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Department of Health and Mental Hygiene

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536th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
December 14, 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**

PUBLIC SESSION
1:30 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on November 9, 2016** - *to be Amended*

2. **Executive Director's Report**

3. **New Model Monitoring**

4. **Docket Status – Cases Closed**
   2353A – Priority Partners
   2356A - Maryland Physician Care
   2358A - MedStar Family Choice
   2359A - MedStar Family Choice
   2360A - University of Maryland Health Advantage, Inc.
   2361A – Maryland Health Partners
   2362A – Johns Hopkins Health
   2363A - Johns Hopkins Health System
   2364A - University of Maryland Medical Center
   2365A - University of Maryland Medical Center

5. **Docket Status – Cases Open** - *All below cases were Approved*
   2357A - Hopkins Health Advantage
   2365A - University of Maryland Medical Center
   2366A - Johns Hopkins Health System
   2367A - Johns Hopkins Health System
   2368A - Johns Hopkins Health System

6. **Recommendations for Updating the Quality-Based Reimbursement Program for Rate Years 2017 (Final- *Approved*), 2018 (Draft), and 2019 (Draft)**

7. **Extension of Medicaid Current Financing Policy** - *Pending further review*

8. **CRISP Update**

9. **Legal Update**

10. **Hearing and Meeting Schedule**

EXECUTIVE DIRECTOR'S UPDATE TO THE

HEALTH SERVICES COST REVIEW COMMISSION

DECEMBER 14, 2016

PROGRESSION PLAN

Working together with hundreds of stakeholders over the past year, HSCRC and DHMH have been preparing a Progression Plan for a second term of the All-Payer Model, which will begin January 1, 2019.

- The Plan was posted to DHMH and HSCRC websites and distributed to stakeholders via email. We have updated the Plan in response to comments.
- The Governor's office will submit the Progression Plan to CMS/CMMI by December 31.
- DHMH and HSCRC have provided presentations on the Plan to the several committees of the State legislature.
- Two detailed components of the Plan are also being submitted in more detail: A Maryland Comprehensive Primary Care Model and a Dual Eligibles component. DHMH has posted the Comprehensive Primary Care Model concept paper for public comment.
- We wish to thank everyone for their efforts and comments in bringing this to completion.

During 2017, Maryland will work to:

- Gain approval for the Maryland Comprehensive Primary Care Model, and begin implementation activities, with planned initiation for 2018.
- Negotiate a second term of the All-Payer Model and an updated All-Payer Model Agreement.

Achieving these goals will require extensive efforts from DHMH, HSCRC, and stakeholders.

CARE REDESIGN AMENDMENT

At stakeholder request, we asked CMS to approve an amendment to our All-Payer Model ("Model") to obtain comprehensive, patient-level Medicare data to support care coordination; to allow hospitals to share resources with non-hospital providers; and to allow hospitals to share savings with non-hospital providers. CMS approved Maryland's Care Redesign Amendment, but we are still awaiting final legal documents. Governor Hogan and all members of the Maryland delegation have urged CMS to complete the documents.

In the meantime, the Care Redesign Amendment has been launched as an official model of CMMI. This is important for MACRA requirements, as we are hopeful that participation in the Amendment's Care Redesign programs will qualify physicians as qualifying participants in an

Advanced Alternative Payment Model once HSCRC adds a Total Cost of Care incentive to the value-based payment programs, which is applied to Maryland hospitals under their GBRs.

As a reminder, the two programs currently developed are:

- The Hospital Care Improvement Program (HCIP) is designed to be implemented by hospitals and physicians with privileges to practice at a hospital. HCIP aims to improve the efficiency and quality of inpatient episodes of care by encouraging effective care transitions; encouraging the effective management of inpatient resources; and promoting decreases in potentially avoidable utilization.
- The Complex and Chronic Care Program (CCIP) is designed to be implemented by hospitals in collaboration with community physicians and practitioners. CCIP strives to link hospitals' resources for managing the care of individuals with severe and chronic health issues with primary care providers' efforts to care for the same populations, as well as for patients with rising needs. The approach is designed to reduce potentially avoidable utilization and to facilitate overall practice transformation towards more person-centered care.

The Amendment gives Maryland the flexibility to refine and expand Care Redesign Programs as appropriate.

CMMI, HSCRC, and MHA have been conducting webinars for potential participants to prepare for the initiation of the Care Redesign programs.

- All hospitals have submitted a non-binding Letter of Intent to participate in at least one of the Care Redesign programs under the Amendment. Among these, 37 hospitals expressed intent to participate in both programs (44 are planning to participate in HCIP, and 37 in CCIP). We are excited to see this level of hospital engagement, as the HCIP and CCIP Amendment programs are very well-aligned with the hospital transformation strategic plans and regional partnerships.
- In early January, hospitals will be required to submit a list of care partners, who may participate in the care redesign programs, to CMS for vetting and approval. MHA and CRISP are providing support to hospitals in this effort.
- Program Templates for both the CCIP and HCIP programs will be posted to the HSCRC website in the next week. The Program Templates will provide the critical information necessary for hospitals to plan the design and implementation of their programs.

JANUARY 1 RATE UPDATE

The revenues deferred from the July 1 rate order to January 1 will soon be added to hospital rates. These amounts were built into hospital approved revenues, but deferred through the allocation of the GBR from the first half of the year to the second half of the year. HSCRC provided a list of activities that need to be undertaken relative to the additional revenues. Many of those activities tie directly into the Care Redesign Amendment programs that stakeholders requested. In particular, a top priority for Maryland is providing care supports for 20,000 of the

most complex Medicare patients and an estimated 80,000 high needs patients. The HSCRC expects that hospitals will fund and undertake this effort. Getting the data as part of the Amendment will allow for better targeting, and programs will need to be scaled up. HSCRC tied the current rate adjustment to this effort as well as to the focus on Medicare Total Cost of Care.

- Staff expects to tie future rate adjustments to successful execution of care supports for high needs individuals and Medicare's Total Cost of Care.
- We will discuss future targets at upcoming Commission meetings, beginning with July 1 rate update.
- CRISP will be presenting later today on the status of efforts to date.

The scaling of these efforts is not easy, but it is important for success of the All-Payer Model in achieving better care, better health, and lower costs.

CRISP is in the process of working with hospitals to register their case managers and implement processes for registering care alerts and care plans. This is hard work, involving new work flows and processes. We understand that it will be a work in process and the work will not be complete by the end of the year. Our expectation is that hospitals will meet with CRISP and schedule a timeline and process for the submission and update of this information in the near term. We expect to have a timeline documented for each hospital by early January, with execution before the July update.

Work Group Updates

DHMH and HSCRC are coordinating the initiation of **the Consumer Standing Advisory Committee (C-SAC)**. The initial meeting is scheduled for December 19, 2016 and will provide an update on the Progression Plan and the proposed Maryland Comprehensive Primary Care Model. The future work of the committee will also be discussed.

The Behavioral Health Subgroup will advise the Performance Measurement Work Group and the Commission on measures of performance for care provided to persons with mental health or substance use disorders that should be considered for HSCRC implementation. The initial meeting is scheduled for December 16, 2016.

The Total Cost of Care (TCOC) Workgroup will provide feedback to HSCRC on the development of the hospital-level TCOC guardrails for the Care Redesign Amendment programs and measures that can be introduced into performance-based payment relative to Medicare TCOC for FY 2018. The initial meeting was held December 14, 2016.

ICD 10

HSCRC has detected problems with the ICD-10 conversion. Medical cases are being classified as surgical cases. Rehab cases are not properly handled. Until this is corrected, we cannot

complete market shifts or update quality policies. Staff has asked for help from consultants, MHA, and hospitals.

YTD Results and Recent National Results

We are nearing the end of the third year of the All-Payer Model. The following chart contains high-level summaries of performance for the current year, available through September. The current year results are preliminary and may change as the year progresses.

Performance Measures	Targets	2014 Results	2015 Results[1]	2016 Year-to-Date Results (preliminary)[2]
All-Payer Hospital Revenue Growth	≤ 3.58% per capita annually	1.47% growth per capita	2.31% growth per capita	0.35% growth per capita
Medicare Savings in Hospital Expenditures	≥ $330m over 5 years (Lower than national average growth rate from 2013 base year)	$116m (2.15% below national average growth)	$135m $251m cumulative (2.22% below national average growth since 2013)	$178m $429m cumulative (4.60% below national average growth since 2013)
Medicare Savings in Total Cost of Care	Lower than the national average growth rate for total cost of care from 2013 base year	$133m (1.53% below national average growth)	$80m $213m cumulative (0.85% below national average growth since 2013)	$106m $319m cumulative (1.63% below national average growth since 2013)
All-Payer Quality Improvement Reductions in PPCs under MHAC Program	30% reduction over 5 years	26% reduction	35% reduction since 2013	49% reduction since 2013
Readmissions Reductions for Medicare	≤ National average over 5 years	20% reduction in gap above nation	57% reduction in gap above nation since 2013	71% reduction in gap above nation since 2013
Hospital Revenue to Global or Population-Based	≥ 80% by year 5	95%	96%	96%

[1]*-2015 figures for readmissions are preliminary because CMS is evaluating the readmission data after ICD-10.*

[2]*Year-to-date results compare the performance available in calendar year 2016 to the same months in prior year or to the same months in the 2013 base year, as applicable: all-payer revenue through September; MHAC through June; readmissions through July; Medicare savings through August.*

Johns Hopkins Compliance and EPIC Conversions

For the month of October 2016, JHH undercharged by approximately $21 million. The month of October revenues are lower for JHH and other hospitals due to fewer workdays in the period (20 vs 22 in the prior year).

Evidence Based and Models for Complex and Chronic Care

The American Health Association (AHA) will begin to develop and test a new care model for older adults. The Institute for Healthcare Improvement (IHI) will work with the AHA and others to develop and test a prototype to transform care for older adults. Using a grant from the John A. Hartford Foundation, IHI and AHA will develop and test the Age-Friendly Health Systems prototype with four health systems that together serve older adults in 30 states: Kaiser Permanente in Oakland, CA; Trinity Health System in Steubenville, OH; Providence St. Joseph Health in Los Angeles; and **Anne Arundel Medical Center**. The goal is to spread an evidence-based prototype to 20% of hospitals and health systems in the U.S. by 2020.

Web Resource Compiles Promising Practices for Patients with Complex Needs

Five health care foundations released an online resource on promising approaches to improving health outcomes for patients with complex medical, behavioral and social needs.

Thank you to Steve Ports

Monitoring Maryland Performance

Medicare TCOC Data

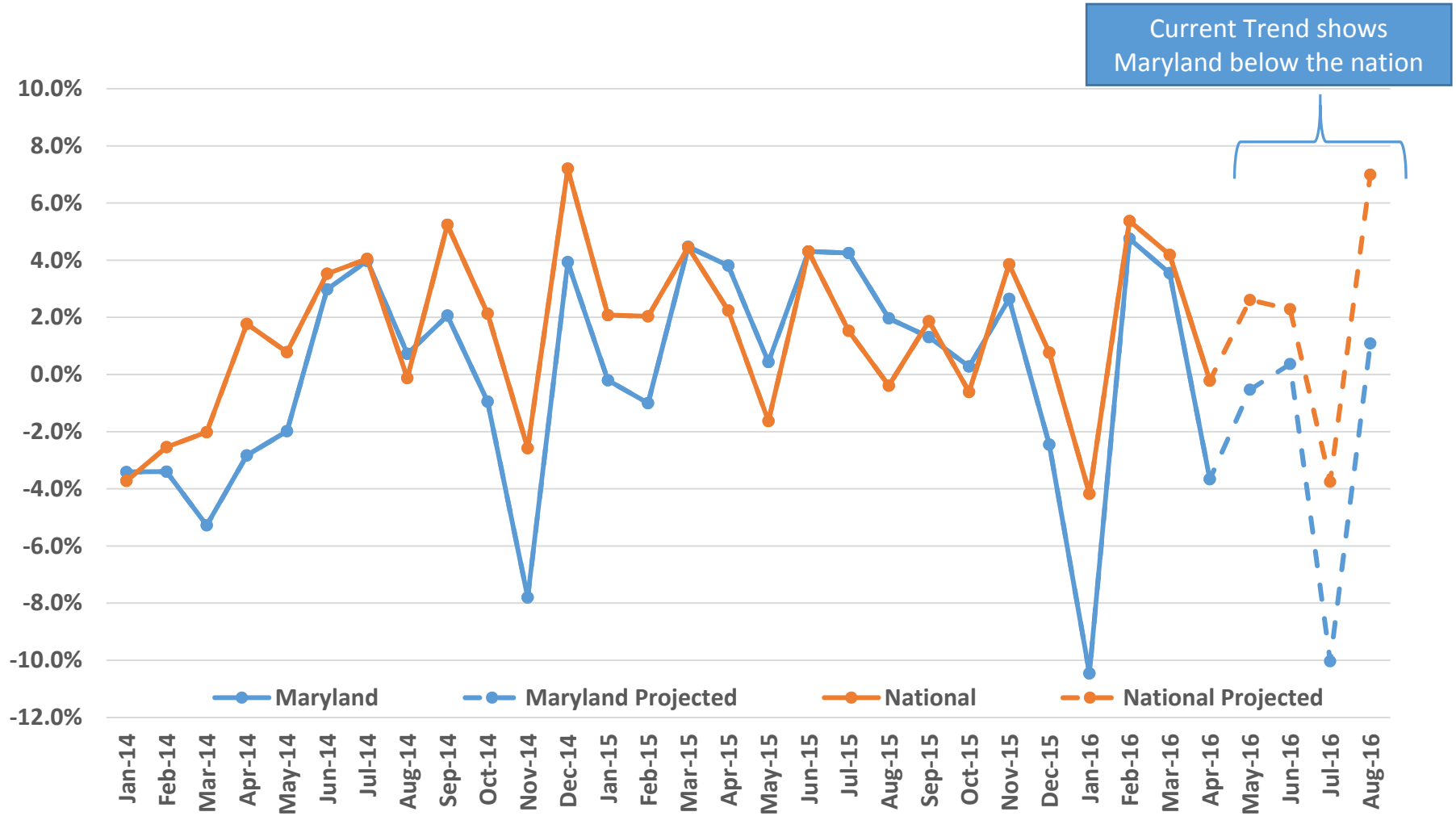
Data through August 2016 – Claims paid through October 2016

Disclaimer

Data contained in this presentation represent analyses prepared by 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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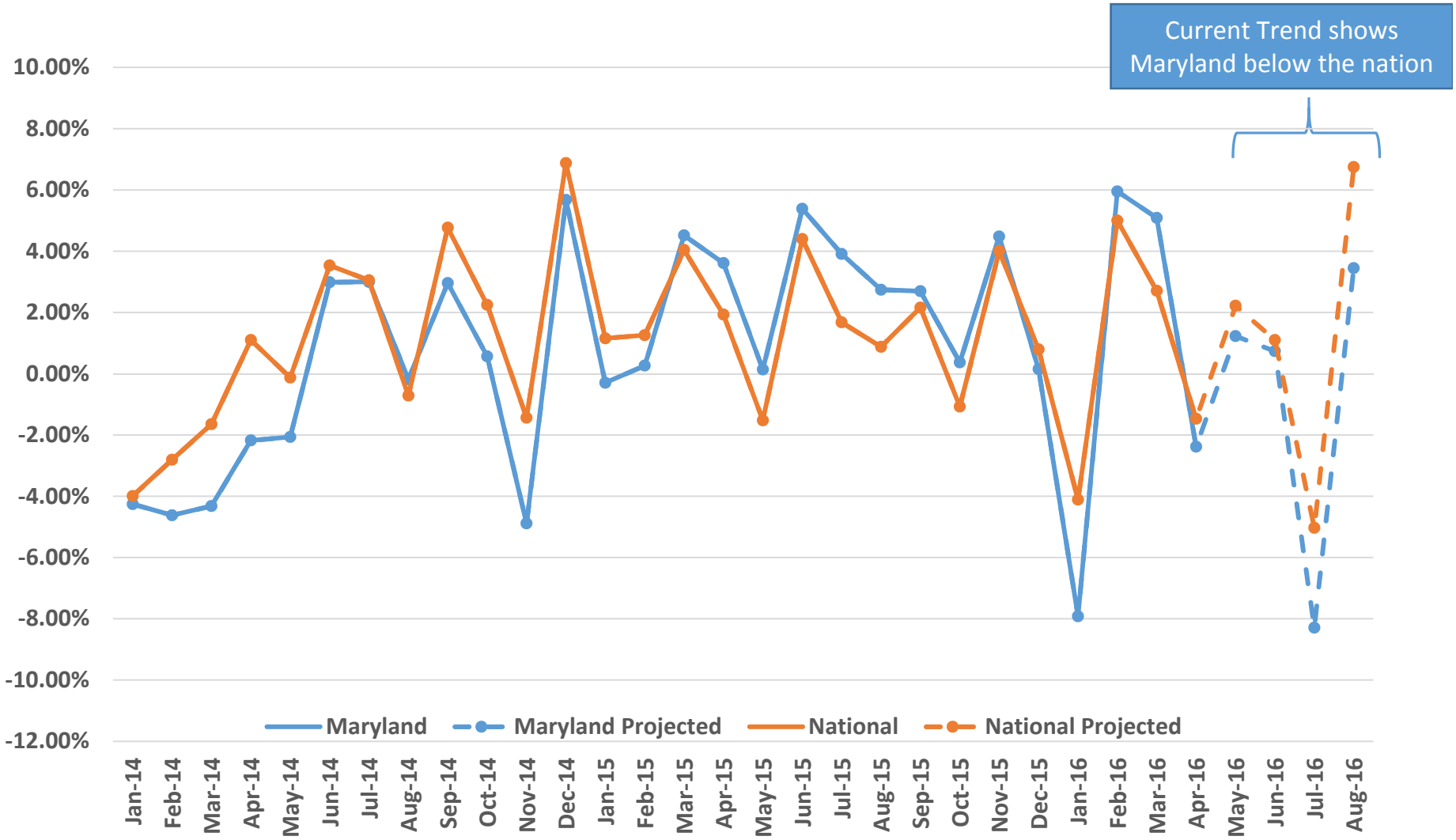
Total Cost of Care Per Capita

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



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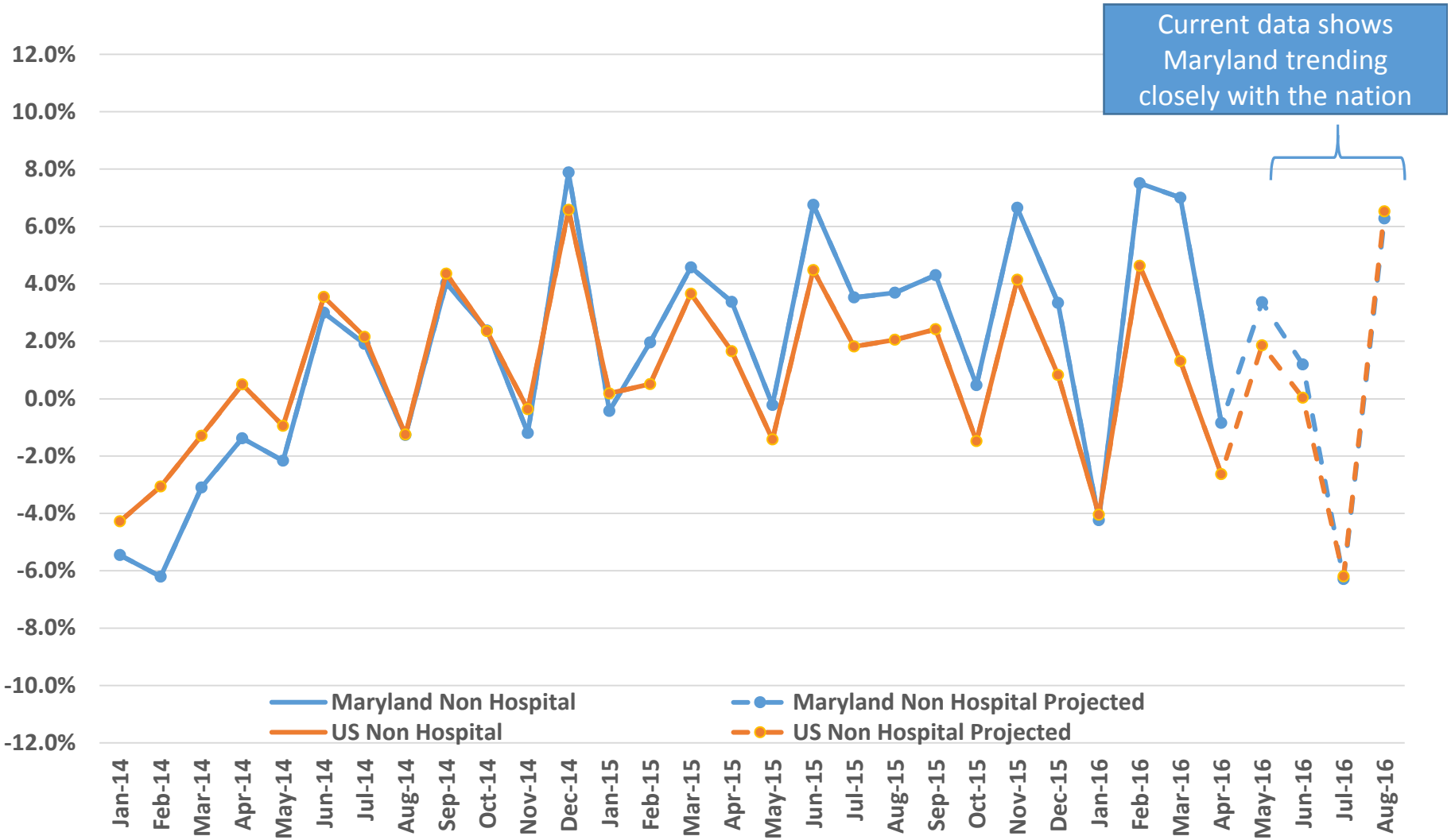
Non Hospital Spending per Capita

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



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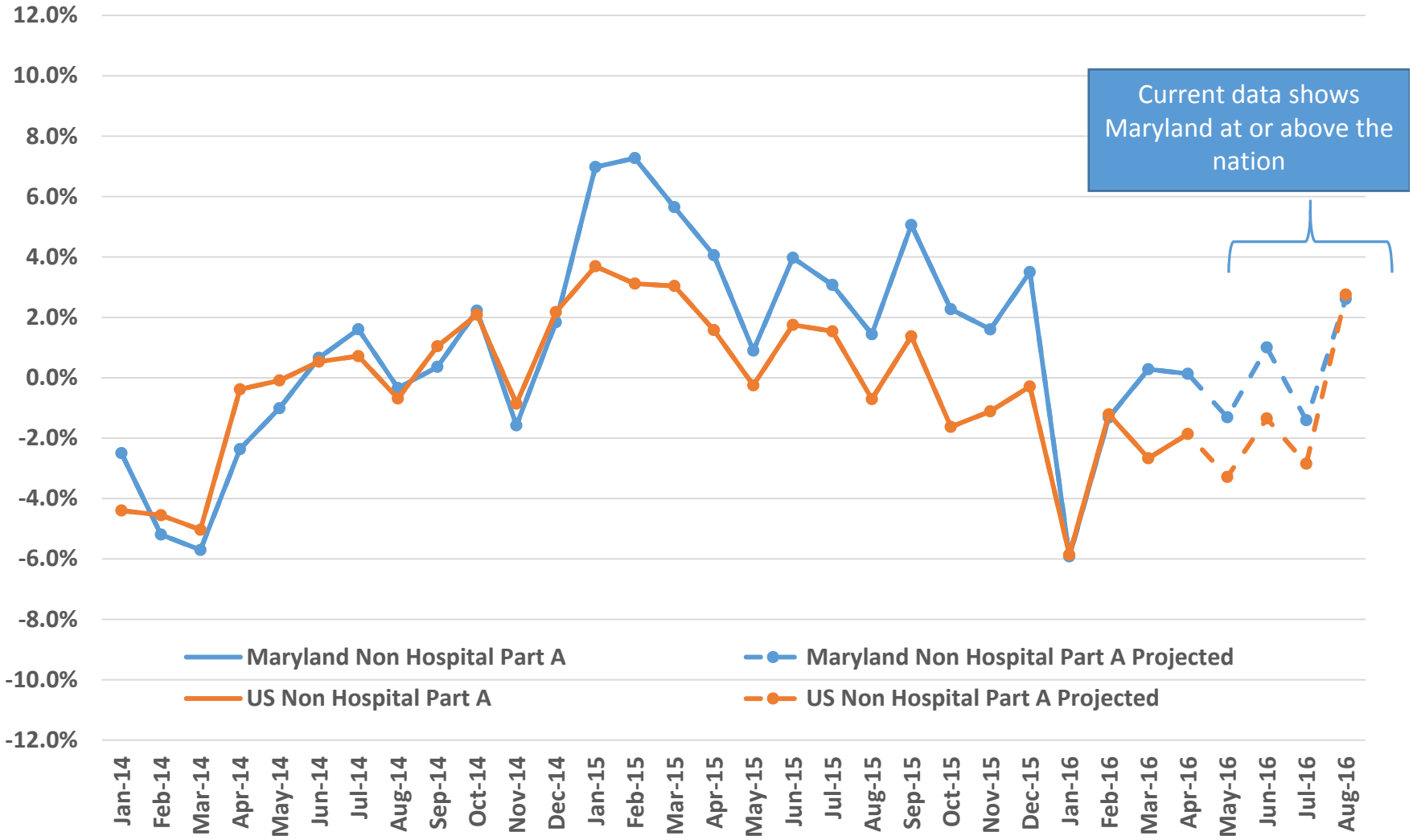
Non Hospital Part A Spending per Capita

