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Department of Health and Mental Hygiene

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534th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
October 19, 2016

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 2PM.)

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, §3-103 and §3-104**

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

3. **Comfort Order – Washington Adventist Hospital – Authority General Provisions Article, §3-305 (b)6**

PUBLIC SESSION
2:00 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on September 14, 2016**
2. **Executive Director's Report**
3. **New Model Monitoring**
4. **Docket Status – Cases Closed**
   2319R – Sheppard Pratt Health System **2350R – Prince George's Hospital Center**
   2351A – Johns Hopkins Health System
5. **Docket Status – Cases Open**
   2352N – MedStar Harbor Hospital **2353A - Priority Partners**
   2354A - University of Maryland Medical Center **2355A - University of Maryland Medical Center**
   2356A - Maryland Physicians Care **2357A – Hopkins Health Advantage**
   2358A - MedStar Family Choice **2359A - MedStar Family Choice**
   2360A – University of Md, Health Advantage Inc. **2361A - University of Md. Health Partners Inc.**
6. **Final Recommendation for Approval of Baltimore Population Health Workforce Collaborative Award** - *Approved*
7. **Draft Recommendation for Updating the Quality-based Reimbursement Program for Fiscal Year 2019**
8. **Draft Recommendation for Second and Final Round of Transformation Implementation Grant**

Awards

9. **Fiscal Year 2015 Community Benefits Report**
10. **CRISP Update**
11. **Hearing and Meeting Schedule**

Closed Session Minutes
of the
Health Services Cost Review Commission

SEPTEMBER 14, 2016

Upon motion made in public session, Vice Chairman Wong called for adjournment into closed session to discuss the following items:

1. Discussion on the State's Primary Care Model
2. Discussion on Planning for Model Progression - Authority General Provisions Article §3-103 and §3-104

The Closed Session was called to order at 12:11 p.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

In attendance in addition to Vice Chairman Wong were Commissioners Antos, Bayless, Bone, Colmers, and Keane. Also Ms. Fran Phillips was in attendance in a non-voting ex-officio capacity as an MHCC Commissioner.

In attendance representing Staff were Donna Kinzer, Steve Ports, Chris Peterson, Sule Gerovich, Ellen Englert, Amanda Vaughn, Liz Fracica and Dennis Phelps.

Also attending were Dr. Howard Haft, Deputy Secretary of Public Health, Department of Health and Mental Hygiene (DHMH), Chad Perman DHMH, Deborah Gracey and Eric Lindeman, Commission Consultants, and Stan Lustman and Leslie Schulman Commission Counsel.

Item One

Dr. Haft summarized and the Commission discussed DHMH's Person Centered Home Care Model.

Item Two

Donna Kinzer, Executive Director, discussed the progression of the All-Payer Model and the Model Amendment and the need for additional resources including implementation of resources.

The Closed Session was adjourned at 2:11 p.m.

MINUTES OF THE
533rd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
September 14, 2016

Vice Chairman Herbert Wong, Ph.D. called the public meeting to order at 12:04 p.m. Commissioners Joseph Antos, Ph.D., Victoria Bayless, George H. Bone, M.D., John Colmers, Jack C. Keane, and Fran Phillips, nonvoting ex-officio member, were also in attendance. Upon motion made by Commissioner Colmers and seconded by Commissioner Bayless, the meeting was moved to Executive Session. Vice Chairman Wong reconvened the public meeting at 2:19 p.m.

REPORT OF THE SEPTEMBER 14, 2016 EXECUTIVE SESSION

Mr. Dennis Phelps, Associate Director, Audit & Compliance, summarized the minutes of the September 14, 2016 Executive Session.

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ITEM I

REVIEW OF THE MINUTES FROM THE AUGUST 10, 2016 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the August 10, 2016 Executive Session and Public Meeting.

ITEM II

EXECUTIVE DIRECTOR REPORT

Donna Kinzer, Executive Director, reported that Staff is currently seeking stakeholder input around the progression of the All-Payer Model, especially as it pertains to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) and physician alignment. MACRA federal legislation is a dual value-based incentive program that targets Medicare physician reimbursement by removing payment reductions for excess volume. MACRA is designed to encourage participation in Alternative Payment Models (APMs) to provide better care, lower costs, and reward physicians for participation through two methods:

- Merit-Based Incentive Payment System (MIPS) provides incentive that could range from +/- 9% over time, and reward participation in APMs.
- Physicians can choose to opt out of the MIPS program and receive a 5% lump sum bonus and higher fee schedule updates.

Ms Kinzer stated that Staff is also focused on the following key strategies as they relate to Total Cost of Care (TCOC) and system-wide outcomes:

- Create a Primary Care Model that provides person-centered care through support teams,

data driven care coordination, and a supporting payment model.
- Incorporate Medicare TCOC targets and common system wide outcome goals into all providers' incentive structures.
- Develop a focused portfolio of payment and delivery system transformations to support key goals
- Develop/support models that include upside and downside risk or increased levels of incentive tied to performance targets.

Ms. Kinzer noted that Staff has issued a request for white papers to help guide the necessary performance measurement/methodology policy changes for FY 2018 and the Quality/performance measurement goals for the 2nd phase of the All-Payer Model.

Ms Kinzer introduced Chris Peterson. Mr. Peterson is the Commission's new Director, Center for Clinical and Financial Information.

ITEM III

NEW MODEL MONITORING

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

Note: the figures presented include a data caveat involving delays of data from Dimensions Health System and John Hopkins Health System. Reported figures will likely fluctuate at next month's meeting until data issues are resolved.

Ms. Vaughn reported that for the one month period ended July 31, 2016, All-Payer total gross revenue decreased by 6.76% over the same period in FY 2016. All-Payer total gross revenue for Maryland residents decreased by 6.35%; this translates to a per capita growth of (6.84%). All-Payer gross revenue for non-Maryland residents decreased by 10.89%.

Ms. Vaughn reported that for the seven months of the calendar year ended July 31, 2016, All-Payer total gross revenue increased by 0.62% over the same period in CY 2015. All-Payer total gross revenue for Maryland residents increased by 0.75%; this translates to a per capita growth of 0.23%. All-Payer gross revenue for non-Maryland residents decreased by .80%.

Ms. Vaughn reported that for the one month period ended July 31, 2016, Medicare Fee-For-Service gross revenue decreased by 8.05% over the same period in FY 2016. Medicare Fee-For-Service gross revenue for Maryland residents decreased by 7.40 %; this translates to a per capita growth of (8.79%). Maryland Fee-For-Service gross revenue for non-residents decreased by 15.27%.

Ms. Vaughn reported that for the seven months of the calendar year ended July 31, 2016, Medicare Fee-For-Service gross revenue decreased by 0.59% over the same period in CY 2015. Medicare Fee-For-Service gross revenue for Maryland residents decreased by 0.56%; this

translates to a per capita growth of (2.16%). Maryland Fee-For-Service gross revenue for non-residents decreased by 0.90%.

Ms. Vaughn reported that for the seven months of the calendar year ended June 30, 2016 over the same period in CY 2013:

- Net per capita growth was 4.11 %.
- Per capita growth before UCC and MHIP adjustments was 5.94%.
- Net per capita Medicare growth was 1.80%.
- Per capita growth Medicare before UCC and MHIP was 3.58 %

Ms. Vaughn reported that for the seven months of the calendar year ended June 30, 2016 over the same period in CY2015:

- All-Payer admissions decreased by 1.58%;
- All-Payer admissions per thousand residents decreased by 2.04%;
- Medicare Fee-For-Service admissions decreased by 3.14%;
- Medicare Fee-For-Service admissions per thousand residents decreased by 5.19%;
- All-Payer bed days decreased by 0.47%;
- All-Payer bed days per thousand residents decreased by 0.94%;
- Medicare Fee-For-Service bed days decreased by 1.82%
- Medicare Fee-For-Service bed days per thousand decreased by 3.90%;
- Emergency visits decreased by 1.44%
- Emergency visits per thousand decreased by 1.90%

Dr. Sule Gerovich, PhD., Director, Population Based Methodologies, presented utilization trend reports reflecting the Equivalent Case-Mix Adjusted Discharges (ECMAD) growth for the six months of the calendar year ended July 30, 2016.

Dr. Gerovich reported that for the seven months of the calendar year ended June 30, 2016, All Payer ECMAD growth decreased by 1.01% over the same period in CY 2015. Medicare Fee for Service ECMAD growth for Maryland residents decreased by 3.19%. Dr. Gerovich noted that the decrease in ECMAD growth is likely due to the EPIC conversion issues.

Dr. Alyson Schuster, PhD., Associate Director Performance Management, presented a quality report update on the Maryland Hospital Acquired Conditions program based upon readmission data on discharges (through June 2016).

Readmissions

- The All-Payer risk adjusted readmission rate was 11.41% for June 2016 YTD. This is a decrease of 11.09% from the June 2013 risk adjusted readmission rate.
- The Medicare Fee for Service risk adjusted readmission rate was 12.32% for June 2016 YTD. This is a decrease of 9.68% from the June 2013 YTD risk adjusted readmission rate.

- Based on the New-Payer model, hospitals must reduce Maryland's readmission rate to or below the national Medicare readmission rate by 2018. The Readmission Reduction incentive program has set goals for hospitals to reduce their adjusted readmission rate by 9.5% during CY 2016 compared to CY 2013. Currently 27 out of 46 hospitals are on track for achieving the improvement goal.

ITEM IV

DOCKET STATUS- CLOSED CASES

2346A- John Hopkins Health System
2347A- University of Maryland Medical Center
2348A- University of Maryland Medical Center
2349A- Johns Hopkins Health System

ITEM V

DOCKET STATUS- OPEN CASES

2350A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed an application with the HSCRC on August 30, 2016 on behalf of its member hospitals (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 participation in a global rate arrangement for heart failure services, solid organ and bone marrow transplant services with Optum Health, a division of United HealthCare Services for a period of one year beginning October 1, 2016.

Staff recommended that the Commission approve the Hospitals' application for an alternative method of rate determination for heart failure services, solid organ and bone marrow transplant services for one year beginning October 1, 2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2351A- Johns Hopkins Health System

Johns Hopkins Health System ("System") filed an application with the HSCRC on August 30, 2016 on behalf of its member hospitals (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 participation in a global rate arrangement for Bariatric Surgery Procedures with the Priority Partners Managed Care Organization Inc., the Johns Hopkins Employer Health Programs, Inc., and the Johns Hopkins Uniformed Services Family Health Plan for a period of one year beginning October 1, 2016.

Staff recommended that the Commission approve the Hospitals' application for an alternative method of rate determination for Bariatric Surgery Procedures for one year beginning October 1,

2016, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

30 Day Extension

2352N MedStar Harbor Hospital

The Commission voted unanimously to approve staff's request to extend the time for review on proceeding 2352N MedStar Harbor Hospital for 30 days.

ITEM VI

FINAL RECOMMENDATION FOR APPROVAL OF GARRETT REGIONAL MEDICAL CENTER POPULATION HEALTH WORKFORCE SUPPORT FOR DISADVANTAGED AREAS AWARD

Mr. Steve Ports, Director, Engagement and Alignment, presented Staff's final recommendation on the Garrett Regional Medical Center Population Health Workforce Support for Disadvantaged Areas Program (See "Final Recommendation for the Garrett Regional Medical Center Award under the Population Health Workforce Support for Disadvantaged Areas Program Implementation Awards" on the HSCRC website).

The Maryland Department of Health and Mental Hygiene (DHMH) and the HSCRC are recommending that Garrett Regional Medical Center's proposal for a competitive Population Health Workforce Support for Disadvantaged Areas Program (PWSDA) grant be funded beginning in fiscal year (FY) 2017. This recommendation follows the Commission's decision in December 2015 authorizing up to $10 million in hospital rates for hospitals that commit to train and hire workers from geographic areas of high economic disparities and unemployment. These workers will fill new care coordination, population health, health information exchange, health information technology, consumer engagement, and related positions. The ultimate goals of the program are to create community-based jobs that pay reasonable wages, contribute to improving population health in Maryland, and further the goals of the All-Payer Model.

The PWSDA program will continue through June 30, 2018 on a hospital-specific basis assuming the hospital's ongoing compliance with the grant requirements. The grants could be renewed as of July 1, 2018, for an additional period if the Commission finds that the program is effective.

The Commission received three proposals for award funding. Commission staff established an independent committee to review the grant proposals and make recommendations to the Commission for funding. The PWSDA Implementation Award Review Committee (Review Committee) included representatives from DHMH, the Commission, and other subject matter experts, including individuals with expertise in such areas as population health, health disparities, workforce development and adult learning, health education, healthcare career advancement, and workplace and employee wellbeing.

Based on its review, the Review Committee recommended the following grant proposals for FY 2017 funding:

Garrett Regional Medical Center Health Work Force Support Program:

- $221,485 to be phased in over three years based on proposed expenses.
- At least 50 percent of hires through the program must be Maryland residents.

Mr. Ports noted that the Staff has extended the public comment period through September 30, 2016 for the Baltimore city hospital collaborative proposal.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII

CHESAPEAKE REGIONAL INFORMATION FOR OUR PATIENTS (CRISP) UPDATE

Mr. David Horrocks, CRISP President, and Jeff Reardon, Director of CRISP reporting updated the Commission on the impact on the tools available through the Amendment to the All-Payer Model (See "CRISP Medicare Data Update" on the HSCRC website).

Mr. Horrocks and Mr. Reardon reviewed the progress made so far on four data sets that support the waiver amendment:

- Case mix driven Patient Hospital utilization dashboard (PaTH) and High Utilizers reports,
- GBR PSA level Total Cost of Care reports,
- Patient level episodes analysis (non-patient identification) available by mid- October, and
- CMS/CCLF Data (patient identifiable) available to hospitals and CRISP as of 1/1/17

They also spoke of the challenges faced so far and the goals for the upcoming year,

ITEM VIII

LEGAL REPORT
REGULATIONS

Proposed Action

Rate Application and Approved Procedures– COMAR 10.37.10.07-2

The purpose of this action is to designate those outpatient services provided at a freestanding medical facility that are subject to Health Services Cost Review Commission rate regulation in conformance with the newly enacted law.

The Commission voted unanimously to forward the proposed regulation to the AELR Committee for review and publication in the Maryland Register with a public comment period.

ITEM XI

HEARING AND MEETING SCHEDULE

October 19, 2016	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
November 9, 2016	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 3.38 pm.

Executive Director's Update to the Health Services Cost Review Commission October 19, 2016

CMS Annual Meeting

Maryland met with CMS and CMMI staff to discuss performance for the second year and the Progression Plan under development.

Care Redesign Amendment

CMS approved Maryland's Care Redesign Amendment, but we are still awaiting legal documents.

Care Redesign Amendment

At stakeholder request, we asked CMS to approve an amendment to our All-Payer Model (Model) to obtain comprehensive patient level Medicare data to support care coordination, to allow hospitals to share resources with non-hospital providers, and to allow hospitals to share savings with non-hospital providers. CMS has approved that amendment. As we move forward to keep our current model successful in providing care coordination for high needs and rising risk patients and episodes of care, we must work with physicians and nursing home care partners to make this happen. MACRA has provided us with the possibility to tie physicians into the All-Payer Model and participate in an Advance Alternative Payment Model.

The State believes that working with care partners is crucial to the current and future success of the Model. We are asking every hospital and system to participate in the amendment program(s). Hospitals are already working on many of the initiatives that are envisioned in the amendment and the additional tools stakeholders requested will prove to be helpful.
In that regard, we have scheduled a series of webinars with CMMI staff to begin the launch of the program, which will start in 2017 and expand in 2018.

Hospital leaders should plan to attend the joint CMMI-HSCRC-CRISP-MHA Webinar 1 this Friday, October 21st from 1:00-2:00pm EST. You can register here: https://attendee.gotowebinar.com/register/8666939266781516804 and direct questions to hscrc.care-redesign@maryland.gov.

More information on implementation of the Care Redesign Programs is available on HSCRC's website: http://www.hscrc.maryland.gov/care-redesign.cfm

January 1 Rate Update

The revenues deferred from the July 1 rate order to January 1 will soon begin to increase rates for hospitals. These were built into hospital approved revenues, but deferred through the allocation of the GBR from the first half of the year to the second half of the year. HSCRC provided a list of activities that need to be undertaken relative to the additional revenues. Many of those activities tie directly into the amendment programs that stakeholders requested. In particular, the need to focus on providing care management for 20,000 of the highest need

Medicare patients with an estimated 80,000 very high needs patients is a top priority for Maryland. The HSCRC has an expectation that hospitals will fund and undertake this effort. Getting the data as part of the Amendment will allow better targeting, and programs will need to be scaled up. HSCRC tied the current rate adjustment to this effort as well as the focus on Medicare TCOC. Staff also expects to tie future rate adjustments to successful execution of care supports for high needs individuals and a focus on TCOC.

MHA and CRISP will be presenting later today on work to support hospitals in these efforts.

Regulatory Duplication

The Amendment requires submission of implementation protocols and reports relative to care redesign programs. HSCRC also has reports for GBR infrastructure and implementation grants. HSCRC staff is looking to streamline reporting to reduce the GBR and implementation grant report requirements. This is intended to reduce overlap and regulatory burden.

MACRA Update

CMS released its final MACRA regulations. Maryland has the opportunity to create an Advanced Alternative Payment Model (AAPM) to attach physicians who want to participate to the All-Payer Model through the Care Redesign Amendment program, a primary care initiative, and changes to hospital's value-based payment programs. Staff will aim to provide additional information at upcoming meetings.

This website has a link to CMS' final rule, its executive summary, and some fact sheets, including one on AAPM models. Maryland's All-Payer Model is not listed as an AAPM, similar to the proposed rule, but there is discussion regarding a pathway to make it an AAPM.

Progression Plan

HSCRC and DHMH are working to prepare the Progression Plan for submission to CMS/CMMI by December 31.

- The Plan follows the outlines that have already been presented to stakeholders.
- DHMH and HSCRC staff are providing presentations on the plan to the legislature committees.
- A first draft of the plan will be released on October 21 to the Advisory Council for their review and comment. Following an Advisory Council meeting on October 28, we will prepare an updated version for further stakeholder comment. We hope to post a draft for public comment by mid-November, with submission planned to CMS/CMMI by the end of the year.

Pay for Performance Programs Update

As Maryland implemented the initial phase of an all-payer model since January 1, 2014, existing pay-for-performance programs have been modified to ensure the state reached the performance goals of the new model. HSCRC established improvement targets for complications and readmissions and increased the revenue impact of all programs. Performance measurement incorporated both the attainment rates compared to national or state specific benchmarks, and improvement rates. HSCRC also moved towards predictable scoring and payment adjustment

approach where hospitals can monitor progress. Under this revised approach, payment adjustments are determined by a point-system rather than a relative ranking of the performance.

As Maryland is working towards a more coordinated health care system that is person-centered, this provides a valuable opportunity to rethink the pay-for-performance programs and measurement approaches that would align the system and diverse groups of providers to achieve a common set of goals to improve population health, health care quality, and health equity. Through the annual program update process, stakeholders expressed interest in making further modifications to move the programs towards more outcome-based, person-centered measurement approaches and at the same time evaluate opportunities for further simplification.

HSCRC requested white papers on cross-cutting issues that may have relevance to many specific programmatic options/topics that hold potential promise for refining our performance based payment programs to better support and measure the success of Maryland's system transformation. More information on white papers can be found at http://hscrc.maryland.gov/hscrc-workgroup-performance-measurement.cfm.

HSCRC staff is planning to work on developing new methodologies to align measurement across providers and create a person-centered approach to performance based payment adjustments in conjunction with the strategic direction the State is undertaking with the All-Payer Model Progression Plan. Specifically, staff will be focusing on the following concepts in the upcoming year and is not planning to make major changes to the existing pay-for-performance programs.

1. Developing service line/episode value measurement that could potentially combine and streamline different quality measures such readmissions, complication rates, mortality, patient experience and costs, at an episode/service line level such as surgery, medicine, obstetrics, psychiatry, oncology, emergency medicine, outpatient surgery etc.

2. Incorporating population health measures that would align the payment approaches with the top priorities set by the State in reducing avoidable utilization that can be impacted through improved community based care and interventions.

3. Developing performance metrics targeting high-need patients and care coordination.

4. Incorporating new measures for outpatient and ambulatory services that would harmonize measurement across different providers such as Accountable Care Organization (ACO) Measures, CPC+, etc.

5. Creating a road map towards outcomes based performance measurement, focusing on population health, new measures available from EMRs and registries, and patient reported outcomes, as well as administrative data.

Workgroup Updates

Performance Measurement Workgroup

The Performance Measurement Workgroup will continue to have monthly meetings to discuss updated to the pay for performance programs and road map. The work group will need to be expanded to incorporate additional non-hospital providers.

To help achieve the broad improvement goals under Maryland's Model, HSCRC is working to implement three new workgroups.

Consumer Standing Advisory Committee (C-SAC)

Working with other state agency partners, HSCRC and DHMH are coordinating the formation of C-SAC with representation that leverages the consumer engagement and involvement to date across the various work groups, and reflects the broad consumer diversity of the state. The group will bring together a diverse cross-section of consumers, consumer advocates, relevant subject matter experts, and provider, payer and other key stakeholders. An initial meeting is anticipated in the December/January timeframe.

Behavioral Health Subgroup

The Behavioral Health Subgroup will advise the Performance Measurement Work Group and the Commission on measures of performance for care provided to persons with mental health or substance use disorders that should be considered for HSCRC implementation initially and over time. The group will bring together a broad array of key stakeholders. The initial meeting is anticipated in December. MHA has also been focusing on behavioral health needs and will provide input to the subgroup.

Total Cost of Care Workgroup

The Total Cost of Care Workgroup will be formed to provide feedback to HSCRC on the development of the hospital-level TCOC guardrails for the Care Redesign Amendment Programs. The staff will also work with this group to develop measures that can be introduced into performance based payment for FY 2018. An initial meeting is anticipated early November.

QBR

As discussed in the June HSCRC meeting, staff was concerned that there were problems with the QBR scaling for the FY 2017 QBR adjustment. Staff attempted to develop a scale in advance of the year, but the scale was problematic. It provided rewards where performance was not improved. This will be discussed in today's meetings. Staff has revised the scaling to correct it.

January Update

We will update hospitals' July 1 rate order on January 1 for the following:

- Settlement of rate and global revenue compliance from FY 2016
- QBR
- Market shift adjustment for 6 months (January through June 2016)
- Allocation of additional set aside for drug cost growth (approx. $16 million)

Update on Case Mix Data

The case mix data is still defective due to Johns Hopkins EPIC conversion. We have not yet received usable data since the conversion. We are expecting corrected data in the near future. We cannot produce market shift analysis or ECMAD volume analysis without corrected data.

Medicare Total Cost of Care Performance

June figures have been restated due to claims held by Novitas. July figures are not available due to Johns Hopkins EPIC conversion.

Monitoring Maryland Performance
Medicare TCOC Data

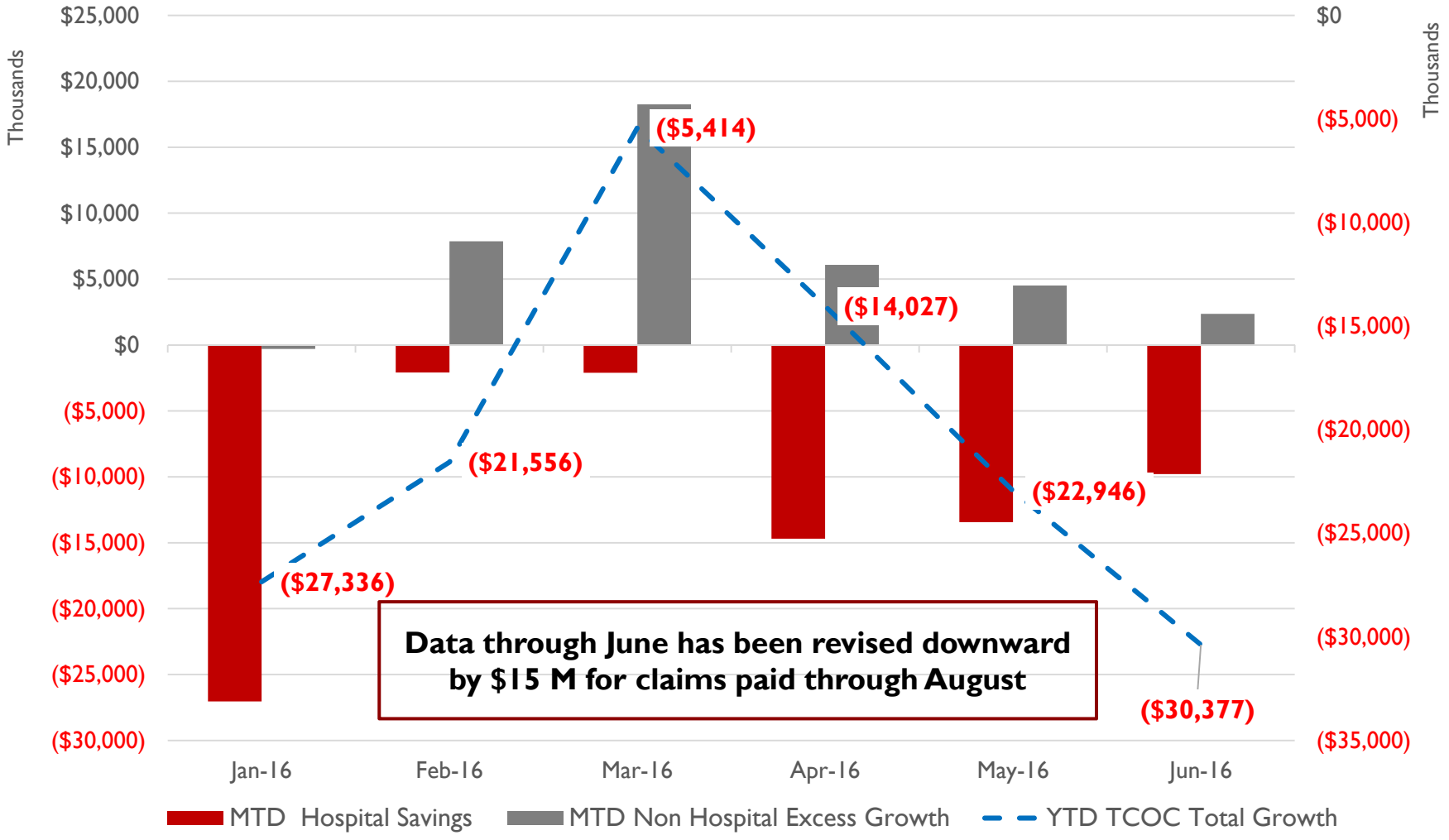
Data through June 2016 - Paid Claims through August

HSCRC
Health Services Cost Review Commission

Disclaimer

Data contained in this presentation represent analyses prepared by MHA and HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

Medicare Hospital & Non Hospital Growth (with completion) CYTD through June 2016



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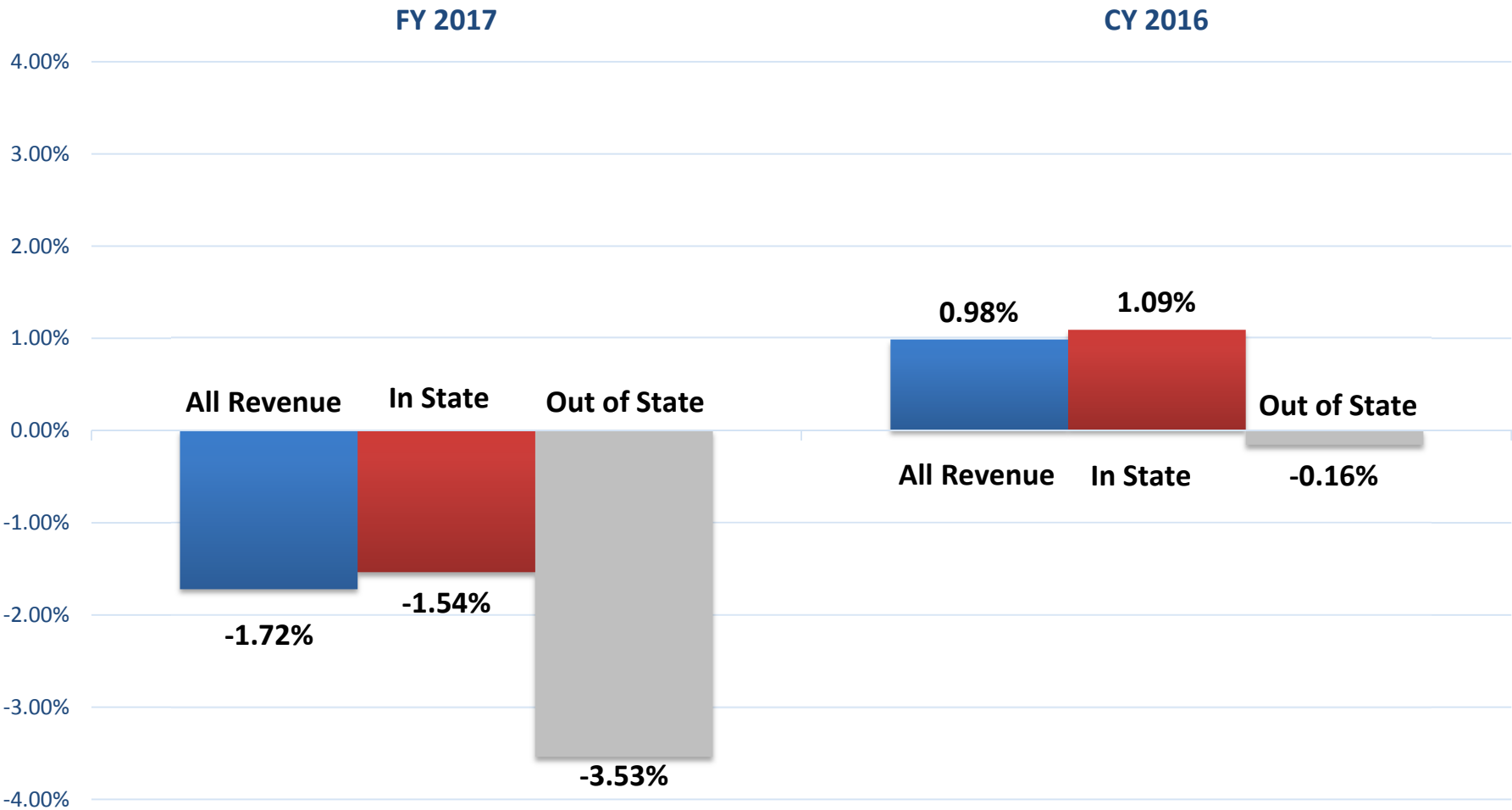
Monitoring Maryland Performance

Financial Data

Year to Date thru August 2016

Gross All Payer Revenue Growth

Year to Date (thru August 2016) Compared to Same Period in Prior Year



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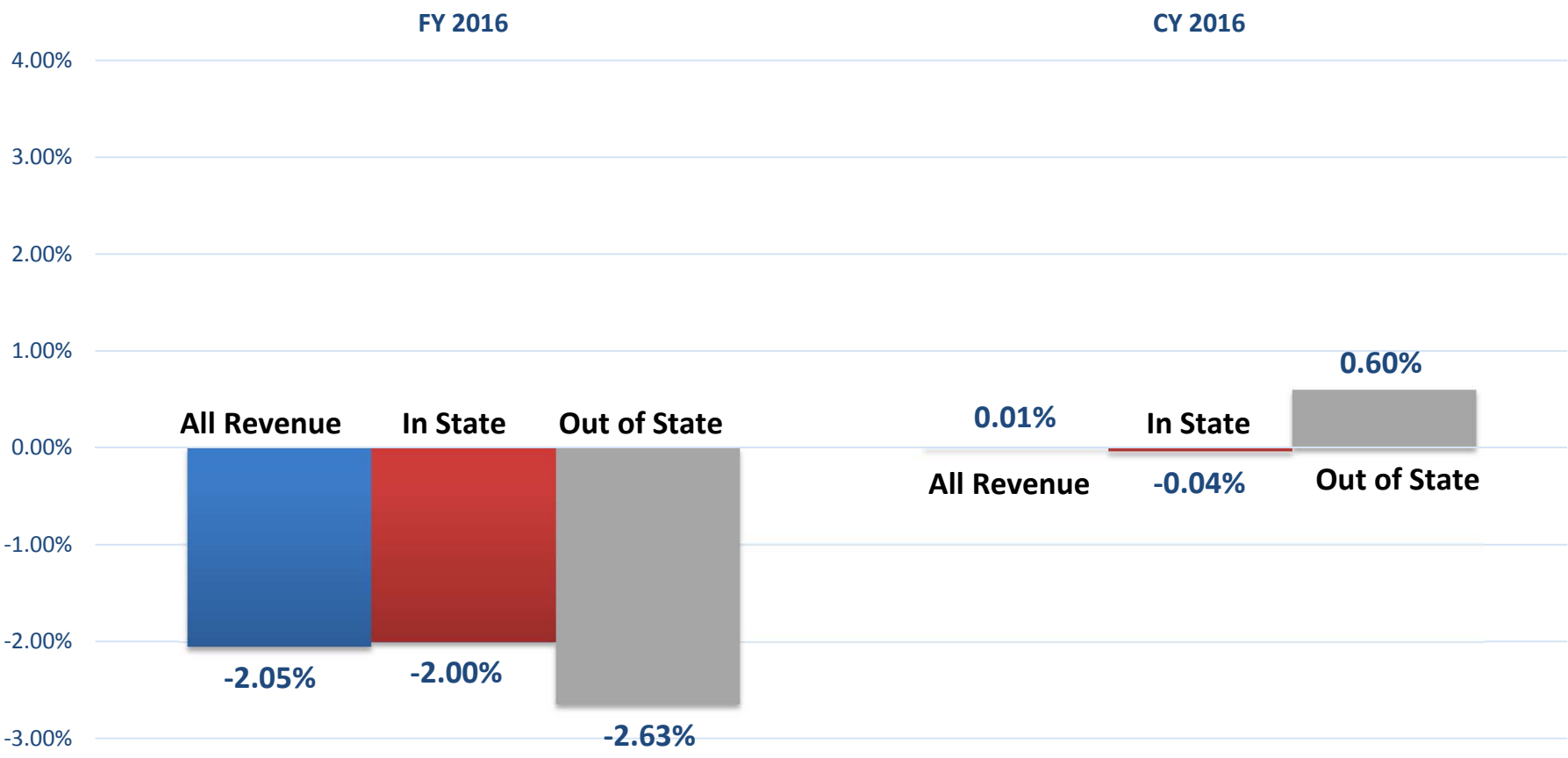
Gross Medicare Fee-for-Service Revenue Growth

