STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

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Herbert S. Wong, Ph.D.
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George H. Bone, M.D.

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Research and Methodology

504th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
January 8, 2014

EXECUTIVE SESSION
12:00 p.m.

1. **Waiver and Personnel Update**
2. **Future Meeting Dates**
3. **Budget and Legislative Update**

PUBLIC SESSION OF THE
HEALTH SERVICES COST REVIEW COMMISSION
1:00 p.m.

1. **Review of the Minutes from the Executive Session and Public Meeting on December 4, 2013**

2. **Executive Director's Report**

3. **Update on Activities of the Advisory Council on All-Payer Hospital System Modernization**

4. **Docket Status – Cases Closed**

   2234N – Peninsula Regional Medical Center
   2235A – Johns Hopkins Health System
   2236A – Johns Hopkins Health System
   2237A – Johns Hopkins Health System

5. **Docket Status – Cases Open**

   2238A – Johns Hopkins Health System - *Approved*
   2239A – Johns Hopkins Health System - *Approved*
   2240A – Johns Hopkins Health System - *Approved*

6. **Draft Recommendations for Transitional Rate Setting Policies to Govern the Implementation of the Proposed All-Payer Model Effective January 1, 2014** - *Postponed*

7. **Final Recommendations for Updating the Quality Based Reimbursement and Maryland Hospital Acquired Conditions Programs for FY 2016** - *Approved*

8. **Hearing and Meeting Schedule**

Executive Director's Report

January 8, 2014

Monitoring Maryland Performance

For Twelve Months Ended November 2013:

- Charge per Case increased 4.96%
- Cases (admissions + new born) decreased (3.74%)
- Inpatient revenue increased 1.03%
- Outpatient revenue increased 5.52%
- Total gross revenue increased 2.78%

For Four Months Ended November 2013 versus the same time period in last year:

- Charge per Case increased 6.40%
- Cases (admissions + new born) decreased (4.05%)
- Inpatient revenue increased 2.09%
- Outpatient revenue increased 5.53%
- Total gross revenue increased 3.46%
- Total gross revenue per capita increased by 2.8% but this does not exclude revenues for out of state residents.

Financial Condition

Data are available for profits for the first five months of FY 14 (July through November 2013). For this year to date period, average operating profits for all acute care hospitals was 1.27 percent. The total profit margin for this period is 4.57 percent. The median hospital had an operating profit of 1.85 percent, with a distribution as follows:

- 25th percentile at -0.33%
- 75th percentile at 4.56%

Change in Commission Meeting Date

The HSCRC has changed the dates of Commission meetings beginning March of 2013. The new dates may be found on the Commission's website. Beginning in March, we will hold the public meeting

typically on the second Wednesday of the month (at 1PM), to allow additional time for staff review of monthly monitoring reports.

Medicaid Enrollment Under ACA

The total newly added to full Medicaid benefits is 111,148. This reflects the population converted from Primary Adult Care coverage (PAC) to full Medicaid (91,570) plus the new eligibles received and added from Maryland's Exchange (19,578).

Progress on the Application for the Maryland's All-Payer Model

The Governor submitted the State's updated application to the Center for Medicare & Medicaid Innovation on October 11, 2013.
http://dhmh.maryland.gov/SitePages/Medicare%20Waiver%20Modernization.aspx
Implementation activities are in process for a proposed start date of January 1, 2014.

Implementation Steps for All-Payer Model

Hospital data submission for monitoring: Staff is performing audits of the data, since it will form the basis of monitoring under the All Payer model.

Transitional implementation policies: Proposed policies relative to implementation of proposed All-Payer model will be introduced shortly after the January HSCRC meeting and available on the HSCRC website. These will include interim changes to variable cost policies, payment model approaches, and other policy changes.

Advisory Council Update: Advisory Council meetings have begun and an initial report is expected at the end of January. The next meeting of the Advisory Council is meeting on January 9, and materials are on the HSCRC website.

Transition activities: In the short term, HSCRC staff are focused on transitional activities

- Transition Approach with changes in hospital payment models to global models or modified charge per episode
- Monitoring changes

Priorities after January 1: The HSCRC staff will establish priorities for activities after January 1, with input from the Commissioners, Advisory Council, and workgroups.

- Work Groups-Staff is preparing to begin focused activities for four work groups. Draft work group charges will be on the HSCRC website after the end of the week, and we will begin to schedule meetings.

- Monitoring and Contract Compliance activities are underway

Other Activities

Charge per case update: HSCRC staff is working on incorporating both inpatient and outpatient activity into the new charge per case approach.

Two-midnight rule: Payers still need additional run out on claims for accurate reporting on the reduction in long observation cases.

Outpatient Tiering Report

The Budget Reconciliation and Financing Act of 2013 ("BRFA"), requires the Commission to submit a consultant report to the Governor and the General Assembly on the projected impact of outpatient tiering on the Department of Health and Mental Hygiene.

Under the BRFA, DHMH is required to achieve $30,000,000 of General Fund savings in fiscal year 2014 from a combination of tiered rates for hospital outpatient and emergency department services. Within this mandate, the HSCRC is required to contract with an independent consultant to prepare an analysis that projects the savings Medicaid could achieve from tiered. If the projected savings are less than $30 million, the Commission is required to take one or a combination of the following actions:

1. adjust the Medicaid deficit assessment so that the percentage of net patient revenue it represents equals that percentage in FY 2013;
2. reduce the MHIP assessment by an amount sufficient to ensure that the combined Medicaid deficit and MHIP assessments do not exceed $518 million in FY 2014; and/or
3. identify and implement other actions to provide the necessary savings.

On December 18, 2013, staff submitted the consultant's report to the Governor and General Assembly that estimated the savings from tiering to be $5.88 million in FY 2013, and projected the FY 2014 savings to be $7.37 million - well short of the targeted $30 million.

Staff intends to submit emergency regulations at the February Commission meeting to reconcile the savings through the second option listed above. The regulations will permit the Commission to reduce the current 1% MHIP assessment during the remainder of FY 2014 by the estimated shortfall of $22.6 million, and increase the Medicaid deficit assessment by the same amount – in a manner that is cost neutral to payers and revenue neutral to hospitals.

Executive Session Minutes
Of the
Health Services Cost Review Commission

December 4, 2013

Upon motion made, Chairman Colmers called the Executive Session to order at 12:12 p.m.

The Executive Session was held under the authority of Section 10-508 of the State-Government Article.

In attendance, in addition to Chairman Colmers, were Commissioners Jencks, Keane, Loftus, Mullen, and Wong.

In attendance representing staff were Donna Kinzer, Steve Ports, Jerry Schmith, Sule Calikoglu, and Dennis Phelps.

Also attending were Stan Lustman and Leslie Schulman Commission counsel.

Item One

The Chairman updated the Commission on the status of the State's Model Demonstration Proposal.

Item Two

The Acting Executive Director discussed the rationale for moving future Commission public meeting dates.

Item Three

The Commission discussed various personnel matters.

The Executive Session was adjourned at 1:01 p.m.

MINUTES OF THE
503nd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

December 4, 2013

Chairman John Colmers called the meeting to order at 1:05 p.m. Commissioners George H. Bone, M.D., Stephen F. Jencks, M.D., M.P.H., Jack C. Keane, Bernadette C. Loftus M.D, Tom Mullen, and Herbert S. Wong, Ph.D. were also in attendance.

REPORT OF THE DECEMBER 4, 2013 EXECUTIVE SESSION

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the December 4, 2013 Executive Session.

Chairman Colmers announced that the Commission meetings will be scheduled later in the month, possibly starting with the March 2014 meeting. Chairman Colmers explained that in light of the new waiver system and the HSCRC receiving data on a monthly basis, Staff will be able to provide monthly status reports, and Commissioners will have an opportunity to make decisions more expeditiously if the meetings are moved.