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



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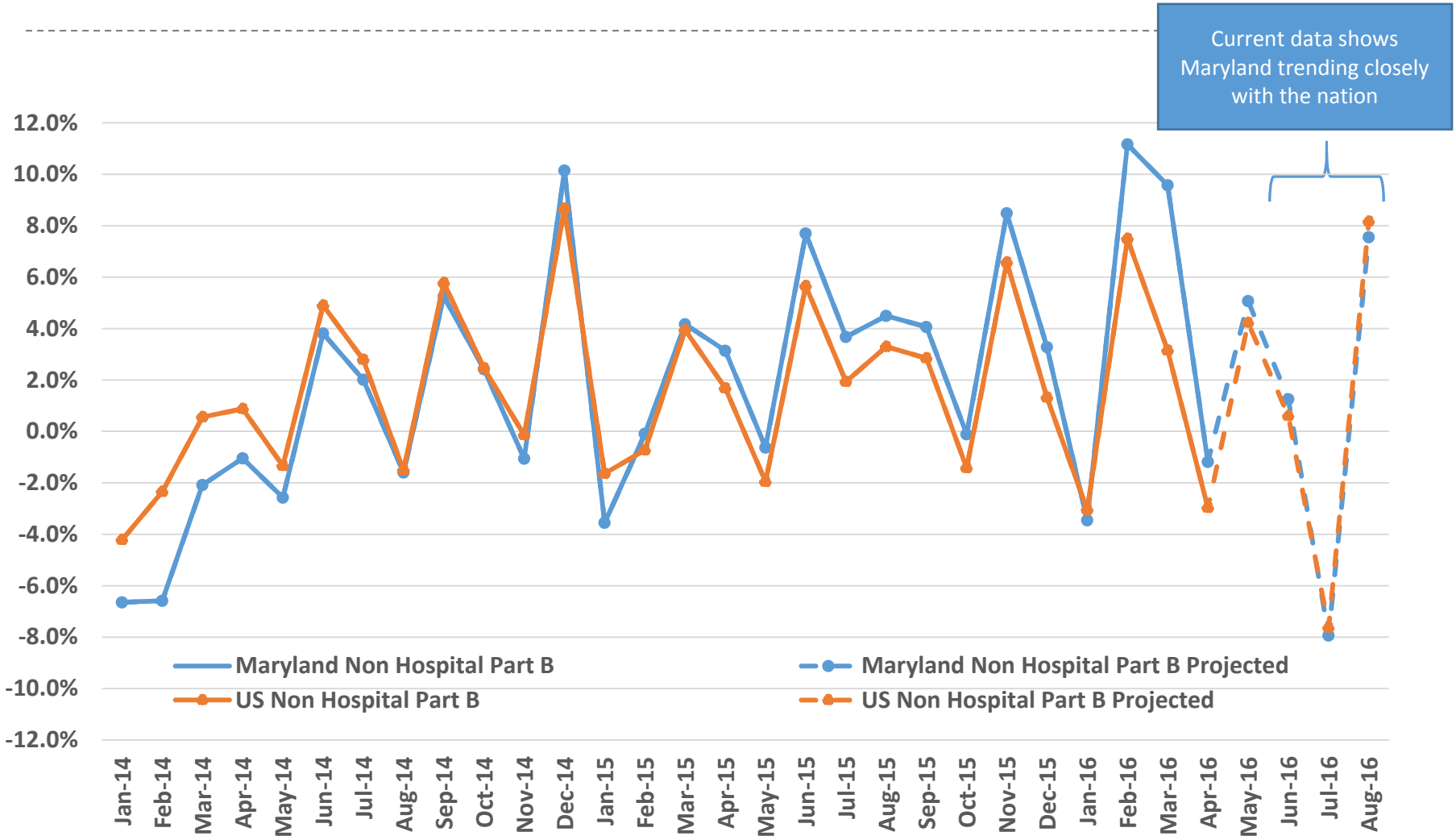
Non Hospital Part B Spending per Capita

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



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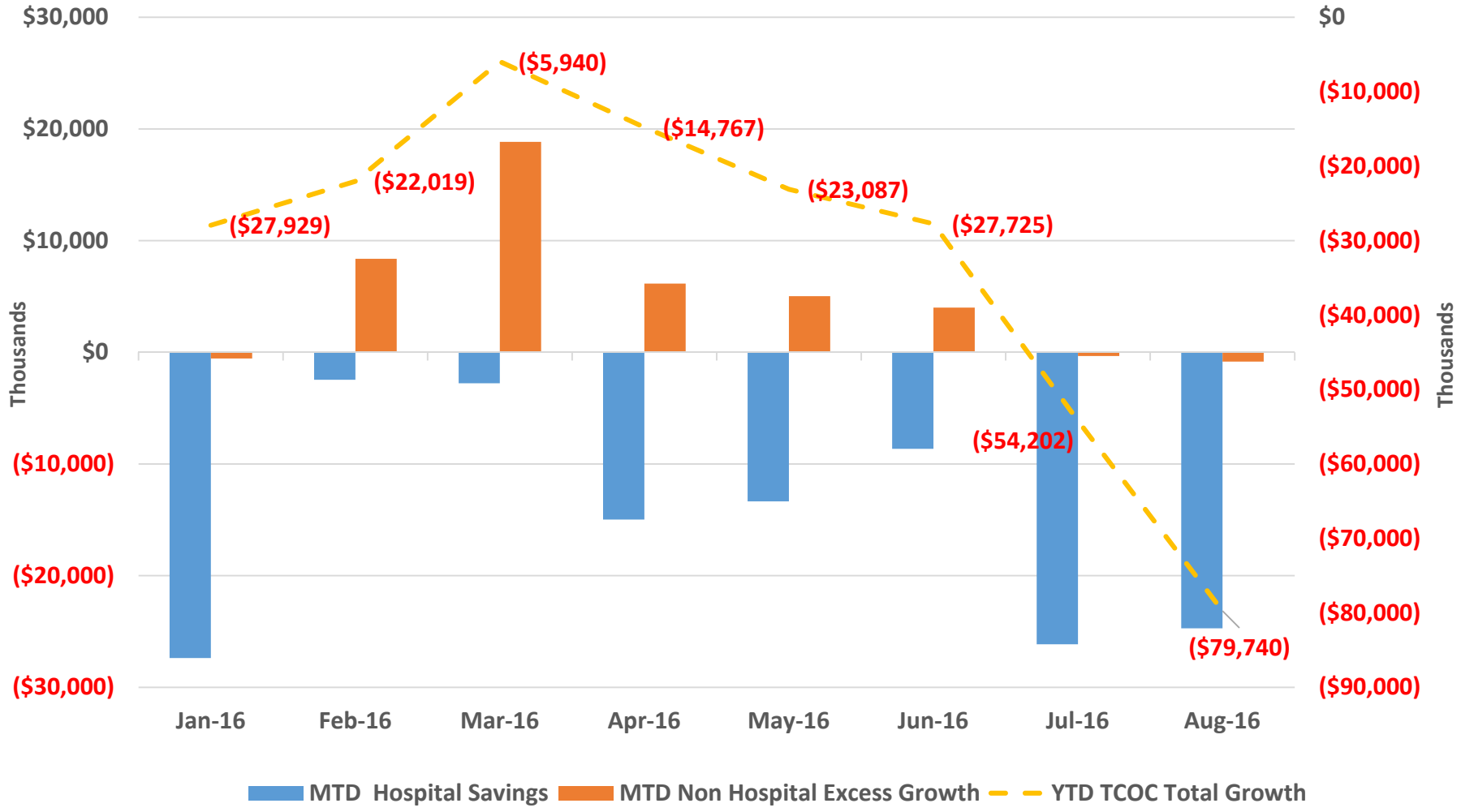
Medicare Hospital & Non Hospital Growth

(with completion) CYTD through August 2016



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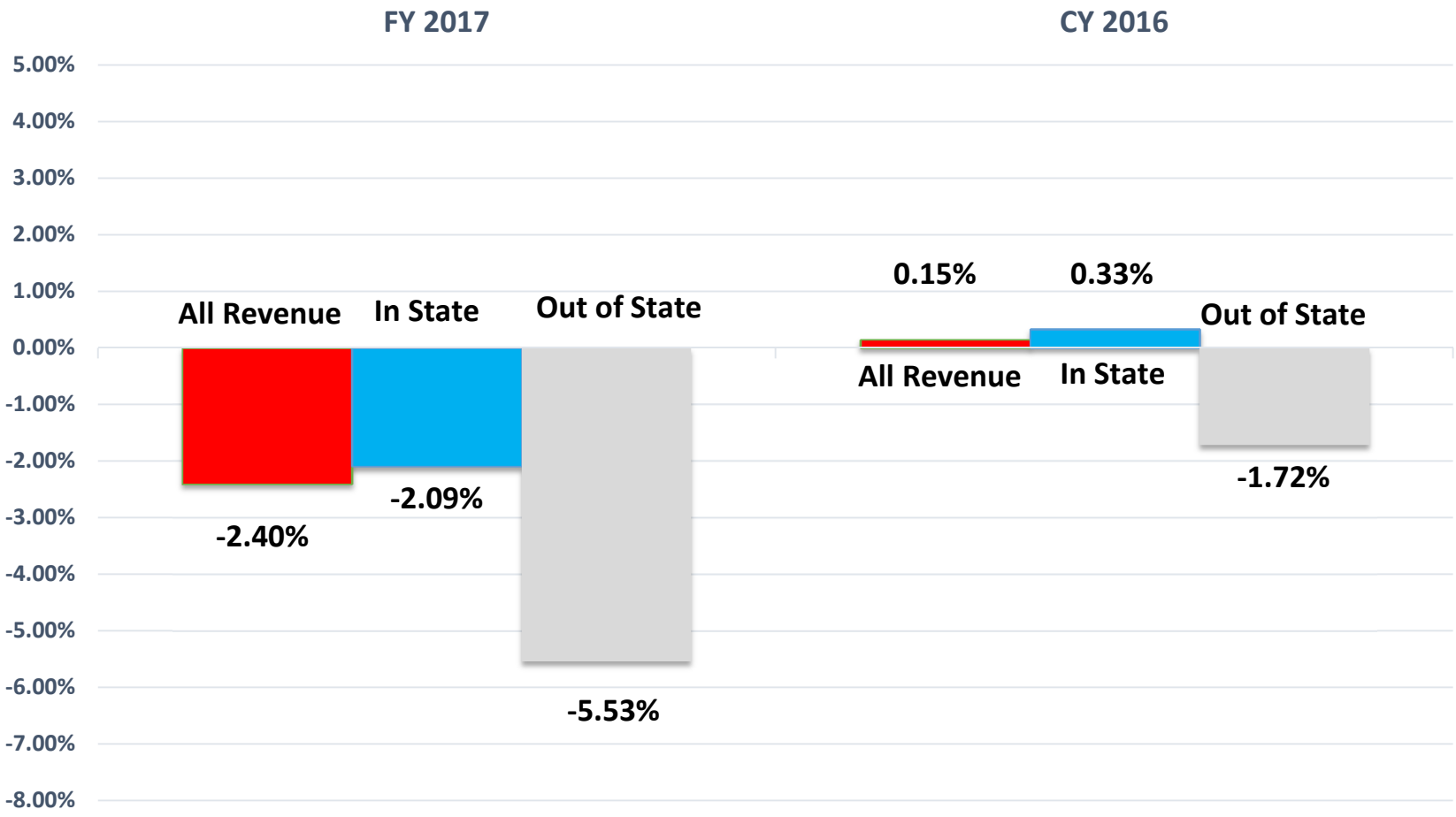
Monitoring Maryland Performance

Financial Data

Year to Date thru October 2016

Gross All Payer Revenue Growth

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



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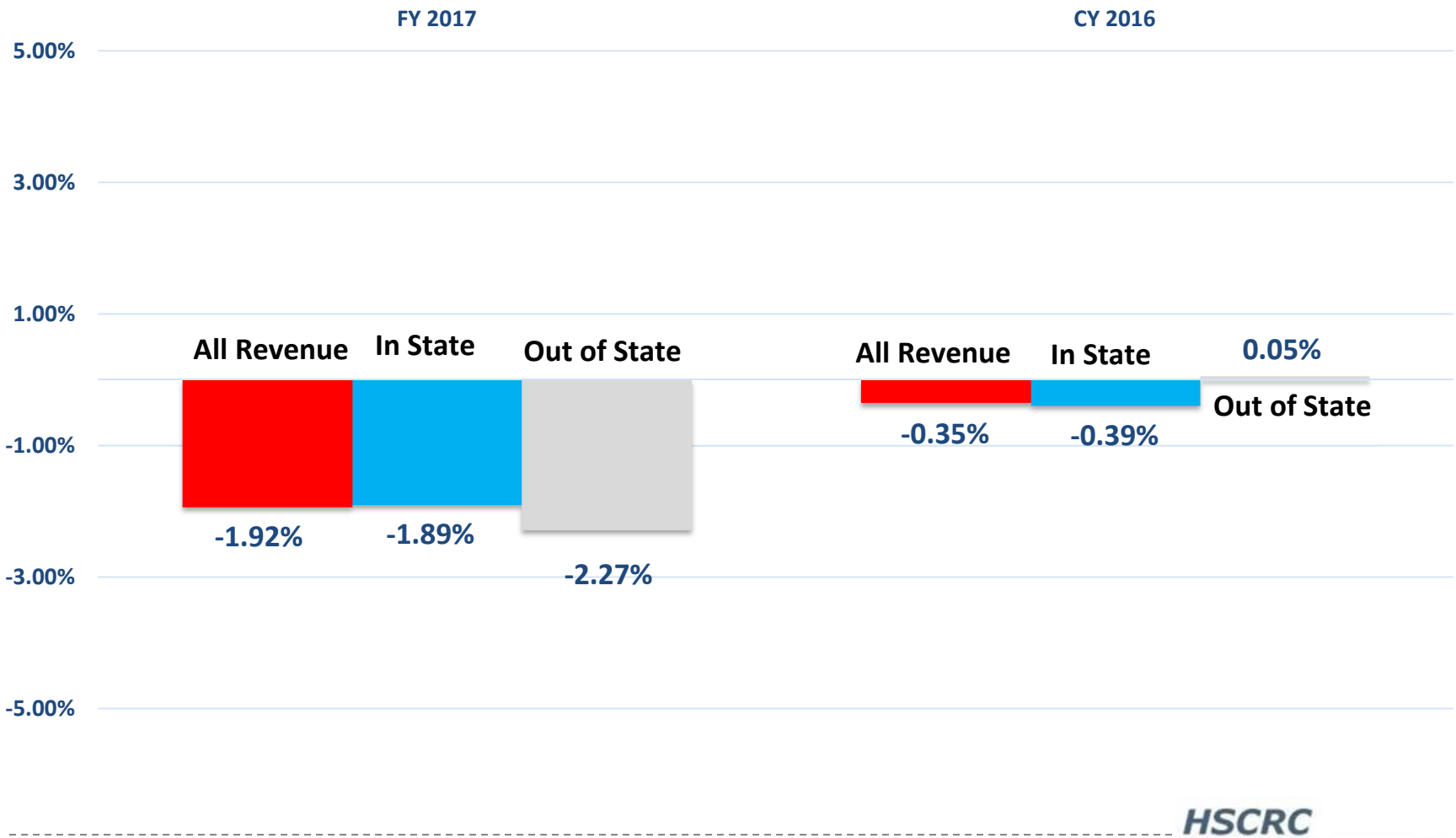
Gross Medicare Fee-for-Service Revenue Growth

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



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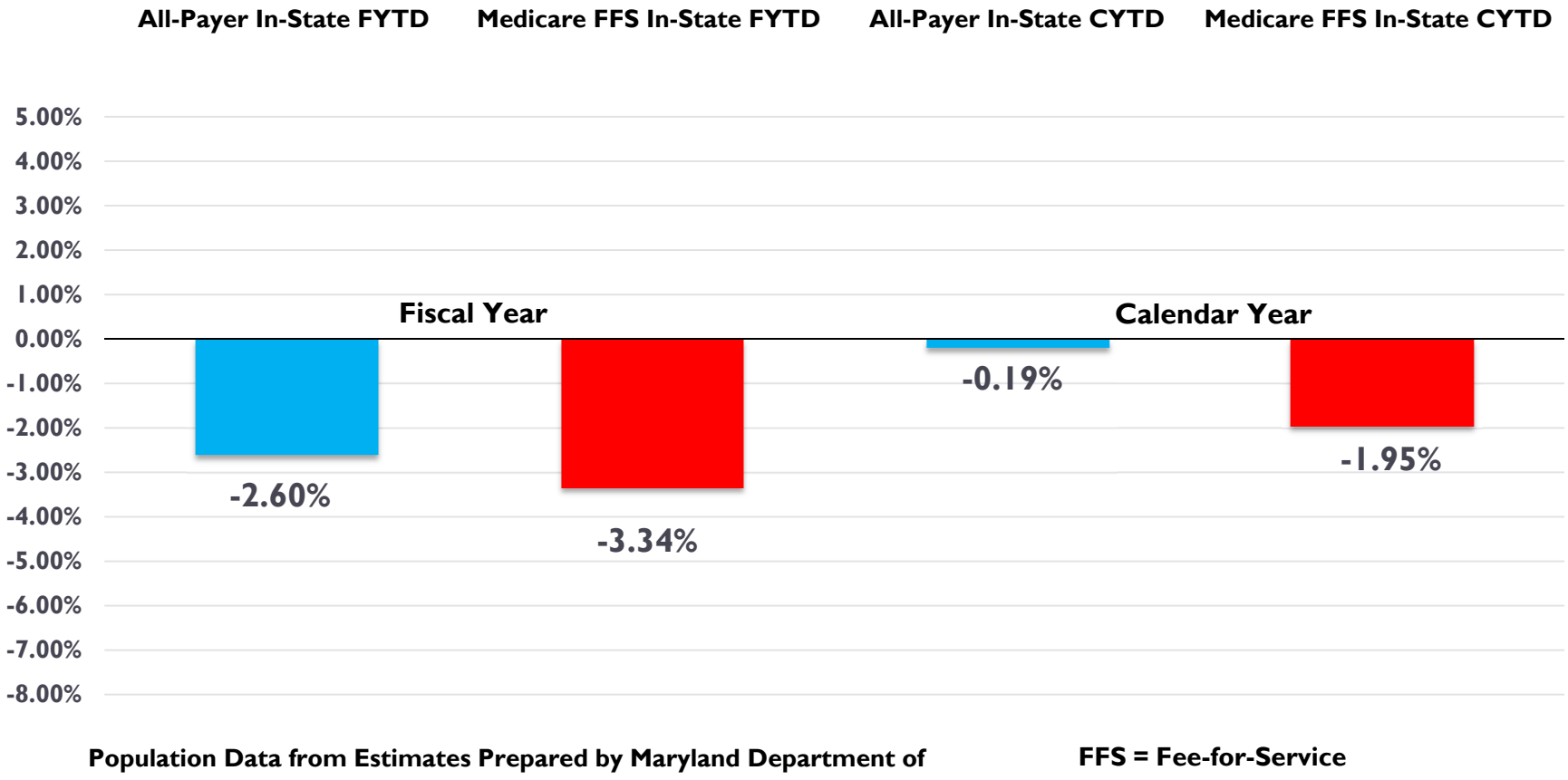
Per Capita Growth Rates

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



Population Data from Estimates Prepared by Maryland Department of

FFS = Fee-for-Service

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

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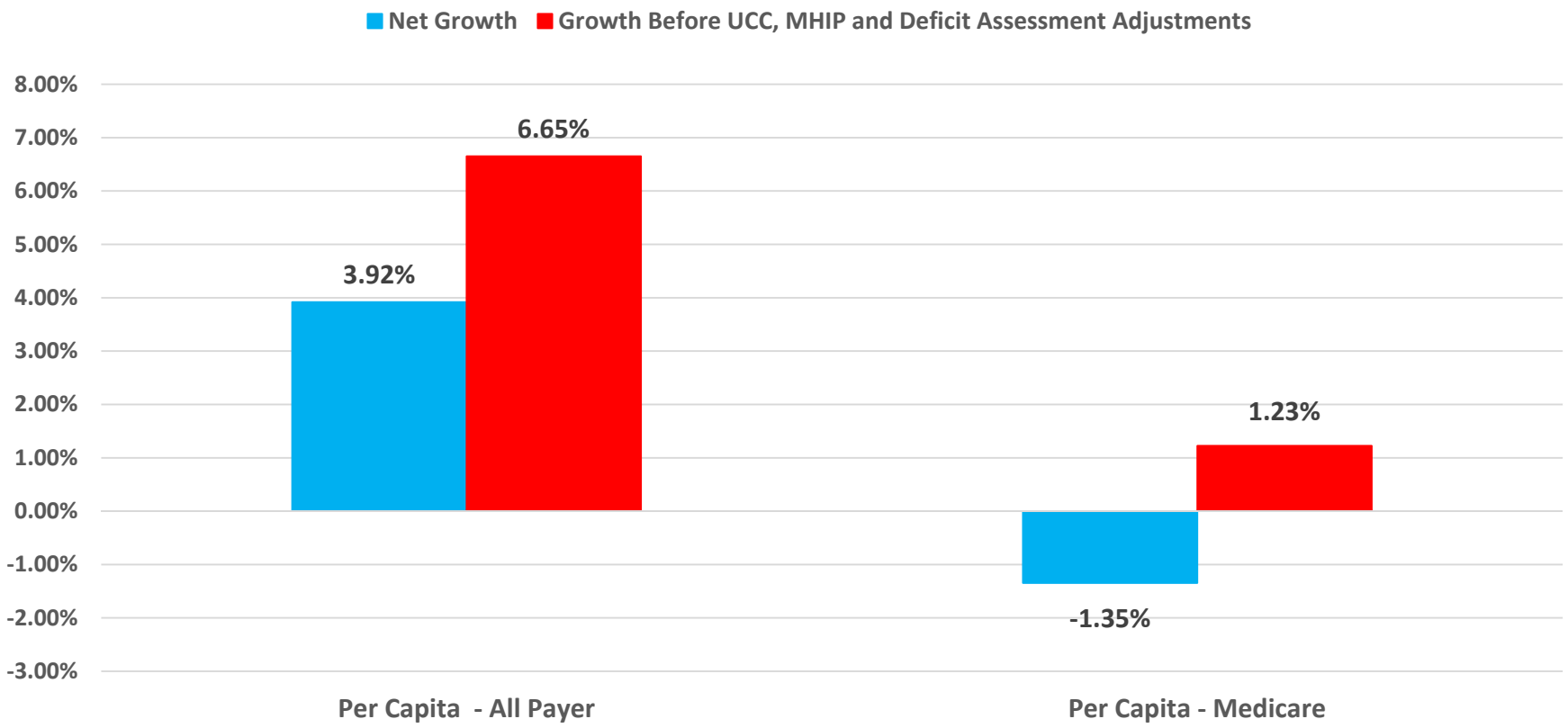
Per Capita Growth – Actual and Underlying Growth

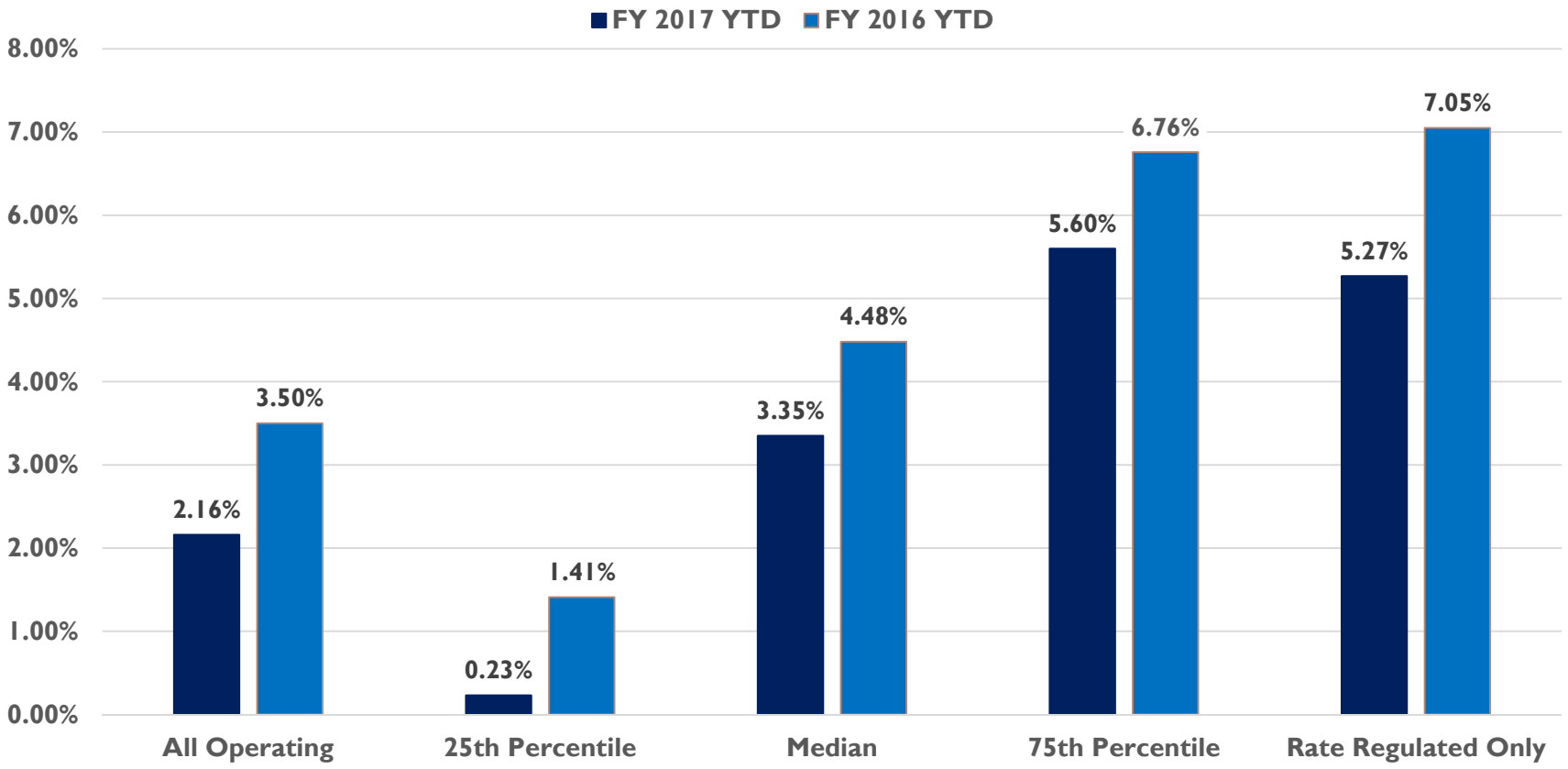
CY 2016 Year to Date (Jan-Oct) Compared to Same Period in Base Year (2013)



- 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 adjustments for FY16 revenue decreases that were budget neutral for hospitals. 2.52% hospital bad debs and elimination of MHIP assessment and FY17 revenue decreases of .49% UCC and 0.15% Deficit assessment.

