State of Maryland
Department of Health and Mental Hygiene

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

511th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
September 10, 2014

EXECUTIVE SESSION
12:00 p.m.

1. **Administrative Issues**

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

1. **Review of the Minutes from the Executive Session and Public Meeting on July 9, 2014, and Executive Session on August 13, 2014**

2. **Executive Director's Report**

3. **New Model Monitoring**

4. **Docket Status – Cases Closed**
   2248N – Baltimore Washington Medical Center
   2250A – University of Maryland Medical Center
   2251A – MedStar Health
   2252A – MedStar Health
   2255A – Holy Cross Health

5. **Docket Status – Cases Open**
   2253N – Fort Washington Medical Center - Approved
   2254A – University of Maryland Medical Center - Approved
   2256A – University of Maryland Medical Center - Approved
   2257A – MedStar Health
   2258A – University of Maryland Medical Center - Approved
   2259A – Johns Hopkins Health System - Approved
   2260R – Holy Cross Germantown Hospital - Approved, awaiting additional language
   2261A – Johns Hopkins Health System - Approved
   2262A – Johns Hopkins Health System - Approved
   2263A – Johns Hopkins Health System - Approved

6. **Draft Recommendation on CRISP Funding and Partnership**

7. **Draft Recommendation for Updating the Quality Based Reimbursement Program for FY 2017**

8. **Update on Global Budgets**

9. **Report on Strategies for an Efficiency Measure**

10. **Summary of FY2013 Community Benefit Report**

11. **Hearing and Meeting Schedule**

Executive Session Minutes
Of the
Health Services Cost Review Commission

July 9, 2014

Upon motion made, Chairman Colmers called the Executive Session to order at 11:39 a.m.

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

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

In attendance representing staff were Donna Kinzer, David Romans, Steve Ports, Sule Calikoglu, Ellen Englert, and Dennis Phelps.

Also attending were Stan Lustman, Commission counsel, and Jack Meyer, Ph.D., Facilitator.

Item One

Donna Kinzer, Executive Director, provided data and the Commission discussed the opportunities for improvement in potential avoidable utilization associated with "High Needs Patients" as the Commission moves forward under the new Model.

Item Two

With Phase I of the All-Payer Model completed, Ms. Kinzer presented, and the Commission discussed, a draft of Phase 2 activities which included: regulation, partnerships for public engagement, monitoring, infrastructure development, provider alignment, process improvement, and the role of the Advisory Council and work groups.

Item Three

The Commission directed the Executive Director to come back with a plan for flexible and timely resources and funding for imminent and important activities needed to support successful implementation of Phase 2.

The Executive Session was adjourned at 1:07 p.m.

MINUTES OF THE
510th MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION

July 9, 2014

Chairman John Colmers called the meeting to order at 1:13 p.m. Commissioners George H. Bone, M.D., Stephen F. Jencks, M.D., MPH, Jack C. Keane, Bernadette C. Loftus, M.D., Tom Mullen, and Herbert S. Wong, Ph.D. were also in attendance.

REPORT OF THE JULY 9, 2014 EXECUTIVE SESSION

Dennis Phelps, Associate Director-Audit & Compliance, summarized the minutes of the July 9, 2014 Executive Session.

ITEM I
REVIEW OF THE MINUTES FROM JUNE 11, 2014 EXECUTIVE SESSION AND PUBLIC MEETING

The Commission voted unanimously to approve the minutes of the June 11, 2014 Executive Session and Public Meeting.

ITEM II
EXECUTIVE DIRECTOR'S REPORT

Mr. David Romans, Director Payment Reform and Innovation, stated that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of May will focus on fiscal year (July 1 through June 30) as well as calendar year results.

Mr. Romans reported that for the eleven months ended May 31, 2014, total gross revenue increased by 2.54% over the same period in FY 2013. Total gross revenue for Maryland residents increased by 2.40%; this translates to a per capita growth of 1.67%. Gross revenue for non-Maryland residents increased 3.98%.

Mr. Romans reported that for the five months of the calendar year ended May 31, 2014, total gross revenue increased by 1.35% over the same period in FY 2013. Total gross revenue for Maryland residents increased by 1.52%; this translates to a per capita growth of .81%. Gross revenue for non-Maryland residents decreased by .38%. Total Revenue under Global Budget Agreements increased by 1.88%; revenue under Total Patient Revenue agreements decreased by 1.52%; and total Out of State revenue decreased by 2.21%.

Mr. Romans reported that for the ten months ended April 30, 2014, Medicare Fee-For-Service gross revenue increased by 2.77% over the same period in FY 2013. Medicare Fee-For-Service for Maryland residents increased by 2.22%; this translates to a per capita growth decrease of

1.15%. Maryland Fee-For-Service gross revenue for non-residents increased by 9.04%.

Mr. Romans reported that for the fourth months of the calendar year ended April 30, 2014 Medicare Fee-For-Service gross revenue increased by .79%. Medicare Fee-For-Service for Maryland residents increased by .46%; this translates to a per capita growth decrease of 2.85%. Maryland Fee-For-Service gross revenue for non-residents increased by 4.48%.

Mr. Romans noted that May's Medicare Fee-For-Service revenue is still under review.

According to Mr. Romans, for the first eleven months of fiscal year 2014, the unaudited average operating profit for acute hospitals was 2.29%. The median hospital profit was 2.83%, with a distribution of 0.89% in the 25th percentile and 5.84% in the 75th percentile.

Dr. Alison Schuster, Associate Director Data & Research, stated that there will be no official update on the Potentially Preventable Conditions (PPC) data for May 2014 as staff found significant differences in the April 2014 monthly PPC rate from what was reported for April last month. Staff is currently looking into the causes for the change and plan on communicating their findings to the hospitals and emphasize to them that the preliminary monthly data need to be complete and accurate as possible for monitoring purposes and to ensure Medicare is receiving accurate Present-On-Admission on submitted claims.

Dr. Schuster reported that the April 2014 data on readmissions were not available.

Per Donna Kinzer, Executive Director, stated that staff focused on the following implementation activities June and July:

- Continuing implementation of global budgets and planning for July 1 update.
- Global budgets and Charge per Case monitoring.
- Continuing the development of monitoring for both the All-Payer and Medicare requirements.
- Preparing data analysis to calculate possible adjustments to global budgets for changes in transfers to Johns Hopkins Hospital and University of Maryland Medical Center.
- Preparing data analysis to develop approaches for market share adjustments.
- Developing additional implementation planning.
- Meeting regularly with the Center for Medicare and Medicaid Innovation staff to provide and obtain data needed for monitoring.

REPORT OF THE DATA AND INFRASTRUCTURE WORK GROUP

Dr. Sule Calikoglu Ph.D., Deputy Director Research and Methodology, presented an update on the status of the Data and Infrastructure Work Group (See "Data and Infrastructure Work Group Report: Recommendations on Data Infrastructure to Support Care Coordination" on the HSCRC website).

The Data and Infrastructure work group made the following recommendations:

- The State public and private sector health leaders need to develop a roadmap for its health care infrastructure.
- There should be a focused effort to get access to Medicare data because of its importance to care coordination and achieving the goals of the new model.
- The HSCRC and stakeholders should pursue the use of other data sources, in addition to comprehensive Medicare data, to support care coordination.
- The most efficient and effective way to host Medicare data is through a shared infrastructure that is accessible to hospitals and other providers
- Defining specific use of data will be important to preparing Maryland to setup an infrastructure efficiently as well as supporting the case to the Center for Medicare and Medicaid Innovation to secure the data.
- There needs to be an analysis of potential use cases of data to identify gaps in data sharing policy that should be addressed.
- Other infrastructure needs will need to be addressed.

REPORT OF THE PERFORMANCE MEASUREMENT WORK GROUP

Ms. Dianne Feeney, Associate Director Quality Initiative, presented an update on the status of the Performance Measurement Work Group (See "Performance Measurement Work Group Report to the Commission: Strategy for Population Based, Patient Centered Performance Measurement" on the HSCRC website).

WORK GROUP PLAN JULY – DECEMBER

Ms. Kinzer presented a draft update on implementation of Phase 2 of the Maryland New All-Payer Model (See "Maryland's New All-Payer Model Phase 2 of Implementation Planning, Public Engagement, Monitoring, and Infrastructure" on the HSCRC website).

ITEM III
PRESENTATION ON CARE MANAGEMENT/COORDINATION STRATEGIES AND DEMONSTRATIONS

Jack Meyer Ph.D., Managing Principal, Health Management Associates Advisory Council Facilitator, presented his report on the impact of care management on hospital utilization and spending (See "The Impact of Care Management on Utilization and Spending" on the HSCRC website).
Dr. Meyer shared his findings in which he provides a review of evidence about care management initiatives and a guide to setting priorities as the State implements the new all-payer model. He outlined the characteristics of successful strategies to improve health outcomes and lower total spending through improved care management for patients with complex medical needs.

MARYLAND'S HOSPITALS AND CARE COORDINATION UPDATE

Ms. Carmela Coyle, Maryland Hospital Association (MHA) President and CEO, shared the activities Maryland hospitals have engaged in to improve care coordination and MHA's work statewide with its readmission reduction initiative, "Transitions: Handle With Care"(See "Maryland's Hospitals & Care Coordination" on the HSCRC website).

ITEM IV
DOCKET STATUS CASES CLOSED

ITEM V
DOCKET STATUS CASES OPEN

2248N-Baltimore Washington Medical Center

On May 1, 2014, University of Maryland Baltimore Washington Medical Center (the Hospital"), a member of the University of Maryland Medical System, submitted a partial rate application to the Commission requesting a new rate for Anesthesiology (ANS) and Operating Room Clinic (ORC) services. The Hospital is requesting that the new rates be effective July 1, 2014.

After reviewing the application, Staff recommended:

1. That the ANS rate of $2.15 per minute be approved effective July 1, 2014;
2. That the ORC rate of $16.57 per minute be approved effective July 1, 2014;
3. That the Operating Room (OR) rate of $26.19 per minute be approved effective July 1, 2014;
4. That the ANS, ORC, and OR rates not be rate realigned until a full year's cost experience data have been reported to the Commission; and
5. That these new services will be subject to provisions of the new volume or Global Budget policies.

The Commission voted unanimously to approve staff's recommendation.

2250A- University of Maryland Medical Center

University of Maryland Medical Center (the "Hospital") filed an application on June 4, 2014 requesting continued participation in a global rate arrangement for solid organ transplant and blood and bone marrow transplants for one year with Aetna Health, Inc. beginning August 1, 2014.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ transplant, gamma knife, and blood and bone marrow transplant services for one year beginning August 1, 2014, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

2251A- MedStar Health

On June 19, 2014, MedStar Health System filed an application on behalf of Union Memorial Hospital (the "Hospital) requesting to continue to participate in a global rate arrangement for Cardiovascular services with Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. for one year period beginning August 1, 2014.

Staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for cardiovascular services for one year beginning August 1, 2014, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation. Commissioner Loftus recused herself from the discussion and vote.

2252- MedStar Health

On June 19, 2014, MedStar Health System filed an application on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals) requesting to continue to participate in a global rate arrangement for orthopedic services with MAMSI for a one year period beginning September 1, 2014.

Staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for orthopedic services for one year beginning September 1, 2014, and that the approval be contingent upon the execution of the standard Memorandum of Understanding.

The Commission voted unanimously to approve staff's recommendation.

ITEM VI
REPORT ON GLOBAL BUDGET CONTRACTS AND FY 2015 CHANGES

Ms. Kinzer presented an update on the global budget contracts and changes for Rate Year 2015 and beyond (See "Progress Report – Update on Global Budget" On the HSCRC website).

ITEM VII
FINAL RECOMMENDATION FOR REVISION TO THE RELATIVE VALUE UNITS SCALE FOR LABORATORY

Chris Konsowski, Assistant Chief-Audit & Compliance, presented staff's recommendation to adopt revisions to the Relative Value Units Scale for Laboratory.

The Commission voted unanimously to approve staff's recommendation.

ITEM XIII
LEGAL REPORT

Regulations

Final Action

New All-Payer Model Agreement Data Requirements- COMAR 10.37.10.03

The purpose of this action is to require hospitals to submit all data required for evaluation and monitoring purposes in compliance with the January 1, 2014 All-Payer Agreement executed between the State of Maryland and the Center for Medicare and Medicaid Innovation. This proposed regulatory change appeared in the May 2, 2014 issue of the Maryland Register. (41:9 Md. R 530).

The Commission voted unanimously to approve the final adoption of this proposed regulation.

Working Capital Differentials- Payment of Charges- COMAR 10.37.10.26B

The purpose of this action is to bring about greater uniformity in the calculation of current financing. This proposed regulatory change appeared in the May 2, 2014 issue of the Maryland Register. (41:9 Md. R 530-531).

The Commission voted unanimously to approve the final adoption of this proposed regulation.

ITEM XIV
HEARING AND MEETING SCHEDULE

August 13, 2014	Time to be determined, 4160 Patterson Avenue HSCRC Conference Room
September 10, 2014	Time to be determined. 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 3:33 pm.

Executive Session Minutes
Of the
Health Services Cost Review Commission

August 13, 2014

Upon motion made, Chairman Colmers called the Executive Session to order at 12: 45 p.m.

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

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

In attendance representing staff were Donna Kinzer, David Romans, Steve Ports, Sule Calikoglu, Ellen Englert, and Dennis Phelps.

Also attending were Stan Lustman, Commission counsel, and Jack Meyer, Ph.D., Facilitator.

Item One

Donna Kinzer, Executive Director, presented and the Commissioners discussed the proposed draft staff organization restructuring, implementation planning, and execution priorities.

Item Two

David Romans, Principal Deputy Director of Payment Reform and Methodology, presented the Medicare Monitoring Report through June 2014 and the Medicare Monitoring Report containing national Medicare data from CMMI.

Item Three

Ms. Kinzer led a discussion on external resource needs and possible partnership options.

The Executive Session was adjourned at 2:15 p.m.

Monitoring Maryland Performance

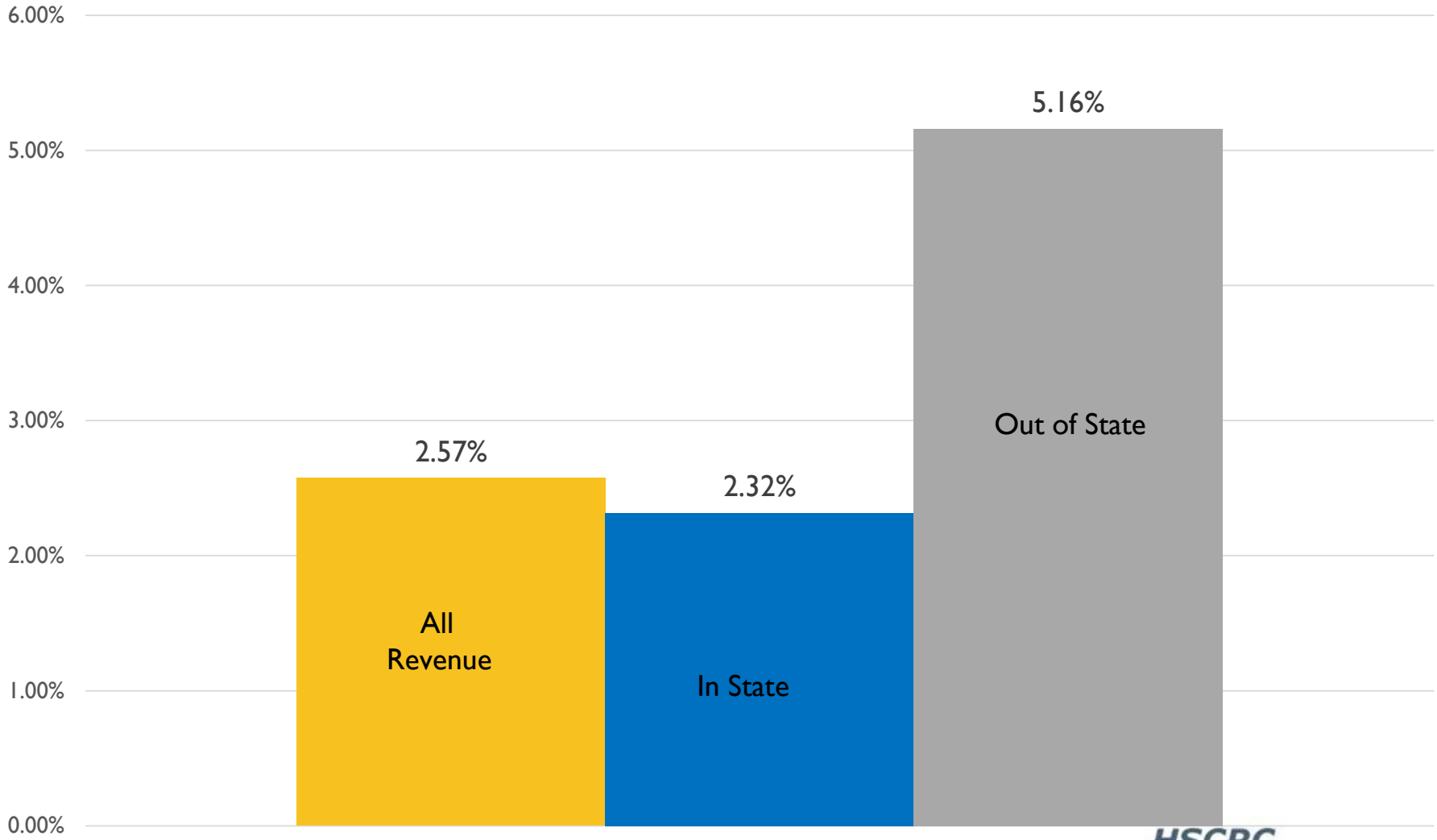
Financial Data

Year to Date thru July 2014

HSCRC
Health Services Cost Review Commission

Gross All Payer Revenue Growth

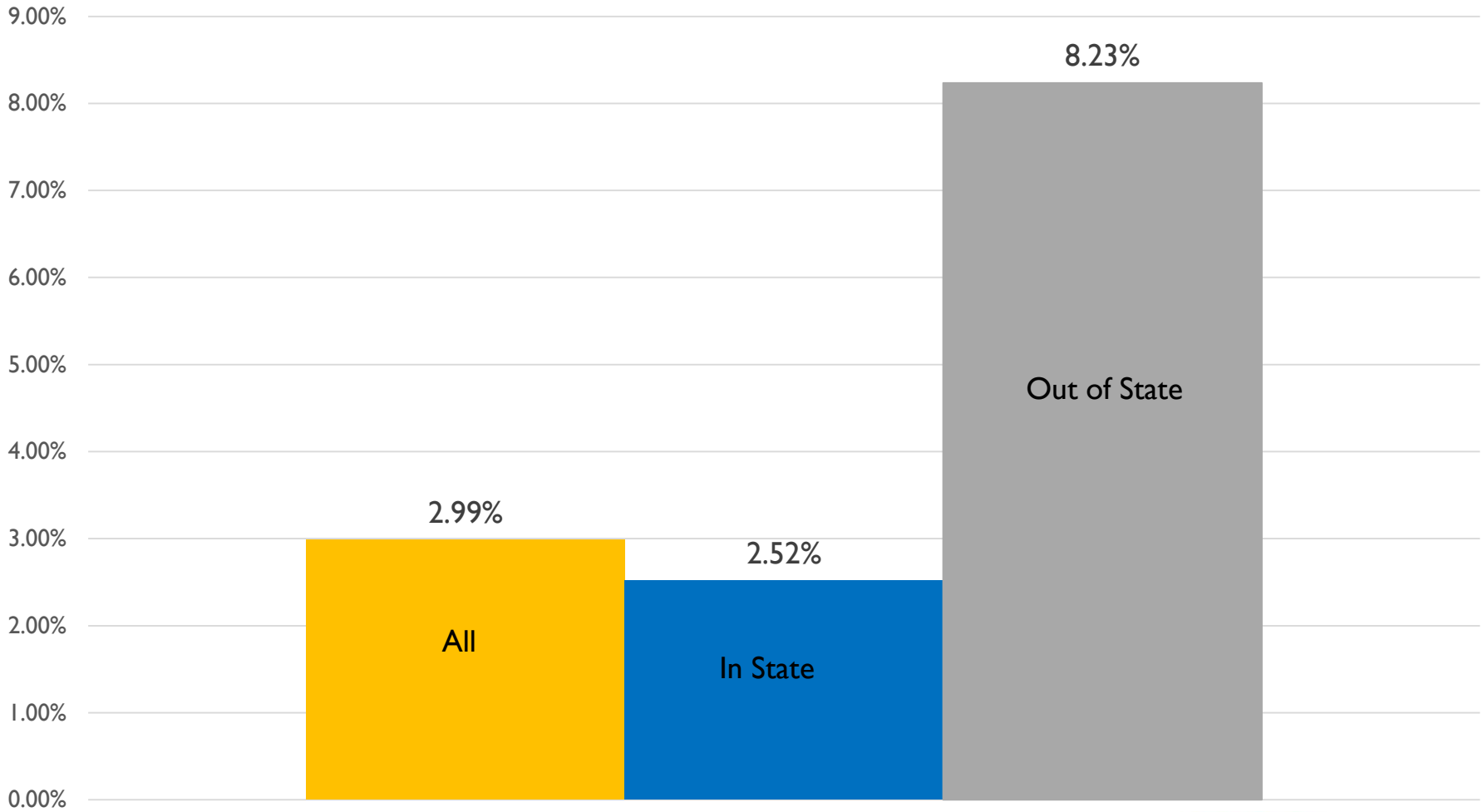
FY 2014 Final Compared to FY 2013 Final



HSCRC
Health Services Cost Review Commission

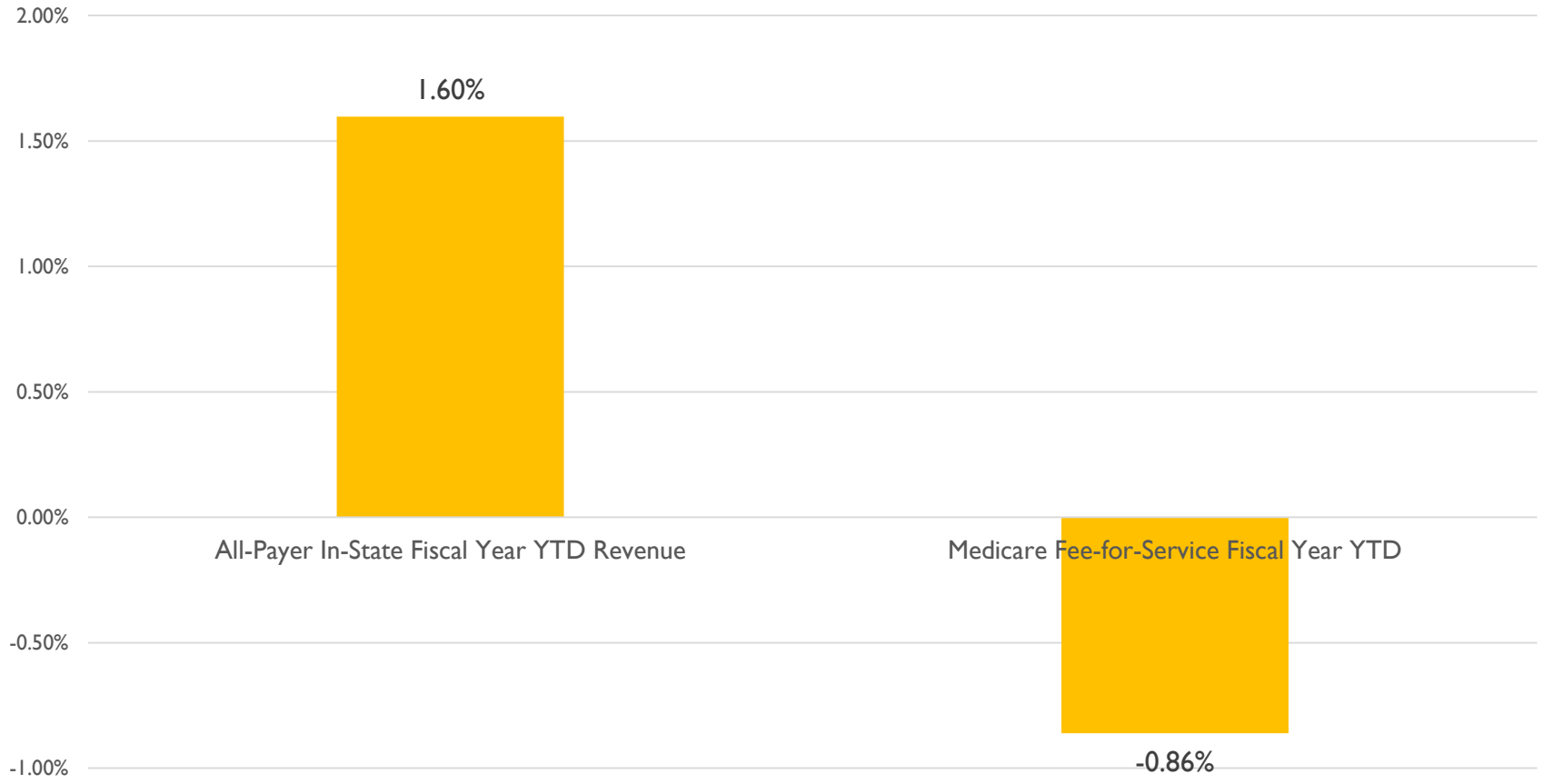
Gross Medicare Fee-for-Service Revenue Growth

