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Department of Health and Mental Hygiene



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**523rd MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION**  
**November 18, 2015**

**EXECUTIVE SESSION**  
**12:00 p.m.**

(The Commission will begin in public session at 12:00 p.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1PM.)

1. Update on Contract and Modeling of the All-payer Model vis-a-vis the All-Payer Model Contract – Administration of Model Moving into Phase II - Authority General Provisions Article, §3-104
2. Personnel Matters - General Provisions Article, §3-305 (b)(1)(ii)

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

1. Review of the Minutes from the Public Meeting and Executive Session on October 14, 2015
2. Executive Director's Report
3. New Model Monitoring
4. Docket Status – Cases Closed  
2300R – Washington Adventist Hospital                      2309A - University of Maryland Medical Center  
2312A - University of Maryland Medical Center            2313A - University of Maryland Medical Center
5. Docket Status – Cases Open  

2304N – UM St. Joseph Medical Center	2307A – Maryland Physician Care
2308A – Priority Partners	2310A – MedStar Family Choice
2311A – MedStar Family Choice	2314A – Riverside Health of Maryland
2315A – Johns Hopkins Health System	2316A – Johns Hopkins Health System
2317R – Holy Cross Health	2318A – University of Maryland Medical System
6. Preliminary Staff Report Regarding Health Job Opportunity Program Proposal
7. Update from Performance Measurement Work Group
8. Disclosure of the Hospital Financial and Statistical Data for Fiscal Year 2014
9. Legal Report
10. Hearing and Meeting Schedule

Minutes to be included into the post-meeting packet  
upon approval by the Commissioners

## Executive Director's Report

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



# Monitoring Maryland Performance Preliminary Utilization Trends

Year to Date thru August 2015

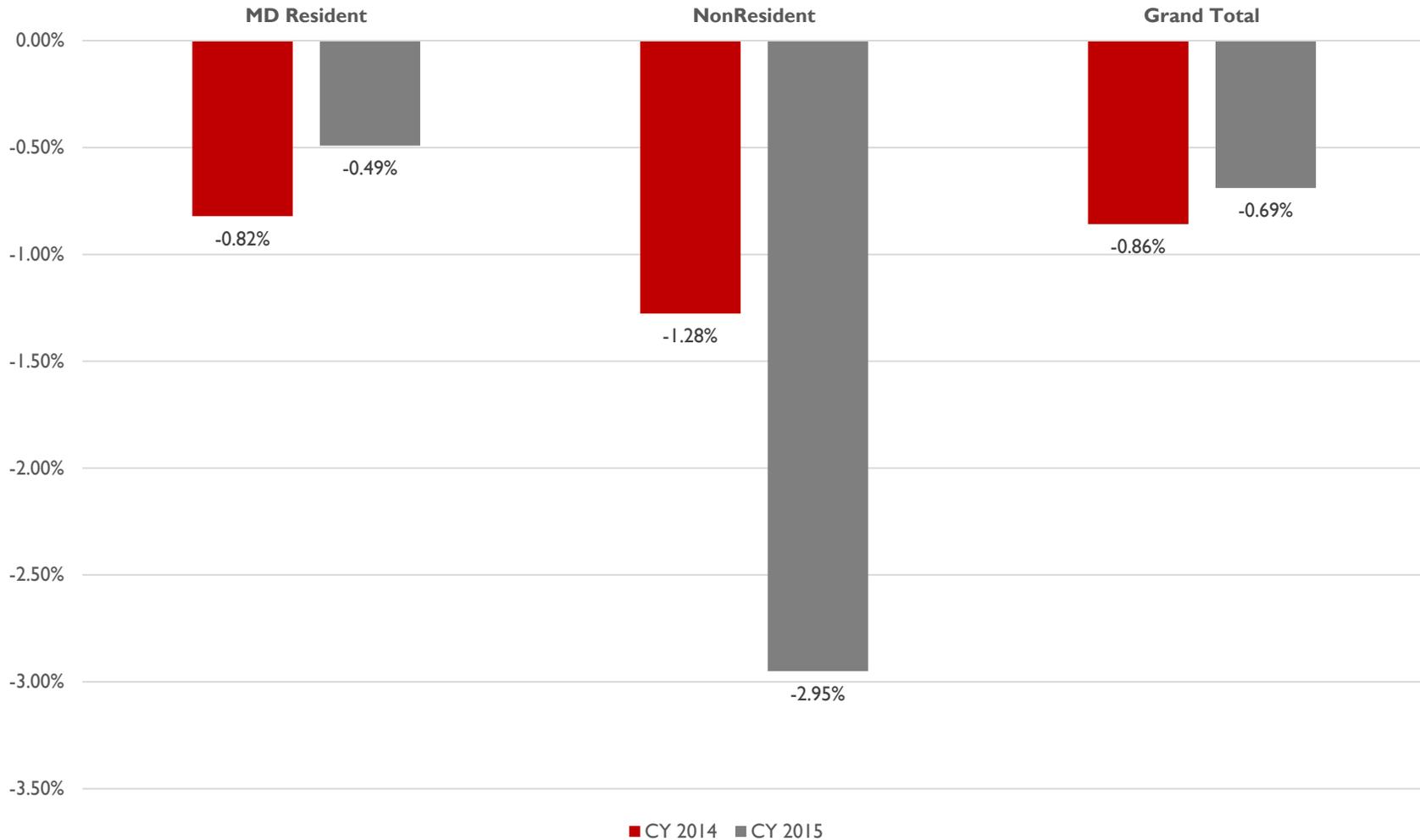


**HSCRC**

Health Services Cost  
Review Commission

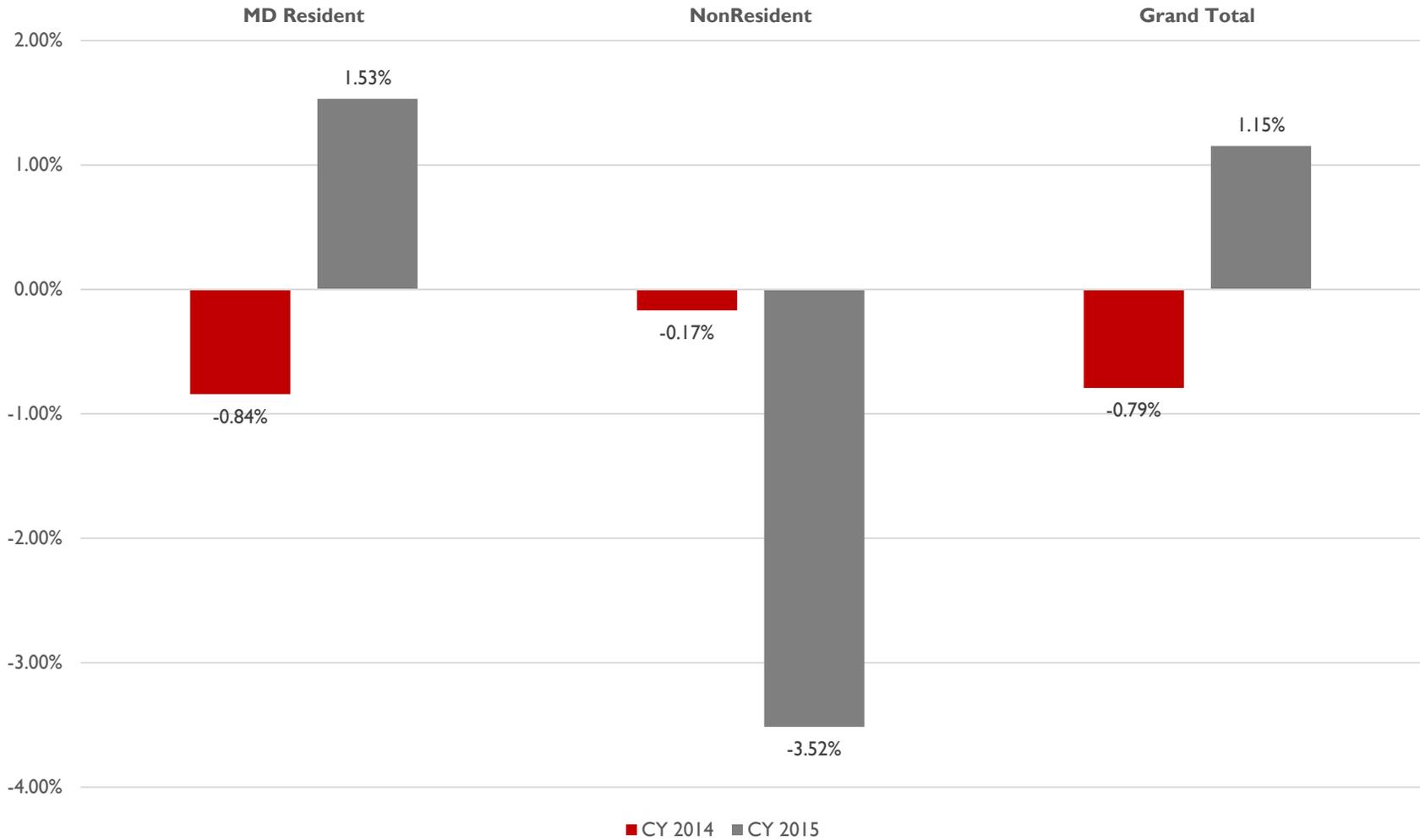
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# All Payer ECMAD GROWTH - Calendar Year to Date (thru August 2015) Compared to Same Period in Prior Year

