STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE

John M. Colmers
Chairman

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

George H. Bone, M.D.

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

Jack C. Keane

Bernadette C. Loftus, M.D.

Thomas R. Mullen

HEALTH SERVICES COST REVIEW COMMISSION
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

Donna Kinzer
Executive Director

Stephen Ports
Principal Deputy Director
Policy and Operations

Gerard J. Schmith
Deputy Director
Hospital Rate Setting

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

505th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
February 5, 2014

EXECUTIVE SESSION
12:00 p.m.

1. **Waiver and Personnel Update**
2. **Update on Hospital Contracting Process**

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 January 8, 2014**

2. **Executive Director's Report**

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

4. **Status of Work Groups for All-Payer Hospital System Modernization**

5. **Docket Status – Cases Closed**

   2238A – Johns Hopkins Health System
   2239A – Johns Hopkins Health System
   2240A – Johns Hopkins Health System

6. **Docket Status – Cases Open**

   2241A – Johns Hopkins Health System
   2242N – UM St. Joseph Medical Center

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

8. **Legislative Update**

9. **Legal Report**

10. **Hearing and Meeting Schedule**

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

AS OF JANUARY 28, 2014

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
2241A	Johns Hopkins Health System	12/30/2013	N/A	N/A	ARM	DNP	OPEN
2242N	UM St. Joseph Medical Center	1/27/2014	2/26/2014	6/26/2014	RDL	CK	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:**	**2051**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2241A**

Staff Recommendation

February 5, 2014

I. INTRODUCTION

Johns Hopkins Health System ("System') filed an application with the HSCRC on December 7, 2013 on behalf of its member hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to combine two currently approved arrangements (proceedings 2182A and 2194A) to provide solid organ and bone marrow transplants services with Cigna Health Corporation. The System requests approval of the revised arrangement for a period of one year beginning February 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 continue to 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 for solid organ transplants was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting 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

Staff found that the experience under the two arrangements for the last year has been favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for participation in an alternative method of rate determination for bone marrow and solid organ transplant services, for a one year period commencing February 1, 2014, and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU"). 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.

HSCRC STAFF RECOMMENDATIONS FOR TRANSITIONAL RATE SETTING POLICIES TO GOVERN THE IMPLEMENTATION OF THE APPROVED ALL-PAYER MODEL EFFECTIVE JANUARY 1, 2014

Health Services Cost Review Commission
4160 Patterson Avenue Baltimore, MD 21215
(410) 764-2605
February 5, 2014

This document contains the staff recommendations for policies to govern the initial implementation of a new All-Payer model, with a requested implementation date of January 1, 2014. These recommendations are ready for Commission action at the February 5, 2014 Public Commission Meeting. Public comments should be sent to Dennis Phelps at the above address or by e-mail at Dennis.Phelps@Maryland.gov. For full consideration, comments must be received by January 24, 2014.

HSCRC STAFF RECOMMENDATIONS FOR TRANSITIONAL RATE SETTING POLICIES TO GOVERN THE IMPLEMENTATION OF THE PROPOSED ALL-PAYER MODEL EFFECTIVE JANUARY 1, 2014

Contents

HSCRC STAFF RECOMMENDATIONS FOR TRANSITIONAL RATE SETTING POLICIES TO GOVERN THE IMPLEMENTATION OF THE PROPOSED ALL-PAYER MODEL EFFECTIVE JANUARY 1, 2014

A. Introduction

The HSCRC expects to implement policy steps, effective January 1, 2014, to transition revenue controls for hospitals in Maryland. These changes are proposed to address the application to the Center for Medicare & Medicaid Innovation (CMMI), filed on October 11, 2013, that was approved on January 10, 2014. The resulting All-Payer Model introduces a new approach into the Maryland hospital payment system and the broader health care environment. Specifically, it establishes a framework in which the revenue controls operated by the HSCRC shift from the current focus on controlling increases in revenue per inpatient case and per outpatient service to a focus on controlling increases in total hospital revenues within an all-payer cap, to generate savings for the Medicare program and to achieve a range of improvements in quality and outcomes.

The new All-Payer Model ("the Model") approved by CMMI builds upon decades of innovation and equity in health care payment and delivery in Maryland by modernizing our all payer rate setting system for hospital services.
The plan includes:

- **A five year model** focused on improving health care quality, delivery of services, and the affordability of health care.
- **A new approach to Maryland's all-payer hospital system,** that moves from the current statutory waiver based on Medicare payment per admission to a new all-payer hospital payment model that focuses on overall hospital expenditures per capita.
- **Strong incentives for better outcomes at lower cost** by shifting away from fee-for-service reimbursement to models that reward hospitals when care is high quality and fewer admissions are needed.
- **Improved quality**, including substantial reductions in hospital readmissions and potentially preventable complications.
- **Controls on costs**, including an annual limit on the total increase in gross revenue per capita based on the 10-year average growth in the State's economy and at least $330 million in savings over five years to Medicare.

The Model is designed in conjunction with a number of other efforts currently underway in Maryland, including efforts to strengthen primary care, map and track preventable disease and health costs, develop public-private coalitions for improved health outcomes, establish health enterprise zones, and enroll Marylanders in health coverage through Maryland Health Connection. The application is available on the Department of Health and Mental Hygiene website at:
http://dhmh.maryland.gov/SitePages/Medicare%20Waiver%20Modernization.aspx

The purpose of this document is to provide the HSCRC staff's draft recommendations for rate setting policies to govern the initial implementation of the All-Payer model, which begins January 1, 2014. These policies support the transition from the current focus on charge per case and outpatient unit of service revenue controls, and on efforts to limit the growth in Medicare payments per inpatient case, to a new All-Payer model that is designed to control the growth of overall hospital expenditures on a per capita basis and to achieve important improvements in quality, population health, and other measures of care. These recommendations, which may be modified, are proposed for action by the Commission at the public meeting on February 5, 2014.

B. Initial Implementation Steps of New Model Framework and Stakeholder Input Process

The most immediate effort required of the HSCRC to implement the new rate setting framework is the establishment of rate setting policies that will govern the transition from the existing rate setting system to the new Model with a proposed effective date of January 1, 2014. The remainder of this document identifies, describes and discusses the key components of the rate setting strategy recommended by HSCRC staff to the Commission to begin the initial implementation and transition.

