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531st MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
June 8, 2016

EXECUTIVE SESSION
11:00 a.m.
(The Commission will begin in public session at 11:00 a.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 p.m.)

1. **Update on Contract and Modeling of the All-payer Model vis-a-vis the All-Payer Model Contract – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-103 and §3-104**

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

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Public Meeting and Executive Session on May 11, 2016**
2. **Executive Director's Report**
3. **New Model Monitoring**
4. **Docket Status – Cases Closed**

   2342A – Johns Hopkins Health System
   2343A – Johns Hopkins Health System

5. **Docket Status – Cases Open**

   2319R – Sheppard Pratt Health System
   2339R – Prince George's Hospital Center
   2344A - MedStar Health
   2345A- MedStar Health
   2346A – Johns Hopkins Health System

6. **Final Recommendation for Modification to the Readmission Reduction Incentive Program for FY 2018**
7. **Final Recommendation for Total Amount at Risk for Quality Programs for FY 2018**
8. **Final Recommendation for Potentially Avoidable Utilization Savings Policy for Rate Year 2017**
9. **Final Recommendation for Uncompensated Care for FY 2017**
10. **Final Recommendation for Update Factor for FY 2017**

11. **Final Recommendation for Transformation Implementation Grant Awards**

12. **Hearing and Meeting Schedule**

Minutes to be included into the post-meeting packet

upon approval by the Commissioners

Executive Director's Report

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

New Model Monitoring Report

The Report will be distributed during the Commission Meeting

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF MAY 31, 2016

A: PENDING LEGAL ACTION : NONE
B: AWAITING FURTHER COMMISSION ACTION: NONE
C: CURRENT CASES:

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2319R	Sheppard Pratt Health System	11/24/2015	7/13/2016	7/13/2015	CAPITAL	GS	OPEN
2339R	Prince George's Hospital Center	3/16/2016	6/8/2016	8/15/2016	PEDS/MSG	CK	OPEN
2344A	MedStar Health	5/6/2016	N/A	N/A	ARM	DNP	OPEN
2345A	MedStar Health	5/6/2016	N/A	N/A	ARM	DNP	OPEN
2346A	Johns Hopkins Health System	5/31/2016	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
MEDSTAR HEALTH	*	**DOCKET:**	**2016**
	*	**FOLIO:**	**2154**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2344A**

Staff Recommendation

June 8, 2016

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on May 6, 2016 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for joint replacement services with MAMSI for a one year period beginning September 1, 2016.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Helix Resources Management, Inc. (HRMI). HRMI will manage all financial transactions related to the global price contract including payments to the Hospitals and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating the 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 HRMI for all contracted and covered services. HRMI is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The Hospitals contend that the arrangement between HRMI and the Hospitals holds the Hospitals harmless from any shortfalls in payment from the global price contract.

V. STAFF EVALUATION

The staff reviewed the experience under this arrangement for the last year and found that it was favorable. The staff believes that the Hospitals can continue to achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for continued participation in the alternative method of rate determination for orthopedic services, for a one year period, commencing September 1, 2016. The Hospitals will need to file a renewal application for review to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospitals for the approved contract. This document will formalize the understanding between the Commission and the Hospitals, and will 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, and 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**	
MEDSTAR HEALTH	*	**DOCKET:**	**2016**
	*	**FOLIO:**	**2155**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2345A**

Staff Recommendation

June 8, 2016

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on May 6, 2016 on behalf of Union Memorial Hospital (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for cardiovascular services with the Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. for one year beginning August 1, 2016.

II. OVERVIEW OF APPLICATION

The contract will continue to be held and administered by Helix Resources Management, Inc. (HRMI). HRMI will manage all financial transactions related to the global price contract including payments to the Hospital and bear all risk relating to services associated with the contract.

III. FEE DEVELOPMENT

The hospital portion of the global rates was renegotiated in 2007. The remainder of the global rate is comprised of physician service costs. Also in 2007, additional per diem payments were negotiated for cases that exceed the outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff reviewed the results of last year's experience under this arrangement and found that they were favorable.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's request for continued participation in the alternative method of rate determination for cardiovascular services for a one year period commencing August 1, 2016. The Hospital will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2016**
SYSTEM	*	**FOLIO:**	**2156**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2346A**

Staff Recommendation

June 8, 2016

I. INTRODUCTION

Johns Hopkins Health System (“System’) filed an application with the HSCRC on May 31, 2016 on behalf of its member hospitals (the “Hospitals”) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global arrangement to provide solid organ and bone marrow transplants services with Cigna Health Corporation. The System requests approval of the arrangement for a period of one year beginning July 1, 2016.

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 arrangement 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 July 1, 2016, 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.

Final Recommendations for the Readmissions Reduction Incentive Program for Rate Year 2018

June 8, 2016

Health Services Cost Review Commission

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Table of Contents

LIST OF ABBREVIATIONS

ACA	Affordable Care Act
ADI	Area deprivation index
APR-DRG	All-patient refined diagnosis-related group
ARR	Admission-Readmission Revenue Program
CMS	Centers for Medicare & Medicaid Services
CMMI	Center for Medicare and Medicaid Innovation
CRISP	Chesapeake Regional Information Systems for Our Patients
CY	Calendar year
ED	Emergency department
FFS	Fee-for-service
FFY	Federal fiscal year
FY	Fiscal year
HRRP	Hospital Readmissions Reduction Program
HSCRC	Health Services Cost Review Commission
ICD-10	International Classification of Disease, 10th Edition
MHA	Maryland Hospital Association
MHAC	Maryland Hospital-Acquired Conditions Program
PAU	Potentially avoidable utilization
PPC	Potentially preventable complication
PQI	Prevention quality indicator
RRIP	Readmissions Reduction Incentive Program
RSSP	Readmissions Shared Savings Program
RY	Rate year
SES/D	Socio-economic and demographic
SOI	Severity of illness
YTD	Year-to-date

INTRODUCTION

The purpose of this report is to make recommendations for updating the Readmissions Reduction Incentive Program (RRIP) for the state rate year (RY) 2018 methodology and making revisions to the application of the RY 2017 RRIP. This recommendation is finalized with no substantial changes from the second draft recommendation presented at the May 11th, 2016 Maryland Health Services Cost Review Commission (HSCRC or Commission) meeting. This final recommendation includes supporting details that were not available for the second draft recommendation.

The final recommendation, which introduces major changes relative to the RY 2017 policies adopted by the Commission, addresses the following policy elements:

- Updating the policy to include an "attainment" as well as an improvement evaluation;
- Establishing an estimate of readmissions occurring outside of Maryland;
- Using "attainment" measures to finalize adjustments for RY 2017, moderating adjustments that were based exclusively on improvements;
- Evaluating risk adjustments applied in the methodology, including an evaluation of the potential impact of socioeconomic factors on the results;
- Evaluating Calendar Year 2015 performance versus the All Payer Agreement requirements and recommending targets to ensure continued progress; and
- Developing targets for attainment and improvement with established preset rewards/penalties scaling for application of the RY 2018 RRIP.

The RRIP policies, as recommended, are not intended to assure savings. Savings are addressed under the proposed PAU Savings Program. These recommendations for the RRIP are based on the assumption that the Commission will adopt the proposed PAU Savings Program. If there are modifications to that proposal, the final recommendations for the RRIP may need to be adjusted to ensure savings under the policies..

BACKGROUND

Medicare Hospital Readmissions Reduction Program

The United States health care system currently has an unacceptably high rate of preventable hospital readmissions. These excessive readmissions generate considerable unnecessary costs and substandard care quality for patients. A readmission is defined as an admission to a hospital within a specified time period after a discharge from the same or another hospital. Under

authority of the Affordable Care Act (ACA), the Centers for Medicare & Medicaid Services (CMS) established its Medicare Hospital Readmissions Reduction Program (HRRP) in federal fiscal year (FFY) 2013. Under this program, CMS calculates the average risk-adjusted, 30-day hospital readmission rates for patients with certain conditions using claims data. If a hospital's risk-adjusted readmission rate for such patients exceeds that average, CMS penalizes it in the following year for all Medicare admissions; the penalty is in proportion to the hospital's rate of excess readmissions. Penalties under the HRRP were first imposed in FFY 2013, during which the maximum penalty was 1 percent of the hospital's base inpatient claims. The maximum penalty increased to 2 percent for FFY 2014 and 3 percent for FFY 2015 and beyond. CMS uses three years of previous data to calculate each hospital's readmission rate. For penalties in FFYs 2013 and 2014, CMS focused on readmissions occurring after initial hospitalizations for three conditions: heart attack, heart failure, and pneumonia. For penalties in FFY 2015, CMS included two additional conditions: chronic obstructive pulmonary disease and elective hip or knee replacement. In the future, CMS intends to continue with these conditions and will add the assessment of performance following initial diagnosis of coronary artery bypass graft surgery to the list for FFY 2017.[1]

Overview of the Maryland RRIP Program

Because of its long-standing Medicare waiver for its all-payer hospital rate-setting system, special considerations were given to Maryland, including exemption from the federal HRRP. The ACA requires Maryland to have a similar program and achieve the same or better results in costs and outcomes in order to maintain this exemption. The Commission made an initial attempt to encourage reductions in unnecessary readmissions when it created the Admission-Readmission Revenue (ARR) program in RY 2012. The ARR program, which was adopted by most Maryland hospitals, established "charge per episode" constraints on hospital revenue, providing strong financial incentives to reduce hospital readmissions. The ARR program was replaced with global budgets in RY 2014. In May 2013, the Commission also approved the Readmission Shared Savings Program (RSSP) for RY 2014 to achieve savings that would be approximately equal to those that would have been expected from the federal Medicare HRRP. Based on hospital achievement levels in reducing readmissions, the RSSP decreased hospital inpatient revenues on average by 0.20 percent of state total revenue in its first year.

The All-Payer Model Agreement with CMS replaced the requirements of the ACA by establishing two sets of requirements to maintain exemptions from federal programs for readmissions and hospital-acquired conditions. One set of requirements established performance targets for readmissions and complications, while the second set of requirements ensured that the amount of revenue adjustments in Maryland's quality-based programs matched CMS levels in

[1] For more information on HRRP, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.

aggregate. For readmissions, Maryland's statewide hospital readmission rate must be equal to or below the national Medicare readmission rate by CY 2018. Maryland must also make scheduled, annual progress toward this goal.

In order to meet the new Model requirements, the Commission approved a new readmissions program in April 2014—the RRIP—to further bolster the incentives to reduce unnecessary readmissions. The Performance Measurement Work Group established the following guiding principles for the RRIP:

- The measurements used for performance linked with payment must include all patients, regardless of payer.
- The measurements must be fair to hospitals.
- Annual targets must be established to reasonably support the overall goal of meeting or outperforming the national Medicare readmission rate by CY 2018.
- The measurements used should be consistent with the CMS readmissions measure.
- The approach must include the ability to track progress.

The RRIP provided a positive increase of 0.50 percent of inpatient revenues in RY 2016 for hospitals that were able to meet or exceed a pre-determined reduction target for readmissions in CY 2014 relative to CY 2013. Readmission rates are adjusted for case-mix using all-patient refined diagnosis-related group (APR-DRG) severity of illness (SOI) (see Appendix I for details of indirect standardization method). The readmissions reduction target was set at 6.76 percent of for all-payer case-mix adjusted readmission rates.[2] The HSCRC did not impose penalties in the first year of the RRIP program.

As the progress in reducing readmissions was slower than projected, the RRIP methodology was updated for RY 2017 to include both higher potential rewards for hospitals that achieved or exceeded the readmission reduction target and payment reductions for hospitals that did not achieve the required readmission reductions. Rewards and payment reductions were allocated along a scale commensurate with hospital improvement rates. The readmission reduction target for RY 2017 was set at 9.30 percent from CY 2013 all-payer case-mix adjusted readmission rates.[3]

[2] This target was based on the excess levels of Medicare readmissions in Maryland in CY 2013 (8.78 percent), divided by five (representing each year of the Model Agreement performance period), plus an estimate of the reduction in Medicare readmission rates that would be achieved nationally (5.00 percent)

[3] The target was updated based on remaining national Medicare readmission rates and a projected 1.34 percent decline in the national Medicare readmission rates in CY 2015.

ASSESSMENT

Maryland's Performance to Date

Medicare Waiver Test Performance

With the onset of the All-Payer Model Agreement, HSCRC and CMS staff worked to refine the Medicare readmission measure specifications used to determine contract compliance. These changes narrowed the gap between the Maryland and national Medicare readmission rates to 7.96 percent for CY 2013 (or 1.23 percentage points), as the original estimates included planned admissions, and more importantly, specially-licensed rehabilitation and psychiatric beds for Maryland, but not for the nation (see Appendix II for details). Final calculations indicate that Maryland's Medicare readmission rate was 16.61 percent compared with the national rate of 15.39 percent for CY 2013.

Using the revised final measurement methodology, Maryland performed better than the nation in reducing readmission rates in both CY 2014 and CY 2015. The Model Agreement requires Maryland to make annual progress by reducing the gap by one-fifth each year to lower Maryland's readmission rates to the national level by the end of the demonstration period. Figure 1 provides the calculations for this test and results for CY 2014 and CY 2015.

The top portion of the figure shows the calculations for determining the annual reduction required to close the gap between the Maryland and national Medicare readmission rates, as required by the All-Payer Model Agreement. The second portion of the figure shows the calculations for determining Maryland's progress in meeting the readmissions reduction target. Maryland is required to close the gap by 0.25 percentage points each year. Maryland performed better than the CY 2015 target gap of 0.74 percentage points by reducing the gap to 0.53 percentage points.[4]

[4] Staff was able to resolve the issues related to ICD-10 and updated the results presented in the draft recommendation.

Figure 1. All-Payer Model Maryland Medicare Readmissions Test

BASE YEAR RATES

CY 2013 National Medicare Readmission Rate	A	15.39%
CY 2013 MD Medicare Readmission Rate	B	16.61%
MD vs National Difference*	C=B-A	1.23%
Annual Reduction needed to Close the Gap	D=C/5	0.25%

PERFORMANCE YEAR CALCULATIONS

Calendar Year	National Rate	MD-National Required Difference	MD Required Rate	MD Actual Rate	MD-National Difference
E	**F**	**G=C - (D*YearX)**	**H=F+G**	**I**	**J=I-F**
CY 2014	15.50%	**0.98%**	16.48%	16.47%	**0.97%**
CY 2015	15.42%	**0.74%**	16.15%	15.95%	**0.53%**

*Percents are rounded up to two decimal points in the tables.

All-Payer Performance

While the CMS readmission target is based on the unadjusted readmission rate for Medicare patients, the RRIP adjustments measure the all-payer case-mix adjusted readmission rate, in line with the guiding principles and all-payer approach used in all other programs in Maryland. The RRIP measure was refined to incorporate many of the elements of the CMS Medicare measure specifications (e.g., planned admissions and transfer logic). See Appendix I for more details on the RRIP methodology.

In CY 2015, Maryland made progress towards meeting the Medicare readmission reduction contract requirement, although this may be mainly attributed to a slower than expected rate of decline in the national readmission rates. Despite this progress, the all-payer readmission rate decline has fallen short of the statewide CY 2015 cumulative target of 9.30 percent. Appendix III provides hospital-level improvement rates for discharges occurring through December 2015.[5] Overall, all-payer readmission rates declined by 7.13 percent over CY 2013, with nearly one-

third of the hospitals meeting or exceeding the 9.30 percent reduction target. Seven hospitals had an increase in their readmission rates; the highest increase was 17.34 percent.

Improvement Target Calculation Methodology for Rate Year 2018

As previously stated, under the All-Payer Model Agreement, Maryland is required, at a minimum, to close one-fifth of the gap between the national and Maryland readmission rates and match the national decline in Medicare readmission rates to eliminate the excessive level of readmissions by CY 2018. Although we now know that one-fifth of the gap is 0.25 percentage points, it is challenging to predict national readmission rates and to set targets for the state prospectively. Furthermore, additional adjustment factors are necessary to convert the Medicare readmission target to an all-payer case-mix adjusted target. HSCRC contractor Mathematica Policy Research modeled different specifications to predict national readmission rates. The target calculation models assume that Maryland would need to match the annual decline in the national Medicare readmission rate, close the remaining gap between the Maryland and national rates by one-third, and adjust the target upward to close the gap between the Maryland Medicare readmission rates from CMMI calculations and the HSCRC all-payer case-mix adjusted trends.

Figure 2 provides the calculation of the target gap for CY 2016. The remaining gap between the national and Maryland Medicare readmission rates was 0.53 percentage points in CY 2015. If we set the target to reduce the remaining gap in equal amounts annually over the remaining years in the Model period, the CY 2016 target gap between the national and Maryland Medicare readmission rates would be 0.36 percentage points. This calculation is more aggressive than the All-Payer Model test, which requires Maryland to meet a 0.49 percentage point difference in CY 2016.[6] Staff modeled different assumptions for estimating the national readmission rates in CY 2016 to calculate the Maryland Medicare readmission reduction target. Figure 3 is based on an estimate provided by Mathematica Policy Research of the projected decline in the national readmission rate using regression models that incorporate trends from the last five years. Based on this model, the required Medicare readmission reduction is 5.77 percent in CY 2016 compared to CY 2013.

[6] The CMMI calculation is based on reducing the base year gap by one-fifth annually. The CY 2015 required gap for the CMS test was 0.74 percentage points, and Maryland's performance was 0.53 percentage points. Since Maryland reduced the gap by more than what was required in CY 2015, we gained some cushion in our estimates.

Figure 2. Calculation of the Readmissions Target Gap for CY 2016

CY 2015 National Medicare Readmission Rate	A	15.42%
CY 2015 MD Medicare Readmission Rate	B	15.95%
MD vs. National Difference	C=B-A	0.53%
Annual Gap Reduction needed to Close the Gap	D=C/3	0.18%
CY 2016 Target Gap	E=C-D	0.36%

Figure 3. Two Projections for the Estimating CY 2016 Maryland Medicare Readmissions Target

	National % Annual Change	National Medicare Readmission Rate	MD-National Target Gap	MD Medicare Readmission Target Rate	MD Annual % Medicare Readmission Target	MD % Change from CY 2013
A	**B**	**C=15.42%*(1+B)**	**D**	**E=C+D**	**H=D/15.95%-1**	**I=E/16.61%-1**
CY 16 –Regression Trend Estimate for National Annual Change	-0.80%	15.30%	**0.36%**	15.65%	-1.89%	-5.77%

The final step in calculating the RRIP target, illustrated in Figure 4, is to convert the Medicare target to an all-payer reduction target. The all-payer adjustment is based on the difference in the rate of change between CY 2015 and CY 2013 in the Medicare and all-payer readmission rates, which is 3.17 percentage points. This calculation produced an improvement target of 8.94 percent. Staff recommends setting a target of 9.50 percent to continue supporting strong performance in reducing readmissions in Maryland. Given that we met the Medicare target for CY 2015 with a 7.13 percent cumulative all-payer reduction, staff believes that 9.50 percent is a reasonably aggressive target for CY 2016.

Figure 4. Calculations for Converting the Medicare Reduction Target to an All-Payer Target

		Projection B
Medicare Readmission % Change CY13-CY15	**A**	-3.96%
All-Payer Readmission % Change CY13- CY15	**B**	-7.13%
All-Payer Adjustment Factor	**C=A-B**	3.17%
CY 16 Medicare Readmission Rate Reduction Target from CY 13	**D**	-5.77%
CY 16 All-Payer Readmission Rate Reduction Target from CY 13	**E=D-C**	**-8.94%**

One of the guiding principles of Maryland's quality programs is to measure performance on an all-payer basis. CareFirst advocates establishing Medicare-specific targets to ensure that hospitals' focus on Medicare reductions. To maintain all-payer measurement, CareFirst

suggested creating separate measurements and targets for the other payers. Staff and other stakeholders are concerned with this proposed approach because hospitals implement their programs for all patients regardless of payer status. Although converting the Medicare target to an all-payer target introduced further uncertainty for setting appropriate benchmarks, staff recommends keeping the all-payer approach since the state is meeting the Medicare target

In establishing a cumulative readmission reduction target for the RRIP for RY 2018, staff previously noted that it is important to strike a reasonable balance between the desire to set a target that is not unrealistically high and the need to conform to the requirements of the Model Agreement. With each passing year, underachievement in any particular year becomes increasingly hard to offset in the remaining years before CY 2018. Again, the consequence for not achieving the minimum annual reduction would be a corrective action plan and potentially the loss of the waiver from the Medicare HRRP. The consequences of not meeting the target are stated in the Model Agreement as follows:

> *If, in a given Performance Year, Regulated Maryland Hospitals, in aggregate, fail to outperform the national Readmissions Rate change by an amount equal to or greater than the cumulative difference between the Regulated Maryland Hospitals and national Readmission Rates in the base period divided by five, CMS shall follow the corrective action and/or termination provisions of the Waiver of Section 1886(q) as set forth in Section 4.c and in Section 14.*

Requiring Maryland to conform to the national Medicare HRRP would reduce our ability to design, adjust, and integrate our reimbursement policies consistently across all payers based on local input and conditions. In particular, the national program is structured as a penalty-only system based on a limited set of conditions, whereas the Commission prefers to have the flexibility to implement much broader incentive systems that reflect the full range of conditions and causes of readmissions on an all-payer basis. Given that Maryland's readmission rate is still high compared with the national rate, some stakeholders supported a more aggressive target. Other stakeholders felt that because Maryland is making good progress toward meeting the Model Agreement requirement, the target should be less aggressive.

Measuring the Better of Attainment or Improvement

In order to refine the methodology for RY 2018, the HSCRC solicited input from the Performance Measurement Workgroup. The Workgroup discussed pertinent issues and potential changes to Commission policy for RY 2018 that were approved by the Commission and reviewed the most recent performance data available. Workgroup members recommended to delay the final recommendations until the impact of socio-economic adjustments are better understood.

In the March draft report, HSCRC staff indicated that it was unable to measure whether a particular hospital has a low or high readmission rate, commonly referred to as "attainment" in

quality improvement. Since that time, staff has made progress in measuring attainment with assistance from Mathematica Policy Research and in filling in gaps in estimates for out-of-state readmissions using Medicare data. In our preliminary report, staff expressed a concern that hospitals with low initial readmission rates appeared to be unduly penalized under the RRIP improvement targets. Since that time, the Maryland Hospital Association (MHA), CareFirst, the HSCRC, and Mathematica Policy Research have been examining models to see if we can address the major concerns in measuring attainment (See Appendix IV for Mathematica's report). Staff greatly appreciates stakeholders' careful consideration and constructive suggestions to improve the current methodology.

Staff recommends adding a new component to the RRIP methodology to provide rewards or penalties contingent upon the level of readmission rates, based on MHA's proposed approach. MHA's proposal sets a statewide readmission attainment target (benchmark), similar to the current policy which sets an improvement target. Individual hospitals' performance relative to the statewide target would be tied to specific payment adjustment amounts, and hospitals would be evaluated on both attainment and improvement performance. The hospital's final payment adjustment would be based on the "better of" the two adjustments. MHA also supports linking performance milestones to pre-set payment adjustments to make the results predictable. (See Appendix V for MHA's proposal).

Staff believes that adequate progress has been made in developing a model that could be used in evaluating attainment and improvement. Below are the summary of the discussions and staff recommendations to move the program from improvement only measures to better of attainment and improvement.

MHA's letter of 5/25/16 with comments on the May 2016 draft updated policies for the Readmission Reduction Incentive Program, Potentially Avoidable Utilization (PAU) Savings Program, and on Aggregate Revenue Amount at Risk for Hospital Quality Programs is provided in a separate attachment file entitled: ***Attachment I_ RRIP_PAU Shared Savings_Aggregate at Risk_2016.05.25_MHA HSCRC Letter Quality for FY2018_attachments.pdf.***

Adjustment for Socio-Economic and Demographic Factors

Substantial evidence exists that hospital readmission rates are affected to some degree by socioeconomic/demographic factors (SES/D)—such as income, education, race, and occupation—and that inclusion of these factors in the establishment of targets for readmission levels would likely improve the fairness of those targets for hospitals that have patient populations that are relatively disadvantaged. However, there is no consensus at this time regarding the precise impacts of these variables or about the best ways to collect such information on a patient-specific level. Research into the applicability and usefulness of indices of socioeconomic deprivation that are computed on a geographic basis (e.g., census tracks or neighborhoods) rather than a patient-specific basis is ongoing and promising, but this research is still in its formative stages. HSCRC formed a subgroup to discuss details on SES/D and

readmission rates. In addition to individual measures such as age, payer status, and race/ethnicity, the subgroup assessed the use of a geographic measure called the Area Deprivation Index (ADI). The ADI is a validated census-based measure available at the block-group level (neighborhood level containing between 600 and 3,000 people), first created in 2003 based upon the 2000 census by Singh and colleagues.[7] The ADI is a factor-based index with 17 census-based indicators assessing education, income, poverty, housing costs, housing quality, employment, and single-parent households. The HSCRC contracted with Dr. Amy Kind, the lead author of a seminal article showing a strong relationship between ADI and Medicare readmission rates, to update the 2000 ADI based on the 2009-2013 American Community Survey using a very similar methodology as Singh.

Mathematica's analysis found that the current adjustment methodology using APR-DRGs provides adequate risk adjustment, and including additional measures in the risk adjustment model - such as age, sex, Elixhauser Comorbidity Index,[8] primary payer, and updated ADI using 2013-2015 information[9] - does not substantially change the model accuracy and hospital rankings based on readmission rates. Although patients from deprived areas have significantly higher readmission rates independent of the hospital in which they were admitted, using fully adjusted risk models did not change the financial impact of the RRIP program significantly since the program measures improvement (see Appendix IV for Mathematica's executive summary of their final report).

Furthermore, the application of SES/D adjustments to hospital quality measures is a subject of national debate, requiring extensive discussions and stakeholder input to determine the policy implications and alternative methods of controlling for SES/D factors. The relationship between ADI and readmission rates is a complex one, and complicated statistical analyses may be needed to measure readmission rates with full risk adjustment. Most Workgroup members expressed a need for balance between precision in risk models and practicality for implementation. As we adjust readmission rates for additional factors, it becomes difficult for hospitals to understand and reproduce the methodology for monitoring purposes. Carefirst suggested an adjustment for Medicaid patients and to create two readmissions rates for the RRIP program to account for higher readmission rates for the disadvantaged patients. None of the risk adjustment models developed by Mathematica Policy Research and by the MHA had significant impact on the final payment adjustments for the RRIP program, diminishing the need for further risk adjustment beyond the current model based on APR-DRGs. Based on the input from Workgroup members and analysis results, HSCRC staff recommends continuing to use case-mix adjustment to

[7] For more information on the ADI, see http://www.hipxchange.org/ADI
[8] The Elixhauser Comorbidity Index is a method for measuring patient comorbidity based on patient diagnosis.
[9]. Higher values of the index indicate higher levels of socioeconomic deprivation. For more information, see: https://www.hipxchange.org/ADI.

measure readmission rates for the RRIP program, as long as the program provides rewards for improvement rates.

Adjustments for Out-of-State Readmissions

Since HSCRC data include admissions from Maryland hospitals, an attainment model requires adjustment for readmissions occurring at non-Maryland hospitals. Currently, the only reliable source of out-of-state readmissions is monthly reports from CMMI. HSCRC validates CMMI reports using HSCRC data and Medicare claims that HSCRC has access to via the CMS data warehouse. The MHA proposes to use the information the state receives from CMS on Medicare readmissions occurring at out-of-state hospitals. Some Workgroup members expressed concern about only using Medicare information to calculate out-of-state readmissions because Medicare may not be representative of the experience of other payers. HSCRC staff recommends using Medicare information to adjust the readmission rates. Without this adjustment the attainment rates are biased for hospitals near the state borders. For example, based on the CMMI reports, the out-of-state readmission rate is equal to 30 percent of in-state readmissions for Fort Washington Medical Center. (Please see Appendix VIII for modeling results for Medicare out-of-state readmission ratios). Although the readmission experience of other patients may vary, Medicare ratios may be adequate as Medicare patients constitute more than 50 percent of readmissions, which has substantial impact on the all-payer readmission rates.

HSCRC staff will continue to collect more information from other payers to broaden the scope of this adjustment in future years. Additional clinical information could be made available from Medicare claims to help hospitals understand readmission patterns at out-of-state hospitals. Another source that can be used for both analytical and care transition programs is the readmission notifications provided by the Chesapeake Regional Information System for our Patients (CRISP), the state health information exchange. CRISP receives real-time data from hospitals located in the District of Columbia (D.C.) and Delaware. Six out of eight D.C. hospitals participate directly in CRISP, and the state is working on adding the final two: Children's and United Medical Center. Any time a Maryland resident arrives at a Delaware or D.C hospital, a readmission alert can be sent to any hospital that had a prior admission for that patient. CRISP also receives messages from Inova hospitals.

Determination of an Attainment Target

To establish payment scale based on readmission rates, the Commission would need to determine a benchmark where the rewards and penalties would start. The MHA proposes to use statewide average readmission rates as the benchmark for penalties and rewards. HSCRC staff and payer representatives at the Workgroup expressed a need to have benchmarks that are better than the state average given the high readmission rates in Maryland. Only two Maryland hospitals were statistically significantly better than the national average based on CMS Medicare hospital-wide readmission rates available at hospitalcompare.gov. One option might be to adjust the attainment target down to the national average rate using information from CMS Medicare readmission

trends. However, the HSCRC staff believes that attainment benchmarks need to be more stringent than the national average rates to improve readmission rates in Maryland. Figure 5 provides the distribution of CY 2015 readmission rates and the imputed national average.

Figure 5. CY 2015 All-Payer Readmission Rates and Estimated National Average

		CY 2015 Case-Mix Adjusted Readmission Rates Adjusted for Out-of-State Readmissions
Lowest Readmission Rate	A	9.72%
Lowest 25th percentile	B	12.09%
State Average	C	13.29%
Highest 25th percentile	D	14.16%
Highest Readmission Rate	E	16.59%
MD/National Difference in Medicare Readmission Rates	F	4.89%
National Imputed Average for All-Payer	G=C*(1-F)	12.64%

* Medicare out-of-state readmissions are used for adjustments.

Staff recommends setting the benchmark at the lowest 25th percentile for RY 2017, which is 12.09 percent based on CY 2015 rates. Hospitals that meet this benchmark constitute 14 percent of total discharges and 11 percent of readmissions in the state. In other words, if the benchmarks were weighted by the number of discharges, 12.09 percent would be equal to the top 14 percent performance. Staff recommends using the unweighted lowest 25th percentile for the benchmark due to the high readmission rates in Maryland compared to the national rates. Moving forward, this benchmark needs to be updated to maintain the incentive for continuous improvement. Based on the input from the Workgroup, staff recommends adjusting this benchmark prospectively, rather than calculating the lowest 25th percentile concurrently with CY 2016 results. This will enable hospitals to have concrete targets and predict the payment impacts prospectively. Staff recommends reducing the benchmark by 2 percent to 11.85 percent, which is similar to the increase in the improvement target for CY 2016.

Compared to a reward and penalty structure that targeted 9.30 percent improvement, rewarding hospitals based on existing readmission rates may be perceived as reducing incentives for further improvement. Hospitals that have low readmission rates would not have incentives to improve if they are guaranteed to have a reward the next year. HSCRC maintains continuous improvement incentives in all programs by setting targets each year and by updating the points for payment adjustments (i.e., scaling). Figures 6 and 7 provide the targets and scaling points for RYs 2017 and 2018, respectively. Based on the RY 2017 targets, any hospital with 18 percent or higher reductions or any hospital with a readmission rate of 10.61 percent or lower would receive the maximum rewards of 1 percent inpatient revenue. The same scores in RY 2018 would result in smaller rewards (0.81percent) due to updated targets and scaling points. HSCRC staff believes

that these two adjustments in the RRIP program will incentivize all hospitals to improve, as only maintaining CY 2015 levels would result in smaller rewards or even possible penalties.

Figure 6. RY 2017 RRIP Adjustments

RY 2017 Scaling Points
Improvement Target: CY 13-CY15 Change =-9.30%
Attainment Benchmark: CY 2015 Readmission Rate=12.09%

All-Payer Readmission Rate Change CY13-CY15	RRIP % Inpatient Revenue Payment Adjustment	All Payer Readmission Rate CY15	RRIP % Inpatient Revenue Payment Adjustment
A	C	D	F
Lower	**1.00%**	**Lower**	1.00%
-18.0%	1.00%	**11.04%**	1.00%
-15.0%	0.66%	**11.41%**	0.66%
-10.0%	0.08%	**12.01%**	0.08%
-9.3%	0.00%	**12.09%**	0.00%
-9.0%	-0.03%	**12.13%**	-0.03%
5.0%	-1.56%	**13.82%**	-1.56%
9.0%	-2.00%	**14.31%**	-2.00%
Higher	**-2.00%**	**Higher**	**-2.00%**

Figure 7. RY 2018 RRIP Adjustments

RY 2018 Scaling Points
Improvement Target: CY 13-CY16 Change =-9.50%
Attainment Benchmark: CY 2016 Readmission Rate=11.85%

All-Payer Readmission Rate Change CY13-CY16	RRIP % Inpatient Revenue Payment Adjustment	All Payer Readmission Rate CY16	RRIP % Inpatient Revenue Payment Adjustment
A	C	D	F
Lower	1.00%	**Lower**	1.00%
-20.0%	1.00%	**10.61%**	1.00%
-18.0%	0.81%	**10.85%**	0.81%
-15.0%	0.52%	**11.20%**	0.52%
-10.0%	0.05%	**11.79%**	0.05%
-9.5%	0.00%	**11.85%**	0.00%
-9.0%	-0.05%	**11.91%**	-0.05%
5.0%	-1.49%	**13.57%**	-1.49%
9.0%	-1.90%	**14.05%**	-1.90%
10.0%	-2.00%	**14.16%**	-2.00%
Higher	-2.00%	**Higher**	-2.00%

Adjustment of the Improvement Target

If the changes to the measurement allow positive adjustments for hospitals, the required statewide improvement target may need to be increased to ensure that the Medicare readmission targets are met. Staff recommends keeping the improvement target at 9.50 percent as hospitals meeting the attainment benchmark constitute only 11 percent readmissions in the state.

The Link between Shared Savings and RRIP

As mentioned in the overview, the HSCRC Savings Program prospectively adjusts hospital rates to achieve a specified statewide savings amount. For the past several years, the shared savings adjustment for each hospital was based on past readmission rates. Staff proposes to broaden the savings program to include additional categories of PAU. This proposal is described in a separate draft report.

CareFirst supports prospectively applying rate adjustments based on performance, and, in effect, blending the RRIP incentives with the Shared Savings Program adjustment (Appendix VI). The CareFirst proposal supports testing the relevance of adjusting hospital readmission rates based on its distribution of indigent and non-indigent patients. If there is a difference in readmission rates for these two patient cohorts statewide, CareFirst supports applying a proportional adjustment to each hospital's readmission rate and measuring hospital performance by blending their indigence/case-mix adjusted readmission rate and actual base year readmission rate. At this time, staff does not support blending the programs since we are planning to broaden the categories of PAU included in the Savings Program, both for RY 2017 and on an ongoing basis.

Considerations for the RY 2017 RRIP Policy

One of the guiding principles for Maryland's hospital quality programs is to set the policy and benchmarks ahead of the performance periods. However, in light of the extensive changes in the RRIP policy for RY 2017, the Commission requested staff to examine the developing policy results during the performance period because of some potential payment equity issues. In approving a policy that sets improvement targets equally for all hospitals, there were concerns that individual hospitals might be penalized even though they were performing relatively well. For example, if the initial readmission rate for a hospital was relatively low, it may be harder to reduce the same percentage of readmissions as other hospitals with higher initial rates.

Staff has evaluated a RY 2018 approach based on the better of attainment or improvement to moderate adjustments in light of recent analysis. Given the substantial progress made in the attainment and improvement model for RY 2018, staff proposes to adopt a similar methodology for the RY 2017 time period. The modeling results based on the staff recommendations below are provided in Appendix VIII. Overall, the new approach would lower the statewide total penalties from $36.3 million to $28.9 million. The total rewards would increase from $8.3

million to $12.9 million. These effects combined would change the net impact of the RRIP, from -$27.9 million to -$16 million (see Appendix VII for the hospital level results).

RECOMMENDATIONS

Based on this assessment, HSCRC staff recommends the following updates to the RRIP program for RY 2018:

1. The RRIP policy should continue to be set for all-payers.

   Staff supports this recommendation because Maryland continues to meet the CMS Medicare readmissions target and because hospitals implement their readmissions reduction programs for all patients, regardless of payer status.

2. Hospital performance should be measured as the better of attainment or improvement.

   Staff has worked closely with Mathematica Policy Research and stakeholders in the Performance Measurement Workgroup to refine the RRIP methodology. Staff supports this recommendation so that hospitals that started with particularly low or high readmission rates are not unfairly penalized.

3. The attainment benchmark should be set at 11.85 percent.

   Because Maryland's readmission rate is still higher than the nation, staff support an attainment benchmark of the lowest 25th percentile, which is projected to be 11.85 percent. Moving forward, this benchmark needs to be updated to maintain the incentive for continuous improvement.

4. The reduction target should be set at 9.50 percent from CY 2013 readmission rates.

   Staff believe that 9.50 percent is a reasonably aggressive target that will motivate improvement and keep the state on track toward meeting the CMS requirements.

Staff also recommends the following:

5. For RY 2017, apply the same methodology recommended for RY 2018 based on a 9.30 reduction target and 12.09 percent attainment benchmark.

   Given the substantial improvements made to the methodology for RY 2018, staff supports making these revisions for RY 2017 as well.

APPENDIX I. HSCRC CURRENT READMISSIONS MEASURE SPECIFICATIONS

1) Performance Metric

The methodology for the Readmissions Reduction Incentive Program (RRIP) measures performance using the 30-day all-payer all hospital (both intra and inter hospital) readmission rate with adjustments for patient severity (based upon discharge all-patient refined diagnosis-related group severity of illness [APR-DRG SOI]) and planned admissions.

The measure is very similar to the readmission rate that will be calculated for the new All-Payer Model with a few exceptions. For comparing Maryland's Medicare readmission rate to the national readmission rate, the Centers for Medicare & Medicaid Services (CMS) will calculate an unadjusted readmission rate for Medicare beneficiaries. Since the Health Services Cost Review Commission (HSCRC) measure is for hospital-specific payment purposes, adjustments had to be made to the metric that accounted for planned admissions and SOI. See below for details on the readmission calculation for the program.

2) Adjustments to Readmission Measurement

The following discharges are removed from the numerator and/or denominator for the readmission rate calculations:

- Planned readmissions are excluded from the numerator based upon the CMS Planned Readmission Algorithm V. 3.0. The HSCRC has also added all vaginal and C-section deliveries as planned using the APR-DRGs rather than principal diagnosis (APR-DRGs 540, 541, 542, 560). Planned admissions are counted in the denominator because they could have an unplanned readmission.
- Discharges for newborn APR-DRG are removed.
- Admissions with ungroupable APR-DRGs (955, 956) are not eligible for a readmission but can be a readmission for a previous admission.
- Hospitalizations within 30 days of a hospital discharge where a patient dies is counted as a readmission, however the readmission is removed from the denominator because there cannot be a subsequent readmission.
- Admissions that result in transfers, defined as cases where the discharge date of the admission is on the same or next day as the admission date of the subsequent admission, are removed from the denominator counts. Thus, only one admission is counted in the denominator and that is the admission to the transfer hospital. It is this discharge date that is used to calculate the 30-day readmission window.
- Discharges from rehabilitation hospitals (provider ids Chesapeake Rehab 213028, Adventist Rehab 213029, and Bowie Health 210333).

- Holy Cross Germantown is excluded from the program until it has one full year of base period data; Levindale is included in the program; and chronic beds within acute care hospitals are excluded for this year but will be included in future years.
- In addition, the following data cleaning edits are applied:
    - Cases with null or missing Chesapeake Regional Information System unique patient identifiers (CRISP EIDs) are removed.
    - Duplicates are removed.
    - Negative interval days are removed.
    - HSCRC staff is revising case-mix data edits to prevent submission of duplicates and negative intervals, which are very rare. In addition, CRISP EID matching benchmarks are closely monitored. Currently, 99 percent of inpatient discharges have a CRISP EID.

3) Improving Accuracy of Maryland and National Readmission Rate Comparison

In addition to the above adjustments, below are the specification changes made to allow an accurate comparison of Maryland's Medicare readmission rates with those of the nation.

- Requiring a 30-day enrollment period in fee-for-service (FFS) Medicare after hospitalization to fully capture all readmissions.
- Removing planned readmissions using the CMS planned admission logic for consistency with the CMS readmission measures.
- Excluding specially-licensed rehabilitation and psychiatric beds from Maryland rates due to inability to include these beds in national estimates due to data limitations. In contrast, the HSCRC includes psychiatric and rehabilitation readmissions in the all-payer readmission measure used for payment policy.
- Refining the transfer logic to be consistent with other CMS readmission measures.
- Changing the underlying data source to ensure clean data and inclusion of all appropriate Medicare FFS claims (e.g., adjusting the method for calculating claims dates and including claims for patients with negative payment amounts).

4) Details on the Calculation of Case-Mix Adjusted Readmission Rate

Data Source:

To calculate readmission rates for the RRIP, the inpatient abstract/case-mix data with CRISP EIDs (so that patients can be tracked across hospitals) is used for the measurement period plus an extra 30 days. To calculate the case-mix adjusted readmission rate for the CY 2013 base period

and the CY 2016 performance period, data from January 1 through December 31, plus 30 days in January of the next year would be used.

SOFTWARE: APR-DRG Version 32

Calculation:

$$\text{Risk-Adjusted Readmission Rate} = \frac{\text{(Observed Readmissions)}}{\text{(Expected Readmissions)}} \times \text{Statewide Readmission Rate}$$

Numerator: Number of observed hospital specific unplanned readmissions.

Denominator: Number of expected hospital specific unplanned readmissions based upon discharge APR-DRG and Severity of Illness. See below for how to calculate expected readmissions adjusted for APR-DRG SOI.

Risk Adjustment Calculation:

- Calculate the Statewide Readmission Rate without Planned Readmissions.
    - Statewide Readmission Rate = Total number of readmissions with exclusions removed / Total number of hospital discharges with exclusions removed.
- For each hospital, calculate the number of observed unplanned readmissions.
- For each hospital, calculate the number of expected unplanned readmissions based upon discharge APR-DRG SOI (see below for description). For each hospital, cases are removed if the discharge APR-DRG and SOI cells have less than two total cases in the base period data (CY 2013).
- Calculate the ratio of observed (O) readmissions over expected (E) readmissions. A ratio of > 1 means that there were more observed readmissions than expected based upon that hospital's case mix. A ratio < 1 means that there were fewer observed readmissions than expected based upon that hospital's case mix.
- Multiply O/E ratio by the statewide rate to get risk-adjusted readmission rate by hospital.

Expected Values:

The expected value of readmissions is the number of readmissions a hospital, given its mix of patients as defined by discharge APR-DRG category and SOI level, would have experienced had its rate of readmissions been identical to that experienced by a reference or normative set of hospitals. Currently, HSCRC is using state average rates as the benchmark.

The technique by which the expected value or expected number of readmissions is calculated is called indirect standardization. For illustrative purposes, assume that every discharge can meet the criteria for having a readmission, a condition called being "at risk" for a readmission. All discharges will either have no readmissions or will have one readmission. The readmission rate is the proportion or percentage of admissions that have a readmission.

The rates of readmissions in the normative database are calculated for each APR-DRG category and its SOI levels by dividing the observed number of readmissions by the total number of discharges. The readmission norm for a single APR-DRG SOI level is calculated as follows:

Let:

N = norm
P = Number of discharges with a readmission
D = Number of discharges that can potentially have a readmission
i = An APR DRG category and a single SOI level

$$N_i = \frac{P_i}{D_i}$$

For this example, this number is displayed as readmissions per discharge to facilitate the calculations in the example. Most reports will display this number as a rate per one thousand.

Once a set of norms has been calculated, they can be applied to each hospital. For this example, the computation is for an individual APR-DRG category and its SOI levels. This computation could be expanded to include multiple APR-DRG categories or any other subset of data, by simply expanding the summations.

Consider the following example for an individual APR DRG category.

Expected Value Computation Example

1 Severity of Illness Level	2 Discharges at Risk for Readmission	3 Discharges with Readmission	4 Readmissions per Discharge	5 Normative Readmissions per Discharge	6 Expected # of Readmissions
1	200	10	.05	.07	14.0
2	150	15	.10	.10	15.0
3	100	10	.10	.15	15.0
4	50	10	.20	.25	12.5

Total	**500**	**45**	**.09**		**56.5**

For the APR-DRG category, the number of discharges with readmission is 45, which is the sum of discharges with readmissions (column 3). The overall rate of readmissions per discharge, 0.09, is calculated by dividing the total number of discharges with a readmission (sum of column 3) by the total number of discharges at risk for readmission (sum of column 2), i.e., 0.09 = 45/500. From the normative population, the proportion of discharges with readmissions for each SOI level for that APR-DRG category is displayed in column 5. The expected number of readmissions for each SOI level shown in column 6 is calculated by multiplying the number of discharges at risk for a readmission (column 2) by the normative readmissions per discharge rate (column 5) The total number of readmissions expected for this APR-DRG category is the expected number of readmissions for the SOI.

In this example, the expected number of readmissions for this APR-DRG category is 56.5, compared to the actual number of discharges with readmissions of 45. Thus, the hospital had 11.5 fewer actual discharges with readmissions than were expected for this APR-DRG category. This difference can also be expressed as a percentage.

APR-DRGs by SOI categories are excluded from the computation of the actual and expected rates when there are only zero or one at risk admission statewide for the associated APR-DRG by SOI category.

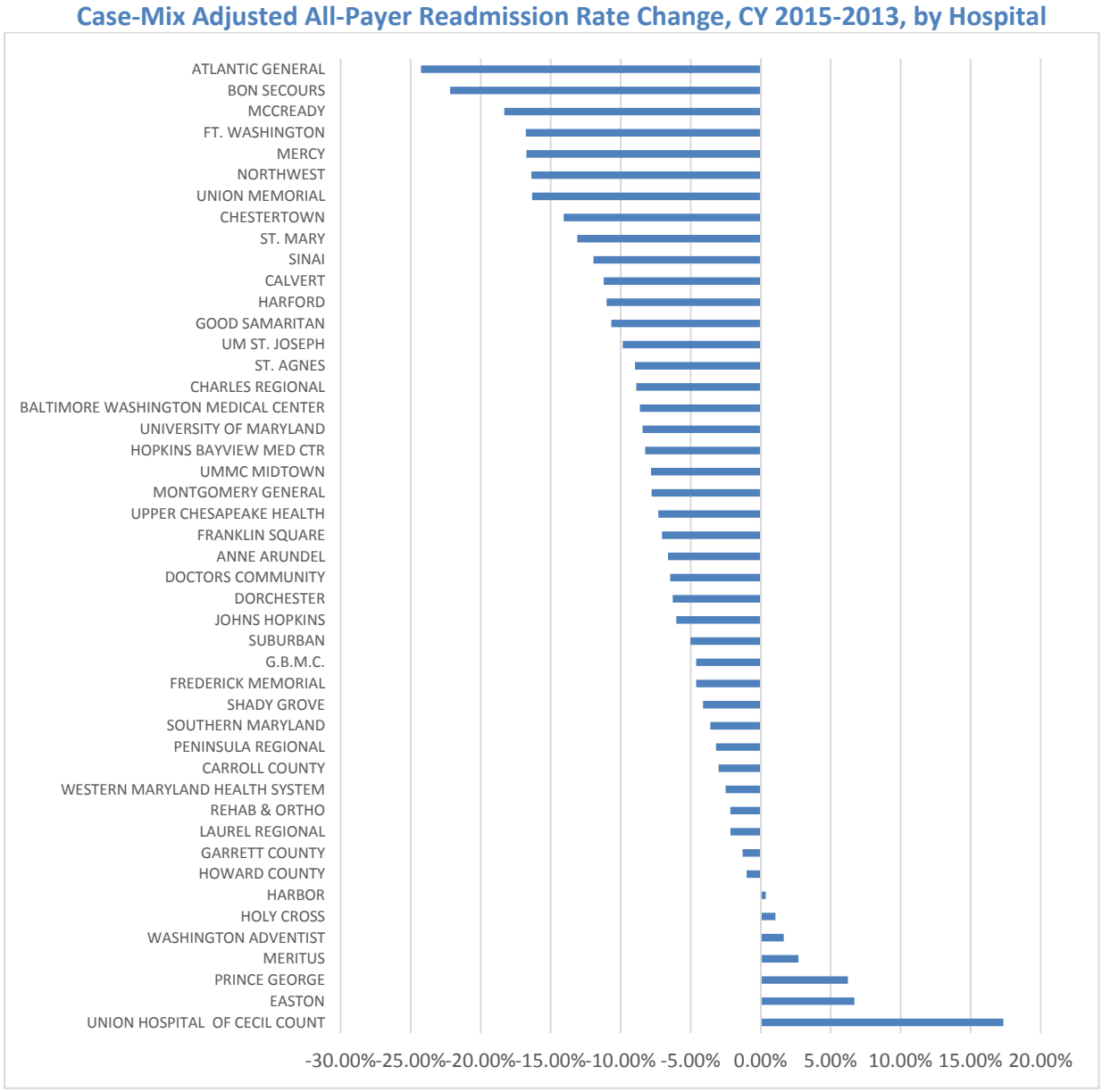
APPENDIX II. CMS MEDICARE TEST READMISSION MEASURE VERSION 5 CHANGES

Below are the specification changes made to allow an accurate comparison of Maryland's Medicare readmission rates with those of the nation.

- Requiring a 30-day enrollment period in fee-for-service (FFS) Medicare after hospitalization to fully capture all readmissions.
- Removing planned readmissions using the CMS planned admission logic for consistency with the CMS readmission measures.
- Excluding specially-licensed rehabilitation and psychiatric beds from Maryland rates due to inability to include these beds in national estimates due to data limitations. In contrast, the HSCRC includes psychiatric and rehabilitation readmissions in the all-payer readmission measure used for payment policy.
- Refining the transfer logic to be consistent with other CMS readmission measures.
- Changing the underlying data source to ensure clean data and inclusion of all appropriate Medicare FFS claims (e.g., adjusting the method for calculating claims dates and including claims for patients with negative payment amounts).

APPENDIX III. ALL-PAYER HOSPITAL-LEVEL READMISSION RATE CHANGE CY 2015-2013

The following figure presents the change in all-payer case-mix adjusted readmissions by hospital between CY 2013 and CY 2015 (Final calculations with ICD-10 Corrections).



APPENDIX IV. REPORT BY MATHEMATICA POLICY RESEARCH – DEVELOPMENT OF A RISK-ADJUSTED READMISSION RATE: SUMMARY OF FINDINGS

MATHEMATICA Policy Research

REPORT

Development of a Risk-Adjusted Readmission Rate: Summary of Findings

June 2, 2016

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CONTENTS

EXHIBITS

A. Overview[10]

Hospital readmission rates in the state of Maryland historically have been significantly higher than the national average. Through its waiver agreement with the Center for Medicare and Medicaid Innovation (CMMI), the state must reduce its average 30-day readmission rate among Medicare fee-for-service beneficiaries to the national average readmission rate by 2018. Progress toward this goal is monitored by CMMI each year. Meeting the terms of the waiver agreement is challenging because of Maryland's high readmission rate at baseline, and because the national readmission rate has been decreasing in recent years.

The Health Services Cost Review Commission (HSCRC) developed the Readmissions Reduction Incentive Program (RRIP) to incentivize reductions in readmissions in the state. The program is based on hospital performance on a measure of all-payer readmissions, in line with the state's all-payer approach to health care finance reform. Hospital performance in the program is assessed by measuring improvement (reductions) in hospital readmission rates from a baseline readmission rate. The baseline rate is currently based on performance during calendar year (CY) 2013. HSCRC sets improvement targets each year and applies financial adjustments to hospitals' budgets based on their ability to meet those targets.

B. Research objectives

The primary goal of our analysis is to assess how HSCRC calculates the expected number of readmissions at each hospital, which affects the risk-adjusted readmission rate (RARR) used in the RRIP. The current approach relies on an indirect standardization method that adjusts a hospital's expected number of readmissions based on its distribution of inpatient stays across each combination of All Patient Refined Diagnosis Related Group (APR-DRG) and Severity of Illness (SOI). To assess this method, we estimate logistic regressions, taking as the dependent variable readmission within 30 days, to perform the following key steps:

1. **Estimate a regression-based version of the current indirect standardization method.** We estimate an APR-DRG SOI fixed effects regression, which yields mathematically equivalent numbers of expected readmissions. This allows us to assess the baseline predictive ability (via the c-statistic) and the percentage of variation explained (via the r-square) of the current approach. We also compare the hospital ranks produced by the current approach to ranks produced by CMS' Hospital-Wide Readmission (HWR) measure. We do so to assess how well the HSCRC approach captures hospital performance, relative to CMS's well-vetted model. HSCRC measure is based on all-payer readmission rate, while CMS HWR measure only measures Medicare patients.

[10] This summary is based on Mathematica's analyses that can be found in "Final Report: Development of a Risk-Adjusted Readmission Rate and Peer Grouping Strategy", June 2016.

2. **Test the impact of controlling for other patient-level covariates, like age, gender, co-morbidities, primary payer, and socio-economic status.** Once we establish the baseline regression, we assess how adding covariates impacts model performance and investigate the correlation of the additional covariates with the probability of readmission. We use the Area Deprivation Index (ADI) as a measure of patient socioeconomic status.[11]

3. **Assess the impacts of alternate model specifications on hospitals' RARRs and improvement rates**. For each model specification, we examine the impact of the new model on hospital performance, relative to the baseline model. This enables us to observe whether particular covariates, or combinations of covariates, have larger impacts on hospitals' baseline rates and/or rates of improvement or whether particular hospitals have larger deviations from baseline than others. The various models we run change the set of covariates included as explanatory variables.

C. Key findings

The risk-adjustment analysis yielded a few clear findings and considerations:

1. **The current HSCRC methodology yields predictive ability that is greater than other readmission measures that are widely used.** The current approach yields a c-statistic of .712, which meets the "rule of thumb" threshold of .70 for acceptable predictive ability of a model (see Exhibit 1), and is greater than the c-statistic of CMS' HWR measure and each of the condition- and procedure-specific readmission measures used in CMS' Hospital Readmission Reduction Program (all have a c-statistic of less than .70).[12]
2. **The addition of covariates improves model predictive power marginally, relative to baseline.** APR-DRG SOI categories appear to be the most powerful predictors of readmissions, relative to other covariates. (Exhibit 1).
3. **The baseline model yields hospital ranks that are positively correlated with the ranks from the CMS HWR measure.** The correlation coefficient between the ranks was .69 (data not shown). Perfect correlation was not expected across the two measures, given the underlying differences in data, time frame, patient population, covariates, and statistical methods. However, the positive correlation evidences the validity of the current method, suggesting that it measures "true" hospital performance and is a useful tool for assessing attainment within the RRIP.
4. **ADI is correlated with the probability of readmission at the patient-level, and the magnitude of the association is slightly attenuated when hospital fixed effects are**

[11] For information on the development and content of the ADI, see: https://www.hipxchange.org/ADI
[12] See the CMS readmission measure methodology reports, available here: https://www.qualitynet.org/dcs/ContentServer?c=Page&pagename=QnetPublic%2FPage%2FQnetTier4&cid=1219069855841

included in the model (Exhibit 2). Patients from areas at the highest end of the ADI distribution have higher odds of readmission, although those odds decrease slightly when hospital fixed effects are included. This suggest that some portion of the relationship between patient-level ADI and probability of readmission is driven by hospital-level factors.

5. **Compared to the baseline, hospital rankings for readmission rates and improvement are not impacted greatly by adjustment using a model containing other available patient-level characteristics. (Exhibits 3 and 4).** The correlations between CY 2013 RARRs derived from the baseline model and Models 15, and Models 18 – 20 are all greater than .90. The risk-adjusted models yield improvement rates that are generally similar to the improvement rates from the baseline model. For example, Exhibit 4 shows that improvement rates from Model 20 are close to baseline improvement rates, and become slightly larger. Adding a hospital-level covariate such as a hospital's proportion of high ADI patients reduces correlation with the baseline substantially (r=.616).

6. **APR-DRG fixed effects can be replaced by APR-DRG readmission norms to reduce computational intensiveness**. We found that a model based on CY 2013 norms (Model 15) yielded almost identical results as the baseline model and is much simpler to estimate because it replaces over 1,000 dummy variables with a single continuous variable. The norms are similar to APR-DRG weights but calibrated to 30-day readmissions, as opposed to resource use.

7. **Incorporating comorbidities into RRIP requires defining covariates over both ICD-9 and ICD-10 data.** Some of the covariates that we tested are sensitive to the underlying form of the diagnosis codes. For example, the Elixhauser co-morbidity algorithm reads diagnosis codes and creates flag for whether a diagnosis code indicates a co-morbid condition. Implementing a risk-adjusted model that uses Elixhauser co-morbidities as covariates will require the use of both an ICD-9 and an ICD-10 version of the algorithm.

D. Limitations

There are a few limitations to this analysis. First, our assessment of the impact of adopting alternate risk-adjusted models on the measurement of hospital performance focused on how they affect improvement, reflecting the current design of the RRIP. If the design of the RRIP were to be changed to incentivize attainment, we recommend additional analyses to compare impacts of the various models on attainment. Second, measurement of improvement from CY 2013 to CY 2015 was incomplete due to the ICD-10 diagnosis codes used in 2015; all analyses on improvement used rates calculated on data in which the fourth quarters of 2013 and 2015 were excluded. Third, none of these risk-adjustment approaches addresses the issue that hospitals with relatively low readmission rates in CY 2013 have less opportunity for improvement than other hospitals. This issue would have to be addressed through the policy design. Finally, at this time, neither statistical reliability nor validity of these models has been comprehensively assessed.

E. Recommendations

Based on these findings, we do not see compelling evidence that HSCRC should change its risk-adjustment methodology at this time. APR-DRG SOI categories appear to contain much of the predictive and explanatory information that other potential covariates contribute to the model. As noted above, if HSCRC decides to adopt an alternate risk-adjusted model, it should consider (1) adopting a model based on CY 2013 norms to reduce computation times, (2) planning and testing for the implementation of the model on ICD-10 data, and (3) performing additional tests of the impacts of the model on hospital performance measurement (attainment and improvement).

Exhibit 1. Summary of models tested and performance statistics

Model	Controls	c-statistic	Max-rescaled R square
Baseline	APR-DRG SOI Fixed Effects	0.712	0.128
B2	ADI Vigintiles	0.547	0.006
Model 1	APR-DRG SOI Fixed Effects and ADI Vigintiles	0.715	0.131
Model 2	Baseline Plus Gender and Age	0.713	0.129
Model 3	Model 2 Plus Elixhauser Comorbidities	0.728	0.144
Model 3P	Model 3 Plus Payer	0.732	0.149
Model 4	Model 3 Plus ADI Vigintiles	0.730	0.146
Model 4P	Model 3P Plus ADI Vigintiles	0.733	0.150
Model 5	APR-DRG Weight	0.594	0.010
Model 6	Model 5 Plus Gender and Age	0.599	0.030
Model 7	Model 6 Plus Elixhauser Comorbidities	0.688	0.086
Model 8	Model 7 Plus ADI Vigintiles	0.690	0.089
Model 9	CY 2013 Norms (linear)	0.712	0.114
Model 10	Model 9 Plus ADI Vigintiles	0.714	0.117
Model 11	Model 9 Plus Gender and Age	0.712	0.117
Model 12	Model 11 Plus Elixhauser Comorbidities	0.726	0.132
Model 13	Model 12 Plus Payer	0.729	0.136
Model 14	Model 13 Plus ADI Vigintiles	0.730	0.137
Model 15	CY 2013 Norms (logged)	0.712	0.127
Model 16	Model 15 Plus ADI Vigintiles	0.715	0.130
Model 17	Model 15 Plus Gender and Age	0.713	0.129
Model 18	Model 17 Plus Elixhauser Comorbidities	0.726	0.142
Model 19	Model 18 Plus Payer	0.730	0.147
Model 20	Model 19 Plus ADI Vigintiles	0.731	0.148
Model 21	Model 20 Plus Hospital-level control for High ADI	0.732	0.149

Source: Mathematica analysis of CY 2013 Readmissions data provided by HSCRC.
Notes: (1) Elixhauser comorbidities were identified using the diagnostic information on the index stay.
(2) ADI = Area Deprivation Index. Mathematica used the values carried on the file provided by HSCRC.
(3) The ADI vigintile indicators reflect the placement of the ADI value in the national distribution of ADI values.
(4) Hospital-level control for High ADI (Model 21) is the percentage of patients from the 85th or higher percentile in the ADI distribution that were discharged by the hospital in 2013.

Exhibit 2. Relation between ADI and readmissions

	Without hospital fixed effects		With hospital fixed effects	
ADI vigintile	Odds ratio	p-value	Odds ratio	p-value
1st (lowest)	1.173	<.0001	1.186	<.0001
2nd	1.250	<.0001	1.267	<.0001
3rd	1.227	<.0001	1.254	<.0001
4th	1.261	<.0001	1.289	<.0001
5th	1.198	<.0001	1.232	<.0001
6th	1.220	<.0001	1.253	<.0001
7th	1.197	<.0001	1.244	<.0001
8th	1.300	<.0001	1.342	<.0001
9th	1.243	<.0001	1.284	<.0001
10th	1.305	<.0001	1.329	<.0001
11th	1.298	<.0001	1.312	<.0001
12th	1.234	<.0001	1.250	<.0001
13th	1.209	<.0001	1.224	<.0001
14th	1.314	<.0001	1.327	<.0001
15th	1.313	<.0001	1.331	<.0001

	Without hospital fixed effects		With hospital fixed effects	
ADI vigintile	Odds ratio	p-value	Odds ratio	p-value
16th	1.321	<.0001	1.316	<.0001
17th	1.335	<.0001	1.316	<.0001
18th	1.317	<.0001	1.282	<.0001
19th	1.397	<.0001	1.303	<.0001
20th (highest)	1.378	<.0001	1.252	<.0001
ADI Missing	*Reference*	*Reference*	*Reference*	*Reference*

Source: Source: Mathematica analysis of CY 2013 Readmissions data provided by HSCRC.

Notes: (1) ADI = Area Deprivation Index. Mathematica used the values carried on the file provided by HSCRC.

(2) The table reports the odd ratios on the indicator variables for each vigintile of the ADI Distribution from estimating Model 20 with and without hospital fixed effects.

Exhibit 3. Correlation of CY 2013 hospital rates across select models

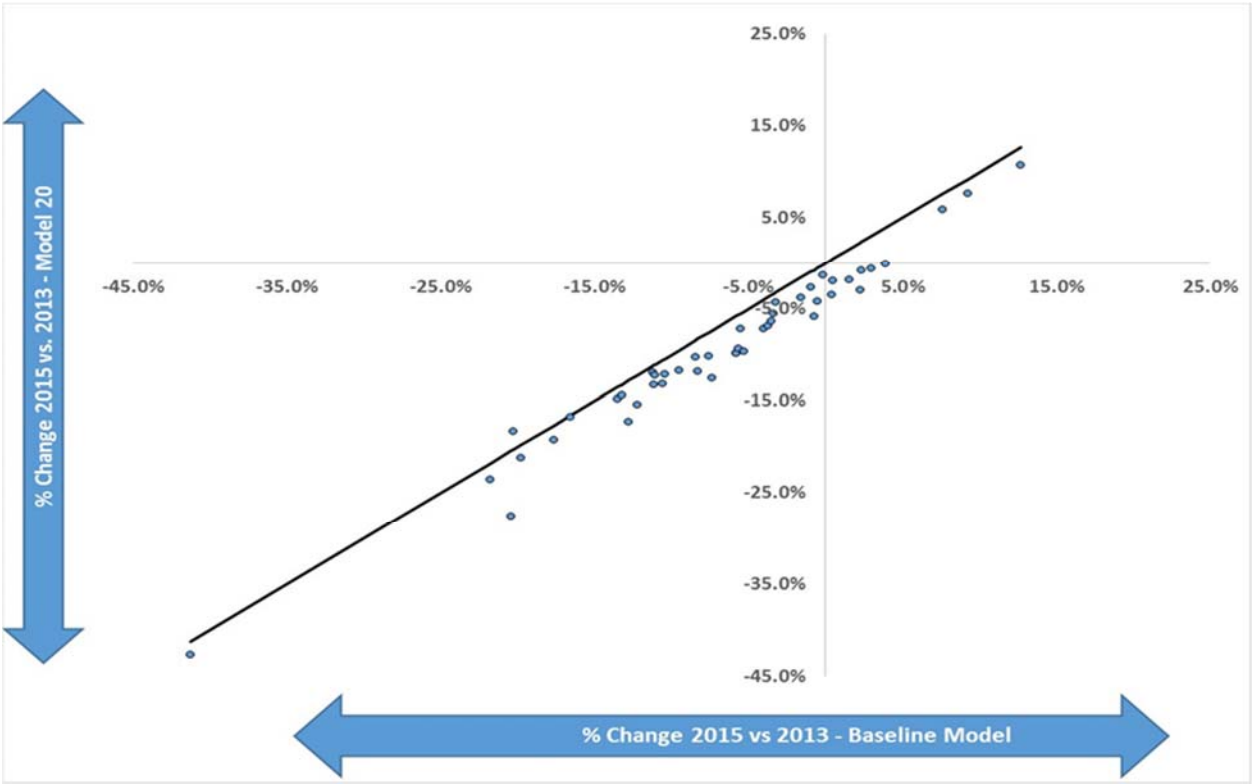
	Baseline	Model 15	Model 18	Model 19	Model 20	Model21
Baseline	1.000	0.999	0.964	0.943	0.908	0.616
Model 15	0.999	1.000	0.965	0.944	0.909	0.617
Model 18	0.964	0.965	1.000	0.992	0.978	0.756
Model 19	0.943	0.944	0.992	1.000	0.992	0.801
Model 20	0.908	0.909	0.978	0.992	1.000	0.856
Model 21	0.616	0.617	0.756	0.801	0.856	1.000

Source: Mathematica analysis of CY 2013 Readmissions data provided by HSCRC.

Notes: (1) Models 1) Models 15 and 18 – 21 use the CY 2013 norms as a basis, in place of the individual APR-DRG SOI fixed effects.

(2) Each of the correlation coefficients reported in the table are statistically significant at the <.0001 level.

Exhibit 4. Impact of risk-adjustment on rates on improvements



Source: Mathematica analysis of 2013 and 2015 Readmissions data provided by HSCRC.

Notes: (1) Quarter 4 of 2013 and 2015 have been excluded because of discharges containing ICD10 in Q42015.

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APPENDIX V. SUMMARY OF THE MARYLAND HOSPITAL ASSOCIATION RATE YEAR 2018 RRIP PROGRAM PROPOSAL

MHA Readmissions Policy Recommendations

April 2016

MHA is recommending a readmissions policy that includes consideration of the readmission rate that a hospital attains (the hospital's rate compared to a target rate) and how much the hospital has improved its readmission rate compared to its own performance in a base period. The MHA recommendations for an attainment and improvement policy can be added to the HSCRC's current approach that sets an improvement target and ties specific improvement milestones to payment adjustment. The MHA approach can also be used with the current risk model—statewide readmission rates, or "norms"—or one of the more sophisticated risk models in development. MHA's preference is for a risk model that moves beyond the norms and includes additional factors such as age, gender, primary payer, additional chronic co-morbid conditions and measures of neighborhood socio-economic status; however, we recognize that these models are still in development and need to be fully vetted before they are used in a payment policy.

To include both attainment and improvement in the readmissions policy, MHA proposes to set a statewide risk-adjusted readmission attainment target, similar to the current policy which sets an improvement target. Individual hospitals' performance relative to the statewide risk-adjusted target would be tied to specific payment adjustment amounts, and hospitals would be evaluated on both attainment and improvement performance. The hospital's final payment adjustment would be the "better of" the two adjustments.

The chart below shows how the performance milestones could be linked to pre-set payment adjustments. For example, if a hospital's readmission rate in the performance year is 3.0 percent above (worse than) the target, the hospital would score a 0.25 percent attainment penalty. However, if that hospital had improved its readmission rate by 7.5 percent, it would score a 0.72 percent improvement reward. The actual payment adjustment would be the better of the two scores, or a positive 0.72 percent adjustment. Similarly, if a hospital's readmission rate is 5.5 percent below the target, the hospital would score a 0.51 percent payment increase for attainment. On the improvement scale, if the hospital had improved compared to its base rate by 2.0 percent, its improvement payment adjustment score would be a positive 0.15 percent. The actual payment adjustment would be the better of the two scores, or a 0.51 percent positive adjustment. A hospital with a readmission rate worse than the target and that fails to improve would receive a negative payment adjustment.

Attainment Payment Scale					**Improvement Payment Scale**			
	Performance vs Target	Payment Adjustment				Percent Improvement	Payment Adjustment	
Outperform target by	-20.0%	2.00%	Max attainment reward		Performance improves	-20.0%	2.00%	Max improvement reward
	-15.0%	1.50%				-15.0%	1.50%	
	-12.3%	1.20%				-12.3%	1.20%	
	-10.3%	1.00%				-10.3%	1.00%	
	-7.5%	0.72%				-7.5%	0.72%	
	-5.5%	0.51%				-5.5%	0.51%	
	-3.0%	0.25%				-3.0%	0.25%	
	-2.0%	0.15%				-2.0%	0.15%	
	-1.0%	0.05%				-1.0%	0.05%	
Target	0.0%	0.00%						
Miss target by	1.0%	-0.05%			Performance declines	1.0%	-0.05%	
	2.0%	-0.15%				2.0%	-0.15%	
	3.0%	-0.25%				3.0%	-0.25%	
	5.5%	-0.51%				5.5%	-0.51%	
	7.5%	-0.72%				7.5%	-0.72%	
	10.3%	-1.00%				10.3%	-1.00%	
	12.3%	-1.20%				12.3%	-1.20%	
	15.0%	-1.50%				15.0%	-1.50%	
	20.0%	-2.00%	Max attainment penalty			20.0%	-2.00%	Max improvement pe

This approach includes several features that have worked well in the HSCRC's Quality Based Reimbursement and Maryland Hospital Acquired Conditions programs. The "better of" attainment or improvement is designed to "raise all boats" by providing an incentive to achieve best performance for all hospitals regardless of where on the spectrum they are starting. In addition, the use of defined performance targets and evaluation of individual hospital performance relative to those targets tied to payment adjustments provides a clear goal and predictable revenue consequences that hospitals can monitor progress toward throughout the year. Because the approach is straightforward, it requires little to no additional work to implement and could be accomplished using the current readmissions reporting and tracking systems.

APPENDIX VI. SUMMARY OF THE CAREFIRST RATE YEAR 2018 RRIP PROGRAM PROPOSAL

Summary of the CareFirst Proposal to modify the RRIP and Combine it with the HSCRC's RSSP

In response to complaints from hospitals regarding a potential unfairness in the Readmission Reduction Incentive Program (RRIP) policy, the HSCRC staff revised the RRIP methodology to reduce the uniform readmission rate reduction percentage for hospitals with lower base year readmission rate attainment levels. This modification was based on a presumption that hospitals with low readmission rates may have less opportunity to reduce their readmission rates at the same percentage than hospitals with higher base year readmission rates. However, in making this modification to the RRIP policy, the staff did not account for certain factors (i.e., a hospital's number of out-of-state readmissions or the Socio-Economic Status (SES) of a hospital's patients), which can have a substantial (both positive and negative) impact on hospital readmission rate attainment levels.

Also, given the multitude of overlapping incentives in the rate setting system for readmission reduction, many representatives of the HSCRC's Performance Measurement Work Group (PMWG) have suggested that the Commission staff consider the development of a single incentive-based readmission policy that would combine elements of the RRIP and the HSCRC' Readmission Shared Saving Program (RSSP), address certain issues in the measurement of readmission attainment, improvement performance and hopefully streamline the Commission's overall attempt to incentivize hospitals to reduce unnecessary readmissions.

CareFirst's proposed modification to the RRIP and RSSP draws on previous HSCRC policy approaches (specifically the HSCRC's Uncompensated Care and Disproportionate Share methodologies) that attempted to address similar policy issues and proposes a method for combining the RSSP and the RRIP methodologies into one integrated readmission incentive structure. The proposed approach includes suggested adjustments to improve the overall fairness of a readmission performance assessment by taking into consideration the Socio-Economic Status (SES) of a hospital's patients, its level of out-of-state readmissions and its base year readmission rate attainment level. Finally, the proposal recommends combining elements of the HSCRC's RSSP and RRIP into a single program that takes into account both readmission attainment and improvement, unifies and strengthens the incentives for hospitals to reduce their readmissions and provides flexibility for the HSCRC to incorporate other categories of unnecessary hospital utilization, such as the Patient Quality Indicators (PQIs), into the methodology in future years.