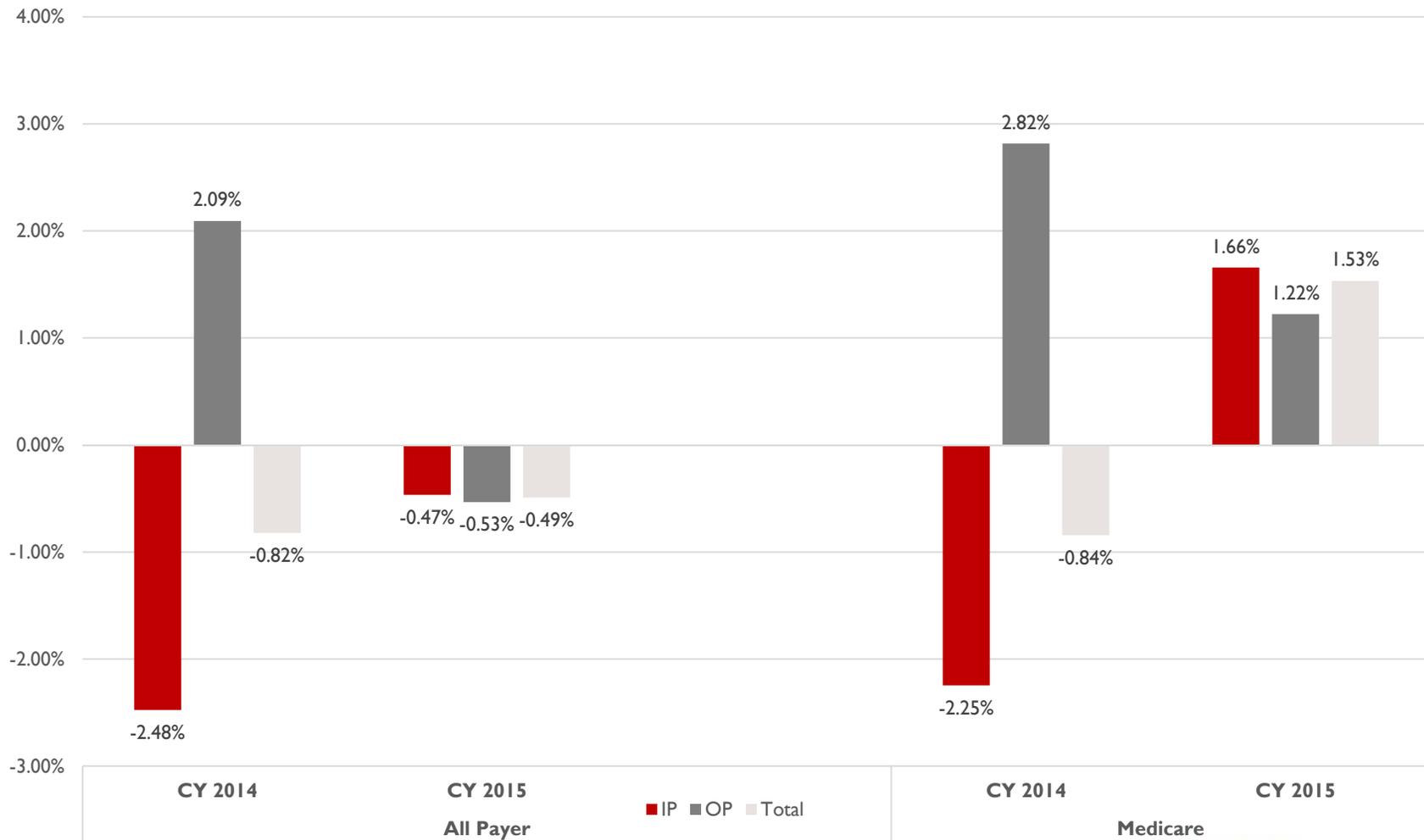


# Medicare ECMAD GROWTH - Calendar Year to Date (thru August 2015) Compared to Same Period in Prior Year

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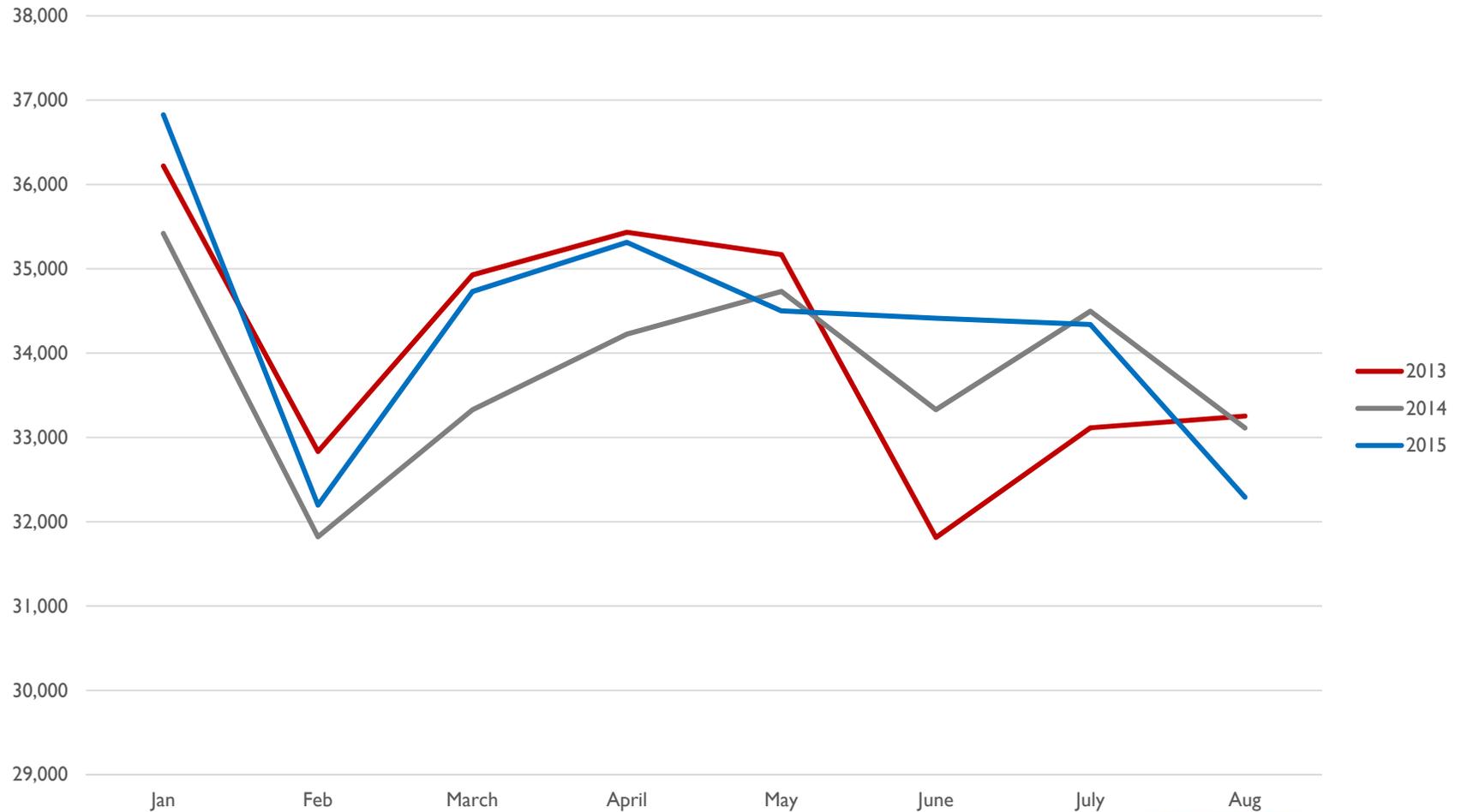


# MD Resident ECMAD GROWTH by Location of Service - Calendar Year to Date (thru August 2015) Compared to Same Period in Prior Year