The HSCRC established and commenced public meetings of an Advisory Council that was asked provide input on broad policy issues that must be addressed to implement the All-Payer Model. In addition, the HSCRC will establish a number of Work Groups that will provide technical assistance on topics identified by the HSCRC. The Commission acknowledges the need and recommends including consumer members on these Work Groups, and for those Work Groups, particularly as it relates to the performance measurement, to consider making the system and its methodologies, to the extent practicable, more accessible and transparent to patients and consumers. The membership of the Advisory Council is currently available on the Commission's website and the Work Groups will be announced soon, and all meetings to be held by these bodies will be posted on the HSCRC website and will be open to the public. Additionally, the HSCRC solicited a number of "White Papers" focused on specific rate setting policy issues, technical problems and other subjects to support the efforts of the HSCRC, the Advisory Council and the Work Groups. The White Papers that are submitted will be available on the HSCRC web site. All interested persons were invited to submit these papers.

C. The New Maryland Model: Cost, Quality, and Outcome Goals and Requirements

The proposed new All-Payer Model establishes a highly progressive hospital financing system that will include specific performance requirements on total per capita hospital revenue growth, Medicare savings and improvements in quality, health, and outcomes. The new All-Payer Model will transform the hospital economic environment by shifting it away from the traditional set of volume-based, fee-for-service (FFS)

driven payment incentives to a value-based system that will focus on improving care and reducing costs on a population-wide basis.

The All Payer Model has overall requirements and goals in two primary areas of focus outlined below.

1. Revenue Increase Ceiling for All-Payer Hospital Revenues and a Savings Requirement for Medicare

The All-Payer Model establishes a "hard revenue cap" covering all payers, which is based on the allowable per capita growth rate in total hospital revenues and an allowance for population growth in Maryland. It also establishes a requirement that savings of at least $330 million be generated for the Medicare program during the five year term of the new program. Under the terms of the revised application, Maryland would commit to expenditure controls, with highly specific performance measures, on two levels:

- ***The All-Payer Revenue Growth Rate:*** Under the Model, the annual growth rate in total per capita hospital revenues must not exceed 3.58% per year for CY 2014 through CY 2016 for residents of Maryland served in Maryland hospitals. The 3.58% maximum allowed growth rate is based on a ten year compound average per capita rate of growth in the Maryland Gross State Product (GSP). In CY 2017 and 2018, the growth rate ceiling would remain the same, unless it were changed based on an updated calculation of GSP that incorporates the most recent ten year period.

- ***Medicare Savings:*** The Model includes a Medicare-specific savings requirement. The rate of growth in Medicare's per capita hospital expenditures for Medicare beneficiaries who reside in Maryland must be less than the national average growth rate in Medicare expenditures per beneficiary by at least $330 million over the CY 2014 through CY 2018 period. In CYs 2014 and 2015, the All-Payer Limit would allow total hospital revenue per Maryland resident to increase by up to 3.58%. In contrast, CMS is projecting that national Medicare hospital payments per beneficiary will increase by approximately 1.9% in CY 2014 and by 1.6% in CY 2015. Recent historical growth rates in Medicare payments per beneficiary have been lower than the growth rates of all payer expenditures per capita, both nationally and in Maryland, due to different dynamics affecting Medicare spending. Therefore, the savings requirement for Medicare will necessitate policy changes and close monitoring to ensure that the requirements are met.

  The application states that all parties believe that the Medicare savings requirements can be achieved without a change in the payer differential, but focused efforts will be needed to achieve this outcome given the lower national rate of increase in Medicare payments per beneficiary projected in the next several years and the savings that Maryland must achieve relative to the national trend. Since Medicare utilization is generally "unmanaged" as compared with many other payers in Maryland, this result can be achieved, in part, with effective care delivery improvements focused on reducing avoidable utilization. The HSCRC intends to introduce a number of new policies and measures to ensure that interventions linked to quality and care

improvement are achieving the required savings and care improvements. For example, Medicare readmissions in Maryland are high, and the HSCRC staff may propose specific policies that would augment the general readmissions reduction program in ways that would produce differentially large Medicare improvements. The lower projected national rate of increase for Medicare is influenced by the reduction in payments to Disproportionate Share Hospitals (DSH), particularly in 2015. Therefore, the HSCRC will need to pay attention to the timing of rate changes for reductions in uncompensated care that might occur from expansion of coverage under Medicaid. This is particularly important given that the Medicare reductions are more or less certain whereas the reductions in uncompensated care in Maryland are not.

2. Quality and Outcome Requirements

The Model provides for a broad array of patient-centered and population-based measures of care and outcomes along with a set of related performance improvement requirements. The measures include all of the existing components of the Maryland Hospital Acquired Conditions (MHAC) program, the Quality Based Reimbursement (QBR) program, readmissions, and a number of other measures of population health and preventive care. The HSCRC will collect, report, and monitor a wide variety of data streams to ensure that the improvements that are required under the Proposal are being achieved on a timely basis. The application also outlines requirements for linking payment and quality that will need to be addressed by HSCRC on an ongoing basis.

In combination, the All-Payer Revenue Limit, the required Medicare savings and the improvements in patient-centered and population-based measures of care and outcomes form the core elements of the approved All-Payer Model.

D. HSCRC Staff Recommendations for Transitional Rate Setting Policies

This section describes the core elements of the transitional approach to rate setting in Maryland recommended by HSCRC staff:

1. The All-Payer Revenue Limit

The HSCRC staff proposes to use the methodology that is presented below to calculate and administer the All-Payer Limit on revenue growth from January 1, 2014 through June 30, 2014. On July 1, 2014, the HSCRC will provide an update to cover the second half of CY 2014.

The All-Payer Limit on revenue increases would be calculated as follows:

The Base Period (BP) revenue will be the total hospital revenue for the calendar year (CY) ending December 31, 2013.

a. CY 2013 total revenue will not be available until sometime into CY 2014. Therefore, the HSCRC will use the total revenue from the period January 1 through June 30, 2013, with

certain adjustments, as the Base Period revenue to guide its monitoring of the maximum revenue growth ceiling for the first six months of CY 2014. After it obtains the final total hospital revenue amount for CY 2013, the HSCRC will adjust the calculations, if necessary, to take into account the effects of seasonality or other factors in allocating the revenue between the first half and second half of the year.

b. The Base Period all payer total revenue will be separated into two categories—specifically, the total revenue that was associated with Maryland residents and the total revenue that was associated with non-Maryland residents. The All Payer revenue ceiling will be applied to the revenue associated with Maryland residents and will not be applied to the revenue associated with patients who were not residents of Maryland. (Rates for non-residents will be consistent with rates for residents, and the HSCRC's quality policies will apply to all patients.)

c. The All-Payer Base Period revenue for residents will be multiplied by 1.00 plus the growth rate ceiling of 3.58% and the population growth estimates obtained from the Department of State Planning.

d. This resulting maximum revenue ceiling will be used to ensure that the requirements of the model are being met and that the ceiling is not exceeded.

e. A calculation will be performed to compute the rate of growth in Medicare expenditures per beneficiary, using data that will be provided by CMS, and to determine whether the required Medicare savings are being achieved on a timely basis. This calculation is different than the calculation illustrated below, as it compares Maryland's rate of growth to the national rate of growth, rather than comparing the growth to a ceiling.

