Health Services Cost Review Commission
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525th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
December 9, 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 – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-104**
2. **Commission Process Regarding Legislation - 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 November 18, 2015**

2. **Executive Director's Report**

3. **New Model Monitoring**

4. **Docket Status – Cases Closed**

   2304N – UM St. Joseph Medical Center
   2307A – Maryland Physician Care
   2308A – Priority Partners
   2310A – MedStar Family Choice
   2311A – MedStar Family Choice
   2314A – Riverside Health of Maryland
   2315A – Johns Hopkins Health System
   2316A – Johns Hopkins Health System
   2318A – University of Maryland Medical System

5. **Docket Status – Cases Open**

   2317R – Holy Cross Health
   2319R – Sheppard Pratt Health System
   2320N – Sheppard Pratt Health System
   2321A – Johns Hopkins Health System
   2322A – Johns Hopkins Health System
   2323A – Johns Hopkins Health System
   2324A – Johns Hopkins Health System
   2325A – Johns Hopkins Health System
   2326A – Johns Hopkins Health System
   2327A – Johns Hopkins Health System

6. **Final Staff Report Regarding Health Job Opportunity Program Proposal** - *approved as amended*

7. **Draft Recommendation for Maryland Hospital Acquired Condition (MHAC) Policy for Rate Year 2018**

8. **Confidential Data Request – Final Staff Recommendation** - *approved*

9. **Legal Report**

10. **Hearing and Meeting Schedule**

Closed Session Minutes
of the
Health Services Cost Review Commission

November 18, 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;
2. Consultation with Legal Counsel
3. Personnel Matters

The Closed Session was called to order at 12:03 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, Mullen and Wong.

In attendance representing Staff were Donna Kinzer, Steve Ports, Sule Gerovich, Claudine Williams, Amanda Vaughn, Jessica Lee, and Dennis Phelps.

Also attending were Eric Lindeman, Commission Consultant, and Leslie Schulman and Stan Lustman, Commission Counsel.

Item One

Stan Lustman, Commission Counsel, advised the Commission on the legal authority for a moratorium on full rate applications.

Item Two

Donna Kinzer, Executive Director, and Eric Lindeman, Commission Consultant, presented and the Commission discussed analyses of Medicare per beneficiary data.

Item Three

Steve Ports, Principal Deputy Director, presented a staff recommendation to reconvene the Advisory Council to provide stakeholder input on the long term vision for transformation of Maryland's payment and delivery system. The

Commission voted unanimously to approve staff's recommendation on the charge to the Council. The Commission indicated its intent to hold an Executive Session telephone call before the next Commission public meeting to vote on the appointment of Advisory Council members.

The Closed Session was adjourned at 1:05 p.m.

Closed Phone Conference Session Minutes
Of the
Health Services Cost Review Commission

December 4, 2015

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

1. Selection of new members to be added to the Advisory Council;

The Closed Session was called to order at 10:34 a.m. and held under authority of - §§ 3-103 and 3-104 of the General Provisions Article.

Participating by telephone, in addition to Chairman Colmers, were Commissioners Bone, Keane, Loftus, and Wong.

In attendance representing Staff were Donna Kinzer, Steve Ports, Jerry Schmith, Ellen Englert, Jessica Lee, and Dennis Phelps.

Also attending was Leslie Schulman, Commission Counsel.

Item One

Steve Ports, Principal Deputy Director, presented staff's recommendations on expanding the membership of the Advisory Council. After discussion involving the Commission and the Executive Director, the Commission voted unanimously to add seven new members to the Advisory Council. The members added were: Izzy Firth, Joe Dematttos, Ramani Peruvemba, Vince Ancona, Ben Steffen, Thomas Walsh, M.D., and Bruce Vladeck.

The Closed Session was adjourned at 11:00 p.m.

MINUTES OF THE
524th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

November 18, 2015

Chairman John Colmers called the public meeting to order at 12:05 pm. Commissioners George H. Bone, M.D., Stephen F. Jencks, M.D., MPH, Jack C. Keane, 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 1:10 pm.

REPORT OF THE NOVEMBER 18, 2015 EXECUTIVE SESSION

Mr. Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the November 18, 2015 Executive Session.

ITEM I
REVIEW OF THE MINUTES FROM OCTOBER 14, 2015 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the October 14, 2015 Executive Session and Public Meeting.

The Commissioners voted unanimously to ratify their vote on Staff's recommendation on the charge to the Advisory Council made in the Executive Session.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Executive Director, noted that staff has been paying attention to volume changes in hospitals. Ms. Kinzer stated that the success of the All-Payer Model is to reduce unplanned hospitalizations that could be avoided with better care, care coordination, and care integration. By reducing avoidable utilization, funds are freed up to allow for investing in care coordination, delivering new services, and implementing other initiatives. Staff is also attentive to Medicare growth in charges and utilization as the All-Payer Model has specific savings requirements for Medicare. Beginning this month, staff will provide reports on utilization trends to the Commission on a regular basis.

Ms. Kinzer noted the results of year 1 of the All-Payer Model are as follows:

- Calendar year 2014, statewide, all payer revenue per capita grew 1.47% below the 3.58% target.

- Hospital services for Maryland's Medicare beneficiaries generated $116 million of savings to Medicare.
- Total Medicare spending for Maryland beneficiaries was 1.5% lower than the national growth rate for the same period.
- Potentially preventable complications declined by 26%.
- The difference between Maryland and national Medicare readmission rates decreased by 0.21 percentage points.

Ms. Kinzer stated that with the All-Payer Model nearing its second year of operation, the Department of Health and Mental Hygiene (DHMH) and the Health Services Cost Review Commission (HSCRC) are reconvening the Advisory Council. The Council is now needed to provide advice on the potential future directions for Maryland's health care improvement and population health initiatives and the All-Payer progression. In order to create sustainability of the existing All-Payer model, the delivery system needs to develop partnerships and infrastructure that will help it improve care with resulting reductions in avoidable hospitalization and costs. Ms. Kinzer stated that the Agreement between the Centers for Medicare and Medicaid Services (CMS) calls for Maryland to submit a proposal for a new model no later than January 2017, which shall limit, at a minimum, the Medicare beneficiary total cost of care growth rate.

Ms. Kinzer reported that the HSCRC and DHMH are also working with the Center for Medicare & Medicaid Innovation (CMMI) to amend the existing All-Payer Model Agreement to allow for alignment activities needed to support the gains made in the first year and ensure they are sustainable in the future. Tools that are available to Accountable Care Organizations (ACOs) and bundled payment programs need to be made available to support the integration and care coordination activities needed. They include: sharing internal cost savings; pay-for-outcomes programs that share internal cost savings when avoidable and unnecessary utilization is decreased through improvements in care delivery; and investments in care coordination infrastructure and that supports care coordination in the community. To facilitate these activities, the model will need to be enhanced to provide protections similar to those granted to ACOs. In addition, staff will seek access to data to support care coordination, evaluation, and monitoring of results by providers, similar to data provided by CMS to ACOs and bundled payment providers.

Ms. Kinzer noted that DHMH is considering the development of an approach to address the need of dual eligible beneficiaries (those with both Medicare and Medicaid coverage). The development process will also include input from All-Payer Model Work Groups.

Ms. Kinzer stated that staff will be presenting a regulation today to establish a temporary moratorium on full rate reviews. This new regulation is necessary as the Commission's current policy does not adequately reflect the existing global budget revenue structure and the current system incentives to reduce potentially avoidable utilization that all acute hospitals are currently under.

Ms. Kinzer noted that the Commission previously issued moratorium of full rate reviews for

three years to accommodate the development and coding changes necessary to implement APR-DRGs. This regulation anticipates a much shorter moratorium while efficiency measures are being developed. Hospitals will continue to have all other rate relief remedies at their disposal.

Ms. Kinzer stated that staff has extended the submission date of the Transformation Implementation Program application by two weeks in order to give hospitals more time to refine the proposals. The new submission date is December 21, 2015. She noted that the reports of Regional Partnership Planning Grantees that receive funding in rates are still due December 7, 2015. Likewise, the Strategic Hospital Transformation Plans are also due on December 7, 2015.

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

- Continuing to review radiation therapy, infusion, and chemotherapy market shift adjustments with stakeholders.
- Reviewing Certificate of Need applications that have been filed. Staff has recently provided comments to the Maryland Health Care Commission regarding two applications.
- 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. It will be focused on ensuring the success of the All-Payer Model and providing a proposal no later than January 2017 as required under the All-Payer Model Agreement with CMS.

ITEM III
DOCKET STATUS CASES CLOSED

2300R- Washington Adventist Hospital
2309A– University of Maryland Medical Center
2312A– University of Maryland Medical Center
2313A– University of Maryland Medical Center

ITEM IV
DOCKET STATUS- OPEN CASES

2304N -UM St. Joseph Medical Center

On July 17, 2015 University of Maryland St. Joseph Center (the "Hospital"), a member of the University of Maryland Medical System, submitted a partial rate application to the Commission requesting a new rate for Definitive Observation (DEF) and Coronary Care (CCU) services. The Hospital requests that DEF and CCU rates be set at the lower of a rate based on its projected costs to provide DEF and CCU services or the statewide median rate. The Hospital would like

the new rates to be effective November 1, 2015.

Staff recommended:

- That the Medical Surgical Acute (MSG) rate of $1,162.16 per patient day be approved effective November 1, 2015;
- That a DEF rate of $1,120.45 per patient day be approved effective November 1, 2015;
- That a Medical Surgical Intensive Care (MIS) rate of $2,507.77 per patient day be approved effective November 1, 2015;
- That a CCU rate of $2,038.36 per patient day be approved effective November 1, 2015;
- That the MSG, DEF, MIS, and CCU rates not be rate realigned until a full year's cost experience has been reported to the Commission; and
- That no change be made to the Hospital's Global Budget Revenue.

The Commission voted unanimously to approve staff's recommendation

2307A- Maryland Physician Care

Mr. Steve Ports, Deputy Director Policy and Operations, summarized staff's final recommendation on the application filed by Saint Agnes Health System, Western Maryland Health System, Holy Cross Health, and Meritus Health (the "Hospitals"). The Hospitals are seeking approval for continued participation of Maryland Physician Care (MPC) in the Medicaid Health Choice Program. The Hospitals are requesting to renew the contract for one year beginning on January 1, 2016.

Staff recommended:

- Approval of the alternative rate application for one year period beginning January 1, 2016.
- That MPC report to the 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.
- That this approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

2308A- Priority Partners

Mr. Ports summarized staff's final recommendation on the application filed by Johns Hopkins Health System (the "System") on behalf of John Hopkins Hospital, Johns Hopkins Bayview Medical Center, Howard County General Hospital, and Suburban Hospital (the "Hospitals"). The System is seeking approval for continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. The Hospitals are requesting to renew the contract for one year

beginning on January 1, 2016.

Staff recommended:

- Approval of the alternative rate application for one year period beginning January 1, 2016.
- That Priority Partners Inc. report to the 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.
- That this approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2310A- MedStar Family Choice

Mr. Ports summarized Staff's final recommendation on the application of the MedStar Health System on behalf of Franklin Square Hospital, Good Samaritan, Harbor Hospital and Union Memorial Hospital. MedStar Health seeks renewal for continued participation of MedStar Family Choice ("MFC") in the Medicaid Health Choice Program for one year beginning in January 1, 2016.

Staff recommended:

- Approval of the alternative rate application for one year period beginning January 1, 2016.
- That MFC report to the 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.
- That this approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

2311A- MedStar Family Choice

On September 23, 2015, MedStar Health filed an application on behalf of Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital (the "Hospitals"). MedStar Health is seeking approval for MedStar Family Choice ("MFC") to continue to participate in a CMS approved Medicare Advantage Plan. MFC assumes the risk under this contract. The Hospitals are requesting an approval for one year beginning January 1,

2016.

Staff recommends that the Commission approve the Hospitals' request to continue to participate in the CMS Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation

2314A University of Maryland Medical Systems

Mr. Ports summarized Staff's final recommendation on the application of Riverside Health ("Riverside"), a Medicaid Managed Care Organization (MCO), on behalf of the University of Maryland Medical System Corporation (the "Hospitals). Riverside and the Hospitals seek approval for the MCO to continue to participate in the Medicaid Health Choice Program for one year beginning January 1, 2016.

Staff recommended:

- Approval of the alternative rate application for one year period beginning January 1, 2016.
- That Riverside report to the 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.
- That this approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

2315A- Johns Hopkins Health System

Johns Hopkins Health System (JHHS) filed an application on November 2, 2015 seeking approval for Hopkins Health Advantage Inc. (HHA) to participate in the CMS approved Medicare Advantage Plan. HHA is the JHHS entity that assumes the risk under this contract. JHHS is requesting an approval for one year beginning January 1, 2016.

Staff recommends that the Commission approve the JHHS request to participate in the CMS Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Chairman Colmers

recused himself from the discussion and vote.

2316A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on October 30, 2015 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") requesting approval from the HSCRC for continued participation in a capitation arrangement among the System, the Maryland Department of Health and Mental Hygiene (DHMH), and the CMS. The Hospital, doing business as Hopkins Elder Plus ("HEP"), serves as a provider in the federal "Program of All-inclusive Care for the Elderly ("PACE"). Under this program, HEP provides services for a Medicare and Medicaid dually eligible population of frail elderly. The requested approval is for a period of one year effective December 1, 2015.

Staff recommends that the Commission approve the Hospital's renewal application for an for an alternative method of rate determination for one year beginning December 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. Chairman Colmers recused himself from the discussion and vote.

2318A- University of Maryland Medical System

University of Maryland Medical System ("UMMS") filed an application on November 9, 2015 seeking approval for University of Maryland Health Advantage, Inc. ("UMHA") on behalf of its constituent hospitals (the "Hospitals") to participate in the CMS approved Medicare Advantage Plan. UMHA is the UMMS entity that assumes the risk under this contract. UMHA is requesting an approval for one year beginning January 1, 2016.

Staff recommends that the Commission approve the Hospitals' request to participate in the CMS Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2016, 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 V
LEGAL REPORT

Regulations

Final Action

Uniform Accounting and Reporting System for Hospitals and Related Institutions- COMAR 10.37.01.02

The purpose of this action is to update the Commission's Accounting and Budget Manual for Fiscal and Operating Management, which has been incorporated by reference. This action appeared in the October 2, 2015 issue of the Maryland Register (42:20 Md. R. 1268).

The Commission voted unanimously to approve the final adoption of the proposed regulation.

Rate Application and Approval Procedures- COMAR 10.37.10.10

The purpose of this action is to assure that rate applications are submitted in easily readable formats. This action appeared in the October 2, 2015 issue of the Maryland Register (42:20 Md. R. 1269).

The Commission voted unanimously to approve the final adoption of the proposed regulation.

Rate Application and Approval Procedure – COMAR 10.37.10.07-1

The purpose of this action is to conform COMAR to legislation passed in the 2015 Session of the General Assembly that established that outpatient services associated with the federal 340B Program and that meet certain criteria shall be considered "at the hospital" and thereby subject to HSCRC rate jurisdiction. This action appeared in the October 2, 2015 issue of the Maryland Register (42:20Md. R. 1268-1269).

The Commission voted unanimously to approve the final adoption of the proposed regulation.

Proposed and Emergency

Rate Application and Approved Procedures – COMAR 10.37.10.03 and 10.37.10.03-1

The purpose of this action is to establish a moratorium on the filing of regular rate applications pending the development and approval of rate efficiency measures that are consistent with all-payer model. This emergency regulation is for the period December 1, 2015 to May 1, 2016.

Commissioners discussed the regulation and revised the duration of the moratorium on the filing of full rate applications. The moratorium will be lifted by September 30, 2016 at the latest, with the hope that efficiency measures be developed by July 2016.

The Commission voted unanimously to forward the revised proposed regulation to the AELR Committee for review and publication in the Maryland Register as a proposed and emergency regulation.

ITEM VI
NEW MODEL MONITORING

Amanda Vaughn, Program Manager, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of September focuses on fiscal year (July 1 through June 30) as well as calendar year results.

Ms. Vaughn reported that for the three month period ended September 30, 2015, All-Payer total gross revenue increased by 3.18 % over the same period in FY 2014. All-Payer total gross revenue for Maryland residents increased by 3.34%; this translates to a per capita growth of 2.76%. All-Payer gross revenue for non-Maryland residents increased by 1.63%.

Ms. Vaughn reported that for the nine months of the calendar year ended September 30, 2015, All-Payer total gross revenue increased by 2.58% over the same period in CY 2014. All-Payer total gross revenue for Maryland residents increased by 2.92%; this translates to a per capita growth of 2.34%. All-Payer gross revenue for non-Maryland residents decreased by 0.79 %.

Ms. Vaughn reported that for the three months ended September 30, 2015, Medicare Fee-For-Service gross revenue increased by 4.05% over the same period in FY 2014. Medicare Fee-For-Service gross revenue for Maryland residents increased by 4.32%; this translates to a per capita growth of 1.30%. Maryland Fee-For-Service gross revenue for non-residents increased by 1.11%.

Ms. Vaughn reported that for the nine months of the calendar year ended September 30, 2015, Medicare Fee-For-Service gross revenue increased by 4.15%. Medicare Fee-For-Service gross revenue for Maryland residents increased by 4.75%; this translates to a per capita growth of 1.51%. Maryland Fee-For-Service gross revenue for non-residents decreased by 2.37%.

According to Ms. Vaughn, for the three months of the fiscal year ended September 30, 2015, unaudited average operating profit for acute hospitals was 3.32%. The median hospital profit was 3.99%, with a distribution of 1.43% in the 25th percentile and 6.49% in the 75th percentile. Rate Regulated profits were 7.68%.

Dr. Alyson Shuster, Ph.D., Associate Director Performance, presented a quality report update on the Maryland Hospital Acquired Conditions program based on readmission data on discharges through August 2015.

Readmissions

- The All-Payer risk adjusted readmission rate was 12.86 % for the period of January 2015 to August 2015. This is a cumulative decrease of 7.10% from the August 2013 risk adjusted readmission rate.

- The Medicare Fee for Service risk adjusted readmission rate was 13.72% for the period January 2015 to August 2015 YTD. This is an accumulated decrease of 5.96% from the August 2013 risk adjusted readmission rate.
- Based on the New-Payer Model, hospitals must reduce Maryland's readmission rate to or below the national Medicare readmission rate by 2018. The Readmission Reduction incentive program has set the goals for hospitals to reduce their risk adjusted readmission rate by 9.3% during CY2015 compared to CY2013. Currently, only 16 out of 46 hospitals have reduced their risk adjusted rate by more than 9.3%.

Dr. Sule Gerovich Ph.D., Deputy Director, presented utilization trend reports reflecting the Equivalent Case-Mix Adjusted Discharges (ECMAD) growth for the calendar ending September 2015.

Dr. Gerovich reported for the nine months of the calendar year ended September 30, 2015, All Payer ECMAD growth decreased by 0.69% over the same period in CY 2014. ECMAD growth for Maryland residents decreased by 0.49%. This is made up of Maryland inpatient and outpatient ECMAD decreasing by 0.47% and 0.53%. ECMAD growth for non-residents decreased by 2.95%.

Dr. Gerovich reported for the nine months of the calendar year ended September 30, 2015, Medicare ECMAD growth increased by 1.15% over the same period in CY 2014. ECMAD growth for Maryland residents increased by 1.53%. This is made up of Maryland inpatient and outpatient ECMAD increasing by 1.66% and 1.22%. ECMAD growth for non-residents decreased by 3.52%

ITEM VII
PRELIMINARY STAFF REPORT REGARDING HEALTH JOB OPPORTUNITY PROGRAM PROPOSAL

Ms. Kinzer provided a preliminary staff report on the Health Job Opportunity Program Proposal (the Proposal) introduced at the September 9, 2015 public meeting. The Proposal suggests that the HSCRC provide up to $40 million through hospital rates to establish about 1,000 entry level health jobs in areas of extreme poverty and unemployment. This proposal came about due to the unrest in Baltimore City and the belief that employment is an important element needed to change the current situation. 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.

Ms. Kinzer noted that the Payment Model Workgroup held a meeting on October 5th to discuss the Proposal and other topics. Program description materials and a series of questions were sent out prior to the meeting and are posted at the HSCRC website. Comments were also accepted from individuals attending the meeting.

The work group members and commenters expressed their appreciation for the leadership in bringing forward this job proposal.

The work group comments included:

- That it was 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, lowering costs.

- That it would be important to focus on jobs outside of the hospitals such as Community Health Workers. The concern was raised that the reduction of avoidable utilization in hospitals might reduce the need for some of the hospital jobs that were part of the Proposal.

- That the infrastructure adjustments already provided to hospitals or the additional amount that is slated for award in January 2016, which focuses on similar activities, would be duplicative.

- It was suggested that other funding sources be considered for Proposal implementation

- That if the Proposal were to move forward, much more detailed design work needs to take place.

Ms. Kinzer noted that a number of letters of support for the Proposal were sent in from public officials and other interested parties. These letters outline the need for jobs and support for the Proposal.

Ms. Kinzer noted that staff has several concerns about the Proposal:

- Staff is concerned about including traditional jobs inside of hospitals in a grant program. These should be funded through hospital budgets. Furthermore, if the health care transformation is successful, hospital usage should decline and there is a concern that individuals in need of jobs might be employed in jobs that would be eliminated, thereby defeating the purpose of the Program.
- Staff supports expanding hospital resources deployed for positions that support the transitions anticipated in the All Payer Model-- care coordination, population health, health, information exchange, health information technology, alignment, and consumer engagement. However, staff is concerned about the funding sources and the potential for overlap with the additional resources that are being provided through rates as noted above. Furthermore, there are hospital community benefit dollars that could potentially be deployed in this effort. Grants are another potential source of funding.

- In order to implement programs such as those described above, significant amounts of training and coaching would be required. The programs require significant design and dedication of resources. HSCRC staff believes that considerable development needs to take place to plan, develop, and execute these programs successfully, similar to the planning and development that have gone into nursing education programs in the past.
- The HSCRC staff acknowledges the importance of jobs creation in areas of high economic deprivation, but staff is concerned about HSCRC's role in addressing this issue

Based on the commentary received to date, HSCRC staff offers several options, in no particular order of preference, for discussion with the Commission and for further public input.

Option 1—Earmark 25% (approximately $10 million) of the .25% pool for competitive transformation implementation grant funds for hospitals committing to hire workers from geographic areas of high socioeconomic deprivation to fill new care coordination, population health, health information exchange, alignment, consumer engagement, and related positions. Hospitals should provide matching funds to increase the resources that could be deployed. Under this option, staff would anticipate proposals for the $10 million from hospitals in March 2016, with implementation beginning by July 2016.