ITEM I
REVIEW OF THE MINUTES OF THE NOVEMBER 6 AND NOVEMBER 13 EXECUTIVE SESSIONS AND THE MINUTES OF THE NOVEMBER 6, 2013 PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the November 6 and November 13, 2013 Executive Sessions. In addition, the minutes of the November 6, 2013 Public Meeting were unanimously approved.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Ms. Donna Kinzer, Acting Executive Director, reported that Monitoring Maryland Performance (MMP) indicated that the rate of growth in charge per case increased 3.86% for the twelve months ended October 31, 2013, and that inpatient revenue increased by .07%. Ms. Kinzer stated that for the same period, the number of inpatient cases decreased 3.65%; FY 2013 outpatient revenue increased by 6.05%; and total gross revenue increased by 2.38%.

Ms. Kinzer reported that MMP indicated that the rate of growth in charge per case increased 5.55% for four months ended October 31, 2013, and that inpatient revenue increased by 1.62%. For the same period, the number of inpatient cases decreased by 3.72%. In addition, outpatient

revenue increased 5.58%, with total gross revenue increasing by 3.19%. Total gross revenue per capita increased by 2.53%. The total revenue includes revenue for out of state residents.

As a follow up to concern expressed by Commissioner Mullen at the November meeting about the September volume increase, Ms. Kinzer stated that according to staff analysis, volumes were exceptionally low in September 2012, which explains the size of the increase in September 2013. Ms. Kinzer noted that October volumes are higher than expected. Staff is still reconciling price variances and other unanticipated volume changes in its review of the October results.

According to Ms. Kinzer, for the first four months of fiscal year 2014, the unaudited average operating profits for acute hospitals was 1.54%; the total profit margin for this period was 4.69%; and the median hospital profit was 1.95%, with a distribution of (.12%) in the 25th percentile and 4.20% in the 75th percentile.

Ms. Kinzer stated that the Staff is continuing to move toward a January 1 implementation date for the All Payer Model. She noted that HSCRC staff has received monthly hospital financial data to begin monitoring hospital performance, including Medicare/Non Medicare, and in state/out of state residency data. Staff is performing audits of the data, since it will form the basis of monitoring under the All Payer model.

Ms. Kinzer noted that transitional implementation policies for the proposed All Payer model will be introduced at the January public meeting. These policies will include interim changes to variable cost policies, payment model approaches, and other policy changes.

The Advisory Council has started meeting in November. Their initial report is expected at the end of January.

Ms. Kinzer stated that throughout December, Staff will prioritize workgroup activities and appoint workgroups to focus on priority tasks.

Ms. Kinzer noted that Staff is busy reprogramming computer systems to develop monitoring programs for the new All Payer System.

In regards to charge per case, Ms. Kinzer stated that Staff is currently working on incorporating both inpatient and outpatient activity into the new charge per case approach. She noted that staff is making good progress but the new approach will not be ready by January 1, it should be ready for review, however, in early 2014.

Ms. Kinzer noted that Staff will present a policy update today concerning the modifications to the Maryland Hospital Acquired Conditions and Quality Based Reimbursement programs for the rate year 2016.

Ms. Kinzer pointed out that those hospital submitting new partial rate applications should not assume that there will be a revenue guarantee associated with the new rate centers. New rate centers and services will need to be funded out of population adjustments and other available mechanisms consistent with the proposed All Payer model.
Ms. Kinzer stated that the review of the 2013 annual filings shows an increase in the level of

uncompensated care. Staff is estimating that the total hospital uncompensated care percentage is about 7.30% for FY 2013. This is above the 6.85% now funded in rates. Ms. Kinzer noted that Staff will be reviewing the uncompensated care results and update HSCRC policies for the upcoming year.

ITEM III
UPDATE ON ACTIVITIES OF THE ADVISORY COUNCIL ON NEW ALL-PAYER HOSPITAL SYSTEM

Ms. Kinzer presented an update on the activities of the Advisory Council (see, "Minutes of The Joint Meeting of The Health Services Cost Review Commission and the All Payer Hospital Modernization Advisory Council" on the HSCRC website).

Ms. Kinzer's Advisory Council status report noted the following:

- On November 13th the Advisory Council had a joint session with the Health Services Cost Review Commission.
- The first meeting of the Advisory Council was held on November 21st.
- A high level outline of the All Payer final report was discussed. The final report will include priorities for implementation phasing, some guiding principles to help ensure successful implementation of the new All Payer System, and recommendations for workgroup focus.
- The Advisory Council began to define the critical issues that should be addressed for which there is some consensus.
- Upcoming meetings will address areas of consensus and will report back to the Commission in detail.

Upcoming meetings are scheduled for December 12th, January 9th, and January 23rd. Meeting locations are posted on the HSCRC website. Also, all information about the meetings will be posted on the website.

ITEM IV
DOCKET STATUS CASES CLOSED

2220N- University of Maryland Medical Center

ITEM V
DOCKET STATUS CASES OPEN

2234N- Peninsula Regional Medical Center

On November 4, 2013 Peninsula Regional Medical Center (the "Hospital") submitted a partial rate

application to the Commission requesting a rate for Psychiatric Day/Night (PDC) services. The Hospital is requesting that the PDC rate be set at the lower of projected PDC costs or the statewide median rate with an effective date of January 1, 2014.

After reviewing the Hospital application, Staff recommended the following:

- That a PDC rate of $389.47 per visit be approved effective January 1, 2014;
- That no change be made to the Hospital's Charge per Episode standard for PDC services;
- That the PDC rate not be rate realigned until a full year's cost experience data have been reported to the Commission; and

This new service will be subject to the provisions of the new volume or Global Budget policies.

The Commission voted unanimously to approve staff's recommendation.

2235A- Johns Hopkins Health System

Johns Hopkins Health System (the System) filed a renewal application with the HSCRC on November 20, 2013 on behalf of its member hospitals, the Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the Hospitals) requesting approval to continue to participate in a capitation arrangement serving persons insured with Tricare. The arrangement involves the Johns Hopkins Medical Services Corporation and Johns Hopkins Healthcare as providers for Tricare patients. The System requested approval of this arrangement for a period of one year beginning January 1, 2014.

The staff recommends that the Commission approve the capitation arrangement with Tricare for a one year period commencing January 1, 2014, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2236A- Johns Hopkins Health System

Johns Hopkins Health System (the System) filed a renewal application on November 21, 2013 on behalf of its member hospitals, the Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the Hospitals) requesting approval to continue to participate in a revised global price arrangement with Life Trac (a subsidiary of Allianz Insurance Company of North America) for solid organ and bone marrow transplants and cardiovascular services. The Hospitals requested approval of this arrangement for a period of one year beginning January 1, 2014.

The staff recommends that the Commission approve the revised global price arrangement with

Life Trac for a one year period commencing January 1, 2014, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2237A- Johns Hopkins Health System

Johns Hopkins Health System (the System) filed a renewal application on November 21, 2013 on behalf of its member hospitals, the Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the Hospitals) requesting approval to continue to participate in a revised global price arrangement for cardiovascular procedures with Global Excel Management, Inc.. The Hospitals requested approval of this arrangement for a period of one year beginning January 1, 2014.

The staff recommends that the Commission approve the revised global price arrangement with Global Excel Management Inc. for a one year period commencing January 1, 2014, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

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

2182A- Johns Hopkins Health System Extension Request

On July 28, 2013, in accordance with the authority granted by the Commission, staff approved a 3 month extension of the Commission's approval of the alternative rate arrangement between the Johns Hopkins Health System (JHHS) and Cigna Health Corporation. This extension expires on December 31, 2013. However, JHHS and Cigna have not completed negotiations to extend this arrangement. JHHS has requested that the Commission extend its approval for an additional month, to January 31, 2014 to complete the negotiations.

Staff recommended that the Commission grant JHHS's request for a one month extension to January 31, 2014 for approval, with the condition that if negotiations are not completed before the expiration of this extension, that the arrangement end and that no further services be provided under this arrangement until a new application is approved.

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

ITEM VI
FINAL RECOMMENDATION ON UPDATE FACTOR EFFECTIVE JANUARY 1, 2014

Mr. Steve Ports, Principal Deputy Director Policy and Operations, presented a final recommendation for the continuation of the existing update factor polices through June 30, 2014. (see "Final Recommendation on Continuation of the Update Factor Approved on June 5, 2013" on the HSCRC website).

