NOTICE OF WRITTEN COMMENT PERIOD

Notice is hereby given that the public and interested parties are invited to submit written comments to the Commission on the staff draft recommendation that will be presented at the September 11, 2019 Public Meeting:

1) Draft Recommendation on the MPA Framework - Comments should be sent to hscrc.tcoc@maryland.gov

WRITTEN COMMMENTS ON THE AFOREMENTIONED STAFF DRAFT RECOMMENDATIONS ARE DUE IN THE COMMISSION'S OFFICES ON OR BEFORE SEPTEMBER 18, 2019, UNLESS OTHERWISE SPECIFIED IN THE RECOMMENDATION.

*****The October Commission meeting date has been RESCHEDULED to Wednesday, October 16.*****

State of Maryland
Department of Health

Nelson J. Sabatini
Chairman

Joseph Antos, PhD
Vice-Chairman

Victoria W. Bayless

Stacia Cohen

John M. Colmers

James N. Elliott, M.D.

Adam Kane

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Katie Wunderlich
Executive Director

Allan Pack, Director
Population Based
Methodologies

Chris Peterson, Director
Payment Reform &
Provider Alignment

Gerard J. Schmith, Director
Revenue & Regulation
Compliance

William Henderson, Director
Medical Economics &
Data Analytics

564th MEETING OF THE HEALTH SERVICES COST REVIEW COMMISSION
September 11, 2019

EXECUTIVE SESSION
11:30 a.m.
(The Commission will begin in public session at 11:30 a.m. for the purpose of, upon motion and approval, adjourning into closed session. The open session will resume at 1:00 p.m.)

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

2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

PUBLIC SESSION
1:00 p.m.

1. **Review of the Minutes from the Public and Closed Meetings held on July 9, 2019**

2. **Docket Status – Cases Closed**
   2484A – University of Maryland Medical Center

3. **Docket Status – Cases Open**
   2485A - Johns Hopkins Health System
   2486A - Johns Hopkins Health System
   2487A - Johns Hopkins Health System
   2488A - Johns Hopkins Health System
   2489A – MedStar Health
   2490R – Suburban Hospital
   2491A – MedStar Health
   2492A - MedStar Health
   2493A – Johns Hopkins Health System
   2494A – Johns Hopkins Health System
   2495A - Johns Hopkins Health System
   2496A - Johns Hopkins Health System

4. **New Model Monitoring**

5. **Draft Recommendation on MPA Framework Policy**

6. **Policy Update and Discussion**

   a. **Feedback on Integrated Efficiency Policy**
   b. **Update on Statewide Integrated Health Improvement Strategy**
   c. **PACCAP and EQIP Update**
   d. **ET3 Update**

7. **Presentation on CEO Focus Group Discussions**

8. **MDPCP Update**

9. **Hearing and Meeting Schedule**

Closed Session Minutes
Of the
Health Services Cost Review Commission

July 10, 2019

Upon motion made in public session, Chairman Sabatini called for adjournment into closed session to discuss the following items:

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

2. Update on Administration of Model - Authority General Provisions Article, §3-103 and §3-104

The Closed Session was called to order at 11:36 a.m. and held under authority of §3-103 and §3-104 of the General Provisions Article.

In attendance in addition to Chairman Sabatini were Commissioners Antos, Bayless, Cohen, Colmers, Elliott, and Kane.

In attendance representing Staff were Katie Wunderlich, Allan Pack, Chris Peterson, Jerry Schmith, Geoff Dougherty, Will Daniel, William Henderson, Amanda Vaughan, Joe Delenick, Tequila Terry, Bob Gallion, and Dennis Phelps.

Also attending were Eric Lindemann, Commission Consultant, and Stan Lustman, Commission Counsel.

Item One

Eric Lindemann, Commission Consultant, updated the Commission on Maryland Medicare Fee-For-Service TCOC versus the nation.

Item Two

Will Daniel, Deputy Director-Payment Reform and Provider Alignment, summarized and the Commission discussed, staff's workplan to develop a policy for major capital projects.

Item Three

Tequila Terry, Deputy Director-Payment Reform and Provider Alignment, updated the Commission, and the Commission discussed, the Regional Transformation Grant Program.

Item Four

Geoff Dougherty, Deputy Director- Analytics & Modeling, led a discussion on the impact of neighborhood environment on hospital readmissions based on a published paper by former HSCRC Commissioner Stephen F. Jencks, former HSCRC staffer Sule Gerovich, current HSCRC staffers Alyson Schuster and Dr. Dougherty, and Amy Kind.

The Closed Session was adjourned at 1:10 p.m.

MINUTES OF THE
563rd MEETING OF THE
HEALTH SERVICES COST REVIEW COMMISSION
July 10, 2019

Chairman Nelson Sabatini called the public meeting to order at 11:36 a.m. Commissioners Joseph Antos, Victoria Bayless, Stacia Cohen, John Colmers, James Elliott, M.D., and Adam Kane were also in attendance. Upon motion made by Commissioner Antos and seconded by Commissioner Elliott, the meeting was moved to Closed Session. Chairman Sabatini reconvened the public meeting at 1:17 p.m.

STACIA COHEN

Chairman Sabatini introduced new Commissioner Stacia Cohen R.N. MBA. Commissioner Cohen has over 20 years of industry experience, and is currently the Executive Vice President of Medical Affairs for CareFirst Inc.

REPORT OF JULY 10, 2019 CLOSED SESSION

Mr. Dennis Phelps, Associate Director, Audit & Compliance, summarized the minutes of the July 10, 2019 Closed Session.

ITEM I
REVIEW OF THE MINUTES FROM JUNE 12, 2019 CLOSED SESSION AND PUBLIC MEETING

The Commissioners voted unanimously to approve the minutes of the June 12, 2019 Public Meeting and the minutes of the Closed Session.

ITEM II
DOCKET STATUS CLOSED CASES

2481A- Johns Hopkins Health System
2482A- Johns Hopkins Health System
2283A- Johns Hopkins Health System

ITEM III
DOCKET STATUS – CASES OPEN

2484A- University of Maryland Medical Center

The University of Maryland Medical Center ("Hospital") filed an application with the HSCRC on June 4, 2019 for an alternative method of rate determination under COMAR 10.37.10.06. The

Hospital requests approval to continue to participate in a global rate arrangement with the Kaiser Foundation Hospitals and the Permanente Federation, LLC ("Kaiser") for Heart Transplant and Mechanical Circulatory Support services for a period of one year beginning July 5, 2019.

The staff recommends that the Commission approve the Hospital's application to continue an alternative method of rate determination for Heart Transplant and Mechanical Circulatory Support services, for a one year period commencing July 5, 2019.

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.

Commissioners voted unanimously to approve Staff's recommendation.

ITEM IV
NEW MODEL MODELING

Ms. Caitlyn Cooksey, Assistant Chief, Hospital Rate Regulation presented CY2018 Medicare Fee-For-Service (FFS) data through March 2019 (with claims paid through May 2019). During this period, Maryland Medicare per capita Total Cost of Care (TCOC) spending was favorable for January and February but unfavorable for March when compared to the nation. More specifically, Maryland Medicare per capita hospital spending has been favorable when compared to the nation; however, per capita non-hospital spending has been mostly unfavorable.

Ms. Amanda Vaughan, Associate Director Clinical and Financial Information, reported that Monitoring Maryland Performance (MMP) for the new All-Payer Model for the month of May 2019 focuses on the fiscal year (July 1 through June 30) as well as calendar year results.

Ms. Vaughan reported that for the eleven months of the fiscal year ending May 31, 2019, All-Payer total gross hospital revenue increased by 1.97% over the same period in FY 2018. All-Payer total gross hospital revenue for Maryland residents increased by 1.98%. All-Payer gross hospital revenue for non-Maryland residents increased by 1.89%.

Ms. Vaughan reported that for the five months of the calendar year ending May 31, 2019, All-Payer total gross hospital revenue increased by 1.94% over the same period in CY 2018. All-Payer total gross hospital revenue for Maryland residents increased by 1.91%. All-Payer gross hospital revenue for non-Maryland residents increased by 2.32%.

Ms. Vaughan reported that for the eleven months of fiscal year ending May 31, 2019, Medicare FFS gross hospital revenue increased by 0.32% over the same period in FY 2018. Medicare FFS gross hospital revenue for Maryland residents increased by 0.44%. Maryland FFS gross hospital revenue for non-residents declined by 1.16%.

Ms. Vaughan reported that for the five months of the calendar year ending May 31, 2019, Medicare FFS gross hospital revenue increased by .01% over the same period in CY 2018. Medicare FFS gross hospital revenue for Maryland residents increased by .18%. Maryland FFS gross hospital revenue for non-residents declined by 2.02%.

Ms. Vaughan reported that for the eleven months of the fiscal year ending May 31, 2019, over the same period in FY 2018, All Payer in State per capita hospital revenue growth was 1.68%. Ms. Vaughan noted that the Medicare Fee-For-Service in State per capita hospital revenue for the same period declined by 1.37%.

Ms. Vaughan reported that for the five months of the calendar year ending March 31, 2019, over the same period in FY 2018, the All Payer in State per capita hospital revenue growth was 1.60%. The Medicare Fee for Service per capita hospital revenue growth declined by 2.11% over the same period in CY 2018.

According to Ms. Vaughan, for the eleven months fiscal year ending May 31, 2019, unaudited average operating profit for acute hospitals was 2.50%. The median hospital profit was 2.40%, with a distribution of negative 0.43% in the 25th percentile and positive 5.13% in the 75th percentile. Rate Regulated profits were 6.10%.

ITEM V
DRAFT RECOMMENDATION ON INTEGRATED EFFICIENCY POLICY

Mr. Allan Pack, Principal Deputy Director, population-Based Methodologies presented Staff's draft recommendation on Integrated Efficiency Policy (see " Draft Recommendation on Integrated Efficiency Policy: Withholding Inflation for Relative Efficiency Outliers and Potential Global Budget Revenue Enhancements" on the HSCRC website).

During the course of the All-Payer Model, the HSCRC annually made efficiency adjustments to hospital revenues based on their levels of Potentially Avoidable Utilization. In February of 2018, the HSCRC staff presented a strategic plan that had been formulated by the Commission after receiving public input. Several components of the plan addressed concerns regarding growing inefficiencies due to excessive retained revenue and a need not only for additional efficiency policies, but ones that reflect the goals of the Total Cost of Care (TCOC) Model. There were two key strategies to address these concerns. The first was to remove revenue from hospitals' global budgets when services were shifted to deregulated settings, in accordance with hospitals' agreements with the HSCRC. This ensures that a hospital's GBR does not include revenues for services that are provided outside of the hospital in unregulated space. The second was to enter into negotiated revenue reduction agreements with hospitals that were deemed outliers, as determined by cost-per-case under the Inter-hospital Cost Comparison (ICC) and by Medicare Total Cost of Care metrics.

Additionally, the Commission identified several critical building blocks that were needed to improve the ICC and the way in which per capita efficiency measures were incorporated into the Commission's efficiency methodologies. In response, staff has revised the underlying methodologies of the ICC, including completing an update to the outpatient case-mix methodology to break out accounts that are billed on a monthly basis into encounters, thereby allowing evaluation of the ICC on most hospital cases and revenues. More recently, staff has also amended the ICC to account for Quality performance and changes in Volume that have occurred as a result of a hospital responding to the incentives of the Model to reduce avoidable utilization.

In response to directives to incorporate per capita efficiency measures into overall efficiency analyses in line with the TCOC Model, staff has developed an integrated efficiency methodology that uses and equally weights the Quality and Volume Adjusted ICC and Medicare Total Cost of Care growth calculations, together referred to as the Efficiency Matrix. Incorporating the traditional cost per case analysis with total cost of care growth analysis ensures that the HSCRC still adheres to its statutory mandate of approving charges that are reasonably related to costs, while at the same time incorporating new population based measures of reasonable cost in line with the per capita tests of both the All-Payer Model initiated in 2014 and the successor Total Cost of Care Model initiated in 2019.

Staff will focus on outliers and recommend that high cost outliers have their Medicare share of the RY 2020 update factors withheld, effective January 1, 2020, based on a 50/50 weighting of Quality and Volume adjusted cost per case and geographic Medicare total cost of care growth calculations. Hospitals in the bottom quintile of performance and in excess of one standard deviation of average Quality and Volume Adjusted ICC performance or 1.21 times the ICC standard will be deemed outliers.

Efficient hospitals will be eligible for a GBR enhancement outside of a full rate application. These hospitals will be limited to those that are among the highest quintile on the Efficiency Matrix and must be better than one standard deviation from average Quality and Volume Adjusted ICC performance. Hospitals will be required to request the GBR enhancement from the HSCRC as it will not be automatically provided in rates. Funding amounts for the GBR enhancement will be limited to the set-aside (0.1%) in the Update Factor and the withhold from the high-cost outlier hospitals.

Staff recommends the following:

1. Formally adopt policies to
    - Determine relative efficiency outliers
    - Evaluate Global Budget Revenue enhancement requests;

2. Use the Inter-Hospital Cost Comparison, including its supporting methodologies, to compare relative cost per case for the above evaluations;

3. Use Total Cost of Care measures with a geographic attribution to evaluate per capita cost performance for the above evaluations;
4. Withhold the Medicare portion of the Annual Update Factor for efficiency outlier hospitals based on criteria described herein, effective January 1, 2020; and
5. Use set aside outlined in the Annual Update Factor (.1% in RY 2020) and funding secured from withhold from outlier hospitals to fund potential Global Budget Enhancement Requests.

Commissioner Colmers commented on the inconsistency in the policy and incentives of the Enhanced TCOC Model. As hospitals work to reduce volumes, prices go up under the GBR, and they appear less efficient. Commissioner Colmers also commented that the ICC cannot be a reasonable measure of efficiency if all hospitals have a negative result.

Mr. Pack reiterated that the methodology is a relative measure to a cost standard, and that the cost standard does not include profit, as the HSCRC is mandated to ensure revenue is reasonable related to costs, not costs plus profit.

Mr. Pack emphasized several times throughout the discussion that the final results of the Efficiency Matrix are relative. The fact that all of the hospitals have a negative final score is not necessarily a detriment to the policy, as hospitals are penalized or rewarded based on their relative position to each other and their standard deviations away from the mean.

Commissioner Bayless added that the policy should build in a reasonable profit adjustment, and suggested anecdotally 2.75% as a target operating margin.

Commissioner Bayless also contended that the ICC should account for physician expenses, as they are required to operate a hospital.

Mr. Pack stated Staff is considering incorporating credits for physician practice investments in future iterations of the methodology.

Commissioner Kane recommended that the policy look at more than just outliers, and that it address the issue of excess capacity through an ICC adjustment. He also asked if Staff is evaluating overhead costs through this methodology.

Mr. Pack indicated Staff would be looking to evaluate overhead specifically, but under current reporting instructions, the variability in overhead reported is too great for it to be sufficiently evaluated.

Commissioner Kane also suggested that he expected the final statewide penalty to be larger than the recommended $3.6M. Commissioner Colmers agreed that the impact is much smaller than he had anticipated.

Commissioner Colmers suggested that any decisions made on this recommendation be delayed until October to give more time for analysis and feedback. This suggestion was endorsed by Chairman Sabatini and other Commissioners.

ITEM VI
POLICY UPDATE AND DISCUSSION

Ms. Katie Wunderlich, Executive Director, provided an overview of some of the new and existing workgroups that will be meeting in the upcoming months. The Payment Model workgroup on capital funding will begin developing a policy for incorporating capital funding under the TCOC Model. Another subgroup under the Payment Model workgroup will look at potential changes to the demographic adjustment and to continue to monitor the appropriateness of the demographic adjustments year to year. The Performance Measurement workgroup will be reconvening the Readmission workgroup to explore potentially modifying measurements for scaling the Readmission Reduction Incentive Program.

Ms. Wunderlich also announced that the Commission has received and reviewed a new article outlining the Area Deprivation Index and hospital safety net index and their effects on Maryland populations. The article emphasizes the importance of looking at social determinants of health in reducing utilization.

ITEM VII
HEARING AND MEETING SCHEDULE

August 14, 2019	Cancelled
September 11, 2019	Times to be determined, 4160 Patterson Avenue HSCRC Conference Room

There being no further business, the meeting was adjourned at 2:40 p.m.

Cases Closed

The closed cases from last month are listed in the agenda

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

AS OF SEPTEMBER 3, 2019

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
2485A	Johns Hopkins Health System	6/27/2019	N/A	N/A	ARM	DNP	OPEN
2486A	Johns Hopkins Health System	6/27/2019	N/A	N/A	ARM	DNP	OPEN
2487A	Johns Hopkins Health System	6/28/2019	N/A	N/A	ARM	DNP	OPEN
2488A	Johns Hopkins Health System	6/28/2019	N/A	N/A	ARM	DNP	OPEN
2489A	MedStar Health	8/12/2019	N/A	N/A	ARM	DNP	OPEN
2490R	Suburban Hospital	8/13/2019	1/10/2020	1/10/2020	FULL RATE	GS	OPEN
2491A	MedStar Health	8/22/22019	N/A	N/A	ARM	DNP	OPEN
2492A	MedStar Health	8/22/2019	N/A	N/A	ARM	DNP	OPEN
2493A	Johns Hopkins Health System	8/26/2019	N/A	N/A	ARM	DNP	OPEN
2494A	Johns Hopkins Health System	8/30/2019	N/A	N/A	ARM	DNP	OPEN
2495A	Johns Hopkins Health System	8/30/2019	N/A	N/A	ARM	DNP	OPEN
2496A	Johns Hopkins Health System	8/30/2019	N/A	N/A	ARM	DNP	OPEN

PROCEEDINGS REQUIRING COMMISSION ACTION - NOT ON OPEN DOCKET

NONE

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
JOHNS HOPKINS HEALTH	*****	**DOCKET:**	**2019**
SYSTEM	*****	**FOLIO:**	**2295**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2485A**

Staff Recommendation

September 11, 2019

I. INTRODUCTION

Johns Hopkins Health System ("System') filed an application with the HSCRC on June 27, 2019 on behalf of its member hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global arrangement to provide solid organ and bone marrow transplants services with Cigna Health Corporation. The System requests approval of the arrangement for a period of one year beginning August 1, 2019.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for participation in an alternative method of rate determination for bone marrow and solid organ transplant services, for a one year period commencing August 1, 2019, and that this approval be contingent upon the execution of the standard Memorandum of Understanding ("MOU"). The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*****	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*****	**SERVICES COST REVIEW**	
DETERMINATION	*****	**COMMISSION**	
JOHNS HOPKINS HEALTH	*****	**DOCKET:**	**2019**
SYSTEM	*****	**FOLIO:**	**2296**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2486A**

Staff Recommendation

September 11, 2019

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on June 28, 2019 on behalf of its member Hospitals (the "Hospitals") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in a global rate arrangement for cardiovascular and joint replacement services with Health Design Plus, Inc. and to add oncology evaluation services. The Hospitals request approval for a period of one year beginning August 1, 2019.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the updated global rates was developed by calculating mean historical charges for patients receiving similar joint replacement at the Hospitals. The remainder of the global rate is comprised of physician service costs. Additional per diem payments were calculated for cases that exceed a specific length of stay outlier threshold.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff found that the actual experience under this arrangement for the last year has

been favorable. Based on the information provided, staff believes that the Hospitals can achieve favorable experience providing the new service.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application for an alternative method of rate determination for cardiovascular, joint replacement, and oncology evaluation services for a one year period commencing August 1, 2019. 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:**	**2019**
SYSTEM	*	**FOLIO:**	**2297**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2487A**

Staff Recommendation

September 11, 2019

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on June 28, 2019 on behalf of Johns Hopkins Hospital and Johns Hopkins Bayview Medical Center (the "Hospitals") and on behalf of Johns Hopkins HealthCare, LLC (JHHC) for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to add prostate cancer surgery to its prior approved global rate arrangement for transplant, joint replacement, and pancreatic cancer services with AP Benefit Advisors, LLC, formerly Crawford Advisors, LLC, effective August 1, 2019.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payer, collecting payments, disbursing payments to the Hospitals at their full HSCRC approved rates, and reimbursing the physicians. The System contends that the arrangement among JHHC, the Hospitals, and the physicians continues to hold 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 actual experience under this arrangement for the last year has been favorable. Based on the information provided, staff believes that the Hospitals can achieve favorable experience providing the new service.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' application to add prostate cancer surgery to its prior approved alternative method of rate determination for transplant, joint replacement and pancreatic cancer services effective August 1, 2019. 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:**	**2019**
SYSTEM	*****	**FOLIO:**	**2298**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2488A**

Staff Recommendation

September 11, 2019

I. INTRODUCTION

Johns Hopkins Health System (the "System") filed an application with the HSCRC on June 28, 2019 on behalf of its member hospitals (the Hospitals), requesting approval to add simultaneous pancreas and kidney transplant services to the prior approved global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplant services. The Hospitals request that the Commission approve the new service effective August 1, 2019.

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II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

The hospital portion of the 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 calculated for cases that exceed a specific length of stay outlier threshold were similarly adjusted.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff found that the actual experience under this arrangement for the last year has

been favorable. Based on the information provided, staff believes that the Hospitals can achieve favorable experience providing the new service.

VI. STAFF RECOMMENDATION

Staff recommends that the Commission approve the Hospitals' application to add simultaneous pancreas and kidney transplant services to the prior approved global price arrangement with Aetna Health, Inc. for solid organ and bone marrow transplant services effective August 1, 2019. The Hospitals must file a renewal application annually 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**
MEDSTAR HEALTH	*	**DOCKET: 2019**
	*	**FOLIO: 2299**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2489A**

Staff Recommendation

September 11, 2019

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on August 12, 2019 on behalf of Union Memorial Hospital and Good Samaritan Hospital (the "Hospitals") to participate in an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for joint replacement services with MAMSI for a one year period beginning September 1, 2019.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospitals' request for continued participation in the alternative method of rate determination for orthopedic services, for a one year period, commencing September 11, 2019. The Hospitals will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**
DETERMINATION	*	**COMMISSION**
MEDSTAR HEALTH	*	**DOCKET: 2019**
	*	**FOLIO: 2301**
BALTIMORE, MARYLAND	*	**PROCEEDING: 2491A**

Staff Recommendation

September 11, 2019

I. INTRODUCTION

MedStar Health filed an application with the HSCRC on August 22, 2019 on behalf of Union Memorial Hospital (the "Hospital") for an alternative method of rate determination, pursuant to COMAR 10.37.10.06. Medstar Health requests approval from the HSCRC for continued participation in a global rate arrangement for cardiovascular services with the Kaiser Foundation Health Plan of the Mid-Atlantic, Inc. for one year beginning September 1, 2019.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

The staff reviewed the results of last year's experience under this arrangement and found that it was slightly unfavorable. However, staff believes that the Hospital can still achieve a favorable experience under this arrangement.