The calculations involved in the determination of the All Payer Limit for the January through June, 2014 period are illustrated below:

		Illustrative Figures
L. 1	Adjusted Base (1/1/2013 Through 6/30/2013)[1]	$7.5 billion
	Less:	
L. 2	Revenue for Non-Residents	$0.6 billion
L. 3	Net Base Revenue (L1 – L2)	$6.9 billion
L. 4	Revenue Growth Ceiling Factor	1.0358

[1] When final revenue and utilization is available for CY 2013, the HSCRC staff will make adjustments to the All Payer Limit for the 1/1/14 through 6/30/14 period as necessary, considering seasonality and price leveling of the base period for rate changes during the year (see 1.a. above).

L. 5	Equals Revenue Ceiling Prior to Population Adjustment (= L3 x L4)	$7.15 billion
L. 6	Population Growth Factor (Estimated)	1.0060
L. 7	**Revenue Ceiling for Maryland Residents For January 1 through June 30, 2014 (= L5 x L6)**	**$7.19 billion**

This All Payer Limit would be applied to hospital revenue for residents of Maryland. The revenue associated with non-resident revenue would be subject to HSCRC rate regulations but would not be included under the All Payer Limit. The calculations would be used to establish the All Payer Limit, to monitor performance under it and to identify and administer corrections that would be needed if the evidence accumulated suggests that the revenue ceiling is being exceeded.

2. Movement to Global Budgets

Over the course of the first five year term, the application proposes to migrate increasing proportions of approved hospital revenue to population-based or "global" approaches, with a goal of shifting virtually all hospital revenue into these models by the end of the 5 year period. Under the new system, a population-based or "global" model is defined as either a model under which a hospital's allowed revenue is explicitly tied to a defined population and its service needs (i.e., a "population-based" budget), or a model in which a hospital's revenue is fixed for a given period of time (e.g., an upcoming rate year), based not on explicit links to a specific population, but on its previously approved budget trended forward.

The movement to global budgets, which is at the center of the proposed Model, is meant to facilitate the conversion of the hospital economic environment from one that makes revenue and profitability dependent on utilization levels to one that provides hospitals with a financial model and opportunities to: (1) improve care and outcomes and to eliminate avoidable volume; (2) provide care in the most appropriate settings; (3) reduce the need for readmissions; (4) increase prevention efforts in combination with physicians and health agencies; and (5) promote overall improvements in population health status. Under global budgets, hospitals will be able to focus on generating needed, high quality, and cost-efficient services that are at the core of patient-centered-care. Hospitals with global budgets will be able to apply the resources that are freed by the elimination of avoidable volume to activities that will promote the goals of better care, better health, and lower costs.

Finally, the use of global budgets for an increasing number of hospitals will begin to align the incentives of hospitals with the goals and objectives for greater affordability and improved health, which are likewise the goals of emerging physician delivery models such as Primary Care Medical Homes (PCMHs) and Accountable Care Organizations (ACOs) as well as major payers, employers and many other organizations. Hospitals that operate under global budgets will not be vulnerable to the volume-reducing efforts of such organizations because their budgets will not be dependent on utilization levels.

Global budget hospitals will be able to work with these various other entities to lower cost and improve care without destabilizing their own finances.

Given the above policy considerations, and the prescribed movement to global models that is prescribed by the application, the HSCRC staff recommends that the HSCRC transition hospitals in Maryland to the new rate setting environment by allowing them to choose either of two options for January 1, 2014:

- *Transition to a global budget* model under the framework already approved and used in Total Patient Revenue agreements. The revenue that would be covered by the global budgets would be the total allowed revenues for residents of Maryland for all included services or service areas; or

- *Continue to use the charge-per-case/episode structure that is currently in place with two important modifications:*

  - The Variable Cost Factor (VCF) of 85% that is currently applied to most volume changes will be reduced from eighty-five percent (85%) to fifty percent (50%) and the volume adjustment will be made on a concurrent basis (i.e., during the year in which the volume change occurs).
  - A Volume Governor (similar to the existing case mix governor) will be applied to reduce allowed revenue if actual volume increases exceed the levels built into the revenue limit for these hospitals.

Thus, hospitals that elect to go onto global budgets effective January 1, 2014 will move from a system that is volume-dependent to one that is value-dependent and will have the flexibility to use their agreed-on budgets in ways that they believe are most compatible with the health care needs of their patients and their communities. Hospitals that elect to remain on the existing charge-per-case (CPC)/episode of care methodology, with the important volume adjustment modifications described above, would be collectively at risk (with the other hospitals that opt for the modified CPC/episode of care methodology) for any rate adjustments that need to be made to recapture the revenue associated with their combined excess volume levels.

3. The Global Budget Option January 1, 2014

The Global Budget option that will be offered to hospitals for January 1, 2014, which may be further refined, will be supportive of the general commitment that Maryland is making to population-based health management with a focus on affordability, better quality and outcomes, and improved overall health status.

As previously stated, the basic approach that would be used for the Global Budgets would be based upon the framework used for the Total Patient Revenue arrangements that are already in place as follows:

a. Approved revenue would be established for the Base Period.

b. A one-time adjustment, if needed, would be provided to assist adopters of the Global Budget approach to establish the infrastructure needed to manage on a global budget basis.

c. The approved revenue would be adjusted to include an allowance for population driven volume increases for the upcoming year.

d. Other adjustments may be made as needed including:

- Quality-based or efficiency based rewards, penalties, or scaling then applicable to global budget hospitals would be applied. These adjustments currently include the Commission's Quality-Based Reimbursement and Maryland Hospital Acquired Conditions;
- The payer differential would be adjusted to reflect changes in the mix of payers, changes in approved differential amounts and changes in uncompensated care levels;
- Any savings adjustments, such as the readmissions savings requirement, would be applied;
- One-time adjustments would be applied/reversed as appropriate; and
- Other adjustments may be applied

e. Approved revenue may also be modified for:

- Shifts to unregulated settings: Some services may be offered more effectively in an unregulated setting. When services are shifted to an unregulated setting, HSCRC staff will work with the hospital to calculate and apply a reduction for an appropriate portion of the Hospital's approved revenue designed to assure a savings to the public.
- Service level and market share changes: Approved revenues may be adjusted for changes in service levels (e.g., closure of a program) or due to market share changes.

f. Once established, the revenue base would be increased for update factors approved by the Commission.