Mr. Ports reported that on June 5, 2013, the Commission approved an update factor of 1.65% for inpatient and outpatient services for all regulated hospitals (except private psychiatric hospitals) for a period of July 1, 2013 through December 31, 2013. At the July meeting, the Commission approved an update factor of 1.8% for the private psychiatric hospitals. The June recommendation indicated that the Commission would revisit the update factor for the second half of the year, from January 1, 2014 through June 30, 2014.

However, due to the continued uncertainty associated with the new all-payer model, the status of the current waiver test, and the financial condition of hospitals, staff recommends that the policies adopted by the Commission at the June 2013 meeting be carried forward for the period January 1 to June 30, 2014 as follows:

- continue the update factor of 1.65% (1.8% for psychiatric hospitals) for both inpatient and outpatient services for all regulated hospitals for the period January 1 through June 30, 2014;
- continue with other recommendations made on June 5, 2013 and rate settlements until modified; and
- continue to monitor federal changes that might affect Medicare payments.

Mr. Ports noted that there were no written comments received during the 30 day comment period.

Mike Robbins, Senior Vice President, Financial Advocacy and Policy of the Maryland Hospital Association, spoke in support of the update factor recommendation but expressed concern about the financial condition of Maryland's hospitals. Mr. Robbins stated that hospital margins, despite recent improvement, are below HSCRC targets and requested that the Commission expedite its work to define "efficient and effective hospitals" early in the work group process to implement the new waiver.

The Commission voted unanimously to approve staff's recommendation.

ITEM VII
FINAL RECOMMENDATION ON FUTURE FUNDING SUPPORT FOR THE CHESAPEAKE REGIONAL INFORMATION SYSTEM FOR OUR PATIENTS (CRISP)

Mr. Ports and David Sharp, Director of the Maryland Health Care Commission's Center for

Health Information Technology, presented a final recommendation for continued funding support for the Chesapeake Regional Information System for our Patients (CRISP) (see, "Final Recommendation for the Chesapeake Regional Information System for our Patients" on the HSCRC website).

The purpose of the final recommendation is to continue funding for CRISP, Maryland's designated Health Information Exchange (HIE), for the period FYs 2015 through 2019.The funding amount will assist CRISP in fulfilling its role in implementing the HIE and health care reform in Maryland. As the State's HIE, Staff views CRISP as a critical partner as they begin to track utilization across care settings and implement per capita and population-based payment methodologies.

The Maryland Health Care Commission and HSCRC recommended funding of up to $2.5 million annually through Maryland's unique all-payer hospital rate setting system to CRISP over the next 5 years (FYs 2015 – FY 2019) to support the continued development and use of the State-Designated HIE. The continued funding is necessary to meet the anticipated uses of health information exchange, as well as the needs of the HSCRC under the new All-Payer Model Design. The funding will also be utilized for quality measurement and improvement such as monitoring and reducing readmissions across the State.

Commissioner Mullen indicated support for the recommendation but expressed concern about the number of initiatives that are funded through hospital rates when hospitals are subject to a global cap.

Traci LaValle, Vice President, Financial Policy & Advocacy of the Maryland Hospital Association, spoke in support of the CRISP funding and reiterated Commissioner Mullen's concerns.

The Commission voted unanimously to approve staff's recommendation.

ITEM VIII
REPORT ON FY2014 UNCOMPENSATED CARE POLICY AND FINAL RECOMMENDATION REGARDING CHARITY CARE ADJUSTMENT

Mr. Nduka Udom, Associate Director, Research and Methodology, presented a report on the results of the Uncompensated Care Policy and the final recommendation to change the formula for calculating the hospital specific results (see, "Report on Results of Uncompensated Care Policy and Final Recommendation to Suspend the Formula for Calculating the Hospital Specific Results" on the HSCRC website).

Mr. Udom noted that there were no changes made to the previous draft recommendation.

Mr. Udom stated that based on the wide hospital level variation in the percentage of charity care reported from 2011 to 2012, staff does not have confidence that the current Charity Care

Adjustment policy accurately distinguishes charity care from bad debts. Also, Staff is not confident that charity care is accurately and consistently reported by hospitals, which may well relate to the implementation of presumptive charity care software by some hospitals and insufficient identification of patients meeting charity care guidelines by others. Finally, the current UCC policy, absent the Charity Care Adjustment, fully adjusts rates for all uncompensated care historically provided to hospitals

Based on this Report, staff recommends that the Commission suspend the Charity Care Adjustment for FY2014 until an alternative Charity Care Adjustment methodology is developed and approved.

Traci LaValle, Vice President, Financial Policy & Advocacy of the Maryland Hospital Association spoke in support of the recommendation. She suggested that white papers and the pending HSCRC workgroup be used as a forum to review the Charity Care Adjustment. Ms. LaValle also recommended that the HSCRC not seek to prospectively adjust uncompensated care but rather utilize data to determine appropriate uncompensated care adjustments.

The Commission voted unanimously to approve staff's recommendation.

ITEM IX
DRAFT RECOMMENDAON REGARDING FY 16 MAGNITUDES AND STANDARDS FOR THE QUALITY-BASED REIMBURSEMENT AND MARYLAND ACQUIRED CONDITIONS PROGRAMS

Diane Feeney, Associate Director Quality Initiative, summarized staff's draft recommendation (see "Draft Recommendation for Updating the Quality Based Reimbursement (QBR) and Maryland Acquired Conditions (MHAC) Programs for FY 2016"on the HSCRC website). The draft recommendations included: 1) increasing the approved inpatient revenue in the QBR program from 0.5% to 1% 2) increasing the benchmark for expected MHAC values to 15%, which represents a more linear relationship between scaling and performance; and 3) aligning the QBR process of care measures, threshold, benchmark measures and time lag periods with those of CMS to allow HSCRC to compare performance scores.

Commissioner Jencks asked how many measures were included in both the MHAC and QBR programs, and whether fewer measures would make the programs more effective and yield better results. Commissioner Bones noted that limited hospital resources prevent hospitals from attaining targets, and that more emphasis should be placed on overall hospital improvement.

Traci LaValle, Vice President, Financial Policy & Advocacy of the Maryland Hospital Association, expressed support for the staff recommendation to align QBR measure and performance periods with those of CMS. She also agreed with Commissioner Jencks that a more focused approach to the number of measures would be favorable.

Since this was a draft recommendation, no action was required.

ITEM X
HEARING AND MEETING SCHEDULE

January 8, 2014 HSCRC	Time to be determined, 4160 Patterson Avenue, Conference Room
February 5, 2014 HSCRC	Time to be determined, 4160 Patterson Avenue, Conference Room

STUART ERDMAN AND HSCRC PERSONNEL UPDATE

Chairman Colmers announced that Stuart Erdman, Assistant Treasurer and Senior Director of Finance Johns Hopkins Health System, was retiring at the end of December. The Chairman noted that for 30 years Mr. Erdman has been an integral and constructive part of the Maryland rate setting system.

Steve Ports and Jerry Schmith introduce the two newest members to the HSCRC staff, Kaitlin Grimm and Paul Hoover.

There being no further business, the meeting was adjourned at 2:17 p.m.

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

AS OF DECEMBER 17, 2013

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
2238A	Johns Hopkins Health System	11/25/2013	N/A	N/A	ARM	DNP	OPEN
2239A	Johns Hopkins Health System	11/25/2013	N/A	N/A	ARM	DNP	OPEN
2240A	Johns Hopkins Health System	11/25/2013	N/A	N/A	ARM	DNP	OPEN

NONE

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2013**
SYSTEM	*	**FOLIO:**	**2048**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2238A**

Staff Recommendation

Approved

January 8, 2014

I. INTRODUCTION

Johns Hopkins Health System (System) filed an application with the HSCRC on November 25, 2013 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for cardiovascular and orthopedic services with PepsiCo, Inc. for a period of one year beginning January 1, 2014.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff found that the experience under this arrangement has been favorable for the last year.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular and orthopedic services for a one year period commencing January 1, 2014. 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:**	**2013**
SYSTEM	*	**FOLIO:**	**2049**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2239A**

Staff Recommendation

Approved

January 8, 2014

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on November 25, 2014 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to participate in a global rate arrangement for joint replacement and cardiovascular services with Health Design Plus, Inc. for clients other than those of Pacific Business Group on Health for a period of one year beginning January 1, 2014.