VI. STAFF RECOMMENDATION

The staff recommends that the Commission approve the Hospital's request for continued participation in the alternative method of rate determination for cardiovascular services for a one year period commencing October 1, 2019. The Hospital will need to file a renewal application for review to be considered for continued participation.

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

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2019**
SYSTEM	*	**FOLIO:**	**2304**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2494A**

Staff Recommendation

September 11, 2019

I. INTRODUCTION

On August 30, 2019, 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 to continue to participate in a revised global price arrangement with Life Trac (a subsidiary of Allianz Insurance Company of North America) for solid organ and bone marrow transplants and cardiovascular services. The Hospitals request that the Commission approve the arrangement for one year beginning October 1, 2019.

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 to bear all risk relating to regulated services associated with the contract.

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT RISK

The Hospitals will continue to submit bills to JHHC for all contracted and covered

services. JHHC is responsible for billing the payers, 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 that it has been active in similar types of fixed fee contracts for several years, and that JHHC is adequately capitalized to bear the risk of potential losses.

V. STAFF EVALUATION

The staff found that the experience under the arrangement has been favorable for the last year. Staff believes that the Hospitals can continue to achieve a favorable performance under the 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 and cardiovascular services for the period beginning October 1, 2019. The Hospitals must file a renewal application annually 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:**	**2019**
SYSTEM	*****	**FOLIO:**	**2305**
BALTIMORE, MARYLAND	*****	**PROCEEDING:**	**2495A**

Staff Recommendation

September 11, 2019

I. INTRODUCTION

Johns Hopkins Health System ("System") filed an application with the HSCRC on August 30, 201 on behalf of Johns Hopkins Hospital and its affiliated hospitals ("the Hospitals") for renewal of a revised alternative method of rate determination arrangement, pursuant to COMAR 10.37.10.06. The System requests approval from the HSCRC to continue to participate in the global rate arrangement for hospital, physician services and certain non-medical services for patients who are not residents or citizens of the United States for a period of one year beginning October 1, 2019.

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II. OVERVIEW OF APPLICATION

The contract will be continue to be held and administered by Johns Hopkins International ("JHI), which is a subsidiary of the System. JHI 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 utilizing historical charges for patients at the Hospitals. The remainder of the global rate is comprised of physician service costs and the cost of certain non-medical services, i.e., coordination of care, interpreters, hotel and travel arrangements, etc.

IV. IDENTIFICATION AND ASSESSMENT OF RISK

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

V. STAFF EVALUATION

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 the provision of hospital, physician and certain non-medical services to patients who are not residents or citizens of the United States for a one year period commencing October 1, 2019. 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, and confidentiality of data submitted, penalties for noncompliance, project termination and/or alteration, on-going monitoring, and other issues specific to the proposed contract. The MOU will also stipulate that operating losses under the contract cannot be used to justify future requests for rate increases.

IN RE: THE APPLICATION FOR	*	**BEFORE THE MARYLAND HEALTH**	
ALTERNATIVE METHOD OF RATE	*	**SERVICES COST REVIEW**	
DETERMINATION	*	**COMMISSION**	
JOHNS HOPKINS HEALTH	*	**DOCKET:**	**2019**
SYSTEM	*	**FOLIO:**	**2306**
BALTIMORE, MARYLAND	*	**PROCEEDING:**	**2496A**

Staff Recommendation

September 11, 2019

I. INTRODUCTION

On August 30, 2019, Johns Hopkins Health System ("System") filed an application on behalf of its member hospitals, Johns Hopkins Hospital, Johns Hopkins Bayview Medical Center, and Howard County General Hospital (the "Hospitals") requesting approval to participate in a global price arrangement with One Team Health, an international TPA, for cardiovascular services. The Hospitals request that the Commission approve the arrangement for one year beginning October 1, 2019.

II. OVERVIEW OF APPLICATION

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

III. FEE DEVELOPMENT

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

IV. IDENTIFICATION AND ASSESSMENT RISK

The Hospitals will submit bills to JHHC for all contracted and covered services. JHHC is responsible for billing the payers, 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 that 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 believes that the Hospitals can achieve a 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 the period beginning October 1, 2019. The Hospitals must file a renewal application annually 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.

Monitoring Maryland Performance
Medicare Fee-for-Service (FFS)

Data through May 2019– Claims paid through July 2019

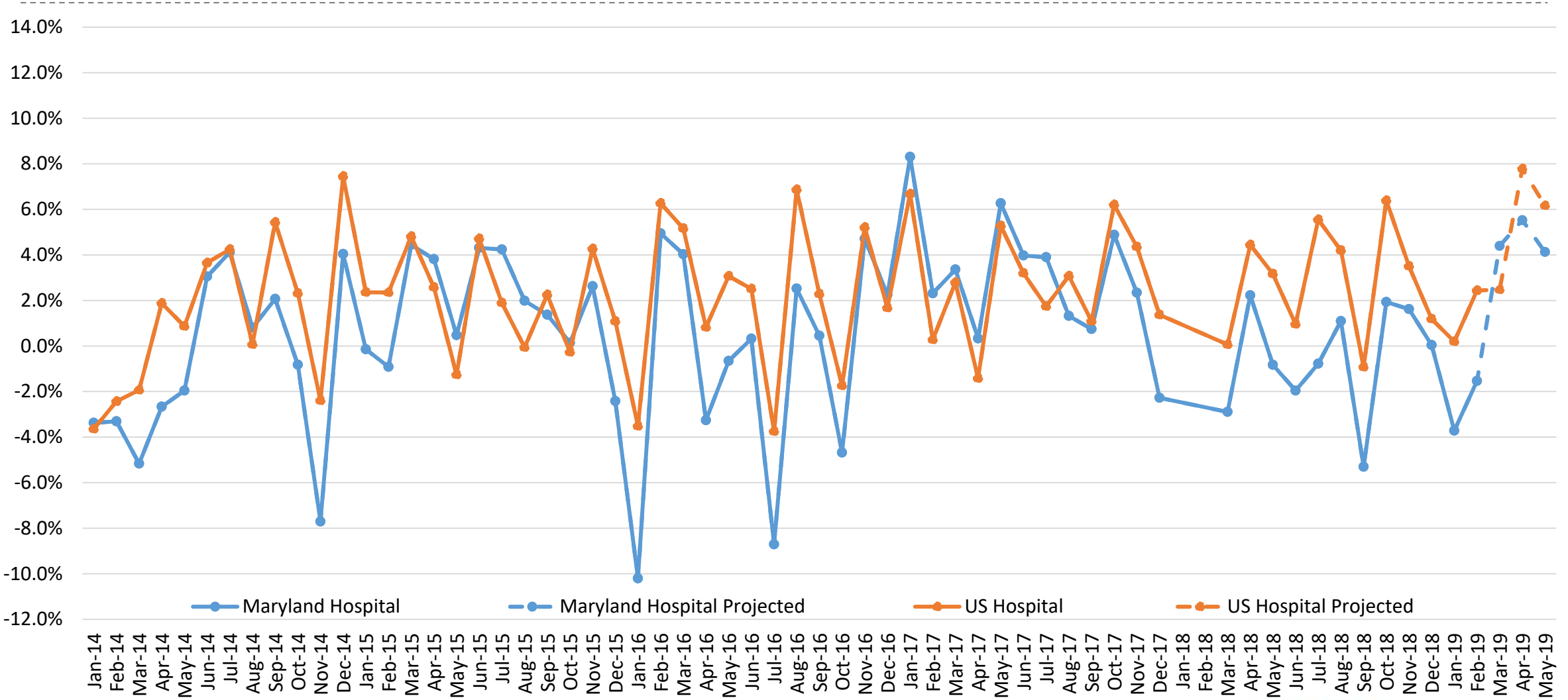
Source: CMMI Monthly Data Set

Disclaimer:

Data contained in this presentation represent analyses prepared by HSCRC staff based on data summaries provided by the Federal Government. The intent is to provide early indications of the spending trends in Maryland for Medicare FFS patients, relative to national trends. HSCRC staff has added some projections to the summaries. This data has not yet been audited or verified. Claims lag times may change, making the comparisons inaccurate. ICD-10 implementation and EMR conversion could have an impact on claims lags. These analyses should be used with caution and do not represent official guidance on performance or spending trends. These analyses may not be quoted until public release.

Medicare Hospital Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



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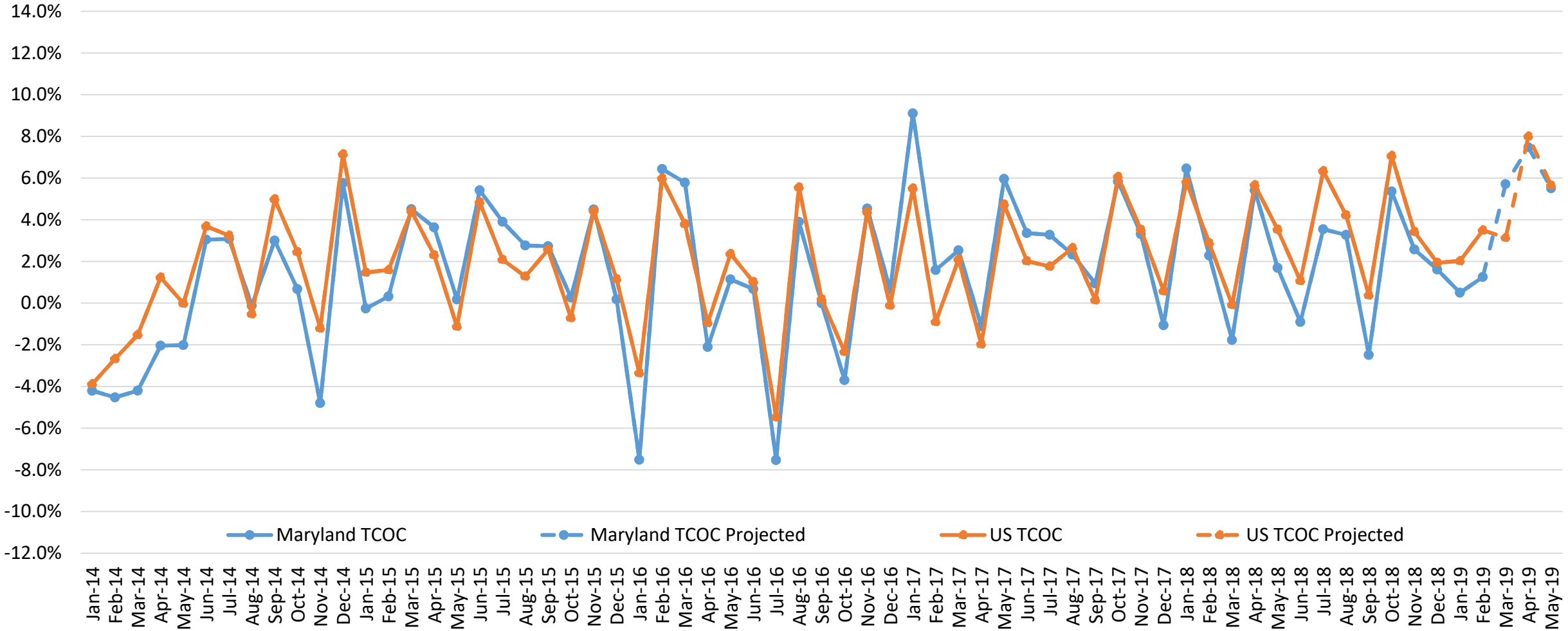
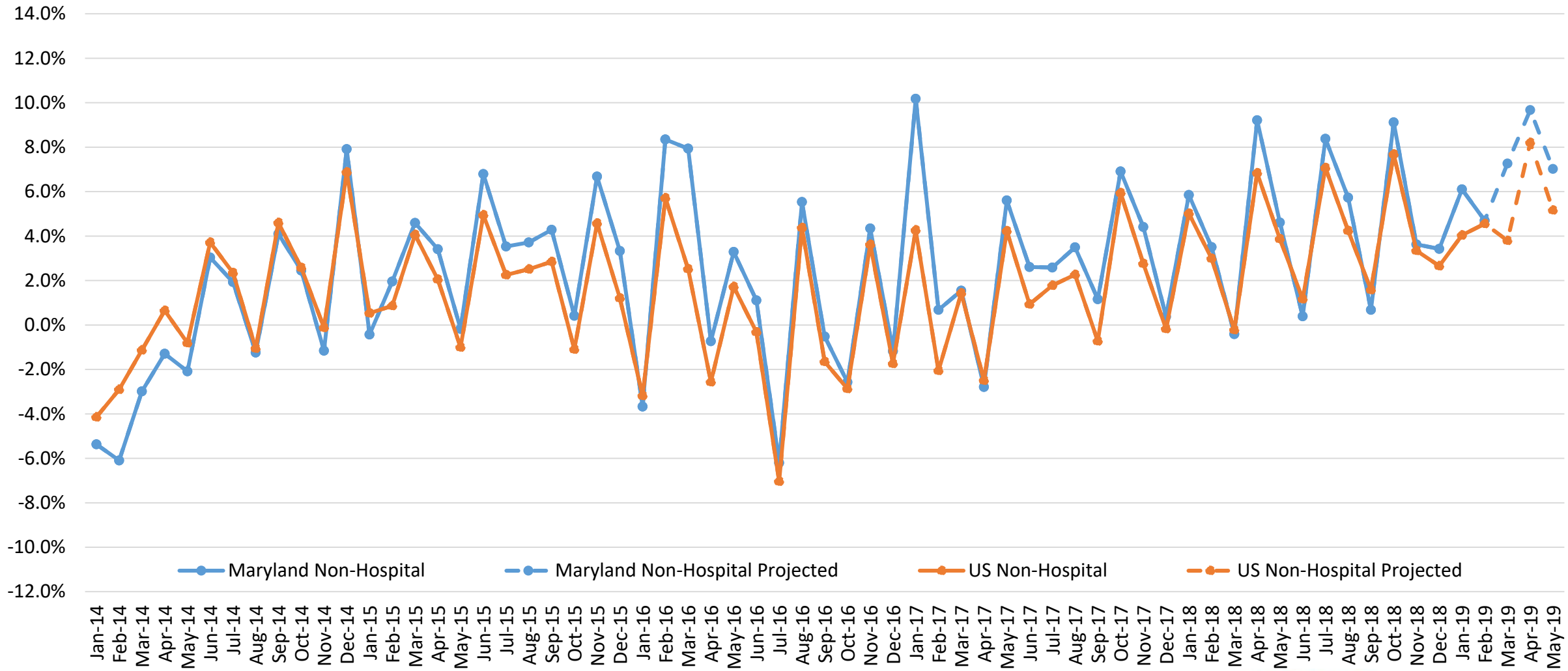
Medicare Total Cost of Care Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



Medicare Non-Hospital Spending per Capita

Actual Growth Trend (CY month vs. prior CY month)



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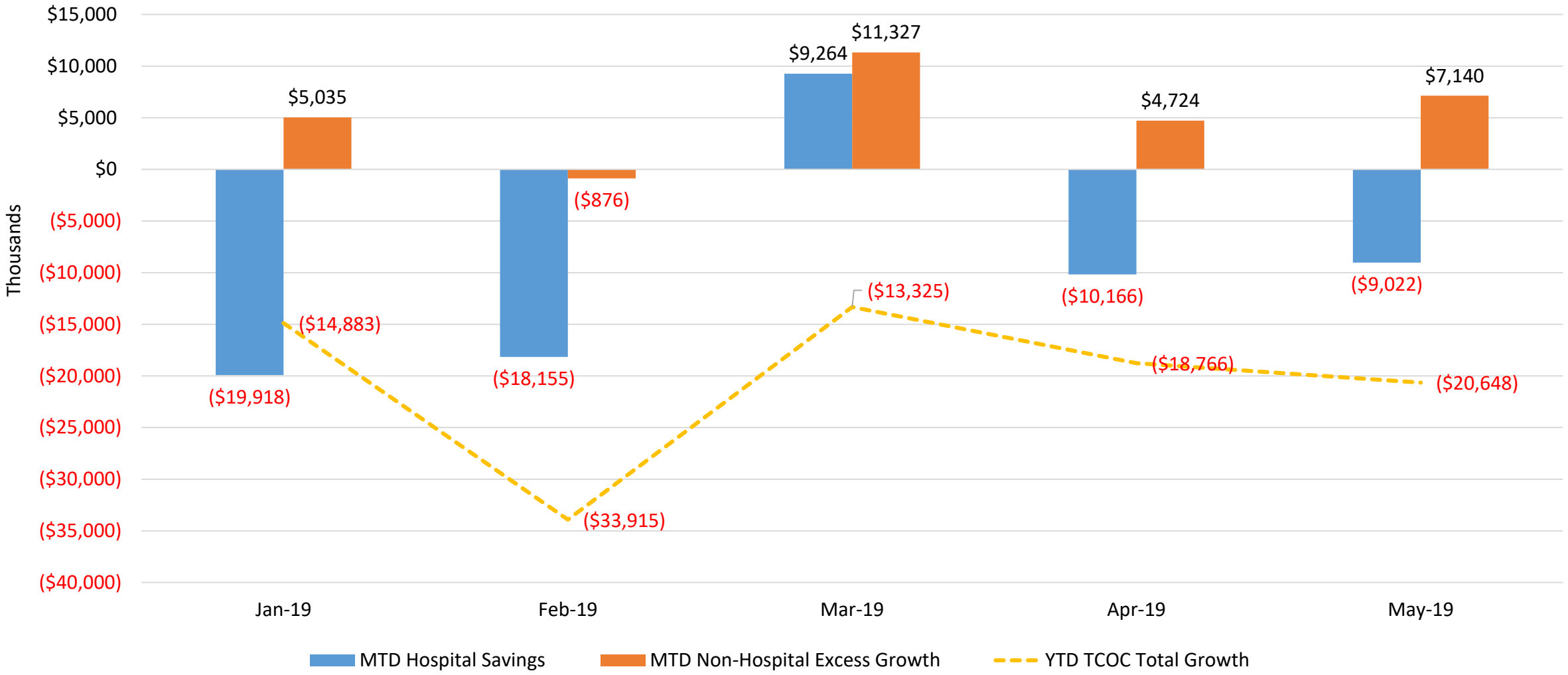
Maryland Medicare Hospital & Non-Hospital Growth



HSCRC
Health Services Cost Review Commission

Monitoring Maryland Performance Financial Data

Fiscal and Calendar Year to Date through June 2019

Includes FY19 Experience Report Revisions

Source: Hospital Monthly Volume and Revenue

Run: Sept 4, 2019

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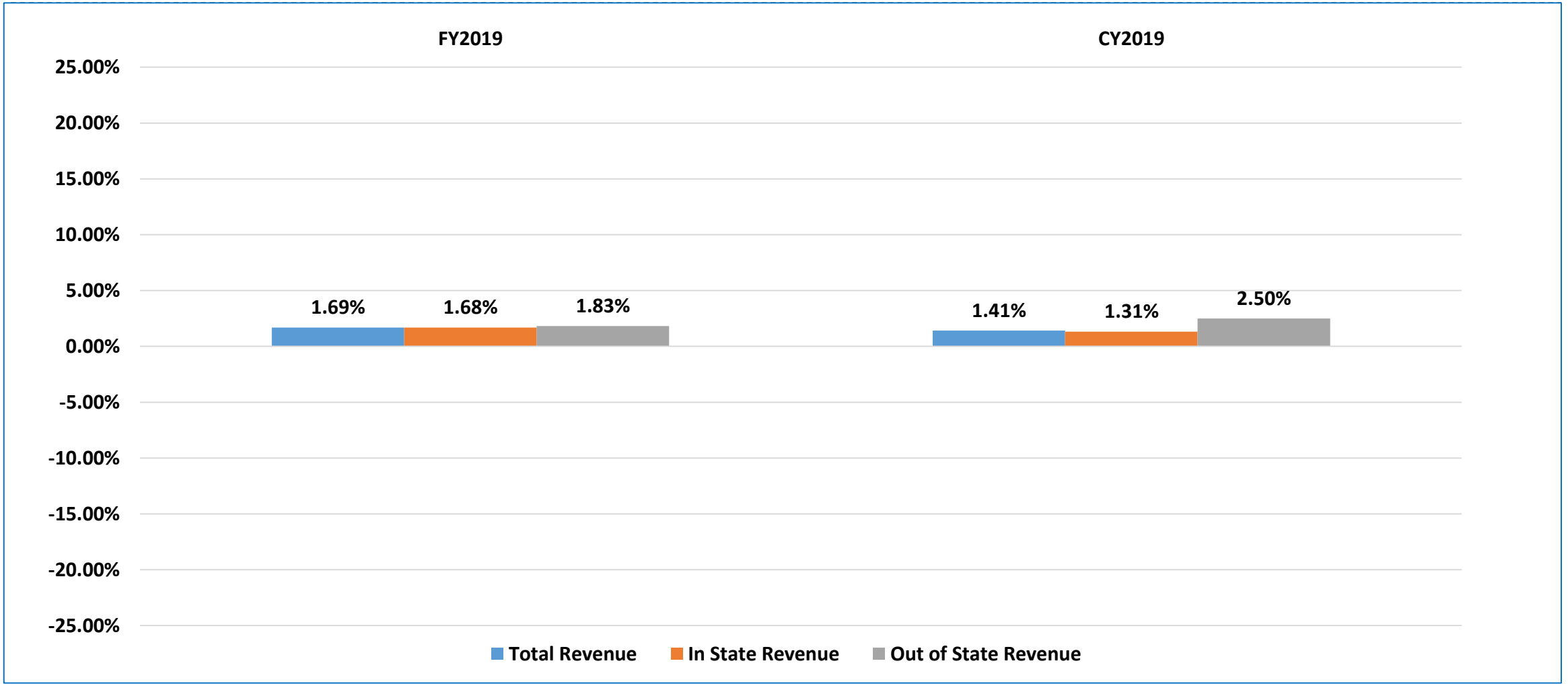
Gross All Payer Hospital Revenue Growth