The HSCRC expects to include requirements for readmission and MHAC reductions as well as other care delivery improvements. Policies relative to efficiency in the context of population-based concepts, market share calculations, demographic models, adjustments for avoidable volumes, and other policies will be further addressed and refined by Work Groups established by HSCRC.

4. The Modified CPC/Episode of Care Option

Hospitals that are not prepared or do not desire to move to a Global Budget Model will be able to choose to remain on the existing CPC/Episode of care rate setting methodologies inclusive of the reduction of the

Variable Cost Factor (VCF) from 85% to 50%, and the use of a Volume Governor, which are described in Section D-2. Hospitals choosing this modified existing system will be subject to the same rate settlements, quality measurements and performance requirements and Medicare savings requirements that are applied to the hospitals that choose to accept global budgets. Some hospitals may elect to include a portion of their revenues in a Global Budget Model but exclude certain categories of revenues. Any revenue excluded from the Global Budget Model that is for Maryland residents will be subject to the revised volume policies that are focused on assuring that revenues are maintained within the limits of the new All-Payer Model. The CPC/Episode methodology and the new volume policies will be applied to the revenue for Maryland residents (which is the revenue that is limited under the new All-Payer model ceiling) that is not under a Global Budget Model. Revenue for non-residents (which is not subject to the limits of the new All-Payer model ceiling) will be charged the same rates as residents and subject to the MHAC, QBR, readmission and other policies of the HSCRC. However, the HSCRC staff proposes to exclude non-residents from the volume policies.

a. The Rationale for the VCF Reduction

The current VCF of 85% has generally been acknowledged to provide marginal revenues that typically substantially exceed marginal costs for most volume increases. The profitability of volume increases has encouraged hospitals to provide additional services. This incentive has been augmented by the FFS incentives that continue to drive most physician payment arrangements. At the same time, the 85% VCF has discouraged reductions in avoidable volumes, because hospital fixed costs associated with volume reductions usually greatly exceed the 15% that the current rate setting methodology permits hospitals to retain in their revenue base when volumes decline. By removing 85% of the revenue associated with volume reductions, the current VCF formula strips hospitals of funds that they could use to finance the intervention efforts required to achieve care model changes that will reduce avoidable utilization.

The desirable shift to population-based management that is central to the new All-Payer Model proposal requires an adjustment in the financial incentives that apply to hospital volume changes. The global budget option will discourage volume increases that are not driven by underlying service needs and population changes and will encourage hospitals to reduce avoidable utilization and to use the related savings to invest in other, more productive activities. It is necessary to ensure that those hospitals that do not choose the global budget option also face appropriate volume incentives so that volume increases at the hospitals that choose the modified CPC/episode of care option do not exceed the levels that are affordable within the All Payer Limit and the Medicare savings requirements.

In addition, all of the hospitals (i.e., those that choose Option 1 or Option 2) will be subject to the numerous quality-based performance requirements that are contained in the new All Payer model. The proposed modifications to the VCF will be supportive of these efforts.

The HSCRC used a 50% VCF for many years. The existence of substantial opportunities to reduce the level of hospital utilization in Maryland, which has relatively high hospital use rates, is supported by a well-established body of health services literature. Global budgets and a VCF of 50%—which is much less punitive than the existing 85% in regard to volume declines, and will discourage unnecessary volume

increases—will be supportive of efforts by hospitals to work with PCMHs, ACOs and other entities to improve quality, efficiency, and health status levels.

b. Calculation and Application of the Revised Variable Cost Factor

Currently, the VCF adjustment is calculated at the time of the annual update process, with the impact deferred until the subsequent rate year. Under current policies, the hospital keeps or loses one hundred percent of the revenues due to volume changes during the rate year. In the following year, the HSCRC builds 85% of the additional revenue charged for the incremental volume growth into the hospital's permanent rate base or, conversely, it removes 85% of the revenue associated with any volume decline from the hospital's permanent rate base.

Under the proposed policy, a hospital that elects to be covered for part or all of its services by the modified CPC/episode of care rate setting model (including the related inpatient and outpatient revenues that are not part of the CPC/episode but are subject to a volume adjustment) will keep or lose fifty percent (50%) of the revenues associated with its volume change during the rate year for volumes included under the All-Payer Model (i.e., the volumes for residents of Maryland). Specifically, hospitals will be directed to apply the volume adjustment to their charges during the rate year to minimize retroactive rate settlements. Any under (or over) recovery of such revenues by hospitals will be treated as a one-time adjustment to be settled at the same time as other rate updates.

After January 1, 2014, The HSCRC staff will work with hospitals, payers, and other parties to develop appropriate policies on the following VCF-related topics:

- The establishment of appropriate charge compliance corridors to supplement this policy;
- The methods for exclusion of out-of-state volumes;
- The parameters and effect of the exemption of the new Germantown hospital from volume policies; and
- The calculation and application of the Case Mix and Volume Governors

Currently, under the charge per case rate setting system, the HSCRC uses a case mix governor to provide an overall constraint on revenue growth that is associated with case mix increases. The HSCRC sets a policy at the beginning of the year to establish a maximum amount of allowable case mix growth for the upcoming rate year. This case mix governor approach will be maintained for cases within the All-Payer Revenue limit (i.e., for cases that involve Maryland residents) that are covered by the CPC/Episode of Care method rather than by a global model. The case mix governor limit that is currently in place is a zero percent allowance for overall case mix growth for the first six months of FY 2014.

The HSCRC staff proposes to establish a volume governor and to apply it in a way that is similar to the way in which the case mix governor is applied, while noting that only those hospitals and services that are

not included in a Global Budget model will be included in calculating the volume governor. The HSCRC staff proposes to establish a maximum volume growth of 2.0%, inclusive of case mix, in hospitals that elect the CPC/episode of care option. A 2% governor could be increased up to 2.5%[2] if hospitals electing CPC were located in higher than average population growth areas. The case mix governor will be applied before the volume governor is applied.