Year to Date (thru August 2016) Compared to Same Period in Prior Year



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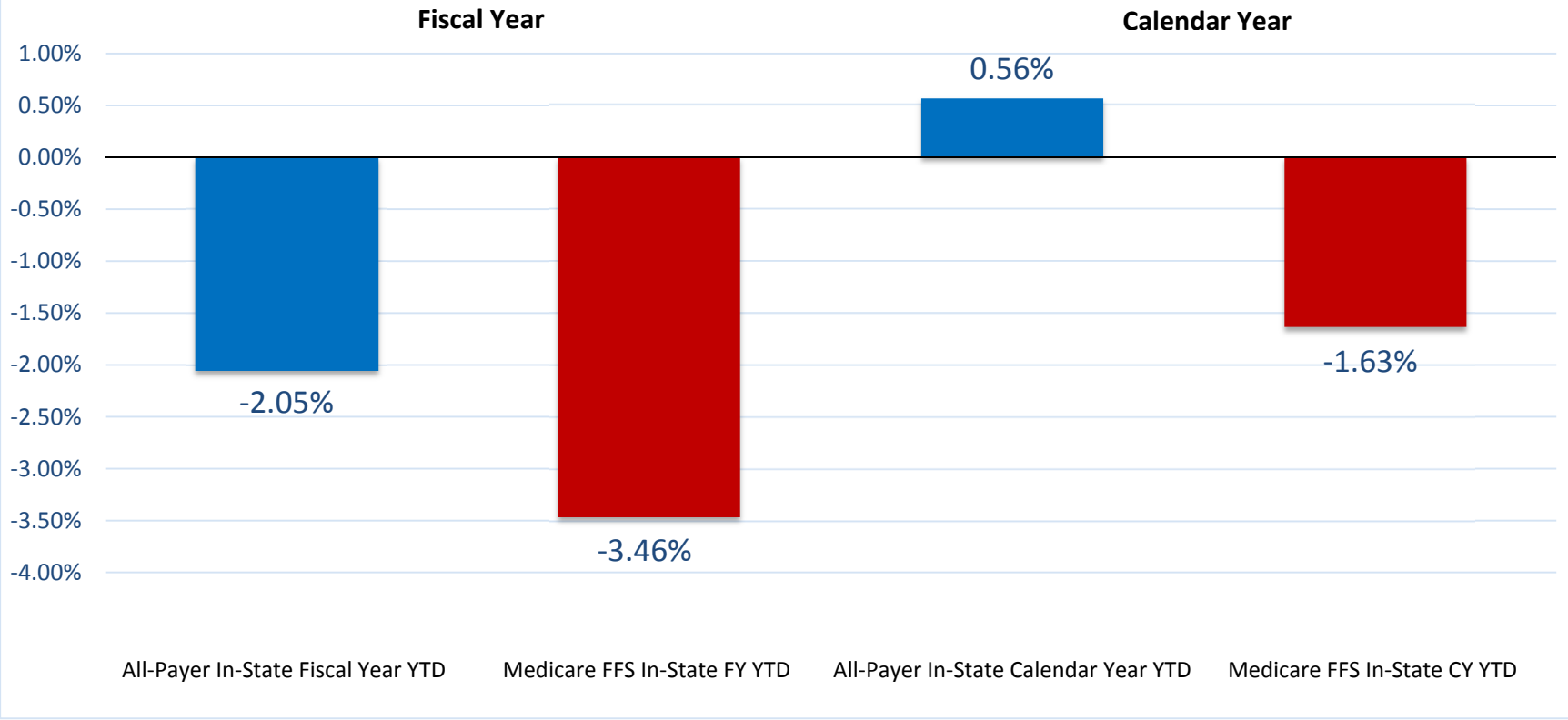
Per Capita Growth Rates

Fiscal Year 2017 (YTD Aug 2016 over YTD Aug 2015) and Calendar Year 2016 (Jan-Aug 2016 over Jan- Aug 2015)



- **Calendar and Fiscal Year trends through August are below All-Payer Model Guardrail of 3.58% per year for per capita growth.**

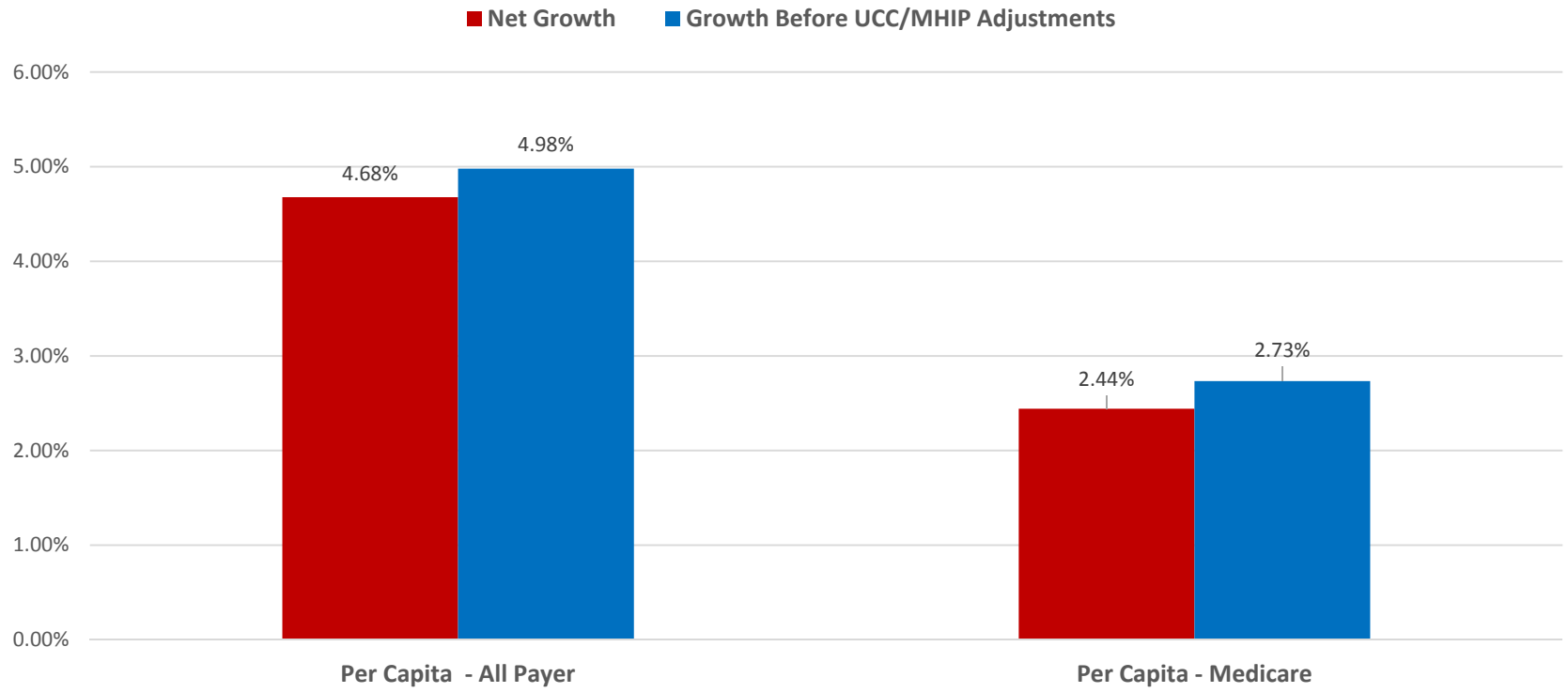
FFS = Fee-for-Service

Population Data from Estimates Prepared by Maryland Department of Planning

HSCRC
Health Services Cost Review Commission

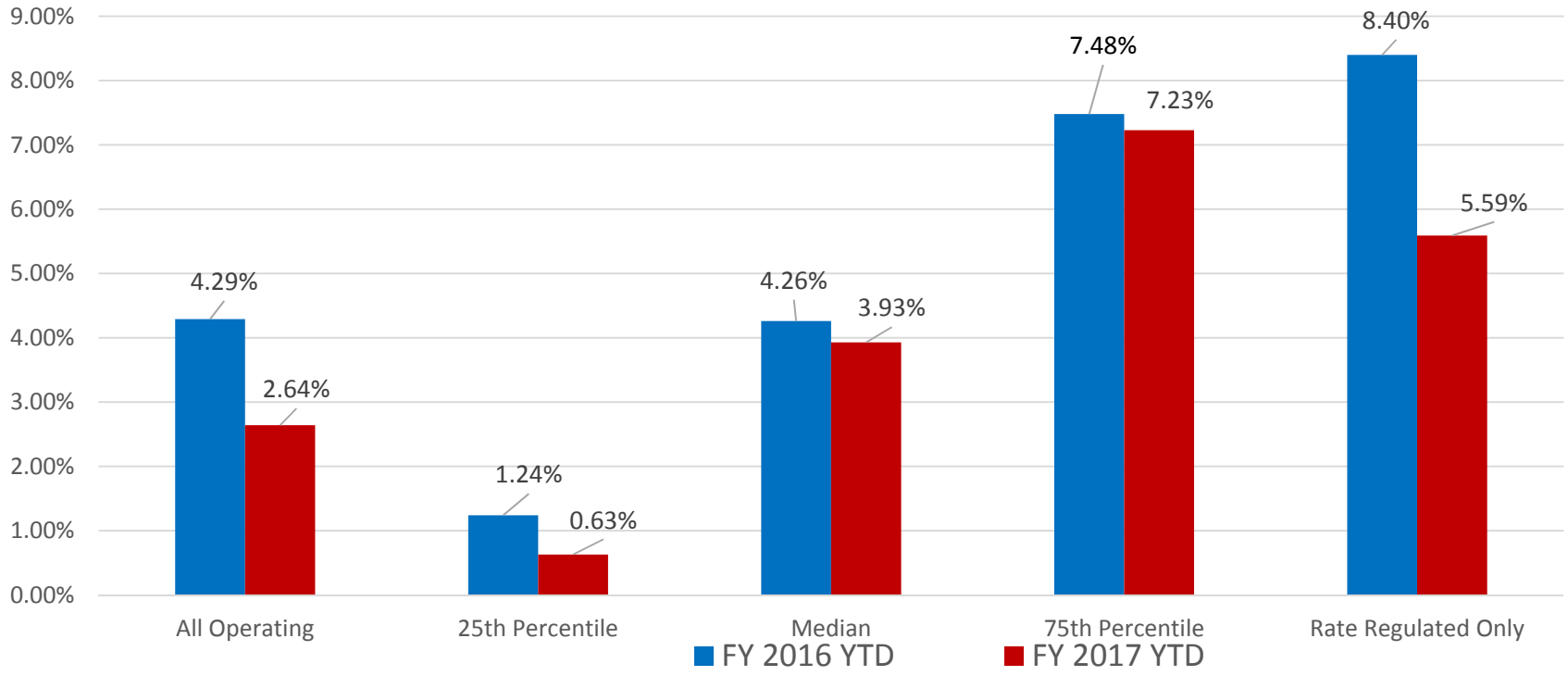
Per Capita Growth – Actual and Underlying Growth

CY 2016 Year to Date (Jan-Aug) Compared to Same Period in Base Year (2013)



- Three year per capita growth rate is well below maximum allowable growth rate of 11.13% (growth of 3.58% per year)
- Underlying growth reflects adjustment for FY16 revenue decreases that were budget neutral for hospitals. 2.52% hospital bad debts and elimination of MHIP assessment.

Total Operating Profits FYTD 2016 vs FYTD 2017
(July-August)



- FY 2017 unaudited hospital operating profits show a decline of 1.64 percentage points in total profits compared to the same period in FY 2016. Rate regulated profits have declined by 2.81 percentage points compared to the same period in FY 2016.

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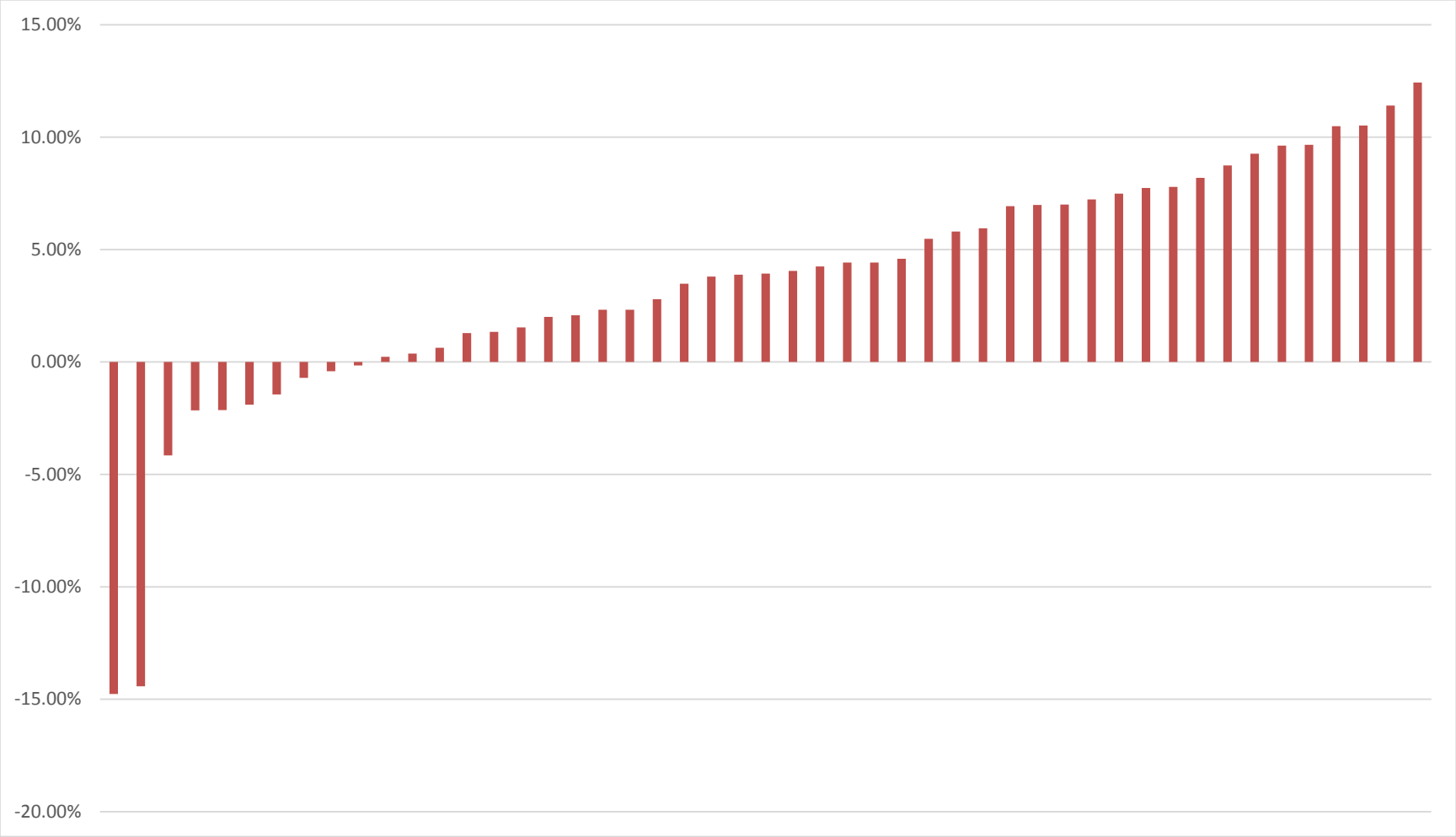
Total Operating Profits by Hospital

Fiscal Year 2017 to Date (Jul-Aug 2016)



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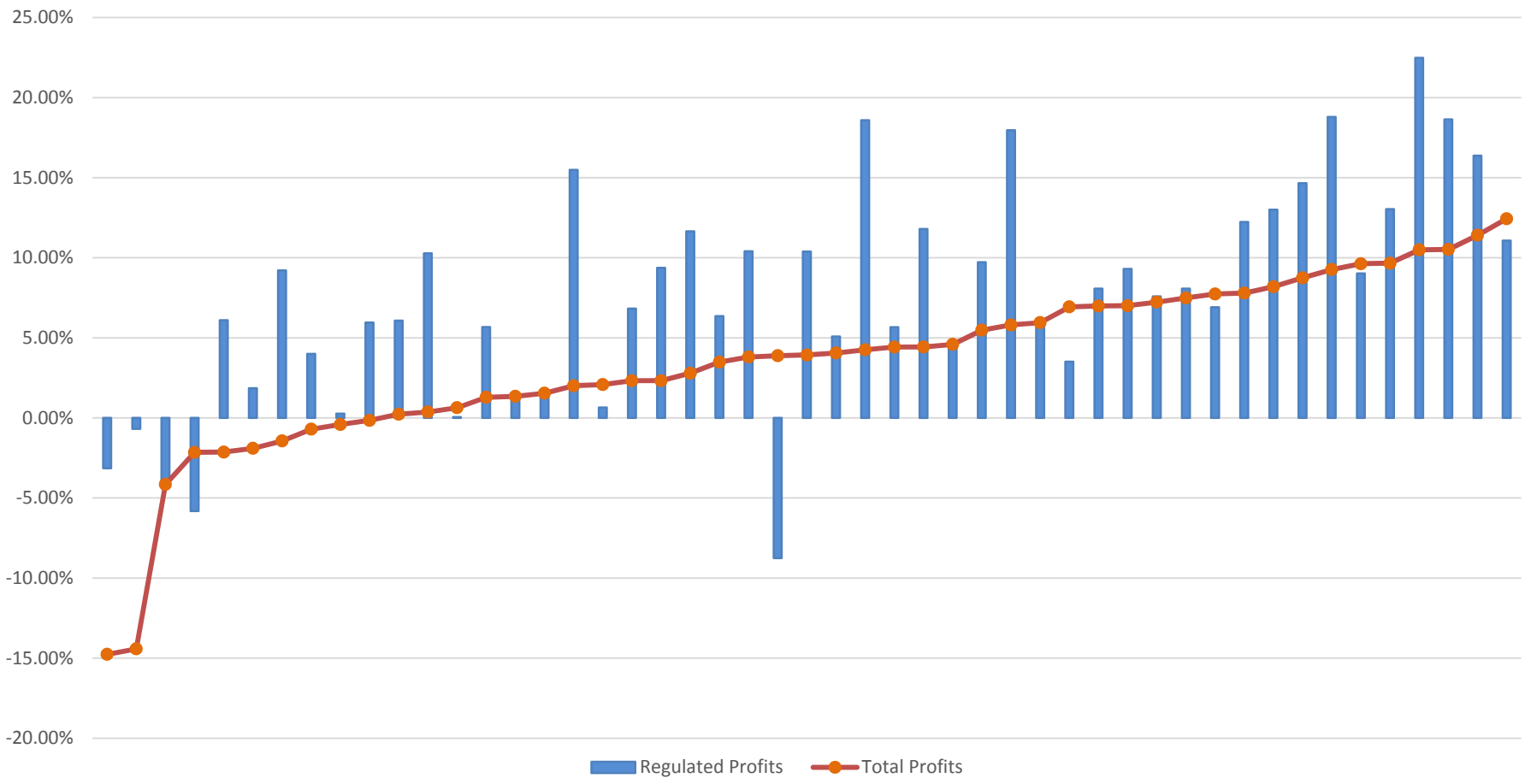
Health Services Cost Review Commission

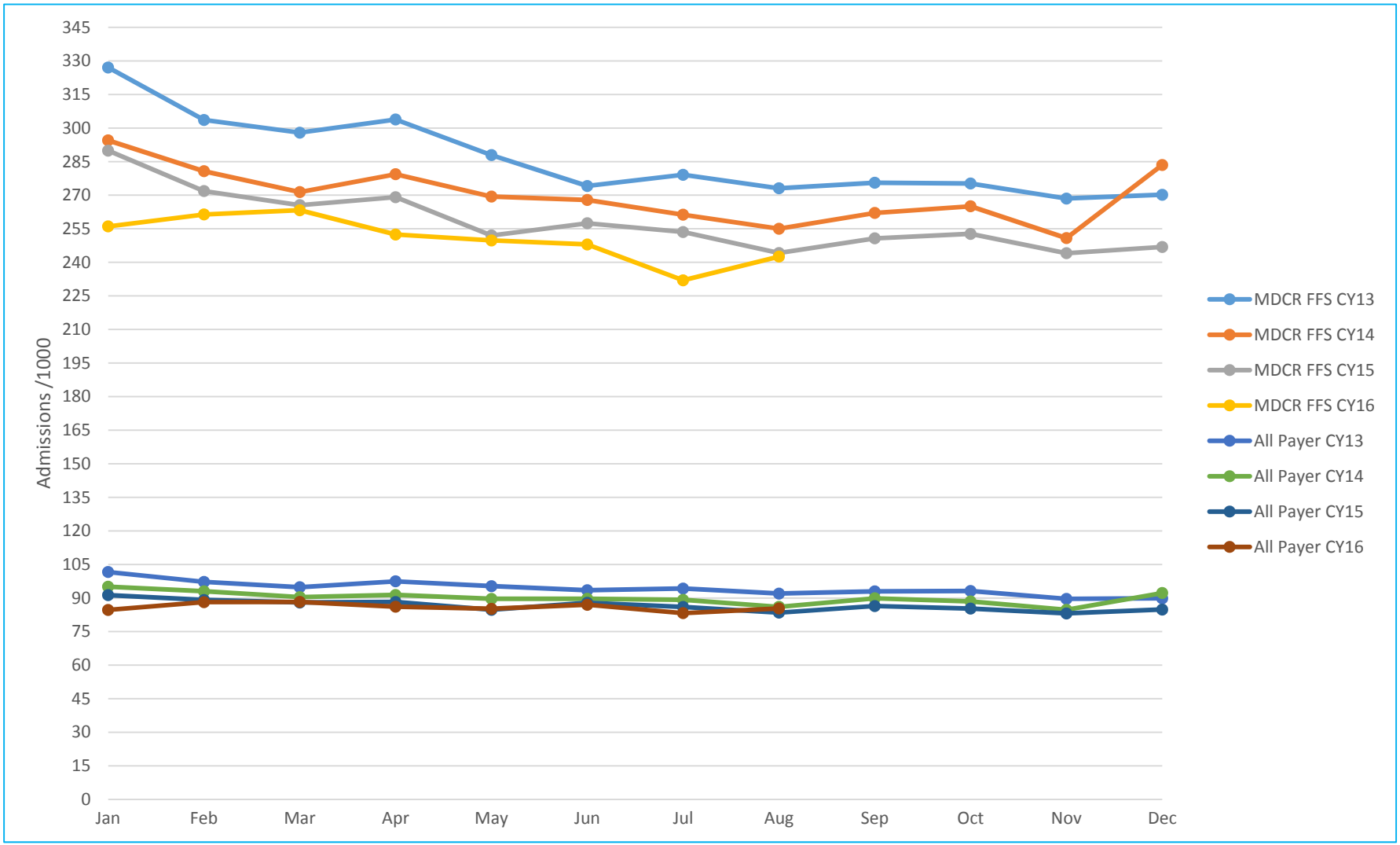
Regulated and Total Operating Profits by Hospital

Fiscal Year 2017 to Date (Jul-Aug 2016)



HSCRC
Health Services Cost Review Commission

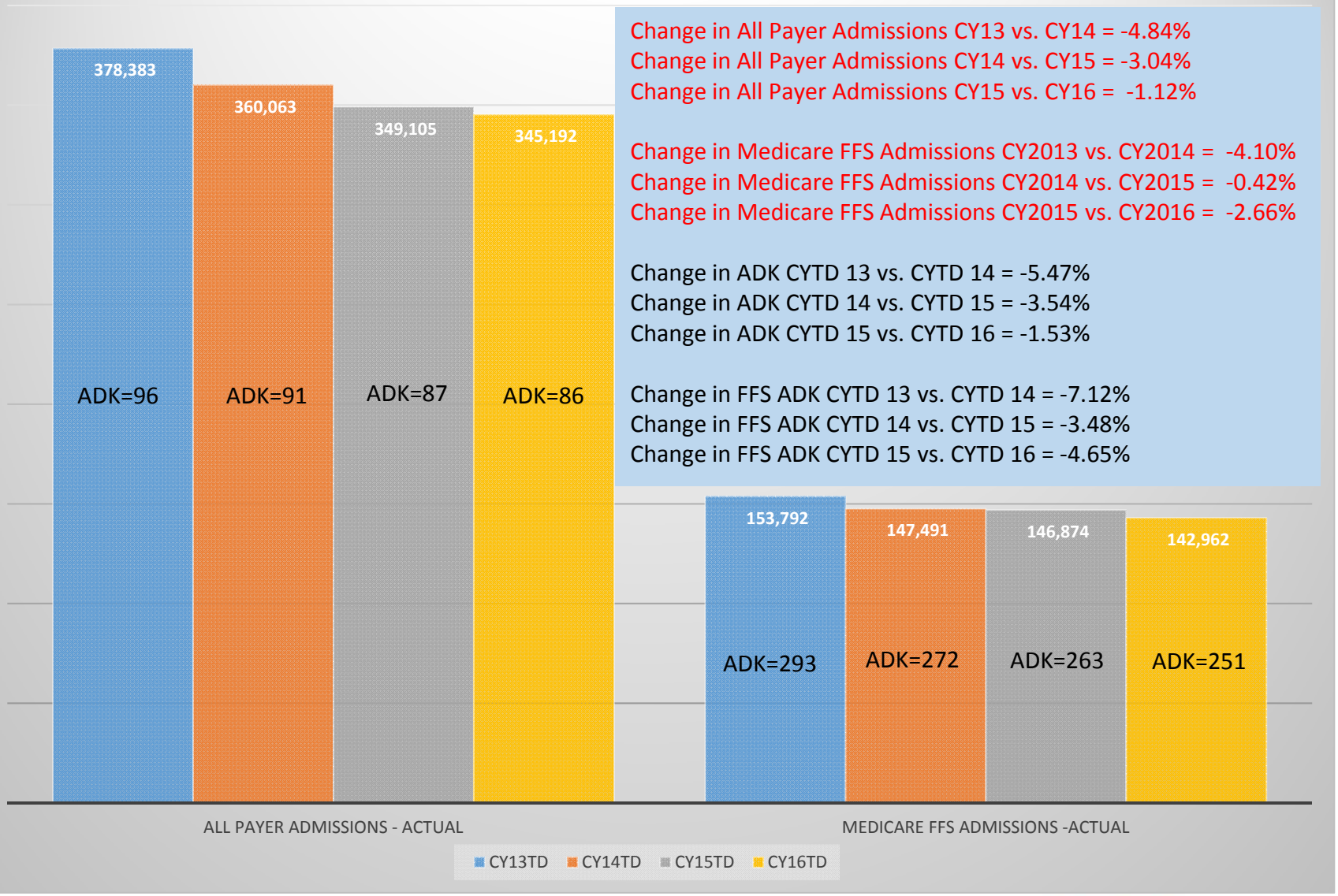
Annual Trends for Admissions/1000 (ADK) Annualized Medicare FFS and All Payer (CY 2013 through CY 2016 YTD)



*Note – The admissions do not include out of state migration or specialty psych and rehab hospitals

HSCRC
Health Services Cost Review Commission

Actual Admissions by Calendar Year to Date through August



Change in All Payer Admissions CY13 vs. CY14 = -4.84%
Change in All Payer Admissions CY14 vs. CY15 = -3.04%
Change in All Payer Admissions CY15 vs. CY16 = -1.12%

Change in Medicare FFS Admissions CY2013 vs. CY2014 = -4.10%
Change in Medicare FFS Admissions CY2014 vs. CY2015 = -0.42%
Change in Medicare FFS Admissions CY2015 vs. CY2016 = -2.66%

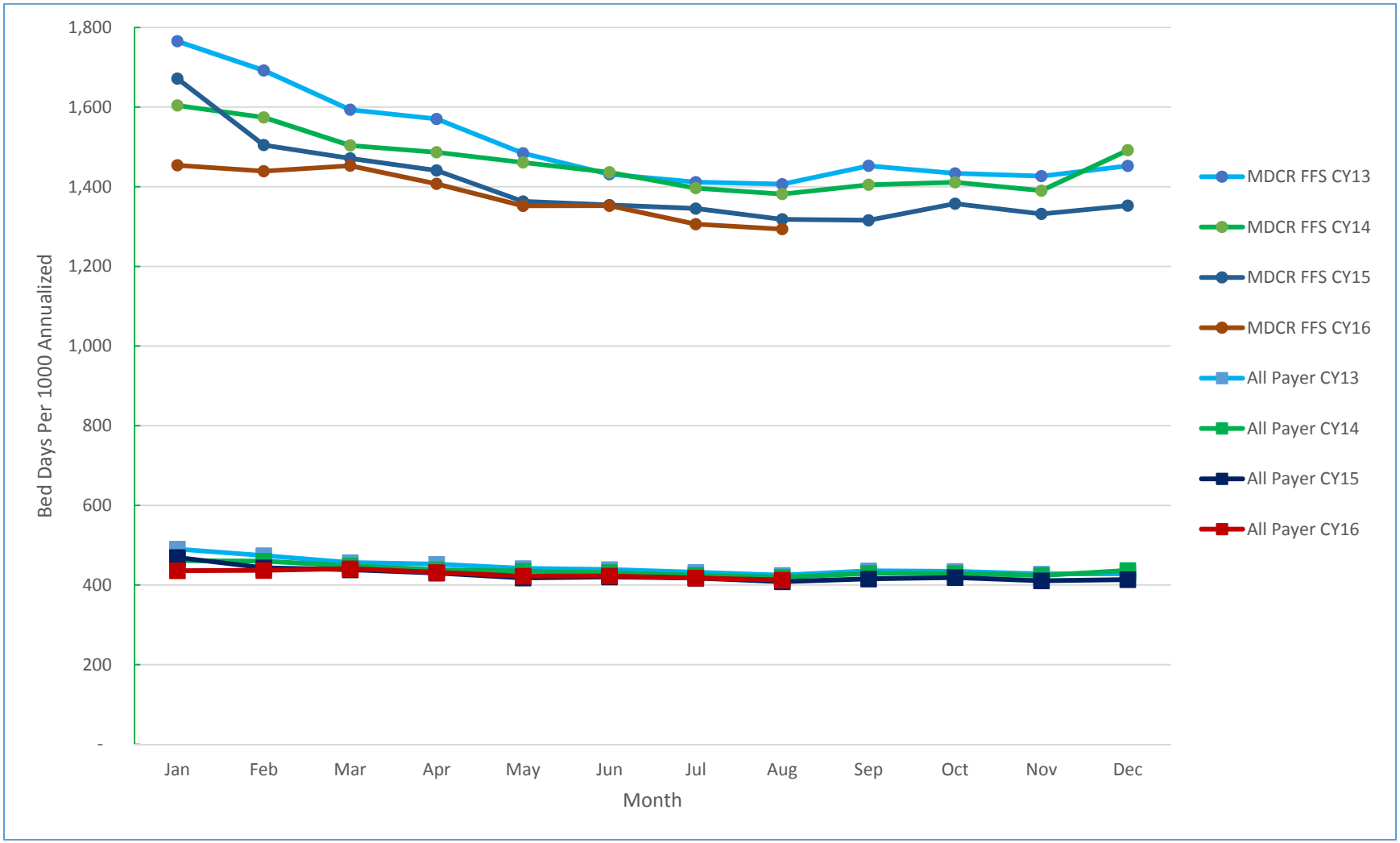
Change in ADK CYTD 13 vs. CYTD 14 = -5.47%
Change in ADK CYTD 14 vs. CYTD 15 = -3.54%
Change in ADK CYTD 15 vs. CYTD 16 = -1.53%

Change in FFS ADK CYTD 13 vs. CYTD 14 = -7.12%
Change in FFS ADK CYTD 14 vs. CYTD 15 = -3.48%
Change in FFS ADK CYTD 15 vs. CYTD 16 = -4.65%

*Note – The admissions do not include out of state migration or specialty psych and rehab hospitals

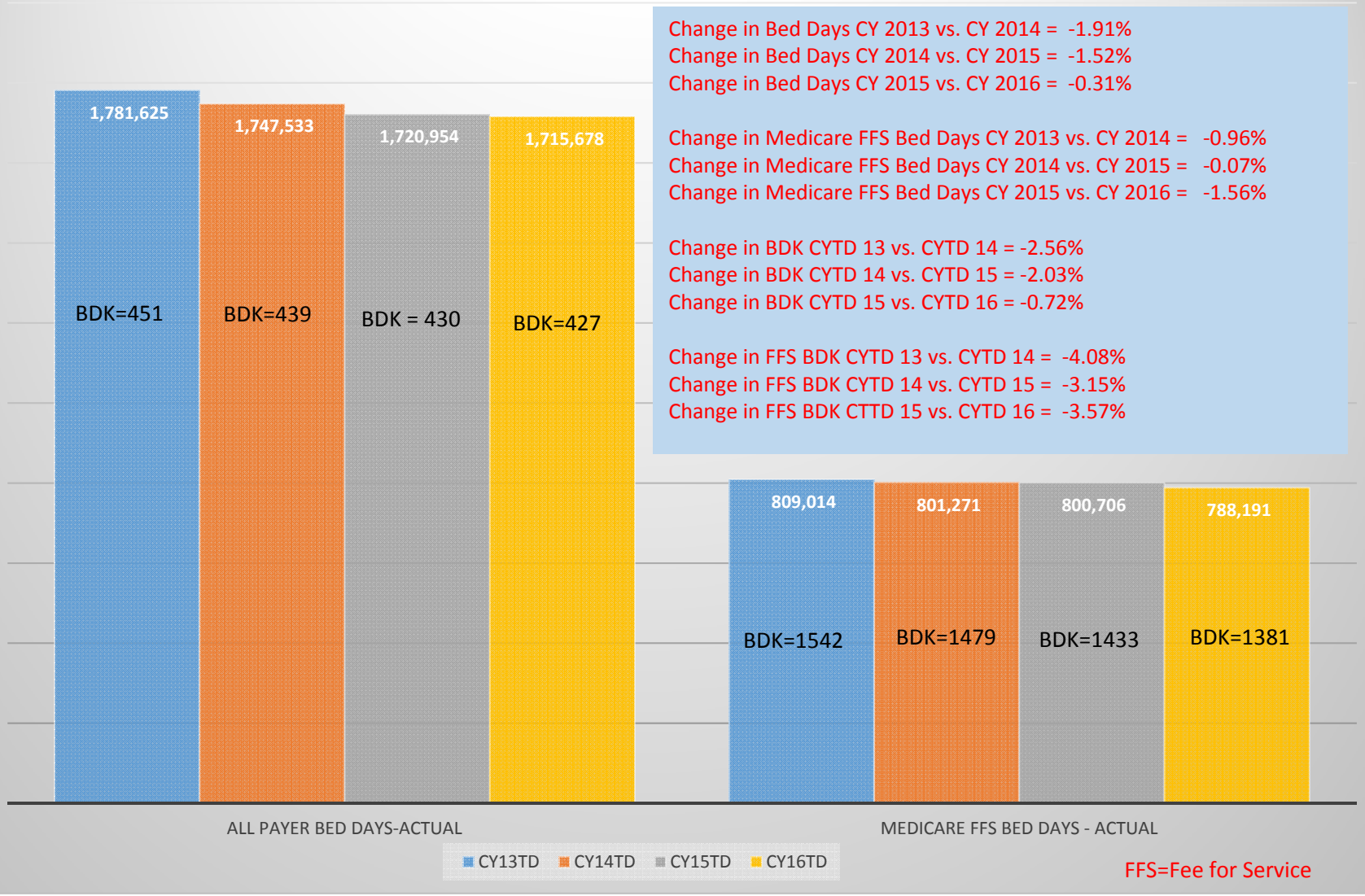
HSCRC
Health Services Cost Review Commission

Annual Trends for Bed Days/1000 (BDK) Annualized Medicare FFS and All Payer (CY 2013 through CY 2016 YTD)



*Note – The bed days do not include out of state migration or specialty psych and rehab hospitals.