Option 2—Set aside $5 million of the .25% competitive transformation implementation grant funds to provide one time seed money for Program implementation once design is complete with expectation of implementation by July 2016. Expect hospitals to fund positions from infrastructure in rates, community benefits funds, return on investment, hospital resources, and other grant, philanthropy, and foundation support. Under this option, staff would expect that program design would commence as soon as possible. The program design group would decide the best ways to deploy the $5 million in seed money including program development, training, coaching, funding of trainers, educators, coaches, etc. Hospitals would apply for the funds in March 2016, with anticipated implementation beginning by July 2016.

Option 3—Defer funding and have Proposers continue to develop Program design, implementation, and evaluation parameters by March 2016, together with AHECs and other job training resources, with a potential for future funding of some educational resources or seed funding in July 2016. Funding could potentially include program development, training, coaching, funding of trainers and coaches, etc. Expect hospitals to fund positions from infrastructure in rates, community benefits funds, hospital resources such as return on investment, and other grant, philanthropy, and foundation support. HSCRC staff would expect that the resources provided would not be greater than the $5 million noted in Option 2 above.

Any of these options would require considerable development and structuring for success and accountability and a fully developed evaluation process. If these or other options are pursued, resources will be needed to develop and administer the Program.

In summary, HSCRC staff understands the need for expansion of employment and for improvement in health outcomes and reductions in disparities for populations living in economically deprived areas of the State. The Commission has developed policies and programs and provided funding that supports reducing health disparities under the All Payer Model. Staff has provided several options for discussion by the Commission regarding additional progress that might be made in developing employment opportunities, while addressing changes in hospital employment that are needed to successfully reach the goals of the new All Payer Model and the State Health Improvement Plan.

Mr. Robert Murray, representing CareFirst of Maryland and Ms. Kimberly Robinson, Executive Director of the League of Life and Health Insurers of Maryland spoke in opposition to funding the Proposal by increasing rates.

Ms. Jen Brock-Cancellieri, Senior Policy Analyst 1198SEIU United Healthcare Workers East and Reverend Andrew Foster Connors Co-Chairman, Antoine Smith Leader, William Glover Bay Leader, and Robert English Organizational Leader of Baltimoreans United in Leadership Development spoke in favor of the Proposal.

No Commission action was necessary as this issue will be voted on in the December Public meeting.

ITEM VIII
UPDATE FROM PERFORMANCE MEASUREMENT WORK GROUP

Ms. Dianne Feeney, Associate Director, presented an update on the Performance Measurement Workgroup (See Performance Measurement Workgroup Update" on the HSCRC website).

ITEM IX
DISCLOSURE OF THE HOSPITAL FINANCIAL AND STATISTICAL DATA FOR FISCAL YEAR 2014

Mr. Dennis Phelps, Associate Director – Audit & Compliance summarized the annual disclosure of financial and statistical data for Maryland hospitals for FY 2014 (See "Disclosure of Hospital Financial and Statistical Data" on the HSCRC website). Major highlights of the report were:

- Gross per capital hospital revenue grew 1.6%, which was slower than the per capita growth in the Maryland economy of about 2%.
- Hospital profits on regulated activities increased from $677 million to $950 million.

- Hospital operating profits from regulated and unregulated activities increased from $164 million to $424 million.
- Excess profits total profits from all activities operating and non-operations increased from $549 million to $901 million
- Maryland hospitals incurred $1 billion in uncompensated care, approximately 7% of charges.
- Gross revenue associated with potentially preventable complications declined by 25% from $391 million to $292 million, and gross revenue from readmissions fell slightly from $1.306 billion to $1.285 billion. These reductions reflect improvement in the quality of care in Maryland Hospitals.

ITEM X
HEARING AND MEETING SCHEDULE

December 9, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
January 14, 2015	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:54 pm.

Executive Director's Report

Health Services Cost Review Commission

December 9, 2015

All Payer Results

In CY 2015, hospitals are continuing to produce strong all payer results. Volume growth is contained, and revenue growth is on track with approved global budgets. Planning for scaling care coordination is underway across the State, and infrastructure expansion to support care coordination has begun at Chesapeake Regional Information System for our Patients (CRISP), the designated statewide Health Information Exchange entity. In spite of the strong hospital performance, there are concerns regarding growth in total cost of care for Medicare beyond hospital costs, and the extent of the transformation effort that is needed to rapidly bring care coordination to scale, ensuring better care and reductions in avoidable Medicare hospital utilization — both of which are critical to balance under the All-Payer Model. HSCRC may need to make policy adjustments in the near term to ensure continued success of the Model. HSCRC also needs to work closely with the Maryland Hospital Association (MHA), the long term and post-acute provider associations, LifeSpan and Health Facilities Association of Maryland (HFAM), and other stakeholders to develop additional monitoring and reporting approaches to address these concerns.

Medicare Performance Monitoring

HSCRC staff has been working with the Center for Medicare and Medicaid Innovation (CMMI), MHA, and our contractors since we first received detailed data for monitoring the new All-Payer Model last December. We reconciled the data and have begun to develop trending reports. CMMI and HSCRC staff came to an agreement in November 2015 regarding sharing the interim analyses we prepare with hospitals and other stakeholders. These analyses are summaries of trends, and do not contain any patient level or protected data. As we begin to share these data, we need to do so with the understanding that the data may change, or that there could be changes in claims lags that affect our interpretation of the analyses.

In addition to hospital cost trends, CMMI also provides us with information regarding total cost of care trends for Medicare beneficiaries.

For CY 2015, we began to see costs outside of hospitals growing, particularly post-acute care costs. The information we receive for non-hospital costs has a longer claims lag time than the acute care data, so the information we are receiving about cost growth was received very recently. Our All-Payer Model Agreement with CMS requires us to focus on total cost of care within "guardrail" limits and to take action if we are not within the guardrails. As discussed in the following section, the HSCRC staff intends to accelerate analysis of post-acute care cost trends and to consider the need for a pay-for-performance program or any adjustments to global budgets if services are shifted across settings.

CMMI has also provided us with county level total cost of care trend data by type of service (hospital, post-acute, physician, etc.) for 2011 through 2014 for use in strategic planning. HSCRC will work with MHA and post-acute and long term care trade associations (LifeSpan and HFAM) to increase the amount of information that is available to providers for strategic planning as well as evaluating current Medicare trends. We have asked our contractors to create county level trend reports as well as drill downs on post-acute costs and other increasing trends.

MHA provides hospitals a dashboard report each month of key monitoring metrics. HSCRC will work with MHA to add supporting information for year over year hospital and total cost of care trends, plus total cost of care performance by type of service (skilled nursing, home health, etc.). We will work with MHA to develop target metrics that reflect the needed values for the Model. We will also work with MHA to provide hospitals with the total cost of care trend reports recently released to us by CMS.

Policy Development Strategies

Post-Acute

The increasing cost of post-acute care needs to be addressed quickly. In CY 2014, there was a decreasing trend in post-acute costs per beneficiary. Data for CY 2015 for services in the first six months of the calendar year show a rapidly increasing trend for CY 2015. HSCRC staff intends to address this in the following manner:

- Evaluate the sources and causes of post-acute cost increases.
- Evaluate the accuracy of the data and causes of growth, including increased referrals, post-acute length of stay changes, increased billing per episode, etc.
- Evaluate contract and policy implications once analysis is complete.
- Share the results of the analysis with acute and post-acute providers.

- In light of accelerating cost trends and the aim of CMS acceleration of payment models aimed at optimizing post-acute care, begin discussing options with hospitals, post-acute providers, and DHMH regarding more comprehensive acute/post-acute care models.
- Develop total cost of care performance measures, starting with Medicare, which can be applied with gain sharing or pay-for-outcomes programs to ensure that care redesign is taking place with consideration of the total health care system.

Reducing Avoidable Acute Hospitalizations

As reported in the last three Commission meetings, Maryland Medicare utilization (hospital inpatient and outpatient) for CY 2015 has increased over CY 2014. While there was a corresponding increase in beneficiaries and the per beneficiary figures for CY 2015 are lower than CY 2014, the All-Payer Model formulas used for rate setting assume a two percent difference in the per beneficiary/per capita growth for Medicare versus All Payer. HSCRC is watching the national Medicare trend data carefully to determine the impact on Medicare savings levels. The economic recovery and drug cost growth have contributed to Medicare utilization growth nationally, and we are focused on understanding the impact of these trends on national data as well as Maryland data.

In Maryland, the success of the All-Payer model is dependent on reducing avoidable utilization that can be achieved through care improvements. Reductions need to be accelerated through the implementation of care coordination and care redesign.

In order to achieve a sustainable decrease in avoidable hospitalizations, care delivery needs to be transformed. In particular,

- Providers need to deliver enhanced care coordination for complex and high needs patients;
- Long term and post-acute providers need to work with hospitals to improve care in ways that will prevent avoidable hospitalizations and re-hospitalizations; and
- Hospitals need to work with primary care and other community based providers caring for high needs patients and patients with multiple chronic conditions in order to coordinate care, improve health, and prevent avoidable hospitalizations.

HSCRC needs to establish specific goals for care coordination and reductions in avoidable utilization. These goals can be established on a regional basis. For example, as previously presented to the Commission, there are approximately 25,000 to 40,000 Medicare patients with high needs who may benefit from intense care coordination. There are another 240,000 Medicare patients with multiple chronic conditions who could benefit from chronic care management. The HSCRC needs to establish goals and measure progress toward those goals.

For example, goals may include:

- 20,000 high needs Medicare patients with care plans and care coordinators by the end of 2016.
- Another 40,000 patients with multiple chronic conditions and high levels of hospital utilization with care plans and chronic care management by the end of 2017, addressing a total of 60,000 patients.
- Chronic care management to scale in 2018, with 100,000 additional Medicare patients obtaining chronic care management.

Hospitals have budgets to initiate these activities and planning processes are underway. Success of the Model is dependent on the ability of providers to bring these models to scale for Medicare patients. Success is also dependent on integrating community based primary care and other community providers into the process of community based, chronic care management. Medicaid MCOs and commercial payers have already made progress in implementing approaches for high needs patients and Medicare needs to catch up in this area, as it represents the payer with the highest percentage of complex patients. This highlights the priority of bringing Medicare care strategies to scale, as we continue to make progress in conjunction with other payers for Medicaid and commercial patients.

HSCRC will need to closely evaluate hospitals' plans for bringing care coordination to scale, recognizing that less rapid implementation may affect hospitals' annual updates, which are based on the combination of price and volume that results in per beneficiary costs.

Planning for Ongoing Implementation and Application to Extend the All Payer Model

At the November meeting, we discussed that with the State's All-Payer Model nearing its second full year of operations, DHMH and the HSCRC are reconvening the Advisory Council. The Council, originally charged with recommending guiding principles for the implementation of the new model, is now needed to provide advice on the potential future directions for Maryland's health care improvement and population health initiatives and the All-Payer Model progression. We are currently in the process of organizing meetings of the Advisory Council, with a plan to meet in mid-January through February to develop high level strategic input to the future direction of the model. We will also schedule additional meetings for March through June, to provide additional input to the longer term development of the Model. We would expect to meet with the Advisory Council again later in the fall, as the application nears completion.

Staff Focus

HSCRC staff is currently focused on the following activities:

- Evaluating the reasons for increases in post-acute care costs, and developing strategies to moderate or adjust for those costs.
- 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 progressing toward a focus on outcomes and costs across the health care system.
- Preparing to review, synthesize, and report on the hospital submissions of:
    - Global Budget Infrastructure Reports for FY 14 and FY 15;
    - Strategic Hospital Transformation Plans;
    - Final Reports of the Regional Planning Transformation Grantees; and
    - Proposals for the Transformation Implementation Program.
- Preparing to finalize and support a stakeholder process that will be executed together with DHMH and other agencies. It will be focused on ensuring the success of the All-Payer Model and providing a proposal no later than January 2017 as required under the All-Payer Model Agreement with CMS.

Monitoring Maryland Performance

Financial Data

Year to Date thru October 2015

HSCRC
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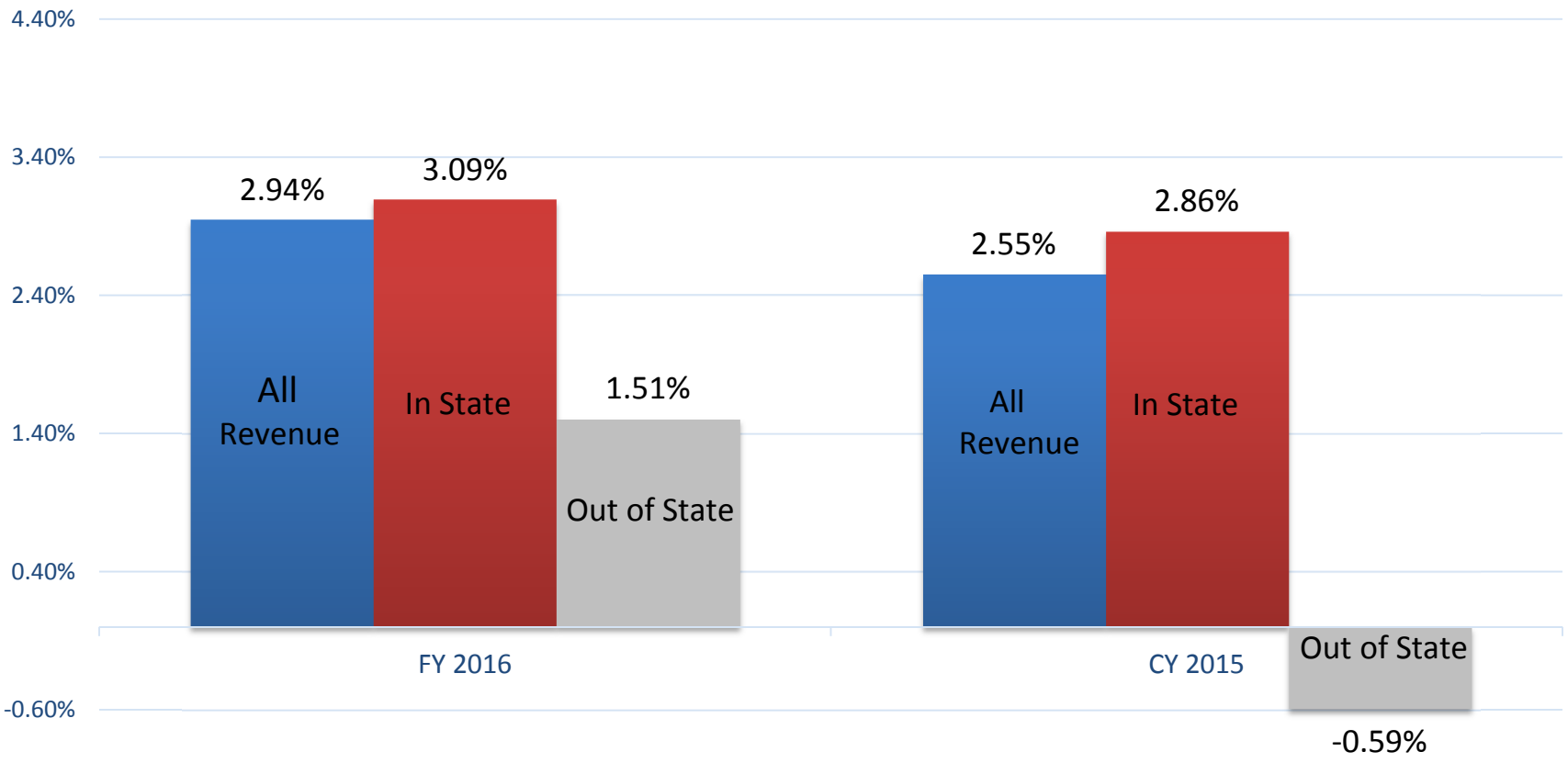
Gross All Payer Revenue Growth

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



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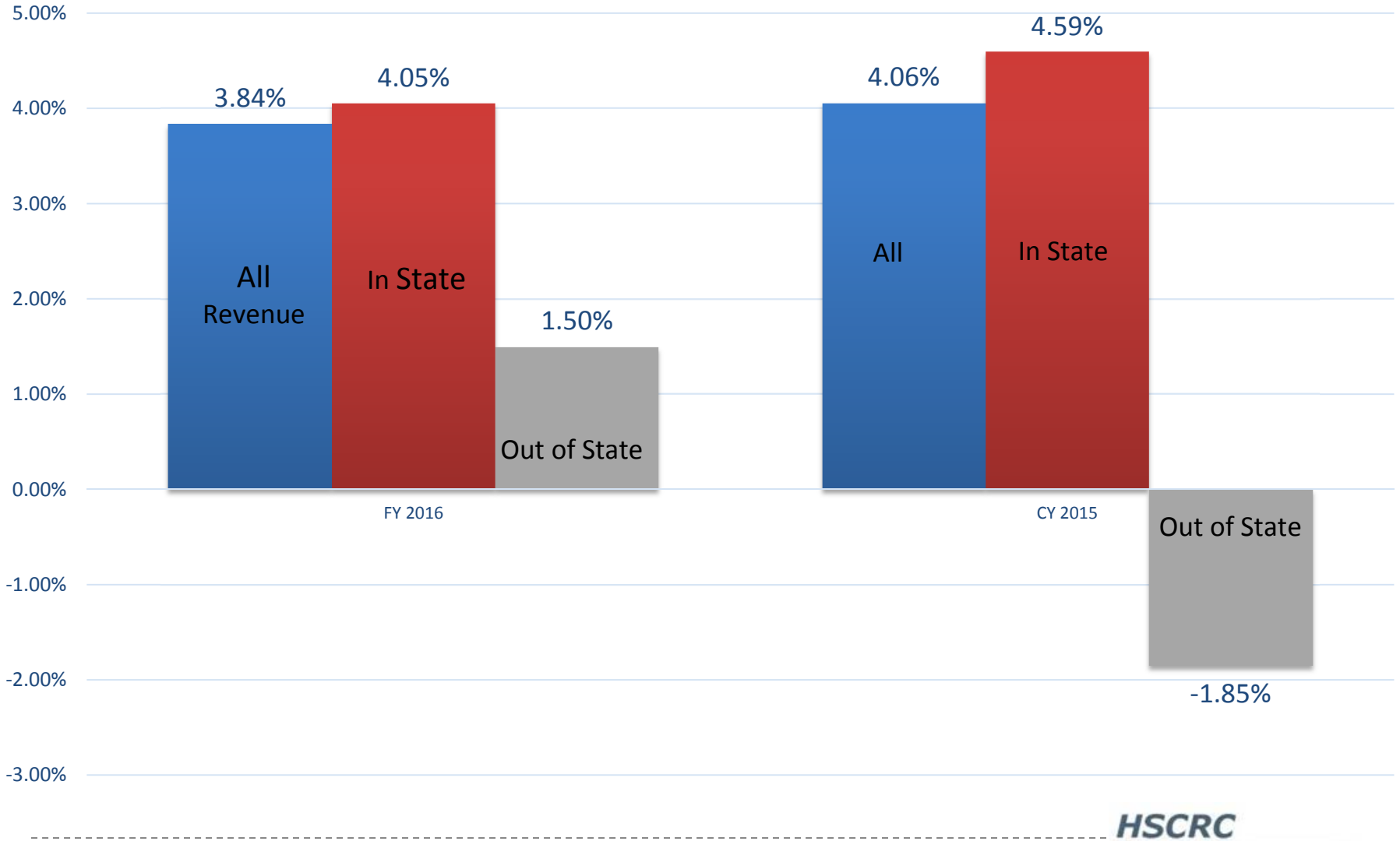
Gross Medicare Fee-for-Service Revenue Growth

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



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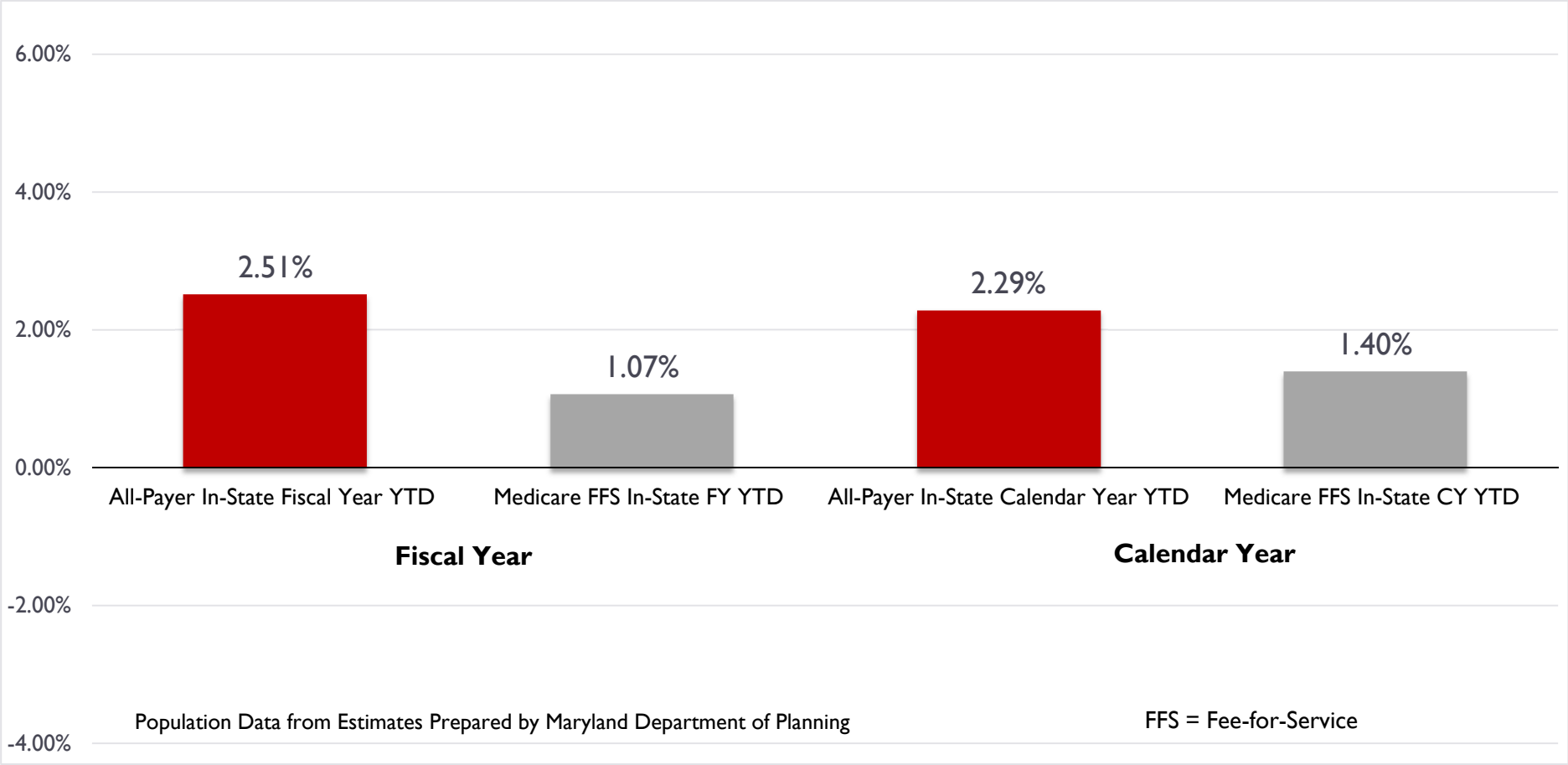
Per Capita Growth Rates
Fiscal Year 2016 and Calendar Year 2015