Under the CPC/episode of care system, case mix growth is treated as volume growth. Recent data suggest that there is continued movement between inpatient and outpatient settings, partly because of the Medicare two day limits, and this movement is likely to increase with reductions in avoidable volume levels. Therefore, the HSCRC staff is proposing a case mix governor of 0.5% for the January 1 through June 30, 2014 period. HSCRC staff notes that unlike the current case mix governor that uses cases from all hospitals statewide, the calculation would use only the case mix change that occured in those revenues that remain outside of Global Budget arrangements. The overall maximum allowed volume increase of 2.0% for the hospitals that elect the modified CPC/episode of care model for this period will be established in the steps outlined in general below.

- In Step One, the HSCRC staff will multiply the actual volumes for residents of Maryland of the applicable hospitals for the January 1, 2013 through June 30, 2013[3] period by the hospitals' approved rates for FY 2014.

- In Step Two, the HSCRC staff will compute actual volumes at approved rates for services to Maryland residents treated in the January 1, 2014 through June 30, 2014.

- In Step Three, the current approved revenue at actual volumes computed in Step 2 will be divided by base volumes at approved rates calculated in Step 1.

- In Step Four, the HSCRC staff will reduce the ratio computed in Step Three by the proportion of the hospitals' revenues attributable to case mix increases disallowed by the case mix governor. If this calculation—which will be performed in the aggregate for all of the hospitals that elect the CPC/episode of care system—yields a ratio that exceeds 1.02, the volume governor will be applied in a manner that will hold the hospitals covered by it that have volume increases collectively accountable for the excess volume. The VCF of 50% will be in effect, so that 1% would be the maximum additional revenue that would be available to hospitals under the modified CPC/episode of care option after application of the proposed volume governor.

The HSCRC staff intends to calculate volume variances on a monthly basis. The staff may apply the volume governor on an interim basis during any particular rate period if it determines that volumes in the

[2] The estimated utilization allowance resulting from demographic changes for the hospitals included under the CPC would be calculated in the same manner as those used for global budget hospitals. If the estimated demographic changes for the CPC hospitals were higher than the state average, the population related portion of the governor would be increased proportionately.

[3] The volume levels for this calculation would be reduced if final base year volumes for calendar 2013 were lower than volumes experienced in the first half of the calendar year after giving consideration to seasonality.

CPC/episode of care hospitals are causing those hospitals to exceed the prescribed revenue limits. These adjustments might occur on a quarterly or semi-annual basis if deemed necessary by the HSCRC staff. Otherwise, the volume governor would be applied at the end of the rate period.

The HSCRC staff will be alert to shifts in volume from hospitals on global budgets to hospitals on the CPC/episode of care system (or vice versa) and may adjust the volume governor that is applicable to the CPC/episode of care hospitals. These shifts, and the appropriate methods of identifying and adjusting for them, will be a topic for discussion by the relevant Work Groups.

HSCRC staff expects the opening of the new hospital in Germantown, Maryland in fall 2014, and that development will necessitate some exceptions to the proposed VCF and volume governor policies for revenues under the All Payer Limit. The HSCRC staff intends to calculate the impact of this new hospital on the revenue limits and proposes to adjust update factors, market shares, volume policies, demographic assumptions as applied to global revenue budgets, and any other appropriate factors to accommodate the projected volume growth attributable to this new hospital. The HSCRC staff will propose specific methods for this adjustment before July 1, 2014.

Although HSCRC staff has recommended the exclusion of out-of-state volume changes from the VCF and volume governor policies, rates for these patients will remain regulated and subject to all quality policies and policies regarding avoidable utilization. While in migration and outmigration levels have been stable historically, HSCRC staff will be alert to changes in volume levels. Excessive decreases in out-of-state patients could result in increased rates to in-state residents, particularly in global budget models where these volumes may not be explicitly excluded. Excessive increases in out-of-state volumes could be concerning if savings from reducing avoidable volumes of Maryland patients were used to promote volume growth outside of Maryland rather than being redeployed into population health improvement. Both of these dynamics will be monitored and the HSCRC will develop policy changes as needed.

E. HSCRC Staff Recommendations for the Recovery of Revenue Overages

The HSCRC intends to establish the global budgets and the CPC/episode of care rates and volume governor in a conservative manner in order to increase the likelihood that Maryland will meet the All Payer Limit. The HSCRC staff will closely monitor hospital revenue levels and growth rates during each year to minimize the possibility of any inadvertent revenue overages. The HSCRC will also increase its efforts to enforce price compliance, since overcharges could result in overages. If, despite these precautions, the All Payer Limit were not met, the HSCRC staff proposes to make an adjustment to revenue as follows:

- If, during the six month transitional period from January 1 through June 30, 2014, Maryland were to exceed the allowed 3.58% revenue growth rate, and corrections become necessary, the HSCRC would recover these costs according to the following approach:

- These costs might be assessed proportionately across hospitals in Maryland based on approved revenues; or

- The update factor at July 1, 2014 might be adjusted based on the correction factor required to achieve compliance within the ceiling by calendar year end.

- A revised overage policy may result from Work Group activities and future recommendations for consideration by the HSCRC.

F. Enhanced Monitoring Activities

The HSCRC staff has worked with the hospital community to develop several changes in hospital data submissions, which will enable us to perform more accurate and timely performance monitoring of the All Payer Limit, the Medicare savings requirements, and the quality, outcomes, and care coordination improvements that are prescribed in the revised application. These changes in hospital data submissions, which will apply to all hospitals, include:

- Expanded use of a real time information exchange capability with CRISP (the State's Health Information Exchange entity) that will now include most outpatient encounters in addition to inpatient admissions and emergency encounters;

- Monthly case mix data submissions, which will build on the quarterly submissions that cover all hospital services; and

- Enhanced monthly financial submissions to facilitate more timely monitoring of the All Payer Limit for Maryland residents, growth in Medicare revenue, and the impact of the modified volume policies of the HSCRC.

The HSCRC staff will work with payers and hospitals to develop and implement additional monitoring approaches and tools to ensure that the requirements and goals of the Model are being met.

G. Settlements of Prior Rate Adjustments

During the June 2013 public meeting, the HSCRC approved an expedited rate order process effective July 1, 2013. Under this policy, the HSCRC deferred the settlement adjustments for the FY 2013 year ended June 30, 2013 until January 1, 2014. These adjustments will be incorporated into the January 1, 2014 rate approval process. Preliminary estimates indicate that these adjustments will not result in a net increase in revenue and will therefore not need to be considered in administering the revenue limit through June 30, 2014. In addition, settlement adjustments that result from the July 1, 2013 to December 31, 2013 period will be settled on July 1, 2014 or thereafter.