Actual Bed Days by Calendar Year to Date through August 2016



Change in Bed Days CY 2013 vs. CY 2014 = -1.91%
Change in Bed Days CY 2014 vs. CY 2015 = -1.52%
Change in Bed Days CY 2015 vs. CY 2016 = -0.31%

Change in Medicare FFS Bed Days CY 2013 vs. CY 2014 = -0.96%
Change in Medicare FFS Bed Days CY 2014 vs. CY 2015 = -0.07%
Change in Medicare FFS Bed Days CY 2015 vs. CY 2016 = -1.56%

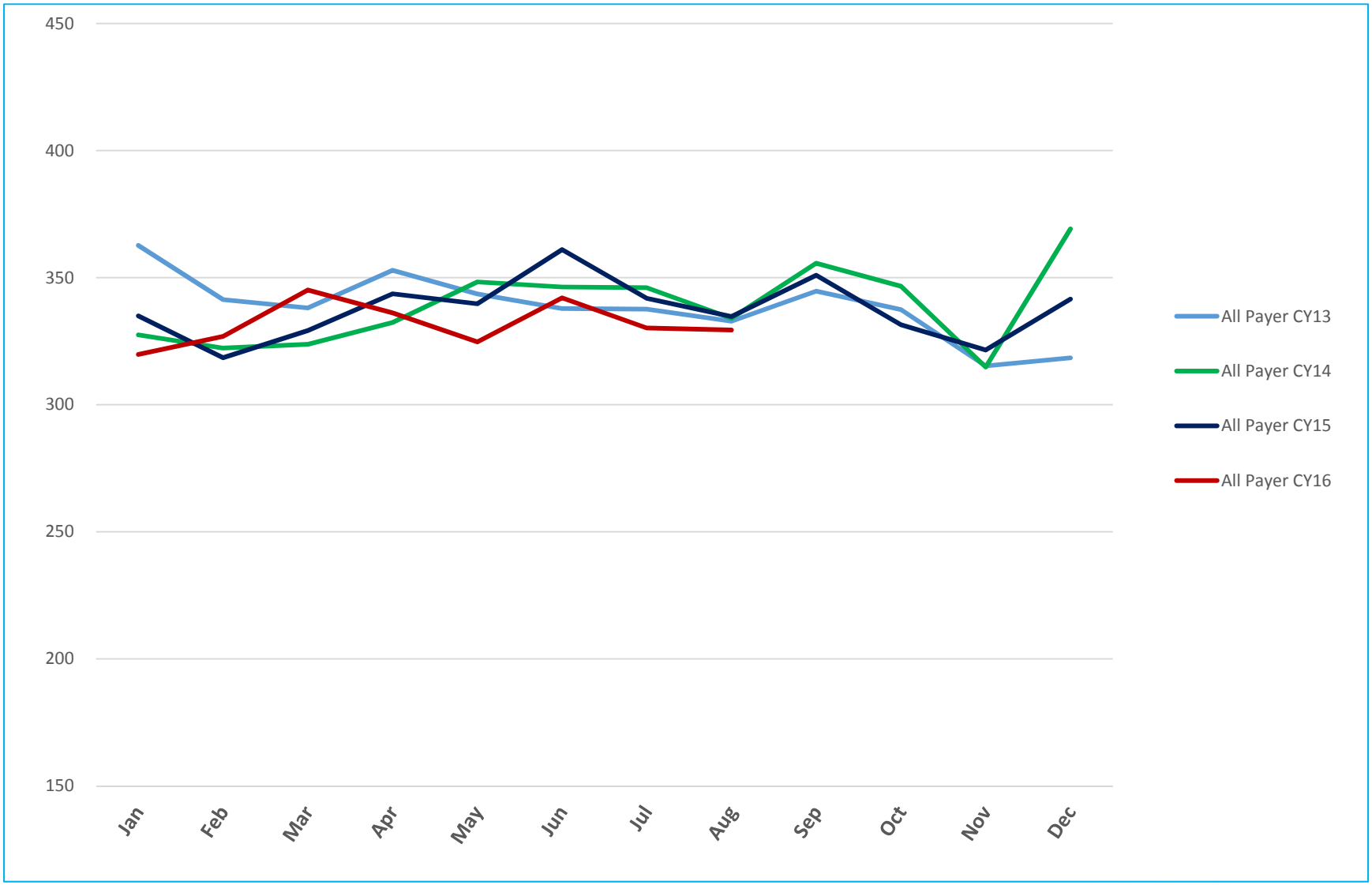
Change in BDK CYTD 13 vs. CYTD 14 = -2.56%
Change in BDK CYTD 14 vs. CYTD 15 = -2.03%
Change in BDK CYTD 15 vs. CYTD 16 = -0.72%

Change in FFS BDK CYTD 13 vs. CYTD 14 = -4.08%
Change in FFS BDK CYTD 14 vs. CYTD 15 = -3.15%
Change in FFS BDK CTTD 15 vs. CYTD 16 = -3.57%

FFS=Fee for Service

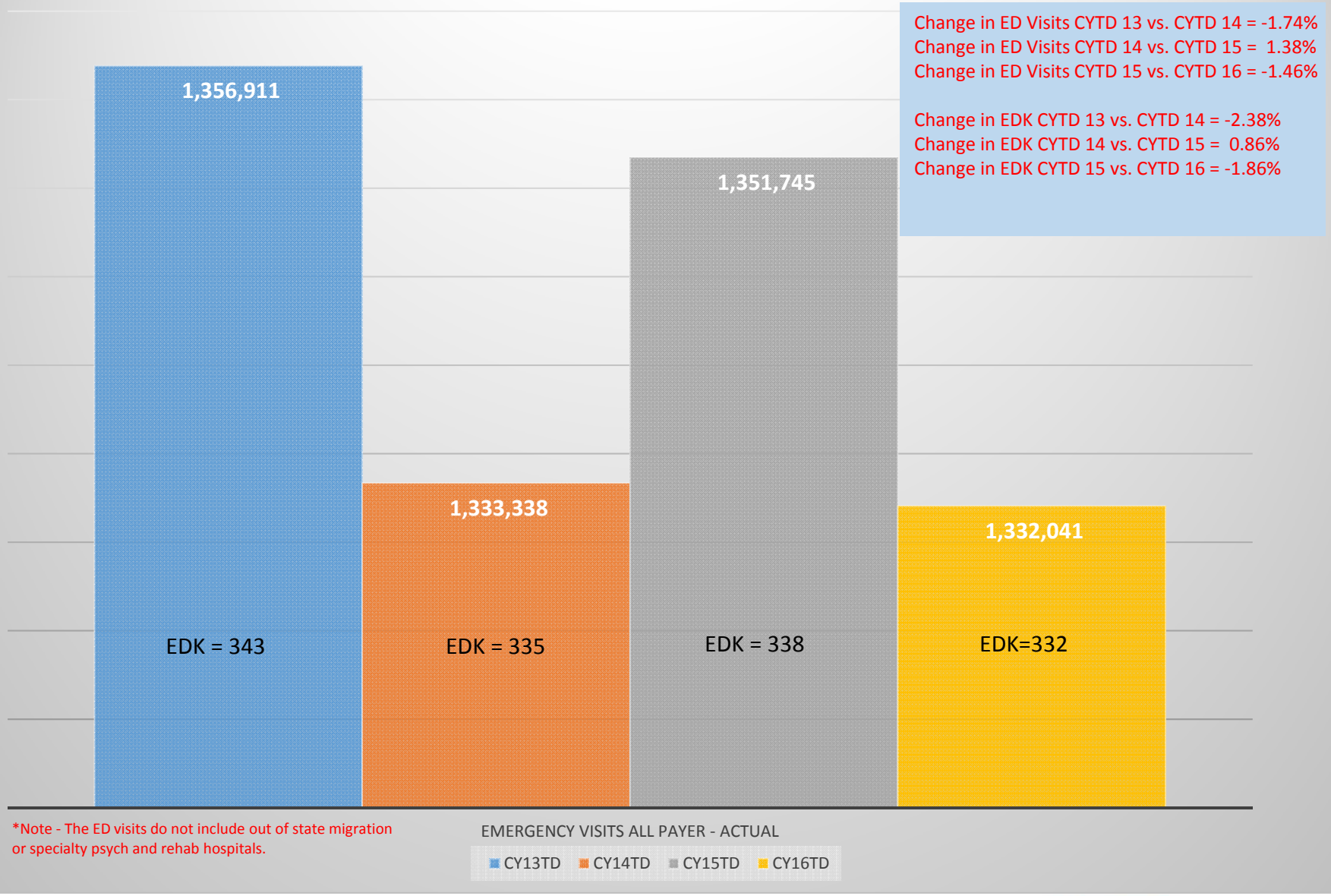
*Note – The bed days do not include out of state migration or specialty psych and rehab hospitals.

Annual Trends for ED Visits /1000 (EDK) Annualized All Payer
(CY2013 through CY2016 YTD)



HSCRC
Health Services Cost Review Commission

Actual ED Visits by Calendar YTD through August 2016



*Note - The ED visits do not include out of state migration or specialty psych and rehab hospitals.

HSCRC
Health Services Cost Review Commission

Purpose of Monitoring Maryland Performance

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

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

Data Caveats

- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- All-payer per capita calculations for Calendar Year 2015 and Fiscal 2016 rely on Maryland Department of Planning projections of population growth of .52% for FY 16 and .52% for CY 15. Medicare per capita calculations use actual trends in Maryland Medicare beneficiary counts as reported monthly to the HSCRC by CMMI.

Data Caveats cont.

- The source data is the monthly volume and revenue statistics.
- ADK – Calculated using the admissions multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- BDK – Calculated using the bed days multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- EDK – Calculated using the ED visits multiplied by 365 divided by the days in the period and then divided by average population per 1000.
- All admission and bed days calculations exclude births and nursery center.
- Admissions, bed days, and ED visits do not include out of state migration or specialty psych and rehab hospitals.

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 OCTOBER 11, 2016

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
2352N	MedStar Harbor Hospital	9/6/2016	11/5/2016	2/3/2017	PSY & PDC	CK	OPEN
2353A	Priority Partners	9/28/2016	N/A	N/A	N/A	DNP	OPEN
2354A	University of Maryland Medical Center	9/28/2016	N/A	N/A	N/A	DNP	OPEN
2355A	University of Maryland Medical Center	10/4/2016	N/A	N/A	N/A	DNP	OPEN
2356A	Maryland Physicians Care	10/4/2016	N/A	N/A	N/A	DNP	OPEN
2357A	Hopkins Health Advantage	10/4/2016	N/A	N/A	N/A	DNP	OPEN
2358A	MedStar Family Choice	10/10/2016	N/A	N/A	N/A	DNP	OPEN
2359A	MedStar Family Choice	10/10/2016	N/A	N/A	N/A	DNP	OPEN
2360A	University of Maryland Health Partners, Inc.	10/10/2016	N/A	N/A	N/A	DNP	OPEN
2361A	University of Maryland Health Advantage, Inc.	10/10/2016	N/A	N/A	N/A	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**
APPLICATION OF THE	*	**COST REVIEW COMMISSION**
MEDSTAR HARBOR	*	**DOCKET: 2016**
HOSPITAL	*	**FOLIO: 2162**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2352N**

Staff Recommendation

October 19, 2016

Introduction

On September 6, 2016, MedStar Harbor Hospital (the Hospital), a member of MedStar Health (the System), submitted a partial rate application to the Commission requesting new rates for Psychiatric Acute (PSY) and Psychiatric Day & Night Care (PDC) services. The Hospital requires the new rate because the 26 acute inpatient psychiatric bed program is being transitioned from MedStar Union Memorial Hospital (MUMH). The Hospital requests that the PSY and PDC rates be set at MedStar Union Memorial rates of $878.48 per day for PSY services and 479.79 per visit for PDC services and be effective November 1, 2016.

Staff Evaluation

Since MedStar Health will be transitioning its 26 acute inpatient psychiatric bed program from MUMH to the Hospital, staff consulted with the Maryland Health Care Commission (MHCC) to determine if all regulatory requirements have been satisfied. MHCC confirmed that the change in bed capacity at MedStar Harbor Hospital and MedStar Union Memorial and the introduction of acute psychiatric services at MedStar Harbor Hospital do not require MHCC review and approval.

Based on Staff's review, MUMH's rate for PSY services, $874.00 per patient day, is below the statewide median of $1,102.19 per patient day. MUMH's rate for PDC services, $477.34 per visit, is above the statewide median of $457.52 per visit.

Recommendation

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

1. That a PSY rate of $874.00 per patient day be approved effective November 1, 2016;
2. That a PDC rate of $457.52 per visit be approved effective November 1, 2016;
3. That the PSY and PDC rates not be rate realigned until a full year's cost experience data have been reported to the Commission; and
4. That no change be made to the Hospital's Global Budget Revenue.

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
THE JOHNS HOPKINS HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2016**
	*	**FOLIO:**	**2163**
BALTIMORE, MARYLAND	*	**PROCEEDING**	**2353A**

Draft Recommendation

October 19, 2015

This is a draft recommendation. Any comments shall be submitted by COB on October 31, 2016 to Steve Ports at steve.ports@maryland.gov.

I. Introduction

On September 19, 2016, Johns Hopkins Health System ("JHHS," or the "System") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Suburban Hospital, and Howard County General Hospital ("the Hospitals"). The System seeks renewal for the continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. Priority Partners, Inc. is the entity that assumes the risk under the contract. The Commission most recently approved this contract under proceeding 2308A for the period from January 1, 2016 through December 31, 2016. The Hospitals are requesting to renew this contract for a one-year period beginning January 1, 2017.

II. Background

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

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

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

Priority Partners is a major participant in the Medicaid Health Choice program, providing managed care services to 2405% of the State's MCO population, up from 23.6% in CY 2015.

III. Staff Review

This contract has been operating under the HSCRC's initial approval in proceeding 2308A. Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2015, 2016, and 2017. The statements provided by Priority Partners to staff represent both a "stand-alone" and "consolidated" view of Priority's operations. The consolidated picture reflects certain administrative revenues and expenses of Johns Hopkins Health Care. When other provider-based MCOs are evaluated for financial stability, their administrative costs relative to their MCO business are included as well; however, they are all included under the one entity of the MCO.

With the exception of CY 2015 in which all provider-based MCOs experienced unfavorable performance, the consolidated financial performance of Priority Partners has been favorable. Priority Partners is projecting to favorable performance in CY 2016 and marginal performance in CY 2017.

IV. Recommendation

With the exception of CY 2015, Priority Partners has continued to achieve favorable consolidated financial performance in recent years. Based on past and projected performance, staff believes that the proposed renewal arrangement for Priority Partners is acceptable under Commission.

Therefore:

1) **Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2017.**
2) **Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance in CY 2016, and the MCOs expected financial status in to CY 2017. Therefore, staff recommends that Priority Partners report to Commission staff (on or before the September 2017 meeting of the Commission) on the actual CY 2016 experience, and preliminary CY 2017 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2018.**
3) **Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates,**

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION *		**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2016**
MEDICAL CENTER	*	**FOLIO:**	**2164**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2354A**

Staff Recommendation

October 19, 2016

I. INTRODUCTION

The University of Maryland Medical Center (the Hospital) filed a renewal application with the HSCRC on September 28, 2016 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and blood and bone marrow transplant services with OptumHealth Care Solutions, Inc. for a one-year period, effective November 1, 2016.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

been favorable.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application to continue to participate in an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period beginning November 1, 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**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2016**
MEDICAL CENTER *		**FOLIO:**	**2165**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2355A**

Staff Recommendation

October 19, 2016

I. INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on September 28, 2016 requesting approval to continue its participation in a global rate arrangement with BlueCross and BlueShield Association Blue Distinction Centers for blood and bone marrow transplant services for a period of one year beginning December 1, 2016.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

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

one year period commencing December 1, 2016. The Hospital will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
SAINT AGNES HEALTH	*	**COMMISSION**	
WESTERN MARYLAND HEALTH SYSTEM	*	**DOCKET:**	**2016**
MERITUS HEALTH	*	**FOLIO:**	**2166**
HOLY CROSS HEALTH	*	**PROCEEDING:**	**2356A**

Draft **Recommendation**

October 19, 2016

This is a draft recommendation. Any comments shall be submitted by COB on October 31, 2016 to Steve Ports at steve.ports@maryland.gov.

I. Introduction

On August 31, 2016, Saint Agnes Health System, Western Maryland Health System, Holy Cross Health, and Meritus Health ("the Hospitals") filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06. The Hospitals seek renewal for the continued participation of Maryland Physicians Care ("MPC") in the Medicaid Health Choice Program. MPC is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 22307A for the period January 1, 2016 through December 31, 2016. The Hospitals are requesting to renew this contract for one year beginning January 1, 2017.

II. Background

Under the Medicaid Health Choice Program, MPC, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. MPC pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. MPC is a major participant in the Medicaid Health Choice program, and provides services to 18.8% of the total number of MCO enrollees in Maryland, which represents approximately the same market share as CY 2015.

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

III. Staff Review

This contract has been operating under previous HSCRC approval (Proceeding 2307A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2015, 2016, and 2017. In recent years, the financial performance of MPC overall has been marginally favorable with unfavorable performance in CY 2015 (as with all of the provider-based MCOs), and favorable projections for CYs 2016 and 2017.

IV. Recommendation

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

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2017.

(2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance for CY 2016 and the MCO's expected financial status into CY 2017. Staff recommends that Maryland Physicians Care report to Commission staff (on or before the September 2017 meeting of the Commission) on the actual CY 2016 experience, preliminary CY 2017 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2018.

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

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**	
RATE APPLICATION OF	*	**SERVICES COST REVIEW**	
MEDSTAR HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2016**
	*	**FOLIO:**	**2168**
COLUMBIA, MARYLAND	*	**PROCEEDING:**	**2358A**

Draft Recommendation

October 19, 2016

This is a draft recommendation. Any comments shall be submitted by COB on October 31, 2016 to Steve Ports at steve.ports@maryland.gov.

I. Introduction

On October 10, 2016, MedStar Health filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of the MedStar Hospitals ("the Hospitals"). MedStar Health seeks renewal for the continued participation of MedStar Family Choice ("MFC") in the Medicaid Health Choice Program. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2310A for the period from January 1, 2016 through December 31, 2016. The Hospitals are requesting to renew this contract for one year beginning January 1, 2017.

II. Background

Under the Medicaid Health Choice Program, MedStar Family Choice, a Managed Care Organization ("MCO") sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services, as well as certain non-hospital services, while MFC receives a State-determined capitation payment. MFC pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. MFC provides services to 7.1% of the total number of MCO enrollees in Maryland, which represents a slight increase in its market share compared to CY 2015.

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

III. Staff Review

This contract has been operating under previous HSCRC approval (proceeding 2310A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2015, 2016, and 2017. Over this three year period, all actuals and projections are unfavorable. All provider based MCOs experienced unfavorable performance in CY 2015. While this time last year, MFC projected favorable performance for CY 2016, current projections are marginal to unfavorable.

IV. Recommendation

Based on this three year analysis, HSCRC has concerns about whether this arrangement could be deemed a loss contract from an MCO ARM perspective.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2017, however, staff is placing MFC on a watch list as described in item (2) below.

(2) Since sustained losses, such as those currently being experienced by MFC, may be construed as a loss contract necessitating termination of this arrangement, staff is recommending the following actions:

a. On the earlier of July 1, 2017or if/when Medicaid applies a mid-year adjustment, MFC shall report to HSCRCstaff on the impact that any such adjustment is expected to have on CY 2017 financial performance.

b. HSCRC staff shall be cognizant of the MCO's financial performance and

the potential for a loss contract in considering any requested adjustments to rates or global budgets of the associated hospitals during FYs 2017 and 2018.

c. In addition to the report provided in (2)(a), MFC shall report to Commission staff (on or before the September 2017 meeting of the Commission) on the actual CY 2016 experience and preliminary CY 2017 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2018.

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

IN RE: THE ALTERNATIVE	*	**BEFORE THE HEALTH**
RATE APPLICATION OF	*	**SERVICES COST REVIEW**
UNIVERSITY OF MARYLAND MEDICAL	*	**COMMISSION**
SYSTEM CORPORATION		
	*	**DOCKET: 2016**
	*	**FOLIO: 2171**
*		**PROCEEDING: 2361A**

Draft **Recommendation**

October 19, 2016

This is a draft recommendation. Any comments shall be submitted by COB on October 31, 2016 to Steve Ports at steve.ports@maryland.gov.

I. Introduction

On October 10, 2016, University of Maryland Health Partners, Inc. (UMHP), a Medicaid Managed Care Organization ("MCO"), on behalf of The University of Maryland Medical System Corporation ("the Hospitals"), filed an application for an Alternative Method of Rate Determination ("ARM") pursuant to COMAR 10.37.10.06. UMHP and the Hospitals seek approval for the MCO to continue to participate in the Medicaid Health Choice Program. UMHP is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2314A for the period from January 1, 2016 through December 31, 2016.The former MCO known as Riverside was purchased by University of Maryland Medical System Corporation in August 2015. The new MCO, UMHP, and Hospitals are requesting to implement this new contract for one year beginning January 1, 2017.

II. Background

Under the Medicaid Health Choice Program, UMHP, a MCO owned by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. UMHP pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. UMCP is a relatively small MCO providing services to 3.1% of the total number of MCO enrollees in the HealthChoice Program, which represents approximately the same market share as CY 2015.

UMHP supplied information on its most recent financial experience as well as its preliminary projected revenues and expenditures for the upcoming year based on the revised

Medicaid capitation rates.

III. Staff Review

This contract has been operating under previous HSCRC approval (proceeding 2314A). Staff reviewed the operating financial performance under the contract. Staff reviewed available final financial information and projections for CYs 2015, 2016, and 2017. In its third year of operation, Riverside/UMHP reported unfavorable financial performance for CY 2015 after favorable performance in CY 2014. Projections for CYs 2016 and 2017 are unfavorable.

IV. Recommendation

Since Riverside/UMHP is a new MCO, one would expect ramp up during its first few years. However, based on existing expectations, UMHP will have unfavorable performance for three years in a row.

Therefore:

(1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2017 however, staff is placing UMHP on a watch list as described in item (2) below.

(2) Since sustained losses, such as those currently being experienced by UMHP, may be construed as a loss contract necessitating termination of this arrangement, staff is recommending the following actions:

a. On the earlier of July 1, 2017 or if/when Medicaid applies a mid-year adjustment, UMHP shall report to HSCRC staff on the impact that any such adjustment is expected to have on CY 2017 financial performance.

b. HSCRC staff shall be cognizant of the MCO's financial performance and

the potential for a loss contract in considering any requested adjustments to rates or global budgets of the associated hospitals during FYs 2017 and 2018.

c. In addition to the report provided in (2)(a), UMHP shall report to Commission staff (on or before the September 2017 meeting of the Commission) on the actual CY 2016 experience, preliminary CY 2017 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2018.

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

Final Recommendation for Population Health Workforce Support for Disadvantaged Areas Program Awards

Baltimore Population Health Workforce Collaborative

10/19/2016

HSCRC
Health Services Cost Review Commission

Background

- In December 2015, the Commission authorized up $10 million in hospital rates for hospitals that commit to train and hire workers from geographic areas of high economic disparities and unemployment.
- These workers will fill new care coordination, population health, health information exchange, health information technology, consumer engagement, and related positions.
- The program will continue through June 30, 2018, on a hospital-specific basis assuming the hospital's ongoing compliance with the grant requirements. The grants could continue July 1, 2018, if, after evaluation, the Commission finds that the program is effective.

Review Process

- Commission hired a contractor to facilitate the review process, as well as the evaluation process.
- Review Committee comprised of DHMH, HSCRC, and Subject-Matter Experts
- The review committee received three applications by the submission date of June 30, 2016
- Commission required a 50% match of the amount requested to be included in rates.

Preference

- The Review Committee gave preference to those proposals that included the following features:
  - The likelihood that the proposed programs would be successful in reducing avoidable utilization and improving population health
  - The operational readiness and sustainable staffing detail of the proposal
  - The overall feasibility of the proposal to be successful
- The Commission approved the Garrett Regional Hospital proposal during the September Commission Meeting
- The Baltimore Collaborative revised their original proposal to:
  - increase the number of jobs hired
  - reduce the ratio of trained to hired
  - Requesting approval of this as Phase I with opportunity to propose Phase II

Revised Baltimore Population Health Workforce Collaborative

- A consortium of four major health systems that includes nine hospitals proposes to train and hire individuals from high poverty communities in the Baltimore Metropolitan area to be community healthcare workers (CHWs), peer outreach specialists (PRSs), and certified nursing /geriatric nursing assistants (CNAs/GNAs).
- They propose to partner with the Baltimore Alliance for Careers in Healthcare (BACH), which will coordinate the recruitment and training of individuals from the community.
- They will also target hospital employees from "high poverty communities" to train and promote them to positions with a "career ladder."
- In the revised proposal they will screen, select, and train 444 individuals in essential skills over three years. Of these individuals, 263 will be trained as CHWs, PRSs, or CNAs/GNAs.
- The applicant projected that of those technically trained 208 will be hired by the hospitals.

Recommendations

Applicant	Revised Award Request	Rate Award Amount	Hospital(s) in Proposal
BPHWC Phase I	$6,675,666	$6,675,666	Johns Hopkins Hospital Johns Hopkins – Bayview LifeBridge Health Sinai Hospital MedStar Franklin Square Medical Center MedStar Harbor Hospital MedStar Good Samaritan Hospital MedStar Union Memorial Hospital University of Maryland Medical Center University of Maryland – Midtown Campus
Sinai Hospital (Safe Streets)	N/A	$200,000	LifeBridge Health Sinai Hospital
Total		$6,875,666	

Conditions

- In Phase I, provide $6,675,666 to be awarded and phased in over three years
- Require a match of at least $3,337,833
- With the resurgence of violence in Baltimore City, HSCRC staff recommends that $300,000 be added to the Sinai portion of the proposal to expand the Safe Streets Program by one additional "pod." Sinai Hospital shall contribute $100,000 of the $300,000. Individuals hired to support this program shall be from disadvantaged areas as defined in the RFP
- Authorize Commission staff to review and approve a second phase of funding provided that BPHWC:
  - Meets the letter and spirit of the RFP
  - The total amount provided in rates to all hospitals (including the amount approved for Garrett Regional Hospital) does not exceed $10 million when fully phased in by FY 2019

Reporting and Evaluation

- Hospitals receiving funding under this program shall report to the Commission periodically, including annual reports beginning in the spring of 2017.
- The contractor shall evaluate the effectiveness of the program prior to July 1, 2018, and Staff shall make a recommendation to the Commission on whether the program should be continued in general, or for individual hospitals.

Final Recommendation for the Baltimore Population Health Workforce Collaborative Award under the Population Health Workforce Support for Disadvantaged Areas Program (PWSDA)

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

This final recommendation was approved by the Commission on October 19, 2016.

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OVERVIEW

The Maryland Department of Health and Mental Hygiene (Department or DHMH) and the Maryland Health Services Cost Review Commission (HSCRC or Commission) are recommending that the revised Baltimore Population Health Workforce Collaborative (BPHWC) proposal for a competitive Population Health Workforce Support for Disadvantaged Areas Program (PWSDA) grant be funded, beginning in fiscal year (FY) 2017. This recommendation follows the Commission's decision in December 2015, which authorized up to $10 million in hospital rates for hospitals that commit to train and hire workers from geographic areas of high economic disparities and unemployment. These workers will fill new care coordination, population health, health information exchange, health information technology, consumer engagement, and related positions. The ultimate goals of the program are to create community-based jobs that pay reasonable wages, contribute to improving population health in Maryland, and further the goals of the All-Payer Model.

The PWSDA program will continue through June 30, 2018, on a hospital-specific basis, assuming the hospital's ongoing compliance with the grant requirements. The grants could be renewed as of July 1, 2018, for an additional period, should the Commission find that the program is effective.

BACKGROUND

The Commission received three proposals for award funding. Commission staff established an independent committee to review the grant proposals and make recommendations to the Commission for funding. The PWSDA Implementation Award Review Committee (Review Committee) included representatives from the Department, the Commission, and other subject matter experts, including individuals with expertise in such areas as population health, health disparities, workforce development and adult learning, health education, healthcare career advancement, and workplace and employee wellbeing.

Following a comprehensive initial review, two of the three applicants were invited to provide clarifying information related to their proposals. The full proposals of the two applicants that were considered for approval (Garrett Regional Memorial Hospital and Baltimore Population Health Work Force Collaborative) may be found on the Commission's website at http://www.hscrc.maryland.gov/rfp-pwsda.cfm. The Garrett Regional Memorial Hospital proposal was approved by the Commission on September 14, 2016.

Following additional consideration, the Review Committee is pleased to present a recommendation to the Commission to fund the revised BPHWC. The Review Committee is strongly encouraged that this proposal will leverage the unique position that hospitals hold as economic pillars of their communities and create strong partnerships with community-based providers to respond to ongoing socioeconomic and health disparities in Baltimore. After deliberations by the Review Committee and Commission staff, we recommend that the Commission approve a first round of rate support to the BPHWC for a total of $6,875,666 across FYs 2017 through 2019.

COMPETITIVE POPULATION HEALTH WORKFORCE SUPPORT FOR DISADVANTAGED AREAS PROGRAM REQUEST FOR PROPOSALS

In order to improve population health and address disparities in the community, the Department, in collaboration with the HSCRC, released a request for proposals (RFP) for funding to implement the PWSDA on May 1, 2016. HSCRC received three applications by the extended due date of June 30, 2016.

The RFP invited proposals to support job opportunities for individuals who reside in neighborhoods with a high area deprivation index (ADI), and thus enable low-income urban, suburban, and rural communities to improve their socioeconomic status while working to improve population health. The overall objective is to address the social determinants of health and assist hospitals in bolstering population health and meeting the goals of the All-Payer Model.

The RFP limits the award total to $10 million in hospital rates over a three-year period, with the condition that hospitals provide matching funds of at least 50 percent of the amount included in their rates. The applicants were required to explain how they will use these rate increases to support the training and hiring of individuals consistent with the program.

Funding will be allocated through HSCRC-approved rate increases for hospitals that train and/or hire individuals from deprived areas, with the expectation of reducing potentially avoidable utilization for Medicare and promoting population health in Maryland. Awardees will be required to report on the status of their ongoing implementation activities within six months of the initial award and annually thereafter.

THE REVIEW COMMITTEE AND EVALUATION CRITERIA

The review committee gave preference to those models that included the following characteristics/features:

- Specific target population that could be trained and recruited to bolster population health and help reduce hospital utilization
- Strong collaboration with community organizations that will facilitate recruitment of potential trainees who live in disadvantaged communities
- Efficient training to provide to selected individuals who will be employed in health-related positions, (e.g., community healthcare workers, peer recovery specialists, case managers, patient care workers, transport facilitators, etc.)
- Defined settings where trained workers can deliver the intended services to patients and other community members and contribute to promoting the health of the Maryland population
- Consistency with the goals of the All-Payer Model
- Focus on patient-centered care
- Valid implementation plan

- Reasonable budget

The review committee established evaluation and weighting criteria in each of the following categories:

1. Needs assessment (the disadvantaged community and the target workforce) -10 points
2. Work plan (partnership(s) with community organization(s), type of training, qualifications of the trainees, implementation, and employment retention) - 30 points
3. Evaluation (tracking and reporting; strategy to evaluate process and outcomes) -10 points
4. Sustainability, impact, and replicability by others -15 points
5. Resources (community resources, trainers, and organizations) -10 points
6. Support requested (budget and its justification) – 25 points

The review committee gave preference to those proposals that included the following characteristics/features:

- The likelihood that the proposed programs would be successful in reducing avoidable utilization and improving population health
- The operational readiness and sustainable staffing detail of the proposal
- The overall feasibility of the proposal to be successful

RECOMMENDATIONS

Recommended Awardee

The BPHWC initially proposed a plan requesting a cumulative amount of $9.8 million through rates ($14.8 in total) to provide essential skills training to 578 individuals, provide technical skills training to 238 individuals, and sustainably employ 120 full-time and 15 part-time individuals from disadvantaged areas. The Review Committee and staff asked BPHWC to revise its request to include incremental costs (not cumulative costs) based on reasonable ratios of individuals trained and employed, as well as sustainably employing a greater number of individuals from disadvantaged areas.

After meeting with partners and other stakeholders, BPHWC submitted a revised budget and requested that funding be provided in two phases. This recommendation represents the first phase of the requested rate funding. Any request for the second phase of funding would need to be submitted to staff for review. The revised proposal for the first phase would provide essential skills training to 444 individuals, provide technical skills training to 263 individuals, and sustainably employ 208 individuals by the third year of the project.

Staff recommends the following for Commission approval of the BPHWC proposal:

- Award $6,675,666, to be phased in over three years based on proposed expenses (approximately $1.97 million in FY 2017, an additional $4.23 million in FY 2018, and an additional $470,047 in FY 2019).
- Require the participating hospitals to contribute 50 percent of the amount provided in rates (approximately $3,337,833).
- With the resurgence of violence in Baltimore City, add $300,000 to the Sinai Hospital portion of the proposal to expand the Safe Streets Program by one additional "pod." Sinai Hospital shall contribute $100,000 of the $300,000. Individuals hired to support this program shall be from disadvantaged areas as defined in the RFP.
- Authorize Commission staff to review and approve a second phase of funding provided that BPHWC:
    - Meets the letter and spirit of the RFP
    - The total amount provided in rates to all hospitals (including the amount approved for Garrett Regional Hospital) does not exceed $10 million when fully phased in by FY 2019

Table 1 below lists the recommended award amounts from rates and the hospitals affected. A summary of the recommended proposal may be found in the Appendix.