FY 2019 (July 18 – June 19 over July 17 – June 18) CY 2019 (January 19 – June 19 over January 18 – June 18)



The State's Fiscal Year begins July 1

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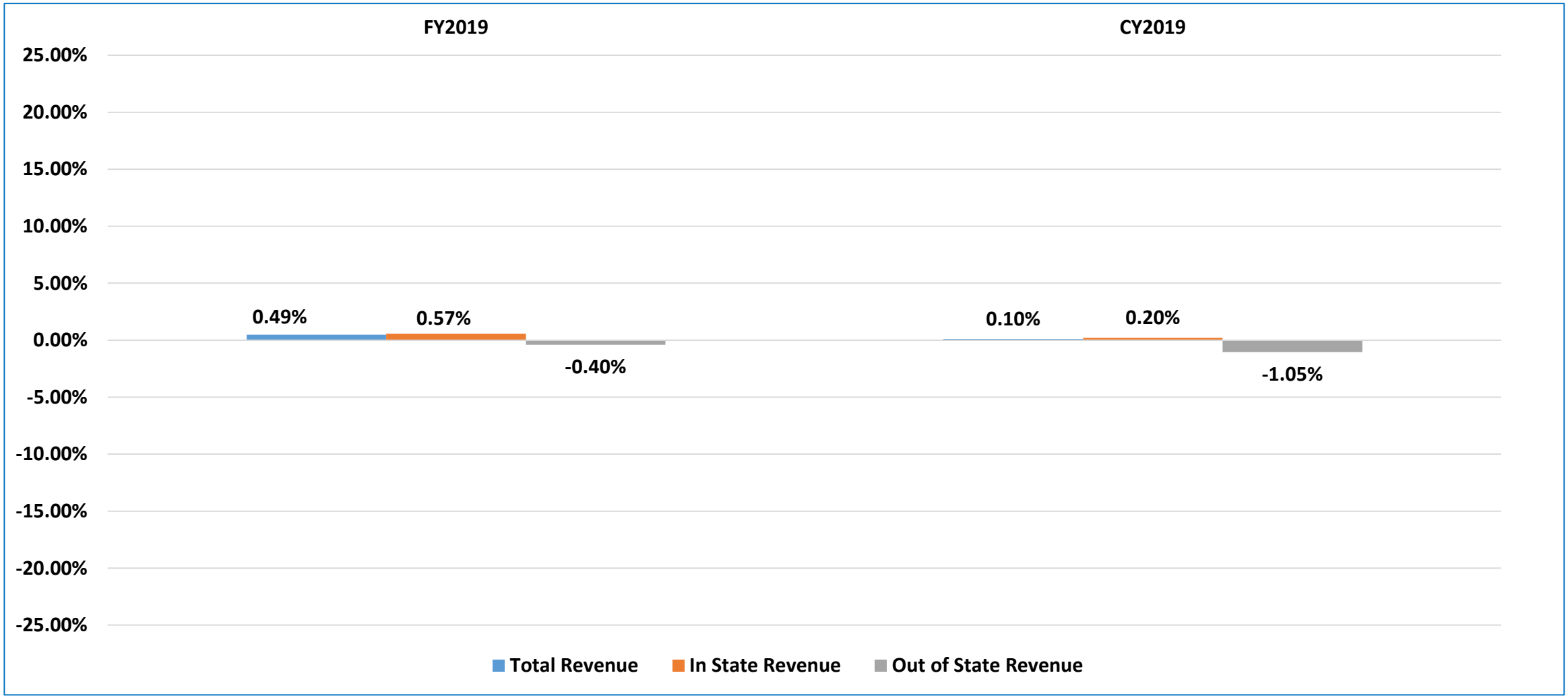
Gross Medicare Fee for Service Hospital Revenue Growth

FY 2019 (July 18 – June 19 over July 17 – June 18) CY 2019 (January 19 – June 19 over January 18 – June 18)



The State's Fiscal Year begins July 1

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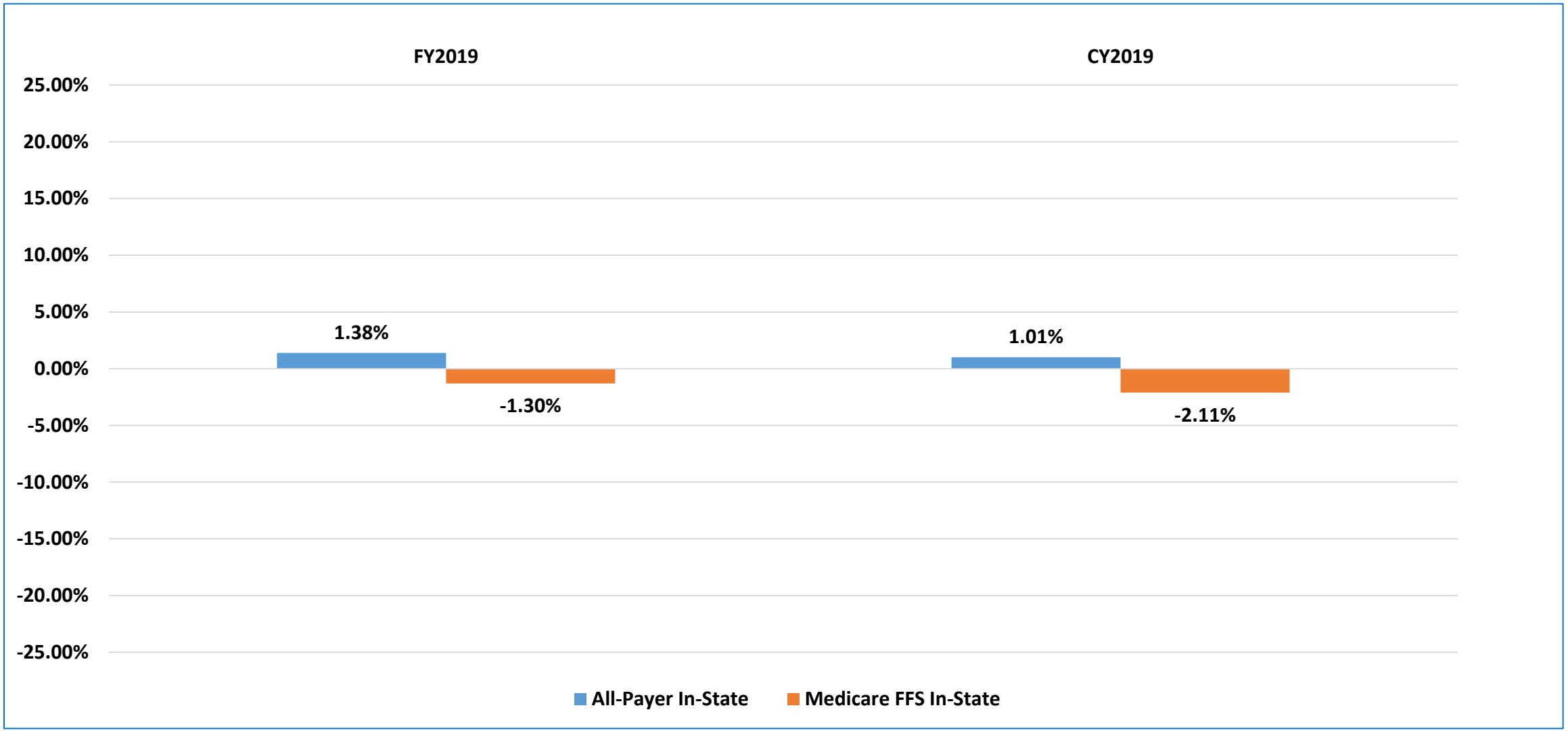
Hospital Revenue Per Capita Growth Rates

FY 2019 (July 18 – June 19 over July 17 – June 18) CY 2019 (Jan 19 – June 19 over Jan 18 – June 18)



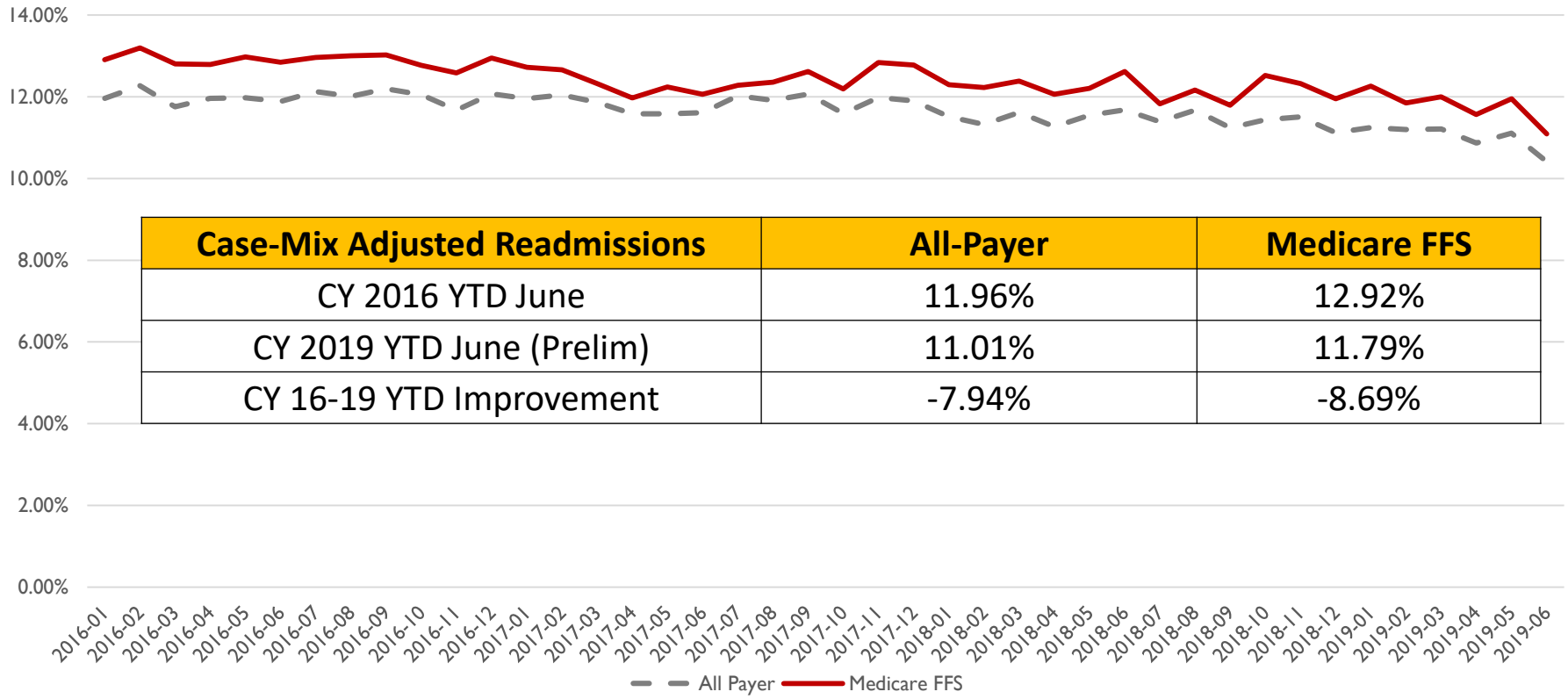
The State's Fiscal Year begins July 1

Monitoring Maryland Performance
Quality Data

September 2019 Commission Meeting Update

Readmission Reduction Analysis

Monthly Case-Mix Adjusted Readmission Rates

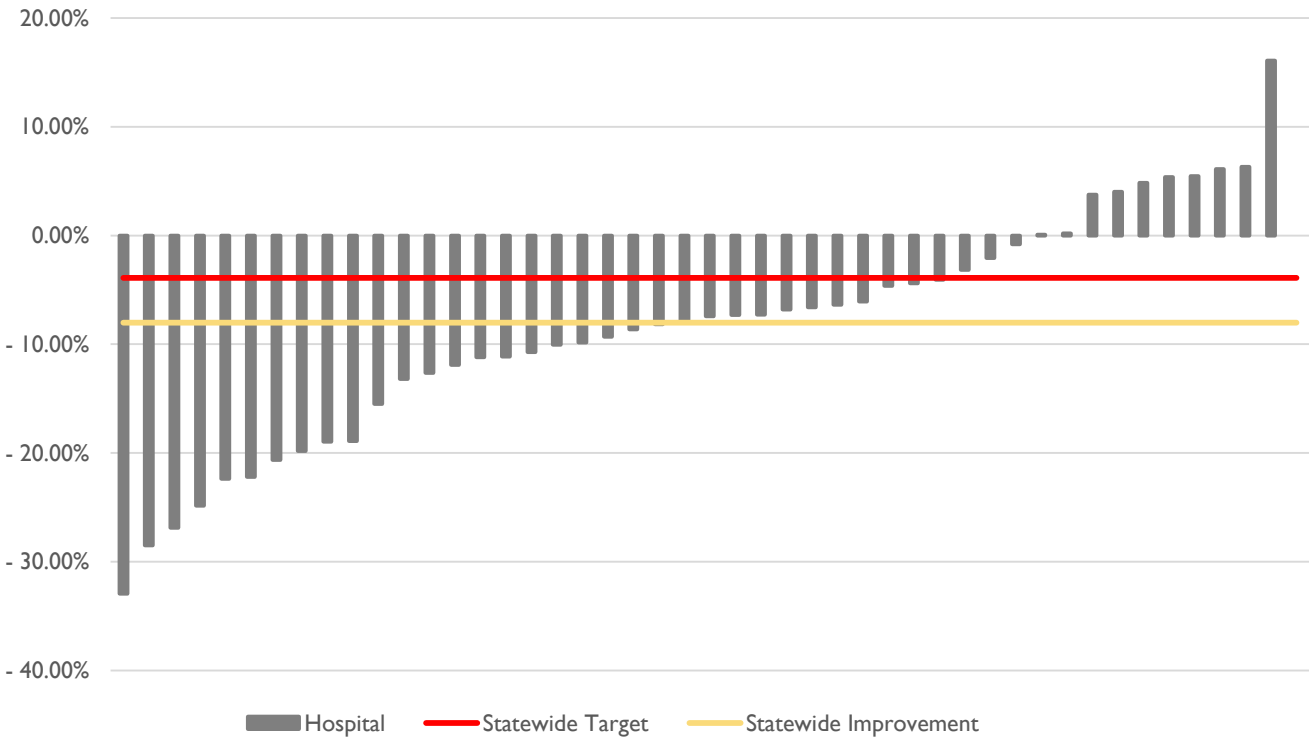


Case-Mix Adjusted Readmissions	All-Payer	Medicare FFS
CY 2016 YTD June	11.96%	12.92%
CY 2019 YTD June (Prelim)	11.01%	11.79%
CY 16-19 YTD Improvement	-7.94%	-8.69%

Note: Based on final data for Jan 2016 – Mar 2019; Preliminary data through July 2019. Statewide improvement to-date in RY 2021 is CY 2019 YTD compared to the same timeframe in CY 2016.

Change in All-Payer Case-Mix Adjusted Readmission Rates by Hospital

Improvement (or Change) CY 2016 YTD compared to CY 2019 YTD through June



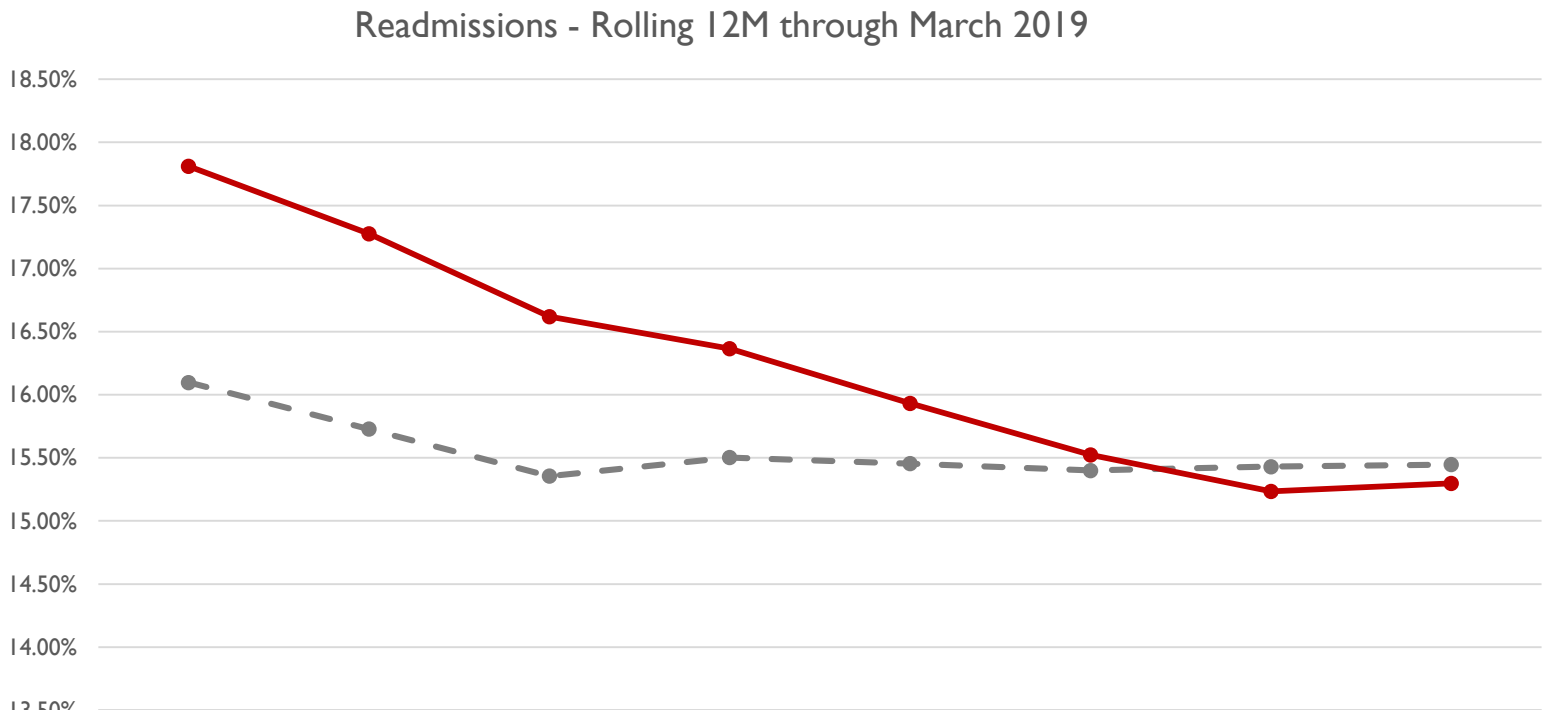
34 Hospitals are on Track for Achieving Improvement Goal

An Additional 2 Hospitals on Track for Achieving Attainment Goal

Note: Based on Final data through Mar 2019; Preliminary data through July 2019.
*** Graph does not include Chestertown Hospital.**

Medicare Readmission Model Test

Medicare Waiver Test: At or below National Medicare Readmission Rate by CY 2018



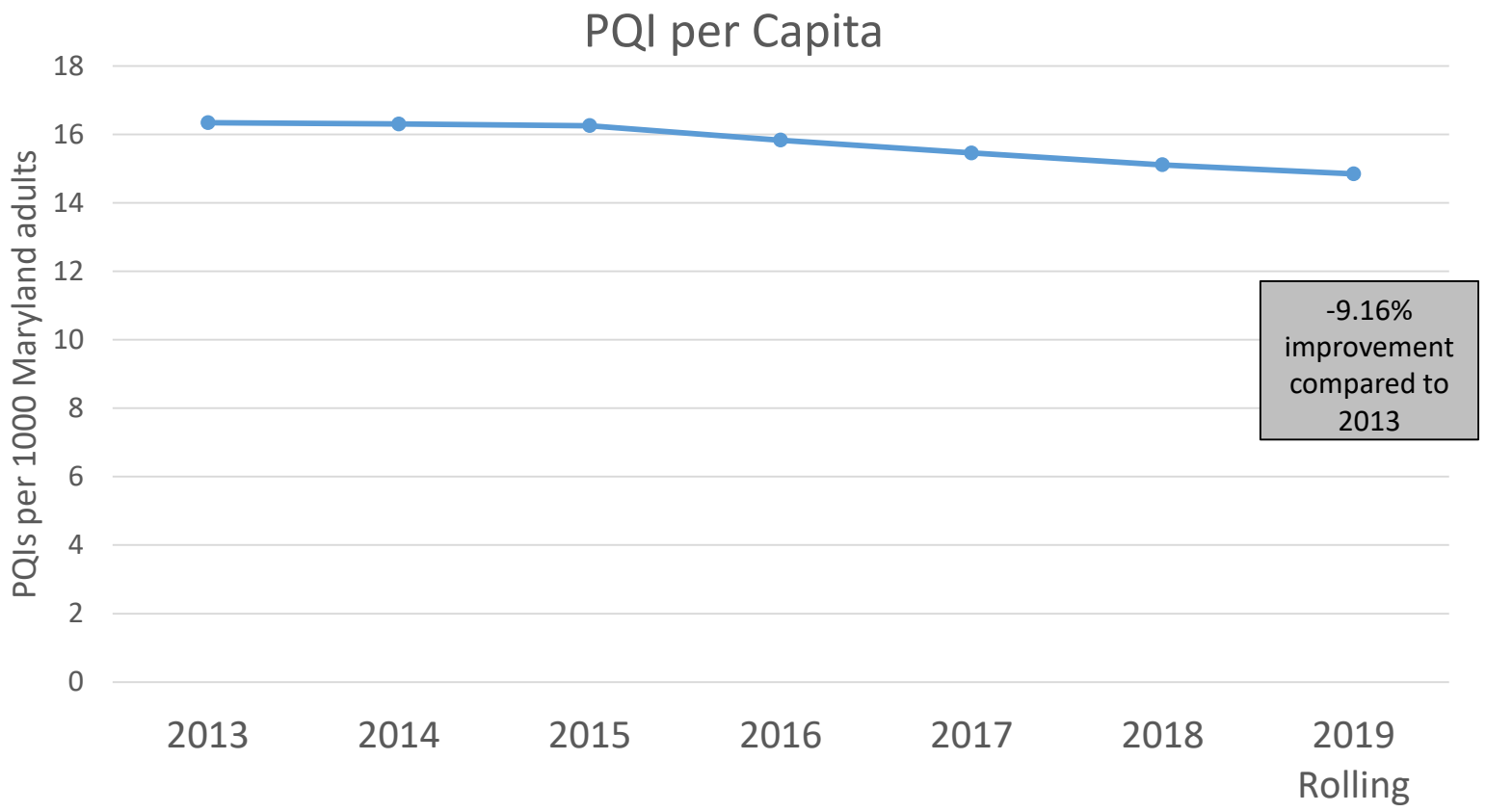
	Rolling 12M 2012	Rolling 12M 2013	Rolling 12M 2014	Rolling 12M 2015	Rolling 12M 2016	Rolling 12M 2017	Rolling 12M 2018	Rolling 12M 2019
National	16.10%	15.73%	15.36%	15.50%	15.45%	15.40%	15.43%	15.45%
Maryland	17.81%	17.28%	16.62%	16.37%	15.93%	15.52%	15.23%	15.30%