APPENDIX VII. RY 2017 IMPROVEMENT AND ATTAINEMENT MODEL RESULTS

The following figure presents the proposed CY 2016 readmission target rates. Columns A and B show the hospital's actual case-mix adjusted readmission rates for CYs 2013 and 2015 respectively; column C shows the percent change between the two years. Columns D through G present the scaling results using the current methodology, and columns H through L present the scaling results using the proposed attainment methodology. (FY 16 Permanent Global Budgets and Readmission Rates are updated from the draft recommendation)

				Improvement Scaling (Current)				Attainment (Proposed)				
Hospital Name	CY 13 Case-Mix Adjusted Rate Adjusted for Out of State A	CY 15 Case-Mix Adjusted Rate Adjusted for Out of State B	% Change In In-state readmission Rate C	Target D	Over/ Under Target E=C-D	FY 17 Scaling F	FY 17 Adjustment G	Target (Best % 25 in CY15) H	Over/ Under Target I	FY 17 Scaling J	FY 17 Adjustment K	FY17 Better of Attainment/ Improvement L =(G or K)
ATLANTIC GENERAL	14.15%	10.91%	-24.27%	-9.3%	-15.0%	1.00%	$377,503	12.09%	-9.8%	1.00%	$377,503	**$377,503**
BON SECOURS	20.69%	16.29%	-22.18%	-9.3%	-12.9%	1.00%	$747,897	12.09%	34.7%	-2.00%	-$1,495,794	**$747,897**
MCCREADY	13.05%	10.66%	-18.31%	-9.3%	-9.0%	1.00%	$28,152	12.09%	-11.9%	1.00%	$28,152	**$28,152**
FT. WASHINGTON	17.84%	15.09%	-16.77%	-9.3%	-7.5%	0.86%	$169,027	12.09%	24.8%	-2.00%	-$393,495	**$169,027**
MERCY	16.09%	13.37%	-16.73%	-9.3%	-7.4%	0.85%	$1,829,580	12.09%	10.5%	-1.15%	-$2,462,822	**$1,829,580**
NORTHWEST	16.13%	13.63%	-16.38%	-9.3%	-7.1%	0.81%	$928,955	12.09%	12.7%	-1.39%	-$1,589,234	**$928,955**
UNION MEMORIAL	15.43%	12.92%	-16.33%	-9.3%	-7.0%	0.81%	$1,924,508	12.09%	6.8%	-0.74%	-$1,769,936	**$1,924,508**
CHESTERTOWN	15.51%	13.65%	-14.07%	-9.3%	-4.8%	0.55%	$118,368	12.09%	12.8%	-1.40%	-$302,789	**$118,368**
ST. MARY	14.96%	12.89%	-13.10%	-9.3%	-3.8%	0.44%	$302,515	12.09%	6.6%	-0.72%	-$495,911	**$302,515**
SINAI	15.33%	13.55%	-11.94%	-9.3%	-2.6%	0.30%	$1,261,452	12.09%	12.0%	-1.32%	-$5,468,066	**$1,261,452**
CALVERT	12.02%	11.26%	-11.22%	-9.3%	-1.9%	0.22%	$137,271	12.09%	-6.9%	0.80%	$496,475	**$496,475**
HARFORD	12.86%	11.25%	-11.01%	-9.3%	-1.7%	0.20%	$90,002	12.09%	-6.9%	0.80%	$365,003	**$365,003**

				Improvement Scaling (Current)				Attainment (Proposed)				
Hospital Name	CY 13 Case-Mix Adjusted Rate Adjusted for Out of State A	CY 15 Case-Mix Adjusted Rate Adjusted for Out of State B	% Change In In-state readmission Rate C	Target D	Over/ Under Target E=C-D	FY 17 Scaling F	FY 17 Adjustment G	Target (Best % 25 in CY15) H	Over/ Under Target I	FY 17 Scaling J	FY 17 Adjustment K	FY17 Better of Attainment/ Improvement L =(G or K)
GOOD SAMARITAN	15.17%	13.61%	-10.67%	-9.3%	-1.4%	0.16%	$253,081	12.09%	12.5%	-1.37%	-$2,204,272	**$253,081**
UM ST. JOSEPH	12.83%	11.60%	-9.85%	-9.3%	-0.6%	0.06%	$148,146	12.09%	-4.0%	0.47%	$1,090,176	**$1,090,176**
ST. AGNES	15.03%	13.65%	-8.98%	-9.3%	0.3%	-0.04%	-$82,444	12.09%	12.9%	-1.40%	-$3,262,263	**-$82,444**
CHARLES REGIONAL	14.19%	13.30%	-8.88%	-9.3%	0.4%	-0.05%	-$30,756	12.09%	9.9%	-1.09%	-$728,126	**-$30,756**
BALTIMORE WASHINGTON MEDICAL CENTER	15.52%	14.12%	-8.63%	-9.3%	0.7%	-0.07%	-$173,421	12.09%	16.8%	-1.83%	-$4,362,101	**-$173,421**
UNIVERSITY OF MARYLAND	15.99%	14.53%	-8.43%	-9.3%	0.9%	-0.09%	-$860,116	12.09%	20.1%	-2.00%	-$18,120,681	**-$860,116**
HOPKINS BAYVIEW MED CTR	16.65%	15.30%	-8.26%	-9.3%	1.0%	-0.11%	-$391,289	12.09%	26.5%	-2.00%	-$6,864,594	**-$391,289**
UMMC MIDTOWN	17.86%	16.60%	-7.84%	-9.3%	1.5%	-0.16%	-$202,322	12.09%	37.2%	-2.00%	-$2,527,986	**-$202,322**
MONTGOMERY GENERAL	14.15%	12.82%	-7.80%	-9.3%	1.5%	-0.16%	-$124,483	12.09%	6.0%	-0.66%	-$496,524	**-$124,483**
UPPER CHESAPEAKE HEALTH	12.87%	11.94%	-7.32%	-9.3%	2.0%	-0.22%	-$294,598	12.09%	-1.3%	0.15%	$205,126	**$205,126**
FRANKLIN SQUARE	14.12%	13.22%	-7.05%	-9.3%	2.3%	-0.25%	-$675,389	12.09%	9.3%	-1.01%	-$2,780,816	**-$675,389**
ANNE ARUNDEL	13.37%	12.64%	-6.62%	-9.3%	2.7%	-0.29%	-$856,386	12.09%	4.5%	-0.49%	-$1,427,315	**-$856,386**
DOCTORS COMMUNITY	14.70%	14.20%	-6.47%	-9.3%	2.8%	-0.31%	-$410,140	12.09%	17.4%	-1.90%	-$2,523,233	**-$410,140**
DORCHESTER	12.91%	12.06%	-6.28%	-9.3%	3.0%	-0.33%	-$89,117	12.09%	-0.2%	0.03%	$7,682	**$7,682**

				Improvement Scaling (Current)				Attainment (Proposed)				
Hospital Name	CY 13 Case-Mix Adjusted Rate Adjusted for Out of State A	CY 15 Case-Mix Adjusted Rate Adjusted for Out of State B	% Change In In-state readmission Rate C	Target D	Over/ Under Target E=C-D	FY 17 Scaling F	FY 17 Adjustment G	Target (Best % 25 in CY15) H	Over/ Under Target I	FY 17 Scaling J	FY 17 Adjustment K	FY17 Better of Attainment/ Improvement L =(G or K)
JOHNS HOPKINS	16.60%	15.45%	-6.02%	-9.3%	3.3%	-0.36%	-$4,455,925	12.09%	27.8%	-2.00%	-$24,885,958	**-$4,455,925**
SUBURBAN	13.06%	12.83%	-5.02%	-9.3%	4.3%	-0.47%	-$903,478	12.09%	6.0%	-0.66%	-$1,275,325	**-$903,478**
G.B.M.C.	12.09%	11.68%	-4.61%	-9.3%	4.7%	-0.51%	-$1,064,485	12.09%	-3.4%	0.39%	$812,483	**$812,483**
FREDERICK MEMORIAL	11.97%	11.43%	-4.60%	-9.3%	4.7%	-0.51%	-$977,105	12.09%	-5.5%	0.63%	$1,195,780	**$1,195,780**
SHADY GROVE	12.63%	12.10%	-4.12%	-9.3%	5.2%	-0.57%	-$1,248,641	12.09%	0.1%	-0.01%	-$19,893	**-$19,893**
SOUTHERN MARYLAND	15.42%	15.35%	-3.60%	-9.3%	5.7%	-0.62%	-$974,946	12.09%	26.9%	-2.00%	-$3,131,295	**-$974,946**
PENINSULA REGIONAL	12.73%	12.13%	-3.19%	-9.3%	6.1%	-0.67%	-$1,619,362	12.09%	0.3%	-0.03%	-$70,296	**-$70,296**
CARROLL COUNTY	13.20%	12.81%	-3.01%	-9.3%	6.3%	-0.69%	-$937,201	12.09%	5.9%	-0.65%	-$883,889	**-$883,889**
WESTERN MARYLAND HEALTH SYSTEM	14.14%	13.84%	-2.51%	-9.3%	6.8%	-0.74%	-$1,244,301	12.09%	14.4%	-1.57%	-$2,639,220	**-$1,244,301**
REHAB & ORTHO	9.70%	9.49%	-2.16%	-9.3%	7.1%	-0.78%	-$500,112	12.09%	-21.5%	1.00%	$641,344	**$641,344**
LAUREL REGIONAL	15.71%	14.98%	-2.16%	-9.3%	7.1%	-0.78%	-$471,514	12.09%	23.9%	-2.00%	-$1,208,622	**-$471,514**
GARRETT COUNTY	10.65%	9.73%	-1.29%	-9.3%	8.0%	-0.88%	-$167,557	12.09%	-19.6%	1.00%	$191,491	**$191,491**
HOWARD COUNTY	13.12%	13.00%	-1.01%	-9.3%	8.3%	-0.91%	-$1,501,802	12.09%	7.4%	-0.81%	-$1,348,528	**-$1,348,528**
HARBOR	14.10%	14.18%	0.36%	-9.3%	9.7%	-1.06%	-$1,195,307	12.09%	17.2%	-1.88%	-$2,132,008	**-$1,195,307**
HOLY CROSS	13.49%	13.61%	1.05%	-9.3%	10.4%	-1.13%	-$3,585,730	12.09%	12.5%	-1.37%	-$4,340,616	**-$3,585,730**
WASHINGTON ADVENTIST	13.86%	14.04%	1.65%	-9.3%	10.9%	-1.20%	-$1,857,099	12.09%	16.1%	-1.76%	-$2,733,125	**-$1,857,099**

				Improvement Scaling (Current)				Attainment (Proposed)				
Hospital Name	**CY 13 Case-Mix Adjusted Rate Adjusted for Out of State A**	**CY 15 Case-Mix Adjusted Rate Adjusted for Out of State B**	**% Change In In-state readmission Rate C**	**Target D**	**Over/ Under Target E=C-D**	**FY 17 Scaling F**	**FY 17 Adjustment G**	**Target (Best % 25 in CY15) H**	**Over/ Under Target I**	**FY 17 Scaling J**	**FY 17 Adjustment K**	**FY17 Better of Attainment/ Improvement L =(G or K)**
MERITUS	13.27%	13.50%	2.70%	-9.3%	12.0%	-1.31%	-$2,499,678	12.09%	11.6%	-1.27%	-$2,424,359	**-$2,424,359**
PRINCE GEORGE	14.56%	15.02%	6.23%	-9.3%	15.5%	-1.70%	-$3,738,798	12.09%	24.2%	-2.00%	-$4,406,129	**-$3,738,798**
EASTON	11.96%	12.73%	6.69%	-9.3%	16.0%	-1.75%	-$1,782,013	12.09%	5.3%	-0.57%	-$585,325	**-$585,325**
UNION HOSPITAL OF CECIL COUNT	12.61%	15.35%	17.34%	-9.3%	26.6%	-2.00%	-$1,387,798	12.09%	26.9%	-2.00%	-$1,387,798	**-$1,387,798**
State	**14.26%**	**12.84%**	**-7.13%**	**-9.3%**			**$(27,986,857)**				**$(107,337,130)**	**$(16,007,336)**

APPENDIX VIII. OUT-OF-STATE MEDICARE READMISSION RATIOS

The following figure presents calculation of Out-of-state adjustments using the Medicare readmission information from CMMI. The table is sorted by column C. Garrett County Hospital has the largest proportion of their readmissions occurring at hospitals outside of Maryland, which is equal to 38 percent of their instate readmissions.

HOSPITAL NAME	CY 13 Casemix Adjusted All Payer Readmission Rate (In-State Readmissions)	CY13 Total Medicare Readmission Rate/In-state Readmission Rate	CY 13 Casemix Adjusted Rate with Out-of-State	CY 15 Casemix Adjusted All Payer Readmission Rate (In-State Readmissions)	CY15 Total Medicare Readmission Rate/In-state Readmission Rate	CY 15 Casemix Adjusted Rate with Out-of-State	PERCENT CHANGE Case-mix Adjusted	PERCENT CHANGE WITH OUT-OF STATE Adjustment
A	B	C	D=B*C	E	F	G=E*F	H=E/B-1	I=G/D-1
GARRETT COUNTY	7.73%	1.38	10.65%	7.63%	1.28	9.73%	-1.29%	-8.66%
FT. WASHINGTON	13.95%	1.28	17.84%	11.61%	1.30	15.09%	-16.77%	-15.40%
PRINCE GEORGE	11.56%	1.26	14.56%	12.28%	1.22	15.02%	6.23%	3.17%
SOUTHERN MARYLAND	12.77%	1.21	15.42%	12.31%	1.25	15.35%	-3.60%	-0.43%
UNION HOSPITAL OF CECIL COUNT	10.90%	1.16	12.61%	12.79%	1.20	15.35%	17.34%	21.75%
WASHINGTON ADVENTIST	12.13%	1.14	13.86%	12.33%	1.14	14.04%	1.65%	1.30%
CALVERT	10.61%	1.13	12.02%	9.42%	1.19	11.26%	-11.22%	-6.36%
ST. MARY	13.43%	1.11	14.96%	11.67%	1.10	12.89%	-13.10%	-13.87%
CHARLES REGIONAL	12.95%	1.10	14.19%	11.80%	1.13	13.30%	-8.88%	-6.30%
HOLY CROSS	12.37%	1.09	13.49%	12.50%	1.09	13.61%	1.05%	0.86%
ATLANTIC GENERAL	13.02%	1.09	14.15%	9.86%	1.11	10.91%	-24.27%	-22.88%
JOHNS HOPKINS	15.44%	1.08	16.60%	14.51%	1.07	15.45%	-6.02%	-6.93%
SUBURBAN	12.15%	1.07	13.06%	11.54%	1.11	12.83%	-5.02%	-1.80%

HOSPITAL NAME	CY 13 Casemix Adjusted All Payer Readmission Rate (In-State Readmissions)	CY13 Total Medicare Readmission Rate/In-state Readmission Rate	CY 13 Casemix Adjusted Rate with Out-of-State	CY 15 Casemix Adjusted All Payer Readmission Rate (In-State Readmissions)	CY15 Total Medicare Readmission Rate/In-state Readmission Rate	CY 15 Casemix Adjusted Rate with Out-of-State	PERCENT CHANGE Case-mix Adjusted	PERCENT CHANGE WITH OUT-OF STATE Adjustment
A	B	C	D=B*C	E	F	G=E*F	H=E/B-1	I=G/D-1
WESTERN MARYLAND HEALTH SYSTEM	13.16%	1.07	14.14%	12.83%	1.08	13.84%	-2.51%	-2.15%
PENINSULA REGIONAL	11.93%	1.07	12.73%	11.55%	1.05	12.13%	-3.19%	-4.70%
SHADY GROVE	11.89%	1.06	12.63%	11.40%	1.06	12.10%	-4.12%	-4.19%
LAUREL REGIONAL	14.81%	1.06	15.71%	14.49%	1.03	14.98%	-2.16%	-4.65%
DOCTORS COMMUNITY	13.91%	1.06	14.70%	13.01%	1.09	14.20%	-6.47%	-3.37%
MERITUS	12.61%	1.05	13.27%	12.95%	1.04	13.50%	2.70%	1.74%
MONTGOMERY GENERAL	13.47%	1.05	14.15%	12.42%	1.03	12.82%	-7.80%	-9.41%
CHESTERTOWN	14.78%	1.05	15.51%	12.70%	1.07	13.65%	-14.07%	-11.98%
UNIVERSITY OF MARYLAND	15.30%	1.05	15.99%	14.01%	1.04	14.53%	-8.43%	-9.14%
FREDERICK MEMORIAL	11.51%	1.04	11.97%	10.98%	1.04	11.43%	-4.60%	-4.51%
HARFORD	12.44%	1.03	12.86%	11.07%	1.02	11.25%	-11.01%	-12.49%
MERCY	15.60%	1.03	16.09%	12.99%	1.03	13.37%	-16.73%	-16.92%
ANNE ARUNDEL	13.00%	1.03	13.37%	12.14%	1.04	12.64%	-6.62%	-5.49%
DORCHESTER	12.58%	1.03	12.91%	11.79%	1.02	12.06%	-6.28%	-6.53%
EASTON	11.66%	1.03	11.96%	12.44%	1.02	12.73%	6.69%	6.40%
HOPKINS BAYVIEW MED CTR	16.35%	1.02	16.65%	15.00%	1.02	15.30%	-8.26%	-8.12%

HOSPITAL NAME	CY 13 Casemix Adjusted All Payer Readmission Rate (In-State Readmissions)	CY13 Total Medicare Readmission Rate/In-state Readmission Rate	CY 13 Casemix Adjusted Rate with Out-of-State	CY 15 Casemix Adjusted All Payer Readmission Rate (In-State Readmissions)	CY15 Total Medicare Readmission Rate/In-state Readmission Rate	CY 15 Casemix Adjusted Rate with Out-of-State	PERCENT CHANGE Case-mix Adjusted	PERCENT CHANGE WITH OUT-OF STATE Adjustment
A	B	C	D=B*C	E	F	G=E*F	H=E/B-1	I=G/D-1
CARROLL COUNTY	12.97%	1.02	13.20%	12.58%	1.02	12.81%	-3.01%	-2.94%
HOWARD COUNTY	12.92%	1.02	13.12%	12.79%	1.02	13.00%	-1.01%	-0.97%
BALTIMORE WASHINGTON MEDICAL CENTER	15.29%	1.01	15.52%	13.97%	1.01	14.12%	-8.63%	-8.99%
UPPER CHESAPEAKE HEALTH	12.71%	1.01	12.87%	11.78%	1.01	11.94%	-7.32%	-7.25%
G.B.M.C.	11.94%	1.01	12.09%	11.39%	1.03	11.68%	-4.61%	-3.35%
UM ST. JOSEPH	12.69%	1.01	12.83%	11.44%	1.01	11.60%	-9.85%	-9.57%
BON SECOURS	20.47%	1.01	20.69%	15.93%	1.02	16.29%	-22.18%	-21.25%
HARBOR	13.97%	1.01	14.10%	14.02%	1.01	14.18%	0.36%	0.56%
UNION MEMORIAL	15.31%	1.01	15.43%	12.81%	1.01	12.92%	-16.33%	-16.26%
ST. AGNES	14.93%	1.01	15.03%	13.59%	1.00	13.65%	-8.98%	-9.20%
UMMC MIDTOWN	17.74%	1.01	17.86%	16.35%	1.02	16.60%	-7.84%	-7.05%
SINAI	15.24%	1.01	15.33%	13.42%	1.01	13.55%	-11.94%	-11.61%
GOOD SAMARITAN	15.09%	1.01	15.17%	13.48%	1.01	13.61%	-10.67%	-10.26%
FRANKLIN SQUARE	14.05%	1.00	14.12%	13.06%	1.01	13.22%	-7.05%	-6.38%
NORTHWEST	16.06%	1.00	16.13%	13.43%	1.02	13.63%	-16.38%	-15.50%
MCCREADY	13.05%	1.00	13.05%	10.66%	1.00	10.66%	-18.31%	-18.31%
REHAB & ORTHO	9.70%	1.00	9.70%	9.49%	1.00	9.49%	-2.16%	-2.16%
Hospital Average	**13.44%**		**14.22%**	**13.22%**		**13.22%**	**-6.80%**	**-6.59%**

Maryland
Hospital Association

May 25, 2016

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

Dear Chairman Sabatini:

On behalf of the 64 hospital and health system members of the Maryland Hospital Association (MHA), we appreciate the opportunity to comment on the *Draft Recommendations for the Readmissions Reduction Incentive Program for Rate Year 2018*, the *Draft Recommendations for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018,* and the *Draft Recommendations for the Potentially Avoidable Utilization Savings Policy for Rate Year 2017*. On the whole, we support the HSCRC staff recommendations related to readmissions and the amounts of revenue at risk for specific quality programs; however, we disagree with the staff recommendation on Potentially Avoidable Utilization (PAU) savings and the resulting quality-based payment program adjustment to the update.

MHA's position: the net quality-based payment program adjustment should be reduced from -0.61 percent to -0.16 percent by lowering the expected shared savings offset for Potentially Avoidable Utilization. This would reduce to 0.80 percent HSCRC staff's recommendation of a 1.25 percent reduction in hospital revenues.

- The recommendation to reduce hospital revenue by 1.25 percent according to hospitals' individual percentages of readmissions and admissions for certain chronic conditions, or Prevention Quality Indicators (PQIs), uses an Agency for Healthcare Research and Quality (AHRQ) metric in a way it was not intended. The metric was created not for hospitalized patients, but to measure prevention opportunities in the broader population. It has not been applied as a payment incentive anywhere else in the nation. In fact, a report of an AHRQ Clinical Expert Review Board on expanding the use of PQIs for pay for performance notes that "(p)anelists showed comparatively less support for using these indicators in pay for performance applications." They noted the need for careful risk adjustment and that "higher stakes use" may encourage adverse effects of implementation.

- In our April 4 comment letter (attached), we expressed concerns about, among other things, using the AHRQ measure to require an 11.4 percent reduction in readmissions and PQIs combined in one year. That steep of a reduction is, simply, unattainable, and if an incentive is unattainable it no longer acts as an incentive. It is instead just an arbitrary cut.

- The attempt to justify setting a goal of an 11.4 percent reduction in readmissions and PQIs using a 2012 Institute of Medicine report that suggests 27 percent of health care spending was for unnecessary services, compares apples to oranges. Unnecessary care can occur for many reasons: unnecessary screening exams, duplicative tests, invasive procedures near the end of life, lack of patient understanding of treatment options, defensive medicine and more. The opportunity to reduce this care and the interventions, if available, are varied and require patient and provider behavior change over the long term. Those efforts do not necessarily directly help a Maryland hospital meet a specific PQI reduction of more than 11 percent in one year.

- HSCRC staff's recommendation to reduce hospital revenue by 1.25 percent comes against a backdrop of a proposed global budget increase of just 1.1 percent for all hospitals, already far below inflation. Our recommendation of removing the PQI component and lowering that reduction to 0.80 percent to adjust only for readmissions – an adjustment we agree with – is still an increase over last year's reduction of 0.60 percent.

Aggregate Revenue at Risk
We support the staff recommendations on the remaining amounts at risk for the individual quality programs: Quality Based Reimbursement, Maryland Hospital Acquired Conditions, Readmissions, and the Maximum Penalty Guardrail of 3.5 percent of total revenue.

It is critical to note that, for fiscal year 2017, Maryland's potential all-payer revenue at risk is more than 11 percent – far higher than the nation's Medicare revenue at risk of 6 percent. The amount of actual adjustments or "realized risk" by Maryland's hospitals is also significant – projected at more than 4 percent of all-payer revenue. Therefore, there is plenty of room for HSCRC to make the minor adjustment for potentially avoidable utilization that we are recommending.

Readmissions
We support HSCRC staff's recommendations on fiscal year 2017 and 2018 readmissions results. We appreciate and commend HSCRC staff's diligence in developing a well-balanced readmissions policy that includes the concept of attainment – something that has not been achieved elsewhere. The policy does have opportunities for future refinement, in particular regarding the risk model that would recognize characteristics such as social and demographic predictors of readmission, as well as refinements to the out-of-state adjustment. The policy currently adjusts in-state risk-adjusted all-payer readmissions by the percentage of unadjusted Medicare readmissions that occur out of state. We are still working to understand the Medicare data, and may find that there is a better way to account for the all-payer readmissions that occur out of state.

The hospital field's strong performance on all of the Medicare demonstration metrics indicates that the current performance incentives are working. There are already incentives to reduce PQIs inherent in the global budget, and the Maryland amount of revenue at risk is greater than the nation, no matter which way it is measured. Experimenting with new, untried pay for performance metrics now would shift important focus away from the metrics that are actually generating valuable results for our state, its hospitals, and the communities and people we all serve.

We appreciate the commission's consideration of our comments.

Sincerely,

Traci La Valle
Vice President

cc: Herbert S. Wong, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Jack C. Keane
Donna Kinzer, Executive Director
Dianne Feeney, Associate Director, Quality Initiatives

Enclosures

Maryland
Hospital Association

April 4, 2016

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

Dear Ms. Feeney:

On behalf of the 64 hospital and health system members of the Maryland Hospital Association (MHA), we appreciate the opportunity to comment on the proposed changes to the *Draft Recommendation for Updating the Readmissions Reduction Incentive Program for Rate Year 2018* and the *Draft Recommendation for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018*. The draft recommendations raise three important policy concerns: the need for individual hospital consideration when there is no performance standard for readmissions; the lack of justification for expanding a penalty-only performance metric (shared savings) and to include an ill-conceived idea of measuring Prevention Quality Indicators and sepsis cases at the hospital level; and the amount of revenue at risk under quality-related programs. It is important that these policies be considered in the context of a second year of very favorable performance on the financial and quality metrics specified in the all-payer demonstration agreement. The hospital field has demonstrated that it can deliver on the demonstration targets ahead of the pace outlined in the agreement. In submitting our comments, we urge you to keep in mind the Health Services Cost Review Commission (HSCRC) Advisory Council's early advice to implement the agreement using broad targets and incentives and to avoid excessive regulation, thus allowing hospitals the flexibility to meet those targets.

Fiscal Year 2018 Policy (Calendar 2016 Performance)

HSCRC staff and the hospital field have made considerable progress in understanding readmissions rates over the last year. Most notably, we finally have a method to calculate Medicare readmissions that we believe fairly compares Maryland's unadjusted readmissions rates to the nation. We have also made progress on measuring social and demographic factors that affect readmissions rates and in quantifying the impact of other factors in a risk-adjusted model. However, we do not yet have a model that everyone agrees should be used to set a target readmissions rate for each hospital.

In calendar year 2015, it became clear that hospitals with lower starting readmissions rates were less likely to reduce readmissions and may even experience increases. We also saw a pattern that readmissions rates move up or down in tandem with admissions. Just as we do not fully understand the complex interplay of factors driving hospital readmissions rates, we are not yet

able to fully account for the factors driving overall utilization in each market, such as changes in physician and payer referral patterns.

Last year, HSCRC's readmissions policy included a provision that any hospital that believed the readmissions reduction policy was penalizing them inappropriately could bring additional information to HSCRC to more fully explain their individual circumstances. To date, a number of hospitals have met with HSCRC, but none has received penalty relief. HSCRC staff does not yet appear to have a mechanism to determine when a hospital is a good performer, even on an individual basis.

We recommend that HSCRC continue to work with the hospital field to come to agreement on a mechanism to determine a hospital-specific readmissions target so that the readmissions policy can recognize both attainment and improvement. Hospitals that have attained lower readmissions rates should not be penalized, particularly when those rates are well below state and national averages.

Penalty Relief Fiscal Year 2017 (Calendar 2015 Performance)

MHA has been advocating for a mechanism to recognize hospitals that have low readmissions rates and those that have significantly improved. Our recommended modification to fiscal 2017 policy accomplishes that by lowering the statewide target and mitigating penalties for hospitals whose rates are among the lowest third of the state in both the base year and the performance year. The options proposed by HSCRC do one or the other, but not both. The options to recognize Medicare improvement or all-payer improvement tend to help hospitals that have experienced larger reductions in readmissions generally. The option to lower the improvement target for hospitals with base rates below statewide average is a step in the right direction, but still leaves subject to penalties too many hospitals with low readmissions rates. Appendix 1 shows the MHA proposal, and our projection of the hospital-specific and statewide impact of all three proposals.

HSCRC staff stated in their recommendation that they disagree with lowering the statewide reduction target. However, at the time the 9.3 percent target was set, there was significant uncertainty around what an appropriate target would be. Maryland did not yet have the base year readmissions rates for the state and the nation, so we did not know how much difference Maryland's hospitals needed to make up, nor whether our year one performance was on track to meet the Medicare demonstration target. Now, with better data, we know that the 7.1 percent all-payer reduction through November 2015 has Maryland comfortably meeting the statewide Medicare readmissions target as specified in the demonstration agreement. Clearly, the 9.3 percent target was too aggressive.

Expanding "Shared Savings"

The staff recommendation links fiscal year 2017 penalty relief to a proposed larger "shared savings" reduction, to generate additional savings for Medicare and all other payers. This is completely unnecessary from a financial incentive standpoint, and poorly conceived from a

performance measurement standpoint. The financial targets of the all-payer model would allow the commission to mitigate fiscal 2017 penalties without additional offsets. Maryland is already far ahead of the Medicare savings targets. The cumulative year two savings target is $49 million, but in year one alone more than $100 million in savings was generated. Likewise, there is plenty of cushion under the all-payer cap. In fiscal year 2015, commissioners approved a 2.35 percent per capita increase to global budgets. The per capita increase actually provided in global budgets was 1.85 percent, according to commission data. Likewise, in fiscal 2016, commissioners approved an increase of 2.61 percent per capita, and through January, hospital per capita revenue has increased only 1.52 percent. Across the two years combined, 5.02 percent per capita growth was approved, but only 3.47 percent per capita has been reflected in hospital rates.

From a performance measurement standpoint, adjusting hospital revenues by a modified version of the Agency for Healthcare Research and Quality Prevention Quality Indicator (PQI) admissions disregards the important fact that the measure is intended to evaluate the rate of preventable admissions in a *population*. The agency never intended for the admissions to be counted at the provider level without knowing the population at risk for a PQI admission. Without understanding the denominator, or the ability to quantify the number of people who were at risk for admission to a hospital, PQI performance cannot be compared across hospitals. Hospitals with a more surgical focus will have lower PQI rates, hospitals in areas where there is low population density and fewer physicians will have higher rates. The enclosed chart shows that PQI admissions per 1,000 population vary significantly by county. The concept, perhaps well intentioned, is that the hospital is responsible for the health of its community, so if fewer people are admitted for chronic conditions, it must mean that the community is healthier. It could also mean that primary care services are more available, or that patients went to another hospital.

The measurement issues related to sepsis are also significant, and should cause concern when being considered for inclusion in the proposed readmissions shared savings policy. There is national debate among physicians and infection preventionists about when a patient's clinical conditions should be labeled as sepsis. Over-identification can lead to overuse of antibiotics and proliferation of other complications, such as Claustridium Difficile. Patient Safety Organizations and the Centers for Medicare & Medicaid Services are focused on reducing sepsis mortality by identifying people who are in the early stage of sepsis and need antibiotics and hydration within three hours to reduce the risk of dying. Patient safety interventions such as these that rely on early detection may cause an initial increase in the number of sepsis cases, but should also be accompanied by reductions in sepsis mortality. Adding an incentive to reduce sepsis cases could be at odds with efforts to identify and reduce sepsis mortality. Septicemia and shock, which may be the result of the body's reaction to sepsis, are included in the Maryland Hospital-Acquired Conditions program, and sepsis mortality is included in HSCRC's Quality Based Reimbursement program.

The HSCRC staff recommendations on a fiscal year 2018 readmissions policy, fiscal year 2017 readmissions penalty mitigation, and in particular, the recommendation to tie penalty relief to an expansion of a penalty-only policy based on performance metrics that are not suited to hospital

level measurement and which seem to be hastily constructed, are overly punitive. The hospital field's strong performance on all of the Medicare demonstration metrics indicate that the current performance incentives are working well. There are already incentives to reduce PQIs inherent in the global budget, and the Maryland amount of revenue at risk is greater than the nation, no matter which way it is measured. Piling on additional metrics, additional penalties and additional risk would jeopardize and remove focus from the good work and good results hospitals are already delivering.

We appreciate the commission's consideration of our comments.

Sincerely,

Traci La Valle
Vice President

Enclosure

"Shared Savings" Reductions are Simply Revenue Reductions

- The net proposed shared savings adjustment of 0.65 percent would remove $98.4 million from hospital budgets
- It's been characterized as a savings mechanism that allows hospitals to retain 100 percent of the reduction beyond the savings benchmark. However, since costs are both fixed and variable, savings are generated and accrued at less than 100 percent.
- Assuming hospital costs are 50% variable, for the hospital field to break even on a $98.4 million reduction, the field must reduce volume equivalent to $198.6 million ($98.4 x 2)
- A hospital would not begin to keep any cost savings until PQIs and readmissions were reduced by over 11 percent

	CY 2015 Average Charge	Number cases to reduce to achieve $198.6 million savings	CY 2015 number of cases (including Observation)	**Percent reduction required for hospital to break even**
		(Savings target of $198.6 M / PQI avg chg $10,651)		(Cases to reduce / CY 15 number of cases)
PQI	$10,651	18,646	77,654	**-24.0%**
Readmissions	$15,277	13,001	83,412	**-15.6%**
Combined	$13,961	14,226	124,499	**-11.4%**

FINAL Recommendations for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018

June 8, 2016

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

Table of Contents

LIST OF ABBREVIATIONS

CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
FFY	Federal fiscal year
FY	State fiscal year
HSCRC	Health Services Cost Review Commission
MHAC	Maryland Hospital-Acquired Conditions Program
PAU	Potentially avoidable utilization
PQI	Prevention quality indicator
QBR	Quality-based reimbursement
RRIP	Readmissions Reduction Incentive Program
RY	State rate year
VBP	Value-based purchasing

INTRODUCTION

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

Maryland entered into a new All-Payer Model Agreement with the Centers for Medicare & Medicaid Services (CMS) on January 1, 2014. One of the requirements under this new agreement is that the proportion of hospital revenue that is held at risk under Maryland's quality-based payment programs must be greater than or equal to the proportion that is held at risk under national Medicare quality programs. The Model Agreement also requires Maryland to achieve specific reduction targets in potentially preventable conditions and readmissions, in addition to the revenue at risk requirement. In an effort to meet these reduction targets, Maryland restructured its quality programs in such a way that financial incentives are established prior to the performance period in order to motivate quality improvement and the sharing of best practices while holding hospitals accountable for their performance.

The purpose of this report is to make recommendations for the amount of revenue that should be held at risk for rate year (RY) 2018. Except for some QBR measures that are based on CMS timelines, the performance year for Maryland's quality-based payments is a calendar year. The base year from which the improvement is calculated is the state fiscal year, and the adjustments are applied in the following rate year. For RY 2018, which starts in July 2017, the performance year is calendar year (CY) 2016, and base year is state fiscal year (FY) 2015. The timeline for the RY 2018 aggregate at risk recommendation was postponed to align with the RY 2018 Readmissions Reduction Incentive Program (RRIP) recommendations. Final recommendations for both policies may require alignment with the updated Shared Savings Policy to estimate the overall impact of all programs in tandem including shared savings adjustments, as staff is contemplating revisions to the shared savings policy.

BACKGROUND

1. Federal Quality Programs

Maryland's amount of revenue at risk for quality-based payment programs is compared against the amount at risk for the following national Medicare quality programs:

- The Medicare Hospital Readmissions Reduction Program, which reduces payments to inpatient prospective payment system hospitals with excess readmissions.[1]
- The Medicare Hospital-Acquired Condition Reduction Program, which ranks hospitals according to performance on a list of hospital-acquired condition quality measures and reduces Medicare payments to the hospitals in the lowest performing quartile.[2]
- The Medicare VBP program, which adjusts hospitals' payments based on their performance on the following four hospital quality domains: clinical care, patient experience of care, outcomes, and efficiency.[3]

Across these programs, 5.75 percent of inpatient revenue was at risk for federal fiscal year (FFY) 2016 and 6.0 percent in FFY 2017.

2. Maryland's Quality-Based Programs

As discussed in the introduction section of this report, Maryland is exempt from the federal Medicare hospital quality programs. Instead, Maryland implements the following quality-based payment programs:

- The QBR program employs measures in several domains, including clinical care, patient experience, outcomes, and patient safety. Since the beginning of the program, financial adjustments have been based on revenue neutral scaling of hospitals in allocating rewards and reductions based on performance, with the net increases in rates for better performing hospitals funded by net decreases in rates for poorer performing hospitals.[4] The distribution of rewards/penalties has been based on relative points achieved by the hospitals and were not known before the end of performance period. Starting in FY 2017, the QBR program revenue neutrality requirement was removed from the program, and payment adjustments were linked to a point-based scale (i.e., present payment scale) instead of relatively ranking hospitals, all of which was designed to provide hospitals with more predictable revenue adjustments based on their performance.

[1] For more information on the Medicare Hospital Readmissions Reduction Program, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.
[2] For more information on the Medicare Hospital-Acquired Condition Reduction program, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/HAC-Reduction-Program.html.
[3] For information on the Medicare VBP program, see https://www.medicare.gov/hospitalcompare/Data/hospital-vbp.html.
[4] The term "scaling" refers to the differential allocation of a pre-determined portion of base regulated hospital revenue contingent on the assessment of the relative quality of hospital performance. The rewards (positive scaled amounts) or reductions (negative scaled amounts) are then applied to each hospital's revenue on a "one-time" basis (and not considered permanent revenue).

- The Maryland Hospital Acquired Conditions (MHAC) program measures hospital performance using 3M's potentially preventable complications. HSCRC calculates observed-to-expected ratios for each complication and compares them with statewide benchmarks and thresholds. This program was modified substantially in the CY 2014 performance period to align with the All-Payer Model Agreement. Revenue adjustments are determined using a preset payment scale. The revenue at risk and reward structure is based on a tiered approach that requires statewide targets to be met for higher rewards and lower reductions.
- Up to and including rate year 2016, the RRIP establishes a readmissions reduction target and rewards/penalties for hospitals. The statewide minimum improvement target is established to eliminate the gap between the national Medicare readmission rate and the Maryland Medicare readmission rate.
- In addition to the three programs described above, two additional quality-based payment adjustments are implemented to hospital revenues prospectively. The Readmission Shared Savings Program reduces each hospital's approved revenues prospectively based on its case-mix adjusted readmission rates. Potentially avoidable utilization (PAU) efficiency reductions are applied to global budgets to reduce allowed volume growth based on the percentage of revenue associated with PAU for each hospital. These adjustments are considered within the context of the update factor discussions, and measurement periods are based on a previous calendar year. For FY 2017, the measurement period will be based on the CY 2015 period.

The Commission approved the following amounts of inpatient revenue to be held at-risk for rate year 2016:

- QBR– A maximum penalty of 1.00 percent of inpatient revenue, with revenue-neutral scaled rewards up to 1.00 percent.
- MHAC– A maximum penalty of 4.00 percent of inpatient revenue if the statewide improvement target is not met; a 1.00 percent maximum penalty and rewards up to 1.00 percent if the statewide improvement target is met.
- RRIP– A reward of 0.50 percent of inpatient revenue for any hospital that improves its all-payer readmission rate by at least 6.76 percent.
- Readmission Shared Savings- An average reduction of 0.60 percent of total hospital revenue.

The Commission approved the following amounts to be held at-risk for RY 2017:

- QBR– A maximum penalty of 2.00 percent of inpatient revenue, with rewards scaled up to a maximum of 1.00 percent.
- MHAC– A maximum penalty of 3.00 percent of inpatient revenue if the statewide improvement target is not met; a 1.00 percent maximum penalty and rewards up to 1.00 percent if the statewide improvement target is met.

- RRIP– A maximum penalty of 2.00 percent of inpatient revenue, and a 1.00 percent maximum reward for hospitals that reduce readmission rates at or better than the minimum improvement target.
- Maximum penalty guardrail– A maximum penalty guardrail of 3.50 percent of total hospital revenue. This means, for example, that a hospital that received the maximum penalty for all three quality-based payment programs would have a maximum penalty of 7.00 percent inpatient revenue, which is equal to 4.20 percent of total hospital revenue. Staff used the Medicare aggregate amount at risk total as the benchmark for calculating the hospital maximum penalty guardrail (e.g. 6 percent * 58 percent of inpatient revenue).

ASSESSMENT

In order to develop the amount of revenue at risk for RY 2018, HSCRC staff consulted with CMS, conducted analyses, and solicited input from the Performance Measurement Workgroup.[5] During its January meeting, the Performance Measurement Workgroup reviewed (1) data comparing the amount of revenue at risk in Maryland with the national Medicare programs, and (2) staff's proposal for the amount at risk for RY 2018.

MHA's letter of 5/25/16 with comments on the May 2016 draft updated policies for the Readmission Reduction Incentive Program, Potentially Avoidable Utilization (PAU) Savings Program, and on Aggregate Revenue Amount at Risk for Hospital Quality Programs is provided in a separate attachment file entitled: ***Attachment I_ RRIP_PAU Shared Savings_Aggregate at Risk_2016.05.25_MHA HSCRC Letter Quality for FY2018_attachments.pdf.***

Aggregate Revenue At-Risk Comparison with Medicare Programs

After discussions with CMS, HSCRC staff performed analyses of both "potential" and "realized" revenue at risk. Potential revenue at risk refers to the maximum amount of revenue that is at risk in the measurement year. Realized risk refers to the actual amounts imposed by the programs. The comparison with the national amounts is calculated on a cumulative basis. Figure 1 compares the potential amount of revenue at risk in Maryland with the amount at risk in the national programs. The difference between the national Medicare and Maryland all-payer annual amounts are summed after each year's experience to compare the cumulative difference over the Model agreement term.

The top half of Figure 1 displays the percentage of potential inpatient revenue at risk in Maryland for all payers for each of Maryland's quality-based payment programs for rate years

[5] For more information on the Performance Measurement Workgroup, see http://www.hscrc.state.md.us/hscrc-workgroup-performance-measurement.cfm.

2014 through 2017. The bottom half of the figure displays the percentage of potential national Medicare inpatient revenue at risk for quality-based payment programs for FFYs 2014 through 2017. Due to efforts to align Maryland's quality-based payment programs with the national programs and the increasing emphasis on value-based payment adjustments, Maryland exceeded the national aggregate maximum at risk amounts in both RYs 2016 and 2017. Cumulatively, Maryland's maximum at risk total would be 8.49 percent higher than the nation in FFY 2017.

Figure 1. Potential Revenue at Risk for Quality-Based Payment Programs, Maryland Compared with the National Medicare Programs, 2014-2017

% of MD All Payer Inpatient Revenue	**FY 2014**	**FY 2015**	**FY 2016**	**FY 2017**
MHAC	2.00%	3.00%	4.00%	3.00%
RRIP			0.50%	2.00%
QBR	0.50%	0.50%	1.00%	2.00%
Shared Savings	0.41%	0.86%	1.35%	*4.30%**
GBR PAU	0.50%	0.86%	1.10%	*1.12%*
MD Aggregate Maximum At Risk	3.41%	5.22%	7.95%	12.41%

*Subject to change based on RY 2017 policy, which is to be finalized at June 2016 Commission meeting. Net Shared Savings Maximum penalty is 3.52 %.

Medicare National - Potential Inpatient Revenue at Risk Absolute Values

% of National Medicare Inpatient Revenue	**FFY 2014**	**FFY 2015**	**FFY2016**	**FFY2017**
HAC		1.00%	1.00%	1.00%
Readmissions	2.00%	3.00%	3.00%	3.00%
VBP	1.25%	1.50%	1.75%	2.00%
Medicare Aggregate Maximum At Risk	3.25%	5.50%	5.75%	6.00%
Cumulative MD-Medicare National Difference	**0.16%**	**-0.12%**	**2.08%**	**8.49%**

As Maryland's programs moved away from revenue neutral rewards and penalties and toward payment adjustments based on preset payment scales, the actual amounts imposed in quality-based programs differ from the maximum amounts established in the policies. For example, the maximum penalty is set to the lowest attainment score in the base year measurement. As hospitals improve their scores during the performance year, none of the hospitals may be subject to the maximum penalty when the payment adjustments are implemented. On the other hand, the national Medicare programs may make payment adjustments only to the lowest performing hospitals, limiting the reach of the performance-based adjustments. CMMI and HSCRC staff worked on a methodology to compare the total actual payment adjustments by summing the absolute average payment adjustments across all programs, namely aggregate realized at risk. Maryland is expected to meet or exceed both the potential and realized at risk amounts of the national Medicare programs. Figure 2 provides average adjustment amount comparison between Maryland and national programs. The overall aggregate average adjustments was 1.95 percent of the total inpatient revenue in FY2016, compared to 1.14 percent in the Medicare programs in

FY 2016. Based on the current recommendations, Maryland adjustments will go up to 4.31 percent as a result of higher PAU savings adjustments in RY 2017.

Figure 2. Realized Revenue at Risk for Quality-Based Payment Programs, Maryland Compared with the National Medicare Programs, 2014-2017

Maryland

% All Payer Inpatient Revenue	SFY 2014	SFY 2015	SFY 2016	SFY 2017
MHAC	0.22%	0.11%	0.18%	0.61%
RRIP			0.15%	0.42%
QBR	0.11%	0.14%	0.30%	0.51%
PAU Savings	0.29%	0.64%	0.93%	2.46%
GBR PAU:	0.28%	0.33%	0.39%	0.34%
MD Aggregate Maximum At Risk	**0.90%**	**1.22%**	**1.95%**	**4.31%**

Medicare National

% Medicare Inpatient Revenue	FFY 2014	FFY 2015	FFY2016	FFY2017*Estimated
HAC		0.22%	0.23%	0.23%
Readmits	0.28%	0.52%	0.51%	0.51%
VBP	0.20%	0.24%	0.40%	0.40%
Medicare Aggregate Maximum At Risk	**0.47%**	**0.97%**	**1.14%**	**1.14%**
Cumulative MD-US Difference	**0.43%**	**0.68%**	**1.49%**	**4.66%**

Figure 3 summarizes the statewide totals and average payment adjustments for Maryland hospitals for RY 2016. The first five blue columns display the results for each of the quality-based payment programs. The sixth blue column displays the aggregate amount of revenue at risk, summed across all five programs. The final blue column, "Net Adjustment Across all Programs," represents the maximum penalty and reward for an individual hospital (rows 2 and 3)

and the average absolute adjustments across all hospitals (row 4). The final row shows the total net adjustments, accounting for both penalties and rewards. While aggregate potential amount at risk was at 7.76 percent, the sum of average adjustments across all programs was 1.95 percent of inpatient revenue, which is higher than the estimated CMS rate of 1.01 percent. When we sum penalties and rewards across the hospital, the maximum penalty and reward received by one hospital was 1.95 percent, and 1.09 percent respectively. In RY 2016, the total net adjustments were $38.3 million, with $68.3 million in total penalties and $29.9 million in total rewards. When summarized at the hospital level, one hospital received a reduction of 1.95 percent of inpatient revenue across all the programs. The maximum reward received across all programs was 1.09 percent of hospital inpatient revenue.

Figure 3. Actual Revenue Adjustments and Potential at Risk Percent Inpatient Revenue for Maryland's Quality-Based Payment Programs, RY 2016

	MHAC	RRIP	QBR	Shared Savings	PAU	Aggregate (Sum of All Programs)	Net Hospital Adjustment Across all Programs
Potential At Risk (Absolute Value)	4.00%	0.50%	1.00%	1.16%	1.10%	7.76%	
Maximum Hospital Penalty	-0.21%	NA	-1.00%	-0.29%	-1.10%	-2.59%	-1.95%
Maximum Hospital Reward	1.00%	0.50%	0.73%	NA	NA	2.23%	1.09%
Average Absolute Level Adjustment	**0.18%**	**0.15%**	**0.30%**	**0.93%**	**0.39%**	**1.95%**	**0.70%**
Total Penalty	-$1,080,406	NA	-$12,880,046	-$27,482,838	-$26,900,004	-$68,343,293	
Total Reward	$7,869,585	$9,233,884	$12,880,046	NA	NA	$29,983,515	
Total Net Adjustments	**$6,789,180**	**$9,233,884**	**$0**	**-$27,482,838**	**-$26,900,004**	**-$38,359,778**	

Figure 4 summarizes preliminary statewide totals and average payment adjustments for Maryland hospitals for RY 2017 for the MHAC, RRIP, shared savings, and QBR programs. Figure 4 follows the same format as Figure 3. Reflecting higher amounts at risk approved for RRIP and QBR approved by the Commission for RY 2017 and staff proposal to increase the shared savings amount to 1.25 percent of total revenue, the aggregate maximum potential penalty is 12.41 percent. Year-to-date actual adjustment calculations for QBR is based on first six months of data update. MHAC and RRIP calculations are final reflecting corrections for the ICD-10 and updated FY 2016 permanent. The sum of average payment adjustments across all programs is 4.31 percent of inpatient revenue. On a hospital specific basis, the maximum reduction received by a single hospital is 2.52 percent of total revenue, and the maximum reward is 1.02 percent. On a statewide basis, the total impact of performance-based adjustments is -1.15 percent of the state total revenue (the net impact is -0.54 percent).

Figure 4. Actual Revenue at Risk for Maryland's Quality-Based Payment Programs, RY 2017 Year-to-Date

	MHAC	RRIP	QBR***	PAU Savings***	Net PAU Savings***	PAU	State Aggregate	Hospital Net Impact % Total Revenue
	A	B	C	D	E	F	G=Sum(A-D and F)	
Potential At Risk (Absolute Value)	3.00%	2.00%	2.00%	4.30%	3.45%	1.12%	12.41%	
Maximum Hospital Penalty (% Inpatient Revenue)	-0.25%	-2.00%	-1.78%	-4.30%	-3.45%	-1.12%	-9.44%	-2.52%
Maximum Hospital Reward (% Inpatient Revenue)	1.00%	1.00%	1.00%	NA	NA	NA	3.00%	1.02%
Average Absolute Level Adjustment (% Inpatient Revenue)	0.42%	0.61%	0.51%	2.43%	1.50%	0.34%	4.31%	0.64%
Total Penalty	-$647,766	-$28,953,933	-$4,815,695	-$194,198,835	-$102,899,143	-$25,863,479	-$254,479,708	
Total Reward	$29,904,456	$12,946,597	$33,855,819	$0	$285,060	$0	$76,706,871	
Total Net Adjustments	$29,256,690	-$16,007,336	$29,040,124	-$194,198,835	$(100,678,086)	-$25,863,479	-$177,772,836	
% Total Revenue	0.19%	-0.10%	0.19%	-1.25%	-0.65%	-0.17%	-1.15%	

*Calculations are updated based on ICD-10 Correction for Rehab cases and updated Permanent Revenues for FY2016
**RRIP results reflect the proposed adjustments for FY2017 policy.
***QBR year-to-date results are preliminary estimates based on two quarters of new data due to data lag for measures from CMS. Staff will provide updated calculations for the final recommendation.
****Shared Savings are based on a 1.25 percent statewide reduction with protections for high socio-economic burden based on the final FY2017 recommendation.

In summary, Maryland outperformed the national programs in both the scope of the measurements and in the aggregate payment amounts at risk. Maryland hospitals improved their performance in reducing complications and more recently in improving readmissions. All-Payer Model financial success will depend on further reductions in PAU, and staff intends to shift more focus on potentially avoidable admissions in quality-based payment programs in the future and reduce penalties other areas. Staff will continue to discuss the appropriate amounts for quality-based payment programs with the Performance Measurement and Payment Models Workgroups.

See Appendix I for hospital-level results.

Maximum Revenue at Risk Hospital Guardrail

As the HSCRC increases the maximum revenue adjustments statewide, the potential for a particular hospital to receive large revenue reductions that may cause unmanageable financial risk has raised concerns. As hospitals improve quality in the state, the variation between individual hospitals is expected to decline, increasing the chances of a single hospital receiving the maximum penalties from all programs. Similar to the risk corridors in other VBP programs, a maximum penalty guardrail may be necessary to mitigate the detrimental financial impact of unforeseen large adjustments in Maryland programs. Given the increases in risk levels in other programs, a hospital-specific guardrail will provide better protection than a statewide limit. In RY 2017, the hospital maximum penalty guardrail was set at 3.50 percent of total hospital revenue.

RECOMMENDATION

Based on this assessment, HSCRC staff recommends the following maximum penalties and rewards for the QBR, MHAC and RRIP programs for RY 2018:

1. QBR: The maximum penalty should be 2.00 percent, while the maximum reward should be 1.00 percent.

   The maximum penalty matches the penalty in Medicare's VBP program and increases the incentive for hospitals to improve their Hospital Consumer Assessment of Healthcare Providers and Systems survey scores, which continue to be low compared with the nation.

2. MHAC: There should be a 3.00 percent maximum penalty if the statewide improvement target is not met; there should be a 1.00 percent maximum penalty and a reward up to 1.00 percent if the statewide improvement target is met.

3. RRIP: The maximum penalty should be 2.00 percent, and the reward should be 1.00 percent for hospitals that reduce readmission rates at or better than the minimum improvement.

4. Maximum penalty guardrail: The hospital maximum penalty guardrail should continue to be set at 3.50 percent of total hospital revenue.

5. The quality adjustments should be applied to inpatient revenue centers, similar to the approach used by CMS. HSCRC staff can apply the adjustments to hospitals' medical surgical rates to concentrate the impact of this adjustment on inpatient revenue, consistent with federal policies.

APPENDIX I. RY 2016 HOSPITAL-LEVEL SCALING RESULTS FOR QUALITY-BASED PAYMENT PROGRAMS

Appendix 1 contains the following figures for rate year 2016:

1. The consolidated revenue adjustments across all quality-based payment programs, by hospital
2. The adjustments for the quality-based reimbursement (QBR) program, by hospital
3. The adjustments for the Readmission Reduction Incentive Program (RRIP), by hospital
4. The adjustments for the Maryland Hospital-Acquired Conditions (MHAC) program, by hospital

Figure 1. Consolidated Adjustments for All Quality-Based Payment Programs for Rate Year 2016, by Hospital

Hospital Name	FY 2015 Permanent Inpatient Revenue	MHAC % Revenue Adjustment	RRIP % Revenue Adjustment	QBR % Revenue Adjustment	NET Shared Savings % Revenue Adjustment	PAU % Revenue Adjustment	Net Impact %	Net Impact $
SOUTHERN MARYLAND	$161,253,766	-0.21%	0.00%	-0.51%	-0.31%	-0.92%	-1.95%	$(3,138,427)
DORCHESTER	$23,804,066	0.00%	0.00%	-0.54%	-0.29%	-0.75%	-1.58%	$(374,986)
PRINCE GEORGE	$176,633,177	0.00%	0.00%	-1.00%	-0.30%	-0.27%	-1.57%	$(2,773,413)
GOOD SAMARITAN	$178,635,338	0.00%	0.00%	-0.46%	-0.39%	-0.31%	-1.15%	$(2,059,395)
ANNE ARUNDEL	$308,739,341	0.00%	0.00%	-0.42%	-0.23%	-0.35%	-1.00%	$(3,087,905)
CHARLES REGIONAL	$76,417,734	0.21%	0.00%	-0.06%	-0.37%	-0.85%	-1.07%	$(816,786)
UNION MEMORIAL	$239,732,514	0.00%	0.50%	-0.85%	-0.43%	-0.31%	-1.09%	$(2,602,721)
FRANKLIN SQUARE	$282,129,812	0.00%	0.00%	-0.35%	-0.28%	-0.30%	-0.93%	$(2,614,927)
HOLY CROSS	$319,832,140	0.00%	0.00%	-0.31%	-0.35%	-0.25%	-0.91%	$(2,900,125)
CARROLL COUNTY	$136,537,813	-0.17%	0.00%	0.31%	-0.24%	-0.70%	-0.80%	$(1,090,207)
HARBOR	$122,412,282	0.00%	0.00%	-0.36%	-0.33%	-0.18%	-0.87%	$(1,066,772)
WASHINGTON ADVENTIST	$160,049,373	0.00%	0.00%	-0.15%	-0.35%	-0.42%	-0.93%	$(1,484,691)
SUBURBAN	$182,880,097	0.00%	0.00%	-0.10%	-0.28%	-0.47%	-0.84%	$(1,534,715)
ATLANTIC GENERAL	$38,616,313	0.63%	0.00%	-0.72%	-0.33%	-0.41%	-0.82%	$(318,359)
BALTIMORE WASHINGTON MEDICAL CENTER	$224,082,798	0.00%	0.00%	0.42%	-0.36%	-0.72%	-0.67%	$(1,492,281)
FT. WASHINGTON	$17,901,765	0.95%	0.00%	-0.18%	-0.43%	-1.10%	-0.77%	$(137,591)
SHADY GROVE	$231,030,092	0.00%	0.00%	-0.22%	-0.22%	-0.29%	-0.72%	$(1,672,839)
DOCTORS COMMUNITY	$136,010,794	-0.17%	0.50%	0.10%	-0.27%	-0.88%	-0.72%	$(982,849)
GARRETT COUNTY	$18,608,187	0.00%	0.50%	-0.81%	-0.15%	-0.47%	-0.94%	$(173,989)
EASTON	$95,655,306	0.00%	0.00%	0.03%	-0.41%	-0.36%	-0.74%	$(707,029)
UMMC MIDTOWN	$137,603,928	0.00%	0.00%	-0.20%	-0.46%	-0.13%	-0.79%	$(1,089,137)
HOWARD COUNTY	$167,430,727	0.00%	0.00%	0.19%	-0.23%	-0.51%	-0.54%	$(910,182)
MERITUS	$188,367,776	0.05%	0.00%	0.01%	-0.21%	-0.27%	-0.41%	$(778,226)
FREDERICK MEMORIAL	$190,475,901	0.00%	0.00%	0.13%	-0.18%	-0.42%	-0.47%	$(889,726)
HARFORD	$46,774,506	0.00%	0.00%	0.15%	-0.35%	-0.37%	-0.58%	$(270,103)

Hospital Name	FY 2015 Permanent Inpatient Revenue	MHAC % Revenue Adjustment	RRIP % Revenue Adjustment	QBR % Revenue Adjustment	NET Shared Savings % Revenue Adjustment	PAU % Revenue Adjustment	Net Impact %	Net Impact $
UNIVERSITY OF MARYLAND	$869,783,534	0.00%	0.00%	-0.09%	-0.23%	-0.14%	-0.46%	$(3,997,336)
UNION HOSPITAL OF CECIL COUNT	$67,638,499	0.05%	0.00%	0.23%	-0.10%	-0.57%	-0.39%	$(263,934)
MONTGOMERY GENERAL	$87,866,458	0.00%	0.50%	-0.12%	-0.28%	-0.53%	-0.43%	$(380,174)
UPPER CHESAPEAKE HEALTH	$153,131,633	0.00%	0.00%	0.35%	-0.34%	-0.43%	-0.42%	$(636,439)
LAUREL REGIONAL	$77,138,956	0.00%	0.50%	-0.20%	-0.30%	-0.40%	-0.40%	$(310,923)
G.B.M.C.	$200,727,665	-0.14%	0.00%	0.20%	-0.29%	-0.23%	-0.45%	$(909,220)
JOHNS HOPKINS	$1,303,085,115	0.00%	0.00%	0.30%	-0.40%	-0.14%	-0.24%	$(3,063,257)
ST. AGNES	$238,960,906	0.05%	0.50%	-0.10%	-0.36%	-0.34%	-0.25%	$(592,138)
BON SECOURS	$75,937,922	0.47%	0.50%	-0.84%	-0.33%	0.00%	-0.20%	$(148,483)
PENINSULA REGIONAL	$232,896,408	0.16%	0.00%	0.08%	-0.20%	-0.13%	-0.09%	$(204,159)
HOPKINS BAYVIEW MED CTR	$354,237,613	0.37%	0.00%	0.15%	-0.25%	-0.19%	0.07%	$242,340
MERCY	$232,326,849	0.00%	0.50%	0.28%	-0.46%	-0.19%	0.13%	$293,111
WESTERN MARYLAND HEALTH SYSTEM	$182,494,313	0.00%	0.00%	0.73%	-0.15%	-0.11%	0.46%	$846,736
REHAB & ORTHO	$69,116,851	0.37%	0.00%	N/A	-0.42%	-0.15%	-0.20%	$(138,972)
NORTHWEST	$141,883,177	0.68%	0.50%	0.10%	-0.26%	-0.48%	0.55%	$775,801
SINAI	$428,400,532	0.32%	0.50%	0.28%	-0.34%	-0.19%	0.57%	$2,422,359
CHESTERTOWN	$29,287,619	0.53%	0.50%	0.15%	-0.23%	-0.25%	0.70%	$205,232
CALVERT	$67,061,373	0.63%	0.50%	0.11%	-0.13%	-0.54%	0.57%	$382,528
UM ST. JOSEPH	$230,010,193	0.58%	0.00%	0.58%	-0.32%	-0.26%	0.58%	$1,335,237
ST. MARY	$69,990,405	0.68%	0.50%	0.34%	-0.11%	-0.40%	1.01%	$710,270
MCCREADY	$ 3,571,064	1.00%	0.50%	N/A	-0.36%	-0.04%	1.09%	$39,024

Figure 2. Adjustments for the QBR Program for Rate Year 2016, by Hospital

Hospital Name	FY 2015 Permanent Inpatient Revenue	QBR Final Points	Scaling Basis	Revenue Impact of Scaling	Revenue Neutral Adjusted Revenue Impact of Scaling	Revenue Neutral Adjusted % Payment Adjustment
A	B	C	D	E=B*D	F	G=(B+F)/B-1
PRINCE GEORGE	$176,633,176.79	0.204	-1.000%	-$1,766,332	-$1,766,332	-1.000%
UNION MEMORIAL	$239,732,514.10	0.236	-0.848%	-$2,032,700	-$2,032,700	-0.848%
BON SECOURS	$75,937,921.77	0.237	-0.842%	-$639,466	-$639,466	-0.842%
GARRETT COUNTY	$18,608,187.37	0.243	-0.811%	-$150,839	-$150,839	-0.811%
ATLANTIC GENERAL	$38,616,312.78	0.262	-0.721%	-$278,422	-$278,422	-0.721%
DORCHESTER	$23,804,066.20	0.300	-0.536%	-$127,696	-$127,696	-0.536%
SOUTHERN MARYLAND	$161,253,765.94	0.306	-0.506%	-$815,828	-$815,828	-0.506%
GOOD SAMARITAN	$178,635,337.98	0.316	-0.457%	-$817,238	-$817,238	-0.457%
ANNE ARUNDEL	$308,739,340.58	0.324	-0.420%	-$1,297,299	-$1,297,299	-0.420%
HARBOR	$122,412,281.84	0.337	-0.355%	-$434,912	-$434,912	-0.355%
FRANKLIN SQUARE	$282,129,811.54	0.338	-0.351%	-$990,065	-$990,065	-0.351%
HOLY CROSS	$319,832,140.30	0.347	-0.309%	-$989,139	-$989,139	-0.309%
SHADY GROVE	$231,030,091.92	0.366	-0.215%	-$497,403	-$497,403	-0.215%
LAUREL REGIONAL	$77,138,956.35	0.369	-0.203%	-$156,364	-$156,364	-0.203%
UMMC MIDTOWN	$137,603,928.30	0.370	-0.199%	-$273,596	-$273,596	-0.199%
FT. WASHINGTON	$17,901,765.04	0.373	-0.183%	-$32,819	-$32,819	-0.183%
WASHINGTON ADVENTIST	$160,049,372.87	0.379	-0.153%	-$245,350	-$245,350	-0.153%
MONTGOMERY GENERAL	$87,866,457.56	0.387	-0.117%	-$102,775	-$102,775	-0.117%
ST. AGNES	$238,960,906.16	0.390	-0.099%	-$236,680	-$236,680	-0.099%
SUBURBAN	$182,880,097.32	0.391	-0.095%	-$174,048	-$174,048	-0.095%
UNIVERSITY OF MARYLAND	$869,783,533.93	0.392	-0.089%	-$777,220	-$777,220	-0.089%
CHARLES REGIONAL	$76,417,733.97	0.399	-0.057%	-$43,855	-$43,855	-0.057%

Hospital Name	FY 2015 Permanent Inpatient Revenue	QBR Final Points	Scaling Basis	Revenue Impact of Scaling	Revenue Neutral Adjusted Revenue Impact of Scaling	Revenue Neutral Adjusted % Payment Adjustment
MERITUS	$188,367,775.67	0.415	0.020%	$37,886	$23,050	0.012%
EASTON	$95,655,306.19	0.420	0.045%	$42,869	$26,081	0.027%
PENINSULA REGIONAL	$232,896,407.52	0.439	0.139%	$323,230	$196,651	0.084%
NORTHWEST	$141,883,177.42	0.446	0.169%	$240,213	$146,144	0.103%
DOCTORS COMMUNITY	$136,010,793.59	0.446	0.169%	$230,271	$140,095	0.103%
CALVERT	$67,061,372.88	0.447	0.174%	$116,461	$70,854	0.106%
FREDERICK MEMORIAL	$190,475,900.63	0.455	0.216%	$411,978	$250,644	0.132%
HOPKINS BAYVIEW MED CTR	$354,237,613.19	0.460	0.239%	$845,105	$514,157	0.145%
HARFORD	$46,774,506.17	0.461	0.245%	$114,535	$69,683	0.149%
CHESTERTOWN	$29,287,619.34	0.462	0.250%	$73,134	$44,494	0.152%
HOWARD COUNTY	$167,430,726.52	0.476	0.318%	$531,634	$323,443	0.193%
G.B.M.C.	$200,727,664.89	0.478	0.327%	$656,806	$399,596	0.199%
UNION HOSPITAL OF CECIL COUNT	$67,638,499.19	0.488	0.375%	$253,429	$154,185	0.228%
MERCY	$232,326,849.10	0.504	0.453%	$1,052,795	$640,513	0.276%
SINAI	$428,400,532.05	0.505	0.456%	$1,953,758	$1,188,653	0.277%
JOHNS HOPKINS	$1,303,085,115.22	0.512	0.490%	$6,390,980	$3,888,230	0.298%
CARROLL COUNTY	$136,537,812.51	0.516	0.510%	$696,104	$423,505	0.310%
ST. MARY	$69,990,405.25	0.525	0.554%	$387,680	$235,862	0.337%
UPPER CHESAPEAKE HEALTH	$153,131,633.20	0.531	0.583%	$892,707	$543,117	0.355%
BALTIMORE WASHINGTON MEDICAL CENTER	$224,082,797.59	0.552	0.684%	$1,533,183	$932,778	0.416%
UM ST. JOSEPH	$230,010,193.37	0.609	0.961%	$2,209,908	$1,344,493	0.585%
WESTERN MARYLAND HEALTH SYSTEM	$182,494,313.32	0.657	1.192%	$2,175,921	$1,323,816	0.725%
Statewide	**$8,904,474,715**			**$8,290,541**	**$0**	**0%**

Figure 3. Adjustments for the RRIP Program for Rate Year 2016, by Hospital

HOSPITAL NAME	FY 2015 Permanent Inpatient Revenue	CY 13 Base Year Risk-Adjusted Readmission Rate	CY 14 Performance Period Risk-Adjusted Readmission Rate	CY 14 Readmission Improvement	% Payment Adjustment	Revenue Impact of Scaling
A	B	C	D	E=D/C-1	H	I=H*B
MCCREADY	$3,571,064.06	11.82%	9.30%	-21.30%	0.50%	$17,855
ST. MARY	$69,990,405.25	12.09%	10.21%	-15.52%	0.50%	$349,952
CALVERT	$67,061,372.88	9.63%	8.16%	-15.30%	0.50%	$335,307
BON SECOURS	$75,937,921.77	18.43%	15.79%	-14.31%	0.50%	$379,690
DOCTORS COMMUNITY	$136,010,793.59	12.52%	10.77%	-13.97%	0.50%	$680,054
CHESTERTOWN	$29,287,619.34	13.29%	11.79%	-11.24%	0.50%	$146,438
NORTHWEST	$141,883,177.42	14.52%	13.11%	-9.70%	0.50%	$709,416
ST. AGNES	$238,960,906.16	13.43%	12.15%	-9.53%	0.50%	$1,194,805
UNION MEMORIAL	$239,732,514.10	13.78%	12.53%	-9.08%	0.50%	$1,198,663
MERCY	$232,326,849.10	13.96%	12.77%	-8.56%	0.50%	$1,161,634
MONTGOMERY GENERAL	$87,866,457.56	12.03%	11.11%	-7.58%	0.50%	$439,332
SINAI	$428,400,532.05	13.67%	12.67%	-7.34%	0.50%	$2,142,003
LAUREL REGIONAL	$77,138,956.35	13.18%	12.23%	-7.27%	0.50%	$385,695
GARRETT COUNTY	$18,608,187.37	7.21%	6.69%	-7.24%	0.50%	$93,041
HOPKINS BAYVIEW MED CTR	$354,237,613.19	14.71%	13.86%	-5.78%	0.00%	$0
PRINCE GEORGE	$176,633,176.79	10.04%	9.49%	-5.47%	0.00%	$0
G.B.M.C.	$200,727,664.89	10.67%	10.09%	-5.43%	0.00%	$0
UMMC MIDTOWN	$137,603,928.30	15.97%	15.16%	-5.07%	0.00%	$0
ANNE ARUNDEL	$308,739,340.58	11.99%	11.38%	-5.06%	0.00%	$0
HOWARD COUNTY	$167,430,726.52	11.81%	11.21%	-5.04%	0.00%	$0
UM ST. JOSEPH	$230,010,193.37	11.40%	10.83%	-4.97%	0.00%	$0

HOSPITAL NAME	FY 2015 Permanent Inpatient Revenue	CY 13 Base Year Risk-Adjusted Readmission Rate	CY 14 Performance Period Risk-Adjusted Readmission Rate	CY 14 Readmission Improvement	% Payment Adjustment	Revenue Impact of Scaling
ATLANTIC GENERAL	$38,616,312.78	11.65%	11.09%	-4.86%	0.00%	$0
HARBOR	$122,412,281.84	12.81%	12.28%	-4.15%	0.00%	$0
SHADY GROVE	$231,030,091.92	10.84%	10.42%	-3.87%	0.00%	$0
SOUTHERN MARYLAND	$161,253,765.94	11.39%	10.96%	-3.83%	0.00%	$0
GOOD SAMARITAN	$178,635,337.98	13.62%	13.10%	-3.80%	0.00%	$0
BALTIMORE WASHINGTON MEDICAL CENTER	$224,082,797.59	13.77%	13.30%	-3.38%	0.00%	$0
CARROLL COUNTY	$136,537,812.51	11.86%	11.53%	-2.77%	0.00%	$0
UNIVERSITY OF MARYLAND	$869,783,533.93	13.78%	13.55%	-1.63%	0.00%	$0
WESTERN MARYLAND HEALTH SYSTEM	$182,494,313.32	11.89%	11.73%	-1.31%	0.00%	$0
SUBURBAN	$182,880,097.32	10.94%	10.81%	-1.27%	0.00%	$0
FRANKLIN SQUARE	$282,129,811.54	12.63%	12.50%	-1.05%	0.00%	$0
HARFORD	$46,774,506.17	11.04%	10.95%	-0.80%	0.00%	$0
REHAB & ORTHO	$69,116,850.62	11.46%	11.47%	0.01%	0.00%	$0
JOHNS HOPKINS	$1,303,085,115.22	13.97%	13.97%	0.04%	0.00%	$0
UNION HOSPITAL OF CECIL COUNT	$67,638,499.19	9.77%	9.82%	0.51%	0.00%	$0
UPPER CHESAPEAKE HEALTH	$153,131,633.20	11.45%	11.59%	1.27%	0.00%	$0
FREDERICK MEMORIAL	$190,475,900.63	10.38%	10.51%	1.30%	0.00%	$0
MERITUS	$188,367,775.67	11.38%	11.53%	1.36%	0.00%	$0
FT. WASHINGTON	$17,901,765.04	12.53%	12.74%	1.65%	0.00%	$0
DORCHESTER	$23,804,066.20	11.07%	11.28%	1.89%	0.00%	$0
CHARLES REGIONAL	$76,417,733.97	11.57%	11.90%	2.82%	0.00%	$0
PENINSULA REGIONAL	$232,896,407.52	10.77%	11.08%	2.88%	0.00%	$0
HOLY CROSS	$319,832,140.30	11.12%	11.69%	5.09%	0.00%	$0

HOSPITAL NAME	FY 2015 Permanent Inpatient Revenue	CY 13 Base Year Risk-Adjusted Readmission Rate	CY 14 Performance Period Risk-Adjusted Readmission Rate	CY 14 Readmission Improvement	% Payment Adjustment	Revenue Impact of Scaling
WASHINGTON ADVENTIST	$160,049,372.87	10.79%	11.42%	5.77%	0.00%	$0
EASTON	$95,655,306.19	10.47%	11.93%	13.98%	0.00%	$0
	$8,977,162,630				**Rewards:**	**$9,233,884**

Figure 4. Adjustments for the MHAC Program for Rate Year 2016, by Hospital

Hospital Name	FY 2015 Permanent Inpatient Revenue	Final MHAC Score	% Payment Adjustment	Revenue Impact of Scaling
A	B	C	D	E
SOUTHERN MARYLAND	$161,253,765.94	0.40	-0.2069%	-$333,628
DOCTORS COMMUNITY	$136,010,793.59	0.41	-0.1724%	-$234,501
CARROLL COUNTY	$136,537,812.51	0.41	-0.1724%	-$235,410
G.B.M.C.	$200,727,664.89	0.42	-0.1379%	-$276,866
SUBURBAN	$182,880,097.32	0.47	0.0000%	$0
LAUREL REGIONAL	$77,138,956.35	0.48	0.0000%	$0
WASHINGTON ADVENTIST	$160,049,372.87	0.48	0.0000%	$0
ANNE ARUNDEL	$308,739,340.58	0.48	0.0000%	$0
HARBOR	$122,412,281.84	0.49	0.0000%	$0
MONTGOMERY GENERAL	$87,866,457.56	0.50	0.0000%	$0
DORCHESTER	$23,804,066.20	0.52	0.0000%	$0
PRINCE GEORGE	$176,633,176.79	0.52	0.0000%	$0
FREDERICK MEMORIAL	$190,475,900.63	0.53	0.0000%	$0
UNION MEMORIAL	$239,732,514.10	0.53	0.0000%	$0
FRANKLIN SQUARE	$282,129,811.54	0.54	0.0000%	$0
HOWARD COUNTY	$167,430,726.52	0.54	0.0000%	$0
HOLY CROSS	$319,832,140.30	0.54	0.0000%	$0
HARFORD	$46,774,506.17	0.54	0.0000%	$0
BALTIMORE WASHINGTON MEDICAL CENTER	$224,082,797.59	0.54	0.0000%	$0
GARRETT COUNTY	$18,608,187.37	0.55	0.0000%	$0
WESTERN MARYLAND HEALTH SYSTEM	$182,494,313.32	0.55	0.0000%	$0
JOHNS HOPKINS	$1,303,085,115.22	0.56	0.0000%	$0
UNIVERSITY OF MARYLAND	$869,783,533.93	0.57	0.0000%	$0

Hospital Name	FY 2015 Permanent Inpatient Revenue	Final MHAC Score	% Payment Adjustment	Revenue Impact of Scaling
A	B	C	D	E
UPPER CHESAPEAKE HEALTH	$153,131,633.20	0.57	0.0000%	$0
SHADY GROVE	$231,030,091.92	0.58	0.0000%	$0
GOOD SAMARITAN	$178,635,337.98	0.58	0.0000%	$0
UMMC MIDTOWN	$137,603,928.30	0.60	0.0000%	$0
EASTON	$95,655,306.19	0.60	0.0000%	$0
MERCY	$232,326,849.10	0.61	0.0000%	$0
UNION HOSPITAL OF CECIL COUNT	$67,638,499.19	0.62	0.0526%	$35,599
ST. AGNES	$238,960,906.16	0.62	0.0526%	$125,769
MERITUS	$188,367,775.67	0.62	0.0526%	$99,141
PENINSULA REGIONAL	$232,896,407.52	0.64	0.1579%	$367,731
CHARLES REGIONAL	$76,417,733.97	0.65	0.2105%	$160,879
SINAI	$428,400,532.05	0.67	0.3158%	$1,352,844
HOPKINS BAYVIEW MED CTR	$354,237,613.19	0.68	0.3684%	$1,305,086
REHAB & ORTHO	$69,116,850.62	0.68	0.3684%	$254,641
BON SECOURS	$75,937,921.77	0.70	0.4737%	$359,706
CHESTERTOWN	$29,287,619.34	0.71	0.5263%	$154,145
UM ST. JOSEPH	$230,010,193.37	0.72	0.5789%	$1,331,638
ATLANTIC GENERAL	$38,616,312.78	0.73	0.6316%	$243,893
CALVERT	$67,061,372.88	0.73	0.6316%	$423,546
ST. MARY	$69,990,405.25	0.74	0.6842%	$478,882
NORTHWEST	$141,883,177.42	0.74	0.6842%	$970,780
FT. WASHINGTON	$17,901,765.04	0.79	0.9474%	$169,596
MCCREADY	$3,571,064.06	0.83	1.0000%	$35,711
	$8,977,162,630			**$6,789,180**

APPENDIX II. FY 2017 YEAR-TO-DATE HOSPITAL-LEVEL CONSOLIDATED RESULTS (SORTED BY COLUMN J)

Hospital Name	FY 16 Permanent Total Revenue A	FY 16 Permanent Inpatient Revenue B	MHAC (Below Target) Finalized C	RRIP (Proposed) D	QBR YTD E	FY 17 Net Shared Savings (Proposed) F	Demographic Adjustment G	Net Impact % Inpatient H=Sum(C-G)	Net Impact $ I=H*B	Net Impact % Total Revenue J=I/A
REHAB & ORTHO	$117,875,574	$64,134,443	0.43%	1.00%	0.00%	0.44%	-0.01%	1.87%	$1,197,128	1.02%
UM ST. JOSEPH	$384,647,527	$234,223,274	0.59%	0.47%	0.86%	-0.59%	-0.20%	1.12%	$2,622,918	0.68%
MERCY	$491,288,212	$214,208,592	0.46%	0.85%	0.46%	-0.37%	-0.16%	1.25%	$2,673,146	0.54%
MCCREADY	$14,230,659	$2,815,158	1.00%	1.00%	0.00%	-1.09%	0.83%	1.74%	$49,019	0.34%
GARRETT COUNTY	$45,640,340	$19,149,148	1.00%	1.00%	0.39%	-1.84%	-0.06%	0.49%	$94,151	0.21%
CALVERT	$140,329,390	$62,336,014	0.95%	0.80%	0.61%	-1.64%	-0.26%	0.45%	$279,132	0.20%
UNIVERSITY OF MARYLAND	$1,289,991,934	$906,034,034	0.65%	-0.09%	0.32%	-0.66%	-0.13%	0.09%	$786,922	0.06%
SINAI	$698,636,216	$415,350,729	0.41%	0.30%	0.29%	-0.83%	-0.17%	0.00%	-$17,754	0.00%
UNION MEMORIAL	$411,630,821	$238,195,335	0.22%	0.81%	0.50%	-1.20%	-0.35%	-0.02%	-$56,234	-0.01%
PENINSULA REGIONAL	$413,594,890	$242,318,199	0.76%	-0.03%	0.64%	-1.33%	-0.17%	-0.13%	-$307,854	-0.07%
ATLANTIC GENERAL	$100,960,082	$37,750,252	0.27%	1.00%	0.46%	-1.68%	-0.30%	-0.25%	-$93,004	-0.09%
FREDERICK MEMORIAL	$350,725,799	$190,413,775	0.27%	0.63%	0.61%	-1.28%	-0.41%	-0.19%	-$363,148	-0.10%
ST. MARY	$168,090,518	$69,169,248	0.84%	0.44%	1.00%	-2.05%	-0.52%	-0.29%	-$201,302	-0.12%
G.B.M.C.	$423,026,290	$207,515,795	0.00%	0.39%	0.39%	-0.94%	-0.20%	-0.35%	-$729,128	-0.17%
UPPER CHESAPEAKE HEALTH	$319,063,053	$135,939,076	0.62%	0.15%	0.61%	-1.43%	-0.54%	-0.59%	-$802,069	-0.25%
HOPKINS BAYVIEW MED CTR	$610,423,590	$343,229,718	0.68%	-0.11%	0.36%	-1.23%	-0.21%	-0.52%	-$1,782,501	-0.29%
SUBURBAN	$290,002,663	$193,176,044	0.32%	-0.47%	0.86%	-0.83%	-0.40%	-0.51%	-$993,867	-0.34%
ANNE ARUNDEL	$553,902,629	$291,882,683	0.16%	-0.29%	0.50%	-0.89%	-0.31%	-0.83%	-$2,426,795	-0.44%

Hospital Name	FY 16 Permanent Total Revenue A	FY 16 Permanent Inpatient Revenue B	MHAC (Below Target) Finalized C	RRIP (Proposed) D	QBR YTD E	FY 17 Net Shared Savings (Proposed) F	Demographic Adjustment G	Net Impact % Inpatient H=Sum(C-G)	Net Impact $ I=H*B	Net Impact % Total Revenue J=I/A
FRANKLIN SQUARE	$488,282,513	$274,203,013	0.54%	-0.25%	0.36%	-1.23%	-0.24%	-0.82%	-$2,239,370	-0.46%
JOHNS HOPKINS	$2,178,990,299	$1,244,297,9	0.00%	-0.36%	0.32%	-0.72%	-0.16%	-0.92%	-$11,410,965	-0.52%
CHESTERTOWN	$53,997,130	$21,575,174	0.62%	0.55%	0.68%	-2.60%	-0.57%	-1.32%	-$284,855	-0.53%
FT. WASHINGTON	$46,558,629	$19,674,774	1.00%	0.86%	0.68%	-2.90%	-1.04%	-1.39%	-$274,323	-0.59%
SHADY GROVE	$374,624,719	$220,608,397	0.11%	-0.01%	0.29%	-1.12%	-0.37%	-1.11%	-$2,442,990	-0.65%
ST. AGNES	$413,273,339	$232,266,274	0.51%	-0.04%	0.39%	-1.77%	-0.33%	-1.23%	-$2,848,049	-0.69%
HARBOR	$190,199,181	$113,244,592	0.62%	-1.06%	0.57%	-1.16%	-0.16%	-1.18%	-$1,339,504	-0.70%
WESTERN MARYLAND HEALTH SYSTEM	$312,666,774	$167,618,972	0.11%	-0.74%	0.39%	-1.17%	0.05%	-1.36%	-$2,285,659	-0.73%
GOOD SAMARITAN	$283,376,592	$160,795,606	0.16%	0.16%	0.61%	-1.78%	-0.50%	-1.35%	-$2,176,921	-0.77%
HOWARD COUNTY	$284,424,840	$165,683,744	0.27%	-0.81%	0.93%	-1.39%	-0.45%	-1.46%	-$2,417,449	-0.85%
MONTGOMERY	$168,451,048	$75,687,627	0.43%	-0.16%	0.39%	-1.99%	-0.68%	-2.01%	-$1,520,611	-0.90%
CHARLES REGIONAL	$143,315,213	$67,052,911	0.30%	-0.05%	0.79%	-2.28%	-0.72%	-1.97%	-$1,321,070	-0.92%
NORTHWEST	$247,056,826	$114,214,371	0.22%	0.81%	-	-2.02%	-0.47%	-2.01%	-$2,296,947	-0.93%
HARFORD	$100,472,983	$45,713,956	0.92%	0.80%	0.18%	-3.37%	-0.59%	-2.07%	-$945,429	-0.94%
BALTIMORE WASHINGTON	$396,558,220	$237,934,932	0.46%	-0.07%	0.32%	-1.92%	-0.39%	-1.60%	-$3,798,510	-0.96%
EASTON	$192,089,981	$101,975,577	0.19%	-0.57%	0.29%	-1.55%	-0.16%	-1.81%	-$1,850,684	-0.96%
CARROLL COUNTY	$245,978,519	$136,267,434	0.19%	-0.65%	0.71%	-1.81%	-0.45%	-2.01%	-$2,734,704	-1.11%
UMMC MIDTOWN	$223,767,089	$126,399,313	0.38%	-0.16%	-	-1.22%	-0.13%	-2.03%	-$2,560,363	-1.14%
DORCHESTER	$49,366,715	$26,999,062	0.84%	0.03%	0.64%	-3.45%	-0.21%	-2.15%	-$581,802	-1.18%
BON SECOURS	$122,434,137	$74,789,724	0.00%	1.00%	-	-1.13%	-0.05%	-1.96%	-$1,463,774	-1.20%
MERITUS	$309,029,336	$190,659,648	0.22%	-1.27%	0.29%	-1.21%	-0.15%	-2.13%	-$4,059,537	-1.31%

Hospital Name	FY 16 Permanent Total Revenue A	FY 16 Permanent Inpatient Revenue B	MHAC (Below Target) Finalized C	RRIP (Proposed) D	QBR YTD E	FY 17 Net Shared Savings (Proposed) F	Demographic Adjustment G	Net Impact % Inpatient H=Sum(C-G)	Net Impact $ I=H*B	Net Impact % Total Revenue J=I/A
HOLY CROSS	$473,189,703	$316,970,825	0.62%	-1.13%	-	-1.13%	-0.31%	-2.29%	-$7,255,443	-1.53%
UNION HOSPITAL OF CECIL COUNTY	$153,588,495	$69,389,876	0.51%	-2.00%	0.46%	-2.05%	-0.56%	-3.63%	-$2,518,551	-1.64%
HOLY CROSS	$88,000,000	$57,164,163	0.0%	0.0%	0.0%	-2.21%	-0.31%	-2.53%	-$1,444,747	-1.64%
WASHINGTON ADVENTIST	$253,346,309	$155,199,154	-0.06%	-1.20%	0.25%	-1.13%	-0.55%	-2.69%	-$4,168,361	-1.65%
DOCTORS COMMUNITY	$226,236,757	$132,614,778	0.03%	-0.31%	0.18%	-2.32%	-1.12%	-3.54%	-$4,694,560	-2.08%
LAUREL REGIONAL	$101,288,035	$60,431,106	0.03%	-0.78%	-	-1.16%	-0.54%	-3.57%	-$2,154,785	-2.13%
SOUTHERN MARYLAND	$265,443,855	$156,564,761	0.00%	-0.62%	0.11%	-2.24%	-1.07%	-3.83%	-$5,994,345	-2.26%
PRINCE GEORGE	$278,868,894	$220,306,426	-0.25%	-1.70%	0.07%	-0.93%	-0.39%	-3.19%	-$7,032,536	-2.52%

Maryland
Hospital Association

May 25, 2016

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

Dear Chairman Sabatini:

On behalf of the 64 hospital and health system members of the Maryland Hospital Association (MHA), we appreciate the opportunity to comment on the *Draft Recommendations for the Readmissions Reduction Incentive Program for Rate Year 2018*, the *Draft Recommendations for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018,* and the *Draft Recommendations for the Potentially Avoidable Utilization Savings Policy for Rate Year 2017*. On the whole, we support the HSCRC staff recommendations related to readmissions and the amounts of revenue at risk for specific quality programs; however, we disagree with the staff recommendation on Potentially Avoidable Utilization (PAU) savings and the resulting quality-based payment program adjustment to the update.