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

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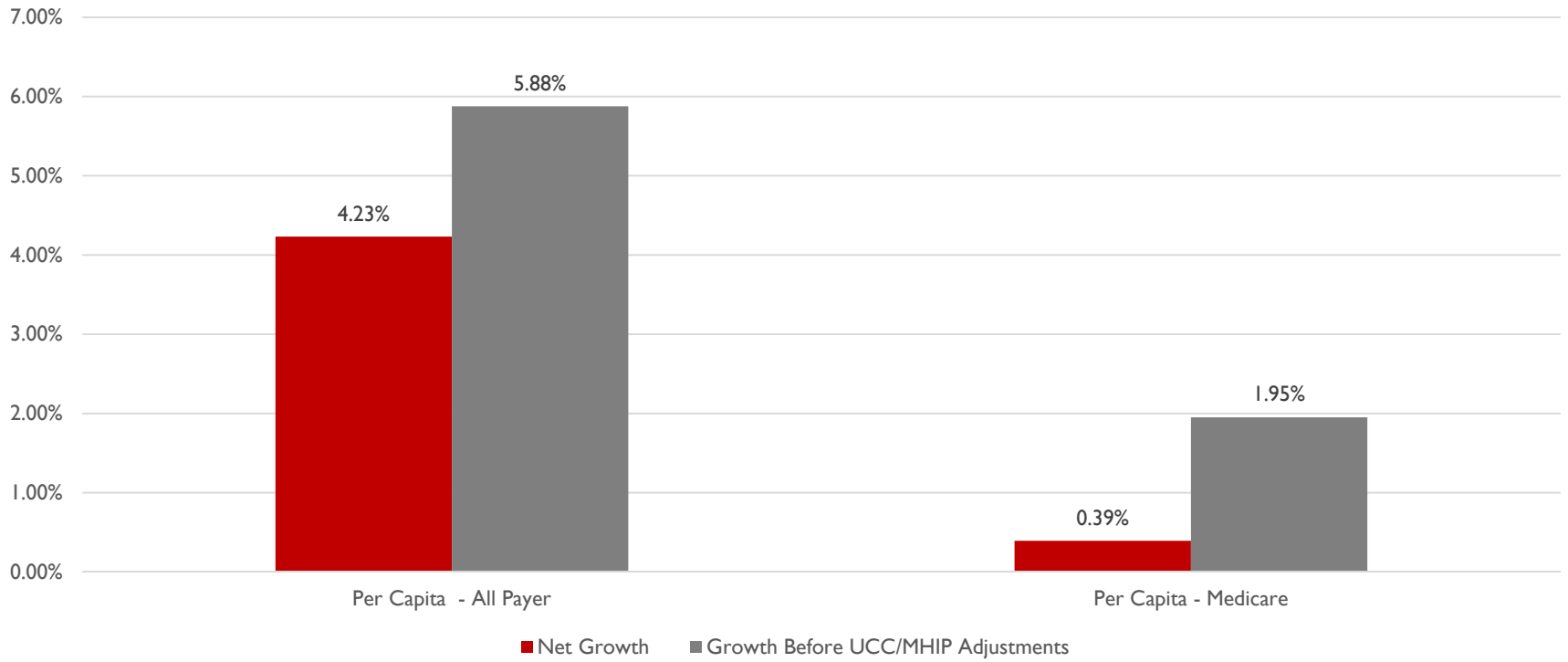
Per Capita Growth – Actual and Underlying Growth

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.

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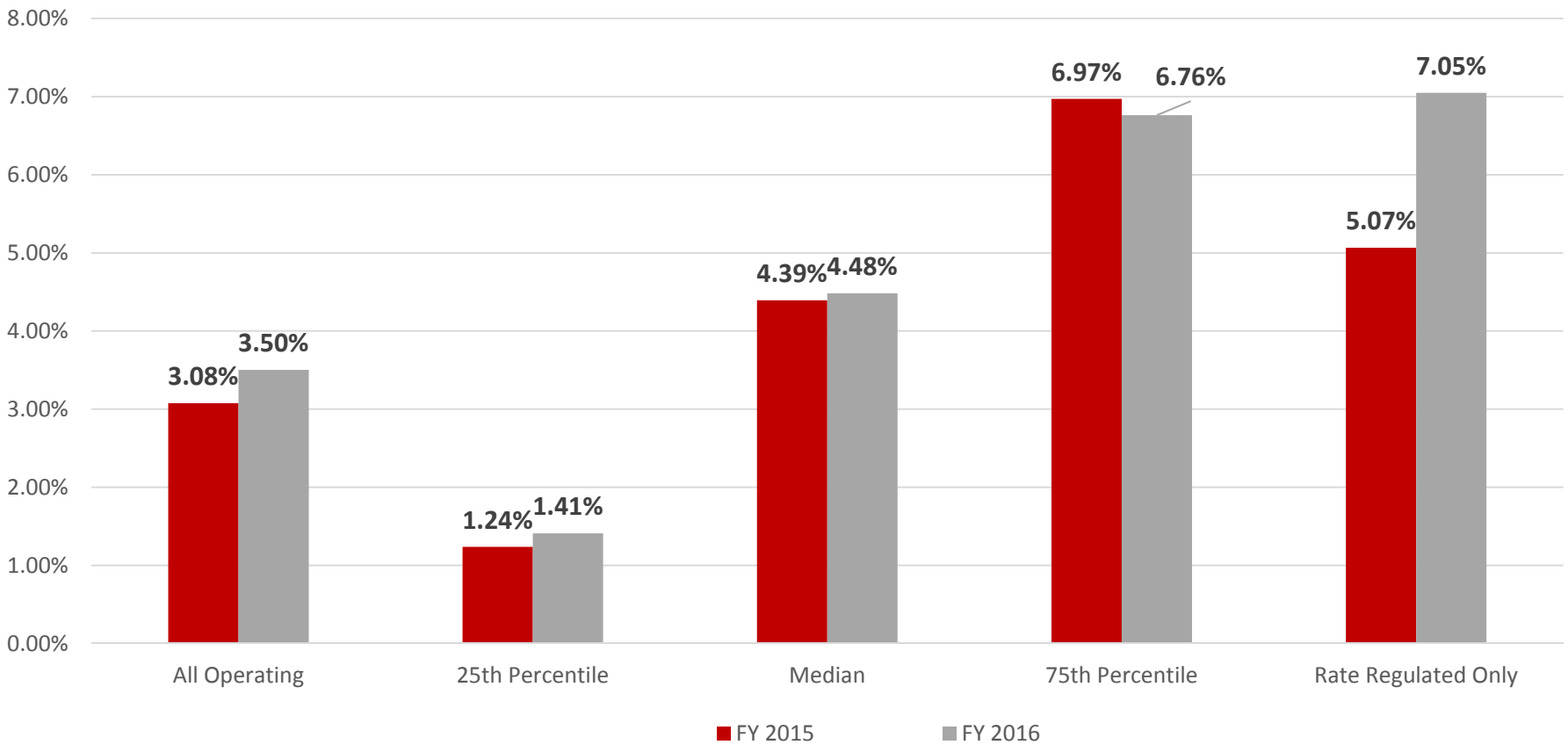
Operating Profits: Fiscal 2016 Year to Date (July-October) Compared to Same Period in FY 2015



- Year to date FY 2016 unaudited hospital operating profits shows little change in total profits compared to the same period in FY 2015. Rate regulated profits have increased by 1.98% compared to the same period in FY 2015.

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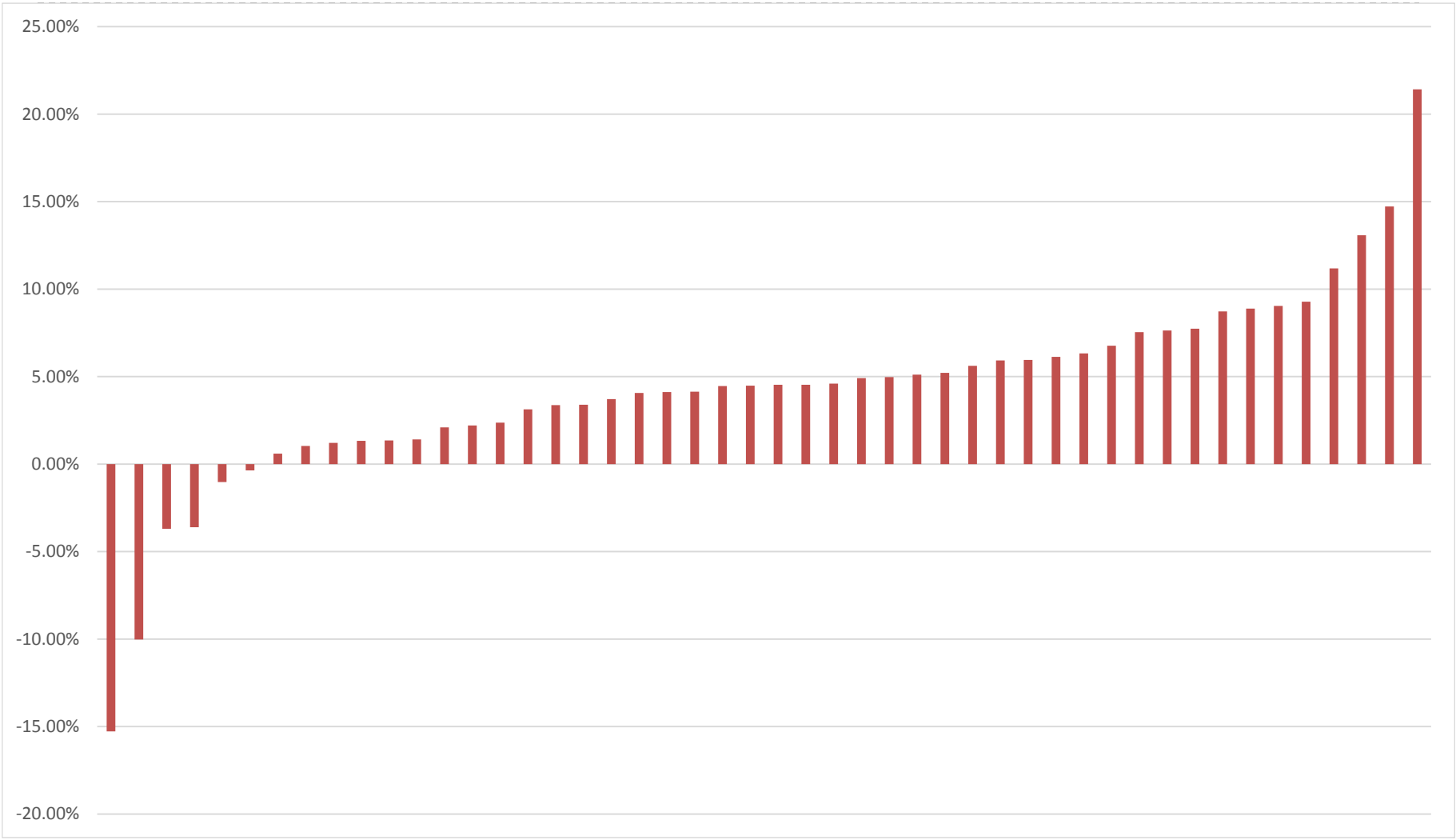
Operating Profits by Hospital

Fiscal Year to Date (July – October)



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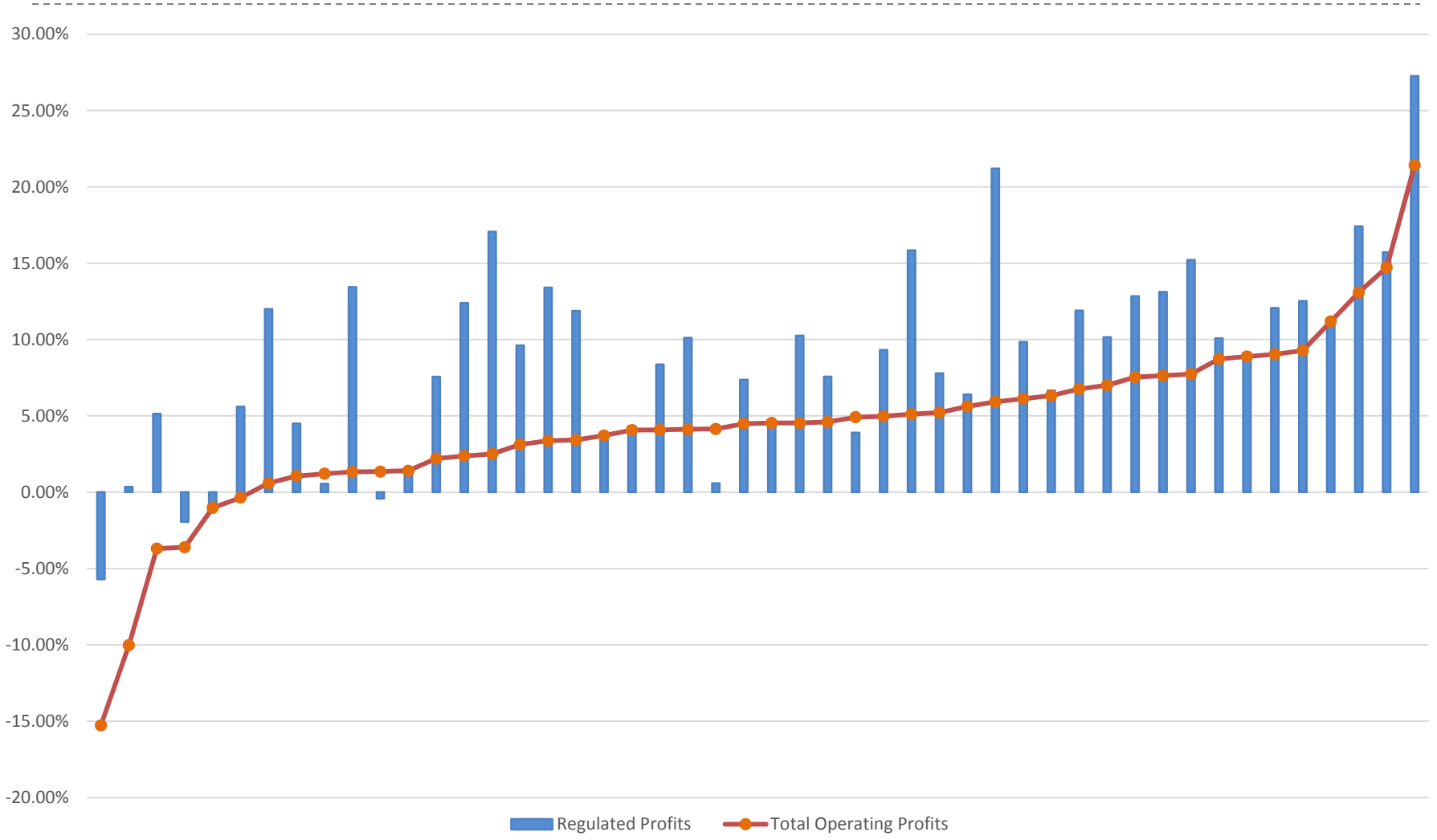
Regulated and Total Operating Profits by Hospital

Fiscal Year to Date (July – October)



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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

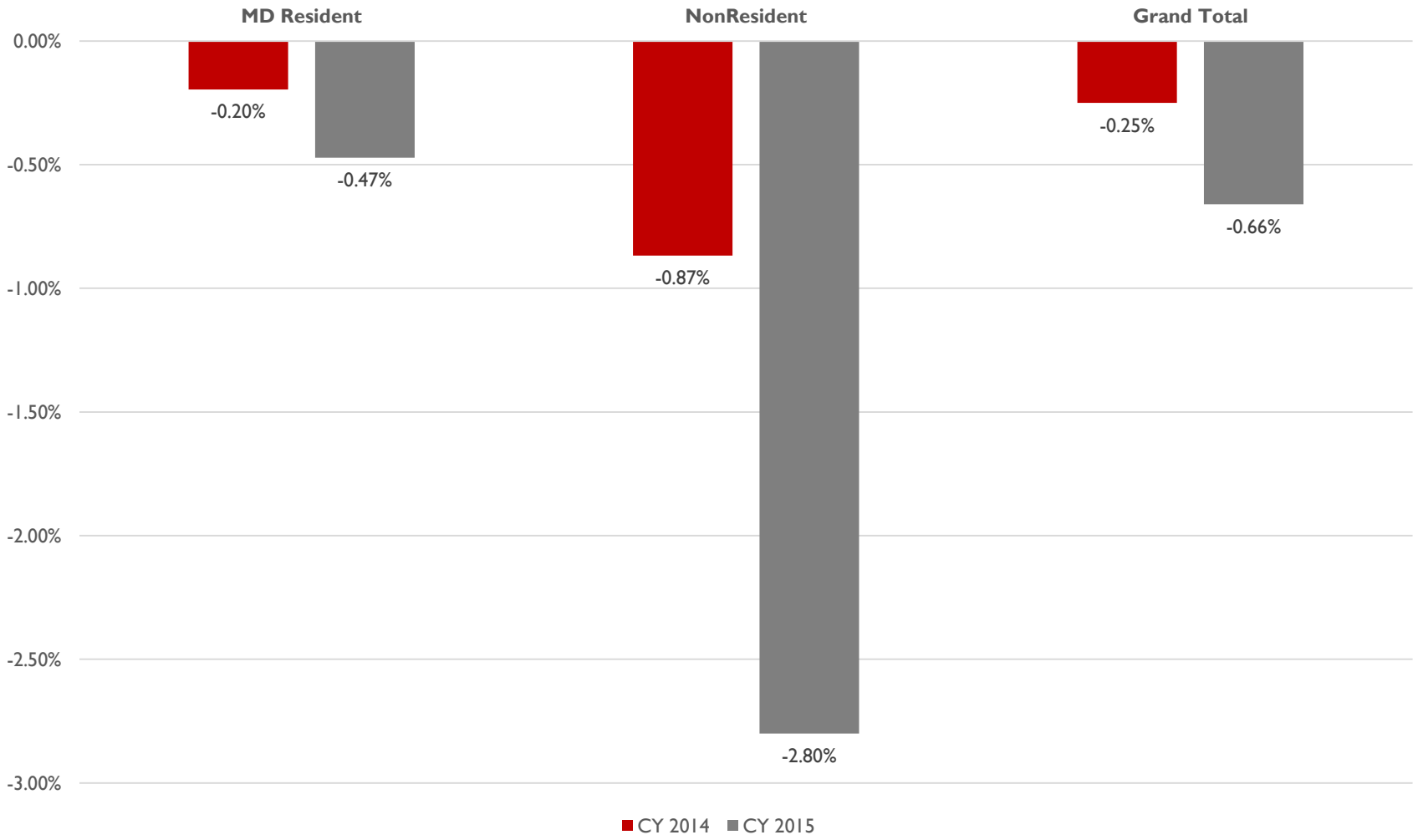
Data Caveats

- 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
Preliminary Utilization Trends

Year to Date thru September 2015

All Payer ECMAD GROWTH - Calendar Year to Date (thru September 2015) Compared to Same Period in Prior Year



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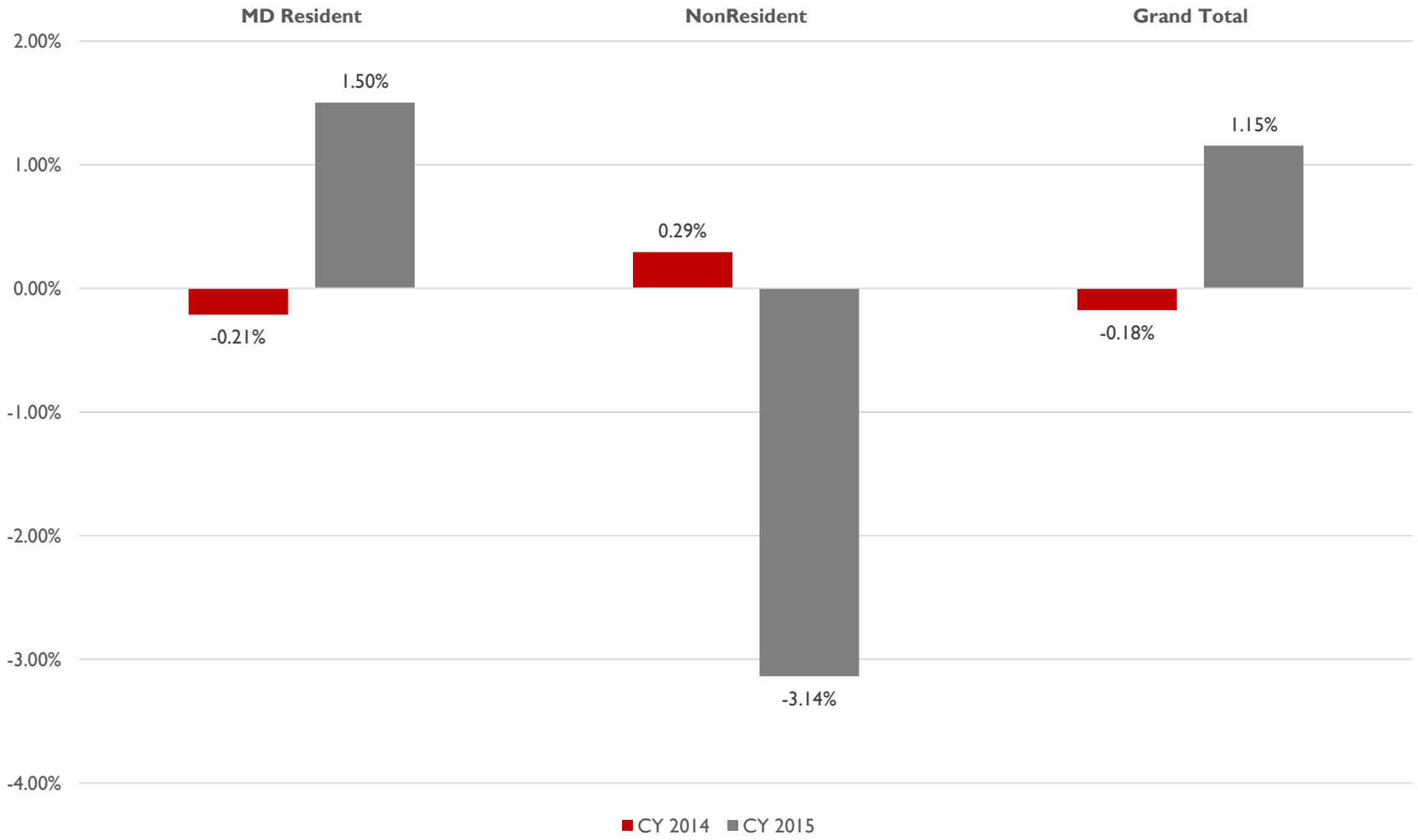
Medicare ECMAD GROWTH - Calendar Year to Date (thru September 2015) Compared to Same Period in Prior Year



