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535th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
November 9, 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 1:30 p.m.)

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**

4. **Legal Implications of Maryland Health Care Commission CON Decision on Prince George's Hospital Center - Authority General Provisions Article, §3-305 (b)7**

PUBLIC SESSION
1:30 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on October 19, 2016**
2. **Executive Director's Report**
3. **Commission Discussion on Expiration of the CareFirst Common Model with Medicare**
4. **New Model Monitoring**
5. **Docket Status – Cases Closed**
   2352N – MedStar Harbor Hospital
   2354A - University of Maryland Medical Center
   2355A - University of Maryland Medical Center
6. **Docket Status – Cases Open**
   2353A - Priority Partners
   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.
   2362A – Johns Hopkins Health System
   2363A - Johns Hopkins Health System
   2364A – University of Maryland Medical Center
   2365A – University of Maryland Medical Center

7. **Final Recommendation for Second and Final Round of Transformation Implementation Grant Awards**

8. **Hearing and Meeting Schedule**

Closed Session Minutes
Of the
Health Services Cost Review Commission

OCTOBER 19, 2016

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

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. Update on administrative and procurement matters – Authority General Provisions Article §3-103 and §3-104

The Closed Session was called to order at 12:08 p.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

In attendance in addition to Chairman Sabatini were Commissioners Antos, Bone, Colmers, Keane, and Wong. 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, Liz Fracica and Dennis Phelps.

Also attending were Deborah Gracey and Eric Lindeman, Commission Consultants, and Stan Lustman and Leslie Schulman Commission Counsel.

Item One

Donna Kinzer, Executive Director, and Eric Lindeman, Commission Consultant, updated and the Commission discussed Medicare data and analysis vis-a-vis the All-Payer Model Agreement.

Item Two

The Commissioners discussed Model Progression to Phase II, including the strategic plan, which is in the process of development.

Item Three

Ms.Kinzer updated the Commissioners on administrative and procurement matters.

The Closed Session was adjourned at 1:49 p.m.

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

Chairman Nelson Sabatini called the public meeting to order at 12:08 p.m. Commissioners Joseph Antos, Ph.D., George H. Bone, M.D., John Colmers, Jack C. Keane, Herbert Wong, Ph.D., and Fran Phillips, nonvoting ex-officio member, were also in attendance. Upon motion made by Commissioner Wong and seconded by Commissioner Keane, the meeting was moved to Executive Session. Chairman Sabatini reconvened the public meeting at 2:02 p.m.

REPORT OF THE OCTOBER 19, 2016 EXECUTIVE SESSION

Mr. Dennis Phelps, Associate Director, Audit & Compliance, summarized the minutes of the October 19, 2016 Executive Session.

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ITEM I

REVIEW OF THE MINUTES FROM THE SEPTEMBER 14, 2016 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the September 14, 2016 Executive Session and Public Meeting.

ITEM II

EXECUTIVE DIRECTOR'S REPORT

Donna Kinzer, Executive Director, noted that Staff met with the Centers for Medicare & Medicaid Services (CMS) and Center for Medicare & Medicaid Innovation (CMMI) to discuss performance under the new All–Payer Model and the status of the State's Progression Plan.

Ms Kinzer stated that CMS approved the Care Redesign Amendment to the current All-Payer Model. Under this new amendment, the State can:

- Obtain comprehensive patient level Medicare data to support care coordination;
- Allow Hospitals to share resources with non-hospital providers;
- Allow Hospitals to share savings with non-hospital providers.

Ms. Kinzer noted that we must work with physicians and nursing home care partners to keep our current model successful in providing care coordination for high needs and rising risk patients. The Medicare Access and CHIP Reauthorization Act (MACRA) has provided us with the possibility of bringing physicians into the All Payer Model and participating in an Advance Alternative Payment Model (AAPM). 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 programs.

Ms. Kinzer noted that the new amendment program will be launched on October 21st with the first in a series of webinars programs with CMMI staff.

Ms. Kinzer noted that the new Amendment requires submission of implementation protocols and reports relative to care redesign programs. HSCRC also requires reports for GBR infrastructure and implementation grants. Staff is looking to streamline reporting to reduce the GBR and implementation grant requirements this effort is intended to reduce overlap and regulatory burden.

Ms. Kinzer stated that CMS released its final MACRA regulations. Ms. Kinzer noted that Maryland has the opportunity to create an Advanced Alternative Payment Model to attract physicians who want to participate in the All-Payer Model through the Care Design Amendment program, a primary care initiative, and changes to hospitals' value base payment programs.

Ms. Kinzer reported that HSCRC and DHMH are working to prepare the Progression Plan (Plan) for submission to CMS/CMMI by December 31st. Ms. Kinzer noted that DHMH and Staff are providing presentations on the Plan to the legislative committees. The first draft of the Plan will be released to the Advisory Council for review and comment on October 21st. Staff hopes to post a draft of the Plan for public comment by mid-November.

Ms. Kinzer stated that to ensure that the State reaches the performance goals of the new Model, Staff has modified the existing pay-for-performance programs. The Staff is planning to work on developing new methodologies to align measurement across providers and to create a person-centered approach to performance-based payment adjustments in conjunction with the strategic direction the State is undertaking with the Progression Plan. 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.

- Developing service line/episode value measurement that could potentially combine and streamline different quality measures such as 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.;

- 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;

- Developing performance metrics targeting high-needs patients and care coordination;

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

- 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.

Ms. Kinzer noted that to help achieve the improvement goals under the Model, Staff is working to implement three new workgroups:

- Consumer Standing Advisory Committee (C-Sac) - To provide consumer engagement and involvement. Group will bring together a diverse cross –section of consumers, consumer advocates, relevant subject matter experts, providers, payers, and other key stakeholders;

- Behavioral Health Subgroup- This group will advise the Performance Measurement Work Group and the Staff on measures of performance for care provided to persons with mental health or substance use disorder;

- Total Cost of Care Workgroup – This group will provide feedback to HSCRC on the development of the hospital level Total Cost of Care guardrails for the Care Design Amendment Programs.

Ms. Kinzer noted that Staff will update hospital July 1st rate orders on January 1st for the following reasons:

- Settlement of rate and global revenue compliance for FY 2016

- Quality Based Reimbursement

- Market shift adjustment for 6 months (January through June 2016)

- Allocation for drug growth (approx. $16 million)

Ms. Kinzer reported that the case mix data is still defective due to Johns Hopkins' Epic conversion. Staff is hopeful to have the correct data in the near future.

ITEM III

FINAL RECOMMENDATION FOR APPROVAL OF BALTIMORE POPULATION HEALTH WORKFORCE COLLABORATIVE AWARD

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

The Maryland Department of Health and Mental Hygiene (DHMH) and the HSCRC 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 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 HSCRC, 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.

The BPHWC initially proposed a plan requesting a cumulative amount of $9.8 million through rates ($14.8 million 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.

Melvin Wilson, Co-Director of BUILD's Turnaround Tuesday program addressed the Commission in support of the recommendation.

Chairman Sabatini thanked Ms. Pegeen Townsend, MedStar Health Vice President of Government Affairs, for her role in putting this proposal together.

The Commission voted unanimously to approve staff's recommendation.

ITEM IV

CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS (CRISP) UPDATE

A panel consisting of Carmela Coyle, President and CEO of the Maryland Hospital Association, Dr. Stephen Evans, Chief Medical Officer MedStar Health, Dr. Walter Ettinger, Chief Medical Officer University of Maryland Medical System, Thomas Kleinhanzl, President and CEO of Frederick Regional Health System, and Dr. Mark Keleman, CRISP Board, updated the Commission on the comprehensive and challenging care transformation work underway to further the successful progression on the All-Payer Model.

Ms. Coyle noted the early success of the Model and a number of statewide engagement activities that MHA worked on with hospitals and provider partners in the past year. She highlighted the keys to future success as the Model progresses:

- Partnerships and collaboration with providers, state and federal agencies;
- Focusing, harmonizing, and simplifying our care transformation efforts;
- Flexibility in approaches and testing different models to achieve the Model's desired outcomes:
- Sufficient time to ensure success of the Model.

Dr. Keleman noted the number of tools that CRISP is making available to hospitals to assist in these care transformation efforts, including providing data that will allow hospitals to flag patient

relationships, and share care planning data with other providers, and by using care alert mechanisms and designing new reports that can be used as part of hospitals' performance improvement activities.

The panel also outlined strategies they have employed to identify high-risk patients and target a range of specific programs tailored to meet individual needs of these patients. They reported on the impact of these programs on reducing avoidable utilization and managing Medicare total cost of care.

ITEM V

NEW MODEL MONITORING

Chris Peterson, Director Center for Clinical and Financial Information, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of August 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 in receiving data from Johns Hopkins Health System. Reported figures will likely fluctuate at next month's meeting once the data issues are resolved.

Mr. Peterson reported that for the two month period ended August 31, 2016, All-Payer total gross revenue decreased by 1.72% over the same period in FY 2016. All-Payer total gross revenue for Maryland residents decreased by 1.54%; this translates to a per capita growth of (2.05%). All-Payer gross revenue for non-Maryland residents decreased by 3.53%.

Mr. Peterson reported that for the eight months of the calendar year ended August 31, 2016, All-Payer total gross revenue increased by 0.98% over the same period in CY 2015. All-Payer total gross revenue for Maryland residents increased by 1.09%; this translates to a per capita growth of (3.46%). All-Payer gross revenue for non-Maryland residents decreased by 0.16%.

Mr. Peterson reported that for the two month period ended August 31, 2016, Medicare Fee-For-Service gross revenue decreased by 2.05% over the same period in FY 2016. Medicare Fee-For-Service gross revenue for Maryland residents decreased by 2.00 %; this translates to a per capita growth of 0.56%. Maryland Fee-For-Service gross revenue for non-residents decreased by 2.63%.

Mr. Peterson reported that for the eight months of the calendar year ended August 31, 2016, Medicare Fee-For-Service gross revenue increased by 0.01% over the same period in CY 2015. Medicare Fee-For-Service gross revenue for Maryland residents decreased by 0.04%; this translates to a per capita growth of (1.63%). Maryland Fee-For-Service gross revenue for non-residents increased by 0.60%.

Mr. Peterson reported that for the eight months of the calendar year ended June 30, 2016 over the same period in CY 2013:

- Net per capita growth was 4.68 %.
- Per capita growth before UCC and MHIP adjustments was 4.98%.
- Net per capita Medicare growth was 2.44%.
- Per capita growth Medicare before UCC and MHIP was 2.73 %.

According to Mr. Peterson, for the two months of the fiscal year ended August 31, 2016, unaudited average operating profit for acute hospitals was 2.64%. The median hospital profit was 3.93%, with a distribution of 0.63% in the 25th percentile and 7.23% in the 75th percentile. Rate Regulated profits were 5.59%.

Mr. Peterson reported that for the eight months of the calendar year ended June 30, 2016 over the same period in CY2015:

- All-Payer admissions decreased by 1.12%.
- All-Payer admissions per thousand residents decreased by 1.53%.
- Medicare Fee-For-Service admissions decreased by 2.66%.
- Medicare Fee-For-Service admissions per thousand residents decreased by 4.65%.
- All-Payer bed days decreased by 0.31%.
- All-Payer bed days per thousand residents decreased by 0.72%.
- Medicare Fee-For-Service bed days decreased by 1.56%.
- Medicare Fee-For-Service bed days per thousand decreased by 3.57%.
- Emergency visits decreased by 1.46%.
- Emergency visits per thousand decreased by 1.86%.

ITEM VI

DOCKET STATUS- CLOSED CASES

2319R- Sheppard Pratt Health System
2350R- Prince George's Medical Center
2351A- Johns Hopkins Health System

ITEM VII

DOCKET STATUS- OPEN CASES

2352N- MedStar Harbor Hospital

On September 6, 2016, MedStar Harbor Hospital (the Hospital), a member of MedStar Health, 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. The Hospital requests that the PSY and PDC rates be set at MedStar Union Memorial
Hospital rates of $878.48 per day for PSY and $479.79 per visit for PDC services. The Hospital is requesting these rates begin on November 1, 2016.

After reviewing the Hospital's application, the staff recommends the following:

- That a PSY rate of $874.00 per day be approved effective November 1, 2016.
- That a PDC rate of $457.52 per visit be approved effective November 1, 2016.
- That the PSY and PDC rates not be rate realigned until a full year's cost experience report data have been reported to the Commission;
- That the Hospital's Global Budget Revenue would be changed according.

The Commission voted unanimously to approve staff's recommendation.

2353A- Priority Partners, Inc.

Mr. Steve Ports, Director Center for Engagement and Alignment, summarized staff's draft recommendation on the application filed by Johns Hopkins Health System (the "System") on behalf of John Hopkins Hospital, Johns Hopkins Bayview Medical Center, Howard County General Hospital, and Suburban Hospital (the "Hospitals"). The System is seeking approval for continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. The Hospitals are requesting to renew the contract for one year beginning on January 1, 2017.

Mr. Ports announced that the final recommendation will be presented at the November public Meeting.

2354A- University of Maryland Medical Center

The University of Maryland Medical Center (the "Hospital") filed an application on September 28, 2016 requesting continued participation in a global rate arrangement for solid organ and blood and bone marrow transplant services with OptumHealth Care Solutions, Inc. beginning November 1, 2016.

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

2355A- University of Maryland Medical Center

The University of Maryland Medical Center (the "Hospital") filed an application on September 28, 2016 requesting continued participation in a global rate arrangement for blood and bone marrow transplant services with Blue Cross Blue Shield Blue Distinction Centers beginning December 1, 2016.

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 one year beginning December 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.

2356A- Maryland Physician Care

Mr. Ports summarized staff's draft recommendation on the application filed by Saint Agnes Health System, Western Maryland Health System, Holy Cross Health, and Meritus Health (the "Hospitals"). The Hospitals are seeking approval for continued participation of Maryland Physician Care in the Medicaid Health Choice Program. The Hospitals are requesting to renew the contract for one year beginning on January 1, 2017.

Mr. Ports announced that the final recommendation will be presented at the November public meeting.

2358A- MedStar Family Choice

Mr. Ports summarized Staff's draft recommendation on the application of the MedStar Health on behalf of their member hospitals. MedStar Health seeks renewal for continued participation of MedStar Family Choice ("MFC") in the Medicaid Health Choice Program for one year beginning in January 1, 2017.

Mr. Ports announced that the final recommendation will be presented at the November public meeting.

2361A- Maryland Health Partners, Inc.

Mr. Ports summarized Staff's draft recommendation on the application of Maryland Health Partners, Inc. (UMHP), a Medicaid Managed Care Organization (MCO), on behalf of the University of Maryland Medical System Corporation (the "Hospitals). UMHP and the Hospitals seek approval for the MCO to continue to participate in the Medicaid Health Choice Program for one year beginning January 1, 2017.

Mr. Ports announced that the final recommendation will be presented at the November public meeting.

ITEM VIII

DRAFT RECOMMENDATION FOR UPDATING THE QUALITY-BASED REIMBURSEMENT PROGRAM FOR FISCAL YEAR 2019

Ms. Dianne Feeney, Associate Director Quality Initiative, and Dr. Sule Gerovich, Director Center for Population Based Methodologies, presented Staff's draft recommendation on updating the Quality Based Reimbursement (QBR) Program for FY2019 (See "Draft Recommendation for Updating the Quality Based Reimbursement Program for FY 2019" on the HSCRC website).

HSCRC'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 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.

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 draft recommendation is to propose 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.

Staff analyzed hospital performance scores relative to the QBR preset scale determined last year and notes that almost all hospitals will 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 versus 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 a 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. Staff provided 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.

The current preset QBR scale rewards $27.1 million for Maryland Hospitals; however, Maryland QBR scores have declined relative to the nation across all categories. The newly proposed scale would instead result in a $9.9M penalty, a difference of $37.0M.

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

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% of the final score; the safety measures at 35%; and the Patient and Community Engagement measures at 50%; and

4. Continue to set the maximum penalty at 2% and the maximum reward at 1% of approved hospital inpatient revenue.

A panel led by Carmela Coyle, and including Executive VP of MedStar Health Eric Wagner, Johns Hopkins President Redonda Miller, President and CEO of Meritus Health Joseph Ross, and President and CEO of UMMS Robert Chrenchik, argued that this attempt to retrospectively make a monetary adjustment is different from others in the past because it would be applied after the performance period and after the start of the fiscal year. The panel's main argument was that it sets a bad precedent to set rules for the hospitals, assign money based on those rules, and then change the monetary rewards after the start of the fiscal year, especially when the QBR rewards/penalties were supposed to place an emphasis on predictability. Collectively, they shared views that retrospectively making an adjustment would lower morale, overwhelm clinicians, and demotivate workers.

Commissioner Bone asked how hospitals would handle calculation errors on performance metrics when performance lags the nation, particularly on activities such as gainsharing. Chairman Sabatini observed that we could resolve the issue by making a hard and fast policy of no retrospective adjustments, and added that it is "nickels and dimes" anyway. Dr. Bone added that nickels and dimes add up, and that as more parties come to the table, bumps in the road will occur.

Commissioner Colmers asserted that there are legitimate arguments on all sides, and that the goal of changing the payment scale was set to provide a degree of predictability for hospitals in responding to quality measures. It is difficult to incentivize people if they don't know until after the fact whether they are achieving their goals. Commissioner Colmers also expressed concern about asking CMS to continue to grant us an exemption from a federal policy with a performance that we all agree is disappointing. However, retroactive rule making and retroactive activity is generally something the Commission has historically not done. Commissioner Colmers recommended that staff, the hospitals, and the payers spend some serious time in the next month on the resolution of this issue that fairly addresses all the legitimate concerns.

Commissioner Antos asked rhetorically whether the policy is about quality or money, and further questioned whether the policy is actually effective in improving quality. Appearing to answer the question, he said that if the policy is not improving quality, perhaps the amount at risk should be lowered.

Commissioner Keane agreed with HSCRC staff that Maryland performance was not commendable and agreed with others about the importance of prospective policies. He raised the concern that the number are too close to the Medicare total cost of care guardrail for calendar 2016 and that holding back the $27 million reward and the 0.56 percent due to go into hospital budgets in January would provide more certainty on that metric.

Commissioner Wong summarized the points made by other Commissioners and the hospital panel and reiterated Colmers' statement that a fair solution needs to be on the table next month.

Robert Murray, on behalf of CareFirst, opposed the retroactive adjustment on principle saying that retroactive changes create uncertainty and undermine predictability. He further advised Commissioners to "wait" on this adjustment and on the "ill-advised" 0.56 percent adjustment expected in January to provide more cushion on Medicare total cost of care.

As this is a draft recommendation, no Commission action is necessary.

ITEM IX

DRAFT RECOMMENDATION FOR SECOND AND FINAL ROUND OF TRANSFORMATION IMPLEMENTATION GRANT AWARDS

Mr. Ports presented staff's draft recommendation on Regional Partnership for Health System Transformation Rewards for FY 2016 (See "Draft Recommendation for Competitive Transformation Implementation Awards- Secondary Review" on the HSCRC website).

The HSCRC and DHMH are recommending that five proposals for health system transformation grants be partially funded beginning in fiscal year (FY) 2017. This recommendation concludes the Commission's decision in June 2015 to authorize up to 0.25% 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.

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 DHMH and HSCRC 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, 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.

Based on its review, the Review Committee recommends the following five additional grant proposals for partial funding beginning January 1, 2017. 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.

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**	

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.

The Request for Proposal (RFP) specifically states, "in addition to the Return on Investment (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.

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

*10% more than the previous fiscal year.

Commissioner Keane stated that it is not necessary to fund these efforts. Hospitals should be doing this on their own with their own resources, which would force them to be more astute in their spending.

Mr. Ports announced that the final recommendation will be presented at the November public meeting.

ITEM X

FISCAL YEAR 21015 COMMUNITY BENEFITS REPORT

Mr. Ports provided background and summarized the FY 2015 Maryland Hospital Community Benefits Report (CBR) (see "HSCRC FY 2015 Community Benefits Report Findings" on the HSCRC's website).

Each year, the HSCRC collects community benefit information from individual hospitals to compile into a publicly available statewide CBR. Current year and previous CBRs submitted by hospitals are available on the HSCRC website. According to Mr. Ports, the FY CBR indicated that hospitals: 1) reported a total of $1.5 billion in community benefits for FY 2015 (FY 2014 amount was also approximately $1.5 billion); 2) provided an average of 10.80% of total operating expenses in community benefits (compared to 11.12% in FY 2012); 3) provided net charity care of $43.6 million; and 4) provided net community care of $840.3 million or 5.72% of hospitals' net operating expenses (up from $724.7 million and 5.14% of hospitals' net operating expenses in FY 2014).

ITEM XI

HEARING AND MEETING SCHEDULE

November 9, 2016	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room
December 14, 2016	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 5:24 pm.

Executive Director's Report

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

Chet Burrell
President and Chief Executive Officer

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

CareFirst BlueCross BlueShield

November 2, 2016

Nelson J. Sabatini, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Nelson,

I write in follow up to the proposal CareFirst made on August 17 to extend the Common Model to Medicare FFS beneficiaries and Dual Eligible beneficiaries on the same basis as was piloted through a CMMI Health Care Innovation Award during 2012-15 and maintained in 2016 through a Community Giving Award by CareFirst in 2016.