FY 2014 Final Compared to FY 2013 Final



HSCRC
Health Services Cost Review Commission

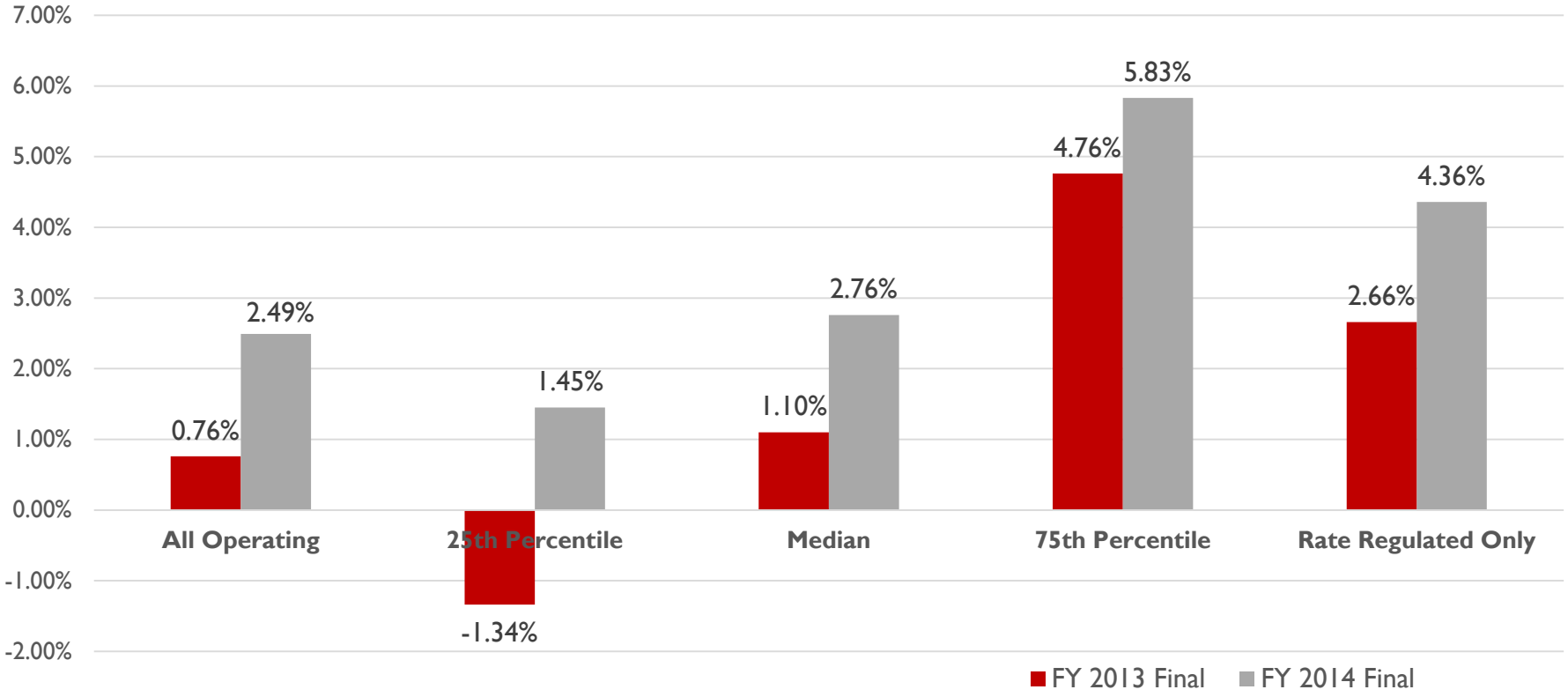
Per Capita Growth Rates
Fiscal Year 2014 Final



- **Fiscal Year 2014 trends were below All-Payer Model Guardrail for per capita growth.**

HSCRC
Health Services Cost Review Commission

Operating Profits: FY 14 Final (July through June)



- FY 2014 hospital operating profits improved compared to FY 2013.
- Total profit margin (operating & non-operating) also improved rising from 3.42% for FY 2013 to 5.04% in FY 2014.

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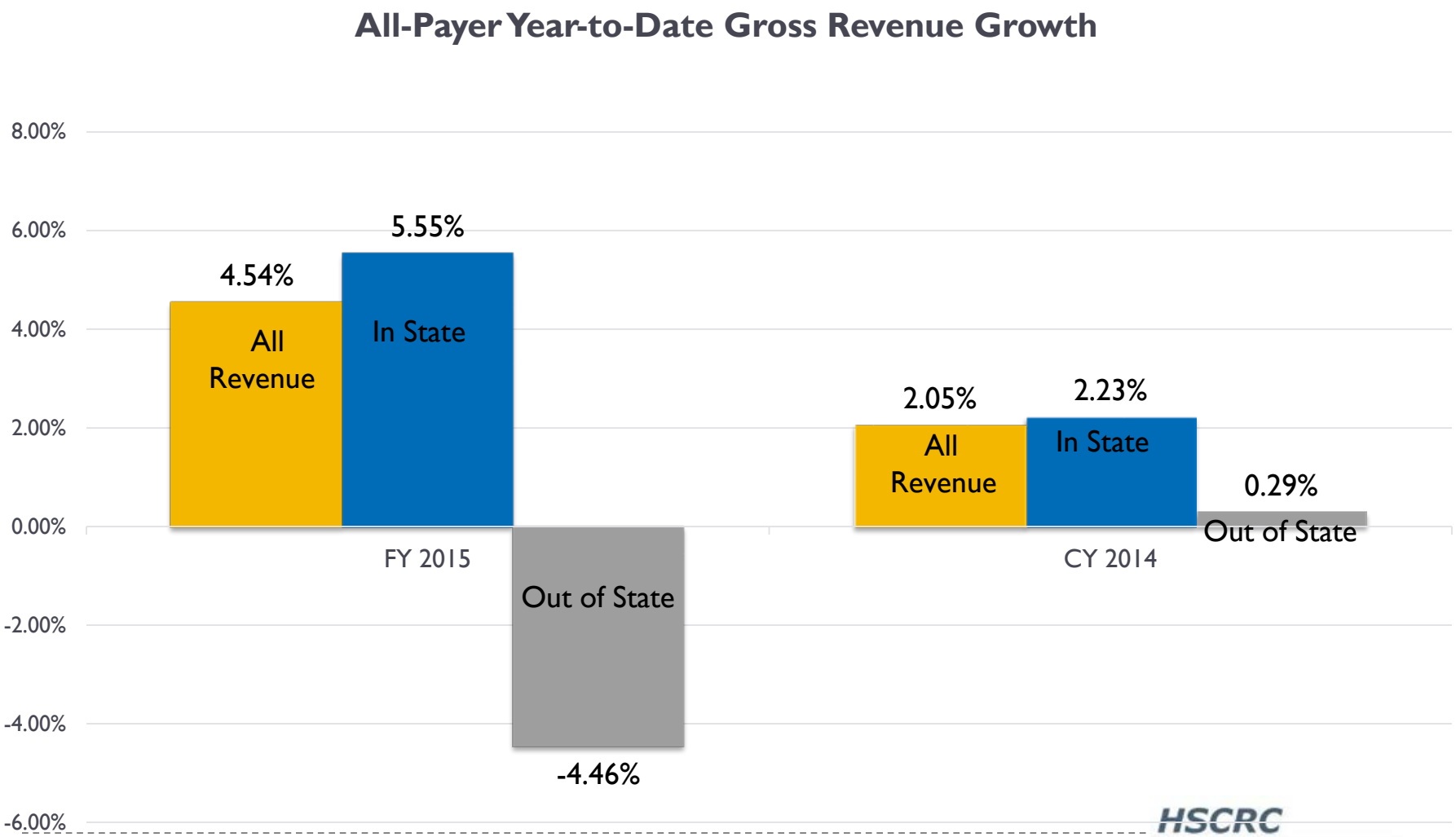
Health Services Cost Review Commission

Gross All Payer Revenue Growth

Year to Date (thru July 2014) Compared to Same Period in Prior Year



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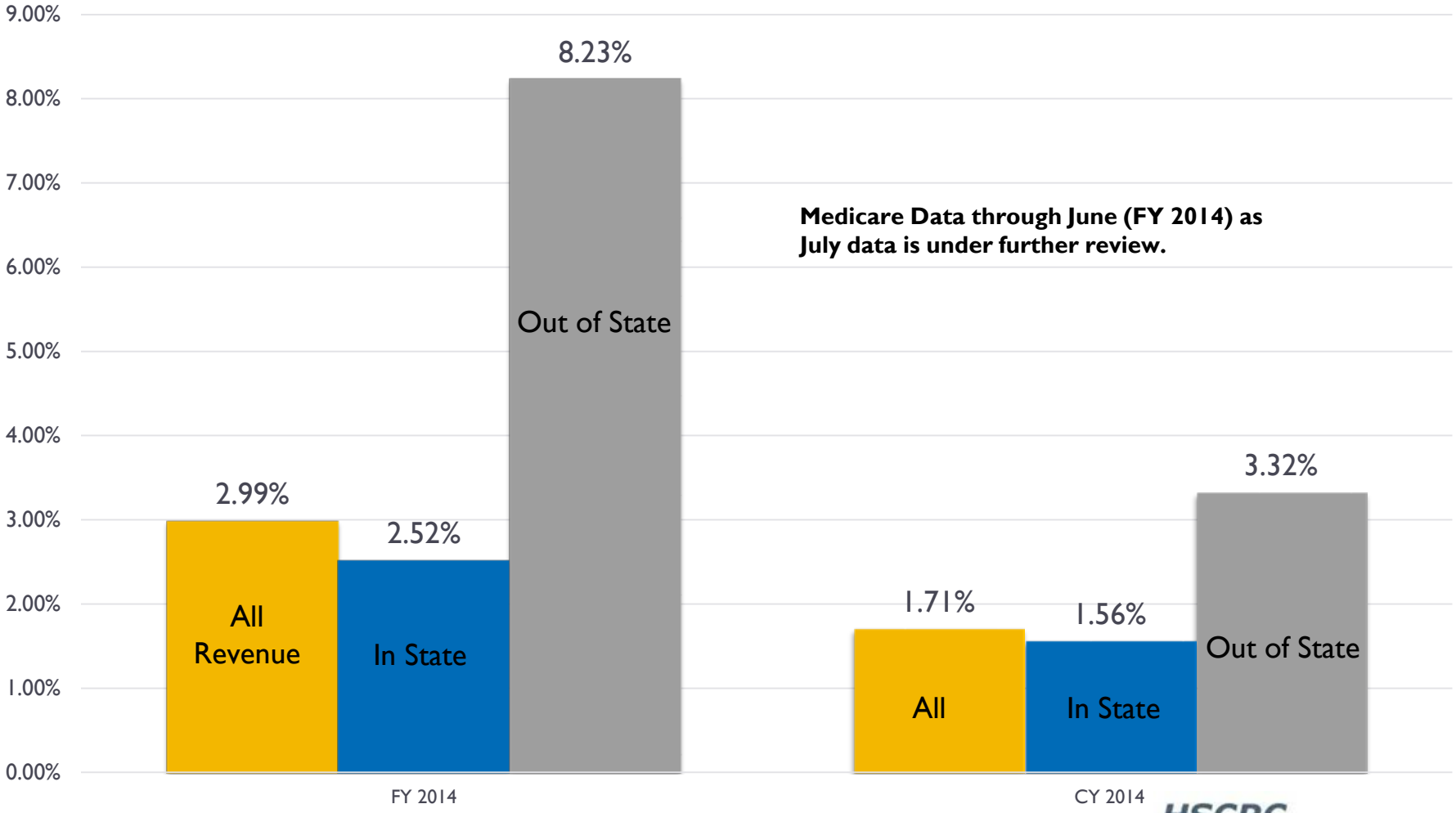
Gross Medicare Fee-for-Service Revenue Growth

Year to Date (thru June 2014) Compared to Same Period in Prior Year



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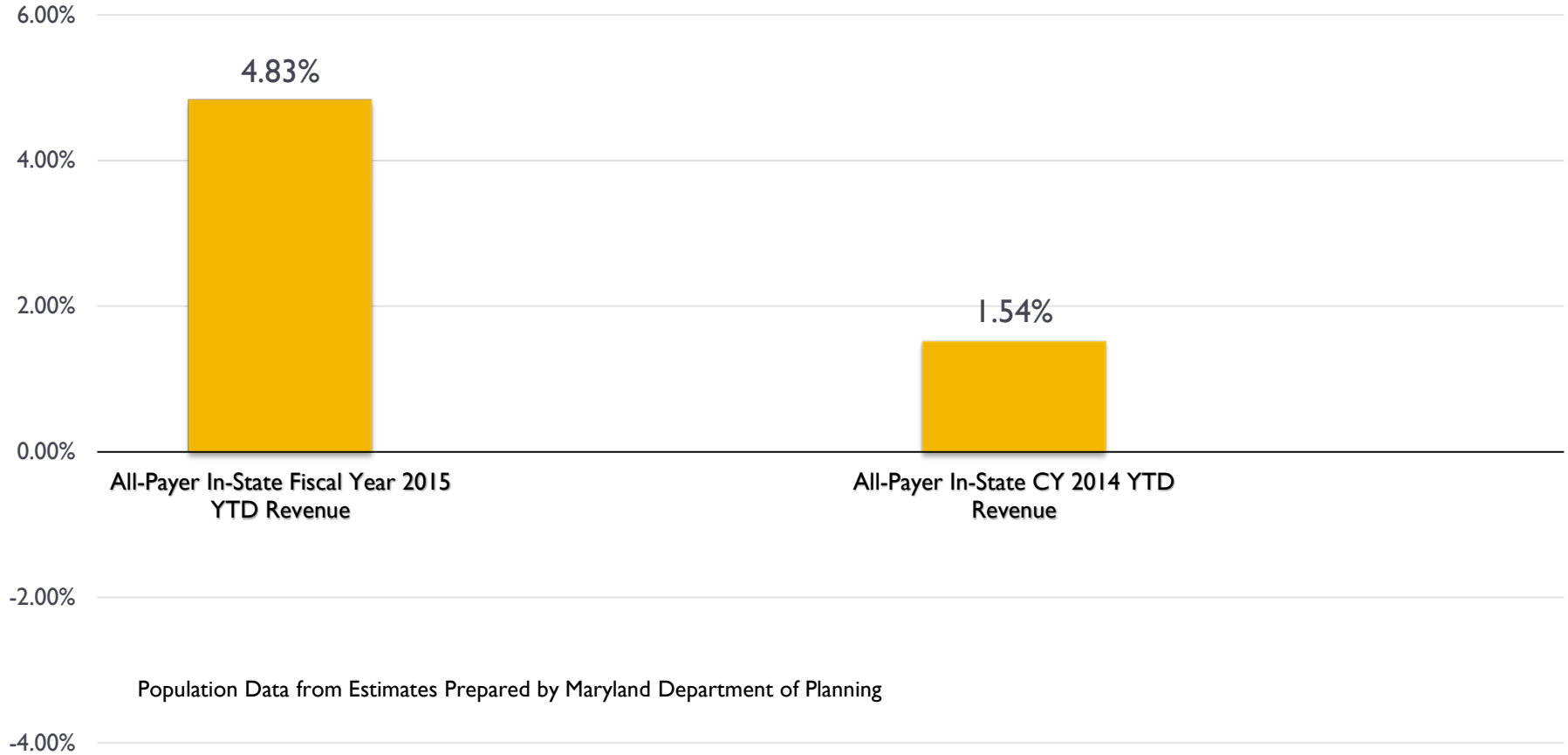
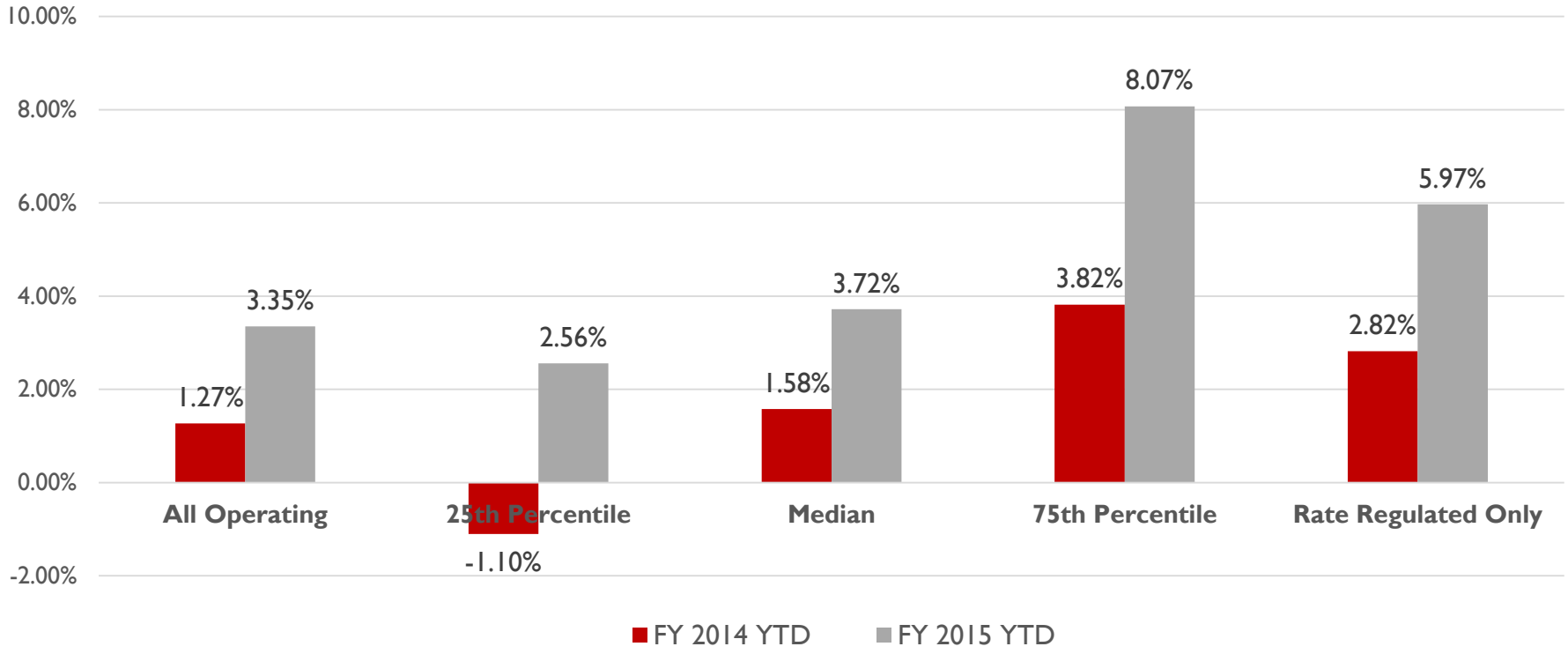
Per Capita Growth Rates
Fiscal Year 2015 and Calendar Year 2014



- **Calendar Year trend to date is below All-Payer Model Guardrail for per capita growth.**

HSCRC
Health Services Cost Review Commission

Operating Profits: Fiscal 2015 Year to Date (July) Compared to Same Period in FY 2014



- Year-to-Date FY 2015 hospital operating profits improved compared to the same period in FY 2014.

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Health Services Cost Review Commission

Purpose of Monitoring Maryland Performance

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

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

Data Caveats

- Data revisions are expected.
- For financial data if residency is unknown, hospitals report this as a Maryland resident. As more data becomes available, there may be shifts from Maryland to out-of-state.
- Many hospitals are converting revenue systems along with implementation of Electronic Health Records. This may cause some instability in the accuracy of reported data. As a result, HSCRC staff will monitor total revenue as well as the split of in state and out of state revenues.
- Medicare financial data are through June rather than July as additional data scrubbing for July is required to ensure Medicare/Non-Medicare and In-State/Out-of-State splits are recorded correctly.
- Per capita calculations for Calendar Year 2014 and Fiscal 2015 rely on Maryland Department of Planning projections of population growth of .68% and 2.73% age over 65, used as a proxy for growth in Medicare beneficiaries.

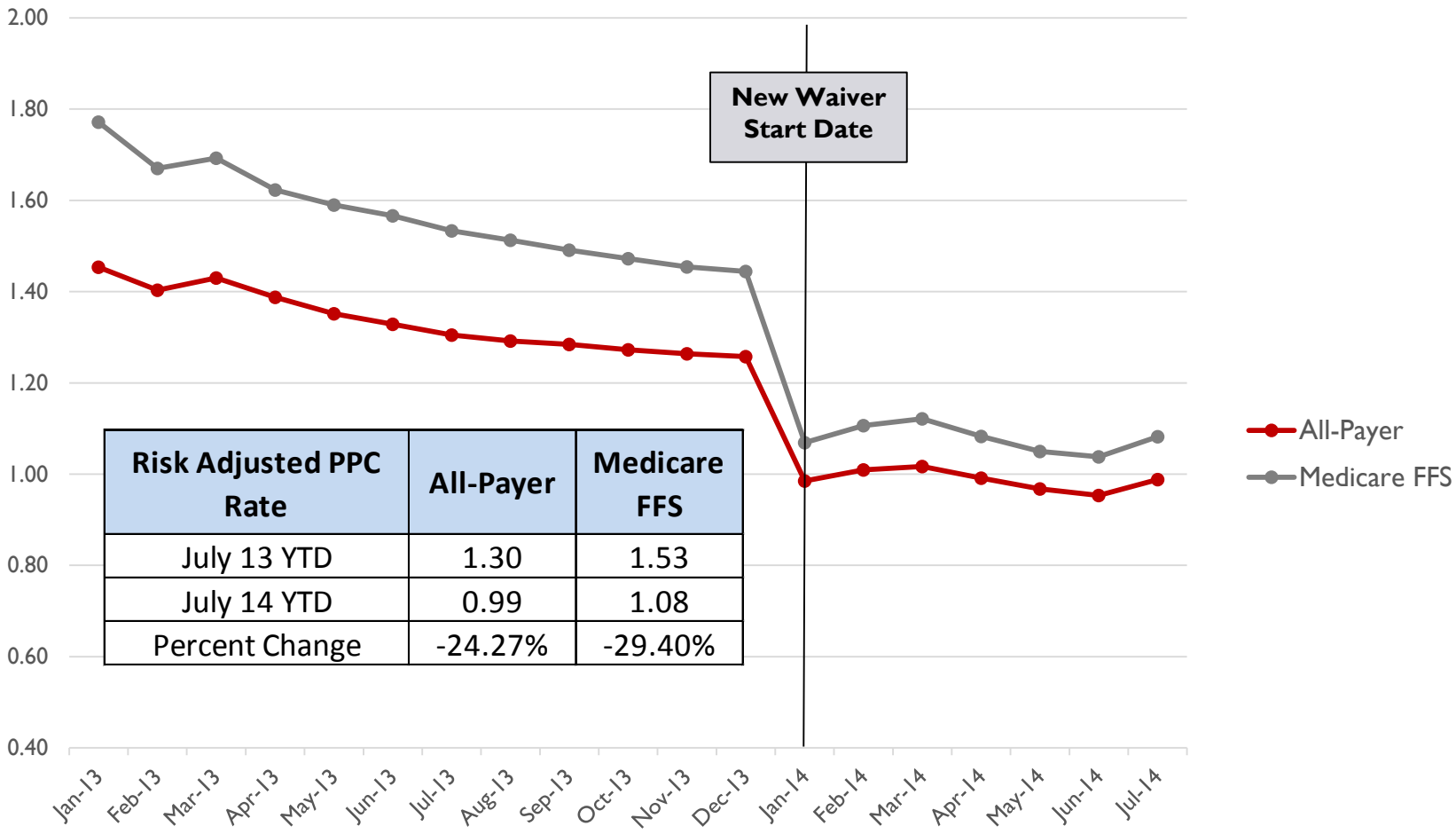
Monitoring Maryland Performance

Quality Data

Year to Date thru July 2014

HSCRC
Health Services Cost Review Commission

Risk-Adjusted PPC Rates YTD



Risk Adjusted PPC Rate	All-Payer	Medicare FFS
July 13 YTD	1.30	1.53
July 14 YTD	0.99	1.08
Percent Change	-24.27%	-29.40%

Note: Based on final data for January 2013 - June 2014 and preliminary data for July 2014.

