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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**

Minutes to be included into the post-meeting packet

upon approval by the Commissioners

Executive Director's Report

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

New Model Monitoring Report

The Report will be distributed during the Commission Meeting

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF SEPTEMBER 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
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
FAX: (410) 358-6217

This document contains the final staff recommendations for updating the Quality-Based Reimbursement (QBR) Program for FY 2018 for consideration 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

Notice of Final Action

10.37.10.26-1

to be posted after adoption

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.

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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.