.

(2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance for CY 2015 and the MCO's expected financial status into CY 2016. Staff recommends that Maryland Physicians Care report to Commission staff (on or before the September 2016 meeting of the Commission) on

the actual CY 2015 experience, preliminary CY 2016 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2017.

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE ALTERNATIVE	*****	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*****	**SERVICES COST REVIEW**	
THE JOHNS HOPKINS HEALTH	*****	**COMMISSION**	
SYSTEM	*****	**DOCKET:**	**2015**
	*****	**FOLIO:**	**2118**
BALTIMORE, MARYLAND	*****	**PROCEEDING**	**2308A**

Draft Recommendation

October 14, 2015

This is a draft recommendation.

I. Introduction

On September 14, 2015, Johns Hopkins Health System ("JHHS," or the "System") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Suburban Hospital, and Howard County General Hospital ("the Hospitals"). The System seeks renewal for the continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. Priority Partners, Inc. is the entity that assumes the risk under the contract. The Commission most recently approved this contract under proceeding 2269A for the period from January 1, 2015 through December 31, 2015. The Hospitals are requesting to renew this contract for a one-year period beginning January 1, 2016.

II. Background

Under the Medicaid Health Choice Program, Priority Partners, a provider-sponsored Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. Priority Partners was created in 1996 as a joint venture between Johns Hopkins Health Care (JHHC) and the Maryland Community Health System (MCHS) to operate an MCO under the Health Choice Program. Johns Hopkins Health Care operates as the administrative arm of Priority Partners and receives a percentage of premiums to provide services such as claim adjudication and utilization management. MCHS oversees a network of Federally Qualified Health Clinics and provides member expertise in the provision of primary care services and assistance in the development of provider networks.

The application requests approval for the Hospitals to continue to provide inpatient and

outpatient hospital services, as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. Priority Partners pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. The Hospitals supplied information on their most recent experience as well as their preliminary projected revenues and expenditures for the upcoming year based on the initially revised Medicaid capitation rates.

Priority Partners is a major participant in the Medicaid Health Choice program, providing managed care services to 23.6% of the State's MCO population, up from 22.8% in CY 2014.

III. Staff Review

This contract has been operating under the HSCRC's initial approval in proceeding 2269A. Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2014, 2015, and 2016. The statements provided by Priority Partners to staff represent both a "stand-alone" and "consolidated" view of Priority's operations. The consolidated picture reflects certain administrative revenues and expenses of Johns Hopkins Health Care. When other provider-based MCOs are evaluated for financial stability, their administrative costs relative to their MCO business are included as well; however, they are all included under the one entity of the MCO.

In recent years, the consolidated financial performance of Priority Partners has been favorable. The actual financial experience reported to staff for CY2014 was positive. However, projections for CY 2015, like all of the provider-based MCOs, are unfavorable. Priority Partners is projecting to resume favorable performance in CY 2016.

IV. Recommendation

Priority Partners has continued to achieve favorable consolidated financial performance in recent years. However, all of the provider-based MCOs are expecting losses in CY 2015. Based on past and projected performance, staff believes that the proposed renewal arrangement for Priority Partners is acceptable under Commission.

Therefore:

1) **Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2016.**
2) **Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance in CY 2015, and the MCOs expected financial status into CY 2016. Therefore, staff recommends that Priority Partners report to Commission staff (on or before the September 2016 meeting of the Commission) on the actual CY 2015 experience, and preliminary CY 2016 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2017.**
3) **Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates,**

treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2015**
MEDICAL CENTER	*****	**FOLIO:**	**2119**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2309A**

Staff Recommendation

October 14, 2015

I. INTRODUCTION

The University of Maryland Medical Center (the Hospital) filed a renewal application with the HSCRC on September 18, 2015 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with OptumHealth Care Solutions, Inc. for a one-year period, effective November 1, 2015.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

been favorable.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period beginning November 1, 2015.

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

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
MEDSTAR HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2015**
	*	**FOLIO:**	**2120**
COLUMBIA, MARYLAND	*	**PROCEEDING:**	**2310A**

Draft Recommendation

October 14, 2015

This is a draft recommendation.

I. Introduction

On September 21, 2015, MedStar Health filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital ("the Hospitals"). MedStar Health seeks renewal for the continued participation of MedStar Family Choice ("MFC") in the Medicaid Health Choice Program. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2257A for the period from January 1, 2015 through December 31, 2015. The Hospitals are requesting to renew this contract for one year beginning January 1, 2016.

II. Background

Under the Medicaid Health Choice Program, MedStar Family Choice, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services, as well as certain non-hospital services, while MFC receives a State-determined capitation payment. MFC pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. MFC provides services to 6.2% of the total number of MCO enrollees in Maryland, which represents approximately the same market share as CY 2014.

The Hospitals supplied information on their most recent experience as well as their preliminary projected revenues and expenditures for the upcoming year based on the Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (proceeding 2257A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2014, 2015, and 2016. In recent years, the financial performance of MFC has been favorable. The actual financial experience reported to staff for CY 2014 was positive. However, projections for CY 2015, like all of the provider-based MCOs, are unfavorable. MFC is projecting to resume favorable performance in CY 2016.

IV. Recommendation

MFC has continued to achieve favorable financial performance in recent years. However, all of the provider-based MCOs are expecting losses in CY 2015. Based on past performance, staff believes that the proposed renewal arrangement for MFC is acceptable under Commission policy.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2016.

(2) Since sustained losses may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance to determine whether favorable financial performance resumes in CY 2016. Staff recommends that MedStar Family Choice report to Commission staff (on or before the September 2016 meeting of the Commission) on the actual CY 2015 experience

and preliminary CY 2016 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2017.

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2015**
MEDICAL CENTER	*****	**FOLIO:**	**2122**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2312A**

Staff Recommendation

October 14, 2015

I. INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on September 28, 2015 requesting approval to continue its participation in a global rate arrangement with BlueCross and BlueShield Association Blue Distinction Centers for blood and bone marrow transplant services for a period of one year beginning November 1, 2015.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff found that the experience under this arrangement for the prior year has been favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for blood and bone marrow transplant services, for a

one year period commencing November 1, 2015. 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 Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
UNIVERSITY OF MARYLAND	*****	**DOCKET:**	**2015**
MEDICAL CENTER	*****	**FOLIO:**	**2123**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2313A**

Staff Recommendation

October 14, 2015

I. INTRODUCTION

The University of Maryland Medical Center (the Hospital) filed a renewal application with the HSCRC on September 28, 2015 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for participation in a new global rate arrangement for solid organ and blood and bone marrow transplant services with Humana for a one-year period, effective November 1, 2015.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

favorable.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period beginning November 1, 2015.