H. Uncompensated Care Adjustments and Other Expected Changes Resulting from the Affordable Care Act

Effective January 1, 2014 there was an increase in the number of Medicaid enrollees and an increase in the number of Marylanders with insurance coverage obtained through the Exchange. These increases will require adjustments to the projected levels of uncompensated care in Maryland hospitals.

The HSCRC staff intends to use a combination of hospital discharge data and the CRISP Master Patient Index to estimate the reduction in uncompensated care levels due to the expansion in Medicaid enrollment, and expects to consider an adjustment to rates for these enrollees on July 1, 2014. At the same time, the HSCRC staff notes that there was an increase in uncompensated care during FY 2013 that has not yet been reflected in hospital rates that could have the effect of offsetting the reduction that would otherwise be expected from the expansion in access under Medicaid. CMS will be reducing hospital rates for Medicare patients for DSH payments in other states during this timeframe. It will be important to consider the timing of the reduction for uncompensated care in Maryland because of the potential need to match the timing of DSH reductions. Estimating the impact of the Exchange on bad debts will be more complicated. The HSCRC staff will monitor changes that occur in bad debts from this new enrollment. Some of the new policies under the Exchange have high deductibles, and disenrollment may also occur as policy prices increase for some current enrollees. The HSCRC staff will continue to monitor activity levels and report back to the HSCRC by July 2014 with an estimate of the likely impact of these developments.

It is possible that newly enrolled Medicaid patients or Exchange patients will increase their utilization of hospital services. Although the recent research and projections do not project these increases, the HSCRC staff will focus utilization levels through the use of CRISP IDs, HSCRC case mix data and policy information from Medicaid and the Exchange (if available) in its evaluation of possible volume effects. The HSCRC staff will provide a preliminary analysis of this issue by December 31, 2014 and a final analysis by December 31, 2015.

The HSCRC will need to develop a revised policy for predicting uncompensated care levels as input to a revised policy for its uncompensated care pool including funding the pool and making payments from the pool. The HSCRC currently uses a three year average of uncompensated care experience for its policy analysis. This approach may not be appropriate given the significant changes that are expected to occur with the health insurance expansions under the Affordable Care Act. The HSCRC will invite the submission of White Papers and analyses by hospitals, payers, and other parties on the model that should be used for uncompensated care and the methods that should be employed to project bad debts after July 1, 2014. In particular, the HSCRC staff would like to examine the impact on uncompensated care levels that may be associated with individuals who do not qualify for Medicaid or Exchange policies, such as

uninsured immigrants, as well as other factors that may contribute to changes in uncompensated care levels in particular communities.

I. Summary

This document describes the key tasks that are posed for the Maryland rate setting system by the revised application that has been approved by CMS/CMMI for implementation for an initial five year period beginning on January 1, 2014. The Proposal establishes an All Payer Limit on hospital revenue growth per capita; it requires Maryland to produce Medicare savings of at least $330 million, relative to the national average rate of increase in Medicare payments per beneficiary, over the five year period; and it specifies quality, outcomes, and care coordination results that must be measured and achieved.

The HSCRC staff recommendations contained herein are directed primarily at the transitional period that begins on January 1, 2014 and continue through June 30, 2014. Staff proposes that the HSCRC offer hospitals a choice between two budget options: a global budget or a modified CPC/episode of care methodology with a reduced variable cost factor and a volume governor that would be designed to ensure that volume increases at hospitals that do not elect the global budget option do not exceed the level that can be accommodated within the All Payer Limit and the HSCRC policies.

The global budgets and the modified volume policies for CPC/episode of care methodologies and other revenues excluded from global budgets are both directed at the objective of assuring that the revenue removing the financial incentives that have encouraged excessive volume growth and have discouraged hospitals from reducing their levels of avoidable volumes or marginal services. Both of these models—particularly the global budget approach—encourage avoidable volume decreases and redeployment of the savings that result from these reductions into other activities designed to promote better health care for individuals, higher levels of overall population health, and improved health care affordability.

Specifically, staff makes the following recommendations:

1. Transition hospitals in Maryland to the new rate setting environment by allowing them to choose either of two options for January 1, 2014:
    - *Transition to a global budget* model under the framework already approved and used in Total Patient Revenue agreements. The revenue that would be covered by the global budgets would be the total allowed revenues for residents of Maryland for all included services or service areas; or

    - Continue to use the charge-per-case/episode structure that is currently in place with two important modifications:

- The Variable Cost Factor (VCF) of 85% that is currently applied to most volume changes will be reduced from eighty-five percent (85%) to fifty percent (50%) and the volume adjustment will be made on a concurrent basis (i.e., during the year in which the volume change occurs).
- A Volume Governor (similar to the existing case mix governor) will be applied to reduce allowed revenue if actual volume increases exceed the levels built into the revenue limit for these hospitals.

2. Establish a maximum volume growth of 2.0%, inclusive of case mix, in hospitals that elect the CPC/episode of care option. A 2% governor could be increased up to 2.5%[4] if hospitals electing CPC were located in higher than average population growth areas. Impose case mix governor of 0.5% for the January 1 through June 30, 2014 period.

3. Make an adjustment to revenue for overages as follows:

   - If, during the six month transitional period from January 1 through June 30, 2014, Maryland were to exceed the allowed 3.58% revenue growth rate, and corrections become necessary, the HSCRC would recover these costs according to the following approach:

     - These costs might be assessed proportionately across hospitals in Maryland based on approved revenues; or
     - The update factor at July 1, 2014 might be adjusted based on the correction factor required to achieve compliance within the ceiling by calendar year end.

   - A revised overage policy may result from Work Group activities and future recommendations for consideration by the HSCRC.

[4] The estimated utilization allowance resulting from demographic changes for the hospitals included under the CPC would be calculated in the same manner as those used for global budget hospitals. If the estimated demographic changes for the CPC hospitals were higher than the state average, the population related portion of the governor would be increased proportionately.

Chet Burrell
President and Chief Executive Officer

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

January 27, 2014

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

Re: HSCRC Staff Recommendation for Transitional Rate Setting Policies

Dear Chairman Colmers,

CareFirst is strongly supportive of the staff's recommendation including the proposed policy whereby hospitals would be given a choice between two rate setting systems, a modified Charge per Case (CPC) system or a Global Model; the rates under each system would be set conservatively to ensure compliance with the waiver tests, and the Global Model would mirror the current Total Patient Revenue (TPR) arrangement. However, we also seek some additional clarification regarding the points identified below.

1. **Hospital Specific Population-based Volume Adjustments.** The recommendation does a very good job of outlining a short-term process and necessary policy changes to prepare for the CMS waiver model during the transitional period between January 1, 2014 and June 30, 2014.