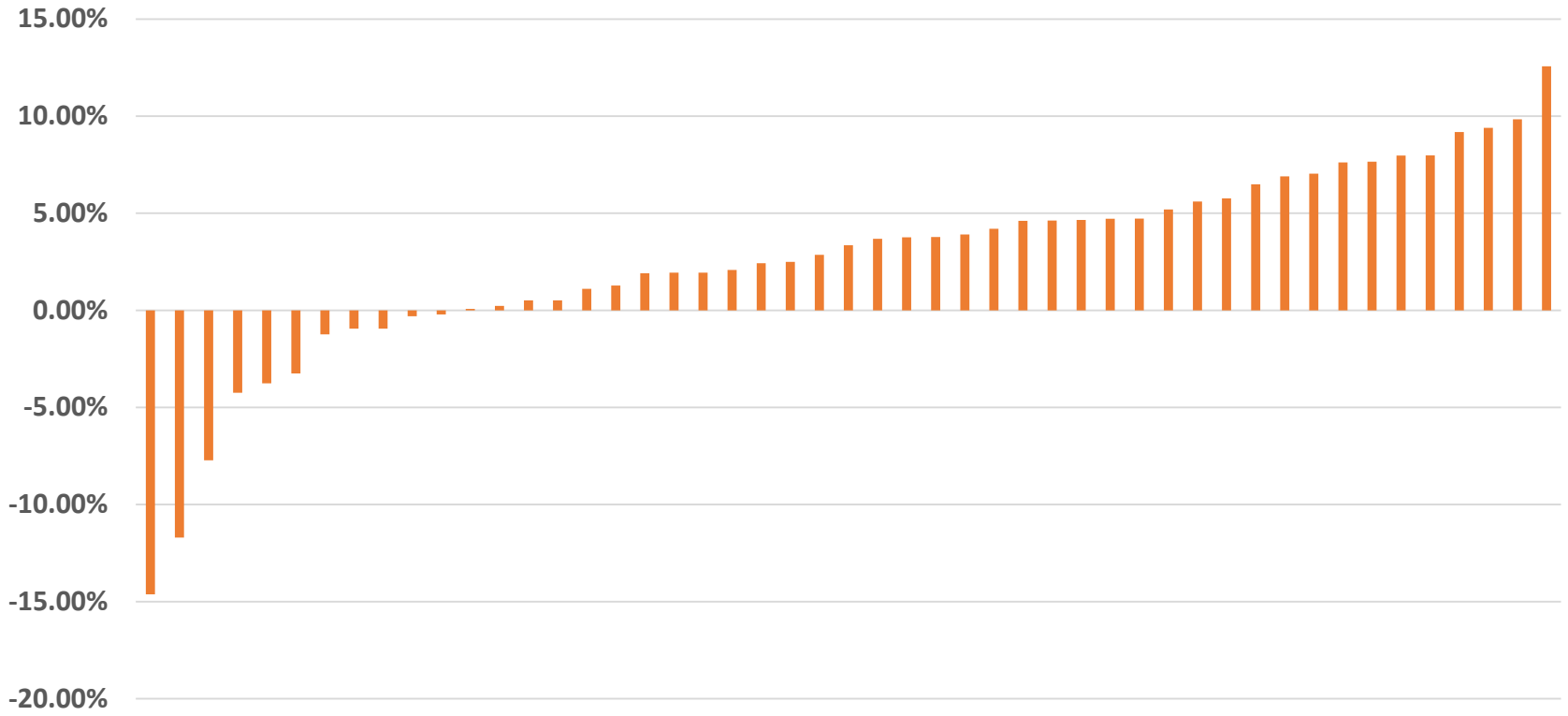
Total Operating Profits

FYTD 2017 vs FYTD 2016 (July-October)



- Total operating profits have decreased by 1.34 percentage points over the same period of the prior year.
- Rate regulated operating profits have decreased by 1.78 percentage points over the same period of the prior year.

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



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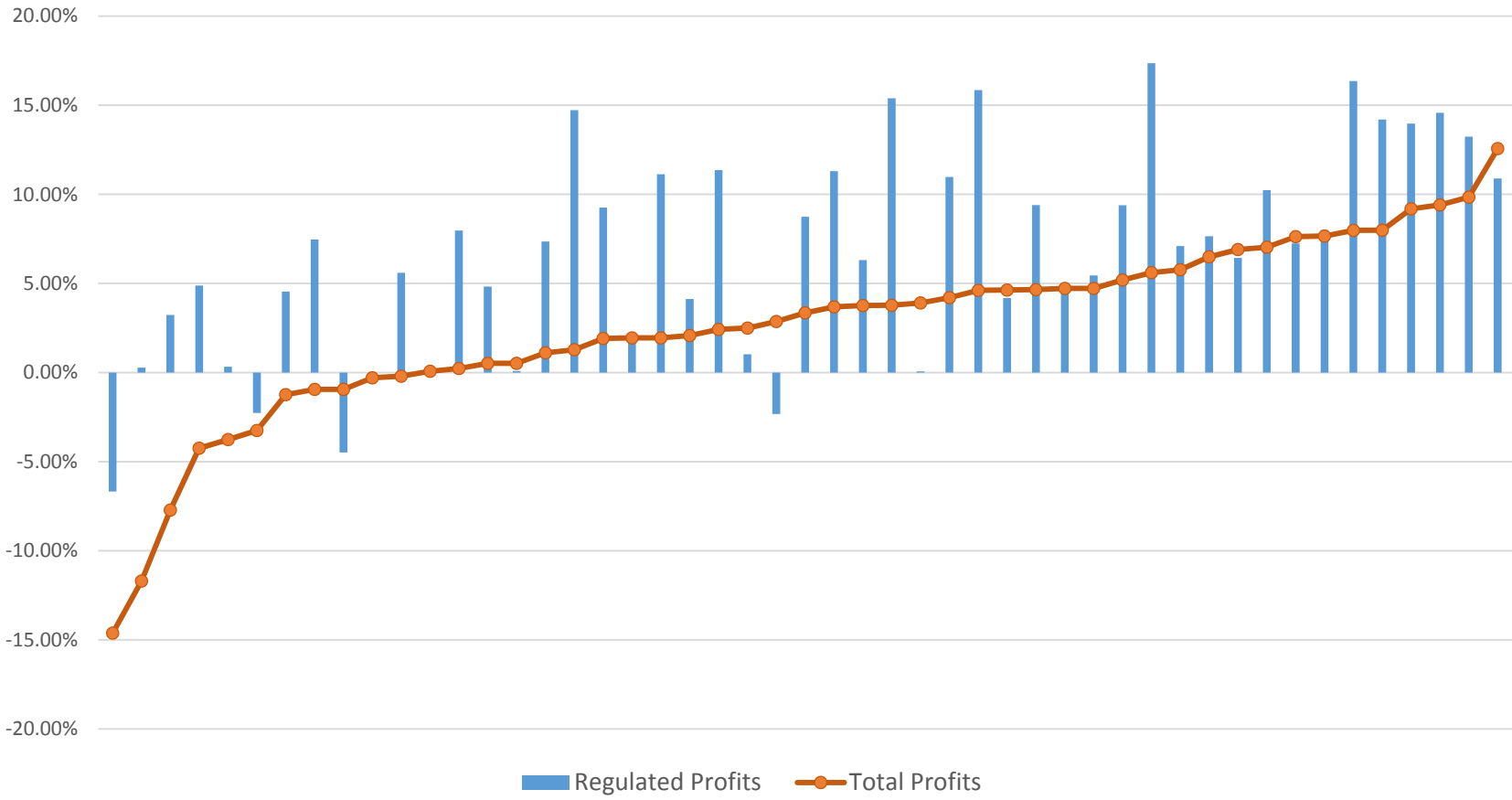
Regulated and Total Operating Profits

Fiscal Year 2017 (Jul-Oct 2016)



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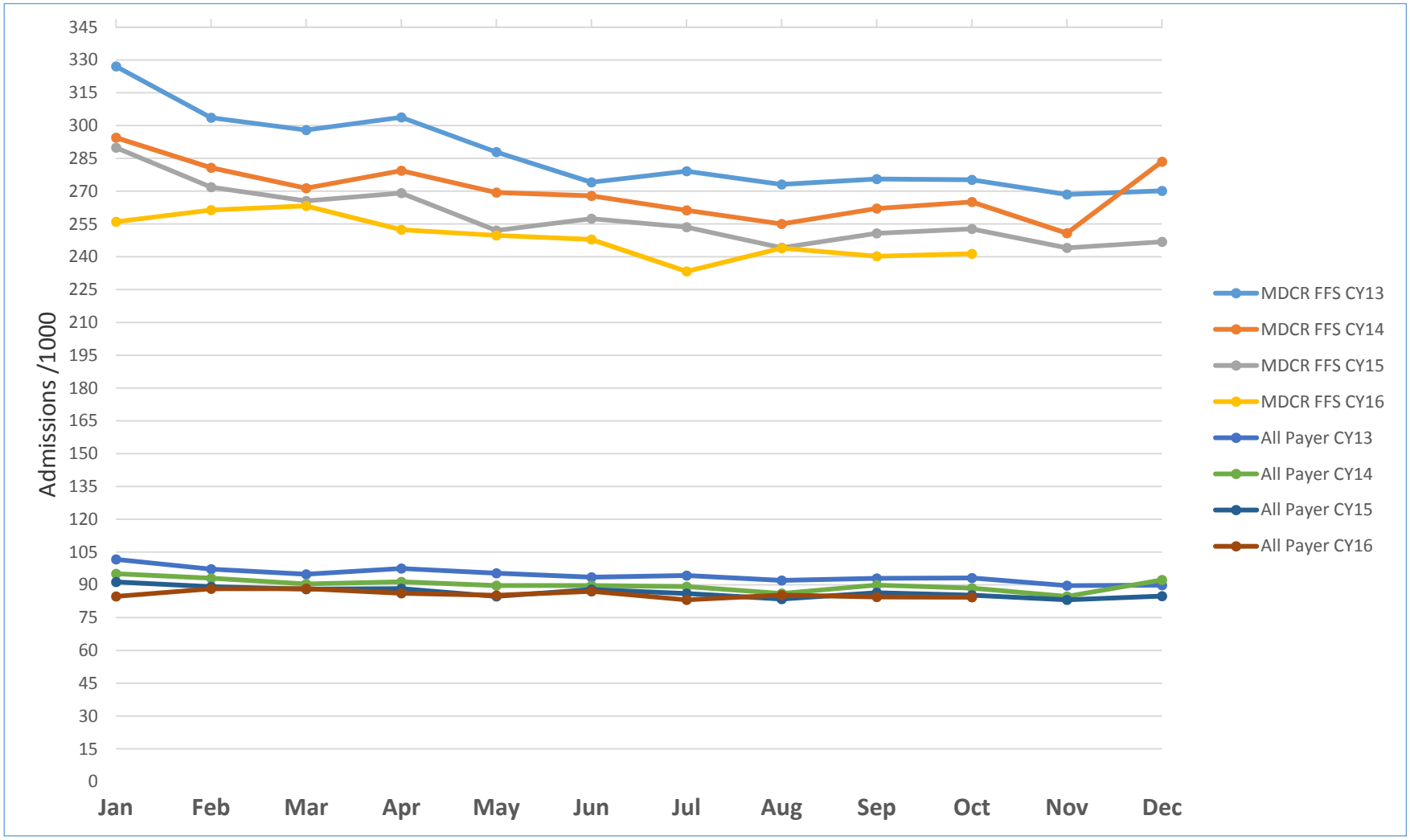
Annual Trends for Admissions/1000 (ADK) Annualized Medicare FFS and All Payer (CY 2013 through CY 2016 YTD)



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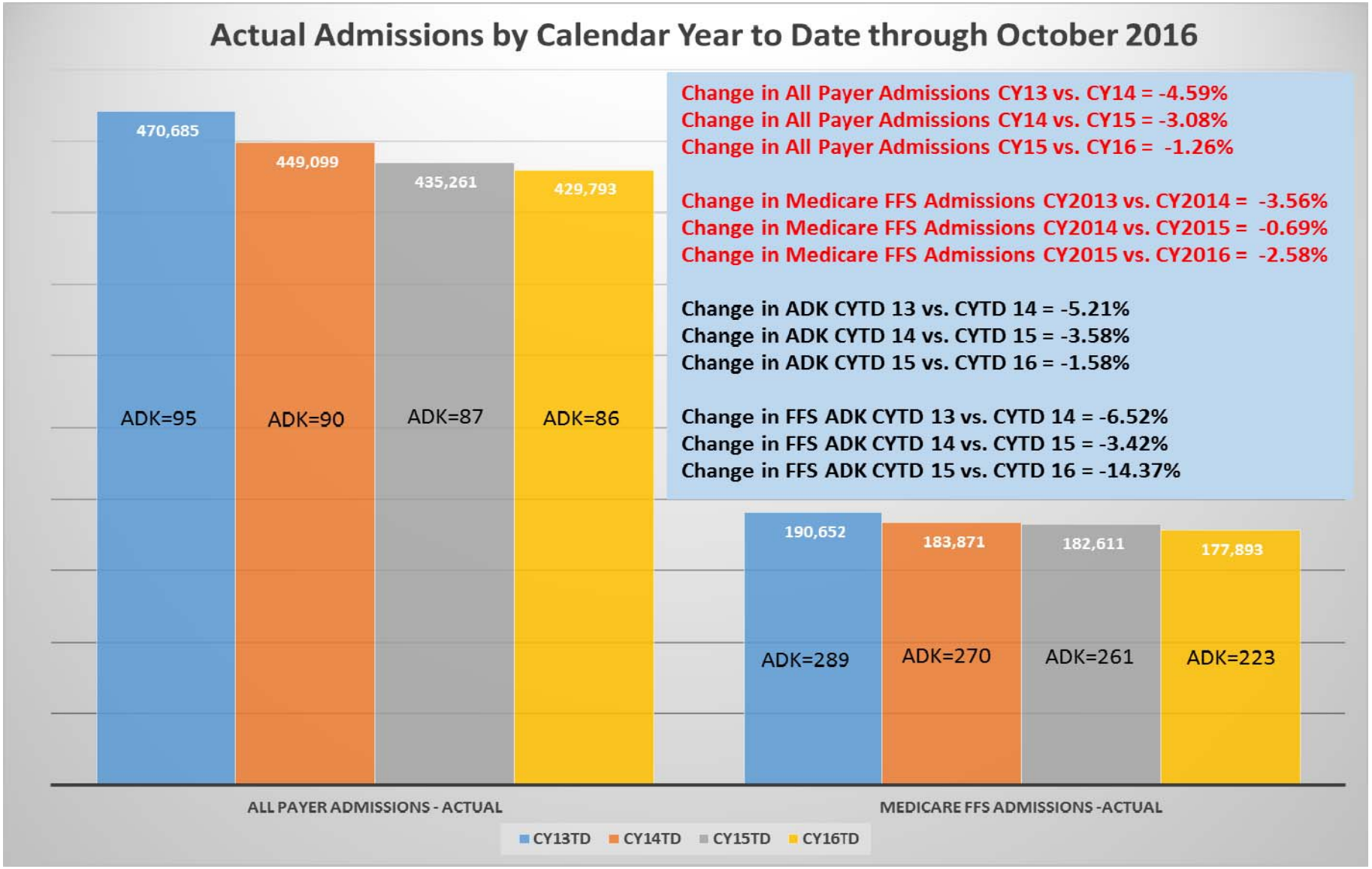
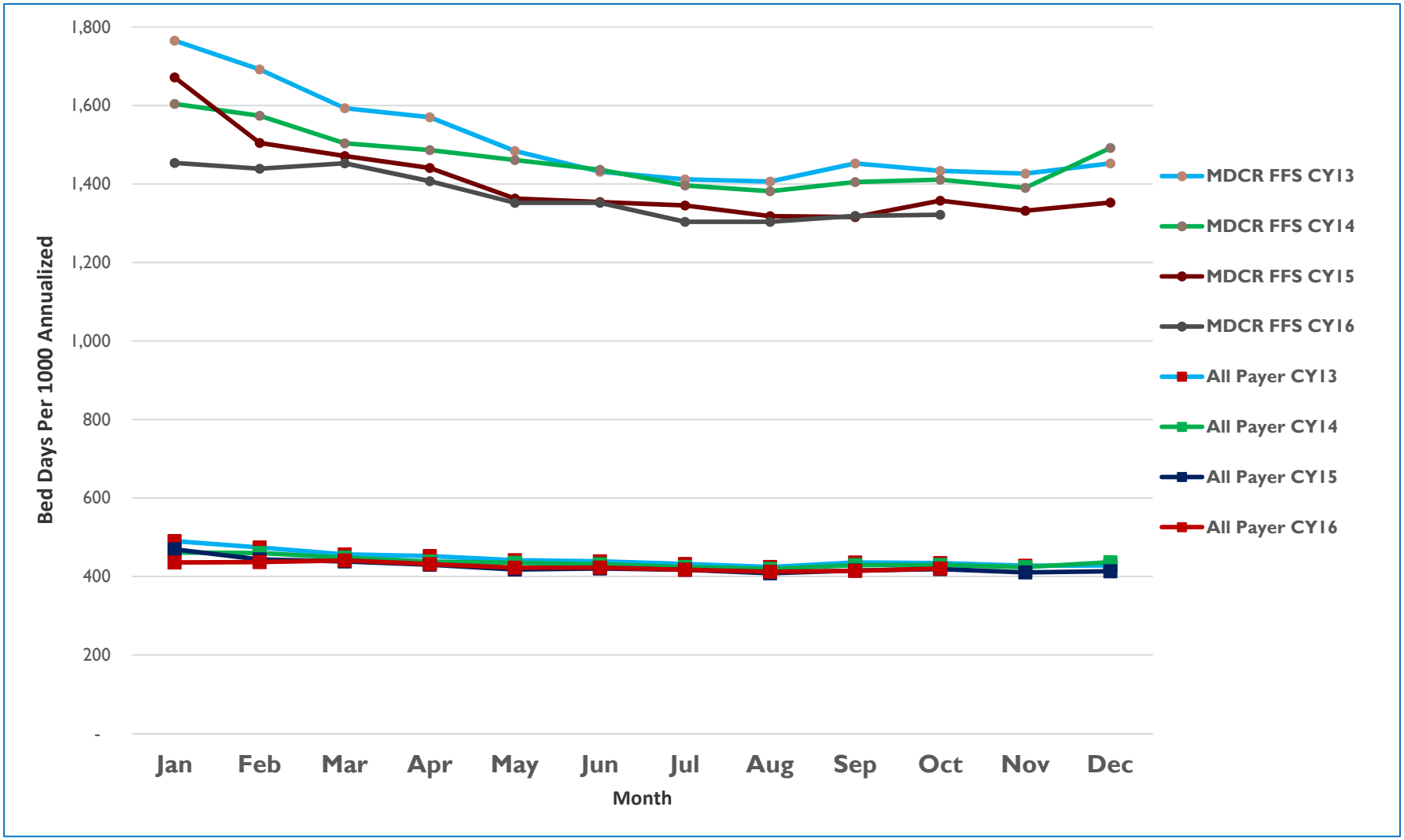


*Note – The admissions do not include out of state migration or specialty psych and rehab hospitals FFS=Fee for Service

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



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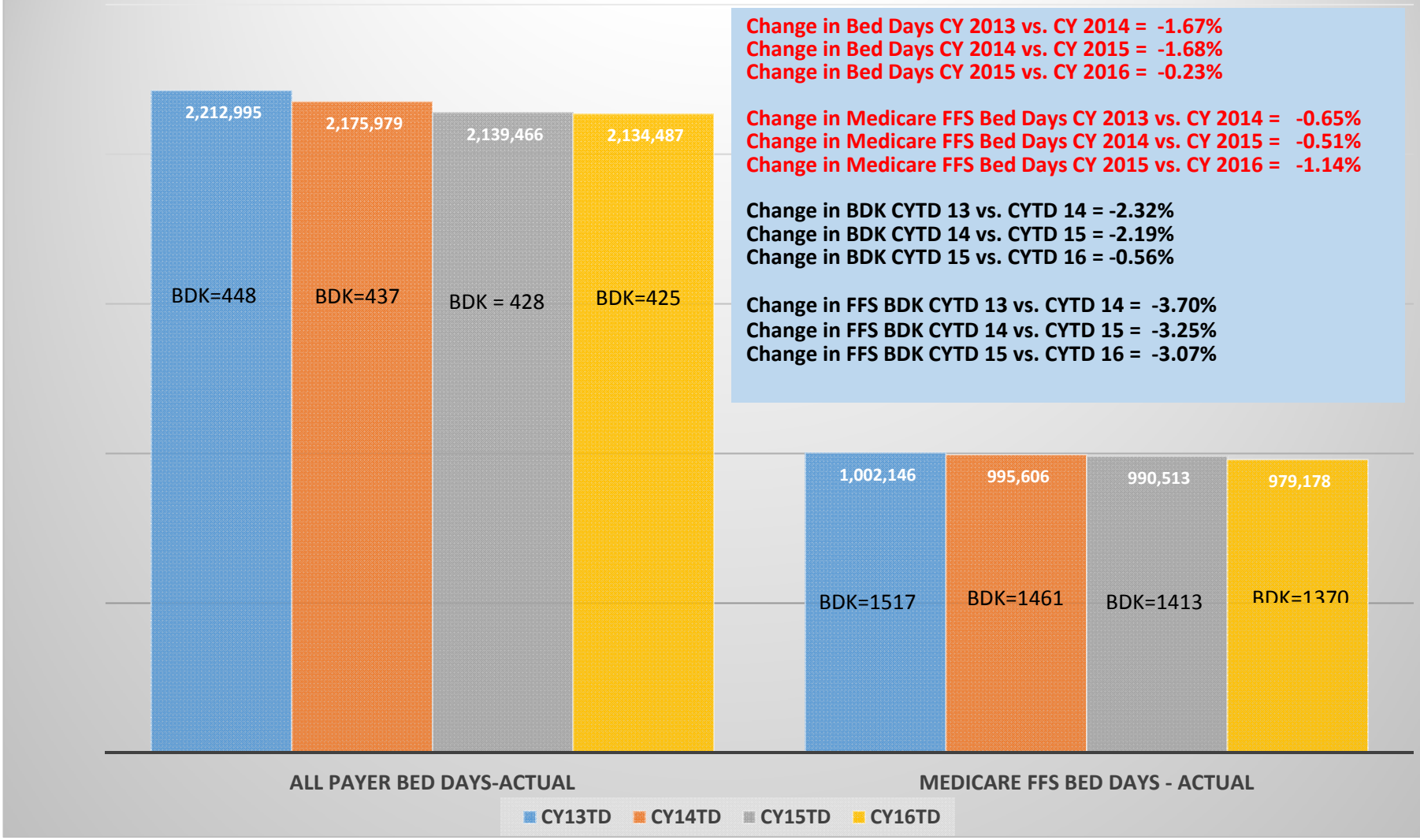
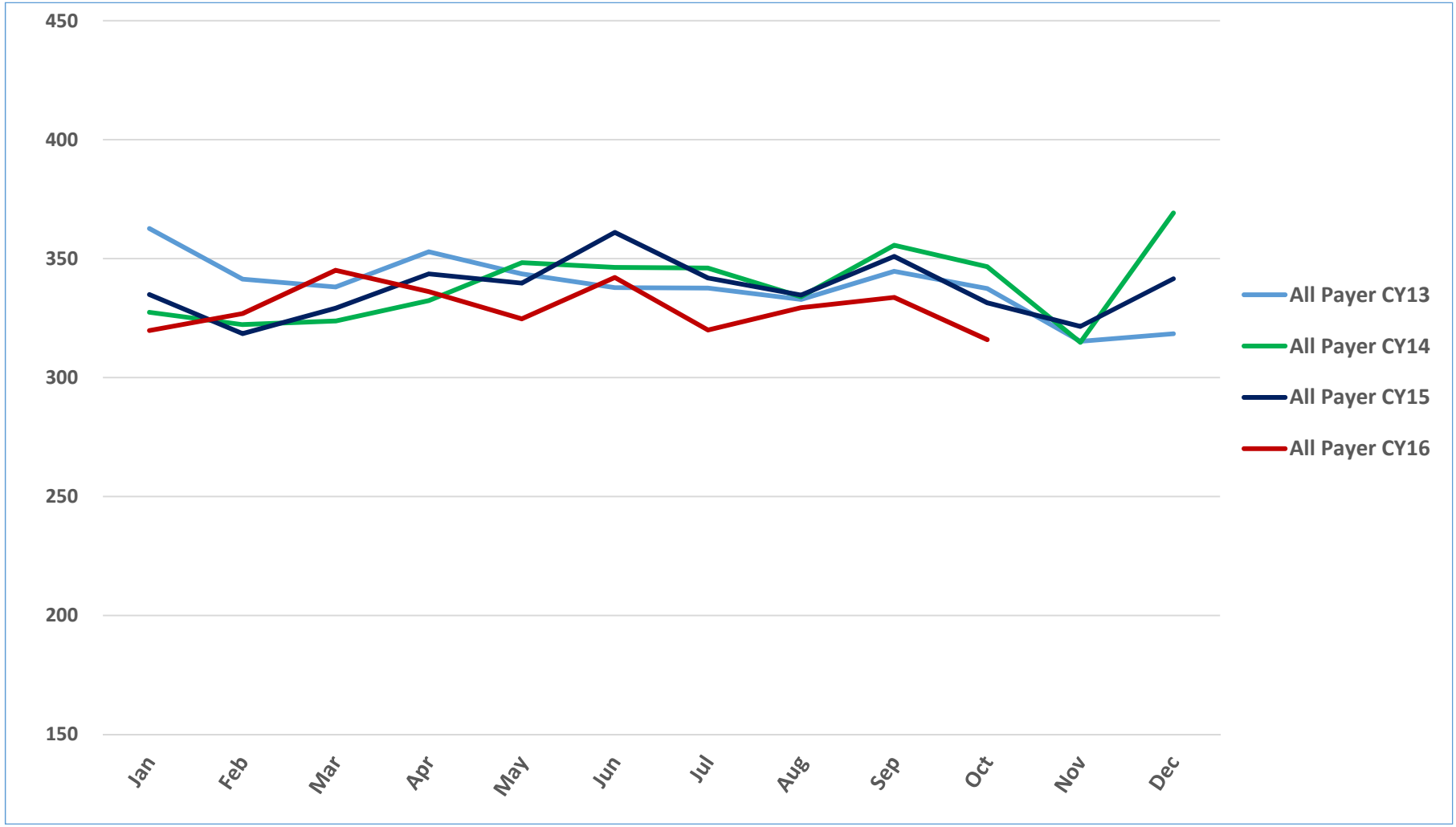
Actual Bed Days by Calendar Year to Date through October 2016