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

IN RE: THE ALTERNATIVE	*****	**BEFORE THE HEALTH**
RATE APPLICATION OF	*****	**SERVICES COST REVIEW**
UNIVERSITY OF MARYLAND MEDICAL	*****	**COMMISSION**
SYSTEM CORPORATION		
	*****	**DOCKET: 2015**
	*****	**FOLIO: 2124**
	*****	**PROCEEDING: 2314A**

Draft Recommendation

October 14, 2015

This is a draft recommendation.

I. Introduction

On September 30, 2015, Riverside Health ("Riverside"), a Medicaid Managed Care Organization ("MCO"), on behalf of The University of Maryland Medical System Corporation ("the Hospitals"), filed an application for an Alternative Method of Rate Determination ("ARM") pursuant to COMAR 10.37.10.06. Riverside and the Hospitals seek approval for the MCO to continue to participate in the Medicaid Health Choice Program. Riverside is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2281A for the period from January 1, 2015 through December 31, 2015. Under that arrangement, Riverside's hospital partners were LifeBridge Health, and Adventist Healthcare, Inc. In August of 2015, Riverside was purchased by University of Maryland Medical System Corporation. The MCO and Hospitals are requesting to implement this new contract for one year beginning January 1, 2016.

II. Background

Under the Medicaid Health Choice Program, Riverside, an MCO sponsored partially by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. Riverside pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. Riverside is a relatively small MCO providing services to 2.4% of the total number of MCO enrollees in Maryland, which represents approximately the same market share as CY 2014.

Riverside supplied information on its most recent financial experience as well as its

preliminary projected revenues and expenditures for the upcoming year based on the revised Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (proceeding 2281A). Staff reviewed the operating financial performance under the contract. Staff reviewed available final financial information and projections for CYs 2014, 2015, and 2016. In its second year of operation, Riverside reported positive financial performance for CY 2014. However, projections for CY 2015, like all of the provider-based MCOs, are unfavorable. Riverside is projecting to resume favorable performance in CY 2016.

IV. Recommendation

Due to startup costs, Riverside's financial performance in its first year (CY 2013) was negative. Its financial performance in CY 2014 was favorable. However, all of the provider-based MCOs are expecting losses in CY 2015. Riverside is projecting a positive margin in CY 2016. Staff believes that the proposed renewal arrangement for Riverside is acceptable under Commission policy but will continue to monitor as the organization has recently changed its ownership arrangement.

Based on the information provided, staff believes that the proposed arrangement for Riverside is acceptable.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2016.

(2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance for CY 2015 and the MCO's expected financial status into CY 2016. Staff recommends that Riverside report to Commission staff (on or before the September 2016 meeting of the Commission) on the actual CY 2015 experience, preliminary CY 2016 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2017.

(3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.

Final Recommendation for Updating the Quality-Based Reimbursement Program for FY 2018

October 14, 2015

Health Services Cost Review Commission
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Baltimore, Maryland 21215
(410) 764-2605
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This document contains the final staff recommendations for updating the Quality-Based Reimbursement (QBR) Program for FY 2018 as approved at the October 14, 2019 Public Commission Meeting.

A. INTRODUCTION

The Health Services Cost Review Commission (HSCRC) quality-based measurement initiatives, including the scaling methodologies and magnitudes of revenue "at risk" for these programs, are important policy tools for providing strong incentives for hospitals to improve their quality performance over time. HSCRC implemented the first hospital payment adjustments for the Quality-Based Reimbursement (QBR) Program performance in July 2009. Current Commission policy calls for measurement of hospital performance scores across clinical process of care, outcome and patient experience of care domains, and scaling of hospital performance results in allocating rewards and penalties based on performance.

"Scaling" for QBR refers to the differential allocation of a pre-determined portion of base-regulated hospital inpatient revenue based on assessment of the quality of hospital performance. The rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year; these scaled amounts are applied on a "one-time" basis (and are not considered permanent revenue).

For fiscal year (FY) 2018, HSCRC staff recommendations include adjusting the weights and updating the measurement domains to be as consistent as possible with the CMS Value-Based Purchasing (VBP) Program and holding steady the amount of total hospital revenue at risk for scaling for the QBR Program.

B. BACKGROUND

1. Centers for Medicare & Medicaid Services (CMS) VBP Program

The Patient Protection and Affordable Care Act of 2010 requires CMS to fund the aggregate Hospital VBP incentive payments by reducing the base operating diagnosis-related group (DRG) payment amounts that determine the Medicare payment for each hospital inpatient discharge. The law set the reduction at 1 percent in FY 2013 and mandates it to rise incrementally to 2 percent by FY 2017.

CMS implemented the VBP Program with hospital payment adjustments beginning in October 2013. For the federal fiscal year (FFY) 2017 (October 1, 2016 to September 30, 2017) Hospital VBP Program, CMS measures include the following four domains of hospital performance with 2 percent of Medicare hospital payments "at risk":

- Clinical care: process of care weighted at 5 percent and outcomes weighted at 25 percent
- Patient experience of care (HCAHPS survey measure) weighted at 25 percent
- Efficiency/Medicare spending per beneficiary weighted at 25 percent
- Safety weighted at 20 percent

HSCRC staff note that, for the VBP Program for FY 2017, CMS has added Health Safety Network ("CDC-NHSN") Clostridium Difficile and Methicillin-Resistant Staphylococcus Aureus measures, as well as the Elective Delivery Prior to 39 Completed Weeks Gestation measure.

2. QBR Measures, Domain Weighting, and Magnitude at Risk to Date

For the QBR Program for state FY 2017 rates, as approved, the HSCRC will: weight the clinical process measures at 5 percent of the final score, the outcomes and safety domains more heavily at 50 percent combined, and the patient experience of care measures at 45 percent; as well as scale a maximum penalty of 2 percent of approved base hospital inpatient revenue. The program uses the CMS/Joint Commission core process measures also used for the VBP Program, clinical outcome measures, "patient experience of care" Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS), and safety measures. The weighting for each domain compared with the CMS VBP program are illustrated below in Figure 1.

Figure 1. Final Measure Domain Weights for the CMS Hospital VBP and Maryland QBR Programs for FY 2017

	Clinical • **Outcomes (Mortality)** • **Process**	**Patient Experience**	**Safety**	**Efficiency**
CMS VBP	• 25 percent • 5 percent	25%	20%	25%
Maryland QBR	• 15 percent • 5 percent	45%	35%	N/A

HSCRC staff have worked with stakeholders over the last three years to align the QBR measures with the VBP Program where feasible, and to align the list of process of care measures, threshold and benchmark values, and time lag periods with those used by CMS,[1] allowing HSCRC to use the data submitted directly to CMS. This alignment has also occurred with the magnitude of revenue "at risk" for the two programs. Maryland has not yet developed and implemented an efficiency measure as part of the QBR Program, but it does apply a Potentially Avoidable Utilization adjustment to hospital global budgets, as well as a shared savings adjustment based on hospitals' readmission rates. HSCRC staff will also work with stakeholders to develop a new efficiency measure that incorporates population-based cost outcomes.