Data are currently available through February 2019

HSCRC
Health Services Cost Review Commission

Potentially Avoidable Utilization (PAU) Monitoring

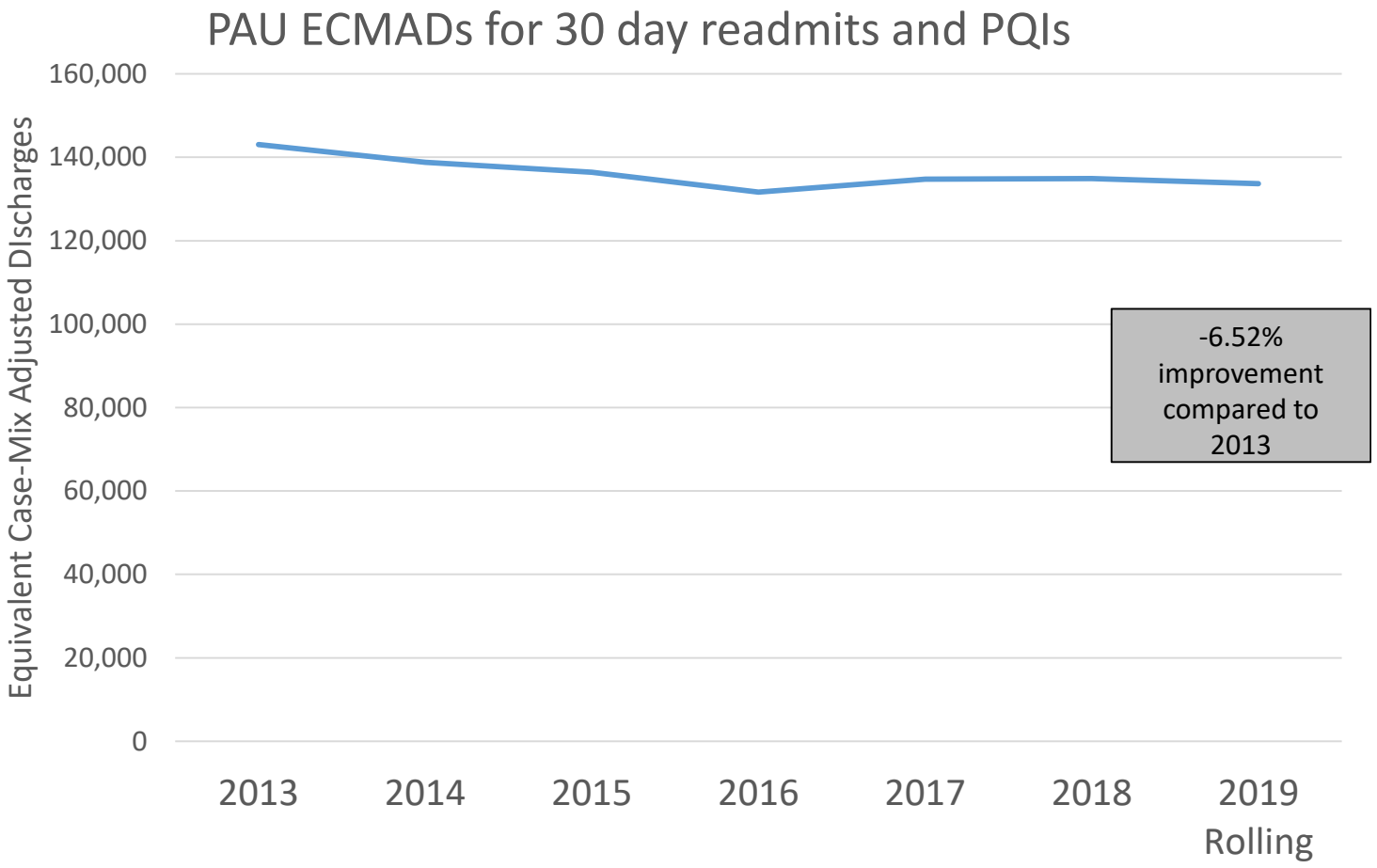
PQI Per Capita



*Analysis shows some hospital data anomalies that may result in actual improvement rate statewide of -7.66%

- 2019 Rolling includes 2019 Q1-Q2 and 2018 Q3-Q4
- Based on final data for Jan 2013 – Jun 2019, PQIs with Maryland zipcodes only

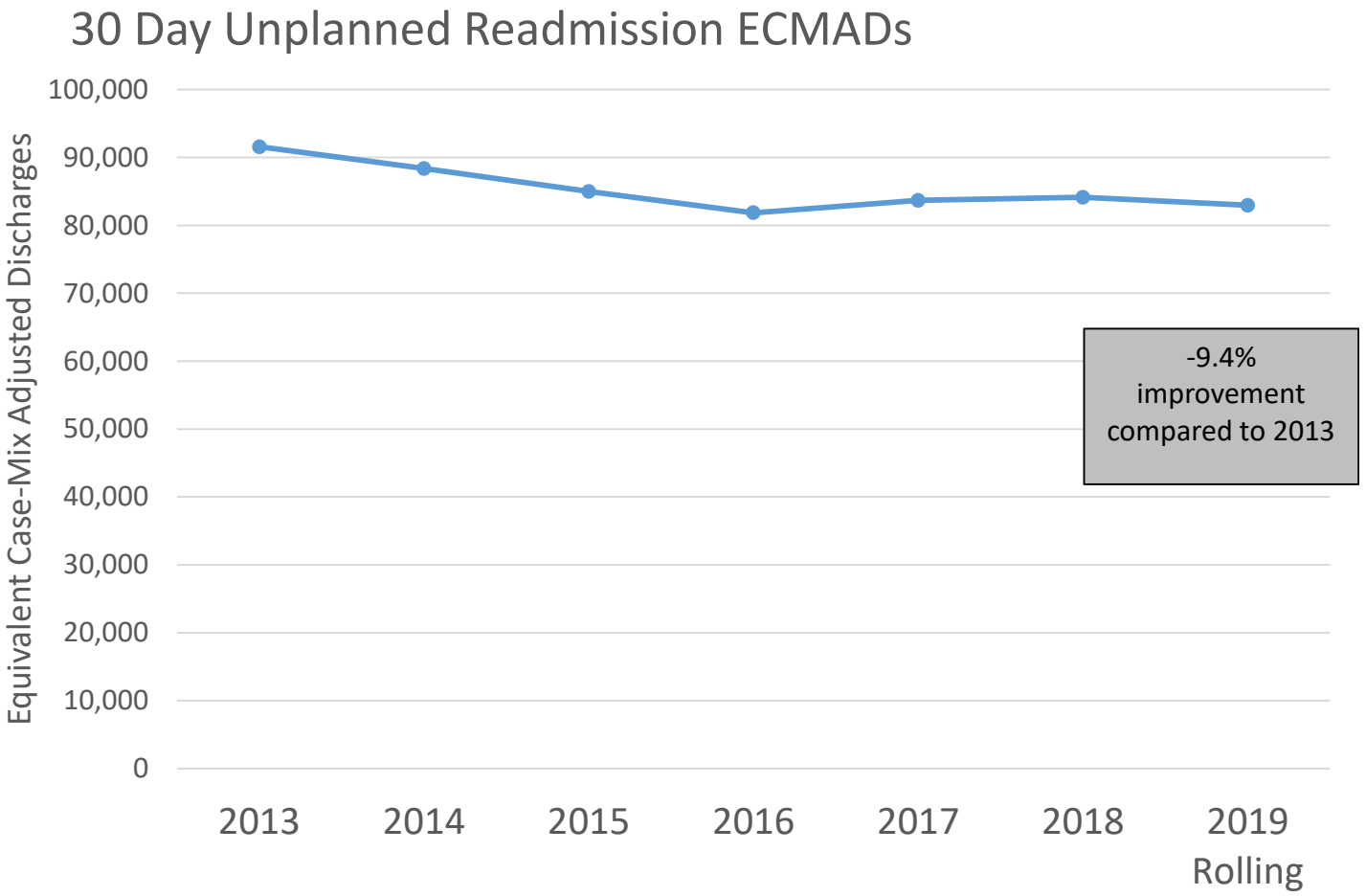
PAU ECMADs



2019 Rolling includes 2019 Q1-Q2 and 2018 Q3-Q4

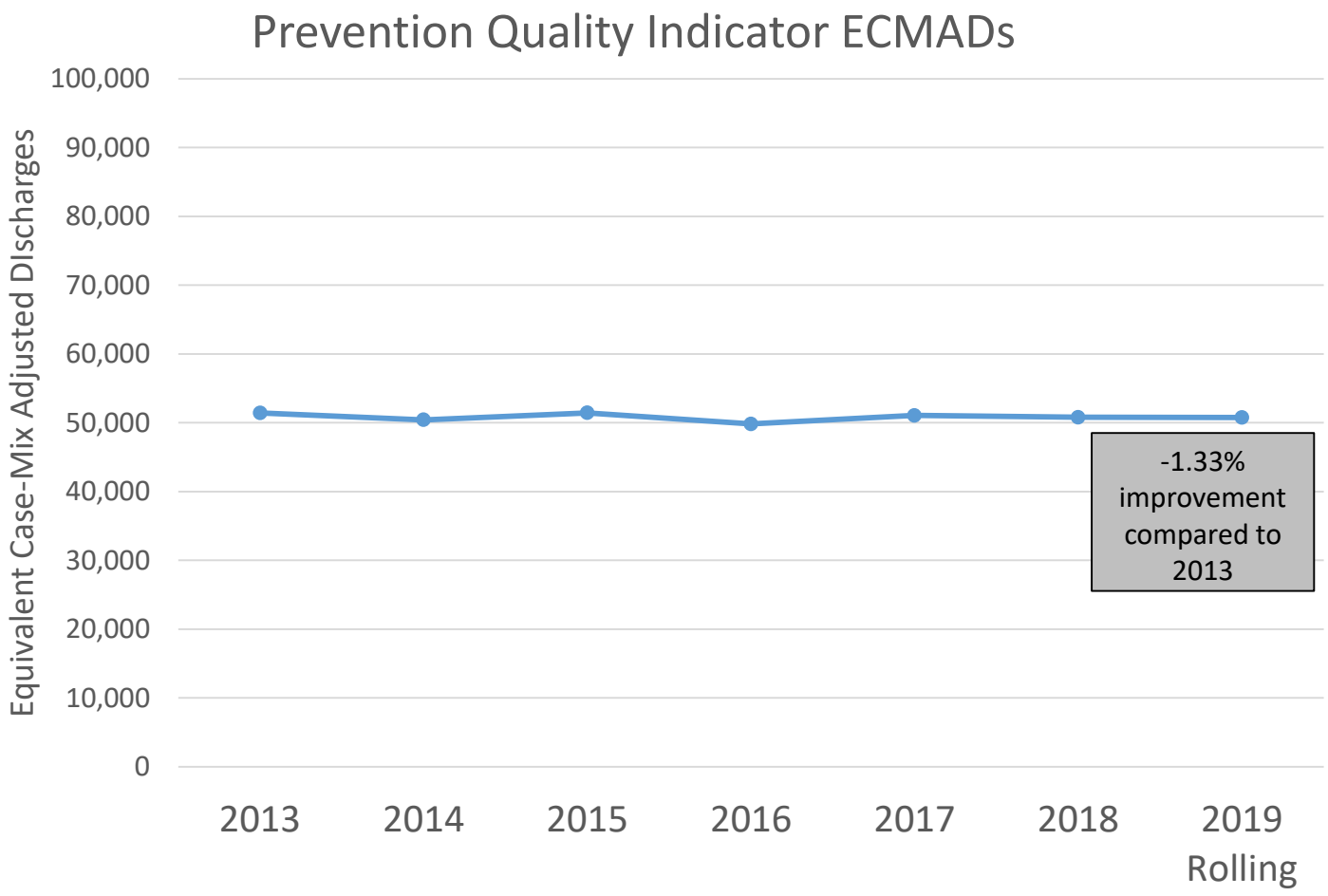
ECMAD = Equivalent Case-Mix Adjusted Discharges.

30 day Readmission ECMADs



- 2019 Rolling includes 2019 Q1-Q2 and 2018 Q3-Q4
- Discharges flagged as both PQI and readmit are included in the readmit count

PQI ECMADs



- 2019 Rolling includes 2019 Q1-Q2 and 2018 Q3-Q4
- Discharges flagged as both PQI and readmit are included in the readmit count

MPA Framework Draft Recommendation

September 11, 2019

HSCRC
Health Services Cost Review Commission

Overview of the MPA Framework

The Savings Component

- The Savings Component can be used to achieve the $300 million Medicare savings target on a Medicare specific basis.
- Staff do not recommend a cut for the first half of CY20.

The Reconciliation Component

- The Reconciliation Components will make payments for quantifiable Medicare TCOC reductions through Care Transformation Initiatives.
- The net reconciliation payments to individual hospitals will be offset across all hospitals to maintain net savings and incent participation.

- This is the new terminology that has replaced the MPA Efficiency Component (MPA-EC).

Savings Component

- The Savings Component reduces Medicare payments in order to meet the TCOC savings targets. Given the State's current performance it will likely be used only to prevent backsliding.
  - This amount is a reduction in Medicare payments for claims submitted by the hospital.
  - The MPA applies only to Medicare claims and would not change the amount paid by other payers.
- No MPA-SC will be applied to hospitals' Medicare payments for January to June 2020.
  - This part of the Framework only establishes the tool that could be used in the future.
  - If a cut is deemed necessary, Staff would make a formal recommendation to the Commission.

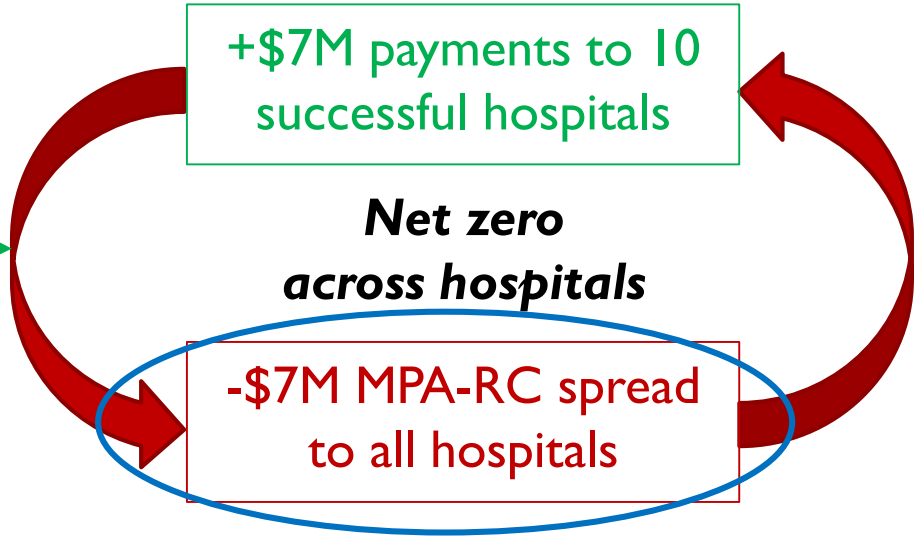
Reconciliation Component

- HSCRC Staff will allow hospitals to identify Care Transformation Initiatives (CTIs) that should receive Reconciliation Payments.
  - As part of this process, HSCRC Staff will quantify the TCOC savings that each CTI produces.
  - The hospital will receive 100% of the savings that are produced by the hospital's CTI.
- The savings produced by the CTI and paid to hospitals through "Reconciliation Payments" will be made in a net neutral manner.
  - Any positive Reconciliation Payment to an individual hospital will be offset by a statewide MPA reduction.
  - The offset will be allocated based on the hospital's share of statewide Medicare revenues.

Example: Under TCOC Model w. MPA Framework for payback **and offset** (2019-)

- 10 hospitals generate $7M in savings and receive $7M in Reconciliation Payments.
- Reconciliation Payments are offset across all hospitals in proportion to their share of statewide Medicare spending.

Post-acute Care Transformation savings achieved	$7M
Reward payments to participating hospitals	($7M)
Offset of reward payment	$7M
Net Savings to Medicare	**$7M**



Rationale for the CTI Process

- Hospitals should capture the returns from interventions they perform and have effects beyond their walls.
  - The CTI Reconciliation Payments will ensure that the hospital which produces the savings receives the rewards.
  - The CTI process will quantify the extent to which care transformation has contributed to the savings run-rate.
- The level of **individual** hospital efforts are not well understood and Staff are concerned about "free riders" that have not invested in care transformation.
  - Costs of CTIs will be born by hospitals that are not participating or are not successful.
  - The offset will begin to address excess retained revenue in hospitals who are not investing in effective population health interventions.

Care Transformation Initiatives Process

- A CTI is any initiative undertaken by a hospital or group of hospitals to reduce the total cost of care (TCOC) of a defined population.
  - Each CTI will identify a population of beneficiaries for which the hospital is accountable for reducing their TCOC.
  - Each CTI will have an established Target Price for its population.

<table>
<tr><th></th><th>Baseline Period</th><th>Performance Period</th><th>Reconciliation Payments</th></tr>
<tr><td>Baseline Population</td><td colspan="2">Baseline Period PBPM x Inflation = Target Price</td><td rowspan="2">(Target Price – Performance Period Costs)
x Number of Benes
= Reconciliation Payment</td></tr>
<tr><td>Intervention Population</td><td></td><td>Performance Period Costs</td></tr>
</table>

Example CTI Submissions

CTI Thematic Area	Overview of Selected CTIs Proposed by Hospitals
Post-Acute Care Episode Management	Hospital employ a multi-disciplinary team including a registered nurse, licensed-clinical social worker, and a community health worker to provide community-based coordinated care management. High-risk patients are targeted to reduce TCOC during the 90-day post-acute care episode. This CTI is intended for conditions not in ECIP. The teams: • Conduct frequent home visits to ensure the patient has a smooth transition from the hospital • Provide home-based medication reconciliation for patients with 5 or more medications • Provide physical therapy services to help increase mobility • Provide behavioral health services via telehealth to medical patients with behavioral health co-morbidities
Home Visits by Community Care Teams	Hospitals employ multi-disciplinary community care teams to visit patients in their homes. These interventions are anchored in the hospital or with a local EMS provider. They perform the following interventions: • Conduct standardized assessments including a social, behavioral, and home safety evaluation • Address advanced care planning, behavioral health, caregiver burden, grief counseling, etc. • Address unmet clinical and social needs by linking residents to community services • Provide scheduled preventative care and chronic disease management

Future Work

- The CTI process will assess the TCOC savings associated with an intervention. This is the "R" in ROI.
  - Next steps will include accounting for the "I" in those interventions.
  - Staff will begin to explore identifying the costs associated with CTIs through the cost reports.
  - Reporting costs could be used to identify where infrastructure dollars, retrained revenue, or other funds are being spent.
- The CTI framework does not account for investments in Public Health.
  - These investments are important to the delivery system but do not correspond to an identifiable patient population.
  - Staff will begin to explore similar processes for public health investments.

Draft Recommendation: MPA Framework

1. MPA-RC will be used to reward hospitals for Care Transformation savings (at up to 100% of savings) with reward payments offset across all hospitals.

2. Commission staff will continue to work with hospitals, providers, and other partners to develop Care Transformation Initiatives (CTIs). Qualifying CTIs will be made available to all hospitals to accelerate delivery system reform and encourage the sharing of best practices.

3. The Update Factor will be set to ensure that hospitals' Medicare payments do not exceed the Medicare total cost of care (TCOC) Guardrail, thereby constraining the growth of hospital costs for all payers in the system. No savings "cushion" will be provided to achieve Medicare savings, instead, the MPA-SC will be set to prospectively attain additional incremental savings necessary to achieve the $300 million Medicare savings target by CY 2023, if needed.

4. There will be no MPA-SC adjustment to hospital rates effective January 1, 2020 due to the total cost of care savings achieved through CY 2018.

Draft Recommendation for the Medicare Performance Adjustment Framework

September 11, 2019

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SUMMARY

The following report includes a draft recommendation for an approach under which the Commission will use the MPA Framework to ensure that the State meets the Medicare savings targets in the Total Cost of Care (TCOC) Model Agreement, while also incentivizing hospitals to engage in Care Transformation Initiatives (CTIs). In order to accomplish these goals, the draft recommendation includes the potential use of both a positive Medicare Performance Adjustment (MPA) to reward hospitals that produce total cost of care savings through CTIs and negative MPA to (1) achieve the required Medicare savings under the TCOC Model and (2) offset the positive payments related to CTIs. The recommendation is updated from the Draft Recommendation dated March 13, 2019 to clarify the link between the MPA Framework and CTIs, further highlight the mechanics of the MPA Framework with other Commission policies including the Update Factor policy, and remove the proposed MPA reduction for RY2020 given the State's current Medicare Savings Run Rate.

POLICY NAMING

This recommendation for the MPA Framework replaces the prior draft recommendation which referred to the MPA Efficiency adjustment. For clarity, the Commission is no longer using the term MPA efficiency or MPA Efficiency Component. Instead this policy will be referred to as the MPA Framework and within this framework there will be two components which will allow adjustments to Medicare rates:

- The MPA Reconciliation Component (MPA-RC): to be used to encourage Care Transformation Initiatives
- The MPA Savings Component (MPA-SC): to be used to help the State achieve its savings benchmarks by reducing hospital Medicare payments

The original Medicare Performance Adjustment policy will be referred to at the Traditional MPA. The Traditional MPA is not governed by this policy.

