State of Maryland
Department of Health and Mental Hygiene

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M.D., M.P.H.

Jack C. Keane

Bernadette C. Loftus,
M.D.

Thomas R. Mullen

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Donna Kinzer
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

Vacant
Director
Payment Reform
and Innovation

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

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

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**

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

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

9. **Legal Report**

10. **Hearing and Meeting Schedule**

Minutes to be included into the post-meeting packet

upon approval by the Commissioners

Executive Director's Report

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

New Model Monitoring Report

The Report will be distributed during the Commission Meeting

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF 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. ST AFF 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.

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 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. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the 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. STAFF 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. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving 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 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 Staff Report for Commission Consideration Regarding Health Job Opportunity Program Proposal 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.

This final report focuses on synthesizing input and providing staff policy analysis for consideration by the Commission in determining how to approach this important Proposal, and suggesting 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.

417 E. Fayette Street
Suite 468
Baltimore, Maryland 21202
Voice 410-396-1910
Fax 410-752-6625
www.baltoworkforce.com

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

CareFirst BlueCross BlueShield
1501 S. Clinton Street, 17th Floor
Baltimore, MD 21224-5744
Tel: 410-605-2558
Fax: 410-781-7606
chet.burrell@carefirst.com

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
2701 WHITNEY PLACE • SUITE 100 • FORESTVILLE, MARYLAND 20747
PHONE: (301) 568-2294 • FAX: (301) 568-7302
WEBSITE: http://tehw.org • EMAIL: info@tehw.org

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.

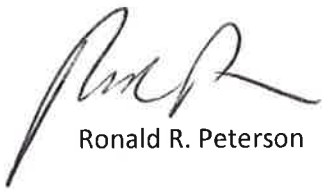
733 North Broadway, BRB 104, Baltimore, Maryland 21205, 410-955-9540 phone, 410-955-0856 fax, rpeters@jhmi.edu

- 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
Jack C. Keane
Donna Kinzer, Executive Director
Bernadette Loftus, MD
Thomas R. Mullen

UNIVERSITY of MARYLAND
MEDICAL SYSTEM

250 W. Pratt Street
24th Floor
Baltimore, Maryland 21201-6829
www.umms.org

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.

- 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.

- 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.

345 St. Paul Place ◆ Baltimore, MD 21202-2123 ◆ (410) 332-9202 Fax (410) 962-1303
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.

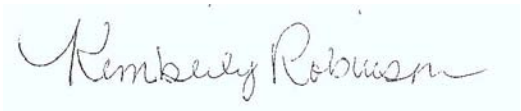
Using the Rate Setting System to Cover the Costs of an Employment Program Goes Beyond the Purposes of the Rate-Setting System

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.

NEW YORK CITY PRINCIPAL HEADQUARTERS
310 West 43rd St.
New York, NY 10036
(212) 582-1890
www.1199seiu.org

ALBANY
155 Washington Ave.
Albany, NY 12210
Tel. (518) 396-2300
Fax (518) 438-1140

BALTIMORE, MARYLAND
611 North Eutaw Street
Baltimore, MD 21201
Tel. (410) 332-1199
Fax (410) 332-1895

MASSACHUSETTS
150 Mt. Vernon Street, 3rd Fl.
Dorchester, MA 02125
Tel. (617) 284-1199
Fax (617) 474-7150

BUFFALO
2421 Main Street, Suite 100
Buffalo, NY 14214
Tel. (716) 982-0540
Fax (716) 876-0930

FLORIDA
14645 NW 77th Avenue, Ste. #201
Miami Lakes, FL 33014
Tel. (305) 623-3000
Fax (305) 826-1604

GOUVERNEUR
95 E Main Street
Gouverneur, NY, 13642
Tel. (315) 287-9013
Fax (315) 287-7226

HICKSVILLE
100 Duffy Ave., Suite 3 West
Hicksville, NY 11801
Tel. (516) 542-1115
Fax (516) 542-0919