Table 1. Recommended Awardees

Applicant	Revised Award Request	Rate Award Amount	Hospital(s) in Proposal
BPHWC) Phase I	$6,675,666	$6,675,666	Johns Hopkins Hospital Johns Hopkins – Bayview LifeBridge Health Sinai Hospital MedStar Franklin Square Medical Center MedStar Harbor Hospital MedStar Good Samaritan Hospital MedStar Union Memorial Hospital University of Maryland Medical Center University of Maryland – Midtown Campus
Sinai Hospital	N/A	$200,000	LifeBridge Health Sinai Hospital
Total		**$6,875,666**	

REPORTING AND EVALUATION

The December 2015 approved Commission recommendations required that:

- Hospitals receiving funding under this program shall report to the Commission by May 1, 2017, and each year thereafter on:
    - The number of workers employed under the program
    - How many of those workers have been retained
    - The types of jobs that have been established under the program
    - How many patients or potential patients have been assisted through these positions
    - An estimate of the impact that these positions have had in reducing potentially avoidable utilization or in meeting other objectives of the All-Payer Model
- Awardees report periodically to the Commission on their program, including an annual report beginning on May 1, 2017
- The Commission evaluate the effectiveness of the program prior to July 1, 2018, to determine if the program should be continued in general, or for individual hospitals
- The Commission utilize external resources in collecting and evaluating proposals, reporting on the results of implementing the program, and assisting in evaluating its effectiveness

Following Commission approval of the awards, staff will provide each awardee with a template for monitoring and reporting on the performance of the programs in meeting the goals of the All-Payer Model and consistency with the application proposal. The Commission reserves the right to terminate or rescind an award at any time for material lack of performance or for not meeting the letter or intent of an application. Pursuant to the Commission mandate, staff will review the program before June 30, 2018, on each hospital's compliance with program requirements and to determine whether the program overall is meeting the Commission's goals. Staff will propose recommendations to the Commission based on their findings.

APPENDIX I. BPHWC PROPOSAL SUMMARY

Johns Hopkins Hospital; Johns Hopkins – Bayview; LifeBridge Sinai; MedStar Franklin Square Medical Center; MedStar Harbor Hospital; MedStar Good Samaritan Hospital; MedStar Union Memorial Hospital; University of Maryland Medical Center; University of Maryland – Midtown Campus.

Applicant	Baltimore Population Health Workforce Collaborative (BPHWC)
Date of Submission	5/27/2016 original submission; 10/04/2016 revised submission
Health System Affiliations	Johns Hopkins MedStar Lifebridge University of Maryland
Total Rate Request	$6,675,666

Summary of the Proposal
A consortium of four major health systems that includes nine hospitals proposes to train and hire individuals from high poverty communities in the Baltimore Metropolitan area to be community healthcare workers (CHWs), peer outreach specialists (PRSs), and certified nursing /geriatric nursing assistants (CNAs/GNAs). They propose to partner with the Baltimore Alliance for Careers in Healthcare (BACH), which will coordinate the recruitment and training of individuals from the community. BACH will rely on several community organizations to select, screen, and provide essential skills training to the potential recipients of the PWSDA program. They will also target hospital employees from "high poverty communities" to train and promote them to positions with a "career ladder." They propose to screen, select, and train 444 individuals in essential skills over three years. Of these individuals, 263 will be trained as CHWs, PRSs, or CNAs/GNAs. For the first two positions, individuals will complete 160 and 50 hours, respectively, of occupational skills training before being recruited. For the CNA position, training and certification will take place at the Baltimore County Community College. The applicant projected that the hospitals will hire 208 individuals by the third year of the program.

Work Plan for the First Year	
Month 1	1. Execute agreements with BACH and its training programs. 2. Establish BPHWC steering committee, comprised of health system representatives. 3. Ongoing evaluating, learning, and making adjustments; adding new community partners when indicated.
Month 2	1. Begin essential skills training. 2. Provide training on data collection to training partners. 3. Establish and post new CHW, PRS and CNA job descriptions.
Month 3	1. Begin CHW, PRS, and CNA training sessions.
Months 4 and 5	1. Move qualified trainees into employment. 2. Connect participants with career coaches. 3. Develop individual workforce development plans for new employees.

MedStar Health

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October 12, 2016

Steve Ports
Deputy Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Deputy Director Ports:

On behalf of the Baltimore Population Health Workforce Collaborative I am writing to provide additional information regarding the proposed plan. As you know from the revised budget submitted last week, we recalculated the budget based on incremental costs rather than cumulative costs, assumed a more reasonable ratio of individuals trained and employed as well as sustainably employing a greater number of individuals from disadvantaged areas.

The changes resulted in a budget for this proposal totaling $6,675,000 in hospital rates with the participating hospitals contributing an additional $3,337,833. This does not include the $300,000 ($200,000 in rates and $100,000 from Sinai) for the Safe Streets Program.

Given the revised budget and the remaining funds available from the $10 million the Commission has approved, we are planning to submit a second phase of the collaborative to train and hire additional individuals from the disadvantaged areas. We are currently working on identifying the jobs we collectively need to advance our goals for improving the health of our communities.

Thank you for your support and assistance in making the Baltimore Population Health Workforce Collaborative a success.

Sincerely,

Pegeen A. Townsend
Vice President
Government Affairs
MedStar Health

1199SEIU
United Healthcare Workers East

October 7, 2016

Mr. Nelson J. Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Ave
Baltimore, MD 21215

Dear Chairman Sabatini, Commissioners and Staff of the HSCRC,

1199SEIU supports the final proposal submission from the Baltimore Population Health Workforce Collaborative (BPHWC).

After a productive meeting with a number of the stakeholders of the Baltimore Population Health Workforce Collaborative, and discussing the proposal in greater detail, we believe that the proposal will ultimately benefit individuals who live in economically disadvantaged communities. Although we believe that the hospital systems included in the Collaborative should be obligated to hire more individuals from the community than the 208 workers proposed, we are hopeful that the program can nevertheless effectuate positive change. We believe that the community organizations involved will strive to ensure that as many individuals as possible have a pathway to the kind of employment that will positively impact both their own individual lives and the broader health of their communities.

Sincerely,

Lisa M. Brown

Executive Vice-President
1199SEIU United Healthcare Workers East
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QBR Program FY 2019
Draft Recommendation

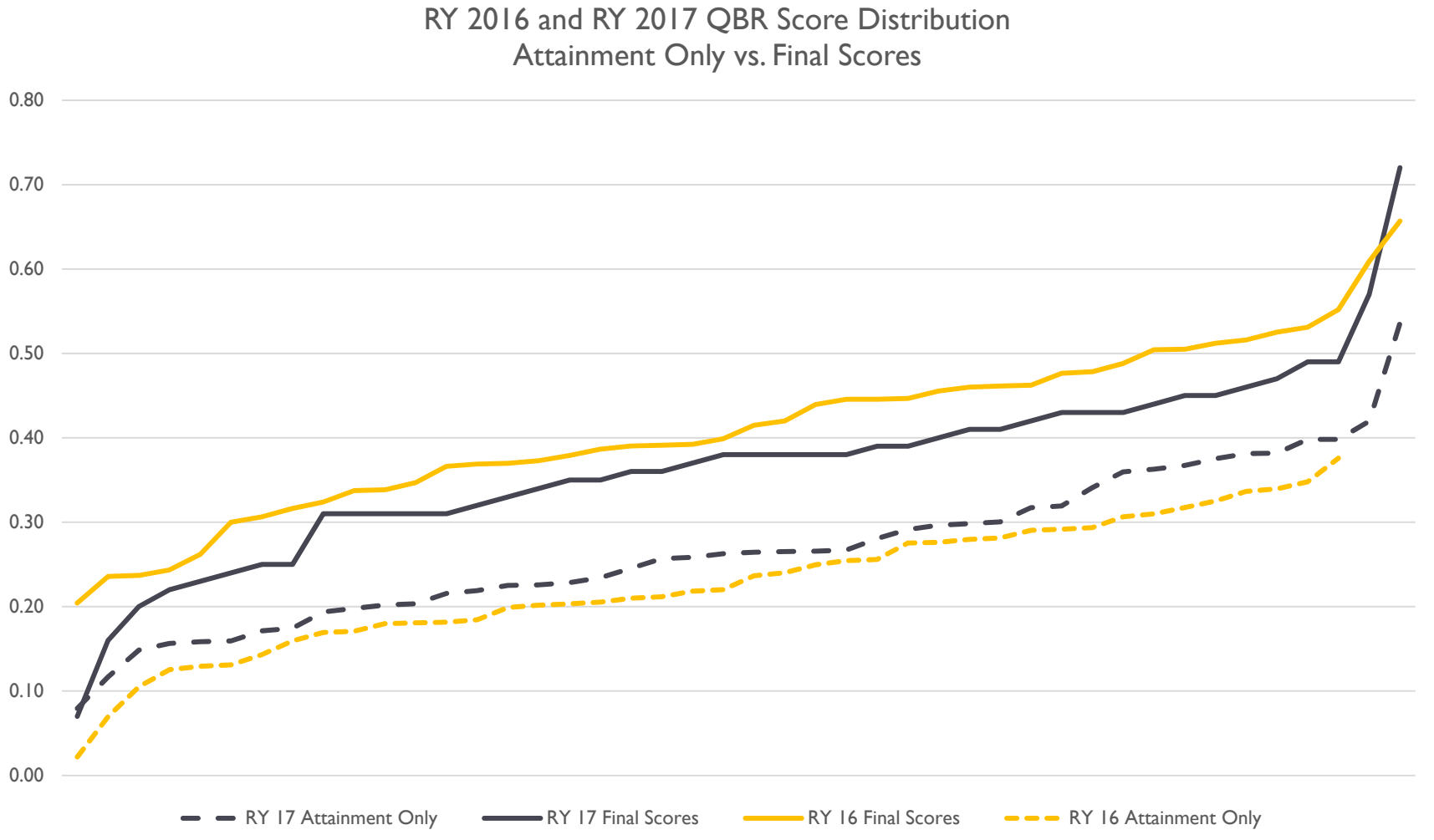
10/19/16 Commission Meeting

HSCRC
Health Services Cost Review Commission

RY 2017 QBR Program: Statewide Performance

- **HCAHPS (weighted 45%)-**
  - Scores lowest for this domain
  - Statewide performance lags behind the nation for both base and performance periods, and gap widened slightly (now at 6.5%)
- **Safety (weighted 35%)-**
  - Scores second lowest for this domain
  - Statewide performance better relative to the national average of 1 for 4 of 5 CDC infection measures
- **Mortality (weighted 5%)-**
  - Statewide performance on all-cause inpatient QBR measure improved
  - Statewide performance on three condition-specific 30-day VBP measures slightly better than the nation and improved from the base year
- **Clinical Care Process (weighted 15%)-**
  - For VBP, weighting for these measures=5% of total score, domain retired for RY 2018
  - Performance on PC 01 measure (moved to Safety domain for RY 2018) declined and worse than the nation, (NOTE: need to validate measure results)
  - Statewide scores highest for this domain

QBR RY 2016 and Ry 2017 Score Comparison



HSCRC
Health Services Cost Review Commission

QBR Draft Recommendations

- Adjust retrospectively the RY 2017 and RY 2018 QBR preset scale for determining rewards and penalties such that the scale takes into account attainment and improvement trends.
- For RY 2019, use the preset scale based on RY 2017 final scores.
- Continue to use the domain weights set for RY 2018

	Clinical Care	Patient Community Engagement	Safety	Efficiency
CMS VBP (proposed)	25% -3 measures: condition-specific mortality	25% -HCAHPS + CTM	25% -CDC infection, PSI, PC01	25% spending per bene
QBR (Draft)	15% - all cause inpatient mortality	50% HCAHPS + CTM	35% - CDC infection, PSI (Suspended?), PC01	N/A

- Continue to set the maximum penalty at two percent and the maximum reward at one percent of approved hospital inpatient revenue.

DRAFT Recommendations for Updating the Quality-Based Reimbursement Program for Rate Year 2019

October 19, 2016

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 Quality-Based Reimbursement (QBR) Program for FY 2019 for consideration at the October 19, 2016 Commission meeting. Please submit comments on the draft to the Commission by Monday, October 31, 2016 via hard copy mail or email to Dianne.feeney@maryland.gov.

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LIST OF ABBREVIATIONS

ACA	Affordable Care Act
CMS	Centers for Medicare & Medicaid Services
DRG	Diagnosis-related group
FY	Fiscal year
FFY	Federal fiscal year
HSCRC	Health Services Cost Review Commission
QBR	Quality-based reimbursement
RY	Maryland HSCRC Rate Year
VBP	Value-based purchasing

INTRODUCTION

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) quality-based measurement and payment initiatives are important policy tools for providing strong incentives for hospitals to improve their quality performance over time. These initiatives hold amounts of hospital revenue at risk directly related to specified performance benchmarks. Maryland's Quality-Based Reimbursement (QBR) program employs measures that are similar to those in the federal Medicare Value-Based Purchasing (VBP) program. Because of its long-standing Medicare waiver for its all-payer hospital rate-setting system, the Centers for Medicare & Medicaid Services (CMS) has given Maryland various special considerations, including exemption from the federal Medicare VBP program. In its place, the HSCRC implements the Maryland-specific QBR program, which is discussed in further detail in the background section of this report.

HSCRC implemented the first hospital payment adjustments for the QBR program in July 2009. The QBR program currently measures hospital performance in the following areas: clinical care (process and outcomes), patient safety, and patient experience of care. The purpose of this report is to make recommendations for the QBR program for fiscal year (FY) 2019. These recommendations include: updating the measurement domains consistent with the direction of the CMS VBP Program, updating the scaling of rewards and penalties retrospectively for RYs 2017 and 2018 and prospectively for RY 2019, and holding steady the amount of total hospital revenue at risk for the QBR Program.

BACKGROUND

Federal VBP Program

The Affordable Care Act (ACA) established the hospital VBP program,[1] which requires CMS to reward hospitals with incentive payments for the quality of care provided to Medicare beneficiaries. The program assesses hospital performance on a set of measures in the following domains: the clinical process of care, patient experience of care, efficiency (i.e., Medicare spending per beneficiary), and safety. The incentive payments are funded by reducing the base operating diagnosis-related group (DRG) amounts that determine the Medicare payment for each hospital inpatient discharge.[2] The ACA set the reduction at 1 percent in federal fiscal year (FFY) 2013 and required that it increase incrementally to 2 percent by FFY 2017.[3]

CMS implemented the VBP Program with hospital payment adjustments beginning in October 2013. For the FFY 2018 (October 1, 2017 to September 30, 2018) VBP Program, CMS measures

[1] For more information on the VBP program, see https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/hospital-value-based-purchasing/index.html?redirect=/Hospital-Value-Based-Purchasing/
[2] 42 USC § 1395ww(o)(7).
[3] 42 USC § 1395ww(o)(7)(C).

will include the following four domains and their relative weights in determining hospital final performance scores, with two percent of Medicare hospital payments at risk:

- Clinical care: weighted 25 percent
- Patient experience of care: weighted 25 percent
- Efficiency/Medicare spending per beneficiary: weighted 25 percent
- Safety: weighted 25 percent

HSCRC staff also notes that, for the VBP program for FFY 2018, CMS measure changes included:

- ***Clinical Care***- removed AMI-7a- Fibrinolytic agent received and the IMM-2 Influenza Immunization process measures
- ***Safety***- Added the PC-01 Early Elective delivery induction or cesarean section
- ***Patient experience of care***- added the CTM-3 Care Transition Measure

For FFY 2019 VBP program, CMS has changed the Patient Experience of Care domain name to Patient and Community Engagement, and although not final, proposes no change to the domain weights from those used for FFY 2018.

Maryland's QBR Program

Maryland's QBR program is similar to the federal VBP program and assesses hospital performance on a similar set of domains: clinical care (process and outcomes), patient safety, and patient experience of care. The HSCRC sets aside a percentage of hospital inpatient revenue to be held at risk for the QBR program and allocates a percentage of this amount across the three domains in a process that is referred to as scaling.[4] After each hospital's score is calculated, rewards (referred to as positive scaled amounts) or penalties (referred to as negative scaled amounts) are then applied to each hospital's update factor for the rate year. The rewards or penalties are applied on a one-time basis and are not considered permanent revenue.

For the FY 2018 QBR program, the HSCRC will weight the clinical care measure at 15 percent of the final score, the safety measures at 35 percent, and the patient experience of care measures at 50 percent. The HSCRC will also scale a maximum penalty of two percent of approved base hospital inpatient revenue. Figure 1 compares the QBR weighting for each domain with the CMS VBP weighting.

[4] Scaling refers to the differential allocation of a pre-determined portion of base-regulated hospital inpatient revenue based on assessment of the quality of hospital performance.

Figure1. Domain Weights for the CMS Hospital VBP and Maryland QBR Programs for FY 2018

	Clinical Care	Patient Experience	Safety	Efficiency
CMS VBP	25% (3 measures: condition-specific mortality)	25% (9 measures: HCAHPS + CTM)	25% (8 measures: infection, PSI, PC01)	25% (spending per beneficiary measure)
Maryland QBR	15% (1 measure: all cause inpatient mortality)	50% (9 measures: HCAHPS + CTM)	35% (8 measures: infection, PSI, PC01)	N/A

HSCRC staff worked with stakeholders over the last several years to align the QBR measures, thresholds, benchmark values, time lag periods, and amount of revenue at risk with those used by the CMS VBP program where feasible,[5] allowing the HSCRC to use data submitted directly to CMS. Maryland has not yet implemented an efficiency measure equivalent to the CMS VBP approach, but we have begun development of a similar measure. We do apply a potentially avoidable utilization savings adjustment to hospital rates based on their costs related to potentially avoidable admissions as measured by the Agency for Healthcare Research and Quality Prevention Quality Indicators (PQIs), and to 30-day readmissions (including observation cases that are greater than 23 hours). HSCRC staff will continue to work with key stakeholders to complete development of an efficiency measure that incorporates population-based cost outcomes.

VBP Exemption Provisions

Under Maryland's previous Medicare waiver, VBP exemptions were requested and granted for FYs 2013 through 2015. The CMS FY 2015 Inpatient Prospective Payment rule stated that, although exemption from the hospital VBP program no longer applies, Maryland hospitals will not be participating in the VBP program because §1886(o) of the ACA[6] and its implementing regulations are waived under Maryland's New All-Payer Model, subject to the terms of the Model agreement as excerpted below:

> **"4. Medicare Payment Waivers.** Under the Model, CMS will waive the requirements of the following provisions of the Act as applied solely to Regulated Maryland Hospitals:
>
> **e. Medicare Hospital Value Based Purchasing.** Section 1886(o) of the Act, and implementing regulations at 42 CFR 412.160 - 412.167, only insofar as the State

[5] HSCRC has used data for some of the QBR measures (e.g., CMS core measures, CDC NHSN CLABSI, CAUTI) submitted to the Maryland Health Care Commission (MHCC) and applied state-based benchmarks and thresholds for these measures to calculate hospitals' QBR scores up to the period used for Rate Year 2017.
[6] Codified at 42 USC § 1395ww(o).

submits an annual report to the Secretary that provides satisfactory evidence that a similar program in the State for Regulated Maryland Hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under 1886(o) of the Act…."

Under the New All-Payer Model, HSCRC staff submitted exemption requests for FYs 2016 and 2017 and received approvals from CMS on August 27, 2015, and April 22, 2016 (see Appendix I).

ASSESSMENT

Performance Results on QBR and VBP Measures Used for FY 2017

Consistent with work done in past years to support identifying important areas of focus in updating the QBR program policy, staff has analyzed Maryland hospital performance to date on the QBR and VBP available measures.

Staff analyzed Maryland statewide performance trends over time and compared to the nation, using the most current data available. The results are summarized in Figures 2 and 3 below. The detailed statistics are provided in Appendix II.

Figure 2 provides final RY 2017 QBR hospital scores by domain. Reflecting the statewide performance on Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) patient experience domain, scores are lowest for this domain with an average score of 0.24 and maximum score of 0.54. The domain with the next lowest scores is safety which is also the second highest weighted domain.

Figure 2. Ry 2017 QBR Scores Distribution by Domain

Domains	HCAHPS Score	Clinical/ Process Score	Mortality Score	Safety Score	QBR Score
Weights	**45%**	**15%**	**5%**	**35%**	**100%**
Minimum Score	0.03	0.00	0.00	0.00	0.07
25th percentile	0.16	0.40	0.33	0.25	0.31
Median	0.23	0.60	0.60	0.39	0.38
Average	0.24	0.56	0.60	0.40	0.37
75th Percentile	0.30	0.80	0.88	0.54	0.43
Maximum Score	0.54	1.00	1.00	1.00	0.72
Coefficient of Variation	46%	59%	48%	54%	30%

In general, as illustrated in Figure 3, Maryland continued to have worse rates than the nation in patient experience measures and better rates in mortality measures; infection rates have improved, with exception of one infection category.

Figure 3. QBR Measures Dashboard

Worse than the National Rate	Worsened	Worse Compared to Base
Better than the National Rate	Improved	Better Compared to Base
National Average	No Change	No Change
		Not available

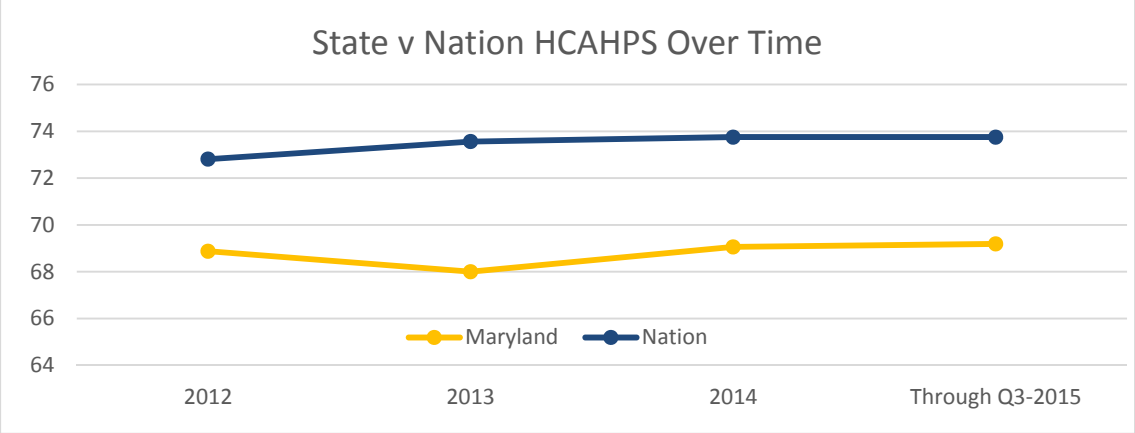
Measure	Most Recent Rate	Improvement from the Base Year	Difference from the National Rate
Responsiveness	59%	-1%	-9%
Overall Rating	65%	0%	-7%
Clean/Quiet	62%	0%	-7%
Explained Medications	60%	0%	-5%
Nurse Communication	76%	0%	-4%
Pain Management	68%	1%	-3%
Doctor Communication	79%	1%	-3%
Discharge Info	86%	0%	-1%
NEW MEASURE			
Three-Part Care Transitions Measure	48%	0	-4%
Mortality Measures			
30-day AMI	14.06%	-0.44%	-0.14%
30-day Heart Failure	10.86%	-0.04%	-0.74%
30-day Pneumonia	10.64%	-0.21%	-0.86%
Safety Measures			
PC-01 Early Elective Delivery	5%	2%	2%
CLABSI	0.50	-5.12%	-0.50%
CAUTI	0.86	-48.04%	-0.14%
SSI - Colon	1.19	12.32%	0.19%
SSI - Abdominal Hysterectomy	0.92	-28.49%	-0.08%
MRSA	1.20	-10.71%	0.20%
C.diff.	1.15	-0.26%	0.15%

Patient Experience of Care Measures

Staff compared the most currently available base and performance periods' data for HCAHPS, i.e. Q4-2013 to Q3-204 and Q4-2014 to Q3-2015 (see Appendix II).

- For the eight measures in aggregate, Maryland statewide performance lags behind the nation for both periods and the gap slightly widened between Maryland and the nation across the two time periods with Maryland 6.19% lower than the nation for Q4-2013 to Q3-2014 and 6.49% lower for Q4-2014 to Q3-2015.
- The nation remained static on 5 measures and improved slightly on 3 measures across the two time periods while Maryland declined on 1 measure, improved slightly on 2 measures and remained static on 5 measures.
- On the three-part care transitions measure added to the HCAHPS survey and adopted for the FY 2018 VBP and QBR programs, Maryland performs significantly below the nation for the data periods Q4-2013 to Q3-2014 and Q4-2014 to Q3-2015, and performance for both Maryland and the nation remains static for the two time periods. .[7]
- Additional analysis comparing Maryland to the nation since 2012 illustrates that Maryland's performance declined in 2013 compared to 2012, and then improved slightly in 2014 and 2015, but the nation has had only modest improvement year over year from 2012 to 2015. (See Figure 4).

Figure 4. Maryland and National HCAHPS Scores over Time



[7] The Care-Transitions Measure is a composite of three questions related to patients' and caregivers' understanding of necessary follow-up care post-discharge, detailed in questions 23-25 of the HCAHPS survey. For specifics on the measure, including question language, please see: https://mhdo.maine.gov/_pdf/CTM%20Microspecifications%20Manual_%20Nov%202013_final.pdf.

Mortality Measures

On the three CMS condition specific 30 day AMI, CHF and pneumonia mortality measures (See Appendix II) used in the VBP program, for the data periods Q3-2010 to Q2-2013 and Q3-2011 to Q2-2014:

- Maryland performed better than the nation with lower mortality rates on all three measures for both time periods.
- Both Maryland and the nation show improvement over the two time periods.
- The gap between Maryland and the nation is narrowing slightly for all three measures across the two time periods.

CMS and HSCRC are evaluating the accuracy of risk adjustment for the CMS mortality measures due to concerns about inaccurate ICD codes in the Medicare claims for Maryland hospitals.

For the Maryland inpatient, all-payer, all-cause mortality measure used for the QBR program, Maryland's mortality rate declined for CY 2015 compared to CY 2014, as illustrated in the table in Appendix II.

Safety Measures

For the data periods Q4-2013 to Q3-2014 and Q4-2014 to Q3-2015:

- For the early elective induction or Cesarean section delivery measure (PC-01), staff notes Maryland performed better than the nation in the Q4-2013 to Q3-2014 period, but worse with a sharp increase in the Q4-2014 to Q3-2015 period. By contrast, the nation improved from the earlier to the latter period. Staff is investigating this increase including any potential data reliability concerns as one hospital with a sharp increase in the early elective deliveries appears to drive the sharp increase (See Appendix II).
- For Centers for Disease Control National Health Safety Network (CDC NHSN) Standardized Infection Ratio (SIR) measures compared to an earlier national base reference period where the SIR was established at the value of 1 (See Appendix II), Maryland statewide performance is:
    - For central line-associated blood stream infections (CLABSI), better than the national baseline for both the earlier and latter periods, and also slightly improving over time.
    - For catheter-associated urinary tract infections (CAUTI), worse in the earlier period and better in the latter period than the national baseline, and improving significantly over time.
    - For surgical site infections (SSI) Hysterectomy, worse in the earlier period and better in the latter period than the national baseline, and improving significantly over time.
    - For SSI Colon, worse than the national baseline in the earlier and latter periods and worsening over time.
    - For Methicillin-resistant Staphylococcus aureus (MRSA), worse than the national baseline in the earlier and latter periods and improving over time.

- For C. difficile (C.diff.), worse than the national baseline in the earlier and latter periods and improving slightly over time.

In summary, Maryland's infection rates were better than the nation only in CLABSI, with the worse performance in CAUTI, which was 65.90% higher than the national rates in the earlier base period. Since the values posted to Hospital Compare are relative to the national average of 1, we can only compare Maryland's rate to the national benchmarks rather than calculating the improvement rates. Maryland's rate is now below the national baseline rate in CAUTI, and SSI-Abdominal Hysterectomy rates. Maryland's standing has improved for the rest of the infections except for SSI – Colon, which jumped from 5.50% higher than the national average to 18.50 % higher.

Additional Measure Results

Staff also analyzed Maryland performance relative to the nation, and over time to the extent the data were available, on the Total Hip and Knee Arthroplasty (THA/TKA) complication measure and on emergency department wait time measures.

For the data periods Q4-2013 to Q3-2014 and Q4-2014 to Q3-2015:

- For the newly published THA/TKA complication measure, performance results were only available for the latter time period. Hospital Compare reports that all Maryland hospitals perform "as expected" on this measure (with exception of one hospital that is better and one that is worse than expected) compared with the nation; staff supports adopting the measure for the FY 2019 QBR program, consistent with the VBP program.
- Staff notes that Maryland performs poorly on the ED wait time measures compared to the nation. In addition Maryland's performance is worsening over time as is the nation's. Therefore, staff strongly advocates "active" monitoring of the ED wait times measures with consideration as to the feasibility of adding these measures to the QBR program in future years (See Appendix II).

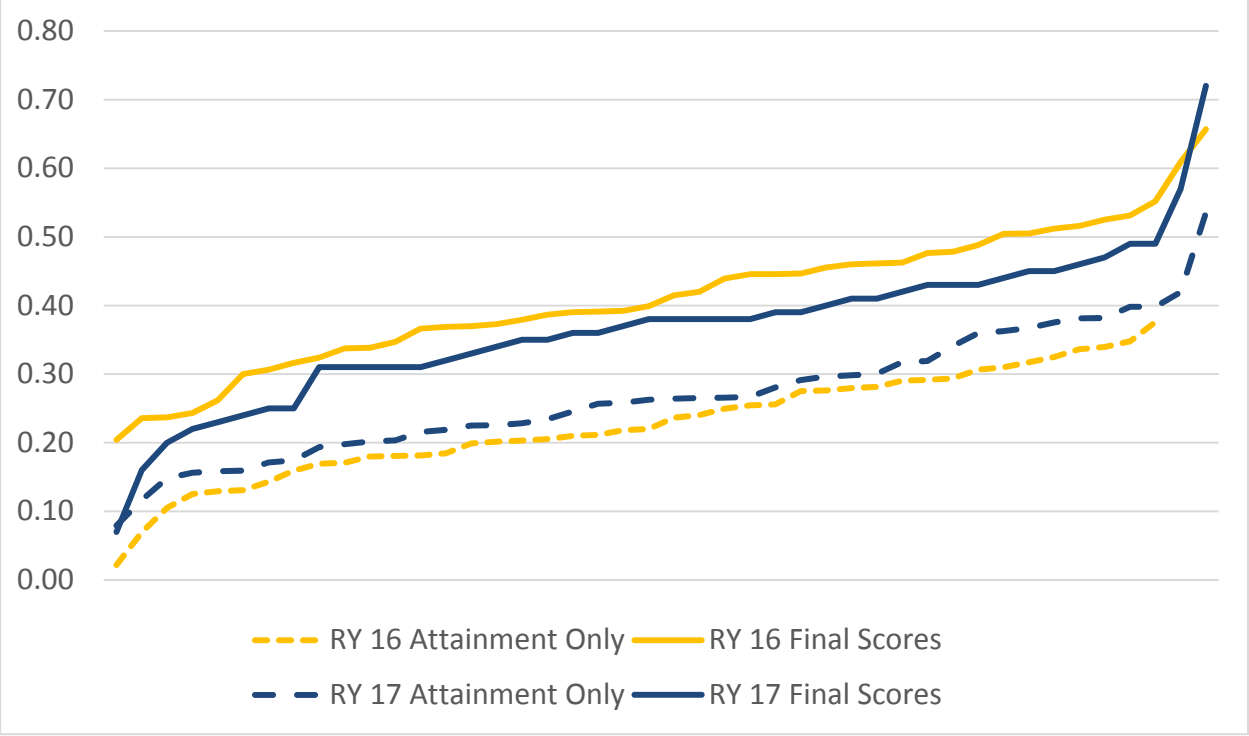
QBR RY 2017 Final Scores and Reward and Penalty Preset Scale

Similar to other quality-based programs, the QBR methodology for calculating rewards and penalties was fundamentally modified for FY 2017 such that the level of rewards or penalties are determined based on performance points achieved relative to a preset scale rather than a relative ranking of the hospitals after the performance period. This transition coincided with major changes in the measures used for QBR program which entailed removal of process measures (which had higher scores), increasing the weight of HCAHPS scores (which had lower scores), and tying the benchmarks to the national distribution. At the time, staff did not have enough data to thoroughly model the implications of these changes on the performance points and set the payment adjustment scale based on the base year performance results. Hospital pay for performance programs implemented nationally and in Maryland score hospitals both on attainment (level of rates compared to benchmarks) and on improvement (rate of change from the baseline). Figure 5 below shows the difference between the attainment only scores for RYs

2016 and 2017 versus the final scores for each year, illustrating a significant increase in the final scores when improvement is taken into account. Due to lack of data, staff was not able to model the final scale for RY 2017 and agreed to set the points for the attainment only scale given the major changes in the program described above.

Staff analyzed hospital performance scores relative to the QBR preset scale determined last year and notes that almost all hospitals receive a reward for RY 2017 despite relatively poor performance, as noted above. With the recommendation to make retrospective adjustments to the readmission policy, staff had noted the issue with the QBR scaling at the June Commission meeting, and has been working since then on understanding the implications. Expecting changes to the results, RY 2017 rate orders and global budgets were sent without QBR program adjustments. Based on the analysis of attainment vs improvement points, staff asserts that the RY 2017 preset scale was set too low because it was developed using base period data to calculate attainment only scores and, again, did not take into account improvement trends. The intention to use preset scale was to improve predictability of the payment adjustments, not to lower the scale. Therefore, the Commission staff proposes a retrospective adjustment to the QBR preset scale for RY 2017 and RY 2018 as part of the RY 2019 QBR draft policy. Appendix III provides the results based on current and proposed scaling adjustments. This change will result in 20 hospitals receiving penalties totaling $20.5 million, and 26 hospitals receiving rewards totaling $10.6 million rewards.

Figure 5. QBR RY 2016-RY 2017 Attainment Only and Final Scores



RECOMMENDATIONS

Staff commends the work of hospitals to continue to improve performance on the QBR program in light of the state's overall improvement trend, and in particular notes the state's sustained improvement trends in the Maryland inpatient, all cause, all payer mortality rate used for the QBR program as well as the CMS three condition-specific mortality measures used for the VBP program. Infection rates also improved in the state for four out of five measures. Staff also notes the continued improvement on the HCAHPS measures, as this measure constitutes 50% of hospitals' QBR scores, and at the same time recognizes the gap that remains between Maryland and national performance.

Based on the above staff observations and analysis, staff makes the following draft recommendations:

1. Adjust retrospectively the RY 2017 and RY 2018 QBR preset scale for determining rewards and penalties such that the scale takes into account attainment and improvement trends.

2. For RY 2019, use the preset scale based on RY 2017 final scores.

3. Continue to use the same domain weights: the clinical care measure at 15 percent of the final score, the safety measures at 35 percent, and the Patient and Community Engagement measures at 50 percent.

4. Continue to set the maximum penalty at two percent and the maximum reward at one percent of approved hospital inpatient revenue.