DRAFT RECOMMENDATIONS FOR THE RY2020 MPA FRAMEWORK POLICY

1. MPA-RC will be used to reward hospitals for Care Transformation savings (at up to 100% of savings) with reward payments offset across all hospitals.

2. Commission staff will continue to work with hospitals, providers, and other partners to develop Care Transformation Initiatives (CTIs). Qualifying CTIs will be made available to all hospitals to accelerate delivery system reform and encourage the sharing of best practices.

3. The Update Factor will be set to ensure that hospitals' Medicare payments do not exceed the Medicare total cost of care (TCOC) Guardrail, thereby constraining the growth of hospital costs for all payers in the system. No savings "cushion" will be provided to achieve Medicare savings, instead, the MPA-SC will be set to prospectively attain additional incremental savings necessary to achieve the $300 million Medicare savings target by CY 2023, if needed.

4. There will be no MPA-SC adjustment to hospital rates effective January 1, 2020 due to the total cost of care savings achieved through CY 2018.

INTRODUCTION

The Medicare Performance Adjustment Framework policy is designed to incentivize hospitals to engage with partners in Care Transformation Initiatives (CTIs) with a goal to reduce the Medicare TCOC across all care settings while ensuring that the State meets its Medicare savings targets in the TCOC Model Agreement.

BACKGROUND

The Maryland All-Payer Model ended on December 31, 2018, after the State successfully met or exceeded its obligations to the federal government. To meet its financial savings obligation, the State targeted an annual growth rate for hospitals' Global Budget Revenue (GBR) to $330 M of cumulative savings to Medicare. By limiting the growth of hospital GBRs, this savings approach created benefits to all payers. By allowing hospitals to keep savings associated with hospital utilization reductions, hospitals were encouraged to engage in care transformation activities and reduce unnecessary utilization. Combined, the All-Payer Model generated savings for all payers, improved quality of care, and incentivized the creation and expansion of successful care transformation programs.

The Maryland TCOC Model replaced the All-Payer Model in January 2019. Under the TCOC Model, the State committed to reach an annual Medicare total cost of care savings rate of $300 million by 2023, inclusive of non-hospital costs. The new model provides a flexible Medicare payment adjustment mechanism. The MPA Framework policy articulates an approach to using this new tool, which incentivizes hospitals to develop CTIs and reduce costs, as well as achieve the Medicare TCOC Savings. The CTI program, which started in 2019, rewards quantifiable care innovation that hospitals have invested in under the Model.

In short, the MPA Framework will allow hospitals to keep savings they produce from non-hospital costs through reconciliation payments (the MPA-RC). This is similar to the way that the GBR allows hospitals to keep hospital utilization savings. In addition, the MPA Framework can prospectively reduce hospital Medicare payments in order to meet the TCOC Medicare savings requirements, if required (the MPA-SC). Combined, the components of this policy will create savings to Medicare and incentivize the creation of successful CTIs that reduce the total cost of care in an intelligent fashion.

A New Tool: The Medicare Performance Adjustment and the MPA Framework

The TCOC Model Agreement (Section 8.c,i,6) allows the State to apply an adjustment to hospital payments in order to reward or penalize hospitals based on their success at controlling Medicare total cost of care. The adjustment is effectuated through a change to the amount paid by the Centers for Medicare & Medicaid Services (CMS), to hospitals after a claim has been received by the Medicare Administrative Contractor (MAC). The State calculates the amount and passes that amount to CMS, which then reduces all claims paid to the hospital by the indicated percentage. This adjustment is additive with other adjustments, like the sequestration adjustment, and is applied by CMS prior to paying a claim. The change does not go into hospital HSCRC rates, does not affect hospitals' GBR calculations, and is not reflected in rate orders.

The TCOC Model Agreement also has a "traditional" MPA component (described in Section 8.c.i.5), which creates a TCOC per capita benchmark by attributing beneficiaries to hospitals and then rewarding or penalizing hospitals based on their performance around that benchmark (Traditional MPA).

A hospital's "net" adjustment is the sum of the Traditional, Reconciliation, and Savings Components. To begin, the State proposes adjusting hospital MPAs semi-annually, though has the authority from CMS to make changes as frequently as quarterly.

THE MPA-RC IN ACTION: REWARDING CARE TRANSFORMATION INITIATIVES

Under the TCOC model, in addition to producing savings to Medicare, the State committed to transforming care in a valuable and sustainable way. In order to demonstrate the continued value of the Maryland Model to CMS, the State must demonstrate care transformation across the entire delivery system and not simply reduce hospital unit costs. This approach is especially important as non-hospital costs are included in the Medicare TCOC test. Thus, developing a care transformation approach that also addresses non-hospital costs is necessary to ensure that the burden of producing TCOC savings is shared by the entire delivery system.

Currently, hospital GBRs do not capture utilization savings that occur outside of their GBR. While a hospital's success at reducing total cost of care helps the State meet the Medicare TCOC financial test the success of those initiatives do not benefit the hospitals themselves. Thus, without the MPA-RC there is relatively little incentive for hospitals to develop CTIs that target the total cost of care.

In order to strengthen hospital incentives for CTIs across care settings and partners, staff recommend the following principles:

1. Hospitals should keep the savings from their CTIs up to 100% to the extent feasible
2. Incentives should be structured to reward participation in CTIs and penalize non-participation
3. New and Existing CTIs that transform care across the entire delivery system should be supported

The MPA-RC is the mechanism by which CTI reconciliation payments are made to participating hospitals. For additional care transformation efforts, staff will use the MPA-RC as a vehicle for achieving principles 1 and 2.

Incentives to Participate in Care Transformation

Incentives to participate in CTIs in the non-hospital setting are critical to Maryland's success. Incentive payments made based on CTIs will allow hospitals to keep the total cost of care savings they produce outside their GBR. For example, if a hospital produces $5 million in savings under the Episode Care Improvement Program (ECIP, discussed later in this recommendation), they will receive a $5 million incentive payment. However, if the MPA-RC is only used to pay out hospitals for ECIP success it will produce limited net savings (since the payments will offset the savings achieved). Therefore, the payments specific to a hospital will be offset with a pro-rata reduction to all hospitals, based on total Medicare payments so that net savings to Medicare still exist but the hospitals that achieved the savings receive the greatest benefit.

Including offsets to incentive payments from CTIs within the MPA Framework has two implications. First, it mitigates the possibility that these care transformation payments will result in a net increase in the TCOC run rate. Second, when a hospital captures the savings from their CTIs, it will spread an offset across all hospitals resulting in non-participating hospitals being penalized for their non-participation. An example of the MPA Reconciliation Component is shown in Table 1.

Table 1. Example MPA Reconciliation Component for 2020

	Hospital Experience Savings (Costs)		Medicare Experience (Savings) Costs
	Participating Hospitals (represent 33% of total Medicare Payments)	Non-Participating Hospitals (represent 67% of total Medicare Payments)	Savings to Medicare
Non-Hospital Care Transformation savings achieved			($7M)
Reward payments to participating hospitals	$6M	$0M	$6M
Offset of reward payment	($2M)	($4M)	($6M)
Net Savings	**$4M**	**($4M)**	**($7M)**

Allowing hospitals to capture the savings they produce through care transformation creates an additional incentive for hospitals to participate in CTIs. As some hospitals begin to succeed in care transformation, the MPA Reconciliation Component offset on all hospitals will increase. Hospitals that do not participate or have less successful CTIs will pay an increasing share of the required TCOC savings. Through this tradeoff, this policy will equally apply pressure for care transformation investment and prioritization.

Supporting CTIs

Because hospital's best path to earn back reductions made through the MPA-RC will be by addressing total cost of care costs through care transformation the staff recommend continuing to develop additional opportunities for hospitals to achieve and quantify total cost of care saving that will be eligible for offsets as discussed for above.

Under the GBR, hospitals have been engaging in care transformation but their efforts have not been systematically assessed. The CTI program was designed to quantify care innovation that hospitals have invested in under the Model to reduce non-hospital costs and achieve the Medicare TCOC Savings. Initiatives must have defined interventions and a trigger to identify a population based on claims data. The trigger can be limited in a way to restrict the population to those most likely to be impacted and should include an intervention window. With this information, HSCRC can measure the impact on TCOC once intervention effects should be observable.

In addition to the CTI, the Care Redesign Program (CRP), which began in 2017, was in part developed to create a new tool to improve alignment between hospitals and non-hospital providers. The CRP allows

hospitals to make incentive payments to non-hospital providers that participate in care transformation. The CRP began with two tracks, the Hospital Care Improvement Program (HCIP) and the Complex and Chronic Care Improvement Program (CCIP). While some savings from these tracks may accrue to Medicare, these tracks were primarily designed to align non-hospital providers with initiatives that produce savings within the hospital setting covered under the GBR.

At the start of 2019, the State implemented the first CTI, the Episode Care Improvement Program (ECIP). ECIP is a CRP track that is based on CMS's Bundled Payment for Care Improvement Advanced (BPCI-A) model and rewards hospitals for post-acute care savings produced through better care management within 23 clinical inpatient episodes of care. If hospitals reduce the post-acute care costs in an episode by more than 3%, they earn a "reconciliation" payment on their Medicare hospital payments equal to the post-acute care savings generated beyond the 3% CMS Savings Discount. The MPA-RC provides a vehicle for making these payments. Because the Commission is offsetting CTI payments using the MPA-RC, staff recommend removing the 3% CMS Savings Discount within the ECIP reconciliation payments. ECIP has limitations — most prominently, it only covers 23 inpatient episodes and does not account for other initiatives and programs that hospitals may have already created to reduce the total cost of care.

THE MPA-SC IN ACTION: ACHIEVING TCOC SAVINGS REQUIREMENTS

Under the previous All-Payer Model, the State included a "savings cushion" in the Update Factor Policy to ensure that the Medicare hospital costs grew less than national hospital costs. The savings cushion amount was set to ensure that the State produced the required $330 million in cumulative five-year hospital Medicare savings required by the All-Payer Model. Under this approach savings targeted for Medicare were also applied to other payers.

The MPA-SC allows the Commission to further refine its Medicare savings approach with regards to the Update Factor Policy. Staff recommends the following principles in setting the annual Update Factor policy:

1. The Update Factor should ensure that the growth rate of Medicare total cost of care in Maryland grows less than national care growth
2. The Update Factor should ensure that hospital spending growth continues to grow less than the Gross State Product (GSP)
3. Remove the 0.5% savings cushion historically used to achieve the required Medicare savings

Importantly, as the TCOC Model's main financial test is now assessed on the basis of the total cost of care, rather than just hospital spending, the Update Factor will need to ensure that excess non-hospital growth in Maryland is offset by slower growth in hospital costs.

Staff view these principles on the Update Factor as consistent with the Commission's approach under the All-Payer Model. By continuing to constrain hospital spending, savings will be generated for all payers and health care costs will be constrained for Maryland citizens while hospitals will be allowed to keep the savings generated through reduced hospital utilization.

The TCOC Model also includes additional financial guardrails to ensure sustainable growth in health care expenditures. First, Medicare TCOC growth in Maryland cannot exceed the national growth rate by more than 1 percentage point in any given year. Second, Medicare TCOC growth in Maryland cannot exceed

national growth in any two consecutive years. By following the Update Factor principles above, the State should ensure that the growth rate of Medicare TCOC in Maryland remains less than national.

Calculating the MPA Savings Component to Achieve Required Medicare Savings

Under the agreement with CMS, the State committed to produce an annual total cost of care savings of $300 million by 2023. Prior to 2023, the State must meet incremental savings targets. The MPA-SC will be used on a prospective basis, as needed, to achieve these targets in place of the adjustment to the Update Factor used previously.

Based on current savings, HSCRC proposes that no Savings Component will be deducted from hospitals' Medicare payments for January to June 2020. There will be another assessment for the second half of the year in early 2020, but application of the MPA-SC is not anticipated.

Staff considered different options for allocating the MPA-SC to individual hospitals and supports a simple approach of allocating the MPA-SC to hospitals based on their share of statewide Medicare hospital payments. The Medicare Savings part of the MPA Savings Component could then be applied as the same flat percentage adjustment across all Maryland hospitals.

Operations of the MPA Savings Component and Interactions with other Commission Policies

Staff intend to calculate savings run rates during the spring of each year to coincide with the annual Update Factor development and leverage existing stakeholder engagement forums (the Payment Models Work Group and the Total Cost of Care Work Group) to evaluate the need for a payment reduction. Staff believe that announcing both the MPA-SC savings reduction and the annual Update Factor simultaneously will reduce hospitals' uncertainty about their Medicare revenues during the upcoming rate year and increase transparency in the HSCRC rate-setting process.

Because the Medicare TCOC savings are assessed on a calendar year basis and the Update Factor operates on a fiscal year basis, estimating the incremental savings to target with the MPA Savings Component will require projecting, during the spring, the following calendar year's total cost of care run rate (see figure). In order to reduce the uncertainty associated with run-rate projections, as opposed to actuals, staff recommends a two-step process for setting the MPA-SC:

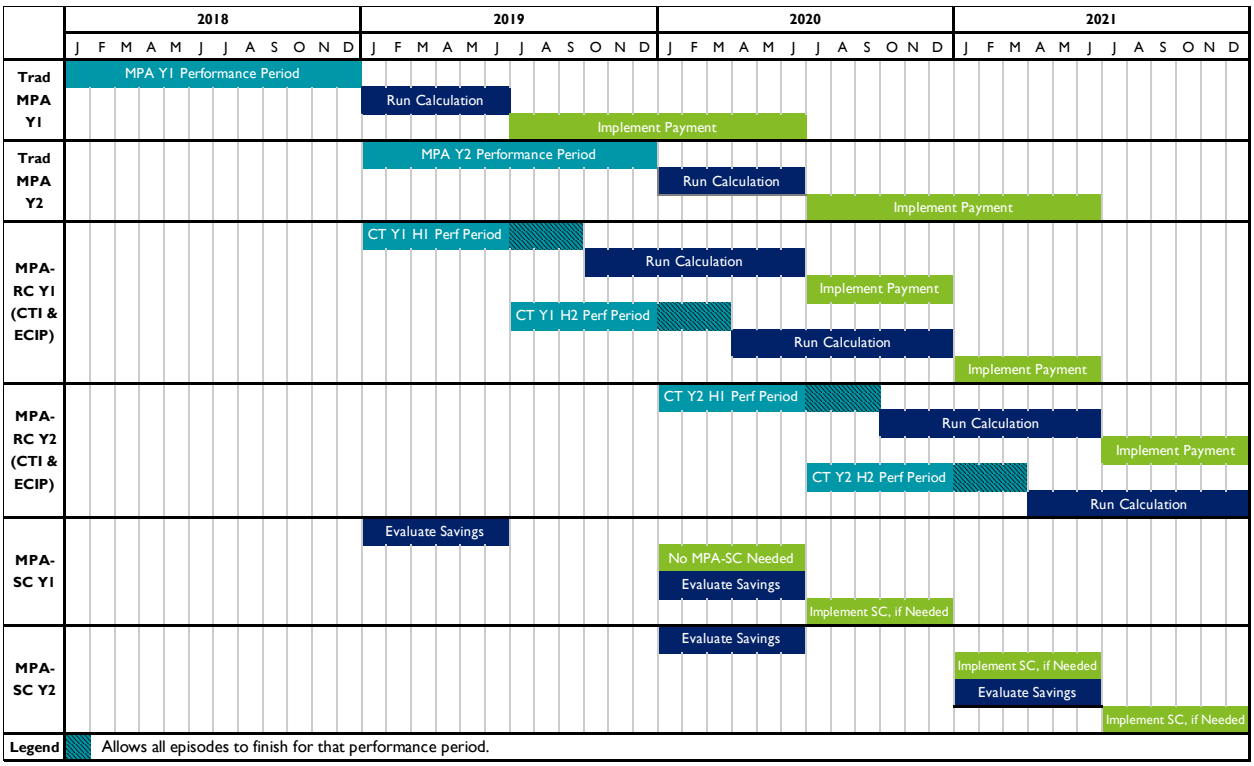
1. Once a full calendar year of Medicare data are available (including 3 months for claims run out) staff will be able to update Run Rate projections. Staff will then recommend an MPA-SC for the first six months of the next calendar year based on the current Medicare TCOC Run Rate; and

2. In the following spring, staff will recommend an update to the MPA-SC for the second six month period of that calendar year.

3. Should an MPA-SC adjustment related to achieving the savings target be determined to be necessary, the Commission will adopt specific policies specifying the adjustment amount.

Figure 1 shows the timing of the MPA Framework components in comparison to the timing of the Traditional MPA.

Figure 1: Timing of the MPA Framework and Traditional MPA



Staff considered either forecasting the total cost of care run rate for an annual MPA-SC or waiting until the end of the calendar year to set the MPA-SC using the actual run rate. However, both of these alternatives would have increased hospitals' uncertainty when estimating Medicare revenues through the annual Update Factor policy. Setting the MPA-SC in the spring of the preceding calendar year and then updating it in the spring of the current calendar year means that June 30 fiscal year hospitals will have insight into the MPA-SC for the entire next fiscal year during their budget process.

DRAFT RECOMMENDATION FOR RY 2020 MPA FRAMEWORK

1. MPA-RC will be used to reward hospitals for Care Transformation savings (at up to 100% of savings) with reward payments offset across all hospitals.

2. Commission staff will continue to work with hospitals, providers, and other partners to develop Care Transformation Initiatives (CTIs). Qualifying CTIs will be made available to all hospitals to accelerate delivery system reform and encourage the sharing of best practices.

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4. There will be no MPA-SC adjustment to hospital rates effective January 1, 2020 due to the total cost of care savings achieved through CY 2018.

APPENDIX 1: EXAMPLE OF MPA FRAMEWORK'S IMPACT ON A HOSPITAL PARTICIPATING AND NOT PARTICIPATING IN CARE TRANSFORMATION

Hypothetical Participating Hospital:

- Hospital represents 5% of total MC hospital payments in the state
- Hospital has achieved a Traditional MPA reward of 1%
- Hospital is participating in CTIs and achieved $5M of savings out of a statewide total of $30 M
- The Commission has adopted a policy implementing incremental savings of $10M through the MPA-SC to ensure the State meets savings targets

Expected annual Medicare hospital payments		$500M
Traditional MPA: Yields +1% adjustment		$5.0M
MPA Framework Adjustment Allocation:		
MPA-SC Calculation: Allocation of Savings Share = 5% of $10M	-$0.5M	
MPA-RC: Positive Reconciliation Payment through CTIs	+5.0M	
MPA- RC: Allocation from Offset of statewide CTI payments = 5% of $30 M	-1.5M	
Total MPA Framework		$3.0M
Result: Hospital A Medicare payments		$508M

Hypothetical Non-Participating Hospital:

- Hospital represents 5% of total MC hospital payments in the state
- Hospital has achieved a Traditional MPA reward of 1%
- Hospital is not participating in CTIs and did not contribute to the statewide total of $30 M
- The Commission has adopted a policy implementing incremental savings of $10M through the MPA-SC to ensure the State meets savings targets

Expected annual Medicare hospital payments		$500M
Traditional MPA: Yields +1% adjustment		$5.0M
MPA Framework Adjustment Allocation:		
MPA-SC Calculation: Allocation of Savings Share = 5% of $10M	-$0.5M	
MPA-RC: Positive Reconciliation Payment through CTIs	$0.0M	
MPA-RC: Allocation from Offset of statewide CTI payments = 5% of $30 M	-$1.5M	
Total MPA Framework		-$2.0M
Result: Hospital A Medicare payments		$503M

Draft Recommendation on Integrated Efficiency Policy: Stakeholder Responses

September 11, 2019

Executive Overview

- Staff received responses from the Maryland Hospital Association (MHA), Johns Hopkins Health System, (JHHS) University of Maryland Medical System (UMMS), MedStar Health, and CareFirst.

- UMMS and MedStar offered support of MHA's comments along with a few additional technical comments. JHHS did not formally endorse MHA's comments but did echo many of the technical points made by MHA as well as larger conceptual arguments. CareFirst supported two of MHA's comments and offered several comments that were at odds with the hospital industry.

- All comments and staff responses will be discussed herein

Unanimous Agreement

- All stakeholder comment letters expressed support for making adjustments based on evaluations of efficiency
- All hospital industry letters expressed support for adjusting efficiency analyses by improvement or lack thereof in Potentially Avoidable Utilization.
- All stakeholders likewise expressed support for maintaining revenue neutrality for efficiency adjustments, albeit for differing reasons:
  - Hospital industry did not support scoring efficiency adjustments as savings to payers and asked that funding be made available to efficient hospitals
  - CareFirst was concerned about the small size of the efficiency policy and that enhancement rewards could eclipse efficiency rate reductions
- **Staff Response:**
  - **Staff supports some redistribution as a means to allow efficient hospitals to obtain additional funding that would not require the rigor of a full rate application.**
  - **Staff also supports employing a transparent process with clear incentives that would cease GBR adjustments made without analysis of efficiency.**
  - **Finally, staff would note that all GBR enhancements would be capped by efficiency adjustments made through the Integrated Efficiency Policy and the annual set aside voted on by Commissioners in the Annual Update Factor Policy.**

Larger Conceptual Concerns: Stated Goal of Policy

- All hospital stakeholder letters expressed concern about the lack of a stated goal and objective in the Draft Integrated Efficiency Policy
  - Comments also made mention of potential applications of the tools discussed in the Integrated Efficiency Policy, specifically scaling the update factor for efficiency, rate applications, GBR enhancements and negotiated spenddowns
- **Staff Response:**
  - **The principal aim of the Integrated Efficiency Policy is to formulaically penalize and reward hospital efficiency while 1) maintaining the Model's incentive to reduce avoidable utilization and 2) keeping fidelity to the Commission's statutory mandate to ensure charges are reasonably related to costs.**
    - **Specifically, staff incorporated the Inter-Hospital Cost Comparison (ICC) methodology because it ensures hospitals charges are reasonably related to costs, as profits are removed from the evaluation.**
      - **There is no statutory mandate to ensure that there is more limited price variation in hospital charges and the Federal government no longer requires Maryland hospitals to maintain charges at a rate lower than national growth**
    - **Any cost or charge per case analysis is a counter incentive to reducing avoidable utilization further. By capping the extent of the ICC score to hospitals above one standard deviation from average performance, staff ensures that efficiency adjustments are only levied on "outliers."**
  - **As staff has mentioned in several workgroup meetings and in the Draft Integrated Efficiency Policy, this policy will only be used for identifying outliers. It will not be used for rate applications or negotiated spenddowns. Future policy recommendations will address these applications of the Efficiency tools.**

Larger Conceptual Concerns: Opportunity to Refine Methodologies

- All hospitals also expressed a desire to maintain transparency and opportunities for further methodology review, including:
  - Additional review of indirect medical education costs
  - Casemix methodology, which requires patient identifiers

- **Staff Response:**
  - **Over the past 20 months, public workgroups have met to discuss and develop the individual aspects of the efficiency methodologies and the larger conceptual framework (ICC, ECMAD, Efficiency Subgroups).**
  - **Moving forward, staff will continue to convene efficiency workgroups to review and potentially refine methodologies, but notes that all the methodologies mentioned as issues for future review were discussed at length during these meetings.**
  - **For the casemix methodology, staff is working on creating a deidentified dataset so that industry can run the new methodology independent of the HSCRC. Expected delivery date- November 30, 2019.**

Larger Conceptual Concerns: Unit Rate Compliance

- MHA asked staff to revisit unit rate compliance once an efficiency measure is in place.