NEW JERSEY
555 Route 1 South, 3rd Fl.
Iselin, NJ 08830
Tel. (732) 287-8113
Fax (732) 287-8117

ROCHESTER
259 Monroe Ave., Suite 220
Rochester, NY 14607
Tel. (585) 244-0830
Fax (585) 244-0956

SYRACUSE
250 South Clinton, Suite 200
Syracuse, NY 13202
Tel. (315) 424-1743
Fax (315) 479-6716

WHITE PLAINS
99 Church St.
White Plains, NY 10601
Tel. (914) 993-6700
Fax (914) 993-6714

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

CareFirst BlueCross BlueShield
1501 S. Clinton Street, 17th Floor
Baltimore, MD 21224-5744
Tel: 410-605-2558
Fax: 410-781-7606
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:

☐ 901 SOUTH BOND STREET, SUITE 310
BALTIMORE, MD 21231
(410) 962–4510
VOICE/TDD: (410) 962–4512

☐ 60 WEST STREET, SUITE 202
ANNAPOLIS, MD 21401–2448
(410) 263–1805
BALTIMORE: (410) 269–1650

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

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

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

September 1, 2015

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

Dear Mr. Colmers:

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

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

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

Sincerely,

Barbara A. Mikulski

Barbara A. Mikulski
United States Senator

BAM:wbk

ELIJAH E. CUMMINGS
7TH DISTRICT, MARYLAND

RANKING MEMBER, COMMITTEE ON
OVERSIGHT AND GOVERNMENT REFORM

RANKING MEMBER,
SELECT COMMITTEE ON BENGHAZI

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

JOINT ECONOMIC COMMITTEE

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

☐ 2230 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–2007
(202) 225–4741
FAX: (202) 225–3178

DISTRICT OFFICES:

☒ 1010 PARK AVENUE
SUITE 105
BALTIMORE, MD 21201–5037
(410) 685–9199
FAX: (410) 685–9399

☐ 754 FREDERICK ROAD
CATONSVILLE, MD 21228–4504
(410) 719–8777
FAX: (410) 455–0110

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

www.house.gov/cummings

August 27, 2015

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

Dear Chairman Colmers:

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

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

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

Sincerely,

Elijah E. Cummings
Member of Congress

DONNA F. EDWARDS
4TH DISTRICT, MARYLAND

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

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

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

September 2, 2015

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

Dear Chairman Colmers:

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

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

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

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

Sincerely,

Donna F. Edwards
Member of Congress

5001 SILVER HILL ROAD
SUITE 106
SUITLAND, MARYLAND 20746
TELEPHONE: (301) 516–7601
FAX: (301) 516–7608

2445 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–2004
TELEPHONE: (202) 225–8699
FAX: (202) 225–8714

877 BALTIMORE ANNAPOLIS BOULEVARD
RITCHIE COURT OFFICE BUILDING
UNIT 101
SEVERNA PARK, MD 21146
TELEPHONE: (410) 421–8061
FAX: (410) 421–8065

DONNA F. EDWARDS
4TH DISTRICT, MARYLAND

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

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

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

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

5001 SILVER HILL ROAD
SUITE 106
SUITLAND, MARYLAND 20746
TELEPHONE: (301) 516–7601
FAX: (301) 516–7608

2445 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–2004
TELEPHONE: (202) 225–8699
FAX: (202) 225–8714

877 BALTIMORE ANNAPOLIS BOULEVARD
RITCHIE COURT OFFICE BUILDING
UNIT 101
SEVERNA PARK, MD 21146
TELEPHONE: (410) 421–8061
FAX: (410) 421–8065

http://donnaedwards.house.gov

C.A. DUTCH RUPPERSBERGER
2ND DISTRICT, MARYLAND

REPLY TO:

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

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

www.dutch.house.gov

PERMANENT SELECT COMMITTEE
ON INTELLIGENCE
RANKING MEMBER

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

August 31, 2015

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

Dear Mr. Colmers:

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

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

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

Sincerely,

C.A. Dutch Ruppersberger

C.A. Dutch Ruppersberger
Member of Congress

CADR:ng

JOHN P. SARBANES
3RD DISTRICT, MARYLAND

COMMITTEE ON
ENERGY AND COMMERCE

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

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

www.sarbanes.house.gov

September 1, 2015

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

Dear Mr. Colmers:

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

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

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

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

Sincerely,

John P. Sarbanes
Member of Congress

JPS/jl

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

44 CALVERT STREET
SUITE 349
ANNAPOLIS, MD 21401
(410) 295-1679
FAX: (410) 295-1682

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

CHRIS VAN HOLLEN
8TH DISTRICT, MARYLAND

COMMITTEE ON THE BUDGET

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

1707 LONGWORTH HOUSE OFFICE BUILDING
WASHINGTON, DC 20515
(202) 225-5341

DISTRICT OFFICES:
51 MONROE STREET, #507
ROCKVILLE, MD 20850
(301) 424-3501

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

www.vanhollen.house.gov

August 26, 2015

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

Dear Chairman Colmers:

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

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

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

Sincerely,

Chris Van Hollen
Member of Congress

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

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

MICHAEL E. BUSCH
SPEAKER OF THE HOUSE

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

September 9, 2015

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

Dear Chairman Colmers:

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

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

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

Sincerely,

Thomas V. Mike Miller, Jr.
Senate President

Michael E. Busch
Speaker of the House

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

PETER A. HAMMEN
46th Legislative District
Baltimore City

Chair
Health and Government
Operations Committee

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

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

THE MARYLAND HOUSE OF DELEGATES
ANNAPOLIS, MARYLAND 21401

September 9, 2015

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

Dear Chairman Colmers:

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

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

Sincerely,

Peter A. Hammen

Peter A. Hammen

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

MAGGIE MCINTOSH
Legislative District 43
Baltimore City

Chair
Appropriations Committee

The Maryland House of Delegates
6 Bladen Street, Room 121
Annapolis, Maryland 21401
410-841-3407 · 301-858-3407
800-492-7122 *Ext.* 3407
Fax 410-841-3416 · 301-858-3416
Maggie.McIntosh@house.state.md.us

The Maryland House of Delegates
ANNAPOLIS, MARYLAND 21401

September 9, 2015

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

Dear Chairman Colmers:

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

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

Sincerely,

Maggie L. McIntosh

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

STEPHANIE RAWLINGS-BLAKE
MAYOR

100 Holliday Street, Room 250
Baltimore, Maryland 21202

September 9, 2015

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

Dear Chairman Colmers:

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

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

Sincerely,

Stephanie Rawlings-Blake
Mayor
City of Baltimore

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

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

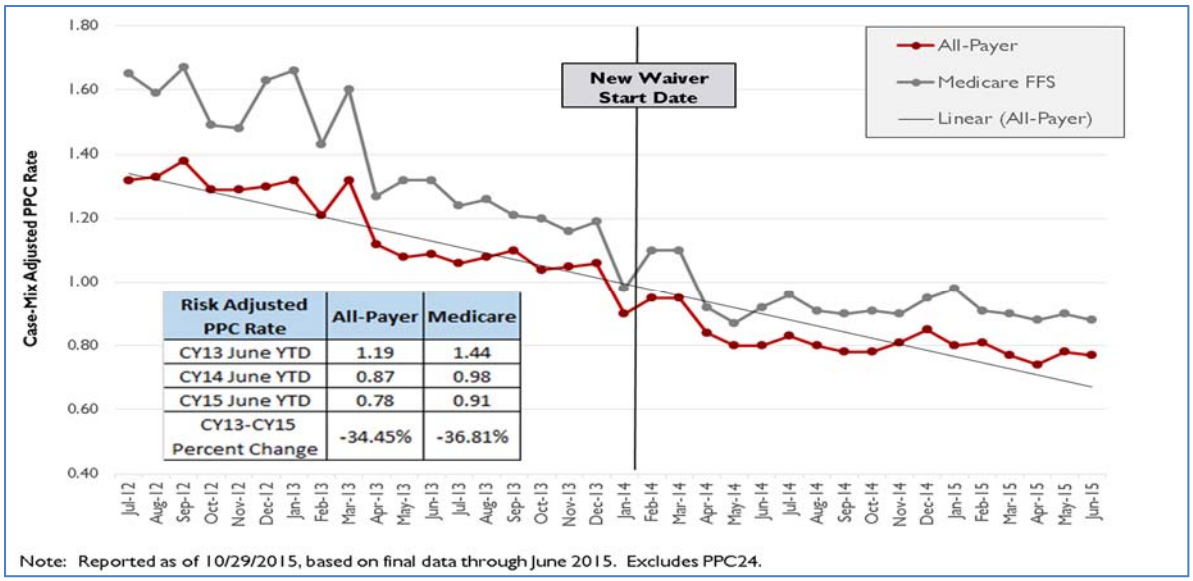
As illustrated in Figure 1 below, the statewide PPC rate decreased significantly year to year between 2013 and 2015, with a total risk-adjusted cumulative improvement rate of 36 percent.