MHA's position: the net quality-based payment program adjustment should be reduced from -0.61 percent to -0.16 percent by lowering the expected shared savings offset for Potentially Avoidable Utilization. This would reduce to 0.80 percent HSCRC staff's recommendation of a 1.25 percent reduction in hospital revenues.

- The recommendation to reduce hospital revenue by 1.25 percent according to hospitals' individual percentages of readmissions and admissions for certain chronic conditions, or Prevention Quality Indicators (PQIs), uses an Agency for Healthcare Research and Quality (AHRQ) metric in a way it was not intended. The metric was created not for hospitalized patients, but to measure prevention opportunities in the broader population. It has not been applied as a payment incentive anywhere else in the nation. In fact, a report of an AHRQ Clinical Expert Review Board on expanding the use of PQIs for pay for performance notes that "(p)anelists showed comparatively less support for using these indicators in pay for performance applications." They noted the need for careful risk adjustment and that "higher stakes use" may encourage adverse effects of implementation.

- In our April 4 comment letter (attached), we expressed concerns about, among other things, using the AHRQ measure to require an 11.4 percent reduction in readmissions and PQIs combined in one year. That steep of a reduction is, simply, unattainable, and if an incentive is unattainable it no longer acts as an incentive. It is instead just an arbitrary cut.

- The attempt to justify setting a goal of an 11.4 percent reduction in readmissions and PQIs using a 2012 Institute of Medicine report that suggests 27 percent of health care spending was for unnecessary services, compares apples to oranges. Unnecessary care can occur for many reasons: unnecessary screening exams, duplicative tests, invasive procedures near the end of life, lack of patient understanding of treatment options, defensive medicine and more. The opportunity to reduce this care and the interventions, if available, are varied and require patient and provider behavior change over the long term. Those efforts do not necessarily directly help a Maryland hospital meet a specific PQI reduction of more than 11 percent in one year.

- HSCRC staff's recommendation to reduce hospital revenue by 1.25 percent comes against a backdrop of a proposed global budget increase of just 1.1 percent for all hospitals, already far below inflation. Our recommendation of removing the PQI component and lowering that reduction to 0.80 percent to adjust only for readmissions – an adjustment we agree with – is still an increase over last year's reduction of 0.60 percent.

Aggregate Revenue at Risk
We support the staff recommendations on the remaining amounts at risk for the individual quality programs: Quality Based Reimbursement, Maryland Hospital Acquired Conditions, Readmissions, and the Maximum Penalty Guardrail of 3.5 percent of total revenue.

It is critical to note that, for fiscal year 2017, Maryland's potential all-payer revenue at risk is more than 11 percent – far higher than the nation's Medicare revenue at risk of 6 percent. The amount of actual adjustments or "realized risk" by Maryland's hospitals is also significant – projected at more than 4 percent of all-payer revenue. Therefore, there is plenty of room for HSCRC to make the minor adjustment for potentially avoidable utilization that we are recommending.

Readmissions
We support HSCRC staff's recommendations on fiscal year 2017 and 2018 readmissions results. We appreciate and commend HSCRC staff's diligence in developing a well-balanced readmissions policy that includes the concept of attainment – something that has not been achieved elsewhere. The policy does have opportunities for future refinement, in particular regarding the risk model that would recognize characteristics such as social and demographic predictors of readmission, as well as refinements to the out-of-state adjustment. The policy currently adjusts in-state risk-adjusted all-payer readmissions by the percentage of unadjusted Medicare readmissions that occur out of state. We are still working to understand the Medicare data, and may find that there is a better way to account for the all-payer readmissions that occur out of state.

The hospital field's strong performance on all of the Medicare demonstration metrics indicates that the current performance incentives are working. There are already incentives to reduce PQIs inherent in the global budget, and the Maryland amount of revenue at risk is greater than the nation, no matter which way it is measured. Experimenting with new, untried pay for performance metrics now would shift important focus away from the metrics that are actually generating valuable results for our state, its hospitals, and the communities and people we all serve.

We appreciate the commission's consideration of our comments.

Sincerely,

Traci La Valle
Vice President

cc: Herbert S. Wong, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Jack C. Keane
Donna Kinzer, Executive Director
Dianne Feeney, Associate Director, Quality Initiatives

Enclosures

Maryland
Hospital Association

April 4, 2016

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

Dear Ms. Feeney:

On behalf of the 64 hospital and health system members of the Maryland Hospital Association (MHA), we appreciate the opportunity to comment on the proposed changes to the *Draft Recommendation for Updating the Readmissions Reduction Incentive Program for Rate Year 2018* and the *Draft Recommendation for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018*. The draft recommendations raise three important policy concerns: the need for individual hospital consideration when there is no performance standard for readmissions; the lack of justification for expanding a penalty-only performance metric (shared savings) and to include an ill-conceived idea of measuring Prevention Quality Indicators and sepsis cases at the hospital level; and the amount of revenue at risk under quality-related programs. It is important that these policies be considered in the context of a second year of very favorable performance on the financial and quality metrics specified in the all-payer demonstration agreement. The hospital field has demonstrated that it can deliver on the demonstration targets ahead of the pace outlined in the agreement. In submitting our comments, we urge you to keep in mind the Health Services Cost Review Commission (HSCRC) Advisory Council's early advice to implement the agreement using broad targets and incentives and to avoid excessive regulation, thus allowing hospitals the flexibility to meet those targets.

Fiscal Year 2018 Policy (Calendar 2016 Performance)

HSCRC staff and the hospital field have made considerable progress in understanding readmissions rates over the last year. Most notably, we finally have a method to calculate Medicare readmissions that we believe fairly compares Maryland's unadjusted readmissions rates to the nation. We have also made progress on measuring social and demographic factors that affect readmissions rates and in quantifying the impact of other factors in a risk-adjusted model. However, we do not yet have a model that everyone agrees should be used to set a target readmissions rate for each hospital.

In calendar year 2015, it became clear that hospitals with lower starting readmissions rates were less likely to reduce readmissions and may even experience increases. We also saw a pattern that readmissions rates move up or down in tandem with admissions. Just as we do not fully understand the complex interplay of factors driving hospital readmissions rates, we are not yet

able to fully account for the factors driving overall utilization in each market, such as changes in physician and payer referral patterns.

Last year, HSCRC's readmissions policy included a provision that any hospital that believed the readmissions reduction policy was penalizing them inappropriately could bring additional information to HSCRC to more fully explain their individual circumstances. To date, a number of hospitals have met with HSCRC, but none has received penalty relief. HSCRC staff does not yet appear to have a mechanism to determine when a hospital is a good performer, even on an individual basis.

We recommend that HSCRC continue to work with the hospital field to come to agreement on a mechanism to determine a hospital-specific readmissions target so that the readmissions policy can recognize both attainment and improvement. Hospitals that have attained lower readmissions rates should not be penalized, particularly when those rates are well below state and national averages.

Penalty Relief Fiscal Year 2017 (Calendar 2015 Performance)

MHA has been advocating for a mechanism to recognize hospitals that have low readmissions rates and those that have significantly improved. Our recommended modification to fiscal 2017 policy accomplishes that by lowering the statewide target and mitigating penalties for hospitals whose rates are among the lowest third of the state in both the base year and the performance year. The options proposed by HSCRC do one or the other, but not both. The options to recognize Medicare improvement or all-payer improvement tend to help hospitals that have experienced larger reductions in readmissions generally. The option to lower the improvement target for hospitals with base rates below statewide average is a step in the right direction, but still leaves subject to penalties too many hospitals with low readmissions rates. Appendix 1 shows the MHA proposal, and our projection of the hospital-specific and statewide impact of all three proposals.

HSCRC staff stated in their recommendation that they disagree with lowering the statewide reduction target. However, at the time the 9.3 percent target was set, there was significant uncertainty around what an appropriate target would be. Maryland did not yet have the base year readmissions rates for the state and the nation, so we did not know how much difference Maryland's hospitals needed to make up, nor whether our year one performance was on track to meet the Medicare demonstration target. Now, with better data, we know that the 7.1 percent all-payer reduction through November 2015 has Maryland comfortably meeting the statewide Medicare readmissions target as specified in the demonstration agreement. Clearly, the 9.3 percent target was too aggressive.

Expanding "Shared Savings"

The staff recommendation links fiscal year 2017 penalty relief to a proposed larger "shared savings" reduction, to generate additional savings for Medicare and all other payers. This is completely unnecessary from a financial incentive standpoint, and poorly conceived from a

performance measurement standpoint. The financial targets of the all-payer model would allow the commission to mitigate fiscal 2017 penalties without additional offsets. Maryland is already far ahead of the Medicare savings targets. The cumulative year two savings target is $49 million, but in year one alone more than $100 million in savings was generated. Likewise, there is plenty of cushion under the all-payer cap. In fiscal year 2015, commissioners approved a 2.35 percent per capita increase to global budgets. The per capita increase actually provided in global budgets was 1.85 percent, according to commission data. Likewise, in fiscal 2016, commissioners approved an increase of 2.61 percent per capita, and through January, hospital per capita revenue has increased only 1.52 percent. Across the two years combined, 5.02 percent per capita growth was approved, but only 3.47 percent per capita has been reflected in hospital rates.

From a performance measurement standpoint, adjusting hospital revenues by a modified version of the Agency for Healthcare Research and Quality Prevention Quality Indicator (PQI) admissions disregards the important fact that the measure is intended to evaluate the rate of preventable admissions in a *population*. The agency never intended for the admissions to be counted at the provider level without knowing the population at risk for a PQI admission. Without understanding the denominator, or the ability to quantify the number of people who were at risk for admission to a hospital, PQI performance cannot be compared across hospitals. Hospitals with a more surgical focus will have lower PQI rates, hospitals in areas where there is low population density and fewer physicians will have higher rates. The enclosed chart shows that PQI admissions per 1,000 population vary significantly by county. The concept, perhaps well intentioned, is that the hospital is responsible for the health of its community, so if fewer people are admitted for chronic conditions, it must mean that the community is healthier. It could also mean that primary care services are more available, or that patients went to another hospital.

The measurement issues related to sepsis are also significant, and should cause concern when being considered for inclusion in the proposed readmissions shared savings policy. There is national debate among physicians and infection preventionists about when a patient's clinical conditions should be labeled as sepsis. Over-identification can lead to overuse of antibiotics and proliferation of other complications, such as Claustridium Difficile. Patient Safety Organizations and the Centers for Medicare & Medicaid Services are focused on reducing sepsis mortality by identifying people who are in the early stage of sepsis and need antibiotics and hydration within three hours to reduce the risk of dying. Patient safety interventions such as these that rely on early detection may cause an initial increase in the number of sepsis cases, but should also be accompanied by reductions in sepsis mortality. Adding an incentive to reduce sepsis cases could be at odds with efforts to identify and reduce sepsis mortality. Septicemia and shock, which may be the result of the body's reaction to sepsis, are included in the Maryland Hospital-Acquired Conditions program, and sepsis mortality is included in HSCRC's Quality Based Reimbursement program.

The HSCRC staff recommendations on a fiscal year 2018 readmissions policy, fiscal year 2017 readmissions penalty mitigation, and in particular, the recommendation to tie penalty relief to an expansion of a penalty-only policy based on performance metrics that are not suited to hospital

level measurement and which seem to be hastily constructed, are overly punitive. The hospital field's strong performance on all of the Medicare demonstration metrics indicate that the current performance incentives are working well. There are already incentives to reduce PQIs inherent in the global budget, and the Maryland amount of revenue at risk is greater than the nation, no matter which way it is measured. Piling on additional metrics, additional penalties and additional risk would jeopardize and remove focus from the good work and good results hospitals are already delivering.

We appreciate the commission's consideration of our comments.

Sincerely,

Traci La Valle
Vice President

Enclosure

"Shared Savings" Reductions are Simply Revenue Reductions

- The net proposed shared savings adjustment of 0.65 percent would remove $98.4 million from hospital budgets
- It's been characterized as a savings mechanism that allows hospitals to retain 100 percent of the reduction beyond the savings benchmark. However, since costs are both fixed and variable, savings are generated and accrued at less than 100 percent.
- Assuming hospital costs are 50% variable, for the hospital field to break even on a $98.4 million reduction, the field must reduce volume equivalent to $198.6 million ($98.4 x 2)
- A hospital would not begin to keep any cost savings until PQIs and readmissions were reduced by over 11 percent

	CY 2015 Average Charge	Number cases to reduce to achieve $198.6 million savings	CY 2015 number of cases (including Observation)	**Percent reduction required for hospital to break even**
		(Savings target of $198.6 M / PQI avg chg $10,651)		(Cases to reduce / CY 15 number of cases)
PQI	$10,651	18,646	77,654	**-24.0%**
Readmissions	$15,277	13,001	83,412	**-15.6%**
Combined	$13,961	14,226	124,499	**-11.4%**

Final Recommendations for the Potentially Avoidable Utilization Savings Policy for Rate Year 2017

June 8, 2016

Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215
(410) 764-2605
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LIST OF ABBREVIATIONS

ADI	Area deprivation index
ARR	Admission-Readmission Revenue Program
CMS	Centers for Medicare & Medicaid Services
CY	Calendar year
DRG	Diagnosis-related group
ECMAD	Equivalent case-mix adjusted discharge
FFY	Federal fiscal year
FY	Fiscal year
GBR	Global budget revenue
HSCRC	Health Services Cost Review Commission
IPPS	Inpatient prospective payment system
PAU	Potentially avoidable utilization
PQI	Prevention quality indicators
RRIP	Readmissions Reduction Incentive Program
RY	Rate year
SOI	Severity of Illness
TPR	Total patient revenue

INTRODUCTION

The Maryland Health Services Cost Review Commission (HSCRC or Commission) operates a potentially avoidable utilization (PAU) savings policy as part of its portfolio of value-based payment policies. This policy was formerly referred to as the readmission shared savings policy. The PAU savings policy is important for maintaining hospitals' focus on improving care and health for patients by reducing PAU and its associated costs. The PAU savings policy is also important for maintaining Maryland's exemption from the Centers for Medicare & Medicaid Services (CMS) quality-based payment programs, as this exemption allows the state to operate its own programs on an all-payer basis.

In this recommendation, staff is proposing to update the policy to incorporate an additional category of PAU, to increase the level of savings derived from the policy, and to specify the calculations and application of the policy in conjunction with the state fiscal year (FY) 2017 update. The purpose of this report is to present background information and supporting analyses for the PAU savings recommendations for rate year (RY) 2017. Based on the stakeholder comments, staff updated the measurement of socio-economic protection from percent of total case-mix adjusted volume for Medicaid patients to percent of inpatient case-mix adjusted volume for Medicaid and self-pay and charity patients. Data for the calculation of PAU is also updated to reflect the corrections made for ICD-10 rehab cases. Staff will finalize PAU percentages by the end of June 2016.

BACKGROUND

The United States ranks behind most countries on many measures of health outcomes, quality, and efficiency. Physicians face particular difficulties in receiving timely information, coordinating care, and dealing with administrative burden. Enhancements in chronic care— with a focus on prevention and treatment in the office, home, and long-term care settings—are essential to improving indicators of healthy lives and health equity. Such indicators include mortality amenable to health care and a healthy life expectancy at age 60. As a consequence of inadequate chronic care and care coordination, the healthcare system currently experiences an unacceptably high rate of preventable hospital admissions and readmissions. Maryland's new All-Payer Model was approved by CMS effective January 1, 2014. This Model is premised on the opportunity for Maryland and CMS to test whether an all-payer system that is accountable for the total hospital cost of care on a per capita basis is an effective model for advancing better care, better health, and reduced costs.

HSCRC, together with stakeholders, has adapted and developed a series of policies and initiatives aimed at improving care and care coordination, with a particular focus on reducing PAU.

Under the state's previous Medicare waiver, the Commission approved a shared savings policy on May 1, 2013, which reduced hospital revenues based on case-mix adjusted readmission rates[1] using specifications set forth in the HSCRC's Admission-Readmission Revenue (ARR) Program. Nearly all hospitals in the state were participating in the ARR program, which incorporated 30-day readmissions into a hospital episode rate per case, or in the Total Patient Revenue (TPR) system, a global budget for more rural hospital settings. Because Medicare policies are tied to a fee-for-service system, it receives savings when avoidable admissions are reduced. In contrast, Maryland's ARR and TPR systems locked in the savings, and Maryland was required to reduce approved revenues to ensure savings to purchasers, including Medicare, from the reductions in readmissions to maintain Maryland's exemption from the CMS Medicare Hospital Readmission Reduction Program. The Commission initiated a reduction of 0.20 percent of total revenues starting in FY 2014 to implement this policy. Under the new All-Payer Model, the Commission continued to use the savings adjustment to assure a focus on reducing readmissions, assure savings to purchasers, and to meet the exemption requirements for "revenue at risk" under Maryland's value-based programs.

For RYs 2014 and 2015, the HSCRC calculated a case-mix adjusted readmission rate based on ARR specifications[2] for each hospital for the previous calendar year.[3] The statewide savings percentage was converted to a required reduction in readmission rates, and each hospital's contribution to savings was determined by its case-mix adjusted readmission rates. Based on 0.20 percent annual savings, the total reduction percentage was 0.40 percent of total revenue in RY 2015.

For RY 2016, the HSCRC updated the methodology for calculating the savings reduction to use the case-mix adjusted readmission rate based on the specifications for the Readmissions Reduction Incentive Program (RRIP).[4] Based on 0.20 percent annual savings, the total reduction percentage was 0.60 percent of total revenue in RY 2016.

Exemption from CMS Quality-Based Payment Programs

Section 3025 of the Affordable Care Act[5] established the federal Medicare Hospital Readmission Reduction Program in federal fiscal year (FFY) 2013, which requires the Secretary of the U.S.

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[1] A readmission is an admission to a hospital within a specified time period after a discharge from the same or another hospital.
[2] Only same-hospital readmissions were counted, and stays of one day or less and planned admissions were excluded.
[3] The case-mix adjustment was based on a total of observed readmissions vs. expected readmissions, which is calculated using the statewide average readmission rate for each diagnosis-related group (DRG) severity of illness (SOI) cell and aggregated for each hospital.
[4] This measures 30-day all-cause, all hospital readmissions with planned admission and other exclusions.
[5] Patient Protection and Affordable Care Act, 124 Stat. 119 (2010) (codified as amended at 42 U.S.C. § 1395ww(q) (Supp. 2010)).

Department of Health and Human Services to reduce payments to inpatient prospective payment system (IPPS) hospitals with excess readmissions for patients in fee-for-service Medicare.[6] According to the IPPS rule published for FFY 2015, the Secretary is authorized to exempt Maryland hospitals from the Medicare Hospital Readmissions Reduction Program if Maryland submits an annual report describing how a similar program in the State achieves or surpasses the nationally measured results for patient health outcomes and cost savings under the Medicare program. As mentioned in other HSCRC quality-based payment recommendations reports, the new All-Payer Model changed the criteria for maintaining exemptions from the CMS programs. As part of the new All-Payer Model Agreement, the aggregate amount of revenue at risk in Maryland quality/performance-based payment programs must be equal to or greater than the aggregate amount of revenue at risk in the CMS Medicare quality programs. The PAU savings adjustment is one of the performance-based programs used for this comparison. This policy is intentionally different from the other quality-based programs that are scaled to provide rewards or penalties based on improvement or attainment levels in that it is designed to assure savings from the application of the policy.

ASSESSMENT

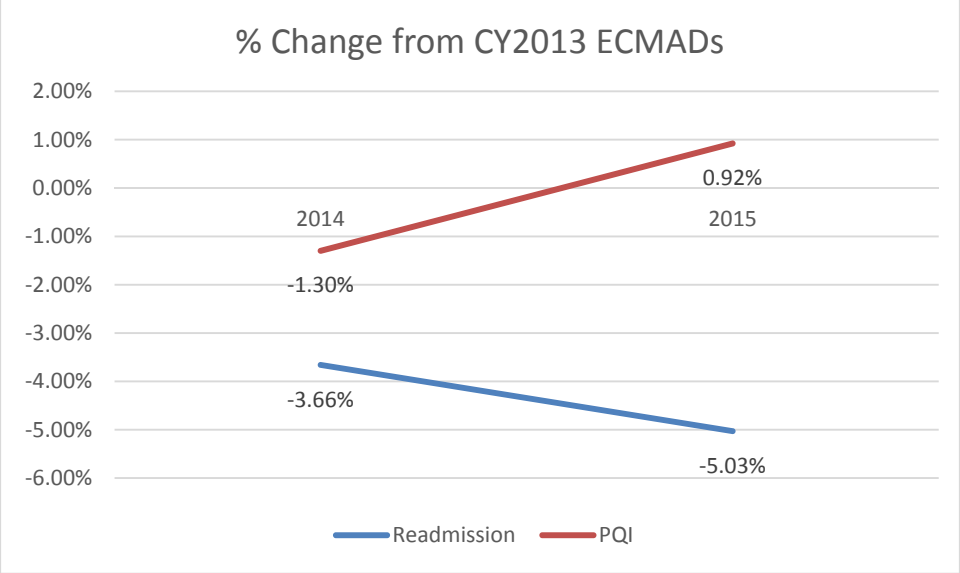
Alignment of Savings with Potentially Avoidable Utilization

With the introduction of the new All-Payer Model and global budgets, reducing PAU through improved care coordination and enhanced community-based care became a central focus. HSCRC provided additional revenue in global budgets over the last three years to bolster investments in care coordination resources and infrastructure. Infrastructure adjustments of 0.325 percent in FY 2014, 0.325 percent in FY 2015, and 0.40 percent in FY 2016 were included in most global budgets to enable the successful transition to the new model and provide funds for the needed investments. The total ongoing commitment for infrastructure is approximately $180 million for global budget revenue (GBR) hospitals—an amount approaching the statewide estimated operating costs for care coordination developed by consultants for the Care Coordination Workgroup.[7] These adjustments recognized the need for investment in care coordination, care management, population health improvement, and other requirements of global models. Successful care management and population health efforts will require hospitals to maintain and enhance their investments in addressing the needs of complex patients; improving and coordinating care for individuals with chronic conditions; integrating and coordinating care with other hospitals and non-hospital providers; and investing in IT, analytics, human resources, training, and alignment models to support these efforts.

[6] For more information on this program, see https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html.
[7] http://hscrc.maryland.gov/hscrc-workgroup-care-coordination.cfm

As the Model is premised on the ability to improve care and health, thereby reducing the pace of hospital cost increases, an intense focus needs to be placed on achieving these results that are both beneficial to patients and the system. HSCRC staff is proposing to focus the savings program more broadly on PAU. For FY 2017, HSCRC staff proposes to use the same definition of PAU that is used for the market shift calculations, incorporating both readmissions and admissions for ambulatory care sensitive conditions as measured by the Agency for Health Care Research and Quality's Prevention Quality Indicators (PQIs) [8]. Last year, the savings measure focused on readmissions, as the Commission was concerned about the slow rate of improvement in readmissions in Maryland. Calendar year (CY) 2015 trends indicate that readmission improvement is accelerating, while progress in reducing PQIs has been limited. Figure 1 below shows trends in readmissions and PQIs since CY 2013. While the CY 2015 equivalent case-mix adjusted readmission discharges (ECMADs) declined by 5.03 percent over CY 2013, PQIs increased by 0.92 percent, which was preceded by a 1.30 percent PQI reduction in CY 2014. Appendix I shows more detailed information on specific PQI trends.

Figure 1. Changes in Maryland's Readmission and PQI Rates over CY 2013



In addition to including PQIs in the savings methodology, alignment with PAU will change the focus of the readmissions measure from "sending" hospitals to "receiving" hospitals. In other words, the PAU methodology currently calculates the percentage of revenue associated with readmissions that occur at the hospital regardless of where the first (index) admission occurred. This is more consistent with the opportunities for savings under global budgets since the readmit hospital only accrues savings if the actual number of readmissions at that hospital decreases. This also incentivizes hospitals to collaborate with other area hospitals to reduce readmissions.

[8] PQIs measure inpatient admissions for ambulatory care sensitive conditions. For more information on these measures, see http://www.qualityindicators.ahrq.gov/modules/pqi_overview.aspx .

Alignment with PAU will also enable the measure to include observation stays in the calculation of both readmissions and PQIs. As the use of observation stays has increased over the past few years, HSCRC staff recommends including observation stays that are longer than 23 hours in avoidable utilization measures.

Proposed Required Revenue Reduction

HSCRC staff proposes to increase annual savings amount from 0.20 % to 0.45 % reductions, which will result in a statewide PAU savings adjustment of 1.25 percent of total hospital revenue. Because last year's statewide savings reduction of 0.60 percent is added back into rates, this represents an incremental reduction of 0.65 percent. Statewide required reductions in PAU are determined based on the proposed reduction in total revenue.

In the third year of the All-Payer Model, with its intense focus on improving care and health and reducing PAU, there is a need to provide increased savings from reducing PAU. This proposal provides these savings and also apportions the savings to hospitals with higher levels of PAU. Both of these policy outcomes are important as the federal government increases the pace of reductions in hospital payments under the Affordable Care Act, (which is discussed in more detail in the RY 2017 Balanced Update Draft Recommendation), and hospitals need to keep up/accelerate the pace in reducing avoidable utilization to achieve the care improvements that are essential for success under the All-Payer Model.

Figure 2. Proposed RY 2017 Statewide Savings

Statewide Savings	Formulas	
RY 2016 Total Approved Permanent Revenue	A	$15.4 billion
Proposed RY 2017 Incremental Revenue Adjustment %	B	-0.65%
Incremental Revenue Adjustment	E=C-D	-$100.6 million

The PAU savings adjustment has a number of advantages, including the following:

- Every hospital contributes to the PAU savings; however, the PAU savings are distributed in proportion to each hospital's PAU in the most recent year. See Appendix II for more information on PAU by hospital.
- The PAU savings adjustment amount is not related to an actual reduction in PAU during the rate year, hence providing an equitable reduction for quality improvement related to PAU reductions across all hospitals. Hospitals that reduce their PAU beyond the savings benchmark during the rate year will retain 100 percent of the difference between their actual reduction and the savings benchmark.
- When applied prospectively, the HSCRC sets the targeted dollar amount for savings, thus guaranteeing a fixed amount of savings.

Hospital Protections

The Commission and stakeholders are concerned about ensuring that hospitals that treat a higher proportion of disadvantaged patients have the needed resources for care delivery and improvement, while not excusing poor quality of care or care coordination because of higher deprivation. The HSCRC convened a subgroup to discuss risk-adjusting the readmissions measures for socio-demographic factors and evaluate the impact of the Area Deprivation Index (ADI) on readmission rates.[9] As the ADI is currently being updated with more recent data, more work is needed to understand the hospital-level impact of this specific measure. In the meantime, staff proposes to apply a methodology similar to last year's and to cap the PAU savings contributions at the state average if a hospital has a high proportion of disadvantaged populations. Last year, staff used the percentage of discharges for those aged 18 years and older with Medicaid as the payer as a measure of the proportion of disadvantaged patients. This year, staff proposes to update the measure to include the percentage of Medicaid and Self-pay or Charity ECMADs for inpatient and observation cases with 23 hour or longer stays, with protection provided to those hospitals in the top quartile.

Appendix III provides the results of the PAU savings policy based on the proposed 0.65 percent annual (1.25 percent total) reduction in total patient revenues with and without these protections.

Comments Received on Proposed Savings Policy Recommendation

MHA's letter of 5/25/16 with comments on the May 2016 draft updated policies for the Readmission Reduction Incentive Program, Potentially Avoidable Utilization (PAU) Savings Program, and on Aggregate Revenue Amount at Risk for Hospital Quality Programs is provided in a separate attachment file entitled: ***Attachment I_ RRIP_PAU Shared Savings Aggregate at Risk_2016.05.25_MHA HSCRC Letter Quality for FY2018_attachments.pdf.*** CareFirst submitted their comments as part of the update factor recommendation.

Future Expansion of PAU

Staff intends to continue its focus of adding categories of admissions to the PAU measures. We considered adding sepsis to the measure for FY 2017, but this will require more vetting and specification development. It also appears that there may be coding discrepancies among hospitals in identifying sepsis cases. Staff is recommending that hospitals with high levels of

[9] The original Area Deprivation Index was developed in 2003 by Gopal Singh, and has been widely disseminated by HIPxChange, which is sponsored by the University of Wisconsin-Madison. The ADI is a composite measure of the socioeconomic deprivation of a geographic location (like a Census-block). It reflects various socioeconomic indicators like the level of education of the population, the employment rate, median family income, home value, and percent of the population below 150 percent of the federal poverty level. Higher values of the index indicate higher levels of socioeconomic deprivation. For more information, see: https://www.hipxchange.org/ADI.

sepsis cases or apparent shifts in PQI coding take the opportunity to evaluate their coding. Staff may need to focus coding audit resources on these hospitals if we do not see progress in this area. Other areas of future focus for additional PAU measures include admissions from long-term care and post-acute settings, as well as unplanned medical admissions through the emergency department setting.

RECOMMENDATIONS

Based on this assessment, staff recommends the following for the PAU savings policy for RY 2017:

1. Align the measure with the PAU definitions used in the market shift adjustment, which is comprised of readmissions and PQIs (inclusive of observation cases that are greater than 23 hours).
2. Increase the annual value of the PAU savings amount from 0.20 percent to 0.45 percent. This will result in 1.25 percent of reduction in total revenue, which is a 0.65 percent net reduction in RY 2017.
3. Cap the PAU savings reduction at the statewide average reduction for hospitals with higher socio-economic burden.
4. Evaluate further expansion of PAU definitions for RY 2018 to incorporate additional categories of unplanned admissions.
5. Evaluate progress on sepsis coding and the apparent discrepancies in levels of sepsis cases across hospitals, including the need for possible independent coding audits.

APPENDIX I. ANALYSIS OF PQI TRENDS

PQIs—developed by the Agency for Healthcare Research and Quality—measure inpatient admissions for ambulatory care sensitive conditions. The following figure presents an analysis of the change in PQI rates between CYs 2014 and 2015. The table shows that 7 of the 13 PQIs measured increased during this time period. PQIs 10 (dehydration), 08 (heart failure), and 14 (uncontrolled diabetes) accounted for the majority of this increase. Of the PQIs that decreased, 05 (chronic obstructive pulmonary disease or asthma in older adults), 03 (diabetes long-term complications), and 11 (bacterial pneumonia) accounted for the majority of the decrease.

Appendix I. Figure 1. PQI Trends, CY 2014-CY 2015

PQI Admission Rate	CY 2014 PQI COUNT A	CY 2015 PQI COUNT B	CY 2014-2015 %CHANGE C=D/A	CY 2015-2014 PQI COUNT D=B-A	CY 2015 % CONTRIBUTION
PQI 15 Asthma in Younger Adults	1,188	1,070	-9.9%	-118	-10.85%
PQI 03 Diabetes Long-Term Complications	4,853	4,454	-8.2%	-399	-36.67%
PQI 05 Chronic Obstructive Pulmonary Disease or Asthma in Older Adults	13,826	13,327	-3.6%	-499	-45.86%
PQI 11 Bacterial Pneumonia	9,712	9,504	-2.1%	-208	-19.12%
PQI 02 Perforated Appendix	1,091	1,069	-2.0%	-22	-2.02%
PQI 07 Hypertension	2,887	2,873	-0.5%	-14	-1.29%
PQI 01 Diabetes Short-Term Complications	2,933	2,935	0.1%	2	0.18%
PQI 12 Urinary Tract Infection	7,446	7,603	2.1%	157	14.43%
PQI 08 Heart Failure	13,744	14,435	5.0%	691	63.51%
PQI 16 Lower-Extremity Amputation among Patients with Diabetes	773	822	6.3%	49	4.50%
PQI 10 Dehydration	4358	5,161	18.4%	803	73.81%
PQI 14 Uncontrolled Diabetes	629	957	52.1%	328	30.15%
PQI 13 Angina Without Procedure	571	889	55.7%	318	29.23%
Total PQI, Unduplicated	**64,011**	**65,099**	**1.7%**	**1,088**	**100%**

APPENDIX II. PERCENT OF REVENUE IN PAU BY HOSPITAL

The following figure presents the total non-PAU revenue for each hospital, total PAU revenue by PAU category (PQI, readmissions, and total), total hospital revenue, and PAU as a percentage of total hospital revenue for CY 2015. Overall, 12.14 percent of total statewide hospital revenue was for PAU. (Updated from the Draft Recommendation to incorporate ICD-10 corrections. Final numbers for RY 2017 rate orders will be published by the end of June 2016).

Appendix II. Figure 1. PAU a Percentage of Total Revenue by Hospital, CY 2015

Hospital Name	Non-PAU Revenue A	Readmission Revenue B	PQI Revenue C	Total PAU Revenue D=B+C	Grand Total Hospital Revenue E=A+D	% Readmission F=B/E	% PQI G=C/E	% PAU H=F+G
MERITUS	$278,758,032	$23,935,112	$16,539,435	$40,474,547	$319,232,579	7.50%	5.18%	12.68%
UNIVERSITY OF MARYLAND	$1,377,464,969	$124,801,439	$28,095,737	$152,897,176	$1,530,362,144	8.16%	1.84%	9.99%
PRINCE GEORGE	$239,882,933	$24,966,656	$15,411,410	$40,378,066	$280,260,999	8.91%	5.50%	14.41%
HOLY CROSS	$423,324,914	$43,016,259	$20,094,808	$63,111,066	$486,435,981	8.84%	4.13%	12.97%
FREDERICK MEMORIAL	$317,248,500	$22,847,968	$17,388,012	$40,235,980	$357,484,480	6.39%	4.86%	11.26%
HARFORD	$85,109,236	$10,887,383	$8,301,450	$19,188,833	$104,298,069	10.44%	7.96%	18.40%
MERCY	$471,837,685	$21,767,464	$10,694,324	$32,461,787	$504,299,472	4.32%	2.12%	6.44%
JOHNS HOPKINS	$2,009,019,808	$198,729,754	$42,322,463	$241,052,217	$2,250,072,025	8.83%	1.88%	10.71%
DORCHESTER	$42,913,840	$5,810,179	$6,099,254	$11,909,432	$54,823,272	10.60%	11.13%	21.72%
ST. AGNES	$357,085,002	$37,698,472	$25,327,535	$63,026,007	$420,111,009	8.97%	6.03%	15.00%
SINAI	$643,855,411	$54,805,585	$23,959,492	$78,765,077	$722,620,488	7.58%	3.32%	10.90%
BON SECOURS	$88,888,125	$15,008,008	$6,078,826	$21,086,833	$109,974,958	13.65%	5.53%	19.17%
FRANKLIN SQUARE	$420,619,700	$51,762,928	$30,126,699	$81,889,627	$502,509,327	10.30%	6.00%	16.30%
WASHINGTON ADVENTIST	$225,202,801	$23,610,443	$13,138,857	$36,749,299	$261,952,100	9.01%	5.02%	14.03%
GARRETT COUNTY	$42,130,137	$1,428,688	$2,998,235	$4,426,923	$46,557,060	3.07%	6.44%	9.51%
MONTGOMERY GENERAL	$148,145,664	$14,176,460	$8,239,791	$22,416,251	$170,561,915	8.31%	4.83%	13.14%
PENINSULA REGIONAL	$373,984,935	$29,899,934	$22,521,716	$52,421,650	$426,406,584	7.01%	5.28%	12.29%

Hospital Name	Non-PAU Revenue A	Readmission Revenue B	PQI Revenue C	Total PAU Revenue D=B+C	Grand Total Hospital Revenue E=A+D	% Readmission F=B/E	% PQI G=C/E	% PAU H=F+G
SUBURBAN	$269,251,785	$21,755,907	$10,402,538	$32,158,445	$301,410,230	7.22%	3.45%	10.67%
ANNE ARUNDEL	$516,488,974	$31,579,286	$22,787,257	$54,366,543	$570,855,517	5.53%	3.99%	9.52%
UNION MEMORIAL	$355,148,712	$33,572,118	$16,492,523	$50,064,641	$405,213,352	8.29%	4.07%	12.36%
WESTERN MARYLAND HEALTH SYSTEM	$289,308,265	$22,810,433	$14,351,484	$37,161,917	$326,470,182	6.99%	4.40%	11.38%
ST. MARY	$150,042,473	$10,201,193	$9,257,977	$19,459,170	$169,501,643	6.02%	5.46%	11.48%
HOPKINS BAYVIEW MED CTR	$516,803,980	$52,100,389	$24,399,968	$76,500,357	$593,304,337	8.78%	4.11%	12.89%
CHESTERTOWN	$51,364,263	$3,656,943	$4,942,230	$8,599,173	$59,963,436	6.10%	8.24%	14.34%
UNION HOSPITAL OF CECIL COUNT	$137,071,783	$11,514,876	$10,577,694	$22,092,570	$159,164,353	7.23%	6.65%	13.88%
CARROLL COUNTY	$218,972,313	$20,254,167	$16,823,734	$37,077,901	$256,050,214	7.91%	6.57%	14.48%
HARBOR	$175,672,868	$17,294,894	$10,450,553	$27,745,447	$203,418,315	8.50%	5.14%	13.64%
CHARLES REGIONAL	$128,961,719	$12,444,699	$10,535,610	$22,980,309	$151,942,028	8.19%	6.93%	15.12%
EASTON	$165,740,757	$12,503,629	$11,444,605	$23,948,234	$189,688,991	6.59%	6.03%	12.62%
UMMC MIDTOWN	$167,394,950	$25,932,131	$8,825,245	$34,757,377	$202,152,326	12.83%	4.37%	17.19%
CALVERT	$127,370,735	$7,752,786	$9,387,103	$17,139,889	$144,510,623	5.36%	6.50%	11.86%
NORTHWEST	$211,908,045	$24,266,540	$18,167,037	$42,433,576	$254,341,622	9.54%	7.14%	16.68%
BALTIMORE WASHINGTON MEDICAL CENTER	$342,411,318	$40,794,574	$25,500,029	$66,294,602	$408,705,920	9.98%	6.24%	16.22%
G.B.M.C.	$400,652,316	$24,235,115	$14,576,995	$38,812,110	$439,464,425	5.51%	3.32%	8.83%
MCCREADY	$13,226,530	$393,646	$699,421	$1,093,067	$14,319,597	2.75%	4.88%	7.63%
HOWARD COUNTY	$252,809,879	$23,143,070	$13,851,236	$36,994,306	$289,804,185	7.99%	4.78%	12.77%
UPPER CHESAPEAKE HEALTH	$284,683,721	$23,198,373	$16,258,058	$39,456,431	$324,140,153	7.16%	5.02%	12.17%
DOCTORS COMMUNITY	$188,832,099	$24,920,871	$15,482,969	$40,403,840	$229,235,939	10.87%	6.75%	17.63%
LAUREL REGIONAL	$79,169,945	$8,475,374	$4,792,072	$13,267,446	$92,437,391	9.17%	5.18%	14.35%
GOOD SAMARITAN	$249,094,825	$31,259,300	$17,277,581	$48,536,881	$297,631,706	10.50%	5.81%	16.31%

Hospital Name	Non-PAU Revenue A	Readmission Revenue B	PQI Revenue C	Total PAU Revenue D=B+C	Grand Total Hospital Revenue E=A+D	% Readmission F=B/E	% PQI G=C/E	% PAU H=F+G
SHADY GROVE	$345,873,078	$29,710,171	$14,228,530	$43,938,701	$389,811,779	7.62%	3.65%	11.27%
REHAB & ORTHO	$104,007,760	$341,828	$-	$341,828	$104,349,588	0.33%	0.00%	0.33%
FT. WASHINGTON	$40,693,732	$3,068,272	$4,358,517	$7,426,789	$48,120,521	6.38%	9.06%	15.43%
ATLANTIC GENERAL	$93,620,264	$4,390,104	$5,193,041	$9,583,145	$103,203,409	4.25%	5.03%	9.29%
SOUTHERN MARYLAND	$216,826,400	$27,065,827	$20,381,819	$47,447,646	$264,274,046	10.24%	7.71%	17.95%
UM ST. JOSEPH	$374,832,474	$22,943,101	$11,745,266	$34,688,367	$409,520,840	5.60%	2.87%	8.47%
HOLY CROSS GERMANTOWN*	$56,181,444	$6,750,014	$5,143,503	$11,893,518	$68,074,962	9.92%	7.56%	17.47%
GERMANTOWN	$13,564,670			$-	$13,564,670	0.00%	0.00%	0.00%
QUEEN ANNES	$5,095,489			$-	$5,095,489	0.00%	0.00%	0.00%
BOWIE HEALTH	$21,300,381			$-	$21,300,381	0.00%	0.00%	0.00%
	$14,109,849,635	$1,283,482,360	$665,672,639	$1,949,154,999	$16,059,004,635	7.99%	4.15%	12.14%

*Holy Cross Germantown will be combined with Holy Cross Hospital for PAU Savings calculations.

APPENDIX III. Modeling Results Proposed PAU Savings Policy Reductions For RY 2017

The following figure presents the proposed PAU savings reduction policy for each hospital for RY 2017 (FY 16 Total Permanent revenue and PAU percents are updated from draft recommendation. Final adjustments will be published by the end of June).

Appendix IV. Figure 1. Proposed PAU Savings Policy Reductions for RY 2017, by Hospital

Hospital Name	FY16 Total Permanent Revenue A	CY15 PAU % B	FY17 PAU Savings Adjustment C=(B*-10.63%)[10]	FY 17 PAU Savings Adjustments before Protection D=A*C	CY 15 % Inpatient ECMAD Medicaid &Selfpay Charity E	FY17 PAU Savings Adjustment with Protection F	FY 17 PAU Savings with Protections Revenue Impact G=A*F	FY2016 PAU Savings Adjustment H	Net Impact to RY 2017 Inflation Factor I=F-H	Net RY 17 Revenue Impact J=A*O
DORCHESTER	$49,366,715	21.72%	-2.31%	$(1,139,783)	23.78%	-2.31%	($1,139,783)	-0.42%	-1.89%	**$(932,671)**
BON SECOURS	$122,434,137	19.17%	-2.04%	$(2,495,066)	57.59%	-1.29%	($1,579,400)	-0.60%	-0.69%	**$(844,796)**
HARFORD	$100,472,983	18.40%	-1.96%	$(1,964,643)	17.98%	-1.96%	($1,964,643)	-0.42%	-1.53%	**$(1,540,409)**
SOUTHERN MARYLAND	$265,443,855	17.95%	-1.91%	$(5,065,179)	22.27%	-1.91%	($5,065,179)	-0.59%	-1.32%	**$(3,508,483)**
DOCTORS COMMUNITY	$226,236,757	17.63%	-1.87%	$(4,238,040)	19.33%	-1.87%	($4,238,040)	-0.56%	-1.31%	**$(2,965,417)**
UMMC MIDTOWN	$223,767,089	17.19%	-1.83%	$(4,089,088)	45.61%	-1.29%	($2,886,595)	-0.60%	-0.69%	**$(1,543,993)**
NORTHWEST	$247,056,826	16.68%	-1.77%	$(4,380,776)	20.24%	-1.77%	($4,380,776)	-0.63%	-1.14%	**$(2,817,106)**
GOOD SAMARITAN	$283,376,592	16.31%	-1.73%	$(4,911,550)	18.26%	-1.73%	($4,911,550)	-0.67%	-1.06%	**$(3,005,753)**
FRANKLIN SQUARE	$488,282,513	16.30%	-1.73%	$(8,457,030)	26.69%	-1.29%	($6,298,844)	-0.60%	-0.69%	**$(3,369,149)**
BALTIMORE WASHINGTON	$396,558,220	16.22%	-1.72%	$(6,836,537)	17.18%	-1.72%	($6,836,537)	-0.64%	-1.08%	**$(4,295,768)**

[10] PAU reduction= % PAU (12.14%) / Savings (-1.25%) + the statewide impact of Medicaid Protection (0.04%) = -10.63%.

Hospital Name	FY16 Total Permanent Revenue A	CY15 PAU % B	FY17 PAU Savings Adjustment C=(B*-10.63%)[10]	FY 17 PAU Savings Adjustments before Protection D=A*C	CY 15 % Inpatient ECMAD Medicaid &Selfpay Charity E	FY17 PAU Savings Adjustment with Protection F	FY 17 PAU Savings with Protections Revenue Impact G=A*F	FY2016 PAU Savings Adjustment H	Net Impact to RY 2017 Inflation Factor I=F-H	Net RY 17 Revenue Impact J=A*O
FT. WASHINGTON	$46,558,629	15.43%	-1.64%	$(763,718)	22.44%	-1.64%	($763,718)	-0.42%	-1.22%	**$(569,724)**
ST. AGNES	$413,273,339	15.00%	-1.59%	$(6,589,540)	21.56%	-1.59%	($6,589,540)	-0.60%	-0.99%	**$(4,102,853)**
CHARLES REGIONAL	$143,315,213	15.12%	-1.61%	$(2,303,733)	16.36%	-1.61%	($2,303,733)	-0.54%	-1.07%	**$(1,531,088)**
CARROLL COUNTY	$245,978,519	14.48%	-1.54%	$(3,785,726)	13.81%	-1.54%	($3,785,726)	-0.54%	-1.00%	**$(2,468,432)**
LAUREL REGIONAL	$101,288,035	14.35%	-1.53%	$(1,545,111)	29.90%	-1.29%	($1,306,616)	-0.60%	-0.69%	**$(698,887)**
PRINCE GEORGE	$278,868,894	14.41%	-1.53%	$(4,270,167)	45.25%	-1.29%	($3,597,409)	-0.56%	-0.73%	**$(2,039,951)**
CHESTERTOWN	$53,997,130	14.34%	-1.52%	$(823,006)	12.40%	-1.52%	($823,006)	-0.49%	-1.04%	**$(560,627)**
WASHINGTON ADVENTIST	$253,346,309	14.03%	-1.49%	$(3,777,493)	31.92%	-1.29%	($3,268,167)	-0.60%	-0.69%	**$(1,748,090)**
UNION HOSPITAL OF CECIL COUNT	$153,588,495	13.88%	-1.48%	$(2,265,797)	28.02%	-1.29%	($1,981,292)	-0.36%	-0.93%	**$(1,424,084)**
HARBOR	$190,199,181	13.64%	-1.45%	$(2,757,225)	33.93%	-1.29%	($2,453,569)	-0.60%	-0.69%	**$(1,312,374)**
HOLY CROSS	$473,189,703	13.53%	-1.44%	$(6,802,600)	22.06%	-1.44%	($6,802,600)	-0.68%	-0.76%	**$(3,587,331)**
HOLY CROSS GERMANTOWN	$88,000,000	13.53%	-1.44%	$(1,265,093)	23.98%	-1.44%	($1,265,093)	0.00%	-1.44%	**$(1,265,093)**
MONTGOMERY GENERAL	$168,451,048	13.14%	-1.40%	$(2,352,971)	15.17%	-1.40%	($2,352,971)	-0.50%	-0.90%	**$(1,509,878)**
HOPKINS BAYVIEW MED CTR	$610,423,590	12.89%	-1.37%	$(8,365,255)	29.06%	-1.29%	($7,874,464)	-0.60%	-0.69%	**$(4,211,923)**

Hospital Name	FY16 Total Permanent Revenue A	CY15 PAU % B	FY17 PAU Savings Adjustment C=(B*-10.63%)[10]	FY 17 PAU Savings Adjustments before Protection D=A*C	CY 15 % Inpatient ECMAD Medicaid &Selfpay Charity E	FY17 PAU Savings Adjustment with Protection F	FY 17 PAU Savings with Protections Revenue Impact G=A*F	FY2016 PAU Savings Adjustment H	Net Impact to RY 2017 Inflation Factor I=F-H	Net RY 17 Revenue Impact J=A*O
HOWARD COUNTY	$284,424,840	12.77%	-1.36%	$(3,858,866)	14.14%	-1.36%	($3,858,866)	-0.57%	-0.79%	**$(2,241,171)**
MERITUS	$309,029,336	12.68%	-1.35%	$(4,164,247)	18.67%	-1.35%	($4,164,247)	-0.60%	-0.75%	**$(2,305,550)**
EASTON	$192,089,981	12.62%	-1.34%	$(2,577,496)	17.32%	-1.34%	($2,577,496)	-0.52%	-0.82%	**$(1,581,849)**
UNION MEMORIAL	$411,630,821	12.36%	-1.31%	$(5,405,268)	17.66%	-1.31%	($5,405,268)	-0.62%	-0.69%	**$(2,852,296)**
PENINSULA REGIONAL	$413,594,890	12.29%	-1.31%	$(5,404,107)	18.16%	-1.31%	($5,404,107)	-0.53%	-0.78%	**$(3,213,316)**
UPPER CHESAPEAKE HEALTH	$319,063,053	12.17%	-1.29%	$(4,127,846)	10.86%	-1.29%	($4,127,846)	-0.49%	-0.81%	**$(2,579,263)**
CALVERT	$140,329,390	11.86%	-1.26%	$(1,768,963)	16.42%	-1.26%	($1,768,963)	-0.33%	-0.93%	**$(1,299,956)**
WESTERN MARYLAND HEALTH SYSTEM	$312,666,774	11.38%	-1.21%	$(3,782,668)	15.60%	-1.21%	($3,782,668)	-0.58%	-0.63%	**$(1,960,906)**
ST. MARY	$168,090,518	11.48%	-1.22%	$(2,050,952)	18.69%	-1.22%	($2,050,952)	-0.38%	-0.84%	**$(1,417,198)**
FREDERICK MEMORIAL	$350,725,799	11.26%	-1.20%	$(4,195,532)	11.03%	-1.20%	($4,195,532)	-0.50%	-0.70%	**$(2,440,515)**
SHADY GROVE	$374,624,719	11.27%	-1.20%	$(4,487,977)	19.76%	-1.20%	($4,487,977)	-0.53%	-0.67%	**$(2,509,843)**
SINAI	$698,636,216	10.90%	-1.16%	$(8,093,502)	24.05%	-1.16%	($8,093,502)	-0.66%	-0.50%	**$(3,462,623)**
SUBURBAN	$290,002,663	10.67%	-1.13%	$(3,288,524)	7.53%	-1.13%	($3,288,524)	-0.58%	-0.55%	**$(1,603,745)**
JOHNS HOPKINS	$2,178,990,299	10.71%	-1.14%	$(24,810,297)	23.04%	-1.14%	($24,810,297)	-0.73%	-0.41%	**$(9,001,453)**

Hospital Name	FY16 Total Permanent Revenue A	CY15 PAU % B	FY17 PAU Savings Adjustment C=(B*-10.63%)[10]	FY 17 PAU Savings Adjustments before Protection D=A*C	CY 15 % Inpatient ECMAD Medicaid &Selfpay Charity E	FY17 PAU Savings Adjustment with Protection F	FY 17 PAU Savings with Protections Revenue Impact G=A*F	FY2016 PAU Savings Adjustment H	Net Impact to RY 2017 Inflation Factor I=F-H	Net RY 17 Revenue Impact J=A*O
ANNE ARUNDEL	$553,902,629	9.52%	-1.01%	$(5,606,617)	12.02%	-1.01%	($5,606,617)	-0.54%	-0.47%	**$(2,608,775)**
GARRETT COUNTY	$45,640,340	9.51%	-1.01%	$(461,240)	19.56%	-1.01%	($461,240)	-0.24%	-0.77%	**$(352,014)**
ATLANTIC GENERAL	$100,960,082	9.29%	-0.99%	$(996,381)	11.51%	-0.99%	($996,381)	-0.36%	-0.63%	**$(634,652)**
UNIVERSITY OF MARYLAND	$1,289,991,934	9.99%	-1.06%	$(13,697,907)	29.87%	-1.06%	($13,697,907)	-0.60%	-0.46%	**$(5,957,955)**
G.B.M.C.	$423,026,290	8.83%	-0.94%	$(3,970,753)	9.87%	-0.94%	($3,970,753)	-0.41%	-0.53%	**$(2,246,614)**
UM ST. JOSEPH	$384,647,527	8.47%	-0.90%	$(3,462,843)	11.82%	-0.90%	($3,462,843)	-0.54%	-0.36%	**$(1,392,995)**
MCCREADY	$14,230,659	7.63%	-0.81%	$(115,452)	15.85%	-0.81%	($115,452)	-0.19%	-0.62%	**$(87,784)**
MERCY	$491,288,212	6.44%	-0.68%	$(3,361,106)	24.64%	-0.68%	($3,361,106)	-0.52%	-0.16%	**$(801,106)**
REHAB & ORTHO	$117,875,574	0.33%	-0.03%	$(41,040)	21.53%	-0.03%	($41,040)	-0.30%	0.27%	**$312,587**
Total	**$15,488,936,318**	**12.14%**	**-1.29%**	**$(199,807,279)**			**($194,157,796)**	**-0.60%**	**-0.65%**	**$(104,405,458)**
				Top Quartile=	21.37%					

Maryland
Hospital Association

May 25, 2016

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

Dear Chairman Sabatini:

On behalf of the 64 hospital and health system members of the Maryland Hospital Association (MHA), we appreciate the opportunity to comment on the *Draft Recommendations for the Readmissions Reduction Incentive Program for Rate Year 2018*, the *Draft Recommendations for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018,* and the *Draft Recommendations for the Potentially Avoidable Utilization Savings Policy for Rate Year 2017*. On the whole, we support the HSCRC staff recommendations related to readmissions and the amounts of revenue at risk for specific quality programs; however, we disagree with the staff recommendation on Potentially Avoidable Utilization (PAU) savings and the resulting quality-based payment program adjustment to the update.

MHA's position: the net quality-based payment program adjustment should be reduced from -0.61 percent to -0.16 percent by lowering the expected shared savings offset for Potentially Avoidable Utilization. This would reduce to 0.80 percent HSCRC staff's recommendation of a 1.25 percent reduction in hospital revenues.

- The recommendation to reduce hospital revenue by 1.25 percent according to hospitals' individual percentages of readmissions and admissions for certain chronic conditions, or Prevention Quality Indicators (PQIs), uses an Agency for Healthcare Research and Quality (AHRQ) metric in a way it was not intended. The metric was created not for hospitalized patients, but to measure prevention opportunities in the broader population. It has not been applied as a payment incentive anywhere else in the nation. In fact, a report of an AHRQ Clinical Expert Review Board on expanding the use of PQIs for pay for performance notes that "(p)anelists showed comparatively less support for using these indicators in pay for performance applications." They noted the need for careful risk adjustment and that "higher stakes use" may encourage adverse effects of implementation.

- In our April 4 comment letter (attached), we expressed concerns about, among other things, using the AHRQ measure to require an 11.4 percent reduction in readmissions and PQIs combined in one year. That steep of a reduction is, simply, unattainable, and if an incentive is unattainable it no longer acts as an incentive. It is instead just an arbitrary cut.

- The attempt to justify setting a goal of an 11.4 percent reduction in readmissions and PQIs using a 2012 Institute of Medicine report that suggests 27 percent of health care spending was for unnecessary services, compares apples to oranges. Unnecessary care can occur for many reasons: unnecessary screening exams, duplicative tests, invasive procedures near the end of life, lack of patient understanding of treatment options, defensive medicine and more. The opportunity to reduce this care and the interventions, if available, are varied and require patient and provider behavior change over the long term. Those efforts do not necessarily directly help a Maryland hospital meet a specific PQI reduction of more than 11 percent in one year.

- HSCRC staff's recommendation to reduce hospital revenue by 1.25 percent comes against a backdrop of a proposed global budget increase of just 1.1 percent for all hospitals, already far below inflation. Our recommendation of removing the PQI component and lowering that reduction to 0.80 percent to adjust only for readmissions – an adjustment we agree with – is still an increase over last year's reduction of 0.60 percent.

Aggregate Revenue at Risk
We support the staff recommendations on the remaining amounts at risk for the individual quality programs: Quality Based Reimbursement, Maryland Hospital Acquired Conditions, Readmissions, and the Maximum Penalty Guardrail of 3.5 percent of total revenue.

It is critical to note that, for fiscal year 2017, Maryland's potential all-payer revenue at risk is more than 11 percent – far higher than the nation's Medicare revenue at risk of 6 percent. The amount of actual adjustments or "realized risk" by Maryland's hospitals is also significant – projected at more than 4 percent of all-payer revenue. Therefore, there is plenty of room for HSCRC to make the minor adjustment for potentially avoidable utilization that we are recommending.

Readmissions
We support HSCRC staff's recommendations on fiscal year 2017 and 2018 readmissions results. We appreciate and commend HSCRC staff's diligence in developing a well-balanced readmissions policy that includes the concept of attainment – something that has not been achieved elsewhere. The policy does have opportunities for future refinement, in particular regarding the risk model that would recognize characteristics such as social and demographic predictors of readmission, as well as refinements to the out-of-state adjustment. The policy currently adjusts in-state risk-adjusted all-payer readmissions by the percentage of unadjusted Medicare readmissions that occur out of state. We are still working to understand the Medicare data, and may find that there is a better way to account for the all-payer readmissions that occur out of state.

The hospital field's strong performance on all of the Medicare demonstration metrics indicates that the current performance incentives are working. There are already incentives to reduce PQIs inherent in the global budget, and the Maryland amount of revenue at risk is greater than the nation, no matter which way it is measured. Experimenting with new, untried pay for performance metrics now would shift important focus away from the metrics that are actually generating valuable results for our state, its hospitals, and the communities and people we all serve.

We appreciate the commission's consideration of our comments.

Sincerely,

Traci La Valle
Vice President

cc: Herbert S. Wong, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Jack C. Keane
Donna Kinzer, Executive Director
Dianne Feeney, Associate Director, Quality Initiatives

Enclosures

Maryland
Hospital Association

April 4, 2016

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

Dear Ms. Feeney:

On behalf of the 64 hospital and health system members of the Maryland Hospital Association (MHA), we appreciate the opportunity to comment on the proposed changes to the *Draft Recommendation for Updating the Readmissions Reduction Incentive Program for Rate Year 2018* and the *Draft Recommendation for the Aggregate Revenue Amount At-Risk under Maryland Hospital Quality Programs for Rate Year 2018*. The draft recommendations raise three important policy concerns: the need for individual hospital consideration when there is no performance standard for readmissions; the lack of justification for expanding a penalty-only performance metric (shared savings) and to include an ill-conceived idea of measuring Prevention Quality Indicators and sepsis cases at the hospital level; and the amount of revenue at risk under quality-related programs. It is important that these policies be considered in the context of a second year of very favorable performance on the financial and quality metrics specified in the all-payer demonstration agreement. The hospital field has demonstrated that it can deliver on the demonstration targets ahead of the pace outlined in the agreement. In submitting our comments, we urge you to keep in mind the Health Services Cost Review Commission (HSCRC) Advisory Council's early advice to implement the agreement using broad targets and incentives and to avoid excessive regulation, thus allowing hospitals the flexibility to meet those targets.

Fiscal Year 2018 Policy (Calendar 2016 Performance)

HSCRC staff and the hospital field have made considerable progress in understanding readmissions rates over the last year. Most notably, we finally have a method to calculate Medicare readmissions that we believe fairly compares Maryland's unadjusted readmissions rates to the nation. We have also made progress on measuring social and demographic factors that affect readmissions rates and in quantifying the impact of other factors in a risk-adjusted model. However, we do not yet have a model that everyone agrees should be used to set a target readmissions rate for each hospital.

In calendar year 2015, it became clear that hospitals with lower starting readmissions rates were less likely to reduce readmissions and may even experience increases. We also saw a pattern that readmissions rates move up or down in tandem with admissions. Just as we do not fully understand the complex interplay of factors driving hospital readmissions rates, we are not yet

able to fully account for the factors driving overall utilization in each market, such as changes in physician and payer referral patterns.

Last year, HSCRC's readmissions policy included a provision that any hospital that believed the readmissions reduction policy was penalizing them inappropriately could bring additional information to HSCRC to more fully explain their individual circumstances. To date, a number of hospitals have met with HSCRC, but none has received penalty relief. HSCRC staff does not yet appear to have a mechanism to determine when a hospital is a good performer, even on an individual basis.

We recommend that HSCRC continue to work with the hospital field to come to agreement on a mechanism to determine a hospital-specific readmissions target so that the readmissions policy can recognize both attainment and improvement. Hospitals that have attained lower readmissions rates should not be penalized, particularly when those rates are well below state and national averages.

Penalty Relief Fiscal Year 2017 (Calendar 2015 Performance)

MHA has been advocating for a mechanism to recognize hospitals that have low readmissions rates and those that have significantly improved. Our recommended modification to fiscal 2017 policy accomplishes that by lowering the statewide target and mitigating penalties for hospitals whose rates are among the lowest third of the state in both the base year and the performance year. The options proposed by HSCRC do one or the other, but not both. The options to recognize Medicare improvement or all-payer improvement tend to help hospitals that have experienced larger reductions in readmissions generally. The option to lower the improvement target for hospitals with base rates below statewide average is a step in the right direction, but still leaves subject to penalties too many hospitals with low readmissions rates. Appendix 1 shows the MHA proposal, and our projection of the hospital-specific and statewide impact of all three proposals.

HSCRC staff stated in their recommendation that they disagree with lowering the statewide reduction target. However, at the time the 9.3 percent target was set, there was significant uncertainty around what an appropriate target would be. Maryland did not yet have the base year readmissions rates for the state and the nation, so we did not know how much difference Maryland's hospitals needed to make up, nor whether our year one performance was on track to meet the Medicare demonstration target. Now, with better data, we know that the 7.1 percent all-payer reduction through November 2015 has Maryland comfortably meeting the statewide Medicare readmissions target as specified in the demonstration agreement. Clearly, the 9.3 percent target was too aggressive.

Expanding "Shared Savings"

The staff recommendation links fiscal year 2017 penalty relief to a proposed larger "shared savings" reduction, to generate additional savings for Medicare and all other payers. This is completely unnecessary from a financial incentive standpoint, and poorly conceived from a

performance measurement standpoint. The financial targets of the all-payer model would allow the commission to mitigate fiscal 2017 penalties without additional offsets. Maryland is already far ahead of the Medicare savings targets. The cumulative year two savings target is $49 million, but in year one alone more than $100 million in savings was generated. Likewise, there is plenty of cushion under the all-payer cap. In fiscal year 2015, commissioners approved a 2.35 percent per capita increase to global budgets. The per capita increase actually provided in global budgets was 1.85 percent, according to commission data. Likewise, in fiscal 2016, commissioners approved an increase of 2.61 percent per capita, and through January, hospital per capita revenue has increased only 1.52 percent. Across the two years combined, 5.02 percent per capita growth was approved, but only 3.47 percent per capita has been reflected in hospital rates.

From a performance measurement standpoint, adjusting hospital revenues by a modified version of the Agency for Healthcare Research and Quality Prevention Quality Indicator (PQI) admissions disregards the important fact that the measure is intended to evaluate the rate of preventable admissions in a *population*. The agency never intended for the admissions to be counted at the provider level without knowing the population at risk for a PQI admission. Without understanding the denominator, or the ability to quantify the number of people who were at risk for admission to a hospital, PQI performance cannot be compared across hospitals. Hospitals with a more surgical focus will have lower PQI rates, hospitals in areas where there is low population density and fewer physicians will have higher rates. The enclosed chart shows that PQI admissions per 1,000 population vary significantly by county. The concept, perhaps well intentioned, is that the hospital is responsible for the health of its community, so if fewer people are admitted for chronic conditions, it must mean that the community is healthier. It could also mean that primary care services are more available, or that patients went to another hospital.

The measurement issues related to sepsis are also significant, and should cause concern when being considered for inclusion in the proposed readmissions shared savings policy. There is national debate among physicians and infection preventionists about when a patient's clinical conditions should be labeled as sepsis. Over-identification can lead to overuse of antibiotics and proliferation of other complications, such as Claustridium Difficile. Patient Safety Organizations and the Centers for Medicare & Medicaid Services are focused on reducing sepsis mortality by identifying people who are in the early stage of sepsis and need antibiotics and hydration within three hours to reduce the risk of dying. Patient safety interventions such as these that rely on early detection may cause an initial increase in the number of sepsis cases, but should also be accompanied by reductions in sepsis mortality. Adding an incentive to reduce sepsis cases could be at odds with efforts to identify and reduce sepsis mortality. Septicemia and shock, which may be the result of the body's reaction to sepsis, are included in the Maryland Hospital-Acquired Conditions program, and sepsis mortality is included in HSCRC's Quality Based Reimbursement program.

The HSCRC staff recommendations on a fiscal year 2018 readmissions policy, fiscal year 2017 readmissions penalty mitigation, and in particular, the recommendation to tie penalty relief to an expansion of a penalty-only policy based on performance metrics that are not suited to hospital

level measurement and which seem to be hastily constructed, are overly punitive. The hospital field's strong performance on all of the Medicare demonstration metrics indicate that the current performance incentives are working well. There are already incentives to reduce PQIs inherent in the global budget, and the Maryland amount of revenue at risk is greater than the nation, no matter which way it is measured. Piling on additional metrics, additional penalties and additional risk would jeopardize and remove focus from the good work and good results hospitals are already delivering.

We appreciate the commission's consideration of our comments.

Sincerely,

Traci La Valle
Vice President

Enclosure

"Shared Savings" Reductions are Simply Revenue Reductions

- The net proposed shared savings adjustment of 0.65 percent would remove $98.4 million from hospital budgets
- It's been characterized as a savings mechanism that allows hospitals to retain 100 percent of the reduction beyond the savings benchmark. However, since costs are both fixed and variable, savings are generated and accrued at less than 100 percent.
- Assuming hospital costs are 50% variable, for the hospital field to break even on a $98.4 million reduction, the field must reduce volume equivalent to $198.6 million ($98.4 x 2)
- A hospital would not begin to keep any cost savings until PQIs and readmissions were reduced by over 11 percent

	CY 2015 Average Charge	Number cases to reduce to achieve $198.6 million savings	CY 2015 number of cases (including Observation)	**Percent reduction required for hospital to break even**
		(Savings target of $198.6 M / PQI avg chg $10,651)		(Cases to reduce / CY 15 number of cases)
PQI	$10,651	18,646	77,654	**-24.0%**
Readmissions	$15,277	13,001	83,412	**-15.6%**
Combined	$13,961	14,226	124,499	**-11.4%**

Final Recommendations for the Uncompensated Care Policy for 2017

June 8, 2016

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

Table of Contents

LIST OF ABBREVIATIONS

ACA	Affordable Care Act
CRISP	Chesapeake Regional Information System for Our Patients
CY	Calendar year
ED	Emergency department
FPL	Federal poverty level
FY	Fiscal year
HSCRC	Health Services Cost Review Commission
MHBE	Maryland Health Benefit Exchange
PAC	Primary Adult Care Program
RY	Rate year
UCC	Uncompensated care

INTRODUCTION

Uncompensated care (UCC) refers to care provided for which compensation is not received. This may include a combination of bad debt and charity care.[1] Since it first began setting rates, the Maryland Health Services Cost Review Commission (HSCRC or Commission) has recognized the cost of UCC within Maryland's unique hospital rate-setting system. As a result, patients who cannot pay for care are still able to access hospital services, and hospitals are credited for a reasonable level of UCC provided to those patients. Under the current HSCRC policy, UCC is funded by a statewide pooling system in which regulated Maryland hospitals draw funds from the pool if they experience a greater-than-average level of UCC and pay into the pool if they experience a less-than-average level of UCC. This ensures that the cost of UCC is shared equally across all of the hospitals within the system.

The HSCRC determines the total amount of UCC that will be placed in hospital rates for each year and the amount of funding that will be made available for the UCC pool. Additionally, the Commission has approved the methodology for distributing these funds among hospitals. The purpose of this report is to provide background information on the UCC policy and to make recommendations for the UCC pool and methodology for rate year (RY) 2017. There are no substantial changes from the draft report. Staff updated the UCC percent number from the draft report to reflect data updates. A new section is added to provide an update on a new methodology to allocate the UCC funding among hospitals.

BACKGROUND

Overview of Maryland's Uncompensated Care Policy

Historical Methodology

Traditionally, the HSCRC prospectively calculated the rate of UCC at each regulated Maryland hospital by combining historical UCC rates with predictions from a regression model.[2] The HSCRC builds a statewide pool into the rate structure for Maryland hospitals, and hospitals either pay into or withdraw from the pool, depending on each hospital's prospectively calculated UCC rate. Each year, the total amount of funds available in the pool is determined by the total percentage of gross patient revenue due to UCC experienced in regulated Maryland hospitals during the previous year. For example, if the actual total cost of UCC was 6 percent in 2015, then the 2016 pool would be prospectively set at 6 percent of the 2016 gross patient revenue.

[1] COMAR 10.37.10.01K

[2] A regression is a general statistical technique for determining how much of a change in an output amount results from a change in measures of multiple inputs.