At its own expense, CareFirst supported the Common Model in 2016 as a bridge to an alternative funding source in moving forward toward Phase 2 of the Maryland All Payer Waiver. The CareFirst funding was extended by the CareFirst Board of Directors twice in order to allow time for an alternative source to be developed. CareFirst funding for Medicare beneficiaries ends on December 31, 2016. We are required to give termination notice to participating providers, vendors/partners and beneficiaries by November 15th if an alternative funding source cannot be found. This would result in dismantling the Common Model and all of its supports and data feeds from CMS effective January 1, 2017.

We are aware that a source of funding effective January 1, 2017 may be possible through rate action by the HSCRC. We ask that this be considered at the upcoming November 9, 2016 meeting as it is the only chance for extension of the Common Model. We believe that the public-private undertaking embodied in the Common Model is an important element in Maryland's approach to Phase 2 and have sought to do all we can do in support of its extension. We hope this opportunity for funding through HSCRC action is available.

If you believe that an action by the HSCRC is possible on November 9th and would wish to have me present, please know that I am at your disposal. Thank you for your consideration. I have attached a fact sheet about the Common Model for easy reference.

Sincerely,

Chet Burrell
President & CEO

Cc: Patrick Conway, CMS, Deputy Administrator for Innovation & Quality
and CMS Chief Medical Officer
Stephen Cha, M.D., CMS, Director
Van Mitchell, State of Maryland, Secretary of Health & Mental Hygiene
Howard Haft, M.D., State of Maryland, Deputy Secretary for Public Health Services
Donna Kinzer, HSCRC Executive Director
Joseph Antos, HSCRC Commissioner
Victoria Bayless, HSCRC Commissioner
George Bone, HSCRC Commissioner
John Colmers, HSCRC Commissioner
Jack Keane, HSCRC Commissioner
Herbert Wong, HSCRC Commissioner

Key Facts Regarding the PCMH/TCCI Program and Common Model with Medicare

Commercial PCMH/TCCI Program Facts

- 90% of all eligible PCPs throughout the region participate in the Program
  (446 Panels, 1,229 Practices, 4,367 Primary Care Providers)
- 1.1 million attributed members are in the Program
- Average Age – 35 Years
- $5 billion in annual claims managed by the Program ($20 Billion in 6 years)
- 15% decline in admissions from 2011 levels
- Care Plans activated for over 60,000 high-risk members annually
- Includes management of all components of total cost of care – hospital in-patient/out-patient, specialty and ancillary services, drug and primary care

Common Model Facts

- Involves 140 Participating PCPs in the PCMH Program
- Includes 40,000 Attributed Medicare Fee for Service Beneficiaries / 60,000 attributed CareFirst members
- Average Age – 75 years for Medicare FFS; 35 years for CareFirst members
- $2.3 billion in claims ($1.2B CareFirst and $1.1B Medicare) over 3 years of Common Model
- Medical total cost of care trend of 1% for 40,000 Medicare beneficiaries over three years (after cost of care coordination) are included
- Quality scores of Panels in the Common Model improved 30 percent above the average of all Panels in CareFirst's larger PCMH/TCCI Program
- 19% decline in hospital admissions for Medicare beneficiaries from baseline in 2012
- Overall beneficiary satisfaction score of 4.4 on a five-point scale (96% above 4)
- 96 % of PCPs would recommend the Program to their patients; 100% want Model to continue

Infrastructure Already in Place Across All Market Segments

- The PCMH Program supports over 300,000 individual subscribers and over 30,000 employer groups
- Virtually all employer groups and all individual exchange products are included
- Fully web-based infrastructure with universal patient health record for each member
- Data feeds for both Medicare beneficiaries and CareFirst members operating in mature state
- All data online and on-demand 24/7 for CareFirst and Medicare
- Trained and highly managed workforce of over 400 nurses in place throughout the region in support of the Program:
  - 250 Local Care Coordinators
  - 85 Case Managers
  - 70 Hospital Transition Nurses
  - 60 Behavioral Health Care Coordinators

Monitoring Maryland Performance
Medicare TCOC Data

Data through July 2016 - Paid Claims through September

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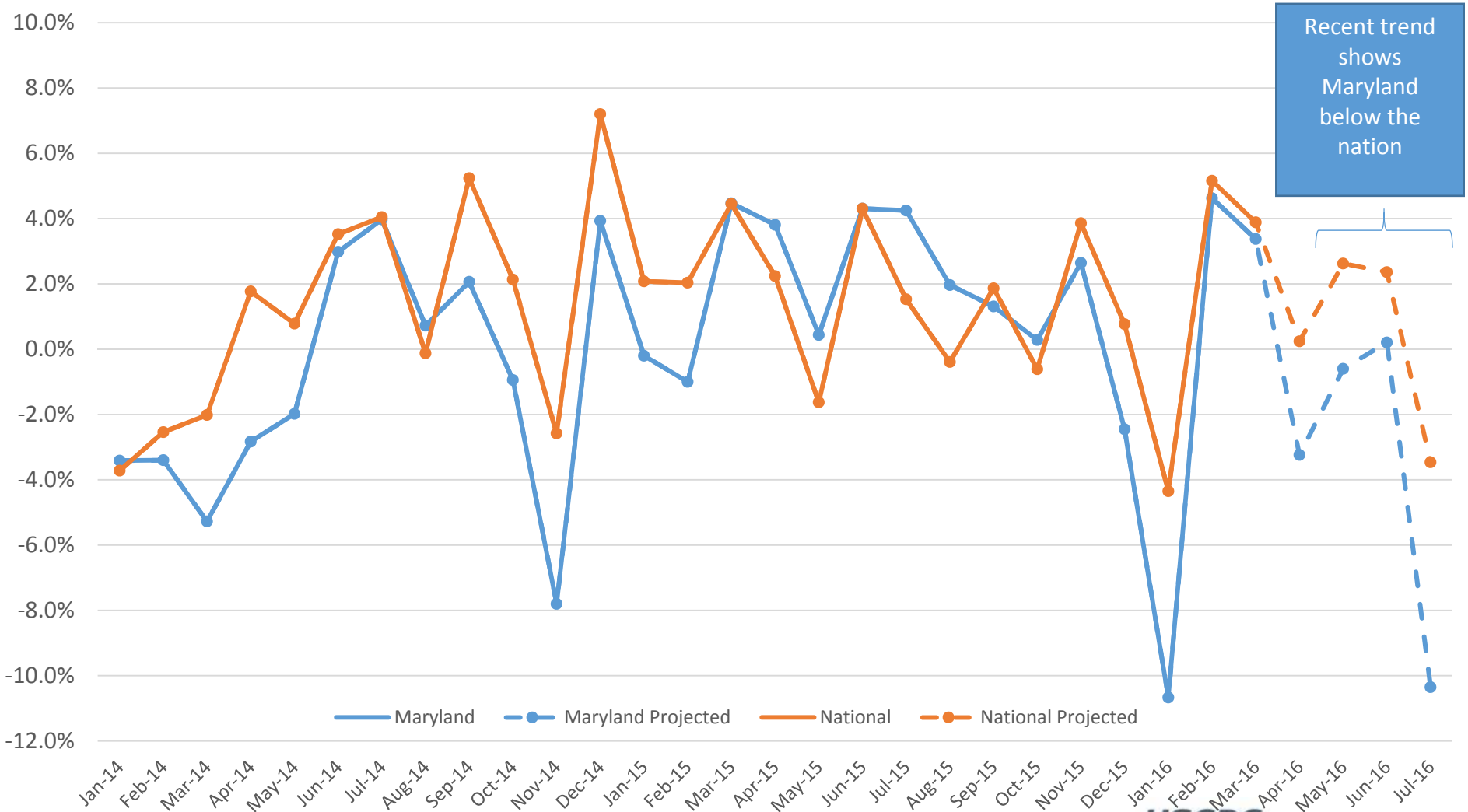
Disclaimer

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 Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



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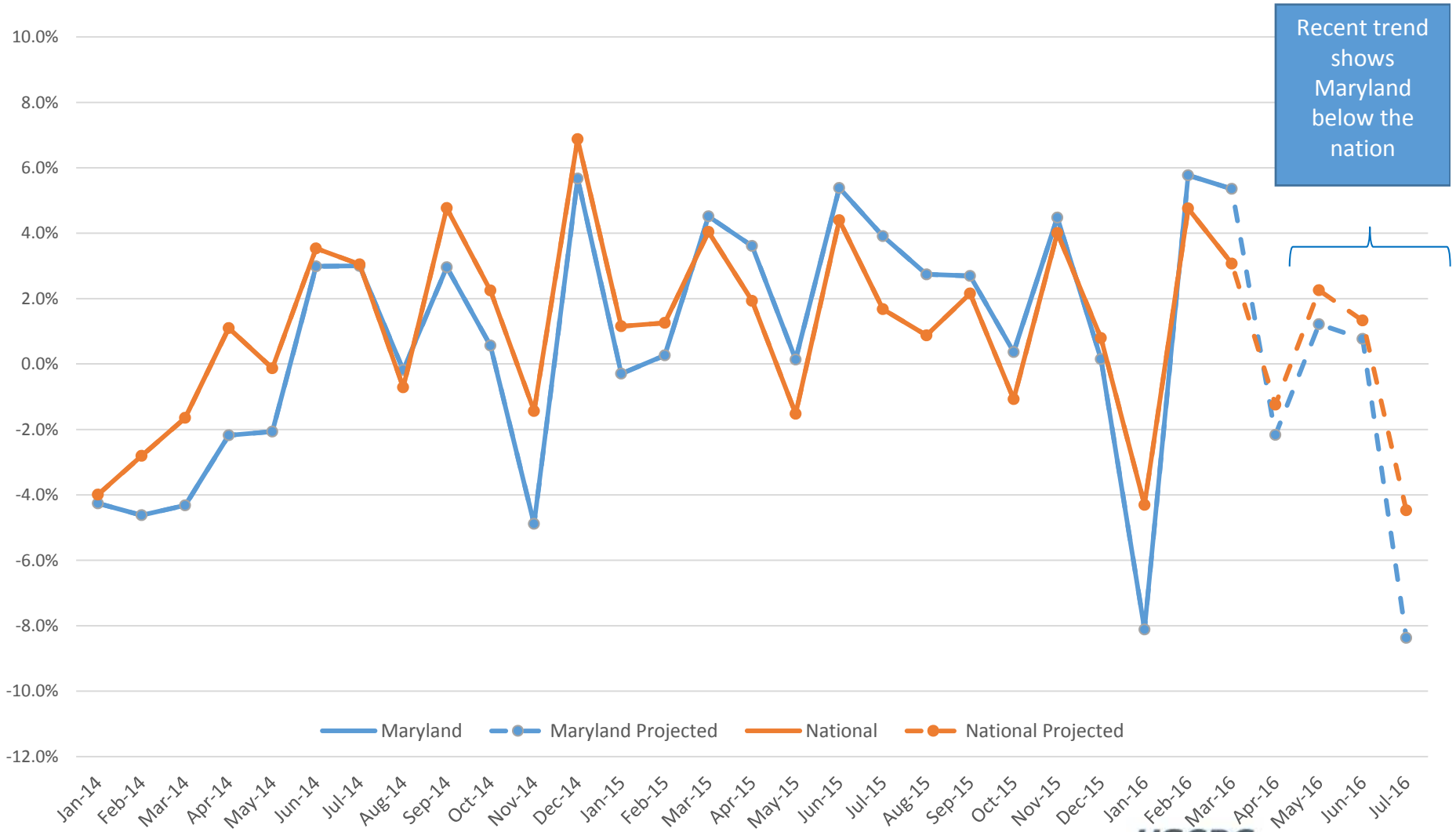
Medicare Total Cost of Care Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



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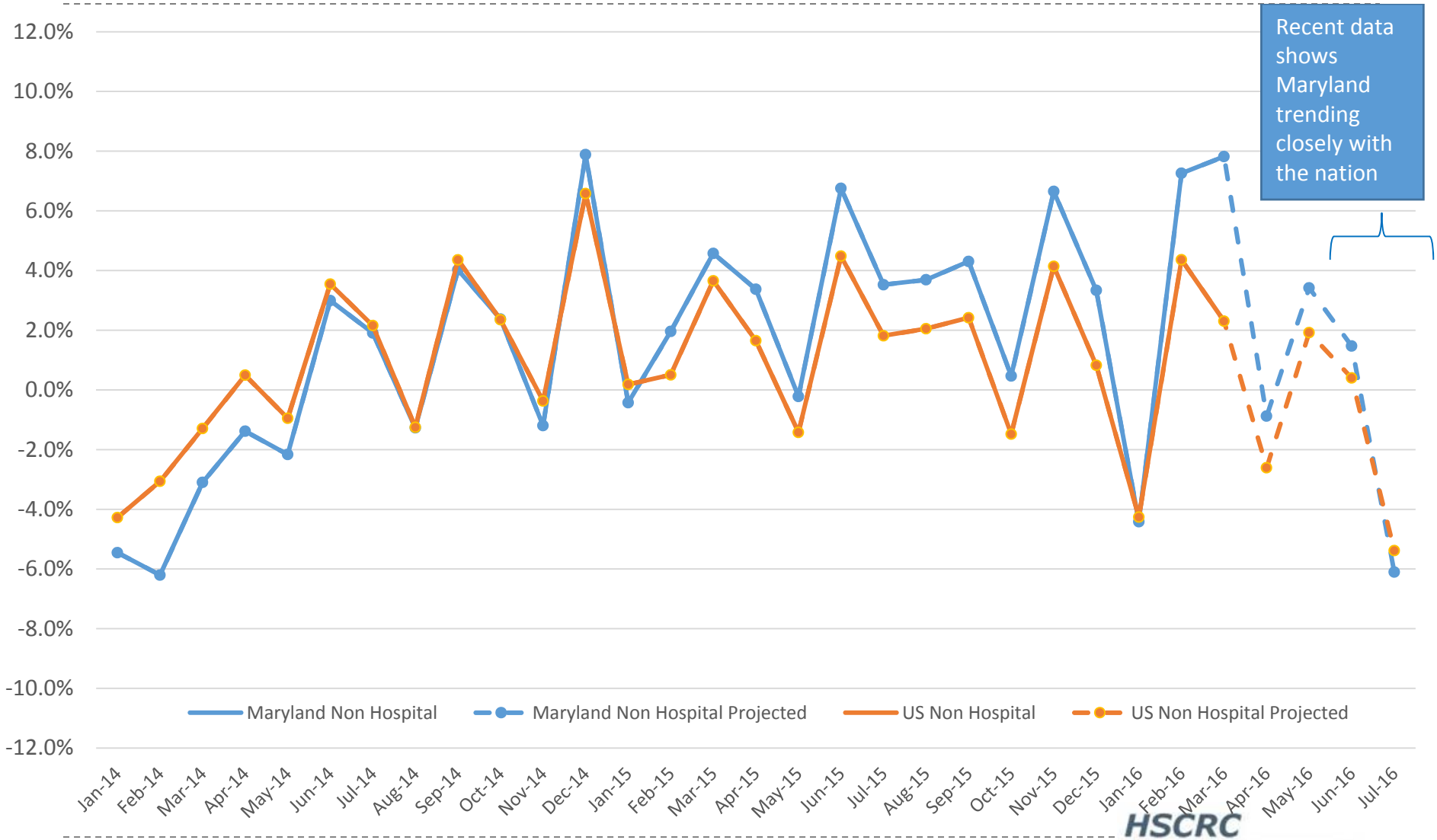
Non-Hospital Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



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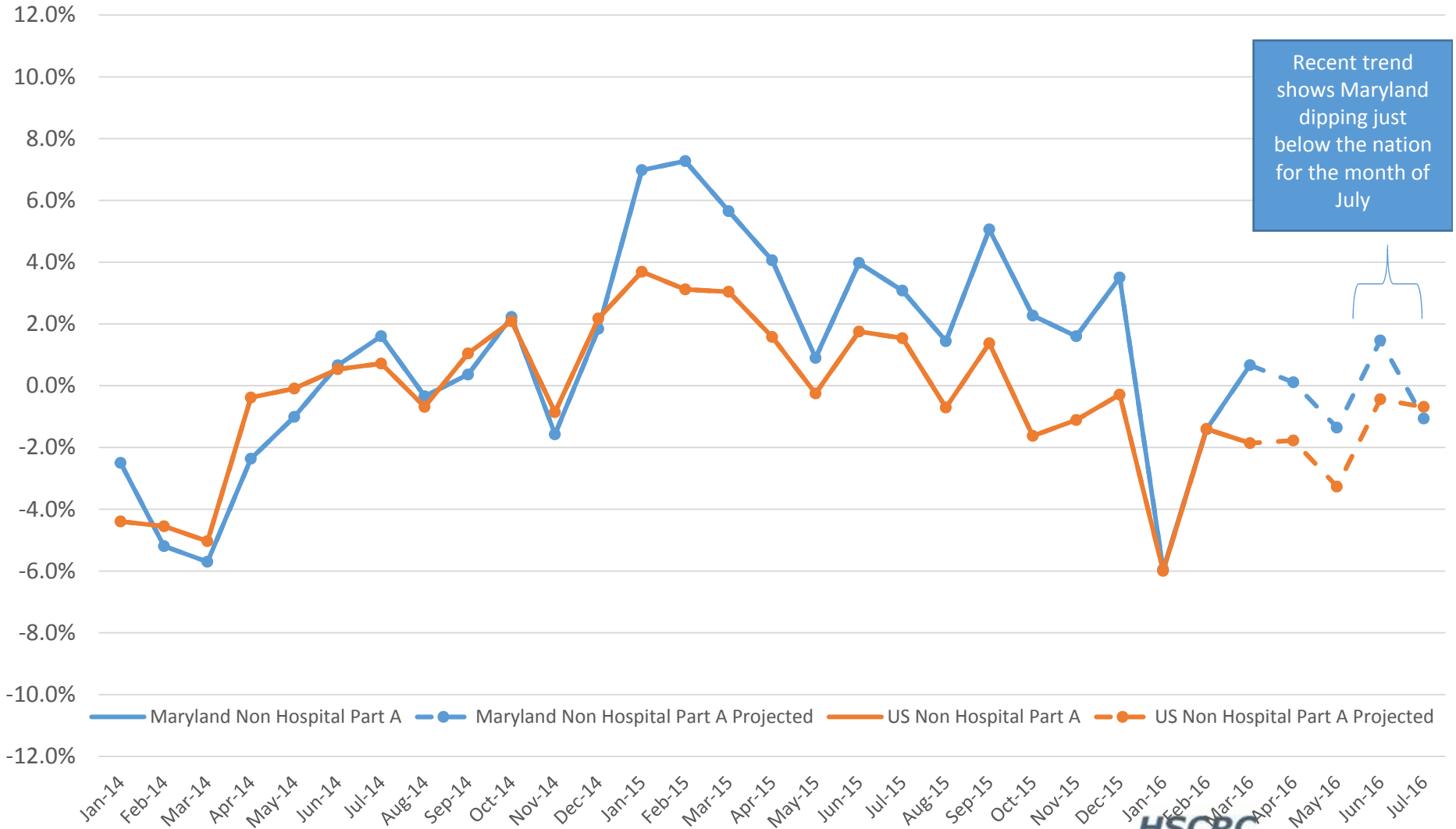
Non-Hospital Part A Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