3. Value-Based Purchasing Exemption Provisions

Under the previous waiver, VBP exemptions had been requested and granted for FYs 2013, 2014, and 2015.

The CMS FY 2015 Inpatient Prospective Payment stated that, although the exemption from the Hospital VBP Program no longer applies, Maryland hospitals will not be participating in the Hospital VBP Program because §1886(o) of the Act and its implementing regulations have been waived for purposes of the model, subject to the terms of the agreement.

[1] HSCRC has used core measures data submitted to the Maryland Health Care Commission (MHCC) and applied state-based benchmarks and thresholds to calculate hospitals' QBR scores up to the period used for state FY 2015 performance.

The section of Maryland All-Payer Model Agreement between CMS and the state addressing the VBP program is excerpted below.

> **…4. Medicare Payment Waivers.** Under the Model, CMS will waive the requirements of the following provisions of the Act as applied solely to Regulated Maryland Hospitals:
>
> > **…e. Medicare Hospital Value Based Purchasing.** Section 1886(o) of the Act, and implementing regulations at 42 CFR 412.160 - 412.167, only insofar as the State submits an annual report to the Secretary that provides satisfactory evidence that a similar program in the State for Regulated Maryland Hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under 1886(o) of the Act….

For FY 2016 under the new All-Payer Model, HSCRC staff submitted an exemption request and received approval on August 27, 2015 from the CMS Center for Medicare and Medicaid Innovation (see Appendix I).

C. ASSESSMENT

1. FY 2016 Performance Results

Staff analyzed changes in performance on the QBR and VBP measures used for FY 2016 performance for Maryland versus the United States for October 2013 through September 2014 compared with the base period. Figure 2 below lists each of the measures used for the VBP and QBR Programs. As the data indicate, Maryland has performed and continues to perform similarly to the nation on the clinical process of care measures but better than the nation on the 30-day condition-specific mortality measures. For the Safety infection measures, Maryland has performed and continues to perform better than the nation on the CLABSI measure; for the other infection measures, Maryland appears to perform worse than the nation, and this may be in part due to limited hospital participation in reporting the data for these measures as hospitals were continuing to align their reporting with Medicare requirements. With exception of the "Discharge Information" measure—for which Maryland is on par with the nation—Maryland has lagged and continues to lag behind the nation on the HCAHPS measures. Final QBR payment scaling for FY 2016 rate year is provided in Appendix II.

Figure 2. QBR Measures Change for Maryland versus U.S.

	Maryland Base	Maryland Current	Difference	US Base	US Current	Difference	MD-US Difference in Base	MD-US Difference in Current
CLINICAL PROCESS OF CARE								
AMI 7a Fibrinolytic agent received w/in 30' of hospital arrival	NA	NA	NA	61%	60%	-1	NA	NA
PN 6 Initial antibiotic selection for CAP immunocompetent pt	96%	98%	2%	95%	96%	1%	1%	2%
SCIP 2 Received prophylactic Abx consistent with recommendations	98%	99%	1%	100%	99%	-1%	-2%	0%
SCIP 3 Prophylactic Abx discontinued w/in 24 hrs of surgery end time or 48 hrs for cardiac surgery	98%	98%	0%	98%	98%	0%	0%	0%
SCIP 9 Postoperative Urinary Catheter Removal on Post Operative Day 1 or 2	96%	99%	3%	100%	98%	-2%	-4%	1%
SCIP-Card 2 Pre-admission beta-blocker and perioperative period beta blocker	97%	98%	1%	100%	98%	-2%	-3%	0%
SCIP VTE2 Received VTE prophylaxis within 24 hrs prior to or after surgery	98%	99%	1%	98%	99%	1%	0%	0%
IMM-2 Influenza Immunization	93%	96%	3%	88%	93%	5%	5%	3%
OUTCOMES								
Mortality								
Observed Mortality Inpatient All Cause (Maryland All Payer)	3.45%	2.50%	-0.95%	NA	NA	NA	NA	NA
30-day mortality, AMI (Medicare)*	14.75%	14.50%	-0.25%	15.20%	14.90%	-0.30%	-0.45%	-0.40%
30-day mortality, heart failure (Medicare)*	10.79%	10.90%	0.11%	11.70%	11.90%	0.20%	-0.91%	-1.00%
30-day mortality, pneumonia (Medicare)*	10.81%	10.85%	0.04%	11.90%	11.90%	0.00%	-1.09%	-1.05%
Safety/Complications								
AHRQ PSI composite (Maryland All Payer)	0.862	0.647	NA	NA	NA	NA	NA	NA
CLABSI	0.532	0.527	NA	1	1	NA	-46.8%	-47.30%
CAUTI	2.327	1.659	NA	1	1	NA	132.7%	65.90%
SSI Colon	0.768	1.055	NA	1	1	NA	-23.2%	5.50%
SSI Abdominal Hysterectomy	1.751	1.281	NA	1	1	NA	75.1%	28.10%
MRSA	NA	1.344	NA	NA	1	NA	NA	34.40%
C.diff.	NA	1.15	NA	NA	1	NA	NA	15.00%
PATIENT EXPERIENCE OF CARE - HCAHPS								
Communication with nurses	75%	76%	1%	78%	79%	1%	-3%	-3%
Communication with doctors	78%	78%	0%	81%	82%	1%	-3%	-4%
Responsiveness of hospital staff	60%	60%	0%	67%	68%	1%	-7%	-8%
Pain management	68%	67%	-1%	71%	71%	0%	-3%	-4%
Communication about medications	60%	60%	0%	64%	65%	1%	-4%	-5%
Cleanliness and quietness	61.0%	61.5%	0.5%	66.5%	68.0%	1.5%	-5.5%	-6.5%
Discharge information	84%	86%	2%	85%	86%	1%	-1%	0%
Overall rating of hospital	65%	65%	0%	70%	71%	1%	-5%	-6%

2. FY 2018 VBP and QBR Measures, Performance Standards, and Domain Weighting

HSCRC staff examined measures finalized for the CMS VBP Program for FY 2018 in the 2016 CMS Inpatient Prospective Payment System (IPPS) Final Rule, as well as those in the potential pool for the QBR Program for 2018. Appendix III details the measures by domain and the available published performance standards for each measure. It also indicates the measures that will be included in the VBP and QBR Programs. Staff note that one process of care measure remains—PC-01 Elective Delivery Before 39 Weeks Gestation—and is now part of the Safety domain that also comprises the CDC NHSN measures.