Impact of the Affordable Care Ace

A primary goal of the Affordable Care Act (ACA) was to expand coverage to uninsured or underinsured individuals. Under these reforms, Maryland expanded Medicaid coverage to individuals with income up to 138 percent of the federal poverty level (FPL). The Medicaid expansion included the extension of full Medicaid benefits to people previously enrolled in the Primary Adult Care (PAC) program. The PAC program offered limited health care coverage to adults aged 19 to 64 years with incomes up to 116 percent of the FPL who were ineligible for Medicaid. PAC covered such services as primary care, family planning, prescriptions, mental health care and addiction services, and outpatient hospital emergency department (ED) services. However, PAC did not reimburse hospitals for inpatient or outpatient care beyond the ED. PAC enrollees were transitioned into full Medicaid benefits—including hospital inpatient and outpatient care—on January 1, 2014. The Medicaid expansion also included individuals with incomes up to 138 percent of the FPL who were not previously enrolled in PAC. In addition to the ACA Medicaid expansion, many individuals received health insurance coverage through the Maryland Health Benefit Exchange (MHBE). Counting both individuals who obtained Medicaid coverage and those who selected a private health plan through the MHBE, more than 375,000 Marylanders enrolled in coverage through February 2015. This included about 254,000 new Medicaid enrollees and 120,000 MHBE enrollees. HSCRC staff has focused efforts on the new categories of Medicaid enrollees covered through the ACA expansions and their impact on UCC.

Updates for RY 2015

Because of the ACA coverage expansion described above, the HSCRC prospectively reduced UCC for RY 2015 to incorporate expected declines in UCC due to the implementation of the ACA on January 1, 2014. HSCRC staff estimated total unpaid hospital charges for the PAC population in the pre-ACA period by linking HSCRC discharge abstract data (case-mix data) and Medicaid PAC eligibility files using a patient-id matching algorithm available through the Chesapeake Regional Information System for Our Patients (CRISP). Based on the estimates from the analysis of historical hospital data, the HSCRC reduced the statewide UCC pool assessment from 7.23 percent to 6.14 percent to reflect the impact of ACA in the first year.

Hospital-specific adjustments combined the two-year historic trend and regression model and included their estimated write-off amounts for the PAC population. The annual UCC percentage for each hospital was weighted equally (50/50) between the two-year average and the predicted regression value as shown in the formula below.

$$\frac{Average\ Uncompensated\ Care\ Rate\ for\ Past\ 2\ Years + Regression\ Value}{2} - Estimated\ UCC\ \%\ for\ PAC\ Population = Annual\ Uncompensated\ Care\ Percentage$$

Once the annual UCC percentages were calculated for each hospital, they were adjusted so that the pooling system would remain revenue neutral.

In addition to prospective reductions for the PAC population, the regression model used to determine the RY 2015 predicted UCC percentage for each hospital was updated based on analysis of fiscal year (FY) 2013 and FY 2014 data. As in previous years, the primary payer and type of service (inpatient, outpatient or emergency) variables were strong predictors of UCC rates. A new variable was added to the regression model to reflect trends in UCC for undocumented immigrants who lack insurance coverage. Since reliable information is not available through the Census Bureau or other sources, zip codes where Medicaid provided emergency coverage for undocumented immigrants were used as a proxy to measure the influence of this specific population.[3] The final regression model relied upon the following five explanatory variables:

- The proportion of a hospital's total charges from inpatient Medicaid admissions through the ED
- The proportion of a hospital's total charges from inpatient commercial insurance cases
- The proportion of a hospital's total charges from inpatient self-pay and charity cases
- The proportion of a hospital's total charges from outpatient self-pay and charity ED cases
- The proportion of a hospital's total charges from inpatient self-pay and charity admissions through the ED from the 80th percentile of Medicaid undocumented immigrant enrollment zip codes

Three hospitals, Levindale Hospital, the University of Maryland Rehabilitation & Orthopedic Institute (formerly Kernan Hospital), and the Shock Trauma Center were excluded from the regression calculations. The HSCRC set the annual UCC percentages for these hospitals at their actual average UCC percentage for the previous three years.

Updates for RY 2016

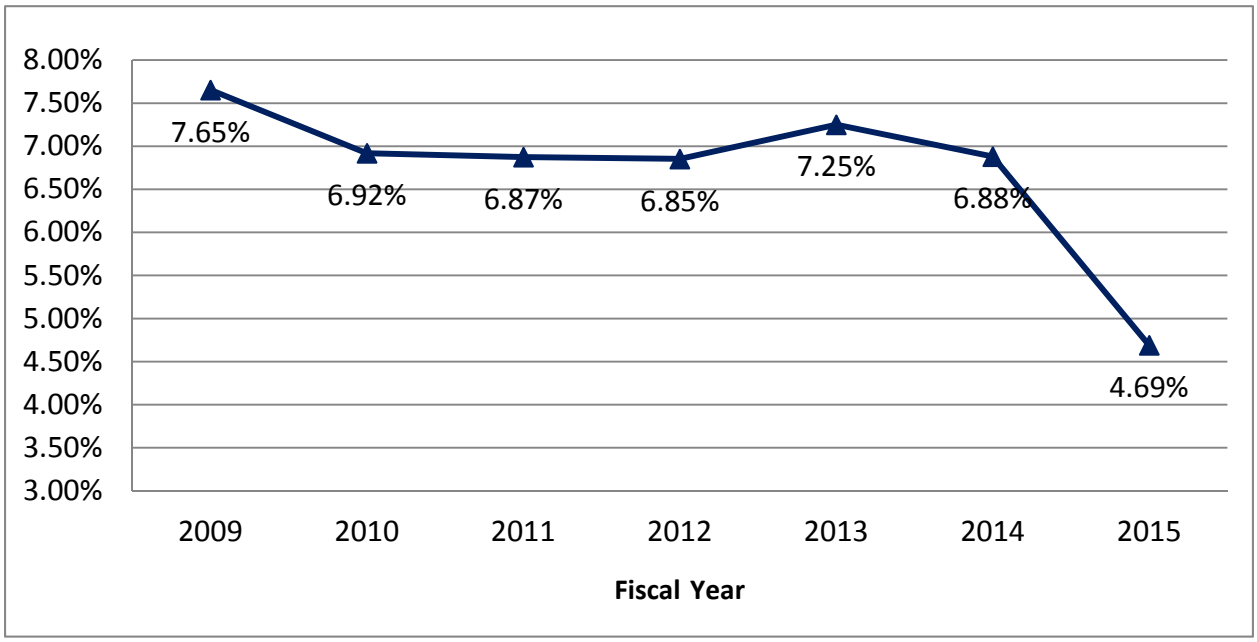
Because the ACA coverage expansions occurred during the middle of FY 2014, staff recommended against using FY 2014 data in the RY 2016 update. Only six months of ACA experience were included in FY 2014 data, which was inadequate for assessing the impact of the ACA on UCC. Instead, staff recommended to continue to reduce the UCC rates prospectively by estimated reductions in unpaid hospital charges for the Medicaid expansion population using a similar approach applied for the PAC population in the RY 2015 rates. The prospective adjustment for RY 2015 was limited to an estimate of the impact of the PAC program gaining full Medicaid coverage. The adjustment for RY 2016, however, captured the actual calendar year (CY) 2014 impact on UCC from extending Medicaid coverage to the entire expansion population (PAC and non-PAC). The RY 2016 UCC amount therefore was set at 5.35 percent.

[3] Medicaid provides coverage of emergency services for undocumented immigrants …

Recent Trends in Uncompensated Care

The figure below shows the actual total UCC rate for all regulated Maryland hospitals between FY 2009 and FY 2015. Over the past three fiscal years, hospitals' UCC costs declined by 2.55 percentage points, a reduction of approximately $311 million in unpaid hospital charges. The declines ranged from -0.42 to -14.16 percentage points across Maryland hospitals. Hospital specific trends are provided in Appendix I.

Figure 1. UCC as Percentage of Gross Patient Revenue, FY 2009-2015



Source: Hospital Annual Financial Audited Cost Reports, RE Schedule

ASSESSMENT

Determining the Appropriate Level of Uncompensated Care Funding in Rates

The HSCRC must determine the percentage of UCC to incorporate in hospitals' rates in order to fund the UCC pool. Based on the most recent audited reports, the statewide UCC rate was 4.69 percent in FY 2015. The rate of Marylanders without health insurance decreased from 10.2 percent to 7.9 percent in 2014, according to the latest statistics from the Census Bureau. A Gallup poll estimated that 7 percent of Marylanders were uninsured at the mid-year point of 2015.[4] While more people are getting insurance coverage, underinsurance and increases in the purchase of high-deductible health plans are creating upward pressures on UCC. Given these two

[4] http://www.marylandhbe.com/fewer-marylanders-without-health-coverage-census-bureau-reports/

dynamics, HSCRC staff recommends funding the full 4.69 percent reported by hospitals in the FY 2015 Annual Audited Cost Reports, which represents the hospitals' post-ACA experience.

Staff and the industry are continuing to work on the methodology for determining each hospital's reasonable level of UCC for RY 2017. HSCRC staff has evaluated the current regression model and found that most of the variables are no longer statistically significant, and therefore those variable should not be used to determine the reasonable level of UCC to be built into individual hospital rates. Because there is only one year of post-ACA data available, there are limitations to using the previous regression models and averaging the historical experience from audited financial reports. Staff will report to Commission on the final analyses completed through the stakeholder process at the July 2016 Commission meeting.

Stakeholder Input and Evaluation of Continuing Sources of Uncompensated Care

After the collection of account level write-off data from hospitals, combined with hospital encounter data, the Commission provided this dataset to the industry and interested parties to determine the sources of UCC and variables that could be used in analyzing and quantifying reasonable percentages of UCC to be built into individual hospital rates. The industry is still working on the analyses and the results will be made available to the Commission in July 2016. Summary level data describing payer distributions are provided in Appendix II.

Staff presented a preliminary data summary at the HSCRC Payment Models Workgroup meeting on May 2, 2016. More detailed analyses and modeling have been discussed by the Maryland Hospital Association Financial and Technical Workgroup. Currently, two main alternative approaches are being evaluated.

1. Estimate "expected" UCC rates based on the statewide average percentage of UCC by payer and patient type
2. Estimate "predicted" UCC rates based on a patient-level regression model to predict the chances of individual patients generating UCC costs, and on the statewide average percent of UCC levels by payer and patient type

Hospital Adjustments for Uncompensated Care

MHA discussed the alternative models and adjustments with the hospitals in various meetings since December. Their final recommendation is to use a regression model that predicts the a patient's chances of having a UCC based on their payer type, location of service (Inpatient, Emergency Department, and Other Outpatient) and the Area Deprivation Index of their residents and calculated the percent of UCC based on average UCC amounts by payer and location of service. MHA modelled inclusion of undocumented immigrants as another predictor for UCC. Regression models did not produce good statistical results. The results may reflect the issues with the measurement of undocumented immigrants in the data or the correlation between self-pay charity variable and undocumented immigrants. HSCRC staff will continue to work with

MHA to get better estimates for the undocumented immigrants. More detail about the methodology from the last MHA Financial Technical Work Group meeting is provided in Appendix III. Staff will provide the detailed description and results of the methodology to allocate the UCC funding among hospitals at the July Commission meeting.

RECOMMENDATIONS

Based on the preceding analysis, HSCRC staff recommends the following:

1. The UCC provision in rates should be 4.69 percent, effective July 1, 2016.

2. The HSCRC should continue to do a 50/50 blend of FY 2015 financial audited UCC levels and FY 2016 predicted or estimated UCC levels to determine hospital-specific adjustments.

Staff will provide the detailed description and results of the methodology to allocate the UCC funding for each hospital at the July Commission meeting.

APPENDIX I. HOSPITAL UNCOMPENSATED CARE TRENDS (HOSPITAL AUDITED FINANCIAL COST REPORTS RE SCHEDULE)

Appendix I. Figure 1. UCC Trends by Hospital, FY 2013-2015

	% Bad Debt and Charity (% UCC)				The Difference from FY 2013	
Hospital Name	FY 2013	FY 2014	FY 2015		FY 2014	FY 2015
ANNE ARUNDEL	5.21%	5.06%	3.04%		-0.15%	-2.17%
ATLANTIC GENERAL	7.68%	6.98%	4.58%		-0.70%	-3.10%
BON SECOURS	18.12%	14.58%	3.96%		-3.54%	-14.16%
CALVERT	6.16%	6.53%	3.34%		0.37%	-2.82%
CARROLL COUNTY	4.70%	4.44%	2.15%		-0.26%	-2.54%
DOCTORS COMMUNITY	9.29%	9.49%	7.28%		0.20%	-2.01%
FORT WASHINGTON	13.63%	10.85%	8.73%		-2.77%	-4.90%
FREDERICK MEMORIAL	6.03%	6.72%	3.39%		0.69%	-2.64%
GARRETT COUNTY	10.86%	9.27%	8.25%		-1.58%	-2.61%
GBMC	3.12%	3.38%	2.48%		0.26%	-0.64%
HOLY CROSS	9.26%	8.78%	8.05%		-0.48%	-1.21%
HOLY CROSS GERMANTOWN			9.57%			
HOWARD COUNTY	5.99%	5.66%	4.14%		-0.33%	-1.85%
JOHNS HOPKINS	4.27%	4.16%	2.25%		-0.10%	-2.02%
JOHNS HOPKINS BAYVIEW	9.28%	8.82%	6.49%		-0.46%	-2.80%
LAUREL REGIONAL	14.23%	11.16%	8.81%		-3.07%	-5.43%
LEVINDALE			4.11%			
MCCREADY	8.32%	8.49%	7.62%		0.17%	-0.70%
MEDSTAR FRANKLIN SQUARE	7.06%	5.93%	4.10%		-1.13%	-2.96%
MEDSTAR GOOD SAMARITAN	6.60%	6.12%	4.02%		-0.48%	-2.59%
MEDSTAR HARBOR HOSPITAL	8.59%	6.04%	5.00%		-2.55%	-3.59%
MEDSTAR MONTGOMERY GENERAL	6.59%	5.44%	4.76%		-1.15%	-1.83%
MEDSTAR SOUTHERN MARYLAND	6.84%	8.25%	5.72%		1.41%	-1.12%
MEDSTAR ST. MARY'S	8.47%	5.49%	5.35%		-2.98%	-3.12%
MEDSTAR UNION MEMORIAL	8.13%	5.58%	3.53%		-2.56%	-4.60%
MERCY	8.29%	8.07%	6.44%		-0.22%	-1.85%
MERITUS	7.20%	7.39%	4.59%		0.20%	-2.61%
NORTHWEST	8.41%	7.76%	6.39%		-0.65%	-2.02%
PENINSULA REGIONAL	6.87%	5.94%	3.72%		-0.92%	-3.15%
PRINCE GEORGE	15.51%	13.05%	9.24%		-2.46%	-6.26%

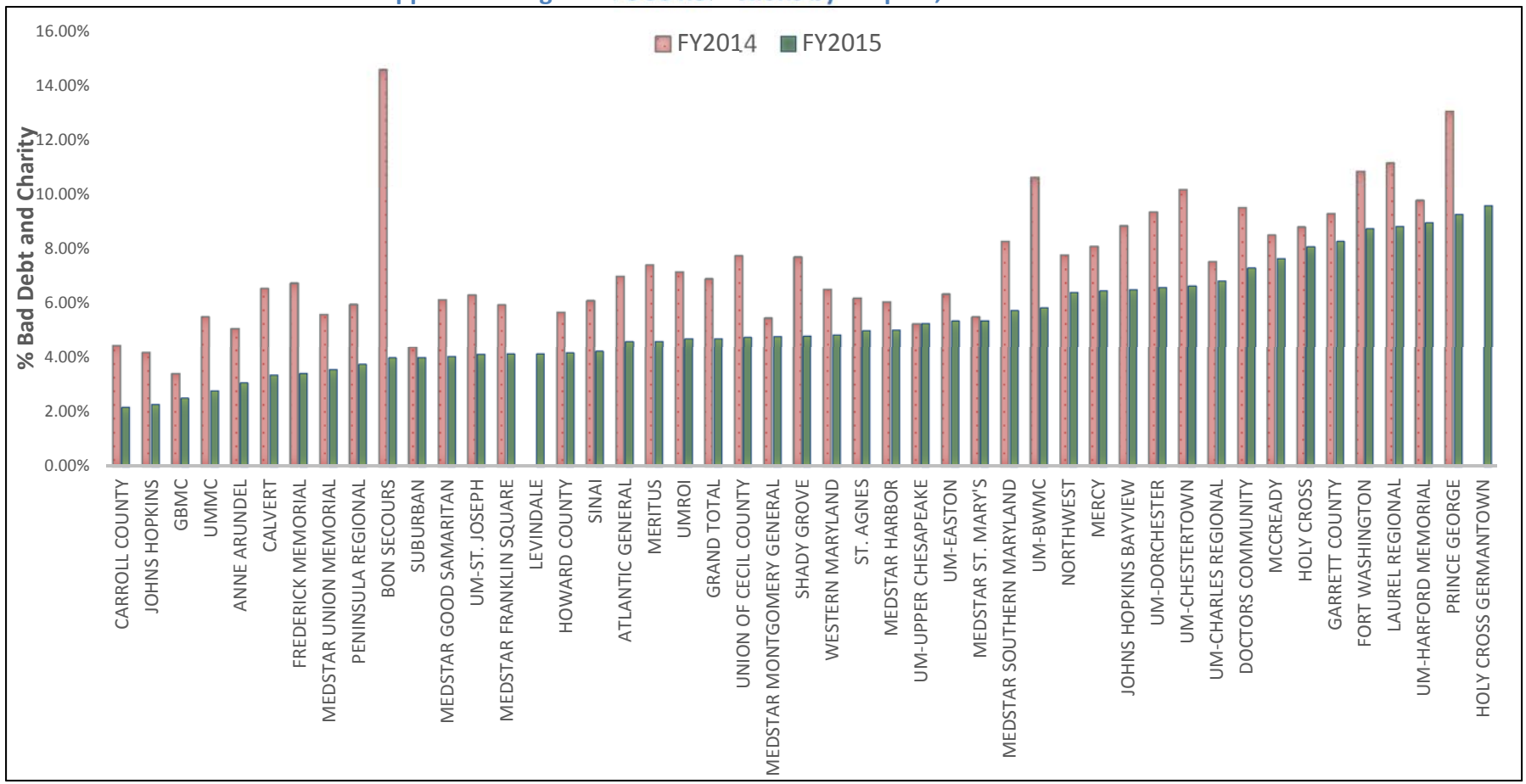
	% Bad Debt and Charity (% UCC)				The Difference from FY 2013	
Hospital Name	**FY 2013**	**FY 2014**	**FY 2015**		**FY 2014**	**FY 2015**
SHADY GROVE	6.76%	7.68%	4.79%		0.92%	-1.97%
SINAI	5.41%	6.09%	4.20%		0.67%	-1.22%
ST. AGNES	7.96%	6.17%	4.99%		-1.78%	-2.97%
SUBURBAN	5.07%	4.35%	3.97%		-0.72%	-1.10%
UM-BWMC	9.78%	10.63%	5.82%		0.85%	-3.96%
UM-CHARLES REGIONAL	7.46%	7.52%	6.81%		0.06%	-0.65%
UM-CHESTERTOWN	10.13%	10.16%	6.62%		0.02%	-3.52%
UM-DORCHESTER	6.99%	9.33%	6.57%		2.34%	-0.42%
UM-EASTON	5.86%	6.32%	5.34%		0.47%	-0.52%
UM-HARFORD MEMORIAL	12.44%	9.76%	8.94%		-2.68%	-3.50%
UMMC	5.40%	5.49%	2.75%		0.09%	-2.65%
UM-MIDTOWN	15.22%	15.08%	10.51%		-0.15%	-4.71%
UMROI	5.20%	7.13%	4.69%		1.94%	-0.51%
UM-ST. JOSEPH	5.13%	6.30%	4.09%		1.18%	-1.04%
UM-UPPER CHESAPEAKE	6.08%	5.23%	5.25%		-0.85%	-0.84%
UNION OF CECIL COUNTY	8.69%	7.73%	4.74%		-0.96%	-3.95%
WASHINGTON ADVENTIST	14.08%	12.20%	10.20%		-1.89%	-3.88%
WESTERN MARYLAND	6.89%	6.50%	4.83%		-0.39%	-2.06%
SHOCK TRAUMA	22.32%	20.06%	12.62%		-2.26%	-9.70%
GRAND TOTAL	**7.25%**	**6.88%**	**4.69%**		**-0.36%**	**-2.55%**

FY 2015 rates for hospitals with a December FYE have been updated since the draft recommendation.

APPENDIX II. WRITE-OFF DATA-SUMMARY STATISTICS

The figure below presents the UCC reduction rate by hospital between FY 2014 and 2015. Reduction rates vary by hospital.

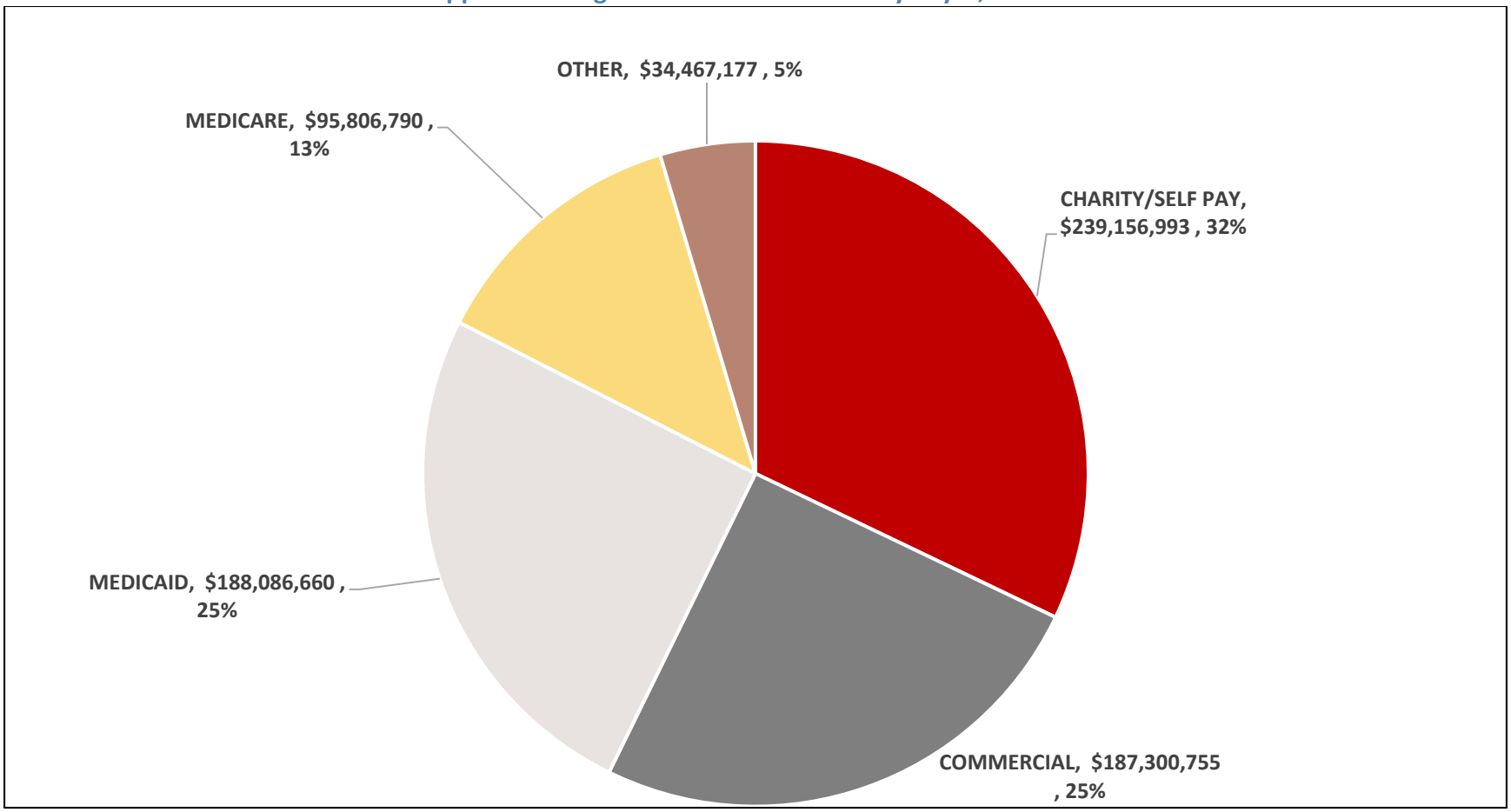
Appendix II. Figure 1. UCC Reductions by Hospital, FY 2014-2015



*Source: HSCRC Financial Audited Data

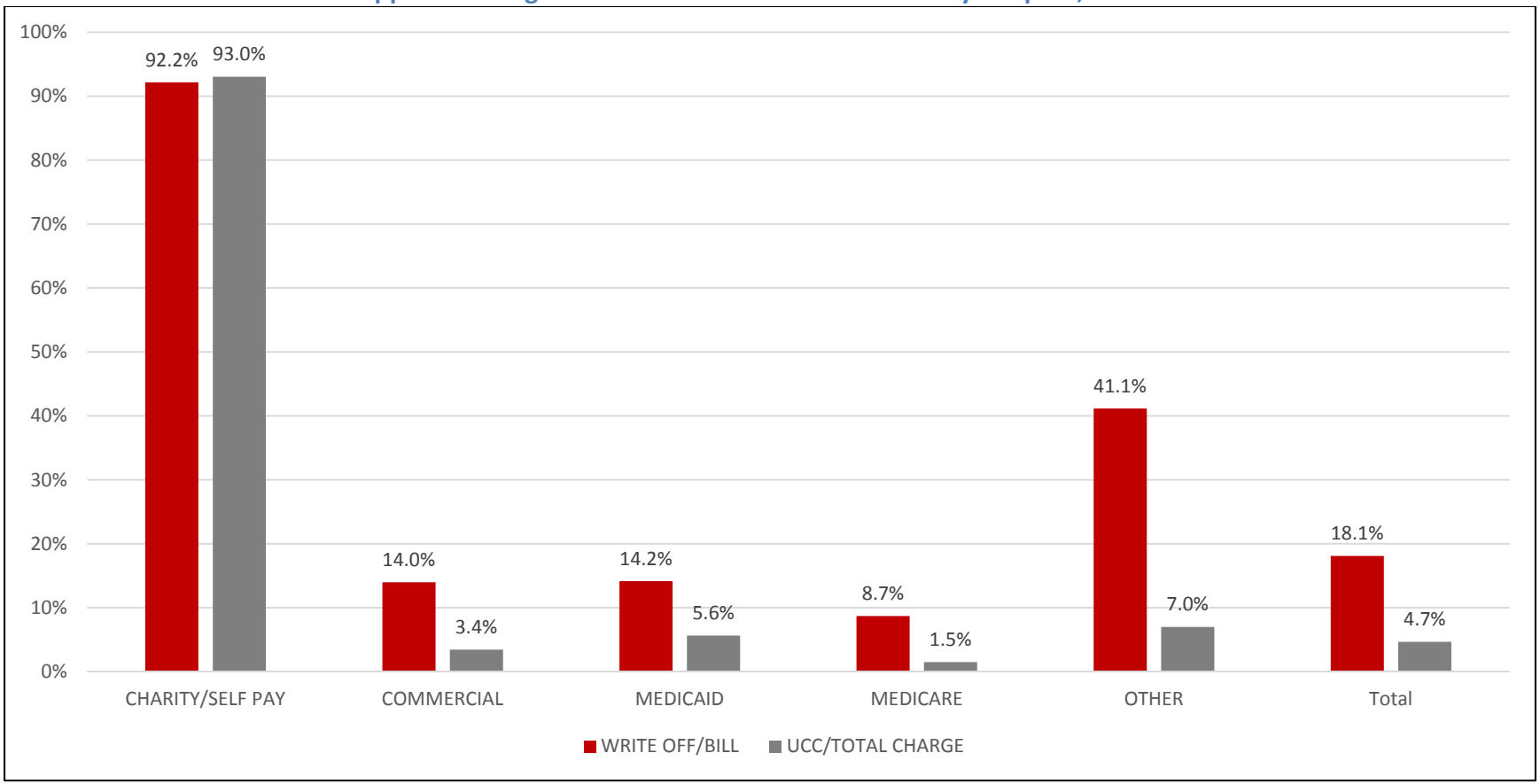
The figure below presents the UCC distribution by payer for services provided in FY 2015 based on the account level information provided to the Commission for the first time last year. Nearly one-third of UCC has a primary payer of charity care/self-pay. Commercial payers and Medicaid (including out-of-state Medicaid) each accounted for 25 percent of UCC.

Appendix II. Figure 2. UCC Distribution by Payer, FY 2015



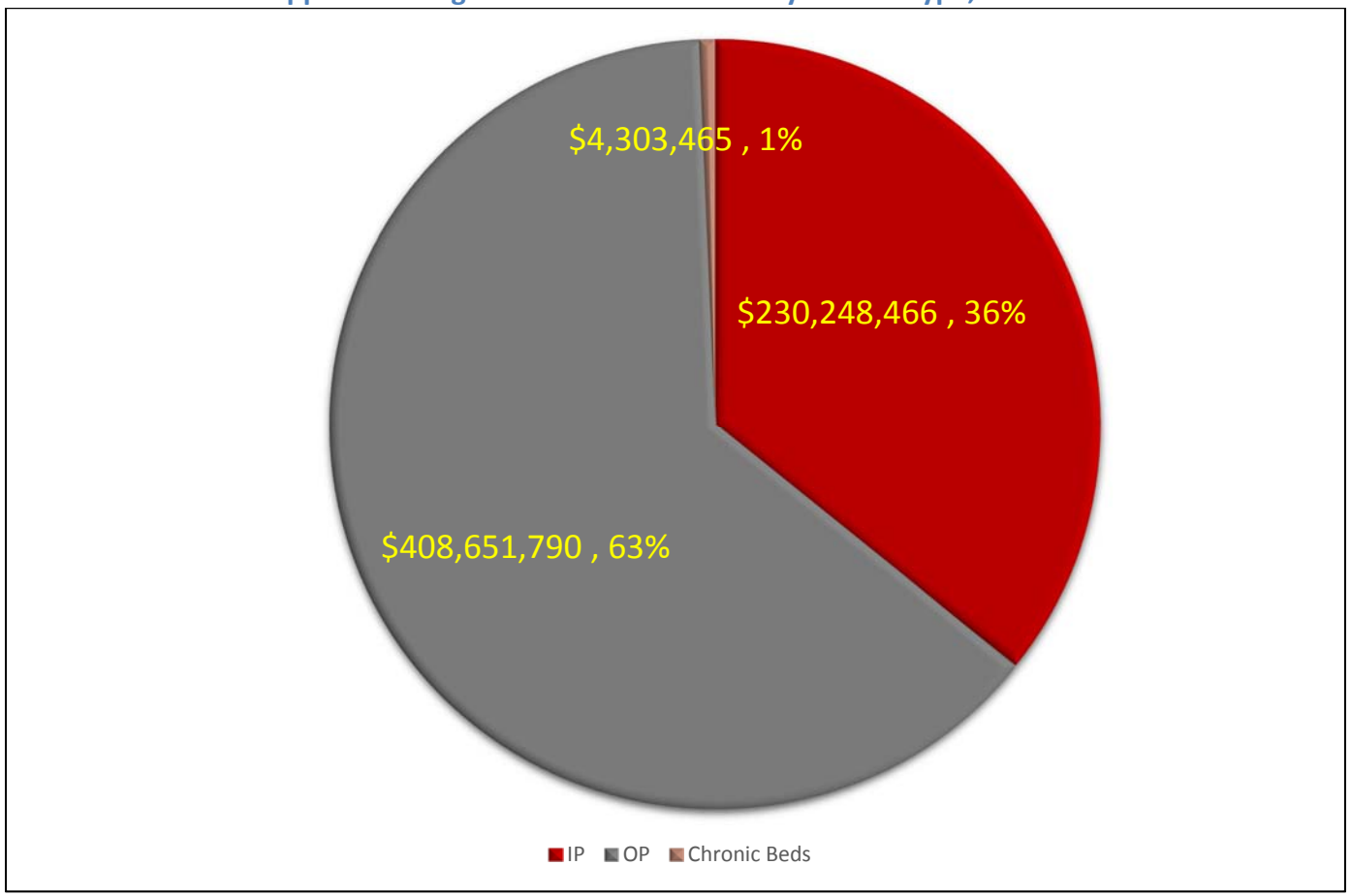
The following figure presents the write-off and UCC percentages by payer for services provided in FY 2015. For example, 92 percent of the bill is written off for charity care/self-pay patients, and the overall UCC amount is 93 percent of total charity care/self-pay charges. This demonstrates that the payer source is a strong predictor of UCC.

Appendix II. Figure 3.Write-Off and UCC Amounts by Hospital, FY 2015



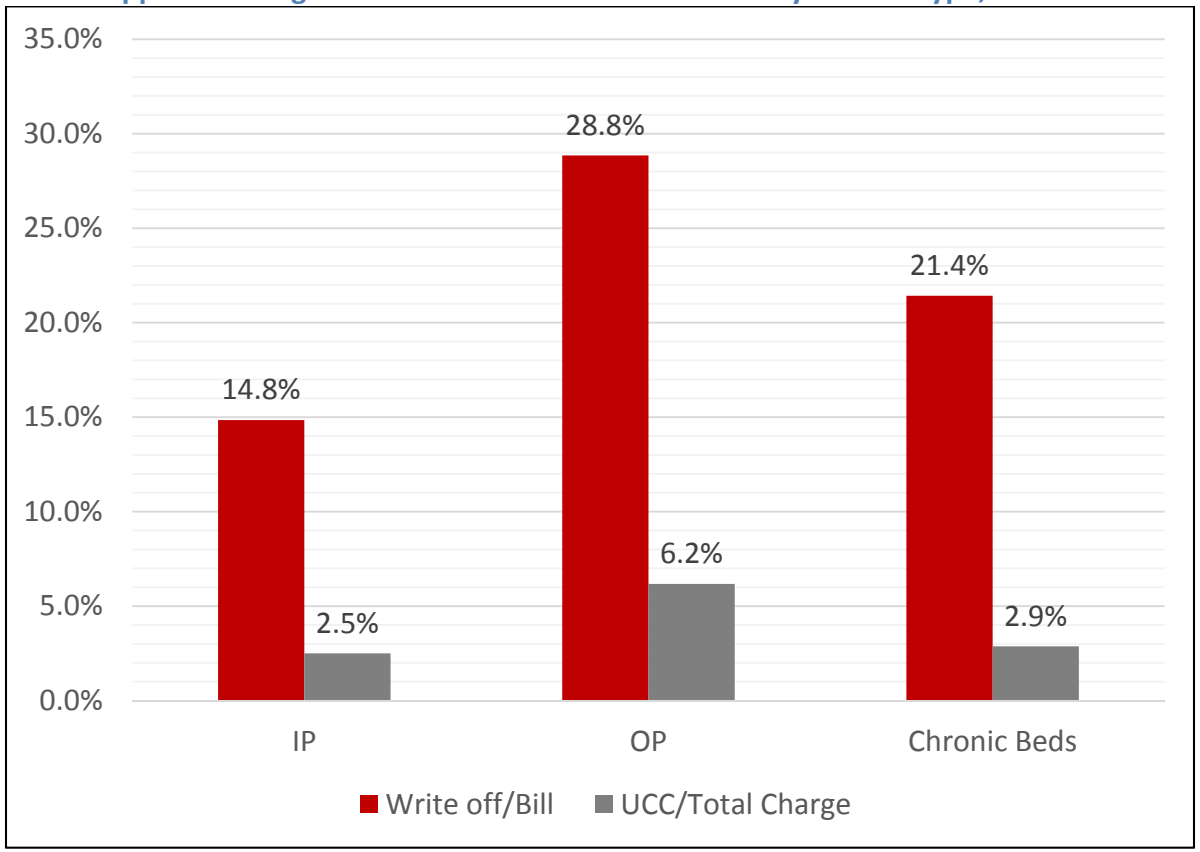
The following figure presents the distribution of UCC by service type (inpatient, outpatient, and chronic beds). Outpatient services account for the majority of UCC dollars.

Appendix II. Figure 4. UCC Distribution by Service Type, FY 2015



The following figure presents the write-off and UCC percentages by service type for services provided in FY 2015.

Appendix II. Figure 5. Write-Off and UCC Amounts by Service Type, FY 2015



Appendix III

Logistic Regression Methodology (1 of 5)

$$Expected\ encounter\ \$UCC\ =\ Chance\ of\ visit\ resulting\ in\ UCC\ \times\ Avg.Charge\ \times\ \%\ UCC\ of\ Bill$$

To calculate each hospital's UCC%:

- An **expected UCC dollar amount** is calculated for every patient encounter
- UCC dollars are summed at the hospital level
- Summed UCC dollars are divided by hospital total charges (from write-off data)

- The **expected UCC dollar amount** is calculated as the product of three numbers:
  - **Chance of visit resulting in UCC**: From logistic regression formula, based on patient ADI (or ADI with other variables)
  - **Avg. Charge**: Average of total charges by hospital, by payer, by patient type
  - **% UCC of Bill**: Statewide average UCC% by payer, by patient type; only for encounters with UCC

The following 6 pages will illustrate an example of this methodology, using ADI as the only predictor

Logistic Regression Methodology (2 of 5)

$$Expected\ encounter\ \$UCC = Chance\ of\ visit\ resulting\ in\ UCC \times Avg.Charge \times \%\ UCC\ of\ Bill$$

Patient Acct	Hospital	ADI Ventile	Patient Type	Payer (clean)	Net Write-Off	W-O Flag	Total Charges	Avg. Charge	Chance of UCC	% UCC of Bill	Expected $UCC (Avg. Charge)	Expected $UCC (Actual Charge)
00000001	A	90	OP	Blue Cross	$ -	0	$ 700		23.5%			
00000002	A	20	IP	Medicare	$ 250	1	$ 4,000		15.6%			
00000003	A	55	IP	Medicare	$ 150	1	$ 2,000		19.2%			
00000004	B	55	IP	Medicare	$ -	0	$ 5,000		19.2%			

To determine each encounter's **Chance of Resulting in UCC**:

- Every encounter is assigned a Write-Off Flag
  - 0 = No write-off reported
  - 1 = Any write-off reported
- All 6.3 million encounters (statewide) are run through a logistic regression model to determine the correlation between the predictor variable (ADI) and the dependent variable (UCC flag)
- The regression outputs result in a formula which calculates a likelihood of UCC using ADI Ventile. Each encounter's ADI Ventile is run through the formula to obtain a Chance of UCC

Please find the formula and resulting Chance of UCC table on the following page

Logistic Regression Methodology (3 of 5)

$$\textit{Expected encounter \$UCC} = \textit{Chance of visit resulting in UCC} \times \textit{Avg. Charge} \times \%\,\textit{UCC of Bill}$$

Patient Acct	Hospital	ADI Ventile	Patient Type	Payer (clean)	Net Write-Off	W-O Flag	Total Charges	Avg. Charge	Chance of UCC	% UCC of Bill	Expected $UCC (Avg. Charge)	Expected $UCC (Actual Charge)
00000001	A	90	OP	Blue Cross	$ -	0	$ 700	$ 700	23.5%			
00000002	A	20	IP	Medicare	$ 250	1	$ 4,000	$ 3,000	15.6%			
00000003	A	55	IP	Medicare	$ 150	1	$ 2,000	$ 3,000	19.2%			
00000004	B	55	IP	Medicare	$ -	0	$ 5,000	$ 5,000	19.2%			

To determine each encounter's **average charge** (and to account for charge structure differences between hospitals:

- A table is created with the average charge by hospital, by patient type, and by payer
- Each encounter's hospital, patient type, and payer are used to look up the appropriate average charge amount

ALTERNATE METHOD

- It may be more telling to use an encounter's **actual charges** (Total Charges field, above) instead of the estimated Avg. Charge
- Expected encounter UCC dollars were also calculated using this alternate method

Logistic Regression Methodology (4 of 5)

$$Expected\ encounter\ \$UCC = Chance\ of\ visit\ resulting\ in\ UCC \times Avg.Charge \times \%\ UCC\ of\ Bill$$

Patient Acct	Hospital	ADI Ventile	Patient Type	Payer (clean)	Net Write-Off	W-O Flag	Total Charges	Avg. Charge	Chance of UCC	% UCC of Bill	Expected $UCC (Avg. Charge)	Expected $UCC (Actual Charge)
00000001	A	90	OP	Blue Cross	$ -	0	$ 700	$ 700	23.5%	15.82%		
00000002	A	20	IP	Medicare	$ 250	1	$ 4,000	$ 3,000	15.6%	6.93%		
00000003	A	55	IP	Medicare	$ 150	1	$ 2,000	$ 3,000	19.2%	6.93%		
00000004	B	55	IP	Medicare	$ -	0	$ 5,000	$ 5,000	19.2%	6.93%		

To determine each encounter's **% UCC of Bill**:

- The dataset is filtered to only look at encounters with write-off amounts
- From this filtered dataset, a table is created with the % UCC of Bill by patient type and by payer
- Each encounter's patient type and payer are used to look up the appropriate % UCC of Bill

EXAMPLE: 15.82% of Patient 1's bill is expected to be UCC, and that bill is expected to be, on average, $700. Therefore, if Patient 1 were to have UCC costs, those costs would average being 15.82% * $700 = $110.74. Additionally, there is a 23.5% chance of Patient 1 having these costs.

Please find table of % UCC of Bill by patient type, by payer on the following page

Logistic Regression Methodology (5 of 5)

$$Expected\ encounter\ \$UCC = Chance\ of\ visit\ resulting\ in\ UCC \times Avg.Charge \times \%\ UCC\ of\ Bill$$

								A1	A2	B	C	A1* B*C	A2*B*C
Patient Acct	Hospital	ADI Ventile	Patient Type	Payer (clean)	Net Write-Off	W-O Flag	Total Charges	Avg. Charge	Chance of UCC	% UCC of Bill	Expected $UCC (Avg. Charge)	Expected $UCC (Actual Charge)
00000001	A	90	OP	Blue Cross	$ -	0	$ 700	$ 700	23.5%	15.82%	$ 26.02	$ 26.02
00000002	A	20	IP	Medicare	$ 250	1	$ 4,000	$ 3,000	15.6%	6.93%	$ 32.43	$ 43.24
00000003	A	55	IP	Medicare	$ 150	1	$ 2,000	$ 3,000	19.2%	6.93%	$ 39.92	$ 26.61
00000004	B	55	IP	Medicare	$ -	0	$ 5,000	$ 5,000	19.2%	6.93%	$ 66.53	$ 66.53

To determine each encounter's **Expected UCC dollar amount**:

- **Using Avg. Charge -** Multiply each encounter's Chance of UCC, Avg. Charge, and UCC%
- **Using Actual Total Charge -** Multiply each encounter's Chance of UCC, Total Charges, and UCC%

These UCC dollar amounts are aggregated at the hospital level and then divided by each hospital's Total Charges to formulate the predicted hospital-level UCC%

- Hospital A UCC%:
  - By Avg. Charge = ($26.02 + $32.43 + 39.92) / ($700 + $4000 + $2000) = 1.47%
  - By Actual Charge = ($26.02 + $43.24 + 26.61) / ($700 + $4000 + $2000) = 1.43%

Maryland
Hospital Association

June 3, 2016

Sule Gerovich, Ph.D.
Deputy Director, Research & Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Dear Sule:

On behalf of the Maryland Hospital Association's (MHA) 64 member hospitals and health systems, we appreciate the opportunity to comment on HSCRC's Uncompensated Care (UCC) policy that will affect hospital rates beginning July 1, 2016. We also appreciate HSCRC staff's work on this important matter.

The rate year 2017 UCC policy reflects the most significant change in UCC funding since the policy was redesigned more than 10 years ago, and accounts for the massive expansion of insurance coverage mandated by the Affordable Care Act on January 1, 2014. Hospital actual UCC data and underlying statistics are from fiscal year 2015, the first full year since coverage expansion and the first full year for which hospital account level write-off information was collected by HSCRC.

After thorough discussion with our members, MHA has developed the following principles that should guide UCC policy:

1) The policy should include a blend of actual and predicted UCC; actual UCC should reflect regulated bad debts and charity care from each hospital's audited income statement
2) The statewide policy should agree with the most recently available audited data
3) HSCRC should not prospectively adjust the policy results
4) The actual data used to construct the policy should be at least one full year after the January 1, 2014, coverage expansion

Using these principles as guidance, Maryland's hospitals recommend that HSCRC staff consider the following when crafting its final recommendation:

1) **The statewide policy should continue to agree with the most recently available statewide audited UCC data**. The draft staff recommendation reflects the fiscal year 2015 statewide amount, the most recently available data. UCC is estimated to be about 4.7 percent of fiscal year 2015 revenues.
2) **Hospital rate funding should continue to reflect a blend of 50 percent actual UCC and 50 predicted UCC**. Using a blend of actual and predicted UCC creates incentives for efficient billing and collection practices.

3) **Use a logistic regression model to predict uncompensated care, reflecting the following variables**:
    a. Area Deprivation Index (ADI), a socioeconomic deprivation metric of a given area
    b. Primary payer: Medicare, Medicaid, self-pay, Blue Cross/commercial/HMO, and other
    c. Patient type: Inpatient, outpatient or emergency room

These recommendations reflect the consensus of the field. By setting the overall uncompensated care funding level at fiscal year 2015 actual, the statewide amount is guaranteed. MHA requests that the commission follow its Advisory Council's opinion and give deference to the consensus hospital position when there is no impact on the statewide total.

Hospital representatives discussed different approaches to predicting UCC, including a non-regression based approach, and three logistic regression alternatives. The work group considered including an emergency Medicaid regression variable as a proxy for identifying undocumented immigrant service use and UCC impact, but ultimately did not recommend including this variable due to considerations about the validity of the underlying data and its application. Hospital representatives would like to continue working with HSCRC staff, the Maryland Department of Health and Mental Hygiene and other stakeholders to explore alternative undocumented immigrant variables for future use; this work should be completed by December 2016.

The statewide funding level is an income statement measure, or uncompensated care as a percentage of revenues. The measure is audited and factored into each hospital's net income or net loss. The income statement allowance, or provision for uncompensated care, required by accounting principle, is an estimate of revenues the hospital will forego in a given period. The new account level write off data reflect balance sheet measures that may differ from the income statement measure for timing reasons. Hospitals and HSCRC staff should continue to analyze hospital UCC data over a longer period to validate the timing differences between the income statement provision and actual account write offs.

Before providing a summary data set to construct the logistic regression, HSCRC staff compared the write off data to the HSCRC medical record abstract data. A primary payer classification of self-pay in the write-off data was changed to match the primary payer in the abstract data if different than self-pay. Hospitals request that a report be created to identify these modifications by hospital, by account, to provide a greater level of transparency when data is modified.

Hospital representatives strongly support an overall limit, or phase-in, of significant rate setting policy changes to make the system more predictable, stable and manageable. The fiscal year 2017 UCC policy changes are large: ACA's dramatic insurance expansion, a new account level data set and a new logistic regression approach, all in a single year. In the future, including additional years of data to predict uncompensated care may mitigate this concern in the UCC policy, particularly as corresponding UCC expenses decline. However, the impact of multiple changes to rate setting methodologies, year in and year out, makes it difficult to predict revenues and plan operations accordingly.

The Uncompensated Care policy is an important component of Global Budget Revenues. We appreciate your time and attention to our input. Should you have any questions, please call me at (410) 540 5060.

Sincerely,

Brett McCone, Vice President

cc: Donna Kinzer, Executive Director
Nduka Udom, Associate Director, Research & Methodology

HOLY CROSS HEALTH

1500 Forest Glen Road
Silver Spring, MD 20910-1484
301-754-7000
www.holycrosshealth.org

June 3, 2016

Mr. Nduka Udom
Associate Director, Research and Methodology
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Mr. Udom,

The purpose of this letter is to comment on the proposed uncompensated care policy (UCC) currently under review for FY2017. Our comments are reflective of the preliminary staff recommendation presented at the May 2016 HSCRC meeting and informed by subsequent discussions at the Maryland Hospital Associations' Financial Technical Issues Task Force and Council on Financial Policy. The details of the regression model were not provided in the staff recommendation so our comments relate to the details discussed in the Task Force and Council meetings which we are led to believe will be reflected in the final staff recommendation.

Recognizing the impact undocumented residents have in determining UCC is an important component and the FY2016 policy addressed the issue directly by including a variable to recognize hospitals who provide care to large numbers of patients who received Emergency Medicaid benefits. It was a statistically significant variable in the regression calculation and those hospitals who reported high numbers of undocumented residents saw higher predicted UCC rates. However, in this year's proposed model, payer, patient type and the area deprivation index (ADI) are used as model variables. We understand the ADI is designed to measure gradations of poverty and is correlated with UCC rates. However, hospitals serving a high number of undocumented residents experienced drops in the expected UCC rates predicted by the regression model. That is certainly not our experience on the ground as probably the largest provider of care to undocumented persons in the State. The MHA work groups reviewed various alternate proxies for undocumented residents including cases receiving Emergency Medicaid benefits but ultimately determined not to include any of the various proxies in the calculation. Ignoring this clear source of UCC seems to be a step backward in the methodology and we strongly urge the Commission to reconsider or find an alternate proxy to properly reflect the impact of undocumented patients or to come up with another approach to reflect the clear record of cases and costs which we have previously shared with the Commission staff.

We also advocate for greater transparency which would permit hospitals to more clearly understand how the data elements combine to produce the UCC regression calculation. Because the methodology is based on confidential data, hospitals are unable to use data to replicate and understand the UCC policy results. It also makes it more challenging to understand the implications of policy changes for our financial planning purposes. We request that staff work with hospital representatives and other stakeholders to make the process more transparent and ensure a fair and accurate calculation.

We appreciate the extensive work that has gone into the development of the revised regression model and for the opportunity to comment on the updated policy.

Feel free to contact me if you should have any questions.

Sincerely,

Anne D. Gillis
Chief Financial Officer

CC Kevin J. Sexton
Julie Keese
Tobie Hollander

Final Recommendations on the Update Factors for FY 2017

June 8, 2016

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

This document contains the final staff recommendations for the update factors for FY 2017.

Table of Contents

LIST OF ABBREVIATIONS

ACA	Affordable Care Act
CMS	Centers for Medicare & Medicaid Services
CON	Certificate of need
CY	Calendar year
FFS	Fee-for-service
FFY	Federal fiscal year
FY	Fiscal year
GBR	Global budget revenue
HSCRC	Health Services Cost Review Commission
MHIP	Maryland Health Insurance Plan
PAU	Potentially avoidable utilization
RY	Rate year
TPR	Total patient revenue
UCC	Uncompensated care

INTRODUCTION AND BACKGROUND

The Maryland Health Services Cost Review Commission (HSCRC or Commission) has been setting hospital payment rates for all payers since 1997. As part of this process, the HSCRC updates hospitals' rates and approved revenues on July 1 of each year to account for such factors as inflation, policy adjustments, and other adjustments related to performance and settlements from the prior year.

On January 1, 2014, the Centers for Medicare & Medicaid Services (CMS) approved the implementation of a New All-Payer Model in Maryland. The All-Payer Model has a triple aim of promoting better care, better health, and lower costs for all Maryland patients. In contrast to Maryland's previous Medicare waiver that focused on controlling increases in Medicare inpatient payments per case, the New All-Payer Model focuses on controlling increases in total hospital revenue per capita. The Model established a cumulative annual limit on per capita growth of 3.58 percent and a Medicare savings target of $330 million over the initial five-year period of the Model.

The update process needs to account for all sources of hospital revenue that will contribute to the growth of total Maryland hospital revenues for Maryland residents in order to meet the requirements of the New All-Payer Model and assure that the annual update will not result in a revenue increase beyond the 3.58 percent limit. In addition, the HSCRC needs to consider the effects of the update on the Model's $330 million Medicare savings requirement and the total hospital revenue that is set at risk for quality-based programs. While rates and global budgets are approved on a fiscal year basis, the New All-Payer Model revenue limits and Medicare savings are determined on a calendar year basis. Therefore, the HSCRC must account for both calendar year and fiscal year revenues in establishing the updates for the fiscal year.

It is important to understand that the proposed updates incorporate both price and volume adjustments for revenues under global budgets. Thus, the proposed updates should not be compared to a rate update that does not control for volume changes. It is also important to view the revenue updates in the framework of gross and net revenue. During the past three years, the expansion of Medicaid and other Affordable Care Act (ACA) enrollment has reduced uncompensated care (UCC), resulting in the State reducing several revenue assessments. The associated rate reductions for UCC and assessment reductions implemented by HSCRC decrease gross revenues, but they do not decrease net revenues. Therefore, the net revenue increases during these periods are higher than gross revenue increases.

There are three categories of hospital revenue under the New All-Payer Model. The first two categories are under the HSCRC's full rate-setting authority. The third category of hospital revenue includes hospitals where HSCRC sets rates, but Medicare does not pay on the basis of those rates. The three categories of hospital revenue are:

1. Hospitals/revenues under global budgets, including Global Budget Revenue (GBR) agreements and Total Patient Revenue (TPR) agreements for the 10 hospitals that were renewed on July 1, 2013, for their second three-year term.

2. Hospital revenues that are not included under global budgets but are subject to rate regulation on an all-payer basis by the HSCRC, such as revenues for out-of-state residents at certain hospitals.
3. Hospital revenues for which the HSCRC sets the rates paid by non-governmental payers and purchasers, but where CMS has not waived Medicare's rate-setting authority to Maryland. This includes psychiatric hospitals and Mount Washington Pediatric Hospital.

The purpose of this report is to present analyses and make recommendations for the update factors for fiscal year (FY) 2017.

ASSESSMENT

Overview of Hospital Performance and Net Revenue Growth

Since the initiation of the All Payer Model effective January 1, 2014, Maryland hospitals in the aggregate have been provided revenue budgets that allow for investments in care coordination and other infrastructure to implement care improvement and population health initiatives. At the same time, hospitals have experienced increased profitability from regulated revenues. This improvement in financial condition can be credited, in large measure, to the success of hospitals in rapid adoption of global budget models, adoption of interventions that have moderated or decreased utilization, implementation of cost controls, and increases in revenues provided by the HSCRC for care coordination infrastructure. Additionally, actual inflation estimates have turned out to be lower than the amount provided in rate updates for the last two years. This higher inflation in rates has allowed for additional investments in care coordination and population health.

For the final six months of FY 2014 (January through June of 2014), HSCRC staff estimates net regulated revenue growth of 0.91 percent, representing one-half of the growth reported in the hospitals' 2014 annual filing data annualized for hospitals with changes in year-end submission dates. For FY 2015, net regulated revenue grew by 4.43 percent, also based on amounts reported in hospitals' annual filings. For FY 2016 to date (through April 2016), net patient revenue growth, as reported on the interim unaudited FS schedules, was 4.02 percent. For RY 2017, the HSCRC staff is proposing a lower update, estimating a 2.80 percent growth in net revenues. This lower update uses a lower future inflation factor. It also reflects an incremental savings adjustment of 0.45 percent. When the Commission increased the update factor in RY 2016 for care coordination infrastructure, it laid out an expectation of future savings. To effectuate this moderation, staff proposed an increase in the savings adjustment for avoidable utilization of 0.45 percent over the prior 0.20 percent adjustment that was focused on readmissions.

Hospitals have commented that the proposed net revenue growth allowed for RY 2017 is too low. However, the HSCRC staff believes that the proposed revenue growth is adequate but not excessive, especially in light of the CMS projection of 1.2 percent revenue growth per Medicare beneficiary estimated for calendar year (CY) 2016 and the estimated Medicare performance for CY 2015, as Maryland hospitals ended the year just under the national growth rate. Other

commenters have indicated that staff should provide a lower update in light of the increase already in place for RY 2016, which extends into CY 2016. HSCRC staff does not agree with the need for further reductions at this time. We intend to closely monitor performance on a monthly basis.

Calculation of the Update Factors for Revenue Categories 1-3

In this final recommendation, staff focused on the update factor for inflation/trend for hospitals or revenues in each of the three categories. Separate staff reports provide recommendations on UCC and potentially avoidable utilization (PAU) savings.

The inflation/trend adjustment for Category 1 and Category 2 revenues starts by using the gross blended statistic of 2.49 percent growth, which was derived from combining 91.2 percent of Global Insight's First Quarter 2016 market basket growth of 2.60 percent with 8.80 percent of the capital growth estimate of 1.30 percent. For the global revenues, staff has determined that the correction factor to the First Quarter market basket growth estimate has averaged -0.56 percent for the last three years. Staff is applying the correction factor in advance, in order to avoid overstatement of growth for FY 2017. For non-global revenues, staff applies the 0.50 percent reduction for productivity and a reduction of 0.75 percent for ACA adjustments that are equivalent to the amount used in Medicare's proposed inpatient prospective payment system update for FY 2017. As a result, the proposed inflation/trend adjustment would be as follows:

Table 1. FY 2017 Proposed Rate Adjustments

	Global Revenues	Non-Global Revenues
Proposed Base Update	2.49%	2.49%
Productivity Adjustment		-0.50%
ACA Adjustment		-0.75%
Average Correction Factor	-0.56%	
Proposed Update	1.92%	1.24%

For psychiatric hospitals and Mt. Washington Pediatric Hospital, staff turns to the proposed psychiatric facility update for Medicare. Medicare applies a 0.50 percent reduction for productivity and a 0.75 percent reduction for ACA savings mandates to a market basket update of 2.80 percent to derive a net amount of 1.55 percent. HSCRC staff recommends adopting the same factor and net adjustments for the Maryland psychiatric hospitals and Mt. Washington Pediatric Hospital.

Summary of Other Policies Impacting FY 2017 Revenues

The update factor is just one component of the adjustments to hospital global budgets for FY 2017. In considering the system-wide update for the All-Payer Model, staff sought balance

among the following conditions: 1) meeting the requirements of the All-Payer Model agreement; 2) providing hospitals with the necessary resources to keep pace with changes in inflation and demographic changes; 3) ensuring that hospitals have adequate resources to invest in the care coordination and population health strategies necessary for long-term success under the All-Payer Model; and 4) incorporating the expectations of reduced avoidable utilization.

Table 2 summarizes the net impact on global revenues of staff proposals for inflation, volume, PAU savings, UCC, and other adjustments. The proposed adjustments provide for estimated net revenue growth of 2.80 percent and per capita growth of 2.28 percent for FY 2017 before accounting for reductions in UCC and assessments. After accounting for those factors, the revenue growth is estimated at 2.16 percent with a corresponding per capita growth of 1.63 percent. Descriptions and policy considerations are discussed for each step in the text following the table.

Table 2. Net Impact of Update Factors on Hospital Global Revenues, FY 2017

Balanced Update Model for Discussion

			Weighted Allowance
Components of Revenue Change Linked to Hospital Cost Drivers/Performance			
Adjustment for Inflation			1.72%
- Total Drug Cost Inflation for All Hospitals*			0.20%
Gross Inflation Allowance	A		1.92%
Implementation for Partnership Grants	B		0.25%
Care Coordination			
-Rising Risk With Community Based Providers			
-Complex Patients With Regional Partnerships & Community Partners			
-Long Term Care & Post Acute			
	C		
Adjustment for volume	D		0.52%
-Demographic Adjustment			
-Transfers			
-Categoricals			
Other adjustments (positive and negative)			
- Set Aside for Unknown Adjustments (Includes .10 Earmark**)	E		0.50%
- Workforce Support Program	F		0.06%
- Holy Cross Germantown	G		0.07%
- Non Hospital Cost Growth	H		0.00%
Net Other Adjustments	I =	Sum of E thru H	0.63%
-Reverse prior year's PAU savings reduction	J		0.60%
-PAU Savings	K		-1.25%
-Reversal of prior year quality incentives	L		-0.15%
-Positive incentives & Negative scaling adjustments	M		0.27%
Net Quality and PAU Savings	N =	Sum of J thru M	-0.53%
Net increase attributable to hospitals	O =	Sum of A + B + C + D + I + N	2.80%
Per Capita	P =	(1+O)/(1+0.52%)	2.27%
Components of Revenue Offsets with Neutral Impact on Hosptial Finanical Statements			
-Uncompensated care reduction, net of differential	Q		-0.49%
-Deficit Assessment	R		-0.15%
Net decreases	S =	Q + R	-0.64%
Revenue growth, net of offsets	T =	O + S	2.16%
Per capita revenue growth	U =	(1+V)/(1+0.52%)	1.63%

* Provided Based on proportion of drug cost to total cost

**Earmark 0.10 percent for new outpatient infusion and chemotherapy drugs

Components of Revenue Change Linked to Hospital Cost Drivers and Performance

Staff accounted for a number of factors that are linked to hospital costs and performance. These include:

- Adjustments for Volume: Staff proposes a 0.52 percent adjustment that is equal to the Maryland Department of Planning's estimate of population growth for CY 2016[1]. In the previous year, staff used an estimate based on five-year population growth projections. For the last two years, the actual growth estimate has been lower than the forecast. As a result, staff proposes to use the most recent growth rate as a proxy for the 2017 growth estimate. Hospital-specific adjustments will vary based on changes in the demographics of each hospital's service area, as well as the portion of the adjustment set aside to account for growth in highly specialized services.
- Rising Cost of New Drugs: The rising cost drugs, particularly of new physician-administered drugs in the outpatient setting, is a growing concern among hospitals, payers, and consumers. Not all hospitals provide these services, and some hospitals have a much larger proportion of costs devoted to these services. To address this situation, staff recommends earmarking 0.20 percent of the inflation allowance to fund increases in the cost of drugs and to provide this allowance to the portion of total hospital costs that were comprised of drug costs in FY 2015. Staff also proposes to earmark 0.10 percent of the set aside for unknown adjustments to fund a portion of the rising cost of new outpatient physician-administered drugs, which will be provided on a hospital-specific basis. Staff is currently working on the methodology for determining how this money will be allocated to the hospitals. This will require cost reporting and collection of actual cost and use data for 20 to 30 specific drugs that make up the majority of costs and cost growth for infusion and chemotherapy. The HSCRC staff expects to continue to refine the policies as it receive additional cost and use information.
- Implementation Grants: Last year, the Commission approved funding of up to 0.25 percent for infrastructure implementation proposals that would accelerate the implementation of care coordination efforts and provide for early reductions in avoidable utilization. The evaluation of these proposals took longer than anticipated, as staff needed to address concerns about the deployment of funds that had already been provided, as well as the concerns regarding the progression in reducing avoidable utilization. As a result, as these funds are awarded, they will increase the hospital revenues in FY 2017 rather than in FY 2016, as originally anticipated.
- Population Health Workforce Program: In December 2015, the Commission approved up to $10 million in FY 2017 hospital rates to be provided on a competitive basis to train and hire workers from geographic areas of high economic disparities and unemployment. The workers will focus on population health and community-based care interventions consistent with the All-Payer Model.

[1] See http://planning.maryland.gov/msdc/.

- Certificate of Need (CON) Adjustments: Holy Cross Germantown Hospital opened in the fall of 2014. The FY 2017 adjustment of 0.07 percent is the estimated increase of $12 million for FY 2017.
- Set-Aside for Unforeseen Adjustments: Staff recommends a 0.50 percent set-aside to fund unforeseen adjustments during the year. A similar allowance was made for both FY 2015 and FY 2016. As indicated above, staff proposes to earmark 0.10 of this amount for possible increases in the use of new outpatient chemotherapy and infusion drugs.
- Reversal of the Prior Year's PAU Savings Reduction and Quality Incentives: The total FY 2016 PAU savings and quality adjustments are restored to the base for FY 2017, with new adjustments to reflect the PAU savings reduction and quality incentives for FY 2017.
- PAU Savings Reduction and Scaling Adjustments: The FY 2017 PAU savings are continued, and an additional 0.65 percent savings is targeted for FY 2017. A recommendation on this item will be submitted to the Commission in a separate staff report and is discussed in additional detail later in this document. Preliminary estimates are provided for both positive and negative quality incentive programs, which have been changed so that they are no longer revenue neutral. Staff is working to finalize these figures.

Components of Revenue Change that are Not Hospital Generated

Several changes will decrease the revenues for FY 2017. These include:

- UCC Reductions: The proposed UCC reduction for FY 2017 will be -0.49 percent. The amount in rates was 5.25 percent in FY 2016, and the proposed amount for FY 2017 is 4.76 percent. The FY 2017 policy is the subject of a separate recommendation to the Commission.
- Deficit Assessment: The legislature provided for a specific level of deficit assessment reduction for FY 2017. This line item reflects that reduction.

While Table 2 computes the central provisions leading to a balanced update for the All-Payer Model overall, there are additional variables to consider such as one-time adjustments, as well as revenue and rate compliance adjustments and price leveling of revenue adjustments to account for annualization of rate and revenue changes made in the prior year.

Medicare's Proposed National Rate Update for FFY 2017

CMS published proposed updates to the federal Medicare inpatient rates for federal fiscal year (FFY) 2017 in the Federal Register in mid-April.[2] These updates are summarized in the table below. These updates will not be finalized for several months and could change. The proposed

[2] See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/FY2017-IPPS-Proposed-Rule-Home-Page-Items/FY2017-IPPS-Proposed-Rule-Regulations.html?DLPage=1&DLEntries=10&DLSort=0&DLSortDir=ascending.

rule would increase rates by approximately 0.40 percent in FFY 2017 compared to FFY 2016, after accounting for inflation, disproportionate share reductions, outlier adjustments, and other adjustments required by law. The proposed rule includes an initial market basket update of 2.80 percent for those hospitals that were meaningful users of electronic health records in FFY 2015 and that submit data on quality measures, less a productivity cut of 0.50 percent and an additional market basket cut of 0.75 percent, as mandated by the ACA. This also reflects a proposed 1.50 percentage point reduction for documentation and coding required by the American Taxpayer Relief Act of 2012 and a proposed increase of approximately 0.80 percentage points to remove the adjustment to offset the estimated costs of the Two Midnight policy and address its effects in FFYs 2014 through 2016.[3] Additionally, -0.20 percent will be removed to account for the increase in a high cost outlier threshold. Disproportionate share payment reductions resulted in a decrease of -0.30 percent from FFY 2016.

Table 3. Medicare's Proposed Rate Updates for FFY 2017

	Inpatient	Outpatient
Base Update		
Market Basket	2.80%	2.80%
Productivity	-0.50%	-0.50%
ACA	-0.75%	-0.75%
Coding	-1.50%	
Two Midnight Rule	0.80%	
	0.85%	1.55%
Other Changes		
DSH	-0.30%	
Outlier Adjustment	-0.20%	
	-0.50%	
	0.4%	

Applying the inpatient assumptions about market basket, productivity, and mandatory ACA outpatient savings, staff estimates a 1.55 percent Medicare outpatient update effective January 2017. This estimate is pending any adjustments that may be made when the proposed update to the federal Medicare outpatient rates get published.

[3] CMS reduced hospital rates for the implementation of the Two Midnight rule, based on an estimate that some patients that were being treated in observation would be admitted. Subsequently, this estimate was overturned. The adjustments noted above include one-time and prospective adjustments relative to this matter.

Discussion of the FY 2017 Balanced Update

The staff proposal increases the resources available to hospitals to account for rising inflation, population changes, and other factors, while providing savings for purchasers through a PAU savings adjustment. The proposed adjustments coupled with the ongoing incentives to reduce PAU inherent to the Model should allow the hospital industry to make additional investments while maintaining operating margins at reasonable levels. As discussed below, the proposed update falls within the financial parameters of the All-Payer Model agreement.

PAU Savings Adjustment

Maryland is now in its third year of the All-Payer Model. The Model is based on the expectation that an All-Payer approach and global or population-based budgets will result in more rapid changes in population health, care coordination, and other improvements, which in turn will result in reductions in avoidable utilization. To that end, the Commission approved budgets that did not offset Medicare's ACA and productivity adjustments, and provided infrastructure investment funding to support care coordination activities. For RYs 2015 and 2016, the HSCRC applied a PAU savings adjustment with an incremental revenue reduction averaging 0.20 percent to allocate and ensure savings for purchasers of care. This was calculated using predicted versus actual readmissions. Staff proposes an incremental increase in the PAU saving adjustment of 0.65 percent (an addition of 0.45 percent above the 0.20 in RY 2016, bringing the total adjustment to 1.25 percent). Staff also proposes to apply the adjustment based on the proportion of each hospital's revenue relative to admissions/observations that are classified as PAU, comprised of readmissions and admissions for ambulatory care sensitive conditions (measured by prevention quality indicators). This progression in approach is important to advance the Model objectives of ensuring savings from reducing avoidable utilization. This approach and its implications are more fully discussed in a separate staff recommendation.

Investments in Care Coordination

The HSCRC has provided funding for some initial investments in care coordination resources. Staff believes that several categories of investments and implementation are critical to the success of the Model. Multiple workgroups have identified the need to focus on high needs patients, complex patients, and patients with chronic conditions and other factors that place them at risk of requiring extensive resources. Of particular concern are Medicare patients, who have more extensive needs but fewer system supports. Additionally, there are several important major opportunities with post-acute and long-term care that are important to address. There is significant variation in post-acute care costs, and hospitals need to work with partners to address this variation. There are also potentially avoidable admissions and readmissions from post-acute and long-term care facilities. There are documented successes in reducing these avoidable admissions, both in Maryland and nationally. These improvements require partnerships and coordination among hospitals and long-term and post-acute care providers. For FY 2018, staff intends to evaluate an update that differentiates the levels of rates provided based on implementation progress in the following three areas:

- Care management for complex patients with regional partnerships and community partners
- Care coordination and chronic care improvement focused on rising risk patients with community partners
- Effective approaches to address post-acute and long term care opportunities

As hospitals continue to implement these approaches in FY 2017, declines in utilization may free up resources to make additional investments (if there is not a corresponding increase in non-hospital costs). The HSCRC staff has been working on an amendment to the All-Payer Model to provide data and additional flexibility in implementing care redesign together with physicians and community-based partners. Implementation of the care redesign envisioned in the amendment may require additional investments in care coordination and care management interventions.

Market Shift Adjustment

The HSCRC staff discussed its intent to move market shift updates to a bi-annual process starting July 1, 2016. At this time, staff would like to consider moving the market shift adjustment to a quarterly adjustment that culminates in a final, year-end adjustment. Quarterly adjustments create some potential flaws, as shorter timeframes exacerbate the impact of small cells. While these will work themselves out over the course of the year, they may create different results as the quarters build on each other. Also, the importance of timeliness and accuracy of hospital data increases. Nevertheless, staff is reviewing market shift with requests for corridor relief, and requests for relief from hospitals that are experiencing increases in market shift. As such, staff requests comments on the advisability of quarterly market shift adjustments.

All-Payer Financial Test

The proposed balanced update keeps Maryland within the constraints of the Model's all-payer revenue test. Maryland's agreement with CMS limits annual growth rate for all-payer per capita revenues for Maryland residents at 3.58 percent. Compliance with this test is measured by comparing the cumulative growth in revenues from the CY 2013 base period to a ceiling calculated assuming annual per capita growth of 3.58 percent. This concept is illustrated in Table 4 below. As shown in the table, the maximum cumulative growth allowed through CY 2017 is 15.11 percent.

Table 4. Calculation of the Cumulative Allowable Growth in Per Capita All-Payer Revenue for Maryland Residents

	CY 2014 A	CY 2015 B	CY 2016 C	CY 2017 D	Cumulative Growth E = (1+A)*(1+B)*(1+C)*(1+D)
Calculation of Revenue Cap	3.58%	3.58%	3.58%	3.58%	15.11%

For the purpose of evaluating the impact of the recommended update factor on compliance with the all-payer revenue test, staff calculated the maximum cumulative growth that is allowable through the end of FY 2017 (the first 42 months of the waiver). As shown in Table 5, cumulative growth of 15.44 percent is permitted through FY 2017. Staff projects actual cumulative growth through FY 2017 of 8.77 percent. This estimate reflects:

- Actual CY 2014 experience for January through June and actual FY 2015 experience;
- The assumption that hospitals will use the full charge capacity available through their global budgets for FY 2016; and
- The staff recommended update for FY 2017.

Table 5 shows allowed growth in gross revenues. Staff has removed adjustments due to reductions in UCC and assessments that do not affect hospital's bottom lines for comparison to the maximum growth allowances. The actual and proposed revenue growth is well below the maximum levels.

Table 5. Proposed Update and Compliance with the All-Payer Gross Revenue Test

	A Actual Jan- June 2014	B Actual FY 2015	C Staff Est. FY 2016	D Proposed FY 2017	E = (1+A)*(1+B)*(1+C)*(1+D) Cumulative Through FY 2017
Maximum Gross Revenue Growth Allowance	**2.13%**	**4.26%**	**4.12%**	**4.12%**	**15.44%**
Revenue Growth for Period	0.90%	2.51%	2.94%	2.16%	8.77%
Savings from UCC & Assessment Declines that do not Adversely Impact Hospital Bottom Line		1.09%	1.41%	0.64%	3.17%
Revenue Growth with UCC & Assessment Savings Removed	0.90%	3.60%	4.35%	2.80%	**12.13%**
Revenue Difference between Cap & Projection					**3.31%**

Maximum Revenue Growth Allowance includes population estimates: FY15/CY14 0.66%; FY16/CY15 0.52%

The figures in the table above are different than the net revenue figures reported at the beginning of this section of the report. The figure above does not reflect actual UCC or include other adjustments between gross and net revenues such as denials. They reflect adjustments to gross revenue budgets.

Medicare Financial Test

The second key financial test under the Model is to generate $330 million in Medicare fee-for-service (FFS) savings over five years. The savings for the five-year period were calculated assuming that Medicare FFS costs per Maryland beneficiary would grow about 0.50 percent per year slower than the national per beneficiary Medicare FFS costs after the first year.

Year one of the demonstration generated approximately $116 million in Medicare savings. CY 2015 savings have not yet been audited, but current projections show an estimated savings of $135 million, bringing the two-year cumulative savings to just over $250 million. Cumulative savings are ahead of the required savings of $49.5 million for two years. However, there has been a shift toward greater utilization of non-hospital services in the state relative to national

rates of growth, and Maryland is currently exceeding the national growth rate for the total cost of care by an estimated $60 million (which is a preliminary figure that is subject to change). When calculating savings on total cost of care, the two-year cumulative estimate is $213 million, still well above the required savings level. Maryland's All-Payer Model Agreement with CMS contains requirements relative to the total cost of care, including non-hospital cost increases. The purpose is to ensure that cost increases outside of hospitals do not undermine the Medicare savings that result from implementation of the All-Payer Model by hospitals. If Maryland exceeds the national growth rate by more than 0.90 percent in any year or exceeds the national growth rate in two consecutive years, it is required to provide an explanation of the increase and potentially provide for corrective action.

Since staff estimates that the total cost of care growth exceeds the national growth for CY 2015, staff is focused on determining the causes of the increase. About half of the excess growth is in Medicare Part A services (skilled nursing facility, home health, and hospice), which are related to hospital services. The other half is in Part B services. Staff determined that the growth is primarily in professional fees and is making further assessments of the cause of these increases. Staff recommends maintaining the goal used in the RY 2015 and 2016 updates of growing Maryland hospital costs per beneficiary about 0.50 percent slower than the nation for RY 2017. Attainment of this goal will maintain any ongoing savings from prior periods and help achieve savings in the total cost of care, as well as provide evidence of continuing success of the model. A commitment to continue the success of the first two years is critical to building long-term support for Maryland's Model.

Allowable Growth

If the projections from the CMS Office of the Actuary for CYs 2016 and 2017 are correct, national Medicare per capita hospital spending will increase by 1.75 percent in FY 2017. The staff goal of limiting Maryland's Medicare per capita growth to 0.50 percentage points below the national rate results in a maximum allowable Medicare per capita growth of 1.25 percent. Since staff is concerned about the total cost of care requirements for Medicare in CY 2016, as previously explained, staff also measures the results against the CY 2016 projection of 1.20 percent growth.

For the purpose of evaluating the maximum all-payer growth that will allow Maryland to meet the per capita Medicare FFS growth target, the Medicare target must be translated to an all-payer growth limit (Tables 6A and 6B). During deliberations on the FY 2015 update, a consultant to CareFirst developed a "difference statistic" that reflected that the historical increase in Medicare per capita spending was lower than all-payer per capita spending in Maryland. HSCRC used a difference statistic of 2.00 percent when calculating the comparisons for the Medicare target limit for FY 2016. However, the actual difference was lower for CY 2015, and as a result, the difference statistic was updated for FY 2017. This figure is added to the Medicare target to calculate an all-payer target. Using a blend of case-mix data from CY 2011-2015 and experience data from CY 2013-2015, the difference statistic was calculated as a conservative projection of 0.89 percent.