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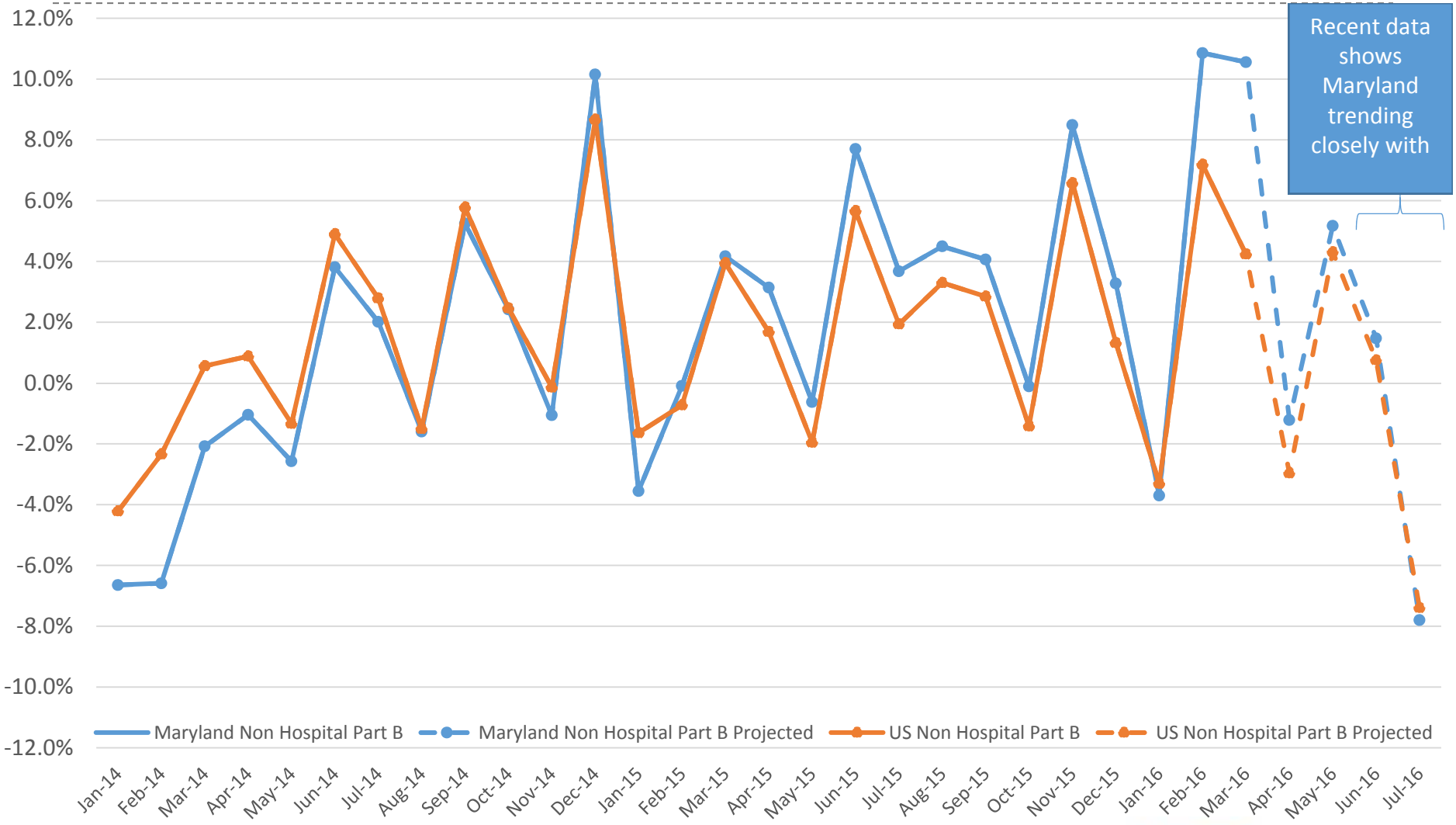
Non-Hospital Part B Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



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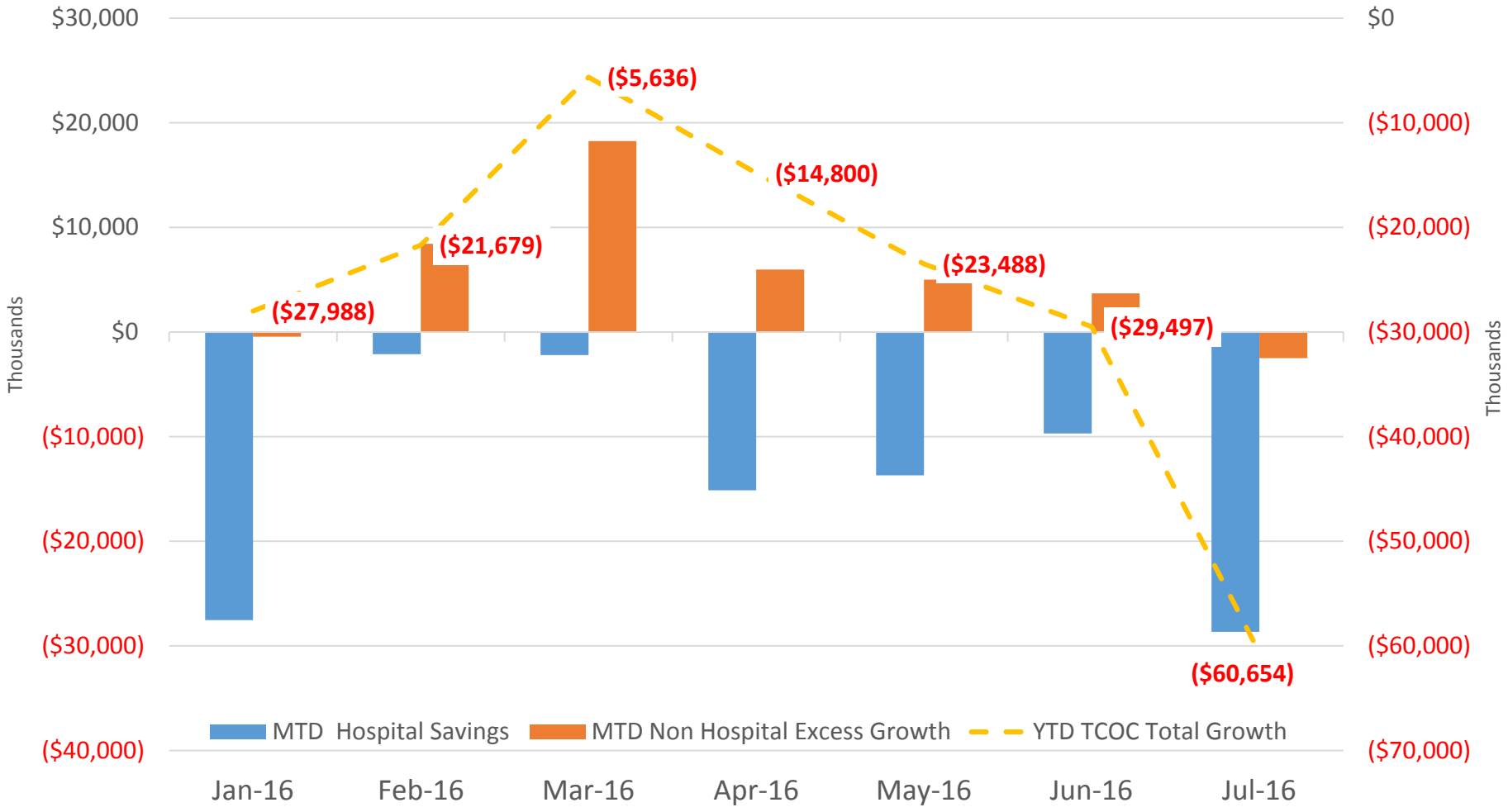
Medicare Hospital & Non-Hospital Growth (with completion) CYTD through July 2016



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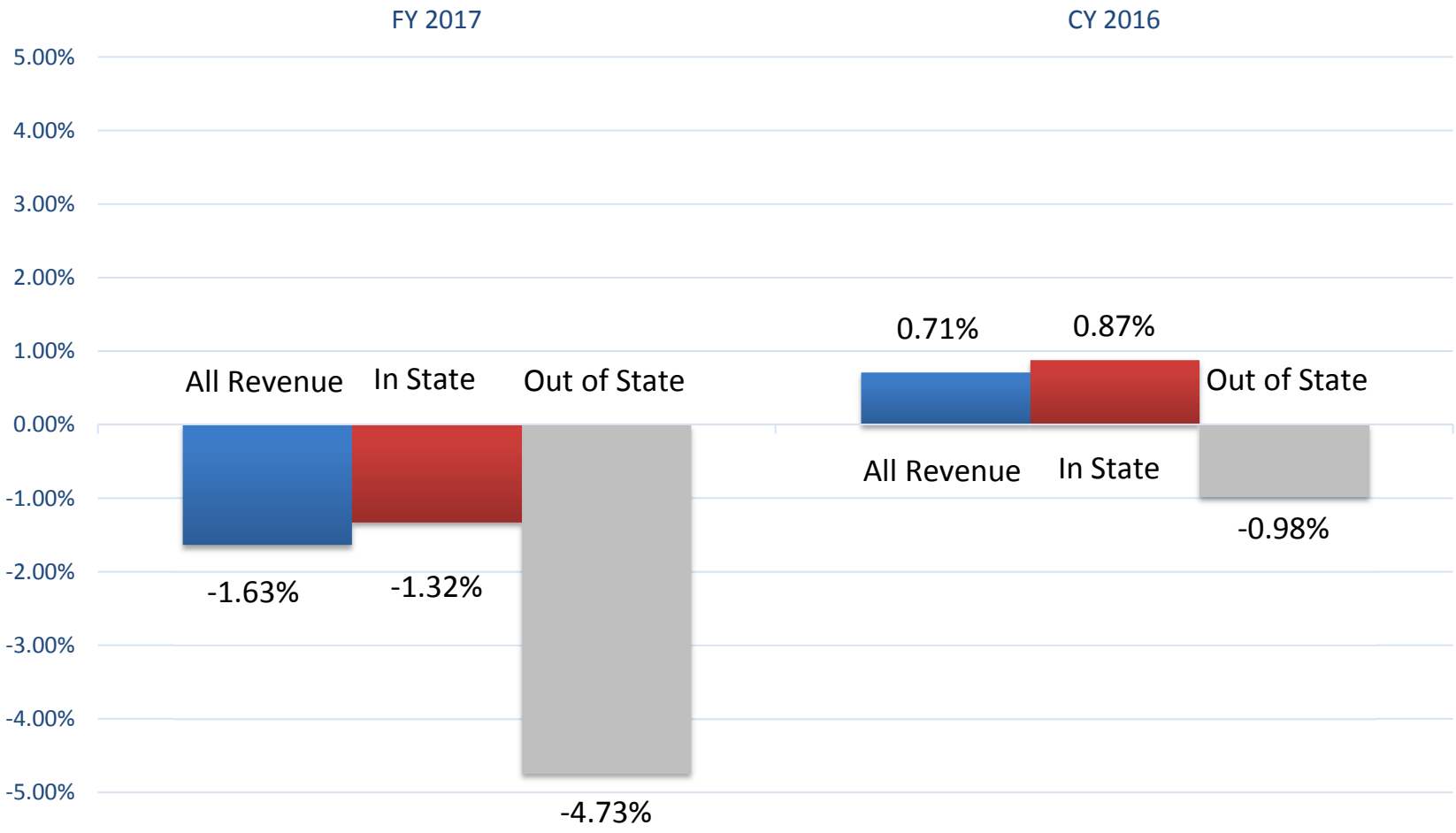
Monitoring Maryland Performance
Financial Data

Year to Date thru September 2016

Gross All Payer Revenue Growth
Year to Date (thru September 2016) Compared to Same Period in Prior Year



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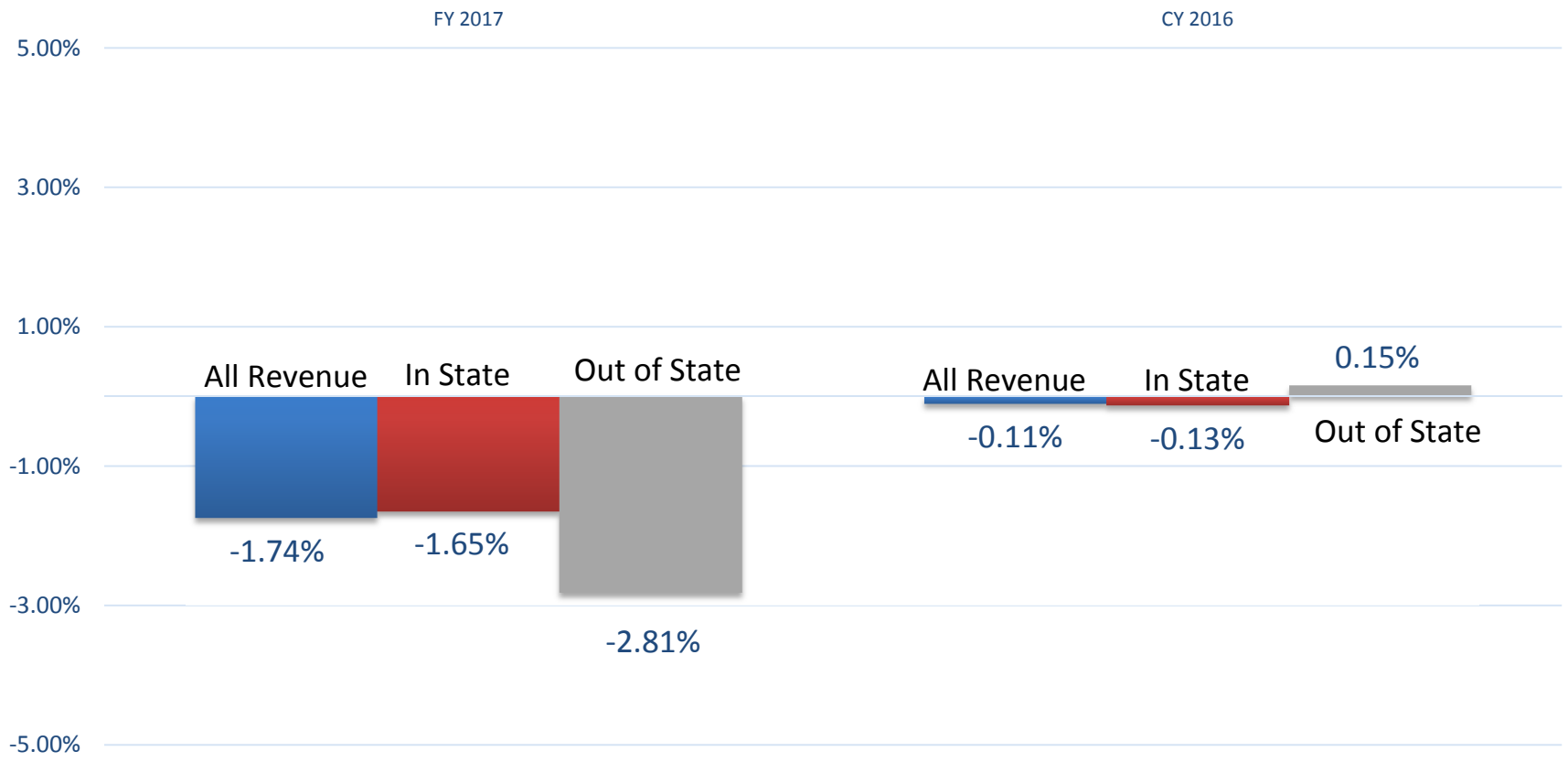
Gross Medicare Fee-for-Service Revenue Growth Year to Date (thru September 2016) Compared to Same Period in Prior Year



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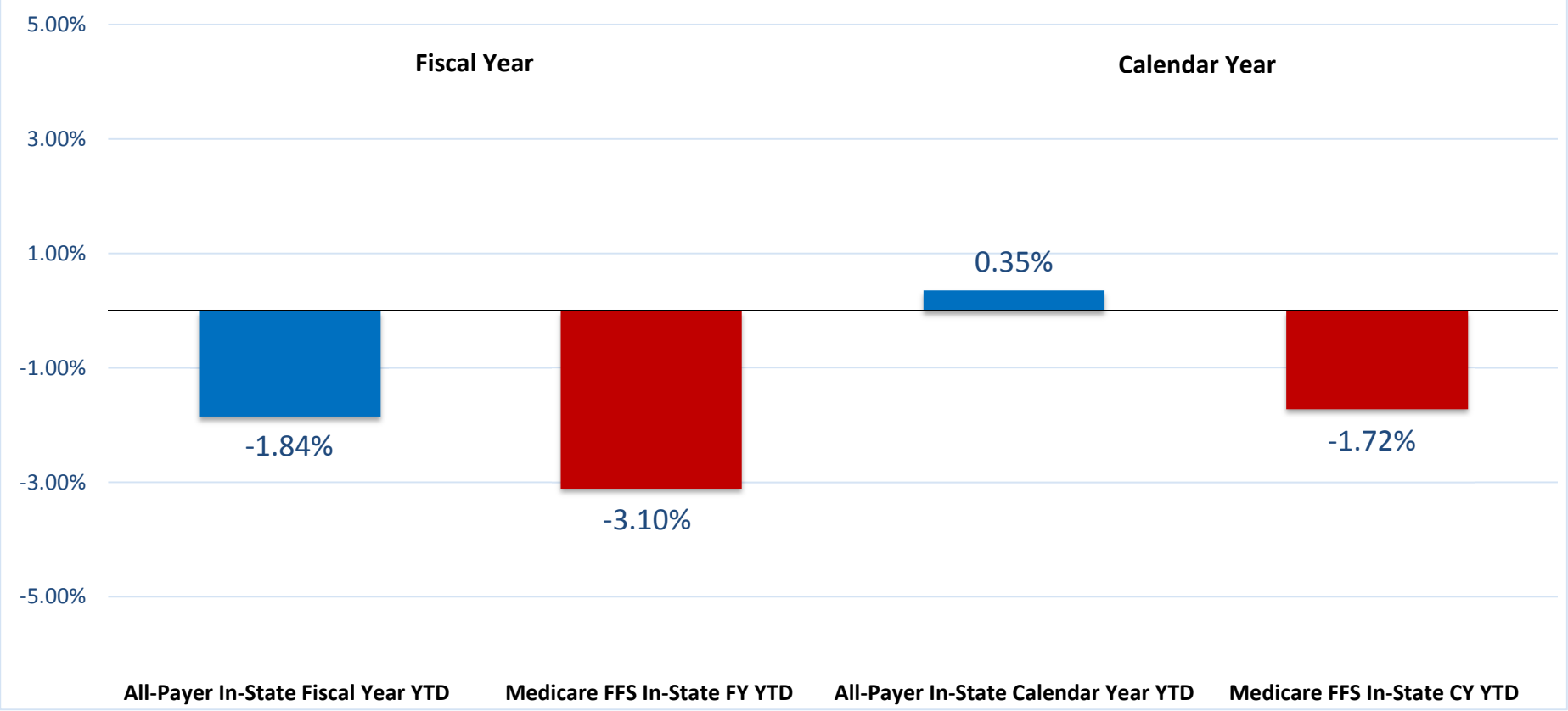
Per Capita Growth Rates

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



- **Calendar and Fiscal Year trends through September 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

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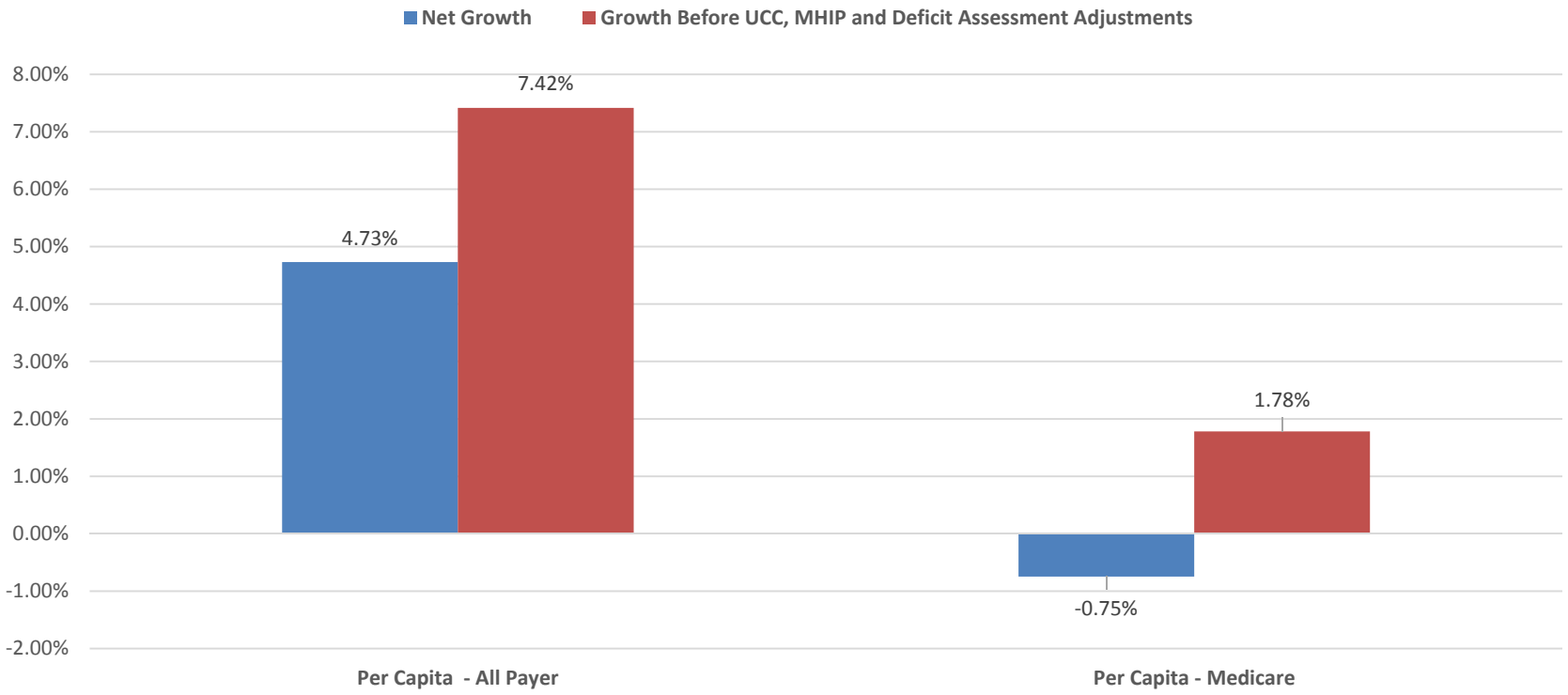
Per Capita Growth – Actual and Underlying Growth

CY 2016 Year to Date (Jan-Sept) 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 and FY17 revenue decreases of .49% UCC and 0.15% Deficit Assessment.