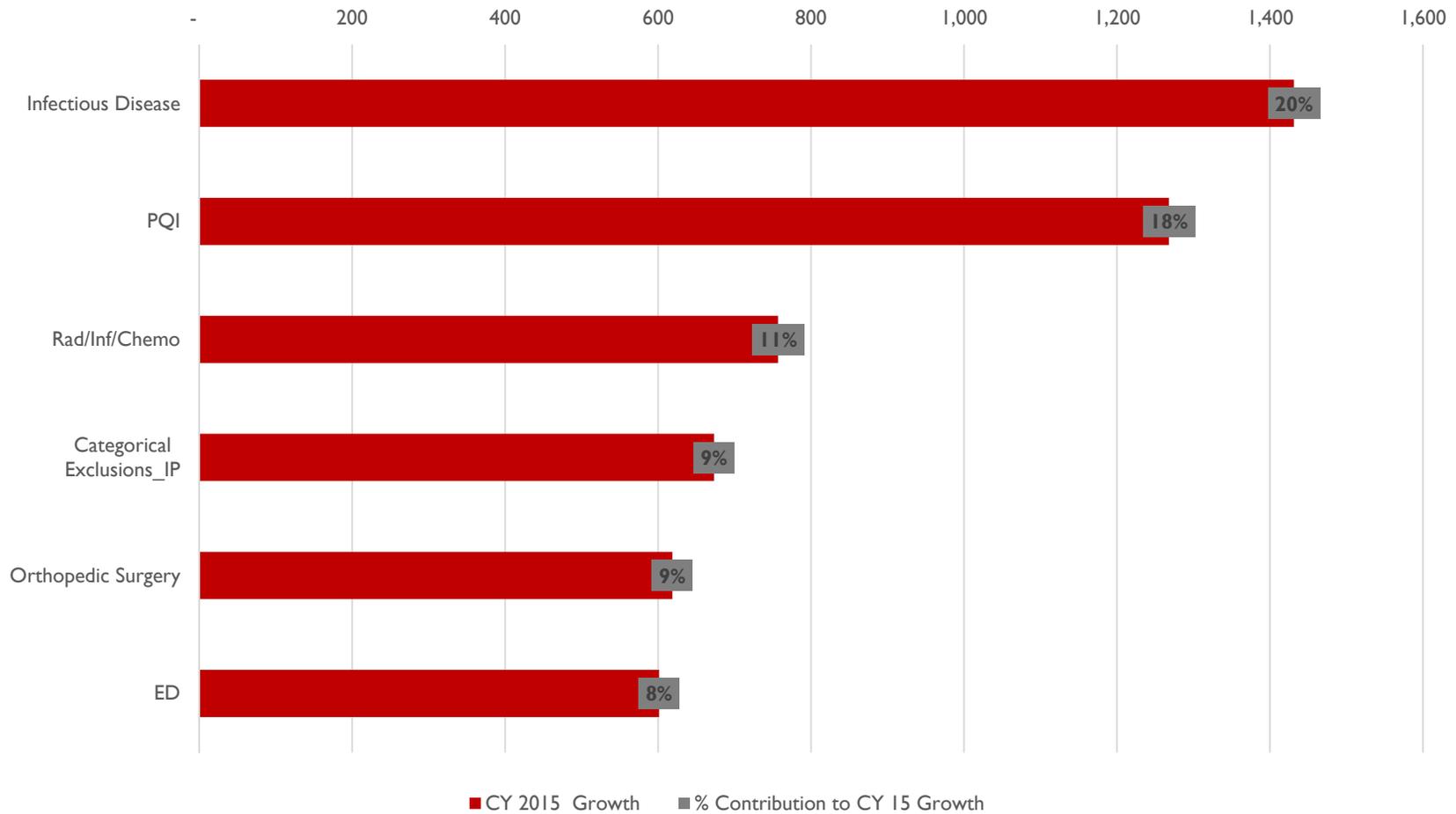
# Medicare MD Resident ECMAD GROWTH by Month

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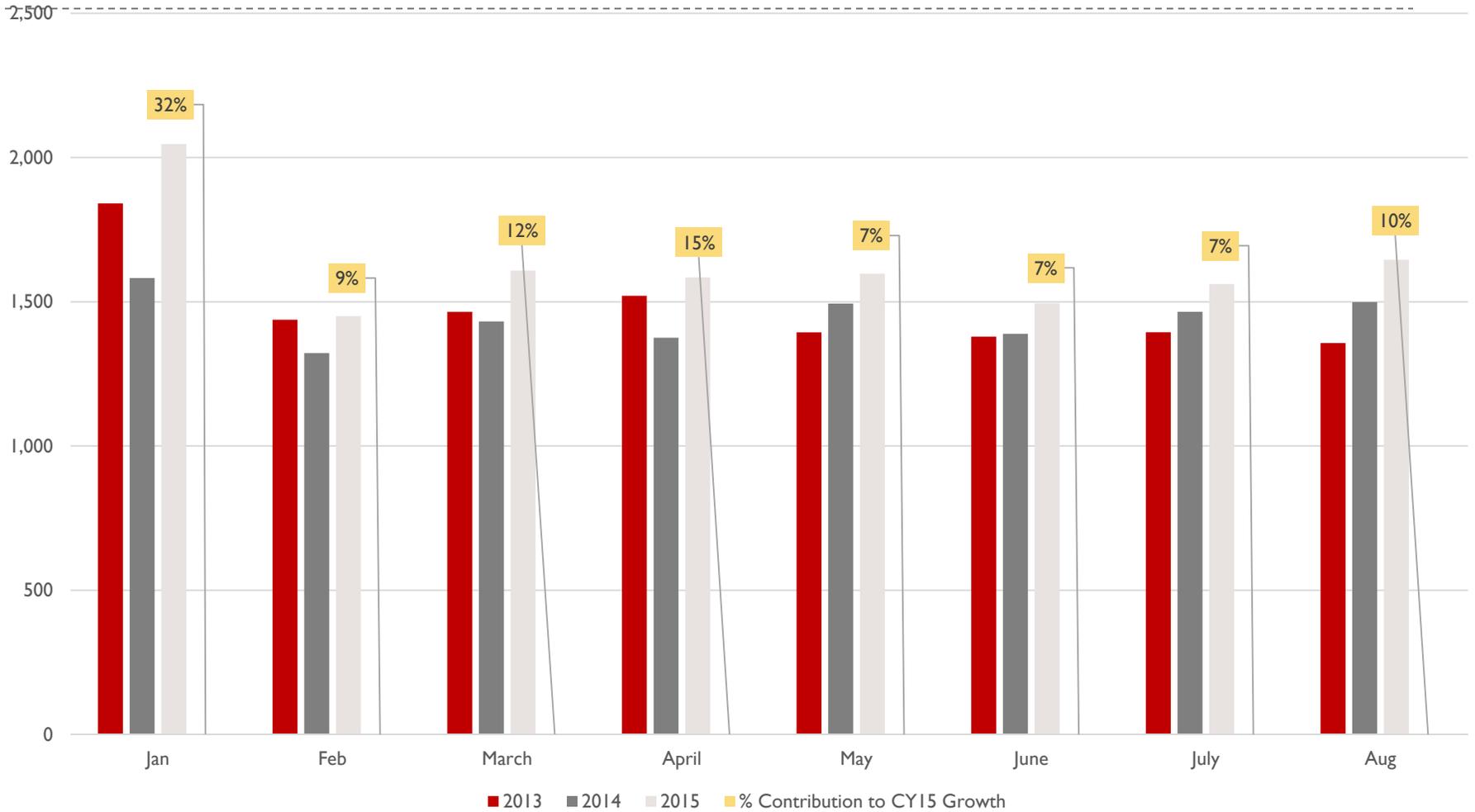


# Medicare MD Resident ECMAD Growth by Service Line

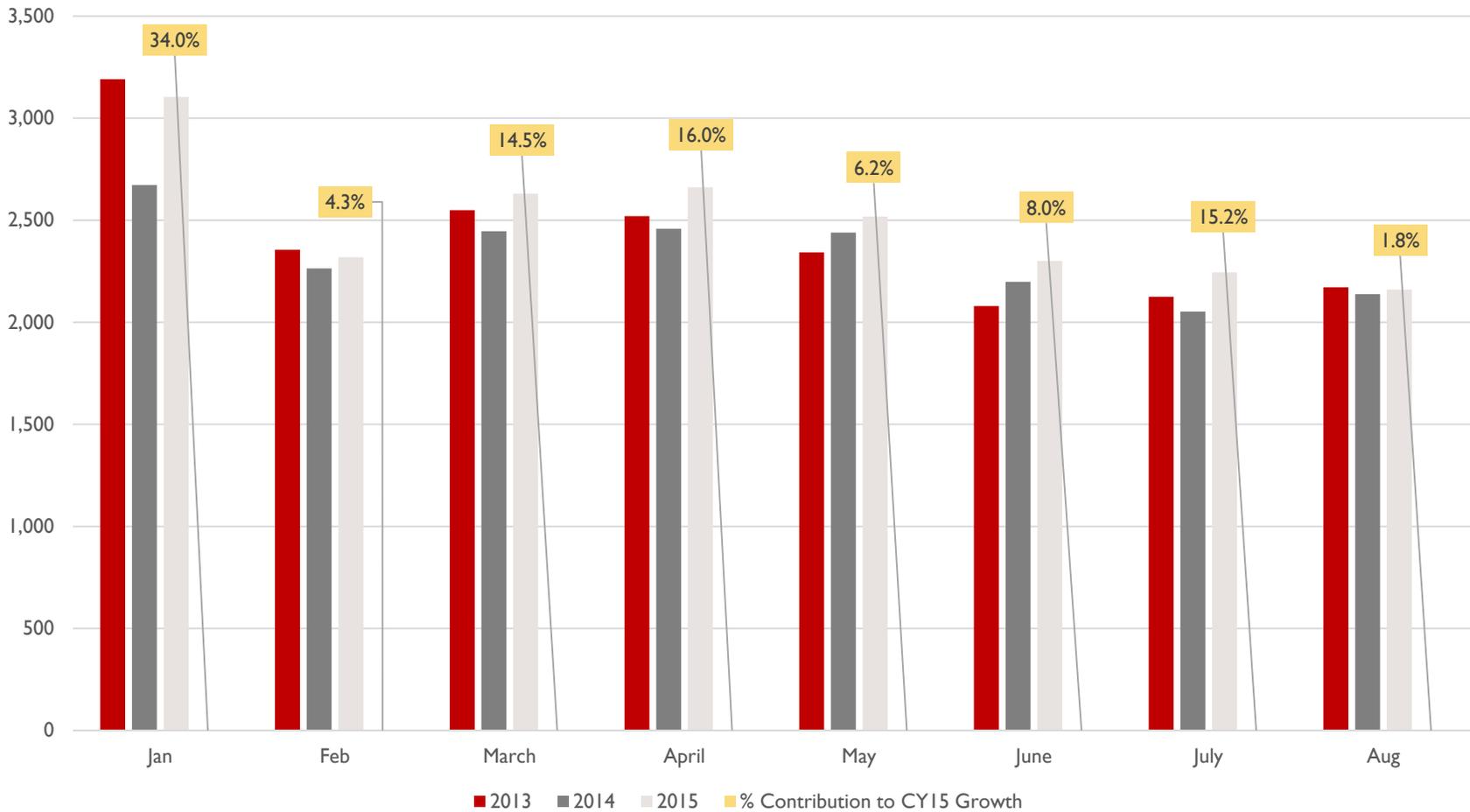
## Calendar Year to Date ECMAD Growth (thru August)