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



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.

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

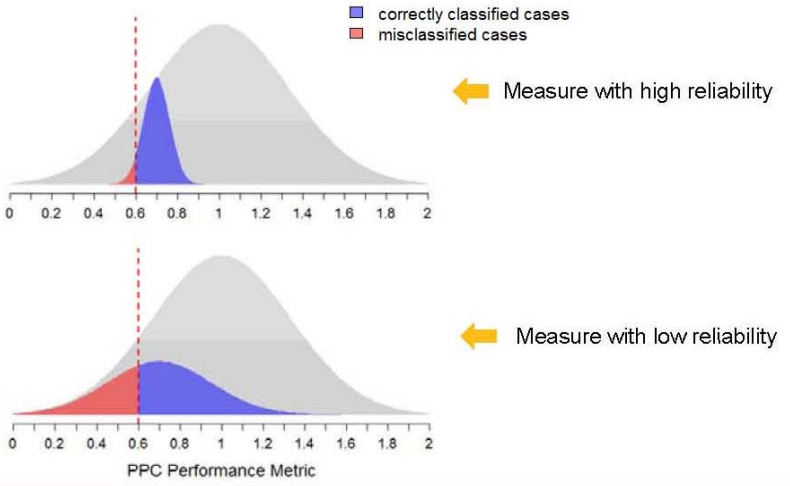
November 20th, 2015

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

Measure Reliability: precision of a quality measure



MATHEMATICA Policy Research

3

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

MATHEMATICA Policy Research

4

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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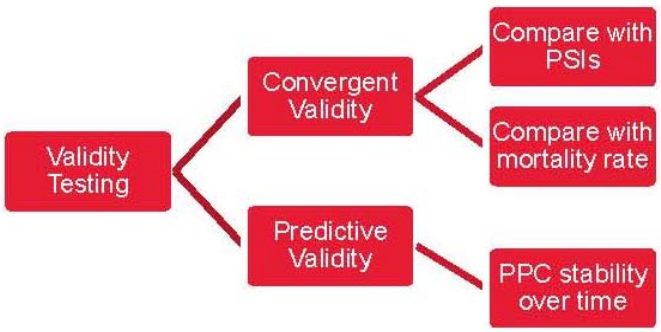
5

Validity testing



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6

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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11

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 for Commission consideration 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

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; 19-207; and 19-219(c), Annotated Code of Maryland

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.*

D.-J. (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

State of Maryland
Department of Health and Mental Hygiene

John M. Colmers
Chairman

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

George H. Bone, M.D.

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

Jack C. Keane

Bernadette C. Loftus, M.D.

Thomas R. Mullen

Health Services Cost Review Commission
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Donna Kinzer
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

Vacant
Director
Payment Reform
and Innovation

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

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

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **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.