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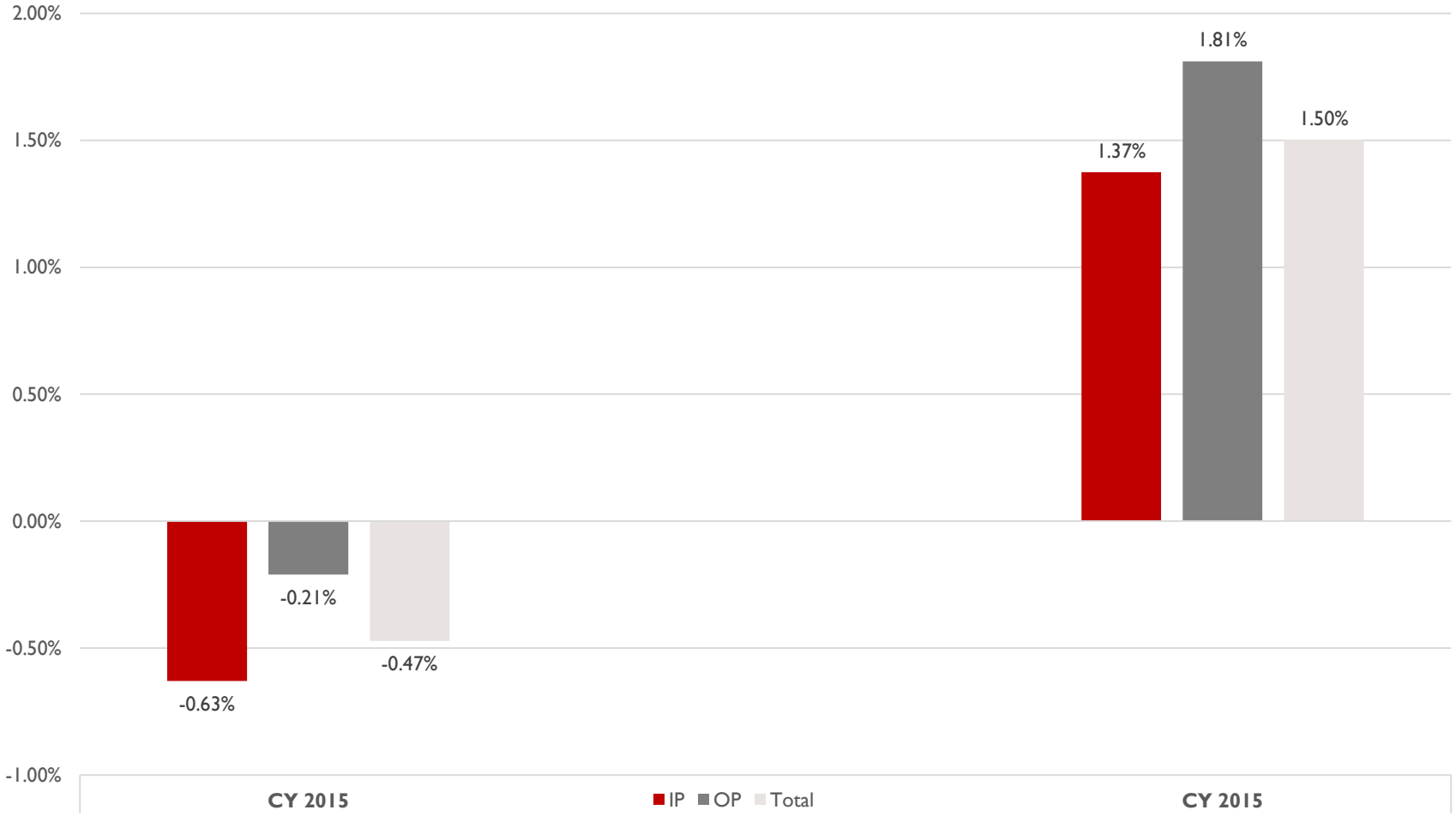
MD Resident ECMAD GROWTH by Location of Service - Calendar Year to Date (thru September 2015) Compared to Same Period in Prior Year



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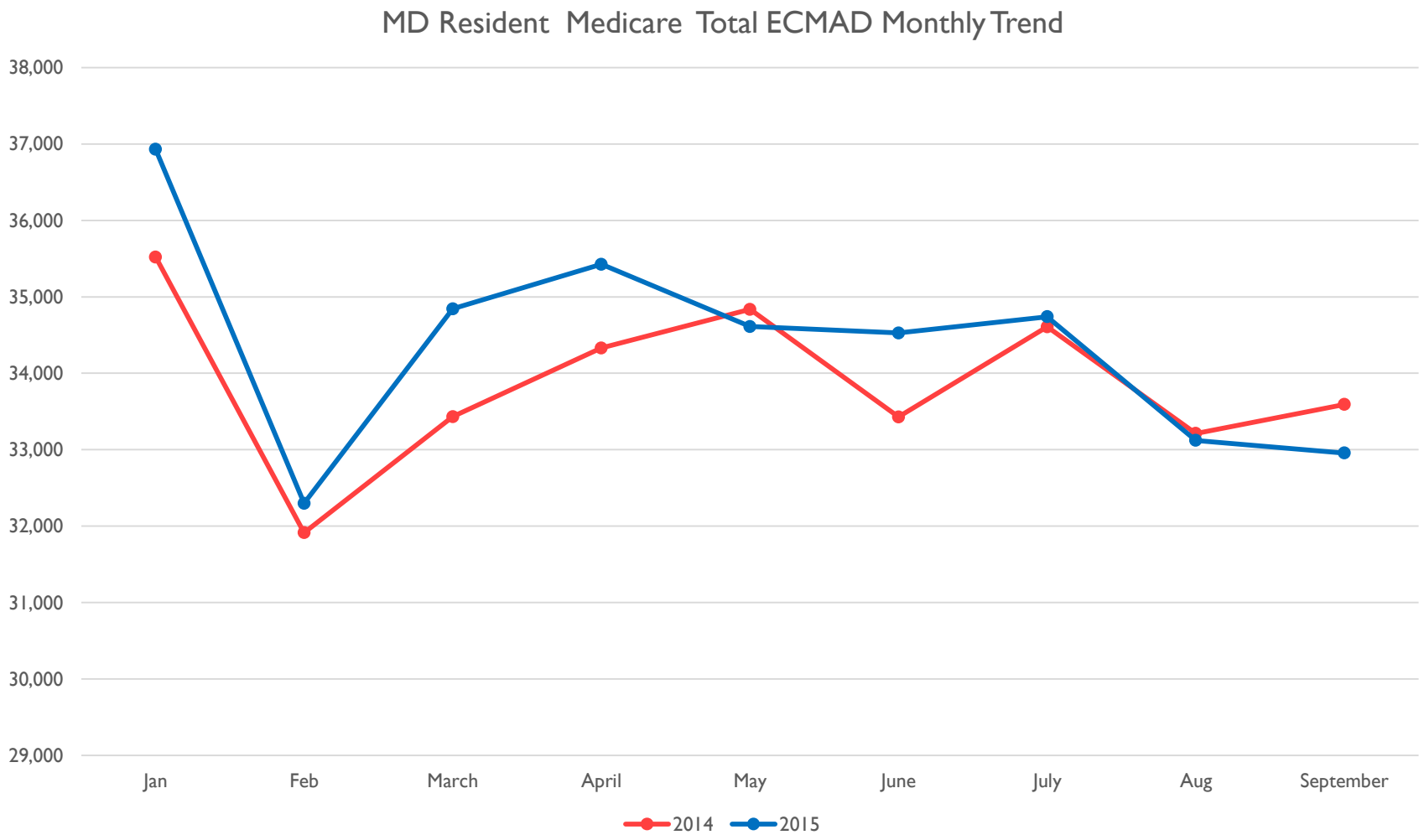
Medicare MD Resident ECMAD GROWTH by Month



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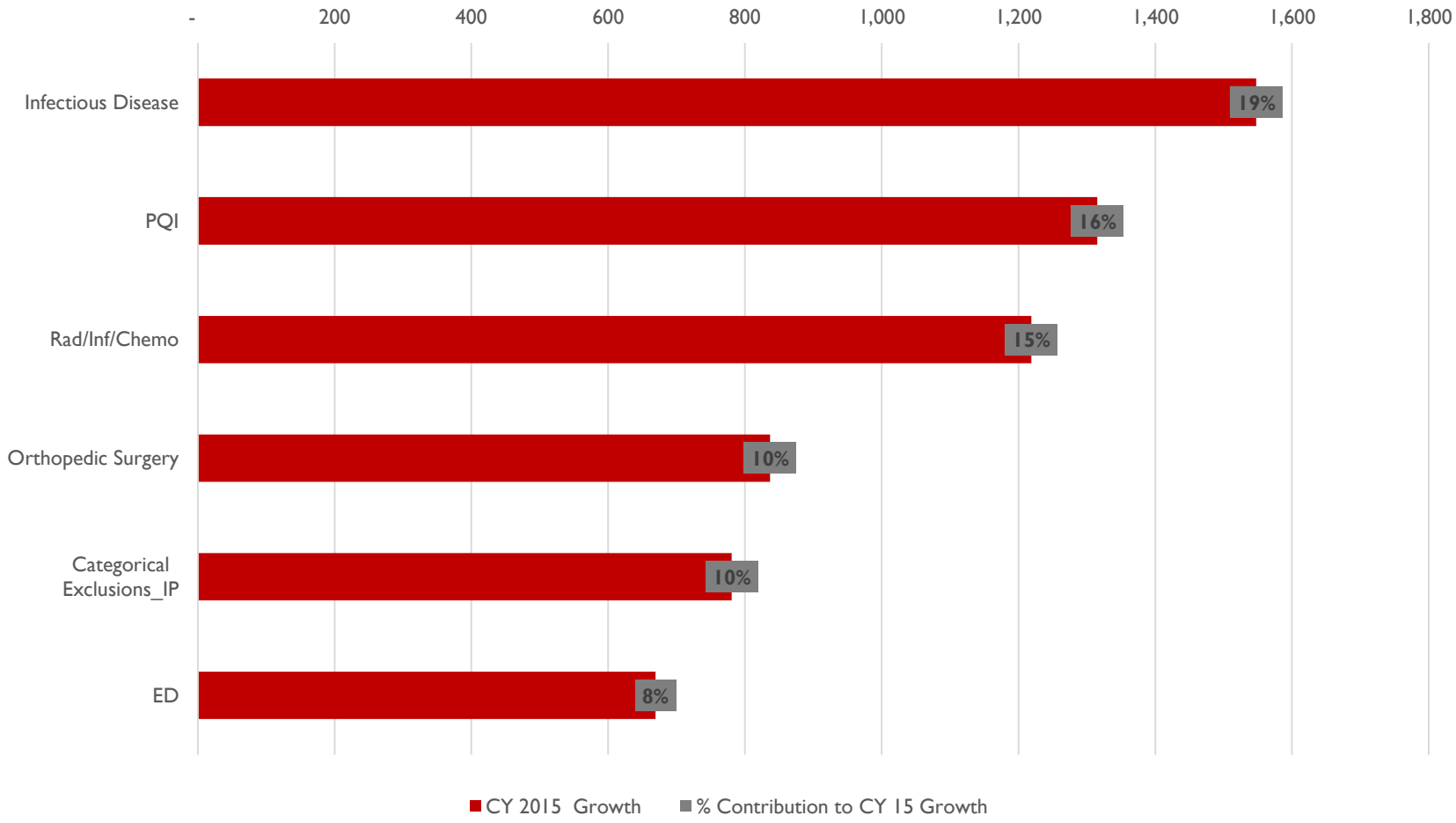
Medicare MD Resident ECMAD Growth by Service Line
Calendar Year to Date ECMAD Growth (thru September)



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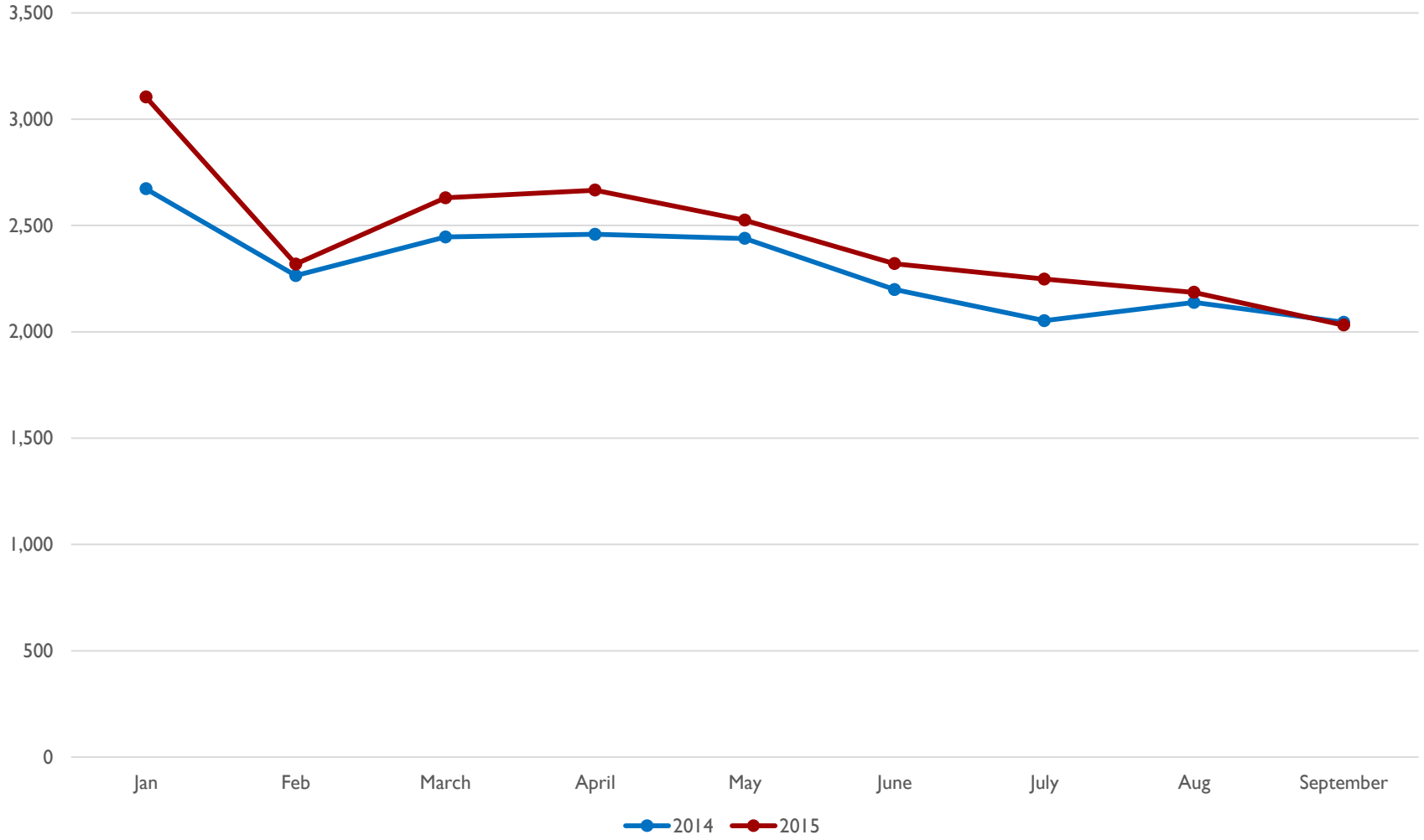
Medicare MD Resident PQI Service Line ECMAD GROWTH by Month



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Utilization Analytics – Data Notes

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

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 DECEMEBER 2, 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
2317R	Holy Cross Health	11/6/2015	12/7/2015	4/4/2016	CAPITAL	GS	OPEN
2319R	Sheppard Pratt Health System	11/24/2015	12/24/2015	4/22/2015	CAPITAL	GS	OPEN
2320N	Sheppard Pratt Health System	11/24/2015	12/24/2015	4/22/2015	OBV	DNP	OPEN
2321A	Johns Hopkins Health System	11/25/2015	N/A	N/A	N/A	DNP	OPEN
2322A	Johns Hopkins Health System	11/25/2015	N/A	N/A	N/A	DNP	OPEN
2323A	Johns Hopkins Health System	11/30/2015	N/A	N/A	N/A	DNP	OPEN
2324A	Johns Hopkins Health System	11/30/2015	N/A	N/A	N/A	DNP	OPEN
2325A	Johns Hopkins Health System	11/30/2015	N/A	N/A	N/A	DNP	OPEN
2326A	Johns Hopkins Health System	11/30/2015	N/A	N/A	N/A	DNP	OPEN
2327A	Johns Hopkins Health System	11/30/2015	N/A	N/A	N/A	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION *		**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2015**
SYSTEM	*	**FOLIO:**	**2131**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2321A**

Staff **Recommendation**

December 9, 2015

INTRODUCTION

Johns Hopkins Health System (System) filed a renewal application with the HSCRC on November 25, 2015 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for continued participation in a capitation arrangement serving persons with mental health needs under the program title, Creative Alternatives. The arrangement is between the Johns Hopkins Health System and the Baltimore Mental Health Systems, Inc., with the services coordinated through the Hospital. The requested approval is for a period of one year beginning January 1, 2016.

II. OVERVIEW OF APPLICATION

The parties to the contract include the System and the Baltimore Mental Health Systems, Inc. Creative Alternatives provides a range of support services for persons diagnosed with mental illness and covers medical services delivered through the Hospital. The System will assume the risk under the agreement, and all Maryland hospital services will be paid based on HSCRC rates.

III. STAFF FINDINGS

Staff found that the experience under this arrangement for FY 2015 was favorable, and believes that the Hospital can continue to achieve a favorable performance under this arrangement.

IV. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's renewal application for an alternative method of rate determination for a one year period commencing January 1, 2016.

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**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2015**
SYSTEM	*	**FOLIO:**	**2132**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2322A**

Staff **Recommendation**

December 9, 2015

I. INTRODUCTION

Johns Hopkins Health System (the System) filed a renewal application with the HSCRC on November 25, 2015 on behalf of its member hospitals, the Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC for continued participation in a capitation arrangement serving persons insured with Tricare. The arrangement involves the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare as providers for Tricare patients. The requested approval is for a period of one year beginning January 1, 2016.

II. OVERVIEW OF APPLICATION

The parties to the contract include the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare, a subsidiary of the System. The program provides a range of health care services for persons insured under Tricare including inpatient and outpatient hospital services. Johns Hopkins Health Care will assume the risk under the agreement, and the Hospitals will be paid based on their approved HSCRC rates.

III. STAFF EVALUATION

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

V. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' renewal application for an alternative method of rate determination for a one year period beginning January 1, 2016. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION *		**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2015**
SYSTEM	*	**FOLIO:**	**2133**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2323A**

Staff Recommendation

December 9, 2015

I. INTRODUCTION

On November 30, 2015, the Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") requesting approval from the HSCRC to continue to participate in a global rate arrangement for cardiovascular procedures with Quality Health Management. The Hospitals request that the Commission approve the arrangement for one year effective January 1, 2016.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff found that there was no activity under this arrangement for the last year. However,

staff believes that the Hospitals can achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services for one year beginning January 1, 2016. The Hospitals must file a renewal application annually for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION *		**COMMISSION**
JOHNS HOPKINS HEALTH	*	**DOCKET: 2015**
SYSTEM	*	**FOLIO: 22134**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2324A**

Staff Recommendation

December 9, 2015

I. INTRODUCTION

On November 30, 2015, the Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval from the HSCRC to continue to participate in a renegotiated global rate arrangement for cardiovascular procedures with Coventry Health Care of Delaware, Inc. for international patients only. The Hospitals request that the Commission approve the arrangement for one year effective January 1, 2016.

II. OVERVIEW OF APPLICATION

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

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

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V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services for one year beginning January 1, 2016. The Hospitals must file a renewal application annually for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION *		**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2015**
SYSTEM	*	**FOLIO:**	**2135**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2325A**

Staff **Recommendation**

December 9, 2015

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on November 30, 2015 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the " Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplants services with INTERLINK Health Services, Inc. The System requests approval for a period of one year beginning January 1, 2016.

II. OVE RVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Although the experience under this arrangement was slightly unfavorable for FY 2014, staff still believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing January 1, 2016. The Hospitals will need to file a renewal application for review to be considered for continued participation, with approval contingent upon a favorable evaluation of performance. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION *		**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2015**
SYSTEM	*	**FOLIO:**	**2136**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2326A**

Staff Recommendation

December 9, 2015

I. INTRODUCTION

Johns Hopkins Health System (System) filed an application with the HSCRC on November 30, 2015 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for cardiovascular and orthopedic services with PepsiCo, Inc. for a period of one year beginning January 1, 2016.

II. OVE RVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. ST AFF EVALUATION

Although the experience under this arrangement has been slightly unfavorable for the last year, staff continues to believe that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular and orthopedic services for a one year period commencing January 1, 2016. The Hospitals will need to file a renewal application for review to be considered for continued participation, with approval contingent upon a favorable evaluation of performance. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION *		**COMMISSION**
JOHNS HOPKINS HEALTHCARE, LLC	*	**DOCKET: 2015**
	*	**FOLIO: 2137**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2327A**

Staff Recommendation

December 9, 2015

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on November 30, 2015 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplants services with 6 Degrees Health, Inc. The System requests approval for a period of one year beginning January 1, 2016.

II. OVE RVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving 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.

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

V. ST AFF EVALUATION

Although there has been no activity under this arrangement in the last year, staff believes

that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for solid organ and bone marrow transplant services, for a one year period commencing January 1, 2016. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Final Report of Health Services Cost Review Commission
Regarding Population Health Work Force Support for Disadvantaged Areas

As Approved by the Commission on December 9, 2015

Introduction

At the Commission's September 9, 2015 public meeting, 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. At the November 18, 2015 public meeting, staff presented a preliminary report on the Health Job Opportunity Program Proposal ("Proposal"), and a number of public comments were received Input was also received from the Payment Models Workgroup comments received highlight the need for a concerted effort by all participants who are serious about improving the unfavorable conditions that exist in economically deprived areas within Maryland.