# Medicare MD Resident Infectious Disease Service Line ECMAD GROWTH by Month



# Medicare MD Resident PQI Service Line ECMAD GROWTH by Month



# Utilization Analytics – Data Notes

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- Utilization as measured by Equivalent Case-mix Adjusted Discharges (ECMAD)
  - 1 ECMAD Inpatient discharge=1 ECMAD Outpatient Visit
- Observation stays with more than 23 hour are included in the inpatient counts
  - $IP = IP + \text{Observation cases } >23 \text{ hrs.}$
  - $OP = OP - \text{Observation cases } >23 \text{ hrs.}$
- Preliminary data, not yet reconciled with financial data
- Careful review of outpatient service line trends is needed
- Tableau Visualization Tools

# Service Line Definitions

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- ▶ **Inpatient service lines:**
  - ▶ APR DRG to service line mapping
  - ▶ Readmissions and PQIs are top level service lines (include different service lines)
- ▶ **Outpatient service lines:**
  - ▶ Highest EAPG to service line mapping
  - ▶ Hierarchical classifications (ED, major surgery etc)
- ▶ **Market Shift technical documentation**

## New Model Monitoring Report

The Report will be distributed during the Commission Meeting

## Cases Closed

The closed cases from last month are listed in the agenda

<b>IN RE: THE PARTIAL RATE</b>	<b>*</b>	<b>BEFORE THE HEALTH SERVICES</b>
<b>APPLICATION OF THE</b>	<b>*</b>	<b>COST REVIEW COMMISSION</b>
<b>UNIVERSITY OF MARYLAND</b>	<b>*</b>	<b>DOCKET: 2015</b>
<b>ST. JOSEPH MEDICAL CENTER</b>	<b>*</b>	<b>FOLIO: 2114</b>
<b>BALTIMORE, MARYLAND</b>	<b>*</b>	<b>PROCEEDING: 2304N</b>

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**Staff Recommendation**

**November 18, 2015**

**Introduction**

On July 17, 2015 University of Maryland St. Joseph 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 Definitive Observation (DEF) and Coronary Care (CCU) services. The Hospital requests that the DEF and CCU rates be set at the lower of a rate based on its projected costs to provide DEF and CCU services or the statewide median and be effective November 1, 2015.

**Staff Evaluation**

To determine if the Hospital’s DEF and CCU rates 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 DEF and CCU for FY 2015. Based on information received from the Hospital, the DEF and CCU rates would be \$1,349.80 per patient day and \$2,965.00 per patient day respectively. The statewide median for DEF and CCU services are \$1,120.45 per patient day and \$2,038.36 per patient day respectively.

This rate request is revenue neutral and will not result in any additional revenue to the Hospital, since it involves carving out DEF and CCU services from the current approved revenue for Med. /Surg. Acute (MSG) and Med/Surg. Intensive Care (MIS) services respectively. The Hospital currently charges DEF as a rollup to its MSG rate and charges CCU as a rollup to its MIS rate. The Hospital wishes to carve these services out to provide a more equitable charging of its patients. The new proposed rates are as follows:

	Current Rate	New Rate	Budgeted Volume	Approved Revenue
Med./Surg. Acute	\$1,147.14	\$1,162.16	30,671	\$35,168,925
Definitive Observation	N/A	\$1,120.45	17,265	\$19,682,434
Med./Surg. Intensive Care	\$2,433.09	\$2,507.77	5,243	\$13,249,849
Coronary Care	N/A	\$2,038.36	992	\$1,882,296

## **Recommendation**

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

1. That a MSG rate of \$1,162.16 per patient day be approved effective November 1, 2015;
2. That a DEF rate of \$1,120.45 per patient day be approved effective November 1, 2015;
3. That a MIS rate of \$2,507.77 per patient day be approved effective November 1, 2015;
4. That a CCU rate of \$2,038.36 per patient day be approved effective November 1, 2015;
5. That the MSG, DEF, MIS and CCU rates not be rate realigned until a full year's cost experience data have been reported to the Commission; and
6. That no change be made to the Hospital's Global Budget Revenue.

<b>IN RE: THE ALTERNATIVE</b>	<b>*</b>	<b>BEFORE THE HEALTH</b>
<b>RATE APPLICATION OF</b>	<b>*</b>	<b>SERVICES COST REVIEW</b>
<b>SAINT AGNES HEALTH</b>	<b>*</b>	<b>COMMISSION</b>
<b>WESTERN MARYLAND</b>	<b>*</b>	<b>DOCKET: 2015</b>
<b>HEALTH SYSTEM</b>	<b>*</b>	<b>FOLIO: 2117</b>
<b>MERITUS HEALTH</b>	<b>*</b>	<b>PROCEEDING: 2307A</b>
<b>HOLY CROSS HEALTH</b>	<b>*</b>	

**Final Recommendation**

**November 18, 2015**

**This is a final recommendation and ready for Commission action.**

## **I. Introduction**

On August 21, 2015, Saint Agnes Health System, Western Maryland Health System, Holy Cross Health, and Meritus Health (“the Hospitals”) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06. The Hospitals seek renewal for the continued participation of Maryland Physicians Care (“MPC”) in the Medicaid Health Choice Program. MPC is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2270A for the period January 1, 2015 through December 31, 2015. The Hospitals are requesting to renew this contract for one year beginning January 1, 2016.

## **II. Background**

Under the Medicaid Health Choice Program, MPC, a Managed Care Organization (“MCO”) sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. MPC pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. MPC is a major participant in the Medicaid Health Choice program, and provides services to 18.2% of the total number of MCO enrollees in Maryland, which represents approximately the same market share as CY 2014.

The Hospitals supplied information on their most recent experience as well as their preliminary projected revenues and expenditures for the upcoming year based on the revised Medicaid capitation rates.

### **III. Staff Review**

This contract has been operating under previous HSCRC approval (Proceeding 2270A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2014, 2015, and 2016. In recent years, the financial performance of MPC has been favorable. The actual financial experience reported to staff for CY2014 was favorable; however, projections for CY 2015, like all of the provider-based MCOs, are unfavorable. MPC is projecting to resume favorable performance in CY 2016.

### **IV. Recommendation**

With the exception of CY 2013, MPC has generally maintained favorable performance in recent years. However, all of the provider-based MCOs are expecting losses in CY 2015. Based on past and projected performance, staff believes that the proposed renewal arrangement for MPC is acceptable under Commission.

#### **Therefore:**

- (1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2016.**
- (2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance for CY 2015 and the MCO's expected financial status into CY 2016. Staff recommends that Maryland Physicians Care report to Commission staff (on or before the September 2016 meeting of the Commission) on the actual CY 2015**

**experience, preliminary CY 2016 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2017.**

- (3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.**

<b>IN RE: THE ALTERNATIVE</b>	*	<b>BEFORE THE HEALTH</b>	
<b>RATE APPLICATION OF</b>	*	<b>SERVICES COST REVIEW</b>	
<b>THE JOHNS HOPKINS HEALTH</b>	*	<b>COMMISSION</b>	
<b>SYSTEM</b>	*	<b>DOCKET:</b>	<b>2015</b>
	*	<b>FOLIO:</b>	<b>2118</b>
<b>BALTIMORE, MARYLAND</b>	*	<b>PROCEEDING</b>	<b>2308A</b>

**Final Recommendation**

**November 18, 2015**

**This is a final recommendation and ready for Commission action.**

## **I. Introduction**

On September 14, 2015, Johns Hopkins Health System (“JHHS,” or the “System”) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, Suburban Hospital, and Howard County General Hospital (“the Hospitals”). The System seeks renewal for the continued participation of Priority Partners, Inc. in the Medicaid Health Choice Program. Priority Partners, Inc. is the entity that assumes the risk under the contract. The Commission most recently approved this contract under proceeding 2269A for the period from January 1, 2015 through December 31, 2015. The Hospitals are requesting to renew this contract for a one-year period beginning January 1, 2016.