APPENDIX I. VBP EXEMPTION REQUEST APPROVALS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Administrator
Washington, D.C. 20201

August 27, 2015

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

Dear Ms. Kinzer:

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

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

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

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

Sincerely,

Patrick Conway, MD, MSc

Acting Principal Deputy Administrator, CMS

Chief Medical Officer, CMS

Deputy Administrator for Innovation and Quality, CMS

Director, Center for Medicare and Medicaid Innovation

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop WB-06-05
Baltimore, Maryland 21244-1850

Center for Medicare and Medicaid Innovation

April 22, 2016

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

Dear Ms. Kinzer:

Thank you for your letter, on behalf of the State of Maryland, requesting an exemption from the FY 2017 Hospital Value-Based Purchasing (VBP) Program. As you know, Section 4(e) of the Maryland All-Payer Model Agreement provides that CMS will waive the Hospital VBP Program requirements for Maryland hospitals, as set out in Section 1886(0) of the Social Security Act and implementing regulations at 42 CFR 412.160 412.167, provided that the State submits "an annual report to the Secretary that provides satisfactory evidence that a similar program in the State for Regulated Maryland Hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under 1886(0) of the Act."

The Centers for Medicare & Medicaid Services (CMS) has reviewed your exemption request and supporting documentation. We officially grant the State of Maryland's exemption request for its hospitals as authorized by Section 1886(o)(I)(C)(iv) of the Act based on the fact that the Maryland program achieved patient health outcomes and clinic process scores not significantly different from those measured in the Hospital VBP Program. CMS has also determined that the Maryland program meets the cost savings requirement for exemption from the Hospital VBP Program for FY 2017 because both programs reward high performers in a revenue-neutral manner.

Last year, when approving your request for an exemption from the Hospital VBP Program for FY 2016, we noted that your state's performance in the Patient Experience of Care domain using data from 2014 significantly lagged behind national medium performance levels, and we strongly encouraged you to take steps to improve performance in that domain. Maryland's performance continues to lag behind the nation in Patient Experience of Care. As indicated in your exemption request, you have assigned comparatively more weight to Hospital Consumer Assessment of Healthcare Providers and Systems performance in the Maryland program, and you are continuing to increase the weight even more in the coming years. We support these efforts to improve Patient Experience of Care and we are eager to assist you in helping hospitals improve in this domain in any way possible.

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

Sincerely,

Stephen Cha, MD, MHS
Director, State Innovations Group,
Center on Medicare and Medicaid Innovation,
Centers for Medicare and Medicaid Services

APPENDIX II. QBR MEASURES PERFORMANCE TRENDS

Figure 1. HCAHPS Analysis

	Base Period			Performance Period				
Measure	**Maryland (Q413-Q314)**	**National (Q413-Q314)**	**Percent difference MD-US**	**Maryland (Q414-Q315)**	**Change from Base**	**National (Q414-Q315)**	**Change from Base**	**Percent difference MD-US**
Responsiveness	60	68	-11.76%	59	-1	68	0	-13.24%
Overall Rating	65	71	-8.45%	65	0	72	1	-9.72%
Clean/Quiet	61.5	68	-9.56%	61.5	0	68	0	-9.56%
Explained Medications	60	65	-7.69%	60	0	65	0	-7.69%
Nurse Communication	76	79	-3.80%	76	0	80	1	-5.00%
Pain Management	67	71	-5.63%	68	1	71	0	-4.23%
Doctor Communication	78	82	-4.88%	79	1	82	0	-3.66%
Discharge Info	86	86	0.00%	86	0	87	1	-1.15%
8 ITEM aggregate TOTAL	**69.1875**	**73.75**	**-6.19%**	**69.31**	**0.13**	**74.1**	**0.38**	**-6.49%**
Three-Part Care Transitions Measure	48	52	-7.69%	48	0	52	0	-7.69%

Figure 2. CMS Condition-Specific Mortality Measures

	Base Period			Performance Period				
Mortality Measures	**Maryland (Q310-Q213)**	**National (Q310-Q213)**	**Percent difference MD-US**	**Maryland (Q311-Q214)**	**Change from Base**	**National (Q311-Q214)**	**Change from Base**	**Percent difference MD-US**
30-day AMI	14.50%	14.90%	-2.68%	14.06%	-0.44%	14.20%	-0.70%	-0.99%
30-day Heart Failure	10.90%	11.90%	-8.40%	10.86%	-0.04%	11.60%	-0.30%	-6.38%
30-day Pneumonia	10.85%	11.90%	-8.82%	10.64%	-0.21%	11.50%	-0.40%	-7.48%

Figure 3. Maryland All-Payer Inpatient Mortality Measure

Mortality Measures	**Maryland FY2014**	**Maryland CY2015**	**Change from Base**
MD Mortality Measure	2.87	2.15	-0.72

Figure 4. Safety Measures

Safety Measures	**Maryland (Q413-Q314)**	**National Baseline Used on Hospital Compare for Q413-Q314**	**Percent difference MD-US**	**Maryland (Q414-Q315)**	**National Baseline Used on Hospital Compare for Q414-Q315**	**Percent difference MD-US**
PC-01 Early Elective Delivery	3%	4%	-25.00%	5%[8]	3%	66.67%
CLABSI	0.527	1	-47.30%	0.500	1	-50.00%
CAUTI	1.659	1	65.90%	0.862	1	-13.80%
SSI - Colon	1.055	1	5.50%	1.185	1	18.50%
SSI - Abdominal Hysterectomy	1.281	1	28.10%	0.916	1	-8.40%
MRSA	1.344	1	34.40%	1.200	1	20.00%
C.diff.	1.150	1	15.00%	1.147	1	14.70%

[8] NOTE: The score of 5 is from the previous quarter (Q314-Q215). We are in the process of validating the data for the most recent quarter.

*Infection measures are expressed as standardized infection ratios (SIRs), adjusting for several risk factors that have been found to be significantly associated with differences in infection incidence. The SIR is calculated by dividing the number of observed infections by the number of expected infections, using infection rates from a standard population during a baseline time period. A SIR greater than 1.0 means that more HAIs were observed in a facility or state than predicted, and a SIR less than 1.0 means there were fewer HAIs observed than predicted. A score of 0, meaning no infections, is best.

Figure 5. Emergency Department Wait Times for Monitoring

Other Measures - Monitoring Status	Maryland (Q413-Q314)	National (Q413-Q314)	Percent difference MD-US	Maryland (Q414-Q315)	Change from Base	National (Q414-Q315)	Change from Base	Percent difference MD-US
ED1b - Arrive to admit	353	273	29.30%	364	11	280	7	30.00%
ED2b - Admit decision to admit	132	96	37.50%	139	7	99	3	40.40%
OP20 - Door to diagnostic eval	46	24	91.67%	48	2	23	-1	108.70%

APPENDIX III. RY 2017 QBR PERFORMANCE SCORES

		QBR Performance Scores				
Hospital ID	**Hospital Name**	**HCAHPS Score**	**Clinical/ Process Score**	**Clinical/ Mortality Score**	**Safety Score**	**QBR Score**
210001	MERITUS	0.17	1.00	0.30	0.53	**0.36**
210002	UNIVERSITY OF MARYLAND	0.25	0.80	0.80	0.33	**0.39**
210003	PRINCE GEORGE	0.03	0.70	0.10	0.50	**0.24**
210004	HOLY CROSS	0.09	0.80	0.30	0.30	**0.23**
210005	FREDERICK MEMORIAL	0.22	0.60	1.00	0.53	**0.46**
210006	HARFORD	0.30	0.80	0.40	0.33	**0.35**
210008	MERCY	0.49	0.00	0.20	0.45	**0.41**
210009	JOHNS HOPKINS	0.33	0.40	0.90	0.15	**0.36**
210010	DORCHESTER	0.24	0.80	0.90	.	**0.44**
210011	ST. AGNES	0.16	0.20	0.80	0.33	**0.32**
210012	SINAI	0.27	0.80	0.40	0.25	**0.31**
210013	BON SECOURS	0.15	0.00	0.00	0.00	**0.07**
210015	FRANKLIN SQUARE	0.13	0.40	0.60	0.40	**0.31**
210016	WASHINGTON ADVENTIST	0.23	0.80	0.70	0.00	**0.25**
210017	GARRETT COUNTY	0.27	0.60	0.70	.	**0.40**
210018	MONTGOMERY GENERAL	0.22	0.40	0.60	0.68	**0.45**
210019	PENINSULA REGIONAL	0.32	0.00	0.40	0.50	**0.38**
210022	SUBURBAN	0.37	0.00	0.50	0.65	**0.47**
210023	ANNE ARUNDEL	0.18	0.60	0.70	0.28	**0.31**
210024	UNION MEMORIAL	0.34	0.40	0.30	0.25	**0.31**
210027	WESTERN MARYLAND	0.32	1.00	0.80	0.08	**0.34**
210028	ST. MARY	0.51	1.00	0.60	1.00	**0.72**
210029	HOPKINS BAYVIEW MED CTR	0.25	0.80	0.50	0.43	**0.38**
210030	CHESTERTOWN	0.10	1.00	1.00	.	**0.38**
210032	UNION OF CECIL COUNT	0.29	0.40	0.40	0.47	**0.37**
210033	CARROLL COUNTY	0.21	0.80	0.60	0.58	**0.43**
210034	HARBOR	0.19	0.40	0.70	0.68	**0.45**
210035	CHARLES REGIONAL	0.22	0.00	0.50	0.70	**0.42**
210037	EASTON	0.24	0.80	0.50	0.25	**0.31**
210038	UMMC MIDTOWN	0.09	0.40	0.30	0.27	**0.20**
210039	CALVERT	0.25	0.40	1.00	.	**0.43**
210040	NORTHWEST	0.19	1.00	0.30	0.10	**0.22**
210043	BWMC	0.16	0.60	0.90	0.28	**0.33**
210044	G.B.M.C.	0.54	0.60	1.00	0.20	**0.49**
210048	HOWARD COUNTY	0.38	1.00	0.80	0.65	**0.57**
210049	UPPER CHESAPEAKE	0.12	0.80	1.00	0.38	**0.38**
210051	DOCTORS COMMUNITY	0.10	0.60	0.30	0.65	**0.35**
210055	LAUREL REGIONAL	0.16	0.00	0.20	.	**0.16**
210056	GOOD SAMARITAN	0.33	0.60	0.60	0.63	**0.49**
210057	SHADY GROVE	0.28	0.60	1.00	0.23	**0.38**
210060	FT. WASHINGTON	0.23	0.80	0.80	.	**0.41**
210061	ATLANTIC GENERAL	0.28	0.10	0.90	0.35	**0.39**
210062	SOUTHERN MARYLAND	0.17	0.00	0.10	0.45	**0.25**
210063	UM ST. JOSEPH	0.21	1.00	1.00	0.40	**0.43**

APPENDIX III. RY 2017 QBR PAYMENT ADJUSTMENT MODELING

HOSPITAL NAME	FY 16 Permanent Inpatient Revenue	QBR FINAL POINTS	Current Preset Scale		Proposed Scale	
			% Revenue Impact	$ Revenue Impact	% Revenue Impact	$ Revenue Impact
Bon Secours Hospital	$ 74,789,724	0.07	-2.00%	-$1,495,794	-2.00%	-$1,495,794
Laurel Regional Hospital	$ 60,431,106	0.16	-1.11%	-$670,785	-1.40%	-$846,035
Maryland General Hospital	$ 126,399,313	0.20	-0.67%	-$846,875	-1.13%	-$1,432,526
Northwest Hospital Center	$ 114,214,371	0.22	-0.44%	-$502,543	-1.00%	-$1,142,144
Holy Cross Hospital	$ 316,970,825	0.23	-0.33%	-$1,046,004	-0.93%	-$2,958,394
Prince Georges Hospital Center	$ 220,306,426	0.24	-0.22%	-$484,674	-0.87%	-$1,909,322
Southern Maryland Hospital Center	$ 156,564,761	0.25	-0.11%	-$172,221	-0.80%	-$1,252,518
Washington Adventist Hospital	$ 155,199,154	0.25	-0.11%	-$170,719	-0.80%	-$1,241,593
Sinai Hospital	$ 415,350,729	0.31	0.18%	$747,631	-0.40%	-$1,661,403
Memorial Hospital at Easton	$ 101,975,577	0.31	0.18%	$183,556	-0.40%	-$407,902
Anne Arundel Medical Center	$ 291,882,683	0.31	0.18%	$525,389	-0.40%	-$1,167,531
Franklin Square Hospital Center	$ 274,203,013	0.31	0.18%	$493,565	-0.40%	-$1,096,812
Union Memorial Hospital	$ 238,195,335	0.31	0.18%	$428,752	-0.40%	-$952,781
St. Agnes Hospital	$ 232,266,274	0.32	0.21%	$487,759	-0.33%	-$774,221
Baltimore Washington Medical Cente	$ 237,934,932	0.33	0.25%	$594,837	-0.27%	-$634,493
Western MD Regional Medical Cente	$ 167,618,972	0.34	0.29%	$486,095	-0.20%	-$335,238
Harford Memorial Hospital	$ 45,713,956	0.35	0.32%	$146,285	-0.13%	-$60,952
Doctors Community Hospital	$ 132,614,778	0.35	0.32%	$424,367	-0.13%	-$176,820
Meritus Hospital	$ 190,659,648	0.36	0.36%	$686,375	-0.07%	-$127,106
Johns Hopkins Hospital	$ 1,244,297,900	0.36	0.36%	$4,479,472	-0.07%	-$829,532
Union of Cecil	$ 69,389,876	0.37	0.39%	$270,621	0.00%	$0
Johns Hopkins Bayview Medical Cen	$ 343,229,718	0.38	0.43%	$1,475,888	0.05%	$171,615
Shady Grove Adventist Hospital	$ 220,608,397	0.38	0.43%	$948,616	0.05%	$110,304
Peninsula Regional Medical Center	$ 242,318,199	0.38	0.43%	$1,041,968	0.05%	$121,159
Upper Chesapeake Medical Center	$ 135,939,076	0.38	0.43%	$584,538	0.05%	$67,970
Chester River Hospital Center	$ 21,575,174	0.38	0.43%	$92,773	0.05%	$10,788
University of Maryland Hospital	$ 906,034,034	0.39	0.46%	$4,167,757	0.10%	$906,034
Atlantic General Hospital	$ 37,750,252	0.39	0.46%	$173,651	0.10%	$37,750
Garrett County Memorial Hospital	$ 19,149,148	0.40	0.50%	$95,746	0.15%	$28,724
Fort Washington Medical Center	$ 19,674,774	0.41	0.54%	$106,244	0.20%	$39,350
Mercy Medical Center	$ 214,208,592	0.41	0.54%	$1,156,726	0.20%	$428,417
Civista Medical Center	$ 67,052,911	0.42	0.57%	$382,202	0.25%	$167,632
Carroll Hospital Center	$ 136,267,434	0.43	0.61%	$831,231	0.30%	$408,802
Calvert Memorial Hospital	$ 62,336,014	0.43	0.61%	$380,250	0.30%	$187,008
UM ST. JOSEPH	$ 234,223,274	0.43	0.61%	$1,428,762	0.30%	$702,670
Dorchester General Hospital	$ 26,999,062	0.44	0.64%	$172,794	0.35%	$94,497
Montgomery General Hospital	$ 75,687,627	0.45	0.68%	$514,676	0.40%	$302,751
Harbor Hospital Center	$ 113,244,592	0.45	0.68%	$770,063	0.40%	$452,978
Frederick Memorial Hospital	$ 190,413,775	0.46	0.71%	$1,351,938	0.45%	$856,862
Suburban Hospital	$ 193,176,044	0.47	0.75%	$1,448,820	0.50%	$965,880
Greater Baltimore Medical Center	$ 207,515,795	0.49	0.82%	$1,701,630	0.60%	$1,245,095
Good Samaritan Hospital	$ 160,795,606	0.49	0.82%	$1,318,524	0.60%	$964,774
Howard County General Hospital	$ 165,683,744	0.57	1.00%	$1,656,837	1.00%	$1,656,837
St. Mary's Hospital	$ 69,169,248	0.72	1.00%	$691,692	1.00%	$691,692
Statewide Total	**$8,730,031,841**			**$27,058,414**		**-$9,883,530**
		Total Penalties		-5,389,617		-20,503,119
		% Inpatient Revenue		-0.06%		-0.23%
		Total rewards		32,448,031		10,619,589
		% Inpatient revenue		0.37%		0.12%

Draft Recommendation for Final Round of Transformation Implementation Grants

October 19, 2016

HSCRC
Health Services Cost Review Commission

Background

- In June 2015, the Commission authorized up to 0.25% of total hospital rates to be allocated to deserving applicants under a competitive Healthcare Transformation Implementation Grant Program.
  - "Shovel-ready" projects that generate short-term ROI and reduced Medicare PAU
  - Involve community-based care coordination and provider alignment and not duplicate care transitions and prior infrastructure funding
- The RFP was released on August 28, and applications were submitted by COB December 21, 2015
- HSCRC received 22 proposals from single- or multiple-hospital applicants, addressing needs of particular regions

Review Process

- Review Committee comprised of DHMH, HSCRC, and Subject-Matter Experts
- Extensive review process evaluating several different criteria (detailed in report on page 2-3) including having the best opportunity to help Maryland on achieving the goals of the All-Payer Model
- In June, the Commission approved $30.6 million for round 1 of Implementation grants leaving $6.4 million

Re-convening of Review Committee

- Commission agreed to conduct a second review to provide partial funding based on:
  - Individual projects that are efficacious
  - Support promising regional partnerships
- Review Committee reconvened to consider:
  - Specific promising programs within remaining proposals
  - Compelling community-based regional partnerships
  - Programs to address underserved geographic areas
  - Reduction of TCOC

Recommendations

Partnership Group Name	Award Request	Award Recommendation	Hospital(s) in Proposal - Purpose of Award
Calvert Memorial	$ 361,927.00	$ 360,424.00	Calvert Memorial Hospital
Lifebridge Health System	$ 6,751,982.00	$ 1,350,396.00	Carroll Hospital Northwest Hospital Sinai Hospital - 24-hour call center/care coordination hub - Efforts to enable seniors to age in place - Tele-psychiatry capability expansion
Peninsula Regional	$ 3,926,412.00	$ 1,570,565.00	Atlantic General Hospital McCready Memorial Hospital Peninsula Regional Medical Center - Inter-Hospital Care Coordination Efforts - Patient Engagement and Activation Efforts - Crisfield Clinic - Wagner Van
Totally Linking Care – Southern MD	$ 6,211,906.00	$ 1,200,000.00	Calvert Memorial Hospital Doctor's Community Hospital Fort Washington Medical Center Laurel Regional Hospital MedStar Southern Maryland Hospital MedStar St. Mary's Hospital Prince George's Hospital Center - Support the continuation of the regional partnership - Reinforce care coordination with special focus on medication management - Support physician practices providing care to high-needs patients
West Baltimore Collaborative	$ 9,902,774.00	$ 1,980,555.00	Bon Secours Hospital St. Agnes Hospital University of Maryland Medical Center UMMC – Midtown Campus - Patient-related expenditures - Care Management Teams, particularly focused on primary care - Collaboration and sharing resources with community providers
	$27,154,371.00	$ 6,461,940.00	

Next Steps

- The Review Committee has recommended the five additional proposals based on the review criteria totally $6.46 million.
- HSCRC will monitor the implementation of the awarded grants through additional reporting requirements.
- HSCRC is also recommending that a schedule of savings be remitted to payers through the global budget on the following schedule.
  - (Savings represent the below percentage of the award amount)

FY2018	FY2019	FY2020
10%	20%	30%

- The revised RFPs and summaries of the awardees will be posted on the HSCRC website.

DRAFT Recommendation for Competitive Transformation Implementation Awards – Secondary Review

October 19, 2016

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

This is a draft recommendation. Any public comments should be submitted to Steve Ports at **steve.ports@maryland.gov** on or before October 31, 2016.

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OVERVIEW

The Maryland Department of Health and Mental Hygiene ("Department", or "DHMH") and the Maryland Health Services Cost Review Commission ("HSCRC," or "Commission") are recommending that five proposals for health system transformation grants be partially funded, beginning in fiscal year 2017. This recommendation concludes the Commission's decision in June 2015 to authorize up to 0.25 percent of total hospital rates to be distributed to grant applicants under a competitive process for "shovel-ready" care transformation improvements that will generate more efficient care delivery in collaboration with community providers and entities and achieve immediate results under the metrics of the All-Payer Model.

BACKGROUND

The Commission received 22 proposals for transformation implementation award funding. Commission staff established an independent committee to review the transformation grant proposals and make recommendations to the Commission for funding. The Transformation Implementation Award Review Committee (Review Committee) included representatives from the Department and the Commission as well as subject matter experts, including individuals with expertise in such areas as public health, community-based health care services and supports, and health information technology. Following a comprehensive review process, nine of the 22 proposal applicants were awarded monies through hospital rates at the June 2016 Commission meeting, which were included in the FY 2017 rate orders.

The Commission authorized up to 0.25 percent of approved FY 2016 revenue for this program, meaning that up to $37,036,786 may be provided through rates to support community-based care coordination and health care transformation. The initial nine grantees received a total of $30,574,846 in FY 2017, leaving a remainder of $6,461,940. The Commission tasked the HSCRC and DHMH with re-evaluating the proposals that did not receive funding to determine whether the remainder could be used to further the goals of the All-Payer Model by approving individual projects, or to provide partial funding to support promising collaborations and regional partnerships.

THE REVIEW COMMITTEE AND EVALUATION CRITERIA

In this secondary review process, the review committee looked at the remaining applicants and discussed individual proposals' strengths and weaknesses on the following criteria:

- Does this proposal have any **specific, promising programs**?
- Does the proposal have a compelling, community-based **regional partnership**?
- Does the proposal address an **underserved geographic area**?
- Will partially funding this proposal lower the **Medicare Total Cost of Care**?

RECOMMENDATIONS

Recommended Awardees

Based on its review, the Review Committee recommends five additional grant proposals for partial funding beginning January 1, 2017. Table 1 below lists the recommended awardees, the award amount, the hospitals affected, and the intent of the funding. A summary of each recommended proposal may be found in the Appendix. Note that the existing summaries do not reflect what will be funded through this program since, with the exception of Calvert Memorial Hospital, all are partially funded. The review committee provided each awardee with the projects that should be supported with the funding. Table 1 lists those projects.

Table 1. Recommended Awardees

Partnership Group Name	Award Request	Award Recommendation	Hospital(s) in Proposal - ***Purpose of Award***
Calvert Memorial	$ 361,927.00	$ 360,424.00	**Calvert Memorial Hospital**
Lifebridge Health System	$ 6,751,982.00	$ 1,350,396.00	**Carroll Hospital** **Northwest Hospital** **Sinai Hospital** - *24-hour call center/care coordination hub* - *Efforts to enable seniors to age in place* - *Tele-psychiatry capability expansion*
Peninsula Regional	$ 3,926,412.00	$ 1,570,565.00	**Atlantic General Hospital** **McCready Memorial Hospital** **Peninsula Regional Medical Center** - *Inter-Hospital Care Coordination Efforts* - *Patient Engagement and Activation Efforts* - *Crisfield Clinic* - *Wagner Van*
Totally Linking Care – Southern MD	$ 6,211,906.00	$ 1,200,000.00	**Calvert Memorial Hospital** **Doctor's Community Hospital** **Fort Washington Medical Center** **Laurel Regional Hospital** **MedStar Southern Maryland Hospital** **MedStar St. Mary's Hospital** **Prince George's Hospital Center** - *Support the continuation of the regional partnership* - *Reinforce care coordination with special focus on medication management* - *Support physician practices providing care to high-needs patients*
West Baltimore Collaborative	$ 9,902,774.00	$ 1,980,555.00	**Bon Secours Hospital** **St. Agnes Hospital** **University of Maryland Medical Center** **UMMC – Midtown Campus** - *Patient-related expenditures*

			- *Care Management Teams, particularly focused on primary care* - *Collaboration and sharing resources with community providers*
	$27,154,371.00	**$ 6,461,940.00**	

Reporting and Evaluation

Following Commission approval of the awards, staff will provide each awardee with a template for monitoring and reporting on the performance of the programs in meeting the goals of the All-Payer Model and consistent with the application proposal. The Commission reserves the right to terminate and rescind an award at any time for material lack of performance or for not meeting the letter or intent of an application, including not working with CRISP or not achieving results consistent with the All-Payer Model.

Savings to Purchasers

The RFP specifically states, "in addition to the ROI for the participating hospitals, the HSCRC expects that a portion of the ROI accrue to payers. Applicants were expected to show how the ROI will be apportioned between the hospital(s), and payers, and how the payer portions will be applied (global budget reduction, etc.)." Because most applications were not specific on this point, the Commission is requiring a schedule of savings to purchasers for each awardee hospital through a reduction in its global budget or total patient revenue amounts. The following table presents the scheduled reduction in the award amount for each hospital receiving funding through rates.

Table 2. Recommended Reduction Percentage

FY 2018	FY 2019	FY 2020
-10%	-20%*	-30%*

*10% more than the previous fiscal year.

APPENDIX

Please NOTE that these proposal summaries reflect the initial submission from the five applicants, and are therefore not wholly representative of the extent and scope of the recommended grantees' efforts.

Calvert Memorial Hospital

IT TAKES A VILLAGE:
Implementation of Senior Life Centers in Calvert County
Proposal Summary

Hospital/Applicant	Calvert Memorial Hospital
Date of Submission	12/21/15
Health System Affiliation	Calvert Health System
Number of Interventions	**1,312**
Total Budget Request	**$ 361,297.00**

Target Patient Population (limit to 300 words)

Through the creation of communities modeled on the popular "villages" concept, Calvert Memorial Hospital (CMH) aims to create three Senior Life Centers in Calvert County which will:

- Serve 1,312+ Medicare-eligible participants correlating to the target population of TLC-MD thus impacting the readmission rate and cost of care for this population
- Serve an 405 Calvert County residents (Medicare, Medicaid, other insured or non-insured) age 50+ as a prevention study population to determine the program's effectiveness in reducing risk factors associated with chronic diseases significantly found within our Medicare population
- Address disparities such as lack of public transportation, significantly low ratios of physician and non-physician providers, difficulty accessing and enrolling in benefits, need for navigation to and better coordination of local community resources, access to healthy food sources and basic home maintenance for healthy home environments.

Summary of program or model for each program intervention to be implemented.
Include start date and workforce and infrastructure needs.
(limit to 300 words)

CMH's "Villages" model, Senior Life Centers, will use elements of various Villages-model programs to address local needs, utilize available resources, expand a long-standing successful relationship with the Offices on Aging (OOA), build on already successful programs using engaged staff and volunteers, and create a platform for growth of the program to other targeted populations. The Centers will be co-housed in three Calvert locations – the OOA in Lusby (southern Calvert), Calvert Pines in Prince Frederick (central Calvert) and the OOA in North Beach (northern Calvert). CMH currently has a MOU with the OOA's for implementation of the *Ask the Nurse* program which has provided health and

wellness services, on a drop-in basis, to Medicare-eligible seniors throughout Calvert. Additionally, multiple social programs are offered at each senior center and volunteer opportunities abound for seniors to serve within the centers or within the greater Calvert area.

The proposed program will bring the addition of professionals to the care team at the centers including (but not limited to) primary care providers, social workers, personal trainers and diabetes educators who will address locally identified health disparities, modifiable risks and chronic disease management.
Because space is currently on hold for implementation of the Centers, and because this program extends a program with which CMH has been a partner (the *Ask the Nurse Program)* the program can begin serving participants and having an immediate impact at the onset of a grant award.

Measurement and Outcome Goals
(limit to 300 words)

As needs have been identified in the community, particularly through the Community Health Needs Assessment and through strategic planning to align with MD SHIP objectives, the concept of the Senior Life Centers has been planned and a model has been created as a mechanism to easily and efficiently take health and wellness services to seniors. Taking the care where it is needed most addresses the significant challenges in Calvert with access to care, a primary care provider shortage, avoidable ED utilization and overall better coordination of available services in the community.

The goals of the Senior Life Centers are to serve (1) the 50+ age population who are at-risk for high utilization due to health conditions and (2) those defined by our collaboration with TLC-MD as high utilizers who are part of the single-payer/"Medicare for All" models and who desire or intend to age in place. The program aims to serve 1,312+ target patients (who are also targeted as high utilizers by TLC-MD) by serving as a partner in their care coordination efforts. An additional 405 participants (age 50-64) who are engaged with the local Offices on Aging and are candidates for our Senior Life Center programs, but who are not currently being served due to program financial restrictions, will be served through the Centers in an effort to treat their conditions, or intervene while their risk is modifiable, to avoid their becoming high-utilizers.

Return on Investment and Total Cost of Care Savings
(limit to 300 words)

The return on investment (ROI) for CMH's strategies for implementation of Senior Life Centers is detailed in Table 9 of the full proposal. We will evaluate and monitoring the ROI as we move forward balancing investments with outcomes. We believe the ROI will be positive, but the range of the ROI will vary and we will be adjusting future years as we move forward based on actual experience.

A summary of projected ROI, over a three period with investments by HSCRC, yield the following:

Year 1 – 1.60
Year 2 – 1.61
Year 3 – 1.62

Scalability and Sustainability Plan
(limit to 300 words)

CMH aims to duplicate their Villages model program to other targeted populations in Calvert County. CMH is currently working with the Collaborative for Children and Youth and Calvert County Public Schools to identify the most urgent needs among Calvert's youth population. Future plans include expansion of a Villages modeled program to be housed in local schools and also within planned youth/family community center. CMH is also working with their Health Ministry Network to plan a Villages model program at a local church which currently offers a food pantry, clothing program and jobs-link program and is offering space to CMH to host a Villages model (funding from the HSCRC .50% proposal with TLC-MD will support this model through the Calvert Health Ministry.)

Sustaining the Senior Life Centers will be achieved through billable services as allowed by the grant and seeking additional grant opportunities and community investments. CMH generally invests in programs which present a cost savings to the hospital, and the program will be monitored for future investments by CMH. Utilizing the resources of local partners will also contribute to the overall sustainability and expansion of the program.

Participating Partners and Decision-Making Process
(including amount allocated to each partners)
(limit to 300 words)

In order for the Senior Life Centers to be successful, CMH will utilize existing partnerships which have proven successful in responding to the needs of the local Southern Maryland community. CMH will also utilize the partnerships, expertise and collaborative platform provided through their membership with TLC-MD – work of the Senior Life Center program will aim to help to achieve the overall goals and measures set by TLC-MD and data will be reported accordingly.

The following chart demonstrates the existing partnerships which will be used to launch the Senior Life Centers. Decision making will take place by CMH leadership in collaboration with the Office on Aging and other community partners. MOUs or other appropriate contracts for service will be used to clarify relationships and expectations between other partners. Additional partners will be added as the program grows and needs are identified:

Organization/Partner	Role	Overview
Calvert Memorial Hospital	Project lead	Manage the establishment and operation of all aspect of the senior life centers in 3 local Office on Aging facilities; manage the grant project; track and report data
Calvert County Office on Aging	Project partners	Access to target population; provide space, at no cost, for establishment of centers; program oversight
Calvert County Health Department	Community partner	Provide behavioral health services to participants at the Senior Life Centers

World Gym	Community partner	Low cost access to fitness and personal training
TLC-MD, Inc.	Community partner	Utilize available partnerships in the provision of services; leverage lessons learned from TLC-MD partners on best practices; share data for establishment of outcome goals set by TLC-MD

Implementation Plan
(limit to 300 words)

As the program is an extension of an existing partnership between Calvert Memorial Hospital, the Calvert Office on Aging, the Calvert Health Department and other local providers, and as the program has completed the design phase through the strategic planning work of Calvert Memorial Hospital in achievement of their population health strategies, much of the pre-requisite work is completed. CMH is positioned to launch the program at the onset of a grant award in space which is on hold in the 3 local Offices of Aging, utilizing existing staff (as well as growing the program team) and working with participants already engaged at the hospital and/or Offices on Aging. A summary of the major implementation activities is charted in the full proposal; all work noted as ongoing would continue into years 2 and 3 with additional investments from HSCRC.

Budget and Expenditures
(include budget for each intervention)
(limit to 300 words)

Investments from HSCRC will be used to increase staffing to meet the greater number of participants who will utilize the OOA's programs by implementing dedicated Senior Life Centers for improvement of health among the target population and through additional outreach of services provided aboard the CMH Mobile Health Unit. Investments will be used in year one for IT infrastructure to support the program which will serve as a model for the state of MD; subsequent year IT funding will be used to support monthly per user fees. Funding for equipment and supplies will enable CMH to outfit three clinics, one at each Senior Life Center, with needed items from our CRNP, RN, specialists, dentists, hygienists, social workers, health educators, ministry partners, personal trainers and others. A dedicated nurse info phone line, as referenced by TLC-MD, will serve as a model to be expanded to other areas of MD and will work to efficiently and effectively direct patients to the right places for their health care needs (and lead to a decrease in avoidable ED and Urgent Care utilization.) Finally, to tackle the challenges of medication management, a program will be launched in partnership with local pharmacies to host pharmacists at the Senior Life Centers to counsel patients on their

medication use and management – this, alone, stands to greatly impact the already challenged local public transportation system and will help CMH in efforts to improve medication use (and abuse) in our communities.

Lifebridge Health

Proposal Summary

Hospital/Applicant:	Sinai Hospital, Northwest Hospital, and Carroll Hospital
Date of Submission:	December 18, 2015
Health System Affiliation:	LifeBridge Health
Number of Interventions:	4
Total Budget Request ($):	$6,089,727 (CY 2016)

Target Patient Population

The target population is high-utilizer patients who frequent LifeBridge Health (LBH)'s acute care hospitals, including Sinai (Baltimore City), Northwest (Baltimore County), and Carroll (Carroll County). These **2,690 adult patients** had three or more inpatient or observation encounters of 24 hours or more in FY 2015, and while they represent only 2% of LBH's entire patient population, their usage accounted for 19% of total charges. Nearly all (96%) high utilizers have at least one chronic condition, and 86% have at least two (primarily hypertension, diabetes, congestive heart failure, and coronary artery disease); 70% have a behavioral health condition. Within the target population of 2,690 high utilizers (emphasizing the middle tier of 2,074 patients), LBH plans to focus on the **1,256 patients with Medicare** as their primary payer source and **actually reach 1,000** during the first ramp-up year (CY 2016).

Summary of program or model for each program intervention to be implemented.

In four comprehensive interventions to improve care coordination and population health based on medical and supportive needs of the target population (to begin in Q1 CY2016), LBH will:

1. **Optimize care coordination for high utilizers through a system-wide "care coordination hub:"** with an integrated, professionally staffed, 24/7 call center; expanded workforce (RNs, LCSWs, care navigators, CHWs, NPs, pharmacists, and nutritionists/dietitians); use of new protocols and pathways; emphasis on patient/caregiver engagement; and strengthened data reporting/analytic capabilities.
2. **Provide intensive care coordination for complex patients at highest risk for readmission:** 240 targeted patients having 7 to 10 chronic conditions each and $21.4 million in total charges in the last FY will benefit from the evidence-based Project RED discharge model system-wide, improved integration with long-term and post-acute facilities through the "LBH Preferred Skilled Nursing Facilities Network" and "Post-Acute Physician Partners," and aging-in-place support for seniors in partnership with community-based agencies. New outpatient palliative care services and piloting of new technology opportunities will be implemented.
3. **Strengthen primary care access and delivery:** New Primary and Chronic Care Pavilions on two campuses; 24/7 access to nurse triage through an integrated call center; an evidence-based patient-centered medical home (PCMH) model; embedded intensive care coordinator resources within primary care practices by hiring triads of RN care navigators, social workers, and medical assistants and testing new technology capabilities; and connection to a medical home established for all target patients.
4. **Strengthen behavioral health care access and delivery:** Screening tools to diagnose and assess behavioral and mental health disorders, coordinated programs to prioritize and refer patients, and centralized low-level behavioral health needs at the primary care level; expansion of behavioral health workforce, including primary care-based Behavioral Health Navigation Teams comprising LCSW navigators, bachelor's or master's prepared social work navigators, and community health workers; and piloted telepsychiatry through a phased approach beginning in January 2016.