- **Staff Response:**
  - **Staff is not supportive of this request. The Integrated Efficiency Policy is intended to penalize and reward efficiency outliers. Unit rate compliance, i.e. ensuring charges do no fluctuate with volume changes more than the standard amount of 5%, is assessed across all hospitals.**

Larger Conceptual Concerns: Small Size of Efficiency Adjustments

- CareFirst expressed concern over the small size of the revenue adjustments for poor performing outlier hospitals and posited that an alternative efficiency methodology could provide stronger incentives to hospitals to control TCOC.

- **Staff Response:**
  - **Staff welcomes any suggestions to better improve the efficiency methodologies, which are attempting to navigate two competing policy goals of incentiving further reductions in avoidable utilization and maintaining charges reasonably related to costs.**
  - **Also, staff believes it is important to consider the proposed efficiency methodologies in the context of the other efficiency adjustments and in terms of the revenue of the individual hospitals affected. See chart:**

Larger Conceptual Concerns: Small Size of Efficiency Adjustments

Hospital Name	RY 2020 Staff Proposed Efficiency Adjustment	RY 2020 Annual PAU Reduction*	Regulated Profit Margin RY 2018	Staff Proposed Efficiency Adjustment as a Percentage of Regulated Profit Margin	Efficiency Adjustment with Full Year Implementation	Efficiency Adjustment with Full Year Implementation on All-Payer Basis	Efficiency Adjustment with Full Year Implementation on All-Payer Basis as a Percentage of Regulated Profit Margin
University of Maryland Shore Medical Center at Chestertown	$481,423	$101,718	$10,412,434	5%	$962,845	$1,793,448	17%
University of Maryland Rehabilitation & Orthopedic Institute	$653,787	$0	$4,643,810	14%	$1,307,574	$4,032,858	87%
Montgomery General Hospital	$1,359,439	$599,522	$23,716,788	6%	$2,718,879	$5,907,054	25%
Union Hospital of Cecil County	$1,062,045	$497,665	$8,625,180	12%	$2,124,089	$5,377,991	62%
Total	$3,556,694	$1,198,905	$47,398,212	8%	$7,113,388	$17,111,352	36%
Bon Secours	$591,340	$541,365	$16,704,617	4%	$1,182,680	$3,778,279	23%
Midtown Hospital	$1,253,873	$870,993	$30,917,722	4%	$2,507,745	$7,481,604	24%
Total with Hospitals not Exempted due to Prior Efficiency Arrangements	$5,401,907	$2,611,263	$95,020,551	6%	$10,803,814	$28,371,236	30%

*PAU Reduction is approximately $50 million annually across the entire State.

Larger Conceptual Concerns: Small Size of Efficiency Adjustments

- A potential option to increase the size of the efficiency adjustments is to array hospitals into quartiles instead of quintiles.

Hospital Name	RY 2019 Permanent Revenue	Utilized Medicare FFS %	Medicare Portion of RY 2019 Permanent Revenue Base	Update Factor	Potential Cap on Withhold per Efficiency Matrix	Staff Proposed Efficiency Adjustment	Efficiency Adjustment with Full Year Implementation on All-Payer Basis
Algebra	A	B	C=A*B	D	E=D*C	F=E/2	G=A*D
McCready Memorial Hospital	$14,249,481	44%	$6,219,237	3.35%	$208,344	$104,172	$477,358
Calvert Memorial Hospital	$146,163,780	39%	$57,728,268	3.35%	$1,933,897	$966,948	$4,896,487
Carroll Hospital Center	$227,083,963	47%	$106,205,599	3.35%	$3,557,888	$1,778,944	$7,607,313
Total	$387,497,224	44%	$170,153,104	3.35%	$5,700,129	$2,850,064	$12,981,157

- This would increase the potential full year efficiency adjustment on an all-payer basis from $28 million to $41 million.
- Staff remains concerned that an expansion of this nature would begin to move away from identifying outliers and may disincentive further reduction in avoidable hospital utilization.

Larger Conceptual Concerns: Profit Strip Considerations

- MHA and members of the hospital industry expressed a desire to eliminate the regulated profit strip in the Integrated Efficiency Policy and to utilize a total operating profit strip in a full rate application.

- CareFirst disagreed with inclusion of unregulated losses in HSCRC efficiency methodologies.

- **Staff Response:**
  - **There are no directives from the contract with the Federal Government nor from State statute to eliminate the profit strip when determining efficiency. Moreover, if a hospital follows the fundamental incentive of the Model to reduce avoidable utilization, which is a constant incentive across multiple policies (RRIP, PAU, Market Shift), then the charges of the hospital will increase. Penalizing hospitals for price inefficiency and not cost inefficiency is a direct counter incentive to the Model. The ICC, which does include a profit strip, does comport with State statute to ensure that charges are reasonably related to costs. Therefore, staff does not recommend eliminating the profit strip in the Integrated Efficiency Policy.**

  - **Staff is working on creating a mechanism by which unregulated losses in line with the Model earn credit in HSCRC efficiency methodologies. Credit will require proven return on investments and will be reported and audited through annual filings. Workgroups will have a chance to review and refine staff's proposal on this matter.**

Appendix: Technical Considerations

Technical Considerations

- The hospital industry recommended eliminating Quality Adjustments in the ICC.
  - **Staff concurs**
- The hospital industry with the exception of MedStar Health recommended eliminating general volume adjustment in the ICC.
  - **Staff believes it is important that all avoidable utilization is accounted for in the efficiency methodologies but recognizes that determining all inpatient Medical DRG's and emergency room utilization is potentially too broad. Staff will therefore work to include additional avoidable utilization in the PAU and ICC programs, most notably avoidable ED utilization.**
- The hospital industry recommended eliminating the productivity adjustment in the ICC for the Integrated Efficiency Policy.
  - **Staff understands the industry's argument but disagrees with its conclusion, as the productivity adjustment does not just have bearing on peers within a peer group. If a productivity adjustment for one peer group is larger than another peer group and all hospitals are then relatively ranked, it will have a material impact.**

Technical Considerations

- The hospital industry expressed concern over the 2010 basis for the productivity adjustment or excess capacity calculation.
  - **Staff has made several adjustments to ensure that any substitution of lost volume/capacity from 2010 has been appropriately accounted for in its excess capacity calculation, including the growth of observation stays greater than 24 hours and outpatient surgery cases with a length of stay greater than 1. Staff therefore does not have concern about quantifying excess capacity from 2010, especially as there have been limited efficiency reductions since this time period.**
- The hospital industry expressed a desire to revisit the peer groups in the ICC.
  - **Staff has reviewed the peer groups due to various questions raised in negotiations with hospitals and has found that the basis for the peer groups, i.e. to group hospitals with teaching costs, similar geographic costs, and similar patient populations, has remained relatively reliable. Moreover, the additional adjustments such as IME, DME, and casemix adjust for many of the concerns raised by industry. Staff does welcome the opportunity to review peer groups if Commissioners and stakeholders believe this to be a pressing priority.**
- Industry expressed concern that Indirect Medical Education calculated costs are based off of 2015 data.
  - **Staff would note that the last time Medicare made an adjustment to IME payments was in 2008 and therefore believes its calculations is current.**

Technical Considerations

- The hospital industry expressed a desire for staff to continue to study calculations for DSH. CareFirst supported staff's conclusion that there was not empirical evidence to support the need for a DSH calculation, especially as the Commission has a refined all-payer casemix methodology and have retained peer groups.
  - **Staff will continue to consider DSH calculations.**
- The hospital industry supports using Medicare wage data to improve the accuracy of the labor market adjustment but cautions about cliffs created by narrowly defined geographic labor markets.
  - **Staff concurs with this concern and will work with industry this upcoming year to refine the LMA with this concern in mind.**
- MHA expressed a concern that the Commission strive for consistency in TCOC attribution and Johns Hopkins suggested it would appropriate to include TCOC attainment.
  - **Staff will try to maintain consistency but notes that the growth rate dating back to 2013 requires the primary service area attribution in lieu of the MPA attribution. Once staff completes the TCOC benchmark analyses, it is conceivable that the Integrated Efficiency Model could abandon the growth rate calculation and solely rely on attainment, which would remove the concern about consistency in attribution logic.**

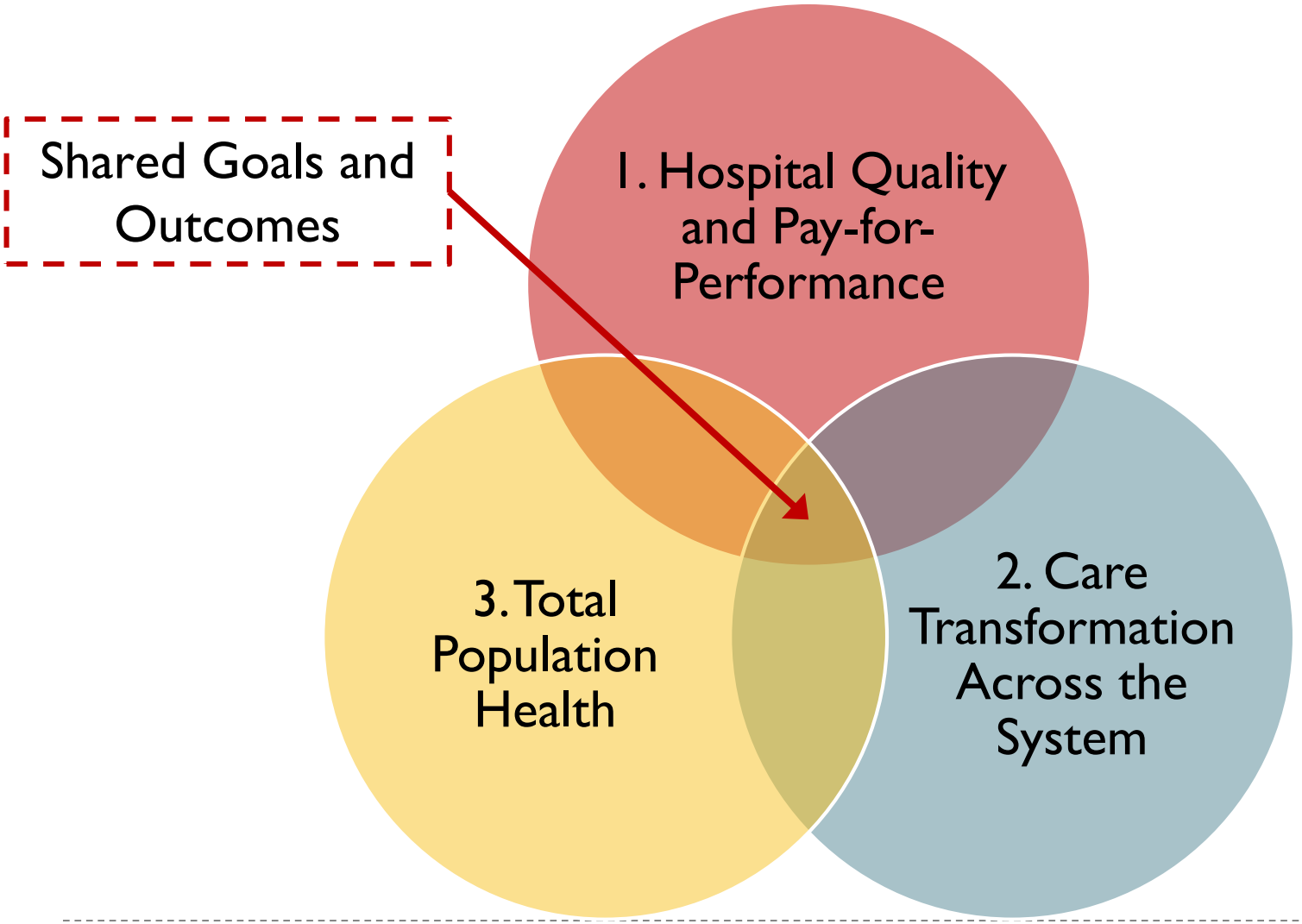
Technical Considerations

- MedStar expressed concern over the impact of rate increases related to significant capital expenditures for hospitals that have overlapping service areas
  - **Staff will investigate this concern.**
- UMMS expressed concern over identification of smaller facilities as outliers in the Integrated Efficiency Policy and asked that staff look into circumstances contributing to this phenomenon.
  - **Staff will investigate this concern.**
- CareFirst requested that staff finalize its policy intention of combining the national academic analysis and the State ICC analysis for Johns Hopkins Hospital and University of Maryland Medical Center and also consider extending this analysis to Bayview and Sinai.
  - **For the RY 2019 casemix / RY 2020 revenue ICC, staff will endeavor to complete this analysis for Johns Hopkins Hospital and University of Maryland Medical Center.**

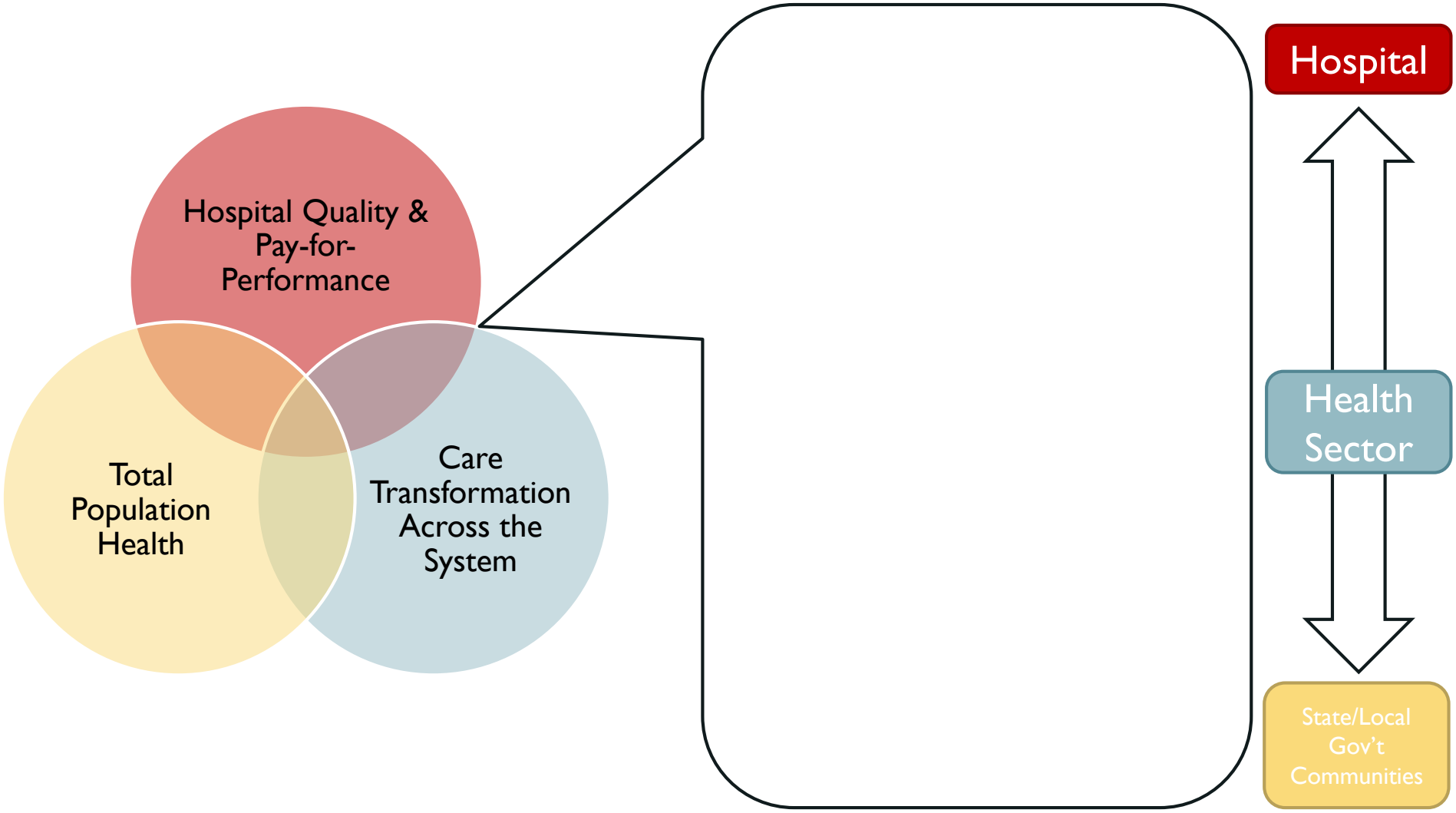
Integrated Health Improvement:
Maryland's Quality and Population Health Strategy

HSCRC Commission Meeting
9/11/2019

Diverse Approaches for Integrated Health Improvement



Potential Examples of Shared Outcomes and Goals



Guiding Principles for Maryland's Integrated Health Improvement Strategy

- Maryland's strategy should fully **maximize the population health improvement opportunities** made possible by the Model
- Goals, measures, and targets should:
  - Be **specific to Maryland** and established through a collaborative public process
  - Reflect an **all-payer** perspective
  - Target statewide improvements, including **improved health equity**
  - Be **synergistic and mutually reinforcing** across the three domains
  - Focus on **outcomes whenever possible**; milestones, including process measures, may be used to signal progress toward the targets
- Maryland's strategy must **promote public and private partnerships** with shared resources and infrastructure

1. Hospital Quality & Pay-for-Performance under the TCOC Model

Refine existing hospital pay-for-performance programs and quality reporting

- Maintain waivers from CMS
- Maximize all-payer opportunity
- Sustain and improve high quality care under capitated hospital model
- Monitor additional types of performance metrics for holistic evaluation of hospital quality

Develop paradigm for including population health metrics into pay-for-performance and monitoring as well as various HSCRC financial methodology applications

- Align with outcomes-based credit
- Foster hospital accountability for population health
- Utilize HSCRC hospital pay-for-performance expertise to support and align with other state value based initiatives to achieve statewide population health goals

2. Care Transformation Across the System

- Objective: Create measure(s) of progress toward improved statewide outcomes and meaningful development of care transformation in Maryland
- Example: Structural measure of share of Medicare beneficiaries in Category 3

Category 1 No change in practice of care	**Category 2** Providers accept value-based payments for patients in their own setting of care	**Category 3** Providers financially accountable for value and care quality for a population regardless of setting*
E.g., FFS payments for providers Some link to value and quality of care may be included (e.g., MIPS) but do not fundamentally change the incentives	E.g., Hospitals under global budgets accountable for services in the hospital Moves to value within own setting but little/no financial accountability for outcomes or what happens in other settings	E.g., ACO, ECIP This could be an attribution-based approach (e.g., ACO, ECIP, EQIP) or it could include self-defined populations (e.g., hospitals' Care Transformation Initiatives)

* For approaches beyond the Traditional MPA, which captures 100% of Medicare beneficiaries

3. Total Population Health: Strategy for Starting with Diabetes

- Leading cause of preventable death and disability
- Increasing prevalence reflecting significant racial, ethnic and economic disparities
- Evidence-based interventions (EBIs) can prevent or delay onset and improve outcomes
- Maryland Medicaid launching Diabetes Prevention Program (DPP) this Fall
- Diabetes/obesity cited as a priority by every jurisdiction's Local Health Improvement Coalition (LHIC) and every hospital's Community Health Needs Assessment (CHNA)
- Strong private sector support for a sustained statewide initiative
- Success provides credit in TCOC Agreement

Total Population Health Requires Broader Engagement: Work Led by MDH

ALIGN RESOURCES, MESSAGES AND ACTION

- Release Draft State Diabetes Plan for Public Comment
- Develop and Implement a Statewide Communication Plan
- Convene Local Health Improvement Coalitions
- Convene Hospital Population Health Team Leaders
- Launch an Interactive Online Inventory of Diabetes Resources
- Engage Academia in Building Evidence around Effective Strategies
- Engage Providers Through MDPCP, Newly Certified CHWs, etc.
- Engage Payers Beyond CareFirst
- Engage Businesses and Residents in Why and How
- Report to CMMI on Progress

What Has CMMI Said?

- CMMI insists that for the TCOC Model to be "expanded" (made permanent) based on data through 2021:
  - Targets must be set and progress shown in the domains of hospital quality, care transformation, and population health
  - Although outcomes are preferred to show success, they are less likely to be obtained in 2021 data
- CMMI requested the State to agree to amend the TCOC Contract, but instead accepted having an MOU that:
  - Establishes a framework and process that would be agreed on by the end of 2019
  - Requires the State to establish targets in all three domains as soon as possible in 2020
  - Each goal /measure could have, for example, a 2021 milestone, a 2023 interim target, and a 2026 target

Process for Establishing Targets and Being Successful

- Set the Goals: Establish a collaborative process to select targets, measures and milestones (discussions beginning)
  1. Hospital Quality and Pay-for-Performance (HSCRC Performance Measurement WG)
  2. Care Transformation Across the System (HSCRC TCOC WG)
  3. Total Population Health (MDH, Diabetes Action Team)
- Message the Goals: Develop communications/outreach strategy for statewide engagement
- Resource the Goals: Develop multisector alignment of investments and accountability
- Act on the Goals: Launch and support a statewide network of effective change
- Monitor the Progress: Evaluate outcomes, reassess investments, adjust approaches accordingly

CEO Discussion Group Final Report

By Westcott Partners LLC for the Maryland Health Services Cost Review Commission

September 11, 2019

Overview

- Purpose, Participants, and Meetings Held
- Key Topics
  - Maryland Hospital Capacity
  - Global Budget Methodology and Transparency
  - Shifting Services from Regulated Settings
  - Capital Funding
- Summary and Recommendations

Purpose:
Provide HSCRC Commissioners, Hospital CEOs and other leaders the opportunity to discuss the Total Cost of Care Model and its implications for the health system.