In proposing updated measure domain weights based on the VBP measure domain weights published in the CMS IPPS Final Rule, staff considered the following:

- The measures and domains available for adoption in the QBR rate year FY 2018
- Maryland's continued need to improve on the HCAHPS measures, and addition of the Care Transition (CTM-3) measure, an area of critical importance to the All-Payer Model success
- Number of measures in each domain, for example the Clinical Care domain comprising only the inpatient all-cause mortality measure, different number of measures for each hospital in Safety domain due to low cell sizes for some of the measures

Figure 4 below illustrates the CMS VBP final domain weights for FY 2018 and the QBR proposed domain weights for FY 2018 compared to the domain weights from FY 2017.

Figure 3. Final Measure Domain Weights for the CMS Hospital VBP Program and Proposed Domain Weights for the QBR Program, FY 2018

	Clinical Care	**Patient experience of Care/ Care Coordination**	Safety	Efficiency
QBR FY 2017	15% (1 measure- mortality) 5% (clinical process measures)	45% (8 measures- HCAHPS)	35% (3 infection measures, PSI)	PAU
Proposed QBR FY 2018	15% (1 measure- mortality)	50% (9 measures- HCAHPS + CTM)	35% (8 measures- Infection, PSI, PC -01)	PAU
CMS VBP FY 2018	25% (3 measures- condition specific mortality	25% (9 measures- HCAHPS + CTM)	25% (8 measures- Infection, PSI, PC -01)	25%

Staff vetted the draft recommendation with relevant stakeholders. The draft recommendation was sent via e-mail to the members of the QBR Subgroup of the Performance Measurement Workgroup discussed at the in-person QBR Subgroup meeting on August 24, 2015. Hospital representatives and Maryland Hospital Association (MHA) staff voiced their concerns that 50 percent weighting of the Patient Experience/Care Coordination domain was too high, and that this area has proved difficult to improve upon. In their correspondence of August 27, 2015, approving the FY 2016 VBP Exemption (Appendix I), the Innovation Center notes Maryland's significantly lagged performance on HCAHPS and supports increasing the weighting by 5 percent. Hospital representatives and MHA staff also noted that it would be useful to analyze to what extent small sizes impacted the number of measures that may be used for QBR on a hospital-specific basis in the Safety domain. Staff modeled FY 2016 performance data in their analysis and found that the vast majority of hospitals had data for 7 or 8 measures out of 8 in the Safety domain (See Appendix IV). HSCRC received CareFirst's letter in response to the draft recommendation presented in the September Commission meeting in which Jonathan Blum indicates CareFirst's support of the recommendation, specifically noting that the changes will bring better overall alignment of the structure and weighting of the Maryland program with the VBP program as well as provide stronger incentives to improve performance and meet the All-payer model agreement requirements (Appendix V).

Staff has identified key decision points for calculating hospital QBR scores. CMS rules will be used when possible for minimum measure requirements for scoring a domain and for readjusting domain weighting if a measurement domain is missing for a hospital. Staff will also score

hospitals on attainment only for any measures obtained from the CMS Hospital Compare website where only performance period data is available (i.e., base period data is missing such that improvement cannot be assessed). Furthermore, staff will consider giving a score of zero for hospitals that are missing both base period and performance period data on Hospital Compare. Hospitals are strongly encouraged to review their data as soon as it is available and to contact CMS with any concerns related to preview data or issues with posting data to Hospital Compare, and to alert HSCRC staff in a timely manner if issues cannot be resolved. Hospitals will be required to have scores on at least 2 out of 3 of the QBR Domains to be included in the program.

Staff note again that the established revenue "at risk" magnitude for the CMS VBP Program is set at 2 percent for 2017.

A memo summarizing the updates to the QBR methodology, base period data, and preset revenue adjustment scale will be sent to the hospitals shortly after CY 2014 data is available on Hospital Compare (estimated release mid-October 2015).

D. RECOMMENDATIONS

For the QBR Program, staff provide the following recommendations:

1. Continue to allocate 2 percent of hospital-approved inpatient revenue for QBR performance in FY 2018 to be finalized by the Aggregate Revenue "at risk" recommendation.
2. Adjust measurement domain weights to include: 50 percent for Patient Experience/Care Transition, 35 percent for Safety, and 15 percent for Clinical Care.

APPENDIX I. CMS INNOVATION CENTER CORRESPONDENCE APPROVING THE FY 2016 VBP EXEMPTION REQUEST

DEPARTMENT OF HEALTH & HUMAN SERVICES Office of the Administrato
Washington, D.C. 20201

August 27, 2015

Ms. Donna Kinzer
Executive Director, Maryland Health Services Cost Review Commission
State of Maryland Department of Health and Mental Hygiene
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Kinzer:

Thank you for your letter, on behalf of the State of Maryland, requesting an exemption from the FY 2016 Hospital Value-Based Purchasing (VBP) Program. As you know, Section 4(e) of the Maryland All-Payer Model Agreement provides that CMS will waive the VBP Program requirements for Maryland hospitals, as set out in Section 1886(o) of the Social Security Act and implementing regulations at 42 CFR 412.160 - 412.167, provided that the State submits "an annual report to the Secretary that provides satisfactory evidence that a similar program in the State for Regulated Maryland Hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under 1886(o) of the Act."

The Centers for Medicare & Medicaid Services (CMS) has reviewed your exemption request and supporting documentation. We officially grant the State of Maryland's exemption request for its hospitals as authorized by Section 1886(o)(I)(C)(iv) of the Act based on the fact that the Maryland program achieved or exceeded patient health outcomes measured in the Hospital VBP Program. CMS has also determined that the Maryland program meets the cost savings requirement for exemption from the Hospital VBP Program for FY 2015 because both programs reward high performers in a revenue-neutral manner.

Last year, when approving your request for an exemption from the Hospital VBP Program for FY 2014, we noted that your state's performance in the Patient Experience of Care domain significantly lagged behind national medium performance levels, and we strongly encouraged you to take steps to improve performance in that domain. Maryland's performance continues to lag behind the nation in Patient Experience of Care, however, as you indicated in your exemption request, you have assigned comparatively more weight to Hospital Consumer Assessment of Healthcare Providers and Systems performance in the Maryland program, and you are considering increasing that weight by an additional 5%. We support these efforts to improve Patient Experience of Care and we are eager to assist you in helping hospitals improve in this domain by other means.

Should you have any questions, please do not hesitate to contact the Maryland All Payer Model Team.