At the December 9, 2015 public meeting, the Commission determined that the approach suggested by the Proposal was not within its framework. However, the Commission adopted an alternative approach building on the staff policy analysis and within the framework of the HSCRC that focuses on supporting the implementation of the All Payer Model.

This final report focuses on synthesizing input provided through the staff policy analysis for consideration by the Commission and the Commission's final determination in approving efforts that can support the important objectives of the initiative within the framework of the HSCRC.

Background

The Proposal came about as a result of the unrest in Baltimore City and the strong 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 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.

All parties have acknowledged the importance of jobs in reducing economic disparities. However, there are critical differences in thinking about how creating job opportunities should be addressed and who should provide the funding for job creation.

The Proposal submitted was very broad in nature, extending beyond the areas of focus and expertise of the Health Services Cost Review Commission. Additionally, as initially proposed, the jobs program would have Medicare, Medicaid, insurers, businesses, and patients represent the sole source of funding through hospital rate increases, with no funding identified from the considerable resources of hospitals or from their charitable community benefits funds. On December 1, 2015, letters from Ronald R. Peterson of Johns Hopkins Medicine and Robert A. Chrencik of the University of Maryland Medical System offered an alternative proposal that called for a 20% hospital match for any amount funded in rates. Public comments and letters received from a number of the parties who would constitute the primary funding sources indicate that they were not on board with the proposal before it was submitted to the HSCRC. Further work is required by the proposers to gain stakeholder agreement.

The Department of Mental Health and Hygiene and the Health Services Cost Review Commission have been implementing extensive changes in health care delivery and financing that focus on improving population health, especially in areas of the State with extreme poverty and unemployment. These efforts are expected to result in population health initiatives that increase the need for "community-based" employment by hospitals and other organizations.

Analysis

Summary of Input Received--

Payment Models Work Group

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. All parties acknowledged the importance of jobs in reducing disparities.

Following is a general summary of work group comments, as presented in the Executive Director's report at the October 14, 2015 Commission meeting:

- Several commenters expressed the view that if the Commission were to take on a program of this nature, that 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 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 expressed 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.

Letters and Public Comment

There were a number of letters of support received. Those include letters from public officials and other interested parties. These letters outline the need for jobs and support for the Proposal.

Letters were also received from DHMH-Medicaid, CareFirst, 1199 SEIU United Healthcare Workers East, Baltimoreans United in Leadership Development (BUILD), The League of Life and Health Insurers of Maryland, Maryland Hospital Association, and Mercy Hospital.

While appreciating the effort to identify potential ways to address the daunting issue of poverty and unemployment in Baltimore and other areas of the State, especially as it relates to disadvantaged youth, letters from DHMH-Medicaid, CareFirst, and the League of Life and Health Insurers of Maryland expressed disagreement about the specifics of the Proposal. There are concerns regarding the source of funding, the lack of funding from hospitals or sources other than purchasers, businesses, and patients, and the overlap with funding already provided for hospital operations and infrastructure through existing rates or through the upcoming competitive transformation implementation grants. There is also the concern that using the rate setting authority of HSCRC to cover the costs of an employment program goes beyond the purpose of the rate setting system. Each of these parties made public comments for Commission consideration at the November 18, 2015 meeting.

1199 SEIU provided both a comment letter and public comments at the November Commission meeting. SEIU expressed concerns that the systematic poverty which hospitals seek to address through the jobs proposal will not be solved by merely creating new jobs. Jobs should also provide a meaningful pathway for workers to the middle class. SEIU also notes that while hospitals have long been Baltimore City's largest employers, they are not traditionally viewed as experts in workforce development for the people targeted by the Proposal. If the HSCRC were to move forward with a job program proposal, SEIU recommended increased transparency along with collection of extensive information about the program participants, credentials of individuals entering the program, retention details, etc. Should the HSCRC determine that further review or proposal development is needed, SEIU offered to be a resource to the process.

Mercy Hospital submitted a letter in support of the Proposal and in opposition to using funds earmarked for transformation for this purpose.

Maryland Hospital Association (MHA) submitted a letter after the November Commission meeting. The letter supports Option 3 outlined in the Staff's preliminary report, which focused on the need to continue to further evaluate and develop the proposal. MHA indicated that it supported this option but without the dollar limit the staff had indicated for the option, which was $5 million. Option 3 provided for the following: "Defer funding and have Proposers continue to develop Program design, implementation, and evaluation parameters by March 2016, together with AHECs and other job training resources, with a potential for future funding of some educational resources or seed funding in July 2016. Funding could potentially include program development, training, coaching, funding of trainers and coaches, etc. Expect hospitals to fund positions from infrastructure in rates, community benefits funds, hospital resources such as return on investment, and other grant, philanthropy, and foundation support." MHA is not supportive of diverting funds from transformation implementation, which is important to the goals of improving health, reducing disparities in population health, and maintaining the All Payer Model.

The Commission heard from representatives of a community group, Baltimoreans United in Leadership Development (BUILD), at the October 14, 2015 and at the November 18, 2015 Commission meetings. At the October meeting, BUILD stressed the importance of jobs in improving the situation in Baltimore. The representatives described existing programs that are making progress in employing individuals in economically deprived areas and the process they have used to ensure that the individuals employed through these programs are successful. At the November meeting, BUILD reiterated the importance of jobs and indicated that they were not supportive of staff options because the resources provided were not adequate and they were not confident of funding from other sources. The staff and Commission were very appreciative of their presentations and advice.

Commissioners expressed serious concerns about the problems and the complexity of economic disparities, and the necessary limitations of HSCRC as a hospital rate setting agency in addressing the broad public policy issues that are raised, which include job development, housing, food, transportation, and education, as well as other issues such as safety and security for community residents. There was also a discussion regarding the need for employment outside of hospitals, in primary care settings, health insurance counselors, and non-health jobs. There is a need for increased and continuing conversation among the participants.

HSCRC Staff Commentary

The Commission and staff are very concerned about health disparities and have focused extensive policy development around ensuring that resources are available for enhanced hospital care in areas of disparities. This includes financial policies such as disproportionate share adjustments that provide additional revenues to hospitals in areas of the State where there is a higher estimated level of poverty. These adjustments are derived from claims data and indirect medical education allowances that provide revenues to hospitals, many of which are located in areas of the State with economic disparities. These policies have been applied in developing hospital rates for many decades. The HSCRC staff has also been attentive in developing value based performance measures to consider the impact of the social determinants of health. In fact, the HSCRC staff has been working on an Area Deprivation Index to enhance measurement of socioeconomic disparities and evaluating incorporating the index into its policies.

More needs to be done, however. In spite of significant amounts of additional funding provided to hospitals and a significantly higher amount of overall health care dollars being spent in areas of high socioeconomic disparities, serious disparities in health outcomes exist in Baltimore City as well as in other parts of the State. These disparities have been measured and documented in the State Health Improvement Plan. Hospitals have also recognized these disparities in their Community Health Needs Assessments.

The new All Payer Model recognizes that a new approach is needed to address population health and disparities in outcomes. The Commission has approved numerous policies aimed at redirecting resources to this important objective including:

- Working with hospitals to move payment to global budgets so that when care and health are improved and utilization reduced, hospitals will be able to reinvest retained savings in interventions that are focused on improving health and outcomes. Hospitals have been accorded a great deal of flexibility in spending these resources. Hospitals with historically higher levels of potentially avoidable utilization, such as readmissions, complications, and ambulatory sensitive conditions, have greater opportunities to achieve savings to invest in successful strategies, including training and employment.
- The Commission approved the funding of eight regional partnership grants focused on planning of patient-centered care coordination initiatives involving hospitals and community providers and partners. Out of $2.5 million of funding, 40% was provided to Baltimore City and Prince George's County partnerships, counties where there are high levels of health disparities.
- By July 1, 2015, the Commission had placed more than $200 million of funding in rates earmarked for providing infrastructure and support for interventions to improve health

and outcomes and reduce avoidable utilization. Hospitals have completed reports on historic expenditures, and strategic plans are due in December.

- In December of 2015, HSCRC will review grant applications for up to $40 million of care coordination initiatives that would be funded through hospital rates.

Others have devoted resources as well:

- The State of Maryland has also invested in programs focused on addressing health disparities in economically deprived areas such as the expansion of Medicaid and investments in Health Enterprise Zones.
- Hospitals, government agencies, and other grantors have also dedicated resources to individuals with disparities, including free clinics, transportation, some housing, as well as other interventions.
- Public health resources in Maryland are focused on similar needs.
- The significant Medicaid expansion which took place effective January 1, 2014, provided coverage for numerous individuals in areas of high deprivation, providing a source of health coverage that has improved the access to health care services, including preventive care.
- The federal government has provided grant awards, focused in part on workforce training. Several of the hospital awardees include hospitals located in Baltimore City.

With the new focus on chronic conditions and high needs patients, situations more prevalent in populations with health and economic disparities, HSCRC and hospitals will be directing funding toward reducing health disparities, which will include creation of new positions focused on care coordination and population health improvement.

Relative to the Proposal, HSCRC staff expressed several concerns in the preliminary report.

- Staff is concerned about including traditional jobs inside of hospitals in a grant program. These should be funded through hospital budgets.
- Staff supports expanding hospital resources deployed for positions that support the transitions anticipated in the All Payer Model-- care coordination, population health, health information exchange, health information technology, alignment, and consumer engagement. However, staff is concerned about the funding sources and the potential for overlap with the additional resources that are being provided through rates as noted above. Furthermore, there are hospital community benefit dollars that could potentially be deployed in this effort. Grants are another potential source of funding.
- In order to implement programs such as those described above, significant amounts of training and coaching would be required. The programs require significant design and

dedication of resources. HSCRC staff believes that considerable development needs to take place to plan, develop, and execute these programs successfully, similar to the planning and development that have gone into nursing education programs in the past.

The HSCRC staff acknowledges the importance of jobs creation in areas of high economic deprivation, and both HSCRC and DHMH have taken proactive roles in promoting transformation that should expand opportunities. Staff is concerned about HSCRC's role in addressing the Proposal outside the context of the extensive transformation activities already underway.

Final HSCRC Staff Commentary for Commission Consideration

At the November 18, 2015 meeting, HSCRC staff offered several options for discussion with the Commission and for further public input. Staff has reviewed the letters of comment received and has listened attentively to the public comments provided. The public input process clarified that the Proposal had not been developed in concert with the parties who were identified as the sole or primary funding sources.

As a general matter staff reiterates that a principal aim of the All Payer Model, which is being implemented to improve population health. In focusing on better chronic care and socioeconomic determinants of health, it is expected that hospitals and community partnerships will propose approaches that include development of community based care coordination resources. Staff also notes that several other states are using savings from hospital cost reductions to invest in community based resources, such as housing, food, transportation, and community based workers. As the All Payer Model develops, it is expected that there should be fewer hospitalizations, particularly in areas with very high hospital use rates such as Baltimore City and, therefore, resources will become available under hospital global budgets to help support better community based care and more dedicated resources devoted to the socioeconomic determinants of health.

Given the totality of the input received, the staff recommends as follows:

Addressing disparities and deprivation is important to Marylanders and to the All Payer Model. The Proposal set out an approach for addressing the problem through a jobs creation program in hospitals. However, the stakeholder input process conducted by the HSCRC made clear that many of the proposed funders were not in agreement with key aspects of the Proposal. Proposers will need to continue the dialogue with community organizations, payers, providers, employers, and other stakeholders in identifying approaches to address these important issues.

Discussions with stakeholders should include a focus on how the existing community benefits programs could be repurposed in a transformed health system, as this may be an important

funding source for addressing socioeconomic determinants of health in a post insurance expansion environment.

The HSCRC should maintain its focus on implementation of the All Payer Model with its aim of better care, better health, and lower costs. HSCRC already has efforts underway in conjunction with DHMH. Hospitals will be filing strategic plans for transformation in December. DHMH and HSCRC will work together to evaluate these plans.

The scope of HSCRC participation in these efforts should be maintained within its areas of focus and expertise. In order to address workforce needs in a transformed Maryland health system, there may be an appropriate role for HSCRC to play. HSCRC staff recommends earmarking up to $5 million of the fiscal year 2017 update factor for this purpose, with matching funds by hospitals that apply to participate in the development and implementation efforts. For example, the HSCRC could provide opportunities for funding of some transitional educational resources in the form of seed funding. This could potentially include program development, training, coaching, funding of trainers and coaches, etc., particularly in areas with high economic disparities and unemployment. These efforts should be targeted to assist the State and the Commission in meeting the goals of the All Payer Model. Hospitals should be expected to fund positions from existing rates, community benefits funds, resources derived from reductions in hospitalizations, and other grant, philanthropy, and foundation support. The federal government has provided workforce development grants in the past, and this avenue could be explored as a possible source of some funding.

HSCRC staff should continue to work together with DHMH diligently and expeditiously on the implementation of the All Payer Model. Implementing the Model will mean more comprehensive and permanent solutions to help improve health, improve care, and reduce costs, with an increased emphasis on addressing socioeconomic determinants of health, workforce transformation, and enhancing the workforce in Baltimore City and other economically challenged areas of the State.

Final Commission Considerations and Approval

The Commission built on the principles outlined in the staff recommendation, and expanded the program and scope from $5 million to $10 million in hospital rates, to create a final recommendation, which was approved by the Commission.

The recommendation approved by the Commission provides up to $10 million in hospital rates on a competitive basis by July 1, 2016 for hospitals committing to train and hire workers from geographic areas of high economic disparities and unemployment to fill new care coordination, population health, health information exchange, alignment, consumer engagement, and related

positions. Hospitals should provide matching funds of at least 50% of the amount included in rates to increase the resources that could be deployed. Thus, if $10 million is provided in rates, the hospital match would be at least $5 million.

Hospitals receiving funding under this program shall report to the Commission by May 1, 2017, and each year thereafter on:

- the number of workers employed under the program;
- how many of those workers have been retained;
- the types of jobs that have been established under the program;
- how many patients or potential patients have been assisted through these positions; and
- an estimate of the impact that these positions have had in reducing potentially avoidable utilization or in meeting other objectives of the All-Payer Model.

The program will run through June 30, 2018 on a hospital-specific basis assuming on-going compliance by a hospital with the requirements, and could be renewed as of July 1, 2018 for an additional period if it is found to be effective.

The HSCRC will utilize consulting resources to assist in developing and monitoring the program who have expertise in similar work force development activities. The HSCRC will also utilize external resources in collecting and evaluating proposals, reporting on the results of implementing the program, and assisting in evaluating its effectiveness.

Hospitals will be required to submit proposals to obtain funding through rates and hospitals will be required to demonstrate how their plans would address the multiple needs of providing population health improvement related jobs to individuals in disadvantaged areas and meeting the objectives of the All-Payer Model.

Awardees would be required to report periodically to the Commission on their program, including annually beginning May 1, 2107. The Commission will evaluate the effectiveness of the program prior to July 1, 2018 to determine if the program should be continued in general, or for individual hospitals.

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BALTIMORE WORKFORCE INVESTMENT BOARD

December 7, 2015

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

Dear Chairman Colmers:

On behalf of the Baltimore Workforce Investment Board I am writing to express our support for the concept of a hospital-led employment program that hires from communities of high rates of poverty and unemployment.

We believe the proposed program represents the opportunity to create a broad-based collaboration of government, hospitals, and workforce development entities to address both health and income disparities in our most disadvantaged communities.

Creating an employment path for those living in impoverished communities not only improves the economic stability of those communities, but will also have a positive impact on the overall health of these communities. In addition, as hospitals shift their focus to providing more community-based preventive care; this program will assist in training the workforce needed to make that shift successful.

All of the factors outlined above are aligned with the vision and mission of the BWIB.

Thank you for the opportunity to share our views and, if we can be of assistance as this program is further developed, we stand ready.

Sincerely,

Andrew Bertamini
Chair
Baltimore Workforce Investment Board

STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene

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

December 7, 2015

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

Dear Chairman Colmers:

I write to offer the Department's support for the December 9, 2015 HSCRC staff recommendation regarding the Health Employment Program document prepared by the Maryland Hospital Association.

In short, the revised proposal recognizes that HSCRC's scope and efforts should remain focused on the continued development of the All-Payer Model. The revised staff recommendation addresses the Department's previously stated interest in making this investment one-time and also requires hospitals to have 'skin in the game' through matching funds to support the development and implementation of the program. We strongly believe that after an initial investment of $5 million from the fiscal year 2017 update factor, hospitals should plan to fund positions from existing rates, community benefits funds, resources derived from reductions in hospitalizations, and other grant, philanthropy, and foundation support. It is 100 percent in the interest of the hospitals – both collectively and individually – to make sure ongoing community resources are available to meet the goals of the agreement with the Centers for Medicare and Medicaid Services under the All-Payer Model.

As one of the largest payers and employers in the state, we thank you and the Commission for the work on this complex effort and look forward to participating in developments moving forward. Please contact Shannon McMahon, Deputy Secretary of Health Care Financing at 410-767-4139 with questions.

Sincerely,

Van T. Mitchell
Secretary

Chet Burrell
President and Chief Executive Officer

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December 9, 2015

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

Dear John,

I am writing to express CareFirst's support of the HSCRC staff's final recommendations regarding the Health Job's Opportunity Program.

We believe the staff recommendations provide a sound policy direction for the HSCRC, are consistent with the goals of the All-Payer Model and are within the limits of the HSCRC rate setting authority. We are prepared to work with the HSCRC, the hospitals and other interested parties within the recommended framework.

Sincerely,

Chet Burrell
President and CEO

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

Transit Employees'
HEALTH AND WELFARE PLAN
metro
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John Colmers
Chairman
Maryland Health Services Cost Review Commission
4160 Patterson Ave.
Baltimore, MD 21215

Donna Kinzer
Executive Director
Maryland Health Services Cost Review Commission
4160 Patterson Ave.
Baltimore, MD 21215

Dear Mr. Colmers and Ms. Kinzer:

The purpose of this letter is to offer qualified support for the staff comments on the Health Job Opportunity Program Proposal offered by the Maryland Hospital Association (MHA). The MHA is to be commended for raising an issue that is extremely important to the future discussions about the health and health care for critically underserved Marylanders.

The proposal before the commissioners from the Maryland Hospital Association (MHA) presents both a unique opportunity and a unique challenge. I represent the perspective of a plan sponsor - those employees and employers who pay the bills in our current system - what has been called the foundation of the American health care system. I do not suggest that my perspective is representative of the plan sponsor community, but I do hope it may help to frame future dialogue on the topic. This topic addressed here will not go away.

My comments are not only addressed to the Commissioners, but also to those political leaders who wrote in support of the MHA proposal.

Health care is more than medical care

To frame this discussion, I would like to make a distinction between medical care and health care. Medical care is the care delivered by doctors and hospitals and other health care facilities and professionals. For my purposes, health care is more than medical care and includes what are often referred to as the "social determinants" of health.

In moving to a system of hospital global budgeting, Maryland is doing more than just moving away from fee for service Medicine. It is recognizing that health care is more than just medical care. It is attempting a transformation from a system that pays only for medical care to one that pays to deliver health. It is learning that health care is more than just medical care. Much of the discussion at the Care Coordination Work Group centered on exactly that topic.

As plan sponsors we have traditionally paid for medical care. That may be unfortunate, but it is the system we have. Although we call it health insurance, it is more aptly labelled sick insurance. Too often we pay the cost consequences for those who have not had adequate health care before becoming our employees, union members or family members. Some of us are moving to adopt

wellness programs and moving toward a more holistic approach to health. But that is for our own population and may or may not even include the families of our workers.

I remember attending one of the first Payment Model Work Group meetings. One of the hospital representatives commented on the new global budgeting opportunity by saying that it would allow them to spend money on areas that improve health care delivery but that they would also have to increase charges for the things that they do get paid for.

Addressing the social determinants of health

Relative to other countries, the United States spends far more for health services and far less on the social services that have been documented to improve health outcomes. The proposal by the MHA is further recognition of the social determinants of health and once again we employers and plan sponsors are asked to foot the bill. This cannot and should not continue. The question before the Commission and, in part, the question before those politicians whose endorsements accompany the MHA proposal, is twofold: to what extent are hospitals responsible for addressing the social determinants of health and to what extent are plan sponsors responsible for bearing that cost?

While there may surely be a role for hospitals in addressing some of the social determinants of health, the scale of the gap is huge. It is unrealistic to expect hospitals, and by extension, plan sponsors fill this need. The potential bill is enormous. And those politicians supporting the proposal are abdicating their own responsibility to achieve a more coherent approach to meeting the health needs of Marylanders.

The Rate Setting mechanism is the wrong solution

I question whether in the long run it is the responsibility of Plan sponsors to bear those costs through the current rate setting mechanism. There are many factors that affect the health and well-being of the people we cover in our plans. Will this proposal help them? I think not

It will provide much needed help to populations in great need in ways that are well documented by the MHA paper. But is it fair to ask plan sponsors to bear that cost, especially when we will soon be facing a 40% excise tax on costs above the excise tax threshold? I think not.

The 57% of employers who offer health insurance to their employees should not bear this cost. It is a cost that should be supported by local, state, and federal support of social services through equitable taxation that treats all employers fairly.

Politicians endorsing this proposal should not look to plan sponsors to absorb costs they are not willing to grapple with themselves. It is time our political leaders address the shortcomings of the Affordable Care Act and the limitations of a hospital global budgeting system that tries to find a way to address the larger issues of delivering health in a payment system that only pays for medical care.

The HSCRC staff comments offer a reasonable approach

The staff of the HSCRC is to be commended for keeping the Commission focused on its Triple Aim of improving care, improving health, and lowering costs. In the context of lowering costs, the Commission should note the observation form a recent Commonwealth Fund Report: [i]"One

potential consequence of high health spending is that it may crowd out other forms of social spending that support health."

The complexity of economic disparities, which the staff notes, include job development, employment security, housing, food, transportation, and education, as well as other issues such as safety and security for community residents, exceed the scope of the Maryland rate setting process, even in the context of global budgeting.

The Commission is to be commended for the steps it has taken thus far, including allocating money for infrastructure development. Hospitals are to be commended for exceeding revenue reduction targets and quality improvements goals, while at the same time improving their own profitability. It is time for political leaders to address the much larger issues related to the social determinants of health care without passing the buck onto the employees and employers who currently fund health care in Maryland.