## **II. Background**

Under the Medicaid Health Choice Program, Priority Partners, a provider-sponsored Managed Care Organization (“MCO”) sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. Priority Partners was created in 1996 as a joint venture between Johns Hopkins Health Care (JHHC) and the Maryland Community Health System (MCHS) to operate an MCO under the Health Choice Program. Johns Hopkins Health Care operates as the administrative arm of Priority Partners and receives a percentage of premiums to provide services such as claim adjudication and utilization management. MCHS oversees a network of Federally Qualified Health Clinics and provides member expertise in the provision of primary care services and assistance in the development of provider networks.

The application requests approval for the Hospitals to continue to provide inpatient and

outpatient hospital services, as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. Priority Partners pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. The Hospitals supplied information on their most recent experience as well as their preliminary projected revenues and expenditures for the upcoming year based on the initially revised Medicaid capitation rates.

Priority Partners is a major participant in the Medicaid Health Choice program, providing managed care services to 23.6% of the State's MCO population, up from 22.8% in CY 2014.

### **III. Staff Review**

This contract has been operating under the HSCRC's initial approval in proceeding 2269A. Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2014, 2015, and 2016. The statements provided by Priority Partners to staff represent both a "stand-alone" and "consolidated" view of Priority's operations. The consolidated picture reflects certain administrative revenues and expenses of Johns Hopkins Health Care. When other provider-based MCOs are evaluated for financial stability, their administrative costs relative to their MCO business are included as well; however, they are all included under the one entity of the MCO.

In recent years, the consolidated financial performance of Priority Partners has been favorable. The actual financial experience reported to staff for CY2014 was positive. However, projections for CY 2015, like all of the provider-based MCOs, are unfavorable. Priority Partners is projecting to resume favorable performance in CY 2016.

#### **IV. Recommendation**

Priority Partners has continued to achieve favorable consolidated financial performance in recent years. However, all of the provider-based MCOs are expecting losses in CY 2015. Based on past and projected performance, staff believes that the proposed renewal arrangement for Priority Partners is acceptable under Commission.

#### **Therefore:**

- 1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2016.**
- 2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance in CY 2015, and the MCOs expected financial status into CY 2016. Therefore, staff recommends that Priority Partners report to Commission staff (on or before the September 2016 meeting of the Commission) on the actual CY 2015 experience, and preliminary CY 2016 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2017.**
- 3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals,**

**and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.**

<b>IN RE: THE ALTERNATIVE</b>	<b>*</b>	<b>BEFORE THE HEALTH</b>	
<b>RATE APPLICATION OF</b>	<b>*</b>	<b>SERVICES COST REVIEW</b>	
<b>MEDSTAR HEALTH</b>	<b>*</b>	<b>COMMISSION</b>	
<b>SYSTEM</b>	<b>*</b>	<b>DOCKET:</b>	<b>2015</b>
	<b>*</b>	<b>FOLIO:</b>	<b>2120</b>
<b>COLUMBIA, MARYLAND</b>	<b>*</b>	<b>PROCEEDING:</b>	<b>2310A</b>

**Final Recommendation**

**November 18, 2015**

**This is a final recommendation and ready for Commission action.**

## **I. Introduction**

On September 21, 2015, MedStar Health filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital (“the Hospitals”). MedStar Health seeks renewal for the continued participation of MedStar Family Choice (“MFC”) in the Medicaid Health Choice Program. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2257A for the period from January 1, 2015 through December 31, 2015. The Hospitals are requesting to renew this contract for one year beginning January 1, 2016.

## **II. Background**

Under the Medicaid Health Choice Program, MedStar Family Choice, a Managed Care Organization (“MCO”) sponsored by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services, as well as certain non-hospital services, while MFC receives a State-determined capitation payment. MFC pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. MFC provides services to 6.2% of the total number of MCO enrollees in Maryland, which represents approximately the same market share as CY 2014.

The Hospitals supplied information on their most recent experience as well as their preliminary projected revenues and expenditures for the upcoming year based on the Medicaid capitation rates.

### **III. Staff Review**

This contract has been operating under previous HSCRC approval (proceeding 2257A). Staff reviewed the operating performance under the contract as well as the terms of the capitation pricing agreement. Staff reviewed available final financial information and projections for CYs 2014, 2015, and 2016. In recent years, the financial performance of MFC has been favorable. The actual financial experience reported to staff for CY 2014 was positive. However, projections for CY 2015, like all of the provider-based MCOs, are unfavorable. MFC is projecting to resume favorable performance in CY 2016.

### **IV. Recommendation**

MFC has continued to achieve favorable financial performance in recent years. However, all of the provider-based MCOs are expecting losses in CY 2015. Based on past performance, staff believes that the proposed renewal arrangement for MFC is acceptable under Commission policy.

#### **Therefore:**

- (1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2016.**
- (2) Since sustained losses may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance to determine whether favorable financial performance resumes in CY 2016. Staff recommends that MedStar Family Choice report to Commission staff (on or before the September 2016 meeting of the Commission) on the actual CY 2015 experience**

**and preliminary CY 2016 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2017.**

- (3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.**

<b>IN RE: THE ALTERNATIVE</b>	<b>*</b>	<b>BEFORE THE HEALTH</b>	
<b>RATE APPLICATION OF</b>	<b>*</b>	<b>SERVICES COST REVIEW</b>	
<b>MEDSTAR HEALTH</b>	<b>*</b>	<b>COMMISSION</b>	
<b>SYSTEM</b>	<b>*</b>	<b>DOCKET:</b>	<b>2015</b>
	<b>*</b>	<b>FOLIO:</b>	<b>2121</b>
<b>COLUMBIA, MARYLAND</b>	<b>*</b>	<b>PROCEEDING:</b>	<b>2311A</b>

**Final Recommendation**

**November 18, 2015**

## **I. Introduction**

On September 23, 2015, MedStar Health filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of Franklin Square Hospital, Good Samaritan Hospital, Harbor Hospital, and Union Memorial Hospital (the “Hospitals”). MedStar Health seeks approval for MedStar Family Choice (“MFC”) to continue to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. MedStar Family Choice is the MedStar entity that assumes the risk under this contract. The Hospitals are requesting an approval for one year beginning January 1, 2016.

## **II. Background**

MFC has been operating a CMS-approved Medicare Advantage Plan under the plan name of MedStar Medicare Choice for the last three years in the District of Columbia. Last year CMS granted MFC permission to expand under the same Medicare Advantage plan number to provide coverage to Maryland eligible residents in Anne Arundel, Baltimore, Charles, Howard, Prince George’s, St. Mary’s counties and Baltimore City for CY 2015. The application requests continued approval for MFC to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a CMS-determined capitation payment. MFC will continue to pay the Hospitals HSCRC-approved rates for hospital services used by its enrollees.

MFC supplied financial projections for its operations in Maryland for CY 2016.

## **III. Staff Review**

Staff reviewed the reviewed the financial projections for CY 2016, as well as MFC’s experience and projections for CY 2015. The information reflected the anticipated negative

financial results associated with start-up of a Medicare Advantage Plan.

#### **IV. Recommendation**

Based on the financial projections and the fact that MFC has achieved favorable financial performance in its Maryland Medicaid's Health Choice Program, staff believes that the continued approval of the arrangement between CMS and MFC is acceptable under Commission policy. Therefore, staff recommends that the Commission approve the Hospitals' request to continue to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2016. The Hospitals must file a renewal application annually for continued participation. In addition, MFC must meet with HSCRC staff prior to August 31, 2016 to review its financial projections for CY 2017.

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 ALTERNATIVE** \* **BEFORE THE HEALTH**  
**RATE APPLICATION OF** \* **SERVICES COST REVIEW**  
**UNIVERSITY OF MARYLAND MEDICAL** \* **COMMISSION**  
**SYSTEM CORPORATION**  
\* **DOCKET: 2015**  
\* **FOLIO: 2124**  
\* **PROCEEDING: 2314A**

**Final Recommendation**

**November 18, 2015**

**This is a final recommendation and ready for Commission action.**

## **I. Introduction**

On September 30, 2015, Riverside Health of Maryland, Inc. (“Riverside”), a Medicaid Managed Care Organization (“MCO”), on behalf of The University of Maryland Medical System Corporation (“the Hospitals”), filed an application for an Alternative Method of Rate Determination (“ARM”) pursuant to COMAR 10.37.10.06. Riverside and the Hospitals seek approval for the MCO to continue to participate in the Medicaid Health Choice Program. Riverside is the entity that assumes the risk under this contract. The Commission most recently approved this contract under proceeding 2281A for the period from January 1, 2015 through December 31, 2015. Under that arrangement, Riverside’s hospital partners were LifeBridge Health, and Adventist Healthcare, Inc. In August of 2015, Riverside was purchased by University of Maryland Medical System Corporation. The MCO and Hospitals are requesting to implement this new contract for one year beginning January 1, 2016.

## **II. Background**

Under the Medicaid Health Choice Program, Riverside, a MCO owned by the Hospitals, is responsible for providing a comprehensive range of health care benefits to Medical Assistance enrollees. The application requests approval for the Hospitals to provide inpatient and outpatient hospital services as well as certain non-hospital services, while the MCO receives a State-determined capitation payment. Riverside pays the Hospitals HSCRC-approved rates for hospital services used by its enrollees. Riverside is a relatively small MCO providing services to 2.4% of the total number of MCO enrollees in the HealthChoice Program, which represents approximately the same market share as CY 2014.