Sincerely,

Patrick Conway, MD, MSc

Acting Principal Deputy Administrator, CMS

Chief Medical Officer, CMS

Deputy Administrator for Innovation and Quality, CMS

Director, Center for Medicare and Medicaid Innovation

APPENDIX II. FINAL QBR PROGRAM PAYMENT SCALING FOR RY 2016

HOSPITAL ID	HOSPITAL NAME	FY 2015 PERMANENT INPATIENT REVENUE*	QBR FINAL POINTS	SCALING BASIS	REVENUE IMPACT OF SCALING	REVENUE NEUTRAL ADJUSTED REVENUE IMPACT OF SCALING	REVENUE NEUTRAL ADJUSTED PERCENT
A	B	C	D	E	F = C*E	G	H=(C+G)/C-1
210003	PRINCE GEORGE	$176,633,176.79	0.204	-1.000%	-$1,766,332	-$1,766,332	-1.000%
210024	UNION MEMORIAL	$239,732,514.10	0.236	-0.848%	-$2,032,700	-$2,032,700	-0.848%
210013	BON SECOURS	$75,937,921.77	0.237	-0.842%	-$639,466	-$639,466	-0.842%
210017	GARRETT COUNTY	$18,608,187.37	0.243	-0.811%	-$150,839	-$150,839	-0.811%
210061	ATLANTIC GENERAL	$38,616,312.78	0.262	-0.721%	-$278,422	-$278,422	-0.721%
210010	DORCHESTER	$23,804,066.20	0.300	-0.536%	-$127,696	-$127,696	-0.536%
210062	SOUTHERN MARYLAND	$161,253,765.94	0.306	-0.506%	-$815,828	-$815,828	-0.506%
210056	GOOD SAMARITAN	$178,635,337.98	0.316	-0.457%	-$817,238	-$817,238	-0.457%
210023	ANNE ARUNDEL	$308,739,340.58	0.324	-0.420%	-$1,297,299	-$1,297,299	-0.420%
210034	HARBOR	$122,412,281.84	0.337	-0.355%	-$434,912	-$434,912	-0.355%
210015	FRANKLIN SQUARE	$282,129,811.54	0.338	-0.351%	-$990,065	-$990,065	-0.351%
210004	HOLY CROSS	$319,832,140.30	0.347	-0.309%	-$989,139	-$989,139	-0.309%
210057	SHADY GROVE	$231,030,091.92	0.366	-0.215%	-$497,403	-$497,403	-0.215%
210055	LAUREL REGIONAL	$77,138,956.35	0.369	-0.203%	-$156,364	-$156,364	-0.203%
210038	UMMC MIDTOWN	$137,603,928.30	0.370	-0.199%	-$273,596	-$273,596	-0.199%
210060	FT. WASHINGTON	$17,901,765.04	0.373	-0.183%	-$32,819	-$32,819	-0.183%
210016	WASHINGTON ADVENTIST	$160,049,372.87	0.379	-0.153%	-$245,350	-$245,350	-0.153%
210018	MONTGOMERY GENERAL	$87,866,457.56	0.387	-0.117%	-$102,775	-$102,775	-0.117%
210011	ST. AGNES	$238,960,906.16	0.390	-0.099%	-$236,680	-$236,680	-0.099%
210022	SUBURBAN	$182,880,097.32	0.391	-0.095%	-$174,048	-$174,048	-0.095%
210002	UNIVERSITY OF MARYLAND	$869,783,533.93	0.392	-0.089%	-$777,220	-$777,220	-0.089%
210035	CHARLES REGIONAL	$76,417,733.97	0.399	-0.057%	-$43,855	-$43,855	-0.057%
210001	MERITUS	$188,367,775.67	0.415	0.020%	$37,886	$23,050	0.012%
210037	EASTON	$95,655,306.19	0.420	0.045%	$42,869	$26,081	0.027%
210019	PENINSULA REGIONAL	$232,896,407.52	0.439	0.139%	$323,230	$196,651	0.084%
210040	NORTHWEST	$141,883,177.42	0.446	0.169%	$240,213	$146,144	0.103%
210051	DOCTORS COMMUNITY	$136,010,793.59	0.446	0.169%	$230,271	$140,095	0.103%
210039	CALVERT	$67,061,372.88	0.447	0.174%	$116,461	$70,854	0.106%
210005	FREDERICK MEMORIAL	$190,475,900.63	0.455	0.216%	$411,978	$250,644	0.132%
210029	HOPKINS BAYVIEW MED CTR	$354,237,613.19	0.460	0.239%	$845,105	$514,157	0.145%
210006	HARFORD	$46,774,506.17	0.461	0.245%	$114,535	$69,683	0.149%
210030	CHESTERTOWN	$29,287,619.34	0.462	0.250%	$73,134	$44,494	0.152%
210048	HOWARD COUNTY	$167,430,726.52	0.476	0.318%	$531,634	$323,443	0.193%
210044	G.B.M.C.	$200,727,664.89	0.478	0.327%	$656,806	$399,596	0.199%
210032	UNION HOSPITAL OF CECIL COUNT	$67,638,499.19	0.488	0.375%	$253,429	$154,185	0.228%
210008	MERCY	$232,326,849.10	0.504	0.453%	$1,052,795	$640,513	0.276%
210012	SINAI	$428,400,532.05	0.505	0.456%	$1,953,758	$1,188,653	0.277%
210009	JOHNS HOPKINS	$1,303,085,115.22	0.512	0.490%	$6,390,980	$3,888,230	0.298%
210033	CARROLL COUNTY	$136,537,812.51	0.516	0.510%	$696,104	$423,505	0.310%
210028	ST. MARY	$69,990,405.25	0.525	0.554%	$387,680	$235,862	0.337%
210049	UPPER CHESAPEAKE HEALTH	$153,131,633.20	0.531	0.583%	$892,707	$543,117	0.355%
210043	BALTIMORE WASHINGTON MEDICAL CENTER	$224,082,797.59	0.552	0.684%	$1,533,183	$932,778	0.416%
210063	UM ST. JOSEPH	$230,010,193.37	0.609	0.961%	$2,209,908	$1,344,493	0.585%
210027	WESTERN MARYLAND HEALTH SYSTEM	$182,494,313.32	0.657	1.192%	$2,175,921	$1,323,816	0.725%
	Statewide	**$8,904,474,715**			**$8,290,541**	**$0**	0.000%

***FY 2015 Permanent IP Revenue = FY 2015 Total GBR Revenue + out of state and other non-GBR revenue x percent inpatient revenue from FY 2013**

				Rewards	21,170,587	0.608	ratio of rewards/penalties
		Average Score	41.07%	Penalties	-12,880,046		