Ground rules:
The group was assigned the task of discussing the implications of implementing the TCOC Model, but not making decisions or setting policy for the HSCRC. The format was an open dialogue facilitated by a third party (Westcott Partners). Each session was two hours.

Meeting Schedule:
October 17, 2018
November 12, 2018
January 15, 2019
March 22, 2019
May 3, 2019

Participants:

Hospitals:
Bob Chrencik (UMMS), Henry (Hank) Franey (UMMS), Tom Kleinhanzl (Frederick), Tom Mullen (Mercy), Joe Ross (Meritus), Eric Wagner (MedStar), Kevin Sowers (Johns Hopkins), Dean Teague (Calvert)

MHA:
Bob Atlas (CEO), Brett McCone, Mike Robbins,

HSCRC Commissioners:
Joseph Antos, John Colmers, James Elliot, MD Adam Kane, Nelson Sabatini (Chair)

HSCRC Staff: William Henderson, Madeline Jackson, Chris Peterson, Jerry Schmith, Allan Pack, Will Daniel, Judy Wang, Katie Wunderlich (Executive Director)

Westcott Partners:
Jonathan Foley, John O'Brien

Maryland Hospital Capacity

Issue

The HSCRC and the MHCC have each produced reports that indicate that Maryland's total hospital capacity currently exceeds the State's needs and is inconsistent with the provision of efficient, quality care. In its FY 2017 Annual Report on Maryland Hospitals, MHCC reported:

- 40 general hospitals in Maryland with 6,185 licensed acute care beds report the availability of physical bed capacity that exceeds their licensed capacity;
- Central Maryland has the greatest excess, with reported physical bed capacity exceeding licensed bed capacity of 932 beds, followed by Southern Maryland with 497 more physical beds than licensed beds.

Removing excess hospital capacity has the potential of reducing fixed costs and generating savings for the health system as a whole.

Insights and Comments

- Comprehensive assessment of excess capacity needed:
  - Quantify excess capacity consistently across all hospitals.
  - Develop and apply efficiency and effectiveness standards to guide capacity reduction.
  - Measure excess cost by considering a combination of physical occupancy, rate efficiency, and quality.
- Range of options to reduce excess capacity should be considered:
  - Incentives;
  - Trade offs within hospital systems (e.g., Laurel, Prince George's).
- There are numerous considerations as to how to implement:
  - In principle, funding should follow shift of services to the community so that access and quality do not suffer.
  - Community and political leaders need to be involved in the process.
  - Need to align provider model and payer model and involve Maryland Department of Health and provider community, ensuring alignment with the new Maryland Primary Care Program.
  - Need to consider the hospital demographics and variability; e.g., rural hospital issues are not the same as those of academic medical centers.

Global Budget Methodology and Transparency

Issue

While hospital global budgets set clear goals for hospitals, the factors that determine those budgets are not static. There is a need to account for:

- Population changes,
- Technology innovation,
- Service mix changes.

Also, the impact of these factors on global budget incentives need to be considered. This process can lead to sudden, significant changes in individual hospital revenue projections.

Expanding the scope of the Model from hospital costs to total cost of care heightens the need for a more integrated and aligned health delivery system.

Insights and Comments

- The TCOC Model needs to be as transparent as possible.
- Technical aspects of the model need to be communicated more clearly and comprehensively so that hospital administrators and board members can understand why shifts in funding occur and their implications for service delivery.
- The Model needs to provide a predictable funding path for each hospital to facilitate planning.
- Hospitals are contracting with more physicians, in part to ensure their practices remain viable and they are retained in the community. Hospitals are concerned that pressure to contract with physicians is affecting the hospital's ability to meet GBR targets. More research is needed to understand whether Maryland physicians are reasonably compensated.
- The Model should incorporate incentives to reduce excess capacity along the lines of what is occurring through the Care Transformation Initiatives.
- The Model development should continue to account for disease patterns and population health trends more globally.

Shifting Services From Regulated Settings

Issue

The distinction between the HSCRC regulated space and unregulated outpatient services has been a recurrent issue for the Maryland all-payer system. Making this distinction is even more pressing because:

- Global targets increase the incentive to move services away from the hospital into unregulated, and often less expensive settings.
- Patients are paying more out of pocket for the cost of care because employers and payers are incentivizing enrollment in high deductible plans and increasing consumer cost sharing requirements in traditional product offerings.
- Cost-to-charge ratios have not been updated since the 1970s and are inflated, creating opportunities for other providers to undercut hospital prices.

Managing this shift presents several challenges to the HSCRC.

Insights and Comments

- **Policy Clarity:** HSCRC should clearly articulate the deregulation policy for the benefit of hospitals and the general public. There is a need for benchmarks to help determine when services should be shifted out of hospital regulated space, more information on the processes for moving services out of hospital regulated space, and examples of best practices.
- **Price Transparency:** The lack of price transparency for patients and payers is fueling confusion about cost responsibility.
- **Impact on Access to Care and Consumers:**
  - Lack of coverage of uncompensated care in community settings;
  - Hospital in a rural community is often the major employer; and,
  - Concern about a subset of patients with co-morbidities that cannot be shifted to unregulated space safely.
- **Cost reduction**: Moving services out of the inpatient setting has not necessarily reduced costs. For example, there has been an increasing concentration of observation beds that are classified as outpatient, but still in the hospital setting.

Capital Funding

Issue

The traditional mechanism for capital funding within the HSCRC rate setting formula is no longer applicable under a global or population-based revenue model.

While funding for small capital projects may be included in a global budget, there is a need to:

- Explore ways to fund larger capital projects; and,
- Balance ongoing capital funding to keep hospital infrastructure current with the constraints of TCOC's fixed budget model.

Insights and Comments

- Many considerations in developing policies concerning capital funding:
  - Looking at the replacement of obsolete facilities;
  - Recognizing the cost of new technology;
  - Accounting for the unpredictable nature of some capital needs.
- Possibly developing a separate methodology to account for big replacements.
- Accounting for capital funding relative to meeting targets negotiated with CMS. Hospitals concerned about whether capital funding must always remain within negotiated targets or would exceptions be considered?

Using MPA Framework to Achieve TCOC Savings

Proposal

- TCOC Model is required to save $300 million annually in Medicare expenditures by 2023.
- Objectives:
  - Create a predictable and transparent approach to set the annual Update Factor and achieve TCOC Model Medicare Savings;
  - Incentivize and prioritize participation in Care Transformation Initiative to share accountability for total cost of care with other provider types;
  - Establish a framework for reinvesting system savings in population health, infrastructure, or other innovative policies.
- Under proposed approach:
  - Continue to set Maryland hospital revenue at an economically sustainable rate for all payers;
  - Meet Medicare savings targets using MPA Framework;
  - Savings from other policy levers can be reinvested.

Insights and Comments

- Use of Care Transformation Initiative to achieve savings:
  - Need to include other, hospital-initiated Care Transformation Initiatives, not part of current approach;
  - Openness by HSCRC to consider hospital-initiated Care Transformation Initiatives beyond those formally recognized under Care Transformation Initiative.
- No impact of the Maryland Primary Care Program (MDPCP) reflected in modelling of savings; need for dialogue with MDH
  - Hospitals that run Care Transformation Organizations (CTOs) stand to gain from MDPCP.
- Combination of Care Transformation Initiatives and price levers should be used to achieve the financial targets required by the TCOC Model.

Summary and Recommendations

- HSCRC should assess hospitals on technical efficiency, total cost of care and quality.
- Investments should be directed to those CON-approved projects that score well on the three dimensions (i.e., efficiency, TCOC, quality).
- Need for a clear set of rules that defines the assessment process and the reallocation of resources to approved projects.
- In recommending shifting services out of hospital, HSCRC and other policy bodies need to consider the impact on access to care (especially for uninsured and underinsured), population health needs, the capacity of community-based providers to handle the increased demand, cost growth implications, and public awareness of the change.
- Need to make sure retained revenue is used appropriately, but an acknowledgement that transformation will vary by local circumstances.
- Need for greater transparency: 1) with respect to hospital prices; 2) HSCRC methodologies; 3) Policies supporting hospital transformation.
- Expand the dialogue on TCOC Implementation to MDH, MHCC, Payers, Physicians, and other providers.

SUMMARY OF HOSPITAL CEO DISCUSSION GROUP MEETINGS

Presented to the HSCRC at its September 11, 2019 Commission Meeting

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Overview

Purpose of the Discussion Group

The Total Cost of Care (TCOC) Model State Agreement calls for continued transformation of the delivery system in Maryland, and, consequently, continued evolution in Health Services Cost Review Commission (HSCRC) policy governing hospital global budgets and how the HSCRC and Maryland hospitals interact. As part of its efforts to facilitate these changes, the HSCRC committed to a series of discussion group meetings involving Commissioners and hospital CEOs to occur during the latter half of 2018 and the first half of 2019. The purpose of the meetings was to provide a forum for Commission members and key hospital leaders to discuss issues central to the long-term success of the TCOC Model. The group was assigned the task of considering the strategic implications of implementing the TCOC Model, but not making decisions or setting policy for the HSCRC or supplanting the HSCRC's normal work group process.

Background

Maryland has a distinguished and unique history of cooperation between hospitals and state government to control health care costs, while ensuring patient access and improving quality of care. Implemented in the 1970s initially through state authorizing legislation and subsequently a federal waiver granted by the Health Care Financing Administration (the predecessor to the Centers for Medicare and Medicaid Services (CMS)), the Maryland All Payer rate setting system established a uniform, prospective methodology for all payers (public and private) to reimburse Maryland hospitals for the cost of care.

The All Payer rate setting system is credited with holding down hospitals costs and ensuring equitable access to hospital services for all Marylanders while providing financial stability for hospitals facing large uncompensated care burdens. In 1976, the cost of an admission to a Maryland hospital was 26% above the national average; in 2007, the cost of admission to a Maryland hospital was, on average, 2% less than the national average.[1]

In January, 2014, CMS approved a revised waiver proposal submitted by the state to modernize the All Payer system. The new model required that Maryland move to global budgets per hospital and limit annual all-payer per capita total hospital cost growth to 3.58%. Under this waiver, Maryland was expected to generate $330 million in savings to Medicare over a 5-year period; however, the Model saved Medicare $916 million over the first four years[2]. At the same time, the state agreed to significant quality improvements: reducing hospital readmissions and hospital acquired conditions, while establishing and reporting on a series of population health measures.

In April 2017, Maryland and CMS signed an amendment to create the Care Redesign Program (CRP). The State began implementation of the Program in July 2017. Under CRP, Maryland hospitals, hospital-based providers, and community providers are offered incentives to develop and implement care pathways to

[1] Murray, Robert, (2009), "Setting Hospital Rates To Control Costs And Boost Quality: The Maryland Experience," *Health Affairs*, VOL. 28, NO. 5: Bending The Cost Curve, https://doi.org/10.1377/hlthaff.28.5.1395

[2] See: https://pub.maryland.gov/sites/HSCRC/Documents/Modernization/Updated%20APM%20results%20through%20PY4.pdf

improve care coordination during and after a hospital admission and care management outside of the hospital.

The TCOC Model State Agreement, which was signed by Governor Hogan and CMMI Director Adam Boehler on July 9, 2018, extends the global budget concept to include hospital and out of hospital expenditures. At a minimum, the state has agreed to reach $300 million in Medicare hospital expenditure savings relative to the growth in Medicare hospital expenditures nationally by 2023. By its very nature, this revised waiver emphasizes cooperation and collaboration between hospital and community providers to provide a continuum of services that ensure high quality and accessible care. To assist with this transition, the new waiver envisions the implementation of the Maryland Primary Care Program (MDPCP), which is designed to improve the capacity and capability of community-based providers. Through this agreement, the state also has agreed to establish Bold Improvement Goals, which challenge the health system to make demonstrable improvements in population health.

The TCOC Model Agreement outlines an innovative approach to controlling costs and improving health outcomes through comprehensive reform of the delivery system underpinned by financial incentives. The TCOC Model builds on Maryland's unique history of public-private cooperation in health service delivery and financing.

Approach and Structure of Discussion Group

The discussion group consisted of Maryland hospital CEOs and HSCRC Commissioners. The meetings were supported by HSCRC staff and Maryland Hospital Association (MHA) staff and facilitated by Westcott Partners, a health care consulting firm. The participants in one or more of the meetings included:

Hospitals: Bob Chrencik (UMMS), Henry (Hank) Franey (UMMS), Tom Kleinhanzl (Frederick), Tom Mullen (Mercy), Joe Ross (Meritus), Eric Wagner (MedStar), Kevin Sowers (Johns Hopkins), Dean Teague (Calvert)

MHA: Bob Atlas (CEO), Brett McCone, Mike Robbins

HSCRC Commissioners: Joseph Antos, John Colmers, James Elliot, MD, Adam Kane, Nelson Sabatini (Chair)

HSCRC Staff: William Henderson, Madeline Jackson, Chris Peterson, Jerry Schmith, Allan Pack, Will Daniel, Judy Wang, Katie Wunderlich (Executive Director)

Westcott Partners: Jonathan Foley, John O'Brien

Five meetings took place between October, 2018 and May, 2019:

- October 17, 2018
- November 12, 2018
- January 15, 2019
- March 22, 2019
- May 3, 2019

The meetings were each 2 hours in length and consisted of an open format where participants were encouraged to share insights and concerns. The facilitators provided read-ahead materials prior to each meeting and meeting notes following each meeting.

Key Issues Discussed

The group acknowledged that the TCOC Model Agreement raised many critical issues for Maryland hospitals and the health system as a whole. The group focused on four main topics:

- Maryland Hospital Capacity
- Global Budget Methodology and Transparency
- Shifting Services from Rate Regulated Settings
- Capital Funding

These issues are of paramount concern to hospital CEOs and, by and large, fall within the jurisdiction of the HSCRC. Other issues important to the success of the TCOC waiver include: implementing the Maryland Primary Care Program, improving population health and incentivizing investment, striking meaningful partnerships between hospitals and community-based providers, defining the roles of the HSCRC and other state agencies in coordinating the TCOC Model, and funding unexpected cost increases such as a sudden and steep rise in the cost of specialty drugs. The group agreed that continued discussion of these and other topics is important, but should occur with a wider group of participants, including the Maryland Department of Health (MDH), the Maryland Health Care Commission (MHCC), physician groups, managed care organizations, and health insurers.

The Maryland Hospital Association proposed a strategic vision to guide discussions concerning implementation of the TCOC Model:

> *A **sustainable health care system** is one in which the population sees steadily improving experience of care and better health, all payers and consumers spend reasonable sums for health services in total, and health care facilities and providers are compensated adequately both to furnish needed services and to continually refresh their capabilities to maintain excellence.*

Maryland Hospital Capacity

Issue

The HSCRC and the MHCC have each reported that Maryland's total hospital capacity currently exceeds the State's needs and is inconsistent with the provision of efficient, quality care. In its FY 2017 Annual Report on Maryland Hospitals[3], MHCC reported:

[3] Maryland Health Care Commissions, "Annual Report on Selected Acute Care and Specialty Hospital Services: Fiscal Year 2017," https://mhcc.maryland.gov/mhcc/pages/hcfs/hcfs_hospital/documents/acute_care/chcf_Annual_Rpt_Selected_Hospital_Services_FY2017.pdf

- 40 general hospitals in Maryland with 6,185 licensed acute care beds report the availability of physical bed capacity that exceeds their licensed capacity;
- Central Maryland has the greatest excess, with reported physical bed capacity exceeding licensed bed capacity of 932 beds, followed by Southern Maryland with 497 more physical beds than licensed beds.

Removing excess hospital capacity has the potential of reducing fixed costs and generating savings for the health system as a whole. If implemented in a thoughtful manner, reductions in hospital capacity should not result in deteriorations in quality of care or restrictions in access to needed services. Insights from hospital CEOs with on the ground experience will aid the HSCRC in formulating an equitable methodology for reducing excess capacity, while acknowledging that the impact on Maryland hospitals will vary and the process affects the health care system as a whole.

Insights and Comments

The group acknowledged the need to reduce overall bed capacity and the associated fixed costs to live within budgets. The group discussed the financial burden on the entire hospital system posed by excess capacity. Carrying that excess capacity in some hospitals and not in others leads to an inequitable distribution of resources. Currently, the system lacks clear policies or incentives to reduce excess capacity. Without such levers, political factors take over. The group discussed recent examples of vocal community opposition and the involvement of elected officials in preventing hospital downsizing.

There was general agreement that the first step is to use data to define excess capacity. The group did not attempt to develop such a definition, but generally acknowledged that the Commission should attempt to develop measures of excess cost by considering a combination of physical occupancy and rate efficiency, and apply such measures to all hospitals to facilitate an informed discussion of options to remove excess capacity from the system. The group acknowledged that quality of care and total cost of care (TCOC) also need to be considered along with excess cost and efficiency. The Commission should also look at excess cost in the context of defined catchment areas.

Once these efficiency and effectiveness standards are agreed upon, an assessment of the hospital system should occur to identify areas and institutions with excess cost. This assessment should be performed in a transparent manner. Community and political leaders need to be involved in the process from the beginning to facilitate fact-based discussions of future options.

A range of possible options for reducing excess capacity was discussed. Overall, the group favored the development of incentives that lead to changes in service configuration without necessarily removing services entirely from the community. Bon Secours Hospital in west Baltimore was offered as an example of such an approach. In this case, the hospital leadership was committed to continuing to offer services in the community; however, instead of struggling to maintain inpatient hospital services that were not financially sustainable, the hospital board agreed to reconfigure the service delivery model to one based on non-institutional, community-based services that improved access to primary care, behavioral health and outreach services.

Another example of a conversion rather than closure was Laurel. In this case, the hospital was downsized from an inpatient facility to an outpatient facility. The downsizing of Laurel occurred in the context of the

opening of the Prince George's Hospital Center in nearby Largo. Hence, the wider Prince George's County community was not losing inpatient capacity, but that capacity was being relocated to a newer facility.

Both of these examples occurred within the context of transforming facilities within hospital systems. All agreed that such transitions have different dimensions for a solo hospital in a community where no reasonable alternatives exist. For example, safe harbors may be needed for certain costs associated with a vital service in the community (e.g., prenatal and maternal care). Some rural hospitals in Maryland may be in this situation. The group also discussed whether reductions in hospital capacity may necessitate increasing the volume or intensity of services delivered in less costly community settings.

The group acknowledged that in seeking alternatives, the Commission should look at advances in technology that have improved access and quality. Developments to ambulance capabilities have resulted in "ERs on wheels," enabling staff the ability to diagnose and initiate treatment for some conditions well before arriving at an ER or inpatient facility. Other advances in telehealth and remote monitoring have effectively removed or greatly reduced barriers to specialty care and disease management. Improved highways also have reduced travel times in rural communities.

Additionally, there is a need to consider the capacity of community-based providers and alignment with the Maryland Primary Care Program and payer policies. In some communities, there may be a lack of community-based providers to absorb services shifted from hospitals. To the extent that MDPCP and payer policies support increased capacity in the community, there may be more opportunities to move services out of hospital.

There was some frustration expressed at the lack of savings to the system resulting from previous hospital closures or conversions. It was acknowledged that some hospital transformations will lead to the development of more appropriate services for the community, but they may not lead to significant savings.

There was a general consensus that the Commission should:

- Assess hospitals on technical efficiency, total cost of care and quality;
- Direct investments to those CON-approved projects that score well on the three dimensions (i.e., efficiency, TCOC, quality);
- Focus discussion less on general excess capacity and more on different capacity;
- Develop a clear set of rules that defines the assessment process and the reallocation of resources to approved projects; and,
- Acknowledge retained revenue must be used appropriately, but the shape and direction of hospital transformation will vary by local circumstances.

Global Budget Methodology[4] and Transparency

Issue

While hospital global budgets set clear goals for hospitals, the factors that determine those budgets are not static. If not administered carefully, this process can lead to sudden, significant changes in individual

[4] The HSCRC now refers to Global Budgets as Population-based Revenue (PBR).

hospital revenue projections. There is a need to account for: population changes, technology innovation, and service mix changes. Also, the effects of these factors on global budget incentives need to be considered.

The impact of global budgets on hospitals overall is still unfolding: a recent evaluation shows that savings from global budgets were largely due to expenditure reductions on outpatient services while reductions in avoidable hospital admissions were mixed and relationships with community providers had not improved.[5] Expanding the scope of the Model from hospital costs to total cost of care heightens the need for a more integrated and aligned health delivery system and incentive structure.

Insights and Comments

The question was posed to the group about the possibility of re-basing the rate setting model. If so, how would re-basing occur and what methodologies would be used? After considerable discussion, there was no consensus on the need to re-base. However, there seemed to be agreement on several aspects of the rate setting model going forward:

- All agreed that the technical aspect of the Model needed to be communicated more clearly and comprehensively so that hospital administrators and board members can understand why shifts in funding occur and their implications for service delivery.
- To the greatest extent possible, the Model needs to be transparent and allow for predictability and understanding of the adjustments made to global budgets.
- The group also agreed that the Model needs to provide a predictable funding path for each hospital to facilitate planning.
- The group thought that the Model should incorporate incentives to reduce excess capacity along the lines of what is occurring through the Care Transformation initiatives.
- The group also thought that the model should continue to account for disease patterns (e.g., growth in diabetes prevalence) and population health trends more globally, along with overall health care spending patterns.