   In addition, it addresses longer-term processes for establishing the rate setting policies necessary for the Maryland system to perform successfully under both the all-payer and the Medicare-specific per capita limitations. It clearly articulates the need to transform the incentives in the rate system away from a volume-based model, where increases in hospital service use result in increased profitability, to one that discourages unnecessary volumes and instead supports hospital activities aimed at improving care and reducing cost on a population-wide basis.

   CareFirst supports the use of a 50% VCF, both retroactively and prospectively, along with a volume governor to meet the waiver test requirements. While we believe the volume target of 2.0% - 2.5% appears, on its face, to be high, the Staff has incorporated safeguards to ensure compliance with the all-payer target.

   Beyond the transitional period, we believe that the Volume Governor should be tied to the projected aggregate demographics, adjusted up or down, for CPC hospitals based on the demography of the regions *(or counties)* in which they operate. We have submitted a White Paper that articulates this position.

2. **Care Migration from Regulatory to Non-Regulatory Settings**. The recommendation recognizes the need to align the incentives of hospitals with physicians and other providers operating under the incentives of various "shared-savings programs" (SSPs) in the State *(such as the existing and planned PCMH programs and ACO organizations).* We believe this to be a critical factor in successfully achieving Medicare's three part aim and ultimately providing the basis to encourage hospitals and physicians to treat patients in the appropriate care settings. We also support the staff's intention to tie a hospital's reimbursement levels to its quality performance.

   The Staff recommendation acknowledges that directing cases out of the regulatory system could impact overall costs and recognizes the need for monitoring and potentially adjusting regulated revenues. Staff has begun development of policies directed at Market Share changes between hospitals, which we support. We have submitted a White Paper to propose a methodology for calculating Market Share changes. In addition, we would suggest that the HSCRC develop a policy to account for volumes directed out of the regulatory system in alternative care settings.

3. **Dual All-Payer and CMS Targets**. While the recommendation emphasizes the key issues, it does not fully explain and provide the path to achieve both the all-payer and CMS targets. There are safeguards inherent in the methodology to achieve the all-payer target, but not so for the CMS target. That is somewhat troublesome to CareFirst since failure to meet the CMS target, while achieving the all-payer target, could result in a change to the differential.

   The staff recommendation rightly notes that Medicare utilization of services is relatively unmanaged and the differential reductions in Medicare claims "can be achieved, in part, with effective care delivery improvements focused on reducing avoidable utilization." However we would suggest that the technical work groups address achievement of both dual targets as one of their primary objectives and deliverables and provide more specifics as to utilization controls on the Medicare population.

CareFirst believes that the close monitoring of financial and performance data, on a timely basis, is essential to the success of the program. We have submitted another White Paper to provide our input in improving this process and stand ready to assist Staff, as necessary.

Overall, we believe the staff's recommendation does a good job developing the framework and identifying the policies necessary to allow Maryland to succeed under the new model, but think the recommendation would be stronger if the three highlighted points above were developed more fully.

Thank you for this opportunity to provide comments on these critical issues.

Sincerely,

Chet Burrell
President & CEO

January 24, 2014

Dennis Phelps
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
Dennis.Phelps@Maryland.gov

Dear Mr. Phelps:

The Maryland Women's Coalition for Health Care Reform (Coalition), an alliance of thousands of individuals and 99 organizations, applauds the state of Maryland in updating their all payer hospital reimbursement model. Our Coalition hopes that this, coupled with other initiatives, will foster a model that enhances patient care, improves health and reduces costs. We are pleased to offer the comments below on the February 5, 2014 *HSCRC Staff Recommendations For Transitional Rate Setting Policies To Govern Implementation of the Approved All-Payer Model.*

More than Rate Regulation Is Needed

The changes you envision for Maryland hospitals, and indeed the entire delivery system, are exciting but at the same time fundamentally challenge the long standing operating model and the relationships between providers. The transformation of Maryland's health care delivery system to one that is high functioning and cost-effective will require engaging everyone in the process of change – hospitals, physicians, nurses, nursing homes, community clinics, home health agencies, and the full range of medical professionals and not least of all consumers. These relationships and the operating models are more than a set of financial arrangements and will require more than financial incentives to effect change. We are concerned that the proposed rate setting policies do not include adequate supports and incentives for learning collaboratives and other evaluative initiatives to develop and test new models for the delivery of comprehensive quality care, particularly for vulnerable and low income patients.

Consumer Safeguards

In its design the Maryland waiver will be monitoring certain quality metrics; however, the waiver places all the financial risks on hospitals and indirectly consumers without establishing sufficient safeguards for consumers. We are concerned that the new rate regulations may place undue financial stress on hospital margins which may resulted in reductions in investments in new technologies, training and staffing. It is critical that measures be included that identify whether there is a reduction in needed services or cost shifting to consumers.

Protection of Vulnerable Consumers

The Coalition questions how hospitals that serve the most challenging patient populations will fare under the proposed rate setting policies. Hospitals that serve complex patients will face additional challenges and expenses associated with managing the care for these vulnerable patients. Although Maryland has been progressive in spreading the cost of low income and uninsured populations across all hospitals, now hospitals will need to better manage the care for these patients, and the burdens of managing that care will not be so easily spread. Payment policies should take into account the higher costs incurred by patients who experience barriers to care due to socio-economic status, language and other factors. Hospitals that are serving challenging patient populations will need to invest additional resources needed to manage the special needs of vulnerable patients. There is mention of a one-time adjustment "to assist adopters of the global budget approach to establish the infrastructure needed to manage on a global budget basis." However, it is unclear what that will mean in reality.

Patient Centered Care

There should be a stronger role for consumer engagement in the implementation of the waiver. In order for individuals to make the best healthcare decisions for themselves and their families, a true working partnership must be developed between the individual and their provider(s). Consumers also have difficulty understanding medical information provided to them due to language and literacy barriers, limited tools to support decision-making, and a lack of quality and cost information.

To increase consumer knowledge and engagement, the Coalition recommends that tools be used to increase health and illness self-management, more and better health information in a timely manner, consumer portals, decision-support tools, the leveraging of HIT to disseminate quality and cost data, and the development of consumer information curricula. There is a clear need in all areas for a coordinated effort to create "health literate consumers."