Measurement and Outcomes Goals.

LBH will track and report on each of the measures required by HSCRC for the target population of 1,256 Medicare high utilizers. In addition, LBH data specialists will also monitor measures specific to the interventions described above. The list of outcome and process measures is summarized below.

LBH-defined process measures:

Intervention #1:

- Patients completing a Patient Engagement Survey that tracks improved disease self-management after interventions

- Successful outbound or inbound telephonic contacts with patients (speaking with live patient)
- Patients receiving follow up call to collect medication history within 48 hours of discharge
- Patients receiving follow up call regarding medication education within 48 hours of discharge
- Patients receiving follow up call regarding access to medications within 48 hours of discharge

Intervention #2:

- For patients discharged to a SNF in SNF Provider Network, **ratio** of instances the SNF handoff tool was used, to the total number of SNF Preferred Provider Network discharge encounters (encounter-based measure)
- Palliative Care patients connected to O/P Palliative Care NP

Intervention #3:

- Patients proactively connected with a PCP (Care Navigators or other Care Coordination staff reach out prior to CY2016 acute episode)
- Patients connected with a PCP after acute episode and appointment scheduled
- Patients with identified PCP
- Employed primary care physicians who have subscribed to the ENS CRISP alerts
- Employed PCPs loaded patient panels into CRISP

Intervention #4:

- Patients screened for depression
- Behavioral Health patients identified in acute setting and referred to BH specialist/program
- Behavioral Health patients proactively connected to BH specialist/program (Care Navigators or other Care Coordination staff reach out prior to CY 2016 acute episode).

Return on Investment. Total Cost of Care Savings.

Berkeley Research Group (contracted data specialists) has validated that there will be a positive ROI through the four interventions of the transformation program described above. From a broad perspective, shifting avoidable acute care to more cost effective care in the primary care and community-based settings will inherently save payors money. LBH is estimating ROI in the amounts of 0.50, 0.68, 1.16, and 1.45 for Calendar Years 2016, 2017, 2018 and 2019, respectively. The ROI estimates are based on evidenced-based staffing ratios for the number of high utilizers and the patient profile of high utilizers. It is expected that once the program is fully ramped up, economies of scale and efficiencies will occur in which more patients will be served while using the savings from the reduction in acute hospital utilization to re-invest and expand clinical resources.

Since each of the interventions are expected to positively impact patient avoidable utilizations (PAUs) and patient quality improvements (PQIs), the LBH system will invest these savings to expand upon the proposed program for continued cost savings. Specifically, LBH is strategically planning to focus on the Medicare portion of the high utilizer population during the grant period (CY 2016) to secure the highest ROI in the short term.

Scalability and Sustainability Plan

Through the four interventions described above, LBH expects to realize a sustainable and scalable model of integrated health care that better manages high-risk patients and reduces avoidable hospital admissions and ER visits.

LBH plans to reinvest into the program with scalability plans for dual eligibles, followed by Medicaid beneficiaries, and finally to commercial payors. The requested rate increases will enable LBH to achieve the population health model proposed in this application, which will in turn reduce healthcare costs and ultimately ensure financial sustainability.

Participating Partners and Decision-making Process

In addition to senior leadership from LBH and each of the three lead hospitals, key internal partners include the LBH Physician Network, Carroll Health Group, and Sinai Community Care.

More than 10 external partners (who will not receive funding through this request) include:

- Berkeley Research Group (data specialists)
- Chase Brexton (primary care provider in the Northwest region)
- Access Carroll (primary care provider in the Carroll region)
- Maryland Citizens' Health Initiative Education Fund (sponsoring entity for the Faith Community Network, which will assist with community-based post-discharge support)

- Health departments of Baltimore City, Baltimore County, and Carroll County
- Agencies serving seniors, including CHAI, Home Care Maryland, and Capital Coordinated Medicine (Carroll).

Implementation Plan

Per the attached implementation plan, there are five major areas of responsibility for program implementation in Year One. A Project Manager is responsible for "Implementation across all interventions." Implementation of each of the four interventions will be led by a Director-level LBH resource as follows:

- Intervention #1: Director, Integrative Health and Navigation
- Intervention #2: Director, Integrative Health and Navigation
- Intervention #3: Director, Ambulatory and Practice Outcomes
- Intervention #4: Director, Psychiatry and Behavioral Health Services

All interventions will commence during the first quarter of CY 2016 (with some aspects of Intervention #1 commencing before grant award notification). LBH has already laid the Transformation Program groundwork for management of project integration, cost, scope, human resources, and communications.

Following are major milestones to be reached per intervention:

- Intervention 1:
  - Establish integrated call center: 12/21/15-6/1/16
  - Systems development: 1/4/16-4/1/16
  - Create Care Coordination Hub: 12/21/15-12/30/16
  - Enhance engagement among patients, providers, family and public: 2/1/16-12/31/16
  - Strengthen referral processes to existing chronic care and wellness programs: 2/1/16-7/1/16
  - Track population health outcomes and foster quality improvement: 1/15/16-12/30/16
  - Manage transportation support: 3/1/16-12/30/16
- Intervention 2:
  - Improve transitions to/integration with long-term and post-acute facilities: 2/1/16-12/30/16
  - Enhance community partnerships for aging in place: 4/1/16-9/30/16
  - Standardize and strengthen discharge follow-up procedures: 2/15/16-12/1/16
  - Conduct Palliative Care home visits: 4/1/16-12/30/16
- Intervention 3:
  - Hire and train Care Coordination teams for PCP offices: 3/1/16-6/30/16
  - Proactively connect patients to medical home/PCP: 2/15/16-12/30/16
  - Provide 24/7 access to expanded, integrated call center with 24/7 nurse triage: 2/1/16-3/1/16
  - Adopt patient-centered medical home (PCMH) model (with NCQA certification) for 2 practices: 1/25/16-9/30/16.
- Intervention 4:
  - Standardize use of depression screening tool: 3/1/16-12/30/16
  - Add behavioral health staff to PCP offices, call center and behavioral health navigation teams: 3/1/16-5/1/16
  - Pilot and launch Telehealth psych resource: 1/15/16-9/1/16

Budget and Expenditures.

LBH requests a rate increase of %0.50 of net patient revenue for each hospital. The cost for the interventions described throughout this proposal is $6,089,727 for the first year of the grant period (CY 2016), including $3,187,760 for Sinai Hospital, $1,792,587 for Northwest Hospital, and $1,109,380 for Carroll Hospital.

The cost per intervention (LBH total) is as follows:

- Intervention #1: $3,602,311
- Intervention #2: $369,692
- Intervention #3: $573,922
- Intervention #4: $1,543,802.

In addition, LBH plans to contribute $1,446,801 in-kind in CY 2016 for personnel & contractual expenditures.

Peninsula Regional Medical Center, Atlantic General Hospital, and McCready Memorial

Summary of Proposal:

Hospital/Applicant:	PRMC, AGH, McCready
Date of Submission:	12/21/2015
Health System Affiliation:	
Number of Interventions:	3
Total Budget Request ($):	$3,926,412

Target Patient Population (Response limited to 300 words)
The target population for the Transformation Grant is: Medicare enrollees with two or more inpatient or observation encounters, one or more chronic conditions, and or more than one visit to the emergency department within a 30 day period. The collaboration also identified Medicare patients as being at risk of high utilization based on his/her chronic conditions and patterns of care. The partners determined that the number of patients who utilize both AGH and PRMC is significant to provide services to avoid unnecessary utilization of the emergency room at both hospitals. More specifically, the target population for enrollment in care management program will include: • Individual Medicare beneficiaries identified to be "high utilizers" based on FY2015 activity[1] o In 2015, there were a total of 2,087 Medicare high utilizers served at o Efforts will focus heavily on enrolling high utilizers with 2-6 Chronic conditions, specifically Hypertension, Diabetes, Coronary Artery Disease and Chronic Kidney Disease and congestive heart failure into care coordination and care management activities that take care from the acute setting into the community and primary care setting
Summary of program or model for each program intervention to be implemented. Include start date, and workforce and infrastructure needs (Response limited to 300 words)

[1] High utilizers were defined as adult patients with ≥2 inpatient or observation encounters (referred to here as "bedded care") during FY2015

There are three initiatives which make up the program:
1) Increasing access to primary care via a bridge clinic, and the Wagner Van which will travel to remote areas. Working with McCready, Crisfield clinic and emergence personal to serve the population on Smith Island. Start Date: February Resources:
2) Care Management and Transitions of Care: Expanding the Transitions of Care team to assist Care Managers embedded in 4 primary care practices. Partnering with AGH and McCready Health increase CM/SS workers in the emergency department to care for people who are high utilizers. Working with SNF's and nursing homes provide telemedicine to PRMC hospitalist to prevent unnecessary visits to the ED. Working with a Supportive RN Care manager to assist patients who have late disease states. Start Date: February Resources:
3) Patient Engagement: "Activation" for Disease Management and Infrastructure for Consumer Feedback and Continuous Quality Improvement – Through the actions and support of Care Management and the Transitions of Care team patients will become more empowered in self-management of their chronic diseases. Start Date: March Resources:

Measurement and Outcomes Goals (Response limited to 300 words)

PRMC and its partners AGH and McCready are working to reduce PAU's, utilization of the ED and cost of care, while together and locally each is focusing their population health efforts to achieve the goals of the triple aim. Through the HSCRC baseline outcome core measures and process measures the collaboration will be monitoring those on a quarterly basis. The group has agreed to programmatic measures on each initiative to achieve greater patient engagement, right care within the right setting and to promote caring for patients within the community setting. These measures will also be analyzed on a quarterly basis and brought forth to the governance committee for review and discussion. These measures will be used to evaluate the success of the program.

Return on Investment. Total Cost of Care Savings. (Response limited to 300 words)

From a broad perspective, shifting avoidable acute care to more cost effective care in the primary and community-based settings will inherently save payers money. Through annual program evaluations and evaluations of the financial efficacy other programs to be developed and considered will be physician alignment such as pay for performance for agreed upon quality metrics for which the ROI would be used. Another program such as reducing uncompensated care is another possible outcome for the payers.

Since each of the interventions are expected to positively impact PAUs and PQIs, PRMC and its collaborators will invest these savings to expand upon the proposed program for continued cost savings.

Specifically, PRMC, AGH and McCready is strategically planning to focus on the Medicare portion of the high utilizer population during the grant period (CY 2016) to secure the highest ROI in the short term. PRMC, AGH and McCready will reinvest into the programs with scalability plans for Dual Eligibles, followed by Medicaid beneficiaries, and finally commercial payers.

Scalability and Sustainability Plan (Response limited to 300 words)

Through the interventions listed above, PRMC, AGH and McCready anticipate a sustainable and scalable model of population health management serving high utilizers and patients who are at risk at becoming a high utilizer.

It is expected that through the ROI achieved and savings from reducing PAU's, the hospital(s) will reinvest the savings into expanding the programs with either the necessary staffing or care management technology. The requested rate increases will enable PRMC, AGH and McCready to achieve the population health model proposed in this application which in turn reduce health care costs and ultimately ensure financial sustainability. Other methods for financial sustainability will come in the form of the CCM fee collection and the TOC fee collection.

Participating Partners and Decision-making Process. Include amount allocated to each partner. (Response limited to 300 words)

Peninsula Regional Medical Center, Atlantic General Hospital, and McCready Health have agreed to form a regional partnership to collectively address clinical approaches to better serve at-risk populations in our region. The focus of this grant application is to address Medicare recipients who seek care at our organizations. Specifically it is to focus on high risk, high utilization, and the need to increase access to primary care while also supporting our communities in providing basic care and health literacy to disparate populations. Each hospital will develop and manage a score card(s) on the status of the individual strategic initiatives and the status of the goal achievement.

Two Advisory Councils (Family and Medical) will meet with The Council to provide input and guidance. A summary of the two supportive councils is as follow:

Patient/Family Advisory Council ("PFAC"):

Each organization's PFAC will be utilized to report to the community on the status of the collaborative projects and to gain additional input regarding other potential needs and identify any gaps from the perspective of the care consumer.

Medical Advisory Council ("MDAC"):

The Medical Advisory Council, ("MDAC"), a newly created council, will be composed of providers across the care continuum.

Implementation Plan (Response limited to 300 words)

Please see the appendix for the plan.

Within 10 days of the grant being awarded the Medicare patient list will be refreshed with the newest list of high utilizers. The collaboration will commence with training the current and new TOC and CM nurses. The program will kick-off quickly the bridge clinics and ED care management. While there is a ramp up period of 3-4 months the collaboration is currently working amongst them and with other partners to draft and finalize workflows and communication process flows that would be ready to implement once the grant is awarded. In short the collaboration is working to have all initiatives ready within 30 days.

Budget and Expenditures: Include budget for each intervention. (Response limited to 300 words)

PRMC, AGH and McCready is requesting: $3,926,412 million for the first year of the grant period (January-December 2016).

1) Increasing Access to Care: Bridge Clinic, Wagner Van, Smith Island: $1,077,627

2) Care Management: Training, and Embedding Care Managers; Expansion of TOC; and Care Management in SNF, Care Management in the ED: $2,630,435

3) Patient Activation for Chronic Disease Management: $218,350

Each proposed intervention contains dollars for clinical/social staff and or technology such as tele-medical equipment and equipment such as the Wagner Van to serve the region. Each program has been developed to not only address the high utilizing Medicare patient but also that patient's remoteness within the region. While the first 6 months to 12 months requires investments in technology, clinical staff and population health administration staff it is expected that year going forward the fixed costs will level out. The budget is strategic in that it is meant to build up and lay further necessary foundational elements of care coordination and population health management.

Totally Linking Care – Southern Md

Hospitals/Applicants:	TLC-MD Member Hospitals: Calvert Memorial Hospital, Doctors Community Hospital (lead on Partnership Planning Grant), Fort Washington Medical Center, Laurel Regional Hospital, MedStar Southern Maryland, MedStar St Mary's, Prince George's Health System including Bowie Center
Date of Submission:	December 21, 2015

Health System Affiliation:	MedStar and Dimensions
Number of Interventions:	1. Care Coordination, 2. Medication Management, 3. Physician Engagement and Support, and 4. Learning Organization
Total Budget	**$6,211,906.45**

Table 1: Summary Table Delineating Differences by Intervention

Target Patient Population (Response limited to 300 words)
TLC-MD represents a commitment of all seven of the hospitals within Prince George's, Calvert and St. Mary's Counties to work together to achieve the Triple Aim. Our planning work to date has helped us to clearly identify a High Needs Population to target through proposed TLC-MD interventions. We have three nested populations as formal targets: (1) those identified as high-needs patients when they use our hospitals (High Needs Population), (2) those who live in our hospital service areas (the area for each hospital from which 85% of the hospitalized patients living in Maryland come) (HSA Population); and (3) those who live in our counties (Counties Population). Experience with improving care transitions and providing care coordination has taught us to include all medical diagnoses rather than to restrict the focus to a few well-studied conditions. Many of our high-needs patients have unstable or inadequate supportive services rather than particularly high-risk diagnoses. However, we also recognize that most high-needs patients have Medicare insurance and that Maryland's agreement with CMS focuses upon this population, so we will aim to improve the care of Medicare populations substantially and quickly. Thus, the priority population for initial targeting consists of persons identified as high-needs patients with Medicare coverage now using our hospitals. The core population (including Medicare and non-Medicare patients) will be identified by having each hospital's full list of admissions run through an algorithm to detect persons predicted to be at high risk for high future utilization of medical services.
Summary of program or model for each program intervention to be implemented. Include start date, and workforce and infrastructure needs (Response limited to 300)
TLC-MD plans to reduce unstable health-related situations for persons living with serious or advanced illnesses and disabilities. By doing so, we aim to improve the patient experience and the health of the population and to reduce the need to resort to the hospital. The Clinical Analysts will assist in documenting and reporting the results of the following interventions. **Strategy #1 – Starting January 2016.** The workforce includes hospital case managers to perform RCAs and work with eQHealth predictive modeling; RNs to do home visits, patient and caregiver education, medication reconciliation, navigation for primary and specialty care supportive services, care planning, patient engagement with the use of telehealth technologies with alert notifications, and communication with physicians. **Strategy #2 – Starting March.** TLC-MD recognizes the high rate of medication management shortcomings that affect persons going through hospitals, whether adherence, appropriate dosing, optimal medication choice, duplications and contraindicated medications, side effects, or costs. TLC-MD is set to test as many as four strategies: 30-day supply of medications at discharge, electronic drug monitoring with alerts, specialty skilled pharmacist involvement, and screening for Beers criteria. **Strategy #3 – Starting March 2016,** support physician practices that deal with these high-needs patients by creating individualized approaches to meet the patient's needs, helping with transition to MIPS, and developing gain sharing arrangements. Workforce is eQHealth, MedChi, and hospitals. **Strategy #4 – Starting January 2016.** Test a list of

enhanced services such as self-care activation approach, post clinics, nurse call lines, standardize some ED test that show correlations to chronic illnesses (ex. Vitamin D), and matching behavioral health options with services available.
Measurement and Outcomes Goals (Response limited to 300 words)
TLC-MD measurement strategies begin with a commitment to meeting the terms of the agreement between Medicare and Maryland, and to that end TLC-MD will monitor and manage according to the goals set by the RFP, using the associated data and analysis approaches. TLC-MD will also monitor tests of interventions, looking to measures of process, outcome, potential adverse effects, costs, and spread. For data provided by HSCRC, VHQC and CRISP, TLC-MD will usually request aggregate data and data splits between Prince George's County (northern sector) and the combination of Calvert, Charles, and St Mary's Counties (southern sector), since otherwise gains in the more rural counties (Calvert and St. Mary's and often Charles) will be overwhelmed by the large numbers in Prince Georges County. Similar data splits will be conducted with data generated by the coalition. Although Charles County is not a participating partner of the coalition, TLC-MD recommends including Charles County's data and ultimately TLC-MD hopes that Charles County providers will work with the coalition on future projects. For some metrics, the frequency will be monthly and for others, the data will probably only be available quarterly. For data that is available into the past, we will request data for the last three years (2013-2015) in order to be able to establish seasonal variation and a rough baseline, as well as requesting reasonably prompt data through the future work. Some of this will be displayed on the CRISP dashboard, which we will study and use, but we also want to be able to construct useful process control charts for interventions we implement. We understand from CRISP that they will have data from dual-eligible beneficiaries first, then probably Medicare Parts A, B, and D. Once the core data are all coming in quickly after billable events, additional quality measures will become possible.
Return on Investment. Total Cost of Care Savings. (Response limited to 300 words)
The return on investment (ROI) for TLC-MD's strategies and testing other enhanced services in the regional learning organization model described in the Targeted Population and Program sections are shown in Table 7 in the application. The ROI was calculated using the HSCRC ZIP code data provided in mid-December 2015 on the CY 2014 patient discharges. The patients with 3+ IP/Obs>24 Medicare data was sorted by each hospital. Anticipating that 40% of the patients could be enrolled in a year, a monthly census of 392 patients was calculated and placed into one of 4 acuity level tiers. Patients may be enrolled in a 90, 180 or 365 day program, depending on acuity level or need by exception. This accounts for 1,568 patients being seen in Year 1 and 2,364 being seen in subsequent years, a 60% enrollment rate. Using the 4 tiered acuity levels, different interventions were assigned to each tier based on previous studies by Berkley Research Group (BRG) and the RCA results seen the planning stage. Cost for each service provided for each intervention was calculated from vendor contracts. Thus the Annual intervention cost per patient was calculated to be $3,888.50. The annual charges were calculated from two data sources: first, using the average patient cost from the CRISP report developed with Mary Pohl on the highest acuity de-duplicated patients (369) and second, using the average patient cost from the HSCRC zip code data received. These per patient costs were multiplied by the number of patients to be enrolled, such as 1,568 for Year 1. In Year 1, the development year that includes much testing of interventions, the expected savings is calculated at 15% but future years TLC-MD expects a 29% savings, resulting in a (.15) ROI in Year 1 to a 1.55, 1.61 and 1.32 in future years.
Scalability and Sustainability Plan (Response limited to 300 words)

The current plan is to fully utilize HSCRC/DHMH's grant dollars to operate the coalition's work until December 2018, and to enable the program to yield substantial reductions in utilization. As savings occur at each hospital in the reduction of regulated unnecessary utilization, the variable savings could be shared with the counties, the hospitals, the providers who affected change, and HSCRC. As the program develops, TLC-MD members will be seeking financial investments from other interested parties who share the mission of TLC-MD and who want to see patients remain healthy at home (such as The Harry and Jeanette Weinberg Foundation, other granting foundations, and community partners such as Wal-Mart, Giant, Walgreens and other businesses that invest in the population health needs of their communities.) The hospital partners in TLC-MD are firmly committed to the Triple Aim for our area. We can make major improvements in the health care delivery system and the health of our communities within that budget for at least the four years we are now planning. We have planned to use the funds catalytically and strategically, targeting the high-needs patients who are not well-served in another way, and building a coalition capable of monitoring data and managing some critical parts of the overall

delivery system. The scale of this part of the work is already broad, though carefully targeted. We may find that we need somewhat more or different staffing. The pace of change is somewhat dictated by the funding and the need to ensure staff attention to the testing and implementation of interventions. TLC-MD has strategies to improve the health of the entire region over the long term, beyond just the

Participating Partners and Decision-making Process. Include amount allocated to each partner. (Response limited to 300 words)

The allocation to each partner is listed below by each Strategy.

	eQHealth	Communities, Counties, buses	St Mary's HEZ program	Faith Based and Communities	Behavioral Org	Primary Care Practices	Call Center Partner	UMD, Pharma Dept
Strategy 1	1,027,763.62	488,753.43	369,578.75	500,000.00	131,328.00	192,780.00	125,684.00	
Strategy 2								895,500
Strategy 3		66,000.00						
Strategy 4								
Totals	$ 1,027,763.62	$ 554,753.43	$ 369,578.75	$ 500,000.00	$ 131,328.00	$ 192,780.00	$ 125,684.00	$ 895,500

Implementation Plan (Response limited to 300 words)

The Implementation Plan's categories each have milestones that show how each strategy will move from a planning to implementation phase and then to expansion phase in later years. **Strategy #1 –** Administrative/Infrastructure includes outreach and building awareness, governance, financial sustainability, and IT. The Clinical Improvement includes patient screening, monitoring hospital and eQHealth care coordination, monitor progress on high needs patients, monitor RCA results for process improvements, integrate SNF, home health, and outpatient physician activities, and test 24/7 on call systems. **Strategy #2 –T**he Medication Management section defines criteria for the selection of patients, the testing of the tools, and the incorporation of the University of Maryland's pharmacy programs to optimize medication management, and the monitoring of results. **Strategy #3 –** The Support Physician Practices section identifies the working with practices with high needs patients and identifying how to serve their population within the TLC-MD process. Milestones include activity in CCM services and billings. **Strategy #4 –**Building the Learning Organization section includes testing results, identifying new initiatives based on RCA and patient interactions, Vitamin D testing, behavioral health enhancements through improved screening and proposing alternate workflows per geographic area.

Budget and Expenditures: Include budget for each intervention. (Response limited to 300 words)
Strategy #1 –$3,922,280.80. Our High-Needs Population will have services: home visits, patient and caregiver education, medication reconciliation, navigation for primary and specialty care, supportive services, care planning, and communication with physicians. A summary include reporting (33,850), predictive modeling (12,000), expanding clinics (1,247,771.75) patient transportation (1,568), physician co-pays (192,780), call center staffing (125,684),medicine management/behavioral interventions totaling (1,573,427.05), faith and community outreach (500,000), and patient engagement with telehealth technologies (235,200). **Strategy #2 –$1,201,664.80, which includes:** testing of Vitamin D levels during ED visit (6,272), use of medicine delivery system (203,212.80), issuance of non-medical equipment like scales (15,680), and medicine management or adherence for all tiers (976,500). **Strategy #3 – S271,600.00, which includes:** hosting CME meetings throughout the 3 counties each year. Plans include 11 events at $66,000 for location and food, $7,500 for the speakers, and $15,000 for CME fees. The distribution of patient literature on population health efforts (175,600) and CRISP outreach (7,500). **Strategy #4 –$816,360.00, which includes:** an Executive Director, Financial and Clinical Analysts (450,000), Consultant to assist Executive Director as needed to evaluate initiatives and keep the program moving forward (75,000), Project management of timeline (30,000), Metric management of timeline and results (30,000), Directors and Officers insurance (20,000), Audit/Finance fees (100,000), legal assistance with contracts and Q/A (50,000), website maintenance (30,000), and lab services for testing interventions (31,360).

West Baltimore Collaborative

Hospital/Applicant:	UMMC is the Lead/Application for the WBC
Date of Submission:	December 21, 2015
Health System Affiliation:	UMMC and UM Midtown, Saint Agnes and Bon Secours
Number of Interventions:	1
Total Budget Request ($):	$9,902,774

Target Patient Population (Response limited to 300 words)

The West Baltimore Collaborative will offer comprehensive, robust health management services through embedment in Primary Care Practices and remotely in the community. In the program's initial iteration, service will be offered to patients from member hospitals who meet defined criteria:

- **Criterion 1**: Patient is Medicare or Dually Eligible
- **Criterion 2**: Patient had 3 or more bedded hospital encounters of great than 24 hours as an Inpatient, Observation, or ED setting
- **Criterion 3**: Patient suffers from 2 or more chronic conditions
- **Criterion 4**: Patient does not suffer from a Major Mental Diagnosis (Bipolarity, Schizophrenia, other psychotic disorder). This criterion does not include patients with Depression, anxiety, substance abuse, or and related illness.

In the future, the program criteria will be expanded to offer services to all payers and those with Major Mental diagnoses.

Summary of program or model for each program intervention to be implemented. Include start date, and workforce and infrastructure needs (Response limited to 300 words)

The WBC is a comprehensive collaboration, governed by four institutions within Baltimore City: University of Maryland Medical Center, UMMC Midtown Campus, St. Agnes and Bon Secours. These institutions, through the WBC, will contract with the University of Maryland Medical System's Population Health Services Organization to provide comprehensive, robust care management services to the target patient population. Staff, including RN/Care Managers, Social Workers and Community Health Workers will divide into teams, servicing a fixed number of identified patients. These team members will embed in affiliated primary care practices or engage patients in the community. Telephonic support will also be provided. Ancillary staff will operate out of a centralized data hub, including Clinical Pharmacists for medical reconciliations, Practice Transformation Experts who will assess primary care practices based on quality and cost data and aid in development of care practices for the target patient populations, and IT/Analysts, who would ensure operability of phone and computer connectivity, attribution software management and data analysis. Ramp up to operability would commence upon grant award, with initial service delivery to patients beginning on April 4, 2016.

Measurement and Outcomes Goals (Response limited to 300 words)
WBC will evaluate identified outcome, process and ROI metrics provided in the application as the program proceeds through rollout to full functionality and beyond. Understanding that the HSCRC and others, including CRISP, are still refining the recommended set of metrics, the WBC will make any necessary adjustments as the process evolves. Programmatic Metrics will include: Does the patient have an appointment with a primary care provider prior to discharge and within 7 days of discharge; Did the patient connect with the scheduled primary care provider; Reduce emergency room visit rates; Reduce readmission rates; Was medication reconciliation completed prior to discharge; Was a follow-up call by the transitions team completed within 72 hours; Home visits within 30 days are completed; Care Plans will be completed on all patients in care management; HEDIS and MU measures for program; Total hospital cost per capita; Total hospital admits per capita; Total healthcare cost per person; ED visits per capita. These metrics, while focused on programs, also lend to the overarching outcome metrics captured in the Core Outcomes Measures listed in Table A of the Implementation Grant Request for Proposals. Measures germane to the program, including reduction of PAUs, readmissions, and avoidable utilization of the emergency department will be captured.
Return on Investment. Total Cost of Care Savings. (Response limited to 300 words)
The ROI calculated for the years 2017-2019 are: **0.90, 1.40, and 1.32**, respectively. By shifting avoidable acute care to more cost effective care in the primary care and community-based settings, the intervention will inherently save payers money. Since the program is expected to positively impact PAUs and PQIs, WBC will re-invest these savings to expand the proposed program for continued cost savings. Specifically, WBC is strategically planning to focus on the Medicare and a portion of the dual eligible high utilizers. Based upon total PAU dollars and WBC financial model, it is anticipated that PAUs for the target patient population will be cut up to 15%. This utilization reduction will generate savings towards the $33 million required by the State to meet the waiver requirement. The WBC will reinvest in the program and scale to include other dual eligible, Medicaid and commercial payers with the goal of meeting the waiver requirements to achieve the mandate of an all payer system.
Scalability and Sustainability Plan (Response limited to 300 words)

Scalability will be based on potential savings reinvestment, permitting model expansion of more robust staffing and infrastructure. This expansion will permit the program to change the program criteria to be more inclusive, with the ultimate aim of offering WBC services to high utilizers in all payers.

Sustainability will be based on reduction of PAUs, and it is anticipated these generated savings will be reinvested in the program. Additionally, physician alignment, so crucial to the success of the program, will be encouraged via practice transformation efforts to effectively manage chronic high utilizers and enable participating physicians to capture Medicare CCM fees. Development of saving sharing programs with physicians within legal limits are currently being explored and will be crucial to the speed of the WBC's success.

Participating Partners and Decision-making Process. Include amount allocated to each partner. (Response limited to 300 words)
The primary participants in the WBC are the four member hospitals: UMMC, UMMC Midtown Campus, St. Agnes and Bon Secours. Additionally a number of affiliated and independent entities and practitioners have manifested intent to participate in and support the efforts of the WBC by submitted Letters of Intent and Letters of Support. The WBC will be managed through a governance structure, consisting of the West Baltimore Governing Council, which is made up of leadership of four (4) member hospitals, and a Management Committee, consisting of WBC hospital staff and the WBC Director. The Governing Council will receive input from a Medical Advisory Committee and a Patient and Community Advisory Council. Decisions made by the WBC, through its governance structure will include: decisions regarding the scope of partners' and participant involvement, monitoring programmatic design to achieve targeted patient and financial outcomes, monitoring funds flow, directing decisions regarding program management, directing decisions on vendor contract and decisions affecting savings management
Implementation Plan (Response limited to 300 words)
Within the first months of funded operation, the WBC will bring organizational infrastructure online and begin program operations, endeavoring to meet the following schedule: Upon grant award: Patients identified as eligible will be contacted; Securing program's physical space will occur; A refresh of inter-hospital data to confirm accuracy of metrics and patient capture; If necessary, program scalability will occur; Model implementation for Medicare and Dual Eligible Patients will commence at the member institutions; Candidate evaluations based upon prior position publication will commence; and WBC appoints interim program Director to provide day-to-day leadership during recruitment process. Within 30 days of grant award: Participating hospitals will execute a Memoranda of Understanding, which will dictate member association and organizational structure; FQHCs, hospital-affiliated practices and community-based physicians will begin to execute Participation Agreements; Vetting of potential hires will continue; and the beginning of the hiring process will commence. Within 60 days of grant award: Initiation of practice assessments to identify practice needs and provide appropriate resources and support. Within 90 days of grant award: Enrollment of patients into the program will begin.

Budget and Expenditures: Include budget for each intervention. (Response limited to 300 words)
The WBC budget includes ramp up costs that are fixed to bring the needs of the program's infrastructure to full capability within the first year. The budget captures not only clinical staff, but administrative and analytical staff needed for ongoing data collection and reporting. The WBC has decided that the investment in the UMMS PHSO strategy for clinical services in the community will maximize the full potential of the monies requested; moreover, the centralized strategy allows for well-coordinated care and care management resources that are necessary to meet the needs of the West Baltimore community. The WBC is committed to supporting the community physicians and thereby making the investment in transforming primary care practices prior to the embedment of RN/CMs and their teams. It is anticipated that 100% of the programs described above will be funded by the requested grant amount.