Finally, there was agreement that the HSCRC, in collaboration with other state regulatory bodies and MDH, needs to ensure that the right amount of money is in the health system (regulated and non-regulated) to address documented health needs. The group expressed support for population health analysis that would identify current and projected needs to guide such investment.

Shifting Services From Rate Regulated Settings

Issue

The distinction between the HSCRC regulated space and unregulated outpatient services has been a recurrent issue for the Maryland all-payer system. Making this distinction is even more pressing because:

- Global budget targets increase the incentive to move services away from the hospital into unregulated, (often) less expensive settings.

[5] Haber, Susan et al, "Evaluation of the Maryland All-Payer Model: Third Annual Report," RTI International, March, 2018, https://hscrc.maryland.gov/Documents/Modernization/md-all-payer-thirdannrpt.pdf

- Patients are paying more out of pocket for the cost of care because employers and payers are incentivizing enrollment in high deductible plans and increasing consumer cost sharing requirements in traditional product offerings.
- Cost-to-charge ratios have not been updated since the 1970s and are inflated, creating opportunities for other providers to undercut hospital prices.

Managing this shift from care in rate-regulated space to non-regulated settings presents several challenges to the HSCRC. Additionally, transitioning services to community-based settings requires alignment of policies among HSCRC and other state agencies, principally MHCC and MDH.

Insights and Comments

The group discussed recent trends across the hospital industry driving the move of services out of hospital and the impact of these trends:

- There is a growth of ambulatory surgery centers and other freestanding medical facilities (FMFs) in Maryland and elsewhere. In a 2019 national study, Blue Cross Blue Shield reported that knee and hip replacements for its covered members increased by 17 percent and 33 percent, respectively, between 2010 and 2017. Increasingly, these procedures are occurring in outpatient settings where the cost is approximately one third less. In this study, the rates of outpatient hip and knee replacement rates occurring in Maryland are among the middle tier of states.[6]
- Kaiser California is developing large non-hospital facilities that include many of the services one would expect in a hospital, except the ability to stay overnight. An example closer to Maryland is the NOMA/Capitol Hill Kaiser outpatient facility that was opened in the last couple of years.
- There are more than 300 ambulatory surgery centers in Maryland. However, depending on the configuration, ambulatory surgery centers can be inefficient and more costly than inpatient surgery.
- Some called for a more expansive definition of home care. For example, providers in St. Louis have moved ahead with the "hospital at home" concept. It was noted that the Maryland Department of Health and a provider-led Stakeholder Innovation Group may request a federal waiver from Medicare rules to allow Maryland nurse practitioners to write home health orders and practice to their full capability.
- There is an increasing proportion of Medicare occupancy in hospitals because of demographic shifts and pressure by commercial payers to move services out of hospitals, which leads to higher per unit cost in hospital.
- A downside of moving care to community-based facilities is that such facilities are not currently obligated to accept Medicare and Medicaid. This reduces access for people covered by public payers and increases the concentration of Medicare and Medicaid patients in hospitals, thereby driving up the cost of hospital care. One solution is requiring ambulatory surgery centers and similar facilities to take Medicare and Medicaid as a condition of licensure and/or through the Certificate of Need (CON) process.

[6] Blue Cross Blue Shield, "Planned Knee and Hip Replacement Surgeries are on the Rise in the U.S.," January 23, 2019, https://www.bcbs.com/sites/default/files/file-attachments/health-of-america-report/HoA-Orthopedic%2BCosts%20Report.pdf

Possible Solutions Available within Current HSCRC Policy

Legislation enacted in 2016 gives the Maryland Health Care Commission (MHCC) the ability to issue a CON exemption to a general hospital that is converting to an FMF. FMFs are regulated by HSCRC by extension of regulation of the FMF's parent facility. FMFs provide emergency services and may offer observation beds, but do not have inpatient care capabilities. To date, only one hospital (Laurel) has received a CON exemption to establish an FMF. Members of the group asked for more information on the process of establishing an FMF, the methodology for moving some services out of hospital (but not necessarily to an FMF), and how this can occur within the current regulatory structure.

The group also discussed the possibility of moving services from rate regulated space to non-rate regulated space within the existing hospital physical plant. Some noted that hospitals can provide outpatient surgery as efficiently in a hospital setting as ambulatory surgery centers and could compete on price with non-hospital providers if given the opportunity. The group asked for more information from HSCRC staff on:

- benchmarks available to help determine when services should be shifted out of hospital regulated space;
- the process for moving services out of hospital regulated space; and,
- current models that reduce service capacity.

The group discussed an instance where a hospital shifted a service from regulated to unregulated space on its own volition. Frederick Hospital shifted all cancer services from the inpatient facility to a community-based, unregulated space that is located two miles from the hospital. This initiative was undertaken by the hospital on its own without a regulatory requirement or an explicit incentive. The Frederick Board determined that moving cancer services out of the hospital's rate regulated space made the services more competitive. It was noted that the hospital would undertake more moves of this type if the incentives were aligned to support such moves.

Price Transparency for Consumers and Payers

Public concern about hospital prices is increasing because payers are shifting costs to consumers in the form of higher cost sharing requirements. For example, it is now common for payers in Maryland to require that consumers pay a share of inpatient hospital costs (beyond emergency and outpatient care) as part of standard PPO coverage. Additionally, more patients are in high deductible plans, which require that they pay a greater share of hospital costs. At the same time, cost per unit rates have been affected by global budget revenues (GBRs). This confluence of factors has led the general public to ask more questions about hospital charges. The lack of price transparency for patients and payers is fueling confusion about overall costs, costs per unit, and the extent of consumer responsibility to pay for inpatient hospital services out of pocket. There is a need for HSCRC to clearly articulate the deregulation policy for the benefit of the general public.

In large part, payers are driving the shift to out-of-hospital care. HSCRC is studying what it can do within its own regulatory structure to respond to the trend. The study will encompass what can be done within the Total Cost of Care (TCOC) Model and which services make sense to push out and which to keep in.

It was noted that cost allocations have not been updated since the 1970s and are inflated, creating opportunities for other providers to undercut hospital prices. For example, the current overhead on drugs

is not sustainable. The group asked if the HSCRC could change the overhead allocation for outpatient vs. inpatient services and provide different incentives to appropriately move services from inpatient to outpatient in a way that drives reduction in the total cost of care.

Nagging Difficulties in Reducing Hospital Costs

The group discussed that moving services out of the inpatient setting has not necessarily reduced costs. For example, there has been an increasing concentration of observation beds that are classified as outpatient, but still in the hospital setting. The impact is felt by patients because cost sharing is higher for outpatient care. Additionally, the proportion of monitored beds, particularly for cardiac patients, has increased largely due to physician preference; only about one half of patients require cardiac monitoring based on need.

There is increased expense to the hospital if a service is moved out, but the space remains unused and is not drawing revenue. In some cases, there has been a loss of volume but GBR has increased or has not been reduced as much as expected from the loss of a service unit. Howard County General Hospital presents an example of increased net expenses in the short term despite a shift of care outside the hospital. The shift costs $9 million in one year, but these costs are not made up quickly enough by the revenue from out of hospital services. The result is a net loss of $3 million because the hospital cannot recover costs fast enough.

Despite the shift to out-of-hospital care, residual hospital costs are not declining at the rate one would expect. As utilization of out-of-hospital services is growing, there is a need to monitor overall costs to ensure that the State meets its TCOC model and sustainable growth goals. The group expressed concern about MHCC's approach to granting CONs, which is expanding supply to community-based services without necessarily reducing total spending. Further discussions with MHCC are needed to align CON approval processes with HSCRC efforts to reduce excess capacity within the overarching requirement to reduce the total cost of care.

Impact of Shifting Services out of Hospital on Access to Care

The group discussed the impact of hospital downsizing on access to care and communities more generally. There were several key points:

- Coverage of uncompensated care – whether in hospital or out of hospital – is a key principle that should be retained by the system as a whole (hospital and non-hospital).
- The shift of services out of hospital could reduce access if non-hospital providers do not accept Medicare, Medicaid, certain private insurance, or the uninsured.
- In making the transition, policymakers need to consider the political reality that a hospital in a rural community is often the major employer and, therefore, change is viewed as a job loss.
- The independent, community hospital, especially in rural communities, may be receding as a part of the hospital landscape. Yet, certain community hospitals provide essential services that would be difficult to replace.
- There is concern about a subset of patients with co-morbidities that cannot be shifted to unregulated space safely.

The group reviewed several examples of the pressure on solo community hospitals to consolidate and the advantages and disadvantages of such consolidation. HSCRC should prioritize incenting hospitals to work together, to apply principles of care transformation (e.g., high quality and cost-effective patient transitions to the community) to hospital consolidation, and to build up behavioral health, health information technology, and other infrastructure.

Some asserted that there is a need to increase professional fee reimbursement and believed that health insurers are major culprits in low Maryland physician reimbursement compared to the nation. Low reimbursement drives physicians to increase volume in an effort to gain more revenue. There is a need for more research to understand whether Maryland physicians are reasonably compensated.

Payers need to be more creative in how they encourage care transformation type initiatives. There should be enhanced payments from third party payers to physicians to mitigate concerns about shifting services from the hospital to the community. Additionally, there is a need for more research to understand what is occurring in the community when such shifts occur.

The benefits of the TCOC Model should be articulated to consumers. There is also a need to understand the role, if any, of consumer preferences on the shift to out-of-hospital care.

The MHCC should consider changes to the issuance of CONs (e.g., 1 plus 1 ambulatory surgery centers can be hugely inefficient) and the regulation of self-referral (e.g., urology cases) to radiation centers owned by physicians. If physicians are given protection from Stark rules (i.e., anti-kickback) by the CON process, they need to align with care transformation initiatives and principles.

Capital Funding

Issue

The traditional mechanism for capital funding within the HSCRC rate setting formula is no longer applicable under a global or population-based revenue model.

While funding for small capital projects may be included in a global budget, there is a need to:

- Explore ways to fund larger capital projects, and
- Balance ongoing capital funding to keep hospital infrastructure current with the constraints of TCOC's fixed budget model.

Insights and Comments

The group discussed instances where hospitals have capital needs that may be difficult to accommodate within global budget financing arrangements. One such example is the replacement of obsolete facilities. A major facility replacement requires significant planning and an infusion of funding that may surpass what can be saved through incremental allocations available through global funding. The group discussed the possibility of developing a separate methodology for large replacements.

Another pressure is the unpredictable nature of capital needs. A shift in the need for particular service in a community may occur faster than a hospital's ability to set aside capital funding through GBR.

Another pressure is the cost of technology. To maintain currency with treatment protocols, hospitals continually invest in new technology. While hospitals attempt to keep pace with the demand from clinicians and the public for the latest, most effective technology, the introduction of new technology generally increases health care costs overall, even in health systems with cost controls such as global budgets.[7]

There was some discussion of whether certain capital investment might not count as expenditures for the purposes of achieving the savings targets negotiated with CMS.

Using MPA Efficiency Component[8] to Achieve TCOC Savings

Issue

The TCOC Model is required to save $300 million annually in Medicare expenditures by 2023. The group discussed a proposal put forward by the HSCRC to use the Medicare Performance Adjustment (MPA) Efficiency Component to achieve the $300 million in Medicare savings and encourage participation in Care Transformation Initiatives. Through the MPA, the expenditures of Medicare beneficiaries (in hospital and out of hospital) are attributed to specific Maryland hospitals. The MPA Efficiency Adjustment incorporates each hospital's contributions to improve value-based care. The MPA Efficiency Adjustment allocation would be based on each hospital's share of Medicare expenditures; for example, if the annual savings target is $36 million and a hospital has a 10% share, then the hospital's MPA Efficiency Adjustment would be $3.6 million. That same hospital could recoup the reduction if its reconciliation payment from participating in Care Transformation Initiatives exceeded $3.6 million.

The objectives of the proposal were to:

- Create a predictable and transparent approach to setting the annual Update Factor and achieving TCOC Model Medicare Savings;
- Incentivize and prioritize participation in Care Transformation Initiatives to share accountability for total cost of care with other provider types;
- Establish a framework for reinvesting system savings in population health, infrastructure, or other innovative policies

The proposed approach would:

- Continue to set Maryland hospital revenue at an economically sustainable rate for all payers
- Meet Medicare savings targets using MPA Efficiency Component
- Reinvest savings from other policy levers.

Insights and Comments

There was considerable discussion of the use of Care Transformation Initiatives. Some in the group cited hospital-initiated projects that fulfill the goals of care transformation but are not formally recognized as

[7] Bodenheimer, Thomas, "High and Rising Health Care Costs. Part 2: Technologic Innovation," Ann Intern Med. 2005;142:932-937, https://geiselmed.dartmouth.edu/cfm/education/PDF/heath_care_costs_2.pdf

[8] This is now referred to as the MPA Framework.

Care Transformation Initiatives. The HSCRC expressed openness to consider hospital-initiated Care Transformation Initiatives beyond those formally recognized.

The group noted that there was no impact of the Maryland Primary Care Program (MDPCP) reflected in modelling of savings. There is a need for dialogue with MDH to better understand how MDPCP may contribute to savings. On a related note, several members commented that hospitals that manage Care Transformation Organizations (CTOs) stand to gain financially from MDPCP.

Several in the group recommended that a combination of Care Transformation Initiatives and price levers be used to achieve the financial targets required by the TCOC Model.

Commissioners subsequently decided not to pursue the MPA Efficiency Adjustment proposal described above.

Summary and Recommendations

Through a series of five meetings held over a nine-month period, hospital CEOs, HSCRC Commissioners, and staff from HSCRC and MHA discussed a range of issues that affect the implementation of the Total Cost of Care Model agreed between the State and CMS. The discussion clustered around four key themes: excess capacity in Maryland hospital, the global budget methodology and transparency, shifting care from regulated space to unregulated space, and capital funding. Additionally, the group discussed a way of achieving the TCOC Model savings target using the MPA Efficiency Adjustment. Though this approach is not being pursued, the discussion surrounding this proposal raised important issues about Care Transformation Initiatives.

This dialogue resulted in several high-level recommendations:

- HSCRC should conduct a comprehensive assessment of Maryland hospitals on technical efficiency, total cost of care and quality.
- Investments in Maryland hospitals should be directed to those CON-approved projects that score well on the three dimensions (i.e., efficiency, TCOC, quality).
- There is a need for a clear set of rules that defines the assessment process and the reallocation of resources to approved projects.
- In recommending shifting services out of hospital, HSCRC and other policy bodies need to consider the impact on access to care (especially for uninsured and underinsured), population health needs, the capacity of community-based providers to handle the increased demand, cost growth implications and public awareness of the change.
- There is a need to ensure retained revenue is used appropriately, but an acknowledgement that transformation will vary by local circumstances.
- The general public, community leaders, and hospital boards need greater transparency with respect to: 1) hospital prices; 2) HSCRC methodologies; 3) Policies supporting hospital transformation.
- There is a need to expand the dialogue on TCOC Implementation to include the Maryland Department of Health, MHCC, payers, physicians and other provider groups.

Maryland Primary Care Program

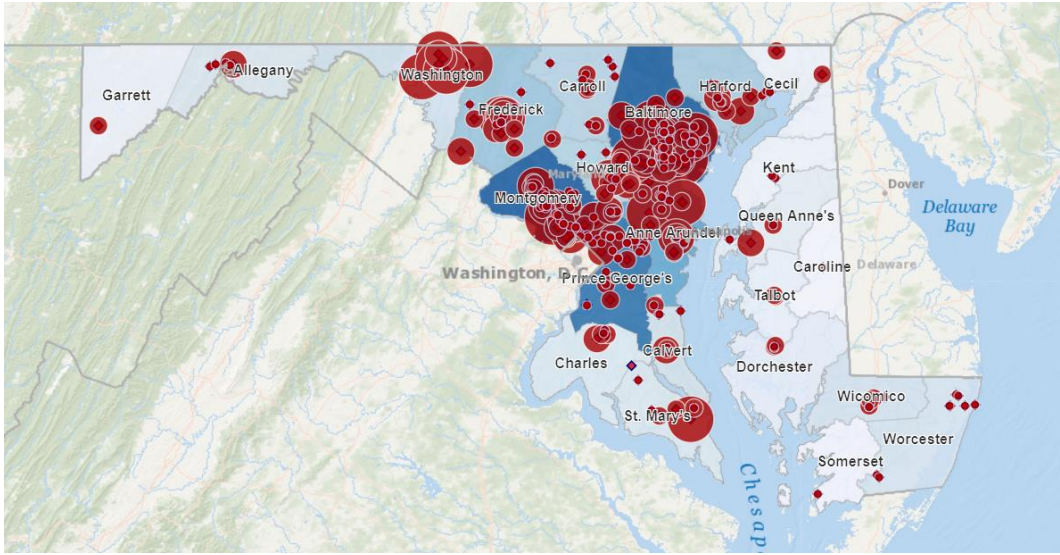
September 11, 2019
Program Update
Howard Haft, MD, MMM, CPE, FACPE
Executive Director, MDPCP

State-wide Health Care Delivery Transformation

- The MDH will assist CMS in the implementation of the Maryland Primary Care Program ("MDPCP") to provide better patient-centered care for Maryland residents.
- Under this Model, CMS and the State will test whether **State-wide health care delivery transformation**, in conjunction with Population-Based Payments, improves population health and care outcomes for individuals, while controlling the growth of Medicare Total Cost of Care ("TCOC").

Overview

- MDPCP
  - is rapidly improving the delivery of healthcare in Maryland
  - covers the entire state and continues to grow
  - focused on unnecessary hospital utilization
  - integrating behavioral health
  - addressing social needs
  - bolstered health data exchange in primary care practices



MARYLAND Department of Health

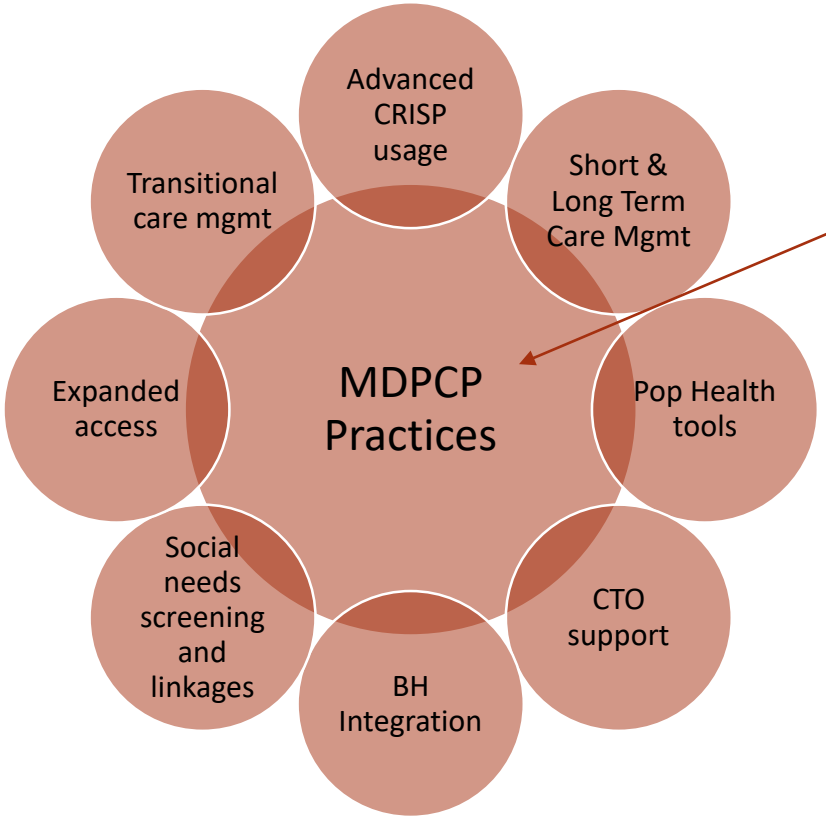
Program Year 1

376 Practices Participating

- ~ 220,000 attributed beneficiaries
- ~ 1,500 Primary Care Providers
- ~ 40% employed by hospitals
- All counties represented
- 21 Care Transformation Organizations (min 6/county)
  - **14 of 21 are hospital-based**

- 150 additional practices applied to participate in 2020
- 3 new CTOs preliminarily approved for 2020

Comprehensive Care



PMO

Coaching;
Technical assistance
Leadership;
Tools;
Contractor support

MARYLAND Department of Health

MDPCP Behavioral Health Integration

BHI Reporting (Q1)

BHI: Strategy for addressing BH Needs	# Practices
Referrals for External Behavioral Specialists	146
Primary Care Behaviorist Model	104
Care Management for Mental Illness Model	89
Other	30

Mosaic SBIRT Implementation Data

SBIRT Readiness	# Practices
Ready to Start	88
In Progress	90
Complete	31

As of Aug 2019

MARYLAND Department of Health

CRISP/HIT Usage

Number of practices

Measure	Quarter 1	Quarter 2
Practices with Active Participation Agreement with CRISP	380	380
Practices using Encounter Notification System (ENS)	166	215
MDPCP CRISP Claims Reports (CRS)	150	375 (Thru July19)
Practices using care alerts	N/A	134
Practices with 2015 Certified Electronic Health Record (EHR)	257	346

Expansion and Innovation

Program Expansion

- Commercial Payer opportunity included in 2020 RFA
- Potential additions for 2021
  - FQHCs Proposed
  - Chronic Health Homes

Operational Developments and Future Innovations

- CRISP MDPCP Dashboard
- eCQM Reporting Tool
- CTO Comparison Tool
- Enhanced Attribution Methodology
- PQI Risk Tool
- E-Referrals for SDoH and Diabetes prevention

Thank you!

Updates and More Information:

https://health.maryland.gov/MDPCP

MARYLAND Department of Health

Policy Update Report and Discussion

Staff will present materials at the Commission Meeting.

Presentation on CEO Focus Groups

Staff will present materials during the Commission meeting.

MDPCP Update

Staff will present materials during the Commission meeting.

State of Maryland
Department of Health

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William Henderson, Director
Medical Economics &
Data Analytics

TO: **Commissioners**

FROM: **HSCRC Staff**

DATE: **September 11, 2019**

RE: **Hearing and Meeting Schedule**

October 16, 2019 To be determined - 4160 Patterson Avenue
HSCRC/MHCC Conference Room
Please note this is a NEW DATE

November 13, 2019 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 11:15 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://hscrc.maryland.gov/Pages/commission-meetings.aspx.

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