Need For Further Risk Adjustment

There is no discussion about ensuring that hospitals do not take steps to avoid serving complex, costly or difficult patient populations. We believe that such safeguards should be put in place at the outset to adjust for social economic status (SES). Adjusting for SES is necessary for fair comparisons of providers, particularly those who care for disadvantaged populations because the effect of SES is beyond the control of the healthcare system. For example, asking providers who work primarily with low-income patient populations to achieve the same results as those working with wealthier populations is effectively asking for more, and in some cases, impossibly more from these providers. The results of such unrealistic demands may be fewer and fewer providers willing to serve the already underserved.

Shared Savings

As cost growth is contained, premium payers must share in the savings. The payment policies should provide explicit methods to assure that savings created by payment reform get passed on to the consumer and other payers. How will consumers be affected by some of the adjustments mentioned in the document? For example, the mid-year adjustments that are described states that "hospitals will be directed to apply the volume adjustment to their charges during the rate year to minimize retroactive rate settlements." We are concerned that any system-wide savings are actually reflected in lower premiums for consumers. The Insurance Administration has the authority to review trend assumptions when reviewing rates for the insured population. Consumers would be better served if rate setting language were explicit that savings will lower premiums. Such a policy would also support greater consumer support for this transformative process, which will be a key to the success of the overall initiative.

Patient Choice and Accessibility

We are concerned that the rate setting policies could impact patients' access to care. We recommend that as part of implementation, the state should establish an ombudsman to investigate and respond to patient concerns about access to care. For example, in California, the Office of the Patient Advocate is an independent state office established to create and distribute educational materials for consumers, public outreach, and evaluation and ranking of health care service plans, collaboration with patient assistance programs, and policy development. Such a position would be advantageous for all of the state's reform initiatives including ACA implementation and the State Innovation Model project.

Transparency of Process

Measures of care and incentives built into the payment system must be transparent and understandable by patients. The implementation process for the new rate setting process should be an open process that provides full disclosure and explanation of payment methods. Given the complexity of this initiative and the new skill set that will be needed, we recommend that HSCRC establish a project management office to lead the implementation, oversee evaluation efforts, engage with stakeholders and other state agencies, manage vendors, and communicate progress to the public, state government, and CMMI. As with the Ombudsman Office, this should be designed to ensure integration and coordination of all health reform initiatives that are being initiated by the state.

Speed of Implementation

The Coalition is concerned the timeline for implementation of the global budget does not allow for initial pilot testing in suburban and urban areas. The movement to global budgets is an extension to the Total Patient Revenue (TPR) program currently operating in rural areas. While the TPR results may be encouraging, this program needs to recognize the imperfect ability to assign accountability for patients. In a suburban or urban setting the problem of patient accountability will be magnified and will require

solutions that need to be pilot tested. We urge you to consider broad consumer involvement in the design and testing process of new payment policies.

Promotion of Public and Community Health

If the vision of reduced hospital admissions and readmissions becomes a reality then there may not be the right mix of health services available. These new payment policies must be accompanied by a renewed commitment to funding public and community health and correctly sizing hospital capacity. If the payment policies are successful it is likely to accelerate the trend to outpatient care and to move care out of the hospital and into less acute community settings. We believe it would be helpful to do an analysis of hospital and community provider capacity in service area designations compared to the population needs.

Evaluation and Monitoring

The rate setting policies should include independent and frequent monitoring and evaluation of the payment system transition, focusing on the quality of care, impact on health outcomes, including patient satisfaction, and quality of life. The transition to a new payment system should permit adjustments as implementation proceeds. It is important that there be timely public reporting of all quality metrics and evaluations of hospital performance.

The Coalition is excited by the opportunity to support a culture of health in Maryland through this and other health care reform initiatives. We welcome the opportunity to support your work and, in so doing, to ensure that all Marylanders are the true beneficiaries.

Sincerely,

Leni Preston, Chair

leni@mdchcr.org 301.351.9381

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207 and 19-214;Insurance Article, §§14-502 and 14-504; State Government Article §10-304(b); Annotated Code of Maryland

Notice of Emergency Action

The Health Services Cost Review Commission has granted emergency status to amend Regulation .26-1 under COMAR 10.37.10 Rate Application and Approval Procedures.

Emergency Status Begins: March 1, 2014

Emergency Status Expires: July 1, 2014

Comparison of Federal Standards

There is currently no corresponding federal standard to this proposed action.

Estimate of Economic Impact

See attachment.

.26-1 Maryland Health Insurance Plan (MHIP) Assessment.

A. (text unchanged)

B. Beginning [July 1, 2008] *July 1, 2014*, the Commission shall assess each hospital *up to* 1 percent of its net patient revenue to operate and administer the MHIP.

C.-D. (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE

Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION

Chapter 10 Rate Application and Approval Procedures

Authority: Health-General Article, §§19-207 and 19-214;Insurance Article, §§14-502 and 14-504; State Government Article §10-304(b); Annotated Code of Maryland

Notice of Proposed Action

The Health Services Cost Review Commission proposes to amend Regulation .26-1 under COMAR 10.37.10 Rate Application and Approval Procedures. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on February 5, 2014, notice of which was given pursuant to State Government Article, § 10-506(c), Annotated Code of Maryland. If adopted the proposed amendments will become effective on or about June 23, 2014.

Statement of Purpose

The purpose of this action is to establish a variable amount of up to 1% in lieu of the fixed 1% assessed on hospitals to operate and administer the MHIP Plan.

Comparison to Federal Standards

There is no corresponding federal standard to this proposed action.

Estimate of Economic Impact

See attachment.

Opportunity for Public Comment

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or via fax to (410) 358-6217, or via email to diana.kemp@maryland.gov. The Health Services Cost Review Commission will consider comments on the proposed amendments until April 7, 2014. A hearing may be held at the discretion of the Commission.

.26-1 Maryland Health Insurance Plan (MHIP) Assessment.

A. (text unchanged)

B. Beginning [July 1, 2008] *July 1, 2014*, the Commission shall assess each hospital *up to* 1 percent of its net patient revenue to operate and administer the MHIP.

C.-D. (text unchanged)

JOHN M. COLMERS
Chairman
Health Services Cost Review Commission

HEALTH SERVICES COST REVIEW COMMISSION
4160 Patterson Avenue, Baltimore, Maryland 21215
Phone: 410-764-2605 · Fax: 410-358-6217
Toll Free: 1-888-287-3229
hscrc.maryland.gov

TO: Commissioners

FROM: Legal Department

DATE: January 29, 2014

RE: Hearing and Meeting Schedule

Public Session:

March 12, 2014 1:00 p.m., 4160 Patterson Avenue, HSCRC Conference Room
April 9, 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 on the Commission's website.
http://hscrc.maryland.gov/commissionMeetingSchedule2014.cfm

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