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

Annual Trends for In State All Payer ED Visits/1000 (EDK) Annualized (CY 2013 through CY 2016 YTD)



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

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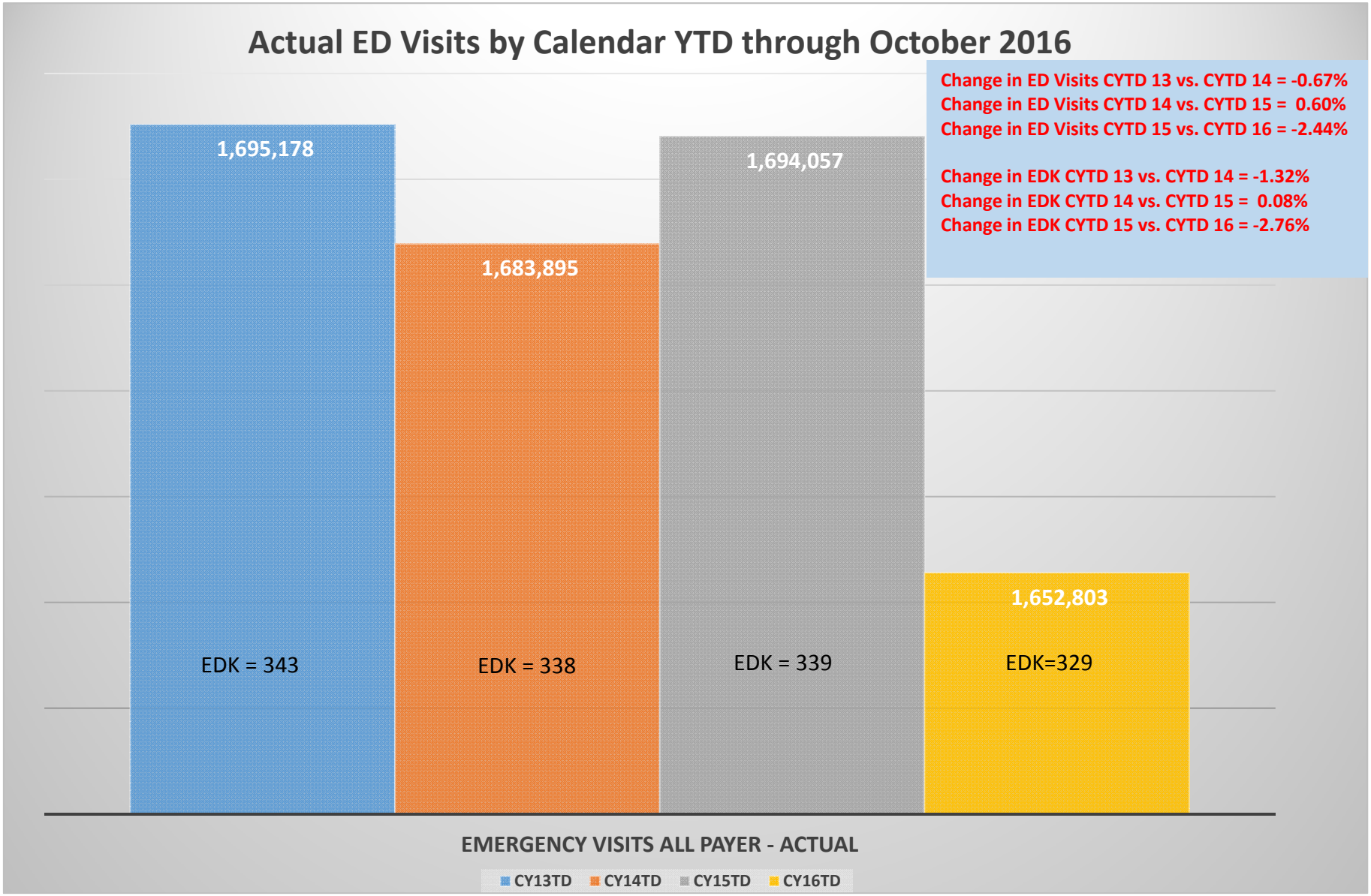


*Note - The ED visits do not include out of state migration or specialty psych and rehab hospitals.

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.

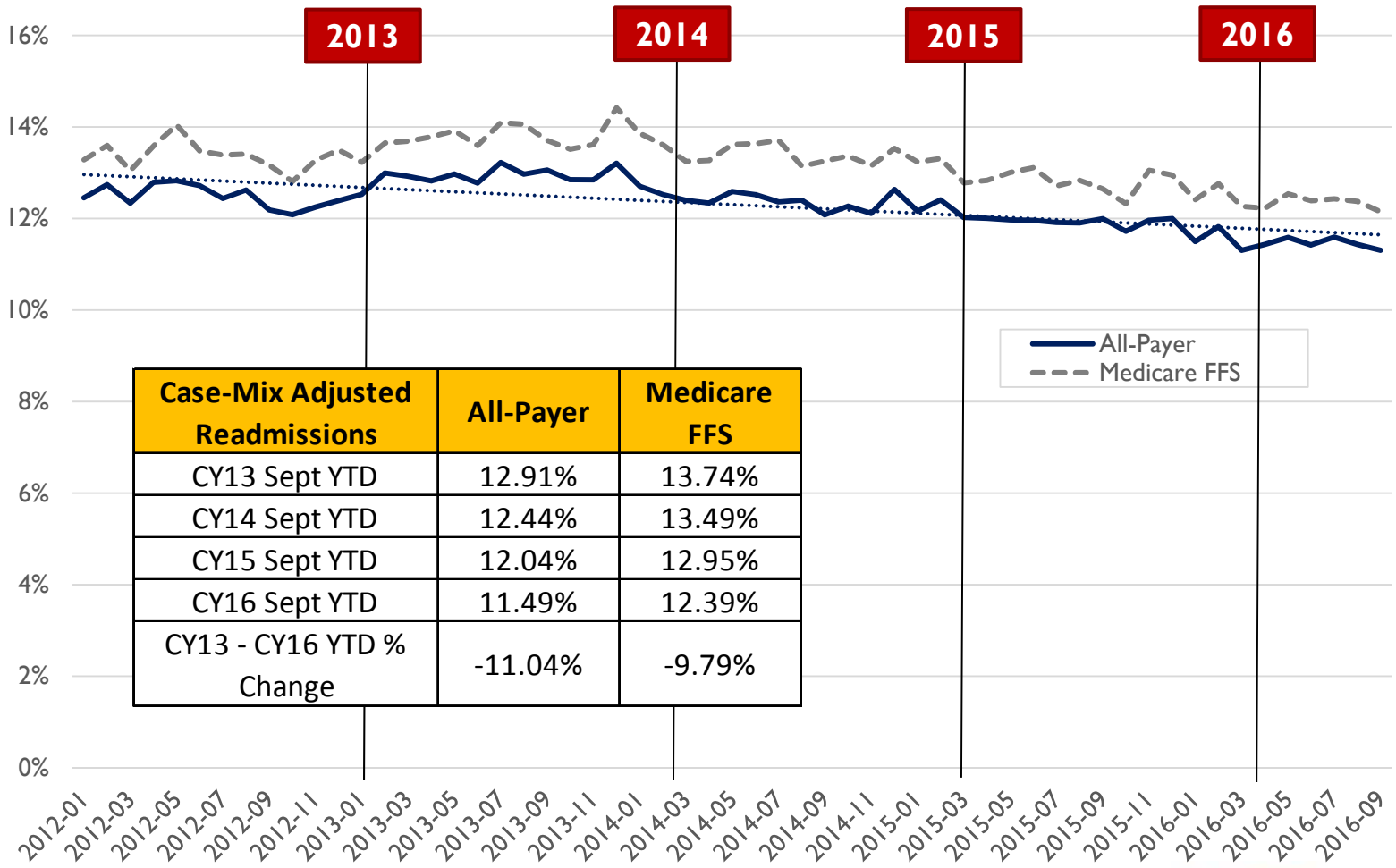
Data Caveats cont.

- 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
Quality Data

December 2016 Commission Meeting Update

Monthly Case-Mix Adjusted Readmission Rates



Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
CY13 Sept YTD	12.91%	13.74%
CY14 Sept YTD	12.44%	13.49%
CY15 Sept YTD	12.04%	12.95%
CY16 Sept YTD	11.49%	12.39%
CY13 - CY16 YTD % Change	-11.04%	-9.79%

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

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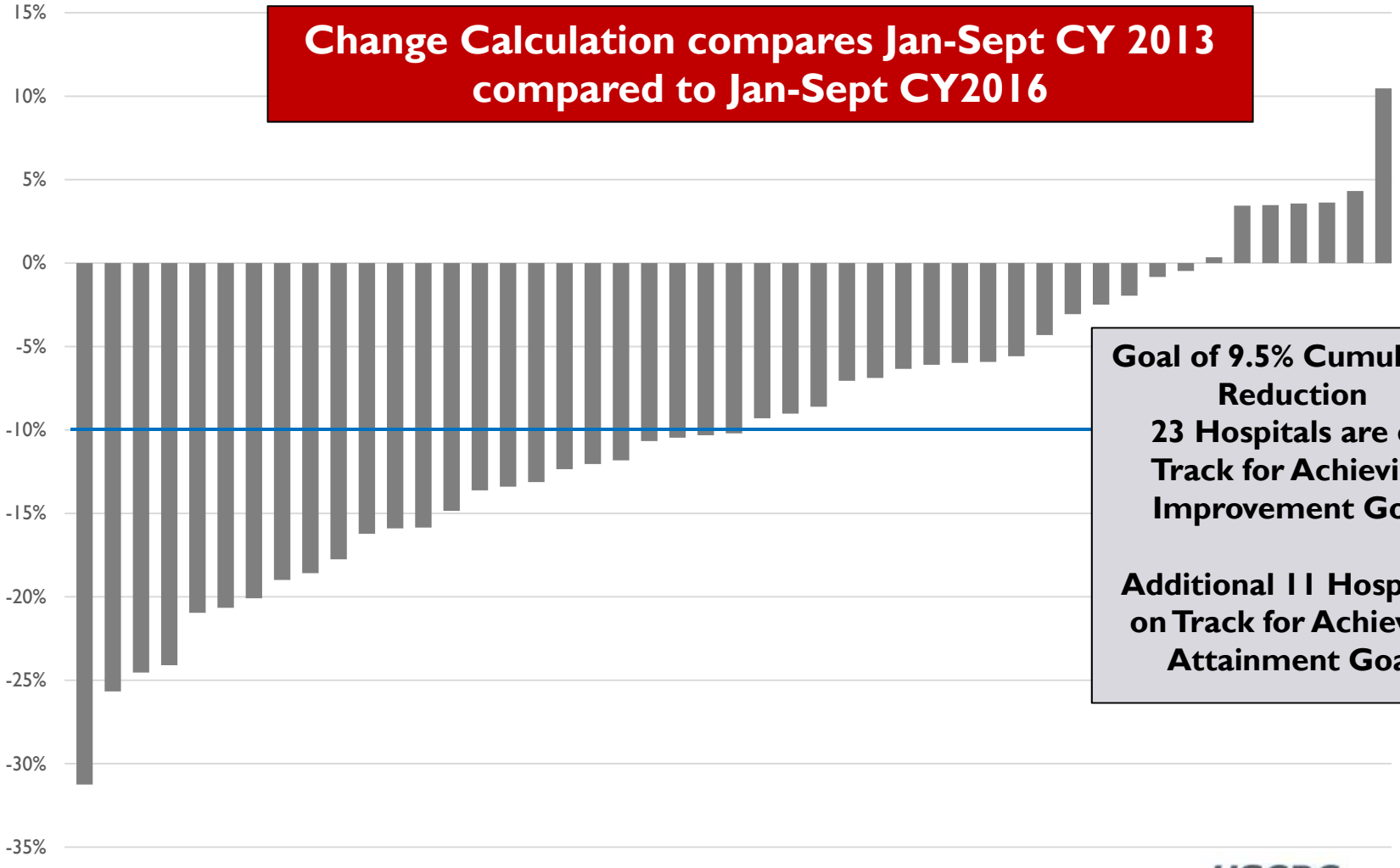
Change in All-Payer Case-Mix Adjusted Readmission Rates by Hospital



Change Calculation compares Jan-Sept CY 2013 compared to Jan-Sept CY2016

Goal of 9.5% Cumulative Reduction
23 Hospitals are on Track for Achieving Improvement Goal

Additional 11 Hospitals on Track for Achieving Attainment Goal

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

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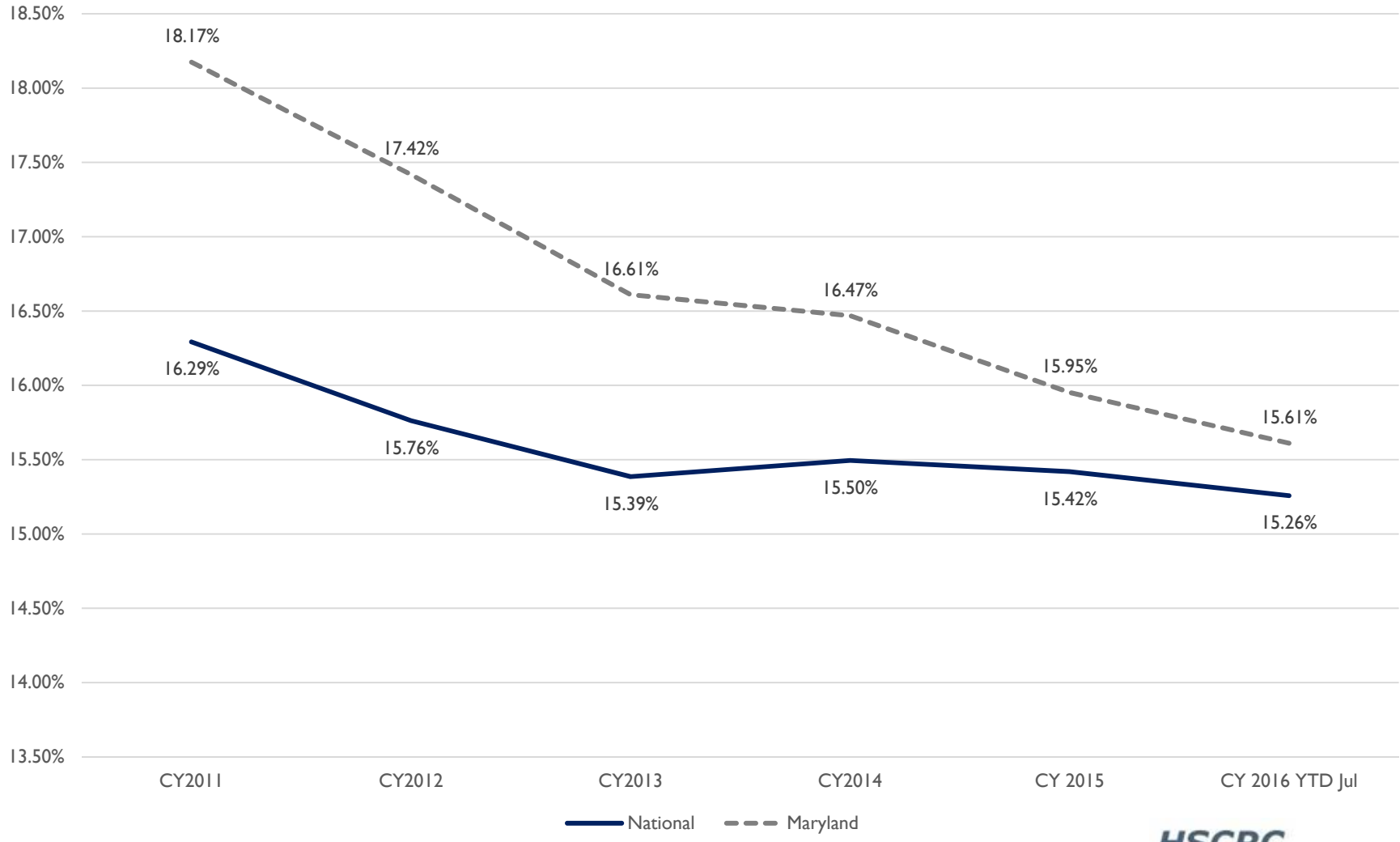
Medicare Readmission All-Payer Model Test

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



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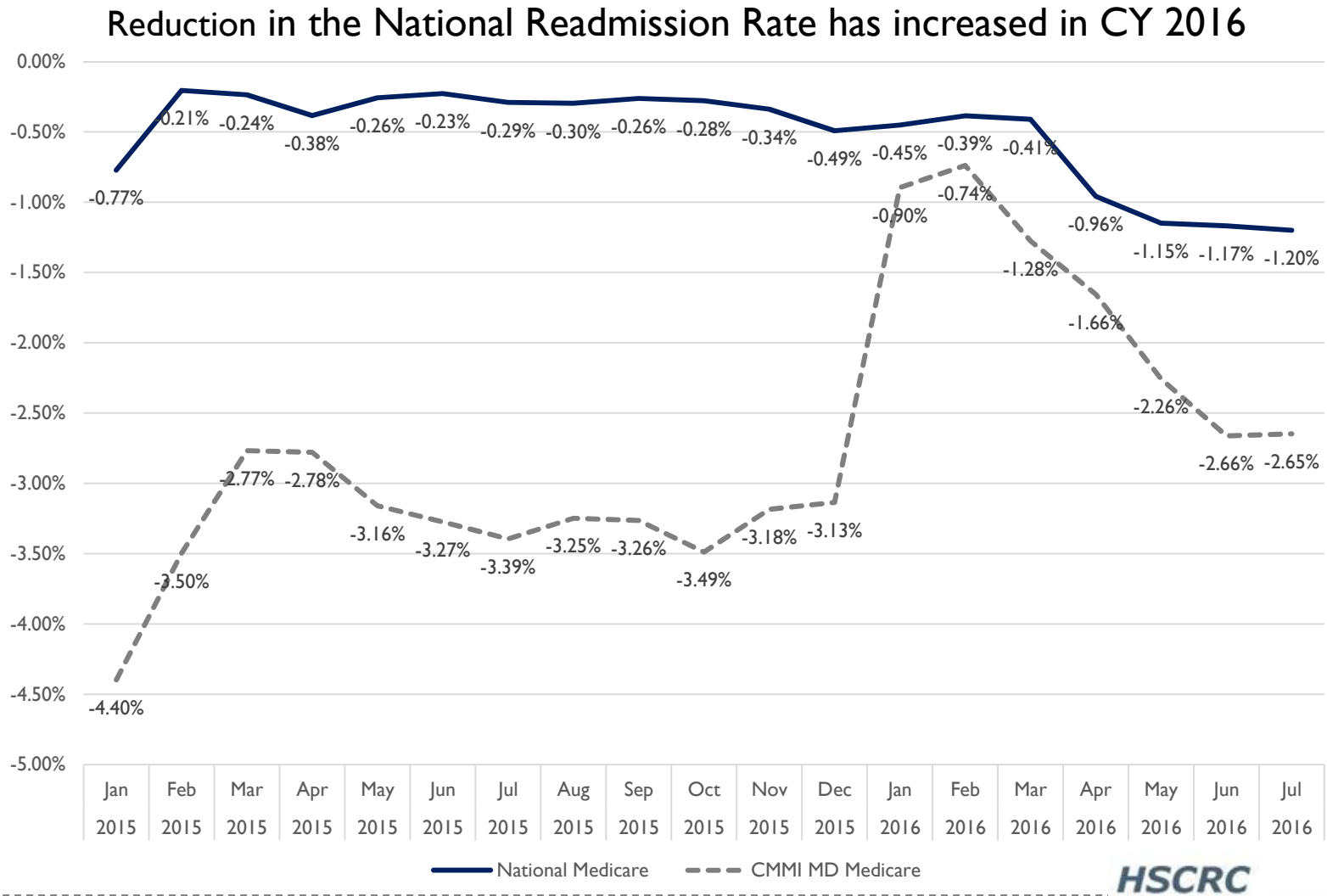
Cumulative Readmission Rate Change by Month (year over year): Maryland vs Nation



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Potentially Avoidable Utilization Update

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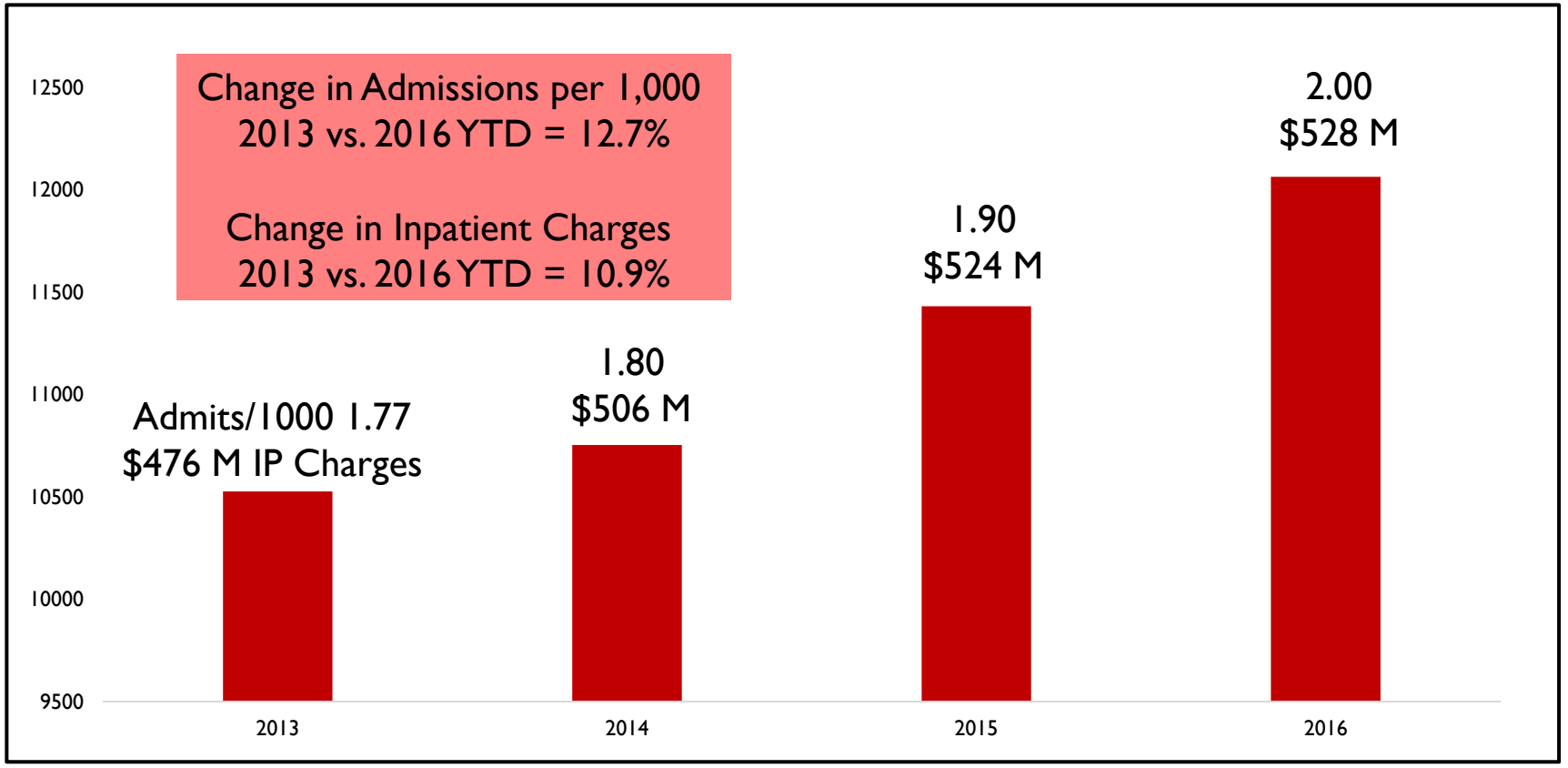
Severe Sepsis/Septic Shock Admissions - CYTD Sept.

High proportion of inpatient sepsis cases may be avoidable (Novosad et al. MMWR, 2016)



Data: HSCRC Case-mix data with any ICD diagnosis of severe sepsis and septic shock. Population data from department of planning.

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 DECEMBER 7, 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
2357A	Hopkins Health Advantage	10/4/2016	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
2366A	Johns Hopkins Health System	11/7/2016	N/A	N/A	N/A	DNP	OPEN
2367A	Johns Hopkins Health System	11/30/2016	N/A	N/A	N/A	DNP	OPEN
2368A	Johns Hopkins Health System	12/5/2016	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**	
JOHNS HOPKINS HEALTH	*	**COMMISSION**	
SYSTEM	*	**DOCKET:**	**2016**
	*	**FOLIO:**	**2167**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2357A**

Final Recommendation

December 14, 2016

I. Introduction

On October 4, 2016, the Johns Hopkins Health System (JHHS) 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"). JHHS seeks approval for Hopkins Health Advantage. Inc. ("HHA") to continue to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. HHA is the JHHS entity that assumes the risk under this contract. JHHS is requesting an approval for one year beginning January 1, 2017.

II. Background

On September 1, 2015, CMS granted HHA approval to operate a Medicare Advantage Plan to provide coverage to Maryland eligible residents in Anne Arundel, Baltimore, Calvert, Carroll, Howard, Montgomery, Somerset, Washington, Wicomico, Worcester counties and Baltimore City. The application requests approval for HHA to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a CMS-determined capitation payment. HHA will pay the Hospitals HSCRC-approved rates for hospital services used by its enrollees.

HHA supplied 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 HHA'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 HHA 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. The Hospitals must file a renewal application annually for continued participation. In addition, HHA must meet with HSCRC staff prior to August 31, 2017 to review its financial projections for CY 2018. In addition, HHA must submit a copy of its quarterly and annual National Association of Insurance Commissioner's (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 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**

Amended

Staff Recommendation

December 14, 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 unfavorable. According to the Hospital, the unfavorable performance was due to clinical

complications associated with transplant case. The case was subsequently pulled from the contract and was paid fee for service. In addition, the contract has been modified to mitigate the effect of such cases in the future.

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.

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:**	**2176**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2366A**

Staff Recommendation

December 14, 2016

I. INTRODUCTION

Johns Hopkins Health System ("System") filed a renewal application with the HSCRC on November 9, 2016 on behalf of the Johns Hopkins Bayview Medical Center (the "Hospital") requesting approval from the HSCRC for continued participation in a capitation arrangement among the System, the Maryland Department of Health and Mental Hygiene (DHMH), and the Centers for Medicare and Medicaid Services (CMS). The Hospital, doing business as Hopkins Elder Plus ("HEP"), serves as a provider in the federal "Program of All-inclusive Care for the Elderly" ("PACE"). Under this program, HEP provides services for a Medicare and Medicaid dually eligible population of frail elderly. The requested approval is for a period of one year effective January 1, 2017.