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 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

The format utilized to calculate the case rates, i.e., historical data for like cases, has been utilized as the basis for other successful joint replacement and cardiovascular arrangements in which the Hospitals are currently participating. 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 joint replacement and cardiovascular services for a one year period commencing January 1, 2014. 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:**	**2013**
SYSTEM	*	**FOLIO:**	**2050**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2240A**

Staff Recommendation

Approved

January 8, 2014

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on November 25, 2014 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to participate in a global rate arrangement for joint replacement services with Health Design Plus, Inc. for Pacific Business Group on Health clients for a period of one year beginning January 1, 2014.

II. OVE RVIEW 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 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 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

The format utilized to calculate the case rates, i.e., historical data for like cases, has been

utilized as the basis for other successful joint replacement arrangements in which the Hospitals are currently participating. 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 joint replacement services for a one year period commencing January 1, 2014. The Hospitals will need to file a renewal application for review to be considered for continued participation. Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document would formalize the understanding between the Commission and the Hospitals, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

Final Recommendation for Updating the Quality Based Reimbursement and Maryland Hospital Acquired Conditions Programs for FY 2016

Health Services Cost Review Commission
4160 Patterson Avenue Baltimore, MD 21215
(410) 764-2605

January 8, 2014

This document contains the final staff recommendations for updating the Quality Based Reimbursement (QBR) and Maryland Hospital Acquired Conditions (MHAC) Programs for FY 2016 as approved by the Commission at the January 8, 2014 Public Meeting.

Final Recommendation for Updating the Quality Based Reimbursement (QBR) and Maryland Hospital Acquired Condition (MHAC) Programs

A. Introduction

The HSCRC quality-based scaling methodologies and magnitudes "at risk" are important policy tools for providing strong incentives for hospitals to improve their quality performance over time.

Current HSCRC policy calls for the revenue neutral scaling of hospitals in allocating rewards and penalties based on performance on the HCSRC's Quality-based Reimbursement ("QBR") and Maryland Hospital Acquired Conditions ("MHAC") initiatives. The term "scaling" refers to the differential allocation of a pre-determined portion of base regulated hospital revenue based on assessment of the relative quality of hospital performance. The rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year; scaling amounts applied for quality performance are applied on a "one-time" basis (and not considered permanent revenue).

The reward and penalty allocations for the quality programs are computed on a "revenue neutral" basis for the system as a whole. This means that the net increases in rates for better performing hospitals are funded entirely by net decreases in rates for poorer performing hospitals. For State FY 2015 rates, as approved by the Commission, the HSCRC will scale a maximum penalty of 0.5% of base approved hospital inpatient revenue for the QBR program (which was the same level as FYs 2010 through 2014), and 3% for the MHAC program (which includes 2% for performance and 1% for improvement); this is a total of 3.5% of hospital base revenue related to quality.

Staff recommends updating the scaling magnitudes and methodologies to translate scores into rate updates for the QBR and MHACs initiatives to be applied to FY 2016 rates for each hospital.

B. Background

1. Centers for Medicare & Medicaid Services (CMS) Value Based Purchasing (VBP) and Hospital Acquired Conditions (HAC) Programs

The Patient Protection and Affordable Care Act of 2010 requires CMS to fund the aggregate Hospital VBP incentive payments by reducing the base operating diagnosis-related group (DRG) payment amounts that determine the Medicare payment for each hospital inpatient discharge. The law set the reduction at one percent in FY 2013, rising to 2 percent by FY 2017.

For the federal FY 2015 (October 1 to September 30) Hospital VBP program, CMS measures include four domains of hospital performance: clinical process of care; patient experience of care (HCAHPS survey measure); outcomes; and efficiency/Medicare spending per beneficiary. Results are weighted by CMS as listed below.

Figure 1. CMS VBP Domain Weights, FY 2015

	Clinical/Process	Patient Experience	Outcome	Efficiency/Medicare spending/beneficiary
FFY 2015	20%	30%	30%	20%

CMS has indicated its future emphasis will increasingly lean toward outcomes in the VBP program. Staff notes that for the CMS VBP program for FY 2015, CMS added additional outcome measures, including the Agency for Healthcare Research and Quality ("AHRQ") Patient Safety Indicator ("PSI") 90 Composite measure and the Centers for Disease Control National Health Safety Network ("CDC-NHSN") Central Line Associated Blood Stream Infection (CLABSI) measure.

The federal HAC program began in FFY 2012 when CMS disallowed an increase in DRG payment for cases with added complications in 14 narrowly defined categories. Beginning in FFY 2015, CMS established a second HAC program, which reduces payments of hospitals with scores in the top quartile for the performance period on their rate of Hospital Acquired Conditions as compared to the national average. In FY 2015, the maximum reduction is 1 percent for all DRGs. HSCRC staff also notes that CMS is using the PSI 90 Composite and the CDC CLABSI and Catheter-Associated Urinary Tract Infection ("CAUTI") measures for its HAC program, with PSI 90 and CLABSI also added to the VBP program, as noted above.

The CMS VBP and HAC measures for FY 2015 are listed in in Appendix I.

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

The QBR program uses the CMS/Joint Commission core process measures—e.g., aspirin upon arrival for the patient diagnosed with heart attack—, eight "patient experience of care" or Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") measures, and a mortality domain newly adopted for rate year 2015 performance which includes all-cause inpatient mortality using the 3M Risk of Mortality classifications; the weighting for each domain is illustrated below.

Figure 2. Maryland QBR Domain Weights, FY 2015

	Clinical/Process	Patient Experience	Outcome
State FY 2015	40%	50%	10%

The QBR and MHAC Programs in Maryland together are consistent in design and intent with the CMS VBP program, and target performance on a robust set of process of care/effectiveness measures, patient safety measures, preventable complication rates, mortality rates, and patient experience of care measures. The programmatic elements of both the QBR and MHAC programs together comprise "VBP-like" measures that overlap the two programs.

The MHAC program currently uses a large subset of the 65 Potentially Preventable Complications developed by 3M Health Information Systems, which computes actual versus expected rates of complications adjusted for each patient by the All Patient Refined Diagnosis Related Group ("APR DRG"), and severity of illness ("SOI") category. The attainment scale measures the proportion of each hospital's inpatient revenue from excess PPCs compared to the benchmarks. For FY 15, the Commission approved targeting improvement in the following measures for scaling 1% of inpatient revenue, bringing the "at risk" revenue to 3% for the MHAC program. The 5 measures targeted under the improvement methodology are PPC5 – Pneumonia and Other Lung Infections, PPC6 – Aspiration Pneumonia, PPC16 – Venous Thrombosis, PPC24 – Renal Failure without Dialysis, and PPC35 – Septicemia and Severe

Infections. Each year, staff will re-evaluate the PPCs used for the improvement scale based on improvement rates, prevalence, cost, and policy considerations and input from MHAC/QBR work group.

The overall risk adjusted hospital-acquired potentially preventable complication (PPC) rates have declined from the first quarter of state fiscal year 2011 to the present by 34.6%. For FY 2015, the expected performance benchmark is calculated using a value of 15% below the statewide average performance for each PPC used in the MHAC program, as approved by the Commission last year.

Appendix II lists the measures used for the QBR and MHAC programs for FY 2015.

3. *Value Based Purchasing Exemption Provisions*

Pursuant to 1886(o)(1)(C)(iv) of the Social Security Act, "the Secretary may exempt such hospitals from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection." VBP exemptions have been requested and granted for FYs 2013 and 2014. A VBP exemption request for FY 2015, which includes a report of Maryland's health outcomes and cost savings for the MHAC and QBR programs and a support letter from Secretary Sharfstein, was submitted to HHS Secretary Sebelius on November 15, 2013.