Sincerely,

James L. McGee, CEBS

Executive Director

CC: Barbara A. Mikulski, United States Senator
Elijah E. Cummings, Congress of the U.S
Donna F. Edwards, Congress of the U.S,
C.A. Dutch Ruppersberger, Congress of the U.S
John P. Sarbanes, Congress of the U.S
Chris Van Hollen, Congress of the U.S.,
Thomas V. Mike Miller, Jr, Maryland General Assembly
Michael E. Bush, Maryland General Assembly
Peter A. Hammen, Maryland House of Delegates
Maggie MacIntosh, Maryland House of Delegates
Susan C. Lee, Maryland Senate

[i] U.S. Health Care from a Global Perspective: Spending, Use of Services, Prices, and Health in 13 Countries, David Squires and Chloe Anderson, Commonwealth Fund pub. 1819 Vol. 15

JOHNS HOPKINS
MEDICINE

Ronald R. Peterson

President
Johns Hopkins Health System
The Johns Hopkins Hospital

Executive Vice-President
Johns Hopkins Medicine

December 1, 2015

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

Dear Chairman Colmers:

The purpose of this letter is to provide comments on the staff's recommendations related to the Health Job Opportunity Program. Johns Hopkins Health System and University of Maryland Medical System propose alternative options beyond what was presented at the Commission meeting on November 18, 2015. Each of the options outlined in the HSCRC Staff Recommendation fall significantly short of overall goal the Health Opportunity Job Program aims to achieve: 1,000 new jobs. While hospitals appreciate staff's willingness to allow a modest amount of existing funds already dedicated to transformation implementation grant funds to be diverted to this program the recommendations take funds away from current transformation initiatives. Without new and permanent funding there will be no opportunity to create new jobs targeted at disadvantaged communities. Because we believe that Baltimore City and other disadvantaged communities throughout the state need immediate action to create a new sense of hope and opportunity, we propose an alternative proposal.

- The HSCRC will structure a voluntary statewide program to provide limited phased in funding:
    - Effective January 1, 2016, $10 million will be available on an annualized basis (which will equate to $5 million in revenue during FY 2016). This immediately creates 250 jobs.
    - Effective July 1, 2016, $10 million additional grant funds will be available to bring the cumulative funding to $20 million or 0.125 % of statewide approved revenue. This will create an additional 250 jobs bringing newly created jobs in disadvantaged neighborhoods to 500.
- The HSCRC will require hospital grant applications to demonstrate that the hospital will provide a 20% match for any amount funded in rates. The hospital match can be made up from specific costs of the jobs program for direct neighborhood recruitment, job training, employee benefits, etc. This match requirement will add to and enhance the jobs generated through the program.

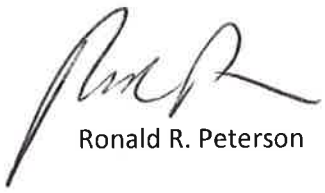
733 North Broadway, BRB 104, Baltimore, Maryland 21205, 410-955-9540 phone, 410-955-0856 fax, rpeters@jhmi.edu

- Consider the Jobs program a pilot project that will reviewed at June 30, 2017 to see if the intended benefits to disadvantaged neighborhoods were achieved Benefits would include creation of new incremental hospital jobs and measurable improvement in the health status of the targeted communities These variables are objectively measurable off of a base period and can be reported to the HSCRC commissioners for review and evaluation.

- Require quarterly hospital reporting that demonstrates grant money is spent on time and for appropriate job program costs and that hospital administration certifies that jobs are incremental and not a replacement of existing positions. These reports can be verified annually as part of the HSCRC Special Audit.

Again, without new funding for a proposal that can be swiftly implemented, we pass on an opportunity to create a transformative program that will make a difference in the lives of those most in need of help. We believe this alternative appropriately balances the concerns voiced by HSCRC staff and Commissioners, as well as payers, while still providing for an innovative and immediate solution for the challenges facing targeted disadvantage communities in dire need of assistance.

Sincerely,



Ronald R. Peterson

cc: Herbert Wong, PhD, Vice Chairman
George H. Bone, MD
Stephen F. Jencks, MD, MPH
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Bernadette Loftus, MD
Thomas R. Mullen

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CORPORATE OFFICE

December 1, 2015

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

Dear Chairman Colmers:

Each of the options outlined in the HSCRC Staff Recommendation fall significantly short of overall goal the Health Opportunity Job Program aims to achieve; 1,000 new jobs. While hospitals appreciate staff's willingness to allow a modest amount of existing funds already dedicated to transformation implementation grant funds to be diverted to this program the recommendations take funds away from current transformation initiatives. Without new and permanent funding there will be no opportunity to create new jobs targeted at disadvantaged communities. Because we believe that Baltimore City and other disadvantaged communities throughout the state need immediate action to create a new sense of hope and opportunity, we propose an alternative proposal.

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    - Effective January 1, 2016, $10 million will be available on an annualized basis (which will equate to $5 million in revenue during FY 2016). This immediately creates 250 jobs.
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- Consider the Jobs program a pilot project that will be reviewed at June 30, 2017 to see if the intended benefits to disadvantaged neighborhoods were achieved. Benefits would include creation of new incremental hospital jobs and measurable improvement in the health status of the targeted communities. These variables are objectively measurable off of a base period and can be reported to the HSCRC commissioners for review and evaluation.

- Require quarterly hospital reporting that demonstrates grant money is spent on time and for appropriate job program costs and that hospital administration certifies that jobs are incremental and not a replacement of existing positions. These reports can be verified annually as part of the HSCRC Special Audit.

Again, without new funding for a proposal that can be swiftly implemented, we pass on an opportunity to create a transformative program that will make a difference in the lives of those most in need of help. We believe this alternative appropriately balances the concerns voiced by HSCRC staff and Commissioners, as well as payers, while still providing for an innovative and immediate solution for the challenges facing targeted disadvantage communities in dire need of assistance.

Sincerely,

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

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

Maryland
Hospital Association

November 23, 2015

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

Dear Chairman Colmers:

On behalf of the Maryland Hospital Association's 66 member hospitals and health systems, I am writing in support of Option 3 of the staff proposals for the Health Jobs Opportunity Program, with one important modification related to the level of funding. As the hospital field commits to further development of this important program's design and implementation with the commission, we cannot support the up-front funding limitation of $5 million indicated by staff; instead, the amount and its source should be defined by the further work to be done under Option 3.

We appreciate the thoughtful consideration that staff has given in its proposed range of options for the jobs program, and would agree with commissioner comments made at the November 18 public meeting, that the needs of addressing health care disparities throughout the state, including the lack of meaningful job opportunities in areas of high unemployment and poverty, is one of the most challenging issues the commission has had to address. While the proposed options fall short of the $40 million in new rate funding that supporters requested to begin to address these needs, Option 3 will allow hospitals to continue to explore these challenges and solutions with the commission. Options 1 and 2 are not acceptable to the hospital field, as they would divert equally important competitive transformation implementation grant funds toward the Health Jobs Opportunity Program. As collaborative efforts are well under way for the expected December 21 submission of those grant applications, we believe it would be inappropriate to redirect any portion of those funds — even to meet the important goals of the jobs program.

We look forward to your consideration of our recommendation at the December 9 public meeting.

Sincerely,

Michael B. Robbins

Michael B. Robbins
Senior Vice President

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

Office of the President & CEO

Mercy
HEALTH SERVICES

University Affiliated

Sponsored by the Sisters of Mercy

November 17, 2015

Health Services Cost Review Commission (HSCRC)
C/O Donna Kinzer, Executive Director
4160 Patterson Avenue
Baltimore, Maryland 21215

RE: Response to Preliminary Staff Report on Health Job Opportunity Proposal

Dear Commissioners and Staff:

On behalf of Mercy Medical Center, this letter is to offer comment regarding the Health Services Cost Review Commission (HSCRC) preliminary staff recommendations on the Health Job Opportunity Program Proposal. Mercy Medical Center was proud to participate in the development of the proposal and supports the effort of expanding 1,000 hospital employed positions to be hired from low income, high unemployment areas for the purpose of: (1) Improving the overall socioeconomic determinants of health in the community and (2) Expanding the community health workforce to assist hospitals in improving population health.

As noted in the jobs program proposal, Baltimore and other parts of Maryland are especially challenged with high poverty rates which correlate to significant health disparities and poor health with higher costs to the health care system. The proposal represents a relatively small, targeted, and appropriate front-end investment to address the issue in a way that meets the triple aim of better care, better health, and lower costs. The proposal is aligned with Maryland's All-Payer model and should be viewed as complementary to other ongoing efforts in the state to improve public health and reduce health disparities while also recognizing that more work and investment is clearly needed.

Further, as large employers with existing, effective workforce development programs designed for entry-level and lower-skill workers, health systems are uniquely-positioned to expand career development opportunities through increased access to education, mentorship, and general skills-building. For example, at Mercy Medical Center we offer a host of programs specifically for this purpose including; tuition assistance, continuing education, computer training, GED preparation, literacy, and a comprehensive "Career Ladder" program that assists individuals in earning promotions and higher wages. The jobs program proposal would allow institutions like Mercy to expand these workforce development opportunities to more individuals in targeted communities while also supporting population health efforts.

Regarding the staff recommended options which seek to earmark dollars away from the Transformation Implementation Grants, Mercy agrees with our hospital partners who believe this approach would be disruptive to significant planning efforts already underway to respond to the Transformation Plan and RFP requirements.

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TTY (410) 332-9888

In conclusion, printed on the doors of our hospital is a welcome from the Sisters of Mercy and a declaration of a core belief to serve "all people of every creed, color, economic and social condition." We have carried on that principle for over 140 years in downtown Baltimore, especially during times of great challenge. With the April unrest, Baltimore has experienced a devastating manifestation of poverty, lack of access to jobs and upward mobility. We support jobs proposal to address the challenge while improving the health of our communities. Thank you for the opportunity to comment.

Sincerely,

BARBARA A. MIKULSKI
MARYLAND

United States Senate

WASHINGTON, DC 20510–2003

November 5, 2015

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

Dear Mr. Colmers:

In September, you received a letter from me in support of an exciting and innovative new proposal from Maryland's hospitals, called the "Health Job Opportunity Program." This proposal, submitted to the Health Services Cost Review Commission (HSCRC), would create a hospital-led employment program to hire 1,000 additional people from Maryland communities with high rates of poverty and unemployment. I am so excited about the promise that this proposal has for our most distressed communities.

We have very real challenges facing Baltimore City that deserve more aggressive, comprehensive, and innovative solutions. The recent tragic death of Freddie Gray brought to light what many of us already knew to be true: we must address issues of social inequality in Baltimore City. The lack of stable, entry-level employment with opportunities for career advancement is a contributing factor to this social inequality. Unemployment contributes to poverty and poverty contributes to poor health. It is staggering that residents in Guilford have a life expectancy of nearly 20 years longer than residents of Greenmount East.

This is where the "Health Job Opportunity Program" could help play a pivotal role. As you know, Maryland's modernized all-payer waiver encourages hospitals to pursue creative solutions to improve the overall health and wellness of our communities. Since meaningful and stable employment can contribute to greater social and economic stability for underserved regions, and since hospitals have a role to play as some of our state's largest employers and community anchors, I am excited about what the "Health Job Opportunity Program" could mean to Baltimore City.

By creating this program – to allow for the expansion of up to 1,000 hospital-employed positions to be hired from low-income, high-unemployment areas – we could accomplish two important goals. First, by providing stable entry-level employment with advancement opportunities, we would be improving the overall socioeconomic determinants of health in distressed communities. And second, by expanding the community health workforce, we would assist Maryland's hospitals in providing health care to those in need.

I would urge the HSCRC to give the "Health Job Opportunity Program" every favorable consideration and stand ready to help in any way possible to get this proposal implemented on behalf of the people of Maryland. Thank you and please do not hesitate to contact me with any questions or concerns.

Sincerely,

Barbara A. Mikulski
United States Senator

The
League
of
Life and
Health
Insurers
of
Maryland

200 Duke of Gloucester Street
Annapolis, Maryland 21401
410-269-1554

November 13, 2015

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

Re: Hospital Job Opportunity Proposal

Dear Mr. Colmers:

The League of Life and Health Insurers of Maryland, Inc. (the League) is the trade association representing carriers who write life and health insurance in Maryland. Through our various membership categories, we work with every carrier writing major medical health insurance in this State. The League has had an opportunity to review the Health Employment Program proposal put forward by the Maryland Hospital Association and under consideration by the HSCRC. While we appreciate the effort to identify creative ways to address the daunting issue of poverty and unemployment in Baltimore and other areas of the State, especially as it relates to disadvantaged youth, for the reasons articulated below, we must oppose this program and urge the Commission to decline the request to support it through an increase in hospital rates.

Hospitals Have the Ability to Pay for the Program out of Existing Revenue Budgets

Two years into the implementation of the new waiver, hospitals are making record profits on regulated business – 5.86% for FY2015, up from 4.28% in FY2014. In fact, there are only five hospitals in the state that failed to realize a profit during that time period. In addition and more significantly, the HSCRC has already made infrastructure adjustments to the hospitals' rates totaling almost $200 million. These are not one-time adjustments; rather, they have been built permanently into hospital global budgets. That means unless the Commission takes action, hospitals will receive this money year after year. As a result, a portion of these funds could - and should- adequately fund this proposed program without the need for an additional increase.

Cost of Employment Programs for Hospital Workers Should Not be Born by Consumers and Businesses

Every additional increase to hospital rates has a direct impact on premiums paid by individuals, and employers - small and large, insured and self funded - in the State of Maryland. This proposal comes at a time of increased concern for rising insurance premiums, stringent Medical Loss Ratio requirements which must be met by carriers and a need to see a reduction of overall healthcare costs. At a time when all stakeholders in the health care community are working to

identify ways to reduce costs to the system, this program achieves the opposite effect, adding yet another layer of expense to premiums that have already experienced significant increases on average over the past several years.

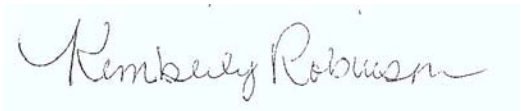
Using the Rate Setting System to Cover the Costs of an Employment Program Goes Beyond the Purposes of the Rate-Setting System

While there have been instances in the past where "employment" programs have been funded through hospital rates, those initiatives were on a much smaller scale with a purpose that more closely aligned with health care and the provision of clinical services. For example, the nursing support programs were created in response to a real, near crisis in the form of a nursing shortage. In addition, the average cost provided through rates to fund these nurse support programs was far less than $40 million annually – averaging closer to $10 million on an annual basis. While one can argue that community health workers may extend the ability of the hospitals to provide care to the community, the current proposal envisions hiring positions that go well beyond community health workers, to include general facility support such as janitors and security guards. All hospital related expenses necessary to satisfy current hospital service area populations are already currently funded in hospital rates.

The League supports the concept of this initiative which is intended to improve community health while addressing longstanding economic issues; however, as noted above, we cannot support the proposed funding arrangements which would increase hospital rates an additional $40 million to address issues that go beyond the scope of the all-payer system. Funding of jobs necessary to conduct hospital operations should be covered within the hospitals' current rate base. Any additional jobs should have a direct impact on a hospital's ability to improve population health and lower utilization of hospital services, all of which will improve hospitals' global budget savings.

For these reasons, we strongly urge the Commission to vote against any hospital rate increase to support this program.

Very truly yours,



Kimberly Y. Robinson, Esq,
Executive Director

Cc: Donna Kinzer, Executive Director, Health Services Cost Review Commission

1199SEIU
United Healthcare Workers East

November 11, 2015

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

Dear Chairman Colmers:

1199SEIU United Healthcare Workers East represents 9,000 healthcare workers throughout Maryland and the District of Columbia, many of whom live and work in Baltimore City. 1199SEIU represents workers at almost every stage of the health care delivery process, both in long term care facilities and hospitals. 1199SEIU also jointly operates a labor-management fund that provides educational and job training programs to eligible members. **It is with this expertise that we urge the Health Services Cost Review Commission (HSCRC) to consider our concerns and suggestions towards improving the proposed Health Job Opportunity Program currently under review - in the short term through this letter and in the future as a member of the potential program review panel and/or workgroup.**

Through their consideration of the proposal, the HSCRC acknowledged the role that the hospital industry plays in the economic well-being of Baltimore and its residents. The themes in the hospital's proposal are ones which our union has worked to highlight for many years. Our most recent and public evidence of this was our 2014 campaign to improve the economic security of workers at Johns Hopkins Hospital through wage increases designed to pull workers out of poverty. We have long advocated for improved wages and benefits for the workers at all levels of the healthcare workforce. Entry-level healthcare jobs MUST provide a meaningful pathway for workers to the middle class.

As mentioned above, our union also developed infrastructure and expertise in the details of workforce development. The 1199SEIU Training and Upgrading Fund (TUF) of the Maryland/DC region provides a safe and confidential space for union members to meet their educational goals. The Fund offers career and educational counseling services, coaching/case management, skill assessment, continuing education, tuition benefits and development of individual career and educational plans to thousands of 1199 members throughout the state.

We urge the HSCRC to consider that the systemic poverty which hospitals seek to address will not be solved by merely creating new jobs. The proposal as currently written suggests that the HSCRC establish a program review panel to determine which hospital applications should be funded. Should the HSCRC move forward with this proposal, we urge the Commission to include stakeholders who can offer guidance and expertise on the challenges faced by entry-level workers (such as our union's Training and Upgrading Fund) onto such a program review panel.

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We also want to note that while hospitals have long been Baltimore City's largest employers, they are not traditionally viewed as experts in workforce development for the people who are being targeted in this proposed program. This program as designed requires hospitals to engage in a process that they have never been asked to engage in before. While some of the City's hospitals have embarked on relationships with community workforce organizations that assist individual employees in their career development goals, the sheer scale of what is being proposed requires hospitals to confront the challenges of workforce development in ways they have never had to in the past.

The Nurse Support I Program and the Nurse Support II Program (NSP Programs) have been cited as precedent for a collaborative response to this state's workforce crisis. While the NSP Programs have increased the number of nurses in Maryland, the workforce development strategies designed to address adults with limited education and income, or who live in high-poverty neighborhoods, are quite new to hospitals as employers.

We believe that hospitals must be able to provide specific details about what their outreach and retention strategies from low-income/high-unemployment zip codes would look like. And with the challenges of systemic poverty in mind, we propose to the HSCRC that in such a program, hospitals should detail the following:

- Assessment tools used by hospitals to identify candidates who will succeed. For example, how will the net be cast in poverty stricken communities to identify eligible workers? What will be the pre-requisite skills needed for workers to apply for these jobs? What assessment tools will be used to verify that the workers who are placed in these opportunities will succeed?
- Methods that will be used to train new entrants for the workforce. For example, will workers be trained cohort-style? Will they be grouped with incumbent workers? Details on how these workers will be trained will not only hold hospitals accountable, but also be useful for future evaluation of whether a specific hospital could retain workers, and why they were able to do so.
- Details about the case management and support systems that will be in place for workers to help them succeed. We have long heard from low-wage hospital workers on the difficulties they face utilizing education programs that exist in their institutions.

If the HSCRC were to move forward with this initiative, increased transparency would be critical to its success. For example, we believe that the HSCRC should collect demographic information about the participants in this program so that its strengths and weaknesses can be assessed in the future. Requiring submission of information such as the age range, education, prior experience and credentials of

workers who enter into hospital employment - and are retained –would also help stakeholders evaluate the program, adjust its goals and - ideally - replicate its success.

Should the HSCRC determine that further review and/or development of the proposal is required, we believe that our Training and Upgrading Fund could provide additional insight into the components required to initiate true workforce development that leads individuals towards economic stability and improves the health of our communities.

Sincerely,

Jen Brock-Cancellieri
Senior Policy Analyst
1199SEIU United Healthcare Workers East

Chet Burrell
President and Chief Executive Officer

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chet.burrell@carefirst.com

October 21, 2015

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

Dear Chairman Colmers,

I am writing to provide comments regarding the "Health Employment Program" (HEP) that was proposed by Johns Hopkins Hospital and other hospitals to the HSCRC on September 9, 2015.

As you know, the proposal would have the HSCRC put $40 million annually in additional funds into the rates of hospitals principally located in the city of Baltimore to fund approximately 1,000 additional jobs for disadvantaged inner city residents. While we certainly recognize the difficult economic and social circumstances that are challenging the inner city of Baltimore, we see this proposal as seriously flawed.

The following four points more specifically constitute our view of the proposal:

First, while the central purpose of the program is to increase employment opportunities for inner city residents with limited education and job experience, we question how the hospitals will use such individuals to provide needed capabilities. If the hospitals seek to hire more skilled and educated persons, this misses the target population most in need. Further, if the jobs to be created are really needed and are not simply "make work" jobs to fulfill a jobs program, then we question why the hospitals would not simply employ these individuals in the normal course of their operations.

Second, Johns Hopkins and the other hospitals have proposed a program of employment to which they would contribute no financial support. Instead they would pass the entire bill for the program along to other employers and individuals in the form of higher hospital rates (and ultimately health care premiums). With employers and individuals struggling to pay health care premiums, we think increasing their burden is not justified and we see no basis to believe that the expenditure of $40 million for the proposed jobs would result in equivalent or greater savings.

In effect, it would be like CareFirst suggesting it wanted to hire 1,000 new employees while handing the bill for this to Johns Hopkins and other hospitals. What at first seems like a virtuous attempt to fill a legitimate need becomes distinctly less so when one realizes that the sponsors intend others to pay for the program while paying nothing themselves.

Third, hospitals have been provided an increase of approximately $160M in rates to satisfy infrastructure changes under the new waiver model. If hospitals are committed to the dual objectives of improving community based care and raising employment levels in their communities, we ask why some of this additional funding would not be used for the achievement of these goals? This is particularly pertinent since all financial savings through lower utilization, improved community health, etc. will result in greater GBR savings that will accrue solely to the hospitals.

Fourth, since the advent of the new hospital all payer waiver in Maryland, hospital profit margins have soared to all time high levels on their regulated businesses. The hospitals suggest that the $40 million HEP is a small amount for the payers (ultimately employers and individuals) to bear. If the cost is so modest, why, we ask, could the hospitals not easily bear this small amount themselves out of the generous margins they are now enjoying? Indeed, we see the HEP as an activity that is consistent with the hospital's community benefit responsibilities. What, we would ask, holds them back - particularly in light of the large reductions in hospital charity care in recent years caused by ACA enrollment?

In sum, we believe that the proposed goal is laudable and that the funds for its achievement are available based on actions the HSCRC already has taken for the hospitals.

A proper judgment of this proposal turns not on the details of how it might be administered but rather, on the fact that its laudable purpose should be carried out in a fundamentally different way. Funding additional jobs by raising hospital rates is an unsound policy that has no obvious limits: if hospital rates can be raised to create jobs, why couldn't they be raised to fund myriad other social projects of greater or lesser merits?

The HSCRC's statutory role is to approve hospital rates that are consistent with the efficient and effective provision of hospital services. It is not the HSCRC's function to serve as the arbiter of resource expenditures in activities across a broad range of social purposes.