II. OVE RVIEW OF APPLICATION

The parties to the contract include the System, DHMH, and CMS. The contract covers medical services provided to the PACE population. The assumptions for enrollment, utilization, and unit costs were developed on the basis of historical HEP experience for the PACE population as previously reviewed by an actuarial consultant. Johns Hopkins HealthCare, LLC assumes the risks under the agreement, and all Maryland hospital services are paid based on HSCRC rates.

III. STAFF EVALUATION

Staff found that the experience under this arrangement for FY 2016 to be favorable. The Program is projecting a breakeven year in FY 2017.

III. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospital's renewal application for an alternative method of rate determination for one year beginning January 1, 2017. The Hospital will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the

standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document formalizes the understanding between the Commission and the Hospital, and includes 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 also stipulates 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:**	**2177**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2367A**

Staff Recommendation

December 14, 2016

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on November 30, 2016 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (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 requests approval from the HSCRC to participate in a global rate arrangement for executive health services, joint replacement, and pancreatic cancer services with Crawford Advisors, LLC for a period of one year beginning January 1, 2017.

II. OVE RVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

bear the risk of potential losses.

V. STAFF EVALUATION

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

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:**	**2178**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2368A**

Staff Recommendation

December 14, 2016

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on December 5, 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 Under Armor, Inc. for a period of one year beginning February 1, 2017.

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 February 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.

Recommendations for Updating the Quality-Based Reimbursement Program for Rate Years 2017 (Final), 2018 (Draft), and 2019 (Draft)

December 14, 2016

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

The final staff recommendation for RY 17 was approved at the December 14, 2016 Commission Meeting.

This document also contains the draft staff recommendations for updating the QBR Program for RYs 2018 and 2019. Please submit comments on the draft recommendations to the Commission by Tuesday, January 3, 2017 via hard copy mail or email to hscrc.quality@maryland.gov.

Table of Contents

LIST OF ABBREVIATIONS

ACA Affordable Care Act

CDC Centers for Disease Control & Prevention

CY Calendar year

CAUTI Catheter-as sociated urinary tract infection

CLABSI Central line-associated blood stream infections

CMS Centers for Medicare & Medicaid Services

DRG Diagnosis-related group

ED Emergency department

FY Fiscal year

FFY Federal fiscal year

HAI Healthcare Associated Infections

HCAHPS Hospital Consumer Assessment of Healthcare Providers and Systems

HSCRC Health Services Cost Review Commission

MRSA Methicillin -resistant staphylococcus aureus

NHSN National Health Safety Network

PQI Prevention quality indicators

QBR Quality-Based Reimbursement

RY Maryland HSCRC Rate Year

SIR Standardized infection ratio

SSI Surgical site infection

THA/TKA Total hip and knee arthroplasty

VBP Value-Based Purchasing

INTRODUCTION

The Maryland Health Services Cost Review Commission's (HSCRC's or Commission's) quality-based measurement and payment initiatives are important policy tools for providing strong incentives for hospitals to improve their quality performance over time. These initiatives hold amounts of hospital revenue at risk directly related to specified performance benchmarks. Maryland's Quality-Based Reimbursement (QBR) program, in place since July 2009, employs measures that are similar to those in the federal Medicare Value-Based Purchasing (VBP) program, in place since October 2012. Because of its long-standing Medicare waiver for its all-payer hospital rate-setting system and the implementation of the QBR program, the Centers for Medicare & Medicaid Services (CMS) has given Maryland various special considerations, including exemption from the federal Medicare VBP program.

Similar to the VBP program, the QBR program currently measures performance in clinical care, patient safety, and experience of care domains. Despite higher weighting of financial incentives on the experience of care domain (50%) which employs the national Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) survey instrument, Maryland has continued to perform below the national average over the last several years with little or no improvement, including for the Rate Year (RY) 2017 completed performance year. The patient safety domain was weighted second highest, and scores on average for this domain were next lowest.

The purpose of this report is to make draft recommendations for the QBR program for fiscal year (FY) 2019. The report also recommends updates to the approach for scaling rewards and penalties retrospectively for RY 2017 and 2018 in order to assign rewards and penalties consistent with hospital performance levels based on data now finalized for RY 2017.

BACKGROUND

Federal VBP Program

The Affordable Care Act (ACA) established the hospital VBP program,[1] which requires CMS to reward hospitals with incentive payments for the quality of care provided to Medicare beneficiaries. The program assesses hospital performance on a set of measures in clinical care, experience of care, safety, and efficiency (i.e., Medicare spending per beneficiary) domains. The incentive payments are funded by reducing the base operating diagnosis-related group (DRG) amounts that determine the Medicare payment for each hospital inpatient discharge.[2] The ACA

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

set the reduction at 1 percent in federal fiscal year (FFY) 2013 and required that it increase incrementally to 2 percent by FFY 2017.[3]

CMS will calculate FFY 2018 hospital final scores based on measures in the four equally weighted domains (Appendix I). Although not final, CMS has proposed no changes to the domain weights for the FFY 2019 program from those used for FFY 2018.

Maryland's Current QBR Program (RY 2018 Performance Period)

For the RY 2018 performance period, Maryland's QBR program like the federal VBP program, assesses hospital performance on similar (or the same where feasible) measures, and holds 2% of hospital revenue at risk based on performance. (See Appendix II for more detail, including the timeline for base and performance years impacting RYs 2017-2019).

For RY 2018, the QBR domains are weighted differently than those of the VBP program as illustrated in Figure 1 below. Main changes for this performance year are that the three-item Care Transition Measure (CTM-3)[4] dimension was added to the HCAHPS survey, and the PC01-Early Elective Delivery measure was added to the Safety domain. The QBR program does not include an efficiency domain within the QBR program; however, Maryland has implemented an efficiency measure in relation to global budgets based on potentially avoidable utilization as measured by the Agency for Healthcare Research and Quality Prevention Quality Indicators (PQI) and readmissions. HSCRC staff will continue to work with key stakeholders to complete development of an efficiency measure that incorporates population-based cost outcomes.

Figure 1. RY 2018 Measures and Domain Weights for CMS VBP[5] and Maryland QBR Programs

	Maryland QBR Domains and Measures	CMS VBP Domain Weights and Measure Differences
Clinical Care	15% (1 measure: all cause inpatient mortality)	25% (3 measures: condition-specific mortality)
Experience of Care [6]	50% (9 measures: HCAHPS 8 dimensions + CTM 3 dimension)	25% Same

[3] 42 USC § 1395ww(o)(7)(C).

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

[5] Details of CMS VBP measures may be found at: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HospitalQualityInits/Measure-Methodology.html

[6] For the FFY 2018 VBP program, CMS changed the name of this domain from "Patient experience of care" to "Patient and Caregiver-Centered Experience of Care/Care Coordination," and for the 2019 VBP program, CMS changed the name to "Patient and Community Engagement." For purposes of this report, this domain will be referred to as "experience of care" across the program years.

	Maryland QBR Domains and Measures	CMS VBP Domain Weights and Measure Differences
Safety	35% (8 measures: CDC NHSN, all-payer PSI 90, PC01)	25% PSI 90 Medicare only; others same
Efficiency	N/A	25% (Medicare spending per beneficiary measure)

ASSESSMENT

This section summarizes Maryland hospital performance including scores for RY 2017 (completed), and the most updated performance data on a select subset of measures currently in use for the RY 2018 QBR or VBP program.

Performance Results on QBR and VBP Measures with Most Recent Data Available

For a **subset** of the measures across the domains used for the RY 2018 QBR and/or VBP programs based on the most current data available from CMS, Figure 2 below provides Maryland's performance levels (Most Recent Rate), the change from the previous 12-month period (Improvement from Previous Year), and the difference between the most recent national VBP program performance and the most recent Maryland rates (Difference from National Rates). The colors of the cells illustrate comparisons to national or previous year's rates (see color key). Figure 2 is designed to provide a concise snapshot on performance, but detailed data for this Figure and additional comparison calculations are available in the series of tables found in Appendix III. Additional highlights regarding Maryland's performance on the measures by domain are provided in the text just following Figure 2.

Figure 2. Selected QBR/VBP Measures: Maryland Current Rates, Improvement from Previous Year, and Change in Difference from National Performance

Color Codes	Worse than the National Rate Better than the National Rate At National Average	Worse than MD Previous Year Improved from MD Previous Year No Change	MD-National gap worse than previous yr. gap MD National gap better than Previous year gap No Change Not Available
Domain (RY 2018) Measure	**Most Recent Rate**	**Improvement From Previous Year**	**Difference from National Rate**
Experience of Care Domain (HCAHPS Percent "top box" or most positive response reported)			
Responsiveness	59%	-1%	-9%
Overall Rating	65%	0%	-7%
Clean/Quiet	62%	0%	-7%
Explained Medications	60%	0%	-5%
Nurse Communication	76%	0%	-4%
Pain Management	68%	1%	-3%
Doctor Communication	79%	1%	-3%
Discharge Info	86%	0%	-1%
Three-Part Care Transitions Measure	48%	0%	-4%
Clinical Care- Outcome Domain (Mortality Risk Adjusted Rates)			
30-day AMI	14.06%	-0.44%	-0.14%
30-day Heart Failure	10.86%	-0.04%	-0.74%
30-day Pneumonia	10.64%	-0.21%	-0.86%
Safety Domain			
PC-01 Early Elective Delivery (% Deliveries)	5%	2%	2%
NHSN SIR: Standardized Infection Ratios			
CLABSI	0.50	-5.12%	-0.50%
CAUTI	0.86	-48.04%	-0.14%
SSI – Colon	1.19	12.32%	0.19%
SSI - Abdominal Hysterectomy	0.92	-28.49%	-0.08%
MRSA	1.20	-10.71%	0.20%
C.diff.	1.15	-0.26%	0.15%

Measurement time periods for HCAHPS and Safety measures: Q4-2013 to Q3-2014 and Q4-2014 to Q3-2015 (most recent rate); for 30-day mortality Q3-2010 to Q2-2013 and Q3-2011 to Q2-2014 (most recent rate).
For measures reported as a percentage, the improvement and National gap are reported as percentage points; for SIRs, the improvement and National gap are reported are percent differences.

Safety Measures

For the early elective induction or Cesarean section delivery measure (PC-01), staff notes that Maryland performed better than the nation in the earlier time period but worse with a sharp increase in the later period. By contrast, the nation improved from the earlier to the latter period.

For Centers for Disease Control National Health Safety Network (CDC NHSN) Standardized Infection Ratio (SIR) measures compared to a national reference period (2008-2011) where the SIR was established at the value of 1 (See Appendix III, Table 4 for detailed data), Maryland statewide performance appears better on average than the national average for some of the measures and worse for others in both the earlier and later time periods. Staff was unable to compare changes in the national rate from a previous time period (indicated in Figure 2 above as grey "not available").

Experience of Care Measures

As noted previously, the experience of care domain is weighted most heavily in the Maryland QBR Program (45 percent in RY2017 and 50 percent in RY 2018). Staff compared the most recently available two years of data for experience of care with that of the nation (Figure 2; see Appendix III, Table 1 for detailed data) and notes that compared to the nation, Maryland's most recent rates are worse for all nine of the experience of care HCAHPS dimensions (indicated in Figure 2 as all red).

Maryland's performance has not changed significantly overall, and the nation has had modest improvement year over year from 2012 to 2015. In their letters exempting Maryland from the VBP program in 2015 and 2016 (see Appendix II), CMS also notes Maryland's ongoing significant lag behind national medium performance levels and has been strongly in favor of increasing weight for this domain in the QBR program. Additional analysis of experience of care scores (an aggregate of eight dimensions available since 2012) comparing Maryland to the nation shows that, as illustrated in Figure 3 below, Maryland's performance declined in 2013 and improved in 2014 to 2012 levels. Given that 2013 was the base period for RY 2017, some of the improvement seen in the RY 2017 QBR scores is due to declines in performance in the base year.

Staff notes that, consistent with the VBP program determination in the FY 2017 Outpatient Prospective Payment System (PPS) Final Rule,[7] the pain management question will be prospectively removed from the QBR program for RY 2019.

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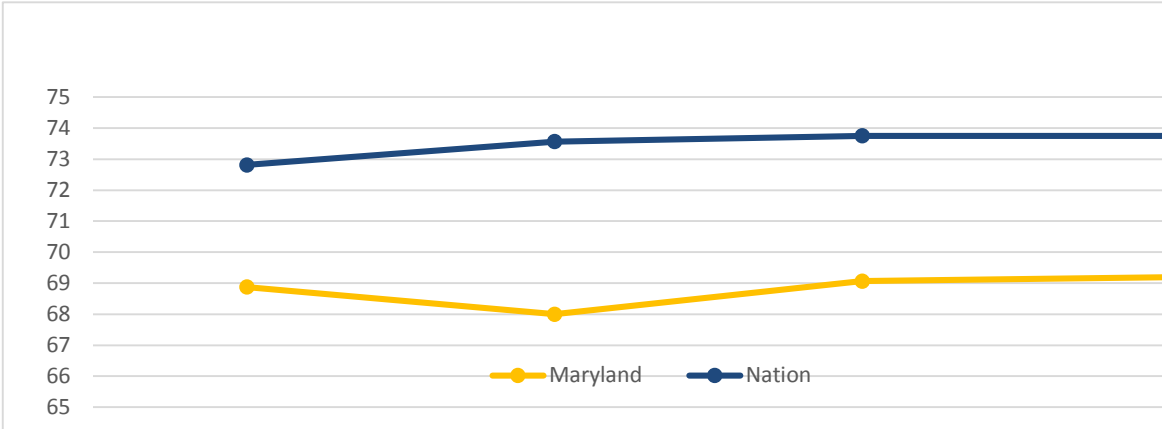
[7] FY 2017 OPPS Final Rule found at: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS/Hospital-Outpatient-Regulations-and-Notices-Items/CMS-1656-P.html, last accessed December 1, 2016.

Figure 3. Maryland vs. National Experience of care
Aggregate Scores over Time



Clinical Care Mortality Measures

On the three CMS condition-specific mortality measures used in the VBP program—30 day heart attack (AMI), heart failure (CHF), and pneumonia— Maryland performs better than the nation with the gap narrowing over time (Figure 2 above; See Appendix III, Table 2 for detailed data).

For the Maryland inpatient, all-payer, all-cause mortality measure used for the QBR program, Maryland's mortality rate declined from 2.87 percent to 2.15 percent between RY 2014 and calendar year (CY) 2015 (see Appendix III, Table 3). Staff analyzed the trend in mortality rates and concluded that the palliative care exclusion has contributed to the decline in the all-payer, all-cause mortality rates. As illustrated in Figure 4 below, the percentage of deaths with palliative codes increased from 42.92 percent to 61.09 percent over the last two years. To prevent further impact of changes in palliative care trends on mortality measurement, the palliative care case exclusion will be eliminated for RY 2019, and these cases will now be included in calculating benchmarks, thresholds, and risk-adjusted hospital mortality rates.

Figure 4. Maryland Statewide Hospital Total and Palliative Care Cases, CY 2013-2015

Calendar Year	Total Discharges	Discharges w/ Palliative Care (PC) Diagnosis (Dx)	Total Deaths	Total Deaths w/ PC Dx	% of Total Discharges w/PC Dx	% of Deaths w/PC Dx	% Live Discharges w/PC Dx
2013	664,849	14,038	13,105	5,625	2.11%	42.92%	1.29%
2014	642,139	17,464	12,670	6,802	2.72%	53.69%	1.69%
2015	624,202	19,447	12,114	7,401	3.12%	61.09%	1.97%

Additional Measure Results

For the newly published Total Hip and Knee Arthroplasty THA/TKA complication measure, performance results were only available for the latter time period. *Hospital Compare*[8] reports that all Maryland hospitals perform "as expected" on this measure (with the exception of one hospital that is better and one that is worse than expected) compared with the nation; staff supports adopting the measure for the RY 2019 QBR program, consistent with the national VBP program.

As part of the strategic plan to expand the performance measures, staff started to examine other measures available in public reporting. Staff notes that Maryland performs poorly on the ED wait time measures compared to the nation. In addition, Maryland and national performance is declining over time. Therefore, staff strongly advocates "active" monitoring of the ED wait times measures with consideration as to the feasibility of adding these measures to the QBR program in future years (See Appendix III, Table 5).

QBR RY 2017 Final Scores and Reward and Penalty Preset Scale

Similar to other quality-based programs, the Commission voted to modify fundamentally the QBR program methodology for calculating rewards and penalties for RY 2017, such that the level of rewards or penalties is determined based on performance points achieved relative to a preset scale, rather than a relative ranking and scaling of the hospitals determined after the performance period. This transition coincided with major changes in the measures used for the QBR program, which entailed removing the process measures (which had higher scores), increasing the weight of experience of care (which had lower scores), and tying the benchmarks to the national distribution. At the time, staff did not have sufficient data to model the implications of these changes on the performance points thoroughly and, therefore, set the payment adjustment scale based on the base year attainment-only performance results relying on input from the Performance Measurement Workgroup.

Hospital pay-for-performance programs implemented nationally and in Maryland generally score hospitals on both attainment (level of rates compared to benchmarks) and on improvement (rate of change from the baseline). Hospitals may earn two scores on the measure specified within each domain—one for attainment (0-10) and one for improvement (0-9). The final score awarded to a hospital for each measure is the higher of these two scores. For experience of care measures, there are also consistency points. All measure scores, with exception of the HSCRC-derived measures using Maryland all-payer case mix data (e.g., PSI 90, all-cause inpatient mortality), include assignment of points between 0 and 10 based on the national average rate for 0 points and the top 25 percent national performance for 10 points. Details regarding the scoring calculations are found in Appendix II.

[8] See https://www.medicare.gov/hospitalcompare/search.html for more information.

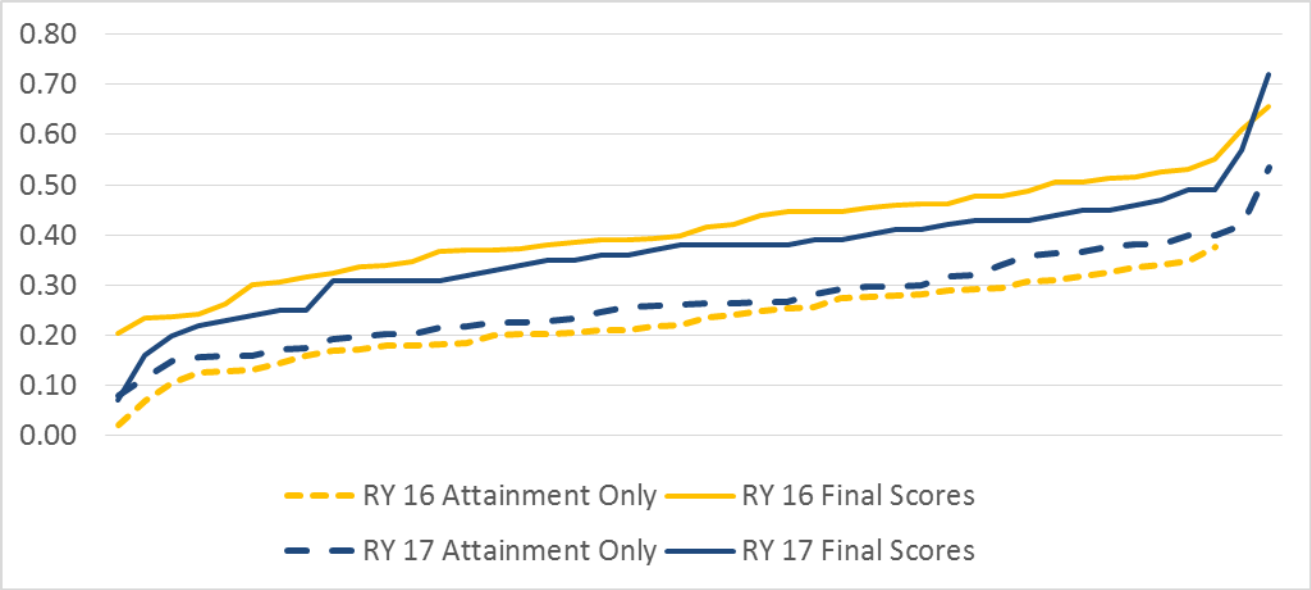
Figure 5 below provides descriptive statistics on the final statewide total QBR scores and scores by each domain for RY 2017. These aggregate level domain scores reflects the proportion of total available points received by the hospital. A 0 score represents none of the measures in that domain were better than the national average or did not improve. A score of 1 represents all measures are at or better than the top 25 percent performance. Experience of care is the most heavily weighted domain, and Maryland scores are lowest for this domain, with an average score of 0.24 and maximum score of 0.54. The domain with the next lowest distribution of scores is safety, with an average score of 0.40; this domain is also weighted second highest in calculating hospitals' total QBR scores. Appendix IV presents RY 2017 final QBR score results by hospital and domain.

Figure 5. RY 2017 Final QBR Scores Distribution Overall and by Domain

Domains	Experience of Care	Clinical Care- (Process *Sub-domain retired after RY 2017*)	Clinical Care- (Outcome Sub-domain)	Safety	Total QBR Score
Measure Description	HCAHPS	AMI 7a-Fibrinolytic Therapy IMM 2- Influenza Immunization	Inpatient All DRG Mortality	CDC NHSN Infection (3 measures), PSI 90	
RY 2017 Weights	45%	5%	15%	35%	100%
Minimum Score	0.03	0.00	0.00	0.00	0.07
25th percentile	0.16	0.40	0.33	0.25	0.31
Median	0.23	0.60	0.60	0.39	0.38
Average	0.24	0.56	0.60	0.40	0.37
75th Percentile	0.30	0.80	0.88	0.54	0.43
Maximum Score	0.54	1.00	1.00	1.00	0.72
Coefficient of Variation	46%	59%	48%	54%	30%

While the figure 5 provides information for the FY 2017 Final QBR scores, Figure 6 below shows the difference between the base period attainment-only scores for RYs 2016 and 2017 versus the final scores for each period, illustrating a significant increase in the final scores when improvement is taken into account. Absent data, staff was unable to model the final scale for RY 2017 and agreed to set the points for the attainment-only scale given the major changes in the program described above.

Figure 6. QBR RY 2016-2017 Attainment-Only and Final Scores (Reflecting the better of Attainment or Improvement)



Staff calculated hospital RY 2017 QBR scores and analyzed the scores relative to the QBR preset scale determined last year and notes that almost all hospitals receive a reward for RY 2017 despite relatively poor performance (Appendix V). With the recommendation to make retrospective adjustments to the readmission policy, staff had noted the issue with the QBR scaling at the June 2016 Commission meeting and has been working since then to understand the implications. Expecting changes to the results, July RY 2017 rate orders and global budgets were sent without QBR program adjustments.

Based on the analysis comparing attainment and improvement points, staff asserts that the RY 2017 preset scale was too low, because it was developed using base period data to calculate attainment-only scores and, again, did not account for improvement trends. The intention to use a preset scale was to improve predictability of the payment adjustments, not to lower the scale as Maryland has been progressively "raising the bar" for performance. Staff is proposing the following for RY 2017 scaling adjustment to correct the issue of the current preset scale being too low:

- Revise preset scale to use final RY 2017 QBR scores. This would result in a relative ranking within the State that penalizes hospitals with QBR scores below the statewide average and reward hospitals with scores above the statewide average (i.e., RY 2017 State average score is 0.37). Staff has provided modeling of the RY 2017 scores using the final scores for FY 2017 in Appendix V.

HSCRC has received input from stakeholders regarding the draft recommendation updating the QBR program presented in the October Commission meeting. As mentioned earlier, HSCRC has also received VBP exemption approval letters from CMS directly addressing the experience of care domain performance lag in Maryland (Appendix II). Highlights of the issues raised

during the meeting and in the letters submitted to the Commission by CMS, the Maryland Hospital Association (MHA) and Consumer Health First (CHF), along with staff responses, is provided below, and the MHA and CHF comment letters are provided in Appendix VI.

- ***Consistency with the CMS VBP approval letters (CMS)-*** Staff asserts that Maryland has committed to adjusting incentives to support improvement in experience of care as part of the conditions for seeking the Maryland exemptions from year to year from the VBP program. In their responses, CMS has voiced strong support for increasing the weight of the experience of care domain to improve Maryland's poor performance. Staff asserts that using a scale that rewards poor performance is not consistent with Maryland's commitments to, and recommendations from, CMS.

- ***Need for predictability (MHA, hospital stakeholders)-*** Staff supports the principle of predictability and asserts this must be balanced with the principle of fairness. Staff, for example, made retrospective changes to the Readmission policy in June 2016 to reduce penalties for hospitals with low readmission rates and low improvement. Staff also voiced the concern regarding the low bar for the QBR program scaling in the same June 2016 meeting.

- ***Approach must maintain trust between stakeholders and Commission (MHA, hospitals, CHF)***- Staff asserts that justified corrections, just as they have been made historically, will continue to strengthen trust, and providing rewards not aligned with performance has potential to erode public trust.

- ***QBR must support patient-centered care and the goals emphasized by the All-Payer Model (CMS, CHF)- S***taff is in strong agreement that improved performance on experience of care is of high importance and priority as part of Maryland's patient centered care model as it strives to achieve better care, better outcomes, and lower costs.

- ***No error in policy was made in determining RY 2017 scaling approach (MHA, hospitals)-*** The distribution of the scores used to set the payment scale (Figure 6 above) using base year attainment only scores was done with the assumptions that changes in the measures and benchmarks would precipitate lower scores for RY 2017. Preliminary performance score calculations in May 2016 showed a $30M net positive impact despite low performance scores. Staff again believes there was an error and supports a technical correction to the point intervals used for scaling.