C. Assessment

Since the inception of the program and as is currently the case, HSCRC solicits input from stakeholder groups comprising the industry and payers to determine appropriate direction in areas of needed updates to the programs, including the measures used, and the programs' methodology components.

Staff examined measures proposed for the CMS VBP and HAC programs and those in the potential pool for the QBR program and in the MHAC program for 2015 and 2016 and notes that Maryland lags behind in adopting measures.

Staff has convened three work group meetings last two months and has deliberated the addition of both the AHRQ PSI 90 measure and of the CMS CLABSI measure to the QBR program for FY 2016, again, both of which were already added to the CMS VBP program as of FY 2015. Staff believes there was broad agreement in the most recent work group meeting convened to add these measures for FY 2016, as well as to weight the measure domains as illustrated below, particularly in light of lacking an efficiency domain, and the need to continue to focus on HCAHPS and to further focus on outcomes. Figure 3 details the CMS VBP domain weights compared with the Maryland domain weights for FY 2016.

Figure 3. CMS VBP and Maryland QBR Domain Weights, FY 2016

FY 2016	Clinical/ Process	Patient Experience	Outcome	Efficiency
CMS VBP	10%	25%	40%	25%
Maryland QBR	30%	40%	30%	N/A

In addition to the added measures, the group agreed to align the list of process of care measures, threshold and benchmark values, and time lag periods with those used by CMS.[1] This will allow HSCRC to use the data submitted directly to CMS and to align our performance scores precisely, which to date have been slightly different from CMS'. Because CMS has a 9 month lag in the performance period in the data they release and because they use four rolling quarters to update hospitals' performance scores, the group agreed to move the performance period back by one quarter for FY 2015 and use October 1, 2012 to September 30, 2013, and use this same performance period going forward. This results in counting CY 2012 quarter 4 for performance in both FY 2014 and FY 2015. HSCRC agreed to re-calculate QBR scores using the original performance period of CY 2013 when the data becomes available and to make any adjustments if the difference in scores are significant in FY 2016.. This recalculation will occur only for CY2013 measurement year as the timelines will be aligned with the proposed schedule in FY2016.

Appendix III details the baseline and performance periods for both the QBR and MHAC programs for 2014 through 2017.

To determine the potential impact of increasing the amount of revenue at risk for the QBR program, and in order to have an "at risk" magnitude consistent with the CMS VBP program, staff conducted modeling using the most recent results for FY 2014 to consider altering the magnitude of scaling to 1% of total inpatient revenue. The results in Appendix IV reveal that a total of $8,430,202 is redistributed under the revenue neutral scaling methodology. There was broad agreement at the last work group meeting to increase the revenue "at risk" to 1% for FY 2016.

For the MHAC program, the QBR MHAC work group convened on December 13, 2013 to discuss modifications to the current MHAC program. Representing the industry, the MHA presented issues of concern they have with the current MHAC scaling approach used to translate performance into payment of rewards and penalties, and outlined generally the areas where changes to the policy should be considered—see Appendix V. Of note, the MHA presentation highlighted the concerns that:

- the MHAC reduction goals should be more directly aligned with the new waiver targets;
- there is little hospital-level predictability of revenue rewards and penalties with the current approach where hospital performance is scaled relative to other hospitals' performance after the performance period is ended; and,
- the scaling approach also promotes competition rather than collaboration and sharing of best practices to reduce MHACs.

The MHA strongly advised the Commission to consider a revised MHAC approach that could be finalized in part way into the measurement period of CY 2014 but applied retroactively starting January 1, 2014. The revised approach would set individual targets for hospitals and for each PPC, allowing hospitals to earn back part or all of the revenue set aside for the program based on levels of performance.

[1] HSCRC has used core measures data submitted to MHCC and applied state-based benchmarks and thresholds to calculate hospitals' QBR scores up to the period used for State FY 2015 performance.

As a fall back to overhauling of the MHAC program methodology that could be successfully implemented for rate year 2016, Commission staff presented the following modifications to the current MHAC methodology:

- Modify the benchmark for the FY 2016 to one that constitutes a more linear relationship between performance and scaling.
- Make minimal adjustments to the measure list used based on the updated regression results.
- Add measures to the "improvement" PPC list by considering as candidate measures:
  - PPCs that overlap with the new CMS HAC program Domain 1, specifically those that comprise the AHRQ PPC 90 Composite measure; and,
  - PPCs recommended by MHA that are high cost, high volume, have opportunity to improve and align directly with the new waiver targets.
- Establishing a minimum threshold number of total PPC cases for including hospitals in the improvement scale.

As updating the measures does not require Commission approval, HSCRC will continue to work with stakeholders to receive input on recommended MHAC measure updates.

A memo summarizing the changes in the QBR and MHAC methodologies with the required benchmark data will be sent to the hospitals in January.

In order to enhance our ability to meet the targets proposed in the CMMI All-payer model demonstration application, the Commission will be conducting a series of work groups to discuss pertinent issues and potential changes to current Commission policy. A Performance Measurement and Improvement Work Group will be convened in early 2014 to consider issues relating to the Commission quality initiatives such as redesigning the incentives and shifting from revenue neutral scaling to establishing targets that allow hospitals to earn up to the full designated amounts if they meet the targets. While it is likely that any changes would apply to FY 17 payment policy, it is possible that the recommendations in this report for FY 16 could be altered after taking into account the timing and implications of the data available for the base and performance periods for payment adjustment. The work group will also be developing readmission and efficiency policies and a timeline and process for implementation under the new model. The readmission policy will be effective by July 1, 2014, and the efficiency standard at a future designated date.

D. Recommendations

For QBR and MHAC scaling, staff provides the following recommendations:

1. Allocate 1% of hospital approved inpatient revenue for QBR relative performance in FY 2016.
2. Through the effort of the Performance Measurement and Improvement Work Group to begin in January 2014, work to adapt the MHAC policy to the new waiver requirements with a reasonable implementation period that is consistent with the new all-payer model.
3. Absent Commission approval of an alternative MHAC policy, continue the current MHAC policy for FY 2016 (which provides for 2% at risk for attainment and 1% for improvement) and increase the benchmark to establish the expected MHAC values for attainment to 75% of the statewide average, which represents a more linear relationship between scaling and performance.

Appendix I. CMS VBP and HAC Measures for FY 2015

Process of Care Measures
AMI–7a ..... Fibrinolytic Therapy Received Within 30 Min- utes of Hospital Arrival.
AMI–8a ..... Primary PCI Received Within 90 Minutes of Hospital Arrival.
PN–3b ..... Blood Cultures Performed in the Emergency Department Prior to Initial Antibiotic Re- ceived in Hospital.
PN–6 ..... Initial Antibiotic Selection for CAP inImmunocompetent Patient.
SCIP–Card–2 .... Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta- Blocker During the Perioperative Period.
SCIP–Inf–1 ..... Prophylactic Antibiotic Received Within One Hour Prior to Surgical Incision.
SCIP–Inf–2 ..... Prophylactic Antibiotic Selection for Surgical Patients.
SCIP–Inf–3 ..... Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time.
SCIP–Inf–4 ..... Cardiac Surgery Patients with Controlled 6AM Postoperative Serum Glucose.
SCIP–Inf–9 ..... Urinary Catheter Removed on Postoperative Day 1 or Postoperative Day 2.
SCIP–VTE–2……. Surgery Patients Who Received Appropriate Venous Thromboembolism Prophylaxes Within 24 Hours Prior to Surgery to 24 Hours After Surgery.
MORT–30–AMI, MORT–30–HF , MORT–30–PN
PSI–90
CDC NHSN- CLABSI

HCAHPS Survey Dimension
Communication with Nurses .....
Communication with Doctors .....
Responsiveness of Hospital Staff .....
Pain Management .....
Communication about Medicines .....
Hospital Cleanliness & Quietness .....
Discharge Information .....
Overall Rating of Hospital .....