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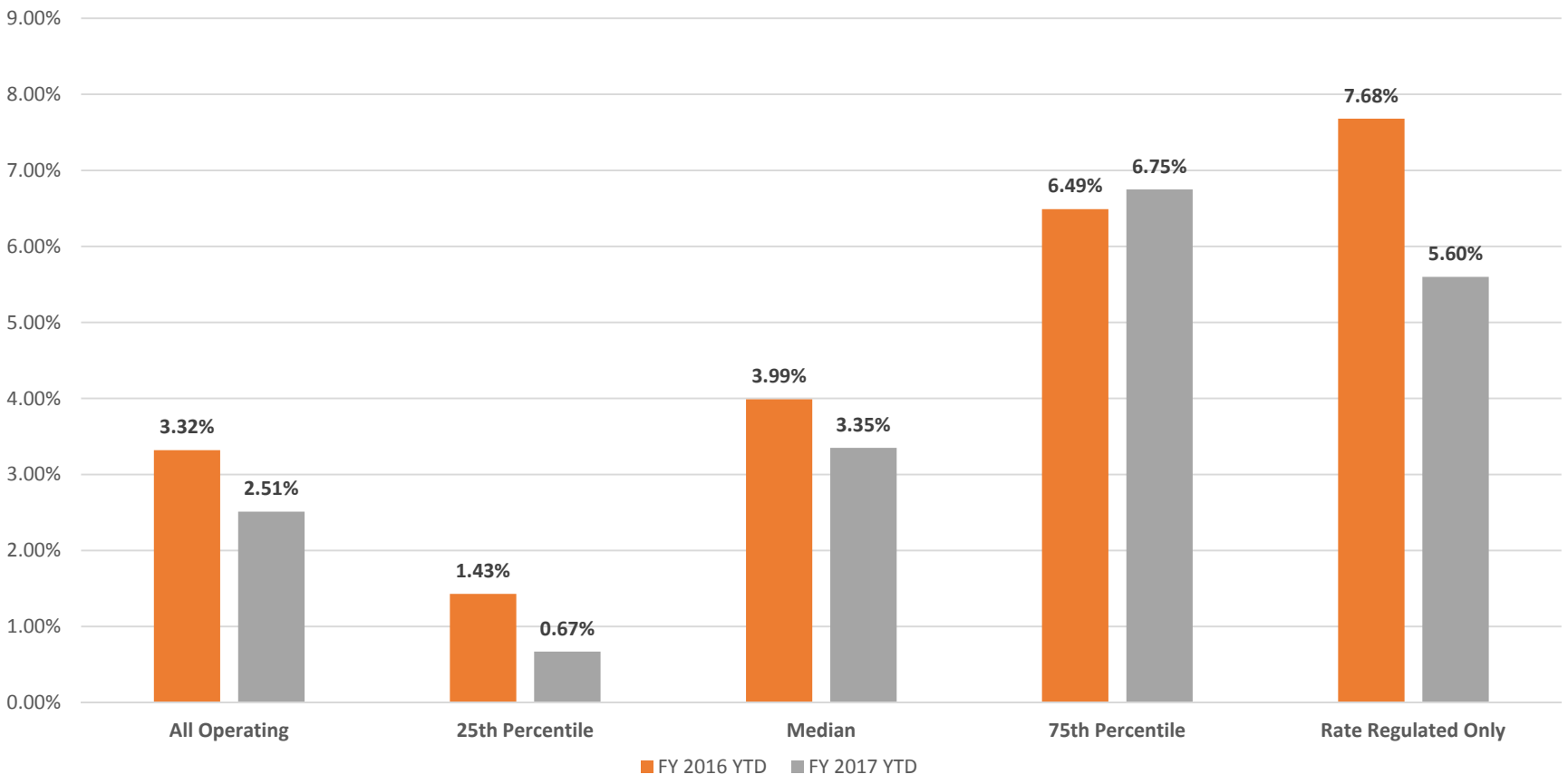
Total Operating Profits FYTD 2016 vs FYTD 2017
(July-September)



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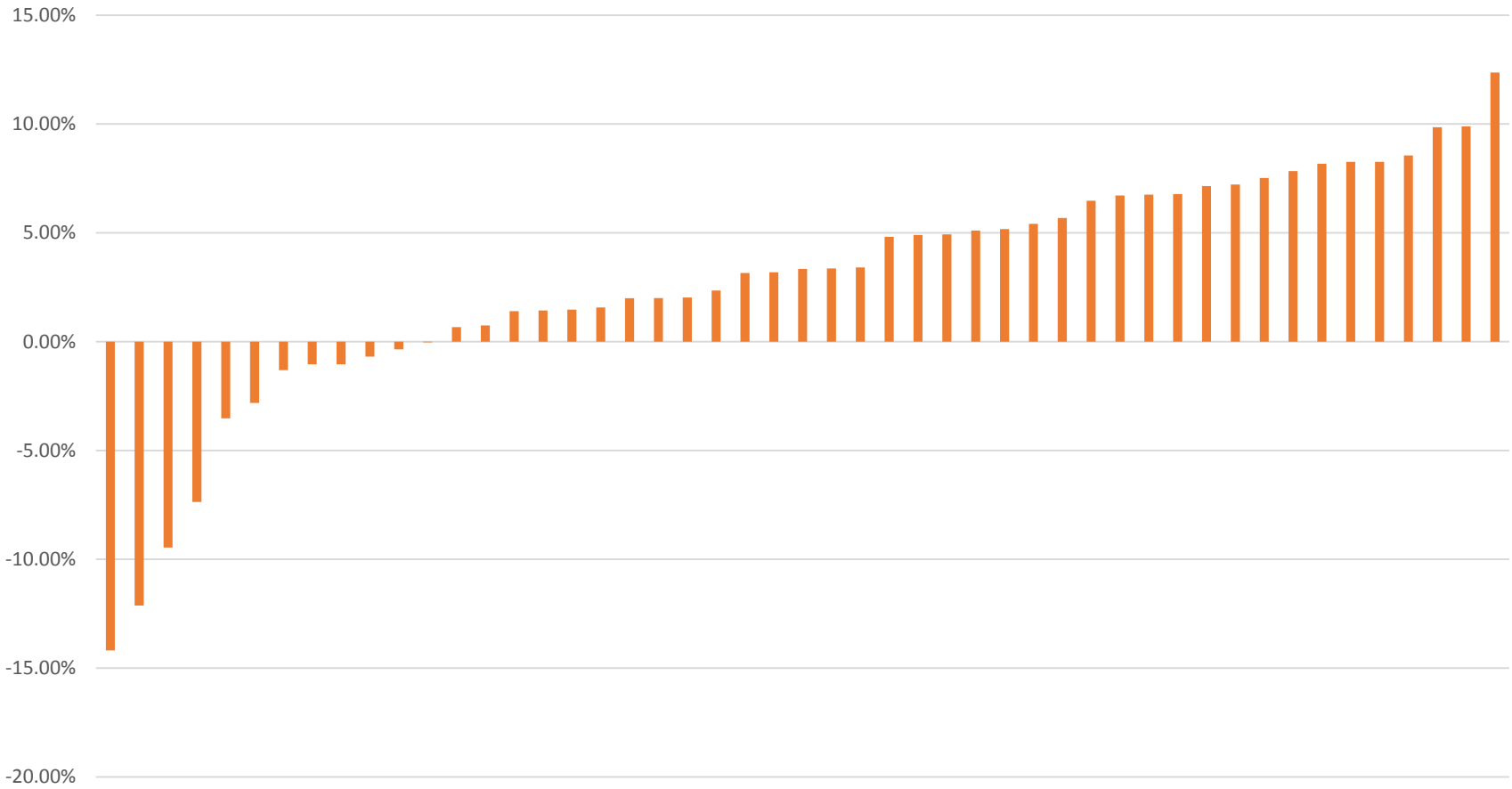
Total Operating Profits by Hospital
Fiscal Year 2017 to Date (Jul-Sept 2016)



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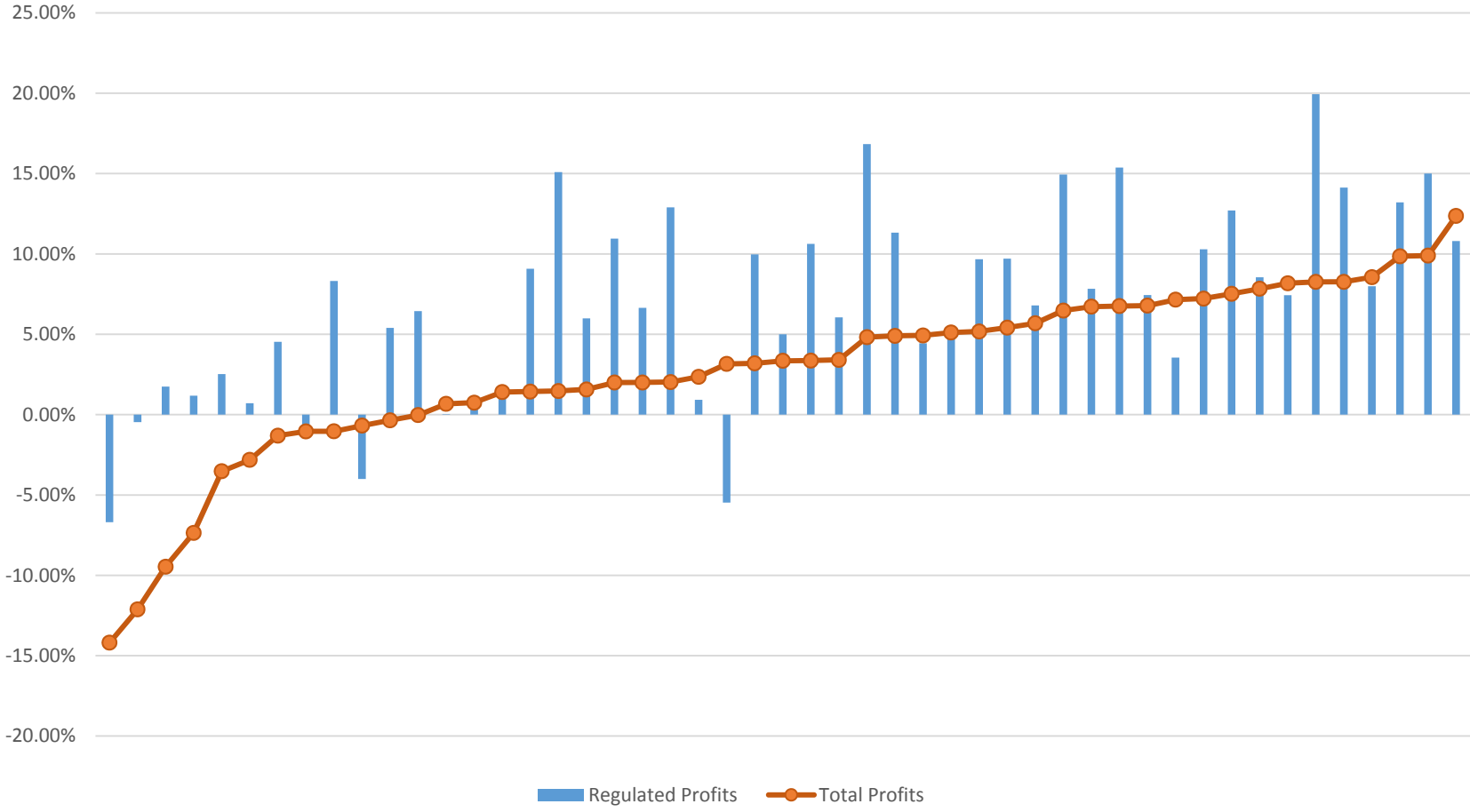
Regulated and Total Operating Profits by Hospital Fiscal Year 2017 to Date (Jul-Sept 2016)



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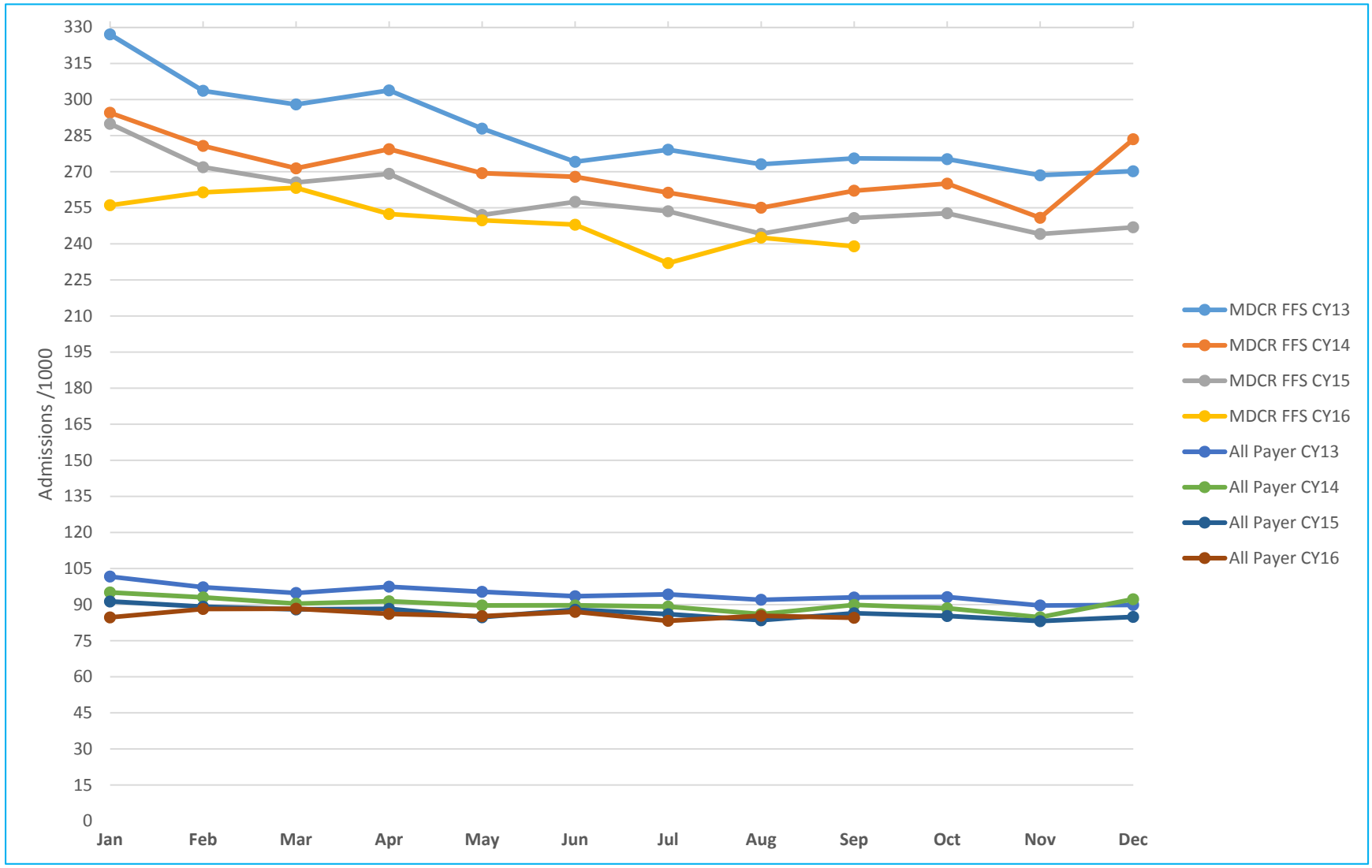
Annual Trends for Admissions/1000 (ADK) Annualized Medicare FFS and All Payer (CY 2013 through CY 2016 YTD)



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

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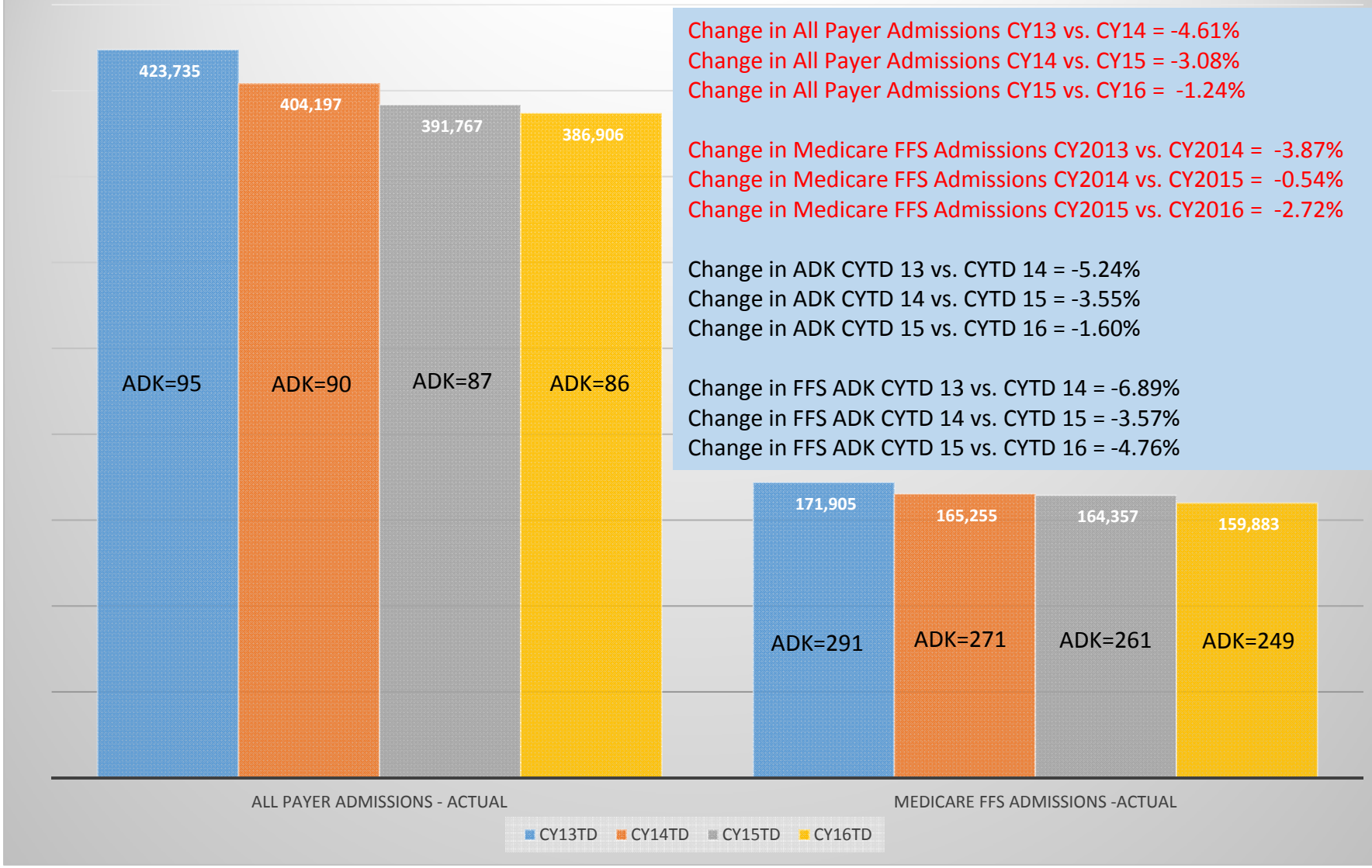
Actual Admissions by Calendar Year to Date through September



Change in All Payer Admissions CY13 vs. CY14 = -4.61%
Change in All Payer Admissions CY14 vs. CY15 = -3.08%
Change in All Payer Admissions CY15 vs. CY16 = -1.24%

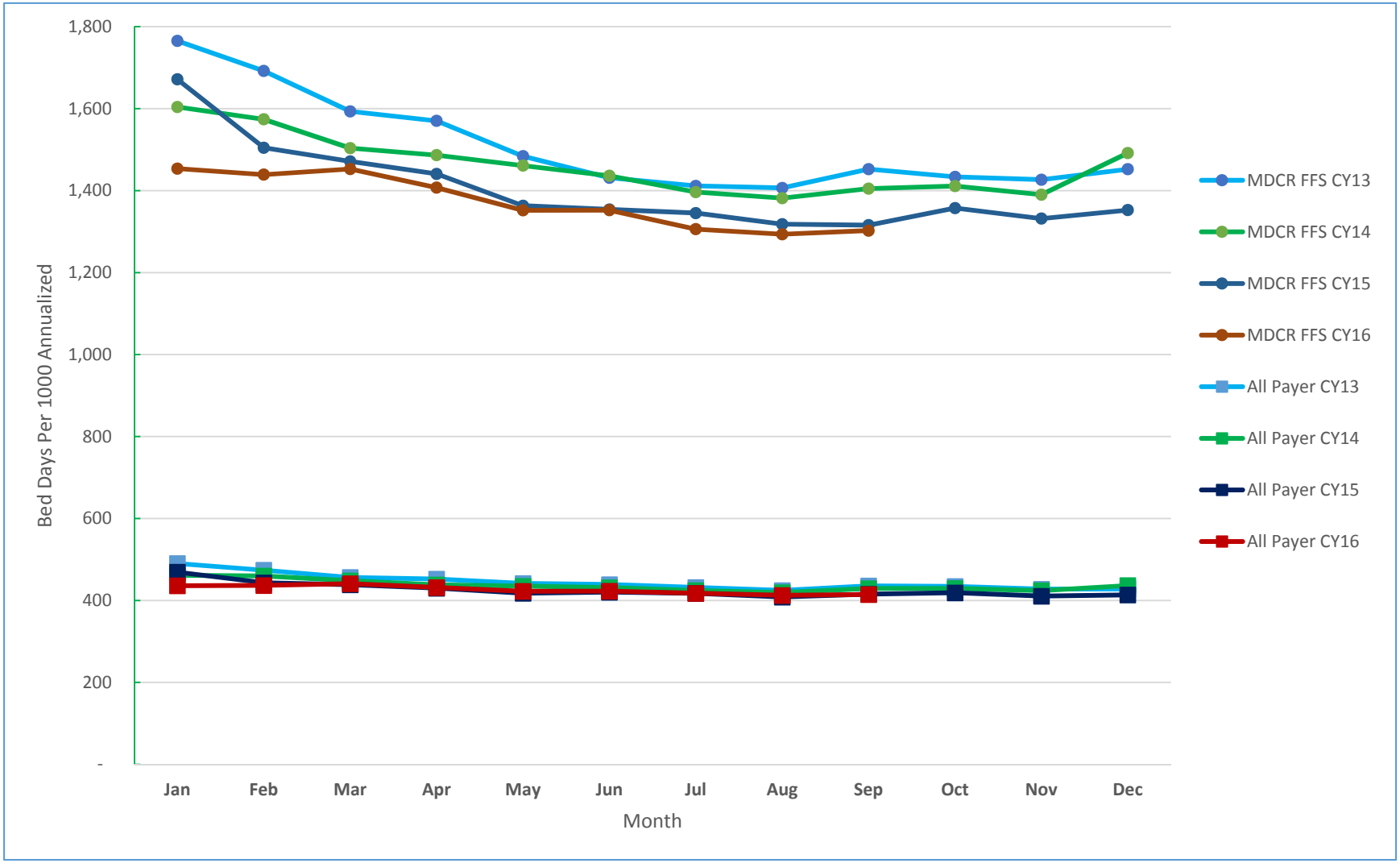
Change in Medicare FFS Admissions CY2013 vs. CY2014 = -3.87%
Change in Medicare FFS Admissions CY2014 vs. CY2015 = -0.54%
Change in Medicare FFS Admissions CY2015 vs. CY2016 = -2.72%

Change in ADK CYTD 13 vs. CYTD 14 = -5.24%
Change in ADK CYTD 14 vs. CYTD 15 = -3.55%
Change in ADK CYTD 15 vs. CYTD 16 = -1.60%

Change in FFS ADK CYTD 13 vs. CYTD 14 = -6.89%
Change in FFS ADK CYTD 14 vs. CYTD 15 = -3.57%
Change in FFS ADK CYTD 15 vs. CYTD 16 = -4.76%

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

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.