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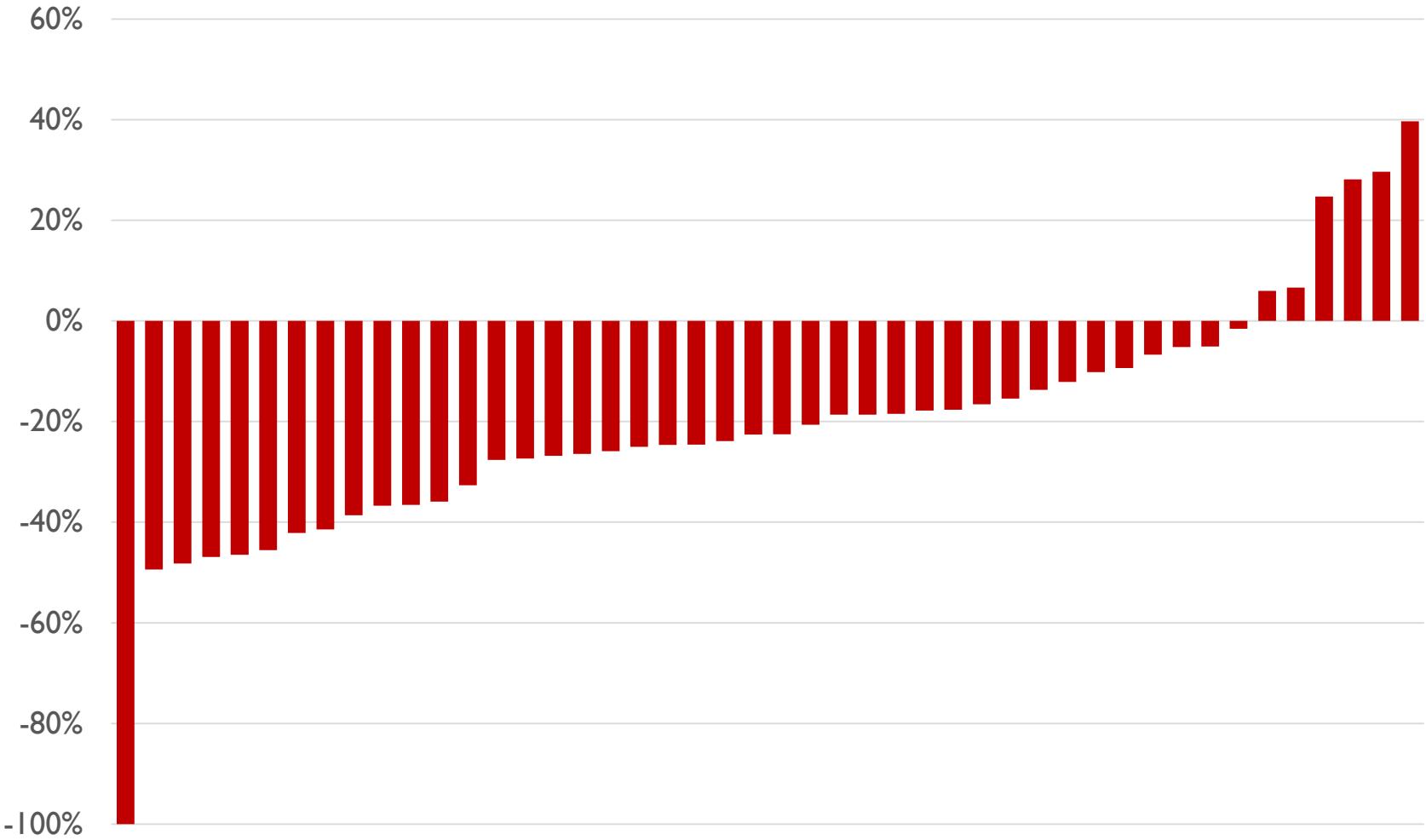
Improvements in All-Payer Risk-Adjusted PPC Rates YTD by Hospital



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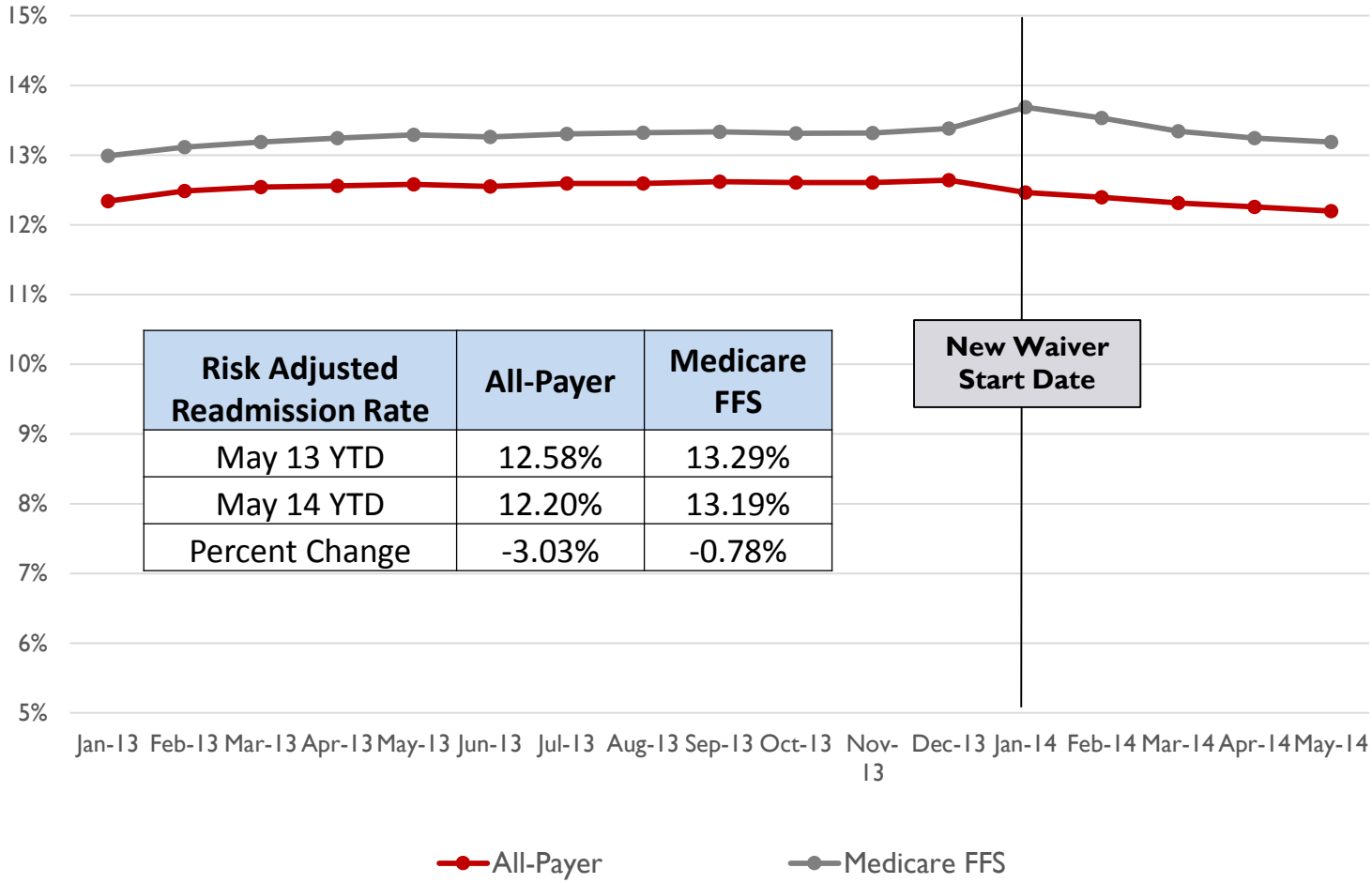
Risk-Adjusted Readmission Rates YTD

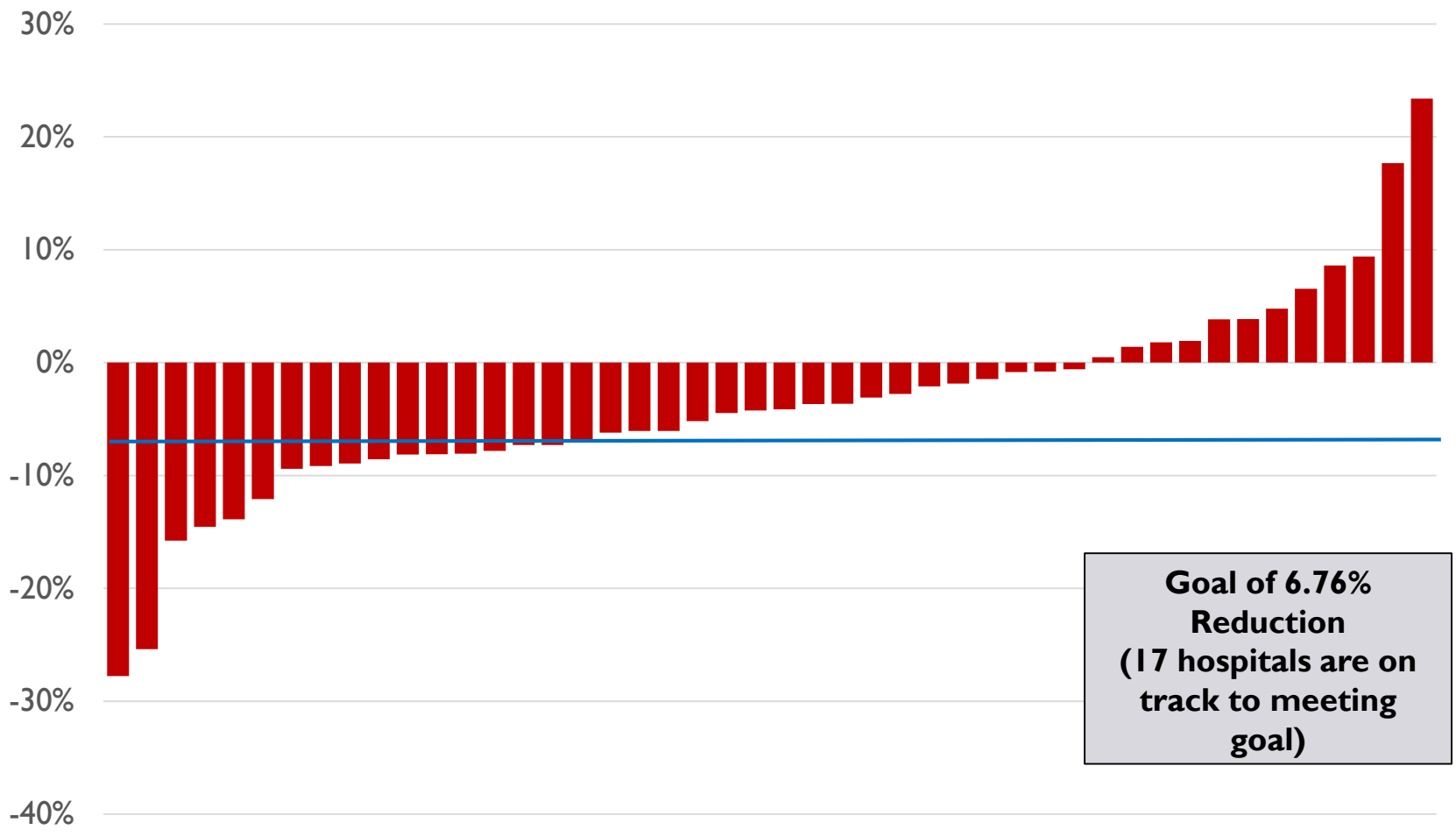


Risk Adjusted Readmission Rate	All-Payer	Medicare FFS
May 13 YTD	12.58%	13.29%
May 14 YTD	12.20%	13.19%
Percent Change	-3.03%	-0.78%

Note: Based on final data for January - December 2013 and preliminary data January - June 2014.

HSCRC
Health Services Cost Review Commission

Improvement in All-Payer Risk-Adjusted Readmission Rates YTD by Hospital



HSCRC
Health Services Cost Review Commission

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

AS OF AUGUST 27, 2014

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

Docket Number	Hospital Name	Date Docketed	Decision Required by:	Rate Order Must be Issued by:	Purpose	Analyst's Initials	File Status
2253N	Fort Washington Medical Center	6/26/2014	9/10/2014	11/24/2014	CL	CK	OPEN
2254A	University of Maryland Medical Center	7/1/2014	N/A	N/A	N/A	DNP	OPEN
2256A	University of Maryland Medical Center	7/15/2014	N/A	N/A	N/A	DNP	OPEN
2257A	MedStar Health	7/17/2014	N/A	N/A	N/A	SP	OPEN
2258A	University of Maryland Medical Center	7/23/2014	N/A	N/A	N/A	DNP	OPEN
2259A	Johns Hopkins Health System	7/24/2014	N/A	N/A	N/A	DNP	OPEN
2260R	Holy Cross Germantown Hospital	8/14/2014	9/13/2014	1/12/2015	FULL	JS	OPEN
2261A	Johns Hopkins Health System	8/25/2014	N/A	N/A	N/A	DNP	OPEN
2262A	Johns Hopkins Health System	8/25/2014	N/A	N/A	N/A	DNP	OPEN
2263A	Johns Hopkins Health System	8/27/2014	N/A	N/A	N/A	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

IN RE: THE PARTIAL RATE	*	**BEFORE THE HEALTH SERVICES**	
APPLICATION OF	*	**COST REVIEW COMMISSION**	
FORT WASHINGTON	*	**DOCKET:**	**2014**
MEDICAL CENTER	*	**FOLIO:**	**2063**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2253N**

Staff Recommendation

September 10, 2014

Introduction

On June 26, 2014, Fort Washington Medical Center, submitted a request to the Commission requesting a rate for its new Clinic (CL) service. The Hospital requests that the CL rate be set at the lower of a rate based on its projected costs to provide CL services or the statewide median and be effective September 1, 2014.

Staff Evaluation

To determine if the Hospital's CL rate should be set at the statewide median or at a rate based on its own cost experience, the staff requested that the Hospital submit to the Commission all projected cost and statistical data for CL services for FY 2014. Based on information received, it was determined that the CL rate based on the Hospital's projected data would be $16.08 per RVU, while the statewide median rate for CL services is $37.11 per RVU.

Recommendation

After reviewing the Hospital's application, the staff recommends as follows:

1. That a CL rate of $16.08 per RVU be approved September 1, 2014;
2. That no change be made to the Hospital's Charge per Episode standard for CL services;
3. That the CL rate not be rate realigned until a full year's cost experience data have been reported to the Commission; and
4. That these new services will be subject to the provisions of the new volume or Global Budget policies.

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IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2014**
MEDICAL CENTER	*	**FOLIO:**	**2064**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2254A**

Staff Recommendation

September 10, 2014

I. INTRODUCTION

University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on July 1, 2014 for an alternative method of rate determination pursuant to COMAR 10.37.10.06. The Hospital requests approval from the HSCRC for continued participation in global rates for solid organ transplant, gamma knife, and blood and bone marrow transplants for three years with Aetna Health, Inc. beginning August 1, 2014.

II. OVERVIEW OF THE APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff reviewed the experience under this arrangement and found it to be favorable. Staff believes that the Hospital can continue to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

Based on the Hospital's favorable performance, staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ transplant, gamma knife, and blood and bone marrow transplant services, for a one year period beginning August 1, 2014. The Hospital will need to file a renewal application to be considered for continued participation.

Consistent with its policy paper regarding applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU") with the Hospital for the approved contract. This document would formalize the understanding between the Commission and the Hospital, and would include provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the contract, quarterly and annual reporting, 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**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2014**
MEDICAL CENTER	*	**FOLIO:**	**2066**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2256A**

Staff Recommendation

September 10, 2014

I. INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on July 15, 2014 requesting approval to continue its participation in a global rate arrangement with BlueCross and BlueShield Association Blue Distinction Centers for blood and bone marrow transplant services for a period of one year beginning September 1, 2014.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff believes that the Hospital can achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for blood and bone marrow transplant services, for a one year period commencing September 1, 2014. The Hospital will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
UNIVERSITY OF MARYLAND	*	**DOCKET:**	**2014**
MEDICAL CENTER	*	**FOLIO:**	**2068**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2258A**

Staff Recommendation

September 10, 2014

I. INTRODUCTION

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on July 23, 2014 requesting approval to continue its participation in a global rate arrangement with Maryland Physicians Care ("MPC") for solid organ and blood and bone marrow transplant services for a period of one year beginning August 23, 2014.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Staff found that the actual experience under the arrangement for the last year has been favorable. Staff believes that the Hospital can continue to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's application for an alternative method of rate determination for solid organ and blood and bone marrow transplant services, for a one year period commencing August 23, 2014. The Hospital will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2014**
SYSTEM	*	**FOLIO:**	**2069**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2259A**

Staff Recommendation

September 10, 2014

I. INTRODUCTION

On July 24, 2014, the Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") requesting approval from the HSCRC to continue to participate in a global rate arrangement for cardiovascular procedures with Quality Health Management. The Hospitals request that the Commission approve the arrangement for one year effective September 1, 2014.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. 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 payment, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that there was no experience under this arrangement for the last year.

However, staff believes that the Hospitals can achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services for one year beginning September 1, 2014. The Hospitals must file a renewal application annually for continued participation, with approval contingent upon a favorable evaluation of performance.

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 PERMANENT RATE	*	BEFORE THE HEALTH SERVICES
APPLICATION OF HOLY CROSS	*	COST REVIEW COMMISSION
GERMANTOWN HOSPITAL,	*	DOCKET: 2014
GERMANTOWN, MARYLAND	*	FOLIO: 2070
	*	PROCEEDING: 2260R

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STAFF RECOMMENDATION

*Language is being amended per Commission instruction
and will be posted as soon as available

September 10, 2014

Chet Burrell
President and Chief Executive Officer

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September 5, 2014

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

Donna Kinzer
Executive Director
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: HSCRC DRAFT Recommendation: Update Factors for FY2015

Dear Mr. Colmers and Ms. Kinzer,

CareFirst appreciates the opportunity to comment on the rate recommendation for the Holy Cross Germantown Hospital (HCGH).

Overall, CareFirst believes that Staff conducted a thorough and comprehensive review of HCGH's rate application. While the HSCRC traditionally holds hospitals to the representations made in a CON application, the current proposal represents a slight restructuring of HCGH's rates that results in aggregate revenues that are at or below those proposed in the CON application. The linkage to Holy Cross Hospital (HCH) rates also eliminates barriers to entry while at the same time maintains the integrity of HSCRC's rate process. Given these considerations, CareFirst believes that the modifications and other provisions proposed in the staff recommendation are reasonable and appropriate.

We also understand that as a new facility, HCGH has no record on which to base their uncompensated care (UCC) allowance. Given that a significant portion of HCGH's patient population will draw from the HCH patient service area and HCH's UCC allowance closely approximates the state average, CareFirst believes it is reasonable to use the state average until actual costs are established.

Again, CareFirst supports the Staff's recommendation and we thank you for this opportunity to provide our comments.

Sincerely,

Chet Burrell
President & CEO

CareFirst BlueCross BlueShield is an independent licensee of the Blue Cross and Blue Shield Association. ® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
JOHNS HOPKINS HEALTH	*****	**DOCKET:**	**2014**
SYSTEM	*****	**FOLIO:**	**2071**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2261A**

Staff Recommendation

September 10, 2014

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on August 25, 2014 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplants services with INTERLINK Health Services, Inc. The System requests approval for a period of one year beginning October 1, 2014.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Although the experience under this arrangement was slightly unfavorable for FY 2014, staff still believes that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2014**
SYSTEM	*	**FOLIO:**	**2072**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2262A**

Staff Recommendation

September 10, 2014

I. INTRODUCTION

On August 25, 2014, the Johns Hopkins Health System ("System") filed a renewal application on behalf of its member hospitals Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval from the HSCRC to continue to participate in a renegotiated global rate arrangement for cardiovascular procedures with Coventry Health Care of Delaware, Inc. for international patients only. The Hospitals request that the Commission approve the arrangement for one year effective October 1, 2014.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the global rates was developed by calculating mean historical charges for patients receiving the procedures for which global rates are to be paid. The remainder of the global rate is comprised of physician service costs. 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 payment, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians holds the Hospitals harmless from any shortfalls in payment from the global price contract. JHHC maintains it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

Staff found that the experience under this arrangement to be favorable for the last year. Staff believes that the Hospitals can continue to achieve favorable performance under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular services for one year beginning October 1, 2014. The Hospitals must file a renewal application annually for continued participation, with approval contingent upon a favorable evaluation of performance.

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**	
JOHNS HOPKINS HEALTHCARE, LLC	*	**DOCKET:**	**2014**
	*	**FOLIO:**	**2073**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2263A**

Staff Recommendation

September 10, 2014

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on August 27, 2014 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the Hospitals) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for solid organ and bone marrow transplants services with 6 Degrees Health, Inc. The System requests approval for a period of one year beginning October 1, 2014.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

Although there has been no activity under this arrangement in FY 2014, staff believes

that the Hospitals can achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

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

Draft Recommendation for Additional FY 2015 Funding for CRISP

HSCRC Commission Meeting

September 10, 2014

Prior Actions for FY2015 Funding

- In December 2013, the Commission authorized funding for CRISP through rates up to $2.5 million per year from 2015-2019
- In May 2014, staff provided funding of $1.65 million for CRISP core operations in FY15
- In June 2014, staff provided additional funding for $850,000 for a limited set of reporting services in FY 2015.