CMS HAC MEASURES Implemented Since FY 2012

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

CMS HAC Measures Implemented FY 2015

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

Appendix II: QBR and MHAC Measures, FY 2015

QBR Measures

DOMAIN	MEASURE
AMI	AMI-8a - Primary PCI Received Within 90 Minutes of Hospital Arrival
CAC	CAC-3-Home Management Plan of Care (HMPC) Document Given to Patient/Caregiver
HF	HF-1 Discharge instructions
IMM	IMM-1a Pneumococcal vaccination
IMM	IMM-2 Influenza vaccination
PN	PN-3b Blood culture before first antibiotic – Pneumonia
PN	PN-6 Initial Antibiotic Selection for CAP in Immunocompetent Patient
SCIP	SCIP INF 1- Antibiotic given within 1 hour prior to surgical incision
SCIP	SCIP INF 4- Cardiac Surgery Patients with Controlled 6 A.M. Postoperative Serum Glucose
SCIP	SCIP INF 9- Urinary catheter removed on Postoperative Day 1 or Postoperative Day 2

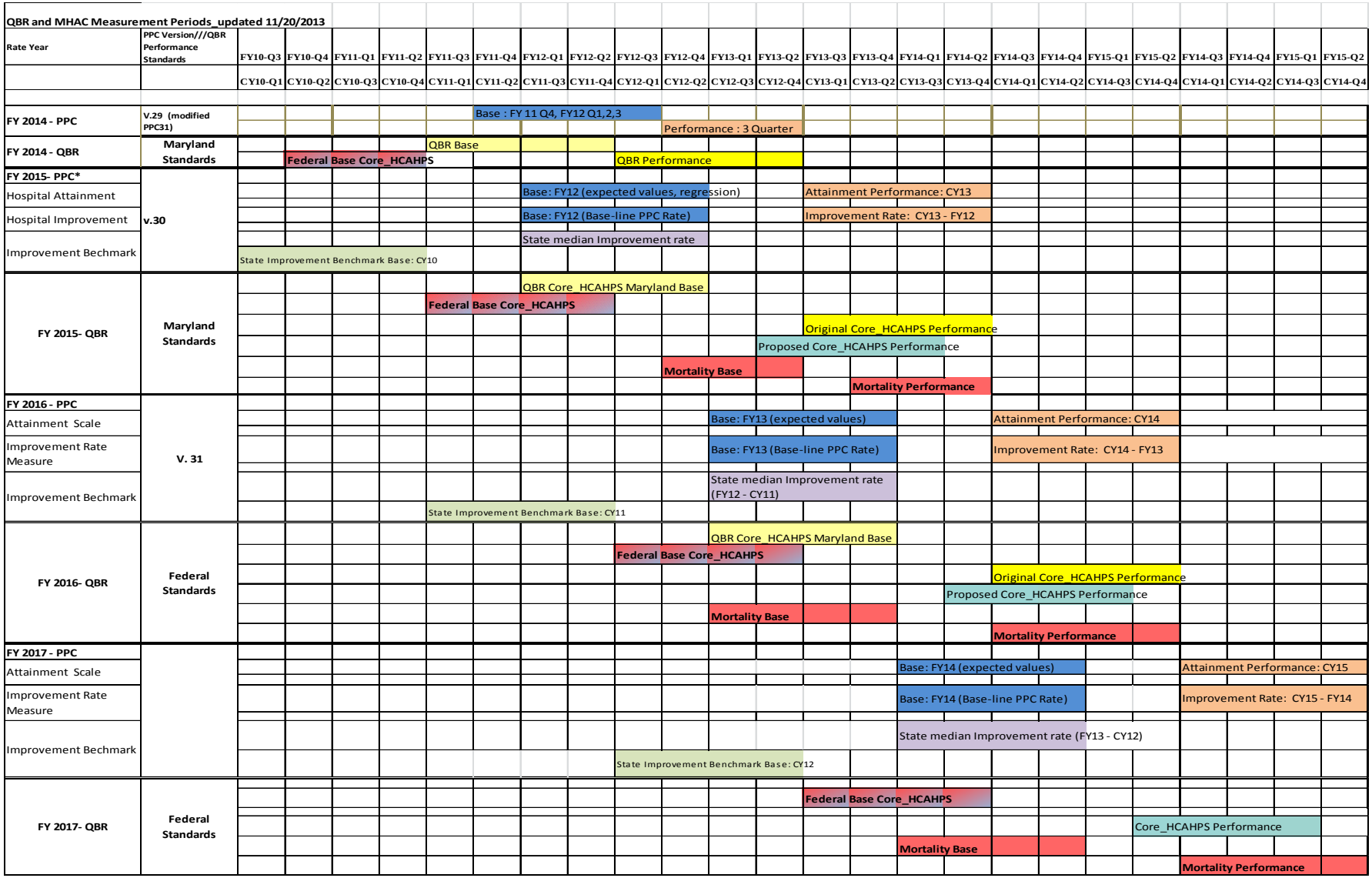
Domain	MEASURE
HCAHPS	Cleanliness and Quiteness of Hospital Envir
HCAHPS	Communication About Medicines (Q16-Q17)
HCAHPS	Communication With Doctors (Q5-Q7)
HCAHPS	Communication With Nurses (Q1-Q3)
HCAHPS	Discharge Information (Q19-Q20)
HCAHPS	Overall Rating of this Hospital
HCAHPS	Pain Management (Q13-Q14)
HCAHPS	Responsiveness of Hospital Staff (Q4,Q11)