Riverside supplied information on its most recent financial experience as well as its

preliminary projected revenues and expenditures for the upcoming year based on the revised Medicaid capitation rates.

### **III. Staff Review**

This contract has been operating under previous HSCRC approval (proceeding 2281A). Staff reviewed the operating financial performance under the contract. Staff reviewed available final financial information and projections for CYs 2014, 2015, and 2016. In its second year of operation, Riverside reported positive financial performance for CY 2014. However, projections for CY 2015, like all of the provider-based MCOs, are unfavorable. Riverside is projecting to resume favorable performance in CY 2016.

### **IV. Recommendation**

Due to startup costs, Riverside's financial performance in its first year (CY 2013) was negative. Its financial performance in CY 2014 was favorable. However, all of the provider-based MCOs are expecting losses in CY 2015. Riverside is projecting a positive margin in CY 2016. Staff believes that the proposed renewal arrangement for Riverside is acceptable under Commission policy but will continue to monitor as the organization has recently changed its ownership arrangement.

Based on the information provided, staff believes that the proposed arrangement for Riverside is acceptable.

#### **Therefore:**

- (1) Staff recommends approval of this alternative rate application for a one-year period beginning January 1, 2016.**

- (2) Since sustained losses over an extended period of time may be construed as a loss contract necessitating termination of this arrangement, staff will continue to monitor financial performance for CY 2015 and the MCO's expected financial status into CY 2016. Staff recommends that Riverside report to Commission staff (on or before the September 2016 meeting of the Commission) on the actual CY 2015 experience, preliminary CY 2016 financial performance (adjusted for seasonality) of the MCO, as well as projections for CY 2017.**
- (3) Consistent with its policy paper outlining a structure for review and evaluation of applications for alternative methods of rate determination, the staff recommends that this approval be contingent upon the continued adherence to the standard Memorandum of Understanding with the Hospitals for the approved contract. This document formalizes the understanding between the Commission and the Hospitals, and includes provisions for such things as payments of HSCRC-approved rates, treatment of losses that may be attributed to the managed care contract, quarterly and annual reporting, the confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU also stipulates that operating losses under managed care contracts may not be used to justify future requests for rate increases.**

<b>IN RE: THE ALTERNATIVE</b>	<b>*</b>	<b>BEFORE THE HEALTH</b>	
<b>RATE APPLICATION OF</b>	<b>*</b>	<b>SERVICES COST REVIEW</b>	
<b>JOHNS HOPKINS HEALTH</b>	<b>*</b>	<b>COMMISSION</b>	
<b>SYSTEM</b>	<b>*</b>	<b>DOCKET:</b>	<b>2015</b>
	<b>*</b>	<b>FOLIO:</b>	<b>2125</b>
<b>BALTIMORE, MARYLAND</b>	<b>*</b>	<b>PROCEEDING:</b>	<b>2315A</b>

**Final Recommendation**

**November 18, 2015**

## **I. Introduction**

On November 2, 2015, the Johns Hopkins Health System (JHHS) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of its constituent hospitals (the “Hospitals”). JHHS seeks approval for Hopkins Health Advantage, Inc. (“HHA”) to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. HHA is the JHHS entity that assumes the risk under this contract. JHHS is requesting an approval for one year beginning January 1, 2016.

## **II. Background**

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

HHA supplied a copy of its contract with CMS and financial projections for its operations.

## **III. Staff Review**

Staff reviewed the CMS contract and the financial information and projections for CYs 2016 and beyond.

#### **IV. Recommendation**

Based on the financial projections, staff believes that the proposed arrangement for HHA is acceptable under Commission policy. Therefore, staff recommends that the Commission approve the Hospitals' request to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2016. The Hospitals must file a renewal application annually for continued participation. In addition, HHA must meet with HSCRC staff prior to August 31, 2016 to review its financial projections for CY 2017.

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  
ALTERNATIVE METHOD OF RATE  
DETERMINATION  
JOHNS HOPKINS HEALTH  
SYSTEM  
BALTIMORE, MARYLAND**

**\* BEFORE THE MARYLAND HEALTH  
\* SERVICES COST REVIEW  
\* COMMISSION  
\* DOCKET: 2015  
\* FOLIO: 2126  
\* PROCEEDING: 2316A**



**Staff Recommendation**

**November 18, 2015**

## **I. INTRODUCTION**

Johns Hopkins Health System (“System”) filed a renewal application with the HSCRC on October 30, 2015 on behalf of the Johns Hopkins Bayview Medical Center (the “Hospital”) requesting approval from the HSCRC for continued participation in a capitation arrangement among the System, the Maryland Department of Health and Mental Hygiene (DHMH), and the Centers for Medicare and Medicaid Services (CMS). The Hospital, doing business as Hopkins Elder Plus (“HEP”), serves as a provider in the federal “Program of All-inclusive Care for the Elderly” (“PACE”). Under this program, HEP provides services for a Medicare and Medicaid dually eligible population of frail elderly. The requested approval is for a period of one year effective December 1, 2015.

## **II. OVERVIEW OF APPLICATION**

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

## **III. STAFF EVALUATION**

Staff found that the experience under this arrangement for FY 2015 to be slightly unfavorable. The PACE Program Administrator explained that the relatively poor performance was attributable to several factors that have been addressed in this year’s budget. The Program should produce a small profit in FY 2016. However, because the membership in the Program is restricted, one or two outlier hospital admissions could eliminate the surplus. Therefore, in taking a conservative approach, the Program is projecting a breakeven year in FY 2016.

## **III. STAFF RECOMMENDATION**

Staff recommends that the Commission approve the Hospital’s renewal application for an alternative method of rate determination for one year beginning December 1, 2015. The Hospital

will need to file a renewal application for review to be considered for continued participation.

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

<b>IN RE: THE ALTERNATIVE</b>	<b>*</b>	<b>BEFORE THE HEALTH</b>	
<b>RATE APPLICATION OF</b>	<b>*</b>	<b>SERVICES COST REVIEW</b>	
<b>UNIVERSITY OF MARYLAND</b>	<b>*</b>	<b>COMMISSION</b>	
<b>MEDICAL SYSTEM</b>	<b>*</b>	<b>DOCKET:</b>	<b>2015</b>
	<b>*</b>	<b>FOLIO:</b>	<b>2128</b>
<b>BALTIMORE, MARYLAND</b>	<b>*</b>	<b>PROCEEDING:</b>	<b>2318A</b>

**Final Recommendation**

**November 18, 2015**

## **I. Introduction**

On November 9, 2015, the University of Maryland Medical System (UMMS) filed an application for an Alternative Method of Rate Determination pursuant to COMAR 10.37.10.06 on behalf of its constituent hospitals (the “Hospitals”). UMMS seeks approval for University of Maryland Health Advantage, Inc. (“UMHA”) to participate in a Centers for Medicare and Medicaid Services (CMS) approved Medicare Advantage Plan. UMHA is the UMMS entity that assumes the risk under this contract. UMHA is requesting an approval for one year beginning January 1, 2016.

## **II. Background**

On September 1, 2015, CMS granted UMHA approval to operate a Medicare Advantage Plan to provide coverage to Maryland eligible residents in Anne Arundel, Baltimore, Caroline, Cecil, Carroll, Dorchester, Harford, Howard, Kent, Montgomery, Queen Anne’s, Talbot counties and Baltimore City. The application requests approval for UMHA to provide inpatient and outpatient hospital services, as well as certain non-hospital services, in return for a CMS-determined capitation payment. UMHA will pay the Hospitals HSCRC-approved rates for hospital services used by its enrollees.

UMHA supplied a copy of its contract with CMS and financial projections for its operations.

## **III. Staff Review**

Staff reviewed the CMS contract and the financial information and projections for CYs 2016 and beyond.

#### **IV. Recommendation**

Based on the financial projections, staff believes that the proposed arrangement for UMHA is acceptable under Commission policy. Therefore, staff recommends that the Commission approve the Hospitals' request to participate in CMS' Medicare Part C Medicare Advantage Program for a period of one year beginning January 1, 2016. UMHA must meet with HSCRC staff prior to August 31, 2016 to review its financial projections for CY 2017.

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.

# **Preliminary Staff Report for Commission Consideration Regarding Health Job Opportunity Program Proposal November 18, 2015**

## **Overview Health Job Opportunity Program Proposal**

At the Commission's September 9, 2015 public meeting, a panel of several hospital representatives and the Maryland Hospital Association proposed that the HSCRC provide up to \$40 million through hospital rates to establish about 1,000 entry level health care jobs in areas of extreme poverty and unemployment. This staff report provides input on several options for Commission discussion, based on input from the Payment Models Workgroup, public comment, and staff policy analysis.

## **Background**

The Health Job Opportunity Program Proposal ("Proposal") came about as a result of the unrest in Baltimore City and the strong belief that employment is an important element needed to change the current situation. Hospitals are among the largest employers in Baltimore City as well as in other areas of the State that have pockets of extreme poverty and unemployment. The Proposal seeks to create community-based jobs that can contribute to improved community health as well as hospital jobs that create employment opportunities in economically challenged areas.