APPENDIX III FY2018 VBP AND QBR MEASURES AND PERFORMANCE BENCHMARKS AND THRESHOLDS

Measure ID	Description	Achievement threshold	Benchmark
Safety			
CAUTI	National Healthcare Safety Network Catheter-associated Urinary Tract Infection Outcome Measure.	0.906	0
CLABSI	National Healthcare Safety Network Central Line-associated Bloodstream Infection Out- come Measure.	0.369	0
CDI (new QBR FY 2018)	National Healthcare Safety Network Facility- wide Inpatient Hospital-onset *Clostridium difficile* Infection Outcome Measure.	0.794	0.002
MRSA bacteremia (new QBR FY 2018)	National Healthcare Safety Network Facility- wide Inpatient Hospital-onset Methicillin-re- sistant *Staphylococcus aureus* Bacteremia Outcome Measure.	0.767	0
PSI–90 (VBP)	Patient safety for selected indicators (com- posite).	0.577321	0.397051
	American College of Surgeons—Centers for Disease Control and Prevention Har- monized Procedure Specific Surgical Site Infection Outcome Measure.		
PSI-90 (QBR)	All-Payer	TBD	TBD
Colon and Abdominal	• Colon	• 0.824	• 0.000
Hysterectomy SSI	• Abdominal Hysterectomy	• 0.710	• 0.000
PC–01	Elective Delivery before 39 weeks	0.020408	0
Clinical Care Measures			
MORT–30–AMI	Hospital 30-Day, All-Cause, Risk-Standard- ized Mortality Rate Following Acute Myo- cardial Infarction Hospitalization *.	0.851458	0.871669
MORT–30–HF	Hospital 30-Day, All-Cause, Risk-Standard- ized Mortality Rate Following Heart Fail- ure *.	0.881794	0.903985
MORT–30–PN	Hospital 30-Day, All-Cause, Risk-Standard- ized Mortality Rate Following Pneumonia Hospitalization *.	0.882986	0.908124
(VBP Only, condition specific measures not in QBR)			
Mortality	Inpatient All-Payer, All Cause	TBD	TBD
(MARYLAND)			
Efficiency and Cost Reduction Measure			
MSPB–1 (not included in QBR)	Payment-Standardized Medicare Spending per Beneficiary	Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period.	Mean of the lowest decile Medicare Spending per Beneficiary ratios across all hospitals during the performance period.
Patient and Caregiver-Centered Experience of Care/Care Coordination	Floor (percent)	Achievement threshold (percent)	Benchmark (percent)
Communication with Nurses	55.27	78.52	86.68
Communication with Doctors	57.39	80.44	88.51
Responsiveness of Hospital Staff	38.4	65.08	80.35
Pain Management	52.19	70.2	78.46
Communication about Medicines	43.43	63.37	73.66
Hospital Cleanliness & Quietness	40.05	65.6	79
Discharge Information	62.25	86.6	91.63
3-Item Care Transition	25.21	51.45	62.44
Overall Rating of Hospital	37.67	70.23	84.58

APPENDIX IV. HOSPITAL SPECIFIC COUNTS OF SAFETY DOMAIN MEASURES MODELED USING FY 2016 PERFORMANCE DATA

Hosp ID	Hospital Name	CLABSI	CAUTI	SSI-Colon	SSI-Hysterectomy*	MRSA	C. diff	PC -01	PSI-90 (CY14)	Count of Measures
210001	MERITUS MEDICAL CENTER	0.586	1.057	0	0	0.939	1.196	Not Available	0.399	7
210002	UNIVERSITY OF MARYLAND MEDICAL CENTER	0.54	2.353	2.437	0	2.191	1.274	1	0.722	8
210003	PRINCE GEORGES HOSPITAL CENTER	0.236	0.06	1.599	<1 predicted	2.004	0.549	20	0.733	7
210004	HOLY CROSS HOSPITAL	0.888	1.407	0.112	1.787	0.604	1.127	1	0.779	8
210005	FREDERICK MEMORIAL HOSPITAL	1.037	0.854	1.914	0.988	3.174	0.724	4	0.920	8
210006	UNIVERSITY OF MARYLAND HARFORD MEMORIAL HOSPITAL	<1 predicted	1.696	<1 predicted	Not Applicable	<1 predicted	0.441	shorter/no cases met criteria	0.800	3
210008	MERCY MEDICAL CENTER INC	0.431	1.654	1.029	1.93	1.445	1.086	8	0.917	8
210009	JOHNS HOPKINS HOSPITAL, THE	0.628	1.179	1.642	2.944	1.598	1.06	0	0.819	8
210011	SAINT AGNES HOSPITAL	0.678	1.64	0	0	0.216	1.759	0	0.646	8
210012	SINAI HOSPITAL OF BALTIMORE	0.855	4.465	1.418	3.088	1.382	1.071	Not Available	0.660	7
210013	BON SECOURS HOSPITAL	0.455	2.508	<1 predicted	Not Applicable	0.896	0.943	Not Available	0.656	5
210015	MEDSTAR FRANKLIN SQUARE MEDICAL CENTER	0.524	2.648	0.422	0.519	1.012	1.315	0	0.653	8
210016	ADVENTIST HEALTHCARE WASHINGTON ADVENTIST HOSPITAL	0.164	0.679	1.869	0.707	0.422	1.695	6	0.768	8
210017	GARRETT COUNTY MEMORIAL HOSPITAL	<1 predicted	<1 predicted	<1 predicted	<1 predicted	<1 predicted	0.788	4	1.059	3
210018	MEDSTAR MONTGOMERY MEDICAL CENTER	0	0.831	0.827	0	0.637	0.653	0	1.134	8
210019	PENINSULA REGIONAL MEDICAL CENTER	0.127	3.135	0.539	1.036	2.268	1.495	0	0.447	8
210022	SUBURBAN HOSPITAL	0.194	1.548	0	1.653	1.202	1.962	Not Available	0.770	7
210023	ANNE ARUNDEL MEDICAL CENTER	Not Available	Not Available	Not Available	Not Available	Not Available	Not Available	2	0.705	2
210024	MEDSTAR UNION MEMORIAL HOSPITAL	0.116	0.239	0.56	0	1.738	0.869	shorter/no cases met criteria	1.011	7
210027	WESTERN MARYLAND REGIONAL MEDICAL CENTER	0	2.102	1.928	<1 predicted	0.56	1.529	0	0.663	7
210028	MEDSTAR SAINT MARY'S HOSPITAL	0	1.543	0	<1 predicted	2.298	1.342	0	0.741	7
210029	JOHNS HOPKINS BAYVIEW MEDICAL CENTER	0.383	1.818	<1 predicted	1.289	2.468	1.011	0	0.510	7
210030	UNIVERSITY OF MD SHORE MEDICAL CTR AT CHESTERTOWN	<1 predicted	<1 predicted	<1 predicted	<1 predicted	<1 predicted	0.946	shorter/no cases met criteria	excluded due	1
210032	UNION HOSPITAL OF CECIL COUNTY	<1 predicted	<1 predicted	1.852	<1 predicted	<1 predicted	1.425	10	0.742	4
210033	CARROLL HOSPITAL CENTER	0	1.142	0.221	0	0.805	1.103	0	0.546	8
210034	MEDSTAR HARBOR HOSPITAL	0.417	1.387	0	0.548	0.52	0.569	shorter/too few cases to report	0.703	7
210035	UNIVERSITY OF MD CHARLES REGIONAL MEDICAL CENTER	0.455	0	0	<1 predicted	0	1.4	0	0.668	7
210037	UNIVERSITY OF MD SHORE MEDICAL CENTER AT EASTON	<1 predicted	0.831	1.818	<1 predicted	0	0.374	3	0.894	6
210038	UNIVERSITY OF MD MEDICAL CENTER MIDTOWN CAMPUS	1.359	0.538	<1 predicted	<1 predicted	<1 predicted	0.867	shorter/no cases met criteria	1.092	4
210039	CALVERT MEMORIAL HOSPITAL	<1 predicted	<1 predicted	<1 predicted	<1 predicted	0	0.962	8	1.022	4
210040	NORTHWEST HOSPITAL CENTER	0.335	2.636	1.664	<1 predicted	1.025	0.887	shorter/no cases met criteria	0.630	6
210043	UNIVERITY OF MD BALTO WASHINGTON MEDICAL CENTER	0	2.051	1.798	0	<1 predicted	1.448	2	0.626	7
210044	GREATER BALTIMORE MEDICAL CENTER	0.792	0.278	1.582	1.001	0.842	0.992	1	0.720	8
210045	EDWARD MCCREADY MEMORIAL HOSPITAL	Measures does not apply for this reporting period	Measures does not apply for this reporting period	Results not available for this reporting period	Not Applicable	<1 predicted	<1 predicted	Not Available	excluded due	0
210048	HOWARD COUNTY GENERAL HOSPITAL	0.236	1.143	0	0.932	0.347	1.004	2	0.808	8
210049	UNIVERSITY OF M D UPPER CHESAPEAKE MEDICAL CENTER	0	3.052	1.145	<1 predicted	1.175	0.669	3	0.509	7
210051	DOCTORS' COMMUNITY HOSPITAL	0.207	0.214	<1 predicted	0	0	1.192	Not Available	1.027	6
210055	LAUREL REGIONAL MEDICAL CENTER	0.774	0	<1 predicted	<1 predicted	1.819	0.723	Not Available	0.658	5
210056	MEDSTAR GOOD SAMARITAN HOSPITAL	0.683	0.274	1.99	<1 predicted	0.389	1.727	shorter/no cases met criteria	0.694	6
210057	ADVENTIST HEALTHCARE SHADY GROVE MEDICAL CENTER	0.428	1.01	0.699	0	2.007	1.404	4	0.681	8
210060	FORT WASHINGTON HOSPITAL	<1 predicted	<1 predicted	<1 predicted	<1 predicted	<1 predicted	0	Not Available	0.831	2
210061	ATLANTIC GENERAL HOSPITAL	<1 predicted	<1 predicted	0.587	<1 predicted	<1 predicted	0.485	Not Available	1.125	3
210062	MEDSTAR SOUTHERN MARYLAND HOSPITAL CENTER	0.297	0	0	0	2.234	1.508	4	0.774	8
210063	UNIVERSITY OF MARYLAND ST JOSEPH MEDICAL CENTER	Not Available	Not Available	Not Available	Not Applicable	Not Available	Not Available	3	0.469	2
	Statewide								Average	6.045454545
									Median	7
									Minimum	0
									Maximum	8