Using the revised difference statistic, staff calculates two different scenarios. Under the first scenario (Table 6A), the maximum all-payer per capita growth rate that will allow the state to realize the desired FY 2017 Medicare savings is 2.12 percent. The second scenario (Table 6B) shows a maximum all-payer per capita growth rate of 2.68 percent. Both scenarios are pictured below and fall within the all-payer guardrails.

Table 6A. Scenario 1 Maximum All-Payer Increase that will still produce the Desired FY 2017 Medicare Savings

Maximum Increase that Can Produce Medicare Savings		
Medicare		
Medicare Growth CY 2016	A	1.20%
Savings Goal for FY 2017	B	-0.50%
Maximum growth rate that will achieve savings (A+B)	C	0.70%
Conversion to All-Payer		
Actual statistic between Medicare and All-Payer	D	0.89%
Conversion to All-Payer growth per resident (1+C)*(1+D)-1	E	**1.60%**
Conversion to total All-Payer revenue growth (1+E)*(1+0.52%)-1	F	**2.12%**

Table 6B. Scenario 2 Maximum All-Payer Increase that will still produce the Desired FY 2017 Medicare Savings

Maximum Increase that Can Produce Medicare Savings		
Medicare		
Medicare Growth (CY 2016 + CY 2017)/2	A	1.75%
Savings Goal for FY 2017	B	-0.50%
Maximum Growth Rate that will Achieve Savings (A+B)	C	1.25%
Conversion to All-Payer		
Actual Statistic between Medicare and All-Payer	D	0.89%
Conversion to All-Payer Growth per Resident (1+C)*(1+D)-1	E	**2.15%**
Conversion to Total All-Payer Revenue Growth (1+E)*(1+0.52%)-1	F	**2.68%**

Note: National Medicare growth projection 1.2% for CY 2016 and 2.3% for CY 2017 from CMS Office of Actuary, February 2016 analysis.

The staff recommended update will produce the desired savings if national actuarial projections are accurate; the difference statistic correctly translates the Medicare growth to all-payer growth (Tables 7A and 7B); and the carryover from the RY 2016 adjustment does not result in excessive growth. The allowance for unforeseen adjustments may be needed to offset excessive growth, if any, from the RY 2016 adjustments.

Table 7A. Scenario 1 Comparison of Medicare Savings Requirements to Model Results

Comparison to Modeled Requirements	All-Payer Maximum to Achieve Medicare Savings	Modeled All-Payer Growth	Difference
Revenue Growth	2.12%	2.16%	0.03%
Per Capita Growth	1.60%	1.63%	0.03%

Table 7B. Scenario 2 Comparison of Medicare Savings Requirements to Model Results

Comparison to Modeled Requirements	All-Payer Maximum to Achieve Medicare Savings	Modeled All-Payer Growth	Difference
Revenue Growth	2.68%	2.16%	-0.52%
Per Capita Growth	2.15%	1.63%	-0.52%

Stakeholder Input

HSCRC staff worked with the Payment Models Workgroup to review and provide input on the FY 2017 updates. Staff also received and reviewed comments on the final recommendation from CareFirst, the Maryland Hospital Association, and 20 member hospital or systems.

CareFirst expressed support for the recommendation, but cautioned staff that approving a full update on July 1, 2017, could result in Maryland exceeding the total cost of care guardrail for the second year in a row, thus causing a 'triggering' event for CMS. They recommended a lower adjustment in light of this possible outcome.

The Maryland Hospital Association and its member hospitals expressed the need for a higher update factor and recommending the following:

- Allow for the full inflation amount of 2.49 percent without the correction factor applied.
- Decrease the expected PAU savings offset.
- Do not apply the ACA reduction of 0.75 percent to psychiatric and Mt. Washington Pediatric hospitals.
- Use part of the allowance for unforeseen adjustments to cover the costs of new outpatient physician-administered drugs.

The Maryland Hospital Association and a number of member hospitals believe that the savings in the recommended update factor will make it difficult to move forward with all the momentum and investments that they have worked during the last two years of the Model.

See Appendix II for all written comments on the staff recommendation for the FY 2017 update factors

RECOMMENDATIONS

The final recommendations of the HSCRC staff are as follows and are offered on the assumption that the other policy recommendations that affect the overall targets are approved (including the PAU savings adjustment and the UCC reductions):

1. Update the three categories of hospitals and revenues as follows:
    a. Revenues under global budgets should increase by 2.16 percent.
    b. Revenues that are not under global budgets but subject to the Medicare rate-setting waiver should increase by 1.24 percent.
    c. Revenues for psychiatric hospitals and Mt. Washington Pediatric Hospital should increase by 1.55 percent.

2. Earmark 0.10 of the allowance for unforeseen adjustments for increases in costs related to new outpatient physician-administered drugs.

3. Evaluate the need for additional revenue flexibility in January 2017, relative to progression of the All-Payer Model and increase in focus on implementation outside of hospitals.

APPENDIX I. UPDATING AND RE-EVALUATING THE DIFFERENCE STATISTIC METHODOLOGY

Calculating the Annual Update Allowance Under the Demonstration

Updating and Reevaluating the Difference Statistic Methodology

Jack Cook

April 15, 2016

Executive Summary

In a previous paper, *Calculating the Annual Update Allowance under the Demonstration*, we suggested a methodology for calculating the annual update so as to have the HSCRC be in compliance with both the All-Payer Waiver Test and the Medicare Waiver Test prescribed by the Demonstration.

Each of the Waiver Tests prescribed a limit on the rate of growth in hospital payments calculated on a per capita basis. The All-Payer Waiver Test limits the annual growth in the hospitals charges for services to Maryland residents calculated on a per resident basis (the All-Payer Statistic). The Medicare Waiver Test limits the growth in all hospital payments for services to resident Medicare FFS beneficiaries calculated on a per beneficiary basis (the Medicare Statistic). The proposed methodology is formulated in terms of an estimate (the Difference Statistic) of the difference between the annual increase in the All-Payer Statistic and the annual increase in the Medicare Statistic. For example, if in 2015, the All-Payer Statistic had increased by, say, 2.58% and the Medicare Statistic by 1.53%, then the Difference Statistic for 2015 would be 1.05%.

$$1.05\% = 2.58\% - 1.53\%$$

In the previous paper we estimated the Difference Statistic using five years of HSCRC claims data (2009-2013), determined the average over the five years, 2.94%, and proposed the use of a conservative Difference Statistic of 2.0% for the purpose of deriving he Annual Update Allowance. The technical details of the suggested methodology require the use of a conservative Difference Statistic in order to provide reasonable assurance that both Waiver Tests will be met.

This paper updates the calculation of the Difference Statistic using the HSCRC claims from 2011 to 2015 and an enhanced method of estimating the increase in the Medicare Statistic: the initial derivation of the Difference Statistic estimated the annual increase in the FFS beneficiaries based on the increase in the age 65+ population in Maryland; the updated estimates used the actual number of Part A and Part B beneficiaries weighted to create a single measure of the FFS beneficiaries residing in Maryland.

The updated calculation resulted in an average Difference Statistic of 2.10 and a conservative Difference Statistic projection of 1.24. However, it was noted that the Difference Statistic applicable to 2012 was unusually large (3.50) and that the four years of Difference Statistics used to calculate the average split between the first two years (2012 and 2013) preceding the term of the Demonstration and the second two years (2014 and 2015) being the first two years of the Demonstration. This split, for which there was no counterpart in the initial calculation of the Difference Statistics since the Demonstration hadn't begun, suggests that the updated calculation might be limited to the first two years of the Demonstration. Using the data from the first two years of the Demonstration, the Difference Statistic is 1.73% and a conservation projection is 1.0%.

One would like to corroborate the estimates of the Difference Statistics derived from the HSCRC claims data by the use of Medicare payment data, preferably including out of state claims. These complete payment data from 2006 to 2012 are available from CMS and the Maryland hospital payments for Medicare services to resident FFS beneficiaries are available from 2013 to 2015. However, we have not been able to reconcile and unify these Medicare payment data in a credible way. Therefore, the corroboration that we have been able to carry out involves only the Maryland hospital payments from 2013 to 2015.

For these years the average Difference Statistic was 1.80% and the conservatively projected Difference Statistic was .89%. These results therefore corroborate the Difference Statistic (1.73%) and the conservation projection (1.0%) derived from the HSCRC claims in the period 2013-2015.

1. Schedule 1: Maryland Hospital Charges per Resident

The hospital charge data in columns 1 and 2 of Schedule 1 were derived from the HSCRC's case mix tapes for 2011 through 2015 by the HSCRC staff.

Column 1 includes the hospital charges for all services and column 2 the hospital charges for services to Maryland residents. Column 3 computes the percentage of the hospital's total charges accounted for by services to Maryland residents. The uniformity of the column 3 percentages suggests that the coding of the residences of Maryland patients was done consistently throughout 2011 to 2015.

Column 4 records the Maryland population; column 5 the hospital charges per Maryland resident (col 2/ col 4); and column 6 the annual rate of increase in the charges per resident. The annual increases in the hospital charges for services to Maryland residents is the first of the two statistics used to derive the Difference Statistic.

Schedule 1

Maryland Hospital Charges per Resident
Annual Increases: 2011- 2015

Hospital Charges (000,000's)

CY	Total	MD Residents	% MD Res Claims	MD Population (000's)	MD Res Claims/ Capita Charge	% Change from Prior Year
2011	$14,540.1	$13,317.2	91.6	5,844.2	$2,279	-
2012	$15,017.5	$13,732.1	91.4	5,890.7	$2,331	2.38
2013	$15,44.3	$14,025.2	90.8	5,936.0	$2,363	1.37
2014	$15,741.2	$14,331.8	91.0	5,975.3	$2,399	1.52
2015	$16,211.1	$14,784.6	91.2	6,006.4	$2,461	2.58

2. Schedule 2: Maryland Hospital Charges per Resident Medicare FFS Beneficiary

The hospital charges in column 1 represent the charges of Maryland hospitals to Medicare FFS beneficiaries residing in Maryland. Column 2 reports the number of such beneficiaries; column 3 the hospital charges per beneficiary (column 1/ column 2); and column 4 records the annual percentage change in the hospital charges per FFS beneficiary. The annual percentage change in the hospital charges per FFS beneficiary are the second statistics used to derive the Difference Statistic.

Schedule 2

Maryland Hospital Charges per Resident Medicare FFS Beneficiaries
Annual Increase 2011- 2015

Year	Hospital Charges (000,000's)	Resident FFS Beneficiaries (000's)	Charge/Beneficiary	% Charge
2011	$4,958.1	712.6	$6,958	
2012	$5,058.9	736.1	$6,873	-1.22
2013	$5,270.3	767.3	$6,869	-.06
2014	$5,391.5	792.0	$6,807	-.89
2015	$5,641.8	816.3	$6,911	1.53

3. Schedule 3: The Difference Statistic and Variances

Columns 1 and 2 record the hospital charges per resident for services to Maryland residents and the annual increases in such charges per resident from Schedule 1. Column 3 and 4 record the Maryland hospital charges per resident FFS beneficiary and the annual increase in these amounts from Schedule 2.

Column 5 calculates the Difference Statistic in each year 2012-2015 and the average 2.10 over the five years. Column 6 specifies for each year the absolute value of the difference between the particular year's Difference Statistic and the average. For example, in 2012, the variance in Column 6 is 1.40, the difference between the Difference Statistic (3.50) and the average Difference Statistic (2.10):

$$1.40= 3.50 – 2.10$$

The conservative projection of the Difference Statistic based on the results of Schedule 3 is 1.24, the average Difference Statistic (2.10) minus the average variances (0.86):

$$1.24 = 2.10- .86$$

Schedule 3

The Difference Statistic and Variance
Maryland Hospital Charge Data: 2011- 2015

Maryland Residents

Year	Chrg/Res	% Change	Chrgs/FFS Beneficiary	% Change	Diff Statistic	Variance
2011	$2,279	-	$6,958	-		
2012	$2,331	2.28	$6,873	-1.22	3.50	1.40
2013	$2,363	1.37	$6,869	-.06	1.43	0.67
2014	$2,399	1.52	$6,807	-.89	2.41	0.31
2015	$2,461	2.58	$6,911	1.53	1.05	1.05
Average					2.10	0.86
Difference Statistic – Avg Variance					1.24	

4. Discussion of Schedule 3

The statistics on Schedule 3 are derived from the consistently accumulated claims data of the HSCRC. However, these claims data for Medicare FFS beneficiaries residing in Maryland provide only an imperfect estimate of the statistic used in the Medicare Waiver Test (the total Medicare payments for hospital services to the resident FFS beneficiaries) because:

- The HSCRC claims do not include the claims for hospital services of resident FFS beneficiaries provided by out of state hospitals, and
- The claims do not reflect the variation in the payment to charge ratio for Medicare hospital services resulting from Medicare policies, including the Sequester

In addition, the four years of estimated Difference Statistics cover two periods in which the dynamics of hospital reimbursement in Maryland were very different. The first period (2012-2013) preceded the term of the All-Payer Model Demonstration and included the beginning of the Sequester in March 2013. The second (2014-2015) represented the first two years of the Demonstration, the implementation of the GBR target budgets, and the impact of enrollment under the ACA.

Over these two periods the average Difference Statistic dropped from 2.465 ((3.5 + 1.43)/2) to 1.730 ((2.41 + 1.05)/2), reflecting a moderation in the growth of private sector volume in period 2. Furthermore, the average variance dropped from 1.035 ((1.40+0.67)/ 2) to 0.68 ((.31+ 1.05)/ 2). This suggests that the use of a Difference Statistic of approximately 1.00 would be an appropriately conservative estimate based on the second period's data.

5. Alternative Estimates of the Difference Statistic

The HSCRC staff has accumulated Medicare inpatient and outpatient payments for Maryland hospital services for resident Medicare FFS beneficiaries for the period 2013-2015, including a 2-month run out with completion factors. Schedule 2A sets forth these payment data, the number of FFS beneficiaries, the payment per beneficiary and the annual percentage change in these payments per beneficiary in 2014 and 2015. These percentage changes are then used on Schedule 3A to re-estimate the Difference Statistic.

Schedule 2A

Summary of Maryland Hospital Medicare Payments
FFS Beneficiaries 2013-2015

CY	Inpatient	Outpatient	Total	FFS Beneficiaries (000's	Payment/ Beneficiary	% Change Payment/ Beneficiary
2013	$3,379.1	$1,285.3	$4,664.4	767.3	$6,079	-
2014	$3,390.0	$1,366.0	$4,756.0	792.0	$6,005	-1.20
2015	$3,514.5	$1,469.9	$4,984.5	816.3	$6,106	1.69
Combined	2015/2013					.49

Schedule 3A records the percentage change in the Maryland hospital charges per resident for 2014 and 2015 from Schedule 1 and the percentage change in the payments per beneficiary from Schedule 2A. The Difference Statistics derived from these results average 1.80 and the average variance is .91. This suggests that the use of a Difference Statistic of .89 would be likely to ensure compliance with the Medicare Waiver Test.

Schedule 3A

CY	% Change MD Resident Charges per Capita (Sch 1)	% Change Medicare Payment Per Beneficiary (Sch 2A)	Difference Statistic	Variance
2013	1.52	-1.20	2.72	.92
2014	2.58	1.69	.89	.91
Average			1.80	
Average Variance			.91	
Conservatively Projected Diff Statistic			.89	

APPENDIX II. COMMENT LETTERS ATTACHED

CareFirst Comment Letter May 6, 2016

MHA Comment Letter May 9, 2016

MHA Comment Letter May 18, 2016

Garrett Regional Medical Center May 19, 2016

Meritus Medical Center May 19, 2016

MedStar St. Mary's Hospital May 19, 2016

Union Hospital of Cecil County May 20, 2016

Doctor's Community Hospital May 23, 2016

Peninsula Regional Medical Center May 23, 2016

MedStar Franklin Square Medical Center May 23, 2016

MedStar Southern Maryland May 23, 2016

Adventist HealthCare May 23, 2016

Johns Hopkins Health System May 23, 2016

Calvert Memorial Hospital May 24, 2016

Western Maryland Health System May 24, 2016

Atlantic General Hospital May 24, 2016

Frederick Regional Health System May 24, 2016

LifeBridge Health May 25, 2016

St. Agnes Hospital May 25, 2016

Holy Cross Health May 25, 2016

University of Maryland Medical System May 25, 2016

MedStar Montgomery Medical Center May 25, 2016

Mt. Washington Pediatric Hospital May 26, 2016

Anne Arundel Medical Center May 31, 2016

Maryland Hospital Association June 2, 2016

Chet Burrell
President and Chief Executive Officer

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chet.burrell@carefirst.com

May 6, 2016

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

Dear Mr. Sabatini and Ms. Kinzer:

This letter provides CareFirst's comments on the HSCRC staff's Draft Recommendations for the Update to Hospital Rates and the "PAU Savings Program" (PSP) for the Fiscal Year ending 2017.

Background

It appears that in the first year of the Model Agreement (CY 2014), the Maryland rate setting system easily met the All Payer test and both of the Medicare financial tests: 1) the U.S. FFS Medicare hospital expenditure savings requirement of $0; and 2) the national total Medicare Part A and Part B expenditures "Total Cost of Care" (TCOC) test. However, while continuing to achieve strong cumulative savings through CY2015, this performance trend has slipped somewhat causing a need for further root cause assessments. Preliminary data indicates that Maryland is exceeding the U.S. Medicare TCOC growth rate in CY 2015 and it is imperative to provide an Update at July 1, 2016 that ensures compliance with this waiver term for CY2016. If Maryland's Medicare TCOC growth exceeds that of the U.S. by more than 1.0 percentage points in CY 2015, or if it exceeds the national growth rate for two consecutive years (e.g., CY 2015 and CY 2016), the State would experience a "Triggering Event," which would elicit a "Warning Notice" from CMS that might, after some discussion, require Maryland to file an acceptable "Corrective Action Plan" (CAP) with CMS to avoid termination of the Model Agreement. Obviously, termination of the waiver would be disastrous for the State and its hospitals. Experiencing a Triggering Event in the midst of negotiations with CMS/CMMI regarding the continuation of the Model Agreement could jeopardize the ability of the State to obtain a Phase II extension.

The less favorable performance in CY 2015 appears to be a function of:

1) A high FY 2016 Update that increased both CY 2015 and CY 2016 spending, but has not been offset by reduced Medicare utilization;

2) An increase in the use of Part A post-acute care services (i.e., skilled nursing facility and home health services) in CY 2015 that will likely continue into CY 2016. The Model Agreement included the TCOC test so that savings under the hospital system would not be more than offset by increases in costs outside the hospital setting and to ensure that hospitals did not shift routine hospital services to non-hospital settings/facilities; and

3) What the HSCRC staff has characterized as an "uneven implementation of care coordination strategies thus far" by hospitals (particularly as it relates to the Medicare population);

Moreover, despite the infusion of nearly $200 million of care management infrastructure funding into the hospital system, there appears to have been virtually no change to date in the statewide level of PAUs over the past several years. Significantly, slightly more than half of the hospitals currently have increases in PAUs.

PAU Savings Program

Given these results, CareFirst strongly supports the staff's proposal to increase the PAU Savings Program (PSP) offset to rates to 1.25% in FY 2017 (from 0.60% in FY 2016) and to scale these rate offsets based on each hospital's level of PAUs. An increased emphasis on reducing PAUs is consistent with the HSCRC's GBR-based model of rate control. The Commission has frequently noted that, under fixed target budgets, the reduction of unnecessary utilization is an essential source of savings that should be used to offset investments in community-based initiatives and care coordination activities.

2017 Update Factor

In addition, we believe that the FY 2017 update factor must reflect the reality of the State's current and projected position relative to TCOC. We base this on the fact that CY 2015 performance on the Medicare TCOC test appears to have been unfavorable and this performance may also negatively affect performance in the first half of CY 2016 because the relatively high update factor that was approved in July 2015 will remain in effect until June 30, 2016.

The FY 2016 Update Factor— which provided hospitals with over 4.0% additional revenue, when the effects of termination of the MHIP assessment and reduction in hospital Uncompensated Care (UCC) provisions are considered— was predicated on a projected level of Medicare volume reductions that has not been realized.[1]

We have reviewed the methodology and the assumptions that the HSCRC staff used to develop the draft FY 2017 Update of 2.02% that is contained in the "Draft Recommendations on the Update Factor for FY 2017" (May 2, 2016) and provided in the pre-meeting package for the May public meeting and we generally support the approach taken by the staff. However, we have concerns that approving the full Update provision at July 1 could result in Maryland exceeding the National TCOC guardrail for the second consecutive year, causing a "triggering event". Specifically, we believe that the total hospital revenue increase needs to be held to no more than 2.11% in CY 2016 if Maryland is to meet the Medicare tests in the Model Agreement. Given that the approved revenue increase for FY 2016 was 2.94%, approximately half of that amount (i.e., 1.47%) will have been consumed in the first half of CY 2016.

[1] The elimination of the MHIP assessment and reduction in hospital UCC worked to reduce hospital gross patient revenues (their gross charge levels), however, hospital net patient revenues increased by approximately 4.35%. A similar dynamic is occurring in FY 2017 associated with a reduction in the Medicaid Deficit Assessment of 0.15% and an estimated drop in hospital Uncompensated Care of 0.55%. Thus, while gross patient service revenue would increase by 2.01% (under the current staff proposal), the hospitals' net revenues would increase by 2.71% (the 2.02% recommended GBR increase plus 0.70% = 0.15%+0.55%).

This would mean that the maximum revenue increase that the HSCRC could approve effective July 1, 2016 without jeopardizing the Model Agreement is 1.28% (i.e., 1.47% + .50 x 1.28% = 2.11%). Exhibit 1 to this letter illustrates this point in more detail.

If, after six months, it is clear that the system is outperforming the Medicare financial tests, the HSCRC could reasonably consider increasing the Update effective January 1, 2017.

PAUs

Finally, we believe that the HSCRC staff's formulation of PAUs—which includes unplanned readmissions, observation cases, Prevention Quality Indicator (PQIs) and Maryland Hospital Acquired Conditions (MHACs) —is a good first step in defining a methodology to incent hospitals to reduce PAUs.

However, we believe that the Commission should consider the following modifications and refinements to the PAU methodology:

1) The PAU list consists of inpatient services only in relation to each hospital's total (inpatient and outpatient) revenue. This calculation masks the level of PAUs at hospitals that have relatively large proportions of outpatient services;

2) The exemption of procedure-based utilization from the PAU list leaves a large pool of services that may or may not be appropriate outside the scrutiny of the PAU methodology. This means that hospitals with relatively high levels of procedural services— which are not considered in the determination of PAU levels— will tend to show lower PAU levels as a proportion of their total services. We suggest that the HSCRC revise its PAU methodology to compute the level of PAUs relative to the share of each hospital's revenue that is subject to the PAU definitions; and

3) The PAU list currently does not address the fact that the health services literature has amply established the fact that a substantial number of hospital procedures are unnecessary—either because they have little value under any circumstances, or they are over-utilized or they could be performed in more appropriate settings. The HSCRC should over time expand the PAU list to encompass such procedures with the assistance of experts— such as those at RAND, Dartmouth and other organizations—that have done extensive work in this area for many years.

We would like to recognize the HSCRC Staffs openness throughout this process of balancing all stakeholder concerns and comments and putting forward a very reasonable and workable recommendation. Thank you for this opportunity to comment on these very important policy initiatives.

Sincerely,

Chet Burrell
President & CEO

Exhibit I – Recommended Modification to the staff FY Update Proposal

In order for the State to achieve its goal of generating the desired level of 0.5% savings relative to the U.S. Medicare national FFS hospital growth rate, the impact of the FY 2016 approved revenue Update on the period January through June 2016 must be offset by a lower approved Update for FY 2017 (which will impact the last six months of CY 2016).

Table 1 below shows that, in order to meet the staff's goal, the HSCRC should approve a FY 2017 overall GBR revenue Update of 1.28%, not 2.01%, which was the amount that was being considered by the staff at the time of the May 2 Payment Models work group meeting. This 1.28% amount is the maximum affordable update for FY 2017 because the Commission must offset the impact of the large FY 2016 Update, which has inflated hospital revenues during the first six months of the calendar year.

If the HSCRC were to approve a 2.02% GBR revenue Update for FY 2017, Maryland could fail to meet the goal of achieving the desired level of Medicare hospital savings in CY 2016 (i.e., the CY 2016 U.S. Medicare FFS hospital expenditure per beneficiary growth rate less the 0.5% savings provision).

TABLE 1[2]

Meeting the Dual Waiver Tests with a Projection of Maximum GBR Increases
Combining Fiscal Year Approved Revenue Growth for both FY16 & FY 17

		Per Beneficiary	
(1) CMS Actuary Projection CY16 US hospital growth		**1.20%**	
(2) Less annual Savings %		-0.50%	
(3) Medicare Test Target		0.70%	
(4) Conservative Difference Statistic		0.89%	
(5) Projected Increase in MD Charges per Resident		1.59%	
(6) Population Growth		0.52%	
(7) Allowed CY 2016 Revenue Growth ((5) + (6))		2.11%	
	FY16 Approved Revenue Increase		FY 17 Approved Revenue Increase to hit Medicare Waiver Target
(8) Approved GBR Revenue Increase	2.94% (1)		1.28%
(9) Six Months of FY16 Approved GBR	1.47%		
(10) Six Months of FY 17 Approved			0.64%
(11) Allowed CY 2016 Revenue Growth (9) + (10)		2.11%	

(1) Derived from the FY16 approved Update of 3.19% less the 0.25% Transformation Grant funding delayed to FY17

[2] Table 1 shows a 2.11% update because this is the level necessary to meet the U.S. Medicare FFS Hospital expenditure per beneficiary less 0.5% target for FY 2016. Staff recommended a 2.02% update in order to provide a cushion for meeting this goal. However, as noted, it did not factor in the impact of the larger Update effective FY 2016 which impacts the first six months of CY 2016.

Maryland
Hospital Association

May 9, 2016

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

Dear Chairman Sabatini:

On behalf of the Maryland Hospital Association's 64 member hospitals and health systems, I am writing to provide feedback on the Health Services Cost Review Commission (HSCRC) staff draft recommendations on the global budget update factor for fiscal year 2017. The decision before you is critical to the future of the all-payer model in Maryland. Every one percentage point subtracted from or added to this update equals $160 million either withheld from or paid to Maryland's hospitals for patient care inside and outside the hospital.

We ask that commissioners please consider the following important data that augment the current draft recommendation:

Savings Far Exceed Targets
As stated in our April 19 letter, substantial progress has been made in the first two years of the waiver, particularly on Medicare savings (see attached charts):

- The Medicare hospital savings through the end of the waiver's second year was more than ***five*** **times the minimum savings required under the agreement**, and already ahead of the minimum required by June 30, 2017 (chart 1)
- If hospitals continue to save 0.50 percent ***below*** the national growth rate for the remainder of the agreement, total savings are projected to exceed **$850 million, more than *two-and-a-half times* the agreement's minimum required savings of $330 million** (chart 2)
- If Maryland hospital spending grew ***at*** the national rate for the balance of the five-year agreement, total hospital savings would be **$681 million, more than *double* the minimum savings requirement** (chart 2)

The staff's proposed update would push savings and reductions in the all-payer rate of spending for hospital care even further. Staff propose a total all-payer growth through June 30, 2017, of **7.81 percent per capita** (**6.40 percent** after removing the savings from uncompensated care and assessment reductions). This limited growth in spending for hospital care is more than ***one-third*** lower than the allowed ceiling under our all-payer demonstration (chart 3).

Full Range of Allowable Growth Options Not Presented
On pages 13-14 of the staff proposal, two charts present paths to achieve the desired fiscal year 2017 Medicare hospital savings of 0.50 percent. This is an opportunity to engage in a critical policy discussion about the cumulative minimum level of Medicare hospital savings to be achieved, when the minimum required savings through June 30, 2017 have already been exceeded and the all-payer agreement specifies a minimum ***cumulative*** five-year savings total of $330 million.

The Medicare hospital savings requirement of $330 million was calculated assuming the growth in Maryland's spending for hospital care would be lower than the national growth rate by 0.50 percent per year. In the agreement's first year, Maryland reduced that growth rate by far more – 2.15 percent. The commission can set a savings target for fiscal year 2017 less than the 0.50 percent recommended by staff, and still ***significantly exceed*** the minimum savings required. Setting a policy on hospital savings that does not account for the significant cumulative savings to date would undermine the still-tenuous status of the all-payer model.

In addition, Page 13 of the draft proposal suggests that the maximum all-payer growth rate that could be granted to achieve desired savings is limited to between 2.12 percent and 2.68 percent (1.59 percent to 2.15 percent per capita). However, two elements of the calculation are subject to a range of estimates not presented:

- **The projection of national Medicare spending growth for fiscal year 2017.** Several sources of data can be used for projecting Medicare national spending growth. We believe the most reliable is the projection of hospital spending in the Medicare Trustees annual report to Congress. In its latest report, spending growth is projected at 1.81 percent in calendar year 2016 and 2.52 percent in calendar year 2017, for a fiscal year 2017 projected growth of 2.18 percent (compared with staff's indicated range of 1.20-1.75 percent). Further, in its report, the CMS Actuary indicates that based on a study of its estimates for the time period 1997-2013, it has historically *underestimated* hospital spending by about 0.4 percentage points per year.

- **The "difference statistic" that estimates the difference in all-payer spending per capita and Medicare hospital spending per beneficiary.** In calendar years 2014 and 2015, the average difference between the all-payer spending per capita and the Medicare spending per beneficiary was 1.62 percent, nearly double the "conservative projection" of the difference statistic staff are using (0.89 percent).

In short, there are several alternative scenarios not shown on pages 13 and 14 of your materials that commissioners might consider for fiscal year 2017's maximum allowable all-payer increase. These scenarios demonstrate the ability to further increase the update.

Maximum Increase that Can Produce Desired FY 2017 Medicare Savings

	Scenario 1 (Page 13)	**Scenario 2 (Page 14)**	**Alternative Scenario 3**	**Proposed Scenario 4**
Estimated Medicare Growth (FY 2017)	1.20%	1.75%	2.18%	1.85%
Savings Goal (FY 2017)	-0.50%	-0.50%	-0.0%	-0.25%
Maximum Growth Rate that Will Achieve Savings	0.70%	1.25%	2.18%	1.60%

Conversion to All-Payer

	Scenario 1 (Page 13)	**Scenario 2 (Page 14)**	**Alternative Scenario 3**	**Proposed Scenario 4**
Actual Statistic Between Medicare and All-Payer	0.89%	0.89%	1.62%	1.25%
Conversion to All-Payer per Resident	1.60%	2.15%	3.84%	2.87%
Conversion to Total All-Payer Revenue Growth	2.12%	2.68%	4.38%	3.41%

At the May 11 meeting, MHA will provide commissioners with our recommendation for the update for fiscal year 2017, which will be well within the range of allowable increases that commissioners could consider. We ask commissioners to review the broader range of alternative scenarios and provide an update that does not undercut, at this still early stage, the important achievements and continued investments needed for successfully improving care delivery and health in Maryland.

Thank you for your consideration.

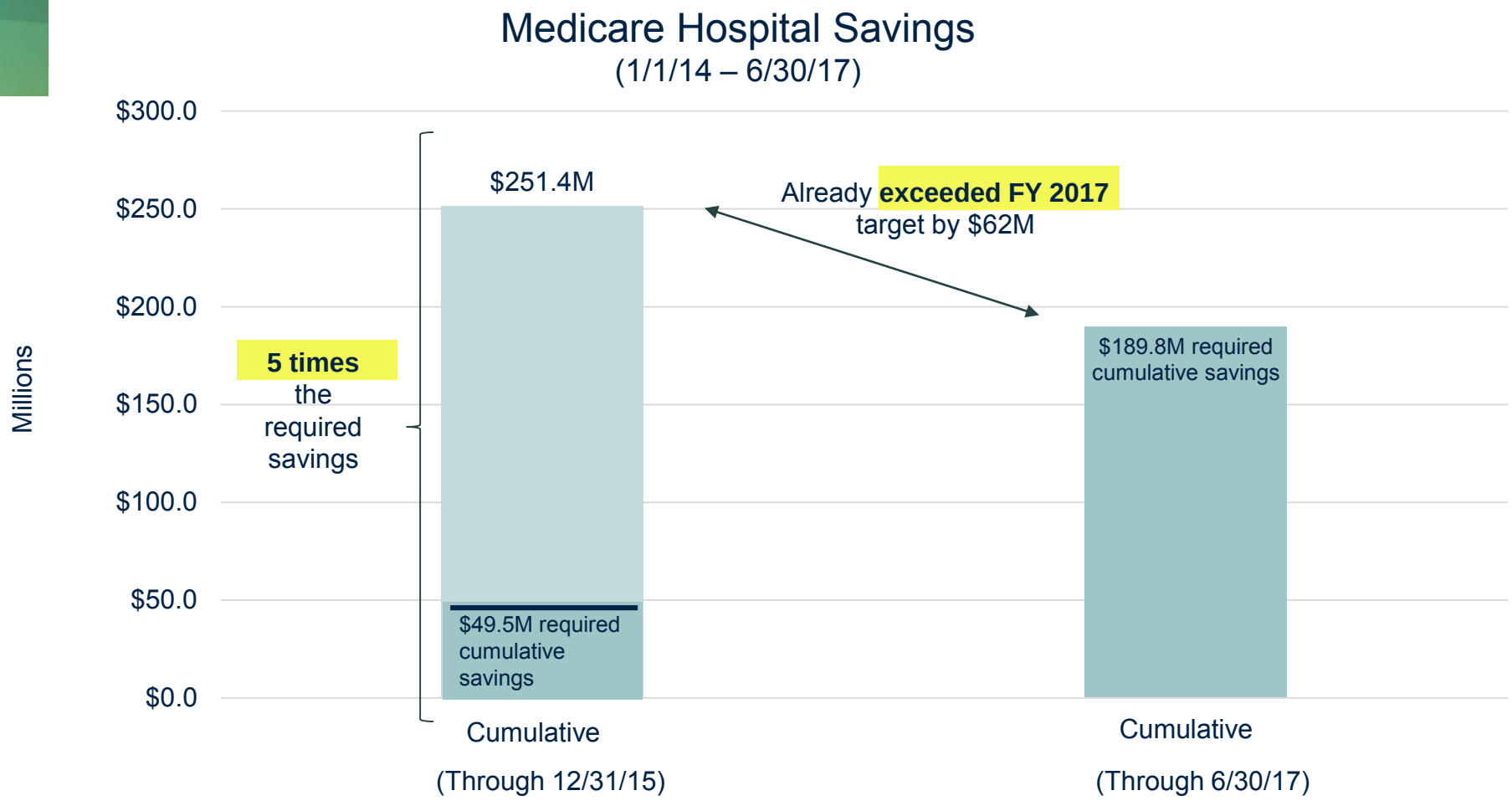
Sincerely,

Michael B. Robbins
Senior Vice President

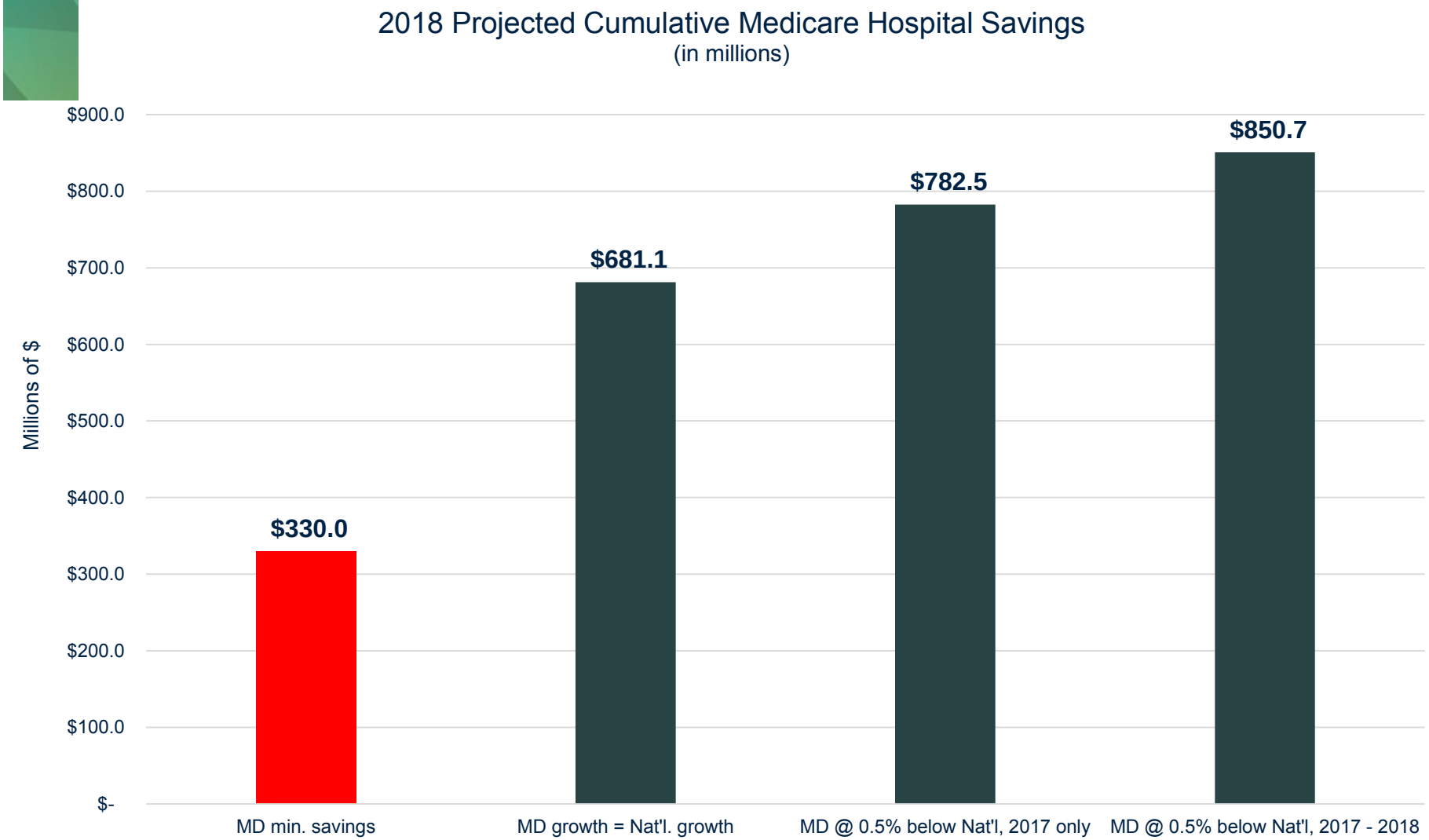
cc: Herbert S. Wong, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Jack C. Keane
Donna Kinzer, Executive Director

Attachment

Medicare Hospital Savings is Already Five Times the Required Amount

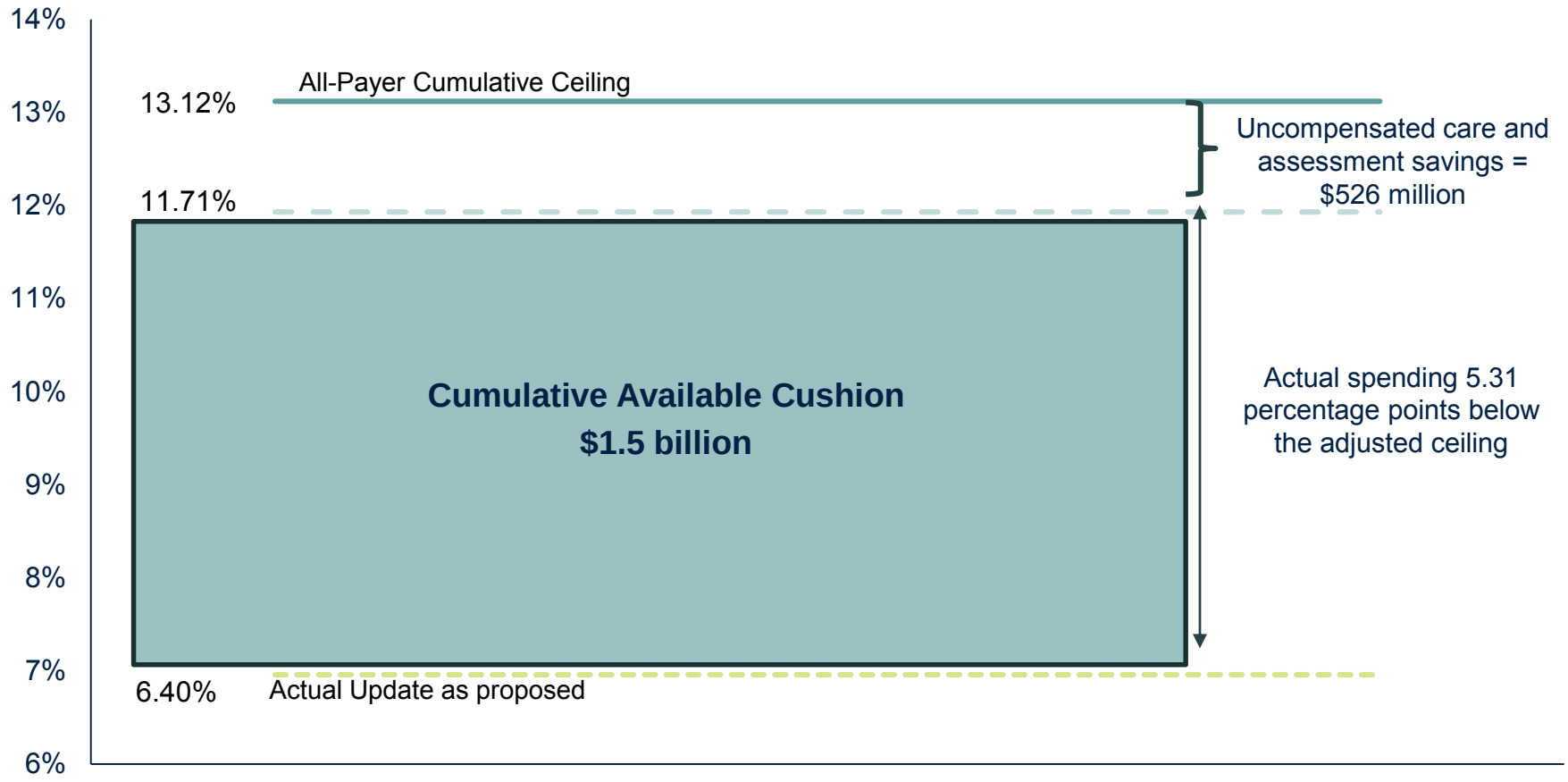


Expected Medicare Savings will far Exceed Requirement



Plenty of Cushion is Available

All-Payer Cumulative Update Capacity
(per capita; 1/1/14 – 6/30/17)



Maryland
Hospital Association

May 18, 2016

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

Dear Chairman Sabatini:

On behalf of the Maryland Hospital Association's (MHA) 64 member hospitals and health systems, this letter follows up on the May 11 commission meeting, at which we offered alternative proposals to the current staff-recommended global budget update and update for revenues not governed by global budgets for fiscal year 2017. In addition to this letter, MHA will be sending two others: one on the regional transformation grants, and another on the quality-based incentive programs. You'll also receive letters from Maryland's hospitals in response to Commissioners' questions about the transformative work they've been engaged in over the past two years.

If adopted, the staff proposed update would be a premature overcorrection that would jeopardize Maryland's momentum under the new All-Payer Model. As described below, what has been displayed as a proposed two percent increase in total revenue for hospitals in the state, **is actually only a one percent increase available to all hospitals**. Also described below: based on more current data than used by staff, **a higher update can be provided without encroaching on the staff-recommended Medicare total cost of care cushion.**

Constraining hospital funding now, at this sensitive stage, would undermine hospitals' nascent success and threaten their ability to meet the waiver's continued requirements; the commission's support through reasonable funding levels early on has been an essential building block of the success to date. But at levels as low as those proposed by staff, hospitals will be unable to pay needed wage increases, cover the increased cost of core operations and care, or follow through on population health investments in the community.

Of greater concern, an update this low calls the question on support for the demonstration and next steps. Now is a time when the state and stakeholders should be together, sharing with federal officials and the nation our collective successes in the first two years of this model and continuing to shape the hard work still ahead. But a too-low update would confirm concerns expressed all along about the model – that because of the total cost of care metric, we in Maryland could be hampered in truly innovating care delivery and reduced to simply chasing national Medicare performance. Cumulatively to date Maryland has met every metric and far exceeded most. Hospitals have outspent the funding provided in rates by the Commission for investments in population health. The delivery of care has changed and continues to change against a backdrop of exceedingly, and sometimes unrealistically, high expectations about the time and resources required to implement dramatic change not only inside hospitals but also

within communities working voluntarily with physicians, nursing homes and other community partners.

Instead, MHA proposes a modest addition of 1.12 percentage points to the per capita staff recommendation.

Update for Revenue under Global Budgets
HSCRC staff's proposal suggests a limit on revenue growth for hospitals in 2017 of 2.02 percent (1.49 percent per capita) after accounting for required reductions in uncompensated care and the Medicaid hospital assessment spend-down. However, as shown in the chart below, that number is misleading. In fact, a significant portion of the proposed update would be available only to *some* hospitals:

- **0.50 percent** is for unforeseen adjustments which, as reported at the last meeting, has been set aside for the last two years but not added to rates
- **0.07 percent** is for one hospital only - Holy Cross Germantown Hospital
- **0.51 percent** is for certain hospitals that apply and are approved for specific programs (e.g. high-cost drugs, partnership grants, workforce support) where in all cases, hospitals will likely spend more money than the amount proposed
- **0.52 percent** is for needed care increases due to population growth

Factoring in those set-asides for only some hospitals, *all* hospitals, on average, would receive a total revenue increase of just 1.1 percent (***a scant 0.60 percent per capita*** compared to the one-year ceiling of 3.58 percent per capita) to cover the increased costs of caring for patients (workers' wages, operations, care improvement and community investment).

HSCRC Proposed Update: An Alternative Presentation		**Total Revenue Growth**	**Per Capita Revenue Growth**
Total Revenue Growth, Per Staff Presentation		2.02%	1.49%
Less:	Amounts for unforeseen adjustments that may never be paid	(0.50)%	
	Amount only provided to Holy Cross Germantown	(0.07)%	
	Amounts only provided to hospitals that apply and are approved to incur new expenses for specified programs (new drugs, partnership grants, workforce support)	(0.51)%	
	Amount provided to hospitals incurring new expenses associated with population growth	(0.52)%	
Plus:	Reduction in funding needed for uncompensated care and Medicaid taxes	0.70%	
Balance:	Available to all hospitals for operations, care improvement, and community investment	1.12%	0.60 %

MHA is proposing a modest increase to the update. **A 1.12 percentage point increase to the 1.49 percent per capita staff recommendation – for a total 2.60 percent per capita update.** Only some of this (1.80 percent per capita) would go to all hospitals. The 2.60 percent per capita update would still fall far below the one-year 3.58 percent per capita growth ceiling, but would provide hospitals with the resources and stability they need to advance ongoing health care delivery transformation and maintain success under the all-payer model.

This alternative could be achieved with three minor adjustments to the current staff proposal, as detailed on Chart 1:

- **Increase the proposed 1.72 percent inflation adjustment to the currently projected 2.49 percent growth**. Staff has proposed applying an estimated downward "correction factor" in advance. However, as noted in Chart 2, based on a 16-year analysis of Global Insights projections, Global Insights is more likely than not to *underestimate, not overestimate,* inflation. Basing a forecast error adjustment on just the three most recent years is arbitrary. Applying it now for the first time to reduce the update while ignoring years in which inflation was underestimated and hospital rates should have been increased is arbitrary. This fosters system instability and unpredictability. And a higher amount is important because your update decision is *not solely a unit price inflationary increase*. Rather, it is the limited amount by which hospitals' total revenue may increase, which means it must accommodate price increases, funds to cover the risk assumed by hospitals in their global budgets for volume, case mix change and other costs, as well as the investments needed to improve the health of entire communities.
- **Reduce from -0.61 percent to -0.16 percent the net quality-based payment program adjustment by lowering the expected shared savings offset for Potentially Avoidable Utilization.** As we'll detail in a separate letter, this adjustment sets an expectation that hospitals will reduce Prevention Quality Indicators and readmissions by a combined *11 percent in a single year*. That is both unrealistic and unachievable. In the last two years, the annual reduction averaged three percent. To our knowledge, no other demonstration in the nation has shown a one-year reduction in potentially avoidable utilization of the magnitude suggested by staff.
- **Reduce from 0.50 percent to 0.40 percent the set-aside for unforeseen adjustments**. This 0.5 percent has been set aside but not used in each of the past two years, withholding more than $150 million in payments. These funds could be used to further develop much-needed partnerships with non-hospital community providers or to cover the expense of high-cost drugs without carving more from the inflation update.

Total Cost of Care Concerns

Most important, these modest changes would keep the state *well within the boundaries of the waiver's financial metrics* – metrics. Specifically:

- **Per Capita Spending** – MHA's proposal yields cumulative all-payer spending growth through FY 2017 of 7.5 percent per capita, far below the 13.1 percent ceiling

- **Medicare Savings** – Cumulative Medicare savings of $251 million are already more than five times the 2015 target of $49 million and savings through FY 2017 are projected to surpass the target, even if no additional hospital savings accrue
- **Medicare Total Cost of Care** – While Medicare total cost of care grew faster than the nation in 2015, Maryland did not exceed the ceiling.

However, HSCRC staff have proposed a lower update designed to reduce hospital spending even more, beyond the current $251 million in savings, in an effort to use lower hospital spending to drive lower total cost of care. That reduction is unnecessary. Staff has estimated the maximum per capita increase that can be given to obtain the desired savings to control the total cost of care. But in that calculation – the difference statistic – staff uses older data (CY 2015) to derive the factor (0.89) to translate Medicare spending trends into all payer trends. The most recent data (January - March 2016) for the conversion factor is higher (2.13), which translates into an allowable all-payer per capita growth rate of 3.38 percent (Chart 3). MHA's proposed update of 2.60 percent is well within this updated allowable growth rate.

Moreover, it is in neither the state's nor the federal government's interest to manage the total cost of care metric as a guillotine, rather than a guardrail. It is important to all stakeholders for the HSCRC to manage and balance the system within the financial targets of the all-payer model. MHA's proposed 2.60 percent global budget update would do just that. But even the agreement with CMMI acknowledges that Maryland may meet one metric (per capita hospital spending) and not meet another (Medicare savings) and still provides for a path forward. And there are several indications that CMS would work closely with Maryland to ensure that the all-payer system remains viable and replicable in other parts of the country:

- **Model architects understood that over a five-year period, there would be volatility in year-over-year performance and data calculations**, which is why the contract includes a comprehensive process to analyze and for the state to explain any infractions should they occur, and specifically says that CMS "…may or may not require corrective action, depending on the totality of the circumstances."
- **Maryland has already experienced what occurs when a metric is not met, and CMMI has been highly supportive of working with the state without threatening a waiver termination** – When readmissions reduction targets appeared to fall short in calendar years 2014 and 2015, CMMI not only recognized the possibility of data integrity issues, but worked closely with the state to continue the progress under the all-payer model
- **CMMI is looking at Maryland as a model for the rest of the country** – A recent Request for Information published by CMS (Chart 4) looks to interest hospitals nationally in global budgets, and cites Maryland's global budget approach as the example of "better management of cost and quality for a community's population, by providing clear revenue expectations and connecting services across outpatient and inpatient sectors"

Update for Revenue Not under Global Budgets
MHA recommends an update of 1.99 percent (instead of 1.24 percent) for non-global revenues, and 2.30 percent (instead of 1.55 percent) for the psychiatric hospitals and Mt. Washington Pediatric Hospital. The HSCRC staff recommends a 0.50 percent adjustment for productivity improvement, with which we agree. However, their recommendation also includes a reduction of 0.75 percent, which is the Medicare hospital payment cut intended to fund part of the cost of the Affordable Care Act. It is inappropriate to apply this federal Medicare reduction amount to all payer revenue in Maryland (Medicaid, CareFirst, United, others). It creates a larger-than-intended reduction for hospitals and a windfall for non-Medicare payers.

We look forward to further discussion of our proposal with you, as the commission moves forward on this critical funding decision for the next year. Thank you for your consideration.

Sincerely,

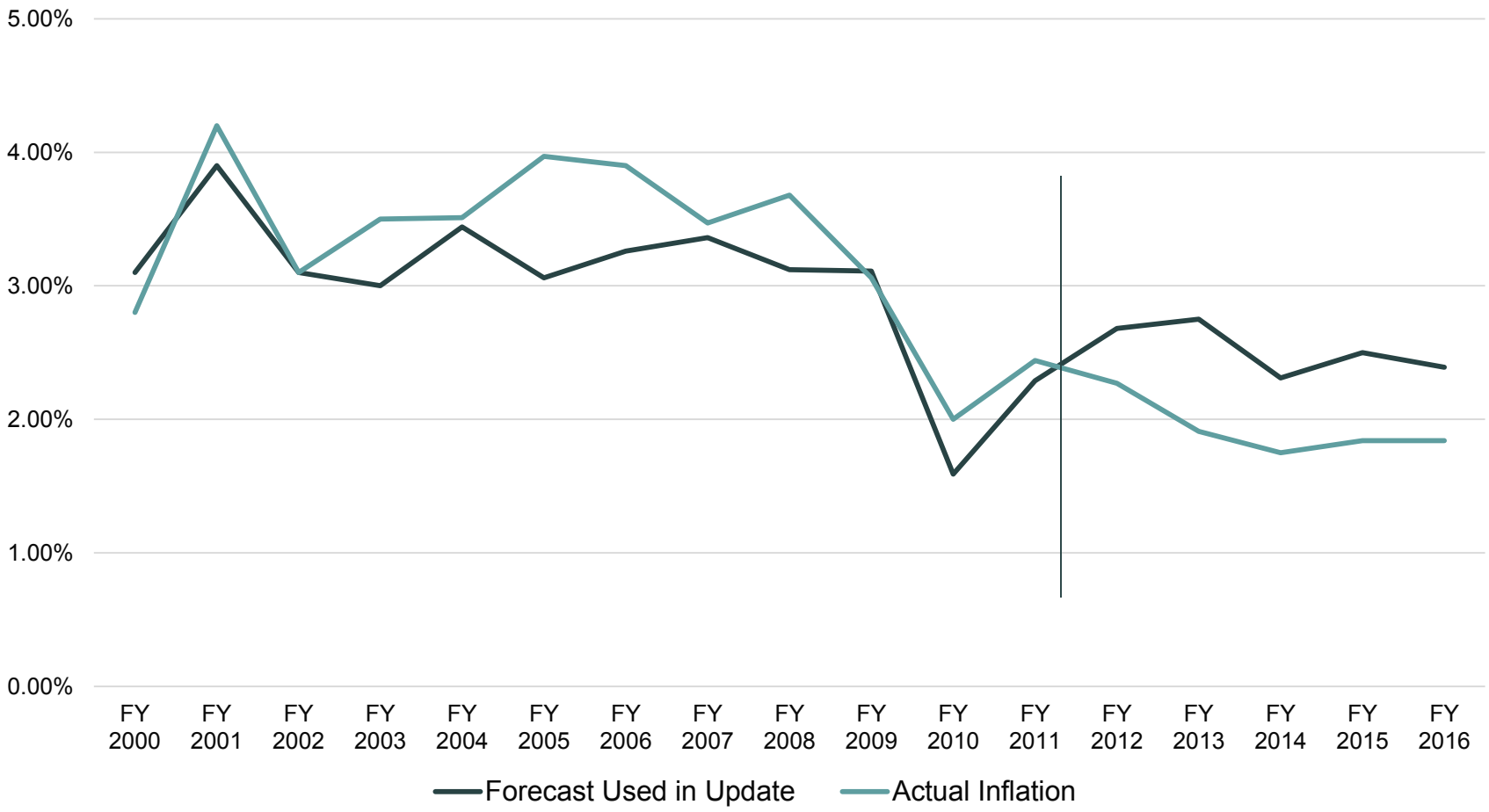
Michael B. Robbins
Senior Vice President

cc: Herbert S. Wong, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Jack C. Keane
Donna Kinzer, Executive Director

HSCRC Staff Preliminary Update Factor Component Breakdown FY 2017

	HSCRC Staff Proposal 05/11/16	MHA Proposal 05/11/16	Difference
Inflation (Current Market Basket is 2.49%)	1.72%	2.49%	0.77%
Net Quality-Based Payment Programs	-0.61%	-0.16%	0.45%
Adjustment for ACA Savings (Productivity)	0.00%	0.00%	0.00%
Subtotal	**1.11%**	**2.33%**	**1.22%**
Adjustment for Volume	**0.52%**	**0.52%**	0.00%
Care Coordination Allowances, by Application			
Rising Risk with Community Based Providers	0.00%	0.00%	0.00%
Complex Patients w/ Regional & Community Partnerships	0.25%	0.25%	0.00%
Long Term & Post-Acute Care	0.00%	0.00%	0.00%
Workforce Support Program, by Application	0.06%	0.06%	0.00%
Allowance for High Cost New Drugs, by Application	0.20%	0.20%	0.00%
Subtotal - available through application process	**0.51%**	**0.51%**	**0.00%**
Other Statewide Amounts			
Holy Cross Germantown	0.07%	0.07%	0.00%
Set Aside for Unknown Adjustments	0.50%	0.40%	-0.10%
Subtotal	**0.57%**	**0.47%**	**-0.10%**
Statewide Total Revenue Growth, prior to UCC/assessments	**2.72%**	**3.84%**	**1.12%**
Statewide Per Capita Growth, prior to UCC/assessments	**2.18%**	**3.30%**	**1.12%**
Other Adjustments			
Uncompensated Care Allowance	-0.55%	-0.55%	0.00%
Medicaid Tax Reduction	-0.15%	-0.15%	0.00%
Statewide Total Revenue Growth, after UCC/assessments	**2.02%**	**3.14%**	**1.12%**
Statewide Per Capita Growth, after UCC/assessments	**1.49%**	**2.60%**	**1.12%**

Why Adjust the Inflation Forecast Now?



Note: 9 of 16 years under estimated by avg. 0.02%
2000-2010 Underestimated 8 of 10 years by avg. 0.40%
2011-2016 Overestimated 5 of 6 years by avg. 0.54%

Allowable All-Payer Growth

Maximum Medicare Increase that Can Produce Desired FY 2017 Medicare Savings

	Scenario 1 (Staff proposal)	Scenario 2 (Staff proposal)	Scenario 3 (Current difference statistic)
Estimated Medicare Growth (FY 2017)	1.20%	1.75%	1.75%
Savings Goal (FY 2017)	-0.50%	-0.50%	-0.50%
Maximum Growth Rate that Will Achieve Savings	0.70%	1.25%	1.25%

Conversion to All-Payer

	Scenario 1 (Staff proposal)	Scenario 2 (Staff proposal)	Scenario 3 (Current difference statistic)
Actual Statistic Between Medicare and All-Payer	0.89%	0.89%	2.13%
Conversion to All-Payer per capita	1.60%	2.15%	3.38%
Conversion to Total All-Payer Revenue Growth	2.12%	2.68%	3.92%

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Regional Budget Payment Concept

Share

The Centers for Medicare & Medicaid Services (CMS) is interested in seeking input on a concept that promotes accountability for the health of the population in a geographically defined community. Under the Maryland All-Payer Model, CMS and the State of Maryland are testing a new hospital global budget payment program in which all payers in aggregate pay hospitals a fixed annual amount for inpatient and outpatient services, adjusted for quality and irrespective of hospital utilization. CMS is seeking input on the feasibility of similar approaches for other geographical areas, which could include areas smaller than a state. In this concept, providers could receive a prospective budget for the care of the population of a community, and would be accountable for the total cost of care across the entire continuum of care and health outcomes for the entire population. The purpose of this approach would be to support better management of cost and quality for a community's population, by providing clear revenue expectations and connecting services across outpatient and inpatient sectors. The concept could also incentivize collaboration of provider systems with community-based services outside the traditional health system. Lastly, this concept could encourage the inclusion of rural providers through providing incentives tailored to the unique needs and opportunities presented in rural areas.

GARRETT REGIONAL MEDICAL CENTER

A PROUD AFFILIATE OF
WVUMedicine

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

May 19, 2016

Dear Chairman Sabatini:

On behalf of Garrett Regional Medical Center (GRMC), this letter is in response to the May 11, 2016 commission meeting, at which the Maryland Hospital Association (MHA) offered alternative proposals to the current staff-recommended global budget update and update for revenues not governed by global budgets for fiscal year 2017. I contend that, if adopted, the staff proposed update would be a premature overcorrection that would jeopardize the momentum under the new All-Payer Model and that a higher update can be provided without encroaching on the staff-recommended Medicare total cost of care spending cushion.

GRMC has been engaged in work to transform healthcare in the region over the past two years. The hospital has made significant investments in patient care management and care coordination. GRMC has added social workers and case management staff in an effort to reduce readmissions and manage chronic disease conditions in the most appropriate and cost effective settings. New programs that work to reduce the overall cost of healthcare in the region include the following:

- The implementation of an outpatient cardiac rehabilitation program to reduce inpatient utilization for COPD, CHF, and AMI
- A Chronic Kidney Disease (CKD) clinic to better manage patients with potential renal failure
- Diabetes education programs and obesity counseling
- A wound care clinic to prevent inpatient hospital utilization for wound management
- The hospital now employs an integrated team approach to focused patient care management (Case Management) of the identified high utilizers of inpatient care through a multi-stakeholder discharge planning team. This team includes physicians, social workers, pharmacists, home health nurses, hospital nursing staff, behavioral health practitioners, and nursing home representatives.
- GRMC funds the activities of a Health Planning Council which is a multi-stakeholder team based at the Garrett County Health Department to create the community health plan and health needs assessment.
- GRMC also reaches out to each of the local nursing homes to assure successful care transitions and effective care management to reduce readmissions and potentially avoidable utilizations.

- The hospital's community wellness and outreach also includes the following:
    - GRMC Leads and sponsors the County Annual Health Fair
    - Sponsors tobacco cessation programs
    - Provides preventive health screenings and blood draw panels at local events
    - Provides bone density screenings
    - Provides medically supervised diet and exercise classes
    - Public Flu Vaccination Clinics
    - Provides atrial fib screenings
    - Facial skin analysis cancer screens
    - Breath carbon monoxide screens and expiratory lung capacity tests
    - Public programs that assist people with weight, body fat, BMI management
    - Dental health improvement initiatives in partnership with Garrett County Health Department

All of this aforementioned work takes an incredible amount of resources and funding in order to implement successfully. Indeed GRMC has been successful and consistently experiences a very low readmission rate. The hospital is committed to reducing the total cost of care, which takes resources and time. Finally, the hospital assumes all risk for these aforementioned initiatives; therefore a reasonable revenue update will be critical to continued success.

With respect to the current update, there is plenty of cushion for a more appropriate update; the cumulative savings the model has already secured for Medicare, Medicaid and commercial payers ensures that a reasonable update can be provided that will be far below the model's spending guardrails.

The current staff proposal for the update is inadequate, as it is far below inflation. It also sets aside funding available only to some hospitals via an application process, which means commissioners would put at risk wage increases for workers, and the ability of GRMC to keep up with the basic costs of running the hospital, notwithstanding the investments required to improve community care and reduce utilization. GRMC currently has the lowest charge per case in the state. However, at this time, GRMC is also running on a negative 2% operating margin, which it cannot sustain without staffing cuts that will be detrimental to the local economy.

In summation, I am reaching out to you to support a more appropriate global budget update. The Maryland Hospital Association sent you a fiscal year 2017 global budget update recommendation, which provides commissioners specific ways to turn the HSCRC staff's proposal from inadequate to helpful, without threatening the all-payer model's spending limits. I ask you to please consider these recommendations before approving the global budget update.

Best Regards,

Mark Boucot,
President and CEO

May 19, 2016

Dear HSCRC commissioners:

As the President and CEO of Meritus Medical Center and a member of the executive committee of the Maryland Hospital Association, I would like to address the proposed fiscal year 2017 global budget update for hospitals.

Since our entry into Total Patient Revenue or TPR nearly six years ago, we have remained resolute to improve the health of the population, enhance the experience and outcomes of the patient and reduce the cost of care. In just a few years into our health care transformation, we have experienced success in reducing emergency room visits and hospital admissions, decreasing readmissions from skilled nursing facilities, lowering health care-associated infections and driving out waste and removing variability in patient care processes throughout the health system.

Although early in our care delivery transformation, we have already experienced significant improvement in how to manage the health of our community.

For instance, we have hired an inpatient diabetes educator to educate patients about their disease process and provide resources to help them remain compliant with their care plan. We have also placed diabetic educators in primary care practices to act as a resource to physicians and patients and round out the continuum of diabetic care in the community. Preliminary data indicates that among a sample group of Meritus Health patients engaged with an outpatient diabetes educator, a four percent reduction in HbA1c levels was attained.

In addition, four years ago we began to place RN care managers in our emergency department to develop care plans for high utilizers. Since then, we have seen a 26 percent reduction in ED visits, a 36 percent drop in inpatient admissions and a 25 percent decrease in observation unit visits.

Also, the physicians in our primary care practices utilize RN care managers and a team of social work care managers, diabetic educators, pharmacists, behavioral health counselors and respiratory therapists to proactively manage patients' health care needs. This outpatient team allows primary care providers to focus on providing medical care to patients while the team helps educate, mitigate and resolve psychosocial barriers to improve patient compliance and outcomes. This multidisciplinary team has also been instrumental in creating disease management programs for patients with COPD, asthma and congestive heart failure.

Funding from the Health Service Cost Review Commission has given us the resources to create this multidisciplinary health care team and focus on improving the health of our patients.

When we embedded RN care managers into skilled nursing facilities or SNFs, we immediately saw a decrease in 30-day readmission rates. Since this partnership began, we have improved care transitions, provided patient education and benchmarked quality data sharing. Meritus Health pharmacists also provide consultation on formulary changes between hospital-to-SNF-to-primary care handoffs. The teamwork between care managers and pharmacists saves time and money, prevents possible adverse medication events and optimizes drug therapy.

We have also discovered that 80 percent of our behavioral health ED visits do not require hospitalization. Recently, we integrated behavioral health professionals into our primary care practices to bring behavioral health services to the patient versus the patient coming to a behavioral health practice. Our counselors identify patients at risk, initiate treatment and support and link patients to appropriate community resources. Already, we are increasing immediate access to behavioral health care, improving care coordination, enhancing patient engagement and treatment compliance and decreasing ED visits and potential hospitalization.

As you can see, we are on the path to better care, healthier people and smarter spending, but to continue in this direction, we need investment in innovative care programs, adequate staffing and competitively compensated health care workers and the resources necessary to meet the basic costs of running a hospital.

Hospitals are the only entities at risk for the model's success. In order for us to succeed, we require a reasonable update to the 2017 global budget. However, the imminent decision as to how much of a global budget update will be provided to hospitals at the midpoint of our five-year Medicare agreement concerns me. Maryland's hospitals must have adequate investment to deliver on cost control and quality improvements.

As a hospital CEO, I support MHA's Fiscal Year 2017 Global Budget Update recommendation. I am committed to the care transformation goals of the all-payer model and I share your desire to provide care in the most efficient and cost-effective manner. However, in order to achieve success in population health and lead the nation in transforming health care delivery, Maryland's hospitals, like Meritus Medical Center, need your help and consideration.

Sincerely,

Joseph P. Ross, FACHE
President and CEO, Meritus Medical Center

Heather Lorenzo, M.D.
Vice President and Chief Medical Officer

Thomas Chan
Vice President and Chief Financial Officer

MedStar St. Mary's Hospital

25500 Point Lookout Road
P.O. Box 527
Leonardtown, Maryland 20650
301-475-8981 **PHONE**
MedStarStMarys.org

May 19, 2016

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

Dear Commissioners,

We are writing to detail our response to recent deliberations at the Health Services Cost Review Commission (HSCRC) meetings, specifically over the stated concerns of some commissioners that some hospitals are not focused enough on reducing avoidable utilization and reining in Medicare total costs of care.

Please allow us to detail for you some of our efforts at MedStar St. Mary's Hospital (MSMH). With a long standing tradition of caring for our community by "continuously promoting, maintaining and improving health" per our Mission statement, we are proud of our record near the top in Quality Based Reimbursement scoring every year since its inception. We are a Maryland Performance Excellence Award recipient and pursue performance excellence in all we do. We offer some examples below.

Regarding our work to reduce potentially avoidable utilization of hospital services:

- With the end of the HEZ project in FY17 we will need to sustain the successful care coordination and community health worker programs out of hospital operating dollars. This will not expand our capacity but simply maintain it. To expand the HEZ pilot to the entire county we estimate we will need an additional two FTE RNs, one FTE Social Worker and four - six FTE Community Health Workers on top of the five FTEs that will need to be absorbed when the grant ends. Currently Care Coordinators are carrying case loads above best practice recommendations and many patients that would benefit from care coordination are not able to be offered the service.
- MedStar St. Mary's Hospital was not awarded any funding for the transformation grants putting us at a severe disadvantage to continue to implement our population health strategy to support the Waiver.
- We successfully reduced readmissions 15.52% and 13.17% in CY'14 and CY'15 respectively compared to our base rates. With no additional resources new progress to continue to reduce readmissions and other unnecessary utilization will most likely stall.
- MSMH has invested in real time quality and safety processes to reduce MHACs. This strategy resulted in a 24.85% improvement in 2015. This important but labor intensive work requires resource commitments to sustain these cost saving improvements.

Regarding our work with community partners in non-hospital settings to reduce total cost of care spending:

- We meet regularly with care coordinators from surrounding hospitals to share best practices and discuss common patients.
- We meet quarterly with representatives of other facilities (like skilled nursing facilities and the Charlotte Hall Veterans Home) to discuss best practices, readmissions rates, and specific processes that are in place for smoother transitions of care.
- We have collaborated with a local homeless shelter to create a Medical Respite program, launching soon.
- We attend community inter-disciplinary team meetings to develop community care plans for high utilizers.
- There is limited public transportation in St Mary's County which limits access to medical care for those with special needs from chronic disease. With the HEZ grant we created additional transportation options via a shuttle bus route and medical specialty route van service allowing patients to visit primary care and specialty physicians. This has proven to be a successful strategy to remove transportation as a barrier to self management for some of our patients. Post HEZ it will be important to sustain this service ourselves or find a community partner able to absorb the work.
- Hospital associates sit on various boards, workgroups and committees in our community to address social determinants.
- Our staff are supporting the work of all four teams of the Healthy St Mary's Partnership (Local Health Improvement Coalition).

As the sole hospital in our county, our commitment to improving health is ardent and ever expanding, but we must remain fiscally solvent in order to continue this important, long range work of providing the resources necessary to address growth of appropriate volume while reducing potentially avoidable utilization.

We are indeed a hospital committed to the care transformation goals of the Maryland All-Payer Model and thus we are also committed to ensuring that there is adequate funding to create the infrastructure necessary to make the connections and hand-offs to community providers and alternatives. Further, within the current model, the only entities at risk for the Model's success are the hospitals, yet success is dependent upon many other organizations, not to mention patient compliance.

The cumulative savings the Model has already secured for Medicare, Medicaid and the commercial payers ensure that a reasonable update factor can be provided that will be far below the Model's spending guardrails. Moreover, approving an update that is far below inflation and that sets aside funding available only to some hospitals via an application process, means commissioners would put at risk wage increases for workers, and the ability of hospitals to keep up with the basic costs of running a hospital, much less the investments required to improve community care and reduce utilization. A low update factor such as that proposed would cause MSMH will undoubtedly reduce funding available for wage increases – made more complicated by recent living wage efforts and the shortage in health care providers notably in the Emergency Department is a growing concern.

Finally, we support the Maryland Hospital Association Fiscal Year 2017 Global Budget Update recommendation and believe it provides the commissioners specific ways to turn the HSCRC Staff's proposal from inadequate to helpful, without threatening the All Payer Model's spending limits. We would appreciate your serious consideration of this recommendation.

Regards,

Barbara R. Thompson
Board Chairwoman

Christine R. Wray
President

Stephen T. Michaels,
COO and CMO

CC: Mike Robbins, Senior Vice President, Rate Setting, MHA
Michael Curran, Executive Vice President, Chief Administrative & Financial Officer, MedStar Health
Kathy Talbot, Vice President, Rates & Reimbursement, MedStar Health

UNION HOSPITAL

May 20, 2016

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

Dear Chairman Sabatini:

On behalf of Union Hospital of Cecil County, we would like to respond to your staff-recommended global budget update and update for revenues not governed by global budgets for fiscal year 2017 discussed at your May 11 commission meeting.

First and foremost, it takes resources to reduce potentially avoidable utilization of hospital services. Over the past six years, we have been employing primary care and specialists to provide access to care in the ambulatory setting, spending millions of dollars. We have added social workers and care managers to improve transition of care to home and post-acute facilities. We opened a clinic for self-pay and Medicaid patients to provide adequate access for our cardiology patients. Finally, we are in the process of developing a free comprehensive care clinic to coordinate health care and social services for our patients outside the four walls of the hospital.

In addition, we have been partnering with our local Health Department and Department of Aging to better coordinate the resources they can provide. We also meet regularly with the three skilled nursing facilities to review readmissions data and the rationale to mitigate in the future. We are exploring the use of telehealth and seeding of "SNFists" in the facilities to keep their residents from returning to the hospital.

Finally, the hospital is committed to the care transformation goals of the all-payer model, but it takes financial support and time to do it right. Hospitals are the only entities at risk for the model's success; to succeed, a reasonable update is critical. Any improvements we make benefit our patients, but also accrue to the bottom lines of the insurance companies.

We look forward to further discussion with you as the commission moves forward on this critical funding decision for the next year. Thank you for your consideration.

106 Bow Street • Elkton, Maryland 21921 • 410/398-4000 • Fax: 410/392-9486 • TTY: 800-735-2258
www.uhcc.com

Sincerely,

Richard C. Szumel
President/CEO

Laurie R. Beyer
Senior VP/CFO

Martin Healy,
Chairman of the Board

Cc: Herbert S. Wong, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Jack C. Keane
Donna Kinzer, Executive Director

DOCTORS COMMUNITY HOSPITAL

May 23, 2016

Nelson J. Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215
(erin.schurmann@maryland.gov)

Dear Commissioners,

We appreciate this opportunity that you are allowing for Doctors Community Hospital (DCH) to discuss all our transformative work that we have implemented to reduce utilization and save per capita costs in Maryland. To implement our care coordination and management programs within our hospital and with non-hospital community partners, we are using both infrastructure dollars allocated over the past two years and the variable cost savings from CY 2014 and CY 2015 as a result of reducing readmissions by 13.97% and 6.47%, against HSCRC goals of 6.76% and 9.3%, respectively. Our programs have also shown success in "quality-based" improvement efforts, such as MHAC in which we moved from 45th to 39th in the State, and receiving a reward. In CY 2015, PQIs and PAUs both show a reduction of 5% over prior year's values as seen in Appendix A, our Monthly Population Health GBR Dashboard. Now, in our third year, we are beginning two new efforts in implementing total cost of care initiatives. Every year we add programs and initiatives with our community partners, since the effort of reducing healthcare costs must be a collaborative approach although only hospitals are at risk for the model's success. A reasonable update factor is critical to allow a few more years to meet this first Medicare Waiver mandates.

The cumulative savings, the all-payer model has already secured from Medicare, Medicaid and commercial payers, is a result of programs such as the ones identified in *Table 1: Infrastructure Funds*. In FY 2016, an additional $891,502 was provided as Infrastructure Funds, and as you can tell the three years of funding don't begin to cover the costs to implement the community programs needed to meet the Triple Aim strategies of cost reduction, community health improvement, and patient satisfaction.