Purpose of Additional Funding Request

- In the June 2014 report to the Commission, staff indicated that it was exploring expanding the current partnership with CRISP to assist with meeting expanded needs under the New All-payer model, and facilitating transparent availability of population based reports and analyses.
- Staff recommends obtaining additional CRISP resources to be used to:
  - Additional Ad Hoc Analysis, Monitoring and Reporting;
  - Evaluation and Planning

Additional Analysis, Monitoring and Reporting

- In order to conduct additional analyses and monitoring activities, CRISP will need to access additional resources.
- Staff is proposing that approximately $1 million could be used for the following expanded services:
  - Analyses of Medicaid Saving from All-payer model
  - Further UC analytics from the ACA Medicaid Expansion
  - Detail and summary reports on PAU at the case level
  - Other population-based reports
  - High utilizer analyses for care management planning
  - Tableau programming to support report production

Evaluation and Planning Resources

- Several Work Groups made recommendations to develop and maintain a statewide infrastructure to support care coordination/management and physician alignment
- Phase 2 of the Work Group process will require consulting and expert resources in a timely manner to support more planning, evaluation, and stakeholder input in these areas. Timing is important because:
  - Expedited decision making can provide cost-effective guidance to hospitals as they are considering applying for expanding accountable care and care coordination activities
  - More detailed planning will be necessary before considering if or how up to $15 million in funding under BRFA might be most efficacious in FY15.
- Staff anticipates earmarking approximately $1 million for this purpose and will use an MOU to ensure that work is executed to the satisfaction of the Commission, hospitals, and stakeholders

Expansion of CRISP represents a logical progression

- This continued partnership makes sense because:
  - Logical extension and progression of work already delegated to CRISP;
  - Is transparent and meets the time-compressed demands of the all-payer model
- Staff recommends increasing hospital rates to provide an additional $2 million for CRISP in FY15 to obtain additional capacity for:
  - Additional monitoring, analysis and reporting; and
  - Further evaluation of planning of possible statewide infrastructure and approaches for care coordination and physician alignment

Final Recommendation:

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients: Additional FY 15 HSCRC Funding

September 10, 2014

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

This is a report to be presented at the September 10, 2014 HSCRC public meeting.

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients:

Additional HSCRC Funding

Overview

This recommendation is to request additional funding through hospital rates, over and above the existing $2.5 million limit approved by the Commission, for Chesapeake Regional Information System for our Patients (CRISP) to continue to:

- Expand capacity to supporting monitoring and reporting services;
- Bring on experts to assist the Commission in developing care coordination and physician alignment strategy and conducting Work Group activities

Background

In December 2013, the Commission adopted a recommendation to permit continued funding support during FYs 2015 through FY 2019 not to exceed $2.5 million in any year.

During the May 2014 public meeting of the Commission, staff reported on funding support of CRISP operations in FY 2015 in the amount of $1.65 million. This amount is designed to provide funding support of CRISP's core operations and core service offerings, such as the Query portal and the associated support center that enables providers to search for patient information in real-time. In June of 2014, the Commission increased the funding amount to $2.5 million. The additional $850,000 was approved to finance a specific set of CRISP reporting services important to HSCRC's inter-hospital reporting capabilities.

CRISP Reporting Services to be Funded

When staff considered the additional $850,000, it considered the potential for CRISP to provide various levels of reporting services to both hospitals and the HSCRC. Given the $2.5 million constraint, staff made recommendations to provide funding for three of the six levels of services considered. They include the following:

Unique ID Creation and Assignment

- CRISP will link the unique ID to the HSCRC abstract data and provide the unique ID linkage to HSCRC staff for further inter-hospital and other analysis.

Basic Cross-Entity Report Production for HSCRC

- CRISP will host HSCRC abstract data in order to generate reports requested by HSCRC, such as inter-hospital readmission rates.

Static Report Creation for Hospitals

- CRISP will provide hospitals with a core set of static reports on a monthly basis focused on inter-hospital readmissions and primary service area / clinical service line analysis, and super-utilization analysis.

Maryland's Statewide Health Information Exchange, the Chesapeake Regional Information System for our Patients:

Additional HSCRC Funding

The June 2014 recommendation anticipated considering expanding the role of CRISP when it stated:

> *CRISP has outlined additional services beyond those outlined in this update. These additional services include expanded dynamic reporting for hospitals and other providers, hosting of Medicare data, and application of predictive modeling tools. HSCRC staff will continue to work with CRISP to evaluate if and how the HSCRC should be engaged in pursuing and financing those activities in partnership with CRISP or with other vendors.*

After further conversations with CRISP and a re-evaluation of the Commission's resource needs after the first phase of the public engagement process (Phase I of the Work Groups), staff believes that enhancing the partnership with CRISP during this fiscal year will advance and expedite the new all-payer model implementation and public engagement processes. Specifically, staff sees significant value in partnering with CRISP on the following additional projects:

Expand CRISP Capacity to Support Additional Monitoring

Staff has brought on resources to accomplish the tasks described above under the $2.5 million approved in May and June of 2014. CRISP can bring on additional resources to support additional monitoring functions such as:

- Medicaid savings analyses as required in statute;
- Further uncompensated care analytics related to the ACA expansion outside of the initial Primary Adult Care Program (PAC) expansion;
- Reporting on Potential Avoidable Utilization (PAU) at the case level including regular detail and summary reports;
- Other quality reports;
- More detailed reporting on high utilizers of hospital care around the State; and
- Tableau programming support.

Work Group Support and Strategy Development

There is also tremendous utility and value for CRISP to work with the Commission to access resources pursuant to a Memorandum of Understanding (MOU) to assist the Commission with the development, organization, and implementation of the Work Groups on Care Coordination Initiatives and Infrastructure, and Physician Alignment. CRISP will bring on individuals with expertise in the areas of care coordination, care management, integrated savings organizations (like ACOs), and gain sharing. The experts will help the Work Groups

and the Commission explore best practices that hospitals and partners can employ to improve care coordination and management in the health care delivery system and work on proposals that could be submitted to CMS to establish broad integrated shared savings entities for patients with chronic conditions that are not already participating in a managed care plan or an integrated care model. They will also assist in considering ways to improve gain-sharing with physicians, coordination with long-term care facilities, and address potential anti-trust issues. This will involve both the development of a strategy and the administration of the Work Group process during Phase II.

Recommendation

HSCRC staff recommends that the funding provided to CRISP through a broad-based assessment on hospital rates be increased by $2 million in FY 2015 to support expanding its current monitoring capacity and to access resources to help support the development of care coordination and physician alignment strategies and the work group process.

However, staff reserves the right, subsequent to reporting its intention to the Commission, to discontinue CRISP funding for these purposes during the course of FY 2015 under the following circumstances:

- Staff finds that either the reporting services are not as efficacious, accurate, or timely as anticipated in order to meet the goals of the all-payer model;
- The State determines that a different vendor would be more appropriate to provide these services; or
- If funding from other grants or sources becomes available for these purposes.

Draft Recommendation for Updating the Quality Based Reimbursement Program for FY 2017

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

September 10, 2014

This document contains the draft staff recommendations for updating the Quality Based Reimbursement (QBR) Program for FY 2017 for consideration at the September 10, 2014 Public Commission Meeting. Public comments should be sent to Dianne Feeney at the above address or by e-mail at Dianne.Feeney@Maryland.gov. For full consideration, comments must be received by September 22, 2014.

A. Introduction

The HSCRC quality-based measurement initiatives, including the scaling methodologies and magnitudes of revenue "at risk" for these programs, are important policy tools for providing strong incentives for hospitals to improve their quality performance over time. For HCSRC's Quality-based Reimbursement ("QBR") Program, current Commission policy calls for measurement of hospital performance scores across clinical process of care, outcome and patient experience of care domains, and revenue neutral scaling of hospitals in allocating rewards and penalties based on performance.

"Scaling" for QBR refers to the differential allocation of a pre-determined portion of base regulated hospital inpatient revenue based on assessment of the relative quality of hospital performance. The rewards (positive scaled amounts) or penalties (negative scaled amounts) are then applied to each hospital's update factor for the rate year; these scaled amounts are applied on a "one-time" basis (and not considered permanent revenue), and are computed on a "revenue neutral" basis for the system so that the net increases in rates for better performing hospitals are funded entirely by net decreases in rates for poorer performing hospitals.

For the QBR program for State FY 2016 rates, as approved by the Commission, the HSCRC will weight the clinical outcomes domain more heavily than the previous year, and scale a maximum penalty of 1% of approved base hospital inpatient revenue.

Staff recommends adjusting the weights of the measurement domains so that outcome domains account for a greater proportion of the hospital's overall performance scores going forward, as well as updating the amount of total hospital revenue at risk for scaling for the QBR program.

B. Background

1. *Centers for Medicare & Medicaid Services (CMS) Value Based Purchasing (VBP) Program*

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

CMS implemented the VBP program with hospital payment adjustments beginning in October 2013. For the federal FY 2016 (October 1, 2015 to September 30, 2016) Hospital VBP program, CMS measures include four domains of hospital performance: clinical process of care; patient experience of care (HCAHPS survey measure); outcomes; and efficiency/Medicare spending per beneficiary. Results are weighted by CMS as listed below, with 1.5% of Medicare hospital payments "at risk" for 2016.

Figure 1. CMS VBP Domain Weights, FY 2016

	Clinical/Process	Patient Experience	Outcome	Efficiency/Medicare spending/beneficiary
FFY 2016	10%	25%	40%	25%

CMS indicated its future emphasis will increasingly lean toward outcomes in the VBP program. In addition, staff notes that for the CMS VBP program for FY 2016, CMS added additional outcome measures, including the Agency for Healthcare Research and Quality ("AHRQ") Patient Safety Indicator ("PSI") 90 Composite measure and the Centers for Disease Control National Health Safety Network ("CDC-NHSN") Central Line Associated Blood Stream Infection (CLABSI) and Catheter Associated Urinary Tract Infection (CAUTI) measure.

2. *QBR Measures, Domain Weighting and Magnitude at Risk to Date*

HSCRC implemented the first hospital payment adjustments for QBR program performance in July 2009. For rate year 2016 (July 1, 2015-June 30, 2016), the QBR program scales 1% of revenue at risk and uses the CMS/Joint Commission core process measures—e.g., aspirin upon arrival for the patient diagnosed with heart attack—, "patient experience of care" or Hospital Consumer Assessment of Healthcare Providers and Systems ("HCAHPS") measures, and three outcome measures, which include AHRQ PSI 90, the CDC-NHSC CLABSI measure, and all-cause inpatient mortality using the 3M Risk of Mortality classifications. The weighting for each domain compared with the CMS VBP Program are illustrated below in Figure 2.

Figure 2. Maryland QBR Compared with CMS VBP Domain Weights, FY 2016

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

Staff convened several meetings of the QBR Update Workgroup in October and November of 2013 and the Performance Measurement Workgroup, which began meeting in January 2014, where there was agreement to add measures to be consistent with the VBP Program where feasible, and to align the list of process of care measures, threshold and benchmark values, and time lag periods with those used by CMS, [1] allowing HSCRC to use the data submitted directly to CMS. This alignment must include the measures used, data sources and magnitude of revenue "at risk" for the program. Maryland has not, to date, developed and implemented an efficiency measure as part of the QBR program. As part of the implementation of New All-Payer Model; there was agreement among Workgroup members and staff that a new efficiency measure is needed to incorporate population-based outcomes.

3. *Value Based Purchasing Exemption Provisions*

Pursuant to 1886(o)(1)(C)(iv) of the Social Security Act, "the Secretary may exempt such hospitals from the application of this subsection if the State which is paid under such section submits an annual report to the Secretary describing how a similar program in the State for a participating hospital or hospitals achieves or surpasses the measured results in terms of patient health outcomes and cost savings established under this subsection." VBP exemptions have been requested and granted for FYs 2013, 2014 and 2015.

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

The CMS FY 2015 Inpatient Prospective Payment final rule states that, in order to implement the Maryland All-Payer Model, CMS has waived certain provisions of the [Social Security] Act, and the corresponding implementing regulations, as set forth in the agreement between CMS and Maryland and subject to Maryland's compliance with the terms of the agreement. The final rule continues that, in other words, although the exemption from the Hospital VBP Program no longer applies, Maryland hospitals will not be participating in the Hospital VBP Program because section 1886(o) of the Act and its implementing regulations have been waived for purposes of the model, subject to the terms of the agreement

The section of Maryland All-Payer Model Agreement between CMS and the State addressing the VBP program is excerpted below.

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

Staff will work out requirements and timelines with CMS for submitting an annual report on comparable programs to the VBP program in the State.

C. Assessment

Staff analyzed changes in performance on the QBR and VBP measures used for FY 2015 performance for Maryland versus the US for October 2012 through September 2013 compared with the immediately prior 12 month period. Figure 3 below lists each of the measures used for the VBP and QBR programs. The data indicate that Maryland improved at a slightly higher rate and/or performed slightly better for all but one of the process of care measures. Maryland also performed significantly better than the US on the CLABSI measure for both time periods and also improved. For HCAHPS, Maryland declined slightly in performance for almost half (4 out of 10) of the measures, and performed below the US on all measures with the exception of "Patient given information about recovery at home" where Maryland improved significantly and now performs the same as the US.

Figure 3. QBR Measures Change for Maryland Versus US

	CLINICAL OUTCOME Mortality						
		MD Base Period	MD Most Current Performance		US Base Period	US Most Current Performance	
		Q308-Q211	Q309-Q212	Difference	Q308-Q211	Q309-Q212	Difference
	Combined CHF, AMI, Pneumonia 30 day mortality	11.56	11.38	-0.18	12.34	12.31	-0.03
	CLINICAL PROCESS						
		Maryland Base Period	MD Performance Period		US Base Period	US Performance Period	
		Oct 11-Sep12	Oct12-Sep13	Difference	Oct11-Sep12	Oct12-Sep13	Difference
AMI 8a	Primary PCI within 90 minutes	89.96	94.68	4.72	95.22	96.25	1.03
HF 1	Discharge instructions	92.94	94.28	1.34	92.59	93.9	1.31
IMM 1	Pneumococcal vaccination*	91.59	94	2.41	88.28	92	3.72
Imm 2	Influenza vaccination*	90.19	94	3.81	84.16	90	5.84
PN 3b	Blood culture before first antibiotic	96.53	97.03	0.5	96.93	97.4	0.47
PN 6	Initial antibiotic selection	95.82	97.29	1.47	94.63	95.19	0.56
SCIP INF 1	Antibiotic givin within 1 hour	97.79	97.7	-0.09	97.96	98.3	0.34
SCIP INF 4	Cardiac surgery patients with controlled 6am postop serum glucose	94.23	96.51	2.28	95.88	96.47	0.59
SCIP INF 9	Urinary catheter removed postop day 1 or 2	93.69	97.74	4.05	94.98	96.84	1.86
Clinical Process	***Average Total Score***	93.64	95.91	2.28	93.40	95.15	1.75
	PATIENT EXPERIENCE (HCAHPS)						
HCAHPS	Doctors always communicated well	77.51	78	0.49	81.34	82	0.66
HCAHPS	Nurses always communicated well	74.84	75	0.16	78.18	79	0.82
HCAHPS	Patients always received help as soon as they wanted	59.19	58	-1.19	66.63	68	1.37
HCAHPS	Staff explained about medication	59.02	58	-1.02	63.47	64	0.53
HCAHPS	Pain was always controlled	67.67	67	-0.67	70.63	71	0.37
HCAHPS	Patient room always kept quiet	56.05	57	0.95	60.35	65	4.65
HCAHPS	Patient room always kept clean	65.21	64	-1.21	72.78	73	0.22
HCAHPS	Patient given information about recovery at home	82.93	85	2.07	84.21	85	0.79
HCAHPS	Patient would definitely recommend hospital to friends and family	66.88	67	0.12	70.76	71	0.24
HCAHPS	***Average Total Score***	***67.70***	***67.67***	***-0.03***	***72.04***	***73.11***	***1.07***
	SAFETY**						
		MD Base Period	MD Most current performance	Difference	US Base Peroid	US Most current performance	Difference
	CLABSI	0.55	0.53	-0.02	1	1	N/A
	CAUTI	1.59	1.78	0.19	1	1	N/A
	MRSA	N/A	1.83	N/A	N/A	1	N/A
	C-diff	N/A	1.16	N/A	N/A	1	N/A
	SSI Colon	N/A	0.95	N/A	N/A	1	N/A
	SSI Hysterectomy	N/A	1.51	N/A	N/A	1	N/A
	PSI 90	Data Unavailable			Data Unavailable		

*Data collection periods for Immunization measures differ than those for other measures.

**For the Safety measures are ratios where a decrease indicates improvement. An average score for the saferty domain was not calculated due to incomplete data.

Staff examined measures finalized for the CMS VBP Program for FY 2017 in the 2015 CMS Inpatient Prospective Payment System (IPPS) Final Rule and those in the potential pool for the QBR program for 2017. Figure 4 below details the measures by domain and the available published performance standards for each measure, and indicates the measures that will be included in the VBP and QBR programs.

Figure 4. Measures and Performance Standards for the FY 2017 CMS Hospital VBP Program Compared with Maryland QBR Program

Measure ID (Applicable Programs)	Description	Achievement Threshold	Benchmark
Safety Measures			
CAUTI (VBP and New QBR)	Catheter-Associated Urinary Tract Infection	0.845	0.000
CLABS (VBP and QBR)	Central Line-Associated Blood Stream Infection	0.457	0.000
C. *difficile* (New VBP and QBR TBD- MD data collection began in July 2013.)	*Clostridium difficile* Infection	0.750	0.000
MRSA Bacteremia (New VBP and QBR TBD- MD data collection began in July 2013)	Methicillin-Resistant *Staphylococcus aureus* Bacteremia	0.799	0.000
PSI-90 (VBP and QBR)	Complication/patient safety for selected indicators (composite)	0.577321* (*VBP MEDICARE ONLY;QBR All-PAYER THRESHOLD TBD)	0.397051* (*VBP MEDICARE ONLY;QBR All-PAYER BENCHMARK TBD)
SSI (VBP and New QBR)	Surgical Site Infection • Colon • Abdominal Hysterectomy	• 0.751 • 0.698	• 0.000 • 0.000
Clinical Care – Outcomes Measures			
MORT-30-AMI (VBP ONLY)	Acute Myocardial Infarction (AMI) 30-day mortality rate	0.851458	0.871669
MORT-30-HF (VBP ONLY)	Heart Failure (HF) 30-day mortality rate	0.881794	0.903985
MORT-30-PN (VBP ONLY)	Pneumonia (PN) 30-day mortality rate	0.882986	0.908124
Mortality (QBR ONLY)	All-cause inpatient using 3M risk of mortality	TBD	TBD
Clinical Care – Process Measures			
AMI-7a (VBP and QBR)	Fibrinolytic Therapy Received Within 30 Minutes of Hospital Arrival	0.954545	1.000000
IMM-2 (VBP and QBR)	Influenza Immunization	0.951607	0.997739

Measure ID (Applicable Programs)	Description	Achievement Threshold	Benchmark
PC-01 (New VBP and QBR TBD- MD data collection began in January 2014)	Elective Delivery Prior to 39 Completed Weeks Gestation	0.031250	0.000000
Efficiency and Cost Reduction Measure			
MSPB-1 (VBP ONLY)	Medicare Spending per Beneficiary	Median Medicare Spending per Beneficiary ratio across all hospitals during the performance period	Mean of the lowest decile Medicare Spending per Beneficiary ratios across all hospitals during the performance period

Patient and Caregiver-Centered Experience of Care/Care Coordination Domain			
HCAHPS Survey Dimension (VBP and QBR)	Floor (percent)	Achievement Threshold (percent)	Benchmark (percent)
Communication with Nurses	58.14	78.19	86.61
Communication with Doctors	63.58	80.51	88.80
Responsiveness of Hospital Staff	37.29	65.05	80.01
Pain Management	49.53	70.28	78.33
Communication about Medicines	41.42	62.88	73.36
Hospital Cleanliness & Quietness	44.32	65.30	79.39
Discharge Information	64.09	85.91	91.23
Overall Rating of Hospital	35.99	70.02	84.60

Staff is proposing updated measure domain weights based on the VBP measures domain weights published in the CMS IPPS Final Rule, Maryland's need to improve on the HCAHPS measures, and the measures and domains available for adoption in the QBR rate year FY 2017; Figure 4 below illustrates the VBP final domain weights and the QBR proposed domain weights.

Staff circulated the draft recommendation via email to the members of the Performance Measurement Workgroup as in person meetings were not feasible due to summer schedules. The draft recommendation will be discussed at the September 19 in person meeting and issues raised in the discussions will be incorporated into the final recommendation.

Figure 4. Final Measure Domain Weights for the Hospital VBP Program and Proposed Domain Weights for the QBR Program FY 2017

	Clinical • Outcomes (Mortality) • Process	Patient Experience	Safety	Efficiency

CMS VBP	• 25 percent • 5 percent	25%	20%	25%
Proposed Maryland QBR	• 15 percent • 5 percent	45%	35%	N/A

Staff notes again that the established revenue "at risk" magnitude for the CMS VBP Program is set at 2% for 2017. To determine the potential impact of increasing the amount of revenue at risk for the QBR program to 1.5% versus 2%, staff used the most recent scaling results (October 1, 2012 to September 30, 2013 performance period) that apply to hospitals for rate year FY 2015 for modeling purposes. The results, to be considered for altering the magnitude of revenue to be scaled for rate year FY 2017, detailed in Appendix I, reveal that a total range of $7.7M to $10.3M is redistributed under the revenue neutral scaling methodology.

A memo summarizing the updates to the QBR methodology with the required benchmark data will be sent to the hospitals after final Commission approval of the QBR program updates for FY 2017.

D. Recommendations

For the QBR program, staff provides the following recommendation:

1. Allocate 2% of hospital approved inpatient revenue for QBR relative performance in FY 2017.
2. Adjust measurement domain weights to include 5% for process, 15% for outcomes (mortality), 35% for safety, and 45% patient experience of care.