*SSI-hystertectomy values shaded in grey are from MHCC. These are hospitals that with 12 months of data are estimated to have >1 predicted but currently have < 1 predicted in the 9 months of data on CMS Hospital Compare

APPENDIX V. CAREFIRST COMMENT LETTER

CareFirst BlueCross BlueShield
1501 S. Clinton Street
Baltimore, MD 21224-5730

CareFirst BlueCross BlueShield

September 17, 2015

John M. Colmers
Chairman, Health Services Cost Review Commission
4201 Patterson Avenue
Baltimore, Maryland 21215

Donna Kinzer
Executive Director, Health Services Cost Review Commission
4201 Patterson Avenue
Baltimore, Maryland 21215

Re: Draft Recommendation on Revisions to the Quality Based Reimbursement (QBR) Program for Rate Year (RY) 2018

Dear Mr. Colmers and Ms. Kinzer:

Thank you for this opportunity to provide comments on the Staff's Draft Recommendation for Updating the HSCRC's Quality Based Reimbursement (QBR) Policy for RY 2018. As you know, Section 4(e) of the Maryland All-Payer Model Agreement indicates that the Center for Medicare and Medicaid Services (CMS) will waive the federal Value Based Purchasing (VBP) program requirements for Maryland hospitals provided that the State can demonstrate that Maryland hospital performance achieves or surpasses the measured results (in terms of specified patient outcomes and safety and satisfaction measures) of hospitals nationally.

CareFirst supports the Staffs' recommended changes, which better align the categorical weights with the CMS program. Overall, we believe these changes will better align the structure and weighting of the Maryland program with the VBP, provide stronger overall incentives to encourage Maryland hospital performance improvement and satisfy the performance-based payment policies under the demonstration agreement.

As always, we sincerely appreciate the work of the Staff and the Commission to ensure these policies are routinely assessed and updated to meet our challenging waiver targets.

Sincerely,

Jonathan Blum
Executive Vice President
Medical Affairs

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-207 and 19-214; Insurance Article, §§ 14-502 and 14-504; Annotated Code of Maryland

NOTICE OF FINAL ACTION

On October 14, 2015, the Health Services Cost Review Commission adopted amendments to Regulation **.26-1** under **COMAR 10.37.10 "Rate Application and Approval Procedures."** This action, which was proposed for adoption in 42:15 Md. R. 1026-1027 (July 24, 2015), has been adopted as proposed.

Effective Date: October 24, 2015

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

.08 Authorization Requirements.

A. (text unchanged)

[B. For services outlined in COMAR 10.21.25.05, the specialty mental health utilization review agent may authorize up to 12 visits per fiscal year.]

[C.] *B.* The ASO shall authorize services that are:

(1)—(2) (text unchanged)

(3) Delivered in a manner consistent with [COMAR 10.21.17.03] *this chapter*.

[D.] *C.* (text unchanged)

[E.] *D.* Except as provided in Regulation [.07D] *.08C* of this chapter, no payment shall be rendered for services that have not been authorized.

.09 Payment Procedures.

A. (text unchanged)

B. A provider shall deliver and document services in accordance with Department regulations in order to receive reimbursement.

[B.] *C.* Unless [otherwise stipulated] *the care is free to other patients*, a provider shall bill the Program its usual and customary charge to the general public [for similar services].

[C.] *D.*—[D.] *E.* (text unchanged)

[E.] *F.* A provider may not bill the Program for:

(1)—(2) (text unchanged)

(3) Professional services rendered by mail or telephone; *or*

[(4) Services which are provided at no charge to the general public, except as provided under Title V of the Social Security Act; or]

[(5)] *(4)* Services not authorized consistent with Regulation [.07E] *.08* of this chapter.