HSCRC
FY 2015 Community Benefit Report Findings

Steve Ports, Principal Deputy Director

October 19, 2016

Findings from FY 2015 Summary Report

- FY15 – total of 53 hospitals: 48 acute and 5 specialty hospitals
  - (Holy Cross Germantown new hospital and Levindale categorized as an acute hospital rather than a specialty hospital)
- FY14 – total of 52 hospitals: 46 acute and 6 specialty hospitals
- Reported Total Community Benefits
  - FY 15 – $1.5 billion
  - FY 14 – $1.5 billion
- CBR Dollars as a Percentage of Hospital Operating Expenses
  - FY 15 – Ranging from 3.03% to 45.06% - total of 10.8%
  - FY 14 – Ranging from 2.61% to 27.46% - total of 10.6%
- Staff Hours Dedicated to CB
  - FY15 – Average 1,803 hours
  - FY 14– Average 1,514 hours

Offsetting Charity Care, DME, and NSPI

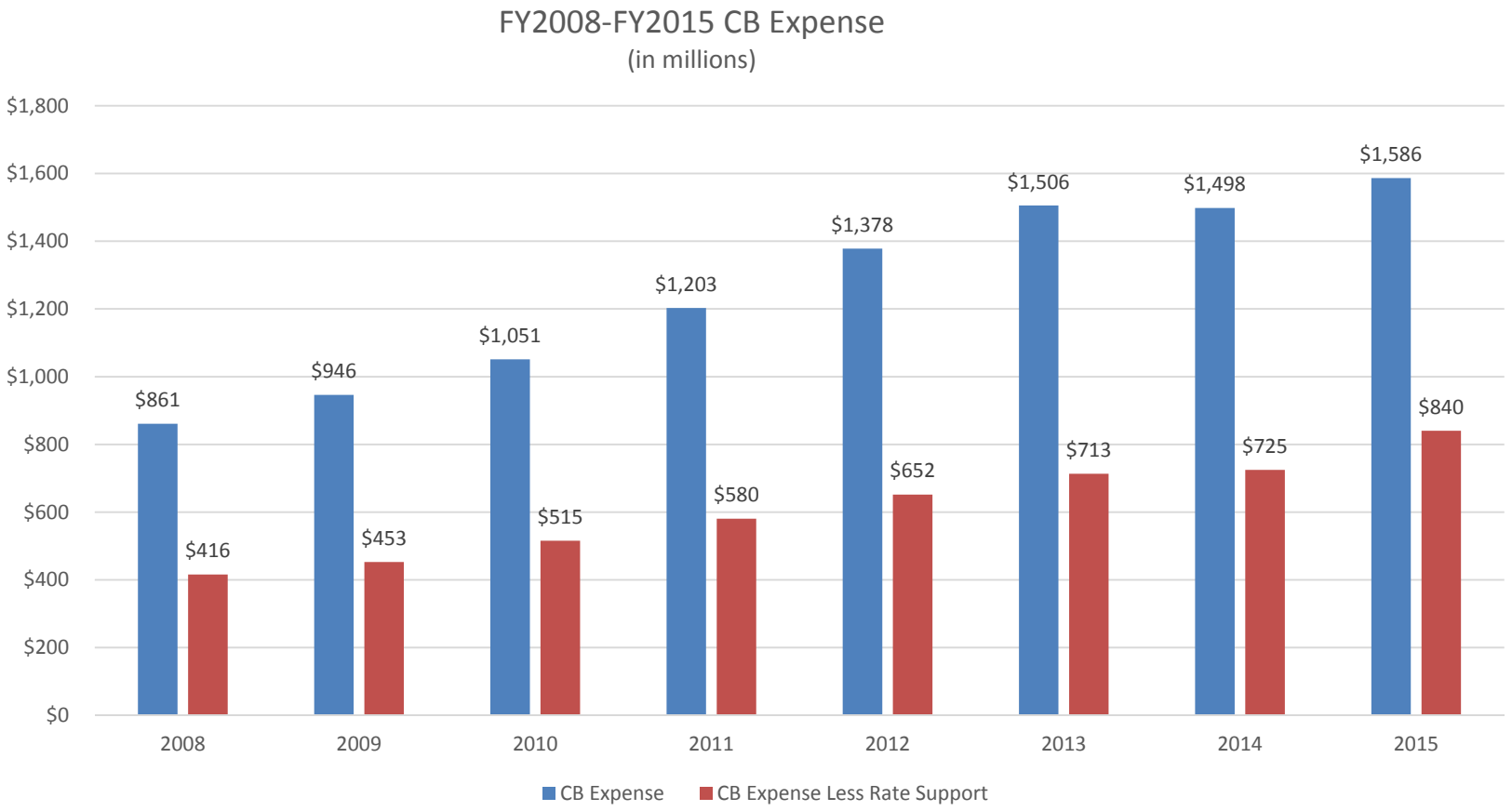
- 2015 Charity Care DME and NSPI Rate Funding:
  - Charity Care - $428.1 million
  - DME - $302.6 million
  - NSPI - $15.3 million

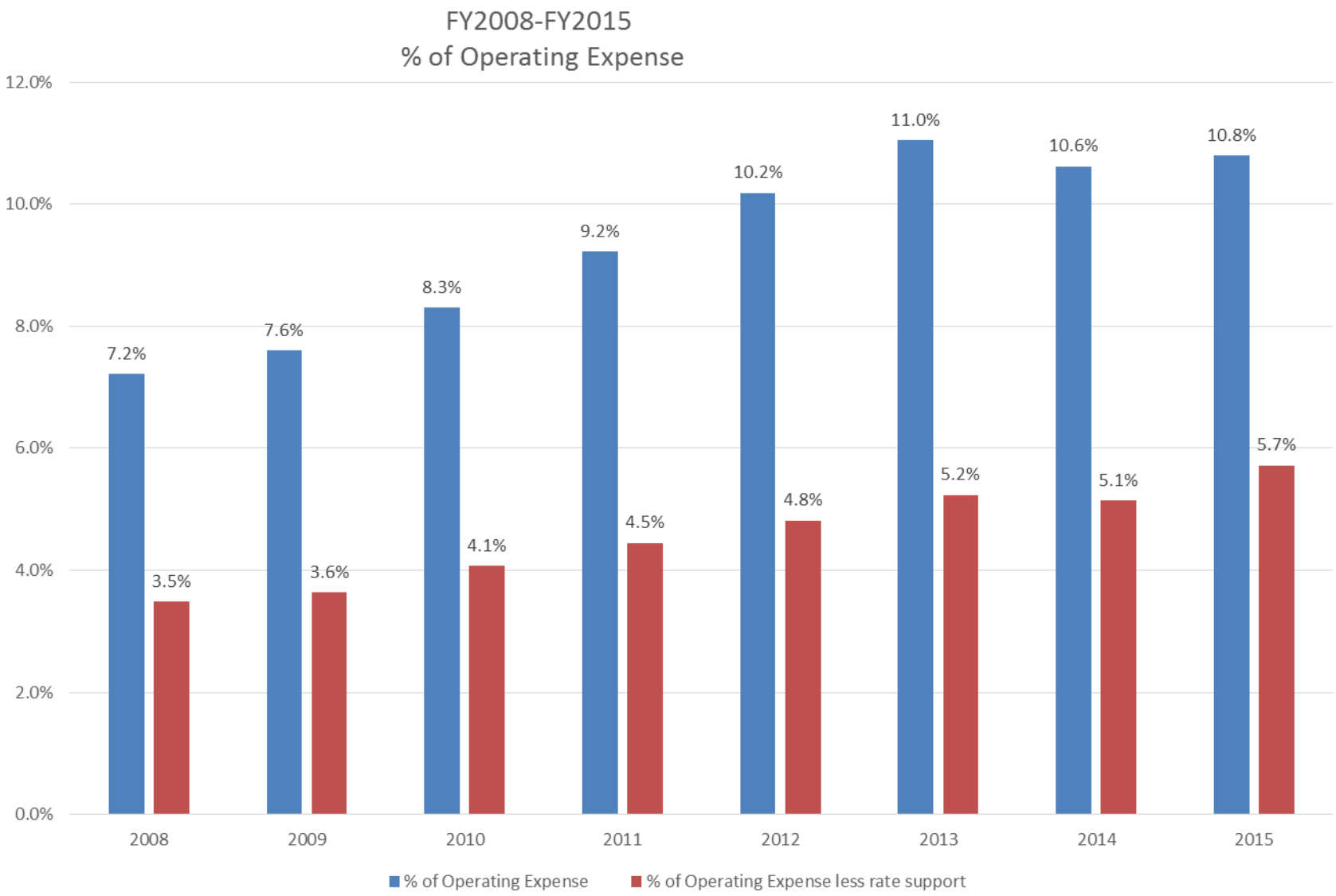
- Total Net Community Benefit Expenditures
  - 2015 - $840.3 million (5.72% of expenses)
  - 2014 - $724.7 million (5.14% of expenses)

- In FY 15 Hospitals provided $43.6 million more in Charity Care and Medicaid expansion services than was provided in rates.
  - Charity Care - $362.6 million
  - ACA Medicaid expansion services - $109.1 million in expanded utilization by formerly uninsured and underinsured population, not included in hospitals' Global Budgets

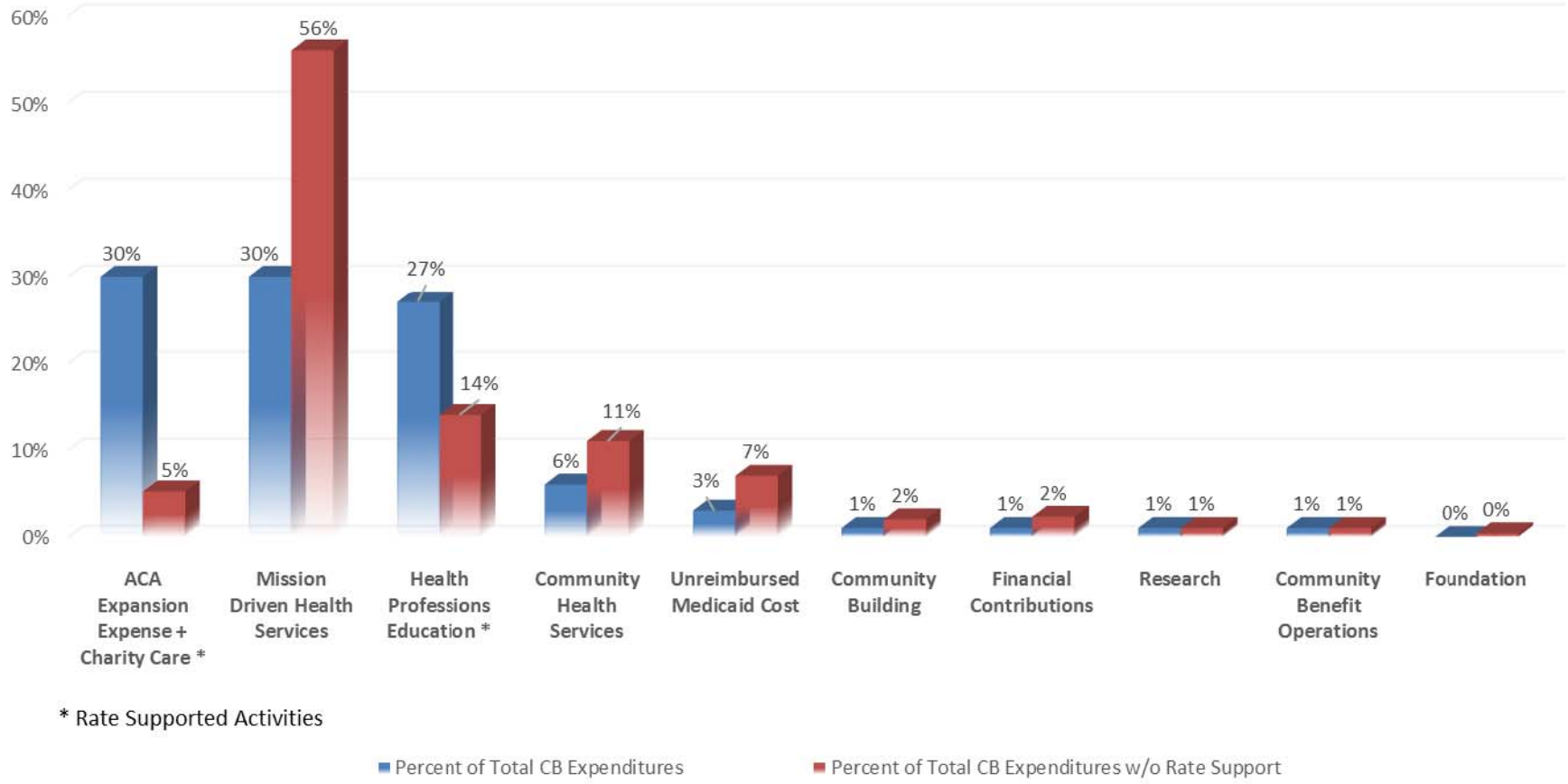
FY2008-FY2015 Community Benefit Expenditures

- Increase from $861 million to $1.5 billion




FY2008-FY2015
% of Operating Expense
12.0%
10.0%
8.0%
6.0%
4.0%
2.0%
0.0%
7.2%
3.5%
7.6%
3.6%
8.3%
4.1%
9.2%
4.5%
10.2%
4.8%
11.0%
5.2%
10.6%
5.1%
10.8%
5.7%
2008
2009
2010
2011
2012
2013
2014
2015
% of Operating Expense
% of Operating Expense less rate support

FY15 PERCENT OF CB EXPENDITURES WITH AND WITHOUT RATE SUPPORT



Narrative Highlights

- Hospital defined ‘Community Benefit Service Area’ driven by following need related factors:
    - Prevalence of poverty
    - Infants with low birth weight
    - Specific diseases or conditions
    - Predominant areas of residence for charity care patients
    - Designation as a medically underserved area
- Primary Health Needs to be addressed by Community Benefit Initiatives:
    - Access to care
    - Behavioral health
    - Substance abuse/addiction
    - Obesity
    - Diabetes
    - Cancer
    - Heart disease/hypertension/stroke
    - Healthy lifestyle
- Primary Needs to be addressed that are associated with social determinants of health:
    - Housing
    - Economic factors
    - Access to healthy food
    - Employment
    - Advocacy
    - Education

Observations

- Dollars and effort toward CB has continued to grow in FY 2015
- Reductions in the percentage of charity care may impact the total amount invested in CB going forward
- The quality of the narrative reporting is getting better but still room for improvement
  - Describing information gaps impacting ability to assess needs of community
  - Describing process and methods to conduct CHNA's
  - Prioritizing community needs with criteria
  - Explanation of unmet needs
- HSCRC has contracted with the Hilltop Institute for three years:
  - Automate the collection and aggregation of the community benefit data
  - Align the reporting process with the federal standards wherever possible
  - Align the reporting with the "all payer model measures" wherever possible
  - Create community benefit report dashboards for public use

Maryland Hospital Community Benefit Report: FY 2015

October 19, 2016

Health Services Cost Review Commission
4160 Patterson Avenue
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Table of Contents

LIST OF ABREVIATIONS

ACA	Patient Protection and Affordable Care Act
CB	Community benefit
CBR	Community benefit report
CBSA	Community benefits service area
CHNA	Community health needs assessment
DME	Direct medical education
FY	Fiscal year
HSCRC	Health Services Cost Review Commission
IRC	Internal Revenue Code
IRS	Internal Revenue Service
LHIC	Local Health Improvement Coalition
MHA	Maryland Hospital Association
NSPI	Nurse Support Program I
VHA	Voluntary Hospitals of America

INTRODUCTION

Each year, the Maryland Health Services Cost Review Commission (HSCRC) collects community benefit information from individual hospitals to compile into a publicly available, statewide Community Benefit Report (CBR). Current year and previous CBRs submitted by the individual hospitals are available on the HSCRC website.

This summary report provides background information on hospital community benefits and the history of CBRs in Maryland. It is followed by an overview of the data and narrative reporting for fiscal year (FY) 2015, which includes the second year of reporting from Maryland specialty hospitals. It concludes with a summary of data reports from the past twelve years. Attachments present additional information regarding hospital rate support, community benefit data for each hospital, and the breakdown of costs by community benefit activity.

Background

Section 501(c)(3) of the Internal Revenue Code (IRC) identifies as tax-exempt, organizations that are organized and operated exclusively for specific purposes including religious, charitable, scientific, and educational purposes.[1] Nonprofit hospitals receive many benefits from their tax-exempt status. They are generally exempted from federal income and unemployment taxes, as well as state and local income, property, and sales taxes. In addition, they are allowed to raise funds through tax-deductible donations and tax-exempt bond financing.

Originally, the Internal Revenue Service (IRS) considered hospitals to be "charitable" if they provided charity care to the extent of their financial ability to do so.[2] However, in 1969, the IRS issued Revenue Ruling 69-545, which modified the "charitable" standard to focus on "community benefits" rather than "charity care."[3] Under this IRS ruling, nonprofit hospitals are required to provide benefits to the community in order to be considered charitable. This has created the "community benefit standard," which is necessary for hospitals to satisfy in order to qualify for tax-exempt status.

In March 2010, Congress passed the Patient Protection and Affordable Care Act (ACA).[4] Section 9007 of the ACA established IRC §501(r), which identifies additional requirements for hospitals that seek to maintain tax-exempt status. Every §501(c)(3) hospital, whether independent or part of a hospital system, must conduct a community health needs assessment (CHNA) at least once every three years in order to maintain its tax-exempt status and avoid an annual penalty of up to $50,000.[5] The first CHNA was due by the end of FY 2013. Assessments must incorporate input

[1] 26 U.S.C. §501(c)(3)
[2] Rev. Ruling 56-185, 1956-1 C.B. 202.
[3] Rev. Ruling 69-545, 1969-2 C.B. 117.
[4] The Patient Protection and Affordable Care Act, P.L. 111-148 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152.
[5] 26 U.S.C. §501(r)(3); 26 U.S.C. §4959

from individuals who represent the broad interests of the communities served, including those with special knowledge or expertise in public health, and they must be made widely available to the public.[6] CHNAs must include an implementation strategy describing how the hospital plans to meet the community's health needs, as well as a description of what the hospital has done historically to address its community's needs.[7] Furthermore, the hospital must identify any needs that have not been met by the hospital and explain why they have not been addressed. Tax-exempt hospitals must report this information on Schedule H of IRS form 990.

The Maryland CBR process was adopted by the Maryland General Assembly in 2001,[8] and FY 2004 was established as the first data-collection period. Under Maryland law, CBRs must include the hospital's mission statement, a list of the hospital's initiatives, the cost of each community benefit initiative, the objectives of each community benefit initiative, a description of efforts taken to evaluate the effectiveness of initiatives, a description of gaps in the availability of specialist providers, and a description of the hospital's efforts to track and reduce health disparities in the community.[9]

The HSCRC worked with the Maryland Hospital Association (MHA), interested hospitals, local health departments, and health policy organizations and associations to establish the details and format of the CBR. In developing the format for data collection, the group relied heavily on the experience of the Voluntary Hospitals of America (VHA) community benefit process. At the time, the VHA possessed more than ten years of voluntary hospital community benefit reporting experience across many states. The resulting data reporting spreadsheet and instructions were used by Maryland hospitals to submit their FY 2004 data to the HSCRC which resulted in the publishing of the first annual CBR in July 2005. The HSCRC continues to work with the MHA, public health officials, individual hospitals, and other stakeholders to further improve the reporting process and refine the definitions, as needed. The data-collection process offers an opportunity for each Maryland nonprofit hospital to critically review and report the activities it has designed to benefit the community.

The FY 2015 report represents the HSCRC's twelfth year of reporting on Maryland hospital community benefit data.

Definition of Community Benefits

Maryland law defines a "community benefit" (CB) as an activity that is intended to address community needs and priorities, primarily through disease prevention and improvement of health status, including:[10]

- Health services provided to vulnerable and underserved populations

[6] 26 U.S.C. §501(r)(3)(B)
[7] 26 U.S.C. §501(r)(3)(A)
[8] Health-General Article §19-303 Maryland Annotated Code
[9] Health-General Article §19-303(a)(3) Maryland Annotated Code
[10] Health-General Article §19-303(c)(2) Maryland Annotated Code

- Financial or in-kind support of public health programs
- Donations of funds, property, and other resources that contribute to a community priority
- Health care cost-containment activities
- Health education screening and prevention services

As evidenced in the individual CBRs, Maryland hospitals provide a broad range of health services to meet the needs of their communities, often receiving partial or no compensation. These activities, however, are expected from Maryland's 48 acute and seven specialty nonprofit hospitals in return for their tax-exempt status.

ANALYSIS

Following are highlights of the FY 2015 data reporting and narrative reporting.

FY 2015 Data Reporting Highlights

The reporting period for this CBR is July 1, 2014, through June 30, 2015. Hospitals submitted their individual CBRs to the HSCRC by December 15, 2015. Audited financial statements were used to calculate the cost of each of the community benefit categories contained in the data reports. Of the 55 nonprofit hospitals in Maryland, 52 submitted individual data reports. Two hospital systems, University of Maryland Shore Regional Health and the University of Maryland Upper Chesapeake Health, submitted narratives covering both hospitals in their system. Shore Health submitted a single narrative covering both the University of Maryland Shore Medical Center at Easton and the University of Maryland Shore Medical Center at Dorchester. Upper Chesapeake Health submitted a single narrative covering both the University of Maryland Upper Chesapeake Medical Center and the University of Maryland Harford Memorial Hospital. Two specialty hospitals did not file a report for FY 2015.

As shown in Table 1, Maryland hospitals provided just over $1.5 billion dollars in total community benefit activities in FY 2015 – a total that is slightly higher than that in FY 2014. The FY 2015 total comprises net community benefit expenses of $471.7 million in combined charity care and Medicaid expansion services due to the ACA, $468.6 million in mission-driven health care services (subsidized health services), $435.8 million in health professions education, $362.6 million in charity care, $91.3 million in community health services, $56.5 million in unreimbursed Medicaid costs, $21 million in community-building activities, $16.6 million in financial contributions, $10.9 million in community benefit operations, $10.8 million in research activities, and $3.2 million in foundation-funded community benefits. These totals include hospital-reported indirect costs, which vary by hospital and by category from a fixed dollar amount to a calculated percentage of the hospital's reported direct costs.

Table 1. Total Community Benefits

Community Benefit Category	Number of Staff Hours	Number of Encounters	Net Community Benefit Expense	Percentage of Total Community Benefit Expenditures	Net Community Benefit Expense Less Rate Support	Percentage of Total Community Benefit Expenditures without Rate Support
Unreimbursed Medicaid Cost	0	0	56,475,886	3.56%	56,475,886	6.72%
Community Health Services	1,047,380	4,082,976	91,349,595	5.76%	91,349,595	10.87%
Health Professions Education *	6,810,049	173,372	435,849,333	27.47%	117,891,257	14.03%
Mission Driven Health Services	2,519,324	781,989	468,569,852	29.54%	468,569,852	55.76%
Research	101,193	5,909	10,819,734	0.68%	10,819,734	1.29%
Financial Contributions	35,605	187,456	16,578,083	1.04%	16,578,083	1.97%
Community Building	241,527	554,013	20,983,322	1.32%	20,983,322	2.50%
Community Benefit Operations	95,550	2,974	10,872,915	0.69%	10,872,915	1.29%
Foundation	63,332	11,721	3,218,210	0.20%	3,218,210	0.38%
Charity Care*	0	0	362,585,727	22.86%	(65,556,478)	-7.80%
ACA Medicaid Expansion Expense	0	0	109,137,135	6.88%	109,137,135	12.99%
Charity Care* + ACA Medicaid Expansion Expense	0	0	471,722,861	29.73%	43,580,656	5.19%
Total	**10,913,958**	**5,800,412**	**$1,586,439,791**	**100.0%**	**$840,339,510**	**100.0%**

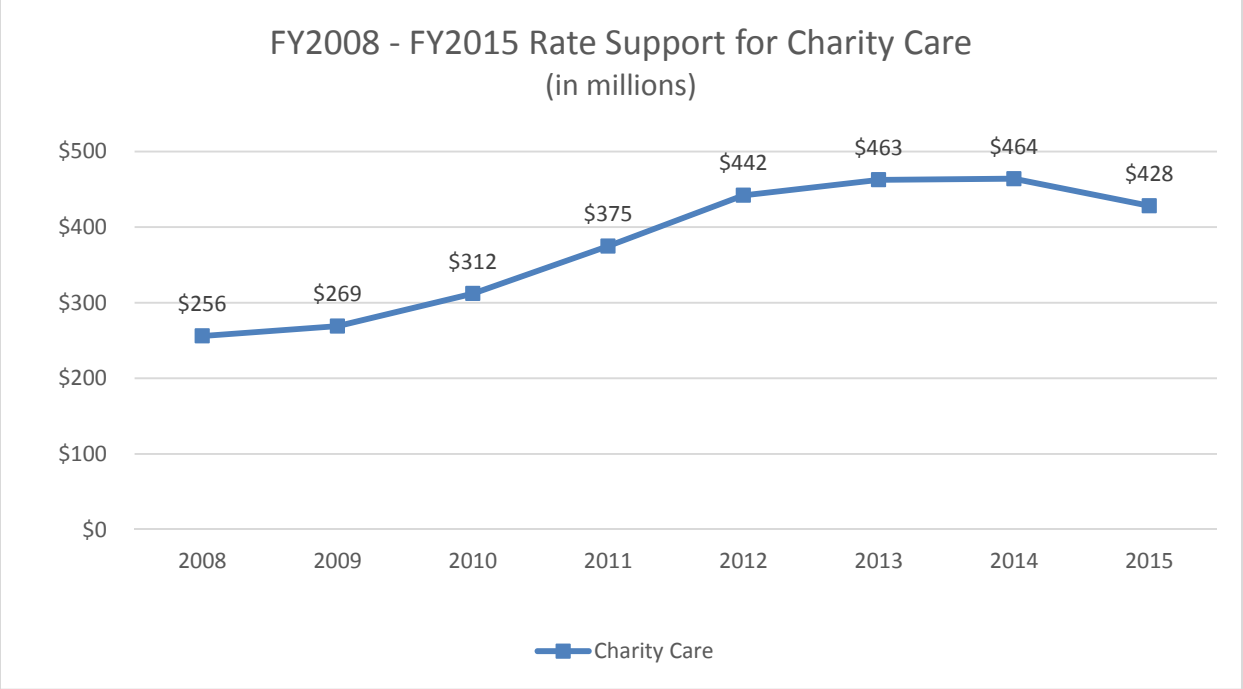
(*) Indicates category adjusted for rate support (i.e., direct medical education, Nurse Support Program I, and charity care).

In Maryland, the costs of uncompensated care (including charity care and bad debt) and graduate medical education are built into the rates for which hospitals are reimbursed by all payers, including Medicare and Medicaid. Additionally, the HSCRC rates include amounts for nurse support programs provided at Maryland hospitals. These costs are, in essence, "passed-through" to the purchasers and payers of hospital care. To comply with IRS form 990 requirements and avoid accounting confusion among programs that are not funded by hospital rate setting, the HSCRC requests that hospitals exclude from their reports all revenue that is included in rates as offsetting revenue on the CBR worksheet. Attachment I details the amounts that were included in rates and funded by all payers for charity care, direct graduate medical education, and nurse support programs in FY 2015.

As noted, the HSCRC includes a provision in hospital rates for uncompensated care, which includes charity care, because it is considered to be a community benefit. It also includes bad debt, which is not considered to be a community benefit. As the need for charity care declined after the implementation of the ACA, and amounts provided in rates were reduced, hospitals incurred the expenses of formerly uninsured and underinsured individuals increasing their utilization of hospital services after enrolling in Medicaid. The HSCRC analyzed the enrollment and utilization data and calculated that $109.1 million in expanded services qualify as a community benefit expense to be included in the FY 2015 report.

Figure 1 shows the rate support for charity care from FY 2008 through FY 2015. The rate support for charity care continuously increased from FY 2008 through FY 2013 and then began to gradually decline in FY 2014 due to implementation of the ACA. Attachment I shows that $428.1 million in charity care was provided through Maryland hospital rates in FY 2015 and funded by all payers. When offset by the $362.6 million in charity care reported by hospitals, and the $109.1 million in expanded services to the Medicaid population, the net amount of charity and ACA Medicaid expansion services provided by the hospitals and not through rates is $43.6 million dollars

Figure 1. Rate Support for Charity Care, FY 2008 through FY 2015



Another social cost funded through Maryland's rate-setting system is the cost of graduate medical education, generally for interns and residents who are trained in Maryland hospitals. Included in graduate medical education costs are the direct costs (i.e., direct medical education, DME), which include the residents' and interns' wages and benefits, faculty supervisory expenses, and allocated overhead. The HSCRC's annual cost report quantifies the DME costs of physician training programs at Maryland hospitals. In FY 2015, DME costs totaled $302.6 million.

The HSCRC's Nurse Support Program I (NSPI) is aimed at addressing the short- and long-term nursing shortage impacting Maryland hospitals. In FY 2015, $15.3 million was provided in hospital rate adjustments for NSPI. See Attachment I for detailed information about rate funding provided to specific hospitals.

When the reported community benefit costs for Maryland hospitals were offset by rate support, the net community benefits provided in FY 2015 totaled $840.3 million, or 5.72 percent of total hospital operating expenses. This is an increase from the $724.6 million in net benefits provided in FY 2014, which totaled 5.14 percent of hospital operating expenses (see Attachment II: FY 2015 Community Benefit Analysis for additional detail).

Table 2 shows the breakdown of staff hours, number of encounters, and expenditures for health professions education by activity. The education of physicians and medical students comprises the majority of expenses in the category of health professions education, totaling $379.4 million.

The second highest category is the education of nurses and nursing students, totaling $27.2 million. The education of other health professionals totaled $19.4 million.

Table 2. Health Professions Education Activities and Costs, FY 2015

Health Professions Education	Number of Staff Hours	Number of Encounters	Net Community Benefit with Indirect Cost
Physicians and Medical Students	5,841,483	38,141	$ 379,449,051
Nurses and Nursing Students	475,296	55,322	$ 27,203,753
Other Health Professionals	343,259	51,893	$ 19,352,956
Other	142,392	26,178	$ 6,640,883
Scholarships and Funding for Professional Education	7,619	1,838	$ 3,202,739
Total	**6,810,049**	**173,372**	**$ 435,839,332**

Table 3 presents the number of staff hours, number of encounters, and expenditures for community health services by activity. Health care support services comprise the largest portion of expenses in the category of community health services, totaling $40.7 million. Community health education is the second highest category, totaling $25.5 million, and the "other" category is the third highest, totaling $8.2 million. For additional detail and a description of subcategories of the remaining community benefit categories, see Attachment III: FY 2015 Hospital Community Benefit Aggregate Data.

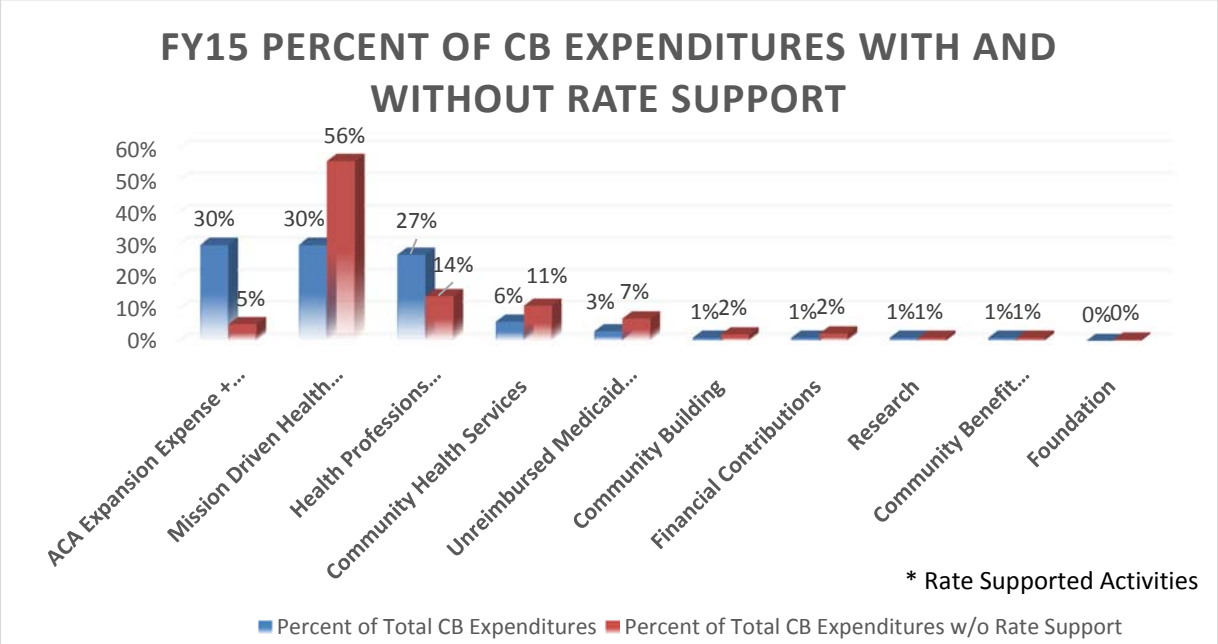
Table 3. Community Health Services Activities and Costs, FY 2015

Community Health Services	Number of Staff Hours	Number of Encounters	Net Community Benefit With Indirect Cost
Health Care Support Services	250,379	190,090	$ 40,713,064
Community Health Education	299,811	3,083,111	$ 25,461,832
Other	57,738	129,276	$ 8,197,656
Community-Based Clinical Services	280,714	358,387	$ 6,457,454
Free Clinics	42,497	33,112	$ 3,861,581
Screenings	40,749	53,970	$ 2,832,583
Self-Help (Wellness and Health Promotion Programs)	26,557	179,657	$ 1,566,072
Support Groups	15,206	26,288	$ 1,384,292
Mobile Units	30,081	11,658	$ 511,841
One-Time and Occasionally Held Clinics	3,649	17,427	$ 363,220
Total	**1,047,380**	**4,082,976**	**$ 91,349,595**

Rate offsetting significantly affects the distribution of expenses by category. Figure 2 shows expenditures in each community benefit category as a percentage of total expenditures. ACA

expansion expenses and charity care, mission-driven health services, and health profession education represent the majority of the expenses, at 30 percent, 30 percent, and 27 percent, respectively. Figure 2 also shows the percentage of expenditures by category without rate support, which changes the configuration significantly: Mission-driven health services becomes the category with the highest percentage of expenditures, at 56 percent. Health professions education follows, with 14 percent of expenditures, and community health services comprises 11 percent of expenditures.

Figure 2. Percentage of Community Benefit Expenditures by Category with and without Rate Support



Utilizing the data reported, Attachment II: FY 2015 Community Benefit Analysis compares hospitals on the total amount of community benefits reported, the amount of community benefits recovered through HSCRC-approved rate supports (i.e., charity care, direct medical education, and nurse support), and the number of staff and staff hours dedicated to community benefit operations. On average, in FY 2015, 1,803 staff hours were dedicated to community benefit operations, an increase of 19 percent from 1,514 staff hours in FY 2014. Seven hospitals reported zero staff hours dedicated to community benefit operations, the same number as in FY 2014. The HSCRC continues to encourage hospitals to incorporate community benefit operations into their overall strategic planning.

The total amount of community benefit expenditures as a percentage of total operating expenses ranged from 3.03 percent to 45.06 percent, with an average of 10 percent. This is a decrease from an average of 10.47 percent in FY 2014. Fifteen hospitals reported providing benefits in excess of 10 percent of their operating expenses, compared with 22 hospitals in FY 2014. In addition, 21 hospitals reported providing benefits between 7.5 percent and 10 percent of their operating expenses, compared with 17 hospitals in FY 2014.

FY 2015 Narrative Reporting Highlights

Maryland's 53 hospital community benefit narrative reports were reviewed by a consultant on behalf of the HSCRC. There are five main sections in the narrative portion of the CBR: the community the hospital serves, the hospital's community benefit administration, external community benefit collaborations, the community's health needs and how they were identified, and the hospital's community benefit initiatives.

For the first section, hospitals are required to provide a detailed description of the community they serve, including a list of Community Benefits Service Area (CBSA) zip codes, and a description of how the CBSA was determined. Thirty-six hospitals provided an adequate description of their CBSA that included a list of CBSA zip codes. Only 20 hospitals reported that their CBSA determinations were driven by need-related factors. Examples of need-related factors included the prevalence of poverty, infants with low birth weight, specific diseases or conditions, predominant areas of residence for charity care patients, and designation as a medically underserved area.

The second section of the narrative report focuses on community benefit administration; hospitals answer a series of yes/no questions and provide related narrative descriptions. As shown in Table 4, all hospitals completed the required checklists, with all but two hospitals indicating that community benefit planning was part of the hospitals' strategic plan.

Table 4. Community Benefit Administration Summary, FY 2015

Question	Checklist Response		Provided Adequate Narrative Description
	Response = Yes	Response = No	
Is community benefits planning part of your hospital's strategic plan?	51	2	41
Are hospital stakeholders involved in the hospital's community benefit process/structure to implement and deliver community benefit activities?	53	0	43
Is there an internal audit of the HSCRC Community Benefit Inventory Spreadsheet?	50	3	37
Is there an internal audit of the HSCRC Community Benefit Narrative?	44	9	37
Is there Board approval of the HSCRC Community Benefit Inventory Spreadsheet?	45	8	
Is there Board approval of the HSCRC Community Benefit Narrative Report?	41	12	

FY 2015 was the first year in which the HSCRC required narrative descriptions for the community benefit administration section. Although many hospitals provided an adequate narrative description for the required questions, a substantial number did not.