Appendix I. QBR Continuous Linear Scaling- Modeling Maximum Penalty of 1.5% Versus 2% of Hospital Inpatient Revenue Using Data Results for RY 2015

HOSPID	HOSPITAL NAME	INPATIENT REVENUE	QBR FINAL POINTS	SCALING BASIS 1.5%	SCALING BASIS 2%	REVENUE IMPACT OF SCALING 1.5%	REVENUE IMPACT OF SCALING 2%	REVENUE NEUTRAL ADJUSTED REVENUE IMPACT OF SCALING 1.5%	REVENUE NEUTRAL ADJUSTED REVENUE IMPACT OF SCALING 2%	REVENUE NEUTRAL ADJUSTED GROSS REVENUE 1.5%	REVENUE NEUTRAL ADJUSTED GROSS REVENUE 2%	REVENUE NEUTRAL ADJUSTED PERCENT 1.5%	REVENUE NEUTRAL ADJUSTED PERCENT 2%
A	B	C	D	E	F	G	H	I	J	K	L	M	N
210062	Southern Maryland Hospital Center	$ 159,227,525	0.050	-1.500%	-2.000%	-$2,388,413	-$3,184,551	-$2,388,413	-$3,184,551	$156,839,112	$156,042,975	-1.500%	-2.000%
210003	Prince Georges Hospital Center	$ 172,920,161	0.110	-1.253%	-1.671%	-$2,167,170	-$2,889,561	-$2,167,170	-$2,889,561	$170,752,991	$170,030,601	-1.253%	-1.671%
210048	Howard County General Hospital	$ 163,303,899	0.230	-0.760%	-1.013%	-$1,240,839	-$1,654,452	-$1,240,839	-$1,654,452	$162,063,061	$161,649,448	-0.760%	-1.013%
210013	Bon Secours Hospital	$ 76,305,158	0.251	-0.675%	-0.900%	-$514,792	-$686,390	-$514,792	-$686,390	$75,790,366	$75,618,769	-0.675%	-0.900%
210019	Peninsula Regional Medical Center	$ 228,027,801	0.269	-0.600%	-0.800%	-$1,367,997	-$1,823,995	-$1,367,997	-$1,823,995	$226,659,805	$226,203,806	-0.600%	-0.800%
210044	Greater Baltimore Medical Center	$ 196,617,898	0.279	-0.560%	-0.747%	-$1,101,266	-$1,468,354	-$1,101,266	-$1,468,354	$195,516,632	$195,149,544	-0.560%	-0.747%
210029	Johns Hopkins Bayview Medical Center	$ 347,704,294	0.285	-0.534%	-0.712%	-$1,855,601	-$2,474,135	-$1,855,601	-$2,474,135	$345,848,693	$345,230,159	-0.534%	-0.712%
210055	Laurel Regional Hospital	$ 75,611,683	0.294	-0.495%	-0.661%	-$374,653	-$499,537	-$374,653	-$499,537	$75,237,030	$75,112,146	-0.495%	-0.661%
210060	Fort Washington Medical Center	$ 17,342,569	0.295	-0.493%	-0.657%	-$85,421	-$113,895	-$85,421	-$113,895	$17,257,148	$17,228,674	-0.493%	-0.657%
210022	Suburban Hospital	$ 176,985,550	0.310	-0.431%	-0.574%	-$762,580	-$1,016,774	-$762,580	-$1,016,774	$176,222,969	$175,968,776	-0.431%	-0.574%
210001	Meritus Hospital	$ 182,862,924	0.310	-0.431%	-0.574%	-$787,904	-$1,050,539	-$787,904	-$1,050,539	$182,075,019	$181,812,385	-0.431%	-0.574%
210040	Northwest Hospital Center	$ 138,718,749	0.316	-0.407%	-0.543%	-$565,094	-$753,459	-$565,094	-$753,459	$138,153,654	$137,965,289	-0.407%	-0.543%
210057	Shady Grove Adventist Hospital	$ 223,152,951	0.320	-0.390%	-0.520%	-$869,741	-$1,159,655	-$869,741	-$1,159,655	$222,283,210	$221,993,296	-0.390%	-0.520%
210018	Montgomery General Hospital	$ 85,514,349	0.335	-0.328%	-0.437%	-$280,547	-$374,063	-$280,547	-$374,063	$85,233,802	$85,140,286	-0.328%	-0.437%
210011	St. Agnes Hospital	$ 233,289,323	0.335	-0.328%	-0.437%	-$765,354	-$1,020,472	-$765,354	-$1,020,472	$232,523,969	$232,268,851	-0.328%	-0.437%
210015	Franklin Square Hospital Center	$ 278,723,093	0.345	-0.287%	-0.383%	-$799,797	-$1,066,396	-$799,797	-$1,066,396	$277,923,296	$277,656,697	-0.287%	-0.383%
210037	Memorial Hospital at Easton	$ 92,515,251	0.364	-0.208%	-0.277%	-$192,111	-$256,149	-$192,111	-$256,149	$92,323,139	$92,259,102	-0.208%	-0.277%
210016	Washington Adventist Hospital	$ 157,754,799	0.367	-0.196%	-0.261%	-$308,512	-$411,350	-$308,512	-$411,350	$157,446,287	$157,343,450	-0.196%	-0.261%
210024	Union Memorial Hospital	$ 236,590,732	0.374	-0.166%	-0.221%	-$392,446	-$523,262	-$392,446	-$523,262	$236,198,286	$236,067,471	-0.166%	-0.221%
210033	Carroll Hospital Center	$ 134,838,320	0.380	-0.143%	-0.191%	-$192,858	-$257,144	-$192,858	-$257,144	$134,645,462	$134,581,176	-0.143%	-0.191%
210004	Holy Cross Hospital	$ 311,801,309	0.400	-0.061%	-0.081%	-$189,539	-$252,719	-$189,539	-$252,719	$311,611,770	$311,548,590	-0.061%	-0.081%
210056	Good Samaritan Hospital	$ 176,449,767	0.405	-0.040%	-0.054%	-$70,983	-$94,644	-$70,983	-$94,644	$176,378,785	$176,355,124	-0.040%	-0.054%
210061	Atlantic General Hospital	$ 37,698,304	0.426	0.048%	0.064%	$18,052	$24,069	$12,462	$16,616	$37,710,766	$37,714,920	0.033%	0.044%
210012	Sinai Hospital	$ 418,687,491	0.446	0.127%	0.169%	$529,804	$706,406	$365,751	$487,668	$419,053,243	$419,175,160	0.087%	0.116%
210038	Maryland General Hospital	$ 130,524,694	0.451	0.148%	0.197%	$192,860	$257,147	$133,141	$177,522	$130,657,835	$130,702,215	0.102%	0.136%
210035	Civista Medical Center	$ 74,476,146	0.455	0.165%	0.220%	$123,164	$164,218	$85,026	$113,368	$74,561,172	$74,589,514	0.114%	0.152%
210034	Harbor Hospital Center	$ 120,977,775	0.469	0.221%	0.295%	$267,581	$356,775	$184,725	$246,300	$121,162,500	$121,224,075	0.153%	0.204%
210032	Union of Cecil	$ 66,197,257	0.482	0.277%	0.369%	$183,360	$244,480	$126,583	$168,777	$66,323,840	$66,366,034	0.191%	0.255%
210002	University of Maryland Hospital	$ 842,774,096	0.484	0.284%	0.379%	$2,394,842	$3,193,122	$1,653,283	$2,204,377	$844,427,379	$844,978,473	0.196%	0.262%
210039	Calvert Memorial Hospital	$ 65,741,743	0.491	0.315%	0.420%	$207,196	$276,261	$143,038	$190,717	$65,884,781	$65,932,461	0.218%	0.290%
210049	Upper Chesapeake Medical Center	$ 145,284,971	0.495	0.330%	0.440%	$479,229	$638,972	$330,837	$441,116	$145,615,808	$145,726,087	0.228%	0.304%
210043	Baltimore Washington Medical Center	$ 217,712,318	0.495	0.330%	0.440%	$718,134	$957,512	$495,765	$661,020	$218,208,083	$218,373,338	0.228%	0.304%
210005	Frederick Memorial Hospital	$ 184,859,281	0.500	0.350%	0.467%	$647,774	$863,699	$447,192	$596,256	$185,306,473	$185,455,537	0.242%	0.323%
210030	Chester River Hospital Center	$ 28,699,194	0.539	0.509%	0.679%	$146,086	$194,781	$100,851	$134,467	$28,800,045	$28,833,662	0.351%	0.469%
210051	Doctors Community Hospital	$ 132,902,820	0.540	0.515%	0.687%	$684,311	$912,415	$472,416	$629,887	$133,375,236	$133,532,708	0.355%	0.474%
210010	Dorchester General Hospital	$ 24,515,059	0.552	0.563%	0.751%	$137,989	$183,986	$95,261	$127,015	$24,610,320	$24,642,073	0.389%	0.518%
210027	Western MD Regional Medical Center	$ 179,984,650	0.589	0.718%	0.957%	$1,291,486	$1,721,982	$891,580	$1,188,773	$180,876,229	$181,173,423	0.495%	0.660%
210008	Mercy Medical Center	$ 227,476,677	0.609	0.799%	1.065%	$1,816,689	$2,422,252	$1,254,154	$1,672,206	$228,730,831	$229,148,882	0.551%	0.735%
210017	Garrett County Memorial Hospital	$ 18,267,389	0.611	0.806%	1.074%	$147,177	$196,236	$101,604	$135,472	$18,368,993	$18,402,861	0.556%	0.742%
210023	Anne Arundel Medical Center	$ 302,553,244	0.615	0.823%	1.098%	$2,490,917	$3,321,222	$1,719,608	$2,292,811	$304,272,852	$304,846,055	0.568%	0.758%
210006	Harford Memorial Hospital	$ 45,941,091	0.632	0.894%	1.192%	$410,619	$547,492	$283,472	$377,962	$46,224,563	$46,319,053	0.617%	0.823%
210009	Johns Hopkins Hospital	$ 1,260,991,141	0.634	0.900%	1.200%	$11,344,725	$15,126,300	$7,831,850	$10,442,466	$1,268,822,991	$1,271,433,607	0.621%	0.828%
210028	St. Mary's Hospital	$ 67,824,688	0.698	1.164%	1.552%	$789,483	$1,052,644	$545,021	$726,694	$68,369,709	$68,551,383	0.804%	1.071%
	Statewide Total	**$8,460,348,137**				**$7,747,859**	**$10,330,478**	**$ (0.0)**	**$ (0.0)**	**$ 8,460,348,137**	**$ 8,460,348,137**	**-0.1%**	**-0.1%**

Update on Global Budgets and Work Groups

- FY2015 Rate Orders
- GBR Transfers Adjustments
- GBR Market Share Adjustments
- Performance and Payment Work Group Schedules

FY2015 Rate Order Update

- All hospitals received their complete annual update model on August 20, 2014 including mid year targets
- Contract Addendums for FY 2015, as outlined at the July 9, 2014 Public Meeting of the Commission, will be sent to all CFOs the week of September 8, 2014
  - Appendices F and G, which must be updated annually, will be included with the Addendums. and
  - The interim revenue target for December 31, 2014 and the annual revenue targets for FY 2015 will be provided

FY2015 Rate Order Update

- Rate Order preparation should be completed by September 15, 2014
  - All outstanding issues concerning rates and revenue should be finalized prior to this date
  - The final corresponding update file will be sent to each hospital for their records

- A summary of the key results of the FY 2015 annual update will be provided to the Commission at the October 15, 2014 Public meeting

GBR Transfer Adjustments Update

- Payment Work Group and Transfer Subgroup meetings in June, July and August
- Focused to ensure access to care for complex cases and patient protections
- Transfer cases payment adjustments to GBR revenues based on variation from the baseline transfer rates to Academic Medical Centers

Measurement and Data Validation

- Transfer indicators in case-mix data are not reliable
- Transfers from Emergency Departments and Inpatient
- CRISP patient id and date of admission/discharge dates
  - Same or next day admissions
- Case level data is sent to 22 sending hospitals and 2 AMCs
  - Expanding the window from same day to next day increased the false positives
  - Appropriate exclusion list

Market Share Analysis Update

- First subgroup meeting held on September 9th
  - Inpatient and observation cases with 24 hours more are combined
  - Remaining Outpatient cases are grouped in product lines based on weights updated using APGs (Ambulatory Patient Groups) and 3M EAPGs(Enhanced Ambulatory Patient Groups) based on a revised hierarchy
  - Exploring patient-centered measurement approaches
- Updating the Reasonableness of Charges Analysis (ROC) for expected full rate applications delayed the development of market share measurement
- Review of guiding principles and policies will be at Payment Work Group meeting on October 1st

Payment Work Group Schedule

Tentative Meeting Date	Meeting Goals
August 6, 2014 **1:00-4:00**	1. Review Transfers Sub-Workgroup Report 2. Review GBR Revenue Corridor Sub-Workgroup Report 3. Review Modifications to the GBR Agreement template 4. Review Phase 2 work plan
October 1, 2014 **1:00-4:00**	1. Finalize Transfer Adjustments 2. Finalize GBR Revenue Corridor Approach 3. Review Total Cost of Care Template 4. Review Guiding Principles for Market Share Policy 5. Review Data Analytics for Market Share
October 29, 2014 **9:00-12:00**	1. Presentation from Ken Thorpe on Market Share 2. Review Market Share Sub-Workgroup Calculations 3. Review GBR Infrastructure and Investment Sub-Workgroup Report 4. Review and Finalize Medicaid Savings Sub-Workgroup Report
November **TBD**	1. Finalize Market Share Policy 2. Finalize GBR Infrastructure and Investment Sub-Workgroup Template 3. Review GBR Reporting Template Sub-Workgroup Report 4. Review updates on Uncompensated Care
December **TBD**	1. Review Efficiency Sub-Workgroup Report 2. Finalize GBR Reporting Template

Performance Work Group Schedule

Meeting Date	Meeting Goals
Commission Meeting Date: September 10, 2014 (Draft QBR FY2017 Policy)	
Sep.19, 2014 9:00 – 11:30 Room 100	1. Overview of Meeting Schedule/Agendas 2. Draft QBR Policy -(Draft policy shared w/workgroup for comment in August) 3. MHAC: General discussion of FY2017 Updates 4. Readmission : General discussion of FY2017 Updates
Commission Meeting Date: October 15, 2014 (Final QBR FY2017 Policy)	
Oct.17, 2014 9:00 – 11:30 Room 100	1. MHAC: Progress report 2. POA Audits/Possible presentation 3. Readmission : Socio Economic Adjustments
Nov. 5, 2014 9:00 – 11:30 Room 100	1. MHAC: Draft MHAC policy (including benchmarks and targets) 2. Readmissions : MD vs. National trend modeling
Commission Meeting Date: November 12, 2014 (Draft MHAC FY2017 Policy)	
Nov.21, 2014 9:00 – 11:30 Room 100	1. Readmission: Draft FY 2017 policy review 2. MHAC: Final FY 2017 policy review
Commission Meeting Date: December 10, 2014 (Final MHAC FY2017 Policy; Draft Readmission FY2017 Policy)	
Dec. 19,2014 (tentative) 9:00 – 11:30 Room 100	1. Readmission: Final FY 2017 readmission policy review 2. Potentially Avoidable Utilization Measurement 3. Patient Centered Performance Measurement Strategy
Jan.6, 2015 9:00 – 11:30 Room 100	1. Potentially Avoidable Utilization Measurement 2. Topics TBD based on future work group plans
Commission Meeting Date: Jan 14, 2015 (Final Readmission FY2017 Policy)	

Strategies for Efficiency Measure

September 10, 2014

HSCRC
Health Services Cost Review Commission

Performance Work Group Report

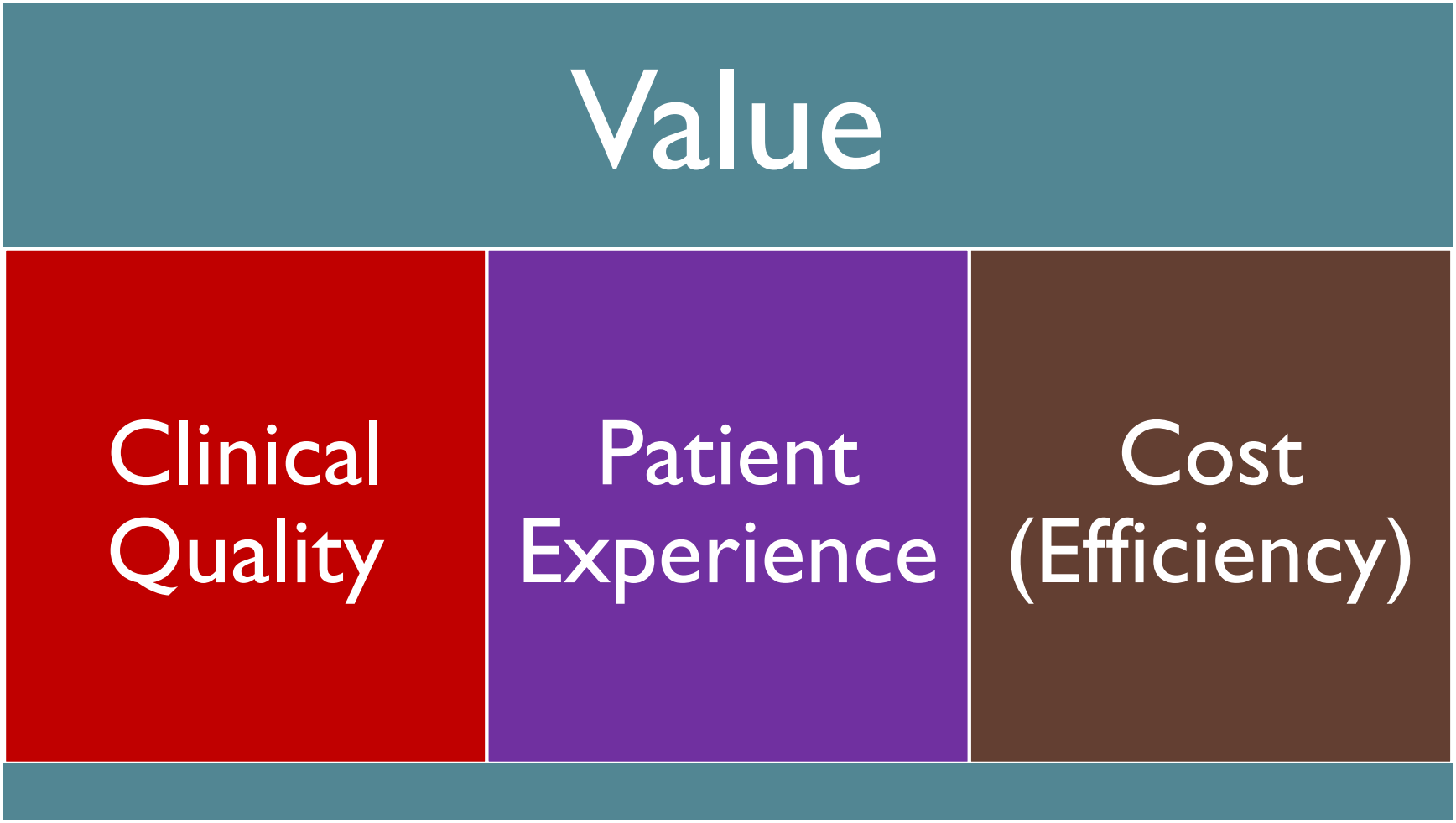
- Maryland's near term efficiency measurement and payment approach must focus on the policy objectives to establish payment levels related to the cost of providing services under new All-Payer Model, and its requirements.
- This report summarizes the discussions of the performance work group including strategy considerations, discussions, presentations and measurement options to move forward in the efficiency measurement domain.
- We would like to thank the work group members and our contractor Tom Valuck, MD, JD and his team at Discern.

What is efficiency?

- Patient-centered definition
  - Relationship between inputs and outputs
  - Efficiency = quality / costs
  - Can increase efficiency by increasing quality, decreasing costs, or both; but cheaper is not necessarily more efficient
  - To measure efficiency, need both the quality and cost components

National Quality Forum Definition: Value vs. Efficiency

HSCRC Conceptual Framework



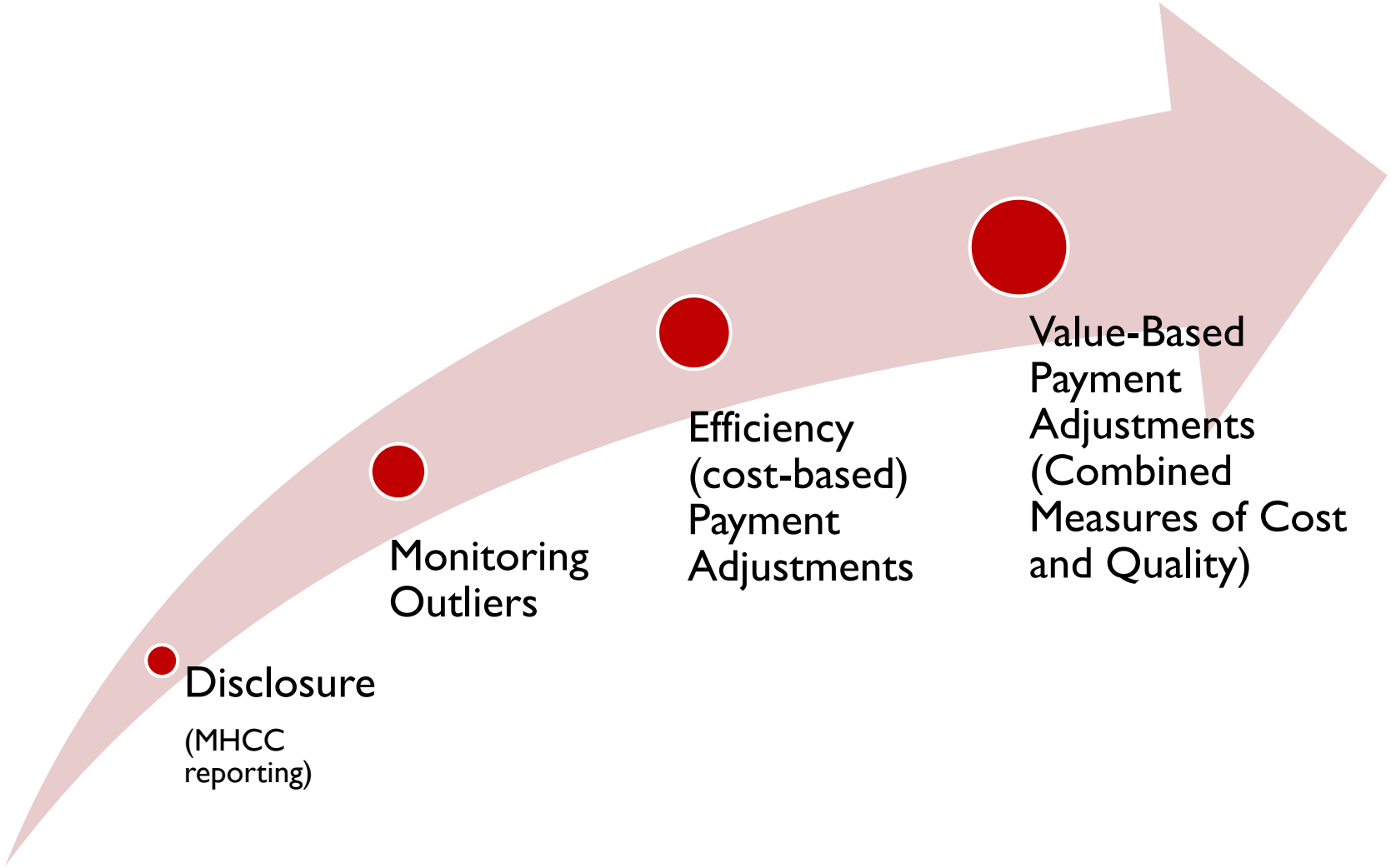
Efficiency, Cost, Quality

- Cost/resource Use
  - Utilization – counts of service
  - Length of stay
  - Episode cost of procedures or conditions
  - Expenditures per member per month
- Appropriateness/Overuse
  - Choosing-wisely
  - Preventive service utilization etc.
- Measures of inefficiency
  - Waste (e.g., appropriateness, overuse)
  - Safety (e.g., harm, complications)
  - Care coordination (e.g., readmission reduction, duplicate tests)
  - Patient engagement (e.g., misalignment with preferences)
  - Population health (e.g., missed prevention or patient education opportunities, poor health status that might be improved such as obesity, hypertension)
  - Operations (e.g., throughput, staffing, workforce injuries)

Efficiency Measurement Units

- Service unit of service
  - for a single patient
  - provided by one entity
- Episode
  - bundle of services
  - for a single or multiple patients
  - provided by one or more entities
- Population
  - wide range of services
  - for multiple individuals
  - provided by one or more entities

Phased Approach to Efficiency Measurement



HSCRC Reasonableness of Charges (ROC) General Information

- Was published each fall by HSCRC
- Hospitals are Stratified into Peer Groups. Current Peer Groups:

Non- Urban Teaching	Suburban/Rural Non Teaching
Urban	AMC Virtual

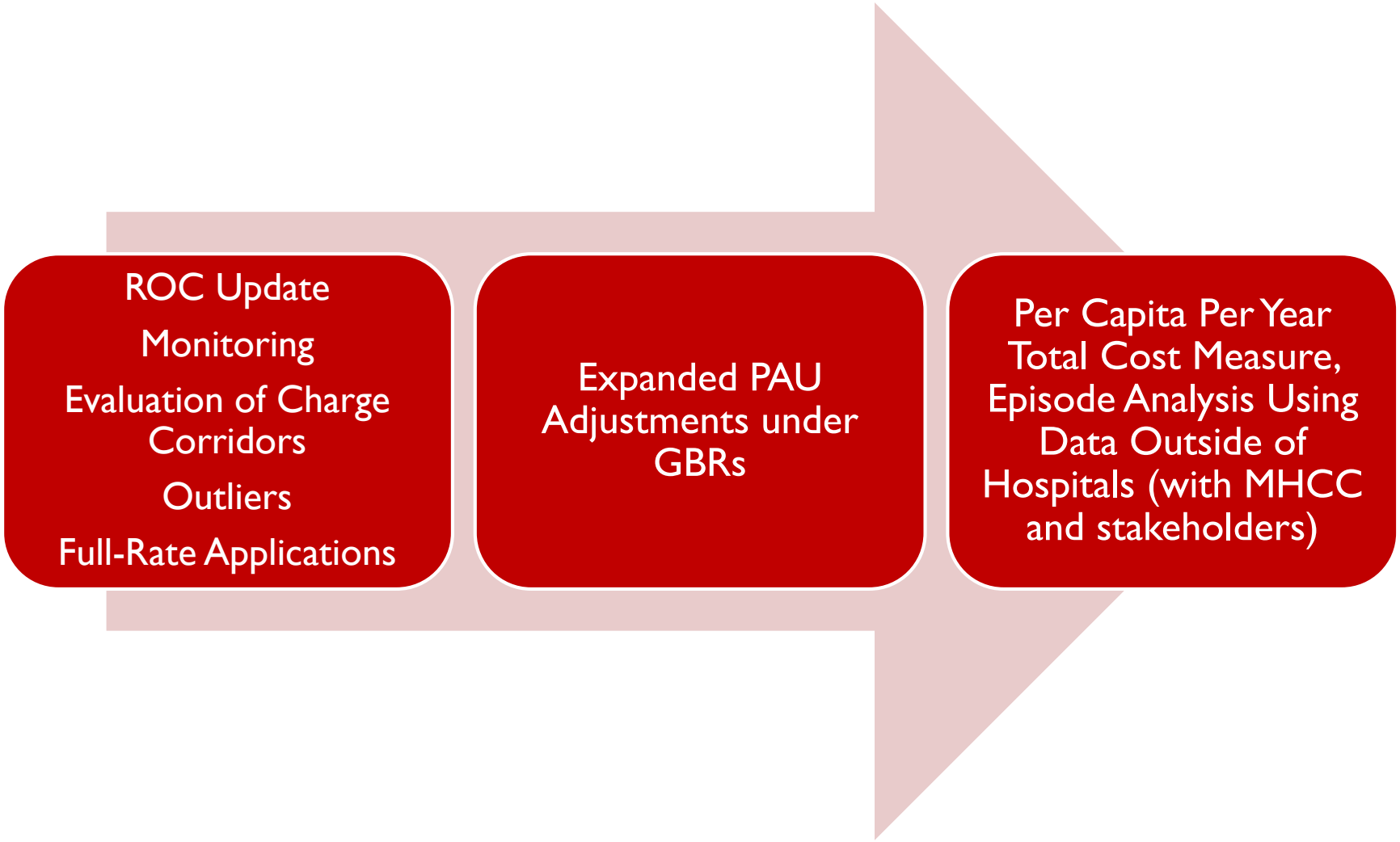
- Threshold for "Reasonableness" of charges
- Hospital options after failing
  - Reduce CPC to Peer Group Average over 2 years
  - File full Rate Review Application (ICC)

- ROC was suspended as the application conflicted with the goals of reducing avoidable utilization, which contributed to an increase in cost per case

ROC Adjustment Factors

- **Mark-up** – Commission approved markups over costs that reflect uncompensated care built into each hospital's rate structure.
- **Direct Strips** – (Direct Medical Education, Nurse Education, and Trauma) remove partial costs of resident salaries, nurse education costs and incremental costs of trauma services of hospitals with trauma centers
- **Labor Market** – Adjustment for differing labor costs in various markets
- **Case Mix** – Adjustment accounts for differences in average patient acuity across hospitals
- **Indirect Medical Education**- Adjustment for inefficiencies and unmeasured patient acuity associated with teaching programs.
- **Disproportionate Share** – Adjustment for differences in hospital costs for treating relatively high number of poor and elderly patients
- **Capital** – Costs for a hospital are partially recognized

Staff Strategy for Efficiency Measurement



Next Steps

- HSCRC staff will need to continue to work with the Work Group to develop needed calculations of efficiency to support the new All-Payer model
  - Per capita hospital cost
  - Per capita total cost
  - Episode costs
- Staff will work with the Work Group to develop timelines and processes for completing these efforts

Performance Work Group Report to the Commission : Efficiency and Cost Measures

Health Services Cost Review Commission

4160 Patterson Avenue Baltimore, MD 21215

(410) 764-2605

September 10, 2014

This document provides input from the Performance Work Group on measuring efficiency and cost in the context of the new All-Payer Model. The recommendations in this report are for discussion purposes and do not require formal action by the Commission.

INTRODUCTION

The charge of the Performance Measurement Workgroup was to make recommendations on what specific measures of cost, care and health should be considered for adoption, retention or development in order to evaluate and incentivize performance improvements under the population-based All-Payer Model. This measurement and payment approach also relates to the policy objectives of establishing payment levels that are reasonably related to the cost of providing services on an efficient basis in accordance with the value concepts embodied in the new All-Payer Model. The Performance Measurement Workgroup participated in discussions of developing efficiency measurement options as well as presentations of specific examples of efficiency measures. Much of the content covered in the Workgroup meetings is included in the subsections of the report that follow. The Performance Measurement Workgroup members agreed that the first step must be to develop an overall strategy that articulates the principles or criteria, and the needs and interests of each stakeholder group relative to the adoption of specific measures.

This report summarizes the work to date in this area, including strategy considerations, discussions, presentations and measurement options to move forward in the efficiency measurement domain.

EFFICIENCY MEASUREMENT STRATEGY CONSIDERATIONS

Regarding the strategy for efficiency measurement, Figure 1 presents the key principles and stakeholders proposed by the Workgroup that must be considered in measure selection and implementation.

Figure 1. Efficiency Measurement Proposed Principles and Stakeholders

Principles/criteria to guide measure domains to be implemented:
❖ Accountability
➢ Payment
➢ Public reporting
➢ Program monitoring and evaluation
❖ Improvement
❖ Alignment with Model targets and monitoring commitments
Stakeholders
❖ Policymakers – CMS, HSCRC (commission, staff), MHCC, DHMH
❖ Providers – hospitals, physicians, others
❖ Payers/purchasers – health plans, employers
❖ Patients – consumers

The CMS Measures Blueprint 10.1 identifies several criteria for measurement selection that overlap with those identified by the Performance Measurement Workgroup and offers additional criteria that should be considered when developing and implementing new efficiency measures. These include:

- Measure is responsive to specific program goals and statutory requirements.
- Measure addresses an important condition or topic with a performance gap and has a strong scientific evidence base to demonstrate that the measure when implemented can lead to the desired outcomes and more affordable care (i.e., NQF's Importance criteria).
- Measure addresses one or more of the six National Quality Strategy (NQS) priorities.[1]
- Measure selection promotes alignment with CMS program attributes.
- Measure reporting is feasible and measures have been fully developed and tested.
- Measure results and performance should identify opportunities for improvement.
- Potential use of the measure in a program does not result in negative unintended consequences like excessive reduced length of stay, overuse or inappropriate use of treatment, or limited access to care.

Maryland's near term efficiency measurement and payment approach must focus on the policy objectives to establish payment levels related to the cost of providing services under new All-Payer Model, and its requirements. From the perspective of both policymakers and hospital providers, it is vital that Maryland meets the cost containment targets set forth in the New All-payer Model contract with CMMI. Therefore, measures that track or incentivize cost containment are important to consider for the nearer term, with an anticipated implementation timeframe of 2015. Among the possible measures for this purpose are the Potentially Avoidable Utilization measures and episode or per capita based cost measures that take into account some of the adjustments used in the HSCRC Reasonableness of Charges/Inter Hospital Cost Comparison methodology.

A set of efficiency measurement tools should also be fine-tuned to evaluate the ongoing reasonableness of rates under global budgets. These tools should address accountability at multiple levels, as illustrated below.

More population-based

- Service
  - unit of service
  - for a single patient
  - provided by one entity
- Episode
  - bundle of services
  - for a single or multiple patients
  - provided by one or more entities
- Population
  - wide range of services
  - for multiple individuals
  - provided by one or more entities

[1] http://www.ahrq.gov/workingforquality/about.htm

In addition to measurement unit (ie, case, episode, person), benchmarking for each of these measurement levels are also important elements of any efficiency measurement strategy and should be considered as part of the measure development. Examples of measures that may be used for benchmarking and trending Maryland efficiency that should be considered earlier for development include:

- A per capitacost measure for Maryland residents, and
- Maryland allowed-to-Medicare allowed ratios, both for state internal comparisons and national benchmark comparisons.

Measures such as these would likely be first monitored and then used for accountability, with results targeted for providers and policymakers.

Further work by an efficiency measurement sub-group to be established in the fall of 2014 will be to consider the audience(s) for the measures staged over time for the various accountability and transparency purposes and levels. For example, the group needs to consider Maryland's recent grade of "F" for pricing transparency given by one national advocacy group and the timing and staging of public reporting of pricing data for the consumer audience. MHCC currently provides the consumer transparency disclosures and HSCRC will need to work with MHCC in furtherance of these goals.

A phased approach to measuring efficiency could begin with measuring cost and appropriateness, with side-by-side reporting of measures of cost and clinical quality outcomes. The next phase could focus on developing composite measures that account for both cost and quality. In this context, it is important to recognize that HSCRC has already started to use some measures of Potentially Avoidable Utilization , such as readmissions and complications/adverse events, that combine both cost and quality aspects into the measure or benchmark.

EFFICIENCY MEASUREMENT

Definition of Efficiency and Value

Efficiency measurement is a complex topic. One reason for the complexity is that people use different terms and definitions to describe efficiency. National organizations such as the Agency for Healthcare Research and Quality (AHRQ), the National Quality Forum (NQF), and the Ambulatory Quality Alliance (AQA) have undertaken efforts to define efficiency. The general agreement among these efforts is that efficiency is a function of quality and cost, such that efficiency = quality/cost. In this way, efficiency can be maximized by increasing quality, decreasing costs, or both; but cheaper is not necessarily more efficient. It follows that to measure efficiency, both quality and cost components are necessary.

The terms *value* and *affordability* are subjective assessments of efficiency. They depend on stakeholder perspectives and preferences; that is, the cost to the stakeholder and the quality received. For example, consumers want the best quality care, but are sensitive to out-of-pocket costs. A policymaker, such as CMS, which is both a purchaser and payer, wants to maximize health and health care outcomes while maintaining the focus on unit costs as well as per beneficiary costs. Hospitals strive for operational efficiency to maximize their operating

margins, but also need to consider appropriateness, such as the need for a CT scan after head trauma.

In thinking about what is measured in assessing efficiency and for whom, there is a continuum from less to more population-based. Efficiency can be measured at the service level for one entity, or for episodes of care for a bundle of services, or through population-based measurement by examining a range of services provided by one or more entities.

As mentioned previously, there are both cost and quality components to measuring efficiency and there are different inputs for each component. For example, with regard to cost, there are different types of measures that focus on price and volume, representing potential practice variation in the form of utilization/volume differences or production cost variation in measures that focus on cost per unit differences. As previously noted, varying time periods for measuring costs may be important when measuring chronic versus acute episodes. There are also multiple dimensions of quality to consider, such as clinical effectiveness, safety, and patient experience.

Key Efficiency Measurement Components and Potential Sub-Domains

Once the different components of cost and quality measures have been defined for a particular measurement need, a determination must be made regarding how the components will be combined to measure efficiency. A relatively straightforward option for linking cost and quality measures to assess efficiency include side-by-side display of cost and quality measures (aggregate or condition-specific). Other options for achieving more precision may require a more complex measurement such as use of algorithms, indexing, roll-up scoring with weighting, and a composite measurement.

Another way to assess efficiency is to measure inefficiency, including domains such as waste (e.g., appropriateness, overuse), safety (e.g., harm, complications), care coordination (e.g., readmission reduction, duplicate tests), patient engagement (e.g., misalignment with preferences), population health (e.g., missed prevention or patient education opportunities), and operations (e.g., throughput, staffing, workforce injuries).

Appendix A provides the results of an initial horizon scan for efficiency measures. Examples of these measures listed with their associated category include:

- Cost/resource use
    - Utilization – counts of services
    - Casemix-Adjusted Inpatient Hospital Average Length of Stay, for medical and surgical admissions (United Health Group)
    - Intensive Care Unit Length of Stay, observed and risk-adjusted (Lee Institute)
- Condition- or procedure-specific cost/resource use
    - Episode Treatment Groups, e.g., hip/knee, pneumonia (Optum)
    - CMS draft resource use measures
- Total cost/resource use – individual or population
    - Payment-Standardized Medicare Spending per Beneficiary (CMS)

    - Total Cost of Care/Resource Use Population-Based PMPM Index (HealthPartners)
- Appropriateness/Overuse
    - Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury (Partners HealthCare)
    - Back Pain series, e.g., surgical timing, imaging (NCQA)
    - Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery (CMS)
    - Cardiac Stress Imaging: Routine Testing After Percutaneous Coronary Intervention (ACC)
    - Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients (AMA-PCPI)
    - Cesarean Section, nulliparous women with term, singleton baby in a vertex position (TJC)

Some specific examples of how cost and quality are being linked together include:

- Displaying results as an index
    - The NCQA Relative Resource Use (RRU) measures provide total annual resource use results for diabetes, asthma, COPD, cardiovascular conditions, hypertension, and low back pain, which are reported as an indexed observed-to-expected ratio for a plan's population. The RRU index and quality index are then linked together.
- Roll-up with weighting
    - CMS (FY 2015) combines together results from clinical process of care (20%), patient experience of care (30%), outcomes (30%) and efficiency (20%) to provide a total performance score.
    - Leapfrog Hospital Recognition Program combines the hospital's quality score (65%) with their resource use score (35%) to generate an overall value score.

HSCRC Approach to Efficiency Measurement

Reasonableness of Charges (ROC)

Historically the HSCRC has included some form of efficiency measurement in its arsenal of tools used to set Maryland hospital rates. Most recently, the Reasonableness of Charges (ROC) was the HSCRCSs tool for measuring efficiency, which assessed the adequacy of each hospital's charges on a per case basis relative to their peer institutions in the state. This is accomplished by placing hospitals into peer groups and comparing the ROC after adjusting for a number of factors that account for differences in costs faced by each hospital.

The factors that areadjusted for, in comparing hospitals within a peer group, include the following:

- Mark-up – Commission approved markups over costs that largely reflect uncompensated care built into each hospital's rate structure.

- Direct Medical Education, Nurse Education, and Trauma – Adjustments that remove part of the costs of residents' salaries and some of the incremental costs of providing trauma services for hospitals with trauma centers.
- Labor Market Adjustor – an index that reflects recognized differences in labor costs across hospital markets
- Case Mix – Adjustment accounts for differences in average patient acuity across hospitals.
- Indirect Medical Education - Adjustment for inefficiencies and unmeasured patient acuity associated with teaching programs.
- Disproportionate Share – Adjustment for differences in hospital costs for treating relatively high proportions of poor patients
- Capital – Costs for a hospital are partially recognized – for each hospital, the ROC recognizes 50 percent of its actual capital costs and 50 percent of the peer group's costs.

After these adjustments the HSCRC has used the ROC to determine rate actions when hospitals are relatively high compared to their peers. In the recent past, if a hospital was more than 3 percent above its peer group average, the HSCRC would enter into discussions with the hospital to reduce its rates.

The ROC is also used by HSCRC in full rate reviews or rate applications.

Maryland Per Resident Costs

As the hospital payment system moves toward global payment, there is a need to align the efficiency measures with population based metrics. Currently the HSCRC staff is working to first drill down and clearly specify the component measurements needed to calculate costs per Maryland resident similar to PMPM or PMPY (per month or per year) measures. The general formula for calculating PMPM costs is as follows:

PMPM or PMPY Costs = Adjusted Total Revenue for Maryland Residents / Total Maryland Population

Determinations of what adjustments should be made to hospital charges must first be done in a PMPM calculation; some of these adjustments may be the same as HSCRC ROC adjustments previously outlined, and through defining the denominator for each hospital. Additional adjustments will need to be considered including a risk adjustment that considers the age of each patient in the defined population as well as the health status. Comparisons over time can be performed to assess changes in the cost of care. However, it is recognized that per capita comparisons across hospitals and regions is more difficult. When considering per resident cost comparisons across regions and hospitals, the HSCRC needs to expand the cost definitions from hospital services to include the total cost of care. This is important in order to capture comparable costs, since the same service might be performed in both regulated and unregulated settings. The HSCRC will also need to consider border crossing, since some of the services are provided out-of-state, and this will vary by region. Other complications include taking into account the variation in services provided veteran or department of defense facilities.

As with the ROC analysis, the PMPM costs for hospitals will need to be adjusted so that selected factors that result in costs differences among hospitals are removed.

Potentially Avoidable Utilization (PAU)

While more comprehensive PMPM measures are being developed, the Performance Measurement Workgroup also has had various discussions on defining potentially avoidable utilization, which represents immediate opportunities for focus under the new All-payer Model. The definition of potentially avoidable utilization currently used by HSCRC is as follows:

> "Hospital care that is unplanned and can be prevented through improved care coordination, effective primary care and improved population health".

HSCRC work to date has focused on existing measures that are used widely in the public domain where the potentially avoidable cost of care can be attributed, and include the following:

- Rehospitalization
  - Inpatient- All Hospital, All Cause 30-Day Readmissions using CMS methodology with adjustment for planned admissions
  - ED – any visit within 30 days of an inpatient admission
  - Observation - any observation within 30 days of an inpatient admission
- Potentially Avoidable Admissions/Visits
  - Inpatient - Agency for Health Care Quality (AHRQ) Prevention Quality Indicators (PQIs) Ambulatory care sensitive admissions
- Hospital Acquired Conditions as measured by Potentially Preventable Complications (PPCs)

As the list illustrates, these measures are also used for quality of care measurement and provide good examples of the intersection between better quality and reduced costs. The Performance Measurement Workgroup identified a general lack of ambulatory care measures. This should be explored further by the efficiency measures sub-group that will be convened.

CONCLUSION

Ensuring efficient hospital costs has been one of the central missions of the HSCRC. The new All-payer Model will require developing and redefining existing efficiency measures so that they can be used to evaluate hospital performance in the state. As the system is moving toward population-based approaches and is in a transitional period, phasing should begin by focusing on the obvious opportunities to meet model targets.

Potentially avoidable utilization cost measures are currently used as one of the many data points for constructing global budgets, and are monitored, as they represent clear a relationship between improved quality of care and reduced cost. In addition, they are highly prevalent in the Medicare population and a focused approach to reduce PAUs in this population will help ensure that

saving targets for Medicare are met while at the same time improving quality. PAUs have already been incorporated in the demographic adjustment for global budget agreements. Discussions will continue in the Payment Workgroup on how to incorporate performance on PAUs into some of the payment policies.

HSCRC staff will work in the near term to adjust and adapt the ROC ICC methodology and begin monitoring performance. Adjustments or additional ROC calculation steps may be needed to account for a shift from case-based measurement to episode-based and population-based measurement.

Staff will also work to develop and adopt a resident PMPM or PMPY methodology that encompasses defined hospital populations, with a goal to use this for payment adjustments for FY 2016 at the earliest. To start, it is anticipated that the efficiency measurement will include inpatient and outpatient hospital service costs, and then expand to the full range services provided or the total cost of care. Staff will consider other options to combine the cost measures with quality measures in order to construct a full picture of efficiency.

Going forward, the Commission and external performance measurement stakeholders should also monitor activities related to efficiency measurement being conducted by other prominent groups, such as CMS' implementation of the Hospital Value-Based Purchasing and Physician Value-Based Payment Modifier programs; NQF's initiatives in endorsement of cost and resource use measures and episode grouper evaluation criteria, linking cost and clinical quality, and the MAP Affordability Family of Measures; and the Choosing Wisely initiative which focuses on appropriate care choices by physicians and patients.

Appendix A

EFFICIENCY-RELATED MEASURES

Initial Scan

COST AND RESOURCE USE MEASURES

Row #	Steward	NQF #	Title	Description	Notes
UTILIZATION					
1	United Health Group	0328	Casemix-Adjusted Inpatient Hospital Average Length of Stay	This measure calculates a casemix-adjusted inpatient average length of stay (ALOS) for medical and surgical admissions for Commercial and Medicare populations. The measure can be reported at the hospital level or the service category level (medical vs. surgical).	
2	Philip R. Lee Institute for Health Policy Studies	0702	Intensive Care Unit (ICU) Length-of-Stay (LOS)	For all patients admitted to the ICU, total duration of time spent in the ICU until time of discharge; both observed and risk-adjusted LOS reported with the predicted LOS measured using the Intensive Care Outcomes Model - Length-of-Stay (ICOMLOS).	
3	AHRQ	0340	Pediatric Heart Surgery Volume (PDI 7)	Number of discharges with procedure for pediatric heart surgery	
4	Virtual PICU Systems, LLC	0334	PICU Severity-adjusted Length of Stay	The number of days between PICU admission and PICU discharge.	
5	Premier, Inc.	0327	Risk-Adjusted Average Length of Inpatient Hospital Stay	Percentage of inpatient & outpatients with excessive in-hospital days	
6	Leapfrog Group	0331 (though no longer endorsed)	Severity-Standardized Average Length of Stay -- Routine Care (risk adjusted)	Standardized average length of hospital stay (ALOS) for routine inpatient care (i.e., care provided outside of intensive care	

Row #	Steward	NQF #	Title	Description	Notes
				units).	
7	The Society of Thoracic Surgeons	0732	Surgical Volume for Pediatric and Congenital Heart Surgery: Total Programmatic Volume and Programmatic Volume Stratified by the Five STS-EACTS Mortality Categories	Surgical volume for pediatric and congenital heart surgery: total programmatic volume and programmatic volume stratified by the five STS-EACTS Mortality Levels, a multi-institutional validated complexity stratification tool	
CONDITION- OR PROCEDURE-SPECIFIC					
8		1560	Relative Resource Use (RRU) for People with Asthma	The risk-adjusted relative resource use by patients with asthma during the measurement year.	NCQA computes a relative resource use index and a quality index (derived from the NCQA quality measures for each specific condition) to allow for comparison of plans on both resource use and quality at the same time. The RRU measures are population based measures that are used to compare health plans or ACOs on resources used to care for beneficiaries with six conditions. Published tables allow organizations to match severity-adjusted resource use within service categories
9		1557	Relative Resource Use for People with Diabetes	The risk-adjusted relative resource use by patients with diabetes (type 1 and type 2) during the measurement year.	
10		1558	Relative Resource Use for People with Cardiovascular Conditions	The risk-adjusted relative resource use by patients with specific cardiovascular conditions during the measurement year.	
11		1561	Relative Resource Use for People with Chronic Obstructive Pulmonary Disease	The risk-adjusted relative resource use by patients with COPD during the measurement year.	
12			Relative Resource Use for People with Hypertension	The risk-adjusted relative resource use by patients with hypertension during the measurement year.	
13			Relative Resource Use for People with Low Back Pain	The risk-adjusted relative resource use by patients with low back pain during the measurement year.	