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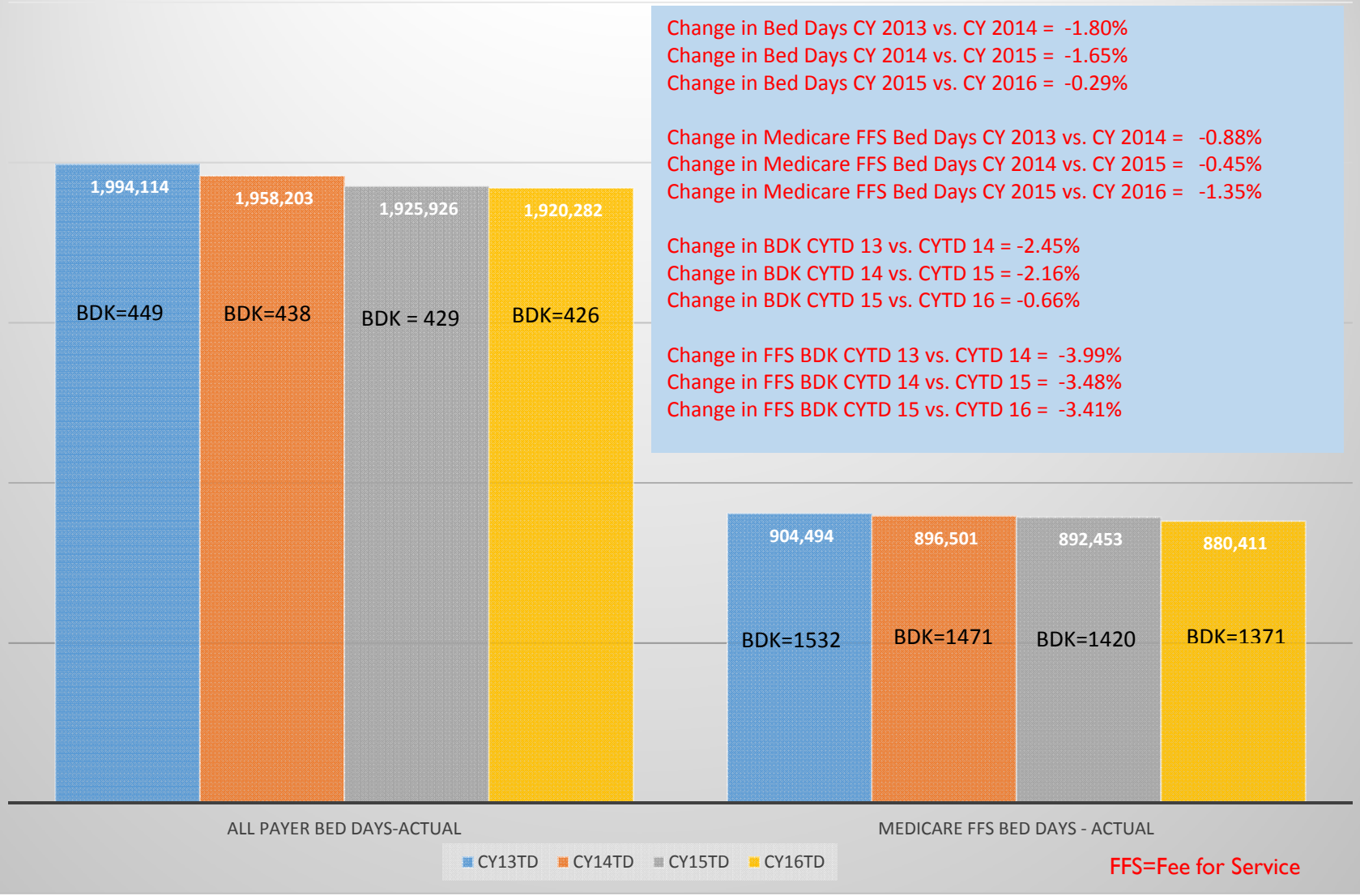
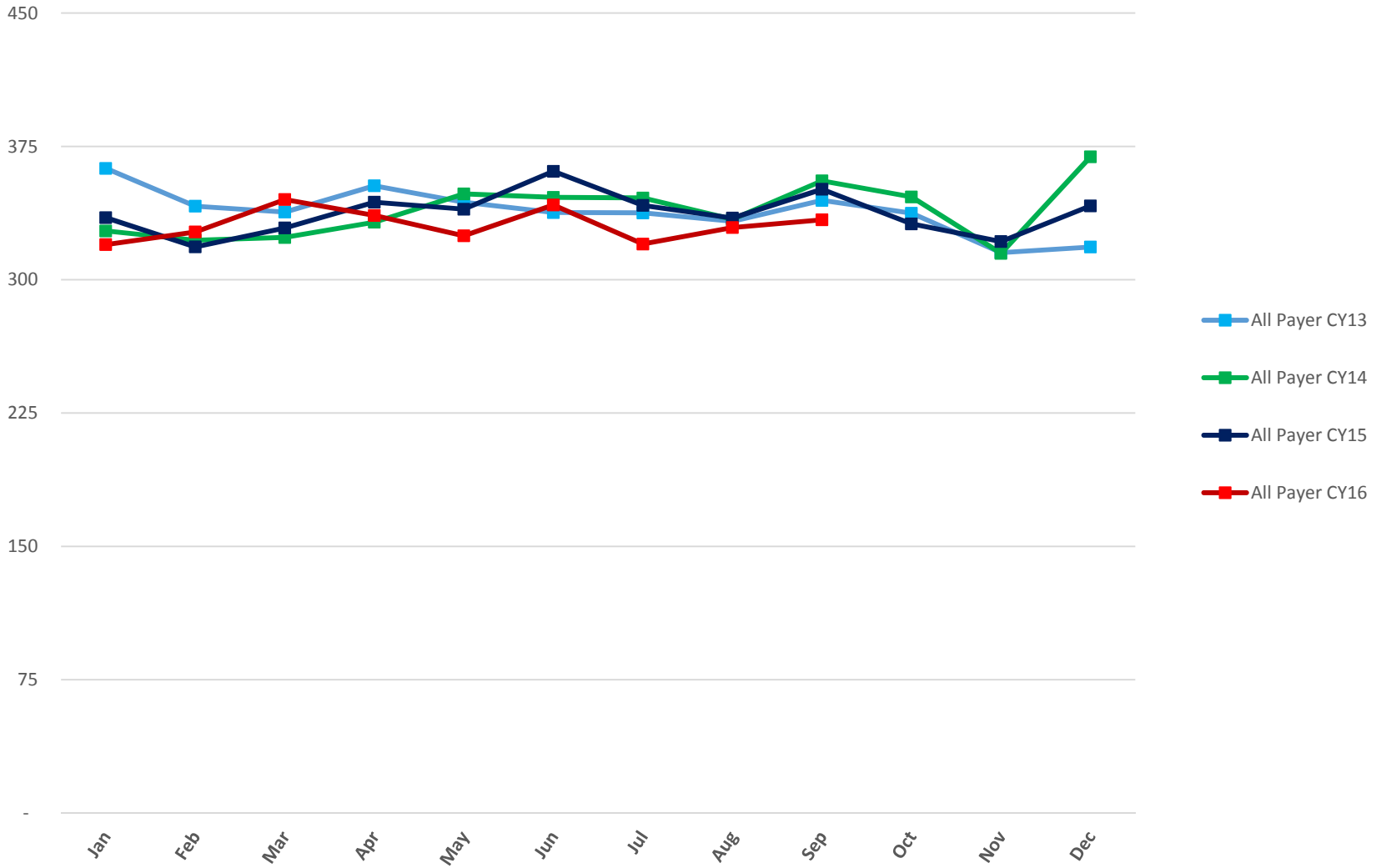
Actual Bed Days by Calendar Year to Date through September 2016



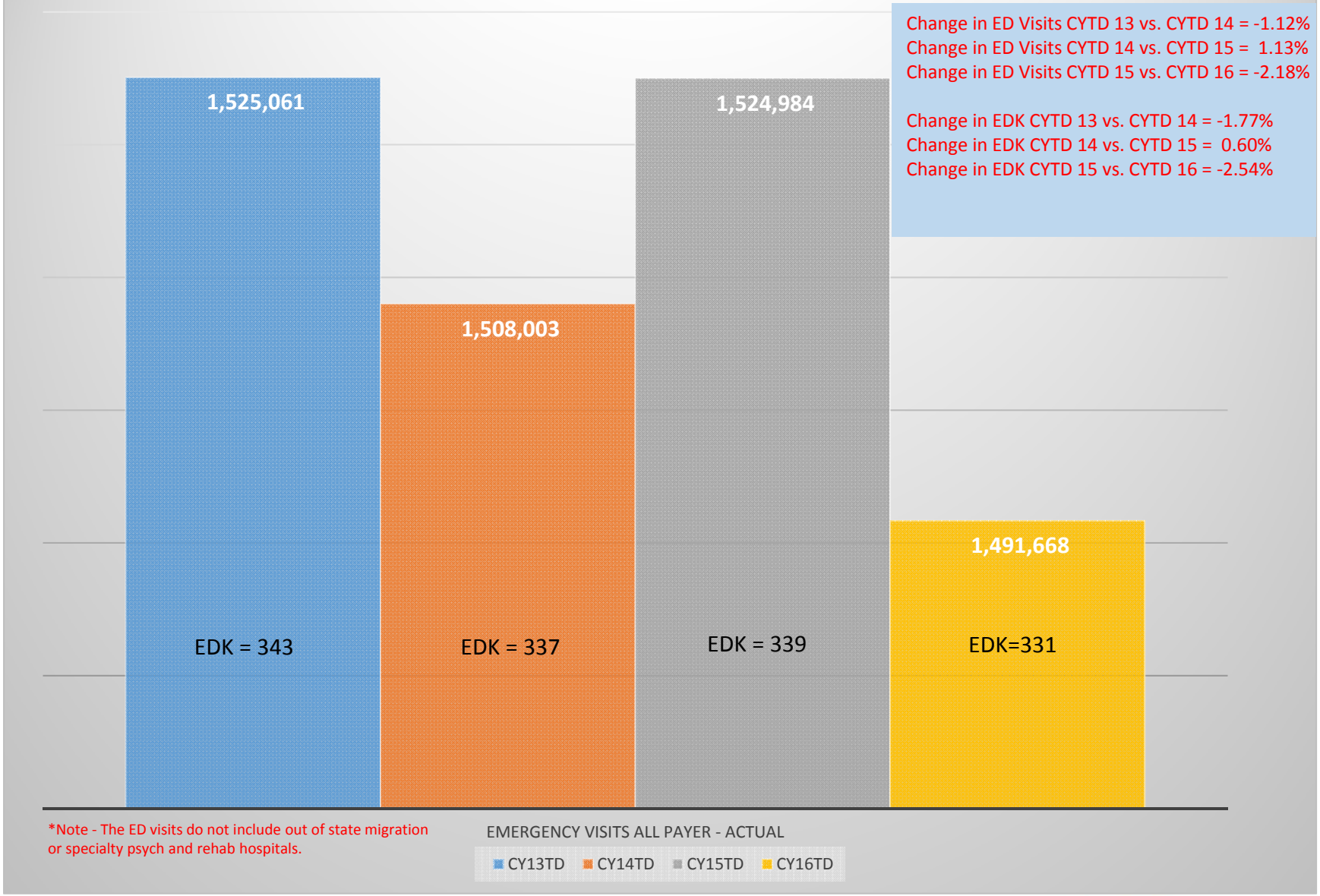
*Note – The bed days do not include out of state migration or specialty psych and rehab hospitals.

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



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

Actual ED Visits by Calendar YTD through September 2016



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Purpose of Monitoring Maryland Performance

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

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

Data Caveats

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

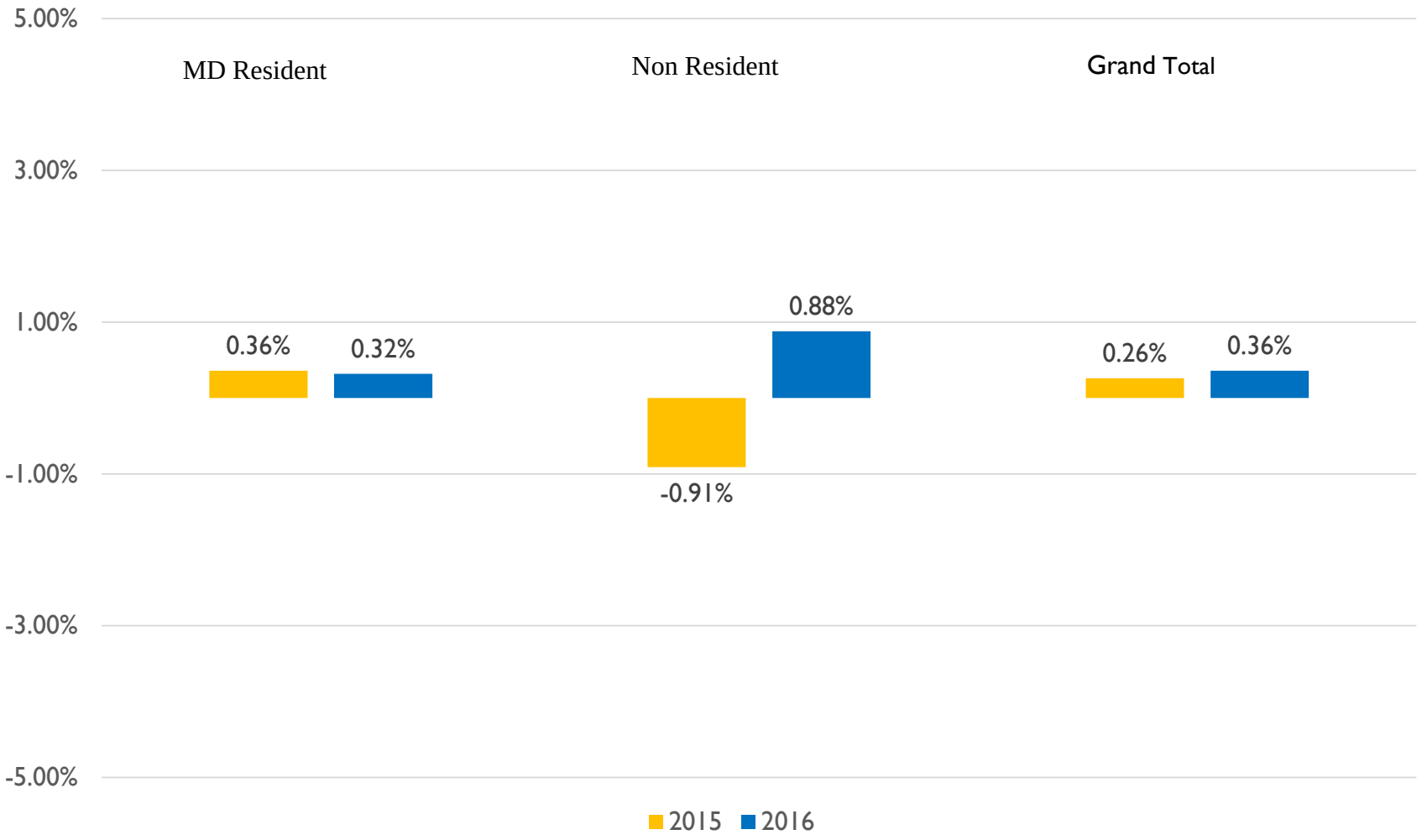
Data Caveats cont.

- 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.