Sincerely,

Chet Burrell
President & CEO

cc Herbert Wong, PhD Vice Chairman
Stephen F. Jencks, MD
George H. Bone, MD
Jack C. Keane
Bernadette Loftus, MD
Thomas R. Mullen
Donna Kinzer, Executive Director
Van Mitchell, State of Maryland DHMH

BUILD
ROOTED IN COMMUNITY
COMMITTED TO CHANGE

October 14, 2015

Dr. Bernadette Loftus
Health Services Cost Review Commission
4160 Patterson Ave.
Baltimore, MD 21215

Dear Dr. Loftus:

As Maryland's largest citizens' power organization representing more than 40 faith, school, and community institutions and over 20,000 members, Baltimoreans United in Leadership Development (BUILD) is asking for your support of the Healthcare Workers Opportunity Initiative. We believe this is a critical time in our city's history. We must act boldly to address the many issues of Baltimore city. This initiative is a major step in the right direction. It will create the opportunity to employ over 1,000 families in our city plus introduce families to more informative and engaged healthcare options and outcomes. We have listened to over 5,000 people across our city and overwhelmingly they have told us jobs is the most important issue facing their families.

BUILD has a 38 year track record of organizing to better Baltimore by winning the first living wage ordinance in the country, developing over 1200 affordable homes, and founding College Bound and the Child First Authority. Most recently, BUILD created Turn Around Tuesday to address the culture of violence in our City. Turn Around Tuesday is a jobs movement to help put Baltimore back to work by creating a jobs pipeline with hospitals, universities, and construction firms to hire returning citizens and residents living in distressed neighborhoods. Already, 74 men and women who had little to no opportunity for work have secured employment with an 89% six month retention rate. The unrest in Baltimore continues to galvanize us to create further opportunities with Baltimoreans.

BUILD is encouraged that area hospitals want to make a commitment to provide hiring opportunities, with training, and upward mobility within the health care field for area residents. Their proposal for a .25% rate increase to fund the hiring of 1,000 residents is promising. BUILD supports this proposal and asks you to join with us and stand for families all across our city.

Please contact BUILD Organizer, Terrell Williams, at 202-427-6876 or via email at novellae11@msn.com to schedule a meeting to discuss this important matter. We thank you in advance. BUILD looks forward to the opportunity to work with you to build a better Baltimore.

Sincerely,

Glenna Huber

Rev. Glenna Huber
BUILD Co Chair

Rev. Andrew Foster Connors
BUILD Co Chair

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

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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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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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

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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
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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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C.A. DUTCH RUPPERSBERGER
2ND DISTRICT, MARYLAND

REPLY TO:

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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
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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

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CHRIS VAN HOLLEN
8TH DISTRICT, MARYLAND

COMMITTEE ON THE BUDGET

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House of Representatives
Washington, DC 20515

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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
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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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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

Maryland Hospital Acquired Conditions Policy Updates for RY2018

12/9/2015

HSCRC
Health Services Cost Review Commission

RY2018 MHAC Update Considerations

- Program guiding principles
- PPC reliability and validity testing preliminary results
- PPC List-
  - Merging PPCs
  - Suspending PPCs
  - PPC listings for tiers
  - PPC tier weighting
- Revenue at Risk
- Statewide target
- Potential 1-10 transition implications
- Recommendations

Guiding Principles for the MHAC Program

- The program must improve care for all patients, regardless of payer.
- The breadth and impact of the program must meet or exceed the Medicare national program in terms of measures and revenue at risk.
- The program should identify predetermined performance targets and financial impact.
- An annual target for the program must be established in the context of the trends of complication reductions seen in the previous years, as well as the need to achieve the new All-Payer Model goal of a 30 percent cumulative reduction by 2018.
- The program should prioritize PPCs that have high volume, high cost, opportunity for improvement, and are areas of national focus.
- Program design should encourage cooperation and sharing of best practices.
- The scoring method should hold hospitals harmless for a lack of improvement if attainment is highly favorable.
- Hospitals should have the ability to track progress during the performance period.

PPC Review and Validation Process

- HSCRC, MHA and 3M clinical logic review committee (meets quarterly review the definitional/clinical issues raised by the field)
- HSCRC coding audit (10 hospitals a year)
- Statistical analysis
  - Reliability: Signal to noise ratio. Are we measuring real difference in performance or random variation ?
  - Predictive validity: Do current results predict future performance ?
  - Convergence validity: Are they correlated with other measures conceptually related ?

PPC Validity and Reliability Testing

- Mathematica Policy Research (MPR) conducted a number of analyses and presented their results to the Workgroup at its November 20 meeting (see Appendix III of the recommendation).

- Reliability was analyzed comparing between-provider variation (signal) and within-provider sampling variation (noise).
  - PPC measure is low in reliability if its reliability estimate is less than the cut-off point of 0.4.
  - With serious reportable event PPCs excluded from this reliability assessment, there were 12 total "low reliability" PPCs, with the majority from Tier C used for FY 2017 weighting.

Predictive Validity Results

- Predictive validity means that the current results predict future performance.
- Based on these results, HSCRC staff note that there is a relatively high level of consistency.
- Also, the consistency percentage is greatest for PPCs in Tier A, and there is a decreasing percentage of PPCs with consistency in Tiers B and C.

PPC Result	Tier A	Tier B	Tier C
Consistent:	PPC 3, 4, 5, 6, 7, 9, 14, 16, 24, 35, 37, 40, 42, 49, 54, 65, 66	PPC 8, 10, 11, 19, 41, 48, 27	PPC 1, 12, 13, 21, 23, 34, 36, 46, 47, 50, 51, 52, 53, 55, 56, 57, 58, 59, 60, 61, 62, 67
Total	17 (85%)	7 (78%)	22 (69%)
Inconsistent:	PPC 28, 31, 38	PPC 17, 18	PPC 2, 15, 20, 29, 30, 32, 33, 39, 44, 45
Total	3 (15%)	2 (22%)	10 (31%)
Tier Total	20	9	32

Convergent Validity Results

- Correlations of PPCs were measured with external measure.
- A subset of PPCs were roughly matched with the PSIs in the Agency for Healthcare Research and Quality (AHRQ) PSI 90 Composite measure reveal that most, but not all, of these "matched" measures are correlated.
- Six PPCs are relatively highly correlated with mortality in the MPR analysis.

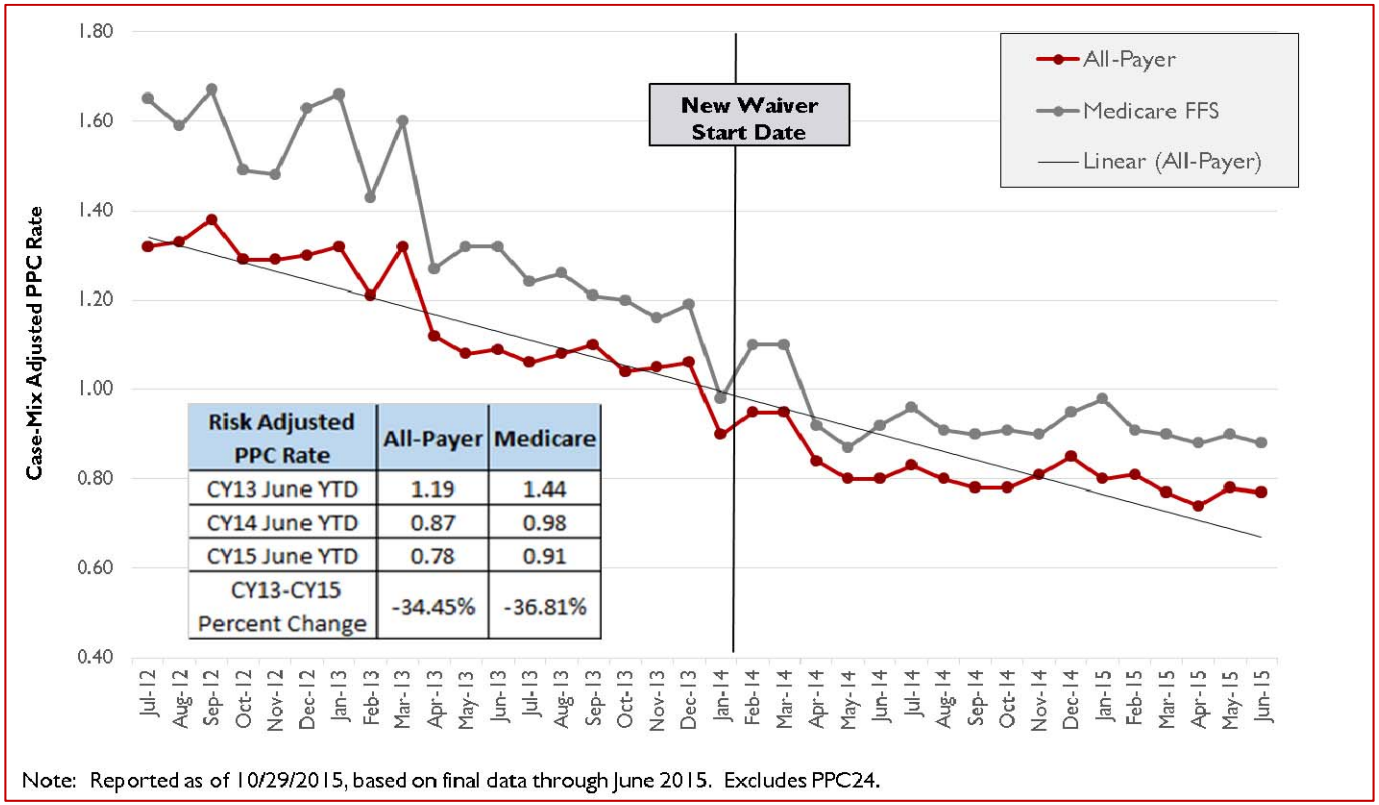
Statistical Results Must be balanced with the Clinical Design Approach of the PPCs

- 3M Health Information System's review of these analyses and initial feedback includes the following:
  - The PPC and PSI measure definitions are inconsistent,
  - Mortality rates and PPCs measure different domains of care, and,
  - The PPC model is constructed based on clinical rules defined by clinicians rather than statistical analysis of observed outcomes; therefore, the statistical analyses must be considered in light of these issues

PPC List

- Statistical and clinical review process pointed out only a handful of PPCs emerge as candidates for modifications
- PPCs with lower scores of reliability and validity, staff is continuing to vet options for combining some PPCs for measurement, or suspending use
- Staff is using the results of statistical analysis and clinical input to modify high priority PPCs (Tier A)
- Staff is working on simplifying the program by reducing PPC tiers from 3 to 2
- Additional discussion and input of stakeholders will be included in the final recommendation.

Monthly Year to Date Trends in PPC Rates



Risk Adjusted PPC Rate	All-Payer	Medicare
CY13 June YTD	1.19	1.44
CY14 June YTD	0.87	0.98
CY15 June YTD	0.78	0.91
CY13-CY15 Percent Change	-34.45%	-36.81%

Note: Reported as of 10/29/2015, based on final data through June 2015. Excludes PPC24.

Staff note the consistent trends downward in PPC reductions support using updated benchmarks for FY 2018.

Setting Annual Target for FY 2018

PPC Rates in Maryland- State FY 2013-2015						
	PPC RATES (FY 14 NORMS vs. 32)			Annual Change (FY 14 Norms vs. 32)		Cumulative Improvement
	FY 13	FY 14	FY 15	FY 13 – FY 14	FY 14 – FY 15	FY 13 – FY 15
TOTAL NUMBER OF COMPLICATIONS	27,939	21,059	17028	-24.6%	-19.1%	-39.1%
CASE-MIX ADJUSTED COMPLICATION RATE	1.25	0.97	0.8	-22.4%	-17.5%	-36.0%

- The state has achieved and exceeded the 30 percent target required by the All-Payer Model agreement with CMMI in two years.
- The reduction target for FY 17 is set at 7%.
- Staff notes there is need to continue to improve care and reduce cost by reducing PPC rates, and supports setting the statewide improvement target at 6%
- Staff supports no changes to the revenue at risk and scaling methodology for the program for FY 2018.

PPC ICD-10 Transition

- For the majority of PPCs, replication in the ICD-10 coding system is straightforward.
- The clinical definitions of the PPCs remain valid for ongoing use in the ICD-10 Coding System, however extra consideration will be required for rate comparisons during the transition year.
- The HSCRC will monitor the impact of the transition and determine appropriate actions to manage the transition year comparison rates and policy implications.

FY 2018 Draft Recommendations

For the FY 2018 MHAC program, staff make the following draft recommendations:

- The statewide reduction target should be set at 6 percent, comparing FY 2015 with CY 2016 risk-adjusted PPC rates.
- The program should continue to use a tiered scaling approach where a lower level of revenue at risk is set if the statewide target is met versus not met as modeled in the FY 2016 policy.
- Rewards should be distributed only if the statewide improvement target is met and should not be limited to the penalties collected.

Draft Recommendation for Modifying the Maryland Hospital Acquired Conditions Program for FY 2018

December 9, 2015

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

This document contains the draft staff recommendations for updating the Maryland Hospital Acquired Conditions (MHAC) Program for FY 2018. Please submit comments on this draft to the Commission by Wednesday, January 4th, 2015, via hard copy mail or email to Dianne.feeney@maryland.gov.

INTRODUCTION

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) quality-based payment methodologies are important policy tools for providing strong incentives for hospitals to improve their quality performance over time.

The HSCRC implemented the Maryland Hospital Acquired Conditions (MHAC) program in state fiscal year (FY) 2011. In order to enhance the HSCRC's ability to incentivize hospital care improvements and to meet the MHAC reduction targets in its All-Payer Model agreement with the Center for Medicare and Medicaid Innovation (CMMI) beginning January 1, 2014, the Commission approved changes to the program. These changes included 1) measuring hospital performance using observed-to-expected ratio values for each Potentially Preventable Complication (PPC) rather than using the additional incremental cost of the PPCs measured at each hospital, and 2) shifting from relative scaling to pre-established PPC performance targets for payment adjustments for FY 2016. The revised approach established a statewide MHAC improvement target with tiered amounts of revenue at risk based on whether or not the target is met; it also allocated rewards consistent with the amount of revenue in penalties collected. The FY 2017 policy adopted retrospective changes to the FY 2016 MHAC policy, allowing for high-performing hospitals to earn rewards not limited to the penalties collected. The FY 2017 policy also adopted changes to the statewide improvement target.

This draft recommendation proposes continuing with the current MHAC program core methodology for FY 2018 and updating the statewide improvement target.

BACKGROUND

1. Centers for Medicare & Medicaid Services (CMS) Hospital Acquired Conditions (HAC) Reduction Program

The federal HAC program began in federal fiscal year (FFY) 2012 when CMS disallowed an increase in diagnosis-related group (DRG) payments for cases with added complications in 14 narrowly defined categories. Beginning in FFY 2015, CMS established a second HAC Reduction program that reduced payments to hospitals with scores in the top quartile for the performance period on their rate of HACs as compared with the national average. In FFY 2016, the maximum reduction remains at one percent of total DRG payments.

The CMS HAC measures for FY 2017 are listed in Appendix I. In the 2016 Inpatient Prospective Payment System (IPPS) Final Rule, CMS indicated that, going forward, the collection and reporting of data through health information technology will greatly simplify and streamline reporting for the HAC Reduction programs and the CMS quality reporting programs overall.

2. MHAC Measures, Scaling, and Magnitude at Risk to Date

The MHAC program is currently based on the 64 PPCs developed by 3M Health Information Systems. The MHAC program was updated for FY 2017 in light of the established guiding principles for the program, including the following:

- The program must improve care for all patients, regardless of payer.
- The breadth and impact of the program must meet or exceed the Medicare national program in terms of measures and revenue at risk.
- The program should identify predetermined performance targets and financial impact.
- An annual target for the program must be established in the context of the trends of complication reductions seen in the previous years, as well as the need to achieve the new All-Payer Model goal of a 30 percent cumulative reduction by 2018.
- The program should prioritize PPCs that have high volume, high cost, opportunity for improvement, and are areas of national focus.
- Program design should encourage cooperation and sharing of best practices.
- The scoring method should hold hospitals harmless for a lack of improvement if attainment is highly favorable.
- Hospitals should have the ability to track progress during the performance period.

To achieve a policy that supports the guiding principles, the program methodology was substantially modified affecting the calendar year (CY) 2015 performance period, which was applied to rate year FY 2017 (see the detailed description in Appendix II). The key changes to the program were as follows:

- Using the Observed (O)/Expected (E) value for each PPC to measure each hospital's performance.
- Using the appropriate exclusion rules to enhance measurement fairness and stability.
- Prioritizing PPCs that are high cost, high volume, have opportunity to improve, and are of national concern in the final hospital score through grouping the PPCs and weighting the scores of PPCs in each group commensurate with the level of priority.
- Calculating rewards/penalties using preset positions on the scale based on the base year scores.
- Using an annual statewide improvement target with tiered scaling.

ASSESSMENT

The HSCRC continues to solicit input from stakeholder groups comprising the industry and payers to determine the appropriate direction regarding areas of needed updates to the programs. These include the measures used and the program's methodology.

The Performance Measurement Workgroup has deliberated pertinent issues and potential changes to Commission policy for FY 2018 that may be necessary to enhance the HSCRC's ability to continue to improve quality of care and reduce costs related to HACs through continued PPC rate reductions. In its October and November meetings, the Workgroup reviewed analyses and discussed issues related to 1) PPC measurement trends, 2) the reliability and validity analyses results of the PPC measures, and 3) PPC tier adjustment options.

1. Updated PPC Measurement Trends

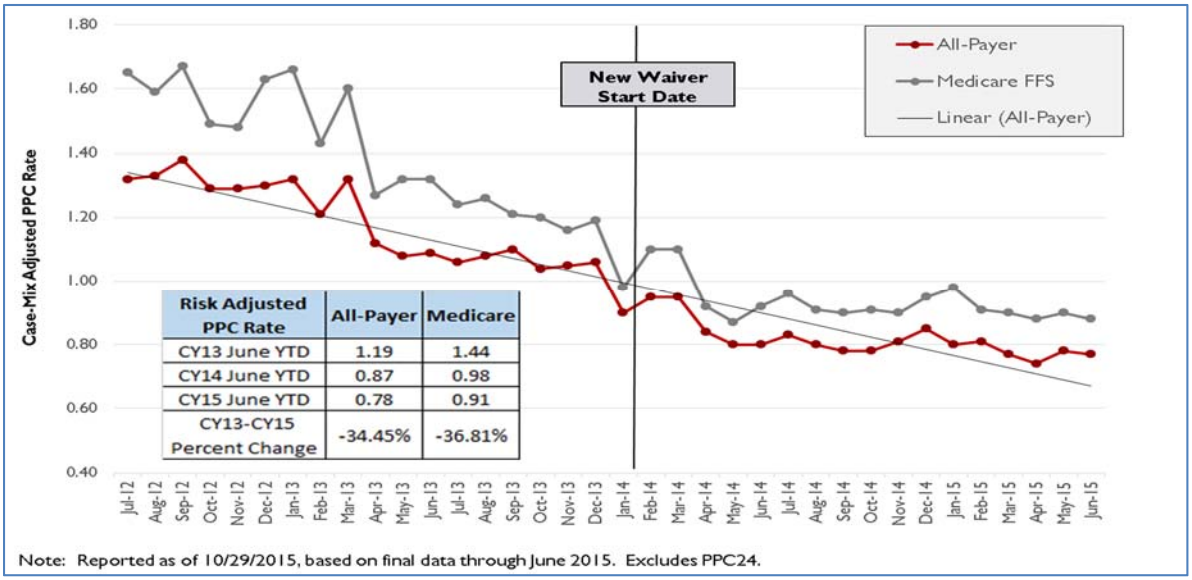
As illustrated in Figure 1 below, the statewide PPC rate decreased significantly year to year between 2013 and 2015, with a total risk-adjusted cumulative improvement rate of 36 percent.

Figure 1. PPC Reduction Trends FY 2013-2015

PPC Rates in Maryland- State FY 2013-2015						
	PPC RATES (FY 14 NORMS vs. 32)			Annual Change (FY 14 Norms vs. 32)		Cumulative Improvement
	FY 13	FY 14	FY 15	FY 13 – FY 14	FY 14 – FY 15	FY 13 – FY 15
TOTAL NUMBER OF COMPLICATIONS	27,939	21,059	17028	-24.6%	-19.1%	-39.1%
CASE-MIX ADJUSTED COMPLICATION RATE	1.25	0.97	0.8	-22.4%	-17.5%	-36.0%

In addition to the annual change in PPC rates, staff also analyzed monthly year-to-date (YTD) PPC Medicare and all-payer changes for 2013 through 2015 and discussed the findings at a public Commission meeting and with the Workgroup. Figure 2 shows the monthly trends in the case-mix adjusted PPC rate and the YTD through June rates for 2013, 2014, and 2015.

Figure 2. FY 2013-2015 Monthly PPC Rate and YTD Comparisons



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CY15 June YTD	0.78	0.91
CY13-CY15 Percent Change	-34.45%	-36.81%

Note: Reported as of 10/29/2015, based on final data through June 2015. Excludes PPC24.

2. Reliability and Validity of PPC Measures

To explore questions of the PPC measures' reliability and validity, under contract with HSCRC, Mathematica Policy Research (MPR) conducted a number of analyses and presented their results to the Workgroup at its November 20 meeting (see Appendix III).

Reliability was analyzed comparing between-provider variation (signal) and within-provider sampling variation (noise). To conduct the analysis, MPR pooled FY 2014 and 2015 PPC performance data. A PPC measure is low in reliability if its reliability estimate is less than the cut-off point of 0.4. With serious reportable event PPCs excluded from this reliability assessment, there were 12 total "low reliability" PPCs, with the majority from Tier C.

Validity analyses of the PPC rates conducted by MPR included the following:

- For predictive validity, the correlation of PPCs across years from CY 2012 to CY 2015, quarters 1 and 2, was measured.
- For convergent validity, correlations of PPCs with external measures including Patient Safety Indicators (PSIs) from the PSI-90 composite and mortality rates were measured.

Figure 3 outlines the predictive validity analysis results. Based on these results, HSCRC staff note that there is a relatively high level of consistency. Also, the consistency percentage is greatest for PPCs in Tier A, and there is a decreasing percentage of PPCs with consistency in Tiers B and C.

Figure 3. Predictive Validity Results

PPC Result	Tier A	Tier B	Tier C
Consistent:	PPC 3, 4, 5, 6, 7, 9, 14, 16, 24, 35, 37, 40, 42, 49, 54, 65, 66	PPC 8, 10, 11, 19, 41, 48, 27	PPC 1, 12, 13, 21, 23, 34, 36, 46, 47, 50, 51, 52, 53, 55, 56, 57, 58, 59, 60, 61, 62, 67
Total	17 (85%)	7 (78%)	22 (69%)
Inconsistent:	PPC 28, 31, 38	PPC 17, 18	PPC 2, 15, 20, 29, 30, 32, 33, 39, 44, 45
Total	3 (15%)	2 (22%)	10 (31%)
Tier Total	20	9	32

Convergent validity analysis results of selected PPCs that were roughly matched with the PSIs in the Agency for Healthcare Research and Quality (AHRQ) PSI 90 Composite measure reveal that most, but not all, of these "matched" measures are correlated. Six PPCs are relatively highly correlated with mortality in the MPR analysis.