Row #	Steward	NQF #	Title	Description	Notes
					(Inpatient Facility, Surgery and Procedure, Evaluation and Management (E&M), and Pharmacy) to a standardized allowed payment in order to calculate total standard costs for their eligible members across different areas of clinical care.
14	Optum	1609	ETG Based HIP/KNEE REPLACEMENT cost of care measure	The measure focuses on resources used to deliver episodes of care for patients who have undergone a Hip/Knee Replacement. Hip Replacement and Knee Replacement episodes are initially defined using the Episode Treatment Groups (ETG) methodology and presence describe the unique of the condition for a patient and the services involved in diagnosing, managing and treating the condition.	This measure is a per episode evaluation. A number of resource use measures are defined for Hip/Knee Replacement episodes, including overall cost of care, cost of care by type of service, and the utilization of specific types of services.
15	Optum	1611	ETG Based PNEUMONIA cost of care measure	The measure focuses on resources used to deliver episodes of care for patients with pneumonia. Pneumonia episodes are defined using the Episode Treatment Groups (ETG) methodology and describe the unique presence of the condition for a patient and the services involved in diagnosing, managing and treating pneumonia.	A number of resource use measures are defined for pneumonia episodes, including overall cost of care, cost of care by type of service, and the utilization of specific types of services. Each resource use

Row #	Steward	NQF #	Title	Description	Notes
					measure is expressed as a cost or a utilization count per episode and comparisons with internal and external benchmarks are made using risk adjustment to support valid comparisons.
16	CMS	N/A Not endorsed	Condition-specific per capita cost measures for COPD, diabetes, HF, and CAD	The ratio of all actual Medicare FFS Parts A and B payments to a physician or medical group for beneficiaries attributed to them over a calendar year with one of four specific chronic health conditions— diabetes, coronary artery disease, chronic obstructive pulmonary disease, and heart failure— to all expected payments to the physician or medical group for those beneficiaries, multiplied by the payment for the average beneficiary in the sample.	
17	CMS	N/A not endorsed	Draft: Ischemic Heart Disease Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
18	CMS	N/A not endorsed	Draft: Acute Myocardial Infarction Condition Phase Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
19	CMS	N/A not endorsed	Draft: Coronary Artery Bypass Graft Treatment Episode for CMS Episode	Draft: Resources used in caring for the condition (duration TBD	

Row #	Steward	NQF #	Title	Description	Notes
			Grouper		
20	CMS	N/A not endorsed	Draft: Heart Catheterization Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD	
21	CMS	N/A not endorsed	Draft: Percutaneous Coronary Intervention Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
22	CMS	N/A not endorsed	Draft: Hip Osteoarthritis Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD	
23	CMS	N/A not endorsed	Draft: Hip Replacement/Revision Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD	
24	CMS	N/A not endorsed	Draft: Hip/Femur Fracture Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD	
25	CMS	N/A not endorsed	Draft: Hip/Femur Fracture Repair Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD	
26	CMS	N/A not endorsed	Draft: Knee Osteoarthritis Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
27	CMS	N/A not endorsed	Draft: Knee Replacement/Revision Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
28	CMS	N/A not endorsed	Draft: Shoulder Osteoarthritis Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	

Row #	Steward	NQF #	Title	Description	Notes
29	CMS	N/A not endorsed	Draft: Shoulder Replacement/Repair Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
30	CMS	N/A not endorsed	Draft: Asthma Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
31	CMS	N/A not endorsed	Draft: Bronchiectasis Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
32	CMS	N/A not endorsed	Draft: Chronic Bronchitis/Emphysema Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
33	CMS	N/A not endorsed	Draft: Cataract Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
34	CMS	N/A not endorsed	Draft: Cataract Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
35	CMS	N/A not endorsed	Draft: Glaucoma Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
36	CMS	N/A not endorsed	Draft: Glaucoma Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
37	CMS	N/A not endorsed	Draft: Retinal Disease Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
38	CMS	N/A not endorsed	Draft: Retinal Disease Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
39	CMS	N/A not endorsed	Draft: Heart Failure Condition Episode for CMS Episode	Draft: Resources used in caring for the condition (duration TBD)	

Row #	Steward	NQF #	Title	Description	Notes
			Grouper		
40	CMS	N/A not endorsed	Draft: Cardiac Arrhythmia Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
41	CMS	N/A not endorsed	Draft: Heart Block Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
42	CMS	N/A not endorsed	Draft: Cardioversion Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
43	CMS	N/A not endorsed	Draft: Pacemaker/AICD Implantation Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
44	CMS	N/A not endorsed	Draft: Pneumonia Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
45	CMS	N/A not endorsed	Draft: Respiratory Failure Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
46	CMS	N/A not endorsed	Draft: Hypertension Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
47	CMS	N/A not endorsed	Draft: Shock/Hypotension Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
48	CMS	N/A not endorsed	Draft: Nephropathy/Renal Failure Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
49	CMS	N/A not endorsed	Draft: Diabetes Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	

Row #	Steward	NQF #	Title	Description	Notes
50	CMS	N/A not endorsed	Draft: Sepsis/SIRS Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
51	CMS	N/A not endorsed	Draft: Ischemic Cerebral Artery Disease Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
52	CMS	N/A not endorsed	Draft: Carotid Artery Stenosis Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
53	CMS	N/A not endorsed	Draft: Breast Cancer Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
54	CMS	N/A not endorsed	Draft: Breast Cancer Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
55	CMS	N/A not endorsed	Draft: Lung Cancer Condition Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
56	CMS	N/A not endorsed	Draft: Lung Cancer Treatment Episode for CMS Episode Grouper	Draft: Resources used in caring for the condition (duration TBD)	
57	CMS	N/A not endorsed	Draft: Prostate Cancer Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider	
58	CMS	N/A not endorsed	Draft: Prostate Cancer Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider	
59	CMS	N/A not endorsed	Draft: Colon Cancer Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider	
60	CMS	N/A not endorsed	Draft: Colon Cancer Treatment Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider	

Row #	Steward	NQF #	Title	Description	Notes
61	CMS	N/A not endorsed	Draft: Dementia Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider	
62	CMS	N/A not endorsed	Draft: Back Pain Condition Episode for CMS Episode Grouper	Draft: Resources used in the episodes attributed to the provider	
TOTAL COST					
63	HealthPartners	1604	Total Cost of Care Population-based PMPM Index	Total Cost Index (TCI) is a measure of a primary care provider's risk adjusted cost effectiveness at managing the population they care for. TCI includes all costs associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services.	Per capita (population- or patient-based).
64	HealthPartners	1598	Total Resource Use Population-based PMPM Index	The Resource Use Index (RUI) is a risk adjusted measure of the frequency and intensity of services utilized to manage a provider group's patients. Resource use includes all resources associated with treating members including professional, facility inpatient and outpatient, pharmacy, lab, radiology, ancillary and behavioral health services.	Per capita (population- or patient-based)
65	CMS	2158	Payment-Standardized Medicare Spending Per Beneficiary (MSPB)	The MSPB Measure assesses the cost of services performed by hospitals and other healthcare providers during an MSPB hospitalization episode, which comprises the period immediately prior to, during, and following a patient's	This measure is a per episode evaluation.

Row #	Steward	NQF #	Title	Description	Notes
				hospital stay. Beneficiary populations eligible for the MSPB calculation include Medicare beneficiaries enrolled in Medicare Parts A and B who were discharged from short-term acute hospitals during the period of performance.	
66	CMS	N/A Not endorsed	Total Per Capita Cost Measure	The ratio of all actual Medicare FFS Parts A and B payments to a physician or medical group for beneficiaries attributed to them over a calendar year to all expected payments to the physician or medical group, multiplied by the payment for the average beneficiary in the sample.	

APPROPRIATENESS/OVERUSE

Row #	Steward	NQF #	Title	Description	Notes
67	AHRQ	0357	Abdominal Aortic Aneurysm (AAA) Repair Volume (IQI 4)	The number of hospital discharges with a procedure for abdominal aortic aneurysm (AAA) repair for patients 18 years and older or obstetric patients. Includes metrics for the number of discharges grouped by diagnosis and procedure type.	
68	AHRQ	0355	Bilateral Cardiac Catheterization Rate (IQI 25)	Percent of discharges with heart catheterizations in any procedure field with simultaneous right and left heart (bilateral) heart catheterizations.	
69	AHRQ	0361	Esophageal Resection Volume (IQI 1)	Number of discharges with a procedure for esophogeal resection	
70	AHRQ	0366	Pancreatic Resection Volume	The number of hospital discharges with a procedure	

Row #	Steward	NQF #	Title	Description	Notes
			(IQI 2)	code of partial or total pancreatic resection for patients 18 years and older or obstetric patients. Excludes acute pancreatitis admissions.	
71	AMA-PCPI	0654	Acute Otitis Externa: Systemic antimicrobial therapy – Avoidance of inappropriate use	Percentage of patients aged 2 years and older with a diagnosis of AOE who were not prescribed systemic antimicrobial therapy	
72	Partners HealthCare System, Inc.	0755	Appropriate Cervical Spine Radiography and CT Imaging in Trauma	Percent of adult patients undergoing cervical spine radiography or CT imaging for trauma who have a documented evidence-based indication prior to imaging (Canadian C-Spine Rule or the NEXUS Low-Risk Criteria).	
73	Partners HealthCare System, Inc.	0668	Appropriate Head CT Imaging in Adults with Mild Traumatic Brain Injury	Percent of adult patients who presented within 24 hours of a non-penetrating head injury with a Glasgow coma score (GCS) >13 and underwent head CT for trauma in the ED who have a documented indication consistent with guidelines(1) prior to imaging.	
74	NCQA	0002	Appropriate Testing for Children With Pharyngitis (CWP)	The percentage of children 2–18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus (strep) test for the episode. A higher rate represents better performance (i.e., appropriate testing).	
75	NCQA	0069	Appropriate treatment for children with upper respiratory infection (URI)	Percentage of children 3 months to 18 years of age with a diagnosis of URI who were not dispensed an antibiotic medication.	

Row #	Steward	NQF #	Title	Description	Notes
76	NCQA	0058	Avoidance of Antibiotic Treatment in Adults with Acute Bronchitis	The percentage of adults 18–64 years of age with a diagnosis of acute bronchitis who were not dispensed an antibiotic prescription.	
77	NCQA	0315	Back Pain: Appropriate Imaging for Acute Back Pain	Percentage of patients at least 18 years of age and younger than 80 with a diagnosis of back pain for whom the physician ordered imaging studies during the six weeks after pain onset, in the absence of “red flags” (overuse measure, lower performance is better).	
78	NCQA	0309	Back Pain: Appropriate Use of Epidural Steroid Injections	Percentage of patients at least 18 years of age and younger than 80 with back pain who have received an epidural steroid injection in the absence of radicular pain AND those patients with radicular pain who received an epidural steroid injection without image guidance (i.e. overuse measure, lower performance is better).	
79	NCQA	0312	Back Pain: Repeat Imaging Studies	Percentage of patients at least 18 years of age and younger than 80 with a back pain episode of 28 days or more who received inappropriate repeat imaging studies in the absence of red flags or progressive symptoms (overuse measure, lower performance is better).	
80	NCQA	0305	Back Pain: Surgical Timing	Percentage of patients at least 18 years of age and younger than 80 with a back pain episode of 28 days or more without documentation of red flags who had surgery within the	

Row #	Steward	NQF #	Title	Description	Notes
				first six weeks of back pain onset (overuse measure, lower performance is better).	
81	CMS	0669	Cardiac Imaging for Preoperative Risk Assessment for Non-Cardiac Low-Risk Surgery	This measure calculates the percentage of low-risk, non-cardiac surgeries performed at a hospital outpatient facility with a Stress Echocardiography, SPECT MPI or Stress MRI study performed in the 30 days prior to the surgery at a hospital outpatient facility (e.g., endoscopic, superficial, cataract surgery, and breast biopsy procedures). Results are to be segmented and reported by hospital outpatient facility where the imaging procedure was performed.	
82	American College of Cardiology Foundation	0670	Cardiac stress imaging not meeting appropriate use criteria: Preoperative evaluation in low risk surgery patients	Percentage of stress SPECT MPI, stress echo, CCTA, or CMR performed in low risk surgery patients for preoperative evaluation	
83	American College of Cardiology Foundation	0671	Cardiac stress imaging not meeting appropriate use criteria: Routine testing after percutaneous coronary intervention (PCI)	Percentage of all stress SPECT MPI, stress echo, CCTA and CMR performed routinely after PCI, with reference to timing of test after PCI and symptom status.	
84	American College of Cardiology Foundation	0672	Cardiac stress imaging not meeting appropriate use criteria: Testing in asymptomatic, low	Percentage of all stress SPECT MPI, stress echo, CCTA, and CMR performed in asymptomatic, low CHD risk patients for initial detection and risk	

Row #	Steward	NQF #	Title	Description	Notes
			risk patients	assessment	
85	Partners HealthCare System, Inc.	0667	Inappropriate Pulmonary CT Imaging for Patients at Low Risk for Pulmonary Embolism	Percent of patients undergoing CT pulmonary angiogram for the evaluation of possible PE who are at low-risk for PE consistent with guidelines prior to CT imaging.	
86	CMS	0514	MRI Lumbar Spine for Low Back Pain	This measure calculates the percentage of MRI of the Lumbar Spine studies with a diagnosis of low back pain on the imaging claim and for which the patient did not have prior claims-based evidence of antecedent conservative therapy.	
87	AMA-PCPI	0655	Otitis Media with Effusion: Antihistamines or decongestants – Avoidance of inappropriate use	Percentage of patients aged 2 months through 12 years with a diagnosis of OME were not prescribed or recommended to receive either antihistamines or decongestants	
88	AMA-PCPI	0657	Otitis Media with Effusion: Systemic antimicrobials – Avoidance of inappropriate use	Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic antimicrobials	
89	AMA-PCPI	0656	Otitis Media with Effusion: Systemic corticosteroids – Avoidance of inappropriate use	Percentage of patients aged 2 months through 12 years with a diagnosis of OME who were not prescribed systemic corticosteroids	
90	AMA-PCPI	0562	Overutilization of Imaging Studies in Melanoma	Percentage of patients, regardless of age, with a current diagnosis of Stage 0 through IIC melanoma or a history of melanoma of any stage, without signs or symptoms suggesting systemic spread, seen for an office visit during the one-year measurement period, for whom no diagnostic imaging studies were	

Row #	Steward	NQF #	Title	Description	Notes
				ordered	
91	The Joint Commission	0469	PC-01 Elective Delivery	This measure assesses patients with elective vaginal deliveries or elective cesarean sections at >= 37 and < 39 weeks of gestation completed.	
92	The Joint Commission	0471	PC-02 Cesarean Section	This measure assesses the number of nulliparous women with a term, singleton baby in a vertex position delivered by cesarean section.	
93	AMA-PCPI	0389	Prostate Cancer: Avoidance of Overuse of Bone Scan for Staging Low Risk Prostate Cancer Patients	Percentage of patients, regardless of age, with a diagnosis of prostate cancer at low risk of recurrence receiving interstitial prostate brachytherapy, OR external beam radiotherapy to the prostate, OR radical prostatectomy, OR cryotherapy who did not have a bone scan performed at any time since diagnosis of prostate cancer	
94	CMS	0513	Thorax CT: Use of Contrast Material	This measure calculates the percentage of thoracic CT studies that are performed with and without contrast out of all thoracic CT studies performed	
95	NCQA	0052	Use of Imaging Studies for Low Back Pain	The percentage of members with a primary diagnosis of low back pain who did not have an imaging study (plain x-ray, MRI, CT scan) within 28 days of the diagnosis.	
96	CMS	N/A Not endorsed	Overuse of Diagnostic Imaging for Uncomplicated Headache	DRAFT: Percentage of all adult (>=18 years old) uncomplicated headache patients who received an order for a brain computed tomography (CT), computed tomography angiogram (CTA), magnetic resonance	

Row #	Steward	NQF #	Title	Description	Notes
				(MR), or magnetic resonance angiogram (MRA) study during the measurement period.	
97	CMS	N/A Not endorsed	Appropriate Use of DXA Scans in Women Under 65 Who Do Not Meet the Risk Factor Profile	DRAFT: Percentage of women ages 18 to 64 without select risk factors for osteoporotic fracture who received an order for a dual-energy x-ray absorptiometry (DXA) scan	
98	ACEP	N/A Not endorsed	Avoidance of inappropriate use of head CT in ED patients with minor head injury	Percentage of emergency department patients with minor head injury who received inappropriate imaging study (not clinically indicated)	
99	ACEP	N/A Not endorsed	Avoidance of inappropriate use of imaging for adult ED patients with atraumatic low back pain	Percentage of emergency department patients aged >= 18 years with atraumatic low back pain who received an inappropriate imaging study (not clinically indicated)	
100	American Society of Clinical Oncology	0213	Proportion admitted to the ICU in the last 30 days of life	Percentage of patients who died from cancer admitted to the ICU in the last 30 days of life	
101	American Society of Clinical Oncology	0215	Proportion not admitted to hospice	Percentage of patients who died from cancer not admitted to hospice	
102	American Society of Clinical Oncology	0210	Proportion receiving chemotherapy in the last 14 days of life	Percentage of patients who died from cancer receiving chemotherapy in the last 14 days of life	
103	American Society of Clinical Oncology	0211	Proportion with more than one emergency room visit in the last days of life	Percentage of patients who died from cancer with more than one emergency room visit in the last days of life	
104	Alabama Medicaid Agency	1381	Asthma Emergency Department Visits	Percentage of patients with asthma who have greater than or equal to one visit to the emergency room for asthma during the	

Row #	Steward	NQF #	Title	Description	Notes
				measurement period.	
105	CMS	0173	Emergency Department Use without Hospitalization	Percentage of home health stays in which patients used the emergency department but were not admitted to the hospital during the 60 days following the start of the home health stay.	

Maryland Hospital Community Benefits Report
FY 2013

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August 2014

INTRODUCTION

Each year, the Health Services Cost Review Commission ("Commission" or "HSCRC") collects community benefit information from individual hospitals to compile into a publicly available statewide Community Benefit Report ("CBR"). This document contains summary information for all submitting Maryland hospitals for FY 2013. Past and current year's CB reports submitted by the individual hospitals are available on the Commission's website.

Background

Section 501(c)(3) of the Internal Revenue Service Code exempts organizations that are organized and operated exclusively for, among other things, religious, charitable, scientific, or educational purposes. As a result of their tax exempt status, nonprofit hospitals receive many benefits. They are generally exempted from federal income and unemployment taxes as well as from state and local income, property, and sales taxes. In addition, they have the ability to raise funds through tax-deductable donations and tax-exempt bond financing. Originally, the IRS permitted hospitals to qualify as "charitable" if they provided charity care to the extent of their financial ability to do so. However in 1969, Rev. Ruling 69-545 issued by the IRS broadened the meaning of "charitable" from charity care to the "promotion of health", stating':

> "[T]he promotion of health, like the relief of poverty and the advancement of education and religion, is one of the purposes in the general law of charity that is deemed beneficial to the community as a whole even though the class of beneficiaries eligible to receive a direct benefit from its activities does not include all the members of the community, such as indigent members of the community, provided that the class is not so small that its relief is not of benefit to the community"

Thus was created the "community benefit standard" for hospitals to qualify for tax exempt status.

In March 2010, Congress passed the Patient Protection and Affordable Care Act ("ACA"). Under the ACA, every § 501(c)(3) hospital, whether independent or in a system, must conduct a community health needs assessment at least once every three years in order to maintain its tax-exempt status and avoid an annual penalty of up to $50,000. The first needs assessment was due by the end of the hospital's fiscal year 2013. Each community health needs assessment must take into account input from persons who represent the broad interest of the community served, including those with special knowledge or expertise in public health, and the assessment must be made widely

available to the public. An implementation strategy describing how a hospital will meet the community's health needs must be included, as well as a description of what the hospital has done historically to address its community needs. Furthermore, the hospital must identify any needs that have not been met by the hospital and why these needs have not been addressed. Tax-exempt hospitals must report this information on Schedule H of the IRS 990 forms.

The Maryland CBR process was adopted by the Maryland General Assembly in 2001 (Health-General Article §19-303 Maryland Annotated Code), with FY 2004 set as the first data collection period. The Commission worked with the Maryland Hospital Association ("MHA") and interested hospitals, local health departments, and health policy organizations and associations on the details and format of the community benefit report. In developing the format for data collection, the group drew heavily on the experience of the Voluntary Hospitals of America ("VHA") community benefit process which possessed, at the time, over ten years of voluntary hospital community benefit reporting experience across many states. The resulting data reporting spreadsheet and instructions were used by Maryland hospitals to submit the FY 2004 data to the Commission in January 2005. The Commission's first CBR, detailing FY 2004 data, was published in July 2005.

The HSCRC continues to work with the MHA, public health officials and individual hospitals to further improve the reporting process and to refine the definitions as needed. The data collection process offers an opportunity for each Maryland non-profit, acute care hospital to critically review and report its activities designed to benefit the community it serves.

The Fiscal Year 2013 report represents the HSCRC's tenth year of reporting on Maryland hospital community benefit data.

Definition of Community Benefits

Maryland law defines a "community benefit" (CB) as an activity that is intended to address community needs and priorities primarily through disease prevention and improvement of health status, including:

- Health services provided to vulnerable or underserved populations;
- Financial or in-kind support of public health programs;
- Donations of funds, property, or other resources that contribute to a community priority;
- Health care cost containment activities; and

- Health education screening and prevention services.

As evidenced in the individual reports, Maryland hospitals provide a broad range of health services to meet the needs of their communities, often receiving partial or no compensation. These activities, however, are expected from Maryland's 46 acute, not-for-profit hospitals as a result of the tax exemptions they receive.

ANALYSIS

FY 2013 Data Reporting Highlights

The reporting period for this CBR is July 1, 2012 – June 30, 2013. Hospitals submitted their individual community benefit reports to the HSCRC by December 15, 2013 using audited financial statements as the source for calculating costs in each of the community benefit categories. Of the 48 not-for- profit hospitals in Maryland, 46 Community Benefit Reports were submitted. There are two hospital systems, Shore Health System and Upper Chesapeake Hospital, which submitted Community Benefit Reports covering both hospitals in their system. Shore Health submitted a single Community Benefit Report covering both Easton and Dorchester Hospitals. Upper Chesapeake Hospital submitted a single Community Benefit Report covering both Upper Chesapeake Medical Center and Harford Memorial Hospital.

As shown in Table I below, in FY2013, Maryland hospitals provided approximately $1.5 billion dollars in total community benefit activities in FY 2013 (up from $1.4 billion in FY 2012). This total is comprised of $518.2 million in Charity Care, $412.9 million in Health Professions Education, $379.0 million in Mission Driven Health Care Services, $ 82.7 million in Community Health Services, $56.4 million in Unreimbursed Medicaid Cost, $20.0 million in Financial Contributions, $ 16.9 million in Community Building Activities, $8.2 million in Community Benefit Operations, $ 7.9 million in Research activities, and $1.9 million in Foundation Funded Community Benefits[1].

[1] These totals include hospital reported indirect costs, which vary by hospital and by category from a fixed dollar amount to a calculated percentage of the hospitals reported direct costs.

Table I –Total Community Benefit

Community Benefit Category	Number of Staff Hours	Number of Encounters	Net Community Benefit Expense	Percent of Total CB Expenditures	Net Community Benefit Expense Less: Rate Support	Percent of Total CB Expenditures w/o Rate Support
Unreimbursed Medicaid Cost	0	0	$ 56,475,876	3.8%	$ 56,475,876	7.9%
Community Health Services	949,714	18,964,608	$ 82,744,997	5.5%	$ 82,744,997	11.6%
Health Professions Education *	6,380,270	238,664	$ 412,874,329	27.4%	$ 83,356,744	11.7%
Mission Driven Health Services	2,315,237	870,142	$ 380,227,201	25.3%	$380,227,201	53.4%
Research	64,052	5,932	$ 7,949,004	0.5%	$ 7,949,004	1.1%
Financial Contributions	44,652	216,700	$ 20,051,769	1.3%	$ 20,051,769	2.8%
Community Building	152,743	675,369	$ 16,886,257	1.1%	$ 16,886,257	2.4%
Community Benefit Operations	86,836	2,121	$ 8,180,001	0.5%	$ 8,180,001	1.1%
Foundation	48,532	11,987	$ 1,930,355	0.1%	$ 1,930,355	0.3%
Charity Care *	0	0	$ 518,234,532	34.4%	$ 54,624,388	7.7%
Total	10,042,036	20,985,523	$ 1,505,554,322	100.0%	$ 712,426,593	100.0%

(*) Indicates category adjusted for rate support (GME, NSPI, Charity Care)

In Maryland, the costs of uncompensated care (both charity care and bad debt) and graduate medical education are built into rates for which hospitals are reimbursed by all payers, including Medicare and Medicaid. Additionally, the HSCRC includes amounts in rates for hospital nurse support programs provided at Maryland hospitals. These costs are, in essence, "passed-through" to the purchasers and payers of hospital care. To be consistent with IRS form 990 requirements and to avoid accounting confusion among programs that are not funded in part by hospital rate setting (unregulated), the HSCRC requested that hospitals not include revenue provided in rates as offsetting revenue on the CBR worksheet. Attachment III details the amounts that are included in rates and funded by all payers for charity care, direct graduate medical education, and the nurse support program in Fiscal Year 2013.