Monitoring Maryland Performance
Preliminary Utilization Trends

2016 vs 2015
(January to September)

All Payer ECMAD CYTD Annual Growth



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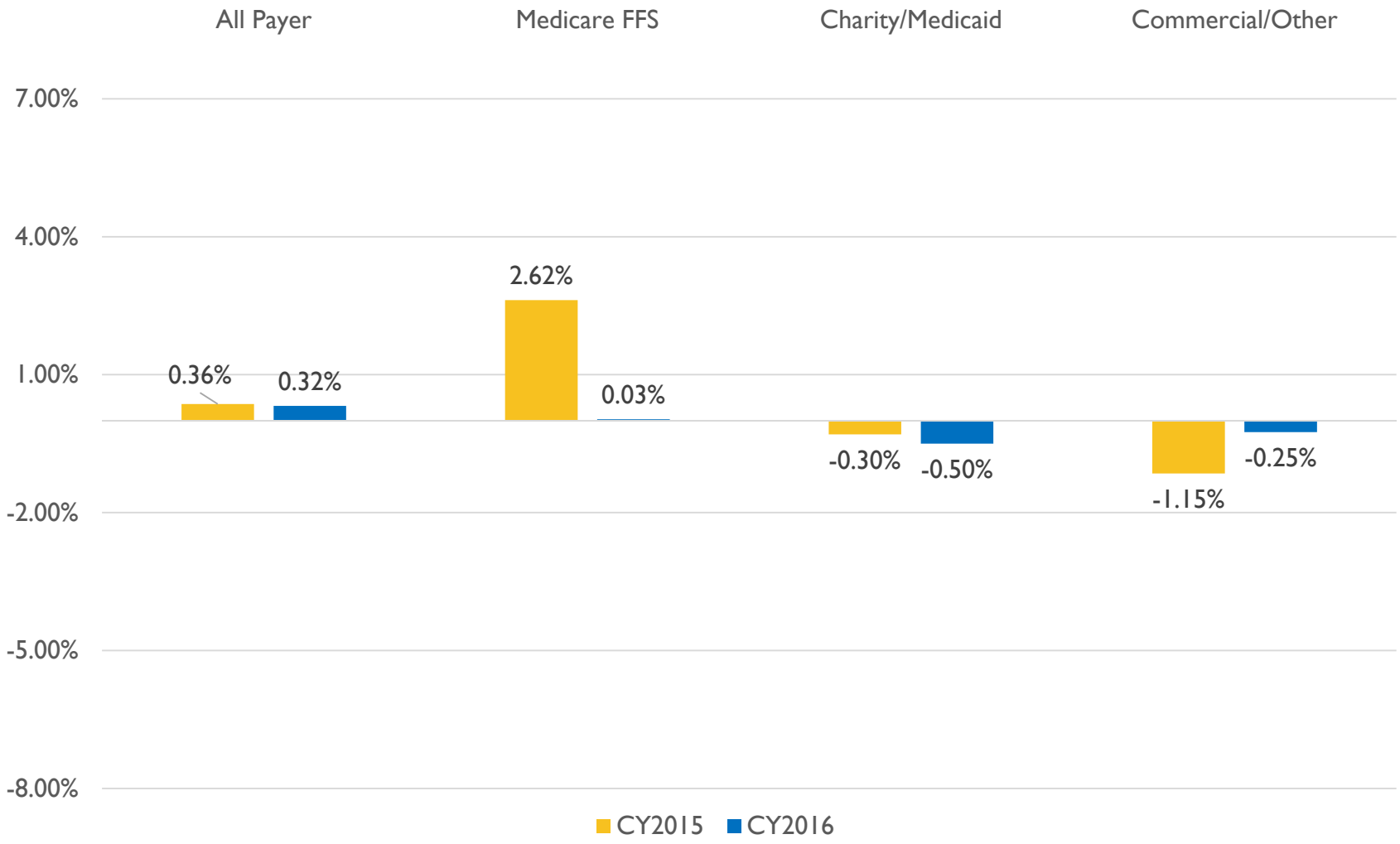
MD Resident ECMAD CYTD Annual Growth



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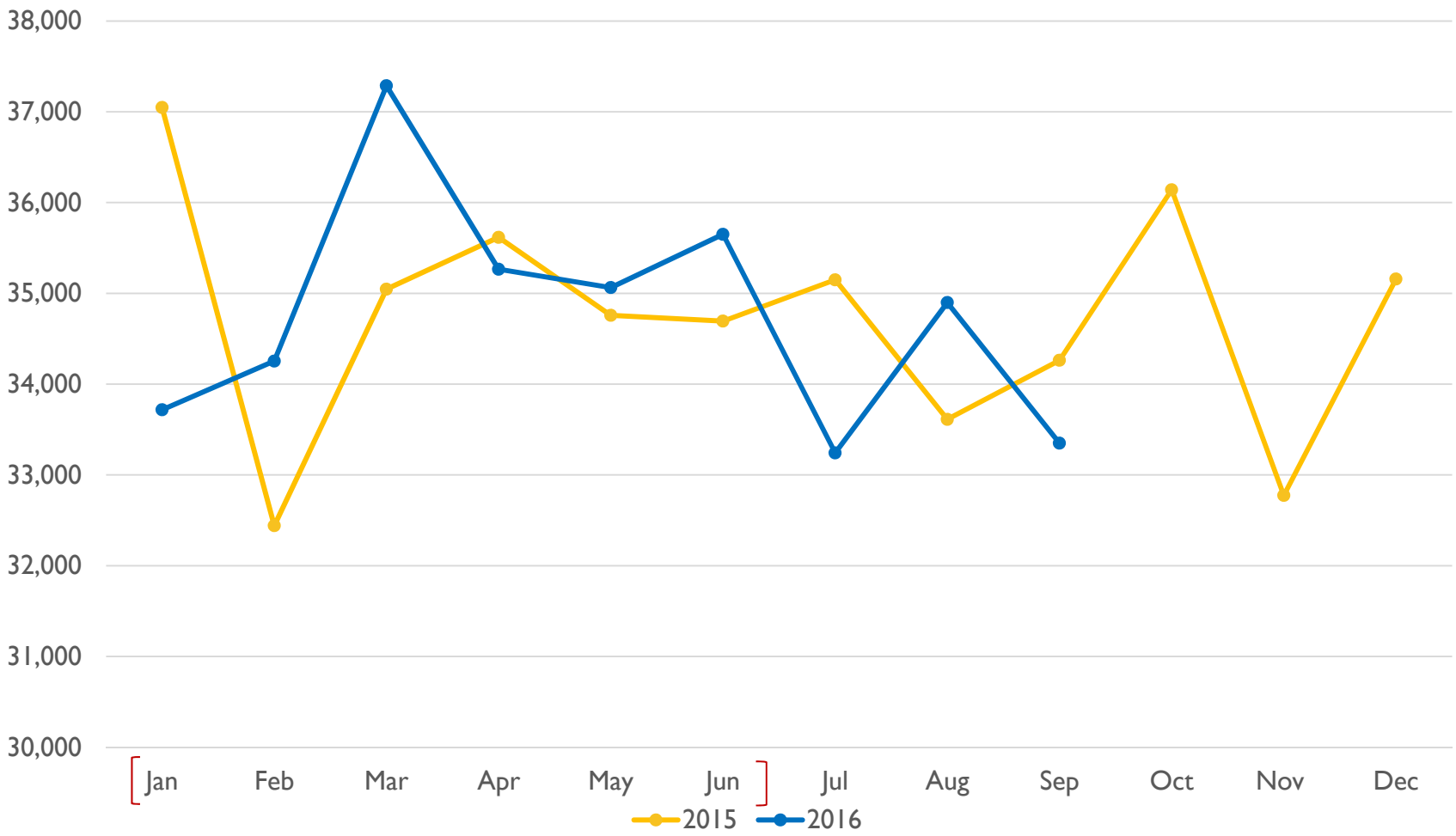
Medicare MD Resident ECMAD Annual Growth by Month



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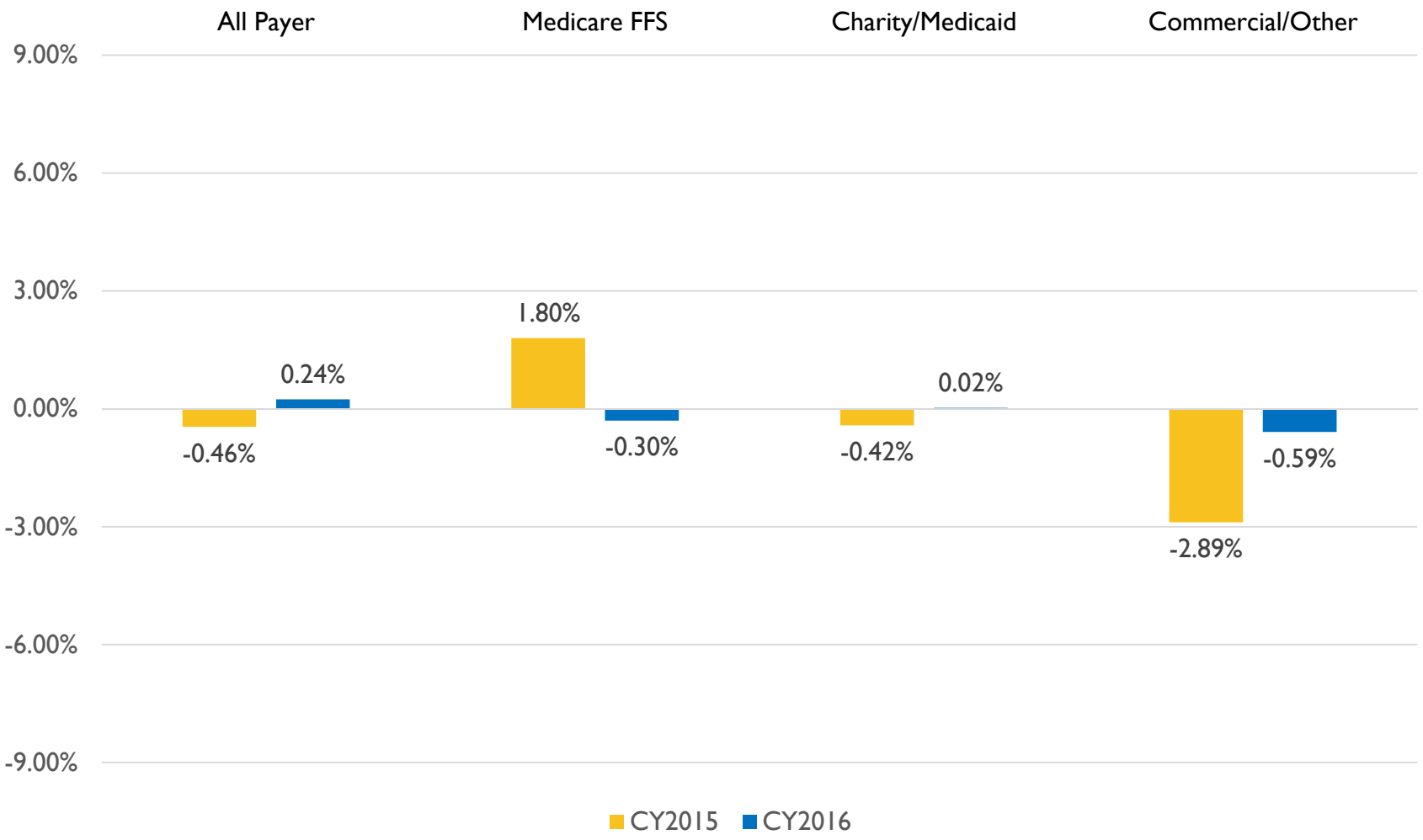
MD Resident Inpatient ECMAD CYTD Annual Growth



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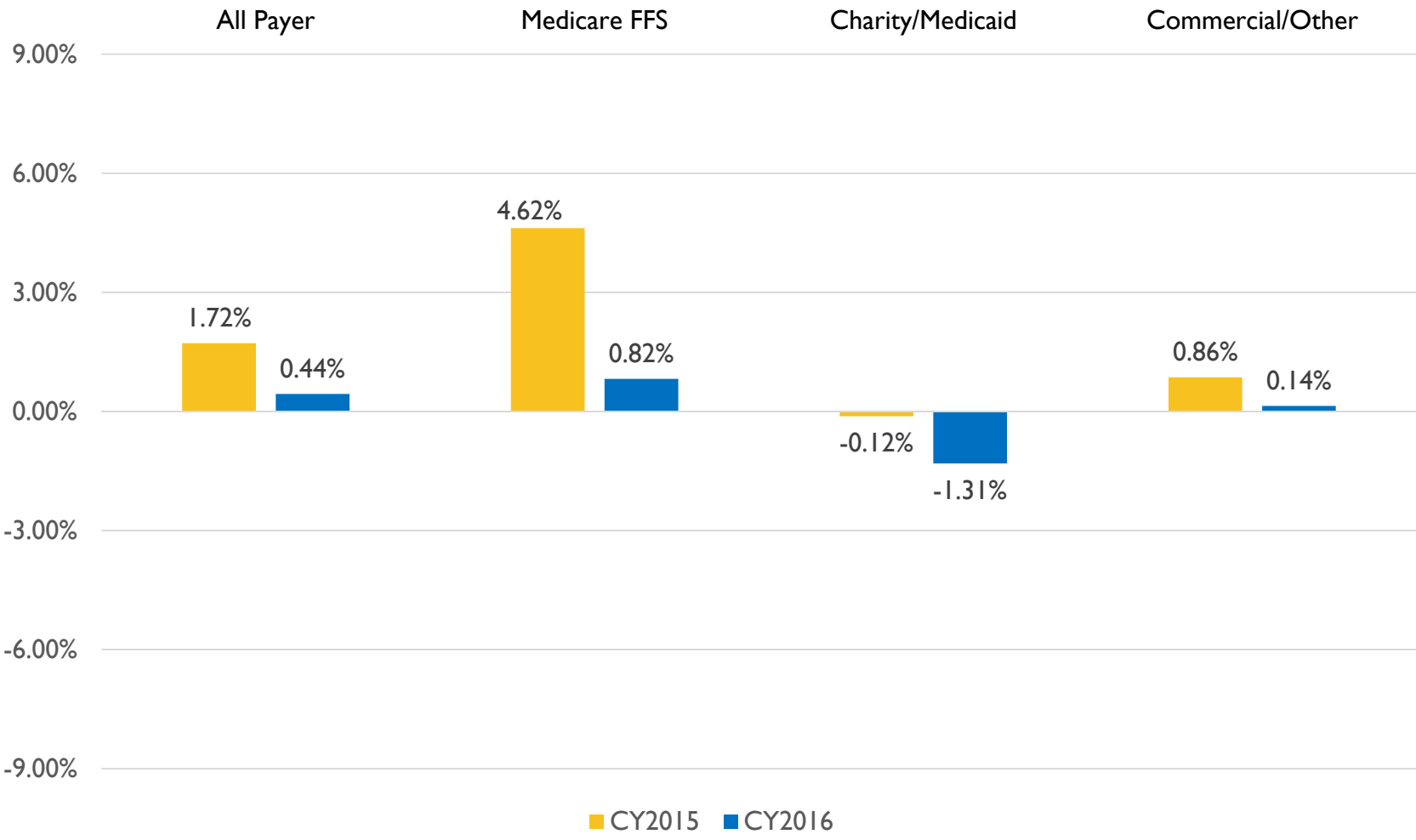
MD Resident Outpatient ECMAD CYTD Annual Growth



31
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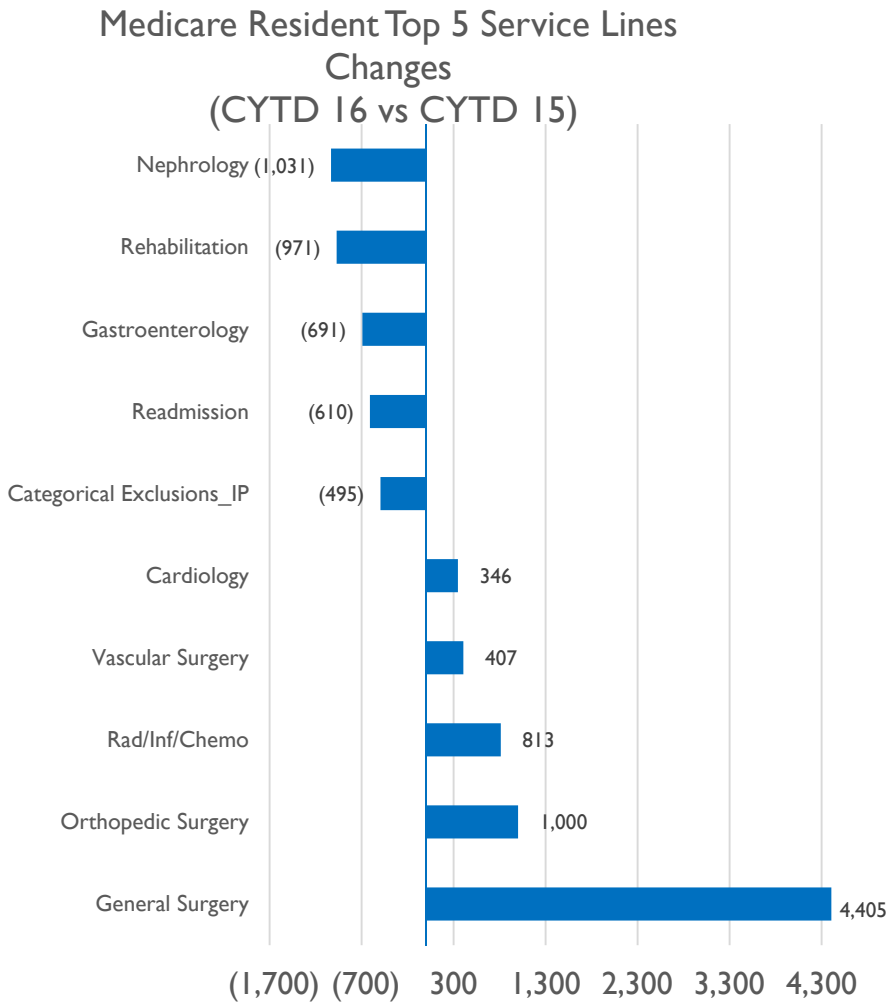
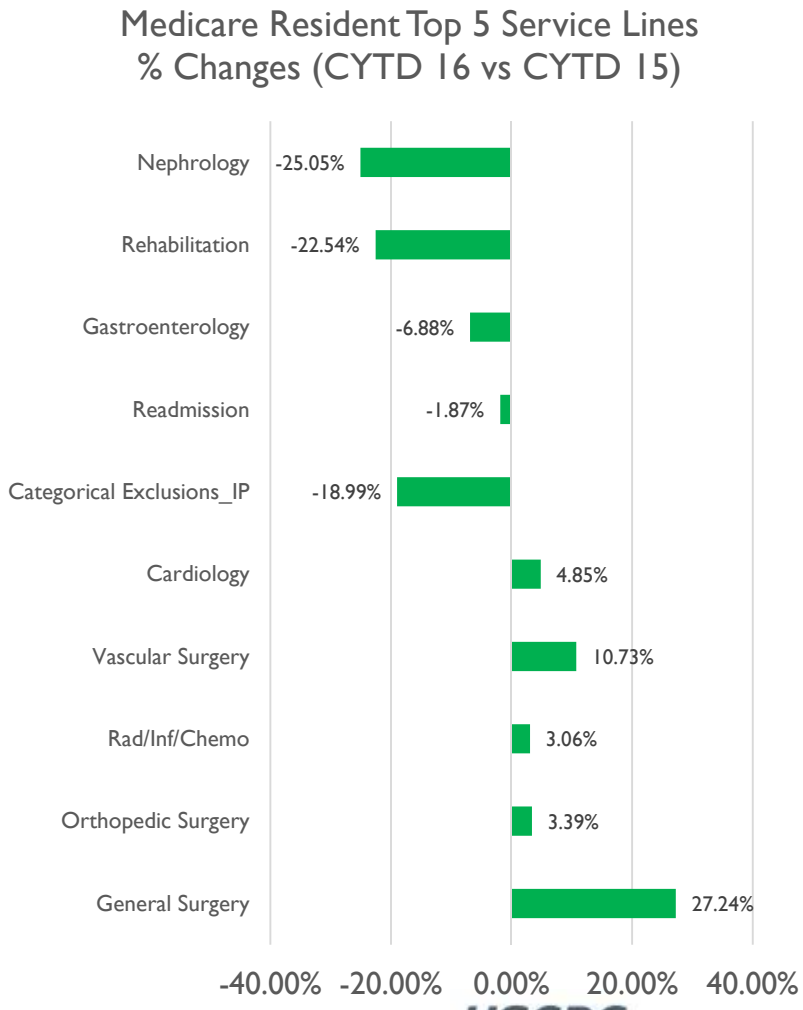
Medicare MD Resident Top 5 Service Line Changes (Total ECMAD Increase = 101





Note: General Surgery surge due to transition from ICD 9 to ICD 10 Coding

HSCRC
Health Services Cost Review Commission

Utilization Analytics – Data Notes

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

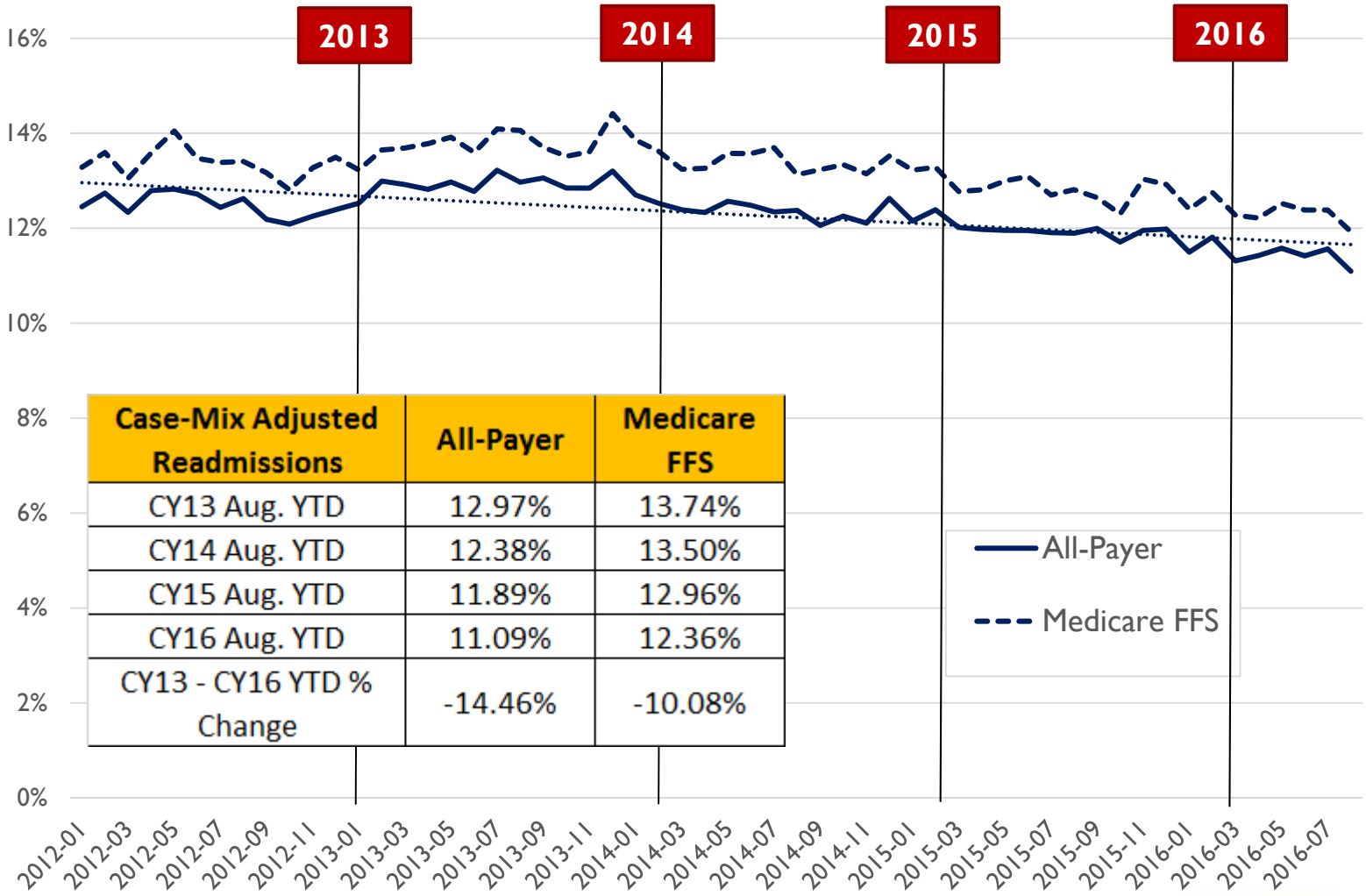
Service Line Definitions

- Inpatient service lines:
  - APR DRG (All Patient Refined Diagnostic Related Groups) to service line mapping
  - Readmissions and PQIs (Prevention Quality Indicators) are top level service lines (include different service lines)
- Outpatient service lines:
  - Highest EAPG (Enhanced Ambulatory Patient Grouping System) to service line mapping
  - Hierarchical classifications (Emergency Department, major surgery etc)
- Market Shift technical documentation