[F.] *G.*—[G.] *H.* (text unchanged)

.12 [Provider Complaints, Hearings, and Appeals] *Appeal Procedures for Providers.*

Appeal procedures *for providers* are as set forth in COMAR 10.09.36.09.

.13 [Grievance Procedure and] Appeal Rights — Denial of Services.

[Grievance] *Appeal* procedures *for applicants and participants* are as set forth in COMAR 10.01.03 and 10.01.04.

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 15 FOOD

10.15.07 Shellfish Sanitation

Authority: Health-General Article, §§ 18-102, 21-211, 21-234, *21-235*, 21-304, 21-321, and 21-346—21-350, Annotated Code of Maryland

Notice of Proposed Action

[15-199-P-I]

The Secretary of Health and Mental Hygiene proposes to amend Regulation **.01** under **COMAR 10.15.07 Shellfish Sanitation**.

Statement of Purpose

The purpose of this action is to update to the most recent revision the incorporation by reference of the National Shellfish Sanitation Program Guide for the Control of Molluscan Shellfish.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499 (TTY 800-735-2258), or email to dhmh.regs@maryland.gov, or fax to 410-767-6483. Comments will be accepted through August 24, 2015. A public hearing has not been scheduled.

Editor's Note on Incorporation by Reference

Pursuant to State Government Article, §7-207, Annotated Code of Maryland, the National Shellfish Sanitation Program (NSS), Guide for the Control of Molluscan Shellfish, 2013 Revision, has been declared a document generally available to the public and appropriate for incorporation by reference. For this reason, it will not be printed in the Maryland Register or the Code of Maryland Regulations (COMAR). Copies of this document are filed in special public depositories located throughout the State. A list of these depositories was published in 42:1 Md. R. 9 (January 9, 2015), and is available online at www.dsd.state.md.us. The document may also be inspected at the office of the Division of State Documents, 16 Francis Street, Annapolis, Maryland 21401.

.01 Incorporation by Reference.

In this chapter, the following documents are incorporated by reference:

A. National Shellfish Sanitation Program Guide for the Control of Molluscan Shellfish, [2011] *2013* Revision, Section I. Purpose and Definitions and Section II. Model Ordinance, except for Chapter IV, Shellstock Growing Areas; and

B. (text unchanged)

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207 and 19-214; Insurance Article, §§14-502 and 14-504; Annotated Code of Maryland

Notice of Proposed Action

[15-200-P]

The Health Services Cost Review Commission proposes to amend Regulation **.26-1** 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 May 13, 2015, notice of which was given pursuant to General Provisions Article , §3-301(c), Annotated Code of Maryland.

Statement of Purpose

The purpose of this action is to impose a moratorium on the Commission's Maryland Health Insurance Plan (MHIP) assessment for Fiscal Year 2016 in response to the Budget Reconciliation Act of 2015 changes to the program as of July 1, 2015.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. The action establishes a moratorium on the previously annual assessment to help fund the Maryland Health Insurance Plan (MHIP) for FY 2016.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	(R-)	Moderate
C. On local governments:	NONE	
	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	(+)	Moderate
E. On other industries or trade groups:	NONE	
F. Direct and indirect effects on public:	(+)	Minimal

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

B(1). The amount of $62.2 million represents what was assessed to hospital rates for FY 2015. Because of the provisions of the Affordable Care Act, MHIP is not providing health insuran coverage as of January 1, 2015.

D(2). The moratorium means that hospital rates will not be increased to cover the funding for MHIP. As a result of the Affordable Care Act, all Marylanders can now obtain health insurance notwithstanding the moratorium.

F(3). The public will be paying less for hospital charges as a result of the moratorium on this MHIP assessment. As a result of the Affordable Care Act, all Marylanders can now obtain health insurance notwithstanding the moratorium.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Diana Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215, or call 410-764-2576, or email to diana.kemp@maryland.gov, or fax to 410-358-6217. Comments will be accepted through August 24, 2015. A public hearing has not been scheduled.

.26-1 Maryland Health Insurance Plan (MHIP) Assessment.

A. (text unchanged)

B. The Commission shall assess each hospital up to 1 percent of its net patient revenue to operate and administer the MHIP. *There shall be no MHIP assessment for Fiscal Year 2016.*

C.—D. (text unchanged)

JOHN M. COLMERS
Chairman

Title 11
DEPARTMENT OF TRANSPORTATION

Subtitle 07 MARYLAND TRANSPORTATION AUTHORITY

Notice of Proposed Action

[15-197-P]

The Executive Director of the Maryland Transportation Authority proposes to:

(1) Amend Regulations **.01** and **.04** under **COMAR 11.07.02 Vehicle Size and Width Restrictions;**

(2) Amend Regulations **.02** and **.04** under **COMAR 11.07.05 Public Notice of Toll Schedule Revisions;**

(3) Amend Regulation **.02** and repeal Regulations **.06** and **.07** under **COMAR 11.07.10 Parking on Maryland Transportation Authority Property;** and

(4) Amend Regulations **.02** and **.05** and repeal Regulation **.16** under **COMAR 11.07.11 Public Use of Interstate 95 Service Plazas.**

This action was considered by the Chairman and members of the Maryland Transportation Authority at an open meeting held on November 20, 2014 notice of which was published pursuant to General Provisions Article, §3-301, Annotated Code of Maryland.

Statement of Purpose

The purpose of this action is to conform regulations to current business practice, to make the regulations' definitions consistent with statute, to remove redundant language from the regulations and to eliminate the regulations pertaining to and the references in other regulations to citations and penalties for parking on Maryland Transportation Authority Property and for infractions at the Interstate 95 Service Plazas.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed acti

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on sm businesses.

Impact on Individuals with Disabilities

The proposed action has an impact on individuals with disabiliti as follows:

The amendments to 11.07.11.05 broaden what animals are allowe in the Interstate 95 Service Plazas from the current regulation which only allows "guide dogs for the blind or hearing impaired" to include "service animals as defined in Human Services Article, §7-701, Annotated Code of Maryland"

State of Maryland
Department of Health and Mental Hygiene

John M. Colmers
Chairman

Herbert S. Wong, Ph.D.
Vice-Chairman

George H. Bone,
M.D.

Stephen F. Jencks,
M.D., M.P.H.

Jack C. Keane

Bernadette C. Loftus,
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Thomas R. Mullen

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Donna Kinzer
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

David Romans
Director
Payment Reform
and Innovation

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

Sule Calikoglu, Ph.D.
Deputy Director
Research and Methodology

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **October 14, 2015**

RE: **Hearing and Meeting Schedule**

November 18, 2015	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
December 9, 2015	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 11:45 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://www.hscrc.maryland.gov/commission-meetings-2015.cfm

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