- ***Burdensome to make mid-year GBR adjustment (MHA, hospitals)***- Although not preferable, if the retroactive scaling adjustment is approved for RY 2017, MHA will support it without a "retroactive budget change" in the current fiscal year. Staff proposes to limit negative revenue adjustments during the current RY with partial penalties up to the amount indicated in the preset scale in the January RY 2017 rate adjustments, and the remaining penalties July RY 2018 rate adjustment. Staff supports hospitals receiving their full rewards under the revised scaling for RY 2017 in the January rate update. Figure 7 below shows the partial rate adjustment implementation scenarios

Figure 7. Examples of Implementation of Revenue Adjustments for RY2017

	Original Preset Scale	Revised Revenue Adjustment	January Adjustment	July Adjustment
Hospital A	-100,000	-120,000	-100,000	-20,000
Hospital B	10,000	-30,000	0	-30,000
Hospital C	100,000	60,000	60,000	0

QBR RY 2019 Payment Adjustment Scaling

In order to finalize the recommendation for RY 2019, staff is continuing to vet with stakeholders a scaling approach that would move away from a relative ranking based on final scores, to one that uses a national scale to assess Maryland hospital performance. As the benchmarks and thresholds are determined by national rates, moving to a national scale in the payment adjustments will align the financial results with quality performance. Specifically, the staff is proposing the following for the RY 2019 scaling adjustment:

- Use a national scale that ranges from 0 to 1 and establish reward/penalty cutoffs such that a hospital scoring greater than 0.50 is rewarded. With the exception of the HSCRC-derived measures using Maryland all-payer case mix data (e.g., PSI 90, all-cause inpatient mortality), the thresholds and benchmarks for the scoring methodology are based on the national average (threshold) and the top performance (benchmark) values. A score of 0 means all measures are below the national average or not improved, while a score of 1 would mean all measures are at or better than top 25 percent best performing rates. Although hospital scores reflect performance relative to the national thresholds and benchmarks, the use of a statewide distribution to set the scale to allocate financial adjustments creates a disconnect between Maryland's performance and the national trends. Adjusting the scale to reflect a national distribution will ensure that QBR revenue adjustments are also linked with Maryland hospital performance relative to the nation. As Maryland raises the bar for obtaining rewards with this approach, the potential rewards should be commensurate and should be increased from 1 percent to 2 percent. The benefits of using a national scale are that it can be set prospectively, and hospitals are not relatively ranked after the performance period. Most importantly, the use of a national scale ensures that hospitals that perform better than the national average will be rewarded, and hospitals that are worse than the national average will be penalized.

QBR RY 2018 Payment Adjustment Scaling Options

For RY 2018, a retrospective change is also needed to the preset payment scale as the payment scale was set with the same points last year given a lack of timely data. Staff is recommending using the same approach proposed for RY 2017, where final scores will be used to create a scale that penalizes those hospitals with below average performance. However, staff will continue to vet with stakeholders whether it is preferable instead to make the shift to a national scale for RY 2018 (i.e., the proposed RY 2019 scaling). Furthermore, for RY 2018 (and beyond) staff needs

to finalize timing of the revenue adjustments given the delay in the RY 2017 adjustments. Staff is vetting implementing the full adjustment for QBR routinely in January or delaying until July (i.e., the subsequent rate year), lengthening the time interval between the performance period and the payment adjustment impact by 6 months to one year.

RECOMMENDATIONS

Staff notes the State's improvement trends in the Maryland inpatient, all-cause, all-payer mortality rate used for the QBR program as well as the CMS condition-specific mortality measures used for the VBP program but cautions these observations should be tempered with the knowledge that the previous palliative care exemption will not be applied going forward. Staff also recognizes the gap that remains between Maryland and national performance on the experience of care measures in particular, the domain that constitutes 45 percent for RY 2017 and 50 percent for RY 2018 of the hospitals' QBR total scores. In this section of the report, staff presents final recommendations for changes to the QBR program for RY 2017 and draft recommendations for RYs 2018 and 2019.

Final Recommendations for RY 2017

Based on the analysis and observations presented above, staff recommends the following retrospective adjustments to the RY 2017 QBR program:

- Adjust retrospectively the RY 2017 QBR preset scale for determining rewards and penalties such that the scale accounts for both attainment and improvement trends.
- Use a relative scale to linearly distribute rewards and penalties based on the final QBR scores, without revenue neutrality adjustment.
- Adjust rates in the updated rate orders to reflect the proposed updated QBR scaling approach.
- Limit negative revenue adjustments during the current RY by partially implementing penalties (up to the amount indicated in preset scale) in the January RY 2017 rate adjustments, and implementing the remaining penalties in the July RY 2018 rate adjustments.

Draft Recommendations for RY 2018

Staff recommends that the following be considered for RY 2018:

> Calculate the scaling points based on RY 2018 performance periods and provide rewards to hospitals that are above the average score in accordance with the above RY 2017 scaling recommendation, with a maximum penalty of 2 percent and maximum reward of 1 percent of inpatient revenue distributed linearly in proportion to calculated scores.

Draft Recommendations for RY 2019

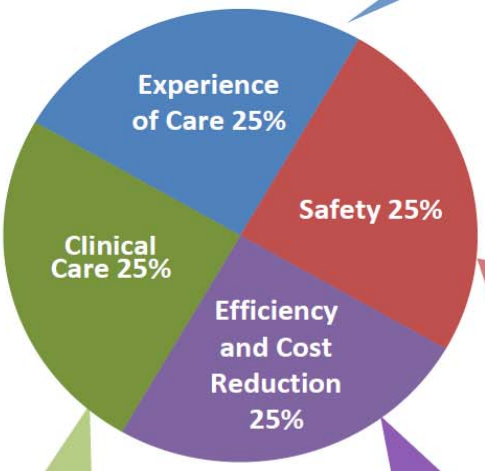
Staff recommends that the following be considered for RY 2019:

Move to a national distribution and determine the score at which rewards should start and the amount of maximum/minimum penalties to be applied. (HSCRC staff modeled a national scale from 0-0.80 with a reward/penalty threshold of 0.40 based on the Maryland Hospital Association's distributional analysis of national scores). Increase the maximum reward to 2 percent as the achieving rewards will be based on national distribution.

APPENDIX I. CMS FFY 2018 VBP MEASURES AND PERFORMANCE PERIODS

FY 2018 Value-Based Purchasing Domain Weighting

(Payment adjustment effective for discharges from October 1, 2017 to September 30, 2018)



PATIENT AND CAREGIVER-CENTERED EXPERIENCE OF CARE/CARE COORDINATION

Baseline Period	Performance Period
January 1, 2014 – December 31, 2014	January 1, 2016 – December 31, 2016

HCAHPS Survey Dimensions	HCAHPS Performance Standard		
	Floor (%)	Threshold (%)	Benchmark (%)
Communication with nurses	55.27	78.52	86.68
Communication with doctors	57.39	80.44	88.51
Responsiveness of hospital staff	38.40	65.08	80.35
Pain management	52.19	70.20	78.46
Communication about medications	43.43	63.37	73.66
Cleanliness and quietness	40.05	65.60	79.00
Discharge information	62.25	86.60	91.63
New! CTM-3 3-item Care Transitions Measure	25.21	51.45	62.44
Overall rating of hospital	37.67	70.23	84.58

SAFETY

Complication/Patient Safety for Selected Indicators

Baseline Period	Performance Period
July 1, 2010 – June 30, 2012	July 1, 2014 – June 30, 2016

Measure	Threshold	Benchmark
AHRQ PSI 90 composite	0.577321	0.397051

Perinatal

Baseline Period	Performance Period
January 1, 2014 – December 31, 2014	January 1, 2016 – December 31, 2016

Measure	Threshold	Benchmark
PC-01 Elective Delivery Prior to 39 Completed Weeks Gestation (Moved from Clinical Care)	0.020408	0.000

Healthcare-Associated Infections*
*Current standard population data

Baseline Period	Performance Period
January 1, 2014 – December 31, 2014	January 1, 2016 – December 31, 2016

Measure	Threshold (†)	Benchmark (†)
CLABSI	0.369	0.000
CAUTI	0.906	0.000
SSI Colon‡	0.824	0.000
Abdominal Hysterectomy‡	0.710	0.000
C. difficile (CDI)	0.794	0.002
MRSA	0.767	0.000

†Standardized infection ratio.
‡There will be one SSI measure score that will be a weighted average based on predicted infections for both procedures.

CLINICAL CARE

Baseline Period	Performance Period
October 1, 2009 – June 30, 2012	October 1, 2013 – June 30, 2016

Measure (Displayed as survival rate)	Threshold (%)	*Benchmark (%)*
30-day mortality, AMI	85.1458	87.1669
30-day mortality, heart failure	88.1794	90.3985
30-day mortality, pneumonia	88.2986	90.8124

EFFICIENCY AND COST REDUCTION

Baseline Period	Performance Period
January 1, 2014 – December 31, 2014	January 1, 2016 – December 31, 2016

Measure	Threshold (%)	Benchmark (%)
MSPB-1 Medicare spending per beneficiary	Median Medicare spending per beneficiary ratio across all hospitals during performance period.	Mean of lowest decile of Medicare spending per beneficiary ratios across all hospitals during performance period.

APPENDIX II. HSCRC QBR PROGRAM DETAILS: DOMAIN WEIGHTS, REVENUE AT RISK, POINTS CALCULATION, MEASUREMENT TIMELINE AND EXEMPTION FROM CMS VBP PROGRAM

Domain Weights and Revenue at Risk

As illustrated in the body of the report, for the RY 2018 QBR program, the HSCRC will weight the clinical care domain at 15 percent of the final score, the safety domain at 35 percent, and the experience of care domain at 50 percent.

The HSCRC sets aside a percentage of hospital inpatient revenue to be held "at risk" based on each hospital's QBR program performance. Hospital performance scores are translated into rewards and penalties in a process that is referred to as scaling.[9] Rewards (referred to as positive scaled amounts) or penalties (referred to as negative scaled amounts) are then applied to each hospital's update factor for the rate year. The rewards or penalties are applied on a one-time basis and are not considered permanent revenue. The Commission previously approved scaling a maximum reward of one percent and a penalty of two percent of total approved base inpatient revenue across all hospitals for RY 2018.

HSCRC staff has worked with stakeholders over the last several years to align the QBR measures, thresholds, benchmark values, time lag periods, and amount of revenue at risk with those used by the CMS VBP program where feasible,[10] allowing the HSCRC to use data submitted directly to CMS. As alluded to in the body of the report, Maryland implemented efficiency measure in relation to global budgets based on potentially avoidable utilization outside of QBR program. The HSCRC does apply a potentially avoidable utilization savings adjustment to hospital rates based on costs related to potentially avoidable admissions, as measured by the Agency for Healthcare Research and Quality Prevention Quality Indicators (PQIs) and avoidable readmissions. HSCRC staff will continue to work with key stakeholders to complete development of an efficiency measure that incorporates population-based cost outcomes.

QBR Score Calculation

Attainment Points: During the performance period, attainment points are awarded by comparing an individual hospital's rates with the threshold, which is the median, or 50th percentile of all hospitals' performance during the baseline period, and the benchmark, which is the mean of the top decile, or approximately the 95th percentile during the baseline period. With the exception of the mortality and AHRQ PSI 90 measure applied to all payers, the benchmarks and thresholds are the same as those used by CMS for the VBP program measures. For each measure, a hospital

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

[10] HSCRC has used data for some of the QBR measures (e.g., CMS core measures, CDC NHSN CLABSI, CAUTI) submitted to the Maryland Health Care Commission (MHCC) and applied state-based benchmarks and thresholds for these measures to calculate hospitals' QBR scores up to the period used for RY 2017.

that has a rate at or above benchmark receives 10 attainment points. A hospital that has a rate below the attainment threshold receives 0 attainment points. A hospital that has a rate at or above the attainment threshold and below the benchmark receives 1-9 attainment points

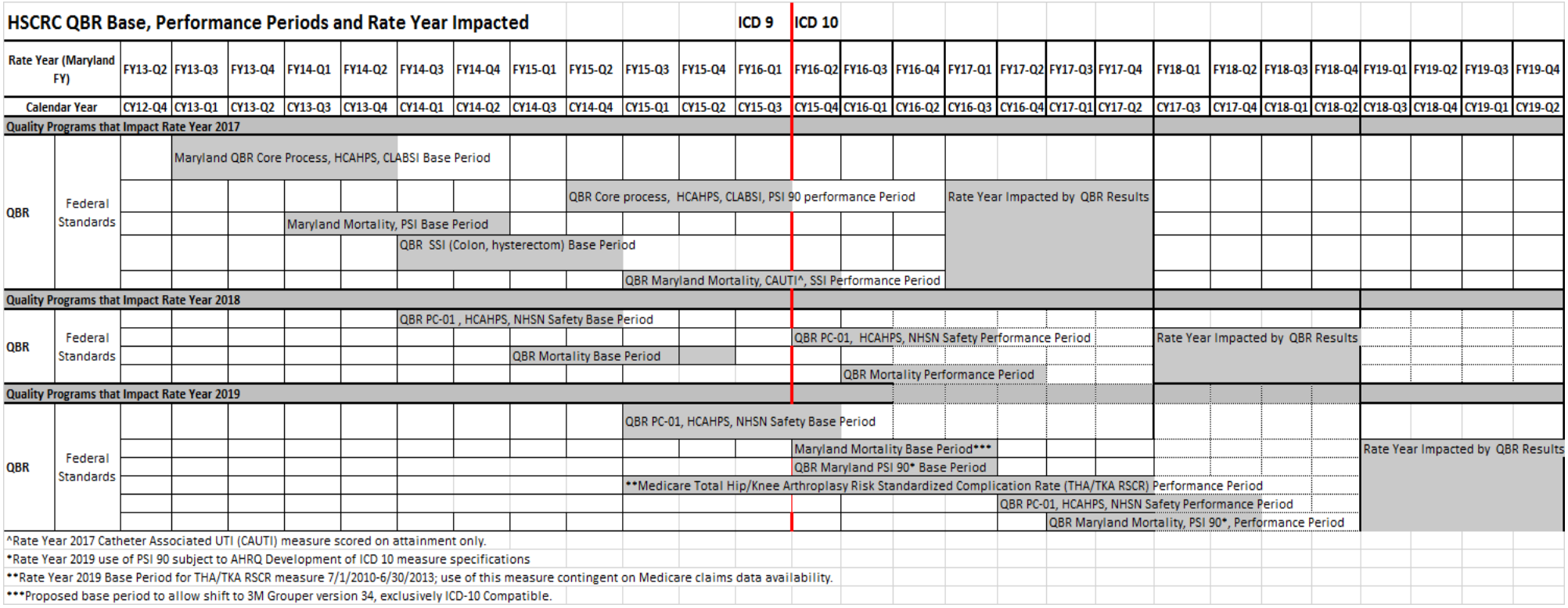
Improvement Points: The improvement points are awarded by comparing a hospital's rates during the performance period to the hospital's rates from the baseline period. A hospital that has a rate at or above benchmark receives 9 improvement points. A hospital that has a rate at or below baseline period rate receives 0 improvement points. A hospital that has a rate between the baseline period rate and the benchmark receives 0-9 improvement points

Consistency Points: The consistency points relate only to the experience of care domain. The purpose of these points is to reward hospitals that have scores above the national 50th percentile in all of the eight HCAHPS dimensions. If they do, they receive the full 20 points. If they do not, the dimension for which the hospital received the lowest score is compared to the range between the national 0 percentile (floor) and the 50th percentile (threshold) and is awarded points proportionately.

Domain Scores: Composite scores are then calculated for each domain by adding up all of the measure scores in a given domain divided by the total possible points x 100. The better of attainment and improvement for experience of care scores is also added together to arrive at the experience of care base points. Base points and the consistency score are added together to determine the experience of care domain score.

Total Performance Score*:* The total Performance Score is computed by multiplying the domain scores by their specified weights, then adding those totals and dividing them by the highest total possible score. The Total Performance Score is then translated into a reward/ penalty that is applied to hospital revenue.

QBR Base and Performance Periods Impacting RYs 2017-2019



Maryland VBP Exemption

Under Maryland's previous Medicare waiver, VBP exemptions were requested and granted for FYs 2013 through 2015. The CMS FY 2015 Inpatient Prospective Payment rule stated that, although exemption from the hospital VBP program no longer applies, Maryland hospitals will not be participating in the VBP program because §1886(o) of the ACA[11] and its implementing regulations are waived under Maryland's New All-Payer Model, subject to the terms of the Model agreement as excerpted below:

> **"4. Medicare Payment Waivers.** Under the Model, CMS will waive the requirements of the following provisions of the Act as applied solely to Regulated Maryland Hospitals:
>
> > **e. Medicare Hospital Value Based Purchasing.** Section 1886(o) of the Act, and implementing regulations at 42 CFR 412.160 - 412.167, only insofar as the State submits an annual report to the Secretary that provides satisfactory evidence that a similar program in the State for Regulated Maryland Hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under 1886(o) of the Act…."

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

[11] Codified at 42 USC § 1395ww(o).

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of the Administrato
Washington, D.C. 20201

August 27, 2015

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

Dear Ms. Kinzer:

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

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

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

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

Sincerely,

Patrick Conway, MD, MSc

Acting Principal Deputy Administrator, CMS

Chief Medical Officer, CMS

Deputy Administrator for Innovation and Quality, CMS

Director, Center for Medicare and Medicaid Innovation

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

Center for Medicare and Medicaid Innovation

April 22, 2016

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

Dear Ms. Kinzer:

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

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

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

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

Sincerely,

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

APPENDIX III. RY 2017 QBR PERFORMANCE SCORES

Table 1. HCAHPS Analysis

Measure	Maryland (Q413-Q314)	National (Q413-Q314)	Percent difference MD-US	Maryland (Q414-Q315)	Change from Base	National (Q414-Q315)	Change from Base	Percent difference MD-US
Responsiveness	60	68	-8	59	-1	68	0	-9
Overall Rating	65	71	-6	65	0	72	1	-7
Clean/Quiet	61.5	68	-7	61.5	0	68	0	-7
Explained Medications	60	65	-5	60	0	65	0	-5
Nurse Communication	76	79	-3	76	0	80	1	-4
Pain Management	67	71	-4	68	1	71	0	-3
Doctor Communication	78	82	-4	79	1	82	0	-3
Discharge Info	86	86	0	86	0	87	1	-1
8 Item Aggregate TOTAL	**69.1875**	**73.75**	**-4.56**	**69.31**	**0.13**	**74.1**	**0.38**	**-4.81**
Three-Part Care Transitions Measure	48	52	-4	48	0	52	0	-4

Table 2. CMS Condition-Specific Mortality Measures

Mortality Measures	Maryland (Q310-Q213)	National (Q310-Q213)	Percent difference MD-US	Maryland (Q311-Q214)	Change from Base	National (Q311-Q214)	Change from Base	Percent difference MD-US
30-day AMI	14.50%	14.90%	-0.40%	14.06%	-0.44%	14.20%	-0.70%	-0.14%
30-day Heart Failure	10.90%	11.90%	-1.00%	10.86%	-0.04%	11.60%	-0.30%	-0.74%
30-day Pneumonia	10.85%	11.90%	-1.05%	10.64%	-0.21%	11.50%	-0.40%	-0.86%

Table 3. Maryland All-Payer Inpatient Mortality Measure

Mortality Measures	Maryland RY2014	Maryland CY2015	Change from Base

MD Mortality Measure	2.87%	2.15%	-0.72%

Table 4. Safety Measures

Safety Measures	Maryland (Q413-Q314)	National (Q413-Q314)	Percent difference MD-US	Maryland (Q414-Q315)	Change from Base	National (Q414-Q315)	Change from Base	Percent difference MD-US	Change from Base Period
CLABSI	0.527	1	-47.30%	0.5	NOTE: Change from base is not calculated because MD SIR is in relation to national SIR of 1	1	NOTE: Change from base is not calculated because MD SIR is in relation to national SIR of 1	-50.00%	-0.027
CAUTI	1.659	1	65.90%	0.862		1		-13.80%	-0.797
SSI - Colon	1.055	1	5.50%	1.185		1		18.50%	0.13
SSI - Abdominal Hysterectomy	1.281	1	28.10%	0.916		1		-8.40%	-0.365
MRSA	1.344	1	34.40%	1.2		1		20.00%	-0.144
C.diff.	1.15	1	15.00%	1.147		1		14.70%	-0.003
PC-01 Elective Delivery	3	4	-1	5		3		2	

Table 5. Measures for Monitoring

Other Measures - Monitoring Status	Maryland (Q413-Q314)	National (Q413-Q314)	Percent difference MD-US	Maryland (Q414-Q315)	Change from Base	National (Q414-Q315)	Change from Base	Percent difference MD-US
IMM-2 Influenza Immunization	*96*	*93*	*3.23%*	*97*	*1*	*94*	*1*	*3.19%*
ED1b - Arrive to admit	353	273	29.30%	364	11	280	7	30.00%
ED2b - Admit decision to admit	132	96	37.50%	139	7	99	3	40.40%
OP20 - Door to diagnostic eval	46	24	91.67%	48	2	23	-1	108.70%

APPENDIX IV. QBR MEASURES PERFORMANCE TRENDS

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

APPENDIX V. MODELING OF QBR SCALING OPTIONS

HOSPITAL NAME	RY 16 Permanent Inpatient Revenue	RY 2017 QBR FINAL POINTS	1.RY 2017 Current Scale		2a.Proposed RY 2017 Scale		2b. January 2017 and July 2017 Implementations		3. RY 2018	4. National Scale (Draft Recommendation for RY 2019)	
			% Impact	$ Impact	% Impact	$ Impact	Jan 2017 Rate Order Adjustment effective July 2016	Rate Order FY18 GBR (July 2017)	Use Relative Scale or National	% Impact	$ Impact
Bon Secours Hospital	$74,789,724	0.07	-2.00%	-$1,495,794	-2.00%	-$1,495,794	-$1,495,794	$0	TBD	-1.65%	-$1,234,030
Laurel Regional Hospital	$60,431,106	0.16	-1.11%	-$670,785	-1.40%	-$846,035	-$670,785	-$175,250	TBD	-1.20%	-$725,173
Maryland General Hospital	$126,399,313	0.20	-0.67%	-$846,875	-1.13%	-$1,432,526	-$846,875	-$585,650	TBD	-1.05%	-$1,327,193
Northwest Hospital Center	$114,214,371	0.22	-0.44%	-$502,543	-1.00%	-$1,142,144	-$502,543	-$639,600	TBD	-0.95%	-$1,085,037
Holy Cross Hospital	$316,970,825	0.23	-0.33%	-$1,046,004	-0.93%	-$2,958,394	-$1,046,004	-$1,912,391	TBD	-0.90%	-$2,852,737
Prince Georges Hospital Center	$220,306,426	0.24	-0.22%	-$484,674	-0.87%	-$1,909,322	-$484,674	-$1,424,648	TBD	-0.85%	-$1,872,605
Southern Maryland Hospital Center	$156,564,761	0.25	-0.11%	-$172,221	-0.80%	-$1,252,518	-$172,221	-$1,080,297	TBD	-0.80%	-$1,252,518
Washington Adventist Hospital	$155,199,154	0.25	-0.11%	-$170,719	-0.80%	-$1,241,593	-$170,719	-$1,070,874	TBD	-0.80%	-$1,241,593
Sinai Hospital	$415,350,729	0.31	0.18%	$747,631	-0.40%	-$1,661,403	$0	-$1,661,403	TBD	-0.50%	-$2,076,754
Memorial Hospital at Easton	$101,975,577	0.31	0.18%	$183,556	-0.40%	-$407,902	$0	-$407,902	TBD	-0.50%	-$509,878
Anne Arundel Medical Center	$291,882,683	0.31	0.18%	$525,389	-0.40%	-$1,167,531	$0	-$1,167,531	TBD	-0.50%	-$1,459,413
Franklin Square Hospital Center	$274,203,013	0.31	0.18%	$493,565	-0.40%	-$1,096,812	$0	-$1,096,812	TBD	-0.50%	-$1,371,015
Union Memorial Hospital	$238,195,335	0.31	0.18%	$428,752	-0.40%	-$952,781	$0	-$952,781	TBD	-0.50%	-$1,190,977
St. Agnes Hospital	$232,266,274	0.32	0.21%	$487,759	-0.33%	-$774,221	$0	-$774,221	TBD	-0.45%	-$1,045,198
Baltimore Washington Medical Center	$237,934,932	0.33	0.25%	$594,837	-0.27%	-$634,493	$0	-$634,493	TBD	-0.40%	-$951,740
Western MD Regional Medical Center	$167,618,972	0.34	0.29%	$486,095	-0.20%	-$335,238	$0	-$335,238	TBD	-0.35%	-$586,666
Harford Memorial Hospital	$45,713,956	0.35	0.32%	$146,285	-0.13%	-$60,952	$0	-$60,952	TBD	-0.30%	-$137,142
Doctors Community Hospital	$132,614,778	0.35	0.32%	$424,367	-0.13%	-$176,820	$0	-$176,820	TBD	-0.30%	-$397,844
Meritus Hospital	$190,659,648	0.36	0.36%	$686,375	-0.07%	-$127,106	$0	-$127,106	TBD	-0.25%	-$476,649