Monitoring Maryland Performance
Quality Data

November 2016 Commission Meeting Update

Monthly Case-Mix Adjusted Readmission Rates

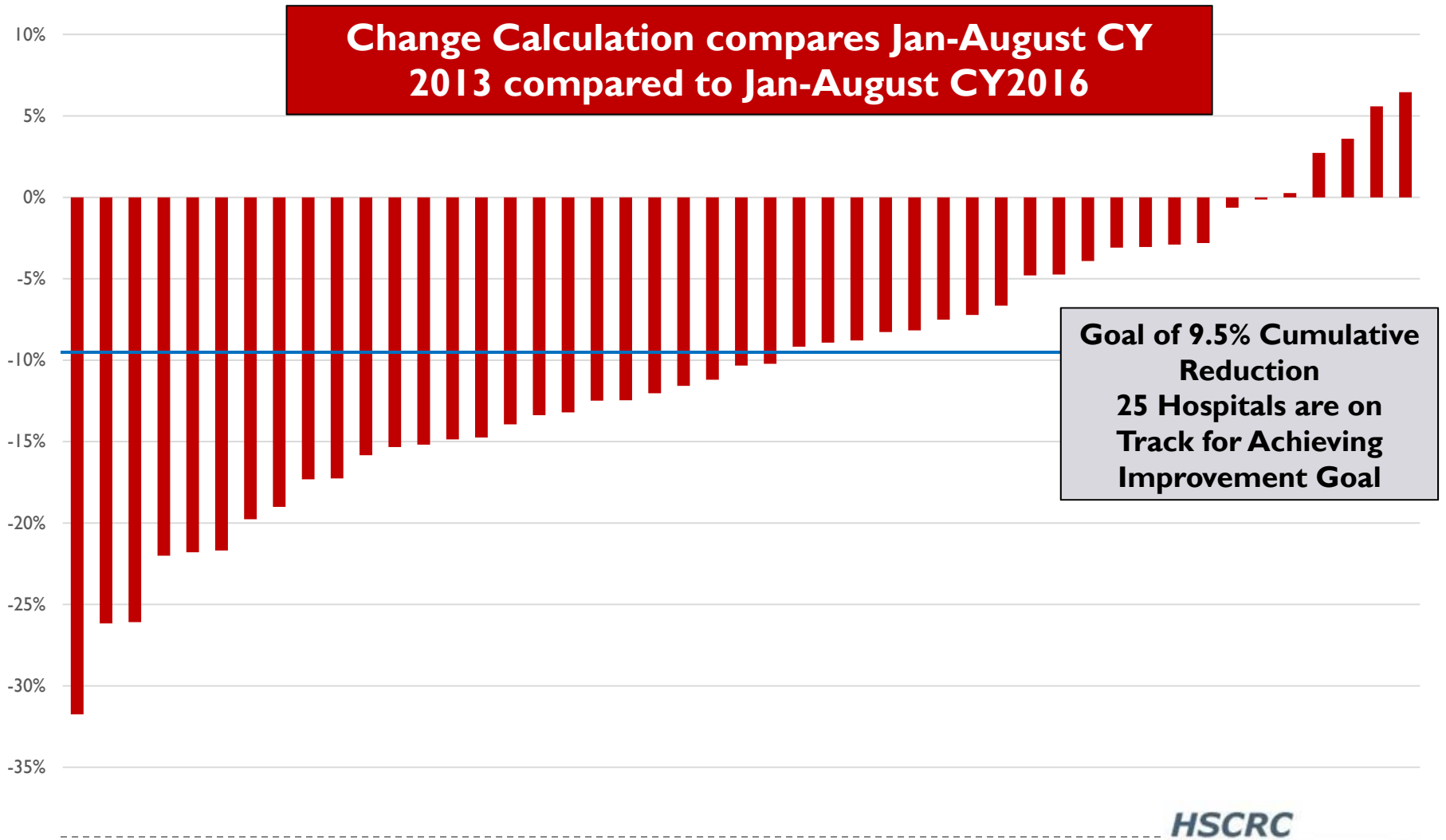


Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
CY13 Aug. YTD	12.97%	13.74%
CY14 Aug. YTD	12.38%	13.50%
CY15 Aug. YTD	11.89%	12.96%
CY16 Aug. YTD	11.09%	12.36%
CY13 - CY16 YTD % Change	-14.46%	-10.08%

Note: Based on final data for January 2012 – June2016, and preliminary data through September 2016.

HSCRC
Health Services Cost Review Commission

Change in All-Payer Case-Mix Adjusted Readmission Rates by Hospital

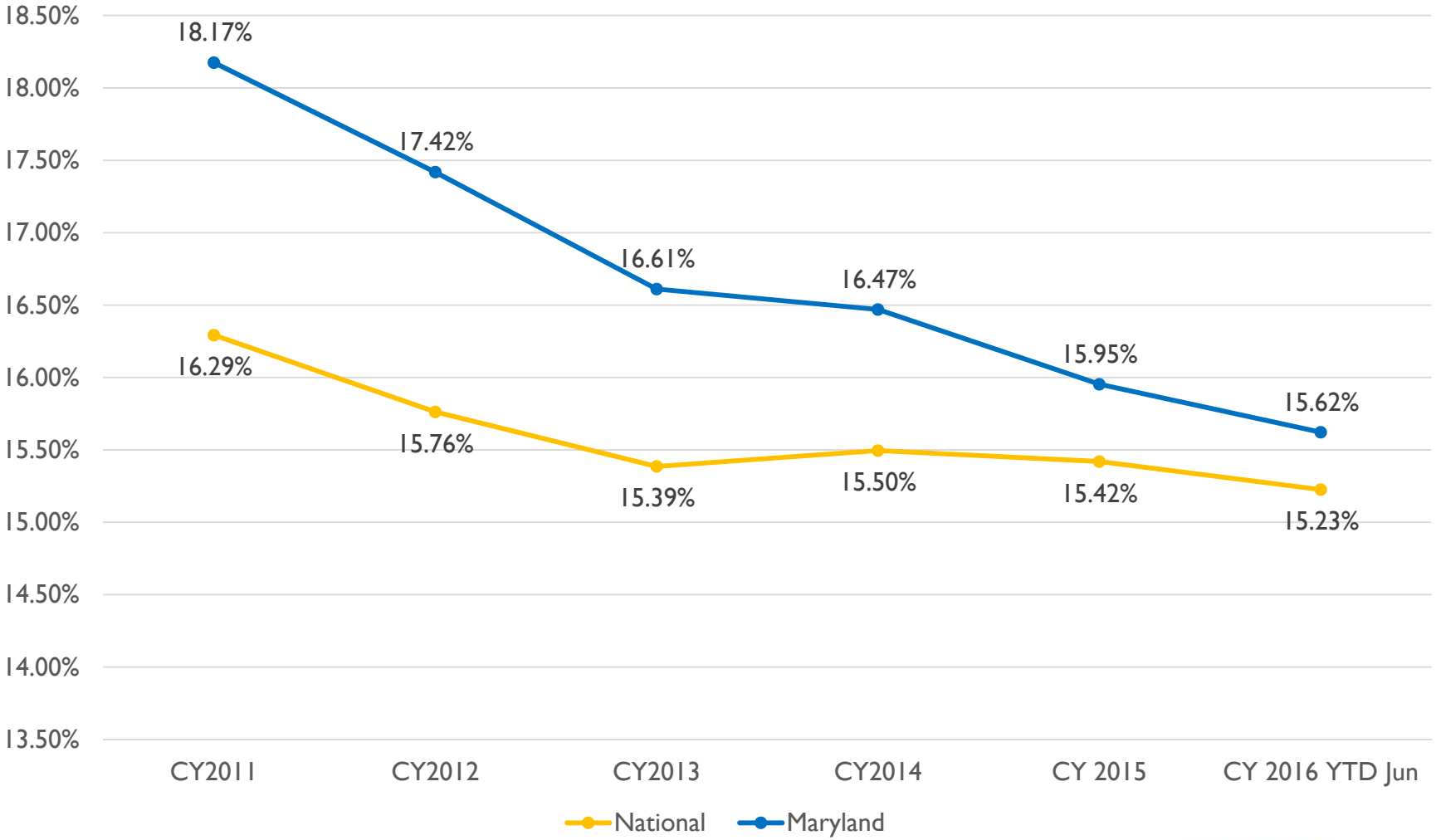


Note: Based on final data for January 2012 – June2016, and preliminary data through September 2016

HSCRC
Health Services Cost Review Commission

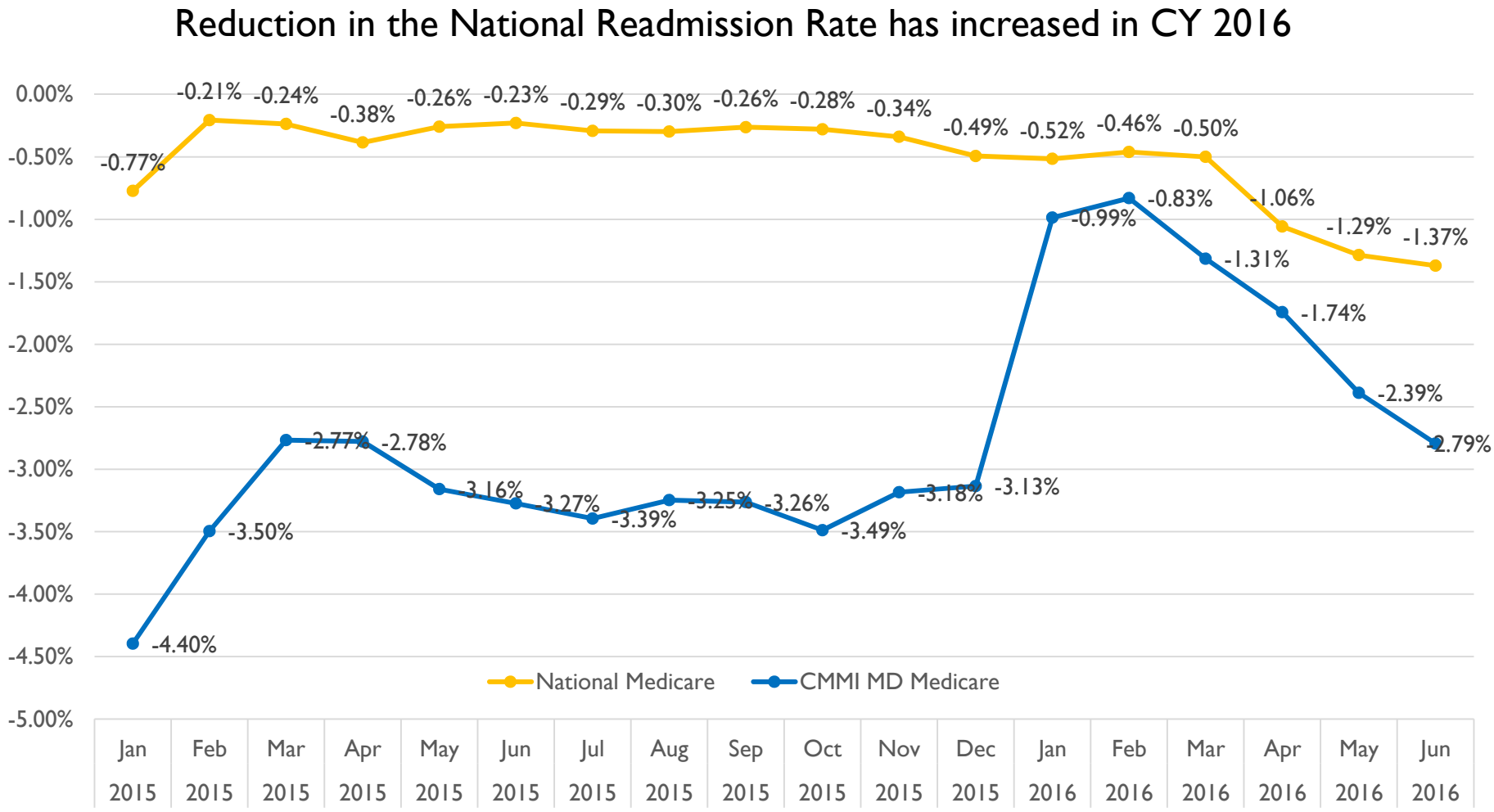
Medicare Readmission All-Payer Model Test

Maryland is reducing readmission rate but only slightly faster than the nation



HSCRC
Health Services Cost Review Commission

Cumulative Readmission Rate Change by Month (year over year): Maryland vs Nation

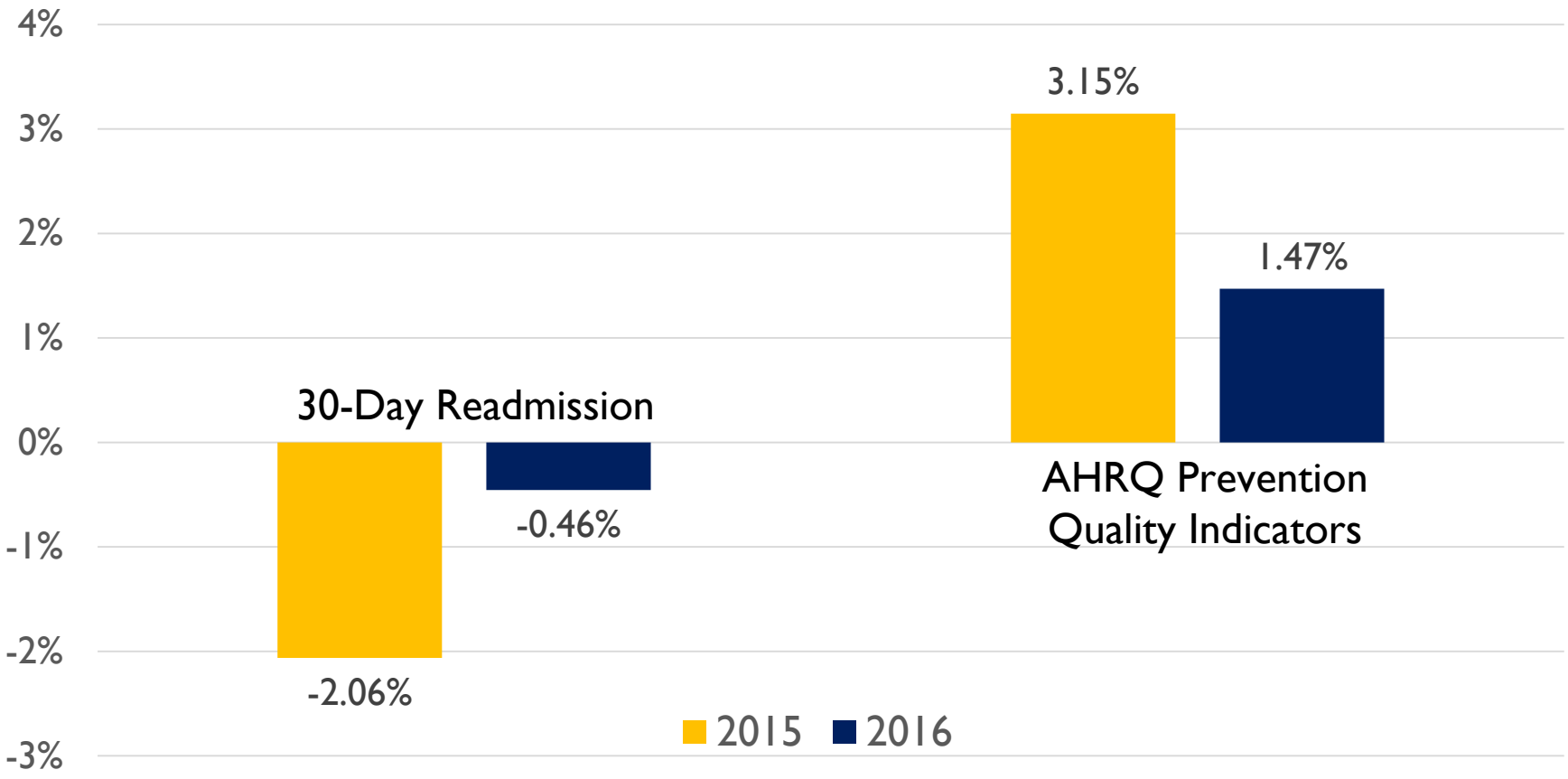


HSCRC
Health Services Cost Review Commission

Potentially Avoidable Utilization Update

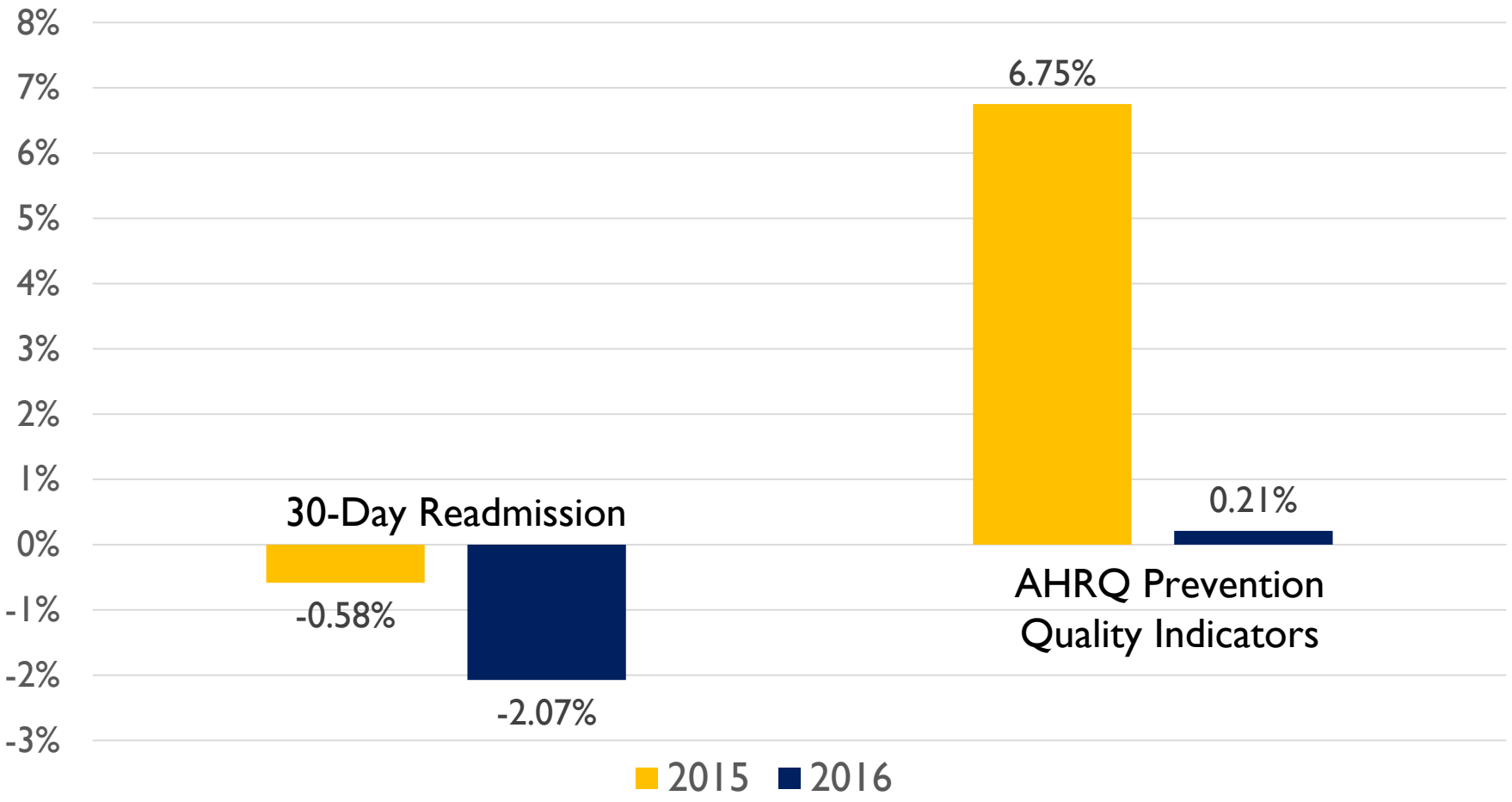
HSCRC
Health Services Cost Review Commission

All Payer Readmission and Prevention Quality Indicator ECMAD Annual Growth – CYTD Sept.