As noted, the HSCRC includes a provision in hospital rates for uncompensated care; this includes charity care (eligible for inclusion as a community benefit by Maryland hospitals in their CBRs) and bad debt (not considered a community benefit). As detailed in Attachment III, $462.6 million in charity care was provided through Maryland hospital rates in FY 2013 that was funded by all payers. When offset against the hospital reported amount of $517.6 million in charity care, the net amount provided by the hospitals is $55.0 million.

Also as noted, another social cost funded in Maryland's rate-setting system in the cost of graduate medical education, generally for interns and residents trained in Maryland hospitals. Included in graduate medical education costs are the direct costs (Direct Medical Education or "DME"), which constitute wages and benefits of residents and interns, faculty supervisory expenses, and allocated overhead. The Commission utilizes its annual cost report to quantify the DME costs of Physician training programs at Maryland hospitals. In FY 2013, DME costs totaled $316.2 million.

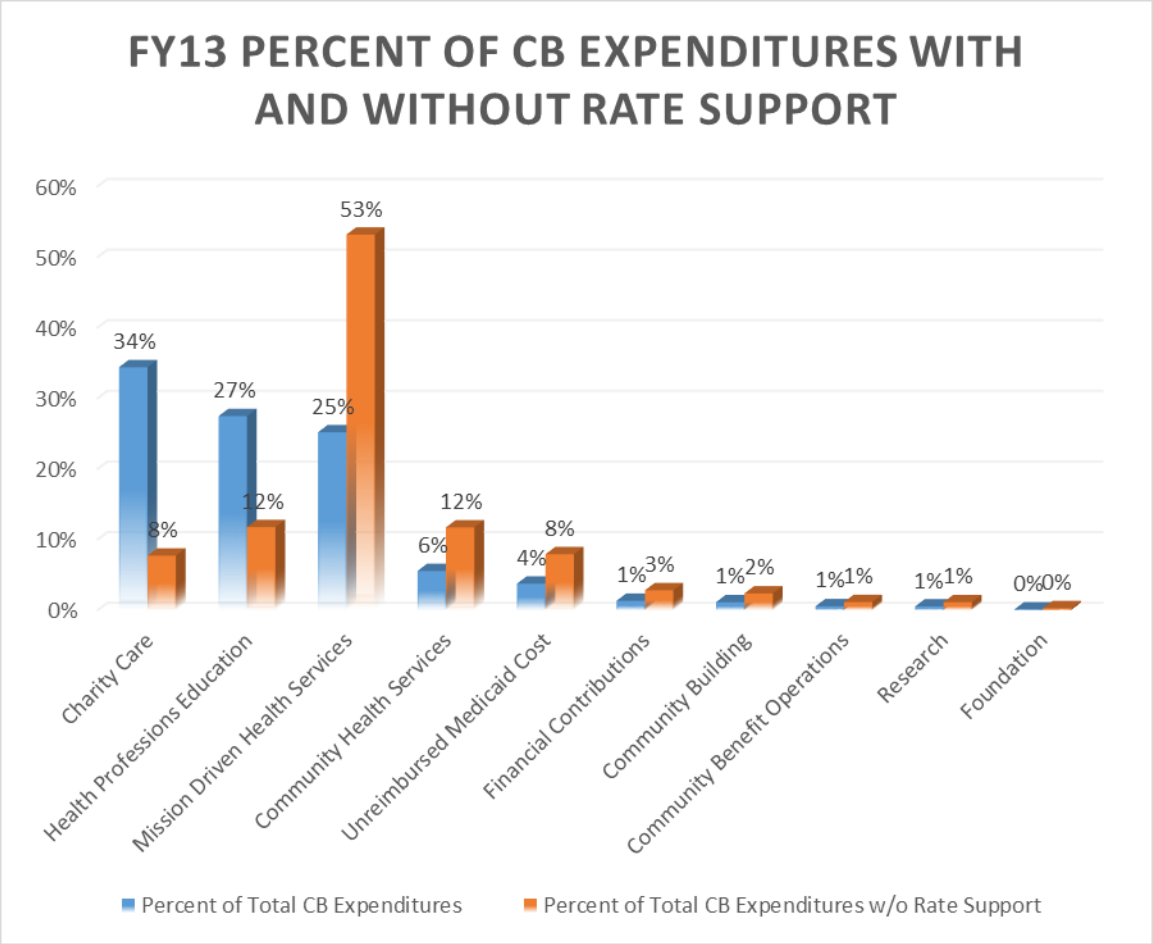
The Commission's Nurse Support Program I (NSPI) is aimed at addressing the short and long-term nursing shortage impacting Maryland hospitals. In FY 2013, $13.3 million was provided in hospital rate adjustments for NSPI. For further information about funding provided to specific hospitals, please see Attachment III.

When the reported community benefit costs are offset by rate support, the net community benefit provided by Maryland hospitals in FY 2013 was $712.4 million, or 5.2% of the total hospital operating expenses. This is up from the $651.6 million in net benefits provided in FY 2012 which totaled 4.82% of hospitals' operating expenses. Please see the chart in Attachment II for more detail.

For additional detail and a description of subcategories under each community benefit category, please see the chart under Attachment I – Aggregated Hospital CBR Data.

The distribution of expenses by category is significantly impacted by offsets in rates. Expenditures in each category as a percentage of total expenditures (see Table II below*)* Charity Care, Health Professions Education and Mission Driven Health Services represent the majority of the expenses at 34%, 27%, and 25%, respectively. However, when considering the expenditures without amounts provided in rates, the configuration changes significantly, moving Mission Driven Health Services (subsidized health services) into the largest category with 53%. (See Table II) Community Health Services and Health Professions Education follow each representing 12% of expenditures, respectively.

Table II –% of Expenditure by Category



Utilizing the data reported, Attachment II of the FY 2013 CB Analysis compares hospitals on the total amount of community benefits reported, the amount of community benefits that are recovered through HSCRC approved rates (charity care, direct medical education, and nurse support), and the number of staff and staff hours dedicated to the community benefit operations. On average, in FY 2013, 1,848 staff hours were dedicated to CB Operations. This is up 24% from last year's 1,491 staff hours. There are 4 hospitals reporting zero staff hours dedicated to CB Operations. The HSCRC continues to encourage hospitals to incorporate CB Operations into their overall strategic planning.

The total amount of community benefit expenditures as a percentage of total operating expenses ranges from 24.06% to 3.12% with the average percentage being 11.12%. This has increase from FY 2012's average of 10.06%. There are 23 hospitals that report providing benefits in excess of 10% of their operating expenses, as compared with twenty in FY 2012. Another fifteen hospitals exceed 7.5%.

FY 2013 Narrative Reporting Highlights

In FY 2013, hospitals were again asked to respond to narrative questions regarding their CB programs. The questions were developed, in part, to provide a standard reporting format for all hospitals. This uniformity not only provided readers of the individual hospital reports with more information than was previously available, but also allowed for comparisons across hospitals. The narrative guidelines were aligned, wherever possible, with the IRS form 990, schedule H, in an effort to provide as much consistency as is practicable in reporting on the State and Federal levels.

The HSCRC also considers the narrative guidelines to be a mechanism for assisting hospitals in critically examining their CB programs. Any examination of the effectiveness of major program initiatives should help hospitals determine which programs are achieving the desired results and which are not.

Through the hospitals' Community Health Needs Assessments (CHNA) a multitude of health concerns were identified. The top health needs consistently identified in the CHNAs include heart disease, obesity, behavioral/mental health/substance abuse, diabetes, access to care, and cancer. Many hospitals chose to address needs which align with the Maryland State Health Improvement Process's (SHIP) and/or the U.S. Department of Health and Human Services (DHHS) Healthy People 2020 initiative. SHIP provides a framework for continual progress toward a healthier Maryland. The SHIP includes 40 measures in five focus areas that represent what it means for Maryland to be healthy. Healthy People 2020, launched in December 2010, is the DHHS's 10 year plan for improving the health of all Americans

Hospitals were asked to include a list of unmet health needs which were identified through the most recent community health needs assessment, but which remain unaddressed due to a variety of circumstances. The most prevalent unmet health need noted in the FY 2013 was behavioral/mental health/substance abuse. This was also the most prevalent unmet need in FY 2012. Other unmet health needs, consistently identified were transportation, cancer, safe housing, and dental health. Some hospitals indicated these needs were being met by other community organizations as well as a lack of expertise/infrastructure/funding at the hospital as reasons for not addressing the identified needs.

The evaluation tool, resulting from the HSCRC advisory group was again used to evaluate hospitals' Community Benefit Narrative Reports. The group of evaluators consisted of three individuals, a representative of the HCSRC, a representative of the Maryland Hospital Association, and a public health official from the Delmarva foundation. FY 2013 showed little improvement in the narrative reporting process. The total points available were 209. Of the 47 hospitals evaluated, the average score was 192.1 or 92%. No submissions earned 100%, the top score was 207 points or 99.2%, and the lowest score was 125 points or 60%.

The section of the narrative report that lost most points on average was Section II, the Community Health Needs Assessment. According to the reporting instructions the CHNA must include a description of the community served by the hospital and how it was determined, the process and methods used to conduct the assessment, the CHNA and input collaborators identified by name and title, gaps in information, broad community input, a list of prioritized needs, the process and criteria used to prioritize the identified needs, and a description of the existing resources to meet the needs. The evaluators found numerous gaps in alignment of the actual reports with the above instructions.

FY2004 – FY2013 TEN YEAR SUMMARY

Fiscal Year 2013 marks the tenth year since the inception of the Community Benefit Report. In FY 2004, CB expenses represented $586.5 million or 6.9% of operating expenses. In FY 2013, CB expenses represented $1.5 billion or 11% of operating expenses. As Maryland Hospitals have increasingly focused on implementation of cost and quality improvement strategies, an increasing percentage of operating cost has been directed toward CB initiatives.

The reporting requirement for revenue offsets and rate support has changed since the inception of the CB report in FY 2004. For consistency purposes, the below charts

graphically represent Community Benefit Expense from FY2008 – FY2015. Table III (A & B) below represent the trend of CB expense in total and net of rate supports. On average, approximately 50% of the expenses have been reimbursed through the rate setting system.

Table III A - FY2008 – FY2013 Expenditures Total and Net of Rate Support

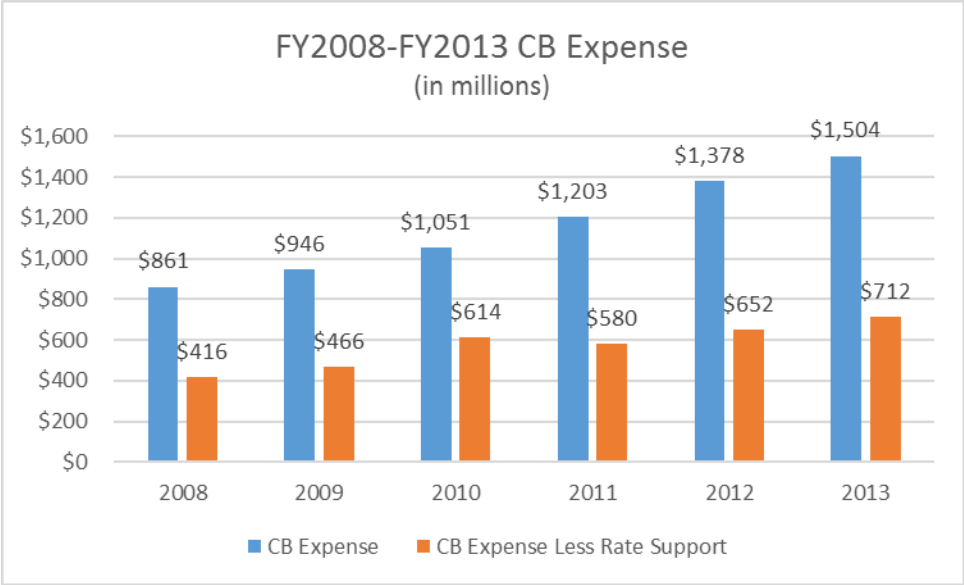
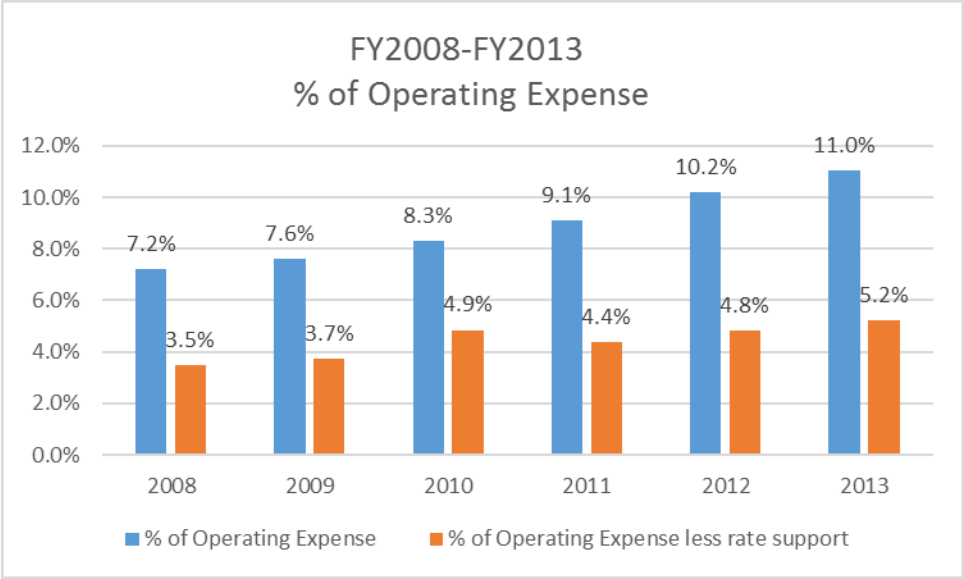


Table III A - FY2008 – FY2013 % Expenditures Total and Net of Rate Support



Maryland Hospitals' commitment to community benefits continues to grow when considered on either gross expenditure basis or when offsetting for amounts that are included in hospital rates as a result of Commission policy. These amounts do, however, include restricted grants that are provided to hospitals for community benefit related activities. The Internal Revenue Service has recently changed its rules to exclude or offset restricted grants and contributions the hospital uses to provide a community benefit. Staff is interested to observe how this new policy might impact the amount of dollars reported in future community benefit reports. With the State's drive toward population health and achieving the three-part aim, Commission staff will also continue to monitor the extent to which hospitals are making their community benefit mission part of their overall hospital strategic planning, and how they are collaborating with other hospitals, state and local health departments and policy makers, and other key community stakeholders on providing appropriate services that benefit people in the communities that they serve.

Community Benefit Report FY 2013
HSCRC Narrative Scoring Highlights
June 6, 2014

The following is a summary of the HSCRC scoring of the FY2013 Community Health Needs Assessments Surveys. The HSCRC engaged **BA Spallitta Consulting, LLC** to compile the scores. The Narratives were scored by Kristen Connor, Senior Consultant. The results are as follows:

The average score was 183 out of a possible 209 pts or 87.6%. The top score was 204 points or 97.6%, and the lowest score was 73 points or 34.9%.

Section I – General Hospital Demographics and Characteristics

The average score was 11.6 out of 12 possible points. Of those 12 possible total points, question 2a and 2b were worth 6pts each. Question 2a asked for a detailed description of the community or communities the organization serves (the Community Benefit Service Area –"CBSA"). Question 2b asked hospitals to describe the significant demographic characteristics and social determinants relevant to the needs of the community with source information included.

- Two hospitals lost points because they did not describe their CBSA.
- Two hospitals lost points because actual statistics were missing within the table.
- Seven hospitals lost points because their data was not supported with sources of information provided.

Section II - Community Health Needs Assessment

The average score for all hospitals was 76.2 points out of 90 or 84.5%. This section of the narrative was made up of two questions, which scored the hospitals' Community Health Needs Assessment ("CHNA") worth 70 points and the Implementation Strategy worth 20 points. The average score for the CHNA section was 58 out of 70 points or 82.9%. The average score for the Implementation Strategy section was 19 out of 20 points or 95%.

According to the reporting instructions the CHNA must include a description of the community served by the hospital and how it was determined, the process and methods used to conduct the assessment, the CHNA and input collaborators identified by name and title, gaps in information, broad community input, a list of prioritized needs, the process and criteria used to prioritize the identified needs, and a description of the existing resources to meet the needs.

- Four hospitals failed to describe how the community it serves was determined.

- Three hospitals failed to describe the process and methods they used to collect their data.
- Four hospitals did not describe any gaps in information.

- Nine hospitals did not provide specific information such as the name, title, or qualifications of the parties who collaborated in the CHNA conduction.
- Twenty-six hospitals stated that input was gained from community leaders/stakeholders, organizations, and/or individuals with special knowledge or expertise, but did not identify these individuals by name or title
- Only eight of the hospitals actually prioritized their list of community needs. All of the other hospitals provided a list of needs, which they found to be priorities within the community, but did not actually prioritize those priority needs.
- Sixteen hospitals failed to describe the process and criteria used in prioritizing the health needs.
- Ten hospitals failed to identify available facilities/resources within the community available to meet the community health needs identified through the CHNA.

In regards to the Implementation Strategy, most hospitals scored the maximum 20 points available. The exceptions are as follows:

- One hospital did not provide an Implementation Strategy for their identified needs and scored zero.
- One hospital scored zero on this question because the needs outlined in their Implementation Strategy were not the needs identified in their CHNA.
- One hospital scored zero because their implementation strategy was not specific and they failed to give an explanation of why identified needs were not met.

Section III - Community Benefit Administration

In this section, hospitals were asked to answer questions regarding the decision making process of determining which needs in the community would be addressed through the community benefits activities of the hospital. This section was worth a total of 32 points. Most hospitals received all 32 points.

- Two hospitals lost points in this section because there was no internal audit of the Community Benefit Report in terms of spreadsheet and/or narrative.
- One hospital lost points because clinical leadership was not involved in the hospital community benefit process/structure to implement and deliver community benefit activities.

Section IV - Hospital Community Benefit Program and Initiatives

Hospitals were asked to fill in Table III to provide a description of the primary needs identified in the CHNA. This section was scored on 3 different areas with a maximum score of 50 points. The average score was 42.5 out of 50 points or 85%.

The hospitals were given 0-20 points based on the description and detail given in regards to the identified community needs and initiatives undertaken. Seven hospitals described initiatives which did not reflect any/all of the needs identified in their CHNA and therefore lost points. Twenty-three hospitals lost points because the identified need did not include any measurable disparities and poor health status of racial and ethnic minority groups. The average score in this section was 17 out of 20 points or 85%.

In addition to describing the identified needs, hospitals were asked to provide the principle objective of each need, how the results would be measured, time allocated, key partners, measured outcomes, whether each initiative would be continued based on outcomes, and the FY cost. This section was also worth 20 points. The most common area where hospitals lost points in this section was related to the outcome. Fourteen hospitals gave outcomes that did not reflect how the initiative addressed the community health need, such as a reduction or improvement in rate. These hospitals did not demonstrate in data collected how these outcomes were tied to the objective. Other reasons hospitals lost points in this section were because data/information was missing from the table and for a lack of description of how the outcome was evaluated. The average score for this question was also 17 out of 20 points or 85%.

The third part of this section asked hospitals to provide a list of needs that were identified through the CHNA but were not addressed, and to give justification if the needs were not addressed. This question was worth 10 points. Seven hospitals lost points because not all of the identified needs were implemented and no justification was given for the unmet needs. The average score for this question was 8 out of 10 points or 80%.

Section V - Physicians

The average score for this section was 3 out of 5 points or 60%. This section was made up of two questions. **The first asking for a written description of the gaps in availability of specialist providers to serve the uninsured cared for by the hospital**. Seven hospitals lost points on this question because they failed to provide description of gaps in a way that answered the question. The answers provided to this question instead described; the specialists actually available, what is done when a gap occurs i.e. patient transfer, gaps within the general community but not within the hospital itself, gaps that have been recently filled, but not what gaps still exist, or states that initiatives are in place to fill ‘gaps’ but does not define what the ‘gaps’ are.

Section VI - Appendices

In the Appendices section, most hospitals scored the maximum 20 points. The average score was 18 out of 20 points or 90%. There were four appendices required in this section; a description of how the hospital informs patients about eligibility for assistance under the hospitals Financial Assistance Policy, a copy of the hospitals Financial Assistance Policy, a copy of the Patient Information Sheet, and the hospitals mission/vision/values statement.

- Two hospitals did not describe how patients are informed about eligibility for assistance.
- All but one hospital included a copy of their Financial Assistance Policy.
- Eleven hospitals received zero points in regards to their Patient Information Sheet.
- One hospital did not provide the Patient Information Sheet at all.

Eleven Hospitals' scored zero points because their Patient Information Sheets did not conform to Health-General §19-214.1(e). According to the HSCRC website, a compliant Patient Information Sheet will include; a description of the Financial Assistance Policy, a description of the patient's rights and obligations with regards to billing and collection under the law, contact information for someone at the hospital to assist the patient with billing and how to apply for assistance, contact information for Maryland Medical Assistance Program, and a statement that physician charges are not included in the hospital bill and are billed separately. Ten Patient Information Sheets did not include information on Maryland's Medical Assistance Program. Five Patient Information Sheets did not include the statement that Physician charges are not included in the hospital bill and are billed separately. Three Patient Information Sheets were missing a description of the patient's rights and obligations with regards to billing and collection under the law.

Overall Summary

The standard reporting format did provide a great deal of information and allowed for comparisons across hospitals. However, the way that some of the questions were interpreted by individual hospitals was not consistent. This holds true especially for the questions regarding the CHNA, Implementation Strategy, and Initiatives. With regards to the CHNA scoring, the fact that very few hospitals actually prioritized their needs suggests that most hospitals interpreted the question as requiring a description of priority needs as opposed to a "prioritized description of all the community health needs identified through the CHNA" as outlined in the Community Benefit Narrative Reporting Instructions. Because many hospitals lost points for failing to include names and titles of collaborators of the CHNA and input in to the assessment, it would be helpful to require and additional appendix which outlines the collaborators by organization, name, and title. It would also be helpful to the scoring process to list the prioritized needs and unmet needs on the Community Benefit Narrative Report itself in addition to providing the

information within the CHNA and Implementation Strategy accessed through the web-link given in the report.

With regards to the Implementation Strategy question, it would be helpful to have a fill in the blank question on the narrative Section II, to give the date the Implementation Strategy was approved by the governing body of the hospital organization.

In the Community Benefits Initiatives table, many hospitals based their outcome on the number of encounters, but the number of encounters alone does not tie the outcome to the objective in a way that demonstrates an impact on the identified need.

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Deputy Director
Research and Methodology

TO: **Commissioners**

FROM: **Legal Department**

DATE: **September 10, 2014**

RE: **Hearing and Meeting Schedule**

October 15, 2014	Time to be determined, 4160 Patterson Avenue HSCRC Conference Room
November 12, 2014	Time to be determined, 4160 Patterson Avenue HSCRC Conference Room

Please note that the Commissioner's packets will be available in the Commission's office at 11:45 a.m.

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

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