Domain	Measure
MORTALITY	**3M Risk of Mortality**

	MHAC Measures	Rate Year 2015 (Based on FY2012 Q1234 Data)			
PPC #	PPC Description	Adm $	Adm T	Cases	Notes
			T Value<1.96		Exclusion Reason
1	Stroke & Intracranial Hemorrhage	$13,527.00	34.48	825	
2	Extreme CNS Complications	$14,228.00	25.38	415	
3	Acute Pulmonary Edema and Respiratory Failure without Ventilation	$9,808.00	57.56	4635	
4	Acute Pulmonary Edema and Respiratory Failure with Ventilation	$32,783.00	80.64	780	
5	Pneumonia & Other Lung Infections	$20,888.00	102.53	3174	
6	Aspiration Pneumonia	$16,628.00	55.74	1423	
7	Pulmonary Embolism	$15,051.00	32.59	583	
8	Other Pulmonary Complications	$9,405.00	49.36	3659	
9	Shock	$19,321.00	65.17	1506	
10	Congestive Heart Failure	$6,375.00	19.93	1235	
11	Acute Myocardial Infarction	$8,294.00	23.2	985	
12	Cardiac Arrythmias & Conduction Disturbances	$2,586.00	6.22	977	
13	Other Cardiac Complications	$5,664.00	7.34	207	
14	Ventricular Fibrillation/Cardiac Arrest	$20,204.00	47.42	706	
15	Peripheral Vascular Complications Except Venous Thrombosis	$16,972.00	21.58	202	
16	Venous Thrombosis	$17,730.00	50.87	1047	
17	Major Gastrointestinal Complications without Transfusion or Significant Bleeding	$15,508.00	35.18	639	
18	Major Gastrointestinal Complications with Transfusion or Significant Bleeding	$20,802.00	29.6	250	
19	Major Liver Complications	$21,822.00	35.52	333	
20	Other Gastrointestinal Complications without Transfusion or Significant Bleeding	$14,443.00	25.43	388	
21	Clostridium Difficile Colitis	$17,412.00	60.61	1524	Clinical
22	Urinary Tract Infection	$0.00	.	0	
23	GU Complications Except UTI	$7,016.00	12.72	407	
24	Renal Failure without Dialysis	$8,248.00	59.86	6925	
25	Renal Failure with Dialysis	$41,311.00	49.57	179	
26	Diabetic Ketoacidosis & Coma	$8,617.00	5.22	45	
27	Post-Hemorrhagic & Other Acute Anemia with Transfusion	$6,618.00	19.35	1070	
28	In-Hospital Trauma and Fractures	$8,560.00	8.9	134	
29	Poisonings Except from Anesthesia	$-1,331	-1.31	119	t-value
30	Poisonings due to Anesthesia	$14,971.00	1.34	1	t-value+case
31	Decubitus Ulcer	$32,815.00	49.94	288	
32	Transfusion Incompatibility Reaction	$21,835.00	1.97	1	t-value+case
33	Cellulitis	$10,216.00	26.15	831	
34	Moderate Infectious	$22,835.00	50.37	621	
35	Septicemia & Severe Infections	$18,853.00	68.29	1823	
36	Acute Mental Health Changes	$3,787.00	8.76	659	
37	Post-Operative Infection & Deep Wound Disruption Without Procedure	$16,777.00	46.81	1052	
38	Post-Operative Wound Infection & Deep Wound Disruption with Procedure	$34,433.00	29.67	93	
39	Reopening Surgical Site	$16,986.00	19.38	163	
40	Post-Operative Hemorrhage & Hematoma without Hemorrhage Control Procedure or I&D	$9,819.00	41.69	2283	
41	Post-Operative Hemorrhage & Hematoma with Hemorrhage Control Procedure or I&D Pr	$13,367.00	15.73	171	
42	Accidental Puncture/Laceration During Invasive Procedure	$6,503.00	19.09	1087	
43	Accidental Cut or Hemorrhage During Other Medical Care	$259.00	0.17	54	t-value
44	Other Surgical Complication - Mod	$14,852.00	22.46	284	
45	Post-procedure Foreign Bodies	$1,762.00	0.8	27	t-value
46	Post-Operative Substance Reaction & Non-O.R. Procedure for Foreign Body	$-8,577	-1.05	2	t-value+case
47	Encephalopathy	$11,772.00	36.2	1194	
48	Other Complications of Medical Care	$18,559.00	42	640	
49	Iatrogenic Pneumothrax	$9,534.00	23.58	782	
50	Mechanical Complication of Device, Implant & Graft	$16,993.00	34	495	
51	Gastrointestinal Ostomy Complications	$26,871.00	40.61	284	
52	Inflammation & Other Complications of Devices, Implants or Grafts Except Vascular Infec	$11,290.00	30.89	954	
53	Infection, Inflammation & Clotting Complications of Peripheral Vascular Catheters & Infus	$14,455.00	20.57	250	
54	Infections due to Central Venous Catheters	$29,152.00	45.6	315	
55	Obstetrical Hemorrhage without Transfusion	$406.00	1.39	1494	Clinical
56	Obstetrical Hemorrhage wtih Transfusion	$3,723.00	8.09	605	
57	Obstetric Lacerations & Other Trauma Without Instrumentation	$436.00	1.33	1160	t-value
58	Obstetric Lacerations & Other Trauma With Instrumentation	$609.00	1.11	409	t-value
59	Medical & Anesthesia Obstetric Complications	$1,239.00	2.8	646	
60	Major Puerperal Infection and Other Major Obstetric Complications	$-625	-0.58	107	t-value
61	Other Complications of Obstetrical Surgical & Perineal Wounds	$1,276.00	1.54	181	t-value
62	Delivery with Placental Complications	$688.00	1.03	281	t-value
63	Post-Operative Respiratory Failure with Tracheostomy	$103,152.00	62.65	46	Clinical
64	Other In-Hospital Adverse Events	$5,354.00	10.89	509	Clinical
65	Urinary Tract Infection without Catheter	$14,313.00	77.79	3794	
66	Catheter-Related Urinary Tract Infection	$11,718.00	10.18	93	

Note: Yellow and Gray Shaded PPCs are excluded. Green shaded PPCs are also used for the improvement measurement.

Appendix III. MHAC and QBR Base and Performance Periods, FY 2014-2017



Appendix IV

QBR Continuous Linear Scaling of Maximum Penalty of 0.50% vs. 1.00% of Hospital Inpatient CPC Revenue with Revenue Neutrality Adjustment - For Rate Year FY 2014