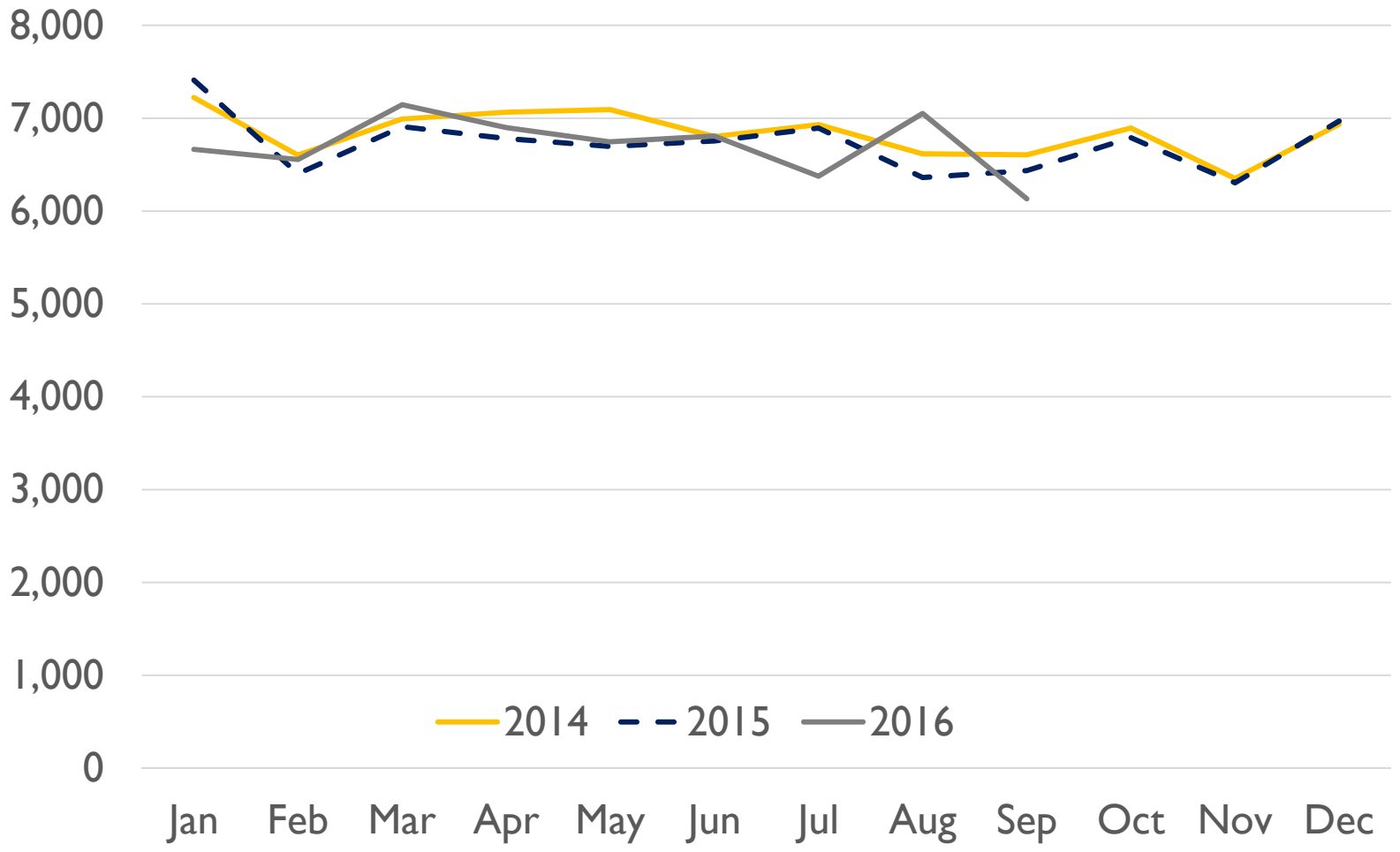
HSCRC
Health Services Cost Review Commission

Medicare FFS Readmission and Prevention Quality Indicator ECMAD Annual Growth – CYTD Sept.



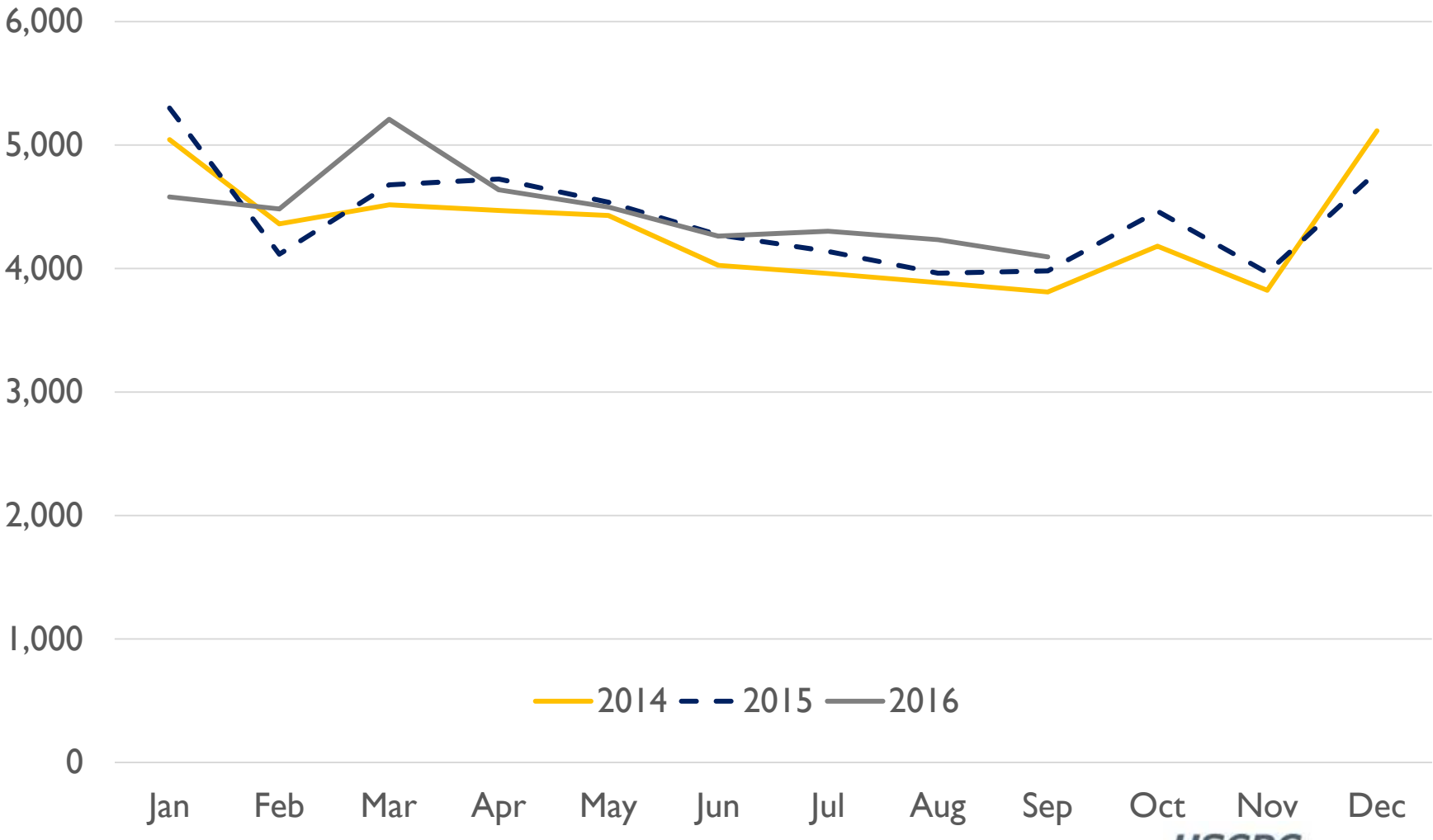
HSCRC
Health Services Cost Review Commission

All-Payer Readmission ECMAD Growth by Month



HSCRC
Health Services Cost Review Commission

All-Payer PQI ECMAD Growth by Month



HSCRC
Health Services Cost Review Commission

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF NOVEMBER 2, 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
2353A	Proirty Partners	9/20/2016	N/A	N/A	N/A	SP	OPEN
2356A	Maryland Physicians Care	10/4/2016	N/A	N/A	N/A	SP	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	SP	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	SP	OPEN
2361A	University of Maryland Health Advantage, Inc.	10/10/2016	N/A	N/A	N/A	DNP	OPEN
2362A	Johns Hopkins Health System	10/25/2016	N/A	N/A	N/A	DNP	OPEN
2363A	Johns Hopkins Health System	10/25/2016	N/A	N/A	N/A	DNP	OPEN
2364A	University of Maryland Medical Center	10/31/2016	N/A	N/A	N/A	DNP	OPEN
2365A	University of Maryland Medical Center	10/31/2016	N/A	N/A	N/A	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

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**

Final Recommendation

November 9, 2016

This is a final recommendation and ready for Commission action.

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 24.5% 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 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**

Final Recommendation

November 9, 2016

This is a final recommendation and ready for Commission action.

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**	
UNIVERSITY OF MARYLAND	*	**COMMISSION**	
MEDICAL SYSTEM	*	**DOCKET:**	**2016**
	*	**FOLIO:**	**2167**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2357A**

Final Recommendation

November 9, 2016

This is a final recommendation and ready for Commission action.

I. Introduction

On October 4, 2016, the University of Maryland Medical System (UMMS) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of its constituent hospitals (the "Hospitals"). UMMS seeks approval for University of Maryland Health Advantage, Inc. ("UMHA") to continue to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. UMHA is the UMMS entity that assumes the risk under this contract. UMHA is requesting an approval for one year beginning January 1, 2017.

II. Background

On September 1, 2015, CMS granted UMHA approval to operate a Medicare Advantage Plan to provide coverage to Maryland eligible residents in Anne Arundel, Baltimore, Caroline, Cecil, Carroll, Dorchester, Harford, Howard, Kent, Montgomery, Queen Anne's, Talbot counties and Baltimore City. The application requests approval for UMHA to provide for inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a CMS-determined capitation payment. UMHA will pay the Hospitals HSCRC-approved rates for hospital services used by its enrollees.

UMHA supplied staff with a copy of its contract with CMS and financial projections for its operations.

III. Staff Review

Staff reviewed the reviewed the financial projections for CY 2017, as well as UMHA's experience and projections for CY 2016. The information reflected the anticipated negative

financial results associated with start-up of a Medicare Advantage Plan.

IV. Recommendation

Based on the financial projections, staff believes that the proposed arrangement for UMHA is acceptable under Commission policy. Therefore, staff recommends that the Commission approve the Hospitals' request to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2017. UMHA must meet with HSCRC staff prior to August 31, 2017 to review its financial projections for CY 2018. In addition, UMHA must submit to the Commission a copy of its quarterly and annual National Association of Insurance Commissioners' (NAIC's) reports within 30 days of submission to the NAIC.

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

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

Final Recommendation

November 9, 2016

This is a final recommendation and ready for Commission action.

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**	
MEDSTAR HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2016**
	*	**FOLIO:**	**2169**
COLUMBIA, MARYLAND	*	**PROCEEDING:**	**2359A**

Final Recommendation

November 9, 2016

This is a final recommendation and ready for Commission action.

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 MedStar Franklin Square Hospital, MedStar Good Samaritan Hospital, MedStar Harbor Hospital, MedStar Union Memorial Hospital, MedStar Montgomery Medical Center, MedStar Southern Maryland Hospital Center, and MedStar St. Mary's Hospital (the "Hospitals"). MedStar Health seeks approval for MedStar Family Choice ("MFC") to continue to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Hospitals are requesting an approval for one year beginning January 1, 2017.

II. Background

MFC has been operating a CMS-approved Medicare Advantage Plan under the plan name of MedStar Medicare Choice for four years in the District of Columbia. In 2014 CMS granted MFC permission to expand under the same Medicare Advantage plan number to provide coverage to Maryland eligible residents in Anne Arundel, Baltimore, Charles, Howard, Prince George's, St. Mary's counties and Baltimore City. The application requests continued approval for MFC to for provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a CMS-determined capitation payment. MFC will continue to pay the Hospitals HSCRC-approved rates for hospital services used by its enrollees.

MFC supplied financial projections for its operations in Maryland for CY 2016.

III. Staff Review

Staff reviewed the reviewed the financial projections for CY 2017, as well as MFC's experience and projections for CY 2016. The information reflected the anticipated negative financial results associated with start-up in Maryland of a Medicare Advantage Plan.

IV. Recommendation

Based on the financial projections and the fact that MFC has achieved favorable financial performance in its Maryland Medicaid's Health Choice Program, staff believes that the continued approval of the arrangement between CMS and MFC is acceptable under Commission policy. Therefore, staff recommends that the Commission approve the Hospitals' request to continue to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2017. The Hospitals must file a renewal application annually for continued participation. In addition, MFC must meet with HSCRC staff prior to August 31, 2017 to review its financial projections for CY 2018. In addition, UMHA must submit a copy to the Commission of its quarterly and annual National Association of Insurance Commissioners' (NAIC's) reports within 30 days of submission to the NAIC.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of

data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

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

Final Recommendation

November 9, 2016

This is a final recommendation and ready for Commission action.

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.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION *		**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2016**
SYSTEM	*	**FOLIO:**	**2172**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2362A**

Staff Recommendation

November 9, 2016

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on October 25, 2016 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (“the Hospitals”) and on behalf of Johns Hopkins HealthCare, LLC (JHHC) and Johns Hopkins Employer Health Programs, Inc. for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to participate in a global rate arrangement for Executive Health Services with Total Wine and More, a multi-state alcohol retailer, for a period of one year beginning December 1, 2016.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION ANDASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in

similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

After reviewing the Hospital experience data, staff believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Executive Health Services for a one year period commencing December 1, 2016. The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION *		**COMMISSION**
JOHNS HOPKINS HEALTH	*	**DOCKET: 2016**
SYSTEM	*	**FOLIO: 2173**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2363A**

Staff Recommendation

November 9, 2016

I. INTRODUCTION

Johns Hopkins Health System (“System”) filed an application with the HSCRC on October 25, 2016 on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the “Hospitals”) and on behalf of Johns Hopkins HealthCare, LLC (JHHC) and Johns Hopkins Employer Health Programs, Inc. for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System and JHHC request approval from the HSCRC to participate in a global rate arrangement for Executive Health Services with Incadence Strategic Solutions, a defense and space technology company, for a period of one year beginning December 1, 2016.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs.

IV. IDENTIFICATION ANDASSESSMENT OF RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in

similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear risk of potential losses.

V. STAFF EVALUATION

After reviewing the Hospital experience data, staff believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for Executive Health Services for a one year period commencing December 1, 2016. The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

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: 2174**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2364A**

Staff Recommendation

November 9, 2016

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed a renewal application with the HSCRC on October 31, 2016 for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for participation in a new global rate arrangement for solid organ and blood and bone marrow transplant services with Humana for a one-year period, effective December 1, 2016.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

favorable.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services for a one year period beginning December 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:**	**2175**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2365A**

Staff Recommendation

November 9, 2016

I. INTRODUCTION

The University of Maryland Medical Center ("the Hospital") filed an application with the HSCRC on October 31, 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 INTERLINK for a period of one year, effective December 1, 2016.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by University Physicians, Inc. (UPI). 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 like procedures. 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 among UPI, the Hospital, and the physicians holds the Hospital harmless from any shortfalls in payment from the global price contract. UPI maintains it has been active in similar types of fixed fee contracts for several years, and that UPI is adequately capitalized to the bear the risk of potential losses.

V. STAFF EVALUATION

Staff reviewed the experience under this arrangement for the last year and found it to be favorable

V I. 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 with INTERLINK for a one year period commencing December 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.

Final Recommendation for Competitive Transformation Implementation Awards – Secondary Review

November 9, 2016

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

No comments were received during the comment period. The recommendation, therefore, remains unchanged from the draft version (except for a few updated summaries in the Appendix). **This is a final recommendation was approved by the Commission**.

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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, except for PRMC, AGH and McCready, and the West Baltimore Collaborative, these proposal summaries reflect the initial submissions, 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	

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 – $271,600.00, 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:	October 19, 2016
Health System Affiliation:	UMMC, UM Midtown, Saint Agnes and Bon Secours
Number of Interventions:	2
Total Budget Request ($):	$1,980,555

Target Patient Population
The West Baltimore Collaborative will offer care management and transportation services via private contractors to the high-utilizing Medicare patients of the member-hospitals. In the program's initial iteration, service will be offered to patients who meet defined criteria: • Criterion 1: Patients enrolled in or eligible for Medicare • Criterion 2: Patients who reside in one of the identified zip codes: 21229, 21216, 21217, 21223 and 21201 • Criterion 3: Patients who have had two (2) or more bedded acute care encounters within the past year, occurring at 2 different West Baltimore facilities o Encounters would be in the following settings: Inpatient, Inpatient Observation Status and Emergency Department • Criterion 4: Patients diagnosed with at least one (1) of the following Chronic Conditions and/or a Mental Health (depression, anxiety, etc.) and/or Substance Abuse issue o Hypertension, Chronic Obstructive Pulmonary Disease (COPD), Diabetes and Congestive Heart Failure (CHF)

Summary of program or model for each program intervention to be implemented. Include start date, and workforce and infrastructure needs
The WBC is a comprehensive collaborative, comprised of four hospitals and community-based providers. The four hospitals are University of Maryland Medical Center, UMMC Midtown Campus, St. Agnes Hospital and Bon Secours Hospital. The other WBC members include the FQHCs (Total Health Care, Chase Brexton, Baltimore Medical Systems and Healthcare for the Homeless) and other primary care practices serving West Baltimore. The WBC will provide high touch interventions for identified Medicare high utilizers by contracting with vendors to provide care management utilizing a RN care management model and transportation services to members of the target patient population. The care management vendor will make appropriate referrals for behavioral health services and other services necessary to address social determinant of health barriers.

Measurement and Outcomes Goals
The WBC will evaluate identified outcome, process and ROI metrics provided in the application as the program proceeds from rollout to full functionality and beyond. The WBC will also comport with the metrics required by the HSCRC and others, including CRISP, as necessary. Programmatic Metrics determined by the WBC 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.
The ROI calculated for the years 2018-2020 are: .44, 1.04, and 1.74 respectively. By shifting avoidable acute care to more cost effective care in the primary care and community-based settings, the interventions 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 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 $330 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, alignment with FQHCs, so crucial to the success of the program, will be encouraged via the management of patients in the community, aiding successful care intervention and reducing high-cost hospital recidivism.

Participating Partners and Decision-making Process. Include amount allocated to each partner.
The primary participants in the WBC are the four hospital members and a number of affiliated and independent entities and practitioners which have manifested an intent to participate in and support the efforts of the WBC by submitted Letters of Intent/Support. The WBC will be managed through a governance structure consisting of a Management Committee, comprised of the WBC members (i.e. the four hospitals, the FQHCs and other community-based providers) and the WBC Director. The Management Committee will oversee the daily operations of the WBC and the Implementation Grant. It will also 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 participation and performance of the WBC members and vendors, 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
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: the WBC will appoint a program Director to provide day-to-day leadership; a refresh of inter-hospital data to confirm accuracy of metrics and patient capture will occur; patients identified as eligible will be contacted; and model implementation for Medicare high utilizers will commence at the member hospitals and community-based practices. Within 30 days of grant award: participating hospitals receiving grant revenue will execute a Memoranda of Understanding, which will inform member association and organizational structure; identification of high utilizers and rising risk patients will be made via data and hospital-based risk assessments for patients currently in one of the 4 hospitals or the member primary care practices. The Care Management Vendor (the WBC is currently exploring a relationship with Health Care Access Maryland (HCAM)) will connect with enrolled patients. Patients will be identified for transportation services (currently exploring a relationship with Transdev; other community-based transportation provider(s) may be considered as well); access to care will be addressed, and if a patient does not have a primary care physician follow-up may occur within a geographically-convenient FQHC.

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 vendor contracts, but administrative and analytical staff needed for ongoing data collection and reporting. The WBC has decided that the investment in this strategy for clinical services in the community will maximize the full potential of the funds 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. It is anticipated that 100% of the programs described will be funded by the requested grant amount.

Final Recommendation for Final Round of Transformation Implementation Grants

November 9, 2016

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 be approved based on the revised review criteria totaling $6.46 million.
- HSCRC will monitor the implementation of the awarded grants through reporting requirements.
- HSCRC is also recommending that a portion of the ROI be used to reduce hospital global budgets 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.

State of Maryland
Department of Health and Mental Hygiene

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Chairman

Herbert S. Wong, PhD
Vice-Chairman

Joseph Antos, PhD

Victoria W. Bayless

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Compliance

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **November 9, 2016**

RE: **Hearing and Meeting Schedule**

December 14, 2016	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
January 11, 2017	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.