HOSPITAL NAME	RY 16 Permanent Inpatient Revenue	RY 2017 QBR FINAL POINTS	1.RY 2017 Current Scale		2a.Proposed RY 2017 Scale		2b. January 2017 and July 2017 Implementations		3. RY 2018	4. National Scale (Draft Recommendation for RY 2019)	
			% Impact	$ Impact	% Impact	$ Impact	Jan 2017 Rate Order Adjustment effective July 2016	Rate Order FY18 GBR (July 2017)	Use Relative Scale or National	% Impact	$ Impact
Johns Hopkins Hospital	$1,244,297,900	0.36	0.36%	$4,479,472	-0.07%	-$829,532	$0	-$829,532	TBD	-0.25%	-$3,110,745
Union of Cecil	$69,389,876	0.37	0.39%	$270,621	0.00%	$0	$0	$0	TBD	-0.20%	-$138,780
Johns Hopkins Bayview Medical Center	$343,229,718	0.38	0.43%	$1,475,888	0.05%	$171,615	$171,615	$0	TBD	-0.15%	-$514,845
Shady Grove Adventist Hospital	$220,608,397	0.38	0.43%	$948,616	0.05%	$110,304	$110,304	$0	TBD	-0.15%	-$330,913
Peninsula Regional Medical Center	$242,318,199	0.38	0.43%	$1,041,968	0.05%	$121,159	$121,159	$0	TBD	-0.15%	-$363,477
Upper Chesapeake Medical Center	$135,939,076	0.38	0.43%	$584,538	0.05%	$67,970	$67,970	$0	TBD	-0.15%	-$203,909
Chester River Hospital Center	$21,575,174	0.38	0.43%	$92,773	0.05%	$10,788	$10,788	$0	TBD	-0.15%	-$32,363
University of Maryland Hospital	$906,034,034	0.39	0.46%	$4,167,757	0.10%	$906,034	$906,034	$0	TBD	-0.10%	-$906,034
Atlantic General Hospital	$37,750,252	0.39	0.46%	$173,651	0.10%	$37,750	$37,750	$0	TBD	-0.10%	-$37,750
Garrett County Memorial Hospital	$19,149,148	0.40	0.50%	$95,746	0.15%	$28,724	$28,724	$0	TBD	-0.05%	-$9,575
Fort Washington Medical Center	$19,674,774	0.41	0.54%	$106,244	0.20%	$39,350	$39,350	$0	TBD	0.00%	$0
Mercy Medical Center	$214,208,592	0.41	0.54%	$1,156,726	0.20%	$428,417	$428,417	$0	TBD	0.00%	$0
Civista Medical Center	$67,052,911	0.42	0.57%	$382,202	0.25%	$167,632	$167,632	$0	TBD	0.05%	$33,526
Carroll Hospital Center	$136,267,434	0.43	0.61%	$831,231	0.30%	$408,802	$408,802	$0	TBD	0.10%	$136,267
Calvert Memorial Hospital	$62,336,014	0.43	0.61%	$380,250	0.30%	$187,008	$187,008	$0	TBD	0.10%	$62,336
UM ST. JOSEPH	$234,223,274	0.43	0.61%	$1,428,762	0.30%	$702,670	$702,670	$0	TBD	0.10%	$234,223
Dorchester General Hospital	$26,999,062	0.44	0.64%	$172,794	0.35%	$94,497	$94,497	$0	TBD	0.15%	$40,499
Montgomery General Hospital	$75,687,627	0.45	0.68%	$514,676	0.40%	$302,751	$302,751	$0	TBD	0.20%	$151,375
Harbor Hospital Center	$113,244,592	0.45	0.68%	$770,063	0.40%	$452,978	$452,978	$0	TBD	0.20%	$226,489
Frederick Memorial Hospital	$190,413,775	0.46	0.71%	$1,351,938	0.45%	$856,862	$856,862	$0	TBD	0.25%	$476,034
Suburban Hospital	$193,176,044	0.47	0.75%	$1,448,820	0.50%	$965,880	$965,880	$0	TBD	0.30%	$579,528
Greater Baltimore	$207,515,795	0.49	0.82%	$1,701,630	0.60%	$1,245,095	$1,245,095	$0	TBD	0.40%	$830,063

HOSPITAL NAME	RY 16 Permanent Inpatient Revenue	RY 2017 QBR FINAL POINTS	1.RY 2017 Current Scale		2a.Proposed RY 2017 Scale		2b. January 2017 and July 2017 Implementations		3. RY 2018	4. National Scale (Draft Recommendation for RY 2019)	
			% Impact	$ Impact	% Impact	$ Impact	Jan 2017 Rate Order Adjustment effective July 2016	Rate Order FY18 GBR (July 2017)	Use Relative Scale or National	% Impact	$ Impact
Medical Center											
Good Samaritan Hospital	$160,795,606	0.49	0.82%	$1,318,524	0.60%	$964,774	$964,774	$0	TBD	0.40%	$643,182
Howard County General Hospital	$165,683,744	0.57	1.00%	$1,656,837	1.00%	$1,656,837	$1,656,837	$0	TBD	0.85%	$1,408,312
St. Mary's Hospital	$69,169,248	0.72	1.00%	$691,692	1.00%	$691,692	$691,692	$0	TBD	1.60%	$1,106,708
Statewide Total	**$8,730,031,841**			**$27,058,414**		**-$9,883,530**	**$5,229,972**	**-$15,113,502**			**-$21,514,008**
		Total Penalties		-5,389,617		-20,503,119	-5,389,617	-15,113,502			-27,442,552
		% Inpatient Revenue		-0.06%		-0.23%	-0.06%	-0.17%			-0.31%
		Total Rewards		32,448,031		10,619,589	10,619,589	0			5,928,544
		% Inpatient Revenue		0.37%		0.12%	0.12%	0.00%			0.07%

APPENDIX VI. COMMENT LETTERS

Consumer Health First

Access ▪ Quality ▪ Equity

Leni Preston, *President*
Madeleine Shea, *Vice-President*
Mary Lou Fox, *Treasurer*
Adrienne Ellis, *Secretary*
Leigh S. Cobb
Debra Hickman
Anne Langley
Elizabeth Sammis
Benjamin Turner
Ellen Weber
Susan F. Wood

Jeananne Sciabarra, *Executive Director*

1 November 2016

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

Dear Chairman Sabatini:

I am writing on behalf of the Board and members of Consumer Health First (CHF) to express our strong support for the HSCRC staff recommendation for a retroactive change to the RY 2017 Quality Based Reimbursement program. CHF is a nonprofit organization dedicated to the advancement of health equity through access to high-quality, comprehensive and affordable health care. Since 2013 we have dedicated much of our time and resources to ensuring that the All-Payer Model (APM), in both its design and implementation does indeed put consumers first. To do that we have been pleased to serve on many of the workgroups and the Advisory Council. It was also an honor to serve as Chair of the Consumer Engagement Task Force and we look forward to the implementation of its recommendations going forward. Most immediately, of course, we are pleased that the Standing Advisory Committee is to be formed shortly.

For us, one of the most important aspects of the APM, and the new Progression Model, is HSCRC's emphasis on a patient-centered approached focused on addressing the Triple Aim. As you know, one aim is to improve both quality and patient satisfaction. The fact that Maryland is near the bottom of the national rankings on patient experience of care and, rather than improving, actually regressed in this area, is extremely disappointing. Therefore, we believe it would be wholly inappropriate to reward hospitals for their inadequate performance in this area. In this regard, too, we believe it is important that Maryland hospitals be measured against a national and not a state level. That would appear to us to be consistent both with CMS' granting of an exemption from the Value Based Purchasing Program and Marylanders' own expectations that the care they receive within our borders is equal to, or better than, that found in other states.

I also feel called upon to express my profound disappointment in the reasons put forward by the hospitals for rejection of the staff recommendation. Not one of the speakers expressed a concern for the individuals under their care. In fact, there appeared to be a complete lack of understanding of the implications of the HCAHPS findings on their patients, or a commitment to make improvements going forward. The reality was that those speaking for Maryland's hospitals seemed solely concerned about a negative impact on the morale of their clinicians and other staff. Others clung to some arcane 'principle' that the Commission should continue to do business as always, i.e., reward substandard performance. Both as a consumer advocate and, as a recent consumer of health care at a Maryland hospital, I can say that I was offended by their lack of acknowledgement that these findings signal problems with the health, safety, well-being and satisfaction of hospitalized Marylanders.

Therefore, we again want to express our support for the staff QBR proposal. We also wish to offer our assistance and support in identifying additional outcome measures that can serve as effective guideposts to improve the patient experience of care and advance the Triple Aim. We commend the work in this regard being undertaken by the Performance Measures Workgroup. We would also note the recommendation made by Stan Dorn of the Urban Institute at last week's Advisory Council meeting. He stressed the need for greater examination of outcome-based measures related to the Progression Model. That we believe could have positive implications for the QBR measures as well.

Lastly we would note that we have specifically proposed to the Maryland Hospital Association that we work with them, and individual hospitals, to analyze current patient surveys and other tools as the basis for making future improvements. For your consideration we would suggest that a greater emphasis on incentives or other efforts to encourage hospitals to "engage" with consumer groups on efforts such as this would be helpful. To date we have seen little interest in this regard and we believe there are very positive outcomes that could be achieved.

As always, we look forward to working with the Commission and staff as we continue this exciting, and challenging, endeavor.

Sincerely,

Leni Preston, President
leni@mdchcr.org Cell: 301.351.9381

cc: Donna Kinzer

Maryland
Hospital Association

December 2, 2016

Dianne Feeney
Associate Director, Quality Initiatives
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Ms. Feeney:

On behalf of the 64 hospital and health system members of the Maryland Hospital Association (MHA), we appreciate the opportunity to comment on the October *Draft Recommendation for Updating the Quality Based Reimbursement Program for Rate Year 2019.* Since the draft recommendations address the payment scale for fiscal years 2017 and 2018, our comments will address the 2017, 2018 and 2019 policies.

We appreciate the work that the Health Services Cost Review Commission (HSCRC) staff has put into the development of the new methodology for Quality-Based Reimbursement (QBR) and understand some of the challenges discussed at the October meeting that the commission would like to address. We also appreciate commissioners' willingness to listen to the issues raised by hospitals that we believe need to be addressed. In an effort to work together to address multiple views, we offer two possible resolutions for fiscal year 2017 and views on 2018 and 2019 policy.

Background

The QBR methodology for fiscal year 2017, when set by the commission in 2014, reflected a fundamental change, supported by the hospital field, from the previous way of translating quality scores into payment adjustments. Because the policy was new and the data unavailable at the time, the ultimate outcome of the policy could not be known in advance. In addition, the movement of metrics into and out of the Maryland and national programs creates uncertainty from year to year, as well as difficulty in modeling the outcome. The payment scale was set in a way that took into account performance attainment, but not improvement, as has been done with other HSCRC pay-for-performance policies. While no errors were made in the data or calculations, the ultimate outcome was not anticipated. HSCRC staff analyzed current Maryland statewide performance trends and concluded that 2017 hospital performance does not merit the reward that the previously-set methodology would have yielded.

We offer two suggestions to better align QBR policy and methodology with commission expectations moving ahead:

1. The QBR payment scale is set in advance so clinicians can understand the goals toward which they are working. However, while HSCRC approves the weights to be applied to each measure and the maximum amount of rewards and penalties, it has not set explicit performance targets and does not approve how hospitals' performance will be arrayed within those reward and penalty boundaries. For example, the "break point" – the point chosen within the distribution of Maryland's hospitals that defines where rewards end and penalties begin – is a critically important decision and more strongly influences the outcome than does the decision about where the maximum rewards and penalties are set. **We suggest that HSCRC expand its discussion and explicit commission approval of additional elements of the QBR policy, to include setting a break point that determines the penalty and reward zones in advance**. This should foster a better understanding of the potential range of results and align them with expectations.

2. Of greater importance, as noted at the October commission meeting, is the big picture question: what are we trying to achieve? Performing at the highest levels is desirable, but, as in all incentive-based programs, the objective is to apply an incentive that yields a specific change and result. What are the specific goals for each measure? What level of improvement in each of the metrics do HSCRC and the Centers for Medicare & Medicaid Services (CMS) consider meaningful? What do the evidence and research show about how quickly any particular measure can be improved, about the mix of providers and interventions needed to achieve that change, or about the time needed to achieve the desired change? These questions are critical for commission discussion and consideration, both in setting targets for improvement and in informing the staff's development of current and future goals and methods. **We suggest that HSCRC expand its discussion of QBR policy to include these broader questions and discuss performance expectations**.

Fiscal Year 2017 Recommendation

With Maryland on the leading edge of innovation, it is likely that there will be other policies, like the QBR policy, that, while developed in good faith, may yield unintended or unexpected results.

Maryland's hospital payment system, like the national Medicare hospital payment system, is a prospective payment system, with policies set in advance to create stability and predictability for hospitals and clinicians. The prospective nature of payment and policymaking is critically important to the system's success. That's why the proposed fiscal year 2017 retroactive policy elicits such a strong response.

To be clear, there are circumstances or criteria under which looking back and adjusting policies is appropriate. For example, adjusting backwards for material data errors or for data updates is appropriate. Adjusting backwards pursuant to a corrective action plan to avoid imminent danger of losing the Maryland demonstration may also be appropriate. Adjusting backward to

address unintended consequences or gross inequities prior to the start of the fiscal year may be appropriate. Making adjustments to individual hospital global budgets backwards should be a decision left to individual discussions between the HSCRC and a hospital.

Changing a policy ***after the start of a performance period*** (i.e. after the time period of change to be measured is already over) is undesirable as it allocates rewards and penalties based on performance that has already occurred and cannot be changed, making it difficult to engage clinicians. Changing a payment policy ***after the start of a fiscal year*** – is inappropriate. This is especially true for policies yielding payment reductions, as it negatively affects hospital budgets that are already approved and set. This type of change runs contrary to the principles of the Maryland system. Some have commented that the HSCRC made a previous retroactive adjustment to the readmissions policy to which hospitals did not object. It is important to clarify that the readmissions policy change was not in violation of these principles – the change was discussed ***before*** the start of the performance period, and was made ***before*** the start of the fiscal year.

As a reminder, the QBR policy provides one-time revenue, added one year then fully backed out of hospital revenue at the beginning of the following year before the next year's QBR adjustment is made.

Hospitals' preferred approach is to make any needed policy changes prospectively. However, in an effort to find a resolution that addresses multiple issues and views, we offer the following:

- Approve the revised staff-proposed QBR payment scale in fiscal year 2017, even though it is retroactive to the performance period, while otherwise ensuring that hospitals do not experience a retroactive budget change in the current fiscal year. This could be achieved through additional revenue made available to hospitals in fiscal year 2017 in a substantially similar amount and distribution. While not preferred, this also could be achieved by leaving current funds (+ $27 million) in fiscal year 2017 and recouping all of the proposed reductions (- $37 million) at the beginning of fiscal year 2018.

Fiscal Year 2018 Recommendation

We support HSCRC's proposed QBR payment scale change for fiscal year 2018. This would mean a change after the performance period, but before hospitals' fiscal 2018 budgets are set. The fiscal 2018 performance period ended September 30 for some metrics and ends December 31 for others.

Fiscal Year 2019 Recommendation

HSCRC staff have proposed three options for the fiscal 2019 payment scale:

1. *Returning to a relative scale*
   This option is undesirable because the payment adjustments are not known until all hospitals' final performance scores are calculated. The lag in publicly available data means that the payment adjustment is not usually known until a few months after the start of the fiscal year in which the adjustment applies, making it difficult for hospitals to budget for the payment adjustment.

2. *Pre-set scale based on fiscal 2017 actual Maryland performance*
   While we support this approach for fiscal 2018 only, improvements are needed for 2019 and future years. Simply setting the payment scale on the most recent year's performance does not account for potential movement up and down in overall scores as measures are moved into the program. This approach risks another misalignment of actual payment adjustments and performance expectations.

3. *National scale based on possible points (range from 0 - 1, with a break point set at 0.5.*)
   This option is also undesirable. Under CMS' Value-Based Payment program, hospitals can score anywhere between 0 and 1.0 total points. However, the program adjusts for relative ranking, effectively grading on a curve. Using the 0-1 range and 0.5 as the break point will create a significantly higher performance standard in Maryland than the nation.

MHA proposes an alternative approach. Maryland's performance scores are a little more tightly clustered around the median, and overall a few points lower than the median. This suggests that moving the Maryland payment scale closer to national performance would move the Maryland performance curve to the right. The challenge in simply setting the Maryland scale with the break point a few points higher than the most recent Maryland median, or at the most recent year's national median score, is that the national scores also move up or down by a few basis points, depending on which metrics are included.

To address this uncertainty, we propose creating a zone in the midrange where no payment adjustment is made. This creates a "buffer zone" to protect against volatility that results from changing metrics and is therefore beyond HSCRC's ability to predict. The no-adjustment zone would be set at a quarter of the standard deviation, centered on either side of a median score. As mentioned earlier, we recommend that HSCRC commissioners discuss where to set the break point of the scale, informed by expectations of improvement and median performance.

We modeled this alternative using Maryland fiscal 2017 scores with a break point set at 0.38 (two basis points higher than the Maryland median and one point lower than the national median for 2017.) The results are shown on the next page, along with HSCRC options 2 and 3, all of which are based on 2017 data.

We appreciate the commission's consideration of our comments and the opportunity to continue working with HSCRC staff as we implement multi-faceted and groundbreaking policies.

Sincerely,

Traci La Valle
Vice President

Enclosure

cc: Nelson J. Sabatini, Chairman
Herbert S. Wong, Ph.D., Vice Chairman
Joseph Antos, Ph.D.
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Jack C. Keane
Donna Kinzer, Executive Director

FY 2019 Options

HOSPITAL NAME	FY 16 Permanent Inpatient Revenue	QBR FINAL POINTS	HSCRC Option 2		HSCRC Option 3		MHA Option	
			% Revenue Impact	$ Revenue Impact	% Revenue Impact	$ Revenue Impact	% Revenue Impact	$ Revenue Impact
Bon Secours Hospital	$ 74,789,724	0.07	-2.00%	-$1,495,794	-1.72%	-$1,286,383	-2.00%	-$1,495,794
Laurel Regional Hospital	$ 60,431,106	0.16	-1.40%	-$846,035	-1.36%	-$821,863	-1.33%	-$805,748
Maryland General Hospital	$ 126,399,313	0.20	-1.13%	-$1,432,526	-1.20%	-$1,516,792	-1.04%	-$1,310,808
Northwest Hospital Center	$ 114,214,371	0.22	-1.00%	-$1,142,144	-1.12%	-$1,279,201	-0.89%	-$1,015,239
Holy Cross Hospital	$ 316,970,825	0.23	-0.93%	-$2,958,394	-1.08%	-$3,423,285	-0.81%	-$2,582,725
Prince Georges Hospital Center	$ 220,306,426	0.24	-0.87%	-$1,909,322	-1.04%	-$2,291,187	-0.74%	-$1,631,899
Southern Maryland Hospital Center	$ 156,564,761	0.25	-0.80%	-$1,252,518	-1.00%	-$1,565,648	-0.67%	-$1,043,765
Washington Adventist Hospital	$ 155,199,154	0.25	-0.80%	-$1,241,593	-1.00%	-$1,551,992	-0.67%	-$1,034,661
Sinai Hospital	$ 415,350,729	0.31	-0.40%	-$1,661,403	-0.76%	-$3,156,666	-0.22%	-$923,002
Memorial Hospital at Easton	$ 101,975,577	0.31	-0.40%	-$407,902	-0.76%	-$775,014	-0.22%	-$226,612
Anne Arundel Medical Center	$ 291,882,683	0.31	-0.40%	-$1,167,531	-0.76%	-$2,218,308	-0.22%	-$648,628
Franklin Square Hospital Center	$ 274,203,013	0.31	-0.40%	-$1,096,812	-0.76%	-$2,083,943	-0.22%	-$609,340
Union Memorial Hospital	$ 238,195,335	0.31	-0.40%	-$952,781	-0.76%	-$1,810,285	-0.22%	-$529,323
St. Agnes Hospital	$ 232,266,274	0.32	-0.33%	-$774,221	-0.72%	-$1,672,317	-0.15%	-$344,098
Baltimore Washington Medical Center	$ 237,934,932	0.33	-0.27%	-$634,493	-0.68%	-$1,617,958	-0.07%	-$176,248
Western MD Regional Medical Center	$ 167,618,972	0.34	-0.20%	-$335,238	-0.64%	-$1,072,761	0.00%	$0
Harford Memorial Hospital	$ 45,713,956	0.35	-0.13%	-$60,952	-0.60%	-$274,284	0.00%	$0
Doctors Community Hospital	$ 132,614,778	0.35	-0.13%	-$176,820	-0.60%	-$795,689	0.00%	$0
Meritus Hospital	$ 190,659,648	0.36	-0.07%	-$127,106	-0.56%	-$1,067,694	0.00%	$0
Johns Hopkins Hospital	$ 1,244,297,900	0.36	-0.07%	-$829,532	-0.56%	-$6,968,068	0.00%	$0
Union of Cecil	$ 69,389,876	0.37	0.00%	$0	-0.52%	-$360,827	0.00%	$0
Johns Hopkins Bayview Medical Center	$ 343,229,718	0.38	0.05%	$171,615	-0.48%	-$1,647,503	0.00%	$0
Shady Grove Adventist Hospital	$ 220,608,397	0.38	0.05%	$110,304	-0.48%	-$1,058,920	0.00%	$0
Peninsula Regional Medical Center	$ 242,318,199	0.38	0.05%	$121,159	-0.48%	-$1,163,127	0.00%	$0
Upper Chesapeake Medical Center	$ 135,939,076	0.38	0.05%	$67,970	-0.48%	-$652,508	0.00%	$0
Chester River Hospital Center	$ 21,575,174	0.38	0.05%	$10,788	-0.48%	-$103,561	0.00%	$0
University of Maryland Hospital	$ 906,034,034	0.39	0.10%	$906,034	-0.44%	-$3,986,550	0.05%	$476,860
Atlantic General Hospital	$ 37,750,252	0.39	0.10%	$37,750	-0.44%	-$166,101	0.05%	$19,869
Garrett County Memorial Hospital	$ 19,149,148	0.40	0.15%	$28,724	-0.40%	-$76,597	0.11%	$20,157
Fort Washington Medical Center	$ 19,674,774	0.41	0.20%	$39,350	-0.36%	-$70,829	0.16%	$31,065
Mercy Medical Center	$ 214,208,592	0.41	0.20%	$428,417	-0.36%	-$771,151	0.16%	$338,224
Civista Medical Center	$ 67,052,911	0.42	0.25%	$167,632	-0.32%	-$214,569	0.21%	$141,164
Carroll Hospital Center	$ 136,267,434	0.43	0.30%	$408,802	-0.28%	-$381,549	0.26%	$358,599
Calvert Memorial Hospital	$ 62,336,014	0.43	0.30%	$187,008	-0.28%	-$174,541	0.26%	$164,042
UM ST. JOSEPH	$ 234,223,274	0.43	0.30%	$702,670	-0.28%	-$655,825	0.26%	$616,377
Dorchester General Hospital	$ 26,999,062	0.44	0.35%	$94,497	-0.24%	-$64,798	0.32%	$85,260
Montgomery General Hospital	$ 75,687,627	0.45	0.40%	$302,751	-0.20%	-$151,375	0.37%	$278,849
Harbor Hospital Center	$ 113,244,592	0.45	0.40%	$452,978	-0.20%	-$226,489	0.37%	$417,217
Frederick Memorial Hospital	$ 190,413,775	0.46	0.45%	$856,862	-0.16%	-$304,662	0.42%	$801,742
Suburban Hospital	$ 193,176,044	0.47	0.50%	$965,880	-0.12%	-$231,811	0.47%	$915,044
Greater Baltimore Medical Center	$ 207,515,795	0.49	0.60%	$1,245,095	-0.04%	-$83,006	0.58%	$1,201,407
Good Samaritan Hospital	$ 160,795,606	0.49	0.60%	$964,774	-0.04%	-$64,318	0.58%	$930,922
Howard County General Hospital	$ 165,683,744	0.57	1.00%	$1,656,837	0.28%	$463,914	1.00%	$1,656,837
St. Mary's Hospital	$ 69,169,248	0.72	1.00%	$691,692	0.88%	$608,689	1.00%	$691,692
FY17 Statewide Total	**$8,730,031,841**			**-$9,883,530**		**-$48,787,350**		**-$5,232,563**
		Total Penalties		-20,503,119		-49,859,954		-14,377,891
		% Inpatient Revenue		-0.23%		-0.57%		-0.16%
		Total rewards		10,619,589		1,072,604		9,145,329
		% Inpatient revenue		0.12%		0.01%		0.10%

CareFirst BlueCross BlueShield
1501 S. Clinton Street
Baltimore, MD 21224-5744

December 13, 2016

Nelson Sabatini, Chairman
Donna Kinzer, Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Mr. Sabatini and Ms. Kinzer:

Thank you for this opportunity to provide comments regarding the HSCRC Staff's recommendations for modifications to the Quality Based Reimbursement Program (the "QBR"). We understand that the FY 2017 QBR Methodology for calculating QBR rewards and penalties was substantially modified along with major changes in the measures used in the QBR.

We further understand that the HSCRC did not have enough data to reliably establish the level of the pre-set scale used to determine rewards and penalties under the Program. As a result, the pre-set scale was set too low, contributing to larger than expected net payment made to Maryland hospitals compared to the hospital industry's actual performance under the FY 2017 QBR.

The HSCRC staff is proposing that a retrospective adjustment be made to the QBR to take back this overpayment. CareFirst continues to oppose this change and strongly believes that Maryland's prospective rate setting policies should not make retroactive adjustments as they undermine program incentives. CareFirst has consistently been on record opposing other retrospective adjustments that have been made, such as the Commission's Readmission Reduction Improvement Program (RRIP) last year.

As we have stated previously, we fear that the QBR and other Commission quality-based payment policies and methodologies have become increasingly complex, and this complexity has contributed to the present circumstance. In this light, we would encourage the HSCRC and its staff to work to simplify all of its payment methodologies.

We understand that the current staff report also includes draft recommendations on the HSCRC's FY 2018 and FY 2019 QBR policies and methodologies. We wish to defer our comments on these proposed policies pending further discussion with the staff and review of the staff's simulations. We understand that some have recommended the incorporation of a "buffer zone" in the middle of the QBR scaling range for the FY 2019 QBR Policy. CareFirst has consistently supported continuous scaling of rewards and penalties to incent incremental improvements. Accordingly, we would strongly oppose this approach if recommended.

Sincerely,

Jonathan Blum
Executive Vice President, Medical Affairs

CareFirst BlueCross BlueShield

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Staff Recommendation

Medicaid Current Financing

December 14, 2016

The final status of this recommendation is Pending further review.

Background

The Medical Assistance Program (MAP) requested at the Commission's April 13, 2016 public meeting to continue a modified current financing formula, i.e., increasing its CY 2015 current financing deposits by the HSCRC's final update factor with the caveat that they would develop a revised methodology for CY 2017.

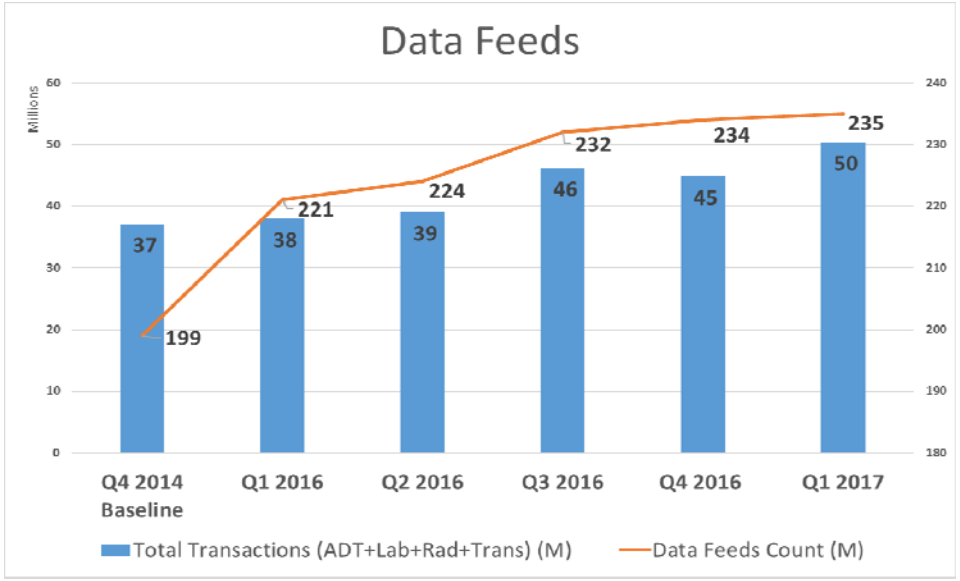
The Commission approved MAP's request, but directed MAP to return in six months with a revised current financing methodology and that If MAP did not develop a revised methodology by then, that it would be required to use the standard current financing methodology.