HOSPID	HOSPITAL NAME	GROSS INPATIENT CPC/CPE REVENUE	QBR FINAL SCORE	SCALING BASIS 0N 0.50%	SCALING BASIS 0N 1.00%	REVENUE IMPACT OF SCALING 0.50%	REVENUE IMPACT OF SCALING 1.00%	REVENUE NEUTRAL ADJUSTED REVENUE IMPACT OF SCALING 0.50%	REVENUE NEUTRAL ADJUSTED REVENUE IMPACT OF SCALING 1.00%	REVENUE NEUTRAL ADJUSTED GROSS REVENUE 0.50%	REVENUE NEUTRAL ADJUSTED GROSS REVENUE 1.00%	REVENUE NEUTRAL ADJUSTED PERCENT 0.50%	REVENUE NEUTRAL ADJUSTED PERCENT 1.00%
A	B	C	D	E	F	G	H	I	J	K	L	M	N
210003	Prince Georges Hospital Center	$163,205,248	0.2972	-0.500%	-1.000%	-$816,026	-$1,632,052	-$816,026	-$1,632,052	$162,389,221	$161,573,195	-0.500%	-1.000%
210043	Baltimore Washington Medical Center	$184,662,660	0.4688	-0.216%	-0.433%	-$399,417	-$798,834	-$399,417	-$798,834	$184,263,243	$183,863,826	-0.216%	-0.433%
210012	Sinai Hospital	$362,977,920	0.4811	-0.196%	-0.392%	-$711,291	-$1,422,583	-$711,291	-$1,422,583	$362,266,629	$361,555,337	-0.196%	-0.392%
210051	Doctors Community Hospital	$119,486,136	0.4867	-0.187%	-0.373%	-$223,082	-$446,165	-$223,082	-$446,165	$119,263,054	$119,039,971	-0.187%	-0.373%
210062	Southern Maryland Hospital Center	$145,134,232	0.4923	-0.177%	-0.355%	-$257,531	-$515,061	-$257,531	-$515,061	$144,876,701	$144,619,171	-0.177%	-0.355%
210061	Atlantic General Hospital	$33,780,340	0.4938	-0.175%	-0.350%	-$59,103	-$118,206	-$59,103	-$118,206	$33,721,237	$33,662,134	-0.175%	-0.350%
210022	Suburban Hospital	$151,177,296	0.5002	-0.164%	-0.329%	-$248,508	-$497,017	-$248,508	-$497,017	$150,928,788	$150,680,279	-0.164%	-0.329%
210015	Franklin Square Hospital Center	$241,738,193	0.5108	-0.147%	-0.294%	-$355,010	-$710,020	-$355,010	-$710,020	$241,383,183	$241,028,173	-0.147%	-0.294%
210055	Laurel Regional Hospital	$53,359,459	0.514	-0.142%	-0.283%	-$75,539	-$151,078	-$75,539	-$151,078	$53,283,920	$53,208,381	-0.142%	-0.283%
210040	Northwest Hospital Center	$121,348,486	0.5191	-0.133%	-0.266%	-$161,557	-$323,114	-$161,557	-$323,114	$121,186,929	$121,025,372	-0.133%	-0.266%
210024	Union Memorial Hospital	$215,726,275	0.5248	-0.124%	-0.247%	-$266,878	-$533,755	-$266,878	-$533,755	$215,459,397	$215,192,520	-0.124%	-0.247%
210013	Bon Secours Hospital	$70,685,898	0.5345	-0.108%	-0.215%	-$76,111	-$152,221	-$76,111	-$152,221	$70,609,787	$70,533,677	-0.108%	-0.215%
210035	Civista Medical Center	$60,770,370	0.5438	-0.092%	-0.185%	-$56,090	-$112,180	-$56,090	-$112,180	$60,714,280	$60,658,190	-0.092%	-0.185%
210056	Good Samaritan Hospital	$172,932,011	0.5485	-0.085%	-0.169%	-$146,176	-$292,353	-$146,176	-$292,353	$172,785,835	$172,639,658	-0.085%	-0.169%
210032	Union of Cecil	$60,653,880	0.551	-0.080%	-0.161%	-$48,763	-$97,525	-$48,763	-$97,525	$60,605,117	$60,556,355	-0.080%	-0.161%
210011	St. Agnes Hospital	$209,768,089	0.5535	-0.076%	-0.153%	-$159,973	-$319,946	-$159,973	-$319,946	$209,608,116	$209,448,143	-0.076%	-0.153%
210048	Howard County General Hospital	$146,791,098	0.5673	-0.053%	-0.107%	-$78,454	-$156,909	-$78,454	-$156,909	$146,712,644	$146,634,189	-0.053%	-0.107%
210039	Calvert Memorial Hospital	$57,493,422	0.5756	-0.040%	-0.079%	-$22,839	-$45,677	-$22,839	-$45,677	$57,470,583	$57,447,745	-0.040%	-0.079%
210034	Harbor Hospital Center	$116,221,680	0.5793	-0.034%	-0.067%	-$39,058	-$78,117	-$39,058	-$78,117	$116,182,622	$116,143,563	-0.034%	-0.067%
210029	Johns Hopkins Bayview Medical Center	$248,923,504	0.5963	-0.006%	-0.011%	-$13,693	-$27,386	-$13,693	-$27,386	$248,909,811	$248,896,118	-0.006%	-0.011%
210002	University of Maryland Hospital	$783,335,558	0.6008	0.002%	0.004%	$15,188	$30,376	$11,838	$23,675	$783,347,396	$783,359,233	0.002%	0.003%
210030	Chester River Hospital Center	$26,318,692	0.6017	0.003%	0.007%	$902	$1,804	$703	$1,406	$26,319,395	$26,320,098	0.003%	0.005%
210060	Fort Washington Medical Center	$16,249,592	0.6082	0.014%	0.028%	$2,303	$4,606	$1,795	$3,590	$16,251,387	$16,253,182	0.011%	0.022%
210005	Frederick Memorial Hospital	$170,650,516	0.609	0.015%	0.031%	$26,444	$52,887	$20,611	$41,221	$170,671,127	$170,691,737	0.012%	0.024%
210018	Montgomery General Hospital	$79,741,456	0.6187	0.032%	0.063%	$25,145	$50,289	$19,598	$39,196	$79,761,054	$79,780,652	0.025%	0.049%
210019	Peninsula Regional Medical Center	$219,461,838	0.6188	0.032%	0.063%	$69,565	$139,130	$54,220	$108,440	$219,516,058	$219,570,278	0.025%	0.049%
210027	Western MD Regional Medical Center	$159,433,379	0.6241	0.040%	0.081%	$64,508	$129,015	$50,278	$100,556	$159,483,657	$159,533,935	0.032%	0.063%
210023	Anne Arundel Medical Center	$250,956,754	0.6255	0.043%	0.086%	$107,347	$214,694	$83,668	$167,336	$251,040,422	$251,124,090	0.033%	0.067%
210001	Meritus Hospital	$165,746,592	0.6308	0.052%	0.103%	$85,422	$170,843	$66,579	$133,158	$165,813,171	$165,879,750	0.040%	0.080%
210017	Garrett County Memorial Hospital	$17,951,439	0.6345	0.058%	0.115%	$10,350	$20,700	$8,067	$16,134	$17,959,506	$17,967,573	0.045%	0.090%
210049	Upper Chesapeake Medical Center	$115,418,544	0.6438	0.073%	0.146%	$84,291	$168,581	$65,697	$131,394	$115,484,241	$115,549,938	0.057%	0.114%
210044	Greater Baltimore Medical Center	$184,989,402	0.6457	0.076%	0.152%	$140,909	$281,819	$109,827	$219,654	$185,099,229	$185,209,056	0.059%	0.119%
210007	St. Joseph Medical Center	$180,611,979	0.6463	0.077%	0.154%	$139,367	$278,733	$108,624	$217,249	$180,720,603	$180,829,228	0.060%	0.120%
210016	Washington Adventist Hospital	$155,015,406	0.6517	0.086%	0.172%	$133,455	$266,910	$104,017	$208,033	$155,119,423	$155,223,439	0.067%	0.134%
210004	Holy Cross Hospital	$276,326,064	0.6532	0.089%	0.177%	$244,745	$489,491	$190,758	$381,516	$276,516,822	$276,707,580	0.069%	0.138%
210057	Shady Grove Adventist Hospital	$195,270,023	0.666	0.110%	0.219%	$214,276	$428,553	$167,010	$334,020	$195,437,033	$195,604,043	0.086%	0.171%
210008	Mercy Medical Center	$191,948,526	0.687	0.144%	0.289%	$277,274	$554,549	$216,112	$432,223	$192,164,638	$192,380,749	0.113%	0.225%
210037	Memorial Hospital at Easton	$82,689,144	0.6998	0.166%	0.331%	$136,945	$273,891	$106,737	$213,474	$82,795,881	$82,902,618	0.129%	0.258%
210038	Maryland General Hospital	$105,819,110	0.7008	0.167%	0.335%	$177,001	$354,003	$137,957	$275,915	$105,957,067	$106,095,025	0.130%	0.261%
210033	Carroll Hospital Center	$118,189,180	0.7018	0.169%	0.338%	$199,647	$399,293	$155,607	$311,215	$118,344,787	$118,500,395	0.132%	0.263%
210006	Harford Memorial Hospital	$42,495,040	0.739	0.230%	0.461%	$97,919	$195,837	$76,319	$152,638	$42,571,359	$42,647,678	0.180%	0.359%
210010	Dorchester General Hospital	$28,755,684	0.7679	0.278%	0.556%	$79,999	$159,999	$62,353	$124,705	$28,818,037	$28,880,389	0.217%	0.434%
210009	Johns Hopkins Hospital	$843,010,098	0.8032	0.337%	0.673%	$2,837,275	$5,674,550	$2,211,412	$4,422,825	$845,221,510	$847,432,923	0.262%	0.525%
210028	St. Mary's Hospital	$53,846,970	0.8667	0.442%	0.883%	$237,761	$475,521	$185,314	$370,628	$54,032,284	$54,217,598	0.344%	0.688%
	Statewide Total	$7,401,067,183				$1,192,936	$2,385,872	$0	$0	$7,401,067,183	$7,401,067,183		
		Average Score:	59.96%	**Total rewards**		5,408,037	10,816,073	0.779414	0.779414				
				Total Penalties		-4,215,101	-8,430,202						

Appendix V. MHA MHAC Policy Change Considerations

Maryland
Hospital Association

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Fax: 410-379-8239

DRAFT

MHAC Payment Policy Changes

- Ensure we achieve waiver targets
- Match payment policy metrics to waiver target metrics as closely as possible
- Set targets and reward/penalty in advance—Eliminate scaling
- Straightforward methodology and easy to monitor progress
- Encourage cooperation and sharing of best practices

- Selecting PPCs on which to focus—asking for input from quality
  - Top 10 by dollar amount (Actual number of PPCs x PPC weight) + a few others
  - Sweet spot of high volume combined with high cost and ability to affect change

- Setting statewide targets
  - How much would the state save and how many PPCs would be reduced if all hospitals performed at the 75th percentile (for example) on all of the target PPCs

- Set targets for each hospital
  - Case-mix adjusted
  - May not expect same amount of improvement for each PPC—the improvement rate varies dramatically by PPC
  - Ability to improvement may depend on starting point—coding and documentation practices are highly influential for certain PPCs

- Create stepped or progressive targets tied to progressive earn back amounts

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
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Deputy Director
Research and Methodology

TO: Commissioners

FROM: Legal Department

DATE: December 20, 2013

RE: Hearing and Meeting Schedule

Public Session:

February 5, 2014 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room
March 12, 2014 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room

Please note**,** Commissioner's packets will be available in the Commission's office at 11:45 p.m.

The Agenda for the Executive and Public Sessions will be available, for your review, on the Thursday before the Commission meeting: hscrc.maryland.gov/commission-meetings-2014.cfm

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