"Community Benefit External Collaboration" was added as a new narrative report section in FY 2015. The first question asks whether hospitals engage in external collaboration with one of the following entities: other hospital organizations, local health departments, local health improvement coalitions, schools, behavioral health organizations, faith-based community organizations, and social service organizations. Forty-nine hospitals responded that they collaborated with at least one of the listed entities. When asked whether they collaborated with meaningful core partners to conduct the CHNA, 41 hospitals provided complete entries, and eight hospitals responded incompletely, omitting one or more of the required fields. The final question in this section concerns the hospital's participation and leadership in the Local Health Improvement Coalition (LHIC) for jurisdictions in which the hospital targets community benefit dollars. Of the 49 hospitals that responded, 37 indicated that a hospital representative attended LHIC meetings, and 17 indicated that a hospital representative chaired a relevant LHIC. Of the 14 hospitals in Baltimore City, ten indicated that they had neither led nor participated in an LHIC, and three of these hospitals responded that there were no active LHICs in Baltimore City.

The fourth section of the report focuses on the CHNA and implementation strategy. All 53 hospitals indicated that they had conducted a federally compliant CHNA within the previous three FYs, and 52 of the hospitals indicated that they had adopted a federally compliant implementation strategy. Table 5 displays the number of hospitals that addressed the 18 CHNA and implementation strategy elements that were developed based on federal requirements. The breadth and depth of the CHNAs and implementation strategies varied significantly from hospital to hospital.

Table 5. CHNA and Implementation Strategy Element Summary, FY 2015

CHNA and Implementation Strategy Element	Number of Hospitals Addressing
Adequate description of data sources	46
Description of analytical methods	45
Description of information gaps	20
Identification of collaborating organizations	48
Identification of third parties who assisted in conducting the CHNA	22
Qualifications of third parties who assisted in conducting the CHNA	16
A description of how hospital obtained community input from representatives of the broad interests of community	51
If organizational input was taken into account, organizations identified	40
Name and title supplied for organization(s) providing input	32

CHNA and Implementation Strategy Element	Number of Hospitals Addressing
Specific identification of public health experts providing input	15
Identification of public health experts by name, title, and affiliation	13
Description of public health experts' areas of expertise	3
Identification of leaders and representatives of specific populations providing input	7
A prioritized description of all of the community health needs identified through the CHNA	36
Description of process and criteria used to prioritize identified health needs	32
Description of the existing health care facilities and other resources in the community available to meet the CHNA-identified community health needs	27
Implementation strategy describes how the hospital facility plans to meet CHNA-identified community health needs	46
Implementation strategy identifies CHNA-identified needs that it does not intend to address and explains why the hospital does not intend to address them	27

The last section focuses on community benefit initiatives. Hospitals are asked to provide a clear and concise description of the primary needs identified in the CHNA, the principal objective of each evidence-based initiative, how the results of initiatives will be measured, and whether the outcome measures are aligned with measures such as the State Health Improvement Process and all-payer model monitoring measures. Collectively, hospitals reported 310 community benefit programs and initiatives to address a wide variety of community needs. The "primary needs" that these hospitals intended to address included: access to care, behavioral health, substance abuse/addiction, obesity, diabetes, cancer, heart disease/hypertension/stroke, healthy lifestyle, and other chronic diseases. Needs associated with social determinants of health (e.g., housing, economic factors, access to healthy food, employment, advocacy, and education) were the object of several initiatives.

FY 2004 – FY 2015 TWELVE-YEAR SUMMARY

FY 2015 marks the twelfth year since the inception of the CBR. In FY 2004, community benefit expenses represented $586.5 million, or 6.9 percent of operating expenses. In FY 2015, these expenses represented $1.5 billion, or 10 percent of operating expenses. As Maryland hospitals have increasingly focused on implementation of cost- and quality-improvement strategies, an increasing percentage of operating expenses has been directed toward community benefit initiatives.

The reporting requirement for revenue offsets and rate support has changed since the inception of the CBR in FY 2004. For consistency purposes, the following figures illustrate community benefit expenses from FY 2008 through FY 2015. Figures 3A and 3B show the trend of

community benefit expenses with and without rate support. On average, approximately 50 percent of expenses have been reimbursed through the rate-setting system.

Figure 3A. FY 2008 – FY 2015 Community Benefit Expenses with and without Rate Support

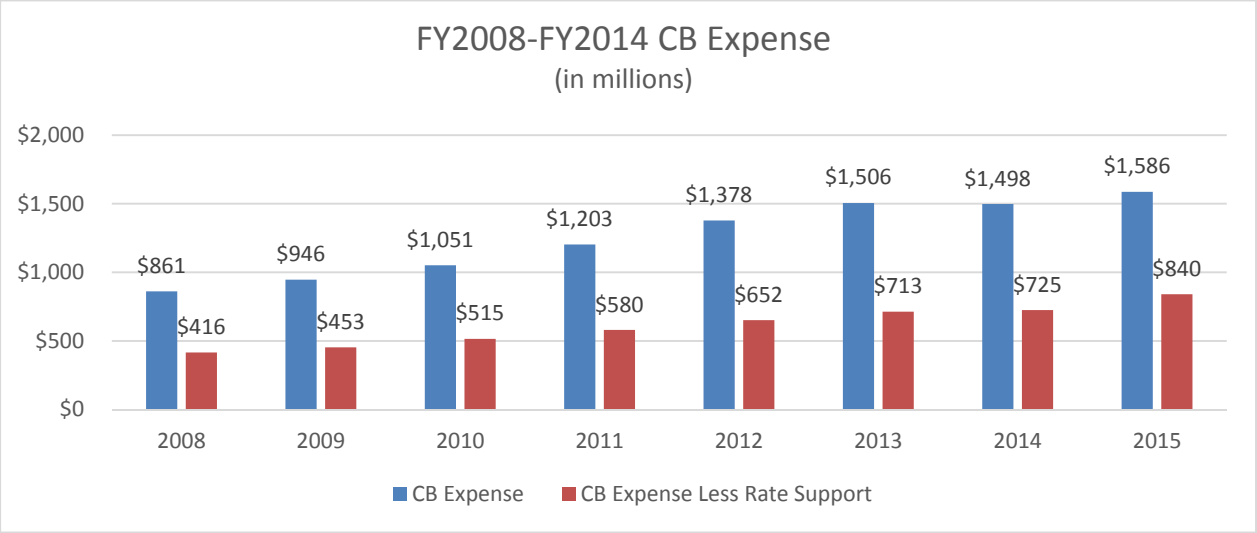
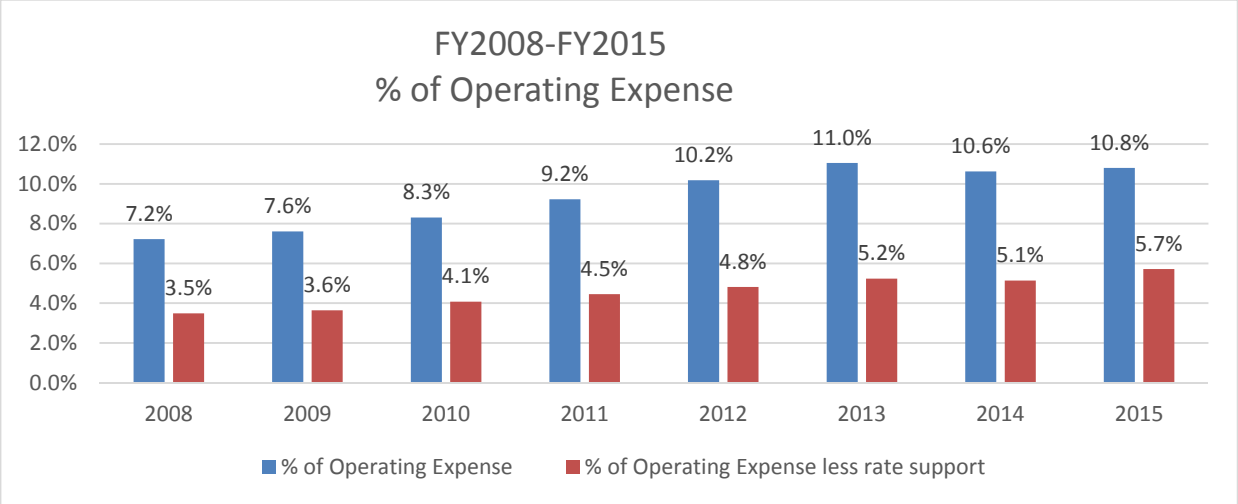


Figure 3B. FY 2008 – FY 2015 Community Benefit Expenses as a Percentage of Operating Expenses with and without Rate Support



CHANGES TO FY 2015 REPORTING REQUIREMENTS

The changes to Maryland's hospital narrative reporting requirements have resulted in more detailed narrative reports. For FY 2016, Section V. Hospital Community Benefit Program and Initiatives was updated to provide informational links to the CDC's website. Section VI. Physicians was updated to include a table to assist in the reporting of information related to physician subsidies. The HSCRC will continue to modify the community benefit reporting requirements to enhance consistency and improve evaluations.

Attachment I: Hospitals' FY 2015 Funding for Nurse Support Program I, Direct Medical Education, and Charity Care

Hospital Name	Nurse Support Program I (NSPI)	Direct Medical Education (DME)	Charity Care in Rates	Total Rate Support
Meritus Medical Center	$ 301,351	-	$ 5,020,441	$ 5,321,792
UMMC*	$ 1,430,282	$ 1,315,600	$ 57,147,372	$ 149,893,255
Dimensions Prince Georges Hospital Center	$ 249,193	$ 4,388,670	$ 24,439,746	$ 29,077,608
Holy Cross Hospital	$ 461,351	$ 2,658,000	$ 28,728,873	$ 31,848,224
Frederick Memorial	$ 337,094	-	$ 15,677,121	$ 16,014,215
UM Harford Memorial	$ 77,692	-	$ 3,182,027	$ 3,259,719
Mercy Medical Center	$ 470,760	$ 4,874,380	$ 15,019,122	$ 20,364,262
Johns Hopkins Hospital	$ 2,132,419	$ 110,114,790	$ 47,504,296	$ 159,751,505
UM Shore Medical Dorchester	$ 59,898	-	$ 1,266,421	$ 1,326,319
St. Agnes	$ 404,670	$ 6,863,970	$ 20,607,771	$ 27,876,411
LifeBridge Sinai	$ 684,517	$ 15,453,348	$ 4,699,062	$ 20,836,927
Bon Secours	$ 87,398	-	$ 5,832,640	$ 5,920,038
MedStar Franklin Square	$ 469,792	$ 8,467,280	$ 9,984,649	$ 18,921,721
Adventist Washington Adventist	$ 245,900	-	$ 18,531,753	$ 18,777,653
Garrett County Hospital	$ 42,302	-	$ 2,803,143	$ 2,845,445
MedStar Montgomery General	$ 166,869	-	$ 4,161,429	$ 4,328,299
Peninsula Regional	$ 412,642	-	$ 8,633,326	$ 9,045,967
Suburban Hospital	$ 280,579	$ 339,710	$ 5,164,263	$ 5,784,551
Anne Arundel Medical Center	$ 541,868	-	$ 3,814,644	$ 4,356,511
MedStar Union Memorial	$ 406,582	$ 11,093,490	$ 6,854,625	$ 18,354,697
Western Maryland Health System	$ 314,237	-	$ 10,430,905	$ 10,745,143
MedStar St. Mary's Hospital	$ 154,603	-	$ 2,105,531	$ 2,260,134
Johns Hopkins Bayview Medical Center	$ 596,807	$ 22,227,000	$ 17,582,500	$ 40,406,307
UM Shore Medical Chestertown	$ 62,792	-	$ 1,514,324	$ 1,577,116
Union Hospital of Cecil County	$ 153,373	-	$ 1,127,878	$ 1,281,251
Carroll Hospital Center	$ 249,075	-	$ 2,577,788	$ 2,826,863
MedStar Harbor Hospital	$ 201,141	$ 4,637,050	$ 4,375,595	$ 9,213,786
UM Charles Regional Medical Center	$ 137,004	-	$ 2,085,248	$ 2,222,252
UM Shore Medical Easton	$ 186,359	-	$ 3,758,169	$ 3,944,528
UM Midtown	$ 186,645	$ 4,028,360	$ 11,966,807	$ 16,181,812
Calvert Hospital	$ 138,863	-	$ 6,199,558	$ 6,338,421

Hospital Name	Nurse Support Program I (NSPI)	Direct Medical Education (DME)	Charity Care in Rates	Total Rate Support
Lifebridge Northwest Hospital	$ 248,253	-	$ 3,878,864	$ 4,127,117
UM Baltimore Washington	$ 376,813	$ 422,730	$ 10,775,825	$ 11,575,368
GBMC	$ 421,138	$ 4,976,560	$ 2,309,767	$ 7,707,465
McCready	$ 16,124	-	$ 218,521	$ 234,645
Howard County Hospital	$ 278,902	-	$ 4,378,119	$ 4,657,020
UM Upper Chesapeake	$ 190,046	-	$ 4,821,892	$ 5,011,938
Doctors Community	$ 216,855	-	$ 12,769,984	$ 12,986,838
Dimensions Laurel Regional Hospital	$ 121,542	-	$ 6,600,779	$ 6,722,321
Fort Washington Medical Center	$ 46,157	-	$ 1,281,924	$ 1,328,080
Atlantic General	$ 99,487	-	$ 3,941,120	$ 4,040,607
MedStar Southern Maryland	$ 289,967	-	$ 2,896,946	$ 3,186,913
UM St. Joseph	$ 337,662	-	$ 7,583,292	$ 7,920,954
Lifebridge Levindale	$ 53,610	-	$ 8,023,394	$ 8,077,004
Holy Cross Germantown Hospital	-	-	-	-
UM Rehabilitation and Ortho Institute	$ 83,135	$ 4,287,880	$ 99,264	$ 4,470,279
MedStar Good Samaritan	$ 295,737	$ 3,914,080	$ 873,884	$ 5,083,701
Adventist Rehab of Maryland	$ 50,000	-	-	$ 50,000
Adventist Behavioral Health at Eastern Shore	-	-	-	-
Sheppard Pratt	$ 137,929	$ 2,359,270	-	$ 2,497,199
Adventist Behavioral Health Rockville	-	$ 199,999	-	$ 199,999
Mt. Washington Pediatrics	$ 53,308	-	-	$ 53,308
Adventist Shady Grove Hospital	$ 375,190	-	$ 4,891,604	$ 5,266,794
Total	$ 15,335,909	$ 302,622,167	$ 428,142,205	$ 746,100,281

*Contains both UMMC and Shock Trauma

FY 2015 Analysis

Hospital	Hospital Name	Employees	Total Staff Hours CB Operations	Total Hospital Operating Expense	Total Community Benefit	FY 2015 Hospital Expense for Expanded Medicaid coverage due to ACA	Total Community Benefit W/Medicaid Expansion Expense	Total CB as % of Total Operating Expense	FY 2015 Amount in Rates for Charity Care, DME, and NSPI*	Total Net CB minus Charity Care, DME, NSPI in Rates + ACA Expansion Expense	Total Net CB(minus charity Care, DME, NSPI in Rates) as % of Operating Expense	CB Reported Charity Care
1	Meritus Medical Center	1984	826	298,834,515	21,327,823	877,147	22,204,969.56	7.14%	5,321,792	$16,883,178	5.65%	4,027,266
2	UMMC	8,244	1,002	1,362,492,000	207,723,792	16,635,897	224,359,689.14	15.25%	149,893,255	$74,466,435	5.47%	52,771,969
3	Dimensions Prince Georges Hospital Center	1,733	1,800	220,302,100	63,794,575	1,796,434	65,591,008.82	28.96%	29,077,608	$36,513,401	16.57%	15,079,327
4	Holy Cross Hospital	3,499	6,900	378,544,268	56,371,399	642,201	57,013,599.50	14.89%	31,848,224	$25,165,375	6.65%	29,924,630
5	Frederick Memorial	1740	0	323,272,000	27,152,850	2,320,849	29,473,698.84	8.40%	16,014,215	$13,459,484	4.16%	10,472,000
6	UM Harford Memorial	810	613	79,992,100	7,680,636	578,686	8,259,321.60	9.60%	3,259,719	$4,999,603	6.25%	3,080,091
8	Mercy Medical Center	3224	2,554	440,636,000	59,330,416	3,138,797	62,469,212.58	13.46%	20,364,262	$42,104,951	9.56%	17,927,395
9	Johns Hopkins Hospital	0	7,634	2,047,447,000	193,469,131	11,043,440	204,512,570.97	9.45%	159,751,505	$44,761,066	2.19%	30,276,000
10	UM Shore Medical Dorchester	649	375	38,814,754	4,850,285	993,488	5,843,772.53	12.50%	1,326,319	$4,517,453	11.64%	1,542,184
11	St. Agnes	2,734	0	415,945,815	34,708,326	8,971,993	43,680,318.72	8.34%	27,876,411	$15,803,907	3.80%	17,827,208
12	LifeBridge Sinai	4,713	7,643	690,482,000	50,421,644	2,384,635	52,806,279.30	7.30%	20,836,927	$31,969,352	4.63%	4,172,967
13	Bon Secours	725	0	111,386,997	9,648,218	(824,402)	8,823,816.50	8.66%	5,920,038	$2,903,778	2.61%	2,390,079
15	MedStar Franklin Square	3,426	2,714	486,989,680	29,884,752	5,209,403	35,094,155.00	6.14%	18,921,721	$16,172,434	3.32%	6,028,378
16	Adventist Washington Adventist*	1,354	4,256	213,524,356	36,176,232	3,074,905	39,251,137.48	16.94%	18,777,653	$20,473,484	9.59%	9,217,136
17	Garrett County Hospital	363	45	38,506,317	3,316,683	187,988	3,504,671.09	8.61%	2,845,445	$659,226	1.71%	2,561,792
18	MedStar Montgomery General	1,340	200	148,463,817	7,225,262	1,070,598	8,295,860.00	4.87%	4,328,299	$3,967,561	2.67%	3,172,151
19	Peninsula Regional	2,639	203	378,327,991	33,681,798	2,856,268	36,538,066.23	8.90%	9,045,967	$27,492,099	7.27%	6,622,800
22	Suburban Hospital	1,776	846	263,831,000	21,373,204	1,343,697	22,716,901.38	8.10%	5,784,551	$16,932,350	6.42%	4,093,000
23	Anne Arundel Medical Center	0	3,459	520,531,000	40,713,388	2,056,020	42,769,408.00	7.82%	4,356,511	$38,412,897	7.38%	2,703,700
24	MedStar Union Memorial	2,369	40	420,732,087	33,392,444	3,875,917	37,268,360.21	7.94%	18,354,697	$18,913,664	4.50%	4,022,477
27	Western Maryland Health System	1,826	245	290,767,947	36,954,026	1,439,182	38,393,208.22	12.71%	10,745,143	$27,648,065	9.51%	9,705,306
28	MedStar St. Mary's Hospital	1,200	8,720	139,396,080	9,866,196	1,071,770	10,937,965.50	7.08%	2,260,134	$8,677,831	6.23%	1,782,643
29	Johns Hopkins Bayview Medical Center	3,392	1,025	563,029,000	53,566,258	3,197,266	56,763,523.50	9.51%	40,406,307	$16,357,216	2.91%	16,531,000
30	UM Shore Medical Chestertown	330	742	49,362,348	8,186,910	671,315	8,858,224.19	16.59%	1,577,116	$7,281,108	14.75%	1,230,831
32	Union Hospital of Cecil County	1,082	2,189	150,962,001	7,690,587	1,893,165	9,583,752.00	5.09%	1,281,251	$8,302,501	5.50%	833,308
33	Carroll Hospital Center	2,179	2,100	219,182,979	15,118,006	1,962,553	17,080,558.91	6.90%	2,826,863	$14,253,696	6.50%	1,228,796
34	MedStar Harbor Hospital	1,185	198	191,580,981	19,108,297	2,059,139	21,167,436.00	9.97%	9,213,786	$11,953,650	6.24%	2,859,045
35	UM Charles Regional Medical Center	890	1,670	109,684,000	11,036,988	718,577	11,755,565.00	10.06%	2,222,252	$9,533,313	8.69%	1,464,645
37	UM Shore Medical Easton	1,353	960	169,250,126	15,738,036	1,851,904	17,589,940.04	9.30%	3,944,528	$13,645,412	8.06%	4,177,836
38	UM Midtown	1480	312	192,081,025	38,357,586	4,490,176	42,847,761.83	19.97%	16,181,812	$26,665,950	13.88%	13,771,000
39	Calvert Hospital	1,105	13	124,536,666	16,781,438	930,667	17,712,105.00	13.48%	6,338,421	$11,373,684	9.13%	3,943,515
40	Lifebridge Northwest Hospital	1,658	481	217,152,668	15,826,911	1,512,285	17,339,195.60	7.29%	4,127,117	$13,212,079	6.08%	3,226,996
43	UM Baltimore Washington	2,906	2,876	328,186,000	26,584,904	3,599,391	30,184,294.23	8.10%	11,575,368	$18,608,926	5.67%	8,041,930
44	GBMC	2,498	6,450	392,457,000	16,166,774	1,020,662	17,187,435.67	4.12%	7,707,465	$9,479,971	2.42%	1,674,433
45	McCready	0	26	14,814,155	502,427	146,796	649,222.52	3.39%	234,645	$414,578	2.80%	278,769
48	Howard County Hospital	1,754	1,712	237,010,000	18,479,755	832,540	19,312,294.74	7.80%	4,657,020	$14,655,275	6.18%	3,169,655
49	UM Upper Chesapeake	2,349	1,431	241,611,000	15,230,272	920,018	16,150,289.00	6.30%	5,011,938	$11,138,351	4.61%	4,942,659
51	Doctors Community	1,449	162	176,703,878	15,690,214	2,341,520	18,031,734.30	8.88%	12,986,838	$5,044,896	2.86%	10,947,888
55	Dimensions Laurel Regional Hospital	645	800	96,291,500	43,392,662	616,813	44,009,474.66	45.06%	6,722,321	$37,287,154	38.72%	4,726,000
60	Ft. Washington	433	0	40,859,307	1,839,676	151,986	1,991,661.77	4.50%	1,328,080	$663,581	1.62%	1,455,012
61	Atlantic General	850	62	108,255,887	12,102,750	821,326	12,924,075.22	11.18%	4,040,607	$8,883,468	8.21%	2,952,568
62	MedStar Southern Maryland	1,605	11,722	233,355,690	10,765,960	3,124,485	13,890,445.00	4.61%	3,186,913	$10,703,532	4.59%	2,514,686
63	UM St. Joseph	2,044	0	319,343,921	36,491,872	34,164	36,526,035.50	11.43%	7,920,954	$28,605,082	8.96%	8,002,483
64	Levindale	805	520	72,485,946	2,842,192	-	2,842,192.29	3.92%	8,077,004	-$5,234,811	-7.22%	930,520
65	Holy Cross Germantown	632	790	68,283,993	5,248,540	190,964	5,439,504.49	7.69%	-	$5,439,504	7.97%	2,108,744
2001	UM Rehabilitation and Ortho Institute	557	656	106,210,000	9,207,692	1,543,768	10,751,459.29	8.67%	4,470,279	$6,281,180	5.91%	877,000
2004	MedStar Good Samaritan	2,200	1,165	303,538,841	20,857,499	2,261,664	23,119,162.50	6.87%	5,083,701	$18,035,462	5.94%	3,151,845
3029	Adventist Rehab of Maryland*	485	332	35,485,321	3,968,899	-	3,968,899.08	11.18%	50,000	$3,918,899	11.04%	2,086,400
3478	Adventist Behavioral Health at Eastern Shore*	120	0	9,590,451	886,125	-	886,125.15	9.24%	-	$886,125	9.24%	32,069
4000	Sheppard Pratt	2,586	380	205,790,209	11,024,642	-	11,024,642.30	5.36%	2,497,199	$8,527,443	4.14%	4,858,679
4013	Adventist Behavioral Health Rockville*	373	0	34,810,449	2,732,333	-	2,732,332.81	7.85%	199,999	$2,532,334	7.27%	818,860
5034	Mt. Washington Pediatrics	660	1,381	54,688,892	1,654,434	-	1,654,433.92	3.03%	53,308	$1,601,125	2.93%	109,595
5050	Shady Grove*	2,001	5,323	317,638,545	31,158,934	1,499,088	32,658,022.47	9.81%	5,266,794	$27,391,229	8.62%	10,238,461
	All Hospitals	**79,526**	**95,550**	**$14,693,452,602**	**$1,477,302,656**	**$109,137,135**	**$1,586,439,790**	**10.05%**	**$746,100,281**	**$840,339,509**	**5.72%**	**$362,585,727**

Attachment III: FY 2015 Hospital Community Benefit Aggregate Data

Category Type	Type of CB Activity	Number of Staff Hours	Number of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
Unreimbursed Medicaid Costs								
T00	Medicaid Costs							
T99	Medicaid Assessments	**0**	**0**	**$ 389,824,999**	**-**	**$ 333,349,113**	**$ 56,475,886**	**$ 56,475,886**
Community Health Services								
A10	Community Health Education	299,811	3,083,111	17,861,587	9,702,297	2,102,052	25,461,832	$ 15,759,534
A11	Support Groups	15,206	26,288	866,833	522,526	5,067	1,384,292	$ 861,766
A12	Self-Help	26,557	179,657	1,223,931	670,425	328,283	1,566,072	$ 895,648
A20	Community-Based Clinical Services	280,714	358,387	11,501,293	2,295,129	7,338,968	6,457,454	$ 4,162,325
A21	Screenings	40,749	53,970	2,234,527	1,361,479	763,423	2,832,583	$ 1,471,104
A22	One-Time and Occasionally Held Clinics	3,649	17,427	289,353	127,527	53,660	363,220	$ 235,693
A23	Free Clinics	42,497	33,112	2,711,354	1,409,036	258,809	3,861,581	$ 2,452,545
A24	Mobile Units	30,081	11,658	1,206,778	456,189	1,151,127	511,841	$ 55,651
A30	Health Care Support Services	250,379	190,090	28,920,049	13,956,138	2,163,123	40,713,064	$ 26,756,926
A40	Other	49,854	94,811	3,724,737	1,535,295	79,044	5,180,987	$ 3,645,693
A41	Other	7,311	29,248	1,703,890	1,150,686	8,500	2,846,076	$ 1,695,390
A42	Other	572	5,217	96,655	73,938	0	170,593	$ 96,655
A99	**Total**	**1,047,380**	**4,082,976**	**$ 72,340,987**	**$ 33,260,664**	**$ 14,252,057**	**$ 91,349,595**	**$ 58,088,931**

Health Professions Education								
Category Type	**Type of CB Activity**	**Number of Staff Hours**	**Number of Encounters**	**Direct Cost ($)**	**Indirect Cost ($)**	**Offsetting Revenue**	**Net Community Benefit with Indirect Cost**	**Net Community Benefit without Indirect Cost**
B1	Physicians and Medical Students	5,841,483	38,141	305,398,583	74,350,468	300,000	379,449,051	$ 305,098,583
B2	Nurses and Nursing Students	475,296	55,322	21,788,796	5,414,958	0	27,203,753	$ 21,788,796
B3	Other Health Professionals	343,259	51,893	15,307,184	4,316,865	271,093	19,352,956	$ 15,036,091
B4	Scholarships and Funding for Professional Education	7,619	1,838	3,091,421	111,318	0	3,202,739	$ 3,091,421
B50	Other	108,952	22,739	4,938,981	1,170,116	32,760	6,076,337	$ 4,906,221
B51	Other	28,000	1,750	1,355,101	242,507	1,217,998	379,610	$ 137,103
B52	Other	5,440	1,689	213,036	43,320	71,469	184,887	$ 141,567
B99	**Total**	**6,810,049**	**173,372**	**$ 352,093,102**	**$ 85,649,551**	**$ 1,893,320**	**$ 435,849,332**	**$ 350,199,781**
Mission-Driven Health Services								
C	**Mission-Driven Health Services Total**	**2,519,324**	**781,989**	**510,333,561**	**126,292,812**	**168,056,521**	**468,569,852**	**$ 342,277,040**
	Research							
D1	Clinical Research	63,486	5,714	11,038,197	2,766,652	5,748,769	8,056,079	$ 5,289,427
D2	Community Health Research	5,425	157	864,584	292,521	0	1,157,104	$ 864,583
D3	Other	32,282	38	1,396,747	209,804	0	1,606,551	$ 1,396,747
D99	**Total**	**101,193**	**5,909**	**$ 13,299,527**	**$ 3,268,977**	**$ 5,748,769**	**$ 10,819,734**	**$ 7,550,758**
Financial Contributions								
E1	Cash Donations	**855**	**24,622**	**8,975,024**	**325,371**	**70,620**	**9,229,776**	**$ 8,904,404**
E2	Grants	64	32	429,233	97,380	287,557	239,056	$ 141,676
E3	In-Kind Donations	29,484	154,603	6,123,474	611,785	218,339	6,516,920	$ 5,905,135
E4	Cost of Fundraising for Community Programs	5,203	8,199	472,645	119,686	0	592,331	$ 472,645
E99	**Total**	**35,605**	**187,456**	**$ 16,000,376**	**$ 1,154,222**	**$ 576,516**	**$ 16,578,083**	**$ 15,423,860**

Community-Building Activities								
Category Type	**Type of CB Activity**	**Number of Staff Hours**	**Number of Encounters**	**Direct Cost ($)**	**Indirect Cost ($)**	**Offsetting Revenue**	**Net Community Benefit with Indirect Cost**	**Net Community Benefit without Indirect Cost**
F1	Physical Improvements and Housing	7,672	302,805	2,813,165	38,014	2,096,683	754,496	$ 716,482
F2	Economic Development	14,085	3,240	594,745	342,643	245,831	691,557	$ 348,914
F3	Support System Enhancements	74,381	26,664	4,296,668	2,195,311	775,646	5,716,334	$ 3,521,023
F4	Environmental Improvements	8,965	194	970,475	354,698	21,370	1,303,803	$ 949,105
F5	Leadership Development and Training for Community Members	8,187	2,001	295,550	182,934	0	478,484	$ 295,550
F6	Coalition Building	22,136	18,494	2,141,668	1,202,824	167,621	3,176,871	$ 1,974,047
F7	Community Health Improvement Advocacy	25,842	3,585	2,156,125	1,222,769	0	3,378,893	$ 2,156,125
F8	Workforce Enhancement	71,479	165,574	3,416,478	1,952,610	441,091	4,927,997	$ 2,975,387
F9	Other	8,580	31,380	365,510	195,017	23,090	537,436	$ 342,420
F10	Other	199	78	11,412	6,039	0	17,451	$ 11,412
	Total	**241,527**	**554,013**	**17,061,796**	**7,692,858**	**3,771,332**	**20,983,322**	**13,290,464**
Community Benefit Operations								
G1	Dedicated Staff	83,363	760	5,878,288	2,661,847	55,764	8,484,372	$ 5,822,524
G2	Community Health and Health Assets Assessments	4,057	1,612	418,431	188,620	15,048	592,003	$ 403,383
G3	Other Resources	8,130	603	1,233,222	584,816	21,498	1,796,540	$ 1,211,724
	Total	**95,550**	**2,974**	**7,529,942**	**3,435,283**	**92,310**	**10,872,915**	**$ 7,437,632**
Charity Care								
H	**Charity Care (report total only)**							**$ 362,585,727**
Foundation-Funded Community Benefits								
J1	Community Services	5,395	2,407	1,406,811	140,603	726,656	820,759	$ 680,155

Category Type	Type of CB Activity	Number of Staff Hours	Number of Encounters	Direct Cost ($)	Indirect Cost ($)	Offsetting Revenue	Net Community Benefit with Indirect Cost	Net Community Benefit without Indirect Cost
J2	Community-Building Activities	57,937	9,314	2,087,628	30,227	37,878	2,079,977	$ 2,049,750
J3	Other	0	0	317,474	0	0	317,474	$ 317,474
J99	**Total**	**63,332**	**11,721**	**$ 3,811,913**	**$ 170,830**	**$ 764,534**	**$ 3,218,210**	**$ 3,047,379**
Total Hospital Community Benefits								
T99	Medicaid Assessments	0	0	$ 389,824,999	-	$ 333,349,113	$ 56,475,886	$ 56,475,886
A	Community Health Services	1,047,380	4,082,976	$ 72,340,987	$ 33,260,664	$ 14,252,057	$ 91,349,595	$ 58,088,930
B	Health Professions Education	6,810,049	173,372	$ 352,093,102	$ 85,649,551	$ 1,893,320	$ 435,849,333	$ 350,199,782
C	Mission-Driven Health Services	2,519,324	781,989	$ 510,333,561	$ 126,292,812	$ 168,056,521	$ 468,569,852	$ 342,277,040
D	Research	101,193	5,909	$ 13,299,527	$ 3,268,977	$ 5,748,769	$ 10,819,734	$ 7,550,758
E	Financial Contributions	35,605	187,456	$ 16,000,376	$ 1,154,222	$ 576,516	$ 16,578,083	$ 15,423,860
F	Community-Building Activities	241,527	554,013	$ 17,061,796	$ 7,692,858	$ 3,771,332	$ 20,983,322	$ 13,290,464
G	Community Benefit Operations	95,550	2,974	$ 7,529,942	$ 3,435,283	$ 92,310	$ 10,872,915	$ 7,437,632
H	Charity Care	0	0	$ 362,585,727	-	-	$ 362,585,727	$ 362,585,727
J	Foundation-Funded Community Benefits	63,332	11,721	$ 3,811,913	$ 170,830	$ 764,534	$ 3,218,210	$ 3,047,379
K99	**Community Hospital Benefit Total**	**10,913,958**	**5,800,412**	**$ 1,744,881,930**	**$ 260,925,198**	**$ 528,504,472**	**$ 1,477,302,656**	**$ 1,216,377,458**
	Total Operating Expenses	**$14,693,452,602**						
	Percentage of Operating Expenses with Indirect Cost	**10.05%**						
	Percentage of Operating Expenses without Indirect Cost	**8.28%**						

Update from CRISP on Implementation of Infrastructure and Analytics

Representatives for CRISP testified by spoken discussion only during the Commission meeting.

State of Maryland
Department of Health and Mental Hygiene

Nelson J. Sabatini
Chairman

Herbert S. Wong, PhD
Vice-Chairman

Joseph Antos, PhD

Victoria W. Bayless

George H. Bone, M.D.

John M. Colmers

Jack C. Keane

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Sule Gerovich, PhD, Director
Population Based
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Chris L. Peterson, Director
Clinical and Financial
Information

Gerard J. Schmith, Director
Revenue and Regulation
Compliance

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **October 19, 2016**

RE: **Hearing and Meeting Schedule**

November 9, 2016	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
December 14, 2016	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-2016.cfm

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