All parties have acknowledged the importance of jobs in reducing economic disparities. However, there are critical differences in thinking about how creating job opportunities should be addressed and who should provide the funding for job creation.

This report focuses on synthesizing input and providing staff policy analysis for consideration by the Commission in determining how to approach this important proposal.

## **Analysis**

### ***Summary of Input Received--***

#### **Payment Models Work Group**

The Payment Models Workgroup held a meeting to discuss this and other topics on October 5, 2015. Program description materials and a series of questions were sent out in advance of the meeting and posted to the website. Comments were also accepted from other individuals attending the meeting.

The work group members and other commenters expressed their appreciation for the leadership in bringing forward this proposal. All parties acknowledged the importance of jobs in reducing disparities.

Following is a general summary of work group comments, as presented in the Executive Director's report at the October 14, 2015 Commission meeting:

- Several commenters expressed the view that if the Commission were to take on a program of this nature, that it would be very important to define success. Success would need to be framed not only in creating jobs, but also in the context of the New All Payer Model and Triple Aim of improving care, improving health, and lowering costs.
  - A program that could not meet those requirements might be better implemented outside of the rate system.
  - Proposers of the Program indicated that evaluative criteria should be developed and that if the Program was not meeting those criteria, that it should be discontinued.
  - Because the jobs are entry level and for untrained workers, there was an indication that it might take some time to evaluate the impact on health and costs. Whether the jobs could be filled and the workers maintained could be determined much sooner.
- Several commenters felt that it would be important to focus on jobs outside of hospitals, such as Community Health Workers. The concern was expressed that the reduction of avoidable utilization in hospitals might reduce the need for some of the hospital jobs that were referred to in the Proposal.
  - One of the Academic Medical Centers felt that its utilization would not decrease with potentially avoidable utilization, but would backfill as out of state volumes increased or other referrals could be served.
  - One commenter expressed concern about the need for training of Community Health Workers, making sure they were prepared to be in the community working with frail and severely ill patients. (Note that there was a work group that recently produced a set of recommendations regarding Community Health Workers.) More design and structure would need to be in place.
- Several commenters felt that infrastructure adjustments already provided to hospitals, or the additional amount that is slated for award in January 2016, were already focused on similar activities and that this effort would be duplicative.
  - Proposers expressed that the infrastructure funds were already committed in their budgets for other purposes, and that a new source of funding is needed for rapid deployment of additional jobs.

- Commenters indicated that a Return on Investment should be expected, similar to the recent infrastructure increases approved by the Commission.
- It was also suggested that other funding sources be considered for Program implementation.
  - The proposers indicated that this might slow the process down, or detract from the level of possible implementation and impact.
- Several commenters indicated that if the Proposal were to move forward, much more detailed design work needs to take place.
  - One suggestion was to ask the hospitals to organize an effort with other stakeholders and experts to further develop potential design criteria.
  - Another commenter indicated that the Commission staff might take this on and organize a work group to develop the program.
  - One commenter expressed concerns about accountability to payers, including the need for a return on investment.

### **Letters of Support and Public Comment**

There were a number of letters of support received. Those include letters from public officials and other interested parties. These letters outline the need for jobs and support for the Proposal.

Letters were also received from DHMH-Medicaid and CareFirst. These letters express support for the need for jobs, but express concerns similar to those expressed in the payment work group regarding funding mechanisms and other considerations as outlined above.

All of these letters are attached to this report.

The Commission also heard from representatives of a community group, Baltimoreans United in Leadership Development (BUILD), at the October 14, 2015 Commission meeting. They stressed the importance of jobs in improving the situation in Baltimore. The representatives described existing programs that are making progress in employing individuals in economically deprived areas and the process they have used to ensure that the individuals employed through these programs are successful. The Staff and Commission were very appreciative of their presentation and advice regarding successful approaches that could be employed to make the Program work.

### **HSCRC Staff Commentary**

The Commission and its staff are very concerned about health disparities and have focused extensive policy development around ensuring that resources are available for enhanced hospital care in areas of disparities. This includes financial policies such as disproportionate share adjustments that provide additional revenues to hospitals in areas of the State where there is a higher estimated level of poverty. These adjustments are derived from claims data

and indirect medical education allowances that provide revenues to hospitals, many of which are located in areas of the State with economic disparities. These policies have been applied in developing hospital rates for many decades. The HSCRC staff has also been attentive in developing value based performance measures to consider the impact of the social determinants of health. In fact, the HSCRC staff has been working on an Area Deprivation Index to enhance measurement of socioeconomic disparities and evaluating incorporating the index into its policies.

More needs to be done, however. In spite of significant amounts of additional funding provided to hospitals and a significantly higher amount of overall health care dollars being spent in areas of high socioeconomic disparities, serious disparities in health outcomes exist in Baltimore City as well as in other parts of the State. These disparities have been measured and documented in the State Health Improvement Plan. Hospitals have also recognized these disparities in their Community Health Needs Assessments.

The new All Payer Model recognized that a new approach is needed to address population health and disparities in outcomes. The Commission has approved numerous policies aimed at redirecting resources to this important objective including:

- Working with hospitals to move payment to global budgets so that when care and health are improved and utilization reduced, hospitals will be able to reinvest retained savings in interventions that are focused on improving health and outcomes. Hospitals have been accorded a great deal of flexibility in spending these resources.
- The Commission approved the funding of eight regional partnership grants focused on planning of patient-centered care coordination initiatives involving hospitals and community providers and partners. Out of \$2.5 million of funding, 40% was provided to Baltimore City and Prince Georges County partnerships, counties where there are high levels of health disparities.
- By July 1, 2015, the Commission had placed more than \$200 million of funding in rates earmarked for providing infrastructure and support for interventions to improve health and outcomes and reduce avoidable utilization. Hospitals have completed reports on historic expenditures, and strategic plans are due in December.
- In December of 2015, HSCRC will review grant applications for up to \$40 million of care coordination initiatives that would be funded through hospital rates.

Others have devoted resources as well:

- The State of Maryland has also invested in programs focused on addressing health disparities in economically deprived areas such as the expansion of Medicaid and investments in Health Enterprise Zones.

- Hospitals, government agencies, and other grantors have also dedicated resources to individuals with disparities, including free clinics, transportation, some housing, as well as other interventions.
- Public health resources in Maryland are focused on similar needs.
- The significant Medicaid expansion which took place effective January 1, 2014, provided coverage for numerous individuals in areas of high deprivation, providing a source of health coverage that has improved the access to health care services, including preventive care.
- The federal government has provided grant awards, focused in part on workforce training. Several of the hospital awardees include hospitals located in Baltimore City.

With its new focus on chronic conditions and high needs patients, which are more prevalent in populations with health and economic disparities, HSCRC and hospitals will be directing funding toward reducing health disparities.

Relative to the Proposal, HSCRC staff has several concerns.

- Staff is concerned about including traditional jobs inside of hospitals in a grant program. These should be funded through hospital budgets. Furthermore, if the health care transformation is successful, hospital usage should decline and there is a concern that individuals in need of jobs might be employed in jobs that would be eliminated, thereby defeating the purpose of the Program.
- Staff supports expanding hospital resources deployed for positions that support the transitions anticipated in the All Payer Model-- care coordination, population health, health, information exchange, health information technology, alignment, and consumer engagement. However, staff is concerned about the funding sources and the potential for overlap with the additional resources that are being provided through rates as noted above. Furthermore, there are hospital community benefit dollars that could potentially be deployed in this effort. Grants are another potential source of funding.
- In order to implement programs such as those described above, significant amounts of training and coaching would be required. The programs require significant design and dedication of resources. HSCRC staff believes that considerable development needs to take place to plan, develop, and execute these programs successfully, similar to the planning and development that have gone into nursing education programs in the past.
- The HSCRC staff acknowledges the importance of jobs creation in areas of high economic deprivation, but staff is concerned about HSCRC's role in addressing this issue.

## HSCRC Staff Options

Based on the commentary received to date, HSCRC staff offers several options, in no particular order of preference, for discussion with the Commission and for further public input.

Option 1—Earmark 25% (approximately \$10 million) of the .25% pool for competitive transformation implementation grant funds for hospitals committing to hire workers from geographic areas of high socioeconomic deprivation to fill new care coordination, population health, health information exchange, alignment, consumer engagement, and related positions. Hospitals should provide matching funds to increase the resources that could be deployed. Under this option, staff would anticipate proposals for the \$10 million from hospitals in March 2016, with implementation beginning by July 2016.

Option 2—Set aside \$5 million of the .25% competitive transformation implementation grant funds to provide one time seed money for Program implementation once design is complete with expectation of implementation by July 2016. Expect hospitals to fund positions from infrastructure in rates, community benefits funds, return on investment, hospital resources, and other grant, philanthropy, and foundation support. Under this option, staff would expect that program design would commence as soon as possible. The program design group would decide the best ways to deploy the \$5 million in seed money including program development, training, coaching, funding of trainers, educators, coaches, etc. Hospitals would apply for the funds in March 2016, with anticipated implementation beginning by July 2016.

Option 3—Defer funding and have Proposers continue to develop Program design, implementation, and evaluation parameters by March 2016, together with AHECs and other job training resources, with a potential for future funding of some educational resources or seed funding in July 2016. Funding could potentially include program development, training, coaching, funding of trainers and coaches, etc. Expect hospitals to fund positions from infrastructure in rates, community benefits funds, hospital resources such as return on investment, and other grant, philanthropy, and foundation support. HSCRC staff would expect that the resources provided would not be greater than the \$5 million noted in Option 2 above.