Table 1: Use of Infrastructure Funds and Spending Levels for FY 2014 and FY 2015

	Infrastructure rate order	$ 718,517.00	$ 701,230.14
Investment 1:	Population health focused reports to track potentially avoidable utilization and identify key areas to focus on. Routine reports are generated daily (Daily Scorecard), monthly (Monthly GBR Dashboard), and quarterly (BRG report) to help clinicians monitor their efforts centered around population health patient care.	$ 209,502.74	$ 365,967.15
Investment 2:	Outcomes Imrovement Committee will be implemented in Q3 of FY 2015 to create structure and accountability around the reduction of potientially avoidable utilization, MHAC and Readmissions. Focus is to use BRG reports to identify what and how to reduce PQIs. Hired Navigators and PAs to visit the patients	n/a	$ 160,528.76
Investment 3:	Mobile Clinic: The "Community Health Connector" is a mobile van that travels to various locations in Prince George's County to help patients maintain or improve their health. The mobile clinic is staffed with DCH healthcare professionals. The clinic provides a wide range of services to people ages 16 and older, including:+ Blood pressure screenings,+ Electrocardiogram (EKG) testing,+ Flu and pneumonia vaccinations,+ Tetanus shots,+ HIV screenings,+ Pulmonary function testing,and + Routine physicals	$ 2,403.85	$ 4,807.69
Investment 4:	Sickle Cell Clinic: As a result of the review of readmission patients, the hospital identified that Sickle Cell patients were being readmitted due to the lack of proper outpatient protocols. After discussions with the local physician practices and meetings with Johns Hopkins clinical representatives, the hospital decided to offer the Johns Hopkins protocols in our Infustion Clinic Center.	$ 54,318.00	$ 79,771.60
Investment 5:	CHF Clinic: The Congestive Heart Failure Clinic is a comprehensive program that provides: + An experienced and board-certified heart failure cardiologist + A holistic care approach that includes the collaborative services of pharmacy, nutrition, physical therapy, cardiology, physician assistant, social work, home health and hospice care professionals – all accessible on Doctors Community Hospital's campus	$ 21,551.08	$ 185,036.00
Investment 6:	Accountable Care Organization ("ACO") / Clinically Integrated Network ("CIN"): The rationale / primary objective for joining an ACO is to build relationships with physicians in the community. The CIN will allow for gain sharing with the physicians once the business becomes profitable.	$ 174,957.88	$ 1,747,040.00
Investment 7:	ER Through-put / Readmission Initiative (consulting by Medical Strategies and Management). The objectives of this consulting engagement were to reduce ER wait times, increase patient satisfaction in the ED, reduce unneccessary admissions to the Telemetry unit that belong in a Med/Surg unit. The second phase of the consulting engagement focused on reducing readmissions.	$ 520,453.00	$ 243,959.77
Investment 8:	Committee formed to reduce Readmissions from Genesis Nursing Home to DCH.	$ 2,884.62	n/a
Investment 8	Premier Cost Savings Initiatives Professional Fees: In an effort to reduce hospital costs, we reduced staffing, supply expenses, and other expenses to meet our goals versus our peers in Premier's national database.	n/a	$ 1,242,305.02
Investment 9	Ambulatory Care Center - Leiland Hospital		
	Total Spent	$ 986,071.15	$ 4,029,416.00
	Dollars from Variable Cost Savings	**$ (267,554.15)**	**$ (3,328,185.86)**

Table 2: TLC-MD describes the Transformation Partnership efforts started in March 2015 and continues through today with 6 hospitals and over 40 community partners in an effort to offer care coordination in Prince George's County, St. Mary's County, and Calvert County. Although TLC-MD Transformation Grant was not funded in round one, we will continue to serve our counties on a smaller level as HSCRC staff evaluates if funding is available. Here are the four Strategic Efforts that are offered or being developed in our counties to meet the Triple Aim strategies.

Table 2: Strategy #1

Strategy #1 – Screen all admissions to our hospitals and implement layered care coordination.	**$ 3,922,280.80**	**REVISION NOTES**	**1,575,509.00**
Our High-Needs Population will have care coordination provided by their hospital or by eQHealth, under contract with TLC-MD. The eQHealth suite of services includes home visits, patient and caregiver education, medication reconciliation, navigation for primary and specialty care and supportive services care planning, and communication with physicians. We will track the effectiveness of this approach by monitoring readmission rates, total cost of care, and RCA of readmissions and preventable hospitalizations. Patient satisfaction and engagement will be critical and regular surveys will be conducted to receive patient (and caregiver/family) feedback.			
Reporting on Care Coordination: EQHealth - Implementation of Business Intelligence. This tool is used for reporting on the results of care coordination.	33,850.00		33,850.00
Predictive Modeling: EQHealth Business Intelligence (Hopkins). This tool is used to place all claims data on our population so that predictive modeling can identify patients with needs before readmissions begin after the first visits.	12,000.00		12,000.00
Rent and Organizational Costs for Small Villages for the St Mary's HEZ, to pay fees to have educational services throughout the community as needed.	27,000.00		27,000.00
St Mary's Clinic staffing and other costs is the expense of the HEZ clinic, one of the unique programs we will be having for care coordination that is different from the eQHealth approach since this rural approach works better for this population.	369,578.75	Open a smaller clinic	184,789.00
Three Discharge Clinics Staffing and other costs is the expense of the Discharge clinics, one of the unique programs we will be having for care coordination that is different from the eQHealth approach since this rural approach works better for this population. We are planning to add 2 more clinics to support this approach to care coordination as guided by the evidence.	851,193.00	Open 1 clinic in Prince George's County	283731.00
Transportation Services for patients whose cost of transportation keeps them from meeting an	1,568.00	@ 50%	784.00

Strategy #1 – Screen all admissions to our hospitals and implement layered care coordination.	**$ 3,922,280.80**	**REVISION NOTES**	**1,575,509.00**
appointment.		volume	
Physician Care is for the payment of co-pays or physician office visits for the self-pay or indigent patient who is not eligible for insurance coverage or Medicaid or Medicare.	192,780.00	No free MD care	0
Call Center is the expense to cover after hours call coverage from 6pm to 8am M-F and all weekend.	125,684.00	6 hours a night	62,842.00
The following Tiers are based on the acuity level of the patient and months in TLC-MD's program. Tier 1 – High utilizers 10% – Time on program all year Tier 2 – High utilizers 78% – Time on program 90 days Tier 3 – High utilizers 6% – Time on program 180 days Tier 4- high acuity – High utilizers 6% – Time on program 180 days			
Tier 1 - Social and Medical is costs associated county case workers to support our patients, as TLC-MD identifies.	140,708.57	@ 50% volume	70,354.00
Tier 1 – Behavioral is costs associated with services provided to patients needing mental health assistance that is not part of the insurance coverage.	131,328.00	@ 50% volume	65,664.00
Tier 2 - Social and Medical is costs associated county case workers to support our patients, as TLC-MD identifies.	319,476.86	@ 50% volume	159,738.00
Tier 2 - EQ Medical is the cost of the software and the professional services from an RN to visit the Care Transition patients in the hospital and place them in a care coordination program. The cost includes the use of this software for care coordination programs within the hospitals whose staff work directly with patients, such as Cancer Navigators.	851,754.38	@ 50% volume	425,877.00
Tier 3 - EQ Medical is the cost of the software and the professional services from an RN to visit the Care Transition patients in the hospital and place them in a care coordination program. The cost includes the use of this software for care coordination programs within the hospitals whose staff work directly with patients, such as Cancer Navigators.	130,159.24	@ 50% volume	65,080.00
Faith and Community Based is the cost of working with the community to help TLC-MD visit with patients who need volunteers to assist them. Recruit 100 congregations and community organizations, health liaison training, feedback and evaluation with participating organizations, add training for community health workers for congregations, community organizations that would want their own paid staff and nurse support for outreach health fairs and screenings at participating organizations.	500,000.00	@ 25% volume	125,000.00
Patient Engagement is the cost to support the use of telehealth technologies, such as fitbits, that can be provided to patients and linked back to the eQHealth software tool to notify TLC-MD care coordinators when patients are possibly having difficulty in managing their care processes.	235,200.00	@ 25% volume	58,800.00

Table 3: Strategy #2

Strategy #2 – Reinforce the care coordination with special focus on medication management.	**$1,201,664.80**	**REVISION NOTES**	**600,832.00**
Vitamin D levels cost is payment to the Emergency Rooms of the Member Hospitals to monitor levels.	6,272.00	@ 50% volume	3,136.00
Medication Delivery System has been tested by Union Memorial Hospital, and we have decided to test the use of an alarm system that sounds when the patient does not take their medication timely.	203,212.80	@ 50% volume	101,606.00
Non-Medical Equipment is the cost for scales and other minor equipment that can be provided to patients to assist patients who are possibly having difficulty in managing their care processes.	15,680.00	@ 50% volume	7,840.00
Tier 1 - Medicine Management is cost associated with services provided to help review the patient medications past medication reconciliation and medicine adherence to are the prescriptions appropriate for the patient.	49,500.00	@ 50% volume	24,750.00
Tier 2 - Medicine Management is cost associated with services provided to help review the patient medications past medication reconciliation and medicine adherence to are the prescriptions appropriate for the patient.	643,500.00	@ 50% volume	321,750.00
Tier 3 - Medicine Adherence is the cost of placing the tool in the patients' homes that filled with a month of medication and is linked to eQHealth to notify the TLC-MC care coordinator if the patient is non-compliant.	81,000.00	@ 50% volume	40,500.00
Tier 3 - Medicine Management is cost associated with services provided to help review the patient medications past medication reconciliation and medicine adherence to are the prescriptions appropriate for the patient.	49,500.00	@ 50% volume	24,750.00
Tier 4 - Medicine Management is cost associated with services provided to help review the patient medications past medication reconciliation and medicine adherence to are the prescriptions appropriate for the patient.	153,000.00	@ 50% volume	76,500.00

Table 4: Strategy #3

Strategy #3 – Support physician practices that deal with these high-needs patients	**$271,600.00**	**REVISION NOTES**	**76,000.00**
Physician Engagement includes hosting CME meetings throughout the 3 counties each year. Plans include 11 events at $66,000 for location and food, $7,500 for the speakers, and $15,000 for CME fees. Three (3) Outreach and Education meetings to explain: Increasing Quality and Revenue Through Medicare Fee-for-Services, EHR Incentive Programs, CRISP Services for Providers, The Post-Acute Care Team Program, All New Payer Model: Performance Improvement Continuing Medical Education (PI CME). Implement the intervention(s) based on the results of the analysis	88,500.00	Us MedChi's CME license	76,000.00
Physician Engagement is a cost to communication to practices, such as (a) distributed by participating sites *(placed in inpatient packets, waiting rooms, mobile clinic, health fair packets, social work packets, etc.,* (b) Postcard mailed to targeted ZIP codes to inform patients of this service, (c) Public service announcement audio/video*(distributed to local radio and television stations, and placed on participating sites' Web and YouTube pages,* (d) participation with health fairs, and (e) brochures for awareness to other offices, such as County offices and Agency Area on Aging offices.	175,600.00	No physician office site visits	0
CRISP Outreach: Initial goal of 50 physicians. Reach out to targeted individual practices as identified by the coalition to register for CRISP services: Encounter Notification Service (ENS), Prescription Drug Monitoring Program (PDMP), Query Portal	7,500.00	Free services	0

Table 5: Strategy #4

Strategy #4 – Cultivate a highly reliable learning organization, with ongoing testing, adaptation, and adoption.	**$816,360.00**	**REVISION NOTES**	**398,180.00**
Executive Director who will management this program.	200,000.00		200,000.00
Financial Analyst will perform all the financial reporting to ensure we are documenting our expenditures properly per initiative. This person will also ensure that each hospital supplies their grant values quarterly to TLC-MD to pay the bills. The ROI will be a combination of the Clinical and the Financial Analysts work.	80,000.00	Exec Dir to do	0
Clinical Analyst will monitor all the clinical components for reporting to committees to ensure we have positive outcomes or can offer suggested improvements to our processes.	80,000.00		80,000.00
Benefits at 20% of Wages are the related to the staffing benefit and tax costs.	90,000.00	Adjust	70,000.00
Consultant costs are for the continued facilitation of the grant as an assistant to the Executive Director as needed to evaluate initiatives and keep the program moving forward.	75,000.00	No Altarum	0
Project Management is the cost of maintaining the Timeline and reporting on progress.	30,000.00	Exec Dir to do	0
Metric Management is the cost of maintaining the Timeline and reporting on progress.	30,000.00	Clinical Analyst to do	0
Insurance is the cost of Directors and Officers insurance.	20,000.00		20,000.00
Audit / Finance is for the annual fiscal and compliance audits, and any cost of complying with HSCRC reporting.	100,000.00	No audit, just Acctg	12,500.00
Legal is the cost for additional legal assistance with contracts and questions that arise.	50,000.00	No legal	0
Website is the cost of maintaining a website with relevant data.	30,000.00	No website	0
Lab services are the cost of providing other testing of interventions as necessary.	31,360.00	Hospitals pay from Comm Benefits	15,680.00

In the synergy between the *Table 1* Investment 6: ACO/CIN effort and *Table 2* of care coordination, DCH staff recently identified that the patients of the ACO can have their claims history processed through TLC-MD's eQHealth's predictive modeling tool so patients who might be considered high-needs patients in a year or two, can be care coordinated through TLC-MD today in an attempt to meet the Triple Aim strategies. The building of care coordination and total cost of care efforts are not simple, but complex programs that support unique patients.

Based on the demographics seen in *Table 6*, Prince George's county falls short in so many categories as compared to Maryland: non-Hispanic African-Americans, more diabetes, more food insecurity, less physicians, less health care cost because of not being able to see a doctor, and other disparities. To meet our community and give patients the opportunity for preventive care, during FY 2016 and in preparation for FY 2017, DCH has been adding Navigators, Physician Assistants, Nurse Practitioners, and Physicians to place these providers in the community in outpatient locations within Prince George's County. The plan is to purchase primary care and specialty practices to expand the number of providers to offer the community preventive medicine. At this time, we have purchased 3 practices and have at least 3 more planned. With 50% funding from the MHA Hospital Bond Capital Project, our plan is to open two multi-purpose clinics to serve the communities. In FY 2017, we will be joining with LaClinica, a FQHC, in the opening of a PCP/Specialty Care Clinic to service Hispanics, a growing population of Prince George's County.

DCH has a relationship with Genesis, a nursing home owner and manager. We have been meeting to develop a program to reduce readmissions. Our intent is to develop a risk relationship on bundled services when a DCH inpatient is transferred to a Genesis skilled nursing facility. This effort has been in process for a few months, a costly process of studying the reasons for nursing home patients and putting together protocols to reduce unnecessary readmissions.

Table 6: Demographics

Demographics				
	2013	2014	2015	Maryland
Population				
% below 18 years of age	24.00%	23.00%	22.70%	22.70%
% 65 and older	10.00%	10.00%	10.80%	13.40%
% Non-Hispanic African American	63.00%	63.00%	62.80%	29.20%
% American Indian and Alaskan Native	1.00%	1.00%	1.00%	0.60%
% Asian	4.00%	4.00%	4.50%	6.10%
% Native Hawaiian/Other Pacific Islander	0.00%	0.00%	0.20%	0.10%
% Hispanic	15.00%	15.00%	16.20%	9.00%
% Non-Hispanic white	n/a	15.00%	14.50%	53.30%
% not proficient in English	5.00%	5.00%	5.10%	3.00%
% Females	52.00%	52.00%	51.90%	51.50%
% Rural	2.00%	2.00%	2.00%	12.80%
Health Outcomes				
Diabetes	11%	11%	12%	10%
HIV prevalence			830	633
Premature age-adjusted mortality			348.2	320.8
Infant mortality			9.9	7.7
Child mortality			77.8	55.2
Health Behaviors				
Food insecurity			15%	13%
Limited access to healthy foods	3%	4%	4%	3%
Motor vehicle crash deaths			12	10
Drug poisoning deaths			6	13
Health Care				
Uninsured adults	21%	20%	20%	15%
Uninsured children			5%	4%
Health care costs	$8,484	$8,592	$8,607	$9,263
Could not see doctor due to cost	14%	11%	15%	11%
Other primary care providers			2,782:1	1,439:1
Social & Economic Factors				
Median household income	$69,258	$71,169	$71,682	$72,482
Children eligible for free lunch	46%	46%	49%	36%
Homicides			13	8

Prince George's County Data provided by County Health Rankings
http://www.countyhealthrankings.org/app/maryland/2015/rankings/prince-georges/county/outcomes/1/additional

As for the FY 2017 update factor, the thought that after two years under the GBR model, that a hospital can turn around its community is not realistic. From the tables above, you can see how complicated the changing of life long habits can be when all providers do not have the same financial incentives – GBR vs. volume. The hospitals are being held accountable for management by community-based physicians.

The most disturbing component of HSCRC staff's proposed update factor is the use of PQI to penalize hospitals. Some hospitals specialize in conditions unrelated to a PQI diagnosis. Thus, hospitals have lower or higher PQIs depending on the specialty services offered and using the PQI as a good or bad performance measurement distorts the results. Besides the social-economic factors are only sex and age, and not all the other differences that make Prince George's County's patients different are considered.

Three years ago we entered the GBR with the understanding that the GBR would have a reasonable inflation factor, population changes, and valid rewards/penalties. The PQI penalty seems to miss the validity of the update factor. Also, the HSCRC staff's inflation factor assumes that the Global Insights will again overstate the market basket forecast but in the past, Global Insights also understated the forecast. Hospitals have taken on the total risk of volume/case-mix, *and* price increases within the global budgets, while the forecast error is a significant adjustment to the *unit* cost increases, without recognition of the total risk we have assumed under the global budget. Why start to adjust the update factor in this fourth year of the GBR and chance that the hospitals find they cannot continue new and unique services that support community change? At the May 2016 commissioner meeting, it was said that HSCRC does not want to penalize hospitals who gave their staff market raises in prior years, but reducing a future inflation factor does just that by having hospitals choose how to deal with less funding for today's inflation.

We are supportive of the GBR, the Triple Aim, and the movement towards a healthier community. We just need a fair update factor to allow us the time to finish the projects mentioned in our Tables and start new projects that show Maryland is the model for the county. We look forward to further discussion of the MHA proposal with you, as the commission moves forward on this critical funding decision for the next year. Thank you for your consideration.

Sincerely,

Philip B. Down, CEO Sunil Madan, MD, CMO Camille R. Bash, CFO

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Appendix A: Monthly Population Health GBR Dashboard

Doctors Community Hospital

GBR Quality Measures

Source: HSCRC, as of 4/20/2016

	CY 2014 (Final) - Effects Rate Year 2016					CYTD 2015 - Effects Rate Year 2017						
	Result	Goal[1]	Rank	$ Impact	Revenue Impact[2]	Result	Goal[1]	Rank	$ Impact (Estimated)	Revenue Impact[2]	Data Period	Notes:
Readmission Reduction	-13.97%	-6.76%	5	$ 680,054	Reward	-6.47%	-9.30%	26	$ (398,000)	Penalty	January - December 2015	Improvement in risk-adjustment readmission rate vs. prior calendar year
MHAC	0.41	≥ 0.80	45	$ (234,501)	Penalty	0.45	≥ 0.80	39	$ 66,000	Reward	January - December 2015	CY15 % penalty/reward from monthly dashboard
QBR	0.45	1.00	18	$ 140,095	Reward	TBD	≥ 0.54	TBD	TBD	TBD	Data Unavailable	Need QBR scaling results for RY16
Market Shift	3.41%	> 0.00%	18	$ 231,321	Increase	0.83%	> 0.00%	29	$ (678,059)	Decrease	January - September 2015 (Preliminary)	Includes market shift reduction for infusion/oncology/etc
PQI Volume/Charges[3]	18.42%	0.00%	41	$ 18,719,206	Bad Volume	18.36%	0.00%	41	$ 17,768,767	Bad Volume	January - November 2015	PQI % of discharges. Dollar Amount is total charges reflective of PQI cases.
Total PAU Volume/Charges[3]	28.32%	0.00%	37	$ 45,713,838	Bad Volume	29.74%	0.00%	41	$ 43,609,775	Bad Volume	January - November 2015	Total PAU % of discharges. (Readmissions, PQI, PPC's). Dollar Amount is total charges reflective of PQI cases.

Note (1): Goals reflect maximum reward.

Note (2): Reward / Penalty: Reversed annually and new amount calculated each year.
Market Shift: Calculated annually by Product Line and zip code.
Bad Volume: Reflects actual dollar amount of PQI/PAU charges. These charges do not benefit the GBR cap.

Note (3): Results reflect the PQI/PAU percent of total discharges.

EXCEPTIONAL HEALTHCARE. EXCEPTIONAL PEOPLE.

PENINSULA REGIONAL MEDICAL CENTER

May 23, 2016

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

Dear Chairman Sabatini:

On behalf of Peninsula Regional Medical Center, this letter follows up on the current staff-recommended global budget update for fiscal year 2017. If the Health Services Cost Review Commission's (HSCRC) staff recommendation is adopted, it will jeopardize Maryland's momentum under the new All-Payer Model. In the past, the rate setting system updates have not been adequate, and once again the commission has recommended an unacceptable update. Additionally, PRMC and other Eastern Shore hospitals were excluded from the HSCRC's Transformation Implementation Program.

Constraining the hospital industry funding now, at this sensitive stage, would undermine our emerging success and threaten our ability to meet the waiver's continued requirements. The commission's support through reasonable funding levels early on has been an essential building block of the success to date. At levels as low as those proposed by HSCRC staff, Peninsula Regional Medical Center and other Maryland hospitals will be unable to pay necessary wage increases, meet the increased cost of core hospital operations, cover the increase in drug costs, maintain facility infrastructure, invest in improved electronic medical records, and follow through on population health initiatives in the community.

Of greater concern, an update this low calls into question the support required to move to the next generation of care coordination and transformation. Now is a time when the state and stakeholders must be united, sharing with federal officials and the nation our collective successes in the first two years of this model, and continuing to shape the hard work still ahead. An inadequate update will confirm concerns expressed all along about the model – that because of the total cost of care metric, PRMC and all other Maryland hospitals will be hampered in delivering truly innovative care, and reduced to simply chasing national Medicare performance. Cumulatively to date, Maryland has met every metric of the All-Payer Model and far exceeded most. Like many hospitals across Maryland, PRMC has outspent the funding provided in rates by the Commission for investments in population health. The delivery of care has changed and continues to evolve against a backdrop of exceedingly, and sometimes unrealistically, high expectations about the time and resources required to implement dramatic change, not only inside PRMC but also within our community.

Specific to PRMC, we have a larger structural margin issue that must be addressed, and the systematic erosion of our bottom line through inadequate rates jeopardizes our ability to continue as a tertiary referral center. As the Lower Eastern Shore's only tertiary referral center, we offer trauma care, open heart surgery, structural heart surgery, robotic surgery, comprehensive cancer care, neurosurgery, and we deliver more babies than all the other local hospitals combined.

Since 2010 PRMC has experienced update factors below inflation. In fiscal year 2013, PRMC experienced its first ever layoff since opening in 1897. While there was an improvement in the amount of the rate increase in fiscal years 2015 and 2016, those rate increases only provided a part of the funding of the infrastructure to begin our journey into population health.

The HSCRC FY 2017 proposed update factor for PRMC will be about 1.00%. This clearly does not allow for wage increases for employees and it will not cover supply inflation. We support the MHA's global update recommendation as it provides commissioners specific ways to turn the HSCRC staff's proposal from inadequate to helpful, without threatening the All-Payer Model's spending limits.

Population health has become a strategic focus at PRMC with the establishment of a new department and the appointment of a vice president assigned specifically to oversee hospital and community transformation initiatives. PRMC is located in a rural, geographically isolated area with Maryland's poorest county in its primary service area, as well as the proportionally highest elderly population in the state. As a result, it is essential that PRMC offer a robust community outreach program that prioritizes the prevention of readmissions and other potentially avoidable utilization. Through these efforts, PRMC's risk-adjusted readmission rate has improved by 3% through CY2015 vs the base period CY2013, and was 11.90% to start, which was in the top quartile.

Peninsula Regional's mission is to improve the health of the communities we serve. We are no longer just in the hospital business; we are in the health business, with an emphasis on preventing illness, keeping our community healthier, improving quality and lowering costs. The change has been revolutionary. Below are a few examples of the actions PRMC has taken to reduce potentially avoidable utilization of hospital services:

- Administered over 6,000 annual community flu shots (including a drive-thru flu clinic)
- Monthly community education via public access programming
- Opened an on-site pharmacy, *HomeScripts,* for 30-day first fills
- Created a focused transitional care nursing team
- Implemented standardized education for clinical and physician staff
- Enhanced discharge processes (including verbal and written instructions)
- Created dedicated emergency department case managers deployed across the unit
- Implemented follow-up appointments within 72 hours for high-risk discharges
- Assigned pharmacists to high-risk hospital units

- Developed a 24 hour RN-staffed patient call line for high-risk patients
- Implemented the Philips Lifeline CareSage program to identify inpatients at risk for falls
- Enacted a falls prevention and education program in cooperation with Maryland Active Citizens, Inc (MAC) to identify ED patients at risk for falls at home with referral to a proven falls prevention program
- Awarded a CMS Transformational Care Practice Initiative (TCPI) grant to assist independent local providers
- Actively engaging skilled nursing home clinical and administrative leadership to drive down hospital utilization/readmissions
- Developed standardized education modules on CAUTIs and UTIs in the post-acute care and community setting
- Implemented a medically based weight loss program
- Delivered education to community providers on PAU and other population health initiatives
- Applied lean principles of standard work to derive improvement of processes
- Engaged physicians on all quality initiatives
- Provide diabetes awareness, education and management to the community

In addition, PRMC has been working across the continuum with a multitude of community partners in non-hospital settings to reduce total cost of care.

- Developed partnerships with local law enforcement, health department and other community providers to address a local opioid epidemic
- Formed a strategic partnership with the YMCA for health and wellness initiatives
- Sponsor of an annual health fair with the Wicomico County Board of Education offering free screenings and education to over 1,200 residents
- Partnered with a home health agency on medication reconciliation
- Provided funding and partnered with Lower Shore Clinic-CareWrap program-targeting primary and mental health at-risk patients to reduce readmissions
- Working with the United Way, Wicomico County Library and Rotary Clubs to develop and implement a health literacy program to provide basic health information to poor and underserved members of our community
- Partnered with Maryland Active Citizens, Inc (MAC) to provide falls prevention, cancer support, chronic disease management and chronic disease self-management
- Use of PRMC's Wagner Wellness van (a mobile clinic) in conjunction with Urban Ministries to provide primary care and screening services
- Worked with our joint venture partnerships for home health, durable medical equipment, SNF, outpatient rehab, diagnostic imaging and ambulatory surgery to reduce total cost of care
- Created a clinically integrated network/accountable care organization (ACO) with independent physician practices, Three Lower Counties (TLC) a Federally Qualified Health Center and PRMC's own medical group

- Actively working with the regional SNFs and Acute Rehab facilities to reduce readmissions and ED use with nurse case managers who round on-site with the SNF teams.
- Submission of the first "regional" grant as a partnership with all three hospitals that included strategies to impact gaps in care that exist on the Lower Eastern Shore. The entire community was engaged in the development of this request for funding, including all Health Departments, local churches, skilled nursing facilities, non-profits, home health, local FQHC, and others.

These valuable programs, by their episodic and ongoing nature, are time-consuming but incredibly impactful beyond the short run. Redesigning a hospital delivery system focused on population health and value-based payment models is a Herculean task; it involves not only brick and mortar structural changes, but a wide array of process changes in both the inpatient and outpatient environment. Cultural changes need to be fostered in both acute-care hospitals as well as post-acute care and office-based practices. The seeds of these structural and cultural changes have been sown, but regulatory patience is required while we work together to orient our entire system of care delivery toward population health and wellness.

Approving an update that is far below inflation and sets aside available funding only to some hospitals via an application process means commissioners put at risk wage increases for workers and the ability of hospitals to keep up with the basic operational costs...much less the investments required to improve community care and reduce utilization. As discussions evolve concerning the rate structure, hospitals are at the forefront of an evolutionary change. Maryland hospitals are struggling to strike a balance during this transitional period, and are the only entities at risk for the success of the All-Payer Model. A reasonable update is critical for the continued success of the new All-Payer Model, and based on the cumulative savings so far, there is plenty of cushion.

We look forward to further discussions as the commission moves forward on this critical funding discussion.

Sincerely,

Peggy Naleppa, MS, MBA, DrM, FACHE
President/CEO

CB Silvia, MD
Chief Medical Officer

Bruce Ritchie
Chief Financial Officer

Monty Sayler
Chairman, Board of Trustees

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Administration

May 23, 2016

SENT VIA ELECTRONIC MAIL; ORIGINAL TO FOLLOW VIA US MAIL
Nelson J. Sabatini
Chairman, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Chairman Sabatini:

We write on behalf of MedStar Franklin Square Medical Center ("MFSMC") to express our serious concerns surrounding the current staff-recommended global budget update for fiscal 2017.

MFSMC, a non-profit, community teaching hospital that relocated to Eastern Baltimore County in 1969, serves a very diverse patient population. In the southeast portion of Baltimore County, the estimated percentage of all people whose income is below the federal poverty level is 11.4 percent, compared to 8.2 percent in all of Baltimore County (American Community Survey, 2007-2011). Four of the zip codes in MFSMC's service area (21206: Overlea; 21221: Essex; and, 21222 and 21224: Dundalk) have poverty rates that are considerably higher (11.0-19.2%) than the Baltimore County average. Rates in MFSMC's service area for asthma, heart disease, hypertension and cancer are all higher than rates in Baltimore County and the State as a whole. The Baltimore County Local Management Board identified a small community (3 census block groups) within the Essex zip code that annually produced the most negative birth outcomes, including infant mortality, babies born of low birth weight, and births to adolescents in the State of Maryland.

MFSMC has made serving these needs a priority if we are to succeed in a manner called for in the revised Waiver the State of Maryland entered into with CMS.

Rate Increase for MFSMC is 1%; NOT the 2% Being Presented

For MedStar Franklin Square, the staff proposal translates into an approximate 1% rate increase, not the 2% that is being presented to the public. As the leadership of MedStar Franklin Square, we believe—in fact, we know— the staff proposed update factor will

jeopardize the momentum we have made based on IHI's Triple Aim framework. Further, we believe the staff proposal represents an overcorrection that would jeopardize the State of Maryland's momentum under the new All-Payer Model. We believe, based on more current data than used by HSCRC staff, that a higher update can be provided without encroaching on the staff-recommended Medicare total cost of care cushion.

Proposed Global Budget Update Does Not Adequately Recognize Inflation; Will Lead to Further Job Losses & Program Closures

As the leaders of MFSMC, we believe that constraining hospital funding now will not only lead to a reversal in the investments we have made to manage the population's health (which will be discussed below), but also require us to reduce employment beyond the most recent workforce reductions. The initial reductions put in place in April and May—totaling 122 positions or 4% of MFSMC's workforce—were made based on an update factor of 2.6%. These decisions were necessary as a result of increases well in excess of inflation in such areas as pharmaceuticals & medical supplies and compensation increases made to retain a well-qualified workforce. We believe these increases are further proof that the staff proposed update factor is too low given its assumption that health care inflation is 1.72% (against a projected 2.49%).

Regrettably, should the proposed update factor be implemented, MFSMC will be forced to reduce employment further and close certain non-rate regulated centers that serve our community (e.g., Women's & Children's Center).

MFSMC Has Invested in Population Health Beyond Funded in Rates

Since the initiation of the new waiver with CMS, MedStar Franklin Square has invested in the development of a Population Health Division. The funds invested in the Population Health Division exceed those provided by the HSCRC update factor in fiscal years 2015 and 2016.

We believe our initiatives and partnerships have been extremely valuable to achieving the objectives outlined in the Triple Aim framework. The first initiative is our work with the neighboring Genesis Franklin Woods Nursing Home. We have instituted a Congestive Heart Failure Team ("CHF Team") whose focus is to manage patients in the Nursing Home with the goal to provide proactive care and, in doing so, reduce admissions (and readmissions) to MFSMC. The CHF Team consists of cardiologists, case managers, social workers, pharmacists, and transitional care nurses from MFSMC, as well as a dietician, social worker, and cardiac rehabilitation specialist from Genesis Franklin Woods. In CY16, patients in this program have seen a significant reduction in their 30-day readmission rates: from 28% to 11.5%.

We are also proud of the initiation of a Navigator Program within our Emergency Department intended to link ED patients with primary and specialty care providers so that we reduce unnecessary ED utilization and provide greater continuity of care for patients who have chronic medical conditions. In FY 2015, MedStar Franklin Square saw a reduction of approximately 3,000 ED visits. Some of this ED visit reduction can be attributed to this initiative. MedStar as a system has also established Palliative Care Programs in many of the System's nine acute care hospitals, including MFSMC. MFMSC's Program was initiated in FY 2015 and is currently staffed by a full-time physician, pharmacist and social worker.

Finally, MFSMC is also pleased with the outcomes of the work by our Department of Family Medicine which is managing the health of approximately 11,000 patients and has entered into shared savings initiatives with certain commercial payers. The shared savings are based on performance in reduced hospital utilization (ED and inpatient). The mainstay of this initiative is the investment in a Care Coordination Program ("CCP") for those patients at highest risk for avoidable high-cost utilization. The CCP includes care by a multidisciplinary team, a home visit program, telemedicine follow-up visits, and a community-based team of community health workers, advocates and primary care providers. To-date, our results have demonstrated significant savings of nearly $11,000/month in avoidable inpatient utilization and $9,000/month in avoidable ED visits for participants in the CCP.

MFSMC is also part of a new Regional Partnership with the John Hopkins Hospital, John Hopkins Bayview Medical Center, MedStar Harbor Hospital and Sinai Hospital. Our Regional Partnership Grant received partial funding starting in FY17. We are thankful for the additional funding, but the continued constraints on needed dollars will make it difficult to fully meet the goals of the New Waiver.

Also of note is the staff recommended Global Budget Update factors including an additional 0.65% for shared savings, a total of 1.25% over the three years, without being provided adequate rates or funding for programs to achieve the outcomes or savings.

Now is Not the Time to Withdraw Support

Federal officials have recognized the success of the new CMS waiver in its first two years and cite the Maryland waiver experiment as a new model that moves providers to improve community health outcomes, improve quality of care and reduce the cost of care. The State of Maryland has moved extraordinarily fast to adapt to the new CMMI Waiver metrics and can claim success in our first two years. We do not believe the proposed Global Budget Update will allow us to sustain the momentum of the last two years.

It is for this reason that MedStar Franklin Square respectfully requests that the HSCRC increase the FY 2017 Global Budget Update factor to 2.6%. With a rate increase of 2.6% in FY 2017, the State will be well below the 13.1 percent ceiling. In addition, our cumulative Medicare savings will far exceed the target (even if we do not produce any additional savings in FY 2017). Finally, while Medicare's total cost of care grew faster than the nation in 2015, Maryland did not exceed the waiver's ceiling. This increased funding will provide for the investments needed to meet the ultimate objective guiding the Waiver Demonstration entered into by the State of Maryland with CMMI.

We stand ready to answer any questions you may have. Thank you.

Most sincerely,

Michael Dietrich
Chair, Board of Directors

Samuel E. Moskowitz, FACHE
President, MedStar Franklin Square Medical Center
Sr. Vice President, MedStar Health

Stuart M. Levine, FACP
Vice President of Medical Affairs & CMO

cc: Herbert S. Wong, Ph.D., Vice-Chairman
Victoria (Tori) W. Bayless
George H. Bone, MD
John M. Colmers
Stephen F. Jencks, MD, MPH
Jack C. Keane
Donna Kinzer, Executive Director
Mike Robbins, MHA
Kathy Talbot, MedStar Health

MedStar Southern Maryland Hospital Center

May 23, 2016

Commissioners, Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Commissioners:

We are writing to detail our response to recent deliberations at the HSCRC meetings, specifically over the stated concerns of some Commissioners that some hospitals are not focused enough on reducing avoidable utilization and reining in Medicare total costs of care.

Please allow me to detail for you some of our efforts at MedStar Southern Maryland Hospital Center (MSMHC). With the purchase of the hospital by MedStar Health, the first focus was on driving quality and safety improvements. Significant progress was made in both arenas including considerable and important turnover in providers, improvements in Core Measures to result in MSMHC being named one of the Joint Commission's Top Performers in Key Quality Metrics last Fall, and a run of twenty-four months of zero ICU CLABSIs, among others. We offer some further examples below.

- To address Potentially Avoidable Utilization of hospital services, we are staffing case managers in our Emergency Department (ED). We also have a Behavioral Health Social Worker in the Emergency Department to coordinate services for those patients who can be discharged from the ED. Additionally, we are partnering with the Prince Georges County Health Department to provide grant funded Social Workers. We have invested in new Case Management software across our MedStar Health system to facilitate more effective management of our inpatient clinical cases, with the objective to reduce the number of days leading up to potential denials and improve the care coordination. We have also improved the engagement of payers to plan more strategically for their at risk patients.

  Further we have a Length of Stay Reduction initiative focused on streamlining processes particularly around the last 24 hours of the stay. This includes identifying test results more timely and preparing patient families for discharge expectations. We have an ongoing review of observation cases to ensure appropriateness. We also offer education to our patients and guidance on resource utilization in the ED.

- Regarding our work with community partners in non-hospital settings, we have participated with our Nursing Home partners to provide lab services to reduce the need for Emergency Room visits. We opened a Medical Specialty Unit to accommodate chronic vent patients from the Nursing Homes such as Pineview, which accepts chronic vent patients. This helps us to avoid patients having to be admitted to the Intensive Care Unit or have prolonged stays there.

Also regarding our work with non-hospital settings, we are establishing a Transitional Care Clinic to reduce readmissions to MSMHC. The staff will include a Nurse Practitioner, a Registered Nurse Case Manager, as well as, a Registered Nurse. Finally, we have joined with our fellow Prince George's County hospitals to learn from recent HEZ demonstration projects and to identify community care collaboration opportunities.

We are indeed a hospital committed to the care transformation goals of the Maryland All-Payer Model and thus are also committed to ensuring that there is adequate funding to create the infrastructure necessary to make the connections and hand-offs to community providers and alternatives. Within the current model, the only entities at risk for the Model's success are the hospitals. However, success is dependent upon many other organizations, not to mention patient compliance.

The cumulative savings the Model has already secured for Medicare, Medicaid and the commercial payers ensure that a reasonable update factor can be provided that will be far below the Model's spending guardrails. Moreover, approving an update that is far below inflation and that sets aside funding available only to some hospitals via an application process, means Commissioners would put at risk wage increases for workers, and the ability of hospitals to keep up with the basic costs of running a hospital, much less the investments required to improve community care and reduce utilization. A low update factor such as that proposed would cause MSMHC to undoubtedly reduce further positions, as significant cuts have already been made this year in order to fund these new initiatives.

Finally, we support the MHA Fiscal Year 2017 Global Budget Update recommendation and believe it provides the commissioners specific ways to turn the HSCRC Staff's proposal from inadequate to helpful, without threatening the All Payer Model's spending limits. We would appreciate your serious consideration of this recommendation.

Regards,

John W. Rollins	Christine R. Wray	Yvette Johnson-Threat, MD
Board Chairman	President	Vice President, Medical Affairs

CC: Mike Robbins, Senior Vice President, Rate Setting, Maryland Hospital Association
Michael Curran, Executive Vice President, Chief Administrative & Financial Officer, MedStar Health
Kathy Talbot, Vice President, Rates & Reimbursement, MedStar Health

Adventist HealthCare

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

May 23, 2016

Dear Chairman Sabatini:

On behalf of Adventist HealthCare (AHC) and its member hospitals, Washington Adventist Hospital and Shady Grove Medical Center, we want to thank you for the opportunity to provide comment on the Draft FY 2017 Update Factor Recommendation presented at the May 11, 2016 meeting. AHC has been and continues to be committed to improving care coordination to ensure that our community receives health services and interventions in an efficient and effective manner that ultimately leads to more efficient use of healthcare dollars with improved outcomes. AHC recognizes great opportunity to gain efficiencies and generate savings through improved care coordination and the reduction of unnecessary utilization, however continued investment in programs to redesign and transform the delivery system are necessary to generate significant stakeholder engagement and alignment against a common goal.

While there is significant work going on within our hospitals to put in place processes to reduce readmissions, hospital acquired conditions and unnecessary length of stay, AHC believes that in order to achieve significant reductions in unnecessary or preventable high cost care, engagement and alignment of stakeholders across the entire care continuum, including areas outside of the health systems' direct control is necessary. Unfortunately, reimbursement models for the entire care continuum are not yet fully aligned which requires AHC to provide funding to help our provider partners that are still reimbursed on volume maintain financial stability as we engage them in our goal of improving the health of our community and ultimately driving down utilization. Additionally, even with a high level of engagement in this common goal, we see a need for continued investment to address gaps in access to primary care and preventative services for the uninsured and underinsured population in our community. We believe that addressing this gap is critical to ensuring that the health needs of this population are met to avoid unnecessary ED visits and prevention of avoidable inpatient admissions and readmissions. Below is a summary of some of the investments and programs at AHC related to improving care coordination:

Physician led strategies for improving care coordination:

- Developed and provide continuous funding and management to a Medicare Shared Savings ACO in conjunction with many community based physicians
- Developed and funded a separate clinically integrated network of community physicians with the physicians co-managing this network expressly for the purpose of improving quality and lowering cost
- Implementation of care coordination workflow and analytics software which provides the physicians critical information to better manage high risk populations

- AHC Infection control physician rounding at high volume referring nursing homes
- Contracts to better align waiver goals and provide financial support to hospital based physicians for reductions in unnecessary utilization

Hospital led strategies for improving care coordination and transitions:

- Implementation of electronic medical record sharing with Skilled Nursing, rehabilitation and home health providers
- Addition of Care Transitions nurses and case managers to ensure adequate post discharge follow-up and compliance, including in-home follow-up
- Implementation of telehealth monitoring and follow-up
- Discharge medications provided to patients at the bedside prior to discharge
- Enrollment of high risk medical and psychiatric patients in community based care management programs
- Constant and continuous engagement of senior hospital leadership and physician leadership in care coordination planning and monitoring activities.
- Additional resources for more robust patient discharge and outpatient education programs related to chronic disease management

System Investments to provide improved access for un- and underinsured patients:

- Investment and continued funding for FQHC (CCI) on Washington Adventist Hospital Campus
- Collaboration with FQHC to provide a continuum of care to some of our most vulnerable patient populations, including screenings to ensure that our patients have access to things such as housing, childcare, transportation, food, CHIP, free and reduced school meals, utility assistance, water assistance, WIC, telephone assistance, free tax preparation, etc. that have a direct effect on an individual's health outcomes.
- Additional investments in primary care practices in Montgomery County

Participation in multi-stakeholder collaborations to reduce avoidable utilization and provide improved care for high risk populations:

- Collaboration and work with all other hospitals in Montgomery County to develop NexusMontgomery, a regional partnership dedicated to developing and implementing community wide outpatient focused strategies to enhance care coordination and disease management
- Development of the Centers for Heath Equity and Wellness, a recognized leader within the state for research and education regarding health disparities, community health improvement and impact on the social determinants of health

Under the new waiver, hospitals bear all the risk related to the model's success. In addition, almost all hospital revenues are now covered under global budget or total patient revenue caps, which removes the risk for increased hospital utilization from the system. In order for the hospitals to manage this risk while also investing in programs to continually reduce avoidable utilization, the hospitals require adequate annual updates. Without sufficient annual updates that allow for stable and reasonable margins, hospitals will be faced with difficult decisions related to cost cutting which could impede the progress of achieving the goals of the model. If the current HSCRC staff proposal is adopted, both SGMC and WAH could be subject to revenue reductions in FY 2017 (see estimate below) which places considerable strain on AHC's ability to provide adequate wages to maintain an engaged workforce and keep up with inflationary increases on basic hospital costs, much less to continually invest in care coordination, improved access to primary care and alignment of stakeholders in the care continuum at a level to achieve desired results.

Hospital Specific Revenue Updates:	SGMC	WAH
Adjustment for Inflation	1.72%	1.72%
Allowance for High Cost Drugs	0.00%	0.00%
Net Shared Savings	-0.65%	-0.65%
Population/Demographic Adjustment (est.)	0.52%	0.56%
Quality Scaling (not final)	0.03%	-0.73%
Market Shift	-0.92%	0.22%
Uncompensated Care Funding (est.)	-1.20%	-3.20%
Total Revenue Increase/(Decrease)	**-0.50%**	**-2.08%**

AHC recognizes the constraints of the waiver but analyses by the HSCRC staff show that the HSCRC can provide additional update without risking the current guardrails of the model including both the per capital test and the total cost of care measure. AHC respectfully requests that the Commissioners consider the strain that suppressed update factors place on hospitals ability to invest in long term care coordination and care delivery redesign strategies that do not produce immediate financial savings to the hospital but are required to achieve material reductions in avoidable utilization over a longer period of time.

We support MHA's Fiscal Year 2017 Global Budget Update recommendation. We want to thank you again for the opportunity to provide you with more information regarding the many initiatives related at AHC intended to transform care delivery to provide more efficient and cost-effective care. We hope that the this letter conveys that AHC is fully committed to the care transformation goals of the all-payer model while also providing you with information to support MHA's Update recommendation.

Sincerely,

Terry Forde

Terry Forde
President & CEO
Adventist HealthCare

James G. Lee
Executive Vice President & CFO
Adventist HealthCare

JOHNS HOPKINS
MEDICINE
JOHNS HOPKINS
HEALTH SYSTEM

May 23, 2016

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

Dear Mr. Sabatini:

The purpose of this letter is to provide Johns Hopkins Health System's comments on the staff's recommendation on the update factor for FY2017. We appreciate the opportunity to provide comments.

JHHS has always supported Maryland's All Payer System with its improved equity for Maryland patients and for the access it has provided by funding the social costs of providing hospitals services in the State. We continue to support the system as it has transformed into the Hospital All Payer Model with CMMI, with its new emphasis on population health. We believe that this is the right path to improve the quality of care for patients and to align payments with improved population health efforts.

Recognized Successes

We have completed the first two years of the model and the system has generated Medicare savings well ahead of those scheduled in the model agreement with CMMI. The system has also delivered per capita hospital spending well below the 3.58% all payer limit established under the agreement.
While this performance is extraordinary, we must take time to consider the broader question of system needs. Hospitals are being asked to fund a number of population health initiatives and their related infrastructure as well as the routine costs of operation such as wages, medical supplies, drugs and capital costs. Funding that was once generated through hospital volume is no longer available under the new model. To fund these expenses and generate margins to maintain our mission, the FY 2017 update factor needs to be a minimum of 2.49% to fund projected inflation for the upcoming fiscal year.

Funding Other Investments

Achieving our tripartite mission of patient care, teaching and research (and meeting the requirements of the Waiver) requires transformation of the systems, technology, behavior and performance of our large health care system. Such a transformation requires an enormous investment of resources, time and comprehensive population health solutions. There is evidence that some population health methodologies are cost effective and can achieve both a clinical and financial return. But there is much to be learned about which programs achieve the desired clinical outcomes and justify the large expense over the long term. Thus, innovation and experimentation in care delivery will be critical to our long term success. Moreover, we do not know the effects these changes in care delivery will have on the immediate health of Maryland's residents. This is of the utmost

importance and must be carefully measured and monitored. Moving too fast may have unintended consequences and adverse effects on patients and providers.

While we believe these efforts are worthwhile and can ultimately improve care for Maryland patients, we must use this opportunity to voice our concern over the update factor for FY2017 recommended by the staff. While the Commission has included money for population health initiatives, the amounts have been limited – and the funds have been designated for specific purposes with corresponding expenses, not for patient care expenses. Hospitals are expected to fund clinical innovation, new information technology, and infrastructure improvements to support population health initiatives. These needs have to be funded along with wage increases for our employees, capital replacement to maintain our facilities, rising drug and supply costs, true medical innovation and breakthroughs, higher severity cases only treatable at research based AMCs, and real use rate growth associated with an aging population in areas such as oncology, orthopedics and others. If an appropriate level of funding is not provided hospitals will need to evaluate the financial viability of clinical programs that the population currently has access to.

Efforts to Reduce Potentially Avoidable Utilization

JHHS is actively working within this new system to transform the care we deliver. We are working hard to reduce potentially avoidable utilization (PAU) and we are making significant investments in population health programs that are designed to improve quality, safety and efficiency of care and to assure success of the Waiver (more detail by hospital is provided below). The results of most of these initiatives will be realized years from now as the population changes behavior over different generations. However the system assumes that financial results will be realized immediately to fund necessary operating expenses.

The Johns Hopkins Health System – Summary of Strategic Hospital Transformation Plans

The Johns Hopkins Health System Academic Division Overview and Outcomes

The Johns Hopkins Hospital
The Johns Hopkins Bayview Medical Center

In December of 2009, a Johns Hopkins health system wide taskforce was created to begin to transform acute patient care delivery in order to achieve the "triple aim" of "better health, better care and lower cost." The recommendations from this taskforce were translated into the JHHS "care coordination bundle" informed by CMS demonstration projects and emerging evidence that individual interventions targeting a single aspect of care delivery tended to have limited impact on utilization rates, and that bundled interventions fostering coordinated care processes may have significant impact on care delivery, quality outcomes, and utilization.

The implementation of these strategies began in earnest in April of 2011 with the initiation of pilot units across all of the JHHS entities. The targeted populations for intervention were ALL hospitalized patients and vulnerable Medicare and Medicaid patients from the 7 zip codes surrounding the East Baltimore and Bayview Campuses.

Over the 3 years since work began, the JHH and JHBMC care coordination bundles were expanded to include the majority of adult inpatients as well as outpatients served in the Emergency Department. The patient-centered care coordination concepts were embedded in the Johns Hopkins Medicine Strategic Plan and continue to be evaluated, modified and expanded as new evidence emerges and our own experience and outcomes analysis inform our strategies. The "bundle" addresses care coordination that transcends the inpatient setting and is focused on transitional care strategies to return patients to their optimal level of care.

Our experiences over the last five years in improving care delivery have yielded positive outcomes as well as helped to inform us of the challenges in implementing cross continuum care coordination processes and the identification of factors that influence the success of these strategies. Risk screening tools are highly effective, but low sensitivity requires the use of other methods to augment appropriate patient identification. Patients identified as "high risk" fit a multitude of profiles which do not necessarily suggest a specific collection of chronic conditions, socio-economic disparities, or payer, but reflect other variables not easily measured by severity of illness or other indicators available through administrative data. The definition of what constitutes "high risk" is critical in determining appropriate interventions at the right juncture in the health illness continuum. The current literature expands on the concept that the characteristics of patients most at risk for increased utilization include such factors as patient activation and healthcare literacy, social support at home, functional status as well as type and amount of disease burden.

The Johns Hopkins Hospital – Early Outcomes and Strategic Objectives

From FY 2014—2015, of the 44,376 JHH eligible adult discharges, almost 40% received a high intense care coordination intervention in addition to the standard care coordination bundle for all patients. Of the patients who received high intense interventions (as identified by risk), nearly 50% were Medicare, and 18% were Medicaid or Medicaid Managed care. Two of our major strategies for post-acute follow-up include post-discharge phone calls for all patients returning home (without home care), and home visits by a Registered Nurse *"Transitions Guide"* for our highest risk patients. For both of these programs, adjusted data demonstrate a significant reduction in readmissions for those who received the intervention versus those who could not be reached or refused the intervention. Propensity analyses of these interventions highlight the inherent challenges in improving readmission and utilization rates at Johns Hopkins. The variables that are associated with higher readmission rates are also the same variables that predict whether a patient will be successfully reached by one of the care coordination interventions. In other words, the precise people that we want to reach with our interventions are the patients we are least likely to reach. These results highlight the importance of patient engagement in driving change.

Our work in transforming patient care delivery through a model for care coordination has yielded positive results and improved clinical outcomes in numerous domains. Both internal and external (CMS) early evaluation suggests reductions in 30 day readmissions as well as total cost of care for Medicare beneficiaries in the 90-days following discharge.

Strategies to increase acceptance for post-acute services and engagement to recommended follow-up plans are paramount to yield the desired outcomes of better health and lower utilization. Patient/family centered care requires the partnerships between patients/caregivers and providers to empower patients for shared decision making while acknowledging patient goals and preferences for treatment. While we have been able to successfully implement many of our targeted strategies for all hospitalized and high risk patients, many of our challenges are related to systemic processes that contribute to barriers for timely access to care, provider communication and handoffs, as well as the availability of appropriate community services for our high needs populations. Our strategic Johns Hopkins Hospital objectives are focused on the expansion of our current cross continuum care coordination model and addressing the major systemic barriers impeding our progress. These include the following.

- **Access to Urgent Care**: Provide alternatives to ED visits and/or hospitalization for the provision of services to address acute healthcare needs, bridging the service gap between the Medical Home and the Hospital.

- **Care Coordination Across the Continuum**: Include care coordination services as a core component in programs that service high risk patients, including those with multiple chronic conditions, mental illness and addictions across the continuum of care.
- **Patient/family Engagement**: Enhance strategies to improve patient engagement for active participation in healthcare decisions and self-care management.

The Johns Hopkins Bayview Medical Center – Early Outcomes and Strategic Objectives

From FY 2014—2015, of the 28,133 JHBMC eligible adult discharges, 48% received a high intense care coordination intervention in addition to the standard care coordination bundle for all patients. Of the patients who received high intense interventions (as identified by risk), 62% were Medicare, and 18% were Medicaid or Medicaid Managed care. Two of our major strategies for post-acute follow-up include post-discharge phone calls for all patients returning home (without home care), and home visits by a Registered Nurse *"Transitions Guide"* for our highest risk patients. For both of these programs, adjusted data demonstrate a significant reduction in readmissions for those who received the intervention versus those who could not be reached or refused the intervention. Propensity analyses of these interventions highlight the inherent challenges in improving readmission and utilization rates at JHHS. The variables that are associated with higher readmission rates are also the same variables that predict whether a patient will be successfully reached by one of the care coordination interventions. In other words, the precise people that we want to reach with our interventions are the patients we are least likely to reach. These results highlight the importance of patient engagement in driving change.

The most recent JHBMC Community Health Needs Assessment identifies the health needs of our community as: Adult and childhood obesity; Addiction and mental health problems in adults and children; the sequelae of chronic illness; and access to care for Spanish and non-English speaking individuals. These problems are clear in our work on hospital readmissions and ED utilization where patients with heart failure, COPD, diabetes, heart disease, addictions and mental illness are those most often readmitted to the medical center. The JBMC leadership has incorporated our learning from our readmissions work, the evidence from the CHNA and the guidance from Healthy Baltimore to create the strategic plan for transformation summarized below.

Our work in transforming patient care delivery through a model for care coordination has yielded positive results and improved clinical outcomes in numerous domains. Both internal and external (CMS) early evaluation has demonstrated a statistically significant decrease in 30 day readmissions as well as total cost of care for Medicare beneficiaries in the 90-days following discharge.

Building on this success, JHBMC will continue to redesign care delivery systems to improve accessibility, to foster patient and family engagement, and to build on current and future partnerships with community organizations to meet the needs of our patient population. The JHBMC strategies support these three areas of transformation.

- **Access to Care**: Improving access to primary care, specialty care, and urgent care. Particularly, for patients and families with high risk, chronic illness, including addictions and mental health.
- **Care Coordination Across the Continuum**: Includes focusing on patients with high-risk conditions and deploying strategies for patient/family engagement and care.
- **Quality and Efficiency:** Improving quality and efficiency of inpatient, outpatient and emergency department care through implementation and monitoring of clinical best practices for high risk populations.

Howard County General Hospital – Strategic Objectives

The Maryland Waiver presents hospitals with a glide-path for change to realize health system transformation. Howard County General Hospital (HCGH) is committed to developing the Howard County Regional Partnership (HCRP) as the primary vehicle to coordinate efforts that improve the care delivery system and improve population health for our community.

- Improve care coordination to ensure seamless transitions between care settings and better manage patients' complex needs, focusing in particular on post-acute care coordination and processes to connect patients with multiple chronic conditions and significant social determinants to community-based resources and programs.
- Develop data analytics infrastructure to support population health goals as outlined by the HCRP and provide real-time decision support for providers. Ultimately, we want to be able to proactively manage the health of the community instead of waiting for hospital utilization to intervene.
- Involve primary care providers in the development and execution of a specific action plan to create an effective continuum that ensures access to care in the most appropriate setting. As HCRP focuses initially on a pathway for provider referrals to a community-based care coordination intervention for high-risk Medicare beneficiaries, the hospital will work with primary care practices to determine the top two to three projects that need to happen in calendar years 2016 and 2017 to achieve better provider alignment.
- Improve access to urgent care mental health services. There are several gaps in the care continuum for behavioral health here in Howard County. This has been identified not only by our community health needs assessment but also by our Local Health Improvement Coalition as well as by a recent Howard County Behavioral Health Task Force. One such gap is a lack of access to urgent care mental health services. HCGH, with support from the Horizon Foundation, partnered with Way Station, Inc. to pilot a rapid access program. The pilot runs from September 1, 2015 through August 31, 2016. Although initially a short term investment, we will evaluate the program's effectiveness in order to determine what longer term investments are needed.

Suburban Hospital – Strategic Objectives

Suburban Hospital supports the CMMI and HSCRC efforts at healthcare transformation. Achieving these goals is essential to the success of the all payer system and a commitment that will permeate throughout our hospital culture. Our goals include:

- Coordinating care across the continuum in a structured, organized and efficient manner,
- Aligning hospital based and community practicing physicians to support the needs of patients with chronic conditions and high utilization , and;
- Strengthening patient education processes to provide relevant on time information to change patient's behavior and improve post-hospitalization compliance and potentially avoidable utilization.

The All Payer Model has offered an innovative approach to addressing problems that we faced under the old waiver model and has placed Maryland hospitals at the center of national efforts to transform the delivery system. We continue to support these efforts while noting that we are working in large complex organizations that require time to change. After only two full years of the model, we have made remarkable progress, and that progress can continue if we work together with a balanced funding approach. We appreciate the opportunity to comment on the staff recommendation.

Sincerely,

Ron Werthman
Sr. VP and CFO, Johns Hopkins Medicine and
CFO of Johns Hopkins School of Medicine

Carl Francioli
CFO, Johns Hopkins Bayview Medical Center

Jim Young
CFO, Howard County General Hospital

Marty Basso
CFO, Suburban Hospital and Sibley Memorial Hospital

Cc: Nelson J. Sabatini, Chairman

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

Victoria (Tori) W. Bayless

George H. Bone, M.D.

John M. Colmers

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

Jack C. Keane

Donna Kinzer

Calvert Memorial Hospital
Tradition. Quality. Progress.

May 24, 2016

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

Chairman Sabatini:

I am writing on behalf of Calvert Memorial Hospital in Calvert County, Maryland. The proposed rate update for FY 2017 from the HSCRC will undermine our hospital's ability to continue the groundbreaking work we've undertaken to meet the care transformation goals of the all-payor model and it will threaten our ability to meet our operating plan without significant cuts to wages, quality improvement initiatives and critical technology. We urge you to consider the MHA Fiscal Year 2017 Global Budget Update recommendation.

At Calvert, we have wholeheartedly embraced the goals of better managing chronically ill, high-risk patients and reducing potentially avoidable readmissions. In fact, in 2015, Calvert Memorial Hospital had the second lowest readmission rate in the State of Maryland. We largely attribute this achievement to our investments in community outreach, chronic disease management and wellness. Since FY11, Calvert has spent $13.5 million in programs aimed at improving the health and wellness of our community. A key part of our chronic disease and readmission reduction program is the "Calvert Cares" initiative - a multi-faceted outreach program focused on the identification and proactive management of patients at the highest risk for readmission. Since the program's inception in the first quarter of 2014, we have leveraged case managers, social workers, physicians and pharmacists to coordinate the care of these vulnerable patients outside the hospital setting. In the first year of the program, we saw a 30 percent reduction in nursing home patient readmissions, a 27 percent reduction in Medicare patient readmissions and a 38 percent reduction in all cause readmissions. In 2016, the program was recognized as a leading edge initiative by the Maryland Patient Safety Center with a poster display at the Maryland Patient Safety Conference. All the services provided under this program are free of charge and offered as a community benefit with a goal of improving patient outcomes and reducing overall healthcare costs.

This year, we had hoped to expand the program's success to a larger group of at-risk patients, potentially contributing to an even larger reduction in avoidable health care utilization. We applied for the HSCRC regional grant which would have covered the cost of this expansion, but we were not approved for the funds. Now, news of the proposed update factor will force us to

not only eliminate the *expansion* of the program, but to consider cuts to the existing program which is showing so much promise. It is heartbreaking to have to eliminate important population health initiatives that are showing great progress at a time when Maryland hospitals are being asked to work with community partners to reduce the overall healthcare spending. It is frustrating to have achieved great success in a program that other hospitals are trying to emulate, only to have the funding removed from our budget and re-directed to other select hospitals through a grant process.

In addition, the update factor as it stands will make it impossible for us to meet our operating budget requirements without eliminating a wage increase for our employees or reducing spending on other critical quality initiatives. As the second largest employer in Calvert County, a freeze on wages has a ripple effect throughout our community.

We strongly believe that the proposed update factors will adversely affect the work already being done in our community to meet the goals of the Medicare Waiver program and we support the Maryland Hospital Association's assessment that a higher update can be provided without encroaching on the staff-recommended total cost of care cushion. We feel that the reduced update factors over the last two years has benefitted the payors in an inequitable fashion and that update factors of less than 2 percent fall woefully short of the 3.58 percent target that was agreed upon by the payors and the hospital industry.

We urge the Commission to reconsider the proposed update and adopt the MHA Fiscal Year 2017 Global Budget Update recommendations. This investment will allow Maryland hospitals like ours to continue to fund the types of innovative programs that will reduce costs for all Marylanders over the long term.

Respectfully,

Henry Trentman, Chairperson
Board of Directors

Dean Teague, FACHE
President and CEO

Robert Kertis
CFO & V.P. of Finance

Cc: Herbert S. Wong, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Jack C. Keane
Donna Kinzer, Executive Director

WESTERN MARYLAND
HEALTH SYSTEM

May 24, 2016

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

Dear Chairman Sabatini:

On behalf of the Western Maryland Health System (WMHS), we are writing to provide our perspective on the proposed FY2017 global budget update for hospitals and the impact it will have on our continued efforts to improve the health and well being of the communities we serve.

For the past six years, we have embraced the components of value-based care and have seen dramatic improvements in the clinical outcomes and health status of the patients we serve. There are many value-based care delivery initiatives that we have implemented since moving to the Total Patient Revenue payment methodology in 2010 and a sampling of these initiatives is attached. Although the journey continues, we have significantly reduced unnecessary admissions, readmissions, Emergency Department visits, observation visits and ancillary utilization. In addition, our performance metrics have improved with WMHS receiving the highest reward in 2015 for PPC compliance.

However, it is becoming increasingly more difficult to sustain these improvements and further enhance the health our patients. A study by the University of Wisconsin Public Health Institute indicates that only 20 percent of health outcomes can be attributed to clinical care. Health behaviors account for 30 percent and social determinants make up the remaining 50 percent. In order for hospitals to make lasting changes to improve community health, we must continue to invest in initiatives to encourage healthy life-styles and address social issues.

This is especially true in Allegany County, which is one of the poorest counties in Maryland and has extremely high rates of co-morbidities, including obesity, diabetes, and high blood pressure. Continued investment in support services and education is essential to change health behavior. Although there has been a decrease in avoidable utilization of hospital services among high-risk patients, additional patients need education about how to manage their chronic conditions to reduce their reliance on hospital care. In many cases, these are the family members of our current high-risk patients. We also need to invest in changing the behaviors of the community at large to improve health and reduce utilization for the long term.

12500 Willowbrook Road
Cumberland, MD 21502
Telephone: 240-964-7000
Website: www.wmhs.com

Socioeconomic factors create barriers for many of our patients and there are limited programs to benefit the poor and disenfranchised in our rural community. In recent years, WMHS has become the safety net for our region. WMHS has been using our savings under TPR to better address the many social and health needs that contribute to higher utilization of services by our patients. WMHS also provides leadership for many community-based programs to address poverty, eliminate barriers and improve overall health.

WMHS is part of the Trivergent Health Alliance, along with Meritus Medical Center in Hagerstown and Frederick Memorial Hospital. With the recently awarded Regional Care Transformation Grant from the HSCRC, the Trivergent hospitals can reach approximately 500,000 people in our three counties to enhance care delivery and improve overall health. We will be able to take our care delivery model to the next level and reach our patients in their homes, homeless shelters, low-income housing units, and other non-traditional sites of care. Sufficient global funding for FY 2017 is needed to support these new initiatives and maintain our existing programs.

The changes we have implemented over the past six years are having a profound impact on the health and well being of the patients we serve. Continued investment in these initiatives is critical to continuing this success. Without adequate global budget funding, we project a $4 million budget shortfall, which will impact the staffing and support needed to maintain our new care delivery model.

In addition, our fiscal health continues to be impacted by the high incidence of cancer among western Maryland residents and drug affordability. The skyrocketing cost of new bio-pharmaceutical agents continues to be a fiscal barrier to providing the best care and treatment for these patients.

We support MHA's recommendations for the Fiscal Year 2017 global budget updates and encourage you to provide a reasonable update for all Maryland hospitals so that we can continue to improve the health of the patients we serve and lower the overall cost of providing care. Thank you.

Sincerely,

Barry P. Ronan
President and CEO

Nancy D. Adams, RN
Senior Vice President,
Chief Operating Officer/Chief Nurse Executive

Kimberly S. Repac
Senior Vice President
Chief Financial Officer

Gerald Goldstein, MD
Senior Vice President,
Chief Medical Officer

CC HSCRC Commissioners

Western Maryland Health System

Value-Based Care Delivery Initiatives

- Inpatient admissions are down 25 percent from FY2011.
- Expanded care coordination efforts have reduced readmissions by 17 percent since 2011.
  - Expanded care coordination 24/7, including in the Emergency Department
  - Initiated Med-Start so post-charge medications are delivered to the bedside before patient leaves WMHS
  - Every readmission is subjected to a root cause analysis-like review to determine factors causing the readmission and how to avoid recurrence
  - Developed the Transitional Care Clinic to ensure all high-risk patients receive follow-up care within 5 days of discharge when their PCP is unable to see them
- High-risk patients who use the Center for Clinical Resources to manage their diabetes, congestive heart failure, lung disease and/or anticoagulation medications have experienced lower utilization of hospital services, resulting in a cost savings/avoidance of more than $7 million in two years.
- Case management for behavioral patients has reduced the inpatient admissions by 9.8 percent and readmissions by 46 percent over the past four years.
- Care coordination for hemodialysis patients with End-Stage Renal Disease to address all the patient's needs across the continuum has reduced readmissions by 67 percent over the past four years.
- Collaborative efforts with skilled nursing facilities to reduce readmissions by 30 percent
  - Host bi-monthly *Partnership to Perfection* meetings to address mutual topics
  - Implemented SNF Transitionist position in Care Coordination to facilitate better transitions from hospital to SNF
  - Developed the SNFist program that puts a physician and CRNP's onsite daily at 3 SNF's
  - Began medication delivery to SNF's for residents being discharged from WMHS
- Community Care Coordination with RNs and social workers placed in physician offices to address patient needs—referrals, transportation, education, emotional support, assistance with obtaining medical equipment and supplies and addressing basic social needs.
- Leadership role in Making Healthy Choices Easy, a community-based wellness coalition, has resulted in community fitness challenges and work-site wellness programs.
- Community garden started in 2015 to for low-income families to grow fresh fruits and vegetables. Five additional gardens are now underway in 2016.

ATLANTIC
GENERAL HOSPITAL
care.givers

May 24, 2016

Nelson J. Sabatini, Chair
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

RE: Staff Proposal for FY 2017 for Maryland Hospitals

Dear Mr. Sabatini,

As you are aware, Maryland hospitals are very concerned with the HSCRC staff proposals regarding the 2017 global budgets update. The Maryland Hospital Association (MHA) has communicated to you specific state-wide financial data to support these concerns, and we will not duplicate that information in this letter. Rather, we are communicating with the HSCRC commissioners the real-life experience of Atlantic General Hospital (AGH), one of the non-Baltimore-based hospitals in Maryland serving a unique rural, retirement and resort community on Maryland's Eastern Shore. AGH is the only hospital in Worcester County.

AGH is a relatively small hospital from a licensed bed perspective (48 licensed beds in FY 2016), but due to the nature of our community and the way we have prepared our service delivery over the past decade, we have rate-regulated revenue in our GBR that exceeds $100 million annually. AGH has a higher rate-regulated outpatient to inpatient service revenue ratio than any other hospital in Maryland. Part of this is due to the fact that we serve a thriving resort industry, accommodating approximately 39,000 annual emergency room visits (approximately 1/3 of which is directly attributable to resort visitors). We have developed a robust outpatient service delivery system, creating close relationships with our community physicians so that their patients are cared for in a very efficient and personal manner in our community.

The AGH Board of Trustees, Medical Staff, and Leadership Team have taken seriously the Maryland commitment to the GBR and the tenets of the new all-payer system. We were a first adopter of the patient-centered medical home (PCMH) in Maryland. We were one of the first hospitals in Maryland to

participate in a Medicare Shared Savings Program (MSSP) Accountable Care Organization (ACO), and the first on the Eastern Shore. AGH was one of the first three telemedicine grant awardees by the Maryland Health Care Commission (MHCC) in 2014-2015. These are just a few examples of how AGH has invested in adopting the service delivery changes necessary to achieve the goals of the GBR system.

What has been the results of these investments, and our operational commitment to the goals of the GBR program? In the base period of the GBR system, AGH was already at or below the statewide means for most measures. In the most recent quality data that is being utilized by the HSCRC to influence the 2017 rates (MHAC scaling, readmission scaling, QBR scaling comparing 2015 results with 2014 results), AGH far exceeded the statewide average overall scaling (AGH = 1.68% versus State = 0.19%). AGH was by far the top performer in reducing Medicare unadjusted readmission rates during this measurement period, lowering readmissions by -27.31% versus the state average reduction of -3.09% (the next best reduction rate in the state was -13.09%). With the intentional focus by the Board, Medical Staff and Leadership, AGH has fully demonstrated its commitment to achieving the "triple aim" goals of the GBR system in the community for which we are held responsible.

With the improvements made in the cost of care delivered by hospitals in Maryland in the first two years of the demonstration project, we have already saved Medicare approximately $257 million when our two-year goal was $49.5 million. Again, the data suggests that Maryland hospitals are living up to their commitment to this process.

Since we regularly monitor our performance in the measurement system described to us by the HSCRC, and we monitor the statewide performance, we fully expected positive scaling overall to our projected FY 2017 rates. To our surprise and disappointment, the HSCRC staff created a new "adjustment" to add to the quality scaling program – the Potentially Avoidable Utilization Savings Policy (PAU). With this new, heretofore unknown and unexpected -1.25% "adjustment", AGH will be receiving a negative quality adjustment of -0.18%. Where deserved rewards for investment in community-based initiatives to achieve the objectives established in advance by the HSCRC were expected as a "return on investment", to put it metaphorically, Lucy has once again pulled the football away from Charlie Brown.

Maryland's unique all-payer system is only viable when all of the parties are committed to a fair, mutually agreed upon process for healthcare delivery and financial support for quality care. Just as the HSCRC desires "predictability" in the costs for the delivery of healthcare services for the state, the Maryland hospitals desire similar predictability in the resources they will have available to support the care delivery in the communities they serve. The delivery of sudden, draconian policies based upon future concerns that are not being borne out by the actual data will erode the support of the community-based Boards of Trustees and Medical Staffs that are vital to the success of the community hospitals and the Maryland demonstration project. On behalf of AGH and community hospitals in Maryland, we request the HSCRC not adopt the newly proposed PAU policy for FY 2017, allowing for deeper analysis and further actual data to support a fair application of the policy.

Sincerely,

Michael A. Franklin, FACHE
President/CEO

Cheryl Nottingham
Vice President, Finance

Louis H. Taylor, Chair
Board of Trustees

FREDERICK
REGIONAL HEALTH SYSTEM

May 24, 2016

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

Dear Chairman Sabatini:

Frederick Memorial Hospital has been very supportive of the recent mandates to elevate the healthcare delivery system in Maryland. Transforming the health care delivery system is a difficult task and requires reconfiguring the clinical delivery system and supporting infrastructure. In this new environment, the Global Budget Reimbursement (GBR) system has been crucial to allowing quality improvements and efficiencies to be implemented without threatening the financial stability of the overall health system. More time is needed though, to continue the journey.

It is for this reason that, we are prompted to write this letter. Prior to the implementation of GBR, FMH began investing in quality and care management initiatives, with good quality results; albeit with significant negative impact to operating results. However, under GBR, key funding has been provided for infrastructure and population health measures addressing some of the potential concern over sustainability. The other key success factor has been a reasonable Update Factor to support continuing the investment in the people and programs that support the overall care transition.

FMH investments to date have been focused on reducing overall hospital utilization and readmissions, potentially avoidable utilization, and improving the care continuum for patients with chronic disease.

The improvement as a result of the investment in Care Management and related activities have resulted in FMH being in the top 5 hospitals with the lowest readmission rate in Maryland at 10.97%, compared to a statewide average of 12.5% for CY15.

FMH has also made improvements in MHAC's (Maryland Hospital Acquired Conditions) for CY15 in excess of 20%.

To influence the behavior of many of our sickest (or neediest or chronically ill or most complex) patients we have reached out to them in many dimensions. Specifically, these are some of the major initiative we have implemented:

- Hired and assigned Care Managers to chronic care patients to assist in their care management
- Embedded Care Managers in 13 primary care offices.
- Hired Care Managers to work with patients in the Emergency Department for proactive management of care coordination and education on community resources.
- Hired Pharmacists to work with patients to improve their understanding of appropriate medication management in the Emergency Department, upon discharge, and at home.
- Implemented a Care Clinic for patients without a PCP to access a follow up appointment with an advance practice nurse post discharge and provide access for individuals with chronic conditions to a multidisciplinary team of clinicians.
- Contracted with physicians to work with patients in their home to manage their chronic health needs.
- Engaged The Coordinating Center and Potomac Case Management (Behavioral Health) to provide care management to high risk individuals.
- Provided telemonitoring capabilities for home bound patients.
- Launched a community wide Advance Directive initiative, with over 40 community education events, reaching over 1,800 individuals. Currently, 98% of our inpatients who request AD information receive it while in the hospital.
- Developed relationship with the Skilled Nursing Facilities in our area and implemented a dashboard for quality/costs. This information is used to provide a preferred list for referrals based on quality criteria.
- Held several Lay Health Educator programs with multi-cultural communities to enable the graduates of the program to provide health education in their community
- Formed Trivergent Health Alliance with Meritus Health and Western Maryland Health System with the mission to improve population health in our communities. Trivergent submitted and received approval for the Regional Transformation Grant.

We believe that proposed inflation adjustment will impair the hospital's ability to provide reasonable wages to our employees and continue enhancements to the current programs that are directly improving the waiver metrics. In addition, the industry is experiencing unprecedented increases in the costs of drugs.

In order to continue to the progress that has been made to date, we urge the HSCRC to continue to provide resources to the hospital via a reasonable update factor. The hospital industry has performed well under this new system and can continue to do so with realistic investment. The Maryland Hospital Association has proposed a reasonable alternative to the staff-recommended global budget update. FMH supports the MHA recommendations that were reviewed at the most recent HSCRC Payment Model Work Group.

We look forward to more discussion on this important issue and thank you for your consideration of the issues we have raised in this letter.

Sincerely,

Thomas A. Kleinhanzl
Chief Executive Officer

Michelle K. Mahan
Chief Financial Officer

cc: Herbert S. Wong, Ph.D., Vice-Chairman
Victoria (Tori) W. Bayless
George H. Bone, M.D.
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Jack C. Keane
Donna Kinzer, Executive Director
Mike Robbins, MHA, Senior Vice President

LIFEBRIDGE
HEALTH

Sinai Hospital
Northwest Hospital
Carroll Hospital
Levindale Hebrew Geriatric Center and Hospital

May 25, 2016

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

We write to you to express our concerns over the proposed Global Budget update for FY 17. LifeBridge Health is facing a rate change well below inflation. This rate change and the growing levels of commercial payor payment denials will make it exceptionally challenging to maintain and expand our investments in care and infrastructure that address the total cost of healthcare for our citizens.

We have made significant progress in reducing: potentially avoidable utilization, readmissions, and unnecessary testing. We have expanded care coordination, community partnerships and collaboration across the continuum. These endeavors have and do require commitment of staff, resources and technology. With the proposed rate changes, we will be unable to devote what is required to continue and grow these initiatives.

Some of the areas of where we have made significant progress to date include:

Developing collaborative relationships with community agencies in Baltimore City and the surrounding counties and partnerships with Health Departments to support the health objectives and social determinant infrastructure in these communities. We have created effective programs and outcomes by providing care to our patients in our facilities and in their homes through a community health worker model. We have leveraged our existing programs and personnel to develop and implement programs to improve the management of the high risk, high utilizer patients. These programs focus on managing to better outcomes, improving access to primary care and subspecialty disease management, providing social services support, facilitating transition of patients to a primary care medical home and engaging patients in understanding and accessing their health information in support of improved self-management. We have placed significant emphasis on bolstering inpatient and ED care management services and on building an aligned care transitions program using HomeCare and Post-Acute Physician Partners, while adding new care navigation and social work positions.