Based on 3M Health Information System's review of these analyses and initial feedback, staff note that 1) the PPC and PSI measure definitions are inconsistent, 2) mortality rates and PPCs measure different domains of care, and 3) the PPC model is constructed based on clinical rules defined by clinicians rather than statistical analysis of observed outcomes. Therefore, the statistical analyses must be considered in light of these issues, and additional discussion of 3M and other stakeholder input will be included in the final recommendation.

3. PPC Tier Adjustment

Based on the results of the MPR validity and reliability testing and continued small cell size issues for certain PPCs, staff support consideration for moving from a three-tier weighting to a two-tier weighting of PPCs, potentially combining some clinically similar PPCs, and potentially moving a small subset of PPCs to a "monitoring" position and suspending their use for payment for FY 2018. Staff will continue to vet the PPC proposed tiers and additional changes before finalizing these proposed changes for FY 2018 policy implementation.

Staff note that an overhaul of the program that would potentially entail composite measures for certain high-cost and high-volume conditions or procedures and encompass a broader range of services will entail further conceptual development and testing prior to implementation. In addition, such large scale updates to the program should be done in the context of a re-designed performance management strategy that is patient-centered and supports and measures population health improvement.

4. Annual Statewide MHAC Reduction Target and Score Scaling FY 2018

The Workgroup discussed options for the revised annual MHAC reduction target. Some participants noted that the state has achieved and exceeded the 30 percent target required by the All-Payer Model agreement with CMMI in two years. Staff noted the need to continue to improve care and reduce cost by reducing PPC rates.

Staff advocate for a 6 percent improvement target, which is on par with the improvement trends the state has been observing and is a reduction from last year's annual improvement target of 7 percent. Staff also advocate for no change in the scaling approach by keeping the tiered score scaling constant, with no rewards if the statewide target is not met.

Using a tiered scaling approach provides strong incentives for collaboration between hospitals to share best practices and continue to improve to ensure the statewide target is achieved. While the current scaling approach is based on rewards and penalties for hospitals at the tail end of the scores and holds hospitals with scores in the middle harmless, other revenue reduction programs (Potentially Avoidable Utilization and Readmission Shared Savings) are based on a continuous scale where all hospitals receive reductions in proportion to their performance.

RECOMMENDATIONS

For the FY 2018 MHAC program, staff make the following draft recommendations:

1. The statewide reduction target should be set at 6 percent, comparing FY 2015 with CY 2016 risk-adjusted PPC rates.
2. The program should continue to use a tiered scaling approach where a lower level of revenue at risk is set if the statewide target is met versus not met as modeled in the FY 2016 policy.
3. Rewards should be distributed only if the statewide improvement target is met and should not be limited to the penalties collected.

APPENDIX I.
CMS HAC MEASURES FOR FY 2017

CMS HAC MEASURES Implemented Since FY 2012

HAC 01: Foreign Object Retained After Surgery
HAC 02: Air Embolism
HAC 03: Blood Incompatibility
HAC 04: Stage III & Stage IV Pressure Ulcers
HAC 05: Falls and Trauma
HAC 06: Catheter-Associated Urinary Tract Infection
HAC 07: Vascular Catheter-Associated Infection
HAC 08: Surgical Site Infection - Mediastinitis After Coronary Artery Bypas Graft (CABG)
HAC 09: Manifestations of Poor Glycemic Control
HAC 10: Deep Vein Thrombosis/Pulmonary Embolism with Total Knee Replacement or Hip Replacement
HAC 11: Surgical Site Infection – Bariatric Surgery
HAC 12: Surgical Site Infection – Certain Orthopedic Procedure of Spine, Shoulder, and Elbow
HAC 13: Surgical Site Infection Following Cardiac Device Procedures
HAC 14: Iatrogenic Pneumothorax w/Venous Catheterization

CMS HAC Reduction Program Measures Implemented Since FY 2015

- Domain 1- the Agency for Health Care Research and Quality (AHRQ) composite PSI #90 which includes the following indicators:
    - Pressure ulcer rate (PSI 3);
    - Iatrogenic pneumothorax rate (PSI 6);
    - Central venous catheter-related blood stream infection rate (PSI 7);
    - Postoperative hip fracture rate (PSI 8);
    - Postoperative pulmonary embolism (PE) or deep vein thrombosis rate (DVT) (PSI 12);
    - Postoperative sepsis rate (PSI 13);
    - Wound dehiscence rate (PSI 14); and
    - Accidental puncture and laceration rate (PSI 15).
- Domain 2- two healthcare-associated infection measures developed by the Centers for Disease Control and Prevention's (CDC) National Health Safety Network:
    - Central Line-Associated Blood Stream Infection and
    - Catheter-Associated Urinary Tract Infection.

For the FY 2017 CMS HAC reduction program, CMS decreased the Domain 1 weight from 25 percent to 15 percent and increased the Domain 2 weight from 75 percent to 85 percent.

CMS also expanded the data used for CLABSI and CAUTI measures and will include data from pediatric and adult medical ward, surgical ward, and medical/surgical ward locations, in addition to data from adult and pediatric ICU locations.

APPENDIX II.
PPC MEASUREMENT DEFINITION AND POINTS CALCULATION

Definitions

The PPC measure would then be defined as:

Observed (O)/Expected (E) value for each measure

The threshold value is the minimum performance level at which a hospital will be assigned points and is defined as:

Weighted mean of all O/E ratios (O/E =1)

(Mean performance is measured at the case level. In addition, higher volume hospitals have more influence on PPCs' means.)

The benchmark value is the performance level at which a full 10 points would be assigned for a PPC and is defined as:

Weighted mean of top quartile O/E ratio

For PPCs that are serious reportable events, the benchmark will be set at 0.

Performance Points

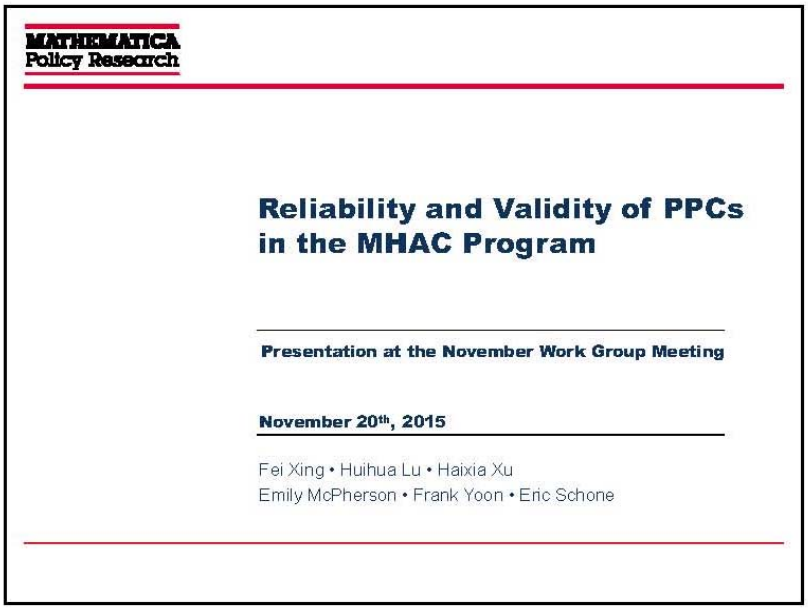
Performance points are given based on a range between a "Benchmark" and a "Threshold," which are determined using the base year data. The Benchmark is a reference point defining a high level of performance, which is equal to the mean of the top quartile. Hospitals whose rates are equal to or above the benchmark receive 10 full attainment points.

The Threshold is the minimum level of performance required to receive minimum attainment points, which is set at the weighted mean of all the O/E ratios which equals to 1. The improvement points are earned based on a scale between the hospital's prior year score (baseline) on a particular measure and the Benchmark and range from 0 to 9.

The formulas to calculate the attainment and improvement points are as follows:

- Attainment Points: [9 * ((Hospital's performance period score - threshold)/(benchmark – threshold))] + .5, where the hospital performance period score falls in the range from the threshold to the benchmark
- Improvement Points: [10 * ((Hospital performance period score -Hospital baseline period score)/(Benchmark - Hospital baseline period score))] -.5, where the hospital performance score falls in the range from the hospital's baseline period score to the benchmark.

APPENDIX III.
PPC MATHEMATICA POLICY RESEARCH VALIDITY AND RELIABILITY ANALYSIS AND FINDING



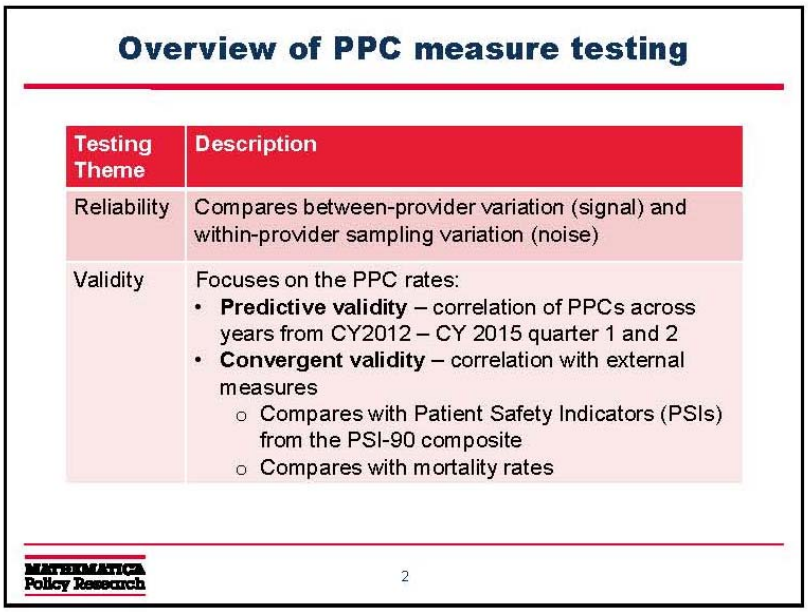
MATHEMATICA Policy Research

Reliability and Validity of PPCs in the MHAC Program

Presentation at the November Work Group Meeting

November 20th, 2015

Fei Xing • Huihua Lu • Haixia Xu
Emily McPherson • Frank Yoon • Eric Schone



Overview of PPC measure testing

Testing Theme	Description
Reliability	Compares between-provider variation (signal) and within-provider sampling variation (noise)

Validity	Focuses on the PPC rates:
	• **Predictive validity** – correlation of PPCs across years from CY2012 – CY 2015 quarter 1 and 2
	• **Convergent validity** – correlation with external measures
	  o Compares with Patient Safety Indicators (PSIs) from the PSI-90 composite
	  o Compares with mortality rates

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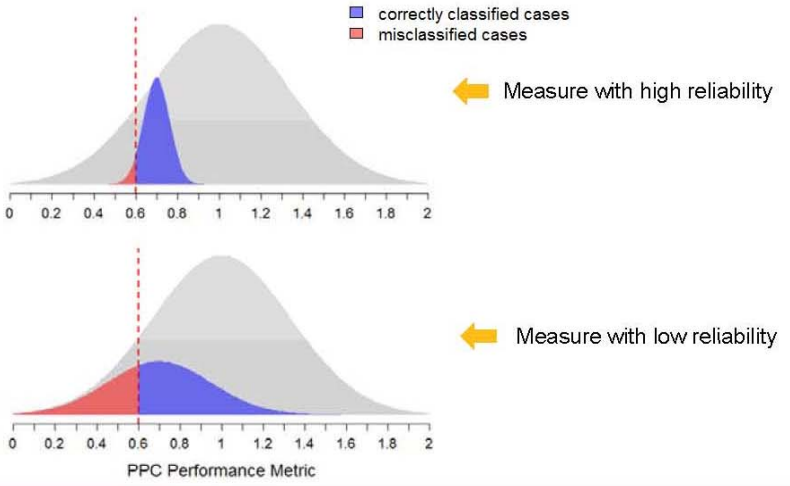
Measure Reliability: precision of a quality measure



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Reliability testing: signal-to-noise framework

- **Data:**
  - **Performance period: pooled FY2014, 2015 data***
- **Reliability standard:**
  - **A PPC measure is in low reliability if its reliability estimate is less than the reliability cut-off point (0.4).**
  - **Serious reportable PPCs are excluded from reliability assessment.**
- **Low reliability PPCs: 12 in total, majority in Tier C**
  - **Tier A: PPC 38**
  - **Tier B: PPC 17 and 18**
  - **Tier C: PPC 2, 15, 20, 29, 33, 34, 44, 51, and 60**

* Indirectly standardized using FY 2014 norms

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PPC reliability by hospital

Low reliability PPCs	Description	Tier	Number of observed PPCs in FY15	Number of hospitals with the PPC	
				All hospitals	Hospitals with low reliability rate
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	A	28	23	23
17	Major Gastrointestinal Complications without Transfusion or Significant Bleeding	B	215	41	27
18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding	B	103	38	38
2	Extreme CNS Complications	C	71	31	22
15	Peripheral Vascular Complications Except Venous Thrombosis	C	77	29	29
20	Other Gastrointestinal Complications without Transfusion or Significant Bleeding	C	113	34	34
29	Poisonings Except from Anesthesia	C	55	33	16
33	Cellulitis	C	156	40	26
34	Moderate Infectious	C	65	32	27
44	Other Surgical Complication - Mod	C	96	33	33
51	Gastrointestinal Ostomy Complications	C	89	37	24
60	Major Puerperal Infection and Other Major Obstetric Complications	C	57	27	27

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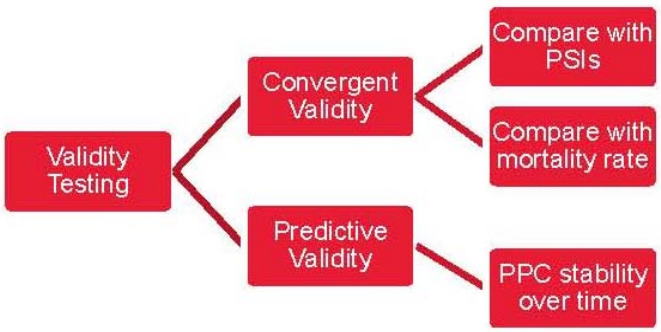
Validity testing



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Predictive validity

- Predictive validity means that current results predict future performance.
- Data:
  - Performance period: CY 2012, 2013, 2014, and six months of 2015 (Jan – Jun)*
- Predictive validity rule:
  - A PPC performance metric has predictive validity if at least one of the studied pairs (CY 2012 vs CY 2013, CY 2013 vs CY 2014, and CY 2014 vs CY 2015 Jan – Jun) is positively correlated (and statistically significant).

*All indirectly standardized using FY 2014 norms

Predictive validity analysis summary

PPC Result	Tier A	Tier B	Tier C
Consistent:	PPC 3, 4, 5, 6, 7, 9, 14, 16, 24, 35, 37, 40, 42, 49, 54, 65, 66	PPC 8, 10, 11, 19, 41, 48, 27	PPC 1, 12, 13, 21, 23, 34, 36, 46, 47, 50, 51, 52, 53, 55, 56, 57, 58, 59, 60, 61, 62, 67
Total	17 (85%)	7 (78%)	22 (69%)
Inconsistent:	PPC 28, 31, 38	PPC 17, 18	PPC 2, 15, 20, 29, 30, 32, 33, 39, 44, 45
Total	3 (15%)	2 (22%)	10 (31%)
Tier Total	20	9	32

Correlations between PPCs and PSIs

PSI description	PPC description	Correlation (FY 2013)	Correlation (CY 2014)	Correlation (FY 2014)	
PSI03 - Pressure Ulcer	PPC31 - Decubitus Ulcer	0.499	0.466	0.411	
PSI06 - Iatrogenic pneumothorax	PPC49 - Iatrogenic Pneumothrax	0.513	0.419	0.618	
PSI07 - Central line associated BSI	PPC54 - Infections due to Central Venous Catheters	0.542	0.848	0.588	
PSI09 - Perioperative Hemorrhage or Hematoma Rate	PPC41 - Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Proc	0.169	0.480	0.568	
PSI11 - Postoperative Respiratory Failure Rate	PPC3 - Acute Pulmonary Edema and Respiratory Failure without Ventilation PPC4 - Acute Pulmonary Edema and Respiratory Failure with Ventilation PPC63 - Post-Operative Respiratory Failure with Tracheostomy	0.229	0.116	0.532	A
PSI12 - Postoperative PE or DVT	PPC7 - Pulmonary Embolism PPC16 - Venous Thrombosis	0.714	0.880	0.924	
PSI13 - Postoperative sepsis	PPC35 - Septicemia & Severe Infections	0.219	0.692	0.432	
PSI14 - Postoperative wound dehiscence	PPC38 - Post-Operative Wound Infection & Deep Wound Disruption with Procedure	0.373	0.218	0.164	B
PSI15 - Accidental puncture or laceration	PPC42 - Accidental Cut or Hemorrhage During Invasive Procedure	0.577	0.768	0.799	

Data: PPCs use three different performance periods (FY 2013, CY 2014 and FY 2014), and are indirectly standardized using FY 2014 norms. PSIs are the risk adjusted rate from FY2013, CY 2014 and FY 2014.

Causes of unexpected results

- A. The substantial observed change in correlation between PSI 11 and the combination of PPCs 3, 4 and 63 may be due to the low reliability of PPC 63.
  - PPC 63 is currently combined with four other PPCs into PPC 67.
- B. PSI 14 and PPC 38 have low correlation in both periods. This may be due to the low reliability of PPC 38.

PPCs having high correlations with mortality

PPC	Description	Tier	Correlation with mortality rate	Also low reliability?
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	A	0.405	no
14	Ventricular Fibrillation/Cardiac Arrest	A	0.450	no
9	Shock	A	0.388	no
54	Infections due to Central Venous Catheters	A	0.389	no
2	Extreme CNS Complications	C	0.453	yes
50	Mechanical Complication of Device, Implant & Graft	C	0.453	no
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infection	C	0.377	no

Data: PPCs use CY 2014 as performance period with FY 2014 norms; mortality rate uses CY 2014 risk adjusted mortality rate.

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Staff Recommendation on the Johns Hopkins School of Nursing (JHSON) Request to Access HSCRC Confidential Patient Level Data.

Health Services Cost Review Commission

4160 Patterson Avenue, Baltimore, MD 21215

December 9, 2015

This is a final recommendation was approved by Commission at the December 9, 2015 Public Commission Meeting.

1. SUMMARY STATEMENT

This confidential data request from the Johns Hopkins School of Nursing (JHSON), is to perform a cost-effective evaluation of research funded by the Center of Medicare & Medicaid Innovation (CMMI). The innovative program - Community, Aging in Place, Advancing Better Living for Elders (CAPABLE) - is testing a program designed to help reduce functional limitations and reduce health care costs of dually-eligible older adults in Baltimore.

2. OBJECTIVE

To accomplished this research, JHSON will be comparing and linking participant's health care utilization before, during, and after their involvement in the CAPABLE study, and by linking 500 dually-eligible, frail elders on the Home and Community Based Services (HCBS) Waiver waiting list in Baltimore. Investigators received approval from the Johns Hopkins Office of Human Subjects Research-Institutional Review Board (IRB) on July 14, 2015. These data will not be used to identify individual hospitals or patients.

REQUESTS FOR ACCESS TO THE CONFIDETIAL PATIENT LEVEL DATA

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

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

The independent Confidential Data Review Committee, comprised of representatives from HSCRC staff, the Department of Health and Mental Hygiene ("DHMH"), U.S. Department of Health & Human Services ("HHS"), and the University Of Maryland School of Medicine reviews the application to ensure it meets the above minimum requirements as outlined in the application form.

In this case, the Confidential Review Committee reviewed the request and unanimously agreed to recommend access to a confidential limited data set. As a final step in the evaluation process, the applicant will be required to file annual progress reports to the Commission, detailing any changes in goals or design of project, any changes in data handling procedures, work progress, and unanticipated events related to the confidentiality of the data.

STAFF RECOMMENDATIONS

1. HSCRC staff recommends that the request to the inpatient and outpatient confidential data files Calendar Year 2010 through 2014 be approved.

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

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-201; and 19-207; and 19-219(c), Annotated Code of Maryland

NOTICE OF EMERGENCY ACTION

The Health Services Cost Review Commission has granted emergency status to amend Regulation **.07-1** under **COMAR 10.37.10 Rate Application and Approval Procedures**.

Emergency Status: **January 1, 2016**

Emergency Status Expires: **May 1, 2016**

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

There is economic impact. See Estimate of Economic Impact attached.

.07-1 Outpatient Services – At the Hospital Determination.

A. (text unchanged)

B. (text unchanged)

C. In accordance with Health-General Article, § 19-201, Annotated Code of Maryland, the Commission's rate-setting jurisdiction extends to outpatient services provided at the hospital. Outpatient services associated with the federal 340B Program under the federal Public Health Service Act provided in a department of a regulated hospital that, on or before June 1, 2015, is under a merged asset hospital system, and which are physically located at another regulated hospital under the same merged asset hospital system, shall be subject to the rate-setting jurisdiction of the Commission. *The Commission may begin setting rates for these services in anticipation of the hospital's obtaining provider-based status for purposes of the 340B Program.*

D.-J. (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

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NOTICE OF PROPOSED ACTION

The Health Services Cost Review Commission proposes to amend Regulations **.07-1** 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 December 6, 2015, notice of which was given pursuant to General Provisions Article, § 3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about April 11, 2016.

Statement of Purpose

The purpose of this action is to allow the Commission to set rates for outpatient services associated with the federal 340B Program in anticipation of the hospital's obtaining federal provider-based status.

Comparison of Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

See Statement of Economic Impact.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or (410) 764-2576, or fax to (410) 358-6217, or email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed amendments until February 8, 2016. A hearing may be held at the discretion of the Commission.

.07-1 Outpatient Services – At the Hospital Determination.

A. (text unchanged)

B. (text unchanged)

C. In accordance with Health-General Article, § 19-201, Annotated Code of Maryland, the Commission's rate-setting jurisdiction extends to outpatient services provided at the hospital. Outpatient services associated with the federal 340B Program under the federal Public Health Service Act provided in a department of a regulated hospital that, on or before June 1, 2015, is under a merged asset hospital system, and which are physically located at another regulated hospital under the same merged asset hospital system, shall be subject to the rate-setting jurisdiction of the Commission. *The Commission may begin setting rates for these services in anticipation of the hospital's obtaining provider-based status for purposes of the 340B Program.*

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JOHN M. COLMERS
Chairman
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Department of Health and Mental Hygiene

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TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **December 9, 2015**

RE: **Hearing and Meeting Schedule**

January 13, 2016	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
February 10, 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.