Any of these options would require considerable development and structuring for success and accountability, and a fully developed evaluation process. If these or other options are pursued, resources will be needed to develop and administer the Program.

In summary, HSCRC staff understands the need for expansion of employment and for improvement in health outcomes and reductions in disparities for populations living in economically deprived areas of the State. The Commission has developed policies and

programs and provided funding that supports reducing health disparities under the All Payer Model. Staff has provided several options for discussion by the Commission regarding additional progress that might be made in developing employment opportunities, while addressing changes in hospital employment that are needed to successfully reach the goals of the new All Payer Model and the State Health Improvement Plan.



# Performance Measurement Workgroup Update

HSCRC Commission Meeting 11/18/2015

# Reviewed Guiding Principles For Performance-Based Payment Programs

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- ▶ Program must improve care for all patients, regardless of payer
- ▶ Program incentives should support achievement of all payer model targets
- ▶ Program should prioritize high volume, high cost, opportunity for improvement and areas of national focus
- ▶ Predetermined performance targets and financial impact
- ▶ Hospital ability to track progress
- ▶ Encourage cooperation and sharing of best practices
- ▶ Consider all settings of care

## RX2018 Readmission Reduction Incentive Program Update Considerations

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- ▶ Measure updates (e.g., planned admissions definitions, transfer logic)
- ▶ Medicare versus all payer rates
- ▶ Consideration of non-Maryland peer group rates
- ▶ Improvement target
- ▶ Payment adjustment structure and amounts
- ▶ Adjustments/protections based on socio-economic and other factors
- ▶ Draft recommendation in January 2016 and Final in February 2016

## RY2018 MHAC Update Considerations

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- ▶ Analysis of statistical validity and reliability and small hospital, small cell size issues
- ▶ Evaluation of PPC tier groups
- ▶ Setting the statewide target
- ▶ Maximum at risk determination
- ▶ Monitoring of ICD-10 Impact
- ▶ Draft recommendation in December 2015 and final in January 2016

# Potentially Avoidable Utilization Measure

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- ▶ **Expanding the definition to other areas (9 Months)**
  - ▶ Nursing home admissions
  - ▶ High risk patient utilization
  - ▶ Sepsis admissions
  - ▶ Avoidable Emergency Department Visits
- ▶ **Risk adjusted measure of PAUs (18 months)**

# Efficiency Measure Considerations

- ▶ Measurement of Total Cost of Care (need all payer claims)
- ▶ Risk Adjustment
  - ▶ Demographics (Age, Sex, Social/economic factors)
  - ▶ Risk Adjustment Methodology
- ▶ Denominator
  - ▶ Virtual Patient Service Area
- ▶ Out of State Utilization Adjustment
- ▶ Benchmarks
- ▶ Timelines
  - ▶ Per Case measure revisions (next 3 months)
  - ▶ Per Capita Hospital Cost (next 9 months)
  - ▶ Per Capita Total Cost (next 18 months)

# Key Strategic Considerations

## ▶ Prioritization

- ▶ Leverage IT tools and measures
- ▶ Use existing data and measures if possible

## ▶ Care coordination

- ▶ Measures must be developed/adopted
- ▶ Consider measures that are important to patients (functional status, quality of life)

## ▶ Condition-specific bundles

- ▶ Target high cost, common procedures
- ▶ Cut across measurement domains and settings of care
- ▶ Consider “value”

## Disclosure Report

This report will be available early next week.

# **Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

## **Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION**

### **Chapter 10 Rate Application and Approval Procedures**

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

#### **NOTICE OF EMERGENCY ACTION**

The Health Services Cost Review Commission has granted emergency status to amend Regulation **.03 and .03-1** under **COMAR 10.37.10 Rate Application and Approval Procedures**.

**Emergency Status: December 10, 2015**

**Emergency Status Expires: May 1, 2016**

#### **Comparison to Federal Standards**

There is no corresponding federal standard to this proposed action.

#### **Estimate of Economic Impact**

There is economic impact. See Estimate of Economic Impact attached

### **.03 Regular Rate Applications.**

A. A hospital may not file a regular rate application with the Commission until [November 1, 2008, or until an earlier date as designated by the Commission] rate efficiency measures are adopted by the Commission which are consistent with the all-payer model contract approved by the Centers for Medicare & Medicaid Services (CMS). During this interim period of time, a hospital may seek a rate adjustment under any other administrative remedy available to it under existing Commission, law, regulation, or policy. [As of November 1, 2008 or as of the earlier date if so designated by the Commission,] Once the rate efficiency measures are adopted by the Commission, a hospital may file a regular rate application with the Commission at any time if:

(1) (text unchanged)

(2) (text unchanged)

B. – D. (text unchanged)

### **.03-1 Partial Rate Applications.**

A. (text unchanged)

B. A hospital may file a partial rate application with the Commission at any time, consistent with the provisions of Regulation .03A of this chapter. [The moratorium provisions associated with Regulation .03A apply only to partial rate applications associated with a capital project.] A partial rate application is not a contested case under the provisions of the Administrative Procedure Act.

C. – D. (text unchanged)

JOHN M. COLMERS  
Chairman  
Health Services Cost Review Commission

# **Title 10 DEPARTMENT OF HEALTH AND MENTAL HYGIENE**

## **Subtitle 37 HEALTH SERVICES COST REVIEW COMMISSION**

### **Chapter 10 Rate Application and Approval Procedures**

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

#### **NOTICE OF PROPOSED ACTION**

The Health Services Cost Review Commission proposes to amend Regulations .03 and .03-1 under **COMAR 10.37.10 Rate Application and Approval Procedures**. This action was considered and approved for promulgation by the Commission at a previously announced open meeting held on November 18, 2015, notice of which was given pursuant to General Provisions Article, § 3-302(c), Annotated Code of Maryland. If adopted, the proposed amendments will become effective on or about March 8, 2016.

#### **Statement of Purpose**

The purpose of this action is to establish a moratorium on the filing of regular rate applications pending the development and approval of rate efficiency measures that are consistent with the all-payer model.

#### **Comparison of Federal Standards**

There is no corresponding federal standard to this proposed action.

#### **Estimate of Economic Impact**

The proposed action has no economic impact.

#### **Opportunity for Public Comment**

Comments may be sent to Diana M. Kemp, Regulations Coordinator, Health Services Cost Review Commission, 4160 Patterson Avenue, Baltimore, Maryland 21215, or (410) 764-2576, or fax to (410) 358-6217, or email to [diana.kemp@maryland.gov](mailto:diana.kemp@maryland.gov). The Health Services Cost Review Commission will consider comments on the proposed amendments until January 11, 2016. A hearing may be held at the discretion of the Commission.

### **.03 Regular Rate Applications.**

A. A hospital may not file a regular rate application with the Commission until [November 1, 2008, or until an earlier date as designated by the Commission] *rate efficiency measures are adopted by the Commission which are consistent with the all-payer model contract approved by the Centers for Medicare & Medicaid Services (CMS)*. During this interim period of time, a hospital may seek a rate adjustment under any other administrative remedy available to it under existing Commission, law, regulation, or policy. [As of November 1, 2008 or as of the earlier date if so designated by the Commission,] *Once the rate efficiency measures are adopted by the Commission*, a hospital may file a regular rate application with the Commission at any time if:

(1) (text unchanged)

(2) (text unchanged)

B. – D. (text unchanged)

### **.03-1 Partial Rate Applications.**

A. (text unchanged)

B. A hospital may file a partial rate application with the Commission at any time, consistent with the provisions of Regulation .03A of this chapter. [The moratorium provisions associated with Regulation .03A apply only to partial rate applications associated with a capital project.] A partial rate application is not a contested case under the provisions of the Administrative Procedure Act.

C. – D. (text unchanged)

JOHN M. COLMERS

Chairman

Health Services Cost Review Commission

State of Maryland  
Department of Health and Mental Hygiene



John M. Colmers  
Chairman  
Herbert S. Wong, Ph.D.  
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Bernadette C. Loftus,  
M.D.  
Thomas R. Mullen

Donna Kinzer  
Executive Director  
Stephen Ports  
Principal Deputy Director  
Policy and Operations  
David Romans  
Director  
Payment Reform  
and Innovation  
Gerard J. Schmith  
Deputy Director  
Hospital Rate Setting  
Sule Calikoglu, Ph.D.  
Deputy Director  
Research and Methodology

**Health Services Cost Review Commission**

4160 Patterson Avenue, Baltimore, Maryland 21215  
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Toll Free: 1-888-287-3229  
hsrc.maryland.gov

**TO: Commissioners**  
**FROM: HSCRC Staff**  
**DATE: November 18, 2015**  
**RE: Hearing and Meeting Schedule**

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December 9, 2015	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room
January 13, 2015	To be determined - 4160 Patterson Avenue HSCRC/MHCC Conference Room

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

The Agenda for the Executive and Public Sessions will be available for your review on the Thursday before the Commission meeting on the Commission's website at <http://www.hsrc.maryland.gov/commission-meetings-2015.cfm>

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