We have improved follow-up care for patients after an inpatient stay or ED visit to include primary care provider connections and a wide array of social services. We have developed disease management programs to support transitions of care for the highest risk patients (COPD, CHF, and Diabetes) and increased access to primary care through partnerships with Federally-Qualified Health Centers and

community clinics. We continue to enhance internal infrastructure to support behavioral health and expand our palliative care program.

This multi-faceted strategy has necessitated a substantial investment in IT infrastructure to develop and manage the data components of all of the quality metrics needed to support population health, the PCMH model, NCQA requirements and the ACO's in our system. This infrastructure will provide disease registry information attributable by provider and will expand to perform analytics as well as serve as a system health information exchange (HIE).

In every program and initiative we are committed to developing measurable goals, measures of success, and to re-evaluating outcomes, as they impact the three elements of the Triple Aim, in order to improve the health of our communities and reduce the total cost of healthcare.

LifeBridge Health has been refining its patient-centered continuum of care to address avoidable hospital utilization. This has been and continues to be accomplished by improving access to primary care and chronic health care clinics and segmenting the population by risk level to provide targeted care models and goals. At the heart of this approach are clinically integrated networks using team-based care models that include care navigators and social workers in addition to multi-disciplinary teams of clinicians, ensuring the maximum level of care using the lowest-cost provider, and tracking success through measurable, evidence-based, pre-determined metrics.

We have established and invested in our clinical call center to ensure comprehensive, seamless care coordination for patients with a focus on reducing preventable hospital utilization for "high-utilizers" across our four acute care hospitals and in partnership with other hospitals around the state. This clinical call center also assists our outpatient pharmacy with Free Home Prescription Delivery, Bedside Delivery, Employee Prescriptions and ED prescription pick-up & drop-off window

We have implemented our technology platform for population health management. This long-term IT solution for Population Health Management that is EMR-agnostic, integrates with CRISP and other state-level solutions and provides or will provide: 1) clinical decision support at the point of care supporting evidence-based best practices, 2) attribution and risk stratification for focused populations, 3) patient engagement, 4) analytics, reporting, and performance tracking including scorecards that track provider, provider group, hospital, and system population health interventions and measures, and 5) actionable registries for improved clinical outcomes (Diabetes, CHF and Adult Wellness registries, as well as IVD/CAD, Asthma, Hypertension, COPD, Atrial Fibrillation, Depression, Maternity Health, Pediatric Wellness, Senior Wellness).

Our investment in Palliative Medicine means a team now exists of a Medical Director, LCSW Coordinator, Nurse Practitioners and other clinicians. They provide services that include consultative assistance for patients with end of life situations or conditions with chronic deterioration, symptom and pain management, family support, referrals to home care, hospice and assisted living facilities. The Palliative Medicine team facilitates directional change for appropriate use of resources for better comfort care and avoidance of

SAINT AGNES
HOSPITAL

May 25, 2016

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

RE: Comments on HSCRC staff's Draft Recommendation of FY 2017 Update Factor

Dear Mr. Sabatini,

Saint Agnes Healthcare welcomes this opportunity to provide comments on the HSCRC staff's Draft Recommendation for the Update to Hospital Rates for the Fiscal Year Ending 2017. Saint Agnes is committed to the care transformation goals of the all-payer model and believes that the innovative care delivery and care coordination work being done by Maryland hospitals is the reason for the success experienced under the new waiver agreement.

However, with hospitals now fully at-risk under the global revenue model, a reasonable update to hospital rates is critical to our ability to keep up with basic operating costs, including much needed wage increases for workers and investment in equipment and infrastructure replacement.

HSCRC staff's recommendation for the annual update (shown in the table below for Saint Agnes) is far below factor cost inflation needed to maintain these basic costs much less fund the continued investments to improve community care and reduce utilization.

Staff's Proposed Update Factor for Saint Agnes	
Adjustment for Inflation	1.72%
Allowance for High cost new drugs	0.20%
Gross Inflation Allowance	1.92%
PAU Shared Savings Offset	-1.09%
Net provided for inflation	0.83%
Inflation (Global Budget Insights)	2.49%
Shortfall in Funding for Inflation	-1.66%

Simply stated, it could mean the reduction and/or closure of hospital services and impact access to care.

Potentially Avoidable Utilization Initiatives

Saint Agnes is committed to improving the health of its patients including the underserved residents of West Baltimore – a community challenged with numerous socio-economic barriers as they strive to become healthier. Below are some of the initiatives Saint Agnes has undertaken as it works to reduce avoidable utilization and strengthen the health of the community it serves.

- Creation of the HealthLink program in partnership with Health Care Access Maryland (HCAM) to provide enhanced care coordination for high cost, high need patients.
- Deployed relationship with The Coordinating Center via West Baltimore Care (HEZ) to provide community-based care coordination services for West Baltimore HEZ patients.
- Formation of the High Utilizer Task Force charged with creating shared care plans for community providers via CRISP for over 100 high need, high cost patients.
- Development of a Comprehensive Care Center for high need and rising risk acute patients without access to adequate primary care.

Care coordination and provider alignment initiatives such as these come with a substantial financial investment and take time to realize the full impact. A hospital rate update that is far below inflation may disrupt their progress or unseat the programs altogether.

Potentially Avoidable Utilization Savings Adjustment

Included in staff's draft recommendation of the update factor is a sizeable increase in the shared savings reduction. On a statewide basis, the proposed savings reduction increases from $89.3m in FY 16 to $193.4 in FY 17 which represents a **217%** increase over the prior year. The increase for Saint Agnes specifically is $4.5 million and represents a **281%** increase over the prior year adjustment. For the past three years, each hospital's contribution to the savings reduction was based on its case-mix adjusted inpatient readmission rates.

HSCRC staff is now proposing to expand the savings by focusing the program more broadly on PAU which also includes the AHRQ Prevention Quality Indicators (PQIs). The PQI measure was developed and validated to monitor how health care systems that include community-based physicians are managing ambulatory sensitive conditions for a given population. This is not an appropriate individual hospital measure for two reasons:

1) Differences in hospital specialization threaten the validity of the measure – A hospital with a higher mix of medicine cases (vs. surgical cases) will have a higher PQI score. Logically then, a hospital with a higher mix of surgical cases, and a lower PQI score, is not necessarily delivering better outcomes by managing patients with ambulatory sensitive conditions in the community.
2) Differences in the socio-economic status of populations served by hospitals threaten the validity of the measure - Currently, PQI measures are adjusted only for age and sex of patients. It is well documented that poorer populations have higher rates of admission to the hospital for ambulatory sensitive conditions than wealthier populations. In the application of the savings adjustment, staff provides protection for hospitals with Medicaid encounters in the top quartile

of the state. However, this protection falls short of a comprehensive socio-economic risk adjustment that should be applied to all Maryland hospitals.

The proposed changes to the shared savings adjustment will, in effect, remove the very funding that we need to invest in potentially avoidable utilization reduction and maintain the savings secured in the first two years of the waiver model. The cumulative savings already secured for Medicare, Medicaid and commercial payers ensure that a reasonable update can be provided that will be far below the model's spending guardrails.

The Maryland Hospital Association (MHA) has submitted an alternative rate update recommendation for consideration, which is more reflective of the issues mentioned above. Saint Agnes fully supports the MHA Fiscal Year 2017 hospital rate update recommendation.

Thank you for this opportunity to provide these comments.

Sincerely,

Keith Vander Kolk
Health System President & CEO, Baltimore

Scott Furniss
Senior Vice President/CFO

Cc: Herbert S. Wong, PhD., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Jack C. Keane
Donna Kinzer, Executive Director
Mike Robbins, MHA Sr. VP Rate Setting

I am writing to provide comments from Holy Cross Health's perspective on the FY17 global budget update. I know from personal experience that this is a complex, challenging decision for the Commission.

For FY17, I believe the increase proposed by the Maryland Hospital Association is the minimum amount necessary to support a balanced implementation of the Maryland all-payer system. I will not repeat the points made in the MHA proposal – they are clearly stated and reasonable, in my view.

From the standpoint of a health system CEO, I can tell you that the cost pressure which flows from our commitment to paying a living wage to all staff (Holy Cross, as of October 1, will reach its target of an hourly minimum of $15) and the need to be competitive in the overall labor market is very significant. Making extensive investments in population health has been the focus of our very limited discretionary funds and we have implemented an extraordinary number of efforts to improve population health and avoid expensive utilization, which are summarized in an attachment to this document. We also need to invest in general clinical excellence, which is also vital to serving our communities. Resources must be found from our GBR payment update – there is no other place today.

From the standpoint of a member of the HSCRC's Advisory Council on the Implementation of the All-Payer System, I would reference its original recommendations (report of January 31, 2014), which the Commission has cited as very helpful. Specifically, Recommendation 2.2 states that, given the challenges hospitals face, the HSCRC should set spending targets as close to the demonstration limits as practicable. Even if the Commission accepts the MHA proposal, the three-year spending target will be 43 percent below the allowable per capita limit of the demonstration. The Staff proposal would result in a three-year cumulative target of less than half of the per capita limit. I do not believe either level meets the thrust of pages 5-7 of the Advisory Council's report but I believe we need the higher adjustment to prevent an even more negative situation.

In addition to these specific comments on the FY17 update, I would like to provide a few thoughts related to the long-term future of the all-payer system. As you may know, I have been a strong supporter of the new system and served as Co-Chair of the Governor's Executive Input Group, which helped bring about a consensus on its final terms among hospitals, the State of Maryland, the payer industry and CMS. I would raise two items for your consideration:

1. The Maryland All-Payer System for hospital reimbursement cannot be measured on a Medicare only scale and then broadly "cushioned", or it will fail to meet Maryland's overall goals.

A major reason the prior waiver got into difficulty was its exclusive focus on Medicare growth per inpatient admission relative to the U.S. The new waiver avoided that problem. First, it moved the compliance test to all hospital spending, measured it on a per capita basis, and set a spending target (never before accomplished) that held hospital spending increases to the level

of Maryland's overall economic growth. Second, the final negotiations reached a successful conclusion by making this all-payer per capita target, which was unprecedented and extremely challenging, the primary measuring stick for waiver success. It was expected that, if the per capita test were met, cumulative Medicare savings of $330 million over five years would be obtained (obviously, we are doing way better through two years). If the per capita test were met and the Medicare savings did not happen, CMS' position was that it was open to alternatives, including modifying the Medicare discount.

The total Medicare spending provision and the out-of-state provisions were included to check against gross manipulation. It will be a mistake to underfund and risk long-term harm to an extremely effective all-payer program, which is far ahead of expectations, because of potential concerns in these areas. Over fifty years, healthcare spending in the U.S. has tripled its share of the overall economy. Changing that trajectory will take a generation of modifying institutional and individual behavior. However, since the start of this program, hospital spending in Maryland has succeeded in not growing its share of the overall Maryland economy. If we are able to continue to stay close to that level of performance which, I believe, will be very difficult given the rapid aging of the population, we will be perhaps the most effective demonstration ever conceived by CMS. I do not believe we should manage as though this demonstration is in a precarious position.

2. Longer term, the reimbursement system needs to move closer to being tied to capitation to match the overall thrust and target of the waiver requirements.

The GBR system has been extremely effective in moving the system quickly away from fee-for-service and ensuring that Maryland has lived within the financial targets of the waiver during the first two plus years. Long term, however, it is unwieldy, inflexible and promotes micro-management of every hospital transaction. The GBR system struggles and so far has not succeeded in having "the money follow the people", one of our original mantras established to recognize the importance of patient and payer choice in meeting the triple aim. It puts an extraordinary burden on the Commission staff, who are exceptional but cannot match up to the monitoring requirements, which grow with every additional provision.

I urge the Commission to solicit ideas with a bias to move toward some form of per capita reimbursement principles for hospitals which would promote their efforts to provide great service that attracts and satisfies patients so the system can attain all of its goals while meeting the financial targets. If the final, critical measure of system success is limiting the increase in per capita expenditures, linking hospital reimbursement to its "per capitas" has great power. It would also promote less micro-management in keeping with the Advisory Council recommendation 2.6 (p.6), "Within the context of per capita growth ceilings on hospital spending, HSCRC should allow considerable flexibility for the health care sector to implement its own strategies for achieving the desired results while recognizing the importance of following evidence-based best practices and the potential value of some standardization." The Advisory Council report goes on to say that we should stress performance over detailed design standards.

I believe as we look ahead to Phase II, we must look to transition toward per capita payment models that unleash innovation while ensuring that we meet overall cost and quality standards. Getting this right is our number one long-term challenge. I urge a broadly consultative and collegial process as envisioned by the Advisory Council in recommendation 2.7 "The consensus of the hospital industry should have a significant weight in policy development."

No one has ever come close to succeeding at what Maryland is attempting under this waiver. It will take everyone's ideas and follow through for it to have a chance for success.

Thank you for the opportunity to comment.

Sincerely,

Kevin J. Sexton

Attachment: Holy Cross Health Population Health/Utilization Reduction Initiatives

Holy Cross Health is engaged in a significant number of activities to reduce potentially avoidable hospital utilization and total cost of care, with particular attention to vulnerable populations including senior and uninsured residents. These initiatives include community based primary care serving mostly at risk individuals, hospital-based initiatives to improve communication and care coordination, post-discharge programs to reduce re-admissions and provider-supported self-care programs. In addition, Holy Cross, along with the other Montgomery County hospitals, is committed to implementing Nexus Montgomery as an innovative and far-reaching regional partnership.

In this attachment, we will identify Holy Cross Health's extensive efforts to reduce potentially avoidable hospital utilization. But we note, we are also humbled by the challenges of achieving significant change and are troubled by the inappropriateness of hospital –specific measures that are not considered within context of the patient's delivery system (especially for Kaiser Permanente patients) and the use of community-based measures to assess hospital performance.

Our four health centers serve nearly 9,000 low income individuals, 84% of whom are uninsured. We provide on average 3.6 visits per patient per year, visits which would likely occur in a rate-regulated emergency department in the absence of the health centers. Our two OB-Gyn clinics provide prenatal care and deliveries to over 1,000 uninsured women each year (over 21,000 since we created the partnership with Montgomery County in 2000). Our low birthweight rates are well below the state average. We have established a primary care practice embedded in Asbury Methodist Village, a senior living community with 1,500 residents where we can promote continuity of care across multiple settings to better manage care for our patients, 80% of whom are over age 80.

Improved communication among physicians enhances effective utilization management. We have partnered with Kaiser Permanente (KP) to provide in-hospital access to all of its electronic health records and a secure network for telemedicine consultations. We restructured our inpatient units to cohort KP patients so their hospital-based physicians and care managers can most effectively impact care. We are working with CareFirst to connect hospitalists with PCPs to better coordinate hospital and ambulatory care plans. Holy Cross Health and CareFirst representatives now meet together with those physicians toward that end.

Holy Cross has implemented multiple post-acute care interventions to reduce the likelihood of future utilization both within the 30 day window and beyond. We call every adult medical/surgical patient discharged to home to assure that they have the required medications, have made the necessary follow-up appointments, have been in contact with homecare or DME vendors, and are aware of the red flags of their clinical condition. Concerns are elevated to a Holy Cross Health nurse care coordinator. At no cost to patient or payer, we offer transitional care services to high risk patients who are not eligible for home care services. These services include visits during their hospital stay; an extended RN home visit for medication reconciliation, safety evaluation and symptom review; and a series of nurse-led health coaching calls. We instituted care alerts in our EMR for home care and transitional care patients. Emergency Department providers have access to a 24/7 phone number to arrange for an in-home visit in lieu of hospitalization. We also contract with Family Services, Inc., to provide enhanced support for patients with behavioral health and substance abuse issues. Our post-acute liaison nurse provides next day follow-up on patients transitioning to and from Skilled Nursing Facilities (SNFs). We are working with SNFs throughout Montgomery County in a variety of forums including MHA, VHQC, and

independently with select high value partners. In FY17, we will fund a pharmacist led in-home medication reconciliation and home delivery program for high risk patients.

Holy Cross Health has community health workers who work in underserved communities to provide health information and referrals to our health centers and to other services that can help individuals address social determinants of health. We also provided health insurance enrollment support to more than 10,000 people last year. We offer extensive community health programming to engage individuals in their own health. For example, each week 1,200 individuals participate in Senior Fit exercise classes offered free of charge by Holy Cross Health at 23 sites around the region. In annual assessments, we see a high percentage of participants improving strength, flexibility as well as their sense of well-being. Other valuable self-care programs include Living Well: Chronic Disease Self-Management Program, Diabetes Prevention and Diabetes Self-Management, Pulmonary Maintenance, Falls Prevention, Memory Academy, Better Bones, Heart Failure Management, Kids Fit and Kids Shape. We also offer multiple other exercise and intellectual engagement programs offered at Senior Source, our center for active aging and at multiple community locations. Our Medical Adult Day Center provides a safe, medically supervised, engaging setting for vulnerable adults, particularly those with dementia. It can be a valuable resource for families to help seniors remain in the community rather than becoming institutionalized. The Caregiver Resource Center, which is affiliated with the Medical Adult Day Center, provides information, referrals and numerous support groups to help people manage the responsibilities and challenges of caregiving.

Together with the other Montgomery County hospitals, Holy Cross Health secured a Regional Partnership for Health System Transformation design grant which led to the creation of Nexus Montgomery. Our plan, which focuses on preemptive care coordination of high risk individuals to prevent initial admissions, was recognized in the HSCRC's January 13, 2016 Executive Summary report as "a notable standout in terms of detail and plausible impact." Nexus Montgomery has been selected as one of nine awardees in the HSCRC Transformation Implementation Program. In addition to the pre-emptive care coordination program we also will expand existing post-acute care programs and focus on care coordination for two particularly vulnerable populations: patients who are uninsured and those with severe mental illness.

These efforts demonstrate Holy Cross Health's commitment to effective and appropriate hospital utilization. Our focus on high reliability clinical processes and consistent documentation has resulted in a dramatic reduction in complications. However readmission rates have been more difficult to move. Our Maryland all-site readmissions were significantly below the state average in CY13 but our CY15 risk adjusted readmissions were unchanged despite major investment. Our same site readmissions are down 5% over that period. This speaks to the importance of information sharing and risk sharing across communities as exemplified by Nexus Montgomery. Hospital readmission rates only tell a part of the story and cannot be fully understood without characterizing the population the hospital serves and the care systems in place. KP is a case in point for Holy Cross Health. They provide a highly respected and highly integrated model of care delivery, much of which is the basis for changes currently being implemented across Maryland. As part of that process, KP has built large "clinical decision units" that hold patients for a day and keep them out of the hospital. This resulted in a significant decrease in Observation patients and avoided many inpatient stays in FY14 and 15, likely by patients with the lowest risk for readmission. But, with the increased enrollment in KP and their active steering of patients to Holy Cross, we have seen a marked increase in KP inpatients and Observation patients in FY16. Despite their highly integrated delivery system and fully aligned incentives, KP's risk adjusted readmission rate for HCH has increased slightly between CY13 and CY15 with the latter representing a recovery from a

major rise in CY14. We have worked with KP to understand and improve readmission trends and they have implemented pharmacist medication reconciliation, high priority post discharge appointments, changes in their SNF discharge and rounding process, and a "concierge practice" with two internists focused on a small number of high utilizing patients. The inability of HCH and KP to lower already low readmission rates is humbling and challenges us to better understand readmissions as only one element of overall utilization of expensive healthcare by a defined population.

We view Prevention Quality Indicators (PQIs) as a misleading and inappropriate measure of hospital performance. PQIs were conceived by AHRQ as global population measure and expressed as rates per 100,000—not percent of hospital admissions. Over 90% of PQIs are medical and represent "bread and butter" medicine—heart failure, pneumonia, COPD, out of control diabetes. The number at any hospital is reflective of community resources, local referral practices, ease of access, the disease burden in the community, the availability of primary care, the availability of hospital beds, and the proportion of the population whose basic medical needs are served. The percentage of a hospital's inpatients who have a PQI will be lower for hospitals with large elective medical (and particularly surgical) cases, lower for hospitals with high obstetrical volume, and higher for community hospitals with good access through emergency departments or clinics. Patients who are admitted to a hospital with a PQI do not represent care that can be avoided at that moment. Hospitals already deal with justifying the need for hospitalization to payers based on medical necessity. Prevention is far upstream and requires concerted community-wide interventions shared by all of the stakeholders—hospitals, payers, doctors, pharma, public health entities, and post-acute providers. The Nexus Montgomery program is a tiny step in that direction, but is orders of magnitude short of what is needed and hospitals alone cannot shoulder the cost.

KP's practices as reflected in Holy Cross Health metrics illustrate some key points about PQIs. Three examples are particularly telling.

-For PQI-16, amputations in diabetics, Kaiser increased from 27 in CY13 to 47 in CY15. This may represent adverse selection in KP enrollment but the over-riding factor was the decision by KP leadership to direct their vascular and general surgery from across their system to Holy Cross Hospital (HCH).
-Overall, for commercially insured patients, PQIs represent 11% of KP medical admissions to HCH and 20% at Holy Cross Germantown Hospitals (HCGH). Does that represent a nearly 100% difference in the effectiveness of KP's practice across the 20 mile distance between the two hospitals?
-At HCGH that 20% PQIs is above the community level of 14% for commercial insurance. Does this reflect a significant deficiency in care by KP's referrals from outside the immediate community?

We believe these examples and others illustrate the difficulty of using PQIs as a measure of hospital performance or the combined role of hospital and community, without understanding the aggregate population served. We need to think, measure and act in terms of attributable populations rather than trying to control narrow measures which can never be fairly assessed as independent variables.

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CORPORATE OFFICE

May 25, 2016

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

Dear Ms. Kinzer:

On behalf of the University of Maryland Medical System's (UMMS) and its' 12 member hospitals, this letter is in response to the HSCRC draft staff recommendation for the FY 2017 Update Factor, dated May 2. We appreciate the opportunity to provide comments.

The University of Maryland Medical System has supported Maryland's All Payer System with its improved equity for Maryland patients and for the access it has provided by funding the social costs of providing hospitals services in the State. We continue to support the system as it has transformed into the Hospital All Payer Model with CMMI, with its new emphasis on population health. This is the right path to improve the quality of care for patients and to align payments with improved population health efforts.

Achieving the Triple Aim (and meeting the requirements of the Waiver) requires transforming the systems, technology, behavior and performance of our large, fragmented, statewide health care system. Such a transformation requires significant resources (hundreds of millions of dollars), time (measured in years) and comprehensive population health solutions (people, process and technology). There is evidence that some population health methodologies are cost effective and can achieve both a clinical and financial return. But there is much to be learned about which programs achieve the desired clinical outcomes and justify the large expense over the long term. Thus, innovation and experimentation in care delivery will be critical to long term success. Making change of this magnitude in a health care system has never been done before. The effects of such profound change on Maryland's health system are unprecedented, challenging and risky. Moreover, we do not know the effects on the health of Maryland's residents. The latter is of utmost importance and must be carefully measured and monitored. Moving too fast may have unintended consequences and adverse effects on patients and providers.

Efforts to Reduce Potentially Avoidable Utilization

UMMS has actively worked to transform care delivery. We have put in place a number of efforts to reduce potentially avoidable utilization (PAU). UMMS is funding significant investments in population health programs in excess of the HSCRC GBR Infrastructure funding. These investments are designed to improve quality, safety and efficiency of care and to assure success of the Waiver. We have made these investments after extensive strategic and operational planning; and we have involved our own experts and engaged external partners to implement population health strategies. UMMS is making good progress in implementation of these programs, but these are large undertakings which take time. Our health system's strategies include building relationships and aligning incentives with both employed and independent physicians and aligning the physicians and other care providers in clinically integrated networks. We are employing sophisticated technology to track total cost of care and quality of care. We are building capabilities in complex care management, medication management, and behavioral health. Finally we are working with the physicians to optimize performance using the tools and technology described above. The population health capabilities described above will be applied to different populations of patients including Medicare FFS, Medicaid and Medicare Advantage and those who are insured commercially. There are differences in the approaches to achieving the Triple Aim by hospitals and health systems. These differences should be embraced as we learn what works and what does not and how we best address the dissimilarities among our communities and providers.

Funding Other Investments

While we believe these efforts are appropriate and improve care for Maryland residents, we must use this opportunity to register our concern over the update factor for FY2017 recommended by the staff. Based upon the HSCRC's staff recommendation, UMMS is estimating an updated factor of 1.07% (1.72% market basket less the .65% shared savings reduction) to fund core inflation for necessary wage increases and non-salary inflation. This number is woefully inadequate creating cost pressures to manage unfunded inflation. Additionally, under the new Waiver hospitals must find ways to fund clinical innovation, new information technology, population health strategies and capital replacement.

The staff has noted that hospitals could fund these expenses by reducing PAU. However, to reduce PAU requires spending, as described above, and the spending that can be financed by these reductions is limited by the fact that PAU is potentially avoidable, not avoidable with certainty. Further, the Commission's policy has been to reduce update factors below the level of the market basket to share the savings with payers. As a consequence, hospitals must reduce PAU first to fund the shared savings and then even more to generate funds to finance hospital investments. The dollars to be saved are being designated for multiple purposes, and the first dollars of savings are already spoken for in the update factor policy.

Recognize Success – and Needs

The current update factor proposal is sending a message of failure and discouragement, reminiscent of the last days of the old waiver model when we faced loss of the waiver and the need to change the delivery system in light of the national trend in healthcare reform. We have now completed two years of the model and the system has generated Medicare savings well ahead of those scheduled in the model agreement with CMMI. Further, we have delivered per capita hospital spending well below the 3.58% all payer limit established under the agreement.

This performance is cause for celebration. It is also a time to consider the broader question of system needs. Hospitals are being asked to fund a number of population health initiatives and their related infrastructure as well as the routine costs of operation for wages and capital costs. Funding that was once generated through hospital volume is no longer an avenue under the new model. To fund those expenses and generate margins to maintain our facilities, update factors need to be closer to the market basket to cover general inflation, without specifically targeted purposes designated by the Commission.

The University of Maryland Medical System supports the Maryland Hospital Associations (MHA) Update Factor recommendation and urges you to move towards a more balanced update. The MHA recommendation provides for specific ways to increase the current proposal without threatening the all-payer model's spending limits. The All Payer Model has offered an innovative approach to addressing problems that we faced under the old waiver model and has placed Maryland hospitals at the center of national efforts to transform the delivery system. We continue to support these efforts while noting that we are working in large organizations that require time to change. After only two full years of the model, we have made remarkable progress, and that progress can continue if we work together with a balanced funding approach.

We appreciate the opportunity to comment on the staff recommendation. If you would like to discuss further, please contact me at 410-328-5165.

Sincerely,

Robert A. Chrencik
President and Chief Executive Officer

cc: Nelson J. Sabatini, Chairman
Herbert S. Wong, Ph.D., Vice-Chairman
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Victoria (Tori) W. Bayless
Jack Keane
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Thomas J. Senker, FACHE
President

Administration

May 25, 2016

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

Dear Chairman Sabatini:

As the new hospital president at MedStar Montgomery Medical Center (MMMC), I am very concerned about the recent dialogue around the Health Services Cost Review Commission (HSCRC) global budget update for fiscal year 2017. As an organization that is committed to serving our local community by caring for patients and advancing health, MMMC has been very focused on impactful efforts to reduce potentially avoidable utilization (PAU) and unnecessary cost. While the incentives for doing this are not yet perfectly aligned, we believe it is the right thing to do and have made several investments to support these efforts. Limiting hospital funding at this critical stage could be detrimental to the progress that we have made and could prevent our ultimate success.

As you know, the issue of avoidable utilization has many facets that are intertwined. To appropriately focus us on the key issues, I have expanded a senior leadership role to have specific responsibility for population health. This senior leader helps to design and monitor our PAU efforts in conjunction with a multi-disciplinary team consisting of case management, physicians, laboratory technicians, radiology technologists, pharmacists, nursing, and social work. The team has developed a range of solutions focused initially in the emergency department but continuing through the entire care continuum. As part of these efforts, they have also focused on the reduction of redundant or avoidable testing in radiology, cardiology and laboratory. This critical work has resulted in appropriate changes in practice, workflow changes to ensure appropriate testing and the identification of appropriate alternatives to high cost pharmaceuticals from the inpatient formulary.

To ensure that we are intervening at the earliest possible stage, we have invested in a streamlined navigation process and have expanded case management staffing in our Emergency Department (ED). To better identify potential super-utilizers, we have implemented an all patient risk assessment program that stratifies all patients for risk of readmission. Depending on the level of risk identified, navigators help to coordinate appropriate care and identify follow-up care planning, including involvement in the transitional care program. The transitional care program tracks and follows our discharged to home patients for 30 days. As part of this program, we have also partnered with a private duty nursing company to provide home visits, help with obtaining medication and medically related transportation.

MMMC has also expanded its reach into the community by partnering with skilled nursing facilities to better manage discharged patients. Building relationships with medical leads at each of the facilities enables us to better co-manage these patients and avoid unnecessary hospital stays and improved collaboration in care. Additionally, we have successfully piloted a program in a local nursing home in which hospitalist physicians from the hospital provide direct medical care and oversight at the nursing home. This program alone has resulted in an 18% reduction in readmissions for this patient population and will be expanded to other post acute centers if the update

factor allows us to fund it. We also run the medical clinic at a local retirement community at a significant loss in order to reduce unnecessary ED visits and admissions and are just beginning to see reduction of PAU associated with these patients.

Despite all of the progress we have made, our efforts to contain cost and improve the quality of care that we provide are at risk if we are not properly funded. Regrettably, the current HSCRC staff proposal, if implemented, will result in the reduction of approximately 27 positions here at MMMC, some of which will directly impact our population health efforts. Given the very positive results and cumulative savings that have been generated in the initial years of the new waiver, now is the time to maintain the state's investment in its hospitals at least at the rate of inflation as we collaboratively work to aggressively shift into a value-based model.

We are confident that we are making great strides at MMMC towards a population health focused model, in which increased coordination of care and partnerships with a variety of community partners will yield significant benefits for our community and the state of Maryland. We are proud to be a part of a forward-thinking waiver that has the opportunity to set the bar for the rest of the country. Please continue to support our efforts and the great progress that we have made by carefully reconsidering the HSCRC staff's inadequate annual update proposal.

Thank you for the opportunity to share this important information – I appreciate your thoughtful consideration and your leadership. Please let me know if I can be of assistance in any way.

Sincerely,

Thomas J. Senker, FACHE
President, MMMC and Senior Vice President, MedStar Health

Cc: Michael Robbins, Senior Vice President, Rate Setting, MHA
Kathy Talbot, Vice President, Rates & Reimbursements, MedStar Health
Michael J. Curran, Executive Vice President, Chief Administrative & Financial Officer, MedStar Health

Mt. Washington Pediatric Hospital
Where Children Go to Heal and Grow

An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

May 26, 2016

Donna Kinzer, Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Dear Ms. Kinzer:

The purpose of this letter is to provide comments on the staff recommendation for the FY2017 update factor on behalf of Mt. Washington Pediatric Hospital. We appreciate the opportunity to provide our views on this important issue.

We support the All Payer Model and the underlying goals of improving the quality and value of care for patients in Maryland's unique hospital regulatory system. We understand the Commission's desire to achieve the model's performance targets well in advance of the end of the demonstration model, but if rate updates ignore the rising cost of providing care, hospitals cannot sustain quality patient care. To operate our facility, we need to fund the basic costs of the hospital, including competitive wage structures and replacement capital. To do so, update factors need to reflect underlying market basket growth.

We support an update of 2.30 percent (instead of 1.55 percent) for Mt. Washington Pediatric Hospital, as recommended by the Maryland Hospital Association. The HSCRC staff recommends a 0.50 percent adjustment for productivity improvement, with which we agree. However, the staff recommendation also includes a reduction of 0.75 percent, which is the Medicare hospital payment cut intended to fund part of the cost of the Affordable Care Act. It is inappropriate to apply this federal Medicare reduction amount to all payer revenue in Maryland (Medicaid, CareFirst, United, others). It creates a larger-than-intended reduction for hospitals and a windfall for non-Medicare payers -- a particularly relevant issue for our hospital, given that we have almost no Medicare patients.

Although not a GBR hospital, MWPH helps reduce overall healthcare costs by providing a lower-cost option for pediatric inpatient care. An appropriate update factor will assure that the hospital maintains its ability to help the acute care hospitals meet their goals.

Mt. Washington Pediatric Hospital
Where Children Go to Heal and Grow

An affiliate of University of Maryland Medical System and Johns Hopkins Medicine

We appreciate the opportunity to comment on this recommendation. Please contact me if you have any questions.

Sincerely,

Mary Miller

Mary Miller, CFO

cc: Nelson J. Sabatini, Chairman
Herbert S. Wong, Ph.D., Vice-Chairman
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
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Jack Keane
George H. Bone, M.D.
Mike Robbins
Sheldon Stein

unnecessary and potentially harmful, end of life interventions in the inpatient and ICU settings. Improved Patient experience --- better pain and symptom management, alignment of goals between patient, family members, and providers. Facilitation of outcomes and goal alignment with treatment options.

Palliative care decreased Potentially Avoidable Utilization by ensuring more appropriate use of supportive care, avoidance of inappropriate and costly ICU/emergency care interventions that are futile or unwanted by the patient and alignment of patient goals with services at appropriate level of care- home rather than hospital, hospital rather than ICU.

All of the above have required a financial investment that will not be possible with the proposed rate changes. In addition, commercial payors increasingly are denying payment for services rendered and ordered by physicians. Payment denials in a Global Budget, with penalties and incentives for unnecessary care, are inconsistent and a financial burden to hospitals that prevent expansion of initiatives that could improve our healthcare system. We urge you to reevaluate so that we have the resources required while still maintaining the requirements of the all payer model.

Sincerely,

Neil M. Meltzer
President/CEO

Jason Blavatt
Chair, LifeBridge Board

David Krajewski
Sr. Vice President/CFO

Dr. Jonathan Ringo
Chief Medical Information Officer & VP, Clinical Transformation

c: Herbert S. Wong, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Jack C. Keane
Donna Kinzer, Executive Director

Anne Arundel Medical Center

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May 31, 2016

Dear Chairman Sabatini,

On behalf of Anne Arundel Medical Center (AAMC), the twelve member organizations that comprise our health system, our 4,500 employees, 1,100 member medical staff, and most importantly, the 1.2 million people we serve every day in our region, we appreciate the opportunity to express our concerns about the proposed HSCRC staff recommendation for the FY 2017 Update Factor. We believe that the HSCRC proposal is insufficient to support Maryland hospitals' continued focus on the many transformational initiatives for care integration into our communities and could force many organizations to focus simply on survival of their existing hospital services, discontinuing their investment in the outreach services that have driven the reform to date.

Maryland hospitals have been receiving rate increases for years at below inflation levels. This erosion in revenue increases has occurred at a time of rising costs for expected patient care expertise, significant advancements of expensive medical technology and a dynamic evolution in drug therapies, particularly for cancer treatment, that are effective but enormously expensive. Hospitals have counter balanced the gap with a renewed focus of care delivery costs reductions including more recently reductions in avoidable utilization. However, these reductions in avoidable utilization take time to manifest with changes in clinical training and protocols through iterative data analytics as well as patient education and real cultural behavior modifications.

AAMC is committed to the components of Maryland's evolving value based system of care. We have made very significant strides in improvements in our community's health, both inside and outside the "four walls" of our hospital. The statewide savings achieved are documented, undeniable and directly attributed to the efforts of Maryland's hospitals. And we have made significant investments to attain these savings, more than double the funding that we have received in hospital rate increases. A system created over 40+ years cannot be transformed in three. We are leading unprecedented shifts in the delivery of healthcare, and reducing the total costs of care will simply take time to be realized.

Our journey of health improvement began in 2010 when our Board of Trustees approved our ten year strategic plan, "Vision 2020 – *Living Healthier Together*". That plan set forth a course for a coordinated system of integrated care that extended beyond the walls of the hospital, placing greater emphasis on primary care, chronic disease management, wellness, and prevention – from birth to end of life. Our early electronic medical record investment (the first Epic partner in Maryland), our investments in community based clinics for the underserved

(unquestionably our most vulnerable population), and recognized care coordination partnerships with other regional care providers have driven health improvement of those we serve.

In 2009, AAMC extended its EPIC platform, connecting inpatient, outpatient and community providers of care as well as the patients themselves, through our patient portal.

In 2010, AAMC promoted the broad adoption of Patient Centered Medical Home model of care for both non-employed and employed practices by hosting regional learning collaboratives for both the Maryland PCMH pilot and the CareFirst PCMH program.

In 2011, AAMC started its first patient-centered medical home for uninsured and undocumented individuals. We have provided a reliable source of primary care for 9,882 unduplicated patients in this cost-effective, bilingual setting.

In 2012, AAMC was the second hospital in the state to form a Medicare Accountable Care Organization, forming a partnership between our employed primary care groups and two large external groups to improve the coordination of care and as well as the cost reductions of care for over 10,000 Medicare beneficiaries.

In 2012 and 2015, we collaborated with UM Baltimore Washington Medical Center (BWMC) and the local health department in assessing our community's needs. We take seriously our responsibility to meet and close the gaps in care that were identified related to cancer, obesity, cardiac disease and mental health. The Community Health Needs Assessments serve as our roadmap for service and program development.

In 2013, AAMC, in partnership with the Housing Authority of the City of Annapolis, was awarded one of five state Health Enterprise Zone grants to build a PCMH clinic in the Morris Blum Senior Center, a public housing facility in Annapolis. This clinic increased access to health care services in the building and surrounding public housing. For the chronically ill cohort living in the building, we reduced readmissions by 80%, admissions by 43%, ED visits by 28%, and medical 911 calls by 34%. To date, the site has provided primary care services to more than 1,800 unduplicated patients.

Also, in 2013, AAMC partnered with Arundel Lodge, a community-based behavioral health resource for the chronically mentally ill, to integrate primary care and behavioral health in a trusted "Health Home" for individuals.

In 2014, AAMC partnered with The Coordinating Center and Johns Hopkins Health Care to provide community-based care coordination that follows high-need patients in their homes and across care settings. We have served more than 1,000 individuals and families served so far though these efforts alone. We increased the number of care managers in the emergency room to help respond to and educate the increasing number of patients who could be cared for in less costly settings. AAMC began expansion of its regional mental program to complement its

successful substance abuse program at Pathways with the creation of a new behavioral health clinic serving adults and children, as well as a partial day program for more intensive outpatient mental health services. These comprehensive outpatient services will be complemented by a new inpatient mental health hospital, to be built in 2018 (CON application filed March 2016).

Also in 2014, AAMC was the first hospital to be certified by Maryland Medicaid in the Hospital Presumptive Eligibility program to assist patients in obtaining Medicaid benefits immediately for all healthcare services. More than 700 patients in the region have received coverage through this program.

In 2015, AAMC partnered with Chesapeake Palliative Medicine and The Coordinating Center to launch Community Care for Complex Illness, a pilot program providing more than 100 patients suffering from advanced complex illness with navigational and caregiver support services to reduce potentially avoidable utilization. In the next year, AAMC will open a Palliative Medicine outpatient community-based clinic. AAMC also launched the Collaborative Care Network, a regional clinically integrated network, physician-led and AAMC-sponsored that provides a platform to share data, resources, and opportunities to succeed in a value-based environment

And in 2015, AAMC partnered with UM BWMC, the Anne Arundel County Health Department and the Anne Arundel Department of Aging and Disabilities to form a population health alliance now known as the Bay Area Transformation Partnership (BATP). The BATP is focused on rapidly deploying interventions to reduce the per capita hospital expenditures and potentially avoidable utilization (PAU) of Medicare and aged Dual-Eligible patients. The BATP applied for and was awarded an HSCRC Transformation Implementation Grant last month, and was noted by the HSCRC staff to be the highest scoring application funded. The program will target extremely high-need individuals safely and sustainably in the community and thus reduce their reliance on hospitals for non-medical crises.

Already in 2016, AAMC has partnered with UM BWMC and CRISP, creating and piloting regionally-based innovative, rapid and secure communication tools that support clinicians' decisions to reduce potentially avoidable utilization by providing safe alternatives to ED visits and hospital admissions. This initiative is believed to be portable to other organizations across the state.

Next up in 2016, AAMC will launch its skilled nursing facility (SNF) preferred provider program to improve care of mutual SNF patients, reduce SNF utilization and hospital readmissions through mutual expectations on cost and quality performance. Through coordinated collaboration with documented quality performers, we believe we can begin to influence non-performers to better outcomes. We have already reduced the percentage of joint replacement patients who were admitted to SNFs for rehab from a high of 35.2% to 18% over the past 3 years.

At AAMC, we are taking responsibility for the health of the patients in our region. We serve as the convener of health care services and redesign in our region. We are committed to these

initiatives but adequate continued funding is critical. Stable, reasonable rate increases are the foundation of our long range planning. AAMC takes reduction of unnecessary costs seriously, noted often by the HSCRC staff and payers as one of the lowest cost hospitals in the state despite being the third busiest hospital in the state. However, cost reductions can only be taken so far before services are impacted. The proposed increase by the HSCRC staff simply does not fund enough of the anticipated costs to sustain new improvements we need to make and, in fact, jeopardizes the momentum of initiatives already underway. The proposed rate increase of 1.2% for our organization seriously undermines our ability to provide a reasonable wage increase to retain our talented workforce who have made our achievements possible. We believe the staff's proposal will force hospitals to make choices that will impact the care patients will receive.

As the American Hospital Association reminds us, the proverbial Blue H serves as a beacon of hope, healing and health in the communities we serve. We have a responsibility to support those communities' increasing focus on health and wellness as they seek to improve the quality of their lives. We accept that responsibility but we need the proper support from the HSCRC to accomplish and sustain those goals successfully.

We urge you to hear and support the Maryland Hospital Association's proposal for reasonable funding – the patients in Maryland are benefitting from the hospitals' investments and focus on high quality care.

Sincerely,

Maulik Joshi, DrPH
EVP, Integrated Care Delivery
& Chief Operating Officer

Dr. Mitchell Schwartz
Chief Medical Officer

Bob Reilly
Chief Financial Officer

Maryland
Hospital Association

June 2, 2016

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

Dear Chairman Sabatini:

With your critical decision on hospitals' global budget update for fiscal year 2017 coming in less than a week, we wanted to make sure you had some important new information about why Maryland is well on track to meet the Medicare Total Cost of Care guardrail, which would allow for the higher MHA-proposed update of 2.75 percent ***without jeopardizing the total cost of care spending guardrail*** in calendar year 2016.

The information below is conclusive: Maryland is besting the total cost of care spending guardrail so far this year; the historical data clearly suggest that the hospital rate increase doesn't harm that performance in the second half of the year; the historical data also indicate that we ***improve*** on our total cost of care performance over the second half of the year.

With the most recent Medicare Chronic Conditions Warehouse (CCW) data made available just last week, Maryland currently has information for calendar year 2016 for claims processed through April 30, 2016. Staff are likely to share this data with you before the June 8 meeting, but because concern about total cost of care guardrails has been at the center of the update discussion, we wanted to bring it to you as soon as possible. Here is what that data show:

Medicare savings are even higher than expected
Maryland Medicare spending per beneficiary ***hospital*** savings has grown by an additional **$74 million**, bringing the cumulative savings to date to $325 million. With more than 2½ years to go, we will clearly exceed the minimum savings requirement of $330 million, with the savings rate so far this year exceeding that of the first two years of the all-payer model.

Maryland's total cost of care growth is less than the nation's
Maryland Medicare spending per beneficiary ***total cost of care*** growth so far this year has been ***less than the national growth rate by 0.75 percentage points***. The test this year required that Maryland not exceed the national growth and the new data suggest we are on track.

Historically, spending slows in the second half of the year
Data for the past three years show that ***both Medicare hospital spending AND total cost of care spending*** per beneficiary have been ***less*** in the second half of the year than the first half of the calendar year, ***even with the HSCRC hospital rate increase being put into effect in July***. That

is, the seasonality of spending has historically offset the full impact of hospital rate increases in the second half of the calendar year.

Maryland spending declined more rapidly than national spending

Data for the past three years show that Maryland actually spends increasingly less relative to the national growth rate in the second half of the calendar year for ***both hospital and total cost of care spending***.

The data and trending revealed by this latest information provides a solid basis for your support of MHA's update proposal of 2.75 percent.

If you have any questions on the attached information please do not hesitate to contact me. We look forward to your consideration of this critical information as part of next week's commission action on the update to global budgets for fiscal year 2017.

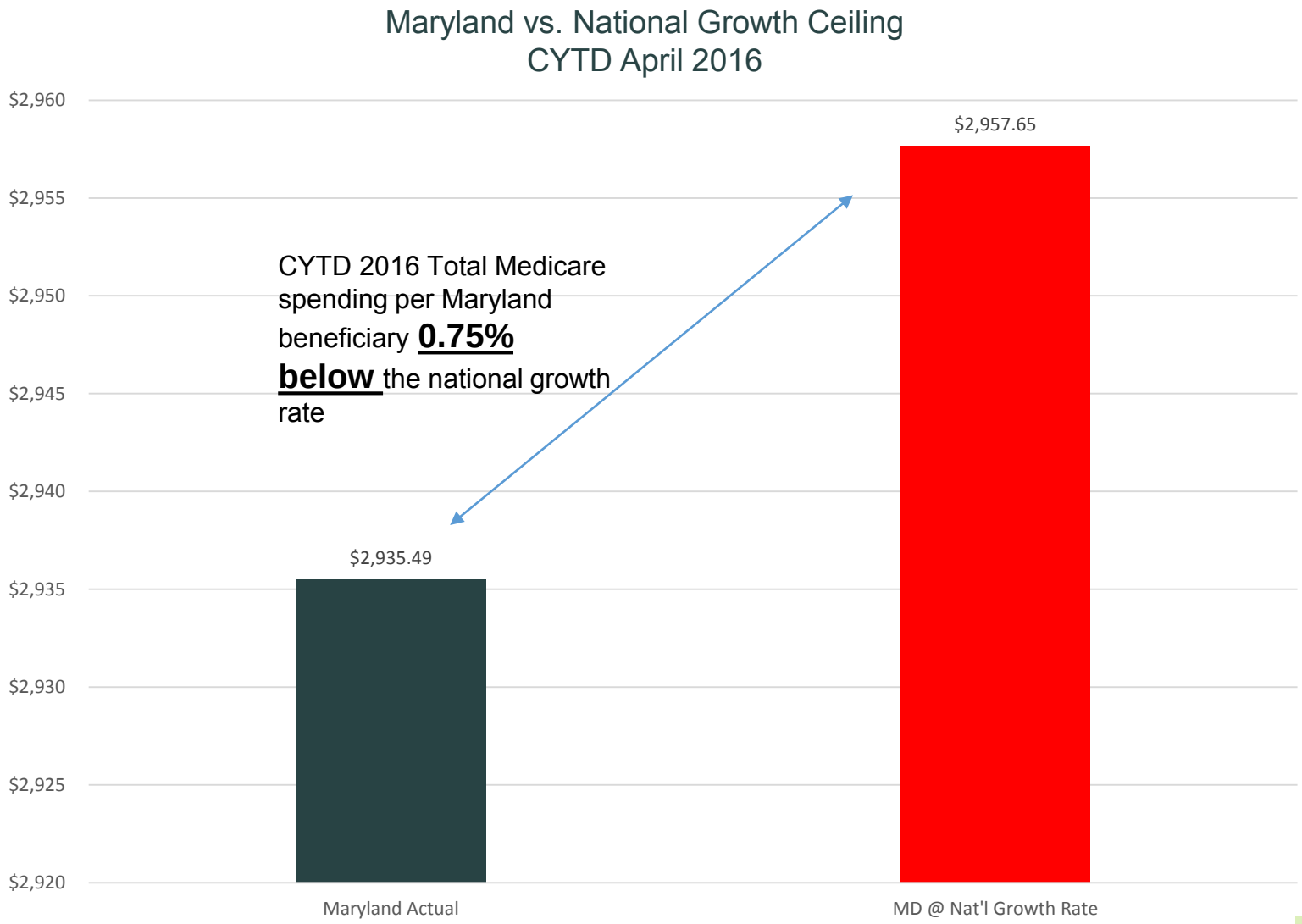
Sincerely,

Michael B. Robbins
Senior Vice President

cc: Herbert S. Wong, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Jack C. Keane
Donna Kinzer, Executive Director

Enclosure

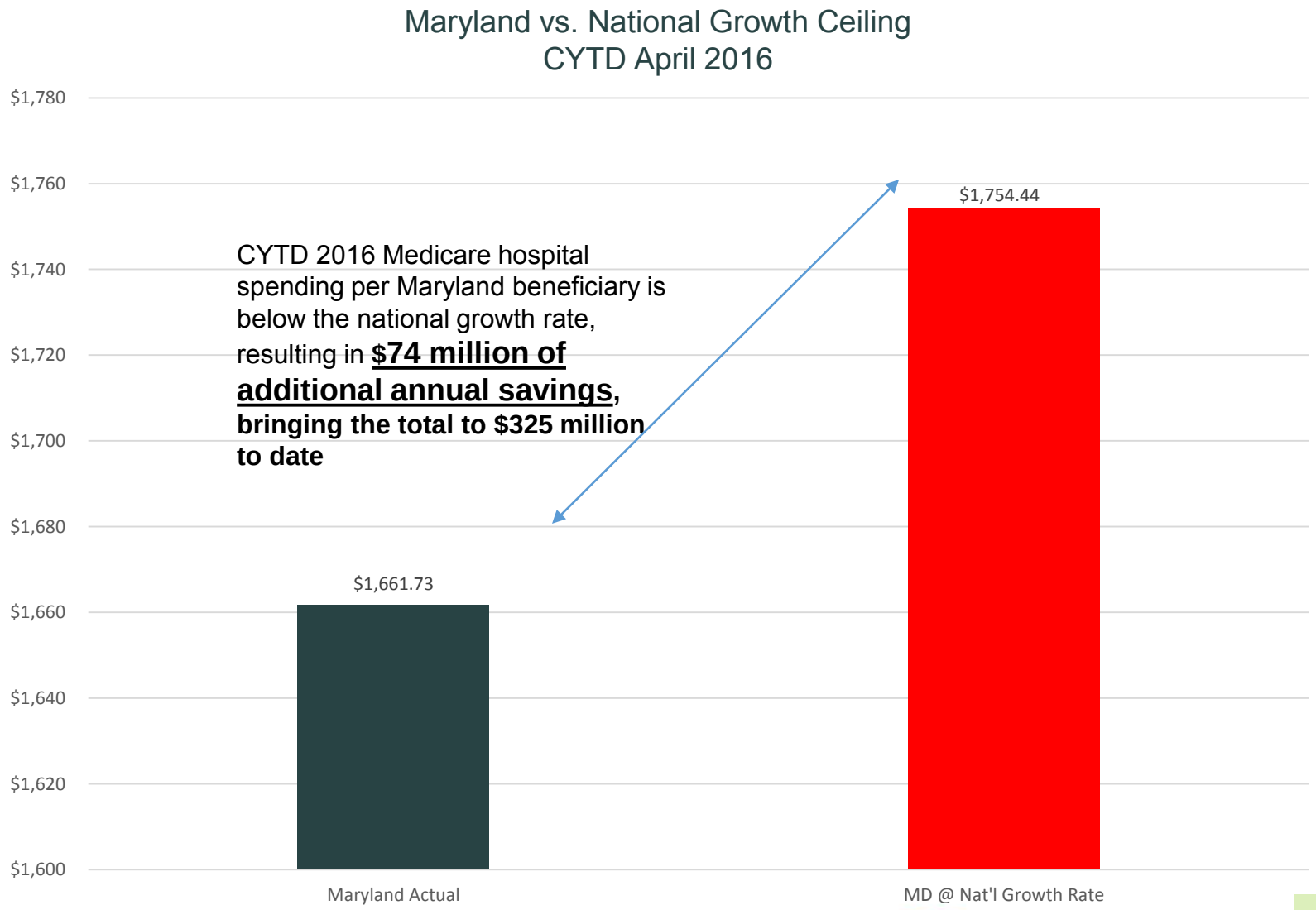
Medicare Total Spending per Beneficiary



Source: Medicare CCW Data Received from HSCRC 5/25/16

Maryland Hospital Association

Medicare Hospital Spending per Beneficiary



Source: Medicare CCW Data Received from HSCRC 5/25/16

Final Recommendations for Competitive Transformation Implementation Awards

June 8, 2016

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

This is final recommendation and ready for Commission action.

Table of Contents

OVERVIEW

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

BACKGROUND

The Commission received 22 proposals for transformation implementation award funding. Commission staff established an independent committee to review the transformation grant proposals and make recommendations to the Commission for funding. The Transformation Implementation Award Review Committee (Review Committee) included representatives from the Department and the Commission as well as subject matter experts, including individuals with expertise in such areas as public health, community-based health care services and supports, and health information technology. Following a comprehensive initial review, nine of the 22 proposal applicants were invited to provide clarifying information related to their proposal. These nine applicants, along with their community partners, were invited to present their proposals to the Review Committee.

After its thorough review, the Review Committee is pleased to present these recommendations to the Commission. The Review Committee is strongly encouraged about the prospects of the proposed interventions, which we believe will expand upon existing infrastructure investments to improve care coordination and population health management in Maryland and help achieve the goals of the All-Payer Model. This report reflects the Review Committee's recommendations to grant a total of just over $30.5 million for Transformation Implementation awards in FY 2017 of the authorized amount of up to 0.25 percent of FY 2016 approved hospital revenue ($37,036,786).

COMPETITIVE TRANSFORMATION IMPLEMENTATION GRANTS

In order to achieve the goals of healthcare transformation and to pave a way for success of the All-Payer Model, on August 28, 2015 the Department, in collaboration with the HSCRC, released a Request for Proposals ("RFP") for funding to implement health system transformation. Twenty-two applications were received by the extended due date of December 21, 2015.

The RFP invited proposals to build upon developed partnerships capable of identifying and addressing their regional needs and priorities and, in turn, shaping the future of health care in Maryland. The conceptual model is intended to focus on particular patient populations (e.g., patients with multiple chronic conditions and high resource use, frail elders with support

requirements, and dual-eligibles with high resource needs) and may also include a strategy for improving overall population health in the region over the long-term, with particular attention paid to reducing risk factors. The overarching goal is to utilize community-based partnerships to assist hospitals in meeting the goals of the new All-Payer Model and the Triple Aim.

The RFP limits the maximum award to 0.5 percent of a hospital's FY 2016 global budget for each approved application (although hospitals obtaining revenue through multiple awards may not receive a cumulative amount exceeding .75 percent of their revenue). Funding will be allocated via HSCRC-approved rate increases for hospitals working in conjunction with partner organizations, with the expectation of reducing potentially avoidable utilization for Medicare and dual-eligible patients. Successful proposals will be required to submit additional reporting details on the status of their ongoing implementation as the funding is released.

THE REVIEW COMMITTEE AND EVALUATION CRITERIA

The Review Committee gave preference to those models that included the following characteristics/features:

- Identified a target patient population that could be reached to improve care delivery and achieve results for the All-Payer Model;
- Built a programmatic model that would likely be successful in improving efficient care delivery;
- Remained consistent with the goals of the All-Payer Model;
- Remained consistent with the partner hospitals' Strategic Transformation Plans;
- Considered existing GBR Infrastructure Investments;
- Complemented existing resources;
- Leveraged available information technology tools;
- Focused on the needs of patients;
- Demonstrated a feasible Return on Investment and viable plan to translate into Payer Savings;
- Presented a valid implementation plan; and
- Presented a reasonable budget.

The Review Committee established evaluation criteria and weighting in each of the following categories:

1. Target Population – 10 points
2. Model Success – 20 points
3. Consistency with All-Payer Model – 10 points

4. Consistency with Strategic Transformation Plans – 10 points
5. Efficacy of Previous Investments – 5 points
6. Complement to Existing Resources – 5 points
7. Use of Existing Information Technology Resources – 5 points
8. Patient-Centeredness – 10 points
9. Feasibility of Return on Invest (ROI) and Payer Savings – 10 points
10. Implementation Plan – 10 points
11. Budget – 10 points

For applicants that were invited to present their proposal, the Review Committee gave preference to those models that included the following characteristics/features:

- A comprehensive, diverse set of community and hospital partners with standing in the region;
- The likelihood that the proposed programs would be successful in reducing avoidable utilization and improving population health;
- The operational readiness and sustainable staffing detail of the proposal;
- The timely generation of a return on investment and sustainable impact on total cost of care; and
- The overall feasibility of the proposal to be successful.

The Review Committee established evaluation criteria and weighting in each of the following additional categories:

1. Overview of Program Design – 5 points
2. Community Involvement and Community Partners' Roles – 5 points
3. Staffing Detail – 5 points
4. ROI Assumptions and Budget Request – 5 points
5. Impact on Total Cost of Care and Non-Hospital Services – 5 points
6. Operational Readiness – 5 points
7. Overall Impression – 5 points

RECOMMENDATIONS

Recommended Awardees

Based on its review, the Review Committee recommends nine grant proposals for FY 2017 funding. Table 1 below lists the recommended awardees, the award amount, and the hospitals affected. A summary of each recommended proposal may be found in the Appendix.

Table 1. Recommended Awardees

Partnership Group Name	Award Request	Award Recommendation	Hospital(s) in Proposal
Bay Area Transformation Partnership	$4,246,698.00	$3,831,143.00	Anne Arundel Medical Center; UM Baltimore Washington Medical Center
Community Health Partnership	$15,500,000.00	$6,674,286.00	Johns Hopkins Hospital; Johns Hopkins – Bayview; MedStar Franklin Square; MedStar Harbor Hospital; Mercy Medical Center; Sinai Hospital
GBMC	$2,942,000.00	$2,115,131.00	Greater Baltimore Medical Center
Howard County Regional Partnership	$1,533,945.00	$1,468,258.00	Howard County General Hospital
Nexus Montgomery	$7,950,216.00	$7,663,683.00	Holy Cross Hospital; Holy Cross – Germantown; MedStar Montgomery General; Shady Grove Medical Center; Suburban Hospital; Washington Adventist Hospital
Total Eldercare Collaborative	$1,882,870.00	$1,882,870.00	MedStar Good Samaritan; MedStar Union Memorial
Trivergent Health Alliance	$4,900,000.00	$3,100,000.00	Frederick Memorial Hospital; Meritus Medical Center; Western Maryland Hospital Center
UM-St. Joseph	$1,147,000.00	$1,147,000.00	UM St. Joseph Medical Center
Upper Chesapeake Health	$2,717,963.00	$2,692,475.00	UM Harford Memorial Hospital; UM Upper Chesapeake Medical Center; Union Hospital of Cecil County
Total	**$42,820,692.00**	**$ 30,574,846.00**	

Reporting and Evaluation

As shown above, not all of the meritorious applicants received the full amount requested. In such cases, the Review Committee considered, among other things, the FY 2016 revenue limitation, whether the proposed initiatives truly involved care coordination, whether the initiatives could have been funded with existing infrastructure dollars provided permanently in rates or resulting from ROI, and previous rate increases granted for the same or similar purposes.

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

Savings to Purchasers

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

Table 2. Recommended Reduction Percentage

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

*10% more than the previous fiscal year.

Remaining Funding Available Under 0.25 Percent of Revenue

As previously mentioned, the Commission authorized up to 0.25 percent of approved FY 2016 revenue for this program, meaning that up to $37,036,786 may be used for the Healthcare Transformation Grants. This recommendation, if approved by the Commission, would allocate a total of $30,574,846 in FY 2017, leaving a remainder of $6,461,940. Staff is proposing that HSCRC and DHMH re-evaluate the remaining applications to determine whether the remainder could be used to further the goals of the All-Payer Model by approving individual projects proposed in the applications that have not yet received funding, or to provide partial funding to support promising collaborations and regional partnerships. The intent is to issue a draft recommendation at the Commission's September public meeting on how the remaining dollars could be distributed in this manner.

APPENDIX

Bay Area Transformation Partnership

Anne Arundel Medical Center and UM Baltimore Washington Medical Center

Hospital/Applicant:	Bay Area Transformation Partnership (BATP)
Date of Submission:	12/21/15 original submission, 01/08/16 revised submission
Health System Affiliation:	Anne Arundel Medical Center and University of Maryland Baltimore Washington Medical Center
Number of Interventions:	12 major interventions as described in section 3
Total Budget Request ($):	$ 4,010,576

Target Patient Population
The Bay Area Transformation Partnership's (BATP) target population in 2016 includes 1,260 high-utilizing Medicare and aged Dual-Eligible patients residing in the primary service areas for Anne Arundel Medical Center and the University of Maryland Baltimore Washington Medical Center. This includes 1,152 Medicare high utilizers (>=3 inpatient or observation visits >=24 hours) and 108 aged (>=65 years) Dual-Eligible individuals. Table 1 on page 1 lists the primary service area zip codes and shows a map of the areas. Berkeley Research Group (BRG) provided the baseline data for our target population and will continue to update this information on a quarterly basis throughout CY2016. Even as BATP directs its high-intensity, resource-rich interventions at this population of 1,260 in 2016, at the same time, work will begin on addressing the rising-risk population, as described in the narrative. In years 2017 thru 2019, we aspire to cumulatively expand the scope of target patients to include the high utilizers from all payers, adding segments each year, including portions of the rising-risk population, based upon our data analysis, resource and volume capabilities and BATP-generated funds that will be reinvested back into interventions for the target populations. We anticipate that in 2019 we will have the capacity to reach all-payer high-utilizers while addressing rising-risk members of the population, in order to appreciably reduce the per capita total cost of care.
Summary of program or model for each program intervention to be implemented. Include start date, and workforce and infrastructure needs

The work plan demonstrates significant preparatory work in 2015 that extends through January 2016 in anticipation of an early February award announcement.

Intervention	Start Date	Workforce and Infrastructure Needs
A. Shared Care Alerts	2/1/16	$ 591,843
B. Shared Care Plans	3/1/16	Included in above
Data Analytics	1/1/16	$ 173,060
C. Ambulatory Care Supports		
a) One-Call Care Management	2/1/16	$ 105,984
b) Physician House Calls	1/1/16	No funds required
c) Quality Coordinators (AAMC)	2/1/16	$ 138,368
D. Expansion of Behavioral Health and Integration with Primary Care		
a) Integration of Behavioral Health with Primary Care	2/1/16	$ 414,816
b) Behavioral Health Navigator Program	1/1/16	$ 107,668
E. Community Care Management	1/1/16 for AAMC 5/1/16 for UM BWMC	$ 725,058
F. Readmissions Analysis	2/1/16 begin hire 5/1/16 start services	$99,433
G. Skilled Nursing Facility Collaborative	1/1/16	$230,033
H. DoAD Senior Triage Team	1/1/16 develop material April hire, May Training, 6/1/16 services begin	$188,681
Clinical Transformation Specialist	5/1/16	$ 46,100
I. CRISP Service Expansion		
a) SNF Integration & Reporting Pilot	11/12/15 Sites identified for CRISP 1/1/16 CRISP start	Cost covered by CRISP
b) Ambulatory Care ENS and Clinical Query Portal expansion	10/30/15 Sites Identified for CRISP 1/1/16 CRISP start	Cost covered by CRISP
c) CRISP Secure Texting Pilot	10/1/15 Requirements 12/11/15 RFP reviews 3/1/16 AAMC/UM BWMC Pilot Secure Texting	Cost covered by CRISP and absorbed by AAMC/UM BWMC resources
K. Joint Patient & Family Advisory Council	1/1/16	$ 3,200
L. AAMC Collaborative Care Network	1/1/16	$ 500,000
BATP Program Oversight	1/1/16	$ 411,461
Indirect Costs	2/1/16	$ 274,871

Measurement and Outcomes Goals
The overarching goal of BATP for 2016 is to decrease the potentially avoidable hospital utilization (PAU) of our target population and realize an annual gross savings of $9.28M (16% of annual baseline charges), resulting in $4.6M in variable savings. A **sampling** of intervention-specific measures and outcomes (using the letters corresponding to section 3 above): A. Shared Care Alerts - % of target population with a Care Alert, pre- and post- Care Alert ED utilization, inpatient admissions and per patient charges. B. Shared Care Plans and E. Community Care Management - % of target population with Care Managers and Care Plans and % shared via CRISP; pre- and post- care manager measures - ED visits, inpatient admissions, per patient charges; % of patients who declined services. We predict a 10% reduction in bedded care for those patients who have care management services. C. Ambulatory Care a) One-Call Care Management – number and types of calls, patient zip code, number and types of referrals made. b) Physician House Calls – number of patients referred and number receiving services. c) Quality Coordinators (AAMC) - % of target population whose conditions are being successfully managed by their PCP D. Behavioral and Physical Health integration – number of therapy and psychiatry visits and navigator referrals for target population and impact on ED visits, inpatient/observation visits, LOS. G. Skilled Nursing Facility Collaborative - touching 4,400+ patients, track 30-day readmission rates of target population. Expected outcome is reduced readmissions, reduced ED visits, reduced potentially preventable conditions and reduced length of stay in SNFs. H. Senior Triage Team (DoAD) - # of super-utilizers being managed, pre- and post- care manager assignment track; per patient charges, EMS utilization, ED visits, length of stay, number of guardianships established, and patient satisfaction. Outcome should be decreased EMS utilization, decreased ED visits and decreased length of stay. I. CRISP Services - # of SNFs and ambulatory practices using ENS and Clinical Query Portal.

Return on Investment. Total Cost of Care Savings.
CY2016 focus will be on 1,260 high utilizer Medicare/Aged Dual Eligible patients with 2 or more chronic conditions in our Primary Service Area. We expect an annual gross savings of 16%, $9,280,000, and annual net savings of $629,424. ROI = 1.157. Each year, the annual net savings will be reinvested in those interventions that are most effective, and will be applied within the following calendar year.

CY2017: Expand to an additional 400 Medicare high utilizers/Dual-Eligible Aged patients in our Primary Service Area, reaching a cumulative total of 1,660 patients, realizing an annual gross savings of 15%, $11,454,000, and annual net savings of $1,716,424. ROI = 1.428

CY2018: Include an additional 647 unique patients including Secondary Service Areas, and additional payers (Medicaid, Other), reaching a cumulative 2,307 patients, reaching an annual gross savings of 12% or $12,843,336, annual net savings of $2,411,092, and an ROI of 1.601. Importantly, we will seek to leverage the Payer infrastructure for chronic care management, taking advantage of collaboration and communication and utilizing the cross-organizational tools we have developed as both scalable and reusable year over year (such as Care Alerts and Care Plans).

CY2019: Aspire to reach the full 2,953 all-payer high utilizer patients and leverage Payer infrastructure for chronic care management, use CRISP Care Management tools to focus and prioritize interventions. An expected 10%, $13,764,820, annual gross savings and annual net savings of $2,871,834, an ROI of 1.716.

Apportioning ROI to Payers: In 2018 and 2019, BATP will share 10% of annual net savings, proportionate to hospital savings, to payers through a GBR agreement reduction by hospital or other approved HSCRC methodologies. Since the hospitals receive funds via rate increases, the apportionment of savings for the hospitals occurs automatically for each hospital as savings are realized as the interventions result in reduced PAU.

Scalability and Sustainability Plan

The scalability of our model comes from the efficiencies gained by creating and using multi-disciplinary, cross-organizational people, processes and tools to aid in streamlined care coordination and population health management. Scalability is also gained by widening and strengthening our network of BATP participants based upon the focus of each year's target population, for example, leveraging Payer infrastructure and programs for care management in 2018 and 2019.

Sustainability without additional rate increases will be obtained by:
a) Using resources once to implement interventions which then become incorporated into everyday operations for hospital (ED, inpatient care managers), ambulatory and specialty care providers, post-acute care settings (SNFs) and private/government and payer care management,

b) Creating interventions and tools that are themselves built once, and then shared with both hospitals by CRISP and available in their portal, following the patient year over year across care settings (shared Care Alerts, shared Care Plans),

c) Reinvesting our annual net savings back into the resource-intense, hands-on interventions such as behavioral health navigation and psychiatric therapy and treatment,

d) Risk stratifying our patient populations and using different types of resources appropriately, e.g. Quality Coordinators for rising-risk populations, The Coordinating Center for high utilizers, the Senior Triage Team for super-utilizers and those with significant non-medical support/service needs.

Participating Partners and Decision-making Process. Include amount allocated to each partner.

The Governance structure for BATP includes a Board consisting of three Managers from each hospital who have met throughout the planning phase, to manage the initiative going forward. In addition, there will be an Advisory Council consisting of representatives spanning the public, private, and government sectors. Importantly, the Council will include participants who are actively engaged in the various interventions to improve care coordination and population health for our target population. Advisory Council membership will be confirmed in January 2016.

After careful review of the BATP subprojects with external legal counsel, leadership determined that the most efficient, effective governance structure would be to use a formal Memorandum of Understanding (MOU) between AAMC and UM BWMC as co-leaders of BATP. Tri-party service contract/MOU will be executed with third parties providing initiative services for BATP. Business Associate Agreements will be used for data sharing between the hospitals, and between third parties, as appropriate.

Decision-making process: The Governance Board's primary responsibilities include budget approval, oversight, allocations and adjustments. The Board will meet at least quarterly and will incorporate Advisory Council recommendations and assessments regarding subproject performance and effectiveness, intervention portfolio adjustments, issue resolution and risk management. Governance Board Managers will be entitled to vote upon all matters submitted to the Board, and the affirmative vote of the Managers from each hospital (voting as a block) shall be required to take any action.

Funding allocation for each hospital:
AAMC: $ 2,306,698
UM BWMC: $ 1,703,878
Total BATP Request: $ 4,010,576

In CY2016, there are two vendors who will bill the hospitals for care management services: The Coordinating Center and the Department of Aging & Disabilities for the Senior Triage Team intervention.
Otherwise, there are no fund distributions to agencies outside of the hospitals in CY2016.

Implementation Plan

Highlights from the BATP Implementation Plan

		AAMC	UM BWMC	CRISP	TCC	DoAD	SNFs
January	Physician entry of Care Alerts	√	√				
	Test Care Alert CCD exchange AAMC/CRISP	√		√			
	Configure shared Care Plans (Epic)	√					
	Write job descriptions: new hires	√	√		√	√	
	Obtain updated target pop list	√	√				
		AAMC	UM BWMC	CRISP	TCC	DoAD	SNFs
Feb	Go-live shared Care Alerts AAMC to CRISP	√		√			
	Care Alert re-configuration		√				
	HSCRC Announcement of Implementation Grant Awards						
	Kick-off BATP Implementation phase	√	√		√	√	√
	Initiate hiring process for new hires (start nlt May 1)	√	√	√	√	√	
	11 AAMC, 10 UM BWMC, 5 DoAD	√	√		√	√	
	Develop training plans	√					
	AAMC CCN meetings						
March	UM BWMC Go-live Shared Care Alerts	√	√	√			
	Pilot Secure Texting (CRISP)	√	√				
	Quarterly meetings:						
	a) SNF Collaborative	√	√				√
	b) PFAC	√	√				
	c) Advisory	√	√	√	√	√	√
	e) Governance	√	√				
April	Test shared Care Plans w/CRISP	√	√	√			
	Continue hiring	√	√		√	√	
May	New Hires Begin Work	√	√		√	√	
	Cross-training sessions (Senior Triage, One Call Care Management, community care managers & DoAD using Care Plans, Readmissions Analyst,	√	√		√	√	√

	Quality Coordinators, Post-Acute Care Manages)						
June	Shared Care Plans live UM BWMC Psychiatrist Starts CRISP ENS/Query Portal onboarding complete for SNFs, Ambulatory Practices Quarterly meetings (as above)	√ √ √	√ √ √ √	√ √ √	 √	 √	 √ √
Jul – Sep	All 12 interventions fully operational Monitoring and process improvement Evaluate interventions/metrics Quarterly meetings (as above)	√ √ √ √	√ √ √ √	√ √ √	√ √ √	√ √ √	√ √ √
		AAMC	UM BWMC	CRISP	TCC	DoAD	SNFs
Oct - Dec	Monitor & improve interventions Report & evaluate metrics, make recommendations for 2017 Quarterly meetings (as above)	√ √ √	√ √ √	√ √	√ √	√ √	√ √

Budget and Expenditures	
Intervention	Budget
A. Shared Care Alerts	$ 591,843
B. Shared Care Plans	Included in above
Data Analytics	$ 173,060
C. Ambulatory Care Supports	
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K. Joint Patient & Family Advisory Council	$ 3,200
L. AAMC Collaborative Care Network	$ 500,000
BATP Program Oversight	$ 411,461
Indirect Costs	$ 274,871
Total Budget	$ 4,010,576
AAMC Allocation	$ 2,306,698
UM BWMC Allocation	$ 1,703,878

Community Health Partnership of Baltimore

Johns Hopkins Hospital; Johns Hopkins – Bayview; MedStar Franklin Square; MedStar Harbor Hospital; Mercy Medical Center; Sinai Hospital

9. Summary of Proposal

Hospital/Applicant:	The Johns Hopkins Hospital
Date of Submission:	December 21, 2015
Health System Affiliation:	Johns Hopkins (JHH, JHBMC), Mercy Medical Center, Lifebridge (Sinai), MedStar (Harbor and Franklin Square)
Number of Interventions:	11
Total budget requested for CY16:	$12,334,379
CY17 Budget without offsets:	$15,500,000

The target population of the Community Health Partnership of Baltimore (the Partnership) is Medicare high utilizers. In alignment with the HSCRC and the West Baltimore Collaborative, high utilizers are individuals who experienced three or more hospitalizations in the past year.

Geographically, the target population resides in the following 19 zip codes: 21202, 21205, 21206, 21209, 21211, 21213-19, 21222-25, 21230, 21231, and 21237 which represent the combined community benefit service areas (CBSAs) of the partner hospitals. The Partnership worked with the Berkley Research Group (BRG) to further define the target population.

BRG limited the target population to high utilizers (3 or more admissions in FY2015) who lived in the 19 zip codes, who were over age 18, and who had touched one of the partner hospitals in this time period and who have specific chronic and potentially avoidable conditions, including mental health and substance abuse. Using these criteria, BRG found that there were 3,148 unique high utilizers (all payers) who had a total of 11,247 inpatient visits in FY2015. Among these high utilizers, 904 were Medicare beneficiaries and 808 were dually eligible for Medicare and Medicaid. Looking at the inpatient utilization specific to this population, almost 30% of utilization is associated with conditions that are potentially avoidable. Therefore, our initial target population is the 1,712 patients in the combined Medicare and dually eligible population.

The top conditions among the target population identified by BRG were heart failure, sepsis and disseminated infections, renal failure, chronic obstructive pulmonary disease, diabetes, hypertension, obesity, pneumonia and hepatitis. Mental health and substance abuse conditions were also highly prevalent: 61% (547) of Medicare patients and 78% (627) of dually eligible patients had a mental health or substance abuse condition. Total charges for the combined Medicare and dually eligible population in FY2015 were $119,400,000.

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

Partnership across city hospitals to address regional health offers a new perspective and new opportunities to come together to address health determinants. By partnering across hospitals, primary care practices, community organizations, and skilled nursing facilities, this regional partnership hopes to begin changing the drivers of health in Baltimore City that have led to high utilization and poor health outcomes to a long term financially sustainable model with improved health outcomes.

In designing interventions, the partnership's initial focus was to address current gaps in the regional system's ability to coordinate care for the target population. The strategies identified below, incorporated coordination across the different settings to ensure patients are moving across the settings and receiving care in settings that are the most appropriate.