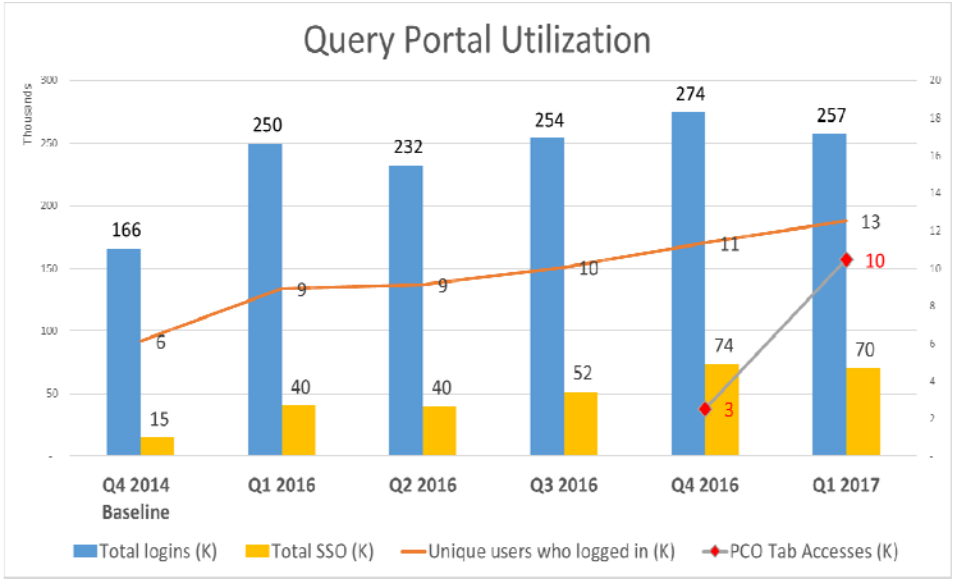
Staff Recommendation

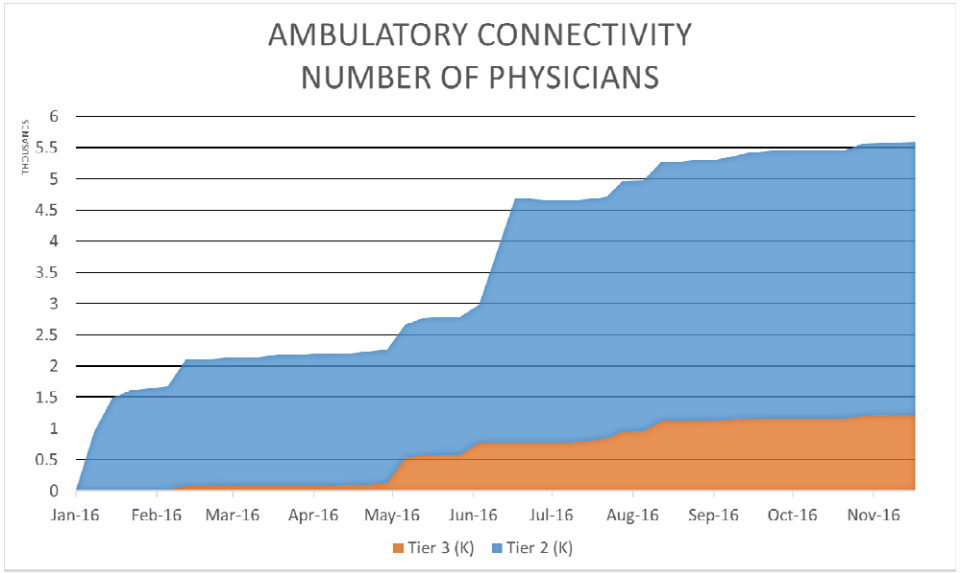
Although, MAP has been working with staff to develop a revised methodology. However, because of the pressure of the State's continuing budget crisis and the efforts of both staff and MAP on the New Model Progression to Phase II, staff recommends that the time for MAP to develop a revised current financing methodology be extended to the April 2017 Commission public meeting.

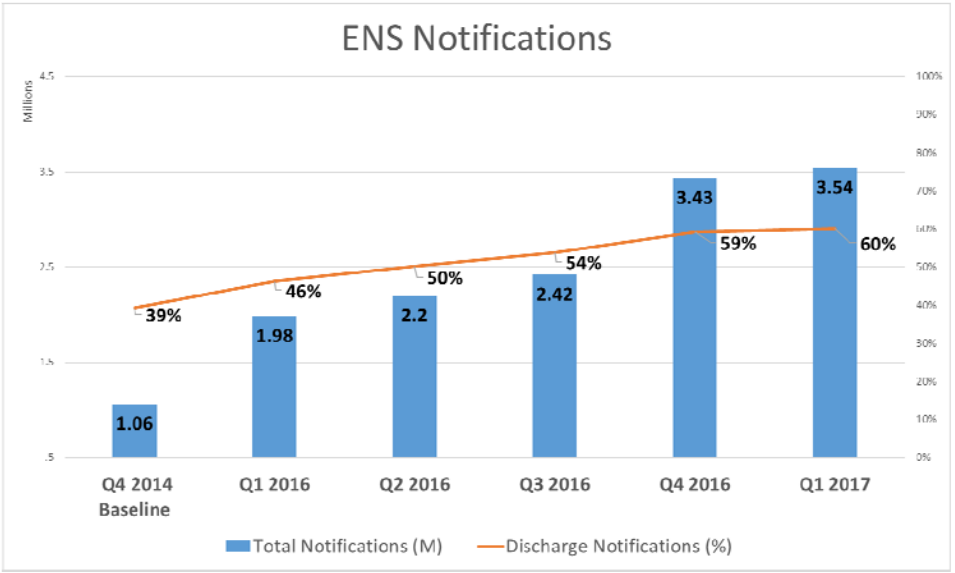
The final status of this recommendation is Pending further review.

Steady Growth of Mature CRISP Services









FY17: Focus on Care Coordination

CRISP will support Maryland hospitals this year, with an aim of helping them all do these four things, to collectively improve care coordination:

1. **Flag Patient Care Management Relationships:** Notify CRISP for each patient who is enrolled/dis-enrolled in a care management program, including contact information for the patient, care coordinator, and primary care provider.
2. **Share Care Planning Data**: Whenever care management information appropriate for sharing is created or updated for a participating patient, send a copy of the information to CRISP.
3. **Use In-Context Alerts:** Create an “alert mechanism” in your hospital EHR so your clinicians know when a person who is in care management has shown up, with easy access to the full data.
4. **Use CRISP Reports:** Incorporate CRISP reports and compiled data into the work of the population health team. (For patient identification and performance measurement.)

This approach should align with broader interventions and programs in place to support the high need / complex patients

Focus Aligns with State Priority on High and Rising Need Patients

Bringing high need and rising need Medicare patients into care management is key to reducing potentially avoidable utilization (PAU):

- **High Need:** patients with at least 3 inpatient visits* in past 12 months
- **Rising Need:** patients with at least 2 hospital visits in the past 12 months, where a hospital visit is defined as an inpatient OR ED visit
- Use in statewide monitoring, assessment of care coordination activities, and CRISP reports

Medicare Fee For Service	High Need	Rising Need
# of Beneficiaries	20,000	95,000
Total Hospital Charges	$1.4 billion	$2 billion
Total Potentially Avoidable Utilization	$550 million	$330 million
% PAU	40%	17%

Numbers will change with each monthly data submission and QA

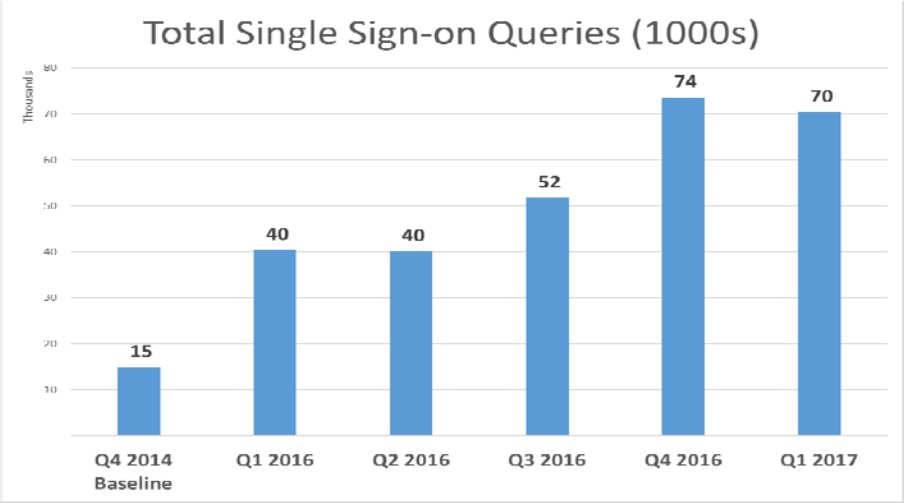
* inpatient visits = inpatient discharges or observation visits > 23 hours

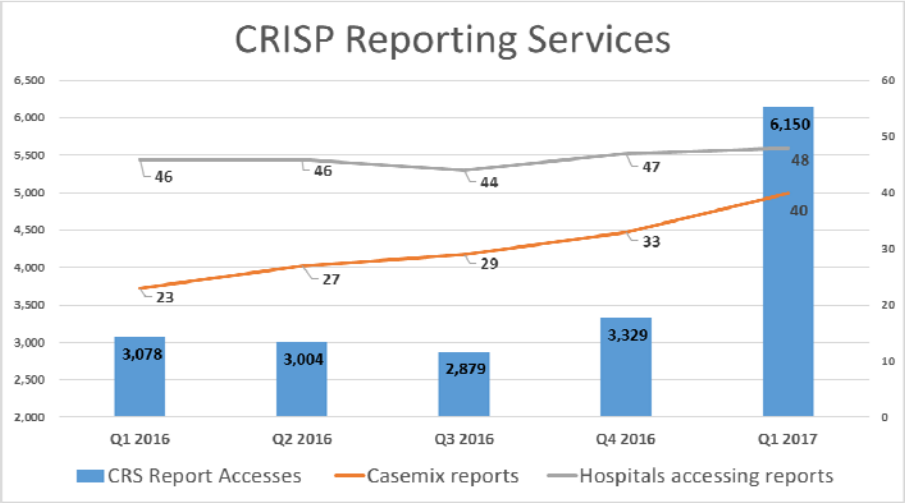
Positive Trends at Midpoint of FY17

Care Coordination Measures – High-needs Medicare FFS Beneficiaries

Beneficiaries	Total	w/PCP		w/CM		w/both	
12/13/2016	18,729	9,799	52.32%	798	4.26%	651	3.49%
12/7/2016	18,752	9,139	48.74%	463	2.47%	241	1.29%
11/29/2016	21,509	10,427	48.48%	499	2.32%	254	1.18%
11/4/2016	21,849	10,379	47.50%	468	2.14%	239	1.09%
9/27/2016	21,644	9,453	43.67%	172	0.79%		

Beneficiaries	Total	w/CareAlert		w/CarePlan		w/either	
12/13/2016	18,729	506	2.70%	276	1.47%	781	4.17%
12/7/2016	18,752	508	2.71%	277	1.48%	784	4.18%
11/29/2016	21,509	410	1.91%	248	1.15%	658	3.06%
11/4/2016	21,849	394	1.80%	231	1.06%	625	2.86%
9/27/2016	21,644	244	1.13%	157	0.73%	401	1.85%





At this point, these numbers are mostly a measure of CRISP's success gaining connectivity, rather than reflecting on the volume of care management actually occurring.

Focus for Remainder of FY17

CRISP has been working with MHA to support hospital efforts to meet the conditions for the mid-year update.

All hospitals currently:

- Utilize CRISP's reporting and analytics platform in support of care coordination and population health management.
- Have signed a Data Use Agreement with CMS to access the Medicare Limited Data Set (LDS) for population health management.
- Have signed a letter of intent to participate in one or both Care Redesign programs.

- Many hospitals have completed or made significant progress with the following:
  - Sharing known primary care provider and care manager relationships for high needs patients
  - Sharing care alerts and/or care plans for high needs patients
  - Implementing in-context alerts within hospital EHRs, to make CRISP's care coordination information readily available at the point of care

The remaining open items will be scheduled for completion in the coming months. CRISP and MHA have launched a six-month sprint to accelerate the creation and adoption of care alerts in particular.

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-201, 19-209, and, 19-222, Annotated Code of Maryland

NOTICE OF FINAL ACTION

On December 14, 2016, the Health Services Cost Review Commission adopted amendments to Regulation .03 under COMAR 10.37.10 "Rate Application and Approval Procedure." This action, which was proposed for adoption in 43:20 Md. R. 1115 (September 30, 2016), has been adopted as proposed.

Effective Date: December 24, 2016

NELSON SABATINI
Chairman
Health Services Cost Review Commission

D. Grant or Denial of Licensure Standards Waiver.

(1) The Department may grant a waiver request if the Department determines that:

(a) Compliance with the regulation from which the waiver is sought cannot be accomplished without substantial hardship; and

(b) A waiver will not adversely affect residents.

(2) If the Department determines that the conditions of §D(1) of this regulation are not met, the Department shall deny the request for a waiver. The denial of a waiver may not be appealed.

E. Written Decision.

(1) The Department shall issue and mail to the applicant a written decision on a waiver request submitted under §B of this regulation within 45 days from receipt of the request and all appropriate supporting information.

(2) If the Department grants the waiver, the written decision shall include:

(a) The waiver's duration; and

(b) Any conditions imposed by the Department.

F. If the limited private inpatient facility violates any condition of the waiver, or if it appears to the Secretary that the health or safety of residents residing in the limited private inpatient facility will be adversely affected by the continuation of the waiver, a waiver may be revoked. The revocation of a waiver may not be appealed.

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207, 19-219, and 19-222, Annotated Code of Maryland

Notice of Proposed Action

[16-248-P]

The Health Services Cost Review Commission proposes to amend Regulation .03 under **COMAR 10.37.10 Rate Application and Approval Procedures**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on August 10, 2016, notice of which was given pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about December 19, 2016.

Statement of Purpose

The purpose of this action is to extend a moratorium on the filing of regular rate applications given the progression of the all-payer model.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

I. Summary of Economic Impact. Filing of full rate applications has become the exception as hospitals are able to avail themselves of other administrative remedies for seeking rate relief.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	Magnitude
D. On regulated industries or trade groups:	(-)	Minimal
E. On other industries or trade groups:	(+)	Minimal
F. Direct and indirect effects on public:	(+)	Minimal

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

D. This assumption is based on the belief that although hospitals will not be able to file full rate applications during the moratorium, they have other administrative remedies and opportunities available for obtaining rate relief during the moratorium.

E. This assumption is based on the belief that third party payers will not be paying higher rates associated with a full rate application during the moratorium. However, the filing of full rate applications has become the exception as hospitals are able to avail themselves of other administrative remedies for seeking rate relief.

F. This assumption is based on the belief that the public will not be paying higher rates associated with a full rate application during the moratorium. However, the filing of full rate applications has become the exception as hospitals are able to avail themselves of other administrative remedies for seeking rate relief.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Diana Kemp, Regulation Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215, or call 410-764-2576, or email to diana.kemp@maryland.gov, or fax to 410-358-6217. Comments will be accepted through October 31, 2016. A public hearing has not been scheduled.

.03 Regular Rate Applications.

A. A hospital may not file a regular rate application with the Commission until rate efficiency measures are adopted by the Commission which are consistent with the all-payer model contract approved by the Centers for Medicare & Medicaid Services (CMS). During this interim period of time, a hospital may seek a rate adjustment under any other administrative remedy available to it under existing Commission, law, regulation, or policy. The rate efficiency measures shall be adopted by the Commission no later than [July 1, 2016] *October 31, 2017*. [In no event shall the moratorium continue in effect beyond September 30, 2016.] Once the moratorium is lifted, a hospital may file a regular rate application with the Commission at any time if:

(1) — (2) (text unchanged)

B. — D. (text unchanged)

NELSON SABATINI
Chairman
Health Services Cost Review Commission

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter10 Rate Application and Approval Procedures

Authority: Health-General Article, §§ 19-201 and 19-211, Annotated Code of Maryland

NOTICE OF FINAL ACTION

On September 14, 2016, the Health Services Cost Review Commission adopted amendments to Regulation .07-2 under COMAR 10.37.10 "Rate Application and Approval Procedure." This action, which was proposed for adoption in 43:22 Md. R. 1244 - 1245 (October 28, 2016), has been adopted as proposed.

Effective Date: December 24, 2016

NELSON SABATINI
Chairman
Health Services Cost Review Commission

sanction under Health Occupations Article, §14-5A-17, Annotated Code of Maryland, for a first offense, for the failure of a licensee to obtain continuing education [contact] hours required by the Board.

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

10.37.10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-201 and 19-211, Annotated Code of Maryland

Notice of Proposed Action

[16-277-P]

The Health Services Cost Review Commission proposes to adopt Regulation .07-2 under **COMAR 10.37.10 Rate Application and Approval Procedures**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on September 14, 2016, notice of which was given pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland. If adopted, the proposed regulation will become effective on or about January 16, 2017.

Statement of Purpose

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

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action

Estimate of Economic Impact

I. Summary of Economic Impact. The purpose of this action is to designate those outpatient services provided at a Freestanding Medical Facility that are subject to Commission rate regulation in conformance with newly enacted legislation.

II. Types of Economic Impact.	Revenue (R+/R-) Expenditure (E+/E-)	Magnitude
A. On issuing agency:	NONE	
B. On other State agencies:	NONE	
C. On local governments:	NONE	
	Benefit (+) Cost (-)	**Magnitude**
D. On regulated industries or trade groups:	(+)	Moderate
E. On other industries or trade groups:	(-)	Moderate
F. Direct and indirect effects on public:	(+)	Moderate

III. Assumptions. (Identified by Impact Letter and Number from Section II.)

D. This assumption is based on the expectation that hospitals will receive Commission approved rates for the outpatient services which are reasonably related to costs incurred

E. This assumption is based on payers not being able to negotiate rates for these services, but will be required to pay Commission approved rates, which will tend to be higher than rates negotiated.

F. This assumption is based on the expectation that the public will gain access to these services, and that the charges will be certified as reasonable, to be paid by all payers, by the HSCRC.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Diana Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, MD 21215, or call 410-764-2576, or email to diana.kemp@maryland.gov, or fax to 410-358-6217. Comments will be accepted through November 28, 2016. A public hearing has not been scheduled.

.07-2 Outpatient Services — Freestanding Medical Facility.

A. Definition. In this regulation, "freestanding medical facility" means a freestanding medical facility licensed under Health-General Article, Title 19, Subtitle 3A, Annotated Code of Maryland.

B. The following outpatient services provided at a freestanding medical facility are considered hospital services under Health-General Article, §19-201, Annotated Code of Maryland:

(1) Emergency Services;

(2) Observation Services; and

(3) Associated Ancillary Services, such as laboratory, radiology, imaging, EKG, and Medical/Surgical Supplies and Drugs.

C. In accordance with Health-General Article, §19-201, Annotated Code of Maryland, the Commission's rate-setting jurisdiction extends to those outpatient services provided at a freestanding medical facility, as designated by the Commission.

D. A freestanding medical facility or a proposed freestanding medical facility that desires to provide a service not designated in §B of this regulation (an undesignated service) must receive a determination under the provisions of this regulation.

E. Commission Approval.

(1) A freestanding medical facility may not charge a Commission-approved rate for an undesignated service without prior Commission staff approval.

(2) A freestanding medical facility may not open a new outpatient service, relocate an existing outpatient service, or convert an existing outpatient service from regulated or unregulated status without a prior determination from the Commission's staff as to whether the service constitutes a hospital service subject to Commission rate regulation. A request for determination shall be made in writing at least 60 days before the contemplated action.

F. Upon request for a determination, the Commission's staff shall:

(1) Review the information presented;

(2) Consult with appropriate parties;

(3) Visit the site of the service as it considers necessary; and

(4) Notify the freestanding medical facility of its determination as soon as practicable.

G. In deciding whether the service constitutes a hospital service subject to Commission rate regulation, Commission staff shall consider, among other things, the following criteria:

(1) Cost of the service;

(2) In consultation with Maryland Health Care Commission (MHCC) staff, access to and need for the service in the community;

(3) Feasibility of providing the outpatient service in the community on an unregulated basis; and

(4) Impact of the service on the All-Payer Model including, but not limited to, the Total Cost of Care limitations as prescribed in the All-Payer Model Agreement with the Center for Medicare and Medicaid Innovation.

H. Based on the consideration of the criteria stated in §G of this regulation, the Commission staff shall make its determination on the request made under §E of this regulation within a reasonable period of time, taking into account, among other things, whether either a Certificate of Need application to establish a freestanding medical facility or a request for exemption from Certificate of Need to convert a licensed general hospital to a freestanding medical facility is pending before the MHCC and, if so, the time frame for staff to comment to MHCC on the financial feasibility of the proposed project.

I. A freestanding medical facility that fails to obtain, or violates, a staff determination on the regulated status of a given service may be subject to fines for inaccurate reporting under COMAR 10.37.01.03R and paybacks for inappropriate charges made during the time a staff determination on an outpatient service was not obtained or adhered to.

NELSON SABATINI
Chairman
Health Services Cost Review Commission

Subtitle 44 BOARD OF DENTAL EXAMINERS

10.44.20 Fees

Authority: Health Occupations Article, §4-505, Annotated Code of Maryland

Notice of Proposed Action

[16-272-P]

The Secretary of Health and Mental Hygiene proposes to amend Regulation **.02** under **COMAR 10.44.20 Fees**. This action was considered by the Board of Dental Examiners at a public meeting held on September 7, 2016, notice of which was given under the Notice of Public Meetings link on the Board's website pursuant to General Provisions Article, §3-302(c), Annotated Code of Maryland.

Statement of Purpose

The purpose of this action is to establish a 50 percent reduction in the late fee and reinstatement fee in 2017 and 2018 for dental radiation technologists with even-numbered certificates resulting in a staggered renewal period for all dental radiation technologists. Since those with even-numbered certificates will renew their certificates in 2017 for a 1-year period, and again in 2018 for a 2-year period, in the interests of fairness, any late fee or reinstatement fee should be 50 percent of the customary 2-year fee since those individuals will be renewing their certificates twice while those with odd numbered certificates will be renewing their 2-year certificate only once during the same period.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

The proposed action has no economic impact.

Economic Impact on Small Businesses

The proposed action has minimal or no economic impact on small businesses.

Impact on Individuals with Disabilities

The proposed action has no impact on individuals with disabilities.

Opportunity for Public Comment

Comments may be sent to Michele Phinney, Director, Office of Regulation and Policy Coordination, Department of Health and Mental Hygiene, 201 West Preston Street, Room 512, Baltimore, MD 21201, or call 410-767-6499 (TTY 800-735-2258), or email to dhmh.regs@maryland.gov, or fax to 410-767-6483. Comments will be accepted through November 28, 2016. A public hearing has not been scheduled.

.02 Fee Schedule.

The following fees are established by the Board:

A.—G. (text unchanged)

H. Dental radiation technologist certification fee:

(1)—(3) (text unchanged)

(4) For the period March 2, 2017 through April 1, 2017, for the 2017 renewal period, a late renewal fee for dental radiation technologists whose certificates end in an even number...$25;

(5) On and after April 2, 2017, for the 2017 renewal period, a certification reinstatement fee for dental radiation technologists whose certificates end in an even number...$59;

(6) For the period March 2, 2018 through April 1, 2018, for the 2018 renewal period, a late renewal fee for dental radiation technologists whose certificates end in an even number...$25;

(7) On and after April 2, 2018, for the 2018 renewal period, a certification reinstatement fee for dental radiation technologists whose certificates end in an even number...$59;

[(4)] *(8)*—[(5)] *(9)* (text unchanged)

I.—II. (text unchanged)

VAN T. MITCHELL
Secretary of Health and Mental Hygiene

Subtitle 62 NATALIE LAPRADE MEDICAL CANNABIS COMMISSION

Notice of Proposed Action

[16-262-P]

The Secretary of Health and Mental Hygiene proposes to:

(1) Amend Regulation **.01** under **COMAR 10.62.01 Definitions**;

(2) Repeal existing Regulations **.03** and **.07**, adopt new Regulations **.03** and **.07**, and amend Regulations **.05** and **.06** under **COMAR 10.62.08 Medical Cannabis Grower License**;

(3) Amend Regulation **.03** under **COMAR 10.62.09 Medical Cannabis Grower Agent**;

(4) Amend Regulation **.02** under **COMAR 10.62.12 Inventory Control by Grower**;

(5) Amend Regulations **.04—.07** under **COMAR 10.62.15 Medical Cannabis Grower Quality Control**;

(6) Amend Regulations **.02**, **.04**, and **.05**, repeal existing Regulation **.06**, and adopt new Regulation **.06** under **COMAR 10.62.19 Medical Cannabis Processor License**;

(7) Amend Regulation **.03** under **COMAR 10.62.20 Medical Cannabis Processor Agent**;

(8) Amend Regulation **.02** under **COMAR 10.62.22 Medical Cannabis Processor Operations**;

(9) Repeal existing Regulations **.03** and **.07**, adopt new Regulations **.03** and **.07**, and amend Regulations **.05** and **.06** under **COMAR 10.62.25 Medical Cannabis Dispensary License**;

(10) Amend Regulation **.03** under **COMAR 10.62.26 Registered Dispensary Agent**; and

State of Maryland
Department of Health and Mental Hygiene

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Herbert S. Wong, PhD
Vice-Chairman

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Clinical and Financial
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Gerard J. Schmith, Director
Revenue and Regulation
Compliance

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **December 14, 2016**

RE: **Hearing and Meeting Schedule**

January 11, 2017	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
February 8, 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.