Intervention	Start Date	Workforce and Infrastructure Needs
Community Health Care Teams	Operational	In place
Bridge Team	Y1, Q2	• Psychiatrist, physician addictions specialist, medical consultant, peer support specialists, Health Behavior Specialist, Health Behavior Specialist team leader, community health workers, nurse (some may be re-deployed from other programs)

		• Space—identified with Catholic Charities, MOU in process
House Calls	Y1, Q3	• Geriatrician and other team members (some to be redeployed) • Space
Community-based CHWs	Operational	• Expand CHW team • Case management IT platform that allows sharing of data with CBOs (system identified, to be deployed)
Neighborhood Navigators	Operational	In place. Additional CBO will be identified Y1, Q2 to host the intervention in another location in the city.
Patient Engagement Training	Operational	Team in place and has capacity.
CHWs in the ED	Y1, Q2	Hire additional community-based CHWs and deploy in the ED.
Convalescent Care	Operational	Intervention is in operation; funds will allow hiring of staff to create additional capacity.
SNF Collaborative	Y1, Q2	None
SNF Protocols	Ready to be deployed	None
Home-based Strategies	Ready to be deployed	None

Measurement and Outcomes Goals (300 word limit)

In designing metrics that will be used to measure progress, we focused on evidence-based measures that we can reliably report on, using existing data sources whenever possible. We recognize the value of aligning performance measures with existing initiatives such as the Maryland State Health Improvement Plan, Meaningful Use, Patient Centered Medical Home, the National Quality Forum, CMS Physician Quality Reporting System, Johns Hopkins Community Health Partnership (J-CHiP), and the Johns Hopkins Medicine Alliance for Patients (JMAP) ACO in order to reduce duplication of data collection and reporting efforts. Our measurement plan was shared with the West Baltimore Collaborative, and the partnerships mutually agreed that alignment across measures would be beneficial for working towards common city health goals, for simplifying documentation necessary from providers, and for maximizing our mutual understanding of how health outcomes change across Baltimore City as a result of the proposed interventions.

The measures chosen for the dashboard represent a high level view of how progress across the Partnership will be measured, based on the interventions that are deployed by all hospital partners. The measures fall into three main domains: process, quality, and utilization and costs. Metrics were chosen based on the following considerations:

- Availability of data
- Quality of data
- Feasibility of data collection
- Source of data
- Potential to inform quality improvement and demonstrative improvement
- Alignment with current reported performance metrics
- Alignment with the West Baltimore Collaborative

Additional measures will be incorporated into an internal monitoring plan that will provide information necessary to monitor implementation plans and to provide data for continuous quality improvement initiatives for the interventions described in this proposal.

Return on Investment. Total Cost of Care Savings (300 word limit)

The number of patients reached in the Partnership is based on reaching 50% of the 3,148 high utilizers defined in the catchment area in CY 16. In CY 17, the assumption is that 75% of the high utilizers will be engaged in an intervention and in CY18, 100% of the high utilizers will be engaged in an intervention. A savings of 5% in annual charges is expected in CY16 due to reductions in inpatient hospitalizations, including readmissions, decreases in lengths of stay and reductions in ED utilization. With ongoing efforts of the Partnership, savings are expected to increase to 10% in CY17 and 15% in CY18.

Annual Net Savings ($9,228,900) ($6,782,404) $1,471,346 $1,471,346
Return on Investment 0.23 0.55 1.10 1.10

Though not reflected in the ROI calculations, changes in the delivery system including provider training and education on patient engagement, the development of a SNF collaborative and community engagement through our partners are all expected to engage patients in their overall care and improve prevention efforts that could accelerate the expected savings described so that they are realized sooner than 2018 and are potentially larger than the conservative estimate provided above. As a positive ROI is realized funds will be reinvested back into the interventions that show the most benefit.

Scalability and Sustainability Plan (300 word limit)

Scalability

All of the interventions in the Partnership are scalable. Decisions to expand to additional practices, expand teams or deploy interventions in new zip codes within the Partnership will be based on lessons learned. Because the evaluation metrics may take several months to manifest, we will complement these longer-term metrics with short-term metrics. This data will enable ongoing performance monitoring and rapid-cycle feedback and allow for expansion of successful interventions more quickly.

Sustainability

Measuring and improving value is the driving force of the Partnership. Value in healthcare is defined as quality outcomes achieved per dollar spent, or expressed as Value=Quality/Cost. If the Partnership's interventions result in improvements in quality health outcomes and positive member experience while cost is held constant, we will have improved the value of healthcare to Medicare beneficiaries. The Partnership will integrate alternative funding through improved billing practices to help ensure long-term sustainability. During Q1, the Partnership will work with entities such as Med Chi to address barriers to use of the chronic care management code and to increase provider utilization. Changes to the 2016 Medicare physician fee schedule will include two new advance care-planning codes; we will educate providers and encourage appropriate use. As additional services/codes become reimbursable from the payer(s), we will pursue them.. As we find sustainable reductions to hospital services under the GBR, a portion of those funds will be reinvested in the programs.

Over the longer term, it is unlikely that the funding of these interventions can remain solely the financial responsibility of the hospital secondary to potential changes in the hospital's rates. The hospitals will work with the HSCRC and the payer community to assure that the savings achieved benefit not only the payers but that the savings ultimately flow back to patients.

Participating Partners and Decision-making Process. Include amount allocated to each partner. (300 word limit)

The hospital members of The Community Health Partnership of Baltimore (Johns Hopkins Hospital, Bayview Medical Center, Sinai Hospital, Mercy Medical Center, MedStar Franklin Square Hospital and MedStar Harbor Hospital) all participated in the planning process and contributed to the development of the proposed interventions. A steering committee and multiple subcommittees and workgroups were established. Decision-making was consensus-based. Each hospital agreed to share the costs of leadership and central operational functions proportionate to total revenue. Hospitals were able to select which specific interventions to implement, which created flexibility and made decision-making easier.

Each hospital partner has agreed to pool its .25%. JHH and JHBMC are including an additional .25 to cover interventions not selected by the Hospital partners as Johns Hopkins is not filing a separate application like many of the other hospital partners.

Hospital Partners	amount allocated
Johns Hopkins Hospital (.5)	8M
Johns Hopkins Bayview Medical Center (.5)	2.8M
MedStar Franklin Square Medical Center (.25)	1.1M
MedStar Harbor Hospital (.25)	0.5M
Mercy Medical Center (.25)	1.3M
Sinai Hospital (.25)	1.8M
Total	15.5M

The hospital partners have discussed a governance structure. A finalized structure will be described in a definitive agreement among the parties to be signed by each hospital's President before the end of Q1, calendar year 2016. Each of the hospitals will participate in the governance of the venture and will appoint representatives to a board or operating committee to be formed once the definitive agreement is executed. The board or operating committee will review the previous year's performance, including finances, quality and strategic direction. The board or operating committee will appoint a management company to manage the business and affairs of the venture and provide leadership, grant administration

The following implementation activities will be launched immediately and simultaneously.

Leadership: Will consist of Director, Administrator, Case Manager and Behavioral Health Program Managers, Project Manager, Provider Champions and a Financial Analyst.

Operations: The leadership team will launch CQI, Analytics, Evaluation, and IT efforts.

House Calls: Provide home-based medical care, care management, caregiver support, counseling, and acute inpatient continuity to high-need, high-cost home-bound individuals longitudinally.

Community-based CHWs: Provide intensive, longitudinal community-based care coordination to mitigate barriers to access, engagement, and adherence.

Neighborhood Navigators: Build capacity through intensive training and mentoring of community residents, who in turn provide social support**,** education, resource connection and linkage to care and promote engagement and help mitigate barriers to appropriate care for all members of the community (payer-agnostic).

Patient Engagement Training: Train providers and staff on the skills needed to facilitate patient engagement, effect health behavior change and promote patient satisfaction.

ED Coordination with CHWs: Deploy CHWs to the EDs to help address social determinants of health barriers and connect patients to a patient-centered medical home.

Convalescent Care: Expand access for people experiencing homelessness who are discharged from the hospital to a place to stay and recuperate from an acute illness or surgery.

SNF Collaborative: Create a SNF Preferred Provider Network modeled on Lifebridge's, conditioning referral relationships on quality and process criteria.

SNF Protocols: Implement standardized protocols for heart failure, COPD, sepsis and other infections, end of life and behavioral health problems.

Home-Based Strategy: Deploy remote patient monitoring and home health aide services.

Budget and Expenditures. Include budget for each intervention (300 word limit)

Personnel $1,490,977
Information Technology $395,670
Primary Care Teams/Care Coordination $2,748,920
Bridge Team $901,203
House Calls $606,820
CHWs in the Community $1,850,771
Neighborhood Navigators $805,522
Patient Engagement Training $91,580
ED Coordination with CHWs $422,825
Convalescent Care $374,568
Skilled Nursing Facility Collaborative $0
Skilled Nursing Facility Protocols $131,050
Home Based Strategies $953,942
Intervention Monitoring $519,164
Other Indirect Program Support $1,041,367

Total Request CY16 (start-up year) $12,334,379

Greater Baltimore Medical Center

Greater Baltimore Medical Center

Hospital/Applicant:	Greater Baltimore Medical Center
Date of Submission:	12/21/15
Health System Affiliation:	GBMC
Number of Interventions:	3
Total Budget Request ($):	$3,444,002 FY16 and FY17

Target Patient Population (Response limited to 300 words)
The target population is high-utilizer patients who frequent GBMC's acute care hospital. These **1,054 adult patients** had two or more inpatient or observation encounters in FY 2015, they represent 56% of GBMC's high utilizing patient population, their usage accounted for 36% of total Medicare charges last fiscal year. More than half (56%) of high-utilizers have at least one chronic condition and/or mental health and substance abuse diagnosis. Of the 1.054 Medicare high utilizing patients 97% have at least 1 chronic condition, 98% of the cases and 97% of charges are associated with Chronic Conditions and 84% of the patients have at least 2 or more chronic conditions (primarily hypertension, diabetes, congestive heart failure, and coronary artery disease). Within the target population of 1,054 high utilizers (emphasizing the middle tier of 840 patients), GBMC plans to focus Medicare high utilizers as the first payer source to provide services to.
Summary of program or model for each program intervention to be implemented. Include start date, and workforce and infrastructure needs (Response limited to 300 words)

Upon awarding of the grant within 10 days we expect to begin rolling out the following programs:
• **The Behavioral Health Enhanced Patient-Centered Medical Home (BHE-PCMH)** - The proposed program builds upon the patient-centered medical home model already operating in GBMC's primary care practices by strengthening existing primary care teams with a mental health professional and by providing ready access to psychiatric consultation services.
  ○ **The Behavioral Health Network (BHN)** - The proposed model integrates new behavioral health resources into the continuum of care to provide the following:
  ▪ Psychiatric consultation in the hospital
  ▪ Post discharge mental health support
  ▪ Telehealth services
• **Palliative Care and Support Our Elders: Home- and Facility-Based Care for Complex Chronic Patients** – The proposed program in partnership with Gilchrist and MedStar, will identify patients with multiple chronic conditions who require frequent hospitalizations due to the advanced degree of the chronic condition(s). This program will also provide clinical staff for palliative care efforts in 2 nursing homes within the services area. In partnership with MedStar, GBMC will coordinate efforts to provide care within patients home through home visits by a nurse practitioner.
• **Expansion of Care Coordination and Care Management Services**- GBMC has embraced the PCMH model in nine primary care offices with a deliberate focus on care coordination, preventive health care and population health. GBMC's approach placed an emphasis on helping patients achieve and maintain better health with tactics in place to reduce avoidable hospital admission and unnecessary emergency department use, eliminate gaps in care for routine screenings and improve quality outcomes for patients with chronic conditions.

Measurement and Outcomes Goals (Response limited to 300 words)
The overall goals of the programs described above are to reduce readmissions, reduce visits to the emergency room, and reduce PAU's and to reduce the cost of care to patients. The objective is to move patient care back into the community with primary care physicians and care managers providing the services needed. In order to reach the overarching outcomes GBMC has designed programmatic goals and measures to achieve the global outcomes. Please see Appendix A, tables 1-3 to view the HSCRC required outcomes and GBMC's programmatic metrics.
Return on Investment. Total Cost of Care Savings. (Response limited to 300 words)
The ROI calculated for the years 2017-2019 are: **1.28, 1.92, and 1.92** respectively. From a broad perspective, shifting avoidable acute care to more cost effective care in the primary are and community-based settings will inherently save payers money, as we have found with our ACO and the implementation of patient centered medical homes. Since each of the interventions are expected to positively impact PAUs and PQIs, the GBMC system will invest these savings to expand upon the proposed program for continued cost savings. Specifically, GBMC is strategically planning to focus on the Medicare portion of the high utilizer population during the grant period (CY 2016) to secure the highest ROI in the short term. Thereafter, GBMC will reinvest into the program with scalability plans for Dual Eligibles, followed by Medicaid
Scalability and Sustainability Plan (Response limited to 300 words)
Through the three interventions described above, GBMC expects to realize a sustainable and scalable model of integrated health care that better manages high-risk patients and reduces avoidable hospital admissions and ER visits. The requested rate increases will enable GBMC to achieve the population health model proposed in this application, which will in turn reduce healthcare costs and ultimately ensure financial sustainability. Since the three programs are leveraging existing population health efforts the programs are easily scalable across this patient population and eventually across all payers whose patients need the services GMBC is proposing
Participating Partners and Decision-making Process. Include amount allocated to each partner. (Response limited to 300 words)

In addition to utilizing the current ACO structure to be consistent the population health approach and management of the high utilizers, GBMC has partnered with the following community resources to provide the needed resources to make the three interventions successful.

- Allegeant
- Baltimore County Health Department
- Care Progress, LLC
- Catholic Charities
- Evergreen Health
- Health Care for All Coalition
- Keswick Multi-Care Center
- Kolmac Clinic
- Mosaic community services
- MedStar
- Sheppard Pratt Health System

As such there is representation as advisors to our ACO governance structure from SNF's, nursing homes, families and patients as well as other community resources GBMC depends upon.

Implementation Plan (Response limited to 300 words)

The attached implementation plan is geared to beginning much of this work February 1st. The initiative to provide care to our elders is a service that is "shovel ready" to begin today. The Behavioral Health network is a referral process that can be provided today. To strengthen our patient centered medical home we will contract with Mosaic and Sheppard Pratt to have psychiatry and other behavioral health resources available to our existing medical home offices as of February 1, 2016. The additional resources to expand our patient centered medical home to care for the top utilizers will fill a need for the patients who are utilizing acute services.

The three new initiatives are leveraging existing population health efforts and providing further services to a much needed patient population.

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

The total program budget for the new initiative is $3,444,002 million which includes clinical professionals, administrative and analytics functions, training, and consulting support. GBMC anticipates that in the first six months of the grant award that there will be a "ramp-up" of clinical staff and more in the following calendar year. GBMC expects that the total clinical staff required for the program will be fully in place by 2017. GBMC does see the challenge of fully staffing mental health professionals in the PCMH, however has partnered with Kolmac and Shepperd Pratt to provide services for patients early on.

Howard County Regional Partnership

Howard County General Hospital

Hospital/Applicant:	Howard County General Hospital (HCGH)/Howard County Regional Partnership (HCRP)
Date of Submission:	December 21, 2015
Health System Affiliation:	Johns Hopkins Health System
Number of Interventions:	7
Total Budget Request:	$1,533,945

Target Patient Population

Given Howard County's growing aging population and the high costs associated with chronic conditions in the older population, HCRP will initially focus its efforts on county residents who are Medicare high utilizers. Concentrating on high cost, complex Medicare beneficiaries aligns with the goals of Maryland's All-Payer Model. The Regional Partnership defines a Medicare "high utilizer" as a Howard County resident with at least two hospital encounters (inpatient, observation and ER visit) at HCGH in the past year, including individuals who are dually eligible for Medicare and Medicaid. Using FY15 case mix data from HCGH, 7,280 patients (all payer) were identified as high utilizers. Among this group, 1,940 were Medicare beneficiaries and 670 were dually eligible, which together comprised 36% of the total high utilizer population in Howard County. The target population (2,610) accounted for 3,579 inpatient visits, 196 observation stays greater than or equal to 24 hours, 243 observation stays less than 24 hours, and 3,859 ED visits. Of the 2,610 patients in the target population, the majority (1,710) had between 2 and 6 chronic conditions. Eighty percent (2,090) of the target population is 65 years or older; 51% of those individuals are 80 years or older.

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

HCRP will deploy specific strategies that result in a highly reliable, efficient, and patient-centered health care delivery system. Interventions to be implemented or expanded in 2016 include:

- **Community Care Team (CCT)** – Existing care coordination intervention, based on Camden Coalition model. Referral pathway from acute setting will be expanded and two new pathways implemented from the post-acute and primary care settings.
- **Acute Interventions** – Embed a community health worker in the ED to coordinate real-time referrals to community-based services. Continue existing Rapid Access Program to address urgent mental health care needs.
- **Post-Acute Interventions** – Implement final phase of standardized discharge process from HCGH to Lorien's three skilled nursing facilities (SNFs). Implement care pathways for sepsis and congestive heart failure (CHF), the two leading causes of readmissions from SNFs. Establish referral pathway to CCT from SNF. Monthly case conferences to review discharges, planned and unplanned transfers and identify areas for improvement.
- **Primary Care Interventions** – Implement referral pathway to CCT in six practices. Continue existing practice transformation efforts. Align Advanced Primary Care Collaborative with HCRP.
- **Patient Engagement Training (PET)** – Training program for CCT, providers and staff in each care setting to realize goals of person-centered care.
- **Specialized Care Coordination** – Through partnership with Gilchrist Services, implement 1) in-home medical care program for home-bound frail elderly; 2) care choices program for hospice eligible cancer, COPD, CHF and HIV/AIDS patients; and 3) care coordination program for those discharged from hospice. Expand connection points to faith-based initiative - Journey to Better Health - for those needing ongoing community support.
- **Support Tools for Care Coordination** – Expand remote patient monitoring program for CHF patients. Implement "Powerful Tools for Caregivers" program through County Office on Aging. Develop Community Resources Management System with County Health Department.

Measurement and Outcomes Goals

HCRP's initial focus is on Medicare high utilizers but ultimately looks to address the needs of all Howard County residents. To measure these outcomes and progress, HCRP created a high level metrics dashboard that represents the key interventions proposed, key quality and patient satisfaction measures, and key outcome measures to be monitored. Internally, more extensive monitoring of each intervention will be done for ongoing operational and quality improvement purposes. The Ambulatory Quality and Transformation Team from Johns Hopkins Community Physicians will perform continuous quality improvement (CQI) functions for our partner primary care practices. The population health analytics team established by HCGH, will perform CQI functions for the acute and post-acute settings, in coordination with existing internal hospital efforts as well as those in place for Lorien facilities. HCRP's Partnership Performance subcommittee will monitor performance and outcome metrics, oversee quality improvement activities and, if needed, propose changes to programs. Based on an analysis of FY15 case mix data, there are 2,610 individuals in our target population. The average total hospitals charges is $16,590 per person. The average number of total visits was 3.02 per person, with an average hospitalization and observation rate of 1.61 per person and an average ER visit rate of 1.48 per person. The readmission rate for the target group was 21% (781) and potentially avoidable utilization (based on prevention quality indicator categories) accounted for 19% (734) of the 3,775 inpatient and observation cases (greater than or equal to 24 hours) in the target population.

Return on Investment and Total Cost of Care Savings

HCRP anticipates a 5% savings on the annual charges associated with the target population engaged in CY16. The savings rate increases to 10% in CY17 as initiatives continue to positively impact the patients engaged. Finally, by years three and four of the projection period, the savings rate stabilizes at 15% as the initiatives are fully productive and successful. Savings are recognized through the reduction of readmissions, the avoidance of hospitalization encounters and the reduction in the length of stay for those patients who ultimately require acute care services. The ROI projections anticipate that HCRP will reach 100% of the target population in year three (CY18). This also represents 36% of all-payer high utilizers. For CY16, 25% of the target population will be engaged in Regional Partnership interventions; 75% will be reached in CY17. The projections are based primarily on CCT, the Rapid Access Program and Gilchrist initiatives. Other initiatives such as physician alignment and provider education, the development of a SNF collaborative and other community partnerships should enhance the ability to appropriately reduce acute care utilization, achieve greater savings and improve the ROI outcomes.

Scalability and Sustainability Plan

HCRP interventions are scalable over time. Our intervention timeline, while aggressive, is sound in its staged rollout and affords for ramp up time as well as a period of stabilization and assessment. Real-time evaluation of Regional Partnership efforts will be critical to our success. The Partnership Performance subcommittee of HCRP's Steering Committee will be tasked with ongoing performance monitoring and rapid cycle feedback to enable any necessary mid-course changes. A principal goal of the interventions is the reduction of readmissions and other potentially avoidable utilization. Commensurate with a reduction in avoidable utilization and good expense management, the global revenue model (GBR) should serve as one source of sustainable funding for components of care coordination and other HCRP activities. Just as we will work with the HSCRC and the payer community to identify new funding opportunities, HCRP will also look to its community partners. Several HCRP interventions are already funded in part by community partners, including the specialized care coordination programs, the community resources management system and RAP. In addition, HCRP is working with primary care practices to explore opportunities to use a portion of Medicare reimbursement for TCM and CCM to support care coordination interventions.

Participating Partners and Decision-making Process

The Regional Partnership is made up of representatives from the hospital, primary care and specialty care

providers, skilled nursing facilities, home care services, behavior health providers and community-based organizations. Several key community-based organizations include the Health Department, the Department of Citizen Services and its Office on Aging, as well as member organizations of the Local Health Improvement Coalition (LHIC). During the planning grant process, we actively engaged with patients, family and caregivers and will continue to keep the voice of the patient and family at the center of HCRP efforts moving forward. Howard County is unique in that it has one hospital within its geographic borders. HCGH is truly the community's hospital; a majority of residents utilize the hospital for acute care needs. The HCGH Board approved the creation of a new board committee – the HCRP Steering Committee. This committee sets strategic direction and priorities**;** makes decisions regarding target population, budget and reinvestment of savings; and approves changes to interventions. Subcommittees will be established to perform planning and monitoring functions for key aspects of HCRP: Partnership Performance, Finance and Sustainability; Provide Alignment and Network Development; Consumer and Family/Caregiver Engagement;
and Community Health Integration and Social Determinants.

Implementation Plan

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The Maryland All-Payer Model provides a glide-path for change to realize health system transformation.

HCRP will serve as the primary vehicle to coordinate and deploy specific strategies to drive this transformation. As outlined above in the summary of the program, our work centers around seven categories of interventions – 1) Community Care Team; 2) Acute Care; 3) Post-Acute Care; 4) Primary Care;
5) Patient Engagement Training; 6) Specialized Care Coordination; and 7) Support Tools for Care Coordination. Detailed project plans have been developed for each intervention category. In addition, the Regional Partnership has mapped out a plan for standing up HCRP leadership and operations (including analytics, CQI and evaluation). We have prioritized shovel-ready programs, and therefore much of the work in CY16 will focus on the expansion of existing initiatives such our principal care coordination intervention – CCT. HCRP will fully leverage existing programs of community partners including Gilchrist Services, Healthy Howard's Journey to Better Health, and the County's Office on Aging. We are also breaking new ground with our SNF collaborative and with new programs in our primary and acute care settings to address the needs of our target population of Medicare high utilizers.

The total annual cost for HCRP is $1,533,945. The prorated costs for 2016 is $1,033,077 and is based on the implementation timeline and other sources of funding, both one-time and expected ongoing investments. For example, the CCT has funding through June from the Health Department as well as a grant from the Department of Health and Mental Hygiene. In addition, the hospital's strategic transformation plan is aligned with the work of the Regional Partnership. Building on infrastructure investments made to date, HCGH has committed to funding efforts in the areas of care coordination, population health analytics, behavioral health and provider alignment. The following table lists the budget (both total annual cost and prorated 2016 cost) for leadership, operations, and interventions. Interventions that fall under Specialized Care Coordination are not included as the costs at this time are covered by partner organizations.

Budget Category	Total Annual Cost	Prorated CY16 Request
HCRP Leadership	$279,588	$245,630
HCRP Operations (Analytics, CQI, Evaluation)	$137,853	$131,853
CCT	$827,026	$468,606

Acute Interventions	$56,250	$28,125
Post-Acute Interventions	$120,000	$90,000
Primary Care Interventions	$67,500	$33,750
Patient Engagement Training	$21,228	$10,614
Support Tools for Care Coordination	$24,500	$24,500
Total:	**$1,533,945**	**$1,033,077**

Nexus Montgomery

Holy Cross Hospital; Holy Cross – Germantown; MedStar Montgomery General; Shady Grove Medical Center; Suburban Hospital; Washington Adventist Hospital

Hospitals/Applicants	**Six Lead Applicants: Holy Cross Hospital, Holy Cross Germantown Hospital, Shady Grove Medical Center, Washington Adventist Hospital, MedStar Montgomery Medical Center, Suburban Hospital**
Date of Submission:	**December 21, 2015**
Health System	Hospital / Health System Affiliation Holy Cross Hospital — Holy Cross Health Holy Cross Germantown Hospital — Holy Cross Health Shady Grove Medical Center — Adventist HealthCare Washington Adventist Hospital — Adventist HealthCare MedStar Montgomery Medical Center — MedStar Health Suburban Hospital — Johns Hopkins Medicine
Number of Interventions	**Four**
Total Budget Request ($)	**$7,950,216**

1. Target Patient Population

The geographic scope of services consists of the Maryland ZIP codes that represent the residence of 80% of the combined patient discharges across all six lead hospitals. These ZIP codes contain the incorporated cities: Gaithersburg, Rockville, Takoma Park, College Park, Glenarden, Greenbelt, Hyattsville, Laurel, and New Carrolton.

Health Stabilization for Seniors	Hospital Care Transition Programs	Post-Acute Specialty Care Ineligible-Uninsured	Service Capacity Building for Severely Mentally Ill
Medicare and Dually Eligible, Age 65+ • Seniors in community, unstable health, chronic illness, at risk of PAU • Seniors discharged from hospital-to-SNF-to-home, at high risk of readmission	All Payer Patients discharged from hospital-to-home • High utilizers • High risk of re-admit Each hospital uses risk assessment criteria to select patients.	Uninsured patients ineligible for ACA plans or Medicaid Discharged with specialty care needs • High utilizers • High risk of re-admit or PAU	Medicaid and Dually Eligible, all ages Patients with severe behavioral health diagnoses • High utilizers • High risk of re-admit or PAU

2. Program Interventions

Health Stabilization for Seniors	Hospital Care Transition Programs	Post-Acute Specialty Care Ineligible-Uninsured	Service Capacity Building for Severely Mentally Ill

Referral by senior housing resident counselors, EMS, PCPs, or at time of discharge to SNF Risk assessment using Care at Hand (mobile technology) and intensive care coordination with follow-up risk monitoring Start: May 2016	Care transitions services and warm hand-offs using Coleman method with modifications per each hospital Start: July 2016 Workforce: RNs, Case Managers, Community Health Workers	Ineligible-uninsured patients at high risk of readmission for up to 30 days post-acute ambulatory specialty care needs referred to Project Access. Start: April 2016 Workforce: RN Navigator	Start up funds to expand crisis beds (8 beds) and add Assertive Community Treatment (ACT) team Behavioral Health Integration Manager (BHIM) to support care team meetings and cross-organizational services.
Workforce: Care team: Nurse, scheduler, six community health coaches. Program manager and social worker oversee three teams. Infrastructure: Care At Hand mobile software. SNF-to-home root cause analysis and process improvement.	Infrastructure: • Learning collaborative for cross-hospital program improvement. • Care plan sharing. • Coordination with payer case management.	Infrastructure: Existing Project Access program. Existing electronic referral system.	Start: Crisis Beds: Feb 2017 ACT team: May 2016 BHIM: April 2016 Workforce: BHIM Infrastructure: Existing ACT and crisis bed providers.

3. Measurement and Outcomes Goals

The NM RP region (42 target ZIP codes) generally has lower utilization and readmission rates than Maryland overall. However, the sheer size of the region's population – 23% of the Maryland population and 21% of Medicare FFS beneficiaries) magnifies even small changes in measured rates when translated to costs. Therefore, also faces a rapidly growing senior population that is becoming a larger percent of the total population. Therefore, the NM RP hospitals performance on outcome measures can have significant impact on NAPM. As the senior population grows, the NM RP hospitals and the region must have strong programs in place to maintain and improve performance on the key NAPM measures.

The NM RP interventions are designed to produce reductions in the following outcome measures, both for All Payer and for Medicare FFS and Dually Eligible, as follows:

Outcome Measure	All Payer				Medicare FFS			
	Baseline	Projections			Baseline	Projections		
	CY2014	CY2016	CY2017	CY2018	CY2014	CY2016	CY2017	CY2018
Total hospital cost per capita (charges per person)	$1,436	$1,432	$1,424	$1,424	$4,493	$4,461	$4,415	$4,414
Total hospital admits per capita (admits per 1000)	84.3	83.9	83.2	83.2	235.5	232.9	228.3	228.3
ED visits per capita (ED visits per 1000)	246.2	246.0	245.7	245.7	281.7	280.8	279.8	279.8
Readmission Rate	11.73%	11.40%	10.92%	10.90%	16.47%	15.72%	15.15%	15.12%

Initially, beginning to serve clients drives improvement. Later reductions come through the NM RP process improvement infrastructure, including a learning collaborative for the hospitals care transition programs and gains made in use of CRISP. Process improvement will focus on critical elements that improve return on investment: driving down program per patient cost; improving the targeting of patients to those at highest risk of hospital utilization; and increasing the efficacy of the programs at reducing admissions, readmissions and/or ED Visits for the patients served.

4. Return on Investment / Total Cost of Care Savings

The Governance Board intends a tiered framework for reinvestment into programs that support shared populations or shared challenges of the NM RP hospitals. This tiered framework focuses first on programs supporting immediate NAPM goals, second on programs creating longer-term gains in population health status, and third on developing programs mutually benefiting payers and NM RP hospitals. Payers will realize a return from the NM RP programs in the form of reduced hospital utilization by their members. Net savings and ROI for each intervention is shown below. The interventions proposed have not been evaluated for their capacity to reduce total cost of care beyond the hospitals.

Health Stabilization for Seniors (HSS)	CY2016	CY2017	CY2018	CY2019
Annual Net Savings (Medicare)	-$1,210,513	$1,968,703	$2,119,059	$2,119,059
ROI: HSS Program ROI	0.48	1.54	1.58	1.58
Hospital Care Transitions Expansion	**CY2016**	**CY2017**	**CY2018**	**CY2019**
Annual Net Savings (All Payer)	$14,215	$ 655,489	$ 786,976	$ 925,037
Annual Net Savings (Medicare)	$ 8,422	$ 310,822	$ 372,297	$436,846
ROI: Hospital Care Transitions	1.01	1.33	1.40	1.47
Post-Acute Sp. Care (Ineligible Uninsured)	**CY2016**	**CY2017**	**CY2018**	**CY2019**
Annual Net Savings (Uncomp. Care)	$ (4,499)	$ 10,333	$ 10,333	$ 10,333
ROI: PA-SC	0.97	1.04	1.04	1.04
Capacity Building for the SMI	**CY2016**	**CY2017**	**CY2018**	**CY2019**
Annual Net Savings (Medicaid)	$(841,649.5)	$ 106,028	$434,226	$ 434,226
ROI: Capacity Building for the SMI	0	1.22	3.08	3.08

5. Scalability and Sustainability Plan

The NM RP programs are sustainable without additional rate increases. Each program creates a positive return on investment, though each has a different cumulative net savings curve and date at which the program passes the breakeven mark. All programs produce cumulative savings through reduced admissions within two years. NM RP will use the savings to scale these or other programs, to sustain programs with reinvestment as costs rise over time or new technologies become available, or to build out new programs with evidence-based potential for return. Each of the programs is designed for further scaling as long there remain more high risk/ high utilizing patients than capacity of a program. NM RP recognizes that program return on investment is predicated on serving only those patients that meet high-risk criteria, so programs will not be scaled beyond that need.

Broadening scope will also be considered for reinvestment funds. For example, as PCPs referring high-risk seniors to the HSS program develop trust in the program, this may create interest in a Chronic Care Management program for their chronically ill, but stable, Medicare patients, which could be built as a shared resource with the physician community.

As the NM RP matures, joint efforts for upstream interventions to prevent or control the disease states that most impact hospital utilization (e.g. cardiovascular disease, diabetes) is expected.

6. Participating Partners and Decision-Making Process

All six Montgomery County hospitals are lead applicants and full collaborative partners in NM RP, each contributing an equal percentage of net revenue plus markup to the programs and interventions, making each an equal participant relative to its revenues. The rate increase total of $7,950,216 is allocated to partners, as follows: Holy Cross Hospital ($2,228,020), Holy Cross Germantown Hospital ($267,233), Shady Grove Medical Center ($1,856,312), Washington Adventist Hospital ($1,230,145), MedStar Montgomery Medical Center ($855,404), and Suburban Hospital ($1,513,102).

The NM RP Governing Board will have a representative from each hospital and set policy and direction for NM RP under the guidance of an Operating Agreement (key aspects of governance: committees, board seats, partners roles, voting rights) and a Participation Agreement (partnership processes: e.g. non-performance of an NM RP member, data management and sharing plan, patient protection plan, financial accountability and conflict of interest, and reporting requirements). The Governing Board can expand to up to nine seats to incorporate community partners and representatives with particular expertise. A Physician Advisory Board, comprised of a range of providers from the community, will advise the Board. The Board has two standing committees – a Partnership Program Intervention Committee (P-PIC) and a Finance Committee. The P-PIC is comprised of board and community representatives. In addition, interventions will work with specific networks of community stakeholders, including patients, families, and care-givers.

7. Implementation Plan

The workplan details:

- Implementation: four interventions
- Technology improvements (CRISP use and care plan sharing)
- Monitoring and evaluation (data collection and analysis/evaluation)
- Governance and management

All four interventions are ready for implementation immediately post-award.

- Health Stabilization for Seniors: NM RP selected a care coordination vendor (The Coordinating Center, TCC). TCC, PCC, senior living facilities, residents/, and stakeholders continue meeting to accomplish preliminary activities in expectation of funding. With March award, TCC can begin seeing clients on May 1, 2016. Expansion to SNF-to-home clients occurs in August 2016, and reaches scale in December 2016.
- Scale Up of Existing Hospital Care Transitions Programs: Each hospital needs only to add staff to scale existing operations. Staff recruitment and training is planned for 16 weeks post-award, with an estimate of July 1, 2016 as the date the programs are scaled. As 30-day readmission programs, new staff will manage full caseloads by late July 2016.
- Post-Acute Specialty Care Ineligible-Uninsured: An existing program, Project Access, has the needed infrastructure (e-referrals, network of specialists, RNs and bilingual client support workers). In the first month, the initial high readmission risk criteria will be refined, and hospital discharge planner/care transitions teams will be trained in referral processes. Months 3, 4, and 5 will pilot the program at reduced patients, with full patient load reached July 1, 2016.
- Capacity Building for Severely Mentally Ill: Cornerstone Montgomery started their second 8 bed crisis house in 2014 and will follow the same work plan. Milestones: procure Crisis House by September 2016, renovate and open by February 2017. ACT team start-up is a well-documented process. NM RP is meeting with potential vendors (PEP, Cornerstone); with selection targeted pre-award. Pending DHMH approval for ACT team expansion, clients are seen in month 3, with full client load by month 20 (estimate October 2016).

8. Budget and Expenditures

The budget presented is a Rate Year 2017 budget. This represents the annualized operational costs for the NexusMontgomery Regional Partnership interventions and infrastructure going forward. The total request, representing 0.5% of FY15 Approved Net Revenue plus markup for each of the Lead Hospitals, is **$7,950,216.**

Budget Category	1. Health Stabilization for Seniors	2. Hospital Care Transitions	3. PA-SC for Ineligible-uninsured	4. Capacity Building for SMI	NM RP Infrastructure
Labor	$ 2,499,276	$ 1,919,144	$ 29,267	$ 206,937	$ 910,984
IT/Technologies	$ 326,927	n/a	n/a	n/a	n/a
Other Impl. Act.	$ 598,020	55100	$ 224,400	$ 690,000	$ 13,287
ODC	$ 98,293	0	0	0	$ 378,582
TOTALS	$ 3,522,515	$ 1,974,244	$ 253,667	$ 896,936	$ 1,302,853

CY2016 will be a shortened operating year (ten months) and is the year in which all interventions ramp up and achieve steady state, except Crisis Bed and ACT Team expansions. The CY2016 budget is $5,639,434.

Total Eldercare Collaborative

MedStar Good Samaritan; MedStar Union Memorial

Hospital/Applicant:	MedStar Good Samaritan Hospital; MedStar Union Memorial Hospital
Date of Submission:	December 18, 2015
Health System Affiliation:	MedStar Health, Inc.
Number of Interventions:	One
Total Budget Request ($):	$1,882,870 Permanent Funding

Target Patient Population
The ***Total Elder Care Collaborative (TEC-C)*** seeks to ***demonstrate the efficacy and scalability of the shovel-ready MedStar Total Elder Care (MTEC) home-based primary care*** model for complex older patients in order to: 1) improve clinical outcomes; 2) improve the patient and family experience; and 3) lower the total costs of care. The *TEC-C* will achieve this vision by delivering home-based primary care to elders in **eight ZIP codes in the county of Baltimore City**, including the cities of Baltimore, Roland Park, Govans, Idlewylde, Loch Hill, and Northwood. Unlike traditional disease management programs, the MTEC model of home-based primary care ***focuses on the overall needs of high-risk elders, regardless of specific disease conditions***. The major health needs for this population are functional disability, care coordination, social support services, management of multiple severe chronic illnesses, and palliative and end-of-life care. The targeted geographic area in Baltimore City includes a population of elders that have multiple chronic conditions. The major conditions found in this population include dementia, stroke, psychiatric disease, congestive heart failure, chronic obstructive pulmonary disease (COPD)/respiratory failure, severe chronic kidney disease, cancer, diabetes, hypertension, and falls. Typically, several of these conditions are present in one individual. These frail elders have high symptom burden and functional impairment, which predict greater mortality and higher medical costs, including a risk of emergency department visits, hospital admission, and use of postacute care services (De Jonge et al., 2014).
Summary of program or model for each program intervention to be implemented

Frail elders will receive services from MedStar's shovel-ready, nationally recognized house call model of primary care (De Jonge et al., 2014). This home-based primary care program was previously known as the Medical House Call Program (MHCP) when developed in Washington D.C. and is now known as ***MedStar Total Elder Care (MTEC)***. Since 1999, MedStar Health has operated an MTEC-style program through MedStar Washington Hospital that cares for ill elders at home and across all settings. MTEC teams are guided by four principles: 1) a humane approach to care of frail elders; 2) state-of-the-art diagnostic tests, treatment, and technology at home; 3) coordination of all medical and social services across settings, until the end of life; and 4) economic viability for patients, providers, and payers.

MTEC consists of modular and geographically-targeted teams who serve the most ill subgroup of elders in a catchment area, usually within a 20-minute driving radius. Each team module consists of 10 staff, including geriatricians, nurse practitioners, care coordinators, triage nurses, and social workers. The core element of success is ability to offer ***a single, comprehensive source of home-based medical and social services for patients and their families.*** Core services include home-based primary care, 24/7 on-call medical staff, continuity to the hospital, intensive social services, and coordination of all specialty and ancillary services. As of 2015, MTEC has served over 3,200 elders in Washington D.C. and has an active census of 620 patients. Each team can serve a total of 300-350 frail elders. The goal of the *TEC-C* is to demonstrate the scalability of this model to Maryland, beginning with eight targeted ZIP codes in the county of Baltimore City.

Measurement and Outcomes Goals

TEC-C will monitor the following core outcome measures in the population of frail elders enrolled in *TEC-C*:

- Total hospital cost per capita; Total hospital admits per capita; Total health care cost per person; ED visits per capital; Readmissions; Potentially avoidable utilization; Patient experience

TEC-C will approach the core process measures in the following way:

- *TEC-C* is a home-based care delivery model. The *TEC-C* team is fully registered with CRISP and receives 100% of the alerts from CRISP.
- *TEC-C* screens for eligibility for the MTEC program using a geriatrics health risk assessment at intake. As all patients are screened, we expect 100% completion.
- *TEC-C* care teams currently develop and document care plans, goals of care, and advanced directives within the clinical notes for all patients enrolled in *TEC-C*. *TEC-C* will continue this method and expect 100% completion.
- The MTEC approach is designed so that each member of the care team works together serves as a collective group of care manager for each patient enrolled in *TEC*-C. By definition, this measure will be 100% for all patients at all time points.

TEC-C will monitor the following programmatic measures for patients enrolled in *TEC-C*:

- Follow-up visit completed within 2 days of hospital discharge or ED visit; Medication reconciliation completed within 2 days after transition from hospital or ED; Cause of Program Exit; Death Data; Provider Satisfaction / Retention

Return on Investment. Total Cost of Care Savings

The *TEC-C* care model will help move the state of Maryland towards the overall goals and requirements of the new All-Payer Model by decreasing hospital inpatient utilization by 19% and outpatient utilization by 20%, thus decreasing hospital cost of care. The TEC-C will decrease total cost of care by also reducing post acute care services specifically, skilled nursing facility costs. Finally, TEC-C will improve the quality measures by reducing readmissions and improving patient satisfaction.
A positive ROI of 6,754 is expected by CY2018 with a total of 528 reached patients. The number of patients enrolled is based on historic experience of staff recruitment and actual patient enrollment.

As positive ROI is realized. Payers will benefit through a lower total cost of care and a lower per capita cost for their patients

Scalability and Sustainability Plan

TEC-C is sustainable without additional rate increases in future years, beyond the ongoing amount associated with this award in the following ways:

- The MTEC program has demonstrated success having reduced per capita Medicare costs by 20 percent as part of IAH, and having received a 60% share a $1.8 million payment from CMS in July, 2015 (MedStar Washington Hospital Center, 2015). ***We hypothesize that Baltimore City elders enrolled in MTEC teams will also experience similar significant Medicare savings***.
- By operating in the proposed *TEC-C*, the catchment area of the two lead hospitals becomes central to the identification of frail elders eligible for enrollment. As these hospitals which are operating under the GBR capped revenue model begin to reduce utilization and increase quality, margins have the potential to become larger in the long-term. ***These dollars could be reinvested back into the program to sustain and further expand this population health model***.

This award will allow *TEC-C* to build upon the existing evidence base of the MTEC model by providing an evidence base for MTEC implementation in Maryland. This evidence base will allow us to quantify the return on investment as a result of reductions in utilization and increased quality. ***While the model will require an initial investment in infrastructure for the care teams, the evidence-based return on investment should promote hospital leadership's willingness to invest in the MTEC model*** and ultimately position these hospitals to recognize similar savings due to reductions in utilization and increased quality.

Participating Partners and Decision-making Process.

TEC-C is designed to function as a true collaborative for the effective care of frail elders enrolled in MTEC. Therefore, regular forums involving the mobile care teams, clinical partners, and community partners are essential to foster a shared decision-making process around care plans, challenges, and opportunities. *TEC-C* has weekly care team meetings where all teams and partners are invited to attend.

The formalized governance structure of *TEC-C* is positions the patient at the center of *TEC-C*. Given this paradigm, we have "flipped" the traditional top-down nature of our governance chart and include the patient and the services received toward the top and programmatic leadership at the bottom.

The current clinical and administrative leaders for MTEC will function as the clinical and administrative leaders for *TEC-C*. These individuals will be responsible for the overall leadership of the collaborative, including the MTEC program. *TEC-C* clinical, community, "other" partners will directly interface and collaborate with the mobile care teams in MTEC. The monitoring and evaluation partners will work with data, information systems, billing, and financial specialist to ensure accurate and timely reporting of key measures.

Implementation Plan

Deployment of the first mobile care team will occur in April 2016. Deployment of the second mobile care team will occur in July of 2017, once the first care team reaches the capacity of 300-350 patients. Other activities that facilitate implementation include: establishing the business structure; executive staffing; clinical staffing; community partner engagement; establishing operational guidelines; leasing facilities and purchasing equipment; and EMR transition.

Budget and Expenditures: Include budget for each intervention

Workforce: *TEC-C* personnel salaries will be established based on fair market compensation and a small premium for the difficult work of making house calls. Three additional FTEs for data analytics, increased outreach, & HSCRC reporting were added to the budget. We estimate $1,294,577 in year 2016, $1,938,509 in year 2017, and $2,605,107 in year 2018 for this budget category.

IT/Technologies: IT/Technologies include expenses for start-up needs, and modest adaptation. These include laptops with mobile data plans; cell phones; server configuration and support to access patient information under HIPPA standards; some EMR specialization for population health management such as time tracking and interface configuration to CRISP alerts; and "black bag" medical supplies such as pulse oximeters, stethoscopes, B/P cuffs, and wound debridement supplies. Budget amount is based on experience and market rates. We estimate $82,688 in year 2016, $101,463 in year 2017, and $110,160 in year 2018 for this budget category.

Other implementation Activities: Other implementation activities include clinical personnel regulatory requirements, adequate safety support to teams and patients, community partners' engagement, emergency patient care needs, and workflow improvements to enhance provider efficiency and flexibility. We estimate $57,260 in year 2016, $103,501 in year 2017, and $145,948 in year 2018 for this budget category.

Other Indirect Costs: We estimate $305,579 in year 2016, $298,178 in year 2017, and $330,865 in year 2018 for this budget category.

Based on the above, total expenses/investments for *TEC-C* are $1,581,072 in year 2016, $1,882,870 in year 2017, and $1,863,492 in year 2018.

Trivergent Health Alliance

Frederick Memorial Hospital; Meritus Medical Center; Western Maryland Hospital Center

Hospital/Applicant:	Trivergent Health Alliance Regional Partnership, consisting of three co-lead applicants: Meritus Medical Center (MMC), Western Maryland Health System (WMHS), Frederick Regional Health System (FRHS)
Date of Submission:	December 21, 2015
Health System Affiliation:	Trivergent Health Alliance, LLC.
Number of Interventions:	4
Total Budget Request ($):	$7,707,608 (Year 2, following ramp up completion in Year 1)

Target Patient Population (Response limited to 300 words)
The Alliance Regional Partnership has four interventions with three distinct target populations within our tri-county region of Allegany, Frederick and Washington counties: **1. Patients with Behavioral Health (BH) diagnoses.** This includes all BH diagnoses, with the top five being Depression, Anxiety, Bipolar, Psychosis and Substance Abuse, with a focus on patients who have had an inpatient BH stay and/or ED visit with BH diagnosis. **2. High utilizers of inpatient services who may benefit from Complex Care Management.** These patients have three or more Inpatient/Observation discharges in a year with diagnoses of diabetes, cardiac disease including Congestive Heart Failure (CHF), and/or respiratory disease including Chronic Obstructive Pulmonary Disease (COPD), as well as anticoagulation patients. 3. **High utilizers of Emergency Department (ED) Services**. These patients have six or more ED visits in a year. These target populations capture many of our highest cost Medicare and dual eligible patients, to align with the goals of the All-Payer Model. Although the preliminary focus is on the Medicare population, the target population also includes patients from all other payers who meet the criteria. Our long-term plan is to improve population health for the 455,000 Marylanders in our region, which includes all zip codes and cities/towns in our three counties.
Summary of program or model for each program intervention to be implemented. Include start date, and workforce and infrastructure needs (Response limited to 300 words)
1. **Behavioral Health (BH):** We will provide outpatient BH case management, early detection, and support for at-risk patients, including: - **1.1: Implement BH Care Management (leveraging the model in place at WMHS).** The start date is April 2016. Masters-level BH Case Managers are needed to support this initiative. - **1.2: Integrate BH into primary care to identify patients at-risk and link them to appropriate resources.** The start date is April 2016. The Masters-level BH CM's added for BH initiative 1.1 along with primary care office teams will work together to implement this initiative. - **1.3: A Population Health initiative to reduce stigma and increase understanding of BH needs through community health education, such as Mental Health First Aid (MHFA).** The start date is April 2016. Workforce and infrastructure needs for this initiative are the hiring of an MHFA regional coordinator as well as books and supplies for the trainings.

2. **Complex Care Management for High Utilizers:** We will replicate and refine components of local best practices and standardize common metrics for a regional care management model for hospital High Utilizers with certain chronic disease conditions. The start date is April 2016 .The workforce and infrastructure needs are 45.7 FTE.
3. **Potentially Avoidable ED Visits:** We will reduce potentially avoidable ED use by (a) improving care coordination and transitions, and (b) providing high-touch support to ED High Utilizers to identify needs early, aid in care transitions, and engage community-based support. The start date is April 2016. The workforce and infrastructure needs are 13.6 FTE.
4. **Regional Care Management Education Center (RCMEC):** The RCMEC will offer education programs to Care Management professionals and relevant support staff of the Alliance member hospitals and partners. The start date is May 2016. The workforce and infrastructure needs are 4 FTE, plus $1M technology start up.

Measurement and Outcomes Goals (Response limited to 300 words)

Progress will be gauged using process and outcome measures, including quality, patient experience, and financial indicators. We will use CRISP data to monitor and track the overarching measures that are critical to the success of the All-Payer Model (such as hospital costs per capita, readmission rates, and ED visits per capita). We will also use hospital data for intervention-specific metrics such as behavioral health admission and readmission rates. Measures will be collected and analyzed at least monthly. Progress will be tracked at the hospital and the regional level using a centralized dashboard that provides actionable information about areas for needed improvement. ***Attachment A, Table 5*** shows, by strategy, our FY15 baselines on key metrics for each target population, including:

- **1.1:** In FY15, this target population had 9,098 behavioral health ED visits. Goal: 6% reduction.
- **1.2:** Currently 46% of employed and ACO practices screen annually for depression. Goal: Universal screening (100%).
- **1.3:** In FY15, 440 individuals were trained Mental Health First Aid. Goal: 500 individuals in Yr1.
- **2:** In FY15, there were 4.4 admissions and 1.3 readmissions per High Utilizer patient; in total, they incurred ~$52.5 million in inpatient and observation charges. Goal: Reduce HU admissions, readmissions, and charges, using the WMHS costs avoided algorithm to track progress.
- **3:** In FY15, the target population had 5.7 ED visits per patient and ~$10.5 million in total ED charges. Goals will be established by July 2016.
- **4:** We will track the # of individuals trained through the new RCMEC and establish baseline in Yr1.

Spanning all initiatives, we will use CRISP/HSCRC data to measure aggregate improvements on All-Payer measures listed in the RFP, which are closely linked with our intervention-specific measures. The evidence supporting our initiatives can be found in the literature and in the positive outcomes experienced within our individual hospitals.

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

We expect to achieve a four-year, cumulative Medicare and Dual Eligible cost savings of $13,629,629 and an overall Return on Investment (ROI) of 2.78, using the ROI template provided in the RFP. Savings will build from year one, and we expect the initiatives to remain sustainable via the ongoing hospital retention of the global budgets at each hospital. The total savings for all payers of $55,645,962 exceeds the total intervention costs for all payers of $29,436,309 to result in a four year cumulative savings of $26,209,653. These savings will accrue as a result of our proposed initiatives due to the reduction of PAU,

Readmissions, Admissions, ED visits, and Observation visits among the target populations. Strategy 2 has the largest ROI because the High Utilizer population for this strategy is 79% Medicare/Dual Eligible and thus the interventions directly impact Medicare costs. Additional detail on ROI by strategy and by payer can be found in ***Attachment B.*** We plan to reinvest these savings we achieve as a Regional Partnership in hospital care management programs and outpatient care managers and BH counselor programs to sustain the existing programs. We also expect to identify new opportunities and areas for potential investment. Additional areas of opportunity that we would like to explore to achieve All-Payer aims include end-of-life care and improving utilization and costs in Skilled Nursing Facilities. The CHWs, BH counselors, and care managers that will be hired as part of our Regional Partnership initiatives will also be able to expand their caseloads as they become more experienced in working with these populations, resulting in additional efficiencies and returns. All payers (Medicare, Medicaid, commercial) are expected to receive savings via reductions in ED, Inpatient, and Behavioral Health inpatient utilization rates.

Scalability and Sustainability Plan (Response limited to 300 words)

The financial sustainability of our initiatives is based in large part on cost reductions for High Utilizers, complex patients, and behavioral health patients through better care management and reductions in avoidable, ambulatory-sensitive utilization. The target populations we have identified are among the highest-cost, highest-need patients we see, and we believe there is vast opportunity for improving the processes and tools we use to treat them that will yield positive results, both in reduced medical costs and improved patient outcomes. The sponsor hospitals have provided the Initial Equity Funding for the Trivergent Health Alliance, and the Trivergent Health Alliance MSO. The Alliance also intends to address Skilled Nursing facility utilization. With the Strategy 2, we identified that approximately 17% of the HU patients were residents of a SNF. We believe that further investigation in each of our communities is warranted for this patient population as a group unto itself. Because 58% of all Medicaid patients in these counties are covered by Maryland Physicians Care (MPC) MCO, we believe that the savings generated from these strategies for Medicaid lives will be shared with MPC through reduced utilization The nonprofit Maryland health systems have participated in HealthChoice since inception. MPC has helped the DHMH and the State to resolve serious threats to Maryland's Medicaid program. We also believe that there is opportunity to address end of life care. The Sponsor Hospitals have committed their senior Leadership teams as well as their Board Chairs and Vice Chairs to provide guidance and support to the Executive teams. These corporations (LLC's) were created for the purpose of furthering the triple aim of CMS as embodied in the mission, vision, and values of the Alliance: reduce costs, improve quality, and improve the health of the populations of the geographic regions served by the three sponsor hospitals.

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

Trivergent Health Alliance was created to pursue the Triple Aim as embodied in its mission, vision, and values. The Alliance Regional Partnership has developed a transparent and collaborative regional governance structure that includes representation from each of our three health systems. The Executive Committee, reporting to the Alliance Board of Directors, meets biweekly and provides hands-on oversight of the multidisciplinary work teams. Dedicated work teams support each strategy that will remain in place during implementation. Each work team has representation from each hospital, has a designated Chief Financial Officer to provide financial advice, a data analyst, and designated team lead(s).
The Executive Committee is the decision-making body that includes senior leadership from FRHS, MMC and WMHS. The Executive Committee provides recommendations and updates to the Alliance Board of Directors. Decisions are made based on achieving consensus among representatives from all three Alliance hospitals. The Alliance Board of Directors meets quarterly, or as needed, to review and approve

key items such as clinical initiatives, financial models, funds allocation, and staffing. If our proposed funding amount is approved, the amount we will allocate to each Alliance hospital by CY 2017 when the initiatives have scaled will be: **WMHS:** $2,248,938; **MMC:** $2,697,758; **FRHS:** $2,760,929; **Total:** $7,707,625.

Additionally, physician and community partners are foundational to the success of Regional Care Transformation, both have voiced their support and willingness to engage in the strategies detailed in this application. Physician and community partner groups are engaged at the front lines with our work teams. The Alliance has also established a Community Advisory Committee (CAC), comprising community partner representatives including LHICs, Core Service Agencies, Skilled Nursing Facilities, Departments of Social Services, and Hospice agencies. The first CAC meeting was held in November. The group will continue to meet every other month and participate in the implementation process.

Implementation Plan (Response limited to 300 words)

The implementation work plan begins upon receipt of the award in February. Once the award value is known, the project budget will be brought into alignment with the award value. After finalizing the projects budgets, the new FTE positions will be posted. For year 1, an aggressive plan to deploy four strategies, their respective processes, workforce and technology needs, and a phased flagging process to identify the targeted HUs across the regional continuum of care has been defined. During year 1, engagement of PCP's will be phased: first to focus on deployment of the strategies in sponsor hospital employed practices, and then to deploy the strategies across hospital affiliated ACO PCPs. Community Partners will be engaged through the Community Advisory Council and partner with the strategy work teams during process development and refinement. RCMEC will be launched and utilized to train the new staff for Strategies 1, 2, and 3. Year 2 will focus on continuous process improvement of the newly deployed strategies to ensure desired outcomes are being achieved; if not, apply Lean principles regarding problem solving to foster the cycle of continuous improvement. Year 2 into 3, opportunity to deploy the strategies to non-affiliated PCPs will be pursed within compliance of the Stark Laws. During Year 3 and 4, processes will be hard wired; areas for expansion will be identified and pursued based on regional data and applying Lean continuous improvement methodology.

Community and physician partners' engagement is vital for a successful implementation of the strategies proposed in the application. The implementation timeline defines their engagement from Feb. 2016 thru Dec. 2019, The level of engagement and specific key physician partners will evolve and change over time pending the needs of the targeted HU populations.

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

Our summary costs by hospital and by strategy are shown below. This includes all of the costs (workforce, IT/Technology, and enabling infrastructure) to implement the four strategies. All Year 1 FTE costs have been pro-rated to fund nine months of implementation, given that the award notice will be received in February, and allotting for the time needed to recruit and hire. The 2017, 2018, 2019 total costs include full implementation of all four strategies.

Strategy:	CY 2016	CY 2017	CY 2018	CY 2019
Strategy 1- BH	$1,916,216	$2,201,379	$2,147,449	$2,147,449
Strategy 2- CCM	$3,702,624	$4,312,274	$4,201,754	$4,201,754
Strategy 3- ED PAU	$1,094,640	$1,193,955	$1,158,405	$1,158,405
Total Cost per Year	$6,713,480	$7,707,608	$7,507,608	$7,507,608

UM St. Joseph

UM St. Joseph Medical Center

Hospital/Applicant:	University of Maryland-Saint Joseph Medical Center
Date of Submission:	12/21/15
Health System Affiliation:	University of Maryland Medical System
Number of Interventions:	1
Total Budget Request ($):	$1,147,000

Target Patient Population (Response limited to 300 words)

In the program's initial iteration, the Behavioral Health Center ("BHC") at University of Maryland Saint Joseph Medical Center ("UM SJMC") will provide specialized psychiatric outpatient resources focused on relapse reduction coupled with community health worker in-home support to a target patient population who meet the following criteria:
• Medicare patients
• Who suffer from a Major Mental Health diagnosis
  o Schizophrenia, Bi-Polarity, or other psychotic disorder
• Identified as high utilizers
  o 2+ bedded care admissions of greater than 24 hours within past year
• Who also suffer from at least 1 chronic condition
The BHC will function in tandem with UM SJMC's Post Discharge Center (PDC), currently under development, to offer treatment to those patients whose mental health conditions manifest as a Major Mental Health illness, separate but not exclusive from depression or related illness. There are very limited transition options for these patients, and the BHC will serve as an important and essential bridge resource for patients in the community.

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

The BHC will provide comprehensive psychiatric management of the target patient population, with interventions to include: pharmacological treatment, evidence-based cognitive group psychotherapies and Centeral case management. The BHC will work out of the existing space utilized by the PDC on UM SJMC campus. BHC staff will include psychiatrists, psychiatric social workers, psychiatric nurses and psychologist therapists, who will offer evaluation, a specialized treatment focused on relapse prevention, and support to patients in collaboration with existing providers. Following the period of supervision, the BHC will transition the patient to existing community resources, allowing for continuity of treatment.

To ensure patient well-being in the community, UM SJMC will fund an expansion of its Maxim Transition Assist (MTA) program, to offer in-home services to BHC patients. MTA is a private health services entity that already provides care management to UM SJMC patients for a period following discharge, will staff Behavioral Technicians dedicated to furnishing services to BHC patients, in line with Assertive Community Treatment models. It is anticipated that the BHC and MTA expansion will come online shortly after grant award, with BHC operations beginning February 29, 2016.

Measurement and Outcomes Goals (Response limited to 300 words)
In the program's initial iteration, programmatic metrics will be consist of: • process metrics with the following data elements: # monthly encounters: center visits/telephonic CM; # of encounters by initial admission DRG; % of High Risk patients scheduled at center prior to discharge; No show rate for patients scheduled at center; Average number of days between discharge and being seen at center; % of patients with: hand off to PCP or appropriate specialist within 90 days; medication reconciliation; Advanced Care planning, who test positive for mental health diagnosis; Referral source; Average number of days between 2nd visit to center (if applicable). • Clinical outcomes, post-intervention, including: % of patients receiving pharmacy support, NP/MD support; % of referrals made to community programs; 90 utilization rates for Admissions, Observations and ED visits. • patient satisfaction surveys addressing Access, Quality and Communication The program will also maintain core process measures provided by the HSCRC to include: Use of CRISP (Encounter Notification Alerts, etc.); Completion of Health Risk Assessments; Established longitudinal care plans; Shared care profile, and target population with contact from an assigned care manager.
Return on Investment. Total Cost of Care Savings. (Response limited to 300 words)
The ROI calculated for the calendar years 2017-2019 are **1.48, 2.23, and 2.23** respectively. UM SJMC is anticipating that by addressing mental and behavioral health needs of the Medicare patient population this will impact PAUs and PQIs, and the hospital will re-invest these savings to expand upon the proposed program for continued cost savings. UM SJMC is strategically planning to focus on the Medicare portion of the high utilizer population during the grant period (CY 2016) to secure the highest ROI in the short term. Thereafter, UM SJMC will reinvest into the program with scalability plans for Dual Eligibles, followed by Medicaid beneficiaries, and finally to commercial payers. Our goal is to meet the waiver requirements and to achieve the mandate of the all payer system.
Scalability and Sustainability Plan (Response limited to 300 words)
The UM SJMC program is strategically targeting the Medicare patient population and building core competencies around mental health programs to address their needs. With yearly program evaluations and meeting established outcomes and metrics, the BHC will be scaled to other payers such as Medicaid, Duals and Commercial payers. Year 1 and 2 expense will be offset by avoidable utilization savings which will be reinvested into the program. In future models, the program will expand to provide services to all payers with major mental health conditions. Such expansion will require additional staff, technology and infrastructure, that will be supported by the program's sustainability efforts. The program will be sustained primarily through savings generated through the reduction of PAUs, and funds captured through the permanent rate increase authorized by the grant award. Additionally, any billings for services rendered to the target patient population will be retained by the program.

Participating Partners and Decision-making Process. Include amount allocated to each partner. (Response limited to 300 words)
The BHC will receive advice and strategy on program structure and interventions from a governance council, made up of members from UM SJMC leadership and a number of stakeholders, categorized into three distinct categories along the care continuum: Community-Based Care, Acute Care and Post-Acute Care. The below mentioned members have submitted Letters of Intent to work closely with UM SJMC to best impact our Medicare target patient population: Primary care physicians, MTA, leadership from the Visiting Nurses Association, and Post-Acute providers: Lorien Health, Stella Maris, Genesis Health and Manor Care. Sheppard Pratt leadership and community service groups such as Mosaic and Keypoint have also expressed a strong interest to work collaboratively with UM SJMC. In the first year of this collaborative, decision-making power rests with UM SJMC.
Implementation Plan (Response limited to 300 words)
The attached implementation plan kicks off February 1st. The BHC is anticipated to be opened within 30 days of the grant award. Prior to that, UM SJMC is working towards solidifying workflow processes, communication plans to the targeted patient population, and continuing to work with providers. UM SJMC anticipates a patient ramp-up time of 3-4 months.
Budget and Expenditures: Include budget for each intervention. (Response limited to 300 words)
Findings from literature and existing initiatives provide strong and compelling support for UM SJMC to address unmet needs and develop creative new solutions for high-risk patients with severe and chronic mental illnesses as well as the chronically ill medical patients impacted by psychiatric comorbidities. The goal is to offer this high-risk cohort a relapse preventing treatment program coupled with comprehensive case management services in the outpatient setting for 60-90 days. Treatment will be provided by a highly trained team: psychiatrist with extensive pharmacological experience, psychiatric social workers with specialized experience in short-term crisis management and psychotherapy, as well as full knowledge of the breadth of community resources available to this population. The budget includes the expansion of MTA which will build off of their community health worker model (CHW) to assist with successfully transitioning this specific group of patients back into the community. To further hone in on the Medicare high utilizers that are admitted to UM SJMC, we will deploy two additional transitional nurse navigators that will channel patients to the post-discharge center and potentially the behavioral health center (as needed).

Upper Chesapeake

UM Harford Memorial Hospital; UM Upper Chesapeake Medical Center; Union Hospital of Cecil County

Hospital/Applicant:	Harford Memorial Hospital & Upper Chesapeake Medical Center, Union Hospital of Cecil County
Date of Submission:	December 21, 2015
Health System Affiliation:	University of Maryland Upper Chesapeake Health (UMMS), Union Hospital of Cecil County
Number of Interventions:	1 Integrated Set of Post Discharge / Community-based Interventions
Total Budget Request ($):	$2,716,456

Target Patient Population (Response limited to 300 words)
The purpose of the University of Maryland Upper Chesapeake Health (UMUCH) and Union Hospital of Cecil County (UHCC) Regional Partnership (RP) is to address the medical and social needs of high utilizer patients and those with multiple chronic conditions in Cecil and Harford Counties. The Regional Partnership will target Medicare and dual-eligible patients with either high rates of hospital utilization and/or multiple chronic conditions. High risk patients will be defined as patients with five or more ED visits or three or more admissions during the year. Also, patients with multiple chronic conditions will be identified as high risk. Of the 348,000 residents of the two county area, HSCRC data indicates that there are 1,550 patients classified as high utilizers and nearly 20,000 with two or more chronic conditions in Cecil and Harford Counties. The 2012 HSCRC data shows greater than 81,000 patients with a hospital encounter and at least one chronic condition. Cardiac related conditions such as coronary artery disease and hypertension were recorded in at least 30,000 charts for patients. Of the nearly 15,000 unique Medicare patients with at least one chronic condition, more than 50% have hypertension in Harford County and 40% in Cecil County. The initial focus of the program will require interacting with patients after they have "identified" themselves by coming back to the hospital. The RP also recognizes that a process for engaging these patients before they come to the hospital will be necessary and will allow providers in the community to refer patients to the program, even if they have not met the hospital utilization threshold. These patients may be described as moderate or rising risk that could benefit from these new interventions.
Summary of program or model for each program intervention to be implemented. Include start date, and workforce and infrastructure needs (Response limited to 300 words)
The RP aims to leverage existing investments in Post Discharge Clinics to extend the time that high risk patients are engaged with care management and coordination services. The new program creates a Community-based Care Management program that is comprised of teams of Community Health Workers or Social Workers lead by Nurse Care Managers. Patients may receive intensive medical and social support in the PDC (Day 0-30) and be transitioned to the CBCM (Day 31-90) to refine the care plan, coordinate patient appointments, provide ongoing education, and assess the patient's home situation. This new model will create a seamless support program for the patients that meets their needs and connects them with their existing or a new primary care provider in the community. Early data shows that the PDC is able to eliminate hospital utilization in 60% of patients in the 90 days post engagement. This program would extend this success to tackle the 40% that did have additional utilization. Direct referral to the CBCM program from Primary Care will also be developed to address the needs of the rising risk patients. This program relies on IT infrastructure that fosters greater communication among providers and allows for outreach as patient risk dictates. A partnership with CRISP will allow for stakeholders across the continuum of care to use a common Care Management and Secure Texting tools. Telehealth capabilities will also be added to the region to support home vital sign monitoring and video consultations for patients at home or in SNFs. UMUCH and UHCC will share learnings and use common approaches in the care of these patients. The RP will ramp up this activity and be ready to see patients by end of quarter 1 beginning of quarter 2 of calendar 2016.
Measurement and Outcomes Goals (Response limited to 300 words)

The program will target metrics consistent with the state transformation framework. This includes outcome measures that capture both utilization and cost (charges) data, as well as process measures that indicate improvement within the new delivery model. The RP will also develop a patient survey to monitor the satisfaction of patients with the CBCM program.

The outcome measures tracked by the RP include:

-30-day all-cause readmissions
-30-day ED revisits
-30-day readmission to observation status
-48-hour readmission from SNF
-Reduction in charges for High Risk Patients
-90 day pre/post intervention utilization

Process Metrics to be tracked include:

-Percent of patients that meet criteria that are referred to the PDC & CBCM
-ENS Subscribers in the community
-Percent of patients with a care plan in the new CRISP-hosted Care Management System
-EMS Call/ Response data by address
-Patient experience survey

This data will be collected and analyzed through emerging CRISP reporting capabilities as well as the implementation of a RP-wide Data Warehouse that incorporates information from multiple sources including the hospital EMRs, ambulatory EMRs, CRISP and eventually claims data. Preliminary review of the data relating to high risk patients indicates a reduction in the hospital utilization for patients that receive care in the UMUCH PDC. The expanded program and related IT capabilities will allow the RP to refine these care management processes, share clinical and social information with appropriate providers and better understand which patients should be targeted. The goal is to begin to draft and share reports, by community provider, that reflect Primary Care performance within these categories.

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

Building from the success of the current and planned PDCs at UMUCH and UHCC, the RP believes that an 8% reduction in the hospital utilization, as measured by charges, is possible within the first year of the program. This is contingent upon the program engaging 60% of the High Utilizer patients and 7% of the Multiple Chronic Condition patients. The gross savings is expected to rise incrementally in year 2 by 12.5% and another 11% in year 3. This is based on a greater percentage of engagement and more targeted outreach of patients, as the data analytics from both CRISP and the RP Data Warehouse become available. The ROI calculation results in a positive return ratio of 1.43 in year 1 with increases in the following two years (1.66, 1.93 respectively).

The RP is proposing a sliding scale savings sharing methodology with the payers in this program. The sliding scale is tied to the actual ROI performance of the program each year. The target ROI calculated is the anchor point on which savings would be shared with payers via a GBR reduction. In year one, for example, the target ROI is 43%. The RP would establish a performance corridor that earns the payer a 10% share and a performance corridor with a 15% share. Performance exceeding the high range of the second corridor would generate a third tier of savings with 25% of these dollars returning to the payers. The RP would be open to reevaluating the shared savings percentage at predetermined intervals if the data is available from the HSCRC or other sources. For example, if the ROI for the first two years significantly exceeds the projected target, the RP would be willing to increase the share percentage in each performance corridor for year 3.

Scalability and Sustainability Plan (Response limited to 300 words)
The hospital systems have agreed to use these grant dollars to jointly fund infrastructure that assist in the management of high risk patients. This includes IT Capabilities such as the Data Warehouse, Care Management Platforms, Secure Texting Programs and telehealth programs that are best deployed across a larger populations. For example, this RP spreads the costs associated with establishing the Data Warehouse over two counties and more than 350,000 potential patients. The RP has also worked closely with the CRISP team to identify opportunities for pilot programs that can be scaled within the state. The RP will help implement and design key functionality of the CRISP Care Management and Secure Texting programs to demonstrate value and ease implementation in other areas of the state. Additionally the RP will deploy a home telemonitoring program, Vivify, which allows program coordinators to manage larger patient populations as the risk of hospitalization increases. The CBCM teams are also scalable with four teams of five providers including RN Care Managers, Community Health Workers, and Social Workers. Based on funding and impact, the teams can be reduced to fewer positions that work with a smaller population in a defined geography in the two counties. Alternatively, these CBCM teams may remain intact, but the hiring of all four teams may be staged or delayed based on finances. This would leave a 5-person team operating in a slightly larger geography. Additional resources such a pharmacists, or the development of a PDC elsewhere in the RP market would be funded by savings from this program and would not require additional rate increases. The projected ROI for each year is expected to exceed 1.0-indicating self-sustainment as currently composed. The breakeven point for Year 1 is a savings of 5.6% with the RP projecting a savings of 8.0%.
Participating Partners and Decision-making Process. Include amount allocated to each partner. (Response limited to 300 words)
The use of these grant dollars will be governed by a Steering Committee comprised of members of the two hospital organizations. A Memo of Understanding will be finalized that details the expectations for both organizations and delineates the decision-making authority. This includes approving annual budgets, determine expansion or contraction of the program, and the exploration of participating in alternative payment programs such as the Medicare Shared Savings Program. An operating committee that includes members of the hospital systems, Cecil and Harford Departments of Health and Offices of Aging, Healthy Harford as well as CRISP to manage the process on an ongoing basis. This includes the decisions on data governance, CRISP Pilot program feedback, geographic assignment of patients or other tweaks to the process flows that improve the effectiveness of the intervention. The operating committee will make recommendations to the Steering Committee about future investment and programmatic changes based on data analysis via CRISP reports or the new Data Warehouse. The Offices of Aging will house an embedded Community Health Worker (1 for each county) as will the respective Departments of Health (1 each). The operating committee will determine if a similar resource should be deployed within the two FQHCs- West Cecil and Beacon Health. Additional stakeholders, such as Amedysis Home Health, Lorien Health, Hart to Heart Transportation, and MedChi will be invited to participate in the operating committee or necessary subcommittees. These stakeholders were active participants in the Transformation Planning Process this summer and fall.
Implementation Plan (Response limited to 300 words)
The RP has developed a robust project plan to bring the implement and deploy the needed resources for the new program. The program is based on the Deming Cycle (Plan-Do-Check-Act) such that new protocols, pathways or treatment algorithms will be created, reviewed and adjusted based on the needs of the target population. The project plan is divided into four sections: 1) The PDC 2) the CBCM 3) IT – Telehealth 4) Data

Warehouse. Additional project plans for the CRISP-hosted tools, Care Management and Secure Texting, will be developed in conjunction with CRISP and the technology vendor. The PDC plan is focused mostly on developing process flows and policies that enable the smooth transition of the target population from the hospital to the PDC to CBCM and on to the Primary Care Provider. The CBMC plan relates to drafting job descriptions, hiring and training staff and conducting employee assessments. A process to deploy temporary resources, currently existing within the hospital systems is also contemplated. The IT- Telehealth Plan calls for the acquisition of the technology with testing and training also covered. The Data Warehouse plan is a four phase plan that will be managed by an outside vendor. The plan detail shows when the reporting capabilities will come on-line and the length of time each aspect of the development takes.

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

The Hospital organizations are requesting $2,716,456 in funding to support this new, patient-focused program. The budget is comprised of three major components: Staffing, Information technology infrastructure and operating expenses. The staffing model calls for the addition of four (4) Nurse Care Managers, (16) Community Health Workers, two (2) social workers, and one (1) pharmacist to provide direct patient care, coordination or education to patients. Additionally two (2) clinical coordinators, one (1) program coordinator and 1 Data Warehouse administrator will be hired. The associated expense with benefits is $1,568,237. The IT infrastructure including the CRISP-hosted programs, Telehealth capabilities, and Data Warehouse will cost $834,408 annually. The staff training and program outreach activities will cost another $61,500 per year. The operating costs (mileage, data plans, and continuing education) and indirect costs associated with sharing an HR resource for posting jobs/ screening candidates, rent, etc., is budgeted for $228,330.

Maryland
Hospital Association

May 23, 2016

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

Dear Chairman Sabatini:

On behalf of the Maryland Hospital Association's (MHA) 64 member hospitals and health systems, I am writing to share concerns and recommendations regarding the Health Services Cost Review Commission's (HSCRC) Healthcare Transformation Implementation Grant Program.

HSCRC staff's proposal for the grant program awards funding for only nine out of 22 proposals. The total funding for these programs is $30.5 million, out of $42.8 million requested and from a previously-authorized pool of $37 million. Only two of the proposals received their full funding request and one program received just 43 percent of its request. This is troubling for several reasons:

- Hospitals that received partial funding or were rejected outright have not been given any explanation for those actions, raising questions about the evaluation and award process and its transparency. This will be important for those pursuing future grant programs.
- The 72-hour window that initially was provided to awardees to accept or reject the grants was unreasonable, considering the number of community partners involved and the unexpected less-than full grant funding. The last-minute staff recommendation to require that grant funds be shared back with payers between fiscal years 2018 and 2020 also affected the awardees' decision-making process. And this was unnecessary, given final action on these grant awards is not to be taken until the June commission meeting.
- It's unclear why only $30.5 million of the $37 million was awarded, when many programs that were vetted and deemed worthy by HSCRC staff remain underfunded. An explanation would be helpful. Withholding nearly 18 percent of the available grant money may limit the scope and success of the program, especially when a return on investment is expected in later years.

To ameliorate these concerns, we would recommend that the following steps be taken:

- Before finalizing the grant awards, give applicants a detailed explanation for rejection or partial funding

- Ahead of the September consideration of the allocation of the remaining $6.5 million in the grant program, provide greater clarity on criteria and the staff evaluation process, so that it is straightforward and transparent to those additional applicants who staff may consider for awards at that time

Thank you for your consideration.

Sincerely,

Michael B. Robbins
Senior Vice President

cc: Herbert S. Wong, Ph.D., Vice Chairman
Victoria W. Bayless
George H. Bone, M.D.
John M. Colmers
Stephen F. Jencks, M.D., M.P.H.
Jack C. Keane
Donna Kinzer, Executive Director
Steve Ports, Deputy Director, Policy and Operations

State of Maryland
Department of Health and Mental Hygiene

Nelson J. Sabatini
Chairman

Herbert S. Wong, Ph.D.
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Donna Kinzer
Executive Director

Stephen Ports, Director
Center for Engagement and Alignment

Sule Gerovich, Ph.D., Director
Center for Population Based Methodologies

Vacant, Director
Center for Clinical and Financial Information

Gerard J. Schmith, Director
Center for Revenue and Regulation Compliance

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **June 8, 2016**

RE: **Hearing and Meeting Schedule**

July 13, 2016	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
August 10, 2016	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room

Please note that Commissioner's binders will be available in the Commission's office at 10:45 a.m. and 11:45 a.m., respectively.

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website at http://www.hscrc.maryland.gov/commission-meetings-2016.cfm

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